Gambling Treatment and Support

On behalf of GambleAware

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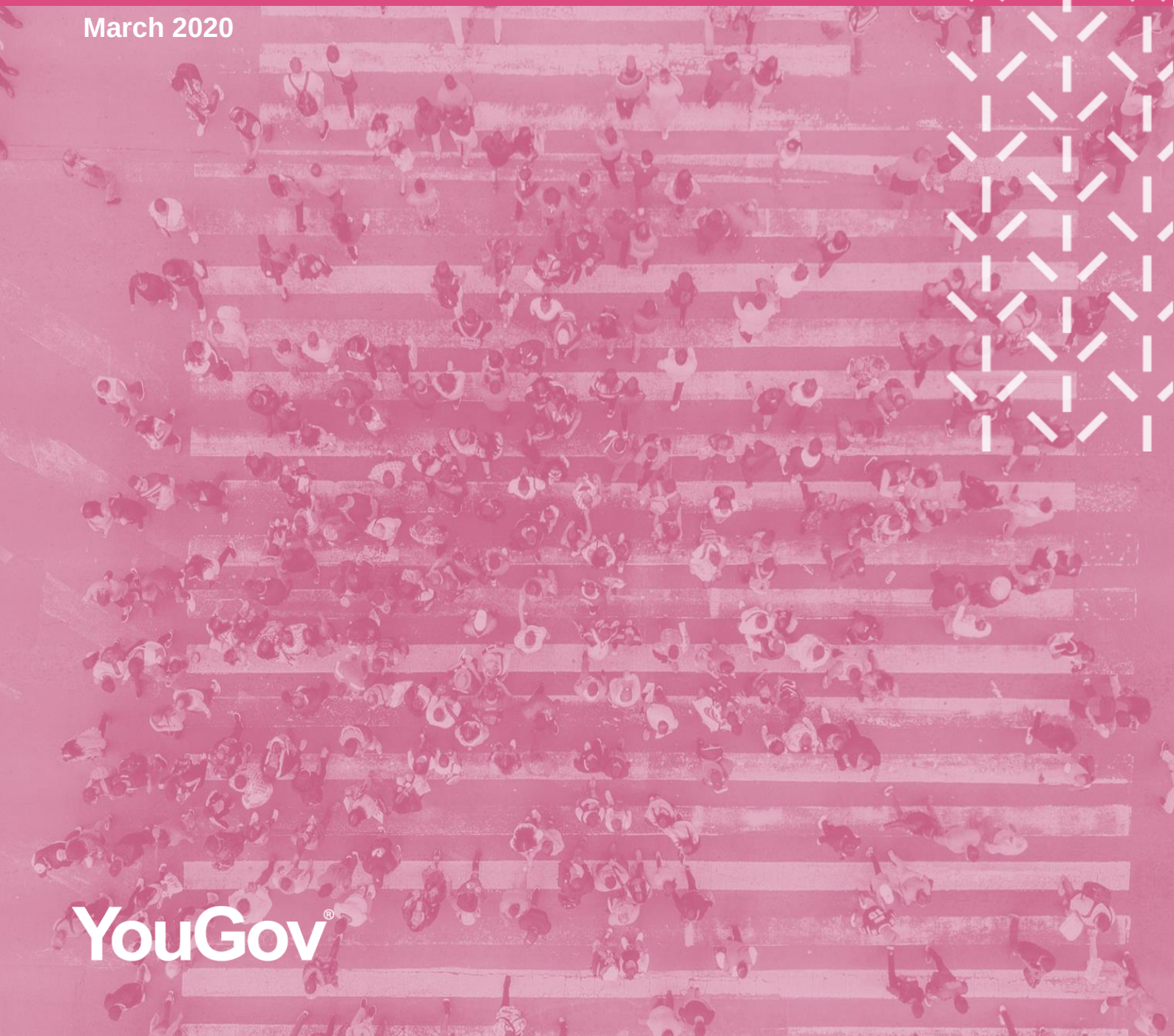

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Funding Statement

GambleAware is a wholly independent charity and has a framework agreement with the Gambling Commission to deliver the National Strategy to Reduce Gambling Harms within the context of arrangements based on voluntary donations from the gambling industry. GambleAware commissions research and evaluation to build knowledge of what works in prevention and reduction of gambling harms that is independent of industry, government and the regulator.

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.

1 Key Findings

Three-fifths of adults reported participating in any gambling activity in the last 12 months, and half have gambled in the last four weeks; roughly consistent with the level recorded by the Gambling Commission's tracker. Participation is higher among men, the middle age groups and those in C2DE social grades (see section 2.3 for a description of social grade). Overall participation is higher among white adults than among Black, Asian and Minority Ethnic (BAME) adults, but BAME individuals are more likely to take part in casino and gaming activities when they do participate, whereas white respondents are more likely to take part in lotteries.

Overall, 13% of adults scored one or higher on the Problem Gambling Severity Index (PGSI) scale (see section 3.2 for more detail). This comprises seven percent who were classified as a low-risk gambler (a PGSI score of 1-2); three percent who were classed as a moderate-risk gambler (a PGSI score of 3-7) and three percent who were classified as a problem gambler (a PGSI score of 8+). The proportion qualifying as a gambler with a score of 1+ (i.e. experiencing some level of harm) was higher among men and younger adults, and slightly higher among C2DEs. BAME adults also recorded higher scores than white adults, which might be related to the different profile of activities they participate in.

Among gamblers with a PGSI score of one or higher, 17% reported having used either treatment and/or support/advice to cut down on their gambling in the last 12 months. This equates to two percent of the total adult population. Use of treatment and support/advice was greater among gamblers with higher PGSI scores, including younger and BAME gamblers.

Most sources of treatment, support and advice were found helpful for cutting down gambling by those who used them. Generally, professional treatment options (e.g. specialist face-to-face treatment services, mental health services or social, youth or support workers) received lower ratings than less formal sources of support (e.g. support groups, websites or friends and family) did. However, we note that the professional treatment services were predominantly used by those with higher PGSI scores, whereas when those with lower scores sought support, they tended to use the less formal sources as opposed to professional treatment services.

Among gamblers with a PGSI score of one or higher, 18% said that they currently want any form of treatment, advice or support. This equates to two percent of the total adult population. Demand for treatment and support/advice is higher among gamblers with higher PGSI scores, including younger and BAME gamblers.

The predominant barrier to seeking treatment or support was the perception that the gambling was not harmful or that they only gambled small amounts; this was stated by close to half (45%) of those not wanting treatment/support. Other key barriers were the perception that treatment and support was not relevant to them or would not be suitable for someone like them, and recognising positive impacts from gambling.

Over a quarter (28%) of gamblers recognised one or more factors which might motivate them to seek treatment, support or advice. Most commonly, this was knowing support was available via a particular channel (telephone, online or face-to-face). Others thought they would be motivated by knowing support was easy to access (including the ability to self-refer) or by a partner or family member speaking to them about their gambling.

Overall, seven percent of the population qualify as 'affected others' (those that have been negatively affected by a gambling problem of someone else). There is an inter-relationship between an individual's own gambling and experiencing issues related to others' gambling, with problem gamblers (PGSI score 8+) more likely to identify as being an affected other. Affected others are more likely to be women than men, likely due to the male dominated gambling population and a higher proportion of heterosexual relationships resulting in more female partners and spouses being affected.

Affected others are most likely to be negatively affected by a gambling problem of someone in their immediate family (61%), most commonly by a spouse or partner, or a parent. The impact of a gambling problem is felt most severely by immediate family members. Those affected by a spouse or partner are more likely to report a severe negative impact, likely due to the close and intense nature of this relationship. Impacts include effects on relationships, negative sentiments such as anxiety and depression, and financial impacts.

Over two in five (45%) affected others have sought advice or support in some form, either for themselves or on behalf of the person or people they know with a gambling problem. This includes advice and support from less formal sources (such as advice from a friend or family member) as well as from a professional or treatment service (such as mental health services or a GP).

Concern for safety or wellbeing is the most common reason given by affected others for seeking advice or support, whether on behalf of themselves or on behalf of the person or people they know with a gambling problem. This is followed by needing help or not knowing how to deal with the situation, in addition to a range of prompts, including impacts on relationships, mental health problems and financial impacts being mentioned.

There is strong demand for advice or support among affected others, with close to half (46%) reporting this. Again, the demand is for both less formal types of support and advice, and those provided by a professional or treatment service. Among the less formal support sources, there is greatest demand for a support group, and among the more formal sources, there is greatest demand for mental health services.

The most common barrier for wanting advice or support among affected others is the person with a gambling problem not considering it a problem (43%). There is a common perception that gambling would not be helpful or effective. For others, the stigma surrounding a gambling addiction remains a barrier to accessing support or advice.

2 Introduction

This report presents the findings of a study to explore the usage of, and demand for, treatment and support services among gamblers and those affected by another's gambling. This involved identifying problem gamblers in the sample, using a validated measure of problem gambling, that have and have not engaged in any form of treatment, as well as for affected others. A further objective was to extrapolate the findings to a detailed local level. The research was conducted by YouGov on behalf of GambleAware.

2.1 Background

The latest data published by the Gambling Commission[1] on the number of problem gamblers and those at-risk of problem gambling is much higher than the proportion of problem gamblers that accessed GambleAware-funded treatment services in 2016-17. This large discrepancy between the number of people currently receiving treatment and the number of people estimated to be in need of treatment because they have been classified as problem, moderate or low risk gamblers on the PGSI scale suggests that there must be an issue with either the demand for services and/or the supply of treatment services.

As a result of this, in 2018 GambleAware commissioned a research initiative in order to examine gaps and needs that exist within treatment services for problem gamblers and those affected by gambling related harm. This initially consisted of two programmes of research. The National Centre of Social Research (NatCen) reviewed and produced evidence about gambling related harms and pathways to support among the general UK population, whilst ACT Recovery focused on the harms and risks among vulnerable populations and evaluated specific clinical treatment services and pathways into these.

[1] Data combined from the Health Survey for England (HSE) 2015, the Scottish Health Survey (SHeS) 2015 and the Wales Omnibus in 2015: http://www.gamblingcommission.gov.uk/PDF/survey-data/Gambling-behaviour-in-Great-Britain-2015.pdf

Following this, GambleAware commissioned YouGov to undertake a two-stage study to 1) identify gamblers with a PGSI score of 1+ in the sample, as well as affected others, and their overall usage of and demand for treatment, advice or support and 2) explore the views and experiences of gamblers and affected others regarding seeking treatment/support, motivations and barriers. This report outlines the research findings.

GambleAware wished to estimate the proportion of the gambling population that has received, and that wants to receive, any form of treatment or support in relation to their gambling. In particular, a gap in evidence was identified regarding the geographical distribution of these groups, and consequently the demand for treatment/support at local level. This research will help enable better targeting of support, identify current capacity issues, and support the strategic development of future treatment services and ultimately help reduce gambling-related harm.

Additionally, the study was intended to investigate 'affected others' (those who have been negatively affected by another's gambling) as an audience and the characteristics of this group, as well as enhancing understanding of behaviour, needs, and impacts experienced among this group. Current prevalence estimates do not take into consideration the effects that gambling can have on those other than the gambler. More recent thinking has focussed on measuring gambling-related harms, and it is now understood that harms may affect not only the individual gambler but also their family, friends, communities and broader society. These wide ranging impacts are not captured within current definitions of disordered gambling, therefore this is one of the first (if not the first) survey to explore the usage of and demand for advice and support services among such individuals.

2.2 Method

A particular challenge with this study was to reach a large enough sample of the general population to produce robust data on the geographical distribution of the target populations, while also reaching adequate numbers of these audiences to interview in more detail about their experiences. To meet this challenge, we utilised a two-phase approach.

The purpose of the Phase 1 study was to identify gamblers experiencing some level of harm from their gambling (a score of 1+ on the PGSI scale) in the sample, as well as for affected others, and the overall usage of and demand for treatment, advice or support among these groups. This national-level data was also used to support Multilevel Regression and Post-stratification (MRP), with the purpose of estimating the demand for treatment/support at local authority level. Multilevel regression and post-stratification (MRP) is a method used to estimate public opinion/behaviour by taking observations in sub-national (small areas) and applying these to the wider population. Further details of this modelling are provided later in this chapter.

For Phase 2 we conducted a separate study which targeted gamblers experiencing some level of harm (a score of 1+ on the PGSI scale) and affected others only, with the objective of exploring their views and experiences in more detail, including experiences of seeking treatment/support, motivations and barriers. Further details of both phases are provided below.

Phase 1 (nationally representative)

The Phase 1 fieldwork was carried out between 24th September and 13th October 2019. Interviews were conducted online using YouGov's online research panel. In total, 12,161 adults in Great Britain were surveyed. Results have been weighted to be representative of the GB adult population according to age, gender, UK region, socio-economic group and ethnic group.

Table 1. Phase 1 sample breakdown (nationally representative)

Category	Unweighted n	Weighted n
Men	5,971	5,948
Women	6,190	6,213
18-34	3,462	3,415
35-54	4,078	4,073
55+	4,621	4,674
ABC1	6,535	6,504
C2DE	5,626	5,657
White	10,778	10,723

BAME	1,383	1,438
North East	466	504
North West	1,407	1,366
Yorkshire and the Humber	1,059	1,030
East Midlands	948	914
West Midlands	1,105	1,103
East of England	1,204	1,166
London	1,491	1,639
South East	1,698	1,713
South West	1,121	1,072
Wales	621	596
Scotland	1,041	1,058

Phase 2 (targeted sample)

Phase 2 comprised a targeted survey of gamblers experiencing some level of harm (a PGSI score of 1+), and 'affected others' (anyone who feels they have been affected by another's gambling). Respondents could qualify as both a gambler and an affected other, if relevant.

It was permitted (but not required) for respondents to take part in both Phase 1 and Phase 2. Some respondents for Phase 2 were recruited via their participation in the preceding survey, while others were identified via screening of YouGov's wider panel. In total, 3,001 gamblers and affected others were interviewed online between 23rd October and 12th November 2019.

The Phase 2 data was weighted to match the group of PGSI 1+ gamblers and affected others found in Phase 1, according to age, gender, social grade, region, gambler/affected other status and PGSI score category. The rationale for this was that the Phase 1 study, being nationally representative, provides more authoritative information on the overall characteristics of this audience, in comparison to Phase 2's targeted sampling approach.

Table 2. Phase 2 sample breakdown (PGSI 1+ gamblers and affected others)

Category	Unweighted n	Weighted n
Men	1,594	1,678
Women	1,407	1,323
18-34	903	1,065
35-54	1,238	1,155
55+	860	780
ABC1	1,697	1,485
C2DE	1,304	1,516
White	2,711	2,679
BAME	279	312
North East	151	126
North West	348	393
Yorkshire and the Humber	306	309
East Midlands	210	225
West Midlands	232	282
East of England	290	264
London	381	411
South East	415	399
South West	239	228
Wales	144	123
Scotland	285	240

Multilevel Regression and Post-stratification (MRP)

MRP is based on the premise that similar people hold similar views and behaviours, irrespective of exactly where they live, and it allows us to paint a much more detailed picture with our data. We assess everything we know about the demographic make-up of a particular place and match individuals from our wider pool of respondents with the types of people that live there. For example, if 5% of people in a particular location are female graduates in their thirties at a certain income level, we can look at the attitudes and behaviours of all such people in our wider sample and apply them to that location.[2]

Even with the large sample size included in the Phase 1 study, on average each of the 371 local authorities in Britain would have contained too few respondents for robust analysis. MRP was therefore used to model responses to three key variables: PGSI score category, previous usage of treatment/support, and current demand for treatment/support.

It is important to note that this analysis produces rough estimates only. MRP is not intended to produce an accurate figure for each locality, but rather to give indicative estimates that then provide a sense of how usage/demand is spread across the country in relative terms.

2.3 Standardised tools

The following standardised tools were included in the survey and analysis process:

Problem Gambling Severity Index (PGSI)

The study utilised the full (9-item) Problem Gambling Severity Index (PGSI) to measure levels of gambling behaviour which may cause harm to the gambler. The PGSI[3] 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.

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[2] Model-Based Pre-Election Polling for National and Sub-National Outcomes in the US and UK (Lauderdale et al. 2017) http://benjaminlauderdale.net/files/papers/mrp-polling-paper.pdf

[3] Gambling behaviour in Great Britain in 2016, NatCen: http://www.gamblingcommission.gov.uk/PDF/survey-data/Gambling-behaviour-in-Great-Britain-2016.pdf

When scores to each item are summed, a total score ranging from 0 to 27 is possible. A PGSI score of 8 or more represents a problem gambler. This is the threshold recommended by the developers of the PGSI and the threshold used in this and previous reports.

The 9 items are listed below:

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

Respondents were placed into the following categories, according to their score on the PGSI measure. The report often refers to gamblers with a score of 1+; this term encompasses low-risk (PGSI score 1-2), moderate-risk (3-7) and problem (8+) gamblers.

Table 3. PGSI score categories

Category	PGSI score
Non-problem gambler	0
Low-risk (gamblers who experience a low level of problems with few or no identified negative consequences)	1-2
Moderate-risk (gamblers who experience a moderate level of problems leading to some negative consequences)	3-7
Problem gambler (gamblers who gamble with negative consequences and a possible loss of control)	8+

Social Grade

Social grade is a classification system that is based on occupation. Developed by the National Readership Survey (NRS), it has been the research industry's source of social-economic classification for over 50 years. The categories can be found below. For analysis purposes, these have been grouped together into ABC1 and C2DE; comparisons between these groups have been made throughout the report.

Table 4. NRS Social Grade categories

		% of population (NRS Jan- Dec 2016)
A	Higher managerial, administrative and professional	4
B	Intermediate managerial, administrative and professional	23
C1	Supervisory, clerical and junior managerial, administrative and professional	28
C2	Skilled manual workers	20
D	Semi-skilled and unskilled manual workers<	15
E	State pensioners, casual and lowest grade workers, unemployed with state benefits only	10

2.4 Notes for interpretation

The findings throughout are presented in the form of percentages, and all differences highlighted between subgroups are statistically significant unless otherwise indicated. These differences are statistically significant to a confidence interval level of 95%.

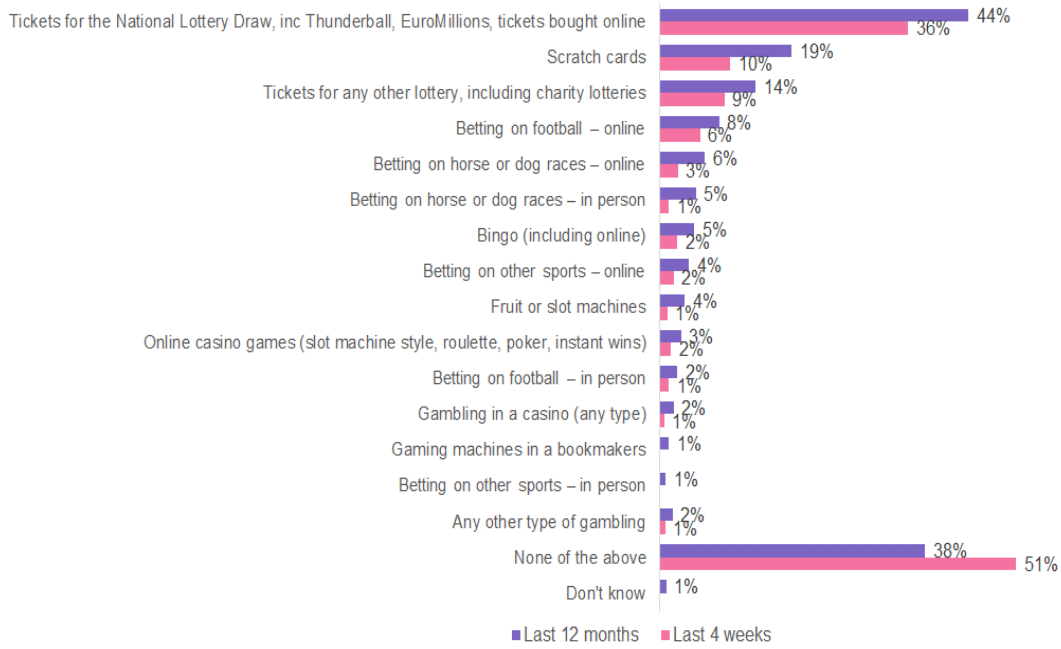
Where percentages do not sum up to 100, this may be due to rounding, the exclusion of 'don't know' and 'prefer not to say' responses, or because respondents could give multiple answers.

3 Gambling landscape

3.1 Gambling participation

The survey asked whether respondents had participated in a range of gambling activities in the last 12 months and in the last four weeks. Overall, three-fifths (61%) of adults reported participating in any activity in the last 12 months, and half (49%) in the last four weeks. The proportion doing so in the last four weeks compares with 46% recorded by the Gambling Commission.[4]

Figure 1. Participation in gambling in the last 12 months / 4 weeks



Base: all GB adults (n=12,161)

[4] Gambling Participation in 2018, Gambling Commission (2019): http://www.gamblingcommission.gov.uk/PDF/survey-data/Gambling-participation-in-2018-behaviour-awareness-and-attitudes.pdf

As has been observed in other studies, gambling participation is higher among men than women (53% of men reported participating in the last four weeks, compared with 44% of women). Additionally, men show a different profile of gambling participation, being more likely to participate in sports betting (14% in the last four weeks, compared with four percent of women), and also more likely to take part in casino gambling and games (three percent vs. one percent). By contrast, when women gamble it is more likely to involve bingo, scratch cards and lottery participation.

Those in the middle age years were the most likely to report participation in the last four weeks (57% of those aged 45-54 and 56% of the 55-64 age group); again this is consistent with the pattern seen in previous research. Participation was slightly higher among C2DE respondents (51% in the last four weeks compared with 47% of ABC1s).

Comparing ethnic groups, participation is significantly higher among white than among BAME respondents (62% vs 52% in the last 12 months, and 50% vs 41% in the last four weeks). However, certain individual gambling activities show a different pattern: BAME respondents are more likely to have gambled in a casino (3.1% have done so in the last 12 months, compared with 1.8% of white respondents), or via a gaming machine in a bookmakers (2.0% vs. 1.1%). Although these proportions remain small, they suggest a slightly different pattern of behaviour, with BAME individuals less likely to gamble overall, but more likely to take part in gaming activities when they do participate. By contrast, white respondents are more likely to take part in the National Lottery and other lotteries.

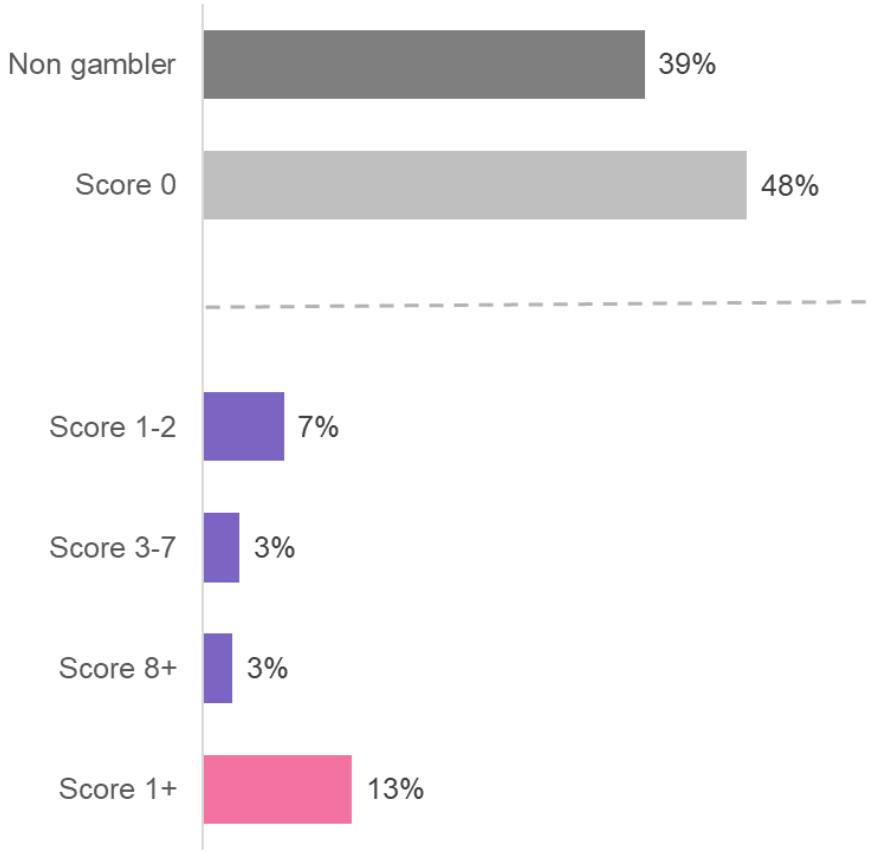
3.2 Extent of harmful gambling

In order to know the size of the population wanting any form of treatment or support, it was first necessary to calculate PGSI scores to know the proportion of the population experiencing gambling related harms. As set out in Section 2.3, the study utilised the full (9-item) PGSI to measure levels of gambling behaviour which may cause harm to the gambler, with respondents placed into the following categories according to their score:

- Non-problem gambler (PGSI score of 0)
- Low-risk gambler (PGSI score of 1-2; gamblers who experience a low level of problems with few or no identified negative consequences)
- Moderate-risk gambler (PGSI score of 3-7; gamblers who experience a moderate level of problems leading to some negative consequences)
- Problem gamblers (PGSI score of 8 or more; gamblers who gamble with negative consequences and a possible loss of control)

Overall, 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 eight or higher). The following table shows the proportion falling into each category in the survey.

Figure 2. Participation in gambling in the last 12 months / 4 weeks



The proportions falling into each PGSI category are significantly higher than those recorded via other studies. According to The Gambling Commission's official statistics, just over four percent of the population qualify as gamblers with a PGSI score of 1+[5]. For each category, the proportion observed via our study is approximately three times the proportion reported by the Commission. For further details on different methodologies, please see the technical appendix and report written by Professor Patrick Sturgis (also published on GambleAware's website).

As might perhaps be expected, men were more likely to be classified as gamblers with some level of harm (a score of one or higher on the PGSI scale) than women were (17% vs. 10%). Notably, men were also twice as likely to be classified as problem gamblers, with a score of eight or higher (four percent compared with two percent).

As shown in Table 5, younger adults (aged 18-34) were less likely to gamble at all, but among those who do gamble they were more likely to be classified as gamblers with some level of risk (a score of one or higher). Eighteen percent of this age group recorded a score of 1+, compared with 16% of 35-54 year olds, and just seven percent of those aged 55+. Most notably, five percent of 18-34 year olds were classified as problem gamblers (a score of 8+), compared with three percent of those aged 35-54, and under half a percent of adults aged 55+.

Table 5: 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%

[5] Gambling Participation in 2018, Gambling Commission (2019): http://www.gamblingcommission.gov.uk/PDF/survey-data/Gambling-participation-in-2018-behaviour-awareness-and-attitudes.pdf

While social grade makes only a modest difference to the likelihood of participating in gambling at all, the results show that respondents in C2DE social grades are slightly more likely to be classified as gamblers with some level of harm (a score of one or higher) than those in ABC1 social grade (14% vs. 12%). This variation is driven predominantly by the 'low risk' and 'moderate risk' categories, whereas the 'problem gambler' category shows minimal variation by social grade.

One of the most noticeable demographic differences is by ethnic group. As described in Section 3.1, BAME respondents were less likely to participate in gambling overall than their white counterparts. However, among those who do gamble, BAME respondents recorded higher scores on the PGSI scale. A fifth (20%) of BAME adults were classified as gamblers with some level of harm (a score of 1+), compared with 12% of white adults, and strikingly, seven percent of BAME respondents were classified as problem gamblers, with a score of eight or higher, compared with two percent of white respondents.

As discussed earlier, BAME adults showed a different profile of gambling participation, being more likely to participate in activities such as casino games and less likely to be 'Lottery only' gamblers, compared with white respondents. This difference in gambling activities may explain the higher PGSI scores recorded among the BAME subgroup in the survey.

Table 6: PGSI score categories – by social grade and ethnic group

	All	ABC1	C2DE	White	BAME
Non-gambler	39%	40%	37%	38%	48%
Non-problem gambler (score 0)	48%	48%	48%	50%	31%
Low-risk gambler (score 1-2)	7%	7%	8%	7%	8%
Moderate-risk gambler (score 3-7)	3%	3%	4%	3%	6%
Problem gambler (score 8+)	3%	3%	3%	2%	7%
All gamblers with a score of 1+	13%	12%	14%	12%	20%

The MRP modelling identified certain local authorities with a higher estimated proportion of gamblers experiencing some level of harm (PGSI 1+). Whilst the overall proportion of the British population who fall into this category is 13%, the estimated proportion is notably higher in Brent (27%) and Newham (25%), followed by certain other boroughs in London and the West Midlands. These are all areas with relatively high BAME populations, which is consistent with the overall findings of this study. Across all local authorities, the estimated proportion of gamblers experiencing some level of harm (PGSI 1+) varies widely from 27% to 8%.

4 Gamblers' use of treatment and support

This chapter will discuss engagement of treatment, advice and support by gamblers experiencing some level of harm (a PGSI score of 1+). Results reported throughout this section are based on those with a PGSI score of 1+ only.

4.1 Usage of treatment and support in the last 12 months

The table below summarises usage of treatment services and less formal support and advice, by gamblers experiencing some level of harm, in the last 12 months. These proportions are taken from the Phase 1 study. Overall, 12% of these gamblers reported having used any type of treatment (such as mental health services, their GP, or specialist face-to-face treatment). Thirteen percent indicated that they had used any form of less formal support or advice (such as from family and friends, support groups, websites or books). Overall, 17% had used either treatment and/or support/advice, in the last 12 months.

As might be expected, those gamblers with higher PGSI scores were much more likely to have used treatment and support. While just three percent of those classified as low risk gamblers had used treatment, support or advice, this rises to 17% of those classified as moderate risk gamblers, and over half (54%) of problem gamblers (with a score of 8+). While usage of both treatment and support/advice increase with PGSI category, support/advice shows a more consistent pattern of increase with each PGSI category. By contrast, usage of treatment remains fairly low even among moderate-risk gamblers (nine percent), before jumping dramatically to 43% of those in the 'problem gambler' category.

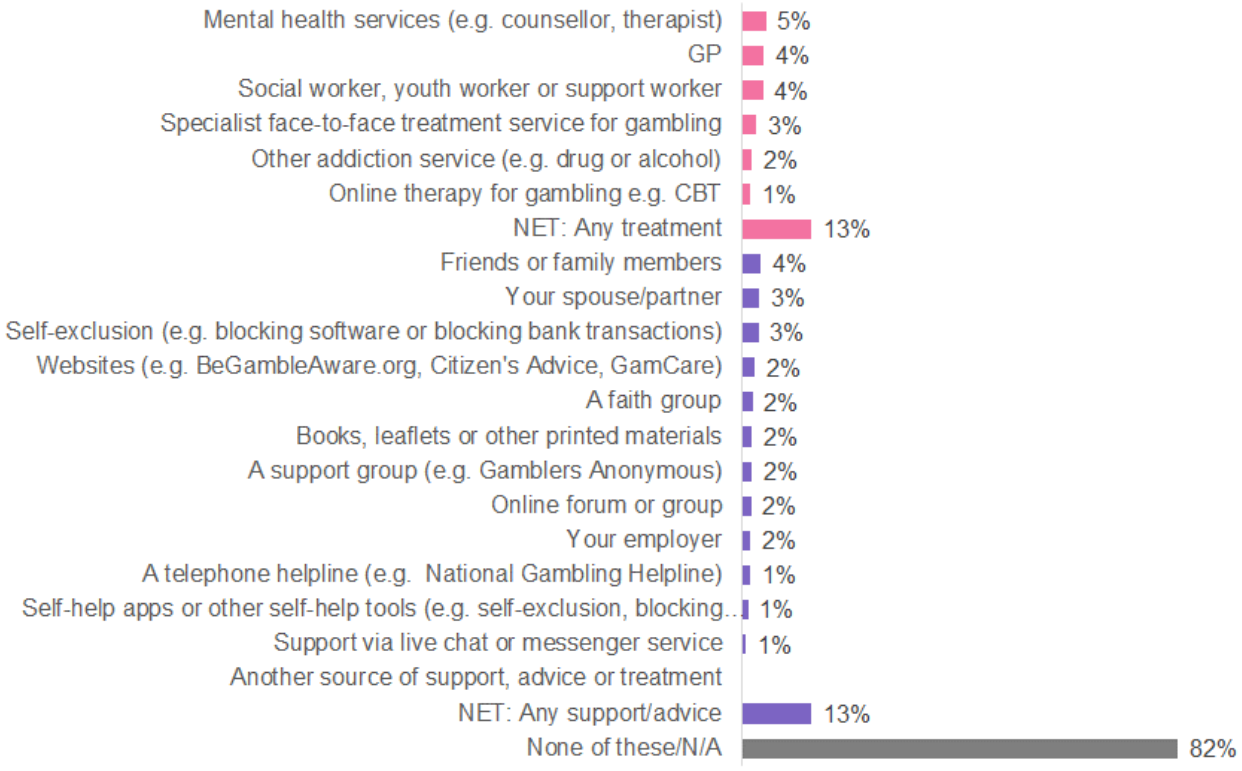
Table 7: Usage of treatment and support/advice – by PGSI score category

	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/advice	13%	2%	14%	39%
Used any treatment/support/advice	17%	3%	17%	54%
Have not used any	83%	97%	83%	46%

Estimated usage of treatment and support services by locality broadly mirrors the pattern seen in relation to gamblers experiencing some level of harm. Those living in Brent, the local authority with the highest proportion of gamblers with a PGSI score of one or higher, are also most likely to have used any treatment/support services (estimated at 11%). In areas with lower levels of problem gambling, usage of treatment/support services also tends to be much lower. Across all local authorities, estimated usage ranges from 11% to 1%.

The Phase 2 study brings the opportunity to explore in more detail the usage of treatment and support/advice among gamblers with a PGSI score of one or higher. Among professional services, mental health services had most commonly been used (five percent) followed by GPs and social or support workers (both four percent). When considering less formal sources of support and advice, gamblers had most commonly sought support from friends and family members (four percent). Few had used self-help apps or tools, or a telephone helpline such as the National Gambling Helpline (both one percent).

Figure 3. Usage of treatment/support/advice in last 12 months



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

Men and women were similarly likely to have sought treatment or support/advice (17% of men and 20% of women). However, younger gamblers, who had higher PGSI scores on average, were more likely to seek treatment or support: a quarter (25%) of 18-34 year olds had done so, falling to 15% of 35-54 year olds, and just eight percent of those aged 55+. This pattern is particularly striking among the youngest respondents (aged 18-24): 29% of gamblers in this age group had sought treatment, support or advice. Those aged 18-24 were the most likely to have used a specialist face-to-face treatment service (seven percent) as well as a social worker, youth worker or support worker (nine percent) and a telephone helpline (six percent).

As set out in Section 3.2, the proportion falling into each PGSI category was fairly similar among ABC1 and C2DE gamblers. However, ABC1 gamblers were significantly more likely to have sought treatment, advice or support: 22% had done so compared with just 14% of C2DE gamblers. In particular, they were more likely to have used mental health services (six percent vs. three percent), a social worker, youth worker or support worker (six percent vs. two percent) and specialist face-to-face treatment for gambling (four percent vs. one percent). It is worth noting that some services would, in some cases, cost money (such as private counselling), making them more accessible to those on higher incomes. Other factors which could help to explain this difference include: varying levels of provision in different local areas, access to transport, and a higher prevalence of co-morbidities among C2DE respondents[6] (which might make accessing treatment and support more difficult, or divert attention from gambling where other health issues are more pressing).

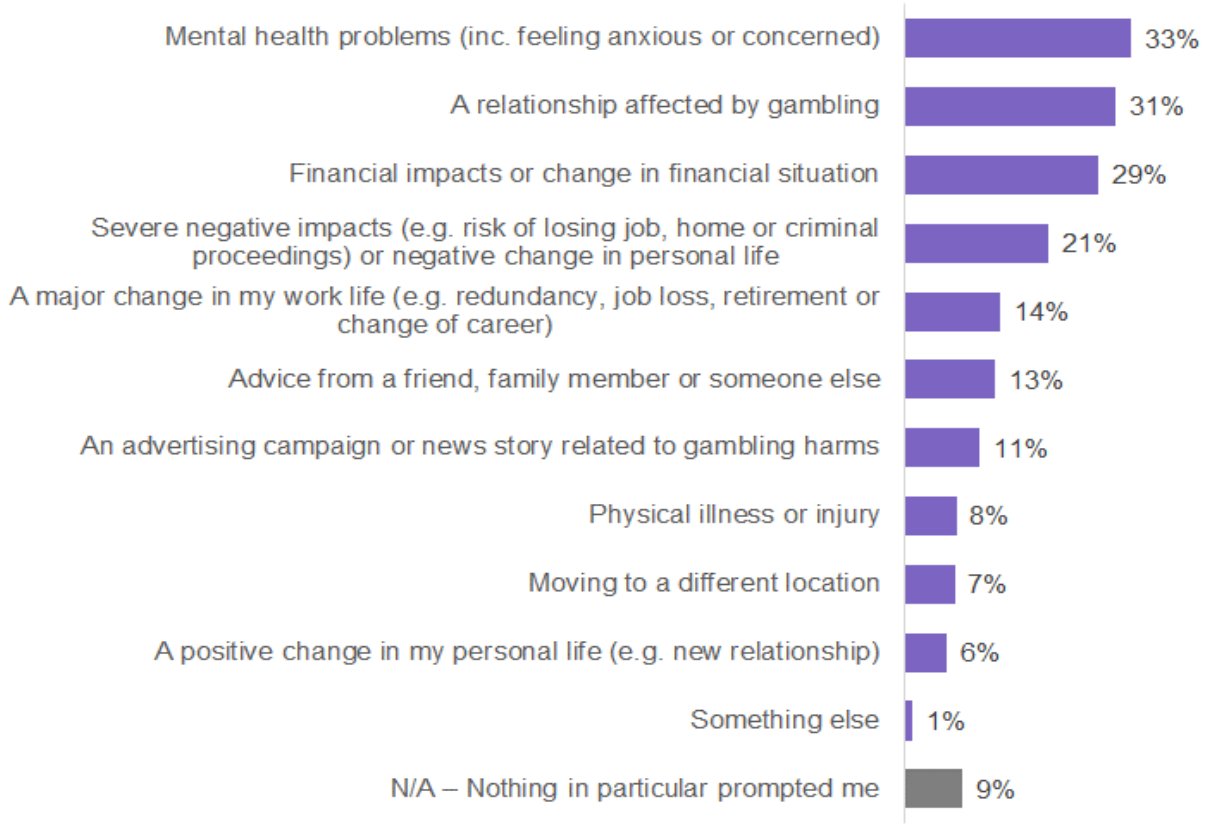
Respondents in BAME groups, who had higher PGSI scores on average than their white counterparts, were significantly more likely to have used treatment or support: a third (34%) had used any source, compared with 16% of white gamblers.

4.2 Reasons for seeking treatment/support

Gamblers who sought treatment or support tended to be motivated to do so by mental health problems including feelings of anxiety or concern over their gambling (33%), as well as the gambling affecting their relationships or family (31%), and financial impacts or a change in their financial situation (29%). Notably, a fifth (21%) were motivated by severe negative impacts from their gambling (such as the risk of losing their job or home, or the threat of criminal proceedings), or by a negative change in their personal life such as bereavement or relationship breakdown.

[6] The Phase 2 research showed that C2DE gamblers and affected others were more likely than ABC1s to say they have any long term health conditions (55% vs. 48%), including arthritis, asthma, hypertension (high blood pressure) or a mental health condition.

Figure 4: Factors that prompted gamblers to seek treatment/support/advice



Base: all gamblers with a PGSI score of 1+ who sought treatment/support (n=471)

Those classified as problem gamblers, with a PGSI score of 8+, were more likely to recognise various motivators than those classified as moderate risk gamblers including effects on their relationships/family (37% vs. 17%) and the gambling having severe negative impacts or a negative change in their personal life (27% vs. 13%). By contrast, moderate-risk gamblers were more likely to mention mental health issues as a motivator to seek treatment (43% vs. 31%). There were too few low-risk gamblers who sought support to include in analysis here.

Male and female gamblers generally had similar motivators although men were more likely to mention moving to a different location (10% vs. 4% of women) and physical illness or injury (11% vs. three percent). While an advertising campaign or news story was a motivator for only 11% overall, this rises to 18% among the 18-24s who sought support, perhaps indicating that a campaign aimed at this age group has achieved good cut-through.

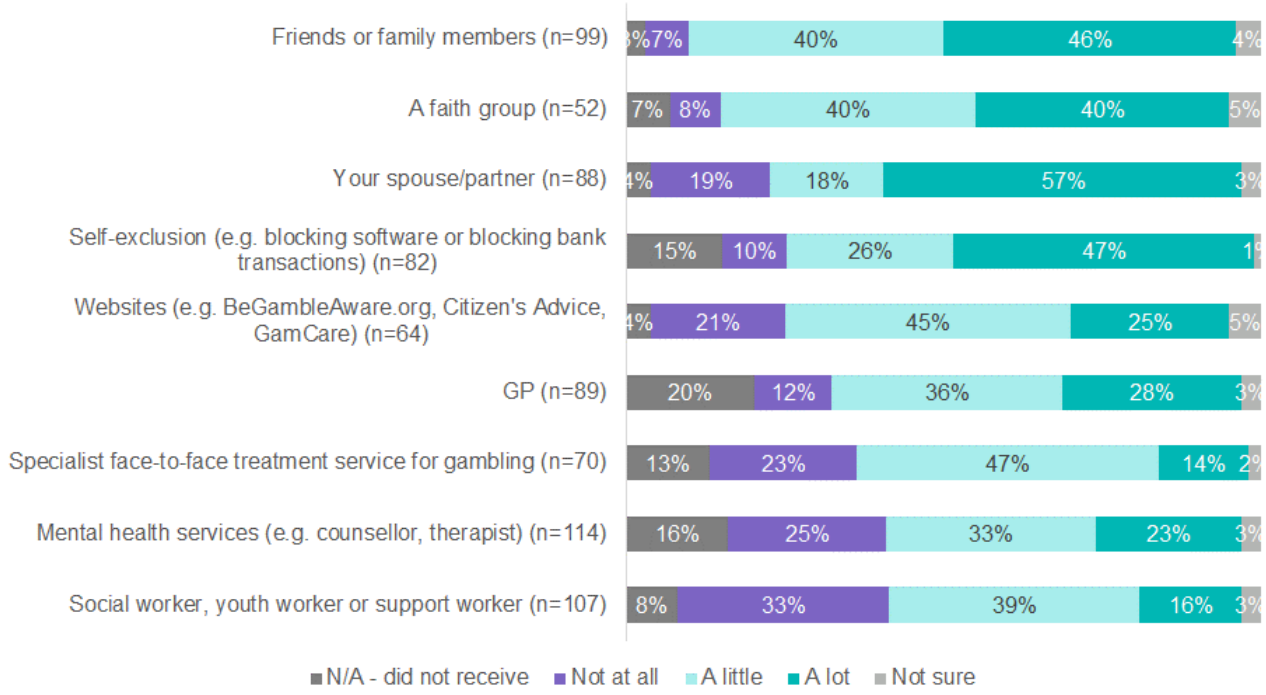
Gamblers in ABC1 social grades were more likely than C2DEs to mention relationship effects (36% vs 24%) and severe negative impacts or a negative change in their personal life (25% vs. 15%). However, C2DE respondents were not significantly more likely to mention any other motivators; rather, they were more likely to say that they were prompted to seek help by nothing in particular.

4.3 Efficacy of treatment/support

Those respondents who had sought treatment, support or advice were asked about its efficacy in terms of helping them to cut down their gambling. For all sources, over half of users stated that it had helped to some extent, and for most sources it was around two-thirds or higher. Support from family or friends was rated as most helpful (86% of those who sought it said it helped a little or a lot). While very few respondents had sought support from a faith group, eight in ten (79%) of those who did found it helpful.

Support from a social worker/youth worker/support worker was rated as the least helpful: just over half (55%) of those who sought such support found that it helped, and 57% of those using mental health services reported the same. Generally, professional treatment options received lower ratings than did less formal sources of support. However, it is important to remember that the professional treatment services were predominantly used by those with higher PGSI scores, (whose problems may typically be more difficult to address), whereas those with lower PGSI scores tended to use the less formal sources of support, if anything.

Figure 5: Extent to which treatment/support helped to cut down gambling



Base: all who sought treatment/support from each source (base sizes as shown)

5 Gamblers' demand for treatment and support

5.1 Current demand for treatment and support

Table 8 summarises current demand for treatment services and less formal support and advice, by gamblers experiencing some level of harm (a PGSI score of 1+). These proportions are taken from the Phase 1 study. Overall, 18% of these gamblers said they currently would want some form of treatment, advice or support. Among this group, four percent have not accessed any form of treatment, advice or support before in the last 12 months but have a demand for it, whilst 14% have accessed some support before but would like more. The 18% of gamblers that want some form of treatment, advice or support includes 13% who expressed a desire for any form of treatment from professional sources, and 13% who wanted any form of less formal support or advice (such as from family and friends, support groups, websites or books).

In line with the pattern seen in relation to existing usage of treatment and support, those classified with higher scores on the PGSI were much more likely to want treatment and support. Among low-risk gamblers, just four percent wanted any form of treatment, support or advice, this rises to 15% of those with a moderate risk score, and over half (57%) of problem gamblers (with a score of 8+). Again, in common with the earlier findings, those classified as low risk and moderate risk gamblers are more likely to want support and advice from less formal sources than to want treatment from professional services. For the 'problem gambler' category, this pattern is reversed, with higher demand for professional treatment (48%) than for less formal support and advice (41%).

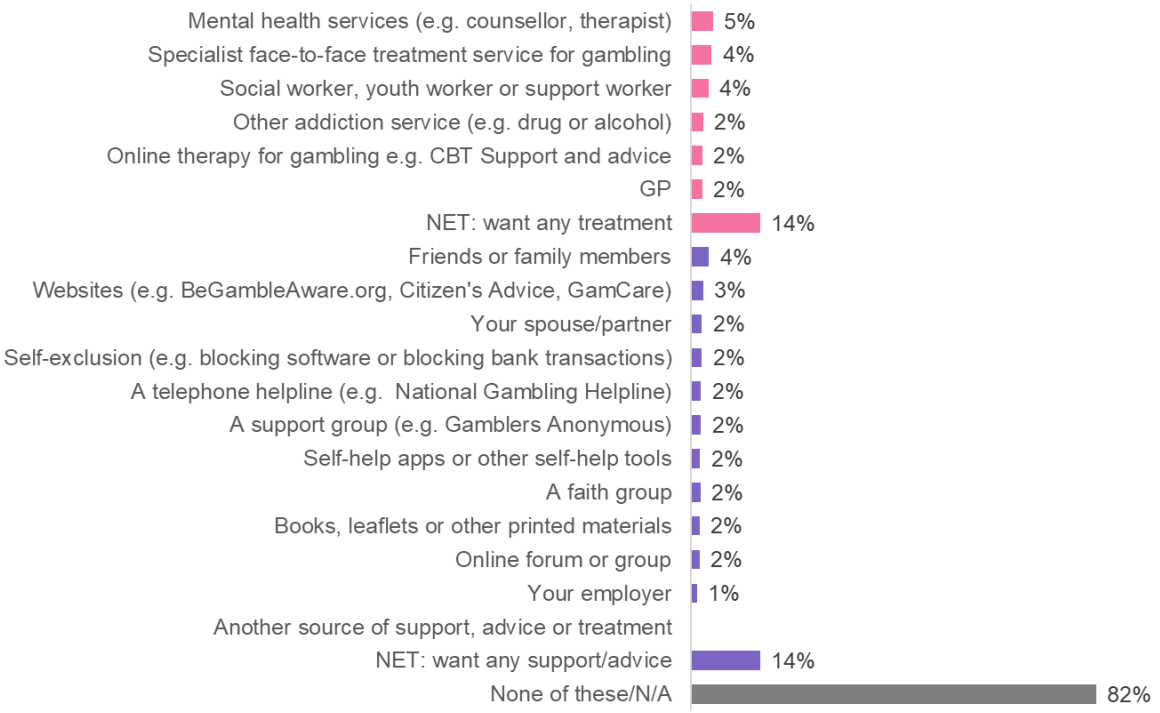
Table 8: Demand for treatment and support/advice – by PGSI score category

	All gamblers with score of 1+	Low-risk (score 1-2)	Moderate-risk (Score 3-7)	Problem gambler (Score 8+)
Want any treatment	**13%**	**2%**	**8%**	**48%**
Want any treatment and have received some before	10%	1%	6%	39%
Want any treatment and have not received any before	3%	1%	2%	10%
Want any support/advice	**13%**	**3%**	**12%**	**41%**
Want any support/advice and have received any before	9%	1%	7%	31%
Want any support/advice and have not received any before	4%	2%	4%	10%
Want any treatment/support/advice	**18%**	**4%**	**15%**	**57%**
Want any treatment/support/advice and have received some before	13%	2%	11%	48%
Want any treatment/support/advice and have not received any before	4%	2%	5%	9%
Do not want any	82%	96%	85%	43%

When looking at local authority level estimates, demand is highest in the areas with higher proportions of gamblers with a PGSI score of one or higher. An estimated one in ten (10%) adults 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 10% to 1%.

The Phase 2 study brings the opportunity to explore in more detail the demand for treatment and support/advice among these gamblers. Most commonly, gamblers feel they would like treatment from mental health services (five percent) or specialist face-to-face treatment for gambling (four percent). It is notable that, while GPs were the most commonly used treatment option (Figure 2), they come at the bottom of the list of professional sources which gamblers would like to receive treatment from. This could be due to some people perceiving GPs as a referral source as opposed to the source that will provide treatment. Among less formal sources of advice/support, family and friends are the most popular option (four percent). This is followed by websites (e.g. BeGambleAware.org, Citizen's Advice, GamCare), spouses / partners and self-exclusion, which has been grouped with blocking software or blocking bank transactions for the purpose of this research.

Figure 6: Sources that gamblers currently want to receive treatment/support/advice from



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

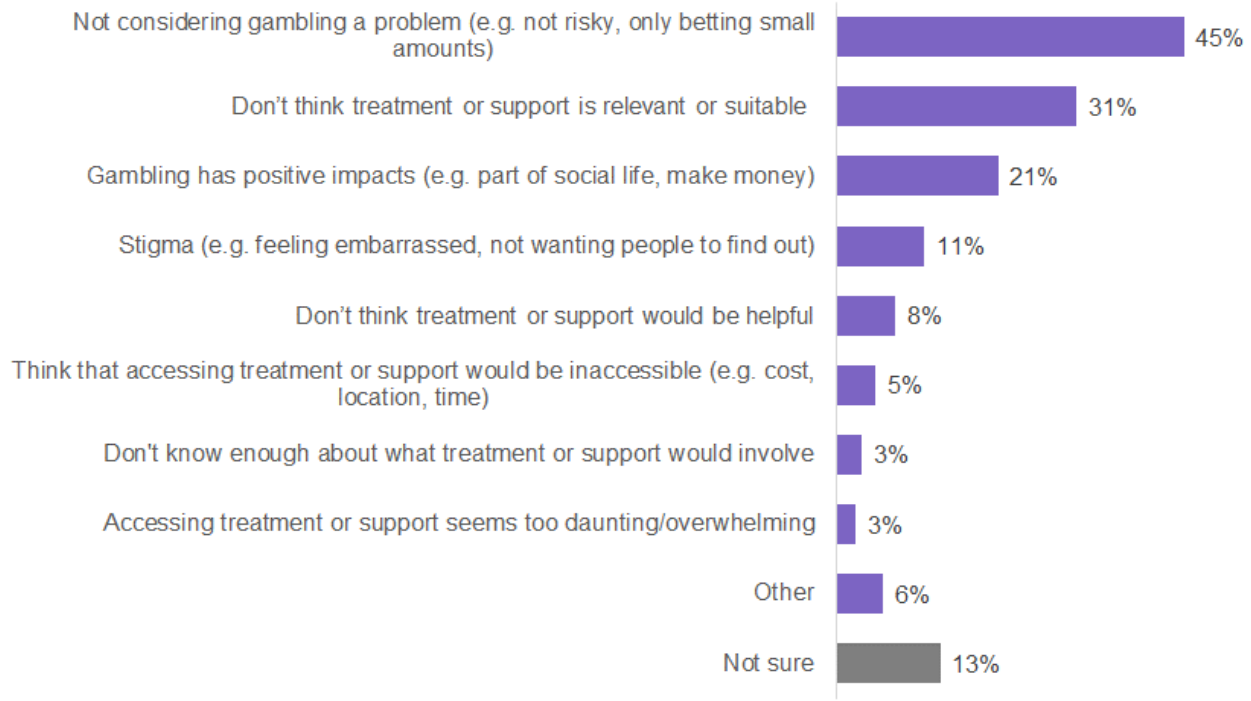
Male and female gamblers were equally likely to want treatment or support/advice. Younger gamblers, who had higher PGSI scores on average, were much more likely to want treatment or support. A quarter (25%) of 18-34s selected one or more sources, including 31% among the 18-24 age group; this falls to 17% of 35-54s and just eight percent of gamblers aged 55+. In particular, the youngest age group (18-24) were much more likely to want treatment from a social worker/youth worker/support worker (nine percent) and from an 'other addition service (e.g. drug or alcohol) (eight percent).

Earlier in this chapter, we outlined that gamblers in ABC1 social grades were more likely to have sought treatment, advice or support. The same pattern is evident when considering future treatment or support: 23% of ABC1 gamblers stated that they would want any form of treatment/support, compared with just 14% of C2DEs. ABC1s were more likely to want treatment from a specialist face-to-face service (six percent vs. three percent) and a social worker/youth worker/support worker (five percent vs. two percent), but also showed greater interest in support from an online forum, a telephone helpline and a faith group (all three percent ABC1 vs. one percent C2DE).Respondents in BAME ethnic groups, who had higher PGSI scores on average than their white counterparts, were also significantly more likely to want treatment or support: over a third (36%) wanted treatment/support from any source, compared with 16% of white gamblers. Among the individual sources of support, some notable differences include specialist face-to-face treatment for gambling (10% BAME vs. 4% white), other addiction services (six percent vs. two percent), and support from a faith group (five percent vs. one percent).

5.2 Barriers to seeking treatment and support

Among respondents stating that they did *not* want any form of treatment, advice or support, the barriers were further explored. Most commonly, gamblers stated that their gambling was not harmful or that they only gambled small amounts of money (45% of this group). 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 (making money, or it being part of their social life or leisure time). For one in ten (11%), stigma or shame was a barrier to seeking help.

Figure 7: Barriers to seeking treatment/support/advice



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

Unsurprisingly, these barriers varied according to the level of harm experienced due to gambling. Those classified as low-risk and moderate-risk gamblers were much more likely to say that their gambling was not harmful or only involved small amounts of money (53% and 51% respectively); this proportion declines to 17% of those in the 'problem gambler' category. By contrast, those in the 'problem gambler' category were much more likely to experience stigma or shame (27%, compared with 12% of moderate-risk gamblers and four percent of low-risk gamblers).

Problem gamblers were also more likely to believe that treatment/support would not be helpful (which includes some reporting that they had received treatment before and it didn't help) – this was a barrier for 14% of problem gamblers compared with eight percent of moderate-risk gamblers and four percent of low-risk gamblers. Interestingly, the feeling that gambling has positive impacts (such as making money or being part of their social life or leisure time) was not significantly different among the PGSI categories.

Male and female gamblers mostly mentioned similar barriers, although women were more likely to cite practical barriers such as cost, time or location in relation to accessing treatment or support (nine percent vs. three percent). Men were indicatively (not significantly) more likely to feel that their gambling has positive impacts such as making money or being part of their social life or leisure time (22% of men; 17% of women).

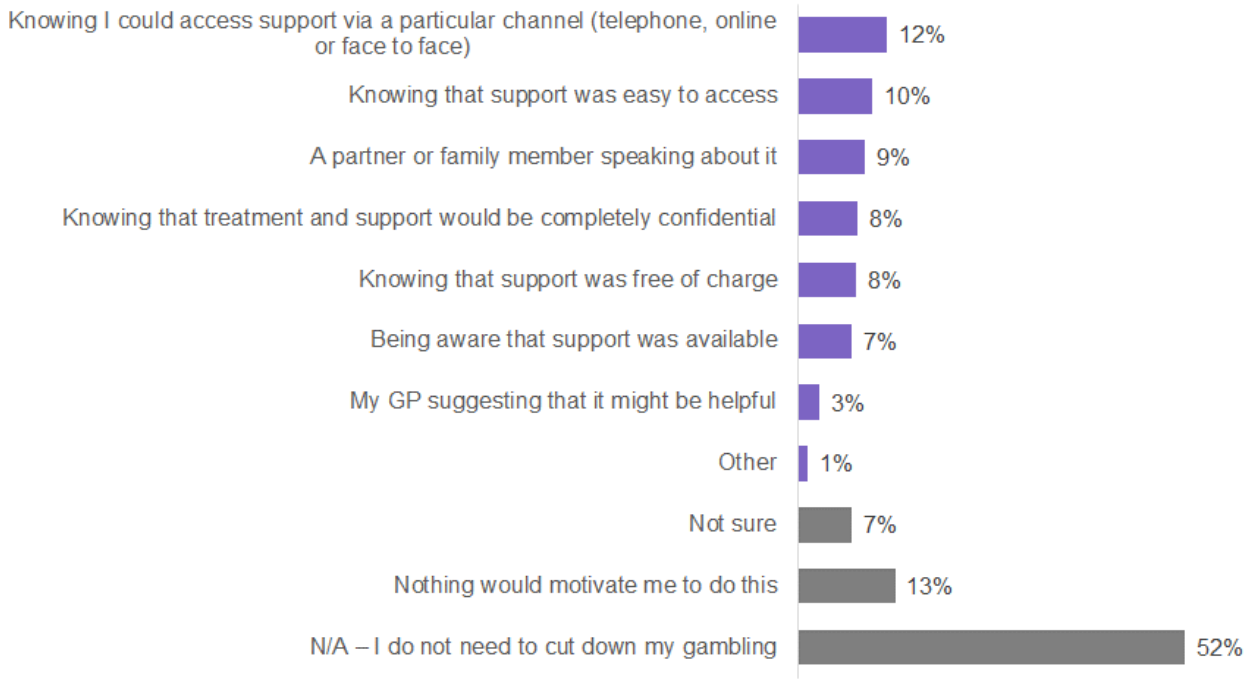
Older gamblers aged 55+ (who typically had lower PGSI scores) were more likely to feel that treatment or support was not relevant or suitable for them (38% compared with 26% of 35-54s and 31% of 18-34s). Younger gamblers, aged 18-34, were the most likely to say that they make money through gambling (nine percent, falling to three percent of 35-54s and two percent of 55+).

Barriers were generally similar among ethnic groups, however white gamblers were more likely to mention their gambling having positive impacts such as making money or being part of their social life or leisure time (23% vs. 6% of BAME gamblers). By contrast, BAME gamblers were more likely to state that the gambling activities they participate in are not harmful (29% vs. 14% of white gamblers).

5.3 Motivators to seek treatment and support

Overall, 28% of gamblers with a PGSI score 1+ recognised one or more factors which might motivate them to seek treatment, support or advice. This includes those who had already accessed some form of treatment, support or advice in the last 12 months as well as those who had not. Most commonly, gamblers thought they could be motivated by knowing support was available via a particular channel (telephone, online or face-to-face). Twelve percent mentioned one or more channels, with online being the most popular (six percent), followed by telephone (five percent) and finally face-to-face (four percent). One in ten (10%) thought they would be motivated by knowing support was easy to access, including the ability to self-refer, and a similar proportion would be motivated by a partner or family member speaking to them about their gambling (nine percent).

Figure 8: Factors that might motivate gamblers to seek treatment/support/advice



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

Unsurprisingly, problem gamblers (with a PGSI score of 8+) recognised several factors which might motivate them to seek treatment or support. Three in ten (31%) said that they might be motivated by knowing support was available via a particular channel (compared with 12% of moderate-risk gamblers and five percent of low-risk gamblers), and a fifth (22%) by a partner or family member speaking to them about it (compared with 10% and four percent respectively). By contrast, those classified as low and moderate risk gamblers were more likely to state that they did not need to cut down their gambling.

Gamblers in social grades ABC1 mentioned more potential motivators than their C2DE counterparts. 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%). Those in social grades C2DE were more likely to say that nothing would motivate them to seek support (17% vs. 9%).

There were few differences by age or gender. Comparing ethnic groups, BAME gamblers (who had higher PGSI scores on average) were more likely to be motivated by knowing that support was available via a particular channel (20% vs. 11% of white gamblers). Among the individual channels, these gamblers were particularly likely to mention knowing that support was available by telephone (12% vs. 4% of white gamblers), perhaps indicating a need to publicise the National Gambling Helpline more to this audience. White gamblers (with lower PGSI scores on average) were more likely to state that they did not need to cut down their gambling.

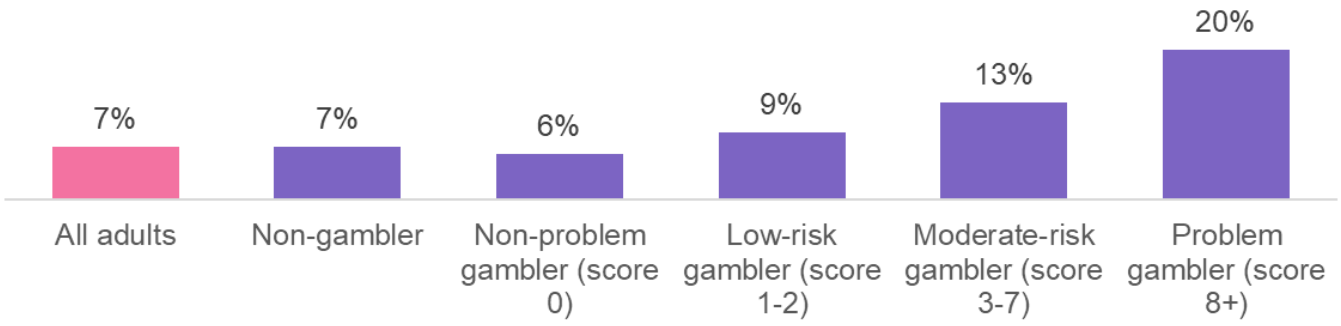
6 Affected others landscape

6.1 Amount of affected others

Gambling is a widespread issue that can have a profoundly negative impact, not just on those gambling, but on those close to them. ‘Affected others’ are people that 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 (or people's) gambling behaviour. This could include family members, friends and work colleagues, amongst others, with the negative effects ranging from financial to emotional or practical impacts.

Overall, 7 percent of the total adult population qualify as affected others. Among gamblers, the likelihood of being an affected other increases with PGSI score, showing an inter-relationship between an individual’s own gambling and experiencing issues related to others’ gambling. For example, one in five (20%) problem gamblers (PGSI score 8+) also identify as being an affected other. This alludes to the complexity of disordered gambling.

Figure 9: Proportion who are an affected other, by gambling category



Base: all GB adults (n=12,161)

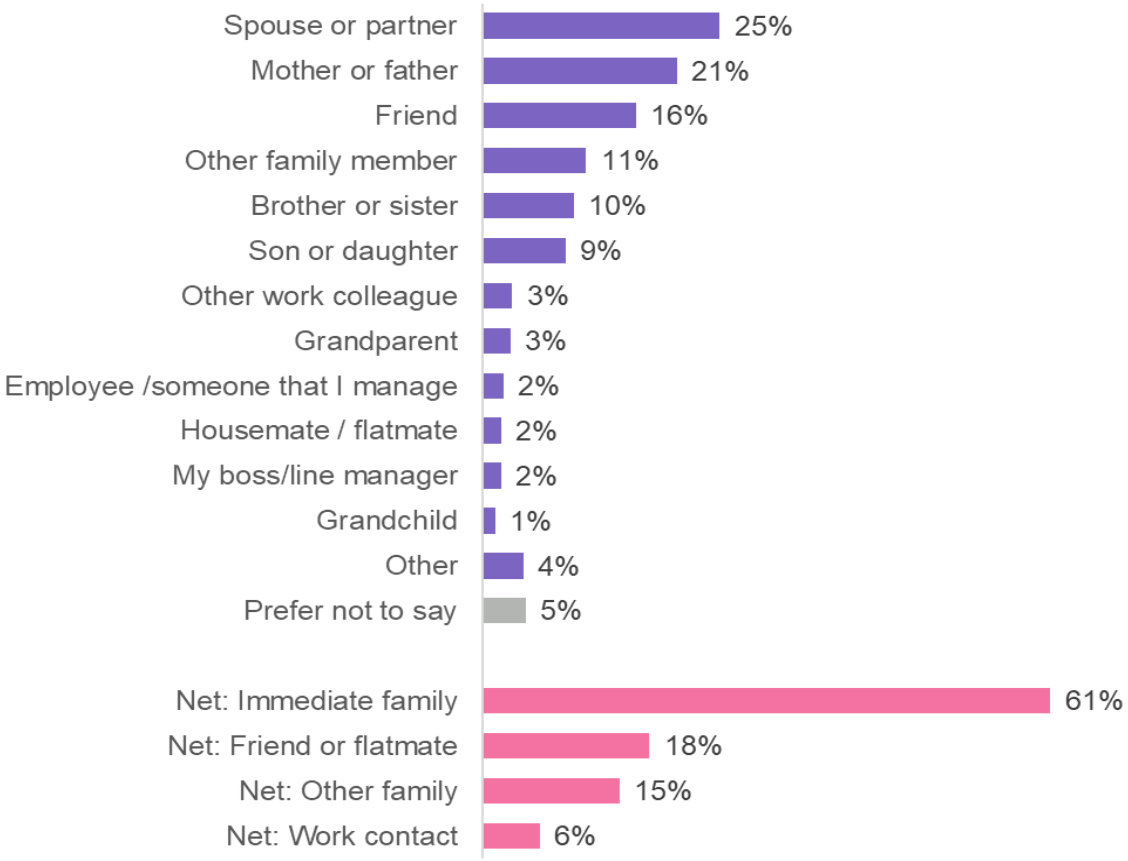
Affected others are more likely to be women than men. Fifty-seven percent of affected others are women (compared to 52% of the overall population) and 43% are men. This is likely explained by the typology of the gambling population, with significantly more men than women being classified as problem gamblers (PGSI score 8+). The higher proportion of heterosexual relationships means that there are more female spouses or partners being affected by a gambling problem of their significant other.

There is a fairly even split across age, with approximately a third of affected others falling into each age category: 18-34 (30%), 35-54 (36%) and 55+ (34%); fairly similar to the overall population. Affected others are more likely to be of social grade C2DE, with 51% of affected others classified as C2DE (compared to 46% in the population). They are also slightly more likely to be of BAME ethnic origin (16%, compared with around 12% in the total population).

6.2 Type of affected other

Affected others are most likely to be negatively affected by a gambling problem of someone in their immediate family (61%). This is most commonly a spouse or partner (25%), followed by a parent (21%). Less commonly, this group are negatively affected by a friend or flatmate (18%), their non-immediate family (15%) or a work contact (six percent).

Figure 10: Whose gambling affected others have been affected by



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

Female affected others are more likely than males to be affected by a gambling problem of someone in their immediate family (71% vs. 44%), with women particularly more likely to be affected by a spouse or partner (35% vs. 9%). This is likely due to there being more male problem gamblers and more heterosexual relationships. By contrast, men are more likely than women to have been negatively affected by a gambling problem of a work contact (11% vs. 3%) or a friend or flatmate (33% vs. 9%).

Younger affected others aged 18-24 are most likely to have been negatively affected by a gambling problem of a parent (37% vs. 21% overall), whilst those aged 55+ are more likely to have been negatively affected by their child (18% vs. 9% overall), in accordance with their age.

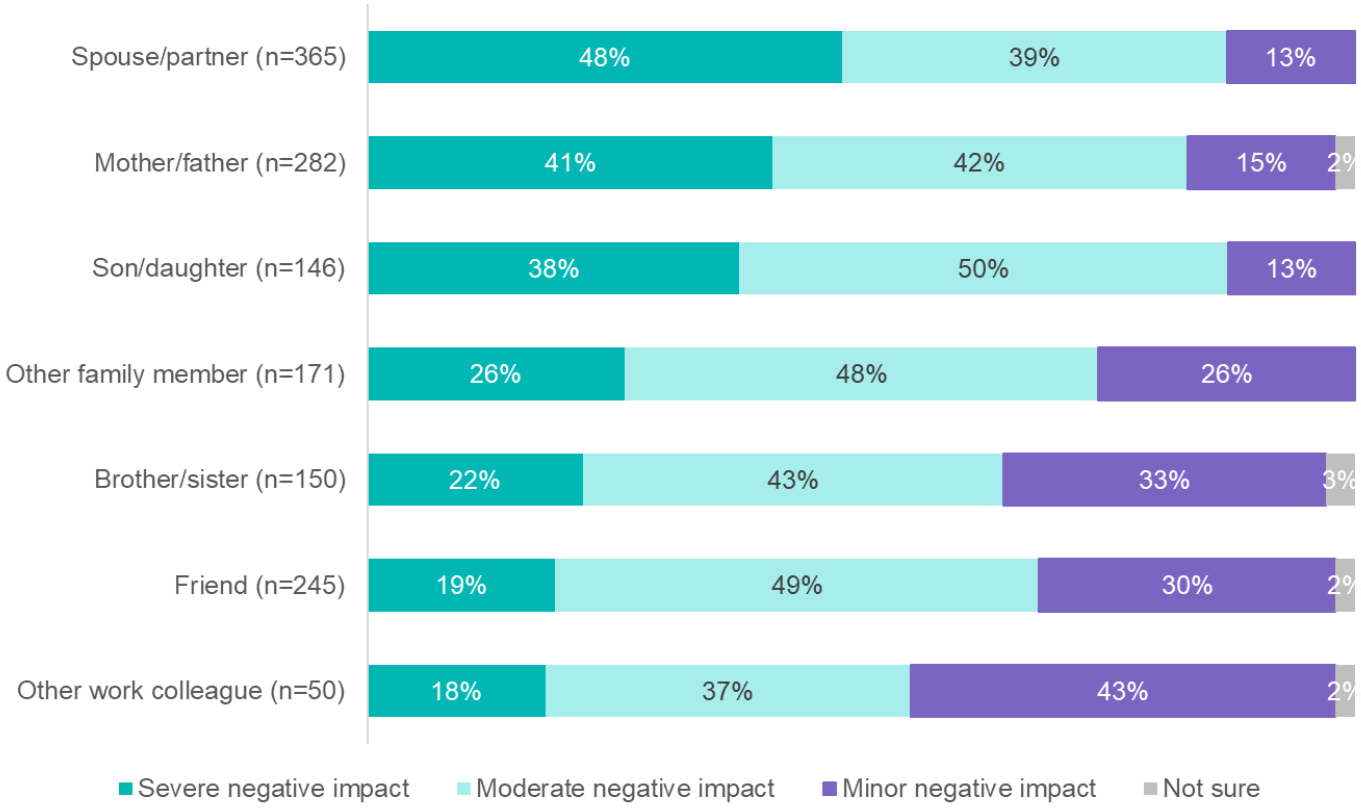
White people are more likely to say they have been negatively affected by the gambling problem of a spouse or partner (26% vs. 16% of BAME respondents), whilst BAME respondents are more likely to have been affected by a parent (30% vs. 20% of white respondents).

Problem gamblers (PGSI score 8+) are not just affected by their own gambling, with one in five (20%) also identifying as affected others. Those who are both affected others and problem gamblers themselves are more likely than average to say that they have been negatively affected by the gambling problem of a son or daughter (15%), implying that gambling can have profound impacts on the family as a whole. Problem gamblers are also more likely than average to say they have been negatively affected by a non-immediate family member or a work contact, suggesting that gamblers might be more likely to socialise with other gamblers.

6.3 Severity of impacts

The impact of a gambling problem for affected others is felt most severely by immediate family members. Close to half (48%) of affected others that are affected by a spouse or partner's gambling report a severe negative impact, likely due to the close and intense nature of this relationship. This is followed by those affected by a gambling problem of a parent (41%) or a child (38%). Whilst a relatively high proportion (16%) of affected others are affected by a friend, this is likely to be a lesser impact, with one in five (19%) reporting a severe impact and three in ten (30%) saying the gambling problem has a minor negative impact on them. This suggests that the type and closeness of the relationship, for example whether they have a family or joint finances together, plays a key role in determining the severity of the negative impact.

Figure 11: Severity of impacts



Base: all affected others who are/were affected by each party (base sizes as shown)

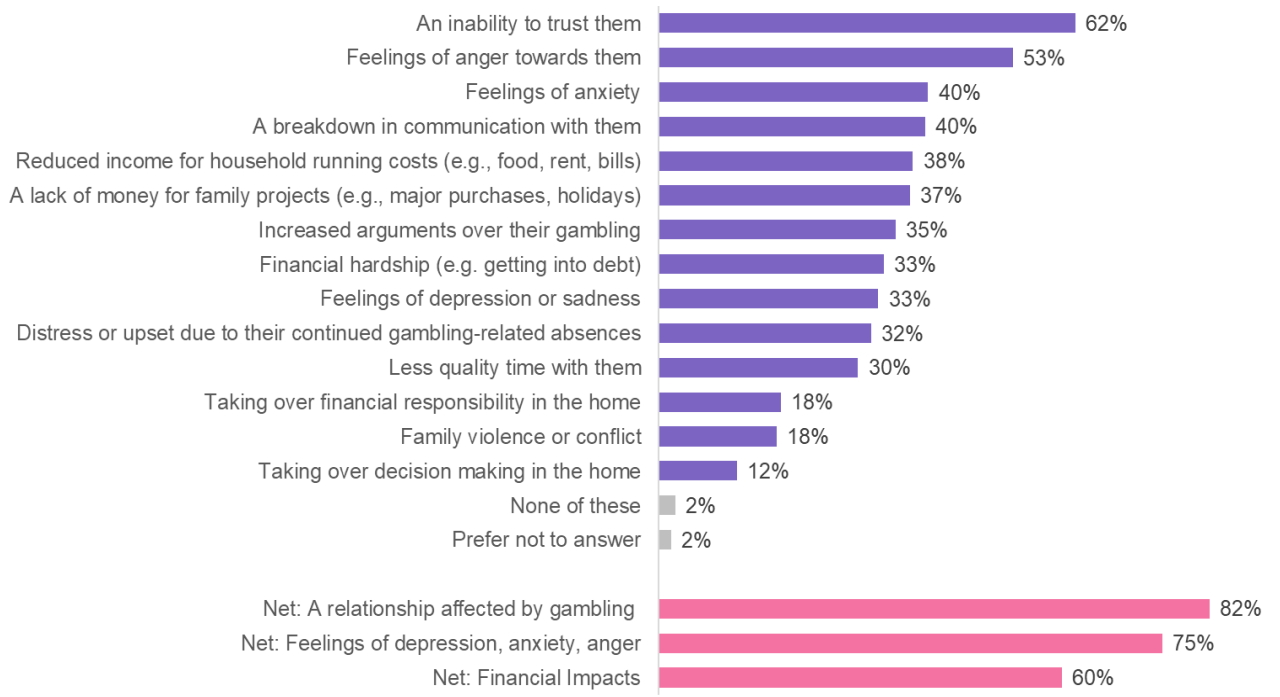
6.4 Types of impacts

Gambling-related harms are the adverse impacts from gambling on the health and wellbeing of individuals, families, communities and society.[7] Gambling can have a profound impact on the day-to-day lives of not only gamblers, but those close to them, on resources e.g. work and employment, money and debt, crime etc.), health (e.g. physical health, psychological distress, mental distress etc.) and relationships (e.g. partners, families and friends, communities etc.).

It is widely felt that the gambling problem of someone else has an impact on relationships, with the vast majority (82%) of affected others saying that a relationship has been affected by the gambling problem of someone else. This includes an inability to trust them, a breakdown in communication with them, increased arguments over their gambling, less quality time with them, family violence or conflict and taking over decision making in the home. Gambling can also result in negative sentiments among affected others, with three quarters (75%) saying they have felt feelings of anger, anxiety, depression, sadness, or distress and upset due to their continued gambling-related absences. A sizable proportion (60%) report experiencing financial impacts, including reduced income for household running costs, a lack of money for family projects, financial hardship and taking over financial responsibility in the home.

[7] Measuring gambling-related harms, Gambling Commission (2018): https://www.gamblingcommission.gov.uk/PDF/Measuring-gambling-related-harms.pdf

Figure 12: Types of impacts



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

Women are more likely than men to say they have experienced almost all of the negative impacts of being an affected other, with four in five (81%) saying that they have felt feelings of depression, anxiety, anger (compared with 64% of men). They are also more likely to say they have experienced financial impacts (67% vs. 48% of men). In line with earlier findings, this is probably due to the fact they are more likely be to affected by the gambling problem of a spouse or partner, whom they might be living with and share finances with.

Younger respondents aged 18-24 are more likely to report spending less quality time with someone due to their gambling problem (41% vs. 30% average). This group are more likely to have been negatively affected by the gambling problem of a parent, hinting at the negative impact gambling can have on family time.

7 Affected others: usage of advice or support

7.1 Usage of advice or support

Affected others may seek advice or support both for themselves, and on behalf of the person or people they know with a gambling problem. The following sections will focus on affected others that know someone who has had a problem with gambling in the last 12 months. Among those who have been affected in the last 12 months, overall, over two in five (45%) have sought advice or support in some form, whether that be from a professional or treatment service, such as mental health services or a GP, or less formal types of advice or support, including friends or family members or visiting a website.

When affected others seek advice or support, either on behalf of themselves or the person or people they know with a gambling problem, this is most likely to be from less formal sources, with around a third (36%) having done do. This can be as simple as just talking to someone, with one in five (19%) saying they sought advice or support from a friend or family member. The next most common sources of less formal advice or support include a partner or spouse and websites (e.g. BeGambleAware.org, Citizen's Advice, GamCare) (both 11%).

In addition to these sources of less formal advice or support, a smaller but significant proportion (21%) say that they have sought advice or support from a professional or treatment service. This is most often mental health services such as seeing a counsellor or therapist (12%) or a GP (eight percent). Five percent have sought advice or support from another addiction service (e.g. drug or alcohol), highlighting the complex nature of addiction, and the links between a gambling addiction and other addictive behaviours.

The majority (64%) of affected others have not sought advice or support on behalf of the person with the gambling problem, and they are even less likely to have done so for themselves (72% have not done so). When affected others do seek advice or support on their own account, it is most likely to be from mental health services (nine percent).

YouGov

Table 9: Usage of advice or support

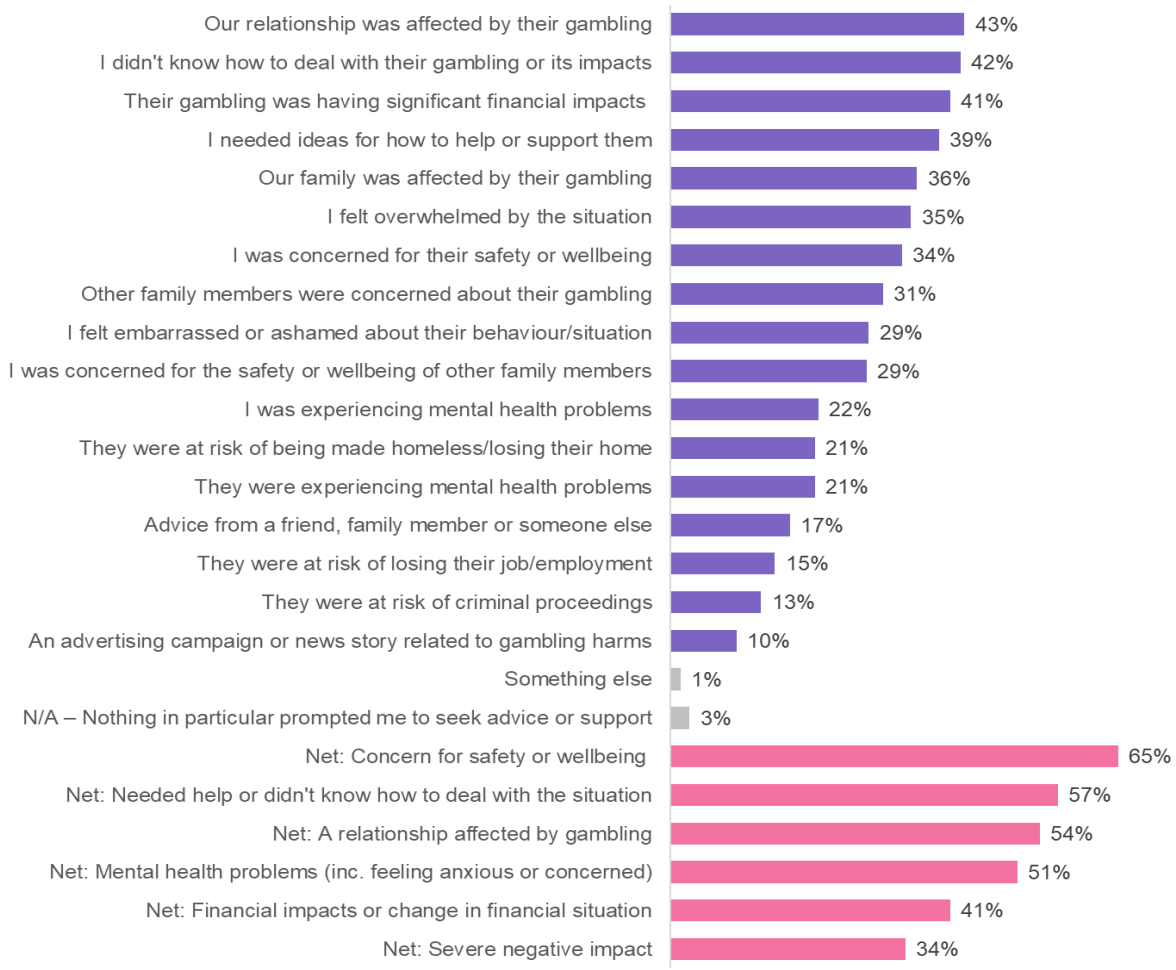
	Sought advice/ support at all	Sought advice/support on behalf of gambler	Sought advice/ support for themselves
Mental health services (e.g. counsellor, therapist)	12%	7%	9%
GP	8%	5%	5%
Social worker, youth worker or support worker	7%	5%	4%
Specialist face-to-face treatment service for gambling	5%	4%	2%
Other addiction service (e.g. drug or alcohol)	5%	3%	2%
Friends or family members	19%	15%	8%
Your spouse/partner	11%	8%	5%
Websites (e.g. BeGambleAware.org, Citizen's Advice, GamCare)	11%	9%	5%
A support group (e.g. Gamblers Anonymous)	6%	5%	3%
Books, leaflets or other printed materials	6%	4%	3%
A faith group	5%	3%	2%
Online forum or group	4%	3%	3%
Your employer	4%	3%	1%
A telephone helpline (e.g. National Gambling Helpline)	3%	3%	1%
Another source of advice or support	2%	1%	1%
Net: Any advice or support overall	45%	36%	28%
Net: Any advice/support from a professional/treatment service	21%	16%	16%
Net: Any less formal advice/support	36%	30%	19%

ABC1 respondents were more likely than C2DEs to have sought any advice or support generally, with half (52%) having done so in comparison to a third (36%) of CD2Es. This included a range of sources, including a social worker, youth worker or support worker (10% vs. three percent), a specialist face-to-face treatment service for gambling (eight percent vs. two percent) and another addiction service (e.g. drug or alcohol) (seven percent vs. one percent). This suggests seeking treatment and support might be normalised for this group with less of a stigma associated with it, or that they are more likely to know where to turn to. ABC1s were also more likely to have used less formal sources, such as websites (e.g. BeGambleAware.org, Citizen's Advice, GamCare) (14% vs. 7%) and a telephone helpline (e.g. National Gambling Helpline) (five percent vs. one percent).

7.2 Prompts for seeking advice or support

Concern for safety or wellbeing (65%), either related to the person with a gambling problem or for other family members, is the most common reason given by affected others for seeking advice on support. There is an evident need for help, with over half (57%) saying they sought advice or support as they needed ideas for how to help or support the person, or they did not know how to deal with their gambling or its impacts. A similar proportion report seeking advice or support due to a relationship/their family being affected by gambling (54%), or due to mental health problems (51%) such as feeling overwhelmed by the situation. Whilst a lower proportion, a significant number (34%) said they were prompted by a severe negative impact (e.g. risk of losing job, home or criminal proceedings), demonstrating the grave consequences that gambling can have.

Figure 13: Prompts for seeking advice or support



Base: all affected others in the last 12 months (n=429)

Female affected others were more likely than men to say that they were prompted to seek advice or support due to not knowing how to deal with the person's gambling or its impacts (49% vs. 30%), their gambling having significant financial impacts (e.g. couldn't pay rent, bills, afford food etc.) (47% vs. 30%) and feeling overwhelmed with the situation (41% vs. 25%). This is possibly due to the fact they are more likely to be affected by a gambling problem of their partner or spouse, and therefore tend to experience severe negative impacts. In the case of their financial situation, they might have joint finances, increasing the need to seek advice or support.

The prompts for seeking advice or support for themselves broadly mirror those for seeking it on behalf of someone with a gambling problem (see further details in Appendix).

8 Affected others: current demand for advice or support

8.1 Current demand for advice or support

There is strong demand for advice or support among those that have been affected by the gambling problem of someone else in the past 12 months, with close to half (46%) reporting a need for this, whether that be on behalf of themselves or their partner, family member, friend or colleague about their gambling.

The demand for support is a combination of less formal types of support and advice (34%) and advice or support from a professional or treatment service (29%). Among the less formal supports sources, there is greatest demand for a support group (e.g. Gamblers Anonymous) (14%), through websites (e.g. BeGambleAware.org, Citizen's Advice, GamCare) and a telephone helpline (e.g. National Gambling (both nine percent) are also popular. Among the more formal sources of advice or support, there is evident demand for mental health services (18%), followed by a specialist face-to-face treatment service for gambling (14%). Once again highlighting the link between addictive behaviours, there is a small but sizable (eight percent) demand for other addiction services (e.g. drug or alcohol).

Table 10: Demand for advice and support

	Want any advice/support	Want any advice/support on behalf of gambler	Want any advice/support for themselves
Mental health services (e.g. counsellor, therapist)	18%	15%	8%
Specialist face-to-face treatment service for gambling	14%	13%	6%
Other addiction service (e.g. drug or alcohol)	8%	7%	3%
GP	8%	6%	4%
Social worker, youth worker or support worker	6%	4%	4%
A support group (e.g. Gamblers Anonymous)	14%	10%	5%
Friends or family members	13%	7%	8%
Websites (e.g. BeGambleAware.org, Citizen's Advice, GamCare)	9%	7%	6%
A telephone helpline (e.g. National Gambling Helpline)	9%	7%	4%
Online forum or group	8%	7%	4%
Books, leaflets or other printed materials	8%	7%	4%
Your spouse/partner	7%	4%	4%
Your employer	4%	3%	1%
A faith group	3%	3%	1%
Another source of advice or support	2%	2%	1%
Net: Any advice or support overall	46%	43%	31%
Net: Any advice/support from a professional/treatment service	29%	26%	16%
Net: Any less formal advice/support	34%	28%	21%

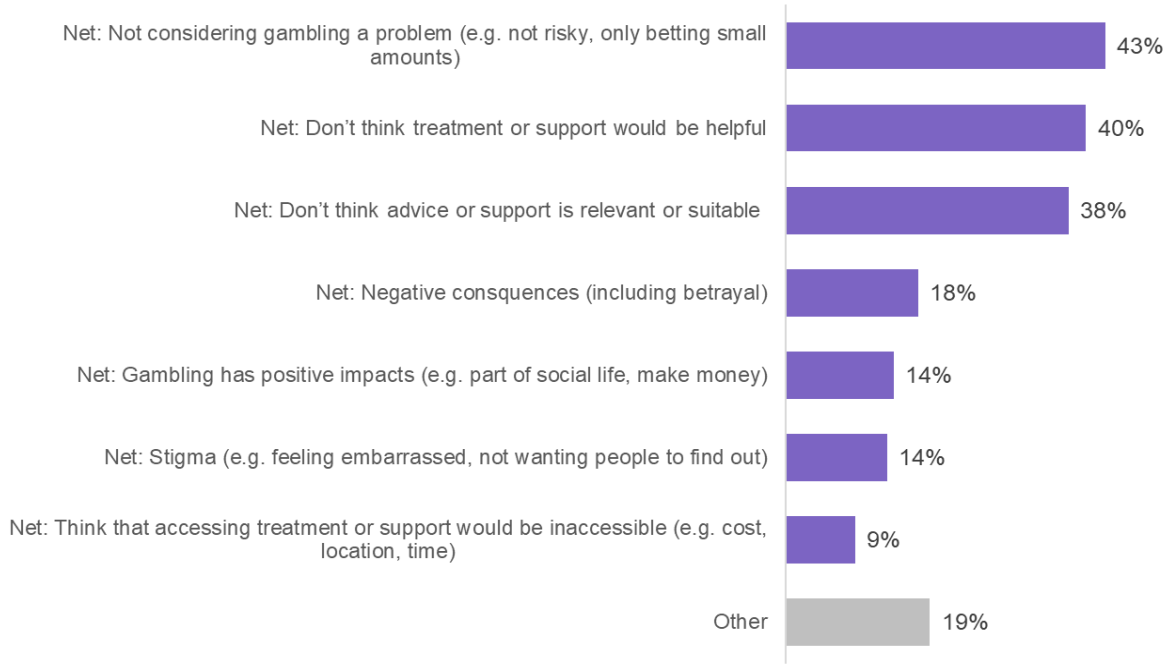
Affected others aged 18-34 have a greater demand than their older counterparts for any advice or support services listed, with over half (58%) saying they would want to receive advice or support either for themselves or for the person or people they know with a gambling problem (compared with 39% of 35-54 year olds and 42% of 55+). This is mostly due to wanting professional support or treatment services, with two in five (42%) reporting a demand for this (compared with 23% of 35-54 year olds and 21% of 55+).

In line with earlier findings that ABC1 respondents were more likely than C2DEs to have sought any advice or support, they also have a greater demand for it (51% vs. 40%). There is a particular difference when considering professional support or treatment services. Thirty-four percent of ABC1s would like to receive this in some form, compared with 23% of C2DEs. This could be due to differences in perception of professional support and treatment, which might be more normalised for ABC1 respondents.

8.2 Barriers to wanting advice or support

The most common barrier for wanting advice or support, either for themselves or on behalf of themselves or their partner, family member, friend or colleague, is the person not considering their gambling a problem (43%). There is still a common perception that gambling treatment would not be helpful or effective (partly due to people receiving it before and not thinking it helped), with two in five (40%) reporting this. The stigma surrounding a gambling addiction also prevents some affected others from wanting advice or support, with 14% saying that they would have been embarrassed or ashamed to ask for advice or support, or that they would not want anyone to find out socially or professionally.

Figure 14: Barriers to wanting advice or support



Base: all affected others in the last 12 months (n=429)

Men are more likely than women (20% vs. 11%) to say that the positive impacts of gambling (e.g. part of social life, making money) are reasons that they would not currently want to receive advice or support.

The barriers for seeking advice or support are broadly similar, whether on behalf of themselves or on behalf of someone with a gambling problem (see Appendix). Male affected others tend to feel that treatment or support on behalf of themselves would not be helpful, with two in five (39%) reporting this in comparison to a quarter (25%) of women.

9 Conclusions

Overall, 18% of gamblers with a PGSI score of one or higher currently want some form of treatment, support or advice. This includes 4% of gamblers with a PGSI score of 1+ who want some form of advice or support and have *not* received any in the past 12 months. Additionally, close to half (46%) of affected others say that they want some form of treatment, support or advice.

Demand for treatment, support and advice is naturally higher in locations with higher proportions of gamblers experiencing some level of harm, and varies significantly by locality. For example, an estimated 10% of adults in Brent say that they would like some form of treatment or support, compared with just 1% in the localities with lowest demand (and 2.31% of the overall population). The areas with the highest demand tend to be urban areas with relatively high BAME populations, which is consistent with patterns seen throughout this research. The wide disparity in demand by local area could inform the provision of local treatment services.

There are a multitude of barriers to receiving treatment, advice and support with harmful gambling. Many (45%) of those stating they did *not* want any form of treatment, advice or support felt that their gambling was not harmful or that they only gambled small amounts of money. This was also the most common barrier mentioned by affected others. This suggests there could be value in producing communications in order to inform people about gambling related harms and how treatment could be relevant to them, as well as increasing awareness of treatment services and their suitability for different types of people.

10 Appendix: additional tables

Table 11: Prompts for affected others to seek advice or support

	Prompts to seek advice or support at all	Prompts to seek advice or support on behalf of someone else	Prompts to seek advice or support for themselves
Our relationship was affected by their gambling	43%	41%	33%
I didn't know how to deal with their gambling or its impacts	42%	37%	33%
Their gambling was having significant financial impacts	41%	40%	29%
I needed ideas for how to help or support them	39%	38%	27%
Our family was affected by their gambling	36%	34%	22%
I felt overwhelmed by the situation	35%	29%	31%
I was concerned for their safety or wellbeing	34%	31%	19%
Other family members were concerned about their gambling	31%	27%	20%
I felt embarrassed or ashamed about their behaviour/situation	29%	26%	19%
I was concerned for the safety or wellbeing of other family members	29%	29%	13%
I was experiencing mental health problems	22%	15%	20%
They were at risk of being made homeless/losing their home	21%	17%	16%
They were experiencing mental health problems	21%	26%	n/a

Advice from a friend, family member or someone else	17%	13%	15%
They were at risk of losing their job/employment	15%	15%	6%
They were at risk of criminal proceedings	13%	10%	13%
An advertising campaign or news story related to gambling harms	10%	8%	8%
Something else	1%	1%	1%
N/A – Nothing in particular prompted me to seek advice or support	3%	1%	7%
Net: Concern for safety or wellbeing	65%	61%	41%
Net: Needed help or didn't know how to deal with the situation	57%	52%	43%
Net: A relationship affected by gambling	54%	50%	40%
Net: Mental health problems (inc. feeling anxious or concerned)	51%	47%	39%
Net: Financial impacts or change in financial situation	41%	40%	29%
Net: Severe negative impact	34%	32%	28%

Table 12: Barriers for affected others to seeking advice or support

	Barriers to seeking advice or support at all	Barriers to seeking advice or support on behalf of someone else	Barriers to seeking advice or support for themselves
They don't think/accept that they have a problem	43%	40%	27%
I don't think advice or support would be helpful/effective	39%	26%	29%
I don't think advice or support is relevant to them/me	35%	6%	35%
They have to want to change themselves	31%	36%	n/a
I would feel like I was betraying them or 'going behind their back'	14%	14%	8%
Gambling is part of their social life or leisure time	13%	17%	n/a
They have stopped gambling now	10%	13%	n/a
I would be embarrassed or ashamed to ask for advice or support in relation to gambling	10%	7%	8%
I don't want anyone to find out (socially or professionally)	8%	6%	6%
I don't know enough about what advice or support would involve	8%	6%	4%
Getting advice/support might have negative consequences for them	7%	7%	5%
I don't think advice or support would be available in my area/in a convenient location	5%	4%	4%
I don't think the support available would be suitable for people like me	5%	3%	4%

Accessing advice or support seems too daunting/overwhelming	5%	4%	4%
I've received advice or support before and it didn't help	5%	5%	2%
They make money through gambling	4%	5%	n/a
I think accessing advice or support would take too much time	3%	1%	2%
Accessing advice or support wouldn't fit into my schedule	2%	1%	2%
I think accessing advice or support would cost money	1%	0%	1%
Other	19%	14%	13%
Net: Not considering gambling a problem (e.g. not risky, only betting small amounts)	43%	40%	27%
Net: Don't think treatment or support would be helpful	40%	28%	30%
Net: Don't think advice or support is relevant or suitable	38%	8%	38%
Net: Negative consequences (including betrayal)	18%	17%	10%
Net: Gambling has positive impacts (e.g. part of social life, make money)	14%	18%	n/a
Net: Stigma (e.g. feeling embarrassed, not wanting people to find out)	14%	10%	10%
Net: Think that accessing treatment or support would be inaccessible (e.g. cost, location, time)	9%	5%	7%

11 Technical appendix

This appendix describes the methods used for data collection, sampling and weighting, as well as some relevant information relating to the placement of the PGSI questions in the surveys. It also briefly outlines the methods used by the Health Survey for England / Scottish Health Survey / Welsh Problem Gambling Survey, which are relevant to comparisons made between these studies and our survey findings. Methodological differences are summarised in a table at Section 11.4, with further information available in the report written by Professor Patrick Sturgis (also published on GambleAware's website).

11.1 Sampling and data collection methods

The two YouGov surveys were conducted online, with respondents drawn from YouGov's online panel of over 1,000,000 adults in the UK. YouGov employ an active sampling method, drawing a sub-sample from its panel that is representative of the group in question in terms of socio-demographics.

YouGov has a proprietary, automated sampling system that invites respondents based on their profile information and how that aligns with targets for surveys that are currently active. Respondents are automatically, randomly selected based on survey availability and how that matches their profile information.

Respondents are contacted by email and invited to take part in an online survey without knowing the subject at this stage. We use a brief, generic email invitation which informs the respondent only that they are invited to a survey. This helped to minimise bias from those opting in/out based on level of interest in the survey topic.

The Health Survey for England, Scottish Health Survey and Welsh Problem Gambling Survey are household face-to-face-studies, administered by an interviewer (the gambling-related questions are contained in a self-completion paper booklet).

These studies use a stratified random probability sample of households. This is a two-stage design which involves 1) selecting a random sample of primary sampling units (PSUs), based on postcode sectors and 2) drawing a random sample of postal addresses from each selected PSU.8

11.2 Weighting

Weighting adjusts the contribution of individual respondents to aggregated figures and is used to make surveyed populations more representative of a project-relevant, and typically larger, population by forcing it to mimic the distribution of that larger population's significant characteristics, or its size. The weighting tasks happen at the tail end of the data processing phase, on cleaned data.

In order to make this study representative, the Phase 1 sample was weighted to be representative of the GB adult population according to age, gender, UK region, socio-economic group and ethnic group. The Phase 2 data was weighted to match the profile of the group of PGSI 1+ gamblers and affected others found in Phase 1, according to age, gender, socio-economic group, region, gambler/affected other status and PGSI score category.

The Health Surveys also utilised weighting by the key demographic factors of age, sex and Government Office region (but not ethnic group or socio-economic group). Other weighting used for these studies related to the selection of different types of address and other technical factors which are related to the household sampling method and do not relate to the YouGov surveys.

11.3 Placement of PGSI questions

In both the Phase 1 and Phase 2 studies, the PGSI questions are positioned near the start of the survey, following three initial questions that identity the types of gambling activities, if any, that people have participated in during the past 12 months and 4 weeks, as well as gambling frequency.

[8] Health Survey for England 2016 Methods: http://healthsurvey.hscic.gov.uk/media/63778/HSE2016-Methods-text.pdf

In the Health Surveys the PGSI questions are asked at a later stage, after other modules (the General Health Questionnaire, ONS measure of life satisfaction, and Warwick Edinburgh Mental Wellbeing Scale).

11.4 Summary of method differences

Table 13: Summary of method differences between YouGov surveys and Health Surveys

	YouGov surveys	Health Surveys
Data collection method	Online – self completion	Household face to face - interviewer administered (gambling-related questions are contained in a self-completion paper booklet)
Sampling	Quota sampling	Random probability
Weighting	Age, sex, Government Office region, NRS social grade, ethnic group	Age, sex, Government Office region, some weighting related to household selection
Question placement	Early in survey (after three introductory questions related to gambling)	Later in survey (after other modules related to general health and wellbeing)