
Citation:

Woodall, J and Freeman, C (2021) Emerging lessons from the commissioning and delivery of a gambling treatment service. *Public Health*, 196. pp. 69-73. ISSN 0033-3506 DOI: <https://doi.org/10.1016/j.puhe.2021.05.008>

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Emerging lessons from the commissioning and delivery of a gambling treatment service

Objectives: Gambling is a public health concern, given the multiplicity of harms for individuals, families and communities. This paper reports on the commissioning and delivery of a problem gambling treatment service in a metropolitan area in England where the concentration of problem gambling is often higher than the national average.

Study design: A cross-sectional study, using purposively sampled 'experts' and stakeholders involved in the conception and set-up of the service.

Methods: Individual semi-structured interviews were used to ascertain the depth of information required to fully appreciate the nuances and complexities of the service. Eight participants took part in the interviews with an additional respondent providing written comments in relation to the interview schedule as a workaround to accommodate the organisational impacts of Covid-19.

Results: The paper identifies several factors contributing to the successful delivery of the service. Well-managed collaborative provision with expertise from across sectors is critical, but this needs to be balanced against the challenges faced by bridging cultural variances in practice and language. Adopting evidence-based models of delivery was central to practice and moreover geographical location is a key consideration to encourage access for those facing gambling problems and discourage feelings of stigma.

Conclusions: This paper offers a unique contribution to understanding more about the provision of gambling treatment services. This is crucial given that greater numbers of people face challenges as a consequence of gambling harms and such services should be seen part of forming a coherent public health response.

Key words: gambling, qualitative, commissioning, problem gambling

Emerging lessons from the commissioning and delivery of a gambling treatment service

Introduction

'Problem gambling', is described as gambling that is out of control and can contribute to social, personal and interpersonal problems¹. Problem gambling has not yet been viewed fully as a public health matter in the UK, but the implications for communities can be significant². Some have distilled the consequences of gambling into six types of harms: financial harms; relationship conflict; psychological distress; health decrement; cultural harm; work/study impact; criminal activity; and life course harms^{3,4}. Calls for problem gambling to be fully recognised as a public health concern have been consistently made, with evidence reiterating the adverse social, economic and health consequences³.

While 'whole systems' approaches to public health challenges, such as obesity⁵, are becoming increasingly attractive and gaining some political momentum, it seems that gambling is some way behind⁶. That said, policy frameworks have been established to reduce the impact of gambling. Wardle et al.⁷ used the socio-ecological model and outlined the possible interventions available to tackle problem gambling from the level of the individual, such as addressing risk taking behaviour, all the way through to the societal level and addressing ineffective regulation. The UK rates of gambling disorder are estimated at 0.4% of all adults but there are approximately 340,000 people who experience problem gambling and a further 1.75 million people who are experiencing some level of harm to health and well-being⁸. These cases are not distributed equally, as research suggests that the impacts of gambling may be more concentrated in particular sub-groups of the population (Black minority ethnic groups, young people and people with mental health and substance misuse problems)⁴ and in metropolitan areas^{1,9}.

There has been a vision that local authorities and their partners can take action to reduce gambling-related harm¹⁰. This includes a range of measures from prevention and education to more 'downstream' interventions focusing on treatment and support. Indeed, activities targeted at high risk individuals (the focus of this paper) form part of a coherent prevention strategy¹¹. GambleAware (the national commissioner of gambling research, education and treatment) recognise the need to increase the national capacity for the treatment of those affected by gambling harms. A report titled 'Gambling addiction and its treatment within the National Health Service'¹² noted that there were almost no treatment services available for problem gamblers within the NHS. Indeed, until 2019 the majority of treatment services for those affected by gambling-related harm in Britain were funded via GambleAware. Since then, as part of the NHS Long Term Plan¹³, NHS England committed to funding fourteen gambling clinics across England, reflecting the growing awareness of the potential health benefits to be gained from the effective treatment of problem gambling.

This paper focuses on the commissioning and delivery of a gambling treatment service in a metropolitan area in England where the concentration of problem gambling is higher than the national average. The service was created following the submission of a joint proposal between two providers: the local Mental Health Trust and an independent UK charity. The model would provide care, based on the assessment of need, for the full spectrum of people experiencing problem

gambling. It was a key assumption that referrals into the service would come from an independent UK charity (via a national helpline) along with a direct referral system from other care providers such as GPs and mental health practitioners, self-referral, and from the criminal justice system and wider support services.

This paper offers a contribution to understanding more about the provision of gambling treatment services in the UK, given that the design and implementation of such services are not readily reported. The importance of such services is critical to reduce the gambling related harms for individuals, families and communities¹⁴. The paper reports on the experiences and emerging lessons from the commissioning and delivery of a gambling treatment service and moreover to identify 'what worked well' and challenges to be avoided should similar services be replicated.

Methods

Qualitative methodology sought to access expert opinion on the commissioning, design and implementation of the service. Evidence hierarchies recognise the value of professional and expert knowledge to generate information for decision-making purposes¹⁵. Expert knowledge is defined as "substantive information on a particular topic that is not widely known by others"^{16 30}. Expert knowledge can be particularly useful in understanding the process and mechanisms of implementing an intervention and hence used here to understand the gambling treatment service¹⁷. While experts are regarded as proving credible sources of information in many fields, the use of experts to inform decision-making processes is contentious and has been challenged¹⁶. In addition,, understanding gambling treatment services from the perspective of service users is critical, but this was not the focus of this research.

Individual semi-structured interviews were used to ascertain the depth of information required to fully appreciate the nuances and complexities of the service. A small sample of eleven experts were identified in consultation with key service personnel in the treatment providers. This approach followed what Patton¹⁸ describes as 'critical case sampling', where critical cases are selected as they offer particularly important insight or knowledge on the issue being studied. Experts were drawn from different fields and sectors, including: the local NHS Mental Health Trust, the local authority, the commissioning organisation and a service user representative. Eleven key stakeholders were invited to take part in one hour telephone or face-to-face semi structured interviews during February and March 2020 (modifications were made in line with the public sector response to Covid-19 and latter interviews were all conducted over the telephone). However, eight participants agreed to take part in the interviews with an additional respondent providing written comments in relation to the interview schedule as a workaround to accommodate the organisational impacts of Covid-19.

Data were analysed using Framework Analysis, which was considered an appropriate method given the applied nature of the study and the emphasis on policy and practice¹⁹. The term 'framework' relates to the central part of the analytical process, that is, the development of a framework or matrix. Concepts and themes in the data are then summarised and charted in the matrix. The matrix was constructed using thematic categories and several subthemes. All of the data were charted and the final matrix and themes were agreed by members of the research team.

Results

This section reports several thematic areas highlighting 'what worked well' and what challenges were faced during the conception, commissioning, and delivery of a problem gambling treatment service.

What worked well: Working in partnership

The range of partners involved with the service was key to its success. Partnership with the voluntary sector, providing connections into the community and delivering education and awareness raising, and the local authority in supporting implementation *'behind the scenes'* (Stakeholder 2) and ensuring the backing of elected members, were seen as critical components.

Though there were some initial problems with clarity around the expectations the commissioners had of providers, the positive impact of the partnership approach was highlighted in relation to working through issues and finding a way forward:

"It was a very useful meeting in terms of clearing the air...It was good because it was the first time all key players were round a table and were communicating directly. So people were able to expose their own basic assumptions and be exposed to other people's basic assumptions, seeing where there was commonality, and seeing where there was ground to close before moving forward." (Stakeholder 4)

The long-standing goodwill between the partners was noted as a key driver in bringing the plans for the service to fruition. While language; culture; established practices; and ways of working were highly varied, the common aspiration to support individuals and families dealing with the effects of problem gambling were shared unequivocally.

What worked well: Adopting an evidence-based approach

The service was committed to embedding research-led strategies and reflecting on internal practices to ensure the service was being delivered as effectively as possible. The key characteristics of the model included: engagement strategies; modifying and evaluating the referral and assessment processes; weekly multidisciplinary team meetings; a range of therapeutic interventions; and aftercare. Stakeholders talked positively about the care provided through the model, and how the service was agile with staff open to making modifications to service provision as the evidence base developed:

"...It's more or less stayed the same but [the service is] learning as it goes ahead."
(Stakeholder 8)

Despite staff being empowered to modify and alter service provision based on professional judgement, stakeholders noted how no substantial changes had been required to date:

"[The service] has got lots of experience with different approaches and models and ways of working so are consciously reflecting on [what is being learned] and whether the model is completely fit." (Stakeholder 1)

The range of therapeutic interventions available to service users was felt to be working very well because *'people who've got gambling addiction need different things and need a range of different interventions and [the service] is well able, right from the off, to deliver that'* (Stakeholder 3).

What worked well: Central location

The city centre location was important to facilitate ease of access to the service through existing public transport links and car parking. In addition, the location within a busy local government facility was noted as an asset of the service (*'the walk-in is brilliant'* (Stakeholder 9)), as an individual

with concerns about their or another person's gambling behaviour could seek help without the stigma which may be attached to approaching more traditional mental health services:

"There are some real advantages...The fact that people aren't coming into a hospital, into a mental health unit, they're coming into the same place where people are talking about their housing benefit or registering the birth of their son. It's a multipurpose council building and I think there is less stigma associated with it than walking into somewhere that says 'here's the gambling clinic'." (Stakeholder 3)

Co-location within a multipurpose government building presented an additional benefit, as it raised the profile of gambling related harm with other professional groups or teams. On a wider level, the co-location of the service in a council building was felt to be symbolic of what could actually be achieved when partners came together to tackle gambling related harm. It was regarded as indicative of how crossing organisational boundaries in formal and informal ways could benefit the delivery of a gambling treatment service(s).

Challenge: Commissioning clarity

The commissioning of the treatment service was often challenging for the providers delivering the service, as the way the partnership operated was not *'clearly articulated with direction and support from the commissioner'* (Stakeholder 2). Such ambiguities led to challenges in interpreting a number of facets of the service, including the referral pathway and criteria and issues with estates and accommodation. On the referral pathway and eligibility, several stakeholders highlighted the challenges and lack of clarity in the way it operated:

"No one has to come to any conclusion how you would specify who a complex client is." (Stakeholder 8)

For future service development, the fluidity of the light touch commissioning approach (which had been adopted) needed to be balanced more carefully with formal contracting which provides structure and *'a single vision of what is going to be achieved'* (Stakeholder 6) for the providers of the service. It could also avoid any unnecessary harms to a service user placed in an inappropriate part of the care pathway.

Challenge: Management and project management

Good management and appropriately trained and skilled personnel were critical to the successful set-up of the service. Clear and systematic project management of the service was a challenge discussed by the stakeholders. As an example, the absence of a financial breakdown and spending plan contrasted with some stakeholder's experiences in other services where these important projections were made in order to facilitate planning. This may be related to the lack of structure in the way the service was commissioned, as discussed previously. It was noted by the stakeholders that strong project management was essential, but absent, and *'there needed to be someone who was taking the reins and steering it more systematically'* (Stakeholder 1). For future service development, the commissioner should take a strong project management approach with appropriate governance, logging and management of risks and issues, and financial planning would be essential.

Challenge: Organisational culture

Stakeholders described how differences in culture between a statutory organisation, a voluntary sector organisation and council services led to issues in the implementation of a joined-up service, and investment may have been needed to overcome the barrier of cultural difference and to develop shared values:

"It's always going to be complicated when you've got the NHS, council and a charity partner involved. The NHS are just coming to the realisation that that's something that needs to be done but they do come along a bit with the attitude that they are the NHS and therefore this needs to be done in this manner. Which is fine, but part of working in partnership is that you've all got to give a bit and you've all got to take a bit as well." (Stakeholder 6)

A future service may benefit from investing the time needed to cement partner relationships and build trust between the two organisations. Though good personal relationships between key individuals were noted, there needs to be a way to escalate concerns and ensure that formal or informal organisational barriers do not hamper the delivery of the service.

Discussion

Research has previously raised the question as to whether more services are required to better meet the needs of problem gamblers, with further calls for gambling to be regarded as a public health concern²⁰. Some studies continue to assert that specialist treatment services for problem gambling remain relatively rare²¹. Given the exponential growth in gambling and the epidemiological evidence showing the prevalence of problematic gambling, suitable and accessible treatment options are required quickly²⁰. Nevertheless, there is limited evidence about how clinics and services for people classified as being 'problem gamblers' are organised. This study sought to examine views on the commissioning and delivery of a problem gambling treatment service so as to provide some guidance for future roll-out and commissioning.

The paper suggests that a partnership approach in a clinic for problem gamblers and affected others brings unique benefits. One of the salient factors contributing to the success of the clinic was collaborative working because the broad-based expertise that was brought to the clinic, plus the shared vision from all stakeholders to cross organisational boundaries, made the clinic 'work'. In crossing organisational boundaries, differences in culture between a statutory organisation, a voluntary sector organisation and council services were highlighted, leading to issues that could have been mitigated by a more directive commissioning approach allowing more time to build organisational relationships. Previous literature has focused on services for problematic gambling being delivered by discrete sectors (i.e. voluntary and statutory providers) in isolation², which has brought benefits in terms of shared practices and tacit knowledge. This study suggests that bringing together the expertise of different providers is critical but must be tempered by a shared organisational culture – including language, working practices etc. And clear referral pathways to enable productive working. This links closely to the importance of good management and oversight of operational issues to ensure that collaboration works effectively with responsibility taken for budget management, timelines, risk management and governance.

The importance of evidence-based practice was noted and embedding research-led strategies and reflecting on internal practices seen as a prime vehicle to do this. The field is in its infancy in the UK, although research is beginning to develop to identify effective ways of treating and supporting

problem gamblers, including a range of cognitive-behavioural approaches and motivational interventions²² online²³ and residential programmes²⁴. The service discussed here were research-led and were also instrumental in gathering their own evidence so as to reflect on their own delivery and pro-active about changing ways of working to improve service delivery. This is particularly important given the importance of client-driven models of working and being responsive to need²⁵. Current evidence, however, notes that gambling treatment providers often operate with no clearly defined model of care⁴.

The location of the service – being based in the city centre with good transport infrastructure and benefiting from co-location in a council building has strengthened the profile of the service and helped reduce any stigma associated with seeking help. Research suggests that stigma and shame is often a barrier for problem gamblers accessing services²⁶. Research in Ireland, for instance, suggested that problem gamblers have to access generic addiction services, instead of receiving specialised treatment for gambling disorder²⁷ and this approach to embedding gambling treatment in addiction services is an approach with some endorsement⁴. The current evidence base does not provide data on how stigma is experienced by people with gambling problems, including how this experience might differ amongst various groups²⁸. Stakeholders in this research noted how any stigma associated with attending the service was tempered by co-location with other (generic) services and this seems an important consideration in service design. Such practical issues also raise broader issues about those living in rural locations and how those individuals may be best served if access is problematic. Those living in small towns or the countryside often have difficulties in finding any other form of help than that offered via the internet²⁹.

This study focussed on the experiences of key stakeholders in the development of the service. It did not gather the views of those experiencing the service first-hand or family members (evidence suggests that for every person addicted to gambling, up to eight others are also directly affected⁴). To that extent, future research and evaluation should access these perspectives as they will be crucial in refining service delivery. In addition to accessing these views, an assessment of the effectiveness and cost-effectiveness of services designed to support problem gamblers is further needed to ascertain how well they support individuals and families. The evidence base here remains unclear and warrants further investigation.

Conclusion

This paper sought to provide learning for the development of services aimed at supporting problem gamblers. It drew evidence from the set-up of a service in a metropolitan area in the UK. The paper is one of the few to explore this area and provide guidance for the roll-out of future services. The paper is particularly timely for two reasons: first, data shows an increasing number of people requiring supporting for gambling-related harms; and second, there seems a desire to provide more support for those facing challenges associated with gambling. The paper identifies several factors contributing to the successful delivery of the service. This paper has limitations in that it focused exclusively on the view of identified ‘experts’ and suggests that understanding lay perspectives is essential in future service design.

Author Statement

The study was funded by Gambleaware and ethical approval was obtained by Leeds Beckett University.

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