Primary Care Gambling Service Pilot Evaluation: Final Report

Prepared for GambleAware by IFF Research

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Contents

List of figures

List of tables

Acknowledgements

GambleAware is a grant-making charity using best-practice in commissioning, including needs assessment, service-planning, evaluation and outcome-reporting to support effective, evidence-informed, quality-assured prevention of gambling harms. Guided by a public health model, GambleAware commissions integrated prevention services on a national scale and in partnership with expert organisations and agencies, including the UK National Health Service, across three areas of activity: universal promotion of a safer environment (primary); selective intervention for those who may be 'at risk' (secondary); and, direct support for those directly affected by gambling disorder (tertiary). www.about.gambleaware.org

IFF Research 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. More information on IFF Research can be found at: www.iffresearch.com.

IFF Research would like to thank the Hurley Group and its partners and GambleAware for their support throughout the evaluation. We would also like to thank the patients who generously gave their time to share their experiences with the researchers.

Glossary

Term/phrase	Definition
Affected other	An individual who experiences harm as a result of someone else's gambling. For example, this might be a partner, family member or friend.
Core-10	Core-10 is a short outcome measure containing 10 statements about how a patient has been feeling psychologically in the last week.
Data Reporting Framework (DRF)	The Data Reporting Framework (DRF) is a set of reporting guidelines developed by GambleAware that their funded treatment providers need to follow. GambleAware commissioned View It UK to independently collect and analyse this DRF treatment output and outcome data. Data is validated by checks and is made available to the NHS. The data is intended to support a range of activities including statistics and analysis of national data, policy development, commissioning, performance management, service planning and improvement.
GambleAware	GambleAware is an independent, grant-making charity commissioning prevention and treatment services across England, Scotland and Wales in partnership with expert organisations and agencies, including the NHS.
GamCare	GamCare provides information, advice and support for anyone affected by gambling harms. They operate the National Gambling Helpline. GamCare is a partner in the delivery of the Primary Care Gambling Service (PCGS).
Gordon Moody	Gordon Moody is a charity in the UK that provides support and treatment for gambling addiction. They offer residential treatment centres, recovery housing and a retreat counselling programme for those needing support. Gordon Moody is a partner in the delivery of the PCGS.
Hurley Group	The Hurley Group is an NHS Partnership led by practicing GPs, providing patient-centred care in London since 1969. Staff from the Hurley Group deliver the Primary Care Gambling Service.
National Gambling Treatment Service (NGTS)	The National Gambling Treatment Service (NGTS) is a network of organisations working together to provide confidential treatment and support to those experiencing gambling-related harms. Both GamCare and Gordon Moody are part of the network.
National Problem Gambling Clinic (NPGC)	The National Problem Gambling Clinic (NPGC) is part of the NGTS and is jointly commissioned by GambleAware and NHS England. The NPGC treats problem gamblers living in England and Wales aged 16 and over. The team assesses the needs of problem gamblers as well as those of their partners and family members.
Patient Tracker	The Patient Tracker is an Excel spreadsheet containing information about PCGS patients including demographic information, information about their gambling history, family and medical history, their treatment plan, dates of assessments and questionnaire scores.

Problem Gambling Severity Index (PGSi)	The Problem Gambling Severity Index is the standardised measure of at-risk behaviour in problem gambling. It is a tool based on research on the common signs and consequences of problematic gambling.
Primary Care Gambling Service (PCGS)	The PCGS is a primary care-based pilot service located in Southeast London for adults aged 18 or over experiencing harm from gambling. It integrates primary care and third sector support to provide accessible, consistent and whole patient focussed support to gamblers.
Psychlops	Psychlops is a one-page mental health outcome measure and can be used during the course of any psychotherapeutic intervention. It covers three main domains: problems, function and wellbeing.

1 Executive Summary

Introduction

This evaluation explores the implementation journey of the Primary Care Gambling Service (PCGS), a primary care-based pilot service located in South East London for adults aged 18 or over experiencing harm from gambling. It provides early lessons about establishing and delivering a new service, and early evidence on the impact of the service on the patients it supports.

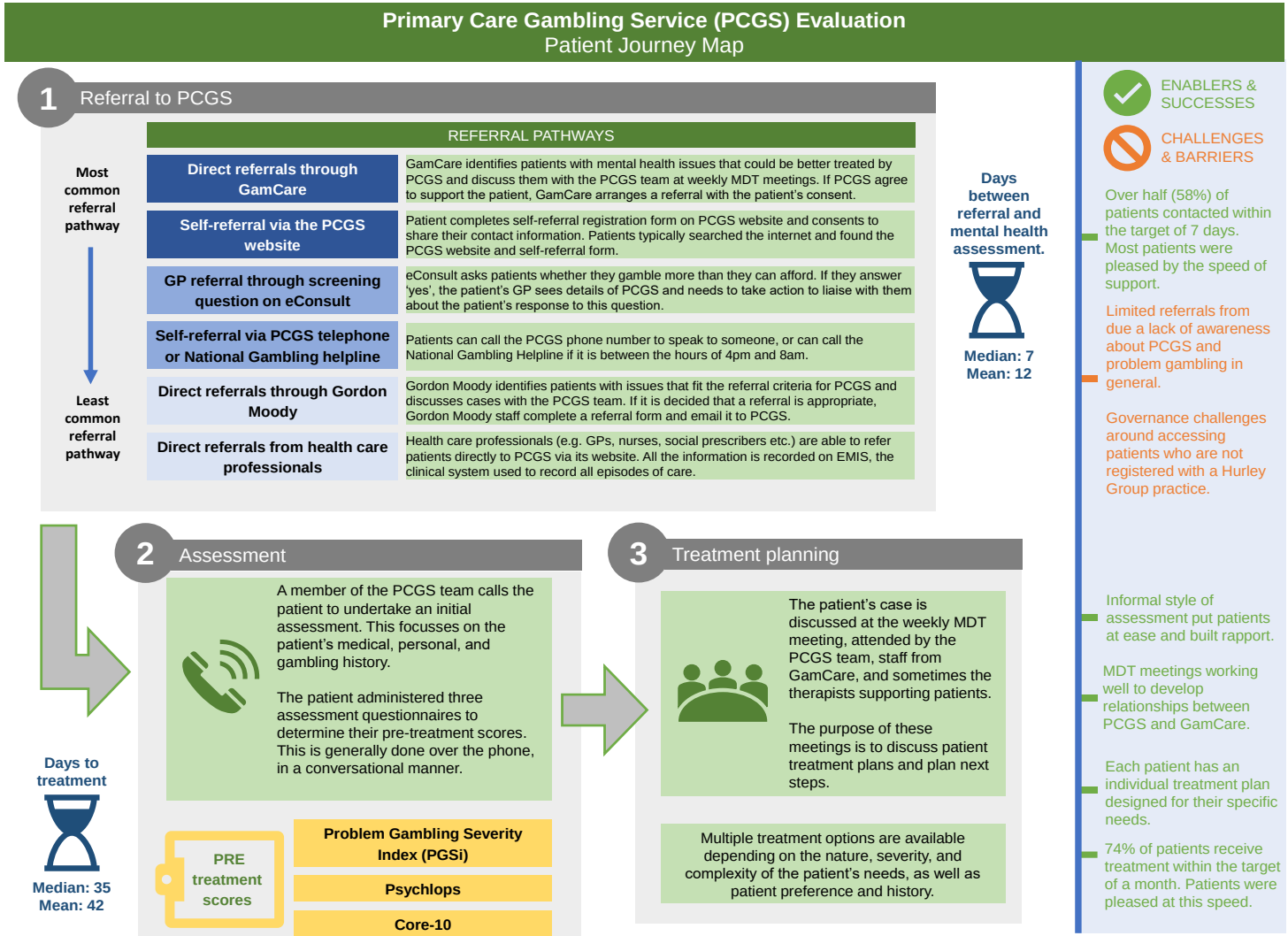
The Hurley Group – an NHS Partnership led by practicing GPs in London – developed and delivers the PCGS. The service integrates primary care and third sector support to provide accessible, consistent and whole patient focused support to gamblers. The service is delivered by a multidisciplinary team consisting of two GPs, a mental health nurse, an addiction psychiatrist, a peer support worker, and externally-employed therapists. The service works in partnership with GamCare and Gordon Moody.

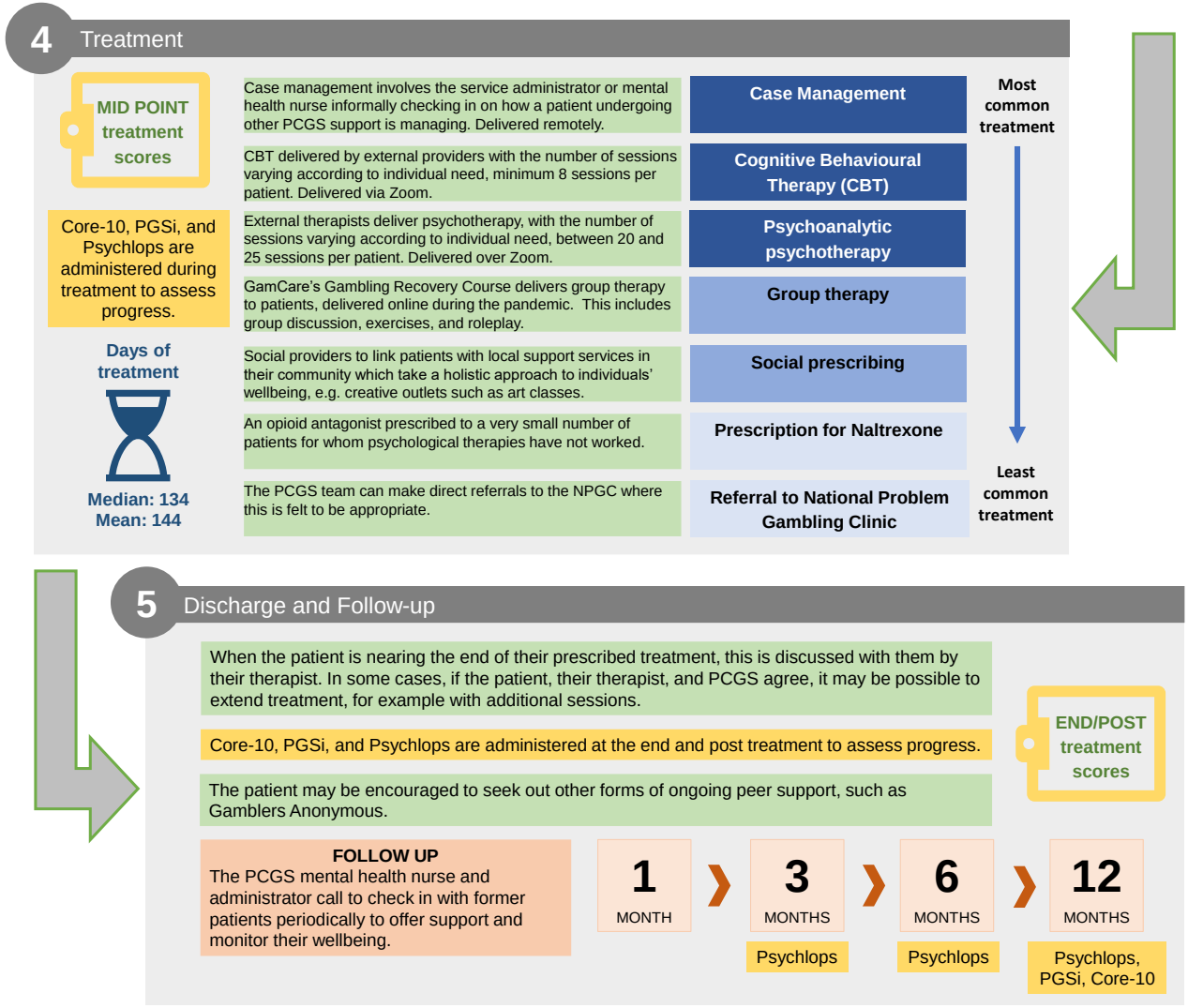
PCGS was funded by a regulatory settlement from the Gambling Commission between October 2019 and March 2022. From April 2022, GambleAware funds the service.

GambleAware commissioned IFF Research to carry out a pilot evaluation of the implementation of the PCGS. The evaluation was conducted between November 2021 and April 2022, and involved qualitative discussions with service and partner staff, and patients, analysis of performance and management information and a survey of England-based GPs.

Key findings

The PCGS patient journey and the common enablers and barriers patients experienced are presented below.


Primary Care Gambling Service (PCGS) Evaluation
Patient Journey Map
1 Referral to PCGS
REFERRAL PATHWAYS
Most common referral pathway
Least common referral pathway
Direct referrals through GamCare
GamCare identifies patients with mental health issues that could be better treated by PCGS and discuss them with the PCGS team at weekly MDT meetings. If PCGS agree to support the patient, GamCare arranges a referral with the patient's consent.
Self-referral via the PCGS website
Patient completes self-referral registration form on PCGS website and consents to share their contact information. Patients typically searched the internet and found the PCGS website and self-referral form.
GP referral through screening question on eConsult
eConsult asks patients whether they gamble more than they can afford. If they answer 'yes', the patient's GP sees details of PCGS and needs to take action to liaise with them about the patient's response to this question.
Self-referral via PCGS telephone or National Gambling helpline
Patients can call the PCGS phone number to speak to someone, or can call the National Gambling Helpline if it is between the hours of 4pm and 8am.
Direct referrals through Gordon Moody
Gordon Moody identifies patients with issues that fit the referral criteria for PCGS and discusses cases with the PCGS team. If it is decided that a referral is appropriate, Gordon Moody staff complete a referral form and email it to PCGS.
Direct referrals from health care professionals
Health care professionals (e.g. GPs, nurses, social prescribers etc.) are able to refer patients directly to PCGS via its website. All the information is recorded on EMIS, the clinical system used to record all episodes of care.
Days between referral and mental health assessment.
Median: 7
Mean: 12
2 Assessment
A member of the PCGS team calls the patient to undertake an initial assessment. This focusses on the patient's medical, personal, and gambling history.
The patient administered three assessment questionnaires to determine their pre-treatment scores. This is generally done over the phone, in a conversational manner.
PRE treatment scores
Problem Gambling Severity Index (PGSi)
Psychlops
Core-10
Days to treatment
Median: 35
Mean: 42
3 Treatment planning
The patient's case is discussed at the weekly MDT meeting, attended by the PCGS team, staff from GamCare, and sometimes the therapists supporting patients.
The purpose of these meetings is to discuss patient treatment plans and plan next steps.
Multiple treatment options are available depending on the nature, severity, and complexity of the patient's needs, as well as patient preference and history.
ENABLERS & SUCCESSES
CHALLENGES & BARRIERS
Over half (58%) of patients contacted within the target of 7 days. Most patients were pleased by the speed of support.
Limited referrals from due a lack of awareness about PCGS and problem gambling in general.
Governance challenges around accessing patients who are not registered with a Hurley Group practice.
Informal style of assessment put patients at ease and built rapport.
MDT meetings working well to develop relationships between PCGS and GamCare.
Each patient has an individual treatment plan designed for their specific needs.
74% of patients receive treatment within the target of a month. Patients were pleased at this speed.



- The Covid-19 pandemic prevented face-to-face treatment, which patients viewed as a potential area for service improvement.
- Remote treatment options considered in response to the Covid-19 pandemic, which expanded the pool of potential referrals.
- Patients receiving treatment positive about friendly and personalised approach.
- Mid-point treatment scores inconsistently collected by therapists.
- Stigma and logistical issues (e.g. timing and location) prevented group therapy take-up.
- Patients wanting ongoing support after their sessions end.
- Post-treatment scores inconsistently collected by therapists.
- Post treatment scores (where available) show promise of improvement.
- Follow-up supported offered in almost all cases, and patients value this support.

Establishing a pilot NHS service under challenging circumstances

PCGS was established as a proof-of-concept NHS service. As the first of its kind in the country, there was no template to draw upon in setting it up. Shortly after the service was established, the Covid-19 pandemic began and brought challenges, including the need to pause pilot operations, move to a remote service, remove co-location of two GamCare practitioners, and pause planned awareness raising and education outreach activities with GPs. These challenges and unexpected design changes greatly impacted the referral volumes from all intended referral pathways into the service, the composition of patients the service received, and the types of treatment and support provided.

Until April 2022, PCGS was a NHS service not aligned with the National Gambling Treatment Service (NGTS). This status led partner organisation staff to question how it fitted within the system, who should be referred and how to juggle that with other system organisations' requirements. Since GambleAware began funding the service in April 2022, it has worked with the PCGS team and other network services to align the PCGS to the wider support infrastructure and help other network services to understand how PCGS complements the available treatment and support provision available in England.

Although referral numbers have been lower than targets set pre-Covid, the service has managed to secure a high number of referrals from GamCare and the service's website. The other four pathways are also now beginning to see patients' referrals to the service. Further work will need to continue to strengthen the referral pathways to support increasing numbers of referrals and a diversity of patients.

The patient experience of being referred to the service has broadly been positive. Patients found the referral pathways easy and straightforward, and welcomed the ability to access support from PCGS without too much effort on their part.

Patient experiences have been positive, though disengagement remains a risk to service delivery

Patients were broadly positive about their experiences of the PCGS. The speed of patient access to support and treatment, and the personalised and welcoming approach were key drivers of this. This approach to service delivery has to date been possible due to the relatively small number of patients supported compared to the service size, and it will be important as the service grows to retain these unique selling points.

Nearly a third of patients had disengaged with the PCGS at some point during their service use. This disengagement is not surprising though, given the complexity of patients' needs and the disengagement rates of other, similar gambling support services, including Leeds and York Partnership Foundation Trust's (LYPFT) Northern Gambling Service and the National Problem Gambling Clinic (NPGC). Disengagement remains though a key risk to the service achieving two of its mid-term outcomes: patients receiving treatment plan as intended and receiving continuity of care.

There is early evidence of promise for the PCGS' impact on patient

It is too early to say whether the PCGS is impacting patients as intended. However, the evaluation has found early evidence of promise for patients. There is no evidence of outcomes for GPs because the planned outreach work was paused during the Covid-19 pandemic.

Qualitative evidence suggested that patients felt able to engage with the service because of the friendly and informal manner in which the service is delivered. The speed of support access, and personalised and friendly approach to treatment and support are viewed by patients and service staff as unique selling points of the service.

Core-10, is an outcome measure assessing psychological wellbeing, and is used by the service to assess changes to patient wellbeing across their treatment. Data was available for 14 of the 103 patients because the service experienced difficulties in getting patients to complete the questionnaire midway through and at the end of treatment. At the time of writing, the service was reviewing how best to improve questionnaire completion. Although data was only available for 14 of the 103 patients, analysis indicates that, psychological distress had reduced for these patients.

Recommendations for the future delivery of the PCGS

Partnership and sector working: a key priority for the PCGS, working with GambleAware, will be to define the service offer (including eligibility) and position more clearly this with the national system. Once agreed, making sure this is clearly communicated to key partners will be important to further improve relationships and reduce some of the barriers to partners referring into the service.

GP outreach activity: the evaluation evidence has clearly shown the need for a plan of engagement and outreach activities with GPs, once this is possible. This should help with GPs in the survey lacking awareness generally of gambling services and requesting more information about identifying patients at risk and developing their conversation in framing conversations about gambling harms with patients. It should also support greater awareness about how to refer, and so support an increase in referrals to PCGS via GPs.

Referral pathways: although the evaluation has found that having a range of referral pathways is working well and is an aspect of the model that should continue, we recommend focussing (at least initially) on the following pathways that have the greatest potential to increase volumes of referrals:

- GP outreach activity;
- Increasing advertising within constraints to promote self-referrals through the PCGS website;
- Continuing to explore ways to access more referrals via eConsult, given the high number of potential patients.

As patient volumes increase, it will be important to ensure there is sufficient capacity within the PCGS team to meet demand and continue to deliver a high-quality service.

Team capacity and composition: the consistent message from patients and PCGS staff was that the tailored and personal care provided is a key aspect of delivery, as is the speed of access to support. Whilst this is currently possible with the lower than anticipated number of referrals, maintaining the tailored and personal care, and speed of access, necessitates more staff time. Going forward, it will be important to review the capacity and confirm the ideal composition of the staff team needed to deliver the service effectively and efficiently.

Monitoring patient engagement and experience: given the evaluation findings about the relatively high level of patient disengagement and some patients waiting longer than anticipated for treatment, it will be important to monitor and track changes in these indicators as the service's referral volume increases.

2 Introduction

This is the final report of the pilot evaluation of the Primary Care Gambling Service (PCGS). GambleAware commissioned IFF Research to evaluate the PCGS pilot to ensure lessons are learned to inform future practice in the service and elsewhere.

Background

Gambling is a serious public health issue in Great Britain. Problem gambling commonly has a negative impact on an individual's physical and mental health, and that of their family and wider society. Problem gamblers report high rates of physical and psychiatric complaints, including various stress-related conditions, depression, anxiety spectrum disorders, substance misuse and personality disorders.[1]

Public Health England carried out a recent evidence review looking at the prevalence, risk factors and public health harms associated with gambling, and its economic and social burden.[2] The review estimated that the cost of gambling-related harms in England are likely to be *"in excess of £1.27 billion".* It noted the most vulnerable groups in England have the lowest gambling participation rates, but the highest levels of harmful gambling, and they are also the most susceptible to harm. It concluded that "*if there are no interventions to improve this situation, harmful gambling is likely to make existing health inequalities worse. The harms identified and the cost to society suggests that more needs to be done to prevent and reduce the harms associated with gambling".*

Primary care is a potential context for addressing the health-related behaviours of gamblers, and there is an established view that more should be done to address gambling harms in primary care (and more widely in the NHS). The British Medical Association in its publication, 'Gambling addiction and its treatment within the NHS: A guide for health care professionals' called for all health care professionals to be aware of problem gambling and common comorbidities, and specifically highlighted the need for *"education and training in the diagnosis, appropriate referral and effective treatment of gambling problems to be addressed within GP training"*.[3]

Overview of the Primary Care Gambling Service

The PCGS is a primary care-based pilot service located in Southeast London for adults aged 18 or over experiencing harm from gambling. It integrates primary care and third sector support to provide accessible, consistent and whole patient focussed support to gamblers. Specifically, PCGS aims to:

- Treat gamblers through pharmacological, psychological and peer group interventions;
- Improve primary care practitioner awareness of how problem gamblers can present and knowledge of available support, and support practitioners to identify gamblers using validated questionnaires.

[1] Amanda Roberts et al., 'Gambling and negative life events in a nationally representative sample of UK men,' *Addictive Behaviours* 75 (December 2017): 95-102, https://doi.org/10.1016/j.addbeh.2017.07.002
[2] Public Health England, 'Gambling-related harms: evidence review', Gambling-related harms evidence review: summary - GOV.UK (www.gov.uk), (30 September 2021)
[3] Mark D. Griffiths, *Gambling addiction and its treatment within the NHS: A guide for healthcare professionals (*London: British Medical Association, 2007)

The Hurley Group – an NHS Partnership led by practicing GPs in London – developed the PCGS. The service is delivered by a multidisciplinary team consisting of a mental health nurse, two GPs, an addiction psychiatrist, a peer support worker, and externally-employed therapists.[4] The PCGS offers a range of support either face-to-face (post Covid-19 restrictions), online or over the phone, with the service supporting gamblers, as well as those affected by the gambling behaviour of a family member or friend.

PCGS was funded by a regulatory settlement[5] from the Gambling Commission between October 2019 and March 2022. The pilot mobilisation phase began in October 2019, and the service started receiving patient referrals in January 2020. The pilot paused in March 2020 because of the Covid-19 pandemic and relaunched in July 2020. From 1st April 2022, GambleAware are funding the service, starting with a one-year funding agreement.

Evaluation objectives

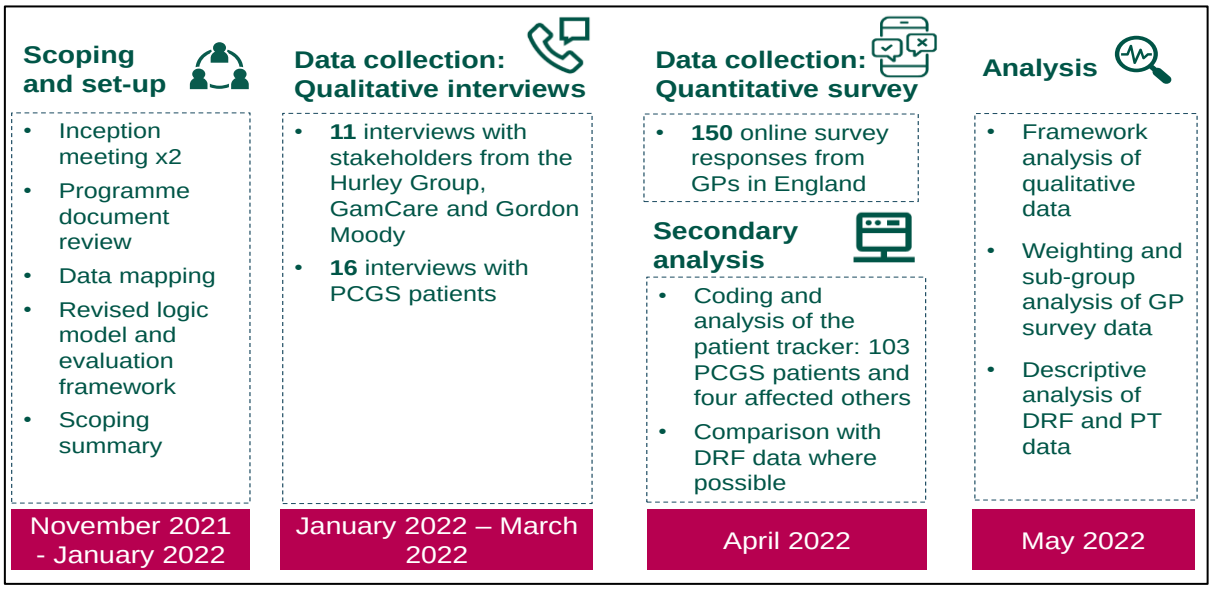
The evaluation explored the process of implementing the pilot. The overarching objectives of this evaluation were to:

- Understand how each of the referral pathways were working and identify the enablers and barriers to each.
- Understand how patients experienced their PCGS journey.
- Where possible, explore early emerging patient outcomes.
- Make recommendations for improving the future delivery of the PCGS.

Evaluation approach

The evaluation approach for PCGS is summarised in Figure 2.1 below. Further detail about each element is also provided, and more technical details about the approach are in Appendix A.

Figure 2.1 Summary of the evaluation approach



[4] A peer support worker was in post between October 2020 and April 2021, but at the time of writing the role was vacant.
[5] Gambling Commission, 'Gambling licence information, guidance and advice for businesses and individuals'

Scoping and set-up

During the scoping stage, the evaluation team:

- **Held two inception meetings** with GambleAware and PCGS staff involved in the design and delivery of the service to get an up-to-date understanding of the context, delivery progress to date, and potential challenges with the evaluation objectives and approach.

- **Reviewed and synthesised seven strategic and delivery programme documents** to inform our review of the service's logic model and evaluation approach. These included documents summarising the referral processes, 'did not attend' policies and the prescription of Naltrexone. Documents relating to the Gambling Competency Framework and a presentation on PCGS delivered by the Hurley Group for the Royal College of General Practitioners were also reviewed. Please see Appendix H for more information.

- **Reviewed existing data to assess the PCGS' delivery and impact**, with a focus on whether and how the data could be used to answer the evaluation objectives. This focussed on the service's Patient Tracker. The Patient Tracker is an Excel spreadsheet containing information about PCGS patients including demographic information, information about their gambling history, family and medical history, their treatment plan, dates of assessments and questionnaire scores.

- **Reviewed and updated the logic model and evaluation framework** that had been developed by IFF Research during the feasibility study in 2020.[6] The logic model and evaluation framework were reviewed against how the service had evolved since the feasibility study to ensure it remained fit-for-purpose. More detail on the logic model can be found in Chapter 3 and the evaluation framework can be found in Appendix B.

An outcome of the scoping stage was recognising the need to revise the evaluation approach, particularly as the General Practitioner (GP) outreach activity had not progressed as planned due to the Covid-19 pandemic. Our updated evaluation design was outlined in the scoping summary and agreed with GambleAware and PCGS staff.

Qualitative research

Stakeholders

Between January and March 2022, qualitative discussions were conducted with staff involved in the strategic and operational delivery of PCGS: seven interviews were undertaken with PCGS staff, three interviews with staff from GamCare and one interview from Gordon Moody.[7] The interviews covered a range of topics, including how the PCGS referral pathways were working and the enablers and barriers to each, their experience of what is working well (or not) about service delivery, and their perceptions on the service's outcomes for patients.

[6] Prior to this process evaluation, IFF had been commissioned by GambleAware in 2020 to undertake a feasibility study to understand the optimal evaluation design.
[7] From PCGS: the Clinical Director, Lead GP, Mental Health Nurse, Consultant Psychiatrist, Lead Administrator and the Director of Operations. From GamCare: the Interim Head of Clinical Services, the Director of Clinical and Communities and the Service Manager. From Gordon Moody, the Clinical Director.

Patients

Between January and March 2022, qualitative interviews were conducted with 16 patients who had been supported by the PCGS between May 2020 and October 2021 – representing 20% of the 79 patients referred during that period.

The interviews discussed how individuals first learnt about the service, how they engaged with the service, what they liked and disliked about it, and how, if at all, it had changed the way they feel or behave. The interviews lasted up to 60 minutes and patients received an incentive for taking part. See Appendix A for the achieved sample and Appendix G for the topic guide.

Quantitative online survey of GPs

Between 28th March and 6th April 2022, a quantitative online survey of 150 GPs practising in England was conducted. This involved email invites being sent to GPs via purchased sample and through a provider panel.[8] The aim of the survey was to baseline GPs understanding of gambling harms, their awareness of support services (including the PCGS), potential challenges and barriers in referring to the PCGS, and what additional support is needed to improve their understanding of gambling harms and increase referrals for treatment. See Appendix G for a copy of the survey.

To ensure findings were representative of all licensed doctors, weighting was applied using General Medical Council (GMC) population data on age, gender, and place in which primary medical qualification was gained. See Appendix A for the weighted profile of respondents.

A sample size of 150 means that findings have a maximum margin of error +/- 8 percentage points at a 95% confidence interval.[9]

Where a difference between subgroups is commented upon in the report, it can be assumed to be statistically significant.

Performance and management information

The evaluation team analysed management information collected by the PCGS service and recorded in its Patient Tracker. This is an Excel spreadsheet containing patient-level data, including demographics, treatment received and outcomes data for 103 patients between May 2020 and March 2022.[10] A separate, less detailed tracker including information about the four affected others was also analysed.

Where possible, data from the Patient Tracker was compared to data held in the Data Reporting Framework (DRF). This included comparing the profile and demographics of PCGS patients and those in the DRF who had accessed support via the National Gambling Treatment Service (NGTS). Given the DRF only included data up until March 2021, and the Patient Tracker largely included patients treated after March 2021, it was decided to only include entries in the DRF from the beginning of May 2020 to the end of March 2021 to ensure data from as similar as possible timeframes was being analysed.

IFF Research recommended in the scoping study that a flag was added to the DRF for PCGS patients for future impact evaluation. The flag was added by GambleAware for data related to timescales later than the period of time the analysis for this evaluation was conducted. This means that PCGS patients could not be separated in the DRF and so are included within the DRF data.

[8] A provider panel is a group of respondents recruited to take part in a number of market research sessions or projects over a period of time. For this evaluation, IFF Research used the GP provider panel operated by M3 - Medical Market Research | Physician Research - M3 Global Research. M3 sent the IFF-hosted survey link to GPs on their panel, until the target number of responses was reached.

[9] By this, we mean that if 50% of the sample of 150 agreed with a statement in the survey, we can be 95% confident that the response from all England-based GPs would lie between 42% and 58%. The margin of error falls to just +/- 7 percentage points for a survey result of 25% or 75%, and 5 percentage points for a survey result of 10% and 90%.

[10] Most patients recorded in the Patient Tracker received treatment after March 2021.

3 Programme theory: PCGS logic model

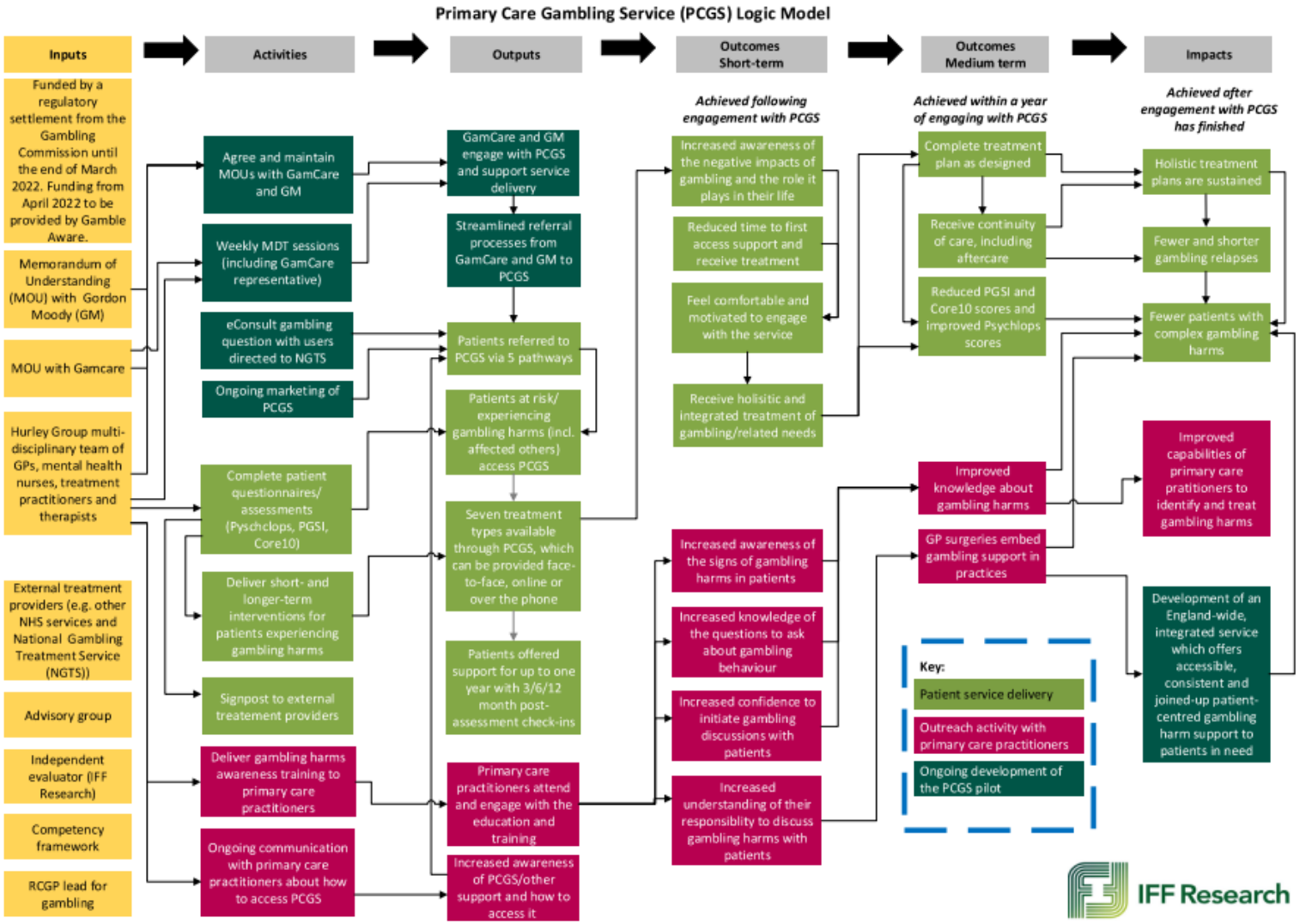
This chapter presents the logic model for the PCGS pilot. A logic model was developed in collaboration with stakeholders from GambleAware, PCGS and GamCare during the feasibility study and it was updated at the start of this evaluation.

What is a logic model?

A logic model is a visual representation of how a service is intended to impact its beneficiaries. It outlines all the things that a service does for its beneficiaries, the ultimate impact that it aims to have on them, and all the separate outcomes that lead or contribute to that longer-term impact. It summarises the rationale for acting, sets out the inputs, activities, outputs, intended outcomes and impacts, and also tries to show some of the mechanisms by which change might come about.

The PCGS logic model

The updated PCGS logic model is presented overleaf, and it is discussed in more detail below.


Primary Care Gambling Service (PCGS) Logic Model
Inputs
Activities
Outputs
Outcomes Short-term
Outcomes Medium term
Impacts
Achieved following engagement with PCGS
Achieved within a year of engaging with PCGS
Achieved after engagement with PCGS has finished
Funded by a regulatory settlement from the Gambling Commission until the end of March 2022. Funding from April 2022 to be provided by Gamble Aware.
Memorandum of Understanding (MOU) with Gordon Moody (GM)
MOU with Gamcare
Hurley Group multi-disciplinary team of GPs, mental health nurses, treatment practitioners and therapists
External treatment providers (e.g. other NHS services and National Gambling Treatment Service (NGTS))
Advisory group
Independent evaluator (IFF Research)
Competency framework
RCGP lead for gambling
Agree and maintain MOUs with GamCare and GM
Weekly MDT sessions (including GamCare representative)
eConsult gambling question with users directed to NGTS
Ongoing marketing of PCGS
Complete patient questionnaires/ assessments (Pyschclops, PGSI, Core10)
Deliver short- and longer-term interventions for patients experiencing gambling harms
Signpost to external treatement providers
Deliver gambling harms awareness training to primary care practitioners
Ongoing communication with primary care practitioners about how to access PCGS
GamCare and GM engage with PCGS and support service delivery
Streamlined referral processes from GamCare and GM to PCGS
Patients referred to PCGS via 5 pathways
Patients at risk/ experiencing gambling harms (incl. affected others) access PCGS
Seven treatment types available through PCGS, which can be provided face-to-face, online or over the phone
Patients offered support for up to one year with 3/6/12 month post-assessment check-ins
Primary care practitioners attend and engage with the education and training
Increased awareness of PCGS/other support and how to access it
Increased awareness of the negative impacts of gambling and the role it plays in their life
Reduced time to first access support and receive treatment
Feel comfortable and motivated to engage with the service
Receive holisitic and integrated treatment of gambling/related needs
Increased awareness of the signs of gambling harms in patients
Increased knowledge of the questions to ask about gambling behaviour
Increased confidence to initiate gambling discussions with patients
Increased understanding of their responsiblity to discuss gambling harms with patients
Complete treatment plan as designed
Receive continuity of care, including aftercare
Reduced PGSI and Core10 scores and improved Psychlops scores
Improved knowledge about gambling harms
GP surgeries embed gambling support in practices
Holistic treatment plans are sustained
Fewer and shorter gambling relapses
Fewer patients with complex gambling harms
Improved capabilities of primary care pratitioners to identify and treat gambling harms
Development of an England-wide, integrated service which offers accessible, consistent and joined-up patient-centred gambling harm support to patients in need
Key:
Patient service delivery
Outreach activity with primary care practitioners
Ongoing development of the PCGS pilot
IFF Research

Context and rationale

The PCGS works with adults who are at risk of, or are experiencing, gambling harms. The service seeks to address the issue that these gamblers do not have easily accessible, consistent and whole-patient focused support. PCGS support is expected to be more consistent and focused on the whole patient because a person's support is coordinated by the service, working in partnership with their treatment team, including their GP, case worker or therapist.

Assumptions

There are five circumstances that PCGS assumes will, and need to, occur for the outcomes and impacts outlined on the right side of the model to be achieved:

- Gamblers are not already aware of treatment or support options because if they were they may not see the need to access PCGS support.
- Gamblers can be reached by the PCGS referral pathways, and those that do have the 'right' needs for the PCGS.
- PCGS treatment options are sufficient for the needs of gamblers referred and are an effective approach to addressing gambling harms amongst adults.
- The memorandum of understanding (MOU) with GamCare and Gordon Moody operate as anticipated and support the delivery of the PCGS.
- Within the context of Covid and the associated demand on the time of primary care practitioners, the PCGS team are able to engage primary care practitioners with gambling awareness raising activities and training on how to support gamblers. Primary care practitioners are also able to apply this information and resources in their work to help them identify and signpost gamblers to relevant support.

Inputs

The PCGS received funding from the Gambling Commission until the end of March 2022 and has then received funding (initially for a period of one year) from GambleAware. This funding is used to employ a multidisciplinary team of health care practitioners to deliver the PCGS, including GPs, a mental health nurse, treatment practitioners and externally-employed therapists.

Activities

Activities that are part of the ongoing development of the PCGS pilot include agreeing and maintaining the MOUs with GamCare and Gordon Moody for the referral of patients between the services. Scoping the different ways patients could access the service also included developing a screening question at the front end of eConsult to identify patients at risk or currently experiencing gambling harms. Weekly multi-disciplinary team (MDT) meetings, with both PCGS and GamCare representatives, are also held to discuss patients that could be suitable for referral to PCGS.

Ongoing marketing of the PCGS is also a key activity, with the aim of raising awareness of the service and engaging patients and practitioners. The future plan is for a wider, more formal communications strategy to be developed and current materials refined to support engagement work.

Outputs

It is hoped that through the MOUs with GamCare and Gordon Moody and regular meetings, both organisations will engage with the PCGS and support its delivery. Work will also be ongoing to streamline referral processes from GamCare and Gordon Moody to PCGS.

It is also intended that patients will be referred to the PCGS via six referral pathways. Patients who access PCGS will be offered support either face-to-face, online or over the phone for up to one year, with regular post-assessment check-ins.

It is anticipated that, Covid-19 allowing, education and training activity will be delivered to primary care practitioners and that ongoing communication with practitioners will increase awareness of the PCGS and how it can be accessed.

Outcomes

Short-term outcomes

Short-term outcomes are the changes for practitioners and patients the PCGS expects to happen quickly, in the weeks or months following engagement with the PCGS activities and outputs.

It is anticipated that following patient referral to PCGS and the offer of treatment (the outputs), patients will have an increased awareness of the negative impacts of gambling and the role it plays in their lives. The PCGS team also aim to contact patients and initiate assessment and treatment within a week of referral, meaning patients should benefit from a reduced waiting time to first access and receive treatment. As a result, it is hoped that patients will feel comfortable and motivated to engage with the service and so benefit from the holistic and integrated support offer.

In terms of practitioners, it is anticipated that through engaging in education and training delivered by the PCGS team, they will have increased awareness of the signs of gambling harms and feel they have the knowledge and confidence to discuss gambling behaviour with patients and feel that it is their responsibility to do so.

Medium-term outcomes

Medium-term outcomes are the outcomes expected to take longer to emerge – approximately within a year of engaging with the PCGS, and are likely if positive changes from short-term outcomes are sustained. For practitioners, this is anticipated to be continuing to improve their knowledge of gambling harms. Practitioners embedding gambling support is also expected to be a pre-condition for the impacts of the PCGS to be seen.

For patients, medium-term outcomes could be many and varied, depending on the unique needs of the patient. To focus patients and service priorities, during the feasibility study, the PCGS team identified four priority medium-term outcomes for their patients. These relate to treatment scope and intensity (e.g. complete eight therapy sessions and receive good and uninterrupted aftercare), and health and social improvements (e.g. reduced Problem Gambling Severity Index (PGSi), Core10, and Psychlops scores).

Impacts

Long-term impacts are the ultimate, high-level effects that the service is working towards. PCGS is ‘contributing to’ their achievement rather than ‘causing’ it. Impacts cannot be directly associated with or referenced as a sole direct result of the programme, as it is likely that there are a number of other influencing factors contributing to any impact.

The PCGS aims to bring about positive change to the profession, its service, and the patients it supports.

If the intended practitioner and wider profession outcomes are realised, the PCGS hopes to contribute to improving the capabilities and capacity of primary and secondary healthcare practitioners to identify and treat gambling harms.

An intended unique selling point of the PCGS is its focus on holistic, patient-centred care. If this approach leads to patient improvements, the service hopes these improvements are sustained and that patients will have fewer and shorter gambling relapses. Ultimately, if the service provides the right support early enough to patients in need, it expects to change the profile of gamblers, with fewer patients with complex gambling harms. This has to be balanced with other comorbidities such as severe trauma, mental health diagnosis, family support and aftercare support.

If the PCGS operates as intended and achieves the priority patient outcomes, it hopes to scale service delivery beyond South East London to England. The aim is for an England-wide, integrated service that offers accessible, consistent, joined-up patient centred gambling harm support to people in need.

4 Gambling support demand and awareness

This chapter discusses demand for gambling support, and explores the perceptions, current levels of awareness and confidence in supporting problem gamblers amongst the GPs surveyed for the evaluation.

Gambling support demand and awareness: Headline messages

- Gambling is a serious public health issue in Britain, with over half (59%) of adults living in Britain participating in some form of gambling activity in the previous 12 months. Among these, approaching 1.5 million can be classified as problem gamblers. This highlights the clear need for gambling support services, such as the PCGS.
- GPs recognised the need for specialist gambling and support services, with over four in five (82%) agreeing that there is a need for a service like PCGS in their area.
- However, only a quarter (25%) of GPs reported being aware of gambling harm treatment and prevention services in their area.
- A quarter of GPs (25%) had heard of PCGS, which is a large proportion given that the new service is still a pilot and that planned awareness raising activity among GPs was limited due to the Covid-19 pandemic.
- There was an appetite for a range of practical support and information that GPs could provide to patients or use to understand how the service works and how it could be of benefit to their patients.

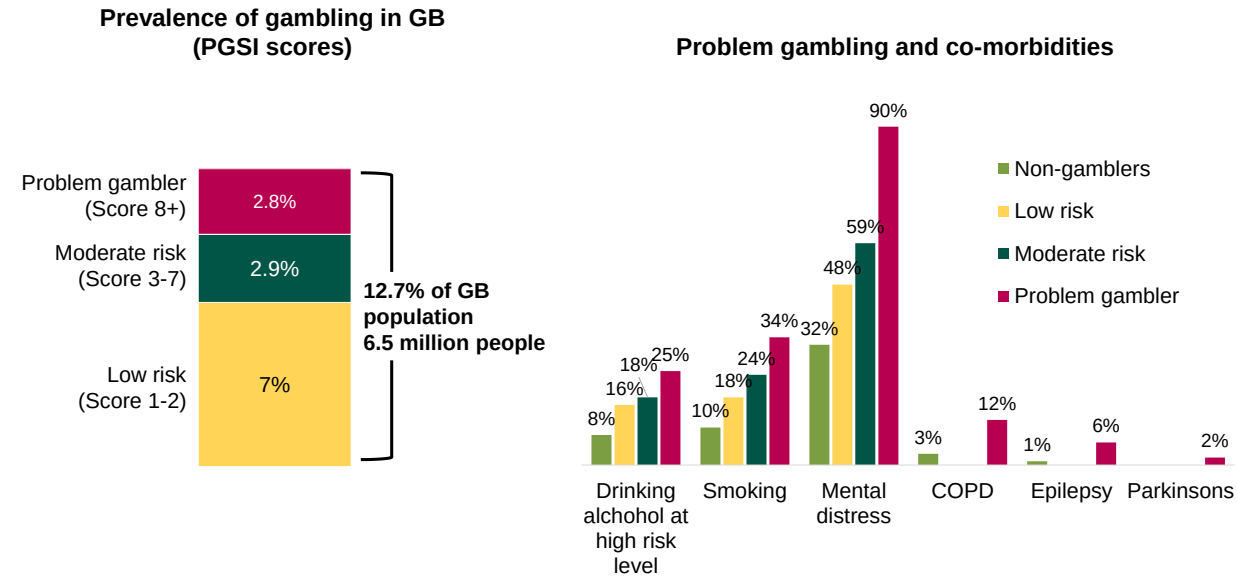
Gambling is a serious public health issue in Britain and there is clearly a need for gambling support services, such as the PCGS.

GambleAware research[11] into demand for treatment and support services among gamblers and affected others from November 2021 highlighted that (and also represented in Figure 4.1 overleaf):

- Over half (59%) of adults living in Britain reported participating in some form of gambling activity in the previous 12 months (equating to around 30.5 million adults);
- 1.44 million adults (2.8%) scored eight or higher on the PGSi,[12] classifying them as a problem gambler; and
- There is a a need for a holistic approach to support problem gamblers, as they had increased prevalence of other addiction problems, mental distress and physical co-morbidities.

[11] Briony Gunstone et al., *Annual GB Treatment and Support Survey Report 2021* (London: YouGov, 2021). This study was conducted by YouGov with its online research panel. It was completed by 18,038 British adults.; Gambling Commission, 'Problem Gambling Screens,' Problem gambling screens - Gambling Commission (12 April 2021)
[12] The PGSi consists of nine questions about gambling, each of which is assessed on a four-point scale (never, sometimes, most of the time, almost always).

Figure 4.1 Prevalence of gambling, and associations with co-morbidities



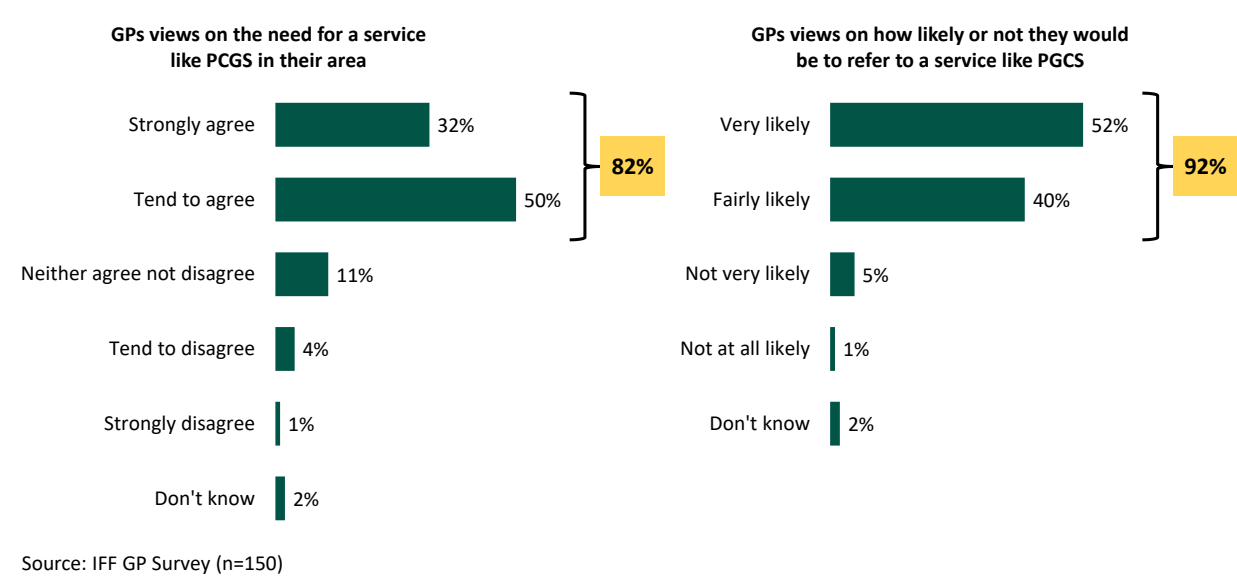
Source: Annual GB Treatment and Support Survey 2021

GPs also recognised the need for specialist gambling and support services. Figure 4.2 below shows that of the GPs who completed the online survey as part of this evaluation most (82%) agreed that there was a need for a service like PCGS in their area. A higher proportion (92%) agreed that if they were aware of a service like the PCGS in their area, they would be likely to refer patients into it.

"There is definitely a need for services like this and if I knew what was available, I think it could only be valuable to use when appropriate."

GP

Figure 4.2 GP support for a service like PCGS in their area



Source: IFF GP Survey (n=150)

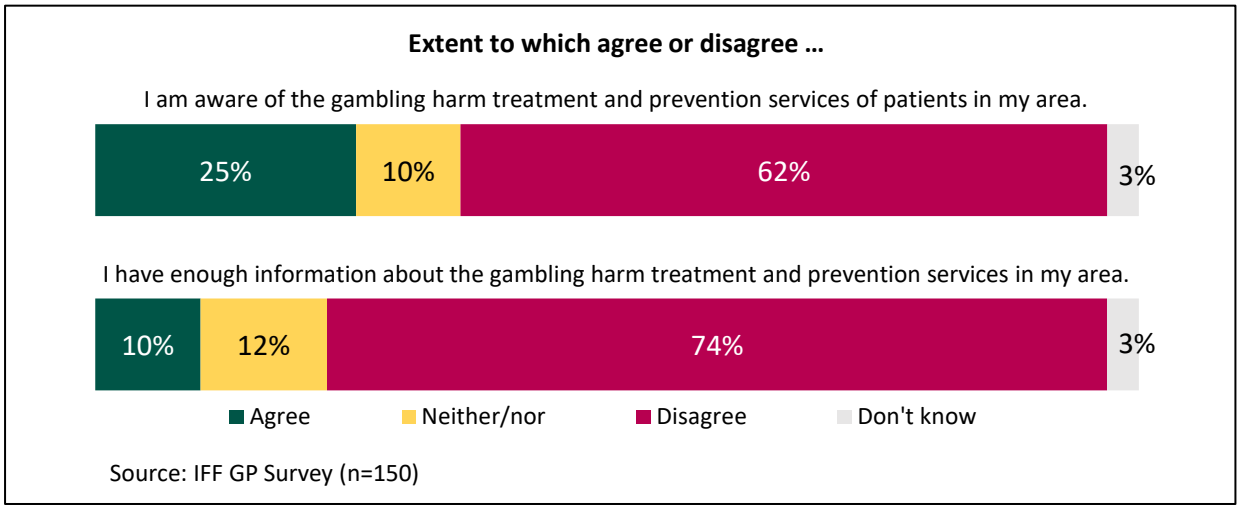
Despite acknowledging the need for gambling support services, awareness was generally low amongst GPs.

A quarter of GPs surveyed (25%) reported they were aware of gambling harm treatment and prevention services in their area, and only one in ten (10%) agreed they had sufficient information about services in their area (Figure 4.3).

"[A challenge is] not knowing of services locally to signpost to and there may be other services out there that I don't know about."

GP

Figure 4.3 GP awareness of gambling harm treatment and prevention services



Awareness of specific gambling support services varied (Figure 4.4), with most GPs having heard of Gambler's Anonymous (86%) and GambleAware (79%). However, the level of awareness was low: most GPs aware of these services said they only knew 'a little' or 'almost nothing' about them, and only 15% said they know 'a lot or fair amount' about Gambler's Anonymous, and only 21% said the same for GambleAware.

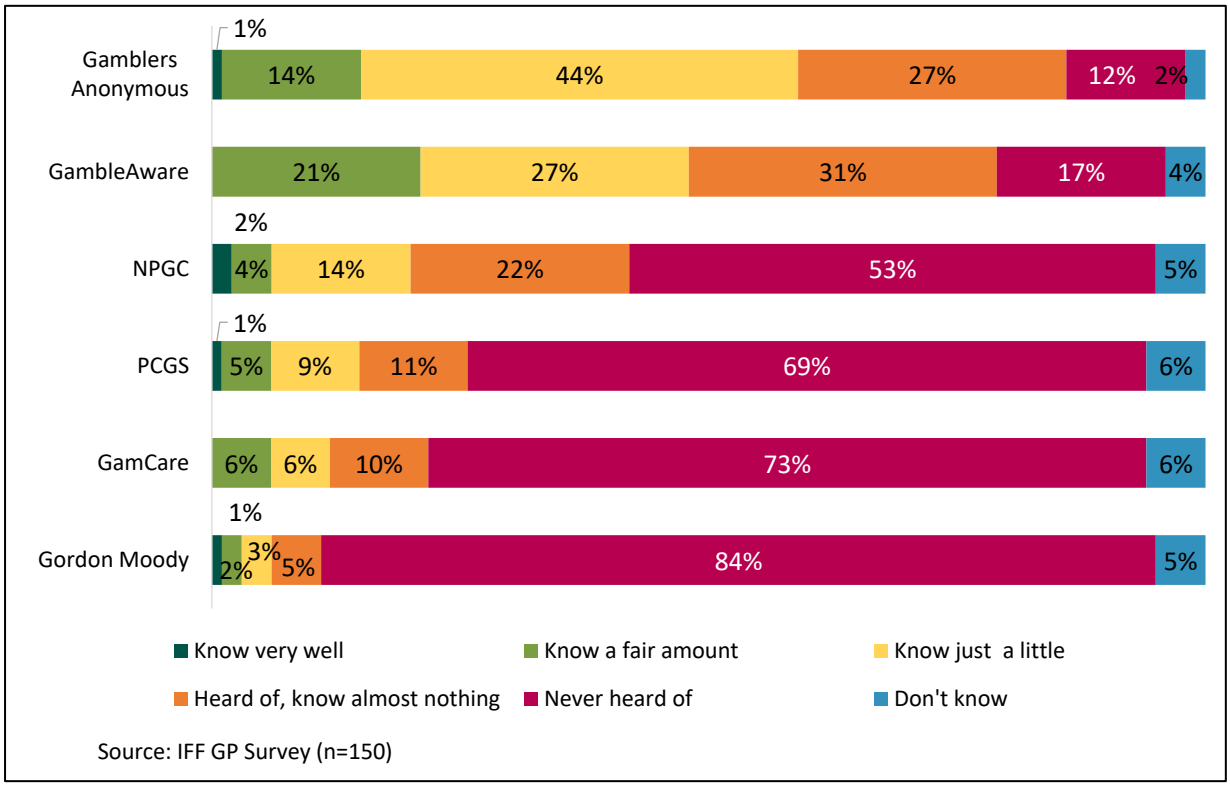
Awareness of other gambling support services was lower, with the next known service being the NGTS (42%), before awareness levels fell further for the PCGS, GamCare and Gordon Moody services.

A quarter of GPs (25%) had heard of PCGS, which is a large proportion given the new service is still in the pilot stage, and its planned GP awareness raising activity was limited due to the Covid-19 pandemic.

GPs from a White background were less likely to have heard about available gambling services than GPs from an ethnic minority, with the exception of GambleAware and GamCare where there were no statistically significant differences.

White GPs were also more likely to say they have not heard of Gordon Moody than GPs from an ethnic minority (92% compared to 74%), PCGS (80% compared to 59%), NGTS (63% compared to 43%), and GambleAware (95% compared to 72%).

Figure 4.4 Awareness of specific gambling support services



GP views varied about whether it was their responsibility and a priority for them to support patients with gambling, and even those who wanted to support patients generally had low confidence in doing so.

Although most GPs had an appetite for engaging with gambling services, their views on whether they were responsible for helping patients with gambling problems, how high a priority this was for them and how confident they felt in being able to support gambling problems varied (Figure 4.5, overleaf).

Overall, it is a positive sign that more GPs agreed than disagreed that it was their responsibility to discuss gambling harms with patients, though only just over half (55%) agreed. Considering the ongoing Covid recovery pressures on GPs, it is positive that four in ten (40%) felt that helping patients with gambling harms was a priority, though a similar proportion (36%) felt that it was a low priority given other priorities and pressures on primary care staff time and capacity.

"It is a challenge to find time to have the conversation, especially with everything else we have on our plates."

GP

Male GPs were more likely to say that helping patients with gambling harms was a low priority for them given other pressures on primary care staff (48% of males GPs agreed, compared to 28% of female GPs).

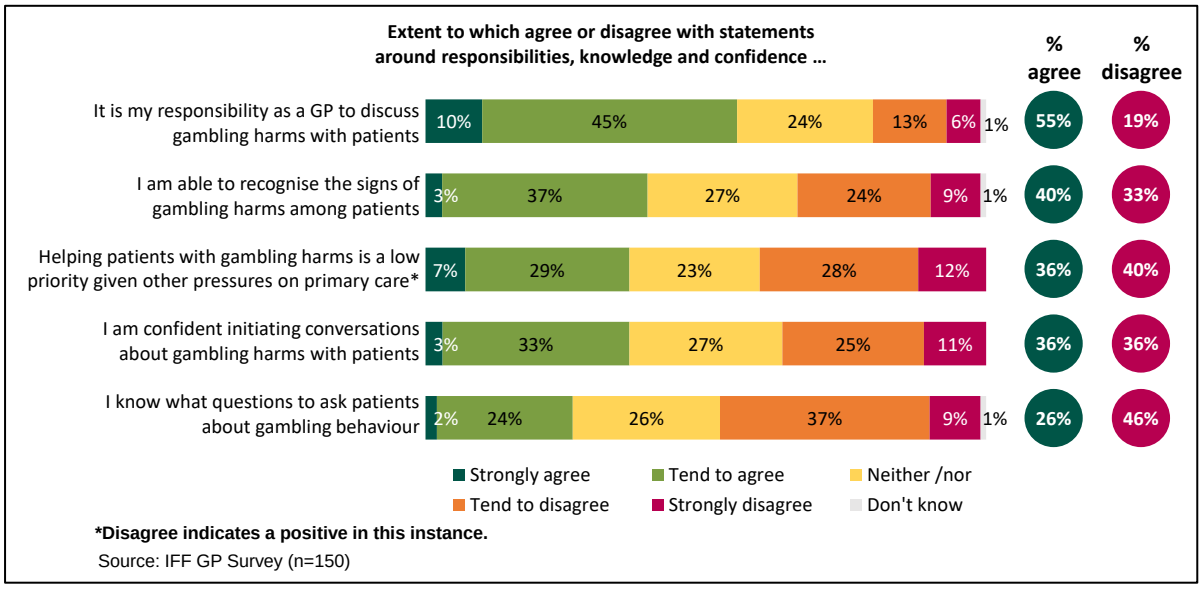
There was generally low confidence though amongst GPs about their ability to support gambling problems. Four in ten GPs (40%) felt able to recognise the signs of gambling harms among patients, though slightly fewer (36%) were confident about initiating conversations about gambling harms with patients and even fewer (26%) agreed that they knew what questions to ask patients within these discussions.

"I have not had any training in this [supporting patients with gambling], and so would not be aware of the subtle cues to be aware of. Also due to lack of experience here, I would not feel confident having this discussion with the patient, as feel other than signposting (and googling for the appropriate resource) I would be able to offer very little else."

GP

Across all of the survey questions covering the above topics, around a quarter of GPs selected the 'neither agree nor disagree' option, suggesting they do not have a strong opinion either way. This will be important to monitor in future surveys to see if future outreach activity impacts this.

Figure 4.5 GP perceptions of their responsibilities and knowledge of gambling harms



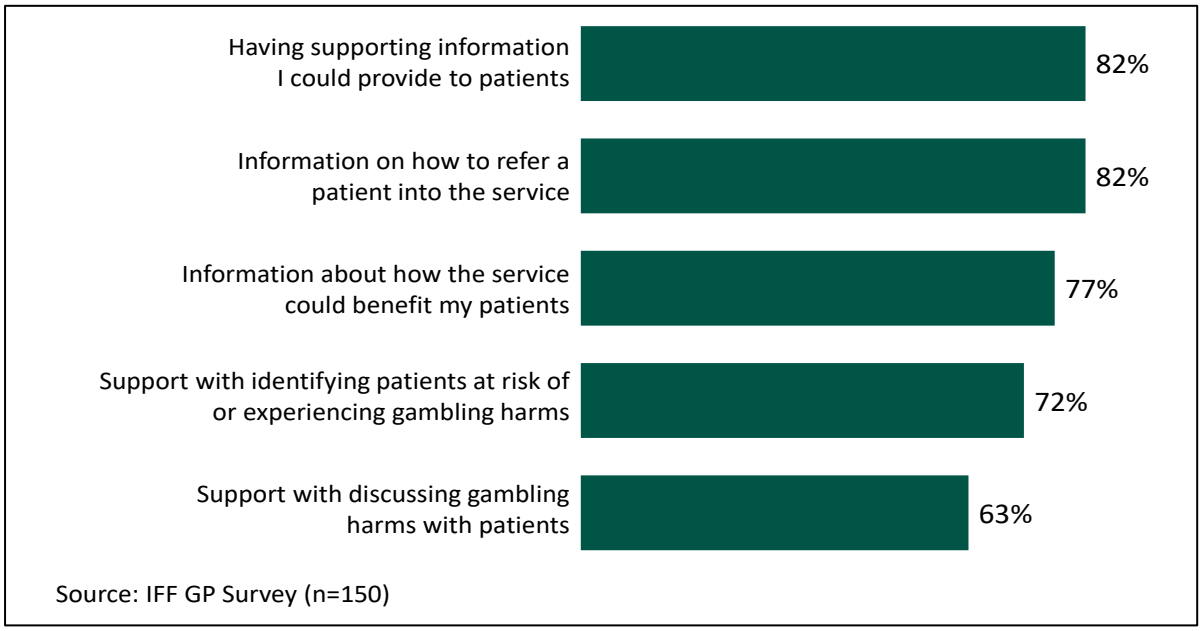
Looking ahead, GPs need access to more, practical information to make it easier for them to refer to PCGS.

There was an appetite for a range of practical support and information that GPs could either provide to patients or that they could use to understand how the service works and could be of benefit to their patients (Figure 4.6, overleaf). GPs would welcome more support and guidance to identify patients at risk and to develop their confidence in framing conversations about gambling harms with patients.

"[There is] uncertainty about how to identify and assess a gambling problem in a patient. Further training [is] required."

GP

Figure 4.6 Suggestions for making the identification and referral of patients to PCGS easier



5 Establishing the PCGS

This chapter discusses the implementation of the PCGS, including the significant contextual factors that impacted its implementation. It also covers the set-up of governance and partnership working with PCGS' partners (GamCare and Gordon Moody).

Establishing the PCGS: Headline messages

- The PCGS service is the first of its kind in the country and was established as a proof-of-concept in October 2019. Shortly after the service was established, the Covid-19 pandemic began. The challenges of setting up and delivering a new NHS service under such circumstances should not be underestimated.
- The main challenges brought on by social distancing restrictions, primary care staff shortages and GPs prioritising the Covid-19 response included the need to pause pilot operations between March and June 2020, move to remote service delivery, and pause planned awareness-raising and educational outreach activities with GPs.
- These challenges and unexpected design changes greatly impacted the referral volumes from all intended referral pathways into the service, the composition of patients the service received, and the types of treatment and support provided.
- The Hurley Group has formed good working relationships with GamCare, though the status of the PCGS outside the NGTS (from pilot launch until end of March 2022) influenced whether and how much NGTS partners, like GamCare and Gordon Moody, felt able to refer into it.

The PCGS service is the first of its kind in the country and was established as a proof-of-concept in October 2019. Shortly after the service was established, the Covid-19 pandemic began. The challenges of setting up and delivering a new NHS service under such circumstances should not be underestimated. The main challenges brought on by social distancing restrictions, primary care staff shortages and GPs prioritising the Covid-19 response included:

- the need to pause pilot operations between March and June 2020, just six months after it first began setting up;
- moving to remote service delivery;
- not being able to implement the intended plan for two GamCare practitioners to be physically co-located in pilot GP surgeries two days a week;
- pausing planned awareness-raising and educational outreach activities with GPs. This was an important activity for supporting referrals into the service and for achieving intended impacts among GPs.

These challenges and unexpected design changes greatly impacted the referral volumes from all intended referral pathways into the service, the composition of patients the service received, and the types of treatment and support provided. Additional information on the context in which the PCGS was implemented can be found in Appendix C.

"Covid has had such an impact on what we could deliver and how we could deliver it…though I'm really proud of what we have achieved given the circumstances."

PCGS staff member

PCGS' status outside the NGTS influenced partners understanding of its remit

As an NHS service that was funded by a regulatory settlement from the Gambling Commission (from pilot launch to the end of March 2022), PCGS sat outside the NGTS during its first 29 months of operation. This status influenced whether and how much NGTS partners, like GamCare and Gordon Moody, felt able to refer into it. For example, it was unclear to partner stakeholders how PCGS compares with the responsibilities of the NHS clinics in the NGTS, which provide partners with access to clinical advice. Partner staff interviewed for the evaluation queried when they should refer into NHS clinics or access NHS clinical advice and when they should refer into PCGS.

"I'm still not clear how the PCGS compares with the responsibilities of the NHS clinics in the NGTS. It would be helpful to know when I should refer to the NHS clinics, and when I should refer to PGCS."

PCGS partner

Related to this, GambleAware's treatment service funding terms may have limited NGTS partners' ability to refer to PCGS at the volume that was originally anticipated, and that the Hurley Group hoped for. Some partners felt they had received clear guidance from GambleAware in the past to refer within the national system, and so they are unclear how and when they should refer to PCGS.

Questions about how the PCGS fits into the gambling treatment and support landscape underpinned confusion about the eligibility criteria for patient referrals into PCGS. The Hurley Group will accept any patient not requiring intensive support, like residential care. Partners and patients interviewed for the evaluation understood the service to be for individuals who gamble and who have comorbidities, particularly serious mental health issues.

Since GambleAware began funding PCGS in April 2022, it has been working with PCGS and NGTS partners to clarify the PCGS' remit, how it fits within the national system's referral pathways, and how it can complement existing treatment and support.

Developing a partnership

Within this broader operating context, the Hurley Group has formed good working relationships with GamCare. While the pandemic has limited their ability to be co-located in GP surgeries, both organisations have shared patients, and assessed and agreed appropriate treatment plans for presenting patients, in weekly multidisciplinary team (MDT) meetings. PCGS and GamCare are committed to working together to benefit patients, and the relationship continues to evolve as the service beds in. The weekly MDT meetings, chaired by one of the lead GPs, has provided opportunities for relationship building and communication, as have the monthly meetings that are also attended by therapists and the PCGS' consultant psychiatrist.

The Hurley Group also has terms of reference agreed with Gordon Moody, and has shared knowledge about each service (e.g. PCGS staff have done a site visit to their residential service). The PCGS has received two referrals from Gordon Moody to date and Hurley Group and Gordon Moody stakeholders anticipate more referrals.

"I think it has been a really good collaboration and we have learnt a lot from each other…I hope it continues to develop and we see more referrals."

PCGS partner

6 Patient engagement and profile

This chapter discusses patient engagement and the profile of patients who were referred.

Patient engagement and profile: Headline messages

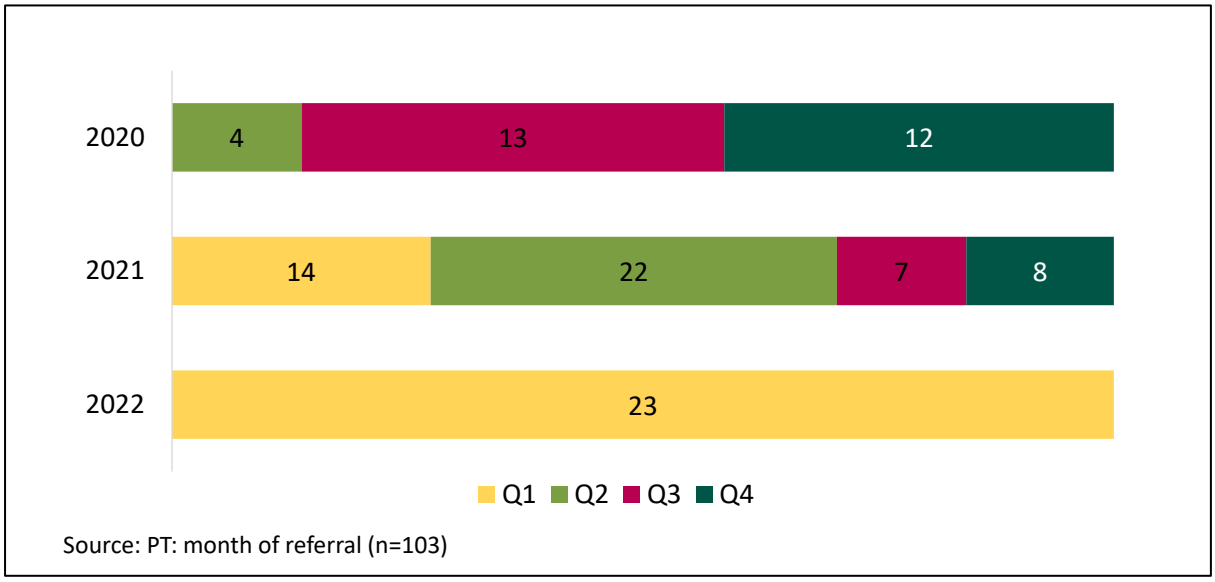
- Referral numbers have increased over time but remain lower than anticipated before the pandemic. The service had hoped to support between 150-180 patients during its first two and a half years of operation. Between 9th May 2020 and 22nd March 2022, 103 patients and four people that experienced harms because of someone else's gambling were referred to the PCGS .
- Comparing data in the PCGS Patient Tracker and the DRF showed that patients referred to both PCGS and the NGTS were predominately white, male and on average, 36 years old.
- PCGS have supported patients with more complex needs than initially anticipated. Amongst those referred to the PCGS, all had a co-morbidity, with depression being the most common (60%). Patients referred to PCGS also reported more severe gambling problems and higher levels of psychological distress, than those who had accessed the NGTS.

Referral numbers have increased over time, but remain lower than anticipated before the pandemic.

On its launch, before the Covid-19 pandemic, the PCGS hoped to support between 150 and 180 patients during its first two and a half years of operation. Between 9th May 2020 and 22nd March 2022 (including a four-month pause in service delivery due to the pandemic), 103 patients and four people that experienced harms because of someone else's gambling, commonly referred to as 'affected others' were referred to the service. For example, this might be a partner, family member or friend.

Referral numbers have increased over time (Figure 6.1), with most referrals made after the service re-opened following a pause in delivery due to the pandemic. Thirty-four patients were referred in the first half of 2021, and 23 patients were referred in the first quarter of 2022.

Figure 6.1 Count of referrals per quarter



Source: PT: month of referral (n=103)

The profile of patients referred into PCGS was similar to patients who had accessed the NGTS.

Comparing data in the PCGS Patient Tracker and the DRF[13] (Figure 6.2) showed that patients referred to both PCGS and the NGTS were predominately white, male and on average, 36 years old. Though, there were a few differences in the profiles of patients between the two datasets:

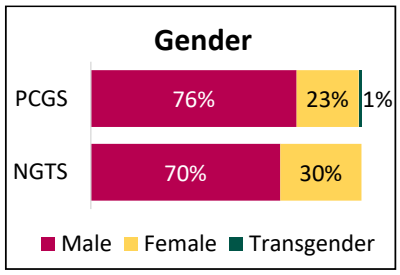
- Patients referred to PCGS were more likely to be from an ethnic minority group (28% PCGS compared with 12% NGTS), though it is currently unclear why this is the case. This is positive for the PCGS as evidence points to higher levels of gambling amongst ethnic minorities[14] and also challenges that can be faced in encouraging those from ethnic minorities to access support, like cultural barriers and the stigma associated with receiving support.

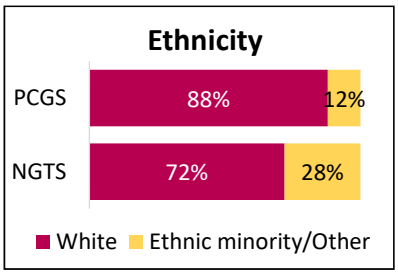
- Patients referred to the service were less likely to be in employment (24% unemployed at the time of referral) compared to those who had accessed NGTS (11% unemployed at the time of referral).

Table 6.1 Patient demographics – age, gender and ethnicity

Age

	PCGS	NGTS
Average age	36	36
Maximum age	71	90
Minimum age	16	15





Source: PT: age, gender and ethnicity (n=103) & DRF: age, gender and ethnicity (n=8323).

PCGS has supported patients with more complex needs than initially anticipated[15]. Amongst those referred to the PCGS, all had a co-morbidity[16], with depression being the most common. (60%), followed by anxiety (44%).

More than half (53%) of the patients referred to the service reported having no other addiction problem, but of those who did, alcohol (23%) and drug misuse (21%) were the most common addictions.

While physical health issues were not as prevalent as mental health issues among PCGS patients, almost a fifth (18%) had a long-term chronic condition (e.g., diabetes, hyperthyroidism etc.) and one in ten (12%) had mobility issues.

[13] As a flag for PCGS patients was not added to the DRF data covering the evaluation timescales, PCGS patients could not be separated in the DRF and so are included within the findings reported for the DRF.
[14] Gunstone et al., 'Annual GB Treatment and Support Survey 2021'
[15] The PCGS team anticipated that patients supported by the service would be problem gamblers living with low to medium level harms, and that the service would act as the bridge between NHS primary and specialist (secondary care) services. Patients with complex needs and serious co-morbidities, or those who required intensive, specialist interventions such as residential care, were intended to be referred to secondary care services.
[16] Defined as the simultaneous presence of two or more diseases or medical conditions in a patient.

Patients referred to PCGS reported more severe gambling problems and higher levels of psychological distress, than those who had accessed the NGTS.

Core-10 is a 10-item wellbeing monitoring scale the PCGS uses to access the changes in patient psychological distress throughout treatment. It covers anxiety, depression, trauma, physical problems, functioning and risk to self. The average score for a PCGS patient was in the range of moderate to severe for range of psychological distress, which was significantly higher than patients referred to the NGTS (the average score was in the moderate range).

The Problem Gambling Severity Index (PGSI) is a standardised measure of at-risk behaviour in problem gambling, based on the common signs and consequences of problematic gambling. Those referred to both the PCGS and NGTS were in the highest category of severity – gambling with negative consequences and a possible loss of control – though the average score for PCGS patients was higher (+0.9).

These findings support the view shared by PCGS staff that they have supported patients with more complex needs than initially intended. It is likely that this complexity is being driven by patients being most commonly referred to the service via GamCare.

Table 6.1 shows the comparison between PCGS and NGTS patients as measured through secondary analysis of the Patient Tracker and DRF.

Table 6.1 Levels of psychological distress and gambling harm

Type of Treatment	Mean PCGS score	Mean NGTS Score	Difference
Core-10	22.0	17.8	+4.2
PGSi	18.8	17.9	+0.9

Source: Patient Tracker: initial Core-10 and PGSi scores for 93 and 92 patients respectively at the first appointment. DRF: score at first appointment where available (n=5258 for the PGSi and 6199 for Core-10) and based on care plans.

7 PCGS delivery and patient experience

This chapter discusses the delivery of the PCGS, including patient experiences of referrals and treatment. It also describes how delivery deviated from the intended delivery model. Detail on the intended delivery model can be found in Appendix D.

PCGS delivery and patient experience: Headline messages

- Most patients were referred by GamCare (68%) and through the PCGS website (19%), though numbers are slowly increasing across other referral pathways.
- Most patients had a positive experience of their referral to the PCGS, with the process described as *"easy"* and *"straightforward"*.
- Most patients praised the PCGS team on the highly personal and informal manner in which the mental health assessment and referral questionnaires were delivered. The questionnaires also appeared to be working well together when administered upon referral, however the service has found it difficult to secure completed questionnaires midway through and at the end of treatment.
- Specialist treatment and support have evolved in response to new opportunities to support patients. The most common treatment received by PCGS patients was CBT (52%), with psychotherapy (24%) the second most common.
- Patients were typically positive about their treatment, with the friendly and informal manner of support delivery benefitting patients in a range of ways.
- Experience of follow-up support varied, though most patients were reassured by the friendly and informal ongoing calls.

Referrals to PCGS: intended delivery

Figure 7.1 shows the six pathways through which patients were intended to access the PCGS.

Figure 7.1 PCGS referral pathways

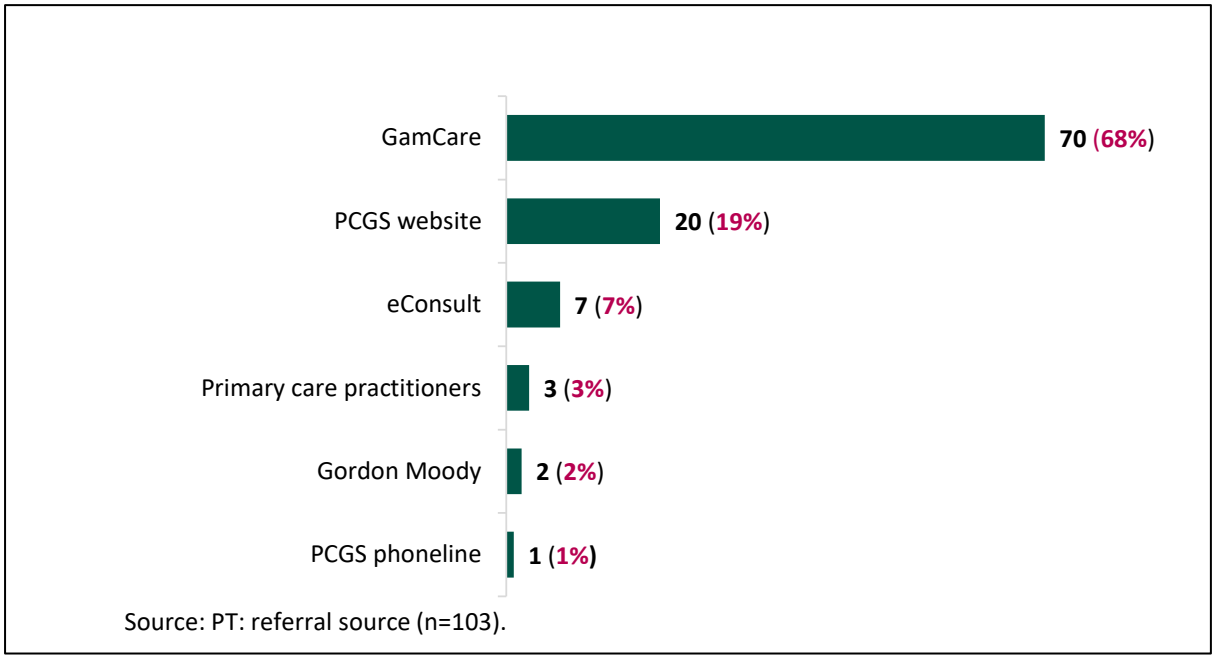
REFERRAL PATHWAYS	
Direct referrals through GamCare	GamCare identifies patients with mental health issues that could be better treated by PCGS and discuss them with the PCGS team at weekly MDT meetings. If PCGS agree to support the patient, GamCare arranges a referral with the patient's consent.
Self-referral via the PCGS website	Patient completes self-referral registration form on PCGS website and consents to share their contact information. Patients typically searched the internet and found the PCGS website and self-referral form.
GP referral through screening question on e-Consult	e-Consult asks patients whether they gamble more than they can afford. If they answer 'yes', the patient's GP sees details of PCGS and needs to take action to liaise with them about the patient's response to this question.
Self-referral via PCGS telephone or National Gambling helpline	Patients can call the PCGS phone number to speak to someone, or can call the National Gambling Helpline if it is between the hours of 4pm and 8am.
Direct referrals through Gordon Moody	Gordon Moody identifies patients with issues that fit the referral criteria for PCGS and discusses cases with the PCGS team. If it is decided that a referral is appropriate, Gordon Moody staff complete a referral form and email it to PCGS.
Direct referrals from health care professionals	Health care professionals (e.g. GPs, nurses, social prescribers etc.) are able to refer patients directly to PCGS via its website. All the information is recorded on EMIS, the clinical system used to record all episodes of care.

In practice, most patients were referred by GamCare and through the PCGS website, though numbers are slowly increasing across other referral pathways.

Most patients were referred to PCGS from GamCare: 70 of 103 (68%) patients (Figure 7.2). PCGS staff felt this reflected the positive and collaborative partnership developed between PCGS and GamCare, and the productive nature of the MDT meetings to identify appropriate patients for referral.

The PCGS website was the second most common pathway: 20 of 103 referrals (19%). Referrals started coming through this pathway in September 2020, suggesting the limited service awareness activities PCGS could undertake during the Covid-19 pandemic were starting to lead to referrals.

Figure 7.2 Volume of referrals across different pathways



The Hurley Group learned lessons from the other four referral pathways and took steps to mitigate the challenges experienced.

eConsult is live across 3,247 GP practices in the UK, providing over 29 million NHS patients with digital access.[17] Yet, the number of referrals from eConsult have been small (seven in total). PCGS staff discussed four challenges limited eConsult referrals:

- Prior to October 2021, eConsult signposted patients to the National Problem Gambling Clinic (NPGC), not the PCGS. This has been updated and eConsult now signposts to the PCGS[18];
- Governance issues meaning the PCGS can only access patients registered with the Hurley Group, due to patient consent and data sharing agreements;
- GPs either not noticing the flag for gambling behaviour or not following it up due to other priorities. PCGS staff noted that this will be covered in any future GP awareness raising activity;
- Patient hesitation to disclose gambling behaviours through the question, potentially because of fear it will be added to their medical record.

[17] eConsult, 'Case Studies', https://econsult.net/primary-care/evidence/case-studies (Accessed 27 May 2022)
[18] eConsult, 'eConsult platform updates log,' eConsult platform updates log | eConsult Help Centre (27 May 2022)

The PCGS has received two referrals from **Gordon Moody** to date. This was largely felt to be due to the drop in patients being referred to Gordon Moody resulting from the Covid-19 pandemic and the small volume of patients who meet the eligibility criteria for PCGS as perceived by Gordon Moody staff[19]. PCGS and Gordon Moody staff anticipated more referrals as the partnership develops.

GPs were expected to one of the main referral sources, but the Covid-19 pandemic limited the planned GP engagement activities. Hurley Group instead has shared promotional service materials by email to all South East London surgeries, and many voluntary services and Universities. Hurley Group staff were also regularly presenting at industry workshops, seminars and conferences, including at Pulse events[20], a nursing conference, and at GambleAware events.

PCGS staff suggested that patients actively seeking support by phoning a **helpline** might be too daunting for them, and the existence of the more widely publicised National Gambling Helpline may also be limiting referrals via this pathway.

Most patients had a positive experience of their referral to the PCGS.

Patients interviewed for the evaluation included individuals referred by GamCare, the PCGS website and eConsult. Across all three pathways, patients recalled:

- The referral process being *"easy"* and *"straightforward"*, with patients reporting the handover process to be quick and smooth from GamCare and the website referral form *"simple"* to complete.
- The PCGS being positioned to them as support for mental health and gambling, and their initial impressions were mixed. There was general agreement that they appreciated that the service was free to access, and that support was delivered by qualified healthcare professionals.
- Understanding that by sharing their contact details, or GamCare sharing on their behalf, they had agreed to be contacted by the PCGS team to schedule an assessment.
- Finding the information about the PCGS provided to them being informative. Patients liked the clear and concise detail provided about the service offer and the process.
- Being impressed with how quickly a PCGS staff member contacted them. This was especially the case for referral via eConsult and the PCGS website, where patients were "*pleasantly surprised*" when, a few days later, the PCGS mental health nurse called the patient to discuss what the PCGS was and what support and treatment they could offer. See Chapter 8 for more detail on waiting times.

"I think it [the referral process] worked really well – nothing to complain about."

PCGS patient

The main difference in patient experience by referral pathway was that patients referred by GamCare were initially more hesitant and anxious because they were moving to a new service, and there was some reluctance to access support from a different organisation. Although this is not an uncommon response from patients with complex needs when moving to a new service, GamCare staff noted that the move to PCGS can sometimes be a challenging sell to patients, who often did not want another organisation involved in their care, did not feel they would benefit from PCGS support, or did not want an NHS organisation involved in their care because of their concern of their gambling problem being on their medical record.

[19] A patient who complex physical health needs and does not require residential care.
[20] Pulse LIVE, 'About', About Pulse LIVE Virtual Event 2021 (pulse-live.co.uk) (Accessed 27 May 2022)

"I didn't want to leave [GamCare] at first because it had been really good and I wasn't sure about having to start something new…I wasn't sure I wanted it on my [NHS medical] record that I was having these problems."

PCGS patient

Most patients praised the PCGS team on the highly personal and informal manner in which the mental health assessment and referral questionnaires were delivered.

Patients often did not recall the assessment questionnaires in detail or distinguish between the three different questionnaires. This was largely because of the conversational and informal manner they were administered by the PCGS team. Patients also recalled answering questions over the phone or a Zoom call that focussed on their gambling and their mental health but were unaware that these had been three separate questionnaires. The service's aim of administering the questionnaires as simply, easily and comfortably as possible has been achieved, with patients describing the process as a *"friendly chat"* or *"giving my history".*

The questionnaires also appeared to be working well together when administered upon referral, however the service has found it difficult to secure completed questionnaires midway through and at the end of treatment. None of the patients recalled having been asked by their therapists to complete questionnaires at later points in their treatment. At the time of writing, PCGS staff are currently exploring ways to make it mandatory for therapists to submit these questionnaires.

Specialist treatment and support has evolved in response to new opportunities to support patients.

Figure 7.3 summarises the currently available treatment and support options offered to PCGS patients.

Figure 7.3 PCGS available treatment and support options

TREATMENT PATHWAYS	
Case management	Case management support involves the service administrator or mental health nurse informally checking in on how a patient undergoing other PCGS support is managing. Delivered remotely.
Cognitive Behavioural Therapy (CBT)	CBT delivered by external providers with the number of sessions varying according to individual need, between 6 and 12 sessions per patient. Delivered via Zoom.
Psychoanalytic psychotherapy	External therapists deliver psychotherapy, with the number of sessions varying according to individual need, between 20 and 25 sessions per patient. Delivered over Zoom.
Group therapy	GamCare's Gambling Recovery Course delivers group therapy to patients, delivered online during the pandemic. This includes group discussion, exercises, and roleplay.
Social prescribing	Social providers to link patients with local support services in their community, which take a holistic approach to individuals' wellbeing, e.g. create outlets such as art classes.
Prescription for Naltrexone	An opioid antagonist prescribed to a very small number of patients for whom psychological therapies have not worked.
Referral to National Problem Gambling Clinic	The PCGS team can make direct referrals to the NPGC where this is felt to be appropriate.

PCGS delivered its specialist treatment and support as intended (see Appendix D), with three notable differences.

- The prescription of Naltrexone was introduced after the launch of the pilot. Naltrexone is a medication originally used to combat opioid and alcohol addiction, but in recent years has been considered by some psychiatrists in reducing the compulsion to gamble among problem gamblers. The medication was prescribed to two patients who received it alongside psychological interventions.

- PCGS planned to refer patients to lifestyle classes as part of holistic care plans. Since pilot launch, this support has evolved to referrals to social prescribing. Social prescribing takes a holistic approach to individuals' wellbeing and may include creative outlets such as art classes, or more practical advice, like how to apply for benefits and other financial aid.

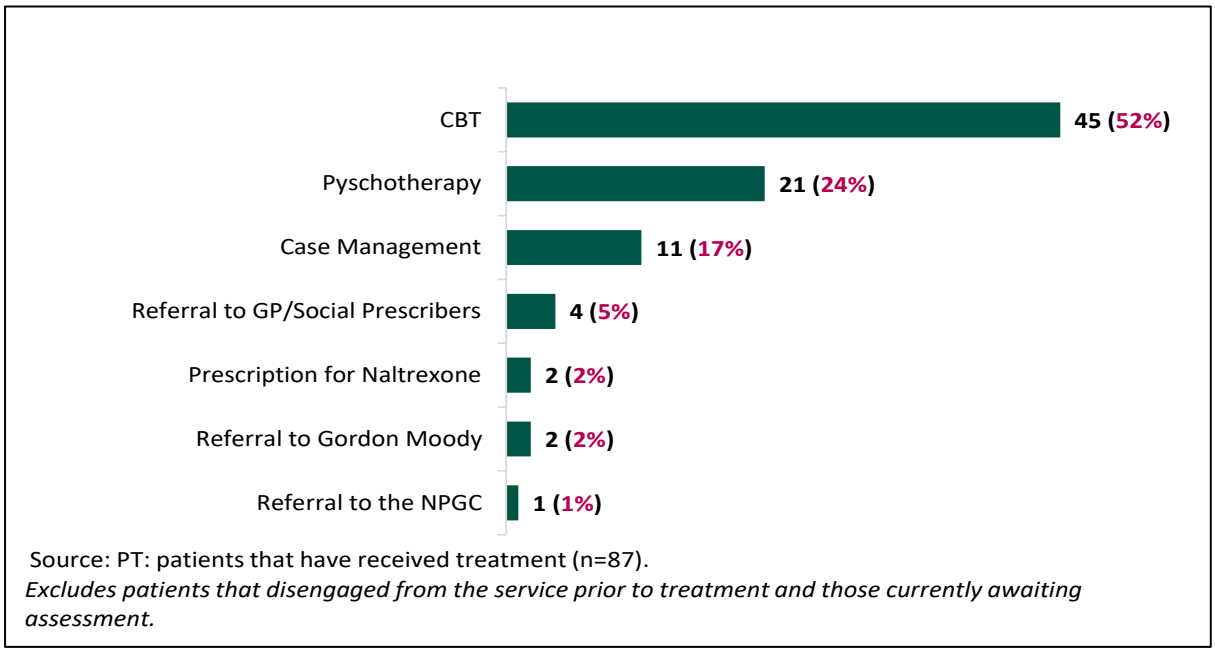
- Patients have been offered more treatment sessions than initially planned. For example, patients were intended to receive between six and 12 CBT sessions. In practice, PCGS now begin with eight sessions, and reassess patient needs after eight sessions, to determine when more session would be beneficial.

The most common treatment received by PCGS patients was CBT, with psychotherapy the second most common.

Over half of patients have received CBT (52% or 45 patients), and nearly a quarter have received psychotherapy (24% or 21 patients) (Figure 7.4). It was rare for patients to be prescribed Naltrexone (2% or 2 patients) or referred to the NPGC (1% or 1 patient).

Patients typically received multiple treatments, either concurrently, or one after the other. However, Patient Tracker data makes it difficult to know when each treatment began or was completed, and likely underrepresents the number of patients who received the informal check-ins provided by PCGS staff – called case management – because PCGS staff reported most received this at some point in their service engagement. Therefore, Figure 7.4 summarises the main treatment PCGS patients received.

Figure 7.4 Volume of patients receiving each treatment



Source: PT: patients that have received treatment (n=87).
Excludes patients that disengaged from the service prior to treatment and those currently awaiting assessment.

Patients were typically positive about their treatment, with the friendly and informal manner of support delivery benefitting patients in a range of ways.

Overall, patients who took part in one-to-one support, either talking therapies delivered by external therapists, or less formal check-ins from PCGS staff, were positive about having someone to talk to about their own experiences and complimented the professionals who delivered the support for being friendly and reassuring.

"A sincere friendly service. She [psychotherapist] was very knowledgeable and really helped."

PCGS psychotherapy patient

Patients interviewed with experience of case management felt this element helped reassure them of what was involved in the service and support them to engage with other PCGS treatment.

"She [PCGS staff member] reassured me about the treatment, that it's not all self-learning. She explained everything. She really took the time to listen to me and understand my own circumstances…"

PCGS case management patient

Patients with previous experiences of counselling initially felt hesitant about their CBT or psychotherapy referrals; they were either nervous or sceptical about its benefits. Yet, once they engaged with the treatment, these patients felt they were beneficial because of therapists' knowledge and skill, and the focus on exploring the impact of past trauma on the gambling behaviours.

"At first, I was so negative. I said no to everything. I thought the sessions wouldn't help because I'd had CBT before, and it was rubbish… But after two or three sessions, I could see it started to work, and that helped change my mindset."

PCGS CBT patient

Specialist treatment was delivered remotely because of social distancing restrictions due to the pandemic. While patients understood this, some still suggested they would prefer the option of face-to-face sessions.

"I was initially anxious about having therapy online, but it actually worked ok, but I still would have liked to see [the therapist] in person if Covid had allowed."

PCGS CBT patient

Patients who received CBT or psychotherapy referrals were typically happy with the number of sessions offered, except for some who felt *"vulnerable"* and *"unsupported"* once these sessions ended. Most felt they would have benefitted from knowing where they could access additional support once the sessions had ended and the PCGS team could look to provide more post-support signposting information.

"Although I knew the sessions were coming to an end, I really missed talking to [the therapist] and didn't know where to go to for other support."

PCGS CBT patient

The number of specialist, external therapy sessions a patient receives is reviewed in the weekly MDT meetings. Hurley Group and GamCare practitioners discuss the opportunities of extending treatment alongside any perceived risk of patient reliance on the support. If they agree to offer further sessions, this is discussed and agreed with the therapist and patient.

It was common for more sessions to be offered: more than a quarter of patients who received CBT received more sessions than planned (30%, or 13 of 44 patients) and nearly one in five accessing psychotherapy received more sessions (18%, or 4 of 22 patients). The latter is likely because the number initial psychotherapy sessions offered was higher than CBT (20-25 sessions compared with eight for CBT).

"I was really pleased when they said I could have more sessions, because they were really good and I had more stuff to talk about."

PCGS CBT patient

Group therapy was a less popular option among patients interviewed, with all but one patient interviewed turning down this offer. This reflects the few patients who accessed group therapy noted in the Patient Tracker (eleven) and the 10 patients out of 21 patient who declined group therapy after initial specialist treatment. Patients declined group therapy for two main reasons; practicalities of attending sessions at a specific time that was not convenient and concerns about stigma and lack of anonymity in a group setting. The fear of 'running into' a group member in a local setting was a recurring view.

Experience of follow-up support varied, though most patients were reassured by the ongoing calls.

After treatment is completed, the service offers patients support for up to one year, with post-assessment check-ins being conducted at three, six and nine months, though this is flexible and more frequent contact is offered as needed.

Patients described these phone calls as friendly and informal, with the main aim being to reassure the patient that they have not been forgotten. One patient noted that the expectation of receiving a follow-up call contributed to him maintaining his recovery.

"It is good they are going to check in, because it will help me not fall back into it [gambling]."

PCGS CBT patient

A less common experience among those interviewed was that they reported having no further contact from PCGS after their treatment concluded. While some accepted that this was because their treatment had concluded, few mentioned they would have welcomed ongoing check-ins.

Data in the Patient Tracker confirms that this experience is uncommon, with all but one of the 24 patients who had completed treatment (and therefore eligible for follow-up support) receiving follow-up at the intended intervals. The one patient disengaged from the service after the second follow-up and asked not to be contacted.

8 Early evidence of outcomes

This chapter discusses the early evidence of the outcomes of PCGS, drawing on qualitative depth interviews and analysis of patient Core-10, PGSi and Psychlops scores at referral and the end of their treatment.

Early evidence of outcomes: Headline messages

- It is too early to say whether the PCGS is delivering its intended impacts for patients. However, the evaluation has found early evidence of promise.
- Most patients were quickly contacted following referral to complete their assessment, and in just over half (53%) of cases the target waiting time of seven days was met. Within the qualitative interviews, patients praised how quickly they were contacted after being referred to the service, especially when comparing this to their experiences of waiting times for other NHS services.
- Patients engaged with the service and treatment because of the interpersonal skills of the PCGS team and therapists. They reported feeling comfortable discussing their circumstances openly and honestly, and often more so than with previous professionals.
- Nearly a third (32%) of patients had disengaged with the PCGS at some point during their service use. This level of disengagement is not surprising, given the complexity of patients' needs and the disengagement rates of other gambling support services.
- All 14 patients for whom data was available saw an improvement between their initial and exit scores across all three questionnaires (Psychlops, Core-10, PGSi).
- There is no evidence of outcomes for GPs because the planned outreach work was paused during the Covid-19 pandemic.

Short-term outcomes

Reduced time to first access support and receive treatment

Most patients were quickly contacted following referral to complete their assessment, and in just over half (53%) of cases[21] the target waiting time of seven days was met (see Figure 8.1). The mean waiting time between referral and mental health assessment was 12 days and the median (often a more useful calculation of the average in datasets with outliers[22]) was seven days.

Waiting times were quickest for referrals where PCGS had direct control (i.e. via the website and eConsult), compared with those from their partner GamCare. Patients who were referred through eConsult typically waited just three days to be contacted, compared to six days for those who self-referred via the website and 15 days for those who were referred by GamCare.[23]

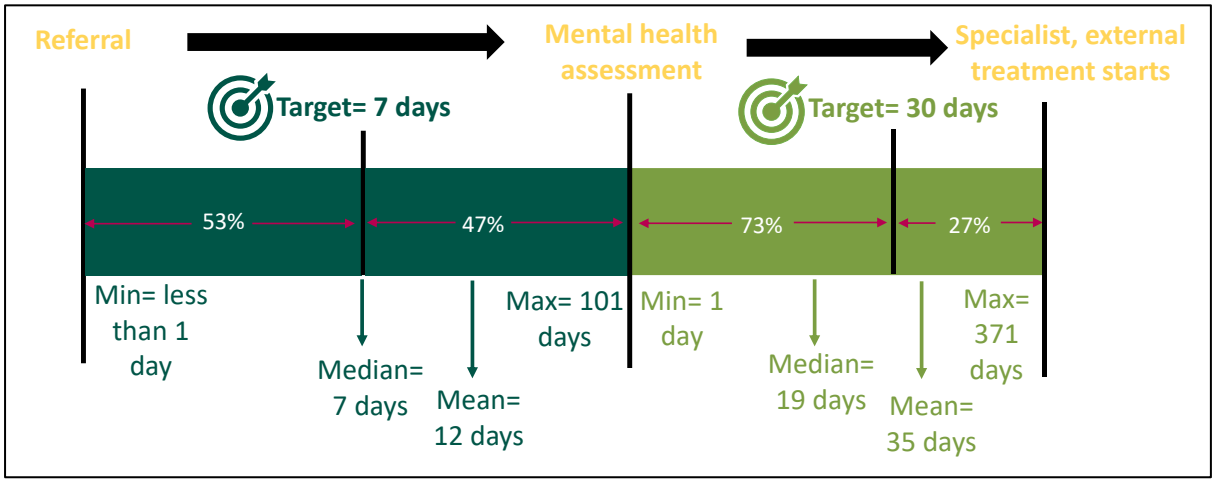
PCGS staff noted that waiting time for referrals via GamCare were impacted by the time taken for assessment forms to be completed and the time elapsed when waiting for the next weekly MDT meeting. At the time of writing the Patient Tracker does not contain data on the date of the initial point of contact by the PCGS team. Adding this would help monitor, more granularly, the time PCGS is taking to contact patients once they have the information needed.

[21] Base number = 87.
[22] These were often flagged in the Patient Tracker as where patients wanted space to reflect on the PCGS offer or felt it was not the right time for them to engage.
[23] Note the number of referrals via other pathways were too small to make any analysis meaningful.

For most patients (73%)[24], the target of patients starting specialist, external treatment (i.e. not including case management with PCGS staff) within one month was met. The mean waiting time between referral and mental health assessment was 35 days and the median was 16 days. In some cases, delays resulted from patients preferring to wait for specialist treatment to start due to personal circumstances.

Psychotherapy often required the longest wait due to the time required for the PCGS team to find an appropriate, specialist therapist. The mean average was 24 days, compared to CBT with a mean average of 19 days. This points to the need for the PCGS team to explore adding more psychotherapists to their available list of external therapists.

Figure 8.1 Waiting times



Source: PT: date of referral & PCGS mental health assessment (n=87); date of PCGS mental health assessment & start of specialist treatment (n=67).

Within the qualitative data, patients praised how quickly they were contacted after being referred to the service, especially when comparing this to their experiences of waiting times for other NHS services.

"Without such a quick call [from PCGS], I would have lost my nerve."

"I was surprised how quickly it was… I thought it could be 6 months or 12 months."

PCGS patients

Increased awareness of the negative impacts of gambling and the role it plays in their life

Patients interviewed that accessed CBT and psychotherapy found the process of exploring their gambling history and talking about its consequences on their mental health, finances and relationships helped them to improve their understanding of the impacts of gambling on their lives and the reasons reducing their gambling was important for them.

Patients also reported developing the emotional tools to identify and counteract the mindset that led them to gamble and engage in other damaging behaviours.

"Doing CBT opened up my eyes, made me aware of why I gambled...The reasons I was doing it and why I couldn't stop and why I always started again… Made me think of things in a different way."

PCGS CBT patient

[24] Base number = 67.

Patients feel comfortable and motivated to engage with the service

Patients engaged with the service and treatment because of the interpersonal skills of the PCGS team and therapists. They reported feeling comfortable discussing their circumstances openly and honestly, and often more so than with previous professionals. Support received was described by patients interviewed as delivered in a friendly, informal and non-judgemental way, meaning it did not feel like 'treatment' in a medical sense.

"I felt relaxed. I didn't feel threatened. She was a friendly face."

PCGS patient

Yet nearly a third (32%) of patients had disengaged with the PCGS at some point during their service use. This level of disengagement is not surprising, given the complexity of patients' needs and the disengagement rates of other gambling support services:

- the Leeds and York Partnership Foundation Trust's (LYPFT) Northern Gambling Service showed that of the 73 patients for whom an end reason for treatment was available, 14 (or 19%) were reported to have dropped out;
- the NPGC run by Central and North West London NHS Foundation Trust showed that of data available for 96 patients, 51 (or 53%) had either dropped out or declined treatment.[25]

Disengagement with PCGS was higher amongst the youngest patients (6 of 8 16-24 year olds disengaged, compared with 4 of 9 patients over 55) and those from an ethnic minority background (a third of whom disengaged from the service (12 of 36 patients), compared to just under a quarter of White patients (16 of 67)).

PCGS staff should monitor the level of disengagement as the number of referrals to the service increases and work to improve the recording of reasons for disengagement because disengagement rates will influence the mid-term outcomes. Analysis of the reasons for disengagement would also be useful to highlight potential areas for service improvement.

Receive holistic and integrated treatment of gambling and related needs

PCGS staff spoke positively of supporting patients' needs in a holistic way through offering joined-up and integrated support alongside other services. This was particularly the case with GamCare, where patients needs were jointly supported by both services and treatment plans were discussed in MDT meetings.

Patients echoed the PCGS staff view that the support received supported them with their life and current challenges holistically. This included signposting and referral to other sources of support, including social prescribing, their own GP, and debt or employment support to name a few.

"I had support from both people [PCGS and GamCare] but it didn't feel like different because it was linked and they knew what each other was doing."

PCGS patient

Due to the limitations of the current Patient Tracker, it is not possible to accurately quantify this activity, but patients described it as being very important in helping them to start to address all of their problems that were causing them to gamble, and hopefully help them to sustain positive outcomes in the longer-term.

[25] This split was 28 treatment declined and 23 dropped out. The LYPFT data recorded no-one as having declined treatment.

Mid-term outcomes

Reduced PGSi, Core10 and Psychlops scores

The evidence for demonstrating patient outcomes achieved within a year of engaging with the service comes from comparing the mid-point and end-point assessment scores with the scores at the point of referral. Given that there were only 14 patients for whom this data was available, these findings should be interpreted very cautiously, though for the very small sample of patients for which data is available (14 patients), scores across all three questionnaires improved (Table 8.1):

- All 14 patients saw an improvement between their initial and exit scores across all three questionnaires. Overall, the difference between the initial to exit scores for Psychlops, Core-10 and PGSi were -11.1, -8.8 and -13.4 respectively;
- Core-10 scores moved from moderate/ severe distress to the non-clinical range[26];
- PGSi scores moved from gambling with negative consequences to a moderate level of problems[27].

Table 8.1 Comparison of overall initial, mid and exit point scores

	Initial score average	Mid-point score average	Exit point average	Difference initial to exit
Psychlops	17.3	12.8 (-4.5)	6.2 (-6.6)	-11.1
Core-10	18.3	15.5 (-2.8)	9.5 (-6)	-8.8
PGSi	18.2	15 (-3.2)	4.8 (-10.2)	-13.4

Source: Patient Tracker: Patients with all three scores available (n=14).

The key mechanisms behind these changes were reported qualitatively as being related to the treatment and support received e.g., with the support feeling better able to cope, possessing the tools needed to deal with various life challenges and being more self-aware.

"I 100% feel better and know what to do know if I feel bad again."

PCGS patient

[26] The categories for Core-10 scores are: Less than 10 – non-clinical range; 11 to 14 – mild psychological distress; 15 to 19 – moderate psychological distress; 20 to 24 – moderate-to-severe psychological distress; 25 or above – severe psychological distress.

[27] The categories for PGSi scores are: 0 - Gamblers who gamble with no negative consequences; 1-2 - Gamblers who experience a low level of problems with few or no identified negative consequences; 3-7 - Gamblers who experience a moderate level of problems leading to some negative consequences; 8 or more - Gambling with negative consequences and a possible loss of control.

Receive continuity of care, including follow-up

As discussed in the previous chapter, after treatment is completed, the PCGS team have offered all patients follow-up support as intended. Patients reported that these calls were reassuring and had in some cases, helped them to sustain their recovery (though this is not currently possible to measure within the data available in the Patient Tracker).

Complete treatment plan as intended

There is less evidence to indicate that treatment plans have been completed as designed. Within the Patient Tracker, 42 patients (41%) were marked as having been discharged from the service. It is not always possible to determine whether this discharge was due to treatment plans being completed as intended, whether treatment plans changed, in what ways and at what points because of Patient Tracker data quality.

9 Conclusions and implications

Overall, patients and those involved in the delivery of the Primary Care Gambling Service (PCGS) were positive about the service and its model of delivery. The evaluation also demonstrated there is GP demand for a service like PCGS and that the PCGS model has a role to play in the support network individuals can draw upon to manage their gambling. However, there are key areas that could be improved, and recommendations to consider in future delivery of this and other gambling support services.

Referral pathways

The pilot was established shortly before the Covid-19 pandemic which led to unavoidable changes in the delivery model, most significantly that their partner, GamCare, could not be co-located and GP outreach activity has not taken place. These changes, and the ongoing delivery during the pandemic, greatly impacted the volume and profile of patients accessing the service, and the type of treatment and support offered during the pilot.

The Hurley Group has taken the opportunities that the pandemic's challenges presented to develop the delivery model. Notably, the absence of opportunities for GP outreach activity focussed the team on developing relationships with GamCare, resulting in this being the most effective referral pathway to date. This is a positive sign for the future development of the service, as it means the service is not overly reliant on GP referrals – something that could have been the case given the service's position as an NHS provider.

Patient experiences of service delivery

Patients are broadly positive about their experiences of the PCGS. The speed of patient access to support and treatment, and the personalised and welcoming approach are key drivers of this. Most patients were satisfied with the number of sessions of treatment they received and in many cases, patients have received more sessions than originally intended.

Waiting times between key stages of the PCGS patient journey did not always meet targets set by the service. This was a more common patient experience between referral and mental health assessment where just over half of cases met the seven-day target. This compares to nearly three-quarters of cases which met the target of 30 days between mental health assessment and when specialist, external treatment started. Nonetheless, these waiting times were viewed positively amongst patients and compare favourable to waiting times experienced to access other NHS services.

Early evidence of patient outcomes

PCGS is still on an implementation journey, and improvement to patient and GP outcomes will necessarily take time to become evident. Nonetheless, the evaluation found promising early evidence of progress towards the patient outcomes outlined in the logic model. Patients feel better able to cope, in possession of the tools to deal with various life-challenges (including gambling) and more self-aware of the impact of gambling on their lives. Going forward, a greater volume of patients accessing and completing treatment, and consistent and complete collection of demographic, service and outcome data, will be necessary for the service to demonstrate its impact on patients.

Recommendations for the future delivery of the PCGS

Partnership and sector working: a key priority for the PCGS, working with GambleAware, will be to define the service offer, including eligibility, and position more clearly this with the national gambling treatment system. Once agreed, making sure this is clearly communicated to key partners will be important to further improve relationships and reduce some of the barriers to partners referring into the service. PCGS staff continuing with their speaking engagements to promote the work of the service will be an important component of this.

GP outreach activity: the evaluation evidence has clearly shown the need for a plan of engagement and outreach activities with GPs, once this is possible. This should help with GPs in the survey lacking awareness generally of gambling services and requesting more information about identifying patients at risk and developing their conversation in framing conversations about gambling harms with patients. It should also support greater awareness about how to refer and in turn lead to an increase in GP referrals to PCGS.

This evaluation builds on recent research that showed GPs were less likely to identify a care pathway for a gambler if they were to disclose to the GP.[28] Future research is needed to better understand GP barriers to awareness of and referral to gambling support services, like PCGS, and why they might not see it as their responsibility and priority to support patients with gambling.

Referral pathways: although the evaluation has found that having a range of referral pathways is working well and is an aspect of the model that should continue, we recommend focussing (at least initially) on the following pathways that have the greatest potential to increase volumes of referrals:

- GP outreach activity;
- Increasing advertising within constraints to promote self-referrals through the PCGS website;
- Continuing to explore ways to access more referrals via eConsult, given the high number of potential patients.

As patient volumes increase, it will be important to ensure there is sufficient capacity within the PCGS team to meet demand and continue to deliver a high-quality service.

Team capacity and composition: the consistent message from patients and PCGS staff was that the tailored and personal care provided is a key aspect of delivery, as is the speed of access to support. Whilst this is currently possible with the lower than anticipated number of referrals, maintaining the tailored and personal care, and speed of access, necessitates more staff time. Going forward, it will be important to review the capacity and confirm the ideal composition of the staff team needed to deliver the service effectively and efficiently.

Monitoring patient engagement and experience: given the evaluation findings about the relatively high level of patient disengagement and some patients waiting longer than anticipated for treatment, it will be important to monitor and track changes in these indicators as the service's referral volume increases. More detail on how the monitoring and evaluation of the service could be improved can be found in Appendix F.

[28] Amanda Roberts, Henrietta Bowden-Jones, David Roberts and Stephen Sharman. Should GPs routinely screen for gambling disorders? British Journal of General Practice 2019; 69 (682): 226-227.

Implications for replicating the service

This evaluation has concluded that the PCGS is a promising model of delivering support to those experiencing gambling harms. An impact evaluation is needed to assess the impact of the service on patients, and GPs, and the causes of any observed changes. This evaluation captured successes and challenges for delivering the PCGS, and these lessons have implications for any similar services.

The need for integrated working: the service offers bespoke and tailored support provided by a multi-disciplinary team with specialist skills and expertise. Integrated working is a key mechanism for provide this type of support, and helps to limit the need for the patient to access multiple, and often siloed, support services. Patients and service staff discussed the benefits of the a service integrated within primary care and this as an important setting to consider for future services.

The importance of the service's role within the national gambling support system: any new gambling support services need a clearly communicated role and purpose within the context of the national system. It is important to clearly define the service offer, including eligibility criteria, at the outset and make sure this is clearly communicated to all key stakeholders within the system for system providers to feel confident in referring to the service. The NHSE decision in February 2022[29] to stop participating in dual commissioning and funding to treat people experiencing gambling harms must also be factored into decision making about how a service like PCGS is funded.

The need for promotion and awareness raising activity: promotion activities are important for any new service to ensure patients are referred and can be supported to manage their gambling. Diverse promotion and outreach activities are essential at the start of implementing a new service and on-going.

[29] Murdoch, C., (2022) Ceasing of the dual commissioning and funding by GambleAware f the NHS elements of the problem gambling treatment pathway. NHS England » Ceasing of the dual commissioning and funding by GambleAware of the NHS elements of the problem gambling treatment pathway

10 Appendices

Appendix A: Methodology detail

Table A.1 chieved number of patient interviews – total number of interviews = 16

N= 16		
Gender	Male	12
	Female	4
Age	18 – 24	1
	25 – 34	7
	35 – 44	7
	45 – 55	1
Referral source	GamCare	12
	Self-referral via PCGS website	3
	e-Consult	1
Treatment received (as outlined on the Patient Tracker)	CBT	9
	Psychotherapy	4
	Case management	3*
Comorbidities	Mental health condition	16
	Physical health condition	8
	Other addiction	9

*Note this is likely to be an underestimation, as discussed in the report. This relates to three patients who did not have any specialist external treatment, and only had case management with PCGS staff.

Table A.2 Achieved number of stakeholder interviews – total number of interviews = 11

N=11	
Hurley Group	7
GamCare	3
Gordon Moody	1

Stakeholder and patient qualitative interviews

Our approach to the analysis of the qualitative data to date has been iterative and inductive – building upwards from the views of participants. All interviews were written up in detail, including verbatim quotes, in an analytical framework in Excel. The framework was structured around the logic model and research questions, with a research question per column, and detail from each qualitative interview entered individually per row. The framework also included key sample data, to allow for comparison of findings by different characteristics. The data was analysed to search for themes and trends, both present and absent.

Initial analysis was undertaken for the interim report (March 2022), with further, more-detailed analysis and triangulation taking place during the analysis for the final report.

GP survey

The final GP survey dataset was weighted to ensure that results were reflective of the population of licensed doctors by age, gender, and place in which primary medical qualification was gained.

The following table shows the demographic profile achieved in the survey, the weighting targets, and then the post-weighted profile, of doctors.

Table A.3 GP survey weighting profile

Profile category		GMC population	Survey completes	Weighting targets[30]	Weighted profile
Age	Under 45	44.00%	56.00%	39.60%	40.00%
	Over 45	56.00%	34.00%	50.40%	50.00%
	Prefer not to say	N/A	10.00%	10.00%	10.00%
Gender	Male	45.00%	46.00%	44.10%	44.00%
	Female	55.00%	52.00%	53.90%	54.00%
	Prefer not to say	N/A	2.00%	2.00%	2.00%
PMQ area	UK	77.27%	81.00%	76.50%	77.00%
	EEA	5.00%	5.00%	4.95%	5.00%
	Outside UK and European Economic Area (EEA)	17.73%	13.00%	17.55%	18.00%
	Prefer not to say	N/A	1.00%	1.00%	1.00%

The survey data was reviewed by two team members and tables were produced for each survey question. The tables and charts were reviewed by members of the project team, with a particular focus on statistically significant differences between GP characteristics.

Patient Tracker and DRF secondary analysis

The qualitative data within the Patient Tracker was coded against the DRF specification. This then enabled the evaluation team to combine the data from both datasets into one SPSS file for descriptive analysis. The data in the final file was cleaned and checked for consistency before analysis.

[30] Weighting targets are the population figures, re-percentaged to take account of unknowns and prefer not to says, this enables more accurate comparisons

Appendix B: Evaluation framework

Note evaluation aim three was not included within the re-scoped evaluation because the work was unable to be delivered by PCGS due to the Covid-19 pandemic.

Key evaluation aim	Key research questions	Measures	Recommended evidence sources
1) Understand the referral pathways and the enablers and barriers to each pathway referring patients into the service	What is the profile of the patients referred from each of the referral pathways: GPs, Gambling Treatment Services: GamCare & Gordon Moody, eConsult, PCGS website and helpline?	Number and profile of patients accessing PCGS through each type of pathway (and changes over time)	Analysis of patient data tracker
		Threshold criteria for entering PCGS or being referred on to other support e.g. Gordon Moody Service, GamCare or National Problem Gambling Clinic	Stakeholder interviews (HG, GC, GM)
		Demographics, gambling history, treatment type, referral source(s) of PCGS patients and compared to other non-PCGS gamblers	Analysis of patient data tracker and comparison with DRF data
	What are the enablers and barriers to each referral pathway?	Perceptions of the challenges/barriers to each referral pathway	Stakeholder interviews (HG, GC, GM)
		Perceptions of the enablers/successes of each referral pathway	Stakeholder interviews (HG, GC, GM)
		Weekly MDT enablers/barriers	Stakeholder interviews (HG and GC)
	What lessons can be learned to help improve referrals, especially less serious gambling harms?	Lessons learnt from overcoming/mitigation challenges/barriers to each referral pathway	Stakeholder interviews (HG, GC, GM)
		Best practice learnings identified	Stakeholder interviews (HG, GC, GM)
		Suggested ways to make it easier to identify and refer patients to PCGS	GP survey

		Primary care practitioner perception of the need and demand for the PCGS	GP survey
2) Understand patient journeys into (and where relevant) out of PCGS, and the enablers and barriers to a supported journey	How do patients become aware of PCGS?	Ways in which patients became aware of PCGS	Patient interviews
		Patient understanding about how they can access PCGS	Patient interviews
		Perceptions of ways to improve patient awareness of PCGS	Patient interviews, stakeholder interviews (HG, GC, GM)
	How do patients experience the three PCGS questionnaires (Psychlops, PGSI, Core10)?	Patient experience of and views on ease of completing each assessment	Patient interviews, stakeholder interviews (HG, GC, GM)
		Stakeholder perceptions on the suitability and ease of completing each assessment	Stakeholder interviews (HG, GC, GM)
		Suggestions for improving patient experience of assessments	Patient interviews, stakeholder interviews (HG, GC, GM)
	How do patients experience treatment and support (including wider than PCGS where relevant)?	Perceptions of treatment received (e.g. likes, dislikes, ease, efficiency)	Patient interviews, stakeholder interviews (HG, GC, GM)
		Number, duration and types of treatment(s) for each PCGS patient (and compared with non-PCGS patients)	Analysis of patient data tracker and comparison with DRF data
		Expectations and actual estimates of wait time to access PCGS (and in comparison to other services)	Patient interviews, analysis of patient data tracker and comparison with DRF data
		Number and types of patients referred to external treatment providers (and reasons for this)	Analysis of patient data tracker and HG stakeholder interviews
		Comparison of PCGS support received with other gambling support	Patient interviews, analysis of patient data tracker and comparison with DRF data

	What do patient suggest to improve the accessibility and usefulness of the service?	Suggestions for improving patient experience of the service	Patient interviews, stakeholder interviews (HG, GC, GM)
		Best practice learnings identified	Patient interviews, stakeholder interviews (HG, GC, GM)
3) Understand the outreach work delivered by PCGS, including rationale for activities undertaken and views on what helps to raise awareness of the service and of gambling harms	What outreach activities were delivered, how and to who?	Number, content and format of outreach activities delivered	2 interviews with PCGS staff Review of documents relating to outreach activity 2 observations of outreach activity sessions
		Number and types of practitioners attending the outreach activities	2 interviews with PCGS staff Review of documents relating to outreach activity
	What factors influenced the intended outreach activities?	Approaches to engaging practitioners with the outreach activities and perceived success of each method	2 interviews with PCGS staff Review of documents relating to outreach activity
		Challenges/barriers impacting on outreach activities	2 interviews with PCGS staff
		Perceptions of the impact of Covid on delivery of outreach activity and the changes this has resulted in	2 interviews with PCGS staff

		Best practice learnings identified	2 interviews with PCGS staff
	How did participants experience the outreach activities?	Previous training and knowledge/understanding about gambling harms	GP survey
		Perceptions on the usefulness of the outreach activities	2 interviews with PCGS staff Review of documents relating to outreach activity
		Practitioner learning taken from the outreach activities	
		Suggestions for improving outreach activity	
	What is known about PCGS and what would help practitioners refer into PCGS?	Marketing/outreach activity undertaken to raise awareness of PCGS	HG stakeholder interviews
		Number of primary care practitioners aware of PCGS (and other gambling services) and how they learned about it	GP survey
		Perceived challenges/barriers to making referrals to PCGS	GP survey
		Suggestions for increasing practitioner referrals to PCGS	GP survey
4) Understand the implications of the model for future delivery, to shape	Were other approaches considered for the pilot and if so, what can we learn from those?	n/a	Stakeholder interviews (HG, GC, GM)

Gamble ware's wider understanding around primary care interventions	What are the key considerations for: - Sustainability of the programme? - Growing the model? -'Replicating' the model elsewhere?	n/a	Review of all the study findings and share on an ongoing basis Best practice learnings identified and communicated

Appendix C: Additional contextual information

As the first of its kind in the country, there was no template to draw upon in setting up the PCGS. It was established as a proof-of-concept service, funded by a regulatory settlement[31] from the Gambling Commission between October 2019 and March 2022. The Hurley Group undertook the following main activities to design and set-up a new NHS pilot service:

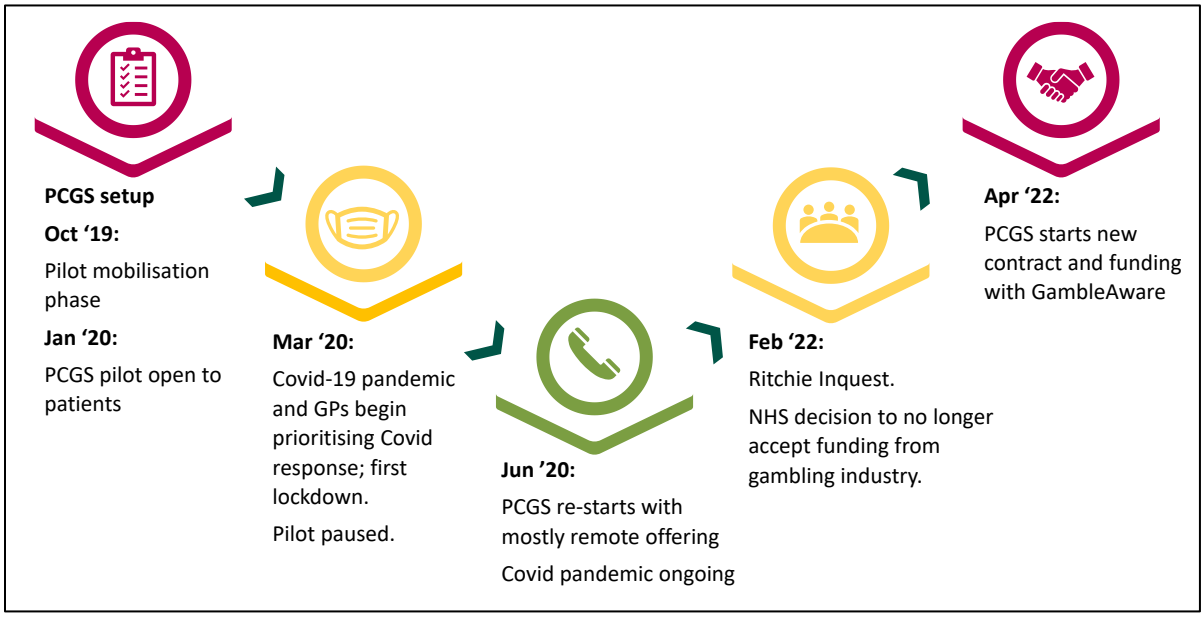
- getting a prescribing number and EMIS number - the clinical system used to record all episodes of care;[32]
- getting data protection, safeguarding and governance processes in place;
- agreeing the composition of the PCGS team, writing job descriptions, drafting contracts and recruiting to the team; and
- developing promotional materials for the service.

Four other contextual developments (summarised in Figure 10.1) also influenced the service and the context in which it has operated to date:

- The Ritchie Inquest in February 2022 into the suicide of Jack Ritchie highlighted that primary care health practitioners may lack the training to be able to recognise, diagnose or treat gambling disorders.
- The NHS released a statement in February 2022, stating that it will no longer accept funding from the gambling industry to treat people experiencing gambling harms.
- In April 2022 the PCGS started on a new one-year funding agreement from GambleAware.
- A review and reform of UK gambling laws is forthcoming, with government proposals expected at the time of publishing this report.

[31] Gambling Commission, 'Gambling licence information, guidance and advice for businesses and individuals'
[32] EMIS, 'About Us', About us | EMIS (emishealth.com) (Accessed 27 May 2022)

Figure A.1 Delivery context timeline



Appendix D: Additional detail on the PCGS intended delivery model

Intended profile

The PCGS team anticipated that patients supported by the service would be problem gamblers living with low to medium level harms, and that the service would act as the bridge between NHS primary and specialist (secondary care) services. Patients with complex needs and serious co-morbidities, or those who required intensive, specialist interventions such as residential care, were intended to be referred to secondary care services.

Assessment

When a patient is referred to a member of the PCGS team, a mental health assessment is intended to be undertaken within seven days of referral. The case is discussed in a weekly MDT meeting involving PCGS and GamCare staff. Direct referrals into the PCGS via the website/telephone are also discussed at this meeting.

Patient assessment is undertaken using the Clinical Outcomes in Routine Evaluation measure (Core-10), PGSi and Psychlops.[33] Core-10 is a validated monitoring tool with items covering **anxiety, depression, trauma, physical problems, functioning and risk to self**. Psychlops is a mental health outcome-measure tool used in primary care or community care settings and is self-completed. It measures mental health problems, quality of life, social functioning, and wellbeing, and is not yet validated but increasingly used in the gambling support sector. For example, the Gordon Moody Association uses Psychlops. The PGSi is the standardised measure of at-risk behaviour in problem gambling. It is a tool based on research on the common signs and consequences of problematic gambling.

Treatment and support

Following the assessment and MDT meeting to discuss the needs of the patient, a care plan was developed. Patients were offered support from the PCGS mental health nurse and/or peer support worker and they can be offered access to one-to-one psychological treatment, group therapy, medical support or if needed onward referral to the NPGC, as appropriate for their needs. This decision-making process in relation to the types of therapy offered is overseen by lead GP for the service. Face-to-face assessments and treatments were also intended to be available to patients seeking care, though less common during the pandemic.

The weekly check-in case management calls were generally delivered by the PCGS team on the phone or over video conference and the frequency depended on the patients' circumstances. Patients received more frequent calls at the start of the their engagement with PCGS, anywhere between once a week to once a month. As intended, the number and frequency of case management calls was flexible to meet patient needs, with all calls recorded on the patient's clinical record.

[33] Psychlops, 'Home', http://www.psychlops.org.uk/ (Accessed 27 May 2022)

Appendix E: Suggested updates to the PCGS logic model

What changes are needed to the logic model?

Reflecting on the evaluation findings, the logic model developed at the outset broadly remains fit for purpose. However, there are some refinements recommended to better reflect how the PCGS operates in practice and to improve the chances of achieving outcomes for patients and practitioners.

Assumptions

One of the assumptions of the logic model was that *"the PCGS team are able to engage primary care practitioners with gambling awareness raising activities and training on how to support gamblers".* As the GP outreach activity has not taken place as planned and has not been covered by this evaluation, this activity has been removed from the logic model. Once the outreach activity does begin, it will be important to develop an updated understanding of how this will work and what the intended outcomes are and reflect this in a revised logic model.

The assumption around *"Gamblers are not already aware of treatment or support options because if they were they may not see the need to access PCGS support"* needs to be refined to reflect the ongoing and holistic nature of a patient's support journey. We recommend that this assumption is rephrased to be *"Gamblers or affected others see the additional value and need to access PCGS support, even if they are aware or have previously accessed treatment or support for gambling harms."*

Another assumption that needs to be refined is around *"Gamblers can be reached by the PCGS referral pathways, and those that do have the 'right' needs for the PCGS".* There are two points of clarification here. Firstly, it has proved more challenging that anticipated to reach patients via the PCGS referral pathways. In relation to the second part of the assumption (that patients have the 'right needs'), the eligibility criteria for PCGS is an area that would benefit from further clarification. There is also recognition that patients have typically had more severe gambling harms that initially anticipated and there is a relatively high level of disengagement. It is therefore recommended that this assumption be refined as *"Patients can be referred to PCGS via the pathways established and are able to benefit from the support available."*

Activities and outputs

An activity that requires updating is *"eConsult gambling question with users directed to NGTS".* Whilst this was true before October 2021, since then, patients are signposted to the PCGS. So this has been updated to *"eConsult gambling question directs users to PCGS where possible within the confines of access to other GP clinical systems."*

It is recommended that the output of *"GamCare and Gordon Moody engage with PCGS and support service delivery"* is split into two and is currently conflates two slightly different concepts. It is recommended that the output is rephased to be *"GamCare and Gordon Moody engage in the referral and assessment processes within PCGS"*, as this reflects their role in referrals and decision-making around support patients receive, but does not include them in direct service delivery.

The evaluation also found that the activity around *"signposting to external treatment providers"* was not widely understood and does not reflect the integrated nature of PCGS delivery. Rather, this sits under the treatment types, with signposting an integral part of line worker support. Referrals to GPs, social prescribers etc. are also made under the treatment option of 'referral to lifestyle classes'. It is therefore recommended that the activity around external treatment providers is removed and the activity around treatment types is updated to *"Seven treatment types including signposting are available through PCGS, which can be provided face-to-face, online or over the phone."*

Throughout the logic model, *"patients"* has been updated to *"patients and affected others"* to reflect the role of PCGS in supporting affected others.

Outcomes

It is recommended that the short-term outcome of *"reduced time to first access support and receive treatment"* is separated into two outcomes. As the evaluation evidence has shown, waiting times and patient satisfaction can differ between referral and first contact from PCGS, and between first contact with PCGS and the start of specialist, external treatment. It was also noted that *"reduced"* time was not clearly understood. It is therefore recommended that the outcome be changed to 1) *"Patients are contacted by PCGS staff, in most cases, within seven days of being referred to the service"* and 2) *"Waiting times between PCGS mental health assessment and the start of specialist treatment are short and meet patient needs."*

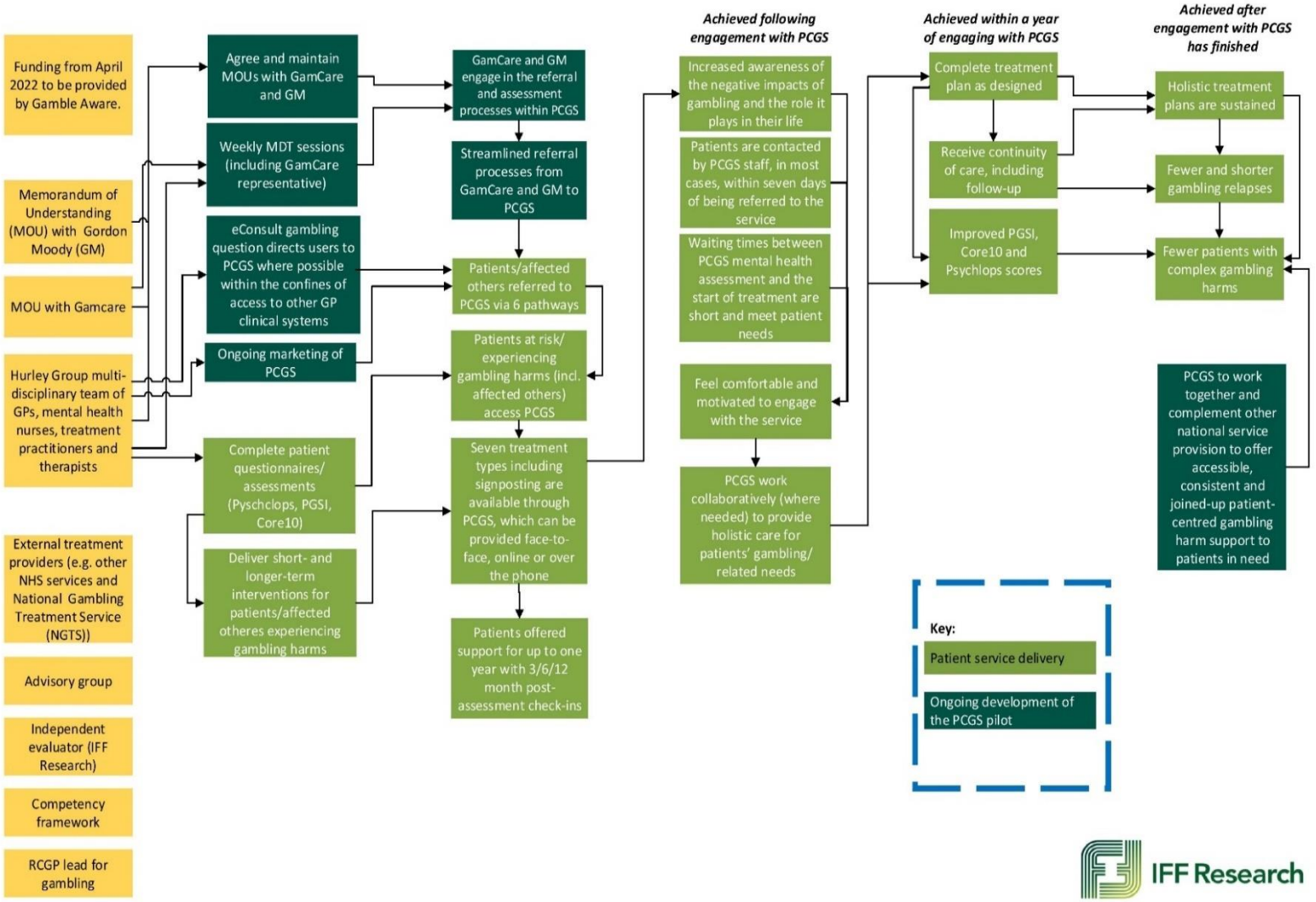
The other outcome which requires refinement is *"Receive holistic and integrated treatment of gambling/related needs."* The inclusion of the term integrated has become somewhat confused and rather than integrated, it is more about PCGS working collaboratively with other organisations to ensure patients receive the holistic support they require. It is therefore recommended that the outcome is re-worded to: *"PCGS work collaboratively (where needed) to provide holistic care for patients' and affected others gambling/related needs."*

It is also recommended that *"aftercare"* is rephased as *"follow-up support"* in the medium-term outcome around receiving continuity of care to reflect the language used by the PCGS staff.

The impact of *"development of an England-wide integrated service which offers accessible, consistent and joined-up patient-centred gambling harm support to patients in need"* is recommended to be re-phrased to reflect the need for PCGS and GambleAware to work together to clarify the PCGS offer and how it complements other national service provision. This impact has therefore become *"PCGS to work together and complement other national service provision to offer accessible, consistent and joined-up patient-centred gambling harm support to patients in need."*

An updated logic model is presented below. Any future changes to the PCGS should be reflected in a revised logic model.

PCGS updated logic model



Updated logic model assumptions:

- Gamblers or affected others see the additional value and need to access PCGS support, even if they are aware or have previously accessed treatment or support for gambling harms.
- PCGS treatment options are sufficient for the needs of gamblers referred and are an effective approach to addressing gambling harms amongst adults.
- The MOUs with GamCare and Gordon Moody operate as anticipated and support the delivery of the PCGS.
- Patients can be referred to PCGS via the pathways established and are able to benefit from the support available.

Appendix F: Improvements to the monitoring and evaluation of the PCGS

Building on the Patient Tracker

The current Patient Tracker is a great source of information for monitoring performance and evaluating the service. Going forward, PCGS should aim to tie any new developments to it to the logic model, and further refine the data fields and response options.

Another overarching recommendation for developing the Patient Tracker will be for the qualitative data to be coded into data that is suitable for quantitative analysis. The evaluation team did this for the purposes of the secondary analysis using the DRF specification[1], as a guide to aid comparison with the NGTS.

Other suggestions that the PCGS team may want to consider, include:

- Making it clearer when patients have received multiple treatments and who these have been provided by;
- Adding a column to evidence if patient treatment plans have been completed as designed;
- Adding a column to indicate if GamCare are involved in the patient's support and a separate column to indicate their role;
- Adding a column for initial point of contact by PCGS;
- Adding additional variables covering previous patient treatment and support, including (where available) dates of previous treatment, the treatment provider and the intensity of support would help to evidence PCGS' added value within the lifecycle of a patient's support journey;
- Making it clearer the final amount of support that a patient has received, as this will be important to understand the dosage of the intervention for future impact evaluation work;
- Making it clearer which stage of the PCGS journey the patient is currently in would help understanding of the volume of delivery;
- Adding a column to capture reasons for patient disengagement, where available, and having a separate columns to flag patient disengagement;
- Improving the formatting of the Patient Tracker spreadsheet, including formatting dates correctly and not combining qualitative and quantitative data in one cell.

[1] Jane Rigbye and Alan Jamieson, *GambleAware Data Reporting Framework: Specification*, (London: Responsible Gambling Trust, 2015)

Gathering patient feedback

PCGS and GambleAware should consider opportunities to incorporate regular monitoring of patient satisfaction and experience with the service delivered. This could be administered in the form of a short, paper, online or SMS/text patient satisfaction questionnaire or a therapist-administered verbal questionnaire. Opportunities for more in-depth topic-specific discussions with patients, should any particular successes or challenges highlighted by patients, need to be explored further.

Improving questionnaire completion and tightening up eligibility criteria

Experimental impact evaluation should be feasible in the future, once patient volumes increase. Considerations before this could be undertaken include:

- Improving completion of all assessment questionnaires (referral, midpoint, endpoint) and including unique identifiers for each patient;
- Establishing an appropriate comparison group, for example using DRF data. This could only be achieved with clear and consistent eligibility criteria;
- Less critical (at least at an early stage) is establishing consent to recontact patients for the purposes of evaluation and ideally by an external third party, and ensuring patient contact details are stored.

Appendix G: Evaluation tools

Patient topic guide

Patient Topic Guide (v1) Date 25/5/22

c.45-60 minutes Zoom/Telephone/Teams/ F2F

A Interview purpose and principles

A1 This guide is for use with one-to-one depth interviews with patients who are currently, or have previously been, supported by the PCGS. Interviews will take place between late January and March 2022.

A2 This research forms one strand of a pilot evaluation focusing on patients' experiences of PCGS. The research objectives and questions relevant for this audience are:

N°	Evaluation objectives	Research questions	Proposed approach
1	Understand the referral pathways and the enablers and barriers to each pathway referring patients into the service	• What is the profile of the patients referred from each of the referral pathways: GPs, Gambling Treatment Services: GamCare & Gordon Moody, eConsult, PCGS website and helpline? • What are the enablers and barriers to each referral pathway? • What lessons can be learned to help improve referrals, especially less serious gambling harms?	16 interviews with pilot patients
2	Understand patient journeys into (and where relevant) out of PCGS, and the enablers and barriers to a supported journey	• How do patients become aware of PCGS? • How do patients experience assessments? • How do patients experience treatment and support (including wider than PCGS)? • What do patient suggest to improve the accessibility and usefulness of the service?	16 interviews with pilot patients

A3 This guide is intended to be used with a mix of individuals with varying characteristics and backgrounds. As such, it does not contain pre-set questions, but rather lists the key themes and sub-themes to be explored with participants in each interview. Words or short phrases are instead used to indicate the study issues and allows the researcher to determine the formulation of questions and how to follow up. This encourages the researcher to be responsive to the situation and most crucially to the terms, concepts, language and behaviours used by the participants.

A4 It does not include comprehensive lists of follow-up questions like 'why', 'when', 'how', etc. as participants' contributions will be fully explored in response to what they tell us throughout in order to understand how and why views and experiences have arisen. The order in which issues are addressed and the amount of time spent on different themes will vary between interviews but the key areas for discussion are the same.

A5 Questioning and probing will be framed to ensure we understand participants' situations as they view them. Researchers will adapt the approach, as much as possible, to suit the needs of each participant. The prompts provided are not exhaustive, but rather indicate the types of content we would expect to be covered – this may vary across participants with different characteristics.

A6 The themes in this guide are intended to be covered across the patients taking part in this stage, rather than in detail in every interview.

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Safeguarding and interviewer wellbeing (please see separate Safeguarding document, saved here - \\iffdfs.iffresearch.com\FileServices\Secure Files\11619\Field\Common Files)

A7 75 minutes have been allowed for the interviews – this is to ensure patients have the time and space they need to discuss this potentially sensitive issue, including taking a break if they need to. Actual interviews are likely to last up to an hour. Not all patients will be able to answer, or speak in detail about every topic e.g., some patients will not remember completing the questionnaires or be able to distinguish between each of them, others who have just started receiving support/ treatment may feel they do not have much to say about outcomes. As such, interview lengths will vary and many are likely to be under an hour. In cases where patients are able to speak on each topic raised, interviewers will keep the interview length to a minimum by limiting probing around each question.

A8 Please protect 30 mins before each interview to engage with patient characteristics and consider how the guide will be used in that interview. Patient details can be found in the "PCGS Patient Tracker Anonymised" spreadsheet here \\iffdfs.iffresearch.com\FileServices\Secure Files\11619\Field\Common Files

A9 Please block at least 30 mins after the interview, to process what was learned and decompress if needed. These interviews are likely to be very difficult emotionally we need to ensure everyone is well-supported. The budget reflects this.

A10 Everyone who has a scheduled interview can (if they choose) have a named buddy for that day who can get in touch to ask how the interviewer is feeling, offer to have a chat to give the interviewer time to process what has been said.

B Researcher introduction (c. 5 mins)

B1 **Thanks & Introduction**: Introduce yourself and IFF Research – independent research agency

B2 **About the client**: GambleAware are a charity that funds gambling prevention and treatment services. They are also funding this research to better understand how the Primary Care Gambling Service (or PCGS for short) is running and how it might be helping those who are being supported by it.

B3 **About the research and purpose of the interview**: The purpose of this research is to understand your views and experiences of receiving support from the PCGS, what has worked well, what might have worked less well and how the service could be improved in the future.

B3a If patients ask for more detail, add: These discussions will help us to understand how people first learn about the service, how they engage with the service, what they like and dislike about it, and how, if at all, it has changed the way they feel or behave. This information will help us to make recommendations about how the PCGS could be improved in the future.

B4 **Anonymity and confidentiality**: Please be assured that anything you say during the interview will be treated in the strictest confidence and we won't include anything in any written documents that could be used to identify you.

B5 **How their information will be used**: IFF Research operates under the strict guidelines of the Market Research Society's Code of Conduct. Only the core members of the research team will have access to any of your details. We will not pass any of your personal details on to the client or any other companies and all the information we collect will be kept in the strictest confidence and used for research purposes only.

B6 **Right to data:** You have the right to have a copy of your data, change your data, or withdraw from the research at any point. You can find out more information about your rights under GDPR regulations by going to https://www.iffresearch.com/gdpr/. We can also email this to you if you'd like.

B7 **Reassurances:**

- Participation is voluntary – you do not have to take part.

- You can choose to take a break, stop the discussion or withdraw from the research at any time without giving a reason.
- There are no right or wrong answers – we are simply asking for people's views and opinions.
- It's really important that you are honest with us, so we can understand your experience of the service and if there is anything that could be improved.
- However, if I ask you anything that you do not feel comfortable answering, or don't have an answer to, that is absolutely fine, just let me know and we can move on.

B8 **Disclosure policy:** If we see or hear something which causes concern about your physical safety, we have a duty to act to make sure you are protected; for example, if you tell us something may cause significant harm to you or another person. If this was to happen, we would talk to you about what to do first – e.g. we would encourage you to talk to someone who can help, or agree that we would talk to support agencies on your behalf. That is the only exception. Otherwise, what you say will stay confidential.

B9 **Duration:** The interview should take between 45 and 60 minutes, depending on how much you have to say. We are happy to talk for longer if you prefer, so that you do not feel rushed. You may not feel you have a lot to say on each topic, or you may not want to talk about something, that is completely fine – please just let me know and we will move on.

B10 **Incentive:** As a thank you for your time, and for taking part, we will send you a £50 Amazon voucher. This can take up to 2 weeks.

B11 **Any questions/concerns?**

B12 **Reminder about audio recording**: the discussion will be recorded so that we can accurately capture their views, and so researchers can listen back when analysing the data. The recorder is encrypted and only the research team will have access to the recordings.[1]

B13 **Confirm happy to proceed** on this basis of information heard and recording.

B14 **Start recording:** acknowledge consent for being recorded.

[1] If using Zoom, remember to use a business account and save the recording to the cloud.

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C Participant introduction and warm-up (c. 5 mins)

Ask all:

To start off with, it would be great to hear a bit about you.

C1 **Whereabouts do you live?** What do you like about your area? Do you live alone or with others?

C2 **How do you typically spend most of your time?** E.g. work, caring responsibilities, hobbies.

D Initial service awareness and referral experience (c.15-20 mins)

Ask all:

Later on, we will discuss your experiences of being supported by the PCGS in more detail but first, it would be helpful to get an overview of how you first learned about the service.

D1 **How did you first hear about PCGS?**

- From whom, or what? (e.g., google, website, leaflet)
- Roughly when?
- Briefly, what was going on for you around that time?
  - Were you receiving any type or treatment or support at the time?
- What were you told about/ did you learn about the service at that time?
- What did you do after you first heard about the service? (e.g., talk to anyone about it, google it)

D2 **What were your initial thoughts about PCGS when you first heard about it?**

- How did it feel to be thinking about accessing support and treatment through the PCGS?
- What (if anything) appealed to you?
- What (if anything) did not appeal to you?
- What type(s) of support did you expect the service to provide?
- What (if any) questions or concerns did you have?
- What (if any) other information would have been useful at this stage?

D3 **In what ways, if any, did you expect PCGS to help you?** *Listen out for our intended outcomes below.*

- Help to reduce or stop gambling
- An increased understanding of gambling harms and behaviours
- Support with other personal challenges that impact gambling (e.g., physical or mental health problems, housing or financial issues)
- Opportunity to meet and speak with others who have had similar experiences with gambling

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- Improved wellbeing/ quality of life

D4 **So, you've learned about this service. What happened next?**

Note to interviewer – for info, the five pathways are:

1. *Direct referrals, available via the PCGS website and all information is recorded on EMIS, the clinical system used to record all episodes of care*
2. *Patient referral from the new screening question on eConsult*
3. *Self-referrals by the patient and/or family through the PCGS website*
4. *Self-referrals by the patient and/or family through the PCGS telephone (or via National Gambling Helpline if received out of hours 4pm to 8am)*
5. *Direct referrals by other support services, like GamCare or other agencies or services*

D5 **Can you briefly talk me through how you were referred to PCGS?**

- **Who referred you?**
  - through GP
  - self-referral
  - family referral
  - through other support services

D6 **Who else was involved at this point in time? What was their involvement?**

D7 **What was involved in that referral process?**

- Information shared/requested
- Extent of involvement in this
- Anything else?

D8 **How involved in the decision to be referred were you?**

- To what extent did you feel you had a choice about whether to use the service?

D9 **How did you find this process? What went well/ less well?**

- What, if anything, put you off participating? (e.g., time commitment, type of support offered, not having enough information)
- What, if anything, made it difficult for you participate? (e.g., time, support from friends and family, concerns about the service)
- What additional information would you have liked to know at this stage?
- What, if any, worries or concerns did you have at this stage? What helped (or could have helped) to reassure you?

D10 If not yet covered: **Why did you agree to be referred?**

D11 **Are you currently being supported by PCGS in any way?**

- If yes:
  - How long have you been supported by PCGS?
  - What treatment/support are you receiving?

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- If no:
  - How long were you supported by PCGS?
  - When did you last receive support from PCGS?

E Experience of questionnaires (c. 10 mins)

Note to interviewer: for info, there are three questionnaires that are used to assess patients upon referral to the service: DO NOT PROMPT

1. *Core10 – a validated monitoring tool covering anxiety, depression, trauma, physical problems, functioning and risk to self. Patients are asked to self-assess ten different aspects of mental distress over the past week.*
2. *PGSi – the Problem Gambling Severity Index is the standardised measure of at risk behaviour in problem gambling. Patients are asked to self-assess their gambling behaviour over the past 12 months by scoring themselves against nine questions.*
3. *Psychlops – a mental health outcomes measure tool used in primary care or community care settings and is self-completed. It measures mental health problems, quality of life, social functioning, and wellbeing, primarily by asking patients to define and assess the severity of problems they face. It is not yet validated but is increasingly used in the gabling support sector. It can be used before, during and after the course of any psychotherapeutic intervention.*

Ask all:

I'd now like to talk about what happened after you were referred to the service and you decided to engage with the service.

(If needed) **Are you happy to continue talking to me? Please let me know at any point if you have any questions for me or would like to take a break.**

E1 **Can you tell me about what happened next?**

E2 **What communication, if any, did you have with PCGS at this stage?**

- From whom? Was this the same each time?
- Through what channels? (e.g., email, phone, letter)
- What was the nature of this communication?
- How did you feel about this communication?
- What, if anything, made it difficult for you to communicate with PCGS?
- Did you have any communication with anyone else at this stage? If so, who? (e.g., GP, other services, family, friends)

Note to interviewer – the aim of this E3 is to gain an understanding of which of the three questionnaires the patient has completed, so that we can then ask specifically about each after. Listen out for clues as to which questionnaires they recall completing, as patients are unlikely to remember/ refer to the names. Some patients may have very little to say in this section.

E3 **Do you recall completing any questionnaires?**

- How many did you complete?
- What do you recall about what was asked – what kinds of questions did these include?
- How did you complete them? (e.g., online, paper copy)

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- Did you complete them by yourself or with someone else? Who? (e.g., with someone from PCGS, with a family member or friend, with your GP)

If needed:

- Do you recall completing a questionnaire with 10 questions that asked about different aspects of your mental distress over the past week? (Core10)
- Do you recall completing a questionnaire with 9 questions that asked about your gambling behaviours over the past 12 months? (PGSi)
- Do you recall completing a questionnaire which involved writing about and scoring problems that you experience in your life? (Psychlops)

Ask for each questionnaire they recall completing

E4 **Overall, how did you find completing this questionnaire?**

- How easy or difficult did you find it to complete it?
- What would have made it easier for you?
- How did you find completing it online/ over the phone/ face-to-face?
- How else would you have preferred to complete it?
- Roughly how long after being referred did these take place? How did this compare to your expectations?
- Before you started completing it, how clear was it to you what the assessment would involve?
- What kind of information were you given about the questionnaire? By whom?
- What other information, if anything, would you have liked at this stage?

Ask if mentioned completing the questionnaire by themselves:

- How did you find this?
- Would you have preferred to have someone with you? Who?

Ask if mentioned completing the questionnaire with someone else from PCGS/ other clinical professional:

- How did you find it completing the questionnaire with this person?

Ask if mentioned completing the questionnaire with a family member or friend:

- How did this help you?
- How clear was it what the next steps would be?
- What, if anything, could have improved your experience of completing this questionnaire?

F Treatment experiences (c. 10-15 mins)

Note to interviewer – for info, the support/ treatment offered are:

- *Line worker support*
- *F2F or online Cognitive Behavioural Therapy*
- *Referral for psychoanalytic psychotherapy*
- *Referral for lifestyle classes*

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- *Group therapy*
- *Referral to National Problem Gambling Clinic*

Participant is likely to use their own language to describe these.

Note to interviewer – some patients may have very little to say in this section, if, for example, they have only just started receiving support/ treatment. Therefore, expect that for some patients, this section will take less time than indicated.

Ask all:

I'd now like to talk about your experience of any support or treatment you have had through PCGS so far.

If needed: **Are you happy to continue talking to me? Please let me know at any point if you have any questions for me or would like to take a break.**

F1 **What support or treatment do you recall being offered through PCGS?**

- By whom? When?
- What was offered?
- What were your initial thoughts?

F2 **Can I briefly check what treatment/ support you have had through the PCGS so far? PROMPT IF NEEDED**

- Therapy (individual or group, Cognitive Behavioural Therapy or psychotherapy)
- Support from a link worker
- Lifestyle classes
- Peer support
- Medication

For each type of treatment/ support described, explore:

Experience:

- Broadly, what was involved in this support?
    - How far into the support are you?
- How was the support introduced/explained to you?
- How soon after referral did this support start, roughly?
- How does that timescale compare with your expectations?
- Who provided the treatment/ support?
- Who else, if anyone, was involved in the treatment (e.g. other patients in peer support)
- How was the support provided? (e.g., online, face to face, combo)
    - How did you find this format?
    - How appropriate was it for your needs?

Views and suggestions:

- What additional information, if anything, would you have liked?
- What did you like/ dislike about it?

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- What, if any, has stopped you engaging in with this treatment/ support?
- How appropriate did it feel for you? Was it specific enough to your circumstances?

Ask of those who received both online and face to face support/ treatment:

F3 **Were there any differences between the support/ treatment you received online vs face-to-face?**

- What worked well/ less well?
- Which format did you find more appropriate for your needs?
- What did you find helpful/ unhelpful about these formats?

Ask all:

F4 **Whilst receiving the support/ treatment we just discussed, did you have to repeat your personal circumstances/ story to different people?**

- How did you find this?
- How confident did you feel that your personal circumstances and medical information were being treated confidentially?

G Follow-up check-ins after treatment (c. 5 mins)

Ask only to those who have completed any support/treatment:

G1 If needed: **check whether patient has completed any PCGS treatment.**

G2 **How did you know your treatment was concluding?**

- What were you told?
- How/who told you that?
- How did you feel at this time?

G3 **What has happened since your treatment concluded?**

- Whether received any information/communication from PCGS
  - What/from who?
  - What did it involve?
- Views on any information/communication received
  - How did/do you feel about this?
  - Overall, was it positive, negative or neither?
  - Like/dislike about this stage?
  - What, if any, has stopped you attending these follow up or check-in appointments?

H Outcomes of PCGS (c. 10-15 mins)

Note to interviewer – below is the list of intended patient outcomes. DO NOT PROMPT, these are for information only

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1. *Reduced time in first accessing support*
2. *Reduced times b/w assessment& receiving treatment*
3. *'Travel' shorter distance to access support*
4. *Understand service is confidential*
5. *Aware of negative impacts of gambling*
6. *Holistic treatment of gambling/related needs*
7. *Complete 8 therapy sessions*
8. *Receive continuity of care, incl. aftercare*
9. *Reduced PGSI & Core10 scores, and improved Psychlops scores*
10. *Deliver peer support*

Note to interviewer – some patients may have very little to say in this section, if, for example, they have only just started receiving support/ treatment. Therefore, expect that for some patients, this section will take less time than indicated.

Ask all:

Now I would like to ask you about how taking part in PCGS has affected you.

If necessary: **for patients still in PCGS, it may be too early to say in which case focus on how you anticipate being affected by the service.**

H1 **How has your engagement with PCGS affected you?**

For each effect mentioned, explore:

- Description of the effect
- If unclear: quality of effect e.g. positive/negative
- Relevance of effect to their needs at the time
- Importance of the effect to the participant
- What they think brought about the effect (listen out for features of PCGS e.g., follow up check-ins, online therapy, ease of referral from GP).
    - The type of treatment?
    - The way it was delivered?
    - Ease of access?
    - Who it was delivered by?
    - The frequency?
    - Knowledge that the service is confidential?

I Final comments and wrap-up / participant care (c. 5 mins)**Ask all:**

I1 **What are your suggestions for improving the service?**

- How could the service be made more impactful for you, or others like you?
- How could the service be made easier to access for others?

I2 **Any final comments or recommendations**.

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I3 Thanks, and reminder of confidentiality and anonymity and that they can get in touch if they think of anything else that is important to evaluate and improve the service.

I4 **Incentive** – can I just double check that we have the correct email address to send this to?

Note to interviewer – read out email address from the recruitment spreadsheet and mark in the incentive column whether or not this is correct.

I5 **Ensure participants leave the interview in a good state:** Thank them for their time; emphasise the importance and value of the research in helping to improve support and services for other people

I6 If necessary: check in on how they are feeling. As needed – let them chat for a bit: What are they doing later, do they have anyone to talk to. (They can call Samaritans on 116 123)

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Stakeholder topic guide

Stakeholder Topic Guide (v1)
c.45 minutes

Date 16/6/22
Zoom/Telephone

A Interview purpose and principles

A1 This guide is for use with one-to-one depth interviews with key stakeholders involved in the delivery of PCGS: Hurley Group stakeholders delivering the service and Gordon Moody and GamCare stakeholders involved primarily in referring patients into the service. Interviews will take place in January 2022.

A2 This research forms one strand of a pilot evaluation focussing on the implementation of the PCGS from the perspectives of the different stakeholders who have been involved in delivering the pilot thus far. The research objectives and questions relevant for this audience are:

Nº	Evaluation objectives	Research questions	Proposed approach
1	Understand the referral pathways and the enablers and barriers to each pathway referring patients into the service	• What is the profile of the patients referred from each of the referral pathways: GPs, Gambling Treatment Services: GamCare & Gordon Moody, eConsult, PCGS website and helpline? • What are the enablers and barriers to each referral pathway? • What lessons can be learned to help improve referrals, especially less serious gambling harms?	• 3 interviews with GamCare stakeholders (unchanged) • 2 interviews with Gordon Moody stakeholders (new) • 7 interviews with Hurley Group stakeholders (expanded from 5)
2	Understand patient journeys into (and where relevant) out of PCGS, and the enablers and barriers to a supported journey	• How do patients become aware of PCGS? • How do patients experience assessments? • How do patients experience treatment and support (including wider than PCGS)? • What do patient suggest to improve the accessibility and usefulness of the service?	• 15 patient interviews (unchanged) – sample to be discussed, though likely to include one of the affected others and at least 2 patients who have left the service
4	Understand the implications of the model for future delivery, to shape GambleAware's wider understanding around primary care interventions	• Were other approaches considered for the pilot and if so, what can we learn from those? • What are the key considerations for: - Sustainability of the programme - Growing the model -'Replicating' the model elsewhere	• 12 qualitative interviews with Hurley Group, GamCare and Gordon Moody

A3 This guide is intended to be used with a mix of individuals with varying characteristics and backgrounds. As such, it does not contain pre-set questions, but rather lists the key themes and sub-themes to be explored with participants in each interview. Words or short phrases are instead used to indicate the study issues and allows the researcher to determine the formulation of questions and how

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to follow up. This encourages the researcher to be responsive to the situation and most crucially to the terms, concepts, language and behaviours used by the participants.

A4 It does not include follow-up questions like 'why', 'when', 'how', etc. as participants' contributions will be fully explored in response to what they tell us throughout in order to understand how and why views and experiences have arisen. The order in which issues are addressed and the amount of time spent on different themes will vary between interviews but the key areas for discussion are the same.

A5 Questioning and probing will be framed to ensure we understand participants' situations as they view them. Researchers will adapt the approach, as much as possible, to suit the needs of each participant. The prompts provided are not exhaustive, but rather indicate the types of content we would expect to be covered – this may vary across participants with different characteristics.

A6 The themes in this guide are intended to be covered across the stakeholders taking part in this stage, rather than in detail in every interview.

A7 For any specialist terms used, please prompt for definitions.

B Researcher introduction (c. 5 mins)

B1 **Thanks & Introduction**: Introduce yourself and IFF Research – independent research agency

B2 **About the client**: GambleAware are funding this Pilot Evaluation of the PCGS

B3 **About the research and purpose of the interview**: The purpose of this pilot evaluation is to understand how the service has been implemented. The focus of the discussion will be about your experiences of the PCGS and views on lessons learned for delivery.

B3b *If stakeholders ask for more detail, add*: Insight from these discussions will enable us to understand how each of the PCGS's referral pathways are working (or not), identify the enablers and barriers to each, understand outcomes for patients thus far, understanding outreach work, and make recommendations for improving the future delivery of the PCGS.

B4 **Anonymity and confidentiality**: Please be assured that anything you say during the interview will be treated in the strictest confidence and results will be anonymised in any reporting. However, as few people are involved in the service, it may be possible for someone who knows you to identify you from your comments.

B5 **How their information will be used**: IFF Research operates under the strict guidelines of the Market Research Society's Code of Conduct. Only the core members of the research team will have access to any of your details. We will not pass any of your personal details on to the client or any other companies and all the information we collect will be kept in the strictest confidence and used for research purposes only.

B6 **Right to data:** You have the right to have a copy of your data, change your data, or withdraw from the research at any point. You can find out more information about your rights under GDPR regulations by going to iffresearch.com/gdpr. We can also email this to you if you'd like.

B7 **Reassurances:** No right or wrong answers - we are simply asking for people's views and opinions; you may not know or have a view on something – just let me know and we can move on; comfort – let me know if you'd like a break at any time.

B8 **Duration:** Up to 45 minutes. Check that still suits them.

B9 **Health warning:** We have a lot to cover in the interviews and we are conscious of not taking too much of your time, so at points we may have to move the discussion along to ensure we cover everything.

B10 **Reminder about audio recording**: the discussion will be recorded so that we can accurately capture their views, and so researchers can listen back when analysing the data. The recorder is encrypted and only the research team will have access to the recordings.[1]

B11 **Confirm happy to proceed** on this basis of recording.

B12 **Any questions/concerns?**

B13 **Start recording:** acknowledge consent for being recorded

[1] If using Zoom, remember to use a business account and save the recording to the cloud.

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C Participant introduction (c. 5 mins)

ASK THOSE WHO HAVE NOT PREVIOUSLY BEEN INTERVIEWED

C1 **Roles and responsibilities**

- About their **role**, incl. responsibilities, outside PCGS
- **Any other roles related to their work at PCGS** e.g. advisory, volunteer
- **Role/responsibilities** in relation to **PCGS** ***(****Interviewer note whether they are directly involved in the referral process)*

C2 **Briefly, how they became involved in PCGS**

- How did they first hear about the PCGS?
- What were their first impressions of the service?
- What were they expecting from it?

ASK PREVIOUSLY INTERVIEWED PARTICIPANTS

C3 **Whether/how their role and responsibilities** with PCGS **have changed** since we last spoke to them last year

ASK ALL

C4 **Brief overview of their experience with the PCGS to date, explaining the rest of the interview will discuss their experiences in detail**

- How they would describe their experience in a few sentences
- One key success from their perspective
- One key challenge from their perspective

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D Referral pathways (c. 15-25 mins)

Note to interviewer: Explain a core objective of our work is to understand the different referral pathways into the service and how they are working. Go through each of the five referral pathways in turn, as relevant for the stakeholder; not all stakeholders will be familiar with all pathways. For info, the five pathways are:

1. *Direct referrals, available via the PCGS website and all information is recorded on EMIS, the clinical system used to record all episodes of care*
2. *Patient referral from the new screening question on eConsult*
3. *Self-referrals by the patient and/or family through the PCGS website*
4. *Self-referrals by the patient and/or family through the PCGS telephone (or via National Gambling Helpline if received out of hours 4pm to 8am)*
5. *Direct referrals by other support services, like GamCare or other agencies or services*

ASK ALL

D1 **What referral pathways are you involved in**

- Briefly describe role in that/those pathways

ASK SENIOR PARTNER and LEAD GP

D2 **Explore whether criteria for patients accessing PCGS has changed in the last year**

- Inclusion criteria
- Exclusion criteria

Note to interviewer: discuss each pathway in turn and as relevant to the stakeholder, based on their response above. Share screen with participant to show SHOWCARD 1: referral pathways

1. **Direct referrals through PCGS website**

ASK HURLEY GROUP PARTICIPANTS WHO ARE INVOLVED IN THE REFERRAL PROCESS

- Overall, how well does the direct referral process through the website work
  - Quality/accuracy of EMIS recorded info
  - Barriers to successful referrals
- What is the profile of the patients from direct-referrals – any particular 'types' of person, any differences between other referral methods (e.g. more/less engaged with the treatment process)
- Any differences in patient outcomes between direct referrals and other referral methods
- What lessons have you learned about direct referrals through the website

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2. Patient referral through eConsult

ASK HURLEY GROUP PARTICIPANTS WHO ARE INVOLVED IN THE REFERRAL PROCESS

NB. eConsult question is: 'In the last year have you bet more than you can afford to lose? Or has someone in your household bet more than they could afford to lose?'

- Overall, how well does the one eConsult question work in identifying people in need of PCGS support?
  - Whether question phrasing has changed
  - Whether eConsult referrals translate to service referrals
  - Barriers to this type of referral
- What patient trends, if any, have you noticed with patient referrals through eConsult?
- How do patients respond to being referred via a screening question? Any differences in engagement level / uptake versus other pathways?
- What lessons have you learned about eConsult referrals

3. Self-referral through PCGS website

ASK HURLEY GROUP PARTICIPANTS WHO ARE INVOLVED IN THE REFERRAL PROCESS

- Overall, how well does the self-referral process through website work?
- What patient trends, if any, have you noticed with patients who self-refer through website?
- Any differences in patient outcomes between website self-referrals and other referral methods
- What lessons have you learned about referrals through the website

4. Self-referral through PCGS telephone or National Gambling Helpline

ASK HURLEY GROUP PARTICIPANTS WHO ARE INVOLVED IN THE REFERRAL PROCESS

- Overall, how well does the self-referral through the phone work
- What patient trends, if any, have you noticed with patients who self-refer?
- Any differences in patient outcomes between self-referrals through phone and other referral methods
- What lessons have you learned about referrals through the telephone/helpline

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5. Direct referrals through GamCare and Gordon Moody - PRIORITY

ASK LEAD GP, DIRECTOR OF OPERATIONS & MENTAL HEALTH NURSE

- Explore understanding of their agreement with GamCare and Gordon Moody
- Explore expectations of working with them, generally
- Explore expectations of how referrals from them into PCGS would work
- Explore whether/how expectations of working with them, generally, were met
- How does the referral process work in practice
  - How is it decided whether a patient is referred
  - Who is involved in referral decision making
  - Whether/how a patient is involved in the referral decision making
  - Once decided, who actually does the referral
  - Timescales involved in referral decision making and actual referral
  - What information is captured in the referral to PCHS
  - How is that information stored
  - How is information shared with PCGS
  - Whether/how do you know what has happened with the patient after the referral
- Overall, how well does the referral process work
- Lessons learned for improving referrals into PCGS

ASK GAMCARE AND GORDON MOODY

- Explore understanding of their agreement with Hurley Group
- Explore expectations of working with PCGS, generally
- Explore expectations of referring patients into PCGS
- Explore whether/how expectations of working with PCGS, generally, were met
- Approximately how many referrals made to date
- What is the profile of the patients referred
- How does the referral process work in practice
  - How is it decided whether a patient is referred
  - Who is involved in referral decision making
  - Whether/how a patient is involved in the referral decision making
  - Once decided, who actually does the referral
  - Timescales involved in referral decision making and actual referral
  - What information is captured in the referral to PCHS
  - How is that information stored
  - How is information shared with PCGS
  - Whether/how do you know what has happened with the patient after the referral
- Overall, how well does the referral process work through each partner
  - Whether duplication of roles/responsibilities
    - If so, how it can be avoided
- Lessons learned for improving referrals into PCGS

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ASK ALL

D3 **Overall, which pathway is most/least effective at identifying patients; reasons**

- Reasons related to COVID
- Other reasons separate to COVID

D4 **What lessons have been learned to support referrals**

- For any referrals
- For referrals of patients with less serious gambling harms, specifically
- If they could go back in time, what one change (other than covid!) would they make to their referral process

E Patient assessments (c. 10 mins)

ASK HURLEY GROUP PARTICIPANTS WHO ARE INVOLVED IN ASSESSMENTS

E1 **Can I just check, are you involved in conducting assessments?**

E2 **Explore how PGSI, Core10 and Psychlops assessments are working together**

- Please describe the process for conducting these – how each work
- How well is the 7 day target for conducting the initial assessment working
- How do assessment results come together
- How are assessments used by PCGS practitioners to monitor patient progress
- Whether/how they complement or contradict each other
- What is working well/less well

E3 **How do patients experience each assessment? For each, explore:**

- Ease of understanding what assessments are asking e.g. questions on what they mean/are asking
- Ease of completion e.g. length of time; any sense of duplication?

F Patient treatment (c. 5 mins)

ASK PARTICIPANTS WITH KNOWLEDGE OF PATIENT TREATMENT

F1 **Can I check, are you familiar with treatments being offered?**

F2 **What treatments are more/less offered now, reasons?**

- Line worker support
- F2F or lonline CBT
- Referral for psychoanalytic psychotherapy
- Referral for lifestyle classes
- Group therapy
- Referral to National Problem Gambling Clinic

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F3 **How does provision compare to expectations of treatment offered when PCGS launched?**

- Whether/how provision differs
- Reasons they think provision differs

F4 **Under what circumstances are remote treatment or in-person treatment more/less effective**

F5 **Whether/what feedback have patients shared about their treatment experience**

G Implications of the model for future delivery (5 - 10 mins)

ASK SENIOR PARTNER, LEAD GP AND DIRECTOR OF OPERATIONS

G1 **Understand whether alternative models or activities were considered**

- Before the PCGS, did you consider any other models for treating those suffering gambling harms?
  - If yes,
    - What were these
    - Why were they ruled out
    - What lessons, if any, did you take from these for PCGS design?
  - If no, why did you think the model, in its current form, was most appropriate?

ASK SENIOR PARTNER AND CLINICAL PSYCHIATRIST ONLY

G2 **Explore the rationale for Naltrexone's introduction**

- Why was Naltrexone introduced as a treatment option?
- How does Naltrexone complement other PCGS treatment options?

ASK ALL

Interviewer read out: Thinking about your recommendations for improving the future delivery of the PCGS:

G3 **What key considerations or principles would be needed to sustain the model as it currently is?**

- Who would need to be involved in delivery?
- What kind of knowledge, skills or expertise would they need?
- What resources would be required?
- Any other requirements?

G4 **What would be needed to expand and grow the PCGS beyond the pilot area?**

- Who would need to be involved in delivery?
- What kind of knowledge, skills or expertise would they need?
- Who would need to be involved in a larger-scale partnership? (What type of person / organisation?)

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- Who else would ideally need to be on board? E.g. for engagement / outreach?
- What resources would be required? Who should provide these?
- What kind of timescales would be realistic, e.g. to set up, for outreach activities etc?
- Any other requirements?

H Final comments and wrap-up (c. 2 mins)

H1 If you could give your past self one piece of advice about PCGS, what would it be?

H2 **Any final comments or recommendations**

H3 Thanks, and reminder of **confidentiality and anonymity** and that they can **get in touch** if they think of anything else that is important to evaluate and improve the service

H4 If necessary, briefly mention next steps

Online GP Survey Questionnaire

S Landing page

Thank you for participating in this research. Your input is valuable and will help gambling harm treatment and prevention services better support patients at risk from gambling harms.

The survey should only take around 5 minutes to complete.

When completing the survey, please only use the 'next' button on the page, rather than the 'back' and 'forward' buttons in your browser.

You can pause the survey at any time by clicking on the pause symbol at the bottom of the screen, and can re-enter by clicking on the link again.

Thank you again for taking the time to participate.

To begin the survey please click 'Next'.

B Awareness of gambling support services

DISPLAY TO ALL

Firstly, we would like to ask about gambling support services in your area.

ASK ALL

B1 **To what extent do you agree or disagree with the following statements?**

ROTATE STATEMENTS. SINGLECODE.

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't Know
_1 I am aware of the **gambling harm treatment and prevention services** for patients in my area	1	2	3	4	5	6
_2 I have enough information about the **gambling harm treatment and prevention services** in my area	1	2	3	4	5	6

ASK ALL

B2 **How well, if at all, do you feel you know about the services which each of the following organisations offer? Please read the statements below and tick one answer on each row.**

ROTATE STATEMENTS. SINGLECODE.

	Know very well	Know a fair amount	Know just a little	Heard of but know almost nothing about	Never heard of	Don't Know
_1 Gordon Moody	1	2	3	4	5	6

	Know very well	Know a fair amount	Know just a little	Heard of but know almost nothing about	Never heard of	Don't Know
_2 GamCare	1	2	3	4	5	6
_3 The Primary Care Gambling Service	1	2	3	4	5	6
_4 National Gambling Treatment Service	1	2	3	4	5	6
_5 Gamblers Anonymous	1	2	3	4	5	6
_6 GambleAware	1	2	3	4	5	6

ASK ALL

B3 **Since you became a GP, have you ever taken part in any gambling harm awareness training or accessed resources to better equip you to offer solutions to your patients in need?**

SINGLECODE

Yes	1	
No	2	
Don't know	3	
Prefer not to say	4	

C General Views

DISPLAY TO ALL

The next questions are about your perceptions and experiences of helping patients at risk of, or experiencing, gambling harms in primary care.

ASK ALL

C1 **To what extent do you agree or disagree with the following statements? Please read the statements below and tick one answer on each row.**

ROTATE STATEMENTS. SINGLECODE.

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't Know
_1 It is my responsibility as a GP to discuss gambling harms with patients	1	2	3	4	5	6
_2 I know what questions to ask patients about gambling behaviour	1	2	3	4	5	6
_3 I am able to recognise the signs of gambling harms among patients	1	2	3	4	5	6
_4 Helping patients with gambling harms is a low priority given other pressures on primary care	1	2	3	4	5	6
_5 I am confident initiating conversations about gambling harms with patients	1	2	3	4	5	6

ASK ALL

B2 **What challenges, if any, do you currently experience in responding to the needs of patients at risk of, or experiencing, gambling harms?** OPENEND

WRITE IN		
Don't know	1	

D The Primary Care Gambling Service

DISPLAY TO ALL

The next questions aim to gather your views specifically on the Primary Care Gambling Service (PCGS).

PCGS is a primary care-based pilot service in South East London for adults aged 18 or over experiencing harm from gambling. It integrates primary care and third sector support to provide accessible, consistent and whole-patient focussed support to gamblers. Specifically, PCGS aims to:

1. **Improve awareness in primary care of how problem gamblers can present, support practitioners in identifying gamblers using validated questionnaires and improve practitioners' knowledge of the support available for gamblers;**

2. **Treat gamblers through pharmacological, psychological and peer group interventions.**

In time, the PCGS hopes to offer its service to more areas.

ASK ALL

D1 **To what extent do you agree or disagree that there is a need for a service like the PCGS in your area?**

SINGLECODE

Strongly agree	1	
Tend to agree	2	
Neither agree nor disagree	3	
Tend to disagree	4	
Strongly disagree	5	
Don't know	6	

ASK ALL

D2 **To what extent would you be likely to refer patients to the Primary Care Gambling Service (PCGS), if it was possible to do so in your area?**

SINGLECODE

Very likely	1	
Fairly likely	2	
Not very likely	3	
Not at all likely	4	
Don't know	6	

ASK ALL

D3 **What, if anything, would prevent you from referring a patient to the PCGS? Please let us know in the box below.**

OPENEND

WRITE IN		
Don't know	1	

ASK ALL

D4 **What, if anything, would make it easier for you to identify and refer patients to the PCGS? Please let us know in the box below.**

MULTICODE

Information about how the service could benefit my patients	1	
Having supporting information I could provide to patients	2	
Information on how to refer a patient into the service	3	
Support with identifying patients at risk of or experiencing gambling harms	4	
Support with discussing gambling harms with patients	5	
Other (WRITE IN)	6	
Don't know	7	

DISPLAY TO ALL

The survey is now finished. Please click on the submit button below to complete the survey.

Thank you for taking the time to share your views with us.

If you would like to learn more about the Primary Care Gambling Service, visit www.primarycaregamblingservice.co.uk

If you would like to learn more about gambling harms and how to support your patients, visit www.begambleaware.org/for-professionals

Appendix H: Document review and reference list

Documents reviewed as part of the scoping stage

PCGS November 4 Final

This document outlines the PCGS service (including need, rationale and objectives), reflects on progress, achievements, challenges and learnings from the first 12 months of the service.

RCGP presentation slides ER 15.10.2021 v6

This document is a presentation that was delivered to the RCGP in October 2021. The presentation largely reflects the content of the PCGS November final document (therefore only additional points are noted in this row). It outlines the terminology and statistics relating to problem gambling and gambling related harms. It describes the main aims of PCGS, the referral pathway and the goal to educate primary care workforce. It also describes the profiles of current patients and at risk populations, as well as existing treatment clinics.

Gambling Competency Framework

This document presents the PCGS framework for delivering medical and non-medical support to problem gamblers. The document is co-authored by GambleAware, RCGP, RCPsych, GamCare, the Gordon Moody association and others.

Discussion paper for referrals from GamCare to PCGS

Summary of discussion points for a meeting about the referral pathway from GamCare to PCGS.

Did Not Attend policy SF 20201130 Final

Policy document outlining the standard procedures for PCGS staff in cases that patients disengage from PCGS services.

Naltrexone SOP

This document describes the use of Naltrexone - an opioid reception antagonist - which inhibits a surge of endorphins after opioid and alcohol use, prescribed for relapse prevention in formerly opioid-dependent patients. The document discusses the proposal for the use of Naltrexone in problem gambling.

PCGS Patient Tracker empty ONGOING no PID (personally identifying data)

This excel spreadsheet is a PCGS Patient Tracker template, containing no data other than the column headings.

Wider reference list

Roberts A et al (2017) Gambling and negative life events in a nationally representative sample of UK men.

Public Health England (2019) Gambling-related harms: evidence review

Griffiths MD. (2007) Gambling addiction and its treatment within the NHS: A guide for healthcare professionals. London: British Medical Association

Gunstone B et al (2021) Annual GB Treatment and Support Survey 2021 on behalf of Gamble Aware

GambleAware (2015) Data Reporting Framework Specification

Appendix I: Patient Tracker coding framework

Framework created to code the qualitative data in the Patient Tracker to enable comparative analysis with the DRF. The codeframe was created using the DRF spec as a basis.

J11619 Secondary Analysis RSerial		Patient Tracker
Q1		**Gender**
	0	Not known
	1	Male
	2	Female
	3	Transgender
	4	Not stated (person asked but declined to provide a response)
Q10		**Suicide Risk on assessment**
	1	Already has support in place
	2	Disengaged from service
	3	High risk - has suicidal thoughts
	4	Low / no risk
	5	TBC as still in therapy / awaiting therapist feedback
	6	Other
Q11		**Suicide risk post intervention**
	1	Disengaged from service
	2	Low / no risk
	3	TBC as still in therapy / awaiting therapist feedback
	4	Other
Q12		**Learning Disability/Autism/ ADHD**
	1	No - patient reported no diagnosis
	2	Yes - ADHD / Autism / Learning Disability
	3	Other
	4	Unknown
Q13		**Physical Health Issues**
	1	No - patient reported no physical health issues
	2	Yes - Chronic / long term health condition e.g. HIV, Diabetes, Epilepsy, Hyperthyroidism, Cardiothoracic conditions, Asthma etc
	3	Yes - Mental Health / Behavioural issues e.g. Gynaecomastia, eating disorders, depression, anxiety, alcoholism, trauma
	4	Yes - Mobility / dexterity issues e.g. Arthritis, spinal stenosis, knee issues, Sciatica
	5	Yes - other health issues / unspecified
	6	Yes - physical disabilities e.g. deaf, blind
	7	Unknown
Q14		**Social Problems**
	1	Criminal record / previous offender
	2	Debt / financial difficulties

	3	Mental health / behavioural issues e.g. anxiety, depression, trauma, anger issues, learning disability
	4	Minimised social contact / living alone
	5	No - no identified social problems
	6	Relationship difficulties / breakdown
	7	Unemployment / impacting employment
	8	Disengaged from service
	9	Other
Q15		**Significant life events**
	1	Adulthood abuse, assault or other trauma e.g. stalked
	2	Bereavement - partner, child, family, close friend
	3	Childhood abuse, assault, neglect or other trauma e.g. bullying
	4	Childhood family breakdown / displacement e.g. placed into foster care / adopted
	5	Developed / diagnosed with mental illness e.g. Agoraphobia, eating disorder, anger issues, depression, PTSD
	6	Employment disruption e.g. made redundant, fired, changed jobs
	7	Homeless / lived in temporary accommodation / supported housing
	8	Incarceration / charged with criminal activity / social services investigations
	9	Moved home / to a new city / country
	10	No - no significant life events identified / disclosed
	11	Relationship breakdown / difficulties
	12	Self-harm / attempted suicide
	13	Serious illness / disability / injury
	14	Substance abuse / addictions
	15	Trauma - unspecified / other
	16	Other
	17	Don't know
Q16		**Employed/Benefits.**
	1	Employed
	2	Unemployed
	3	Student
	4	Sick-disabled
	5	Homemaker
	6	Not seeking work
	7	Prison-care
	8	Volunteer
	9	Retired
	99	Not stated
Q17		**Children**
	1	Yes
	2	No
	3	Unknown
Q18		**Relationship**
0.00a		Not known
	1	Divorced
	2	Separated
	3	Single
	4	Widowed

	5	In relationship
	6	Married
9.00a		Not stated
Q19		**Type of Therapy/Intervention Identified**
	1	CBT
	2	Counselling
	3	Residential Programme
	4	Brief advice
	5	Psychotherapy
	6	Other
	7	Case management
	8	Disengaged from service
Q2		**Ethnicity**
0000A		White British
0000B		White Irish
0000C		White European
0000D		White Other
0000E		Black, Black British: African
0000F		Black, Black British: Caribbean
0000G		Black, Black British: Other
0000H		Asian, Asian British: Bangladeshi
0000J		Asian, Asian British: Indian
0000K		Asian, Asian British: Pakistani
0000L		Asian, Asian British: Chinese
0000M		Asian, Asian British: Other
0000N		Mixed: White and Asian
0000P		Mixed, White and Black African
0000R		Mixed: White and Black Caribbean
0000S		Mixed: Other
0000Z		Any other ethnic group
	1	Unknown
Q20		**Further Comments**
	1	Case management
	2	Contact GP/Team
	3	Discharged under agreement / plan to discharge
	4	Disengaged from service
	5	Engage patient's personal support network e.g. partner, parents, friends
	6	Engage with support services e.g. Gamblers Anonymous, social prescribing, Gamcare Womens Group
	7	Medications have / will be / may be prescribed
	8	Offered / referred for CBT
	9	Offered / referred for Counselling
	10	Offered / referred for group therapy
	11	Offered / referred for Psychotherapy
	12	Offered / referred for Residential Programme
	13	Offered / referred sessions (unspecified)
	14	Patient no longer gambling/gaming

	15	Progress review at future date
	16	Other
Q21		**Follow up**
	1	Attending / waiting for CBT
	2	Attending / waiting for Counselling
	3	Attending / waiting for Psychotherapy
	4	Attending / waiting for group therapy
	5	Attending / waiting for sessions (unspecified)
	6	Case management
	7	Discharged under agreement / plan to discharge
	8	Disengaged from service
	9	Engaged / following up to enquire if patient is engaged with support services e.g. Gamblers Anonymous, social prescribing, Gamcare Womens Group
	10	Engaged / following up to enquire if patient's personal support network has been engaged e.g. partner, parents, friends
	11	Follow up with GP/Team
	12	Medications have / will be / may be prescribed
	13	Patient is responding well to treatment plan
	14	Patient is still gambling / relapsed / has reduced gambling but is not abstinent
	15	Patient not currently / no longer gambling/gaming
	16	Patient pausing / refusing / doesn't feel further treatment is necessary
	17	Patient reengaged and continued treatment plan
	18	Progress review at future date / after assessment
	19	Self referral signposting / three month holding letter sent to patient
	20	Therapy / counselling sessions completed
	21	Other
	22	None / N/A
Q22		**Discharge**
	1	Yes
	2	No
	3	Disengaged from service
	4	Gamcare requested we cancel assessment as patient had mental health crisis
Q23		**Comments**
	9	No assessment - DNA
	10	Not suitable for service – no action or referral back
	11	Not suitable for service – signposted elsewhere
	12	Discharged by agreement
	13	Referred on (Assessed only)
	14	Treatment declined
	15	Deceased (Assessed only)
	42	Completed scheduled treatment
	43	Dropped out
	44	Referred on (Assessed & treated)
	45	Deceased (Assessed & treated)
	97	Not known (Assessed only)
	98	Not known (Assessed & treated)
Q24		**Follow up (1 month)**

	1	Yes
	2	No
	3	Not applicable
Q25		**Follow up (3 months)**
	1	Yes
	2	No
	3	Not applicable
Q26		**Follow up (6 months)**
	1	Yes
	2	No
	3	Not applicable
Q27		**Follow up (12 months)**
	1	Yes
	2	No
	3	Not applicable
Q28		**Previous contact with Gambling intervention services**
	1	Gamblers Anonymous (GA)
	2	Gamcare
	3	Gordon Moody
	4	National Problem Gambling Clinic (NPGC)
	5	None
	6	Other
	7	Don't know
Q29		**Any further interventions?**
	1	Alternative / additional counselling / therapy
	2	Alternative / additional support - other e.g. housing support
	3	Case management
	4	Disengaged from service
	5	Gamcare - unspecified
	6	No
	7	PCGS - unspecified
	8	PCGS mixed group
	9	PCGS Women's Group
	10	Social Prescribing
	11	Other
Q3		**Source of Referral**
000A1		GP
000A2		Health visitor
000A3		Other primary health care
000B1		Self referral
000B2		Carer
000C1		Social services
000C2		Education service
000D1		Employer
0.00E+00		Police
0.00E+00		Courts
0.00E+00		Probation service

	0.00E+00	Prison
	0.00E+00	Court liaison and Diversion service
	000G1	Independent sector mental health services
	000G4	Voluntary sector
	000H1	A&E department
	000I1	Mental health NHS trust
	000M1	Asylum services
	000M4	Drug Misuse services
	000M5	Jobcentre plus
	000M6	Other service or agency
		New codes - keep?
	1	GamCare
	2	Gordon Moody
	3	Website / online (unspecified)
Q4		**Types of Gambling**
	G-A A1	Bookmakers- Horses
	G-A A2	Bookmakers- Dogs
	G-A A3	Bookmakers- Sports or other event
	G-A A4	Bookmakers- Gaming Machine (FOBT)
	G-A A5	Bookmakers- Gaming Machine (other)
	G-A A6	Bookmakers- Other
	G-A B1	Bingo Hall- Live draw
	G-A B2	Bingo Hall- Terminal
	G-A B3	Bingo Hall- Skill Machine
	G-A B4	Bingo Hall- Gaming Machine (other)
	G-A B5	Bingo Hall- Other
	G-A C1	Casino- Poker
	G-A C2	Casino- Other card games
	G-A C3	Casino- Roulette
	G-A C4	Casino- Gaming Machine (other)
	G-A C5	Casino- Gaming Machine (FOBT)
	G-A C6	Casino- Other
	G-A D1	Live events- Horses
	G-A D2	Live events- Dogs
	G-A D3	Live events- Sports or other event
	G-A D4	Live events- Other
	G-A E1	Adult Entertainment Centre - Gaming Machine (FOBT)
	G-A E2	Adult Entertainment Centre - Gaming Machine (other)
	G-A E3	Adult Entertainment Centre - Skill prize machines
	G-A E4	Adult Entertainment Centre - Other
	G-A F1	Family Entertainment Centre - Gaming Machine (FOBT)
	G-A F2	Family Entertainment Centre - Gaming Machine (other)
	G-A F3	Family Entertainment Centre - Skill prize machines
	G-A F4	Family Entertainment Centre - Other
	G-A G1	Pub- Gaming Machine (other)
	G-A G2	Pub- Sports
	G-A G3	Pub- Poker

G-A G4		Pub- Other
G-A H1		Online- Horses
G-A H10		Online- Betting exchange
G-A H11		Online- Other
G-A H2		Online- Dogs
G-A H3		Online- Spread betting
G-A H4		Online- Sports events
G-A H5		Online- Bingo
G-A H6		Online- Poker
G-A H7		Online- Casino (table games)
G-A H8		Online- Casino (slots)
G-A H9		Online- Scratchcards
G-A I1		Misc- Private/organised games
G-A I2		Misc- Lottery (National)
G-A I3		Misc- Lottery (other)
G-A I4		Misc- Scratchcards
G-A I5		Misc- Football pools
G-A I6		Misc- Service station (gaming machine)
G-A J1		Private members club- Poker
G-A J2		Private members club- Other card games
G-A J3		Private members club- Gaming Machine
G-A J4		Private members club- Other
G-A K1		Other - Other not categorised above
Q5		**Comments (current risk status)**
	1	Finds certain things to be a trigger e.g. pay day
	2	Has blocks in place
	3	Has informed family and friends of the situation
	4	Has urges to gamble
	5	High risk - currently gambling
	6	In debt
	7	Disengaged from service
	8	Other
	9	Unknown
Q6		**Other Addiction/Problem**
	1	Alcohol
	2	Drug misuse
	3	No - Patient reported no other addictions
	4	Pornography / sex
	5	Other
	6	Unknown
Q7		**Family History of Gambling**
	1	Family member engaged patient in gambling activities
	2	Grandparent
	3	No - Patient reported no history of family gambling
	4	Parent
	5	Other
	6	Unknown

Q8	Mental Health Problems
1	Body Dysmorphia / Eating Disorders
2	Emotional regulation issues - anxiety
3	Emotional regulation issues - depression
4	Emotional regulation issues - other
5	No - Patient reported no mental health problems
6	Obsessive Compulsive Disorder (OCD) / Compulsive Behaviour
7	Panic disorder / PTSD / Stress
8	Personality Disorder / Borderline Personality Disorder
9	Schizophrenia / psychosis / mania
10	Self-neglect / self harm / suicidal ideation / suicide attempts
11	Sleep disorders e.g. insomnia, sleep apnoea
12	Social anxiety / Agoraphobia
13	Other
14	Unknown
Q9	**History of Suicide Attempts/Suicidal thoughts**
1	Family members / friends / pets are protective factors
2	No - Patient reported no suicide attempts
3	Would use crisis lines or access support if feeling suicidal
4	Yes - History of suicidal thoughts
5	Yes - History of suicide attempts
6	Disengaged from service
7	Gamcare requested we cancel assessment as patient had mental health crisis
8	Other

“

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