Tackling Gambling Stigma

A review of gambling harm training materials for healthcare professionals

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About us

Tackling Gambling Stigma is a not-for-profit organisation set up to tackle the stigma and discrimination around gambling harm. We do this by sharing the real-life stories of those affected – because evidence shows that social contact is core to tackling any stigma or discrimination. We use best practices in research to gather and analyse lived experiences. This material is used to create a multi-media website where those affected, the public and professionals can learn about gambling harm by reading, listening, or watching people share their experiences. Our team has lived experience of addictions and being affected by the addictions of others.

Declaration

This report was funded by Gambling with Lives for the Greater Manchester Combined Authority (GMCA) and Gambling with Lives, on the understanding that content is not subject to control by them. Control sits solely with Tackling Gambling Stigma.

Clare Wyllie and Alexander Kallman have previously worked for GambleAware. They have also provided evidence and expertise for the Clean Up Gambling Campaign for regulatory reform and the Coalition Against Gambling Advertising.

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Note on language

Language matters. Especially when discussing topics that are highly stigmatised. Terms and phrases that label and blame a person for the harm they experience contribute to both self and public stigma and lead to discrimination. This impacts the lives of those experiencing gambling-related harm.[1] Therefore, where terms such as "problem gambler" have been used in the training materials or as part of a screening tool or prevalence survey, we will use quotation marks to show that this language is not endorsed by Tackling Gambling Stigma.

Healthcare professionals	Workers who advise on or apply preventive and curative measures and promote health with the ultimate goal of meeting the health needs and expectations of individuals and populations and improving population health outcomes.[2]
Commercial gambling	Gambling companies selling or providing gambling to a customer for a profit.
Affected other	Family and social network members who experience harm.
Expert by Experience (EbE) or people with lived experience	People harmed by gambling, who speak with an independent voice, and who provide insight, expertise, and recommendations to ensure that decisions for gambling research, education, treatment and policy are grounded in lived experiences.[3]
Stigma	Negative attitudes, stereotyping and prejudice towards groups based on distinguishing attributes, such as gambling-related harms. These discredit and devalue them, leading to discriminatory actions against them.[4,5]
Structural stigma	The societal-level conditions, cultural norms, and institutional policies and practices that either intentionally restricts the opportunities of stigmatised individuals or unintentionally yield negative consequences for them.[6,7]
Self-stigma	Apprehension of being stigmatised, and the process by which members of stigmatised groups (e.g., individuals experiencing gambling-related harms) come to believe and internalise negative stereotypes and prejudice held by the public and systems to themselves.[8,9]
Discrimination	Behavioural consequences that follow from prejudice towards stigmatised groups. Discrimination can be direct, such as treating someone with a distinguishing attribute unfairly, or indirect, such as practices, policies, or rules that disadvantage groups with particular attributes.

Summary

Gambling needs to be treated as a public health issue like any other, as it causes significant harm to the health and well-being of individuals, families, communities and society. Because of shame and stigma, many struggle to ask for or get help for gambling harm. They frequently report that their interactions with healthcare professionals show a lack of understanding and can add to stigma and shame. At the same time, people talk about what a difference a destigmatising and supportive response can make.

Healthcare and support services provide an important opportunity for conversation about risks and harms from gambling, and for identifying and offering support to people affected by gambling harm. Making conversations about gambling a normal part of interactions with healthcare workers is important for a public health approach, including prevention, early intervention and treatment. This can also play a role in tackling gambling harm stigma and discrimination, by making clear that gambling products and practices are risky and harmful, for anyone. This opposes the industry narrative that gambling harm is caused by a few flawed individuals who misuse their products. In addition, that gambling harm is not currently a standard part of healthcare interactions and statutory services is an example of discrimination against those harmed by gambling, which needs to be addressed.

Stigma may affect healthcare service users and the ways healthcare workers support them, and, as a result, the quality of care. Training provides a key opportunity to mitigate and shift harmful attitudes and behaviours that influence the general health and well-being of people affected by gambling harm. Therefore, it is vital to invest in and implement training that does not create or increase but rather challenges stigmatising attitudes among healthcare professionals towards those who are experiencing difficulties with their gambling.

The aim of the review was to evaluate healthcare training from the perspective of public health, stigma and discrimination and make recommendations for future healthcare training programmes. We looked at how training may implicitly contribute to destigmatising or stigmatising those experiencing gambling harm through the way it constructs the problem of gambling harm, its causes and consequences. We examined the extent to which training explicitly or overtly addressed stigma-related issues. To do this, we reviewed accessible existing healthcare training materials.

Key findings

- Several organisations offer free training to healthcare professionals via guides, eLearning courses, and workshops. In addition, there is a curriculum and a set of competencies. All of these are either produced or commissioned and funded by organisations using donations from the gambling industry.

- Few of the materials were clear about authorship. None of the materials had up-front declarations of potential conflicts of interest, such as gambling industry funding, including where this industry funding had come through another organisation.

- Not all the materials included individuals with lived experience in their development or delivery. However, progress has been made towards good practice, notably with the Royal Society for Public Health and Gambling Health Alliance curriculum, and The Young

Gamers and Gamblers Education Trust training, which include lived experience in development and delivery.

- A destigmatising public health approach starts with healthcare workers understanding that commercial gambling practices and products are harmful and addictive. Unfortunately, some of the resources did not define what gambling is and the numerous different types of gambling or provide information on the topic of commercial gambling, its nature, extent, products, and practices.

- In addition to not addressing the products and practices employed by the gambling industry, issues of public policy and regulation or the social, economic, and environmental factors that impact gambling harm were often missing.

- In some cases, resources developed for other issues, such as gaming or substance misuse, were used without being adequately adapted to gambling. This can result in a misrepresentation of the risks and harms from gambling.

- The way the resources construct the issue of gambling harm can explicitly or implicitly shape or reinforce stigmatising beliefs about gambling harm in healthcare workers. The way this was done in much of the material was highly stigmatising – blaming the person for the harm they experience and removing accountability from the gambling industry and regulators for harmful commercial products and practices. In this way, resources perpetuated gambling industry narratives.

- There was the use of stigmatising language, such as "problem gambler". In much of the material, this term had been replaced by other stigmatising terms, such as 'pathological, hazardous, harmful or disordered'. These make the person and their behaviour the problem. It was the case that, largely, terms were replaced without changing the underlying 'responsible gambling' framework.

- Some of the materials had limited descriptions of the harms caused by gambling, describing harms as linked to individual behaviour, which damaged the person and those around them. Others have incorporated the wide range of harms and that these impact individuals, families, communities and society.

- There has been some progress in moving from 'responsible gambling' and 'problem gamblers' to public health and a spectrum of harm. However, the way this is done is uneven, inconsistent and, at times, misapplies concepts and evidence. In some cases, this involves incorporating elements of a public health and harms approach but retaining a 'responsible gambling' framework. There is confusion in the use of concepts like risk, indicator, protective, vulnerability and harm.

- In some contexts, 'vulnerable groups' was used as an alternate form of saying the issue is one of a few individuals, while most gamble safely, so gambling is safe. The focus becomes on mental illness or other 'vulnerabilities' as the cause of gambling harm, again removing responsibility from the gambling industry and regulation.

- There was inconsistency in what healthcare workers were being trained to do and at what level intervention should occur. Some of the material is based on gambling being an everyday leisure activity. Consequently, if someone is participating in gambling, but not showing evidence of dependency or addiction, no intervention is needed. This is contrary to a public health approach based on prevention and early intervention. It also

does not destigmatise by normalising conversations about the risks and harms of any gambling in a healthcare interaction.

- There has been progress in that some materials recognised the importance of addressing gambling itself, as well as the full range of needs and harms, taking a 'whole-person' approach.

- A confusing range of different screening tools are recommended. Often these are tools designed to identify "problem" or "disordered gamblers" at the clinical level, separate from the rest of the population who gamble "responsibly". These tools perpetuate 'responsible gambling' frameworks. They do not allow healthcare professionals and other frontline workers to achieve prevention and early intervention. Some materials do incorporate tools for assessing harm across the spectrum.

- Resources were inconsistent in the extent they equipped healthcare workers to identify and intervene with people at the severe end of harm, experiencing crisis, self-harm or suicidality, or other risks to self or others. Given the association of gambling harm with suicidality, this is a concern.

- There was a challenge in what additional information or advice the resources signposted to, both for healthcare workers and the people they were supporting. In some cases, such material was also framed by stigmatising 'responsible gambling' narratives. It was not clear how such information and advice had been developed, with what evidence, and if people with lived experience had been involved. Whichever organisation had developed the resource tended to point people to their website, or to other organisations within the industry funded system of gambling harm provision.

- It could be unclear what the difference was between signposting to further help and referral into services. How healthcare professionals should get people access to the most appropriate service for them could be unclear, within the wider lack of clarity on 'treatment pathways' within the NHS.

- There was limited information on how healthcare workers can support affected others who are experiencing gambling-related harm. In some cases, affected others were encouraged to 'take responsibility' for the gambling harm. A key driver of harm, stigma and shame is that the person is made to feel that the person's gambling is their responsibility or fault, and they are left to deal with the consequences.

- There is little in the materials on children and young people, either concerning their own gambling or as 'affected others'. In addition, it seems that young people are largely being addressed separately in 'education' and 'youth work' spaces rather than through health and other workforces.

- In some cases, stigma was explicitly addressed in the materials, but this was typically in the context of self-stigma without acknowledging the individual's wider experiences of stigma and discrimination or the specific drivers of gambling harm stigma and discrimination. No materials directly addressed possible stigmatising attitudes among healthcare professionals.

- Overall, the current situation is an outcome of Government policy for addressing gambling harm through non-statutory organisations with some form of funding from the gambling industry.

Recommendations

System level

For training to be effective, it is important to have high-quality competencies, curricula, and training. But that is only the first step. To see real benefits, this training must be consistently provided to all members of the workforce, their skills evaluated, and they must use what they have learned on the job. The Government has a fundamental role to play in ensuring that healthcare workers receive consistent and comprehensive training on gambling harm and this is implemented effectively in what professionals do. This includes:

- Develop and implement quality standards for curricula competencies and training materials on gambling harm.
- Develop mechanisms for rolling out training on gambling harm across healthcare workers in various settings. For example, including education on gambling harm as a part of healthcare curricula for frontline workers, including physicians, nurses, and other healthcare professionals. Further, encouraging ongoing professional development and continuing education opportunities on gambling harm.
- Build requirements and incentives to address gambling harm into ICSs and into healthcare workers' routine interactions with people.
- Provide evidence-based guidance on the nature and extent of gambling harm and how this should be addressed by healthcare workers in generalist settings to form the basis of training. This should include progressing the evidence-base, including through collecting and analysing data on the prevalence and impact of gambling harm.
- Stigmatising attitudes among healthcare workers should be researched.
- There needs to be a coherent system for training evaluation, quality assurance and accreditation and monitoring of interventions. Evaluations should include the extent to which the training programme effectively changed existing stigmatising attitudes amongst the healthcare workers.
- Make sure conversations on gambling harm in healthcare interactions are supported through government-led public awareness campaigns on the risks and harms of gambling and concrete messages on lower risk gambling limits.
- There need to be high quality services and information, and NHS treatment pathways, for generalist healthcare workers to signpost and refer people to.
- Government should establish a cross-government approach to address gambling harm, involving multiple departments and agencies to ensure a coordinated and comprehensive response.

Training materials must be designed for a public health approach to gambling harm and to tackle stigma and discrimination

Key recommendations for incorporating public health and stigma reduction strategies into healthcare training material include:

- Incorporate education strategies that present accurate information to counteract stereotypes and correct misunderstandings about gambling harm.

- Implement contact interventions to facilitate contact with individuals who have experienced gambling harm to reduce stigmatising attitudes and behaviours.
- Use advocacy strategies to formally object to negative representations of gambling harm in society.
- Improve the health workers' understanding of the harms caused by the gambling industry's products and practices.
- The training materials must provide clear definitions and examples of different types of gambling activities and gambling modes, as well as factors that influence risk attributable to each of these.
- Healthcare workers need to know that gambling harm can impact anyone and harm occurs across a spectrum.
- Healthcare workers need to understand gambling harms and their role in addressing them. Training should include the range of harms, that these are enduring, even life-long, and intergenerational. They impact the person, those close to them, communities and society and contribute to health inequalities. This causes socio-economic costs, including to health and social care.
- Not portray gambling as a controllable behaviour, or solely focusing on individual behaviour.
- Enable prevention and early intervention through normalising conversations about any gambling participation in healthcare interactions.

Training should address the needs of different groups

- Material needs to address affected others 'in their own right' and not only in terms of the relationship harm experienced by the person who gambles or as a support to them.
- Material for affected others must avoid making them 'take responsibility' for the gambling harm and provide adequate information or signposting to support them.
- Targeted interventions and information tailored to the specific dynamics of gambling harm, stigma and discrimination for specific groups should be available. Additionally, this needs to go beyond generic acknowledgement that their experiences differ due to socio-economic position, gender, ethnicity, culture and social group.
- Recognising that some people and groups may have heightened vulnerability to gambling harm should not be used to divert attention from gambling products and practices as harmful and addictive.
- Materials must equip healthcare workers to identify and intervene with people at the severe end of harm, experiencing crisis, self-harm or suicidality, or other risks to self or others.
- Training needs to equip healthcare workers to specifically address gambling harm for CYP as their needs differ from an adult population.
- Healthcare professionals need to be provided with information to recognise health problems that commonly co-exist with gambling difficulties and provide information on different services available to respond to these problems.

Training must incorporate lived experience

- Training programmes should be co-designed and co-produced with people with lived experience of gambling harm.
- As far as possible, the lived experience included should be relevant to the target group.

- People with lived experience of gambling harm should provide their expertise on the language used within training.
- People with lived experience of gambling harm should be involved in the co-delivery of training materials. Where this is not feasible, first-person narratives of people with lived experience should be included in the training.
- Healthcare workers and other frontline staff should be involved in the development of the training material to make sure it is acceptable and feasible for their role.

Training materials should comply with basic quality requirements

- Resources should be clear on what basis they have selected and used evidence.
- Materials should include clear, up-front declarations of conflicts of interest, including gambling industry funding – and where this industry funding has come through another organisation.
- The specific individuals who wrote the resources should be named, in addition to the organisation that produced the material.
- Where stakeholders have been involved, it should be clear what this entailed and whether these other organisations endorse the resource.
- The strategies and methods used to address other issues, such as substance use, should not be copied blindly. It is important to take into account the unique aspects of gambling harm to avoid inaccurate or harmful solutions.
- Materials, including eLearning resources, must be designed with the ability to be updated post-release, ensuring that the content is in line with current evidence and resources.
- Training materials must be evaluated, and the results made publicly available.

About the project

Purpose

> *Gambling addiction and the problems it causes individuals, their families and their communities has sat at the fringes of primary care health services. This is despite general practice offering over three hundred million appointments a year in England. Primary care continues to represent an untapped resource for problem gamblers.*
>
> *General practice NHS services represent a universal life-long gateway to physical, mental and social care. There is a pressing need to improve the knowledge, skills and competence of all primary care staff in addressing issues related to gambling disorder. Most problem gamblers go unrecognised and the health needs arising from their gambling go unaddressed. (A Gambling Competency Framework for Primary Care, P3-5)*

This extract gives a clear statement of why it matters that primary care is equipped to address gambling harm. But it also demonstrates issues with the situation as it is now. It uses stigmatising terms and blames people for the harm they experience due to the products and practices of the gambling industry.

This is indicative of the wider situation of structural stigma and discrimination in relation to gambling harm. Training of healthcare workers, in primary care, community care, public health or other settings, has been left by Government to be led by small organisations funded by the gambling industry directly or indirectly, outside of statutory services. Even where the Royal College of General Practitioners (RCGP) and the Royal College of Public Health (RCPH) have started to develop training, this has come about through commissioning and funding by such bodies. This is an instance of gambling harm not being afforded parity of esteem.

The purpose of this report is to:

- **Review the extent to which available training resources for healthcare workers enable a destigmatising public health approach to gambling harm.**
- **Inform the further development and improvement of healthcare worker training on gambling harm.**

The aim is not to point at or criticise any organisation. More than anything, this report highlights the inadequate response of the government to address the growing problem of gambling harm, leaving these organisations to pick up the slack. However, the absence of clear guidance and leadership from the government has resulted in a fragmented, inconsistent and sometimes ill-founded approach, undermining the effectiveness of their efforts and potentially causing more harm than good.

It is imperative that the government take a proactive and responsible role in addressing gambling harm by providing clear and comprehensive guidance, resources, and support to both frontline workers and organisations working to help those in need. By doing so, we can ensure that everyone affected by gambling harm receives the quality care and support they deserve.

While commissioned by GMCA and GWL, this is done so on the understanding that the project is undertaken independently by Tackling Gambling Stigma and for the benefit of the sector as a whole. We have been asked to do this because of our research with people with lived experience of gambling harm stigma and discrimination, and this is the perspective we take in our review.

Rationale

This section explains why training for healthcare workers is important to address gambling harm. It sets out why this is fundamental to a public health approach. It shows the links between gambling harm as a public health issue and gambling harm stigma and discrimination, and why these need to be tackled together. It gives evidence on problems with the current capabilities of healthcare workers in generalist settings in relation to gambling harm.

Learnings

- Healthcare workers across settings provide a key opportunity for conversations about the risks and harms of gambling, and identifying and offering support to people affected by gambling harm. The fact that they are not equipped with the capability to do this is an instance of stigma and discrimination towards those harmed by gambling.
- People harmed by gambling are stigmatised and discriminated against. A main driver of this is the perpetuation of gambling industry narratives that maintain gambling is a fun everyday activity and blame harm on a few 'irresponsible' individuals.
- A public health approach involves acknowledging gambling harm is caused by harmful and addictive products and practices, which can affect anyone who participates in gambling. In this way, it challenges industry narratives and contributes to addressing stigma and discrimination.
- But for a public health approach to succeed it also must deliberately address the drivers of gambling harm stigma and discrimination. People's experiences of stigma and stigmatising attitudes among healthcare professionals affect their health and the care they receive.
- Research has shown a lack of guidance and training amongst healthcare professionals that limits their awareness, understanding and capability to address gambling harm.

Why healthcare workers in generalist settings need to address gambling harm

Healthcare professionals "advise on or apply preventive and curative measures and promote health with the ultimate goal of meeting the health needs and expectations of individuals and populations and improving population health outcomes."[2] This definition is important, as it recognises not only treating ill-health, but also preventing it, and contributing to the overall health of the population. Healthcare workers may be found in health promotion, primary care, social care and community services, or outside of health settings, such as in criminal justice, welfare and benefits. Consequently, they encounter a wide range of individuals.

The NHS Long Term Plan has prevention of ill-health at the centre, by supporting people to adopt improved healthy behaviours. This will help people to live longer, healthier lives, and reduce the demand for and delays in treatment and care. It should also contribute to closing the gap in inequality of health outcomes for individuals and communities in deprived areas.[3]

Prevention will be achieved by Integrated Care Systems (ICSs), partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas.[4]

It will also be achieved by maximising the opportunities for contact with patients to help people to improve their health.[5] The Making Every Contact Count (MECC) approach encourages health and social care staff to use the opportunities arising during their routine interactions with patients to have conversations about how they might make positive improvements to their health or wellbeing.[6]

> *MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations…A MECC interaction takes a matter of minutes and is not intended to add to the busy workloads of health, care and the wider workforce staff, rather it is structured to fit into and complement existing professional clinical, care and social engagement approaches. Evidence suggests that the broad adoption of the MECC approach by people and organisations across health and care could potentially have a significant impact on the health of our population.*[7]

MECC includes alcohol, smoking, physical activity, health improvement and mental health and wellbeing.

In addition, healthcare workers have an important opportunity for early intervention in health problems and enabling access to treatment. This includes screening, providing interventions or other types of support, or referring the individual to specialist services.[8]

Healthcare workers across a range of settings may be in contact with people at risk of or experiencing harm caused by gambling, which includes harms to mental and physical health, relationships and social connectedness, finances and work and criminal justice. For example, a survey of 1058 patients attending general practices in Bristol, England, found that 0.9% exhibited "problem gambling", and 4.3% were categorised as "low to moderate-risk gamblers" (measured using the Problem Gambling Severity Index, PGSI). In addition, 7% of patients reported gambling problems among family members.[9]

A recent review of screening for risk of gambling-related harm in health, care and support settings noted that the use of screening and brief intervention in these settings for gambling is less well-developed than in other domains (such as alcohol and drugs). Nevertheless, there is increasing evidence that screening and brief intervention for people at risk of gambling harm is feasible in a range of settings and is already being delivered on a small scale. [10]

The government's evidence reviews of gambling harms in England concluded:

> The evidence suggests that harmful gambling should be considered a public health issue because it is associated with harms to individuals, their families, close associates and wider society with an approach that focuses on prevention, early intervention and treatment.[11]

The reviews also show that gambling harms contribute to health inequalities. Consequently, it would seem that gambling harms should be included within the remit of ICSs to foster population health and wellbeing, as part of MECC, early intervention and treatment access.

Healthcare worker training and the link to stigma and discrimination

Addressing gambling as a public health issue, with prevention, early intervention and treatment, has important and fundamental links to gambling harm stigma and discrimination.

Stigma refers to negative attitudes, stereotyping and prejudice that discredit and devalue groups of people. Stigma is structural and embedded in societal-level conditions, cultural norms, and institutional policies and practices. Discrimination is the actions that follow from stigma and are justified by stigma. Discrimination can be direct, such as treating someone in the stigmatised group unfairly. It can also be indirect, such as practices, policies, or rules that disadvantage stigmatised groups – either intentionally restricting their opportunities or unintentionally producing negative consequences for them. People, such as family or friends, can be stigmatised and discriminated against because of their association with someone in the stigmatised group. Through self-stigma people come to believe and internalise negative stereotypes and prejudice held by the public and systems to themselves. Discrimination feeds into stigma, as the actions of government and institutions demonstrate to society how a group of people should be treated. Stigma and discrimination are harms to people in themselves and exacerbate other harms.[12,13]

People harmed by gambling experience stigma and discrimination.[14,15,25,16] This is driven by gambling industry accounts, which have also been perpetuated through policy, services, and research. This blames the harm caused by the products and practices of commercial gambling on a few flawed individuals who gamble 'irresponsibly'. It normalises gambling as a harmless, everyday leisure activity for all. That individuals cause their own gambling harm obscures the role of harmful commercial gambling products and practices. As they are blamed for the harm to those around them and society, they are also seen as a source of danger and disorder.

People with lived experience of gambling harm[17] and gambling stigma research[18] have shown that responsibility discourses play a significant role in the stigmatising of people harmed by gambling. Research has shown that where mental health and addiction are an issue of personal responsibility, this significantly contributes to the stigma and discrimination people experience.[19,20] In the context of healthcare, this may have the added dimension of making professionals feel that people harmed by gambling are not as deserving of help as their 'problems' are 'self-inflicted' – as has been the case with suicidal behaviour or self-harm and people experiencing other dependencies.[21,22]

> ***There's not really much out there really. Obviously at the time, or at the time I didn't think there was any help at all about it until, obviously, it got to [organisation]. Obviously, the GPs and counsellors they've not really helped a lot. They don't know anything about what you're going through, the gambling side. They've not been through it themselves.***

This stigmatising of those harmed by gambling has justified discrimination. It means the focus is getting a minority of 'problem gamblers' to control their behaviour. Rather than regulating the gambling industry products and practices which cause harm, or public awareness of the risk and harms that come with any gambling participation. Consequently, gambling harm has not been addressed as a public health issue and within the statutory health and social care system – which is discriminatory.

> ***If you was to go to your GP and disclose, I've got a mental health condition, I'm not stable, I'm feeling bit suicidal, and relayed that, would they discuss gambling as an option? No, they would probably talk about other addictions because it does come up, you know, are you feeling this way because you've had alcohol, because you've had drugs, etc? Nobody ever proactively will ask the question, "is this gambling related?" And I think that now needs to come to the forefront and be out. Whether the person, it's down to the individual as to whether or not they are going to come out and say, yes, it is. But you know, when you're in a situation where you're almost you're too scared to say something, and you don't want to say something because of everything that's attached to an addict in many respects. Someone like a GP, someone who is not close to the family, that is a different person, that's impartial was to say, do you have a problem with gambling? And will that encourage more people to come out and say yes and speak? I would think so... It needs to just be a cornerstone question there.***

A public health approach is based on acknowledging that commercial gambling products and practices cause addiction and harm and, consequently, that anyone who gambles is at risk of being harmed or developing an addiction. It acknowledges that harm from gambling can occur at any level of gambling participation. Harm is not restricted to a 'pathological few' who 'misuse' gambling. This means that taking a public health approach, including prevention, early intervention and treatment, will contribute to addressing stigma and discrimination. It can do this by normalising awareness and conversations that gambling is risky and harmful and giving parity of esteem to addressing gambling harm.

At the same time, for such a public health approach to succeed, it needs to address the drivers and consequences of gambling harm stigma and discrimination deliberately and explicitly. People's experiences of gambling harm stigma and discrimination damage health and are barriers to people obtaining support. And this is also the case for the stigma and discrimination built into services and which can inform the practice of healthcare workers. Stigmatising attitudes in healthcare, directly or indirectly, may affect healthcare service users and, as a result, the quality of care they receive.

Individuals affected by gambling harm must receive high-quality and evidence-based care that healthcare professionals and the health service have a duty to provide. Healthcare professionals must be empowered with knowledge and skills to have conversations with people about gambling, support individuals experiencing harm and direct them to specialist treatment services that can support their needs. However, the support and quality of care that people receive will be influenced by the training that healthcare workers are provided. Research has shown that for such healthcare interactions to be implemented effectively, key facilitators must be present. These include adequate resources, training, and managerial support, and it requires practitioners to have sufficient confidence and knowledge to engage people without stereotyping them. It is vital to invest in and implement training that does not create or change stigmatising attitudes among healthcare professionals towards those harmed by gambling. Training needs to enable healthcare workers to deliver interventions in a way that is understanding of and addresses the specific dynamics of gambling harm, and stigma and discrimination that people experience.

> ***And to the emergency department, I say to my doctor, it's like that, I am facing this type of problem. So, they totally ignore me. Why you are here. It is for emergency. You cannot come here. I'm pressing problem. I cannot sleep. I cannot eat. A lot of things in my head. So, they just don't give me any treatment, they just print one paper. There are some addresses there like, GA meeting, GamCare number. So it's not enough. Like they hate, it's like that. They hate me or they hate this type of people.***

The situation now

A survey of General Practitioners (GPs) in Solihull, England, reported that many had not received training in how to identify and treat gambling disorder, and 91% of them expressed a lack of confidence in how to manage these patients, but they wanted to do more to help and receive training.[23]

An online survey of 150 GPs in England representative of licensed doctors was undertaken as part of Primary Care Gambling Service pilot evaluation. More GPs agreed than disagreed that it was their responsibility to discuss gambling harms with patients, though only just over half (55%) agreed. Four in ten (40%) felt that helping patients with gambling harms was a priority, though a similar proportion (36%) felt that it was a low priority given other priorities and pressures on primary care staff time and capacity. There was generally low confidence amongst GPs about their ability to support gambling problems. Four in ten GPs (40%) felt able to recognise the signs of gambling harms among patients, though slightly fewer (36%) were confident about initiating conversations about gambling harms with patients and even fewer (26%) agreed that they knew what questions to ask patients within these discussions. A quarter of GPs surveyed (25%) reported they were aware of gambling harm treatment and prevention services in their area, and only one in ten (10%) agreed they had sufficient information about services in their area.[24]

A qualitative study exploring the views of professionals working within health, care and other agencies about harmful gambling among adults with health and social care needs reported a lack of awareness of gambling-related harm and a lack of a clear pathway or guidance to follow when supporting affected individuals. Participants expressed a need for professional development activities to improve their knowledge and expertise in this area.[25]

Where healthcare workers receive training in gambling harms they report a higher knowledge about gambling in the context of mental ill health, more confidence in detecting and screening for gambling issues, and more positive attitudes about responding to gambling harms.[26]

The recent landmark coroner's verdict into the suicide of a 24-year-old man[27], who had been affected by gambling disorder, noted that "whilst there have been improvements made in the areas of warnings, information, training and treatment, the evidence showed there were still significant gaps in these areas. One notable gap was the fact that evidence suggested GPs currently have insufficient training and knowledge to deal effectively with gambling problems. This was of particular concern given that many gamblers affected are likely to contact a GP as their first attempt to seek help."

> ***I actually spoke to my GP… but I thought he was a waste of space to be honest because at no point did he say, "Yes, I'd like to speak to you." He just said, "I'll send you a few links regarding counselling which I found poor, to be honest. Because I do feel as though when you're speaking to someone face to face, you can get your point across and explain stuff and it was just the case of probably. "I don't want to see you. I can just send you links," and the links were just about counselling.***

Tackling Gambling Stigma has heard about people's experiences accessing help or support for gambling through their GP and other organisations. Often, they described their GP as having little knowledge or awareness of gambling harms, and they were the ones who had to start the conversation. Some described feeling interrogated, judged, or simply ignored when accessing support for their gambling. They did not feel understood or valued and felt the support they received was inadequate. This left some people paying for private treatment. Because of shame and stigma, many struggle to ask for or get help for gambling difficulties. They frequently report that their interactions with healthcare professionals show a lack of understanding and can add to stigma and shame. At the same time, people talk about what a difference a destigmatising and supportive response can make.

A recent review[28] found that stigmatising attitudes among healthcare professionals are understudied compared to public stigma (the negative or discriminatory attitudes that others have about individuals experiencing difficulties with gambling), and little is known about the stigma of gambling, specifically among healthcare providers and individuals in other support roles.

> ***I think if you go to your GP and talk about gambling addiction, that's another part where we'll probably go, they'll just put it in Google, and send you to GA [Gamblers Anonymous]. I do think that maybe GP surgeries and GP doctors maybe need to know a bit more about gambling addiction and where to signpost people.***

The NHS Long Term Plan[29] pledged to open 15 gambling clinics by 2023/24. However, the is currently no nationally recognised treatment pathway for gambling-related harm in the UK. This is no system-wide programme for training and supporting implementation of gambling harm interventions in primary care or in the healthcare workforce in generalist settings.

Approach

This section explains the approach we took to the review of existing healthcare worker training materials. It explains the framework we used to assess the training materials, ethics, search and selection criteria, the resources we reviewed and how we undertook the analysis.

Framework

The framework used to assess the materials was informed by the following:

1. Conceptions of stigma and discrimination and the design of interventions to address it from the Lancet Commission on Ending Stigma and Discrimination in Mental Health[30] and The Health Stigma and Discrimination Framework.[31]

    - Fundamental to both frameworks is that stigma and discrimination are not simply a matter of behaviour between individuals and a dichotomy between stigmatiser-stigmatised. Instead, the focus is on the larger contextual and structural factors that drive stigma and discrimination and impact individual behaviour.

    - In addition, understanding the specific drivers and outcomes of stigma and discrimination in a specific context or for a condition enables the design of effective interventions because the intervention can address these dynamics. In the context of mental health, this includes people being blamed for their 'condition' and being seen as a source of danger and disorder.

2. Evidence regarding the dynamics of gambling harm stigma and discrimination specifically.[32] This shows that in this context, industry 'responsible gambling' and 'problem gambler' accounts are fundamental drivers of stigma and discrimination.

3. That the inclusion of people with lived experience is right in principle because we agree with the view of nothing about us without us. Further, the extensive evidence that inclusion of and co-production with people with lived experience is fundamental to effective practice and to addressing stigma and discrimination[33].

4. Evidence on approaches to reducing stigma and discrimination and what is most effective.

    - Typically, interventions to reduce stigma fall into three categories: contact (meeting people affected by gambling harm), education (learning the facts about gambling), or advocacy (speaking out against negative views of gambling). In general, a combination of all three is needed.

    - However, fundamental is the inclusion of opportunities for healthcare professionals to engage with or see first-person accounts of individuals affected by gambling harm either directly (e.g., in-person) or indirectly (e.g., via media). Social contact interventions are supported by decades of evidence as the most effective strategy to change stigmatising

attitudes towards people experiencing addiction and mental illness, because they increase understanding and empathy.[34,35,30] Anti-stigma interventions that use social contact (such as filmed or live recovery testimonials) with education components have been associated with improved outcomes for knowledge and attitudes in healthcare staff than educational interventions alone.[14,36]

5. Good practice in addressing stigma in healthcare contexts.[41]

    - Training should explicitly address possible stereotypes and prejudices of healthcare professionals in addition to providing knowledge. For example, healthcare professionals are influenced by prejudices and stereotypes in the social environment in which they live. There may be specific stigma around particular groups of patients.

    - Training should enable healthcare workers to take account of a person's background and social context and the contribution this makes to shame and stigma.

    - Interactions should support self-esteem, self-efficacy, social inclusion, and a sense of personal value to counter shame and stigma.

6. Good practice in a preventative, public health approach in healthcare interactions, from the MECC quality marker checklist for training resources.[37] This includes:

    - The training demonstrates the impact that MECC can have at an individual and population level. The training enables learners to understand how MECC fits into their role and the core business of the organisation they work for.

    - The training is consistent with the latest evidence-based guidance on being healthy.

    - There is an evaluation process in place for assessing the effectiveness of the training programme.

Consequently, the review looks at the training material in five main areas:

1. The general quality of the materials:

    - In terms of transparency of authorship and funding, use of evidence and resources and evaluation.

    - The inclusion of lived experience in the production of resources and for social contact within the resources.

2. How training may implicitly contribute to destigmatising or stigmatising those experiencing gambling harm through the way it constructs the problem of gambling harm, its causes and consequences and the language it uses.

3. The extent to which the intervention it is training the health professional to undertake is in line with a public health approach and combating stigma and discrimination.

4. Addresses the needs of different groups and their experiences of gambling harm, stigma and discrimination.

5. The way the training explicitly or overtly addressed the specific drivers and consequences of gambling harm stigma, for both healthcare workers and peoples harmed by gambling.

Ethics

Several of the training packages are proprietary and provide value for the providers. Therefore, non-disclosure agreements were put in place to respect intellectual property. This specified that the training material would only be accessed by the Tackling Gambling Stigma researchers for the purpose of the research report, and extracts would be included in the report only for the purpose of illustrating themes in the research.

The approach and framework will be shared with the providers for the review to be of use to the sector in general. Additionally, the report will also be made publicly available.

Search procedure and inclusion criteria

For this review, we have defined "gambling training materials/resources" as a policy document or training material focused on describing or developing knowledge, attitudes, skills, or behaviours that a health professional should possess related to gambling difficulties in a generalist, public health, or primary care setting (rather than specialist gambling or secondary services). In addition, these resources can also include information on how such professionals should be supported to address gambling in generalist organisations, or how generalist healthcare should be organised to address gambling difficulties.

We defined health professionals as any individual that plays a part in improving access and quality healthcare for individuals and populations. They "advise on or apply preventive and curative measures and promote health with the ultimate goal of meeting the health needs and expectations of individuals and populations and improving population health outcomes".[38]

The following criteria had to be met for the material to be included:

- Be for a British audience, reflected by having been explicitly endorsed/produced by any British organisation.
- Have a clear intended audience.

Training materials which include healthcare professionals as an intended audience, were collected and collated between October and November 2022. The National Institute of Clinical Excellence (NICE) guideline stakeholder list[39] - is being used to develop a new clinical guideline on gambling: identification, diagnosis and management, and additional internet searches were conducted to identify relevant material. Organisations were contacted for copies of training materials where these are not publicly available. Appendix 1 outlines the resources that have been identified as meeting the scope of this review.

The resources reviewed

Eight resources were identified (Appendix 1). Five organisations produced these: GambleAware, The Young Gamers and Gamblers Education Trust (YGAM), GamCare, Royal Society for Public Health (RSPH) and The Primary Care Gambling Service (PCGS), within the Hurley Group Practice. All were funded with money from the gambling industry, either through GambleAware, or directly. GambleAware raises money from the gambling industry to deliver and commission research, prevention, and treatment, in the current system of voluntary contributions from the industry to address gambling harm.

Three training resources:

- GambleAware – Brief intervention guide: Addressing risk and harm related to gambling

(**brief intervention guide**)
- RSPH and GambleAware - Understanding and responding to gambling harms: A brief guide for professionals (**eLearning tool**)
- YGAM Mindful Resilience: A Practitioner's Guide (for professionals to support children and young people) (**mindful resilience programme**)

The first two are publicly available. YGAM's resource is not publicly available but is provided free of charge, and access was given to the research team. GamCare was also positive about providing materials for analysis. However, to enable this report to be used for current training development, the decision was taken to complete the report without including GamCare's material, as this would have caused delays in the timeline.

One competency framework: PCGS - A Gambling Competency Framework for Primary Care: Improving the Awareness and Responsiveness of Primary Care to Gambling Harms (**primary care competency framework**). Following from the framework will be a curriculum and training programme to equip primary care teams – currently being developed by the Royal College of General Practitioners and funded by GambleAware.

One curriculum: RSPH - Level 2 Award in Tackling Gambling-Related Harms. The RSPH holds the curriculum and registers centres to deliver training for the **level 2 award curriculum**. The centres develop their own material against the curriculum and qualification requirements. It consists of 6 hours of training (including an assessment at the end). The RSPH provides the final examination and training certificate. Only the RSPH curriculum, "examples of the examination," and the answers are publicly available and reviewed here, not the course material developed by the individual training centres.

The RSPH website indicates that the training is currently offered by six centres: Derbyshire County Council (Adult Social Care & Health), EDAS, Addiction Recovery Agency (ARA), Beacon Counselling Trust (BCT), and the RCA Trust. ARA, BCT and the RCA Trust are part of the National Gambling Treatment Service, at that time contracted by GamCare and funded by GambleAware.[40] EDAS is a charity providing support to those with addiction issues – specifically substance misuse – and/or experiencing mental distress and affected others.[41]

Access to training material was requested from all the accredited centres. ACA and BCT declined. Derbyshire County Council indicated a willingness to participate, but their material has not been included due to the timelines. The remainder did not respond.

Data Analysis

All resources that met the inclusion criteria were imported into NVivo. Text-based resources were included as PDFs, while video and multimedia resources were transcribed and annotated with descriptions and screenshots of on-screen imagery where permission to do so was given.

The coding frame evolved iteratively: an initial reading of the resources, informed by a review of relevant literature, was used to develop a formative codebook covering the areas of the framework below. Two coders subsequently coded and re-coded the resources before deciding on the codebook. NVivo was used to store, manage and code the collected data. In addition, NVivo was used to record key descriptive information about each resource.

Descriptive information

- The name of resource
- The name of the organisation / funding body /author?
- Did it consult other organisations/individuals? Who were they and what was their role? (e.g., Royal Colleges)
- Did it include lived experience in the development? How was this done?
- Is the resource publicly available or proprietary?
- The region on which it focused (if any)
- The date the material was released and the last updated
- The modes of content delivery it employed – e.g., document, article, webinar, e-learning course, training sessions. Within the delivery what formats are used? E.g., checklists, tip sheets, videos, tests, images etc.
- Length of training (if applicable, e.g., workshop duration)
- The specific targets audiences it identified (e.g., type of healthcare professional)
- Type of individual training it intended to help / experience of gambling harm, demographic group – is there training to support affected others?
- Award given? Meaning of award/certification? (Accreditation and by whom)
- What is the focus and/or purpose of the document? What are the intended outcomes?
- Where does the evidence come from / use of references / date of evidence?
- Use and type of external screening tools/documents?
- What support pages/external support services do they reference?
- Has the resource /training been evaluated? What kind of evaluation? Is this evaluation publicly available?

Coding

To identify themes across the existing healthcare training materials, the following was coded for:

- How are the problem, gambling, and gambling harm described/defined?
- What terms are used, and what do they mean? E.g., gambling, gambling harms, harmful gambling, safer gambling, problem gambling, problematic gambling, pathological gambling, gambling disorder, risk, etc.
- How is the cause of gambling harm described/defined?
- How are the consequences of gambling harm described/defined?
- How is the solution to gambling harm described/defined?
- What roles are given to the person affected by gambling, affected others and the healthcare professional?
- How is the wider social, commercial, and regulatory context addressed?
- How does the training address issues of gambling harm stigma and discrimination?
- How does the training address preconceptions, prejudice and stereotypes of gambling harm that healthcare professionals may hold?
- How does the training enable an interaction that addresses stigma and shame experienced by people affected by gambling? E.g., acknowledging their wider context and experiences of stigma and discrimination; how gambling harm stigma interacts with class, gender, age, ethnicity; enabling self-esteem and self-efficacy, etc.
- How does the material make us of imagery and visual features? What types of images are used? (e.g., logos, images of patients/individuals, videos, etc). If people are depicted, who are they (representations; class, gender, and race/ethnicity)? How are people affected by gambling difficulties depicted?

- What are highlighted as key learnings through quizzes or other learning aides?
- How does the document make use of claims to authority? Does the material refer to scientific authority, clinical/medical authority, professional guidelines, and/or lived experience?
- What or who is missing in the document and/or are there any gaps in the document?

Results

Good practice for resources

This section describes the resources in terms of good practice for producing and publishing documents and resources. This includes:

- The extent to which they are transparent about authorship, funding and potential conflicts of interest
- How they set out who they are for and their objectives
- Use of evidence and links to further resources
- How they are made available for use
- Inclusion of lived experience

Learning

Resources need to be transparent about authorship and conflicts of interests.

- They should include clear, up-front declarations of conflicts of interest, including gambling industry funding – and including where this industry funding has come through another organisation.
- Preferably, the specific individuals who wrote the resources should be named, in addition to the organisation who produced the material.
- Where stakeholders have been involved it should be clear what this entailed and whether these other organisations endorse the resource.

Resources should be clear on what basis they have selected and used evidence.

- The gambling harm evidence base has limitations and is rapidly evolving. However, there is a need for a single, systematic, authoritative account of the evidence for the purpose of healthcare worker training, along with a system for keeping this up to date. Otherwise, there will be the perpetuation of varied understandings and misinformation across health care professionals.

Resources should be specific to gambling.

- There may be content and approaches that can be of use from other issues, that can be applied to gambling, especially where other fields are more advanced – such as substance misuse. However, these should not simply be duplicated, in ways that do not consider the specific dynamics of gambling harm, which may be inaccurate to harmful.

Lived experience should be included in the development of resources and in the delivery of training.

- This is a matter of principle, for the quality of the resources and so that they are destigmatising. How lived experience shaped the resources should be explained and, so far as possible, the lived experience included should be relevant to the target group.

There needs to be a coherent system for training evaluation and quality assurance; delivery and accreditation; and incentivising and monitoring implementation in healthcare practice. This needs to connect into local and national statutory systems.

- Competencies, curricula, and training need to be of quality, but then are only of benefit if training is consistently provided, across the workforce, skills assessed and applied.

Transparency and evidence

This section gives an overview of the resources, their target and aims, to what extent they are transparent about authorship and funding, and to what extent evidence was used in the development and body of the resource.

Brief intervention guide (GambleAware)

Author and format

The GambleAware brief intervention guide is a 37-page document publicly available on www.begambleaware.org, featured under resources for health and social care.[42] No authors' names are listed, but it does acknowledge members of an advisory group. There is no statement on conflicts of interest or industry funding.

Date

GambleAware published the brief intervention guide in 2017.

Target

It is aimed at professionals who do not specialise in the treatment of 'gambling problems', including those working in social and criminal justice settings, for example, social workers, employment advisers, probation officers, community workers, counsellors, general practitioners (GPs), nurses and psychologists. However, the guide states that it is also likely useful for others working in primary care and other health settings.

Objectives

The guide is a resource to assist workers in providing a brief intervention to address risks and harms related to 'problematic' gambling. It also has a section to assist organisational leaders in setting up and implementing the processes needed to support workers in providing a brief intervention.

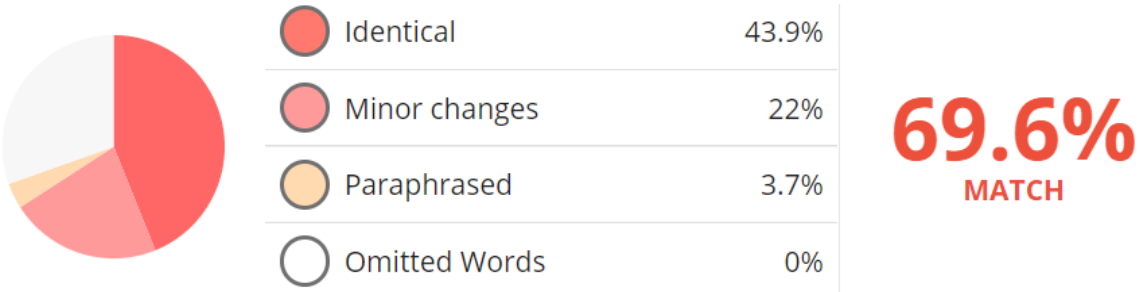
Inclusion of lived experience

The **brief intervention guide (GambleAware)** does not mention drawing on lived experience to develop the training – or use any experiences from people with lived experience during the training (e.g., video clips, quotes, case studies).

Use of evidence and resources

The guide is heavily based on a New Zealand addiction workforce development programme produced by Matua Raki, the 'Brief intervention guide: Addressing risk and harm related to

alcohol, tobacco, other drugs and gambling' – which was used "as the basis for developing the document" (P.1) The intervention guide by Matua Raki was published in 2012. No reasons are given for why GambleAware has selected this as the basis for its guide. However, it is important to highlight that the two are very similar in their content.[43]



The main differences between the GambleAware and the original guide are:

- Use of gambling-specific support services (e.g., directing to begambleaware.org and the National Gambling Helpline)
- The inclusion of British gambling statistics
- Removal of drug and alcohol statistics
- Removal of original support resources (New Zealand focused) and added new ones (although this has not been done throughout)
- Removal of the sections from the original report on 'working with Màori' and 'working with Pasifika'
- In the examples in the 'provide feedback and brief advice section' (P.17) and the 'listen for readiness and confidence' section (P.19), some words have been changed to include gambling rather than alcohol or drugs
- Additional gambling references added
- The specific gambling screening tools and resources that are included
- Organisations that provide help and advice added in for the UK context

The original brief intervention guide was created for drugs, alcohol, and tobacco, and as such, some examples, language, links, and terminology have not been suitably adapted or made specifically for gambling.

The GambleAware brief intervention guide has not been updated since 2017. This is not necessarily an issue; however, the evidence is dated, with research on the effectiveness of brief interventions for gambling from 2015 or before (P.5). It is not clear why the handful of references for gambling harms was selected. For example, the references for "gambling can be related to poor health" are from 2005 and 2006 (P.5).

Some links no longer work, and information on organisations providing support and on self-exclusion are out of date.

- In the self-exclusion section (P.35), it says, "if you are worried about online gambling, then you can download a 'site blocker' such as Gamblock or Netnanny, which can block access to online gambling sites. However, there may be a charge for this" and has not been updated to include GamStop (a free online self-exclusion tool that blocks mobile and website access to gambling companies in Great Britain for a selected period of time), GamBan (a blocking software that blocks individuals from accessing gambling websites and apps) or TalkBanStop (an organisation that combines support via GamCare, GamBan and GamStop)[44] or bank blocks on payments to gambling companies. In

addition, the link to self-exclusion information on the Gambling Commission website provided does not work. Both this guide and the **eLearning tool (RSPH and GambleAware)** recommend the software blocking tool "betfilter"; however, consumers have raised potential concerns over their compliance with UK regulations. [45]

- In the brief intervention section, it says "Use the readiness scale/ruler to quickly elicit change talk. Available at www.adultmeducation.com/downloads/Readiness-to-Change_TOOL.pdf" but the link does not work (P.20).
- The guide states one of the minimum preparation requirements for the worker includes "having the resources needed to support brief intervention…The GambleAware website has helpful information and a range of self-help material, including printable leaflets targeted at identifying a problem, preparing to change, gambling triggers, warning signs etc. More substantial self-help booklets are also available" (P.8) – but it is not clear where these self-help materials and printable leaflets are/they are difficult to find.

eLearning tool (RSPH and GambleAware)

Author and format

Royal Society for Public Health (RSPH) collaborated with GambleAware to turn the brief intervention guide into a free eLearning tool (RSPH and GambleAware). This is publicly available on the RSPH website[46] and takes around two hours to complete. No authors' names are provided. There is no statement on conflicts of interest or industry funding.

Date

The tool was released in 2018. The tool was updated in 2021 to include an introductory topic addressing what gambling disorder and severe gambling disorder are and what signs may indicate that someone is experiencing difficulties with gambling.[47]

Target

The tool is aimed at professionals who do not specialise in treating "gambling disorder", but who work with potentially vulnerable groups. It says it is particularly useful to those working in social and criminal justice settings, including, but not limited to, social workers, employment advisers, GPs, psychologists, and probation officers.

Objectives

The course aims to help people understand and identify risks and harms related to 'gambling disorders' and equip them to provide brief interventions to help address these harms. Additionally, it is a resource to assist organisational leaders in planning for the integration of brief interventions for gambling harms into their services.

Inclusion of lived experience

The eLearning tool does not mention drawing on lived experience to develop the training – or use any experiences from people with lived experience during the training (e.g., video clips, quotes, case studies).

Use of evidence and resources

RSPH states it is designed to complement the MECC training model and fits with the MECC plus approach.

It consists of the content from the GambleAware brief intervention guide in an eLearning format, except for the section added on gambling disorder in 2021. This content and the

evidence used have not been updated, some sources are unclear, and some links are broken. For instance:

- 'Topic 2: What is a brief intervention?' is identical to the evidence base for the GambleAware 2017 brief intervention guide; the evidence on brief interventions has not been updated to include contemporary references.
- The same topic says, "Gambling Disorder can affect an individual's behaviour and concentration in the workplace". This cites a statistic from the same source used as in the brief intervention guide, a 2016 report by Reed in Partnership. However, the link provided by the eLearning tool does not work, and the report is not evident online. In addition, the relevance of the statistic is unclear, as it seems to be about public perceptions: "more than four in five (82%) of British adults think that gambling and debt can be a distraction for people in work."
- Under topic two, it says, "Click on the tabs below to reveal some statistics found by a GambleAware study about gambling in Britain." This appears to be an addition of new statistics not in the brief intervention guide. However, when you click on the link it takes you to the GambleAware 'News' page, and it is unclear which study the statistics come from.
- Once you have completed the course, it says, "You can download a printable PDF version of the Brief intervention guide here", but the link does not work.

Level 2 award curriculum (RSPH)

Author and format

RSPH developed the Level 2 Award in Tackling Gambling-Related Harms in collaboration with organisations from the Gambling Health Alliance (GHA). Beacon Counselling Trust (BCT), Addiction Recovery Agency (ARA), and Unite the Union are listed as involved in its development, but it is unclear if other organisations from the GHA were engaged. The RSPH established the GHA with support from GambleAware.[48] BCT and ARA are part of the GambleAware funded National Gambling Treatment Service (NGTS), contracted by GamCare.[49] No authors' names are provided. There is no statement on conflicts of interest or industry funding.

The curriculum is available to download from the RSPH website. The curriculum specifies the total qualification time is six hours. How the accredited training centres deliver the curriculum varies, with at least one of the centres offering the training as either a full day or two half-day sessions.[50]

Date

The curriculum was made available in 2021.

Target

It is for those working with individuals affected by harmful gambling and gambling-related harm and those working in the wider public health workforce.[51]

Objectives

Its purpose is to fill an educational gap in the public health workforce training, to skill professionals beyond brief interventions to a level comparable to training in other areas of public health. The RSPH website states: "The RSPH Level 2 Award in Tackling Gambling-Related Harms is the first regulated qualification that will teach public health professionals about how to support people who have been affected by problem-gambling".[52]

According to the RSPH curriculum, the learning outcomes of the course are:

> *a) Understand the nature of harmful gambling and gambling-related harms and their impact on health and wellbeing and, b) Know how to provide help and support to an individual at risk of or affected by harmful gambling and gambling-related harm.*

Inclusion of lived experience

RSPH and their partners in the development of the level 2 award curriculum in their welcome webinar,[48] described lived experience being fundamental to the development of the programme through their Northwest service user group (Northwest Gambling Harms Alliance), PG Solutions, the ARA service user group, and other individuals who have accessed the Beacon service:

> *This course has been developed with major input from various service user groups both national and local. And within the handbook we have a number of illustrations from our service users describing their journey. The most important issue they feel needs engaging with within this particular domain is the stigma of gambling-related harm, which massively prevents the healing process.* [48]

The curriculum does not specify that the training developed by accredited centres should include input from people with lived experience or the voice of lived experience in delivery. [1]

Use of evidence and resources

It is an Ofqual-regulated course accredited by the RSPH. The qualification is mapped to the Public Health Skills and Knowledge Framework (PHSKF), to Level 1 of the Kent, Surrey and Sussex guidelines for Make Every Contact Count (MECC) and to the following National Occupational Standards of Skills for Health:

- HT2 Communicate with individuals about promoting their health and wellbeing
- HT3 Enable individuals to change their behaviour to improve their own health and wellbeing
- SJF GAM001 Identify indicators of gambling-related harm in individuals and signpost to appropriate sources of help
- SJF GAM002 Identify and respond to immediate needs related to gambling-related harm

There are no references included in the publicly available material. The curriculum has a "Suggested Reading and Useful Websites" section, but this cannot be accessed unless you are a registered RSPH centre and so could not be reviewed.

Primary care competency framework (PCGS)

Author and format

The primary care competency frame is a 33 page document that can be accessed online.[53] The framework's development was led by the Primary Care Gambling Service (PCGS), through the Hurley Group Practice, commissioned by GambleAware. The PCGS is described as "a new, GP-led, primary care based, integrated-intermediate service, which forms a bridge between existing community and specialist-based services and the National Problem Gambling Clinic" (P.4). The service was initially funded by a regulatory settlement from the Gambling Commission between

October 2019 and March 2022. From April 2022, GambleAware funds the service.[54] There are no authors' names given. There is no statement on conflicts of interest or industry funding.

The document says it was written in consultation with: RCGP, CNWL National Problem Gambling Clinic, GamCare, GambleAware, Gordon Moody Association, Action on Addiction, and SMMGP Substance Misuse Management in General Practice. SMMGP is now Addiction Professionals, a voluntary registration body and network for addiction professionals.[55] The documents feature the logos of the Royal College of General Practitioners (RCGPs) and RCPH prominently on the front page. However, it does not state what this consultation involved and whether these organisations endorse the document.

Date

The document seems not to be dated, but the press release accompanying its publication is dated June 2021.[56]

Objectives

The framework sets out core competencies for primary care practitioners:

> *The framework is designed to describe the breadth of skills required to ensure the provision of safe, effective and high-quality support to problem gamblers by medical and non-medical practitioners. The importance of other health care professionals in the delivery of care is vital given the broadening workforce in primary care within Primary Care Networks.* (P.4)

The document is also concerned with the set-up of gambling-focused services within primary care, which a wider network of generalist primary care professionals would then make use of, and connecting with community, voluntary, mental health, social care, and specialist gambling services. The context is the changes to healthcare, so organisations in an area work together to improve the health of the local population, as set out in the NHS long-term plan – the development of Primary Care Networks and Integrated Care Systems.

> *With the development of Primary Care Networks there is the establishment of social prescriber link workers and a greater appreciation of how to provide joined up care that reaches into the community and is not limited by traditional service delivery boundaries. This provides a unique opportunity to harness this potential… Building on PCGS, there is an ambition to establish a national (England-wide) hub and spoke model of service delivery, building a cadre of general practitioners, nurses and others with special clinical interest in gambling. This expertise would lead services across the seven proposed English regions, 42 Integrated care services and 1,250 Primary Care Networks.* (P.6).

The document does not specifically address arrangements in Wales or Scotland where health and social care are devolved.

Inclusion of lived experience

The primary care competency framework does not mention the use of lived experience in its development. However, the competencies include the importance of peer mentors and creating networks of peer mentors/lived experience.

Use of evidence and resources

The document has introductory sections covering "problem gambling" and includes a short list of references, but it is unclear on what basis this was compiled or how the evidence was selected. In addition, it does not signpost to any additional sources of information or resources.

Much of the document comprises generic content on service delivery, training, and accreditation principles that are not specific to gambling harm. There are seven competencies: awareness, screening, needs assessment, treatment, risk, case management, and health promotion. The competencies are somewhat repetitive, often seeming to contain the same content, but using different phrasing or terms (especially in the 'knowledge' sections). This is confusing, as it becomes unclear whether it is a distinct competency or the same one worded differently. For example:

Under competency 1:

> *1KC: An awareness of the individual, societal and environmental processes that can contribute to harm from gambling activity*
>
> *1KD: An awareness of the financial impact, psychological and physical health impact, relational, work/professional disturbances, cultural harm, and criminal implications from gambling activity*

Under competency 2:

> *2KD: An understanding of the behavioural, social, psychological and personality factors that can contribute to gambling disorders*
>
> *2KE: An awareness of risk factors/vulnerable groups to gambling disorders*

Under competency 3:

> *3KB: Knowledge of population trends in gambling disorders*
>
> *3KC: Knowledge of the multiple factors that affect and are affected by gambling*

Mindful resilience programme (YGAM)

Author and format

The training programme was developed by YGAM, Betknowmore and Bournemouth university.[57] YGAM took responsibility for leading the collaborations and developing the "strategic relevance" of the programme.[58] Bournemouth university developed and wrote the content. Dr Sarah Hodge (Bournemouth University) and Dr Ali Lutte – Elliot (YGAM Mindfulness programme clinical lead) are listed as authors. The programme development and content have also been informed by lived experience. Betknowmore worked with YGAM to deliver practitioner recruitment and training. As of July 2022, Betknowmore withdrew its involvement with the programme.[59] The materials are not publicly available, but the training is delivered free of charge, either online or face-to-face, enabling access.

The training programme is being evaluated by the Responsible Gambling Council (RGC). The evaluation is ongoing and will be published on the YGAM website upon completion.

The programme received funding from Playtech[60] and has received additional funding from Merkur Group UK in 2022 for the most recent phase of the programme.[61] The material does not contain a statement on conflicts of interest or industry funding.

The training programme is two hours in length and provided online.

Date

YGAM launched the mindful Resilience training programme in 2021. The programme received Royal Society for Public Health (RSPH) accreditation in 2022.[62] The programme was developed as a two-year pilot, initially covering London and expanding to the West Midlands. The aim is to roll out the programme more widely following its evaluation.[63] In correspondence, YGAM indicated this rollout will include input through a community of practice with healthcare professionals and Experts by Experience (EbEs).

Target

The course is available for all healthcare professionals who work with children and young people (under the age of 25), including GPs, nurses, social prescribers, mental health workers, pharmacists and more.[64]

Objectives

Mindful resilience is an online or face-to-face training programme addressing both gambling and gaming. The programme has been described as specifically tailored to the modern needs of the NHS and is informed by lived experience and academic insight.[65]

The programme aims to:

> *build the understanding, skills, and capabilities of healthcare professionals in primary care networks and mental-health related Third Sector organisations to enable better awareness, screening and sign-posting support for individuals who are experiencing or at risk of harms related to gambling or gaming.*

The course objectives are:

> *1) to improve knowledge of gambling in children and young people (CYP); 2) identify factors which increase vulnerability in CYP from gaming and gambling harms; 3) understand the role of addictive behaviour and potential consequences of gaming and gambling.*

The goals of Mindful Resilience in practice are to:

> *1) enhance skills in how to approach CYP in conversation; 2) risk assess CYP participation in gaming and gambling and knowing how and when to respond; 3) know where to access available resources and signpost CYP.*

Inclusion of lived experience

The mindful resilience programme describes its training content as informed by academics, psychologists, health professionals, and individuals with lived experience. The programme's PowerPoint slides describe the content as written with support from the lived experience community.

The programme includes lived experience audio clips. For example, individuals talking about their first experiences with gambling when they were young, why gambling is popular, and people talking about feeling stigma, shame and guilt ("*The guilt came in and then the shame. And it was the shame that really crippled me"*). In the training materials, it says, "Lived Experience Advisors have mentioned that a medication-focused approach is often the extent of the treatment plan". In the additional resources document, there is a section on how the type of language used can impact the receiver and outlines the importance of language used by the healthcare practitioner. They have provided a translation of how certain phrases may be interpreted in relation to shame, stigma, and guilt, which their lived experience co-creation group informed.

However, it is not made clear whose lived experience is included. The lived experience audio clips sound like they are from older adults, and many of the experiences they describe relate to traditional and land-based gambling when they were young. It is not stated whether the lived experience advisory panel were of the same age or with relevant experiences for the target audience for the programme, which is under 25.

Use of evidence and resources

The main training programme is a PowerPoint presentation that includes up-to-date references related to gambling and gaming. The PowerPoint is supported with a word document which expands on its content. After the workshop, attendees are provided additional resources for them to embed and apply to their respective organisation's policies and procedures for engaging with and caring for CYP. These resources include further information about the programme with references, screening tools, and signposting information.

The resource is dominated by frameworks and evidence from gaming, with gambling tending to be slotted into this. To start with gaming may be an effective strategy for this target group, as gaming is likely to be more common among CYP. However, gambling is not the same as gaming and most forms of commercial gambling (such as entering a betting shop premises) are illegal for those under the age of 18. The result of including gambling within discussions of gaming and not clearly distinguishing the two is that in some areas the training appears to emphasise the benefits of gambling to CYP and underrepresent the risks. For example, the word document explains how gaming may become a problem for CYP by comparing gaming to other leisure activities and then extends the comparison to include gambling – thereby seeming to normalise gambling as an everyday leisure activity for CYP:

> *Many people watch films and TV series which can be likened to the same process of just escaping. Where there might start to be red flags is when there is overuse of this coping mechanism, so the person is not necessarily stopping the game but continuing it. Rather than having breaks or sessions, they may just have one continuous session or gamble all of their money away.*

Uptake of the reports and organisational arrangements

The value of competencies, curricula and training is in their quality combined with the extent to which people are trained, competency is assessed, they undertake the interventions and do so effectively. Neither providing poor quality training free nor excellent training where cost and other barriers stand in the way of uptake is good enough. Currently, coherent mechanisms for quality assurance of training, skills assessment and accreditation, and incentivising and monitoring implementation do not exist. To achieve impact on healthcare, these mechanisms need to integrate with local and national health and care systems. The problems with the current situation are evident in relation to the uptake of the resources.

A cursory search online indicates the free **brief intervention guide (GambleAware)** and the **eLearning tool (RSPH and GambleAware)** have been widely promoted and used by other organisations, for example:

- https://gamblingwatchscotland.org.uk/frontline-staff-toolkit/
- https://www.begambleaware.org/for-professionals/advice-and-support
- https://safergamblinguk.org/get-involved/resources-for-professionals
- https://www.gamblingcommission.gov.uk/authorities/guide/reducing-gambling-harms-resources

- https://www.thesafeguardingcompany.com/resources/blog/safeguarding-students-engaged-with-online-gambling/
- https://www.nwpopulationhealth.nhs.uk/media/kvrhtlhu/gambling_webinar_resources.pdf
- https://democracy.devon.gov.uk/documents/s27288/Gambling%20update.pdf

As of January 2021, the RSPH announced that over 7,000 people, including nurses, NHS workers and those in the mental health sector, had completed the **eLearning tool (RSPH and GambleAware)**.[66]

Figures for the **level 2 award** uptake are not included on the RSPH website.

The evaluation of the **PCGS** pilot[42] found limited referrals from other GPs and health professionals due to a lack of awareness about PCGS and "problem gambling" in general, as well as challenges integrating into the wider health system. A special interest primary care service can only function if the wider generalist primary care/community workforce has capabilities in gambling harm.

The **mindful resilience programme (YGAM)** reported that in its first year of launch (up to December 2021), it was delivered to 195 healthcare professionals, and it was estimated to have reached 97,500 young people.[67] This was against its target of 425 healthcare professionals reaching 212,500 young people. The workshop is also a regularly scheduled module of the Education Mental Health Practice post-graduate diploma at King's College London.[68]

The importance of organisational arrangements to enable training and changes to practice is, to some extent, acknowledged by the materials.

The **brief intervention guide (GambleAware)** and the **eLearning tool (RSPH and GambleAware)** have sections with guidance to support effective planning, set-up, implementation and monitoring of brief intervention within an organisational context. It states that:

> *Evidence suggests that organisational factors can limit or enable implementation of brief interventions.[69] Successful implementation of brief intervention programmes is more likely when the programme is championed at management and/or leadership level.[70] Commitment at organisational governance and management levels is essential to support workers to provide brief intervention.* (p26)

As the guidance notes, the material it provides is generic. It is not specific to gambling and organisational barriers to addressing gambling harm.

The **primary care competency framework (PCGS)** provides generic content on commissioning services, service delivery models and infrastructure requirements, teaching and learning, assessment, accreditation, and maintenance of competence. This material is not specific to gambling. The document comments:

> *At the time of writing there is no specific course/curriculum/training programme for potential PwSI. It is hoped that this will be addressed as a matter of urgency so that potential PwSI can address their learning needs in a high quality educational process (P.14).*

The document recognises the potential to address gambling within the NHS long-term plan, with a focus on prevention, population health, primary care, and integrated care systems – which are intended to cross traditional service delivery boundaries and better integrate GPs with community, community, mental health, social care, pharmacy, hospital, and voluntary services in their local areas.[71] The introduction states that:

> *98% of general practices are part of the new Primary Care Network architecture, allowing them to more easily adopt a more holistic approach to care. This could form the basis for a more hub and spoke approach to care, integrated with mental health and secondary care specialist input* (P.5).

However, at the current time, the situation, as it was for the NHS gambling clinics, is being repeated with primary care; an industry-funded organisation is commissioning and funding NHS services. This is without the integration, checks and balances of public sector commissioning or proper integration into health and social care systems. The evaluation of the Primary Care Gambling Service Pilot indicates difficulties in obtaining referrals from within primary care, partly due to a lack of awareness within wider primary care teams and confusion between the role of the primary care service and the NHS clinics.[72]

Understanding the issue, its causes, and consequences

The way that an issue is defined or described plays an essential part in how it is understood, who is responsible for it and what should be done. The way the resources construct the issue of gambling harm can explicitly or implicitly shape or reinforce stigmatising beliefs about gambling harm in workers. This section looks at how the material presents the issue of gambling, addiction, and harm; the causes; and consequences.

Learning

Terms like 'problem gambler' blame and stigmatise people harmed by commercial gambling products and practices and are not acceptable. It is not enough just to replace one term with another and fail to change the underlying 'responsible gambling' framework which puts the blame on a few flawed individuals for not controlling themselves.

- Replacing 'problem gambler' with terms like problematic, pathological, or hazardous gambling changes the words but not the implications.
- This also applies to 'harmful gambling'. This incorporates the terminology of gambling harm but attributes the harm to the way a person gambles rather than the gambling industry and its products and practices.
- Gambling disorder is concept from psychiatry and provides the criteria someone must meet to obtain a clinical diagnosis for having a mental illness. This may be useful in highlighting that gambling does make people ill and that this is not something they can 'just stop'. However, it is used to carry on representing a few pathological individuals as the cause of gambling harm as - rather than addiction as a necessary outcome of addictive products and practices. Like 'problem gambler' it separates the disordered few from the many who 'gamble safely'. It is does not distinguish dependence or addiction from harm, which can be experienced at any level of gambling participation.
- The principle should be person-centred language – such as 'person harmed by gambling' and attribute harm to gambling not the person.

Harm and a public health approach are relatively new to gambling. Training needs to be based on a single, clear understanding of what this means and not confused with or mixed into existing responsible gambling approaches. A destigmatising, preventative approach starts from healthcare workers understanding that the products and practices of the gambling industry are harmful and addictive.

- Healthcare professionals know that alcohol, smoking, drugs, certain foods cause harm and will do so for anyone who consumes them. This should be the starting point for gambling.
- Training needs to consistency and clarity in the meaning of use of concepts like risk, indicator, harm, protective, vulnerability and this should align with the usual use of these terms in healthcare.

Health workers need to understand the harms caused by the gambling industry. This is necessary to healthcare recognising the role they should play.

- This should include the range of harms, that these are enduring, even life-long, and intergenerational. They impact the person, those close to them, communities and society and contribute to health inequalities. This causes socio-economic costs, including to health and social care. There are limitations of data and measurements, but this conception is accepted in government health policy.

Gambling

Gambling is a vague term that covers numerous products and activities. Healthcare professionals need to be informed on the topic of commercial gambling, its nature, extent, products, and practices, to understand gambling addiction, and harm – and to do so in a way that does not blame and stigmatise the person. The resources give varied and, in some instances, very little attention to the actual issue – gambling itself.

The **brief intervention guide (GambleAware)** does not define gambling or discuss different types of gambling, changes in gambling or regulation. Implicit in the guide is that gambling is an everyday leisure activity; hence, it does not need to be discussed or explained.

The **eLearning tool (RSPH and GambleAware)** begins by defining gambling ("gambling is a game in which you risk money or something of monetary value in order to have the chance to win money or a prize"). It provides a basic list of traditional types of gambling: "lotteries, scratchcards, card games such as poker or blackjack, betting, casino games, gambling machines, and bingo". It then presents six gambling participation statistics from the Gambling Commission (2019), including how often people have gambled in the past four weeks, used a smartphone to gamble, and the number of people who have reported seeing a gambling advertisement on television in the last week. This has the effect of showing how common gambling and exposure to gambling have become. However, there is no discussion on the addictiveness of gambling products, the nature, scale, or changes in commercial gambling or questioning of whether this extent of gambling is a good thing for public health.

The **level 2 award curriculum (RSPH)** specifies that there should be broader content on the gambling industry. It states training should begin with definitions of gambling, information on

legislation and regulation, "the most popular forms of gambling activity in the UK; gambling-like activities that are not legally recognised as forms of gambling (such as loot boxes); and the difference between remote and premise-based operators".

The **primary care competency framework (PCGS)** introductory sections do not include any information on what gambling is, types of gambling, harmful commercial products or practices, or the context of developments in the gambling industry. Competency 1KA 1 is "an awareness of what gambling is and the types of gambling available in society" (P.15), but there is no further information as to what this consists of. Competency 2KC is "knowledge of gambling types", but the examples refer to types of "problem gamblers", not types of products sold by industry: "for example, action/escape gamblers and pathways model." (P.16). Competency 2KI is "knowledge of up-to-date gambling regulations" – rather than debates or challenges with regulation.

The **mindful resilience programme (YGAM)** defines gambling as wagering money or items, being chance-based, with the intention to win money. The programme provides examples of both gaming (e.g., single/multiplayer, online/offline, apps/mobiles games, and virtual/augmented reality) and gambling (slot/fruit machines, casino games, sports betting, lottery, scratch cards, and bingo). It does not distinguish between land-based or online gambling. It provides examples of crossovers between the two (digital convergence; "how technology has enabled access and opportunities e.g., access to – and new forms of gambling") such as loot boxes, esports betting, skin betting, virtual casinos, arcade games. The programme further defines esports, loot box microtransactions and skins in the additional resource glossary. It has a link for 'What is gambling' from the Gambling Commission (https://www.gamblingcommission.gov.uk/for-the-public/What-is-gambling.aspx) but the link does not work or the page is not active.

The PowerPoint presentation provides statistics for the combined value of the gaming and gambling industry (it is not clear why these two industries should be taken together), as well as statistics for how many 11-16 years olds have spent their own money gambling in the last week. The programme is to support CYP under the age of 25 years old but does not include that gambling can relate to both legal activity (for example playing cards for money with friends and making private bets for money) and illegal activities (for example, entering a betting shop premises under the age of 18). It also does not talk about how certain gambling activities such as family entertainment centres and amusement arcades have no minimum age, whereas other forms of gambling have a minimum age limit of 18 years old. The guide does say that playing age rated games is a risk factor that 'may cause CYP to be vulnerable'. But if children under the age of 18 are engaged in commercial gambling, then this is, for the most part, illegal and would be a clear indicator of risk/harm. This covers to age 25 but does not cover 18-25, which is a period of high risk, when people have access to the full extent of gambling for the first time, at a life-stage of heightened vulnerability.[73,74]

Gambling addiction and harm – language and definitions

People with lived experience have been clear for some time that the term 'problem gambler' is unacceptable because it is highly stigmatising. It blames the person for the harm they experience and removes accountability from the gambling industry and regulators for harmful commercial products and practices. However, it is not enough to change the term, without changing what it means or the underlying framework. For example, the resources often substitute it with other highly stigmatising language such as: 'problematic' or 'pathological' or 'hazardous'.

The resources frequently make use of 'gambling disorder' and the clinical definition from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR)[75]. This does acknowledge that gambling difficulties can be a mental health condition, an addiction which the person cannot simply 'control'. However, the location of the problem remains the disorder of the individual, rather than the fact that commercial gambling products and practices are addictive and harmful. This continuation is very evident in the wording of the definition of 'gambling disorder' for patients and families, which even includes the term 'problem gambling', and that it is this behaviour causes harm:

> *Gambling disorder involves repeated, problem gambling behaviour. The behaviour leads to problems for the individual, families, and society. Adults and adolescents with gambling disorder have trouble controlling their gambling. They will continue even when it causes significant problems.*

In some instances, the resources use the term harm in a way that is again a descriptor for 'problem person or problem behaviour' rather than harmful commercial practices.

It is unhelpful that the resources tend to make use of a range of terms interchangeably, inconsistently, or without definitions; to mix up concepts like behaviour, disorder, addiction, harm, indicator, risk, protective factor, vulnerability, or resilience; and to use these in ways that are different from the usual meaning in public health or healthcare. The resources tend to be unclear about the difference between harm, dependency and addiction. For instance, harm below the threshold for clinical diagnosis and at various levels and across the population. Or gambling as potentially harmful and addiction for all who engage with it – the basis for a public health approach.

The **brief intervention guide (GambleAware)** uses the term 'problematic' gambling rather than 'problem' gambling but does not explicitly define what this means. In the face of objections to the use of the term 'problem gambling,' it seems the word 'problem' has been replaced with 'problematic', without changing the fundamental approach to the issue. It is not explained what distinction is being made with the use of problematic versus problem. Different terms are inconsistently and interchangeably used within the guide and supporting materials. For example, problematic gambling, risk, harmful/hazardous gambling, gambling-related harm, pathological gambling, and dependent or addicted.

The **eLearning tool (RSPH and GambleAware)** provides a short definition of gambling disorder ("behaviour with implications for mental health"), according to the World Health Organisation (WHO). However, the link provided alongside this statement leads to the WHO homepage, and it is difficult to confirm where this definition of gambling disorder originated. It also lists the diagnostic criteria for gambling disorder – although it does not reference the DSM-5 where this was taken from and does not include the DSM-5 definition of gambling disorder.

Unlike the brief intervention guide (GambleAware) and eLearning tool (RSPH and GambleAware), the **level 2 award curriculum (RSPH)** defines the terms used in their training and includes harmful gambling and gambling-related harm. It says:

> *Centres should note that this qualification uses the term harmful gambling to describe the "urge to gamble continuously despite harmful consequences or desire to stop, causing harm to the gambler and to affected others. This is also defined elsewhere as 'problem gambling', 'problematic gambling' or 'disordered gambling', including in statistics that report the number of 'problem gamblers' in the UK. For the purposes of this qualification, centres and learners should treat these terms interchangeably.*

Gambling-related harms are defined as the "adverse impact that gambling has on the health and wellbeing of individuals, families, communities and society". This definition comes from the framework commissioned by GambleAware for the Gambling Commission.[76]

The term 'harmful gambling' may be an advance on labelling people 'problem gamblers'. But it does again attribute harm to an individual's behaviour, rather than commercial products and practices that induce addiction (by definition, behaviour which continues despite harmful consequences or the desire to stop) – and it is explicitly stated as being a synonym for 'problem gambling' and variants of this term. This is added to by the potential ambiguity in the term 'gambling' in this definition of gambling-related harms – whether it means the gambling behaviour of individuals or the gambling industry.

The **primary care competency framework (PCGS)** provides the DSM-5 Diagnostic Criteria for Gambling Disorder in full. It uses the term 'problem gamblers throughout, and as a group or a person which is even more stigmatising than 'problem gambling' as an issue. It also uses interchangeably gambling disorder, pathological gambling, pathological gamblers and gambling related harm. Competency 1KB is "knowledge of the definition of gambling related harm". But the introductory sections do not provide a definition of gambling harm. Where the term is used, it is as if it were a health condition. For example: "managing patients with gambling related harm" (P.6) or "identification and brief intervention of gambling disorders and gambling related harm" (P.9).

The **mindful resilience programme (YGAM)** does not use the term 'problem gambler'. The additional resource glossary uses the term 'problematic' gambling but does not define what is meant by this. Its focus is on gambling disorder as a mental health condition. It uses the DSM-5 clinical definition of gambling disorder ("persistent and recurrent problematic gambling behaviour leading to clinically significant impairment or distress"). It also includes a gambling disorder definition from the Royal College of Psychiatrists:

> *Gambling disorder is a repeated pattern of gambling behaviour where someone; feels they have lost control but continues to gamble despite negative consequences and sees gambling as more important than any other interest or activity.*[77]

The document also refers to 'harms' and 'risk factors', in a way that does not clearly distinguish the two. In the figure on the continuum of harm, in addition to the term "problematic" they also use the terms including "OK", "Minor Risk", and "Major risk" without delineating what these categories mean. Additionally, the training materials talk about gaming providing positive and protective factors which could be misconstrued as also applying to gambling. It says:

> *Just like when kayaking and canoeing, conditions can change suddenly, and what might start as a nice activity can become risky and dangerous. The same is true for gaming and gambling – there might be a sudden change which means the young person moves considerably on the continuum for harms/risks.*

This is statement may be acceptable for gaming, but it normalises gambling as a leisure activity and locates the risk entirely in something changing in the individual versus the addictive products.

The causes of addiction and harm

A significant driver of stigma and discrimination is the normalisation of commercial gambling as a harmless everyday leisure activity, and the conception that problems are caused by a few flawed individuals who misuse these products. This means people harmed by gambling are blamed, but also that gambling in and of itself, for any person, is not addressed by health workers, undermining a public health approach. This is opposed to alcohol or tobacco, or even certain foods, where it is generally understood that these products cause harm, would do for any patient, and be normal to include as part of any healthcare interaction.

In terms of causes or explanations as to why people are harmed by gambling, the **brief intervention guide (GambleAware)** and **eLearning tool (RSPH and GambleAware)** do not address the products and practices of the gambling industry, or regulation or socio-economic context. In the **brief intervention guide (GambleAware)**, the cause of gambling difficulties is defined exclusively in terms of an individual – "people whose behaviour is hazardous or harmful" or "people who are dependent or addicted".

However, the **level 2 award curriculum (RSPH)** states that the training should include "factors that could result in an individual being at risk of or affected by harmful gambling and gambling-related harms". This includes:

> *Social factors and triggers, such as the high visibility of premises-based gambling operators and products; risk of addiction to gambling; growth in availability and accessibility of remote gambling operators and products through smartphones and other forms of technology; stigma; association between gambling and aspects of culture; visibility of gambling operators and products in the media.*

In this way it includes the operations of the gambling industry as a cause of harm. It is not spelt out whether "risk of addiction to gambling" includes the addictive properties designed into gambling products and marketing.

The curriculum includes one further category:

> *Individual-specific factors and triggers such as gender; age; socioeconomic status; ethnic background; peer pressure; exposure to gambling in childhood and the impact of compromised parenting and Adverse Childhood Experiences; pre-existing health and wellbeing issues such as depression, anxiety, loneliness and boredom; gambling as a distraction or coping mechanism; personal financial situation; predisposition to gamble; impact of initial success in first attempts at gambling.*

These are factors that the individual may bring to gambling but are produced within a socio-economic context. For example, trauma and mental ill-health have social gradients. Leisure opportunities and financial position are related to socio-economic position. Further, the gambling industry targets people by gender and socio-economic status[78]; people may use gambling to cope because gambling changes bio-chemical reward systems. Ascribing these factors to an individual without acknowledging their context can be stigmatising through 'blaming' them on the individual or their upbringing. It is unclear what a "predisposition to gambling" is.

The **primary care competency framework (PCGS)** introductory sections largely present the issue as one of individual behaviour, vulnerability, or illness and this is what causes harm, rather than of harmful and addictive commercial products and practices: "gambling addiction and the problems it causes individuals, their families and their communities" (P.3) or "an

opportunity to support individuals and release families from the blight that gambling disorder brings" (P.5). Competency 2KD is "knowledge of the theories of gambling disorder behaviour", although it does not state what these are. In general, the competencies seem to reflect a biopsychosocial approach:

> 2KD: An understanding of the behaviour, social, psychological and personality factors that contribute to gambling disorders *(P.16).*
>
> *2KF: Awareness of risk factors/vulnerable groups to gambling disorders (P.16).*
>
> *1KD: An awareness of the individual, societal and environmental processes that can contribute to harm from gambling activity (P.15).*

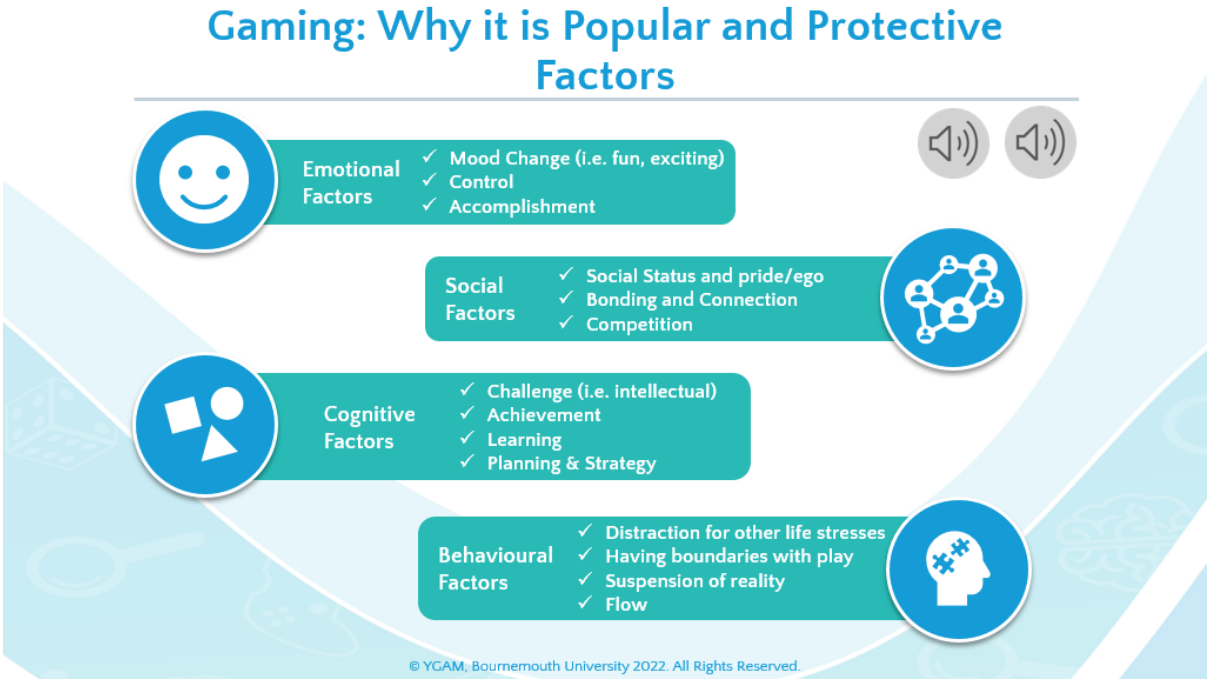
While this is an approach that acknowledges the role of a range of factors in health, there is no mention of gambling industry commercial products or practices.

The **mindful resilience programme (YGAM)** discusses 'risk' factors for why CYP experience gambling and gaming difficulties together, including the role of industry activity:

> *technology (i.e., the game design, accessibility, and marketing) financial (large losses, big wins, debt, costs), environmental (socio-economic background, genetic risk factors, cultural religious beliefs, and the pandemic), social (i.e., peer pressure and social group, enablers, modelling), and individual factors (cognitive distortions, neurodevelopmental conditions, identity, maladaptive problem solving, escapism).*

It mentions the harmful products and practices: "activity/game characteristics; addictive design/properties, dark play design; marketing, adverts & endorsements (these may be appealing to CYP)" (p.5).

However, the challenge is in not clearly differentiating gaming and gambling. The training talks about how loot boxes and how gacha games aggressively advertise microtransaction with randomised in-game items. But there is not discussion of problems with specific characteristics of traditional gambling products or CYP exposure to gambling marketing. The PowerPoint provides a slide on why gaming is popular and beneficial for CYP.



But it then also seems to extend the same characteristics to gambling. While these may well be part of the appeal of gambling, gambling is an inherently risky activity and the products harmful as it is centred on money. These the positive/protective factors displayed on the slide are not protective against gambling harm, but rather play a key part in how gambling is designed to be addictive.

The programme talks about behavioural addictions and how they might meet a psychological need but the focus is on gaming (e.g., "in the case of gaming it has been suggested that gaming can help with real world problems such as stress, aggression, anxiety and managing unpleasant moods, loneliness, and unwanted impulses"). The training says:

> *Gaming and gambling might help meet certain needs and potentially fill the different types of needs we have, whether they are social, cognitive, behavioural or emotional…what might draw CYP to gaming and gambling could be a number of different reasons for seeking certain needs to be met…This can be really helpful for us as practitioners to know why someone might play, because it can flag up any issues from their motivations. For example, a CYP reports feeling depressed which is why they play games to get away from those difficult emotions and make connections /bonding with other people and there is also bonding/connections with virtual/ computer generated characters (which happens to players of all ages).* (P.4)

This frames the issue as a problem of the CYPs 'motivation', where gaming or gambling to escape or cope is overused, and people do it too much. This is very much minimising risks and harms associated with gambling, as well as the role of commercial gambling practices.

There is a tendency in the training to focus on the individual and cognitive distortions. Again, the issue is framed as not about commercial products or practices but the problems of thoughts. The training material uses an example of 'Aladdin's cave' and an analogy of the "gambler's fallacy" within the accompanying audio-clip. It describes the 'Aladdin's cave' as the ideal scenario, "everything you dream of", "feeling at home", "we had the FOBTs with the sounds, colours, noises", "you don't want to come out". However, the "gambler's fallacy" is the incorrect term to use as it refers to the cognitive distortion[79] of not accepting the randomness of an event and having misperceptions that a future win or loss is related to past outcomes, when, in fact, each gambling event is distinct. This 'Aladdin's cave' example talks about the FOBTs sounds, colours, and noises and feeling safe in that environment, making you not want to leave. This analogy presents an opportunity to talk about how the gambling environment and products are specifically designed this way by the gambling operators, but this is not done.

The training also lists familial gambling and peer pressure as predictors of gambling harm but does not discuss the commercial practices exposing children and targeting young people.

The nature and extent of harm

There is acceptance, including from the Gambling Commission and government, that gambling causes harm, that this harm is wide-ranging across domains such as physical and mental health, relationships and social connectedness, work, finances, and crime. These harms impact individuals, family and friends, community, and society and can be enduring, even lifelong, and intergenerational. Harms can occur at any level of gambling, without a clinical diagnosis of addiction. This is set out in a framework on harms produced by the Gambling Commission[80] and in reviews and initial (although limited) socio-economic costs produced by government.[81]

However, in the field of gambling studies, conceptions of harm and public health are relatively recent and there are debates related to data collection and how this harm should be measured.

The resources tend to have limited descriptions of harm or co-opt 'harm' into the existing individualised or medicalised accounts, sometimes seeming to misinterpret or create new models without a clear basis. This means people become the source of the 'danger' and 'disorder, which drives stigma and discrimination. That the gambling industry generates harm, including direct costs to health and social care and contributes to health inequalities, is important for healthcare workers to understand – so that they see why gambling is a public health issue and contributes to addressing gambling harm.

The **brief intervention guide (GambleAware)** does not meaningfully address gambling harm at the individual, family, community or societal levels. The guide says, "problematic gambling often contributes to other problems such as financial, employment, health, family-related and legal issues." Harm is solely attributed to the person's behaviour, and this is a simplistic description of the consequences of gambling difficulties for the individual. For example, it neglects harms related to physical ill-health, psychological distress (including stigma, shame, and guilt), mental ill health (including anxiety and depression), or how gambling is associated with a considerably increased risk of suicidality. It does not describe the emotional and social isolation from family, friends, and communities that people can experience – or how harms from gambling can remain long after the person has stopped (legacy harms).

The guide provides statistics on the number of people who experience 'problematic gambling'. This is 'problem gambling' prevalence changed to 'problematic gambling', without discussing the issues with problem gambling prevalence rates or their use as a measure of harm. It states:

> Problematic gambling directly affects an estimated 430,000 people in Britain, with a further 1,985,000 deemed as being at risk of developing a gambling problem. An estimated 5-8 other people are affected by someone else's gambling problem. This makes gambling a significant social issue. (P.5)

It is unclear what is meant by gambling being a "social issue". Although it refers to gambling as a "significant social issue", it does not address harm to family, friends, or communities and broader society.

The **eLearning tool (RSPH and GambleAware)** says, "Gambling Disorder can affect both the gambler themselves and cause harm to those around them, such as family, friends and colleagues." This is also attributing harm to individual dysfunction. It goes on to explain the effects of 'gambling disorder' and 'severe gambling disorder'. However, it does not explain where these labels originate from (that 4 or more of the DSM-5 criteria indicate gambling disorder, and 8 – 9 classify 'severe' gambling disorder). It says that gambling disorder can cause stress, anxiety, depression, falling behind at work, and money worries, but severe gambling disorder can cause the breakdown of relationships, difficulty maintaining employment, unmanageable debt, and self-harm or suicide. This is not part of the DSM-5, and it is not clear on what basis these harms have been split out. Although the more DSM-5 criteria that are satisfied may increase the harm experienced, those with gambling disorder may still experience the breakdown of relationships, debt, employment difficulties, self-harm, and suicide.

The **eLearning tool (RSPH and GambleAware)** describes a wider range of consequences than the original brief intervention guide. For example:

> *According to the Royal College of Psychiatrists, those with Gambling Disorder are more likely than others to experience stress-related disorders, anxiety, depression, suicidal thoughts and suicide attempts. A study from the Adult Psychiatric Morbidity Survey found that gamblers are 15 times more likely to attempt suicide.*

However, some of the wording describing harms seems stigmatising, potentially characterising people as greedy or irresponsible. For example:

> The financial impact of Gambling Disorder is often one of the first outward signs that someone has a gambling problem. This is because when an individual's gambling becomes uncontrollable, they often gamble more in an attempt to recover the losses.

Or "Gambling Disorder can increase the risk of criminal involvement as a means of gaining more money. Financial obligations such as child support might also be impacted".

By contrast, the **level 2 award curriculum (RSPH)** says that training should cover the "impact of gambling-related harms on the health and wellbeing of the individual, their family members and wider society. It states:

> *For the individual – direct negative impact on both mental health, including increased risk of anxiety and depression, and on physical health, including increased risk of prioritising gambling over health and wellbeing needs; Indirect negative impact on wider health and wellbeing, including increased risk of debt, poverty, alcohol misuse, substance misuse, issues at work and unemployment, homelessness, isolation and suicide.*

It includes a list of impacts:

> *For affected others and wider society – increased risk of domestic violence; damaged relationships with friends and family; crime; anti-social behaviour; criminal behaviour; cost to the NHS; cost to economy of increased unemployment.*

It is unclear on what basis this distinction is made between a direct and indirect negative impact on health and wellbeing or from what evidence or model it derives. Speculatively, it seems to be confusion in the application of the Gambling Commission definition and framework for gambling-related harms.[31] The meaning of 'health and wellbeing' is taken in a very narrow sense, so gambling is represented as directly impacting physical and mental health and then other harms indirectly impact health and wellbeing. Whereas in the framework, there are three broad categories of gambling harm – resources, relationships, and health – interacting with each other at the individual, interpersonal, community and societal levels. This interpretation also means the representation of harms to 'affected others' and society is partial and less than envisaged in the framework.

On the scale of the issue, the curriculum has a section on: "Harmful gambling and gambling-related harms in the UK". However, all the data specified relate to 'harmful (problem) gambling':

> Estimated number of problem gamblers in the UK; difference in estimated number of problem gamblers in England, Scotland and Wales; estimated number of gamblers in the UK at risk of developing a gambling issue; number of calls to National Gambling Helpline; statistics around children and young people participating in gambling activity; take-up of services to support those affected by gambling-related harms; launch of new services to support those affected by gambling related-harms.

The curriculum does not specify the inclusion of data on harms and socio-economic costs.

The **primary care competency framework (PCGS)** introductory sections present harm primarily in terms of health consequences for the individual: "problem gamblers have high rates

of physical and psychiatric comorbidity, which often provide the underlying reason for presenting in primary care". The concern is expressed that primary care teams do not address gambling due to "the problem being regarded by many as solely a social issue rather than a health issue". This harm to heath is described as resulting from individuals rather than as public health consequences from a gambling industry. It states: "Pathological gambling can have many diverse and unintended consequences" and lists physical and mental health conditions. It includes: "Unintended psychological consequences may also include intense levels of guilt and shame, deceptive practices, and heightened impulsivity and impaired decision-making. It adds a list of "social consequences": "strained interpersonal relationships, lost productivity at work, loss of job, financial problems, and issues with the criminal justice system (P.7). Presenting these without providing the context of harmful and addictive products and commercial practices risks perpetuating stereotypes and blaming the individual for harm. It states, "untreated problem gambling negatively impacts on the individual and their family while leading to significant burden on society" (P.5).

The **mindful resilience programme (YGAM)** primarily focuses on harm to the individual and their families. There is little to no discussion of harms at the societal, interpersonal, and community level or the legacy harms associated with gambling. Besides a role-play exercise in the training, there is little mention of the impact on affected others, particularly CYP as affected others. The signs of gambling harms listed are health, financial, relationships, leisure/social, and education.

The training addresses gambling-related suicide. It provides statistics on the number of gambling-related suicides per year in the UK and the increased risk of individuals considering suicide or having suicidal thoughts. However, it does not include anything specific on self-harm and suicidality in CYP. The additional resource document says:

> *In consultations, people with lived experience, whilst grateful their mood is discussed, report feeling the 'real problem', the one driving them towards suicide i.e., their gambling or gaming, is not being dealt with. They know medication is not going to resolve this and feel despair when there is no signposting support for their gambling or gaming.*

Despite this quote from lived experience that the 'real problem' is gambling or gaming, the resource then moves to co-morbidities and co-occurring experiences rather than the specifics of gambling-related suicide.

The training resource lists several co-comorbidities/co-occurring experiences with gaming and gambling. There is a section in the training on co-morbidities that states:

> *There may be conditions which can be exacerbated by gaming and gambling. For example, psychological/mental health issues e.g., mood disorders, anxiety, and depression, may create a need or want to escape from those negative emotions. Gaming and gambling can create these opportunities for mood modification and/or escapism. Narcissistic traits/grandiosity can relate to misattribution of skill. For example, they may feel that because they are 'special' they therefore win, or that they can outwit the system.*

Mental ill health and other conditions can contribute to gambling difficulties, but it is a bidirectional relationship, and gambling also causes mental ill-health. However, the document focuses on individual pathology causing individuals to over or misuse products. There is a table on 'co-occurring experiences or conditions that include depression, anxiety, ADHD, gender identity, trauma, and alcohol use', but there is no recognition within the statistics provided that gambling can cause (rather than be a consequence) of mental ill health – that these may be underlying comorbidities but are also harms from gambling. For example, it says, "drinking

whilst gambling can put people at an increased risk of gambling-related harm", but it does not also explain that people can increase their drinking because of the stress from gambling.

The intervention

This section looks at what healthcare workers are being trained to do, how the resources define who qualifies for help and how they should be identified, and what help and support should be provided – and the extent to which this supports a destigmatising, whole population, preventative approach to gambling harm.

Learning

Workers should be trained to screen and engage with people on any gambling participation to promote health for all and prevent harm. This is the point of equipping the generalist workforce and taking a public health approach. It is also fundamental to destigmatising gambling harm by being clear that commercial gambling products and practices cause harm.

There needs to be one screening tool for use by generalist healthcare workers. This needs to be designed to facilitate a discussion about any gambling, as a normal part of healthcare interactions, like with alcohol or smoking and other health behaviours.

- The problem with not having such a tool is shown in the resources recommending a variety of screening tools, potentially making how workers engage with people inconsistent.
- Many of the existing screening tools have a 'responsible gambling' approach baked in. They are about identifying a person with 'problem behaviour' that reaches high threshold. Everyone else is seen as gambling responsibly on 'everyday' products.
- The tool needs to be based on the understanding that any participation in gambling involves risk of harm and harm occurs across a spectrum.

Healthcare workers need to be trained to engage and provide information about the risks and harms of any gambling participation.

- The further information for healthcare workers and which they give to patients needs to be consistent, clinically sound, informed by lived experience and not stigmatising.
- The fact that there are not coherent health messages about gambling from government makes the task of generalist healthcare workers hard. The healthcare workforce should be supported by general public awareness of gambling as addictive and harmful and concrete information on 'lower risk' limits.

Screening

Overall, the resources aim to equip healthcare professionals to undertake some form of gambling screening, on which to base further action. Brief screening instruments are important for the prevention and early identification of gambling difficulties. Standardised screening tools can provide more accurate information for the person being screened and can be useful for a

generalist who does not have specialist knowledge. However, there is no single accepted gambling screening tool for use in generalist settings.[82] This poses a challenge for consistent action to prevent gambling harm by generalist healthcare workers. It is reflected in the resources recommending a variety of tools. Nonetheless, the choices a resource makes about what screening tools to recommend and what intervention is related to which screening result reflects how the resource has conceptualised the issue.

Many of the existing instruments are designed to identify 'problem gambling' or 'gambling disorder' at the clinical level, and a few can identify 'at-risk' gambling or a spectrum of harm[83]. Focusing on identifying those meeting a clinical criteria follows a 'responsible gambling' approach, which constructs the issue as one of a small number of 'pathological individuals', in a category distinct from the rest of the population who gamble 'responsibly'. People can still experience gambling harm that might not be 'clinically significant' and experience harm without any indication of behavioural dependence.[84] People engaged in any level of gambling have a risk of experiencing harm and developing addiction, even if their gambling is currently at a low level. Using screening tools with structured parameters of strict categories may be helpful from a clinical standpoint, allowing for quick identification of which individuals require a referral and which do not. But in terms of adopting a public health framework, they do not allow healthcare professionals and other frontline workers to achieve the fundamental aim of prevention and early intervention. They do not facilitate a discussion about any gambling, as a normal part of healthcare interactions, like with alcohol or smoking.

Using screening tools with categories such as 'problem gambler' and those who are gambling 'responsibly' or described as 'non-problem gambling' can cause significant stigma and shame for those experiencing gambling harm. This categorisation acts as a barrier to getting and seeking early help. The items on such screening tools consistently emphasise individual responsibility, framing the issue as one of personal control and 'problem gamblers' who manifest symptoms of impaired control. For example: "when you gambled, did you go back another day to try to win back the money you lost?" (PGSI). Using these screening tools could reinforce stigma and leave the person feeling judged or blamed. In addition, individuals could see the terms used in the tools "pathological gambling", and "problem gambler". Less stigmatising attitudes could be encouraged by using a screening tool that emphasises a continuum of symptoms (or harms) rather than a dichotomous diagnostic category. For example, tools such as the short gambling harms screen (SGHS)[85]. Although these are recently developed, it has been noted that such tools currently lack robust psychometric testing outside of initial validation.[86]

Both the **brief intervention guide (GambleAware)** and **eLearning tool (RSPH and GambleAware)** provide as screening instruments the Lie/Bet questionnaire[87], the NODS-Clip Short Problem Gambling Screen (NODS-CLIP)[88], and the Problem Gambling Severity Index (PGSI).[89] These tools have been designed to screen for 'pathological' and/or 'problem gambling'.

The drawback of suggesting using the Lie/Bet questionnaire as the initial screening tool is that it does not pick up on people 'at risk', only "pathological" gamblers. This is because the two-item screening tool was developed to identify those experiencing a gambling disorder as diagnosable using the DMS-5. As a result, The Lie/Bet two-item screening instrument has been shown to be able to detect "problem gambling" as measured using the PGSI. However, it is not able to satisfactorily detect low or moderate-risk gamblers".[90] After completing the Lie/Bet questionnaire, it says 'No' response to both questions: No referral necessary to problem gambling services". Similarly, with the second screen provided – the NODS-CliP Problem Gambling Screen, if "Yes to one or more" of the options provided it says, "Further assessment is advised. Refer to www.begambleaware.org or the National Gambling Helpline: 0808 8020 133" and if you say, "No to all"- "No further assessment is needed." This means that in both guides,

an implicit assumption is that those who do not reach the threshold are free of experiencing gambling harm.

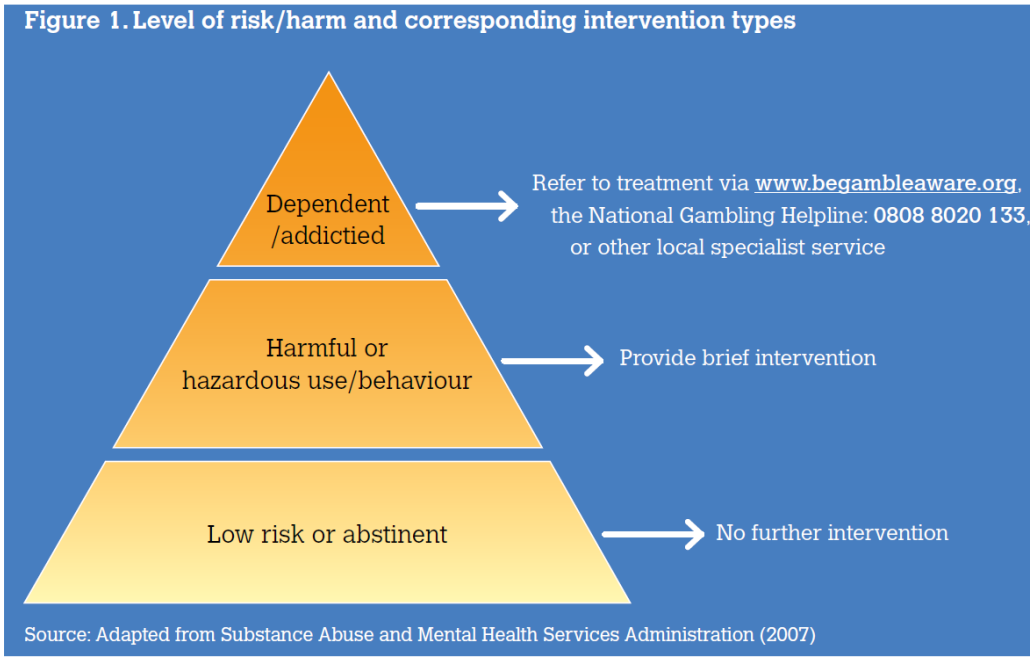
The **brief intervention guide (GambleAware)** suggests "where workers have time and an ongoing relationship with the service user it may be optimal to use a tool that provides information about presence and levels of problem (e.g., AUDIT or ASSIST); where there is limited time a short screen such as AUDIT-C which focuses on the presence/absence of a problem may be more appropriate." (P29). This has been taken directly from the original guide (2012) and refers to the following tools: Alcohol Use Disorders Identification Test (AUDIT); Alcohol Use Disorders Identification Test – C (AUDIT – C); Alcohol, Smoking and Substance Involvement Screening Test (ASSIST). These are not relevant to gambling, and the brief intervention guide users are not provided with information on how to adapt these tools to gambling.

The screening process results "assist the worker to determine whether intervention is required and the level of intervention that is likely to be of most benefit to the person". Both the **brief intervention guide (GambleAware)** and **eLearning tool (RSPH and GambleAware)** use a triangle figure to map the level of risk/harm and corresponding intervention types. This specifies that if the screening results indicate that the individual is:

- "Low risk or abstinent, no further intervention is required"
- "Harmful or hazardous use/behaviour" to provide a brief intervention
- "Dependent/addicted" refer to treatment via www.begambleaware.org, the National Gambling Helpline: 0808 8020 133, or other local specialist service.

The guides do not delineate/clarify the difference between 'harmful or hazardous use/behaviour' and 'dependent or addicted'. Further, it is unclear how GambleAware has determined which level of gambling 'risk or harm' in gambling screening tools maps onto which category of the 'triangle'. Both the **brief intervention guide (GambleAware)** and **eLearning tool (RSPH and GambleAware)** provide the PGSI, with its three levels, but it is unclear what score links to what outcome (i.e., refer to specialist treatment or provide a brief intervention). In addition, the terms "harmful or hazardous use/behaviour" and "addicted/dependent" could be seen as stigmatising, by labelling the person and blaming their 'use' of gambling. There is also the assumption that gambling is an everyday leisure activity, so if someone is currently gambling and is in the no/low-risk category, this does not require any discussion about risk and harm.

Figure 1 (Level of risk/harm and corresponding intervention types) is referenced as being adapted from the Substance Abuse and Mental Health Services Administration (2006). However, it appears to have been adapted from a Substance Abuse Treatment Intervention Protocol (TIP)[91,92] published in 1999 – and adapted from a 1990 figure. The original figure appears more acceptable as it suggests primary prevention rather than no intervention, and healthcare professionals have the perfect opportunity to provide this.



There is contradictory information provided in the **eLearning tool (RSPH and GambleAware)** Topic 3: How to Provide a Brief Intervention 'Screening tools section' says if you answer yes or no to one or both questions on the Lie/Bet questionnaire, then "further assessment is needed. Refer to www.begambleaware.org or the National Gambling Helpline: 0808 8020 133". But in the video example – the person answers 'yes' to one of the lie-bet questions and it says to Provide feedback and brief advice.

The **level 2 award curriculum (RSPH)** provides indicators of harmful gambling and tools available to identify whether an individual is either engaged or at risk of engaging in harmful gambling. The screening tests included are the GamCare self-assessment tools, the Short Gambling Harm Screen and the PGSI. This choice of tools shows concern for the range of harm and prevention and early intervention.

The GamCare Self-assessment tool can be taken online[93], meaning people may be able to answer the questions privately. The GamCare website states the test is designed to "pick up on any early signs of risky gambling behaviour". You can "take the online assessment to find out how much of an impact gambling is having on your life". It says that individuals will receive detailed feedback based on their answers and links to additional resources. The GamCare self-assessment uses GamTest, by Sustainable Interaction in Sweden. GamTest was developed with:

> *the goal of measuring early sign of over consumption and negative consequences in relation to gambling and to give relevant feedback to motivated problem and risk gamblers to make changes to their gambling behaviour.*[94]

Its purpose is to assess gambling harm specifically and to allow for more cost-effective early intervention to reduce gambling-related harm. Although, recent research has argued that this scale could benefit from being adapted to better suit different types of gamblers, including those with lower levels of spending.[95]

Similarly, the Short Gambling Harm Screen[96] has been developed to target harmful outcomes of gambling, rather than risky, uncontrolled, or 'problem gambling', and can identify significant health decrements at low levels of harm.

The **primary care competency framework (PCGS)** states: "validated and easy-to-use screening tools are available for use in primary care but are not currently adopted", and the use of screening tools is included in several of the competencies. But it does not indicate what these are.

The **mindful resilience programme (YGAM)** says that when providing assessment, the focus is to offer a responsive identification of harm and access to treatment and states that "evidence has shown that [by] assessing, whether it be a formal screening tool, a conversation or a combination of these, more individuals are identified than if we wait for them to disclose". The healthcare professionals are encouraged to ask the CYP what they are doing, why they are doing it, how it impacts them, and where they are in the process of change/spectrum help-seeking. This has the potential to normalise and facilitate general discussions about gambling in interactions.

However, the programme provides healthcare professionals with a resource containing several screening tools and classifications. The tools provided are for the measurement of clinical behavioural disorder or distorted cognitions, rather than harm. In addition, there is a general lack of guidance on what screening tools should be applied.

- It provides criteria and classifications for Internet Gaming Disorder (ICD-11 diagnostic criteria and DSM-5 criteria and classification), and Gambling Disorder DSM-5 Criteria and Classification.
- The screening tools it uses are the Lie/Bet questionnaire. It also provides the short-form Problem Gambling Severity Index (PGSI-mini screen), the Problem Gambling Severity Index (PGSI) and the Gambling Related Cognitions Scale.
- It provides screening tools for gaming including the Gaming Disorder Test, Internet Gaming Disorder (IGD 20) and Classification, and the Gaming Disorder Scale for Adolescents.
- Importantly, the resource lists the Diagnostic Statistical Manual-4-MR-J, a revised version of the DSM-4 screening instrument applicable to adolescents.

The help to be provided

Healthcare professionals will provide an individual-level intervention, which inevitably includes changing a person's behaviour. Nonetheless, the way in which this is done can be empowering or perpetuate stigma and harm. If professionals are trained to respond to the issue solely as one of personal responsibility and choice, the person is the problem. Not understanding the addictive and harmful nature of gambling industry products and practices is stigmatising and undermines primary prevention and support effectiveness. This also does not acknowledge the whole person, their wider lives, and their socio-economic context.

The way in which the **brief intervention guide (GambleAware)** and **eLearning tool (RSPH and GambleAware)** instruct professionals to help people overwhelmingly depicts the issues as one of personal responsibility. People, their choices and behaviours are the issue, and people need to make better decisions.

The guide and tool set out an approach to brief interventions, combining FRAMES (feedback, responsibility, advice, menu, empathy, self-efficacy) with motivational interviewing and the 'stages of change' model. Both are well-established approaches to brief interventions and behaviour change. In general, these aim to produce an empathic interaction that enables a

person to identify their behaviour and gives them tools and self-belief to change this in line with their values and goals. Such confidentiality, respect, and affirmation of individual agency are important in the context of gambling harm.

However, the way these approaches are presented in the guide and tool, without acknowledging the addictive and harmful commercial gambling products and practices, replicates the industry discourse of 'responsible gambling'. For example:

> *The purpose is to support the person to think about their behaviour, assisting them to make a connection between their behaviour and any associated risks and harms.*
>
> *The results of a screening process provide an opportunity for a service user to consider the effects of gambling on their lives.*
>
> *The responsibility for choices and change sits with the person. It is not the role of the professional to confront or persuade.*

"Responsibility sits with the person" is repeated at every intervention stage.

The content of the supporting information and tools provided may also shape how healthcare professionals engage. These materials repeat the notion that individuals are responsible for the harm they experience, and they need to get themselves in check through "positive affirmation", information resources, self-exclusion and other blocking tools, and self-discipline tips – mirroring responsible gambling messages and tools promoted by the gambling industry. The guides have a list of "organisations that provide help and advice". In the brief intervention guide, this responsible gambling approach is explicit in the contact details for GambleAware:

> begambleaware.org – A website that advises on gambling responsibly – this means making choices based on all the facts and staying in control of how much time and money you spend (P.37).

Although, in the e-Learning version, the language in this section has been updated to "this organisation provides information to those with Gambling Disorder and affected others experiencing gambling harms to make informed decisions." Both resources include the 'The Money, Access, Time Triangle' and state:

> *An effective way to reduce or stop gambling is to put barriers in place that limit your ability to gamble – specifically barriers to Money, Access and Time. No barrier is infallible but if you have the right barriers they can certainly slow you down enough for you to take a look at what you're doing and decide whether or not you really want to do it.*

The resources contain the same 'scripts', with suggestions for how the worker could discuss the screening results. These represent harms that are the consequence of addictive commercial products and practices as failings of the person. For example:

> *Effective budgeting can restore an understanding of the value of money, and it may also help to improve a negative financial situation brought on by gambling… If you're budgeting effectively you'll be able to inform the person managing your finances of exactly how much you will need on any given day and receipts can be provided as evidence of your purchases* (P.34).
>
> *Explore the type of things that interest you and in particular things you can enjoy doing with friends or family members rather than seeking isolated pursuits. You may also want to look at projects you can undertake such as*

decorating a room or working on the garden. Ensuring that you are engaging with a routine can be very helpful so include yourself in day-to-day tasks around the house so you feel like a valued part of family life. Filling time with positive activities away from gambling can help you to feel productive and healthy and it can strengthen relationship bonds that have previously been neglected (P.34).

The scripts take for granted that gambling should be ubiquitous and that people should have to limit or even exclude themselves from social, digital, and financial access to avoid it. For example:

> *Avoiding places with a high density of betting shops or casinos can be helpful so take care to plan your route before heading out the door. A little planning goes a long way when it comes to avoiding unexpected triggers like the sight of a flashing casino sign. …. If you gamble on a phone or iPad please contact your network provider to discuss the possibility of setting up parental controls to exclude gambling sites. If all else fails, you may need to consider the possibility of getting a low spec phone capable of making and receiving calls, and not having a computer for a while"* (P.34).

> *Ask a friend or family member to take control of your finances during the early stages of recovery. This can be done by giving away any debit or credit cards you may have (If you've memorised the card numbers be honest about that and get replacements before you hand them over)* (P.35).

Universal public health messages that gambling is harmful and addictive and how to limit risk, with clear guidance as to what low-risk gambling[97] looks like, are useful for primary prevention. But because these resources start from the basis that gambling, in general, is a harmless leisure pursuit. Meaning that if someone is engaged in gambling but not seemingly showing any risk or harm, there is no need for a preventive conversation. This is especially perplexing for a tool produced by the RSPH using a MECC model.

Meanwhile, messages about managing behaviour and low-risk gambling are insufficient once people have begun progressing further into harm and towards dependency – when telling them to 'control themselves' is ineffective. Rather these messages are counterproductive and harmful as they blame people and create stigma and shame, which stops people from asking for help.

Those experiencing addiction and dependency are to be referred to begambleaware.org or the National Gambling Helpline, or National Gambling Treatment Service. However, it is unclear how a referral differs from signposting or whether this adequately enables access to specialist clinical services. In addition, there is no component on screening for suicidality, despite the high association of suicidality with the experience of gambling addiction.

Unlike the brief intervention guide (GambleAware)s, the **level 2 award curriculum (RSPH)** includes social support from peers, family, and peer mentors, in addition to using the FRAME model and signposting towards services. Further, it has a section on "barriers to changing behaviour with regard to harmful gambling and how these can be overcome":

> *Barriers such as denial; stigma; lack of knowledge and understanding around gambling-related harms and their impact on the individual and affected others; addiction / physical dependency; difficulty in changing ingrained behaviours; peer pressure and culture; impact of gambling-related harms often not as visible to an observer as the impact of other harms to health; gambling-related harms often coexist with and contribute to other harms to health; distorted*

> *view of their chances of winning. Methods for overcoming barriers such as education, aspirations, opportunities, motivation and self-efficacy.*

Depending on how this is implemented in training, this has the potential to enable the worker to see and support the person considering their social context and life circumstance, and the dynamics of gambling addiction and stigma – using a 'whole person', 'asset-based' and 'recovery-orientated' approach.

The **primary care competency framework (PCGS)** "why now" (p.6) section explains the opportunity of addressing gambling harm in primary care and in the context of integrated care systems focused on prevention and population health. The introductory sections do not include any information on gambling as a public health issue requiring a preventative or a whole-population approach. But the competencies themselves do appear to recognise the full range of actions, from health promotion to clinical treatment.

Competency 1 refers to gambling harm in general, rather than gambling disorder – while this is not explicitly stated or clear, it seems this may refer to non-clinical or lower-level harm. It covers opportunistic brief interventions and motivational interviewing, an attitude which is 'non-judgemental' and which "normalises conversations around gambling with patients".

Competency 7 is "being able to assess the need for, organise and deliver health promotion to patients and the wider population". This includes education and training of colleagues – so potentially building skills across a primary care network. It includes working with other professionals to improve health in the area.

The remainder of the competencies are concerned with diagnosis and treatment: competency 2 is about screening for gambling disorder and referral to treatment, 3 is needs assessment, 4 is assess and manage relevant risk, and 6 case management.

The introductory sections and competencies address multidisciplinary teams, working with non-health professionals and connecting to mental health and secondary care specialist input and services. The need to provide assessment and care in relation to gambling and physical and mental health, other addictions, family, relationships, finances, violence, and criminality is included across competencies. For example:

> *3SA: ability to be flexible and holistic in approach to patients to deal with the interplay of physical and mental health, employment, relational, educational, criminal, and social issues impacting on them.*
>
> *3SC: ability to carry out detailed history of gambling problems and activities"* (P.17).

Treatment includes barriers to gambling (financial, self-exclusion), a range of psycho-educational interventions (cognitive strategies, behavioural strategies, value-based strategies, emotionally focused strategies, relapse prevention management strategies, relational strategies, and mindfulness), and pharmacological interventions. It includes the co-production of care plans, self-care, and relapse prevention. The competencies also reference "awareness of the role/importance of peer mentors in recovery processes in gambling disorders" (4KH) and "encourage the creation of network of peer support and experts by experience (7AC).

The key elements of the **mindful resilience programme (YGAM)** are conversation, assessment, and next steps. The objectives of putting Mindful Resilience into practice include enhancing how healthcare professionals' approach CYP in conversation, risk assessing CYP participation in gambling/gaming, knowing how and when to respond, and knowing where to access available resources and signpost CYP. Mindful resilience thus seems to be describing a

brief intervention, which may be confusing as mindful resilience is usually a description of a particular therapeutic tool.

The help is framed as understanding why gambling/gaming may appeal to CYP, what impact it is having on them, and where they are in the process of changing or help-seeking. The programme says, "not everyone will have challenges, but it is important that risks are dealt with at all levels" and "[gambling/gaming difficulties] are not fixed… this highlights the importance of asking everyone". It states that it is important that CYP feel seen and heard, the support they receive is age appropriate, and they are engaged non-judgementally. Healthcare professionals are encouraged to consider protective factors when they speak to CYP, although no protective factors for gambling have been listed in the training materials. These protective/positive factors are presented as having value for CYP gaming, but this framework is not applicable to gambling in CYP.

When healthcare professionals are assessing CYP the goal is to:

> *offer responsive identification of harm and access to treatment, ensure that appropriate support is offered and accessed through informed discussion and a considered response, to avert crisis and suicide by screening and co-working through services.*

After the initial conversation, healthcare professionals are encouraged to 'make a plan' with the individual. The plan should be collaborative and balanced, and barriers should be identified.

The training programme recognises that due to reasons such as work constraints, some healthcare professionals may be limited in time and suggests different actions based on the time they have with the CYP. If the healthcare professional has more time, they are encouraged to work on actions and goals and engage with the individual about the signposting material and treatment support services. It also highlights the importance of arranging a follow-up meeting with the CYP.

The healthcare professional must determine the level of risk/harm to the individual ("OK or minor" vs "major and problematic"). However, it is not clear how this is decided (i.e., whether through the conversation, application of a screening tool, or both). For either categorisation, the training recommends education. This is important because if a CYP up to age 25 is engaged in any gambling, then because gambling is harmful and addictive, this is an indicator of risk. There is no precise level at which point this behaviour will move from risk to harmful but it will depend on several factors, including frequency, type of gambling (e.g., high event frequency), involvement with multiple types of gambling games, so it is important that education is provided to them.

However, in terms of education, signposting, and next steps, it is not clear exactly what preventative information is to be provided, where to signpost the individual or how to get them into treatment. If the CYP's gaming or gambling is deemed to be "Ok and minor", the outcome in the additional resource document suggests that the signposting options are "schools, parents/carers, teachers". The training is aimed at supporting those up to 25-years - so this signposting may not be applicable. If the CYP level of risk/harm is assessed as "major and problematic", the action advised is to give the CYP education and treatment. The options/signposting for education include school, parents/carers, and teachers, youth groups and community support. But it is unclear what the youth groups and community support are. Treatment includes "addiction" and "self-referral services". There is a list of available support organisations, but not many of the available organisations appear to be specific to CYP. The training does not specifically discuss exclusion tools or blocking tools, but information for these is provided in the 'Support Options and Signposting for Gaming and Gambling Related Harm' section of the additional resource.

Different groups

This section looks at to what extent the resources consider the needs and experiences of different groups of people. In particular, it is concerned with whether resources:

- Equip healthcare workers to identify and support people who are affected by the gambling of another person.
- Address how the experience of gambling harm, stigma and discrimination is influenced by socio-economic position, gender, ethnicity, culture and social group, amongst others.
- Enable workers to engage with children and young people on gambling harm.

Learning

Training needs to equip healthcare workers to identify and support 'affected others' as much as people who gamble. This is necessary for public health to address the full extent of harm from gambling.

- Material needs to address affected others 'in their own right' and not only in terms of the relationship harm experienced by the person who gambles or as a support to them.
- Material should avoid making affected others 'take responsibility' for the gambling harm. A key driver of harm, stigma and shame is that the person is made to the person's gambling is their responsibility or fault, and they are left to deal with the consequences.

Conceptions of 'vulnerability' or 'high risk' groups should not be used is used as an alternate form of representing gambling harm as an issue of a few individuals, while most gamble safely, so gambling is safe.

- There needs to be clarity on the difference between a group being affected more because this group participates more, higher rates of dependency or addiction despite lesser gambling participation in a group, or greater harm.
- Targeted interventions and information tailored to the specific dynamics of gambling harm, stigma and discrimination for specific groups should be available. This needs to go beyond generic acknowledgement that the experiences differ socio-economic position, gender, ethnicity, culture and social group. But this needs to take place alongside universal prevention and health promotion.

Training needs to equip healthcare workers as an important resource to address gambling harm for CYP, as much as the education sector. CYP have specific experiences and needs because of their lifestage. They are fundamental to public health to prevent lost life opportunities, entrenched addiction and life-long harm.

- Gaming is ubiquitous among CYP and so can be a way into engaging with CYP on gambling. However, gaming and gambling should not be conflated. This can minimise the risk and harms from gambling to CYP.

People affected by other's gambling

'Affected others' are harmed by gambling 'in their own right', have their own needs for help and support, and experience stigma and discrimination. The harms extend beyond strained relationships to the full range of harms – physical and mental health, financial, housing, work, social connectedness, and crime. The harms extend out through families and friends. Further, these harms and needs can differ depending on the type of relationship they have with the person with gambling difficulties (for example, partner, child, parent, friend).[98] The extent to which resources equip healthcare professionals to identify and support affected others is somewhat limited. Affected others tend to be discussed as those the 'gambler' harms with their 'problematic behaviour'; the focus is on relationship issues rather than the full range of harms to affected others. Alternately they are included as a source of support for the person, without consideration of what this entailed for them.

A recent scoping review of brief screening tools being used in health or adult social care settings found that there was limited evidence of brief screening tools being used to identify affected others and no evidence of a gold standard for such a screen.[99] They note that this limits health and social care services in identifying affected others at risk of experiencing gambling-related harm. They report that GamCare made screening questions relevant to affected others by adding 'or someone close to you' or 'someone else', but there is no evidence about which services are using these screens, their acceptability for staff and service uses, or their accuracy at correctly identifying affected others. This issue is evident in the resources and limits all healthcare workers and other frontline staff in identifying affected others.

There is little information in either the **brief intervention guide (GambleAware)** or **eLearning tool (RSPH and GambleAware)** relating to affected others. The brief intervention guide provides a statistic for the number of people affected by another's gambling: "an estimated 5-8 other people are affected by someone else's gambling problem." (P.5) (no source provided). However, neither resource discuss the range of harms affected others experience or needs they have – only how they struggle to 'cope' with another's gambling or the damage this causes relationships. For example, in the added section of the **eLearning tool (RSPH and GambleAware)**, relationship harms states, "the impact of someone else's Gambling Disorder can be very stressful for friends and family members. Relationships can become strained and break down".

The **brief intervention guide (GambleAware)** and **eLearning tool (RSPH and GambleAware)** include the 5-Step Method[100] for helping and responding to family members – providing generic information taken from substance use (P.5). There are no screening methods or suggestions for identifying harm being experienced due to other's gambling.

Both the **brief intervention guide (GambleAware)** and **eLearning tool (RSPH and GambleAware)** refer to self-help materials to assist families: 'https://gamblinghelpline.co.nz/data/media/documents'. However, a recurring theme for both guides is the use of resources and external links copied directly from the original Brief intervention guide by Matua Raki. As a result, these resources are a) from New Zealand and b) the link no longer works. In addition, the resources direct people to: "material aimed to support family and friends who are concerned about someone else's gambling. This material is available at: www.begambleaware.org". But this material is not immediately evident on the website and appears hard to navigate. There are sections on "Understanding someone who gambles"[101], "Looking out for you"[102]-, and "How to help someone who gambles".[103] It is unclear what evidence this advice is based on or how it has been developed.

These sections do not refer to 'problem gambling', rather using 'gambling disorder' and explaining this is a medical condition.

> *Understanding that gambling is an addictive behaviour, and that gambling disorder is a recognised medical condition, can be important in helping you to understand why someone might be behaving in a way that can feel hard to explain".* [104]

However, there is no content on harmful and addictive commercial products and practices, content continues to frame resolving gambling difficulties as a matter of individual control and tends to represent people harmed by gambling in a negative way. The sections state that the 'affected other' should not blame themselves; it is "not their responsibility to change behaviour". Yet the way the website makes statements or suggestions may have this effect.

For example:

> *When someone starts to want to change their gambling behaviour, there are often different stages that they move through…. Gambling disorder is a relapsing condition, so it's possible that someone trying to control their gambling might start gambling again. If this happens, try not to feel disheartened. A lapse can be a way of finding out how to adjust the plan to stay on track.*[105]

Or:

> *Avoid rewarding gambling behaviour: Giving or lending money to someone who gambles could make their problem worse. Instead, think about setting up a system that rewards positive behaviour instead. For example, you might consider not lending money if they continue to gamble, however, if they cut back or stop gambling you could offer to conditionally help to pay off a bill.*[106]

As another example, it states:

> *It can be really difficult to know if someone is struggling with gambling, as sometimes it's hard to see the physical effects of someone who's gambling too much. People sometimes say they feel that they should have noticed sooner, but remember the person gambling may have gone to great lengths to hide it from you – especially if they have feelings of guilt or shame.*

This follows a section which tells people to "Be aware of the signs", with a list of signs that is blaming and stigmatising of the person who gambles, and things that may well be difficult for those around them to know:

> *You might not want to believe that someone you know or love is having difficulties with gambling, but you may have noticed them acting differently. Here are some signs to look out for:*
>
> - *They're spending more money and time on gambling than they can afford*
> - *They find it hard to manage or stop gambling*
> - *They have arguments with family or friends about money and gambling*
> - *They've lost interest in usual activities like spending time with friends or family*
> - *They're always thinking or talking about gambling*
> - *They lie about gambling or hide it from other people*
> - *They chase their losses or use gambling to get out of financial trouble*
> - *They gamble until all their money is gone*
> - *They borrow money, sell possessions or avoid paying bills in order to pay for gambling*

- *They gamble with larger amounts of money or for a longer amount of time*
- *They neglect work, school, family, personal needs or household responsibilities*
- *They feel anxious, worried, guilty, depressed or irritable.*[107]

The advice on "Looking after yourself" says "Self-care is super important, as it will help you to cope better in difficult circumstances". The tips include:

> *Relax – Be kind to yourself and make some time for you. You could read a book, treat yourself to a massage, or run a hot bath and forget about everything else just for a moment.*
>
> *Healthy body, healthy mind – Difficult emotions can make it easy for us to reach for the kitchen cupboard, but sugary foods, fatty snacks or alcohol won't help you feel any better in the long run. Try filling your body with foods that you know are good for you – they'll make you feel good too."* [108]

Self-care is important for affected others, but this content does not acknowledge the depth and range of harms an 'affected other' may experience or the extent of help they need – and may even make people feel to blame for their own harm because of not being able to 'relax' and have a 'health body and health mind'. Further, it recommends taking control of finances, creating a realistic budget, and monitoring the post, without any recognition of the stress and additional burden involved in this.[109]

The out-of-date "Organisations that Provide Help and Advice" section of the brief intervention guide has been updated in the eLearning tool. But it does not include a specific section for affected others. Where support organisations also support affected others, this is mentioned (BCT, ARA, NGTS), along with Gam-Anon.

The **level 2 award curriculum (RSPH)** includes minimal content on affected others. Affected others are included as part of the wider damaged caused by 'harmful/problematic/disordered gambling':

> *Harmful gambling (also known as problematic or disordered gambling) defined as the urge to gamble continuously despite harmful consequences or desire to stop, causing harm to the gambler and to affected others.*

According to the curriculum, training material should also discuss "take-up of services to support those affected by gambling related harms; launch of new services to support those affected by gambling related-harms."

The **primary care competency framework (PCGS)** introductory sections have passing reference to the harm caused to families by "problem gambling". The competencies do include the "ability to assess the need of patients' families and others as appropriate" (3SF, P.17) – although it is not clear what support should be made available to affected others. Competency 5 (P.18) includes a range of issues potentially impacting on affected others: "An understanding of the wider impact of gambling on the family, hidden harm to children and the impact of intergenerational gambling" (5KB); "protecting finances from gambling" (5KE); "screening for interpersonal/domestic violence" (5SB) and "financial exploitation to the patient or from the patient". However, this is in the context of risk management of the person with gambling difficulties and working with other agencies rather than identification and provision of care to affected others.

The **mindful resilience programme (YGAM)** provides a definition of affected other(s) in its resource glossary: "Those in an individual's network who are impacted by gaming/gambling".

There is a brief reference to the harm caused to families in a quote from Professor Henrietta Bowden-Jones OBE: "Gambling disorder is a mental health condition which can have a hugely debilitating effect on people's lives, both for the patient and their families who can be left utterly helpless".[110]

Otherwise, affected others seem to be included in so far as they are a support to CYP. It states that "there are some factors which may cause a CYP to be more vulnerable" and lists "network of support – affected other" although it is unclear what is meant by this. The training provides a roleplay exercise between a GP and a parent of a child who is experiencing difficulties with their gaming. There is no information on how healthcare professionals can help CYP who are experiencing gambling harm as affected others (due to the gambling of someone close to them).

The 'support options for gaming and gambling related harm' section includes various organisations and highlights whether these provide support for people affected by another's gambling, including BeGambleAware, GamAnon, and GamCare/National Gambling Helpline, YGAM Parents hub, YGAM Student Hub. However, most of the services/organisations listed do not offer support specifically for children affected by another's gambling – except for Big Deal (https://www.bigdeal.org.uk/) and the Young People's Support Service, provided by GamCare. In addition, the resource provides information on general organisations to support children such as Action for Children, NSPCC, Childline, Young Minds.

Diversity and inclusion

Anyone can become addicted to or be harmed by gambling because it is an addictive and harmful activity. But this experience is influenced by socio-economic position, gender, ethnicity, age and so on. This means there is a need for targeted interventions tailored to specific higher risk groups. But this needs to take place alongside universal prevention for the whole population.[111]

Where there is an apparent "public health approach" without changing the underlying 'responsible gambling' conception, the focus becomes on mental illness or other 'vulnerabilities' as the cause of gambling harm. In this way, 'vulnerable groups' is used as an alternate form of saying the issue is one of a few individuals, while most gamble safely, so gambling is safe. In addition, there is confusion in the evidence on 'higher risk' or 'vulnerable groups' and how this is understood. For example, historically, far more men than women have experienced gambling difficulties, but that is because they were far more likely to gamble, and when participation is considered, rates are largely the same. On the other hand, some groups are likely to experience disproportionately more gambling difficulties – participation is lower, but people are more likely to experience difficulties if they do gamble. Further, there is confusion as to whether the figures are about the greater risk of dependency or addiction in the group or whether greater harms occur from gambling participation or dependency for them. These issues are all reflected in the resources.

Both the **brief intervention guide (GambleAware)** and **eLearning tool (RSPH and GambleAware)** state that "people experiencing gambling problems may be over-represented in certain groups, e.g., young men, some minority ethnic groups.". This is true, but it needs to be highlighted to healthcare workers that gambling can harm anyone. In the eLearning guide, the imagery accompanying the gambling statistics shows only white men and predominantly focuses on online betting. This may reinforce preconceptions about whom is affected by gambling harm.

The resources briefly touch upon working in different cultural settings. However, this is generic advice that does not include anything specific regarding gambling harm in different ethnic or cultural groups.

The **level 2 award curriculum (RSPH)** usefully specifies: "Recognition that whilst certain groups and individuals are more at risk of harmful gambling and gambling-related harms, they can affect anyone" (section 1.1). But it does not specify any information on the dynamics of gambling harm in different groups.

The **primary care competency framework (PCGS)** introduction sections say that:

Wider public health research gives a clearer picture of those who are likely to be more vulnerable to gambling harm which includes ethnic minorities, low IQ, youth, and those with poor mental health or substance misuse issues" (P.7).

It does not include that anyone who gambles is vulnerable to addiction and harm, as gambling is addictive and harmful. The competencies include: "appreciate the cultural, religious and language issues and barriers" (3AC). It does not specify how this may influence the experience of gambling harm.

The **mindful resilience programme (YGAM)** importantly states, "not everyone will have challenges, but it is important that risks are dealt with at all levels" and "It is not fixed… this highlights the importance of asking everyone". It briefly touches upon "environmental risk factors" to consider, which include cultural/religious beliefs and socio-economic background" but does not specify any further information on harm within these groups. The additional resource lists 'co-occurring experience or conditions' and says, "there may be conditions which can be exacerbated by gaming and gambling". One listed is gender identity, and the resource provides statistics on transgender adolescents showing a significantly higher prevalence of gambling harm than their cis-gendered peers.

Children and young people

Children and young people have particular risks and needs due to their life-stage, and also are important to engage with them to prevent harm and addiction, which may damage life chances and continue across the life course. Overall, there is little in the resources on healthcare workers as a support for children and young people, either concerning their own gambling or as 'affected others'. It seems that young people are largely being addressed separately in 'education' and 'youth work' spaces, rather than through health workforces. In this regard, a programme focused on health workers supporting CYP – such as that by YGAM – is important.

Young people are mentioned on several occasions within the **brief intervention guide (GambleAware)** and **eLearning tool (RSPH and GambleAware)**. However, there is little information on how best to apply the guide when working with young people. It states:

> *Where appropriate, specific tips are provided for working with young people. Those working within youth service settings or youth-focused roles are encouraged to use a resource tailored specifically for working with young people.*

But there are no directions on which resources should be applied for young people or to youth-specific support services. The three 'specific tips' provided include ones which are arguably equally applicable to adults.

> With young people: It is generally important to develop rapport before you introduce the issues i.e., by talking about topics other than gambling. Clarity about confidentiality is especially important to develop trust.

Another is:

> With young people: don't discount or minimise the young person's experiences of the good things about gambling. Let them talk about the good things before gently guiding/inviting them to explore the downsides. Avoid coming up with the downsides, let the young person tell you from their own experience.

Both resources say, "With young people: Use a screening tool or process that has been validated for use with young people, for example, The Substances and Choices Scale (SACS) available at www.sacsinfo.com". The screen that it links to is a brief screening and outcome measurement instrument for assessing and monitoring the use and impact of alcohol and drugs in young people. This has been taken from the original Matua Raki guidance. It has not been updated to provide a screening tool specifically designed for young people and gambling, of which a number are available.[112]

The **level 2 award curriculum (RSPH)** does not specify much regarding children and young people. It says that the training should provide statistics about children and young people participating in gambling activities and discusses gambling-related activities that are not legally recognised forms of gambling (such as loot boxes) which may be helpful for young people. The curriculum does not mention a young person-specific screening tool. It does mention providing information for Big Deal – which gives "targeted support for young people, either for themselves or someone they care about".

The **primary care competency framework (PCGS)** does not specifically address identification or care for children and young people.

The **mindful resilience programme (YGAM)** is unique in that it has been designed for healthcare professionals working with CYP aged 25 and under. However, throughout the training, the statistics are predominantly related to children aged 11 – 16. There is a reference

that includes gambling harm in both undergraduate and university students from a 2019 report, but this does not specify the participant's age.[113] The programme does highlight that conversations between the individual and healthcare professional needs to be age appropriate. The only specific dynamic discussed in relation to the CYP is the brain, the front lobes and the limbic system. There is no mention of life stage, exposure, and social factors (such as leaving home, becoming independent, transitioning into adulthood, and access to money for the first time etc.). The training largely focuses on individual factors and their choices. For example, "there could be a lot of change depending on lifestyle and other factors". It also discusses the gateway hypothesis as a cause of gambling difficulties, "the hypothesis that one behaviour/substance (e.g., gaming) may lead to another/potentially problematic one (e.g., problematic gambling)".

Addressing stigma and discrimination

This section looks at how the materials explicitly or directly address stigma and discrimination. This includes whether the resources:

- Cover the specific dynamics and drivers of stigma and discrimination for gambling harm.
- Help workers to consider the experience and impact of stigma when they interact with people.
- Address any stigmatising beliefs about gambling harm that may be specific to healthcare workers.

Learning

The framework training uses plays a big part in whether it produces a destigmatising, public health approach. But training should also directly address the stigma and discrimination linked to gambling harm – because this has specific drivers, is a harm in itself and exacerbates other harms.

- Healthcare workers need to understand that gambling harm stigma and discrimination are driven by narratives of individual responsibility and the normalisation of gambling as harmless everyday fun. This is important to how they engage with people. It is also because these accounts are everywhere in society and may cause preconceptions in healthcare workers also.
- It is important to understand and address any stigma that may be specific to healthcare workers – if this exists for gambling as it does for issues such as self-harm or substance use. For example, people have caused their own illness and so are less deserving of care.
- Co-producing material with people with lived experience provides rich and practical insights on how to support people in way that does not stigmatise. Including the voices of people with lived experience within the training resources provides connection and social contact, which reduces stigma and increases empathy.

How the issue, its causes and solutions are defined or described contribute to or redress stigma and discrimination. But training is also an important opportunity to overtly engage with stigma and discrimination, and this is good practice.[41] This includes the dynamics of stigma and

discrimination for those harmed by gambling – for example, how this is driven by 'responsible gambling' narratives, the presentation of gambling as harmless fun in ubiquitous marketing and advertising, and the lack of parity in regulation and public policy and services. It includes how this may be compounded by sexism, racism or other forms of stigma and discrimination. Contact with healthcare workers provides a key opportunity to discuss the stigma that the individual may be experiencing (feelings of shame, internalised negative stereotypes that may have led to a loss of self-esteem, social withdrawal, and distress). It also means explicitly addressing preconceptions or prejudices healthcare workers may have – either because they are part of a wider social context or which may be specific to healthcare (e.g., "addicts" cause their own problems and are not worthy patients or are "troublesome" or "non-compliant" patients).[114]

Neither the **brief intervention guide (GambleAware)** nor the **eLearning tool (RSPH and GambleAware)** specifically discusses stigma, its causes, the consequences it can have or how to support people with their personal experience of stigma. Instead, these refer to the concealability of gambling difficulties. It is stated:

> *It is important to remember that harmful gambling behaviour is often hidden. It can be really difficult to know if someone is struggling with gambling, that's why it is known as a 'hidden addiction' because unlike other addictions it is hard to see the physical effects of Gambling Disorder. It can also be difficult to detect someone with Gambling Disorder as many people do not show their feelings and may lie or get angry when questioned.*

The resources do not explain that gambling addiction often remains hidden because of the stigma and the anxiety individuals may feel regarding how others may react to them. Telling healthcare workers that someone may "lie" or get "angry" does not help address any stigma they may hold.

There is no recognition that workers may themselves experience gambling harm or may have stigmatising beliefs about those harmed by gambling. Rather, the guides present gambling as an everyday activity the healthcare workers may themselves take part in, and so they may not feel comfortable talking to people about needing to control their gambling:

> *It is not uncommon for a worker who gambles to feel open to being judged as hypocritical when talking with others about these issues. In this circumstance, workers and organisational leaders must be mindful that brief intervention is provided to assist service users in making informed choices. The worker's own use and behaviour patterns are irrelevant and should not be a barrier to providing brief intervention.*

The **level 2 award curriculum (RSPH)** includes stigma at two points, as "factors that could result in an individual being at risk of or affected by harmful gambling and gambling-related harms" and "the barriers to changing behaviour with regard to harmful gambling and how these can be overcome". However, this is as a word, "stigma" only. There is no specificity as to what this should cover, nor does it address stigma within the workforce.

The **primary care competency framework (PCGS)** introductory sections state stigma is a barrier to people disclosing and getting help for gambling harm, and does note some dynamics of gambling harm stigma and discrimination:

> *Most problem gamblers go unrecognised and the health needs arising from their gambling go unaddressed. This may be for various reasons, such as a reluctance in patients to disclose the role gambling has in contributing to negative health outcomes. In addition, healthcare professionals' have low*

> *awareness of problem gambling issues linked to their limited knowledge regarding how to identify and assist patients experiencing gambling-related harm* (P.5).

Also:

> *Managing problem gamblers can be challenging as there are several barriers to identifying and helping them, and for them to be accepting of that help. These include…They may see it as self-inflicted, so feel responsible for resolving it themselves. They may find it difficult to disclose due to stigma, prejudice, shame and possibly fears over the issue remaining confidential from others…They may have concerns about professional implications including recording of the issue in their medical records, causing detriment to career progression, attaining insurance, or the impact of having time off work. As a result of these issues there is a tendency to present late, often as a result of the sequelae of the disorder rather than the disorder itself* (P.7).

While stigma is primarily framed in terms of delays in help-seeking by patients, there is some acknowledgement of the importance of also addressing the knowledge and attitudes of healthcare professionals and wider society. In the competencies: "Have an open manner to reduce stigma among patients and other health professionals in people seeking help for gambling (4AC, P.18) and "be innovative in reducing stigma of gambling in society" (7AB, p.20).

The **mindful resilience programme (YGAM)** addresses stigma among healthcare professionals and the consequences of stigma for people harmed by gambling.

The training describes barriers to engagement between the CYP and healthcare professionals. This includes that CYP may feel guilt, shame, and fear of how others may respond to them because of stigma; and may feel disapproving of themselves due to "perceived shortcomings, failures, and being flawed". The programme explains internalised stigma for the CYP as "beliefs they would receive stigma from others – social factor/process". The programme describes how gambling difficulties are often hidden due to stigma, which contributes to the secrecy and isolation of the individual. They also note that CYP may be concerned that other people, including the healthcare professional, may not understand.

The programme also addresses stigma within the practitioner and lists as barriers their attitudes and beliefs (stereotypes), perception of the problem, and knowledge of resources. The resource uses a roleplay audio clip between a GP and a patient concerned about their gambling. It shows the barriers to accessing support and a dismissive, stigmatising response from the GP, noting that "the language and reaction of the practitioner can feed into feelings of shame, guilt and self-stigma – which are all barriers to support".

The resource materials further describe how it is important for the healthcare worker to be considerate of the language that is used. The lived experience co-creation group informed this section of the training. It provides examples of stigmatising responses from healthcare professionals, for example, "Why don't you just stop" and how these might be interpreted: "you don't have self-control". It notes the different emotional triggers that responses from healthcare professionals can elicit, such as stigma, guilt, and shame. The training notes that phrases like "I can see this is important to you", and "tell me a little more about what that means" can go a long way to demonstrating curiosity and preventing judgement on your part". It provides additional examples of destigmatising responses from the healthcare professional, for example, reassuring people that they "are not along, many people suffer in silence it takes huge courage to share difficulties".

Although this is important, the material does not address the wider context of gambling harm, stigma and discrimination. There is a slide in the training material dedicated to stigma and gambling. However, there is no slide on gaming and stigma and no explanation on why gambling is more stigmatised than gaming.

Conclusion

In this report, we reviewed the information on gambling harm for healthcare professionals in Great Britain. We analysed three training programmes, one training curriculum, and one competency framework. We examined the extent to which training explicitly or overtly addressed stigma-related issues and how training may implicitly contribute to destigmatising or stigmatising those experiencing gambling harm through the way it constructs the problem of gambling harm, its causes and consequences. Linked to this, we looked at the extent to which training addresses gambling harm as a public health issue, enabling prevention and early intervention. We used our findings to provide key recommendations for the development of future training programmes for healthcare professionals.

Gambling harm needs to be treated as a public health issue, as it causes significant harm to the health and well-being of individuals, families, communities and society. Fundamentally, this requires acknowledging that commercial gambling products and practices are addictive and harmful – as with drugs, alcohol, and tobacco. As such, training in gambling harm should be a core element of provision within the NHS and other relevant healthcare or support services. Training provides a key opportunity to mitigate and shift harmful attitudes and behaviours that influence the general health and well-being of people affected by gambling harm. Future training programmes must address stigma and discrimination.

Appendix

Appendix 1. Resources that fit the inclusion criteria

Provider	Name	Description	Audience
GambleAware	Brief intervention guide (GambleAware) - Addressing risk and harm related to gambling	"The Brief intervention guide (GambleAware) has been developed as a resource to assist workers to provide brief intervention to address risks and harms related to problematic gambling. Additionally, it is a resource to assist organisational leaders to set up and implement the processes necessary to support workers to provide brief intervention."	The programme is aimed at professionals who do not specialise in the treatment of gambling disorder for example social workers, employment advisers, probation officers, community workers, counsellors, GPs, nurses and psychologists. The Guide is also likely to be useful for others working in primary care and other health settings.
GambleAware & RSPH	Understanding and responding to gambling harms: A brief guide for professionals	The aim of the eLearning course is to "help people understand and identify risks and harms related to gambling disorders and equip them to provide brief interventions to help address these harms. Additionally, it is a resource to assist organisational leaders in planning for the integration of brief intervention for gambling harms in their services."	The programme is aimed at professionals who do not specialise in the treatment of gambling disorder and may be most suitable for those working in social and criminal justice settings. Examples of these roles include social workers, employment advisers, GPs, psychologists, probation officer
GambleAware	A Gambling Competency Framework for Primary Care Improving the Awareness and Responsiveness of Primary Care to Gambling Harms	The Framework has been designed to describe the breadth of skills required by medical and non-medical practitioners to ensure the provision of safe, effective, and high-quality support to those experiencing gambling harm.	Medical and non-medical practitioners

Provider	Name	Description	Audience
GamCare	Problem Gambling – Identification & Brief Advice	The training "provides in-depth understanding of gambling-related harm, with a focus on key risk factors and how to identify the problem, how to use a brief gambling screen and a range of current referral sources - Understand problem gambling, how to screen for it and structure a brief conversation to elicit further detail. - Attain knowledge of the support and advice available, including player protection tools as well as emotional and practical support."	People working in frontline roles where they may encounter those affected by gambling-related harm
GamCare	Problem Gambling Awareness	The training "provides an understanding of problem gambling and gambling-related harm, including signs, symptoms and the impacts of problem gambling on an individual's life and those around them. Start to understand the psychology of gambling, why people gamble and what happens to the brain when we gamble. Understand the difference between gambling and problem gambling, indicators and how to signpost to appropriate services."	People working in frontline roles where they may encounter those affected by gambling-related harm
GamCare	Women and Gambling Related Harms Training	The training covers gambling-related harm, risk factors, impacts, and how to identify and support people affected. Teaches about the GamCare treatment network and how to refer clients to treatment services.	Professionals or volunteers who work with women and families

Provider	Name	Description	Audience
Young Gamers and Gamblers Education Trust (YGAM)	Mindful resilience programme (YGAM)	"Royal Society Public Health assured CPD training on gaming and gambling harm precent in children and young people. Pilot initiative designed to enable healthcare professionals to access quality training on gambling and gaming harm in children and young people. Designed by psychologists and those with lived experience, this live interactive workshop-based training builds understanding, skills and capabilities to address gambling and gaming harms; whilst reducing stigmatising attitudes which may act as barriers to seeking help and support, through earlier identification and referral to treatment provides. On completion of the workshop, delegates gain access to a comprehensive resource pack including assessment tools, details of organisations for support and referral/signposting, and references for further reading."	Nurses, doctors, pharmacists, social prescribers. It is available to all health professionals who work with children and young people (under the age of 25).
Royal Society for Public Health (RSPH)	Level 2 Award in Tackling Gambling-Related Harms	There are six centres offering this training: Derbyshire County Council (Adult Social Care & Health), Ara, Beacon Counselling Trust, EDAS, RCA Trust, and RSPH Training Solutions. The aim of the qualification is to provide candidates with an understanding of the nature and the impact of the concepts of harmful gambling and gambling-related harm and enable them to signpost affected individuals to sources of reliable information, advice, guidance and support.	The training is designed for anyone working with individuals affected by harmful gambling and gambling-related harm, as well as people working in the wider public health workforce

Provider	Name	Description	Audience
Beacon Counselling Trust (BCT), ARA and RCA Trust. Note – this training is part of the RSPH level 2 Award in Tackling Gambling-Related Harms	Bet You can Help (two levels)	The BYCH programme has been established to facilitate early identification of people who are at risk of harms related to gambling and to support trainees understanding of, and capacity to, address gambling-related harms in their communities. BYCH contributes to the Safer Gambling Movement by increasing awareness of gambling-related harms, enhancing place-based prevention strategies, and improving community capacity to identify at-risk people and groups. Practical first aid for gambling related harm •Level 2 qualification, accredited by the Royal Society for Public Health •One hour' Bet you can help now' introductory session	Professionals in public facing roles; it is for anyone working with individuals affected by harmful gambling and gambling-related harms, or those employed in health social care, education, criminal justice, housing, youth work and anyone working in a helping role, for example workforce well-being and union representatives

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