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Gambling with the health of Londoners: levers and barriers to addressing gambling harms using public health approaches in local government

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DECLARATION

I, Dr Jenny Blythe, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

ABSTRACT

Since the mid-2010s, public health has increasingly been recognised in the UK as one of many gambling harms affecting individuals and society at a time when public health teams had just moved into local government.

There is no legal requirement for local public health teams to be involved in decisions on licencing gambling premises, and several gambling activities (such as the National Lottery and online gambling) fall outside of local government's direct influence. Consequently, these teams must find innovative ways to tackle these growing threats to health.

My research aimed to identify levers and barriers that local authorities in London can adopt to address health-related gambling harms. It used a mixed method approach to identify the underlying "mechanisms" that can support or hinder this approach.

I found an increasing concentration of gambling outlets in deprived areas but also a dominant discourse that conceptualises gambling as a "fun" leisure activity and legislation that seek to confine local government within the narrow silo of land-based licensing.

Surveys and interviews with local public health teams revealed a broad range of interests and influences on gambling policy, but effective action was hindered by their lack of power, financial resources, and knowledge of effective interventions. A poor evidence base exacerbated the situation, much industry-funded and thus downplaying effective measures.

The underlying mechanisms identified in the mixed methods analysis were a tolerance of harm by society, influence exerted by the gambling industry, disempowerment of local government, and heterogeneity (of local government, of public health teams, and of gambling products). These mechanisms can counteract, moderate, or reinforce each other and whether they lead to action is highly context-dependent.

I have used these findings to create a list of recommendations for local public health teams.

CONTENTS

List of figures

List of tables

List of boxes

List of Abbreviations

APPG	All Party Parliamentary Group
ACT	Australian Capital Territory
ADPH	Association of Directors of Public Health
AGC	Adult Gaming Centres
ASBG	Advisory Board for Safer Gambling
ATM	Automated Teller Machine
CDoH	Commercial Determinants of Health
CIA	Cumulative Impact Assessments
CIZ	Cumulative Impact Zones
CLA	Critical Logics Approach
CR	Critical Realism
DA	Discourse Analysis
DCMS	Department of Culture, Media & Sport
DHSC	Department of Health & Social Care
DPH	Director of Public Health
DsPH	Directors of Public Health
EFTPOS	Electronic Funds Transfer at Point of Sale
EGM	Electronic Gaming Machines
FEC	Family Entertainment Centres
FGC	Family Gaming Centres
FOBTs	Fixed Odds Betting Terminals
FTE	Full Time Equivalent
GGY	Gross Gambling Yield
GIS	Geographical Information Systems
GLA	Greater London Authority
GMCA	Greater Manchester Combined Authority
HiAP	Health in All Policies
HWB	Health & Wellbeing Board
IMD	Index of Multiple Deprivation
IPE	Inter-professional education
LBO	licenced betting office
LGA	Local Government Association
LSHTM	London School of Hygiene & Tropical Medicine
MP	Member of Parliament
NAO	National Audit Office
NCD	Non-Communicable Disease
NEL	North East London
NGO	Non-Governmental Organisation
NHS	National Health Service
NICE	National Institute for Health & Care Excellence

NIHR	National Institute of Health Research
OHID	Office for Health Improvement & Disparities
PGSI	Problem Gambling Severity index
PHP	Public Health Practitioners
PSDT	Post Structural Discourse Theory
RA	Responsible Authority
RCGP	Royal College of General Practitioners
RET	Research, Education & Treatment
RGSB	Responsible Gambling Strategy Board
RSPH	Royal Society of Public Health
TfL	Transport for London
UCI	Unhealthy Commodities Industry
UK	United Kingdom
UKHSA	United Kingdom Health Security Agency
USA	United States of America
VLT	Video Lottery Terminals
VPN	Virtual Private Networks
WA	Western Australia
WHO	World Health Organisation
YGAM	Young Gamers and Gamblers Education Trust

Chapter 1 Introduction

1.1 What is this thesis about?

This thesis asks what role public health teams in local government in England can play in tackling gambling harm. Gambling harm has been defined as *"any initial or exacerbated adverse consequence due to an engagement with gambling that leads to a decrement to the health or wellbeing of an individual, family unit, community or population"*[1]. In the UK, gambling harms are increasingly conceptualised as a public health issue by national organisations [2, 3] reflecting growing awareness of their impact not only on the individual but on their family and friends and wider society and the disproportionate risk of harm to some vulnerable groups. Given that a significant proportion of the UK's "*land-based gambling*" (such as bookmakers, arcades and bingo outlets) is found within the Greater London area [4], this thesis focuses on London's local government, although it also looks to other metropolitan areas of the UK to understand how gambling harms are already being addressed. Furthermore, the thesis marries my own personal academic interests in public health and localism and my wish to gain a deeper understanding of local government in my role as a community clinician, as we are now expected to work together under the umbrella of an integrated care system.

1.2 Public health in Local Government

1.2.1 A time of change

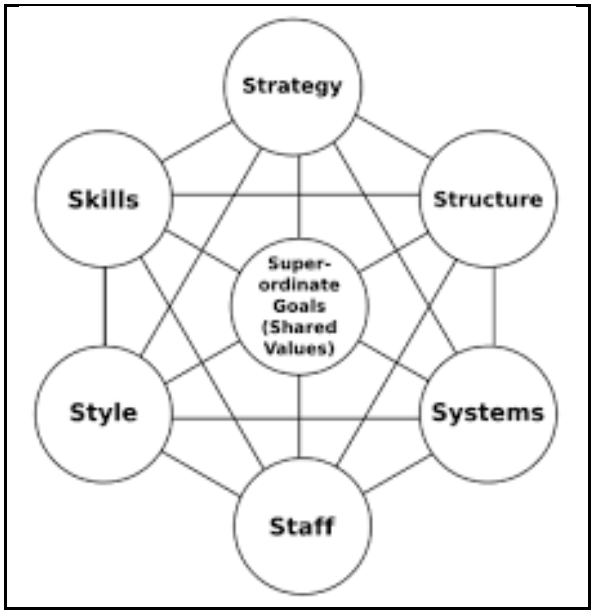
This thesis is timely, having been undertaken at a time of immense change within England's national public health structure. In 2021, Public Health England (PHE) was broken up, creating two new organisations: the UK Health Security Agency (UKHSA), which oversees threats "*such as infectious diseases*", and the Office for Health Improvement and Disparities (OHID), that covers health determinants "*including obesity and nutrition, mental health across all ages, physical activity, sexual health, alcohol and tobacco, amongst other areas*"[5, 6]. This latest reorganisation of public health comes less than a decade after the 2012 Health and Social Care Act, which created PHE and moved public health services from the NHS into local government structures. Under the Act, local public health teams were also given responsibility for a number of clinical activities, including sexual health, smoking cessation and child surveillance, and a Director of Public Health (DPH) was appointed to each local public health team [7].

Although the public health structure in local government will not be altered directly by these national changes, it is an appropriate time to examine how public health teams can influence policy in local authorities. Firstly, under the 2012 Act, public health teams in local government were given "*the responsibility for improving the health of their population*" and "*driving health improvement*"[7], and as such, local public health teams play a crucial role both in terms of activities that fall within their scope of action and through the advice that they offer to their elected members. Secondly, how health determinants are conceptualised nationally by the OHID will impact the prioritisation and delivery of interventions to tackle these determinants at the local level. At present, gambling is set to fall under the remit of the Director of Addictions within the OHID, alongside alcohol, tobacco, and drugs, as opposed to under the Director of Public Health Policy, Innovations and Systems [8].

The Health and Social Care Act also did not specify where local public health teams should be 'placed' within local government structures. Peckham et al. found considerable variation in their locations [9]. A 2020 Kings Fund report concluded that public health teams are "*well embedded*" and "*in the right place*" in terms of being situated within the local government structure [10].

However, the variation in the 'place' of individual public health teams within local government remains a crucial factor influencing their overall effectiveness. This issue is highlighted in organisational management theory, such as McKinsey's 7S structure, which emphasises the importance of the 'hard S's' of Structure, Staff, Systems and Strategy (see Fig 1) [11], and Mendelow's Stakeholder Analysis that considers both power and interest (Fig 2) [12].

Figure 1-1 Visual Representation of McKinsey's 7S Framework Model



Peters & Waterman, 2015 [11]

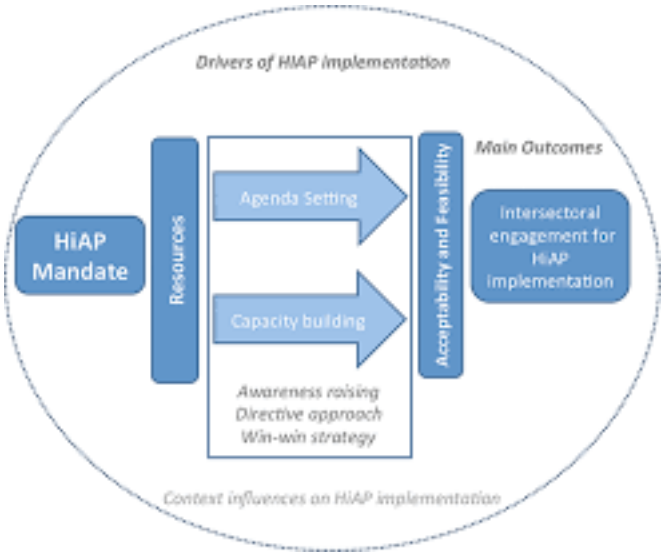
Figure 1-2 Mendelow's Matrix of Stakeholder Analysis

Mendelow, 1991 [12]

1.2.2 Health in All Policies

Health in All Policies (HiAP) recognises that many policies other than those primarily focused on health can impact the population's health. The World Health Organisation (WHO) defines it as "*an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts to improve population health and health equity*"[13, 14]. A conceptual framework for implementing a HiAP framework is displayed below (Fig 3).

Figure 1-3 Conceptual framework of a Health in All Policies (HiAP) approach



Molnar, 2016 [15]

The HiAP approach has attracted widespread support from local government. For example, the UK's Local Government Association (LGA) has stated that: "*It is not about public health taking over the remit of other areas, but about ensuring that there is a common*

understanding of health and health inequalities across the council, a common way of analysing the health impact of the range of council functions and a common commitment to maximising the positive health impact of all of these functions"[16]. The Greater London Assembly (GLA) also advocates a HiAP approach as part of its Health Inequalities strategy[17].

Many published case studies have used a HiAP approach to address issues not classically defined as a 'public health problem'. The King's Fund has described examples where public health teams "*had managed to innovate...outside its usual remit...in violent crime, for example*"[10]. One frequently cited example is the Scottish government's approach to knife crime in which "*working in partnership with other local agencies...developed a comprehensive approach to prevention with measures in the areas of education and law enforcement that sought to intervene early in the journey of individuals who may be affected*"[18]. Public health professionals are increasingly involved in a far wider range of service areas, covering children's services, parks and green spaces, transport, economic policy, libraries, and housing policy [19], and a HiAP approach can support public health teams' integration into such projects.

Notwithstanding the widespread support for HiAP approaches, there are still considerable challenges in implementing them at local government level. Molnar and colleagues suggest that implementation can be facilitated by adopting shared language, agreeing on shared outcomes, and undertaking health impact assessments of policies in other areas [15]. Without a HiAP framework embedded within local authorities, public health teams may struggle to exert influence, hindered by features arising from their place within the organisation and a lack of consensus on what constitutes a "public health problem".

An effective "*Levelling Up*" strategy [20, 21], which addresses inequalities at the local and national level, will require local public health teams to be able to work effectively with a wide range of stakeholders in their local organisation, often in areas not classically recognised as falling within the remit of public health, with or without the assistance of a HiAP framework.

This thesis asks how public health teams in local authorities can influence gambling, an issue not universally conceptualised as a "public health problem", providing an understanding of the structures and processes involved. The thesis comes at a time when national gambling

legislation was under review and commenced at a point when a white paper was being awaited.

1.3 Gambling and Public Health

1.3.1 Gambling as a Public Health issue

In a 2020 editorial, UK Public Health leaders describe gambling as "*a new threat to the public's health*"[22]. Their 'call to action' followed similar statements by the Faculty of Public Health and the Gambling Commission, both conceptualising gambling harms as a public health issue [2, 3] and was followed in 2021 by a PHE evidence review of gambling harms [23]. In their summary, PHE stated:

"The evidence suggests that harmful gambling should be considered a public health issue because it is associated with harms to individuals, their families, close associates and wider society"[23].

Gambling harms can present in the individual in wide-ranging ways. Gambling that is harmful can be associated with stress, depression, alcohol and substance misuse (so-called "co-occurrence"), with the conditions often clustering and the associations being bi-directional [24]. Gambling can also impact the ability to work and, through this mechanism and directly as a consequence of the expenditure on gambling, can lead to financial problems and homelessness [25]. The PHE evidence summary reported that deaths from suicide were significantly higher among adults with gambling disorders or problems compared to the general adult population [23]. Sulkunen and colleagues characterise gambling harms as subject to "*conditional causation*" given that "*problems occur in combination with multiple factors reinforcing one another in a conditional way*" [26].

People can also experience gambling harms indirectly. The PHE evidence summary concluded that 7% of the adult population would consider themselves an "*affected other*" (e.g., a friend or family member affected by someone else's gambling), with 20% of those claiming to experience gambling harms themselves [23, 27]. Yet this statistic does not capture those under 18 years old who experience gambling harms as affected others, although their situations have been recognised in the literature [27].

Societal costs of gambling harms have also been estimated. The PHE evidence review calculated the costs of gambling harms to society in the UK as approximately £1.27 billion

(expressed in 2019/20 prices), with 95% confidence that the precise estimate is between £841 million and £2.12 billion and half of this estimated economic burden (£647.2 million) a direct cost to the government [23]. The review also recognised this "*is likely to be underestimated due to a lack of available evidence, which means that some identified harms have been only costed partially (financial, health, employment and education, crime), while others have not been costed at all (cultural harms and impact on relationships)*"[23].

1.3.2 Framing gambling as a public health issue

It has been suggested by Korn et al. [28], that using a public health approach to address gambling harms is an "*attractive frame*" as it offers the following advantages:

Firstly, a public health approach does not solely focus on the individual "problem gambler" as is the case in much of the discourse. A "Problem Gambler" discourse employs a biomedical approach, using one of several diagnostic criteria used to categorise and define problem gambling (including the DSM5 and the Problem Gambling Severity Index [PGSI] [29, 30]), but they are recognised as highly restrictive.

The recent GambleAware 2019 and 2020 surveys in the UK used the PGSI to identify problem gamblers, yielding, respectively, prevalences of 2.7% and 2.4% in the gambling population[27]. However, both surveys are subject to important limitations that need to be acknowledged when interpreting their findings: firstly, point prevalence data does not capture the widely recognised "*churn*" of problem gambling [31], with individuals moving in and out of the population meeting these criteria, thereby substantially underestimating the lifetime prevalence of problem gambling. Secondly, surveys are subject to selection bias by virtue of the sampling frames used, for example, by excluding people who are homeless or in institutions, or differential nonresponse, which is influenced by the methods used to contact potential respondents.

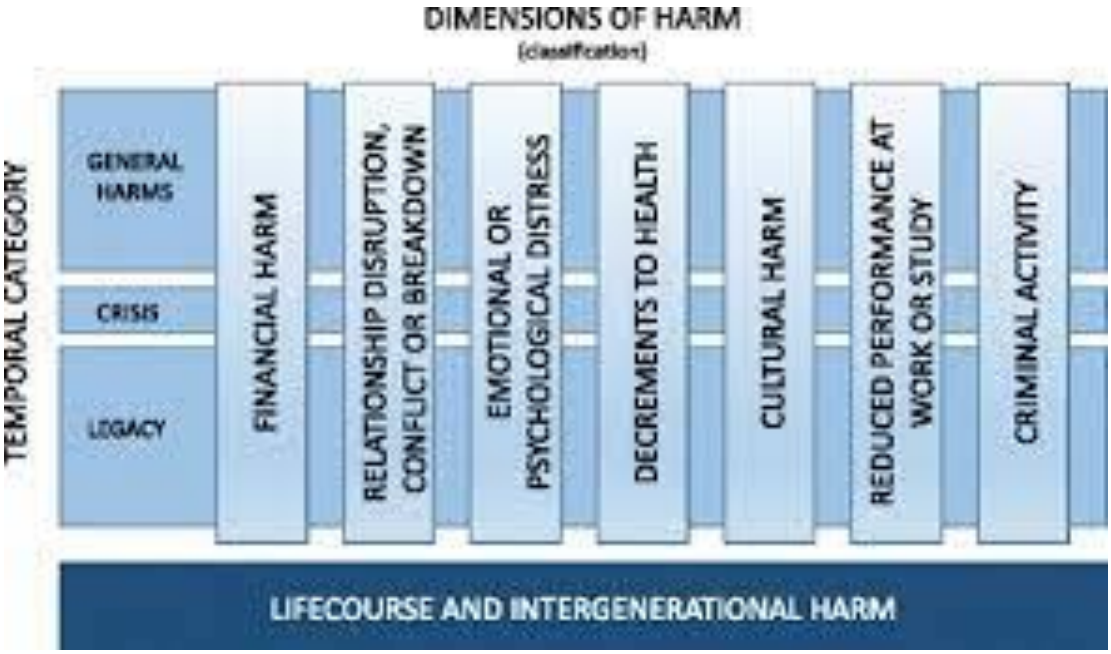
The term "problem gambling" is also contentious, with the "*othering*" of problem gamblers hindering the discussion about whether gambling products and services are inherently dangerous, and feeds into the gambling industry's preferred framing of gambling problems as due to "*defective individuals*" and avoids scrutiny of the availability of potentially dangerous gambling products [32, 33].

To continue with Korn et al.'s argument for adopting a public health framing of gambling harms, a public health approach conceptualises gambling behaviour along a health-related

continuum, as in a recent mixed methods investigation of trends in gambling across Wales [34]. The continuum approach is similar to that taken in alcohol studies [28], and recognises the "*prevention paradox*", that is, the situation in which a greater number of cases of a disease state (here: gambling-related harms) come from low-risk members of a population because they are more prevalent than high-risk members [35].

Thirdly, a public health approach addresses not only the risk of problems for the gambler but also the quality of life of affected others and communities affected by gambling. Langham and colleagues have developed an "*all-harms*" conceptual framework to highlight this (Fig 5) [1], which also recognises the lifetime prevalence of harm.

Figure 1-4 Conceptual Framework for all-harms approach to gambling



Langham, 2016 [1]

Fourthly, public health action reflects values of social justice and equity and pays attention to vulnerable and disadvantaged people [28]. Previous geospatial analysis has already recognised a disproportionately high number of gambling premises in deprived areas of the UK [36, 37]. This is of particular note as, under the provisions of the Gambling Act, betting shops, the most common form of 'land-based' gambling premises, can each house up to four Fixed Odds Betting Terminals (FOBTs), a type of electronic gaming machine (EGM) which is recognised globally as linked to problem gambling [33]. The PHE evidence review found that the socio-demographic profile of gamblers appeared to "*change as gambling risk increases, with harmful gambling associated with people who are unemployed and among people living in more deprived areas. This suggests harmful gambling is related to health inequalities"* [23].

Particular groups within populations (such as those living in deprived areas, those with low incomes, those who are cognitively impaired, migrants, or those living in institutions) have been recognised as being at increased risk of gambling harms [38, 39]. Gambling is also a "*regressive taxation*", with those in lower income brackets spending proportionately more money on gambling products [40]. Sulkunen and colleagues note that "*at least half of those individuals who contribute the largest share of revenues for charitable purposes through gambling are themselves poor, with low educational background, mentally ill, addicted or*

otherwise problem substance users, physically sick or have several of these vulnerabilities" [26].

Relatedly, notwithstanding the extent to which existing surveys underestimate the scale of problem gambling, those who meet these criteria contribute a disproportionate amount of the overall amount of money spent on gambling. A total of 60% of the UK Gross Gambling Yield (GGY), calculated as the total accrued via stakes and other related activities minus the total paid out in winnings and prizes [41], comes from the 5% of gamblers defined as either Problem Gamblers on the PGSI (score 8 or greater) or at risk of becoming so (PGSI score 3-8) [27].

Finally, as noted by Korn (2001), public health agencies exist at both local and national levels and are well suited to developing surveillance systems to track trends in problem and pathological gambling as well as indicators to monitor the social and economic impacts of gambling on communities and population groups [28]. New Zealand is a country that has already adopted a public health approach to gambling harms and where the Ministry of Health is responsible for developing and implementing their integrated problem gambling strategy focused on public health [42].

1.3.3 The Commercial Determinants of Health

In addition to Korn's argument for adopting a public health framing of gambling harms, the gambling industry is increasingly considered as a "*commercial determinant of health*" (CDoH). Kickbusch and colleagues define this as "*strategies and approaches used by the private sector to promote products and choices that are detrimental to health*" [43].

CDoH is closely linked to the critique of neoliberal thinking because both concepts involve the influence of corporate power on public health outcomes.

Neoliberalism is a political and economic ideology that emphasises free markets, deregulation, privatisation, and a reduced role for the state in social services. It assumes that market-driven approaches and individual choice are the most effective means to organise society, including health systems.

The link between CDoH and neoliberal thinking can be summarised under four main headings:

Privatisation, Deregulation, and Market-Driven Healthcare: Neoliberal policies promote the deregulation of industries and the privatisation of public services, including healthcare. This reduces government oversight and increases corporate power, allowing businesses to prioritise profit over health outcomes. Market-driven healthcare often leads to inequities in access, exacerbating health disparities.

Corporate Influence on Policy: Corporations gain significant influence over public policy under neoliberal regimes. They often use their power to lobby against public health regulations that might harm their profits, such as restricting advertising of harmful products. This undermines public health and exacerbates health inequalities.

Individual Responsibility: Neoliberalism emphasises individual responsibility for health, downplaying the role of social determinants and structural factors. This ideology shifts the focus away from the corporate and commercial determinants of health, framing issues like obesity or smoking (and gambling) as personal failures rather than results of aggressive marketing by corporations.

Globalisation and Trade Policies: Neoliberal globalisation, emphasising free trade, often enables the spread of unhealthy products and practices across borders.[44]

These mechanisms create a risk of corruption via corporate industry and policy capture, regulatory evasion and manipulation, conflicts of interest (where individuals in positions of power have financial or personal ties to industries they are supposed to regulate), the weakening of public health institutions (as resources are diverted from intended purposes or as trust in institutions erodes).

Effective governance can either mitigate or exacerbate the impact of commercial activities on public health. Strong governance can support regulatory framework implementation, ensure accountability and transparency, and mitigate corruption through robust conflict-of-interest policies.

Knai and colleagues point out how the gambling industry has adopted similar tactics to the alcohol, tobacco and ultra-processed food industries, collectively termed unhealthy commodity industries (UCIs) [45]. These industries increasingly work together to "*shape the dominant narrative, including scientific and methodological norms, promoting "accountability" mechanisms that avoid scrutiny and support voluntary models, outreach to*

other sectors to create alliances, and the exploitation of "revolving doors linking public and private sectors, as well as across UCIs" [45]. UCIs also often use a common narrative whereby they state that the cause of a problem is so complex that individual products cannot be blamed, and public health measures are "*too simple*" to address them; however, "*inherent contradictions*" are noted in this "*too simple*" framing as the alternative solutions put forward by the industry "*are not, in themselves, complex*"[46].

It is against this backdrop that the narrative around gambling as a public health issue has gained traction. In recent years, several population-level developments have occurred in the UK. In 2015, the presence of betting shops on the high street was recognised by the Royal Society of Public Health as a negative factor when assessing "*healthy high streets*" [47]; in 2018, it was agreed that the maximum stakes for FOBTs would be reduced from £500 to £2 (although the reduction took two more years to implement). Gambling with credit cards was banned in April 2020 [48, 49]. Also, in 2020, recommendations from both the All Party Parliamentary Group (APPG) for online gambling harms and the House of Lords review of the Gambling Act include consideration of the introduction of a mandatory levy on the gambling industry and banning advertising in certain sports environments [50, 51]. Following a three-month call for evidence in early 2021, the White Paper reviewing UK gambling legislation was published in 2023 [52], recommending a series of consultations before any final changes to legislation.

1.3.4 Challenges to the Public Health Narrative

Conceptualising gambling harms as a public health issue has by no means reached dominance in the discourse. Cassidy notes how there was a "*recast of gambling in 2001 from a potential source of crime managed by the Home Office to a leisure activity which is the responsibility of the [central government] Department for Digital, Culture, Media and Sport (DCMS)*" [53]. In their 2020 statement regarding the launch of the Gambling Act review, the DCMS describe gambling as:

> *"a fun leisure activity for many people, with nearly half of adults gambling each month. We respect the freedom of adults to choose how they spend their money and the value of a responsible industry which protects players, provides jobs and pays taxes"* [54].

The gambling industry also conceptualises gambling as an enjoyable and social leisure activity, and their responsible gambling policies emphasise the relatively small number of

individuals that, they argue, experience harm [55]. As previously stated, the restructuring of public health within OHID will place gambling under the remit of the Director of Addictions (alongside drug-taking, alcohol and tobacco) [8], framing individuals experiencing problems with gambling as not gambling correctly rather than being exposed to highly addictive products and predatory marketing [55].

The gambling industry also emphasises its contribution to the economy and community, supporting customers to "*safely gamble*" via protecting the under-age and vulnerable from adverts, identifying at-risk gamblers via technology, and signposting to self-exclusion and setting limits [55]. However, researchers have argued that this discourse conceptualises "*responsible gambling*", now recast as "*safer gambling*", as the responsibility of the individual rather than that of the industry or government [26, 56].

Calls to increase regulation (e.g., a mandatory levy rather than corporate social responsibility strategies) are framed by the industry as prohibitionist and risk of driving consumers onto black market websites [57], although no evidence to support these arguments has been provided.

1.3.5 Issues with gambling research

Proving that the association between gambling and its related harms is causal remains problematic. Firstly, the "co-occurrence" of gambling problems and other mental health conditions and the complexity of physical and social environments make direct causality challenging to establish. Secondly, economic analyses are difficult given that the costs and benefits of gambling, outside of the immediate financial losses and gains, are often intangible and affect many diverse groups of individuals [26].

UCIs use this lack of 'hard data' to "*manufacture uncertainty*" and undermine scientific consensus, thereby curtailing the potential for effective public health policy responses [46]. Insisting upon such "*methodological perfectionism and rejecting methodological pluralism*" [58] is one technique from the industry "*playbook*, a term first coined in relation to the tobacco industry, that describes strategies to protect revenues in the face of mounting evidence of links between their products and serious adverse health outcomes [59]. Vested interests seek to challenge any claims as they promote alternative discourses that benefit them. Hence, a stance that demands 'hard data' poses obstacles to tackling gambling harms on local and national policy agendas.

The change in the UK gambling landscape that is presently underway also makes analyses of related harms difficult. According to Gambling Commission statistics, the number of betting shops in the UK has been decreasing yearly since 2015, a development attributed to a combination of factors. One key factor is the growth of online gambling (less regulated than the land-based industry) on personal devices since the mid-2010s [60]. Prolonged closures of gambling premises due to the Covid pandemic in 2020 and 2021 meant that even more gambling moved online, likely for some irreversibly, and exposed gamblers to 'harder' and less regulated gambling products. Gathering accurate data about online gambling behaviour and related harms is difficult, given the 'domestication' of gambling on private devices, the vast range of gambling products available online, and the products that specifically target young people (such as 'loot boxes') that are not classified as gambling but are felt by many to be a gateway into harmful gambling behaviours [61].

The challenges involved in undertaking research are compounded by the recognition that much of that into gambling is funded either directly or indirectly by the gambling industry. The charity GambleAware was set up to manage and distribute the voluntary contributions from the industry to research, education and treatment (RET), with recipients including national organisations such as GamCare, Gordon Moody, The Young Gamers and Gamblers Education Trust (YGAM) and The Samaritans [62].

As the funding for RET comes from the industry, Adams describes how knowledge via research is widely viewed as "*compromised*" [63]. He continues that the gambling industry also contributes to a "*compromised public good*" (where the industry contributes to government revenue via taxes revenue -£3bn per annum in the UK according to the National Audit Office (NAO)[64]- and by funding problem gambling services) and "*compromised politics*" by "*the commercialisation of addictive products, and government favouring individualised and less effective interventions for problem gambling*"[63]. Adams concludes, *"Fundamentally, a decrease in gambling harms means a decrease in profits for the gambling industry and related stakeholders: a way forward will depend on the willingness of consumers to limit their engagement with this form of addictive consumption"*[63].

1.3.6 A public health "call to action"

As noted above, public health leads in the UK have called for national and local policymakers to adopt a whole council, Health in All Policies approach to tackle gambling-related harms by "*developing a compelling narrative and including it in strategic plans, with meaningful outcomes measures and communicating this to partners*"[22]. Their 'call to action' outlines a 7-point plan (Table 1-1).

Table 1-1 Summary of 'Call to Action' plan for public health approach to tackling gambling-related harms

1. National and local policymakers to adopt a HiAP approach
2. Understand the prevalence of harmful gambling
3. Ensuring tackling gambling harms is a key public health commitment
4. Understanding the assets and resources available in all sectors
5. Raising awareness and sharing data
6. Ensuing all regulatory authorities help under a 'whole council' approach
7. Developing a whole system approach to reduce poverty and tackle inequalities

Adapted from Johnson & Regan, 2020 [22])

Given these recommendations, public health teams in local government must consider what can be done within both their organisations and wider locality to address gambling-related harms.

1.4 The role of Local Government in addressing gambling harms

1.4.1 An overview of the Gambling Act (2005)

The Gambling Act 2005, covering England, Scotland and Wales, is described as a "*key episode in the deregulation of gambling in the UK*" [53] has the following stated objectives:

- To make gambling fair
- To make gambling free of crime
- To protect children and vulnerable from gambling-related harms [65].

The Act mandates licensing authorities, based within local government structures (such as district or country councils and London boroughs) to license gambling premises (licensed betting offices [LBOs] or 'bookies', casinos, bingo halls, adult gaming centres

[AGCs/'arcades'], racing tracks and family entertainment centres [FECs])[65]. According to the license type, different types of gambling premises are permitted a particular number of EGMs, by both number and category. Licensing authorities can also issue permits for some lotteries and poker, EGMs in members' clubs, and temporary licenses, for example, for travelling fairs [65]Applicants who wish to open gambling premises need further licenses to operate, which are acquired via the national regulator, the Gambling Commission.

The Gambling Act also specifies certain parties that must be consulted regarding new gambling premises licenses (so-called Responsible Authorities [RAs]), including local authority planning and environmental departments, police and fire services, and child protection, but not specifically public health. Although it could be argued that initially, this may be because the Gambling Act came into force five years before public health was moved into local government, this legislative oversight has persisted.

The licensing authority within local government is also responsible for producing a triennial statement of principles, usually in the form of a local gambling policy, setting its own fees for licensing gambling premises [65]. Licensing authorities also have powers to spot-check gambling premises for underage consumers, but the number of spot-checks that individual licensing authorities undertake has recently been reported as highly variable [64].

1.4.2 Comparison with the Licensing Act (2003) including Responsible Authorities

At first glance, the gambling premises licensing legislature appears similar to that of alcohol premises licensing as per the Licensing Act 2003 [66]. However, there are clear differences: first, in the case of licenses for alcohol premises, local public health teams are a Responsible Authority and, as such, have a statutory right to be consulted about each application. Second, policy on alcohol (and its related harms) is recognised to fall within the remit of the Department of Health and Social Care (DHSC), while gambling falls under the remit of the DCMS. Of note, a license for premises to sell alcohol can also house up to two EGMs without needing to apply for additional permits [65, 66].

Despite additional planning legislation that sought to limit the expansion of gambling premises in 2014 and 2015, the Gambling Act supports a "*statutory aim to permit*" regarding gambling premises licensure, as highlighted in bold font in successive editions of the Local Government Association (LGA) Counsellor's handbook [67-69].

This legislative framework has, to quote the House of Lords 2020 Report on Gambling-related Harms, created a "*myth*" that decision-making powers on gambling licensure are really local [51]The same report recommended that local authorities be "*given the same powers*" over licenses for gambling premises as they have for alcohol.

However, even when public health practitioners have a legitimate "*seat at the table*", as they do as a Responsible Authority for the purposes of alcohol licensure, they may perceive that they have little capacity to exert influence [70]. Previous research in London's local authorities has found public health team members expressing a feeling of lack of status within the licensing process and difficulty using and communicating public health evidence effectively, especially as there are no specific objectives for licensing that relate to public health [70, 71]. Of note, and in contrast, legislation on licensing alcohol premises in Scotland has a specific public health aim [72].

1.5 Local government considerations of gambling harms in "the digital age"

The current review of the Gambling Act aims to "*bring analogue legislation into the digital age*" [5], with recent surveys having suggested that one in four adults are now participating in some form of online gambling [73].

Local government has no formal powers over online gambling products, but the role that land-based gambling plays alongside the growing online gambling industry should not be ignored for several reasons.

Firstly, the overlap in those populations at increased risk of gambling harms and those more likely to be "*digitally excluded*" is not insignificant [74]. As such, some digitally excluded populations - potentially also in groups at risk of increased gambling harm - will continue to use land-based gambling as their main access point to gambling products.

In their response to the DCMS review of the Gambling Act, charity GamFam and education network GamLearn published the following joint statement that highlighted these concerns:

> *"...land-based gambling remains highly dangerous, is very intrusive in the lives of many local communities and also serves to normalise gambling... There is a grave danger that they [land-based venues] will become even seedier, depressing and unsafe places used only by people who have developed serious gambling disorder..."* [75].

Secondly, although there has been a reduction in the number of LBOs, it is not known if they will be replaced by other types of gambling premises, such as arcades and bingo, that have fewer numerical restrictions on the number of EGMs they can contain. The stakes that can be placed in FOBTs have been reduced, but EGMs remain "*addictive by design*"[33]. EGMs are still present not only in gambling premises but also in those licensed to sell alcohol. Evaluations of the impact of FOBT stake reduction have not been undertaken.

Thirdly, gambling outlets provide a visible source of advertising for the industry on the high street, even if the profits of individual outlets are low [60]. The disproportionate number of gambling premises in areas of high deprivation also persists [37], even with an overall reduction in LBOs.

Fourthly, advances in mobile technology mean that one financial platform can be used by consumers in both online and physical settings (such as the Coral Connect card and the Playtech innovations [60]), alongside 'push' notifications when online customers are in the vicinity of physical gambling premises, which increases the availability and accessibility of potentially harmful gambling products to individuals.

Fifthly, not all gambling is covered by the Gambling Act legislation. Low-stakes gambling opportunities such as the National Lottery and scratch cards are *not* covered by the Gambling Act and are licensed and regulated centrally by the Gambling Commission. This is important because these 'low stakes' forms of gambling have become more popular among vulnerable groups at times of previous economic crisis [76]; the Covid-19 pandemic has impacted severely many people's income and is likely to have consequences for gambling activity [77].

Finally, limiting the scope of local government interventions to licensing alone excludes both the impact of online gambling on gambling harms and the industry's advertising strategies.

1.6 Summary and Questions

Gambling harms can affect individuals, those close to them, and wider society. National bodies increasingly conceptualise harms as needing a public health approach to address them. A Health-in-all policies approach is widely advocated by local government. It is particularly helpful for public health input when the topic under review is one not traditionally conceptualised as a "public health problem."

However, a public health framing of gambling harms has been challenged by certain groups who have promoted a “Problem Gambler” narrative, focussing upon individualistic interventions and emphasising the positive role of the industry contributes to both the economy and workforce and the negative impacts of increased industry regulation, rather than acknowledging the inequitable harms caused to vulnerable groups, and how gambling can be viewed as regressive taxation.

Licensing authorities in local government are tasked with managing premises and electronic gaming machine permit licensure. Still, public health teams in local government do not have to be consulted, unlike their role in alcohol premises licensure. A comprehensive local government approach to gambling harm must go further than measures that consider only the licensing process, as this would neglect the impact of online gambling, advertising strategies, and low-stakes gambling products, such as Lottery, that fall out with the Gambling Act, which is currently under review.

Given that funding for this PhD was awarded on the recognition of a knowledge gap regarding addressing gambling harms at the local government level, and specifically within London local authorities, this thesis asks the following questions:

1. How have local government initiatives addressed gambling harms previously, and what was the impact of these initiatives?
2. How does public health’s place within local government impact its involvement, influence, and interest in addressing gambling harms?
3. As national documents describe, how has local government been constructed concerning addressing gambling harms? What local government actors have been identified as key to addressing gambling harms? What has been the impact of these constructions?
4. How does local government understand a public health response to addressing gambling harms?
5. How can local government be best supported in adopting public health strategies to address gambling harms?

These questions will be addressed by pursuing the following objectives as summarised in Table 2 below:

Table 1-2 Summary of Research questions mapped to thesis objectives

Research Questions	Objective
How have local government initiatives addressed gambling harms previously, and what were these interventions' impacts?	I) A literature review of local government-level interventions to address gambling harms and an analysis of UK local initiatives alignment to "a public health approach".
How does public health's place within local government impact its involvement, influence, and interest in addressing gambling harms?	II) A survey of London Borough Public health teams to understand key organisational elements relevant to addressing gambling harms.
	III) An analysis of gambling premises data at both London and London borough levels, considering both the type and number of premises and IMD 2019 deprivation ranking for the duration of the research period.
Within national documents, how have local governments been constructed concerning addressing gambling harms? What local government actors have been identified as key figures in addressing gambling harms? What has been the impact of these constructions?	IV) A discourse analysis of the relevant national, local government and London documents from 2000 to the present day, specifically considering the construction of local government within those documents and the impacts these constructions have had on local approaches to addressing gambling harms.
How does local government understand a public health response to addressing gambling harms?	V) A reflexive thematic analysis of interviews with local government representatives.
How can local government be best supported in adopting public health strategies to address gambling harms?	VII) A summary of findings and recommendations for local public health teams about interventions to reduce gambling-related harms.

1.7 Outline of thesis

The following chapters of this thesis will outline the proposed methodology to answer the questions above (Chapter 2). This will be followed by chapters presenting the findings for each objective in turn (Chapters 3-7). An analysis and discussion of the overall findings will follow in Chapter 8, followed by a reflective piece and recommendations for local government (Chapter 9). The thesis was undertaken from September 2020 to May 2024. It

was shaped significantly and dynamically by the impact of the Covid-19 pandemic on academia and public health and the review of UK gambling legislation over that time.

Chapter 2 Methodology

2.1 Recap

In Chapter 1, I showed how gambling harms are increasingly conceptualised as a public health issue given the scale and nature of their impact on individuals, those close to them, and wider society. However, we are far away from having a comprehensive public health response to what is now a multi-billion-pound industry that has permeated many areas of society. The Greater London area is an ideal setting to examine the challenges and opportunities in developing such a response. It is the location of approximately a quarter of all 'land-based' gambling premises and, with 32 boroughs, each able to develop its approach, it provides an excellent natural laboratory. An initial scoping exercise revealed wide variation among individual boroughs regarding trends in premises number and type and the extent to which public health teams were involved in developing gambling policies. In addition, understanding how boroughs respond to those aspects that lie within their competence enables an assessment of the gaps concerning gambling activities (such as lottery products and online gambling) that fall outside their remit but contribute to overall gambling harms.

2.2 Background to Research

In early 2020, the UK's National Institute of Health Research (NIHR) advertised for a doctoral fellow to research the London local authority decision-making process regarding licensing for gambling premises. [78] At that time, I was a clinical academic at a London medical school developing curriculum in health equity, with a background in Primary Care and Public Health. In addition, I had been volunteering for a national charity that supports families affected by gambling harm. I felt that I had a unique skill set and combination of skills and experience to bring to the doctoral fellow role; as such, I applied for the post and was successful.

2.3 Research aim

The overall research aim is, therefore, as follows:

"*To identify the levers and barriers to addressing gambling-related harms in local government in London using a Public Health approach and, based on that, to make*

recommendations for local Public Health teams on how to implement interventions to reduce gambling-related harms."

2.4 Research Objectives

I will answer the questions listed in Section 1.6 by meeting the following research objectives:

I. A literature review of population-level interventions within local government to address gambling harms.

II. A survey of public health teams in London Boroughs to understand key organisational elements relevant to addressing gambling harms.

III. An analysis of gambling premises data at both London and London borough levels, considering both the type and number of premises and IMD 2019 deprivation ranking for the duration of the research period.

IV. A discourse analysis of the relevant national, local government and London documents from 2001 to the present, specifically considering the construction of local government within those documents and the impacts of these constructions on local approaches to addressing gambling harms.

V. A reflexive thematic analysis of interviews with local government representatives.

VI. A mixed methods analysis of objectives 1-5 to identify levers and barriers to addressing gambling harms in local government using public health strategies.

VII. A summary of findings and recommendations for local public health teams about interventions to reduce gambling-related harms using public health approaches.

2.5 Over-arching Philosophy: Critical Realism

2.5.1 An overview of Critical Realism

I have adopted a Critical Realism (CR) approach in my research, a philosophy which Bhaskar initially developed in the 1970s [79, 80]. It is a philosophical perspective that aims to understand the relationship between the external world, our perceptions, and the underlying causes (so-called "*mechanisms*") that govern it. The fundamental aim of CR is "*the explanation of real-world phenomena in terms of causality mechanisms underlying the generation of that phenomena*" [81].

CR acknowledges that reality exists independently of our thoughts and perceptions but recognises that our beliefs and social context shape our understanding. Critical realists seek to uncover the hidden structures and processes that influence our observations and interpretations of the world, focusing on social, scientific, and historical contexts. A CR perspective is often applied in fields like sociology, philosophy of science, and social research to provide a more nuanced understanding of complex phenomena [82].

CR does not have "*one unitary framework, set of beliefs, methodology, or dogma that unites*" [83]. It has been described as "*much more like a series of family resemblances in which there are various commonalities that exist between the members of a family*" [84]. These commonalities are:

- Ontological realism-that structures, systems and objects are 'real' outside of individual constructivist interpretations;
- Epistemic relativism- that knowledge is fallible and that to assume only what is directly experienced as 'truth' is an "*epistemic fallacy*";
- Judgemental rationality- that some hypotheses are more likely than others;
- A cautious ethical naturalism (analysis must be cautious and pluralist) [85].

Critical realism also acknowledges that events occur within "*open systems*"; events observed within research do not occur within experimental environments with no outside influences. Danemark goes on to elaborate:

> *"Closure is very hard, probably impossible to reach: openness in the meaning of no invariant regularities, would make social life impossible; social systems are usually partly open/partly closed due to people's reflexivity, creativity and efforts"* [86](page 62).

In addition, mechanisms operate in combination with each other, and the more mechanisms involved, the more difficult to anticipate the outcome [86]. These two factors (events occurring within open systems and multiple mechanisms, some of which may not be identified in empirical events) mean that any findings and conclusions drawn are made with the recognition that they may not give a full picture of reality. As such, within CR, it is advised that researchers engage in critical reflection throughout the research process, being aware of their assumptions, biases, and theoretical orientations that may influence the design, data collection, analysis, and interpretation of findings. In addition, any findings and

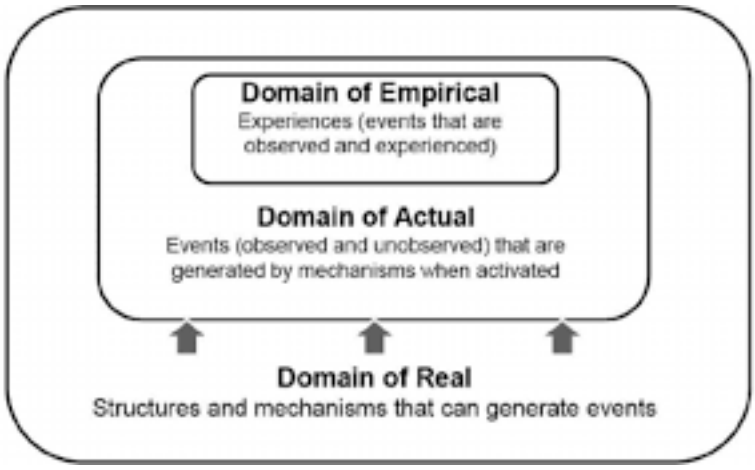
recommendations must be presented to the relevant stakeholders with these factors in mind.

2.5.2 The three 'realities' of critical realism

Bhaskar describes three levels of reality within the critical realist philosophy that interact with each other (see Figure 1 below).

- Domain of the empirical: experiences that are observed and experienced;
- Domain of the actual: events (observed and unobserved) that are generated by activated mechanisms;
- Domain of the real: structures and mechanisms that can generate events in the domain of the actual, with the recognition that mechanisms can reinforce, counteract or moderate each other and are also influenced by the social, political and cultural contexts in which they are occurring within [86].

Figure 2-1 The three layers of reality in critical realism

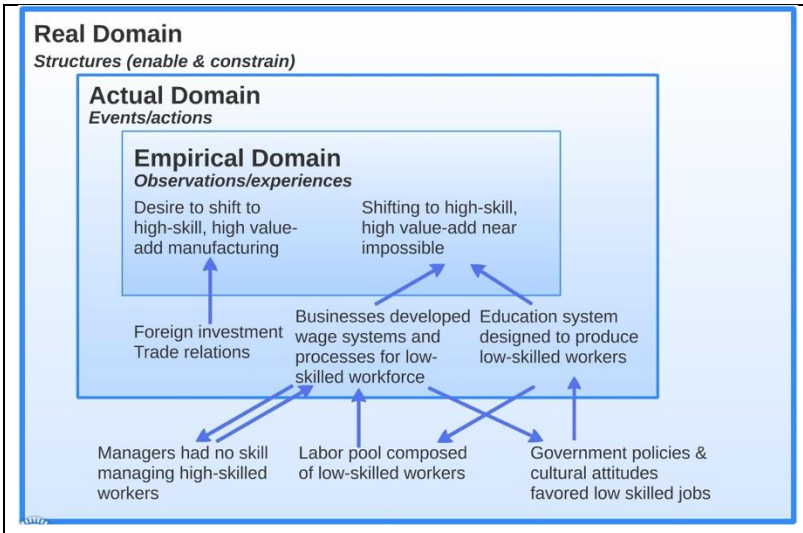


Bygstad & Munkvold, 2011 [87]

Mechanisms in the Domain of the Real may or may not be activated. Once activated, these mechanisms act upon the Domain of the Actual, which again may or may not be activated within the Domain of the Empirical, where research operates. This is why knowledge drawn from research within the Domain of the Empirical is fallible and incomplete. It is often a combination of objects that will trigger a mechanism and produce an outcome that is dependent on, but not reducible to, the objects [87]. Whether the mechanism will be triggered and which result it will produce is not pre-determined but will depend on other active mechanisms, but will have a *tendency* to produce certain outcomes [87].

Figure 2 provides a worked example of using a critical realist lens to analyse an issue in manufacturing.

Figure 2-2 A worked example of critical realism in organisational analysis



During the latter part of the Twentieth Century, low-skilled workers and low-value-added processes dominated the British manufacturing industry. British companies competed globally based on low cost. Foreign investments and trade relations led some businesses to shift their manufacturing towards high-skilled labour and high-value-added processes to make more profits. Companies found making this shift was nearly impossible.

The desire to shift towards high-skilled labour and value-added processes is an experience [empirical domain]. This experience was from foreign direct investment and trade relations [events in the actual domain]. The difficulty businesses experienced in making this shift was another experience [empirical domain]. Underlying structures [in the domain of the real] that enabled and constrained these events included government policies and cultural attitudes favouring low-skilled jobs, a pool of low-skilled workers and a lack of managers' skills in managing high-skilled workers.

Redescue & Vessey, 2009 [88]

Critical realism was chosen as an over-arching philosophy as it can be argued that causal mechanisms are synonymous with the 'levers and barriers' being considered here to address gambling harms using public health approaches. Furthermore, CR has been described by Danemark as "*the best ontological and epistemological point of departure for interdisciplinary research*" [86] An interdisciplinary approach is a key feature of the research planned within this thesis, given that the aim is to make the research findings as applicable to as wide a number of stakeholders as possible.

2.6 Mixed methods research in the CR paradigm

My approach purposefully employs mixed methods. A mixed methods analysis combines both qualitative and quantitative research methods to study a particular phenomenon or research question [89]. It involves collecting and analysing qualitative data (from interviews, surveys, and observations) and quantitative data (such as numerical measurements or structured questionnaires) in a single study. The aim is to provide a more comprehensive understanding of the research topic by integrating the strengths of both qualitative and quantitative methods. Qualitative methods provide contextual insights and explore the mechanisms and processes underlying social phenomena, while quantitative methods can help identify patterns, associations, and generalisability.

Mixed-methods research with a CR philosophical underpinning is widely referenced in the research literature [90]. Mixed methods research can be valuable when using critical realism as it allows researchers to explore the underlying mechanisms and structures of the social world while acknowledging the complexity and multidimensionality of reality. By integrating qualitative and quantitative approaches, researchers can address different aspects of their research questions, capture different levels of reality, and gain a more nuanced understanding of social phenomena. A benefit of using multiple methods within social science research is that it assists in the generation of theory (which aligns with CR's fundamental aim of identifying underlying mechanisms) [86]Given that very little literature currently exists on UK local government and gambling policy, adopting a mixed-method approach in this thesis allows for the generation of theories in several quantitative and qualitative strands, providing a springboard for future research.

Within mixed-methods research in the CR paradigm, Danemark advocates a "*critical methodological pluralism*" which recognises that "*all methods are not equally suitable*"[86]. A "*conscious choice of design and method with different approaches that complement each other*" should be made in which "*the foundation for what is suitable or not is to be found in the relationship between [CR] metatheory and method*" [86]. Methodologically, it is the nature of the object under study that determines what research methods are applicable and also what knowledge claims one may make [86](page 65). In this research, the "object under study" is local government, using local gambling policy and public health approaches to address gambling harms as the lens to view it. Given the "*real local variations*" in local

government that "*stubbornly remain*" despite "*real and pervasive centralism that characterises the British system of government*" [91], the specific mix of quantitative and qualitative methods is discussed in depth in the following section.

2.7 Research Strategy by Objective

I will now review each of my research objectives from Section 2.3, setting out the approach I have chosen to achieve each of them and why. This will be followed by a detailed account of the methods I will employ, including timescale, sampling strategy, data storage, data analysis, and critique. Table 3, in the final section of this chapter, will summarise what is discussed below.

2.7.1 Objective I): A literature review of local government, population-level interventions to address gambling harms.

Research Strategy:

My research question is, "*What interventions have been adopted at subnational levels to address gambling harms, and what lessons can be learned from them?*" The literature to be reviewed will be from academic databases and recent relevant reviews, including an evidence summary and a recent book publication.

Timescale :

Once I have completed the initial systematic searches, I will set up email alerts to rerun the searches twice weekly until the final write-up of the thesis.

Sampling Strategy:

For the database searches, I will design a search strategy and define terms to search the following databases: Medline, Embase, Scopus, Web of Science, Social Policy and Practice, Global Health, PsychInfo & CINAHL. The criteria for inclusion are any publication date, any country, and interventions of any design enacted within a local government framework.

I will search review articles for individual papers that meet the inclusion criteria. Research cited in the book will be identified in the same way. In both cases, I will request the full copies of the relevant articles via library services for review.

Given that the literature review aims to understand what is possible in 'real' settings, I will exclude papers from the literature review if they have used a lab-based setting (e.g., assessing behavioural impacts of alterations in electronic game machine design). I will also

exclude interventions that describe voluntary, individual level actions (e.g., self-exclusion programmes) as these types of interventions do not align with population-level, public health approaches (and have already been widely reported elsewhere in the literature).

Data Storage:

I will collate copies of relevant citations of academic papers from database searches, reviews, and books using Endnote. I will keep links to grey literature documents in an Excel file and store copies of grey literature from open-access resources on a laptop. I will store copies of files from individuals or organisations on an encrypted LSHTM SharePoint drive.

Data Analysis techniques:

I will group findings from the literature review by type of intervention using an abductive approach. WHO's 'best buys' for Non-Communicable Diseases lists approaches to the control of harmful products, such as tobacco and alcohol [92]. These include measures to tackle marketing, pricing, and availability. These same three 'best buys' have recently been used in WHO Europe's framework for action on alcohol [93]. I will use these three headings *a priori* in the literature review to organise findings, to align with both a public health and commercial determinants of health approach (as opposed to an addiction framing using headings such as 'supply reduction', 'demand reduction' and 'harm reduction'), but the review will allow for the creation of new sub-headings if relevant findings are identified. I will also note the source of research funding if it is reported in the papers. Finally, I will use the PRISMA guidelines to report the literature review findings [94].

Critique:

I will have to consider the database search terms carefully, especially those around the activity of gambling itself (as it is not a homogenous activity). Also, gambling legislation differs between jurisdictions in terms of what powers local government have. However, the literature review will outline what is possible under the umbrella of local government power. Finally, I also recognise that gambling research has historically been "c*ompromised*" in terms of its narrow scope, being politically driven, and primarily funded by the gambling industry [63, 95]: this will impact upon the findings of the literature review and will be discussed alongside the results.

2.7.2 Objective II): A survey of London Borough Public Health Teams to understand key organisational elements relevant to addressing gambling harms.

Research Strategy:

I will gather baseline data that describes the public health teams in London's boroughs and their approaches to local gambling policy. I will determine their place within their organisation, leadership roles, and interest and influence in addressing gambling harms. Recognising that gambling harms are, so far, low on the agenda in many boroughs, I have selected an analogous area, alcohol licensure, to understand each borough's broad approach to harmful commodities. I will then compare individual boroughs' interests and influences in both alcohol and gambling policy and, given public health teams' formal role in the former, look for similarities and differences in both policy areas. If there are similarities, if public health teams are equally involved in local alcohol and gambling policy, it may suggest that a local government approach to harmful commodities is more inclusive than solely considering those who are specifically named within the legislative framework.

I will draw on organisational theory from both McKinsey and Mendelow [11, 12], discussed in Chapter 1, to inform the first draft of the survey questions. I will ask questions about the interests of the public health teams and their influence on alcohol licensure (where public health teams are a Responsible Authority) that mirror those asked about gambling licensure, and so used as a comparator. A mixture of single best answer, free text and Likert scale responses will be used to generate both quantitative and qualitative data.

I will co-create the survey with a small advisory group of local public health team representatives who have already expressed interest in being involved in the research. I will share the draft survey with this advisory group and ask for their feedback and input before broader final dissemination.

Timescale:

I will collect the data using a single timepoint survey and invite completion over a six-week period (including fortnightly reminders to complete) in Spring 2022. The exact time for dissemination will be sensitive to the local public health teams' other responsibilities at that time, for example, leading on any Covid-19 vaccination programmes and/or outbreak management activities.

Sampling Strategy:

The London Association of Directors of Public Health (ADPH) will support the survey distribution. They will send an initial email invitation to all DPHs in Greater London, followed by a direct email from me to those who do not respond. These initial invites will have a consent form attached, which must be completed and returned before the survey link is sent. Once the survey link has been sent, I will follow up with respondents at 2 and 4 weeks after the initial request if the survey has not been completed.

Data Collection:
I will use the LSHTM JISC platform to create the survey and securely store the collected data. Once the survey is closed, the data will be downloaded to Excel for statistical analysis.

Data Analysis techniques:

I will analyse the data using Excel for descriptive statistics and thematic analysis of free text responses. I plan to share the data analysed with participants at the interview stage of the research (objective V) to stimulate discussion.

Critique:

A good response rate to the survey relies upon accurate contact details, perceived relevance of the survey topic to the responder, and feasibility of survey completion [96]. A low response rate will mean that generalisability of results is low. Still, the underpinning CR philosophy of this research considers a relativist epistemology (and, as such, acknowledges that knowledge is fallible) and recognises the limitations of drawing definitive conclusions from a survey with a low response rate. The additional step required (to gain consent before the survey is distributed) may impact the response rate. I have enlisted support from the ADPH, which supports the dissemination of the survey and has been both pre-advertised and co-created with local public health teams. In the pilot, the survey was completed in less than fifteen minutes. Delivery by email reduces delivery bias [96].

An external issue that cannot be controlled for is the other commitments of local public health teams: these external pressures on time may impact their ability to complete the survey and its perceived relevance when disseminated.

2.7.3 Objective III) An analysis of gambling premises data, at both London and London borough level, considering both type and number of premises, and IMD 2019 deprivation ranking, for the duration of the research period.

Research Strategy:

I will analyse data on licences for gambling premises by type and number of premises, at the Greater London and London borough level and by borough deprivation ranking (IMD 2019) [97]. All 32 London boroughs will be included in the analysis.

Timescale and Sampling Strategy:

Premises data is published by the gambling regulator (The Gambling Commission) on its website at approximately six-monthly intervals [4]. I will extract and analyse this data at six monthly timepoints for the duration of the research (Sept 2020-Dec 2023).

Data Collection:

I will extract the data for each London borough from the master Excel spreadsheet published by the Gambling Commission and record it in an Excel spreadsheet at both London and London borough level.

Data Analysis:

I will analyse the extracted data by both the number and type of premises and IMD 2019 deprivation ranking in the first instance. If possible, I will undertake further statistical analysis (such as controlling for borough demographics and political control of the borough using the R statistical package) and use Geographical Information Software (GIS) for further analysis.

I will share the findings of this analysis with participants at the interview stage of the research process (objective V) to stimulate discussion.

Critique:

On their website, the Gambling Commission states that "*The [premises] register is published with the caveat that the Gambling Commission cannot provide any assurances on the completeness and accuracy of this data*"[4]The Gambling Commission has confirmed this to me via personal email, noting that data accuracy depends entirely on the quality of local government 'returns'. In my interviews with borough licensing teams (objective 5), I will explore why this might give rise to problems and possible solutions. The quantitative data I will obtain will complement the qualitative objectives of this mixed methods research approach, the strengths of which have already been discussed.

An analysis of the IMD 2019 measure of deprivation was selected because IMD is widely used and familiar to the relevant stakeholders. Pragmatically, it is a useful concept to refer to as this research aims to reach out to a wide range of stakeholders.

Further statistical analysis of data using packages such as R and GIS will depend on the availability of training, IT support, and adequate hardware and software support.

2.7.4 Objective IV) A discourse analysis of the relevant national, local government and London documents from 2000 to the present day, specifically considering the construction of local government within those documents and the impacts these constructions have had on local approaches to addressing gambling harms.

Research Strategy:

I will undertake a discourse analysis of the relevant national, local and London documents addressing gambling policy as it relates to local government, specifically looking at local government construction within these documents. The discourse analysis is to be undertaken using Glynos and Howarth's Critical Logics Approach (CLA) [98]. This framework developed from the post-structuralist paradigm, primarily influenced by political and discourse researchers Laclau and Mouffe [99].

Post-structural discourse theory (PSDT) is a philosophy that focuses on the centrality of discourses as the meaningful practices through which human subjects experience and understand themselves and others, with no philosophical distinction made between discourses, practices, and subject identities [100, 101].

As developed by Laclau and Mouffe and the later work of others, post-structuralist discourse theory (PSDT) offers a theory of discourse based on the primacy of politics and social antagonisms. For Laclau and Mouffe, politics is not to be defined narrowly, as in party politics, but instead as the organisation of society in a particular way that excludes other possible ways [102]. For them, politics is the social organisation that results from continuous political processes [102, 103]. The primacy of politics means that it is only through politics and the antagonistic relationship between 'insiders' who share a given identity and meaning and 'outsiders' who 'see things differently' that social reality is established [103].

In addition, PSDT considers certain discourses can become deeply embedded or 'sedimented' and take on the appearance of necessity or permanence [104]. However, even these *hegemonic* discourses are inherently unstable and potentially vulnerable to moments

of *dislocation* that expose the contingent (other possible) nature of the prevailing social and political order [98, 105].

A Critical Logics Approach was specifically selected for several reasons: firstly, as will be explained below, the CLA approach includes retroduction, a technique that aligns with CR, the over-arching philosophy of this research. Secondly, this research aims to build upon other recent non-industry funded gambling research that used the same framework to assess education materials to schools on addressing gambling harms [105], and as such, build a more cohesive evidence base. Thirdly, previous researchers using this framework have noted that a particular strength of the CLA approach (compared with other discourse analysis techniques used in policy analysis) is that CLA:

> *"seeks to provide a more comprehensive and explanatory account of the complex interplay of social and political practices that catalyse or resist policy change…It also rejects the dichotomy between those approaches that focus on the primacy of agency on the one hand and those that focus on the role of structures on the other".* [98, 103]

The CLA classifies discourse under one of three logics:

Social logics – these discourses aim to enable the researcher to "*come to grips*" with what is "*going on*" in a particular context. They can be seen as representing the "*rules of the game*" or norms and values that guide social practices and enable the researcher to describe and characterise discourses [105].

Political logics – these discourses capture the practices through which a discourse emerges and hegemony, defined by Hawkins as discourses that are "*deeply embedded…sedimented…that take on the appearance of necessity or permanence*"- established and maintained [106]. Political logics includes both logics of equivalence (processes and practices that bind and unite different elements and simplify the social space into two antagonistic poles [105] and the logics of difference (discourses that divide and complexify the social realm to incorporate new grievances or demands [99]). Political logics allow the researcher to explain how certain policies and practices emerge, are reproduced, contested, or transformed [98, 105].

Fantasmatic logics aid understanding as to why and how subjected are "*gripped*" by certain practices, or policy discourses, despite the possibility of other systems of relations, practices

and policies [105]. They serve to capture the "*enjoyment of closure*"- the pursuit of a fully formed complete social identity and order [98]. Glynos and Howarth classify fantasmatic logics as either "*beautific*" (a harmonising and stabilising of the social world) or "*horrific*" (horrors and losses that will unfold if the fantasy object is "taken" by a discursively constructed "other") [98, 105].

Once the logics has been identified within the discourse, I will use a retroductive approach (described by van Shalkwyk as "*a dynamic approach… involving description, explanation, and articulation, 'moving' back and forth across the coded and structured data and intermittently returning to the theory and the literature as particular findings emerge*"[103]) to undertake further analysis. This approach is used to explain how the three types of logic are "articulated" together and to generate the "problematisation" of the object under consideration, with the final stage of the discourse analysis framework being to analyse both the logic and the derived problematization critically [98].

I selected the timeframe of the documents analysed (2001-2023) to encompass the lifespan of current gambling legislation in Great Britain from the point after which key documents on the Gambling Act 2005 were released up to and including the publication of the white paper, where that same legislation is now under review.

Timescale:

I will undertake the discourse analysis over a 12-month period: a first cycle of initial document familiarisation, a second cycle of thematic coding, and a third cycle of mapping generated codes to the logics and articulating the problematisation of local government, critiquing the problematisation including its impact on local government gambling policy.

Sampling Strategy:

I will identify the relevant UK documents from 2001-2023 from initial online searches, background readings of gambling policy literature, and discussions with other academics within the gambling research field. This list will be added to iteratively and contemporaneously throughout the research. I will review relevant UK institution websites (e.g., national and local government websites, London borough websites, Gambling Commission website), create alerts so that I am aware of any new publications, and liaise with colleagues in the fields of gambling and public health research in terms of other

documents to review. For relevant material, I will also review gambling industry websites and affiliated bodies (e.g., GambleAware and The Betting and Gaming Council).

Data Collection:

I will download identified relevant documents onto NVivo and record them and their hyperlinks in an Excel spreadsheet. I will also record relevant website pages in this same Excel spreadsheet file. I will keep my ongoing field notes and reflections on each review cycle in Word files and store all Excel and Word files on the LSHTM server.

Data Analysis techniques:

After familiarisation with all the documents and 'top level' codes identified, I will undertake a second full read-through using NVivo to code the documents thematically. These codes will then be assigned one (or more) of the three 'logics'. This method again mirrors the previously published gambling research using the logics approach [105]My write-up will explain how the logics are articulated to provide a construction of local government and critically analyse these constructions, including whether these constructions have changed over time and differ between actors. I will then also comment on how these problematisations impacted the ability of local government to address gambling harms.

Critique:

I selected this discourse analysis technique as it aims to build upon recent gambling research that used the same technique to assess education materials to schools on addressing gambling harms [105]The hypothesis is that using a similar method to assess written material across the gambling sector will help draw comparisons about how different actors (government, industry, etc.) are problematising key actors and issues in gambling policy and assist in identifying similarities and differences between local and national government discourse and across different actors.

Using an analytical technique similar to that of colleagues researching a similar topic but at the national level offers a pragmatic solution to building a stronger evidence base in this research field, where research is historically problematic. Whilst I acknowledged the risk in aligning methods and data sources with colleagues doing similar work in terms of bias, I justify adopting similar strategies to build a more robust evidence base that can be synthesised.

While post-structural discourse theory understands discourse in a wider sense than the printed word, "*defining discourses as constitutive of the social world, conferring meaning and import to all objects and practices and their relation to each other*" [103], in this research I decided to focus on published documents only rather than a broader definition. This decision was made because although I chose to use a method underpinned by PSDT for the above reasons, I also recognised this discourse analysis forms only one part of the overall research. Therefore, boundaries were put on the discourse included in the analysis for time-pragmatic reasons, recognising this would be one element of a range of findings integrated into a final mixed-methods analysis. However, as the findings of this discourse analysis of documents will be integrated with the findings of the other objectives, including the spoken word of the interview analysis and the quantitative findings of the survey and premises data, in this way, the discourse analysis stays faithful to the PSDT paradigm, that understands discourse as having "*no philosophical distinction between discourses, practices, and subject identities*"[100, 101].

Discourse-theoretically informed analyses aim to study how certain discourses emerge, achieve predominance, are maintained, and are contested at a given time. [102]. Using a framework for discourse analysis assists replicability. Still, it must be recognised that such discourse analyses remain subjective and qualitative (in comparison to objectives II and III, which are objective and quantitative, although the merits of mixed methods research in the CR paradigm have already been discussed). Also, this post-structural framework is built upon the premise of the "*primacy of politics*" [99, 102] so findings may differ from those of other types of discourse analyses that use different approaches.

I recognise that relevant key documents may be missed in the analysis, but keeping the inclusion of documents iterative and open to addition throughout the process, as well as liaising with colleagues regarding recommended inclusions for analysis, aims to reduce this risk.

2.7.5 Objective V) A reflexive thematic analysis of interviews with local government representatives.

Research Strategy:

I will undertake semi-structured interviews with local government representatives, using Braun and Clarke's reflexive thematic process [107, 108] to analyse them.

Timescale:

I plan single-time-point interviews, with no repeat interviews, over six months in 2022-2023. This period will be time-sensitive to any specific pressures on local government representatives (e.g., vaccine programme delivery).

Sampling Strategy:

I will invite members of local public health teams to be interviewed via the DPH survey (objective 2) as well as approaching:

- Local government representatives from London boroughs in related departments (to be identified in the document analysis (objective 4) such as licensing, planning, environment, healthy places, crime prevention, financial inclusion, and safeguarding.
- Pan-London public health-related institutions e.g. (Greater London Authority and Public Health London).
- Elected local council members and MPs in London.

I will also undertake snowball sampling based on recommendations from initial participants. Copies of signed consent forms will be kept on encrypted files on the LSHTM server.

Interviews with NHS staff and patients are not permitted within current ethics approval. In addition, given my concurrent role as an NHS clinician working locally, interviewing both NHS staff and patients was identified early in the research process as potentially ethically challenging, so I have specifically avoided interviewing these groups of stakeholders.

Data Collection:

The interviews will take place virtually and will be recorded for transcription purposes on an encrypted platform (Microsoft Teams). I will use the automatic transcription function for the first draft of the interview transcription, then correct for errors using the recording. At the transcription stage, identifiable participant and borough information will be redacted. A codebook held on LSHTM SharePoint in a separate file will link specific interview participants to anonymised transcriptions. Once I have completed the transcription and uploaded it to the LSHTM SharePoint, the interview recordings will be destroyed.

Data Analysis techniques:

I will upload transcriptions onto NVivo and analyse them using Braun and Clarke's six-step technique [107, 108] (see Table 1 below). The reflexive thematic approach does not identify codes *a priori* but conceptualises final codes as the research outputs. This technique was chosen as Braun and Clarke identify their approach as "*appropriate to critical realism*" (the overall philosophical approach of the research) in that it offers the "*contextual realism that the method supports*" [107]. Alternative thematic strategies that were considered included coding reliability [109] and codebook [template] analysis [110]. However, both of these techniques generate codes (and, as such, hypothesise theory) prior to thematic analysis, while a reflexive approach generates theory by taking findings from within the "domain of the empirical" (to use CR phrasing).

Table 2-1: Braun and Clarke's six-step technique for reflexive thematic analysis

1. Familiarisation with the dataset: reading and re-reading the data, becoming "*deeply and intimately familiar*" with it, and making brief notes about analytical ideas.
2. Coding involves systematically working through the dataset, identifying segments of data that appear potentially interesting, and applying analytically meaningful descriptions.
3. Generating initial themes: identifying shared patterns and compiling clusters of codes that share a core idea or concept.
4. Developing and reviewing themes: Going back to the dataset, checking that themes make sense in relation to codes, and considering the central organizing concept of each theme and how it relates to the overall research.
5. Refining, defining, and naming themes: Write a brief synopsis for each theme and decide on a concise, informative name.
6. Writing up: Finish the writing process, starting informally in earlier stages, to "*tell your reader a coherent and persuasive story about the dataset that addresses your research question*".

Adapted from Braun and Clarke, 2022 [107]

Critique:

Accurate contact information is essential for identifying local government staff, primarily on local government websites and through personal contacts made in the research process.

Given that "*Subjectivity is at the heart of reflexive thematic analysis*" [107], this approach aligns with the core tenet of epistemic relativism within critical realism [85], the overall philosophical approach of the research. In addition, willingness to participate in the interviews, like with the survey, may be influenced by potential participants perceived relevance of the topic to their work: critical realism acknowledges the risk of epistemic fallacy here, that findings within the 'domain of the empirical' are not analogous with the full 'truth' of what is occurring within the domain of the actual or real.

The availability of local government staff may be influenced by factors external to the research process (other workload issues), hence the long timeframe given to allow for postponements, etc.

2.7.6 Objective VI) A mixed-methods analysis of objectives I-V to identify levers and barriers (i.e., mechanisms) to addressing gambling harms in local government using public health strategies

Research Strategy:

I will undertake a mixed methods analysis of objectives I-V to propose levers and barriers (i.e., mechanisms) to addressing gambling harms in local government using public health approaches.

Timescale:

I will undertake this analysis after collecting and analysing data for objectives I-V. The anticipated time for this analysis and its write-up is approximately three months.

Sampling Strategy:

I will include the findings from objectives I-V in this analysis.

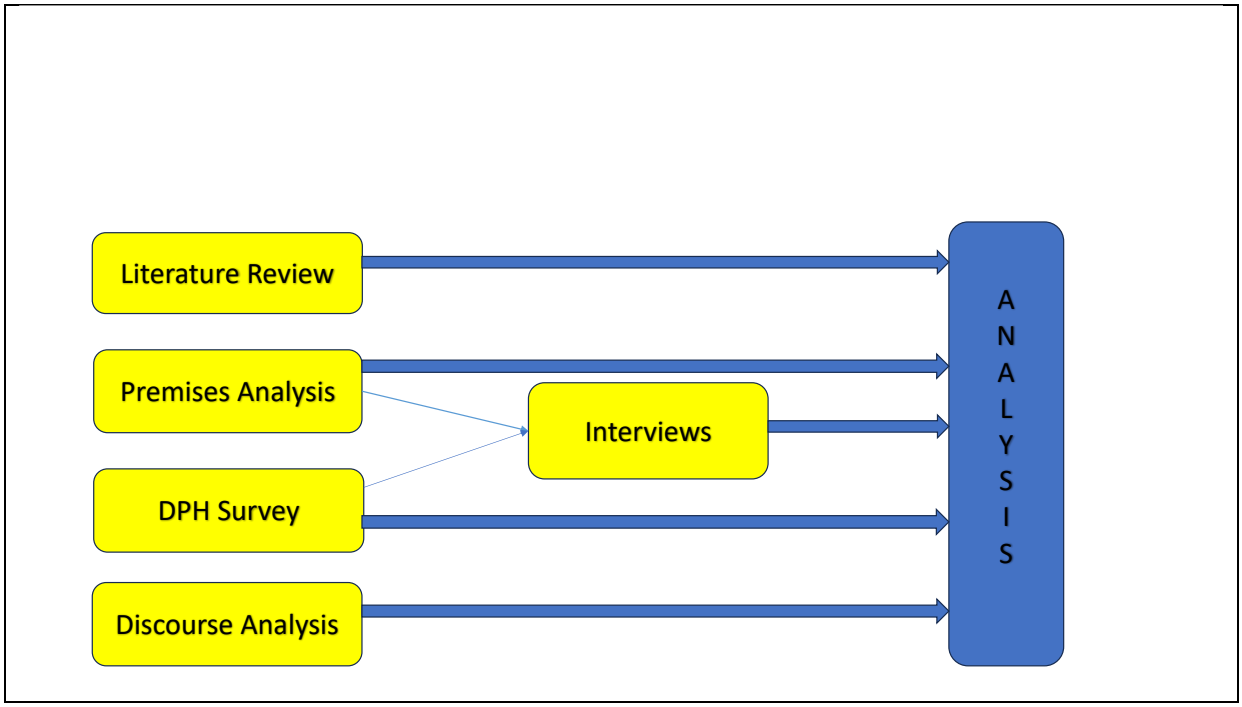
Data Collection:

For this analysis, a review of reflective notes and overall findings from the entire data collection for each of objectives I-V will be collated.

Data Analysis techniques:

The mixed methods analysis will have a parallel convergent design (with sequential explanatory element) (Fig 2-3).

Figure 2-3 Convergent parallel design (with explanatory sequential element) of the mixed methods analysis



Source: author's representation

Findings from both the quantitative and qualitative objectives I-V will be integrated to generate overarching themes. These themes will be presented as the levers and barriers to addressing gambling harms in local government using public health approaches, analogous in this research to mechanisms as per Bhaskar's CR approach.

The generation of themes from the research findings can be described as retroduction- "*a mode of inference, by which we try to arrive at what is basically characteristic and constitutive of … structures*" [86] which aligns with the CR approach. If individual phenomena are understood as embedded in, and an outcome of, social structures, retroduction aims to answer the question "*what is fundamentally constituitive for the structures and what mechanisms are related?*" and aims to ascribe a higher power to these structures tentatively [86].

Mechanisms can reinforce, counteract, or moderate each other [86, 87], and an analysis of how the proposed mechanisms interact will also be presented, using the research findings to support the arguments.

Given that CR also considers the impact of agency on mechanisms [86], I will also undertake interviews with local government representatives from outside London identified in the literature review (objective I) and document analysis (objective IV) who have already undertaken initiatives to address gambling harms. From these interviews, I aim to

understand the impact of the agency on implemented strategies and whether the mechanisms identified in the London data are transferable to other local government settings or unique to London. Interview participants will consent to using the same methods as for Objective V, and data will be held under the same conditions.

Critique:

A mixed methods approach aims to triangulate findings and strengthen the argument for proposing causal mechanisms. Examples from the findings of more than one individual objective can be used to argue for a single proposed causal mechanism.

The reasons why mixed methods research in the CR paradigm has been selected for this research have been discussed in section 2.5. The choice to present findings from quantitative and qualitative in an integrated manner (rather than presenting the two types of findings separately) reflects the ultimate aim of identifying underlying mechanisms that have had both quantitative AND qualitative empirical findings as their consequences; therefore, the overarching themes come from consideration of all of the empirical findings in combination.

Limitations of using a mechanism analysis include maintaining the "*delicate balance*" between being too generic and too contingent- if a mechanism is too general, it loses explanatory power; if it is too specific, it becomes relevant only in the single context where it was identified [87]. The process of conjecturing and assessing mechanisms also implies that the researcher has insight that goes beyond the knowledge of their informants [87], but awareness of the risk of epistemic relativism and the use of reflection built in throughout the research process aim to mitigate this.

The explanatory power of different mechanisms will be evaluated, but CR's tenet of epistemic relativism recognises that explanations can never include all relevant mechanisms and that temporary circumstances (social, political, and cultural) can "*play a decisive role in triggering various mechanisms and above all how the mechanisms more specifically influence events, activities and processes*" [86]. This will be considered as each proposed mechanism is discussed.

2.7.7 Objective VII) A summary of findings and recommendations for local public health teams about interventions to reduce gambling-related harms.

Research Strategy:

I will compile a list of recommendations for local public health teams based on the findings of the individual research objectives i-v and the subsequent mixed methods analysis of these objectives. In addition to using the objectives, these recommendations will incorporate any pertinent findings and examples from wider research-related activities (e.g., from attending meetings and conferences) undertaken during the research period with people working in UK public health and the gambling policy field but from outside of London.

Time Horizon:

I will consider recommendations throughout the research process but will combine them at the final write-up stage after the mixed methods analysis is complete.

Sampling Strategy and Data Analysis:

I will compile the final list of recommendations using findings from objectives i-vi and reflective notes kept throughout the research process, which consider these findings and wider research-related activities.

I will make recommendations on a local public health team, London borough, Greater London, and national level. I will also share examples of learning and good practice from other areas of the UK. Finally, I will outline recommendations for future academic research, primarily based on the findings presented in this thesis.

Critique:

It will be crucial to identify a format to present recommendations that is accessible to local public health colleagues to present these recommendations, and I plan to liaise directly with public health teams before writing up this stage to identify a format that works best for them to implement any recommendations. I also recognise that making regional or national recommendations based on research from the relatively small and specific geographical area of Greater London may be questioned regarding its wider applicability, especially by stakeholders with vested interests. When addressing criticisms of my research findings, I will

need to specifically consider whether they display any markers of “playbook” or corporate agnostic practices.

2.8 Methodological Challenges

It is recognised that integrating realist methods (e.g., survey and premises data) and interpretive methods (e.g., discourse and interview analysis) in research presents methodological challenges due to the differing ontological and epistemological assumptions underlying each approach. These challenges include ensuring methodological coherence and maintaining rigour and validity.

The overall research design has intentionally been developed to accommodate this quantitative and qualitative data. Initially, there is sequential integration: the survey results and premises data are shared with the interview participants to stimulate discussion. Then, at the mixed method analysis stage of the research, there is parallel integration, as findings from all individual objectives are considered when hypothesising the underlying mechanisms under the CR paradigm. Considering each research objective individually before integration preserves the differing assumptions before being brought together for the final analysis.

Integrating these realist and interpretive methods offers the potential for a richer, more nuanced understanding of social phenomena. However, it requires a flexible and reflexive research design, a deep understanding of both paradigms and a commitment to methodological innovation.

2.9 Reflexive Statement

It is important to recognise, initially and throughout the research process, that I approach this research from several perspectives.

I am a clinician. I have been a GP in the North East London area for the last 15 years and worked across the seven North East London (NEL) boroughs during that time, working in areas of high deprivation and inequity. I intend to keep working clinically throughout this thesis. My theoretical background is in science and not politics or policy, and my primary involvement with patients has been at the individual and not population level. It is important to question the relative benefits and disadvantages of individual vs population

intervention strategies and recognition of other community stakeholders' remits and knowledge (such as local government) where traditionally clinicians have not had much involvement. Still, a deeper understanding of the local government system is beneficial when working together via integrated care boards and systems.

I am an academic generalist. I came to this research from a medical education background, with previous research experience in interprofessional education (IPE) strategies. An IPE approach uses generalist, widely accessible language to reach wider audiences [111], but this comes with the recognition that 'experts' in fields may consider that you lack depth in consideration of specific topics. Practical strategies to address this, taken from the IPE literature, include identifying shared aims and using shared language, as well as encouraging co-creation of projects with relevant stakeholders from the outset [112]The influence of IPE has influenced the pragmatic decisions I have made regarding some of the methods chosen, which are purposely generalist and appealing to a wide range of stakeholders.

I am a localist. My experience in the COVID pandemic as a front-line clinician in a deprived area of East London has made me profoundly aware of how national policy is interpreted and translated on the ground and influenced by many stakeholders. I believe in local solutions to local problems, underpinned by health creation developed by the local community but financially supported by the state.

I am an affected other. Although now several years in the past, my experience as an "affected other" (defined as someone who has been impacted and/or harmed by someone else's gambling) prompted my interest in this research initially. I have volunteered for affected others' support groups in the past, and, in my personal capacity, I understand gambling harms as affecting the individual, those close to them and wider society. I believe in an all-harms, preventative framework to articulate and address gambling harms.

2.10 Conclusions

My research aims to identify the levers and barriers in local government to adopting public health strategies to address gambling harms. Using a mixed methods approach underpinned by a critical realist philosophy, my research comprises seven individual objectives to address the research aim and answer the questions posed in Chapter 1. These are summarised in Table 2-3 as follows:

Table 2-3: A Summary of research questions and their related objectives, theoretical underpinnings, and data tools.

Research Questions & Aims	Objective	Theoretical underpinnings	Notes on Data Tools
How have local government initiatives addressed gambling harms previously, and what were these interventions' impacts?	I)A literature review of local government-level interventions to address gambling harms and an analysis of UK local initiatives alignment to "a public health approach".	Literature Review guidelines (PRISMA). WHO 'Best Buys' for NCDs for presentation of results	Use of OVID for database searches and alerts set-up Use of Endnote to collate references Use of Excel to record paper extrapolation from review-level literature and books
How does public health's place within local government impact its involvement, influence, and interest in addressing gambling harms?	II)A survey of London Borough Public health teams to understand key organisational elements relevant to addressing gambling harms.	McKinsey 7S organisational management Mendelow stakeholder analysis	JISC online survey tool Data analysis on Excel
	III)An analysis of gambling premises data at both London and London borough levels, considering both type and number of premises and IMD 2019 deprivation ranking for the duration of the research period.	IMD 2019	Data extracted from the Gambling Commission website Data analysis on Excel in the first instance Further analysis using R and GIS tools, if possible
Within national documents, how have local governments been constructed about addressing gambling harms? What particular local government actors have been identified as key figures in addressing gambling harms? What has been the impact of these constructions?	IV) A discourse analysis of the relevant national, local government and London documents from 2000 to the present day, specifically considering the construction of local government within those documents and the impacts these constructions have had on local approaches to addressing gambling harms.	Glynos and Howarth's Critical Logics Approach (CLA)	Use of NVivo to collate and analyse Reflective notes kept on Word

How does local government understand a public health response to addressing gambling harms?	V) A reflexive thematic analysis of interviews with local government representatives.	Braun and Clarke's reflexive thematic analysis	Use of MS Teams to record and transcribe virtual interviews Codebook of anonymised transcripts to participants on Excel Use of NVivo to collate and analyse Reflective notes kept on Word
OVERARCHING AIM OF THE THESIS To identify the levers and barriers to addressing gambling-related harms in local government in London using a Public Health approach	VI) Mixed methods analysis of objectives i-v to identify mechanisms (i.e., levers and barriers) to addressing gambling harms in local government using public health strategies, underpinned by a critical realist philosophy	Roy Bhaskar	Reflective notes kept on Word during the research process
How can local government be best supported in adopting public health strategies to address gambling harms?	VII) A summary of findings and recommendations for local public health teams about interventions to reduce gambling-related harms.	Presentation format tbc	tbc

Chapter 3 Population-level, local government interventions to address gambling harms: a literature review

Gambling legislation differs between jurisdictions, and the powers of subnational governments vary. Previous reviews have considered population approaches to addressing gambling harms, but none have considered population-level approaches in the specific context of subnational implementation. The literature review in this thesis aims to address this gap.

This literature review systematically explored eight academic databases and two recent "reviews of reviews" on addressing gambling harms using population-level approaches. In addition, a 2012 report summarising evidence on addressing "Problem Gambling" and a recent book publication discussing international gambling policy were reviewed for relevant subnational interventions.

Of approximately 1000 individual papers reviewed, only 19 met the inclusion criteria, and evidence came from only 5 Anglophone countries. Findings are presented using the World Health Organisation's "Best Buys" framework of availability, marketing, and price, and additional themes are developed iteratively and included afterwards. Most of the evidence focused on reducing the availability of electronic gaming machines through temporal restrictions and/or reducing the numbers available. The design of studies often made drawing conclusions challenging, given that multiple interventions were implemented either simultaneously or sequentially. Interventions were also commonly implemented, assuming harm would be reduced, but no evaluations occurred. The funding for many of the studies was either unknown or from gambling industry sources, and most studies pre-dated the "online era" of gambling.

Despite these limitations, the literature review provides examples of "what is possible" regarding sub-national implementation of population-level approaches to addressing gambling harms.

3.1 Introduction

Gambling harms affect the individual gambler, those close to them, and wider society [1, 23]. These harms are not only financial but physical, psychological and cultural, impacting upon relationships, employment and education and contributing to criminal activity, domestic violence and suicides [23]. The increasing recognition of the breadth of problems has encouraged calls from various national bodies in Great Britain to adopt a public health approach to reduce the harms associated with gambling at the population level [2, 3]. This complements but contrasts with the historically widely adopted approach that sees the focus of intervention as being on the individual gambler [2, 23, 113].

Even more recently, gambling has been included in the rapidly expanding concept of Commercial Determinants of Health. These are defined as "*systems, practices and pathways through which commercial actors drive health and equity*" [44], with the gambling industry joining those initially most prominent within this field, such as producers of tobacco, alcohol, and junk food [114]. The commercial determinants framing has now entered the mainstream with, for example, a Lancet series and a programme within the World Health Organisation (WHO), whose "*best buys*" framework now explicitly includes population-level measures to reduce the harms caused by the tobacco and alcohol industry through action on price, availability and marketing (WHO's "*best buys*" framework) [92]. Increasingly, researchers are pointing out the similarities between the tactics employed by the gambling industry and the more traditional industries included within the commercial determinants concept [115]. These tactics include the promotion of individual responsibility paradigms and marketing strategies that normalise gambling. Some national policies can also show the reframing of gambling harms as a public health concern. For example, New Zealand use an "*all-harms*" legislative framework to conceptualise gambling harms rather than purely focusing on individuals [116].

This move upstream, shifting focus from the individual to the population, requires evidence of what works and what does not. The available evidence on measures to reduce gambling harms has been examined in two "reviews of reviews" and an international Delphi study [117-119](Box 1).

Box 1 Summary of recent reviews and consensus development on gambling-related harms

McMahon and colleagues (2018) undertook an umbrella review of prevention and harm reduction strategies designed to reduce gambling harms [117]. They included ten systematic reviews and 55 individual studies. 24% of the reviews considered pre-commitment and limit setting, 20% self-exclusion, 20% youth programmes and 20% machine messages/feedback. The authors concluded that "*the evidence base is dominated by evaluations of individual-level harm reduction interventions, with a paucity of research on supply reduction interventions. Review conclusions are limited by the quality and robustness of the primary research*".

Blank and colleagues (2021) undertook a systematic mapping review and narrative synthesis of public health interventions to address or prevent gambling-related harms [118]. They included 30 reviews, including the umbrella review by McMahon et al. above. Of the 30 reviews, 7 were whole-population preventive interventions, such as demand reduction (n=3) and supply reduction (n=4). The remainder of the reviews included therapeutic interventions (n=12), pharmacological (n=5), and self-help or mutual support (n=4). Two further studies compared these interventions. The authors commented, "*the dearth of evidence for some interventions means that implementation must be accompanied by robust evaluation*."

Regan and colleagues (2022) undertook a three-round expert consensus Delphi to agree public health measures are considered effective and feasible in reducing gambling harms [119]. The initial set of 103 universal and targeted measures was grouped into seven domains: price and taxation; availability; accessibility; marketing, advertising, promotion, and sponsorship; environment and technology; information and education; and treatment and support. The panel reached consensus on 83 (81%) measures. Of these, 40 universal and targeted measures to tackle harmful gambling were identified: 3 measures from the price and taxation domain; 10 from the availability domain; 5 from the accessibility domain; 6 from the marketing, advertising, promotion, and sponsorship domain; 8 from the environment and technology domain; 3 from the information and education domain; and five from the treatment and support domain.

While these reviews included individual and population-level measures, the latter were almost all at the state or national level. This left an important gap of critical importance for this thesis, the scope to act at the local government level. A rerun of Blank's searches in early 2024 revealed no new publications addressing this. Therefore, this chapter seeks to narrow this gap by providing a literature review of the available evidence on population-level interventions to address gambling harms, specifically enacted at the sub-national government level.

This literature review aims to indicate *what is possible,* in this case at the local government level, taking into account the prevailing legislative frameworks at the local and national government levels and, thus, the scope for autonomous action by local government bodies. The rationale for asking this question is that, as will be discussed in detail in later chapters, the dominant narrative in the 2005 Gambling Act and subsequent debates has been that local government's scope of action must be constrained by national legislation. Hence, it is important to be able to demonstrate what interventions have been implemented in other sub-national jurisdictions, whether they have been effective, and whether their enactment at other than national level has faced or created any problems.

3.2 Specific considerations when reviewing evidence on gambling

Any review of the literature on gambling harms and how to address them is subject to several caveats.

First, as noted above, it is important to understand the context and, especially, the scope and powers of local government in the settings where the study was undertaken and where the findings might be applied. This varies greatly across different jurisdictions. For example, in the UK, licensing of physical gambling premises relies on acquiring a licence for the premises where gambling takes place from the local government licensing authority, as well as licences for the operator and individuals involved from the national regulator, the Gambling Commission [65]. Of note, physical outlets that only sell lottery products are excluded from this legislation. In Australia and America, individual states have full control of how and where gambling can take place [26]. In addition, some countries, such as Canada and Finland, maintain state monopolies on gambling [26]. There are also differences in gambling legislation at the national level. For example, in Canada and Australia, gambling on credit is prohibited, where the US house credit is common [26, 120]. Finally, gambling legislation is rapidly changing globally, with a significant number of legislative changes, mostly expanding gambling provision, enacted in recent years [121].

Secondly, "*gambling*" is not a homogenous activity. Terms used in academic database searches must be cognisant of the wide range of activities classed as gambling and the many terms used, both formally and colloquially, to describe similar activities. Box 3-1 gives examples of the different names used in selected jurisdictions to describe electronic gaming machines (EGMs), a gambling product particularly linked to harm [121]. For the purpose of

this review, the term “EGM” will be used for all electronic gaming machines unless otherwise specifically specified (e.g. video lottery terminals [VLTs] found in North America).

Box 3-1 Names of electronic gaming machines, “Colloquialisms” (and locations) in different jurisdictions

- Slot machines, video lottery terminals [‘VLTs] (North America)
- Fruit machines, Fixed Odds Betting Terminals [“FOBTs”] (UK)
- “Pokies” and Pokie machines (Australia & New Zealand)
- Panchinko (Japan)
- Electronic bingo machines (multiple jurisdictions)
- Continuous lottery: electronic keno, ‘Rapido’ (France)

Adapted from Sulkenen, 2019 & Bowden-Jones, 2019 [26, 122]

Thirdly, the availability of gambling products varies among jurisdictions. In the global context, EGMs are the “*mainstay of most present-day casinos*” [26], but EGMs in the UK and Australia are available far beyond the casino setting. The more recent global expansion of internet gambling has increased availability further in terms of temporality and product type. However, local legislation concerning online gambling is especially problematic given the ability for national restrictions to be circumvented by the use of virtual private networks [VPN] [51]).

Fourthly, it has long been recognised that gambling research is “*compromised*” [63], given that, traditionally, the main funding source was the industry. Also, what counts as evidence is influenced by political ideology, and what research is included is often of poor quality [63, 95]. In the umbrella review previously mentioned, the authors note that: “*The evidence-base is dominated by systematic reviews of harm reduction interventions, and interventions targeting individual behaviour* ”[118]. They explain these findings as “*typical of the public health literature…often explained in terms of the ‘inverse evidence law’ (the tendency for there to exist the least evidence and research about interventions that are most likely to be effective) and political context*”. What is not considered here is the core issue that the evidence base is dominated by individually focused behavioural change due to the gambling industry's control of the narrative and historical control of research funding.

These considerations have shaped the literature review being undertaken in terms of its overall design.

3.3 Methodology

The research question for the literature review is: How have local government bodies used population-level initiatives to address gambling harms previously, and what was the impact of these initiatives?

My literature review will systematically search academic databases: Medline, Embase, Scopus, Social Policy and Practice, Global Health, Psychinfo, and CINALH. These academic database searches will be supplemented by a review of relevant publications from the two reviews cited above [117, 118], a book recently published on gambling policy [26] and a 2012 international evidence summary on the prevention of what the authors term "Problem Gambling" [120]. The absence of 'grey literature' in the review here is noted. However, grey literature is planned to be included in the discourse analysis (Chapter 6), and all individual objective findings will be analysed together in the final mixed-method analysis stage (Chapter 8).

My findings will initially be organised using sub-headings derived from a Commercial Determinants of Health lens (using the WHO 'Best Buy' headings of Availability, Marketing and Price) [92] but other sub-headings will be developed inductively throughout the search process.

The inclusion criteria are as follows:

- Primary research and reports of policy interventions found in any of the resources listed above (7 academic databases, two 'review of reviews'[117] [118], a recently published book on gambling policy [26] and an earlier summary of the evidence [120]).
- Primary research and reports of policy interventions of any design enacted at the population level (including 'whole-school' interventions)
- Primary research and reports of policy interventions relating to addressing gambling harms
- Primary research and reports of policy interventions enacted at any of the city, borough, country, state, or provincial level (or equivalent)
- All evaluated outcomes of interventions relating to gambling (where reported) are to be included.

- No limits on dates

The exclusion criteria are as follows:

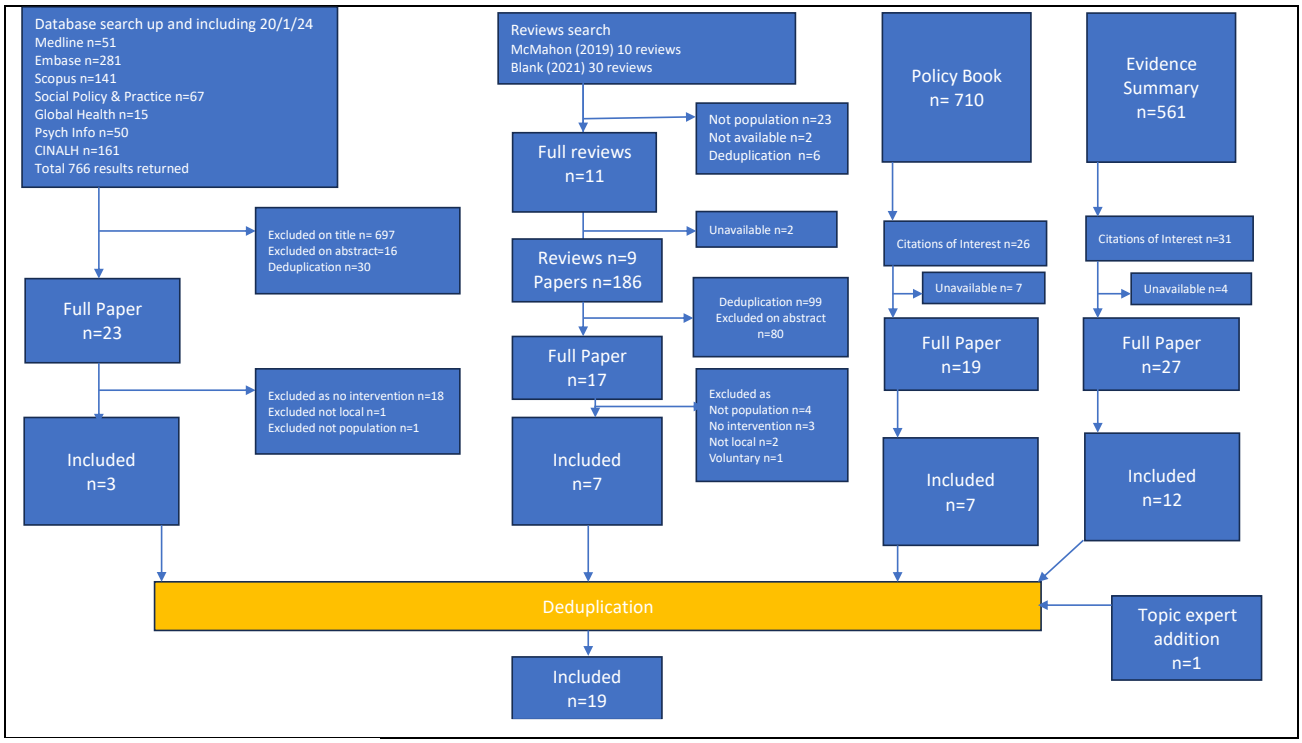
- Interventions that only target specific groups (e.g. “vulnerable”, “high-risk”, “problem gamblers” etc)
- Interventions that require individual agency to enact, for example, voluntary self-exclusion
- Interventions that are lab-based or in simulated settings
- Interventions that are in real-life settings but with experiment/empirical design, e.g., inclusion of control groups
- National-level policy interventions

The database searches were initially undertaken in September 2022, and weekly alerts were generated for new paper inclusions until mid-January 2024.

A table of publications included in the review is reported in Appendix 1. Funding of the publication, where available, is also included in this appendix, noting whether that source is directly or directly associated with the industry, non-industry, or unclear.

Appendix 2 presents the search strategies for the databases, and Figure 1 below outlines the flow of publications considered through the review process.

Figure 3-1 PRISMA Flowchart



Source: author's compilation

All the papers identified came from one of five countries: the UK, USA, Canada, Australia, and New Zealand. Box 2 sets out the distribution of relevant powers between national and sub-national governments in each of these.

Box 2 Powers of sub-national bodies in selected countries

UK	United States	Canada	Australia	New Zealand
Licensing authorities at the sub-national government level licence gambling premises and permits for additional EGMs and gambling activities outside those mandated for premises in the Gambling Act 2005. They can stipulate licensing conditions. However, a "statutory aim to permit" gambling premises is noted in the national legislation [65].	Gambling is legal under U.S. federal law, but there are significant restrictions pertaining to interstate and online gambling. Each state determines what kind of gambling it allows within its borders, where the gambling can be located, and who may gamble. Each state has enacted different laws pertaining to these topics. [123, 124]	Gambling in Canada is conducted and managed by Provincial Gaming Operators: with very limited exceptions (charities and local fairs), no person other than a provincial government is legally permitted to supply gambling facilities or services in Canada. All provinces require registration of any person operating a "gaming site" or supplying goods or services for use in the operation of gambling. There is no substantive difference in the treatment of land-based and online gaming anywhere in Canada other than Ontario, that has opened its online gaming market to private operators. [125]	There is no single overarching statute regulating gambling activities in Australia, nor is there a single overarching gambling authority. Instead, gambling in Australia is regulated at both the state/territory and federal level. Each of Australia's eight mainland states and territories separately regulates gambling activities within each of their respective jurisdictions. In addition, a series of federal statutes also cover certain aspects of gambling activity throughout Australia. [126]	Under the Gambling Act 2003, all territorial/local authorities are required to have policies for gambling venues ('pokie' venues and TAB venues) in their districts. New gaming machine and TAB sites need territorial authority approval and all gaming machine sites need territorial authority approval to increase their number of machines. These policies must be reviewed during every three-year period and communities must be involved in the process. [42]

3.4 Results

I present the results, first, using the WHO CDoH headings of Availability, Price, and Marketing, followed by any additional themes identified. In each case, I briefly summarise the nature of the intervention, clarify any technical terms, and set out the theoretical basis for it. I then summarise the empirical evidence that the intervention can work in practice.

After that, I consider whether, in theory, the intervention could be applied at a local level, taking account to geography and legal competence, as discussed above. Finally. I review critically the empirical experience with implementing these interventions in sub-national jurisdictions.

3.5 Strategies to reduce availability

The availability of gambling can be reduced using a variety of methods (Box 3). The availability theory is the assumption that changes in the availability of gambling opportunities will have effects on the total amount of activity and consequently on the total quantity of related harm [26].

Box 3 Reducing the availability of gambling

- Imposing restrictions on those who can gamble (e.g. by age and/or resident status)
- Putting restrictions on number of gambling premises
- Reducing types of gambling available (either by reducing hours available, or reducing/capping availability)
- Reducing gambling availability outside gambling premises [reduction of so-called convenience gambling])
- Banning certain types of gambling altogether.
- Reducing availability using various monetary restrictions

Sulkenen, 2019 [26]

Two examples of where a reduction in availability has had a positive impact on gambling harms are the "*natural policy experiments*" of Norway and Western Australia (WA) [26, 127]. In both cases, the availability of EGMs, widely thought to be one of the more harmful gambling products [26, 128], was restricted. In Norway, there was a temporary ban on all EGMs in the country for approximately 18 months from mid-2007 before a new type of "*less harmful*" EGM was introduced in 2009. Calls to gambling helplines and referrals to treatment centres were reduced in the six months after the ban was implemented [26]. In Western Australia, where EGMs are only available in one casino (compared to the rest of the country where EGMs are more widely available), a large (n= 15,000) national dataset weighted to standardised population variables showed that although gambling participation was higher in WA compared with the rest of Australia overall, gambling problems and harm

were about one-third lower in WA, and self-reported attribution of harm from EGMs by gamblers and "affected others" was 2.7 times and 4 time lower, respectively [127].

The evidence summary on problem gambling refers to the positive association between gambling availability and product consumption, arguing that it makes "*theoretical sense*" to cap the availability of gambling venues [120]. However, the author of the policy book [26] notes that this assumes that all else remains equal (referred to in economic studies as *ceteris paribus*) whereas in reality, other factors may well change at the same time as any change in availability and thus affect the outcomes. The policy book also notes that measuring physical availability is a challenge as many types of gambling can be concentrated in a single location (e.g., EGMs and tables in casinos) or different gambling possibilities may be spread diffusely throughout a city [26].

3.5.1 Imposing restrictions on those who can gamble

Availability of gambling can be reduced by using restrictions on age and/or residential status (e.g., gambling restricted as a resident of a country but not as a tourist) [120].

Implementing age restrictions on entry to physical gambling premises at a sub-national government level is possible in terms of it being part of legislation and/or a licensing condition of operating a gambling premises. However, in reality, there may be issues in terms of enforcement (e.g., whose individual responsibility is it to check someone's age or residential status), and patrons having the correct identification to show (and whether that would be acceptable to them).

Apart from a few U.S. states (and Alberta, Canada) where bingo playing is permitted at age 16 [26]All other examples of reducing the availability of gambling by age and resident status are at a national policy level and, as such, fall outside this review.

3.5.2 Reduction of gambling premises

A further way availability of gambling can be reduced is by reducing gambling premises in a locality.

The evidence summary notes that in Canada, certain provinces (e.g. British Columbia and Ontario) had capped the number of casinos [120]. In Canada, the policy book author's example of *ceteris paribus* was that the opening of a casino in Quebec was not associated with increased crime or rates of problem gambling, but an opening of a casino in Ontario

was associated with more problem gambling and higher demand for counselling [26]. This example implies that the geographical location of a gambling premises impacts the harms caused by its opening. However, this is a problematic assumption since the studies were not measuring the same harms, and no comment was made regarding any further differences between the physical geography or local populations of the gambling premises.

3.5.3 Reduction of hours available

Gambling availability can be reduced using temporal measures, e.g. implementing certain minimum closing times. The authors of the evidence review and the policy book both contend that most research has focused on EGM shutdown is because there is widespread acknowledgement that they are particularly associated with high rates of problematic gambling behaviours [26, 120].

In Australia, before 2000, most states had no requirement to limit hours when EGM were available [120]. Now, however, all states and territories, except Western Australia (the only one where EGMs are limited to casinos) currently require a 4 – 6 hour break in every 24-hour period [120]. Patterns of EGM closure times vary from state to state (e.g., 6-hour shutdowns can be in either one, two or three parts over 24 hours in some states), and applications to reduce closure times can also be made [129]. In addition, outside of this review, it has been recognised that closing hours between individual venues under the same ownership within close proximity are often staggered, leading to a 24/7 EGM availability in reality [129].

A mandatory 3-hour shutdown of EGMs in the Australian Capital Territory (ACT) between 4:00 am and 7:00am (implemented in September 2001) had a self-reported beneficial effect on a "*small number*" of problem gamblers and a 3 – 10% impact on club revenue [130]. However, the EGM shutdown policy was implemented simultaneously with two other policy changes (an AUS$10 bet limit and a cap on cash payments from EGMs), so it is unclear how much impact the shutdowns would have had in isolation. Also, the study only included gaming clubs licenced by ACT, with a casino and hotels in the Territory excluded, so the full range of venues (and, as such, patrons) was not represented.

A 3-hour shutdown of EGMs in New South Wales (NSW) in Australia in 2002 was deemed to be "*an ineffective harm minimisation strategy*" in reducing problem gambling based on qualitative interviews with problem gamblers (n=10), their family members (n=5) and

support agencies (n=4) [131]. The results should, however, be interpreted with caution as the number of people gambling who were interviewed was small (and not especially diverse), and findings from interviews with support agency representatives are arguably a surrogate marker. Also, the NSW findings may have partly reflected how some clubs varied their shutdown hours and that the major state casino was exempt from the shutdown [130, 131].

Also in Australia, a 2008 review analysed a six-hour shutdown of EGMs in NSW, using both qualitative and quantitative consultations with gamblers, venues, gambling support agencies, and the wider community [132]. A total of 272 people who gambled completed a quantitative survey, with half of the sample recruited when playing close to the venue's closing time, thereby seeking to determine their intended behaviour once machines were turned off. The researchers found that 30% of EGM players at that time were Problem Gamblers, based on CPGI diagnostic criteria (see Box 1 for an explanation and a further measure used in later studies, the Problem Gambling Severity Index-PGSI). 13% of interview participants said they would stay at the venue while, overall, fewer than one in ten (9%) said they would go elsewhere to continue to gamble. However, venue representatives acknowledged that the shutdown "*does not reach all problem gamblers*" and that there were exceptions to the shutdown [132].

Box 3-2 Measures of harmful gambling-the Canadian Problem Gambling Index (CPGI) and Problem Gambling Severity Index (PGSI)

The CPGI was constructed following a literature review. In its final form, the CPGI is comprised of 31 items that provide an estimate of the level of involvement in gambling, the Extent of problem gambling, Correlates of problem gambling, and Demographic characteristics.

The PGSI is a subscale of the CPGI, and consists of nine items with each item assessed on a four-point scale: never, sometimes, most of the time, almost always. Responses to each item are given the following scores: never = 0; sometimes = 1; most of the time = 2; almost always = 3. When scores for each item are summed, a total score ranging from 0 to 27 is possible. A score of eight or more represents a problem gambler. Scores between three and seven represent 'moderate risk' gambling (gamblers who experience a moderate level of problems leading to some negative consequences), and a score of one or two represents 'low risk' gambling (Gamblers who experience a low level of problems with few or no identified negative consequences).

However, many researchers refer to this subscale as the CPGI instead of the PGSI, which causes some confusion in the literature.

Adapted from Ferris and Glynne, 2001, Walker and Blaszczynski, 2010 [30, 133]

The Canadian province of Nova Scotia imposed a shutdown of VLTs in locations outside of casinos at midnight, the first of four interventions to reduce gambling harms implemented over 8 months [134]. 1745 adults were surveyed, and among the subset who played VLTs (n=545), the midnight shutdown resulted in a self-reported 19% reduction in spending among those defined as problem gamblers by the CPGI, a 4% reduction in moderate-risk gamblers, a 4% reduction in low-risk gamblers and a 1% reduction in spending in non-problem gamblers-numbers of responders in each VLT group were unclear in the report.

3.5.4 Reduction in EGMs

Given that EGMs have been recognised as a particularly harmful gambling product, a reduction in their number has been proposed as one way of reducing gambling harms.

There is significant variation globally in the provision of so-called "*convenience gambling*" (e.g. gambling in everyday spaces such as petrol stations and supermarkets) [135]. All states and territories except Western Australia permit EGMs outside casinos in Australia. In Canada, 8 out of 10 provinces permit EGMs outside of gambling venues, the exceptions being Ontario and British Columbia [120]. At the time of the evidence summary in 2012, [120] in the United States, only 6 states allow EGMs outside of gambling venues. The author of the evidence summary states that:

> *"the unique impact of limiting gambling opportunities to dedicated venues is difficult to determine, as jurisdictions with the policy also tend to have other restrictive policies as well (e.g., Western Australia). A more common problem is that jurisdictions with the policy often compensate by having many more 'dedicated gambling venues' so that the actual physical availability/proximity of EGM gambling is not significantly different"* [120].

In New Zealand, local government adopted a "*sinking lid*" policy designed to gradually reduce electronic gaming machines in non-casino establishments by prohibiting the transfer of EGM licences [136]. An evaluation found that this reduced gambling expenditure by 13% relative to regions not adopting policies that went beyond national restrictions. However,

even though such a policy reduces gambling expenditure and indirectly reduces availability via this pathway, the authors stated that "*no comment can be made as to whether people who gamble then diverted to alternative high-speed, equally harmful products (such as certain games found with online gambling)"*.

In Australia, an economic evaluation of a reduction of EGMs by 5% in Victoria found that gambler losses were not reduced, help-seeking by problem gamblers did not change, and there were no sustained revenue losses in venues where machines had been removed) [137]. However, the authors pointed out that the areas with these new caps tended to be areas with the highest EGM per capita ratios to begin with, and a further study noted those machines removed were the least profitable and the least popular [138].

The state of South Australia reduced its EGMs by 14.5% in July 2005, with a single-stage survey of 400 "*regular*" (defined as playing at least twice monthly) machine players being undertaken a year after [139]. 11% of responders said that the reduction in supply had helped them "*a little*" or "*somewhat*" to control their gambling. However, only 30 players (7.5%) reported having changed how often they gambled during the last 12 months. Of these 30, 24 (80%) reported having gambled less often, 14 reported spending less time playing EGMs. Only 13 out of the 30 who reported changing how often they gambled reported spending less money on EGMs.

The Canadian state of Nova Scotia implemented a 25% reduction in video lottery terminals, the second of four interventions over 8 months (the first was a midnight shutdown of EGMs outside of casinos) [134], described in the relevant section above. This second stage was associated with an additional reduction of weekly spending of 11% by Problem Gamblers (as defined in the PGSI), of 10% by moderate gamblers, 13% by low-risk gamblers, and 6% in non-problem gamblers. However, it is unclear from the report whether this was a true panel survey, with all 'post stage 1' responders included in the post-stage 2 survey of 711 VLT players, or whether those selected to complete the post-stage 2 survey were a new random sample.

The searches did not find any publications related to the reduction of convenience gambling in local jurisdictions.

3.5.5 Banning types of gambling

Total legal prohibition of gambling occurs in only a few jurisdictions, such as Cuba, many Islamic countries and the American states of Utah and Hawaii [120]. Albania has recently banned all gambling outside of casino settings, as has Paraguay (although the latter country has simultaneously legislated in favour of the expansion of their online gambling provision) [121]. However, outside of this review, it is clear that restrictions on land-based gambling are often circumvented by provision on docked riverboats or cruise ships.

There is evidence of the impact of EGM bans from two American states, South Dakota and South Carolina [140, 141]. In 1994, South Dakota's 7,859 legal EGMs were shut down for three months, and then reinstated by a public referendum [140]. In the 11 months before the ban, four substance abuse treatment centres averaged 68 inquiries and saw 11 new problem gambling clients per month. During the shutdown, this fell to 2 inquiries and 2 new clients. In the 3 months after EGM reinstatement, these numbers rebounded to reach an average of 24 inquiries and treated 8 gamblers each month. However, the small numbers, the short duration of the ban, and the small number of substance misuse centres involved give grounds for caution.

In 2000, South Carolina banned all 36,000 legal EGMs in the state [141]The number of active Gamblers Anonymous groups fell from 32 to 16 within 90 days of the ban, with several of the remaining groups reporting that the number attending their meetings decreased from around 40 to 1 or 2. In addition, the state's most active gambler's hotline reported that calls fell from 200 a month to zero.

Also in the US, telephone surveys of over 2000 adults from across the country, conducted in 1999–2000 and 2011–2013, showed increased rates of problem gambling, frequent gambling and any gambling in the past year at a time when the number of legal types of gambling increased [142]. In states where the number of types of legal gambling remained constant across the two time periods, problem gambling rates increased as exposure increased. US states with longer temporal exposure to legal lotteries or casinos also tended to have higher rates of problem gambling. States that restricted the types of legal gambling between the two periods saw a reduction in rates of frequent gambling. Although these results support the argument for reducing availability, the survey used self-reporting of the narrowly defined "*problem gambler*" to generate several measures.

All methods of reducing availability discussed above are theoretically possible if local governments in the jurisdiction have either the legislative and/or licensing powers to enforce restrictions at the sub-national level. It is of note that all these studies of EGM shutdown measured self-reported behaviour by responders, categorised into narrow categories such as 'Problem Gamblers', or upon the economic impact on the gambling industry. Furthermore, these studies all predate the widespread adoption of online gambling, so they do not consider the land-based/online nature of modern gambling [60].

3.6 Marketing

Problem gamblers are particularly sensitive to the promotion of gambling products and, by extension, the normalisation of gambling, and advertisements can undermine any intention to reduce or stop playing [26, 120]. These findings were reinforced in a recent umbrella review that concluded there is a "*dose-response*" effect to gambling advertising, with higher exposure to advertising associated with higher gambling rates and severity. There was also evidence that higher exposure to advertising influences betting behaviour in those who are current and higher-risk gamblers [143].

The literature review found one study from the UK that reviewed all 333 local government structures in England for the presence of a harmful product advertising policy [144]. The authors found that out of the 106 that had policies to restrict harmful product advertising locally, 84 (79%) included gambling. Apart from this, I was unable to find any evidence on restricting gambling marketing at a local government level, likely because the marketing vehicles are either able to cross geographical boundaries (e.g. television, radio, and the internet) or because responsibility for regulating fixed sites, such as billboards, can lie at a national level. However, *counter-marketing strategies*, defined (within the context of substance misuse) as "*the use of commercial marketing tactics to reduce the prevalence*"[145], is increasingly recognised as an instrument within this domain, and it will be discussed in the *Additional Themes* section below.

3.7 Price

It has long been recognised that raising price is one of the most effective ways of reducing consumption of products associated with damaging behaviour [120]. It is based on the concept of price elasticity, i.e. consumers change behaviour when prices rise) [26]. Based

upon evidence from Australia from a 1999 report, the evidence review and policy book reports conclude that EGM gamblers are not sensitive to price and that demand is most likely price inelastic [26, 120]. No evidence could be found about local government-led price changes to reduce gambling harms, but this may reflect the commercial nature of the myriad gambling products available. The regulation of a commercial product price would need central legislation to enforce.

3.8 Additional themes:

3.8.1 Counter-marketing Strategies

Counter-marketing strategies can be used to discourage or reduce the consumption of certain products, particularly those considered harmful to individuals or society. They seek to counter the marketing efforts of the companies promoting these products. Counter-marketing campaigns typically employ various techniques to inform and influence consumers, raise awareness about the negative consequences of specific products, and ultimately discourage their use.

In Ontario, Canada, a media campaign designed to dispel myths about how slot machines worked was evaluated in two waves of a random survey of 900 Ontario gamblers in February 2005, before the campaign started, and in April 2007, after it had finished. It was concluded that it "*was successful in significantly reducing these fallacies.*" However, no further information was given except that the citation provided for this in the evidence summary [120] was a personal communication from the Ontario Lottery and Gaming Corporation to the summary authors.

Local government structures potentially have the power to enact campaigns in their locality, although the provenance of the message, the reach of the campaign, and the evaluated outcomes would need to be considered.

3.8.2 Raising Awareness of Problem Gambling

Raising awareness campaigns of health issues are used to stimulate groups or individuals to seek information and services [146]. Through any increase in knowledge, people can, over time, change attitudes and, in the longer term, particularly when other intervention programmes are used, change their behaviour. While the content varies, common elements include understanding gambling, where participants learn about different forms of

gambling, the mechanics of gambling, such as odds or randomness, risks and consequences, including financial problems, addiction, relationship issues, psychological distress, and signs of problem gambling.

In the US state of Indiana, a state-wide awareness campaign to "*increase public awareness of problem gambling*" was implemented in 2000, using radio, billboards, brochures, newspapers, posters, pens, and t-shirts, press conferences, and town hall meetings [147]. A telephone survey of 400 adults in the state after the campaign had been implemented found that only 8% of responders recalled seeing or hearing any advertising. 72% of that 8% reported that the advertising had increased their knowledge of problem gambling. Only one of these responders reported "*taking action*", such as calling the helpline, due to seeing/hearing the message. The authors concluded that "*awareness initiatives appear to have a very limited impact if people are not explicitly asked to attend to the information or have no intrinsic interest in it*"[147].

In Victoria, Australia, there was a state-wide problem gambling awareness program in 1995 consisting of a 5-week multi-language radio, newspaper, and billboard advertisement phase, followed by a 14-week television advertisement phase the following year, and a 30-week radio and television advertisement phase in 1997 and 1998. An evaluation of the program concluded that it increased the number of callers to the gambling helpline and the number of new clients entering treatment. Despite extensive searches, only the summary of this report was available via the evidence summary [120] so no further information about the methods used is available.

In 2001, the Victoria government implemented another information campaign, which reportedly resulted in a 70% increase in calls to the helpline and a 118% increase in clients presenting themselves to treatment. Again, despite extensive searches, only the summary was available in the evidence summary [120].

In the UK, a local council undertook a "*high profile [population-level] communication campaign to coincide with [national] Responsible Gambling Week*" [148]. However, no evaluations were undertaken to measure the campaign's impact on gambling harms. Of note is that the communications campaign was indirectly funded by the gambling industry using payments from a local casino under their licensing agreement. Responsible Gambling

Week, since rebranded "*Safer Gambling Week*" in the UK, is organised by gambling industry representatives [149].

Local governments usually have a degree of autonomy in terms of local campaigns that they can choose to run. However, despite the Responsible/Safer Gambling approach frequently being used in the local government setting, it has been criticised for placing the responsibility to change on the individuals experiencing harms [150]Furthermore, raising awareness campaigns, whether focused on Problem Gambling and/or how to gamble safer, do not necessarily equate to a change in behaviour.

3.8.3 **School Programmes**

School-based prevention programs typically include teaching risk and probability as they apply to gambling, providing information about the potentially addictive nature of gambling, explaining gambling fallacies, building esteem, and developing peer resistance skills [120].

Both of the 'reviews of reviews' included reviews of population-level youth-based programmes [117, 118]. However, all the primary research that they included were small, time-limited studies that were not implemented at a population level so excluded from this review.

3.8.4 Changing Structural Features of EGMs

Game features are developed to encourage and prolong the gambling experience [26]. Examples include speed of play (that determines event frequency-the time between bet and outcome as such, increases participation and the possibility to re-gamble winnings almost immediately) and autoplay features (touch screens and video technology that can accelerate speed of play). [26, 33]. Some jurisdictions mandate a minimum time gap between games. In South Australia, the minimum period is 2.1 seconds, in Victoria, and in Tasmania and Queensland 3 seconds [26].

3.8.4.1 Speed of play and Autoplay features

In Nova Scotia, a 30% reduction in spin speeds was implemented at the same time as the removal of the STOP button on VLTs, the third and final stage in an 8-month programme of changes to VLTs [134]. In a survey of 865 VLT players, an additional 7% of Problem Gamblers, relative to after the second stage changes, was associated with a reduction in reduced weekly spending (now 37%) and an additional 10% of moderate risk gamblers (now 29%).

Victoria, South Australia, and Western Australia have banned the auto-play feature of EGMs (machines that play automatically on insertion of money and pressings of an 'AutoPlay' button) based on their view that this is harmful [26]. However, no evidence of local government policy regarding auto-play could be found for the review.

3.8.4.2 Maximum number of play lines

In recent years, there has been a tendency to increase the number of play lines available on EGMs. These are the lines on which winning combinations can be formed. By activating more paylines, players increase their chances of landing winning combinations and increase the total amount bet. This has the effect of increasing the overall rate of operant reinforcement, a form of learning in which the consequences of an individual's behaviour determine the likelihood of that behaviour occurring again in the future [33]. Very few jurisdictions impose constraints on play lines, except in Australia, where no more than 50 lines are permissible in Queensland and no more than 30 in Tasmania [120]. No evidence of local government policy regarding play lines could be found for the review.

As with pricing, changing the structural characteristics of a commercial product in a locality would most likely require central legislation to enact rather than local government enforcement. Potentially, structural characteristics could be a licensing condition for the local provision of a product.

3.8.5 Monetary Restrictions

Monetary restriction interventions have taken the form of setting a maximum on money in (by bans or limitations on note acceptors or setting bet limits) or money out (via limiting cash payouts), or by reducing access to money (cash or credit) in gambling venues. Much of the evidence in this area comes from Australia.

3.8.5.1 Note acceptors: bans and limitations

Note acceptors on EGMs are prohibited in some jurisdictions (e.g. hotels in South Australia and clubs in Tasmania and the Australian Northern Territory [120]. Other jurisdictions limit the size of bill the note acceptor will take (e.g., $100 note acceptors are banned in the Australian Capital Territory and Victoria [120].

In Queensland, an AUS$20 maximum note acceptor modification, with permission to spend up to $100 AU in one session of play, was found to have no impact on EGM revenue [151].

This intervention appeared agreeable to those who play EGMs-of the 180 responders to a population survey who had played EGMs in the past 12 months, 61% believed that the AUS$20 limit should remain, while an additional 28% felt the note limit should be decreased even further [151].

3.8.5.2 Bet limits and win limits

In Australia, there is an AUS$5 bet limit on EGMs in Tasmania, Victoria, and Queensland (hotels and clubs), and an AUS$10 limit in other states/territories [120, 152]. The introduction of a policy to limit EGM bets to a maximum of AUS$10 in the ACT was reported as not leading to changes in gambling behaviour for either "*recreational*" or "*problem gamblers*"; the authors of the report evaluating this policy suggested that this was "*presumably because AUS$10 represented a higher bet than most EGM players typically made*" [130]. However, this policy was implemented simultaneously with EGM shutdowns and cash payout caps, so the separate impact of $10AU bet limits cannot be determined.

Certain Australian states have a "*no limit win*" (ACT, Northern Territory, South Australia, Tasmania, Victoria, Western Australia), whereas others have limited wins to AUS$10,000 for individual EGMs (South Australia, Queensland, New South Wales) [120]. There is no evidence that this approach has been evaluated in local government.

3.8.5.3 Access to additional funds in gambling venues

ATMs and EFTPOS (Electronic Funds Transfer at Point of Sale) facilities are available at almost all gambling venues (not Tasmania or Victoria since July 2012), although they are not permitted on the actual gambling floor [120]. ATM withdrawals are limited to AUS$200 per day in South Australia and AUS$400 per day in Victoria. In all Australian states and territories (except Western Australia), winnings above certain amounts (between AUS$250 and AUS$2,000, depending on the jurisdiction) are paid by cheque, and certain jurisdictions do not permit the venue itself to cash these cheques [120]. Gambling on credit is banned in all Australian states and territories [120]. Outside of this review, it is noted that the UK banned gambling on credit in 2020 [49]

The removal of ATMs from venues with EGMs in Victoria in July 2012 was associated with a state-wide reduction in EGM expenditure of 7.1% average in the following financial years compared to the same period pre-intervention [153]. In pre-and post-implementation interviews, self-identified Problem Gamblers and ex-Problem Gamblers reported typically

spending less money and time at hotels and clubs housing EGMs. Although the authors of the report concluded that ATM removal had been an effective harm minimisation tool, the focus of this study, in addition to the economic impact on businesses, was on the small number of self-defined Problem Gamblers. Furthermore, the author of the policy book has since cautioned that this approach can encourage cashless transactions [26].

In the Australian Capital Territory, policies to restrict EGM cash payouts to less than AUS$1,000 "*simply caused gamblers to cash out their winnings before the $1,000AU limit was reached and then resume play*"[130].

Monetary restrictions by way of EGM design (note acceptors and bet/win limits) are theoretically possible at a local government level if such restrictions can be part of licensing agreements for premises and/or EGMs available in the locality. Again, it may be possible to restrict access to money via removing ATMs in a gambling venue, but other ATMs outside venues may be close by. In addition, the author of the policy book has since cautioned that this approach can encourage cashless transactions [26]. There is also recognition that *"the shift to cashless gambling appears inevitable…it is vital that governments actively manage this shift in such a way that harms from gambling are reduced, rather than increased"*[154].

Although the empirical findings here did attempt to consider outcomes wider than the economic impact on gambling businesses, gambling harms experienced were equated to financial losses, when in reality, harms are multi-dimensional (e.g., relationship and mental health harms) and temporal [1, 23].

3.8.6 Pre-Commitment cards

Pre-commitment is promoted to help gamblers control their gambling behaviour by setting limits on gambling activities before engaging in them. It can take various forms, e.g., time-based, loss-based, deposit-based or bet-based [155]. In terms of evidence of effectiveness, Norway is cited as having "*the most well-developed cashless gambling card scheme internationally…the scheme has seen a significant decrease in the number of calls to their gambler's helpline, as well as a large decrease of EGM gambling losses and participation rates"* [154]. However, it is also recognised that the "*Norwegian situation is unique, as the gambling industry is wholly government-owned*", and remains the only jurisdiction to have introduced a full, mandatory limit-setting system [154].

Several local jurisdictions have mandated pre-commitment card availability (e.g. Victoria, Queensland and New South Wales in Australia; for VLTs only in Nova Scotia, Canada) but not their uptake [120]. Despite a "*staged adoption*" of full [mandatory registration and mandatory limit setting] pre-commitment systems for EGM gambling across Australia being recommended in 2010, three more recent royal commissions into casinos recommending the same, this has yet to be implemented in a mandatory format in any Australian states [154].

3.8.7 Restrictions on concurrent use of alcohol and tobacco

Gambling and drinking often co-exist, particularly where gambling is at problematic levels, with good evidence of a link between increased drinking and increased gambling [23, 120]. Therefore, restricting access to alcohol in gambling venues has been suggested as a harm minimisation approach. Alcohol service is prohibited in some casinos in British Columbia, where municipal governments assume responsibility for licensing decisions [120]. In the US, free drinks are provided to casino patrons in 13 of 22 states with commercial casinos [120]. No evidence could be found regarding local government restrictions on alcohol at gambling premises.

The evidence summary [120] suggests that "*smoking bans may inadvertently act as one of the more effective policies to reduce problem gambling, given that the majority of problem gamblers are smokers*", hypothesising that "*problem gamblers may be less likely to gamble for extended periods if they cannot smoke, thereby introducing a mechanism for reducing harm*".

In Canada, smoking in casinos is banned in all provinces (except casinos on some First Nations reserves), and in Australia, smoking is generally only permitted in private/premium gambling rooms. However, this is primarily because both countries have comprehensive, state-level smoking bans for enclosed public areas. In the US, 27 states have enacted state-wide bans on smoking in all enclosed public places; however, 9 of these states exempt casinos [120]. Casinos in the US that are situated on Native American reserves are also exempt from the smoking ban [120].

In Australia, the state of Victoria implemented a smoking ban in gambling venues in September 2002: that at the time did not have a smoking ban in enclosed public spaces in place [156]. The ban was associated with a sustained average 14% monthly reduction in

EGM expenditure compared to a neighbouring state with fewer smoking restrictions. The study concluded that "*the smoke-free policy not only protects hospitality workers and patrons from exposure to second-hand smoke but has also had an impact on slowing gambling losses*" [156].

There is, however, evidence that EGM and casino revenues that the impact of any ban is limited in duration and may return to their previous levels after smoking bans have been in place for some time [26, 120]. The policy book author notes that there is "*no empirical research to indicate whether this is due to smokers (and problem gamblers) having adjusted to this requirement, or non-smokers patronizing gambling venues at higher rates because of the smoke-free environment*"[26]. In addition, smoking bans in enclosed public spaces, including gambling venues, have been widely adopted across jurisdictions, so the specific impact of these interventions on any measures of gambling would be extremely difficult to extrapolate.

3.8.8 Problem Gambling Awareness training for employees

Raising awareness of a health issue in populations aims to change a behaviour eventually: raising awareness of an issue of services that populations engage with can potentially support the implementation of screening programmes or consideration of the issue in a wider context.

All Canadian provinces have implemented either mandatory or voluntary problem gambling awareness training programs [120], although neither the evidence summary nor the policy book identified the states it is mandatory. Other sources report that this is the case in British Columbia and Ontario. In the UK, training of front-line local council staff (from customer services, housing, primary care mental health and substance abuse teams) was offered alongside a "*high profile [population-level] communication campaign to coincide with Responsible Gambling Week*" [148]. The evaluation of the training was positive, encouraging wider adoption in neighbouring councils. Still, there was no comment on any impact on reducing gambling harms other than that the implementation had "*built momentum*". Of note, both the training and communications campaign were indirectly funded by the gambling industry using annual payments from a local casino under its licensing agreement, with training sessions funded by GambleAware, an organisation that manages the voluntary

financial contributions made by the gambling industry for research, education, and treatment [114].

3.9 Discussion

This literature review summarises the available evidence on population-level interventions enacted at the subnational level to address gambling harms.

Using WHO's 'best buys' framework, some evidence favoured policies that sought to reduce availability, but no evidence at a local government level could be found on reducing harms using marketing or price strategies.

A wide range of policy interventions has been implemented, primarily restricting the availability of EGMs in some way or altering the operating characteristics of these machines. On occasion, policies were implemented with an assumption of harm (e.g., Auto-play in Australian states), but these were not evaluated.

The literature review included papers and reports taken from seven academic databases, two 'reviews of reviews', an evidence summary of problem gambling and a recently published book on gambling policy. Despite drawing on these broad sources, and nearly 1000 individual study abstracts being reviewed for potential inclusion, only 19 primary research articles or reports could be included. In addition, 2 reviews and 12 papers also had to be excluded from the review as the full copies were unavailable despite comprehensive searches supported by academic libraries.

Search terms for the databases were broad and co-designed with both experienced university library representatives and systematic reviewers. The availability of a policy book and an evidence summary broadened the scope as to what was included (such as economic reports that academic databases may not have picked up). However, some references were unavailable via the provided hyperlinks or internet web scraping or were informal documents (e.g., private communications to the evidence review author). This means that a detailed assessment of some policies was unavailable so reporting may be inaccurate.

A further limitation was that the research came from Anglophone countries only and, therefore, includes only territories where the gambling provision and the population at risk fall within the same territory (unlike places where 'tourist gambling' gambling dominates, such as Macau and Native American reservations. I also recognise that some may argue that

the different constitutional status of the anglophone countries discussed in the review precludes transferability. Still, this review demonstrates that measures can be implemented at the sub-national level and highlights that local government in the UK is especially constrained.

A further complication is that while single interventions were reported, they were often implemented as part of a wider package of policy change, where several harm minimisation policies were implemented at the same time [130] or sequentially over a series of months [134]This makes it difficult to separate the effectiveness of individual interventions. There were also frequent exemptions, such as casinos exempt from EGM shutdowns in Australian states and First Nation casinos exempt from alcohol bans in Canada.

There was also recognition that restriction of gambling in one way (e.g. EGMs in gambling venues only or ATMs) was often compensated with counterbalancing measures (more gambling venues, more cashless transaction possibilities) [26, 120].

The evaluations undertaken predominantly measured economic impact or focussed on behavioural changes within the narrow category of 'problem gambler', while behavioural outcomes by Problem Gamblers were often self-reported and involved small samples. Surrogate markers of harm, such as measures of access to support services, were often used. Some of the most widespread interventions (e.g. raising awareness and counter-marketing strategies) have little evidence of impact of effectiveness (highlighting McMahon's acknowledgement of the "*inverse-evidence law*"-the tendency for there to exist the least evidence and research about the interventions that are most likely to be effective [117].

In addition, the evidence available often dated to the 'pre-online gambling' era, population-level interventions that consider both marketing and price, as well as interventions wider than purely reducing land-based EGM availability, are now more important than ever.

Finally, many of the publications were funded either indirectly by the gambling industry [120] or the source was unclear (see Appendix 1). In addition, even those studies funded by governmental organisations can potentially be influenced by neoliberal thinking, corruption and governance issues as outlined in section 1.3.3, "The Commercial Determinants of Health". This potentially "*compromised*" research [63] reinforces the case for gambling to be

considered a commercial determinant of health: learning can be drawn from previous experiences of the tobacco and alcohol industries' involvement in research, and gambling industry involvement in research should not be tolerated going forward.

3.10 Conclusions

This literature review considered local government and population-level policies that aim to reduce gambling harms. Seven academic databases, two reviews, one evidence summary report, and a recently published book on gambling policy were searched for relevant publications with an end date of mid-January 2024. The review included 19 citations.

The findings were presented using a 'best buys'' framework of availability, marketing, and price, followed by additional themes. In the global context, most evidence came from Australia, Canada, and the United States, all jurisdictions with state-level control over gambling legislation. Most evidence considered the reduction in availability or changes in the so-called structural characteristics of electronic gaming machines (EGMs). There was No evidence regarding price or marketing policies to address harm locally, although counter-marketing campaigns to raise awareness had often been implemented.

Overall, the quality of evidence is limited by evaluations that predominantly rely on self-reported outcomes from the subset of 'Problem Gamblers' or the economic impacts of harm reduction strategies on the industry. Evaluations often used surrogate markers such as calling helplines and attending groups. In some cases, implemented policies were not evaluated, and so-called 'blanket bans' had exemptions for certain gambling premises not included.

Although there was some evidence of reduced harm in terms of reducing availability, given an increasing online gambling market globally, local government strategies that focus solely upon so-called land-based gambling will not capture the full population that gambles and, as such, are exposed to harm. Population approaches considering the combined in-person/online nature of modern gambling must be implemented under the precautionary principle while further impact evaluation is undertaken. Research into any impact must be free of industry influence and focus upon broader impacts than self-reported 'Problem Gambler' behaviour and economic impact on the gambling industry.

Following this literature review, the following two chapters aim to gather some quantitative data on London boroughs and gambling policy and premises to start building an understanding of the 'local picture' before exploring more qualitative elements.

Chapter 4 A Survey of London Directors of Public Health (DsPH) and local gambling policy

The scoping activities that were undertaken in the preparation stages of this thesis found a variation of public health team involvement in their gambling policies at London borough level. It is therefore important to gather some baseline information about individual public health teams in London, and about their interest and influence in local gambling policy.

Organisational theory was used to design and co-create an online survey that was then disseminated to all Directors of Public Health (DsPH) within Greater London. Dissemination was supported by the regional Association of Directors of Public Health (ADPH) team.

Despite this support, and dissemination time sensitive to other public health activities at the time (including vaccine delivery programmes), the response rate was poor (28%). Although no overall conclusions can be drawn, it was noted that there was wide variation in both place and size of individual public health teams and a lack of consensus as to whether gambling harms are considered a public health issue. A positive correlation between a public health team's involvement in alcohol policy (where they have a formal legislative role) and gambling policy (where they don't) was noted- this may suggest that the attitude to public health team involvement in policy is not purely based on legislation. Public health teams also identified a wide range of existing working relationships within local government; those most frequently cited being licensing and planning.

4.1 Recap

So far, this thesis has reviewed the available literature on subnational, population-level interventions to address gambling harms. This chapter is the first of two quantitative analyses and reports on a survey of London borough Directors of Public Health (DsPH) on their interest in and perceptions of their influence on local gambling policy.

4.2 Key Findings

The response rate was 28% overall, with 56% from 'inner' London boroughs

- The number of Full-Time Equivalent public health staff in individual London borough teams ranged from 2 to 46

- 56% of DsPH feel confident in presenting gambling harms as a public health issue to other local authority departments
- The extent to which public health teams feel they have an opportunity to contribute to local gambling policy meaningfully was similar to that with alcohol policy (where public health teams already have a formalised 'Responsible Authority' role), with the two strongly correlated at borough level
- Most DsPH respondents believe they have an influence on their Health & Wellbeing Board, but their influence on licensing committees for gambling premises is less clear.
- DsPH most frequently cited planning and Licensing teams as effective existing partnerships already established in local authorities.

4.3 Background

4.3.1 Public Health in local councils

The Health and Social Care Act 2012 introduced large-scale structural reforms to health and care systems in England, including changing how public health function is delivered [9]. In April 2013, local councils became responsible for public health staff and functions previously within the National Health Service (NHS). Under the same legislation, a Director of Public Health (DPH) was appointed to lead each local public health team [7]. Subsequently, a 3-year study of public health teams within local councils in England by Peckham et al. found considerable variation in the location of public health and the DPH within the structure and hierarchy of the council, with implications for managerial accountability [9]. This variation is important as concerns had already been raised in the House of Commons about DsPH's capacity and autonomy and whether the position within local bureaucracies might make them "subordinate to other officials" [9].

A more recent assessment of those public health reforms concluded that "*the move to local government for many public health services was the right one…in the long-term is the opportunity this has to influence wider local government policy and decisions*" [10]. The Local Government Association (LGA) supports having a Health in All Policies (HiAP) approach to policy-making in local councils as a mechanism for considering health implications of decision-making [16]. In their 2016 publication, the LGA recommended "*structural or procedural change in local government to embed HiAP…as well as development of common monitoring and evaluation tools*" [16].

4.3.2 Licensing in local councils

Local councils have licensing authorities that approve, revoke, and set conditions for certain types of premises that wish to open in their area, such as those selling alcohol and food and entertainment venues. Licensing authority committees comprise permanent council staff and elected members.

Under The Gambling Act 2005, all 'land-based' gambling businesses require a premises license from their local licensing authority [65]. They also require two further licenses (a personal and an operator license) via the national regulator, The Gambling Commission, to operate [65].

For premises that want a license to sell alcohol, local public health teams are what is called 'responsible authorities'- that is, under the Licensing Act 2003, they are one of several groups that must be informed of any new premises applications applying to sell alcohol [66]At the present time, the same does not apply to public health teams under gambling legislation, and they are not a Responsible Authority.

This distinction is important because gambling harms are increasingly conceptualised as a public health issue, given that harms are experienced not only by the individual but also by those close to them and wider society [1-3]. Furthermore, the distribution of harm is inequitable, impacting some of the most deprived and vulnerable groups in society [23], while the economic impact is highly regressive [157].

This survey of London DsPH is a component of a thesis that considers the levers and barriers of adopting public health strategies in London local authorities to address gambling harms. The aims of the survey were two-fold:

Firstly, to understand what interest and influence local public health teams have on local gambling policy and;

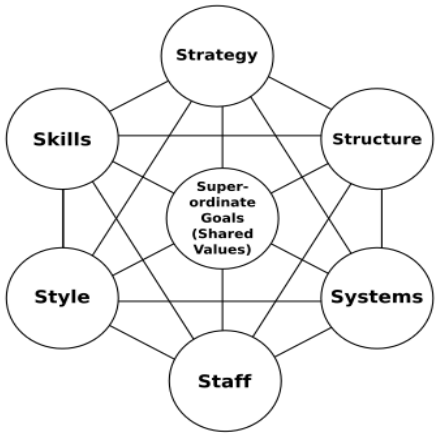
Secondly, to generate data to be used as a prompt in subsequent interviews with interviewees from local councils (interview results reported in Chapter 7).

4.4 Methods

The first draft of the survey was developed in the light of the findings by Peckham et al on the role of public health in local government [9], as well as drawing on two established frameworks that consider organisation change management: McKinsey's 7S

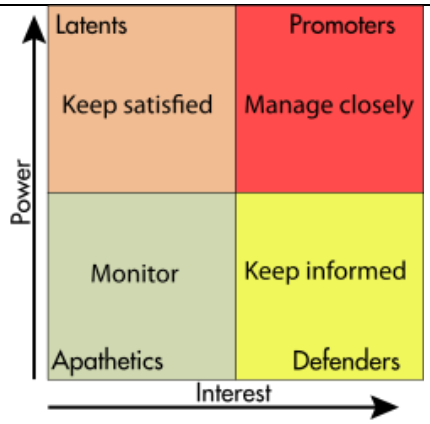
conceptualisation of organisational structure and Mendelow's power-interest matrix that supports stakeholder analysis (see Figures 4-1 & 4-2)[11, 12].

Figure 4-1 McKinsey's 7S organisation structure framework

	A management tool developed in the 1980s, often used to assess and monitor internal change in an organisation. The model is based on the theory that for an organisation to perform well, these interrelated elements need to be aligned and mutually reinforcing [11].

Peters & Waterman, 1982 [11] Image [158]

Figure 4-2 Mendelow's power-interest matrix

	Stakeholder analysis is the process of assessing a system and potential changes to it as they relate to relevant and interested parties. Mendelow's power-interest matrix or grid, is one method of mapping stakeholder "*power and expectations (and therefore their likely interest) ... to determine the potential influence of stakeholder groups*" [12].

Mendelow, 1991 [12] Image [159]

Development of the survey

The draft survey contained questions about the public health team within the borough council (as per Peckham's paper and McKinsey's "*structure*" element of organisations), further "*staff*" questions as per McKinsey, and then questions about public health teams'

perceived power in the council and interest in gambling policy to determine their potential influence.

The draft was then sent to five local public health team representatives based in different boroughs across London for comment and a request to suggest questions and topics they felt were important. Their feedback included adding temporality to certain questions (using a "Yes previously" as a possible response option), and to including questions that would help compare public health teams' interest in both gambling and in local alcohol policy, the latter where their role is more established.

The final co-created survey included a total 20 questions that were a mixture of closed questions with answer options provided, statements that required agreement ranking on a Likert Scale, and one free text question asking about collaborations with their borough. The full survey, information sheet, and consent form sent to DsPH, are attached as Appendices 3-5. Ethical approval was granted for the survey by LSHTM in Jan 2022 (Ref 26646).

The final survey was hosted online using the JISC survey platform [160] and distributed as a hyperlink that linked to the questionnaire.

The survey was announced at the February 2022 London Association of Directors of Public Health (ADPH) online meeting, as well as in their newsletter in the same month. All 32 London DPHs were emailed shortly after the meeting with an invitation to complete the survey, and an information sheet and a consent form were attached. On receipt of the consent form, the hyperlink to the survey was then sent: ethics approval required completion and return of the consent form before the hyperlink to the survey could be forwarded.

Reminders to return the consent form and complete the survey were sent two and four weeks after the initial emails to those DsPH who had not responded.

Although the survey asked respondents to state their borough, this was included as a question for analysis purposes only: the introductory email, information sheet, and consent form confirmed that borough-level anonymity would be maintained for any onward dissemination. Data collection took place between March and April 2022.

4.5 Results

After presenting the response rates, the remaining results are reported in five sections:

Part 1: Public Health in London local authorities

Part 2: Gambling Policy in London boroughs

Part 3: Comparison with public health team involvement with alcohol policy

Part 4: Public Health influence in their London Borough Committees

Part 5: Recognised existing effective partnerships

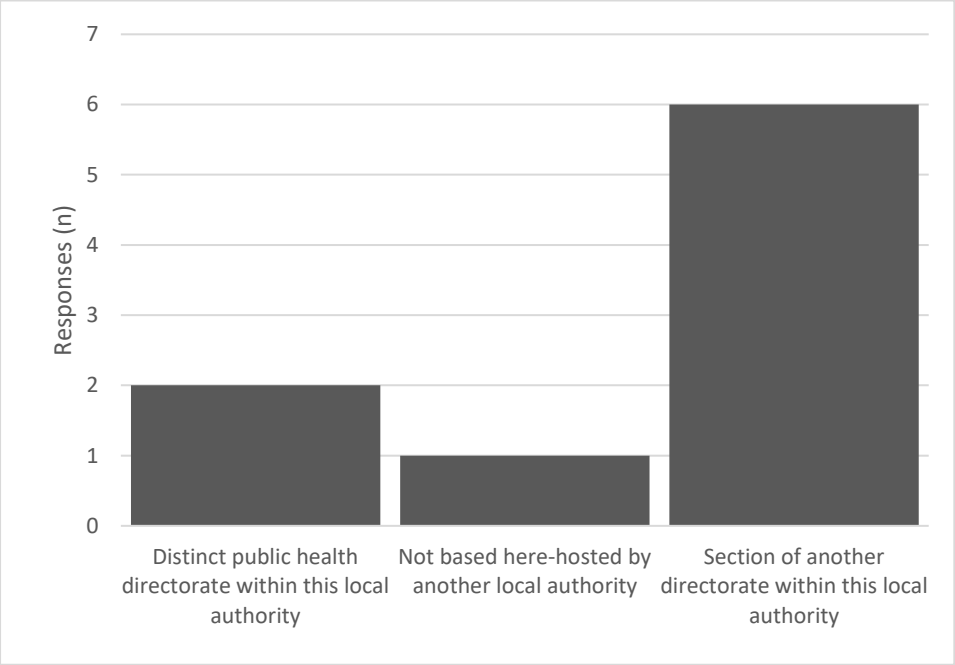
4.5.1 Response rates

Only nine of the 32 boroughs responded (response rate 28%). 5/9 (56%) of responses were from the 12 'inner' London boroughs as defined by both the Local Government Act 1963 [161].

Part 1: Public Health in London local authorities

The responses highlighted a broad range of public health teams 'place' within individual London boroughs (Fig 4-3).

Figure 4-3: Where is the public health team placed within the local authority?



The number of Full-Time Equivalent (FTE) staff within public health teams varied from 2 to 46, with a mean of 37 and a median of 30. 44% of responders reported that a public health team member was currently chair or co-chair on their borough's Health and Wellbeing Board. In addition, 44% of London boroughs with public health teams that responded had a

Health in All Policies working group or equivalent. 44% of responders reported that a public health team member currently has a formal role on their borough's licensing committee.

Part 2: Gambling Policy in London boroughs

Gambling-related harms were recognised as a priority for the local authority of 66% of respondents, of which 66% were 'inner' boroughs (as described in the methods section above).

Similar figures were obtained in response to the question of whether gambling harms were a priority for public health teams-66% of public health teams felt it to be a priority, with 33% of those being inner boroughs.

56% of responders reported having allocated someone to gambling in their public health team. 33% were inner boroughs.

22% of respondents could report that their local authority had responded to the government's call for evidence regarding the Gambling Act review, and 45% did not know.

Part 3: Comparison of involvement and influence in gambling policy with involvement with alcohol policy

DsPHs that responded felt that they have less influence on gambling policy than on alcohol policy (Figs 4 & 5). Only 8/11 (73%) and 9/11 (82%) of responders answered these questions, respectively.

Figure 4-4 Please rate the following statement from Strongly Agree to Strongly Disagree: "The public health team was given the opportunity to meaningfully inform the most recent local authority gambling license policy process".

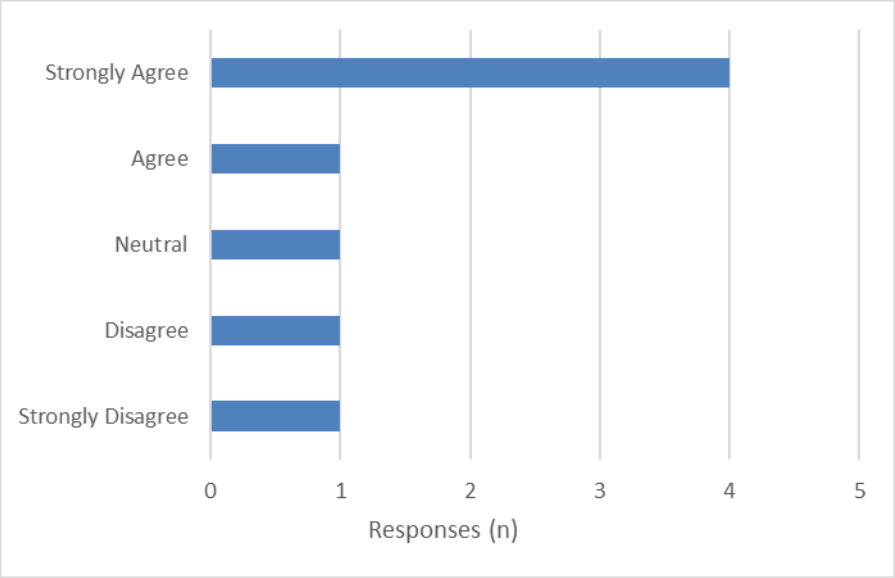
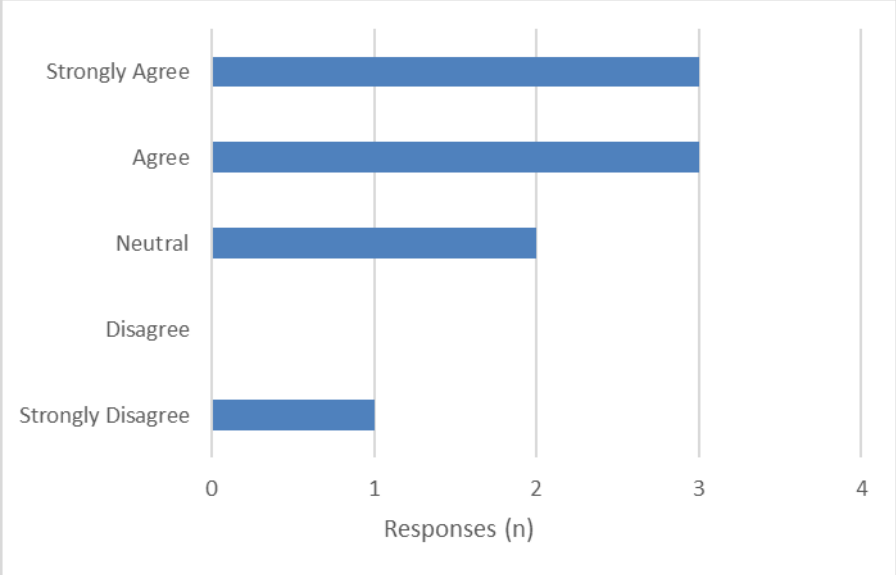


Figure 4-5 Please rate the following statement from Strongly Agree to Strongly Disagree: "The public health team was given the opportunity to meaningfully inform the most recent local authority alcohol license policy process".



DsPH also felt that overall they had less influence on gambling premises licencing decisions than alcohol premises licencing decisions (Figs 6&7). Only 9/11 and 8/11 answered these questions, respectively.

Figure 4-6 Please rate the following statement from Strongly Agree to Strongly Disagree: "I am confident the public health team currently has influence on gambling premises licensing decisions".

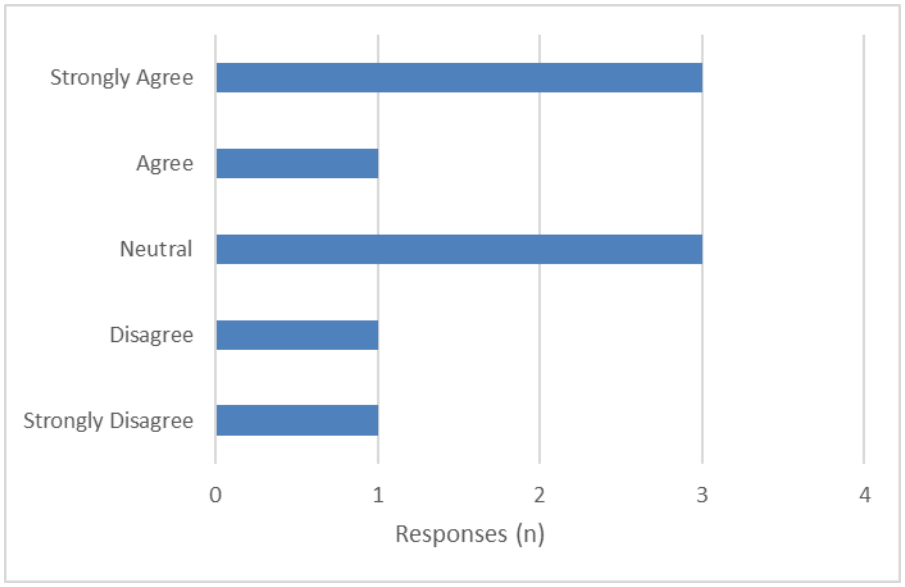
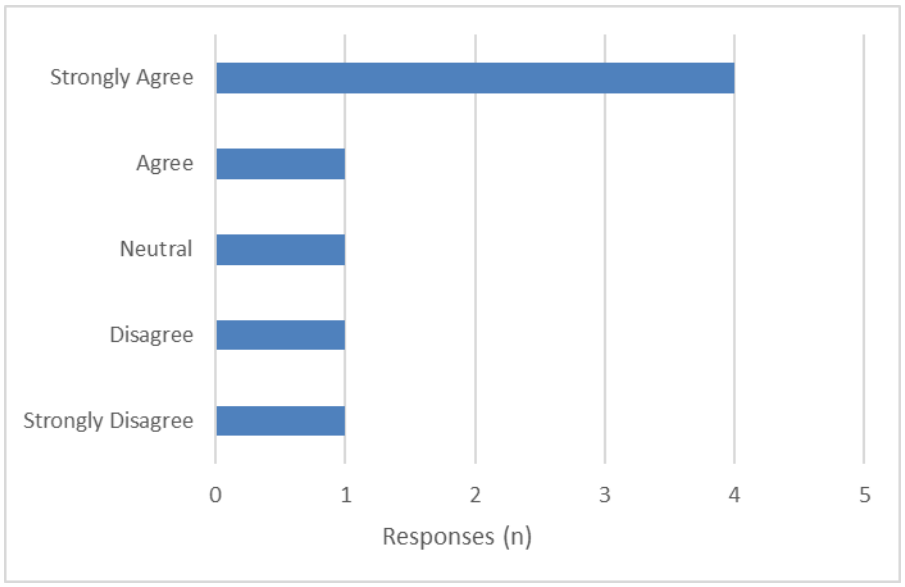
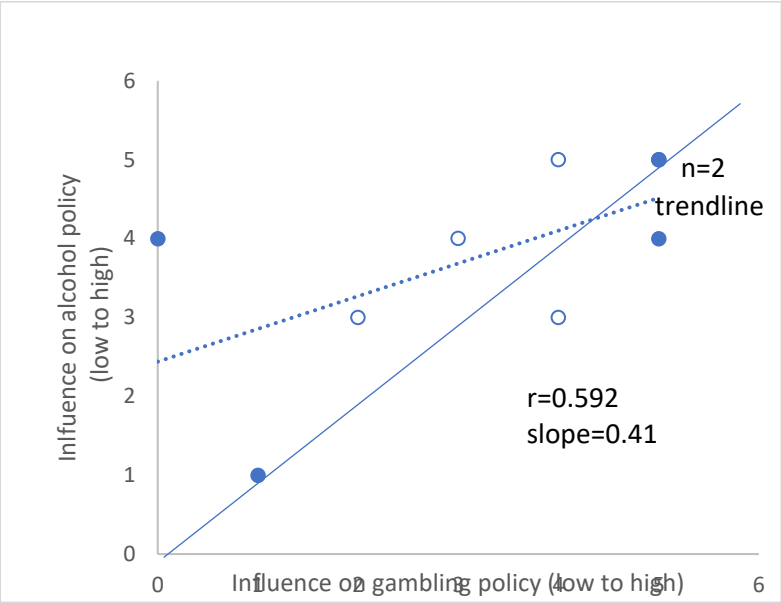


Figure 4-7 Please rate the following statement from Strongly Agree to Strongly Disagree: "I am confident the public health team currently has influence on alcohol premises licensing decisions".



However, there was a positive correlation between perceived influence on alcohol licensing decisions and gambling licence decisions at borough level (Fig 8).

Figure 4-8 Public health's influence on licensing team: gambling premises vs alcohol premises



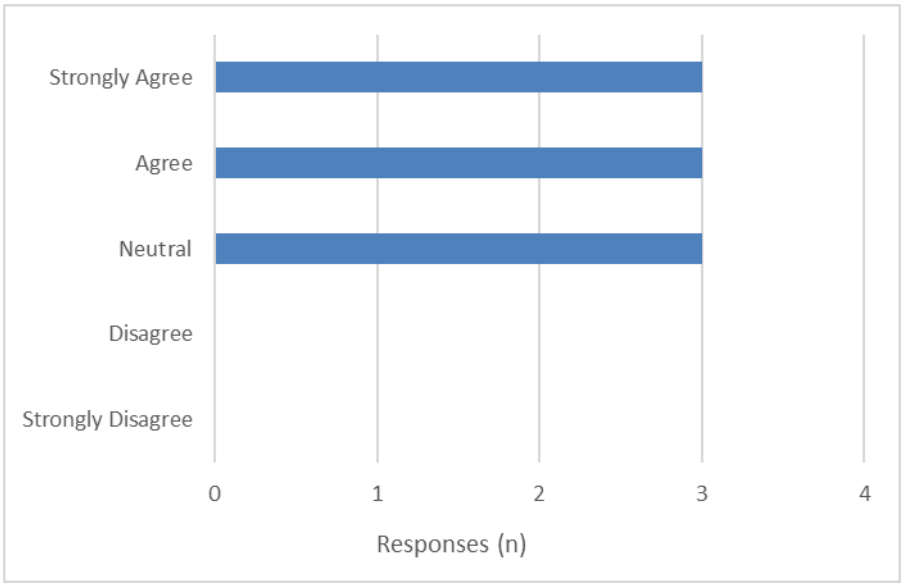
Note: Correlation coefficient and slope are provided for completeness but should not be overinterpreted given small numbers. Open circles are outer London, closed circles are inner London

These results suggest that public health teams believe they can influence their local authorities' approaches to gambling despite not participating in the Responsible Authority role.

Part 4: Public Health influence in their London Borough Committees

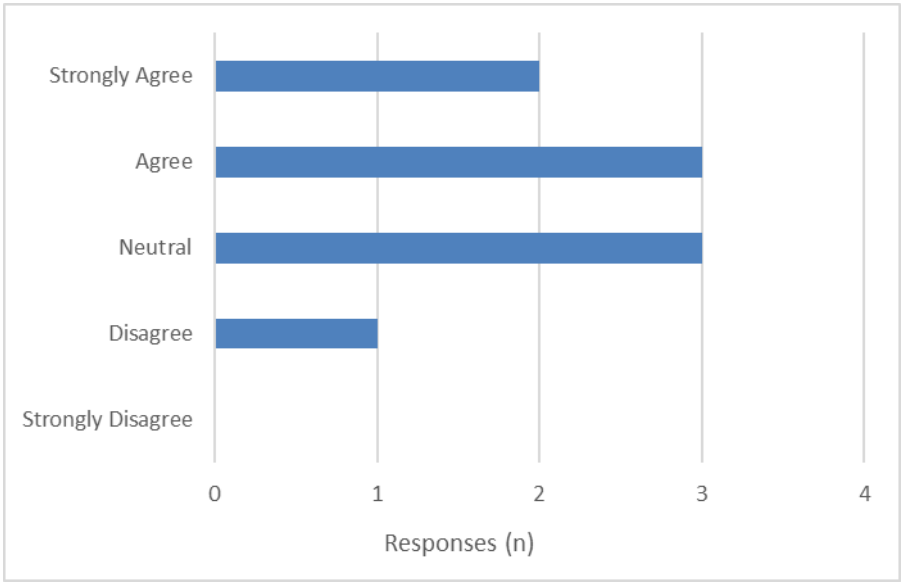
Only 9/11 responders answered the questions in this section. Two-thirds of DsPHs who responded strongly agreed (33%) or agreed (33%) with the statement that gambling harms are a public health issue (Fig 9).

Figure 4-9 Please rate the following statement from Strongly Agree to Strongly Disagree: "I consider gambling harms a public health issue".



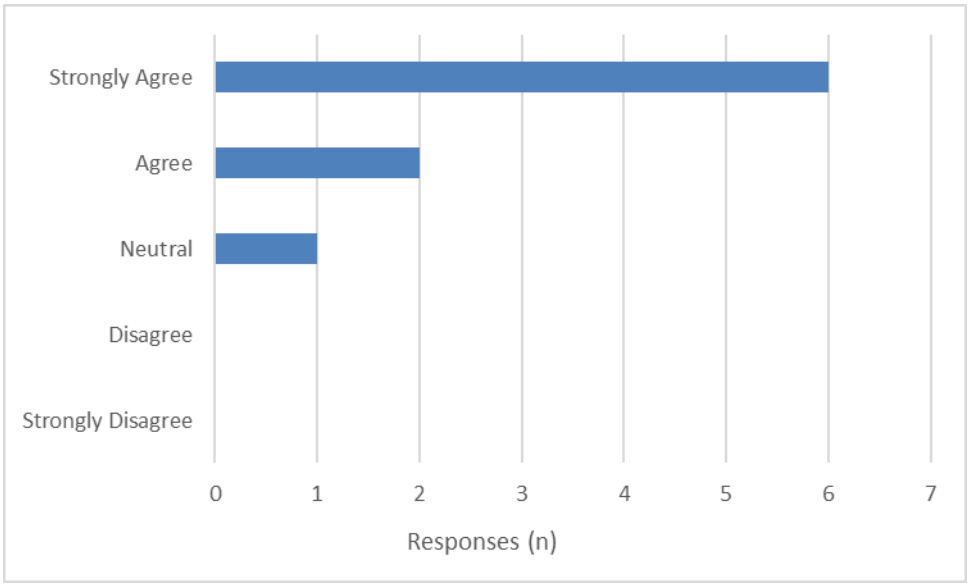
Just over half of DsPH (55%) felt confident presenting gambling harms as a public health issue to other departments in their local authority (Fig 10).

Figure 4-10 Please rate the following statement from Strongly Agree to Strongly Disagree: "I feel confident to present gambling and its related harms as a public health issue to other departments in the local authority".



67% of responders felt they had influence on their Health and Wellbeing Board (Fig 11).

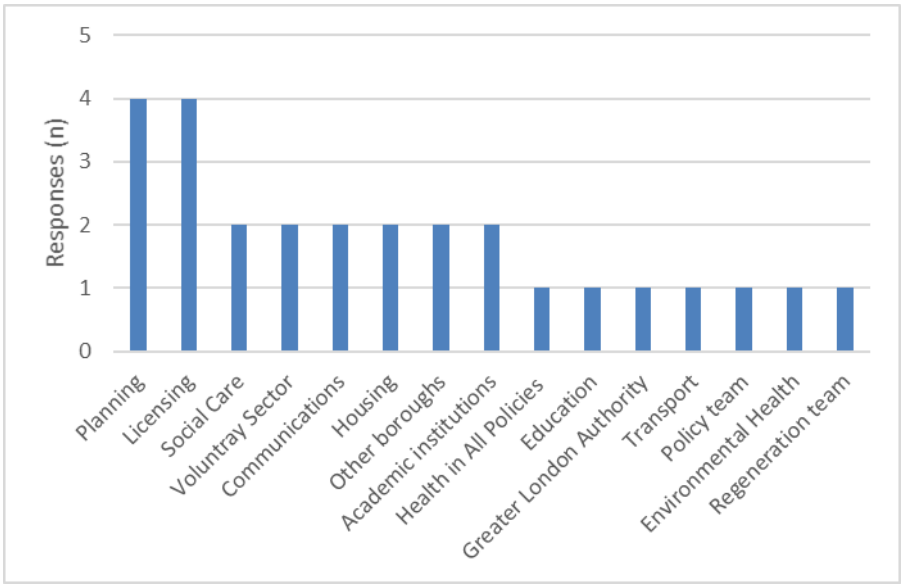
Figure 4-11 Please rate the following statement from Strongly Agree to Strongly Disagree: "I am confident the public health team currently has influence on the Health and Wellbeing Board".



Part 5: Recognised existing effective partnerships (free text response)

All responders answered this question. A wide range of existing effective partnerships were noted, with planning and licensing teams mentioned most frequently (Fig 12).

Figure 4-12 Please list any existing partnerships you feel are particularly effective.



Planning and licensing teams were most frequently cited as effective partners (each cited by 4 respondents).

4.6 Discussion

This survey of Directors of Public Health, conducted in 32 London local authorities, asked about public health teams' interest in and influence on gambling policy, as well as

background information on their 'place' within their local authority, while also comparing their experiences of gambling policy with alcohol, where their role is formally recognised in legislation. The responses reported variations in public health teams' size and place across individual London boroughs and variations in whether gambling harms were a priority for the borough and/or the public health teams. At the borough level, there was a strong positive correlation between a public health team's sense of influence on gambling policy and alcohol policy (the latter where they hold a formal Responsible Authority role): this perhaps says more about the attitude of individual local licensing authorities in terms of the inclusion of public health teams overall, rather than the type of product being licensed specifically. The subsequent interviews with licensing team representatives will investigate this further.

4.6.1 Part 1

These results regarding public health teams' place within organisations confirm Peckham et al.'s findings that public health teams are placed in a variety of settings within their local authorities [9]. This is important as, within the 7S framework, the 'structure' of an organisation remains a 'hard element' that "*allows the firm to focus on areas that are deemed important for its evolution….this includes division of activities; integration and coordination mechanisms*"[11]. The impact of a department's place within the organisation on its interest and influence is not disputed.

The wide range of FTE public health staff in public health teams is striking. This will inevitably impact the team's capacity to act in terms of time resources to consider new activities outside what they are already doing, alongside expectations that are demanded at short notice (e.g., vaccine delivery campaigns).

It is also worth noting that a dedicated HiAP working group or equivalent is not guaranteed within local authorities despite 2016 LGA recommendations for structural reform that would embed such a body. However, there are other ways that HiAP strategies may be delivered, something that can be explored in follow-up interviews.

4.6.2 Part 2

In terms of the priority of gambling harms within boroughs and public health teams, most of those who responded reported that gambling is a priority in their local authorities and their public health teams, and just over half had allocated someone to cover gambling. An

element of bias cannot be excluded here (those with someone in their team allocated to gambling are more likely to respond to the survey). What those team members do, given that public health has no formalised role in gambling policy in local government, will be explored in the interviews. Although gambling was a priority in over half of the public health teams, less than a third of public health teams that responded had had the opportunity to respond to the government's recent call for evidence in relation to the Gambling Act review. This mismatch of interest and opportunity to influence will again be further explored at the interview stage.

4.6.3 Part 3

The positive correlation seen between public health teams' perceived influence on gambling and alcohol licensing, despite only having a formal legislative role in the latter, may say something about how embedded public health are within the licensing process, rather than the specific product under consideration. For those public health teams that already have some influence on alcohol licensure, this could be considered a proxy for their overall influence (although Reynolds et al.'s 2019 study on the role of public health teams and alcohol licensing in London authorities found that membership of licensing committees did not guarantee status as "*a true partner around the table*" [70]).

4.6.4 Part 4

DsPH had more confidence in their ability to influence Health and Wellbeing Boards (HWB) than licensing committees, which likely reflects their statutory roles under the 2012 Health and Social Care Act on HWBs [7]. The frequency of leadership roles on HWB and licensing committees were similar, but the difference in perceived influence is notable.

The results also show that views on gambling harms as a public health issue vary among the DsPH who responded. Although only a very small sample, this is of concern given the recognition of gambling as a public health concern by public health leaders nationally [22]. DsPH's confidence in their ability to present gambling harms as a public health issue was also concerning. Both of these findings will be highlighted in the interview stage of the research for further discussion.

4.6.5 Part 5

Finally, a broad range of existing working relationships were cited by respondents, the most frequent being licensing and planning. These relationships could be leveraged to strengthen

a public health approach. However, opportunities for gambling go beyond land-based premises that fall within the licencing legislation. For example, premises that sell lottery products fall outside it, and online gambling is widespread. Therefore, local public health team responses will have to consider evidence-based population-level approaches to reducing gambling harms. The wide range of effective partnerships cited may reflect the differing structures and public health's place within them in individual local authorities. However, this network of partnerships could also be harnessed to consider local gambling harms in a wider sense than purely considering land-based gambling influence.

4.6.6 Limitations

The survey response rate is low, given the efforts made by ADPH and LSHTM partners to elicit responses. Thus, it is impossible to make generalised comments given the small sample. Discussion as to why the response rate may have been poor and reflection on the survey findings overall provide discussion points for the interviews planned later in the research process.

The two-step process (consent forms needed to be received before a hyperlink to the survey was sent) could have reduced the response rate. However, the ethics committee required this, although advertising the survey at the monthly ADPH meeting and in their newsletter aimed to mitigate this.

It is also recognised that the first part of 2022 was extremely busy for local public health teams. The survey was administered in March and April 2022 when public health teams were heavily involved in local Covid vaccination programmes. The Monkeypox outbreak arose in May 2022, which was why I ceased further reminders to DsPH at this point.

Both inner and outer boroughs were represented in the responses and more responses were from inner London. In general, inner London boroughs tend to be more deprived, and the link between gambling harms and deprivation is well-recognised [36, 37]: despite this, inner boroughs were no more likely to have someone in their public health team allocated to gambling.

Despite the specific request to include temporality in questions during piloting, the responses did not provide any further information about the public health teams' historical activities.

4.7 Conclusions

Although the survey's response rate was low, those who did respond highlighted considerable variation in public health's 'place' within local authorities and in the staff they employed. These factors will inevitably impact their ability to respond to new challenges, including having the capacity to consider 'newer' issues such as gambling harms as part of public health's remit. The wide range of responses to individual questions has also provided material for further interview discussion.

There was considerable variation in the extent to which local authorities had adopted Health in All Policies approaches. Even among London DsPH the perception that gambling harms is a public health issue is far from unanimous. This lack of consensus is concerning given that gambling harms are recognised as such by national bodies.

There is some evidence that public health teams that report having influence on alcohol also do so for gambling, even though they have no formal role in gambling licensing legislation. This may suggest that those licensing teams have more inclusive attitudes to considering harmful commodities rather than being narrowly constrained by the legislative framework.

Harnessing influence on Health & Wellbeing Boards, as well as developing existing effective relationships between local public health teams and planning and licensing teams, as well as considering addressing gambling harms in a wider way than influencing just land-based gambling, may be effective ways to develop a public health approach to gambling harms.

The following chapter is a second quantitative analysis, that reports the number, type and trends of gambling premises across London boroughs over the time frame of the thesis.

Chapter 5 An analysis of 'land-based' gambling premises in London Dec 2020-Dec 2023: numbers, types and trends

There is evidence, both nationally and internationally, that increased land-based gambling premises availability is found in areas of deprivation. Under the Gambling Act 2005, so-called land-based gambling premises (including betting shops, arcades, bingo outlets, casinos and family entertainment centres) require three licences to operate. One of these licences is granted by local licensing authorities, which in London are aligned to each London borough.

The UK gambling regulator, the Gambling Commission, publishes gambling premises data supplied by licensing authorities on its website. This chapter presents the gambling premises data for London, collected at six-monthly intervals across the thesis's timeframe. It reports the trends in the type and number of land-based gambling premises in London and analyses the relationship with borough-level deprivation ranking.

The analysis shows that although gambling premises (specifically betting shops) are reducing overall, they are concentrating on areas of deprivation. The overall reduction in gambling premises has increased in both arcades and bingo outlets, with these types of premises increasing across London, not just in areas of high deprivation.

These findings suggest that not only is gambling (and its potential harms) increasingly inequitable, but the overall landscape of land-based gambling is changing. This is important because arcades (which are increasing) house electronic gaming machines, which are recognised as particularly harmful. In addition, a further concern of this inequitable availability is that cross-platform technology can be used to draw in those who predominantly gamble online to land-based premises (via gambling apps) when in their physical vicinity.

5.1 Recap

So far, this thesis has reviewed published literature on population-level interventions to address gambling harms at the local government level and reported the findings of a survey of public health leads in local government in London to understand their teams' place within the organisation and their interest and influence in local gambling policy. The terms 'land-based' and 'non-remote' gambling refer to opportunities to gamble in person (as opposed

to online), and this chapter analyses the number, types and trends of physical gambling premises in individual London councils (or 'boroughs') in the period that the current gambling legislation has been under review.

5.2 *Executive Summary of Findings*

From December 2020 to December 2023, there has been:

- A net reduction in the overall number of gambling premises in London by 44 from a baseline of 1516.
- A net reduction in the number of betting shops by 64 from a baseline of 1313, but an increased association between the number of betting shops in an area and its deprivation ranking over the three-year period.
- An increase in the number of arcades (by 17 from a baseline of 127) and bingo outlets (by 11 from a baseline of 38) across London over the three-year period, the association with deprivation being less pronounced than for betting shops.
- A reduction in the number of casinos (by 7 from a baseline of 36) and Family Entertainments (by 1 from a baseline of 2)

5.3 Introduction

Under the Gambling Act 2005, the term 'land-based' gambling refers to places such as betting shops, arcades, bingo outlets, casinos, horse and dog tracks and family entertainment centres [65]. There is evidence from several countries, including Great Britain that there is greater availability of land-based gambling in deprived areas [36, 37, 162]. Gambling availability and subsequent harms are, therefore, inequitably distributed.

Under the legislation, all land-based gambling premises require a premises license issued by their local licensing authority, which is based within local government. Two further licenses to operate are acquired from the regulator, The Gambling Commission (which covers only Great Britain, but not Northern Ireland where the relevant legislation does not apply). They publish a register of gambling premises licenses at approximately six-monthly intervals on their website [4], and reported an overall reduction of gambling premises of 17% from March 2020 to March 2022 [163].

In the past few years, there have been several developments in land-based gambling in Great Britain. Firstly, the reported reduction in gambling premises as described above, is felt to be at least partially due to gambling increasingly moving online [164]. Secondly, there has

been a reduction in the stakes from £100 to £2 per spin of Fixed Odds Betting Terminals (FOBTs), the gaming machines found in betting shops and widely recognised as being particularly harmful and "*addictive by design*" [33, 127]. The stakes reduction came into effect in 2019, and these machines now fall into the same category as those found in arcades, bingo and casino premises. The Gambling Commission predicted that "*whilst the exact number of closures is unknown, we do estimate that premises numbers [in Great Britain] will reduce by 25% in the first year following the change [in the FOBT stakes]*" [165]. Thirdly, in the early stages of the Covid-19 pandemic in 2020 and 2021, land-based gambling was closed for considerable periods, with variable reopening times according to the type of premises [166]. Finally, the Gambling Act 2005 legislation is currently under review, with a call for evidence made in late 2020 that closed three months later [54] and a White Paper (the prelude to new legislation) published in the Spring of 2023 [52].

In Great Britain, approximately one-quarter of land-based gambling premises are situated in the London area, which includes only 13% of the population [4, 167]. Given the concern raised in the Greater London Assembly Health Committee's report that London has the highest number of those experiencing gambling harms for any English region [168], it is important to understand the availability of land-based gambling in London and whether it is changing given the developments outlined above.

This analysis will outline the changes in London's gambling premises, by type and number, over the three years from December 2020 to December 2023. It covers the period when gambling premises were closed for prolonged periods due to the COVID-19 pandemic restrictions and from when the review of legislation was announced before publishing the associated White Paper. The analysis aims to establish the changes and trends from the baseline in December 2020 in both the number and type of gambling premises and establish whether these changes have any relationship with deprivation.

London comprises 32 local council areas, called 'boroughs', each with their own licensing authority that manages, approves and enforces gambling premises licences. I will analyse the number and type of gambling premises at the London borough level, alongside that borough's deprivation ranking as measured by the Index of Multiple Deprivation (IMD), as

calculated in 2019 [97].[1] Given that this analysis forms part of a larger piece of research looking at local government and gambling policy, the findings from this analysis will be shared with those being interviewed for the thesis to stimulate discussion (the interview findings are reported in Chapter 7).

5.4 Methods

Licensing authorities in Great Britain submit their data on gambling premises to the Gambling Commission, who publish it on its website [4]. Premises data are published in the form of a single Excel spreadsheet updated at intervals. The information incudes details of the gambling operator, full address and postcode of the gambling premises, and type of gambling premises (licenced betting office, adult gaming centre, bingo, casino, family entertainment centre or tracks). Of note, land-based premises that sell lottery products are not published here-lottery products have their own legislation, and licenses to operate and sell products are all managed by the regulator not the local licensing authority. Previous gambling premises spreadsheets are not freely available on the website: I requested historical spreadsheets from the Gambling Commission via a Freedom of Information request. However, this was declined, advising me to contact individual licensing authorities directly. I challenged this response, asking them to confirm or refute that, as the regulator, they held this historical information, but the correspondence was never replied to.

Although I was unable to obtain historical data, I extracted data from the Gambling Commission website during the course of my thesis at the following time points: December 2020, June 2021, December 2021, June 2022, December 2022, June 2023, and December 2023. I analysed the extracted data using Excel Version 16.83.

Data from December 2020 included items marked 'applications', i.e. gambling premises not yet fully approved by the local licensing authority. I excluded these premises from my analysis as they had not yet been approved and as such the premises had not yet opened. No later datasets made this distinction, so all data was included from the following time points.

1 The English Indices of Deprivation 2019 use 39 separate indicators, organised across seven distinct domains of deprivation which can be combined, using appropriate weights, to calculate the Index of Multiple Deprivation 2019 169. Ministry of Housing Communities and Local Government. *English indices of deprivation 2019*. 2019 [cited 2024 22 February]; Available from: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019..

I analysed the data by the total number of gambling premises in a borough and by the type and number of gambling premises for each of the 32 London boroughs. I then analysed the association between the number of total gambling premises in a borough and the different types and numbers of gambling in a borough and that borough's level of deprivation.

The IMD 2019 measure of multiple deprivation was used to rank London boroughs [170]For this analysis, the data was not adjusted for characteristics such as age, gender, or ethnicity of the borough population.

I also then compared the eight London boroughs (25%) with the highest IMD 2019 deprivation ranking with the eight (25%) with the lowest in terms of the number and type of gambling premises to see if the previously identified inequity of land-based gambling availability was changing.

5.5 Results

The results of the regression analysis are presented using the following key:

LBO = Licensed Betting Offices ("betting shops" or "bookies")

AGCs = Adult Gaming Centres ("arcades" containing gaming machines for those over 18 years of age)

BIN = Bingo premises

CAS = Casino premises

FEC = Family Entertainment Centres

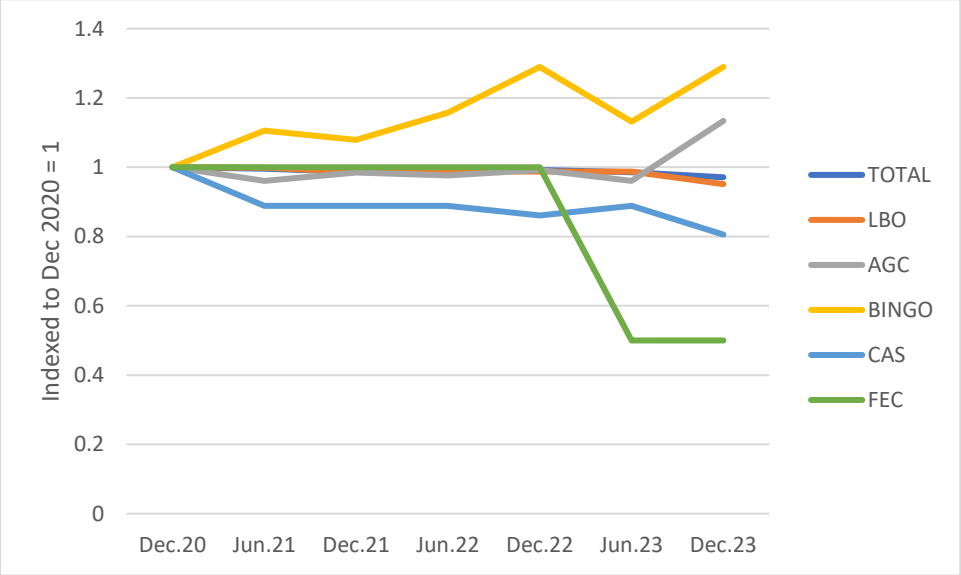
5.5.1 London

Over the period December 2020 to December 2023, there was a net reduction of 44 gambling premises overall in London, 1516 premises down to 1472 (Table 1). Figure 1 shows the trends by indexing the values to December 2020. As this shows, the net reduction hides an increase in AGCs and Bingo venues.

Table 5-1 Total number of gambling premises for London boroughs Dec 2020 to Dec 2023

DATE	TOTAL	LBO	AGC	BINGO	CAS	FEC
Dec.20	1516	1313	127	38	36	2
Jun.21	1509	1311	122	42	32	2
Dec.21	1495	1295	125	41	32	2
Jun.22	1501	1299	124	44	32	2
Dec.22	1504	1296	126	49	31	2
Jun.23	1494	1296	122	43	32	1
Dec.23	1472	1249	144	49	29	1
3 yr difference	-44	-64	17	11	-7	-1

Figure 5-1 Total number of gambling premises for London boroughs Dec 2020 to Dec 2023



In addition, despite a net reduction, the number of gambling premises in the top quartile of most deprived boroughs has increased, and the gap between the numbers of premises in the most and least deprived boroughs is widening (102 in 2020 and 118 in 2023) (Table 2).

Table 5-2 Total number of gambling premises for London boroughs in 25% most and least deprived boroughs Dec 2020 to Dec 2023

DATE	Most deprived quartile	Least deprived quartile	Difference between quartiles
Dec.20	425	323	102

Dec.21	428	312	116
Dec.22	429	314	115
Dec.23	428	310	118
3yr difference	3	-13	16

This means that, between December 2020 and December 2023, the association between the total number of gambling premises in a borough and its ranking for deprivation has strengthened if you compare the r-values (Dec 2020 r^2= 0.1082; Dec 2023 r^2=0.1276) (Figures 2 & 3).

Figure 5-2 Total number of gambling premises for London boroughs Dec 2020

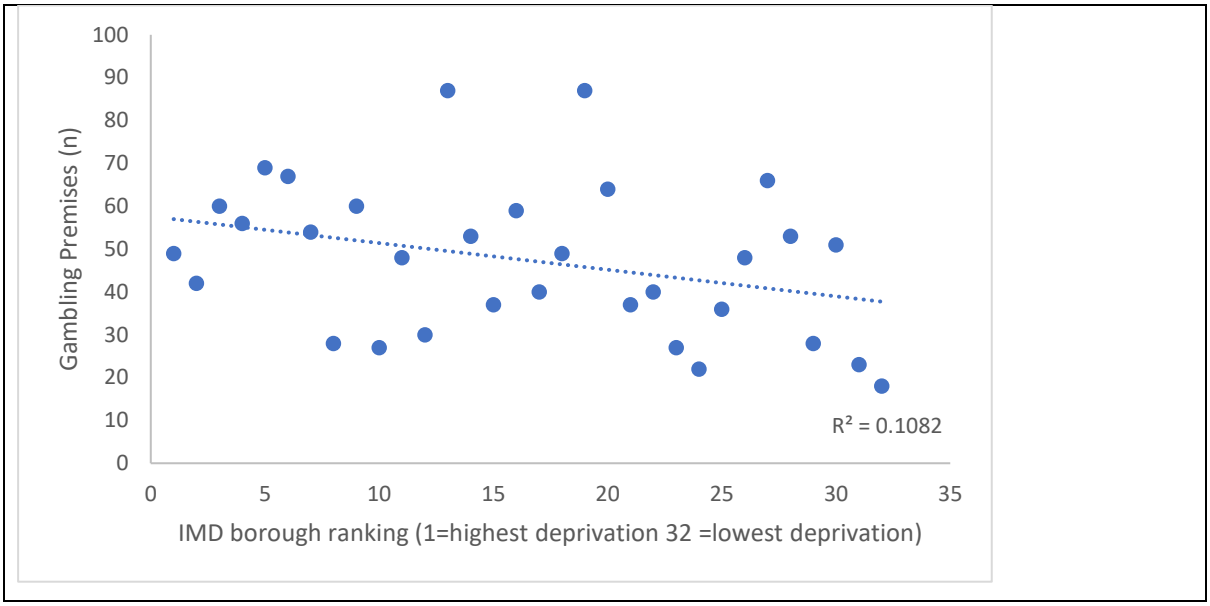
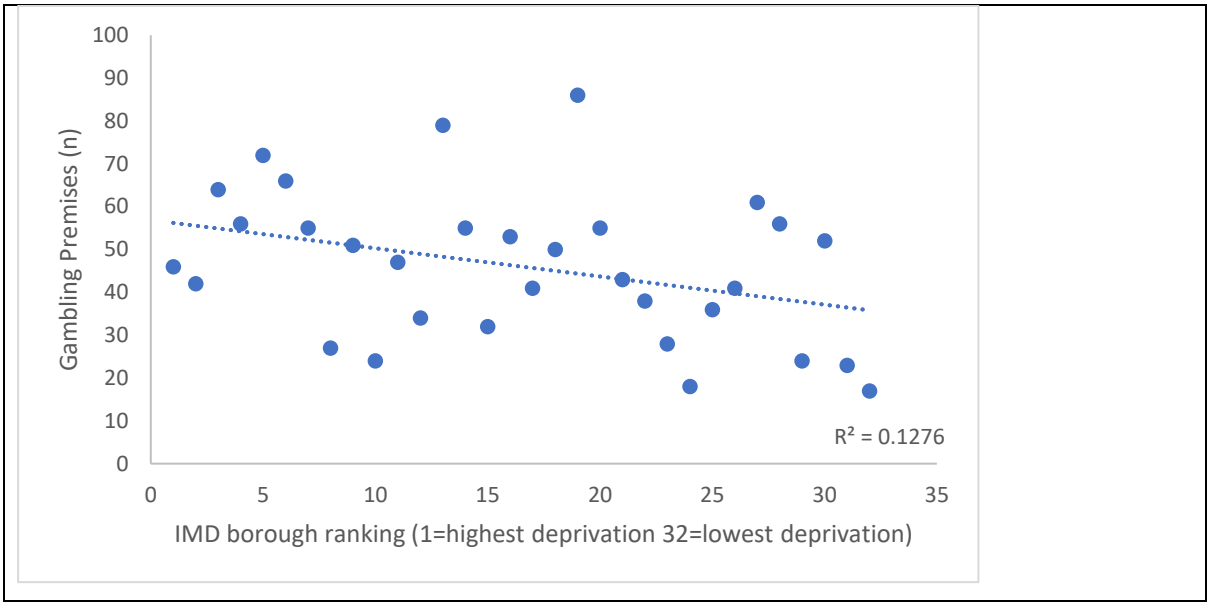


Figure 5-3 Total number of gambling premises for London boroughs Dec 2023



Despite it being strictly true that the number of land-based gambling premises is reducing, overall gambling premises availability is being concentrated into areas of deprivation. In addition, within London, there are examples where the number of gambling premises is increasing in boroughs working in partnership with industry-affiliated charities (the most recent example being Haringey, which in January 2023 launched a partnership initiative with GamCare, and by December 2023 had seen a net increase of gambling premises over the year).

5.5.2 Licensed Betting Offices (LBOs: "Betting Shops")

There has been an overall reduction over of betting shops in London between December 2020 and December 2023 (Table 1), but the reduction is less in the areas of highest deprivation. There has been a net decrease of 11 betting shops in the most deprived boroughs and a net decrease of 22 betting shops in the least deprived, and so the gap between the numbers of betting shops in the most and least deprived boroughs is widening (103 in 2020 and 114 in 2023) (Table 3).

Table 5-3 Total number of betting shops for London boroughs in the 25% highest and lowest for deprivation Dec 2020 -Dec 2023

DATE	Most deprived quartile	Least deprived quartile	Difference between quartiles
Dec. 20	392	289	103
Dec. 21	391	276	115
Dec. 22	391	275	116
Dec. 23	381	267	114
3 yr difference	-11	-22	11

The association between the total number of betting shops in a borough and its ranking for deprivation has strengthened over time if you compare the r values (Dec 2020 r^2= 0.1508; Dec 2023 r^2=0.169) (Figures 4 & 5).

Figure 5-4 Total number of betting shops for London boroughs Dec 2020

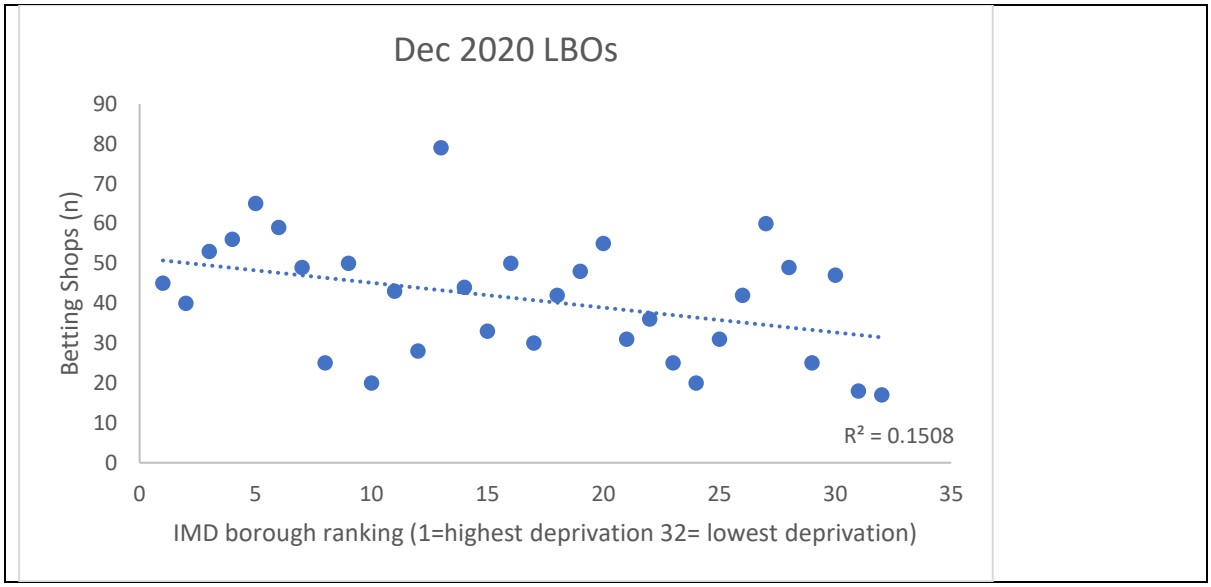
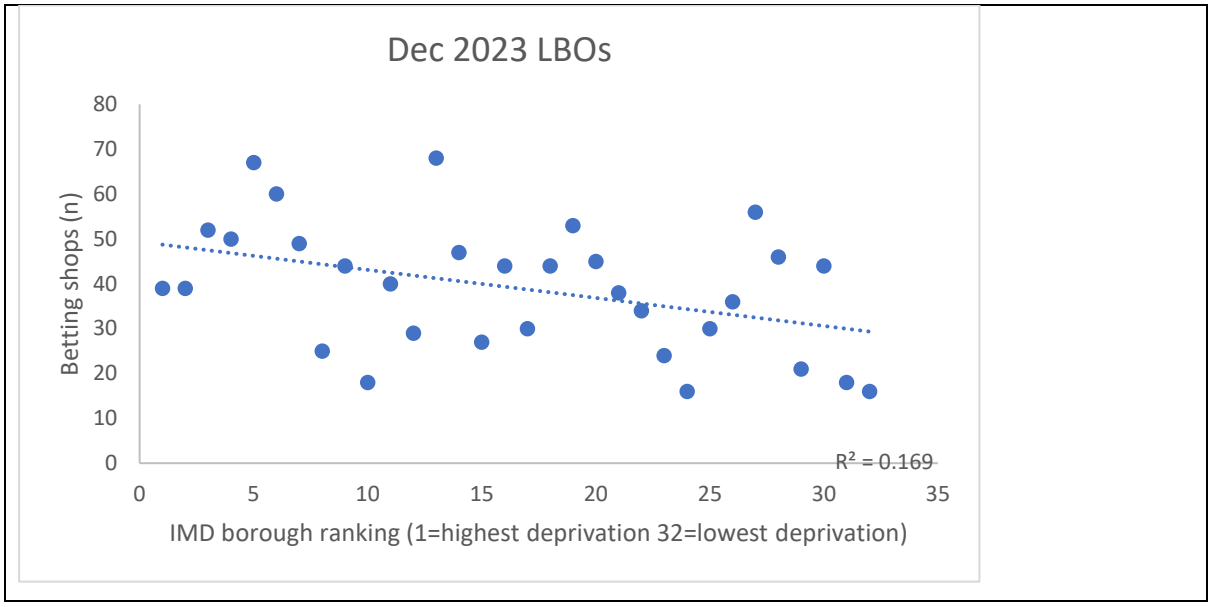


Figure 5-5 Total number of betting shops for London boroughs Dec 2023



Both above analyses confirm that despite an overall reduction in number of betting shops, there is an increasing positive association between the number of betting shops in an area and its deprivation ranking.

5.5.3 Adult Gaming Centres (AGCs: "Arcades")

There has been an increase in number of arcades in London by 17 from a baseline of 127 across the 3 years (Table 1). The increase in the number of arcades was higher in more deprived boroughs compared to least deprived boroughs (7 vs 3) (Table 4). However, unlike betting shops, there is no widening of the gap in arcade availability between the most and least deprived boroughs. In fact, at the start of the analysis, there were two more arcades in the least deprived boroughs. This trend has now reversed, and there are two more arcades in the most deprived boroughs.

Table 5-4 Total number of arcades for London boroughs in 25% highest and lowest for deprivation Dec 2020 to Dec 2023

DATE	Most deprived quartile	Least deprived quartile	Difference between quartiles
Dec.20	26	28	-2
Dec.21	28	25	3
Dec.22	27	27	0
Dec.23	33	31	2
3 yr difference	7	3	4

There is an increasing positive association between arcade availability and borough deprivation ranking between December 2020 and December 2023, as evidenced by

comparing the r-values (Dec 2020: r^2= 0.0005, Dec 2023 r^2=0.0094) (Figures 6&7): however, this strengthening of association is less pronounced than for betting shops.

Figure 5-6 Total number of arcades for London boroughs Dec 2020

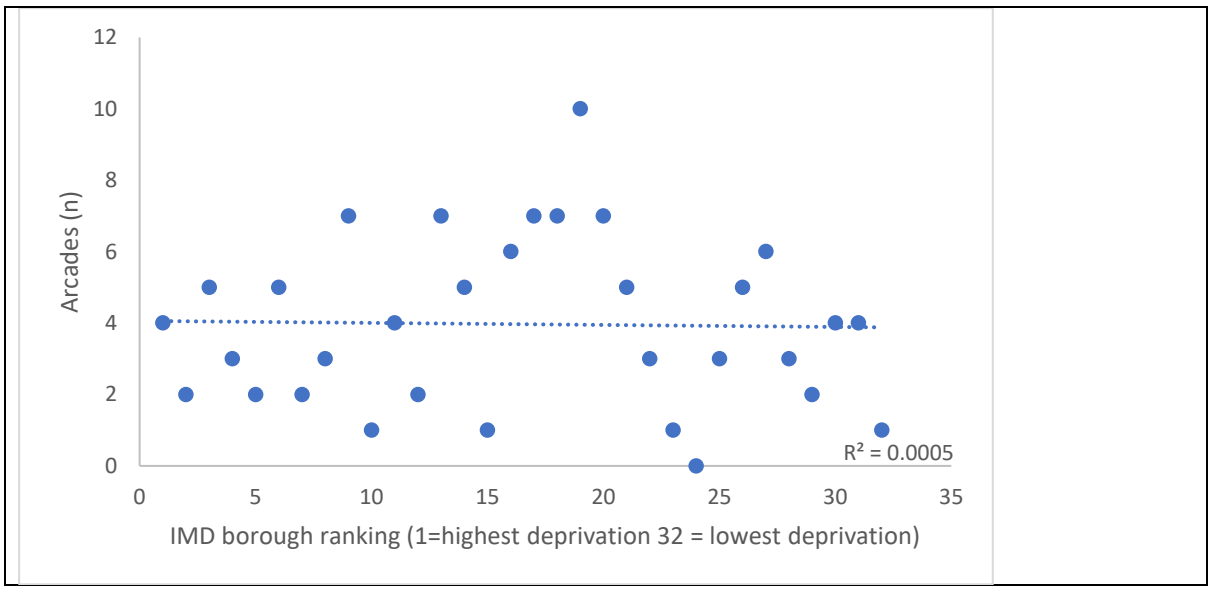
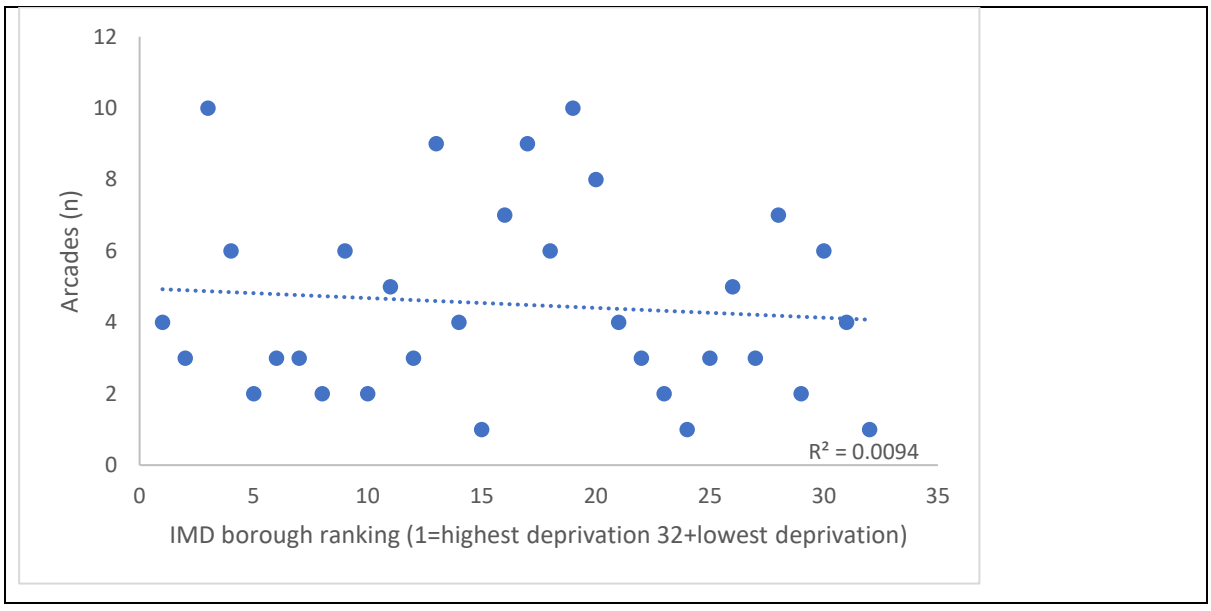


Figure 5-7 Total number of arcades for London boroughs Dec 2023



These results show that the number of arcades is increasing across London and not just within the areas of deprivation, although the increase is slightly more pronounced in areas of deprivation.

5.5.4 Bingo Outlets

The number of bingo outlets has increased by 11 for London over the three-year period from a baseline of 38 (Table 1). Total numbers of bingo venues have increased more in less deprived areas (Table 5).

Table 5-5 *Total number of bingo outlets for London boroughs in 25% highest and lowest for deprivation Dec 2020 to Dec 2023*

DATE	Most deprived quartile	Least deprived quartile
Dec.20	8	4
Dec.21	11	6
Dec. 22	12	9
Dec.23	12	11
3 yr difference	4	7

This narrowing of the gap between the number of bingo outlets in most and least deprived quartiles has contributed towards an overall reduction in the positive association between the total number of bingo outlets in a borough and its higher ranking for deprivation over the period (Dec 2020 r^2= 0.0196; Dec 2023 r^2=0.0112) (Figures 8&9).

Figure 5-8 Total number of bingo outlets for London boroughs Dec 2020

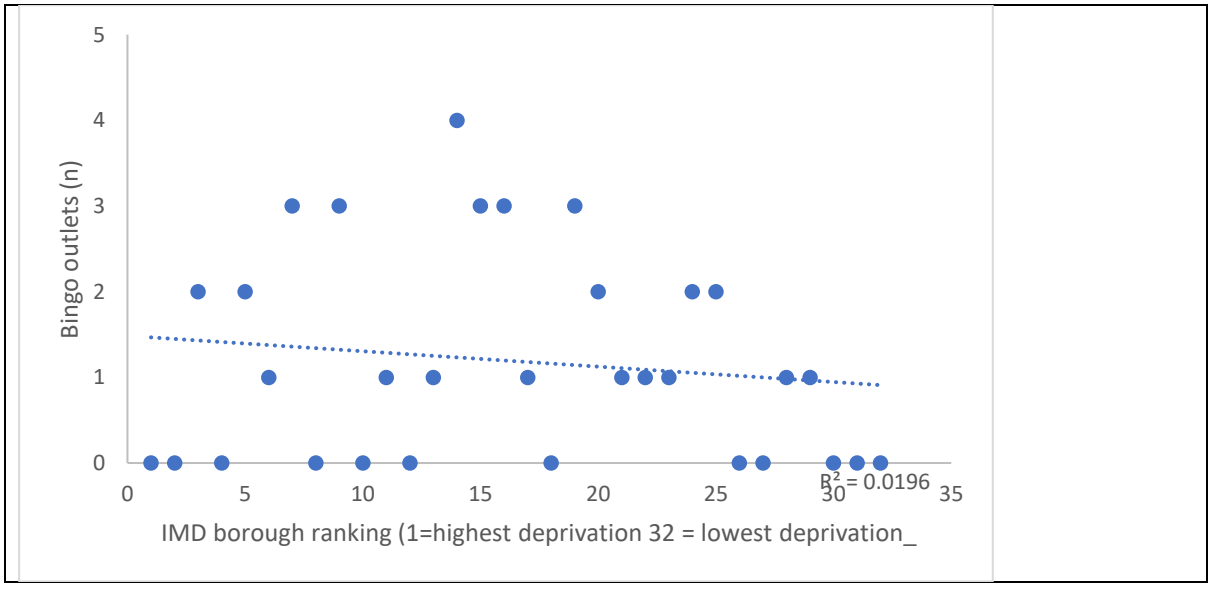
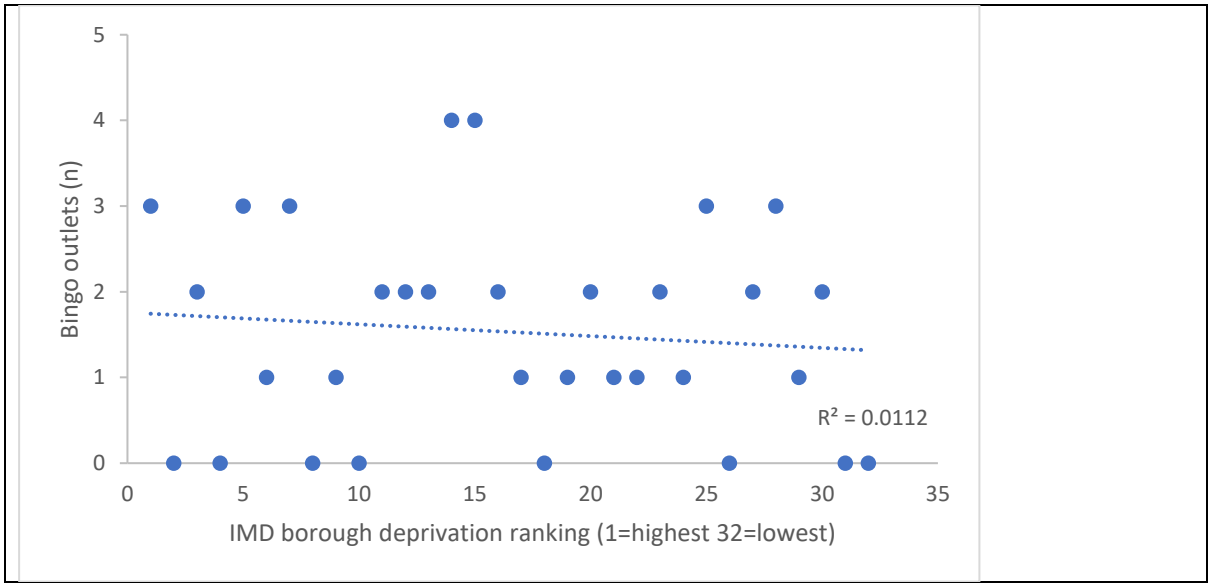


Figure 5-9 Total number of bingo outlets for London boroughs Dec 2023



5.5.5 Casinos

The total number of casinos has reduced (36 in Dec 2020 and 29 in Dec 2023-see Table 1), with these premises concentrated in a small number of (mostly central) boroughs, so no further analysis was undertaken.

5.5.6 Family Entertainment Centres (FECs)

The number of FECs in London has reduced from 2 to 1 in the three years with no location changes.

5.6 Discussion

This chapter reports trends in the number of land-based gambling premises, by number and type, across London over the 3 years December 2020 to December 2023. This coincided with the closure of gambling premises for prolonged periods due to Covid-19 pandemic restrictions and with national gambling legislation in Great Britain being under review. The net decrease in gambling premises in London overall hides an overall increase of premises in the most deprived boroughs and a widening gap between the number of gambling premises in the highest and lowest areas of deprivation.

While betting shops are reducing in number, this is more pronounced in less deprived areas. Arcades are increasing in number in London, but again more in deprived areas. Bingo outlets have also increased in number across London, but with a weaker association with deprivation than other types of gambling. These findings also suggest that the overall landscape of in-person gambling availability in London is changing, and certain types are becoming more widely available. This is important because under the Gambling Act

legislation, arcades and bingo outlets can house more EGMs than betting shops [65], and it is EGMs that are recognised as particularly harmful.

Concerningly, the recent Gambling Act White Paper consultation, that proposed different percentages of higher category EGM availability in land-based gambling premises, gave no option for overall reduction in its proposed reforms [171].

Casinos are concentrated in a small number of mostly inner London boroughs, so the mechanisms that drive change here, such as the impact of tourism and the cost of real estate, are different. The numbers of FECs in London are too small overall to pass comment on, but further research could look at growth in FECs in deprived coastal towns where "*deaths of despair*" are especially high [172] even when gambling and its associated harms are not factored into the analysis.

The observation that gambling premises have increased in a borough working with gambling industry-affiliated charities is noted, and local governments' relationships with businesses that supply harmful commodities will be explored further in the interviews later in this research.

This analysis relies upon the accuracy of the premises data published on the regulator's website as supplied by local licensing teams. The change in the presentation of the data on the website after December 2020 (not distinguishing between licenses still under application and those fully approved) also needs to be considered, as it affects the 2020 baseline data. Of note, while The Gambling Commission states that "*We use the data provided to maintain a register of premises licences…to inform our compliance and enforcement work*" [173] it also states that "*The register is published with the caveat that the Gambling Commission cannot provide any assurances on the completeness and accuracy of this data*" [4]. This, in addition to its lack of cooperation with FOI requests for historical premises data, is concerning given that it is charged with enforcing the objectives of The Gambling Act, including protecting the vulnerable.

While both the national government and the gambling industry have argued that local governments have the powers and the tools to stop the opening of new gambling premises [48], local government representatives continue to challenge this position [69]. The key issue is the "*statutory aim to permit*" gambling premises in the legislation, with local powers

recently described by those in senior government as a "*myth*" [51]. There is evidence of some London councils, like Newham, implementing gambling premises licensing conditions that do not permit gambling premises within certain distances of schools [174]. However, this policy has not reduced the numbers of gambling premises applications significantly in the borough as operators remain free to apply to premises outside of these exclusion zones. Why Great Britain needs a new gambling act, that puts "*health above profits*" and addresses both the "*aim to permit*" issue and other key factors, has been discussed elsewhere [175].

The recent White Paper has proposed legislative changes but none of the proposals put forward consider overall reduction of either gambling premises or specific products. The White Paper also proposes to discuss the implementation of cumulative impact zones (CIZs) for gambling, similar to those for alcohol premises, used where there is evidence to show that the number or density of licensed premises may be contributing to problems that are undermining licensing objectives [176]. CIZs for gambling are due to be discussed "*when parliamentary time allows*" [52], although no timescale has been set for this proposal.

The findings of this analysis are also concerning as they suggest that current trends in land-based gambling premises licensure appear to be reinforcing an increasingly inequitable relationship between living in deprived areas, a known risk factor for experiencing gambling harms, and the availability of land-based gambling. The dominant narrative that "*betting shops are reducing*" from various sectors [177-179] hides an increasing concentration of gambling premises in areas of deprivation in London: the regulator's predictions that more premises would close after the 2019 FOBT stake changes have certainly not been realised in the capital. It may be beneficial to compare trends identified in London with other major cities in Great Britain (such as Manchester and Glasgow) to understand whether this is a city-specific phenomenon or a wider issue.

It is also of note that there was a net increase in gambling premises in areas of highest deprivation during a time when land-based gambling premises were shut for significant periods due to the pandemic and while gambling legislation was under review. It could be argued that all new gambling premises license applications should have been suspended during this time.

In addition, land-based gambling remains a source of high street advertising for operators, who also can use both 'push' notifications on mobile phones and combined online/land-

based customer accounts to encourage land-based gambling when someone who predominantly gambles online is in the vicinity of land-based gambling premises [60].

Furthermore, these results will underestimate overall land-based gambling availability as they do not capture national lottery and scratch card outlets (that fall under different licensing legislation), electronic gaming machines (EGMs) found in premises licensed for alcohol, nor poker, local lottery or gaming machine permits that are also approved by local licensing authorities. Finally, these data do not capture the amount of online gambling in an area. Land-based premises also contribute to the normalisation of gambling among the population and, notably, expose children and young people to gambling imagery.

This analysis supports previous research showing increased physical availability and accessibility of gambling premises in deprived areas, but also shows that in London the strength of this association has increased from the early stages of the Covid-19 pandemic to when national gambling legislation was under review.

5.7 Conclusion

In summary, this analysis has shown an increasing availability of gambling premises in areas of deprivation within London. There is a real risk that the current review of the Gambling Act, with the aim of "*bringing analogue legislation into the digital age*" [5], focuses upon online gambling and ignores the role and the risk that land-based gambling plays in the overall system of gambling harms that are experienced inequitably by the most vulnerable in our society. In addition, the regulator's approach to gambling premises data is of concern as they take no responsibility for its accuracy.

Both this chapter and the previous one have concentrated on gathering quantitative empirical evidence and given that this thesis is intentionally mixed-methods, the following two chapters now complement these findings with qualitative research. The first is a critical discourse analysis of gambling policy, followed by a thematic analysis of interviews with local government representatives.

Chapter 6 An Analysis of how local government is "problematised" in UK gambling discourse 2001-2023

Discourse can describe written prose, verbal transactions, or a wider societal practice, depending on the definition used. A discourse analysis can help understand how an object is characterised within a discourse, and the implications of those characterisations can then be considered.

This chapter undertakes a discourse analysis of policy documents across the Gambling Act 2005's life span (2001 to 2023) to explain how local government has been characterised within those documents.

The analysis uses a critical logics approach framework from the post-structuralist paradigm, that explains how objects are characterised by the articulation of various types of "logics" - social, political and fantasmatic found in the discourse.

The analysis finds that local government has been characterised in different ways over the time- period of the Gambling Act-firstly by questioning its capability, then its power, then by being tasked to deliver (ill-defined) "whole council approaches", and most recently, by describing local government "as one many stakeholders". This latest characterisation has been dominant at the same time as online gambling has been presented as the key problem in regard to harmful gambling and coincides with a reduction of local government as a specific named stakeholder in national documents. The impact of these characterisations in regard to national policy change (and stasis) and potential local government engagement and involvement at the national level is also discussed.

6.1 Recap

Gambling harms are increasingly conceptualised as a public health issue in the UK. This thesis considers the levers and barriers that apply when using public health approaches in local government to address gambling harms, specifically within the 32 boroughs of Greater London. It uses a multi-methods approach, underpinned by a critical realism approach, to identify these levers and barriers.

Previous chapters have already demonstrated a relative "*dearth of evidence*" of local government-level population strategies to address harms [118], and, within London, a

strengthening association between land-based gambling and borough level deprivation. A survey of London Directors of Public Health showed little consensus that gambling is even a public health problem, with only about half of respondents seeing gambling harms as lying within their remit.

This chapter will consider how local government has been characterised (or "problematised", the critical thinking term) over the last 20 years or so in the UK gambling discourse and will reflect on the potential impact that these evolving problematisations have had on both local and national gambling policy.

I define discourse as "*language that is structured according to different patterns that people's utterances follow when they take part in different domains of social life*" [180]and use a framework from post-structural discourse theory to analyse the UK gambling discourse in relation to local government over the lifespan of the current Gambling Act.

6.2 Introduction

6.2.1 A brief history of gambling legislation in the UK

Gambling was legalised in the UK by the 1960 Betting and Gaming Act, which came into effect on the 1st of January 1961 and adopted the principle of "*unstimulated demand*" (that gambling facilities should be "*sufficient, but no more than sufficient, to meet the unstimulated demand*" e.g., no overt advertising) [53, 181]. Until the widespread development of online gambling after about 2000, most legalised gambling activities happened in 'land-based' gambling premises such as betting shops, bingo, arcades, casinos, and racing tracks.

Legislation remained mostly unchanged for the next 40 years until the publication of the Gambling Review Report ("*The Budd Report*") in 2001 [182], described by Cassidy as a "*high water mark for deregulation*"[53], which formed the basis of the white paper "*A Safe Bet for Success*"[183]. It, in turn, would go on to inform the Gambling Act 2005 [65]. This new legislation also saw the creation of a single gambling regulator, The Gambling Commission.

Despite The Budd Report recommending that local government should have full control over licensing gambling premises within their area, this was one of the few recommendations that was not adopted in the new legislation [53]. Under the Gambling Act 2005, local government took over licensing on 1st September 2007. Under this legislation,

gambling premises require both planning permission and a premises license from local government licensing authorities and two other licenses directly from the Gambling Commission [65]. Permits to run private lotteries, play poker, and operate electronic gaming machines (EGMs) outside of gambling premises are also available on application to local licensing authorities. Maximum license fees are set nationally but with the "*aim to ensure that the income from fees as nearly as possible equates to the costs of providing the service to which the fees relate*"[65]. Of note, all land-based National Lottery outlets and products are managed by their national legislation, separate from the Gambling Act, and licensed directly by the Gambling Commission.

Since the Gambling Act 2005 came into effect, further events (that were arguably opportunities for legislative change) have been:

- Newham Council's 2014 challenge to levels of Fixed Odds Betting Terminal (FOBT) stakes in 2014 under the Sustainable Communities Act [184]. FOBTs are a type of EGM widely recognised as particularly harmful given their rapid and continuous play functions [26, 33]. The challenge to the maximum amount of FOBT stake money was unsuccessful, appealed in 2015, and unsuccessful yet again [185].
- The Department of Culture, Media and Sport (DCMS) 2016 call for evidence into gaming machines pricing and social responsibility, that reported in 2018 [48, 186].
- The 2020 call for evidence into a review of The Gambling Act 2005, that reported in the 2023 white paper "*High Stakes*"[52, 187].

Given the key role that local government play in local decision-making, it is important to understand how their role has been characterised (or "problematised"- Box 6-1) in UK gambling discourse, such as that found in legislation, strategy documents, parliamentary debates, and in publications from both national and local government bodies, the regulator and the gambling industry, among others, since the initial discussions on the Gambling Act 2005, legislation that is now being reviewed.

Box 6-1 What is problematisation?

To problematise something is to treat an idea, belief or word as a problem that needs to be examined or solved rather than taking what is coined the 'common knowledge' of a situation for granted.

In critical thinking, "problematisation" is the process of framing or defining an issue as a problem that needs to be addressed. It involves identifying, analysing, and questioning assumptions, beliefs, and practices surrounding a particular topic to understand its complexity and implications. This allows new viewpoints, reflections and actions to occur.

Undertaking a discourse analysis is one way of considering this topic. This discourse analysis will ask the following questions:

How has local government been problematised in the context of UK gambling discourse?

Has their problematisation changed over time?

What have been the possible impacts of these problematisations?

6.3 Methodology

The concept and definition of "a discourse" can be understood in a variety of ways, and, as such, the methods by which discourse can be analysed are myriad. In this research, I use the Critical Logics Approach (CLA), developed by Glynos and Howarth [98] as a way of operationalising discourse analysis that falls under the Post-structuralist Discourse Theory (PSDT) paradigm. Both PSDT and CLA are more fully discussed in Chapter 2 (Methods), but in summary, the CLA "problematises" objects by classifying related discourse under one of three 'logics'. This framework is also fully described in the Methods chapter, but in summary, the three logics are:

Social logics – these discourses aim to enable the researcher to "*come to grips*" with what is "*going on*" in a particular context [98, 105, 188]. They can be seen as representing the "*rules of the game*", or norms and values that guide social practices.

Political logics – these discourses capture the practices through which a discourse emerges and by which hegemony (the dominant way of thinking in a society) is established and maintained [105]. Political logics include both logics of equivalence and difference

(processes and practices that bind and unite different elements) and the logic of difference (discourses that divide and complexify the social realm) [98, 99, 105, 188].

Fantasmatic logics – these discourses aid understanding as to why and how subjects are "*gripped*" by certain practices or policy discourses, despite the possibility of other systems of relations, practices and policies [98, 105]. Glynos and Howarth classify fantasmatic logics as either "*beautific*" (a harmonising and stabilising of the social world) or "*horrific*" (horrors and losses that will unfold if the fantasy object is "*taken*" by a discursively constructed "other")[98]. It has previously been recognised that contradictions, or "*slippages*", are inherently common within the realm of presented fantasmatic logics [105].

Using a retroductive approach, where both inductive and deductive reasoning is considered with the aim of identifying the causal mechanisms of empirical findings, the analysis then goes on to explain how the three types of logics are "*articulated*" together to generate the "*problematisation*" of the object under consideration [98]. Finally, a critical analysis of both the logics and the derived problematisation can be undertaken [98].

In gambling research, a discourse analysis using the CLA has recently previously been undertaken [105]. This research analysed the educational materials provided to youth education programmes by gambling industry-funded charities and their partners. The current research was undertaken over several stages that broadly reflect those used in previous gambling research that used the CLA, given the intention to build a more cohesive and aligned body of evidence on UK gambling.

The first stage involved developing an initial list of relevant publications to review from 2001 onwards. The year 2001 was chosen as this was when the Gambling Review Report (known as The Budd Report), which fundamentally shaped current Gambling Act legislation, was published [182]. A cut-off date of April 2023 was chosen as this was the publication date of the White Paper reviewing the Gambling Act [52].

The initial searches for relevant publications and websites were as follows:

- Review of The Budd Report, the related government response, and the subsequent white paper and The Gambling Act 2005. Relevant parliamentary transcripts were also reviewed from 2001 to the publication of the Gambling Act 2005, helping to fill a gap at

that time, when little material, other than the Budd Report, the government response, and the White Paper, were available to review.

- Search of the DCMS website for gambling-related publications e.g., policy documents, calls to evidence and formal responses;
- Search of the Gambling Commission website, with a focus on the licensing authority guidance section, but also searching the whole website for documents related to the National Strategy to Address Gambling Harms and publications and webpages mentioning public health;
- Search of the Local Government Association, Greater London Assembly and London Councils websites for relevant publications;
- Search of the 32 London borough websites for their most recent gambling policies and local plans;
- Search of the "Big 4" UK gambling industry (GVC Holdings, Bet365, Flutter and William Hill) and Betting and Gaming Council websites;
- Search of the local council and gambling industry written evidence submissions to the upcoming review of the Gambling Act 2005.

Other relevant documents identified during the above searches were added iteratively to the initial list throughout the search process outlined above.

The second stage involved familiarisation with the publications on the initial list, with details stored in a codebook that captured the location, year of publication, and source, categorised as one of five types: national government, local government, city (either city-wide or borough-level publications), non-governmental organisation (including the regulator) and Industry. Further publications were added iteratively to the list if identified at this familiarisation stage. Publications were excluded at this stage if they did not mention "local government" OR "local authority" AND "gambling" in the text corpus of the publication. All included publications were downloaded onto an NVivo file. A full list of the analysed publications can be found in Appendix 6.

The third stage involved in-depth analysis of each included publication, using a template containing the 5 headings of Glynos and Howarth's step-wise process of working through CLA [98]: Logics; Retroduction; Articulation; Problematisation; and Critical Analysis. Quotes were included verbatim under the Logics heading and assigned to one or more of the three

logic sub-types (social, political, fantasmatic). Free-text comments were added to the critical analysis section of each template, as well as noting any 'absences' (of specific actors or concepts or gambling products, for example) in the discourse of that publication.

The fourth stage of the analysis involved a chronological review of the templates completed for each publication. This was made possible by transferring information to an Excel spreadsheet that also included the title and year of publication and the source (National Government, Local Government, City/Borough level, Non-Governmental Organisation [including the regulator] and Industry). I used Excel in preference to qualitative coding software (such as NVivo for example) as the intention was to prepare the data from the outset for potential machine learning analysis in the future.

The fifth and final stage involved a manual Excel spreadsheet analysis by filtering the various headings and constructing the chronology of problematisations through articulation of the dominant logics over time. As with previous analyses undertaken using the CLA, the retroductive approach to also "*involved moving back-and-forth across the structured data and intermittently returning to the original publications and wider literature on gambling*" [105].

In addition to the above actions, any publications appearing in successive editions over the timeframe of the analysis (such as the Local Government Association's Councillor Handbook published in 2015, 2018 and 2021 [67-69], and Gambling Commission bulletins for local licensing authorities, published several times each year (online archive available from 2016 onwards) [177] were analysed to identify any changes in their logics and problematisations between editions.

A total of 154 documents, web-pages and transcriptions were included in the final analysis (Appendix 6).

6.4 Results

The results of the discourse analysis will be presented as follows. First, discourses that fall under each of the three logics will be presented. Each logic will be described, before examining whether it persisted for the entire timeframe of the analysis or whether it emerged at a certain time point, and what policy actors predominantly use the logics in their discourses. Examples for each logic will be given, followed by a comment about

whether the logic has been sedimented or challenged and by whom. Finally, a brief critique and comment will be made on the potential impact of these logics. When quotes are listed as examples under a specific sub-logic, the type of policy actor will be indicated: (National Government [GOV], Local Government [LOC], city/borough level publication [CIT], Non-Government Organisation (including the regulator) [NGO] or Industry [IND]). Additional quotes are provided in Appendix 7.

Secondly, the problematisation of local government will be presented chronologically by articulating these logics together, commenting on how different actors problematise local government in similar or different ways. The problematisations will be presented in four timeframes that align with the "*primacy of politics*" of PSDT [98, 99]:

- 2001-2005: this is the period of preparation for the new Gambling Act until when the Gambling Act 2005 legislation came into effect.
- 2006-2016: this is early stage of local government taking on a new role in local gambling legislation. The end of 2016 saw a call for evidence into gaming machines and social responsibility measures, with its conclusions eventually leading to the reduction of stakes on FOBTs in betting shops.
- 2017- 2020: this is when the responses to the call for evidence mentioned above were considered until there was another call for evidence, this time to review gambling legislation.
- 2021-2023: this began when the call for evidence to inform gambling legislation was made until the publication of the White Paper in April 2023.

This research comprises an analysis that first considers the empirical evidence of the logics, and then "*theory builds*" by proposing problematisations derived from this empirical evidence. This aligns with the critical realist approach that forms the philosophical basis of this research [86].

Finally, the potential impacts of these problematisations will be presented, supported by empirical evidence that considers key events and/or legislative changes that occurred (or not) during each period and suggests how the problematisation of local government at that time may have influenced these events.

6.4.1 Social logics: "the rules of the game"

Social logic in discourse typically concerns the "rules of the game", in this case, relating to the role of local government in gambling legislation or the nature of gambling itself. They are summarised as follows:

- The Social Logic of legislation-how discourse shapes the way that legality is used to define something's purpose or place within the gambling policy field;
- The Social Logic of localism-how discourse presents local government's role and responsibilities in terms of the local community and the role of the physical local environment within that;
- The Social Logic of evidence is how discourse presents the role of evidence in both defining the problem and potential solutions;
- The Social Logic of gambling as a public health issue is how discourse shapes the way public health is defined and its role within gambling policy and addressing harms;
- The Social Logic of legitimacy is how a discourse presents gambling as a socially acceptable pastime run by a respectable and legal industry;
- The social logic of low expectation is how the discourse presents any potential progress or change in gambling policy with caveats and warnings that are then used to justify constitutional delays.

These are classified as social logics used within the discourse, rather than political or fantasmatic, as they consider the norms and values that guide social practices rather than defining collaborating or antagonistic groups or discourses that grip emotively and describe discourses [105].

6.4.1.1 The Social Logic of Legislation

The social logic of legislation is the way that legality is used to define an object's (here-local governments) purpose and place in the gambling policy field. It is a logic that has remained present throughout the entire period of the analysis and is used predominantly by national government and the gambling regulator.

Examples include statements from as far back as the 2002 White Paper to the current Gambling Act, such as *"premises licensing should remain a local function, but exercised solely by local authorities"* [183] and bulletins to local licensing teams from the regulator that focus on the role of legislation and enforcement in their case studies, such as seizing

illegal machines or closing down illegal gambling premises [177]. The recent white paper High Stakes states: *"we support them [local government] in the use of the broad powers which the planning and gambling regulation frameworks give to them"* [52].

There has been no real dispute in the discourse that local government has a role in enforcing legislation, but whether the legislative powers given to local government in respect of gambling are adequate has been contested, primarily in local government discourse: this will also be considered in a later section (*the political difference logic of conflict*).

Despite a persistent discourse used by the regulator that invokes the social logic of legislation, for example, in their bulletins and toolkits [177, 189]There is no meaningful discussion of why infringements of the legislation continue. The impact of this social logic of legislation has been that the role of local government is limited to enforcing laws made at the national level, with no provision for local government to develop its own by-laws.

6.4.1.2 The Social Logic of Localism

The *social logic of localism* presents local government as the institution best placed to represent and advocate for the local community (although the contradiction with the social logic of legislation, that gives local government little legislative discretion, is noted here). The logic is also used to highlight the importance of the local environment to the community. The term localism describes a range of political philosophies which prioritise the local by supporting local production and consumption of goods, local control of government, and promotion of local history, local culture, and local identity [190]. This has also been a persistent discourse across the entire analysis timeframe and different actors. While both national government and industry discourse justify this logic based on both accountability and being "*the most knowledgeable*" about a locality [183, 191], local government frame itself more as representing the communities they speak for, as can be seen in responses to the 2016 call for evidence, for example, Islington Council:

> *"Existing powers do not sufficiently allow for local authorities to support local Communities that do not wish to see clustering of betting shops at the detriment of a diverse high street"[186]*

The concept of "the high street" is aligned to the social logic of localism as *"core to a community's health"* [47]. Within this logic, gambling premises on the high street,

specifically betting shops, have been singled out as having a particular negative impact, with the Royal Society of Public Health's (RSPH) "*Healthy High Streets*" campaign and related publication in 2015 designating betting shops as one of the "*least health-promoting*" businesses to find on a high street [47]. This discourse has been challenged in, unsurprisingly, the industry discourse, where gambling premises have been described as "*an integral part of local community life*" [178]. The recent White Paper argues that bingo "*has a strong community appeal*" [52].

While the social logic of localism has persisted throughout the analysis, it is not without criticism for its "*slippages*" internally and when considered alongside other logics. Firstly, a social logic of localism that places local government at the forefront of responsibility for local change, for example, in the high street, has the advantage of promoting local accountability. Local government bodies are described as "*the most knowledgeable*" about their locality. However, to assume that knowledge and power are intertwined is to assume the existence of legislative powers that can change. Yet local government representatives repeatedly argue that they lack this power in their responses to consultations and written evidence. This will be further considered in the *political difference logics of conflict* later in the chapter.

Secondly, a social logic of localism promotes "*supporting local production and consumption of goods*"[190]. However, gambling industry outlets in local communities do not support local production or consumption of anything, rather "*extract*" money for large multinational corporations [63].

However, it must also be recognised that too much focus on "the local" can risk disregarding system-wise thinking. This can be seen in the RSPH's follow-up publication to Healthy High Streets, called "*Running on Empty*", published in 2018 [179]Here, the imagery and textual focus had moved away from high-street betting shops as a specific cause of harm. This was because a new hegemonic discourse was emerging—that gambling was primarily moving online. The consequence was that the role of local government was diminished as it was primarily responsible for finding local solutions to local problems and nothing beyond that.

The impact of the social logic of localism, therefore, aligns knowledge, power, accountability and advocacy in the discourse - but progress in local solutions is only possible if local-level legislative powers are real to the local actors charged with enacting them.

6.4.1.3 The Social Logic of Evidence

The social logic of evidence encompasses discourses that use evidence to justify their arguments. This logic began to emerge in publications from around 2012, but peaked and around 2016, after which it has plateaued, the same time that gambling began to be discussed more widely as a public health issue (see next section). This logic appears most frequently in the discourse of national government and the regulator. These discourses can be seen to fall into one of four categories:

i) **Policy needing to be evidence based:** e.g., *"gambling policy must be evidence-based"*[183] [GOV] and *"decision making should be born from empirical evidence and not anecdote and sentiment*"[178] [IND].

ii) **Using statistics to support social logics statements:** e.g., statistics used to justify statements such as "*The number of betting shops is reducing*" [177-179] and "*The low and stable rates of Problem Gambling*" [48, 52, 54, 178, 186, 192].

iii) **Local government is responsible for data collection:** e.g., *"Local Authorities, and Health and Wellbeing Boards, should conduct local needs assessments and consider gambling as a key issue"* [113] [NGO] and "They [local government] are an *intelligence source that the Gambling Commission is reliant upon"* [64][NGO].

iv) **The quality of existing evidence is poor.** E.g., *"The allocation of gaming machines under the 2005 Act is complex and was not made on the basis of solid evidence"* [191][GOV] and "*it is difficult to evidence how effective any or all of these [prevention activities] are at reducing gambling harms"* [3] [NGO].

While the argument that policy should be evidence-based has intuitive appeal, what is classed as evidence is often narrow, "*compromised*", and politically influenced [63, 95]. A further problem arises from the phenomenon of "*corporate agnogenic practice*", in which industry actors use "*methods of representing, communicating, and producing scientific research and evidence which work to create ignorance or doubt irrespective of the strength of the underlying evidence*"[193]. In addition, evidence can be cherry-picked or selected to fit the argument being made as seen across the harmful commodities industry in terms of a "*playbook*" tactic [44, 59], at the same time as creating barriers to obtaining data and evidence.

Two arguments have become especially prominent in this discourse. These are that the number of gambling premises is declining and that problem gambling rates are low and stable. Both are highly problematic: the number of betting shops is reducing overall, yet they are increasingly concentrated in more deprived areas (see Chapter 5), while the widely used problem gambling statistic comes from a much-contested single telephone survey with a small sample.

Of note is that not all social logics are presented with accompanying confirmatory statistics. For example, the argument for limiting the maximum stake on FOBTs to £2 appeared in a proposal by the Newham Council proposal [184] and later in multiple responses from local councils to the call for evidence into gaming machines [186]. However, none provided any evidence that it would be effective in reducing the harms associated with gambling, with the discourse instead relying on the social logic that this should work. Some of the discourse using social logics became embedded before relevant statistics emerged. For example, the concept that gambling has predominantly moved online was only confirmed in Gambling Commission survey data from 2019 [194], but was frequently stated in earlier publications [48, 179, 186].

With the local government being held responsible for obtaining data, even if the data is known to be difficult or even impossible to obtain, allows the national government to devolve responsibility (and blame). When the National Audit Office noted that "*Licensing authorities are contributing to gaps in the data*" [64] [NGO] no mention was made as to why that might be so, such as the substantial cuts to local government finances.

Finally, it becomes difficult to make progress in gambling research or policy by sedimenting the discourse that the gambling research evidence base is poor, coupled with the logic that policy must be evidence-based. This situation is compounded by the gambling industry's domination of research, giving the *"illusion of progress"* [105] by funding projects that focus on niche areas (such as new medications for problem gamblers who occupy the extreme end of the harm spectrum).

The impact of the social logic of evidence in the discourse is that progress is delayed, and "perfect evidence is awaited for the sake of methodological purity that will never be achieved.

6.4.1.4 Gambling as a Public Health Issue

The conceptualisation of gambling harms as a public health issue emerged as a social logic in approximately 2016, after the Responsible Gambling Strategy Board (RGSB) (set up in late 2008 to advise the Gambling Commission and, in turn, the Department for Culture, Media and Sport, on research, education and treatment programmes [113]) published a Position Statement stating that "*gambling-related harm should be regarded as a public health issue*" [113]. As discussed in the Introduction chapter, what has been conceptualised as a public health issue has been contested, but there are examples of more contemporary issues (e.g., knife crime) that have been considered.

This logic has since been adopted in discourse by many different organisations [2, 195, 196]. Of note, the discourse from the national government is subtly different, defining gambling as *"a health issue"* (and by implication an issue for individuals) and *"working with Public Health*" in 2018 documents [48]. There is no reference to public health in the entirety of the recent white paper "*High Stakes*" in the context of any upcoming legislative reform [52]. A 2020 House of Lords report rejected transferring responsibility for gambling and its related harms from the Department of Culture, Media and Sport (DCMS) to the Department of Health and Social Care (DHSC), saying that "*despite the symbolic value of a transfer of primary responsibility for gambling from DCMS to DHSC, there would not be any practical benefit from such a transfer, and there might be disadvantages*"[51].

Two additional issues also must be considered. Firstly, organisations' conceptualisation of public health can differ. The 2019 National Strategy to address gambling harms "*sets out collectively how we can adopt a public health approach to reducing gambling harms*" [197], but much of the strategy's focus is on the treatment of select groups (e.g., so-called "Problem Gamblers"), which would not be considered a typical population-level intervention. In the same vein, the Gambling Commission toolkits [189] focus on licensing and enforcement (of existing premises rather than blocking new ones) rather than proven public health interventions to tackle harmful commodities, such as limiting availability and marketing and increasing price [92]. Also, a recent report commissioned by the Gambling Commission confusingly made the statement: *"gambling harms are…a public health issue but not a public health responsibility"* [198]without clarifying whose responsibility it was believed to be.

In terms of groups that challenge this logic, it is also important to note the actors that do not view gambling harms as a public health issue are the gambling industry. The first is the gambling industry; the PHE Evidence Summary clearly states: *"[with the exception of commercial stakeholders] there was consensus across different types of stakeholders that gambling is a public health issue"* [23]. Understandably, the industry rejects any framing of gambling as a public health issue because such a framing would threaten both economic profit and self-regulation (via stricter legislation). However, what is more surprising is that a second group is pushing back on this logic: the Local Government Association (LGA). Successive editions of the LGA's Councillor's handbook have altered their stance on health's place in gambling policy. The 2016 edition reported that the LGA was *"lobbying for a health objective"* in gambling legislation [67]. However, later editions have removed this statement [68, 69], despite simultaneously being "*frustrated*" at their lack of powers [69]. *"Gambling is not a public health issue"* is an explicit statement made in the 2018 LGA document considering 'Whole council approaches" to address gambling harms (co-authored with Public Health England) [199]. A plausible explanation is that local government is facing severe financial constraints that reduce its enthusiasm for adopting measures to reduce gambling harms. Thus, a joint LGA/PHE document states: *"The LGA and Public Health England are clear that a public health response does not equate to local public health funded services having a responsibility for providing treatment for problem gamblers"*[199].

The impact of a lack of uniform definition of a 'public health problem', plus a lack of alignment between key actors about this logic in the discourse, compounded in practical terms by local public health teams not being a responsible authority for gambling premises licensing, has arguably led to inertia in this area.

6.4.1.5 The Social Logic of Legitimacy

Gambling is presented in the discourse as a socially acceptable pastime run by a respectable and legal industry (the social logic of legitimacy). It has persisted to the point of hegemony throughout the analysis. Like the social logics of statistics, it is primarily a discourse in national government publications and the gambling industry.

The white paper that predated the 2005 Gambling Act 2005 stated that *"Gambling is no longer criminal and an established part of economy…[it] has become part of the mainstream of leisure activity"*[183], with similar language used by the DCMS in later publications once

the Gambling Act came into effect, and up until the 2020 Call for Evidence and the following White Paper continuing to reinforce this logic, frequently presenting statements that lack the inclusion of any evidential basis, presented as facts to be taken for granted:

> *"Millions of people enjoy gambling responsibly and the Government is committed to supporting a healthy gambling industry that generates employment and investment"* [54].
>
> *"Gambling in its variety of forms is a popular pastime…most spend small amounts which are similar to or less than spending on other leisure activities"* [52].

The language in this logic mirrors that used with alcohol, as will be discussed in the later section on *Political Equivalence Logics of product alignment*, while the legitimacy of the gambling industry as a partner will be discussed in the section on *Political Equivalence Logics of Collaboration*.

The social logic of legitimacy can be challenged on several fronts. Using the quotes above as examples, there is little evidence that gambling "*generates employment and investment*" outside of the multinationals that form the basis of the business. To describe something as just another "*leisure activity*" can also be questioned, given the evidence of harm to physical, mental and financial health [23]

The impact of framing gambling as an activity and a business as legitimate is two-fold: it has led to stigma in those experiencing harms, and it has given the gambling industry a "*seat a the table*" [70] of policy-making and high levels of influence that can be challenging to draw from.

6.4.1.6 The Social Logic of Low Expectation

Legislative reform proposals have often been watered down or delayed throughout the period. This is often justified by arguments that the evidence is insufficient and further consultation is needed. These points are then used to lower expectations about what can be done to address such a "*complex*" issue (*the social logics of low expectation*).

This logic is most commonly found in the discourse of non-governmental organisations such as the Responsible Gambling Strategy Board (*"Public Health actions adopted need good evidence and careful consideration"*)[113] and the Gambling Commission (*"Reducing gambling harms will not be without challenges, not least because we need to know more about where and how those harms are felt"*)[196].

This logic was noted in the gambling education research previously mentioned [105], and described as "*the logic of incrementalism*". The authors quote Howarth, who noted this strategy can be *"giving the appearance that 'something is being done' while simultaneously doing little to "disturb or modify a dominant practice or regime in a fundamental way"* [105, 188]. An example of this would be that despite taking over two years from the close of the call for evidence to its publication, the 2023 White Paper still predominantly recommended multiple "*consultations*" and further discussion of particular topics "*when Parliamentary time allows*" before committing to enacting any legislative changes [52], citing a need for more evidence. Yet there are multiple recent examples of government being able to act quickly from a legislative point of view when it chooses, from emergency legislation enacted in the Covid-19 pandemic to the decriminalisation of those previously prosecuted for fraud in the UK post office scandal when a recent television series drew attention to it.

The impact of the social logic of low expectation, often coupled with elements of the social logic of evidence as justification, is that progress is stymied before it starts. Expectation is set low, and as such, no ideological investment is made by any actor in the process.

6.4.2 Political logics

Political logics capture the practices through which a discourse emerges, and hegemony is established and maintained, but also contested and challenged [105]. They include a set of "*interrelated and ongoing processes*" of the both the logics of equivalence and difference [105]. Originating from Laclau and Mouffe's work, political logics of equivalence are "*processes and practices that bind and unite difference elements*" while the political logics of difference describe discourses that "*divide and complexify the social realm*" [98, 99, 105].

An example of from the literature would be how gambling education materials produced for schools have drawn equivalence between gambling and other industries or issues [105]: "*Teachers are advised that gambling is a topic to be taught in schools just like any other risky behaviour, such as the use of alcohol, tobacco, and illegal drugs*." In contrast, the logic of difference is deployed by the same materials conceptualising that risk from gambling arises from an individual being different: "*inherent faulty thinking and impulsive decision-making and is related to the 'type' of gambler or gamer they are, and what 'feelings' and 'emotions' they derive from such activities*"[105]. Such equivalence and difference logics within the discourse normalise and stigmatise, respectively.

In contrast with social logics that describe social norms and practices are discussed, political logics capture the practices through which a discourse emerges, maintained and challenged [105].

Given the interrelated nature of political logics, the following logics are presented as two opposing pairs, collaboration and conflict and product alignment and dichotomy and are summarised as follows:

- The political equivalence logics of collaboration: how actors and institutions either align, or are aligned by others, in their language and approach to an issue.
- The political difference logics of conflict: how actors and institutions set to differentiate themselves, or are differentiated by others, in their language and approach to an issue.
- The political equivalence logic of product alignment: how gambling as an activity or behaviour has been likened to other products in the discourse.
- The political difference logic of product dichotomy: how, within gambling products, differentiations have been made between types of products, which has then been used to shape solutions to the issues that have arisen from the use of certain types of products.

6.4.2.1 The political equivalence logics of collaboration

The political logics of collaboration and conflict are presented chronologically but should be seen as an evolving logic in which each step builds on its predecessors rather than a sequence of disconnected ideas. This created a congested discursive field by the mid-2010s.

These logics can be seen in how various actors have worked with or against each other, especially since 2005. Previously, the role of local government was largely limited to planning: *"Licensing of gambling premises should run parallel to planning controls"* [182]. In this context, there was little obvious benefit from wider collaboration.

This changed once the Gambling Act 2005 came into effect, encouraging the industry as a leisure provider. Local councils became concerned about the increasing "*clustering*" of betting shops. A key moment was in 2014 when one London council, Newham, decided to act on problems emerging with FOBTs. Their response was to argue for a limit of stakes to £2, a policy they proposed implementing using provisions in the Sustainable Communities Act 2007, which provided communities the opportunity to identify legislative barriers that

prevent them from improving the sustainability of their local areas and tasked local authorities to ask the national government to remove it [200].

Seeking wider support, they reached out to counterparts in other local authorities:

> *"For a submission to be successful, broad support from local authorities across the country is crucial"* [184].

They succeeded in gathering considerable support, with nearly 100 local councils backing it, but the government rejected their call. Yet, they had put the issue on the table. In response to the 2016 call for evidence on gaming machines and social responsibility, almost all of the local authorities that responded, including 11 from London, made reference to their call for a £2 maximum stake [186]. A London Councils' publication in the following year drew particular attention to how councils had "*campaigned collectively*" on the stake reduction [201]. London Councils had already recognised how "the *move of public health to local authorities provides opportunities…*with *local authorities working together and with the Greater London Authority'* [202].

By 2016, as the scale and nature of the harms caused were becoming impossible to ignore, local government increasingly started working with a broader group of institutions to tackle gambling-related harms: these included central government, the regulator, service providers, academics, professional bodies, other front-line agencies such as healthcare and debt relief, mental health and voluntary services and the "*Responsible Gambling community*" [113, 195, 196, 198, 199, 203].

By 2018, the concept of "*whole council approaches*" can be found in the discourse, including within titles of publications, recognising that *"multiple [council] departments come into contact with those experiencing gambling harms"* [199] and *"A 'whole council' approach to the licensing of gambling premises is, therefore, an effective means to influence the planning process and improve the wider health environment"* [201]. However, despite the use of this phrase, it was never defined until the Greater Manchester Combined Authority did so in 2023 [204, 205].

The situation changed again around 2020. What had been a growing emphasis on the role of local government went into reverse. To the extent that local authorities were mentioned, it was as a *"wide range of stakeholders".* For example, the annual updates regarding the

current national gambling strategy from the ABSG[2] do not mention local authority specifically in the sections considering governance, prevention, education or treatment of addressing gambling harms [207, 208]. The most recent (2021) version does at least mention local authorities in the context of "*primary prevention*", but as part of "*a multi-agency approach*"[209].

A very different type of collaboration began to emerge in 2015 when the LGA Councillor's Handbook 2015 referred to "*working with the industry*". It contained a case study of a local council that had worked with the Association of British Bookmakers, the trade union for betting shops [67]. By the 2018 edition of the Councillor's handbook, this specific case study was being described more generically as "*working with stakeholders*" [68].

By 2016 the nature of this collaboration was changing. By now, a number of new organisations had emerged, some funded by the gambling industry and presented as playing a social responsibility role (although that is widely disputed). In responses to the 2016 call for evidence on gaming machines, some individual local authority responses, plus the LGA and London Council, mentioned working with organisations such as Betwatch (described by The Gambling Commission as "*a partnership between the Gambling Commission, the police, local council and bookmakers",* [210]. These responses were more likely to use the organisations' names rather than phrases such as "*working with operators*" or "*working with the gambling industry*" to describe collaborative working. Bulletins from the Gambling Commission to licensing authorities use the same technique, mentioning collaboration with industry-aligned or industry-funded organisations (such as Betwatch, the Betting and Gaming Council, GamCare and GambleAware) [177].

The most recent edition of the LGA's Councillor's handbook, published in 2021, states that:

> *"the Gambling Commission are encouraging operators and licensing authorities to work together in partnership...the LGA recognises the value of this approach...the Gambling Commission is keen for licensing authorities to foster a partnership approach to local regulation" [69].*

2 The Advisory Board for Safer Gambling (ABSG) provide independent advice to The Gambling Commission 206. Gambling Commission. *Advisory Board for Safer Gambling*. 2024 [cited 2024 25 March]; Available from: https://www.gamblingcommission.gov.uk/absg.. Their members are appointed by the Gambling Commission.

The current Gambling Commission's current online toolkit for local licensing authorities reinforces these "*partnerships*" that include both the Gambling Health Alliance (whose members include industry-funded organisations [211] and GambleAware (who currently manage voluntary contributions from the gambling industry for research, education and treatment [189]The 2023 White Paper makes no specific mention of local authorities working with industry representatives, either directly or through partnered organisations. Given the more authoritative language used in the same document about industry's role in addressing the harms it is increasingly seen as causing, it cannot be commented upon whether this omission is intentional.

Several collaborative terms are used in publications but are rarely defined. Nor is it explained how they would be operationalised or which stakeholders would be involved. Examples include *"Whole council approaches"* [68, 198, 201]; *"Partnership working"*[177, 197, 198, 203], "all interested parties" [54, 183, 186] and *"Wide range of stakeholders"* [52, 207-209] and "multi-agency working"[199]. The only examples identified that list specific stakeholders are from the LGA "*Whole Councils Approach*" publication [199] and the Greater Manchester Combined Authority Strategic Needs Assessment [204], the latter publication operationalising the approach.

Over the period of the analysis, local government has gone from being expected to share knowledge with an increasing number of actors, and most recently, with the gambling industry in its various manifestations. The potential impacts of the political logic of collaboration are three-fold. Firstly, the accumulation of actors that local governments are expected to work with has made the discursive (and operational) field crowded-to find shared strategy becomes more problematic and can delay any progress, especially if actors hold opposing opinions on social logics (for example, local government expected to collaborate with industry when industry do not recognise harms as a public health issue). Secondly, despite the wide range of collaborative terms used, clear definition and operationalising is limited, yet again stalling progress. Finally, local government as a specific stakeholder is increasingly marginalised in the more recent national discourse. As will be discussed in the *Problematisations* section, the impact of this is potentially profound.

6.4.2.2 Political difference logic of Conflict

This logic sees local government as being in potential conflict with the industry, which, as we have seen, is portrayed in central government material as a legitimate leisure industry, but also with central government. Hence, those promoting this discourse argue that the powers of local government should be limited lest they harm this industry.

6.4.2.2.1 Local government vs national government

These concerns can be seen even before the Gambling Act 2005 came into force; national documents highlighted potential concerns about giving full powers regarding licensing to local government. The Budd report *"recognised the possibility of "small town politics" but found no evidence to support this"* [182] but the DCMS response stated: "There is significant apprehension and misgivings about local authorities having these powers [full control of licensing premises locally]… -they can't be trusted with "unfettered discretion" [212].

Newham Council's 2014 case stated that the UK government has "*a duty to try to reach agreement with councils*" [184], but in the subsequent appeal, it was minuted that the national government "*chose*" not to send representation without further information as to why, which may suggest a lack of effort in terms of the national government's "*duty*" here [185].

While local government has persistently used calls for evidence and publications to argue that their powers are inadequate, feeling "*hamstrung*" and "*frustrated*" [69, 184], the discourse from the DCMS takes the view that local government already has the "*tools*" needed. Both cannot be true.

> *"Local authorities already have powers under gambling legislation to ensure necessary public protection" [191].*
>
> *"where current powers are deployed, local authorities can have a greater say over how and where gambling can be offered and will not therefore be bringing forward further changes at this stage" [48].*

The DCMS makes great use of Westminster City Council in London, which it portrays as local government exercising its powers effectively. Yet even a superficial examination shows this to be a poor example. Westminster is very different from the rest of the country in terms of its land-based gambling premises, with many casinos catering, to a substantial extent, to

visitors to the capital. In effect, it imports money from the rest of the country and abroad and exports the resulting harms afflicting those living elsewhere.

Yet even the powers that they have are inadequately employed. Thus, the 2020 National Audit Office report criticised local government licensing teams because "*119 licensing authorities did not conduct any inspections in 2018-19 and around 60 did not conduct any for the past 3 years"* [64]. Unfortunately, it left this observation hanging, failing to ask why they failed to do so (although it is widely recognised that local authorities across England are increasingly struggling financially).

The DCMS's reluctance to increase the existing powers is apparent. When the House of Lords recommended, in 2020, that "*local councillors should be given "the same powers as with alcohol*" [51]the DCMS pushed back on this, using more delaying tactics. They said that *"We will seek views from licensing and local authorities on what, if any, changes they want to see made to their powers"* [213]. This was despite local government calling for more powers over many years.

The 2023 White Paper continued this logic, with the DCMS portraying itself as empowering local authorities to use the tools that they already have [52], even while, in the same document, conceding that these powers may not be adequate. Specifically, it suggests that a new mechanism, cumulative impact zones (such as those with alcohol) will be considered "*when parliamentary time allows*".

6.4.2.2.2 Local government vs regulator

The Gambling Commission has primarily communicated with local government via an irregular series of bulletins and an online toolkit, both directed primarily at local licensing teams [177, 189]. Conflict between these two groups comes through the authoritative, and on occasion arguably patronising, language used by the Commission in these communications with local government. One notable phrase used repeatedly by the regulator is that licensing authorities "*are reminded*" to perform their mandatory activities such as licensing records returns. Extra time was "*given*" by The Gambling Commission for local licensing authorities to complete their mandatory returns in the context of the first year of the Covid pandemic [177].

The London Council publication in 2018 also "*reminds*" councils to "*pay due regard to the Commission guidelines*" [201]. The language used in these publications mirrors the

legislative language in the Gambling Act 2005, which includes many references to the Secretary of State's powers to overturn any local government decisions or develop new regulations [65].

More recent documents from the gambling regulator place responsibility for premises licensing squarely with local licensing authorities and the role of the regulator is to "*facilitate*" and "*not established, and is not resourced, to lead on local gambling regulation"* [203] [189].

6.4.2.2.3 Local government vs the gambling industry

The early documents showed little evidence that local authorities might conflict with the gambling industry. However, as already noted, there were concerns in central government that this could arise. Hence, it was argued that local government's powers should be constrained less they harmed this industry, which, as we have also seen, was viewed as legitimate and even positive. The government's response to the Budd Report noted: *"local authorities already have an important role to play in this area [licensing premises]; but the consultation exercise raised various concerns about their ability to take on an enhanced role"* [212][GOV].

Yet concerns that local government might use its powers to counter the industry seemed unfounded. As Newham Council noted, these powers were very limited. It said that it *"felt [it had] provided sufficient evidence of trying to reach agreement with local businesses regarding clustering and gaming machines "but this has not been possible"* [185].

This view, that local government did need to confront the industry but lacked the powers to do so, was also apparent in the 2015 RSPH Health on the High Street publication. It viewed betting shops negatively, and it stated that "*local authorities need the powers….business profit cannot not be all paramount to public's health…business practices need curtailing*" [47]. The follow-up RSPH publication in 2018 tasked national government "*to provide local authorities with the power and support to restrict the opening of new betting shops and other unhealthy outlets where there are already clusters*" [179].

In recent years, local authorities, individually and collectively, have been more explicit about the conflict between supporting the gambling industry and its obligation to promote the health of its population. In particular, it has started to invoke concepts from the field of

commercial determinants of health and, specifically, evidence on how to deal with industries responsible for health-damaging products.

> *"With some operators receiving multiple fines, it is becoming clear that the fines imposed as a result of enforcement are considered a 'cost of business' which are factored into balance sheets without consideration of the harmful impact on customers."* [214].

In doing so, they come up against the standard industry framing of any problems as lying with "*faulty*" individuals, not a highly addictive product and a predatory industry [215]. For example, the gambling industry has challenged local authorities' approach toward the gambling industry, as seen in a response to the call for evidence in 2016, by stating:

> *"Levels of public concern around the issue of B2 [FOBT] gambling machines have been amplified…and politicised by certain local authority and other political groups…to the benefit of their sectors*" [178][IND].

Written evidence submitted by the gambling industry for the Gambling Act review makes little specific mention of local authorities, with only one response even mentioning local government, and this in the context of electronic gaming machines in pubs, suggesting that given that the right of pubs to install these machines is *"automatic"*, that *"there is no logical reason for them to be informed"* [216]. Written evidence from local government representatives strongly challenges this [214, 217]

The impact of a logic within the discourse that portrays local government in conflict with multiple parties, even while they are also collaborating with them, *"divides and complexifies the social realm"* [98, 188]. This can stall policy progress as energy is taken up in dealing with conflict.

6.4.2.3 Political equivalence logic of product alignment

This logic relates to how gambling, as a product, is conceived. Often, it has been aligned with alcohol in terms of legislation, likely because it is seen as a product creating benefits and harms (the political equivalence logics of product alignment). This contrasts with tobacco, which is now accepted as entirely harmful.

Notably, licensing legislation for alcohol was under review at a similar time to gambling, with the Licensing Act coming into effect in 2003 [66]. Language in the Licensing Act 2003 and The Gambling 2005, in terms of the role of local authorities, often closely mirrors each

other. An example is the description of 'Responsible Authorities', those council departments and external organisations that must be consulted when new applications are received by a local licensing committee for review. Figure 1 sets out the similarities between the two pieces of legislation:

Figure 6-1 Responsible Authorities: Comparison of the language used in the Licensing Act 2003 and Gambling Act 2005

Licensing Act 2003:	Gambling Act 2005:
"Responsible authority" means any of the following— the relevant licensing authority and any other licensing authority in whose area part of the premises is situated, (a)the chief officer of police for any police area in which the premises are situated, (b)the fire and rescue authority for any area in which the premises are situated, the Local Health Board for any area in which the premises are situated" [66]	"For the purposes of this Part the following are responsible authorities in relation to premises— (a)a licensing authority in England and Wales in whose area the premises are wholly or partly situated, (b)the Commission, (c) either— (i)in England and Wales, the chief officer of police for a police area in which the premises are wholly or partly situated, or (ii)in Scotland, the chief constable of the police force maintained for a police area in which the premises are wholly or partly situated, (d)the fire and rescue authority for an area in which the premises are wholly or partly situated" [65]

It is worth noting that while public health departments within local government act as the Responsible Authority for licensing alcohol premises, they do not for gambling premises, despite distinct similarities in the legislation in this aspect.

This alignment of legislation has persisted throughout the period being analysed. The 2001 Budd Report recommended that "*the Gambling Commission should circulate procedural*

rules to deal with issues of the kind mentioned in the Liquor Licensing White Paper" [182], and the 2020 House of Lords report recommended "*The [Gambling] Act should be amended to give licensing committees deciding on the licensing of premises for gambling the same powers as they already have when deciding on the licensing of premises for the sale of alcohol*" [51].

In their written evidence on the review of Gambling Act legislation, the Local Government Association suggested that "*the review to bring forward a new legal power [for local government], whether through a cumulative impact assessment [CIAs)*[3] *or other tool*" [217]. The following White Paper acknowledged this and stated that it "*will consider CIAs for gambling premises when parliamentary time allows*" [52].

Although none of the publications reviewed directly compared these two products, they are both presented as legitimate pastimes:

> *"Millions of people enjoy gambling responsibly and the Government is committed to supporting a healthy gambling industry that generates employment and investment"* [48][GOV].
>
> *"For many people, alcohol can be something to enjoy with friends at home, at a local pub or a community event. As well as contributing to social interaction and local life, the alcohol industry plays an important part in enhancing the health of the economy, supporting over 1.8 million jobs"* [181] [GOV].
>
> *"While gambling as a product and pastime is presented directly and indirectly as legitimate, it is notable that harmful gambling as a behaviour is aligned to "other addictions"* [64]*[NGO].*

The impact of a logic within the discourse that aligns gambling and alcohol in this way helps to normalise gambling. Yet, given the undeniable harm that gambling can cause, there is a need by those promoting it to find a way to differentiate the legitimate from the illegitimate. This gives rise of a political logic of difference-where the problem or irresponsible gambler is constructed as the antagonistic and undesirable other [105]. By

[3] Cumulative impact assessments (CIAs) can be used in England and Wales to limit the number of premises selling alcohol in an area. The purpose of a CIA is to help the authority limit the licences that it grants in areas where there is evidence to show that the number or density of licensed premises may be contributing to problems that are undermining licensing objectives.

aligning “problem” gambling with certain illicit or addictive behaviours, it is possible to invoke some of the language from those fields, such as harm reduction [122].

Of note, so-called land-based gambling has also been aligned to other types of commercial properties considered a negative factor on the high street. Of the local plans from London boroughs that mention gambling (notably only 6 out of 30 available), the discourse typically aligns gambling, and specifically betting shops, to other commercial properties such as hot-food takeaways and payday loan shops. This alignment echoes the imagery of the RSPH 2018 document [179], and can be articulated with the social logics of localism to problematise a local issue. However, discourse that focuses upon betting shops as the high street concern ignores recent changes to FOBT legislation, which means that machines in betting shops, arcades and bingo now all fall within the same category (and the latter two types of premises do not have a fixed upper limit on the number of electronic gaming machines an individual premises can house). It also ignores recent changes in types and trends of gambling premises on the high street, as discussed in Chapter 5. Most importantly, the Local Plan of an area is reviewed and inspected by the national government’s planning directorate before it is adopted as the legally binding development plan for the area [218]. Therefore, how gambling is presented and aligned in the Local Plan discourse has legal implications for an area.

6.4.2.4 The Political difference Logic of Dichotomy of product

Gambling products have been dichotomised in different ways during the study period. In earlier documents, gambling products were differentiated into ‘amusement’ games and gambling [183]; later, gambling was dichotomised into “*hard*” or “*soft*” products [68, 191], classified by level of stakes, prizes and the speed of play. Since the mid-2010s, the discourse has predominantly seen a dichotomy between land-based and online gambling, which has persisted in the most recent publications, such as the 2020 call for evidence in the review of the Gambling Act that aims to *“bring analogue legislation into the digital age”*. This document has separate questions for online and land-based gambling [54].

This logic is primarily found in national government discourse, although the most recent dichotomous discourse has been found in a wider number of publications [177, 189, 196]. Two issues are of note. Firstly, gambling that takes place in person is often referred to as

"non-remote", suggesting the primacy of online gambling, indirectly downplaying the contribution of land-based gambling to the sector.

Secondly, when online gambling *is* mentioned in the context of local government, it is portrayed as outside their scope, invoking *the social logic of legislation*. Thus, *"Councils do not have any regulatory responsibilities in relation to remote gambling"* [69][LOC] and *"Councils' regulatory role applies only to non-remote gambling"*[196][NGO]. No mention is made in any documents from national government of cross-platform technology (that can, for example, mean those who have online accounts can receive 'push' notifications on their phones with enticements to gamble when in the proximity of a land-based gambling premises) even though this is now recognised as a key issue [60].

6.4.3 Fantasmatic logics of beauty and horror

Fantasmatic logics help us to understand why and how subjects are 'gripped' by certain practices or policy discourses rather than others [105]. Glynos and Howarth conceptualise them as either beautific or horrific that can, respectively, "*capture the enjoyment of closure*" or create a horrific scenario if taken away from a discursive "*other*" [98, 105]. Previous CDAs applying the logics approach to gambling discourse have noted how these opposing fantasmatic logics are often used in tandem yet frequently contradict one another and contain *"slippages"* in the arguments put forward [105]. Fantasmatic logics can also be depicted as objects (both actual and abstract) and characterised as being either beautific or horrific, often presented in their opposing pairs. Fantasmatic logics consider ideological "*grip*" rather than social logics' descriptions of societal norms, and political logics recognises how entities are aligned or separated.

As in the earlier political logics section, here the fantasmatic logics of beauty and horror are presented chronologically, followed by examples of fantasmatic objects in their paired opposites. They are summarised as follows:

- The fantasmatic beautific logics of fun-how gambling is portrayed as an enjoyable pastime
- The fantasmatic beautific logics of freedom-how gambling is portrayed as something people should be free to do with their money and time.
- The fantasmatic beautific logics of regulation-how regulation protects from harm

- The fantasmatic horrific logics of fear-how gambling (or the restriction of it) impacts on emotive, abstract concepts ("business", and "crime")
- The fantasmatic beautific horrific logics of the harmed ("the Problem Gambler")-how those who are impacted by harmful gambling are described
- The fantasmatic objects of beauty and horror-how the stake reduction was the solution to of FOBTs, how the levy is the solution to online gambling.

6.4.3.1 Fantasmatic beautific logic of fun

Discourse and imagery that depict gambling as fun can be seen throughout the timeframe of the analysis (*Fantasmatic Beautific Logic of Fun*) in material from certain policy actors, but are also notable for their absence from others.

Prior to the Gambling Act, MPs speaking in the parliamentary debate about the Budd Report described gambling as a fun activity:

> *"People play pusher machines not to gamble but to buy time, to buy fun in an atmosphere of lights and excitement and to while away an hour while they are on holiday… They are harmless fun and no more than that" [219]* (GOV).

Gambling Commission bulletins frequently use stock images of sunny seaside scenes [177], and repeatedly employ the title "Full House!" to congratulate licensing authorities on completing their (mandatory) returns, a phrase synonymous with winning at bingo.

National government publications did not use the word "fun" between the 2005 Act and 2020. Then it described it as "*a fun leisure activity for many people*" in the Secretary of State's introduction to the call for evidence into gambling legislation [52]. In the subsequent White Paper, the word "fun" is only used in the context of reporting the Gambling Commission's 2022 Young People survey results, where *"74% of young people who have ever spent their own money on gambling were with their parents and/or guardians at the time and 78% say they did so for fun"* [52]. There were no local government publications that used the word fun.

One can only speculate why these omissions occurred, but they are noticeable. One possible explanation may be that this word has come to characterise the industry's discourse. The industry's main advertising campaigns were even entitled "*When the Fun Stops Stop*". The

problematic framing around this campaign (and the lack of effectiveness of it as a prevention strategy) has been described elsewhere [150, 220].

6.4.3.2 Fantasmatic beautific logic of freedom (in the context of balance).

The freedom to gamble is a logic that emerged prior to The Gambling Act 2005 coming into force, and that has persisted throughout the timeframe of the analysis (*the Fantasmatic Beautific Logic of freedom*). It is primarily found in publications from national and local government and aligned NGO organisations, such as the gambling regulator and national strategy documents. Examples include:

> *"The draft Bill [of the Gambling Act 2005] will repeal many provisions in the existing legislation which fetter the consumer's freedom to gamble"* [221][GOV].

> *"We respect the freedom of adults to choose how they spend their money"* [54][GOV].

Of note, the freedom to gamble is commonly "balanced". For example:

> *"The Gambling Commission's statutory framework requires it to achieve an appropriate balance between regulatory requirements intended to reduce harm and the desirability of giving players the freedom to choose how to spend their leisure time"* [113][NGO].

> *"betting shops are highly regulated… and strike the right balance between freedom of choice and the prevention of harm"* [178][IND].

> *"Our aim in the [Gambling Act] Review has been…that we have the balance of regulation right between protecting people from the potentially life-ruining effects of gambling-related harm while respecting the freedom of adults to engage in a legitimate leisure activity"* [52][GOV].

In addition, the freedom to gamble is commonly presented indirectly (for example, as the freedom to spend money as one wishes or the freedom of choice).

Notably, concepts of freedom align clearly with the language used by libertarian think tanks and neoliberalism ideology more generally in today's society. Such discourses promote freedom to expose oneself to a harmful product, where individual preferences can be shaped despite outcomes for the individual being to their detriment.

6.4.3.3 Fantasmatic beautific logic of regulation

The concept of regulation as a legitimate means to protect people from gambling, and from the industry that promotes it, can be found throughout the timeframe (*the Fantasmatic*

Beautific Logic of Regulation). This is mainly found in publications from national and local government and the gambling regulator.

> *"Regulation provides accountability and accessibility"* [182][GOV].
>
> *"regulation and enforcement is a strong element of local decision-making and accountability in gambling regulation"* [189][NGO].

When the beatific logic of regulation is articulated alongside the social logics of legislation and legitimacy, the case for action is strengthened, appealing to both the concept that grips us and a "*common sense*" way of doing things. In turn, this contributes to a hegemonic discourse around legislation and regulation (rather than focusing on addictive products and predatory industry tactics).

6.4.3.4 Fantasmatic horrific logic of fear

Emotive language has often been used to create images of horrors and losses that will unfold if the fantasy object is "*taken*" by a discursively constructed "*other*" [98, 105](*The fantasmatic Horrific Logic of Fear*). Examples of such emotive language from before the 2005 Act include the idea that fear of the adverse economic impact on a local area should gambling be restricted: *"The vital seaside businesses will die" and "The sword of Damocles hanging over local businesses"* [219][GOV].

A fear of *"*crime*"* appears in the discourse in two ways. First, it is used in relation to those who are providing illegal gambling: enforcement infringements are reported frequently in the licensing bulletins (accompanied by stock imagery suggesting illegal activity) [177]. Second, it is used in relation to crime as a consequence of gambling e.g., the LGA stating "*these machines* [FOBTs*]…and the crime associated*" [186] and *"problem gambling can ruin lives, wreck families…cause debts that cannot be repaid, crime"* [213]. However, the specific "crime" discussed in the latter discourse is not further articulated.

The fantasmatic horrific logic of fear is often coupled in the discourse with the fantasmatic beautific logic of regulation as the "solution". This concept of coupling will be expanded upon in the *Fantasmatic Objects* discussion later in this section of the chapter.

6.4.3.5 Fantasmatic horrific logic of the harmed (the "Problem Gambler")

A focus upon "problem gamblers" in the discourse emerged after the Gambling Act 2005 came into effect (*fantasmatic horrific logic of the harmed*). This has persisted in many

discourses, despite criticism that this narrow, stigmatising definition is misaligned with a public health approach but rather places the blame on a few individuals whose use of what are legitimate gambling products is problematic [105]. Examples of this stigmatising, fear-inciting language include:

> *"The Gambling Review Body recognised that some individuals become obsessed by gambling to the point at which they cease to function as normal members of society"* [221][GOV].

> *"Problem gamblers typically experience more extreme consequences from gambling, including a possible loss of control of their gambling activity"* [64][NGO].

The impact of this almost hegemonic discourse, focusing attention on a few people and using narrow definitional criteria, closes down discourse about the possibility of population-level interventions and considers spectrums of harm.

Of note, in previous using CDA to examine material used for teaching on gambling, "problem gamblers" were considered as part of political logics of equivalence and difference. In that research, *"the notion of problem or unhealthy gambling (and gaming), and the problem or irresponsible gambler (and gamer) is constructed as the antagonistic and undesirable other"*[105]. The impact of this alternative presentation, once the logics are articulated together, is considered in later, in the discussion.

A fear of the risks of clustering, and later online gambling, were predominant alongside this logic of the harmed. This is an example of *"slippage"* [105]-on one hand, Problem Gamblers are characterised as not interacting with gambling products "in the right way"; on the other hand, it is the product type and availability that is depicted as a "fear" logic or an object or horror.

6.4.4 Fantasmatic Objects of beauty and horror

Fantasy Objects in the discourse are real or abstract concepts that are portrayed as either the cause of all problems or the solutions to these problems (*fantasmatic objects of beauty and horror*). They frequently occur in the discourse in their opposing pairs. The horror of "crime" and "black markets" that can be "solved" by the fantasy of "regulation" has already been discussed. Further fantasmatic object examples are presented here in their coupled pairs.

6.4.4.1 FOBTS and the stake reduction

Once the clustering of betting shops had been identified as a concern, the focus shifted to electronic gaming machines within the shops. FOBTs, as a fantasy object of horror, became almost hegemonic in the discourse. FOBTs were described as *"particularly addictive and linked to anti-social behaviour and crime in betting shops"* [186] and as *"addictive as crack cocaine"* [68]. At the same time, the reduction of FOBT stakes to £2 emerged as the fantasy object of beauty in the discourse to 'solve' this issue: stakes reduction was presented as a way to *"protect the player and to limit losses and this proposal would bring them into line with other machines in the UK*" [184] *and "sufficiently protect consumers*" [186].

6.4.4.2 Online gambling and the statutory levy

Once a commitment to reduce FOBT stakes had been made in 2018, the discourse shifted to a new fantasy horrific object, that of the more abstract "wild west" of online gambling. For example,

> *"The way people gamble is changing, with new risks emerging in online and mobile gambling and other technological developments"* [64][NGO].
>
> *"concerns have been raised that the current system of tailored online protections is not sufficiently effective at preventing gambling harm…leading to devastating effects for individuals and their families"* [54][GOV].

The fantasmatic beautific object of a statutory levy was then presented as the solution:

> *"We also support the introduction of a mandatory levy on gambling firms, based on the 'polluter pays' principle, to help fund a significant expansion of treatment and support for those experiencing gambling-related harm"* [52][LOC].

Concerns by academics that a "*statutory levy may do more harm than good*" have been discussed elsewhere [222]. It is also of note that the previous hegemonic discourse about the £2 stake being the solution to FOBTs has been transferred over to a possible solution to online gambling: the recent White Paper plans consultation on this as a discursive "solution", as well as the levy [52].

6.5 Articulation of the Logics: Problematisations and Impacts

Using a retrodictive approach to analysis, the three types of logics are articulated together in order to create the problematisation of objects [98]. Here, the object under consideration

is local government and problematisations are proposed chronologically. Considering the *"primacy of politics"* in post structural discourse analysis [99], the proposed impacts of the problematisations put forward are based upon both political and/or legislative changes (or inaction) at the time.

Pre 2005, local government was primarily problematised by its capability (or not). The social logics of both legislation and the legitimacy, articulated with the political equivalence logic of product alignment, helped construct the argument that gambling legislation (in terms of local government) should mirror that of the then proposed licensing legislation for alcohol. However, local government's capability to legislate effectively was questioned by articulating both political difference logics of local government being "anti-business", with caution regarding their *"unfettered discretion*", alongside fantasmatic horrific logics of fear such as the risk of "*small town politics*", and that seaside tourist spots *"would die"* while *"the Sword of Damocles"* hung over local businesses if local government had full control of local licensing decision-making.

The impact of this problematisation of local government was that local government was denied the power to licence local premises in the Gambling Act 2005. Cassidy notes that out of over 170 recommendations in the Budd Report, this was one of the few not adopted [53]. Whether local powers are adequate has remained a matter of contention throughout this analysis.

Between 2006 and 2016, local government was primarily problematised by its powers (or lack thereof). The social logics of legislation and legitimacy persisted and became increasingly embedded in the discourse. Local government's role in gambling was primarily discussed in terms of its legislative role and the social logic of localism. While local government repeatedly argued that its powers were inadequate to tackle "*the local issue of clustering*", the national response (political difference logic) was characterised by conflict, repeatedly claiming that the "*tools*" already in place were sufficient. By the end of this period, FOBTs and the £2 stake had been identified as widely as the opposing beautific and horrific fantasmatic objects.

In terms of impacts, this problematisation of local government contributed to the national government decision made in 2018 to commit to the reduction in £2 stakes on FOBTs but make no changes to local legislative powers. The implementation of the fantasy object of £2

stakes meant that the concerns around the fantasy object of horror, the FOBT, had "*enjoyed closure*" [188] with the problem of FOBTs discursively "solved".

Between 2017 and 2020, local government was primarily problematised by its "whole council approaches" to addressing gambling harms. The social logic of legislation was articulated alongside the logic of collaboration, envisaging local government departments working together. Local public health teams were also drawn into this ill-defined "*whole council approach*", reflecting the emerging (but contested) social logic of gambling as a public health issue. Local authorities were increasingly expected to collaborate with a wider number of policy actors, as described within the political equivalence logic of collaboration. Alongside this, the social logic of statistics had now fully emerged and was articulated with the social logic of localism, specifying the need for local-level data before any policy action could be taken.

Once the decision on FOBT stakes had been made in 2018, gambling was increasingly problematised as a dichotomy in terms of land-based and online activities, and local government only broadly or briefly mentioned concerning the new fantasmatic horrific object of online or remote gambling. The legal term of "*non-remote gambling*" used to describe land-based gambling premises was adopted by local government organisations in their publications at that time [199].

This problematisation has both disenfranchised and excluded local government in regard to gambling legislation. This is apparent in two observations: firstly, a marked reduction in mentions of local government in the national discourse. Secondly, there were many fewer responses from local government to the call for evidence on the 2020 Gambling Act than in the 2016 call for evidence on FOBTs (from 96 to 25 individual responses), although there could be other reasons why this may have happened. Local government's adoption of language that potentially "others" (e.g. the use of "non-remote gambling" and not "land-based" in their own publications), can also be seen as unhelpful if it is already feeling disenfranchised.

From 2021, local government were primarily problematised as one of a "wide range of stakeholders" in addressing gambling harms. The social logics of legislation and legitimacy of gambling have persisted, articulated alongside the political logic of collaboration. The new White Paper has reinforced the idea of a levy as a fantasmatic object of beauty. Still,

many of the proposed legislative changes are to be sent for consultation, only to be taken forward when more evidence is available or to be discussed "*when parliamentary time allows*". This employs the social logic of low expectations. Proposals for legislative change include introducing cumulative impact for local government (using the political logic of product alignment of alcohol licensing). The social logic that gambling is a public health issue remains challenged, with recent national documents no longer mentioning the term public health (and bodies outside public health defining what a public health response is and who is responsible for it). The dichotomy of gambling products as land-based and online has also persisted, as has the fantasmatic horrific logic of the harmed "Problem Gambler". Despite local government raising concerns about the clustering of arcades and bingo halls, the only legislative proposals on land-based gambling in the White Paper regard casinos and the expansion of higher category machines under the fantasmatic logic of freedom. In national strategy documents, local government is rarely mentioned outside the context of land-based gambling legislation. The operationalising of a "whole council approach" has emerged in publications.

The potential impacts of these problematisations on local government are yet to be realised fully. Still, between 2017 and 2020, there was evidence of some disengagement from local government, as shown in fewer responses from local government's calls for evidence. The increased number of (undefined) collaborators that local government is expected to work with to address gambling harms and a continuing social logic of low expectation also support the slow progress of any policy change.

6.6 Discussion

This discourse analysis used a Critical Logics Approach framework to analyse publications related to local government and gambling policy over the lifespan of the Gambling Act 2005, from pre-legislative discussion to the 2023 white paper signalling its review. Persistent logics of legislation, legitimacy of gambling, and freedom to gamble appear in the entire timeframe of the discourse. Logics around the use of statistics and local governments adopting "whole council approaches" emerged in the mid-2010s, as well as a shift from a dichotomy of hard/soft gambling products to that of a land-based/online dichotomy discourse. Narratives that have been persistently challenged include the adequacy of local

government powers and, since its emergence, whether gambling harms are a public health issue or not.

In line with these changing logics, the problematisation of local government has also changed over time. Firstly, their capability and then their powers were questioned. Next, local governments were tasked with adopting ill-defined "*whole council approaches*" while collaborating with an ever-increasing number of other institutions. Most recently, local governments have been described as "*one of many stakeholders*" in the discourse on gambling policy. There appears to be a contradiction between increasing mentions of local government in gambling policy discourse and the emerging hegemonic discourse that online gambling is the key issue that now needs addressing.

A land-based/online gambling product discourse, tasking local government to adopt ill-defined "*whole council approaches*" with an ever-increasing list of collaborators, now describing them as "*one of a wide range of stakeholders*," has been the key driver in marginalising and disenfranchising local government in national gambling legislative discourse. The challenges to discourses described above and the emergent social logic of statistics that existing evidence is not good enough have assisted in the continued stalling of any progress in changing national legislation and increasingly disenfranchising local government bodies.

In terms of critical analysis, firstly, it is acknowledged that this analysis remains one person's qualitative analysis of available publications. However, the hypothesised problematisations and impacts put forward in this analysis were supported by the legislative decisions made over the same period using objective evidence.

Secondly, inclusion and exclusion criteria for this analysis (an iterative publication identification process that excluded policy documents that did not contain either "local government" OR local authority" AND gambling" in the text corpus) may have excluded further important publications. These inclusion criteria were particularly restrictive for London borough Local Plans. Of the 32 current local plans, 30 were available online, and only six mentioned gambling, mostly in product alignment with other commercial properties on the high street (e.g., payday loan shops and takeaways). However, a further six Local Plans were excluded due to the inclusion criteria mentioned "betting shops" in the text corpus. This is important because not only does it highlight a limitation of the method, but it

also highlights that at the local government planning level, as opposed to the public health or licensing team level, in a document that is legally binding once ratified, gambling can be conceptualised as something different in definition and alignment.

This analysis also omitted any publications from charities or campaign groups which may have given different perspectives on how local government is problematised.

Thirdly, it must be acknowledged that this is only one researcher's interpretation of the CLA. Depending on the individual researcher, the same discourses can be interpreted as falling into different sub-types of logic. For example, while van Schalkwyk conceptualised "Problem Gamblers" under political logics of difference (dichotomising those who gamble responsibly versus those who are viewed to do problematically), in this analysis, Problem Gamblers were felt to be a fantasmatic logic of fear that "*gripped*". Likewise, it can be argued that the *political equivalence logic of collaboration* could have also been conceptualised as a fantasmatic logic given that collaborative terms such as "whole council" and "partnership working" were not further defined. In addition, identified logic can also be labelled differently across the researchers. Van Schalkwyk and colleagues noted the social logic of incrementalism in their findings; this was analogous to *the social logic of low expectations* described here.

Notably, documents from the national government and the regulator, which most frequently adopted the logic of legislation, legitimacy and freedom and the (minority) harmed, are all discourses shared with gambling industry publications. It is also notable that while local government publications (through the local government counsellor's handbook) distance themselves from direct industry collaboration in successive publication editions, the industry remained a key stakeholder in national documents, including as a treatment provider. It is only in the recent White Paper where industry were much more firmly tasked by the national government with "*not being permitted to place commercial objectives ahead of customer wellbeing so that vulnerable people are exploited*" [52].

Overall, direct mention of local authority in gambling industry publications was minimal. However, in the 2016 responses to the call for evidence, the difference in tone between the sub-sections of the gambling industry concerning local authorities is striking. While responses from those representing betting shops were more critical of local authorities

regarding their power and approach, other branches of the industry either did not mention (e.g., racing and bingo) or were more open to working with them (casino). This is most likely because the review at that time was focusing upon FOBTs which were the main setting for betting shops, and local authorities (in theory) had powers to limit both machines and premises. Individual responses to the 2020 call for evidence have not been made freely available: if these documents could be acquired, it would be interesting to see if discourse from arcade representatives now mirrors betting shops, now that machines in both venue types are of the same stake category.

The social logic that gambling harms are a public health issue remains challenged. Despite various institutions stating this, very little has been published by Public Health bodies outside the Faculty Statement in 2018 [2], the ADPH call to action in 2020 [22] and the Public Health England evidence summary in 2021 [23], the latter publication shortly before its disbandment. Those who state gambling harms are a public health issue most strongly, such as the regulator, still publish guidance that is predominantly legislative focussed (while public health remains as not having a formal legislative role in gambling) and/or promote individualised approaches to addressing harms, which do not align with the public health approach.

Contradiction or "slippages" in the logics were identified here in all three logic subtypes. If *"the clustering of betting shops is a local problem which calls for a local solution"* [191] [GOV], why is licensing those premises not fully devolved to local government? If local authorities have enough power, why discuss more powers "*when parliamentary time allows*"? If the gambling industry is a legitimate stakeholder, why distance mentioning them directly? How can local authorities simultaneously collaborate and conflict with the same stakeholders? How can gambling be "fun" at the same time that significant harms and criminality are a concern? How can legislation and regulation be adequate if the regulator persistently reports criminality? If "Problem Gamblers" are the problem, why focus on particular products and increased availability as the horrific object? If gambling is conceptualised as a Public Health issue, why does the narrative persistently focus on individual risk factors for the narrow definition of harm (e.g. Problem Gambling) that does not align with public health principles?

Similarities in the logics identified in this analysis can be drawn with previous work using the logics approach in gambling education discourse for schools [105]. While the previous research identified the *"social logics of consumerism and commodification"* that justified the need for education in schools, this analysis conceptualised this as *the social logic of legitimacy*, that supported the gambling industry's role as a local business and employer. Both pieces of research identified how gambling products were aligned with other products, such as alcohol. "Problem Gamblers" were othered within a logic of political difference in the education discourse, here they were also 'othered' but conceptualised under a fantasmatic logic of fear. The *logic of incrementalism* identified in the previous work is analogous to the logic of low expectations presented here. Using the same framework to analyse different types of documents in the gambling arena assists in building a more consistent and cohesive evidence base, where key elements of alignment and difference can be identified. On occasion, similar logics have been classified under a differing sub-type but the overall articulation of logics together arrives at the same overall problematisation of the objects under consideration: that the state and society legitimise gambling, that those harmed are a minority who are gambling incorrectly in some way, and that legislation is adequate.

The Methods section of this thesis (Chapter 2) outlined how sedimented discourses take on the appearance of necessity or permanence yet remain inherently unstable. Sedimented discourses in the analysis are the social logics of legislation and legitimacy (appearing predominately in both national government, regulator, and industry publications) and the fantasmatic logics of fun and freedom (found in text and imagery in regulator publications to licensing teams alongside the logic of legitimacy). Adoption of the same logics across sectors is a hegemonic practice that strengthens the embedded discourse, leaving less space in these discursive fields to gain traction on alternative (or "contingent") discourses such as "has the gambling industry proved itself to be legitimate?" "Is gambling 'fun' if it causes such widespread harms?" Potential moments of dislocation, such as calls for evidence, that would expose the contingent nature of the social and political order, can be managed by adopting such hegemonic discourse practices.

To my knowledge, this is the first analysis of the problematisation of local government in British publications in relation to gambling. Actively recognising that these logics and

subsequent problematisations have been unhelpful to local government within the gambling policy discourse means they can now be challenged. For example, exposing that a land-based/online product dichotomy does not capture the "*system of harm*" [103] created by gambling potentially opens dialogue into considering well-established public health strategies that address the availability, marketing and pricing of harmful products [92]. By articulating what a whole council approach looks like operationally and specifically defining the "*wide range of stakeholders*" to be consulted, learning from those already considering this (such as the Greater Manchester combined authority [205], then local strategies can be actively progressed.

In future, this analysis can be built upon by reviewing the responses to consultations in the 2023 white paper, identifying which logics continue to persist, emerge, or be challenged, and hypothesising upon the impacts. In addition, machine learning can be used, for example, to analyse the entire text corpus in terms of the frequency of use of certain terms across publications (words such as "balance" for example): this can provide quantitative data alongside discourse analysis and support use of the Critical Logics Approach.

6.7 Conclusion

This discourse analysis used a framework derived from post-structural discourse theory to analyse how local government has been characterised in gambling policy across the period of the Gambling Act 2005, from its inception in 2001 to its review in the white paper of 2023. Considering how various 'logics' were articulated in the discourse, local government has been characterised in different ways over this time, and the impacts of these were discussed in relation to policy events. The next chapter uses a different qualitative framework, that of reflective thematic analysis, to consider interviews with local government representatives.

Chapter 7 Factors that influence using public health approaches to address gambling harms in London's local authorities- a reflexive thematic analysis

Local government is directly involved in licencing gambling premises via its licensing authorities. In addition, individual public health teams within local government bodies have varying levels of interest and influence in local gambling policy. This chapter presents the findings of interviews with members of licensing and public health teams from across London's local government, aiming to identify levers and barriers to addressing gambling harms as a public health issue in local government. A reflexive thematic analysis was used to analyse the data. 19 interviews were undertaken (5 with licensing team members and 15 with public health team representatives) that had worked across over three-quarters of the 32 London boroughs in the past five years. The findings identified five themes- gambling takes many forms (and all can be harmful); feeling powerless (sub-themes of not enough money and not enough power); not really knowing what public health teams do; and individuality ("my borough is different"). The main difference identified between licensing and public health interview participants was their attitude to considering the gambling industry as a key stakeholder in licensing, which was that they were more open to this arrangement than their public health counterparts.

7.1 Recap

So far, this thesis has used quantitative data (the Director of Public Health [DPH]) survey and borough-level gambling premises analyses) and qualitative data (a critical discourse analysis), informed by a literature review, to investigate potential factors influencing public health involvement with local gambling policy throughout London. This thesis chapter will undertake a reflexive thematic analysis of interviews with public health and licensing team members in London local authorities, identifying factors that influence public health approaches to gambling harms.

7.2 Introduction

Under the Gambling Act 2005, local government licencing authorities licence "land-based" gambling premises (such as bookmakers, arcades, bingo halls and casinos) and also permit specific gambling activities (such as electronic gaming machines outside of gambling premises, small lotteries and facilities providing poker games) [65]. Two further licences are

required to operate gambling premises, but the Gambling Commission manages these nationally. The Gambling Act legislation broadly mirrors the Licensing Act 2003, which covers alcohol licensing, late-night entertainment, and refreshments [66]. However, unlike licensing premises for alcohol, local public health teams are not what is termed a "responsible authority" for gambling premises. As such, it is not mandatory for them to be informed of any applications for new gambling premises licences. Of note is that National Lottery products are covered by separate legislation, with no role for local government.

Given that gambling harms are now widely discussed as a public health issue by many institutions in the UK, including the Gambling Commission[3, 196, 223], it is important to understand from a local government perspective the factors that influence how gambling harms are addressed and the role of public health approaches, especially given that public health role has no formal role concerning gambling in local government.

There is currently very little literature on sub-national approaches to gambling policy to draw upon. In the UK, Scott and colleagues undertook semi-structured interviews with stakeholders from a city council in England that had implemented an Advertising and Sponsorship Policy which restricted advertising and/or sponsorship in council-owned advertising spaces, with restrictions including gambling [224]. The analysis found that policy implementation benefitted from an existing supportive environment following the 'health in all policies' initiative and a focus on reducing health inequalities across the city. In Australia, Marko and colleagues conducted semi-structured interviews with 16 local government representatives to understand how policies on gambling harm were developed and implemented [128]. Three key themes were identified: a shift from individualistic addiction frameworks to population-based public health responses, the role of stakeholder groups in the policy-making process, and barriers and facilitators to policy development and implementation. Barriers included a lack of financial resources and legislative boundaries, and facilitators included "whole council approaches", supportive councillors and collaborative efforts.

Also in the UK, relevant research examines the work of local public health teams in alcohol licensing, where they are responsible authorities. A mixed-methods study was undertaken in 24 London boroughs to understand how local public health teams "*enact their licensing role with alcohol, and how they could influence the local alcohol environment*" [71]. This found

that some public health teams struggle to justify the resources required to engage when they perceive little capacity to influence licensing decisions. Other public health teams considered the licensing role important for shaping the local alcohol environment, which offers strategic benefits in positioning public health within the council. A further study by the same authors comprised a survey of public health practitioners (PHPs) and four focus group discussions with licensing stakeholders in London [70]. It sought to identify how public health teams could influence alcohol licence decision-making in local authorities. The survey revealed a varied picture of workload, capacity to respond to licence applications, and degree of influence over decision-making. Practitioners described their low status within the licencing process and difficulties using and communicating public health evidence effectively, given the absence of an explicit health criterion within the Licensing Act. Other recent research has identified three ways that harmful commodity industries (such as the alcohol and gambling industries) interact with local government in England: via direct involvement, via intermediaries (such as affiliated charities), and through the local knowledge space (such as education programmes and staff training) [144].

The Greater London area, which is the focus of this research, comprises 32 local 'boroughs', each with a local authority public health team. By interviewing representatives of these boroughs, this study aims to address a gap in knowledge of factors that influence local government's use of public health approaches to address gambling harms.

7.3 Methods

I use Braun and Clarke's reflexive thematic analysis approach [108, 225], which is discussed in detail in Chapter 2 (Methods) and summarised in the 'Data Analysis' section of this chapter.

7.3.1 Sampling Strategy

I employed a purposive sampling strategy whereby I invited all Greater London DPHs to participate by way of an invitation attached to an online survey that I had sent to them (results reported in Chapter 4), with subsequent email invitations to them and to the licensing team representatives inviting them to interviews. The original aim was to reach beyond public health and licensing team representatives, considering also representatives of planning and elected members. However, once the interviews were underway and it became clear that there would be great difficulty getting responses from overcommitted

local authority officers and members, a pragmatic decision was made to focus on two local government teams, licensing and public health, and gather a richer and deeper dataset from them before embarking in any broader sampling.

Purposeful sampling is a widely used technique in qualitative research whereby those cases most likely to be information-rich on the topic of interest are selected. It is appropriate where resources are limited, and a larger sample might yield a small and unrepresentative response (12). In addition to emailing all London DPHs directly, an invitation to interview was included in the London Association of Directors of Public Health (ADPH) weekly newsletter and promoted at a weekly online London ADPH event, with a contact email supplied. An online search was conducted to obtain contacts for all London borough licensing teams, who were contacted by email and phone.

7.3.2 Ethics

The London School of Hygiene and Tropical Medicine (LSHTM) ethics committee approved the study in Jan 2022 (Ref 26646). All participants provided written informed consent. The information sheet informed them that they could withdraw at any time. Copies of these documents are provided in Appendices 8 and 9.

7.3.3 Data Collection

Participants consented to recording online interviews, which were simultaneously transcribed (using the Microsoft MS Teams platform). Immediately after the interview, transcripts were reviewed against the recording, corrected where necessary, and anonymised using a code identifying each transcript file. Anonymised interview transcripts and consent forms were stored on an encrypted server. A separate file linked the identifying code given to the anonymised interview transcripts to the individual interview participant. Once files were uploaded onto the server, original recordings and transcripts on MS Teams were destroyed.

7.3.4 Interview Process

Interviews were semi-structured, and a topic guide provided a loose structure to explore the topics of interest (Box 7-1). The topic guide was designed in consultation with personal contacts in local public health teams from London and elsewhere in the UK, who were not invited to be formally interviewed in the study.

Interviews were conducted online at a time and location of the interviewee's choosing. Approximately 48 hours before the interview, two documents were emailed to the interview participant: a summary of DPH survey results (as discussed in Chapter 4) and both Greater London and their specific borough's gambling premises data (collected at six monthly intervals from the Gambling Commission website since December 2020 as part of this thesis and discussed in Chapter 5). These documents were emailed with a notice that there would be an opportunity for interview participants to comment on the findings in the interview.

Box 7-1 Questions in the Topic Guide

Discussion about the job role

1. Can you tell me a bit about your role and how much gambling is part of it?

Local Gambling Policy

2. What should be the aim of local gambling policy?
3. Are you familiar with your local policy?

Can you tell me about your local authority's approach to gambling?

Are there any local strategies to address gambling harms that are you aware of? Do you think they are effective?

(For Public Health interview participants) Are you as a team informed or involved in gambling premises licensing or policy? (expand depending on answer). (For licensing team members) Do you involve anyone from public health in your gambling premises licensing decisions and/or policy?

Industry involvement

Several local councils in England have supported "Safer Gambling Week" as part of addressing gambling harms-what is your opinion on that strategy?

Where do you stand on gambling industry representatives as stakeholders in addressing gambling harms locally?

Share results of the DPH survey and London and local premises data

Do any of the findings surprise you? (Yes/no why/why/not) (follow-up question asks: why do you think the survey response rate was so low?)

Current and Future Considerations

Are you aware that the Gambling Act is currently under review?

In your opinion, what do you think the main changes to legislation should be?

The recent House of Lords report into gambling harms suggested local authorities were given "*the same powers*" for gambling as they have for alcohol. What do you think about that as a proposal?

Closing

Is there anything else you want to mention that we haven't already discussed?

Is there anyone else from your council that you think I should be talking to?

7.3.5 Data Analysis

Consistent with Braun and Clarke's approach, reflexive thematic analysis (RTA) involves "*a reflexive, recursive engagement with the dataset to produce a robust analysis*" [226]. As outlined in Box 7-2, there are six phases of analysis.

Box 7-2 The 6 phases of Braun and Clarke's Reflexive Thematic Analysis

1. **Familiarising yourself with the dataset**: Read and re-read the data to become immersed in and intimately familiar with its content, and make notes on your initial analytic observations and insights.
2. **Coding**: generating succinct labels (codes) that capture and evoke important features of the data that might be relevant to addressing the research question.
3. **Generating initial themes**: examining the codes and collated data to begin to develop significant broader patterns of meaning (potential themes).
4. **Developing and reviewing themes**: checking the candidate themes against the coded data and the entire dataset, to determine that they tell a convincing story of the data, and one that addresses the research question.
5. **Refining, defining and naming themes**: developing a detailed analysis of each theme, working out the scope and focus of each theme, determining the 'story' of each.

6. **Writing up**: weaving together the analytic narrative and data extracts, and contextualising the analysis in relation to existing literature.

Adapted from University of Auckland, 2023 [226]

These six phases are carried out sequentially but also recursively, with movement back and forth between different phases, with coding being flexible and organic, evolving throughout the coding process [226]. Given that coding is an active and reflexive process, it *"inevitably bears the mark of the researcher(s)…with no one 'accurate' way to code data, the logic behind inter-rater reliability and multi-dependent coders disappears"*[107]. Themes are conceptualised as analytic outputs, created from codes and through the researcher's active engagement with the data [107].

There were two reasons why a reflexive thematic analysis approach was explicitly chosen rather than other types of thematic analysis, such as a codebook [110] or coding reliability [109]. Firstly, conceptualising themes as outputs (rather than developing themes *a priori*) and recognising individual interpretation as a valid technique are methods most closely aligned to a critical realist paradigm [79, 80], the over-arching philosophy of the thesis. Secondly, other recent gambling research (where young people were interviewed about the perceived effectiveness of public health measures to address gambling harms) used a similar reflexive thematic approach [227]. A conscious decision to use similar methods in gambling research that is independent of industry influence or funding aims to build a more cohesive evidence base: this is currently a significant limitation in the gambling research field, where limited progress has been made in terms of policy development, partly due gambling industry influence on the research agenda [95].

Once familiarised with the whole dataset, with hand-written notes kept on initial observations, the anonymised transcripts on the LSHTM server were uploaded to the NVivo platform, where coding was undertaken. Contemporaneous hand-written notes were kept during the coding phase of the analysis to assist in generating candidate themes and sub-themes. A sub-theme is defined by Braun and Clarke (2019) as a theme that "*exists 'underneath' the umbrella of a theme…it shares the same central organising concept but focuses on one notable specific element*" [108].

In addition to the reflexive analysis, a basic quantitative textual analysis was performed using the NVivo tool. This analysis identified the frequency of certain words identified at the familiarisation stage as occurring commonly throughout the whole text corpus.

7.4 Results

Nineteen interviews were undertaken, involving 15 public health team representatives and five licensing team representatives from London boroughs. The public health representatives interviewed had a range of specific job titles and responsibilities (e.g., Director of Public Health, Health in All Policies Strategic Lead) but all reported to their local authority public health teams. Licensing team interview participants also had a range of job titles and responsibilities within their individual teams (e.g., some were responsible for all licensing, some aligned to specific areas such as 'high street' or 'environmental'), but all reported to the local licensing team.

One interview with public health teams involved two participants from the same borough and department, and all other interviews were with single participants. Participants had current or recent (last five years) experiences in 25 of the 32 London boroughs. Interviews took place from July to December 2022. Individual interviews lasted between 32 and 63 minutes.

The analysis produced five themes and two sub-themes, summarised in Figure 1 below.

Figure 7-1: Summary of themes and sub-themes of the thematic analysis.

1. Gambling can take many forms…and they can all be harmful.
2. Feeling helpless: sub-themes of "a lack of money" and "a lack of power".
3. "I don't really know".
4. What Public Health teams do (and how they do it).
5. Individualism: "My borough is different": teams, councils and local communities.

Each theme will be described, and some exemplar quotes will be reported (Additional quotes can be found in Appendix 10). Any differences between public health and licence team representative responses will be commented on, followed by a critique of the theme and its potential impacts.

Quotes below are coded as PH (Public Health) and Lic (licensing). Individual borough names have been redacted, using the letter X to signify the borough that the interviewee is

currently working at the time of the interview and Y and Z if other boroughs are mentioned in the interview.

7.4.1 Theme 1: Gambling can take many forms…and they can all be harmful

The interviewees discussed gambling generically and by specific types of location and activity. The frequency of gambling locations and product types mentioned, in descending order, were betting shops, online gambling, adult gaming centres (or arcades), Fixed Odds Betting Terminals (FOBTs), lottery, casino, gaming, and family amusement centres. The interviewees did not mention bingo, horse racing, or dog tracks. Although not mentioning either tracks or racing is understandable given that neither is operational in Greater London, bingo venues are widespread across boroughs and increasing overall (see Chapter 5), so their omission is noteworthy.

All types of gambling were discussed mainly in terms of the harm that people experienced from them. Betting shops were frequently discussed in terms of clustering and their concentration in deprived areas, with these issues raised by public health and licensing teams.

> *"You know how we ended up licensing two of the same badge? Literally, they face each other. I mean, what the hell?" PH7*

> *"The number that the density of betting shops is, it correlates with the socio-economic situation in that immediate area." Lic 2*

Public health interviewees also commented on how betting shops contributed to the demise of high streets.

> *"Betting shop after betting shop followed by pawnbroker, followed by you know, charity shops. It's just so it's urban blight." PH3.*

This observation reflects the RSPH 'Health on the High Street' publication of 2015 (21), which singled out betting shops as having a particular negative impact.

Local public health teams were widely concerned about the potential harms of online gambling. The language used reflected emotional concern (e.g., "worried" and "bothered"). Of note, online gambling did not come up as a topic in any of the interviews with licensing teams, which is perhaps because their involvement with gambling is purely around licensure of premises rather than strategies to address gambling harms.

"I'm really concerned some things I've been reading around online and gambling behaviours and how that's regulated." PH6

"But actually you know what bothers me at the moment is, is how many people out of desperation are being drawn in by online betting." PH11

There was also recognition that the number of arcades is increasing (noted by licensing teams more than public health, but again, this is an element of the local gambling infrastructure they directly involve through legislation). Its impact has yet to be fully recognised, but it still generates concerns from public health.

"Seems to be those amusement arcades, and I'm not quite sure you know what to make of them. I know other boroughs like [Y] have been quite some agitated about them, and I think I am too." PH12

FOBTs were discussed in different ways by licensing teams and public health teams. Public Health teams saw them as a particularly important cause of gambling harms. Licensing teams viewed them in terms of how the change in their stakes and prizes in recent years has driven a reduction in the number of betting shops.

"fixed odds betting machines…I mean they're just toxic." PH11

"I think the decline [in betting shops] I think and it might be my skewed vision is the stakes and prizes. Obviously it had a massive impact." Lic 2

The lottery was discussed by public health in terms of its wider availability and acceptability compared with other forms of gambling. Licensing teams did not mention it (but again, like online betting, it falls outside their jurisdiction).

"the kiosk that sells the cigarettes and everything, they have the lottery in front." PH1

"you don't have the shame of going to buy lottery tickets like going into a betting shop." PH11

"the advertising for lottery…it's like at child eye-level height." PH2

In two interviews, the similarities between gambling and gaming were discussed, and the potential for similar types of harm was identified:

"It's not the same in gaming, but it has the same effect." PH2

"Whether it's up to teachers or you know, coming in and doing assemblies on, you know potential harms through gaming and gambling." PH14

This theme captures the concept that "gambling" is not just one specific activity occurring in one setting. The term 'gambling' captures a range of products that vary in their acceptability and availability. Comparisons between gaming and gambling are also important because gambling legislation makes a clear distinction between these two types of products (excluding gaming from the Gambling Act) when, in reality, the distinction in terms of product and related harms is less clear. Considering gambling as a single entity is both reductive and a potential barrier in terms of addressing harms.

It is also notable that all forms of gambling were linked to harm by public health teams but not by licensing (who tended to only comment on the types of gambling premises that they license). Licensing teams discussed the harms of gambling less overall. No public health or licensing participants credited gambling with any positive associations for individuals or society. This directly contrasts with the national government and industry discourse, whose narratives consider gambling enjoyable and fun, delivered by a legitimate industry that supports the overall economy (Chapter 6).

7.4.2 Theme 2: Feeling helplessness: sub-themes of i) a lack of money and ii) a lack of power.

Interviewees expressed helplessness when discussing a lack of money and power (often compared with those who did have money and/or power). These problems were discussed on individual, council team, local council, and societal scales. This theme occurred frequently in both public health and licensing team interviews.

7.4.3 Sub-theme 1: a lack of money

A lack of money was discussed in terms of both individuals who are gambling and others affected by it. This was raised by both public health and licensing teams.

> *"This rising poverty, rising energy crisis and everything and you've got desperate people who want to gamble." PH1*

> *"If you can't if you don't have enough money etcetera, you can't necessarily bring your children up as you would wish to." Lic 2*

> *"It's not something people readily speak about…they're not the gambler per se, but you know, not being able to eat because that money has disappeared." PH1*

The cost-of-living crisis was also explicitly mentioned by several public health teams, along with the impact of Covid.

"I think it's [gambling] also linked through to mental health and wellbeing and cost of living." PH12

"We came out of one crisis [Covid] into another [cost of living]." PH11

The observations about the cost-of-living crisis are important as they point to the broader causes of financial stressors that may be exacerbating gambling harms rather than blaming individuals. In addition, the recognition of "affected others" is also important because both these narratives challenge the narrow focus of the industry "playbook" with its dominant narrative that only a minority are harmed (captured by the term "the problem gambler", as discussed in Chapter 6) and consider the broader population-level harms. Licensing teams must recognise this, despite it being out of their immediate scope of work.

The commentary on the lack of money points to the stretched financial resources of both public health and licensing teams:

"when we joined local government in 2013 and they moved public health to local government, the first thing a lot of local authorities did was think great, how much can we take out the public health grant to offset our spend elsewhere?" PH7

"It is an area that we would like to spend more time with [gambling premises licensure], to be honest with you, but because of the size of the service at the moment…the lack of resources….we are running on one enforcement officer." Lic 3

Given the announcement in early 2024 that one in ten local councils expects to go bankrupt in the next five years (20), it is important to recognise that the financial situation within individual teams in local government will most likely worsen, increasing the barriers to addressing gambling harms. On this theme and of particular note, an interviewee likened a council struggling for money to the same desperateness as those gambling in a harmful way and potentially making financially risky decisions:

"when people or organisations are desperate, I mean, I hadn't thought about this until I thought about this [interview], but that if you think about the analogy, when you have no money, when you're desperate, don't you have like, doesn't that look attractive, you know." PH11

These financial restrictions have impacted on the ability of local council teams to address gambling harms, with on interviewee describing "*a predisposition in local government to sort of rely on the free national gambling support charities, etcetera, rather than actually*

designing and commissioning local support" (PH7). This is particularly problematic for this sector given that a high proportion of the available helplines and charities providing support for gambling harms are funded indirectly by the gambling industry, either via contributions (managed by intermediaries such as GambleAware) or through regulatory settlements (the industry paying the regulator a settlement fine for breaches of licence). The problems with relying on such charities are two-fold: firstly, industry-funded organisations tend to prioritise a gambling industry-friendly narrative, endorsing individual behaviour change and "safer gambling" messages (rather than focusing on messages about the addictive nature of gambling products and the predatory tactics used by the industry to keep players engaged) ; secondly, relying on finances from the industry to fund support services, under a "polluter pays" principle gives the gambling industry leverage to push back on any proposed legislative changes that might impact their profits. The proposed gambling industry levy to replace voluntary contributions has been criticised for exactly these reasons [228].

7.4.4 Sub-theme 2: Not having power

A lack of power was expressed in different ways. For example, public health teams and licensing teams find legislation restrictive, and there is recognition that the gambling industry has more resources than local government and thus has greater power. Lack of power was also expressed in terms of the lack of agency of those who are harmed, directly or indirectly, by gambling, including gambling industry employees.

Both public health and licensing teams reported that national legislation gave them inadequate powers to address harms.

> *"We've got a long way to go in terms of public health seeing themselves because they're not listed as a responsible authority." PH1*

> *"It's really very difficult for local authorities to control gambling premises…And that's predominantly because of the way the legislation is framed and worded." Lic 1*

> *"It's basically aimed to permit all the way through. That's the problem." Lic 4*

The Gambling Act 2005 states that premises can only be refused based on being in proven conflict with one of the three licensing objectives, with the decision limited to the premises in question rather than the local gambling environment. There is a fundamental paradox given that, until the licence application is granted, it cannot easily be shown that its operation in conflict with something that has not had the opportunity to occur yet. It is also

pertinent to note that the phrase "*statutory aim to permit*" is written in bold multiple times and in successive editions of the local councillor's handbook for gambling premises licensure [67-69]: this semantic detail reinforces the "framing" of the legislation that is discussed in the interviews.

In addition, public health teams expressed a lack of powers concerning local gambling policies.

> *"Yeah, in within that policy you have very, very limited power to actually try and stop them [betting shops] from harming, which obviously would be closing them, which we obviously can't do." PH9*

> *"it doesn't count in the current policy if we get if we get people signing a petition…there's so much we can't do." PH1*

The DsPH survey (Chapter 4) found variation in public health teams' involvement at the borough level, with some correlation between their involvement in gambling and alcohol policy. As discussed in Chapter 4, this suggests something about the licensing/public health team relationship in individual boroughs rather than focussing on public health's differing legislative roles regarding licensing and policy.

Gambling policies are typically developed by licensing teams in local authorities: one licensing team interviewee specifically noted a lack of power for public health teams:

> *"we are quite limited on what you [public health] can do." Lic 3*

More than one licensing team gave examples of the imbalance of power in terms of dealing with the gambling industry's legal teams when applications are challenged.

> *"It's not really a fair fight you know - William Hill comes along with bloody QC on God knows what an hour." PH3*

> *"Some of the bigger betting shops like Paddy Power for example bring a considerable amount of legal weight with them when they're applying to licenses you know." PH7*

> *"they [the gambling industry] got represented by a probably the best barrister on this on this issue." Lic 3*

The visual demonstration of a significantly more well-resourced legal provision is a typical '*playbook*' tactic of harmful industries [59]. This is important because even if a public health approach is adopted to addressing gambling harms in local authorities (and within that,

reducing availability of harmful products is a key tenet [92]) then an imbalance of power at the stage of legal challenge of premises licensure is a significant barrier for reducing physical gambling provision locally.

A lack of power was also expressed in terms of how those who are gambling have no control over their gambling in terms of addiction.

> *"it's the other factors what's driven somebody to gambling…the accessibility of something like gambling and the ease at which something like that to become addicted." PH14*

> *"I have a feeling that people just don't take gambling seriously…they don't realise that it sort of sucks people into a vortex." PH4*

Addiction framing can be problematic because it can potentially place the problem with the person rather than the product [105]. However, in these interviews, it was frequently mentioned as a key issue regarding "not enough power" and important to acknowledge within the overarching theme of helplessness. Of note, this concept of the "addiction" of "the problem gambler" is one of the few times in this analysis where discussions that echo the gambling industry narrative were made by participants, who otherwise considered harms on a population level and did not recognise any of the suggested benefits of gambling that can be found in the dominant narrative already described.

Of note, one licensing team participant mentioned another specific group with "a lack of power", and that was gambling industry workers, in particular, betting shop employees:

> *"It's not in the interest of the person who works there (betting shop] to report it [violence in shops] because they may lose their licence over that and then also the individual loses their job." Lic 3*

There is evidence of harm caused by working in casinos from other jurisdictions [229, 230], but little is known about harm to workers in the UK gambling industry (typically because the gambling industry has historically funded research and this is not an area they would consider, rather producing their own occupational policies). It is known that William Hill, for example, historically had a lone-worker policy as standard within their premises [231], even though the risks were recognised. Intertwined with the first sub-theme of this section, in a cost-of-living crisis, the fear of "a lack of money" can mean employees of gambling industries feel powerless to act even when exposed to harms.

This theme, as shown by emotive quotes about lack of money or power, highlights individuals, organisations and communities' vulnerability when basic needs are unmet. A nebulous, multinational body such as the gambling industry can take economic advantage of these vulnerabilities on the individual, organisation, and community level.

7.4.5 Theme 3: "I really don't know."

Both public health and licensing team interviewees revealed a lack of factual knowledge about several aspects of gambling legislation and local policy and enforcement. While this is perhaps understandable for public health teams with no formal legislative role in gambling policy or licensure and variable levels of involvement, interest, and influence at a borough level, it is a more surprising finding from the licensing team interviews.

> *"Has it been [the Gambling Act Review]? Has the White Paper itself been published?" Lic 2*
>
> *"I don't know how many inspections have been carried out." Lic 5*
>
> *"I think we send ours [gambling premises applications] to I think we do send ours to public health. I'd have to double check on that, and I can confirm, but I'm pretty sure we do." Lic 4*

Lack of knowledge about gambling harm, both locally and more generally, was also expressed. Often, this was coupled with a discussion of the theme of "a lack of money".

> *"If I had more money, I would like to know who is gambling in the borough." PH4*
>
> *"We don't really fully understand what harm it [gambling] is to our individual residents." Lic 1*
>
> *"So there's a lot we need to learn and know. So we're doing a range of focus groups within the community to find out what's their understanding of gambling harms. This is it. But we don't know and we can't assume." PH1*

This last quote implies that local evidence was needed to take action and that the available evidence is insufficient. These findings reinforce those of the discourse analysis (Chapter 6), which discussed the importance of local data and the role of local government in its collection under *the social logic of evidence*.

Several public health interviewees commented on the lack of evidence about gambling harms more generally, especially concerning other harmful products.

> *"There's not much of papers. How would we get? It's a very underdeveloped area of research." PH13*

"I mean, it's unlike a lot of the other public health areas, where we have really robust data. Like the drug and alcohol.. it's analysed to death, so much data available." PH7

"I started trying to look into how much gambling in the borough is done online. Surely we can find what searches have been done for online gambling…So anyway I couldn't." PH3

This is important because of the policy inertia that this generates, as discussed in the Introductory chapter as a "playbook" technique and in discourse analysis (Chapter 6) under the *social logics of evidence* and *the social logics of low expectation*. At the same time "methodological purity" of the evidence base is awaited, more evidence is collected under the illusion of doing something, yet policy change does not progress.

Participants were invited to comment on the premises data from their borough (reported in Chapter 5), as they were often unaware of the results, especially when interviewing public health teams.

"I don't really know that's high or low [gambling premises number for a borough]. You, you know it's probably higher than I'd want it, I don't know where I'd set the bar." PH3

"I was really surprised at the numbers of venues and some of the segmentation of the gambling market." PH6

"Maybe we have a casino I don't know about it, but not that I've seen." PH4

This lack of knowledge may reflect a lack of engagement by public health teams in the gambling licensure process. However, there is also a paradox that local gambling premises data is freely and readily available (via the Gambling Commission website [4]), and public health teams simultaneously want accurate local data, yet this source appears not to be used.

As well as a lack of knowledge about the scale and nature of harm experienced by the local population, there was also little knowledge about what support services were available, and those mentioning anything used the "industry narrative" of problem gambling and self-exclusion.

"I have very little sense of you know how accessible is the support for if we're talking about problem gambling." PH12

"I think there is there like a register [in betting shops] then you can get restricted. I don't know whether that exists." PH9

This is problematic because, without knowledge of what is available, there is a risk that those experiencing gambling harms continue to lack support or approach the well-resourced industry -funded charities for support that places the onus on the individual to change (self-exclusion, blocking apps for example) rather than considering the role of addictive products and the behaviour of a predatory industry.

There were also assumptions by both public health and licensing teams that others knew more about than they did about gambling.

> *"In no way would I say that I'm an expert in this." PH12*

> *"[Industry Compliance] Officers tend to be very hard very… "We know the legislation better than you do", which is probably true. They're industry. I do lots of other things." Lic 2*

> *"[regarding gambling premises number in a borough] I'd like some cleverer than me to set it." PH3*

Expressing a lack of knowledge can be seen as an indirect way of describing a lack of power. Although some of the drivers of lack of knowledge appear to be financial, the possibility of corporate agnogenic practices, discussed in Chapter 1, where industry actors use "*methods of representing, communicating, and producing scientific research and evidence which work to create ignorance or doubt irrespective of the strength of the underlying evidence*" [232, 233] cannot be ignored as a potential driver either.

Finally, in this section, only one participant was aware that the gambling industry funds the annual Safer Gambling Week, formerly Responsible Gambling Week, promoted by some local authorities. Many interviewees were unaware of the annual campaign altogether.

> *"I haven't read up on at all what safer gambling week is." PH2*

> *"I haven't heard of it. To be perfectly honest." Lic 3*

Interestingly, even when the information was shared about the Safer Gambling Week's funding, all public health team interview representatives did not dismiss it outright.

> *"I would want so much detail about it before I could make an informed decision." PH7*

> *"We'd probably review it as a team and to understand what exactly the campaign is, what the message is and where it fit with our priorities." PH10*

On the one hand, a lack of awareness of Safer Gambling Week means that the industry-funded narrative of safer gambling does not permeate the local population through local institutions such as the council. On the other hand, there is a risk that if councils are entirely unaware of this annual multi-media campaign, part of the gambling industry's corporate social responsibility agenda with an industry-friendly narrative underpinning it, then such campaigns could be inadvertently adopted by a local authority who were unaware that they were promoting an industry-backed narrative.

The theme of public health and licensing teams "*not really knowing*" about core elements of legislation or their local enforcement or data suggests that addressing gambling harms is not a large part of their workload or an area in which they have an interest or influence. This is supported by the quotes above and in the related appendix, and is consistent with the findings reported in Chapter 4. However, the potential consequences of not knowing are crucial here, as is the lack of a particular plan to address their knowledge gap.

It is also concerning that even when public health teams were aware of the Safer Gambling Week campaign's link with the gambling industry, some were still willing to explore its implementation further. This may reflect an acceptance of "*working with a wide range stakeholders including the industry*" as per national guidance [69, 197], or it may reflect a pragmatic decision, in times of scarce resources, to consider interventions such as these campaigns offered fully packaged and ready to go at no charge to the local authority, which feels that it can manage any risk. The next theme discusses working with the industry as part of its findings.

7.4.6 Theme 4: What Public Health teams do (and how they do it)

Public health teams described their various work-related activities, which involved liaising with other departments within the council.

> *"I can't really think of very much we do by ourselves." PH3*

The degree of formality of these cross-departmental relationships varied.

> *"where we see the opportunities to look at policy, provide evidence and data, be very helpful to our colleagues in other areas, raise the issue." PH1*

> *"we're really, really embedded within decision making around planning, regeneration, environmental health training, standard license everything." PH10*

"We did quite a lot of lobbying work as well as working with our local authority colleagues looking at ways that we could stem the numbers of fixed odds betting machines." PH12

These findings reflect the results of the DPH survey (Chapter 4), which identified many relationships already existing between public health and other departments within local authorities. They may also reflect proactive relationship-building or councils that have embedded Health in All Policy strategies. The fact that there appear to be differing degrees of formality suggests individual differences at the London borough level.

The Local Plan was the most frequently mentioned policy tool, recognised as a potential mechanism for assisting policy progression for gambling.

"All local authorities responsible for publishing a local area plan, so that shows, for example, it does show where schools are." Lic 2

"Our local plan specifically mentions betting shops." Lic 4

"in terms of looking at our local plan, it would be trying to keep the number of [gambling] premises as low as possible". PH6

"You got a strong local plan, then you are able to have a stronger policy. So for me they go hand in hand". PH8

This is important because, as stated in Chapter 6, Local Plans are legally binding once ratified [218]Therefore, how gambling is depicted and aligned in Local Plans has legal implications for an area, and missed opportunities can result if a Plan's definition of gambling is too restrictive (for example, just considering betting shops and not arcades or bingo).

There was recognition that other teams may not be fully aware of what public health teams do, and there was proactiveness in addressing that learning need of the organisation:

"There's something about helping local councillors from the public health team and helping them understand". PH5

"I think public health can't just expect to provide evidence and then step back. There has to be leadership and delivery alongside that evidence base". PH10

This lack of knowledge about what public health teams do may stem from their relatively new status within local government structures (just over ten years) from an institutional memory perspective. However, it is also of note that what is imparted to the wider councils

about what public health teams do depends on that individual team's vision, beliefs, and focus. This was highlighted in one public health interview.

> *"I think sometimes what happens is when you've got a public health team, people start to think that that represents whatever they do. So like "I'm in transport, I'm in procurement". I do that and that's what public health is". PH5*

This concept is important because it means that at the individual local government level, the definition, scope, and practice of what is understood as public health can vary. The final theme, individualism, will touch upon this.

There was a variation in the experience of public health teams sharing evidence across their organisations.

> *"We don't necessarily wait to be asked. We look at areas that we want to influence, and we will find evidence. We will make ourselves useful, find that evidence and then people. We're victims of our own success." PH1*

> *"I feel like we provide evidence and there is pushback because like the quality of local evidence is needed to embed within localised policy and strategy."PH10*

A focus on public health's role in data collection within local government, as well as evidence not being high enough quality ("*the need for local evidence*"), also echoes the discourse analysis (Chapter 6) *social logic of evidence* as well as discussed in the previous theme of "not really knowing". How presented evidence "lands" also appears to be very borough-specific and may be influenced, amongst other factors, by the overall priorities of the organisation to be touched upon in the "individualism" theme that follows.

The impact of the Covid-19 pandemic on how public health was viewed locally also came up on several occasions.

> *"for public health funding, the best thing that could have happened was the pandemic… It was really effective in changing the profile of public health and it made the authority rethink the public health." PH7*

> *"post pandemic there's more health protection now." PH8*

> *"Because of COVID we got a much better working relationship with, with public health." Lic4*

Although greater visibility and new working relationships developed in the pandemic, there was a sense that all other public health work "apart from the basics" (PH5) had had to be

sidelined over the last few years. Thus, it can be argued that relatively newer public health concepts, such as considering gambling harms, may have fallen victim to resource stretching. In addition, even when gambling-related work is undertaken, it does not make up a large part of the workload for public health.

"It's one of those topics that aren't necessarily a main priority." PH10

"You know that there's a whole raft of that sort of work that's a bit more traditional [than gambling]."PH12

"if a percentage it's probably something less than 10% of my role." PH14

This small percentage of time allocated to gambling was echoed by licensing interviewees, offering similar percentages and a sense of "*scrabbling around for the legislation when an application comes in*" (Lic 1). These factors are structural barriers in terms of addressing gambling harms.

Public health teams and licensing teams differed in terms of working with representatives from the gambling industry. The majority of public health teams were critical and cautious of collaboration:

"I don't know how they could be involved in this process…ultimately they want to make money." PH1

"I would be sceptical if I'm honest. Like tobacco, isn't it? We have to be independent". PH6

"I don't work with any industry." PH10 (of note, this was the same interviewee who said they would "probably review" Safer Gambling Week materials, even once they knew the campaign had industry funding).

However, other public health teams viewed the industry as a stakeholder in local decision-making, even when critical of their behaviour or tactics.

"If we're going to just draw a line and say that we're not going to get involved or engaged I think you know that's a little bit like, you know cutting off noses to spite our faces." PH12

"I'll never say never or anything and I'll be interested to hear what they've got to say, but I would be going into it with some major misgivings at the end of the day." PH7

Licensing teams, in comparison, all viewed the industry as a key stakeholder to consult in local gambling policy.

"I think sometimes the larger operators have better procedures in terms of vulnerable people and visiting gambling, premises and you know they they've got these standard procedures which really helps, and they're better." Lic 3

"It's much better than sitting there without them at the table, going on about gambling. You don't know how to tackle gambling-related harms when you're not actually speaking to the industry that's doing gambling." Lic 4

"I would never have a problem asking any trader to comment upon a policy because ultimately you want you want a policy that is not, maybe not universally accepted. At least you know understood by everybody, and that's a good way of doing it." Lic 5

The discourse analysis (Chapter 6) discussed the gambling industry as a stakeholder under the political equivalence logics of collaboration and conflict. In addition, previous research (discussed briefly in the introductory paragraphs of this chapter) describes three ways that harmful product industries interact with local government [144] these quotes reflect examples of direct involvement.

Work activity for public health teams was described as primarily underpinned by pragmatic decision-making given limited resources.

"We're really careful about what we agreed to and managing demand and capacity in the team on that agenda compared to balancing other priorities." PH10

"We've got enough problems at the moment that will have to wait for now, which is not saying they're dismissing it [gambling] entirely, but it seems to be one of those issues that's very easy for people to put on the backburner." PH7

In addition, suggestions for addressing gambling harms were often aligned with public health teams' current work within the field of alcohol harm prevention.

"it's a bit like alcohol…availability of alcohol I mean…we've not managed to get a kind of minimum". PH11

"if the if there's an area with too many [licensed alcohol premises]…There's policies in place where you can't add to that, so yeah, yeah, so I think it might apply to gambling as well" PH13.

This alignment of product and legislation in the interviews also mirrors the findings of the discourse analysis (Chapter 6) on the *political equivalent logic of product alignment*. It is important because it aligns the harmful product of gambling as widely and legitimately

available and government-endorsed (as opposed to an illicit harmful product, e.g., substance misuse). As such, the suggested solutions, from a public health perspective, can potentially use previous learning from other harmful product work.

Finally, for this theme, the perception from the licensing teams interviewed was that they proactively supported public health's work-related activities without really expressing any knowledge as to what public health teams do:

"There's a standing item on all our committee reports for public health comment." Lic 1

"We would certainly make them [public health teams] aware of any public consultation". Lic 5

"I engage with them early on the reviewing of the [gambling] policy." Lic 4

This is important as it reflects the risk of *"conflating public health teams to public health," a comment made in one public health interview. There* is a significant risk here of local interpretation of what public health is. Therefore, what public health teams "*should*" be involved with, and what licensing teams' impression of what public health "is" is specific to their local setting.

Overall, public health teams described a wide range of collaborations across their institutions, varied methods of making them work with differing degrees of formality, and a sense of involvement that goes beyond providing data and then stepping back. Of note, Health in all Policies (HiAP) as a concept was only mentioned once in the interviews specifically, although often alluded to, e.g.,

"what we try and do is get everyone across the local authority to work on public health." PH3

The philosophical position of this research, critical realism, acknowledges epistemic relativism in that empirical knowledge is fallible: participants not mentioning HiAP more frequently may be unique to this sample or to London-of equal possibility is that, in reality, that an endorsed strategy to embed public health activity is not being adopted as widely as assumed by national bodies that endorse HiAP (such as the Local Government Association [16]) would hope.

7.4.7 Theme 5: Individualism: "My borough is different"

Public health teams described themselves as being different from one another in terms of size and place of their team, their involvement with local gambling policy, their approach to embedding their work within council structures, and in terms of London boroughs more

generally. Much of the structural information about the size and place of public health teams confirmed the DPH Survey findings (Chapter 4). Public health and licensing teams noted structural differences.

> *"the public health team here is really small compared to other boroughs. It's not funded the way it should be compared to other boroughs." Lic 1*

> *"a lot of London teams have 30 plus people so we're not at that stage." PH4*

The public health team members leading on gambling held different roles depending on their borough and the directorate of the council in which their public health team was situated. Public health interview participants themselves note differences between boroughs:

> *"I used to be the licensing lead in the [Y borough] public health team, so we've got a very different approach here in [X borough]. I'd say it's so light touch". PH9*

> *"we're embedded within that side of the organisation [executive structures], which is quite different from how other public health teams I know of." PH10*

The DPH survey also noted variations in the size and place of individual public health teams (Chapter 4). This would be potentially problematic if a London-wide approach to addressing gambling harms were to be considered, given that particular public health teams may have differing levels of local power and knowledge and within directorates with different strategic priorities.

There was also recognition of place within the individual borough institution being an important factor:

> *"I think if there's quite a lot of variability across London and the way that councils organise themselves, but also where they put public health." PH6*

> *"I think it depends how they landed there [in local government]. Public health was thrown in it during the Health and Social Care Act. This was opening up the health service to market forces. It felt a lot more like a divide and conquer and throw them into the snake pit than it was what do we need to do to maximise the health." PH5*

The sense of historical powerless expressed in terms of where public health teams were "*put*" when they were transferred to local government after the Health and Social Care Act

can also be interpreted as another way of saying "*a lack of power*" from the earlier discussed theme.

Individual interview participants described their boroughs as *"sketchy" (PH1)*, *"strange" (Lic 3)*, and *"interesting" (PH10)*. One participant summarised these boroughs differences as follows:

> *"I think that that that this this is one of the reasons why I think London is complex because we're very, very diverse and they're very different experiences around gambling." PH11*

Recognition of population diversity is good because it means that solutions can be tailored to local populations in a localist approach, as discussed in the *social logic of localism* in the previous chapter. However, the risk is that this diversity means that the solution may then be seen as too "*complex*" to solve (so-called complexity arguments are frequently used by harmful product industry and affiliates to stall policy change and create policy inertia) when some of the most effective public health interventions are the most simple [46]. Also, although this final quote reflects one public health practitioner's opinion and possibly direct experience, there is clear contemporaneous evidence, shared in the interviews, that despite the diversity of London, some patterns are evident throughout the metropolis of over 8 million people: this includes that physical availability of gambling premises, licensed by local authorities, correlates with deprivation (Chapter 5), and an already vulnerable population is being exposed to more gambling harms, and that the sense that gambling is harmful in whatever form it takes is pervasive even if there is no clear idea what policies are effective to reduce harms and how they can be enacted at the local level.

7.5 Discussion

This reflexive thematic analysis of interviews with London public health and licensing team members aimed to identify factors influencing the adoption of public health approaches to tackling gambling harm at the local government level. Five themes and two sub-themes were identified: gambling as a term describes a range of activities linked to various degrees of harm individually, but can be harmful in whatever form; there is helplessness that is expressed in terms of not having enough power or money at all levels (individual and personal, and inside and outside of council structures); there is a lack of knowledge about harms and resources, including effective ways of gathering local evidence; and individual public health teams have variation in the formality of their inter-departmental relationships,

as well as differing team place and size between boroughs. Most interviewees pointed to at least one way: their borough differed from others in London.

Although identified themes were similar across public health and licensing team interviewees, a key difference was their approaches to having gambling industry representatives as stakeholders in local decision-making. Most public health teams did not favour this, while a minority of public health teams aligned with their licensing colleagues and felt it pragmatic to have all stakeholders involved. A lack of uniformity of approach to the gambling industry as stakeholders in the relatively small geographical area of Greater London is also potentially problematic given the free movement between boroughs; it means that any public health policies adopted in one borough could be ineffective if all neighbouring boroughs had a difference stance.

All of the interview participants were local government-employed staff. However, this does not preclude conflicts of interest or unconscious bias regarding how the gambling industry is considered within proposed solutions to address harm. For example, one interview participant (from a Licensing department) disclosed they had previously volunteered for a gambling harms charity. This charity receives funding from the gambling industry via voluntary contributions to Gambleaware. This participant was not the only licensing team representative with favourable opinions about gambling industry involvement and did not consider this a conflict-of-interest. In this research, elected members of local government were not interviewed. Still, any future interviews with this particular subset of local government would need to consider either formal disclosure or topic guide questions that explored participants' relationships with local industry directly or indirectly related to gambling.

While lack of money and power is acknowledged at all levels, the overall lack of knowledge about legislation harms, and the existing evidence base is perhaps the key finding in this analysis. In the analysis, “a lack of knowledge” began as a sub-theme of the second theme identified as “feeling helpless.” However, given the reflexive nature of the research method, it became its theme as the analysis continued. The lack of knowledge of evidence expressed by interviewees echoes Cassidy’s 2013 report, *Fair Game: Producing Gambling Research,* where it was noted that:

> *"what counts as evidence is determined by political, rather than academic priorities… a narrow definition of evidence makes many of the questions asked by policymakers impossible to answer, either because they are too simplistic, or because the money does not exist to fund the projects which would allow them to be answered, or because the data required to answer them is inaccessible."* [95]

Not addressing this lack of knowledge at all levels remains a distinct barrier to addressing gambling harms at a local level.

The generally critical attitude toward gambling reflects the recent written evidence submissions from local government bodies (from the Greater Manchester Combined Authority and the ADPH) to the Gambling Act White Paper, both of which called for more local powers to control gambling and recognised the harms being caused to local wider society [234, 235]. Despite these submissions, the white paper states that the government still plans "*further consultation*" with local authorities before any legislative changes are considered [52]. Such action only further delays any radical policy changes and creates a "*policy inertia*" [103], as discussed as the social logic *of low expectation* in the discourse analysis of the previous chapter.

Unlike findings from Australian research with local government representatives [128], little was mentioned about wider stakeholder involvement groups, such as those with lived experience, helping to shape policy. This is potentially an area for future research, especially given that in other parts of the UK, there is a recognised partnership between local government and charities supporting those with lived experience [204]. Compared with Reynolds et al.'s findings about how public health teams feel about their involvement in shaping local alcohol policy [70, 71], where public health does have a formalised role, their approach to gambling policy feels even less developed. However, many interviewees talked about how strategies used locally to address harms related to alcohol may be considered in gambling (such as cumulative impact zones), and the white paper also looks to align the Licensing and Gambling Acts further (if not the licensing objectives) [52].

As far as I know, this is the first set of interviews with local government representatives in the UK on gambling harms from a public health perspective. Findings in the thematic analysis suggest several directions that could move the field forward, such as a specific review of how public health teams could use their existing knowledge and skills to address

alcohol harms with gambling and identify what is needed to address local evidence gaps. A higher-level, pan-London discussion about the role (or lack of one) of the gambling industry in local decision-making is also required. Public health teams should also use the positive exposure gained locally during Covid to drive other agendas for change.

7.5.1 Limitations

Sample size in qualitative research is often mentioned as a limitation, with authors justifying sample size by citing the saturation of themes [236]. This study involved representatives from 24 of the 32 London boroughs (75%), with no new codes generated in the final interview analysed for either public health or licensing. The sample size also broadly aligns with previously published work in London borough public health research into alcohol licensure [70, 71]. Furthermore, the interviews were taking place at a particularly busy time for local public health teams (both Covid and Monkeypox outbreaks and vaccine programmes were occurring), and multiple contact methods had been exhausted.

In addition, the interviews only focus on two administrative areas of local government (public health and licensing): the potential impact is that certain barriers to adopting public health approaches in local government may not be identified here. Initially, the research plan was to sample a broader range of local government workforce (see Chapter 2: Methods). Still, once the practicalities of interview recruitment were recognised, the pragmatic decision was made to focus on two key administrative areas for this research and consider interviews with the wider workforce and elected local government members in future research.

The highly personal, reflexive nature of the analysis technique also means that theme generation could have been developed in many ways, an example being the sub-theme above of "*a lack of knowledge*" that became a theme in its own right as analysis progressed, reflecting the "*flexible and organic*" nature of using this kind of method [107].

7.6 Conclusion

Gambling harms are increasingly recognised as a public health issue. Identifying factors that influence the adoption of public health strategies in local government to address gambling harms is crucial, acknowledging that public health teams have no mandated role in the progress of local licensing decision-making. Interviews with public health and licensing team representatives from across London show that there is recognition that gambling can be

harmful in whatever form and that lack of money, power and knowledge all hinder the adoption of public health strategies. Public health teams use their formal and informal relationships across the council; crucially, there is a lack of consensus about gambling industry representatives being part of the decision-making process. Within London, individual differences between boroughs may also be a factor. Knowledge of how local public health teams address alcohol harms in their local area could be harnessed and adapted for gambling harms.

The next chapter combines the findings from this and the previous chapters into a mixed-methods analysis to identify overarching mechanisms that drive whether public health strategies to address gambling harms are adopted at the local government level within London.

Chapter 8 Levers and barriers to addressing gambling harms using public health approaches in local government in London: a critical realist mixed method analysis

A mixed method analysis brings together both quantitative and qualitative data, allowing for a more comprehensive understanding of a research question or phenomenon. This mixed-method analysis takes the findings from the previous chapters. It aims to identify the underlying levers and barriers (or 'mechanisms') to adopting public health approaches to addressing gambling harms in local government, specifically within London. The analysis adopts a critical realist philosophical paradigm, where objects are understood as real, knowledge is recognised as fallible, and some explanations are more likely than others.

The mechanisms identified were tolerance of harm, the influence of the gambling industry, the disempowering of local government, and heterogeneity (of public health teams, local government, gambling products, and populations). These identified mechanisms can reinforce, moderate and counteract each other, which is also analysed through retrodiction. While evidence from London found mechanisms to reinforce each other, examples from outside London are also presented to demonstrate how individual local government agencies have been used to counteract or moderate these mechanisms.

8.1 Recap

This thesis aims to identify the levers and barriers to addressing gambling harms using local government public health strategies, focusing on the Greater London area. I undertook five separate studies of varying sizes: a literature review, a survey of public health team leads in local government, an analysis of data on gambling premises in London boroughs, an analysis of the gambling discourse in the UK, and a reflective thematic analysis of interviews with members of public health and licensing teams in London boroughs. This chapter will now integrate the findings of these five into a mixed methods analysis using critical realism as an over-arching philosophy.

8.2 Introduction

8.2.1 What are Mixed Methods?

A mixed-method analysis is an approach to research that combines qualitative and quantitative methods to study a particular phenomenon or answer a research question [89].

It involves collecting and analysing qualitative data (such as interviews or observations) and quantitative data (such as numerical measurements or structured surveys) in a single study. By integrating the strengths of both qualitative and quantitative methods, it seeks to provide a comprehensive understanding of the research topic. Quantitative methods can help identify patterns and associations, while qualitative methods explore the mechanisms and processes underlying social phenomena.

8.2.2 What is Critical Realism?

Critical realism (CR) is a philosophical perspective that aims to understand the relationship between the external world, our perceptions of it, and the underlying processes through which it is governed. As initially proposed by Bhaskar [79, 80], it acknowledges that reality exists independently of our thoughts and perceptions but also recognises that our beliefs and social context shape our understanding of it. Critical realists seek to uncover the hidden structures and processes (so-called mechanisms) that influence our observations and interpretations of the world, focusing on social, scientific, and historical contexts. The activation of mechanisms is not absolute: their *tendency* for them to operate but whether they do (or, in the language of CR, whether they fire) depends on the social, cultural and political context [82, 87, 88].

The key underlying principles of a critical realist approach include:

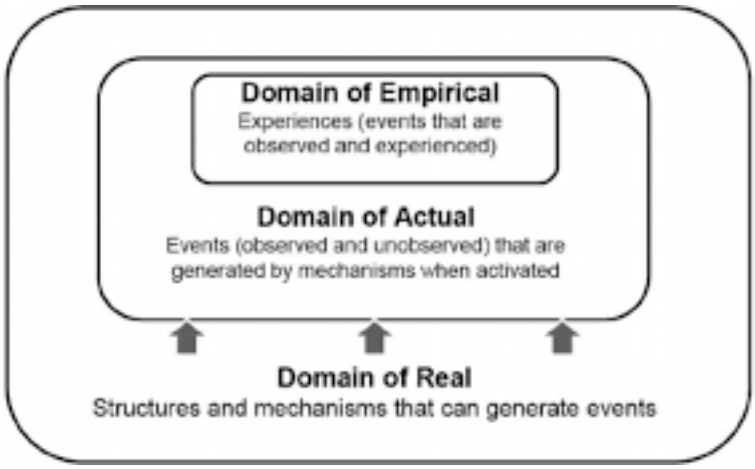
- Ontological realism - that structures, systems and objects are 'real' outside of individual constructivist interpretations;
- Epistemic relativism - that knowledge is fallible and that to assume only what is directly experienced as 'truth' is an "*epistemic fallacy*";
- Judgemental rationality - that some hypotheses are more likely than others; and
- Cautious ethical naturalism - analysis must be cautious and pluralist [85].

In addition, critical realism considers that events occur within '*open systems*', which means that mechanisms operate in combination with each other, and the more mechanisms involved, the more difficult it is to anticipate the outcome [86]. Mechanisms can reinforce, counteract, and moderate each other.

Bhaskar describes three levels of reality within the critical realist philosophy that interact with each other.

- Domain of the empirical: experiences that are observed and experienced but are seen as partial knowledge, and situated within specific contexts and perspectives;
- Domain of the actual: events (observed and unobserved), empirical phenomena and observable patterns that are generated by activated mechanisms;
- Domain of the real: underlying processes or causal mechanisms that generate the observed patterns and phenomena, typically inferred through a combination of empirical evidence, theoretical reasoning, and consideration of context. There is also recognition that mechanisms can reinforce, counteract or moderate each other and that their tendency to fire is also influenced by the social, political and cultural context they are occurring within [88] (see Fig 1).

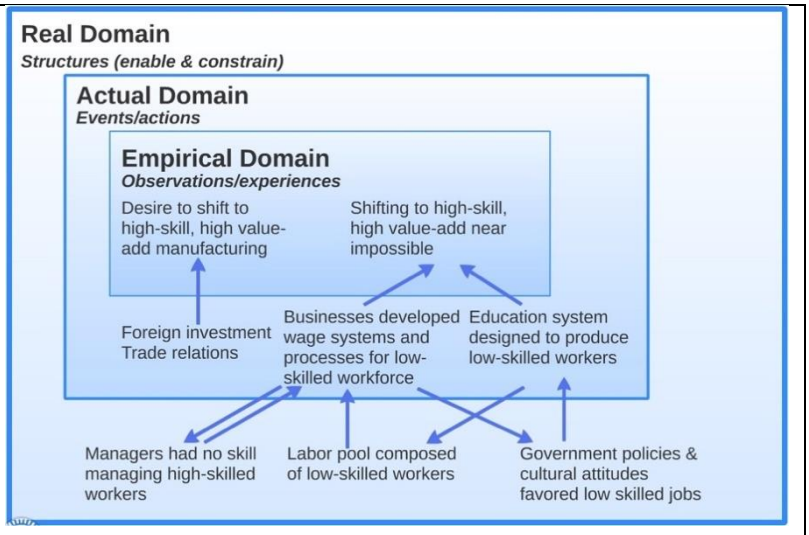
Figure 8-1 Bhaskar's three domains of reality



Bygstad & Munkvold, 2011 [88]

Box 1 sets out a worked example of how a critical realist lens can be applied to an issue in manufacturing.

Box 8-1 Worked example of critical realism in organisational analysis

Within the domain of the empirical, there was a desire to shift towards high-skilled labour and value-added processes during the latter part of the 20th century, but companies found it almost impossible to make this shift. Within the domain of the actual, these experiences were a consequence of British companies having to compete against low-cost global competitors. Some businesses tried to shift their manufacturing towards high-skilled labour and high-value-added processes to increase profits at a time when low-skilled workers and low-value-added processes dominated the British manufacturing industry.	 Within the domain of the real, the underlying mechanisms that enabled and constrained these events included government policies and cultural attitudes favouring low-skilled jobs, the availability of a pool of low-skilled workers, and a lack of managerial skill in dealing with high-skilled workers.

Raduescu and Vessey, 2009 [237]

Structures can be found within both the domain of the actual and the domain of the real. When using CR, it is important to understand how the nature of structures differs between the domains of the "real" and the "actual". Those within the domain of the real involve underlying social arrangements and mechanisms that exist independently of perceptions and observations. They are not directly observable but inferred from their impact on the world. In contrast, structures within the domain of the actual are those directly observable and experienced and include events, empirical phenomena and observable patterns. For clarity in this analysis, if structures are discussed within the domain of the real they are

termed as mechanisms, and any structures discussed are those found within the domain of the actual.

The final element to consider within a CR framework is agency. This is defined as the capacity of individuals and social groups to act upon and shape their social reality within, the constraints of social structures and contexts. CR recognises that structures and mechanisms may exert influence but they do not determine action-individuals and groups possess agency which allows them to make choices, exercise power and enact change within their environment. Within CR, agency is understood as being situated within broader social, historical and cultural contexts that shape and influence actions.

8.2.3 Using Mixed Methods within Critical Realism

When using CR, Arnold suggests that "*a mixed methods approach is particularly justified by the need for completeness, abductive inspiration, and to a lesser extent, confirmation*" [90]: completeness means seeking the widest possible range of views or interpretations, abductive inspiration means moving towards a hypothesis or explanation, and confirmation is achieved by using qualitative and quantitative methods to reinforce findings.

Mixed methods research is especially valuable for CR as it allows researchers to explore the underlying mechanisms and structures of the social world while acknowledging the complexity and multidimensionality of reality. By integrating qualitative and quantitative approaches, researchers can address different aspects of their questions, capture different levels of reality, and gain a more nuanced understanding of social phenomena.

Given that a CR approach recognises that reality exists independently of our knowledge and understanding, it is crucial that researchers engage in critical reflection throughout the research process, being aware of their own assumptions, biases, and theoretical orientations that may influence the design, data collection, analysis, and interpretation of findings.

8.3 Overview of the issue

As previously stated, this research considers levers and barriers to addressing gambling harms using public health approaches within local government in London. Often portrayed as a harmless pastime in the UK, gambling is increasingly being recognised as a public health concern [55]. Gambling harms are multi-faceted as they affect not only the gambler's

financial position but also impact on their relationships, mental and physical health, education, and employment and impact on society via crime and anti-social behaviour [23]. Local government structures have some legislative competence in licensing gambling premises within their jurisdictions but no formal powers in either online gambling provision or specific types of gambling such as The National Lottery. Given the increasing acceptance by national bodies, including the gambling regulator, that gambling is a public health concern [3], it was apparent that there was a gap in the evidence needed to inform local government if it is to address gambling harms using public health approaches. For the purposes of this research, which adopts a CR philosophy, the "levers and barriers" being sought are analogous to the "*mechanisms*" within the domain of the real.

8.4 Methods

Several analytical frameworks in the social sciences can be used in data analyses when coming from a critical realist standpoint, including Danemark's Explanatory Framework [86] and Archer's Morphological Approach [85]. Both approaches include step-wise activities where, once the social phenomena to be analysed is identified, the underlying structures and processes that contribute to its existence and reproduction are examined, considering its historical development, relevant economic factors, power relations, and cultural norms. From these investigations, proposed causal mechanisms can be inferred from the empirical evidence and wider investigation.

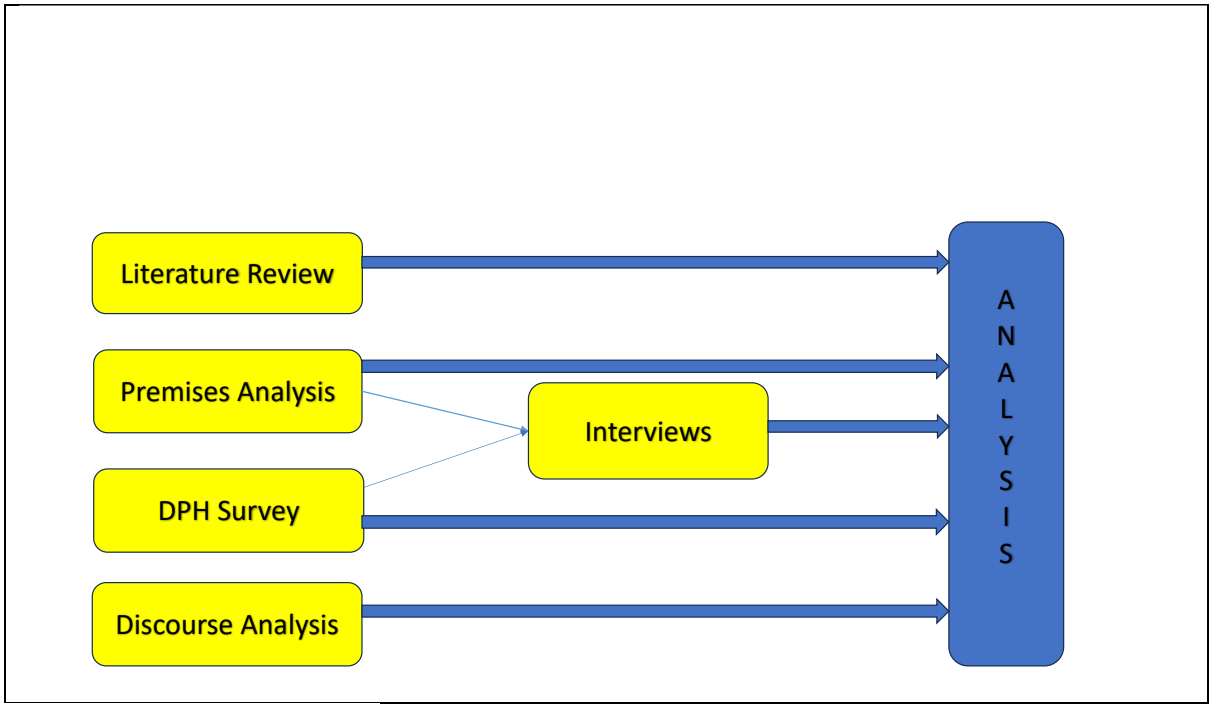
I apply a critical realist framework to my mixed methods analysis, and consider both of these frameworks, but have purposely chosen not to adopt one specific framework.

There are two reasons for taking this approach. As explained in Chapter 1, gambling research is already "*compromised*" by the extensive involvement of the gambling industry [63]. The industry and its promoters, including some researchers, have engaged in agnogenesis, or the manufacture of uncertainty [232, 238]. In this situation, it would be easy to get diverted into obscure disciplinary debates that distract from the main messages. The purpose of this thesis is to inform those in local government seeking to reduce gambling harms, given that, despite the efforts of the industry to minimise them or invoke other causes, there is no doubt that they are significant. It is not to use gambling as an opportunity to develop or test theory.

In Chapter 1, I also described how my approach to this research comes from several perspectives. I come from an academic generalist background, with experience in inter-professional education, and recognise the crucial element of "*shared language and understanding*" for any knowledge to be shared and acted upon [111, 112]. Therefore, presenting findings in the most generalist way makes them as accessible as possible to the widest possible stakeholders.

The mixed methods analysis uses a parallel convergent design (with a sequential explanatory element where findings of the premises analysis and survey of public health teams were used as a basis for discussion in the later interviews) (Fig 2).

Figure 8-2 Overview of mixed methods analysis design



Source: author's compilation

The integration of quantitative and qualitative findings from the five studies will be used to identify putative mechanisms, describing how the findings support or contradict each other and highlighting consistencies and similarities in findings as well as any divergence and differences. Identified mechanisms will be considered as potential levers and barriers to addressing gambling harms using public health approaches within local government more generally, and then within London specifically. In order to consider agency, findings from interviews with local government representatives from outside London, where a range of policies to address gambling harms using public health approaches have already been

implemented, will be included and discussed. The methodological process around interview recruitment, consent and data control of these interviews is fully discussed in Chapter 2: Methods.

8.5 Results

The results will be presented as follows. First, a summary of each research objective (from the domain of the empirical) will be outlined. Secondly, events that occur within the domain of the actual, will be presented within relevant social, cultural, economic, and political structures. Thirdly, the proposed underlying mechanisms that enable and constrain these structures will be presented using quantitative and qualitative research findings. Then, the proposed mechanisms will be reviewed in terms of how they reinforce, counteract or moderate each other, a technique that Danemark terms retrodiction [86]. Finally, the impact of individual agency on the mechanisms will be discussed, comparing the findings from London with case studies from other areas of England, where local governments have made some headway addressing gambling harms using public health approaches.

8.5.1 Domain of the Empirical: Findings from the individual studies

Empirical findings can inform and validate theoretical explanations of social phenomena. Within CR, they are viewed as mediated by underlying structures and mechanisms and are only ever partial, given that they are situated within a particular context.

The findings of each study can be summarised as follows:

- **A literature review** of population interventions to address gambling harms, enacted at the sub-national government level (Chapter 3) searched 8 academic databases, 2 systematic reviews, one book on policy and one evidence summary. Only a few studies were found, many poorly designed (e.g., different interventions implemented simultaneously, non-representative samples) with many interventions either funded by the gambling industry or of uncertain provenance.
- **A survey** of London's Directors of Public Health (DsPH), using a combination of single-best answer and Likert scales, sought to establish the size and 'place' of the public health team within individual boroughs, and understand the interest of public health teams and their influence on local gambling policy, comparing this with alcohol policy (Chapter 4). The response rate was low, which seemed to reflect a combination of the work intensity of invitees and the low priority they gave to of the topic. The responses that were

received revealed great diversity in the size of public health teams and their places in London boroughs, with differing opinions as to whether gambling harms are a public health concern, and a likely positive association between their level of interest and perception of their influence on alcohol policy and licensure (where they have a formal legislative role) and on gambling (where they do not).

- **A quantitative analysis of London's gambling premises data**, by number and type, collected at six-monthly intervals over a 3-year period, including a simple linear regression analysis of the relationship between total gambling premises in a London 'borough' and that borough's ranking for deprivation (Chapter 5). The findings suggest a positive association between the number of gambling premises in a borough and its level of deprivation, increasing over time, but also the expansion of specific types of gambling premises (arcades and bingo venues) across all London boroughs.
- **A discourse analysis (DA)** of documentation on gambling in the UK from 2001 to 2023 (the timescale selected to cover discussions prior to the current gambling legislation coming into effect to the point of the publication of the White Paper signalling its review) to identify dominant discourses within publications (Chapter 6). A Critical Logics Approach (CLA) [98] was used to explain how local government has been problematised in the discourse and what impacts this problematisation may have had concerning policy development and/or legislative change. This analysis revealed a persisting sedimented discourse, with gambling portrayed as a legitimate leisure pastime, well-legislated and provided by a legitimate industry. Challenged discourses included whether the powers of local government are adequate and whether gambling harms are a public health issue. The alignment of gambling and alcohol (both portrayed as legitimised activities with a minority of "problem" individuals) was also noted in the analysis. Local government was initially problematised in terms of its capability (or not) and then the adequacy of its powers (or not) to manage legislation on gambling. Later, local government was problematised as it expected to deliver an abstractly defined "*whole council approach*" to address gambling harms while collaborating or conflicting with an increased number of policy actors. Most recently, local government's appearances as an actor in national policy documents have been much reduced as they have become "*one of many stakeholders*".

- **A reflexive thematic analysis (RTA)** [239] of interviews with both public health and licensing team representatives from London boroughs (Chapter 7). Themes identified included the recognition that gambling was not "just one thing"(but was harmful in whatever form it took); feelings of helplessness (expressed as a lack of money and a lack of power); not really knowing (about effective interventions or local impact of gambling harms); what public health teams do (and how they do it); and individualism-boroughs, teams and local council differences.

8.5.2 Domain of the Actual-events, empirical phenomena and observable patterns

In critical realism, structures refer to the underlying frameworks, systems, and arrangements that shape social reality [82, 85]. These structures are often considered to have an enduring and constraining influence on individuals, groups, and societies. Structures shape the possibilities and constraints within which individuals and social groups operate while also being influenced and transformed by human agency and social change. Examples of structures within critical realism include social hierarchies, cultural norms and practices, discourses, economic systems, and political institutions.

Social, cultural, economic, and political factors influence the challenge of adopting public health approaches in local government.

8.5.2.1 Social factors

Socially, gambling has increasingly been normalised within society, being presented as a legitimate leisure activity. It is highly accessible, in-person and online, with prominent advertising, marketing and sponsorship campaigns that can influence individual perceptions and encourage participation. There can be early exposure to gambling via family, friends and media, with such socialisation influencing the likelihood of participating. There can be peer influence and pressure to gamble (people may be more likely to gamble if their friends or family are doing so). In addition, some forms of gambling are promoted for their supposed positive impact on community cohesion (e.g., bingo), even in national government documents [52]. The expansion of online gambling has increased availability and, as such, further normalised gambling behaviours. The impact of these social factors is that when attempts are made to highlight the negative impacts of what is such a widely sociable acceptable activity, then those experiencing harms are "othered" and depicted as a minority. Those looking to reduce gambling harms through reducing availability or limiting advertising are presented as a manifestation of the "nanny state" or "prohibitionist".

8.5.2.2 Economic factors

Three economic factors influence how local governments can use public health approaches to tackle and address gambling harms. Firstly, the gambling industry is presented in the discourse as a legitimate industry that contributes tax revenue and employment [5], and presents itself, via its contributions to Research, Education and Training (RET) as a force for good. This means that any proposal that limits gambling availability or advertising (and thus reduces industry revenue) is met with counterarguments from the industry such as that stricter legislation will move gambling into black markets (there is no evidence for this [57]), and there will be less revenue for research, education and treatment (RET).

Secondly, local government has, for at least the last decade, suffered funding cuts, to the point where a 2024 LGA report warns that up to half of councils may be bankrupt within the next five years [240]. This means that any resources to address gambling harms within local government will be greatly diminished. The funding given to local government for public health activities is ring-fenced, but has reduced, and as the interviews highlighted, can be siphoned off before reaching public health departments by a widening the definition of public health.

This financial strain on local government, so severe that many lack the resources to deliver even their statutory obligations, means there is no scope to consider newer issues within their portfolios, such as gambling harms. In addition, reduced funding increases the relative power of the gambling industry, which can be important if they want to challenge applications for new premises, with the profits of the gambling industry measured in billions of pounds each, a concern cited in the interviews when possible legal challenges were discussed.

Thirdly, gambling harms are now exacerbating a severe cost of living crisis, with evidence that low-stakes gambling increases at times of financial hardship [76]. Concerns have been raised previously that gambling harms can worsen in economically strained environments such as those caused by the Covid-19 pandemic [77].

8.5.2.3 Cultural factors

Cultural factors that influence the potential for implementing public health strategies to address gambling harms include a dominant narrative that focuses on the “othering” of Problem Gamblers. They are depicted as a small minority, contrasted with the majority of

people who enjoy gambling without any concerns. Such a narrative not only stigmatises those harmed by gambling (as they are depicted as the problem rather that the addictive products or the predatory tactics of an industry that seeks to retain those who attempt to disengage), but by focussing any interventions on those already harmed by gambling rather than preventing the harm in the first place, the industry has already extracted the money. In contrast, the harm to the individual, those close to them and to wider society, has already occurred. This narrative is important for some marginalised groups, such as migrants, where gambling may be stigmatised, and the harms experienced from gambling are more pronounced [77]. In addition, marginalised groups tend to be poorer, a risk factor in itself for experiencing gambling harms [23].

8.5.2.4 Political factors

Political factors that influence this issue include the fact that responsibility for gambling lies within the Department of Culture, Media and Sport (DCMS), rather than the Department of Health and Social Care (DHSC), which reduces the likelihood that the consequences of gambling would be viewed through a health lens. This is different from alcohol-related harms, where the relevant legislation falls under the remit of the DHSC. In 2020 the House of Lords Select Committee recognised the harmful health impacts of gambling but fell short of suggesting a transfer of policy and legislative responsibility to the DHSC [51]Gambling policy and legislation remain within the DCMS's remit, and it continues to be framed as a leisure activity, as exemplified by the discussion of social factors outlined above.

Secondly, gambling legislation is permissive, with a “statutory aim to permit” new gambling premises, and is limited in not designating public health teams as responsible authorities who would then have a statutory right to be informed of any new premises applications in their locality. This, alongside the varying place of public health teams within local government organisations, has contributed to their differing levels of interest and influence in gambling policy, as seen in the survey and the discourse analysis, where local gambling policies and plans varied in the extent to which they mentioned public health and gambling in their documents. Related to the theme of legislation, there are other legally binding documents that local government must be aware of such as Local Plans. The way that gambling is depicted in Local Plans was explored in the discourse analysis and interviews.

Thirdly, as exemplified in the discourse analysis by *the social logics of evidence*, there is a dominant political discourse that any proposed policy change should be evidence-based. Several issues arise here: firstly, the evidence on what works is seriously "*compromised*" [63] and subject to industry influence, what counts as evidence is often politically driven, making impossible demands on researchers [95], while the evidence that does exist must compete with corporate agnogenic practices that "*produce ignorance*" and promote policy inertia [103, 232]. Examples of non-evidence-based policy changes include Australia's implementation of maximum play lines and Great Britain's reducing FOBT stakes, both discussed in the literature review. Thus, which policies are implemented is often due more to political considerations than evidence.

8.5.3 Domain of the Real: proposed mechanisms

The mechanisms within the domain of the real propose underlying processes or structures that generate the observed patterns and phenomena, typically inferred through a combination of empirical evidence, theoretical reasoning, and consideration of context. Here it is important to recall that empirical evidence is only ever partial and situated within its specific context and setting.

The four proposed mechanisms are as follows:

- A Tolerance of Harm
- The influence of the gambling industry
- The disempowerment of local government
- Heterogeneity

8.5.3.1 A Tolerance of Harm

"Tolerating harm" generally refers to accepting or permitting adverse consequences or injuries without taking action to prevent or minimise them. This could include allowing harmful behaviours to continue without intervention or overlooking risks that could lead to harm.

A tolerance of harm mechanism is seen through social factors that normalise and legitimise gambling (as seen in the discourse analysis), simultaneously recognising that it can be harmful (in the interviews). In addition, harm is being tolerated when the focus of interventions is either not evidence-based or focused on primary prevention, as seen in the literature review.

Permissive legislation allows harm to arise via the statutory aim to permit. This allows the gambling industry to apply to open new gambling premises in areas of deprivation (as seen in the premises analysis), even though it is known that gambling is highly regressive [40], with poorer people spending a greater percentage of their income on gambling and a link between lower socioeconomic status and gambling harms [23]. Meanwhile, even though gambling premises are increasing in number and type in some areas, a narrative is maintained that betting shops are closing and gambling is moving online (the pervasive influence of the gambling industry is discussed as a mechanism below).

More broadly, harm is tolerated in decisions by central government to cut funding to local councils, which have many statutory duties that they struggle to provide, leaving them on the verge of bankruptcy. "A lack of money" emerged strongly from the interviews for local government and within society more generally.

Finally, harm continues to be tolerated in the failure to agree that gambling harms are a public health issue; as such, appropriate primary prevention is continuously delayed. The survey showed how, within public health teams, gambling harms were not consistently felt to be a public health issue. The reasons vary (the interviews cited the impact of reduced resources and power imbalances), but individual local public health leads reject statements by their national professional leads [22], providing further evidence of tolerance to harm. Interviews also questioned whether there was support for public health involvement at a national level given the lack of dedicated funding, while the gambling regulator, which claims to take a public health approach, commissioned a report that concluded that gambling harms were "*a public health problem…but not a public health responsibility*"[198]. The ambivalent attitude of some local government teams to industry involvement in local policy decision-making (as evidenced in the interviews) is also at odds with a public health approach to gambling harms, reflecting an increasing understanding of commercial determinants of health. The lack of consensus as to whether gambling harms are a public health issue has led to other organisations (including those funded by the gambling industry such as GambleAware) to state they are taking a public health approach, creating their own definitions of what this might look like. This concept was also brought up by one interviewee, who argued that local government only know what public health is in relation to their own public health team. As such, the public health strategies they present often

reflect how they define prevention (citing material with a weak evidence base e.g. raising awareness and education strategies), or which is narrow in scope (e.g., a focus on gamblers) rather than a true public health approach using evidence-based population level primary prevention.

From these findings, it can be concluded that at the level of mechanisms, tolerating a degree of gambling harms is accepted by national and local government, and by individual council teams. Harm is tolerated and maintained by a deliberately poor evidence base, permissive legislation, 'othering' the narrowly defined Problem Gamblers (who have already experienced harm) while normalising gambling as a legitimate leisure activity, tolerating increased availability of addictive gambling products for populations known to be vulnerable, and by a lack of consensus as to whether gambling is a public health issue.

8.5.3.2 Influence of the gambling industry

In their 2023 opinion piece entitled "*Harm built in*", van Schalkwyk and colleagues summarise the issue of gambling harms as follows:

> *"As we struggle with a cost-of-living crisis, we must ask why we seem unable to act against a powerful industry that, in effect, acts as a mechanism for transferring money from the poor and vulnerable to the wealthy and privileged"* [241].

To influence something means having the capacity or power to affect the character, development, behaviour, or decisions of someone or something. It involves the ability to shape or sway opinions, actions, or outcomes through various means, including persuasion, authority, example, or coercion.

The gambling industry uses its influence to control the field of evidence. The literature review showed examples of how industry funding influenced the questions asked and methods used to answer them. The 2013 Goldsmith's College report *Fair Game*, which researched the challenges of undertaking gambling research, concluded:

> "*There is a lack of transparency about the conditions under which research is produced, and a poor understanding of conflicts of interests… The industry has the most useful data but has limited incentives to share it with researchers. Most requests for access to data are denied or ignored. The industry reserves the exclusive right to determine what is and is not 'commercially sensitive'*" [95].

The above example describes a form of "agnogenic practice", that Fooks describes as "*representing, communicating, and producing scientific research and evidence which work to create ignorance or doubt irrespective of the strength of the underlying evidence*" [232]. Methods used by corporations include discursive practices that demand impossibly high standards of scientific proof, to withholding data, and devising research protocols that are more likely to produce desired results or simply ensuring that some research is not undertaken in the first place for fear of producing unfavourable results.

In these ways, the body of evidence framing the problem and proposed solutions has enabled the industry to influence how gambling harms are framed, who or what is responsible for them, and the potential solutions. Policy reform, which could negatively impact the gambling industry economically, continues to be delayed because the evidence field they are influencing is deemed of poor quality, and as such, it is claimed that more evidence is required before any policy change. These impacts were reinforced in both the discourse analysis, regarding the *social logics of evidence*, and the interviews, where a frequent theme of "not knowing" about effective interventions was identified.

The gambling industry also controls the availability of gambling premises at local level. The premises report showed an increasing concentration of gambling premises within poorer areas. As seen in the discussion of the "tolerance of harm" mechanism, if it is assumed that permissive legislation leaves local licensing teams powerless to challenge new applications, something that emerged strongly in the discourse analysis and the interviews, then the gambling industry is effectively free to locate them where it makes most commercial sense, which is in poorer areas.

Advertising is one way that the gambling industry can influence society's willingness to accept gambling, as well as attracting customers and promoting products. Gambling advertising is ubiquitous across a wide range of media including both traditional forms (e.g. television, newspapers, outdoor and point of sale advertising) and more recent channels (e.g. internet and social media advertising) [242]. Advertising that promotes gambling as fun, something that is never defined, helps to normalise it as an activity (whilst also further stigmatising those who experience harms from it). A recent umbrella review identified a dose-response effect of exposure to gambling advertising on gambling harms [242], and while the literature review identified few marketing interventions that reduced gambling,

both Bristol and Greater London in Great Britain are targeting gambling advertising as a preventative strategy that aims to reduce this influence [168, 224].

The discourse analysis noted similarities in how gambling is portrayed in both the gambling industry and government as a legitimate leisure pastime and the gambling industry as a legitimate stakeholder that can be collaborated with. This latter aspect was apparent in the interviews when licensing teams did not rule out consulting with local gambling industry representatives while simultaneously acknowledging the harms gambling can cause. Ongoing challenged discourses, such as whether gambling harms are a public health issue or not or whether the local government has adequate capability and power to influence gambling policy, have been assisted by the gambling industry's contribution to the discourse, as seen in the analysis. A continued lack of consensus on these topics works in the gambling industry's favour as it impedes progress in gambling policy reform.

Finally, the influence of the gambling industry on individual MPs, parliamentary groupings (such as APPGs) and central government remains pervasive and pernicious and often intentionally concealed. Strategies to counter the industry's powerful influence are discussed further elsewhere [55].

8.5.3.3 The disempowerment of local government

To disempower means to deprive someone or something of power, authority, influence, or control, thereby reducing their ability to act effectively or make decisions autonomously. It involves diminishing the capacity of an individual, group, organization, or entity to exert influence or achieve desired outcomes.

Local government in England has experienced disempowerment through centralisation of decision-making and reduced funding. Austerity measures have constrained their financial autonomy, impacting their ability to deliver services effectively. Additionally, central government often imposes policies and obligations on them, restricting their flexibility to address locally identified needs.

Local government is disempowered by the centralised creation of permissive legislation: the "*statutory aim to permit*" disempowers local licensing authorities from challenging new premises applications. It is notable that when this phrase appears in successive documents of the Local Government Association's Councillor's handbook for gambling licensure, it is highlighted in bold to emphasise its fundamental importance [67-69]. The discourse analysis

showed that calls for evidence in 2016 and 2021 were potential moments of "*dislocation*", when the then-dominant narrative that local powers were adequate were challenged. However, this contingent (alternative) discourse was squashed by the central government's sedimented discourse that local powers were adequate, using the agnogenic practice of cherry-picking an example. Thus, they used Westminster City Council to argue that local powers could be used successfully, without noting that it is in no way representative of councils more generally, given its position in the capital and its many casinos catering primarily for tourism.

Rather than giving local government more powers at these points of potential dislocation, other measures were adopted (e.g., the FOBT stake changes post-2016) and presented discursively as a means to "solve" problems. The recent White Paper said that local government would be discussed at a later date "*when parliamentary times allows*" [52]. As discussed in the *discourse analysis's social logic of low expectations*, such strategies only reinforce local government disempowerment.

The premises data reinforces disempowerment by showing an increase in the concentration of gambling premises in poorer areas, while the dominant discourse is that "*betting shops are closing*" and "*gambling is moving online*". The cognitive dissonance that this situation creates can manifest as a sense of powerlessness while there is attempt to reconcile beliefs about capability and reality.

Local government is also disempowered by reduced funding, especially since 2010. The interviews gave examples of where public health money was siphoned off for other purposes, which has led to resourcing issues when considering newer topics, such as gambling as a public health issue. The interviews also revealed how public health and licensing teams are aware that gambling is harmful and could not see any positive features, yet feel powerless with inadequate resources to address it and have no clear plans for how to do so. This powerlessness is reinforced by a lack of knowledge about the prevalence of gambling harms and what works to reduce them, again reported in the interviews.

Local government is increasingly framed in ambiguous ways in the discourse. A lack of clarity can lead to disempowerment by way of not feeling equipped with adequate knowledge to action anything and diminished in a sense of a right to lead. An example is asking local councils, and public health teams within them, to address gambling harms using a "*whole*

council approach" without clearly defining what this looks like. This makes it difficult to achieve progress as agreement is needed on what this would look like and who would be in control of it. When the central government documents problematise local government as "*one of many stakeholders*", their authority to lead in addressing gambling harms has been diminished. The discourse analysis shows how, since 2020, local government has been mentioned less concerning addressing gambling harms. This is because the dominant discourse frames the problem as driven primarily by online activities, and as such local government is not seen as having any direct involvement as their role has traditionally been focused on licensing of physical premises. Publications by the regulator reinforce this land-based/online dichotomy, as discussed in the discourse analysis.

Local government is also disempowered by its lack of knowledge about gambling harms and, particularly, lack of data, especially when told that local data is needed before intervening, as reported in the interviews. The literature review reinforces this: there is very little within the body of available evidence on population-based interventions at the sub-national level to address gambling harms, and what is available was often poor quality, industry-funded, or from jurisdictions with different legal frameworks, and so can easily be challenged by those who see change as threatening their vested interests. The interviewees highlighted this when asked to respond to the very limited data from the survey and on premises.

As noted in the discourse analysis, local government was framed by both central government and the gambling industry as being "*the most knowledgeable*" about their localities [186, 191], but that knowledge is not matched with adequate powers, even when explicitly asked for, and is being kept intentionally incomplete, consistent with the influence of the gambling industry and the tolerance of harm in financially stretched environments.

8.5.3.4 Heterogeneity

Heterogeneity refers to the unique characteristics, traits, and qualities that distinguish one entity from another. When considered in the context of a structural mechanism, heterogeneity can be viewed as contributing to diversity, innovation, and adaptation. However, there are also some potential disadvantages associated with such individuality including risk of isolation, lack of conformity, resistance to authority, reduced sense of belonging and a potential for misunderstanding.

This research found considerable heterogeneity in local government in terms of individual council structures, groupings of services, and public health teams within that. Moreover, individual gambling products were simultaneously presented as separate entities even though the overarching concept of "gambling" is used in legislation and dominant narratives. The heterogeneity impacted all the empirical findings, disadvantaging those seeking to address gambling harms.

Firstly, the evidence reported in the literature review was heterogeneous regarding how addressing gambling harms had been approached and (where reported) how it had been evaluated. This has led to a lack of conformity in approaches to gambling harms as the evidence is rarely conclusive for individual interventions, a point reinforced in the *social logic of evidence* in the discourse analysis and the "not knowing" theme in the interviews. Secondly, the survey data showed heterogeneity regarding the size and place of public health teams within local government structures, reinforced in the interviews. This can also lead to a lack of conformity, as these differences in place within individual organisations can make it challenging for individual public health team to present a united approach to issues, with powers, resources and influence differing across teams. Another disadvantage of such individuality is resistance to authority and this may be one reason why the survey found that individual DPHs did not follow the national public health guidance [22] that views gambling as a public health issue.

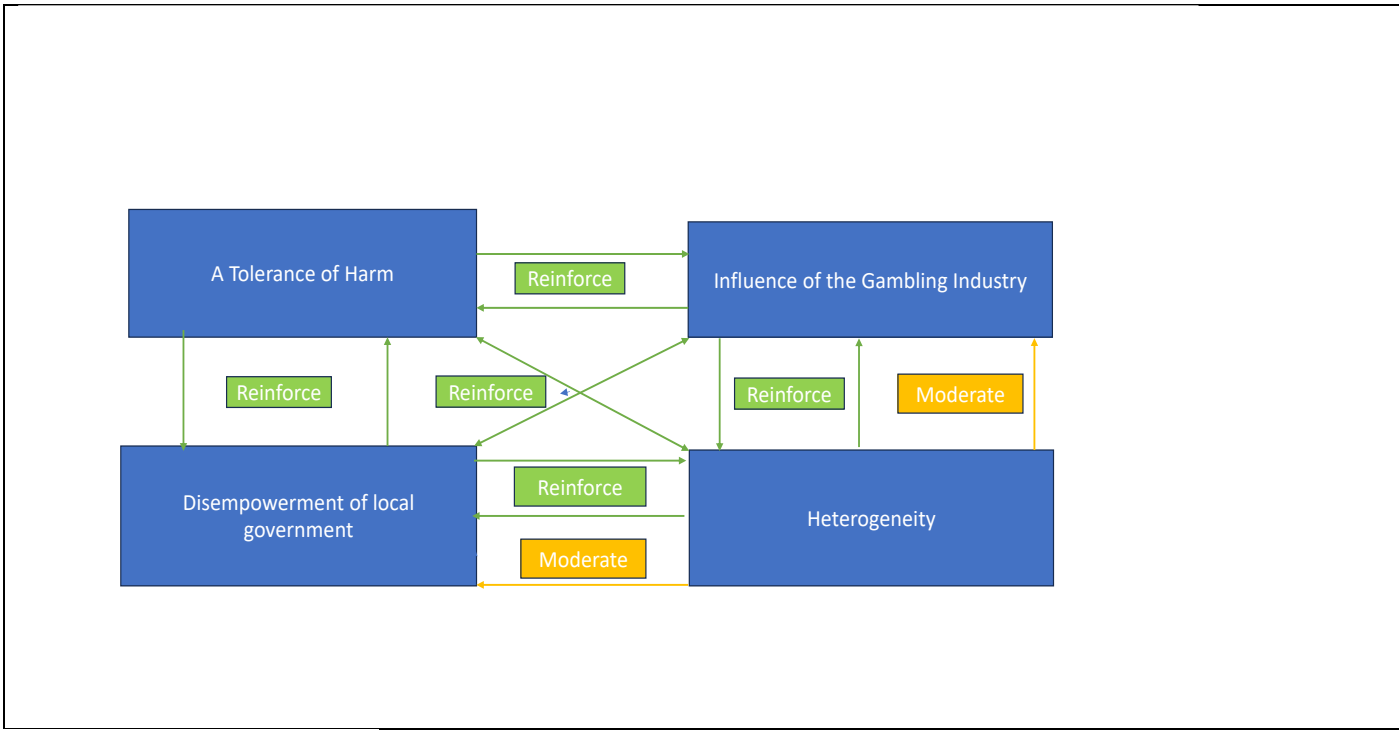
Thirdly, the discourse analysis presented gambling products in heterogenous ways over time, problematising specific gambling products discursively and, as such, presenting solutions to those individual products. Examples include the "problem" with gambling being Fixed Odds Betting Terminals being discursively "solved" by a stake reduction in this particular gambling product [48], and then the "problem" of online gambling being solved by new legislation "*fit for the digital age*" [5]. Paradoxically, while individual gambling products are presented in segmented ways (FOBTs are problematic, bingo is good for communities etc), gambling as an activity and within legislation is presented as a single concept. In the interviews, individual gambling products were discussed, but gambling was recognised globally as harmful. The impact of not having a clear single definition of "gambling" or "harmful gambling", reinforced by a compromised and heterogenous evidence base, leads to ongoing policy stasis.

Beyond public health teams and individual councils, the populations of London boroughs were presented in the interviews as heterogeneous. To a certain extent, this individuality of London boroughs is true. London is a metropolis of nearly 10 million people over 50 km wide, and it is challenging to find similarities between Barking and Dagenham on the one hand and Richmond on the other, these being boroughs with the highest and lowest ranking for deprivation. Heterogeneity at a borough level gives local councils (in theory) the opportunity to tailor services to their local needs. However, these opportunities can be constrained if legislation is controlled at the national level, and opportunities to develop pan-London approaches are felt to be too complex due to the diversity of populations (as the final quote included in the interview analysis [Chapter 7] exemplified). This concept will be further discussed in the context of agency later in this chapter.

8.5.4 Retrodiction

Retrodiction, as described by Danemark, is the way that mechanisms reinforce, moderate and counteract each other [86]. Fig 3 provides a conceptual framework of the findings presented here.

Figure 8-3 Conceptual Framework of Retrodiction



Source: author's compilation

A Tolerance of Harm and the gambling industry's influence mutually reinforce each other, as revealed by dominant “industry-friendly” discourses in policy from national bodies and persistent industry influence on RET given the industry is presented as a legitimate stakeholder. This is seen in the current system that has embedded the influence of the gambling industry within RET, citing prevention as an aim yet adopting industry-sympathetic narratives in education [243], and simultaneously (and paradoxically) planning to increase the number of clinics to address gambling harms to open in the next few years [244].

The influence of the gambling industry and the disempowerment of local government also reinforce each other, with local government not having the legal, financial or workforce capacity to address gambling harms in the context of permissive legislation. This is apparent from the increase of gambling premises in poorer areas, while a dominant (industry-friendly) narrative focuses on a discourse that “*betting shops are closing*”. This disempowerment of local government, in turn, reinforces harm being tolerated, as there is no local resource nor a consensus to consider addressing gambling harms using a public health framework.

The heterogeneity of public health teams and local councils can reinforce both the gambling industry's power and local government's disempowerment. It can lead to a lack of consensus at local government in terms of effective approaches to address gambling harms, and in turn, this can be harnessed by the gambling industry to their benefit (e.g., approaching individual councils to partner with organisations such as GamCare to provide training as has been seen in Haringey in 2023). This allows harm to continue to be tolerated, focusing upon secondary prevention strategies and interventions with a poor evidence base, such as raising awareness. However, although the empirical evidence provides examples of how heterogeneity has reinforced other mechanisms, examples from outside London, investigated as part of the wider exploration of this research, show how heterogeneity has moderated other mechanisms by taking advantage of the agency of individual councils.

8.5.5 The role of agency

Agency is the capacity to make choices and take actions that shape lives and influence environments. Within critical realism, agency recognises the constraints imposed by structures and mechanisms, but not in a deterministic way. Agency plays a role in shaping outcomes and responses to the issue under consideration.

The empirical evidence from London, primarily from the interviews but also the survey and the subset analysis of London documents in the discourse analysis, suggested a lack of agency. Themes expressed in the interviews included lack of power, money and knowledge. At the same time, the survey found a lack of influence on gambling policy and heterogeneity of content of both individual borough's gambling policies and local plans for gambling and public health. All of these implied a reinforcement of tolerating harm. However, as examples from outside London have shown, some councils and regional bodies have demonstrated a cohesive approach that can moderate the influence of the gambling industry and the disempowerment of local government.

Public health representatives from five other local councils in England based outside of Greater London were contacted during the research when wider reading identified that they had made interventions to address gambling harms in their areas. They consented to be interviewed in the same way as the participants from Greater London, and their interviews were recorded, transcribed, and stored in the same way. In this chapter, they will be named, with their permission, alongside the month that the interview took place, although for wider dissemination any quotes would be fully anonymised. Here, however, their experiences and insights provide examples of where they have used their agency to advocate for public health approaches to address gambling harms and, as such, exemplify how heterogeneity can be used to moderate the mechanisms discussed above.

The Greater Manchester Combined Authority (GMCA) comprises ten councils. They have employed a cross-council gambling harms lead to deliver a GMCA-wide public health approach to gambling harms. They have actively chosen not to partner with gambling industry-affiliated organisations, challenged the "problem gambler" narrative in their local advertising campaigns, and have been vocal in their written evidence to the consultation on the White Paper on the dangers of such collaborations [204, 205, 245]. In addition, in their written evidence on Gambling Act reform, they have operationalised what a "*whole council approach*" looks like [245], which could be used by other local councils to mitigate the disempowerment of local councils that feel that they lack the knowledge to implement a strategy for gambling harms.

> *"so we took the best bits from all the gambling policies and there's some standardisation across them now, a template that can be used…and with sport [in the city] It's like come on, let's be*

holistic about this. Let's be rational and I think we do have enough evidence and insight of like sports as being gambling tied and it's become a gamblogenic environment…and we say to councils we are not going to support [gambling industry funded] Safer Gambling Week and these are the reasons why" (Manchester, July 2022)

The Yorkshire and Humber region of England, comprising councils across the North East of England, meet quarterly to share best practices within the Yorkshire and Humber Harmful Gambling Group. Invited stakeholders include council members, local charities and public health academics, while external speakers are invited to present their work.

"The DPH set up the group…there was a stakeholder workshop with people with lived experience and kind of professionals for us to say what we thought were the priorities for a gambling-related harm reduction strategy. We picked five priorities…and part of that was prevention, because we can't treat our way out of the problems. There's a focus on prevention and regulation, as alongside treatment, support, education" (Sheffield, Oct 2022)

Within this meeting space, there is scope to present a collective approach to any gambling premises licence applications across the region.

"We need the industry to know that no matter where they apply across the region, it's going to be the same…we are going to be saying no…we get a solid case together based on those we have already won…we can use evidence we have gathered for the next time and it's economies of scale right? And we can use the same legal stuff" (Wakefield, Jan 2023)

Learning also comes from previous experience, including Leeds City Council's initial partnership with the gambling industry affiliated organisation GamCare, which was later recognised to be problematic and the collaboration was ceased.

"So what you then get is, you know, if you've got GamCare, for example delivering training, they've got tons of stuff. It's a huge organisation. So all of the stuff that they deliver is free, so it's a bit like, well, yeah, well, we wanna be seen to do something. So therefore let's just do, let's just get in what's free and to begin with, you're probably less sort of critical of the delivery of that or the content of that. But we have now got to a point after being... Because if we are promoting this with schools and our other childrens'

staff, I want to make sure that that what you're actually delivering is sort of fit for purpose." (Leeds, July 2022).

Finally, any successful licence challenges can be reviewed for learning.

"My understanding now [after a new gambling premises license was refused] really that's an area that we need to be taught is planning, and the planning team is an area that we needed to be targeting and working more closely with to raise awareness of the issues…if you start with planning policy, we haven't got anything there about concerns around gambling and gambling-related harm. We are very aware of some of the tactics of industry, and I think we need to be clear that we don't believe that gambling industry has a role to play when it comes to protecting vulnerable people or being involved in any strategy or any guidance" (Sheffield, Feb 2024).

These examples show how the agency of individual local councils (or groups of local councils in a region) has countered the mechanisms of tolerating harm, the influence of the gambling industry and the structural barrier of permissive legislation. They have worked collectively to create consensus, reducing heterogeneity that vested interests can take advantage of. Paradoxically, it is their heterogeneity that has also driven this innovation. They have succeeded in beginning to address gambling harms using public health approaches. These are examples that London can draw upon when considering their own interventions.

8.6 Discussion

This mixed methods analysis used a parallel convergent design. It was underpinned by a critical realist (CR) philosophy and framework to identify the levers and barriers to addressing gambling harms in local government using public health approaches. Within CR, findings within the "domain of the empirical" are considered within the "domain of the actual" contextual circumstances where they have occurred. The underlying mechanisms hypothesised that have a "tendency" to fire and create those circumstances are considered within the "domain of the real". In this research, levers and barriers were presented as analogous to both structures in the domain of the mechanisms within the domain of the real.

The findings from the five studies were included in the analysis. The mechanisms proposed were tolerance of harm, the influence of the gambling industry, the disempowerment of

local government, and heterogeneity. The recognition that other mechanisms may exist outside of those identified from empirical data, called “epistemic fallacy” within the CR paradigm, is acknowledged, and the findings are presented with that caveat.

Mechanisms can reinforce, moderate, and counteract each other. Here, a tolerance of harm, the powers of industry and the disempowerment of the gambling industry all reinforce each other. The clearest example of the mechanisms reinforcing each other within London is the example of a public health team in a deprived borough partnering with a gambling industry-affiliated organisation. Yet, at the same time, this borough has seen an increase in gambling premises within that borough, even though the public health team knows that gambling is harmful, whatever form it takes.

Heterogeneity in evidence design, public health teams, local councils and populations, and gambling product segmentation can also reinforce the gambling industry's power and local government's disempowerment. However, experience outside London shows how local government can exploit this heterogeneity. None of the mechanisms identified were thought to counteract each other.

This analysis builds upon a small amount of evidence about gambling policy in local government settings. Previous research in Australia concerning local government EGM policies found that a shift from addiction frameworks to public health policy responses to EGMs, consideration of the role of stakeholder groups in the policy-making process, financial resources and legislative boundaries, whole council approaches and supportive councillors were all underlying drivers to implementation [128]. A second study of a city council in England that implemented a policy restricting advertising and/or sponsorship of harmful commodities found that implementation benefitted from an existing supportive environment following the ‘Health in all Policies’ initiative and a focus on reducing health inequalities across the city [224]. However, this research introduces mechanisms that go beyond local government, in particular, a societal tolerance of harm (e.g., a dominant discourse that frames those who are harmed as a minority and/or interacting with a legitimate product incorrectly), something that has been recognised in previous gambling literature as a harmful commodity industry “*playbook*” tactic [243, 246].

Danemark recognised that “*temporary circumstances*” (social, political and cultural) can “*play a decisive role in triggering various mechanisms and, above all how the mechanisms*

more specifically influence events, activities and processes" [86]. Tolerating a harmful product, presumably for either economic benefit or to preserve individual freedom, aligns with a neoliberal approach that characterised much of the political discourse in the UK. Disempowerment of local government is in direct conflict with the UK's "*levelling up*" agenda [21], frequently cited as the direction of travel of the current government, but recently described as "*stymied from the very start*" with no progress made in 50% of the policy's initial targets [247].

The gambling industry exerted its influence in various ways, using strategies that have previously been seen in relation to other harmful commodities as part of a "playbook" of techniques, including corporate agnogenic practice. Although the interviews inferred the industry's influence, it is most apparent in the financial imbalances between industry and local government.

It is recognised that this is one person's interpretation of empirical findings. In addition, while a combination of quantitative and qualitative methods were selected to achieve each set of objectives, if other objectives had been included (for example, those that involved those with direct or indirect "lived experience" of gambling harms), the findings, and therefore the mechanisms identified, may have been different.

Also, a decision was made to consider only mechanisms within the domain of the real as levers and barriers. However, empirical outcomes rely on mechanisms working through measurable and observable structures within the domain of the actual, so it can also be argued that structures are a barrier or lever. The first example of a structural barrier is gambling legislation. There is a statutory aim to permit gambling premises. Still, the legislation does not formally recognise public health as a responsible authority. Unlike other UK licensing legislation (such as the licensing act for alcohol in Scotland), it does not have a specific public health objective. While the survey showed an association between a public health teams' sense of influence on local alcohol and gambling policy, legislative reform focused on addressing these structures would further support a public health approach, sedimenting its legitimacy in the legislative process. Giving public health a statutory role in gambling regulation by becoming a Responsibility Authority seems justified. Still, its absence should not be seen as a barrier to conceptualising gambling harms as a public health issue. The second structural barrier is a national discourse that mirrors the gambling industry's.

The recent White Paper positioned itself as separate from the operators, but this must be matched with action should the industry not comply. The third structural barrier is the acceptance of gifts and hospitality by MPs from gambling industry representatives and their affiliates. The rules that exist should be enforced and, arguably, tightened up.

Irrespective of their individual place within local government organisations, public health teams can embed their principles of collective action to advance the public good by promoting health, equity, and social justice, adopting a broad and population-level perspective [248] via formal pathways such as Health and Wellbeing boards (where public health teams have a mandatory position) or Health in all Policies directives.

The next steps would be to test the mechanisms proposed here by undertaking case studies of local government and gambling policy activity (such as outcomes to challenges to premises licence applications and local harm reduction advertising campaigns). These case studies (as examples within the domain of the empirical) can then be understood in terms of their "domain of the actual" context and the underlying mechanisms that have been triggered or suppressed to produce the empirical findings.

The final chapter of this thesis will draw together evidence from the five studies to make recommendations for London councils on how to address gambling harms using public health approaches. Recommendations for further research will also be presented, as well as reflections on the overall research process.

Chapter 9 Reflections and Recommendations

9.1 Recap

Many stakeholders are now seeing gambling as a public health issue. This thesis has explored the levers available to local authorities in London and the barriers they face when addressing gambling harm by means of public health approaches.

I undertook a mixed methods analysis with five elements. These were a literature review (Chapter 3), a survey of London borough public health leads (Chapter 4), an analysis of gambling premises by type and number over the duration of the thesis (Chapter 5), a discourse analysis of gambling policy using a "critical logics approach" from political science (Chapter 6), and a thematic analysis of interviews with local government representatives from both public health and licensing teams (Chapter 7). A mixed methods analysis, underpinned by a critical realist philosophy, brought these together to identify a series of "mechanisms" that influenced the scope of a public health approach (Chapter 8). These mechanisms are tolerance of harm by society, the influence exerted by the gambling industry, disempowerment of local government, and heterogeneity (of local government structure, of a public health team's place within it, of local public health team's size and activities, of gambling product and of local populations). These mechanisms come together to counteract, moderate, or reinforce each other and whether they "fire" is highly context-dependent.

This final chapter reflects upon the process, methodology, and findings of the thesis before making recommendations for public health teams in local government and areas for future research.

9.2 Summary of thesis

Gambling harms can impact the individual and society and can take many forms, including financial, health-related, and forensic harms. Conceptualising gambling harms as a public health issue in the UK began to be more widely discussed in the mid-2010s, a few years after public health teams had moved into local authorities following the Health and Social Care Act. This thesis sought to identify the levers and barriers within London's local government (32 London boroughs) to address gambling harm using public health approaches.

Initial findings were that at a local council (borough) level, there were differences in the density of land-based outlets, even in demographically comparable boroughs. There were also differences in individual public health teams' interest in and influence on gambling policy. The presence or absence of gambling in councils' local plans was also highly variable. They faced the problems that national gambling legislation includes a "statutory aim to permit" new gambling premises and Public Health teams are not what is termed a Responsible Authority, and as such, do not have to be informed of new applications, the latter hypothesised as a reason why public health involvement in local policy is so variable. However, even if these issues could be addressed, some gambling products fall out of the scope of local government, such as National Lottery products, covered by specific legislation, and online gambling, as well as widely available workforce training packages and educational materials that adopt an industry-friendly "safer gambling" narrative. Therefore, a wider public health approach that considers aspects beyond local licensing and availability is required to address gambling harms effectively.

Focusing upon the 32 London boroughs and using quantitative and qualitative methods, this research sought to identify underlying levers or barriers to addressing gambling harms using public health approaches in local government. These research projects were undertaken at a very specific time within gambling policy development- national gambling legislation was under review, and the gambling landscape was in a state of flux after prolonged closures of outlets due to the pandemic, alongside a dominant online gambling narrative that aims to bring legislation into the "digital age".

My research found an increasing concentration of gambling outlets in deprived areas and a change in the types of gambling available on the high street. The overall reduction in gambling premises and betting shops has hidden an increase in gaming centres (arcades) and bingo venues, which can accommodate more electronic gaming machines (deemed a more harmful type of gambling product) than betting shops.

Also, in that time, the dominant discourse has sought to ensure that gambling is conceptualised as a "fun" leisure activity, with a narrative that numbers harmed are small and stable. At the same time, the actions of local governments are confined within the narrow silo of land-based licensing. As the dominant discourse has moved to gambling becoming predominately online, local government has been increasingly side-lined as a stakeholder in national policy. Finally, surveys and interviews with local public health teams

revealed a broad range of interests and influences on gambling policy, with public health action to address gambling harms locally hindered by a lack of power, financial resources or knowledge about effective interventions. The overall situation was exacerbated by a historically poor evidence base, primarily due to it being industry-funded and the industry using a recognised "playbook tactic" employed by producers of harmful commodities that demands impossible levels of "methodological purity" before accepting any policy change. From these findings, underlying so-called mechanisms analogous to levers and barriers were proposed. These are:

A tolerance of harm- gambling is normalised by society, and a dominant discourse allows a percentage of those gambling to be harmed. In addition, delaying primary prevention strategies allows this harm to continue (and the gambling industry to continue to "extract" money). Public health teams with stretched resources, limited powers, and knowledge also tolerate these harms as they fail to act.

The influence of industry is pernicious and pervasive. The alignment between the gambling industry, government, and a regulator-dominated narrative (a small number of "problem gamblers" and a focus on their treatment, gambling as a leisure activity, and industry as a legitimate stakeholder) is striking. In addition, many groups (including the Gambling Commission and GambleAware) now claim they are adopting a public health approach. Still, their strategies focus on secondary prevention can have a narrow focus on either raising awareness or gathering data about certain so-called vulnerable groups without discussing how gambling products are "addictive by design" and that potentially everyone is vulnerable to experiencing gambling harms, either directly or indirectly.

The disempowering of local government can be seen in reductions in funds and gives the illusion that local government has legislative powers that it lacks, fitting with a centralist and neoliberal national government agenda.

Heterogeneity can be conceptualised as a barrier and a lever given the context. As a barrier, public health voices lack collective power to demand and/or instigate change. In addition, segmentation of gambling products means there is ineffective action to address the existing and evolving harms from changing land based and online product availability. The scope for leverage can be seen in examples from local government outside London. These take the form of local governments coming together to develop whole council approaches and

regional coalitions to harmonise challenges to new licences while sharing best practice and avoiding industry-influenced evidence.

9.3 Reflections on the PhD process: Covid Impact Statement

This PhD offer was offered and accepted in March 2020 and began in mid-September 2020. This means that it was undertaken entirely during the Covid-19 pandemic; this has inevitably shaped the academic interactions, the choice of methodologies and the constraints arising when applying them, alongside concurrent experiences and challenges outside of the PhD arising from my clinical role, which I continued alongside the PhD.

It is possibly too early for there to be a significant body of published evidence about the impact that the pandemic has had on doctoral studies. However, I anticipate this will be a research topic in its own right. In the early stages of the pandemic, opportunities within academia felt more equitable, given that everyone, irrespective of circumstances, was working remotely. However, evidence then emerged that the pandemic was disadvantaging those with certain characteristics, such as academics with caring responsibilities or needing to cope with homeschooling demands [249]. In my case, balancing clinical responsibilities, which created particular risks from exposure to infection, with the challenges of working in an area of research beset with conflicts of interest involved frequent short-notice adaptations in both roles. However, I recognise that this combination of activities has been of particular value in developing leadership and management and other transferable skills that I will take into my future academic roles.

For most of the time that I was working on the PhD, my interactions were mainly virtual and formal, and so-called “water-cooler” opportunities for informal exchanges were impossible, thereby reducing the networking opportunities that can stimulate new ways of thinking and problem-solving. Online working required me to develop enhanced digital skills, adapt to virtual meeting etiquette, and learn to engage with online curriculum content and delivery, all of which took time. Even when educational spaces reopened, many, including myself, had become accustomed to working outside of the university’s physical environment, especially as travelling involved risks while the virus was still circulating. Finally, my PhD work had to be managed alongside new pressures, such as those arising from unpredictable school closures at short notice and consequent home-schooling.

Overall, this was not the PhD journey I was expecting, primarily working from home, but I have enjoyed it more than I would have anticipated if I had been asked in March 2020. It enabled me to continue to work locally as an in-person clinician and manage my other responsibilities and roles. I had to make an active effort to connect with other doctoral students, so I purposely volunteered as the department student representative and for the local NIHR Early Career Researcher Committee membership. Certain online meetings, such as the monthly meeting of doctoral students on the same funding stream, were prioritised to forge connections. As virtual meetings became standard, I took up an important role as the GP representative on the NICE committee, developing guidance on gambling harms, which complemented my PhD work very well and coincided with my study period. The guideline was scheduled to be published in May 2024 but has been delayed.

The major loss resulting from undertaking a PhD predominantly online has been that it proved challenging to meet with established senior researchers within LSHTM and beyond, all of whom were adjusting to virtual academia. It is easy to ignore an email from a PhD student you have never met asking for help on something or forget to respond to a backlog of emails when you return after a prolonged illness. Likewise, for PhD students, it is not useful to expend energy constantly chasing people who never reply so alternative solutions must be found. I believe that has made me more grateful for the professional relationships that I have made and which I have thus invested in. The acknowledgements section of the thesis recognises those people.

9.4 Reflections on the methodology

I had always planned to undertake a mixed-method PhD, for several reasons. Firstly, I knew my nature as a generalist researcher and feared I would 'miss out' if I concentrated on a single method. Secondly, I wanted to develop a research skill set as wide as possible from my PhD experience. Thirdly, I was aware early in the process that there was little evidence in the field of gambling research that was not industry-funded; I believed that this was an opportunity to explore several aspects of the topic that could later be developed in future research, using funding that was entirely free of gambling industry influence. Finally, I wanted my research to be accessible to as wide a range of stakeholders as possible, and as such I hoped that if at least one element of my research appealed to a particular

stakeholder, then they may go on to read and hopefully, trust other elements that they may have perceived initially as being outside of their academic "comfort zone".

I came across critical realism (CR) as a philosophy early in my PhD when a document was shared between doctoral students via our virtual forum. As a philosophical position, it immediately made sense to me in lay terms: that objects are real, that knowledge is fallible and partial, and that some explanations are more likely than others. It was helpful that several PhD students who had read the same document also decided to use critical realism: we met up online in the early days of discovering CR to explore our thoughts on it. I also came across a Masters module tutor who was using it for her own research, and she signposted me to Danemark's book [86], which was extremely helpful in giving me further understanding. The main challenge of using a CR approach is that it is still relatively new as a philosophical paradigm, and in the various presentations of my research during my thesis, I have found myself having to explain the position, especially to researchers from other countries. This is important as if academics must acquaint themselves with your underpinning philosophy before even considering your research, it can be a barrier to further discussions.

One key element of methodology that changed from the initial plans was the quantitative aspects of the research. Initially, I had planned to undertake a deeper analysis of the gambling premises using Geographical Information Software (GIS) alongside qualitative elements (discourse analysis and interviews). However, a GIS course at the school only ran mid-way through my second year, the GIS software to download was too large for a standard home laptop to run, and the person at LSHTM with GIS skills I was asked to contact did not respond after repeated attempts, so I presumed they were either absent due to prolonged sickness or unwilling to help. Therefore, I made the pragmatic decision to analyse the data in a more straightforward but accessible way using Excel and to complement this simpler analysis with a survey. In this way, the research remained mixed-method, which was my priority for the above reasons.

Within this research, I also made the conscious decision at the outset not to interview or involve those with lived experience, either those who have experienced gambling harms directly or as affected others. There would have been an opportunity to involve them in the study, for example, an opportunity to involve them in research, for instance, by reaching out

to charities or identifying individuals who had helped set up or been involved in local government initiatives to address gambling harms. There are various reasons that I consciously chose not to do this. Firstly, even if I were approaching those with lived experiences as a PhD student, they would know that I am also a GP. I had already stepped away from my role volunteering with GamAnon (a non-industry funded support group for affected others) to undertake this research, recognising that while formally studying gambling, those who attended the group expecting that their interactions would be held in confidence could feel compromised if speaking freely, knowing I was concurrently being paid to study this topic. This would have presented an ethical quandary. Secondly, during informal discussions with those with lived experience in the early stages of the research, many that I spoke to expressed anger at GPs who had either missed or dismissed their harm from gambling over the years. Some also began disclosing personal information not necessarily directly related to gambling, and even if not directly expressed, I recognised that I was being spoken to in the confidential manner that one speaks to their GP. I felt any interviews with those with lived experience would thus be compromised, giving rise to a methodological reason not to involve those with lived experience. I have been questioned about this decision at various stages during my research, always by eminent non-clinicians, but from an ethical standpoint, I remain convinced this was the right course for me as an individual. Other researchers with less complex positions can undertake this type of research.

9.5 Reflections on the findings

The literature review results were not surprising regarding the lack of available evidence on the topic. In preparation for the thesis, I read *Fair Game* [95], an analysis of the complexities of undertaking gambling research, written by a non-industry-funded gambling researcher who was aware of the historical context of gambling research. I definitely experienced an element of frustration, firstly because there were so many papers that did not meet the inclusion criteria (a sign of how "*compromised*" the field is [63]), and secondly, how many papers were either unavailable or took a prolonged time to obtain copies of through the University of London library services. What surprised me was how useful my experience undertaking the literature review proved for my role in the NICE guideline on gambling harms. The structure of NICE guideline development is firstly that the committee is invited

to identify certain topics and questions for the guideline to cover. Then, in-house systematic reviewers will undertake the literature searches and present the results. The committee then makes recommendations based on the evidence presented. The lack of evidence that was available to inform several elements of the guideline was a shock to many on the committee. Still, I was fortunate to be able to use a Commercial Determinants of Health framing and "playbook" theory to explain how this had occurred. These discussions also led to the committee differentiating the available research according to industry funding and stating its provenance within the guidelines. This is important as transparency in the NICE guideline process is paramount, and there will be intense scrutiny once it is finally published, especially since some of the NICE guideline committees have declared interests involving links with the gambling industry and its intermediaries. This is a concern I have raised formally with NICE on more than one occasion in the process.

The low response rate to the DPH survey was disappointing, given that the London branch of the Association of Directors of Public Health (ADPH) had actively supported it. I tried to avoid sending it out when I knew that DPHs were under particular pressure (e.g., during the Covid or monkeypox vaccine delivery windows). I have reflected at length, but I really do not know what else I could have done to improve the response beyond what were quite intensive attempts to engage with ADPH leads, aided by my supervisors, seeking to reinforce the message that the survey had high-level support. However, the findings were situated within the CR paradigm of epistemic relativism (knowledge is fallible and partial), and I have used the low response rate as a discussion point in the later interviews so, in that way, it proved a useful lever for discussion. In addition, as someone looking at local government public health teams "from the outside", the survey gave me some important baseline information that I was previously unaware of, such as the wide variation in placement and staffing of public health teams. If I had not done the survey, I would not have been aware of such differences, as this did not come up directly in the interviews, with participants only saying that boroughs were all "*different*". In that way, I think it has been helpful to be outside of the public health system as I could query assumptions about public health within organisational structures and their impact.

The results of the simple analysis of the premises were striking. Over the period studied, physical gambling premises continued to be concentrated in deprived areas. This

relationship is getting stronger, and there are emerging examples of new premises opening in London boroughs that have partnered with gambling industry-affiliated organisations ostensibly to address gambling harms. Seeing that earlier premises data was so difficult to obtain was frustrating. Multiple FOIs to the Gambling Commission requesting spreadsheets from earlier periods were declined, and I was asked to contact each licensing authority separately. They often did not reply to messages to generic email addresses or to phone messages. The Gambling Commission would not categorise whether they held this data in email communications. I have subsequently referred to their failure to respond to the Information Commissioner, but this will take time to resolve. I was particularly concerned about the approach taken by the Gambling Commission as the regulator, having only the General Medical Council to compare them to, as their approach to record-keeping related to licensure felt "*compromised*"[63].

It was difficult to conclude the limited quantitative data from the survey and the premises data. Still, I acknowledged this when set within a CR paradigm (where knowledge is partial and fallible). Also, I used the findings to stimulate further discussion in the interviews, and the reasons why the response to the survey was so low provided rich thematic data from the interviews. Finally, even the basic data from the quantitative element is enough to merit discussion and point to priorities for monitoring and research.

The most challenging element was the discourse analysis, as this required learning a new way of thinking, drawing on political theory and, in particular, post-structuralism. It helped that a PhD colleague had undertaken a discourse analysis using the same method as we could discuss our findings using the same technical language. It is a relatively new method, and I have presented the findings to diverse audiences, and it has been well received. From my experiences, I believe that, as a method, it is transferable, and it is certainly a method that I will consider using in future research on topics that are characterised by political tensions, such as current issues relating to the primary care workforce.

I conducted the interviews over a protracted time, primarily due to the difficulties in accessing public health staff so the themes emerging in the thematic analysis kept changing, as expected when applying a reflexive approach to analysis. Although the original plan was to speak to a wider range of local government staff, I decided relatively early on to focus on public health and licensing teams, as background reading indicated that these were the key

parts of local government involved in gambling. It was more difficult than anticipated to make initial contacts, most likely because local government staff were transitioning to hybrid ways of working during the different stages of the pandemic and because they faced severe pressures during the roll-out of vaccine programmes and the development of other pandemic-related services. Unfortunately, it was only when I was analysing the interview data and conducting the mixed methods analysis that it became clear that I had missed a third element of local government that is relevant to gambling: planning. Public health teams pointed to the role of Local Plans, which, once agreed, become part of the authority's legal "contract". Therefore, the presence, framing, or absence of gambling in the Local Plan provides a legal underpinning of the authority's long-term vision for its area. If I were to do this research again, I would include planning teams.

When conducting the mixed method analysis, I considered using a specific CR explanatory framework to synthesise the results. I then moved away from this approach for the reasons in Chapter 8. By the time I was undertaking the mixed method analysis, I was acutely aware of the "*playbook tactic*" of corporate agnogenesis [238], witnessing countless examples where those non-industry-funded researchers (and researchers) who challenged the dominant narrative had been rebuked in public arenas because their research did not fit what was considered acceptable. I wanted to protect my research against that now predictable challenge and produce research that used mixed methods (so it cannot be dismissed as being "just qualitative" for example). I also purposely did not adopt a specific framework in the overall mixed method analysis to counter this playbook tactic.

9.6 Recommendations

Before I present my own recommendations, I will comment upon two other sets of recommendations that local government departments concerned with public health and gambling harms should be aware of. The first is the ADPH 2020 'Call to Action' [22], published in the first few months of this research and the second is the recently published Greater London Assembly Health Committee report on gambling harms in London [168], published in the final months of my write-up. I mention these two sets of recommendations specifically as not only do they bookend my own research, but they address issues that my own recommendations do not: my recommendations both complement and challenge these other recommendations where appropriate. Public health teams in local government, and

local government within London more widely, can use all three sets of recommendations to formulate their own strategy, tailored to their locality and resources.

9.6.1 ADPH (2020) Recommendations

The ADPH recommendations were mentioned in Chapter One as a "*call to action*" but also recapped here in Box 2.

Box 9-1: ADPH 2020 Call to Action Summary

1. National and local policymakers adopt a 'health in all policies' approach.
2. Understand the prevalence of harmful gambling and how individuals, their family and friends, and wider community are affected.
3. Ensure tackling gambling harms is a key public health commitment at all levels by including it in strategic plans, with meaningful outcome measures, and communicating this to partners.
4. Understand the assets and resources available in the public, private and voluntary sectors and identifying what actions are underway.
5. Raise awareness, share data, and develop a compelling narrative involving people who have been harmed and are willing to share their experience.
6. Ensure all regulatory authorities help tackle gambling-related harms under a 'whole council' approach.
7. Develop a whole systems approach to reducing poverty and health inequalities that incorporates gambling harm within place-based planning.

Adapted from Johnson and Regan, 2020 [22]

Overall, these recommendations are very strong. They call for a system-wide Health in All Policies approach that recognises the importance of embedding change within legislation at local and national levels, including lived experience, and makes a structural link between gambling harms and poverty. However, they fail to say how these changes can be operationalised at the local level (although the article does signpost particular regions that offer examples of good practice). In addition, there is no mention of the challenges of evidence gathering and the pervasive role of the gambling industry in preventing progress (although a recent ADPH statement has considered this final issue explicitly [250]).

9.6.2 Recommendations to the Greater London Assembly (2024)

The recommendations from the Greater London Assembly (GLA) Health Committee were published in March 2024 (during the final write-up stages of this thesis) and are summarised in Box 3:

Box 9-2 Greater London Assembly Health Committee recommendations to address gambling harms in London 2024

1. The Inequalities Strategy Implementation Plan should give greater prominence to the issue of gambling harm, given the disproportionate impact that gambling harms have on certain demographic groups.
2. National government should reconsider the statutory aim to permit, which would give councils greater powers to refuse applications for new betting shops, where there are already high numbers in a particular area.
3. The Mayor should work with local authorities to share best practices and information about how they can prevent the proliferation of betting shops in London, including by implementing guidance set out in the London Plan and using the anticipated cumulative impact assessments (CIAs) for gambling premises applications.
4. London should seek to learn from Bristol City Council's policy of banning gambling advertisements and analyse the evaluations that are taking place on the impact of Bristol's advertising restrictions to inform its own approach.
5. The Mayor should propose in 2024-25 to ban gambling advertisements on the Transport for London (TfL) network. He should consult with key stakeholders, including charity and health partners and gambling industry representatives.
6. The Mayor should work with NHS England (London) to advocate for training on gambling harms to be adopted across all GP practices in London.
7. The Mayor should use his convening role to help ensure that, while the new commissioning arrangements under the statutory levy are being rolled out, there is effective collaboration and integration between NHS services and the third sector in London in delivering support and treatment for gambling harms.

8. The Mayor should work with the NHS in London to pilot public health awareness messaging about gambling harms, providing advertising space on the TfL network.

Greater London Assembly, 2024 [168]

Recommendations that address gambling harms with a specific London focus are welcome: these consider population-level strategies such as reduction of availability and marketing as in the WHO "Best Buys" approach [92], as well as the introduction of counter-marketing, all strategies discussed within my literature review in Chapter 3. However, these recommendations make little specific mention of the all-harms impact of gambling and have a potentially stigmatising and narrow focus upon "*certain demographic groups*" and those requiring treatment. In addition, there is a presumption that both the cumulative impact assessments and the levy are imminent when in reality, they are still being consulted on and will only be adopted "*when parliamentary time allows*" [52] The focus on advertising is welcome as not only is this a population-level strategy, but it is also an issue that local government has some power over. However, if impact evaluations are poorly designed or inconclusive, operators could easily argue against further restrictions, especially as they remain a "*key stakeholder*" in discussions.

The Health Committee recommendations also focus on betting shops, presumably because betting shops dominate any discourse on gambling within Local Plans, many of which were published before the reduction in FOBT stakes. To focus so narrowly on betting shops, which are already reducing in number overall (albeit concentrating on deprived areas), is a missed opportunity: such a narrow focus ignores activities such as gaming or lottery sales, nor the expansion in numbers of gambling premises that house more machines than do betting shops, such as arcades and bingo. Nor does it consider online gambling or its overlap with land-based gambling via single-platform technology. In addition, gambling industry operators are framed as key stakeholders to be included in discussions, which reinforces their influence and, as such, can reinforce a tolerance of harm, something discussed in this thesis. To give an example of the failure to address the influence of industry, the recommendation that NHSE London should advocate that GPs receive training in gambling harms fails to consider how the new Royal College of General Practitioner's training package for GPs was developed in collaboration with GambleAware [251], while the Health Committee invited some of those involved in the development of this training to provide

written evidence on these recommendations [252] . In summary, these recommendations are a step in the right direction, but the influence of the industry remains pervasive. These concerns have already been raised with the GLA, who will consider holding a meeting to discuss them now that Sadiq Khan has been re-elected for his third term as Mayor, in May 2024.

Considering these points, my recommendations, firstly for public health teams and for London boroughs overall, are as follows:

Recommendations for London Borough Public Health teams

1. **Commit to lead a public health approach to gambling harms.** A lack of consensus within the local public health community (as demonstrated in my survey, discourse analysis and interviews) has led to a situation where other groups are now professing to take a public health approach, imposing their own definition of what this looks like (in some cases one that owes little to public health). The consensus among local public health teams will help to formulate a system-wide approach to addressing harms at the local and regional levels.

2. **Adopt a Commercial Determinants of Health (CDoH) lens to address gambling harms.** It is essential to understand and articulate how the gambling industry is using techniques from the industry 'playbook' developed by manufacturers of harmful products such as tobacco and alcohol to shape ongoing discourse and, especially, the research agenda on gambling. The interviews in this thesis, with public health practitioners from London and other parts of the UK, highlighted the negative impact the industry presence had on public health approaches. In particular, the industry cannot be seen as a legitimate stakeholder in discussions on the harm it causes. This understanding should include corporate agnogenesis, or the manufacture of doubt. When dealing with gambling, it is appropriate to use language that aligns gambling harms with those caused by alcohol (another legalised and perceived socially acceptable product) rather than illicit drug use, as the latter framing can be both limiting and stigmatising.

3. **Avoid language and approaches that compartmentalise and segment gambling.** The discourse analysis and the interviews highlighted the pitfalls of compartmentalising gambling by product. Consider gambling (and therefore harms) in their broadest sense, incorporating gaming and all gambling products, rather than segmenting them into good/bad or land-based/online products. Segmentation of the gambling discourse makes it

easier for public health interests to be side-lined (e.g., removing local government from the discussion of online gambling regulation as demonstrated in the discourse analysis in this research). An "all-products all-harms" framing will support a system-wide approach that can better tackle the cycle of harm. It should also be noted that while gambling may look similar across London, it is not similar across England: for example, some localities may be dominated by racecourses and/or coastal family entertainment centres. By viewing gambling as a system rather than a disconnected list of products, it is possible to tackle barriers created by portraying it as heterogeneous.

4. **Recognise that there is already enough evidence,** locally, nationally, and internationally, to **implement** strategies that can address gambling harms. The literature review in this research outlined strategies implemented to reduce availability. Despite the limitations of available research, there is no excuse for further delay to await "perfect evidence". Local government should develop strategies that include, within the constraints imposed by jurisdictional boundaries, both "upstream" measures, tackling availability and marketing, and "downstream" ones (such as treatment as in the ADPH 2020 call for action [22]).

5. **Allocate a specific Gambling Harms lead within the local Public Health team.** The survey found that half of the responding Public Health teams were already doing this, with this approach further explored in my interviews. The interviews in Chapter 8 identified examples where a gambling lead had effectively implemented local government-level public health strategies. There are numerous activities that Gambling Harms leads could undertake but include proactive liaison with licensing teams to ensure that they are alerted to new gambling premises (if not already); becoming a de facto Responsible Authority for gambling premises within the licensing authority, monitoring data on gambling premises and advertising intensity and comparing with neighbouring boroughs to identify trends; ensuring meaningful contribution to their borough's gambling policy and Local Plan; taking leadership on representations (challenges to new premises applications), learning from other local public health teams; liaising with other localities to learn from best practice in addressing harms.

6. **Adopt a zero-tolerance approach to industry involvement in public health work**. My interviews demonstrated how industry involvement fundamentally led to a sense of powerlessness among local government workers. Public health teams should refuse offers

of training and training materials produced by the industry or organisations they fund and refuse to engage with industry-sponsored research. They should support the acquisition, by educational providers, of materials that are free of industry influence. Any engagement with the industry should only be done within public licensing frameworks to ensure complete transparency.

9.6.3 Recommendations for Public Health teams within a locality region, e.g. sector of London or London-wide

1. **Establish a regional gambling harms group** to harmonise approaches and share learning and best practices. The interviews in Chapter 8 gave an example of how the Yorkshire Humber Gambling Harms network can be used as a blueprint [253].

2. **Lobby nationally for public health to be a recognised Responsible Authority and for there to be a public health objective in gambling legislation**, and to revisit the proposal that gambling harms should move under the umbrella of the Department of Health and Social Care rather than the Department for Culture, Media, and Sport. Becoming an official RA would mandate that public health teams be alerted to new premises applications, formalise their role in the process, and ideally increase their visibility and empowerment, which are currently lacking, according to interviews in decision-making. A public health objective in gambling legislation would be another way local teams could be empowered by increased visibility.

3. **Support non-industry-funded research that progresses the field rather than creates policy inertia (e.g., avoid research that purely focuses on** more data gathering without any implementation, avoid more awareness raising, and focus on measures of the impact of innovations). The literature review (Chapter 3) highlighted some historical issues with the available evidence, including poor design and/or implementation without evaluation. The discourse analysis demonstrated how poor evidence leads to “a logic of low expectation” of change and policy inertia.

4. **Support population-level primary prevention strategies across London,** such as the plan to ban advertising on Transport for London. The literature review (Chapter 3) provides examples of previously enacted primary prevention population strategies.

5. **View gambling harms within The London Plan's "all-products all-harms" framing.** The mixed method analysis identified how heterogeneity was a mechanism that enabled a barrier to address gambling harms using public health approaches. Adopting this framing encompasses all gaming and gambling products, does not segment or dichotomise them (e.g., "online" vs land-based), recognises the blurred boundaries between gaming and gambling products, and shows how cross-platform technology can be used to connect physical and online gambling activity. In addition, the entire spectrum of harm is considered, including affected others, and is not limited to the narrow, stigmatised group of "problem gamblers".

9.6.4 Recommendations for London boroughs, e.g., elected members, Health and Wellbeing Boards, Health in All Policies initiatives

The following recommendations also draw on a wider reading of the gambling literature, in particular, to provide illustrations of where such recommendations have been applied elsewhere.

1. **Recognise gambling harms as a societal issue.** The societal harm outweighs the short-term gain of a filled shop and the revenue. International operators now own most gambling premises, and any money they generate will not be returned to the area, unlike the case with a small family-owned shop. They are not major local employers; given their premises' national and international nature and design, they use large contractors and not local services to maintain them. The money is extracted from the locality, and the local council is left with the cost of the harm. This is the case even with casinos that have local agreements to support the areas in which they are located financially, as casinos remain international businesses.
2. **Recognise that there IS enough evidence to act.** There is national and international evidence of harm, even as the industry constantly questions its quality. This is a "*playbook strategy*" and should be recognised as such. Regarding population-level strategies, local government has some powers over local advertising and other powers in terms of licensing and planning that could reduce land-based availability should be lobbied for. Bristol City Council has banned gambling advertisements , although only council-owned advertising billboards were included.

3. **Adopt a whole council approach to gambling harms**: While the apparent complexity of local government may daunt some, it is possible to adopt whole council approaches that bring all the relevant teams together. These can be facilitated by existing structures, such as Health and Wellbeing Boards, or programmes, such as Health in All Policies initiatives. Such cross-cutting approaches should include Public Health, Planning, Licensing, Safeguarding, and Drugs & Alcohol teams, as well as the voluntary sector (taking care to exclude those funded directly or indirectly by industry) and people with lived experience (with similar caveats). The Greater Manchester Combined Authority provides a clear example of how gambling can be framed as an "all-products all-harms" concept within a whole council approach.[204, 205, 245]

4. **Adopt an "all-products all harms" framing to gambling harms**. An all-products approach encompasses the impact of the availability of all gambling and gaming products, not just particular elements (such as "*online*"). This approach recognises how gambling harms are reinforced as a system, as elements of gaming overlap with gambling activities, and cross-platform technology can be harnessed to bridge land-based and online activities. The danger that arises if the national government focuses on online gambling is that the local government's role is diminished. The cross-platform technology that links online gambling accounts with land-based provision is ignored, as is the advertising that the mere presence of land-based gambling on the high street provides. In addition, an all-harms approach focuses upon the entire spectrum of harms, including primary prevention from an availability point of view, scrutinises educational materials provided in schools, and equally considers affected others alongside those directly harmed to any degree, rather than a narrow focus on "Problem Gamblers".

5. Transparent declarations of interest of elected members with local industry are required, as well as zero tolerance to gift acceptance. Such collaborations cannot be tolerated if reducing gambling harm is a priority. There is evidence of increasing harm (in terms of increasing availability of land-based gambling) in some areas of London that are collaborating with industry-affiliated organisations in their prevention strategies. Given the industry-friendly narrative that it endorses, local authorities should not support Safer Gambling Week. Alternative training and education providers are available. It has been well documented in the media and by organisations like the Good Law Project, a

public litigation group, that the gambling industry continues to court Members of Parliament (MPs) with hospitality, while MPs take consultancy fees from gambling operators and lobby ministers on behalf of the gambling industry. A recent example is Conservative MP Phillip Davies, co-chair of the All Party Parliamentary Group (APPG) on Betting and Gaming, who received £57,000 in consultancy fees and hospitality from Entain Holdings (the owners of Ladbrokes and Coral), including trips to Royal Ascot, Wimbledon and the Cheltenham Races, as well as writing to the incoming DCMS Secretary of State three times in her first month in office to lobby for credit reforms to be included in the White Paper, a measure that would directly benefit casinos [255]. Another example is Scott Benton, a member of parliament who reportedly offered to lobby on behalf of the gambling industry [256], especially concerning given his constituency lies in a tourist coastal area both known for its land-based gambling provision and its significant levels of deprivation. The state of Victoria in Australia has developed a Gambling Industry Funding Policy that can be used as a template for a policy of zero tolerance in public health work [257], and the UK's ADPH 2024 statement includes their position on the involvement of the industry [250].

9.6.5 Recommendations for future research

The recommendations for future research here are subject to the caveat that they do not preclude action now.

1. Further collection of evidence of local government public health initiatives to address gambling harms to support or refute the mechanisms proposed in my mixed method analysis. This research aims to validate the mechanisms identified in this research and identify new ones. Interviews can be conducted with public health teams in local governments who have implemented strategies to address gambling harms in their locality, and the process, outcomes and reflections can be explored. An abductive thematic analysis approach can be used, aligning new findings to already identified mechanisms and having scope to identify new ones. Retrodiction (study of the interaction of mechanisms in reinforcing, moderating or counteracting each other) can also be undertaken to gain further insights. The findings would reinforce the arguments in this research and identify new mechanisms that may act as levers or barriers to addressing gambling harms in the local

setting. Findings can be shared with local authorities to assist them in addressing these underlying factors that may otherwise prevent progress in addressing harms.

2. Research to understand how local planning teams perceive a public health approach to gambling harms; and

3. Research to understand how local council members perceive a public health approach to gambling harms. This research aims to understand how different critical stakeholders within local government conceptualise public health approaches to addressing gambling harms and identify any levers and barriers.

Given that local government is tasked with adopting "*whole council approaches*" to address gambling harms [199, 201], it is crucial to understand how different groups within local government understand public health approaches, identifying both alignment and areas of convergence. The findings would build upon the interviews with public health and licensing teams in this thesis. The themes that were identified in those interviews were that gambling can be harmful, whatever form it takes, those addressing harm feel powerless, and a lack of knowledge of what public health teams do. Interviews can be conducted with these stakeholders using a thematic analysis with an abductive approach, populating already identified themes but providing scope to identify new ones. The findings will deepen understanding of similarities and differences across different teams in local government in terms of how they conceptualise public health approaches to gambling harms, and significant given that a "*Whole Council Approach*" to addressing gambling harms is endorsed by national bodies that represent local government [22, 199].

4. Ongoing analysis of trends in land-based gambling premises and advertising data regarding type, number and links to inequitable availability. Gambling premises data, supplied by local licensing authorities, continues to be published on the Gambling Commission website [4]. This research would aim to provide quantitative data that can be used by public health and licensing teams to support their strategies to address gambling harms. This might include quantitative evidence that gambling premises are concentrated in deprived areas or that gambling availability is changing within a locality (such as increases in arcades and bingo provision). This can help to tailor local responses. The premises data that will be collected includes the type and location of gambling premises, and this can be mapped to deprivation (using independent ranking such as the Index of Multiple

Deprivation [169], and controlled for demographics and political context). Data analysis using Geographical Information Software (GIS) can be used, as well as cross-referencing with data published on the regulator's website [4]. The findings will provide quantitative evidence to support or refute claims made in, for example, challenges to gambling premises application and/or licensing conditions and to support any local gambling policy change implementation.

5. Analysis of land-based gambling advertising

This research aims to provide empirical data that public health teams can use to support their strategies to address gambling harms. This analysis will establish if there is a relationship between advertising exposure and deprivation and whether land-based advertising is "cross-platform" in nature (that is, whether land-based gambling advertising is signposting to online gambling). In-person data collection about land-based advertising's location, the type of gambling product(s) being advertised, and the presence of cross-platform advertising can be mapped to deprivation.[4] The location of advertising can be recorded using mobile technology such as "*what3words*" [258] and mapped to deprivation using Geographical Information Software and Indices of Deprivation [169]. The findings will provide empirical evidence to support local public health teams' strategies to address gambling harms in their locality, such as implementing advertising bans on harmful products. In addition, if cross-platform advertising is present, this evidence can potentially strengthen the role of local government in the national gambling harms strategy. Currently, there is a dominant narrative of "land-based vs online gambling". This has led to local government being marginalised in national policy, given the national agenda is focusing on policies "*fit for the digital age*" [5]. If this research shows that cross-platform advertising is present, it provides evidence that such a narrative creates a false dichotomy.

6. Research to understand the quality and content of the contemporary field of gambling evidence based on the 2013 Fair Game analysis principles.

This research aims to understand and explain how the current gambling research field has remained the same or changed since the 2013 *Fair Game* Report [95]. The original report

[4] This project has already been approved as a Barts and The London Medical School medical student SSC (student selected component) project in collaboration with Haringey Council, for the academic year 2024/2025

presented findings from interviews under various themes such as problems undertaking research, what counts as evidence, money, the field of gambling studies, and access. New research a decade on can identify whether any new themes have arisen or if the fundamental issues remain in undertaking gambling research.[5]

The methods deployed will mirror the 2013 report so that the comparison can be made more readily. Interviews with gambling researchers can use an abductive thematic analysis approach, populating previously identified themes and leaving scope to identify new ones. In addition, Fair Game 2013 produced a 'word cloud' of the key gambling journals' article titles to visually represent the dominant discourses in the research field at that time concerning gambling research; this same method could be used again using the same journals, for comparisons to be made. The findings can help early career researchers more readily navigate the gambling research field, which, in my own experience as a researcher for this thesis, remains the "*complex and politicised activity*" as described in Fair Game.

Any research undertaken needs to report clearly any conflicts of interest and involvement of intermediaries, which must include any current and former relationships to the gambling industry, either directly or indirectly- while acknowledging that declaring conflicts of interest does not remove them. Future research should be funded by non-industry sources and supported by academic institutions that do not receive gambling industry funding, either directly or via intermediaries such as GambleAware.

9.7 Conclusions

This research concludes that while they vary, local public health teams must come together and commit to conceptualising gambling harms as a public health risk. If they do not do this is that other stakeholders will then capture the dominant discourse about what a public health solution looks like. An "all-products all harms" strategy that can look to previous alcohol harms strategy for guidance and language, that considers WHO "Best Buys" of availability and marketing (if price is outside of scope to shape), that considers provenance of local education provision and that evaluates interventions is recommended. A gambling lead or allocated member within a public health team to support this strategy

[5] This research project has already been discussed with international gambling researchers aligned to Critical Gambling Studies journal and has the support of the original Fair Game authors to proceed.

implementation is also recommended and there are examples from other parts of the UK that London can draw upon.

National legislative changes can assist this commitment at a local public health level, making Public Health a responsible authority in gambling licensure and withdrawing the statutory aim to permit new gambling premises in the new Gambling Act. There is precedent for legislation having a public health objective in the Scottish Licensing Act, and public health should lobby for this within gambling legislation, as well as a transfer of the gambling harms strategy over to the Department of Health and Social Care from the Department of Culture Media and Sport, where it currently resides.

If national legislative changes are not forthcoming, one way forward is for local public health to liaise more closely with local planning to influence local plans directly, given that this document becomes legislation once ratified. Too narrow a focus on certain types of gambling within local plans is cautioned, given the continuously changing nature of the physical and online gambling landscape and the overall system of harm that has been created.

Finally, policymakers and public health practitioners must recognise the harm of involving industry as a legitimate stakeholder. The “safer gambling” narrative, which places the onus on individuals to enact change once monies are lost and stigmatises the gambler, only continues the cycle of harm. Industry-funded educational materials and those promoting a pro-industry narrative should be rejected. Meetings with industry representatives must be transparent and exclude discussing policies to reduce harm.

The current political and economic climate leaves local governments increasingly short of funding to provide anything but what is viewed as “core business.” In reality, addressing gambling harms using public health approaches will be one of many issues adversely influenced by vested interests and financial constraints facing those working at the front lines of service delivery.

In its simplest terms, public health focuses on preventing ill health, prolonging life, and promoting health through the organised efforts of society. In terms of gambling harms, a focus on primary prevention strategies using an “all harms, all products” approach that recognises the negative impact of the gambling industry as a stakeholder in decision-making at all policy and legislative levels will help achieve this goal.

Appendices

Appendix 1. Summary of Included Studies

Author	Year	Funding	Location	Intervention	Type of Intervention	Measures reported (if any)	Comments
McMillen & Pitt	2005	COMMISSIONED BY ACT GAMBLING AND RACING COMMISSION	ACT, Australia	3hr EGM shutdown 04:00-07:00am	reduce availability	economic impact, self reporting of PGs	implemented at same time as two other interventions
				bet limit of $AUD10	monetary restriction (in)	economic impact, self reporting of PGs	implemented at same time as two other interventions
				game machine adaptations	EGM structural characteristic changes	economic impact, self reporting of PGs	implemented at same time as two other interventions
AC Neilson	2003	NSW Department of Gaming and Racing	NSW, Australia	3 hr EGM shutdown (variable times)	reduce availability	qualitative interviews with gamblers, their families and support workers	variable shutdown times can mean ongoing availability; casino exempt from shutdown; self reporting small sample
Tuffin & Parr	2008	*Financial assistance for this Project was provided by the New South Wales Government from the Responsible Gambling Fund. The views expressed in this publication however, are solely those of the author/s.*	NSW, Australia	6 hr EGM shutdown (variable times)	reduce availability	quantitative and qualitative interviews (n=277) with gamblers, venues, gambling support agencies, and the wider community; use of the CPGI to categorise those who gamble	half of those recruited near EGM closing time; variable closing time of venues, exemptions and reduction of shutdown times

Corporate Research Associates	2006	Nova Scotia Gaming Corporation, 2006	Nova Scotia, Canada	VLT shutdown (outside of casinos) at midnight CHECK DURATION	reduce availability	survey of gamblers categorised by the CPGI and gambling product used; measuring gambling expenditure	first of four measures implemented over 8 month period
				25% reduction in VLTs	reduce availability	survey of gamblers categorised by the CPGI and gambling product used; measuring gambling expenditure	second of four measures implemented-results carried over from stage 1 results?
				30% reduction in EGM spin speeds	EGM structural characteristic changes	survey of gamblers categorised by the CPGI and gambling product used; measuring gambling expenditure	third of four measures implemented; implemented at same time as STOP feature removed from EGMs; results reported in comparison to previous implementation stage
				removal of STOP buttons	EGM structural characteristic changes	not reported as primary outcome	reduction of EGM speed implemented at same time; results presented in comparison to stage 2 of implementation strategy
Erwin et al	2022	This study was funded by the New Zealand Ministry of Health	New Zealand local government	prohibiting transfer of EGM licenses leading to gradual reduction	reduce availability	gambling expenditure	no comment can be made if gambling activity diverted elsewhere e.g., online
South Australian Centre for Economic Studies	2005	Funded by the Victorian Government through the Community Support Fund. Established in 1991, the Community Support Fund (CSF) is a trust fund governed	Victoria, Australia	reduction of EGMs by 5% across the state	reduce availability	gambler losses, help-seeking by problem gamblers did not change, revenue losses in venues	the areas with these new caps tended to be areas with the highest EGM per capita ratios to begin with, and a further study noted those machines removed were the least profitable and the least popular

		by the Gambling Regulation Act 2003 to direct a portion of gaming revenue back to the community.					
Delfabbro et al	2008	unknown	South Australia, Australia	reduction of EGMs by 14.5% across the state	reduce availability	a single-stage survey of 400 “regular” (defined as playing at least twice monthly) machine players being undertaken a year after reduction; asked about impact on frequency and expenditure of gambling	self reported measures of "regular" gamblers only unclear how recruited
Carr	1996	unknown	South Dakota, USA	EGM ban (for 11 months)	reduce availability	substance abuse centre inquires and referrals	short-term ban; surrogate markers of harm used in terms of treatment centre impact
Bridwell	2002	unknown	South Carolina, USA	EGM ban	reduce availability	number of active Gamblers Anonymous groups, calls to state gambling helpline	surrogate markers of harm
Welte	2016	unknown	various states, USA	various gambling provision types	reduce availability	survey of gambling activity and expenditure	self-reported; some measures reported for Problem Gamblers only
McKevitt	2023	This work was supported by the National Institute for Health and Care Research (NIHR) School for Public Health Research (SPHR) (grant number PD-SPH-2015). FDV is supported by the NIHR	local authorities, England	restricting gambling advertising	marketing	no evaluation	

		Applied Research Collaboration West (NIHR ARC West).					
Ontario Lottery and Gaming Corporation	2005/ 2007	personal communication cited in Williams 2012	Ontario, Canada	dispelling myths about slot machines	counter-marketing	before and after implementation surveys	gamblers only, unsure how recruited; full results unavailable
Najavits	2003	unknown	Indiana, USA	advertising campaign raising awareness about Problem Gambling	raising awareness	telephone survey of 400 adults	?how recruited, small number
Victorian government	1995	reported in evidence summary	Victoria, Australia	advertising campaign raising awareness about Problem Gambling	raising awareness	calls to gambling helpline	full results unavailable
Victorian government	2001	reported in evidence summary	Victoria, Australia	advertising campaign raising awareness about Problem Gambling	raising awareness	calls to gambling helpline; self referral for treatment	full results unavailable
Elbers et al	2022	industry	Leeds, United Kingdom	problem gambling awareness campaign with population	raising awareness	no evaluation	gambling industry funded
				problem gambling awareness training with staff			gambling industry funded
Brodie et al	2003	Queensland Treasury	Queensland, Australia	bank note value acceptor limits	EGM structural characteristic changes	EGM revenue and population survey opinion on policy	small number in population survey played EGMs
				maximum amount per session of play	monetary restriction (in)	EGM revenue and population survey opinion on policy	small number in population survey played EGMs
Thomas et al	2013	unknown	Victoria, Australia	ATM removal	monetary restriction (in)	EGM state-level expenditure; pre and post implementation survey of PGs and ex-PGs; time	survey was secondary evaluation, primary was economic impact

						and money spent at gabling venues	
Lal & Siahpush	2008	AL is supported by the Victorian Health Promotion Foundation (VicHealth) and The Cancer Council Victoria. MS is supported by a fellowship from the Victorian Health Promotion Foundation (VicHealth). At the time of preparing this paper MS was supported by a fellowship from the Victorian Health Promotion Foundation.	Victoria, Australia	smoking ban in gambling venues	concurrent ban of other harmful products	EGM expenditure	casino exempt

Key for funding status of studies:

Non-industry funded
Industry funded or affiliations
Unknown

Appendix 2. Database Searches

Database	Retrieved	Included	Unavailable	Search	
Medline	51	11	2	1	(gambl* or betting or bet or bets or slot machine* or fruit 1275 machine* or "game* of chance" or casino* or scratch card* or poker or roulette).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]
				2	exp Gambling Disorder/ or exp Gambling/
				3	1 or 2
				4	local government/ or state government/
				5	(govern* adj5 (local* or state or city or cities or municipa 952 l or county or metropolitan)).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]
				6	4 or 5
				7	3 and 6
Embase	281	17	1	1	(gambl* or betting or bet or bets or slot machine* or fruit 1275 machine* or "game* of chance" or casino* or scratch card* or poker or roulette).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]
				2	gambling.mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]
				3	1 or 2

				4	local government/ or state government/
				5	(govern* adj5 (local* or state or city or cities or municipa 952 l or county or metropolitan)).mp. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]
				6	4 or 5
				7	3 and 6
Scopus	141	15			(TITLE-ABS-KEY (gambling/) OR TITLE-ABS- KEY (gambl* OR betting OR bet OR bets OR slot AND machine* OR fruit AND machine* OR "game* of chance" OR casino* OR scratch AND card* OR poker OR roulette OR egm OR "electronic gaming machines" OR lotter*) AND TITLE-ABS- KEY (local AND government* OR state AND government OR (govern* W/5 (local* OR stat e OR city OR cities OR municipal OR county OR metropolitan OR provi))))
Social Policy and Practice	67	2		1	(gambl* or betting or bet or bets or slot machine* or "fruit machine*" or "game* of chance" or casino* or scratch card* or poker or roulette or EGM or FOBT).mp. [mp=abstract, title, publication type, heading word, accession number]
				2	((govern* adj5 local) or state or city or cities or municipal or county or metropolitan).mp. [mp=abstract, title, publication type, heading word, accession number]
				2	1 and 2
Global Health	15	6		1	gambling.mp. [mp=abstract, title, original title, heading words, cabicodes words]
				2	(gambl* or betting or bet or bets or slot machine* or fruit machine* or "game* of chance" or casino* or scratch card* or poker or roulette or EGM or "electronic gaming machine").mp. [mp=abstract, title, original title, heading words, cabicodes words]
				3	1 or 2
				4	local government/ or state government/
				5	(govern* adj5 (local* or state or city or cities or province or municipal or county or metropolitan)).mp. [mp=abstract, title, original title, heading words, cabicodes words]
				6	4 or 5
				7	3 and 6
	50	7		1	exp Gambling Disorder/ or exp Gambling/

Psych Info				2	(gambl* or betting or bet or bets or slot machine* or fruit machine* or "game* of chance" or casino* or scratch card* or poker or roulette or EGM or "electronic gaming machine").mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]
				3	1 or 2
				4	(govern* adj5 (local* or state or city or cities or municipal or province or county or metropolitan)).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]
				5	3 and 4
CINAHL	161	11			gambl* OR betting OR bet OR bets OR slot machine* OR "fruit machine*" OR "game* of chance" OR casino* OR scratch card* OR poker OR roulette OR EGM OR FOBT
					govern* NEAR/5 local OR state OR city OR cities OR municipal OR county OR metropolitan

Appendix 3. DPH Survey information Sheet

Survey: Participant Information Sheet March 2022

Title of Project: Gambling with the health of Londoners-what are the levers and barriers in Local Government to adopting a Public Health approach to tackling gambling harms?

Name of Researcher responsible for project: Dr Jenny Blythe

Contact details: jenny.blythe@lshtm.ac.uk

Introduction

We would like to invite you to take part in a research study. Joining the study is entirely up to you. Before you decide, you need to understand why the research is being done and what it would involve. One of our team will go through this information sheet with you, and answer any questions you may have. Ask questions if anything you read is not clear or you would like more information. Please feel free to talk to others about the study if you wish. Take time to decide whether or not to take part.

What is the purpose of the study?

Gambling harms are increasingly conceptualised as a public health issue. This NIHR fully-funded PhD, based at The London School of Hygiene and Tropical Medicine (LSHTM) aims to understand the levers and barriers to adopting public health strategies to address gambling-related harms at the Local Authority level in London.

The research will comprise of a survey of public health teams in London, a critical discourse analysis of the relevant documents, and interviews with those either recruited via the

survey or representatives from local government (eg public health, licensing, elected members) directly approached by the researcher.

Why have I been asked to take part?

You have been invited because you represent a local public health team within London. With the survey, we want to understand how differing structures of organisation, local authority and public health team strategy and staffing may influence both influence and interest addressing gambling harms at the local authority level.

Do I have to take part?

No. It is up to you to decide to take part or not. We will discuss the study together and give you a copy of this information sheet. If you agree to take part, we will then ask you to sign a consent form.

What will happen to me if I take part?

Once you have signed and returned the consent form, you will be sent a link to complete and submit and an online survey.

What will I have to do?

You will receive an online link to take you to a survey to complete. The survey comprises of less than 20 questions and should not take longer than 15 – 30 minutes to complete. You will be asked what London borough you represent, but this information is for research purposes only and all reported results of the survey via presentation or publication will be anonymised.

You will also be asked if you wish to be approached at a later date for interview and asked to provide an email address if you agree to this: these contact details will be removed from the survey on receipt of return of the survey and stored separately to the survey results.

What are the possible risks and disadvantages?

Although the survey is asking about your organization's approach to gambling harms, we recognise that you may have experience of gambling harms personally, and signposting to the relevant national support services is included within the survey.

What are the possible benefits?

We cannot promise the study will help you but the information we get from the study will help our knowledge and understanding of this research area.

What if something goes wrong?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting Patricia Henley at rgio@lshtm.ac.uk or +44 (0) 20 7927 2626>

The London School of Hygiene and Tropical Medicine holds insurance policies which apply to this study. If you experience harm or injury as a result of taking part in this study, you may be eligible to claim compensation.

Can I change my mind about taking part?

Yes. You can withdraw from the study at any time.

If you withdraw from the study we will destroy the copy of your survey responses.

What will happen to information collected?

We will need to use information for this research project. All information collected about you will be kept private. Only the study staff and authorities who check that the study is being carried out properly will be allowed to look at information about you. Information will include your name and contact details.

We will keep all information about you safe and secure.

Your personal details, meaning your name and other identifiable information, will be kept in a different safe place to the other study information and will be destroyed within 10 years of the end of the study.

At the end of the project, the study data will be archived at LSHTM. The data will be made available to other researchers worldwide for research and to improve knowledge on the topic. Your personal information will not be included and there is no way that you can be identified.

What are your choices about how your information is used?

You can stop being part of the study at any time, without giving a reason.

Where can you find out more about how your information is used?

You can find out more about how we use your information · At https://www.lshtm.ac.uk/files/research-participant-privacy-notice.pdf

What will happen to the results of this study?

The study results will be published in an academic journal so that other professionals can learn from them. Your personal information will not be included in the study report and there is no way that you can be identified from it.

Who is organising and funding this study?

London School of Hygiene & Tropical Medicine is the sponsor for the research and they have full responsibility for the project including the collection, storage and analysis of your data,

and will act as the Data Controller for the study. This means that we are responsible for looking after your information and using it properly.

Who has reviewed this study?

All research involving human participants is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by The London School of Hygiene and Tropical Medicine Research Ethics Committee Ref 26646.

Further information and contact details

Thank you for taking time to read this information sheet. If you think you will take part in the study please read and sign the consent form.

If you would like any further information, please contact the researcher who can answer any questions you may have about the study.

Contact details: Dr Jenny Blythe: jenny.blythe@lshtm.ac.uk

Appendix 4. DPH Survey Consent Form

Survey Consent Form March 2022

Title of Project: Gambling with the health of Londoners-what are the levers and barriers in Local Government to adopting a Public Health approach to tackling gambling harms?

Name of PI/Researcher responsible for project: Dr Jenny Blythe

Statement	**Please initial or thumbprint* each box**
I confirm that I have read and understood the information sheet dated……..(version…….) for the above named study. I have had the opportunity to consider the information, ask questions and have these answered satisfactorily.	
I understand that my consent is voluntary and that I am free to withdraw this consent at any time.	
I understand that relevant sections of data collected during the study may be looked at by authorised individuals from The London School of Hygiene and Tropical Medicine where it is relevant to my/the participant's taking part in this research. I give permission for these individuals to have access to these records.	
I understand that data will not be uploaded onto a data repository, but may be shared by sharing directly with other researchers at the	

discretion of the Primary Investigator, and that I will not be identifiable from this information.	
I agree to me/the participant taking part in the above named study.	

Signature of Participant Name in print Date

Signature of Primary Investigator Name in print Date

Appendix 5. DPH Survey Questions

1. Please indicate your Borough (information for analysis purposes only-any identifiable features from survey will be anonymised for public reports)

2. Where is the public health team placed within the local authority borough structure? Select from: Not based here-hosted by another local authority; Own distinct directorate; Part of another directorate; Distributed across other directorates of local authority functions; Other (please specify)

3. How many FTE staff within your public health team? (numerical answer)

4. Does your local authority have a Health in All Policies (HiAP) working group/team or equivalent? Select from: Yes currently; No currently; Yes Previously; Don't Know

5. Is a public health team member either chair or joint chair of the Health and Wellbeing Board? Select from: Yes currently; No currently; Yes Previously; Don't Know

6. Does a public health team member have a formal role on the local authority's licensing committee? Select from: Yes currently; No currently; Yes Previously; Don't Know

7. Is gambling-related harm a priority within your local authority? Select from: Yes currently; No currently; Yes Previously; Don't Know

8. Is gambling and/or its related harms either a priority within your public health team? Select from: Yes currently; No currently; Yes Previously; Don't Know

9. Did your local authority respond to Government's call for evidence in relation to the Gambling Act review? Select from Yes; No; Don't Know

10. Is someone on your public health team presently allocated to gambling? Select from: Yes currently; No currently; Yes Previously; Don't Know

11. Which other local authority teams and/or external partnerships do you most closely work with at present on public health interventions (e.g., planning department, community interventions for obesity)? Do you feel these partnerships are effective? (free text response)

Please rate the following statements from 1 (strongly Disagree) to 5 (strongly Agree):

12. I consider gambling harms a public health issue.
13. I feel confident to present gambling and its related harms as a public health issue to other departments within the local authority and/or other local organisations.
14. The public health team was given the opportunity to meaningfully inform the most recent local authority gambling license policy process.
15. The public health team was given the opportunity to meaningfully inform the most recent Local Authority alcohol license policy process.
16. I am confident the public health team presently has influence on the Health and Wellbeing Board
17. I am confident the public health team presently has influence on local authority alcohol premises licensing decisions
18. I am confident the public health team presently has influence on local authority gambling premises licensing decisions
19. We are hoping to interview local public health representatives as part of this PhD thesis to further understand the levers and barriers to local authorities adopting public health strategies to address gambling harms. If you would be happy to be contacted to be interviewed, please enter your email address here (this contact information will be removed and held separately on receipt of survey)

Appendix 6. List of Documents included in Discourse Analysis

Title	Year	Author	Type
Gambling Review Report ("Budd Report")	2001	A Budd et al	NAT
Budd Parliamentary discussion transcript	2001	Westminster MPs	NAT
Safer Bet for Success	2002	Department for Culture, Media & Sport	NAT
Draft Bill	2003	Department for Culture, Media & Sport	NAT
Gambling Act	2005	Department for Culture, Media & Sport	NAT
Islington Local Plan	2011	Islington Council	LOC
a bet worth taking?	2012	Department for Culture, Media & Sport	NAT
Gambling Regulation: Councillor handbook (England and Wales)	2015	Local Government Association	LOC
Health on the high street	2015	Royal Society of Public Health	NGO
Building on Success	2015	London Councils	CIT
Cards on the Table	2016	IPPR	NGO
Call for evidence-social responsibility and gaming machines	2016	Department for Culture, Media & Sport	NAT
Response to call for evidence	2016	William Hill	IND
Response to call for evidence	2016	Betfred	IND
Response to call for evidence	2016	ABB	IND
Response to call for evidence	2016	Senet Group	IND
Response to call for evidence	2016	Opera	IND
Response to call for evidence	2016	Local Government Association	LOC
Response to call for evidence	2016	Knowsley Council	LOC
Response to call for evidence	2016	NE Lincolnshire Council	LOC
Response to call for evidence	2016	Wolverhampton City Council	LOC
Response to call for evidence	2016	Wandsworth	LOC
Response to call for evidence	2016	Peterborough Council	LOC
Response to call for evidence	2016	Newham Council	LOC
Response to call for evidence	2016	Newcastle City Council	LOC
Response to call for evidence	2016	Lewisham	LOC
Response to call for evidence	2016	Leicester City Council	LOC
Response to call for evidence	2016	Leeds City Council	LOC
Response to call for evidence	2016	Sheffield City Council	LOC
Response to call for evidence	2016	Hackney Council	LOC
Response to call for evidence	2016	Enfield Council	LOC
Response to call for evidence	2016	Bradford City Council	LOC
Response to call for evidence	2016	Islington Council	LOC
Response to call for evidence	2016	Ealing Council	LOC
Response to call for evidence	2016	Sunderland Council	LOC
Response to call for evidence	2016	Tower Hamlets Council	LOC

Response to call for evidence	2016	Medway Council	LOC
Response to call for evidence	2016	Rochdale Council	LOC
Response to call for evidence	2016	Hounslow Council	LOC
Response to call for evidence	2016	Greenwich Council	LOC
Response to call for evidence	2016	Barking and Dagenham Council	LOC
Response to call for evidence	2016	Haringey Council	LOC
Review of Gaming Machines and Social Responsibility Measures Local Government Association response	2016	Local Government Association	LOC
Position Statement	2016	Gambling Commission	NGO
Licensing Authority Bulletin-Jan	2016	Gambling Commission	NGO
Licensing Authority Bulletin-Feb	2016	Gambling Commission	NGO
Licensing Authority Bulletins-Mar	2016	Gambling Commission	NGO
Licensing Authority Bulletin-April	2016	Gambling Commission	NGO
Licensing Authority Bulletin-June	2016	Gambling Commission	NGO
Licensing Authority Bulletin-Summer	2016	Gambling Commission	NGO
Licensing Authority Bulletin-Oct	2016	Gambling Commission	NGO
Licensing Authority Bulletin-Dec	2016	Gambling Commission	NGO
Licensing Authority Bulletin-Jan	2017	Gambling Commission	NGO
Licensing Authority Bulletin-Feb	2017	Gambling Commission	NGO
Licensing Authority Bulletins-Mar	2017	Gambling Commission	NGO
Licensing Authority Bulletin-April	2017	Gambling Commission	NGO
Licensing Authority Bulletin-June	2017	Gambling Commission	NGO
Licensing Authority Bulletin-Summer	2017	Gambling Commission	NGO
Licensing Authority Bulletin-Oct	2017	Gambling Commission	NGO
Licensing Authority Bulletin-Nov	2017	Gambling Commission	NGO
Licensing Authority Bulletin-Dec	2017	Gambling Commission	NGO
Position Statement Gambling Harms	2018	Faculty of Public Heath	NGO
Government response to consultation on proposals for changes to Gaming Machines and Social Responsibility Measures	2018	Department for Culture, Media & Sport	NAT
Healthy streets 2: running on empty	2018	Royal Society of Public Health	NGO
Whole Council approach to Problem Gambling	2018	London Councils	CIT
Gambling Regulation: Councillor handbook (England and Wales)	2018	Local Government Association	LOC
Tackling gambling-related harm-a whole council approach	2018	Local Government Association/Public Health England	LOC
Public Health and gambling	2018	Gambling Commission	NGO
Licensing Authority Bulletin-Jan	2018	Gambling Commission	NGO
Licensing Authority Bulletin-Feb	2018	Gambling Commission	NGO
Licensing Authority Bulletins-Mar	2018	Gambling Commission	NGO
Licensing Authority Bulletin-April	2018	Gambling Commission	NGO
Licensing Authority Bulletin-June	2018	Gambling Commission	NGO
Licensing Authority Bulletin-Summer	2018	Gambling Commission	NGO

Licensing Authority Bulletin-Oct	2018	Gambling Commission	NGO
Licensing Authority Bulletin-Nov	2018	Gambling Commission	NGO
Redbridge Local Plan	2018	Redbridge Council	LOC
National Strategy to reduce gambling harms	2019	Responsible Gambling Strategy Board	NGO
Licensing Authority Bulletin-Feb	2019	Gambling Commission	NGO
Licensing Authority Bulletins-Mar	2019	Gambling Commission	NGO
Licensing Authority Bulletin-April	2019	Gambling Commission	NGO
Licensing Authority Bulletin-June	2019	Gambling Commission	NGO
Licensing Authority Bulletin-Summer	2019	Gambling Commission	NGO
Licensing Authority Bulletin-September	2019	Gambling Commission	NGO
Licensing Authority Bulletin-Oct	2019	Gambling Commission	NGO
Licensing Authority Bulletin-Dec	2019	Gambling Commission	NGO
National strategy year one review	2020	Responsible Gambling Strategy Board	NGO
National Audit Office-Problem Gambling and vulnerable	2020	National Audit Office	NGO
APPG-online gambling	2020	All Party Parliamentary group	NAT
House of Lords-gambling harms	2020	House of Lords	NAT
Government response to House of Lords report	2020	Department for Culture, Media & Sport	NAT
Advertising and Sponsorship Policy	2020	Bristol City Council	LOC
Public Accounts Committee report	2020	Public Accounts Committee	NGO
Call for evidence-gambling act review	2020	Department for Culture, Media & Sport	NAT
Licensing Authority Bulletin-Jan	2020	Gambling Commission	NGO
Licensing Authority Bulletin-Feb	2020	Gambling Commission	NGO
Licensing Authority Bulletins-April	2020	Gambling Commission	NGO
Licensing Authority Bulletin-June	2020	Gambling Commission	NGO
Licensing Authority Bulletin-August	2020	Gambling Commission	NGO
Licensing Authority Bulletin-September	2020	Gambling Commission	NGO
Licensing Authority Bulletin-Dec	2020	Gambling Commission	NGO
Waltham Forest Local Plan	2020	Waltham Forest Council	LOC
Hackney Local Plan	2020	Hackney Borough Council	LOC
Barking and Dagenham Gambling Policy	2021	Barking & Dagenham Council	LOC
Barnet Gambling Policy	2021	Barnet Council	LOC
Bexley Gambling Policy	2021	Bexley Council	LOC
Brent Gambling Policy	2021	Brent Council	LOC
Bromley Gambling Policy	2021	Bromley Council	LOC
Camden Gambling Policy	2021	Camden Council (with Islington)	LOC
Croydon Gambling Policy	2021	Corydon Council	LOC
Ealing Gambling Policy	2021	Ealing Council	LOC
Enfield Gambling Policy	2021	Enfield Council	LOC
Greenwich Gambling Policy	2021	Greenwich Council	LOC

Hackney Gambling Policy	2021	Hackney Borough Council	LOC
Hammersmith and Fulham Gambling Policy	2021	Hammersmith & Fulham Council	LOC
Harringey Gambling Policy	2021	Haringey Council	LOC
Harrow Gambling Policy	2021	Harrow Council	LOC
Havering Gambling Policy	2021	Havering Council	LOC
Hillingdon Gambling Policy	2021	Hillingdon Council	LOC
Hounslow Gambling Policy	2021	Hounslow Council	LOC
Islington Gambling Policy	2021	Islington Council (with Camden)	LOC
Kensington and Chelsea Gambling Policy	2021	Kensington & Chelsea Council	LOC
Kingston Gambling Policy	2021	Kingston Council	LOC
Lambeth Gambling Policy	2021	Lambeth Council	LOC
Lewisham Gambling Policy	2021	Lewisham Council	LOC
Merton Gambling Policy	2021	Merton Council	LOC
Newham Gambling Policy	2021	Newham Council	LOC
Redbridge Gambling Policy	2021	Redbridge Council	LOC
Richmond Gambling Policy	2021	Richmond Council	LOC
Southwark Gambling Policy	2021	Southwark Council	LOC
Sutton Gambling Policy	2021	Sutton Council	LOC
Tower Hamlets Gambling Policy	2021	Tower Hamlets Council	LOC
Waltham Forest Gambling Policy	2021	Waltham Forest Council	LOC
Wandsworth Gambling Policy	2021	Wandsworth Council	LOC
Westminster Gambling Policy	2021	Westminster City Council	LOC
National Strategy year two review	2021	Responsible Gambling Strategy Board	NGO
Gambling Regulation: Councillor handbook (England and Wales)	2021	Local Government Association	LOC
PHE evidence summary	2021	Public Health England	NGO
Licensing Authority Bulletin-March	2021	Gambling Commission	NGO
Licensing Authority Bulletin-Dec	2021	Gambling Commission	NGO
Nat strategy year three review	2022	Responsible Gambling Strategy Board	NGO
Written evidence for Gambling Act review	2022	Local Government Association	LOC
Written evidence for Gambling Act review	2022	Greater Manchester Combined Authority	CIT
Written evidence for Gambling Act review	2022	Association for Directors of Public Health/Faculty of Public Health	LOC
Written evidence for Gambling Act review	2022	BACTA	IND
Brent Local Plan	2022	Brent Council	LOC
Top 10 tips for Councils	2022	Centre for Governance & Scrutiny	NGO
Licensing Authority Bulletin-March	2022	Gambling Commission	NGO
Licensing Authority Bulletin-June	2022	Gambling Commission	NGO

Licensing Authority Bulletin-Dec	2022	Gambling Commission	NGO
Southwark Local Plan	2022	Southwark Council	LOC
Toolkit for Local Authorities	2023	Gambling Commission	NGO
Licensing Authority Bulletins-Mar	2023	Gambling Commission	NGO
High Stakes-Gambling Act white paper	2023	Department for Culture, Media & Sport	NAT

Appendix 7. Discourse Analysis additional quotes

Type of logic	Sub-logic	Additional quotes	Reference
Social	The social logic of legislation	*"The licensing of premises should remain a local decision, but that decision should transfer from magistrates to local authorities"*	Budd Report C18
	The social logic of localism	*"Those who said they were opposed to the establishment of a single regulatory body argued that it would be remote from a local feeling"*	Budd Report C18
		"The Government wants local people to have a say in decisions that affect their lives…licensing authorities should be accountable to the electorate for the decisions they take"	Safe Bet 2002
		"Power should therefore be given to local government to design interventions that respond to local opportunities and challenges as they arise"	London Councils 2015
		"Our general approach in this report has therefore been to support…delegation of decisions to those most knowledgeable about their likely impacts, local authorities"	DCMS 2012
		"Crucially, local Councillor's know and understand their areas as well as anyone, and are well-placed to contribute to the development of local area profiles"	LGA 2015a
	The high street	*The physical environment surrounds our lives, and in subtle and not so subtle ways, affects our health. This campaign focusses on one aspect of place as a determinant of health – the high street retail environment*.	RSPH 2018
		"Changes to gambling laws could have a powerful and enduring effect on what our towns and cities look like, and on how they feel to live in or visit".	DCMS 2002
	The social logic of evidence		

	Policy being evidence based	*"Public Health actions adopted need good evidence"*	RSGB 2016
		"The National Institute for Health and Care Excellence should assess the growing evidence base on the health risks and co-morbidities associated with gambling-related harm"	RSGB 2016
		"Councils would need a robust evidence base to include restrictions on betting shops"	GC/PHE 2018
		"We will seek views from licensing and local authorities…and consider these alongside any evidence they can provide to demonstrate the necessity for these changes"	DCMS 2020a
		"This [Gambling Act] Review is about using the evidence to assess whether we have the balance of regulation right"	DCMS 2020a
		"The aim [of the review] has been to take an objective, comprehensive look at the evidence…and asses the available evidence"	DCMS 2023
	Supporting social logics statements		
	Role of Local Authorities	"They [local government public health teams] *are already holding a lot of data on vulnerable groups"*	GC 2018a
		"Provide local authority area prevalence data"	GC 2018b
	Poor quality evidence	*"There has been insufficient data collected to establish whether or not the 2005 Act has been successful in its aim of protecting children from gambling. This highlights a particular need for more research in this area*	DCMS 2012
		"Many prevention measures are already in place, whilst others are being developed. However, not enough is known collectively about which of these activities and programmes designed to prevent gambling harms should be extended or applied in order to achieve maximum impact	GC 2018b

		"There are gaps in the data and intelligence the Commission uses to identify the problems consumers are experiencing with gambling services or operators".	NAO 2020
		gambling disorder and gambling-related harms are usually attributable to complex Interactions between multiple factors…we cannot straightforwardly quantify the likely reduction in gambling-related harm for individuals or at a population level from this package…This difficulty is further exacerbated by data availability and the difficulty of measuring changes in gambling harms as explored in the introduction to this white paper" (DCMS 2023)[GOV].	DCMS 2023
	Gambling is a public health issue	*"A government strategy to tackle problem gambling and reduce gambling-related harm…recognises problem gambling as a public health issue"*	IPPR 2016
		"Why is Gambling a Public Health Issue?.. Gambling has the potential to cause harm to both individuals and to wider society, and it is an issue that cannot be tackled by interventions aimed solely at individuals"	FPH 2018
		"Gambling is a public health issue	GC 2018a
		"We see gambling-related harm as a health issue and we are working closely with the Department of Health and Social Care (DHSC) and Public Health England (PHE)"	DCMS 2018
		"Gambling is not a public health issue"	LGA 2018a
		"Gambling is a vital and integral, respected part of the economy and a fun and integral part of the holiday seaside experience including for children"	transcript
		"[The gambling industry] is a well-respected employer"	transcript
	The Social logic of legitimacy	*There is a powerful case for lifting regulatory burdens on an industry which has built a world reputation for integrity*	DCMS 2002

		"It makes no sense for law abiding business people [the gambling industry] to have to go before the magistrates repeatedly in order to carry on their business"	DCMS 2002
		"Gambling is now widely accepted in the UK as a legitimate entertainment activity…the rather reluctantly permissive tone of gambling legislation over the last 50 years is now an anomaly"	DCMS 2012
		"The British gambling industry is a significant part of Great Britain's leisure economy and gambling an important leisure pursuit"	DCMS 2012
		For the majority of people in the Gambling Commission's research [on why people gamble], gambling was just another normal activity which they reported feeling completely in control of	DCMS 2023
		Betting shops and betting shop products …are no different to any other retail offering	William Hill 2016
	The Social logic of low expectation	*"It can sometimes be a slow process to change hearts, minds and culture"*	GC 2021
	Political Equivalence logics of collaboration	*there is an urgent need for central government departments, local authorities, service providers, academics and the responsible gambling community to come together to fill gaps in the available evidence base*	IPPR 2016
		a number of agencies and statutory bodies that could and should take actions at a population level have yet to recognise their important role in tackling this issue. Specifically: The Departments of Health..the Chief Medical officers…Public Health England…The National institute for Health and Care Excellence…NHS England and Wales…Local Authorities and Health and Wellbeing Boards…Professional bodies..The Industry group for Responsible Gambling	RGSB 2016
Political		*Very often licensing, public health and other frontline agencies, like debt advice service and mental health professionals, will not know*	GC 2018a

		of referral routes for someone with a gambling problem…multi-agency awareness of delivery routes and local provision is essential	
		Because of the wide range of risk factors, preventing gambling harm involves councils working with relevant partners, such as the NHS, the voluntary sector and mental health services	CfCS 2022
		the [Reducing Gambling Harms] strategy was always about applying a multi-agency approach to tackling gambling harms in a joined-up way. The [Gambling] Commission supported these local authorities in this work	GC 2022
		Councils can also seek to work with local partners and build links with support organisations to help develop specific local referral pathways and ensure these can be accessed from across the full range of local services	LGA 2018b
		the wider and community and health impacts [of gambling harms] lie with the whole council	CfCS 2022
		Councils are not anti-gambling	LGA 2016 response
	Political difference logics of conflict	*"If Budd is applied literally, they [local authorities] will have that power [to close businesses] retrospectively. In other words, someone whose business is currently thriving and worth a considerable amount of money could be left with no business"*	Hansard 2001
		"Councils are currently hamstrung in their ability to deal with the issue of high street clustering as the Gambling Act 2005 created a permissive licensing regime, removing any control from local government"	Newham 2014
		"Councils do not have the [legislative] power to reduce gaming machine stakes…and have very limited powers under both planning and licensing law to refuse new betting shops"	LGA 2015a
		"Neither the licensing nor planning framework give councils or communities the power to limit the number of gambling premises	LGA 2015a

		and gaming machines in their areas, with the statutory 'aim to permit' providing a fundamental obstacle in this regard	
		"Local authorities already have powers under gambling legislation to ensure necessary public protection"	DCMS 2012
		"In regard to the request for more powers, we note that where current powers are deployed, local authorities can have a greater say over how and where gambling can be offered and will not therefore be bringing forward further changes at this stage"	DCMS 2018
		"[we must]help Local Authorities use the powers available to them" (Gambling Commission 2018b)	GC 2018b
		we support them [licensing authorities] in the use of the broad powers which the planning and gambling regulation frameworks give to them	DCMS 2023
		local authorities] already have the power to tackle problem gambling in their own areas. If they are satisfied that the continuation of a particular licence is not reasonably consistent with the licensing objectives…they have the power to revoke that licence and close the shop"	IND 2016
		At present, councils do not have the full powers that they need to effectively manage local gambling premises	LGA 2023 resp
		Currently local authorities do not have sufficiently strong powers to protect the public from gambling harm and the harmful practices of the gambling industry	ADPH FPH 2023 response
		Redress licensing requirements to empower residents and local authorities to have a greater say over the nature, location and density of gambling premises in their neighbourhoods, including making public health a designated 'responsible authority"	GMCA 2023 resp
	Political equivalence logics of product alignment	*"Gambling can be entertaining and sociable, and enhance enjoyment of other activities, and the vast majority of gamblers take part without suffering even low levels of harm. The industry*	DCMS 2020a

		also makes significant contributions to the economy…It also contributes significantly to other industries, including sport, racing and advertising"	
		"In moderation, alcohol consumption can have a positive impact on adults' wellbeing, especially where this encourages sociability. Well-run community pubs and other businesses form a key part of the fabric of neighbourhoods, providing employment and social venues in our local communities. And a profitable alcohol industry enhances the UK economy"	HMG 2012
		"there is evidence from other fields of addiction…"	GC 2018a
		"Government does not have the same level of evidence on gambling addiction compared with other public health issues such as obesity and tobacco"	NAO 2020
	Political Difference logics of product dichotomy	*"The Government's proposals involve drawing a clear distinction between gaming machines and machines which can properly be seen as essentially for amusement"*	DCMS 2002a
		"We support the original vision behind the [Budd report] in which bingo halls were to be maintained as social, soft gambling environments"	DCMS 2013
		"Casinos are the most highly-regulated sector and they are therefore the most appropriate venue for hard, high-stake forms of gaming"	Opera? 2016
		"online shopping provide opportunity for purchasing goods that would usually be bought on the high street…including gambling"	RSPH 2018
		"Venues like casinos and, to a lesser extent, betting shops are at the 'hard' end of gambling, while bingo and family amusement arcades are 'softer'"	DCMS 2012
		"remote (online) gambling and non-remote gambling…remote gambling is the legal term for gambling undertaken other than in a premises, typically over the internet"	LGA 2018a

Fantasmatic			
Beautific	Freedom within the context of balance	*"[industry quote in national government publication]: Our proposals generally move in the direction of allowing greater freedom for the individual to gamble in ways, times and in places than is permitted under current legislation. This move to greater freedoms is balanced by rather tighter controls on the freedom of young people to gamble"*	Select Committee 2020
		it is necessary to maintain the right balance between the freedom to enjoy gambling as a leisure activity and the need to protect vulnerable people	DCMS 2020b
		At the heart of our Review is making sure that we have the balance right between consumer freedoms and choice on the one hand, and protection from harm on the other"	DCMS 2023
	Regulation	*"the Gambling Act creates a specific duty for the Gambling Commission to advise the Government on matters relating to gambling and its regulation, which it carries out with energy and professionalism"*	DCMS 2012
		"the Gambling Act creates a specific duty for the Gambling Commission to advise the Government on matters relating to gambling and its regulation, which it carries out with energy and professionalism"	RGSB 2016
Horrific	Crime	*"the crime associated with bookmakers in…"*	LGA 2015
		"the potentially harmful impact of B2 machines [FOBTs] on individual gamblers, and of associated crime and wider betting shop related crime on those working in betting shops"	DCMS 2016
	The harmed-problem gamblers	*these individual cases of harm spill over into not just the lives of families and friends, but more widely to employers and communities who are also adversely impacted by the gambler's activities"*	DCMS 2016

		problem gamblers' gamble to an extent which can seriously damage or disrupt their family, personal and working lives"	IPPR 2016
		"The effects [of Problem Gambling] can have devastating consequences on people and their families, including financial loss, relationship breakdowns, criminality and suicide"	PAC 2020
Objects	Fantasmatic beautific objects-the levy	*Most submissions to the call for evidence…supported the introduction of a statutory levy to fund projects and services to tackle and treat harmful gambling… It is acknowledged that many stakeholders in academia, health and public health feel strongly that such a levy should be created*	DCMS 2023

Appendix 8. Interview Information Sheet

Gambling Harms Interviews: Participant Information Sheet **22nd June 2022**

Title of Project: Levers and Barriers to Local Authorities in London addressing Gambling Harms using a Public Health Strategy

Introduction
We would like to invite you to take part in a research study. Joining the study is entirely up to you. Before you decide, you need to understand why the research is being done and what it would involve. One of our team will go through this information sheet with you, and answer any questions you may have. Ask questions if anything you read is not clear or you would like more information. Please feel free to talk to others about the study if you wish. Take time to decide whether or not to take part.

What is the purpose of the study?
Gambling harms are increasingly conceptualised as a public health issue. This NIHR fully-funded PhD, based at The London School of Hygiene and Tropical Medicine (LSHTM) aims to understand the levers and barriers to adopting public health strategies to address gambling-related harms at the Local Authority level in London.
The research will comprise of a survey of public health teams in London, a critical discourse analysis of the relevant documents, and interviews with those either recruited via the survey or representatives from local government (eg public health, licensing, elected members) directly approached by the researcher.

Why have I been asked to take part?
You have been invited because you are a representative of local government within London. With the interviews, we want to understand how local government representatives understand gambling harms, and what they feel would be effective at a local level in terms of addressing these harms. Anonymised data from the survey of London public health teams and gambling premises data by borough will also be shared during the interview to stimulate discussion.

Do I have to take part?
No. It is up to you to decide to take part or not. We will discuss the study together and give you a copy of this information sheet. If you agree to take part, we will then ask you to sign a consent form.

What will happen to me if I take part?
Once you have signed and returned the consent form, you will be contacted by the researcher to arrange an interview. The interview will be at a time and date of your choosing, and can be undertaken either in person or virtually (on MS Teams), whatever you prefer.

What will I have to do?
Immediately before the interview starts, your verbal consent for recording the interview will be confirmed. The interview will be audio-recorded (and, if virtual, simultaneously auto-transcribed). A 'back-up' audio recording will also be made using a second device, but this will be immediately destroyed once the clarity of the main recording has been confirmed.

What are the possible risks and disadvantages?
Although the interview is asking about your organisation's approach to gambling harms, we recognise that you may have experience of gambling harms personally, and if you disclose any such information within the interview, this information will be redacted from the recording, and you will be signposted to the relevant national support services at the end of the interview once recording has been completed.

What are the possible benefits?
We cannot promise the study will help you but the information we get from the study will help our knowledge and understanding of this research area.

What if something goes wrong?
If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting Patricia Henley at rgio@lshtm.ac.uk or +44 (0) 20 7927 2626>
The London School of Hygiene and Tropical Medicine holds insurance policies which apply to this study. If you experience harm or injury as a result of taking part in this study, you may be eligible to claim compensation.

Can I change my mind about taking part?
Yes. You can withdraw from the study at any time.
If you withdraw from the study we will destroy all audio recordings and transcriptions of your interview.

What will happen to information collected?
We will need to use information for this research project. All information collected about you will be kept private. Only the study staff and authorities who check that the study is being carried out properly will be allowed to look at information about you. Information will include your name and contact details, which will be held separately from interview recordings and transcriptions.
We will keep all information about you safe and secure.
Your personal details, meaning your name and other identifiable information, will be kept in a different safe place to the other study information and will be destroyed within 10 years of the end of the study.
At the end of the project, the study data will be archived at LSHTM. The data will be made available to other researchers worldwide for research and to improve knowledge on the topic. Your personal information will not be included and there is no way that you can be identified.

What are your choices about how your information is used?
You can stop being part of the study at any time, without giving a reason.

Where can you find out more about how your information is used?
You can find out more about how we use your information · At
https://www.lshtm.ac.uk/files/research-participant-privacy-notice.pdf

What will happen to the results of this study?
The study results will be published in an academic journal so that other professionals can learn from them. Your personal information will not be included in the study report and there is no way that you can be identified from it.

Who is organising and funding this study?
London School of Hygiene & Tropical Medicine is the sponsor for the research and they have full responsibility for the project including the collection, storage and analysis of your data, and will act as the Data Controller for the study. This means that we are responsible for looking after your information and using it properly.

Who has reviewed this study?
All research involving human participants is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by The London School of Hygiene and Tropical Medicine Research Ethics Committee Ref 26646..

Further information and contact details
Thank you for taking time to read this information sheet. If you think you will take part in the study please read and sign the consent form.
If you would like any further information, please contact the researcher who can answer any questions you may have about the study.
Contact details: Dr Jenny Blythe: jenny.blythe@lshtm.ac.uk

Appendix 9. Interview Consent Form

Interview Consent Form June 2022

Title of Project: Gambling with the health of Londoners-what are the levers and barriers in Local Government to adopting a Public Health approach to tackling gambling harms?

Name of PI/Researcher responsible for project: Dr Jenny Blythe

Statement	**Please initial or thumbprint* each box**
I confirm that I have read and understood the information sheet dated…….. for the above named study. I have had the opportunity to consider the information, ask questions and have these answered satisfactorily.	
I understand that my consent is voluntary and that I am free to withdraw this consent at any time.	
I understand that relevant sections of data collected during the study may be looked at by authorised individuals from The London School of Hygiene and Tropical Medicine where it is relevant to my/the participant's taking part in this research. I give permission for these individuals to have access to these records.	
Data will not be shared in a data repository, but I understand that it may be shared upon reasonable request at the Principal Investigator's discretion, and I understand that I will not be identifiable.	
I give permission to be quoted anonymously in future dissemination and/or publications.	

I agree to me/the participant taking part in the above named study.

Signature of Participant Name in print Date

Signature of Primary Investigator Name in print
Date

Appendix 10. Interview additional quotes

Theme	Quote	ID
1. Gambling can take many forms…and they can all be harmful	*we know we've got clustering in areas of deprivation*	PH10
	you would just walk around and say there's too many of these types of premises here. You know that it's just it's obvious.	Lic 3
	what's happening online? It's a free for all	PH1
	despite what things are showing physically and in terms of the numbers of licences and all that, actually the big elephant that we need to look at is online gambling.	PH12
	Say it's online. That worries me more than anything else, and particularly young people coming into it, I think	PH3
	We don't really get new applications for betting shops. We get new applications for adult gaming centres	Lic 2
	some of the betting shops have converted to adult gaming centres.	Lic 4
	we've seen a small increase [in arcades] since 2017.	PH10
	the olden days do you know what I mean before the machines took over the world	Lic 2
	we have reduced our betting shops and the reason for that is because since the fixed odd betting terminals came into the act…a lot of the betting shops have tend to sort of just give up the ghost	Lic 4
	You know that was just madness. We had a debate whether it's like, you know, useful to stop FOBTs like people in the top 10th quintile deprivation spending 100 quid in their lunchtime. We had the debate whether it's a good idea to stop them bloody spending all their children's money on that.	PH11
2. Feeling Helpless		
2a. not enough money	*It's just about and people with limited income will come there [betting shops] to improve their financial position*	PH2
	there's always people spilling out of there [high street betting shop], you know, they've got no money, they're crying their eyes out.	Lic 1
	people might say, OK, that's really good [opening a gambling premises]. That opens up a shop front that brings in business rates. But if you're harming 10 people who go bankrupt or whatever family breakdown, we're paying hundreds of thousands after that.	PH 4
cost of living crisis	*we're doing a lot of work on cost of living crisis…the kind of person who's coming through [food banks] are people so desperate now that maybe gambling is all you know how can I feed myself? Shall I gamble? PH4*	PH4

	just knowing the savings that we're facing. now, you know I managed to weather the sort of 2015 2016 cuts…well, not completely, but relatively. but you know it's an annual battle.	PH8
	"if we really want a strong public health system, we want prevention, we want people in the UK to thrive you'd have well-funded local authorities with a very clear mandate and kind of governance structures and well resourced public health teams"	PH7
	you also have to remember that there's only one person doing gambling in in [borough], one person doing it, so it's it's a very resource, you know, deficient so it's very difficult for them to do everything. And that I think that [gambling] has suffered.	PH13
2b. not enough power	*"I can't make the betting shops provide mental health information because it just doesn't. It's not the remit of the policy".*	PH1
	The government needs to change the legislation before we can really do a lot.	Lic 2
	we had to reach an agreement with them [an arcade] to allow the licence where we'd refused it…we added some extra conditions to the licence, but it just felt they're able to open 24 hours by default.	Lic 3
	We had a barrister look at our case, looked at the evidence and said…This is never gonna get anywhere in the Magistrates Court because of the way that the Gambling Act is written.	Lic 3
	They've [industry] got lots of resources so they challenge you, then you know you need to make… you know it's very difficult to enforce different things with them and in the past, so you have to be really careful because they do have the resources and as the council we don't	PH13
	it is difficult for public health colleagues to bring in some of the messaging and concerns that they have around gambling into applications and to policy because we're bound by those [gambling act] objectives.	Lic 5
	"one woman…basically got completely addicted to it [online bingo] …she couldn't go out because her husband was an alcoholic".	Lic 2
	I've spoken to people who've worked in gambling and they will say that the majority of people who come in and they know they're out of control.	PH1
3. not really knowing	*I don't think we did [respond to call for evidence for White Paper]. Actually I don't recall that we did-when was the call for?*	Lic 3
	I think we send ours [gambling premises applications] to I think we do send ours to public health. I'd have to double check on that and I can confirm, but I'm pretty sure we do.	Lic 4
	Safer Gambling Week-That's just not on our radar.	PH5

	I still very much kind of like a in a kind of a stage to be shaped, a kind of thing. I think you know, it's kind of. There's still a lot of time to understand in room around the prevalence around the fact you know the other factors that are caused. The causations of gambling harms	PH14
	Have there been any international? Has there been any evidence review of what works in reducing gambling harms apart from banning it on religious grounds?	PH4
4. what public health teams do	*We've got more levers, we've got all the people like licensing, environment, housing. I do so much work with housing, jobs. Everything's there for us.*	PH4
	You might be aware that [Y borough] put in an application to do a joint piece of work across a number of boroughs and then to sort of share learning across London and that work, I think, is funded through GambleAware and I think there's been a little bit of knock back. Because it's one set by those organisations. I mean, to my mind it's almost like saying that you know it's a little bit like DrinkAware.	PH12
	I don't see a role for industry operators at all in, you know, I, I think that I think if you look at it quite simply that they've made their bed, they need to lie in it. We need to support the people that they are harming.	PH14
	they [local government] have been completely hoodwinked by the industry to be convinced that somehow this is wonderful for their High Street gonna bring in lots of jobs. It's great for rejuvenation, great for levelling up. PH5	PH5
	Obviously betting shops are businesses and not charities or trying like, do you know? I mean, they're not trying, not looking after the health of the people that go in there, the business.	PH9
	"We've really focused on areas of deprivation and clustering … if we just focused on borough wide, we simply wouldn't respond to all of the new applications".	PH 10
	"I would want the same industry standards in terms of public health recommendations that we have in terms of tobacco and alcohol".	PH6
	there's some other tips and tricks that I used to do with alcohol applications so we could say within 0.4 kilometres of the application, there should be no children settings, no addiction treatment, no, no health venues. So nowhere. Where about homeless hostels? Nowhere. Where a vulnerable person might get sucked in. And then you start putting rings around and then it just becomes so onerous for them that they give up.	PH4
	With gambling, when gambling comes in it, it's immediate sort of scrabbling around to find the legislation to find the guidance. Because we deal with the Licencing Act, you know 95% of the time.	Lic 3
5. Individualism: my borough is different	*We are quite a small team*	PH3
	I work within the health in all policies team of public health.	PH2*

	my job role is the strategic lead for substance misuse and inequalities	PH7*
	I am the program lead for healthy environments.	PH10*
	my team is healthy environments and communities and my team looks more at the wider determinants of health	Ph9
	I've spoken to some of my colleagues and they said we don't see the gambling licenses at all.	PH1
	I think we're one of the only authorities and that has a pool of conditions.	Lic 3
	I sit in the adults and Health Directorate, which includes the public health team.	PH14*
	I have public health within my directorate and I also have children's commissioning services as well… sit on the chief exec so the corporate management board.	PH6*
	I'm Director of Public Health for [X borough] But I'm also assistant director for a wider brief called Healthy and Safe communities.	PH8*
	we're embedded within that side of the organization [executive structures] which is quite different from how other public health teams I know of	PH10

*denotes redaction for wider dissemination as potentially identifiable

Dissemination Activities

Blythe, J, van Schalkwyk, M (2021). Screening for gambling harms in primary care. BMJ. Available: https://blogs.bmj.com/bmj/2021/06/18/screening-for-gambling-harms-in-primary-care/

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van Schalkwyk MCI, McKee M, Cassidy R, Petticrew M, Blythe J. (2022) Gambling Disorder-letter to editors. Lancet Psychiatry. Jun;9(6):429. doi: 10.1016/S2215-0366(22)00068-2.

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Clinical Communications Conference: Manchester University April 2023-Gambling Harms-If you don't ask you don't know (e-poster presentation)

Blythe, J (2023). Gambling addiction in the UK: don't blame GPs. BMJ;381:p1010

Gambling: RCGP is criticised for holding conference with organisation dependent on industry funding. BMJ 2023; 381 doi: https://doi.org/10.1136/bmj.p1248

van Schalkwyk MCI, Cassidy R, Blythe J, Ovenden N. (2023). Health above profits-we need a new Gambling Act. Critical Gambling Studies https://doi.org/10.29173/cgs165

Oral presentation of PhD findings at RANGES Network Canada October 2023

Poster presentation at NIHR Local Authority Public Health Research Network: Gambling Harms Policy DPH Survey March 2024

Presentation to Barts and The London Medical School Student Health Ambassadors-Awareness and Prevention of Gambling Harms April 2024

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