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educational resources and training

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**GamCare Response
to Responsible Gambling Strategy Board:
initial strategy and priorities
for research, education and treatment**

November 2009

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Summary

GamCare has long advocated the importance of addressing problem gambling research, prevention and treatment more strategically. While the social and economic costs of problem gambling have not been fully researched, it is clear they are considerable and could be of the order of £2 billion per annum. We also know that less than 1% of those who would benefit from help are actually receiving it. Urgent action is needed.

GamCare fully supports the Responsible Gambling Strategy Board's (RGSB) emphasis on basing strategy and decisions on evidence and evaluation. We therefore welcome their proposals to review best practice in the fields of prevention and treatment. This work is overdue, and we will cooperate fully with it. It is a vital precursor to any assessment of, or decisions on, the effectiveness and appropriateness of existing provision.

Given this, however, we believe that some of the RGSB's recommendations are premature, and are not clearly based on evidence or evaluation:

- We believe that an independent and impartial national helpline already exists and is working well. The GamCare HelpLine is valued by its users, other treatment providers and the industry, which has made a considerable investment over 12 years in its creation, development and promotion. 94% of its users say it is either excellent or very good. It could undoubtedly be developed and improved. But it is far from clear what benefits there would be for problem gamblers or their families in creating a new helpline with a new number; in lodging ownership of that helpline with the commissioning body; or in separating the helpline from treatment provision when it is in fact an integral part of treatment provision. We believe such changes would actually be detrimental to the quality and effectiveness of the service. There would also be considerable extra one-off and continuing costs for the industry, with no extra benefits for problem gamblers;
- The GamCare counselling network, encompassing our work through Partners throughout Great Britain as well as our own counselling service, similarly represents a considerable investment over a number of years in the development of a national infrastructure and a skilled workforce. The service is effective. At the

moment, though, this specialist gambling counselling is only available to c60% of the country. Our plans, which we have had to put on hold because of the Government review and the continuing uncertainty about funding, would have seen us extending counselling to reach nearly 90% of the country by 2011/12. With quick decisions and certainty of increased funding, we believe that we could still achieve this, as well as increasing our own counselling capacity in London and Manchester. This would be the most effective, most efficient and quickest way of improving treatment services for problem gamblers and their families;

- Expecting the NHS to take responsibility for, and invest in, treating problem gamblers seems to us unrealistic at this time of public expenditure constraint. Instead, we propose a much cheaper awareness programme aimed at the NHS (GPs in particular) with the objectives of giving greater publicity to existing services and providing materials and support for GPs. This would help raise their own awareness of both the nature of problem gambling and how to access the help available. We would also build improved relationships between GamCare, our Partners and the NHS reflecting the different strengths of the complementary services and ensuring the most efficient use of scarce resource, in the way we have already been discussing with the National Responsible Gambling Clinic (NRGC) in London;

We would also encourage the RGSB to explore further the scope for synergies in research funded by other parts of Government - particularly the Home Office, the Department of Health, and the various Research Councils including the Medical Research Council and the Economic and Social Research Council. We believe that there needs to be a clearer distinction between the research needed to allow the Government and the regulator to inform its policies, legislation and regulation - which are legitimately areas for Government funding - and those areas directly connected to treatment and prevention, which seem appropriate for industry funding. We also believe that there needs to be much greater clarity about the purpose, costs and benefits of the Gambleaware website before funding is committed to it.

We believe that building on, and working with, the existing infrastructure and existing providers in this way is the most effective way of developing services for problem gamblers and their families quickly and efficiently.

GamCare response to RGSB initial strategy and priorities

Introduction

1. The Responsible Gambling Strategy Board (RGSB) recently published its first piece of advice to the Gambling Commission¹. Its key messages were:
 - That strategic priorities and programmes for the use of industry funding in support of research, education and treatment of problem gambling should be based on evidence, evaluation and consultation
 - That at present there is an inadequate evidence base available to us about the causes, nature and effectiveness of responses to problem gambling
 - That there needs to be much greater cooperation and coordination between existing service providers and the NHS
 - That the NHS needs to engage much more effectively with the identification and treatment of problem gambling.
2. The paper also recognised that support and treatment services are currently hardly scratching the surface of the problem: “It is known that only a small number of people with gambling problems present to treatment services or to other services.” (p.5) In fact, less than 1% of those who might benefit from support and treatment are actually receiving it.
3. GamCare has been providing information, support and counselling treatment to problem gamblers and their families and friends for over 12 years. During this time we have gained considerable experience of problem gambling and acquired considerable expertise in both treating and preventing problem gambling. We have also built strong relationships with the gambling industry, other parts of the third sector, the NHS and

¹ “RGSB initial strategy and priorities” October 2009

researchers in the field. We want to make this knowledge and expertise available to the RGSB and the Gambling Commission.

4. We agree that strategy, priorities and programmes should be based on evidence and evaluation. We also agree that the existing evidence base is inadequate (though we believe that there is more evidence available about the effectiveness of existing services than the RGSB suggest, as we set out below, and that there is a risk that too much emphasis on the search for evidence could delay useful interventions which could have immediate benefits for problem gamblers). We do not agree, however, with the RGSB's proposal that a new national helpline needs to be owned and commissioned by the new distributor of industry funds, the Responsible Gambling Fund (RGF), and be "separate from existing clinical treatment services" (p.29). This recommendation is unsupported by either evaluation or evidence.
5. The RGSB state that their priorities for treatment, focusing on the development of services in the NHS, "represent a change to the existing service delivery model" (p.20); elsewhere they talk of supporting existing treatment providers in the voluntary sector in "their transition to a new structure for delivering treatment services" (p.4). Given that the RGSB's second key priority and recommendation is "to undertake a review of best practice in the fields of treatment delivery and education/prevention" (p.3), the announcement of the need for change and transition seems premature. Nor do we understand the emphasis the RGSB appears to place on transferring treatment delivery from the third sector to an already over-stretched NHS, following a new model which is neither clearly defined nor sufficiently tested or evaluated in respect of problem gambling. (While similar in some ways to other forms of addiction, problem gambling is also markedly different in important aspects.)
6. This paper expands on these views and suggests an alternative way forward which we believe will represent a basis for constructive and effective collaboration between the third sector and the NHS, and deliver a more efficient and realistic programme of activity which would have immediate benefits for problem gamblers and their families.

The nature of problem gambling

7. Gambling becomes a problem when it ceases to be enjoyable and becomes a necessity. Winning is no longer pleasurable. The money gained is immediately reinvested in gambling. The life of a problem gambler revolves around gambling. They are constantly preoccupied with the next bet, the next game, to the exclusion of relationships, family, job and other things in their lives. They often report that they have stopped caring about themselves, their personal hygiene, appearance and health.
8. Gambling performs a multitude of functions in their lives. It is a way of managing intolerable feelings - sadness, frustration, lack of self-esteem. It gives the person a temporary sense of control and power when otherwise they feel helpless facing life's problems. It may also be a form of self-harm, with losses representing the punishment for being "worthless", "a bad person". It is a way of saying something for which they can not find words.
9. There are certain features which are relatively common in the life-styles of the problem gamblers with whom we work - for example the necessity for secrecy and deception, the presentation of a false self. This means that many problem gamblers are able to hold down a job, can seem to be in control of their lives and so may give the appearance of functioning effectively (unlike many people with an alcohol or drug problem, who are much more clearly "non-functioning"). In most cases it means spending more money than can be afforded, and recent research suggests that levels of debt may be much higher than previously thought (Downs & Woolrych 2009). But not every problem gambler has financial problems², and debt is not a factor for every client.
10. Gamblers tend to manage their lives the way they gamble, by following their impulses. When the façade of control breaks down, it often cracks completely. This means that when problem gamblers ask for help, they are often in a state of real crisis, and helping agencies must be able to provide immediate emotional as well as practical

² Some problem gamblers have considerable financial freedom, where losing money does not present a serious component of the problem. Nevertheless other features of problem gambling (preoccupation, gambling being a necessity, etc.) are present.

support. A number of our callers and clients have considered or attempted suicide and this suicidal tendency is directly linked to their gambling problem. After a huge loss the financial breakdown and the impact on family and relationships as well as on the individual often leads to feelings of hopelessness where suicide seems to be the only way out.

11. Although gambling can be a form of physiological dependence, insofar as gambling provides excitement and produces a “high” in the form of adrenalin, serotonin and endorphin rushes, there are marked differences from alcohol and substance addiction. In terms of treatment there is no need for detoxification prior to therapy and also no need for medication to substitute the substance.

12. So who are problem gamblers? Is it possible to say that a certain gender, class or ethnic group is more likely to gamble?

13. Problem gamblers are not a homogeneous group³. Proportionately about 55-60% percent of our clients are white British, two thirds are between 26-45 years old and 85% are men. But of course, this does not mean that we can conclude that most gamblers are 30-something white males. Our client base reflects those who are willing and able to seek help for their problem gambling. We know that women find it more difficult to seek help due to the considerably higher social stigma they face as a female problem gambler. Equally people from certain cultural and religious backgrounds find it difficult to seek help perhaps due to shame, perhaps to a tradition of not asking for help and support outside the family network. The Gambling Commission’s Prevalence Study 2007 suggested that problem gambling is more prevalent among men and younger age groups but is also significantly associated with being Asian/Asian British, Black/Black British, separated/divorced or having fewer educational qualifications. We are finding that we are receiving more calls from students at college or university – a high risk group which is not fully represented in the Prevalence Study and so which urgently needs to be researched. Other studies

³ Evidence from increasing empirical research and clinical experience (eg Blaszczyński & Nower 2002, Anderson, Dobbie & Reith 2009 – see Annex B) has meant that previous rather rigid and fixed conceptualisations of problem and pathological gamblers and how they are to be assessed and treated are being replaced by a more fluid and complex picture of a wide diversity of problem gamblers with several types and sub-types.

have also shown that problem gambling prevalence amongst adolescents is significantly higher than amongst adults (between 3 and 8%), and that problem gambling prevalence in prison populations - a group also not picked up in the Prevalence Study - may be as high as 25-30%.

14. Many problem gamblers have experienced some form of trauma, abuse or loss in their past, leaving them with a deficiency in expressing and containing their feelings. By the time they seek help this group has usually been gambling for many years, starting from an early age; they may have had a significant figure in their life who gambled (parent, grandparent, uncle) or conversely have had a parent whose injunctions were all about saving money and being risk averse.
15. Many gamblers are co-morbid. This might range from anxiety and depression through alcohol or substance addiction to diagnosed mental health issues. They may also be receiving (or should be receiving) treatment or support from other agencies, the criminal justice system, social services or the NHS. This therefore requires close liaison between all the agencies to ensure effective and coordinated interventions.
16. Problem gambling clearly creates costs for the state associated with health, crime, social security, employment, productivity and so on. As far as we know, there has been no definitive research into the social and economic costs of problem gambling in the UK, but there has been some in other countries. In 1999 the Australian Productivity Commission estimated that the annual social cost of problem gambling ranged from \$AU 1.8bn - \$AU 5.6bn (£1 - £3bn). In the same year the National Opinion Research Centre at the University of Chicago estimated annual and lifetime costs for problem and pathological gamblers, indicating annual costs of \$715 - \$1195 (£435 - £726) per person per annum, and additional lifetime costs of \$5130 - \$10,550 (£3119 - £6413) per person. Grinois & Mustard (2001) averaged the results of 8 US studies and estimated an annual cost per problem gambler of \$13585 (£8258). If this were applied (simplistically) to the current estimate of problem gamblers in Britain - c250,000 - this would imply an annual social cost of nearly £2.1 billion per annum.
17. Whilst there are many questions about the methodologies of these studies and their applicability to the UK, what they all clearly indicate is that the costs of problem

gambling to the state are undeniably considerable; that the proposed industry spend on research, education and treatment in GB is tiny in comparison (whether it is £5m or £10m pa); and that further research into establishing more precise costs, whilst undoubtedly useful, would be unlikely significantly to change this analysis.

Responding to problem gambling

(i) The role and characteristics of a national helpline

18. Helpline services can deliver a range of services in a number of different ways. At one end of the spectrum, a helpline may be a simple information service operated by staff with minimal training (or, indeed, largely automated) and designed to respond only to straightforward requests for standard information. At the other, a helpline can provide emotional support, advice, information and informed signposting, and may be regarded as the first line of treatment provision.
19. It follows from the foregoing analysis of problem gambling that a problem gambling helpline needs to be able to meet the demands of very vulnerable people - problem gamblers themselves, and partners, parents or family members affected by, or concerned about, problem gamblers. The capacity to offer immediate help and emotional support for people who are desperate or in crisis is crucial to the nature of these target populations. Callers need to be given immediate reassurance on a number of issues: that their call will be treated in strictest confidence; that they are not going to be blamed or reprimanded for their behaviour; and that the person they are talking to understands gambling and gamblers - the games, the technology and the psychology. Callers in crisis may be easily discouraged or diverted and are looking for understanding and immediate solutions. If they are simply given or sent information or referred on, or if the person they are talking to is unable quickly to gain their confidence and trust, it is very likely their motivation to get help will end there and then.
20. A necessary skill for problem gambling helpline advisers is therefore the ability to give emotional and practical support in such a highly charged situation, and to be able to de-escalate and direct the client to an emotionally safer place during the call. Help is made accessible when it is needed, is targeted to the specific needs of the caller at

the time of the call, and by being positioned as a “one stop” resource the helpline is able to offer the caller the greatest amount of help with the minimum number of barriers. This is crucial in terms of the help-seeking psychology of the problem gambler, as well as for family or friends of a problem gambler.

21. Accessing the helpline needs to be made as simple as possible. The phone number needs to be widely publicised, not just to gamblers but to their non-gambling families and friends, and to other frontline agencies. These agencies may need help in identifying that gambling is an issue for people presenting with apparently non-gambling problems (debt, anxiety etc) as well as knowing to whom to refer them for help. An online helpline is also vital, particularly for reaching women and young people who may be more comfortable with this than with the telephone.
22. GamCare’s HelpLine and NetLine provide national access to information, advice and immediate emotional support, and an impartial referral service to a wide range of further support. In 2008 we received over 50,000 HelpLine and NetLine calls - 21% more than in 2007. In 2008/9 we spent just over £800k on delivering our HelpLine and NetLine services.
23. The HelpLine and NetLine are staffed by professionally trained and clinically supervised advisers who have counselling experience and training (many have higher qualifications) as well as an understanding of gambling. They receive intensive induction training which equips them to provide immediate help, to explore the nature of the caller’s problems and so to take full advantage of that initial contact. All participate in continuing training and development.
24. More than two-thirds of callers are gamblers, and nearly 25% are family members or friends; other callers include professionals and other helping agencies. HelpLine callers are predominantly male (73%), while almost 33% of NetLine callers are female⁴. The average duration of each target call is nine minutes; as one would expect, counselling calls have a higher average duration of 21 minutes, and some can last an

⁴ The collection of data depends on the willingness of callers to provide it; percentages are of those whose gender is known.

hour or longer. NetLine calls average over 18 minutes and NetLine counselling calls 34 minutes.

25. The pattern of onward referrals reflects the extent to which the HelpLine and NetLine both provide an independent, impartial and national single point of access to the range of support services available from many providers:

- 40% to GamCare services (Counselling, Forum, Chat Room, website)
- 17% to self-exclusion schemes
- 15% to Gamblers Anonymous, Gam-Anon, residential care
- 11% to Partner counselling
- 11% to other agencies (eg CAB, Debtline)
- 6% to NHS/BACP

26. All HelpLine callers who ask for information also receive a one-page evaluation form asking for feedback on their experience of the service. In 2008 94% rated the HelpLine service as either Excellent or Very Good. We work closely with the Telephone Helpline Association (of which we are a member) in developing our policies and practices, and in managing performance. In 2008, through the THA, we gave a well-received presentation to other helpline operators on the development of NetLine, the Forum and Chat Rooms, focusing particularly on our protocols for handling suicidal callers. Evaluations of other helplines (eg Statham & Carlisle, 2004, looking at child protection and Boddy & Smith, 2007, looking at Parentline Plus) have endorsed the appropriateness and value of services of the type we offer for vulnerable groups.

27. The HelpLine number is promoted in all gambling venues (including pubs) throughout Great Britain and online, and is incorporated in all gaming machines either on the body of the machine or in the software. For the industry this represents a significant, long-term commitment and a considerable investment, on top of the funding provided to the GREaT Foundation. Changing the helpline number would impose significant extra costs on the industry.

28. There are considerable advantages and efficiencies in having the helpline and

counselling functions within the same organisation:

- There are clear benefits for clients in terms of ease of access, continuity of support and treatment and establishment of a relationship of trust
- HelpLine advisers and counsellors are able on a daily basis to exchange information about clients and trends, to the immediate benefit of clients and helping the development and improvement of both services
- Counsellors are able to provide advice, support and clinical supervision for the HelpLine team
- Many of our HelpLine advisers go on to train as counsellors and transfer to our counselling staff, so providing a significant contribution to the creation and retention (through the provision of career paths) of a skilled workforce
- Training and development for both teams can be planned and delivered more efficiently and effectively

29. The RGSB's suggested distinction between helpline and treatment provision seems to us a false one - the helpline service is the first and most immediate element in any treatment programme. It corresponds most closely to an NTA Tier 2 service, with some aspects of Tier 3 (see Annex A).

30. In summary, we suggest that an independent and impartial national helpline already exists and is working well. It is valued by its users, other treatment providers and the industry, which has made a considerable investment over 12 years in its creation, development and promotion. It is far from clear what benefits there would be for problem gamblers or their families in creating a new helpline with a new number, in lodging ownership of the helpline with the commissioning body, or in separating it from treatment provision when it is an integral part of treatment provision; indeed, we believe such changes would actually be detrimental to the quality and effectiveness of the service. What is also clear is that there would be considerable extra one-off and continuing costs for the industry, with no extra benefits for problem gamblers.

(ii) Counselling

31. Whilst there is no internationally established model of best practice for treating problem gamblers, there is an emerging consensus (Annex B) that there needs to be a range of interventions available to meet the differing circumstances and needs of individuals, and that these need to be delivered within the individual's community. There is considerable evidence, reflected in NHS practice and guidance and elsewhere, that psychological or "talking" therapies are effective in treating anxiety, depression and connected conditions, including addictions, and that counselling and psychotherapy as well as cognitive behavioural therapy can all play an important part in this provision. The investment of more than £170 million in additional funding to the NHS for the *Improving Access to Psychological Therapies* (IAPT) programme was predicated on an economic, clinical and moral business case argued by Lord Layard and others (Layard et al, 2006) which suggested that the programme would pay for itself within two years. It is clear from the level of social costs likely to be attributable to problem gambling (see para 16) that the logic of this business case applies to problem gambling as well.
32. Every person who approaches us for help is an individual presenting a unique background and situation. For treatment to be successful and long-lasting it is vital to recognize the diversity of each problem gambler. We need to take into account the nature of their gambling: has the individual been gambling a long time, what do they gamble on, how frequently do they gamble and what do they get out of their gambling? We also need to understand how they perceive their problem: what are their immediate concerns - is it gambling *per se* or is it debt, relationships, holding down a job? What do they think will help them? Establishing where the individual is starting from, and what they want to achieve, allows the counsellor to develop a tailor-made treatment plan for each individual.

33. Our counsellors⁵, who are all professionally trained, qualified and clinically supervised, work with a mix of approaches to be able to develop and deliver these individual treatment plans; these include psycho-dynamic, cognitive behavioural, integrative and person-centred approaches. We understand that the root of the problem gambling behaviour often lies in the individual's past and that dealing with the gambling in the long-term requires the individual to identify and admit these issues and develop mechanisms to deal with them. In the shorter term, it is of course equally important to equip the client with strategies to cope with situations that would trigger gambling urges. Our holistic approach allows us to incorporate all aspects of the recovery process starting with evolving immediate coping mechanisms, finding and elaborating the underlying reasons for the gambling problem, working with the emotional impact of these insights, finding ways constructively to resolve past trauma and facilitating relapse-prevention.
34. A common experience of counsellors working in the addiction field is the difficulty in engaging the clients. Some clients arrive seeking a "cure" for their gambling problem. They need, carefully and gradually, to be helped to see that their gambling behaviour is inextricably linked with all other aspects of their life. The investment of adequate time enables the engagement of the client and the development of a transformative therapeutic relationship. This leads to long-term benefits including the cessation from, or controlling of, gambling, regaining financial security, enabling clients to have better relationships with themselves and others, to have greater self-awareness and altogether deal with life-problems more constructively.
35. Many of the therapeutic approaches underpinning GamCare's models of counselling (eg Rogerian, and therapies based on attachment theory) emphasise that the therapeutic relationship between counsellor/therapist and client is the most important determinant of successful interventions. Orlinsky et al's (2004) comprehensive review of the main studies undertaken between 1950 and 2001 of the link between process and successful outcomes across all psychotherapies demonstrated the strongest evidence for the effectiveness of the therapeutic relationship.

⁵ References to GamCare counsellors encompass both those employed directly by GamCare and those working for our Partners who are trained by GamCare and work to our standards.

36. The GamCare counselling process encompasses assessment, allocation, treatment and follow-up (see Annex C), and built in to this is an evaluation of the effectiveness of the treatment. In 2008 GamCare helped more than 1900 people through counselling, holding some 12,500 counselling sessions, 30% more than in 2007. At the beginning of counselling 88% of clients were assessed as problem gamblers (DSM-IV); at the end of treatment this reduced to just 15%. Counselling operations in 2008/9 cost £1,393k.
37. Alongside one-to-one counselling (in person and online) we also provide group support - including the only women's group in the UK, an online Chat Room and an online Forum, all providing the opportunity for peer support for clients. The RIGT-funded investigation of online support forums (Wood, 2008) highlighted their usefulness in meeting the needs of both problem gamblers and those seeking help for others, and in particular their importance to female gamblers.
38. The GamCare counselling network, encompassing our work through Partners throughout Great Britain as well as our own counselling operation, represents a considerable investment over a number of years in the development of a national infrastructure and a skilled workforce. At the moment, though, this specialist gambling counselling is only available to c60% of the country. Our plans, which we have had to put on hold because of the RET review and the ensuing funding uncertainty, would have seen us extending counselling to reach nearly 90% by 2011/12. With quick decisions and certainty of funding for planning purposes, we believe we could still achieve this, as well as increasing our own counselling capacity in London and Manchester. This would be the most effective, most efficient and quickest way of improving treatment services for problem gamblers and their families.

(iii) Working with the NHS

39. NHS provision for the treatment of problem gamblers is negligible. Problem gambling has never been a priority for the Department of Health or the NHS; any initiatives have depended on local interest and resource and so have been few and far between, and certainly have not represented a coherent response to the problem. The fact that the NHS Problem Gambling Clinic in London required industry funding to get it off the ground demonstrated the lack of commitment from the DH and the NHS, and it seems

to us that in the prevailing public expenditure climate this is unlikely to change - indeed, cuts in funding are likely to reinforce the NHS's reluctance to take on any responsibility for treating problem gambling. Their focus will, in our view rightly, remain on those gamblers with severe co-morbidities and mental health problems requiring medication and in-patient services.

40. It has also been well-established (for example most recently in Downs & Woolrych (2009)) that NHS frontline services, and GP practices in particular, have low awareness of the nature of problem gambling (and so are not alert to it as, say, an underlying cause of anxiety or depression) and an even lower awareness of the agencies such as GamCare which can help problem gamblers. Recognition of this led to RIGT funding GamCare to undertake a Pathfinder project in 2008 to explore how best to raise awareness and publicise the help available. The evaluation of this Pathfinder, which endorsed the value of awareness-raising and identified more cost-effective ways of doing it throughout the country, was made available to the RGSB and the RGF in April this year, together with a request for funding to extend the work nationally, but we have so far received no response.
41. On the other hand, our advisers, counsellors and partners already work very closely with the NHS and other services on a case by case basis, where the interests of the client or the holistic management of their treatment requires it. Such arrangements are common on the ground where liaison between case workers can be very effective indeed.
42. The RGSB has recommended that significant industry funding should be devoted to a major development programme within the NHS designed to encourage the identification of gambling-related harms and the delivery of brief interventions, including both further pilots alongside the NRGCC and a significant training programme for primary care staff.
43. We question the evidence base for these conclusions. The NRGCC pilot has (as far as we know) yet to be independently evaluated, but it has been clear from the outset that the designers of the model envisaged a partnership between the NHS and GamCare, one which avoided duplication in Tier 2 and 3 services but rather built on the strengths

of each in the interests of the client. Their vision of the extension of the model to other parts of the country is very firmly based on a developing partnership between the NHS, GamCare and GamCare Partners. This would provide the most efficient use of resources and the quickest way of encouraging real collaboration at grassroots level.

44. The NHS has already embarked upon a major training programme for the IAPT initiative - an initiative which will itself need to be evaluated. It is difficult to see how practical, realistic or effective it would be to seek to graft on to this, or deliver separately, a gambling training programme funded by the industry. Nor is it easy to see that the NHS would have any appetite for this.

45. Our alternative proposal would therefore be based on a twin-track approach:

- An initial focus on an awareness rather than a training programme in the NHS with the objectives of giving greater publicity to existing services and providing materials and support for GPs. This would raise GP awareness of both the nature of problem gambling and how to access the help available. We would like to make this work part of the core activity of our contracts with GamCare Partners
- Building improved cooperation and relationships between GamCare, our Partners and the NHS reflecting the different strengths of the complementary services and ensuring the most efficient use of scarce resource, in the way we have already been discussing with the NRG.

46. This would have the advantage of building on what already works, and so would be the quickest and most efficient way of delivering improved services for problem gamblers.

(iv) Prevention

47. The RGSB paper rightly draws attention to the lack of evidence in connection with the effectiveness of education and prevention measures. However, in doing so we believe it does not fully reflect the extent to which the industry already invests considerable sums in policies and programmes designed to help gamblers gamble responsibly and to

ensure that staff are aware of the indicators of problem gambling and are equipped to help and support their customers. GamCare, through its operator certification and training activities (which are self-funding), has done much to lead this work with industry associations as well as with individual operators. GamCare Certification provides assurance to players that the company they are dealing with has met the standards set by GamCare and has properly trained staff - an assurance that is particularly important for those who gamble online, where most sites are not regulated by the Gambling Commission. We are also putting in a place a new partnership, working with a group of remote operators and Salford University, to explore and develop new approaches and opportunities to improve responsible gambling measures online. This work is a significant contribution to any prevention strategy.

48. GamCare supports strongly the need to develop a clear strategy for prevention amongst young people, and to that end we have created a new post specifically to scope how we might best use our, and our Partners', expertise, experience and networks to design and deliver cost-effective programmes. We already undertake some outreach activities with schools and colleges, and we are also engaging with the Department for Children, Schools and Families to explore how prevention might best be incorporated into the national curriculum. Here, our recent research into gambling and debt (Downs & Woolrych 2009) demonstrated the urgent need for educational interventions, and our partnership with the Money Advice Trust may well allow problem gambling prevention to be effectively delivered as part of a broader approach to educating young people in financial and risk management.

49. We have read carefully the RGF's evaluation of the Gambleaware website. We were surprised that this evaluation focussed much more on the views of industry stakeholders than it did on the perceptions of its users. It is difficult to tell from the report how many users or problem gamblers were interviewed, but their views (recorded on pp 28-30 of the report) were generally negative. The data on "traffic" is scant, but seems to indicate that volumes are low and that 75% of users stay on the site for 10 seconds or less. There is no account of costs, nor any cost/benefit analysis. There is a suggestion that there is much to learn from the Drinkaware site, but there appears to have been no evaluation of the costs or effectiveness of that site. All this

leads us to conclude that there needs to be much greater clarity about the purpose, costs and benefits of the Gambleaware website before funding is committed, as the RGSB recommends, to its redevelopment.

(v) Research

50. We welcome the proposals to review best practice in the fields of prevention and treatment. This work is overdue, and we will support and cooperate fully with it. As we have noted above, it is a vital precursor to any assessment of, or decisions on, the effectiveness and appropriateness of existing provision.

51. We hope that the RGSB might explore further the scope for synergies in research funded by other parts of Government - particularly the Home Office, the Department of Health, the Medical Research Council and the Economic and Social Research Council. We also believe that there needs to be a clearer distinction between the research needed to allow the Government and the regulator to inform its policies, legislation and regulation - which are properly areas for Government funding - and those areas directly connected to treatment and prevention, which seem appropriate for industry funding.

GamCare
November 2009

Annex A

GamCare Provision and the National Treatment Agency Models of Care

The NTA deals with treatment for adult drug misusers. Its models of care identifies four intervention “tiers” which, in simple terms, are defined as:

Tier 1: provision of information and advice, screening and referrals to specialised treatment

Tier 2: provision of information and advice, triage assessment, referral to specialist treatment, brief psychosocial interventions

Tier 3: specialist assessment and co-ordinated care-planned treatment and liaison

Tier 4: provision of residential, in-patient treatment

The model is specific to drugs (though specific drug references - eg to needle exchange, detoxification - have been removed from the above descriptions) and generally envisages delivery in healthcare, social care, education or criminal justice settings. It recognises that there is overlap between, particularly, Tier 2 and Tier 3 interventions

The model does not read across directly to problem gambling. However, the closest matches to GamCare services would appear to be:

HelpLine/NetLine	Tier2/3 (advisers provide specialist assessment)
Counselling	Tier 3/4 (GamCare has access to some short-stay residential provision as part of its partner provision)

Annex B

Problem Gambling Treatment and Effectiveness

The search for empirically based models of best practice in problem gambling treatment is still in its infancy, so practice has largely evolved in response to clinical experience and the limited research that has been done into the comparative effectiveness of different treatment approaches. Good clinicians tend to be more alike than different, regardless of theoretical orientation e.g. cognitive behavioural treatment may actually contain significant psychodynamic ingredients or vice versa. Ultimately, therefore, a four-fold question needs to be asked, namely: which kinds of treatment are effective; for which gamblers; in which ways are they effective and through which kind of mechanisms?

A large Australian study from 2003 (Jackson, A; Blaszczynski, A; & Thomas, S *Best Practice in Problem Gambling Services*) concluded that the predominant Australian model of community-based treatment provides more accessible support for problem gamblers and their families than other approaches. A crucial dimension of these community-based programmes is a multi-modal approach to treatment acknowledging that problem gamblers and those affected need a range of interventions and that these interventions need to be inter-connected.

In research carried out for RIGT by the Auckland University of Technology (Abbot, M; Volberg, R, Bellringer, M & Reith, G (2004) *A Review of Research on Aspects of Problem Gambling: Final Report*) the authors supported the idea of a system of stepped care that had been suggested in the UK Government's Gambling Review Report (Budd, 2001).

A British review of treatment strategies for problem gambling: (George, S & Murali, V (2005) *Pathological gambling: an overview of assessment and treatment, Advances in Psychiatric Treatment* 11: 450-456) concluded that problem gambling should be conceptualised as a heterogeneous entity arising from a "complex interplay of various biological, psychological and social variables". This suggests that an integrative approach that draws on approaches and interventions from a range of different models is the appropriate way to formulate a treatment strategy for problem gambling.

Research carried out for the Gambling Commission (Anderson S Dobbie F & Reith G (2009) "Recovery from problem gambling: a qualitative study") suggested that stages of recovery are better viewed as a fluid, cyclical process rather than a linear one. It reinforced the need for a range of interventions, noting for example that the Gamblers Anonymous approach is not one that suits everyone. Of GamCare's effectiveness (as reflected in an assessment of counselling delivered by our Partner in Scotland) it noted that feedback from clients was "generally extremely positive" with an "emphasis on the practical aspects of such support". The research also reinforced the importance of the client/counsellor relationship, and the important role which family and friends play both in encouraging gamblers to admit they need help and then in helping them through treatment.

Annex C

GamCare Treatment Process

Assessment

After the initial contact or referral the client receives an appointment for an assessment. The counselling team administrator fills out the Initial Assessment Form following a short telephone interview and creates a client folder.

All assessments are conducted by counsellors. When the client arrives for the assessment appointment he/she is given the following documentation:

- Letter of Information and Consent
- Client Information Form
- DSM-IV (Diagnostic and Statistical Manual of Mental Disorders)

During the Assessment the counsellor also uses other screens:

- Christo Inventory for Gambling Services (CIGS)
- South Oaks Gambling Screen (SOGS)

Allocation

After assessment the client folder is handed over for allocation to a counsellor. Allocation meetings take place once a week, ensuring minimum delay. Allocations are made taking into account the client's needs, client/counsellor "match", counsellor availability and scheduling possibilities.

Counselling

In the first regular session the counsellor discusses a treatment plan and targeted outcomes. Counsellors are required to review the plan and progress after 12 sessions. Counsellors liaise with other agencies involved in the overall care plan for the client.

When a client and a Counsellor agree to end the counselling or when a client stays away for more than two sessions, the counsellor closes the treatment and completes the DSM-IV and CIGS forms again to record the condition of the client at the end of treatment.

Follow-up

In order to monitor consistency and effectiveness and as an on-going support to the client our Counsellors conduct three follow-up sessions with closed clients (face to face or on the telephone) 3 months, 6 months and 12 months after the end of their treatment, each time assessing the clients gambling behaviour with the help of the DSM-IV and CIGS forms.

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