Evaluation of the Aftercare Funding Programme

Interim report 2 (Phase 2)
April 2025

Ipsos UK

GambleAware

Ipsos

Contents

Executive summary

The programme and the evaluation

In March 2023, Ipsos UK was appointed as the **evaluation and learning partner** for GambleAware's Aftercare Funding Programme. This programme awarded £2 million to 10 organisations to deliver long-term recovery support services between 2023 and 2026 to individuals affected by gambling harms. The programme aims to **increase and diversify opportunities to help people in their long-term recovery from gambling harm**, an emerging and under resourced area.

This report presents the findings of the second phase (of three) of the evaluation. Phase 1 explored set up, implementation progress, and how project-level Theories of Change (TOCs) were evolving. Phase 2 explored delivery progress, early outcomes and emerging learning about long-term recovery support. Phase 2 activities included: case study visits and interviews with delivery staff and stakeholders from nine projects; interviews with 13 service users from two projects; analysis of project report forms; and learning partner activities such as online workshops and "deep dives" with projects to understand and enhance their data collection and evaluation capabilities.

Programme delivery and implementation

Year two of the programme saw **significant progress in service delivery compared to year one**, which focussed on set up and mobilisation. While two projects had not started front-line service delivery in year one, all projects were engaged in delivery in year two. In addition, the number of individuals supported by projects substantially increased, almost tripling from 660 in year one to 1,864 in year two.[1]

There is significant variation in engagement levels between projects (as measured by the number of sessions delivered and the total number of individuals supported by each project). This can be partly attributed to differences in funding within the programme. However, differences in engagement levels were also observed among projects receiving similar levels of funding, suggesting that other factors, such as the level of experience in long-term recovery from gambling-related harms, also played a role. **Projects relatively new to this field required substantial time and resources to develop their projects and establish referral pathways**, which impacted engagement with their services.

Despite improvements in delivery across the portfolio, securing referrals remained a challenge for most projects in year two. This finding is based on insights collected during case study interviews. Although delivery targets were established, challenges with

[1] It is important to note that these figures may include instances of double-counting, where individuals received both individual and group support. No assessment of the extent of the double counting could be made.

inconsistent and inaccurate target setting meant it was not always straightforward to track progress against these targets.

The evaluation identified several **key enablers of programme success**. The involvement of **individuals with lived experience** of gambling harms emerged as an important factor. Interviews with service users consistently revealed a deep connection with staff who have lived experience, often surpassing the connection felt with counsellors or therapists. **Strong partnerships and collaborations** with the wider gambling harm support system also proved crucial, by helping projects establish referral pathways and facilitating knowledge transfer. Finally, the **adoption of online delivery methods** emerged as an enabler of success. Online delivery reduced barriers to participation, making services convenient for service users, while also reducing operational costs for projects and helping them scale their activities.

The evaluation also identified some **barriers to programme success**. **Establishing referral routes and engaging service users** remained a persistent challenge, risking the potential reach of the programme. This was attributed to several factors, including reliance on a single source of referrals, longer-than-anticipated setup times for projects, and the limited integration of long-term recovery support within the care pathway (the care pathway being the service user journey through accessing available services offered by current providers for people experiencing gambling harms). **Challenges were also encountered within partnerships**, such as difficulties with data sharing, differences in safeguarding and risk management processes which may have reduced the effectiveness of partnerships, and an unequal distribution of responsibility for attracting referrals among partner organisations. Finally, a well-established project that received a large number of referrals faced challenges to **scale its operations** in order to accommodate increasing demand. While this challenge currently affects a single project, it is anticipated to become more prevalent in the portfolio as referral networks continue to expand.

Outcomes arising from the programme

There is **evidence of a range of positive outcomes for both organisations delivering projects and service users** and currently no evidence of unintended or negative outcomes. All projects – apart from Steps to Work, which ended early as the organisation went into administration before the start of Phase 2 – have provided outcomes data and insights for the evaluation. The assessment of outcomes is influenced by the differences between projects (stages of delivery, activities, locations and target groups). These influences were largely expected and anticipated at the inception and scoping stages of the evaluation, enabling the design to cater for these. Therefore, the evidence presented is largely drawn from evaluation interviews with project delivery staff and service users and supported, where possible, by monitoring information. The evaluation assesses this evidence against a robust theoretical underpinning.

Outcomes for organisations relate to **increased awareness** of the needs of people affected by harmful gambling, **improved skills and capacity** to provide long-term recovery support, and **stronger partnerships** with other organisations. The programme also facilitated the creation of **new referral pathways**, enabling organisations to reach service users more easily. Mechanisms to achieve these outcomes include **staff training, working directly with**

service users to test and learn about their needs, and collaborating with partners to reach service users and broaden the range of specialist support offered. Two organisations funded through the programme have integrated into the National Gambling Support Network (NGSN), which represents a positive development in ensuring the network includes providers offering long-term recovery support.

Outcomes for service users included **increased knowledge about, access to and uptake of long-term recovery support services**. The lack of provision prior to the programme has meant that projects have filled a gap in terms of awareness raising and enabling access, and uptake has been facilitated by providing services that met user needs.

Additional outcomes for individuals accessing long term recovery support vary by type of project activity and individual need. These include **increased self-confidence, improved self-image, enhanced mental health and wellbeing, reduced isolation, and strengthened relationships with friends and family**. A key mechanism for these changes is engaging with people with lived experience (through delivery staff) and/or people also in recovery (support groups). This has helped break down stigma associated with problem gambling and harms, provide safe environments for individuals to get support with their individual issues (ranging from understanding triggers to debt resolution), and inspire individuals to remain in recovery. Furthermore, offering a range of flexible services (such as one-to-one sessions, group support, events, specialist support for financial issues) has enabled service users to access support that meets their individual needs.

Learning about long-term recovery, recommendations and implications for the evaluation

This programme represents an important component of GambleAware's five-year strategy, which highlights the need to 'invest in structured aftercare and long term follow up'. The evaluation draws together learning points for GambleAware, and external audiences – such as the NHS as treatment commissioner and OHID as prevention commissioner - that will fund, design and deliver future services to build an emerging understanding of what works for long-term recovery from gambling harms and what factors should be considered.

Learning and recommendations for funders and policymakers about what works for long-term recovery

- **Long term recovery support is needed**. Service users overwhelmingly reported how critical services accessed through the programme have been for their sustained recovery and delivery staff were resolute in their support for the programme. Evidence suggests that the programme is filling a gap in current service provision and addressing unmet needs of recovery. Furthermore, whilst the wider commissioning landscape is undergoing change, the programme is still perceived to have value and learning generated will provide evidence for future services.
- **Long-term recovery support should be offered more systematically.** A more systematic way for service users to access support is needed such as including long-term recovery support in the formal support pathway (whereby service users are routinely signposted to long-term recovery support services following treatment). This is a pivotal moment for

commissioning gambling harms support which presents a unique opportunity to include long-term recovery support in commissioning plans.

- **Long-term recovery support should be considered as separate from treatment** – a view shared by delivery staff and service users. Service users who had accessed treatment previously (sometimes different types through different providers), which typically focussed on abstinence as the primary objective, noted how different the focus of the programme's support was by addressing recovery goals that aimed to rebuild life beyond / without gambling. Service users may need to access treatment and long-term recovery support in a non-linear fashion (e.g. concurrently or back and forth, depending on their specific needs). However, the provision of long-term recovery support should not be conflated with treatment to ensure it is prioritised in its own right.
- **Dedicated funding to continue building the evidence base is needed.** The funding model used in this programme has afforded organisations a helpful amount of flexibility in terms of outcome reporting and space to iteratively develop services around learning about service users.

Reflecting on the learning above, the following recommendations have emerged:

	Recommendation	Source of recommendation
NHS (the new treatment commissioner)	**Include long-term recovery support provision in plans for the future system.** The programme has addressed unmet needs of recovery and highlighted the need to fill this gap in a consistent and ongoing way. Factor long-term recovery support into commissioning plans including objective setting and budget allocation to ensure it is meaningfully considered alongside other priorities.	Analysis of qualitative interviews with project delivery staff and service users
NHS	**Consider the existing evidence base when planning long-term recovery support provision.** Service users have different needs of traditional treatment services and recovery support therefore they should not look the same. Learn from organisations delivering these interventions through knowledge sharing and collaboration with the third sector.	Reflections from the evaluation team

	Recommendation	Source of recommendation
UKRI (the new research commissioner) and other research funders such the National Institute for Health and Care Research (NIHR)	**Continue to fund research and evaluation that builds the evidence base about long-term recovery from gambling harms.** This is an emerging area which lacks evidence about what works. For the field to develop further and to support funding decisions, more evidence will be needed.	Analysis of qualitative interviews with project delivery staff and service users; reflections from the evaluation team
GambleAware (funders of this programme) and NHS	**Continue to support organisations delivering projects to strengthen links between each other as well as NGSN providers.** In the final year, there will be a focus on sustainability of services beyond the funding period. GambleAware (and future funders) could provide the structures for sustainability by 1) establishing a learning community to enable services to collaborate and learn from each other and 2) linking with NGSN providers.	Reflections from the evaluation team

Learning and recommendations for service design and delivery about what works for long-term recovery

- **Lived experience among staff.** Staff with lived experience of gambling harms and recovery can inspire service users and help them feel understood. Consequently, service users may be more likely to engage with long-term recovery support initially and in an ongoing way to enable sustained recovery. Staff with lived experience also bring a personal understanding of the day-to-day challenges of long-term recovery, which makes them uniquely placed to offer practical advice. For example, discussing how to put coping mechanisms into practice to deal with urges to gamble that may continue to be present throughout recovery. This support fills a gap that traditional services, often delivered by professionals without personal experience of gambling harm, cannot address.
- **Partnership working.** Partnerships between organisations have been critical to successful implementation of projects to date, facilitating referrals and continuity of care for service users. The business case for this programme included the aim of nurturing the emerging community of long-term recovery support providers through collaboration rather than competition; this collaboration has been evident.

- **A flexible and client-centred approach.** Offering a range of options such as one-to-one coaching, group sessions, online resources, and practical assistance can allow service users to choose what works best for them. This is important when taking a client-centred approach to empower individuals to feel ownership over their recovery. To offer this approach, staff need the skills and empathy to build trusting relationships with clients, understand their individual needs, and adapt their approach accordingly. This may require a trauma-informed approach, the resources implications for which need to be considered when designing or scaling interventions.
- **A holistic approach.** Comprehensive long-term recovery support should address the broader impact of gambling harms on individuals' lives, not just the gambling itself. This can include providing support with finances, housing, employment, relationships, and overall well-being, which can require multidisciplinary teams with specialist skills. It should not be expected that a single organisation can offer the range of specialist support that is required.

Reflecting on the learning above, the following recommendations have emerged:

	Recommendation	Source of recommendation
NHS and organisations designing interventions	**Include trained staff with lived experience of gambling harms and recovery in delivery teams.** Staff having lived experience emerged as an important enabler of programme success. Ensure that delivery teams comprise individuals with lived experience in roles where they can interact directly with service users. Careful planning should achieve relationship dynamics that ensure service users feel ownership over their recovery journey and can share their experiences without being overshadowed.	Analysis of qualitative interviews with service users
Organisations designing interventions	**Allow more time at set up and mobilisation.** Newer relationships need more time to develop and agree ways of working. Particular areas to focus on include aligning on data sharing processes, safeguarding approaches and ownership of the referrals process.	Reflections from the evaluation team
NHS and organisations designing interventions	**Factor flexibility into service models that allows service users to have choice.** This supports uptake of support by enabling service users to decide what works best for them based on their individual needs. At the design stage, establish what degree of	Analysis of qualitative interviews with project delivery

	Recommendation	Source of recommendation
	flexibility can be offered and whether iterative changes can be integrated throughout (informed by parameters set by the funder as well as delivery staff skills and resources to accommodate changes).	staff and service users
Organisations designing interventions	**Consider partnerships with organisations with different skills and offers.** A joined-up network of providers is required to meet the diverse needs of service users. Identify organisations to collaborate with that can offer other relevant services for example, those with strong links to specific service user groups or those with specialist skill sets.	Analysis of qualitative interviews with project delivery staff

Implications for the final phase of the evaluation

The approach to the final phase of the evaluation remains unchanged – focussing on overall delivery progress, outcomes, factors contributing to outcomes and plans for sustainability. Learning from Phase 2 has implications on the focus of some strands of activity:

- **Increased focus on affected others.** Using an opt-in approach in Phase 2 led to a sample of only those in recovery coming forward to participate. This may be linked to stigma that some affected others experience during recovery, and projects supporting more people in recovery compared to affected others. A more targeted approach to sampling across the remaining projects may be needed to ensure the evaluation can assess experiences and outcomes for affected others and will explore feasibility with projects.
- **Further exploration of supporting different groups and populations.** If many service users are currently accessing projects' services through referrals, it suggests that services are reaching people who typically access other support for gambling harms. This may present a gap in the programme's reach as well as limit the extent to which the evaluation can explore experiences and outcomes for different groups (beyond the projects that focus on specific groups such as veterans and people experiencing homelessness). Therefore, in Phase 3, the evaluation will seek to gather evidence on differences between groups.
- **A more comprehensive and systematic report form for the end of the programme.** There are limitations to using data from project report forms such as lack of comparability. The evidence base would be stronger if gaps or inconsistencies in reporting are addressed for the final reporting deadline. The feasibility of this will be explored, balancing the demands on projects' time with the needs of the evaluation. Tweaks to the reporting template will focus on consistency (for example, reporting

periods) to support comparability of the data across projects. Projects will be able to access ad hoc support from Ipsos to ask any questions or provide any feedback.

1 Introduction

1.1 The Aftercare Funding Programme

In January 2023, GambleAware awarded **£2 million of grant funding for 10 organisations** to provide aftercare services – referred to as long term recovery support services throughout this report - to individuals affected by gambling harms between 2023 and 2026. GambleAware defines aftercare as 'the phase of recovery in which individuals have regained control of their gambling but may still need **services and support to help them sustain that recovery and rebuild their lives'**. The programme aims to:

- Provide a range of aftercare services reflecting the varied and complex needs of people experiencing gambling harms and help them access appropriate services and support for sustained recovery.
- Invest significant funds in aftercare, supporting the development of the sector.
- Nurture the emerging community and network of aftercare provision and encourage partnerships between both gambling harms and non-gambling harms organisations.
- Generate an evidence base of what works in the long-term and establish a pipeline of evidence-based interventions for future commissioning.

Funding has come to an end for three of the 10 funded organisations. See Appendix 1 for information about project activities, organisations, funding, and status.

1.2 The evaluation

Ipsos is delivering a **process and impact evaluation** of the Aftercare Funding Programme, sharing emerging insights with GambleAware between March 2023 and March 2026. Ipsos is also GambleAware's **learning partner**, supporting funded projects to develop their capabilities in project-level evaluation and data collection, and facilitate knowledge sharing among projects as the programme continues. The two key objectives are to:

- Deliver an overall impact and process evaluation of the programme and fund as a whole and ensure learning and emerging insights are fed back to key stakeholders at GambleAware.
- Work closely with the funded projects, to help them develop a clear narrative of the change they are looking to achieve and how, provide advice and guidance on data collection and project level evaluation, and help to share learning and emerging insights.

Phase 1 of the evaluation explored set up, implementation progress, and how project-level Theories of Change (TOCs) were evolving. Phase 2 explored delivery progress, early outcomes and emerging learning about long-term recovery support. This is the second of two interim findings reports (in addition to the final report, which is scheduled to be delivered in early 2026) submitted annually over the course of the evaluation. The chapters in this report focus on programme delivery and implementation, including programme and project progress and enablers of and barriers to implementation; outcomes arising from the programme for projects, service users and wider groups; and learning about long-term recovery and implications, to build an emerging understanding of what works for long term recovery from gambling harms.

Evaluation activities		
Year two case study visits and interviews with nine projects	**Online and telephone interviews with service users from two projects (n=13)**	**Analysis of project report forms**
Interviews with delivery staff and stakeholders (n=28) explored project progress against project-level Theories of Change (TOCs), early outcomes and emerging learning about what approaches are most effective and for whom	Interviews explored service users' experiences of projects' long term recovery support offers, early outcomes, the need for longer-term support to sustain recovery from gambling harms and factors that support or hinder recovery.	A range of report forms including 6-monthly, 12-monthly and end-of-grant forms, which detail progress against activity and outcome targets.

Learning partner activities		
Online learning event	**"Deep dives" with projects (n=7)**	**Two online learning workshops**
The event was designed to facilitate networking and knowledge sharing between projects and introduce Phase 2 of the evaluation and learning support	Discussions with projects and a review of materials to explore data collection to measure and evidence outcomes. Projects received guidance to maximise outcome data collection and reporting. GambleAware received a paper summarising measurement plans, identifying challenges and opportunities, and suggesting ways to strengthen data collection and analysis.	Workshops focussed on data analysis and case studies. Topics were chosen based on requests from projects and an understanding that some projects are relying on qualitative data. Ipsos also offered ad hoc support to projects where they could seek advice or guidance on evidencing outcomes.

Full details of the methodology can be found in Appendix 2. The following methodological limitations should be noted when considering the implications of the findings and drawing learning and/or recommendations from them:

1. **Quality of monitoring information:** The service user groups supported by many projects are small, limiting any statistical and causal analysis. The heterogeneity of project activities, locations and target groups limits the ability to sensibly aggregate and compare. Therefore, the evidence base is largely drawn from qualitative data from evaluation interviews with project delivery staff and service users. Where possible, this is supported by quantitative data submitted to GambleAware through regular monitoring reporting. The quality of monitoring information provided by projects is varied. Steps have been taken to clean the data however there remain some issues with interpretation.
2. **Sample of service users:** Due to announced changes in the commissioning landscape, GambleAware requested that Phase 2 should include a sample of service users to generate some earlier insights from this group. Service users from two projects took part where delivery is established and the support models are similar. The organisations were also already experienced at delivering gambling harms interventions. Outcomes reported may be more positive or significant than for service users of other projects. Furthermore, an opt-in approach may encourage those who had very positive or negative experiences to participate, meaning that insights may represent extremes.

1.3 Recap of key findings from Phase 1 of the evaluation

Upon completion of the first interim report, the following key findings were reported:

1. Programme implementation

- Organisations with more experience in the gambling harms space leveraged existing internal processes and launched more easily.
- Recruitment challenges and lower-than-expected referrals caused delivery delays. Projects led by more experienced organisations benefited from established referral pathways. Efforts to improve referral processes included increasing awareness among treatment services about the value of long-term recovery support.
- GambleAware's flexibility with setup timelines allowed projects to embed the interventions within their organisations.

2. Outcomes

- Delivery was not mature enough to assess project level outcomes, although positive signs emerged. Five projects reported client outcomes, and all were positive.
- Project teams were confident about the effectiveness of the different approaches. There was also evidence of project teams reaching gambling and adjacent services to improve awareness of projects.
- There remained room to enhance understanding of the value of aftercare across the sector.

3. Learning for GambleAware and external audiences

- More time should be invested in early stages of set up and mobilisation to build partnerships and raise awareness among potential referring organisations.
- Models need to be flexible, offering diverse access points and person-centred support to attract referrals and sustain engagement.
- Projects with a strong lived experience focus are particularly effective in building trust and encouraging participation.
- GambleAware could be more active in developing a community and connections between projects. Improving data collection and communication about the programme's impact will be vital for securing future funding and demonstrating value within the broader gambling harm support landscape.

2 Programme delivery and implementation

2.1 Summary of project delivery

1. Activities delivered by projects

The Aftercare programme funds a wide range of activities listed in Table 2.1, which can broadly be categorised as one-to-one support, group support, engagement with professionals, and engagement with the public. The core services offered to individuals experiencing gambling-related harms (including those in recovery and affected others) remained relatively consistent over the two years. However, a few projects implemented notable changes. Some expanded their reach to include affected others and individuals at risk of gambling harms who were not pursuing complete abstinence. The latter adjustment aimed to create a "no wrong door" approach. Rather than turning away individuals who wanted to manage their gambling without giving it up entirely, projects adapted their services to be more inclusive. Additionally, recognising that therapy wasn't suitable for everyone, some projects transitioned from a post-therapy support model to one that engaged individuals at various points in their recovery journey.

A notable development in the second year of delivery was the introduction by some projects of engagement activities alongside core support services. For example, Acta started incorporating engagement activities with professional services to establish new referral pathways and CA Wirral launched awareness campaigns targeting the general public using social media. This development reflects the relative novelty of long-term recovery support, leading projects to engage with both professionals and potential service users to improve its embeddedness in the system.

2. Progress achieved in delivery but difficulties to secure referrals remain.

In its second year, the programme demonstrated significant progress in service delivery compared to its first year. While two projects had not started front-line service delivery in year one, all projects were engaged in delivery in year two. In addition, the number of individuals supported by projects substantially increased, almost tripling from 660 in year one to 1,864 in year two.[2]

However, levels of engagement varied widely across projects, as highlighted in Table 2.1. This can be partly attributed to differences in funding within the Aftercare programme. However, differences in engagement levels were also observed among projects receiving similar levels of funding. This suggests that other factors, such as the level of experience in long-term

[2] It is important to note that these figures may include instances of double-counting, where individuals received both individual and group support. No assessment of the extent of the double counting could be made.

recovery, also played a role. Specifically, projects relatively new to the field required substantial time and resources to develop their programmes and establish referral pathways, which impacted engagement with their service.

Despite improvements in delivery across the portfolio, securing referrals remained a challenge for most projects in year two (for further details, please refer to Section 2.3, which expands on the challenges encountered by projects in securing referrals). This finding is based on insights collected during case study interviews. Although delivery targets were established (shown in Appendix 3), which could have been used to track progress in delivery, this was not possible for several reasons. Firstly, not all projects set delivery targets, and some projects had targets for only a portion of their activities. Secondly, delivery targets were determined internally by project teams, resulting in variations in scale and ambition across the portfolio. Several projects indicated that their targets were overly ambitious, with some attributing this to basing their projections on national statistics on the prevalence of gambling harms, which may not accurately reflect local needs and engagement levels.

Table 2.1: Engagement with activities delivered by projects in 2024

Activity	Projects	Number of sessions in 2024	Number of people engaged in 2024
One-to-one support (including individuals in recovery and affected others)	Cyrenians	69	15
	Epic	720	158
	Veterans Aid	1,087	129
	Citizens Advice Brighton and Hove	-*	56
	GamCare & Reframe	519	95
	Ara	32	32
	Beacon Counselling Trust and Bet Know More	179	35
Total number of one-to-one support sessions delivered in 2024			**2,606**
Total number of people engaged in one-to-one support sessions in 2024			**520**
Group support (including group activities, both online and in-person, and talks)	Epic	81	835
	Acta	18	11
	Citizens Advice Brighton and Hove	-*	172
	Ara	76	211
	Citizens Advice Wirral	44	96
	Beacon Counselling Trust and Bet Know More	77	19
Total number of group support activities delivered in 2024			**296**
Total number of people engaged in group support activities in 2024			**1,344**

*No data provided by the project.

(continued overleaf)

Activity	Projects	Number of sessions in 2024	Number of people engaged in 2024
Engagement with professionals (including upskilling and relationship building)	Cyrenians	104	751
	CA Wirral	15	336
	Epic	58	-*
	Acta	2	-*
	Ara	4	4
Total number of engagement activities with professionals delivered in 2024			**183**
Total number of professionals engaged in 2024 (where reported)			**1,091**
Engagement with the public (including social media campaigns, podcasts and engagement with service users in treatment centres)	CA Wirral	10	7,942
	Epic	74	20,164
Total number of awareness raising campaigns delivered in 2024			**84**
Total number of people engaged in 2024 through awareness raising campaigns			**28,106**

*No data provided by the project.

3. Service user experience

Evidence regarding service user experiences is developing. Initial findings suggest positive outcomes. Feedback gathered directly from service users in CA Wirral, Epic, and Veterans Aid reveals that the vast majority of service users would highly recommend the project. Although these surveys had a limited sample size and may not fully represent all service users' experiences, they offer early indications that these projects are effectively addressing needs and delivering high-quality support.

Similar feedback has been shared during interviews conducted with service users from Epic and Reframe (n=13). These interviews revealed largely positive sentiments, with participants expressing satisfaction and indicating that the services met or exceeded their expectations. This satisfaction stemmed from several factors, including appreciation for the availability and the nature of support (i.e. one-to-one coaching delivered by individuals with lived experience). Service users interviewed also valued the strong relationship they developed with their coaches and the ongoing nature of the support, which they could continue to access if needed.

To strengthen the evidence base and ensure representativeness, more projects should be encouraged to systematically gather and report feedback from a larger number of service users.

2.2 Enablers of programme success

1. Lived experience of gambling harms and recovery

A recurring theme in both case studies and service user interviews highlights the role played by people with lived experience of gambling harms and recovery (either directly or as an affected other) in the success of some projects, which is due to three key reasons.

Firstly, individuals with lived experience have valuable insights into the needs of their audience, which helps design effective support services. One project further emphasised the importance of consulting with individuals with lived experience even after the initial service design, recognising that experiences with gambling harms are diverse and require a broad range of perspectives. Secondly, lived experience fosters trust and helps build rapport with service users. Shared experience helps reduce feelings of judgment and stigma, creating a safe space for service users to open up and feel understood. Interviews with service users consistently revealed a deep connection with recovery workers who have lived experience, often surpassing the connection felt with counsellors or therapists.

Thirdly, by embodying the possibility of recovery, individuals with lived experience create a sense of hope and serve as powerful motivators for service users. The sentiment "if they can do it, so can I" came up frequently in service user interviews.

"I would absolutely 100% say that that [lived experience] is imperative and every single client I've ever spoken to throughout this project has always said that their clinical therapy was helpful, and they are pleased that they did it, but they did not get the same kind of empathy and understanding that they did with someone with lived experience. It made them feel human. Clinical therapy got them in touch with their brain, but lived experience peer support got them in touch with what was going on in their heart, their mind, their body, and they knew that they were talking to someone that genuinely understood." Delivery staff

While the evidence strongly suggests that lived experience is a significant success factor, it is important to note that it should not be viewed as an absolute prerequisite for long-term recovery. The portfolio includes well-designed programmes that were not created by individuals with lived experience. These programmes reported positive feedback from service users, high service user retention rates, and reduced relapse rates.

2. Strong partnerships and collaboration with long-term recovery support providers

Partnering or collaborating with organisations that support individuals affected by gambling harms helped projects establish referral pathways and facilitated knowledge transfer. Partnering or collaborating with therapy providers was common in the portfolio, as long-term recovery often happened in tandem with or followed treatment. Collaborations with primary care facilities, family hubs, and other third sector organisations were also observed amongst projects, although they were less prominent. These organisations were more strategic as a referral source for projects providing support throughout the care continuum (as opposed to those focusing on post-therapy assistance).

Building relationships within the system, whether through formal partnerships or broader collaboration, is expected to remain a key success factor. This is because long-term recovery support is a nascent field that hasn't been fully integrated into the care system. As a result, establishing referral routes will demand more effort from projects compared to more established areas of care.

> **"What made things a lot easier for us was the fact that [the partner organisation] were experienced and skilled at delivering lived experience peer support groups and one-to-one peer support."** Delivery staff

3. Online delivery

Online delivery reduced barriers to participation for many service users due to its convenience, which helped boost referrals for projects. While online delivery posed challenges for a minority of service users with poor internet access, workarounds were found in the form of telephone sessions. This workaround was also used by projects providing group support, where one-to-one telephone calls were scheduled with participants unable to take part online to guide them through the content covered in the group sessions. Another key benefit of online delivery was reduced operational costs for projects (such as office space), which allowed them to scale their activities and reach a wider audience.

Evidence collected so far suggests that online delivery did not negatively impact the quality of interactions or outcomes for service users. Both project staff and the majority of service users reported positive and meaningful online engagement. However, further evidence, including feedback from a wider range of service users, is needed to confirm these findings.

2.3 Barriers to programme success

1. Establishing referral routes and engaging service users

Despite improvements since year one of delivery, the number of referrals continued to fall short of initial expectations for many projects. This challenge was due to a variety of factors that often overlapped. Some projects heavily relied on a single referral partner, which in cases faced their own recruitment challenges. Additionally, some projects were new and required longer-than-anticipated setup times. Structural problems also played a role. These included insufficient integration of long-term recovery support within the care continuum and the limited recognition of gambling as an addiction in the public health system. This lack of recognition leads to the underdiagnosis of gambling-related harms, resulting in low referrals from public health organisations to gambling-related harms support services.

To address these challenges, projects implemented various strategies. Awareness campaigns targeting service providers, such as gambling harms treatment providers, primary care workers, family hubs, and voluntary sector organisations, were initiated. These campaigns aimed to increase awareness about the prevalence and impact of gambling harms

and establish new referral pathways.[3] While this strategy helped boost referrals, some attempts to establish relationships were unsuccessful or did not immediately translate into increased referrals.

Furthermore, a few projects adopted innovative approaches which helped increase service user engagement. For example, shifting from an opt-in to an opt-out approach ensured automatic enrolment of service users in long-term recovery support following their initial assessment, which helped embed it into the care pathway. In addition, introducing long-term recovery services during therapy, with delivery workers reaching out to service users to explain the benefits of the service, helped build rapport and improved participation.

Projects also experimented with overlapping therapy and long-term recovery, where long-term recovery was delivered in separate sessions whilst service users were in therapy. This approach ensured a better integration of long-term recovery in the recovery journey and helped prevent dropouts. Other strategies included adopting online delivery methods to serve a larger number of service users.[4]

2. Challenges faced in partnerships

Partnerships were widely seen as beneficial for improving service offers, boosting referrals and enabling knowledge sharing. However, some challenges were also noted. For instance, securely sharing client data (e.g. session attendance and outcome) presented difficulties for partner organisations using different CRM systems. This was mitigated by utilising a workaround that involved using a software functionality to notify partners of updates.

Another obstacle encountered was the difference in safeguarding and risk management approaches between partnering organisations, where some organisations in a consortium had a strict safeguarding and risk assessment process to follow before onboarding service users, whereas other organisations in the consortium didn't. Workarounds were implemented, such as conducting safeguarding and risk assessments after service users received their first support session when they were referred by partner organisations that did not have a safeguarding and risk assessment process in place. This difference was cited as a source of frustration, which could have potentially hindered collaboration and reduced the partnership's efficacy.

Furthermore, some projects indicated that the lead organisation bore the brunt of responsibility for service promotion and client engagement. They expressed a preference for a more equitable distribution of responsibility for attracting referrals among partners. This imbalance suggests an untapped potential for attracting referrals, ultimately limiting the consortium's capacity to secure them.

[3] Section 2.2 discusses partnership and collaboration initiatives observed in the portfolio.

[4] The adoption of online delivery is further discussed in Section 2.2.

3. Scaling up the activity to meet demand and help more people

One well-established project that received a large number of referrals faced challenges to scale its operations to accommodate the increasing demand and further their reach. While this challenge currently only affects a single project, it is anticipated to become more prevalent in the portfolio as long-term recovery matures and demand increases.

The core issue stems from the high cost, and, in some cases, dependency associated with one-on-one support. To address this, the project is developing strategies to transition towards more scalable support models (such as group support) after a course of one-to-one support sessions has been delivered. Additionally, it is encouraging individuals receiving one-to-one support to simultaneously explore other resources such as support groups and online platforms. This multi-pronged approach aims to enhance service users' recovery capital and reduce reliance on resource-intensive individual support.

> **"The limitation with one-to-one support is you can only do so much of it and it's expensive. So [the goal is to] get more people to access group and online sessions to help us increase our reach."** Delivery staff

3 Outcomes arising from the programme

3.1 Considerations for the assessment of outcomes

This chapter focuses on the shorter- and longer-term outcomes captured in the programme-level Theory of Change (TOC), which might reasonably be materialising at this stage of delivery. The TOC was reviewed at the end of Phase 2 and minor updates were made (see Appendix 4 for detail); however, the logic underpinning the programme that describes how outcomes are expected to be realised remains relevant.

All projects – apart from Steps to Work, which had ended by the start of Phase 2 – have provided outcomes data and insights for the evaluation; these are summarised and triangulated here.

The assessment of outcomes is influenced by the following:

- Projects are at different stages of implementation, due to some variation in start dates and delays linked to low referral numbers;
- The service user groups supported by many projects are small (limiting any statistical and causal analysis);
- The heterogeneity of project activities, locations and target groups, which limits the ability to sensibly aggregate and compare.

These influences were largely expected and anticipated at the inception and scoping stages of the evaluation, enabling the design to cater for these. Therefore, the evidence base presented here is largely drawn from evaluation interviews with project delivery staff and service users. Where possible, this is supported by data submitted to GambleAware through regular monitoring reporting. The evaluation assesses this evidence against a robust theoretical underpinning.

3.2 Outcomes for organisations delivering projects

At this stage, there has been a range of **positive outcomes for the organisations** such as increased awareness of gambling harms, improved capabilities to support service users affected by gambling harms, and stronger partnerships developed between organisations. These outcomes are evident across all projects and within some organisations more widely. Learning described below will influence development of data collection tools for the final phase of the evaluation to validate findings and understand progress.

The programme Theory of Change lists four shorter-term outcomes expected to be realised for projects, which are interrogated below. There are five longer-term outcomes in the TOC, which are expected to be fully or partially realised by the end of the programme. Emerging evidence of these is also included below.

1. Greater awareness of the needs of people affected by harmful gambling

The programme set out to encourage partnerships between both gambling harms and non-gambling harms organisations to support development of the sector. Therefore, it needed to boost knowledge of gambling harms, including the need for longer-term recovery support, among these organisations. As noted in the scoping and first interim evaluation reports, at the start of the Aftercare Programme, awareness of gambling harms and experience working with individuals affected by gambling harms varied between the funded organisations. Organisations with less experience, who may be newer to delivering services that address gambling harms recovery, reported a noticeable **increase in staff awareness and understanding of gambling harms**. As delivery has progressed over the last year, involvement in the projects and interacting with service users has led to staff feeling **more confident and knowledgeable** about supporting those affected by gambling harms with their long-term recovery. Some projects also offer staff training to increase wider awareness internally. For example, one project team identified challenges embedding knowledge of gambling harms across the organisation due to low understanding amongst staff of the prevalence of gambling harm across the organisations' service areas, stigma surrounding gambling, and hesitance from staff to ask vulnerable service users about their gambling behaviours. In response, they delivered extensive training to raise awareness of gambling harms and tackle stigma. They also developed gambling harm reduction resources for staff. Training and resources received positive feedback.

All organisations highlighted **increased learning about how to support individuals with their long-term recovery.** Through delivery of projects, they have gained deeper understanding of their service users' needs, including what is more and less effective at engaging them and supporting their long-term recovery. These experiences have equipped them with more information to steer service development and adaptations. Some projects have iteratively made changes as they learned more about what service users need. For example, one project expanded their offer beyond debt advice to include support for other issues such as housing and benefits, as they and their partner organisation recognised a need for that broader range of support options among service users. Another project moved delivery from in-person to online based on feedback that service users would find it more accessible.

There is consensus across staff delivering projects that recovery is complex, and needs vary from person to person; therefore, there is no one approach to offering support that fits all service users' recovery needs. Delivery staff emphasised the importance of a holistic approach that considers the needs of an individual as a whole person, rebuilding areas of their lives without and beyond gambling, rather than focusing on gambling harms in isolation. This has highlighted value in the programme design which supported partnerships between organisations with and without experience delivering services to people recovering from gambling harms. There is recognition that no one organisation can meet the wide range of needs of different service users. Therefore, partnerships and collaboration with other organisations that can offer other relevant services adds value and builds towards a joined-up network of providers.

> **"It [the project] has really helped us to improve the way that we work with gambling harms in general... it's taught us a lot about how to engage with that as an issue and engage with people who are... affected by it."** Delivery staff

Longer-term outcome: Greater understanding of longer-term needs of those experiencing gambling harms – increased awareness is leading to improved understanding of longer-term needs. Working directly with individuals to provide recovery support has generated learning about their needs. It is anticipated that this will continue over the final year of the programme as more time delivering services passes.

Longer-term outcome: Increased awareness in the sector of the importance of aftercare / greater prioritisation of long-term recovery – there is early evidence of increased awareness of the importance of long-term recovery support starting to materialise. There are examples of where projects have conducted awareness raising and engagement activities and have received referrals from the sector as a result of this engagement. There is limited evidence of greater prioritisation to date.

2. Increased capacity to provide long term recovery support

The programme aimed to provide a range of services reflecting the varied and complex needs of people experiencing gambling harms and help them access appropriate services and support for sustained recovery. Programme funding has enabled projects to design and deliver services to support long term recovery from gambling harms. For some projects, funding enabled recruitment of a dedicated individual to lead the project and deliver key activities.

Organisations have been able to **develop new services, expand existing ones, or tailor their offerings** to better meet the needs of those affected by gambling harms. For example, one organisation was already offering debt advice and knew that some clients must be affected by harmful gambling, however struggled to get people to discuss it. The funding enabled them to partner with another organisation already established and delivering gambling harms services and receive referrals from them. The programme also funded one dedicated staff member to lead the project. This meant they could tailor their existing specialist skills to reach service users in recovery from gambling harms. An organisation working on another project developed an entirely new service that it was not delivering prior to the fund. Staff are also more confident to deliver the support (see previous outcome).

Furthermore, through the development of partnerships between organisations with different offerings, they have been able to **broaden the support options they could offer to their service users** by referring to trusted partners. The funding has increased capacity across the network of organisations to provide long term recovery support, in turn improving experience and expertise and **laying the foundations for sustainable interventions and partnerships**.

"In terms of organisational change, that assurance that we're doing something right and that it's actually working and that's something which we can continue to grow." Delivery staff

Longer-term outcome: Projects are embedded within the local system – there is some evidence of projects integrating locally, for example receiving referrals from organisations outside the programme. Integration and embedding new services take time therefore it is likely that this requires more time to materialise. Two organisations funded through the programme have integrated into the National Gambling Support Network (NGSN), which represents a positive development in ensuring the network includes providers offering long-term recovery support.

3. Appropriate referral pathways created

The programme set out to provide individuals with appropriate services and support for sustained recovery. A critical enabler of this is the establishment of suitable routes for service users to be able to access services. **New referral pathways have been formed** because of the programme. These pathways are predominantly from one organisation to another, where they have worked together to set up processes and agreed parameters for referrals to take place. Self-referral is also possible in some instances. For example, one project described how they rely on word of mouth from service users for some referrals. However, as noted previously, these are new services and awareness of the existence of recovery support is likely to be low; therefore, referral pathways between organisations have been critical to enabling projects to mobilise and reach service users.

As described in chapter 2, these pathways sometimes took time to establish and become embedded, and in places require ongoing efforts to continue reinforcing them to ensure they are used consistently. For example, one project lead regularly attended meetings with referrers at the partner organisation to keep reminding them about the support offer, to ensure it stayed front of mind. However, there is clear evidence that referrals are taking place, directing service users from one organisation to another to enable them to continue recovery and access the programme's support. Through the process of establishing these pathways, organisations often needed to build communication channels and ways of working together, leading to **strengthened bonds and a more joined-up approach** to supporting service users. These included upfront communication about the scope and remit of the organisations, including setting expectations, and regular ongoing meetings between key individuals from both organisations to discuss progress and any issues as they arose.

"There were no problems with the client flow purely because of the successful and open relationship that we had." Delivery staff

Some projects have a linear process for referring with the long-term recovery support being accessed after completing treatment. For instance, this is the model used by one project, which refers an individual on completion of therapy to the partner organisation for one-to-one or group recovery support. If an individual experiences relapse, they may go back to the original provider for further therapeutic intervention before continuing with the partner. The flexibility to go back and forth between the services was facilitated by a strong partnership

and close communication between the organisations and meant that the service users' experience felt joined up and tailored to their individual needs.

The referral process for other projects was more flexible and included models whereby individuals could be referred to long-term recovery support through the programme when at a more acute phase of early recovery. For example, service users of one project may be referred at any stage of their recovery if they present with an issue that the partner organisation could address that would support recovery, or that presents a barrier to recovery progressing (e.g. housing issues).

4. Increased monitoring and evaluation knowledge and capabilities

The programme aims to generate an evidence base of what works to inform future commissioning. This relies on projects collecting some data and therefore having baseline skills and resources around monitoring and evaluation. The learning strand of the evaluation has delivered a range of tailored activities designed to upskill projects. There is some evidence of increased monitoring and evaluation knowledge and capabilities among projects. For example, projects are completing reports that contain core questions to enable generation of a minimum dataset for the programme.

Submissions indicate that there is further work that could be done to the form to make it easier and more consistent for organisations to complete to improve comparability of data across the programme (data sometimes includes gaps or lacks clarity about whether participants are unique or have been double counted). However, it is also important to consider that these could be due to other factors such as delivery pressures or resource challenges meaning that data collection is not the highest priority as opposed to organisations not having the knowledge and capabilities to carry out monitoring and evaluation.

There is enthusiasm from projects for evidencing impact, especially as this is an area where the evidence base needs to be generated. Many projects reported that they collect more data than GambleAware asks for in the regular reporting forms. Projects understood the value of collecting data at different time points to evidence change over time. Interest in and attendance at two learning workshops about data analysis and case studies was positive. Projects rated the usefulness of the sessions as four or five out of five, and anecdotal feedback highlighted specific new techniques or learning they would apply to their project.

'Deep Dives' with seven projects in September 2024 established that there is variation across projects in the type and strength of data being collected, but that almost all are collecting quantitative and qualitative data on outcomes in project-level TOCs. Projects were provided with tailored guidance on ways to strengthen their approaches; the extent to which this is incorporated and used to improve data quality will be picked up in Phase 3 of the evaluation.

Longer-term outcome: Projects are able to clearly articulate and evidence outcomes – evidence varies from project to project. However, there are broader challenges beyond capabilities around quantifying outcomes linked to long-term recovery e.g. relapse reduction that may affect this longer-term outcome being realised. Some projects have tried to collect different types of data linked to sustained outcomes but have found it difficult to

consistently follow up with service users after times passes, therefore evidence is anecdotal. Further learning about this will be generated over the next year of delivery, which could include a greater understanding of the challenges and potential approaches to overcome.

Longer-term outcome: Creation of a learning community – via attending and participating in learning events offered through the evaluation, projects have shared learning with each other. For example, sessions have facilitated discussion around common issues such as low referrals and how projects have overcome them as well as challenges around reporting outcomes. Furthermore, organisations working together to deliver projects are in regular communication and are learning together how to deliver the project. However, evidence of learning and knowledge sharing among the portfolio beyond these mechanisms is limited.

5. Evidence of outcomes that are not yet captured in the original programme TOC

Beyond these four outcomes listed in the Theory of Change, there are also instances of **positive professional and personal outcomes** for staff as a result of delivering the projects. These outcomes were perhaps not anticipated or expected; they were not included in the original Theory of Change. There are instances where staff have been able to access relevant training and qualifications to help them deliver this project, which they would not have had access to otherwise. For example, one project trained individuals with lived experience to qualify as coaches. Additionally, many projects involve people with lived experience, and some have experienced a sense of fulfilment through being able to support others with their recovery journey. A few service users also expressed a desire to volunteer or work within support services for gambling harms in the future, both to support their sustained recovery and to help others earlier in their recovery. Building a recovery network comprising people with lived experience, which not only offers support to others in need of recovery support but also facilitates sustained recovery within the network is a powerful potential mechanism for longevity of outcomes.

> **"Doing this makes me feel good… It makes me feel as though I'm giving something back… It's like an uplifting feeling. That helps my recovery as well as it helps the other person."** Delivery staff

Currently, there is no evidence of other unexpected or unintended outcomes for organisations.

3.3 Outcomes for project service users

The programme intended to achieve a range of outcomes for service users. Participants were asked about all types of outcomes including those that were negative and unintended. Discussion about the programme's interventions was contextualised through reflection on other types of support service users had accessed for gambling harms so they could compare experiences and consider to what extent the programme contributed to positive outcomes. Staff across all projects and service users sampled from two projects were interviewed in Phase 2 and reported overwhelmingly positive outcomes for service users.

The programme TOC lists shorter-term outcomes expected to be realised for service users and which are interrogated below. The first three focus on increased knowledge, access and uptake of support:

1. Increased knowledge about relevant aftercare support available

Before using services provided through the programme, service users interviewed reported limited knowledge of the support available for long-term recovery from gambling harms. While many had sought and accessed treatment for gambling harms, such as residential rehabilitation, they did not know about support for longer-term or sustained recovery.

Many service user participants **learned about services offered by projects through referrals and outreach**, reporting that they had not heard of these before. Increased knowledge of support that exists is an important prerequisite to accessing it, as well as demonstrating to service users that this is an important issue that requires funding. Improved referral numbers over the past year also indicate that more individuals are hearing about and accessing relevant recovery support.

> **"Initially I didn't even know what that was all about... I'd never heard of [the organisation] before."** Service user

2. Improved access to relevant aftercare support

Access to relevant support has improved due to the new provision of these services and growing awareness of them. Access varies by different factors including which services participants have previously engaged with - which affects knowledge of these new services - and location. Participants who took part in interviews had typically accessed services through referral via another organisation, therefore did not have experience of struggling with access. However, case studies with projects indicated that there are minimal eligibility criteria that prevent individuals from accessing services following a referral.

However, there were instances of participants **struggling to access treatment previously, which could present challenges around being able to move onto accessing long-term recovery support**. For example, many participants reported reaching an extremely low point, including suicide ideation and/or attempts, before feeling ready to access treatment. Stigma deters people experiencing gambling harms from seeking help and this barrier applies to long-term recovery support too. Furthermore, one participant shared that homelessness was a barrier to accessing initial treatment as they did not have a fixed address. The experience was different once accessing support through this programme, whereby many service user participants felt supported to engage, through encouragement as well as practical support such as flexible scheduling and covering travel costs for events.

> **"Initially when I left [treatment], I was homeless... They [the organisation] allowed me to participate... they funded fully my train fare, my hotel room, my meals per day... Because they knew I didn't have a home."** Service user

3. Improved uptake of relevant aftercare support

Uptake of long-term recovery support has increased due to the availability of services provided by projects that are tailored to service users' needs. Projects reached 1,864 service

users in year two, almost tripling from 660 in year one. These individuals are unlikely to have been able to participate in long-term recovery support in the absence of the programme due to the wider lack of provision. Interviews were only conducted with service users therefore did not capture views of individuals who were offered the service but did not access support; however, participants cited the relevance and usefulness of the services for their sustained recovery, suggesting that **uptake was facilitated by providing services that met user needs**.

> **"The reason I'm getting better is because I engage, I pick up the tools, I pick up the phone, I reply to the email. And without that I would be in a little urn somewhere."** Service user

Some delivery staff noted that uptake could be affected by individual preferences, such as preferring one-to-one sessions or hesitance to join group support. Many service user participants spoke positively about one-to-one sessions with someone with lived experience. The **connection, trust and rapport established encouraged individuals to remain engaged** for the full course, often leaving them wanting more one-to-one sessions than were on offer.

In terms of uptake, group sessions appear to be polarising. Some service users reported that the group sessions helped their recovery and would routinely attend. The opportunity to **seek connection with others going through recovery journeys and inspiration from guest speakers** appealed to some and kept them engaged in their own recovery journey.

> **"People approach things differently, but I think speaking to people with lived experiences helps a lot. I suppose that's why those groups are quite popular... Because it really, really helps and it helped me."** Service user

Some delivery staff reported reluctance from prospective service users to join group sessions, which was addressed with some encouragement such as a phone call explaining what the group sessions involve and that they could join and keep their camera off if preferred. For some individuals, hesitance disappeared after attending a group and finding a welcoming community. This was not the case for others who reported that the groups did not support their style of communication and did not feel right for their recovery needs.

> **"I don't like group things because my problems are quite serious, and I don't really like talking about them in a group... I like the privacy of one-to-one."** Service user

Further shorter-term outcomes recorded in the programme Theory of Change relate to outcomes achieved for individuals accessing long term recovery support and vary by type of project activity and individual need. There is evidence of a range of positive outcomes for service users:

4. Increased self-confidence to achieve recovery goals

Almost all service user participants reported that using services offered through the programme improved their emotional state and increased their self-confidence in a variety

of ways including their ability to recover, decision making, self-image and social interactions. This was often accompanied by a sense of feeling understood and that they were rediscovering parts of themselves that they felt they had lost as a result of gambling harms. These sentiments suggest that **services have not only supported individuals into longer-term recovery but also made them want to sustain recovery and continue working towards recovery goals**, with the knowledge that they are not alone.

> **"It has surprised me that I have the confidence to make decisions about my future... It's given me a sense of being a person outside."** Service user

Delivery staff also reported increased self-confidence for service users, commenting on service users' journeys moving from hopelessness to confidence in their recovery as a result of using these services. This included evidence of **ownership over their recovery and investment in pursuing their recovery goals**, which felt more achievable alongside the support they were receiving.

> **"I think people often come out of the addiction and treatment with a very fixed view of themselves and why things have happened. They either feel a sense of hopelessness that nothing can change or a sense of blame. But what I've seen is people's self-awareness and then confidence grow, to say actually I can change myself and there are things that are toxic in my life that I probably need to move away from."** Delivery staff

A few service users commented on how the service they used focused on **putting the individual at the centre, and in control, of their recovery journey**. This helped to empower individuals and ensured they attributed positive changes to themselves. This focus on self-efficacy enabled individuals to be satisfied with their progress and believe in themselves, further inspiring continued recovery efforts. This links to a finding in the Phase 1 report that some staff felt the term 'aftercare' implies a passive approach to recovery rather than individual empowerment.

> **"They will not take if I say, "you've done so much for me." They went, "no, we've facilitated you to do it for yourself" ... they are wonderful at making sure that you know it was you."** Service user

5. Improved self-image and relationship with self

Linked to the previous outcome, service users described how gambling addiction and harms had made them lose their "sense of self" and their personality, which often resulted in deterioration of relationships with the people closest to them. Through the programme's support, service users reported rediscovering their sense of self. The **peer support from staff with lived experience, and for some group sessions, validated their experiences and emotions leading them to feeling more connected and understood**. This created opportunities to work through experiences and emotions in a safe and non-judgemental environment.

Furthermore, the one-to-one sessions that focused on aspects like their wellbeing and coping strategies (more so than one-to-one sessions that offered practical support around debt resolution) provided a secure and intimate environment for individuals to work on

personal issues. The format of these sessions offered delivery staff the flexibility to tailor support to individuals' needs, for example enabling them to explore coping strategies that work for them around their own triggers, improving their understanding and relationship with themselves. This improved relationship with self is likely intertwined with self-confidence to achieve recovery goals.

> **"I come home from those [group sessions] so boosted... I'm never going to return to gambling because every time I see those people it's just... a safe zone to talk about anything."** Service user

6. Improved mental health and wellbeing

Many service users reported improved mental health and wellbeing due to services offered through the programme. They discussed a positive shift in their mindset, which allowed them to manage urges and triggers that might previously have led to gambling. This shift was attributed to **coaching sessions and events that increased their knowledge and awareness of triggers**. Some services also introduced participants to practices such as mindfulness and journalling as strategies to cope with triggers.

> **"The dog jumped up... she headbutted my face and snapped my tooth... now I'm going to go into my living room and make some phone calls about a dental appointment... before I'd have probably just gone back to bed with the tooth in my hand and if I had some money, I would definitely have gambled."** Service user

Delivery staff also reported improved mental health through feedback from service users. For example, organisations that offer practical support are able to provide advice or solutions for issues that may present barriers to long-term recovery such as debt. Having access to support to address these issues, that often feel too large to tackle alone, resulted in reduced stress and anxiety and consequently improved mental health.

> **"It's very often the case that the clients will say to me, "thank you. That's such a load off my mind. I feel much better about my situation now. I was worried sick and now I can actually focus on other things."** Delivery staff

7. Improved financial position

A few service users reported reducing debt and achieving greater financial stability as well as making better financial decisions. This was typically **attributed to one-to-one sessions and materials made available that gave them access to specialist financial advice** and / or provided resources to help change their financial mindset.

> **"I was three months behind on my rent. Now I'm one month in credit on my rent... I've actually bought a car. I've actually been to see my son abroad... what I'm trying to say is I am where I want to be at today. I don't owe anyone money... I even bought myself a season ticket at the football club I support... I couldn't do that a year and a half ago."** Service user

Some service users described how they had someone else in control of their finances such as a spouse. This arrangement was agreed with them outside the programme; however, it is

possible that improved relationships, which individuals experienced through accessing services (see 'improved relationships with friends and family' below), influenced their decision to agree to this.

On the other hand, some service user participants reported external reasons for continued financial difficulties and homelessness, even after accessing support. These included the cost of living and housing crises, which negatively impacted their circumstances and mental health, hindering their recovery journey.

> **"I can't save because I'm in temporary housing and the rent is like £1,800 a month. So, if I earn anything, it just comes off my housing benefits... The system doesn't support my recovery to improve myself because if I earn anything, it's taken away."** Service user

Delivery staff echoed some of the challenges with achieving an improved financial outcome stating that their ability to support service users with their housing situation is highly dependent on the external referral processes with the council, which slows down recovery for people in need of housing support.

> **"They're put on a waiting list or they're told that they just don't have priority needs... it's a matter of appealing and trying to help the council understand that they do have priority need and they do need support... there's been quite a few positive outcomes of that in terms of clients being put into temporary and emergency accommodation so they can get back on their feet and get some long term support from their council in terms of getting housing. But there have been, I'd say probably just as many where that hasn't been successful."** Delivery staff

8. Increased personal network of support and reduced isolation

Service users who had positive experiences of attending group sessions reported an improved connection and reduced isolation. Groups often allow people to speak openly about their experiences. The shared experiences and mutual support available gave service users a **sense of belonging, reduced feelings of being alone in their struggles, and provided ongoing motivation to remain in recovery**. Group sessions offered a flexible and accessible form of ongoing support, particularly when one-to-one sessions ended. The drop-in nature of the groups allowed service users to access support as needed, providing a safety net and a sense of continuity in their recovery journey. This flexibility is particularly important for long-term recovery, as individuals may experience fluctuating needs and challenges over time.

> **"It [group session] has helped me through many a struggle through my recovery... whether it's someone else's story that week, someone else's struggle. It reminds me of where I am, why I'm where I am. It's a bit like a backbone for me."** Service user

As described earlier, service users had mixed opinions on groups depending on how comfortable they felt in these situations as well as how they perceived the conversations within them. For those who valued the groups, it gave them **regular and reliable access** to a support network of people who all shared similar experiences.

> **"The groups give me... the security of knowing, as long as they're there, it doesn't matter how much longer I live, if I can keep having that, that is a safeguard for me."** Service user

The shared understanding and empathy of staff with lived experience created a **safe and non-judgemental environment** where service users felt comfortable being vulnerable and honest about their struggles. Attending groups with peers or sessions run by people who have been through something similar made individuals feel like they were less alone in their recovery.

9. Improved relationships with friends and family

Both service users and delivery staff reported improved relationships with friends and family for many service users. Individuals felt more able to speak openly to friends and family about their struggles and recovery needs, allowing them to be more honest with those closest to them and reduce the shame experienced. This was often due to the **confidence gained through speaking with others with lived experience** (e.g. delivery staff or peers), which helped to tackle stigma and shame.

> **"There's been a massive positive. I've been more present, I think, is the underlying feeling which can only benefit... friends and family."** Service user

It is possible that improved relationships have also been facilitated by friends and family seeing individuals engaged in support and pursuing long-term recovery. As a result of using these services, service users reported having more time to focus on relationships and being more present.

> **"I was extremely closed off and I didn't really have much of a personality left or anything like that. I didn't really do anything. I work a lot of hours and then I go gamble... I have a lot more free time where I'm able to engage with people around me."** Service user

3.4 Outcomes data collected by projects

Table 3.1 presents the data reported by each project on outcomes for service users in 2024. There are some limitations to take into consideration, which are discussed below; however, the outcomes data available supports the evaluation findings from qualitative fieldwork that the programme is resulting in positive outcomes for a majority of individuals accessing recovery services.

For five project that report improvements in mental health and/or wellbeing, at least 80% of service users experienced positive increases. Data on other outcomes (such as increased network of support and increased confidence, self-worth and self-efficacy) draw on samples from only two projects but indicate positive increases for the majority of participants. This supports the findings from other data sources in the evaluation. Finally, financial situation is reported by only one project, and a smaller share of individuals experienced improvements.

The limitations to consider when reviewing these data are:

- The sample size of service users varies by project. Furthermore, some sample sizes are low, which limits the ability to draw strong inferences from the data.
- There is possible self-selection bias. Those providing data on outcomes may derive more value from it and experience larger improvements in outcomes compared to those who do not.
- Not every project reported on each outcome, meaning that these results are not directly comparable.
- There is no data on the extent of the change experienced by service users.

Table 3.1: Reported outcomes achieved by service users

Outcome	Projects (sample size of service users surveyed)	Progress achieved in 2024
Share of service users able to identify a positive improvement in mental health and/or wellbeing	CA Wirral (n=31)	98%
	Epic (sample size unknown)	95%
	Veterans Aid (n=60)	100%
	Acta (n=11)	80%
	CABH & Breakeven (n=34)	88%
Share of service users reporting increasing their network of support	Epic (sample size unknown)	89%
	Veterans Aid (n=60)	100%
Share of service users reporting increased confidence, self-worth and self-efficacy	Epic (sample size unknown)	85%
	Acta (n=11)	80%
Share of service users reporting better management of gambling (including reduction in gambling or sustained abstinence)	Acta (n=11)	80%
	CABH & Breakeven (n=32)	100%
Share of service users reporting improved financial situation	CABH & Breakeven (n=36)	64%

3.5 Wider outcomes

There is currently a small amount of evidence of outcomes for others (such as the wider sector), which aligns with the programme TOC – the programme is not expected to result in significant changes for other groups. There have been some awareness raising activities that have led to referrals from the wider sector. Anecdotal evidence about long term recovery

support helping service users to be able to reintegrate into society and contribute in a way they could not before the support has been mentioned. Phase 3 of the evaluation will explore these alongside any other wider outcomes that emerge.

4 Learning about long term recovery, recommendations, and implications for the evaluation

This chapter draws together learning points for GambleAware, and external audiences that will fund, design and deliver future services. It synthesises insights from the evaluation so far to build an emerging understanding of what works for long term recovery from gambling harms and what factors should be considered.

This programme represents an important component of GambleAware's five-year strategy, which highlights the need to 'invest in structured aftercare and long term follow up', as well as a strategic learning opportunity for commissioners of the new system. Delivery is ongoing for most projects, therefore progress over the next year of funding will uncover additional, different and more nuanced insights about what is effective for long-term recovery, to help inform future strategy.

4.1 Learning and recommendations for funders and policymakers about what works for long term recovery

The learning captured in this sub-section is relevant for the NHS as the new treatment commissioner, OHID as the new prevention commissioner, and UKRI as the new research commissioner.

1. Long term recovery support is needed

Evidence suggests that the programme is **filling a gap in current service provision and addressing unmet needs of recovery**. Service users overwhelmingly reported how critical services accessed through the programme have been for their sustained recovery. Many cited that the support they received was essential, but was not something they had ever had access to previously or knew was available. Equally, delivery staff were resolute in their support for the programme for providing much needed formal support for recovery that is currently lacking.

It is too early to assess the impact of providing this support to individuals on longer-term sustained recovery or relapse prevention as not enough time has passed. However, it highlights the value in continuing this support offer to enable longer-term impacts to realise. Furthermore, whilst the wider commissioning landscape has undergone change, the programme is still perceived to have value and learning generated will provide evidence for future services.

> **"It [long term recovery support] is definitely a necessity for me… I probably would have relapsed by now… This is the first time ever that I've changed my attitude and how I think about things. I'm being reflective and I'm making conscious effort. And I do think that is down to [the organisation], because it's the first time anyone's ever really spoken to me about it and called me out on it."** Service user

2. Long term recovery support should be offered more systematically

Stigma and isolation present barriers to individuals seeking and accepting support for recovery from gambling addiction and associated harms. Therefore, there needs to be a more systematic way for service users to access support. This could look like **including long term recovery support in the formal support pathway**, whereby service users are routinely signposted to long-term recovery support services following treatment. A more intentional approach to offering support would prevent it from being viewed as an optional add on or available to some and not others. This is important to ensure equitable access where all individuals in need are reached, and sustained recovery is more likely, regardless of factors like location.

Furthermore, long-term recovery support should be considered as **separate and distinct from treatment** – a view shared by delivery staff and service users. Service users who had accessed treatment previously (sometimes different types through different providers), which typically focussed on abstinence as the primary objective, noted how different the focus of the programme's support was by addressing recovery goals that aimed to rebuild life beyond / without gambling. Service users may need to access treatment and long-term recovery support in a non-linear fashion (e.g. concurrently or back and forth, depending on their specific needs). However, the provision of long-term recovery support should not be conflated with treatment to ensure it is prioritised in its own right.

There is likely overlap between treatment and long-term recovery support, however there are key differences in terms of objectives, intended outcomes and required skills staff that should be recognised. For example, service users found it valuable to focus on aspects of their wider lives that they felt had been affected by harmful gambling, such as their interests and relationships with friends and family. Reported outcomes due to long-term recovery support services went beyond abstinence to increased confidence to achieve recovery goals and improved relationship with self. There was less focus on delivery staff having formal qualifications as therapists delivering psychological interventions or pharmacological treatment, and more emphasis on staff having lived experience and counselling or coaching skills. Treatment also tended to be time-limited whereas long-term recovery support was available in a more ongoing way.

> **"Ultimately recovery is about moving forward and looking at the whole person and how they look after their overall well-being and not just focused on the gambling because that shouldn't be seen as the whole part of their identity."**
> Delivery staff

The evaluation notes that a more systematic approach to the provision of long-term recovery support in addition to treatment may cost more than the current offer. The cost implications of this would need to be assessed, taking into consideration learning presented here about its value.

> **"This [long-term recovery support] should be a core part of a support offer... bringing that into the core commissioning across the network... We're only going to see that revolving door and relapses when we're not able to offer that longer term support for people. The economic cost, the cost on people's mental health, societal cost - all of that is only going to be made worse if we're not able to offer that longer term support for people to be able to sustain this."** Delivery staff

3. Dedicated funding to continue building the evidence base

The programme has shown that forming relationships, setting up services and establishing referral pathways takes time and resources. This programme has started – and is expected to continue – to lay the foundations on which to build sustained provision of support for long-term recovery. For that to happen, ongoing dedicated funding is necessary. **A lack of funding and sustainability of support services risks disruption to people's recovery**, where funding ends and services cannot continue. With the knowledge that recovery is often lifelong, and an individual's support needs can fluctuate and change at different timepoints, it is logical that ongoing recovery services are needed on a longer-term basis. This also highlights the need to fund research and evaluation that continues building the evidence base about long-term recovery from gambling harms. For the field to develop further, more evidence will be needed for the sector to learn about this emerging area.

Furthermore, funders must recognise that **evidence in this area is emerging and funding terms need to build in flexibility**. Rigid funding models with strict key performance indicators can hinder adaptability. The Aftercare Funding Programme has afforded organisations a helpful amount of flexibility in terms of outcome reporting and space to iteratively develop services around learning about service users. For example, one project that was experiencing low engagement switched to online delivery and ran a pilot trialling different approaches to securing referrals. Furthermore, Grant Managers at GambleAware appear to have achieved a helpful balance between hands on vs. hands off, performing a supportive role to projects who wish to discuss changes but allowing them space to deliver their services with light-touch reporting requirements.

Reflecting on the learning above, the following recommendations have emerged:

Key audience	Recommendation	Source of recommendation
NHS (the new treatment commissioner)	**Include long-term recovery support provision in plans for the future system.** The programme has addressed unmet needs of recovery and highlighted the need to fill this gap in a consistent and ongoing way. Factor long-term recovery support into commissioning plans including objective setting and budget allocation to ensure it is meaningfully considered alongside other priorities.	Analysis of qualitative interviews with project delivery staff and service users

NHS	**Consider the existing evidence base when planning long-term recovery support provision.** Service users have different needs of traditional treatment services and recovery support therefore they should not look the same. Learn from organisations delivering these interventions through knowledge sharing and collaboration with the third sector.	Reflections from the evaluation team
UKRI (the new research commissioner) and other research funders such the National Institute for Health and Care Research (NIHR)	**Continue to fund research and evaluation that builds the evidence base about long-term recovery from gambling harms.** This is an emerging area which lacks evidence about what works. For the field to develop further and to support funding decisions, more evidence will be needed.	Analysis of qualitative interviews with project delivery staff and service users; reflections from the evaluation team
GambleAware (funders of this programme) and NHS	**Continue to support organisations delivering projects to strengthen links between each other as well as NGSN providers.** In the final year, there will be a focus on sustainability of services beyond the funding period. GambleAware (and future funders) could provide the structures for sustainability by 1) establishing a learning community to enable services to collaborate and learn from each other and 2) linking with NGSN providers.	Reflections from the evaluation team

4.2 Learning and recommendations for service design and delivery about what works for long term recovery

The learning captured in this sub-section is aimed at those planning to design and deliver services for long-term recovery from gambling harms. This could be those who design programmes such as the NHS as new commissioners of treatment services under whose remit long-term recovery will sit. It could also include organisations like those delivering projects as part of this programme that may apply for future funding opportunities to deliver long-term recovery support services. There are lessons emerging from this programme that are relevant and transferable to future services. There is likely crossover with what works for more acute support for individuals experiencing gambling harms. Therefore, this section aims to emphasise the nuanced differences and new learning for longer-term recovery support.

1. Staff with lived experience of gambling harms and recovery

Project staff and service users consistently emphasised the importance of having delivery staff with lived experience of gambling harms and recovery. Knowing that someone else has gone through similar difficulties can be a powerful tool to reduce the shame and stigma that can be present during gambling addiction. This shame is significant and is not easily overcome, therefore can persist through longer-term recovery. Empathy and shared understanding on offer from services delivered by people with lived experience can help service users feel less alone and more understood. Consequently, they may be more likely to engage with long-term recovery support initially and in an ongoing way to enable sustained recovery. Additionally, **encountering staff who are further along their own recovery journeys can be inspirational for service users** and give them hope that they can experience the same by providing real-life examples of longer-term recovery being possible.

Staff with lived experience also bring a **unique and personal understanding of the day-to-day challenges of long-term recovery**. For example, putting coping mechanisms into practice to deal with urges to gamble that may continue to be present throughout recovery. This makes them uniquely placed to offer practical advice and support that carries weight and fills a gap that traditional services, often delivered by professionals without personal experience of gambling harm, cannot address. Staff with lived experience of gambling harms and recovery may be even more critical in recovery support than more acute support services.

> **"It [the mentor] was someone who was in recovery themselves. It was good to have someone who understood a lot of the things I was going through… really empathetic, really listened to what I was saying, offered me good suggestions in terms of dealing with certain things, coping strategies and things like that."**
> Service user

Despite this, it is important to get the balance and relationship dynamics right when staff have lived experience. For example, service users from one project described how their mentor shared their personal story about their own gambling harms and recovery to build rapport, however, did not continuously refer back to their own experiences. Service users must have space to share their experiences without being overshadowed or overpowered by experiences shared by staff (or other service users in group settings). Feeling connected is important however recovery is a personal experience over which individuals should have ownership and should not be told what they should do.

2. Partnership working

Partnerships between organisations have been critical to successful implementation of projects to date. Awareness of support provision was low given these services are new, therefore partnering facilitated referrals and offered continuity of care for services users in many cases. The business case for this programme included the aim of nurturing the emerging community of long-term recovery support providers through collaboration rather than competition; this collaboration has been evident.

However, it took time to establish some elements of the partnerships such as ways of working, which contributed to delays in some instances. Where organisations are partnering for the first time, it would be sensible to build in more time during set-up and mobilisation stages to acknowledge that relationship building between organisations takes time and to minimise delays. Further important learning for future services has been generated, which could enable faster mobilisation:

- Using the same CRM system across partner organisations to facilitate data sharing, support communication and enhance overall efficiency.
- Agreeing a single, consistent approach to safeguarding and risk assessment upfront to avoid misaligned expectations during early delivery. While smaller organisations might face challenges in implementing such approaches due to limited resources and competing priority of securing referrals, early and open communication about potentially conflicting priorities and how to balance could help improve collaboration and the partnership's efficiency.
- Sharing responsibility for attracting referrals across partner organisations in an even manner to help establish referral pathways and attract service users more quickly. A multi-agency approach, pooling diverse ideas and dedicating more capacity across the consortium for referral generation, is likely to be advantageous. Such an approach has the potential to benefit all organisations within the consortium through a more effective referral system.

3. A flexible and client-centred approach

Effective long-term recovery support needs to be flexible and adapt to individual needs and preferences, rather than imposing a one-size-fits-all model. This includes being responsive to service user feedback, offering a range of support options, and meeting people "where they are" in their recovery journey.

Offering a range of options such as one-to-one coaching, group sessions, online resources, and practical assistance can allow service users to choose what works best for them. This is important when taking a client-centred approach – to **empower individuals to feel ownership over their recovery journey and that they have control**, rather than that support is happening *to* them. People in recovery and affected others may face complex issues and require different types of support, either concurrently or sequentially; therefore, having access to a range of support, and being able to access it in an appropriate sequence based on need, is helpful. For example, delivery staff from one project described the range of issues a service user may be facing, therefore receiving support for each at the same time can be overwhelming and off-putting. There may be a need to phase or stagger support offers based on individual service users' needs and personal circumstances to encourage them to engage with each. This flexibility may also be particularly helpful when engaging affected others. For example, one project described how their affected other service users experienced significant stigma-related barriers and were less willing to join group sessions, but they were interested in one-to-one support. Furthermore, services may need to show flexibility in scheduling around lifestyles that may be chaotic or lack stability, as well as

other responsibilities such as children and employment. This ongoing flexibility is more likely to encourage ongoing engagement and contribute to sustained recovery.

To offer service users a flexible and client-centred approach, staff need the skills and empathy to build trusting relationships with clients, understand their individual needs, and adapt their approach accordingly. This involves being responsive to where service users are in their recovery journey, whether early on or after experiencing setbacks, so they can adjust the support accordingly. Some projects used a trauma-informed approach and recommend this is adopted so staff can take account of the impact of trauma on individuals' lives and provide support in a sensitive and responsive way. Furthermore, when working with partner organisations, strong communication and collaboration is essential to be able to offer clients flexibility. For example, if a client experiences relapse and needs additional treatment, the door should be left open for them to access recovery support when they are ready to.

> **"Providing options because gambling harm and recovery impacts people in so many different ways. I think there's not one size fits all in terms of recovery so it's providing as many options as you possibly can because people engage in different things in different ways."** Delivery staff

4. A holistic approach

Comprehensive long-term recovery support should address the broader impact of gambling harms on individuals' lives, not just the gambling itself. This can include providing support with finances, housing, employment, relationships, and overall well-being, which can require multidisciplinary teams with specialist skills. It should not be expected that a single organisation can offer the range of specialist support that is required. For example, finding sufficient delivery staff with lived experience of gambling harms *and* who have expertise in debt resolution is unrealistic. Therefore, it is crucial that organisations work collaboratively with each other to ensure individual service users can be signposted or referred to relevant support. This reiterates the importance of these organisations 1) laying the foundations of recovery support through delivery of services and 2) developing a network of providers within the system that have experience working together.

Reflecting on the learning above, the following recommendations have emerged:

Key audience	Recommendation	Source of recommendation
NHS and organisations designing interventions	**Include trained staff with lived experience of gambling harms and recovery in delivery teams.** Staff having lived experience emerged as an important enabler of programme success. Ensure that delivery teams comprise individuals with lived experience in roles where they can interact directly with service users. Careful planning should achieve relationship dynamics that ensure service users feel	Analysis of qualitative interviews with service users

	ownership over their recovery journey and can share their experiences without being overshadowed.	
Organisations designing interventions	**Allow more time at set up and mobilisation.** Newer relationships need more time to develop and agree ways of working. Particular areas to focus on include aligning on data sharing processes, safeguarding approaches and ownership of the referrals process.	Reflections from the evaluation team
NHS and organisations designing interventions	**Factor flexibility into service models that allows service users to have choice.** This supports uptake of support by enabling service users to decide what works best for them based on their individual needs. At the design stage, establish what degree of flexibility can be offered and whether iterative changes can be integrated throughout (informed by parameters set by the funder as well as delivery staff skills and resources to accommodate changes).	Analysis of qualitative interviews with project delivery staff and service users
Organisations designing interventions	**Consider partnerships with organisations with different skills and offers.** A joined-up network of providers is required to meet the diverse needs of service users. Identify organisations to collaborate with that can offer other relevant services for example, those with strong links to specific service user groups or those with specialist skill sets.	Analysis of qualitative interviews with project delivery staff

4.3 Implications for Phase 3 of the evaluation

The approach to Phase 3 of the evaluation remains unchanged in terms of planned activities. However, learning from Phase 2 has implications on the focus of some strands of activity:

- **Increased focus on affected others.** The sample of service users in Phase 3 will aim to include affected others, alongside people in recovery. The fact that using an opt-in approach in Phase 2 led to a sample of only those in recovery coming forward to participate may be linked to the increased stigma that some affected others experience during recovery, and projects supporting more people in recovery compared to affected others. The evaluation may need to

take a more targeted approach to sampling across the remaining projects and will explore the feasibility of this with projects.

- **Further exploration of supporting different groups and populations.** Currently, insights add to the otherwise limited evidence base about long-term recovery support for people experiencing gambling harms. If many service users are currently accessing projects' services through referrals, it suggests that services are reaching people who typically access other support for gambling harms. This may present a gap in the programme's reach as well as limit the extent to which the evaluation can explore experiences and outcomes for different groups (beyond the projects that focus on specific groups such as veterans and people experiencing homelessness). Therefore, in Phase 3, the evaluation will seek to gather evidence on differences between groups.
- **A more comprehensive and systematic report form for the end of the programme.** There are currently limitations to using data from project report forms such as lack of comparability. The evidence base would be stronger if gaps or inconsistencies in reporting are addressed for the final reporting deadline. The feasibility of this will be explored, balancing the demands on projects' time with the needs of the evaluation. However, learning from "Deep Dives" conducted in Phase 2 suggests that projects generally already collect the required data. Therefore, tweaks to the reporting template will focus on consistency (for example, reporting periods) to support comparability of the data across projects. Projects will be able to access ad hoc support from Ipsos to ask any questions or provide any feedback.

Appendix 1 – Summary of projects

Table of projects

Project Name	Organisation(s)	Funding	Location	Project status	Summary
The Long Group	Acta Community Theatre	£68,754	Bristol and Bath	Ongoing	A series of creative sessions (e.g. theatre, writing and photography) combined with peer support. The Addiction Recovery Agency (ARA) provides additional advice and guidance.
Pathways to Recovery	ARA	£180,000	Bristol	Funding ended	Coaching, mentoring and peer support to build on progress made during treatment. The Gambling Harms Research Centre (GHRC) at University of Bristol has an advisory role.
Beacon and Betknowmore	Beacon Counselling Trust and Bet Know More	£180,000	Northwest England	Funding ended	1:1 peer support, TREK Therapy, group work, skills development and social integration to support individuals who have previously received treatment via Beacon. Delivered in partnership with Betknowmore.
Citizens Advice Brighton & Hove Aftercare service	Citizens Advice Brighton & Hove and Breakeven	£135,809	South-East England	Ongoing	1:1 financial casework offering tailored advice. An extended package of support delivered alongside Breakeven's Green Shoot Recovery Programme.
Liverpool City Region After Gambling support programme (LCRAG)	Citizen Advice Wirral	£150,000	Wirral and Liverpool City Region	Ongoing	Specialist advice services and personalised recovery support programme. Delivered in partnership with Beacon Counselling Trust.
Cyrenians	Cyrenians	£348,342	Across Scotland	Ongoing	1:1 and group trauma-informed support for the homeless community in Edinburgh to improve their recovery capital and building in-house

					knowledge of gambling harms to share with the broader homelessness sector.
Life after gambling (LAG)	GamCare and Reframe Coaching	£300,000	Across England	Ongoing	Using a professional coaching model to support recovery. Delivered in partnership with Reframe Coaching.
Building recovery capital: restarting lives after gambling harm	EPIC Restart Foundation	£350,000	Nation-wide	Ongoing	A range of transformational programmes delivered by expert facilitators, clinical treatment providers and those with lived experience.
Learning, Evolving, Aspiring, Future Focus (LEAFF) Project	Steps To Work	£150,000	Black Country, Midlands	Funding ended	1:1 sessions focusing on individuals' needs to enhance their recovery capital of internal and external assets.

Appendix 2 – Methodology

Phase 2 methodology

Ipsos is delivering a process and impact evaluation of the Aftercare Funding Programme, sharing emerging insights with GambleAware between March 2023 and March 2026. Ipsos is also GambleAware's learning partner, supporting funded projects to develop their capabilities in project-level evaluation and data collection, and facilitate knowledge sharing among projects as the programme continues.

During Phase 2 of the evaluation, Ipsos caried out:

- **An online learning event in September 2024** for projects to facilitate networking and knowledge sharing, update on project progress, and introduce Phase 2 of the evaluation and learning partner support.
- **Case study visits and face-to-face and online interviews with delivery staff and stakeholders** (n=28) from nine projects between November 2024 and February 2025. Interviews explored project progress against project-level Theories of Change (TOCs) early outcomes and emerging learning about what approaches are most effective and for whom. Case studies interviews aimed to speak to a range of individuals involved in project delivery, to gain a 360-degree view of the project. Ipsos asked project leads to nominate relevant individuals to approach. See Table 4.1 for details of the sample. During case study fieldwork, projects were also offered one-to-one support for any monitoring, evaluation and learning queries.
- **Interviews with service users** (n=13) from two projects conducted between December 2024 and February 2025. Interviews explored service users' experiences of projects' long term recovery support offers, early outcomes, the need for longer-term support to sustain recovery from gambling harms and factors that support or hinder recovery. An opt-in approach was used to minimise sharing of personal data between organisations and Ipsos; therefore, Ipsos shared materials about participation with projects, which they sent to service users who could choose to contact Ipsos to take part. All interviews took place online or by telephone. See Table 4.2 for details of the sample.
- **Analysis of programme monitoring information** provided by projects to GambleAware via report form returns. Ipsos fed into the design of forms to ensure a minimum dataset covering progress against activity and outcome targets. Project completed a mix of 6-month, 12-month, end-of-Year 2 and end-of-grant reports.
- **One-to-one "Deep Dive" discussions with projects** (n=7) to discuss current and planned data collection to measure and evidence outcomes. Projects also shared material for Ipsos to review (e.g., datasets, templates). Ipsos synthesised information collected through these discussions to identify common challenges and opportunities, as well as provide projects with tailored recommendations. Ipsos produced a one-page summary note for each of the seven projects containing personalised recommendations to maximise the value of their

outcome data collection and reporting. Ipsos also produced a briefing paper for GambleAware, providing an overview of outcome measurement plans across the portfolio and making suggestions to strengthen current and planned data collection and analysis.

- **Two online learning workshops for projects** focusing on data analysis in January 2025 and case studies in February 2025. Both workshops were 90 minutes and consisted of masterclasses and interactive question and answer segments. Projects funded through GambleAware's Community Resilience Fund, which Ipsos is currently evaluating, were also invited to the case studies workshop to maximise its value and learning between organisations.

Ethical considerations

The main ethical considerations for the evaluation relate to conducting fieldwork with service users. The following measures were taken to enable inclusion of services users and avoid causing or reinforcing harm:

- Materials were developed and provided to participants to invite them to take part. An information sheet described what the study is about, what taking part would involve and what topics would be covered. It included Ipsos contact details for any questions they wanted to ask. The information sheet also included a list of relevant support sources. This was accompanied by a privacy notice that explained how their data would be securely stored and processed for the study, and when it would be deleted. Both documents were designed to be easy to read and understand, enabling service users to make an informed decision about whether to take part.
- An opt-in approach was used whereby Ipsos sent select projects the information sheet and privacy notice to share with their service users. If a service users wished to take part, they used Ipsos contact details to express interest. This removed the need for data sharing between organisations and Ipsos, and meant participants could take part without projects knowing, encouraging them to speak openly about their experiences of services.
- Individuals in active treatment were not invited to take part. As the Aftercare Funding Programme focuses on long-term recovery, there was a lower chance of encountering anyone in treatment. However, we know that recovery is not linear therefore it was possible someone may need to access treatment again. We asked that where projects knew this about an individual, they did not send the information about the study to them.
- The discussion guide used in interviews was developed to carefully ask participants questions to capture their views without causing any harm. This included trauma-informed research approaches including: explaining what the discussion would involve at the start to ensure the participant was informed and could ask any questions before beginning; reflecting the language participants used; reminding participants that they could skip any questions they did not want to answer, take breaks, or stop taking part at any point; and including the list of resources on the guide so researchers could signpost if needed. This guide was reviewed and signed off by GambleAware.

- An incentive in the form of a £25 gift card was provided to participants, in line with GambleAware's guidelines[5] (page 8), to renumerate them for their time and expertise. This approach was discussed and agreed with GambleAware to ensure it aligned with approaches on other studies.
- The evaluation team held a briefing prior to fieldwork to prepare interviewers. This included covering Ipsos' Disclosure of Harm policy that needed to be followed if any participant indicated that they or someone around them was at risk of harm.

Case study sample

The majority of case study fieldwork took place in-person, involving a visit to the project site. Online interviews were conducted when an individual was not available on the day of the visit, as well as for projects whose funding had ended. Table 4.1 shows the sample of case study participants.

Steps to Work was not included in Phase 2 fieldwork as the project ended early because the organisation went into administration.

Table 4.1:

Organisation	# of interviews completed	# of delivery staff interviewed	Mode
Acta Community Theatre	1	1	Face-to-face visit
ARA	2	2	Online
Beacon Counselling Trust and Bathnewmore	3	3	Online
Citizens Advice Brighton & Hove and Brookover	3	3	Hybrid - face-to-face visit (2 participants) and online interview (1
Citizen Advice Wirral	2	3	Face-to-face visit
Cyrenians	2	2	Face-to-face visit
GamCare and Reframe Coaching	6	7	Hybrid - face-to-face visit (3 participants) and online interviews (4

[5] https://www.gambleaware.org/media/1gicb1ts/research-publication-le-focus-guidelines-final_0.pdf [accessed March 2025].

EPIC Restart Foundation	3	4	Hybrid - face-to-face visit (3 participants) and online interview (1
Veterans Aid	2	3	Face-to-face visit

Service user interview sample

Service users were sampled from two projects where implementation was sufficiently underway and service user numbers were reasonable. Table 4.2 shows the sample breakdown of service users that took part in interviews. Phase 3 will include service users from other projects.

Table 4.2:

Characteristics		Number of participants
In recovery or affected other	In recovery	13
	Affected other	0
Project	EPIC	7
	Reframe/GamCare	6
Gender	Female	5
	Male	8
Age	20-29	1
	30-39	4
	40-49	4
	50-59	3
	60-69	1
Ethnicity	White British	10
	Black African	1
	Other	1
	Not disclosed	1

Limitations of service user fieldwork

- There are advantages and disadvantages of taking an opt-in approach. Some of the advantages are discussed under 'ethical considerations' above. A key limitation is that an opt-in approach may encourage those who had very positive or negative experiences to participate, meaning that the insights reported represent extremes of outcomes. However, triangulation of insights from service users and delivery staff shows alignment and indicates that this is not a significant concern.
- The sample included two projects in total. Four projects, whose delivery was more mature, were initially selected and asked to invite service users to take part through an opt-in approach. However, two of the four projects had policies in place limiting them from contacting service users about topics beyond the support they had received, unless individuals had given permission. Therefore, as sample sizes were very small, it was decided to invite them to take part in Phase 3, ahead of which permissions could be sought. The resulting sample of service users from Phase 2 fieldwork is drawn from two projects where delivery is established, the support models are similar, and organisations were already experienced at delivering gambling harms interventions. It is possible that outcomes reported by service users are more positive or significant than for service users of other projects. However, this is balanced against an aim to generate some insights from service users earlier, in Phase 2, instead of conducting all service user fieldwork in Phase 3.
- All service users that took part in interviews were people in recovery; no affected others were interviewed. The programme is reaching more people in recovery than affected others therefore the available sample of affected others is smaller. Furthermore, the opt-in approach limits the potential to set and reach quotas for different groups because the sample is reliant on the individuals who express interest. For service user fieldwork in Phase 3, the number of projects being asked to invite their service users to take part will be greater, increasing the potential for inclusion of the voice of affected others supported through the programme.

Appendix 3 – Projects delivery target data in 2024

Activity	Projects	Target number of sessions	Actual number of sessions	Difference between actual and target number of sessions	Target number of people engaged	Actual number of people engaged	Difference between actual and target number of people engaged
One-to-one support (including individuals in recovery and affected others)	Cyrenians	260	69	-191	30	15	-15
	Epic	1,000	720	-280	175	158	-17
	Veterans Aid	909	1,087	178	109	129	20
	Citizens Advice Brighton and Hove	N/A	N/A	N/A	69	56	-13
	GamCare & Reframe	N/A	519	N/A	N/A	95	N/A
	Ara	N/A	32	N/A	N/A	32	N/A
	BCT & BKM	N/A	179	N/A	N/A	35	N/A
Total target number of one-to-one support sessions in 2024 (where applicable)							**2,169**
Total difference between actual and target number of one-to-one support sessions in 2024 (for projects setting a target only)							**-293**
Total target number of people engaged in one-to-one sessions in 2024 (where applicable)							**383**
Total difference between actual and target number of people engaged in one-to-one sessions 2024 (for projects setting a target only)							**-25**

(continued overleaf)

Activity	Projects	Target number of sessions	Actual number of sessions	Difference between actual and target number of sessions	Target number of people engaged	Actual number of people engaged	Difference between actual and target number of people engaged
Group support (including group activities, both online and in-person, and talks)	Epic	67	81	14	670	835	165
	Acta	N/A	18	N/A	N/A	11	N/A
	Citizens Advice Brighton and Hove	135	N/A	N/A	N/A	172	N/A
	Ara	N/A	76	N/A	N/A	211	N/A
	CA Wirral	N/A	44	N/A	N/A	96	N/A
	BCT & BKM	N/A	77	N/A	N/A	19	N/A
Total target number of group support activities in 2024 (where applicable)							**202**
Total difference between actual and target number of group support activities in 2024 (for projects setting a target only)							**14**
Total target number of people engaged in group support activities in 2024 (where applicable)							**670**
Total difference between actual and target number of people engaged in group support activities in 2024 (for projects setting a target only)							**165**

(continued overleaf)

Activity	Projects	Target number of sessions	Actual number of sessions	Difference between actual and target number of sessions	Target number of people engaged	Actual number of people engaged	Difference between actual and target number of people engaged
Engagement with professional services (including upskilling and relationship building)	Cyrenians	50	104	54	300	751	451
	CA Wirral	N/A	15	N/A	N/A	336	N/A
	Epic	6	58	52	N/A	N/A	N/A
	Acta	N/A	2	N/A	N/A	N/A	N/A
	Ara	N/A	4	N/A	N/A	4	N/A
Total target number of engagement activities with professional services in 2024 (where applicable)							**56**
Total difference between actual and target number of engagement activities with professional services in 2024 (for projects setting a target only)							**106**
Total target number of professionals engaged in 2024 (where applicable)							**300**
Total difference between actual and target number of professionals engaged in 2024 (for projects setting a target only)							**451**
Awareness raising campaigns aimed at the public and people in recovery (including social media campaigns, podcasts and engagement with service users in treatment centres)	CA Wirral	N/A	10	N/A	N/A	7,942	N/A
	Epic	55	74	19	N/A	20,164	N/A
Total target number of awareness raising campaigns in 2024 (where applicable)							**55**
Total difference between actual and target number of awareness raising campaigns in 2024 (for projects setting a target only)							**19**

Appendix 4 – Theory of Change review

Upon completion of Phase 2 fieldwork and analysis, the evaluation team reviewed the Theory of Change to explore whether any changes were required in light on insights from the data.

The Theory of Change developed at the end of the Scoping Phase remains relevant and fit for purpose. The changes required are minor; these are described below:

- Rationale: A rationale listed is 'there is also a need to identify high-quality projects suitable for future investment and inform GA's new commissioning approach'. There have been changes to the commissioning landscape, with OHID announced as the prevention commissioner and the NHS as the treatment commissioner. Therefore, this rationale has been updated to 'inform OHID and the NHS' new commissioning approach'.
- Assumption: An assumption listed is 'aftercare is an appropriate and suitable description of the programme's focus'. There has been a shift in language from 'aftercare' to 'long term recovery support' to better describe the support. Therefore, the wording in the TOC has been updated throughout. 'Aftercare' is used solely in reference to the programme (the Aftercare Funding Programme).
- Outcome: There is evidence of an outcome related to staff personal and professional development that is not captured in version 1 of the TOC (see section 3.2 of the report). This has been added and will be explored further in Phase 3.
- Impact: An impact listed for GambleAware is 'informs GA's future commissioning plans and longer-term funding strategy'. Therefore, an impact from this programme may be 'informs the NHS's and OHID's future commissioning plans'.
- Risk: A risk listed is 'uncertainty around how national government and local authorities will provide gambling treatment: a lack of clarity around the provision of gambling harms treatment following the publication of the White Paper may pose implications for the future integration of long-term recovery support services'. Despite commissioners being announced and there being more clarity around provision of gambling harms treatment, this risk remains as there is no certainty about the future of long-term recovery support at present. Therefore, there is no change to the TOC, however it seemed pertinent to comment on this risk.

Version 2 of the full TOC containing these amendments is available as a separate document.

Our standards and accreditations

Ipsos' standards and accreditations provide our clients with the peace of mind that they can always depend on us to deliver reliable, sustainable findings. Our focus on quality and continuous improvement means we have embedded a "right first time" approach throughout our organisation.

ISO 20252

This is the international specific standard for market, opinion and social research, including insights and data analytics. Ipsos UK was the first company in the world to gain this accreditation.

Market Research Society (MRS) Company Partnership

By being an MRS Company Partner, Ipsos UK endorse and support the core MRS brand values of professionalism, research excellence and business effectiveness, and commit to comply with the MRS Code of Conduct throughout the organisation & we were the first company to sign our organisation up to the requirements & self-regulation of the MRS Code; more than 350 companies have followed our lead.

ISO 9001

International general company standard with a focus on continual improvement through quality management systems. In 1994 we became one of the early adopters of the ISO 9001 business standard.

ISO 27001

International standard for information security designed to ensure the selection of adequate and proportionate security controls. Ipsos UK was the first research company in the UK to be awarded this in August 2008.

The UK General Data Protection Regulation (UK GDPR) and the UK Data Protection Act 2018 (DPA)

Ipsos UK is required to comply with the UK General Data Protection Regulation (GDPR) and the UK Data Protection Act (DPA). These cover the processing of personal data and the protection of privacy.

HMG Cyber Essentials

Cyber Essentials defines a set of controls which, when properly implemented, provide organisations with basic protection from the most prevalent forms of threat coming from the internet. This is a government-backed, key deliverable of the UK's National Cyber Security Programme. Ipsos UK was assessed and validated for certification in 2016.

Fair Data

Ipsos UK is signed up as a "Fair Data" company by agreeing to adhere to twelve core principles. The principles support and complement other standards such as ISOs, and the requirements of data protection legislation. .

For more information

3 Thomas More Square
London
E1W 1YW

t: +44 (0)20 3059 5000

www.ipsos.com/en-uk
http://twitter.com/IpsosUK

About Ipsos Public Affairs

Ipsos Public Affairs works closely with national governments, local public services and the not-for-profit sector. Its c.200 research staff focus on public service and policy issues. Each has expertise in a particular part of the public sector, ensuring we have a detailed understanding of specific sectors and policy challenges. Combined with our methods and communications expertise, this helps ensure that our research makes a difference for decision makers and communities.