

Treatment Needs and Gap Analysis in Great Britain

Synthesis of findings from
a programme of studies

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The authors alone are responsible for the views expressed in this article, which do not necessarily represent the views, decisions or policies of the institutions with which they are affiliated.

Glossary of terms

Affected others: those who know someone with a gambling problem (either now or in the past) and have experienced negative effects as a result; for more details see section 3.3.2.

BAME: Black and Minority Ethnic.

DRF: Data Reporting Framework.

GB: Great Britain.

GC: GamCare.

GM: Gordon Moody residential treatment service.

GP: General Practice or Practitioner.

HSE: Health Survey for England.

NatCen: National Centre for Social Research.

NGTS: National Gambling Treatment System.

PGSI (and PGSI 1+ and PGSI 8+): Problem Gambling Severity Index; for further details on terminology (i.e. low and moderate risk gambler and problem gambler) see section 3.3.1.

Problem gamblers: a PGSI score of 8 or over, those who gamble with negative consequences and a possible loss of control.

REA: Rapid Evidence Assessment

Support: informal type of support (e.g. support groups, friends, family, employers), online and printed materials, telephone helplines (e.g. National Gambling Helpline)

Treatment: formal treatment services (e.g. GPs, mental health services, social worker), specialist treatment service for gambling (e.g. National Gambling Treatment Service)

SHeS: Scottish Health Survey

Socioeconomic background: based on occupation and developed by the National Readership Survey (NRS); for further details see section 3.3.3

UCL: University College London

2 Executive summary

2.1 Background and method

The National Strategy to Reduce Gambling Harms sets out as one of its core priorities the need to make significant progress towards truly national treatment and support options that meet the needs of current and future service users. This priority is reflected in the aims and activities of Gamble Aware, the main funder of treatment and support to reduce gambling harm in Great Britain.¹

In 2018, GambleAware commissioned a programme of studies to review the current need, demand and use of gambling treatment and support in England, Scotland and Wales, to identify where there are geographic and demographic gaps in provision; and, to detail the demand for treatment and support by gamblers and affected others in Britain.

Whilst previous research provides data on problem gamblers (and those experiencing lower levels of gambling harm) within the general population, there is little (if any) research on the size and characteristics of those seeking or accessing treatment and support for gambling harms. The primary aim of this report is to synthesise findings across all strands of this programme, addressing the following key objectives:

- To investigate the size, distribution and characteristics of the gambling population in Britain;
- To explore the sociodemographic and geographical characteristics of gamblers in Britain accessing treatment and support;
- To assess demand for treatment and support in Britain;
- To explore barriers and facilitators to treatment and support, access and engagement; and,
- To explore the size of the affected others population, the impact of gambling on their lives and their perceptions/experience of available treatment and support.

The findings presented in this report use data gathered from different research strands using mixed methods; a summary of which is provided below (Table 2.1.1).

Table 2.1.1: Research strands

Research Strand	Organisations involved	Key features and considerations
Strand 1: Two Rapid Evidence Assessments (REA)	ACT Recovery NatCen	The aim of the REAs was to identify evidence around population prevalence, its links to seeking treatment and support as well as those treatment and support pathways. Throughout, there was a focus on evidence around population differences across different types of treatment and support
Strand 2: Assessing the experiences and needs of gamblers in (and not in) treatment, affected others, and wider stakeholders	ACT Recovery NatCen	A combination of focus groups and in-depth interviews to explore perceptions and experiences of treatment and support from a) gamblers receiving gambling treatment, b) gamblers not in treatment, c) professionals who either come into contact with problem gamblers or provide gambling treatments and d) affected others

¹ For more details see pages 15-17 in the National Strategy to Reduce Gambling Harms <https://www.reducinggamblingharm.org/about-the-strategy>

Strand 3: Secondary analysis of Health Surveys in Scotland and England and the Data Reporting Framework (DRF)	ACT Recovery NatCen	The aim of this strand was to use existing data to assess demographic and geographic patterns of gambling problems identified in the combined health surveys 2016. These findings were then compared to those populations accessing treatment as identified through the Data Reporting Framework (DRF) from 2015 to 2017.
Strand 4: National, representative population survey of gambling patterns and harms, and help-seeking behaviours	YouGov	A two-phase study to address the question of unmet need was carried out. One population survey identified people with indicated gambling problems from the general population (and those who had been affected by others' gambling), whilst a second survey assessed this group's experiences of treatment and support.
Strand 5: Mapping service use across Britain	UCL	Mapping of gambling prevalence at local authority level across Britain was conducted by applying secondary analyses of data from the YouGov population survey on geographical distribution.

2.1.1 Overview of evidence

The size, distribution and characteristics of the gambling population in Britain

- The YouGov population survey estimated that three-fifths (61%) of adults in Britain have participated in any type of gambling activity in the last 12 months.
- Thirteen percent of adults scored one or higher on the PGSI scale. Seven percent were classified as a low risk gambler (a score of 1-2); 3% as a moderate risk gambler (a score of 3-7) and 3% as a problem gambler (a score of 8 or higher).
- For each category, the proportion identified in the YouGov population survey was approximately three times the proportion reported by the combined health surveys (England, Scotland and Wales).
- Analysis of these differences concluded that probability estimates in the combined health surveys may somewhat under-estimate the true prevalence of problem gambling, whereas in the YouGov population survey estimates are likely to be working in the opposite direction. The true value probably lies closer to the combined health surveys than to the YouGov population survey.
- Men, younger adults (aged 18-34) and adults from a lower socioeconomic or BAME backgrounds were more likely to be classified as experiencing some level of harm (PGSI 1+).

The sociodemographic and geographical characteristics of gamblers in Britain accessing treatment and support

- Approximately 17% of all gamblers (PGSI 1+) reported having used any type of treatment (e.g. mental health services) and support (e.g. friends/family) in the last 12 months.
- The primary driver of accessing treatment and support was the severity of gambling harm. While just 3% of those classified as low risk gamblers reported using treatment and support, this increased to 54% for those classified as problem gamblers (PGSI 8+).
- Younger and BAME gamblers as well as gamblers from higher socioeconomic backgrounds experiencing gambling problems (PGSI 8+) were more likely to report accessing treatment and support.
- Amongst professional treatment services accessed, mental health services (e.g. counsellor, therapist) were the most commonly reported (5%).

- All gamblers who accessed treatment services participated in very similar types of gambling activities. The three most common activities were online gambling, virtual gaming machines in bookmakers (e.g. casino), and online betting with a bookmaker.
- Most gamblers in treatment were male, between 25-34 years and in employment.
- Completion of treatment rates generally improved as age increased.

Demand for treatment and support

- Of all gamblers experiencing some level of harm (PGSI 1+), 18% stated they would like to receive some form of treatment or support in the next 12 months. Over half (57%) of problem gamblers (PGSI 8+) would like to receive some form of treatment and support.
- Those classified as problem gamblers (PGSI 8+) expressed higher demand for treatment (e.g. mental health services), whereas those classified as low risk and moderate risk gamblers were more likely to want support from less formal sources (e.g. family/friends).
- Younger and BAME gamblers and gamblers from higher socioeconomic backgrounds who had higher PGSI scores on average, were much more likely to want treatment or support.
- Demand was highest in the areas with higher proportions of gamblers (PGSI 1+).
- Among sources of support, family and friends were the most popular option.

Barriers and facilitators to treatment and support access and engagement

- Close to a third (31%) of gamblers (PGSI 1+) said that treatment and support was not relevant to them or would not be suitable for someone like them, and a fifth (21%) recognised positive impacts from gambling (e.g. making money). For one in ten (11%), stigma or shame was a barrier to seeking help.
- Low and moderate risk gamblers were more likely to report that their gambling was not harmful or only involved small amounts of money (53% and 51% respectively). However, this proportion declined to 17% of those in the 'problem gambler' category (PGSI 8+).
- Problem gamblers (PGSI 8+) were more likely to report experiencing stigma or shame.
- Women (PGSI 1+) were more likely than men to cite practical barriers such as cost, time or location in relation to accessing treatment or support (9% vs. 3%).
- Older gamblers (PGSI 1+) aged 55 and over were more likely to report that treatment or support was not relevant or suitable for them (38%) compared with 26% of 35-54s.
- A quarter of gamblers (PGSI 1+) recognised one or more factors which might motivate them to seek treatment and support, with online treatment or support being the most popular (6%), followed by telephone (5%) and finally face-to-face (4%).

The size of the affected others population, the impact on their lives and their perceptions/ experience of available treatment and support

- Seven percent of people across Britain were identified as an affected other. The majority were the partner or close family member of a gambler (61%).
- Affected others were more likely to be women (57% vs.43%), people from BAME communities (16% vs.12%) and those from lower socioeconomic backgrounds (51% vs. 46%).
- Twenty percent of affected others also reported experiencing gambling harms themselves (PGSI 1+).

- The most common type of negative impact identified was on relationships (82%) and on finances (60%).
- Half (48%) of those negatively affected by the gambling of a spouse or partner described the impact as “severe” and the proportion was also high when the gambler was a parent (41%) or the child of an affected other (38%).
- Among affected others, 45% had tried to get treatment or support, either for the gambler or for themselves.
- Affected others felt that there was a lack of treatment and support for affected family members and that there was not enough signposting to available services.

2.1.2 Conclusions and recommendations

This programme of studies has provided evidence in relation to the size, characteristics and geographical distribution, engagement, demand and the barriers/facilitators to treatment and support. In particular:

- **Men, younger adults (aged 18-34), BAME and adults from lower socioeconomic background** were more likely to be classified as gamblers with some level of harm (PGSI 1+).
- **The proportion of all gamblers (PGSI 1+) across Great Britain using any type of treatment and support is 17%**, although this increases to 54% for those who are PGSI 8+.
- **Lack of awareness and/or reluctance to admit problematic behaviour** was a particularly salient barrier, often associated with the stigma attached to gambling problems and seeking treatment and support. Sociodemographic differences in reported barriers also highlighted a concern that the needs of specific groups (e.g. women, BAME and people from lower socioeconomic background) are not adequately met.
- **A significant number of people across Britain identified as an affected other** with women, people from BAME communities and from a lower socioeconomic background being affected the most. A significant number of affected others also reported experiencing gambling harms themselves (PGSI 1+).
- **Younger adults and people from BAME communities are more likely to be classified as problem gamblers.** However, they were also more likely to have used treatment or support in the last 12 months, and more likely to report that they would like to receive more treatment or support in the next 12 months.

Recommendations for future provision of treatment and support

Although there was recognition that the treatment and support experience is positive, the following elements were found to be crucial for future provision:

- **Developing new and/or streamlining and strengthening existing services offered.** There is a need to strengthen and improve existing treatment and support offered in terms of the type and extent of available provision. Responding to the complex needs of being an affected other (who may also be experiencing gambling harms themselves) is one area where existing treatment and support provision needs to be strengthened. Helplines are a good facilitator to accessing treatment or support with a potential role to act as a 'safety net' to engage clients and to take a more proactive role in aftercare support.
- **Involve service users in the design and delivery of treatment and support.** Peer-based treatment and support will ensure wider and targeted support for particular groups across various geographical locations, whose needs may not be

adequately met. Using the developing evidence base from this and concurrent research, co-designing prevention and early intervention approaches with people with lived experience including affected others is of vital importance.

- **Targeted support for groups that are less likely to access treatment and support services (or complete treatment).** A number of groups including women, younger people, people from BAME communities and lower socioeconomic backgrounds as well as affected others are in need of targeted treatment and support. Such treatment and support could take the form of culturally adapted interventions aimed at ethnic minorities or services targeting young people and women who are also underrepresented within treatment services.
- **Developing education programmes and campaigns to increase awareness and reduce stigma.** Adverts and/or campaigns communicating gambling related public health messages and available treatment and support are needed, delivered in different forms. Similarly, education programmes around problem gambling aimed at vulnerable groups (e.g. young people, BAME groups) will help raise awareness of the risks of gambling and promote the idea of healthy gambling behaviours.
- **Ensure gambling companies continue to strengthen gambling management tools.** Developing and/or strengthening a universal monitoring system across the industry inclusive of both online and offline gambling is needed in order to proactively identify and monitor activities that can cause gambling harms.

Recommendations for future research

A number of recommendations for future research based on this programme of studies were drawn:

- **Prevalence estimates:** the present report concluded that the true level of problem gambling lies somewhere in between the prevalence estimates of the different data sources. Further evidence is needed to have an accurate estimate of the size of the population experiencing gambling harms.
- **Treatment data:** while there was an improvement in numbers engaging and completing treatment, further research needs to monitor treatment use and drop-out rates year-on-year to see if these patterns continue.
- **Affected others:** more research is needed to investigate the complex needs of this group and to explore and understand the complexity of the relationship between being both a 'gambler experiencing gambling harms' and an 'affected other'.
- **Access to treatment and support:** Additional research is needed to identify motivations for choosing to access specific treatment services as opposed to others and to ensure treatment and support options are accessible to all who need them.
- **Targeted treatment and support needs:** research is needed to examine treatment relevance and/or reach for specific segments of the population including women, young people and BAME communities.
- **Aftercare:** the findings demonstrated a lack of evidence about the existence and effectiveness of aftercare to treatment. This is an area that future research will need to explore in terms of mapping, access/use and effectiveness.

3 Introduction

3.1 Project overview

The National Strategy to Reduce Gambling Harms² sets out as one of its core priorities the need to make significant progress towards truly national treatment and support options that meet the needs of current and future service users. This priority is reflected by GambleAware (as the main commissioner of treatment and support to reduce gambling harm in Great Britain³) and was embedded in this research programme.

An evidence gap exists around access to treatment (e.g. mental health services, GPs, social workers, etc) and support (e.g. friends/family, helplines, websites, etc) and levels and type of demand for treatment and support by individuals experiencing gambling harms. However, there are strong indications that there is a large discrepancy between the number of people currently receiving treatment and support and the numbers estimated to benefit from this. For example, in 2016/17, GamCare received around 20,000 calls to their help lines from gamblers and provided treatment to just around 8,000 individuals⁴. While some people will recover without help, this discrepancy between the numbers of people receiving treatment and support compared to those in potential need, raises concerns about underdeveloped treatment pathways and referral routes, a potential lack of awareness of the treatment and support options available, and a lack of national availability.

More evidence is also needed for those who do not engage with treatment and support to identify the barriers to access and ways to overcome these. Little is currently known about the size of this group, their sociodemographic characteristics, or their gambling behaviours, and how this group may differ from the population of those classified as gamblers experiencing harm who do seek treatment and support.⁵ In addition, further data is needed to understand treatment and support usage and demand for those not yet receiving treatment and support, but who would wish to.

In 2018, GambleAware commissioned a programme of research to review the current need, demand for and supply of gambling treatment and support in England, Scotland and Wales, to identify where there are geographic and demographic gaps in provision and to detail the demand for treatment and support by gamblers and affected others across Britain. The primary aim of this report is to synthesise findings across all strands of this programme, addressing the following key objectives and accompanying research questions (RQ):

- **Objective 1:** To investigate the size, distribution and characteristics of the gambling population in Britain:
 - RQ: What is the size and distribution of the gambling population?
 - RQ: What are the characteristics (e.g. demographic, geographical) of the gambling population?

² <https://www.reducinggamblingharms.org/asset-library/national-strategy-to-reduce-gambling-harms.pdf>

³ It should be noted that there is treatment and support available which is not commissioned by GambleAware

⁴ Source: GamCare Annual Statistics 2017/2018.

⁵ Throughout this report the phrases 'problem gamblers', 'moderate risk gamblers' and 'low risk gamblers' are used to indicate individuals experiencing different degrees of gambling harm according to the PGSI. These descriptions refer to people and their situations at a point in time and are not intended to imply a long-lasting or progressive status.

-
- **Objective 2:** To explore the sociodemographic and geographic characteristics of gamblers in Britain accessing treatment and support:
 - RQ: What is the size and characteristics of the gambling population accessing treatment and support?
 - RQ: What is the type of treatment and support used by the gambling population?
 - RQ: What is the size and characteristics of the gambling population engaged with (and completing) treatment?

 - **Objective 3:** To assess demand for treatment and support in Britain:
 - RQ: What is the level of demand for treatment and support?
 - RQ: What are the sources of treatment and support needed?

 - **Objective 4:** To explore barriers and facilitators to treatment and support access and engagement:
 - RQ: What are the barriers to treatment and support access and engagement?
 - RQ: What are the facilitators to treatment and support access and engagement?

 - **Objective 5:** To explore the size of affected others, the impact of gambling on their lives and their perceptions/experience of available treatment and support:
 - RQ: What is the size and characteristics of affected others?
 - RQ: What is the size and characteristics of affected others that is engaged in any form of treatment and support?
 - RQ: What is the level of demand for treatment and support for affected others?
 - RQ: What are the barriers and facilitators to treatment and support access for affected others?

3.2 Research design

The findings presented in this report use data gathered from all different research strands of this programme led by ACT Recovery, NatCen, YouGov and UCL. NatCen has also led the synthesis of the evidence in the present report.⁶

3.2.1 Strand 1 – Rapid evidence assessments (REAs)

Two REAs were conducted, one led by NatCen and one led by ACT Recovery. The aim of the REAs was to identify evidence around the prevalence of gambling, its links to help-seeking, experiences of engagement with treatment and support, as well as treatment and support pathways and engagement processes across different types of treatment and support. There were 10,649 unique results from the international literature returned from the systematic searches across the chosen academic databases and websites with 66 papers included in the reviews. Studies were prioritised for inclusion based on the number of full text screening criteria they met using a scoring system. International studies were included where there was some evidence that the findings could be ‘transferred’ to the UK context (i.e., similar health and care environments) as well as ensuring, where possible, UK evidence gaps could be mitigated.

⁶ The report draws on data from across all the strands of this programme of studies and the key findings, conclusions and recommendations do not necessarily represent the views of the other authors.

3.2.2 Strand 2 - Fieldwork with individuals experiencing gambling harms, affected others and stakeholders

Two qualitative projects were carried out between April and September 2019, one led by NatCen and one by ACT Recovery. Qualitative methods were used to engage with individuals experiencing gambling problems, affected others and wider stakeholders. This ensured a detailed understanding of participants' own perspectives and experience of needs, treatment and support access and usage as well as barriers and facilitators to accessing treatment and support. Specifically:

- One-to-one interviews with individuals who experienced varying levels of gambling harms as identified using the PGSI classification, who had either accessed treatment and support for gambling problems (n=18) or had yet to access and experience treatment and support (n=26).
- One-to-one interviews and focus groups with affected others such as family members, friends, spouses of problem gamblers (n=12).
- One-to-one interviews and focus groups with stakeholders who a) had direct contact with problem gamblers as part of their role (n=27) or b) may have come into contact with problem gamblers but did not work within gambling treatment and support services (n=10).

3.2.3 Strand 3 – Secondary data analysis

This strand, led by NatCen and ACT Recovery, assessed demographic and geographic patterns of gambling problems identified in the combined Health Survey for England and Scottish Health Survey, and compared these with the population accessing treatment identified through the Data Reporting Framework (DRF).⁷ In particular, the following data sources were used:

Source	Health Survey for England / Scottish Health Survey	Gamble Aware Data Reporting Framework (DRF)
Population covered	General population living in Scotland and England	Gamblers seeking treatment, cases from Wales and NI have been dropped
Time period covered	2015-2016	2015-2016 and 2016-2017
Sample size	21,130 (includes 90 problem gamblers, 188 moderate risk)	2015-2016 (n=7759) and 2016-2017 (n=8147)

3.2.4 Strand 4 – Surveys of the general population, gamblers and affected others

In response to several gaps identified from Strands 1 and 2 around engagement in and/or demand for treatment and support, two online surveys were designed and carried out by YouGov. The aims of the surveys were to a) estimate the total size of the

⁷ GambleAware fund the National Gambling Treatment Service, which is a network of organisations working together to provide confidential treatment and support for anyone experiencing gambling harms, free to access across England, Scotland and Wales. At the time the data was analysed, this treatment system consisted of a residential treatment service, Gordon Moody, based in two locations in England; the Central and North West London NHS Foundation Trust (London Problem Gambling Clinic), which offers treatment for gambling problems especially for people with more severe addictions and also for those with co-morbid mental and physical health conditions; and GamCare and its partner networks which provides a Telephone helpline, a moderated online Forum, Online treatment supported by regular contact with a therapist, One-to-one face-to-face online and telephone therapeutic support and treatment and Group based support.

low risk, moderate risk and problem gambler population as defined by PGSI, and affected other population that is both engaged and not engaged in any form of treatment or support; b) estimate population size at as low a level of geography as possible i.e. local authority level, and c) explore the respective experiences of gamblers and affected others. The two surveys were:

- **YouGov population survey:** A nationally representative online survey of 12,161 adults in Great Britain to establish the prevalence of low risk, moderate risk, problem gamblers and affected others, at an overall level and a detailed local level. The survey was carried out between 24th September and 13th October 2019⁸.
- **YouGov treatment and support survey:** A more detailed follow-up online survey between 23rd October and 12th November 2019 of 3,001 low risk, moderate risk, problem gamblers and affected others, to explore the experiences and views of these groups, including in relation to seeking treatment and support.

3.2.5 Strand 5 – Mapping service use across Britain

Mapping of gambling prevalence at local authority level across Britain was conducted applying secondary analyses of data on geographical distribution from the YouGov population survey. Results from multi-level Regression and Post-stratification (MRP) modelling were utilised develop some interactive maps which will be published at a later date.

3.3 Definitions

3.3.1 Measurement of Gambling Harms

The gambling behaviour of respondents in all quantitative and qualitative data sources used for this programme was classified using the Problem Gambling Severity Index (PGSI). The instrument itself has been subject to critical evaluation and was revised in 2003.⁹ The PGSI consists of nine items ranging from 'chasing losses' to 'gambling causing health problems' to 'feeling guilty about gambling'. Each item is assessed on a four-point scale: never, sometimes, most of the time, almost always. Responses to each item are given the following scores: never = 0; sometimes = 1; most of the time = 2; almost always = 3. The scores for each item are summed to give a total score, which ranges from zero to a maximum of 27.

The score can be used to group respondents into four categories:

- **Gamblers who do not experience any harm:** a PGSI score of zero.
- **Low risk:** a PGSI score of 1 or 2, defined as experiencing a low level of problems with few or no identified negative consequences.
- **Moderate risk:** a PGSI score of 3 to 7, defined as experiencing a moderate level of problems leading to some negative consequences.

⁸ The survey took place during the Responsible Gambling week which could have raised participants' awareness of their own experiences of gambling as well as their treatment and support use and have impacted on their responses (e.g. higher reporting of gambling problems and/or treatment and support use/demand).

⁹ Wynn, H. (2003). *Introducing the Canadian Problem Gambling Index*. Wynne Resources: Canada.

- **Problem gamblers:** a PGSI score of 8 or over, those who gamble with negative consequences and a possible loss of control.

3.3.2 Affected others

This report also explores the negative impact gambling has on other people, besides gamblers themselves. These people, described as affected others in this report, are those who know someone with a gambling problem, either now or in the past, and have experienced negative effects as a result of that person's gambling behaviour. These effects can be financial but also include negative emotional impacts, such as worry and anxiety, or strain placed on their relationships.

3.3.3 Socioeconomic background

The report uses a classification system for socioeconomic background that is based on occupation and was developed by the National Readership Survey (NRS). For analysis purposes, these have been grouped together into ABC1 and C2DE and comparisons between these groups are being reported. For ease of reporting ABC1 and C2DE categories will be referred to in this report as higher and lower socioeconomic backgrounds respectively.

Table 1 Social Grade categories	
A	Higher managerial, administrative and professional
B	Intermediate managerial, administrative and professional
C1	Supervisory, clerical and junior managerial, administrative and professional
C2	Skilled manual workers
D	Semi-skilled and unskilled manual workers
E	State pensioners, casual and lowest grade workers, unemployed with state benefits only

3.3.4 Treatment and support

This report focuses on access, usage and demand for treatment and support to reduce gambling harms. A distinction between treatment and support has been made throughout this report. Specifically:

- **Treatment** refers to formal treatment services including: GP services, mental health services (e.g. counsellor, therapist), social worker, youth worker or support worker, specialist treatment service for gambling (e.g. National Gambling Treatment Service), other addiction services (e.g. drug or alcohol), online therapy for gambling (e.g. CBT), face to face therapy for gambling.
- **Support** refers to informal types of support including: support groups (e.g. Gamblers Anonymous), friends (including work colleagues) and family (e.g. spouse/partner), employers, online and printed materials (e.g. books, leaflets, websites such as BeGambleAware.org, Citizen's Advice, GamCare), online forums/groups, telephone helplines (e.g. National Gambling Helpline), self-help apps or other self-help tools (e.g. self-exclusion, blocking software and blocking bank transactions).

3.4 Limitations/Constraints

This section highlights some of the limitations/constraints to this programme of studies and the synthesis report:

-
- Whilst this programme of studies followed core overarching objectives, each research strand focused on different research questions within this overall focus. This report has synthesised the evidence into a single narrative but in places there is not a direct read across all workstreams. For example, in some cases the report focuses specifically on treatment, where in other cases the focus is just on support.
 - The report synthesises evidence that has been developed using different methodologies. When reporting findings from population surveys and secondary data analyses, the results can be applied to the general population being investigated. Findings from qualitative research are intended to develop theory and provide experiences and perceptions in depth rather than present statistically reliable and generalisable findings. Furthermore, findings from qualitative research are based on small number of participants. Therefore, it is not possible when reporting qualitative research to provide a precise picture of the prevalence of a certain view or experience representative of GB population.
 - Although data allowed for comparisons between Local Authority, more granular information about size and characteristics of the gambling populations within LAs was not available. Therefore, evidence in terms of geographical differences of treatment and support need is not available.
 - There are limitations related to the treatment data collected as part of GambleAware's Data Reporting Framework (DRF) for the years 2015-2016 and 2016-2017. In particular:
 - Scottish residents make up 9% of the combined adult population of England and Scotland, only 4% of problem gamblers and 2% of those at moderate risk are Scottish residents, which suggests that Scottish residents are under-represented in the DRF data, highlighting a disparity of access.
 - DRF data does not contain a standard measure of region that was comparable to the regional variables in the data from the surveys (YouGov population survey and combined health surveys).
 - The individuals accessing treatment are a specific sub-sample of the general population of gamblers. That these individuals have sought treatment, often voluntarily,¹⁰ makes it more likely that they are different in some ways to the general population.
 - During the time that this programme of studies took place, including during the writing of this report, the combined health survey data 2018 had not been archived by NHS Digital or, made publicly available. Lack of access to the latest data meant that secondary data analysis used population data from the 2016 combined health surveys (England and Scotland). However, this also ensured appropriate comparisons with available DRF data (which also only included data from England and Scotland when being compared to the combined health survey data), collected across approximately the same time.

¹⁰ The bulk of individuals are self-referrals; 91% of problem gamblers and 92% of those at moderate risk. Less than 1% in each group have been referred by the police/courts/probation service.

4 Findings

4.1 The size, distribution and characteristics of the gambling population in Britain

The aim of this section is to:

- Outline the proportion of the GB population experiencing some level of gambling harm (based on the PGSI), as identified across a range of data sources;
- Describe the characteristics of the gambling population; and
- Detail where there are demographic and geographical differences between problem gamblers, those at risk of experiencing gambling harms, and the wider population.

Box 4.1.1. Key findings

- More than one in ten adults scored one or higher on the PGSI scale (13%).
- Seven percent were classified as a low-risk gambler (a score of 1-2); three percent as a moderate-risk gambler (a score of 3-7) and three percent as a problem gambler (PGSI 8+).
- For each PGSI category, the proportion observed in the YouGov population survey was approximately three times the proportion reported by the combined health surveys (Health Survey for England, Scottish Health Survey, Welsh Problem Gambling Survey).
- Analysis of the methodological differences between the two data sources concluded that the true level of problem gambling lies somewhere in between the estimates reported by the two surveys (YouGov and the combined health surveys).
- Men, younger adults (aged 18-34) and adults from a lower socioeconomic or BAME backgrounds were more likely to be classified as gamblers experiencing some level of harm (PGSI 1+).
- The highest number of problem gamblers were located in the Midlands, Yorkshire and London.

What is the size and distribution of the gambling population?

To answer this question, data from the YouGov population survey was applied and compared to figures from the 2016 combined dataset of the Health Survey for England, Scottish Health Survey and Welsh Problem Gambling Survey. The gambling behaviour of respondents was classified using the PGSI as outlined in Section 3.3.

According to the YouGov population survey, three-fifths (61%) of adults in Britain have participated in any type of gambling activity in the last 12 months. This compares with 57% in the 2016 combined health surveys. Table 4.1.1 compares PGSI score categories from the YouGov population survey with the combined health survey results and shows from both data sources the proportion falling into each category.

The YouGov population survey found that 13% of adults scored one or higher on the PGSI scale. Seven percent were classified as a low risk gambler (a score of 1-2); three percent as a moderate risk gambler (a score of 3-7) and three percent as a problem gambler (a score of 8 or higher). The proportions falling into each PGSI category are significantly higher than those recorded in the combined health surveys, where just over four percent of the population scored 1 or higher on the PGSI scale. For each category, the proportion identified in the YouGov population survey is approximately three times the proportion reported by the combined health surveys.

Table 4.1.1: PGSI score categories comparisons between combined health and YouGov surveys

	YouGov Population survey 2019	Combined Health Surveys 2016
Non-gambler	38.9%	43%
Non-problem gambler (score 0)	47.9%	52.9%
Low-risk gambler (score 1-2)	7.2%	2.4%
Moderate-risk gambler (score 3-7)	3.3%	1.1%
Problem gambler (score 8+)	2.7%	0.7%
All gamblers with a score of 1+	13.2%	4.2%

In considering these comparisons, it is worth noting some of the methodological differences between the studies which could have impacted on participant responses. The YouGov population survey includes a non-probability sample in which respondents complete the questionnaire online. The combined health surveys use probability sampling and face-to-face interviewing, although the measure of gambling harm is completed by the respondents via a paper questionnaire.

An independent assessment of the accuracy of survey estimates of the prevalence of gambling harms was carried out in March 2020.¹¹ The report provides a description of the range of errors that may be present in the different survey estimates and assesses which of the two surveys is likely to be most affected by these errors and in which ways. The report concluded that on the balance of probability, taking all factors into consideration, the combined health surveys may somewhat under-estimate the true prevalence of gambling harms, whereas the YouGov population survey estimates are likely to be working in the opposite direction and somewhat over-estimating the true prevalence. The true value probably lies closer to the combined health surveys than to the YouGov survey.

The analysis of the methodological differences further concluded that even if the YouGov survey does over-estimate the true level of gambling harm prevalence in Great Britain, it still has value in estimating the distribution of gambling harm prevalence across demographic groups, the attitudes and experiences of individuals experiencing gambling harms and the usage as well as demand for any type of treatment and support.

What are the characteristics of the gambling population?

In applying the PGSI classification (see 3.3), a relationship was found between gambling harms and demographic and geographical characteristics. As Table 4.2.2 shows, men were more likely than women (17% vs. 10%) to be classified as gamblers experiencing some level of harm (PGSI 1+). Men were also twice as likely to be classified as problem gamblers (PGSI 8+; 4% vs. 2%). In exploring different age groups, younger adults (aged 18-34) were less likely to gamble overall, but those that did gamble were more likely to be classified as gamblers with some level of risk (PGSI 1+). Specifically, 5% of younger gamblers (18-34) were classified as problem gamblers (PGSI 8+), compared with 3% of those aged 35-54, and under half a percent of adults aged 55 and over (0.5%).

¹¹ "An assessment of the accuracy of survey estimates of the prevalence of problem gambling in the United Kingdom" - Professor Patrick Sturgis, Department of Methodology, London School of Economics, March 2020.

Table 4.2.2: PGSI score categories by sex and age

	All	Men	Women	18-34	35-54	55+
Non-gambler	39%	36%	41%	47%	32%	38%
Non-problem gambler (score 0)	48%	47%	49%	34%	52%	54%
Low-risk gambler (score 1-2)	7%	9%	6%	9%	8%	5%
Moderate-risk gambler (score 3-7)	3%	5%	2%	4%	4%	2%
Problem gambler (score 8+)	3%	4%	2%	5%	3%	0%
All gamblers with a score of 1+	13%	17%	10%	18%	16%	7%

In addition to sex and age, a relationship was found between PGSI classification and geographical, socioeconomic and ethnic background as well as psychological wellbeing. In particular:

- Geographical distribution:** across all local authorities, the estimated proportion of gamblers experiencing some level of harm (PGSI 1+) varies widely from 8% to 27%. Whilst the overall proportion of the British population experiencing some level of harm is 13%, the estimated proportion is notably higher in Brent (27%) and Newham (25%), followed by certain other boroughs in London and the Midlands. Looking at the prevalence of problem gamblers (PGSI 8+) across local authority areas, higher numbers were more likely to be located in:
 - o **London** with the boroughs of Brent and Newham having the highest number; i.e., 10.7% and 11.5% respectively.
 - o **East Midlands** with Boston, Leicester and Coventry above 6%.
 - o **West Midlands** with Birmingham, Sandwell, Walsall and Wolverhampton between 6% and 8%; and.
 - o **Yorkshire** (7.3%).
- Socioeconomic background:** respondents from a lower socioeconomic background were slightly more likely to be classified as gamblers with some level of harm than those from a higher socioeconomic background (14% vs. 12%).
- Ethnicity:** BAME respondents were less likely to participate in gambling overall than their white peers. Those who do gamble, were more likely to be classified as gamblers with a higher level of harm (PGSI 1+) than white adults (i.e. 20% vs. 12%). In addition, 7% of BAME respondents were classified as problem gamblers (PGSI 8+) compared with 2% of white respondents.
- Psychological wellbeing:** wellbeing decreased as gambling severity increased. Problem gamblers (PGSI 8+) had poorer wellbeing than other gambling groups (i.e. low and moderate risk groups). The relationship between physical health and gambling severity was less clear, with problem gamblers having worse self-reported general health than all other groups, but less likely to have a large number of health conditions than non-gamblers. This was likely due to the underlying age differences of the groups.

Summary

Comparing prevalence estimates between the different data sources, on the balance of probability, the number of individuals who gambled in the last 12 months preceding the surveys is between 54% and 61%, with the true level of low, moderate and problem gambling falling somewhere in between the different estimates.

Associations between gambling problems and sociodemographic characteristics showed that men, younger adults (aged 18-34), BAME and adults from lower socioeconomic backgrounds were more likely to be classified as gamblers with some level of harm (PGSI 1+).

It is notable that whilst the overall proportion of the British population with some level of harm (PGSI 1+) was identified as 13% in the YouGov population survey, the estimated proportion is higher in specific Local Authorities in London and the Midlands. These are also all areas with relatively high levels of deprivation as well as high BAME populations, which is consistent with the overall findings of this programme of studies.

4.2 The sociodemographic and geographical characteristics of gamblers in Britain accessing treatment and support

The aim of this section is to:

- Detail the proportion of gamblers (based on the PGSI) accessing any type of treatment and support;
- Discuss the characteristics of the gambling population accessing any type of treatment and support; and
- Outline the size and characteristics of gamblers engaging with and completing treatment.

Box 4.2.1: Key findings

- The proportion of all gamblers (PGSI 1+) across GB using any type of treatment and support is 17% (2 in 10). 'Treatment' refers to formal services such as mental health and GPs; 'support' refers to family & friends, websites, helplines etc.
- The primary driver underpinning treatment and support access was the severity of gambling harm. Over half (54%) of problem gamblers (PGSI 8+) reported accessing treatment and support.
- Younger and BAME gamblers as well as gamblers from higher socioeconomic backgrounds classified as problem gamblers (PGSI 8+) were more likely to report accessing treatment and support.
- Amongst treatment services accessed, mental health services such as a counsellor or therapist were the most commonly reported (5%), followed by GPs and social or support workers.
- All gamblers experiencing some level of harm (PGSI 1+) and using treatment services participated in very similar types of gambling activities; the most common being online gambling, virtual gaming machines in bookmakers (e.g. casino), and online betting with a bookmaker.
- Most gamblers in treatment were male, between 25-34 years and in employment.
- Completion of treatment rates generally improved as age increased reaching 80% for older age-ranges (35 years old and over).

What is the size and characteristics of the gambling population accessing treatment and support?

Of those experiencing some level of gambling harm (PGSI 1+), 17% reported having used any type of treatment, such as mental health services or GP services, and any type of support, such as friends or family, etc in the last 12 months. The primary driver of accessing treatment and support was the severity of gambling harm, suggesting that many people experiencing lower levels of gambling harm do not necessarily need treatment and support. As shown in Table 4.2.1, while just 3% of those classified as low risk gamblers reported using any type of treatment and support, this increased to 17% for those classified as moderate risk gamblers, and over half (54%) for problem gamblers. Among moderate risk gamblers, use of any treatment only was 9%, increasing to 43% for those in the 'problem gambler' category. Looking at support only, 14% of moderate risk gamblers had used any support, increasing to 39% for those classified as problem gamblers (PGSI 8+).

Table 4.2.1: Use of treatment and support by PGSI score category

	All gamblers with score of 1+	Low-risk (score 1-2)	Moderate-risk (Score 3-7)	Problem gambler (Score 8+)
Used any treatment	12%	2%	9%	43%
Used any support	13%	2%	14%	39%
Used any treatment and support	17%	3%	17%	54%
Have not used any	83%	97%	83%	46%

Some clear relationships were found between demographic characteristics and access to any type of treatment and support. Younger and BAME gamblers as well as gamblers from higher socioeconomic backgrounds experiencing gambling problems (PGSI 8+) were more likely to report accessing any type of treatment and support. In particular:

- **Men (17%) and women (20%)** were similarly likely to have accessed any type of treatment and support.
- **Younger** gamblers were more likely to have accessed any type of treatment and support: a quarter (25%) of **18-34 year** olds had done so, falling to 15% of **35-54 year** olds, and just 8% of those **aged 55 and over**.
- **BAME** gamblers were more likely to have accessed any type of treatment: a third (34%) had accessed any source (e.g. mental health, GP, specialist, etc), compared with 16% of **white** gamblers.
- Gamblers from **higher (22%)** compared to **lower (14%) socioeconomic backgrounds** were more likely to have accessed any type of treatment and support.

What is the type of treatment and support used by the gambling population?

As Figure 4.2.1 shows, among treatment services, mental health services such as a counsellor or therapist had most commonly been accessed (5%). This was followed by GPs and social or support workers (both 4%). When considering informal sources of support, gamblers had most commonly sought support from friends and family members (4%). Gamblers from higher socioeconomic backgrounds were more likely than those in lower ones to have accessed mental health services (6% vs. 3%), a social worker, youth worker or support worker (6% vs. 2%) and specialist face-to-face treatment for gambling (4% vs. 1%). Some services, such as counselling, are available privately, making them potentially more accessible to those on higher incomes. Other factors which could help to explain this difference were related to the varying levels of provision in different local areas, the varying levels of access to transport, and a higher prevalence of mental and physical health problems among respondents from lower socioeconomic backgrounds. These factors might make accessing treatment and support more difficult or require individuals to prioritise treatment for existing health problems before addressing any gambling problem.

Figure 4.2.1: Use of treatment and support in the last 12 months



Base: all gamblers with a PGSI score of 1+ (n=1,960)

In-depth interviews with gamblers experiencing varying levels of harm enabled additional exploration of the use of support. Participants reported using a range of informal support strategies (see Table 4.2.2) to manage gambling behaviour and indicating that such strategies were sometimes viewed as an initial step for controlling gambling behaviour. If these informal techniques had not been successful, some participants envisaged that they may have then accessed more formal modes of treatment, such as mental health services and other types of support, such as helplines. Those who considered that their gambling behaviour was, or could potentially be, problematic or out of control, had at times drawn on the following types of informal support

Table 4.2.2. Types of informal support for managing gambling behaviour

Online information	Gamblers had looked online for information about the nature of disordered or problematic gambling. This was perceived as supporting them to identify whether their own behaviour was problematic and what could be done to address this.
Self-imposed controls	Gamblers had attempted to control or change their access to gambling by imposing a range of measures. Examples included changing jobs, to be further away from a gambling venue; or setting personal limits on the amount of money or time spent gambling. This included taking a set amount of money to the arcade or avoiding gambling for a set period of time by hiding electronic devices.
Self-exclusion tools	Gamblers used a range of tools to help control their gambling, including: self-exclusion schemes; spending limits on betting websites; time reminders to stop gambling after a set period; and arranging for their bank to block any gambling related transactions.
Support from social networks	Gamblers received support to control their gambling from family members and friends. Partners had taken an active role by, for example, closing the computer if they saw the participant had accessed gambling sites. Family and friends were also recognised as an important source of emotional support.

There was a strong consensus amongst the participants experiencing gambling harm interviewed about the type and extent of treatment and support provision that would be helpful. Interviewees felt there should be a greater focus on prevention and early intervention including education in schools and colleges as well as changes to advertising, flagging treatment and support 'up-front' in any websites, rather than at the end; and that any services should be targeted and tailored to the individual. Finally, there was general agreement that the gambling industry needed to take a greater responsibility for working alongside their customers, regulating and identifying when gambling moved from a 'leisure activity' to that of 'problem gambling'.

What is the size and characteristics of the gambling population engaged with and completing treatment?

Gamblers receiving treatment, regardless of the severity of their gambling problems, reported participating in very similar types of gambling activities. The three most common were online gambling, virtual gaming machines in bookmakers (e.g. casino), and online betting with a bookmaker.

Findings from the Data Reporting Framework analysis also suggested a marked gender and age skew, with most gamblers in treatment being male, aged between 25-34 years and in employment. Just 4% of problem gamblers and 2% of those at moderate risk in gambling treatment were Scottish residents, yet Scottish residents make up 9% of the combined population of England and Scotland. This suggests that levels of engagement in treatment is lower in Scotland, given that there were no differences between Scotland and England in rates of problem gambling.

The rate of treatment completion generally improved as age increased, reaching 80% for older age-ranges (35 years old and over). There were also greater odds of completing treatment if the person was White British, employed and married or in a relationship. Although there was a slight improvement in completion rates for young people (under 25 years) between 2015 and 2017, in each of the years analysed these were lower than for other age-ranges. Out of all 16-24-year olds who started treatment, just 55% completed it. This suggests a significant issue with dropping out of treatment services at various stages between being assessed and completing treatment that requires further investigation.

Summary

Evidence from this programme of studies reports that 17% of all gamblers (PGSI 1+) had used any type of treatment and support in the last 12 months.

Access was significantly higher amongst those who may need it the most such as those classified as problem gamblers (PGSI 8+), younger and BAME gamblers. It is important to note that although younger gamblers were more likely to have accessed treatment and support, the drop-out rate was higher for this group, and further research is needed to identify the reasons for this.

Finally, although mental health services were the most commonly reported services accessed, further research is needed to identify motivations for choosing to access some modes of treatment and support over others. For example, why are GP services not more commonly accessed when they tend to be the first point of contact for any mental and physical health related issues?

4.3 Demand for treatment and support

The aim of this section is to:

- Detail the proportion of gamblers in the general population who would like treatment and support;
- Discuss the relationship between demographic and geographical characteristics and level of demand of treatment and support; and
- Outline the type of treatment and support needed.

Box 4.1.1. Key findings

- Out of all gamblers experiencing some level of harm (PGSI 1+), almost half stated that their gambling was not problematic (45%) and just 18% of them stated that they would like to receive some form of treatment or support in the next 12 months.
- Among this group, 4% had not accessed any type of treatment or support in the last 12 months but would like to receive some, whilst 14% had accessed some prior treatment or support but would like to receive more.
- Those classified with higher scores on the PGSI were much more likely to state that they would like to receive treatment or support. Among low risk gamblers, just 4% wanted any type of treatment or support, rising to 15% of those with a moderate risk and over half (57%) of problem gamblers (PGSI 8+).
- Those classified as problem gamblers (PGSI 8+) expressed higher demand for treatment such as mental health and GP services, whereas those classified as low risk and moderate risk gamblers were more likely to want support from less formal sources such as family and friends.
- Younger and BAME gamblers and gamblers from higher socioeconomic backgrounds who had higher PGSI scores on average, were more likely to want treatment or support.
- Demand for treatment and support was highest in the areas with higher proportions of gamblers (PGSI 1+) with the highest demand found in London, notably 10% in Brent and 9% in Newham. Across all local authorities, estimated demand ranges from 1% to 10%.
- Only 14% of all gamblers (PGSI 1+) reported that they would like some treatment, with 5% reporting that they would like treatment from mental health services and 4% specialist face-to-face treatment.
- Among less formal sources of support, family and friends were the most popular option.

What is the level of demand for treatment and support?

Table 4 shows the percentage (18%) of gamblers experiencing harms (PGSI 1+) and problem gamblers (PGSI 8+) who would like some form of treatment and support as a percentage of the population who are classed as PGSI 1+ and PGSI 8+, identified by the YouGov population survey and the 2016 Combined Health Surveys. An estimate of the total number of people wanting treatment and support has also been provided; this is based on GB population figure of 50,940,700. Similar to the prevalence of gambling problems, the proportion who would like some form of treatment or support observed in the YouGov treatment and support survey was approximately three times the proportion reported by the combined health surveys.¹² As discussed in section 4.1, and following independent analysis of the methodological differences between data sources, it is likely that the true figure falls somewhere in between the two survey estimates.

¹² This has been calculated using both the YouGov population survey gambling harms prevalence figures and the 2016 Combined Health Survey gambling prevalence figures to give an estimate of the number of people across GB wanting some form of treatment and support.

Table 4. Demand for treatment and support amongst the GB population

PGSI Score	YouGov Population survey 2019	Combined Health Surveys 2016
PGSI 1+	18% of 13.2% = 2.38% 2.38% of 50,940,700 ¹³ = 1,210,351	18% of 4.2% = 0.76% 0.76% of 50,940,700 = 385,112
PGSI 8+	57% of 2.7% = 1.54% 1.54% of 50,940,700 = 783,977	57% of 0.7% ¹⁴ = 0.4% 0.4% of 50,940,700 = 203,253

Of all gamblers experiencing some level of harm (PGSI 1+), 18% stated they would like to receive some form of treatment or support in the next 12 months. Therefore, 82% of respondents stated they were not in need of treatment or support. Among those who would like treatment or support, 4% have not accessed any form of treatment or support in the last 12 months but would like to receive some, whilst 14% have accessed some prior treatment or support and would like to receive more. The 18% of individuals (PGSI 1+) wanting some form of treatment or support consisted of 13% who wanted treatment, such as mental health or GP services and 13% who wanted support, such as family and friends, support groups, websites or books.

In line with the pattern seen in relation to reported use of all types of treatment and support, those classified with higher scores on the PGSI were much more likely to state that they would like to receive treatment or support. Among low risk gamblers (PGSI 1+), just 4% wanted any type of treatment or support; rising to 15% of those classified as moderate risk (PGSI 3-7), and over half (57%) of those classified as problem gamblers (PGSI 8+). Those classified as low and moderate risk gamblers were more likely to want any type of support than treatment. For the 'problem gambler' category, this pattern was reversed, with higher demand for any type of treatment (48%) than for support (41%). Looking at the demographic profiles of all gamblers with some level of harm (PGSI 1+) in relation to demand for treatment and support:

- **Sex:** Male and female gamblers were equally likely to want any type of treatment or support.
- **Age:** Younger gamblers who had higher PGSI scores on average, were much more likely to want any type of treatment or support. A quarter (25%) of 18-34 year olds selected one or more sources; dropping to 17% for 35-54 year olds and just 8% for gamblers aged 55 and over. In particular, the youngest age group (18-24) were much more likely to want treatment from a social or youth worker (9%) and from other addiction services such as drug or alcohol services (8%).
- **Geographical distribution:** When looking at local authority level estimates, demand for any type of treatment and support was highest in the areas with higher proportions of gamblers (PGSI 1+). An estimated 10% of gamblers living in Brent, and 9% in Newham, would like some form of treatment or support, compared with 2.31% of the total British adult population. Across all local authorities, estimated demand ranges from 1% to 10%.

¹³ The population of GB aged 18+ is 50,940,700 (taken from the ONS' 2018 Mid-Year Population Estimates):

<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2018>

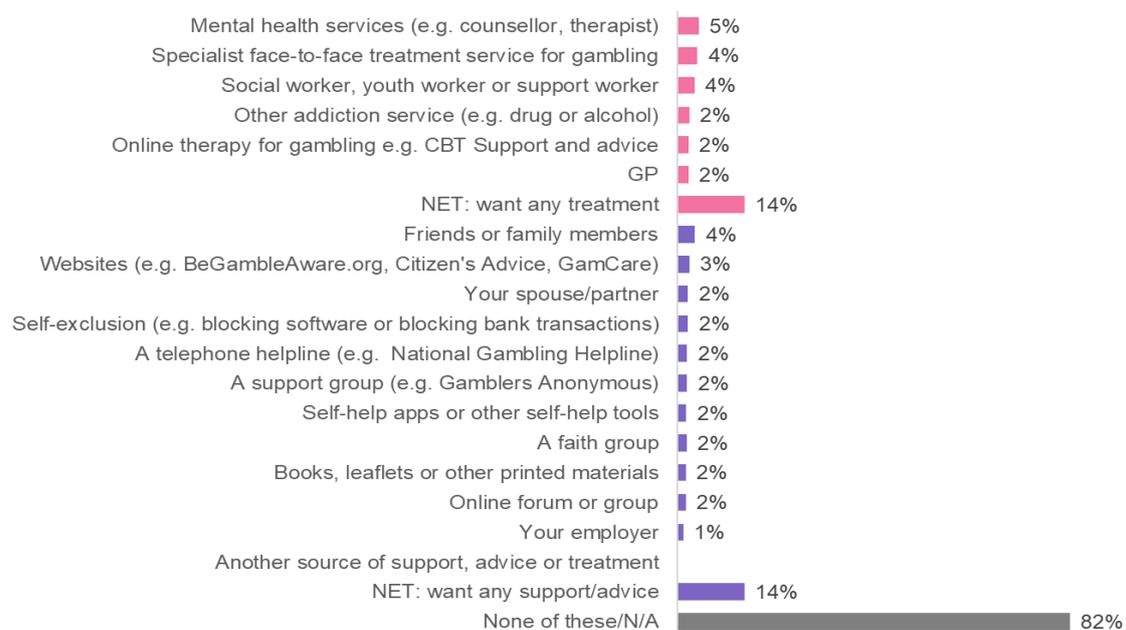
¹⁴ The problem gambler category is derived from the PGSI and DSM-IV. Therefore, the calculated 4.2% for 'all gamblers with a score of 1+' may include some double counting because of the different screens used.

- Socioeconomic background:** 23% of gamblers from a higher socioeconomic background reported that they would like any type of treatment or support, compared with 14% of gamblers from a lower socioeconomic background. The former were also more likely to want treatment from a specialist face-to-face service (6% vs. 3%) and a social or youth worker (5% vs. 2%). Gamblers from a higher socioeconomic background also showed greater interest in support from an online forum, a telephone helpline and a faith group (3% vs. 1% from all these sources of support).
- Ethnicity:** BAME gamblers who had higher PGSI scores on average, were significantly more likely to want any type of treatment or support compared to white gamblers. Over a third (36%) of BAME gamblers wanted any type treatment or support, compared with 16% of white gamblers. Among types of treatment and support, some notable differences included specialist face-to-face treatment for gambling (10% BAME vs. 4% white), other addiction services (6% vs. 2%), and support from a faith group (5% vs. 1%).

What are the sources of treatment and support needed?

As Figure 3 shows, just 13% of all gamblers (PGSI 1+) reported that they would like any type of treatment and the same percentage reported that they would like any type of support. Those who reported that they would like any type of treatment, 5% reported that they would like treatment from mental health services and 4% from specialist face-to-face services. While GPs and mental health services were the most commonly used treatment options, the pattern reversed when gamblers reported the list of professional sources from whom they would like to receive treatment (2%). Among sources of support, family and friends were the most popular option (4%). It is important to note that GP referrals were found to be an area that particularly lacked in evidence as a form of treatment pathway. The little available evidence provided discouraging findings around GPs as a current referral source, mainly because there was lack of appropriate screening for problem gambling, lack of specialist knowledge and lack of training on dealing with problem gambling.

Figure 3. Sources that gamblers currently want to receive treatment and support from



Base: all gamblers with a PGSI score of 1+ (n=1,960)

Interviews were also conducted with individuals experiencing gambling harms who had used treatment and support. Participants expressed the need for additional services to be provided to expand access and awareness for sustained recovery. Such services were related to:

- **Recovery and support:** a recurrent theme identified was around those with personal experience of problem gambling wanting to become an integral part of the support available, helping current gamblers to change their behaviours. Suggestions revolved around volunteering possibilities for ex-gamblers as well as within those peer support groups that are led by trained facilitators. Such involvement was seen as helping to ensure wider and targeted support in the context of the needs of particular groups, such as women and young people, not being adequately met.
- **Professional treatment and support:** people experiencing gambling harms who were in treatment commented on a need for support that focuses on financial management, as opposed to just gambling management practices; and ongoing counselling, rather than a fixed number of sessions without further counselling support. Helplines that operate 24/7 were also identified as additional support that can provide further access and sustained recovery. Helplines were also identified as a standalone form of early intervention as well as an effective pathway into treatment.
- **Aftercare to treatment:** there was a perception that the aftercare currently available following engagement with treatment services does not provide sufficient support. Whilst aftercare was highlighted by a number of participants, the discussion was around the need for such provision, rather than any experience of receiving such support.
- **Self-Exclusion:** individuals with and without experience of accessing treatment and support identified self-exclusion as a useful tool that can aid management of gambling activity and recovery from gambling harms. However, it was recognised that the self-exclusion tools and approaches currently available will need to be developed further. For example, individuals experiencing gambling harm could be self-excluded from one gambling company but continue gambling with another one. The need for adaptations to the existing multi-operator self-exclusion scheme was apparent as well as the development of processes that would make it difficult to re-engage.

Summary

Of all gamblers experiencing some level of harm (PGSI 1+), 18% stated they would like to receive some form of treatment or support meaning that 82% of the respondents did not want any type of treatment and support. Most gamblers felt that their activity did not constitute a problem or pose any harms and it was under control.

Those classified with higher scores on the PGSI were much more likely to state that they would like to receive any type of treatment or support, with over half of problem gamblers (PGSI 8+) reporting that they would like this. Problem gamblers (PGSI 8+) were also more likely to express demand for professional treatment such as mental health and GP services, whereas those classified as low and moderate risk gamblers (PGSI 1-7) were more likely to express higher demand for support from family and friends.

Younger and BAME gamblers and gamblers from higher socioeconomic backgrounds, who had higher PGSI scores on average, were much more likely to want any type of

treatment or support. Similarly, demand was highest in the geographical areas with higher proportions of gamblers (PGSI 1+) with estimated demand ranging from 1% to 10% across all local authorities.

4.4 Barriers and facilitators to treatment and support access and engagement

The aim of this section is to:

- Outline the barriers to treatment and support access and engagement; and
- Highlight those facilitators to accessing and engaging in treatment and support.

Box 4.1.1. Key findings

- Perceiving one's gambling as not problematic was one of the main reasons for not seeking treatment or support, with 17% of those classified as problem gamblers (PGSI 8+) stating that their gambling was not harmful or that they only gambled small amounts of money.
- Close to a third (31%) said that treatment and support was not relevant to them or would not be suitable for someone like them, and a fifth (21%) recognised positive impacts from gambling such as making money, or it being part of their social or leisure time. For one in ten (11%), stigma or shame was a barrier to seeking help.
- Problem gamblers (PGSI 8+) were more likely to report experiencing stigma or shame (27%) compared with 12% of moderate and 4% of low-risk gamblers.
- Women experiencing some level of harm (PGSI 1+) were more likely than men to cite practical barriers such as cost, time or location in relation to accessing treatment or support (9% vs. 3%) highlighting a concern that the needs of specific groups are not adequately met.
- Older gamblers (PGSI 1+) aged 55 and over were more likely to report that treatment or support was not relevant or suitable for them: 38% compared with 26% of 35-54 year olds and 31% of 18-34 year olds.
- Twenty eight percent of gamblers (PGSI 1+) recognised one or more factors which might motivate them to seek treatment and support, with online treatment or support being the most popular (6%), followed by telephone (5%) and face-to-face (4%).
- Gamblers (PGSI 1+) from a higher socioeconomic background were more likely to report that they had knowledge of, and ease of access to, treatment and support as well as availability of support from friends and family.
- Gamblers (PGSI 1+) from lower socioeconomic backgrounds were more likely to report that nothing would motivate them to seek support (17% compared to 9%) indicating that this may be a priority group to target when designing strategies for developing facilitators for routes into treatment.
- Supportive evidence was found around self-exclusion as a facilitator to accessing support albeit tempered by concerns around implementation and effective engagement by gambling operators.

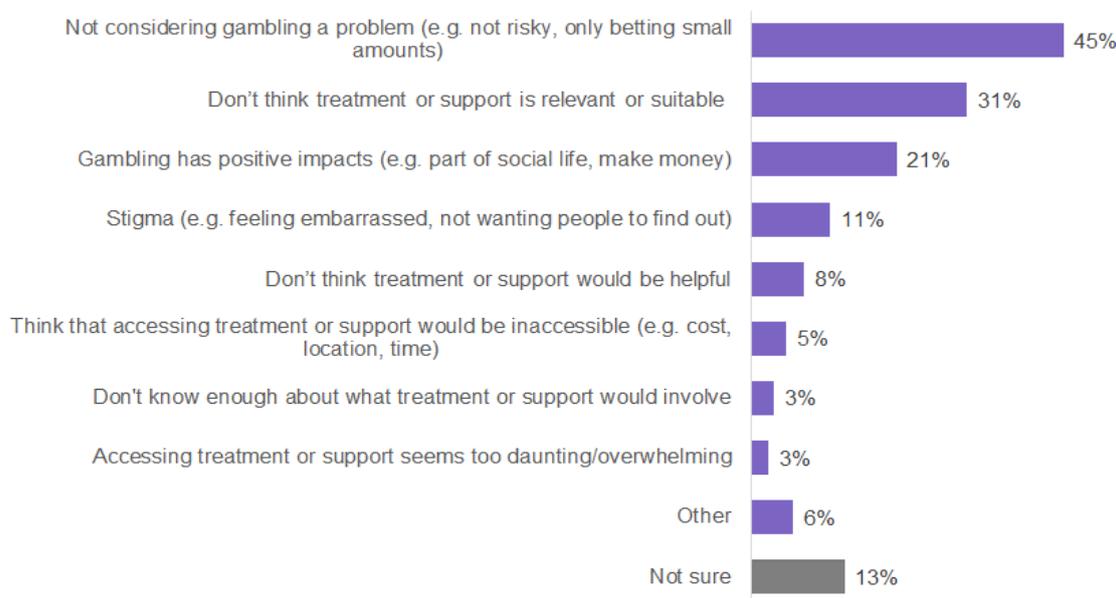
What are the barriers to treatment and support access and engagement?

Several barriers to using treatment and support for gambling harm were identified. The evidence suggests that there are different categories of barriers including: personal barriers, such as ill health; lack of awareness of problem behaviour, mode of therapy, such as group therapy or online-based therapy; practical, such as time constraints; and social, for example perceived social stigma.

Among respondents stating that they did not want any form of treatment or support, the barriers were further explored in the YouGov treatment and support survey.¹⁵ As Figure 4 shows, among gamblers (PGSI 1+) stating that they did not want any type of treatment or support, almost half (45%) stated that their gambling was not harmful or that they only gambled small amounts of money. Close to a third (31%) said that treatment and support was not relevant to them or would not be suitable for someone like them; and a fifth (21%) recognised positive impacts from gambling, such as making money, or it being part of their social or leisure time. For one in ten, (11%), stigma or shame was a barrier to seeking help. These barriers varied according to the level of harm experienced due to gambling.

Those classified as low and moderate risk gamblers (PGSI 1-2 and 3-7) were more likely to say that their gambling was not harmful or only involved small amounts of money (53% and 51% respectively), with this proportion declining to 17% for those in the ‘problem gambler’ category (PGSI 8+). In contrast, those classified as problem gamblers (PGSI 8+) were more likely to experience stigma or shame: 27%, compared with 12% of moderate risk gamblers and 4% of low risk gamblers.

Figure 4. Barriers to seeking treatment and support



Base: all gamblers who would not want treatment or support (n=640)

While almost half of the respondents were not accessing any type of treatment and support because they did not want it or did not identify themselves as in need, a third of respondents perceived that treatment and support was not relevant or suitable for someone like them due to personal reasons, type of therapy, and practical barriers.

Barriers were also discussed in interviews with participants experiencing gambling harm who also identified the social barrier of perceived stigma or shame attached to seeking treatment. Stigma and shame were linked to a belief that gambling problems were a result of their own actions and not directly related to the nature of gambling. Such reluctance to access formal treatment or higher levels of support was often underpinned by initially using personal strategies, such as accessing information online, or self-imposed methods of control to manage problematic gambling; with participants delaying accessing treatment until their gambling was having an extensive impact, such as a financial impact.

¹⁵ A more detailed follow-up online survey to explore the experiences and views of these groups, including in relation to seeking treatment and support (see Methods section 3.2.3).

When exploring the relationship between sociodemographic characteristics and the barriers to treatment and support, women (PGSI 1+) were more likely than men to cite practical barriers such as cost, time or location in relation to accessing treatment or support (9% vs. 3%), highlighting a concern that the needs of specific groups are not adequately met, including those of women. Older gamblers (PGSI 1+) aged 55 and over were more likely to report that treatment or support was not relevant or suitable for them: 38% compared with 26% of 35-54 olds and 31% of 18-34 olds. Although barriers were generally similar among ethnic groups two key differences were found: 1) white gamblers (PGSI 1+) were more likely to state that they did not need to cut down their gambling, claiming that their gambling was having positive impacts such as making money or being part of their social life (23% compared to 6% of BAME gamblers), 2) BAME gamblers (PGSI 1+) were more likely than white gamblers to state that the gambling activities they participate in are not harmful (29% compared to 14%).

The lack of awareness about gambling harms was a particularly salient theme across most strands from this programme of studies. Participants tended to feel one of two very clear positions: they either felt that they had always been able to control their gambling behaviour, seeing it as a leisure pursuit and never spending more than small amounts of their disposable income; or that they lacked control, gambling more frequently or spending more money than they would like. Those who felt that their gambling was problematic explained the negative impact it may have had on them, such as losing money on credit cards and putting strain on their relationships. However, for many participants it was only with hindsight that they could describe the signs that their gambling may have moved from a leisure activity to one of addiction.

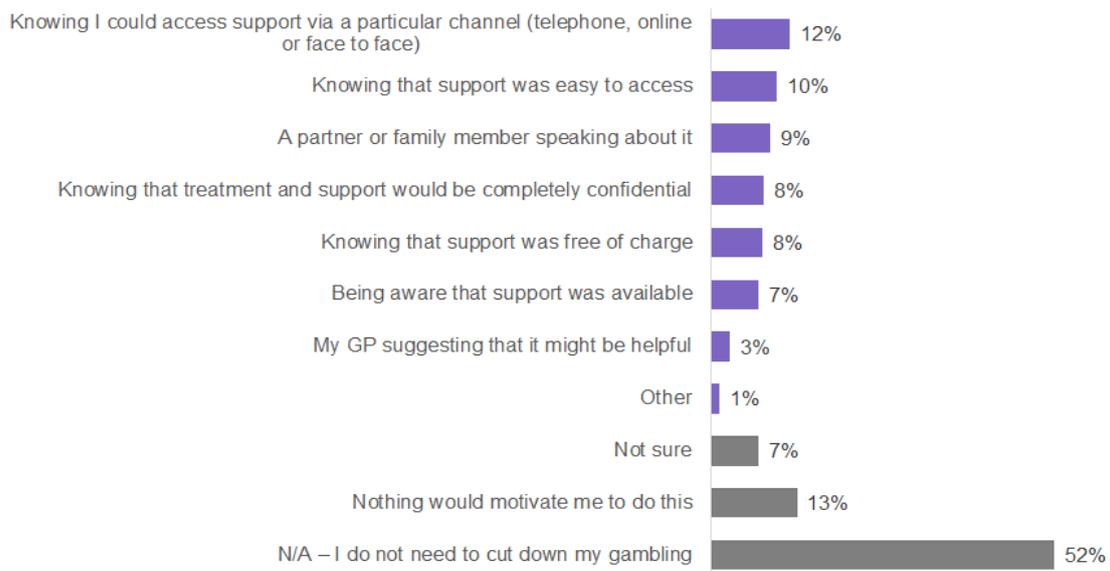
What are the facilitators to treatment and support access and engagement?

Just over a quarter (28%) of those experiencing some level of harm (PGSI 1+) recognised one or more factors which might motivate them to seek treatment and support. This includes those who had already accessed some type of treatment or support in the last 12 months as well as those who had not.

Amongst all gamblers experiencing some level of harm (PGSI 1+), 12% mentioned a range of channels that would facilitate accessing treatment and support, notably telephone, online or face-to-face. As Figure 5 shows, online was the most popular (6%), followed by telephone (5%) and face-to-face (4%). Ease of access was also seen as a facilitator to treatment or support for one in ten participants (10%), including the ability to self-refer; and a similar proportion would be encouraged by a partner or family member speaking to them about their gambling (9%).

For respondents classified as problem gamblers (PGSI 8+), three in ten (31%) identified that they might be motivated by knowing support was available via a particular channel, e.g. online or face to face, and a fifth (22%) by a partner or family member speaking to them about their gambling behaviours.

Figure 5. Factors that might motivate gamblers to seek treatment and support



Base: all gamblers with a PGSI score of 1+

In exploring facilitators or motivators to treatment and support, there were some key differences according to socioeconomic and ethnic background. Gamblers (PGSI 1+) from higher socioeconomic backgrounds were more likely than those from lower socioeconomic background to report that they had knowledge of, and ease of access to, treatment and support as well as availability of support from friends and family.

Gamblers (PGSI 1+) from lower socioeconomic backgrounds were more likely to report that nothing would motivate them to seek support (17% compared to 9%). Looking at ethnic background, BAME gamblers (PGSI 1+) were particularly likely to mention that knowing support was available by telephone was helpful.

Supportive evidence was also found around self-exclusion as a support channel, albeit tempered by concerns around implementation and effective engagement by gambling providers. More generally, online tools removed some of the practical barriers to accessing treatment and support such as the need to travel or speak with a treatment provider face to face.

Summary

The findings illustrated how different barriers may be interlinked; for example, lack of awareness and feelings of stigma and shame. Where almost half of all respondents reported that they did not want any type of treatment or support, the data shows that this could be related to a reluctance to admit problematic behaviour, often because of the stigma associated with gambling problems and seeking treatment and support. For example, eight out of ten gamblers (PGSI 1+) stated that they did not want any type of treatment or support, with almost half stating that their gambling was not harmful or that they only gambled small amounts of money; and close to a third that treatment and support was not relevant to them or would not be suitable for someone like them. Problem gamblers however, (PGSI 8+), were more likely to report that their gambling was harmful than low and moderate risk gamblers.

Sociodemographic differences in reported barriers also highlight a concern that the needs of specific groups, such as women, BAME and people from a lower socioeconomic background, are not adequately met. Flexible treatment and support

options, such as online or telephone services, would potentially improve accessibility for people in these marginalised groups.

4.5 The impact of gambling on affected others

The aim of this section is to:

- Outline the proportion of affected others in the general population;
- Describe the characteristics of affected others;
- Detail the proportion of affected others accessing and needing treatment and support; and
- Explore the barriers and facilitators to treatment and support for affected others.

Box 4.1.1. Key findings

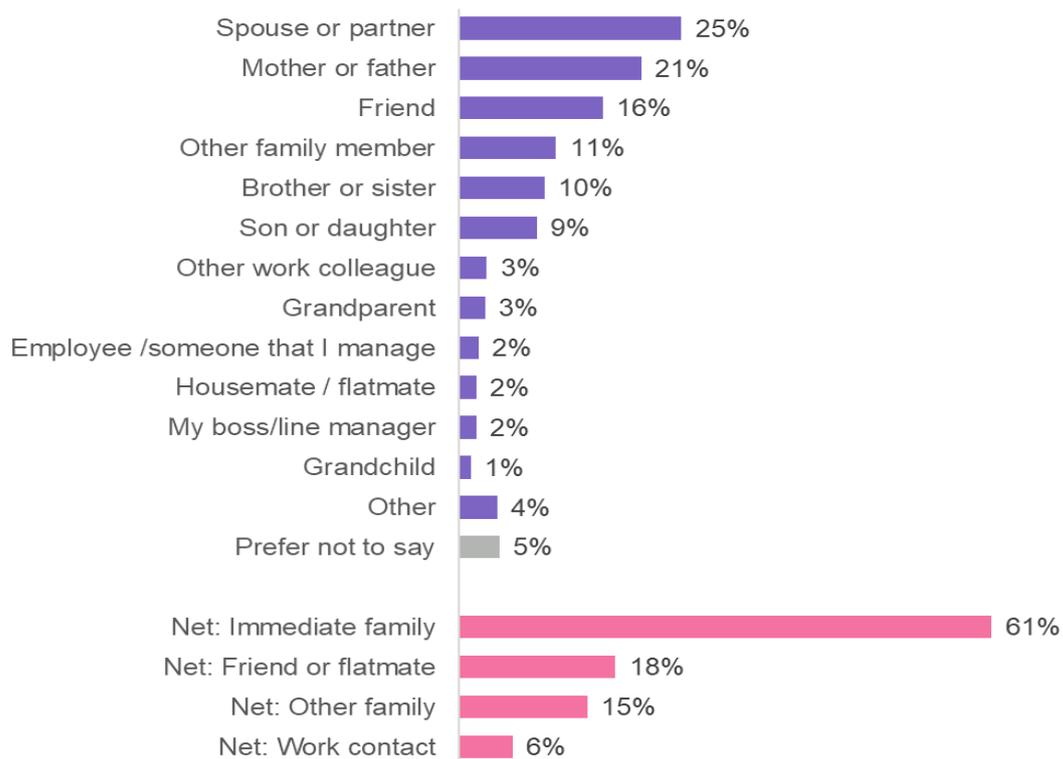
- Seven percent of people across Britain were identified as an affected other. The majority were the partner or close family member of a gambler (61%).
- Affected others were more likely to be women (57% vs. 43%), people from BAME communities (16% vs. 12%) and from a lower socioeconomic background (51% vs. 46%).
- Twenty percent of affected others also reported experiencing gambling harms directly themselves (PGSI 1+).
- The most common type of negative impact identified was on relationships (82%) and on finances (60%). Half (48%) of those negatively affected by the gambling of a spouse or partner described the impact as “severe” and the proportion was also high when the gambler was a parent (41%) or the child of an affected other (38%).
- Among affected others, 45% had tried to get any type of treatment or support, either for the gambler or for themselves. Trying to get treatment or support for themselves was less common (28%).
- Seeking any type of support, rather than treatment, was most common, reported by 30% of affected others; treatment was sought by 16% of affected others.
- Affected others from higher socioeconomic backgrounds were more likely to seek any type of treatment and support than those from lower socioeconomic backgrounds (52% compared with 35%).
- The most common barriers for not wanting to access treatment or support was that the person experiencing gambling problems, who they have been affected by, did not consider their gambling to be an issue (reported by 43% of affected others); the perception that treatment will not work (40%) and that available support was not relevant to them (38%) were also key barriers.
- Affected others felt that there was a lack of treatment and support for affected family members; that there was not enough signposting; and that they were expected to find treatment and support for themselves without any help from services.

What is the size and characteristics of the affected others population?

Seven percent of people across Britain meet the criteria for being an affected other. These are individuals who know someone who has had a problem with gambling, either currently, or in their past, and feel they have personally experienced negative effects from this person’s or people’s gambling behaviour. This could include family members, friends and work colleagues. Affected others could also be people who gamble themselves, with varying levels of harm.

As Figure 6 shows, the majority of those who identified as affected others were the partner or close family member of a gambler (61%), followed by friends and flatmates (18%) and other family members (15%). Less common were those affected others related through work, although 6% of affected others said they were impacted by the gambling problem of someone they know professionally.

Figure 6. Those whose gambling behaviour has impacted others



Base: all affected others (n=1,466)

Women were more likely than men to report being affected by the gambling problem of an immediate family member (71% compared with 44%). Amongst women affected by a family member, the proportion of them affected by a spouse or partner's gambling was particularly high, 35% among women compared with 9% for men. In contrast, men were more likely to have been affected by the gambling of someone they knew through work (11% compared with 3% among women) and by a friend or housemate's gambling (33% of men reported this compared with 9% of women).

A number of individuals experiencing gambling harms (PGSI 1+) also identified as an affected other themselves, demonstrating an inter-relationship between an individual's own gambling and experiencing issues related to others' gambling. Among those experiencing gambling harms (PGSI 1+), the likelihood of also being affected by someone else's gambling increased substantially to 20%, suggesting that those who gamble are more likely to be engaged in social networks with other people who also gamble.

Women were more likely to be affected others than men, with women making up 57% of affected others. This may be linked to the finding that men are more likely to experience gambling harms than women; and as a result of the majority of people being in a heterosexual relationship, women are more likely to be affected by their partner's gambling. Affected others are also slightly more likely to be from BAME communities: 16% of affected others compared with 12% of the white population. They are also more likely to be from a lower socioeconomic background: 51% of affected others compared with 46% across the overall population. There was a broadly even distribution across different age groups.

The most common type of negative impact identified was on relationships, reported by 82% of affected others. These included being unable to trust the person with the

gambling problem (62%), difficulties communicating with them (40%), having arguments about gambling (35%) and spending less time with them (30%). Negative emotions were reported by three quarters (75%) of affected others, such as being angry with the person experiencing gambling harm (53%), anxiety (40%), as well as depression or sadness (33%). Finally, financial impacts were experienced by 60% of affected others. These included a lower household income (reported by 38%), not having enough money for family expenditures such as holidays (37%) and getting into financial difficulties (33%).

The severity of the negative impact experienced by affected others varied by the type of relationship they had with those who gambled. Half (48%) of those negatively affected by the gambling of a spouse or partner described the impact as “severe” and the proportion was also high when the gambler was a parent (41%) or the child of an affected other (38%). The proportion experiencing a severe effect fell when the gambler was a friend (19%) or someone known through work (18%).

What is the size and characteristics of affected others engaged in any type of treatment or support?

Affected others report seeking treatment or support both for themselves, and on behalf of the person or people they know with a gambling problem (Table 4.5.1).

Among affected others who have experienced the impact of someone else’s gambling during the last year, 45% had tried to get any type of treatment or support overall, either for the gambler (36%) or for themselves (28%). Affected others most commonly reported seeking support (30%) on behalf of the gambler from friends/family (15%), a partner (8%), or from websites (9%). In addition, 16% of affected others tried to get treatment on behalf of the gambler such as therapy (7%), help from a GP (5%), or specialist treatment for gambling (4%).

Less common was trying to get any type of treatment or support for themselves, reported by 28% of affected others. For a fifth (19%) this was support, such as from friends or family (8%) or from a partner (5%). A further 16% also attempted to obtain any type of treatment for themselves, the most common type being therapy (9%) for mental health problems.

Table 4.5.1: Use of treatment and support

	Sought any treatment or support	Sought any treatment or support on behalf of gambler	Sought any treatment or support for themselves
Any treatment or support overall	45%	36%	28%
Any treatment	21%	16%	16%
Any support	36%	30%	19%

What is the level of demand for any type of treatment and support for affected others?

Affected others expressed demand for treatment and support for themselves, and on behalf of the person or people they know with a gambling problem (Table 4.5.2).

Demand for any support both on behalf of the gambler and for themselves was reported by a third (34%) of affected others, while demand for any treatment overall was reported by 29%. The most common types of treatment and support people reported wanting were mental health support services (18%), specialist gambling

treatment services (14%), and support groups (14%). A less commonly requested but important type of treatment and support was related to services to help with other addictions, such as with drugs and alcohol, reported by 8% of affected others.

Affected others expressed a demand for any type of treatment and support either on behalf of the gambler or for themselves. Specifically, 43% reported demand for any treatment or support on behalf of the gambler with 26% wanting treatment and 28% wanting support. A smaller percentage (31%) of affected others reported demand for any type of treatment or support for themselves, with 21% wanting support and 16% wanting treatment. Treatment demand was highest for mental health services both on behalf of the gamblers (15%) and for themselves (8%). Support demand was highest for a support group (10%) on behalf of the gambler and for friends or family (8%) for themselves.

Table 4.5.2: Demand for treatment and support

	Want any treatment or support	Want any treatment or support on behalf of gambler	Want any treatment or support for themselves
Any treatment or support overall	46%	43%	31%
Any treatment	29%	26%	16%
Any support	34%	28%	21%

What are the barriers and facilitators to treatment and support for affected others?

Affected others who had experienced a negative effect as a result of someone else's gambling in the last year were also asked what factors had prompted them to try to get treatment and support. The most commonly reported reason, identified by 65% of affected others, was worry about the person they know in terms of their general wellbeing or safety. A majority (57%) also said they sought treatment or support because they did not know how to provide help themselves or to manage the situation. Other common reasons were more related to the ways they were being affected by the gambling behaviour, such as a negative impact on their family or relationships (54%) or issues with their own mental health (51%). Potential 'severe negative consequences' on the gambler were also given by just over a third (34%) as the reason for seeking treatment or support. Examples of these include: the person experiencing gambling harms potentially becoming homeless (21%), losing their job (15%), or being charged with criminal offences (13%).

Socioeconomic characteristics were also related to seeking treatment and support. Affected others from a higher socioeconomic background were more likely to seek treatment and support than those from a lower socioeconomic background (52% compared with 35%). Of those from a higher socioeconomic background, 8% reported seeking treatment, such as mental health provision, in comparison to 2% from a lower socioeconomic background. This trend was also reflected in levels of access to support-related websites (14% vs. 7%).

Of other potential barriers to treatment and support faced by affected others, either for themselves or partner, family member, friend or colleague, the most common was that the person experiencing gambling harm did not consider their gambling to be an issue; reported by 43% of affected others. The perception that treatment would not work was reported by four in 10 (40%), whilst 38% identified that any available treatment or support was not relevant to them (38%).

Less common barriers identified by affected others were feelings of stigmatisation around asking for treatment or support to do with gambling (14%); the belief that gambling has positive results (14%); and that they would not be able to access the treatment or support owing to practical constraints (9%), such as cost, location or available time. Similar views were also expressed through in-depth interviews with affected others. Specifically, they felt that there was a lack of treatment and support for affected family members, that there was not enough signposting and that they were expected to find treatment and support for themselves without any help from services. For affected others who did receive treatment, some felt these services needed to be better informed about their situation and likely support needs, as service providers did not know how to help them.

Summary

Seven percent of people across Britain were identified as an affected other with the majority being affected by their partner or close family member. Affected others were more likely to be women, people from BAME communities and from a lower socioeconomic background. A significant number of affected others (20%) also reported experiencing gambling harm themselves (PGSI 1+). Such a finding requires further investigation to unpack the complexity of the relationship between being a 'problem gambler' and an 'affected other' and the treatment and support needs of this group. Being affected by a partner or a parent/child has a more severe impact on affected others.

Almost half of affected others reported having accessed treatment or support, mainly for the gambler and less so for themselves. Accessing different types of support was more commonly reported than accessing different types of treatment. The most common reason for seeking treatment or support being worry about the safety and wellbeing of the gambler.

The most common barriers for not wanting to access treatment or support was that the person experiencing gambling problems, by whom they have been affected, did not consider their gambling to be an issue, as well as the perception that treatment will not work. Affected others also felt that there was a lack of treatment and support for themselves and lack of signposting.

5 Conclusion and recommendations

Whilst existing research from other sources provides gambling prevalence data, there is limited research on the demand for and uptake of gambling treatment and support provision. This programme of studies provides evidence about gaps in relation to the size, characteristics and geographical distribution of people experiencing gambling harm who are both using and not using treatment and support provision; on levels of engagement with, and demand for treatment and support; and the barriers and facilitators for gamblers and affected others in accessing existing service provision.

- **On the balance of probability between different data sources**, the population who gambled in the last 12 months preceding the YouGov population and combined health surveys was between 54% and 61%, with the true level of low, moderate and problem gambling falling in between the different prevalence estimates but likely to be closer to the combined health surveys than to the YouGov survey. Men, younger adults (aged 18-34), BAME and adults from lower socioeconomic background were more likely to be classified as gamblers with some level of harm (PGSI 1+). The estimated proportion of gamblers with some level of harm was more concentrated in specific local authorities, for example London and the Midlands with relatively high levels of deprivation as well as high BAME populations, and this is a consistent finding across all research strands in this programme
- **The proportion of all gamblers (PGSI 1+) across GB using any type of treatment and support is 17%** Reported access was higher amongst problem gamblers (PGSI 8+), as well as younger and BAME gamblers (PGSI 1+). Low rates of accessing treatment and support was also reflected by perceived low demand. Of gamblers with some level of harm, 82% did not want any type of treatment or support, mainly because they felt that their activity was not problematic. However, over half of problem gamblers with a PGSI score of 8+ would like some form of treatment or support. Younger and BAME gamblers were also more likely to report that they would like to receive any type of treatment or support.. Demand was highest in the geographical areas with higher proportions of gamblers (PGSI 1+), with estimated demand ranging from 1% to 10% across all local authorities.
- **People's gambling behaviour, where problematic, impacted on their family and social environment** with 7% of people across Britain identifying as an affected other; with women, people from BAME communities and lower socioeconomic backgrounds being affected the most. A significant number of affected others also reported experiencing gambling harms themselves (PGSI 1+). Being affected by a partner or a parent/child's gambling was related to experiencing more severe impacts. Almost half of affected others reported having accessed any type of treatment or support, mainly for the gambler and less so for themselves, with support from friends and family more commonly reported than formal treatment. Lack of awareness, or reluctance to admit problematic behaviour, on the part of the gambler, was also one of the most common barriers for not accessing or not wanting to access treatment or support. Affected others also felt that there was a lack of treatment and support for themselves and lack of signposting.
- **Some groups of gamblers are in need of targeted treatment and support.** Whilst younger adults and people from BAME communities are less likely to be participating in any gambling activities at all, those that do gamble are more likely to be classified as problem gamblers. Approximately half of those identified as

problem gamblers accessed treatment and support services. Such use was greater among gamblers with higher PGSI scores as well as younger and BAME individuals identified as problem gamblers. Younger and BAME groups, who are more likely to have used any type of treatment or support in the last 12 months, were also more likely to report that they would like to receive more treatment or support in the next 12 months. Although this is encouraging, younger people had higher rates of treatment drop-out. Therefore, appropriate and accessible engagement with treatment and support services is particularly important. It is also important to highlight that those from a lower socioeconomic background were more likely to say that nothing would motivate them to seek treatment or support suggesting that barriers may be more present amongst this group.

- **Sociodemographic differences in reported barriers highlighted a concern** that the needs of specific groups such as women, BAME and people from a lower socioeconomic background are not adequately met. In relation to the point above about targeted treatment and support, facilitating treatment and support access and engagement requires the provision of flexible options. Such options may include flexibility of delivery e.g. online treatment or support and appropriate accessibility to people from more marginalised communities and/or underrepresented groups (e.g. women).
- **Lack of awareness and the stigma associated with gambling problems are a significant barrier to accessing treatment and support.** A recurrent theme across this programme of studies was related to a lack of awareness of, or hesitation to accept, that gambling behaviour may be harmful. A salient finding was that gambling harms can have a negative impact on the perception of oneself owing to the associated 'stigma'. A shift in the way gambling disorder is perceived would help to address this and in turn, contribute towards reducing a personal barrier to seeking any type of treatment and support. Participants suggested a range of strategies which could help achieve this; for example, increased awareness around the range of people affected by gambling harms and running campaigns with high visibility. Linked to helping address such 'stigma' is a shift in the way people assess their own gambling behaviour. A self-realisation of the negative impacts of gambling encouraged people to seek support.

5.1 Recommendations for future provision of treatment and support

A number of recommendations for future provision of treatment and support for those experiencing gambling harms and affected others were supported by the findings of this programme of studies. Such recommendations focus on streamlining and strengthening existing treatment and support as well as ensuring that the gambling industry continues to strengthen their processes to monitor and manage problematic gambling patterns. Some recommendations are based on qualitative accounts that do not necessarily reflect the experience of the wider gambling population and some are based on quantitative evidence that can be generalised to the gambling population in GB. Therefore, this list is inclusive of this programme of studies and is meant to provide valuable insights for future provision of treatment and support rather than suggest prioritisation of some type of provision over another.

- **Developing new and/or streamlining and strengthening existing services offered.** There is a clear need for strengthening and improving existing treatment and support offered in terms of the type and extent of available provision. The need for flexibility and ease of access was a recurrent theme across most strands from this programme of studies. Needs may vary depending on the age of the individual, their cultural background, their location and other issues such as their health and

additional needs. It is necessary to understand how to engage and respond to such need before developing new interventions or strengthening existing services. Treatment and support provision require the inclusion of a range of services (e.g. bespoke support, modes of delivery, culturally adapted services); treatments (e.g. 1-2-1 counselling, psychotherapy, financial management); and aftercare provision. Responding to the complex needs of being an affected other (who may be experiencing gambling harms themselves) is also one area where existing treatment and support services needs to be strengthened. Although there was recognition that the experience of existing treatment and support was positive, the above elements were perceived by participants to be crucial in moving forward.

- **Involve service users in the design and delivery of treatment and support.** Suggestions from gamblers experiencing harms centred around including those individuals with personal experience of problem gambling in the delivery of treatment and support (including aftercare) offered to current gamblers. Peer-based treatment and support was seen as ensuring wider and targeted support for particular groups, whose needs may not be adequately met such as women, young people, people from BAME communities and people in some specific Local Authorities. Using the developing evidence base from this and other research, co-designing prevention and early intervention approaches with people with lived experience including affected others is of vital importance.
- **Targeted support for groups that are less likely to access treatment and support services (or complete treatment).** A number of groups including women, younger people, people from BAME communities and lower socioeconomic backgrounds as well as affected others, were identified through this programme of studies as more vulnerable and in need of targeted treatment and support. This raises the question as to the relevance of existing treatment and support options and/or reach for specific segments of the population. Such treatment and support could take the form of culturally adapted interventions aimed at ethnic minorities or services targeting young people and women who are also underrepresented within treatment services. It is important to highlight that gamblers (PGSI 1+) from lower socioeconomic backgrounds were more likely to report that nothing would motivate them to seek support, indicating that this may be one of the priority groups to target when designing strategies for developing facilitators for routes into treatment and support.
- **Helplines are a good facilitator to accessing support and further treatment.** Those who gamble were particularly likely to mention the need for helplines as a way to 'lever' and facilitate further support, a finding particularly highlighted by gamblers from BAME communities. This may indicate a need to publicise the National Gambling Helpline to a range of populations. Helplines as a facilitator to treatment access and support was evident across the results of this programme of studies. There is a significant potential role for Helplines to act as a 'safety net' to engage clients and to take a more proactive role in aftercare support. The reported benefits of Helplines included ease and convenience, confidentiality and helping individuals to manage stigma and shame.
- **Developing education programmes and campaigns to increase awareness and reduce stigma.** A common finding across this programme of studies was lack of awareness of gambling problems (both in terms of personal experience of gambling harm and gambling problems as a public health issue) as well as lack of awareness of the variety of treatment and support options available. Often hesitation to accept problematic behaviour and/or access treatment and support was accompanied by feelings of stigma. Adverts and/or campaigns communicating gambling related public health messages and available support and treatment were

felt to be particularly scarce. Therefore, it is recommended that adverts for support and treatment services need to be delivered in different forms, such as television and online adverts, leaflets in libraries or community centres, betting shops, General Practice surgeries, as well as campaigns highlighting the issues that can arise from gambling. Similarly, education programmes around problem gambling aimed at schools and sporting clubs for young people and/or faith communities for BAME groups, will help bring awareness to the risks of gambling.

- **Ensure gambling companies continue to strengthen gambling management tools.** Self-exclusion as a tool for managing problematic behaviour was found to be effective by gamblers who used it. However, developing and/or strengthening a universal monitoring system across the industry (to identify/monitor gambling harm) was suggested to be of particular importance. It is further recommended that such a system needs to be inclusive of both online and offline gambling (e.g. all the accounts linked to an individual need to be monitored or capped) and gambling companies need to remain proactive in monitoring how much people are spending on gambling in relation to their income and/or the frequency of their gambling activity.

5.2 Recommendations for future research

In summarising the findings from this programme of studies, a number of recommendations for future research are highlighted.

- **Prevalence estimates:** The proportions of gamblers falling into each PGSI category were approximately three times higher in the YouGov population survey than those recorded via the combined health surveys. In 2016 just over 4% of the population qualify as gamblers (PGSI 1+). Although the two surveys have used different methodologies to draw their sampling and collect the data, which explains part of the discrepancy in the estimates (and has been discussed in detail in a separate report¹⁶) further follow up research using population survey methodologies is needed to estimate the size of gamblers experiencing harm more precisely. Although it is concluded that the true level gambling harms lies somewhere in between the estimates of the different data sources explored in this programme of studies (and likely closer to the combined health survey estimates), it is not possible to simply split the difference.
- **Treatment data:** Overall, treatment was found to have positive benefits for older, White British gamblers, who were more likely to complete treatment compared to non-White British gamblers. and those who were married or in long-term relationships were also more likely to complete treatment. While there was an increase in numbers engaging and completing treatment in the two years examined through the Data Reporting Framework, (2015-2017), further research using representative samples where possible, needs to monitor treatment use year-on-year to see if this pattern continues. Drawing on both years of data, there is a concern that a high proportion of those who make some attempt to engage with treatment drop-out and this risk is elevated for younger gamblers. This suggests a significant issue with intake processes leading to high early drop-out rates that requires further investigation. Further research also needs to monitor whether treatment uptake correlates with increased demand.
- **Affected others and ‘people experiencing gambling harms’: a complex relationship with complex needs:** An often-neglected group in the gambling

¹⁶ “An assessment of the accuracy of survey estimates of the prevalence of problem gambling in the United Kingdom” - Professor Patrick Sturgis, Department of Methodology, London School of Economics, March 2020 is published alongside this report

literature and research is that of affected others and their treatment and support needs. Like people experiencing gambling harms, affected others may also be in need of treatment and support themselves (either as an affected other or because they experience gambling harms themselves). More research is needed to understand the complex needs of this group and how their own gambling behaviour may be impacted upon by their relationship with a problem gambler. Further research also needs to unpick the complexity of the relationship between being both a problem gambler and an affected other and the treatment and support needs of this group.

- **Access to treatment and support:** Several sources of evidence from this programme of studies suggested that most sources of treatment and support were found helpful for cutting down or stopping gambling by those who used them. While 17% of people experiencing gambling harms (PGSI 1+) reported accessing any type of treatment and support, this increased to 54% for problem gamblers (PGSI 8+), which suggests that access is higher when need is higher. However, further investigation is needed as to why more gamblers are not accessing any type of treatment and support, one potential avenue for future research is to find the best way of raising awareness of gambling problems at an earlier stage, as many have commented that it is only with hindsight they could see that their gambling had moved from a leisure activity to one of addiction. Generally, professional treatment options such as specialist face-to-face treatment services, mental health services or social, youth or support workers, were accessed less than informal sources of support, such as support groups, websites or friends and family. It is also important to underline that although GPs were the most commonly used treatment option, they were the least popular treatment option for people experiencing gambling harms. GPs as a treatment and support pathway was found to be an area that particularly lacked evidence. Additional research is needed to understand motivations for accessing some treatment and support needs and not others.
- **Targeted treatment and support needs:** One pattern that emerged was that younger gamblers and people from BAME, were more prone to experiencing gambling harms. Although they were more likely to access treatment and support than their older and white peers respectively, younger people were also more likely to drop-out of services before completing treatment. This raises the question as to the relevance of such services and/or reach for specific segments of the population; including young people as well as those from BAME communities. More research is needed to understand the level of unmet need in these population groups as well as the treatment and support relevance for specific groups.
- **Treatment service aftercare:** there was a clearly expressed need and demand for availability and/or improvement in aftercare provision amongst interviewees in treatment, with the findings concentrated on the *need* for such provision, rather than any experience of *receiving* such support. Overall, the finding demonstrated a paucity of evidence about the existence and effectiveness of aftercare. This is an area that future research could usefully explore in terms of mapping, access/use and effectiveness.

6 Appendix A

6.1 Links to the published reports from this programme of studies

NatCen reports

<https://about.gambleaware.org/media/2187/a-rapid-evidence-assessment-of-gambling-treatment-services.pdf>

<https://about.gambleaware.org/media/2182/secondary-data-analysis-of-the-data-reporting-framework-and-the-health-survey-for-england.pdf>

<https://about.gambleaware.org/media/2180/a-needs-assessment-for-treatment-and-support-services.pdf>

ACT Recovery report

<https://about.gambleaware.org/media/2184/gambling-treatment-services-needs-assessment-report.pdf>

YouGov report

<https://about.gambleaware.org/media/2185/gambling-treatment-and-support.pdf>

Patrick Sturgis report

<https://about.gambleaware.org/media/2179/an-assessment-of-the-accuracy-of-survey-estimates-of-the-prevalence-of-problem-gambling-in-the-united-kingdom.pdf>