To what extent does initial assessment data provide insights into factors associated with help-seeking?

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To what extent does initial assessment data provide insights into factors associated with help-seeking?
1 Summary

The primary aim of this work was to shed light on what affects help-seeking and to identify areas of strength and improvement in service provision by exploring a dataset relating to clients of the problem-gambling charity GamCare. Quantitative analysis was undertaken on the main dataset, which consisted of records relating to 27,839 cases from 2015 to 2019. A report covering the findings from this analysis was presented to GamCare. The present report focuses on qualitative findings based on an exploration of assessment data covering 713 clients. They were 596 problem gamblers and 117 affected others who sought support from GamCare. Findings from the quantitative analysis were fed into the qualitative research during the analysis period.

Methods

Notes taken by GamCare counsellors during a client’s initial assessment were coded manually by the research team using the NVivo 12 data analysis package. A coding frame was developed after initial analysis of 100 cases, which was devised to address the research questions posed by GamCare. These questions had been developed to explore what affects help-seeking with reference to the main areas covered in assessments. Coding themes were interrogated further using data about improvement outcomes (recorded as good, low or unplanned) based on the CORE-10 scale which measures psychological distress and screens for mental illness, undertaken by all GamCare clients after each treatment session. A set of secondary questions to the overarching question are presented below.

1. To what extent does reported social support from partners, family and friends impact upon help-seeking and treatment outcomes?

Counsellors recorded that the majority of gamblers had social support, and references were made particularly to partners and families. This was also the case for affected others. Social support for gamblers was explored in terms of support from partners, family and friends, and the ability of gamblers to be bailed out and their money managed on their behalf by members of their social support network. Comments by counsellors about affected others show that these clients feel less supported and experience greater shame about admitting the situation to other people than gamblers do. Analysis indicated that women gamblers receive less support than men in the form of someone else managing their money; it is possible that this may be linked with their treatment outcomes, which were less successful than men’s. Affected others are predominantly women; it may be that men are less likely to seek support for their female partners’ gambling problem and that women are less supported in overcoming their problem. Male gamblers frequently mentioned their
employers/colleagues as a source of support, which may be less available to women who, in this sample, were less likely to be employed.

2. Which aspects of the ‘stages of change’ model (i.e. pre-contemplation, contemplation, preparation, action, maintenance and relapse) can be inferred from initial assessment data and does this provide any insight into the likelihood of clients succeeding in their treatment?

The ‘stages of change’ model is commonly used in addiction services (DiClemente, Schlundt, & Gemmell, 2004; Prochaska, DiClemente, & Norcross, 1993) to ascertain the stage at which clients are ready to change their behaviours. GambleAware (2017) suggest that it is useful to have an understanding of the ‘stages of change’ model and of motivational interviewing as a background to providing brief interventions.

Analysis of the coding of gamblers’ assessment data according to the ‘stages of change’ model strongly indicated that the majority were in the action stage. Their stages were ascertained based on counsellors’ records of the actions a client had already taken, such as abstaining from gambling, blocking or banning themselves from venues, revealing their problem to others and if someone else was managing their money. Affected others seemed more likely to be in the preparation stage and to be in the process of making decisions about how best to support both themselves and the gambler. Some gamblers and affected others did unexpectedly well, despite being in the pre-contemplation or contemplation stages (and vice versa, some did badly despite being in the action stage), demonstrating the value and success of counsellors of persevering with all clients.

A few counsellors appeared to be using a motivational index (readiness, motivation and confidence scores) as a way of gauging and recording readiness to change, but this was not consistently recorded in the assessments. Improved recording of the motivation levels or readiness to change of gamblers and affected others could help predict treatment completion and outcomes and might be useful for counsellors in indicating in which areas a client needs greatest support – for example, signposting to additional services.

3. What insight is there from counsellors’ records about the strength of the therapeutic relationship which is being developed with clients?

The vast majority of clients were viewed by counsellors, according to their records, as engaged and motivated to participate in counselling, suggesting positive relationships were being forged. The affected others conveyed greater emotional distress than the gamblers. Counsellors demonstrated their skill in engaging with a wide range of clients, tailoring, for example, approaches for those with communication needs or autism and from black and
minority ethnic communities or backgrounds, vulnerable adults (such as those with health conditions) and ‘hard to reach’ groups. Some comments offered by clients on improving or personalising services included developing options: to choose the gender and cultural background of a counsellor; to continue with the same counsellor with whom the assessment had taken place; or to participate in group, face-to-face or couples therapy.

Analysis of counsellors’ notes showed that they were drawing on a variety of psychodynamic, cognitive behavioural therapy (CBT), motivational or strengths-based approaches when working with clients. This would be expected given the range of clients’ presenting needs. The range of reasons recorded for clients’ gambling highlight the need for varied skills in drawing from different practice frameworks.

4. Which client treatment goals are recorded by counsellors?

Analysis of the assessment data indicates that counsellors perceived that the goal of the vast majority of gamblers was to be abstinent; only a very small number mentioned an interest in controlling and continuing their gambling. Affected others’ goals focused on supporting the gambler, supporting themselves to deal with the problems raised by the gambler, or a combination of the two.

5. What types of mental health and safeguarding concerns are recorded and is there evidence about how they are managed by counsellors during initial assessments?

Counsellors recorded high levels of mental health problems within the sample of gamblers. Many clients reported pre-existing mental health problems and reports of previous suicide attempts were commonly mentioned, including within clients’ families. Counsellors reported that some gamblers and affected others attributed some of these mental health problems, such as depression, anxiety and stress, directly to their gambling problems.

Data analysis suggested that it would be useful to have a clearer approach to recording levels of suicide risk and noting cases as safeguarding. This would avoid duplication and facilitate easier and quicker data interpretation. In the majority of cases where suicide risk was identified, counsellors followed a risk plan and cases were noted for monitoring in future sessions. It was unclear from the assessment data how decisions were made about contacting multiagency partners (e.g. local authority adult social care staff, mental health community health teams or GPs) on behalf of clients. In a couple of instances references were made to GamCare team meetings or discussions with managers about high-risk clients. Accessing GPs was referenced very frequently and a large proportion of clients were already in contact with their GP because of depression, anxiety or other health conditions. It would be worthwhile for GamCare to engage with GPs as a professional group as, with more
information, GPs would be well placed to screen and signpost those affected by gambling harms.

6. What types of harms are recorded by counsellors as experienced by gamblers and affected others?

The most frequently referenced harms for gamblers were debt, engaging in theft and relationship difficulties. For affected others they were mental and physical abuse, being the victim of theft or financial abuse, and having to bail out the gambler. Of note was the large amount of gambling-related theft discussed by gamblers and affected others. The majority of theft admitted by gamblers was from family and friends, although there were also references to stealing from employers and colleagues. Prosecutions and interactions with police and the criminal justice system were rare although some were reported. Domestic violence (physical and mental) relating to gambling was very seldom recorded or admitted to within the gambling sample (although it may have been discussed in later treatment sessions), but it was recorded in relation to the affected others sample.

7. What do gaps in the data tell us about factors associated with help-seeking?

Insights about gender differences in help-seeking were sought within the data recorded by counsellors. However, little evidence was found apart from a very few records of information relating to gamblers’ pregnancies or gambling while on maternity leave. This unexpected finding may reflect the situation that insights were not recorded by counsellors (e.g. only one comment was made about difficulties in accessing services due to childcare) as such difficulties are commonly experienced.

The effect of a parent’s gambling on their children was also not mentioned in detail by gamblers or affected others in the assessment notes. Much of the evidence about the possible impact on children was inferred from counsellors’ notes, rather than being reports of explicit statements from parents. It may be that the children’s perspective is missing from the data as clients are focused on their struggle to cope with problems created by the problem gambler.
2 Recommendations

The points below are based on analysis of initial assessments only rather than treatment notes over time; some of the points raised may therefore be addressed and recorded by counsellors in subsequent treatment sessions.

- **Widen social support.** Given the importance of social support to recovery outcomes and the high incidence of relationship harms caused by gambling, clients should be informed that their partner/family can be signposted to GamCare support for affected others. The records indicate that women are more involved in managing gamblers’ finances than men; encouraging women gamblers whose money was not being managed for them to identify someone to assist with this might be a useful part of their treatment and recovery. Notifying women gamblers that support is available for their partner might encourage more men to access services for affected others. There is potential for more systematic exploration and recording of the social support available to clients, including that available via employers/colleagues, when conducting assessments (acknowledging that there are limits to appointment times).

- **Record more systematically.** More systematic recording of gamblers’ readiness to change and clients’ initial actions (e.g. whether they had stopped gambling, blocked themselves from gambling opportunities, revealed their problem to their social network or arranged for someone to monitor their finances) might be useful. For affected others, the same approach could be applied to recording planning and decision-making around supporting the gambler and/or supporting themselves and any actions taken (e.g. managing the gambler’s money). This might assist counsellors in evaluating clients’ treatment journeys. Some counsellors were already using a motivation index as a way of gauging clients’ progress and more consistent use of this measure could also be considered.

- **Explore the role of negative life events.** References to reasons for gambling revealed high levels of negative life events but the case notes suggested that clients were often not signposted to support services specific to their experiences or trauma. Bereavement, for example, was frequently cited as a ‘reason’ for gambling, but few references were made to the potential for accessing bereavement support such as CRUSE. It is acknowledged that engaging in counselling from different sources at the same time may not be productive but alerting clients to other sources of support during assessment is worth considering. Some commentators (Roberts et al., 2017) have called for clients to be routinely screened for trauma in order to tailor support and signposting to other services.

- **Consider ways of personalising services.** A minority of clients do not attend treatment after assessment. A small number of clients’ comments suggest ways in
which this might be addressed. These include the wish to continue with the same counsellor, working with a counsellor of the same gender (counsellors are predominantly female, which may deter some men), or from the same ethnic background. There was only one reference in the database to seeking a translator/interpreter for a client and this was refused by the client who had brought their partner to assist. Ways of attracting and supporting clients whose first language is not English may need to be considered. However, counsellors recorded cultural aspects about clients, demonstrating cultural competence in working with diverse groups. The demographic composition of counsellors would be worth exploring as would publicising their diverse backgrounds. A small number of well-informed clients were reported as having requested particular approaches, such as CBT or psychoanalysis. This suggests another opportunity to personalise services by offering more overt choices. Virtual assessments might make such preferences easier to accommodate.

- **Help affected others to build resilience.** When considering gambling harms, the frequency of mentions of theft suggest the importance of building resilience within affected others as a way of helping them deal with instances of theft perpetrated by gamblers which they do not wish to report to the police.

- **Develop a more coherent approach to working with other agencies.** Analysis of comments about interactions with multiagency health and social care professionals (e.g. NHS community mental health teams, local authority adult social care services, rehabilitation or substance misuse teams, NHS National Problem Gambling Clinics and other gambling support agencies such as GA) indicate that there may be a lack of consistency about when to contact them. By far the greatest number of references in the records are to interactions with GPs. This suggests a group of professionals whose knowledge and awareness of gambling harms could usefully be enhanced. There have been calls for research about the effectiveness of tailored treatment approaches for clients with dual or multi-morbidities (Yakovenko & Hodgins, 2018). This is another area where more systematic recording could be valuable when thinking of more personalised services. Given the small numbers, this might be viable for groups in the virtual environment or by tailoring support for people with a diagnosis of e.g. schizophrenia, autism or long-term medical conditions.

- **Explore the potential of virtual counselling.** An increase in virtual counselling might offer greater opportunities for more personalised treatment approaches (e.g. for couples, or family or group counselling for specific client groups). Of course, some people may not like this form of engagement, while others may not be able to access it. Ideally the aim would be to facilitate choice within gambling services and meet the needs of clients where possible.
3 Methodology

Introduction

We investigated the following research questions to shed light on what affects help-seeking among people approaching GamCare for support and what might improve the assessment process. Questions were formulated based on an initial analysis of 100 cases from the qualitative sample and with reference to what is missing in the evidence about gambling support and treatment, and were agreed with GamCare. Our sample was drawn from 22,000 cases covering the period 2015–2019. Notes taken by GamCare counsellors during initial assessment were coded manually using NVivo12 (QSR International, 2018). Coding themes were developed inductively through initial analysis of 100 cases, as well as with more deductive codes devised to address the research questions. Coding themes were interrogated further using data about improvement outcomes (judged as good, low or unplanned) based on the CORE-10 scores. The following categories were included in the analysis: type (gambler, or affected other – i.e. partner or family member), gender, past history, risk note, forensic history (i.e. crime), medical history, psychiatric history, family Impact, employment, personal history, mental state, counselling goals, and safeguarding notes.

Research questions

1. To what extent does reported social support from partners, family and friends impact upon treatment outcomes?
2. Which aspects of the ‘stages of change’ model (i.e. Pre-contemplation; Contemplation; Preparation; Action; Maintenance; Relapse) can be inferred from initial assessment data and does this provide any insight into the likelihood of clients succeeding in their treatment as reported in the data?
3. What insight is there from the comments made by counsellors about the strength of the therapeutic relationship which is being developed with clients?
4. Which treatment goals are outlined by clients in the records maintained by counsellors for gamblers and affected others?
5. Which types of mental health and safeguarding concerns are evident within the data and is there any insight to be drawn from how are they recorded and/or managed by counsellors during initial assessments?
6. What types of harms are recorded by counsellors as experienced by gamblers and affected others?
7. What do gaps in the data tell us about factors associated with help-seeking?
Creating a sample for analysis

To minimise the number of records that were required to be anonymised and therefore only take data that was necessary for the present qualitative study, we applied the following filters to all records (n = 22,360) from the three-year period (January 2017–December 2019).

Records were required to have data for client type and gender, and to contain usable data in the following fields:

- past history
- family impact
- personal history
- mental state
- counselling goals

Finally, records were required to have a single defined end with either an outcome measure attached or an unplanned end recorded.

We used the CORE-10 scores (Clinical Outcomes in Routine Evaluation, a 10-item measure of mental health) at assessment and last session to calculate a CORE-10 improvement score. The scores were grouped into those showing an improvement of 6 or more (deemed to be reliable and clinically significant within the CORE-10 schema and then labelled ‘good improvement’ on the outcome scale) and those showing an improvement of less than 6 (labelled as ‘low improvement’ on the outcome scale). Finally, we identified cases which ended in unattended sessions with an unplanned ending, suggesting the client had dropped out of treatment (labelled ‘unplanned’ on the outcome scale).

Of the qualifying 3,192 records – 293 were of affected others (partners, family or friends of a problem gambler) and 2,899 were of gamblers – we took a random sample of approximately 25% (using the Excel RAND function and selecting all records with a value above 0.75). This identified 713 records equating to 22% of all suitable records. We compared these 713 cases with the overall sample by outcomes and client type (gambler/affected other) to gauge their representativeness. Our sample contained proportionately more affected others than the available data (but as they are a much smaller group this appeared helpful to the analysis). No difference was greater than 10% between sample and all data. An overview of the final sample compared to the distribution in the available data is provided below (Tables 1 and 2):
Table 1: Sample by client type

<table>
<thead>
<tr>
<th></th>
<th>Sample</th>
<th>Available data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affected other</td>
<td>17%</td>
<td>9%</td>
</tr>
<tr>
<td>Gambler</td>
<td>83%</td>
<td>91%</td>
</tr>
<tr>
<td>N =</td>
<td>713</td>
<td>3,192</td>
</tr>
</tbody>
</table>

Table 2: Sample by client type and outcome

<table>
<thead>
<tr>
<th></th>
<th>Affected other</th>
<th>Gambler</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sample</td>
<td>Available data</td>
</tr>
<tr>
<td>Good Improvement</td>
<td>58%</td>
<td>66%</td>
</tr>
<tr>
<td>Low Improvement</td>
<td>24%</td>
<td>21%</td>
</tr>
<tr>
<td>Unplanned</td>
<td>18%</td>
<td>13%</td>
</tr>
<tr>
<td>N =</td>
<td>120</td>
<td>293</td>
</tr>
</tbody>
</table>

Anonymisation

All data were checked for identifying content, including client and family names, dates, locations and specific job roles or employers. All potential identifiers were removed from the text and replaced with generic placeholders before data were shared with the research team.

Coding

Initial assessments were coded in NVivo 12. To generate the coding scheme, 100 cases were initially coded to identify prominent themes and topics. The coding scheme focused on the content of the assessment. Themes included: reason for gambler’s problems; social support; approaches used during assessment; indication of quality of assessment; treatment goals; readiness to change; outcomes of assessment; issues with session; mental health problems; types of gambling harm; suicidality; and use of services. Additional codes were added as they emerged from the data and the scheme was refined. To establish coding reliability the researchers reviewed the data regularly to establish a consensus in coding approach. Data were coded manually, with further in-depth analysis of frequently occurring
phrases and emerging relationships undertaken using automated searches. Some codes may therefore be more ‘consistent’ than others.

Analysis

Once coded, the data were analysed using thematic analysis, which enables researchers to scrutinise data through identifying, analysing and reporting themes (patterns) within data (Braun & Clarke, 2006). This process helped address the seven research questions. The five phases of thematic analysis were followed: 1) familiarisation with the data; 2) generating initial codes; 3) searching for themes; 4) reviewing themes; and 5) defining and naming themes.

Client assessments

Table 3 (below) shows the number of client initial assessments that were analysed. This consisted of a total of 596 gamblers’ initial assessments (167 females; 429 males) and 117 affected others’ initial assessments (110 females; 7 males).

<table>
<thead>
<tr>
<th>Table 3: Sample</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gambler</td>
<td>167</td>
<td>429</td>
<td>596</td>
</tr>
<tr>
<td>Partner – affected other</td>
<td>67</td>
<td>1</td>
<td>68</td>
</tr>
<tr>
<td>Family member – affected other</td>
<td>43</td>
<td>6</td>
<td>49</td>
</tr>
<tr>
<td>Total</td>
<td>277</td>
<td>436</td>
<td>713</td>
</tr>
</tbody>
</table>

From Table 4 it is apparent that women who were affected others were seeking support for a husband’s, son’s or partner’s gambling behaviour. Of the small number (7) of men who were seeking help as affected others, this was for support with a son’s or brother’s gambling behaviour. Almost all affected others sought support with the gambling behaviour of men (n = 115) compared to women (n = 2).

Table 4: Relationships of affected others to the gambler

<table>
<thead>
<tr>
<th>Gender of affected other</th>
<th>Husband</th>
<th>Son</th>
<th>Partner</th>
<th>Father</th>
<th>Boyfriend</th>
<th>Brother</th>
<th>Wife</th>
<th>Daughter</th>
<th>Ex-husband</th>
<th>Fiancé</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>42</td>
<td>31</td>
<td>28</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
Limitations

A limitation of this work is that it is based on analysis of initial assessments only, rather than treatment notes over time. It is likely that some of the points raised are addressed and recorded by counsellors in future treatment sessions. In addition, we have no way of validating counsellors’ comments or the accuracy or interpretation of clients’ situations or any other biases. We do not know how long after the assessment the records were created and whether they could be prone to memory bias.
4 Findings

4.1 Social support for clients

Information about levels of social support were generally ascertained by counsellors and recorded within the ‘past history; impact on family, personal history and risk note’ fields. Our qualitative analysis of social support revealed that many gamblers had high levels of support (Table 5).

Table 5: Support for gamblers

<table>
<thead>
<tr>
<th>Social support positive</th>
<th>Gamblers: Good improvement</th>
<th>Gamblers: Low improvement</th>
<th>Gamblers: Unplanned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gamblers</td>
<td>201</td>
<td>149</td>
<td>52</td>
</tr>
<tr>
<td>Social support mixed</td>
<td>117</td>
<td>81</td>
<td>36</td>
</tr>
<tr>
<td>Social support negative</td>
<td>123</td>
<td>87</td>
<td>36</td>
</tr>
<tr>
<td>Partner positive</td>
<td>146</td>
<td>105</td>
<td>41</td>
</tr>
<tr>
<td>Partner mixed</td>
<td>23</td>
<td>21</td>
<td>2</td>
</tr>
<tr>
<td>Partner negative</td>
<td>57</td>
<td>37</td>
<td>20</td>
</tr>
<tr>
<td>Support employers – new code</td>
<td>21</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Someone else managing money</td>
<td>139</td>
<td>107</td>
<td>32</td>
</tr>
<tr>
<td>Bailed out</td>
<td>77</td>
<td>55</td>
<td>22</td>
</tr>
<tr>
<td>Hiding or minimising problems</td>
<td>60</td>
<td>49</td>
<td>11</td>
</tr>
</tbody>
</table>

A multiplicity of internal and external factors can either enhance or detract from an individual’s recovery. A systematic literature review of ‘recovery capital’ in substance misuse identified domains relating to an individual’s capacity to draw on support; this is also of relevance to gambling. Recovery capital domains included physical and mental health, personal recovery, growth, social/family, cultural and community [Hennessy, 2017]. The rest of the findings for research question 1 reflect different examples of recovery capital found in the dataset.

Social/family support

The dataset revealed a link between gamblers with high levels of support and improvement (Table 5). Many factors influenced how supportive family and friends could be and how much gamblers could rely on them for bolstering, or otherwise, their ‘recovery capital’
(Gavriel-Fried, 2018; Gavriel-Fried & Lev-el, 2018). The following quotes illustrate how gamblers’ recovery capital relating to social/family support can be influenced by a variety of factors, such as the proximity of support, the physical and mental wellbeing of the supporter, and the financial resources of the supporter:

Reported that all his family live in (East Asia) and he has lived in the UK for the last 10 years. Described his parents as supportive.

Reports friends and family are supportive, but feels he can no longer approach them for further support. States he recognises the extra stress he caused his parents after they separated. Reports mother has recently been diagnosed with (a form of) cancer and does not want to worry her.

He lives with his family. He reported that he has good parents, but they are not offering him the right support as they do not understand the problem. He has an older (sibling) and younger (sibling). He reported that (the latter) is too young to offer him any support and (the former) is like his parents, (they) does not understand the problem and him. He stated that that he does not have good support around him.

Client has a fractious relationship with her whole family whom she doesn’t see much. She has (many) children; two are stepchildren, and two are in care. Her (sibling) died from drug addiction and her (parent) had problematic drinking. She is currently quite isolated and describes having no close friends. She currently lives with her (adult child).

Our quantitative analysis suggests the importance of support from partners in improving treatment outcomes; this is also highlighted in Table 5 (above). Many gamblers who made good improvement described their partners as supportive and understanding, despite the difficulties that gambling sometimes caused:

[Client] lives with his girlfriend and two children (ages) in his girlfriend’s house and they have been 5 years together. His girlfriend is very supportive, but he recognises that there is some trust issues due to all the lies he told her about his gambling.

[Client] lives with his wife and 2 children. Been married for 10 years. He has a good relationship with his wife but refers his gambling problem is the only thing between them as he needs to lie and conceal his gambling because she does not understand it and it frustrates her. But she knows about his problem and supports him with his recovery.
Less support/good improvement and good support/less improvement

Some less typical patterns identified in Table 5 were explored. For example, some clients with poor support from their partner still went on to make good improvement. Further investigation of this group indicated that some had not yet told their partner about their problems, but who may have turned out to be more supportive than the gambler expected. Very few clients had no support. In some cases, they had split from their partner due to gambling; it is possible that this was a motivating factor encouraging them to work at their recovery in the hope of reconciliation. Alternatively, existing relationship problems may have been exacerbating the gambling and closure of a relationship improved the gambler’s mental health and recovery:

Stated he called Gamcare for help when his girlfriend (g/f) found out he had used the…money…they had saved for their…baby’s christening. Stated his g/f kicked him out of their shared flat, he is now living at his parent’s. Stated that he is now re-evaluating his life and wants to/motivated to stop gambling.

Reports recently separated from partner due to his gambling and alcohol use. States communication is amicable and is hopeful they may reconcile. Has regular access to his (young) child.

Meanwhile, some clients who reported good support from their partner made less improvement than might have been expected. Investigation of this group indicated that some partners may have been unable to be as supportive as others due to other problems in their lives which may affect outcomes, as the following illustrates:

[Client] has been with his girlfriend for 8 years. She is supportive of his recovery, but he is aware that he tends to gamble more when he is frustrated and stressed because of her condition, especially when she is very low. She suffers from bipolar disorder and tends to be ‘very black and white’.

In other cases, affected others may have been supporting a gambler for many years and have run out of patience or motivation to challenge them further. Notes on one gambler included:

Client has been paying everyone back and is very tired of not being able to save money, live properly without thinking about which debt to pay.

Given the importance of having a supportive partner to gamblers’ recoveries, it was interesting to note that only two counsellors recorded (as an outcome of the initial
assessments) signposting to gamblers that their partners could also access support from GamCare.

Support for affected others

Analysis of the affected others’ data highlights the difficulties involved in supporting a gambler in their recovery journey. In contrast to counsellors’ comments about gamblers, their comments about affected others conveys a picture of people feeling less supported and experiencing greater shame about admitting the situation to others. Whilst most affected others reported having some form of social support, upon closer analysis the group experienced high levels of isolation as many said they were not sharing this problem with others.

Table 6: Support for affected others and their own outcomes

<table>
<thead>
<tr>
<th>Type of support</th>
<th>Client type = Family member/friend (49)</th>
<th>Client type = Partner (68)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Good improvement</td>
<td>Low improvement</td>
</tr>
<tr>
<td>Positive</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>Negative</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>Mixed</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>No support</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

No. of cases

In general, those affected others who had support appeared to be more likely to make good improvement [see table 6]. However, some made little improvement even though they had positive support. Some accounts revealed that affected others were also having to manage other problems, such as living in an atmosphere of fear and lack of trust, while others reported problems relating to physical health, including living with co-morbidity:

[Client] suffers daily with anxiety and low mood, being in fear of the gambler.

States she has called the police twice due to her son and will continue to place calls if he is threatening.

Client is experiencing tension with an ex-partner who is the mother of the gambler... Described his relationship with his ex-partner as good but recognises there’s an element of co-dependency, stated although they are no longer together.
Meanwhile, some affected others made a good improvement despite reporting negative support. Many assessments, for example, contained information about loneliness and isolation, perhaps as a result of being unable to share their problems with other people:

She hasn’t told a friend or anyone else, because she ‘wants to keep it private’.

The predominant theme of loneliness, feeling alone and isolated was also evident within the initial assessments of partners who had negative support but made a good improvement. Many stated that they had no-one to turn to, often feeling too embarrassed to open up, as the following extracts highlight:

[Client] feels isolated as she does not talk to anyone about her situation.

Emotionally burdened, were experiencing conflict and did not want to share their problems with other family members as they did not want to burden them.

Her parents are still married and live (not far) from her, but she doesn’t see them very often, and she confesses that they never call her. She has (several) siblings (all brothers) who are all very problematic and all have mental health problems.

[Client] is clearly distressed and emotionally raw. She spoke about being in shock as she had not known anything about her son’s gambling, nor did she suspect anything. She reported feeling guilt for not realising but also feeling that she failed as a mother. She feels embarrassed about her son’s gambling leading to him losing his job. She reported not wanting to see friends and family as a result as she doesn’t want to explain what happened.

One partner was recorded as turning to alcohol to cope with the situation:

She reports she always had to fight for everything in life, had to be strong and now she does not feel able to cope with it anymore. She drinks frequently to cope with the emotions she feels due to financial instability, issues in marriage and not liking her career. She does not think the life she has been living is fair.

There was also some evidence that some members of an affected other’s support network had reached ‘saturation point’ which had negatively affected the extent of support they could request. Others expressed resentment about the situation, as in this example:

[Client] stated that her partner struggles to talk about his gambling further, described him as having ‘taken the monkey off his back and put it on hers’ and she is now ‘carrying the burden’...[Client] stated that she wants support in exploring the impact of her partner’s gambling on herself, their relationship and life in general.
Some affected others seemed to be experiencing conflict with their family, which hampered their support network:

Reports she has told the children about his gambling and they were supportive of him but offered her no support.

Some affected others were experiencing relationship problems and were at risk of financial and emotional abuse so seemed to be less in a position to be supportive:

[Client] is subjected to financial, and emotional abuse from her partner. She reports that he also has an issue with alcohol, and at times can be quite aggressive towards her when she refuses to give him money for gambling.

Some affected family members did not just experience an absence of support from their networks, but reported that they were an additional burden:

Reports that she has found people in her social and family life to be ‘judging’ and some have blamed her for the gambling situation. She adds that she is fed up of people questioning her and doubting her as this has made her more anxious and stressed.

For these individuals, analysing notes from later sessions might provide insights into how the help-seeking journey supported them to good improvement.

Only five references were made to counsellors telling gamblers about counselling available for affected others. It may be that this is just not recorded as it is not viewed as vital information but given the importance of support from affected others in the recovery of gamblers, and the evidence for many of these individuals feeling isolated and unsupported themselves, this could be given more prominence. With the move to virtual counselling due to the pandemic, opportunities for reaching out to a wider range of people via this medium and recording outcomes will need consideration.

Couples and family counselling

Given the importance of social support, and especially a relationship with a partner, it is surprising that more discussion was not recorded about couples therapy during the initial assessments, though this may have been discussed in subsequent sessions.

In assessment outcomes, clients were only signposted to couples sessions twice for gamblers and eight times for affected others. This is despite some promising evidence that gamblers who attend sessions with a concerned significant other have higher treatment
attendance, reduced dropout rates and are less likely to relapse (Jiménez-Murcia et al., 2017; Tremblay et al., 2018). In addition, our quantitative analysis identified that treatment modality was significant, with couple, family and individual online treatment resulting in significantly higher Problem Gambling Severity Index (PGSI) change than individual face-to-face treatment for treatment episodes that resulted in unplanned/unattended ends.

It would be worthwhile exploring whether future initial assessments should take account of partner support more explicitly when considering how best to support gamblers and affected others. The following quote from a counsellor’s notes is a rare example where this was reported:

We discussed potential future couple counselling. ‘My wife hates me...I’ve let her down badly’. Client’s wife was made redundant 3 years ago and she has not worked since. His wife was diagnosed with (cancer) Client said ”I haven’t been very supportive. I’ve not been very pleasant. I’ve been frustrated and disappointed...But I pay everything every month ... I hate having tough conversations. It’s not my natural persona. He described his wife as a ‘life-saving type person’. [] he did not confess to her about the debts which were now substantial eg £90K. ‘Me and my wife never discussed money. She left all that to me - and she shouldn’t have. We didn’t budget together for anything. My wife only realised in the last couple of months. She started looking at the mortgage statement and realised the amount owing was going up. Client said he ‘created an image of “we are okay for money”’. Client said his relationship is his biggest worry.

Meanwhile, from the affected others perspective, only eight references about couples counselling were noted, including those below:

Initially requested couples counselling, following discussion has decided on individual counselling for support for herself.

She knows she ‘...needs to take a different stance’ and wants him to contact GamCare again, go to GA [Gamblers Anonymous] meetings and attend couples counselling. She was crying as she said, ‘...he is less attentive and protective, I wasn’t enough, the wedding was a lie. Trust and respect are eroded, he is immature, more like a child’.

Opinions about and options of taking part in group therapy were discussed and recorded much more frequently by counsellors than couples or family sessions (coded 35 times). Gamblers expressed a range of opinions about taking part, including those who rejected the idea outright due to not feeling comfortable opening up about their lives, some who said they were shy or ashamed, and a couple of women who stated that they did not feel
comfortable in GA groups. Some counsellors offered groups before one-to-one sessions, but their rationale for doing this was unclear. Other counsellors commented that a client would not be suitable for groups due to their specific needs or emotional state. The following illustrate some of these factors:

[Client] said that he is looking forward to working in a group and wants to be challenged as nothing has worked so far. He answered all questions openly, but in a matter-of-fact way. [Client] said that he used to be very sensitive and cry easily, but that gambling hardened him. He spoke of a ‘cold block’.

Client would prefer group. Wants to hear about others experience and to know others can get over it.

Due to the client’s long (working) hours it was discussed that online session might work best. The client has agreed to attend the online group that starts on Saturday in August. The client would also like online 1-2-1 on a Saturday once the group finishes.

Open to any support platform. Would like to try online support group as a structured relapse prevention programme to use in conjunction with looser support style of G.A. Mtgs.

Discussed groups, but declined by client. F2F (face to face) more suitable due to presentation of issues (childhood trauma, co-addiction, anxiety and stress, no support network) and safeguarding concerns.

Bailing out

Being ‘bailed out’ emerged as a theme identified within the support of gamblers and affected others’ data, with 81 references coded to this for gamblers and 48 for affected others. Being able to rely on others for financial support can be viewed as an indication of ‘recovery capital’:

His mother bailed him out his debts and he explains it has a psychological impact on his family (more than financial).

[client]’s family is aware of his gambling and his dad has helped to pay off his debts. [client] is paying his Dad back in monthly instalments.

Reports current debts of £7500, which his grandmother has repaid, and he is now paying her £300 per month back. States parents have repaid his debts in the past.

Affected others discussed supporting gamblers by bailing them out, for example:
Reports as follows: discovered recently via range of small clues that her daughter, who client and her husband had bailed out from gambling debt several years ago, had returned to gambling and has very substantial further debts. Stepchange contacted.

Client has paid daughter’s mortgage payments to ensure she’s not made homeless with her two sons. Also has a son, who is aware and supportive of his parents. Discussing changing will to ensure daughter not able to gamble inheritance away.

‘Bailing out’ raised questions for affected others about how best to support the gambler without enabling their addiction as the following quote indicates:

Client’s son is the gambler. He is currently not living with client as he recently sold some of her household items without her knowledge. He is upset and angry with her because she won’t let him back in the house and told her he was going to take his own life. Client said that her husband has not supported her in trying to help their son and has ‘bailed him out,’ against her wishes.

Counsellors’ records contained a couple of instances of gamblers considering asking those who bail them out to stop. This approach was only recorded twice as an outcome (although this discussion may well take place in future sessions):

States will spend all available money and borrow money from his family. Reports mother manages his money, but ‘I act like a spoilt child when she won’t give me my money’. Identifies ‘knows’ family will lend him money, states will consider asking them to stop lending him money.

Reports owes father money, but father has said this is not an issue at present. States has some council tax arrears. Reports has often lied to father to obtain money, but has now talked with him and father has agreed not to loan him any more.

Managing finances

Being able to rely on partners and family members to manage finances, and differentiating this from being ‘bailed out’, was an important element of recovery capital with 143 gamblers and 29 affected others mentioning this. This chimes with work by Gavriel-Fried and Lev-el (2018) which highlighted the importance of family support and family supervision of finances in assisting recovery.

The following comments illustrate how some gamblers are relieved to have their money managed by someone else, while others feel infantilised or frustrated, and how affected others may face stress and dilemmas when managing the gambler’s finances:
He reports that he has self-excluded from the sites he went on and his wife has financial control, which has been ‘uplifting’.

States wife is now controlling finances and he needs to produce receipts to prove purchases, reports recognises this is necessary at present, but can feel ‘demoralised’ by it.

Reports husband has taken out loans in her name, £24 000. States feels cannot report his actions to the police because this will ‘ruin’ his career and mean they will lose their house. States is now controlling her husband’s finances, states he ‘resents’ her for this.

Reports mother and ex-partner have controlled his finances in the past, but he found ways to get money from them.

His mother controls his finances and is unsure how much pocket money she is supposed to give him per month and how far she should control what he has done with it.

For affected others, dealing with the additional stress of controlling someone else’s money and the arguments this might provoke was difficult:

Reports has taken out loans to pay off son’s debts in the past twice, both for £12 000. Is currently guarantor on son’s rented property and for the past 2 months had had to pay the rent because he has gambled all his money. Currently having son’s wages paid into her account but will give son money when he asks. Discussed if she is best placed to control son’s money for him.

Closer examination of women gamblers was directed by quantitative insights, which found at initial assessment that women were more severely affected by gambling (according to the CORE-10). Women were found to be more likely to drop out of treatment at the start, but once involved were more likely to complete it. However, their progress was found to be less good than men’s, with more still classified as problem gamblers after treatment. A review of literature about women’s gambling (Merkouris et al., 2016) concluded that there was consistent evidence that male problem gambling was associated with impulsivity, substance and alcohol use, while female problem gambling was associated with unemployment, psychological distress and childhood abuse.

Comparison of the code ‘managing money’ raised some points in relation to gender, appearing to suggest that women gamblers receive less practical support with this from partners and family than men. This is interesting, especially because affected others are
predominantly women. It is possible that men are less likely to seek support about their partners’ gambling and it may be that women are less supported in overcoming their problem. In addition, many clients referred to work being a source of support, but possibly this offered less protection for women than men. (See Q2 and Q5 for more information about psychological distress, trauma and childhood abuse.)

Supportive workplaces/colleagues

Another theme that emerged within the assessment data was the positive support some gamblers and affected others reported receiving from their workplaces; only one assessment noted work colleagues reacting negatively. Some clients mentioned being able to access free counselling through their employers. The following example is typical of these notes:

Teaches in adult education. Reports that work have been supportive and understanding and that she is currently seeing the work counsellor. Reports that there is a co-worker who she can go to for support.

The following extract from the notes indicates how some colleagues were supportive even when gambling had led to workplace theft:

(Client) is an accountant. After she told her employers about taking their money, she was ‘given the option to resign’ and she did. She feels she has ‘lost the trust of everybody there’ despite the fact that the general manager met her before she left and told her that she is ‘still that lovely lady’ to him.

Exploring and recording the possibility of accessing support via a client’s employment is another area that could be considered for inclusion in assessments.

Hiding or minimising

The analysis revealed that counsellors recorded that many gamblers were hiding or minimising their problem from some or all members of their social network. It is possible that more systematic recording of this information might be worth consideration as part of an assessment of a client’s social support.

4.2 Behavioural change and motivation

An area that was not directly recorded in assessments, thereby meaning it cannot be specifically ascertained, was motivation or readiness to change. As a way of looking at this we coded initial assessments to highlight the extent that gamblers and affected others
might be considered to be at one of the levels of the ‘stages of change’ model (DiClemente et al., 2004; Prochaska et al., 1993), which is commonly used in addictions services. Comments were coded in accordance with the six levels – 1) Pre-contemplation (no intention of behaviour change), 2) Contemplation (considering behaviour change, but no commitment to action), 3) Preparation (intent upon taking action), 4) Action (actively modifying their behaviour), 5) Maintenance (sustained change and new behaviours), and 6) Relapse (falling back into old patterns of behaviour).

Decisions about where to place gamblers on this scale were based on comments recorded throughout their assessment and the limitations of this are acknowledged. Those determined as being in the Pre-contemplation stage seemed to have no intention of stopping or reducing gambling, those in the Contemplation stage noted they were considering stopping or reducing their gambling, and those in the Preparation stage were considering what steps they might take to stop or reduce their gambling. The majority of the gamblers seemed to be at the Action stage, commonly stating that they had self-excluded or blocked themselves from gambling products, banned themselves from venues, told someone about their gambling problem and that someone else was managing their money.

Some commentators have attempted to minimise problem gambling and the success of counselling by suggesting clients attend sessions to placate their wives. This was not borne out in the data, with only three references categorised under this code. Rather, most gamblers were thought by the counsellors to be serious about tackling their problems; this indicates that the filtering process of selecting those suitable for assessment for counselling is effective.

<table>
<thead>
<tr>
<th>Stage</th>
<th>All gamblers</th>
<th>Good improvement</th>
<th>Low improvement</th>
<th>Unplanned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-contemplation</td>
<td>30</td>
<td>18</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Contemplation</td>
<td>102</td>
<td>57</td>
<td>11</td>
<td>34</td>
</tr>
<tr>
<td>Preparation</td>
<td>108</td>
<td>63</td>
<td>12</td>
<td>33</td>
</tr>
<tr>
<td>Action</td>
<td>213</td>
<td>130</td>
<td>37</td>
<td>46</td>
</tr>
<tr>
<td>Maintenance</td>
<td>31</td>
<td>20</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Relapse</td>
<td>14</td>
<td>7</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

**No. of cases**

Despite many gamblers being in the Active or Preparation stages, dropout rates were high (see Table 7). Examination of those who dropped out or had unplanned exits from
treatment despite being in the Preparation or Action stages revealed a range of indicators, which counsellors had recorded, suggesting reservations about a client’s ability to participate in therapy, or the severity of their problem, for example:

He talked about finding it helpful having counselling with the NHS in the past and not wanting to go into groups, as he finds it difficult to talk in a group setting. I wondered if this related back to his childhood, being the youngest of [large number of] children. [FirstName] had some insights, but struggled to really connect with them.

Client stated he has blocked his portals; smart phone, laptop and tablet but he is secretly using his children’s tablet to gamble while his wife is at work.

In other cases, however, there were no obvious hints that the client would not complete treatment (examination of any future sessions might throw light on this).

Gave himself 10/10 for importance, readiness and confidence when asked MI (motivational interviewing) questions. Said he wants to stop.

Client very articulate, focussed and motivated to change, recover from this period and re-build a foundation for a healthy future and life aspirations. Illustrating active commitment to this, having already proactively cleared debts, installed GamBan and made significant changes in his home/working life to support this.

Some gamblers were thought to have made good improvement even though they were at the pre-contemplation stage. Analysis of comments made by counsellors about these gamblers included conclusions that they were ‘reluctant’ to stop gambling, ‘ambivalent’ about their behaviour or were not ‘very motivated’. That these types of clients made good progress may be of interest to counsellors as it may indicate the effectiveness of their skill in motivating gamblers to attend sessions and make progress in treatment.

The importance of supporting all clients to keep on track whatever their circumstances was demonstrated in the practical notes of some counsellors. For example, the following quote reports on a possible strategy for working with a client who was engaging in avoidant behaviours:

Presents as motivated to engage with sessions. Struggled to maintain focus during assessment, often digressing or changing subject matter completely when discussed proactive change. Displaying some rapidity of speak and racing thought patterns. Did respond to prompts to refocus, may benefit from firm session parameters and structured session plans. Presenting some desire to be rescued, did acknowledge steps he would need to make when challenged.
Similarly, affected others were found to be committed to change during their assessments, indicating that the filtering process enabling clients to be assessed is working well. Decisions about where to place affected others on the readiness to change scale were based on comments about whether they were: contemplating (e.g. considering whether to support a child or partner or seek support for themselves); preparing to take action (e.g. wishing to explore their feelings or understand their partner/child better or find out what support was available to them); taking action to change their behaviour to focus on themselves and/or support a partner or child (e.g. deciding whether to bail them out/manage their finances); maintaining changed behaviours towards themselves, a child or partner; or relapsing, falling back into patterns of behaviour (e.g. not prioritising own wellbeing). None of the affected others’ comments indicated that they were at the pre-contemplation stage, reflecting that they did intend to change their behaviour. The great majority of the affected others’ comments indicated that they were at the preparation or action stages of their help-seeking journey.

Analysis of initial assessment data for affected others was explored for contradictions such as: Why did affected others have an ‘unplanned’ outcome if they were at either the preparation or action stage? Why did affected others make little improvement if at the contemplation, preparation or action stage? Why did affected others make a good improvement if at the contemplation stage (see Table 8)?

<table>
<thead>
<tr>
<th></th>
<th>Family/friend</th>
<th>Partner</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Good improvement</td>
<td>Low improvement</td>
<td>Unplanned</td>
<td>Good improvement</td>
<td>Low improvement</td>
<td>Unplanned</td>
</tr>
<tr>
<td>Pre-contemplation stage</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Contemplation stage</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>11</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Preparation stage</td>
<td>17</td>
<td>8</td>
<td>3</td>
<td>29</td>
<td>15</td>
<td>8</td>
</tr>
<tr>
<td>Action stage</td>
<td>10</td>
<td>3</td>
<td>2</td>
<td>7</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Maintenance stage</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Relapse stage</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Some affected others had an ‘unplanned’ outcome, dropping out after the assessment or exiting early, even though they were identified as being at either the preparation or action stage. Closer analysis of the data suggests such clients included those who had a history of receiving no support. Others had already taken action by paying off the gambler’s debts, no longer giving money to the gambler, safeguarding their financial situation, taking control
of bank accounts or separating from the gambler. It is possible that support enabled them to make these decisions, but once the decisions had been made further support was not required.

Others had made little improvement at the preparation or action stage. Many of these were keen to develop strategies, talk about their problems, understand the gambler and consider their options. However, some remarked that they were confused, feeling anxious and isolated. Those at the action stage had expressed their wish to make plans and actively improve their wellbeing ('time and space to explore situation, effective coping strategy'; 'to develop an action plan to manage future lapses') and it may be that once these actions were completed they decided to cease engaging with support.

Some affected others made a good improvement whilst at the contemplation stage. Evidence of this was found in the accounts relating to five family members. Within their initial assessment data, it appeared that they were unsure of what they were hoping to achieve by engaging with treatment or support. Others were said to be ‘guarded and defensive’, ‘disheartened by past experiences’ and one family member had reportedly been previously unsuccessful at completing the assessment:

This is the fifth contact with this client and third attempt at an assessment. She has been avoidant of the assessment process on previous occasions and has reportedly disconnected from the phone when workers have approached sensitive issues. However, she presented today as open re discussing issues, able to stay with difficult topics and engaged with the process well, albeit a little emotional and uncontained at times.

One partner at the contemplation stage was reported to lack interest in seeking support:

Seems not interested at this point about getting information about addiction in spite of expressed bafflement about it.

Reassuringly it appears that these factors that could have hampered these particular individuals’ help-seeking behaviour were addressed as they made a good improvement, pointing to the skill of the counsellors.

**Motivation to change**

This analysis of the ‘stages of change’ model points to one way of possibly recording progress and developing the motivation to change of gamblers and affected others (Roberts, Murphy, Turner, & Sharman, 2020). Another approach many counsellors are
already recording is an assessment of a client’s motivation. Counsellors commonly used the phrase ‘motivated to engage with counselling process/sessions/support’; this was referenced 117 times within data about gamblers and 17 times within data about affected others. Several counsellors used a Motivational Index scoring system, and recorded scores for importance, readiness and confidence (Miller & Rollnick, 2013). This can be seen as useful for support planning; however, it was not used consistently, featuring in only 19 cases for gamblers.

Some counsellors employing the Motivational Index clearly asked specific questions and recorded clients’ responses (e.g. How important is it for you to change your gambling? 10 – Very important), whereas other counsellors just recorded the score against the topic (i.e. Importance: 10). Given that counsellors are already probing and recording stages of change information and levels of motivation, it may be worth considering use of a validated measure or systematically recording gamblers’ and affected others’ motivation to change.

4.3 The therapeutic relationship

Most gamblers were viewed by counsellors as making a good impression, engaged and/or motivated to engage in counselling sessions, as the top 12 coding references about impressions of the gambler demonstrate (Figure 1).

Figure 1: Counsellors’ impressions of the gambler

![Figure 1: Counsellors’ impressions of the gambler](image)

No. of references

Figure 1 indicates counsellors’ perceptions and records of gamblers demonstrating positive interactions in line with core counselling skills of active listening, questioning, paraphrasing,
reflecting, summarising and challenging (Egan, 2006). Very few negative comments were
coded about clients, and those recorded were useful for future counselling sessions, as the
following examples demonstrate:

He is very self-aware and he acknowledges that his main issue is his ego and his
competitiveness, he wants to be the best at everything. He is going through a crisis of
the self/self concept - no longer feels like he fits in, where he lives everyone is
massively rich and does not want to compete with others about who has the most up
to date blinds/cars and so on.

She told her story without embellishment and seemed removed from any sense of
guilt or shame when talking about crashing cars and stealing money. She doesn’t seem
to be aware of how her actions impact others. (121)

A few references were made to ‘self-care’, as well as gamblers’ appearance and self-
presentation. Some observations were also made about clients expressing incongruent
statements or being in denial about their gambling, but these were uncommon:

Expressing incongruent statements, reporting has recently gambled online and in
betting shops, but then stating does not need to self-exclude from these areas as has
not gambled these ways for some time. Acknowledged did regularly use both betting
shops and online when challenged. Displaying some ambivalence to stopping gambling
and minimising of impacts on self and others.

Similarly, counsellors reported positive interactions with and good impressions of affected
others, as Figure 2 demonstrates.

Figure 2: Counsellors’ impressions of affected others

<table>
<thead>
<tr>
<th>Good impression</th>
<th>Client in distress</th>
<th>Need to talk</th>
<th>Emotionally engaged</th>
<th>Not engaged or ambivalent</th>
<th>Client edgy and defensive</th>
<th>Client holding back</th>
<th>Client detached</th>
<th>Client in shock</th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
<td>40</td>
<td>20</td>
<td>10</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

N. of references
31
As they did with gamblers, counsellors reported ‘good impressions’ of affected others (see Figure 2). They did not comment on the physical appearance or degree of honesty in their assessments of affected others.

Affected others were coded as distressed proportionately more often than gamblers themselves. Common adjectives used by counsellors about affected others were ‘tearful’, ‘anxious’, ‘emotional’, ‘low’ and ‘stressed’. The following extracts about affected others were fairly typical:

Presented as motivated to engage with counselling process. Displaying experiencing high levels of trauma type emotions and uncertainty as to how to proceed. Often became tearful during assessment. Expressing hypervigilance, experiencing continual anxiety that partner is gambling and compulsion to frequently check bank accounts.

“[Client] was very anxious and seemed on the verge of tears throughout. This is the third time she has been to GamCare and is holding on to an ideal image of the perfect relationship she wants. She is genuinely conflicted between the dream and the reality and seems to hold on to the fantasy that she can, somehow, fix her husband and make him want what she wants.

In contrast, there were proportionately far fewer references to gamblers who were distressed, and a larger proportion of those coded as distressed were female:

She engaged very well in the session, however, after starting talking about her history of gambling and touching on a few traumatic events she broke down in tears, started shaking and breathing more frequently. I spent about half an hour to try to bring her in the present, calm her and help her feel more positive thinking about her current achievements (no gambling for over 2 years, employment). Considering this, I avoided questions which could have brought her back into a traumatic past. Anxious, low mood.

Reports that she feels ‘pretty numb’, she reports that she is ‘still functioning’, she reports that she has been in much worse mental health states. Affect appeared appropriate.

(Client) shared very openly about his life and said that people in the past had said that he was oversharing. He acknowledged that he felt tearful and spoke openly about the pain of losing his father to a [illness], a girlfriend aborting his child and being dumped in relationships.

His body language changed significantly when he spoke about his debts. He seemed
quite distressed, anguished, touching his head and putting his hand over his face, as if trying to hide from the reality of his situation. He seemed really grateful for the opportunity to meet for counselling, saying quite pointedly ‘thanks for your time’ at the end of the session.

The range of comments made by counsellors demonstrated their skill in engaging with a wide range of clients, including tailoring approaches for those with communication needs or autism, or from black and minority ethnic backgrounds or hard to reach groups. The following comments, for example, were recorded firstly about three clients with learning disabilities and/or autism and the last for whom English was not their first language:

Expressing proactive approach to engaging with support and limiting access to gambling. Displaying a potential people pleasing behaviour, often agreeing with assessor when it was not immediately clear subject matter was understood. May require prompts to ascertain understanding during sessions.

Reported some speech/language difficulties since birth. No specific diagnosis cited - uses some tech aids for written word but presented as cognitively/verbally fluent during Ass(essment) and happy to receive e-mails/texts.

Presents as motivated to engage with sessions. Expressing little insight into pattern of relapse and difficulty recalling specific details of events leading to relapse. Displaying a number of potential key indicators for autism spectrum disorder on the higher functioning scale. States struggles to spontaneously engage with conversation and may benefit from themed sessions, concentrating on a specific topic or point of reference.

The client’s English is good but he needed me to speak slowly for him to understand. The client was difficult to keep on track and he spoke a lot about his housing and financial concerns. The client became tearful at times when talking about his two daughters in Bangladesh and his thoughts of suicide.

Only two references were made to seeking a translator/interpreter for a client, one of these being highlighted below; this offer was refused by the client who had brought their partner to assist. It might be expected there would be greater demand given increasing evidence about gambling harms disproportionately affecting black and minority ethnic communities (Gunstone & Gosschal, 2020) and migrants (Bramley, Norrie, & Manthorpe, 2020; Wardle, Bramley, Norrie, & Manthorpe, 2019):

He attended with his wife who informed me that he does not understand English very well and will need to come into the session with him. I stated our confidentiality policy
and also said that I would need to speak with my Supervisor. After speaking with [X] it was advised to reschedule for a telephone assessment with an interpreter later in the day to which he quickly rose from his seat and said no, his English is fine, with his wife adding that he wanted her there so that she could hear everything that was being said.

Clients came from a wide range of national backgrounds and counsellors recorded a range of migration narratives and cultural attitudes to gambling in assessments demonstrating their appreciation of the need for cultural sensitivity (Bramley et al., 2020). Migrants to the UK are less likely to become involved in gambling, but when they do, they are more likely to become severely affected (Wardle et al., 2019) which has implications for counsellors’ approaches. The importance of recruiting and training additional counsellors from black and ethnic minority communities (Gainsbury, 2017) might be considered to assist with ensuring services reach all populations and may be more practically viable while online treatment sessions are the norm.

Therapeutic approaches

Counsellors’ notes demonstrated variety in whether they are using psychodynamic approaches, more cognitive behavioural therapy (CBT) (‘problem-focused’ and ‘action-oriented’) or motivational interviewing approaches (see also Q2, comments on stages of change model/motivational interviewing). This is in line with research which has found little difference in the effect of one approach or therapy rather than another in addictions treatment (Orford et al., 2006). In addition, a range of approaches would be expected given the diversity of clients being treated, their various backgrounds and reasons for gambling, some of which included extensive trauma. The following section examines more closely the most frequently referenced reasons for gambling reported for gamblers and affected others - highlighting counsellors’ required expertise and knowledge.
Bereavement and wanting a ‘big win’ were most often referred to by gamblers as a reason for their gambling. Bereavement was high on the list of common traumatic lifetime experiences as this extract illustrates:

Never gambled before until 6 months ago when his mother died. He saw her dying and immediately after, he spent £7000 online. Since then he has been gambling. Gambling relaxed him. 2 weeks ago, he confessed to his partner and 2 sisters and felt much relief. Has self-excluded now for the last 2 weeks.

However, the notes contain records of discussions about bereavement counselling/CRUSE for just 16 gamblers or affected others, and over half of these (n=10) were discussing previous counselling experiences; only six were examples of a counsellor signposting a client to the existence of such a service. Historic child abuse was referenced 15 times by gamblers, but only two mentions were identified in the case notes of counsellors’ signposting to specific support e.g. Survivors UK or NAPAC. This suggests more tailored or personalised signposting might be appropriate in some cases and the views of counsellors about this would be helpful to hear. Some gamblers referred to having drugs and alcohol problems and...
three case notes contained records of clients being in contact with rehab or substance misuse services, which again might be worth considering recording in a standardised way.

It may be that therapists did not want to signpost clients to other support organisations while they were in therapy for gambling. However as a percentage are known to drop out from gambling services, this might be worth consideration. The extract below addresses this possible pathway:

Currently exploring options for support. Has contacted CRUSE and Survivors of Suicide re bereavement counselling & support groups – attending Welcome Day on 13 April so should be clearer re what they can offer by then. Aware of inadvisability of concurrent counselling processes due to risk of splitting/dislocating therapeutic work but that they can sometimes be appropriate/complementary if clear respective remits.

Similarly, despite relationship problems and break-up being a given as reasons for gambling, very few mentions were made of signposting to RELATE or relationship counselling in the data. There was also evidence that counsellors might have discussed GamCare couples counselling with gamblers and affected others but advised them to delay this, as the quotes below illustrate:

Initially requested couples counselling, following discussion has decided on individual counselling for support for herself.

Discussed option of couples counselling after 1:1 counselling has ended.

In the extract below a gambler had made a request for support in explaining his gambling addiction, but couples counselling was not recorded as having been signposted or noted as being discussed:

States wife is supportive now he has told her the full extent of his behaviours, but this has caused conflict. Identifies has been more irritable with his wife and children due to feeling stress due to gambling. States had become ‘withdrawn’ from his family because he was lying to them. States has been married 3 times... During assessment requested practitioner ‘explain’ to his wife about how he has been feeling. Discussed how support can help client to improve confidence and enable him to communicate more openly with his family himself.

Medical and physical problems of the gambler or within the gambler’s family were also given as reasons for gambling. These ranged from people who had started gambling while recovering from surgery or a major illness and others with long-term conditions. These were
recorded separately from those with mental health problems (see Q5). The following examples illustrate a range of situations noted by counsellors:

Client reported he has mobility problems and him being housebound has also contributed to him to buying scratch cards as he is often bored and it helps him and scratch cards help distract him. Client reported that he struggles with budgeting and needs money for a new cooker. He believes he has some debts, stated under £500 in total. Client is receiving (a range of social security benefits)

He was involved in a severe (accident) 10 or 12 years ago and was unable to work for over a year. He tried to hide the fact that he wasn’t bringing any money in from his family and started to gamble as a way of getting money.

Client started gambling when she was diagnosed with (illness) at the age of 20 years old. She was staying in [city] for periods of time for treatment and did not know anyone so started playing poker to kill time. She referred it was also an escapism not to think about her condition. Then she started going to the casino and play other types of games which became a problem. Started through boredom, had one big win and paid for (family celebration), then started losing. Before her illness had not gambled much, father gambles and she played bingo before, since illness has got hooked. Didn’t think she would survive (illness) 2nd time and took out payday loans and gambled it all, (relative) paid it all off. She took them out again 4 days later and is now paying her (another relative) off for them.

[Client] has been diagnosed with (illnesses). [Client]’s wife has dementia. [Client] feels isolated at the moment and feels his quality of life is poor.

Many gamblers also discussed traumatic events or histories, for example, witnessing deaths and distress as part of their jobs, witnessing murders and violence, being physically, mentally or sexually abused when young, rape, bullying, involvement in car accidents, growing up in care or experiencing prison; counsellors occasionally noted clients needed longer-term therapy (see Q5):

Reports that her father died when she was 12, she reports she was bullied at school and was raped at age 16… She reports that she was beaten up by an ex-partner and also had a mentally abusive relationship following that. Reports that she used to previously use alcohol and drugs as an escape but not since having the children, reports she has replaced this with gambling.

Reports she has had ‘difficult relationships’, reports she was raped in 2010 and got pregnant. Reports her mother is ‘very poorly’ and she is her main carer. Reports that
she has to be ‘the strong one’.

Roberts et al. (2017) have called for gambling clients to be routinely screened for trauma in order to tailor support and signposting to other services. This suggestion would be worth consideration.

Finally, some assessments were recorded from the LGBTQ+ community, and consideration could be given to whether any personalised services might be appropriate for this group.

Figure 4 shows the reasons for the person gambling from the perspective of the affected other.

Counsellors’ notes include assessments of whether clients’ reactions to their situations are as would be expected. The phrase ‘affect appeared appropriate’ was referenced 45 times in the gamblers and affected others’ data, as in the following excerpt:

He reports that his best friend died when [Client] was age 17 years. He reports that he had a ‘trauma’ last month when on holiday... he reports that [money] was stolen from their apartment and it felt like when he lost money gambling. He reports that his girlfriend left him 3 weeks ago because of his gambling. Reports he feels ‘lonely’. He reports his ‘head is in a bit of a pickle’, he reports that he ‘feels alright today, not as sad as the past few days’. He reports he is ‘down on some days’. Affect appeared appropriate, mood appeared lowered, appeared motivated to make change.

Figure 4: Counsellors’ notes of affected others’ opinions/explanations of reasons for gambler’s problem
Figure 4 shows the reasons for the person gambling from the perspective of the affected other.

**Practical advice - initial actions from the assessments**

The majority of counsellors recorded ‘initial actions’ based on the assessments. The vast majority of gamblers were told about GamCare online forums and chatrooms, gambling blocks by banks (Squirrel and Monzo), GamCare’s self-help workbook, self-exclusion (GamStop, GamBan, MOSES, SENSE), the gambling therapy app, the GamCare self-help workbook, or were signposted to debt advice (e.g. Step Change). Gamblers were also told about Gamblers Anonymous or other local services, Gordon Moody and the National Problem Gambling Clinic (NPGC).

Individual gamblers were signposted to a range of additional services, but not in large numbers – for example, to Women’s Aid, Citizens Advice, Survivors UK, specialist PTSD support, local NHS mental health services and Mankind Man. The phrase ‘consider additional support options’ was referenced 65 times for gamblers but not once for affected others, suggesting signposting to support for other issues might be explored further in future treatment sessions for gamblers. Given that the dropout rate is not insignificant, consideration could be given to discussing these options sooner.

As noted previously, a small number of gamblers’ assessments included notes about asking their family not to ‘bail them out’ in the future. More systematic recording of this information could be maintained as an indication of a gambler taking action.

For those experiencing suicidality, a safety plan was discussed involving Samaritans, CALM, the Stayalive app, contacting their GP, and going to Accident & Emergency hospital services (see section on safeguarding).

Initial actions for affected others as reported in the assessment notes appear to have focused on help for the gambler with information provided similar to that for gamblers. Affected others were also signposted to Gamblers Anonymous and other helplines or organisations. Some records were made of discussions about stopping giving the gambler money, accepting that a gambler has to want to stop, and signposting to domestic abuse services.
Therapeutic frameworks

There was evidence in the data of counsellors using different approaches according to the needs of individual clients, which can be seen as a strength of the GamCare workforce. In their notes, counsellors used terms that reflected their approach – for example, ‘psychologically minded’ and ‘reflection’.

Psychological mindedness is a construct that originates in psychoanalytic theory and can often be used interchangeably in clinical settings with others such as ‘insight’, ‘reflectiveness’, ‘self-awareness’ and ‘adaptive ego function’ (Owens and Prout, 2012). The phrase ‘psychologically minded’ appeared 18 times in gamblers’ initial assessments and three times in affected others’ initial assessments. Counsellors used the phrase in this study to help make a judgement about whether or not the client seemed to be ‘psychologically minded’ to focus on the practicalities of gambling support or explore deeper issues:

Client came across as psychologically minded but unable to get to the bottom of his problem gambling.

Client (affected other) was talkative. Calm but very communicative. Appeared to be quite psychologically minded and introspective. Showing motivation to work on herself and learn more about her son’s addiction to be able to help him.

Client (affected other) was not deemed to be ‘psychologically minded’. She appeared interested in receiving guidance or advice and at the same time guarded and defensive, as if she expected to be judged. She did not appear psychologically minded and didn’t seem to have any expectations as to what kind of support she would receive.

Counsellors also used more psychodynamic approaches to assess clients, discussing unresolved issues, and exploring with clients their use of gambling to escape emotional pain:

The impact of his parents’ divorce seems huge and has left him with a lot of unresolved, unrecognised emotions and issues that were acted out at school and now with his gambling.

Anxious, slightly paranoid but engaged well. He has lived his life almost fully on the end of his mother’s extreme mood swings and could never get it right, always the brunt of her disappointment and rage. Gambling, alcohol, cocaine are/were all means of escape for him and as we explored it a little he realised it was ultimately an internalised her he was escaping from.
Four references were made by counsellors to gamblers benefiting from psychological support or longer-term counselling – for example:

I feel the client may benefit for some longer-term therapy around his abuse growing up and bereavement that has not been addressed.

He is a psychologically minded person, though very grieved, with a life-time of anger and resentment. He mentioned that he feels proud of himself that he’d never got into alcohol or drugs. He advised that he is quick to attach. Looking at his counselling attendance history, I wondered if he is equally rather quick to detach too, anxiously attached. That he might be saying what he wants the other to hear – and then his anger is acted out. Explored his traumatic background and his somewhat understandable reactions to his history, hence, his compulsive behaviour – and also the complexity of working through all his grievances. I recommended that after GamCare, he could carry on his therapy/counselling, hopefully in a long-term open-ended setting.

There were 12 references to ‘reflection’ were made by counsellors in gamblers’ assessments. These related to counsellors’ thoughts on clients’ reflective capacity – their insight into reasons for gambling – as well as thoughts on their own success in encouraging clients to reflect:

I reflected back that it seems he feels he is never winning, and this also applies to his career.

It was also reflected to him that he seems to try to push boundaries, and he said he had never really thought of this before. He started gambling in arcades at 12/13 to escape from anxiety and ‘everything’ as he was bullied at school. Drinking and gambling often go together.

Within the affected others’ initial assessment data there were seven instances where counsellors had encouraged clients to reflect – for example:

She reflected on her father’s difficult upbringing; growing up with a mentally ill mother, who had suicide attempts when father was a child. Client seemed to have mixed feelings about her father’s frustrated comment as being taken as the dependable one.

[Affected Other] was talkative throughout the session, she was articulate, reflective and engaged in the process of exploring her feelings and thoughts. She linked some of her husband’s gambling problems to the pressure of her illness and seemed angry at
him for putting her in the situation.

For a small number of clients, reflection was part of their counselling goals:

Goal: to reflect about how to set boundaries and redefine responsibilities when she interacts with her father.

A minority of counsellors appeared to be taking a more strengths-based approach and recorded positive information – for example, about hobbies, exercise and diet:

[family member] died... The impact of his relationship ending is larger, is as painful as the death. His friends and family have suggested that he does something he loves and client has no idea what that is. We talked about how transitions are painful and answering ‘big’ questions like what will make you happy is difficult with a current state of mind. I congratulated him for taking the step of going to the gym regularly, taking walks, playing rugby with his friends and cooking curries. Also talking to his friends and family about his feelings. Suggested that he starts writing down his thoughts as a way of distancing and then reflecting. We did some deep breathing exercises and suggested that he might want to attend a yoga class which he said that he was thinking about.

Approaches for supporting affected others

A variety of approaches were used by counsellors when working with people affected by the gambling of a partner or family member including: gambler-focused (advice and supporting behaviour change), family-focused (improving the quality of the relationship, getting information on support options and helping manage the impact of gambling), blended and the stress-strain-coping-support model (Krishnan & Orford, 2002; Rodda, Dowling, Thomas, Bagot, & Lubman, 2019).

Client preferences for different approaches

A small number of well-informed clients requested particular approaches in the counselling assessments, as in the following examples. This might be another opportunity to personalise services, making choices more explicit.

Does not want CBT, he (gambler) is after psycho-education or psychotherapy, CBT does not work with bipolar. He wants to know how to ride the urges, how to balance himself when on highs and how to pick himself up when he feels low.

Client (gambler) would like to look at underlying issues rather than CBT. Client was
very clear about this. Client is already having CBT through Talking Therapies, but client wants counselling, not CBT.

She wants to know more about gambling problem, psycho-educational resources could be helpful.

4.4 Treatment goals

Figure 5 shows the treatment goals that gamblers referenced most. Many gamblers had more than one treatment goal.

The majority of gamblers were committed to abstaining and comparatively few wanted to continue gambling in a controlled manner. However, there was a large number of gamblers who found it hard to pinpoint the underlying reasons for their problem gambling:

Would like to know why he gambles as he can’t really explain it, he doesn’t enjoy it any more or get a buzz. He would like someone to take his brain out and tell him why he does it.

He presented as personable and friendly with a strong accent and was dressed in a fashion-conscious way. He appeared to talk openly about his life and his gambling problems. He spoke about not feeling in control of his gambling problems and not being able to understand why he continues to gamble when it has a negative impact on his life. He was keen to talk and explore what was going on. Figure 5: Counsellors’ records of gamblers’ treatment goals.
The development of coping skills and managing emotions were high on the list of recorded outcomes for some gamblers and included wanting to:

- find ways of coping with life beyond gambling
- develop coping strategies
- understand reasons for gambling
- tackle cognitive distortions.

A small number of clients wanted to ‘improve’ as a person or morally – for example:

He would like to stop gambling and be more honest.

She does not want to gamble anymore, she wants to connect with others, she wants to see her friends again and enjoy life. Wants to prove to her family that she can give up gambling for good.

Finally, some counsellors recorded gamblers’ interest in seeking support for tackling their debts and managing their finances.
Reflecting on the literature on this topic, (Rodda et al., 2019) concluded that affected others’ goals were focused on seeking support for the problem gambler, support for themselves or a combination of these, which may also be seen in the following quotes and Figure 6:

Client wants support and practical help on how to support her son. ‘I need him to stop for my sanity.’

Expressing a desire to explore son’s behaviours and understand them together with her husband. Displaying some insight into son’s behaviours, alongside desire to rescue son from his situation.

To facilitate decisions around supporting their daughter and how to communicate these (she is seeing a Gamcare counsellor and has Gamban).

To help re-engage with her own life and cope with not becoming further enmeshed in her daughter’s. Recognises how difficult she finds it to stand back. Possibly to explore feelings of parental guilt (at having failed to instil financial responsibility). Sorting through raw and confused emotions.

[Client] would like some support in understanding X’s problems and managing how she feels about them. She seems to have positive expectations from counselling and her only question was whether I felt that X could be really helped by engaging with the
service.

A few affected others also noted financial goals, such as changing their will, clearing debts, protecting family finances and the house.

The question of decision-making around ‘enabling’ a gambler and accepting their behaviour or trying to intervene was addressed by some affected others as the following quote highlights:

Emotional support and help with accepting that his son won’t stop gambling or get help unless he wants to. When I explored the possibility of stop giving money to his son, [Client] said he had thought about it but his wife feels they can’t let their son go without.

4.5 Assessing risk and safeguarding

Counsellors recorded high levels of mental health problems within the gambling sample, especially depression, anxiety, substance disorders and some personality disorders, which reflects the literature on this topic (Yakovenko & Hodgins, 2018). Research has highlighted how leveraging recovery capital can be particularly challenging for those with mental health problems (Webber et al., 2014; Webber & Fendt-Newlin, 2017).

Counsellors recorded clients’ pre-existing mental health problems and the ongoing situation (see Figure 7). We coded mental health references as ‘Pre-existing mental health’ or under ‘Harms caused by gambling, mental health’. Untangling the extent to which gambling harmed clients’ mental health or exacerbated already present conditions was hard to establish and we used both codes for many clients. Cause and effect in the relationship between gambling and mental health are particularly difficult to unravel when people have gambled over many years.

Pre-existing depression and anxiety were commonly reported and that many gamblers were taking medication to assist with them. A text search for ‘anti-depressants’ within the gamblers’ notes identified 115 references. Additional text searches for specific medications identified a range (e.g. citalopram, n=29; sertraline, n=48; fluoxetine, n=16; diazepam, n=7). Counsellors’ notes frequently referred to a gambler’s contact with their GP (n=152) relating to obtaining medication, being seen for other conditions or the counsellor signposting them. The prevalence of comments referring to GPs in the dataset highlights their potential role in identifying and supporting patients with gambling problems.
Much less commonly noted were gamblers with other conditions such as bipolar disorder, personality disorders, attention deficit hyperactivity disorder (ADHD), schizophrenia or agoraphobia, although they did appear in the dataset as the following examples demonstrate:

Has been diagnosed on and off with depression, he is currently on quetiapine for bipolar disorder. When he was on antidepressants his symptoms got worse, he did not feel they helped as they would increase his mood when he was feeling ok and he would spend a lot of money on manac episodes as he could not value the money for what it was. Also he would gradually get more destructive and self-medicate by drinking more and more alcohol and bingeing on gambling.

Dual diagnosis: Bipolar 2 (X years ago) + OCD (XX years ago). Also been diagnosed with PTSD more recently due to (child abuse). He was suggested to have EMDR (eye movement desensitization and reprocessing) therapy but wasn’t able to start due to being unstable at the moment and being depressive.

He feels that his medication has been less helpful since he has been struggling with his gambling (refers being 75% effective).

There is evidence from research of a lack of consensus about support for clients with mental health dual diagnosis or co-morbidities and gambling, and calls for more studies to investigate the effectiveness of tailored treatment approaches for these clients (Yakovenko & Hodgins, 2018). An area for consideration would be more systematic recording of mental health conditions.
health diagnoses for which more personalised treatment could be developed and outcomes monitored.

Mentions of pre-existing suicidal ideation were common within the sample of case notes referring to gamblers. Suicide rates in England in 2019 are 15.9 per 100,000 for men and 7.3 per 100,000 for women (Samaritans, 2019). One affected other in our sample was in touch with GamCare following their relative’s suicide, and one assessment mentioned a counsellor calling an ambulance for a client during a suicide attempt.

The following quotes illustrate the range of summaries by counsellors about gamblers’ past suicide attempts:

Suicide attempt 8 or 9 years ago. Cut his wrists, was found by a friend and taken to A&E where he underwent a psychiatric assessment and was referred into ‘intensive counselling’ for a year, it helped him a lot. He thinks he has a lot of unresolved issues around the death of his mum...

Reports that she experiences suicidal ideation at times, usually when she has been drinking, she reports that she thinks ‘through the consequences’ and the impact it would have on her children and this protects her from acting on her thoughts. Reports that when she was younger she tried to commit suicide ‘a few times’, the last time being 6 and a half years ago. No suicidal or self-harm intention or plans reported, to monitor in sessions. No risk to others reported.

[Client] reported that in 2012 he had a relationship breakdown; he was on his own and felt isolated. He felt that he was in a black hole (his words) and one night ended up taking 30 tablets. He went back to bed, the next day he woke up and went to work. He told a work colleague what he had done and was sick a few times then was taken to hospital. He was in hospital for 3 days and saw a psychiatrist. When he was discharged from hospital, he didn’t have any other support from professionals. [Client] reported that he hasn’t felt suicidal since that time and this time he knows he has people around him that he can turn to. No current or historical suicidal ideation or self-harm.

The client has ticked the box suicidal and has hand written next to it ‘Not recently, only initially once addiction had an impact (5/6 years ago)’. When I asked him if he has a plan he said that he tried to commit suicide or more likely to make it look as if was going to commit suicide and it was a cry for help. One night he went back drunk, took some paracetamol tablets and a rope and went to a football field. Then he sent as quoted a ‘sad weird text to my sister’ who picked up on it and went to find him. After
they all sat together to discuss it and they were there for him. [Client] doesn’t believe he would go ahead with it and has not thought about it seriously since then. He thought it was worth mentioning in the assessment.

Reports some past suicidal ideation, states gambling ‘makes me depressed’ and ‘makes me feel worthless’. Reports no current suicidal thoughts, but will require monitoring.

References to suicidality of families and friends were frequently noted. A text search for ‘suicide’ within the code ‘Gambler, reasons for gambling, bereavement’ identified six deaths of gamblers’ relatives by suicide. Within the affected other sample, four records were identified of clients whose parent committed suicide. Many more references were made to suicide attempts by family members and friends:

Client said he has been diagnosed with depression since he was 18 years old. Client said it ‘runs in the family’. His mum has recently tried to commit suicide for the second time.

Client’s parents separated because of his father’s gambling. [Client]’s father had a gambling problem and got himself into debt, which [Client] helped him to pay. At one-point [Client] moved his father to his home to help him for 6 months until he moved to a room, which [Client] helped to arrange. [Client] reported that he feels guilty because he wonders if he could have done more to help his father, who committed suicide 7yrs ago because of his gambling.

Suicidal thoughts ‘cross my mind, but I hope I would not act on them’. He said he has always considered suicide ‘selfish’ and has seen what stepbrother’s suicide did to his dad. He also had another friend who committed suicide.

Pre-existing mental health problems were also mentioned by the affected others, as Figure 8 illustrates.

Figure 8: References to pre-existing mental health problems recorded about affected others
Mentions of mental health harms exacerbated or caused by gambling relating to mental health were also examined for gamblers and affected others (Figures 9 and 10).

Figure 9: Counsellors’ recording of mental health harms to gamblers exacerbated or caused by gambling

Counsellors frequently referred to suicidal ideation and self-harm in their notes about gamblers. The following selection of quotes highlights the variety of cases and understanding and skills needed by counsellors when recording long client histories of mental health problems and gambling and assessing the current risk.

Police involved because she’d gone for a walk with dog and mum thought she’d gone out to kill herself. Has tried to hang herself before but couldn’t do it. Thinks about suicide all the time and believes she’ll find a way to do it one day. Been really bad since she started gambling.

Had suicidal ideation several times over past 3 weeks as he feels he has let his family members down. He has stolen from his mum, £300 from her purse that she hadn’t noticed until he admitted to it. He recently stole his dad’s credit card and accrued debts of £7,000, he has also stolen and used his brother’s credit card in the past. He has thought that he would jump under a train but has never acted on his thoughts. We created a scale from 1 – 10 regarding ideation; he placed himself at 3. He has called Samaritans several times over past few months and thinks about the effect on his family if he harms himself, plus, his family have started to forgive him and he is afraid.
After her mother’s death she twice took an overdose, but then vomited it up.

Some years ago after a big loss at a casino, drank a lot and then outside the casino she tried to cut her wrist (she showed me the mark on her arm) – She used the glass bottle she was drinking from.

About a year ago she tried to kill herself she said; she went to the 10th floor of a parking lot which has surveillance cameras – where there is a police station opposite the building. A policewoman grabbed her just before she was about to jump.

Some gamblers were recorded as blaming their suicidality and poor mental health firmly on gambling:

No specific illnesses reported but states gambling has taken a heavy toll on physical and mental health. States GP offered medication (presume SSRI); decided not to take as ‘only depressed when gambling, and now I’m not’. Little sense of gambling as being an embedded element in his life rather than a hostile intruder.

Reports has felt depressed at times, discussed considering seeing GP if his mood does not improve. States gambling ‘makes me feel like crap’ and ‘I feel like I’m always lying now’. Reports feelings of isolation due to no one being able to understand his behaviours. States not suicidal.

For many, confessing to family and friends about their gambling problems had improved their mental health.

Feeling low and suicidal, mood has improved since he opened up to partner, stopped gambling and self-referred to GamCare (about 3 weeks ago).

(Client) shared that he has never made any plans to end his life, but last week he had thoughts popping into his head around accidents. He shared that since the truth has come out to his parents and partner about the extent of his gambling and debts, he no longer feels this way. Shared that he feels relieved, but that he still feels guilt and shame.

Lack of sleep was a commonly reported harm affecting gamblers, with counsellors’ comments including ‘only getting 5hrs sleep due to the stress of gambling’. A couple of clients reported nightmares about gambling; others mentioned gambling all night and being ‘exhausted for work’.
Counsellors recorded a range of mental health harms for affected others including stress, anxiety, suicidality, depression, taking medication, shock and distress. As with the gamblers themselves, some affected others blamed their mental health deterioration on dealing with the gambler, whereas for others the stress exacerbated previous conditions:

Client stated that she was diagnosed with Depression aged 13 and is prone to suicidal thoughts but has never made a plan or acted upon her thoughts. Stated that when she was aged 19-24 she did not address her mental health but is currently awaiting a referral to Talking therapies ... Stated that since she found out in January 2019 about her boyfriends of 3 years gambling problem, she believes her depression has deteriorated.

Client wrote on the assessment paper ‘not suicidal but doubting if life is worth living’ She stated that 3 years ago she experienced a feeling where she was walking by the River Thames and she had a thought of jumping on the bridge, then immediately realised that she is going through a depressed state, so called her GP and got referral to counselling. At the time the client was going through very difficult financial situation due to her husband’s gambling which she was not aware of, and was being bullied at workplace.

A few affected others reported the shock they felt on finding out about the gambling problem:
Two weeks ago, client found out that her father is ‘significantly’ gambling. When she heard the extent of gambling and the losses she fainted; didn’t sleep for two days; couldn’t talk without crying; and became ill for a week. She found the whole situation ‘horrendous’ she said. She expressed her shock that her perfect idealised dad, her rock, the most solid and dependable figure in her life has been lying for years. She described her mother as ‘very stiff upper lip’, who ‘tries not to get upset’ – however, mum got very upset because of how client had reacted – mother helped client to ‘calm down’ and reassured client that ‘they would be ok’.

Within affected others, a range of medications was discussed and text searches identified references to anti-depressants (n=28) including citalopram (n=3), sertraline (n=5) and fluoxetine (n=2).

Assessing risk – and safeguarding notes

Levels of suicide risk and safeguarding were not always clear from the notes. In the majority of cases where suicide risk was identified and noted, counsellors followed a pattern of discussing a ‘safety plan’, ‘crisis plan’ or ‘care plan’ with clients, which involved them in reaching out to family or friends, contacting their GP, contacting Samaritans or CALM (male suicide), phoning 111 or 999 or going to A&E. The majority of cases were noted to be ‘monitored in future sessions’. A very few references were made to counsellors attending team meetings to discuss high-risk clients or a counsellor discussing potential actions with their supervisor.

Counsellors recorded detailed notes about gamblers’ recent suicidality including whether it was predominantly thoughts (n=92 cases) or detailed plans (n=16 cases), recent attempts (n=9 cases), protective factors (n=79 cases) such as children and partner, friends, experience of the devastation suicide causes, fear or occasionally religious beliefs and where there was no suicidal ideation (n=87 cases). The quotes below demonstrate this range:

Occasional suicidal thoughts with a certain degree of planning. Last episode was about 3 or 4 months ago and he looked online about ways to kill himself (for example how high would a bridge need to be) and he also made sure his life insurance would cover suicide.

He wrote a letter to his wife and children at 3:00 am to say goodbye, and walked out, he was sitting near a bridge and the police came, but he says he does not have any plans to kill himself, as this would affect his children.

[Client] reported that he felt suicidal last Friday after losing all his money gambling, his
mother told him that she is leaving him, and he owed people money. He felt that there was no point in living anymore, went to a train station and was planning to jump in front of a train. People at the train station asked him what he was doing, and the police were called. [Client] was taken to hospital to get assessed, he saw a psychiatrist and went home afterwards. [Client] reported that he doesn’t currently have any suicidal ideation or self-harm. He doesn’t want to die but wants to live, he just doesn’t know what to do about the debt he owns. Social services have been involved in his care for about a month now.

With regard to affected others, 14 clients were experiencing suicidal ideation and one was self-harming; the majority of them had pre-existing conditions.

Counsellors commonly recorded ‘monitor in sessions’ (n=101 gambler references; n=7 affected others) to alert colleagues to the suicide risk.

Decision-making, procedures around gaining GP details or contacting GPs, and multiagency liaison on behalf of clients were unclear from the case records and may have varied, as the following indicate:

(Client) refused to disclose her GP’s details even though I explained to her it was very important for us to guarantee her safety and that we would only contact the GP in case we would be concerned about her safety. [Client] disclosed having only occasionally planned to end her life on the questionnaire (CORE-10), and ticked the suicidal option on her client form, but only disclosed having occasional thoughts about not wanting to be here when asked about self harming.

He agreed to see a GP, advise of his mood and ask for a psychology referral. He understands that he cannot be seen for his gambling problem at Gamcare, unless the above is in place.

In a small number of cases (n=5) counsellors reported having contacted GPs on a client’s behalf or confirmed their attendance at appointments, as the following illustrates:

Counsellor to contact GP if client has failed to do so. Counsellor to confirm has accessed GP. Activate safeguarding policy should this change. Monitor closely.

The quote below shows that in some circumstances a GP is contacted, and the outcomes are noted. It is possible that these actions are more likely to be recorded in treatment notes than in assessment notes:

DATE Client said he had been thinking that ‘he did not want to be here anymore’ and
had told his partner this. I asked if he had planned anything and he said he thought he would take an overdose. I asked of what and he said ‘anything he could get a hold of’. Ensured that he knew that if he was at risk to contact the crisis team, his GP, call an ambulance, present at accident and emergency and he could call the Samaritans. He said that he knew that and had the numbers to call. Prepared and discussed a risk management plan and gave a copy to the client. He agreed that I could contact his GP this afternoon.

I called the clients surgery and spoke to the receptionist and asked if a GP could call me back regarding the client and his well being. Awaiting a call back from Dr. Dr called me and I explained that the clients’ mood had been low and he had some suicidal ideation with some thoughts of planning. I explained that we had prepared a safety plan together and he had taken a copy of this. I explained that the client had claimed that he was finding it difficult to make an appointment to see a GP. Dr said that he would take it from here and would contact the client for a face to face meeting or a telephone call. – (date and time)

Client said that he had seen his GP today and he has prescribed him medication and had prepared a sick note for the client. The client could not remember the name of the medication and said he will text me the details later. Client said that he was going to be transferred to a different department at work tomorrow and he would ‘give this a go’ but if he felt as stressed he was going to use the sick note and take time off. He said his mood was still low but was not suicidal. He said the GP had gone through safeguarding numbers with him. Client has an appointment booked with the GP in 3 weeks time (date)

Client today said his mood was now improving and he felt the medication was starting to work. He said that he was on the waiting list for talking therapies.

Several examples were identified where a GP did not appear to have been contacted on behalf of gamblers or affected others although, from the notes, they appeared to the researchers to be in crisis and at high risk, as in the following example:

Feeling suicidal. Shared that in (month/year) he put a rope around his neck and thought about hanging himself from (xx), but a passerby intervened. He spoke to his GP (date) about his low mood. He was not prescribed any anti-depressants and asked to come back for a follow up appointment, but he did not do this. Informed about Samaritans and texted client their number and the GamCare helpline number. Has a ... deadline to get £3K together for his wife’s visa application []. Shared that he does not eat because he wants to die and he shared that he had only eaten a small amount today.
Clients’ attitudes to GPs and their approaches to gambling harm ranged from finding their GP extremely helpful, to lacking confidence in what they could realistically do to help, to believing they were ‘no use at all’ or not to be trusted. One client was reported to have said her ‘lovely’ GP had been very supportive and offered her a range of different support mechanisms, including signposting her to Gamcare, providing prescriptions for antidepressants and sleeping tablets, and discussing with her the possibility of a referral to mental health services.

The assessment notes mentioned 25 GPs who had referred clients to NHS therapy or counselling services, usually for CBT. The counsellors’ notes showed that their clients’ responses were evenly spread between those finding counselling helpful and those who did not.

Many of the case notes reported that clients had difficulty in taking up talking therapies because of the long wait for an appointment. How long a wait was not stated. Others who wanted therapy were faced with an apparent lack of specialist support for their gambling addiction. One counsellor, for example, reported that a client referred by their GP for counselling ‘found themselves agreeing with the counsellor that he needed more specialist addictions support’. Once at therapy a few were reported to have told the counsellor that they could not be seen for gambling until their other problems had been resolved:

[I] was due to start some psychotherapy but was told that they would not accept [me] as [my] gambling was out of control.

In another case, a counsellor reported:

The GP was uncertain if [the client] was depressed and mental health services said they could not assess him appropriately until he has addressed his gambling.

According to the notes, 36 gamblers were being supported by a psychiatrist and/or local community mental health team (CMHT) or had been previously. Counsellors had noted some of their clients’ experiences of being hospital in-patients and their mental health problems:

The client had suicidal ideations 10 days ago that led to him attempting to hang himself. The client stated he was able to stop himself. The client has had previous medication overdoses and he is currently being supported by a Psychiatrist from (service). The client has also been referred to his local CMHT. We discussed a safety plan and the client stated he would speak to his parents if he feels this way again. He was also encouraged to contact the Samaritans or to call the GamCare helpline.
Vulnerable adult when mood is low. Active risk of suicide. May require multi agency liaison with [X] Mental Health Team. Monitor during sessions and action accordingly.

Decision-making about when multidisciplinary teams or CMHTs should be contacted was unclear from the assessment data but this may not have been the place for it to be outlined.

Some clients were identified as an ‘adult at risk’ or ‘vulnerable’ or at risk of becoming so if their situation deteriorated (gamblers n=187; affected others n=64) within the ‘SafeGuardingNotes’ tab. One definition of a vulnerable adult under The Care Act (2014) is someone ‘who has needs for care and support ... is experiencing, or is at risk of, abuse or neglect, and as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it’. It was not clear if this definition was being used in the case notes.

There was some inconsistency about what was recorded in the safeguarding column in the assessment case notes. Comments were noted about possible domestic violence or suspicions of a controlling partner, possible child neglect, or care for a vulnerable partner. However, data were also recorded here of clients with children where no safeguarding concerns were identified, and where there was a high risk of suicide. The reasons for recording some cases under the ‘SafeGuardingNotes’ tab appeared unclear and, within the data, there were cases where similar details were not recorded in the safeguarding notes. There may be some inconsistency between definitions of vulnerable adults in practice and it may be that some clients were being included in this category because they were at high risk of suicide (as were many others in the sample) rather than ‘vulnerable adults’. We are informed that developments in GamCare may already be addressing these points.

There was evidence of good practice in supporting some vulnerable clients as the following detailed notes demonstrate:

**VULNERABLE ADULT**

I have been reviewing on going risk/safeguarding in our weekly holding sessions. Client is still trying to arrange an initial assessment with NPGC [National problem gambling clinic]. Client has on going occasional thoughts of suicide when she is feeling low, but no plans. We have explored this in a lot of detail. If Client’s mother was to pass away, this would increase her risk of suicide. Current protective factors – Client has good support from her sister and her cat keeps her focused on living. I have signposted to a lot of agencies, as detailed in my weekly session notes, including GP, Samaritans, befriending services, volunteering organisations, local counselling services, Mind service user panel, and Healthwatch. She is open to (local) Recovery
Team and is awaiting a home assessment with (local) Counselling. Date given.

Counsellors’ notes referred to 15 clients involved with local authority child or adult social care services. Cases involved caring responsibilities, domestic violence, child protection concerns and attempted suicide (and caring for children in the aftermath). One affected other had approached the local authority for food because his wife had spent all the family income on gambling. All were positive about their contact with the local authority. Again, procedures for engaging with social care support were unclear from the notes, but counsellors noted liaison with staff on a couple of occasions as the following illustrate:

The client has a mental health team and a social worker attached to her (Housing Provider). She has a good relationship with her sister who brings her food as she gambles all her benefit/disability money away as soon as it lands in her account.

Risk review. Children remain on Child Protection (CP) plan, lots of professionals working with family and I have updated the worker at the Family Safeguarding Team. [Client] still experiences thoughts of suicide, but no plans. Protective factors - her medication is going to increase, she is engaging with CMHT and Mind, she has a crisis plan which we reviewed, signposted to Samaritans, helpline, crisis team, she has been doing reflective writing exercise exploring reasons to live. Potential triggers could be disengagement from services, husband returning to drugs/gambling or finding out husband has lied to her further. Will continue to monitor in weekly sessions.

4.6 Gambling-related harms

A wide range of harms was identified in the data and Tables 9 and 10 illustrate references to gambling harms from the perspective of gamblers and affected others.

Harms to gamblers fell into six categories: financial (debt, engaging in theft, borrowing), housing, work (poor performance, including 21 references to being ‘signed off’ work), relationships (break-up, arguments), impact on family and physical harms.
Table 9: Counsellors’ notes about harms caused to gamblers

<table>
<thead>
<tr>
<th>Harms experienced by gamblers</th>
<th>All gamblers</th>
<th>Gamblers male</th>
<th>Gamblers female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debt</td>
<td>181</td>
<td>135</td>
<td>46</td>
</tr>
<tr>
<td>Theft (including from family)</td>
<td>118</td>
<td>89</td>
<td>29</td>
</tr>
<tr>
<td>Poor work performance</td>
<td>96</td>
<td>84</td>
<td>12</td>
</tr>
<tr>
<td>Partner break-up</td>
<td>68</td>
<td>58</td>
<td>10</td>
</tr>
<tr>
<td>Partner trust broken, lies, deceit, betrayal, stress</td>
<td>61</td>
<td>53</td>
<td>8</td>
</tr>
<tr>
<td>Borrowing</td>
<td>55</td>
<td>39</td>
<td>16</td>
</tr>
<tr>
<td>Impact on family</td>
<td>50</td>
<td>40</td>
<td>10</td>
</tr>
<tr>
<td>Partner arguments or tension, anger, moods</td>
<td>48</td>
<td>36</td>
<td>12</td>
</tr>
<tr>
<td>Housing situation concerns</td>
<td>47</td>
<td>32</td>
<td>15</td>
</tr>
<tr>
<td>Physical harms</td>
<td>38</td>
<td>23</td>
<td>15</td>
</tr>
<tr>
<td>No money for basic needs</td>
<td>24</td>
<td>15</td>
<td>9</td>
</tr>
</tbody>
</table>

No. of references

Table 10: Counsellors’ notes about harms caused to affected others

<table>
<thead>
<tr>
<th>Harms experienced by affected others</th>
<th>Affected others</th>
<th>Affected: Other male</th>
<th>Affected: Other female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional abuse</td>
<td>38</td>
<td>3</td>
<td>35</td>
</tr>
<tr>
<td>Bailed out gambler</td>
<td>37</td>
<td>3</td>
<td>34</td>
</tr>
<tr>
<td>Theft from family partner</td>
<td>28</td>
<td>4</td>
<td>24</td>
</tr>
<tr>
<td>Control gambler’s money to help</td>
<td>28</td>
<td>1</td>
<td>27</td>
</tr>
<tr>
<td>Trouble sleeping</td>
<td>14</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Debt on behalf of gambler</td>
<td>12</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Financial abuse</td>
<td>11</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Asks family for money</td>
<td>10</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Relationships: Lack of trust</td>
<td>19</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td>Relationships: Arguing</td>
<td>10</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Partner: Divorce, break-up</td>
<td>15</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>Housing situation</td>
<td>9</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Spending joint money</td>
<td>8</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>8</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Physical effects</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

No. of references

59
In contrast to gamblers, counsellors reported that affected others referred more often to emotional and physical abuse, bailing out gamblers, being stolen from, their role in controlling the gambler’s money, having trouble sleeping and relationship harms.

There was a disparity between the small amount of abuse referenced in gamblers’ assessments and that in affected others’ reports. This points to research which has found gambling addiction to be on a par with other addictions for the harms it causes to affected others. The worst experiences are those of partners and others living with the gambler (Orford, Cousins, Smith, & Bowden-Jones, 2017). It could also be that affected others often only seek support about severely affected gamblers, and thus the harms they have experienced are particularly extreme. This would be of interest for future research.

Close inspection of the data reveals few instances of gamblers describing abuse whereas 29 cases of emotional abuse, six of which also include physical abuse, were recorded in relation to affected others, as the examples below illustrate:

[Client] talked about some of her partner’s behaviours, particularly around his gambling and stated these were predictable to her and repetitive. She stated there had been no physical abuse but that her partner displayed some symptoms of abusive behaviour around their finances - particularly when his money is managed by her and she refuses him money to gamble with. It has been suggested to her that it might be appropriate for her to obtain some support in this regard from the Women’s Aid Centre.

Reports that her marriage has been difficult over the last 2 years particularly, she reports she has felt lonely and unhappy. Reports they have had couples counselling which she found helpful but he did not open up. She reports that she feels ‘abused’ and ‘violated’ by her husband’s lying about his gambling. Reports that this makes her feel ‘like the little girl who was not loved or liked’.

Client stated that at times, she feels ‘bullied’ by her son. She adds that there is almost an expectation that she will sort out the debt problems and there appears to be no responsibility from him. She adds that this has made her feel ‘mentally tired’. Client describes this as a form of ‘emotional blackmail’.

In contrast, only two cases contained reports of gamblers admitting to being emotionally abusive, and three where they admitted to being physically abusive. The following is a rare example, although this issue may have been discussed in later sessions:

He ticked ‘yes’ in relation to the question asking about domestic abuse. When asked
the nature of abuse he stated that he felt he has been emotionally abusive towards his partner, recalling instances where he has been ‘emotionally manipulative’ describing feeling guilty and ashamed about it. He also mentioned that he would gamble ‘in spite, to how her that I’m the boss’ also stating that he has been ‘dishonest, emotionally blackmailing her.’

Theft

Many of the harms referred to in the case notes have been well documented in the literature; the large number of references to theft was, however, surprising. Most of these cases involved stealing from partners or other family members. Partner theft included taking some or all monies from a joint account without their partner’s knowledge; fraudulent use of a partner’s credit card, cash card or account; taking out a loan in the partner’s name and using the partner’s phone. Several used money that was assigned to specific areas of household spending, such as using the rent for gambling, or had been saved for a one-off event, including a baby’s christening and the funeral of a grandfather. In a few instances the partner (always male in these cases) had stolen and sold his partner’s possessions, such as a car or jewellery. Other members of the family from whom clients stole included mother and father (separately), brothers (no cases reported of a sister), uncle and grandfather. Most cases involved fraud of some sort, such as faking an ID to access a parent’s or brother’s account. There were just a few cases of stealing cash from a parent’s pocket or purse (perhaps reflecting less reliance on cash nowadays). In only one instance had the family reported the client to the police, but they did not go on to press charges. The other main area of theft noted in the assessment reports was from the workplace. This was mostly men, though there were five cases of women among the 40 people reporting workplace theft. Cases involved stealing cash from the till, fraudulently transferring money from a business account to the client’s account, collecting money on behalf of others and using a corporate credit card. Employers tended to be more sympathetic than not. In 40 of the reported cases 15 employers pressed charges or were in the process of pressing charges. In most cases the client lost their job.

Other cases of theft included shoplifting food because there was no money left to buy food for the household, three cases of stolen property, and someone spending the payment for a job before the work was done.

Affected others reportedly experienced strong feelings of frustration, guilt and anger with themselves, coupled with feelings of betrayal at being consistently lied to about money. In most cases, and despite their reporting financial abuse, they had felt the need to support
their partner and help pay off their debts. This resulted in substantial stress and anxiety for the affected other. One client reported being ‘worn out by the whole situation’.

The following comments illustrate the stress placed on affected others:

Client Reports has taken out loans to pay off son’s debts in the past twice, both for £12000. Is currently guarantor on son’s rented property and for the past 2 months had had to pay the rent because he has gambled all his money.

Client report she had paid off some of his gambling debt earlier on this year and her mother had lent her partner money on the condition he stop gambling. Reports struggling to come to terms with the effort needed to repay this as she has always been careful with money herself.

A parent’s need to protect their child was a dominant theme, even when it put them in the invidious position of having to take control of their teenage or adult child’s finances. In one situation, both parents were retired, they had run out of money, and ‘even so they still borrow money to pay for [Son]’s needs while he spends his wages on gambling’.

In another case an affected other had become fearful of opening her front door to debt collectors.

There may be value in opening up channels for affected others undergoing financial abuse to share their feelings of frustration with others in similar situations.

4.7 What do gaps in the data tell us?

One area that has received little attention in the literature is evidence about the direct impact of a parent’s gambling problem on their children. A lot could be inferred from the data about children losing out on basic material requirements, gifts, time and a safe home environment, which are discussed below. A literature review of studies about affected others found children to be particularly affected, appearing to suffer silently due to their reluctance to disclose their parental problem gambling worries (Riley, Harvey, Crisp, Battersby, & Lawn, 2018).

Clients expressed sorrow about the financial impact of their gambling on their children by spending the money for their children’s clothes, outings, shoes, activities, ‘treats’ and holidays on gambling. One assessment included the comment:

This year he could not contribute to son’s birthday present and he realizes he needs help.
Another client reported that:

financial pressures of having a young family had been a motivator to gamble, stated intends to use money to treat children but recognises resulted in doing the opposite. Reports since becoming abstinent, he has already had available money for activities with his children and feels more engaged with them.

In some instances, gambling had impacted on the family’s living accommodation, preventing them from moving to a more suitable home or from buying their own home as the following records demonstrate:

(Client) is living with his partner and his two children 11 years and 6 years in a one bedroom flat, [which] is unsuitable and overcrowded. The client stated his gambling has prevented them from moving to a larger property.

(Client) reports his gambling has prevented him buying a house. [He] wants to tackle gambling to be able to give his children a better life and more security for the future.

Several clients talked of how pregnancy or having a small baby created additional stress resulting in further gambling. This was true for both mothers and fathers. While they said they wanted to give the necessary support they had found the situation made them gamble more. For example:

Client has a baby, about 7 months, and feels a very heavy sense of responsibility; and believes the partner’s pregnancy is main reason for escalation of gambling (escape).

A mother was recorded as stating:

It all came to a head when she was on maternity leave and one night stayed up gambling all night and cleared out their joint bank account.

Another ‘spent the entire [month’s] maternity pay in 3 days’.

As well as the material losses for the children of problem gamblers many clients expressed sadness about the time they spent gambling rather than spending it with their children. This was often about the time lost in developing a good relationship with the child. One client expressed ‘regret for being too preoccupied with gambling to give the children proper attention; as well as not being around for birthdays and outings’.

Others expressed remorse that their gambling-related moods and bad-temperedness had created an awkward home environment for their children:
Has two (young) sons ... they are not directly affected by gambling but [Client] thinks the mood in the house can sometimes affect them.

Some felt that their children often knew that something was amiss. For example, a client reported that his 11-year old son was aware of problems as he has had to go and stay with a relative for a while. Another client was recorded as stating she:

... feels that she is constantly trying to hide from the kids that there is something wrong, but they can tell that there is a problem.

However, counsellors reported that some clients glossed over the possible emotional impact of their gambling on their children, as the following note records:

He doesn’t feel that his gambling has an impact on his children but occasionally he would give them things to do, so that he can gamble instead of doing things with them.

Only one record was made of a client worrying about the possible influence their gambling may have on the likelihood of their child becoming a problem gambler. Many relationships were recorded as having broken up because of a partner’s gambling, which in turn had had an emotional impact on the children.

He only gets to see his son twice a year due to money issues.

Counsellors generally recorded responsibility for children in assessment notes, but it can be seen how their needs could easily be overlooked by parents facing the pressures of dealing with an addiction, often in conjunction with other problems. GamCare may wish to discuss with its counsellors whether there is scope to probe and record this in a more systematic way to help ensure these matters are being appropriately addressed at assessment or whether they should be covered according to individual circumstances and needs in later sessions.
5 Conclusions

To what extent does initial assessment data provide insights into factors associated with help-seeking?

This analysis has explored GamCare’s historic data in depth for insights about what affects clients’ help-seeking, what is currently working well and what could be improved.

The analysis highlighted that counsellors were undertaking a great deal of skilful and specialist work to assist clients’ help-seeking in initial assessments. They are involved in: obtaining and recording detailed personal histories; imparting large amounts of practical information; forging supportive relationships with clients; and practising using a range of therapeutic counselling approaches. This work demands skill given the range of clients, a large proportion of whom are experiencing depression and some suicidal ideation, while a small group have long-standing serious mental health conditions, social care needs or have experienced extensive trauma. Overloading counsellors and clients with additional measures or data management requirements may not be helpful. However, more systematic recording of assessment data might make it easier for counsellors to access and interpret client information in future treatment sessions and thus improve outcomes. It would also facilitate improved evaluation of service outcomes for different groups of clients.

Most counsellors were recording social support as a key element of ‘recovery capital’ (Best & Laudet, 2019) and as a way of assisting a gambler or affected others with their treatment journey; this could be undertaken more systematically. Our analysis showed, however, that some clients made good improvement despite poor support, and others made low improvement even though they had good support, which demonstrated the importance of personalised approaches. For gamblers, being bailed out and having a supportive individual willing to manage their money were identified as important parts of their ‘recovery capital’; for many affected others, on the other hand, offering this support was experienced as emotionally draining. Affected others had support but also discussed feeling isolated, possibly because some felt ashamed and hid the situation. Support from employers/colleagues was identified as an area of potentially under-exploited ‘recovery capital’. Consideration could be given to systematically recording work-based support available – for example, counselling or wellbeing training – and to using more strengths-based assessment approaches (evidenced in some of the assessments) in line with current trends in health and social care services. Women appeared to be more involved in managing gamblers’ finances than men; it may be that female gamblers struggle to find someone to fulfil this role for them, which could affect their outcomes. Those seeking support as
affected others are predominantly women, which suggests that men may be missing the opportunity to learn more about and understand the problem and approaches to supporting someone affected by it. Efforts could be made to signpost partners or family members of women gamblers to services for affected others in order to provide women with more support. Proactively offering clients a wider choice of treatments, including couples and family therapy, might be considered, although it would not be appropriate for all.

Capturing clients’ readiness to change and levels of motivation by using validated measures may improve treatment outcomes and reduce the level of dropping out as it would give counsellors a more explicit indication of where a client might need support. The Transtheoretical Model or ‘Stages of Change’ model of behaviour change (Prochaska et al., 1993; Rollnick, Mason, & Butler, 2010) is often used to describe the experience of behaviour change for those with addictions and can be useful for counsellors to ensure they are in step with a client. Analysis of counsellors’ notes showed that they recorded gamblers’ behaviour change in terms of actions taken, such as whether gamblers had stopped gambling, blocked themselves from gambling opportunities, told others about their problem, or arranged for someone else to manage their finances. For affected others, they recorded conversations about preparing to support a gambler as well as preparing to care more for themselves. Gamblers were identified as more likely to be at the action stage of their journey, while affected others were at the preparation stage. This indicates that the client screening process for accessing treatment was working. The few clients identified as being at the pre-contemplation or contemplation stages might require support from counsellors before they embark on the treatment journey to get them to the preparation stage. More systematic recording of this information might be considered; alternatively, counsellors could ascertain and record clients’ motivation to change using a motivation index or other validated measure.

The range of reasons recorded for help-seeking clients’ gambling highlights the varied skills counsellors are drawing on to support them. There was evidence that counsellors were using a range of therapeutic approaches and that relationships were established which allowed for the sharing and recording of detailed personal histories. Affected others were recorded as being more distressed than gamblers. Counsellors’ advice to clients (from GPs and mental health services too) not to engage in parallel counselling for different problems was recorded occasionally in the data, suggesting this is an issue. Counsellors signposted clients to a very wide range of other services, focusing on the root causes reported to be causing their trauma, although more might have been expected to Relate and CRUSE. A few
clients suggested options for improving services, including opportunities to: choose the style of counselling; choose the gender and/or cultural background of a counsellor; continue with the counsellor who had conducted the assessment; take part in group, face-to-face or couples therapy.

Data analysis demonstrated that the vast majority of help-seeking gamblers wanted to give up the habit totally, with a large group wanting to understand why they gambled. Help-seeking gamblers most frequently referenced debt, engaging in theft, and relationship difficulties as the harms caused by their behaviour. The most frequently referenced harms for affected others were mental and physical abuse, being the victim of theft/financial abuse and bailing out the gambler. Levels of theft have been under-explored in the literature, possibly because they may be categorised within general debts. Affected others were loath to report gamblers who had stolen from them to the police. Consideration of best practice pathways in building the resilience of affected others experiencing financial abuse or enduring theft from gamblers (as opposed to agreed bailing out) may be worth consideration.

Moving to online counselling in the COVID-19 pandemic may provide GamCare with the opportunity to offer more personalised services – for example specialist advisors or treatment programmes for subsets of clients, such as those diagnosed with specific mental health conditions or long-term conditions, those from specific cultural or ethnic communities, or of different ages. Research is needed about the effectiveness of tailored treatment approaches for clients with dual or multi-morbidities or long-term conditions (Yakovenko & Hodgins, 2018). More specific recording of this data would enable cost-benefit analysis and workforce capacity assessment to determine whether to support alternative approaches.

Counsellors’ notes about gamblers and affected others’ mental health problems reveal high levels of depression, anxiety and suicide ideation. How suicide risk and safeguarding were recorded was not always clear, nor were pathways and decision-making about involvement of GPs and other multidisciplinary health and social care teams. Analysis revealed gamblers had high levels of negative life events. Some commentators (Roberts et al., 2017) have called for clients to be routinely screened for trauma to help tailor support and signposting to other services and again this could be considered.

Exploration of the initial assessment data has provided insights into a multiplicity of factors associated with help-seeking – relating to gender, culture, social capital, motivations, mental and physical wellbeing as well as the therapeutic relationship and interactions with
multidisciplinary staff working across health and social care. Above all, this analysis has offered a chance to consider the perspectives of those affected by gambling harms and their attempts to seek support by making good use of rich data collected by experienced and skilled counsellors in a national support and treatment agency.
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