# Treatment and Support Services For Women Experiencing Gambling Harms

## What Women Get and What Women Want

# Contents

# Acknowledgements

Betknowmore would like to thank all the inspirational women who contributed to this research. Without your honesty and candour, this research would not have been possible. It was a pleasure to work with you and to also see how much you enjoyed meeting each other – a testimony to the power of peer support.

**Citation details**

Liz Riley (2021) *Treatment and Support Services for Women Experiencing Gambling Harms: What Women Get and What Women Want,* Betknowmore UK, London

**Contact**

liz@betknowmoreuk.org

# Executive Summary

# 1. Executive Summary

## 1.1 Research aims

This research arose out of a need for Betknowmore UK to expand the evidence on women's gambling harms in order to better understand women's support needs. The research was undertaken to directly inform the provision of support services offered by Betknowmore UK.

**The research had two main aims:**

- To explore how approachable, accessible and effective women find existing support and treatment services in Great Britain;
- To allow women with lived experience to produce recommendations on how services can better attract, retain and help more women who are experiencing gambling harms.

## 1.2 Research questions

- How do women find and choose support services?
- What services are women offered and how are these accessed?
- What services work well and what services are less effective?
- How can services be improved and reach more women?

## 1.3 Research methodology

The research was conducted over a period of nine months.
A review of the existing research base was undertaken to explore the topic of women and gambling harms in general and identify gaps in our current knowledge. A review of British support and treatment services available to women was also conducted using secondary materials and online research. To capture the experiences and opinions of women with lived experience of gambling harms, qualitative evidence was collected through focus groups, which were implemented in pairs and captured the views and experiences of 14 women. To undertake the analysis of the focus group transcripts, constant comparison analysis was used, involving the comparison of interpretations and findings as they emerge through an iterative process. The themes and subthemes that emerged form the basis of the research recommendations. These focus on ways to improve support provision for women experiencing gambling harms.

## 1.4 Key findings

- Models of support are not currently flexible enough to cater to women with different identities, needs and experiences of gambling harms.
- Services do not sufficiently engage in preventative support work to stop women from reaching crisis point.
- Support services rarely actively appeal to women, explicitly making their services more inclusive of women and working to reduce shame and stigma.
- Current safer gambling media campaigns do not feel relevant to women or help them recognise when their gambling is becoming harmful.
- Signposting of gambling treatment and support services in inconsistent and poor quality, especially among primary care health professionals.
- The information that service providers currently give is not detailed enough, failing to sufficiently explain what they offer and how it is delivered. They also rarely cross-refer to other gambling support services and help women make better choices.
- Women needing help have to become researchers, responsible for finding their own support through trial and error.
- The accessibility, quantity and speed of support that women can receive all need to be improved.
- Poor childcare provision and insufficient safeguarding hamper accessibility to services, especially to residential support.
- The focus of support on gambling harms means that women's wider and longer-term needs are not sufficiently met, for example how to return to the workplace, rebuild relationships and improve their self-esteem.
- Support services rarely explicitly acknowledge the differences in the gambling harms experienced by women and men. This means that the specific and complex needs of women may go unrecognised and unmet.
- The provision of peer support and women's support groups is currently insufficient to meet the demand for these services.

## 1.5 Key recommendations

- Women need to see themselves in media campaigns and safer gambling messages to raise their awareness of gambling harms. These should feature "ordinary" women with lived

experience in order to normalise the female gambler, give her hope and enable her to ask for help without shame and fear.

- Treatment and support services need to raise public awareness of the harms associated with gambling by diverse groups of women. The onus should be on preventing harms before they reach crisis levels. This would encourage women to engage with support services earlier.
- Support and treatment services should actively appeal to women and diminish the stigma that surrounds women's gambling harms. This could be through images of diverse women on their websites, social media and promotional materials. Support models should explicitly explore the differences in the gambling harms and support needs of women and men. This would increase the relevance of treatment content to women and help overcome their reluctance to engage with services.
- Knowledge of gambling harms among professionals in statutory services should be increased to enable them to identify and discuss gambling harms and refer women to appropriate sources of support.
- Diversity in support models and means of access is key to meeting the diverse needs of women. To enable them to attend face-to-face support, hubs should be available in every major city, which also strive overcome barriers such as cost or lack of childcare. The Covid-19 pandemic has greatly and rapidly inflated the range and quantity of support available to women. As the pandemic recedes, maintaining the provision of online support is also crucial for women's access to services.
- Services need to provide more accessible and detailed information on what they offer and to whom. Where necessary, they should give effective signposting and referrals to other providers, advising women on how to go about choosing a support service that is right for them.
- A central hub or guide to gambling support and treatment services for women needs to provide an interactive service, giving in-depth information and advice on the support women can access. This could enable women with the most complex needs to access the quantity and range of support they need.
- When women decide to seek help to address gambling harms, services should act quickly to capitalise upon those decisions. Delays can lead women to change their mind and retreat, enabling gambling harms to escalate further.
- The availability and duration of residential treatment services should be expanded for women, with support put in place to enable them to overcome barriers to access such as caring and employment responsibilities.
- The content of support and treatment needs to be diverse and range from practical measures to stop gambling, to

in-depth psychological support, to financial education and strategies to improve health and wellbeing.

- Aftercare packages should be person-centred and accommodate the long-term and diverse needs of women, recognising the enduring nature of legacy harms such as debt, unemployment and loss of self-esteem.
- Gambling peer support groups need to be more accessible to women. The value of peer support is widely recognised and it should not be an “add-on” to therapeutic treatments but have a central place in women’s recovery.
- Women’s support groups should be more widely available. These act as safe spaces where women can discuss issues they would feel uncomfortable talking about with men. They enable a support community of women to grow which protects women from further gambling harms.
- Mixed gender groups should strive for increased membership by women. Improved gender parity would reduce the reluctance of women to join such groups, reducing the stigma they feel and increasing the range of services open to them.
- This research demonstrates the value of the experiences of women who have accessed gambling support services, as well as the quality of their ideas on how to improve services. They have the lived experience and knowledge of the strengths and weaknesses of existing services. As such, these women should play a much greater role in designing gambling treatment and support services for women.

# Introduction

# 2. Introduction

## 2.1 Background

Betknowmore UK, first established as a social enterprise in 2013, became a registered charity in 2021. The organisation has expended rapidly in the last two years, adding considerably not just to its personnel count but also to the range of services it offers. In partnership with GamCare, the charity delivers Peer Aid, the first peer support service for people affected by gambling harms that is part of the British National Gambling Treatment Service. Betknowmore's work to prevent and reduce gambling harms is founded upon a community-based model and through its GOALS programme it offers brief 1:1 interventions to support individuals experiencing gambling harms, partnerships with community organisations to raise awareness and reach people in need, implements media and publicity campaigns to raise public awareness, and works with local authorities to ensure that gambling harms are understood and addressed through a public health policy framework.

Lived experience of gambling harms led to the creation of Betknowmore in 2013 and has been instrumental in its subsequent development. Its services are shaped and delivered by people with lived experience, including a number of women who have been harmed by their own gambling or that of someone close to them. As the reach and scope of Betknowmore's work have increased, there has been a growing awareness in the organisation of the rising number of women seeking help from Betknowmore and other service providers. At the same time, statistics on the prevalence of gambling harms among women have shown a nation-wide growth. Over the past five years, the number of women reporting a problem has risen at more than twice the rate of men, but only about 1% of women experiencing gambling harms receive help and support (Guardian, 2020). In response to the escalation of the problem, the gambling research community has begun to explore the nature of gambling harms experienced by women and the barriers that stop women from seeking support. Women are argued to face twice the amount of emotional, psychological and social difficulties that men confront (Karter, 2013), and women are more likely than men to report feelings of shame as a barrier to help-seeking (Hing et al., 2017). It has been shown that there are clear differences between men and women in how they gamble and the harms they incur, in their experiences of support services and in the range co-occurring issues that affect them, suggesting the need for gender-specific service provision (Best et al., 2019).

As the evidence base has grown and the scale of women's gambling harms has become evident, Betknowmore began to question whether it was sufficiently meeting the needs of women. It was aware that despite the evidence base, there remains a continuing general perception that gambling problems among men and women are largely the same (McCarthy et al., 2019a) and that further research is needed

to establish whether there is a more effective way to reach and engage women experiencing gambling harms (Kaufman et al., 2017). Before deciding to provide a gender-specific service, it was realised that research was needed to specifically examine how women currently access support and treatment services and whether those services are sufficiently tailored to their needs. This research was therefore undertaken to strengthen the evidence base and directly inform the provision of support services offered by Betknowmore. As a result of the findings and recommendations outline in this report, Betknowmore has now launched an online women's group that is peer-led and open to women anywhere within the UK and Republic of Ireland. Women can self-refer into this group and it is designed to bring them all the benefits of peer support and a women-only environment that were identified in this research. Betknowmore does not want this research to simply be released into the online space and accumulate virtual dust. The research has directly informed Betknowmore's own services and the report will be widely circulated in the hope of informing other services who support women experiencing gambling harms.

## 2.2 Research aims and questions

The research had two main aims: to explore how approachable, accessible and effective women find existing support and treatment services in Great Britain; and to allow women with lived experience to produce recommendations on how services can better attract, retain and help more women who are experiencing gambling harms.

The main research questions were: how do women find and choose support services? What services are women offered and how are these accessed? What services work well and what services are less effective? How can services be improved and reach more women?

## 2.3 Approach

The research was conducted over a period of nine months (including analysis and report writing). Initially a review of the existing research base was undertaken to explore the topic of women and gambling harms in general and identify gaps in our current knowledge. The literature review contextualised the research and also identified the existing evidence on what women want and get from the support services that are on offer to them. A review of British support and treatment services currently available to women was also conducted using secondary materials and online research. Using the gendered criteria identified through the literature review, each of the services was assessed, revealing the extent to which they actively seek to attract women and provide them with gender-specific services. This review added to the contextual backdrop to the primary qualitative research that was then conducted.

To capture the experiences and opinions of women with lived experience of gambling harms, qualitative research methods were employed that could produce the richness and depth of information needed. The focus upon experiences of treatment and support services meant that more sensitive topics could be avoided, such as the women's histories of gambling harms, which may have necessitated in-depth individual interviews with women. Instead focus groups with the women enabled them to share their experiences and opinions and the focus groups themselves generated an energy and synergy among the women, some of who have subsequently kept in touch with each other and gone on to be involved in other Betknowmore activities. The focus groups were implemented in pairs, with a total of 14 women taking part. The first focus group in each pair explored the core issues of finding and choosing a support service, the efficacy of the services received and improvements needed to enhance awareness, access and treatment. The second focus group centred on deriving practical suggestions to enhance the awareness, accessibility and efficacy of gambling harm support services. To undertake the analysis of the focus group transcripts, constant comparison analysis was used, involving the comparison of interpretations and findings as they emerge through an iterative process. The themes and subthemes that emerged form the basis of two chapters in this report, and the reflections of those findings in turn form the basis of the research recommendations. Betknowmore's intention in conducting this research was to inform its own practice and that of others, so the majority of the report's recommendations are practical. We hope that other service providers will find them of value.

## 2.4 Declarations

This research was funded by Microgaming, an online gaming software developer that supplies software to gambling operators. Betknowmore and Microgaming together decided that the research should focus upon women experiencing gambling harms in recognition of the increased prevalence of these harms. Beyond this initial decision, Microgaming had no input into the subsequent focus of the research on support services for women. This focus was a response to the need to broaden the evidence base before Betknowmore could expand its service provision in this area. Microgaming had no input into the research questions, the research methods applied or the analysis of data and writing of the final report. The report was released to Microgaming at the same time it was released generally.

When discussing the research questions in the focus groups, the women sometimes mentioned the gambling operators, their advertising and their safer gambling measures, including their inadequacies. These critical comments are reproduced in this report when they relate to one of the themes or subthemes derived through the process of data analysis. That process of data analysis was robust and transparent and designed to reduce bias, including any bias introduced by the source funds for this research.

# Research Methodology

# 3. Research Methodology

## 3.1 Introduction

This chapter outlines how the research was conducted. It begins with a review of the secondary data research undertaken, outlining the approach to the literature review on women and gambling, and the methods and gendered criteria used to assess the support services currently offered to women in the UK. The chapter then explains the primary data collection methods used, namely focus groups, and finally describes how the focus group data were analysed and reported.

## 3.2 Literature review

The purpose of the literature review was to identify and explore existing major themes on the topic of women and gambling harms, identify gaps in our current knowledge and so situate this research project. The literature review thus broadly contextualises the research and also identifies the existing evidence on what women want and get from the support services that are currently on offer to them.

The literature for the review was identified using databases that included PubMed, JSTOR, COPAC, Web of Science, ResearchGate and RefSeek, using the search words “gambling and women”. The bibliographies of peer-reviewed publications were also used to identify further sources. Sources included in the literature review were peer-reviewed journals and books, charity and government research and reports, and a small number of newspaper articles.

To derive a contextual overview on the prevalence of gambling among women in Great Britain, the focus was confined to UK literature. However, when reviewing the available literature on how and why women gamble and their treatment and support needs, research conducted in the US, Canada and Australia was also considered as this work provided valuable information to supplement UK focused literature.

## 3.3 Review of current services for women

Given the focus of this research on what women need in order to address the harms related to their gambling, a review of the support and treatment services currently available to women was conducted using secondary materials and online research. A list was drawn up of service and treatment providers that focus on reducing gambling harms (sometimes in unison with the harms caused by drugs and alcohol). The geographical area covered was Great Britain, thus

excluding Northern Ireland where the context is different because gambling policy is devolved and the Gambling Act 2005 is not in force.

The service providers reviewed were GamCare, the National Problem Gambling Clinic, the Northern Problem Gambling Service, Gamblers Anonymous, Gordon Moody, All Out South, Aquarius, Addiction Recovery Agency, Beacon Counselling Trust, Beat the Odds, Betknowmore, Better Futures for Gamblers, Breakeven, Krysallis, North East Council on Addictions, Options, RVA Trust and Steven James Counselling.

The websites of the service providers were assessed in accordance with a set of gendered criteria that were drawn from the literature review. From the literature, the aspects of a support service that are important to women were identified as:

- Images of women
- Images of BAME women
- Images of women of varying ages
- Services provided by women (counsellors, peer supporters and helpline staff)
- Self-help resources for women
- Information targeted at women
- Services just for women
- Peer support services
- A broad range of support delivery formats (face to face, phone and online, 1:1 and group)
- Confidentiality
- The ability to self-refer
- Short waiting times
- Reduction of stigma and shame
- Support for lapses

From this list, gendered criteria were developed that could be applied solely by examining service provider websites i.e. as though the research was being conducted by a woman looking for help online. The criteria used to assess each service were:

- Website images (videos or stills)
- Self-help resources for women
- Information targeted at women
- Services just for women
- Peer support services
- The range of support delivery formats
- Confidentiality
- The ability to self-refer
- Mention of shame and/or stigma
- Mention of lapses

These criteria were used when exploring the websites of the service providers to assess the extent to which their services are currently tailored toward the needs of women. The aim was not to critique the work of individual service providers but to map what support is currently available to British women who want help to address their gambling harms.

## 3.4 The women

In total 14 women took part in the focus groups, with nearly all of them attending two each. The women ranged in age from mid-20s to late 50s; all were white British, apart from one woman who was black British; and two of the women belonged to the LGBT+ community. The sample was evenly spread among north England and north Wales and south England and south Wales, and one woman was from the Republic of Ireland. All of the women were based in urban areas but these ranged from small towns in semi-rural locations to major cities. Many of the women had children (either young or grown up) and lived with partners, though some had no children, some lived alone, and some were single parents.

The trajectories of the women's gambling were predictably diverse. Most had gambled in harmful ways for many years, sometimes decades, experiencing multiple cycles of wins and losses, highs and lows, as well as multiple crises and attempts to stop, either alone or with help. The gambling itself varied from land-based sports betting, to online slots and casino games, to scratch cards. One woman, whose gambling had escalated very rapidly, had committed a crime due to her gambling and had spent time in prison. Other women had become homeless due to their gambling, while most had lost jobs, careers and relationships. A small number of the women were now active in raising awareness of gambling harms and no longer hid their histories of gambling harms, while most had told just some of the most trusted people in their lives (usually just partners and close family members, as well as services), and one person had told no-one at all outside of the focus groups and her social media support network.

The gambling support services variously accessed by the women were Gamblers Anonymous, Breakeven, GamCare, Gordon Moody, Betknowmore UK, the NHS National Problem Gambling Clinic and online forums and chat rooms, as well as self-exclusion schemes. The women had also sought help for their gambling from NHS primary care services, including GPs and mental health services, social services and drug and alcohol support services.

## 3.5 Focus groups

The focus groups were implemented in pairs, and in total three pairs were held between April and early June 2021, with a one week gap between the first and second group on each pair. The first focus group in each pair explored the core issues of finding and choosing a support service, the efficacy of the services received and improvements needed to enhance awareness, access and treatment. The in-depth topic guide for these focus groups can be found in Appendix II. The aim was also to secure the participation of women of different ages, socio-economic and ethnic backgrounds in the

focus groups so that a range of perspectives could be captured and appropriate inferences drawn. As discussed above, the research did not manage to secure the participation of women from a variety of ethnic groups. The second focus group centred on deriving practical suggestions to enhance the awareness, accessibility and efficacy of gambling harm reduction services. This second focus group was specifically designed to harness women's lived experience to reflect upon awareness-raising, for example as called for by McCarthy et al. (2019b) who argue that there is a need to develop educational campaigns that explain the risks of gambling and a need to design and test media messages targeted at women.

Purposive sampling was used to select the research participants so that participants were chosen who were both knowledgeable and willing to share their knowledge. The staff of Betknowmore who have widely engaged with women with gambling problems in a variety of arena were tasked with recruiting suitable research participants and were given a pro forma to do so, which explained the purpose of the research, informed consent and confidentiality (see Chapter 4 and Appendix I). The focus group participants were 14 women who either previously or currently were engaged with gambling support and treatment services, had a good level of spoken English, represented a range of ages and socio-economic groups, and had the ability to access and attend two online focus groups held on different dates. All participants were given vouchers to compensate them for their time (see Chapter 4 for a discussion of the ethics in relation to this).

Two moderators conducted the focus groups, with the primary moderator being a white woman with lived experience. "Participants take into account who the researcher is, what they could be presumed to know and 'where' they are in relation to themselves in the world they describe" (Rhodes and Coomber, 2010). With this in mind, the primary moderator was chosen for this role owing to her ability to instinctively understand the contributions of the participants and also gain their trust. The non-directive interviewing style used in the focus groups is most effective when there is trust and rapport, with the empathetic researcher having to "balance getting 'close' enough to accomplish trust and rapport while maintaining a 'critical distance'"(Rhodes and Coomber, 2010). The identity of the primary moderator as a women with lived experience, couple with the training she received to perform the moderator role, was judged to be the best means to secure the trust of the focus group participants but also retain "critical distance".

The primary moderator facilitated the discussion, prompting members to speak and encouraging all the members to participate. The secondary moderator was an experienced researcher who monitored the discussion, took notes on and interjected with further questions, monitored the "chat" function and dealt with any issues that arose in relation to the welfare of the participants. The secondary moderator was also responsible for analysis of the focus group data. In the second focus groups of each pair, the format included presenting the participants with stimulus materials and asking for responses, as well as discussion of the questions presented in Appendix II.

The choice of focus groups versus one-to-one interviews warrants an explanation. Focus groups are a more rapid and economical means to collect information than interviews with individuals. Focus groups can accommodate a non-directive interviewing approach that can encourage participants to tell their stories in their own language (Rhodes and Coombes, 2010). Also, this style of interviewing allows for a full description of a phenomenon and allows the moderator to follow any course that is relevance to the study (McCrady et al., 2010). Focus groups are generally felt to be less threatening to many research participants when compared to one-to-one interviews, and they are acknowledged to be a suitable way for participants to discuss perceptions, ideas, opinions and thoughts (Onwuegbuzie et al., 2009). They need to include enough participants to generate a diversity of ideas, but not so big that participants feel uncomfortable sharing their thoughts, and given the online nature of the focus groups in this research, numbers were kept lower than would generally be normal when face to face, at between three and five participants.

The focus groups were held online owing to the Covid-19 pandemic. According to Kite and Phongsavan (2017), using web conferencing for online focus groups has the potential to offer a realistic and comparable alternative to face-to-face focus groups. The online format of the groups has both advantages and disadvantages. Included among the former is the ability to include people who are hard-to-reach, and this could include women with caring responsibilities who have limited free time. Participants can also be recruited from diverse geographical locations as well as from different social and demographic groups, while the electronic medium also makes ensuring the anonymity of group members relatively easy. Kite and Phongsavan (2017) also suggest that the ability to participate from home means that recruitment rates can be higher and, importantly, online focus groups encourage more naturalistic responses from participants because they feel less intimidated and inhibited by the people around them. “The online focus group has a built-in levelling effect, in the sense that shy participants can express themselves as freely as more outgoing participants” (Kite and Phongsavan, 2017). Also, the “chat” function of the software allows participants to privately voice an opinion to the moderator, or to ask for help. Finally, online focus groups are also cheap to run and the conferencing software offers the ability to record and transcribe sessions, speeding up the research process.

On the down side, group dynamics are hard to establish in an online format, as free verbal interaction can feel constrained. Nonverbal inputs from participants also cannot be interpreted or assigned meaning by focus group moderators. Kite and Phongsavan (2017) also identify security as a potential problem, as there is no way to be sure who is in the room, and also guaranteeing the full attention of participants can be a problem when they are able to look at their phones, watch TV or eat while the session is proceeding. An obvious drawback is the need for an internet connection, a suitable devise and digital literacy in order to participate. Poor internet connections can undermine the fluency of discussion and reduce the ability to read people’s body language, making it difficult for participants to know when to speak. Finally, the format also has implications for the

moderator as “the techniques available to a moderator sitting alone at a computer terminal are much more limited because of the lack of face-to-face involvement with participants” (Kite and Phongsavan, 2017). Despite these disadvantages, the focus groups for this research were made essential by the context of the pandemic in 2021. To mitigate the disadvantages to some extent, the moderators intervened when necessary to improve the flow of the online groups and also one moderator monitored the participants who were not talking as a means to assess and then address waning attention levels.

## 3.6 Data analysis

The online review of current services for women warranted analysis of the findings in order to map out the services on offer, as presented in Chapter 6. Using the gendered criteria founded upon evidence from the literature review, each of the current gambling harm support and treatment services was assessed and a descriptive database was generated. This was also supplemented with a further literature search on service provision on offer to all people within the British context.

The main analytic phase of the research focused upon the data generated by the focus groups. According to Onwuegbuzie et al. (2009) there are many sources of focus group data, yet most researchers use only the actual text (i.e., what each of the participants stated during the focus group) in their analyses. In the case of this research, the focus group data were supplemented by notes taken by both moderators during the groups and by debrief sessions between the moderators after each event. The main focus remained, however, the transcripts. Again, there are a variety of choices to be made when analysing focus group data. The most time-intensive includes the analysis of full transcripts and videotapes, alongside supplementary notes. This was the approach used to analyse the first focus groups of each pair, which were about the women’s actual experiences. For the second groups, with their focus on wishes and ideas, the chosen approach was tape-based analysis, in which the researcher listened to the Zoom audio recordings and created an abridged accurate transcript that focused on the most relevant portions (Onwuegbuzie et al., 2009). In reality, very little of the original transcripts of these groups was not included in the analysis.

Analysis of focus groups data also involves the choice of whether to focus on individual data, group data, and/or group interaction data (Onwuegbuzie et al., 2009). Onwuegbuzie et al. (2009) lay out a strong case for an analysis that does not focus on just one level of data in order to increase the depth and validity of findings. They recognise that most focus group researchers use the group as the unit of analysis, focusing on emergent themes, but this provides no information about the degree of consensus and dissent, “resulting in dissenters effectively being censored or marginalized and preventing the delineation of the voice of negative cases or outliers … that can increase the richness of the data” (Onwuegbuzie et al., 2009). Both group and individual

data were the subject of analysis for this project, with this approach aiming to improve validity and depth, also assisting in the identification of the achievement of data saturation. Group interaction data were not analysed because of the nature of the research questions being addressed, and also because of the online format of the focus groups, which makes group interactions harder to achieve.

To undertake the analysis itself, constant comparison analysis was used, which was originally used in grounded theory research but which, according to Onwuegbuzie et al. (2009), is suitable for the analysis of multiple focus group data. Constant comparison analysis involves the comparison of interpretations and findings as they emerge from the data analysis. “Content analysis, or analysing the content of interviews and observations, is the process of identifying, coding, and categorizing the primary patterns in the data” (Dye et al., 2000). It is thus an iterative process ideal for qualitative research that centres on multiple focus groups: “As events are constantly compared with previous events, new topological dimensions, as well as new relationships, may be discovered” (Goetz and LeCompte, 1981).

Once transcriptions of the focus groups were completed, the script content of each transcription was then split into small units, and a descriptor or code applied to each of the units. Interviewers inevitably have biases or personal reactions towards respondents and can subtly code responses differently (McCrady et al., 2010), so to minimise bias, the processes of coding and categorising included another member of Betknowmore staff with research experience but who did not participate in the focus groups. The codes were then grouped into categories or themes, however, with the constant comparison analysis approach, the coding and categorising was a fluid process of continual reflection and reassessment. According to Dye et al. (2000),

> *The researcher should become thoroughly familiar with the data, be sensitive to the context of the data, be prepared to extend, change and discard categories, consider connections and avoid needless overlaps, record the criteria on which category decisions are to be taken, and consider alternative ways of categorizing and interpreting data.*

In detail, from each transcript, the words of individual participants were extracted so as to produce both group and individualised transcripts. Each transcript was then read several times, with notes and descriptive labels added into the margins using the participants’ words. Data that was alike was grouped into piles and indeed sub-divided when necessary into sub-piles, with similarities and differences sought out within and between each grouping. “During the course of the analysis, the criteria for including and excluding observations, rather vague in the beginning, become more precise” (Dye et al., 2000), until finally, themes were developed that expressed the content of each of the groups (Onwuegbuzie et al., 2009), and again these were compared, the relationships between the themes were analysed and clusters of final themes emerged. According to Onwuegbuzie et al. (2009), because focus group data are analysed one focus group at a time, analysis of multiple focus groups can serve as a proxy for theoretical sampling. “Thus, researchers could use the multiple groups to assess if the

themes that emerged from one group also emerged from other groups. Doing so would assist the researcher in reaching data saturation and/or theoretical saturation" (Onwuegbuzie et al., 2009). The cyclical process also involved rechecking that each theme was grounded in the original data. In line with the methodology followed by Kaufman et al. (2017), summary tables were produced that included cluster labels and illustrative quotes. The overarching themes that emerged from the analysis then formed the structure of the main findings of the research (see Chapters 7 and 8), which also included distinctive or contradictory findings, as well those built on consensus. "Importantly, the entire process is supported by a full 'paper trail', so that each step of the analytic process may be traced in detail" (Kaufman et al., 2017)

## 3.7 Summary

The secondary data research undertaken for this project involved a literature review and an analysis of support and treatment services currently on offer to British women. This chapter outlined the databases consulted in the literature search and nature of the sources used, describing the purpose of the literature review as the contextualisation of the research and the identification of knowledge gaps. The literature review also produced evidence used to develop gendered criteria with which to assess the scope of the services on offer to women, the purpose of that assessment being to map the resource opportunities open to women, rather than criticise service providers.

The chapter then progressed to outline the primary data collection method used, namely focus groups. It described the pros and cons of focus groups as a method, as well as the advantages and drawbacks of online focus groups, necessitated by the Covid-19 pandemic. The management of the focus groups was discussed, including those measures put in place to facilitate the building of trust between the focus group moderators and participants, while at the same time ensuring a critical distance was maintained. Finally, the chapter reported that transcriptions of the focus groups were the main unit of analysis, examining group and individual data, also supplemented with moderator notes. Constant comparison analysis was applied to the data and the choice of this method was explained as being suited to the data derived from multiple groups and the validity that can be achieved through the ongoing process of reflection and reassessment of the categories and themes that arise through this method.

# Research Ethics

# 4. Research Ethics

## 4.1 Introduction

This research sought to give women a voice. According to GambleAware (2020a), women are one of the groups that often do not access services and remain "invisible" to researchers and healthcare providers. As such, "research can work to include voices from those who are more peripheral, excluded and marginalised" (GambleAware, 2020a), yet it is essential that such groups are not coerced into participating in research and exploited by the experience. To prevent this, a robust ethics framework was developed during the early stages of this project.

The involvement of people with lived experience of gambling harm was central to this research. Early involvement took the form of a consultation at the outset of the project with a female former gambler and member of Betknowmore's staff to discuss interesting and viable ideas for the research. The primary involvement was, however, through focus groups conduced between April and June, 2021. Not only were 14 women with lived experience involved in the groups, but another female member of staff of Betknowmore with lived experience co-managed the focus groups, having received appropriate training. According to GambleAware (2020a), it is important that the inclusion of people with lived experience of gambling harm in research is ethical, safe and empowering. This section examines the ethics framework of the research project, detailing the processes that were put in place to ensure that no harm (either physical or psychological) was felt by people with lived experienced and that the principle of "respect for persons" was applied throughout.

## 4.2 Voluntary participation and informed consent

Participation in research must be entirely voluntary, with participants fully informed about the procedures involved and the potential benefits and risks to them, with this done in a way that is free of inducement and coercion. Voluntary means that the decision to consent or not to participate in research must be made by the person and must not be influenced by pressure from anyone else. The principle of voluntary participation is especially relevant when research subjects are "captive audiences", in other words those who are socially restricted or marginalised in some way (Miller et al., 2010).

In the case of this project, the focus group participants were women who were or are the clients of gambling support and treatment services. Given the women's ongoing or potential future needs for support, this raises ethical questions with regard to women's perceived freedom to refuse to participate and their perceived

freedom to speak freely about support services, especially those provided by Betknowmore. In response to these ethical problems, early in the research process, careful consideration was given to the focus group recruitment process that would be used and to how the focus groups themselves would be run. A recruitment protocol was written (see Appendix I) that was used by Betknowmore staff when they contacted women. In addition to outlining the purpose of the research, this protocol stated that refusal to participate would not in any way affect the women's access to Betknowmore or other services either now or at any time in the future. The women were also told that their frank opinions were sought in the focus groups and that their identities would be protected and made anonymous to all but those people involved directly in the groups.

According to Miller et al. (2010), research subjects who have lived experience with an addiction also experience a number of other social, economic and psychological conditions that can impair their ability to provide free and uncoerced consent. They may believe, for example, that refusal to participate may lead to the involvement of the justice system or child protection agencies. To counter the danger of such perceptions, in this research it was explained to participants that they could withdraw before, during or after the focus groups. Co-morbidities that may be associated with gambling harms, such as anxiety and depression, may also impair the capacity to voluntarily agree to participate in research and provide informed consent (Miller et al., 2010). With this in mind, the potential participants were screened for such problems during an initial phone call and any one deemed at risk of impaired capacity was not invited to be part of the research for their own safety.

Informed consent means that researchers ensure that before research begins, potential participants have the capacity to:

> *Understand the risks and benefits of participating in research and what their participation will involve; appreciate the consequences of participating and care whether they occur or not; are not under some form of external or internal pressure, real or perceived; and are fully informed of the risks and benefits of participating in the research study, including choosing not to participate* (Miller et al., 2010).

The technique for gaining consent is not set in stone and is usually obtained through one-to-one discussion and signing of a written consent form. In this research a phone call was made to each potential participant, in which the research and informed consent process was explained. The required use and purpose of their testimony was also made clear. The written document was then emailed to the potential participants for them to consider and sign and return, should they decide to participate. Upon the initiation of each online focus group, oral informed consent was also obtained, giving the participants a further opportunity to ask questions and consider their participation.

## 4.3 Confidentiality and anonymity

All data and information collected from the research participants were confidential, with any identifying information about participants unavailable to anyone not directly involved in the research. Confidentiality is not only essential for reasons of ethics and safety, but also helps ensure that the information collected is of high quality. Recordings were made of each focus group and these were stored as password-protected electronic data files. Password-protected files were also generated for transcripts and all data collected by the project were held in accordance with the General Data Protection Regulation, thus ensuring all personal information related to this research was:

- Used fairly, lawfully and transparently;
- Used for specified, explicit purposes;
- Used in a way that is adequate, relevant and limited to only what is necessary;
- Accurate;
- Kept for no longer than was necessary;
- Handled in a way that ensured appropriate security, including protection against unlawful or unauthorised processing, access,
  loss, destruction or damage (GambleAware, 2020a).

To protect the identities of the research participants, they remained anonymous throughout the study, thus avoiding any potential harmful consequences. According to GambleAware (2020a), the ability to identify members of socially excluded and stigmatised communities who participate in research can have substantive and negative consequences for their wellbeing. In the case of this research, during the online focus groups, only participants' first names were used and pseudonyms were later selected for the content analysis and the written outputs of the research. It was decided that pseudonyms would not be used in the focus groups themselves in order to ensure the flow of the discussion was not interrupted by people forgetting their selected pseudonyms. In the outputs of the research, any information used to describe the participants (e.g. age, ethnicity etc.) is not presented with additional information that could unintentionally lead to their identification.

## 4.4 Risks and benefits

In order to obtain informed consent, potential risks and benefits must also be outlined. Potential benefits include therapeutic benefits of engaging with a group of women discussing shared experiences, a (re)engagement with Betknowmore and monetary reward in the form of vouchers for participating in the research. Previous research has shown that women often report personal satisfaction from participating in research, gaining a sense of contributing to a greater purpose and wanting to help others in similar situations. Research can be a supportive and empowering experience for participants (GambleAware, 2020a). In this research, some of the women found the focus groups to be an empowering experience, especially those who had not previously accessed women-only groups.

In terms of monetary reward, some research indicates that providing cash rewards to those with addictions can be counterproductive to their recovery while other research has found that giving vouchers can also have undesired effects, such as the person with the addiction swapping the voucher for less money than it is worth. As individuals with an addiction often have low incomes, Miller et al. (2010) argue that they could be vulnerable to financial inducements to participate but also participants should be compensated for their time and inconvenience in the same way as any other research subject. “A balance needs to be struck between adequately compensating subjects for their time and providing financial inducements that are large enough to make subjects unable to properly assess the consequences of participating in research” (Miller at al., 2010).

According to GambleAware (2020a), people who contribute their time and expertise may reasonably expect compensation, but researchers must consider safeguarding principles when remunerating individuals who may still be in treatment for gambling disorder and may be developing money management skills. For this research, participants were rewarded with a voucher for £20. During the recruitment process for this research, the giving of the voucher was discussed and if it was mutually felt that a woman’s recovery could be put in jeopardy by receiving a voucher, she was excluded from the research or consented to participate without the voucher reward.

Another potential risk to the women during the research included the emergence of difficult feelings during the focus groups. It was made clear to the women, when obtaining their informed consent, that they could leave the focus groups at any time and support was made available to them by a member of Betknowmore outreach staff. In addition, included in the informed consent form was information on support services such as the National Gambling Treatment Service, its national Gambling Helpline and GamCare and the NHS, plus other options for reporting abuse and/or violence. The researchers also provided participants with their contact details to allow for further engagement and subsequent referral information if necessary, in accordance with GambleAware’s (2020a) recommendations.

## 4.5 Language

GambleAware (2020a) also draws the attention of researchers in this field to the importance of language, arguing that some terms can alienate and offend participants, thereby causing and exacerbating harm. Appropriate language is not only important when interacting with people with lived experience, but also when writing up research. GambleAware's recommendation is that language and terminology should describe the behaviour of the person and not reduce the person to their behaviour, for example avoiding phrases such as "gambling addict" (GambleAware, 2020a). These recommendations were followed by the researchers, but the language used by the women in the focus groups was not changed to reflect such sensitivities.

## 4.6 Rules of engagement

Finally, also as a means to avoid harm and ensure that the research process was as rewarding as possible, expectations about behaviour and engagement for both researchers and people with lived experience were set out at the start of the focus groups. The ground rules included the expectation that the participants would not interrupt or speak over one another, and that people would not monopolise discussion at the expense of others' participation (GambleAware, 2020a). The focus group moderators actively tracked participation of each focus group member and when necessary the moderators supportively selected or prompted participants for their opinions.

## 4.7 Summary

This short chapter outlined the ethics framework that was developed to guide this research project. It outlined how people with lived experience participated in all phases of the research to improve its relevance, safety and transparency. The chapter also detailed the processes put in place to ensure voluntary participation and informed consent. The importance of confidentiality and anonymity were also discussed, especially in relation to particular populations who may be harmed if their identity is revealed. All of the women who participated in this research had their identities and their data protected. The risks and benefits of participating in the research were also discussed and the process by which these were made clear to the women was presented. The chapter also touched on the importance of sensitive use of language by researchers, though the genuine voices of the women were protected from unnecessary editing. Finally, the rules of engagement used to govern the participation of the women in the focus groups were briefly explained and were designed to ensure fairness and encourage full participation by all of the women.

# Literature Review

# 5. Literature Review

## 5.1 Introduction

The gambling sector has been transformed in the context of the growing dominance of neoliberalism over the past 40 years. No longer heavily regulated and niche, gambling is now prevalent in many economies, societies and cultures; in 2019, for example, the gross gambling yield was £14.2 billion in the UK (Gambling Commission, 2020). The normalisation and pervasiveness of gambling have resulted in the numbers of people experiencing gambling harms growing exponentially, with this harm stemming from their own or someone else's gambling.

In response, a significant body of research has explored issues such as the reasons why people gamble at harmful levels and what sorts of help they need and can receive. Traditionally gambling has been seen as the domain of men and gambling problems as largely the burden of men, and so research has traditionally focused either explicitly or implicitly on men. While the attention of researchers has begun to turn to women over the last 20 years or so, looking at women as gamblers and affected others, the "lack of gender-specific research has contributed to a perception that gambling problems for women are indistinguishable from those of men, masking the concerns and issues relevant for women who gamble" (McCarthy et al., 2019a). This research aims to help fill this knowledge gap, looking specifically at how women access support and treatment services and whether those services are sufficiently tailored to their needs. It is a response to calls for further work in this area, such as that made by Kaufman et al. (2017), who state that "The field of problem gambling is a complex area where further research is needed to establish whether there is a more effective way to reach and engage women with problems in this area".

## 5.2 Prevalence and nature of gambling harms among women

The traditional barriers to the participation of women in gambling activities have weakened over the last 40 years as legal controls on gambling have been rolled back, as traditional gender roles have changed and as many women have greater financial resources of their own (Rogers et al., 2020). In the UK, the liberalisation of the gambling industry began in the 1980s, after which it gathered speed and was cemented by the 2005 Gambling Act. The landscape of gambling has changed out of all recognition in this time, from men gambling on sports events in dingy high street betting shops, to a complex array of varied gambling products offered in

physical and virtual spaces, easily accessible to men, women and children 24 hours per day. According to McCarthy et al. (2019a),

> *A shift in the gambling landscape in the UK, which saw an increase in online gambling, an increase in gambling advertising and sponsorships and limited government regulation, legitimatised gambling as a valid recreational activity among women.*

Gambling Commission data from 2016 reveal that 53% of men and 44% of women had gambled in the four weeks running up to the survey (Gambling Commission, 2017). The survey found an increase in at-risk gambling in both genders since 2015, with 5.5% of people aged 16+ identified as low or moderate risk gamblers, and with men being more likely to be categorised as at-risk gamblers than women (7.7% of men identifying as such compared to 3.5% of women). Overall 0.7% of respondents identified as problem gamblers with a top score on the Problem Gambling Severity Index (PGSI 8+), again with men more likely than women to be categorised as such (1.2% compared to 0.1%) (Gambling Commission, 2017).

In 2019 YouGov, on behalf of GambleAware, conducted a survey of 12,161 adults in Great Britain, including 6,190 women and 5,971 men, weighting the results to be representative of the adult population according to age, gender, region, socio-economic group and ethnic group. Overall, 10% of women scored one or higher on the PGSI scale (lower than the 17% of men with PGSI 1+). This comprises 6% who were classified as low-risk gamblers (PGSI 1–2), 2% who were classed as moderate-risk gamblers (PGSI 3–7) and 2% who were classified as problem gamblers (PGSI 8+). Female gamblers experiencing high levels of harm from gambling (PGSI 8+) were particularly more likely to be younger. In comparison to the broader female sample, female gamblers with a PGSI score 1+ were also much more likely to be of lower social grades or from a BAME (Black, Asian and minority ethnic) background. Female gamblers experiencing high levels of harm from gambling (PGSI 8+) were again much more likely to be from a BAME background compared with the broader female sample (35% vs. 12%) (Gunstone and Gosschalk, 2019).

In terms of actual numbers of people with gambling problems, the true figure probably lies somewhere between two estimates: one estimate is that around 430,000 adults in the UK gamble at a problematic level, with an additional 2.4 million individuals identified as being at risk (Conolly et al., 2018); the second estimate is that there are about 300,000 gamblers experiencing high levels of harm in the UK at any one time (Bowden-Jones et al., 2016). Over the past five years, the number of women reporting harmful gambling has risen at more than twice the rate of men, from 2,303 in 2014/15 to 3,109 in 2019, according to figures from GamCare, but only about 1% of women experiencing gambling harms receive help and support, and the number of women experiencing harms is thought to be significantly underestimated (Guardian, 22 January 2020).

“Gambling is a well-recognised public health issue that causes significant harms for individuals, their families and communities” (McCarthy et al., 2019a), but detailed explorations of women’s lived

experiences of harm are few in number (McCarthy et al., 2019a), so the assumption remains that gambling harms are largely the same for both women and men. In general, the harms that are known to be associated with gambling harms include: mental and physical health impacts (e.g., depression, anxiety, insomnia, intestinal disorders, migraine, suicidal ideation and other stress related disorders); effects on relationships (including neglect of family and divorce); financial impacts (such as debt, work absenteeism and bankruptcy); and criminal behaviour (including acquisitive crime and domestic and child abuse) (Kerr et al., 2019). "People who experience harms associated with gambling can experience compound and intersecting stigmas, discrimination and social exclusion" (GambleAware, 2020a).

Qualitative research by NatCen for GambleAware found that financial problems are uppermost for many people gambling at harmful levels:

> *This included having to borrow money and getting into debt as a consequence of losing money. This was particularly problematic if the individual gambled away their non-disposable income: such as rent money or money for bills. There were also participants whose level of spending was almost problematic, but they would then 'scrimp and save' in all other areas of their lives (including e.g. food shopping) or, use their savings to account for losses and avoid negative consequences* (Kerr et al., 2019).

Research by Muggleton et al (2021) based, unusually, on big financial data and a very large sample of 6.5 million people tracked over seven years in the UK, found that a number of negative outcomes such as nights awake, unemployment and mortality increase markedly for the highest-spending gamblers, but gambling is associated with negative outcomes even at lower levels of gambling. For example, a 10% increase in gambling spend is associated with an increase in payday loan uptake by 51.5% and the likelihood of missing a mortgage payment by 97.5%. Also, tracking individuals between 2014 and 2019, the researchers found that higher gambling is associated with a higher risk of future unemployment and future physical disability. Gambling at high levels is also associated with levels of mortality at about one third higher than non-gamblers (Muggleton et al., 2021).

In relation to women, research has found that financial losses can be more modest than those of men, due to the lower incomes of women, and these lower levels of debt have traditionally resulted in women's gambling not being regarded as problematic (Crisp et al., 2004), but according to Mark and Lesieur (1992) the effects on women can be equally as devastating. For women, the perceived benefits of gambling can quickly be replaced by problems and "serious financial debt reduces women's autonomy and their ability to socialise and enjoy life" (Hing and Breen, 2017). In research conducted by GamCare, high numbers of women who gamble or used to gamble mentioned suicidal thoughts and feelings and 100% of women who gamble identified a negative impact on their mental health and wellbeing (GamCare, 2020).

According to Pulford et al. (2009), in addition to significant financial losses, poor physical and mental health, and antisocial behaviour, the actions of each gambler negatively affect between five to ten other

people in ways that range from the personal, interpersonal, financial, legal and community, through to the professional. “Problem gamblers who do not seek help, therefore, continue to expose themselves and others to these significant, and potentially resolvable, harms” (Pulford et al., 2009). In general, however, there is scant attention paid to subgroups of women who may conceptualise harm in varying ways (McCarthy et al., 2019a); this is especially true of BAME women who are known to be particularly vulnerable to gambling harms in the UK, but we understanding next to nothing of why this is so.

## 5.3 How women gamble

The rise in the number of women experiencing gambling harms is directly attributable to the ease with which women can now gamble online, allowing them to avoid the male-dominated realm of the bookies (Guardian, 22 January 2020). Gambling Commission data reveal that almost 70% of women who gamble use apps and websites. Male online gamblers are more likely to gamble using a mobile phone than females (32% compared to 25%), whilst female online gamblers are more likely to use a tablet device than males (23% compared to 20%). The most popular location for online gambling is the home, with 97% of online gamblers doing so, but outside of the home, men are most likely to gamble online while at work (13%), while women are most likely to gamble online while commuting (10%). The Commission also found that on average gamblers had three online accounts with gambling companies in 2016, down from the 3.5 reported in 2015, and men have more accounts than women (3.5 compared with 2.5) (Gambling Commission, 2017).

The perception remains that women are more likely to play games that demand low levels of skills such as bingo and electronic gaming machines (Corney and Davis, 2010), while men gamble on games that require higher levels of skill and that are sports related. Piquette-Tomei et al. (2008) summarise this tendency for women to prefer non-strategic and less interpersonally interactive games and men to favour action gambling and games of strategy, but they report that middle-class career women also tend to prefer action gambling that requires skill. Bingo was traditionally a game played by older women in bingo halls but it has reinvented itself as a fun night out for young women too. It has also gone online:

> *Online bingo sites send a digital invitation for a night out with the girls–without having to make the effort of choosing an outfit, leaving the home in the cold and the dark, atten=ding a venue alone and meeting new people–to women whose social lives may be lacking* (Karter, 2013).

Even traditional betting shops or bookies have been transformed over recent decades from seedy shops with frosted glass to brightly lit, inviting premises offering coffees in prime high street locations in most neighbourhoods (Karter, 2013). It is

no longer unusual for women to enter betting shops, even if just to use the fixed odds betting terminals they contain.

Such machines (known variously as slots, video lottery terminals or electronic gaming machines) are considered to be highly addictive and have been referred to as “the crack cocaine of gambling” (Afifi, 2010). Their addictive nature is explained by the opportunity they offer for quick and continuous play, and Afifi (2010) argues that women players can believe they have strategies for winning on electronic gaming machines, the mistaken belief that the machines can be manipulated, poor understanding that longer play means larger loses, the misunderstanding of the odds of winning, and the ability to dissociate during play. Karter (2013) argues that the attraction of online gambling to women also stems from their ability to learn how to play new games with anonymity and without possible embarrassment. “Gambling can be done in secret, where one can try one’s hand at a variety of games and gradually build up skills, experience, and knowledge without seeming a fool” (Granero et al., 2018)

Women’s attraction to gambling on electronic gaming machines in casinos or betting shops has been explained by gambling operators providing female-friendly, easily accessible safe venues that allow women to socialise. Indeed, in Australia, venues supply courtesy buses within women’s local communities (Hing et al., 2017). Because slots require no skill and little concentration to play, Hing et al. (2017) argue that they are attractive to women because they are a means for time-out from everyday demands and can induce a sense of dissociation. Also in Australia, Hing and Breen (2001) found that women had a higher preference for bingo, lotto, lotteries, pools and gaming machines; they gambled less frequently on off-course and on-course betting, casino table games and hotel gaming machines, but more frequently on bingo; they were also more likely to maximise playing time on gaming machines; and they experienced gambling harms at levels comparable to males.

Looking at different subgroups of women, in Australia McCarthy et al. (2019a) found in their sample of women that while electronic gaming machines were the product gambled on most frequently by women overall, younger women were significantly more likely to bet on sports and gamble at casinos than older women. They also found that younger women gambled as part of a “night out”, “with friends”, due to their “ease of access” and perceived “chance of winning big”. Research by Thomas and Lewis (2012) reports that order women have a reduced perception of gambling harms because of the social benefits they derive from it, indeed they view gambling as one of the few available and accessible leisure activities open to them as older women (Pattinson and Parke, 2017).

Dow Schull (2002) argues that many of the differences between male and female patterns of compulsive gambling are down to social context rather than determined by sex. In Vegas, she found that increasing numbers of men were playing video poker machines and “the stereotype of ‘man the dice roller’ and ‘woman the machine

escapist' is rapidly losing ground". She argues that video poker is not "naturally" a female game, but one that women are drawn to for social reasons, including escaping their gendered caretaking responsibilities. There is some evidence then of a waning of gender stereotypes for game preference, with women no longer being the only ones who need and find escape through gambling, especially in context of an environment that is saturated with technologies that satisfy this need (Dow Schull, 2002). McCarthy et al. (2019b) thus conclude that "engagement in gambling and product preferences are 'socially determined', and therefore, these changes are more likely to be due to increased exposure to industry marketing and the influence of socio-cultural and environmental factors".

## 5.4 Why women gamble

Writing in 2002, Dow Schull observed a shift in the perception of excessive gambling from being a social crisis to a personal problem, signalling a growing belief that the solution lay with doctors working with the individual gambler rather than policymakers. Women who gamble excessively have been portrayed in sensational media stories as bad mothers, as criminals, as lacking all self-control (Karter, 2017). Stories about male gamblers tend to focus on their financial difficulties and rarely touch on their parental roles (Dow Scull, 2002), but the print media in particular sensationalise stories about female gamblers and focus on their maternal roles (Mark and Lesieur, 1992). An alternative narrative draws attention to the highly addictive gambling products marketed at women and the unequal burden of care that rests with women and that makes such products a tempting means of escape. "The desire for such an escape ... is symptomatic of unresolved anxieties and tensions surrounding the place of care in our discursively individualist society" (Dow Schull, 2002) that remains characterised by gender inequalities.

The UK government's acknowledgement in 2020 of the need to reform the 2005 Gambling Act shows some recognition that "the gaming industry, by designing consumer technologies that capitalize on potent cultural anxieties, is implicated in the phenomenon of machine addiction among women" (Dow Schull, 2002) as well as the rise of gambling harms among children, men and vulnerable adults. Gambling operators in the UK spend over £1.5 billion per year on advertising and 80% of all gambling marketing activity is now on the internet (House of Lords, 2020). Marketing messages directly aimed at identifiable groups of individuals, such as women of particular age or socio-economic groups, were estimated by the UK government to cost £747 million in 2020 (House of Lords, 2020). In research conducted for the Advertising Standards Authority by Research Works (2014), the participants discussed advertising of online bingo, perceiving it to be clearly targeted at women, especially working-class women, with operators trying to outdo each other with greater rewards and free offers. Research has shown that some women

experiencing high levels of gambling harms have been tempted back into gambling by advertising or by receiving personal emails and promotions with bonus payments (Corney and Davis, 2010).

In addition to the aggressive and seductive advertising of gambling operators using daytime TV and online sites to target women, features of the internet that make it attractive to women gamblers are its accessibility from home, its anonymity and its privacy (Corney and Davis, 2010). Despite that fact that advertising often portrays women's gambling as a sociable activity, research suggests that harmful gambling for women is usually a solitary activity and therefore easily catered for by the internet. While women may gamble initially for social reasons, in time it becomes a solitary activity or a means to socialise without intimacy (Dow Schull, 2002).

> *Women problem gamblers are more socially anxious and avoid social activities compared with either male problem gamblers or women in general. This suggestion may partially explain female problem gamblers' choice of gaming activities, such as slot machines, where interaction with others is low* (Corney and Davis, 2010).

Gambling online allows women to play for points while they learn but "once they started playing for money, it was difficult to go back" (Corney and Davis, 2010). Games offering continuous play, rapid play and high stakes, coupled with the ability to have several accounts that enable simultaneous play on numerous games, are all features of the internet that are particularly problematic, especially for women. It is also argued that women's gambling is more likely than men's to develop rapidly and become harmful and that this is due to the greater addictiveness of the games women find appealing and which are marketed at them (Dow Schull, 2002).

A significant amount of the research on women experiencing gambling harms explores their personal reasons for gambling. "Women appear more prone to developing gambling problems when coping with major life changes, especially when those changes result in social isolation, loneliness and personal distress" (Hing et al., 2017). Research shows that women often gamble to escape personal pressures, boredom, loneliness, social isolation and depression. For women, "Gambling becomes out of control often as a response to feeling psychologically overwhelmed and emotionally out of control" (Karter, 2013). Women spending long periods of time at home, such as those who are ill or disabled, and those with caring responsibilities, are particularly vulnerable to developing gambling problems through online gambling sites (Corney and Davis, 2010). This also includes women caring for young children or for the elderly or disabled. While gambling may start off as a form of entertainment to stop them from feeling lonely, isolated or bored, for some it becomes harmful.

In research by Piquette-Tomei and colleagues (2017), women reported that their gambling was a way of avoiding or escaping their problems and that their gambling increased as their personal problems worsened. Gambling can allow women to "create social isolation and self-abandonment, and becomes a place where their sense of body,

self, place and time dissolves; the women play to disappear, to lose themselves into the machines, to disconnect and turn off the world" (Piquette-Tomei et al., 2017). Burke (1998) found that 70% of women are "escape gamblers", while only 10% are "action gamblers". Motivations for male problem gamblers are seen as being more associated with the enjoyment of the game itself, the sensory stimulation it produces, its excitement and arousal, and the possibilities of winning (Corney and Davis, 2010), but women might use gambling as a maladaptive mechanism of emotion regulation (Granero et al., 2018).

Roberts and colleagues (2017) report that women who gamble at harmful levels and who seek help frequently have depression or an anxiety disorder as a co-morbidity, and they are also likely to report a history of trauma, including childhood trauma or abuse (parental alcoholism or gambling problems and mental illness) and abusive relationships in adulthood. A history of physical and/or sexual abuse is significantly more common for women who gamble harmfully than men, and the marriages of these women are often chaotic, marked by spousal addiction to alcohol, drugs or gambling, mental illnesses, infidelity or absences (Piquette-Tomei et al., 2007). The women also often display co-morbidities that include other behavioural and psychological disorders, including alcohol and substance use (Roberts et al., 2017). Similarly, Boughton and Falenchuk (2007) report that women gambling at harmful levels have significantly higher rates of depression and anxiety than the general female population and than men gambling to the same extent. They also describe isolative behaviour in such gamblers, strong feelings of social discomfort and sensitivity to criticism, especially in women. The authors also note that more female gamblers than male gamblers report lifetime use of psychiatric medications, abuse of medications and medication use at the time of seeking treatment.

Understanding the gambling problems of women in the context of widely available addictive gambling products marketed to them by a liberalised gambling industry, coupled with their excessive caretaking burdens, co-morbidities and histories of abuse, enables us reject the blame and stigma apportioned to women who gamble at harmful levels. Excessive gambling in women is not a matter of lack of self-control and "a related biomedical understanding of excessive gambling as a genetically based 'pathology' ... their play aims above all at a total disconnection from the human, including themselves" (Dow Schull, 2002).

## 5.5 Support and treatment for women

There are currently no guidelines for the treatment of pathological gambling issued by the National Institute for Health and Care Excellence (NICE) and "the geographical distribution of services is informed neither by the prevalence rates of problem gambling, nor by a needs assessment to guide strategic commissioning. Access to services is therefore highly variable across England" (Bowden-

Jones et al., 2016). Of an estimated 300,000 people gambling pathologically, 8,000 (2.7%) are in treatment at any one time (excluding private sector clients), contrasting with 6% of problem drinkers and 50% of Class A drug misusers (Bowden-Jones et al., 2016). Care is currently provided by a network of national and local third sector organisations, most notably GamCare and its regional partners, and Gordon Moody for residential care, with specialist NHS provision in London and more recently northern England.

According to Gunstone and Gosschalk (2019), the huge discrepancy between the number of people receiving treatment for gambling harms and the number in need of treatment suggests that there is an issue with either the demand for services and/or the supply of treatment services. Women are less likely than men to seek help for their own gambling problems, and this is not just because men experience gambling problems at a higher rate that women. GamCare reports that while men tend to call the National Gambling Helpline to talk about their own gambling harms, women are much more likely to call about someone else's gambling: "90% of men, as opposed to 41% of the women who contact the Helpline, call because of their own gambling" (GamCare, 2019). Nevertheless, the number of women seeking help for their own gambling harms is on the increase, with Gordon Moody stating that in 2019, across Gamcare, GambleAware and Gambling Therapy (as part of the National Gambling Treatment Service), 30% of helpline calls came from women, with 59% seeking help for another and 41% seeking help for themselves, in total numbering 9,000 women. In the same year, there was an increase of more than 100,000 women visiting the Gambling Therapy website, taking the total number of hits from women to more than one million, up 76% from the previous year (Gordon Moody, 2020). It still remains the case, however, that women are underrepresented in treatment and support services. GamCare and Gambling Commission data suggest that only around 1% of women who experience gambling harms contact the National Gambling Helpline (GamCare, 2019) and the reduced tendency for women to seek support for their gambling problems contrasts with women's higher rates of help-seeking behaviours in relation to mental or physical health problems, for example.

Gunstone and Gosschalk (2019) found that among its sample of female gamblers with a PGSI score of 1+, 16% reported having used either treatment alone, or a combination of treatment, informal support and advice, to cut down on their gambling. They also found that younger female gamblers were more likely than older female gamblers to have sought treatment and/or support/advice and this was also true for BAME women, people from higher social grades, women caring for children and those drinking at higher risk levels. Seeking treatment, support and advice was greater among gamblers with higher PGSI scores, thus including younger and BAME gamblers (Gunstone and Gosschalk, 2019). Other research, however, contradicts the finding that women who are younger tend to seek help, with Echeburua et al. (2011) reporting that women in Spain typically seek help for gambling problems at an older age, and also that their gambling problems developed more rapidly than the problems of men. The authors also found that women treatment seekers were

more likely to be divorced and to have lower incomes than male treatment seekers. Hing et al. (2017) review research that showed women enter into treatment earlier in their addiction than men due to greater levels of stress over lower levels of debt, with that debt often owed to family and friends rather than to lending institutions.

While there is limited research that identifies the specific barriers faced by women who wish to seek help, Karter (2013) argues that women face twice the amount of emotional, psychological and social difficulties that men confront. In their research, Gunstone and Gosschalk (2019) found that the predominant barrier to seeking treatment, support or advice by both men and women participants was that they did not perceive their gambling to be harmful; this was stated by 44% of those not wanting treatment/support. The researchers speculate that this is because many gamblers who experience low levels of harm may not need treatment and support. Important research has been conducted by Kerr et al. (2019) on women and treatment for gambling harms. They found that some women do not realise that their gambling is problematic at the time of engaging in the activity, and only realise this with hindsight. They also found that women who recognised that their gambling behaviour may be leading to some harm questioned whether this warranted them accessing formal treatment and support services. Nevertheless, recognition of the impact of gambling on family members can be an important motivator for individuals to attempt to control their gambling behaviour (Kerr et al., 2019), and when family and friends are aware of gambling problems, they can help women gamblers seek help from formal treatment and support services (Kerr et al., 2019).

According to Kerr et al. (2019), the overall low level of women seeking help for gambling harms stems from how gambling problems are generally perceived in society. In the UK gambling harms are not widely understood as a public health issue and there remains reluctance among individuals to discuss their gambling behaviour, which is especially true of women. According to the Women's Retreat and Counselling Programme Manager of Gordon Moody, women are uniquely skilled at keeping it all together while they or someone close to them are falling apart, and this means that many women are reluctant to explore anything other than short-term interventions (Gordon Moody, 2020). In this way, "gamblers may have paid less attention to information about gambling treatment and support because they did not feel that it was relevant to them or, they did not want to acknowledge that their gambling was problematic" (Kerr et al., 2019). Similarly, Kaufman et al. (2016) report that internal barriers to women seeking help are denial and fear, stigma and feeling like an "outsider" (partly because of their gender) in treatment services.

This leads on to one of the greatest barriers to women seeking help for their gambling. Gunstone and Gosschalk (2019) found that for women, stigma (e.g. feeling embarrassed, not wanting people to find out) was a key barrier to accessing treatment, support or advice, with this being particularly true for those classified as "problem gamblers" (PGSI 8+). Research explaining the low levels of women who seek help for their gambling problems consistently places stigma and shame among the

main reasons why women do not seek help. Stigma is related to the continuing perception that gambling problems are men's problems (Huffington Post, 2020) and Hing et al. (2017) found that women were more likely than men to report that feeling ashamed for themselves or their family was a barrier to help-seeking. The researchers report on previous work that showed women to be put off from help-seeking by guilt at failing to live up to modern ideals, in addition to fears that treatment could lead to them losing their children or receiving physical abuse from their partners. Thus "Speaking about problem gambling with others was felt to be challenging, because of the 'shame' associated with it as well as the potential negative consequences that disclosing such information could have on the individual" (Hing et al., 2017). GamCare (2020) also identifies layers of stigma as a barrier to seeking support. The layers include cultural stigma for BAME women, the perception of women as primary care givers who are responsible for others, the view that women are not financial "owners" and the perception of gambling as a "male issue" (GamCare, 2020).

Piquette-Tomei et al. (2007) report that personal and interpersonal variables that are the most significant barriers to women accessing services are their partners' influence, their own stage of recovery (i.e., pre-contemplation and contemplation), feelings of shame and guilt, lack of awareness and other personal issues. Looking at lack of awareness and knowledge of gambling treatment and support services, Kerr et al. (2019) found that this was influenced by a lack of clear and informative advertising about the treatment and support services available, including their positive outcomes, especially in local areas. Women described to the researchers how information about treatment and support services on gambling websites or television advertisements was inconsistent and poorly displayed. This acted as a barrier to accessing treatment as there was not only a need to recognise that their gambling was problematic, but also a need to go to the effort of finding out about the treatment and support options available (Kerr et al., 2019).

Women participants in Kerr et al.'s research also reported uncertainty about what services would offer them and whether their problems would be understood; they had concerns about confidentiality and anonymity; and they lacked trust in treatment and support services that were linked to gambling websites (Kerr et al., 2019). There were also concerns that advertising around gambling treatment and support services did not represent the range of people with gambling harms, including those from non-white ethnic groups (Kerr et al., 2019).

Practical barriers also affect the ability of women to seek support, and Kaufman et al. (2016) identify such external barriers as inaccessibility (including waiting times and distance), as well as problems identifying suitable services, including issues around signposting from primary care services. Kerr et al. (2019) also identify a lack of internet access as problematic, undermining the ability of people to find treatment and support services. Discussing its residential rehabilitation services for women, Gordon Moody found that practical issues around safeguarding, childcare and other family responsibilities can stand in the way of women's participation. "That can mean that

for some they opt to just 'put a toe in the water', when the reality is that they need more extensive and intensive residential therapy treatment in order to turn their lives around" (Gordon Moody, 2020).

The ways in which women become aware of treatment and support services were examined by Kerr and colleagues (2019). They found women sought help when they finally recognised that their gambling behaviour was problematic; when they had been told about available treatment and support services by a professional, such as a GP (this "was reported to be helpful, not only in being signposted to sources of support, but also through offering a space where they could reflect on their gambling and its consequences"); when family and friends told them of the services available; when they received information on services from a gambling operator or other source; when they had researched gambling problems and support services online; when they received support from social networks, family, friends and partners; and when they had attempted to control or change their accessibility to gambling and make it difficult to gamble, including the use of blocking software and self-exclusion schemes, though experiences of these varied (Kerr et al., 2019).

With regard to self-help measures such as self-exclusion from gambling sites and premises, the Gambling Commission (2017) reveals that men are more likely to self-exclude than women, with 7% having done so, compared to 5% of women. Men are also more likely to use financial limits and to exclude by product than women, though rates for time outs and reality checks are similar for each gender. The Commission also reveals that women are less likely to read the terms and conditions attached to gambling products, with 19% having done so compared to 27% of men (Gambling Commission, 2017).

In their research, Gunstone and Gosschalk (2019) found that 27% of female gamblers put forward a number of factors that might motivate them to seek treatment, support or advice, the most common of which was knowing support was available via a particular channel (telephone, online or face-to-face). Also significant was ease of access (including the ability to self-refer). This brings us on to how treatment and support services could better cater for the needs of women experiencing gambling harms. Different methods of support may be necessary to engage women and to reduce their gambling harm. "They may respond differently than men to different types of preventive activities, educational messages, and treatment strategies" (Corney and Davis, 2010). Indeed,

> *there are clear differences by gender in trajectories of gambling careers, experiences in treatment services and in co-occurring issues that would suggest the need for exploring gender-specific provision with a greater focus on social isolation, depression and the management of stigma in services for women gamblers* (Best et al., 2019).

Kaufman et al. (2017) researched treatment seeking by women in the UK. In their review of the research base they write of the importance of aggressive and early interventions for women gambling at harmful levels because their gambling problems progress more rapidly than

those of men. They also report on evidence that the treatment of these women should focus on emotional needs. This is backed by other research that argues that treatment offerings should mirror the complex reasons why women gamble at harmful levels, including their higher tendency to have co-morbidities. Roberts et al. (2019), for example, argue that services should consider the implications of underlying co-morbidities, and tailor treatment for clients who exhibit intimate partner violence by offering enhanced treatment to deal with risks for safety and additional underlying psychopathology. Echeburua et al. (2011) conclude that women have different treatment needs then men and that there is a "need of a more intensive treatment programme in women and more focused on how to cope with depression". Mark and Lesieur (1992) write of the evidence that women seeking help have a wide range of complex issues and needs, including mental illness (depression, bi-polar, anxiety disorders, anorexia), substance abuse (mostly alcohol), relationship breakdown, financial difficulties, work issues and crime. "The severity of their additional problems seemed to mask the women's gambling problems" (Mark and Lesieur, 1992) – an important consideration for those providing treatment and support services to women.

When considering the problems specific to women gamblers, especially relationship issues such as dominance, subordination and social control that result from gender inequality and patriarchy, this has practical implications for the way services are offered. Mark and Lesieur (1992), for example, discuss the advice of Gamblers Anonymous that all financial assets of male gamblers be relinquished to, and controlled by, the wife to protect the men from creditors. If this recommendation is made to women gamblers, it would clearly be detrimental to women in relationships where they are coercively controlled by their partners. Indeed, "even in traditional marriages where wives are already subordinate to and financially dependent on their husbands, this suggestion only serves to reinforce the existing patriarchy" (Mark and Lesieur, 1992).

In addition, Mark and Lesieur (1992) found in their research that relapse was also identified as more common among women experiencing more numerous and complex problems, meaning that aftercare provision for women is likely to be especially important. Time is needed in order to identify the variety of problems, complex needs and underlying issues for each individual; this is essential so that gambling concerns can be holistically and appropriately addressed (Hing et al., 2017). The co-morbidities and relationship problems experienced by women necessitate not only better screening and diagnosis for these problems, but more comprehensive treatment programmes too (Mark and Lesieur, 1992), contrasting with the current provision of help for different problems in different locations from different services.

Practical barriers to accessing services also need to be addressed. These affect not just access but also the retention of women in services, as women have higher drop out rates than men. Canadian women reported that accessibility (time and location) was a key element in the efficacy of support groups. The majority of the participants identified that an evening group was most beneficial

because it was accessible to women who work in the daytime (Piquette-Tomei et al., 2007). Migrant women in Australia found financial information and practical childcare assistance to be helpful (Hing et al., 2017). Hing et al. also found that women want culturally specific gambling help, so treatment and support services need to not only be accessible, but also relevant to an individual's background and needs, thus differentiating between subgroups of women and not assuming they all have the same needs. Mark and Lesieur (1992) argue that service provision needs to be far more efficient and reflect that fact that most women work full time, as well as having caring responsibilities. They suggest that outpatient treatment programmes and other services be in one location. In the research conducted by Kerr et al. (2019), participants described how information about treatment and support should be available from a range of sources, including websites, social media and in non-gambling venues such as doctor's surgeries and libraries, with all telephone numbers being free to call. Women also felt that gambling treatment and support could be offered by a range of providers, including non-gambling support services and local councils (Kerr et al., 2019).

In research by Piquette-Tomei and colleagues (2007), women participants said that more advertising of services was needed and they felt that anti-smoking ads were more prevalent. Participants in the research by Kerr at al. (2019) felt that increased advertising about the signs and symptoms of gambling harms and the range of treatment and support available would help raise awareness. "Specific areas where this would be helpful included reassurances around confidentiality and anonymity and how treatment could lead to particular outcomes" (Kerr et al., 2019). Similarly, Boughton and Falenchuk (2007) argue that to support women's efforts to self-change, information specifically designed for them is needed to help them recognise the dangers of gambling, giving them tools to assess their own gambling behaviours, and information to enable and support their change efforts. Such self-help materials should also be free and widely disseminated for the purposes of early intervention. *"Public information sensitive to women needs to normalize, destigmatize, remove self-blame and shame and encourage women towards more satisfying but less risky ways of treating themselves to well-deserved relaxation and fun"* (Boughton and Falenchuk, 2007).

McCarthy et al. (2019b) identify several strands that could constitute an effective gendered practical approach to gambling harm prevention. They identify the need to develop educational campaigns that explain the risks of gambling and the need to design and test media messages targeted at women. A third recommendation is to implement community-based interventions that provide social support and alternative leisure activities for women, and fourthly the researchers recommend the development of partnerships with groups of at-risk women. A final strand is to develop flexible programmes to address the complexities and broad context of women's lives.

Kerr et al. (2019) also recognise the need for treatment and support services to provide "an alternative to the emotional crutch" that gambling provides (Kerr et al., 2019), which can be specific to women.

Surgey (2000) conducted focus groups with 30 women to explore what would help them to manage their gambling problems, finding that harmful gambling definitions needed to be more practical and meaningful for women, also helping instil a “desire to change”. For long playing sessions on slots, the women described helpful measures such as “jogger cards” that they could place in their purses, be displayed in toilets, on ATM receipts or even on T shirts, reminding them of the duration of their play. They also advocated for “women’s spaces” to pursue alternative leisure activities (Surgey, 2000).

In order to reduce the stigma surrounding women’s harmful gambling, which acts as a barrier to them seeking help, women in Kerr et al.’s (2019) study suggested strategies such as increased awareness about the range of people affected by gambling problems and running a celebrity-endorsed campaign. Research conducted by Sagris and Wentzel (1997, cited in Kerr et al., 2019) reported outcomes from two treatment groups that used feminist cognitive behavioural strategies to challenge beliefs, explore roles and myths, use mutual aid to encourage self-help, and lobby for policy change. The result was a reduction in stigma, shame and loneliness reported by the group members.

Perhaps most important in making treatment and support services more attractive and responsive to women is involving women in the design and delivery of the services. To date there is recognition of the need for women to deliver services to women, but less attention has been paid to the potential benefits of involving women with lived experience in all aspects of service design and not just delivery. Mark and Lesieur (1992), for example, call for the rapid training of female peer counsellors and hotline personnel. Piquette-Tomei et al. (2007) found in their research that all of the women participants reported that they were most comfortable in an all-female environment. The women identified the central need for a safe space to discuss personal issues in order to make the group counselling experience effective. Acceptance was the women’s main motivation for their continued participation in the group (Piquette-Tomei et al., 2007). Also in Canada, Piquette and Norman (2013) tested the benefits of women-only gambling treatment and found that the women felt it was a validating experience, valuing the support from other women in the group and learning from each other, including about how to recover from their problems.

Finally, Baxter et al. (2016) argue for the value of a peer outreach strategy for women, with this being a useful way to help them understand how the negative consequences of gambling can outweigh their positive experiences. This peer support model could encourage women to participate in more prosocial activities that provide the same pleasurable feelings as gambling and as well as providing alternative avenues for social engagement (Baxter et al., 2016).

## 5.6 Summary

The gambling sector in the UK has undergone a radical liberalisation process over the last 40 years, and the numbers of women now experiencing gambling harms are increasing rapidly, in addition to which women's gambling problems tend to develop at a faster rate than men's. Women's harmful gambling is predominantly online, with products marketed to women that allow them to play fast-paced games continuously. Such gambling activity has been recognised as highly addictive, allowing women to escape from problems such as mental and physical ill-health, abusive relationships and caring responsibilities, burdens that unequally fall upon women and that reflect continuing gender inequalities and the patriarchal nature of contemporary societies.

The recognition of the specific nature of women's gambling activities, problems and motivations is only recent and treatment and support services very largely remain gender neutral or male oriented. The perception remains that gambling problems are largely men's problems and most treatment and support services were designed by men, for men. The realisation is now emerging that this needs to change. Women are underrepresented in treatment and support services, with barriers to their entry being stigma and shame, lack of awareness of services and of gambling harm in general, issues around trust and safeguarding, and practical barriers such as lack of time and inaccessibility. When women do access treatment and support services, they also have higher drop out rates than men. Increasingly there is recognition of the need to tailor services specifically to women, ranging from how and where services are advertised and offered, to the holistic content of support packages, including self-help resources just for women and support groups just for women. Free helplines staffed by women, women counsellors and women-led peer support groups are just some of the suggestions for practice. Fundamentally, however, women with lived experience need to have opportunities to design the entirety of services for themselves, as it is these women who have the greatest understanding of women's gambling harms.

# Support and Treatment Services for Women Today

# 6. Support and Treatment Services for Women Today

## 6.1 Introduction

Chapter 5 briefly described treatment and support services for gambling harms currently operating in Great Britain. This chapter describes them in more depth. It outlines the separation of these services from drug and alcohol services and the resulting constraints on the integration of gambling harm services into the public health provision network. It is in this context that the National Gambling Treatment Service works through an array of service providers. Most of these are commissioned by GambleAware and they make up an affiliated network, however, provision does not take into account regional variations in need and the current system is neither sufficiently integrated with health service providers, nor sufficiently sited within the community, both in terms of impact and treatment.

The chapter goes on to look specifically at the current support offering for women and finds that very few service providers currently address women as a specific group with specific needs. From the point of view of a woman looking online for help, little was found by way of information and resources just for women, and most services are expressly gender neutral. Given that gambling problems are still widely perceived to be men's problems, current service providers' websites do not sufficiently address the shame and stigma women experience when seeking help, and few go out of their way to specifically address the barriers that may prevent women from contacting them.

## 6.2 Support and treatment services for gambling harms

Services providing support and treatment to people experiencing gambling harms rely on a funding model that contrasts with that of drug and alcohol services, and this hinders the scope to develop an integrated model of care within a public health framework. Except for private sector organisations and Gamblers Anonymous, treatment funding in Britain comes from the gambling operators through a voluntary levy that pays for treatment, research and education. "The Gambling Act 2005 enshrined the principle of 'polluter pays' regarding gambling treatment" (George and Bowden-Jones, 2016), contrasting with the government's direct funding of drug and alcohol treatment services through the NHS, even though as early as 2007, the British Medical Association (BMA) proposed that the NHS should provide sufficient support for gambling disorders, alongside the services it provides for drug and alcohol problems (Kaufman et al., 2017). In addition there is the contrast of gambling policy coming under the remit of the Department of Digital,

Culture, Media and Sport, rather than the Department of Health and Social Care. According to George and Bowden-Jones (2016):

> *Some key limitations of the way current treatment providers operate include lack of a clearly defined model of care (such as a tiered care or a public health multi-tiered prevention approach as exists in the field of substance addictions), inadequate engagement with primary care or specialist mental health services, absence of regional commissioning protocols and lack of integrated care pathways.*

Funds from the levy on gambling operators are distributed via GambleAware, which commissions a range of organisations to provide treatment, the largest being GamCare, which operates the National Gambling Helpline, and its partner network of organisations across Great Britain. Gordon Moody is the only organisation that offers free residential care, retreats and prevention housing, plus an international online support service called Gambling Therapy. The NHS, also with some funding from GambleAware, offers therapy and psychiatric care through the National Problem Gambling Clinic (NPGC) in London and three centres in the north of England (Northern Problem Gambling Service). GambleAware also runs the website BeGambleAware.org, with about 6.2 million visitors per year. This network makes up the National Gambling Treatment Service, and between April 2019 and March 2020, 9,008 clients completed treatment with the Service, a completion rate of 69%, up from 59% in 2015–2016 (GambleAware, 2020b). Other relevant statistics are that 90% of referrals were self-made; 50% of individuals were followed up within three days of referral and 75% within eight days; 75% of clients were male; 89% were white, while 5% were Asian or Asian British, followed by Black or Black British (3%); and clients averaged 34 years of age (GambleAware, 2020b).

As stated in Chapter 5, the are currently no treatment guidelines provided by the National Institute for Health and Care Excellence (NICE), even though "It is a widely held view amongst treatment providers and regulators ... that if NICE were to produce clinical guidelines on the diagnosis and management of gambling disorders, this would be beneficial for patients across the UK" (Kaufman et al., 2017). The services that GambleAware commissions instead include varying combinations of counselling (individual and group), psychotherapy, cognitive behavioural therapy (CBT) (other therapeutic tools used include motivational interviewing and motivational enhancement therapy), advisory services, residential care and pharmacotherapy (Naltrexone). There is also a growth in support services led by people with lived experience of gambling harms, such as the Peer Aid programme offered by GamCare and Betknowmore, as well as health and wellbeing support. The NPGC and its Northern Service offer a programme of individual or group CBT, led by psychiatrists and psychologists, with individuals given a set number of sessions through which to develop strategies to stabilise excessive gambling and they are also offered tools to combat urges to gamble and to minimise harm in the event of a lapse. The programme also teaches life skills, such as mindfulness, and encourages healthy activities and hobbies (Kaufman et al., 2017).

Prior to the Covid-19 pandemic, most support from the National Gambling Treatment Service was offered face to face, though telephone counselling was also significant. The en masse shift to working online and by phone during the pandemic is likely to have an enduring effect, with a lasting growth in remote services.

The ad hoc growth of the National Gambling Treatment Service has resulted in a wheel-like service model, with GamCare at its hub and the spokes leading to its partners. Gamblers Anonymous lies outside of this model and remains popular, while Citizens Advice and Step Change provide financial assistance and the Samaritans and other third sector organisations provide emotional, often emergency, support to people who feel suicidal. Regional coverage by the National Service is patchy and the geographical distribution of services does not take into account prevalence rates of problem gambling; nor is it guided by strategic commissioning based on needs assessments (George and Bowden-Jones, 2016). Most importantly, a significant number of those who would benefit from treatment are not receiving it in any form (Gambling Commission, 2018), for while 9,008 clients completed treatment with the Service in 2019–2020, the number of people estimated to be gambling in a harmful way is currently between 300,000 (Bowden-Jones et al., 2016) and 430,000 adults, with an additional 2.4 million individuals identified as being at risk (Conolly et al., 2018), plus 55,000 children (House of Lords, 2020). Currently, levels of awareness about gambling treatment and support services are variable and weakest with regard to services at the local level (Kerr et al. 2019). In their research, Kerr et al. (2019) found that while it was perceived that gambling operators now play a greater role in advertising gambling treatment and support, there is a lack of clear, prominent and informative advertising about the services available, including their positive outcomes.

In Chapter 5, the literature review showed that people, especially women, experiencing gambling harms frequently have additional problems such as alcohol and drug dependency, mental health problems, abusive relationships and histories of trauma. The separation of gambling treatment services from the broader NHS and public health provision networks makes those co-morbidities and additional problems difficult to manage in a holistic and effective fashion. The Centre for Social Justice (2019) also argues that “recovery” should refer not just to the attainment of a release from physical, psychological and emotional dependence on a substance or behaviour, but also a reconnection with community:

While health may be at the heart of this issue, particularly in the early stages of recovery, the role of family and the importance of stable housing, securing employment or education and engagement with community are not a “bolt on” to a recovery journey: they are instrumental in sustaining it (Centre for Social Justice, 2019).

As such, not only is the current system of gambling support and treatment services insufficiently integrated with the work of other health service providers, but also it insufficiently sites gambling harms within the community, both in terms of impact and treatment.

The Centre for Social Justice argues that tackling the problems of addiction necessitates the work of multiple government departments and "the state's duty transcends merely having resources available to treat those that present themselves but instead involves a need to encourage engagement and to reach out to all" (Centre for Social Justice, 2019).

## 6.3 Services for women

Between 2019 and 2020, just 25% of clients in the National Gambling Treatment Service were women, and most of those were affected others (GambleAware, 2020b). In Chapter 5 it was reported that in 2019, across Gamcare, GambleAware and Gambling Therapy (as part of the National Gambling Treatment Service), 30% of helpline calls came from women, with 59% seeking help for another and 41% seeking help for themselves, in total numbering 9,000 women, a number which then rose by another 4% during the pandemic. Also in 2019 there was an increase of more than 100,000 women visiting the Gambling Therapy website, taking the total number of hits from women to more than one million, up 76% from the previous year (Gordon Moody, 2020). But despite these increases, GamCare and Gambling Commission data suggest that only around 1% of women who experience gambling harms contact the National Gambling Helpline (GamCare, 2019) and the reduced tendency for women to seek support for their gambling problems contrasts with women's higher rates of help seeking behaviours in relation to mental or physical health problems.

The review of the existing research base in Chapter 5 produced some evidence of what women look for and need when engaging with services. Research points to women wanting services provided for women, by women, be that through women counsellors, peers or helpline staff, one to one, in groups, face to face or remotely. Indeed, women need a range of support formats so that they can access help while still also performing their economic and caring roles, and allied with this were women's desire to self-refer and receive support quickly. Shame and stigma were identified as being significant barriers to women seeking help, and they wish their interaction with services to be kept strictly confidential. The stigma of being a woman with a gambling problem owes in part to the perception that women who gamble have failed in their caring roles, and also relatedly to the perception that gambling harms are the domain of men. Thus services need to address issues surrounding shame and stigma, acting to reassure women that they are neither failures nor aberrations. Normalising gambling harms as the experience of anyone, be they men, women and children, of different ages, abilities, socio-economic and ethnic backgrounds, can destigmatise gambling harms for women, so images of women on service and treatment provider websites and resources are important. In this regard, self-help resources and information specifically targeted at women, for example highlighting that women who experience gambling harms are often in abusive relationships, can also reassure

women and make them feel that services will recognise their problems and needs, including if they have received help before but have lapsed.

While the evidence base of what women want from treatment providers remains limited, it is sufficient to enable an evaluation of whether women's needs are currently being met. Just two providers, Gamblers Anonymous and Gordon Moody, provide services exclusively for women, indeed Gambler Anonymous provides "women-preferred" groups in recognition that their standard groups are usually male dominated, yet the ethos of the organisation means it cannot discriminate by explicitly designating some groups as "women only". Prior to the pandemic, Gamblers Anonymous' "women-preferred" groups were face-to-face groups and only available in some areas of the UK. The shift of these groups to the internet owing to Covid-19 has made these groups accessible to women from other geographical locations, however pre-pandemic data suggest that in much of the UK, Gamblers Anonymous groups are normally male dominated and that women participate almost exclusively as partners of men with problems (Roberts et al., 2017).

Gordon Moody, in 2021, is launching an intensive treatment programme to meet the needs of women and opening a women's centre for retreats. This service consists of two short-term residential retreats that bookend 12 weekly therapy sessions delivered either online or face to face. The residential stays are designed to be retreat-style and encourage reflection through therapeutic group workshops. Gordon Moody recognises the value of the all-women cohort: "By bringing together a positive and supportive network of other women who are struggling with similar problems, participants are encouraged to develop an understanding of what has lead gambling to become problematic for them" (Gambling Therapy, 2020). While the service is free and women can self-refer, places are limited, women must wait for the date of their programme to begin, and many women are unable to travel and stay away from their home environments.

Outside of these two services, British support and treatment services offer little to women that is specifically designed with their needs in mind. GamCare is currently into the third year of its Women's Programme, which is "the first national programme of outreach, education and awareness-raising" about women and gambling harms (GamCare, 2020). The programme is training professionals and is networking to raise awareness, developing practical tools to identify girls and women in need of support and also developing the evidence base through an online survey of women. The programme's impact has yet to be felt in the clinical services it offers to women, which remain largely gender neutral.

Gender neutrality is a defining characteristic of the bulk of the treatment and support services offered to British women. An assessment of the network of providers found that in addition to Gordon Moody and Gamblers Anonymous, just one provider makes an explicit reference on its website to the ability of women to access women counsellors. In contrast every provider offers the ability to self-refer into their service and most offer a range of service delivery formats – mostly one to one and group counselling and support

forums, in person, online or via phone (conversations and text). GamCare also offers live chat and one regional provider offers email support too. Support by people with lived experience is offered not just by GamCare and Betknowmore's Peer Aid programme, but also by NHS services, Gamblers Anonymous and a number of regional providers.

Given the recognition that both men and women experience high levels of shame and stigma in relation to their gambling problems, surprisingly few service providers address issues of shame and stigma as barriers to help-seeking on their websites. A means to help reduce stigma would be to show images of a wide range of people on service provider websites, however this is rarely the case. Some service providers show no images of real people at all, presumably as a means to maintain neutrality and discourage no one, while others show images of both men and women, though images of men are in the majority. Even more surprisingly, a number of providers do not make explicit reference to their services being confidential or to their services being open to people who experience lapses. The literature reviewed in Chapter 5 shows that all of these are important factors for women.

Finally, a woman going online to find help for her gambling problem would currently find little information and few resources addressing her problems and needs as a woman. GamCare is one of the few providers that has produced leaflets about women and gambling harms and also has a website section about its Women's Programme. Some regional services have links to GamCare's resources for women, but most provide generic information about gambling problems. Similarly any self-help resources are generic, where they exist at all.

## 6.4 Summary

Treatment and support services for gambling harms in Britain are funded by a voluntary levy paid by gambling operators. GambleAware distributes that levy through commissioning services, the bulk of which are delivered by an affiliated network of providers, with GamCare and its National Helpline at its centre. Just two service providers, Gordon Moody and Gamblers Anonymous offer services just for women, though GamCare has an ongoing Women's Programme to raise awareness. To date, research evidence suggests that barriers to women seeking help for their gambling problems include accessibility, shame and stigma, as well as awareness. Women want services to be confidential, to be delivered in ways that fit in with their caring responsibilities, and also be delivered by women. When reviewing the websites of services providers, from the viewpoint of a woman seeking support, this chapter reported that the services currently on offer to women are very limited. On the whole providers remain steadfastly gender neutral. Few recognise that men and women experience gambling harms for different reasons and with consequences that vary too.

# What Women Get

# 7. What Women Get

## 7.1 Introduction

This chapter is the first of two to present the findings of the research. As described in Chapter 3, constant comparison analysis was applied to the focus group transcripts, with themes and subthemes emerging through an iterative process. In this chapter, women's experiences of gambling support and treatment services are presented. The main themes to emerge from the analysis are: seeking help; finding services; and receiving support. Even within the small sample of women, the range of stories and experiences was great. No one experience of support services was the same as another and in some of the subthemes explored below, considerable divergence among experiences and opinions is evident. In other subthemes, there is greater consensus and uniformity, showing that women share some common needs and experiences of gambling support services. The themes and many subthemes that are discussed below are extensively illustrated quotes from the women (using pseudonyms) so as to include divergent opinions and provide a true reflection of the women's diverse experiences. Also below, the names of the specific services that the women mentioned have been removed because the aim of the analysis is to identify commonalities and differences in experience and infer general lessons, rather than examine the strengths and weaknesses of specific services.

## 7.2 Seeking help

Most of the women who took part in this research had engaged with different services multiple times, so they had made many decisions over long periods of time to seek help. Sometimes those decisions were borne of a crisis, while at other times they were a response to a slowly growing feeling of desperation. Without exception, the cry for help was made with a sense of urgency, of needing support immediately, but their urgent needs were rarely met in any meaningful way. In some cases this lead to a change of heart and the continuation of harmful gambling, while in other cases it led to anxiety and prolonged desperation. The decision to seek help was never an easy one. Not only did it require recognition of the depth of the problem faced, but also the confronting of fear of how their cry for help would be received. The stigmatisation of women who engage in harmful gambling was widely recognised and felt by the women, leading to feelings of shame that impacted upon when and how they sought support.

## 7.2.1 Deciding to engage (again)

Recovery journeys are rarely linear. Sometimes the support the women found the first (or indeed, second or third) time round had clearly not met their needs, while at other times the women explained their stalled recoveries and lapses by saying they had not been ready to fully engage. The decision to fully engage corresponded to moments of realisation, often during periods of crisis frequently described by the women as "rock bottoms". At times such rock bottoms were dramatic and characterised by events such as hospitalisation or homelessness. However, the decision to engage was not always a response to a crisis or rock bottom, with some women having moments of clarity and realisation brought about by witnessing the experiences of others. Equally, some women experienced a cumulative, steadily growing feeling of becoming so "sick of it" that they fully embraced recovery:

> So the services that I have used, I think they have worked for me. And t-hat is in part because I'd reached the point where I decided I needed help. So whatever help was offered, I was going to do all I could for it to work for me. It wouldn't have probably worked 10 years ago because I wasn't ready at that point. I'd reached my rock bottom and needed to it sort out and only I could do that. So yeah, I just embraced what was on offer around. It, it's working for me.
>
> **Jackie (mid-40s)**

> And so when I lost it all and did something dreadful, then I, you know, signed up … I'm really willing to accept recovery and, you know, feel like I can do it now.
>
> **Debbie (early 50s)**

> I remember filling out the application form and I was begging them to help me cause I didn't know what else to do. Um, cause I got to the point where I tried taking my own life. So it was, it was really rock bottom for me.
>
> **Janet (late 30s)**

> [Gambling is] just a normal part of our lives. And I didn't realise it was a problem until I was staying up all night to play my games, so my husband didn't see, um, and I found it really hard to break that cycle. And … I watched one of her videos and thought, oh my god, that's me. I didn't even realise I had a problem until then really.
>
> **Kate (late 40s)**

Despite the complex and individualised relationship between support and change, evidence points to the importance of being able to quickly access suitable support to capitalise upon the desire for change, and thus avoid subsequent lapse.

Among the women in this research, their impetus to abstain from gambling had waned when they did not access the support they needed, causing them to look back and blame themselves:

> I had some follow-up calls and it was just like, how are you getting on, kind of thing. But for me that didn't really work. And I think I wasn't in the right mindset at that time either. Um, so I don't want to like proper say that they're not good because they probably are, but I think it was my, my mindset at that time.
>
> **Caroline (late 30s)**

> I knew it wasn't doing anything cause I was going ... on a Friday evening, the only thing it was doing is giving me something to do on a Friday evening, which wasn't gambling or drinking. I had somewhere to be for like getting there, getting back, like three hours. But then after a few months of attending I found I was rewarding myself for attending by getting a bottle of wine on the way home, and then I'd find myself gambling throughout the week. Each week, I was doing the same thing: I'm really trying, but I've gambled again, I am trying, um, I've gambled and it was just getting repetitive. I thought this isn't helping me because I can't relate to anyone here. Um, like I said, they were mainly older people.
>
> **Sarah (early 40s)**

> I think that might again be something due to my mindset at the time. I was actively gambling at the time that I went. And all I remember is just sitting, talking to this woman and it was all just very sort of quiet. Um, there wasn't a lot said, and, and really, I just had wheels spinning in front of my eyes. I was really, really heavily into it at that point. And I think it would have taken a lot to pull me out of it. Um, but yeah, it was just sort of a conversation on the phone, which just involved them setting me up with an appointment to speak to somebody. And then from there, whether there was follow up or not, it would have been me not, not chasing or not making another appointment, but yeah, it just sort of never, never went anywhere from there.
>
> **Charlotte (early 40s)**

> This is very personal to me, but it just wasn't very comfortable. It wasn't a very nice environment to be in. Do you know, like you go in and open up your heart and try to speak to somebody one-to-one about all these problems that you've got and yeah, I just, it just, it terrified me to be honest. Um, but yeah, I just felt like the environment that I was in wasn't very comfortable to begin with. Um, so then I went in with my guard up maybe, and not very comfortable.
>
> **Caroline (late 30s)**

Achieving and sustaining the right mindset to embrace the multiple challenges of recovery must be married with support that meets the specific needs of that person at that moment in time. This explains why recovery is rarely a linear process and why it is frequently seen as a journey:

> I've tried so many different ways to stop and this time with the help that I got, I've done it.
>
> **Caroline (late 30s)**

> I did get things I needed. I just got them in a different order, at a different pace.
>
> **Jill (early 40s)**

## 7.2.2 It's urgent

Capitalising upon the desire for change and transforming it into a tangible recovery is dependent upon accessing support that is both appropriate and timely. Many of the women commented on how they had wanted to access support urgently, so when they were added to waiting lists and given appointments that seemed too distant, they experienced distress and anxiety:

> The application process was long. Um, and a bit worrying, because they made it quite clear that ... they can't accept everybody. So the anxiety of thinking, oh god, I might not get in, um, was hard.
>
> **Anna (mid-20s)**

> Um, I think they were fairly good at getting back to me, but they said obviously there's a waiting list. Um, so it was a good six months. So again, that's, I found that was a bit of an obstacle ... So I felt that was quite a long gap to wait when you're desperate and you're asking for help.
>
> **Sarah (early 40s)**

> And I remember doing it and I was starting tears as I was writing it because I was so desperate at that point that I needed some help.
>
> **Caroline (late 30s)**

> The most important thing for me was the speed. So something has to be done fast. I couldn't wait for the NHS.
>
> **Jill (early 40s)**

The period of waiting was not conducive to recovery, allowing some women to convince themselves that the problem they had felt so acutely was not that bad after all. This attests to the cognitive

distortions experienced by compulsive gamblers, including the rapid waning of the extreme low that follows a gambling loss and its replacement with the growing conviction that a win is not just probable but also a solution the problem:

> When you're desperate like that, it needs to happen immediately. If you give yourself 24 hours, then you can pretend it's okay again, because you're not in that desperate mindset again.
>
> **Kate (late 40s)**

> I think certainly if you, if you reaching out and then you think, right, okay, I've made the decision, it's a big thing, so right, I'm doing it, I'm doing it now, I'm doing it right now and taking action and you're all focused on that to fix it right now. And someone comes back again, with "Well, it's going to be a few days" and then you just sort of deflated. I think it is kind of a let down because … you can make the decision one night and 24 hours later, you've talked yourself out of it. You've made it all seem, that it's better than it is. And actually, I'm not so bad and I can carry on because that's what your mind does to you when you, when you're dealing with an addiction like that.
>
> **Charlotte (early 40s)**

> But I think it was about a week or 10 days went by. And at that point, I've just put it to the back of my head, um, and carried on. And I was still, I was still gambling at that time … with that wait, you know, a week to 10 days isn't a lot of time, but I probably lost about two grand in that time.
>
> **Caroline (late 30s)**

### 7.2.3 Having the courage to engage

Having reached a decision to seek help, the women reflected upon how the shame and stigma they felt as women gamblers acted as barriers to making the first move. They were aware of the social perception of women as dependable care-givers, responsible for the wellbeing of their families, coupled with the dual identity of being dependable employees. As such they were burdened with shame and guilt because they believed that they had brought about problems for themselves and others, flying in the face of social norms and expectations. The women reflected on how their problems were not taken seriously by others and also the stigma attached to them as women. It can be argued therefore that they were doubly burdened by being not just compulsive gamblers, but female compulsive gamblers:

> It's not just stigmatized, it's taboo, it's taboo. It's not that we're out there and we're facing stigma, we don't even discuss it, it doesn't even exist, but it does.
>
> **Jill (early 40s)**

Women do have a different role on a day-to-day basis normally. Um, and I think there is a stigma around female gambling. For some, for some bizarre reason it's just not spoken about. And I think as a woman ... you kind of just, you put your head down and get on with it.

**Caroline (late 30s)**

At some point someone asked me and you almost feel embarrassed to say it's gambling addiction, you know, it's always, it's always, you'd rather say alcohol, heroin, honestly, because gambling, they're just like, oh wow, you're the first person that's come there with like gambling. Cause again, even addicts probably don't see it as an addiction the same as their addiction ... It's almost like, I feel you don't fit in. You're almost sort of an extra category. You don't kind of fit with other addicts.

**Sarah (early 40s)**

When I was in with the homeless, when I got as low, you know, really, really down on my gambling and I was homeless ... everybody said, oh, that's nothing ... that's not an addiction, that's nothing. And they will, um, you know, drink 40 cans of lager a day and ... you know, they laughed at me.

**Debbie (early 50s)**

Just cause we don't fall over, we still die from it.

**Alison (late 50s)**

People, not only just women, people don't talk about gambling and how destructive it is. It's not something you hear about ... Nobody ever tells you they're a recovering gambling addict. It's just not something people discuss.

**Kate (late 40s)**

The historical absence of media attention to harmful gambling by women and the continuing societal perception of gambling problems as the domain of men result not only in shame and stigma for women, but also a lack of awareness and understanding within families and within communities. Some of the women in this research felt they could not talk openly and ask for help as they would be both stigmatised and misunderstood:

Speaking to friends, they don't really understand. Um, I'm really close to my mum and my nan. And they both say, you know, anytime you feel like you want to gamble, are you thinking about things? Just ring me, but I just wouldn't, I wouldn't put that on them. And I also feel, because I have been to prison, like for me, that should have been the final point. I shouldn't have ever done it again. The fact I still have, it's shameful, it's embarrassing and I don't want my family to [hear about it] ... My mum

used to say to me, like, “why would you do it? I don’t understand why you’d spend all our money. Like, that’s a lot of money” and I’m like “yeh, because I couldn’t control it”, but even to this day, like she doesn’t criticise me or judge me, but she said, “I’ll never, ever understand why you did it”.

**Dawn (mid-30s)**

They just thought it was just a choice and easy, you know, just click your fingers, you can stop.

**Debbie (early 50s)**

But a lot of people still stigmatise gambling addiction as [though] it’s a choice. A lot of people would just say, well just stop.

**Sarah (early 40s)**

My brother and sister are both alcoholics. Um, I’m the youngest, I’ve picked up the gambling addiction. Um, I mean, my sister no longer drinks. My brother still drinks. And, and obviously I’ve been gamble free for three years, but we’re very different in my mum’s eyes. Uh, my sister’s done brilliant, not had drink for seven years now. And she’ll tell her all the time how proud she is, even though my sister lost the children and my sister’s children live with my mum now, um, obviously a lot of, uh, family issues, but she never once said to me you’ve done really well. Cause she didn’t, she doesn’t get it. And I think that’s the whole thing. People do not get gambling addiction.

**Janet (late 30s)**

I think as well, um, obviously I started at 18, so I was going out and nobody knew. I wouldn’t tell anyone cause what 18 year old has a gambling addiction?

**Anna (mid-20s)**

I won’t say certain things because I’m ashamed.

**Jill (early 40s)**

For one woman who, at the time of the focus groups, had not sought out a support service and relied purely upon self-exclusion schemes, the shame she felt because of her gambling meant that it remained a secret from everyone. For others it was a priority to keep their gambling problem hidden from their employers:

Nobody in my family knows, um, that I have a struggle with gambling, not even my husband, cause we keep things very separately. I think maybe I because I haven’t been able to get myself in any more trouble, if I could have been able to, then I would have done, I wouldn’t have thought twice about it, but I actually physically, I could only take my overdraft limit up to its maximum. I can only

spend my wages as they come in. I can't create any more trouble for myself than that. So I think, um, I would want to fix it without anybody knowing. I know that's probably not the right thing cause I'm not getting the right support that I do need, particularly with my family also gambling ... I'd have to come clean and I'm not ready to yet, maybe in the future, but not right now.

**Kate (late 40s)**

But generally you wouldn't, people wouldn't be able to go and discuss a gambling problem with, with an employer.

**Sarah (early 40s)**

I mean, for me, it's quite selfish reason, it's anonymity ... Because of the job that I do, basically, um, for me, if families and parents would find out about my issues, I would be terrified of them. You know, sometimes I have to go to court with families, um, if that came out and that was used against me. You know, you can't lie about it under oath. And I think about what a catastrophic thing it would be to me.

**Caroline (late 30s)**

Shame and stigma also had a practical impact on where women sought out support. Many of them had shunned local services for fear of being recognised and "outed", or had reluctantly engaged with local services with considerable trepidation:

The first meeting I went to, I didn't go for so many weeks until I plucked up the courage because it's, it's just a few miles away down the road. Um, and I was just terrified and it's very near to where one of my friends had recently moved to that road near there. And I was just like, oh, what if she sees me? Or it's just, yeah, it's in a community center so I could have been going there for anything, but there is that fear.

**Sarah (early 40s)**

I would avoid local type of therapy because of the stigma, like we all know we weren't our best selves in our gambling days.

**Gayle (early 30s)**

[I] even Googled [groups] that are in the next city so that I wouldn't see anybody, that I'd know anyone in there, um, which I suppose defeats the object of having a local meeting.

**Jackie (mid-40s)**

You only need somebody with a big mouth who, you know, who doesn't care if they out you, and that's really hurt me.

**Debbie (early 50s)**

As discussed below, the rapid development of online support services has proved hugely beneficial for women, helping them access support without fear of recognition.

## 7.3 Finding services

Armed with the resolve to find support, several obstacles emerged. Even for the majority of women who had made multiple attempts to seek help, these obstacles did not significantly diminish over time. The first hurdle faced by the women was a lack of information about the support available to them, such that none of them felt they had made an informed choice. Most of the women had developed a partial knowledge of the support available through trail and error and luck. Signposting to gambling support services through other service providers, such as GPs and mental health services, was rare, despite them often being a first port of call for help. Generally the women were left to their own devises, asking trusted friends and most usually taking to the internet, often late at night when they felt desperate. Social media proved helpful for some, but overwhelmingly Google gave the women avenues to pursue, though some of these later proved to be dead ends.

### 7.3.1 Ignorance is not bliss

When it comes to finding support, all the women agreed there was an absence of clear and sufficiently detailed information about the support services available to them. This led to the impression that there were few choices open to them. Informed choice was absent and instead women grabbed hold of whenever they could find, sometimes later realising it was inappropriate for their needs:

> I'll just do it because I don't feel there's any other choices.
>
> **Sarah (early 40s)**

> In my journey there was very little information ... I don't think I was in a position to research how to start it ... How did I choose? I mean, there's limited choice, to be honest with you. I'm finding out now about this residential thing, which would have been perfect for me. How mad is that? Like 10 years later.
>
> **Jill (early 40s)**

I had no idea you could block yourself and gambling sites on your bank account. No idea … I just don't know what support there is out there.

**Kate (late 40s)**

My search for support was, was quite fruitless in most cases … Obviously what I've learned about more recently was in recovery, but at the time it was only what was returned by a Google search … I didn't know anything about what the treatment entailed. And so I never went down that route. So I didn't really, all I know is that I went to one session with a counsellor and it was no good for me … I think that was the first time I'd ever really put my hand out and said, look, somebody needs to help me because I'm not able to help myself. And yeah, I think, I think I probably had an unrealistic expectation that I just thought somebody was going to just save me. And um, and that wasn't what happened.

**Charlotte (early 40s)**

I didn't know what to expect when I joined up to any of them, to be honest.

**Jackie (mid-40s)**

I just stumbled across [them] and went for it. Um, but until I was there, I didn't even know … that you could get the software on your phone that stops you accessing sites. I didn't know any of that … It could have been very different years ago and it could have been done a lot sooner, but it might just be me being naive and not looking properly. There isn't like a bank of information that's easily accessible to equip you. Um, and it, it is so difficult. I mean, everyone knows, it's so difficult to take that first step and actually acknowledge that you've got a problem.

**Caroline (late 30s)**

A first port of call for many of the women who decided to get help was their GP, yet only one of them found that to be a fruitful experience. Most of the women were provided with very little information by their doctors and sometimes they were faced confusion or indifference:

I even went to the GP, spoke to the GP because I needed some antidepressants or something to try and manage my anxiety. Um, and they were a bit clueless, you know, there was not really much there. Um, and one GP just said "Google it".

**Caroline (late 30s)**

Meantime I went to the doctors, they said there's a massive waiting list. Um, they didn't offer me any other help, they just said, you need to wait for a counsellor. By the time my appointment came around, I was actually placed in prison. My solicitor said to me, you'd be better off being addicted to drugs or alcohol because they don't care. No one will give you any sympathy. No one will give you any help. So again, through prison

there were no programmes, there was nothing to rehabilitate me, nothing to, no one to talk to. I came out and they said phone the doctor and they said, you have to go back on the waiting list and start again because you missed your appointment. I was in prison, like physically couldn't have got there. So then I went on for another year and then she diagnosed me with PTSD from my prison experience and said that I need help for that, but what, and I'm, ok, but what about the gambling? … During Covid I phoned up the doctor and said I'm really struggling. I was drinking as well, started drinking wine every night just to cope. And then when I was drinking, I wanted to gamble and all they said was, um, stop drinking, um, and I'll leave a prescription for some antidepressants. That was it.

**Dawn (mid-30s)**

I'd gone to half my medication and by the time I left, he went, do you want me to double it? So I was like, okay. They just can't say, it's almost like they just cannot deal with the word gambling at all. It's, it's just to them, it's so nonmedical that they, they just won't get involved.

**Sarah (early 40s)**

The places I found myself are the places where people would really be struggling with these issues. And I've never seen a single [poster], I'd never even met a professional, a mental health professional who knew where to refer you, you know what I mean? I've never had information from the NHS about gambling or stopping gambling or recovering ever. I've had information about PTSD, about various different diagnoses there. Never been given a jot of information about gambling ever … [There is a] void like a deep, deep void lack of information within the NHS, from GP up to psychiatrist, to residential psychiatric ward, to A&E. When I showed up in A&E they didn't have a clue.

**Jill (early 40s)**

## 7.3.2 Signposts to support

Given that statutory services were rarely a source of information and support, the women found help through other avenues. Some found help through the responsible gambling messages displayed by operators:

The only place ironically I came across that was in the places where you shouldn't, where you're gambling, you know, the random little sticker on the wall or, you know … If you think if you've got problems, stop, it was just that little sticker.

**Alison (late 50s)**

I think actually I clicked on to, uh, like just on the bookie's site. I think I just, at the bottom of it, I'd seen something about um, help for problem gamblers. And one evening I just clicked on it and started looking through.

**Sarah (early 40s)**

When you self exclude from something or inquire about something like that, then they then send you links to go to.

**Charlotte (early 40s)**

Other avenues of support were social media and friends:

So I phoned my colleague who was also my friend at work. And she then spoke to one of the directors and they said, well, we know about help ... but I'd never even heard of them before.

**Dawn (mid-30s)**

So it's not really my, um, area of, uh, things to play with, TikTok, but the kids showed me it and I was just scrolling through and it was just a video talking about her gambling and how it made her feel. And I literally thought, god, she could be talking about me.

**Kate (late 40s)**

An online search was by far the most common means to identify potential sources of support. Nearly all of the women had, at some time or another, and often many times, Googled phrases such as "help for gambling", "gambling addiction" and even "female gambling help", scrolling down the list of entries and trying to choose between them:

I just Googled it, just support gambling, help.

**Jackie (mid-40s)**

I was so desperate for help that I were just Googling stuff, um, to try and help.

**Anna (mid-20s)**

I think then I started to Google for help because it was just getting a bit desperate. And I was lonely. I'd recently found myself living on my own for the first time. Um, and I was, I was lonely, um, and I was drinking and gambling really to fill my time. I think I've Googled lots and lots of times.

**Sarah (early 40s)**

I would just put help, you know, I Googled. Um, I actually Googled it.

**Alison (late 50s)**

I was at an absolute breaking point and it was during the night. So I was trying to find someone that I could speak to. So I Googled it and ... I talked to somebody online and I kind of thought, it helped for that moment. I just Googled female and I actually put the female, I remember doing it, female gambling, um, help rather than just gambling help.

**Caroline (late 30s)**

### 7.3.3 Nights are hard

Many of the women had gambled at night, when family members were asleep or when they felt most alone and low. Mirroring this trend was the need to seek support late at night, when they began to feel desperate. Notably, at the time of the research, when most of the women had sought support many times over many years, very few of them were aware of the 24 hour National Gambling Helpline. Instead some of them had turned to the Samaritans:

During the pandemic, actually a few times I've got quite down and I have quite late hours. It's often when you are up late and you're drinking or gambling or something, and I've found, I've kind of looked, I just want to talk to someone. And I feel like I can't talk to anyone because it's quite late. You can't phone friends or anything. So I've looked for, I've looked on Samaritans so many times. I've phoned them so many times and they never ever answer. I'm just on hold for ... it's supposed to be 24 hours ... you can phone, but they're, they haven't got the staff. So I found myself sort of emailing them, like I've been on hold for an hour and complaining to them. And then the next morning I get up and thought, what am I doing? I'm complaining to the Samaritans!

**Sarah (early 40s)**

And the times when I've reached like four, five o'clock in the morning when all my money's gone and that's me sat there dreading, dreading where I'm going to get my bill money from and stuff, that that time is rock bottom. And I think to be able to reach out to somebody, and I don't just mean like an online chat because I don't, I don't know if that's, that's real, I don't think it feels real sometimes. Um, but yeah, having something there, you know, there's 24 hour support lines that, you know, you've got the Samaritans haven't you, you know, you've got Child Line for children, got NSPCC, just to phone line like that, that you could speak to, to somebody and just air it out. And maybe you could speak to them when you're having that urge to stop you from gambling all that money away till four o'clock, five o'clock in the morning.

**Caroline (late 30s)**

I think certainly for me, early hours of the morning, like your three and four o'clock were real danger hours for me. I mean, I'd usually be, I would have exhausted all my resources by that point. I was also, when I was gambling at my worst, I was also abusing alcohol. Um, so that

would lead me to some pretty dodgy situations and some pretty bleak mindsets, sometimes that sort of three and four o'clock in the morning. And, you know, at times that was pretty dangerous and I was at risk. So I think for me, if I'd had the option to just pick up the phone to somebody, sometimes, you know, it, it might've made a difference.

**Charlotte (early 40s)**

I've used the 24 seven like online chat. When I, the, the, the big thing for me is that my problems would happen late at night. I have sleep disorders and my brain tends to be quite wired late at night. And I find that's not a time when I can phone or WhatsApp somebody.

**Jill (early 40s)**

## 7.4 Receiving support

In the focus groups, most time was dedicated to discussing the support that was received after the women had decided they needed help and had found it. One of the subthemes to emerge from the discussions was around the quantity of support needed, and unsurprisingly this varied from one woman to another, though by and large most needed significant help over long periods of time. Barriers to accessing the support they had found were also discussed, as were facilitators, the most notable being the recent proliferation of online support available round the clock. The types of support available were also a key area of discussion with some purely extolling the merits of very practical support to prevent them from gambling, while others valued psychological tools that helped them understand why they had gambled with harmful consequences. Many women recognised the appeal and value of residential support, while some valued broader interventions that focused upon their health and wellbeing. The diversity of views regarding the merits of different models of support contrasted with the unanimous importance attached to talking to people with lived experience and to sharing their experiences with other women who had also been impacted by gambling harms.

### 7.4.1 How much support is enough support?

Unsurprisingly, the support needs of the women varied. While one or two were able to rely solely on blocking software and self-exclusion schemes, a couple structured their days and weeks around accessing multiple support sources, and the rest relied on regular provision of support by just one service. The standard model of accessing some form of support once a week was felt to be insufficient for many of the women. Not accessing enough support to meets their needs when in crisis and subsequently not having consistent support over the longer term was recognised as problematic:

Um, I felt right, well, that was my hour. That wasn't enough. That was my hour for that day. Um, you know, going up there, I was sort of excited to go, coming out, a week, for me a week away, seemed too long. It seemed too long, you know, one meeting in a week, one chat … I now choose, um, to have a recovery programme, which comes from a couple of sources in my life, um, that works for me, you know, that, that, that works for me … It just, the mentality, you know … I choose to have all the services in my life because you know, a day, an hour, a day or maybe two hours, one day, a half hour, the next day, um, stops me from, from gambling … If I do 12 hours or 24 hours a week on recovery meetings, for me, that's life changing.

**Alison (late 50s)**

I think it's finally been a bit about admitting that I'm going to have to maintain a recovery forever rather than it's a problem that I've solved and I can walk away from it.

**Jill (early 40s)**

Once a week when you're really, really an intense gambler is just not enough counselling. One, once a week counselling was a waste of time on me. I really needed intensive treatment to stop and really, you know, have a complete clean period. Cause I tried once a week counselling so many times … Um, I mean, I've tried them all. I, you know, I've paid for it professionally. I've tried, um, hypnosis. I've tried, you know, in, through the years I tried many, many routes and, and you know, it really took, you know, to get along, many, many recoveries to get to a good recovery.

**Debbie (early 50s)**

I had an online chat with somebody … at one stage, probably a couple of stages actually. And again, you think, okay, well I've got this kind of boost. It's going to help. And you come out of the chat with the right mindset, but then moments later you've slipped out of it.

**Charlotte (early 40s)**

And then it turned into Tuesday night doing the two and a half hour Zoom. Wednesday night we had like a social group with the other ladies that I was on the group with, which was really nice. And then Thursday I do my one to one. And at first I was like, oh my god, that's three nights a week. But it was three nights I'd probably spend gambling anyway. That consistency of every week [was essential], knowing what I was doing.

**Caroline (late 30s)**

## 7.4.2 So many obstacles

Over time the women had slowly put in place, usually through processes of trail and error, the support they needed, but significant barriers were recognised. When it came to accessing services face to face, one of those was cost. Given the extent of the financial harms experienced by the women, it is unsurprising that the costs associated with accessing some services were seen as prohibitive, even if they were modest:

> And then one was in Chester, which is about half an hour drive, actually I couldn't afford to get there I had so little money from my gambling and I didn't have petrol money and things like that.
>
> **Jill (early 40s)**

> If I had a drinking problem, I know I could go to a meeting five minutes away and it would be on at eight o'clock and lunchtime and you know, round your work schedule or your commitments, but [my support meetings are] mainly evenings and two and a half hours away on the train to London and that part of London you've got to reach and it's, um, very, very expensive to get to … It costs me 50 quid to get up to London, then I'd have to have a meal or a drink. And when you're broke and you're trying to be on a budget … it was all too expensive and an extra pressure on, you know, when in my recovery.
>
> **Debbie (early 50s)**

> I would have been put off by the distance, although I'm in London, it's the other side of London. So it's, it's an obstacle. It's the financial fare. It's just one more reason not to go.
>
> **Sarah (early 40s)**

While, as seen above, some of the women avoided local services for fear of being recognised, one or two would have liked to access face-to-face support close to home but their residence outside of major cities meant that there was little on offer. In many areas of the country there are no local support groups. Regional service providers who make up the National Gambling Treatment Service generally cover large geographical areas that make it hard for many people to access their services in person:

> And also in my area, there was nothing … There was one [meeting], um, this was prior to Covid, obviously it stopped with Covid, but before that, they said there used to be one, a couple of miles away, but that would have been stopped at, and if there's low numbers, but there was nothing else around me.
>
> **Dawn (mid-30s)**

## 7.4.3 Forget physical meetings?

Given the barriers to accessing services face to face, such as distance, cost and the fear of being recognised, the rapid increase in the provision of online support, owing to the Covid-19 pandemic, has been a lifeline for women, enabling them to seek new avenues of support that are varied, free, accessible, anonymous and safe:

> Online [is] definitely better for me. Um, like I said earlier, I wouldn't go into a local meeting. Um, I said to, I think it was my mum, I wouldn't want to meet anyone that I knew in there … Because it was lock down, I could do the Zoom meetings … dealing with it online in the meetings has been a lot easier for me.
>
> **Jackie (mid-40s)**

> I think people are more now comfortable with that, with things being online than they perhaps they would've been before.
>
> **Charlotte (early 40s)**

> I think it's easy. It's in the comfort of your home as well. And I've got two young kids, I'm a single parent, I haven't got the time, or especially in the evenings to be going traveling anywhere. So, yes, it's easy for me.
>
> **Dawn (mid-30s)**

Interestingly, the shift of many support groups to online delivery has opened up access to groups in other countries and continents, enabling round the clock support and also exposure to new perspectives and ideas:

> Um, what's so lovely is that element of it being people from all over … It's the we're from everywhere, but we've still all got the same problems. And that means a lot to me, actually. I like the diversity of that … There's no, um, local to me, any of this stuff I've had, and this would have never happened local to me. And the other thing about the Zoom and the online format it's taken away, the physical barrier … I'd have to find a car, find transport, get there, um, nerve wracking element as well. So practicality it's taken that way.
>
> **Jill (early 40s)**

> And it's all, for people all around the world now, you know, it's, it's, I learn something every day.
>
> **Alison (late 50s)**

> My gambling was far worse, like at six in or four in the morning. So having something early is a really good start for the day, puts me in the right mindset for the day. Um, and having it on Zoom is more accessible ... So Zoom has saved my life. Definitely ... cause you can check they're all over the world. Some of us are going to Kenya for meetings, you know, South African perspective. It's really fun. And there's some really, really good meetings in, in Africa with amazing speakers and leaders, you know? And um, yeah, I think Zoom has definitely made recovery easier and better and more accessible.
>
> **Debbie (early 50s)**

For one young woman who took part in the focus groups, online was not appealing, while others wanted a combination on online and face to face:

> I think for me, and I don't know if this is, I don't know if maybe I spend so long on my phone and on the internet and in Zooms all day at work and stuff that I don't think it would feel as real to me as going somewhere and being there. I think that I look at so much on my phone and dismiss it. I'm on social media all the time. All I ever do all day, every day, is sit in Zooms and with work and stuff.
>
> **Anna (mid-20s)**

> But from my personal experiences and my personal situation, the online works better for me, but I am excited to go to, to go to this retreat ... but I think I'm more excited to meet everybody cause I've only ever seen them Zoom. Um, so I wonder whether online is the first step and then the retreat is the second step. Once you've built up that confidence. And once you've made a little bit of a relationship, would that be, would that be a better option?
>
> **Caroline (late 30s)**

> I wouldn't want it to be residential, but I wouldn't mind face-to-face and I wouldn't mind it being online. I think a lot of the stigma of doing stuff online has been lifted during Covid because we've had to do it this way. So it's not such a big deal anymore. Um, I don't think it really makes much difference for me.
>
> **Kate (late 40s)**

A distinction was also made been video meetings, such as Zoom, and online forums where video is absent, even if the online forum discussions are held in real time. While some of the women had accessed online forums and used online chat functions, generally it was felt that these were of limited value as they did not facilitate the building up of supportive relationships. This was not the case with video conferencing services such as Zoom, which did enable the women to build rapport with others:

[With] the forums and stuff, you can't really build a relationship, but I think with Zoom, the physical, seeing each other and seeing those faces regularly, it's quite different to a forum or, you know, an old fashioned kind of web chat. You do feel that they're real people and that you can form a bond.

**Sarah (early 40s)**

I think it's hard because you can't really, well I couldn't, over a forum, you can't build up a relationship with somebody or it's very difficult. It's not very personal. That's what I found. And it was nice that I was helping people, but again, no one was really helping me. I would put my story out there for other people to warn them but I was getting nothing back.

**Dawn (mid-30s)**

Um, and then, um, web chats, rubbish, you know ... the web chat forums was a waste of time because I don't like just texting a couple of lines, you know, with, and you can't see anybody, you just text in a chat box, that's a waste of time to me.

**Debbie (early 50s)**

### 7.4.4 Round the clock

The shift to online support has also favoured women given their propensity to gamble and seek help late at night, as mentioned above:

It's good because it is 24 hours. So I found, I have attended some at midnight in America, um, quite a few and it, that is good. It's that fact that it's there when you need it. It's not like, well it's on a Friday at eight o'clock and that's it. And if for some reason you can't make it you've missed that week or you may not feel like you need it at that time. You might feel you need it on like a Wednesday morning at six in the morning. So yeah, I have found it quite useful and it's, it's, it's nice as well just to see faces around the world and that you've all got something in common. So I hope it continues.

**Sarah (early 40s)**

So the 24 seven chat facility on the website, I used it about two months ago, it's brilliant. There's like, there's like a trained person there to speak to you.

**Jill (early 40s)**

Equally, other means to access support round the clock were recognised as important, especially helplines that enabled personal contact:

> They weren't rushing me off the phone. They were quite happy to talk to me even at that time, I felt the man is very much, that I spoke to, he was very much trying to give me practical help. So it'd be things like, um, you know, can you just freeze your accounts? Just, it's not permanent. Just try putting a block on, see how that goes. And I found it quite helpful that they, it was the fact that they were available at any time, because I think with addiction often it is something they're going to be doing in anti-social hours because it's something secretive. [The second time] It was with a woman, which I was really pleased about and she was really chirpy and awake and I was kind of, I felt guilty. I ended up thinking, oh no, I hope I haven't got her out of bed or something, but yeah, she was very helpful, but I almost felt that we just had a chat, actually. It was rather than her giving me practical steps and actually I only needed a quick chat and then I was fine. I was like, you know, I feel ok now, sometimes it's, it's not even that you want to talk to someone for that long. It's just that somebody was there. Um, so yeah, I found that quite helpful. It was the accessibility to it, that it was immediate, when you needed it.
>
> **Sarah (early 40s)**

> I think maybe that's one of the differences between men and women, because it tends to be more secretive to women, we're more likely to be the ones up in the middle of the night gambling. Whereas men are more likely to, I would guess, to be out in the day cause they do it in the open. Whereas we don't, so my only time to myself is once everybody else is asleep. So that would be when I would gamble. So I think maybe that's a reason to have 24 hour support because some people need that.
>
> **Kate (late 40s)**

## 7.4.5 The important practicalities

Regarding the nature or content of the support received, all the women agreed on the usefulness of practical support to help them stop gambling. All the women had employed blocking software to stop them from gambling online on their phones and other devices, sometimes paying for that software and at other times accessing it for free through support services. Some had also activated self-exclusion controls through their banks to further limit their ability to gamble through both online sites and land-based venues:

> I've used their phone line as well and I've had support from them, like practical advice, like for a new bank and get gambling transactions blocked and Gamstop and apps you can use and things like that.
>
> **Jill (early 40s)**

> The fact that I can set up alerts ... so my boyfriend gets an alert if I [try to spend money with a gambling company], for my transactions, that's an option as well, which I think is really good because that gives transparency doesn't it?
>
> **Caroline (late 30s)**

The practical content of support the women received was appreciated by all of them and included not just advice on self-exclusion, but discussions around triggers and how to manage them, as well as their emotional responses to gambling:

> I didn't want somebody to tell me that I gamble cause I've got bloody daddy issues from 20 years ago, or something. So that's not why I'm gambled, it's not. I fell into it for different reasons. And so it was the practical tools that helped me massively as well as the awareness and stuff.
>
> **Anna (mid-20s)**

> It goes through why you gamble and trigger points and warning signs. And I find that really, really helpful.
>
> **Jackie (mid-40s)**

> Like deep delving, very deeply in your problems in six 30 minute phone calls is not going to be that helpful. But what I found really helpful was skills learning, skills to stop me gambling, techniques, methods. So rather than all the deep, deep Freudian stuff, which we can all do in our own time, it was the skills and practical things.
>
> **Jill (early 40s)**

## 7.4.6 Understanding why

Most of the women observed that beyond practical advice and techniques to make access to gambling transactions difficult, they had wanted to explore the reasons behind their gambling problems. Nevertheless, this exposed some contradictory views and tensions. There was some reluctance to talk about deeply personal issues within the context of a brief therapeutic intervention, such as phone counselling sessions:

> I did some one to ones, which I only did one of because I didn't like it cause it was poking about my past and I didn't want to talk about that. The lady straight off the bat asked me about, had been abused as a child. Whoa. And I'm phoning to discuss with you gambling and it completely destabilised me and put me off. Um, I think counselling that talks about your gambling and counselling that talks about your general problems [are] two very different things. And I think it's really dangerous to start going there.
>
> **Jill (early 40s)**

> Counselling, I'm not interested in dwelling on the past. I don't really think it's gonna, I don't really think it's going to get me where I need to be personally.
>
> **Gayle (early 30s)**

Nevertheless, most of the women, within the right context and timeframe, wanted to explore why their gambling had become harmful:

> I had long periods of abstinence but, um, I never really looked at myself ... With the counsellor, I dealt with one issue, not the whole issue.
>
> **Alison (late 50s)**

> It's the urge and the fact that I always find a way around it, it doesn't matter if I give someone my cards, I don't know how I always managed to find a way, but I feel like I wanted to speak to someone about how I was feeling and why I was doing it rather than how to prevent myself doing it ... They are quite happy to say, put these measures in place, don't do this, don't do that ... With gambling no one seems to have done that, getting to the actual root of it.
>
> **Dawn (mid-30s)**

Several of the women raised the problem of counselling being too generic and superficial and not specific enough to gambling:

> Six free counselling sessions that didn't work for me because they, it seems so general.
>
> **Sarah (early 40s)**

> I did actually go arrange to have some counselling with an advisor ... which was conducted in some local community centre and ... it just didn't work for me. It just, it was in fact to be perfectly honest, it was completely useless for me. It was just, um, it, it almost felt non-specific to gambling. It was just asking me how I was feeling, how was coping. And I just remember coming away thinking, well, I'm not going to bother again because that just didn't work. It didn't help. Um, so from there I actually ended up going through a private, um, therapist and, and looking at it that way.
>
> **Charlotte (early 40s)**

> It was on a phone call, box ticking. Every time they spent most of the session, just going through this form. How are you feeling, in a tick, in, in, in just such a way.
>
> **Debbie (early 50s)**

> What didn't work, it was drugs, um, it was counselling not specific to the addiction ... So I wanted to speak to somebody about gambling, not about the fact that I might not feel very good or I'm a bit low or something. I wanted someone to tell me, this is why [you're] gambling.
>
> **Anna (mid-20s)**

What worked for many of the women was the ability to explore the reasons behind their gambling in a trusted space and with sufficient time:

> Their step meetings, which I find really valuable, because what I find is really focusing on your recovery and, um, the steps are going quite deep into and yeah, it, um, uh, matches with your emotions and they're quite small groups and that is just nice.
>
> **Debbie (early 50s)**

> There was a lot of talk about feelings and of why we do it and why ... Um, and the therapist I went to ... that I got my free 12 weeks with and then I paid for, she was very much someone that, um, talked about the emotions. I mean, I, I saw her for a good year.
>
> **Sarah (early 40s)**

> The psychology around it, um, that was really, really insightful for me. And I was like, yeah, that's me. You know? And then I was able to take that away and really reflect on my actions over years.
>
> **Caroline (late 30s)**

Also useful for many of the women was an acknowledgement and discussion of the different reasons why women and men gamble. This helped the women to reflect upon their own behaviours, emotions and motivations. Equally, an absence of discussion of the differences was felt to be problematic:

> A lot of the services are geared up to talk about the problems that men face, which I couldn't relate to. I couldn't relate to certain aspects.
>
> **Jill (early 40s)**

> And actually they did make quite a point of saying the difference between why women gambling, and why men gamble. They're quite different. For women it is usually an emotional escape. Uh, it's not about the money. It's not about the, the high necessarily.
>
> **Sarah (early 40s)**

It's got to be tailored towards women as well, because if somebody gives you some generic advice, it's not going to work for you. They need to understand the difference between men and women's gambling, because it is different. It's okay for men to gamble, but it's more of a taboo for women ... I just think the triggers maybe different, so if you're looking for help, maybe that's when it makes a difference.

**Kate (late 40s)**

## 7.4.7 And breathe

There was an acknowledgement among the women that their gambling had impacted harmfully on both their physical and mental health and that these both needed addressing in recovery. Many of the women also had been introduced to mindfulness techniques through their support services and there was a general recognition of their value:

And um, so, um, you know, I think really looking at your whole, whole health, um, helps you get better.

**Debbie (early 50s)**

I completely changed my diet and my exercise and everything. I changed everything in my life to make this happen, this recovery happen ... I changed my lifestyle, changed all my nutritional habits, started exercising and meditating, which I never would have done in my life before. It's totally not me at all. I changed my entire thinking around that. So taking the holistic view on, on recovery really helped me.

**Gayle (early 30s)**

I couldn't do mindfulness, I'd sit and laugh all the way through it. It's just what kind of person I am. But now actually them telling me about being aware and stuff that was hugely helpful.

**Anna (mid-20s)**

They also did mindfulness at the beginning of every session. And for me, it they've been trying to get us to do that at work, to manage stress. And, um, I'm not a fan of it to be honest, but the lady that does it, her voice just, it just makes you go off to sleep. It's amazing. So now it's something that I do, if I'm struggling to sleep, I'll, I'll look at mindfulness stuff. So me putting the barriers up to mindfulness and thinking that's not, that's not, for me, I'm not into yoga and all that, I didn't really understand what it meant, but they opened up another door that way. There's another way for me to chill out and try and switch my brain off from the gambling thoughts.

**Caroline (late 30s)**

## 7.4.8 The bigger picture

The legacy of gambling harms was also recognised by the women and beyond gambling-specific support, there were calls for support around getting back into work and reducing legacy financial harms. There was also a recognition of the importance of starting new activities and building social networks to fill the hole left when their gambling stopped:

> We can manage our feelings and all this, but if you don't have a career, you know, most of us have lost years and years of working and being out of the workforce, we haven't got a ready job to go back into. Um, many of, you know, um, or, and, you know, gambling had perhaps destroyed us or destroyed me and I didn't have a career and I didn't know where to go ... That's been the difficult, the most difficult thing in my recovery ... It is a, you know, they have programmes for alcoholics and drug users and to get back into work. Um, and it would be nice if they helped with work hand in hand with gamblers as well, to get them back into employment, to relevant employment.
>
> **Debbie (early 50s)**

> When you do stop gambling for a while, you start looking for other things, and then you start looking back and you go, oh my god, the last 10 years I've achieved, you feel like you've achieved nothing. You're like, well how? You start looking for jobs, you've got gaps in your CV. You've got, how do you explain to people what's been going on? ... And then you feel bad about yourself because you don't get into the things you're applying for. You don't get the job. You don't get the courses. There's obstacle after obstacle, financial obstacle. And then you discover, well I may as well just gamble again, because you know, in your head, it's not, it doesn't, it's not going to work out but you're like, well, at least I could manage.
>
> **Sarah (early 40s)**

> So it's a real holistic thing. You have to, you know, as I say, there's employment, there's physical health, there's, you know, your mental side and I did a mixture of individual and groups and also joined other groups so it wasn't everything about gambling. You know, I've got my church groups, I've got music groups, I've got tennis groups, I've got, you know, uh, you know, and I go do my student nursing. There's a lot to try and keep my mind active and happy in areas. So I'm not frustrated and feeling like I need to gamble again because I'm not getting stimulated where I need to.
>
> **Debbie (early 50s)**

## 7.4.9 Getting away

A recurring theme on the focus groups was a the value of residential support, enabling women to leave their homes for a time and receive counselling and other support within a different and safe environment. The women variously talked about wanting someone to take care of them and escape from all their responsibilities and gambling harms. In some cases they referred to wanting to be protected from themselves so that, for a while at least, they could do no more damage:

> So it was really, really scary … I think this is so bad now I need to be taken away. I need to physically not be at home. Someone needs to lock me up so that I can't do it anymore … I wanted someone to take me away and take full control and just do everything for me just for a few days. Just take everything off me and let me forget just for a few days while I work on myself … So taking me out of that environment. So it felt like something very different and something very serious … They took me physically to a place where I could be and they put me in touch with other women. I remember sitting and thinking, oh my god, like, you've actually found it, it were remarkable.
>
> **Anna (mid-20s)**

> I think I ended up looking at … addiction support, but because obviously that's a private facility, the cost was pretty astronomical. Of course, as a gambling addict, I didn't have that kind of money. Um, but yeah, I, if I had known that something that, that was available without a cost attached to it, I would have absolutely gone for that. I felt that that was what I needed. I needed to be out of whatever, whatever I was in, you know, that was familiar to me. I just want it to be taken away, just straight jacketed, whatever was necessary. And just, you know, I really felt that residential would have been, it was what I was looking for at first, but unfortunately couldn't find it for free and I couldn't afford to pay.
>
> **Charlotte (early 40s)**

> I don't think I was offered what I wanted, wanted to be taken out of my home, where I spent 24 seven and never slept and thought about gambling 24 seven. Um, so no, I wanted somebody to say there's a car there, or get on a train, come away and we'll look after you. I'm getting a bit upset because I think actually it made it a lot harder to be still in my environment where it was all happening and that didn't change … It took me a long time to change in an environment that was making it worse for me.
>
> **Jill (early 40s)**

> I was that desperate that I was like, rehab, you know, I want to find like rehab … Um, it was like, they'd put a fluffy, big blanket around me and very strict, but so real.
>
> **Alison (late 50s)**

The barriers to women taking part in retreats were widely recognised. One of these centred around the practical barrier of being unable to leave children and work for any length of time, though there was some frustration with the assumption that all women can only get away for short periods of time:

> Now I think for men it's easier for, and especially if we look at retreats, for example, it might be easier for a man to be able to leave the house because, you know, for example, you know, you've got a mum and a dad and two children, standard family home, whatever, the man could probably leave because the, the woman would stay and look after the children. Um, you know, like that, that mothering role, it's really hard to take yourself away from that. Isn't it?
>
> **Caroline (late 30s)**

> I've got two lads who are older so for me to get away for the residential, if it was on, would have been manageable, but if you've got young children, I can imagine and you're working, it would be very difficult to get away for three days.
>
> **Jackie (mid-40s)**

> I didn't even know that was available, I didn't know that was an option ... Um, yeah, if I didn't have the kids and I could then yeah obviously I would take it.
>
> **Dawn (mid-30s)**

> I read about the men's program and I would've liked to have done that. I think it's 12 weeks residential, but they told me they don't offer that for women. Because again, the stereotype is women have families to the look after. Women have, um, children and families. They can't commit to that. Um, but there are some women that can, we don't all fit into these, these categories the same as some men can't commit to 12 weeks.
>
> **Sarah (early 40s)**

An additional barrier was also the need to maintain secrecy, as taking part in a retreat would necessitate an explanation to family, friends and employers of the person's absence. Equally a residential retreat was appealing precisely because participants would be unlikely to know anyone there and be able to remain anonymous:

> Because I think for me, I mean, I don't know if it's the right thing or not, but not a lot of people know in my family, so my family know, but my partner's family don't know, so that I was worried, like what's, where's she at, you know, they're going to ask questions, where's she at, where am I like, what's she doing, why is she not at home? So I'll be honest. I quite, I quite liked the virtual way of doing it. And I've also got a job that I wasn't very open with my managers because I'm classed as a professional and I would have to, you know, if I told them everything,

> I was scared that I'd have to go up in front of a board and explain myself because I have got a responsibility and a duty. Um, so no for me not going away made me feel a little bit better because I was in my home and I struggle really badly with anxiety at times and it was really high then. Um, so I think me going away, I don't know if I would have been totally honest with people because I wouldn't have been in my safe space, but my home is my safe space.
>
> **Caroline (late 30s)**

> I know it's not practical if people have got children and commitments, but when I went, it's in such a remote location, you can't, and it's quite a small group, you're kind of almost a hundred per cent sure you're not going to know anybody there. Um, it doesn't always work. I know someone who did go and said, one of their neighbours was in the same group, but generally it's so remote from where everybody else is, it's complete anonymity. And it takes that. I kind of, I was worried when I went, oh, I'm not going to know where I am and I don't know where I'm going and it's the middle of nowhere and I might not get on with everybody. But, um, in a way, that's good because you just didn't have to worry that you were seen, um, who might be there, who might work in the same organisation as you or anything. And it was, uh, I think that was so helpful.
>
> **Sarah (early 40s)**

## 7.4.10 Safety nets and long-term support

The importance of ongoing support was stressed. This support was sometimes informal and generated through friendships forged during support groups. Sometimes it was formal and in the form of follow-up group or 1:1 sessions after a residential retreat, or after a set package of support. The importance of aftercare was particularly stressed in relation to residential treatment as the return to the home environment after a residential retreat was seen as dangerous if there was insufficient aftercare:

> Because you go back home and you're back with the same triggers. And for the last year now I've had one-to-one sessions every week, um, for about an hour and, um, a group, a Zoom group, um, one evening a week with the same people. They've been quite good at keeping, I think, I don't know how many groups they have, but they kept each group like six people. So you're consistently with those same people, not like where it can be just anybody can drop in. So there's lots of little groups of six. So I felt I've really bonded now with those, those people. I think that's important that consistency, um, of the same faces.
>
> **Sarah (early 40s)**

There was no aftercare if you didn't have the money. And then I felt bad because everybody else, you know, is rich and could afford aftercare and be in a halfway house. Aftercare now is so much better because we have Zoom meetings every week, I have weekly counselling or fortnightly and I've actually got something really valuable ... and, um, made some good friends.

**Debbie (early 50s)**

I do [it] because of the people that I meet on there ... I'd met [someone] on my first meeting, and since then we have spoke every day and I think that's so important to have someone you can speak to not necessarily about gambling. You can speak and just say how you're doing, what you've been up to, to know that someone's been through it. And times when I've passed the bookies and think, oh, I'll just nip in, I'll ring [her] first ... the telephone's so important and also having someone that you can contact at any time that's been through it.

**Jackie (mid-40s)**

It also creates them contacts, you know, that halftime break, um, where you have a coffee is so much because you know, that sort of contact for me is really important because when I was going gambling I was just in my own head, I was present in body, but not in mind, you know? So having contacts for me, um, and someone to talk to, or just say, hi you, how are you? ... I've always been given a place to call and a place to reach wherever it be, whatever service, you know, believe me, if I feel weak I would phone. I think the telephone, knowing, contacts, but both meetings have given me contacts with unjudgemental feedback ... Even after these, a few years, you know, I've got a set time that I talk to someone and, and everything.

**Alison (late 50s)**

## 7.4.11 Finding hope in others

Time and again in the focus groups the women talked of how essential peer support was to their recoveries. They accessed this in ways that ranged from social media to in-person and online groups and also 1:1 contact. All the women held the view that being with people with lived experience enabled them to feel understood, validated, less alone and ashamed:

I've joined the support groups on Facebook, social media. Um, I follow people on Twitter and read, it's just reading people's accounts and being able to, I think, sympathise from the other side of it now ... It's been reading other people's stories and obviously sometimes somebody will put a post up and it's just so deep in despair that it reminds you and it takes you back and it just reminds you that you just never want to go through that again ... If say, if you're having a day where you're feeling a bit down, you, you know, you have, you feel a bit perhaps vulnerable,

then you can, you can just put a post on there and you've got, you know, 20 people that, you know, to, to support you and well, obviously these people, some people support you, some people don't, uh, it's a mix, but it's just, you know, people to talk to, you often get a message from somebody and they'll say, okay, well, I understand why you're feeling this, but remember this.

**Charlotte (early 40s)**

I think being in a group of people, just normal people who've been through it. Peer support, as you've all said, was what worked for me … Being with people who understood, um, was the most important thing. That was the main key thing in my recovery. It really was … You spend all of your addiction part of your life hiding and not, don't talk about it cause you can't talk about that. So then to really walk in somewhere and everyone's talking openly about it, the belief that you immediately feel is just remarkable. It really is.

**Anna (mid-20s)**

I think also what worked … was, um, you're not being alone. So I remember that first login on to that Zoom and I just looked at the women and I was like, you wouldn't even tell, they don't look like gamblers. What does a gambler look like? I don't know what it is, but I just felt some of the stuff they were saying I'd done. And it was some of the stuff that I was humiliated about and really, really, you know, down at the lowest points that the depths that I've gone to, to get money, the lying that I've done. And I didn't see, I thought that was just me. And so that was really useful, but it was in a group environment as well.

**Caroline (late 30s)**

I'd just come out of there thinking, oh my god, somebody actually understands what I've done and what I'm doing and no one's judged me. No one's told me I'm crazy. And it's just to get it out there, it was just so empowering for me and actually someone listening and, and you know, and not judging you.

**Jenny (early 40s)**

Peer support also enabled the women to meet people who were further into their recoveries and see the benefits of recovery. This gave them hope and fortitude. Being part of a peer support group also gave them a feeling of accountability to the group, which also assisted their recovery. They feared that if they lapsed, they would be letting the group down:

I just wanted to talk to someone who had come out the other end. And that is, that is what it's about, if you've come out the other end, I want to talk to you. I want you to show me the way, show me how you did it. And at least present me with the options that are out there.

**Gayle (early 30s)**

And, and you know, a lot of people sharing positive quotes. Um, so just, just uplifting things, things about their own stories. People who've been, who've been in recovery for a really long time and they'll post. So, you know, say two years ago, I never thought I'd be able to do this. This is all the money I spent gambling, look what I've got now. And it's all kind of inspirational things that people will post on there that you can just go on, flick through and have a read. And it just reinforces that desire to, to stay on the right path because reading people's stories of success and how happy they are and how glad they are. Nobody ever, nobody ever puts a post and says, oh, d'y'know, I really wish I hadn't quit gambling. You know, it's never going to be that is it? So it's always going to be things that reinforce the choice that you've made, which I always found very helpful because sometimes I missed, I missed it.

**Charlotte (early 40s)**

The most important part of all the help I've had has come from peer support without a doubt, without a doubt, it's come from everybody else that's going through it and recovering ... Through meeting other ex-gamblers, recovering gamblers, it's made a big difference this time in the way I've approached it ... With hindsight, what I wanted was a person to tell me they understood why I was doing what I was doing and to show me that it was possible to stop doing it. And I mean, somebody that had gambled and stopped gambling and somebody recovered.

**Jill (early 40s)**

Um, the groups, I do, I personally do get a lot from, you know, because with me complacency was, it was a bit of a problem. Um, you know, it's like, oh, I'm ok now. I need to be in a group. I think you hear, and you can share other people's feelings and it enables you to filter them through yourself, um, remember you don't want to go back there.

**Alison (late 50s)**

And those feelings that you feel, sick and stupid and just worthless, nobody talks about that. And it isn't until somebody else does that then you have something that you can relate to and you can say, well, do you know what? It's not only me and they fixed this, so why can't I, if somebody else can do it, why can't I? ... It's that having a role model who's been through and felt the way you do and then come out the other side of it.

**Kate (late 40s)**

You know, sometimes when you're having a really bad day you can't even, you can't even clean up. And I think this is quite a common theme in our group. We just end up cluttering and your house and life becomes a cluttered mess, like your head ... Like if you've just done a bit of tidying up something or organising some paperwork, it's huge to us. But I can't say that to any of my real life friends. And they're like, what else are you

doing? Like you lazy cow. Like, why can't you go and do it, but we kind of, there's that unspoken understanding that we understand that all these normal life challenges that are small to other people, they're really very big to us ... So the social aspects of talking to people that have experience, even if you're, most of the time, not talking about gambling, that's a huge support because you also don't want to, I've really for the first time ever, I feel I want to really beat this because I don't want to let those people down. Um, [with] a therapist and all that, you don't have that. But I do feel like I would, if I were to really relapse, I would loose this friendship, I would loose this group, I'd lose this support. I may not lose it, but there's that fear. You don't want to let the other people down. You feel you're in it together, but that's helped me more than anything.

**Sarah (early 40s)**

It was rare that the women in the groups had accessed trained counsellors with lived experience, but when this happened it was valuable. By contrast, counsellors without lived experience had a role to play but their value was different and limited when compared to peer support:

Thankfully this therapist was also a sports gambler. So I, she kind of catches me out, which the other therapist wouldn't do, because she knows the pitfalls ... You know, you can't get away with it with somebody that's got experience.

**Sarah (early 40s)**

The one-to-one sessions and you know, the lady was really nice, but she wasn't a gambling addict. Um, and she, she had some form of addiction. Um, but I don't really know what it was, but I know that it wasn't gambling, but it was just me and her. Do you know what I mean? She didn't know what I'd done and she, because she'd never done it and that she, blessed her, she was like, oh, I don't really know what that feels like. And I thought, well, you don't, you don't know what that feels like. So I didn't feel like I was getting much out of that one-to-one stuff.

**Caroline (late 30s)**

I found myself asking immediately, have you been through it? And as soon as they said no, I would think, okay, so you can't really understand, then you can't truly know what I'm going through. It feels like [they] can't resonate to that sick feeling.

**Anna (mid-20s)**

Like when people are trying to help you and you say, and you say to them, but do you, do you know, like if it happened to you and they say, no. This is not a judgment on them. It's just a sinking feeling that you get. Cause you think, but how can you truly know? How can you truly

help me? How can I, because I think is a lot of it with gambling is about trust. You lose trust, you can't gain trust, things like that. And so there's a part of what you want when you first get help is just a person to go, I do understand you, you know what I mean?

**Jill (early 40s)**

I don't want a counsellor who hasn't gambled. They don't get you. They really, really I'll have to say, it's been, you know, now I've been through so many recoveries, it does not help me. I have only really got it and trusted and opened up more to a counsellor that is a gambler.

**Debbie (early 50s)**

I wasn't talking to somebody with lived experience of gambling harm. I was very acutely aware of that throughout the session. So I was talking to somebody who was trying to give me tools to manage cravings and they weren't, but they were non-specific. And I just kind of felt in my mind, I glazed over immediately because I just felt like I'm in the wrong place here. This is not, you know, this is not specific to me. And I think, you know, I became very closed off to, to the tools that were there been suggested to me during that counselling session … I wasn't dealing with somebody who knew how it felt. So it just felt like it was completely pointless.

**Charlotte (early 40s)**

### 7.4.12 Women need women … and men

The ongoing perception that harmful gambling affects mainly men and that support services are therefore mainly geared towards men has the effect of deterring women from seeking help. This was evident in the discourse of the women in this research, some of who had avoided support groups because they anticipated there would be no other women attending, a prospect they found intimidating, and sometimes distracting:

I was put off attending a meeting because I felt that in my mind that it would have been mostly male dominated. Um, it's just, wasn't an environment in which I felt that I would have been comfortable. So for that reason, I never, um, never actually I looked up so many meetings. I found them, you know, and said, okay, well there's this one and this location, but I never once went because I just felt that, um, I just felt intimidated and felt that it wouldn't be my kind of place … I know I'm probably just going with stereotypes here, but in my mind, an addicted gambler was it was sort of a middle-aged man who just, somebody who I'd imagine coming out of the bookies. So for me, that was probably my perception thinking, well, if I go to one of these meetings, I'm probably going to be, you know, one of very few women present.

**Charlotte (early 40s)**

> It just wouldn't be for me to go into a room full of men and tell them everything like deeply personal and upsetting about what brought me to that room.
>
> **Jackie (mid-40s)**

> I certainly wouldn't like to be the only woman in a group of men, because apart from the fact that I would, I would feel like they probably wouldn't understand me in the same way. Again, it would be, it would be, you would feel very outnumbered and very uncomfortable about that.
>
> **Kate (late 40s)**

> For me, I was always worried about the way that I looked and, um, taking away any chance of, and it sounds absolutely awful it does, I know it does, but taking away any chance of someone being letchy or eyeing you up or like anything like that, something that you're just not there for, gave me so much comfort. I mean, I'm gay anyway. So it really didn't bother me, but I know a lot of women have reached out to me and said, it could completely deter you. If there was any kind of attraction there, then you're not going to open up because you're not going to want this person to know … I didn't want to be in there cause I'm the only woman and there's loads of men. And I thought they'll have my number then and what if one of them contacts me privately? … It's happened to me in other circumstances where unwanted attention, you get a sleazy text or something, and then I wouldn't go back to the group or I'd have to tell them, and then it all off to kick off. And do you know what I mean? It's like, there's that awkwardness of it as well.
>
> **Anna (mid-20s)**

While most of the women had avoided groups that were male dominated, some of them had maintained their participation in such groups, often out of lack of choice. They needed group support and despite the drawbacks of male-dominated groups, they would not be put off:

> It didn't ever bother me that it was male dominated because I spent a lot of time in the bookies and that never bothered me, y'know?
>
> **Gayle (early 30s)**

> It was very hard being one woman in a room of 50 men. Um, but I, I desperately wanted it, so I stayed with it.
>
> **Alison (late 50s)**

Nevertheless, a range of drawbacks of male-dominated groups was recognised and revealed by the women:

> I prefer personally, um, a female [group] because male ones I found, you know, always had to have sexual jokes and that I did not find amusing.
>
> **Debbie (early 50s)**

> You know, I was always trying to rescue someone in the meeting, um, like a male … you know, I couldn't think of a man not liking me … You know? … [In a women's group] there's no like, don't worry if you haven't done your hair at all, y'know what I mean?
>
> **Alison (late 50s)**

In mixed-sex groups, women also found that they were uncomfortable discussing some issues, such as the impact of their menstrual cycle or gynaecological problems on their mood and desire to gamble, or experiences of sexual abuse. In such instances they would self-censor and not talk about these topics. Some of the women were resilient and stuck at it for the sake of their recoveries, while some left the groups after a short time:

> And it was last summer when I was on some medication and it was, my mood was terrible and I wanted to gamble cause I wanted to feel good. Um, I can say that openly to you guys. And I don't see like you recoiling from me discussing that female issue. When I go, for nine months, I've been going to my aftercare group with peers, all blokes till very recently. Uh, I had another coil in and out. I've been on certain hormones. It makes me really tearful. So sometimes when I share that in the group, I can't get my words out. And then sometimes I can't get my words out and there's a sea of ten male faces staring at me and I can, I can see they are mega mega uncomfortable. They're so uncomfortable. In nine months … I've showed up with all those blokes, I'm the only person that shed's a tear. And I probably shed a tear in every other meeting, maybe two or three times in some meetings, not one of them has cracked a tear and that's that that's okay, but that's not okay as well. That's not okay for me to feel I'm dealing with my gambling problem and the only person that is allowed to cry or isn't allowed to cry, or it makes me feel that my emotions are invalid, not reciprocated, not understood. I know that now, and I can say that now, but don't particularly feel like telling a group of men that I was abused by a man and I was gambling. And that was one of the reasons and I'd just had coil out and hormones were all over the place. I really, really want to cry. And I cry to let it out, it's a biological factor that cannot be ignored in recovery. So … since November, so four months, five months, and there's been women in the group, I'm coming on leaps and bounds and getting in touch with myself, with other issues that I need to talk about. I can say, I'm, I've got, you know, I've got some gyaeny issues or whatever. I feel I could say it. You know, it's not, there shouldn't be things I have to keep quiet because it's not, I don't want to make the men feel uncomfortable. I don't care about making the, I mean, I'm different because I, I, I'm a bit more bolshy, but even I struggle in that environment. And then I wish, I wish I'd had an all female environment because what I've just said right now to you ladies, is the first time I've been able to say that about gambling to a group of women.
>
> **Jill (early 40s)**

It was just the older men giving you their war stories of how many millions they lost. And when this happens and someone held a gun to their heads and this and that, and it was just repeating their, their stories, which probably is helpful for them because it reminds them of how bad things have got. But I couldn't relate to anyone there. I think a woman came once. The women would tend to come and never come back again. Um, there was, like I said, there was one older lady there, but she very much reverted to her doing the tea and biscuits for everyone at half time … I understand it's whoever's there. They can't dictate who's going to be there, but I just didn't, I didn't feel I could relate. It was all old white men. So there was no one of colour. There was no one, there was no women. It was just very, it just wasn't really something I could relate to.

**Sarah (early 40s)**

You know, when sometimes I've found being with men, you could sit there and I mean, I don't have periods [anymore], but I've been in rooms with women on their period and, uh, say like, you know, just, I'm having a crap day. I'm on, oh,  being on can trigger people to gamble. You know, I've been, you know, that them feelings that emotions from periods, having a safe space for women to sit there and say to know what I'm really struggling this week, I'm on, I feel down, that could be that one time that they were able to share where they wouldn't feel like they'd been able to share in a normal room. And I think a lot of women have got traumatic pasts that I don't feel like for personal reasons that they can't share with a man. I've shared more in the last year in a women's preferred meeting, than I've shared in 27 years of my life.

**Alison (late 50s)**

By contrast, the women who had experience of all-women support groups found them to be valuable and sometimes essential to their recovery:

So being in a group of young women and any woman who said that I know, and they truly did know, was the biggest bit of support for me.

**Anna (mid-20s)**

Through being in rooms, um, for like 20 odd years, um, the last year where I've been in a mixed meeting on Monday and a women's preferred on a Tuesday, the women's preferred meeting absolutely has accelerated my recovery. Um, not that I've got any issues with men. I love men. I've been married three times, d'you know what I mean, it's like I haven't got an issue with men in any way, shape or form. But, uh, it has helped me, um, having a big group of other women who get me, they get me, you know, they, they, they get me, you know, to be able, you know, it's helped being in a big group.

**Alison (late 50s)**

The women's meeting, I just find it quite inspirational.

**Sarah (early 40s)**

> I think that you say women with same experiences and that isn't just because women want to talk to women it's because we have different roles normally within a household. So it affects us differently. It's not necessarily the fact that it's a man. It's just that to me, the way I gambled and the way I dealt with gambling would be very different to the way a man did. So I just think women's support groups are also really important. So I think we, we also take things on board differently, and we care about different things. I care about how it will affect my children. I care about how it will affect my parents. And I don't necessarily think if it was my husband in the same situation, if he would feel like that, cause he would worry about how it would affect him.
>
> **Kate (late 40s)**

> My issue is the societal stigma and the fact that I'm a mother and that really made me feel like a failure having the gambling addiction. And you feel like you're the most selfish person in the world because you have these people who depend on you. So I suppose being able to relate that in a women's group is helpful because the men are not going to understand that. Um, to know that you're not the only one either because you really, when you are in the midst of a gambling addiction, you feel like you are the worst person in the world and no one can be as bad as you and have gone through the same thing. So that is worth everything for a women's group. And I never had any female contact probably until this point.
>
> **Gayle (early 30s)**

Despite the positive and sometimes transformational experiences of being with other women, some women also valued the role of mixed groups within their recoveries. Mixed groups brought additional perspectives and alternative group dynamics, but the important caveat was that mixed groups were most valuable when they had a good gender balance:

> I don't need all women meetings. No, it's, you know, I think that it's good to have, I have a small one … which is all women, which is great, but I like the men in my morning meeting. I like the variety. I've gone to the women's one, which everyone raves about. And I'm not that into it to be fair, but, you know, um, so, you know, I feel, but that's probably because I have got a strong women's group that I go to, which is smaller and I've known for years. So, um, the people in that group, so it's different. So I suppose, but you know, there are women, I, several good women meetings, they are nice, but I don't go. Ooh, you know, I've got to go to a women's meeting. I'm, my favourite meeting is a mixed meeting, which, and it is eight o'clock in the morning rather than the evenings. Cause I'm not an evening person.
>
> **Debbie (early 50s)**

> And there was women I met and felt the first, first time in ages like [it was] a service that catered for me. There was men as well. And that I really liked that … Um, having to be vulnerable in front of a group of men was really, really hard, really impossible at times for me to discuss the reasons that led me towards gambling because they were different to most of the men, um, but then I would say groups where it's 50% men, 50% women, I find really advantageous for the different viewpoints.
>
> **Jill (early 40s)**

> I guess it depends on location, but again, yeah, I mean, like I say, some people get some brilliant ones but I do find they are very male heavy and I know it shouldn't make a difference but a mixed meeting would be fine if it was just a bit more mixed.
>
> **Sarah (early 40s)**

## 7.5 Summary

To undertake this research, 14 women participated in pairs of focus groups. This chapter presented the findings of the analysis of the first focus groups in each pair, where women's experiences of support services were discussed. Through constant comparison analysis, themes and subthemes emerged. The result was three main themes around which this chapter was structured: seeking help; finding services; and receiving support.

When discussing the decisions of women to seek support, the chapter revealed that the women had engaged with different services multiple times, so they had made many decisions over long periods of time to seek help. Decisions were variously stimulated by crises, rock bottoms and dawning realisations. Once realised, the need for help was felt as urgent, and when women did not find the support they needed, this could lead to lapses and self-blame. Deciding to look for help required the women to recognise the problem they faced, but after this many of them confronted fear of how they would be received owing to the shame and stigma they felt as women gamblers.

When setting out to find services, it was shown that women faced many obstacles. These included a lack of information about the support available to them and poor signposting to gambling support services by other service providers. Generally the women had to do their own research, most often using the internet. Overall among the women there was a low level of knowledge of the range of gambling support services available to them and the types of support that each service provides. Informed choice was rarely exercised by the women and so sometime the services they engaged with did not match their needs or were even counterproductive.

The third theme of receiving support produced the greatest volume of transcript for analysis and the greatest number of subthemes. These included the quantity of support needed by the women, which

varied considerably, barriers to accessing support, such as cost and availability, and facilitators of access to support, most notably the recent proliferation of online support services. The content of support was another subtheme, with the women all valuing practical support in the short term and longer-term explorations of motivations to gamble and their wider support needs. Residential support services were also a subtheme, with the recognition that not all women can access such a valuable service. Finally, the roles of peer support and women's support groups were discussed and found to be overwhelmingly positive.

# What Women Want

# 8. What Women Want

## 8.1 Introduction

This chapter is the second to present the findings of the research and should be read in conjunction with Chapter 7. Like Chapter 7, it explores the themes and subthemes that emerged from constant comparison analysis of the focus group transcripts. In this chapter, the focus is on the gambling support and treatment services that the women wish they could access should all barriers be removed. The main themes to emerge from the analysis are: signposting and referrals; raising awareness; flexibility and diversity; accessibility; speed and prevention; and legacies and the long term. Again, the themes and subthemes discussed below are extensively illustrated with quotes from the women (using pseudonyms) so as to include both convergent and divergent opinions, and also the names of the specific services that the women mentioned have been removed.

## 8.2 Signposting and referrals

### 8.2.1 A guide to services

In Chapter 7 it was seen that finding information about gambling treatment and support services is usually a hit and miss affair. Information is partial and lacking in detail. Each service provider will give a brief description of its own service, but women are ill-equipped to make comparisons and decide what is best for them because explanations are superficial, gambling support services rarely cross-refer between themselves and there is no in-depth map or guide to all the services on offer. A woman may make an ill-informed choice between two services and be totally unaware that there is a third or fourth option that would be better suited to her needs:

> It's amazing but unless if you go … you don't know that.
>
> **Alison (late 50s)**

> They just tell you what they can offer, not what other people can offer. Like basically I didn't know what to expect when practitioners and therapists and the admin people are explaining it to you, it doesn't feel as real as if somebody could actually say, look, there will be six people in the screen, and then they'll introduce you and you won't need say this. So although it was very professional, I didn't know that, and it was frightening. Like what would I have to do?
>
> **Jill (early 40s)**

Aware of this information vacuum, the women spoke of the need for services to explain their offering in more depth and to cross-refer if they think another provider could better serve the needs of the woman who approaches them for help. To assist in the process of making an informed decision, it was suggested that a guide be developed that explains the services available and what each one offers, including information on waiting lists. The women ideally wanted this guide to not simply be a website or a leaflet, but a service in itself, run by people with lived experience who would understand and who could offer advice and detailed information. This hub or guide would also reduce the need for women to constantly have to retell their story and reveal their gambling harms as they approached service after service:

> The guide … I think that's really important. Someone that's been through it and knows what's out there and somebody you can talk to about what you're going through.
>
> **Jackie (mid-40s)**

> Um, for me, um, it's the accessibility. Um, if you could design something with all the things in the same place, you know, so no one's left alone, you know, because if you look up, um, rehab, but certain things come up. If you look up [lists services] just those things come up … it's all different sorts of services. Um, unless you're really desperate, you only actually find one of them. Um, and that's often through hearsay. [We need a] gambling awareness site that has all of these things in one, in one place with all the different email addresses or contact numbers on that one site, I think it would be life-changing um … I think the main thing is getting somewhere that, you know, people have got choice, choice that works for them. If it doesn't work for them, they can go back and say, this isn't what really works for me, but there's other help there … There needs to be a hub, you know … I suppose, sometimes until you're presented with a menu, you don't know what your appetite is. With a menu I probably would have chosen very differently. And maybe recovered a lot faster.
>
> **Alison (late 50s)**

> I guess being able to have somebody say, do you need any help, would really work rather than having to go and seek it out for yourself because there's a lot of changes you're already making.
>
> **Kate (late 40s)**

> I felt like I was repeating my story … the more you talk about you, sometimes you forget certain things as well. Do you know? And if you've just had to tell your story, not everything at once, having to repeat yourself and having to actually say it to somebody on the end of the phone, I'm a gambling addict, was humiliating to me because I was at that point where I'd not addressed that. And there should be a guide when you phone that number. Okay if it has to be a call line or whatever, if somebody that is just doing admin can link you within, I would say 24 to 48 hours, you need to be speaking either on the phone or face to

face or via chat, to a guide, a woman that has recovered from gambling or a professional that is trained in gambling that can guide you through all your options. Let me tell you about … let me tell you about … let me tell you about … Someone who knows about everything that's available and can guide you through it and can tell you what to expect, because if you're suicidal or you're at the end of your tether, you need that voice who genuinely feels like somebody you can trust, like somebody who knows and like somebody, if they don't know, we'll find out for you, put you in touch with somebody … So for me, it's that you need – a guide, a peer guide, um, to contact you within like a day or two. But not only that, actually maybe putting in a call for them, because I think sometimes it's hard enough that you've picked up the phone to talk about your gambling. So the guide or the person that's helping, you might call together for an appointment for you, or a bit more info for you and get you across that bridge to that other service.

**Jill (early 40s)**

### 8.2.2 Signposting and referrals by professionals

The failure of all but one woman to get help from her GP or any other statutory service led to calls from the women to improve awareness of gambling harms among these professionals. This would help women to secure appropriate referrals or just better signposting to gambling support services. The women wanted referrals to be as normalised and routine as referrals to mental health services or drugs and alcohol support services. They also wanted such referrals and signposting to occur throughout statutory services so all of the possible multiple points of contact with women could be capitalised upon:

When you sit in the GP surgery and you look at the leaflets, you never see anything about gambling, you see things about alcohol, you see things about drugs, you see everything, but nothing [about gambling]. I've never seen anything around gambling. I look out for it now when I go to the GP and I've never, never seen one single leaflet, um, but also linking in with, um, local councils, what services they offer, like their early help, midwifery services, social services, adult services. There's so many. And I work for a local authority and I never see anything about gambling. Never.

**Caroline (late 30s)**

[A gambling information service] would have to link with the NHS like GPs, district nurses, people at A&E, yeah? People in the NHS that are touching on women that have this problem, um, need to be aware of how to refer somebody quickly. Um, so whether that's when you go on the NHS website and it lists all the different illnesses and the symptoms and the treatments, and there should be a link on there that takes you to somewhere … like a hub that gives you all the different information. So to me, the biggest thing about support services from scratch is to recognise it's a bloody health issue and it's not just a little health issue, it affects particularly people's mental health … Equally social services

need to know about it. All the different social workers should be able to identify it and say, here's a number, you need to ring this number. Have you done it yet? So for me, um, there has to be an awareness about a support service for women and it has to be on a massive level: social services, NHS, it has to be in the media. It has to be on television, radio. I don't think leaflets are enough.

**Jill (early 40s)**

## 8.3 Raising awareness

Beyond a hub or guide providing detailed information and advice for women in need, and beyond raising awareness among health and other professionals, the women recognised the need for more general awareness-raising. It was said that this would reduce the stigma and shame women feel due to gambling harms and normalise conversations around gambling harms, as well as increase general awareness of where to access services if a problem arises. The women talked about how safer gambling messages could be championed:

I think it needs to be advertised. I actually think it would be nice to put it on the radio and hear a woman talk … and you know, to hear a woman, um, advertise or, you know, let people know about the help that's out there in like, say a commercial … You know, all [safe] gambling adverts on the radio are advertised by men … If you advertise it on the radio, it shouldn't always be a famous person. It should be someone that's got the depth of knowledge.

**Alison (late 50s)**

Where are the celebrity voices to help women to step away from it? … To hear voices of other people who have these platforms, it does make a difference. We need a big campaign that's multipurpose, don't we really? That includes lots of different aspects. Like real people, celebrities, radio, television, things like that. It has to be, I just think there's so many types of women gamblers, it has to be flexible for everyone, doesn't it?

**Jill (early 40s)**

Not celebrities that are not relatable, but also someone doing too well isn't great either. Normal, just normal [women]. You have role models, yes. But that wouldn't be a celebrity. It would be maybe someone who was rock bottom and now they're a professional, they've really got their life back. They've got something they're proud of that. They, you know, they've overcome it. That's a role model to me to see somebody who's maybe started a completely new career, whatever it might be, or a family or whatever it is they want. And they, they've turned their life around and that's a role model.

**Sarah (early 40s)**

So if we had a woman that was very, very passionate about gambling, um, who had, you know, three or four million followers or whatever, then I think that would be a massive platform as well, to get that out. Maybe that is the biggest, biggest thing is have hope is, you know, that's what us compulsive gamblers need is having hope that we can recover.

**Jenny (early 40s)**

This led on to a conversation about the National Gambling Treatment Service's campaign aimed at women. The campaign posters (see Appendix III) were shown to the women during the focus groups. Their reactions to the posters were mixed, with some women finding them to the powerful and others uninspiring and oppressive:

Oh, that was totally me.

**Debbie (early 50s)**

I personally think that they're good, very thought provoking, but I feel like, I feel like they're a little bit oppressive. I think it's hard hitting, but for me it would make me feel more sad than I already felt.

**Alison (late 50s)**

I don't think it attracts me enough. I mean, obviously it says "when you're there, but you're not there". It's not all about that. It's about how you're feeling in yourself. So I think it's a bit more, I know it sounds awful when I say it, but if they looked a bit more unhappy, it would attract me more. It sounds awful. But when you're at your bottom and that's when for me, when I wanted to get help and if I saw a poster of someone like at their bottom, I'd be like, that's me. I need to take that.

**Janet (late 30s)**

I think it gives you a starting point and I think that's probably what it's meant to do. It's supposed to sort of show you, it's the diversity, people that do have gambling problems and give you somewhere to start with, um, um, right at the beginning of my journey. So it certainly would make me think. I'm not sure about "when you're there, but not there". I mean, I know somebody has obviously thought about that, but unless you knew what it meant, I'm not sure it really screams out, we're here gambling.

**Kate (late 40s)**

I think it's about relating. And I think that it's like you say, you, your target audiences, people who know what "when you're there, but not there" means, they're the people that you're trying to reach out to. I think it's quite powerful. I think that if I'd seen something with bright colours and happy and soft, then I probably wouldn't, I wouldn't associate with it because that's not how I feel at that point. You want something that says, oh right, okay. Yeah. This gets me. This is, this is what I'm feeling. And I think, I think this does it. I think it's quite good.

**Anna (mid-20s)**

> And if you were just totally revamped the colour scheme, even just make it bright and attractive, make it hopeful, make it something that I want to be a part of. It's: you have a problem, you need to fix it. You know, it's, it's the wrong approach they're taking to it completely... it's just wrong. You know, if you were to say, here's a group of like-minded people call this number, come here. You know, you have great support here, blah, blah, blah, this type of thing that would get me interested because you're, you're making me feel like I'm not doing something shameful, even though, you know, I feel like I am. If you were to take that away in a, in some poster that would get my attention, give me hope is what would get my attention.
>
> **Gayle (early 30s)**

> I think imagery is very powerful, but negative imagery is not going to get the right effect. It might spread some awareness of the problem in general, but it might make the general public think that every woman gambler's a dowdy miserable cow that ignores their family. That's not true ... They're not very inspirational. That's the type of image you don't want to identify with. You probably do. I don't want to, but if it repulses me ... I want to see and I want to be attracted to it and identify with success – a real success story. So you need to entice people, not frighten the heebiejeebies out of them.
>
> **Jill (early 40s)**

> That is one, one tiny segment of the women gamblers. Now that is one tiny segment of the people that do that.
>
> **Alison (late 50s)**

Instead the women had lots of ideas of the type of campaign they would like to see instead, with these ideas united by the theme of giving women hope and inspiration:

> Let's see a recovered person with a sentiment or a statement, which says something like "I was there, but now I'm here". So it's that kind of informative language that we're looking for. Like "stop when the fun stops" – it means nothing to me. It literally doesn't connect to my life. [It needs] real actual words of recovered people or in gambling recovery. Just having a campaign that has graphics where there are all genuine words written because I do feel that women, we are emotive and we are connected to things that touch us in that way ... I know we all have a different recovery, but the sentiment, camaraderie between us all is the most important thing, I think ... We want to be inspired and we find inspiration for each other. So if that can be captured in some way, it's more likely to reach out as a ripple, isn't it? ... Cause we all look different, all different ages, all different backgrounds. We all close our eyes now and listen to each other speak the words we're speaking about our recovery, about how we got help, but what it meant for us to change things around, that's gold. It doesn't matter what you're looking at,

I think words having immense power. And when you know, those words are genuine, have come from somebody, whoever, whatever age they are, colour of skin, whatever type of gambling they were doing, those words and those stories are what mean the most.

**Jill (early 40s)**

You need to see something that explains where this person's been and where they are now. You've got to boost people, you know, give them hope, give them a future. Um, women of all ages. Even if [the image] is sort of, you know, a tunnel or something, you know, cause we was in that tunnel, but there's a nice light.

**Alison (late 50s)**

But if you can tell me that it's a person on the other end of that, it's going to be someone who's coming to the other end of the same problem I have, then I'm going to call that number. You just have real people on this poster who are like, we've come out the other side.

**Gayle (early 30s)**

There [needs to be] real people in that advert. Secondly, look, all the words around it, "aspire", "dream this", you know, and why can't it be done so it's not negative? Yeah, definitely speech bubbles coming out, you know, and sort of saying, you know, don't feel alone, there's help out there … just different quotes and even getting different quotes from people with lived experience, you know, just getting that.

**Jenny (early 40s)**

Maybe put in some, just some quotes from people who have recovered from gambling about how they felt at their worst, might be really eye catching in something like that because you, you do honestly think nobody else knows how you're feeling and what you're doing and that feeling you get about yourself. You really think you're by yourself. Until you start speaking to other people you just don't realise. So I think even now I wouldn't know where to go to start to get help. But there's nowhere I could just go to online and go, I'm a woman gambler who can help me? You just, it's just still not there.

**Kate (late 40s)**

For me, one of the biggest things was, um, it was the financial impact of it and not being able to afford to do stuff. So, you know, if I saw a poster with like, "am I going to afford this drink?" or summit … I think that would have caught my eye and it would have resonated.

**Anna (mid-20s)**

I'm sure there was like a no smoking one, wasn't there? Where it showed two sides of the same person. Um, I think it was a guy. I can't really remember, but I think he was smoking in one and then another picture was like playing with his kids, you know? So could it be like a split thing, you know? "Can you afford to go on night out and can you afford to get

> your kids food?" Just maybe like that ... like split it and put two sides to the story. There is a better side to life after gambling. A real person, a real woman that has not necessarily identified themselves to the whole world, but not a stick thin typical model kind of thing, a real relatable person, you know, a picture of a woman with thought bubbles coming out. Like "I'm not alone". "You're not the only female". Cause that was what my thing was. Yeah. Just something real, nothing that just looks so ridiculous and something relatable. The biggest thing is social media at the minute, isn't it? So loads of different platforms ... TikTok, the amount of users that are using it these days, Instagram, or anything. It's just social media, isn't it?
>
> **Caroline (late 30s)**

Suggestions for a poster tagline included "Why give up everything for one thing when you can give up one thing for everything?" and "Don't let it be rent free in your head". The women also had other ideas on how to boost the effectiveness of an awareness-raising campaign. These reflected their first-hand experiences of the reach and power of marketing by the gambling operators and the contrasting weakness of messages to promote safer gambling and gambling support services:

> And I think when they do campaigns like say national like gambling awareness week or women's gambling, I think it should be by law or a certain moral code where during that week there's no gambling [advertising]. It needs to be a blackout where all the adverts are replaced with the charities and even better, funded by the bookies as well for that week, say on social media a blackout, blackout week, because you can't have mixed messages like that. It's so confusing to have Foxy Bingo telling me to dabble responsibility or whatever. And it probably needs to be not just targeted at women's programmes. Cause I don't think there's really such a thing, it just needs to be targeted everywhere. There are, I guess there are programmes targeted to women, but women fit into all different categories. So I imagine if it was on, I'm guessing you're going with Loose Women or something like that ... I'm guessing it's something like that. That's going to miss a lot of us that would never be watching that. So it probably needs to be widespread over the whole network.
>
> **Sarah (early 40s)**

> I'd like to see some documentaries? Um, I wouldn't, I wouldn't necessarily be interested for it to be a celebrity, you know, I'd rather see somebody real, a real person who's, you know, really come over a hard thing. Not somebody who's too easy. It's some, you know, somebody who's really had to struggle and get out of it, not somebody who could just fix it with a few debt repairs, you know ... some people who's turned their lives around through hardship, you know? Cause it is hard, you know, if you really broken. You know, a mixture of sort of case studies of, you know, recovering addicts, you know, good recovery and yeah, something positive, heart warming. I think it would really be nice to watch.
>
> **Debbie (early 50s)**

There should be a mandatory video that you have to watch before you play. It might be 10 or 15 seconds, to give you that break and actually have it on there because that's the place where people need it. So you have to go off and go on social media. So I think the most important place to advertise help is on the betting site itself. It has to be on there somewhere. Um, so in the bookies is where you actually are in that moment. And it's exactly like you said, because you have that moment where you're desperate and that is only a few minutes or it might be an hour or something after you've gambled, but where are you when you in that moment when you need help, you're actually on a site or you're in a bookies, you've just lost everything. So it has to be on the site.

**Anna (mid-20s)**

When I did my masters, I, uh, did some research, um, little thing and I made a poster and put them into library toilets and with little slips at the bottom. And it had to link in with, and it was around domestic abuse, well you see them quite often on the back of toilet doors in women's toilets, but they have little things and it's surprising how many of those little tabs go, how many people take them. But even those, you know, they might not be able to approach members of staff and reach out to them in a casino, wherever. Well, if they've got, they're probably going to the toilet, the amount of time that they're there and the drinks that they're drinking in the casinos. So just something there on the back of the toilet door, it's anonymous. There's only you probably in that cubicle taking one of them slip things.

**Caroline (late 30s)**

If casinos can get into my inbox and get on my radio, then so should support services for women ... I don't want bingo advertised at me, but if it has to be because it's legal, it has to be. But I also want a number on there that says, this is a national gambling support service for women, ring it. I think women should at least once a week come across, uh, you know, an anti-gambling message. So you need a top marketing executive perhaps who's worked for [gambling] companies and you get them across to the good side and you start like that.

**Jill (early 40s)**

If there was something on the back of the betting slip with all the numbers, like helplines.

**Jenny (early 40s)**

But it's very difficult to approach someone in the middle of a betting shop and say, are you okay, have you got a problem? So I think it needs to be a bit more discreet. Um, so maybe like, put things on the back of the betting slips and just like wear badges. So if you need to talk, we're here and things like that, so that they know ... So maybe a bit more, a bit more training for people that work in betting shops would be great.

**Janet (late 30s)**

That one [little poster] you put in your pocket. People don't want to see a big poster. You know, there's enough stigma to get over. They want something subtle that they can put in their pocket or put in their bag. [A market stall] that's another way of a face-to-face hub and you just have every service on there and that costs hardly anything … Believe me, there's many a time years ago, I'd be walking through my market and if I could've seen someone like that, it would have been, that would have changed my life a lot earlier than I decided to change it. You know, you know, the actual physical hubs, maybe financially, it's very expensive to do that every day, but you can rent a stall from the local library or a desk in the local council anywhere in England for like 12 pounds … Um, you know, volunteer for the day – I do. But you know, that day, that one person that you, you could talk to without judgment.

**Alison (late 50s)**

## 8.4 Flexibility and diversity

### 8.4.1 Flexible support models

The diversity evident between the women and their histories of gambling harms prompted the unsurprising call for support and treatment services to be flexible and cater to the varying needs of women:

So I think being flexible in the approach to recovery and how you do it so that you can kind of see what's right for you. There will be some people that are put off by residential so won't go. Some people don't feel online will be enough. So I think I'd make sure first and foremost that there's a, a range of methods to talk about and go through.

**Anna (mid-20s)**

[The service] has to be, have all different types of recovery included in the service because what works for one will not work somebody else.

**Jill (early 40s)**

If you're probably not so long [experiencing gambling harms], you're easy to fix. You're easier to mould. If your problem's very ingrained and you're very, very addicted, then you need probably residential and be taken completely out of the equation. But you know, just saying, oh well go to this site, is not going to cure us or you still need all those other services because it depends on the level of your addiction and how seriously you are affected by it.

**Debbie (early 50s)**

## 8.4.2 Diverse needs

The need for flexibility reflected the diverse needs of women that ranged from residential care to online support, peer support, face-to-face support and women's groups, with the duration and quantity of support varying from brief and single-service to prolonged and multi-service. The women identified several specific needs that they wished services would address, including the need for access to complementary services, such as those addressing financial harms or harms to careers, as well as cross addictions:

> So … speaking about the financial aspects of that to somebody who had an awareness … I think, you know, under the same umbrella would be a good idea really, like a one-stop shop.
>
> **Caroline (late 30s)**

> The financial aspect for me was the hardest one. Um, it took me over a year to even address it. So … I think it would've been helpful if there was some sort of help in the group that we went to.
>
> **Janet (late 30s)**

> A lot of people have cross addictions or certainly cross issues, even if not addictions. Um, and a lot of us might have maybe needed help with, you know, education, uh, finding work, finding housing, also debt help. It all links in doesn't it?
>
> **Sarah (early 40s)**

> I think [the service] should be mainly about gambling because a lot of women, yeah, they have other issues, but some don't, and if it's more focused towards other things, it may put people off going on it. And that's not to say you can't say if you have other issues to point them in the right direction.
>
> **Jackie (mid-40s)**

> Um, so I, I think it, it definitely, you need signposting because, you know, if you've got, if you want to have hope and a process for change, you can't just say we don't need you [because your problem doesn't fit] … I know from personal experience, I can't just deal with the act of gambling as I have to deal with a lot of other things to change.
>
> **Alison (late 50s)**

> You could [offer other types of support] through optional seminars and workshops. If you did have an actual hub you could offer those types of things as a side, and then you're welcome to take them up or not … So you kind of need a different approach because that's how you're going to get people inspired to change and yeah, a network of peer support, educational workshops on a day-to-day basis on daily life. Like, I mean how to get back into being normal,

a normal member of society and just get your finances in order, this type of stuff, you know, career direction, or maybe it's, you know, you want to go back to school or would like to do that type of thing? I think that'd be so helpful for people. Maybe they don't want to change careers, I don't know, but the options should be there.

**Gayle (early 30s)**

But I do recognise ... like the cross addiction with food and stuff, and actually at the moment, there's no one to sign post me to anywhere to get help with that. So I've had to try and figure it all out, Google it and stuff, which is the same thing that we're talking about with gambling. So I think it's about not duplicating what other services do. It's about understanding what the current services do and explaining that effectively and properly through a guide to the person with the problem. If they have these problems outside the scope of gambling, but another type of addiction, then they need to be helped to get in touch with the other place ... Cause the thing is, if it says about gambling, once you do tackle your gambling, you do have all of the issues that, that, you know, we're not all, we don't all just exist with one problem. Gambling tends to be the problem where we hide or where we seek a bit of comfort from our other problems.

**Jill (early 40s)**

I had masses and masses of debts and, you know, just going to a support group was lovely, but it didn't solve my, you know, feelings of, you know, inadequacy and the shame because I didn't have anything. So I needed some help to restructure a career, which was very difficult considering I'd been so long out of the workplace, which is not having references and things, which is very normal, um, for women who have got a severe gambling problem ... And I know, you know, it's, um, you know, it's a great help to have someone to talk to, but when you're absolutely dying in every area of your life, um, you need a lot more help than just a support group ... You know, with the debts, I can see, you know, the finance, you know, even with a debt plan, people want, I don't know, more from life and if you don't have the job and you don't have things, you know, um, it's hard. So that I think I would definitely think there should be more links to like some kind of education, proper programmes or internships or anything like that would make it a lot nicer in recovery than just mental health groups ... And this is what makes a lot of gamblers gamble because you haven't got a job and something that you want to work in. And, you know, I don't know if there is some sort of career or sort of like, you know, some rehab programmes, you, you know, you do jobs, you know, like in a charity shop or something. Yes, we could all get that, but that's not going to get me jumping out of bed. You know, I have a degree, I would want to do something like an accounting, maybe working with figures or something, or, you know, learn multimedia or something ... it'd be nice if there was some sort of structured programme that could be followed up, not just counselling and all that.

**Debbie (early 50s)**

You feel bad about yourself because you don't get into the things you're applying for. You don't get the job. You don't get the courses. There's obstacle after obstacle, financial obstacles. And then you discover, well I may as well just gamble again, because you know, in your head, it's not, it doesn't, it's not going to work out but you're like, well, at least I could manage. At least I had money coming in. I think that would be a huge, that would be such a positive if there were links with industry, with some of these charities, um, where they had links with industries that are not going to stigmatise gambling, um, same way that a lot of companies take on, um, ex-offenders, they take on drug addicts, um, recovering addicts, but there isn't that for, for gambling, you know, somewhere, a programme where you wouldn't have to explain why you've got gaps in your CV, because they know it.

**Sarah (early 40s)**

So I'm not sure [it would work] if I spent all that energy on trying to focus on my gambling and then all of a sudden I'm reminded that I've got x amount of debt. I think maybe one of your counselling sessions after might be okay, we can introduce a financial advisor or whatever it is, or even someone from like Citizens Advice or something like, well, if there was an option there to have an appointment in aftercare, I think ... about the time we've got to start thinking about other things, but I know I've got an appointment coming up, so that's where I can start addressing it.

**Anna (mid-20s)**

I think having that person is the most important, you know, who can say yeah, we'll deal with the gambling and then we'll deal with the financial side of it. And then do you know what I mean? And then take it on like that.

**Jenny (early 40s)**

### 8.4.3 Access to lived experience

The women also wished that through gambling treatment and support services they could easily access lived experience, either for 1:1 or group support, with the proviso that people with lived experience receive appropriate training:

I think for me having the ability to talk to people who have been through the same thing is the most important thing.

**Kate (late 40s)**

I mean, the thought of, um, when I first started the thought of me, just me and one person who's got experience with gambling and now's gamble free would be a massive relief for me than walking in to a group of 20 people. So, because I can remember it as though it was yesterday that I was, I was so, I mean, my anxiety was through the roof anyway

with everything that was going on at the time. Um, if that was an option that I could have met someone in who's been through similar experience, to me, it would be a massive relief just to meet one person and have that person to talk to. Um, but I think it's a fantastic idea.

**Janet (late 30s)**

I think, um, lived experiences is hugely important because you can relate to it so much, and you can know which person doesn't know. But I think ... you probably need some sort of qualification in there as well about mental health and wellbeing, because I'm sure that we all know you can get to a point where you're suicidal, and it needs somebody who recognises that conversation and understands where it needs to go. So it might be sometimes a little bit more than dealing with an urge or dealing with a relapse. I think you need to be careful ... I think you should also go through a training to be aware, but you have to go through extensive training.

**Anna (mid-20s)**

What we're all really coming back to at the end of the day is your army of peer supporters. That's all you need. You need to get people who have been through it and come out the other side. And they're trained to help other people. And I think that's just the answer to every question you've asked to be honest ... I'd love to see the peer support people who really have come out the other end and can inspire you because that is where it starts. That is where it starts completely. I would take away the doctors to be honest, because I think they actually stunt your development and your process forward and you need to have just this [network of peer supporters]. My last point now, the stigma and shame, they're the biggest problems and they're the biggest issues for women and they need to be tackled. And again, that's going to be done through a peer support network of people who've come out the other side and can show you it's all right – fuck it, you can still live your life afterwards.

**Gayle (early 30s)**

### 8.4.4 More support for women from women

The need for increased provision of women-only support services was also recognised as a means to increase the numbers of women coming forward for help, enabling women to be less shameful, less fearful and less alone in their experience of gambling harms:

If you, if it's not made only women, then it's going to be the same thing. Again, it's going to be dominated by men because there's just more awareness of it with men. So if you don't sort of set that, we're just going to be in the same position again.

**Kate (late 40s)**

We have a different emotional regulation ... Do men understand that? Do you know that? I don't know if they do, um, you know, being a mum, being an aunty, being whatever, as a female, you, you take on a very different role sometimes in a home don't you and, and it's being able to speak to other women who know what it can feel like when maybe it's that time of the month and you're struggling with your emotions. And yeah, just, I dunno, it seems to me, I was put off by going into groups that would have been mixed. So I would think it worked better and knowing that I wasn't the only woman gambler as well, not an alien, like other people existed or the people had gone to the depths that I had gone to ... I think women, women only is definitely better for me anyway.

**Caroline (late 30s)**

It's good to see women and just women sometimes.

**Sarah (early 40s)**

## 8.5 Accessibility

In Chapter 7 several barriers were identified that made access to services more difficult. These included the demands on women's time and the absence of local services and expense of accessing those far away. In response to these barriers, the women had a number of suggestions:

But if you've got children and babies and things like that, you know, I think having a drop-in centre, you know, at a lunchtime, you know, when the kids are at school, where that mum, you know, can go and get through the day.

**Alison (late 50s)**

Residential ... doesn't support everybody. If you work, you know, you've got young children and you can't get away. So maybe offering like a Zoom version of that [even after Covid] ... would suit you.

**Jackie (mid-40s)**

Childcare, um, which I think is a massive thing that stops women actually getting help, um, worried about whether they're going to obviously leave their child. And I mean, if anything can be looked at to help them with childcare, even if it's for a few days, just so they can get the help that they, at the start of the recovery that they need, um, would be a massive help I think.

**Janet (late 30s)**

What's happening to that woman at home? Is there any levels, is there any, is there any other experience of any of abuse at home, you know, like domestic violence? Maybe doing ... a scoring system ... so you know what that woman was experiencing in the home life as well, um, is taken into

consideration. Children, how's she going to work around it ... just to be aware of what women experience at home and whether being involved in a support group and opening up about gambling is going to lead to any other forms of struggles for women in the home, especially.

**Caroline (late 30s)**

In addition to assessing the barriers in the home that hinder access to help, such as lack of childcare or abusive relationships, the women wanted improved physical access to services in a post-pandemic environment as well as continued provision of online support:

For me, there's nothing like a physical meeting. I like physical meetings. I like seeing people, watching their body language, talking. And Zoom for me is second best. Having somewhere where you can actually physically go and sit down and talk to somebody, you know, someone with lived experience who has come at the upper side. Um, because you know, it's not, there's a lot of people that can't get on the internet.

**Jenny (early 40s)**

Having the option would be nice, wouldn't it? Would you prefer to be in a residential or a 12 week online programme? And this is how it would work this structure, these dates. I think having that option from the offset because not one size fits all, doesn't it? So just having that option would be fantastic.

**Caroline (late 30s)**

I loved going there and meeting people, but it scared me to death. And I think that I'm probably more likely to join a Zoom than I am to, to go down and meet people in person because you can kind of, it's an anxiety thing, I suppose, but you can turn your laptop off. Well, you can turn your screen off if you feel uncomfortable. Whereas if you're in a room of people and you do start experiencing that at an extreme level and it doesn't get any better then you're not going to talk. Whereas if you're in your own room, I'm like just chilling on my bed ... Like it's quite easy to talk ... Yeah. I think, I think what might be good would be if you had a point a contact that was local, so you could say actually you ring them and they go and meet you for a coffee somewhere and you talk it through because it's, you don't feel like you're walking into that [intimidating] environment.

**Anna (mid-20s)**

I'd rather go because you get the full experience then and you, you get the focus away from home. You don't, they take your phone off you. You don't have any technology and you're focusing on just the start, just getting into recovery.

**Janet (late 30s)**

I'm sure we could do things online. I'm sure they could run programmes online. Um, you know, it, it may not be as easy to get everybody together, but by being, having online services, they would allow, um, lots to people from all over to attend, um, without, uh, you know, having to travel … Well, there has to be more local groups, like, um, cause obviously I'm in the north, right. You know, it was a five and a half hour journey down the country. Um, and that was somebody, you know, traveling right down south, because there's nothing local around here … And so I think it would be really good to have a women's only gambling, uh, support group, um, and, and something like intense therapy … you know, there's just nothing out there.

**Fiona (early 50s)**

So actual places in city, you know, maybe start off with the four countries of the UK or wider. And in those buildings they are hubs. So you could have different groups coming in there. You could have social services coming in. You could have them linked up to residential programmes … Yeah, because for some people that don't have the internet or they wanna, you know, want to just see a friendly face. There is something about that when you're in a crisis, you might not have any money. Your phone might have been cut off. You might just need somewhere to go. And one in every city, it'd be ideal, but at least one in every country, one office, somewhere where you could, you know, you could turn up and you'd be all right by the end of, you know, a few hours, you'd be linked to having health services. And I wonder if it wouldn't be a better, better idea to think like that. Although we have online and it's very versatile, there are some times where you feel very lonely, and you don't want to go home and you, and you do want to just go, can I just come in? Is this like a safe space? Yeah. There's a meeting going on that or, yeah. Do you want to just talk to one of our mentors? Like it's an ideal world thing because at the moment there's no help, but in the direction of where help could be, could there be things like that? You know, or even where you set up in a community centre for a day and it could be the first time that town or that village has even heard of a hub for gambling, you know, people that pop along – so physical as well as online. Cause I think we're, we're all getting away from the physical world, but fast forward five or ten years, both, I think will be equally important.

**Jill (early 40s)**

Like I say, like I would have done a lot of online gambling and getting out of your home where you do that and going into a place that's specifically for helping you not to [gamble]. Now I can see the appeal there. I can see the progression if you're in a totally different environment. One that wants to help you. Not hinder. I'd love it if there was a hub, to be honest, if, if there was a place I could go and connect to other people going through the same thing as me or who had come out the other side. I really love that idea.

**Gayle (early 30s)**

> Residential, I think that is so important to be taken out of your, um, your normal life, because it's not just the gambling, your whole life becomes chaos. Um, your whole life is chaotic and you kind of need to remember what it's like to have calm again, to have that, to not be living in that life. I think you need to, I know it's not, maybe not practical for all women, but it should be offered. And if people can go to residential, that should be available and not just three days like we had offered or I had offered. Um, and then it's very difficult to focus on your early recovery. I think if you're going back home after three days back straight into that, um, into your normal environment, again, with your normal financial pressures, may be family pressures, whatever it is. I do think there needs to be offered a minimum of say two weeks, um, residential at the start of the programme.
>
> **Sarah (early 40s)**

Improved use of technology was also raised in the focus groups as a means to increase access to services and there was an enthusiastic conversation about how self-exclusion schemes could be improved:

> It'd be great just to have someone, even if it's a web chat. I mean, I, some people find it easier just to text. See if you've got a web chat there just for, just to have someone to talk to and then if they need to ring you, then maybe they can ring you. But just to have someone just to reach out to you would be brilliant. And 24 hours a day, I think.
>
> **Janet (late 30s)**

> They should make it easy for you to get on that appliance, your phone, your iPad, your computer, whatever, and ban yourself that second, like that minute, instead of having to fill out a bloody massive form and they ask you stupid questions, like when did you last get a credit card? When was your last personal loan? What's your bra size? Lots of crap like that. And you're thinking, what the hell? And you can't remember, oh, I had to do it three times, three times before they would accept mine, and then it took the next day for that to kick in. Now that ain't good enough. Set it up as an application where it's straightforward. I'm a compulsive gambler. I tick the box, block me now, from all the websites and give me three months free. Um, and you know, and then once you, once you're in a financial position start paying and you start paying them.
>
> **Jenny (early 40s)**

> So it's 24 hours thing for me. Yeah. And I think in line with that, um, the banking as well, you know, it's 24 hours, maybe the bank could ring, um, 24 hours and have that ability to stop that transaction as well. And then, you know, linking in with someone to speak to you and yeah. Do you know what I mean? Like, but sometimes the bank would message me saying, is this transaction you? Reply yes or reply no, but literally that was like a delay of five minutes and I was straight back on, yes, that was me. And straight there, you know, like, so if you did have that immediate response and maybe the banks just went, no, we need to speak to you on phone. We need to have that conversation. We need to block that

card until you make a physical interaction with us. Not a text message d'y'know like maybe more, something like that. [And on blocking software] what I was thinking is in that moment, when you look at it and it's like, oh, you need to pay, well I've just, I haven't got any money because I'm a, I'm an addict, I don't have it, so I'll have to wait it until next payday and then next payday comes and I'm like, oh, I've lost it all again. And then again, I haven't got that money. Can it not be like a free trial at the beginning where you can go immediately to get that on your phone. And then after three to six months, then start paying. Cause then you've got the money and you're understanding the value of that on your phone, stopping you from accessing those sites. It can be an off-putting thing. I know that nothing really comes for free in this world, but just like an incentive for people who think, I haven't got £2, because in my desperate times I didn't have £2.49 in my bank account. I didn't have it. Um, so I wondered if that might help for that immediate, that immediate fix.

**Caroline (late 30s)**

You can spend a thousand pounds [in the middle of the night] and you only have to text yes or no to somebody at the bank. The bank should be aware that maybe that's a trigger time for lots of people. Again, it's not just between nine and five. So maybe an all-in-one package. So you can sign up to this and this will put blockers on your phone and you will not be able to access gambling. And this is how you stop your bank. So once you've made that decision, instead of having to work at it, because you do have to work at it, you have to do so many different things to put those things in place. Having it all in one place would make such a difference once you made that decision.

**Kate (late 40s)**

## 8.6 Speed and prevention

The desire for improved speed of access was voiced widely and this also tied in with a wish for services to intervene earlier so that levels of harm can be reduced:

The support service for women has to be fast. It has to act quickly in, in whatever that first interaction with it is. It can't be, we'll get back to you in six weeks or there's a 12 month NHS waiting list. It can't be like that. Um, and it has to be free. It has to be for free. So links, awareness, fast and free.

**Jill (early 40s)**

A support service for women should include prevention ... So that's a case of people going out into the country and talking about, you know, in different settings, how they got involved in gambling harms, how quick it was, going into mums groups, going into wherever there are groups of women and having an honest conversation, wouldn't it be lovely to try and capture people before they get that far into it? You know, like a lot of women would go gambling on scratch cards cause they're a

bit cheap, affordable. You pop to the shop every day and you can grab one, like that's what, you know, with drugs, they say there's like gateway drugs, you know? And there are these little gateway issues, all different types. So preventing them and saying like how many scratch cards is too many? How many games of Bingo's too many, you know, how many trips have you been to the, the betting shop or the casino this week? There's some sort of prevention. And I think you need an army of people who have recovered to go out and prevent other people from getting into it because actually we all have been through the gateway of getting involved in different ways and seeing how quickly it can happen.

**Jill (early 40s)**

It's not very often somebody steps in and says, can I help you? Maybe show families what the signs are, that it's happening all over again. Because if you're not an addict you don't know what people are doing, you have no idea.

**Kate (late 40s)**

Why should you get rock bottom? You know, why should you have to get so low? Why can't there be more help out there for, for people.

**Jenny (early 40s)**

## 8.7 Legacies and the long term

All of the women who had accessed multiple support services were adamant that aftercare was central to their recoveries. They wished that aftercare were long term and focused on preventing relapse, as well as providing opportunities to refresh skills and learn new ones, including in annual retreats:

So it should include longevity as in, we're always here for you and we'll always help you cause this is a lifelong problem.

**Jill (early 40s)**

I think it's nice to, it would be nice to go to like a rehab even for like a weekend.

**Debbie (early 50s)**

I would want it to be free because I had, after the 12 weeks free, I had to pay for my therapist … when you are already worried about money and you're already on a budget, it's, it's just the traveling there … So I think aftercare and possibly aftercare with the same residential group you've been with, because you've got that bond with them, would have been a big help … I really do think it should be followed up maybe once a year, once every six months for those that want to, even if it is just another weekend or just enough – four days … I just think it would be really

helpful to have a follow up, um, even if it's just to follow up, you know, voluntary, it's just that some people may not need it, but where you can, anyone that's been through the programme can meet up and have a weekend refresher of, of the stuff you've learned … It's that feeling if you've been through this together and you're just abandoned and then it's all on you, the onus, which is, I understand that is fair enough, but you do want that support to continue. You want to know that it's there forever if you need it.

**Sarah (early 40s)**

Going back as a group once was like big, um, because people talk about relapse and what they've been through. And, um, so speaking with that group again and then learning from that, how to deal with a relapse, if you have had one, why did they relapse? What pushed them into relapse and learning from that as a group. Because I hadn't personally relapsed at that point, so I wouldn't have ever spoken to my counsellor about relapse or what happened or what triggered me. So I think it was a good opportunity to see that not everybody will always, and you don't encourage it obviously, but I think going through that and learning about that is important.

**Anna (mid-20s)**

Again, not one size fits all is it with the after support. And I know that the other girls that I was with have continued to speak, cause I've not felt I needed to … Some of the girls have relapsed and I've not really known what to say to them … I think doing that work around relapse is a really good, really good idea to do. So maybe that could be something, to come together as a group or having, I dunno, like a bank of information. Do you know, like read at your own pace? Um, maybe some like pre-recorded Zoom stuff. Like, I dunno, like maybe that's an idea if people don't want to meet in groups, yeah. [Also] how families can monitor, not monitor, but help manage and maintain that, um, stability for the person who, who is in recovery. So that would be quite a good thing in, in aftercare.

**Caroline (late 30s)**

And when they tell you on WhatsApp that they've relapsed, it's very hard to know what to say to them because in a way, although we shouldn't, we feel a little bit guilty because we haven't relapsed and that's, I know it sounds stupid, but … we're not just gambling addicts, we're people. And I think it is, I think it would be really good to do some work around relapses.

**Janet (late 30s)**

The need to also address long-term legacy harms associated with gambling was also discussed. The women wished that a support service would address longstanding financial harms and career harms:

I've the worst credit rating in the world. And in Ireland that will last you for five years after you've paid your debt. That's not very fair because I'm actually a very stable and responsible person when I'm not gambling and I'll never get a mortgage. That needs to be tackled too.

**Gayle (early 30s)**

When I came out of bankruptcy, which was in 2019, I came out of bankruptcy after seven years and I was bombarded with credit card offers, offering me money after coming out of bankruptcy after seven years, knowing that I was a compulsive gambler … and that's definitely got to change.

**Jenny (early 40s)**

My dad's still got control and he's still looking after my finances, but I'm, you know, I'm 32 years old and I want to take back control but how, how do I approach that? When am I ready? How do I know when I'm ready? You know, that, that might be good to say as a bit of, and I'm not saying someone should tell me when I'm ready, but just knowing, just take that back steadily, because me and my dad don't know. And my dad's like, you just let me know when, when you're ready, but I don't know either. Um, so maybe some advice around that, on how to move on from that and have a bit more financial freedom, but safely and best managed.

**Caroline (late 30s)**

And so I feel very strongly that needs to be something, you know, for either education or internships or work experience that is valid, that it's going to get you a decent job, to really get you and value intelligent women and show that there is, you know, you can get a second chance.

**Debbie (early 50s)**

There needs to be maybe a structure in place that's practical to try and get people back into the workplace, back to education. Um, I feel that there needs to be some sort of hope for a way out.

**Sarah (early 40s)**

## 8.8 Summary

This chapter presented the findings of the analysis of the second focus groups in each pair, where women's wishes and ideas for improved support services were discussed. Through constant comparison analysis, themes and subthemes emerged. The resulting main themes around which this chapter was structured were: signposting and referrals; raising awareness; flexibility and diversity; accessibility; speed and prevention; and legacies and the long term.

The women identified an urgent need for more information about the services available to support people experiencing gambling harms so that an informed choice could be made. They wanted services to cross-refer to other services but also had the idea of a guide or hub,

staffed by people with lived experience who could offer advice and information, and assist with referrals. Improving awareness of gambling harms among health and other professionals was also identified as essential so that women could secure appropriate referrals or just better signposting to gambling support services. The wanted conversations about gambling harms with GPs and other professionals to be normalised and free from stigma. The women also recognised a need to increase awareness of gambling harms in the general population. They talked about how safer gambling messages could be championed by "ordinary" women with lived experience, spreading safer gambling messages across all types of media, with those messages focusing on giving women hope.

Given that women's experiences of gambling harms vary, the need for support and treatment services to be flexible was acknowledged, but the women did identify several specific needs such as access to additional services to address cross addictions and financial and career harms. Included in the diverse support the women wanted was access to people with lived experience, trained to be peer supporters, and also increased provision of women-only support services. To improve accessibility, the women suggested help with childcare and other barriers in the home, such as abusive relationships. They called not just for continued online provision of services but also for a network of physical gambling support hubs where they could access help and meet other women with lived experience. The women also suggested ways in which self-exclusion schemes could be improved, focusing primarily on improving the speed of setting up the blocks on phones, computers and bank accounts. Indeed the need for a swifter response from all services was recognised, with women wanting faster call-backs, shorter waiting lists and earlier interventions so as to prevent levels of harm from escalating. Finally, the value of aftercare was endorsed by the women and they wanted it to be long term and focused on preventing relapse, as well as providing opportunities learn new skills and access to services that could assist with legacy harms.

# Discussion

# 9. Discussion

## 9.1 Introduction

This chapter reflects upon the findings of the focus group research within the broader context of our current knowledge of women and gambling harms, as reviewed in Chapter 5. The chapter is divided into five main sections that reflect upon the themes of deciding to seek help, raising awareness of gambling harms among women, finding services, barriers to accessing services and the types of support for gambling harms that women need. The chapter reflects not just upon the experiences of the women who took part in this research, but also their ideas for how service provision could be improved.

## 9.2 Deciding to seek help

A first step toward engaging with gambling treatment and support services is recognition of the problem and a decision to try to find help. The stories of the women who took part in this research show that pathways to recovery are usually non-linear or cyclical and involve multiple decisions to seek help over, sometimes long, periods of time. The stories of the women undermine the myth that someone will only seek help in a meaningful way when they reach their very lowest point or "rock bottom". This was indeed the case for some of the women, but for others their decision to engage was more gradual and nagging, or it was a response to a moment of clarity that was not borne of crisis. What was consistent among the women was the need to access appropriate help with urgency once the decision had been made. If that need was not met in a timely way or with appropriate support, this prompted a narrative of self-blame: they must have been insufficiently committed and ready for change.

This has important implications for service providers and their work to prevent risky gambling behaviours from reaching levels where harms multiply. Models of support need to be sufficiently flexible to engage with the woman who has gambled for decades, has lost everything and feels suicidal but also the woman who realises that her gambling is getting out of hand and who needs to prevent any real harm from developing. For the women in this study, a failure of services to effectively capitalise upon their desire for change sometimes led to lapses and the escalation of harms. In research conducted by Kerr et al. (2019), it was found that women who recognised that their gambling behaviour may be leading to some harm questioned whether this warranted them accessing formal treatment and support services. The onus is on treatment and support services to appeal to these women, as well as those in crisis, by increasing public awareness of the risks associated with gambling and awareness that services can support women to prevent harms as well as address harms.

## 9.3 Raising awareness and diminishing shame and stigma

In the focus groups, the women also revealed that the decision to seek help was never an easy one. The shame and stigma they felt as women experiencing gambling harms impacted upon when and how they sought support. This tallies with other research, for example by Kaufman et al. (2016), that reveals that women seeking help face the internal barriers of denial and fear, stigma and feeling like an "outsider". Similarly Gunstone and Gosschalk (2019) found that for women, stigma and shame were key barriers to accessing treatment, support or advice. The women in this research were acutely aware of the social perception of women gamblers as deviant and they felt alone and ashamed as a result. Reaching out to services, to family members or friends required that women face their fears that they would be misunderstood at best and rejected or ridiculed at worst. Stigma is related to the continuing perception that gambling problems are men's problems and Hing et al. (2017) found that women are more likely than men to report that feeling ashamed was a barrier to help-seeking. In this research, shame and stigma not only deterred women from seeking help but also impacted upon where they sought help, sometime shunning local services for fear of recognition.

Again, this has implications for service providers. The rapid increase in the number of women in the UK experiencing gambling harms warrants measures by support services to actively appeal to women. Chapter 6 showed that currently too few gambling service providers feature images of women on their websites or information tailored to women in need of help. Women need to see themselves in awareness campaigns, in the media, on the websites and social media posts of support services. The women in the focus groups wanted campaigns that feature ordinary women and that not only raise awareness of gambling harms but also give hope, showing that change is possible. The power of the gambling operators to reach into the homes and phones of women was contrasted with the weakness of media campaigns to promote safer gambling and gambling support services. Some of the women in this research have taken up this cause and are engaging with service providers and the media to normalise the female gambler and enable her to ask for help without fear. Exploding the myth that women do not engage in harmful gambling will reduce the shame and stigma that stop women from seeking support.

## 9.4 Finding services

The ways in which women become aware of treatment and support services were examined by Kerr and colleagues (2019). They found women sought help when they finally recognised that their gambling behaviour was problematic; when they had been told

about available treatment and support services by a professional, such as a GP; when family and friends told them of the services available; when they received information on services from a gambling operator or other source; when they had researched gambling problems and support services online; when they received support from social networks, family, friends and partners; and when they had attempted to control or change their accessibility to gambling and make it difficult to gamble, including the use of blocking software and self-exclusion schemes (Kerr et al., 2019).

These findings were mirrored in the evidence given by the women who took part in the focus groups, though their primary source of information was the online search engine. Despite many of the women asking their GPs for help, few of them received effective signposting through that channel or any other statutory service, attesting to the lack of awareness of gambling harms and support services that still remains among health and other professionals. When identifying the changes the women would like to see to services, improving the knowledge of gambling harms among professionals in statutory services was one of their priorities, thus enabling social workers, criminal justice professionals and doctors in general practice, A&E and hospital wards to be able identify gambling harms, discuss them and refer women to appropriate sources of support. The women wanted referrals to be as normalised and routine as referrals to mental health services or drugs and alcohol support services.

Kerr et al. (2019) also found a lack of awareness among women of the treatment and support services available due to a lack of clear and informative advertising, including on positive outcomes, especially in local areas. The women interviewed by Kerr et al. described how information about treatment and support services on gambling websites or television advertisements was inconsistent and poorly displayed. This acted as a barrier to accessing treatment as there was not only a need to recognise that their gambling was problematic, but also a need to go to the effort of finding out about the treatment and support options available (Kerr et al., 2019). Again, this research produced similar findings, with the women having had to research their options, resulting in only a partial knowledge of the support available. Indeed many of them were unaware of national-level services such as the Gambling Support Helpline, particularly relevant to women given their propensity to gamble and need support late at night. All the women agreed there was an absence of clear and sufficiently detailed information about the support services available to them. Few of the women exercised informed choice and instead grabbed whenever service they could find, sometimes later realising it was inappropriate for their needs. Their response to this problem was to suggest the development of a hub or guide to women's gambling support services, giving not just detailed information on the services available but also individualised advice and help with making choices, staffed by people with lived experience. Accessing help through such a hub would also diminish shame and stigma, as it would reduce the need for women to reveal their gambling harms multiple times as they seek help from multiple services.

Kerr et al. (2019) speculate that female gamblers may be unaware of treatment and support options because they do not feel they are relevant to them until such time that they realise their gambling is harmful. This reflects the absence of effective media campaigns to raise awareness of harms and sources of help, rather than a need for women to necessarily enter into crisis before the harms become evident. Many of the women in the focus groups described how they had realised many times that their gambling was problematic and had sought help many times, but still they had limited awareness of their options, sometimes relying on drug and alcohol services for help and becoming frustrated by their unsuitability. In addition, while women may have a low pre-existing knowledge base because of an initial perception that gambling support services are not relevant to them, this does not explain the absence of knowledge of what support may entail, how it differs from one service to another and which service would best suit their individual needs. Currently listings of support and treatment options tend to offer just basic details and contact information, leaving women to make choices on the basis of scant information. Equally, once contacted, it was described how a gambling support and treatment service would explain its own offering to the woman, but rarely inform her of alternative service providers who may be a better match for her needs. The implications for service providers are obvious: they need to provide more accessible and more detailed information on what they offer and who would and wouldn't be best served by them. Where necessary, they should give effective signposting and referrals to other providers, advising women on how to go about choosing a support service that is most appropriate.

## 9.5 Accessing support

Practical barriers that affect the ability of women to access support were also identified in the research. Kaufman et al. (2016) identify such external barriers as inaccessibility (including waiting times and distance), as well as problems identifying suitable services. In this research, waiting times were also identified as a barrier, with long waits (especially for residential support) being a source of anxiety and/or a chance to rethink the need to engage. The women wanted services to capitalise quickly upon their desire for help before they began to deny the extent of the problem and return to gambling. Childcare or other caring responsibilities were also barriers to women leaving the home, especially to access residential treatment services. While the women in the research recognised that online service provision was an enormous help in overcoming these obstacles, they also wanted the choice to attend face-to-face support and they suggested that a support hub should be available in every major city, providing childcare facilities and access to support during the daytime. They also wanted sufficient recognition of other barriers in the home that could prevent them accessing services, such as domestic violence or coercive and controlling relationships, with service providers screening effectively for such obstacles and providing appropriate help.

Cost was seen as another barrier to accessing face-to-face services. Some services were distant and this attests to the assertion by Bowden-Jones et al. (2016) that the accessibility of services in England is highly variable. Where services were located far from the women, this involved considerable expense, but even when they were local, any expense could be a barrier when the women had no money at all due to their gambling. Given these barriers, plus the fear of being recognised when attending a local service, the rapid and dramatic shift to online service provision owing to the pandemic was (nearly) universally welcomed by the women. The online provision of support enabled women to broaden the range of services they accessed and maintain their anonymity, as well as find services at times of day that suited them best, whether early morning or in the middle of the night. Online video conferencing was not seen as a barrier to building supportive formal or informal relationships, which all the women placed at the heart of their recoveries. While text-based chat rooms and groups had a role to play, these were insufficient alone. As the Covid pandemic slowly recedes, maintaining the provision of online, as well as face-to-face, services is clearly of crucial importance to women who would otherwise struggle to access support services.

## 9.6 Types of support

Just as the histories of all the women were different, so were their experiences of support services. Gunstone and Gosschalk (2019) found that female gamblers used either treatment alone, or a combination of treatment, informal support and advice, to cut down on their gambling. The women in this research had accessed a similar variety of types of support, which included self-exclusion schemes, online and face-to-face support groups, online and face-to-face one-to-one care, social media groups, online forums and chat rooms, and phone support. Those women whose gambling harms were most pronounced and long lasting tended to access the greatest range of support, mixing and matching over a period of time until they had put everything in place that they needed. Those women who sought support when they were in crisis and their lives in turmoil had felt underserved by just one weekly meeting, and also those women who were met with delays and waiting lists, with little interim support while they waited, experienced high levels of anxiety and/or a continuation of harmful gambling. Similarly aftercare following receipt of the standard treatment package, especially if it involved a residential retreat, was seen as essential but often inconsistent. The quantity of support that women can access at any and every stage of their journey, made accessible through a variety of formats, is thus of central importance to the reduction of their gambling harms.

The women in this research universally valued practical guidance on how to install blocking software or activate controls through their banks, as well as how to identify and manage triggers and prevent lapses. Most also wanted to explore the reasons behind their gambling

problems but there was some reluctance to talk about deeply personal issues within the context of brief therapeutic interventions. Kaufman et al. (2017) explore evidence that the treatment of female problem gamblers should focus on emotional needs, and other research (Echeburua et al., 2011; Mark and Lesieur, 1992) argues that treatment offerings should mirror the complex reasons why women gamble at harmful levels, including co-morbidities and abusive relationships. The focus group discussions revealed that time and the building of trusting relationships were needed to enable the revelation and processing of co-morbidities and traumatic life events that had led to their harmful gambling. Hing et al. (2017) argue the same, showing that time is essential to identify the variety of problems, complex needs and underlying issues for each individual. Hing et al. (2017) also argue that that gambling concerns should be holistically addressed. The women in this research revealed that advice and support that was too generic and not focused on gambling was inappropriate and ineffective when first seeking support, but later a focus on health, wellbeing, hobbies, finances and work were considered to be essential to rebuilding their lives after recovery.

Research shows that women respond differently than men to different types of activities, messages and treatment (Corney and Davis, 2010) and Best et al. (2019) argue that there is a need to explore gender-specific provision with a greater focus on social isolation, depression and the management of stigma in services for women gamblers. For many of the women in this research, an acknowledgement of the different trajectories of women and men was valuable, helping them understand their own behaviours and also address the shame and stigma they felt. Where models of care were felt to reflect the male experience of gambling harms, the women felt they were unhelpful and acted to perpetuate the stigma they felt. An explicit exploration of differences in the gambling harms and support needs of women and men, in support groups and one-to-one care, in self-help resources and in media, would increase the relevance of treatment content to women and help overcome their reluctance to engage with services.

Residential rehabilitation services for women were generally valued highly by the group. There was an acknowledgement that as women, they are expected to care for others. Residential retreats offered a break from this and an escape from the home environment where they gambled. The practical barriers to participating in such retreats are widely known and include safeguarding, childcare and other family responsibilities (Gordon Moody, 2020). The women were aware of these, and added to them work responsibilities and the need to avoid having to explain to family and friends why they were going away. Just as no one model of care fits all, so was there resistance by some of the women without children to the generalisation of these barriers to all women. They resisted the idea that women's retreats should be automatically shorter than men's.

Baxter et al. (2016) argue for the value of a peer outreach strategy for women that could encourage women to participate in more prosocial activities that provide the same pleasurable feelings as gambling and as well as providing alternative avenues for social engagement.

Beyond social benefits, the women in this research argued that peer support was essential to their recoveries, enabling them to feel understood, validated and less ashamed, as well as giving them hope when their peers acted as role models and making them feel accountable to the group. Gambling peer support groups are offered by a range of service providers, but are only accessible by engaging with those services. A national peer support service is currently being trialled and increasing the avenues through which people can refer into that service would enable wider access to peer support.

Beyond mixed gender peer support groups, those women who had accessed peer support through all female groups argued that these greatly assisted their recoveries. Piquette-Tomei et al. (2007) found that women were most comfortable in an all-female environment, giving them a safe space to discuss personal issues in an atmosphere of acceptance, which motivated them to continue to participate. Piquette and Norman (2013) found that women felt validated by all-women groups and by the opportunities they gave to learn from each other and help each other. In this research, women's support groups enabled the women to talk about issues that they felt unable to discuss in front of men. Some of the women felt these groups had had a transformational impact upon them.

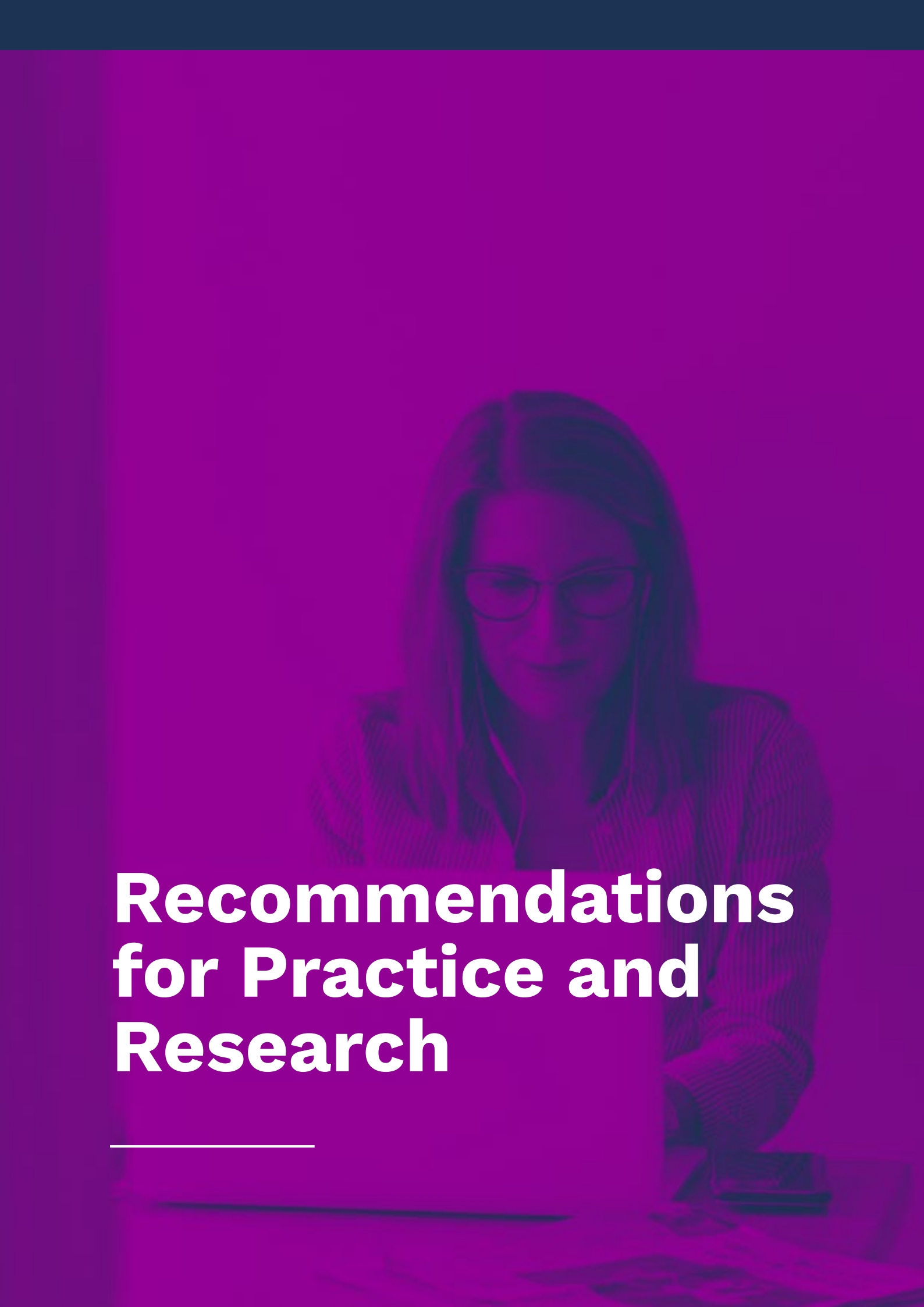
Groups that were predominantly attended by men were either perceived or experienced as intimidating and distracting by most of the women, though a few stuck with those groups because they were all that was on offer and they gradually came to value them. Indeed the alternative perspectives and experiences of men were perceived to be useful, but ideally shared in groups with an even gender balance. Achieving that greater gender balance is a complex challenge that involves reducing the stigma and shame that hold women back and changing the culture of groups to make them more inclusive, welcoming and diverse. Outside of achieving a greater gender balance within mixed groups, the value of women's support groups that was recognised in this and other research and points to the need for more peer-led support groups just for women. Women often find these groups to be a powerful means to address their harmful gambling and bring about positive changes that impact on many areas of their lives.

## 9.7 Summary

This chapter reflected on some of the main findings of the research and the implications for treatment and support services. These included the need for models of support to be sufficiently flexible to cater to different women with different needs and experiencing different levels of gambling harms. The need for services to engage in preventative support work, to stop women from reaching crisis point, was also stressed. It was also argued that support services need to actively increase their appeal to women, explicitly making their services more inclusive of women and working to reduce shame and stigma. Broader media campaigns are also needed to ensure that

women see gambling harms as a something relevant to them and to help them recognise when their gambling becomes harmful. The need for improved signposting of gambling treatment and support services was also evident from the research, especially among primary care health professionals. Service providers within the gambling support sector also need to provide more accessible and detailed information on what they offer, be prepared to cross-refer to other support services and help women make better choices. A central real or virtual place or hub was also requested as a one-stop-gambling-support-shop, thereby doing away with the need for women to be researchers responsible for finding their own support through trial and error.

Following engagement with services, improving that quantity and speed of support that women can receive and the accessibility of that support were further recommendations, including the ongoing provision of online support. The provision of childcare and safeguarding were also measures that could improve accessibility, especially to residential support. Support itself should be holistic, focused initially on gambling but then also embracing the wider support needs of women to help them return to the workplace, rebuild relationships and their self-esteem. The need for support to also explicitly explore the differences in the gambling harms experienced by women and men was recognised, with this helping to ensure that support caters to the complex support needs of women and helps diminish the shame and stigma they feel. Finally the need to expand the provision of peer support and women's support groups was highlighted, owing to the high value women place on these services.



# Recommendations for Practice and Research

# 10. Recommendations for Practice and Research

## 10.1 Practice

- Women need to see themselves in media campaigns and safer gambling messages to raise their awareness of gambling harms. These should feature “ordinary” women with lived experience in order to normalise the female gambler, give her hope and enable her to ask for help without shame and fear.
- Treatment and support services need to raise public awareness of the harms associated with gambling by diverse groups of women. The onus should be on preventing harms before they reach crisis levels. This would encourage women to engage with support services earlier.
- Support and treatment services should actively appeal to women and diminish the stigma that surrounds women’s gambling harms. This could be through images of diverse women on their websites, social media and promotional materials. Support models should explicitly explore the differences in the gambling harms and support needs of women and men. This would increase the relevance of treatment content to women and help overcome their reluctance to engage with services.
- Knowledge of gambling harms among professionals in statutory services should be increased to enable them to identify and discuss gambling harms and refer women to appropriate sources of support.
- Diversity in support models and means of access is key to meeting the diverse needs of women. To enable them to attend face-to-face support, hubs should be available in every major city, which also strive overcome barriers such as cost or lack of childcare. The Covid-19 pandemic has greatly and rapidly inflated the range and quantity of support available to women. As the pandemic recedes, maintaining the provision of online support is also crucial for women’s access to services.
- Services need to provide more accessible and detailed information on what they offer and to whom. Where necessary, they should give effective signposting and referrals to other providers, advising women on how to go about choosing a support service that is right for them.
- A central hub or guide to gambling support and treatment services for women needs to provide an interactive service, giving in-depth information and advice on the support women can access. This could enable women with the most complex needs to access the quantity and range of support they need.

- When women decide to seek help to address gambling harms, services should act quickly to capitalise upon those decisions. Delays can lead women to change their mind and retreat, enabling gambling harms to escalate further.
- The availability and duration of residential treatment services should be expanded for women, with support put in place to enable them to overcome barriers to access such as caring and employment responsibilities.
- The content of support and treatment needs to be diverse and range from practical measures to stop gambling, to in-depth psychological support, to financial education and strategies to improve health and wellbeing.
- Aftercare packages should be person-centred and accommodate the long-term and diverse needs of women, recognising the enduring nature of legacy harms such as debt, unemployment and loss of self-esteem.
- Gambling peer support groups need to be more accessible to women. The value of peer support is widely recognised and it should not be an “add-on” to therapeutic treatments but have a central place in women’s recovery.
- Women’s support groups should be more widely available. These act as safe spaces where women can discuss issues they would feel uncomfortable talking about with men. They enable a support community of women to grow which protects women from further gambling harms.
- Mixed gender groups should strive for increased membership by women. Improved gender parity would reduce the reluctance of women to join such groups, reducing the stigma they feel and increasing the range of services open to them.
- This research demonstrates the value of the experiences of women who have accessed gambling support services, as well as the quality of their ideas on how to improve services. They have the lived experience and knowledge of the strengths and weaknesses of existing services. As such, these women should play a much greater role in designing gambling treatment and support services for women.

## 10.2 Research

- While women of varying ages, socioeconomic backgrounds and geographical locations were involved in this research, the small number of women involved and qualitative nature of the research means that the relationship between identity and experience of support and treatment services could not be explored in any depth. Also unfortunately, the research did not capture women from different ethnic backgrounds. Further research is needed that explicitly explores the experiences of treatment and support services from the perspective of women with diverse (sub)identities, thereby enabling services to better understand and meet diverse needs.
- The stigma attached to women's harmful gambling and associated feelings of shame are mentioned multiple times in this research report, in both the literature and by the women who took part in the focus groups. Shame and stigma stop women from coming forward to seek the help they need. While recommendations are made above on how to reduce shame and stigma, there is insufficient understanding of how best to do this. Further research needs to explore how the media could best be employed to diminish stigma and how treatment and support services could work with women to explicitly reduce the shame and guilt they feel.
- Most of the above recommendations for practice aim to increase access to support for women, and the basis for these recommendations is the experiences of women who have already accessed services. Further research is needed with women who do not engage to understand why they do not want support for the gambling harms they are experiencing. This would enable treatment and support services to change their practices in order to widen their appeal, engage with "hard-to-reach" groups of women and prevent their gambling harms from escalating.

# Appendix I

# We're looking for volunteers to take part in focus groups on women and the support and treatment services they need for their gambling problems.

**In April, we want to hold a series of focus groups and we would like to ask you to participate in two of them.** We think that this project is a really important starting point in order to improve the help available to women.

At the moment not many women seek help for their gambling problems, **but the number of women who are experiencing harm as a result of their own gambling is rising quickly**. The harms that women suffer are sometimes different from those of men but they are just as serious. Our research project aims to understand how support and treatment services can better reach and help women.

**Focus Group 1**

- How approachable, accessible and effective do women find existing support and treatment services? What needs to change?

**Focus Group 2**

- What sort of resources could services use to attract and help more women?

- The research is **not about** Betknowmore UK's services but about treatment & support services in general. We want your open and honest opinions & ideas.
- Any personal information we collect for the project will be **confidential** & your identity will be protected.
- You will be **anonymous** in all subsequent research materials.
- If you agree to participate, you'll be **free to change your mind** at any stage.
- Your decision will **not affect** your access to Betknowmore UK services now or in the future.

The two focus groups will be held through **Zoom** and will last **90 minutes** each.

Only women will take part and there won't be more than 7 or 8 of us in each group. You'll also be offered a **£20 voucher** as a thank you for taking part.

**Interested in taking part?**

For further details about the project, please email to Liz Riley, (Betknowmore UK Research and Evaluation Manager), via liz@betknowmoreuk.org.

# Appendix II

# Focus group topic guides

## Focus Group 1

**Finding a service**

1. When you decided you wanted help, how did you go about finding a support service?
2. How did you choose which service to use?

**Accessing the service**

3. What were your initial referral and contact experiences like?
4. What type of support and treatment were you offered?
5. Where you offered what you wanted?
6. How did you choose between what was offered?
7. 7. What methods did you use to access a service (online, phone, face-to-face) and did those methods work for you?

**The support you received**

8. What services worked for you and why?
9. What services didn't work for you and why?

## Focus Group 2

**If you could design a women's gambling support service from scratch:**

1. What would it offer?
2. How would it deliver its services?
3. How would it advertise or promote its services?

# Appendix III


When you're there,
but not there.
We are here to help. Chat to us online or call for free, confidential advice and start to regain control of your gambling after one conversation.
0808 8020 133
begambleaware.org/ngts
National
Gambling
Treatment
Service


When you're there,
but not there.
We are here to help. Chat to us online or call for free, confidential advice and start to regain control of your gambling after one conversation.
0808 8020 133
begambleaware.org/ngts
National
Gambling
Treatment
Service


When you're there,
but not there.
We are here to help. Chat to us online or call for free, confidential advice and start to regain control of your gambling after one conversation.
0808 8020 133
begambleaware.org/ngts
National
Gambling
Treatment
Service

# References

# References


Afifi, T. O., Cox, B. J., Martens, P. J, Sareen, J. and Enns, M. W. (2010). The relation between types and frequency of gambling activities and problem gambling among women in Canada, *The Canadian Journal of Psychiatry,* 55 (1): 21–28

Baxter, A., Salmon, C., Dufresne, K., Carasco-Lee, A. and Matheson, F. I. (2016). Gender differences in felt stigma and barriers to help-seeking for problem gambling, *Additive Behaviors Reports* 3: 1–8

Best, D., Apperson, R., Rushton, R., Sondhi, A., Youdell, S., Edwards, M. and Johnson, E. (2019). *Gambling Treatment Services Needs Assessment Report for GambleAware,* ACT Recovery, Derby

Boughton, R. and Falenchuk, O. (2007). Vulnerability and comorbidity factors of female problem gambling, *Journal of Gambling Studies* 23: 323–334

Bowden-Jones, H., Drummond, C. and Thomas, S. (2016). *Rapid Evidence Review for Evidence-based Treatment for Gambling Disorder in Britain,* Royal College of Psychiatrists, London

Bramley, S., Norrie, C. and Manthorpe, J. (2017). *The Nature of Gambling-related Harms for Adults at Risk: A Review, Social Care Workforce Research Unit,* Kings College London, London

Burke, J. (1998). *Women and Gambling,* The Women's Addiction Foundation, www.womenfdn.org/Resources/info/gambling.htm

Centre for Social Justice (2019). *Road to Recovery: Addiction in Our Society – the Case for Reform,* Centre for Social Justice, London

Conolly, A., Davies, B., Fuller, E., Heinze, N. and Wardle, H. (2018). *Gambling Behaviour on Great Britain in 2016: Evidence from England, Scotland and Wales,* NatCen for the Gambling Commission, London

Corney, R. and Davis, J. (2010). The attractions and risks of Internet gambling for women: a qualitative study, *Journal of Gambling Issues* 24: 121–139

Crisp, B. R., Thomas, S. A., Jackson, A. C., Smith, S., Borrell, J., Ho, W. and Holt, T. A. (2004). Not the same: a comparison of female and male clients seeking treatment from problem gambling services, *Journal of Gambling Studies* 20 (3): 283–299

Dinos, S., Windle, K., Crowley, J. and Khambhaita, P. (2020). *Treatment Needs and Gap Analysis in Great Britain: A Synthesis of Findings from a Programme of Studies,* NatCen for GambleAware, London

Dow Schull, N. (2002). *Escape Mechanism: Women, Caretaking, and Compulsive Gambling,* Centre for Working Families, University of California, http://hdl.handle.net/2345/4122

Dye, J. F., Schatz, I. M., Rosenberg, B. A. and Coleman, S. T. (2000). Constant comparison method: a kaleidoscope of data, *The Qualitative Report* 4 (1/2), www.nova.edu/ssss/QR/QR4-1/dye.html

Echeburua, E., Gonzalez-Ortega, I., de Corral, P. and Polo-Lopez, R. (2011). Clinical gender differences among adult pathological gamblers seeking treatment, *Journal of Gambling Studies* 27: 215–227

Farstad, S. M. and von Ranson, K. M. (2020). Binge eating and problem gambling are prospectively associated with common and distinct deficits in emotion regulation among community women, *Canadian Journal of Behavioural Science,* https://doi.org/10.1037/cbs0000239

GambleAware (2020a). *Engaging and Involving People with Lived Experience of Gambling Harms in Research and Evaluation,* GambleAware, London

GambleAware (2020b). *Annual Statistics from the National Gambling Treatment Service (Great Britain): 1st April 2019 to 31st March 2020,* GambleAware, London

Gambling Commission (2017). *Gambling Participation in 2016: Behaviour, Awareness and Attitudes,* Gambling Commission, Birmingham

Gambling Commission (2019). *Young People and Gambling,* Gambling Commission, Birmingham

Gambling Commission (2020). *Gambling Industry Statistics: April 2015 to March 2020,* Gambling Commission, Birmingham

Gambling Therapy (2020). *The Gordon Moody Association,* Gambling Therapy, https://www.gamblingtherapy.org/gordon-moody-what-we-do/

GamCare (2019). *Why We're Focusing on Women and Problem Gambling,* GamCare, https://www.gamcare.org.uk/news-and-blog/blog/why-were-focusing-on-women-and-problem-gambling/

GamCare (2020). *Women's Programme, Year One Report: 2019/20*, GamCare, https://d1ygf46rsya1tb.cloudfront.net/prod/uploads/2020/11/GamCare-Women%E2%80%99s-Programme-Report-Year-One-2019-20.pdf

George, S. and Bowden-Jones, H. (2016). *Treatment provision for gambling disorder in Britain: call for an integrated addictions treatment and commissioning model,* BJPsych Bulletin 40 (3): 113–115

Gordon Moody (2020). *GMA Weekly Blog 4th Dec 2020*, by Jane Fahy, Gordon Moody, https://www.gordonmoody.org.uk/blog/gma-weekly-blog-4th-dec-2020?utm_campaign=2862003_Gambling%20Health%20Alliance%20-%20January%20newsletter&utm_medium=email&utm_source=The%20Royal%20Society%20for%20Public%20Health&dm_i=2LGE,1PCC3,A6W13T,5TBIN,1

Goetz, J. P. and LeCompte, M. D. (1981). E*thnographic research and the problem of data reduction,* Anthropology and Education Quarterly 12, 51–70

Granero, R. and 14 others (2018). *Clustering of treatment seeking women with gambling disorder,* Journal of Behavioural Addictions 7 (3): 770–780

Guardian, The (2020). https://www.theguardian.com/lifeandstyle/2020/jan/22/i-was-living-a-secret-life-the-agonising-rise-of-women-gamblers, 22 January

Gunstone, B. and Gosschalk, K. (2019). *Women in Focus: A Secondary Data Analysis of the Gambling Treatment and Support Study,* YouGov on behalf of GambleAware, London

Gunstone, B., Gosschalk, K., Joyner, O., Diaconu, A. and Sheikh, M. (2020). *The Impact of COVID-19 Lockdown on Gambling Behaviour, Harms and Demand for Treatment and Support,* YouGov on behalf of GambleAware, London

Hing, N., Nuske, E. and Breen, H. (2017). *A review of research into problem gambling amongst Australian women,* in Bowden-Jones, H. and Prever, F. (eds). *Gambling Disorders in Women: An International Female Perspective on Treatment and Research,* Taylor & Francis, London

House of Lords (2020). *Gambling Harm: Time for Action, Select Committee on the Social and Economic Impact of the Gambling Industry*, House of Lords, London

Huffington Post (2020). https://www.huffingtonpost.co.uk/entry/problem-gambling-women-in-lockdown_uk_5fb794a6c5b625a2ae66601f, 29 November

Karter, L. (2013). *Women and Problem Gambling: Therapeutic Insights into Understanding Addiction and Treatment,* Routledge, London

Kaufman, A., Jones Nielsen, J. and Bowden-Jones, H. (2016). *Barriers to treatment for female problem gamblers: a UK perspective,* Journal of Gambling Studies 33: 975–991

Kerr, J., Lynch-Higgins, S., Thompson, B., Dinos, S., Khambhaita, P. and Windle, K. (2019). *A Needs Assessment for Treatment and Support Services,* NatCen for GambleAware, London

Kite, J., & Phongsavan, P. (2017). *Insights for conducting real-time focus groups online using a web conferencing service.* F1000Research 6: 122, https://doi.org/10.12688/f1000research.10427.1

LaPlante, D. A., Nelson, S. E., LaBrie, R. A. and Shaffer, H. J. (2006). *Men & women playing games: gander and the gambling preferences of Iowa gambling treatment program participants,* Journal of Gambling Studies 22 (1): 65–80

Mark, M. E. and Lesieur, H. R. (1992). *A feminist critique of problem gambling research,* British Journal of Addiction 87: 549–565

McCarthy, S., Thomas, S. L., Randle, M., Bestman, A., Pitt, H., Cowlishaw, S. and Daube, M. (2019a). *Women's gambling behaviour, product preferences, and perceptions of product harm: differences by age and gambling risk status,* Harm Reduction Journal 16: 18, https://doi.org/10.1186/s12954-018-0227-9

McCarthy, S., Thomas, S. L., Bellringer, M. E. and Cassidy, R. (2019b). *Women and gambling-related harm: a narrative literature review and implications for research, policy, and practice,* Harm Reduction Journal 16: 18, https://doi.org/10.1186/s12954-019-0284-8

McCrady, B. S., Ladd, B., Vermont, L. and Steele, J. (2010). *Interviews,* in Miller, P. G, Strang, J. and Miller P. M. (eds). *Addiction Research Methods,* Wiley-Blackwell, Chichester, 109–126

Miller, P. G., Carter, A. and Hall, W. (2010). *Ethical issues in alcohol, other drugs and addiction-related research,* in Miller, P. G, Strang, J. and Miller P. M. (eds). *Addiction Research Methods,* Wiley-Blackwell, Chichester, 79–93

Muggleton, N., Parpart, P., Newall, P., Leake, D., Gathergood, J. and Stewart, N. (2021). *The association between gambling and financial, social and health outcomes in big financial data,* Nature Human Behaviour, https://doi.org/10.1038/s41562-020-01045-w

Onwuegbuzie, A. J., Dickinson, W. B., Leech, N. L. and Zoran, A. G. (2009). *A qualitative framework for collecting and analyzing data in focus group research,* International Journal of Qualitative Methods 8 (3): 1–21

Pattinson, J. and Parke, A. (2017). *The experience of high-frequency gambling behavior of older adult females in the United Kingdom: an interpretative phenomenological analysis,* Journal of Women Aging 29 (3): 243–253

Piquette, N. and Norman, E. (2013). *An all-female problem-gambling counseling treatment: perceptions of effectiveness,* Journal of Groups in Addiction and Recovery 8 (1): 51–75

Piquette-Tomei, N. Corbin Dwyer, S., Norman, E., McCaslin, E. and Burnet, J. (2007). *Women problem gamblers want more,* Saskatchewan Notes, Canadian Centre for Policy Alternatives–SK, Regina

Piquette-Tomei, N., Norman, E., Corbin Dwyer, S. and McCaslin, E. (2008). *Group therapy for women problem gamblers: a space of their own,* Journal of Gambling Issues 22: 275–296

Pulford, J., Bellringer, M., Abbott, M., Clarke, D., Hodgins, D. and Williams, J. (2009). R*easons for seeking help for a gambling problem: the experiences for gamblers who have sought specialist assistance and the perceptions of those who have not,* Journal of Gambling Studies 25: 19–32

Research Works (2014). *Public Perceptions of Gambling Advertising in the UK,* Research Works for the Advertising Standards Authority, St Albans

Rhodes, T. and Coomber, R. (2010). *Qualitative methods and theory in addictions research,* in in Miller, P. G, Strang, J. and Miller P. M. (eds). *Addiction Research Methods,* Wiley-Blackwell, Chichester, 59–78

Roberts, A., Champion, R. and Irving, S. (2017). *Women and gambling: a UK perspective,* in Bowden-Jones, H. and Prever, F. (eds). *Gambling Disorders in Women: An International Female Perspective on Treatment and Research,* Taylor & Francis, London

Roberts, A., Sharman, S., Landon, J., Cowlishaw, S., Murphy, R., Meleck, S. and Bowden-Jones, H. (2020). *Intimate partner violence and treatment seeking problem gamblers,* Journal of Family Violence 35: 65–72

Rogers, J., Landon, J., Sharman, S. and Roberts, A. (2020). *Anonymous women: a scoping review of the experiences of women in Gamblers Anonymous,* International Journal of Mental Health and Addiction 18: 1008–1024

Slutske, W. S., Blaszczynski, A. and Martin, N. G.  (2009). *Sex differences in the rates of recovery, treatment-seeking, and natural recover in pathological gambling: results from an Australia community-based twin survey,* Twin Research and Human Genetics 12 (5): 425–432

Surgey, D. (2000). *Playing for Time: Exploring the Impacts of Gambling on Women,* Department of Human Services, Melbourne

Thomas, S. and Lewis, S. (2012). *Conceptualisation of Gambling Risks and Benefits: A Socio-cultural Study of 100 Victorian Gamblers,* Office of Gaming and Racing, Department of Justice, Victoria

W: www.betknowmore.org | T: 0800 066 4827 | E: info@betknowmoreuk.org

Betknowmore UK, 200A Pentonville Rd, London, N1 9JP