



GAMCARE

National Association for Gambling Care
Educational Resources and Training

GamCare Care Services 2004 Report



***GamCare** Care Services 2004 Report*

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CARE SERVICES REPORT 2004

Foreword

One major reason for publishing the annual GamCare Care Services report is to track changes in the nature of our clientele, which may be of interest to other treatment professionals and researchers. Another is so that we ourselves can take stock of what we have been doing in the area of treatment. Yet another reason is to demonstrate to our funders how we have spent their money.

The GamCare Care Services report, however, does not purport to provide a demographic portrait of the nation's problem gamblers and still less to apportion blame to different sectors of the industry for being more responsible than others for "causing" problem gambling. GamCare does not aspire to settle public policy issues about what forms of gambling should be legalised or how they should be regulated.

We recognise that government needs to take many interests and issues into account when making laws which will apply to the large majority of people who gamble harmlessly as well as to the minority who gamble compulsively and to excess. We are also acutely aware of how easy it is to misinterpret statistics of the sort we provide here either through thoughtlessness or wilfully. For example, we are pleased to report that the number of calls to our Helpline from people stating they are first time callers and who go on to identify a problem with a particular form of gambling is up from 2772 to 4644.

Similarly, the number of people we treat one to one has increased from 204 in the year 2003 to 299 in 2004. We are pleased about this because we believe it indicates that

more people with gambling problems are hearing about our services and are making use of them.

The availability of our Helpline number in betting and gaming areas has enabled immediate access and help for those who require it.

Some people have criticised us for not bringing publication of this report prior to the passing of new legislation. This has been ostensibly on the grounds that our figures should be informing the political debate but really because they wanted material for sensational and partisan news stories or ammunition for use in commercial competition. We have had to fend off with some vigour all requests for advance access to the data precisely to prevent it from being used inappropriately.

Our figures do however highlight some important facts.

In general our numbers confirm the research evidence from around the world that the riskiness of gambling increases in proportion to gambling opportunities that involve:

- Continuous and rapid-action play
- Involve high stakes and prizes
- Are located so as to increase the likelihood that people will gamble on impulse
- Are offered in the absence of a public education programme about how gambling works, what are its dangers, how these may be avoided, how to recognise problem gambling and how to access help.

With respect to the efficacy of our work, to judge by our counselling outcome measures about 80% of those whom we treat succeed in overcoming their gambling problem by the end of counselling. The average cost of this is in the region of £1,100. On the other hand, only a small number of those who recognise that they have a problem actually present for, and complete a course of treatment. And this in turn is only a small percentage of those who actually gamble to the point where it is seriously harming them and those close to them.

The fact that the majority of those who need help do not seek it is a common feature of all addictions world-wide. Often this is simply because they don't know or are too embarrassed to find out about what help is available. The 'hidden' addiction or the 'missing' addiction, whatever name we want to give to problem gambling, still has the same taboo to overcome. Nevertheless it highlights the need for much greater public awareness of the nature of problem gambling, of how to recognise its symptoms and of how to access the kind of free, confidential, expert help which GamCare provide.

One of the things GamCare most hopes for in the coming year is that such a programme of public education will be developed and implemented.



Professor Peter Collins
Chief Executive

Introduction

We are delighted to publish the Care Services 2004 Report which brings together comprehensive analyses from our national Helpline, face-to-face counselling service and Breakeven partners. This is the 6th year that such a report has been produced but this edition has been more eagerly awaited than most, particularly in the context of the Government's proposed new gambling legislation.

The primary purpose of the Care Services is to provide confidential counselling, advice, information and support for anyone affected by a gambling problem. The data presented here has been collected in that context and its value lies in the significant contribution it makes towards giving a fuller picture of the pattern and trends of problem gambling in the UK.

We are committed to ensuring that assistance is provided to as many problem gamblers and their families as we can within our resources and that such assistance is both effective and of the highest quality. Within this report, therefore, alongside the statistical data on the number of people seeking help from our services and their modes of gambling you will find an analysis of our very high year on year success rates and outcomes of which we can be justifiably proud. All services are to be congratulated on the professional and dedicated way they deliver counselling and support to those who request and need it.

Since the Care Services were launched in October 1997, not only has there been a year on year growth in the numbers of people being helped but the nature of the

problems we deal with have become far more complex. We have witnessed the rise of new technologies and the impact of remote gambling. There has also been a change in the risk profile of problem gambling with increases among women and other population sectors, including ethnic and new migrant minorities. It is, therefore, crucial that the Care Services become ever more flexible in order to work effectively with such a diverse and complex gambling mix. A major response in 2004 was to extend our national helpline to a 24 hour operation. During 2005 we will be adding to the effectiveness and quality of the database built up over the past seven years and looking to develop internet-based systems and materials to engage the challenge that new technologies and communication systems are presenting us.

I want to take this opportunity to say a big thank you and congratulations to all the staff, counsellors, volunteers and partners around the UK who have been involved in the production of this report. Without your considerable skills, commitment and passion the Care Services and their national and international reputation would not have been possible.



Adrian Scarfe B.Sc (Econ) MA MTh Grad
Cert Ed
Clinical Practice Manager

Client Feedback

When I used the phone service, I never thought I was going to speak to someone direct.... but it was good to talk to someone straight away. The talk was very positive and has put me on course to get the right help I need.

The counsellor helped me put the situation in perspective and left me with lots of things to think about and consider. I feel more informed and determined.

I would just like to say that when I called I felt I was very much alone but now I know that I am not.

Thank you, the information you provided is very helpful. I never new there was so much information and help. Hopefully I will be able to do something about my gambling now.

I found it helpful to talk to somebody instead of keeping it to myself.

I was looking for information on the availability of gambling counselling for young people as I work for a youth offending team. The information provided was both very useful and substantial.

I called the line as a counselling student...I was very impressed with the speed and efficiency of the material sent out.

As a social worker in a mental health team I have several clients who have problems of this nature and value this kind of service.

I did not know you existed. I was desperate and looked in the directory. I was very impressed and felt supported for the first time in 8 years!

It was very good to talk to someone who understood my situation. I have talked to other people about my gambling and usually they say just stop as if it was as easy as that.

It's great to find that there is a helpline for such a bad and destructive thing and I would be more than happy to pass on your number to someone else in my position.

GAMCARE HELPLINE

The GamCare Helpline remains a unique resource in the United Kingdom, providing confidential counselling, advice and information for anyone affected by a gambling problem.

The Helpline has 3 main target groups:

- Problem Gamblers
- People affected by problem gambling such as gamblers' partners, family and friends
- Professionals working in the field of gambling dependency or with gambling related issues

The Helpline offers a combination of:

- Crisis intervention
- Telephone counselling
- Advice & information
- Signposting

By offering telephone counselling alongside advice and information at this first point of contact, the Helpline counsellors are able to prime the caller to engage in the counselling process, possibly for the very first time. The caller will then have made a significant first step and developed insights into their personal circumstances. These can become the focus of any future counselling work to which they may be signposted during the call. This includes both our own Counselling Service and those of the Breakeven Partners.

Paid counsellors account for most of the Helpline team, although there remain a few dedicated volunteers. All the counsellors receive specialist training prior to working on the Helpline as well as ongoing training and clinical supervision.

The Helpline underwent significant development in 2004, aimed at increasing service efficiency. This included:

- Employing an overflow service to manage calls when GamCare's counsellors are engaged. The overflow advisors are trained to provide advice and information and a dedicated GamCare counsellor is on stand-by so advisors can transfer the caller, if they require additional support.
- Recruiting and training 30 additional Helpline counsellors in August and November 2004. This enabled GamCare to increase the number of counsellors available on the Helpline at any one time as well as offering additional hours of service. Counsellors are now available 16 hours a day (08:00 to 00:00), 7 days a week, 365 days a year.
- Employing an overnight call answering service to manage calls after midnight. This service gives the caller the opportunity to leave their details for a counsellor to call back.

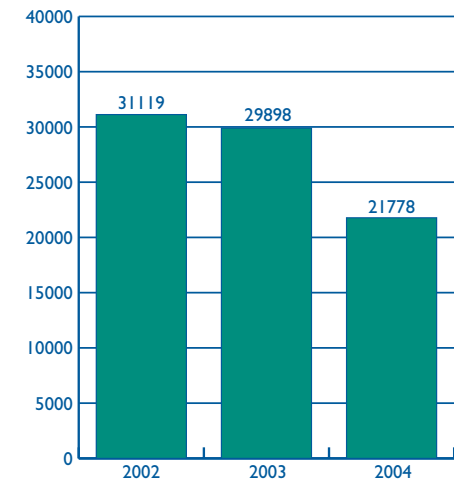
These developments were aimed at increasing the number of calls personally answered by a counsellor or by an advisor who, if necessary, can transfer the caller to a counsellor or take the caller's details so a counsellor can call them back.

This report is intended to give a picture of what has happened on the GamCare Helpline during 2004. The statistics provided in this report come from a variety of sources; our own records, which are collated from direct work on the Helpline, information provided by the overflow service (bss), reports produced by the overnight service (Arc Monitoring) and statistics provided by Call Handling, who operate the Virtual Call Centre (VCC).

Total Calls

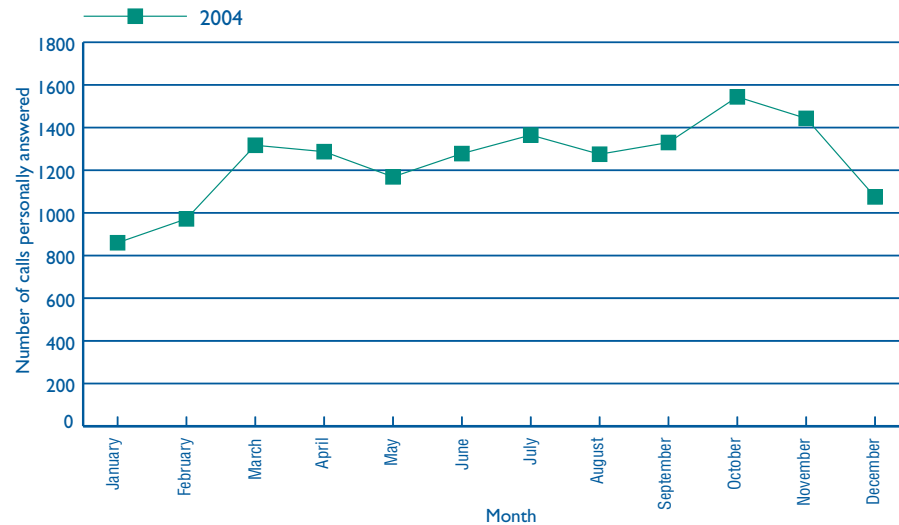
Call Handling figures indicate that 21778 calls were made to the 0845 Helpline number in 2004 (8120 calls approx 27% down on 2003). The reduction in overall call rate may be due to increasing efficiency in answering calls first time, reducing the amount of repeat dialling required.

Fig. 1: Total Inbound Calls



Our records show that Helpline counsellors recorded information for 14915 calls. The discrepancy between the two figures is mainly accounted for by:

- Callers hanging up prior to speaking to a counsellor
- Calls being 'lost' by the telephone system
- Calls not being recorded
- Repeat dialling by callers who cannot get through first time

Fig. 2: Monthly Recorded Calls, 2004

Much of the data presented in this report is based on the 14915 calls recorded by the Helpline counsellors. The chart above indicates the number of calls recorded each month during 2004.

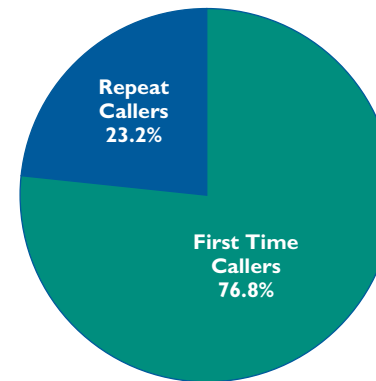
Call Duration

Call Handling figures indicate that in 2004 counsellors spent 135275.48 minutes (2254.59 hours) talking to callers. This equates to approximately 6 hours talk time each day of the year.

The Helpline counsellors' records indicate that the average duration for 'information' calls was 4.34 minutes, for 'Advice' calls was 10.89 minutes and for 'counselling' calls was 23.18 minutes.

First Time & Repeat Callers

At this point it is important to address the issue of first time and repeat callers. Of the 14915 calls, 8991 people disclosed whether they had called the line previously. First time callers accounted for 76.8% (n=6903) of these people, 4% up on 2003. Repeat Callers accounted for 23.2% (n=2088) of this group.

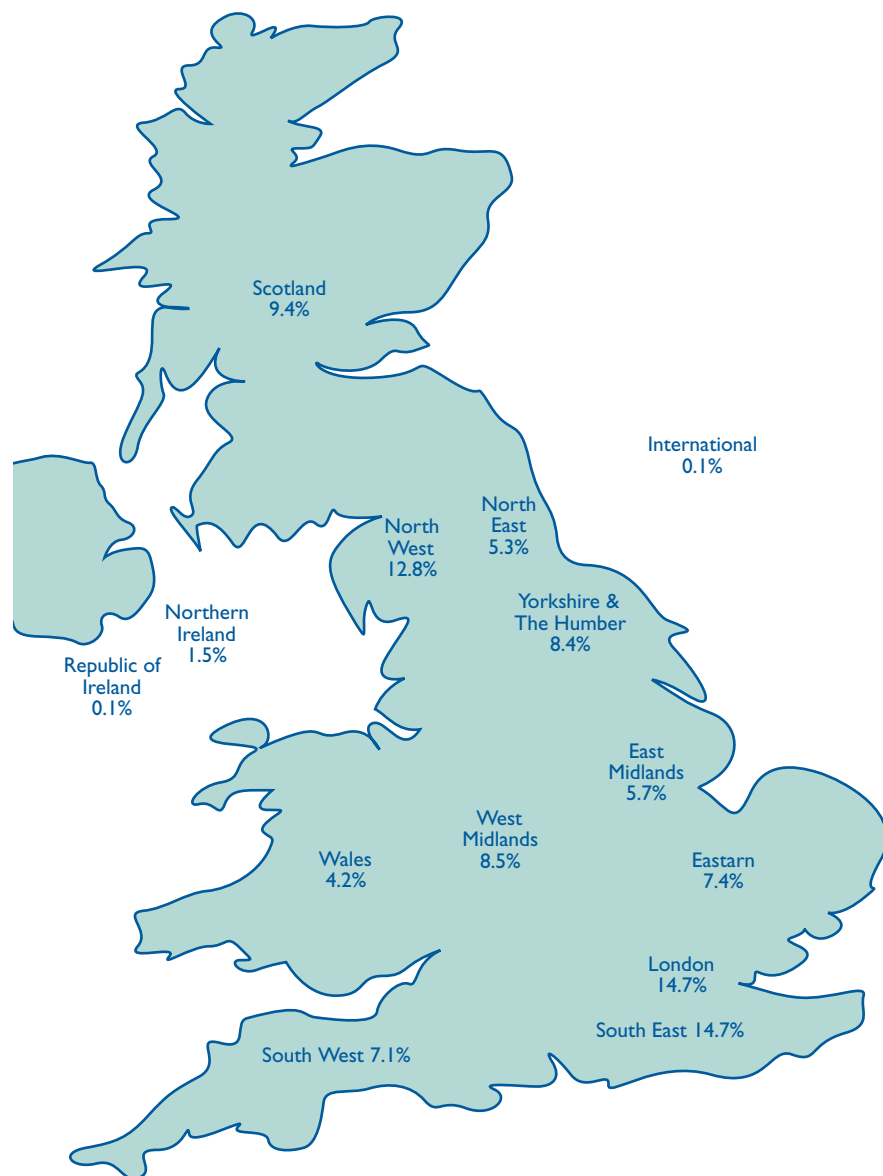
Fig. 3: Caller Analysis

As with previous Care Services Reports, it is considered necessary to separate the data provided by repeat callers and first time callers. This is done to avoid distorting data with repeat call information. There are occasions when it is beneficial to examine the information from both groups but this is generally presented as two separate data sets rather than a combination of both.

Caller Location

In the 2003 report, BT and Call Handling records of STD codes were used to examine the location of all the calls being made to the Helpline. This information is still available but includes all calls, including repeat callers and 4583 calls made from mobile phones. Given that calls from mobiles do not enable a location to be established and repeat calls distort the data, it is considered more useful to present the location information disclosed by first time callers (n=5236). The data has been presented using EU regional boundaries for the UK (see overleaf).

Fig. 4: First Time Callers by Location



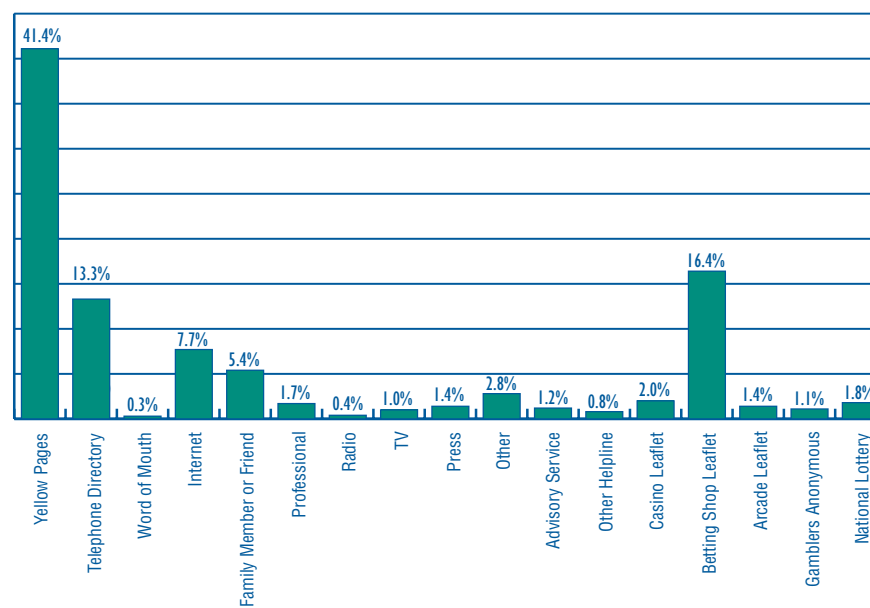
Source of Referral

The main sources of referral to the Helpline in 2004 have not changed substantially since 2003. 4691 first time callers disclosed how they found our number.

Yellow Pages remains the leading source of referral to the Helpline (n=1942). However, referrals from other telephone directories dropped from 21.3% in 2003 to 13.3% in 2004. This year also saw an

increase in referrals from betting shop leaflets, from 10.2% in 2003 to 16.4% in 2004. Generally, other differences are likely to be the result of changes in categorisation. For example the introduction of a 'family member or friend' category in 2004 has impacted on the number of 'word of mouth' referrals, which was how a referral from a friend or family member was previously recorded.

Fig. 5: First Time Referral Source



Call Type

Of all 13411 calls for which counsellors recorded a call type, 22.8% (n=3055) were silent calls, wrong numbers, prank calls or staff calls. The remaining 10356 calls were considered to be information, advice and counselling calls.

We thought it was useful to compare the percentage of calls recorded as 'information', 'advice' and 'counselling' for callers who disclosed that they were first time (n=6153) or repeat (n=1816) callers. There are some notable differences in the call type of the two groups, as demonstrated by the chart below.

Fig. 7: Call Type - First Time Calls vs Repeat Calls

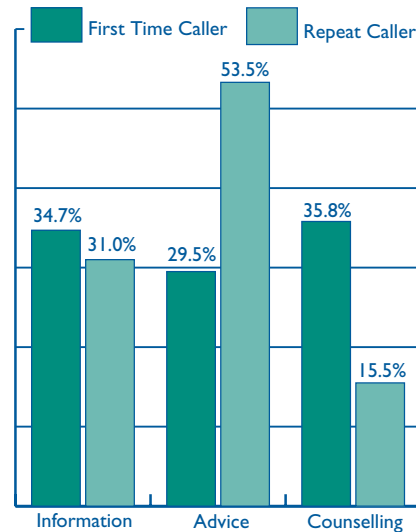
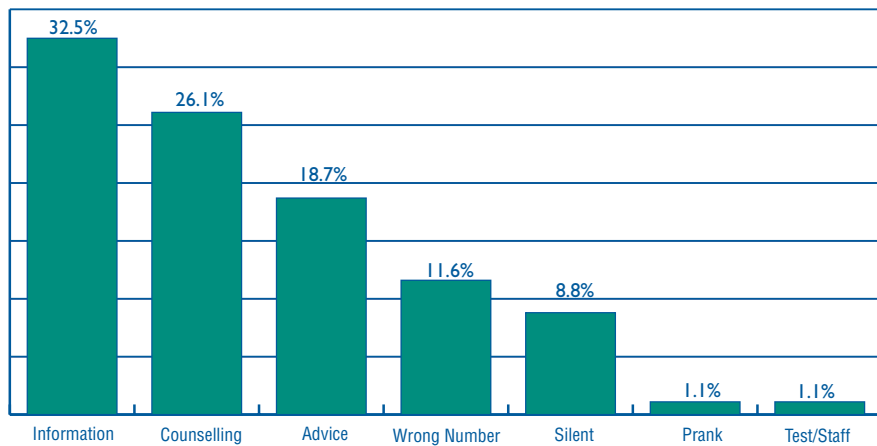


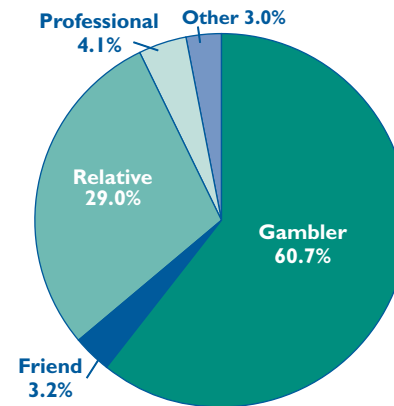
Fig. 6: Call Type



Caller Type

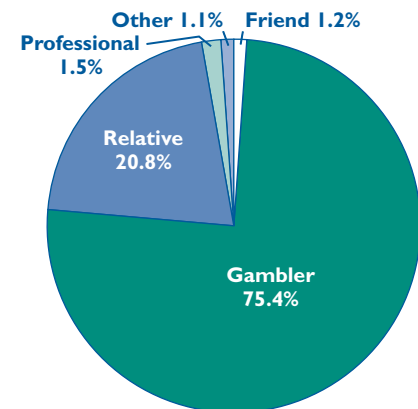
Of 6971 first time callers who disclosed their connection with problem gambling, 60.7% were the gambler themselves (up 1% on 2003) and 29% were a relative or spouse of the gambler (down 2% on 2003). The 'other' types of callers include students, the media and members of the industry.

Fig. 8: First Time - Type of Caller



Of 1968 repeat callers who provided information about their connection with problem gambling, 75.4% were gamblers (up 6% from 2003) and 20.8% were a relative or spouse.

Fig. 9: Repeat Calls - Type of Caller



Age & Gender Analysis

When looking at the problem gambler we take account of different characteristics, principally their age and gender. The counsellor records these details from information provided by the gambler. If the caller is not the gambler, it is the profile of the gambler being referred to that is recorded, not that of the caller.

The 2004 data shows a very similar pattern to 2003. 3483 first time callers disclosed information about the gambler's age. Of these calls the largest proportion placed the gambler between the age of 26 and 35 (n=1099, 31.6%). Of the 6455 first time calls in which the gambler's gender was recorded 89% (n=5743) were male, which is in line with last year's findings.

Fig. 11: First Time Callers - Gender

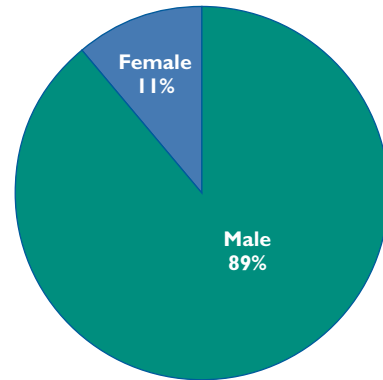
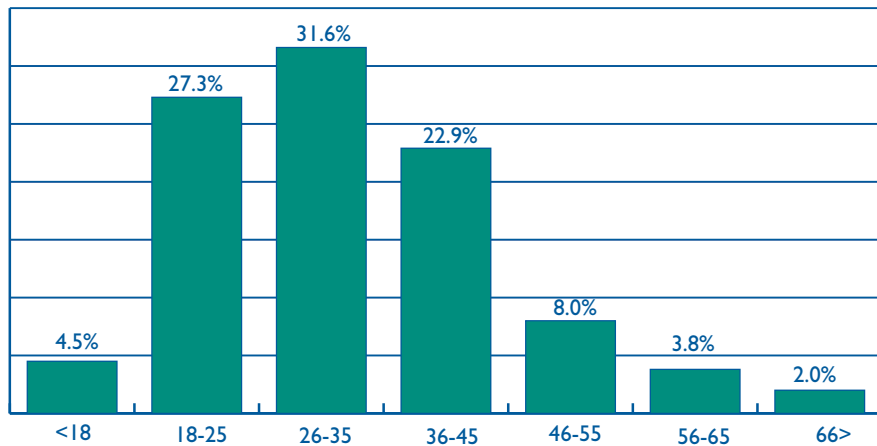


Fig. 10: First Time Callers - Gamblers' Age Analysis



Gambling Activity

Gambling Activities engaged in by the gambler have continued to be categorised in the same way as earlier Care Services reports. However, some of the activities represented separately in 2003 have been added to the 'other' category in 2004, due to low numbers.

Of the 6903 known first time callers, 4584 disclosed the nature of the gambling activity. The figures show a notable decrease in horse racing betting (down 10% from 40.5% in 2003 to 30.1% in 2004) and fruit machine players (down 4% from 33.4% to 28.9%) and a considerable rise in the use of FOBTs (up 13% from 8.3% to 21.5%).

Of the 2088 known repeat callers, 1047 disclosed the nature of the gambling activity. The differences between 2003 and 2004 were similar to those seen for first time callers; horse race betting has dropped 15%, fruit machine players have dropped 3% and FOBTs have risen 17%.

Fig. 12: First Time Callers - Gambling Activity

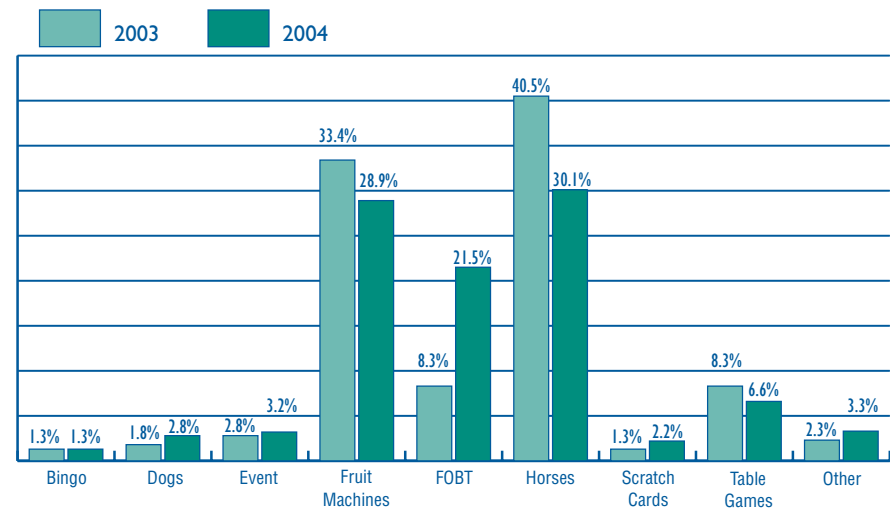
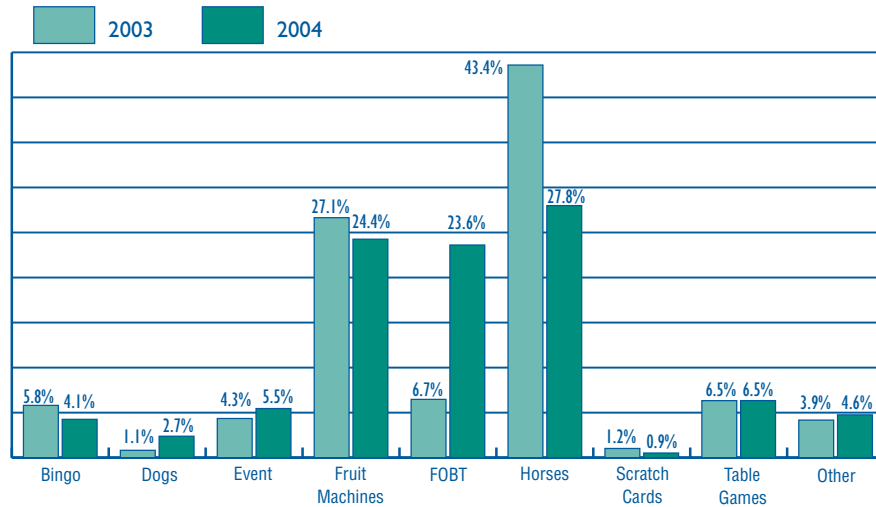


Fig. 13: Repeat Callers - Gambling Activity



Gambling Activity by Age and Gender

As with previous Care Services reports, a comparison has been made of the different gambling activities for various age groups. The table below demonstrates that fruit machines remain the dominant activity of under 18s. However the number has dropped 17% since 2003, whilst all other activities in this age group have increased. Bingo remains more popular with the older age group, with its largest representation being in the 66+ age range. Horse race betting remains the most popular activity of over 25s but has generally declined in all age groups, whilst FOBTs have increased across all age groups. The largest increase was for the 18-25 age group, with a 16% increase in calls referring to FOBT use.

The 'other' gambling activity category has also risen across all groups, although it is anticipated that this is the result of

combining a number of activities that were previously presented separately. The 'Other' gambling activities include lottery and scratchcards, private games, spread betting, prize draws and other uncategorised activities.

The most popular male activity remains horse race betting, although the pattern of male gambling activity imitates the changes seen in gambling activity as a whole i.e. horse race betting has dropped by 12% (n=1345) whilst FOBT use has increased by 14% (n=937).

Fruit Machines remained the dominant activity among women (n=328), although reporting shows a drop of 11% since 2003. Of particular note was the 10.1% (n=58) of callers reporting scratchcards as the gambling activity, which did not appear last year.

Fig. 14: First Time Callers - Gambling Activity by Age Range

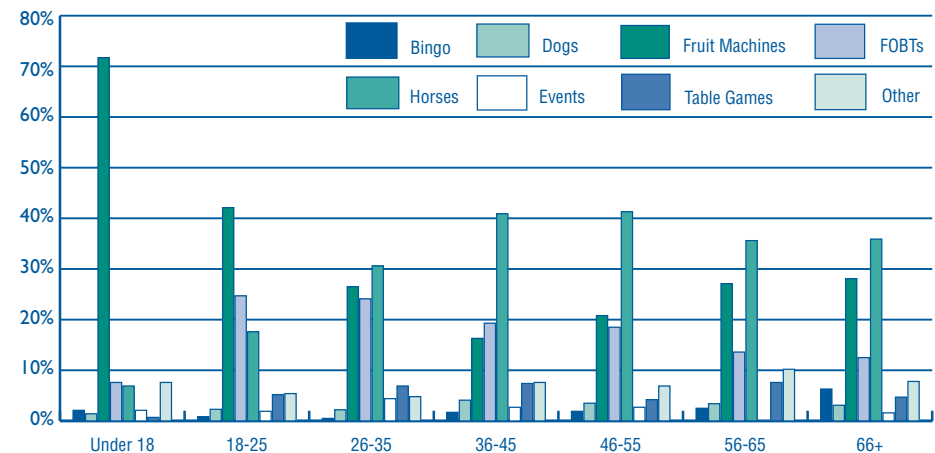


Fig. 15: First Time Callers - Male Gambling Activity

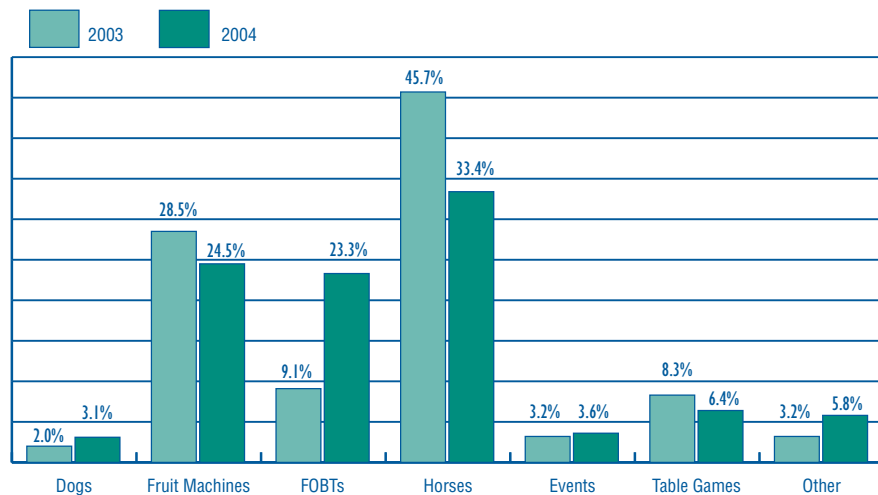
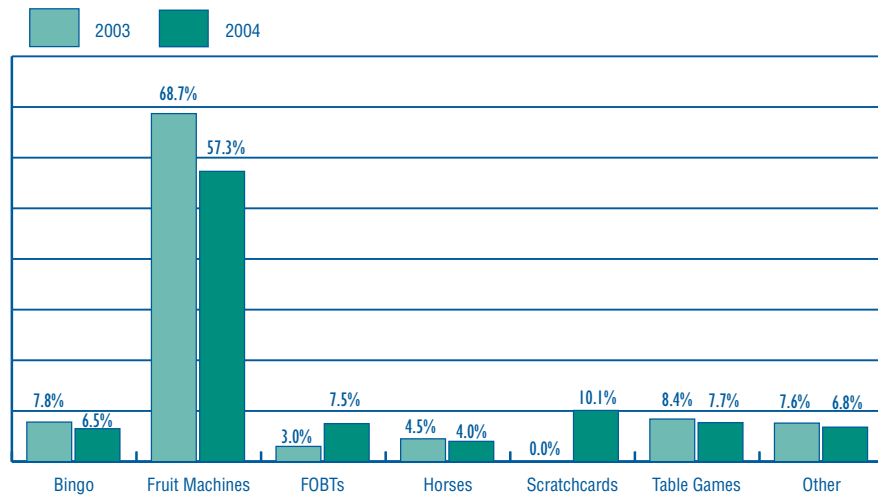


Fig. 16: First Time Callers - Female Gambling Activity

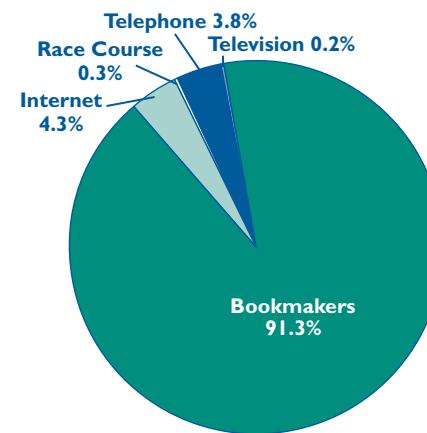


Gambling Location

Horse Race Betting Location

Last year it appeared that the amount of betting at bookmakers was on the decline, whilst telephone and Internet bets were on the increase. However, data from 2004 shows return to betting at the bookmakers. Of 1382 callers who reported horse race betting, 1293 provided information on where they placed their bets. Of those 91.3% (n=1181) were placing bets at the bookmakers. This increase may have some relationship with the increase in callers reporting that they found the Helpline number in a bookmaker's leaflet.

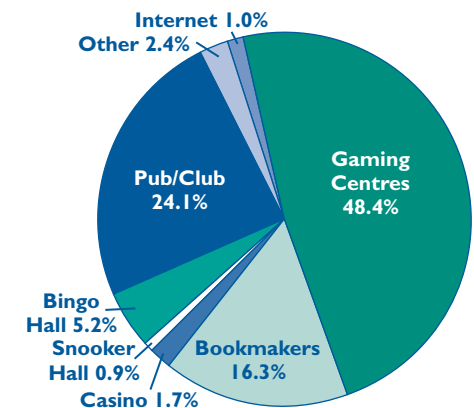
Fig. 17: First Time Callers - Horse Race Betting Location



Fruit Machine Gambling Location

As was seen in 2003, gaming centres make up almost half the calls where the caller provided a location for playing on fruit machines (n=537, 48.4%), although this is 6% down on last year's figures. Most of the other locations are represented in the same proportion as they were in 2003, with the exception of bookmakers where there is an increase from 8% to 16.3% (n=181).

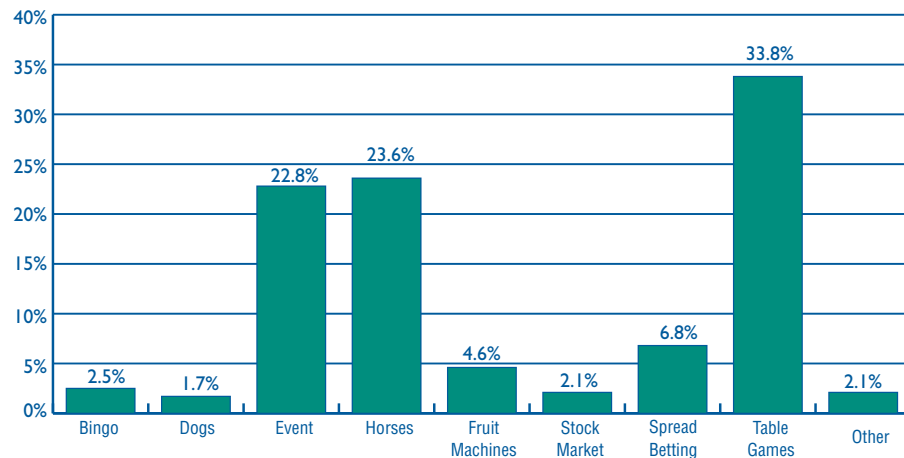
Fig. 18: First Time Callers - Fruit Machine Location



Types of Gambling on the Internet

2004 has seen a rise in the number of first time callers reporting the Internet as a platform of gambling. Of the 4452 first time callers that provided a gambling location, 407 (9.1%) stated that the gambling was taking place on the Internet. This is a rise from last year's figure of 5%. Of the 237 callers who provided details about the specific gambling activity, table games accounted for the largest reported activity (n=80, 33.8%).

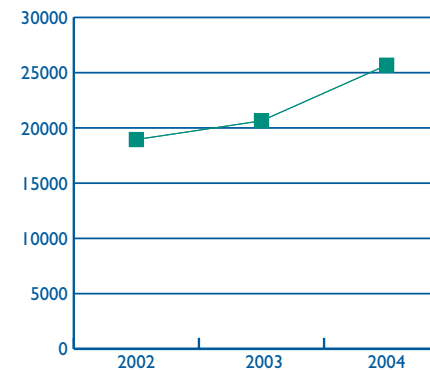
Fig. 19: First Time Callers - Types of Internet Gambling



Debts & Other Difficulties

2975 first time callers disclosed they were encountering problems with debts. Of these, 1874 (63%) reported 'some' debt and 93 (3%) reported a general debt of 'thousands'. 987 (33%) gave a specific figure and the average debt was £25,676, an increase of £5,000 on 2003. 21 first time callers disclosed that they were bankrupt as a result of their gambling activities, double the 2003 figure (n=10).

Fig. 20: First Time Callers - Average Reported Gambling Debt



Other difficulties reported by the 6903 first time callers contacting the Helpline included 820 (11.9%) experiencing difficulties with work and 39 (0.6%) having problems at school as a result of gambling. 314 (4.5%) callers reported depression and 86 (1.2%) spoke of suicidal thoughts. Another 296 (4.3%) reported feelings of stress and anxiety. 1865 (27%) stated that there were relationship difficulties and 8.2% (n=564) discussed housing issues resulting from problematic gambling behaviour.

Summary

GamCare is aware of the important service the Helpline provides to people affected by problem gambling. The organisation is fortunate to have a dedicated team of counsellors who are committed to providing support and information to those who call.

The key Helpline target is to ensure that when an individual makes the decision to call, a counsellor is available to answer immediately. We are aware of the significant impact that may occur when callers are unable to speak to a counsellor e.g. a loss of motivation to address their gambling, a justification to go and gamble or increased feelings anxiety. 2004 saw GamCare introduce major changes to the Helpline to improve service delivery and more training and development is planned for 2005.

GAMCARE COUNSELLING SERVICE

*Facts and figures alone cannot present
the human story of lives changed,
relationships restored and a future
where once there was none.*

Introduction

The GamCare Counselling Service provides specialist individual, couple and group counselling and psychotherapy for problem gamblers, partners and family members. The service is confidential and abides by the British Association for Counselling and Psychotherapy Code of Ethics and Practice. All counsellors are experienced therapists and all client work is regularly supervised.

The main aims of the counselling are:

- To stop or reduce the frequency of problem gambling.
- To develop ways of coping with problem gambling behaviour.
- To understand some of the underlying reasons why gambling has become a problem
- To address associated issues and behaviours.
- To move towards a gambling free and productive lifestyle.

The counselling approach is integrative, using a range of therapeutic interventions relevant to the needs of each individual person. Cognitive Behavioural Therapy is combined with psychodynamic psychotherapy thus addressing in the counselling process both behavioural patterns and underlying issues.

Service Overview

During 2004 service provision was increased by 54%. This was achieved by an expansion of evening opening hours and the introduction of a group counselling programme, thus offering problem gamblers and their families even more opportunities to get help and support. As a result there was a 47% increase in the number of clients who attended for counselling and a 40% increase in the number of new clients who received counselling for the first time. In total, 299 clients (of which 239 were new to the service) attended 1865 counselling sessions during the year. The average number of counselling sessions per client was 12.

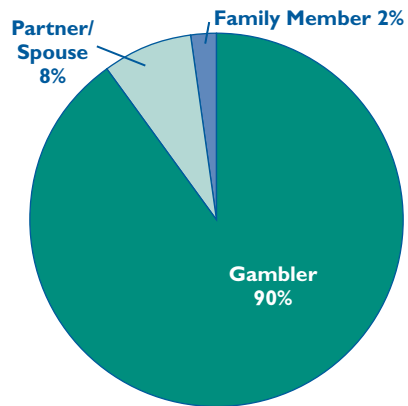
The GamCare Helpline remained the primary referral source with 87% of all referral requests having come from those who had used the helpline for initial support. There continued to be, however, a variety of other channels through which clients were referred for counselling. GamCare has a close working relationship with The Gordon House Association and provided a programme of individual counselling for their residents. There was also ongoing collaboration with the probation and prison services whereby some on probation or serving a custodial sentence were referred for formal assessment at GamCare and, where appropriate, accepted for weekly counselling and treatment. Other referral channels included Community Mental Health Teams, Health Care Professionals and GP practices, Gamblers Anonymous, agencies working with the homeless or those in supported housing, HR Departments and professional sporting bodies.

The GamCare website continued to be an increasingly significant avenue for clients finding out about the service with the counselling page being the most visited on the site. Leaflets and posters in gambling establishments, GamCare's media exposure and recommendations by previous clients all served to raise the profile of the service and open opportunities for help for those who need it.

Client Analysis

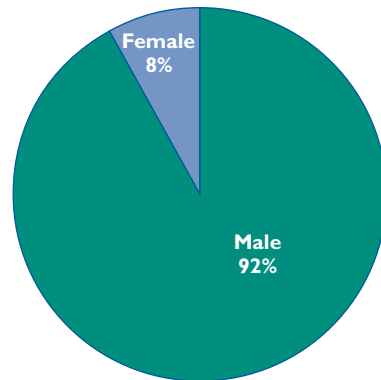
New Client Population (n = 239)

Although supporting the problem gambler remained the primary focus of the service, the importance of individual or couple counselling for partners and family members must never be downplayed. The impact of problem gambling on the family is often hidden yet those living with a problem gambler have difficulties, insecurities and fears every bit as profound, critical and painful as that experienced by the gambler. However, during 2004, partners and family members only accounted for 10% of the counselling work. Resources are being directed to allow greater flexibility of opening times that would enable partners with family commitments to attend. The provision of a dedicated family counselling service continues to be a high priority for the future.



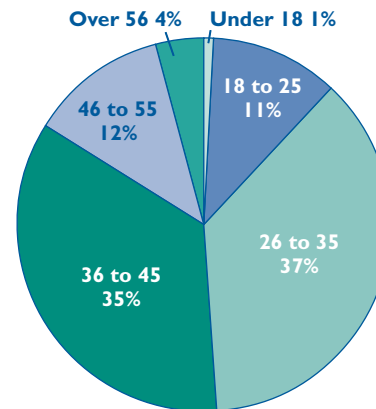
Gender of Gambling Clients (n = 216)

As with partners and family members, women gamblers attending for counselling at GamCare were still under-represented in terms of the increasing number of women who are becoming attracted to gambling. Why women are not being seen in greater numbers may be complex but clearly the service needs to be continually open and sensitive to women's experiences of gambling. It has been the case in the past that women clients have commented on the difficulty of being able to make suitable domestic arrangements in order to attend regular sessions and this would be exacerbated where women may be without a partner yet caring for child dependants. It may also be the case that the issue of women and gambling still does not receive the public recognition that it warrants.



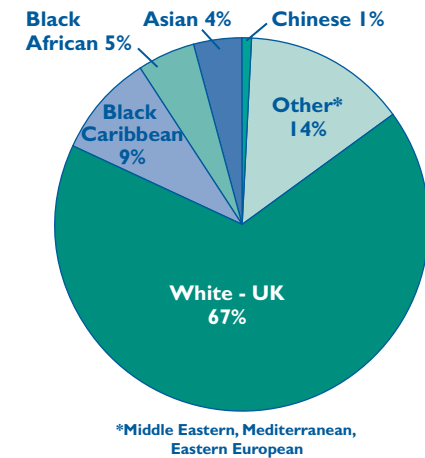
Age Distribution of Gambling Clients (n = 216)

As in previous years, the predominant age group was between 26 and 45. These clients gave evidence of some particularly long-standing and severe gambling problems. Those who were under 18 continued to be reluctant to seek more formal face-to-face counselling preferring to use the helpline service as their means of support. The number of clients over the age of 46 essentially remained the same as in 2003.



Ethnic Distribution of Gambling Clients (n = 216)

Reflecting the highly diverse ethnic mix of London, the number of those from the minority ethnic populations who came for counselling rose to 33% in 2004. Clients were drawn from a wide variety of ethnic backgrounds and affiliations including the Black Caribbean, Black African, Asian and Chinese, Middle Eastern, Eastern European and Mediterranean communities. The number of Chinese accessing the service, however, dropped to its lowest point of just 1% highlighting the need for a culturally appropriate service for problem gamblers within the Chinese community.



Gambling Analysis

In 2004 there was a dramatic and highly significant change in the pattern of primary problem gambling modes and associated problem gambling behaviours reported by clients attending for counselling. In the previous year it was becoming clear that the emergence of Fixed Odds Betting Terminals (FOBTs) in betting establishments and the continuing attraction of remote gambling were beginning to put a different complexion on the face of client problem gambling. This was more than confirmed during 2004 and was consistent across gender, age and ethnicity.

In the 2003 Care Services Report it was recorded that FOBTs had caused considerable problems for 14% of attending clients. During 2004, problematic gambling on FOBTs doubled in percentage terms and more than doubled (often considerably more) among male problem gambling clients, among clients aged 18 to 55 and among clients coming from the different ethnic communities. There was also a rise in problematic FOBT gambling among women clients. Furthermore, evidence from clients showed that, for many, FOBTs had become the mode causing the most damage with the highest levels of preoccupation, chasing and losses and had either been added to pre-existing betting or gambling behaviour or become a problem where none was perceived to have existed before.

Remote problem gambling also rose in 2004 though much more steadily and not as dramatically as with FOBTs. This rise was again across the various age and most of the ethnic groups. Several women clients at GamCare received counselling for their gambling on the internet, including playing poker online.

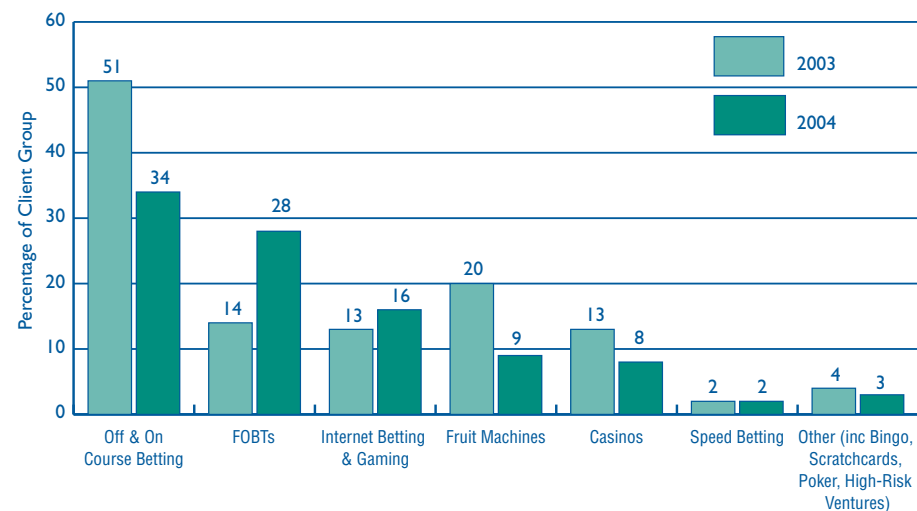
There was a considerable drop across gender, age and ethnicity in the percentage of clients whose modes were off and on course betting and fruit machines. Until 2004, betting and fruit machine playing had predominated as the primary problem gambling modes.

Primary Modes of Client Gambling (n = 216)

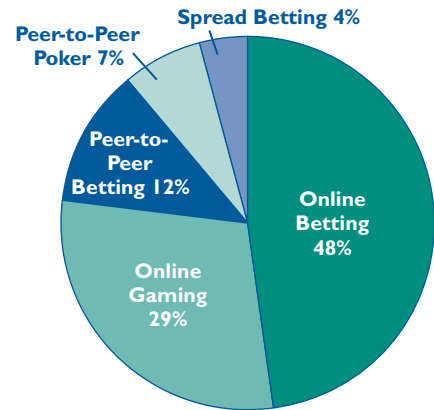
Off and on course betting (mainly off course) remained the primary problem mode in 2004 but FOBTs replaced fruit machines in second place accounting for 28% of clients, double from the previous year. The third primary problem mode was remote betting and gaming with 16% of clients betting online and 29% gaming online. However, 19% had specific problems with the betting exchanges (peer-to-peer betting) and poker. In terms of other primary modes, clients gambling on table games in terrestrial casinos fell by 5% while the incidence of spread betting remained low affecting 2% of clients. Private card games, including poker, accounted for a sizeable percentage of the category "other".

The trend of clients gambling in ever more complex fashion continued in 2004 and has now become well established. About 18% of clients reported having several multiple primary modes (i.e. multiple modes that were all problematic). FOBTs again figured highly, especially in combination with off and on course betting, internet betting and fruit machine playing. Other identified multiple primaries were fixed odds betting and spread betting, remote and terrestrial gaming and fruit machine playing in various combinations with off course betting, casinos, remote gambling and bingo.

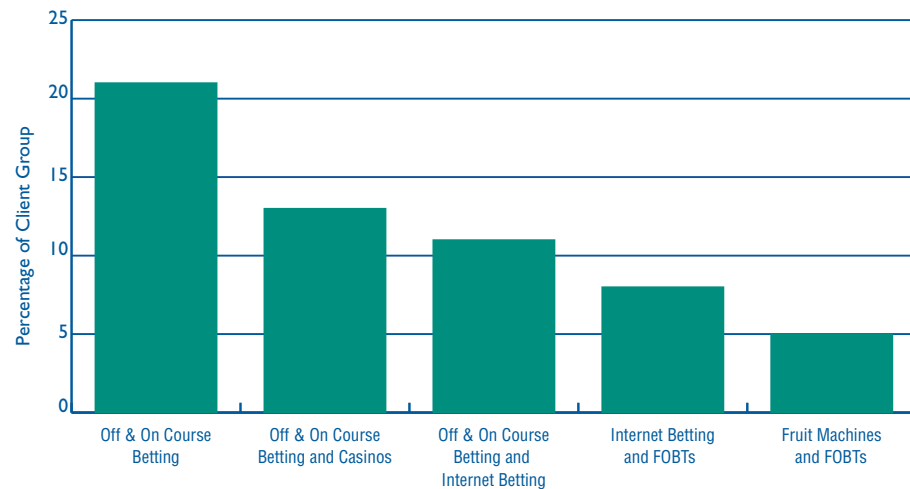
Primary Modes of Client Gambling



Internet Betting and Gaming



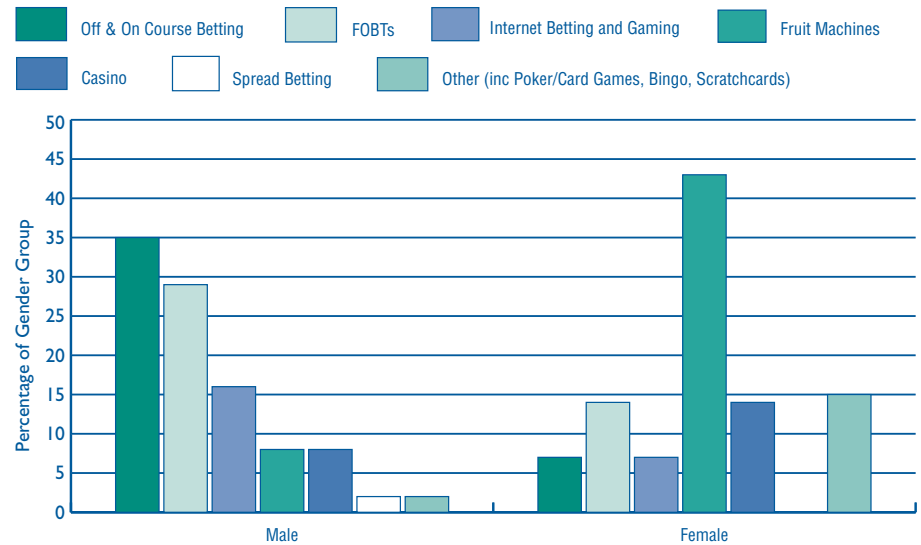
Main Multiple Primary Modes of Client Gambling



Primary Mode of Client Gambling by Gender (n = 216)

As in previous years, male and female clients had quite distinctive and differing choices when it came to gambling modes. For male clients off and on course betting was still the primary problem mode but not by a large margin, having fallen by 12% from 2003. FOBTs increased from 12% to 29%

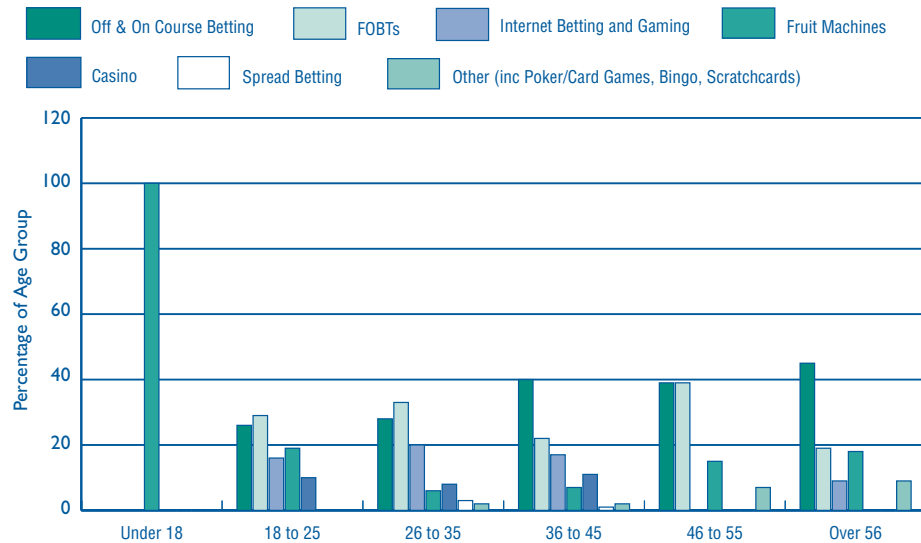
and remote gambling was up by 3%. However, fruit machines dropped from 14% to just 8% of male clients. Women gamblers were more true to form with fruit machines playing still predominant. Bingo and scratchcards were some way behind. Casino table games fell from 22% in 2003 to 14% while, as already stated, there was a rise in the percentage of women clients having problems with FOBTs.



Primary Mode of Client Gambling by Age (n = 216)

In contrast to gender, gambling modes are traditionally more evenly spread when it comes to age differentiation. However, for the first time, FOBTs replaced fruit machines and off and on course betting as the major problem mode for clients aged between 18 and 35 and was alongside betting for clients aged 46 to 55. Even

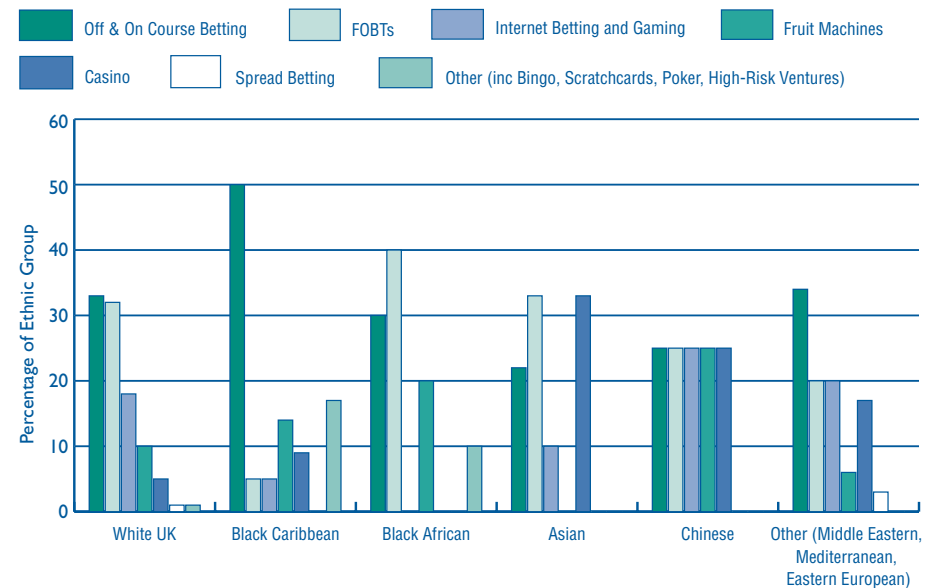
among the 36 to 45 year old clients, where betting has been strongest, FOBTs nearly trebled from 8% in 2003 to 22%. Remote betting and gaming, in the past largely found among the 26 to 35 age group, saw growth across a much wider age range including those over 56. Casino table games remained much as in the previous year but were conspicuously absent from clients 46 and above. There were no incidents of illegal gambling for under 18 clients.



Primary Mode of Client Gambling by Ethnicity (n = 216)

Replicating the pattern already described in the above analyses, the impact of FOBTs was no less significant when it came to problem gambling within ethnic communities. During 2004, off and on course betting was no longer the predominant problem mode across all the different ethnic backgrounds. Asian, Black

Caribbean, Black African, Mediterranean and Eastern European clients all reported problems from playing FOBTs and in some communities there was a substantial percentage rise from 2003. Among the white UK population, FOBTs came second to betting by only one percentage point.



Counselling Outcomes

Clients attending at GamCare typically present long-standing and deep-seated gambling problems with often devastating repercussions on their everyday functioning. For many clients this has meant the breakdown or near breakdown of relationships, impaired physical and psychological health and substantial financial loss. For others it has also involved illegal and criminal activity, loss of jobs and unemployment and, in some instances, the occasional or frequent misuse of alcohol and drugs.

In order to determine the full effectiveness of counselling provision it is, therefore, vitally important that outcomes are measured across a whole range of client functioning and not just problem gambling behaviour. With this in mind, a specific outcome measure "The Christo Inventory for Gambling Services" (CIGS) is incorporated as a core component of the clinical procedures at assessment, closure and follow up with all problem gambling clients. The use of CIGS alongside the DSM-IV criteria for pathological gambling (American Psychiatric Association 1994) and the South Oaks Gambling Screen (SOGS) enables counselling outcomes to be measured across the following areas: gambling behaviour; social functioning (i.e. the client's living situation and relationships); general health; psychological health; occupation status; financial/legal involvement; drug/alcohol misuse; use of ongoing support and aftercare; treatment compliance (i.e. attendance and reliability) and counsellor-client relationship.

Gambling Behaviour

At the time of assessment, 72% of problem gambling clients were regularly gambling or binge gambling at a severe level. A further 13% were gambling periodically. The remainders had severe or moderate gambling problems but were not actively gambling when they were assessed. Furthermore, 98% of clients met the DSM-IV diagnosis for pathological gambling.

At closure, the service achieved a very high 80% success rate with 63% of clients having stopped gambling and a further 17% having been able to exercise more control and reduce the extent and severity of their gambling. The remaining 20% were continuing with their regular or binge gambling.

In addition, 93% of clients were able to demonstrate improved levels of insight into the reasons for their problem gambling, 80% had significantly enhanced coping skills and 78% reported a greater sense of well-being in their day-to-day living.

Most clients were able to sustain and build upon the changes they had made after counselling had ended. At both the 3 months and 6 months follow-up stages, no clients who were gambling free at closure had relapsed. One client, 12 months after closing, had returned to gambling at a severe level and resumed counselling.

Although follow ups are not conducted beyond 12 months, a few clients do remain in contact with the service. During 2004, 75% of those who did keep in contact

were still gambling free (in one case 6 years on). Only one client was continuing to gamble.

Social Functioning

High levels of problem gambling considerably affect the social functioning of clients and place a very great strain on home and family life. As in previous years, for most clients, it was this strain that precipitated requesting counselling. Nevertheless, the vast majority of partners and family members remained supportive through the counselling process and at closure only 15% of clients still had living situations and relationships that were unstable.

Family support was maintained after counselling had finished. Up to 12 months post closure, between 67% and 80% of clients reported experiencing no ongoing family or relationship difficulties.

General and Psychological Health

Although 31% of clients were experiencing related general health problems at the time of assessment, psychological health was the area most severely affected by problem gambling. Only 9% of clients reported having no psychological problems while 77% had general anxiety, mood swings, poor sleep, low self-esteem or felt unhappy and dissatisfied with their lives. Particularly significant for the provision and delivery of counselling, 14% had severe psychological problems including neurotic disorders, recently attempted or seriously considered suicide, clinical depression, manic-

depression and in some cases psychotic disorders (paranoia, hallucinations and schizophrenia)..

By closure, 85% reported being in good physical health, 36% in good psychological health while those having severe psychological problems, especially in regard to depression and suicidal ideation, dropped to 9%. However, for 55% of clients esteem issues remained at some level even where general anxiety, sleep patterns or mood swings had been alleviated or considerably improved. This serves to highlight the complex and often deep-seated interrelationship between problem gambling and self-esteem.

Levels of general and psychological health were sustained, and even improved upon, during the follow up period. By 3 months and 6 months post closure, no clients had regressed, 17% reported increased physical health and 36% increased psychological well-being. Only at the 12 month follow-up stage was any psychological deterioration reported and that was due to a gambling relapse impacting negatively on feelings of self-esteem.

Occupation

Lack of occupation and stimulation is a powerful trigger for problem gambling, especially when combined with an inability to cope with boredom and frustration. It is also a major contribution to poor self-esteem. It is, therefore, significant that although the majority of clients had full-time occupations at the time of assessment, a sizeable 22% were largely unoccupied

with no real social pastime and a further 6% were only occupied for a relatively small part of their daily lives.

These figures remained relatively unchanged at closure and post closure though, at the 3 month follow-up, 7% of clients reported improvements in their occupational status, even if only on a temporary basis.

Financial and Legal Affairs

One of the most positive counselling outcomes was the turnaround in the financial and legal situations of clients. At assessment, 22% of clients had acquired severe debt due to their gambling together with, in several cases, related current or past criminal involvement. A further 38% were facing more moderate levels of debt.

By closure, 84% had largely resolved or brought under control their finances while only 7% and 9% respectively were still in severe or moderate financial difficulties.

Between 80% and 86% of clients were able to maintain financial control after counselling had finished. No clients reporting deterioration in their financial and legal affairs at either the 3 month or 6 month follow-up stage. However, where a gambling relapse did occur 12 months post closure the financial impact was immediately felt.

Drug and Alcohol Misuse

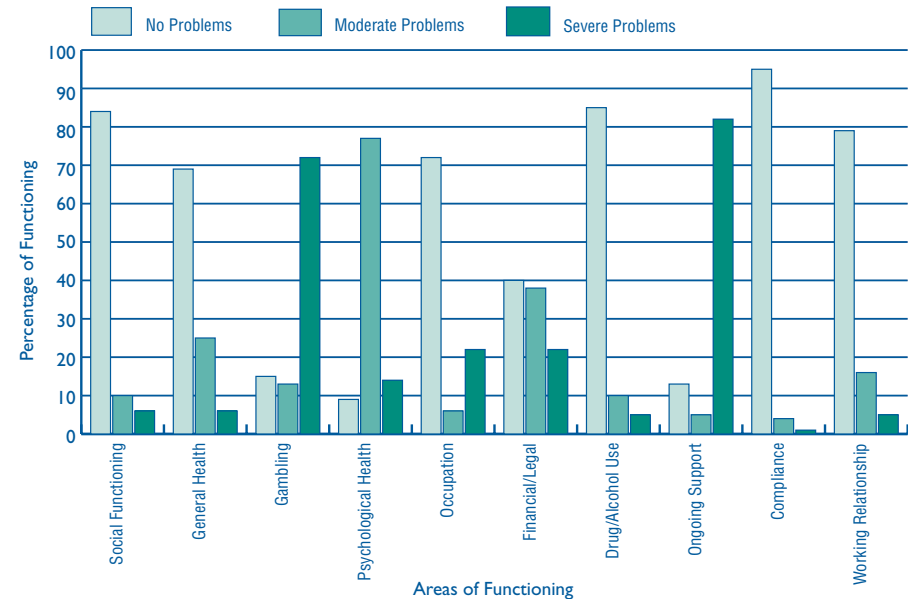
Positive outcomes in terms of co-morbidity were less dramatic than in other areas of client functioning but no less significant for those clients who were able to make changes and stop or reduce their alcohol or drug misuse.

At assessment, 15% of clients reported having a substance use disorder (SUD) alongside their gambling. At closure, that fell to 11% and 3 months after counselling was down to 7%. However, no clients with a SUD attended the follow-up programme beyond 3 months.

Support, Compliance and Working Relationship

Support, compliance and working relationship relate more to the clinical arena and are highly important if counselling is to be really effective. The vast majority of clients came in to counselling with no or only patchy support structures in place. However, once counselling had started, levels of motivation and commitment were generally high even though 16% of clients were quite demanding to work with and a further 5% had multiple needs including severe psychological problems. For those who committed themselves to the follow up programme, compliance rates, and especially working relationships, remained extremely good.

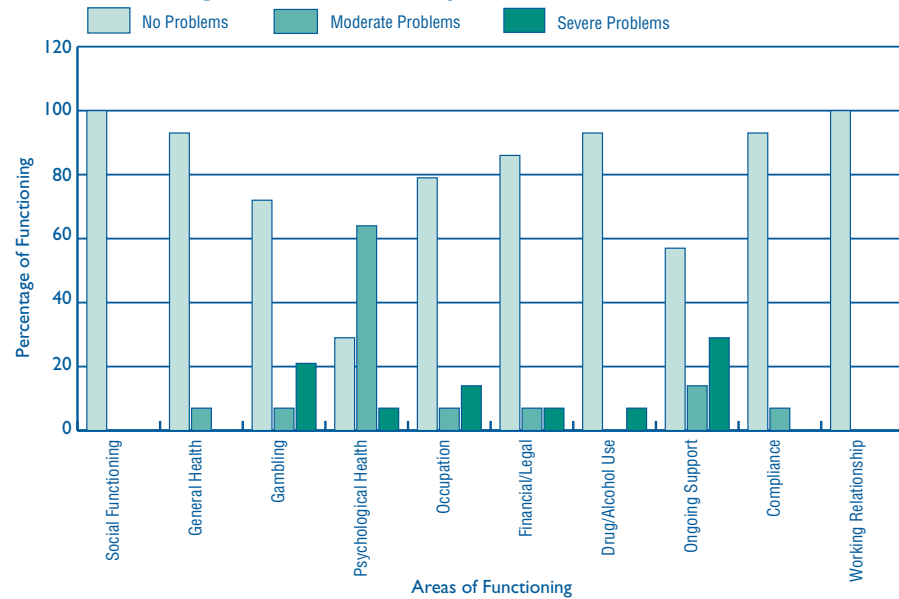
Client Functioning at Assessment



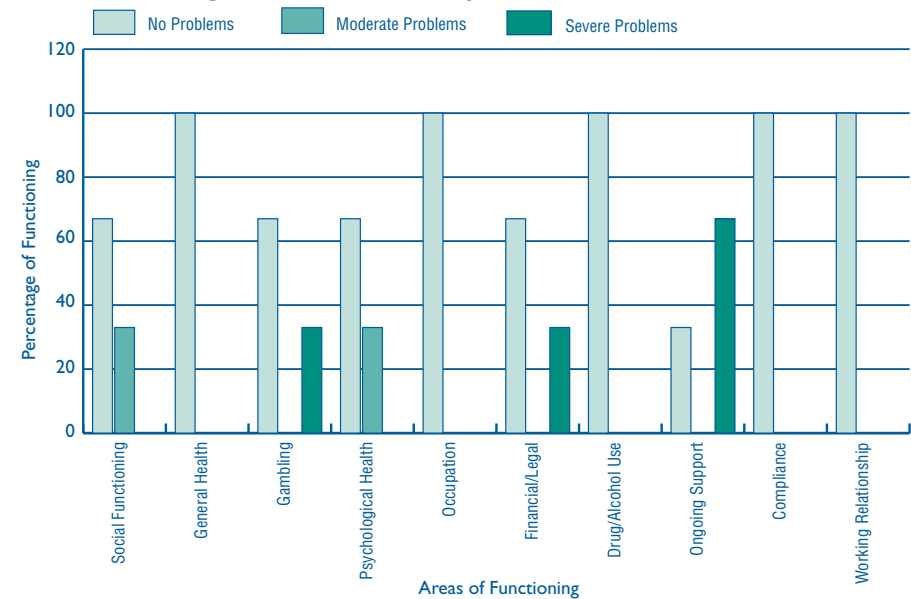
Client Functioning at Closure



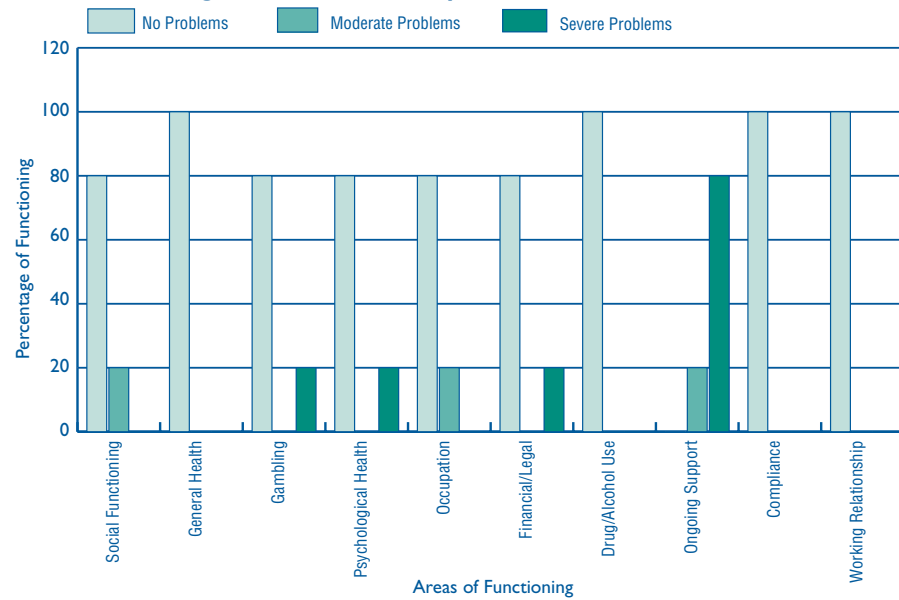
Client Functioning at 3 Month Follow-up



Client Functioning at 12 Month Follow-up



Client Functioning at 6 Month Follow-up



BREAKEVEN PARTNERSHIPS

Working in partnership together to provide professional, effective and integrated services for problem gamblers and their families.

Introduction

The aim of the Breakeven partnerships is to expand the availability of problem gambling counselling provision across the UK. Rather than create a separate organisation in each locality, GamCare works with carefully selected existing agencies that are already providing counselling for addictive behaviours. Finance and support for the training and management of counsellors enables an established professional counselling agency to develop a specific problem gambling service within an area and its surrounding region.

The partnership programme is well established and has been progressively extended since the first joint ventures with the Cumbria Alcohol & Drug Advisory Service (CADAS) and the North East Council on Addiction (NECA) back in 1997 and 1998. In addition to the GamCare Helpline and Counselling Services, problem gamblers and their families can now access face-to-face counselling in Scotland, South Wales, Northern Ireland, Cumbria, the North East, the West Midlands and Southampton and the South Coast. In 2005, counselling provision will be even further extended with new partnerships in Nottingham, Merseyside and Sussex having already undergone training.

Service Overview

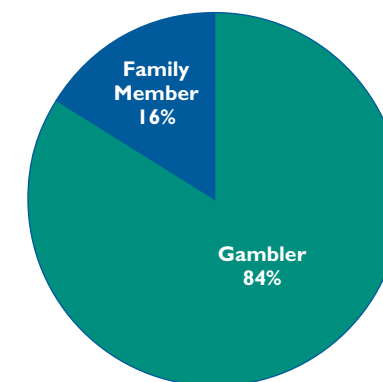
In 2004, service delivery across the partnerships increased substantially with the number of clients seen up by 49% and the number of sessions provided by a dramatic 141% from the previous year. In total, 388 clients attended 1770 sessions of counselling. This was achieved by a combination of factors. First of all, more partners continued to join the Breakeven programme. Secondly, existing individual partners expanded their capacity in delivering problem gambling counselling in their communities. Thirdly, during the course of the year, GamCare instigated more efficient and effective data collection and reporting procedures.

Client Analysis

New Client Population

The Breakeven Partnerships offer counselling for both problem gamblers and family members with the Parents Advice Centre in Northern Ireland having special provision for the family. Encouragingly, the percentage of family members requesting and receiving counselling rose from 12% in 2003 to 16% in 2004.

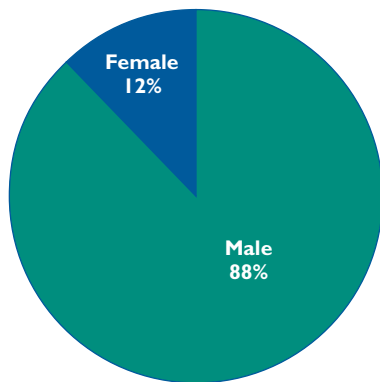
New Client Population



Gender of Gambling Clients

In contrast to the increase in partners and family members receiving counselling, women gamblers were still under-represented across the partnerships and the client group remained predominantly male. Indeed, the overall percentage of women gamblers attending fell from 20% in 2003 to 12%.

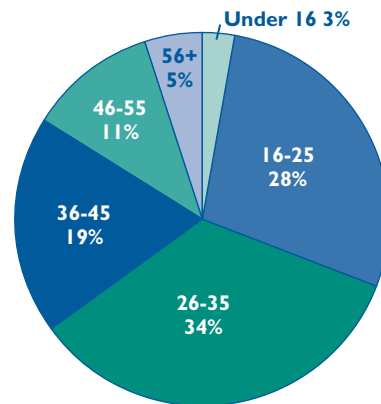
Gender of Gambling Clients



Age Distribution of Gambling Clients

The partnerships have traditionally been able to attract a younger client group in to counselling and this was continued in 2004. Those aged between 16 and 35 accounted for 62% of attending clients with a further 3% being under 16. The percentage of clients over 36 remained essentially the same as in 2003.

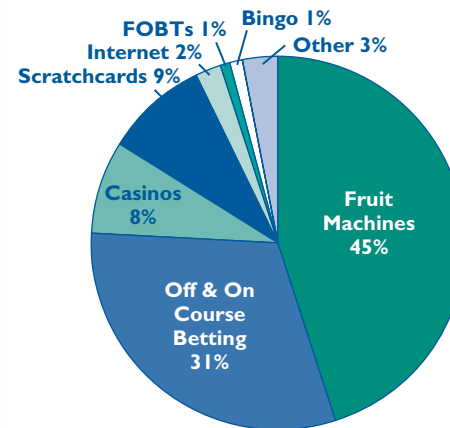
Age Distribution of Gambling Clients



Primary Mode of Client Gambling

Fruit machines playing (54%) and off and on course betting (31%) were by far the primary problem modes of gambling across the partnerships. Unfortunately, there was not sufficient recorded data concerning client gambling on the Fixed Odds Betting Terminals (FOBTs) for a comparison to be made with the trends reported by the GamCare Helpline and Counselling Services.

Primary Modes of Client Gambling



Christo Inventory for Gambling Services

Assessor Date

Client DOB..... M F Intake assessment.....
or
Follow-up assessment

Gambling choices (e.g., horses, cards, fruit machines, etc.)

Residence (e.g., hostel, prison, residential treatment, home, hospital, NFA)

Service Provision:	Name	Date in	Date out	Reason left
First
Second

This form is for evaluation / clinical audit purposes only and is a rough indicator of professional impression of recent gambling related problems in the past month. Specific situations / behaviours are listed only as guiding examples and may not reflect the exact situations / behaviours of the client. (Please ring a number under each heading)

Social functioning

- 0... e.g., client has a stable place to live and supportive friends or relatives who are gambling / drug / alcohol free.
1... e.g., client's living situation may not be stable, or they associate with gamblers / drug users / heavy drinkers..... (Tick one)
2... e.g., living situation not stable, and they either claim to have no friends or their friends are gamblers / drug users / heavy drinkers.

General health

- 0... e.g., client has reported no significant health problems.
1... moderate health problems e.g., teeth/sleep problems, occasional stomach pain, headache, back ache, skin problems.
2... major problems e.g., extreme weight loss, jaundice, abscesses, ulcers, stomach / bowel problems, chest / other infections, coughing up blood, fever, blackouts, seizures, organically caused memory loss, neurological damage.

Gambling

- 0... e.g., no gambling in past month.
1... e.g., client suspected of periodic gambling, or else may be socially gambling for small sums that are not considered a problem.
2... e.g., client suspected of gambling binges or regular gambling.

Psychological

- 0... e.g., client appears well adjusted and relatively satisfied with the way their life is going.
1... e.g., client may have low self-esteem, general anxiety, poor sleep, may be unhappy or dissatisfied with their lot.
2... client has a neurotic disorder e.g., panic attacks, phobias, OCD, bulimia, recently attempted or seriously considered suicide, self-harm, overdose or may be clinically depressed. Or client may have psychotic disorders, paranoia (e.g., everybody is plotting against them), deluded beliefs or hallucinations (e.g. hearing voices)

Occupation

- 0... client is in full time occupation e.g., homemaker, parent, employed, or student.
1... e.g., client has some part time parenting, occupation or voluntary work.
2... e.g., client is largely unoccupied with any socially acceptable pastime.

Financial / Legal

- 0... e.g., no recently acquired debts (apart from usual mortgage or hire purchase agreements) or criminal involvement
1... e.g., client suspected of having unfixed debts (e.g., credit card) or irregular criminal involvement, perhaps petty fraud, petty theft, driving offences.
2... e.g., suspected of having extreme debt or regular criminal involvement, or major fraud, violence, assault, breaking and entering, car theft, robbery.

Drug / alcohol use

- 0... e.g., no recent drug / alcohol misuse.
1... e.g., client suspected of periodic drug / alcohol misuse, or else may be socially using drugs that are not considered a problem, or may be on prescribed drugs but not supplementing from other sources.
2... e.g., client suspected of bingeing or regular drug / alcohol misuse.

Ongoing support

- 0... e.g., regular attendance of GA / AA / NA, treatment, drop in centre, day centre, counselling, telephone support, or treatment aftercare.
1... e.g., patchy attendance i.e., less than once a week contact with at least one of the above.
2... e.g., client not known to be using any type of structured support.

Compliance

- 0... e.g., attends all appointments and meetings on time, follows suggestions, or complies with treatment requirements.
1... e.g., not very reliable, or may have been reported as having an "attitude" problem or other difficulty with staff.
2... e.g., chaotic, may have left treatment against staff advice or been ejected for non-compliance e.g. gambling, attitude problem.

Working Relationship

- 0... relatively easy going e.g., interviews easily, not time consuming or stressful to work with.
1... moderately challenging e.g., a bit demanding or time consuming, but not excessively so.
2... quite challenging e.g., very demanding, hard work, time consuming, multiple needs, emotionally draining or stressful to see.

CI/GS Total Score =



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