

GambleAware[®]

keeping people safe from gambling harms

Evaluation of GameChange, GamCare's Pilot cCBT Programme

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Lead

Research Team

Reviewed by

Alison Clare

Helen Owen

About Us

GambleAware is an independent, grant-making charity commissioning prevention and treatment services across England, Scotland, and Wales in partnership with expert organisations and agencies, including the NHS, across three areas:

- Commissioning the National Gambling Treatment Service
- Producing public health campaigns on a national scale and providing practical support to local services
- Commissioning research and evaluation to improve knowledge of what works in prevention.

Regulated by the Charity Commission for England and Wales, and the Scottish Charity Regulator, GambleAware is wholly independent and has a framework agreement with the Gambling Commission to deliver the National Strategy to Reduce Gambling Harms within the context of arrangements based on voluntary donations from the gambling industry.

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1. Introduction

1.1 Aims and Objectives

The GambleAware Research Team was asked to undertake a light touch, formative process evaluation of the capacity and uptake of the GameChange cCBT programme in its first four months of delivery - November 2019 to February 2020.

The purpose of the evaluation was to inform GambleAware's decision-making about increasing capacity of the pilot service.

The objectives of the evaluation are to identify:

1. Levels of uptake of the cCBT course in the first four months of launch
2. Whether current capacity of the cCBT programme is likely to be sufficient for future uptake
3. Lessons that may be learned from the initial implementation of the programme
4. Implications for GambleAware's next steps regarding potential further commissioning of the programme

1.2 Methodology of the evaluation

The light touch, formative process evaluation was carried out in January and February 2020. The analysis for the project included a review of existing secondary data and conducting primary data collection.

The pilot programme was in the first phase of delivery, which meant that access to data and outcomes produced by the GameChange software was limited. The first quarterly report is due in April 2020, where it is expected that monitoring measure data will be shared.

The findings reported within are based on analysis of the following sources of data:

- Depth interview and written feedback with GamCare, namely:
 - electronic correspondence
 - face-to-face semi-structured conversations with GamCare staff on two occasions in GamCare offices
- Light touch review pertinent literature and grey literature
- Review of existing data sources, namely:
 - GamCare's proposal
 - GamCare materials publicising the cCBT programme.

The structure of the findings of this evaluation is driven by the thematic analysis of email correspondence, notes and transcriptions taken during consultations, with themes emerging through categorisation and re-structuring of data.

1.3 Background to the pilot programme

Reducing gambling harms

There are approximately 340,000 people who experience problem gambling, and a further 1.75 million people who are experiencing some level of harm to health and wellbeing in Great Britain as a result of gambling. Between 2017 and 2018, GamCare's National Gambling Helpline received 30,000 calls and approximately 8,000 people have been able to access their one-to-one or group therapies, either face to face or virtually (online). A further 25,000 people annually complete a 'self-assessment tool' on GamCare's website and 80% of these are screened as experiencing problem gambling.

Cognitive behavioural therapy is widely used in mental health services and throughout the NHS. It is well-demonstrated as effective in treating depression and anxiety, as well as other mental disorders (Hofman *et al* 2017) and gambling disorder (Rash and Petry 2014). Computerised CBT, referred to as cCBT, represents a very cost-effective mode of rollout of CBT, in the context of the cost and resource implications of face-to-face therapy.

There are more limited data demonstrating the impacts of cCBT for problem gambling than for regular CBT. Trials evaluating cCBT for problem gambling (for example see Carlbring *et al* 2012; Nilsson *et al* 2018; also see Smith *et al* 2018) highlight positive outcomes of the intervention and demonstrates reductions in gambling severity and in mental health outcomes (Casey *et al* 2017).

cCBT also has good potential for engaging hard-to-reach communities and those who are reticent to contact service and healthcare providers, since it is accessed virtually (Oei *et al* 2018). The evolving COVID-19 situation and the requirement for increased levels of self-isolation across the general population add another dimension to the value of treatment and support delivered virtually and on-line.

The role of cCBT in reducing gambling harms

In 2019, GambleAware commissioned GamCare to deliver a cCBT programme to widen the choice of brief interventions available through the National Gambling Treatment Service. The commissioned programme, known as Game Change, is aimed at people experiencing problem gambling and is based on a model developed by Sustainable Interaction in Sweden. That programme has been evaluated and evidenced statistically significant reductions in the scores of pathological gambling, anxiety, and depression as well as an increase in quality of life compared to pre-treatment levels. Follow-ups carried out in the treatment group at 6, 18, and 36 months indicated that treatment effects were sustained (Carlbring *et al* 2012).

Overview of the Programme: What is It?

The cCBT programme, referred to as [GameChange](#), is a modular programme consisting of eight modules (see appendix 1 for detail of module content) and designed to be completed in eight weeks.



PROGRAMME CONTENT



cCBT Programme Overview

Screening: Following on-line registration by prospective users a screening process is completed. This is scanned and reviewed by GamCare's cCBT therapists. Where there are safeguarding concerns, the client is telephoned by a therapist for further assessment. If necessary, they are referred onto other services and / or provided with additional support. People with more complex needs are referred on through GamCare and NHS services.

Modules: Once screening is complete and a therapist has approved the user, the modules are released; a time is agreed by the user and the therapist to discuss each module. Progress through the modules is at the users' own pace. Each module takes at least an hour to complete.

At the end of each module, outcome measures are generated according to metrics of the Problem Gambling Severity Index (PGSI) and Clinical Outcomes in Routine Evaluation (CORE)-10, assessing emotional wellbeing and distress. This is based on self-completion by users. Regular check-in sessions with a therapist are available after the completion of every module. Therapist support is known to improve outcomes of cCBT (Petry *et al* 2017).

The cCBT programme is for people who are experiencing problems through their own gambling and not for affected others (although one of the modules looks at the impact of gambling behaviour on friends and family).

2. Summary: Take up in first 4 months of delivery

GamCare data showed the following activity on the cCBT programme for the first four months of delivery¹²:

Take up numbers	Number
Registrations	1000²
Screenings completed	789
Approved but user inactive	146
Flagged for safeguarding of which:	174
Approved to start the programme	30
Referred to other services	15
User Inactive for 3 weeks & no response - deactivated	397
User actively working through the programme	133
User completes all 8 modules (in first 4 months)	20

The assumption in the original pilot proposal was that **675** people would register for the course in Year 1, with **50%** dropping out before completion of all **8** modules (**338** completions).

In the first 4 months of operation, there were approximately **1000** registrations³ leading to currently **133** active users; it is too soon to say how many of these will join the **20** users who have completed, or how many of the **146** users approved, but currently inactive, will start working through the programme.

In any case, it is clear that demand for the cCBT programme has been significantly higher in practice than originally assumed, and that the attrition rate of around **70-80%** has also been much greater than anticipated.

¹ 1 Figures as at March 3, 2020

² This is a minimum figure but is only approximate because when users register (and do not progress with screening), no data is input by the client to collect and log, apart from their email address. GamCare have kept an approximate tally of these registrations.

³ Estimate, as above

3. Key Findings

3.1 Take up

In the original proposal for this pilot it was assumed that 675 people would register for the programme in the first year. In the first four months of the programme, approximately **1,000 users** have registered. If registrations continue at this rate that would mean approximately **3000** registrations in the first year, almost five times as many as originally assumed.

Of those registrations, **789 people completed the screening process**, giving an initial dropout rate of roughly 20%. Anyone dropping out is followed up by email and provided with information about other services and how to access these.

There are **133 active users** who have finished screening and are actively completing modules and **20 users have completed the total programme**,

397 users have dropped out. Accounts are deactivated after no activity for longer than 3 weeks and/or after no response to the therapist attempts to re-engage. **146 users** are still registered but have been **inactive** since they were approved

3.2 Marketing

The original budget included £5,000 for publicity and marketing to raise awareness and uptake of the programme. To date, promotion activity has been relatively low key but has included an external press release and promotional video and awareness raising across the gambling treatment network. Additional promotion on social media is set to begin in March 2020.

3.3 Resourcing model

The original resourcing model was for two therapists plus senior management support. There was no provision for support or administrative staff. Therapists are qualified clinical psychologists with CBT qualifications. According to GamCare, lead time for recruiting new therapists is approximately eight to ten weeks.

Currently, there is a third agency therapist in post and a live recruitment campaign for two advisors/support workers. These functions will focus on administrative work currently undertaken by the therapists.

3.4 Waiting Time During Screening

To date, there was an average 14-day waiting time for users who have completed screening and are awaiting approval by a therapist to start the programme. At the end of February 2020, 130 users were awaiting approval. This was cleared in one day by a single therapist concentrating exclusively on this task; but by the second week of March the backlog was beginning to build up again.

Only a qualified therapist can review and approve pending users' responses to safeguarding. This is due to the importance of determining higher risk and of referring clients on to appropriate services.

One of the therapists working on the cCBT programme expressed the belief that lengthy waiting times contribute to people leaving the programme. Their observation was that fewer clients drop out of the programme when client waiting times are shorter. It is not clear how the addition of a third (agency) therapist has impacted on approval times.

3.5 Emerging Findings on Screening: Triage and Referral

Safeguarding: Identifying and Referring Complex Needs

174 people have been identified as having "potential safeguarding or general risk concerns"⁴ Many of these are identified by GamCare as being 'in crisis'. Respondents specifically expressed the view that, despite being in crisis, people had been able to complete the screening, which takes a minimum of 20 minutes.

Safeguarding-concern clients are contacted via email to arrange a therapist conversation. They are also emailed resources about mental health first aid, self-exclusion, blocking software, blocking gambling via one's bank, money management, and GamCare services access.

15 of the 174 have been referred into GamCare's treatment network. 3 clients' GPs were contacted.

The programme is therefore acting as a gateway through which people are assessed and referred on to appropriate services, for those identified by the therapist as a "vulnerable cohort".

Following safeguarding conversations, 30 of the 174 have been given access to the programme. This is with ongoing risk management.

Not all clients respond to safeguarding follow-up. After contacting non-responsive clients three times, attempts are terminated. They are marked as having dropped out of the programme after three to four weeks of inactivity and unresponsiveness.

Users' Experience of Delivery

Anecdotal qualitative evidence indicates the intervention has been positive for clients. Respondents noted finding the modules reflective, engaging, and emotionally challenging in feedback through the platform.

⁴ GamCare Head of Clinical Services, email correspondence

Respondents consistently emphasised that the modules had increased their feelings of self-awareness with regards to their gambling, as well as their agency, self-determination, and control:

“The questions I have found in the modules **helped me to really reflect** about what was happening internally when I was gambling.” (Client, Responding to cCBT Feedback Request)

“I feel more in control and I have started enjoying doing normal things with my family such as cooking, walking, **being present again.**” (Client, Responding to cCBT Feedback Request)

“I realise now how much **out of control** I was when I was gambling, and that gambling was an escape, a way to cut off difficult emotions.” (Client, Responding to cCBT Feedback Request)

“Reading my answers to the exercises and realise the impact of my gambling behaviour made me feel very sad but at the same time **helped me to face reality and find the motivation** to change.” (Client, Responding to cCBT Feedback Request)

“Module 3 was very hard, I did it with my partner and it was great for her as she felt involved for the first time. But for me **seeing the impact it had on her broke me**” (Client, Responding to cCBT Feedback Request)

4. Conclusions

What's going well

- There has been striking uptake of the programme with limited active promotion
- This indicates a high level of need for the programme and that it is indeed accessible, at least initially, to large numbers of people.
- The programme is providing another pathway for triage and referral for people with more complex problems and where there are safeguarding concerns.
- Recruitment is underway to free up therapist time spent on admin tasks.

What's going less well

- Therapists are currently doing admin work taking them away from the tasks that only qualified therapists can do.
- The additional agency therapist in post and two administrative staff being recruited had not been budgeted for in the original proposal.
- A lack of staff capacity has resulted in waits of upwards of two weeks for users awaiting approval by a therapist and it is likely that this is contributing to people dropping off the programme.
- The monitoring framework and KPIs have yet to be established by GambleAware and GamCare, and accessing activity data to inform this evaluation was not easy.
- The programme is not available to people who have been affected indirectly by harms associated with gambling; this is an area of potential unmet need and a programme could also be conceived and piloted to address that.

“Affected others don't present to treatment enough, so something discrete like this. And maybe something for young people too... this could potentially be in addition to the online treatment that we already have”
(cCBT Therapist, GamCare, March 2020)

5. Recommendations

There is a clear case to be made to increase funding for this programme.

In order to identify the size and potential phasing of that increase, GambleAware should work with GamCare to put in place the following:

1. A formal reporting process and agreed KPIs
2. A Theory of Change and Logic Model setting out clear outcomes and indicators, revised assumptions, a project plan and (detailed) budget for expansion, a clear quality assurance approach and a risk register
3. A clear agreement about what data is to be collected and when [e.g. a profile of people registering, what time of day they are accessing the programme; for how long etc]
4. An impact and process evaluation framework based on the above, designed to ascertain the impact of the programme in reducing gambling harms over the longer term.

GambleAware's cross-organisation evaluation team can provide support and advice on all the above.

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Appendix 1: Overview of the Modules of cCBT

Screening will reveal whether cCBT is suitable for a prospective client's level of need. Screening covers life situation, employment status, familial status. Questions focus on gambling habits, which activities, where the client gambles, how much they gamble, which games, and time spent on gambling in the last month. Focus is also on gambling history, when they started to gamble, and at what age it became a problem. It prompts for an overview of the activity they were involved with initially. There are questions also in terms of health, mental health, and physical health, with more specific questions around mental health, anxiety and depression, and sleep issues. Some of the focus is on psychoactive substances, with referrals on to drug and alcohol services where relevant. There are wider questions about social networks, and financial issues including debt and mortgage issues.

Questions in the screening include those focussing on gambling thoughts and urges, and the client's notions vis-à-vis chance and skills. It is explored if they already have support in place in terms of physical and mental health. Readiness to change is a focus of the screening, looking at motivation to change, and confidence regarding making a change.

Outcome measures of the screening include both the Problem Gambling Severity Index (PGSI) and Clinical Outcomes in Routine Evaluation (CORE)-10, assessing emotional wellbeing and distress. This then provides a visual overview which highlights whether there are red flags. Following screening and decision as to suitability for cCBT, the client will have access to module 1 of the cCBT course.

The focus of **Module 1** is in goals establishment: what is important in the client's life, and how gambling behaviour has impacted on life. The module reflects on positive experiences that can result from gambling, and explores also which activities the client engages in, other than gambling. Questions concentrate on triggers, addressing why people gamble, whether feelings of boredom, depression, and anxiety play a role. Importantly, there are opportunities for reflection in the client's own words; this element - with the client's consent - is published in a forum context, allowing clients to have a window into the progress and experiences of their peers.

Module 2 addresses the fiscal (not social) costs associated with gambling over a year, and therefore allows for a building of capacity in terms of engaging with the reality of one's gambling. A client will be prompted to recall a specific incident, to analyse the incident, and to think involvedly about the situation, about where they were, what they were doing, the emotion they were experiencing before, during, after the incident, and what impact this incident has had financially and emotionally.

Module 3 focusses on the impact on a client's social life. It allows for the inclusion of another person who has been impacted by the client's gambling, prompting a client to sit down with them when working on the module, with questions regarding how the affected person has been impacted, how they feel, and how they view the person experiencing

difficulties. There is signposting and referral on to services and support for this affected third party, should they require support. Again, there is an exercise ascertaining the pros and cons in continuing to gamble.

Module 4 begins with a decision on the part of the client in terms of how they want to move forward. There are discussions of motivation, looking after one's mental health, the impacts of stress and anxiety, and reflection about the thought of winning a jackpot and implications that this could have. There is also reflection around the telling of third parties about the client's problems associated with gambling, concentrating on the concerns that can surround this and the possible responses it may elicit.

Module 5 is informed by understandings that underpin many cognitive behavioural therapies. The initial elements concern mind traps: these are thinking traps that do not accurately reflect reality, but instead are more irrational and assumptive patterns of thought. The client will read in more detail about mind traps, about their possible propensity to expect the worse of situations, of thinking in all or nothing terms, and of their tendencies to generalise. They will reflect on which mind traps are more common in their everyday life and thoughts. Juxtaposed to established mind traps are data and facts concerning chance, skill, and the actual probability of winning when gambling in certain contexts. Alongside these clarifications around misconceptions about chance, the client identifies which irrational thoughts they experience. Again, they are asked to choose specific situations, and are asked to identify which mind trap that these incidents relate to, and further, how they could replace the irrational thought patterns with more rational thoughts. There is also emphasis on the importance of finding alternative activities when quitting or reducing gambling.

Module 6 moves on to high risk situations. The client will identify high risk situations, when they last felt a high-risk urge, and what feelings were associated with their urge. They will be prompted to think what they could have done instead and how could they have prevented themselves. The module deals with the urge to gamble, with information given in terms of urges developing and alternative activities the client can engage with.

Module 7's concentration is the individual's financial situation. It is very similar to the content of module 2, but at this point goes into depth regarding the conceiving of a management plan, regarding debt, and in terms of how they assess their financial situation. This element of the course is more practical, with less of an explicit CBT focus.

Finally, **Module 8** is about preventing relapses. It contains information explaining what a relapse is, highlighting differences between a lapse and a relapse, and focussing on the fact that a lapse should be regarded as a learning experience. There is attention paid to what were triggers for specific relapses, with attendant reflection on life goals. The client is prompted to reflect whether they feel more aligned with their values in life.

For more information

GambleAware
Pennine Place
2a Charing Cross Rd
London
WC2H 0HF

Email: Research@gambleaware.org