THE GAMBLING POLICY & RESEARCH UNIT

Using behavioural insights to increase uptake of remote gambling support and treatment

Findings from an evidence scan, April 2023

Executive summary

Roughly 4 in 10 people who have the greatest need for gambling treatment and support do not seek any form of treatment, advice or support.[1] The types of harms people experience vary and can include, among others, experiencing financial hardship and relationship difficulties. Gambling support and treatment services offer targeted support to help people experiencing this form of harm to get better. This report sets out potential barriers and enablers to accessing gambling support and treatment, and has explored ways behavioural insights can be used to improve uptake of gambling support and treatment services.

We conducted an evidence scan of high quality empirical evidence on several research databases. We targeted more recent evidence – from 2018 onwards – and focused specifically on findings related to support and treatment that is provided remotely (e.g. over the phone, by text, online). We have chosen to focus on remote support and treatment in this instance due to its wide availability and possibility of scaling.

In section 1, we summarise how people seek gambling support and treatment, and what forms of support people use as first steps into support and treatment (i.e. Individuals' first choice of either gambling support or treatment after having decided on seeking gambling support or treatment). We find that self-help (activities, tools, resources and materials people engage with themselves without professional oversight) can be a popular form of support for those who are exploring support and treatment for the first time, compared to more formal types of support such as counselling therapy or cognitive behavioural therapy, group support. Seeking support is often triggered by mental health issues, financial problems, or job loss as a result of gambling. People experiencing gambling harms are less likely to seek support and treatment if they are 55+, male, from a lower socioeconomic background, and from white ethnic backgrounds.

For support and treatment service providers, this means that:

1. Self-help tools and resources are an important stepping-stone for those experiencing harm to get help.
2. However, signposting towards other options at timely moments is essential to ensuring individuals have the appropriate level of support when needed.

3. Other support and treatment options should be framed as the “next step” after self-help if it is not sufficient in providing the necessary support.

In section 2, we explore the barriers, enablers and motivators to accessing gambling support and treatment. We find barriers to accessing support and treatment are primarily related to a) how relevant people think support and treatment options are to them, b) awareness and understanding of support and treatment, c) negative perceptions of help-seeking such as shame and stigma, d) and perceived availability and accessibility of support and treatment. In contrast, important enablers and motivators for promoting uptake are awareness of support and treatment options and what channels they can be accessed by, as well as family/friends encouraging help-seeking. These factors vary by demographics, as older people who gamble generally see support and treatment services as being less relevant to them. Practical barriers can have an even larger impact on females who gamble (such as costs and time), and individuals from lower socioeconomic backgrounds (such as knowledge and ease of access).

For support and treatment service providers, this means:

1. At every stage of the user journey, make services easy to access (e.g. by making them available through multiple channels); confidential, and where possible, free, whilst also making these features salient.
2. Focus information campaigns on the ‘signs and symptoms’ of gambling harms, destigmatising help-seeking (e.g. by emphasising its usage among a diverse range of people), and the expected outcomes of relevant support and treatment options.
3. Develop tailored messaging for specific groups where support and treatment is underused:
    a. Increase the perceived relevance of support and treatment among older people who gamble by emphasising and showing usage in campaign creatives.
    b. Build on the work of the Women’s Gambling Harms Prevention Campaign by BeGambleAware, by emphasising the flexibility of support and treatment options that can work around other life commitments e.g. caring responsibilities.
    c. Target awareness campaigns at people who gamble in disadvantaged regions and/or from a BAME background – for the latter groups, test the effectiveness of using creatives that demonstrate an understanding of cultural values.

In section 3, we set out how the journey from self-help / remote support to more intensive support can be improved. Both self help and more formal forms of initial support and treatment (such as counselling therapy or cognitive behavioural therapy) only provide limited impact on reducing harms. Emerging evidence suggests that for some who require more formal interventions, self-help may delay access to treatment until gambling behaviour results in serious harm. Utilising online mental health services could be an effective next step after initial support and treatment choices, as well as an effective replacement for initial support and treatment choices.

For support and treatment service providers, this means that:

1. For organisations offering self-help as a first step, signposting about other support and treatment options available following self-help needs to be improved.
2. Caution needs to be taken when offering self-help resources, especially to high-risk groups, as there is potential for this to result in them delaying access to formal treatment. However, we note for many individuals, self-help remains an important stepping stone to accessing further support.

Contents

Definitions

Term	Definition[2]
First steps into gambling support and treatment	Individuals' first choice of either gambling support or treatment after having decided on seeking gambling support or treatment.
Gambling harms	"the adverse impacts from gambling on the health and wellbeing of individuals, families, communities and society."[3]
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)."
Gambling 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."
Self-directed / self-help strategies	"include those activities, tools, resources and materials people engage with themselves without professional oversight. They do not necessarily involve other people and are largely under personal control and self-administered."
Person experiencing low gambling harm	"A Problem Gambling Severity Index (PGSI) score of 1 or 2, defined as experiencing a low level of problems with few or no identified negative consequences". *Note if someone scores a 0, this means they are not currently experiencing any gambling harms, according to the PGSI.*
Person experiencing moderate gambling harm	"A PGSI score of 3 to 7, defined as experiencing a moderate level of problems leading to some negative consequences".
Person experiencing	"A PGSI score of 8 or over, those who gamble with negative consequences and a possible loss of control".

high gambling harm	
Person with a gambling disorder	"[...] a repeated pattern of gambling behaviour where someone: ● feels they have lost control, ● continues to gamble despite negative consequences and, ● sees gambling as more important to them than any other interest or activity. ."[4]
Remote gambling support or treatment	Gambling support or treatment that is available through remote channels (e.g. over the phone, by text, or online).
Affected other	A person "who knows someone with a gambling problem, either now or in the past, and has experienced negative effects as a result of that person's gambling behaviour".

Background

Gambling is a popular activity in the UK, but it can also lead to harm. According to the UK Gambling Commission, the percentage of people who indicated they participated in any gambling activity in the last four weeks increased from 40% in 2021 to 43% in 2022.[5] Although most people do not experience issues with their gambling, a small percentage of people experience severe negative consequences. In a survey commissioned by GambleAware, YouGov estimated that up to 2.7% of adults in Great Britain, or nearly 1.4 million people, experience harm from gambling.[6] The costs of gambling related harms are not only borne by individuals, but also by society as a whole. A review by Public Health England shows that the harms associated with gambling cost at least £1.27 billion in 2019 to 2020 in England alone.[7] Gambling harm, however, is difficult to quantify, and many estimates have been made, ranging from £1.05 billion to £1.71 billion per year.[8]

The Annual GB Treatment and Support Survey Report 2021 by YouGov, funded by GambleAware, explored the usage of, and demand for, support and treatment services among individuals who gamble and those affected by another's gambling.[9] Although usage of support and treatment services increases with Problem Gambling Severity Index level, only about six in ten (63%) individuals with a gambling disorder (PGSI 8+) said they had used some form of treatment, advice or support in the past 12 months. This number significantly decreases for individuals with lower PGSI scores, with 15% of those with a PGSI score between 3 and 7, and 4% of those scoring 1 or 2, report having used support and treatment in the past 12 months.

These statistics highlight two key issues that should be addressed. First, generally low uptake of treatment and support services means that people who are experiencing gambling harm are not using services that could help them improve their situation. This is a concern, especially among people with severe issues with gambling (PGSI 8+) where the need and potential harm is highest. The large drop in uptake from PGSI 8+ (63%) to individuals who

score between 3 and 7 (15%) also poses issues, as this group is at risk of gambling harm, but very few have accessed support, treatment, or advice. Second, there are groups of individuals either at-risk of harm or currently experience harm, who want to use support and treatment, but are currently not doing so. Of the 57% of individuals scoring 8+ on PGSI indicating they want to use support and treatment, 11% indicate they have never accessed support and treatment before[10].

This report examines enablers and barriers of accessing gambling support and treatment services. The key question that the report is focused on answering is: “How do we increase uptake of remote support and treatment?” The evidence scan aims to identify the reasons why people do or don’t use support and treatment and provide recommendations to support and treatment service providers on how they could increase uptake of their services.

This evidence scan was conducted in partnership with a number of support and treatment service providers. This piece of work forms part of a wider project, in which we will be testing ways in which we can improve uptake of services.

Research questions

The aim of this evidence scan is to look at ways to improve uptake of remote support and treatment. We do this by identifying evidence related to first steps into accessing gambling support and treatment; barriers and enablers to accessing support and treatment, and the efficacy and sequencing of services used. We will focus specifically on types of support and treatment that are provided remotely (e.g. over the phone, by text, online). We have chosen to focus on remote support and treatment in this instance due to its wide availability and possibility of scaling

1. **Initial forms of gambling support and treatment**
    a. What are the first forms of remote support that people who gamble seek initially?
    b. What prompts people who gamble to seek remote support and treatment for gambling harm?
    c. Are there differences by gender, ethnic background and socioeconomic status in who seeks remote support and treatment?
2. **Barriers, enablers and motivators to accessing gambling support and treatment**
    a. What barriers exist for people who gamble in accessing remote support or treatment for gambling harm?
    b. Do barriers to accessing support and treatment vary by gender, ethnic background and socioeconomic status?
    c. What motivates and enables people who gamble to access remote support or treatment for gambling harm?
3. **Efficacy of initial forms of support and treatment**
    a. What impact does the first form of treatment have?
    b. What support and treatment is needed next, or instead?

Note that while we recognise the importance and role of affected others in the pathways to gambling support and treatment, this review will focus exclusively on the individuals who are gambling and are experiencing harms.

Methodology

We approach this review as an evidence scan, which provides a rapid search of high quality empirical research about a topic. Although all of the evidence is sourced and compiled systematically, evidence scans are not systematic reviews. They do not seek to summarise theoretical literature or to explore in any depth the concepts covered by the scan or those arising from it. The evidence scan process includes a systematic search across a range of databases on the topic of interest, using both text keywords and indexing terms.

Sources were identified using Google, Google Scholar, BIT's Gambling Policy and Research Unit's (GPRU) personal research database (Mendeley), and a second research database, GREO. This review prioritises meta-analyses and existing literature reviews, while also placing a focus on RCTs, longitudinal studies, and in-depth qualitative work wherever available. Key search terms we use are the following:

- "(Reasons for) seeking gambling [support/treatment]"
- "Access gambling [support/treatment]"
- "Barriers to gambling [support/treatment]"
- "Improving access to gambling [support/treatment][services]"
- "Gambling [support/treatment] [service user/patient/consumer] journey"
- "Gambling treatment-seeking behaviour"
- "Pathway to gambling treatment/ gambling treatment pathway"
- "Multiple gambling [support/treatment]"

Our sample criteria includes evidence from 2018 onwards, predominantly conducted in the UK, Finland, the US, Canada and Australia. All evidence must be related to remote treatment/support service provision (online, by call, text etc.). We identified and included over 30 sources (see Bibliography). In the next section, we summarise key findings from the literature we collected.

Findings

1. First steps into accessing gambling support

Section summary

- Self-help can be a popular first step into support, meaning individuals may try this approach before proceeding to other forms of support.
- Significant personal circumstances such as mental health issues, financial problems, or losing a job are key triggers for people to decide to seek initial support.

- People experiencing gambling harms are less likely to seek support and treatment if they are 55+, male, from a lower socioeconomic background, and/or from white ethnic backgrounds.

Implications for support and treatment services

1. Self-help tools and resources are an important stepping-stone for those experiencing harm to get help.
2. However, signposting towards other options at timely moments is essential to ensuring individuals have the appropriate level of support when needed.
3. Other support and treatment options should be framed as the “next step” after self-help if it is not sufficient in providing the necessary support..

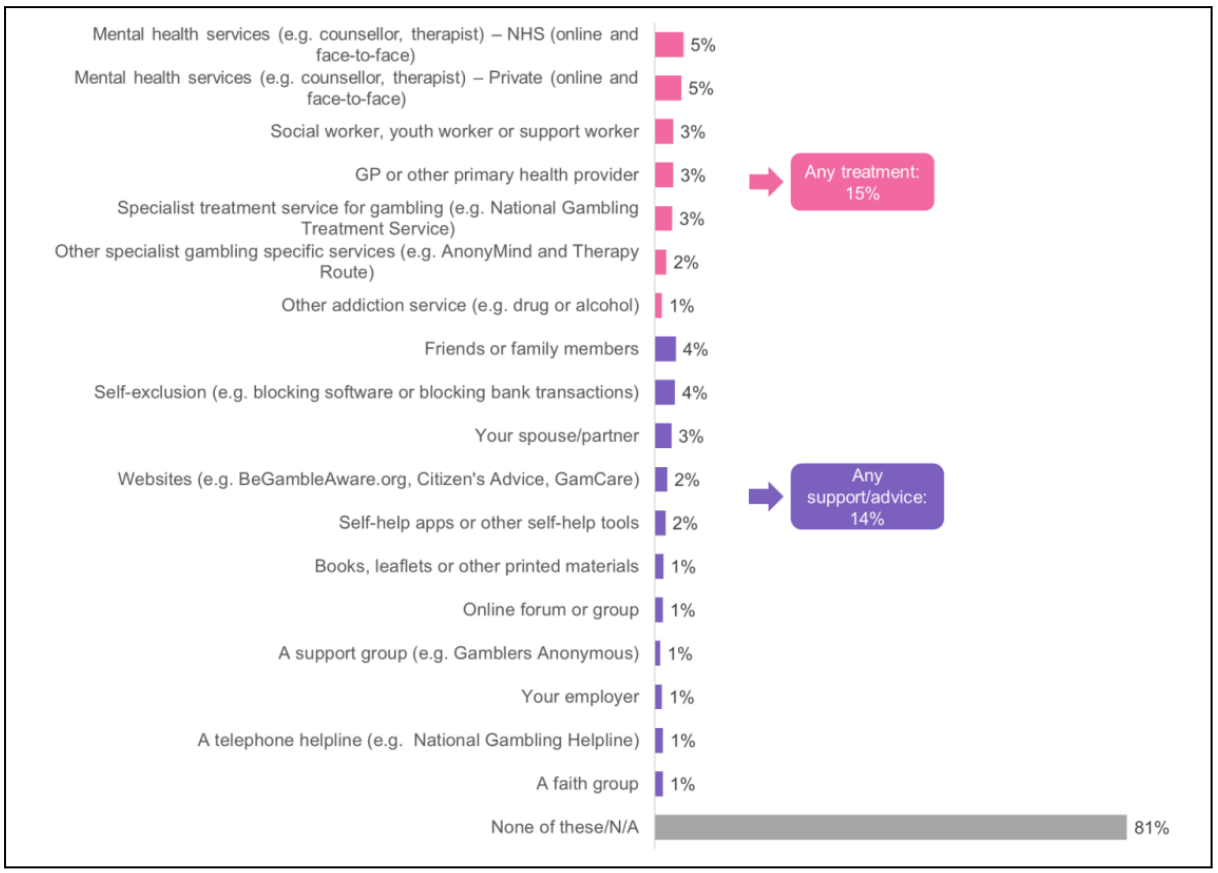
1a. What are the first forms of remote support that people who gamble seek initially?

Self-help is a first step into gambling support

Self help is a common first type of support used by a person experiencing gambling harm, This includes **accessing information online**, or **self-imposed methods** of control to manage problematic gambling, e.g. self exclusion schemes. A survey of 10,054 Canadians who regularly gamble found that among those experiencing problem gambling, almost two thirds (59.8%) had made an attempt to change their gambling, with the majority (90.2%) of these doing so through self-help efforts – only a minority had accessed support or treatment (7.7%).[11] While this is a single study, it indicates for the majority of people experiencing harms, formal support and treatment would not be the first option they seek.

Further evidence on the first forms of support and treatment beyond self-help is limited. However, the 2021 Annual Treatment and Support Survey – conducted by YouGov on behalf of GambleAware – outlines general usage of support and treatment among 2,338 people who gamble and experience some level of harm. The survey found the most common treatment options were **private and NHS mental health services** (both 5%), **social/support/youth worker, GP or other primary health provider**, and **specialist services for gambling** (all 3%). For support, the most popular options were **family/friends**, **self-exclusion** (both 4%), and **a spouse/partner** (3%) (Figure 1). What is evident, however, is that uptake is minimal. This implies that there could be significant barriers to using support and treatment among those who may benefit (see Section 2a).[12]

Figure 1. Usage of gambling treatment/support/advice in Great Britain in the previous 12 months to November 2021. Base: all people who gamble with a PGSI score of 1+ in 2021 (n=2,338).[13]



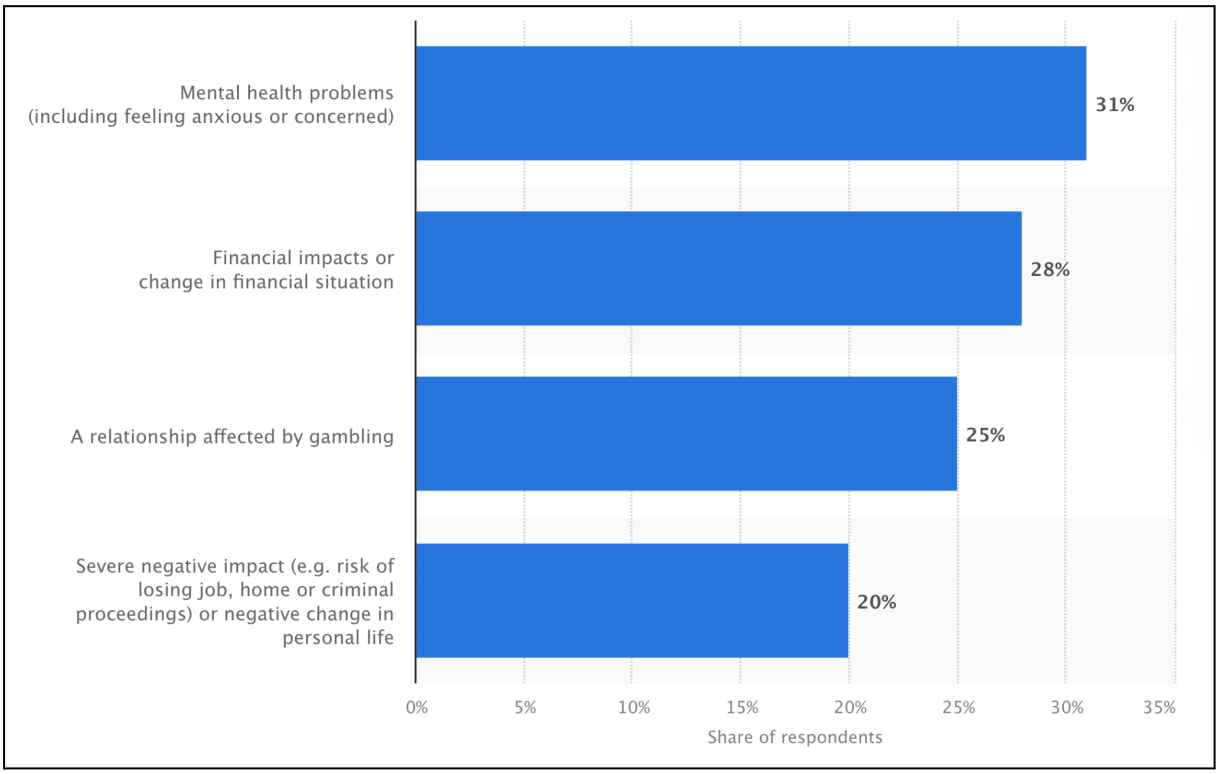
Friends and family play an important role in people seeking support and treatment

Research from Australia also provides insights into using personal contacts (i.e. friends and family) as a first step into help-seeking. An early study – conducted in 2010, prior to the main publication period reported here – among Australian students, presented a ranking of options that people with a gambling disorder could turn to after having decided to seek help. The study found that people who gamble preferred turning to informal sources of help first, before committing to more formal help. **First preferences for help were family, friends, and siblings, while helplines and counsellors only came later.**[14] The finding of personal contacts being a first point of help is echoed in a later 2021 qualitative study conducting semi-structured interviews with 27 Australian people who gamble.[15]

1b. What prompts people who gamble to seek remote support and treatment for gambling harm?

Prompts – sometimes referred to as triggers or cues – are something that tells, or reminds someone to perform a behaviour.[16] GambleAware's 2021 Annual Treatment and Support Survey identified some of the main prompts for seeking support and treatment (Figure 2).[17]

Figure 2. Main factors prompting gamblers to seek treatment, support, or advice in Great Britain as of November 2021. Base: all people who gamble with a PGSI score of 1+ in 2021 (n=2,338).[18]



First, **mental health problems** were found to be the most common prompt for people who gamble to seek support and treatment. A literature review on help-seeking behaviour highlights specific negative emotions people who gamble refer to when mentioning this prompt, including guilt, fear, disappointment, low self-esteem and sense of losing control.[19]

Second, **financial impacts** were another common prompt in seeking support and treatment. People who gamble specifically mentioned that their gambling behaviour results in there being "*no money left for household bills, rent, or food*".[20]

A third prompt is **relationships being affected** by gambling. People who gamble mostly identified relationships with either family members or a spouse/partner. The specific prompt may include a spouse/partner speaking to them about gambling harms they are experiencing.[21]

A fourth prompt people who gamble identified was **severe negative impacts** or changes in personal life. These range from losing a job, a home, or legal issues.[22]

It should be noted that some of these **prompts are intertwined**. For example, an often mentioned interaction in the survey is a "*depressed mood due to loss of money from gambling*".[23] Similarly, professionals such as a GP suggesting it may be helpful to seek support and treatment could have been due to any of the aforementioned prompts, or other symptoms of gambling harm.

A caveat in these findings is that they come from individuals who gamble who have sought help. One study indicates that those who seek help and those who do not have different prompts for potentially doing so. For example, when asked what would hypothetically help motivate someone to get support or treatment, twice as many non help-seekers as help-seekers reported 'problems with family members' as a motive for seeking help (72 % vs. 36 %).[24]

1c. Are there differences by gender, ethnic background and socioeconomic status in who seeks remote support and treatment?

Age

Younger people who gamble were more likely to have accessed any type of support and treatment: 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.[25]

Gender

According to GambleAware's 2019 Annual Treatment and Support Survey, the usage of treatment services is comparable across genders (male = 17%; female = 16%).[26]

Socioeconomic status

People who gamble from higher socioeconomic backgrounds were more likely to have accessed any type of support and treatment, compared to lower socioeconomic backgrounds (22% vs. 14%).[27]

Ethnicity

People who gamble from BAME communities with a PGSI score of 1+, who have higher PGSI scores on average than their white counterparts, were more likely to have used treatment, advice or support to cut down their gambling: over a third (36%) had used any source, compared with 16% of people who gamble from white backgrounds. This includes a higher usage of both treatment services (29% vs. 11%) and sources of support (25% vs. 11%).[28]

2. Barriers, enablers and motivators to accessing gambling support and treatment

Section summary

- Barriers to accessing support and treatment are primarily related to the perceived relevance of support and treatment, awareness and understanding of support and treatment, negative perceptions of help-seeking such as shame and stigma, and perceived availability and accessibility of support and treatment.
- In contrast, awareness of support and treatment options and what channels they can be accessed by, as well as family/friends encouraging help-seeking, are important enablers and motivators for promoting uptake.
- These factors vary by demographics, with perceived relevance of support and treatment lower among older people who gamble. Practical barriers can be exacerbated among females who gamble (such as costs and time), and individuals from lower socioeconomic backgrounds (such as knowledge and ease of access).

Implications for support and treatment services

1. At every stage of the user journey, make services easy to access (e.g. by making them available through multiple channels), free, and confidential, and emphasising that they are.
2. Focus information campaigns on the 'signs and symptoms' of gambling harms, destigmatising help-seeking (e.g. by emphasising its usage among a diverse range of people), and the expected outcomes of relevant support and treatment options.
3. Develop tailored messaging for specific groups where support and treatment is underused:
    a. Increase the perceived relevance of support and treatment among older people who gamble by emphasising and showing usage in campaign creatives.
    b. Building on the work of the Women's Gambling Harms Prevention Campaign by BeGambleAware, emphasise the flexibility of support and treatment options that can work around other life commitments e.g. caring responsibilities.
    c. Target awareness campaigns at people who gamble in disadvantaged regions and/or from a BAME background – for the latter groups, creatives should test demonstrating an understanding of cultural values.

2a. What barriers exist for people who gamble in accessing remote support or treatment for gambling harm?

Barriers are reasons that prevent an individual from accessing remote support and treatment. The barriers identified from this evidence scan have been organised into key themes, and categorised according to the COM-B model.[29] The COM-B model is a behavioural framework which outlines three components – each with two versions – that must be present in order for an individual to carry out a behaviour. These are:

1. *Capability*: having the ability to carry out a behaviour. *Psychological capability* is the necessary mental state, skills and knowledge, while *physical capability* includes any physical skills required.
2. *Opportunity*: having external factors make a behaviour possible. *Physical opportunity* is having the right resources (e.g. time, money) and environmental factors (e.g. prompts, systems) present when needed. *Social opportunity* is having the right influence of others (e.g. social norms, cultural values).
3. *Motivation*: the mental processes that influence a behaviour; when present, motivations help to energise and direct a behaviour. *Reflective motivation* involves belief formation (e.g. what is good or bad, what are the consequences, self-efficacy, planning). *Automatic motivation* involves instinctive and habitual responses (e.g. emotional responses, impulses).

Categorising the barriers by these six sub-factors helps us to consider the implications of our findings for support and treatment services.

The table below provides an overview of the barriers identified, their respective COM-B category, as well as the strength of the evidence found to substantiate how much that barrier affects access of support and treatment. We have categorised the strength of the evidence into:

- *Low*: initial evidence to suggest this barrier may affect access to support or treatment among some people who gamble.
- *Moderate*: some evidence to suggest this barrier is likely to affect access to support or treatment among a majority of people who gamble.
- *High*: convincing evidence to suggest this is a barrier that affects access.

Barrier	Sub-barrier	COM-B model categorisation of the barrier	Strength of evidence for support	Strength of evidence for treatment
Perceived relevance of support and treatment	*Gambling not perceived as harmful or seen as a positive*	*Reflective motivation*	Moderate	Moderate
	Unaware of problem or problem denial	*Reflective motivation*	Moderate	High
	Only perceived as relevant for those with gambling problems	*Reflective motivation*	Low	*No evidence reviewed*
Awareness and understanding	*Unaware what options exist or are relevant*	*Psychological capability*	Moderate	Moderate

of support and treatment	*Lack understanding on format or delivery*	*Psychological capability*	Low	Moderate
	Options are not perceived to be effective for those with co-existing conditions	*Reflective motivation*	Moderate	Moderate
Negative perceptions and affect	*Shame and stigma*	*Automatic motivation + social opportunity*	Moderate	High
Availability and accessibility	*Lack of internet access*	*Physical opportunity*	Low	Low
	Perceived time and/or cost to access	*Automatic + reflective motivation*	Low	Moderate
	GP Referral barriers (e.g. lack of awareness of support and treatment)	*Physical opportunity*	Low	Low

Perceived relevance of gambling support and treatment

Whether an individual deems support and treatment options as relevant to them can be affected by several factors. Firstly, gambling may not be perceived as harmful, and/or the individual feels in control of their gambling, and **has not deemed it to be a problem**.[30] An online experiment with 262 people who gamble at least once a week, but are not currently seeking treatment, found that one of the most common reasons for not completing a problem gambling screener was they felt they didn't have a gambling problem.[31]

Secondly, individuals may instead choose to focus on the **benefits of gambling** – e.g. making money, leisure activity and social time – however, according to GambleAware's Annual Treatment and Support Survey, the prevalence of this barrier has declined (2019 = 21% vs. 2021 = 9%).[32] Both of these barriers stem from evaluations of one's own behaviour and/or attitudes they have formed towards gambling; when present, neither provide the *reflective motivation* to engage with support and treatment.

Thirdly, even if the individual is experiencing gambling harms, they may be **unaware of the extent of their gambling**, or be in a state of **problem denial**, and they do not want to accept that support and treatment would be helpful.[33] Again, this means their *reflective motivations* direct them away from seeking help.

Similarly, support and treatment options may be **perceived as only relevant for those with gambling problems**. A survey of 564 Australians who gamble online found some had a

perception that gambling management tools were only for those with gambling problems.[34] This means that such misperceptions may dissuade individuals from taking up tools designed as more preventative measures – again directing *reflective motivation* away from desired behaviours.

Awareness and understanding of support and treatment options

Individuals may **be unaware of the variety of options available to suit different levels of harm and needs**. In 2019, NatCen conducted in-depth interviews with 28 people experiencing different levels of harm, and 10 other stakeholders. They found there was a lack of awareness of the services that exist, which was in part due to a perceived gap in advertising for these services. Relatedly, individuals were **not always aware of when they should seek support and treatment options**.[35] This means there is an onus on the individual to research options, requiring the motivation to expend the time and energy (see section 2c for evidence relating to what motivates and enables individuals to access support and treatment).[36]

Awareness also spans beyond availability of support and treatment options, to an understanding of the format and delivery. For example, some research found **concerns regarding the perceived efficacy of the services**, which can lower *reflective motivation* to participate. Similarly, **not knowing what is involved or required from an individual** can feel daunting, acting as a psychological barrier. NatCen interviewees raised concerns over confidentiality and anonymity, and their circumstances being understood by service providers.[37]

Relatedly, there is **low understanding about how to get help for other related health and/or circumstantial problems**, as existing services can be **perceived as ineffective at treating co-existing conditions.**[38] A scoping review, predominantly from studies conducted in Canada, the US and Australia, found there was a perceived inability for these services to address multimorbidity.[39] Similarly, a Finnish study[40] conducted interviews with 12 people with problem gambling, and found barriers varied depending on the type of help-seeking behaviour. For multi-problematic help-seekers, namely those experiencing two or more health/social problems, they felt that their **gambling problems were not taken seriously by health or social services**, or that **professional help was not effective** (see the efficacy barrier discussed below). This is problematic, given the greater prevalence of other health behaviours causing harm, among higher risk groups. In GambleAware's Annual Treatment and Support survey, they found alcohol consumption, smoking tobacco, psychological distress, and co-existing conditions (e.g. diagnosed with a mental health, parkinsons, epilepsy and Chronic Obstructive Pulmonary Disease) – were greater for individuals experiencing higher levels of gambling harm.[41] Given these barriers stem from beliefs about the service, which in turn lower intent to participate.

Negative perceptions and affect

Shame and stigma

This psychological barrier stems from **the belief that gambling disorders and related harm is self-inflicted** and therefore could have been avoided, making **individuals hesitant**

to admit this and reach out for help.[42] Similarly, there is **a belief that those who are diagnosed with a gambling disorder** and **seek treatment face stigma**. When compared with other barriers, shame and stigma are often some of the most common reasons preventing help-seeking behaviour, by reducing its desirability (*automatic motivation*).[43]

The previously mentioned online experiment with 262 people who gamble at least once a week, but not currently seeking treatment, found one of the most common reasons for not completing an initial problem gambling screener was to avoid the **anticipated distress** of the findings – **due to shame, guilt or embarrassment**.[44]

Current evidence suggests that shame and stigma is more prevalent among people looking to access treatment[45], rather than support. A survey with 10,054 people who regularly gamble in Canada, found approximately 530 had attempted self-help in the past year – among this group of self-helpers, one third did not want to seek external support as they felt too **ashamed**.[46] Semi structured interviews with 90 stakeholders – including people with gambling disorders, social workers, therapists employed in the addiction treatment facilities, General Practitioners and psychiatrists – also found a common barrier to accessing treatment was **fear and aversion to discussing problems with others**, and disclosing personal experiences. Relatedly, they found fear was linked with concerns of being diagnosed with a gambling disorder, and having to deal with the associated stigma.[47]

A similar trend emerges for those experiencing high gambling harms.[48] In GambleAware's 2021 Annual Treatment and Support Survey, they found stigma as a barrier to access support and treatment increases from 2% among people experiencing low gambling harms, to 24% when harms were high.[49] The aforementioned Finish study – which conducted interviews with 12 people with a gambling disorder – also found shame and stigma mostly affects those who see themselves as the biggest barrier to accessing treatment – termed *individualistic help-seekers*.

Availability and accessibility of support and treatment

A final set of barriers identified relate to the perceived and actual availability and accessibility of remote support and treatment options. Many remote support and treatment services are delivered online and therefore require internet access. Therefore, those **without internet** access have a reduced availability of options – categorised by COM-B as a *physical opportunity* barrier. Qualitative research by NatCen found early evidence for this, whereby those without internet access may find it hard to find out about and access remote support and treatment options.[50]

In 2021, GambleAware's Annual Treatment and Support Survey found that 5% of 533 respondents who were experiencing low, moderate or high gambling harms **thought treatment or support is inaccessible, due to the presumed cost or time required**.[51] This increased to 11% among the 114 participants who reported experiencing high gambling harms (PGSI 8+). The research did not compare this with an objective accessibility evaluation; however, it does indicate part of the issue is based on the perception of accessibility – if individuals have considered the options to be inaccessible, this adds friction to uptake, making it feel less desirable by reducing *reflective motivation*.

Finally, a recent service evaluation of primary care gambling services by IFF Research – on behalf of BeGambleAware – identified **potential barriers during GP referrals**. Among 150 GPs surveyed, only 25% were aware of local gambling support and treatment, and 10% had sufficient information on these services. Furthermore, the minority of GPs reported they were able to recognise symptoms of gambling harms (40%), felt confident initiating conversations about gambling harms with patients (36%), or knew what questions to ask patients during these discussions (26%).[52] This means among those who go to their GP for help, they may face inconsistencies in referral outcome, which creates *physical opportunity* barriers for those whose GP does not have the knowledge to correctly refer them to further support. However, further qualitative research by IFF among women with varying experiences of gambling harms, found for those who had spoken with their GP, most were satisfied with the options they were signposted to. This highlights that given the inconsistencies between GPs, different research may encounter different findings for whether GPs act as a barrier or not.

2b. Do barriers to accessing support and treatment vary by gender, ethnic background and socioeconomic status?

Age

The perceived relevance of gambling support and treatment is lower among older people who gamble (aged 55+). A survey by NatCen found 38% of people who gamble aged 55+ reported this as a reason for not accessing support and treatment, compared with 26% of 35-54 year olds and 31% of 18-34 year olds.[53]

Gender

Practical barriers for accessing support and treatment, such as cost and time, **are greater among women** that gamble compared with men (9% vs. 3%) – however note that this finding is not exclusive to remote options, so could be exacerbated by barriers related to regional availability and travel costs for in-person services.[54] Gendered roles and responsibilities are one reason why these practical barriers are exacerbated, such as needing to balance work with caring responsibilities.[55]

Gendered roles also affect how other barriers, such as **stigma**, emerge. Women report feeling like an outsider to treatment/support, partly due to their gender – with a perception that "*gambling problems are men's problems*". **Shame** can also arise from not meeting the modern ideals of a woman, not wanting to burden family, and fear of losing parental rights and/or abuse from partners. Such norms and roles mean women can feel unwilling to share and address their experiences of gambling harm.[56]

Socioeconomic status

People who gamble from **lower socioeconomic backgrounds** report having **lower knowledge of,** and **ease of access** to, support and treatment as well as **availability of support from friends and family**.[57] These groups were more likely to report that **nothing would motivate them to seek support and treatment** compared with people who gamble from higher socioeconomic groups (17% vs. 9%).[58] Finally, some evidence suggests that **shame and stigma** can be exacerbated among lower socioeconomic groups, making it

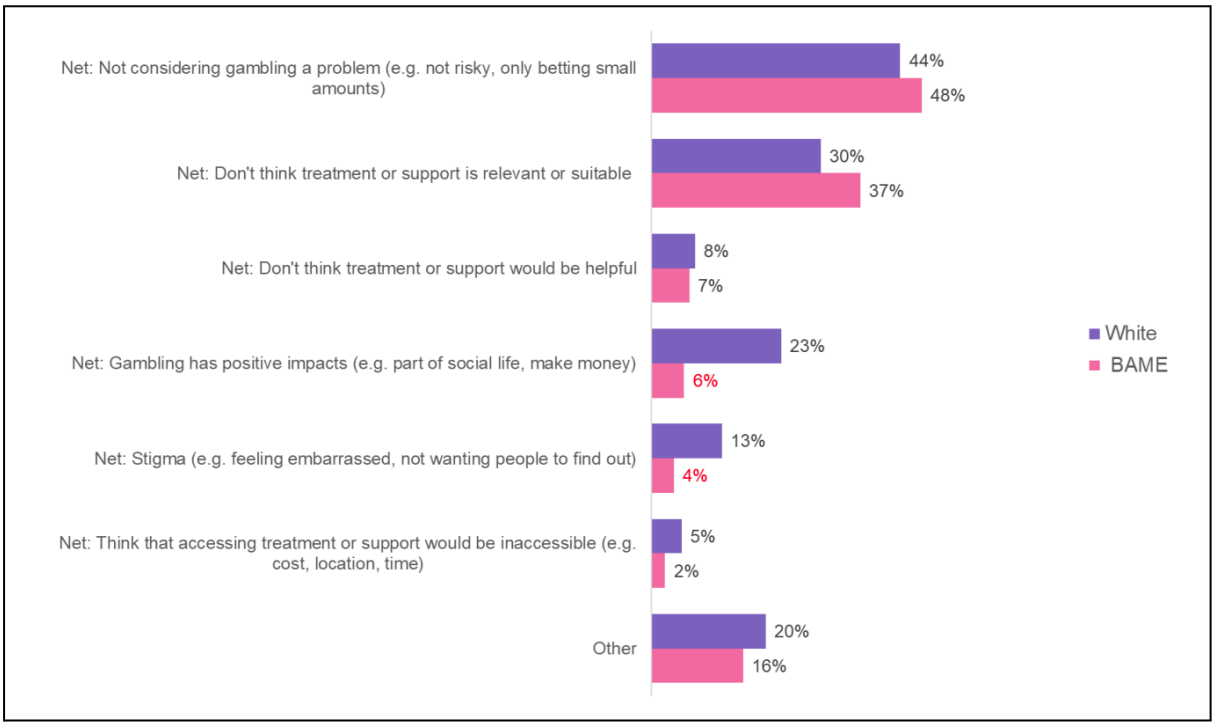
particularly difficult for them to seek help because of concerns related to revealing they need help.[59]

Ethnicity and nationality

Two focus groups with 32 UK **migrants** found barriers to help-seeking behaviour included **trust, confidentiality, social interaction, integration** and **language proficiency**. They expressed there is a need for gambling support services to develop cultural competencies.[60]

In 2019, Gamble Aware commissioned a survey of 3,001 people who gamble and affected others, including 270 people from **BAME** communities. They found among those experiencing some level of harm, who were not already seeking treatment or support, specific barriers were higher for BAME versus white groups; namely, **not considering gambling a problem** or **not seeing treatment/support as relevant** (Figure 3).[61]

Figure 3. Barriers to seeking treatment/support/advice among people who gamble from BAME and white backgrounds in 2019. Base: All gamblers from BAME communities (59) and white gamblers (579) with a PGSI score of 1+ who would not want to receive treatment, advice or support. [62]



Among those **whose first language wasn't English**, there were concerns that accessibility could be limited as they might not be able to understand them. Similarly, perceptions that **services are not culturally adapted**, or **lack understanding of cultural values**, was greater among ethnic minorities.[63]

2c. What motivates and enables people who gamble to access remote support or treatment for gambling harm?

This section aims to summarise the evidence for how to increase uptake of support and treatment among those who would benefit. Specifically, we will discuss factors that enable individuals to carry out a behaviour; in reference to the COM-B model[64] of behaviour we introduced in Section 2a, **enablers** can include individuals having the *psychological* and *physical capability* to carry out a behaviour, as well as the appropriate *physical* and *social opportunities*. On the other hand, **motivations** are the mental processes that energise and direct a behaviour, and can be *reflective* or *automatic*.

What enables someone to seek gambling support and treatment

Below is an overview of the enablers identified, their COM-B model categorisation, and a categorisation of the strength of the evidence:

- *Low*: initial evidence to suggest this enabler/motivator may affect access to support or treatment among some.
- *Moderate*: some evidence to suggest this enabler/motivator is likely to affect access to support or treatment among a majority.
- *High*: convincing evidence to suggest this is an enabler/motivator that affects access.

Enabler	COM-B model categorisation	Strength of evidence for support	Strength of evidence for treatment
Awareness and knowledge of relevant options available	*Psychological capability*	High	High
Perceived efficacy of support and treatment campaigns	*Psychological capability + physical opportunity*	Moderate	Moderate
Encouragement from family/friends	*Social opportunity (+ reflective motivation)*	Moderate	Moderate
Confidentiality	*Social opportunity*	Moderate	High
Ease of access and use	*Psychological + physical capability (+ reflective motivation)*	Moderate	Moderate
Access via a particular channel (e.g. phone, text, or online)	*Psychological capability + physical opportunity*	High	High
Free to access	*Physical opportunity (+*	Low	Moderate

	automatic motivation)		

In order for someone to access support and treatment, they must be aware it is available. Therefore, unsurprisingly, **awareness of support and treatment** comes through as a key enabler to uptake of support and treatment.[65] However once aware, what enables individuals to access appropriate support and treatment is having **knowledge of what options are relevant** to them (*psychological capability*).[66]

Aside from being signposted or referred, awareness of support and treatment predominantly stems from the information shared by services, and any related promotional activity. Information campaigns can do a number of things to improve the efficacy, helping the campaign to deliver intended outcomes e.g. increase awareness and uptake of a service. Making this **information easy to access**, for example by **using common language/messaging** and **integrating information in one place**, is important.[67] Similarly, support and treatment **campaigns that are empowering, use person-first language, and counteract barriers of stigma and self-blame**, are deemed to be more effective.[68]

Awareness of support and treatment can also come from an individual's social network. While we've previously discussed **family and friends** as a type of support, their encouragement can also act as an enabler by normalising help-seeking (*social opportunity*).[69]

Knowing that support and treatment would be **completely confidential** is also an important factor that can encourage individuals to take up support and treatment.[70] A recent systematic review found remote treatment can help preserve anonymity, which may reduce barriers due to stigma and shame[71] – which can be deemed as creating a *social opportunity* to partake in support and treatment.

Ease of access and usage remains an important enabler for remote support and treatment options, despite these options overcoming many of the physical access barriers associated with in-person equivalent services (e.g. time/cost for travel and proximity to local services). For remote options, it is important individuals have the capability to access and use the support and treatment (*psychological + physical capability*), and it's not deemed too difficult to use, lowering *reflective motivation*.[72] In relation to ease of use, a service evaluation of Australia's GambleAware website found **chatbots** significantly increased reported website usability and satisfaction, and resulted in higher ease of task completion.[73]

Related enablers include knowing support and treatment options **can be accessed via a certain channel** (e.g. online, over the phone, by text), and where relevant, offering the ability to **self-refer**. Knowing the service is **free to access** has been reported as helpful[74] – which we hypothesise is due to an individual's financial circumstances (*physical opportunity*), or simply not wanting to pay for help (*automatic motivation*).

What motivates someone to seek gambling support and treatment

As before, the table below provides an overview of the motivators identified, and our assessment for the strength of the evidence supporting these motivations.

Motivator	COM-B model categorisation	Strength of evidence for support	Strength of evidence for treatment
Desire to improve existing relationships	*Reflective motivation*	Low	Low
Form a sense of togetherness with other people experiencing harms	*Reflective motivation*	Low	Low
Regain control over their life/gambling	*Reflective motivation*	Moderate	Moderate

A number of reasons for motivation were identified, most of which are *reflective motivations* – so individuals have consciously processed this reason, internalised it, and can use it to encourage them to take up support and treatment.

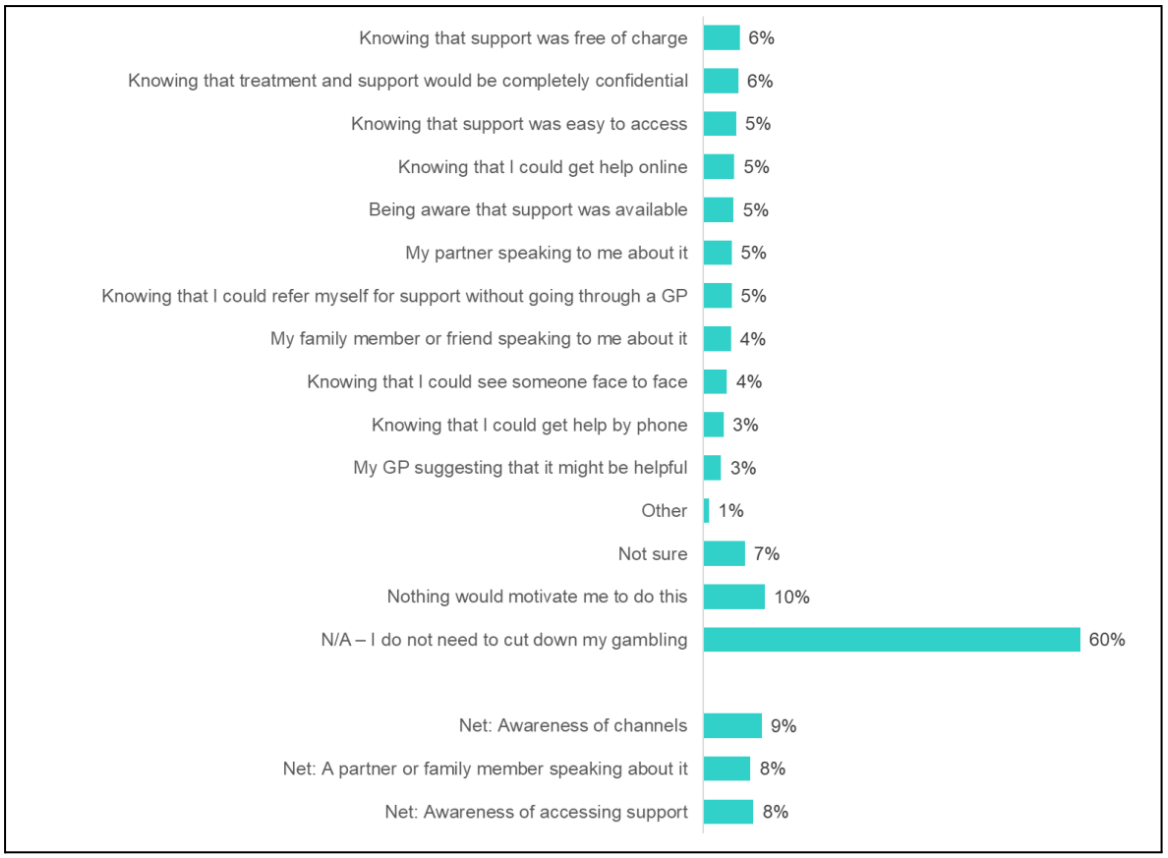
Beyond the aforementioned factors that were also enablers, another motivator for individuals to access support and treatment is the desire to **improve existing relationships** with family, friends, and partners that have been damaged through gambling. Relatedly, **meeting other people experiencing gambling harms, and forming a sense of togetherness**, has been reported as uplifting.[75] These connections may help to reduce stigmatisation amongst people experiencing harm, and motivate them to seek help.

The desire to **regain control over one's own life and/or gambling** can also help motivate help-seeking, particularly for those experiencing higher degrees of harm and who likely need more formal intervention. The idea of regaining this control was expected to provide a sense of empowerment, through taking action to improve their situation.[76]

The relative importance of these enablers and motivators

In terms of what enablers and motivators are more prevalent, findings from GambleAware's 2021 Annual Treatment and Support Survey provides a helpful overview (Figure 4). The top factors were enablers, namely having an **awareness of the channels for support and treatment provision** (9%), **a family/friend speaking to them**, **awareness of support and treatment options** (8%), and knowing **support and treatment was free** and **completely confidential** (both 6%). However, similar to support and treatment usage, the majority of respondents thought they **did not need to cut down their gambling** (60%), or that **nothing would motivate them to get support and treatment** (10%). In contrast, when responses were compared by the level of gambling harms experienced, prevalence of the top factors notably increased. Specifically, awareness of channels (PGSI 1-2 = 3% vs. PGSI 8+ = 27%), awareness of accessing support and treatment (PGSI 1-2 = 3% vs. PGSI 8+ = 21%) and spouse/ family member speaking to them (PGSI 1-2 = 3% vs. PGSI 8+ = 19%).[77]

Figure 4. Enablers and motivators to seeking treatment/support/advice. Base: all people who gamble with a PGSI score of 1+ in 2021 (n=2,338).[78]



2d. Do motivations and enablers to accessing support and treatment vary by gender, ethnic background and socioeconomic status?

Gender

A 2021 literature review on 'women and gambling harm' by BetKnowMore identified a number of motivations and enablers that are particularly relevant to women. Firstly, given practical barriers can often be greater for women who gamble, enablers related to **ease of access** (including the ability to **self-refer**), as well as having an **awareness of what channels** services were available by, have been found to be particularly important.[79]

Secondly, a number of enablers related to the format in which support and treatment is delivered, including reassurances around **anonymity**, especially during initial outreach, allow women to build their confidence and trust in the service. Formats such as **web chats** were reported as giving women the time to collect thoughts and reduce perceived pressure. Similarly, the option to have **immediate access** to support and treatment is seen as important, so that individuals can take action while experiencing concerns; in contrast future commitments e.g. appointments, are more at risk of being overlooked, due to other responsibilities taking priority.[80]

Thirdly, for those seeking treatment, it has been suggested that women can develop gambling disorders more rapidly than men, so **targeting women earlier** and **focusing on emotional needs** can increase efficacy and appeal.[81]

Socioeconomic status

People who gamble from higher socioeconomic backgrounds mentioned more potential motivators than their counterparts from lower socioeconomic backgrounds. They were significantly more likely to mention **knowing support was available** via a particular channel (14% vs. 10%) as well as **knowing support was easy to access** (12% vs. 8%) and a **partner or family member speaking to them about it** (11% vs. 8%).

As previously mentioned, a challenge is that the **lack of motivation to seek support and treatment** is much higher among lower socioeconomic groups. Important enablers therefore include improving perceived access, as well as improving perceived relevance of options, through normalising usage. Specifically, a review of gambling and poverty by GREO found it is important to **integrate support into existing services** (e.g. mental health and addiction services), and include **training service providers in gambling harms and signposting**. Relatedly, it is even more important that gambling services **acknowledge and support co-existing conditions and complex needs**, which may be exacerbating their gambling harm – such support could vary from rehousing to money management.[82]

Ethnicity

People who gamble from a BAME background with a PGSI score of 1 or higher were more likely to be motivated by **knowing that support was available via a particular channel** (20% vs. 11% of people who gamble from white backgrounds). Among the channels, these individuals were particularly likely to mention that they were motivated by knowing that support was available by telephone (12% vs. 4% of people who gamble from white backgrounds), perhaps indicating a need to publicise the National Gambling Helpline more to this audience. Furthermore, knowing that support was **free of charge**, **confidential**, and **easy to access** was more of a motivator for people who gamble from BAME backgrounds compared to white backgrounds.[83]

More broadly for ethnic minority groups, information access and efficacy can be improved by **tailoring messages to cultural beliefs and values**, as well offering information in different languages.[84]

3. Efficacy of first steps into gambling support and treatment

Section summary

- Both self help and more formal first steps into gambling support and treatment only provide limited impact on reducing harms.
- Self-help can act as a way of delaying access to formal treatment until gambling behaviour results in serious negative impacts.

- Online mental health services are a form of support and treatment that could act either as an effective next step after initial support and treatment choices, or as a replacement of initial support and treatment choices.

Implications for support and treatment services

1. For organisations offering self-help as a first step, signposting about other support and treatment options available following self-help needs to be improved.
2. Caution needs to be taken when offering self-help resources, especially to high-risk groups, as there is potential for this to result in them delaying access to formal treatment. However, we note for many individuals, self-help remains an important stepping stone to accessing further support.

3a. What impact do the first steps into gambling support and treatment have?

First steps into gambling support and treatment often only provide limited effectiveness for those experiencing gambling harm. The aforementioned survey of 10,054 regular Canadians who gamble found that among those experiencing harm who tried self-help as an initial form of support, only a third (31%) reported it as successful in reducing their gambling, while a similar proportion (39%) found it was helpful to gather initial information.[85] Relatedly, a scoping review suggests self-help strategies do not address multimorbidity[86], meaning the degree of harm minimisation among those with co-existing conditions may be limited.

Regarding more formal forms of treatment, in the Canadian survey, just over a third (39%) reported formal treatment as a first form of support and treatment as being helpful.[87] Relatedly, in a sample of 277 Australian service users of Gambling Help Online, over 40% rated talking to a counsellor as sufficient, with similar ratings for contributing to an online forum or sending an email. More than half of them who sought information via the website or completed a self-help module rated this as enough or definitely enough to meet their current concern.[88] However, we note the Canadian survey is limited to self-reported measures, therefore does not give an objective evaluation of the impact of self-help versus treatment on gambling behaviour and associated harm.

Reluctance to use other more formal support and treatment options can often stem from using these initial self-help strategies.[89] Self-help allowed people experiencing gambling harm to delay accessing treatment until it resulted in extensive impact, such as financial problems. This suggests that first, for the majority of people experiencing harm, further support was needed. Second, this suggests that self-help may delay access to potentially more effective support and treatment options.

However, other initial forms of social support often play an important role in seeking further support and treatment. For example, family and friends can play an active, facilitation role by helping the people experiencing gambling harm to decide what type of support and treatment to try next.[90] In qualitative research with people who gamble in Finland, one interviewee mentions discussing their gambling problems with their mother,

who then suggested the person who gambles seek professional help. His mother and wife then discussed the situation together, and his wife made his appointments for treatment and financial counselling, which they attended together.[91]

3b. What support and treatment is needed next, or instead?

Several support and treatment services can provide effective next steps after, or as alternatives to, first steps into support and treatment options – but evidence for the efficacy of this sequencing remains limited.

A randomised control trial with 198 people who gamble found **online mental health services** significantly reduced gambling symptoms, and time and money spent post treatment.[92] Online mental health services can include online counselling (i.e. chat, email or video), self-help materials (e.g. self-directed Internet interventions), peer support (e.g. online community forums) and information (e.g. websites). Online mental health services are typically sought after someone has already engaged with a support service or attempted self-help.[93] People who gamble and affected others report e-mental health interventions as easy, convenient and discreet to access.

Next Steps

BIT will be using these findings to guide our work in collaboration with gambling support service and treatment providers, in which we're exploring possible ways to improve uptake of services.

We welcome your feedback on the findings presented. If you would like to discuss these topics, please contact us.

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