# Evaluation of the Effectiveness of the NGSN – Final Report

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# Acknowledgements

We acknowledge the contributions of all NGSN providers and stakeholders who participated in the evaluation, as well as the partners involved in this work. We also thank GambleAware for their support during the process.

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# Glossary

**Table 1. Glossary of terms**

| Term | Description |
|---|---|
| **ALERTS** | A group composed of individuals with lived experience of gambling harms, commissioned by GambleAware to provide insights into service delivery. |
| **CA** (Contribution Analysis) | An evaluation approach which involves the creation of 'Contribution Claims' which describe how a programme is intended to bring about outcomes and impacts. Contribution Claims are then assessed against evidence to determine the extent to which they have been validated in reality. |
| **Brief interventions** | Time-limited, structured conversations or activities that aim to motivate and support individuals to change gambling-related behaviours, used in early intervention contexts. |
| **DRF** (Data Reporting Framework) | A structured framework for collecting, managing, and reporting service-user-level data across the NGSN to enable consistent monitoring and evaluation. |
| **EJP** (Economically Justifiable Price) | The maximum price at which a treatment or service can be offered while remaining cost-effective based on societal willingness to pay for health gains. |
| **EQ-5D** | A tool for measuring health-related quality of life across five dimensions: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. |
| **GA** (GambleAware) | An independent charity commissioning prevention, education, and treatment services to reduce gambling harms in Great Britain. |
| **GAD-7** (Generalised Anxiety Disorder-7) | A validated 7-item screening tool used to assess the severity of generalised anxiety symptoms, commonly used in mental health assessments. |
| **GP** (General Practitioner) | A doctor who provides primary medical care and refers patients to specialist services when needed. |
| **HRQoL** (Health-Related Quality of Life) | A measure of how health impacts a person's physical, mental, and social well-being. |
| **ICER** (Incremental Cost-Effectiveness Ratio) | A statistic used in health economics to assess the cost per additional unit of health benefit (e.g. per QALY) gained by an intervention compared to an alternative. |
| **IOF** (Improving Outcomes Fund) | A fund created to drive change by investing in activities that reduce inequalities in gambling harms support for women and people from minority religious and ethnic communities. |
| **KPI** (Key Performance Indicators) | Quantifiable metrics used to assess the success and effectiveness of services within the NGSN. |
| **LE** (Lived Experience) | Individuals who have first-hand experience of gambling-related harm, and/or NGSN services. |
| **MDT** (Multi-Disciplinary Team) | A group of professionals from different disciplines working collaboratively to deliver holistic, person-centred care within the NGSN. |
| **MLS** (Mobilising-Local-Systems) | An NGSN funding programme, which aims to strengthen collaboration and partnerships between NGSN providers and other regional stakeholders. |
| **Model of Care** | A structured approach, based on 5 principles, outlining how NGSN services should be delivered to ensure consistency, integration, |

| | |
|---|---|
| | and alignment with best practice in supporting individuals affected by gambling harms. |
| **NHS** (National Health Service) | The publicly funded healthcare system in the UK, which will become the sole commissioner of treatment for gambling harms. |
| **NGSN** (National Gambling Support Network) | A network of providers commissioned by GambleAware to deliver coordinated support, advice, and treatment for individuals experiencing gambling harms across England, Scotland, and Wales. |
| **NGTS** (National Gambling Treatment Service) | The predecessor to the NGSN. |
| **NHB** (Net Health Benefit) | A measure that combines the health gains of an intervention with the opportunity costs of funding it, used to assess overall benefit from a health economics perspective. |
| **NICE** (National Institute for Health and Care Excellence) | A UK body that develops evidence-based guidelines and health technology appraisals, often used to inform standards of care and cost-effectiveness thresholds. |
| **NIHR** (National Institute for Health and Care Research) | The UK's main funder of health and care research to improve outcomes and services. |
| **NMB** (Net Monetary Benefit) | An alternative way to express cost-effectiveness, translating health gains into monetary terms to compare the value of different health interventions. |
| **PCGS** (Primary Care Gambling Service) | An NGSN provider offering early intervention, screening, and treatment for gambling-related harms through integration with primary care pathways. |
| **PDC** (Planned Disclosure Charge) | Data detailing the reason or status of a service-user's discharge from treatment. |
| **PGSI** (Problem Gambling Severity Index) | A validated screening tool used to assess the severity of gambling-related harms in individuals. |
| **PHQ-9** (Patient Health Questionnaire-9) | A 9-item validated screening tool used to assess the severity of depressive symptoms in service-users. |
| **PSM** (Participatory Systems Mapping) | A collaborative approach to mapping the factors that influence a complex system, such as the NGSN, and the relationships between them. |
| **Public health approach** | A strategy focused on preventing harm and promoting wellbeing at a population level, aiming to address social determinants and reduce inequalities related to gambling harms. |
| **Q&P** (Quality and Performance) | A set of standards and measures used to assess the effectiveness, efficiency, and impact of services delivered within the NGSN. |
| **QALYs** (Quality-Adjusted Life Years) | A measure combining life expectancy and quality of life, used to assess the effectiveness and value of health interventions. |
| **Quality Assurance framework** | A structured system for ensuring services are delivered to a consistent standard, incorporating continuous monitoring, evaluation, and improvement processes |
| **Service-user** | An individual who engages with support or treatment services provided through the NGSN. |
| **ToC** (Theory of Change) | A framework outlining how and why a programme is expected to work, mapping the causal pathways between inputs and activities, outputs, and intended outcomes and impacts. |
| **Treatment commissioner / service coordinator** | The organisation or body responsible for planning, commissioning, and overseeing the delivery of treatment services such as the NGSN. |

# 1. Executive summary

## NGSN overview

The National Gambling Support Network (NGSN) is a GambleAware-commissioned network of treatment and support providers offering free, confidential assistance for anyone affected by gambling harms across Great Britain. By combining a national helpline, local provider access, varied intervention options, and a strong emphasis on early, user-informed care, the NGSN aims to ensure anyone affected by gambling harms can receive timely, relevant, and supportive help wherever they are in Great Britain.

## Evaluation overview

This report presents the final evaluation findings, and identifies implications and recommendations for GambleAware, the network providers, future system commissioners (the NHS) and wider system stakeholders. The report builds on findings from the Scoping stage of the evaluation, which lasted from July 2024 to January 2025, while the Mainstage of the evaluation concluded in September 2025. The evaluation focused on assessing the operational, clinical and cost effectiveness of the NGSN. It draws on data from various sources, including monitoring information from reports provided by GambleAware and providers to the evaluation team, a survey of providers, in-depth interviews with policy stakeholders and GambleAware staff, Contribution Analysis workshops conducted with NGSN providers and lived experience representatives, and case studies of four NGSN providers involving interviews with staff and leadership. The case study providers were selected to represent the variety of support delivered across the network, however the findings in this report are necessarily influenced by this selection. The reader should therefore be cautious in applying findings from case study evidence to the NGSN as a whole.

## Overall Evaluation Findings

This evaluation found that the NGSN system is clinically, operationally, and economically effective in supporting people experiencing gambling harms. There are further opportunities to enhance equity, consistency, and overall system performance, building on work showing promise that is already underway through other GambleAware funded initiatives.

## Operational effectiveness of the NGSN system

This evaluation found that **the NGSN is operationally effective in supporting people experiencing gambling harms and affected others.** The NGSN's operational success is driven by shared policies and strong relationships between regional providers. However, there is room for improvement in how the NGSN operates at a system level. Greater focus on improving the consistency with which shared policies are implemented across NGSN providers (some of which is already being addressed through roll out of new Model of Care training), and ensuring that providers have referral pathways in place and fully utilise shared learnings to improve services, would strengthen operational effectiveness.

The **NGSN's strategic vision is reflected in shared policies, and the NGSN is structured and governed in a way that enables it to achieve its goals**. Namely, GambleAware sets the strategic direction of the network whilst NGSN providers operate according to the needs of their communities and their own organisational expertise. Shared policies like the Model of Care, the Quality Assurance framework, the use of common measures like the Problem Gambling Severity Index (PGSI) and safeguarding policies reportedly contribute to the NGSN operating effectively. However, this research

revealed some inconsistencies in the extent to which central policies and principles are applied across the network. The review identified opportunities to strengthen the monitoring of shared policies by the treatment commissioner, particularly in ensuring consistent implementation of the Model of Care principles. It should also be noted that work is already underway to address this: concurrent with evaluation activities, training on the completed Model of Care framework was being rolled out across NGSN providers, with the aim of standardising the implementation of Model of Care principles.

**Regular meetings between providers, as well as provider working groups, were found to be particularly important** in the network operating effectively. The success of the NGSN was perceived to be linked to the strength of relationships between providers. This highlights the value in regional providers facilitating these relationships, which have been supported by the GambleAware 'Mobilising Local Systems' funding.

To enhance the efficiency of network operations, there is an **opportunity to further streamline the process of building referral pathways between NGSN providers, and avoiding duplication of services for more coordinated service-delivery**. Case study providers perceived the process of building referral pathways to be time-consuming, and mentioned that allocation of case-by-case contracts can lead to providers offering overlapping services. However, providers reported that building referral pathways is becoming easier due to strengthened relationships between regional providers (supported by the MLS funding). It should also be noted that work is being done to enable the improve the coordination of services at a system-level, through development of a risk stratification tool, currently in its pilot phase, which aims to improve assessment and of service-users and ensure they are referred to appropriate treatment.

**There are several mechanisms through which services are reviewed and improved at a system level.** Monitoring processes led by GambleAware are effective in standardising service reviews and implementing action plans to address areas for improvement. These monitoring processes will be further supported by the roll out of Care Quality Commission (CQC) inspections of NGSN providers, which commenced in April 2025.[1] The aim is for areas of improvement to be picked up through this inspection process, supporting providers in their efforts to deliver high quality services and promoting the best outcomes for people experiencing gambling related harms. Another key mechanism is the working groups, such as the Shared Learning and Quality Forum, where NGSN providers come together to discuss challenges and best practice examples. While the working groups were perceived to be valuable, there was some appetite amongst case study provider leaders for greater translation of what is discussed in the forums into improvements to services. While GambleAware are not involved in the content of the working groups, there is an opportunity for the treatment commissioner to support working groups in creating action plans from an administrative perspective, to maximise the impact of working groups on improving service delivery, alongside GambleAware service reviews and the new CQC inspections.

## Clinical effectiveness of the NGSN system

**The NGSN system is clinically effective for those who access it. While there is room for the NGSN to reach greater proportions of some population groups affected by gambling harms,** (particularly people from ethnic minority groups, young people, and people from the LGBTQ+

[1] Since the CQC inspections are recent, it was not possible to asses the impact of these at the time of the evaluation.

community), **NGSN providers have demonstrated proactivity in addressing access barriers through allocating resource towards targeted engagement initiatives.**

**Certain population groups experiencing gambling harms are under-represented in the population of NGSN service-users.** People from ethnic minority groups represent 30% of those experiencing 'problem gambling' (PGSI 8+) but they make up only 10% of those accessing NGSN support.[2] People aged 18-24 represent 23% of the total share of people experiencing 'problem gambling' but only make up 8% of those accessing NGSN support.[3] LGB+ people make up 13% of the share of people experiencing 'problem gambling' but account for just 3% of those receiving NGSN support.[4] Barriers to accessing support include limited public awareness of gambling harms and available services, stigma, provider capacity constraints, and inconsistent communication across the network.

**NGSN providers have demonstrated commitment to addressing access barriers**, and there is work ongoing to support this, through initiatives such as the Improving Outcomes Fund (IOF) and the Community Resilience Fund (CRF), which have been shown to have a positive impact on NGSN accessibility through independent evaluations. NGSN provider staff also perceive that providers are persistently tailoring services to the needs of different service-users and targeting awareness-raising activities based on evidence of need, supported by GambleAware funding. Continued work on strengthening engagement, increasing visibility of support options, and improving inter-provider coordination are essential to address access challenges.

**Service-user journeys through the NGSN vary**, influenced by factors such as awareness, ease of self-referral, and availability of multiple referral channels. There are several initiatives underway that are aimed at diversifying referral channels and integrating services to make sure service-users receive appropriate support, including the MLS funded initiatives, risk stratification tool pilot and other regional board activities. Continued support of these initiatives could help expand access points to support earlier and more frequent engagement.

The system places **strong emphasis on personalisation, offering service-users' choices in treatment type and engagement with relevant non-gambling services**. Feedback mechanisms are well embedded, and providers use this input to tailor support. Increased uptake among underserved groups requires continued targeted engagement strategies throughout the NGSN alongside service adaptation.

**Providers proactively assess local treatment needs** through community engagement, research, and partnerships. In addition to service reviews conducted by GambleAware, internal service reviews are regularly conducted using internal protocols aligned with the Quality Assurance framework – yet clearer links between internal review findings and service improvement (akin to GambleAware service reviews) would strengthen impact. In the future, this is likely to be supported by the introduction of the CQC Inspections.

**Frontline practitioners consistently refer service-users to wider services based on need.** This often takes the form of signposting, empowering service-users to choose whether to take up additional non-gambling support. Additionally, while frontline practitioners demonstrate strong

[2] Source: Annual GB Treatment and Support Survey 2023
[3] As above
[4] As above

technical and interpersonal skills and integration of lived experience, continued investment in training and capacity is key to maintaining high-quality delivery.

## Economic effectiveness of the NGSN system

Using cost-effectiveness analysis, **the NGSN is estimated to be cost effective to the National Health Service (NHS) for both people who gamble and affected others, when compared with care without the presence of NGSN services**. Specifically, NGSN services are estimated to save money (£497 per person) and generate an estimated 0.15 Quality Adjusted Life Years (QALYs) per person for people who gamble, when evaluating over a 2-year time period. For affected others, NGSN services are expected to be cost incurring at £530 per person but produce more health (0.10 QALYs per person) over a 2-year time period (compared with not having NGSN services)**. The additional costs (for affected others) are within the National Institute for Health and Care Excellence (NICE) threshold, which suggests the additional spending is considered good value for money.** However, it is important to note there is currently limited economic evidence for Tier 1 services. While there is a clear theory of change for why Tier 1 is important (to improve awareness and understanding of gambling harms and increase uptake of Tier 2 and Tier 3 services), the evidence available currently does not lend itself to economic outcomes. Therefore, further evidence is required to confirm the findings of this evaluation also apply to Tier 1 services.

Results of the cost-effectiveness analysis for people who gamble are driven by a reduction in hospitalisations, fewer General Practitioner (GP) appointments, and a decreased prevalence of depression. Results for affected others are driven by a reduction in severity of depression.

## Conclusions and recommendations

In conclusion, **the evaluation findings support the clinical, operational and cost-effectiveness of the NGSN system**, in achieving its aim of supporting people experiencing gambling harms. There is also promising work underway through GambleAware funded initiatives to further improve system operations and delivery. The following recommendations, grouped by audience, focus on further opportunities to compliment this work in enhancing equity, consistency, and overall system performance.

### For NGSN Commissioners

1. Continue to invest in strengthening relationships between providers and local services
2. Continue to strengthen referral pathways into and between services
3. Further clarify long-term recovery support expectations across the network
4. Reduce the risk of duplication and promote service diversity
5. Support economic evaluation and outcome monitoring

### For NGSN Providers

6. Continue prioritising and tailoring awareness-raising to minoritised groups
7. Continue to improve inter-provider collaboration
8. Support economic data collection

9. Continue to improve communications around the contribution of Lived Experience

# 2. Background, purpose and scope of the report

## Research background

GambleAware commissioned IFF Research, in consortium with York Health Economics Consortium (YHEC), CECAN Ltd and Dr Sharon Collard, to evaluate the effectiveness of the National Gambling Support Network (NGSN). The aim of the first stage (Scoping) was to develop a Theory of Change (ToC) and Participatory Systems Map (PSM) for the NGSN, and to refine the initial proposal for evaluating the NGSN.[5] The aim of the second stage (Mainstage) was to speak to stakeholder audiences to understand their views and experiences of the NGSN, and to evaluate the operational, clinical and economic effectiveness of the NGSN.

## NGSN context

The NGSN was redesigned and recommissioned in 2023, replacing the previous National Gambling Treatment Service (NGTS). The transformation was designed to meet the growing and changing needs of those at risk of gambling harms in Great Britain, by rolling out a regional-first approach that facilitates additional focus on early intervention, as part of a public health approach. As well as supporting integration across voluntary and statutory organisations, this approach enabled delivery of more targeted support across the life journey model for those affected by gambling harms.

Two other policy changes in the gambling harms support landscape impacted the way the NGSN operates and motivated the need for an evaluation. Firstly, the 2023 White Paper on gambling reform proposed the introduction of a new statutory levy on gambling operators to fund gambling harms research, prevention and treatment.[6] This replaced the previous voluntary funding system.[7] The Government has confirmed that as part of these changes, the NHS will become the sole commissioner of treatment for gambling harms.[8] Secondly, updated 2023 NICE Guidelines have provided evidence-based recommendations for the treatment of gambling harms, which will shape the support provided by the NGSN and the NHS. These changes introduced uncertainty for the NGSN providers and other third-sector support providers. Compounding this, there is considerable need for effective support and treatment for adults affected by gambling harms, with an estimated 1.6 million adults in England alone who are in need of some form of support.[9] Therefore, there is a need to support the NGSN by evaluating and evidencing the delivery of an integrated, high-quality, and cost-effective system between the third sector and NHS, as the NHS specialist clinics start to develop, to ensure people are accessing effective support at the right time.

Following the recommissioning of the NGSN, GambleAware has funded a number of other initiatives. These initiatives were out of scope for this evaluation, but complimented NGSN activities evaluated in this report.

Initiatives included:

- **Care Quality Commission (CQC) reports** developed to measure and ensure the availability of high-quality support services within the NGSN for people experiencing gambling harm.

[5] Evaluation of the Effectiveness of the National Gambling Support Network – Scoping Report
[6] https://www.gov.uk/government/publications/high-stakes-gambling-reform-for-the-digital-age
[7] Statutory Levy
[8] https://www.nice.org.uk/guidance/gid-ng10210/documents/draft-guideline
[9] https://www.gov.uk/government/publications/gambling-treatment-need-and-support-prevalence-estimates/gambling-treatment-need-and-support-in-england-main-findings-and-methodology

- **Aftercare funding** developed to provide resourcing for services and opportunities for innovation and long-term recovery support from gambling related harms, as well as to build the evidence base of emerging and under-invested areas to understand how people who have experienced gambling harm (directly or as affected others) can have sustained recovery.

- **Mobilising Local Systems (MLS) programme** developed to enhance the support system for gambling-related harms in Great Britain by facilitating an integrated gambling-related harms support system, addressing gaps in identification, prevention and treatment.

- **Improving Outcomes Fund (IOF)** developed in response to research which demonstrated increased levels of harm, burden and barriers in access to services which meet the needs of women and people from minority communities.

- **Community Resilience Fund (CRF)** established in response to the cost-of-living crisis to award grants to community-based organisation in England, Wales and Scotland to support and raise awareness about gambling harms.

## Purpose

This report summarises key findings from the evaluation, and provides recommendations for key stakeholders. This evaluation will inform future actions to improve the NGSN's support by assessing its overall effectiveness, providing evidence of its strengths and identifying areas of improvement. Ultimately, this aims to build credibility and a shared understanding of the role of the NGSN in future, supporting a smooth transition between GambleAware and the NHS as the new treatment commissioner and the Office for Health Improvement and Disparities (OHID) as the prevention commissioner.

# 3. Research objectives and methodology

## Research objectives

The objectives of the evaluation were to:

1. Develop a Theory of Change for the NGSN system.
2. Assess the operational effectiveness of the NGSN system.
3. Assess the clinical effectiveness of the NGSN system.
4. Assess the economic effectiveness of the NGSN system.
10. Generate and disseminate learnings and recommendations to GambleAware, NGSN providers, NGSN treatment clients, wider stakeholders and the NHS.

## Methodology

The evaluation has been carried out across three phases:

- **Phase 1: Scoping** took place between June and December 2024.
- **Phase 2: Mainstage** started in January and was completed in October 2025.
- **Phase 3: Final Outputs** were disseminated in December 2025.

The Scoping stage involved developing a Theory of Change (ToC) and Participatory Systems Map (PMS) for the NGSN to inform the evaluation design, and to refine the initial evaluation objectives, research questions and approach to evaluating the NGSN.

The second phase of the evaluation involved conducting a provider survey and provider case studies to measure staff experiences of the NGSN and two contribution analysis workshops. The full breakdown of the participants and sampling approach of the survey and case studies is outlined in Appendix A: Further detail on methodology.

**Table 2. Summary of research activities in Phase 2**

| Method | Aim/Description | Sample / sources |
|---|---|---|
| **Provider survey** | We carried out an online survey of NGSN providers, receiving 134 survey completes across 9 out of the 13 providers in the NGSN. | Staff in frontline service delivery and leadership roles across NGSN providers. |
| **Case study interviews and focus groups** | We conducted online paired leadership depth interviews and online focus groups with frontline practitioners with four case study organisations. The case study organisations were GamCare, Adferiad, Betknowmore, and Beacon Counselling Trust. | 6 staff in leadership roles (strategic lead, treatment manager, director of external affairs, director of support services, business and performance lead, and director of clinical governance and operations) and 19 staff in frontline delivery roles across 4 NGSN providers. |
| **Contribution Analysis workshops** | We conducted two workshops to test the strength of our contribution claims. One of these was with a group of attendees with lived experience of gambling-related harms and the other was with stakeholders from NGSN providers. | 3 GA staff, representatives from 6 NGSN providers and 9 Lived Experience individuals. |
| **Document review** | Building on the document review from the Scoping stage, we conducted a review and synthesis of various documents to assess the operational, clinical and cost effectiveness of the NGSN. | 84 documents in total, which were provided by Betknowmore (38), Beacon Counselling Trust (26), Adferiad (8), GambleAware (1) and GamCare (11). |
| **Secondary data mapping** | We reviewed secondary data relating to the clinical and economic effectiveness of the NGSN. | GambleAware's Data Reporting Framework (DRF). |
| | | The Annual GB Treatment and Support Survey's (2019-2024) carried out by YouGov, the National Statistics on Gambling commissioned by the Gambling Commission.[10] |
| | | The GambleAware Annual Statistics from the National Support Network 2024/2025 report.[11] |
| | | GambleAware's PDC KPI reports |
| **Economic model** | We developed a Markov model which analysed the change in resource use, costs, and health utility of people who gamble and affected others when using NGSN services compared with not using the NGSN services. | GambleAware's Data Reporting Framework (DRF). |
| | | GambleAware's annual reported statistics. |
| | | Literature evidence. |

## Research considerations

**Due to the scope of and resources available for this study, the research design focused on four case studies and did not include in-depth discussions with all providers.** These considerations, anticipated at the outset, were taken into account when selecting the case study organisations. Four NGSN organisations were initially approached based on their geographical distribution and the diversity of support they offer; however, one declined to participate, and an alternative provider was subsequently included.

**Some findings presented in this report are drawn primarily from the case study providers and may not fully reflect the broader NGSN system.** Where findings are not generalisable, this has been clearly noted in the analysis. The evaluation focused on four contribution claims agreed in consultation with GambleAware. The chosen claims were based on priorities highlighted for further investigation in the Mainstage and informed by feedback during the development of the Theory of Change, areas indicated by the PSM process, knowledge gathered throughout the Scoping document review and input from GambleAware stakeholders.

**Levels of engagement with the evaluation differed between NGSN providers, and this impacted the representativeness of staff views gathered from the provider survey**. To mitigate the effects of this, we weighted the survey data based on the number and profile of staff within each provider. We originally received 151 surveys completed across 13 providers, but in agreement with GambleAware, filtered out responses from 4 providers, making the total base for analysis 134 responses across 9 providers. The reasons for excluding responses from 4 providers were as follow:

- Responses from individuals on behalf of two providers were removed because those providers declined to participate in the survey at an organisation level.[12]
- Two other providers were excluded at the analysis stage because it was felt their responses could not be considered representative of the usual operation of the NGSN, as those organisations had only joined the NGSN immediately prior to the survey fieldwork.[13]

**There were limitations to the economic model primarily because of limited Tier 1 and progression data availability. To mitigate this, we stratified costs by treatment tier based on financial dashboard data and published economic evidence.** However, there were some limitations to this method as cost of resources were not reported for Tier 1 or Tier 4. Tier 4 costs were calculated by dividing total budget by the number of applicants reported by Gordon Moody for 2023. For Tiers 1, 2, and 3, two methods were used. The first method assumed that all three Tiers had the same costs, taken from the GambleAware Finance Dashboard Data total budget. The second method assumed that Tier 2 was the average cost of Tier 1, 2, and 3; Tier 3 was micro-costed using resource use; Tier 1 cost was scaled down by the same difference between Tier 2 and Tier 3. More information on assumptions made at Phase 1 are found in Appendix B: Key modelling assumptions.

[10] Annual GB Treatment And Support Survey - GambleAware
[11] Annual Statistics 2024-25 are not yet available online.
[12] 4 responses from GamCare and Gordon Moody were excluded.
[13] 9 responses from EPIC Restart Foundation and 4 from Reframe Coaching were excluded.

**Table 3. Key modelling assumptions for economic model**

| Assumption | Justification | Likely impact on results |
|---|---|---|
| PHQ-9 can be used as a proxy for CORE-10 scores for affected others. | This was due to limited data on costs and health outcomes linked to CORE-10 scores. This exploratory analysis was discussed with clinical experts to validate the assumptions used. | This may result in an underestimation or overestimation of the impact on affected others through use of the services. It is difficult to estimate the direction of the bias for this assumption.<br><br>Various sensitivity analyses were run to provide a range of estimates, given this assumption. |
| PGSI is the most appropriate measure to track treatment benefit for the economic analysis of those who are gambling. | Previous literature has highlighted that PGSI is the most common measure within economic analysis. Furthermore, there is a substantial range of literature stratifying costs and health outcomes by PGSI. We acknowledge that PGSI may be limited to capture true effectiveness. However, at this time, we believe this is the most appropriate measure of benefit for the economic analysis. | If PGSI is less sensitive to improvements in wellbeing that may stem from intervention, then the model may underestimate the true treatment effect. We believe that future evidence should look to stratify economic outcomes by alternative metrics, such as PHQ-9, CORE-10 or GAD-7. |
| Alcohol and substance misuse are not included in the model. | In the literature, correlation rather than causation between these behaviours has been found, suggesting a shared causal factor. | This may underestimate the impact of services to support people at risk from gambling. However, it is preferable to make a more conservative estimate than to potentially overestimate the impact. |
| Impact of aftercare is not included in the model. | Insufficient evidence base for aftercare and the impact it may have on recurrent gambling in the literature. | This is a limitation, as the model will underestimate the continued benefits of aftercare. As above, it is preferable to make a more conservative estimate in the absence of evidence. |
| Assumed that age of T1 service-users is that of T2-4. | Absence of data for Tier 1 in the data provided by GambleAware. | This assumption will have limited impact to the model results as the model does not have a lifetime time horizon. |

# 4. NGSN Theory of Change

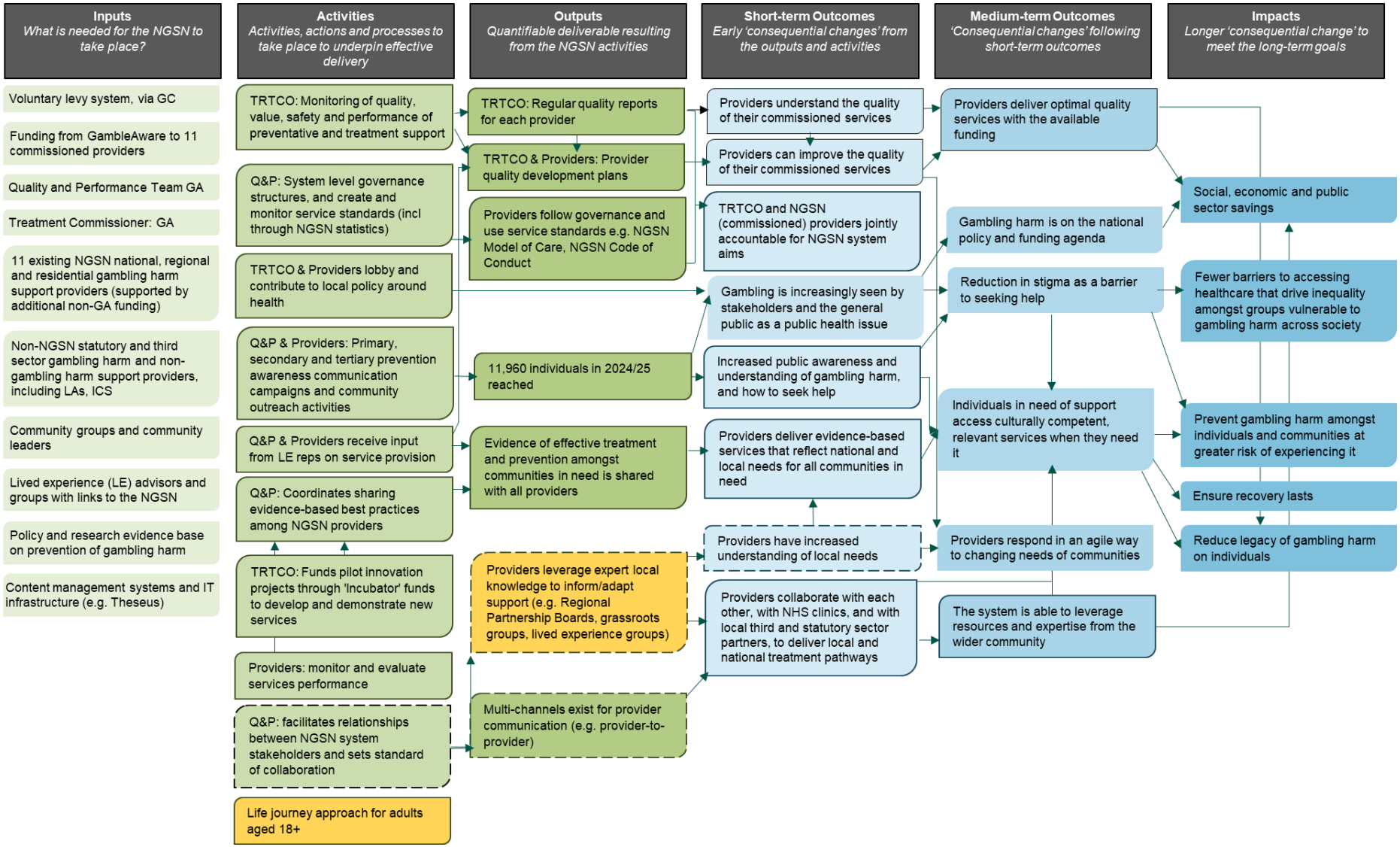
A Theory of Change (ToC) captures our understanding of the NGSN, illustrates the mechanisms for change and how activities are to be translated into impacts.

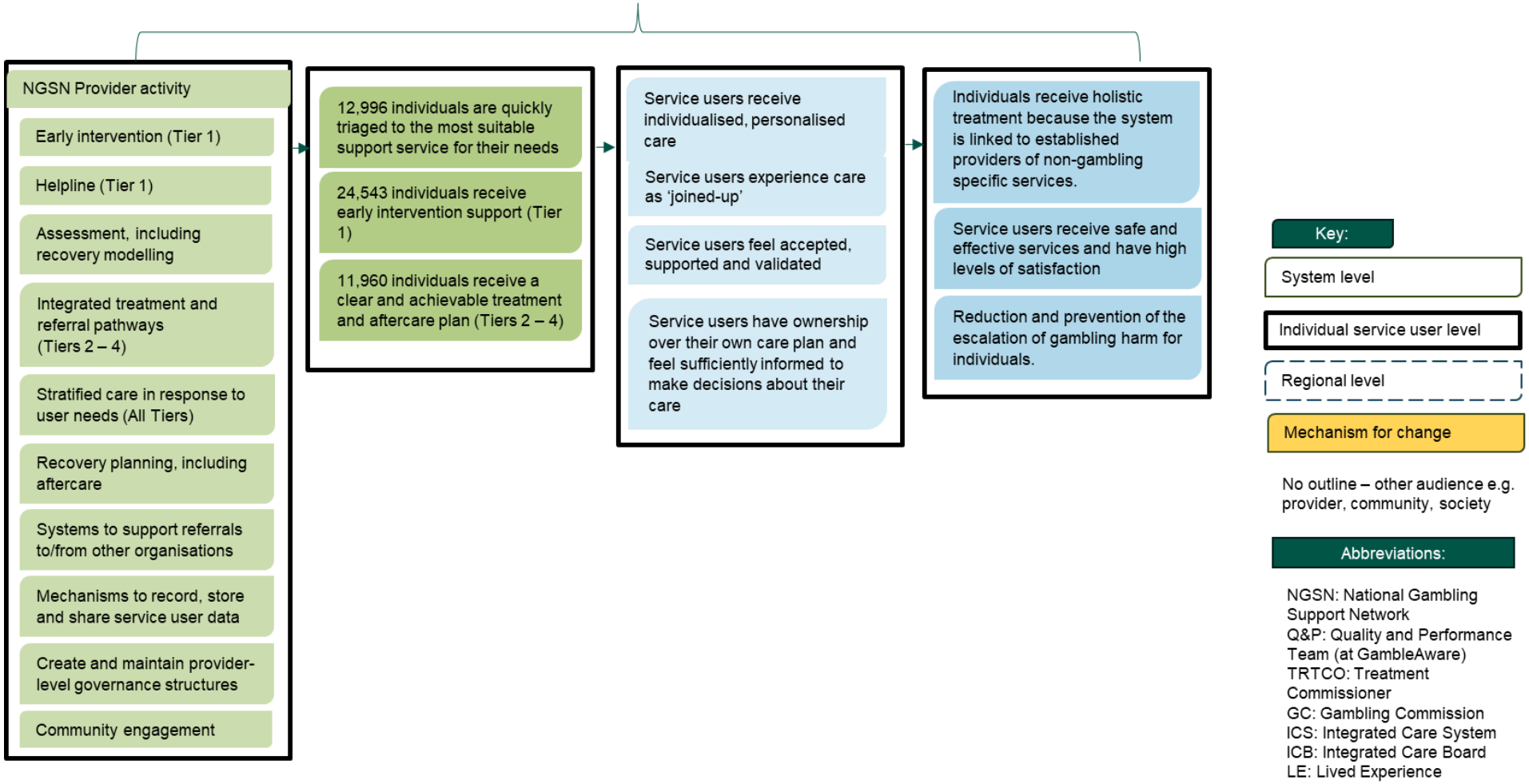
More specifically, it depicts the physical inputs and activities of the programme, the short to medium term outcomes that should be achieved through these processes, and the long-term impacts that should eventually be realised through the programme.

Developing a ToC was a key aim of the Scoping phase as its own deliverable and to inform the design of the remaining phases of evaluation. It has been used to identify contribution claims linking causal pathways that explain how outcomes materialise. We tested these contribution claims through contribution analysis in Phase 2. It is intended that the ToC will also be helpful for those involved in the design and delivery of the NGSN by helping them to understand their delivery model more clearly, identify any potential gaps or opportunities, identify any changes that need to be made, and understand the causal pathways that should lead to positive outcomes.

The final ToC for the NGSN is shown overleaf in Figure 1. The ToC was developed by IFF, in collaboration with GambleAware and some NGSN providers, and informed by key documents and Scoping interviews.

## Figure 1. NGSN Theory of Change




NGSN Provider activity
Early intervention (Tier 1)
Helpline (Tier 1)
Assessment, including recovery modelling
Integrated treatment and referral pathways (Tiers 2 – 4)
Stratified care in response to user needs (All Tiers)
Recovery planning, including aftercare
Systems to support referrals to/from other organisations
Mechanisms to record, store and share service user data
Create and maintain provider-level governance structures
Community engagement
12,996 individuals are quickly triaged to the most suitable support service for their needs
24,543 individuals receive early intervention support (Tier 1)
11,960 individuals receive a clear and achievable treatment and aftercare plan (Tiers 2 – 4)
Service users receive individualised, personalised care
Service users experience care as 'joined-up'
Service users feel accepted, supported and validated
Service users have ownership over their own care plan and feel sufficiently informed to make decisions about their care
Individuals receive holistic treatment because the system is linked to established providers of non-gambling specific services.
Service users receive safe and effective services and have high levels of satisfaction
Reduction and prevention of the escalation of gambling harm for individuals.
Key:
System level
Individual service user level
Regional level
Mechanism for change
No outline – other audience e.g. provider, community, society
Abbreviations:
NGSN: National Gambling Support Network
Q&P: Quality and Performance Team (at GambleAware)
TRTCO: Treatment Commissioner
GC: Gambling Commission
ICS: Integrated Care System
ICB: Integrated Care Board
LE: Lived Experience

The NGSN aims to achieve the intended outcomes (summarised in the Theory of Change) for service-users through activity conducted across systems, regions and individuals. Providers work directly with service-users, therefore most outcomes that are specified at an *individual* level occur because of provider-led activities and outputs. However, the activities that providers undertake, and the way that these are delivered, are guided by *system* level activities and outputs. Therefore, the system level outcomes continuously feed into the way in which individual outcomes manifest. Furthermore, the NGSN intends to take a locally-focused, regional-first approach to service delivery, and as such, the individual outcomes should also be shaped by *regional* activities.

## Assumptions

The assumptions underlying the NGSN Theory of Change are grouped into four key themes:

### Public and societal need for support

- Gambling-related harms may impact on multiple aspects of both an individual's life (including (but not limited to) their relationships, finances, employment, health) and wider communities and society
- Individuals who engage with support want to reduce the level of harm they are experiencing
- There is demand for support amongst those who have experienced gambling-related harm, which can be addressed by NGSN services, and is not already provided elsewhere

### Availability of resources

- There are sufficient resources and funds to meet needs on a local and national level
- There is sufficient clarity and certainty about the future of funding to allow service providers to plan and develop services on a long-term timeframe
- There exists a sufficient network of non-gambling support services for NGSN providers to receive referrals from, and refer individuals onto
- There is capacity amongst staff in third-party organisations to collaborate locally to achieve the NGSN's aims

### Trust and motivation

- There is a base level of trust by the public in the work of the Care Quality Commission (CQC) and the efficacy of gambling treatment services
- There is trust between providers and the treatment commissioner, and the Quality and Performance team that all parties will act in the best interests of service-users
- Individuals and organisations who are part of, or working with the NGSN have the motivation to achieve the aims of the NGSN
- Third-party organisations (other support organisations, public services etc.) trust in the NGSN's ability to reduce the experience of harm from gambling

### Knowledge and understanding

- NGSN staff have the skills, knowledge and capability to deliver a high-quality service
- Third-party organisations have the skills, knowledge and capability to support the delivery of holistic support to individuals who have experienced gambling related harm
- The nuances of gambling support are understood by all parties, so services need to be designed and delivered based on the needs of individuals and communities who have/are experiencing

gambling-related harm (as opposed to being considered as a variation of existing addiction provision, gambling harm services must be approached from the ground up).

# 5. The operational effectiveness of the NGSN system

## Key findings

This chapter presents findings on the operational effectiveness of the NGSN system. It explores staff perceptions of the NGSN's governance structure, the integration of Model of Care principles, and how these and other factors influence the system's overall goal of reducing gambling harms in Great Britain.

- Staff from case study providers felt that the NGSN is operationally effective, but identified several areas where NGSN system operations could be improved to better contribute towards the goal of reducing gambling harms.
- Case study provider staff perceived the NGSN as operationally decentralised (following a regional model), but strategically centralised, supported by core policies and a well-defined vision. Many felt that the governance structure is effective in promoting care for service-users.
- There were five key factors that influenced the operational effectiveness of the NGSN via complex relationships with other factors in the system. These were: awareness of options for help (amongst potential service-users); design and provision of services tailored to diversity of service-user needs; retention of service-users within the NGSN system; monitoring, evaluation and learning of services; and networks and relationships between support organisations. We did not identify any differences in the relevant importance of these factors at a regional and national level.
- Regular contact between providers to share learnings was essential in supporting the system: staff from case study providers felt that GambleAware effectively facilitates this through NGSN working groups, and funding regional collaboratives. However, some mechanisms for sharing learning depended on relationships between providers, which were inconsistent.
- Some provider staff felt that resources could be better distributed across the system. For example, provider-level bidding for outreach and support programme funding can lead to duplication of resources and services, and competition for territory between providers.
- Most staff agreed that local services, and the NGSN as a whole, were informed by the Model of Care principles, especially their work being safe, caring, compassionate, well-led and responsive to service-user needs. Views on integration of Lived Experience (LE) were varied, which could indicate inconsistencies across providers: while LE was felt by some to be well embedded, some staff and LE representatives questioned whether it could be further integrated at executive levels within NGSN providers.

## NGSN governance overview

**GambleAware serves as the national commissioner of the NGSN, setting the strategic direction, defining outcomes frameworks, and allocating funding for prevention, treatment, and support services**. GambleAware's governance is overseen by an independent Board of Trustees (including experts in NHS, public health, and with no ties to the gambling industry), operating under the Charity Governance Code for transparency and accountability. Independent

expert committees, informed by the Lived Experience Council, approve commissioning decisions subject to Board ratification.

**The NGSN adopts a regional-first structure**: providers are organised regionally to deliver locally tailored support, supported by regional boards that include stakeholders such as police, NHS, social care, and community partners.

**GambleAware's Quality and Performance function provides system level governance**, responsible for performance monitoring, quality assurance, and promoting shared standards across providers via outcomes frameworks and consistent policies.

**The NGSN is also subject to Care Quality Commission (CQC) inspection under a tailored framework for gambling harm services**. CQC inspections were rolled out of Care Quality in April 2025 to measure and ensure the availability of high-quality support services for people experiencing gambling harm. Inspections included interviews with leaders, managers, operational staff, office managers and service-users, reviews of their policies and procedures, governance documents and case records, and feedback from GambleAware and other services working with the provider. Inspection reports provided recommendations to providers for their treatment and support services assessed. The introduction of CQC inspections showed progress towards improved governance and monitoring processes by GambleAware, although we were unable to gather evidence on whether recommendations have been implemented by providers as they were recently carried out.

## Provider leadership views on the effectiveness of NGSN governance

**The evaluation found that the governance structure of the NGSN system was broadly effective in supporting operational delivery, promoting collaboration, and guiding strategic alignment**. However, some providers believe that opportunities exist to enhance transparency, improve monitoring, strengthen inter-provider coordination, and embed lived experience more systematically. As this section primarily explores the views of provider leadership among the case study providers, it should be noted that these views may be influenced by the experiences and priorities of providers, and the findings are not necessarily generalisable when taken in isolation.

### Governance structure and strategic alignment

**The NGSN is perceived by case study provider leaders as strategically centralised (led by GambleAware as treatment commissioner) and operationally decentralised (delivered regionally).** The governance model is considered appropriate and aligned with intended roles, with shared policies (e.g. Model of Care, Quality Assurance framework, PGSI use) seen as central pillars of system governance.

**GambleAware was viewed as both a coordinator and facilitator by case study provider leaders.** This is consistent with GambleAware's Quality and Performance team's role of facilitating relationships between NGSN system stakeholders and setting standard of collaboration. **However, some case study provider leaders expressed concern over potential *role ambiguity***, suggesting GambleAware's dual role as commissioner and convener has the potential to create top-down dynamics that may reduce local responsiveness. Clarifying the boundaries between strategic commissioning and operational delivery may help enhance provider autonomy while preserving coherence in the governance of the NGSN.

**Case study provider leaders also felt that working groups and the monitoring processes led by GambleAware were integral to the NGSN's governance structure**. This reflects a good

understanding of GambleAware's role of monitoring the quality, value, safety and performance of preventative and treatment support across the NGSN. However, circumstances within the network did appear to have an impact on the effectiveness of working groups. When the Model of Care group was active, a provider leader flagged that it lost momentum and became ineffective due to the uncertainty around the future of the NGSN at the time. That said, it should be noted that Model of Care training is now being rolled out across the NGSN to help ensure consistency in service delivery and promote service quality.

### Communication and collaboration

**Regular meetings, working groups, and monitoring led by GambleAware were seen by interviewed case study provider leaders as vital to system effectiveness.** These structures support shared learning, alignment, and quality assurance.

**Under the current NGSN governance structure, NGSN providers are responsible for leading on inter-organisational collaboration with other providers**. This is part of the region-first approach undertaken as part of the recommissioning of the NGSN. To enable this transition, GambleAware implemented Regional Boards to support collaboration between NGSN providers. In addition to this, the Mobilising Local Systems programme was implemented to support wider regional integration and collaboration. GambleAware also funded a learning and evaluation partner to disseminate the lessons learned between regional boards and more widely. Provider leaders within case study providers reported building partnerships and referral pathways with other NGSN providers. They noted that doing so was resource-intensive and mentioned that these efforts were often driven by individual members of staff. They valued GambleAware's contributions towards facilitating collaboration, though these perceptions may be outdated given the recent change in governance structure.

**Some provider leaders reported service duplication and gaps in knowledge about partner activity, suggesting that integration varies by region**. Indeed, one provider leader mentioned in an interview that providers are slowly getting more integrated on a region-by-region basis, but that building relationships and referral pathways is very time-consuming because in their experience contracts are established on a case-by-case basis. Where NGSN providers had weaker relationships with other providers in the region, services could reportedly overlap with existing services or take providers by surprise:

*"Services do seem to sort of spring up from the partner network which we don't really have any knowledge of."*

**NGSN Provider Leader**

**Formalising referral processes and creating more structured mechanisms for inter-provider collaboration may help to reduce system inefficiencies and the risk of duplication.** A case study provider leader said that funding can be allocated to projects which conflict with others, while another said that different providers receive funding to target awareness-raising at overlapping populations, which leads to a duplication of efforts and resources. A provider leader suggested that funding could be redirected to smaller services that have been shown to be effective. Another provider leader suggested that more funds could be devoted to expanding Tier 4 treatment options. [1] It is relevant to note here that work is currently ongoing (in collaboration with multiple stakeholders) to support referral processes and the early identification and management of gambling-related harms across the

[1] It is worth reiterating here that these views may be influenced by the particular circumstances of the relevant case study provider and may not be generalisable when taken in isolation.

NGSN. This includes the use of a risk stratification tool which is currently in the pilot phase and is described further below.

For further context, challenges in regional collaboration were also highlighted in a recent report on the MLS funding programme. The report found that the MLS funding programme has helped to improve information-sharing between Regional Board members but that there was room for improvement in wider integration with other organisations. For instance, the report emphasised the importance of 'champions' within key settings like the NHS or local authorities, to lend credibility to the NGSN's efforts and build relationships. The report noted that *'more needs to be done going forward to encourage more cross-agency referrals, deeper joint working and fully integrated service delivery to address GRH'.* The report found that strong relationships between key stakeholders (and maintaining those relationships in the long-term) were key to successful collaboration. This is echoed in this evaluation's findings. For instance, one provider leader mentioned that they had good relationships with the Treatment Managers at other providers. As a result, learnings could be shared informally, as Treatment Managers could comfortably approach one another. Another provider leader remarked that relationships with other organisations were built and maintained by providing accredited training resources, education and programmes on gambling harms. They also highlighted the importance of funding being made available for this purpose.

*"And if that those extra pots of funds weren't available, we wouldn't have been able to do that and we wouldn't have a massive reach across [location redacted]. And it's because of those partnerships that we're able to build and that covers the Tier 2 work and Tier 3."*

**NGSN Provider Leader**

That said, another case study provider leader flagged that their organisation was given funding to raise awareness of gambling harms support for a specific group, but that this group could overlap with another group (namely marginalised communities and women), for whom awareness-raising activities were being conducted by another provider. There was therefore a concern of 'stepping on someone else's toes'. This suggests that funding pots should be combined with clear governance on how to manage overlap between populations.

*"It's very difficult because I'd never turn anyone away... there's been a lot of crossover, it was identified that they needed to improve outcomes for marginalised communities and ladies, but one pot was given to [Provider] and one pot was given to us. But we might have seen a marginalised community come into the raising awareness for women, because if you're going to go and target a woman's group, that might be from a marginalised community. But are we stepping on someone else's toes?"*

**NGSN Provider Leader**

One provider (with multi-stakeholder collaboration and support) was leading the development a digital risk stratification tool to support early identification and management of gambling-related harms. This tool combined PGSI, CORE-10 and clinical indicators of gambling harms into a 'clear, non-stigmatising framework' and was aligned with NHS digital standards and designed for use in primary care and the third sector. Once rolled out in October 2025, this tool could further streamline the process of building referral pathways between NGSN providers and support the early identification, management and referral pathways of users of the NGSN system.

### Monitoring, performance and use of data

**Case study provider leaders interviewed believe the system has effective mechanisms for monitoring quality and performance.** 13 of the 16 NGSN leaders surveyed agreed or strongly agreed that the NGSN has effective mechanisms for monitoring performance and fostering collaboration between providers (just 1 disagreed and 2 neither agreed nor disagreed).[2] However in an interview, one case study provider leader indicated that the implementation of the Model of Care principles could be more consistently monitored across the network (they mentioned that they themselves had internal procedures to monitor this but nothing which was mandated by GambleAware). Since this interview was conducted, training on the Model of Care has been rolled out across the NGSN to help ensure consistency in service delivery and promote service quality. Alignment with the Model of Care is included in quality reviews conducted by NGSN providers, so the impact of this training will be monitored moving forwards.

**Measures such as PGSI and Core-10 were viewed by some case study provider leaders as limited in clinical utility**, particularly for short treatment durations, though recognised as useful for economic evaluations. One provider leader said that because PGSI is based on the last 12 months and service-users only receive support for 6-8 weeks, so they wouldn't expect to see a change if using the PGSI literally (since the majority of the last 12 months would not have changed). It should be noted however that NGSN providers do not measure PGSI over 12 months. This same provider leader suggested it would be helpful to use the 'outcome star' system, mentioning it was a good basis for clients. Provider leaders generally did not have any specific recommendations for suitable measures to replace PGSI and Core-10: however, work is currently underway to develop a suite of new validated measurement tools, the Gambling Harms Scale Initiative. These measurement tools have been co-designed by those with lived experience to ensure they are acceptable to service-users, and have been developed with rigorous psychometric testing to ensure they accurately measure aspects of gambling harms.

### Transparency and accountability

**Case study provider leaders interviewed had limited awareness of specific oversight relating to their own ethics, whistleblowing, and financial management policies. However, they were aware of the Quality Assurance Framework; one provider leader mentioned the move towards ensuring all providers receive and pass an inspection from the Care Quality Commission (CQC).** In a depth interview, one provider leader raised a conflict of interest for a provider within the network regarding referrals but did not mention any plans to raise this with GambleAware. Combined with limited awareness of oversight on such matters among provider leaders, this could suggest that providers do not consider this a facility of the NGSN. GambleAware could communicate to providers that solving such conflicts falls within its purview, and encourage them to step forward in such cases (assurances of anonymity may be required). Contractual measures could be taken to ensure that referrals are managed as intended.

*"That is an obvious conflict of interest when you are both provider of services and you are [referring]…to other providers given they are a national provider […] that can cause friction then within the network."*

**NGSN Provider Leader**

[2] Provider survey: Extent of agreement with the following statement: C2.3: *The NGSN has effective mechanisms for monitoring performance of provider organisations. Base: All leadership staff (16)*

### Inclusion of Lived Experience

**There were some mixed opinions between different audiences in the evaluation on the extent of NGSN provider engagement with lived experience groups.** According to representatives with lived experience, provider engagement can vary significantly across the system. LE representatives that took part in a focus group suggested that some providers didn't want to engage with them because of a concern that service issues would come to light and they would be held accountable. They also felt that there was a disparity between providers in the extent to which lived experience was embedded into the training, administration, frontline peer-support and how lived experience skills were utilised. LE representatives recommended formal inclusion of lived experience on NGSN provider Boards of Directors to ensure services are responsive and grounded in user insight.[3] On the other hand, when asked about the extent to which the principle of 'Harnessing the lens of lived experience' was embedded in practice, all provider leaders surveyed agreed that services were informed by the views of people with lived experience. Frontline practitioners in case study interviews also reported that they used the lens of lived experience whilst delivering support, though some felt this could be scaled up in day-to-day practices. This suggests that lived experience does inform NGSN services, but that the scale and manner of this is not necessarily consistent across the NGSN system. It should be noted that organisations built on peer support as the central service offered are better positioned to further integrate lived experience to day-to-day support, but other providers could further develop their offering with knowledge of what works among these organisations.

NGSN providers could consider being more forthcoming and transparent about the ways in which lived experience currently informs service delivery within their organisation, particularly including how lived experience feeds into decision-making.

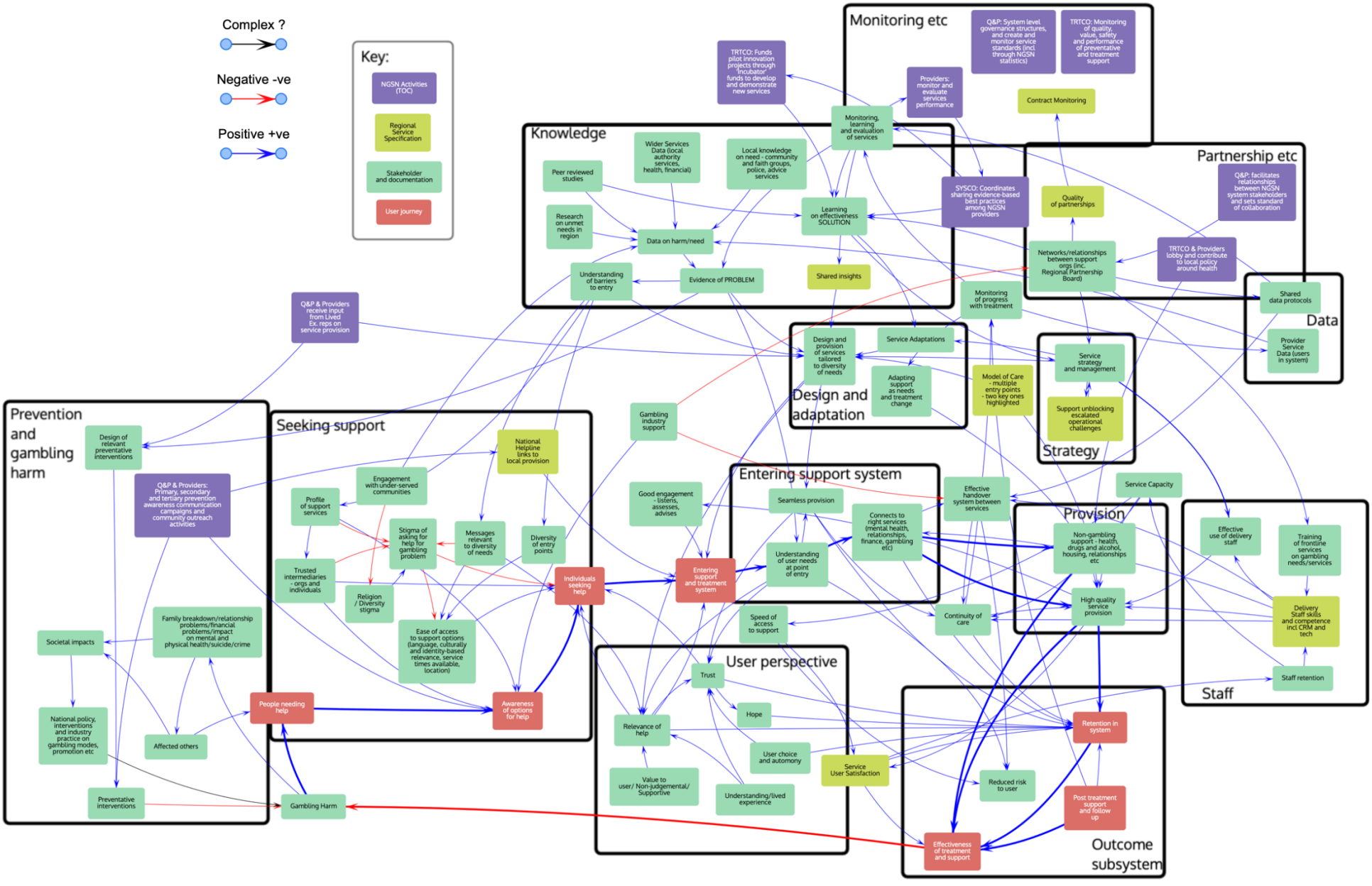
## Factors affecting the NGSN system's ability to reduce gambling harms

In the Scoping stage, a Participatory Systems Map (PSM) was developed to create a visual representation of the factors that influence the system's ability to reduce gambling harms, and the causal relationships between these factors. It was developed by CECAN Ltd in consultation with GambleAware staff and provider and lived experience representatives, through a series of workshops and interviews. Further detail on how the PSM was developed can be found in Appendix A: Further detail on methodology.

The PSM is overleaf in Figure 2, and can also be viewed at: https://www.prsm.uk/prsm.html?room=TME-BLM-ILG-KJQ&copyButton, which allows a more dynamic exploration of the detail of the map by zooming in and out.

[3] It is worth noting that in some cases there is someone with lived experience on the Board of NGSN providers but they choose not to make this information public.

**Figure 2. Participatory Systems Map: The systems driving the NGSN's ability to reduce harm among target groups**



In the Scoping stage, we identified five key factors which the PSM, along with qualitative information that we collected, suggested are important in relation to NGSN operational effectiveness, and its ability to reduce gambling harms. These factors were:

- Awareness of options for help (amongst potential service-users)
- Design and provision of services tailored to diversity of service-user needs
- Retention of service-users within the NGSN system
- Monitoring, evaluation and learning of services
- Networks/relationships between support organisations

In the mainstage, we explored the importance of each of these factors and the relationships between them, through the provider survey and qualitative interviews with staff. **Mainstage findings revealed that the five identified factors had complex relationships with a number of wider factors, some of which are included in the PSM. Therefore, to understand how factors contribute to the operational effectiveness of the NGSN, they must be examined in the context of other factors that influence them, and that they influence**. In this section, we have included staff perceptions on the salient relationships between factors and their contribution to the operational effectiveness of the NGSN, and the system's ability to reduce harm.

In the provider survey, leadership and frontline practitioners ranked the success of each of the five factors identified through the PSM, both at a regional and national level. The results are included in Figure 13 and Figure 14 in the appendix. **The ranking of factors at a regional and national level were very similar**. This may indicate uniformity in the delivery of the NGSN between regional levels and the national level.

### Relationships between support organisations facilitate shared learning and improvement of services

**Networks and relationships between support organisations contributed to the operational effectiveness of the NGSN through fostering collaboration**. Under the current governance structure, regional boards are responsible for building relationships between providers and support organisations in the region, whilst quality and performance monitoring, as well as the sharing of learnings are internal functions within the NGSN, sit with GambleAware. This evaluation found that collaboration created opportunities for sharing of best practices and learnings to improve services across the system. There were several mechanisms through which the NGSN supports the development of these relationships and therefore collaboration: **however, some inconsistency indicates that there is room to further optimise this causal pathway to support reduction of gambling harm**.

One of the more formal mechanisms for facilitating collaboration were the NGSN working groups, such as the Shared Learning and Quality Forum. These working groups create a space for leadership staff to discuss challenges and best practices. **In depth interviews, leadership staff from case study providers were divided on how effective they felt the working groups were in bringing about improvements to services**. Some felt they were effective and were able to provide examples of the positive impact working groups have had on service delivery: for example, one leader adopted tools for engagement with neurodivergent service-users that another provider had developed and brought to an NGSN working group.

*"A lot of us now are sitting on all of these groups to share best practice: what works well, what doesn't, what keeps you awake at night, how to deal with complaints so that we're all working towards the same model of care... they've got a lot of systems in place that providers can share learning...I don't think there's anything that I feel that's less effective. They all have their place and they're all done to a timely manner."*

**NGSN Provider Leader**

However, others felt that the working groups fell short of translating into actionable changes to improve the quality of services delivered – suggesting that **the positive impact of NGSN working groups was not felt consistently across the system**. Therefore, there may be a need to optimise the impact of working groups: for example, by supporting providers to create action plans with actions clearly assigned to attendees to increase accountability in implementing learnings. While providers would be responsible for developing action plans and instigating follow-up in the long-term, the System Commissioner could provide initial administrative support to embed such processes in working groups, and steer expectations for accountability.

**GambleAware also facilitated sharing of learnings and collaboration through funding specific initiatives and regional collaboratives**. For example, the Mobilising Local Systems (MLS) funding programme aims to strengthen partnerships between NGSN providers and other local partners, notably through setting up Regional Boards. Regional Partnership Boards were set up to support the integration of provision with local partners. They aim to provide a setting for stakeholders to collectively identify local needs, align activities and make strategic decisions about focus. Learning events were organised as part of an independent evaluation of the MLS programme, with the aim to give regional and national boards an opportunity to meet, share future plans and build a learning community. A GambleAware report on the MLS funding programme found that the funding had a positive impact on improving collaboration and sharing of ideas between support organisations. Another example is the Aftercare funding programme, where 10 organisations were granted funding to deliver long term recovery support services. The independent evaluation of this programme enabled participating organisations to share strategies for overcoming challenges (e.g. low referrals), discuss outcome reporting and learn from each other's experiences.

In a depth interview with leadership staff at Beacon Counselling Trust, they discussed **the 10-Poin-Plan as another example of an initiative that supported collaboration with NGSN-internal and external stakeholders**, with the common goal of reducing gambling harms.

**Spotlight: Collaboration between NGSN providers and external organisations to reduce gambling harms – The 10-Point-Plan**

Beacon Counselling Trust has worked with Betknowmore, other NGSN providers and external stakeholders to develop the 10-Point-Plan to address gambling related harms. Funded by GambleAware, the aim of the 10-Point-Plan was to tackle gambling related harm through building awareness (especially in frontline practitioners and vulnerable groups), developing early intervention and common referral and long-term recovery pathways, increasing screening, and improving data collection. A key component of this was encouraging local organisations and public health bodies to adopt gambling harms into their own frameworks, which Beacon Counselling Trust has supported through development of training towards their Workplace Charter Programme. The 10-Point-Plan was adopted by various local councils, and endorsed by the CQC. **This is a clear**

**example of how the NGSN has supported the development of relationships between organisations through facilitating collaboration, with the goal of raising awareness and ultimately contributing towards reduction of gambling harms.**

*"The best, the most innovative way [that NGSN mechanisms have driven innovation] has been the pieces of work that GambleAware have funded that have encouraged that collaboration across the partners, and the 10-Point-Plan is a good example of that. We were given funds by GambleAware to work with Betknowmore and other providers within the network to offer an aftercare programme to our service-users."*

**NGSN Provider Leader**

Learning was also shared informally between individual providers. **This mechanism for collaboration was dependent on individual relationships and trust between providers**. Some leadership staff in case study providers said they weren't aware of any 'informal' sharing of learnings, suggesting that this was not consistent across the system. Furthermore, some indicated that individual relationships, and **therefore openness to collaboration and sharing of learnings, varies across the system**. While the MLS fund went some way to improve multi-agency partnership, findings from the mainstage suggest that there may be more work to be done to facilitate the development of trusting relationships across the system.

*"Obviously some partners are closer than others. I think there is a high degree of trust between some of the partners, and there is less trust maybe [between others]."*

**NGSN Provider Leader**

### Relationships between support organisations create stronger referral pathways and individualised treatment

**Networks and relationships between provider organisations were also key in facilitating referral-pathways throughout the system, in turn ensuring service-users receive appropriate support. The NGSN supports the effectiveness of this causal pathway:** in depth interviews, some staff at case study providers indicated that referral pathways between NGSN providers had become more effective over time because relationships between providers had become stronger (through monthly provider meetings, for example, to discuss referrals). Staff at Adferiad, for example, expressed that their referral of residential service-users onto the peer support programme offered by EPIC Reframe was supported by the relationship and collaboration between the two providers. This highlights the importance of facilitating trusting relationships between providers across the system, to ensure that service-users receive the full range of appropriate options for treatment.

*"Initially the person contacts maybe the helpline and then the support network kicks in from there. They'll assess what's the best support for them, whether it's counselling services, therapy services, whether it's affected others, whether it's residential, whether it's home support, we get referrals in from all those networks to see what's best to help the person initially."*

**NGSN Frontline Practitioner**

### Effective resource distribution could optimise awareness-raising and service provision

Potential service-users' awareness of support for gambling harms was a crucial upstream factor in ensuring they can access support they need to prevent escalation of harm. Tailoring of services was also essential in making sure support is relevant and therefore effective in retaining service-users. Both factors require resource and funding to drive awareness-raising and improvements to service delivery. Indeed, a central aim of the redesign of the NGSN to a regional-first commissioning structure was to support effective funding distribution to facilitate targeted engagement with services. As the redesign was relatively recent and still in the process of bedding in across the NGSN, this evaluation may not have captured the full impact of this. **However, in depth interviews, leadership staff at case study providers had different views on the effectiveness of the way in which funding is allocated, indicating suboptimal operational effectiveness in these causal pathways.**

**Some case study provider leadership staff felt that the process of bidding for funding for awareness-raising and support development initiatives was appropriate**, and that GambleAware generally allocates suitable resource to achieve success.

*"We will see where there's more resources needed and nine times out of ten, GambleAware have been there in support of that and give us that extra funds to fill the gaps where we're maybe not covering in terms of our education offer. There is an element of trust there, that they will support us wherever they can and hopefully they know that they will get the outputs from us."*

**NGSN Provider Leader**

**However, others felt that bidding at a provider-level created the risk of overlapping awareness-raising efforts and provision of tailored support, duplicating resources and creating competition between providers.** One case study lead reported that providers are awarded pots of money to raise awareness amongst different groups of people, but in reality, those groups are intersectional, leading to territory encroachment between different providers, and duplication of efforts. Some staff in the provider survey also felt that there was a lack of diversity of tailored support options, partially due to the way that funding is allocated, leading to duplication and competition between providers. While some leadership staff reported that this is mitigated through regional collaboratives (such as the 10-Point-Plan), contradicting opinions suggest that this is not consistently experienced across all regions within the NGSN.

*"The funding set-up and dispersal of funds has created division and in-fighting within the NGSN, instead of being researched thoroughly and the money used to grow collaboration between services. Many providers will provide identical services, wasting much needed funding through fighting each other for share of space and revenue, rather than working together."*

**NGSN Frontline Practitioner**

**Commissioning more awareness-raising efforts and service tailoring at a *system*-level (as opposed to provider-level bidding) could help to prevent duplication of resources, while also encouraging collaboration and relationship development between NGSN providers.** This in turn could influence the success of other factors that flow from networks and relationships between support organisations, such as service strategy and the design and provision of tailored support – strengthening the operational effectiveness of the NGSN.

### Staff retention, shared data protocols and lived experience contribute to the quality of services and retention within the system

Most factors in the PSM converge on retention of users in the system: if service-users are not retained and engaged in support, then the NGSN cannot achieve its goal of reducing gambling harms. In depth interviews and the provider survey, **staff emphasised several factors that influence the system's ability to retain service-users**:

- **Staff retention:** staff felt that delivery of high-quality services depends heavily on retention of competent staff, especially those with diverse skills and expertise, so that a range of treatment options can be provided, tailored to service-user needs. Some staff flagged that staff retention may be negatively impacted by the current funding uncertainty; it will be crucial to support retention of existing staff when transitioning to the new commissioning structure.

- **Shared data protocols:** some leadership staff disclosed that providers across the NGSN don't currently use the same data platform for managing service-user data. This makes it difficult for data, and therefore service-users themselves, to be transferred from one provider to another within the system.

- **Harnessing lived experience:** staff commented that involvement of lived experience is an important factor upstream of offering tailored options for support: both to understand needs for tailoring, but also to act as matched peer supporters to make support more individualised. While many staff felt that that lived experience is embedded within practices, some responses to the provider survey suggested that lived experience is not being integrated to its full potential and there could be greater inclusion of the voice of lived experience in strategic decisions at an executive level. On a related note, many lived experience representatives felt that there were disparities in the extent to which their views were represented and utilised across NGSN providers. They cited that there was inconsistent representation of lived experience at the executive level between NGSN providers, though it is worth noting that some senior leadership members may not have disclosed any lived experience of gambling harms. This suggests some mixed perceptions around the embeddedness of lived experience, with potential scope to further embed this consistently across the NGSN system.

## Integration of NGSN Model of Care principles

### The Model of Care

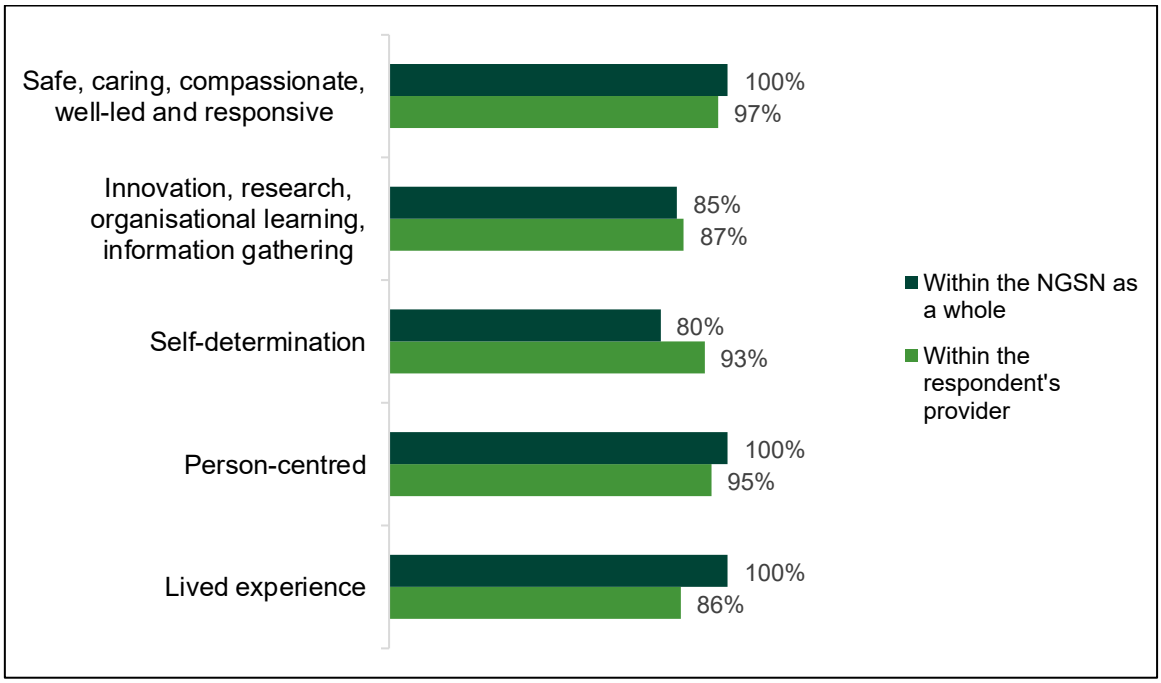
The Model of Care principles underpin the delivery of the NGSN and are intended to be embedded in the NGSN system across all providers. The principles are:

1. Harnessing the lens of lived experience
2. We are person-centred
3. We promote self-determination
4. Advancement through innovation, research, organisational learning and information gathering
5. We are safe, caring, compassionate, well-led and responsive to our service-user needs

**Generally, NGSN staff felt that the structure of provider organisations and the type of support they offered were shaped by NGSN Model of Care principles.** However, not all providers embedded the principles in a formalised way. In-depth interviews with case study frontline practitioners revealed a mixed picture: some reported receiving explicit training on the Model of Care principles, whilst others felt the principles were naturally embedded within their culture. Although survey responses showed high agreement with the principles, depth interviews with case study providers suggested that they did not always perceive consistent implementation across the NGSN system. Some providers noted that they had not yet embedded the principles in a formalised way, although the rollout of Model of Care training is now underway and expected to support more consistent delivery across the NGSN system as a whole.

This contrast may reflect differences between formal organisational commitments and staff experiences of delivery, as well as variation in how the principles are applied in practice. NGSN staff felt strongly that the work they were involved in delivering day-to-day was informed by each of the Model of Care principles, and that their own organisation championed them. In the provider survey, leadership staff were asked the extent to which they agreed or disagreed that each Model of Care principles were upheld across the NGSN system, and frontline practitioners were asked the same question relating to delivery of day-to-day services. Agreement levels for all principles were high, ranging from 80% to 100% for each statement. Taken together, these findings suggest that while the principles are widely endorsed and recognised across the system, the extent of their implementation may vary between organisations and roles.

**Figure 3. Percentage of agreement that each Model of Care principle is upheld across the NGSN and within the respondent's organisation**




*C5/6. Please rate the extent to which you agree or disagree that the NGSN system as a whole… C5: Base: All frontline practitioners (109) C6: Base: All leadership staff (16)*

### Principle 1: Harnessing the lens of lived experience

Overall, staff felt that **lived experience was crucial to understanding the service-user journey and experiences.** When asked about this principle in the provider survey, all 16-leadership staff agreed that services were informed by the views of people with lived experience across the NGSN

system. Similarly, in the case study interviews with leadership staff and frontline practitioners, there was particular emphasis on the role of lived experience and sharing of research across the NGSN as contributing to the holistic approach they offered. Frontline practitioners in case study interviews felt that they used the lens of lived experience, but some thought that learnings from experience could be drawn upon more in their day-to-day practices. A few frontline practitioners and provider leaders mentioned in the case study depth interviews that their organisation specifically built on the perspectives of those with lived experience, although **this principle did not appear to be formalised or taught in training by many NGSN providers and lacked consistency of approaches across providers.**

*"BCT's [Beacon Counselling Trust] Lived Experience Alliance feeds into the quality assurance of our treatment and recovery programmes. The LEA are consulted at every touchpoint of the development on BCT gambling harms programmes, to ensure we have a lived experience perspective throughout our service delivery."*

**Quality Assurance Booklet, Beacon Counselling Trust**

However, whilst, frontline practitioners and staff highlighted the lens of lived experience as prevalent in organisational culture and approaches to support, **some individuals with lived experience felt that further progress could be made in embedding this perspective throughout the system.** Specifically, they suggested that providers should empower service-users to support others at the end of their treatment, as this could aid their transition to life without gambling and reduce the risk of relapse. Additionally, having a lived experience representative in high positions within provider organisations would help ensure that support remained relevant and effective for users. However, lived experience individuals also noted that recruitment for such advisory roles is hindered by low pay, which was a barrier to recruitment.

### Principle 2: We are person-centred

All 16 leadership staff that took part in the survey agreed that the NGSN as a whole was person-centred, and 94% of frontline practitioners agreed that the work they delivered day-to-day was person-centred. **In depth interviews within case study providers, staff emphasised the importance of offering a person-centred, holistic approach to service-users** and were able to evidence this with documents. For example:

- **Adferiad** shared a report as part of the document review that described their personal plans for service-users to ensure that their services were person-centred. The personal plans were reported to be detailed and demonstrated a thorough assessment of individuals' backgrounds, language and culture, strengths, weaknesses, current situation and history. Adferiad also shared documents to show how feedback was collected from service-users to shape their approach, such as a settling-in questionnaire, satisfaction questionnaire and group session questionnaire.

- **GamCare** showcased their person-centred approach by providing a case study of a service-user that contacted their email support team, having previously tried online chat forums and NHS support, neither of which he felt had met his needs. GamCare offered online or telephone support and talked through treatment options including blocking software, self-exclusion and face-to-face treatment. As a result of support, the service-user reported not gambling for 20 days and 12 hours, their longest ever period, as well as improvements in relationships and finances.

### Principle 3: We promote self-determination

Self-determination can be understood as equipping service-users with a combination of skills, knowledge and beliefs including self-awareness, self-advocacy, choice making, self-management, decision making, self-efficacy, and goal setting and attainment.

In the provider survey, 80% of leadership staff agreed that the principle was embedded in the NGSN system as a whole – which was the lowest level of agreement of all the Model of Care principles among leadership staff. **Some frontline practitioners expressed confusion around what was meant by self-determination and struggled to determine whether it was embedded within their organisation and the NGSN as a whole.**

However, some case study providers were able to evidence their work as supporting self-determination among service-users through evaluation reports shared during the document review. For example:

- A 2024 Care Inspectorate Wales report shared by **Adferiad** highlighted how they promoted self-determination by giving service-users control and choice over their daily routines and the therapeutic sessions they attend.
- A case study shared by **GamCare** showcased how they helped a service-user become self-aware and make decisions to control their gambling urges.
- An evaluation report of **Betknowmore's** New Beginnings service showed they had encouraged service-users to take accountability for their recovery process, build confidence to share their recovery story with others, and develop coping strategies for gambling urges.

### Principle 4: Advancements through innovation, research, organisational learning and information gathering

**Advancement through innovation, research, organisational learning and information gathering was thought by NGSN practitioners and leadership to generally be practiced well, and they felt their organisations were receptive to new learnings**. In depth interviews, some provider staff also mentioned involvement in different research projects with other providers in the NGSN and external organisations, such as university research studies, to increase knowledge and understandings of gambling harms.

**Some frontline practitioners from case study providers felt that although collaboration and sharing of learnings across the NGSN was key in upholding Model of Care principles, some providers were more willing to share learnings than others.** Some staff indicated that other providers were reluctant to share learnings and felt that the NGSN system lacked the uniformity to do so as providers use different data collection systems. For example, in case study interviews, providers mentioned using different data systems and ownership models which made it difficult to consistently share and collect data between providers because of data ownership and anonymisation policies.

*"[Provider] has its own systems of reporting, and they are happy to share wider through the NGSN but then there is a standard operating procedure on how to report. Support system should be more about learning, not policies they all have to follow."*

**NGSN Provider Leader**

Staff also said that collaboration with other providers made it easier to disseminate new learnings and helped providers to direct service-users to other services. However, some leadership staff felt that it was **hard to get everyone in the NGSN to agree on the same pathway across the network**. Similarly, some frontline practitioners felt that **information gathering and sharing across the NGSN system lacked consistency** despite the value of each provider bringing different values and experience that would be beneficial to share.

One way in which advancements through innovation and research were demonstrated at a system level is through the Improving Outcomes Fund (IOF). The IOF was a fund developed in response to research conducted by GambleAware that found increased levels of harm, burden and barriers in access to services which meet the needs of women and people from minority communities. This fund drove change in support for these groups by investing in activities that reduced inequalities in gambling harm across all three nations of Great Britain. Innovative new ways of working that were proven to be successful during these projects were then showcased and informed the wider support system on ways to better meet the needs of women and minority communities.

**In depth interviews, frontline practitioners from case study providers perceived that organisational learning was implemented by leadership through quality controls, service-user feedback and three-month follow ups** with service-users to give opportunities for constructive feedback to improve services. For example:

- **GamCare** leadership shared that they conduct monthly reviews with helpline advisors to reinforce best practice and provide training, guided by emerging trends they observed and any recent safeguarding issues they had needed to respond to. Additionally, 10% of work was quality controlled every month to ensure support was being dealt with effectively. GamCare leadership staff felt that they were reactive to training issues uncovered from quality checks and quickly developed training to disseminate learnings.

- **Adferiad** leadership said they gave practitioners reflective time after each one-to-one session with service-users and met regularly with team leads to discuss what was working well in the services to share good practice.

- **Beacon Counselling Trust** leadership mentioned that they had been looking into the black market and illegal gambling to broaden their knowledge. However, another case study provider shared concerns in depth interviews over the unpredictable nature of the gambling market and the speed at which knowledge needs to be updated on emerging financial platforms such as Cryptocurrency.

### Principle 5: We are safe, caring, compassionate, well-led and responsive to our service-user needs

**The principle of being safe, caring, compassionate, well-led and responsive to service-user needs was felt to be at the centre of everything providers do.** These themes were mentioned spontaneously in interviews with frontline practitioners from case study providers when they were asked what they thought the principles were, and most frontline practitioners in the provider survey (97%) agreed that this principle was lived in day-to-day services. **Practitioners from case study providers also highlighted the value of having a workforce with diverse skills and expertise, noting that this helped foster shared learning and enabled a broader range of support for service-users.** However, the extent to which provider workforces were diverse and representative of the local community was less clear. Some frontline practitioners and staff at case study providers expressed uncertainty about whether this was evident within their organisation, and individuals with

lived experience raised questions about how well providers understood and responded to the needs of LGBTQ+ and neurodiverse communities.

These reflections suggest that while the core principles are strongly embedded in practice and widely endorsed, there remains an opportunity to strengthen inclusivity and representation across the system. Building on existing strengths, and developments initiated under programmes such as the Improving Outcomes Fund, providers may benefit from clearer strategies and data to ensure that services are responsive to the full diversity of the communities they serve.

## Specialist knowledge and skills in the NGSN system

**Staff emphasised the importance of having specialist skills and knowledge to effectively carry out their roles**, with 93% of those surveyed agreeing that they possess the necessary competencies to manage their day-to-day responsibilities.[1] Documents shared by case study providers illustrated that NGSN staff were required to have relevant qualifications, an understanding of the gambling harms landscape and soft skills such as empathy and active listening.

**Spotlight: Beacon Counselling Trust's interview matrix**

An interview matrix that Beacon Counselling Trust use to recruit frontline practitioners laid out the following requirements:

- Demonstrated understanding of gambling, addiction, treatment, recovery pathways, suicide bereavement and mental health diagnoses.
- Previous experience in a similar role of managing and mitigating clinical risk and safeguarding concerns.
- Relevant Level 3-4 health and social care or counselling qualification

As is shown in Figure 4 below, in the provider survey frontline practitioners were asked to describe their level of skill in seven areas related to their role. Around 8 in 10 (82%) frontline practitioners felt that they had a 'specialist' level of skills in understanding different gambling types and how they can impact people (including affected others, family and community), and in tailoring support they provide to the needs of individuals and groups (80%). Fewer frontline practitioners, however still a majority, felt they held 'specialist' level skills in organising and delivering health promotion to patients and the wider population (58%), and in delivering trauma-informed treatment and management for people affected by gambling harms.

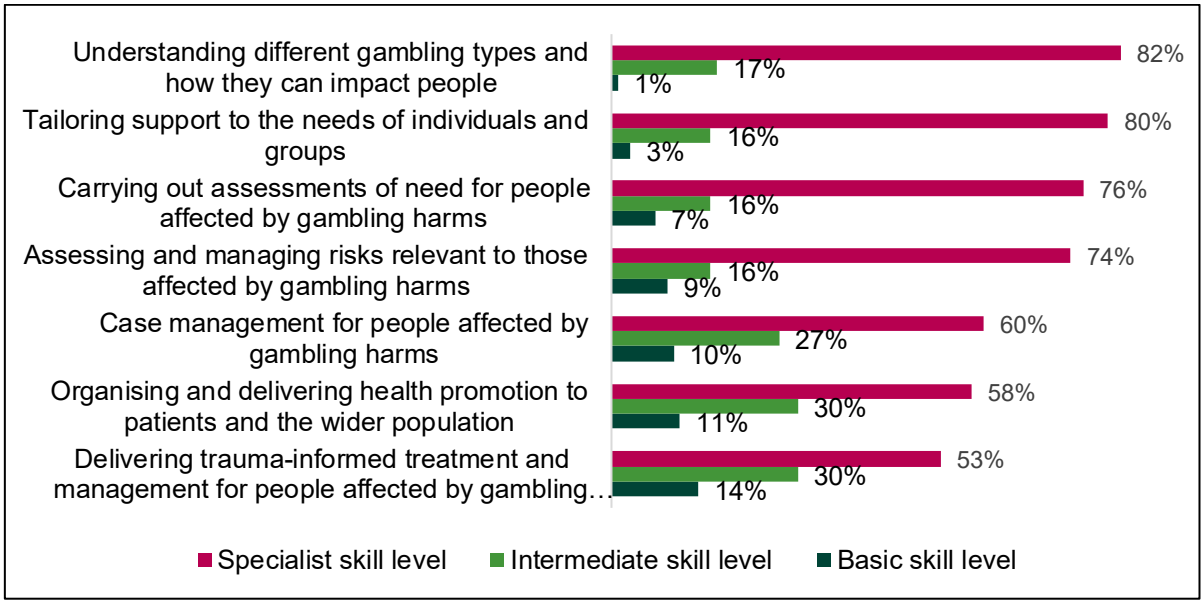
Most staff (86%) agreed that the organisation they work for supported to upskill them and provide training and learning to understand the sector and gambling harms.[2] Most providers also offered on-the-job training, and the majority of staff (83%) in the provider survey had attended continuing

[1] A11.2 To what extent do you agree that "I have the skills to be able to perform my day-to-day responsibilities" Base: All staff (134)
[2] A11.1 To what extent do you agree that "The NGSN organisation I work for supports me to access training that helps me do my job effectively." Base: All staff (134)

professional development courses to improve their skills.[3] Therefore, there was evidence from the provider survey that staff felt supported in up-skilling and providers were able to uphold the Model of Care principle of advancement through organisational learning.

**Figure 4. Subjective skill level in areas relevant to role**

*A12. How would you describe your skill level in the following areas? Base: All frontline staff (109). Excluding Don't Know responses.*




*A12. How would you describe your skill level in the following areas? Base: All frontline staff (109). Excluding Don't Know responses.*

[3] A9. In the last 12 months, have you attended any Continuing Professional Development (CPD) opportunities or training programmes related to your role, which were funded by your provider organisation? Base: All staff (134)

# 6. Clinical effectiveness of the NGSN system

## Key findings

This section aims to assess the clinical effectiveness of the NGSN as a system. This includes detail on the types of service-users eligible for and accessing support across NGSN regions and tiers, perceptions of factors that influence access to support, and existing referral pathways.

The section closes with an analysis of contribution claims derived from the Theory of Change (see Figure 1), aiming to conclude whether mechanisms within the system contribute to intended clinical outcomes. The Contribution Analysis indicated that the NGSN is clinically effective: evidence indicated that all claims contributing to overall reduction in gambling harms have been met with high confidence. Specifically, most providers gathered evidence to understand support needs, regularly reviewed their services, had referral pathways for local non-gambling specific services, and tailored support based on evidence of need. There is room to standardise and formalise evidence gathering for the purposes of assessing local needs to ensure service-users are further supported by a consistent quality of services across the system.

Other key findings on the clinical effectiveness of the NGSN system are summarised below:

- The NGSN supports diverse service-users, though compared to national need, people from minoritised backgrounds are underrepresented: specifically, people from ethnic minority groups, young people, and people from the LGBTQ+ community.
- Barriers to support access included service awareness, service capacity, stigma and life circumstances. Some case study provider staff also believed that a lack of communication and co-operation between some NGSN providers can prevents access at a system level.
- The most common referral source for Tier 1 services was through community outreach events arranged by providers. For Tiers 2 to 4, the helpline was the main referral source (50% of referrals), though there has been an increase in the proportion of self-referral for Tiers 2 to 4 (from 23% in 2023/2024, to 34% in 2024/2025).

## Who the NGSN supports regionally and nationally

One way of assessing the clinical effectiveness of the NGSN is to examine the types of service-users that are currently being supported and assessing whether there are any gaps in provision to particular groups. The NGSN supports diverse service-users, though nationally, most service-users share a few common characteristics. **Service-users were much more likely to identify as male (65%), white (85%), and to be aged between 25-44 year olds (65%). Most service-users identified as heterosexual (58%), while the most common religious views were no faith (35%) and Christianity (12%).** The higher the support tier, the greater the skew towards men compared to women.[4]

Regionally, the highest concentration of NGSN service-users was in the North West (18%), the South East (15%), the East of England (13%) and London (11%). The region with the smallest share of

[4] DRF Data (01/10/23 – 30/09/24). See appendix for full break down

service-users was Scotland (2%). Several regions supported between 6-8% of all NGSN service-users: Wales, North East, East Midlands, West Midlands, South West, Yorkshire and the Humber.[5]

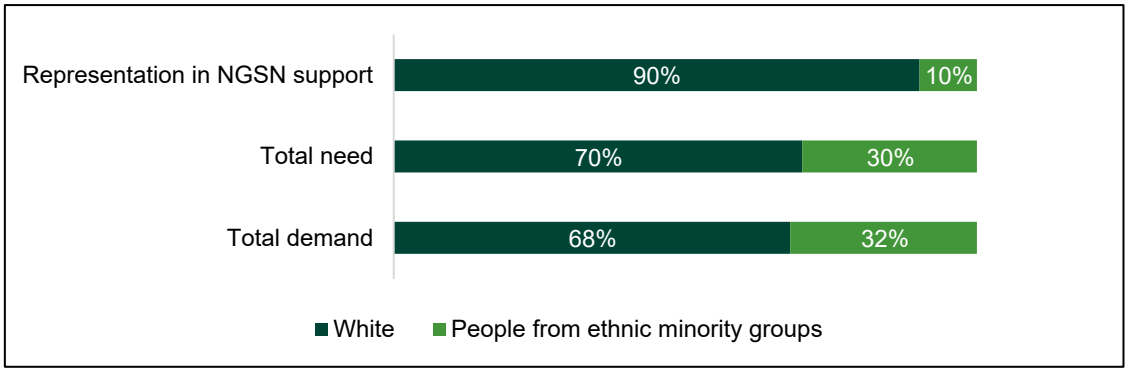
**Regional variation in service-user characteristics was mixed.** Gender identity was consistent across regions, while age showed more differences – Wales had the highest proportion of 18-34 year olds (46%), compared to 39% in the South East. Ethnicity also varied, with London and the West Midlands reporting higher proportions of service-users from ethnic minority groups, reflecting their more diverse populations.[6]

Analysis revealed gaps between those most affected by gambling harms and those receiving support through the NGSN. **People from ethnic minority backgrounds; who identified as Muslim; who were aged 18-24; or who identified as lesbian, gay or bisexual, were all underrepresented in the NGSN compared to the total need and demand of these populations**.[7] However, work to better reach underserved groups is ongoing through initiatives such as the Improving Outcomes Fund (IOF) and Community Resilience Fund (CRF).[8] Providers who received this dedicated funding took measures to tailor their offering to underserved groups and improve access to their services among these groups. NGSN providers' response to the gaps in support among specific subgroups (based on this evaluation's findings) is explored later on in this chapter, specifically in the sub-section titled '*Claim 4: All providers have tailored the treatment and support services they provide based on evidence of need.'*

While people from ethnic minority backgrounds represent 32% of overall treatment demand and 30% of those experiencing harms from gambling (PGSI 8+), they make up only 10% of those accessing NGSN support.[9] Nearly half of people from Asian[10] and Black ethnicity groups who gamble had a PGSI score of 1+, compared to around 20% of White people who gamble.[11] Previous GambleAware research also found that while people from ethnic minority communities experience higher levels of harm and demand for support, many access help outside the (then) National Gambling Treatment Service.[12]

[5] DRF Data (01/10/23 – 30/09/24). See appendix for full break down
[6] DRF Data (01/10/23 – 30/09/24). See appendix for full break down
[7] In the Annual GB Treatment and Support Survey, demand was measured as the proportion saying they wanted any form of treatment or support to cut down their gambling (Q8). Need was measured as the proportion with a PGSI score of 8+ (identified as a problematic level of gambling).
[8] IOF and CRF activities are further explored in this chapter.
[9] Annual GB Treatment and Support Survey 2024; DRF Data (01/10/23 – 30/09/24). See appendix for full break down
[10] 'Asian or Asian British' is defined as service-users who are Bangladeshi, Indian, Pakistani, Chinese, or other Asian group.
[11] Annual GB Treatment and Support Survey 2023
[12] https://www.gambleaware.org/news/gambling-among-adults-black-asian-and-minority-ethnic-communities

**Figure 5. Share of total demand/need compared to representation in NGSN support, split by ethnicity**

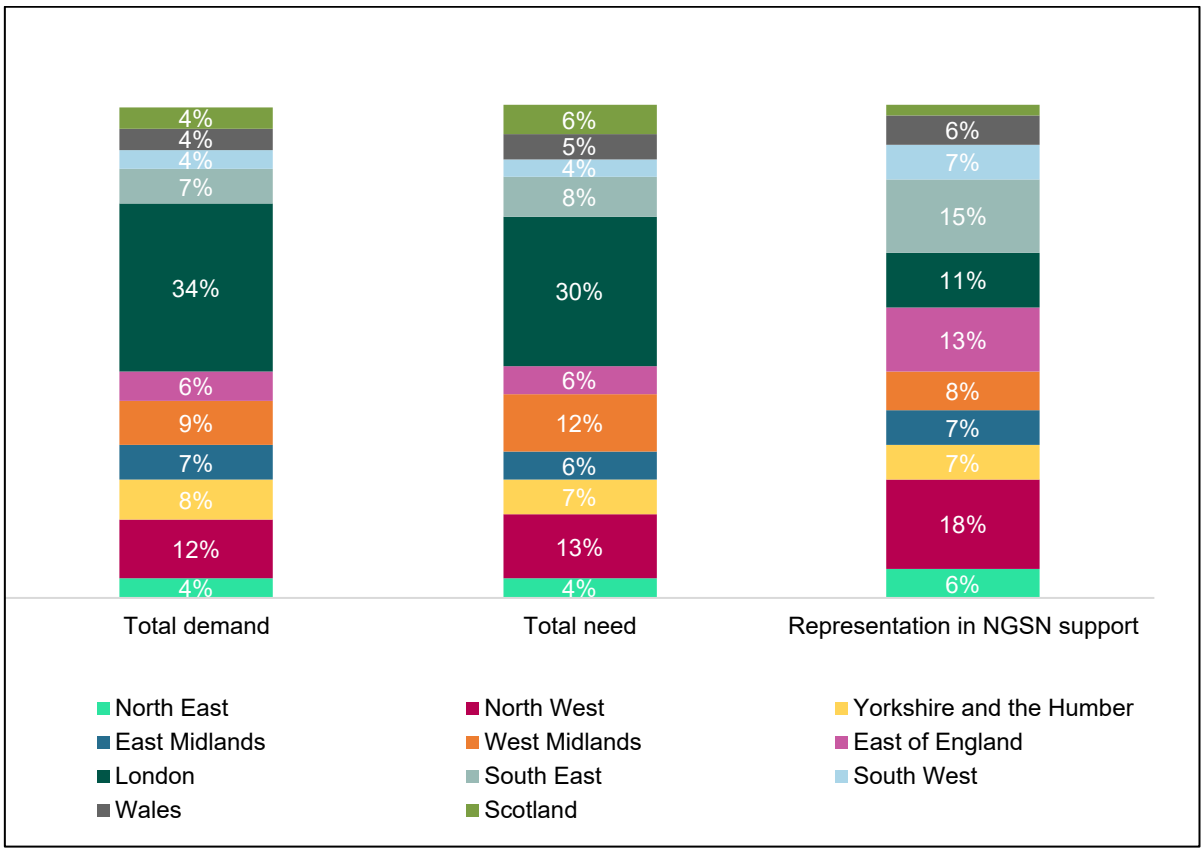



*Source: Annual GB Treatment and Support Survey 2024; DRF Data (01/10/23 – 30/09/24).*

**People from Muslim communities were the most underrepresented religious group**. Just 2% of those receiving NGSN support identified as Muslim, however those who identify as Muslim accounted for 7% of the total demand for treatment/support and 8% of the share of problem gambling (PGSI 8+) in the adult population.

**Younger age groups were also underrepresented in NGSN support.** People aged 18-24 only make up 8% of those receiving treatment by NGSN providers, but accounted for 23% of the total demand and share of problem gambling. **London was also underrepresented; the region accounts for 34% of the demand for treatment/support and 30% of the share of problem gambling, but only 11% of those receiving NGSN support**. In contrast, as is shown in Figure 6 below, the North West and the South East are overrepresented in NGSN treatment, relative to demand/need for support.

**Figure 6. Share of total demand/need compared to representation in NGSN support, split by region**




*Source: Annual GB Treatment and Support Survey 2023; DRF Data (01/10/23 – 30/09/24).*

**Finally, LGB+ people were also underrepresented**; they make up 13% of the demand and share of problem gambling, but account for just 3% of those receiving NGSN support.[13]

Modelling of various data sources by the NHS and Health Economics Unit published in 2023 found that **"if we model the population experiencing gambling harm, we estimate that the treated NGSN users (tier 3 and 4, only) equate to 0.07% of the wider GB population in need.** This indicates that there is a substantial gap in support and treatment for Tiers 3 and 4, however it should be noted that this does not include Tiers 1 and 2.[14]

## Eligibility criteria for support variation, regionally and nationally

Another important way of assessing the clinical effectiveness of the NGSN is by analysing eligibility criteria, to see if any groups may be excluded. **Across providers, there were two overarching criteria for NGSN Tier 3 and 4 support: (1) that people are aged 18 or over and (2) that they live in England, Wales or Scotland**. In contrast, for Tier 1 and 2 support from the helpline, there appeared to be no age restriction, as the service specification stated that "The provider will at all times work to ensure that users are able to access the Helpline irrespective of their age, cultural, physical or other needs."[15]

[13] The acronym 'LGB+' is used because this is the term used in the Annual GB Treatment and Support Survey 2023, reflecting the way the data was captured in the survey
[14] Modelling gambling harm across Great Britain - Health Economics Unit
[15] NGSN Risk Management best practice guide (2024)

Although the primary focus of Tier 1 and 2 support is adults, some providers did offer services and interventions for young people. GamCare, for example, delivered youth-specific services, including education, prevention, and tailored support for individuals under 18 experiencing gambling-related harms.

While not all providers have dedicated pathways for young people, those who do often integrate early interventions, awareness programmes, and brief support tailored to young people.

For regional services, GambleAware's Regional Service Specification sets out the follow criteria:

- **Acceptance criteria**: "Service-users experiencing gambling harms, as a person who gambles or an affected other located in the region. Service-users must be over 18 years of age."
- **Exclusion criteria**: "Those not located in the region will be referred to their local service provider; Those who are actively suicidal; Those who are detained under the Mental Health Act; Those who are in an inpatient/residential unit; Those under the age of 18."

Linked to this, **a stakeholder interviewed during the Scoping stage emphasised that gambling harms need to be the main issue for the service-user, above other clinical needs**. If there are other mental or physical health concerns, then the provider will assess which need is greater before referring them on to another service if needed.

## Provider perceptions of factors impacting service-user support eligibility

However, to gain a fuller picture of eligibility for NGSN support, **it is important not just to understand eligibility criteria but to understand whether all those who are eligible are actually able to access support**. In depth interviews, frontline practitioners from case study organisations identified five barriers that can prevent eligible service-users from accessing NGSN support: low support awareness, stigma, service capacity, service-user's circumstances, and NGSN providers collaboration.

**Low awareness of the NGSN support options available was a barrier to eligible service-users accessing support**. To combat this, providers reported engaging in active awareness-raising initiatives as a way of raising awareness of the support that they offer (e.g. community projects, creating links with the armed forces and police). However, there was a recognition that these awareness-raising efforts do not reach all those who are eligible for support, so this will always be a barrier to some extent.

*"I don't know if there's enough understanding that there is support out there, because that's something that we have a lot where people come in is that they say that they weren't aware how much support there was available until....So I suppose there is a lot of support, but maybe it's not advertised enough."*

**NGSN Frontline Practitioner**

Part of this barrier is a lack awareness of support options available in the NGSN among those who want treatment or support, while another part is eligible service-users not realising that their gambling is at a potentially harmful level, and therefore not realising that they would *benefit from* or *need* treatment or support.

Stigma at accessing support was **a second key barrier that prevented those who are eligible for support from accessing it**. Stigma can be especially powerful within certain cultural or religious groups, and more difficult to combat than lack of awareness. **While raising awareness is just a case of reaching more people with information, combatting stigma requires breaking down long-established cultural taboos**. For example, the fact that gambling is forbidden in some religions can mean that individuals feel much more stigmatised when coming forward to access support.

*"In my mind, gambling and alcohol are quite intertwined. You know, it's sort of in the fabric of our country in many ways. But alongside that, there's also shame and stigma around reaching out to get support."*

**NGSN Frontline Practitioner**

**Insufficient service capacity was a third barrier.** Some staff from case study providers reported that longer waiting times for particular groups (e.g. female affected others) were linked to limited capacity. While they recognised the importance of offering support as soon as someone was ready to engage, they were sometimes unable to do so due to staffing constraints. High workloads for frontline services was also listed as reason why frontline services can be reluctant to screen for gambling harms, which can mean that service-users are not always referred to the correct support. However, overall this view was held by a minority of staff, and contrasts with data collected on waiting times as part of NGSN Annual Statistics 24/25, which showed that 50% had their first appointment within 6 calendar days and 75% of service-users had their first appointment within 12 calendar days of their referral date for Tier 1-3 treatment.[16]

**Service-user's circumstances was a fourth barrier.** Some staff believed that people with childcare responsibilities (who may be more likely to be women) and those in employment may be less likely to access residential support in particular, as it means they are unable to carry out their childcare or employment responsibilities. DRF data supports this, as it shows that service-users who had Tier 4 treatment were much less likely to be in employment than those who had Tier 2 or 3 support. The DRF data does not show that service-users who received Tier 4 treatment were less likely to caregivers for children than those who received Tier 2 or 3 support, however the DRF data does not distinguish between primary caregivers and secondary caregivers. Therefore, provider perceptions may well be accurate, as it is unclear from the data whether *primary* caregivers are less likely to access residential support.[17]In response to this barrier, Gordon Moody has shortened the length of residential stays it offers as part of its delivery of Tier 4 treatment, as a way of making it easier for service-users with different personal circumstances to access Tier 4 support. Gordon Moody also offers other options such as the "Retreat and Counselling Programme", as a way of making Tier 4 treatment more accessible for those who are unable to stay in residential treatment for longer periods of time.[18]

**Finally, while not currently a major issue, providers noted that a decline in communication and collaboration between NGSN providers could become a significant barrier in future**. When functioning well, the system operates on a 'no wrong door' approach – service-users should be referred to the most appropriate provider and treatment, regardless of their entry point. Although referral pathways have strengthened in recent years, staff warned that any deterioration in inter-

[16] GambleAware Annual Statistics from the National Gambling Support Network 2024/2025. It should be noted that waiting times for residential services were higher, with 50% of service-users seen within 14 calendar days of their referral date
[17] DRF Data (01/10/23 – 30/09/24). See appendix for full break down
[18] https://gordonmoody.org.uk/retreat-counselling-programme/

provider communication could undermine this approach and limit access to support. Maintaining strong, consistent coordination is therefore critical to sustaining system-wide accessibility and responsiveness.

### Proportion of provider's service-users experiencing each support tier

**Another way to assess the clinical effectiveness of the system is to look at the support tiers offered by each provider, to see if there are any opportunities to improve the mix of support offered to service-users**. Of the 10 NGSN providers who submitted data to the DRF between Q3 23/24 and Q2 24/25, two providers solely offered Tier 4, one provider was recorded as solely offering Tier 3 support and the other seven provided a mixture of Tier 1-3 support. [19] [20]

Of the seven providers who provided a mixture of Tier 1-3 support, **brief interventions (Tier 1 support) were generally delivered to a greater number of service-users than Tier 2-3 interventions, however, this varied between providers**. Tier 1 support reaches a greater number of service-users, which is expected, as Tier 1 support includes awareness-raising and counts those who may not require structured treatment.

At Tier 1 level, **nearly all providers ran targeted awareness-raising activities aimed at specific groups that were known to be at greater risk of gambling-related harms or underrepresented in NGSN support.** Examples of this work included awareness-raising amongst groups with higher stigma around gambling, such as people from Muslim and Sikh communities, as well as those at higher risk of harm, including people from LGB+ communities, ethnic minority groups, and individuals recently released from prison. One implication of the regional first approach of the NGSN is that while there is a lot of evidence of targeted outreach and awareness-raising at a local level, there is less evidence of co-ordinated activity at a national level, as national level activity is undertaken by GambleAware, instead of individual NGSN providers.

**The National Gambling Helpline is an important Tier 1 resource that offers confidential information, advice and support to anyone affected by gambling harms**. In 2023-24 there were 55,455 calls to the helpline; two-thirds of these were calls from people needing help themselves, and 8% were calls made by affected others. This resulted in 7,529 referrals to further support, and 93% of respondents rated the support they received from the helpline 5 out of 5.[21]

Most providers saw more service-users in Tier 3 support than in Tier 2, though some had an equal split between the two tiers. **This shows that many service-users were moving straight from Tier 1 to Tier 3 support, or starting their journey in Tier 3 support, without first receiving Tier 2 support.** According to the GambleAware Annual Statistics from the National Support Network 2024/2025 report, of the 11,960 service-users who received NGSN support between April 2024 and March 2025, 36% received Tier 2 only, 38% received Tier 3 only, 5% received Tier 4 only, and 21% received Tier 2 and Tier 3.[22]

[19] DRF Data (01/10/23 – 30/09/24).
[20] The two providers offering Tier 4 support only were Adferiad and Gordon Moody. The provider offering solely Tier 3 support was PCGS/Hurley Group
[21] PDC Data Q4 Template Updated KPIs 2024 - GambleAware
[22] GambleAware Annual Statistics from the National Gambling Support Network 2024/2025

## Referral pathways and influential factors

### The importance of referral pathways to clinical effectiveness

So far, this chapter has explored the types of people who are supported by the NGSN, how access to support varies across the network, the scope and scale of the support on offer, and the proportion of service-users experiencing different tiers of support. These are key aspects in assessing the clinical effectiveness of the NGSN and highlighting areas for improvement.

Another important aspect is referral pathways. The NGSN is intended to allow service-users to be referred onto appropriate support according to their needs at any point in their journey, in a timely manner. This includes referrals to other NGSN providers (if they need a different tier of support) or referrals to external organisations (if they have non-gambling support needs). The aim is for service-users to easily access the support they need at the right time. Service-users should also be fully informed of the options available to them throughout their journey, so that their preferences are taken into account as they move through (or out of) the NGSN.

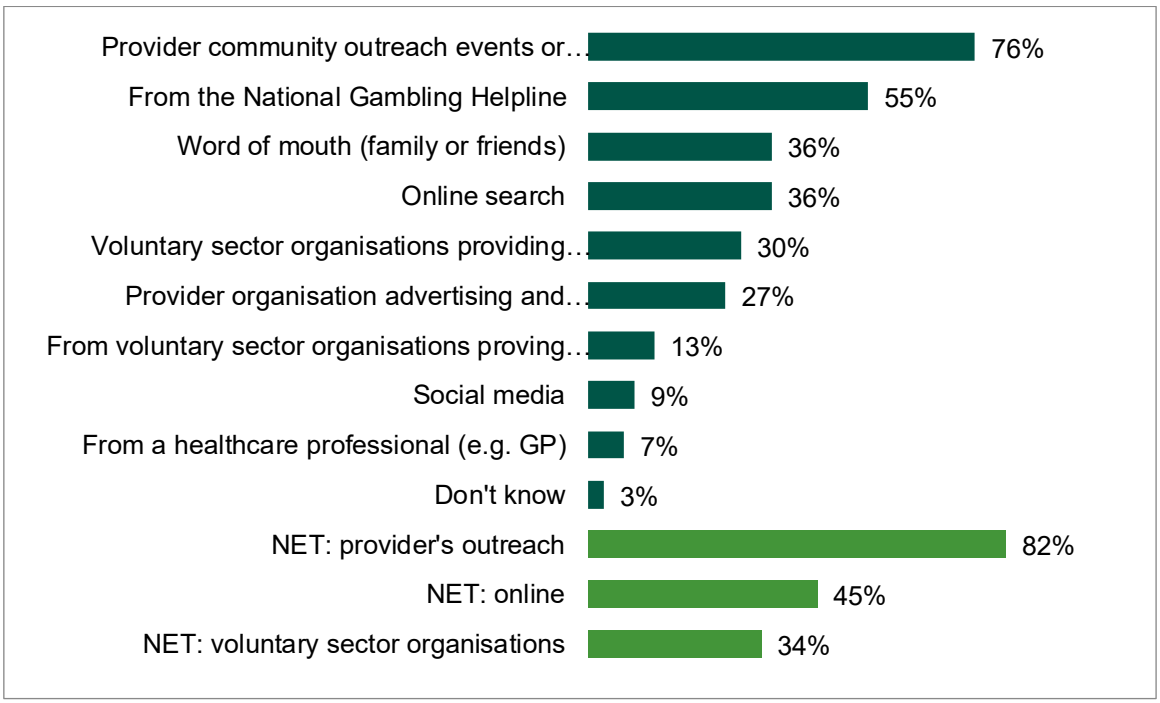
### Referral pathways in practice

This subsection examines how service-users are typically referred to the NGSN and how they move through it according to this research.

#### Referral sources

**Firstly, according to the provider survey, most staff believed Tier 1 users typically found out about services through community outreach events (76%),** followed by the National Gambling Helpline (55%), word of mouth (36%), and online searches (36%). This reflects provider staff perceptions rather than actual referral data.

**Figure 7. Staff perceptions of most common ways that Tier 1 service-users find out about services**

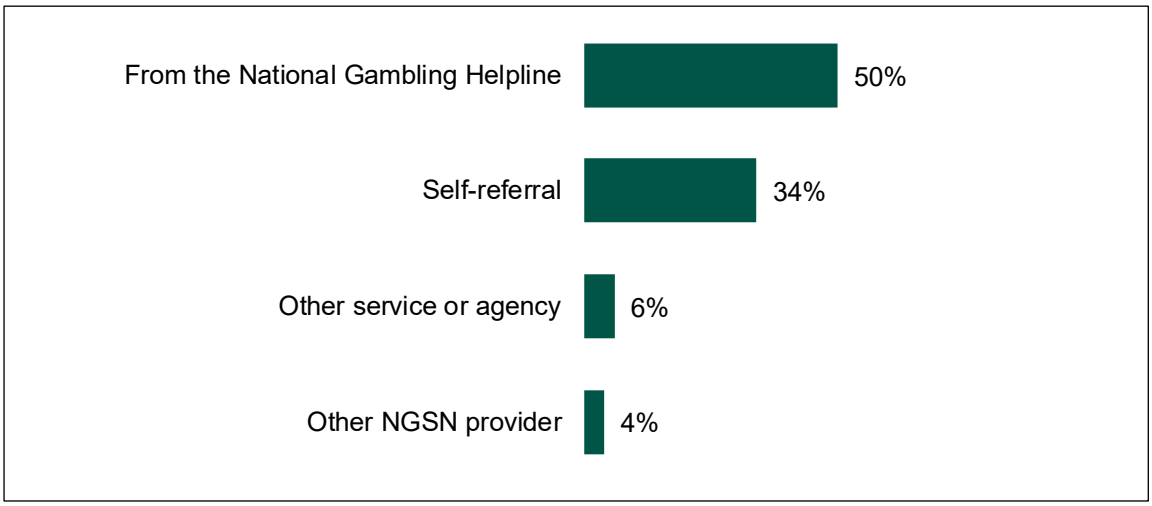



*B7. Which of the following sources are the most common ways in which service-users who receive Tier 1 support find out about your services? Base: All staff who provide Tier 1 support (51)*

A different picture emerges when we look at referral sources for Tier 2-4 support. Data from the Annual Statistics from the National Gambling Support Network 2024/25 indicated that most referrals for Tier 2-4 support were concentrated in a small number of sources. **The helpline was by some distance the most common referral source (50% of all referrals),** followed in second by self-referral (34%).

However, even though the helpline was the most common referral source, **there has been a significant increase in the proportion of self-referrals into Tier 2-4 support over the last year, reflecting the positive outreach and awareness-raising work carried out by providers**. In 2023/24, self-referral accounted for 23% of referrals into Tier 2-4 support. A year later in 2024/2025, this had rise by 11% to 34% of referrals.[23]

**Figure 8. Referral sources for Tier 2-4 support**




*Source: GambleAware Annual Statistics from the National Gambling Support Network 2024/2025*

Other services or agencies were the most frequent source after this (6%), but the rest of sources are responsible for 5% or less of referrals.[24] So, the key difference is that although community outreach plays a central role in how service-users find out about Tier 1 support, it is less important as a formal referral mechanism into Tier 2-4 support.

**There was some variation in the usage of different referrals sources within Tiers 2-4**. Self-referral was much more common among those who received Tier 2 treatment only (49%), and Tier 4 only (43%), but was much less common among those who had any form of Tier 3 support (between 21%-27%). Only a tiny fraction (4%) who had Tier 4 support were referred in via the helpline. The helpline was most common as a referral source among those who had Tier 3 treatment (between 59%-62%).[25]

**There is an opportunity to further diversify and strengthen referral pathways, especially to better reach underrepresented groups.** There are existing programmes and tools (e.g. MLS, risk stratification tools, activities of regional boards) being used to strengthen referral pathways and facilitate integration in the NGSN system, in order to help ensure the right support is reaching those who need it at the right time. Some of these measures are arguably still embedding within the system (e.g. the risk stratification tool is at the pilot stage). This evaluation found that while community

[23] GambleAware Annual Statistics from the National Gambling Support Network 2024/2025
[24] GambleAware Annual Statistics from the National Gambling Support Network 2024/2025
[25] DRF Data (01/10/23 – 30/09/24). See appendix for full break down

outreach helps raise awareness, referrals from these groups into Tier 2-4 support remain low. Key channels like the helpline should be reviewed to ensure they are inclusive and accessible. Underused referral sources, such as police, courts, probation, prisons, mental health services, and Jobcentres, could play a larger role if referral mechanisms were more firmly embedded into awareness-raising activities. A review of the MLS fund found that NGSN providers are increasing the use of these referral sources, so this work is already ongoing and should be maintained.

### How service-users move through the NGSN

According to frontline practitioners from the case study providers, service-users are informed of the options available to them after an initial assessment. When deciding on the appropriate treatment, frontline practitioners take service-user preferences into account (e.g. on individual or group therapy, peer support, female-only support). If needed, the service-user can receive a 'step-up' or 'step-down' referral to another Tier of support. Where the Tier of support needed is not offered by that provider, the service-user is referred onto another NGSN provider. The service-user can also be signposted or referred to external organisations at any point in their journey. **These findings suggest that frontline practitioners feel that referral pathways are broadly working as intended for a typical user. However frontline practitioners from the case study providers also indicated that several factors can affect how consistently these referral pathways are used in practice. These include service-users' awareness of the support available, the ease of self-referral, service-users' choices and their level of engagement, and the scale of providers.**

### Factors impacting referral pathways through the NGSN

This research found that several factors impact how service-users are referred to and move through the NGSN.

**Firstly, case study frontline practitioners reported that awareness of NGSN providers and the support available affected how likely individuals were to self-refer.** For example, service-users were reportedly less likely to self-refer to Tier 4 support, due either to low awareness that this type of support existed, or due to a belief that their needs were not that severe. According to practitioners at GamCare, high awareness of GambleAware among the public (thanks to its logo and website) drove the high level of referrals from the GambleAware website.

**The ease of self-referral was also perceived to affect how often individuals self-refer.** Frontline practitioners from one case study provider mentioned that their referral form was short and only asked for basic information to avoid overwhelming prospective service-users. They also reported that online chat and WhatsApp referrals were increasing and linked this to the privacy and accessibility of these channels.

*"We never used to have WhatsApp [and] live chats but sort of recognising those ways that people like to communicate, [...] how do we allow people to access the different services that suit them in that sort of self-determined way, in a way that is best for their recovery."*

**NGSN Frontline Practitioner**

**Spotlight: GamCare – What is working well to encourage referrals**

1. Online forums and chatrooms are an important source of self-referrals for GamCare according to frontline practitioners.
2. As part of an organisational push for digital innovation, GamCare offer several channels through which individuals can self-refer (including online chat and WhatsApp). This is seen as a way of increasing the variety of service-users who self-refer to the service, as there is a suitable channel for everyone.
3. GamCare emphasises a quick, same-day response to referrals.
4. GamCare receives referrals from industry organisations such as banks or GamStop. This underlines the value in having good relationships with industry organisations to receive more referrals.

**A factor which seemed to impact how individuals were referred to the NGSN was the scale and coverage of the providers they were referred to.** National providers (Betknowmore, GamCare) seemed to have more sources of referral compared to regional or national providers, according to the focus groups with frontline practitioners. GamCare was the only case study provider where frontline practitioners mentioned receiving referrals from the NHS (mental health referrals with social prescribers).

**Furthermore, in line with the intentions of the NGSN, personal choice influences service-users' pathways through the NGSN according to case study frontline practitioners.** For example, practitioners would assign a service-user to a support worker of the preferred gender if requested. They would also accommodate preferences around individual or group support. If the service-users' needs and preferences could not be met within the service offered, they would be referred to another provider (for example, if they wanted peer support or if they needed a higher tier of support). Frontline practitioners from case study providers highlighted that they had a good relationship with a service which provided peer support. This was considered very useful, not just for referrals but also for learning more about peer support.

*"It really boils down to the individual and what they need and what they want as to where we can shoehorn them into one of our services or if they need to go elsewhere."*

**NGSN Frontline Practitioner**

Finally, **the level of engagement of service-users with the support they receive could affect their journey through the NGSN.** For instance, service-users who didn't engage with residential support could reportedly be referred on to community-based support or a peer support programme according to frontline practitioners.

To summarise this section, there is a wide range of pathways through the NGSN according to frontline practitioners from the case study providers. These pathways are **influenced most strongly by the service-user's awareness, needs and choices**. The specific pathways taken can also depend on providers' area of expertise and the support they offer, as well as the referral pathways that are established at these providers.

**Spotlight: Betknowmore – What is working well to encourage referrals**

1. Betknowmore receives referrals from other providers due to their peer support offering. If the service-user wants to receive peer support, this is provided alongside sessions with practitioners.

2. Betknowmore aims to ensure that service-users receive support which is suitable to their needs by signposting them to other tiers of support throughout their treatment (both practitioners and peer supporters do this).

3. When needed, service-users can be referred outside the NGSN to organisations providing debt advice, food banks or other agencies.

4. Long-term recovery support is considered to be very important at Betknowmore according to frontline practitioners, and this is reflected in the expansive aftercare offering. It offers five follow-ups rather than the usual three at other NGSN providers. It is also unusual within the NGSN to offer aftercare groups, so this is seen as a real strength of the service among frontline practitioners.

## Assessing how the NGSN system contributes to intended outcomes

Contribution analysis is a theory-based approach used to evaluate complex systems where causation cannot be easily attributed. In the Scoping stage, we created a Theory of Change (see Figure 1) and extracted four contribution claims, which describe the causal mechanism for the NGSN bringing about intended outcomes and impacts. In the Mainstage, we analysed evidence from the document review, case study interviews, provider survey and DRF analysis against the claims to determine our level of confidence that claims had been met. We then conducted two contribution analysis workshops to present conclusions of claims to NGSN stakeholders and lived experience individuals to refine the conclusions based on discussions. The following scale was used to illustrate different levels of confidence in the claims:

- **Inconclusive:** Where the evaluation evidence was insufficient (including if there was no evidence) to draw a confident conclusion about the extent to which the claim was achieved.

- **Confidence that the claim has not been met:** Where the evaluation evidence was strong and consistent to conclude that this claim was not achieved.

- **Moderate confidence that the claim has been met:** Where the evaluation evidence was strong and consistent to conclude that there was some achievement of this claim; or where evidence was positive about full achievement, but the evidence itself was weak.

- **High confidence that the claim has been met:** Where the evaluation evidence was strong and consistent to conclude that this claim was achieved.

Analysis of the contribution claims builds substantially on evidence from the case study providers, and therefore may not be representative of the NGSN as a whole.

The claims we interrogated, and the reasons for doing so (including links to specific element of the Theory of Change), are summarised in Table 4 below.

**Table 4. Contribution claims and rationale for interrogation**

| Claim | Why it is important that the claim is met |
|---|---|
| **Claim 1:** Providers gather evidence to understand the gambling treatment support needs for Tiers 2 and 3, in their local area. | If this claim is met, that means that providers are leveraging "expert local knowledge", which is an important part of the ToC. It is crucial in enabling providers to produce successful outcomes for all communities in the area, particularly marginalised communities where evidence is more limited.<br><br>We have focused on Tiers 2 and 3 because Tier 4 is not delivered locally, and Tier 1 activities have a much boarder preventative reach, so we consider these activities to be less relevant to the development of treatment pathways. |
| **Claim 2:** Providers regularly review their services in line with the quality assurance framework and implement changes to improve the quality of their services where possible. | In the ToC, this step is key to providers being able to deliver optimal quality services with the available funding. If providers are not regularly reviewing their services and implementing improvements, then they are not delivering optimal quality services. |
| **Claim 3:** Providers have treatment pathways with mechanisms of referral for individuals with local non-gambling specific services | This links to the part of the ToC that refers to collaboration with third sector partners and the leveraging of local resources.<br><br>It is an important indicator of the extent to which local pathways are holistic and embedded in communities. |
| **Claim 4:** All providers have tailored the treatment and support services they provide based on evidence of need. | In the ToC, this claim is crucial as it links the "increased understanding of local needs" with the "delivery of evidence-based services that reflect local needs."<br><br>It is crucial to ensure that services delivered reflect local need, so that those at risk of experiencing gambling harms can access relevant and culturally competent services. |

## Claim 1: Providers gather evidence to understand the gambling treatment support needs for tiers 2 and 3, in their local area

Based on the evidence we have been given from the three case study providers that offered tiers 2 and 3 support, there is **high confidence** that this claim has been met across the NGSN. There is **evidence that tier 2 and 3 providers understand the support needs in their local area in various ways.**[26]

### Local partnerships and community engagement to gather evidence

There is evidence that **case study providers have been able to cultivate local partnerships and expand their service to third parties to increase community reach and knowledge**. All case study providers were able to develop their understanding of community needs by building strong partnerships with external organisations and Public Health teams from the local council. Partnerships often allowed providers to identify areas where higher risk individuals are most likely to reside and engage with the local community through knowledge sharing with support provisions in their local area. Case study providers that had more evidence of understanding the gambling support needs of their local area also had social prescribers that stayed informed and engaged with local services like debt advice, food banks and activities in the local community.

**Case study providers evidenced the success of local partnerships.** For example, GamCare delivered training in 2021 to raise awareness of gambling harm in local services that created the foundations for a strong partnership with the Public Health team. This training allowed them to identify targeted areas in the London borough where higher risk individuals were most likely to reside and offer space for treatment and drop-in sessions to encourage residents of this area to seek support. This partnership also allowed GamCare to deliver an awareness session for Cabinet Members and councillors to better understand resident issues.

### Using evidence to understand support needs

Through the document review, **all case study providers evidenced research and data that they had used to tailor their services**, although not all evidence was gathered by the provider, and some knowledge came from external forums that co-ordinated the evidence gathering.

A few case study providers conducted their own research on the support needs of the local area**, although not all evidence was gathered by the NGSN providers, and some knowledge came from external forums or academic research**. Some case study providers used **externally funded research** to inform the creation of a specific gambling support service within their organisation. In interviews with frontline practitioners and provider leadership, some staff said that **they gather evidence to identify the need for better awareness, education, prevention, treatment and support in their local area**. As a result of this evidence, some content is tailored to the learning styles of different service-users and services have been adapted. To cater to neurodiverse service-users, some providers acknowledged an observed overlap between gambling harms and neurodiversity by adding more mindfulness days/ sessions to treatment programmes. Beacon Counselling Trust shared documents that demonstrated evidence-gathering in six local council areas, as part of local gambling-related harms multi-stakeholder forums led by local councils. Evidence gathering included stakeholder consultations, secondary analysis of health data, surveys of local populations and gap analysis. GamCare mentioned using existing evidence published by

[26] Adferiad was not included in this analysis as they only offer Tier 4 support.

GambleAware to set up new service contracts and use statistical modelling to identify gaps between service availability and community needs. They also provided documents evidencing use of national surveys to benchmark against local data and collaboration with academic research projects to explore more specific needs they had identified.

**Evidence of need for support was mostly gathered through service-user feedback** (which providers have both formal and informal mechanisms for collecting), **and some staff also discussed using published research, internal research projects and consultation of lived experience panels to inform tailoring of services.** For example, in a depth interview, Betknowmore staff discussed how they had developed a bespoke service for women (New Beginnings), informed by research published on the stigma experienced by women affected by gambling harms, as well as their own research evidencing the existence of stigma.

Staff from another provider, Beacon Counselling Trust, also talked about their work with a consultant to adapt their support, driven by an increase in the number of referrals from individuals with ADHD diagnoses. It will be important for the system-coordinator to support all providers to gather robust evidence of need, drawing upon multiple sources instead of solely using service-user feedback.

*"We are seeing a lot of service-users that are coming through with ADHD or possibly undiagnosed ADHD, but they really struggle with certain aspects of the programme. So it's about tailoring to them... it's just something that I feel we just automatically do."*

**NGSN Frontline Practitioner**

**Spotlight: Betknowmore – Creation of the New Beginnings service**

Betknowmore created the New Beginnings service which was directly informed by research findings and recommendations from their 2021 research to better understand women's needs in relation to gambling treatment and support. The service was based around structured group sessions provided by trained lived experience facilitators and was open to women throughout the UK.

Qualitative performance data received consistent positive feedback from attendees and felt that the service was trustworthy, non-judgemental, authentic and demonstrated good levels of knowledge about gambling harms. There were also positive comments on the range of topics discussed, the offer of ongoing support through the health and wellbeing groups, and the value of the WhatsApp group in cementing friendships in the group.

*"I loved the close, female group. We opened up to each other really easily and it made a massive difference in my recovery to know its not only me that has been affected by gambling harm. These groups stood out to me as I have always been put off going to a GA meeting as I felt like I didn't fit the criteria for them or that I would be judged."*

**Service-user, Betknowmore New Beginnings Feedback Report 3**

### Understanding community needs, identifying gaps in support and addressing those issues[27]

**Once providers had gathered evidence to understand local support needs, they engaged in actions to try to address those needs**. Evidence received from case study providers during the document review showed that practitioners actively undertook elements of community engagement including prison work, drop-ins at homeless and substance misuse services, networking events and well-being days. Staff also reported attending various public and professional facing events, such as female focused, mental health services, voluntary sector, debt-related services, substance misuse services, housing services.

**Engaging with underserved groups, such as people from ethnic minority communities, LGBTQ+ communities and people with neurodivergence people in the local area was a focus of community engagement by all case study providers**. Through ongoing community engagement, targeted efforts were made to address stigma and strengthen referral pathways, with a particular focus on ethnic minority communities and vulnerable individuals. For example, GamCare organised a local community inclusion event to raise awareness about the stigma involved in gambling related harms particularly within different ethnicities held at the African Caribbean Centre in Leicester. GamCare also engaged with the community at Northampton pride and participated in International Women's Day events with over 400+ female attendees. As a result, new partnerships were formed, and presentations and leaflet distribution were conducted to address gambling stigma and encourage referrals. Beacon Counselling Trust adopted a community in-reach model that utilised a combination of those with lived experience and community leaders to engage underrepresented groups. According to the provider, this model was very successful and resulted in them exceeding contractual targets. They also delivered a bespoke and externally accredited educational programme, a South-Asian intervention, Veterans specific intervention, young persons' offer and affected others engagement platform.

**Spotlight: GamCare meeting local and community needs**

A document shared by GamCare demonstrated their understanding of local support needs with a case study example of their work.

They built relationships through community engagement and filling a gap in existing provision by building connections within the Caribbean community. They described this as requiring dedication and a patient approach to foster genuine trust.

Consistent attendance at Sutton African Caribbean Community Organisation events allowed them to build a strong rapport with the community, which ultimately led to a meaningful partnership and focused workshops. During these workshops, participants openly discussed their understanding of gambling and its potential harms, including personal stories of gambling-related harm within their families and friendship circles.

The workshop provided a valuable platform for open dialogue, highlighted the far-reaching impact of gambling issues across generations and attendees expressed their

[27] The evidence in this section does not directly contribute to our evaluation of the strength of evidence again Claim 1, however this section contains valuable context about awareness-raising activities that providers reported undertaking in order to support their understanding and interpretation of the evidence they gather.

appreciation for the opportunity to share their thoughts. The workshops also underscored the necessity of culturally sensitive and tailored engagement strategies. Sensitivity to potential judgment or stigmatisation within communities is paramount, requiring a non-condemning approach. Stigma was identified as a significant impediment to both acknowledging gambling problems and seeking appropriate support.

GamCare said that as a result, future efforts will focus on expanding engagement initiatives, continuing to cultivate trust, and ensuring that culturally appropriate support pathways are readily accessible.

Betknowmore have also raised awareness in their local area by working with Islington Council to present the New Beginnings service to their domestic abuse team to aid links between domestic abuse and gambling harms. As a result, Betknowmore established referral pathways with the council and offer free, confidential advice and support at the Islington Hub on a weekly basis. **Case study providers had ongoing partnerships with the criminal justice system and police in their local area which enabled them to strongly embed relationships within prisons and knowledge on identifying gambling harms amongst prison staff and inmates.** Engagement with local police has also contributed to training of police staff and increased stakeholder take-up on the impact of gambling harms. In addition, Beacon Counselling Trust engaged stakeholders in the armed forces to spread knowledge, and support offers amongst that community.

## Claim 2: Providers regularly review their services in line with the quality assurance framework, and implement changes to improve the quality of their services where possible

**Based on evidence from the case studies and provider survey, we can conclude with high confidence that Claim 2 has been met.** The evidence indicates that providers regularly review their services using internally developed protocols, and make changes to improve service delivery. The quarterly monitoring reports provide a structure which standardises service reviews, and prompts reporting on clear action plans to improve quality of services based on reviews.

**As well as NGSN quarterly monitoring reports, case study providers took a range of approaches to reviewing services.** Case study provider documents evidencing service reviews included examples of quality assurance focusing on **specific aspects of service**: such as 'spot check' quality controls of clinical notes, a log of notes from clinical supervisions, and minutes from Multi-Disciplinary Team (MDT) meetings in which frontline practitioners can raise any concerns about services. One document also described how regular mystery shopper calls are made to the national helpline to assess the quality of call handling. In depth interviews, case study leadership and frontline practitioners also mentioned that they regularly review service-user feedback. One leader reported that they quality control 10% of services on a monthly basis, to check whether there are gaps in training or the support they deliver. With regards to the frequency of service reviews, staff reported that reviews were 'regular', and some said that supervisions and MDT meetings took place every 4-6 weeks.

*"We have clinical supervisions every six weeks where somebody will come in and we can raise any issues we've had with [service-users] that we're dealing with that might have impacted us...we look for better practice of how we'd support them."*

**NGSN Frontline Practitioner**

**Some case study providers also conducted reviews of their entire service, albeit less regularly**. GamCare, for example, provided documents evidencing quality assurance service reviews for each regional branch conducted in 2024. Betknowmore also included a quality review report from an annual service review conducted by GambleAware.

**Evidence indicated that case study providers' service reviews generally align with aspects of the Quality Assurance framework**. In a Contribution Analysis workshop, leadership staff explained that questions included in quarterly monitoring reports (which providers must share with GambleAware as part of NGSN quality assurance procedures) were designed around the Quality Assurance framework. Some other provider documents made reference to principles or frameworks that are similar to the Quality Assurance framework. For example, one service review document was organised in line with quality statements from CQC's Single Assessment Framework, some of which align with the domains of quality in GambleAware's Quality Assurance framework. In depth interviews, leadership staff at case study providers felt their internal procedures aligned with aspects of the Quality Assurance Framework.

**There was evidence to indicate that providers implemented changes, as a result of service reviews, in attempt to improve quality of services.** In quarterly monitoring reports, providers must indicate actions that have been taken as a result of service reviews. In the document review, Betknowmore's quarterly monitoring reports provided clear evidence of this in practice. A GambleAware Quality and Performance report concluded that "Providers demonstrated strong performance and adherence to quality", suggesting that other providers also complete quarterly monitoring and implementation of changes to a high standard. Outside of quarterly monitoring reports, GamCare provided documentary evidence of an action plan from a review of regional services, including details on who is responsible for the action, a prioritisation rating, and notes on the status of the action.

**Staff also perceived that changes were made to improve services**. According to the provider survey, the majority (91%) of staff were aware of changes made to improve quality of services in the last 12 months,[28] and 15 out of 16 leadership staff agreed that action is taken as a result of service reviews.[29] Furthermore, their organisation 'always reviewing and improving services' was a key reason why staff felt services had improved (mentioned spontaneously by 19% of staff that felt services had improved, as shown in Figure 10). In depth interviews, frontline practitioners from case study providers were able to give examples of changes that had been made, including making support materials more accessible to neurodivergent service-users, and reducing group sizes so that staff can dedicate more attention to individuals.

*"[Provider] is continually adding support options and collaborations to help us to provide the best care for our service-users' needs. It's always growing, providing training for its staff, increasing support*

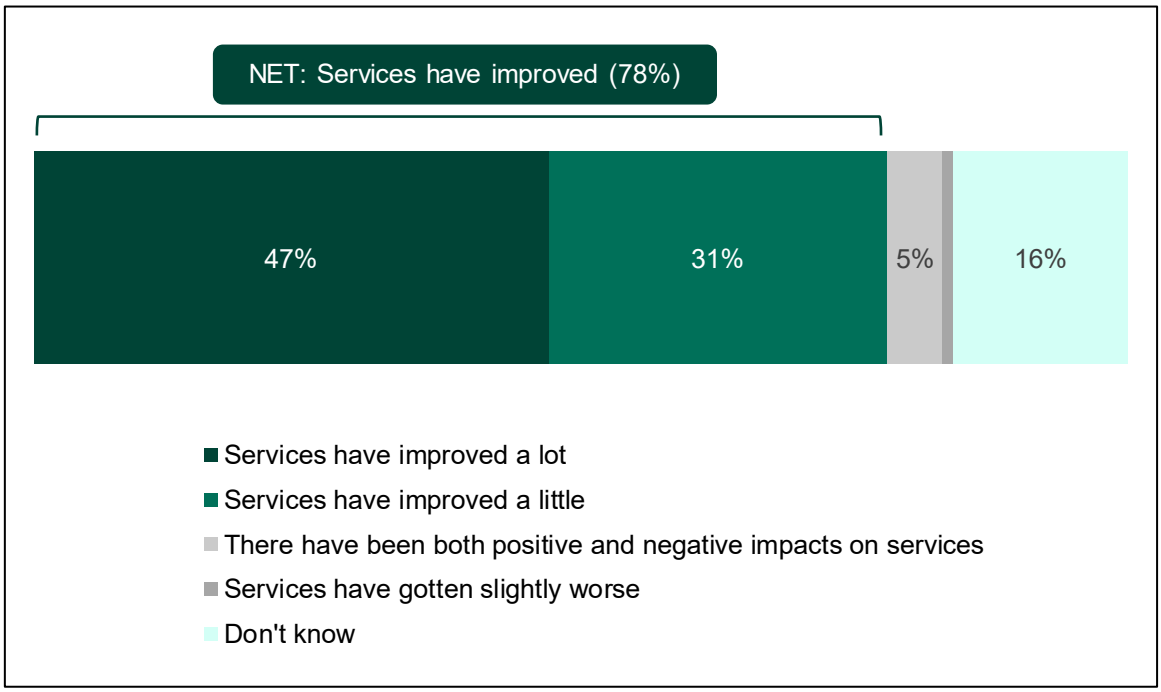
[28] B4. Are you aware of any changes that have been made to try and improve the quality of services offered by your provider organisation in the last 12 months? Base: All staff (134)
[29] B5. Thinking about the last 12 months, to what extent do you agree or disagree that action has been taken to change the way services are delivered at [provider organisation] as a result of service reviews? Base: All leadership staff aware of changes (16)

*options. I feel that services should always be looking to improve, and [provider] always does its best to do that."*

**NGSN Frontline Practitioner**

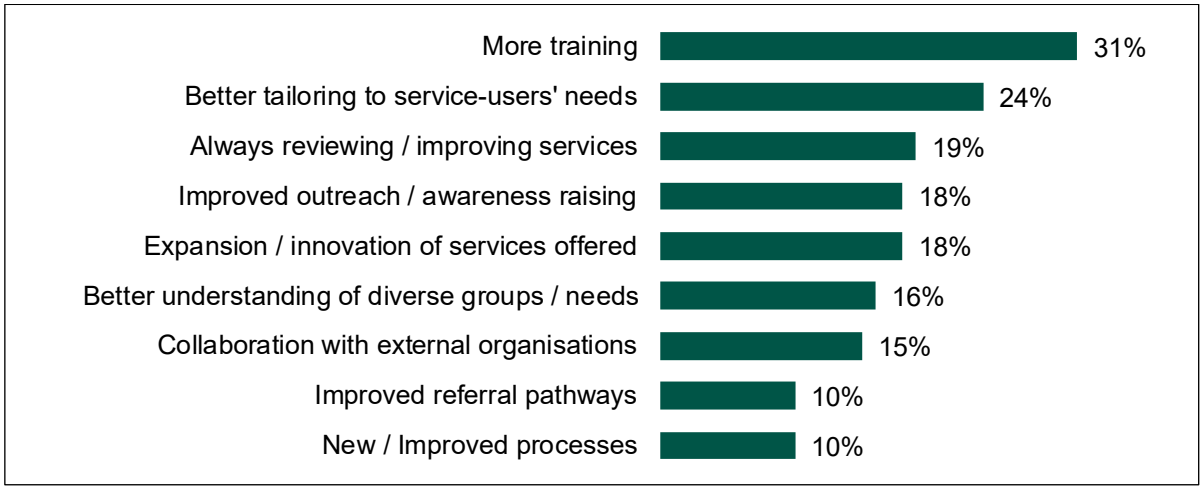
**Finally, staff perceptions and quality and performance monitoring documents indicate that changes made to service delivery represent concrete improvements.** In the provider survey, as shown in Figure 9, just under 8 in 10 (78%) staff felt that services had improved as a result of changes made. As shown in Figure 10, the top reasons for this were more training (31%) and better tailoring to service-users' needs (24%). This was reflected in depth interviews with frontline and leadership staff, who felt that changes made to services were positive. GambleAware Quality and Performance reports reviewed in the Scoping Stage also provided evidence of improvement in Key Performance Indicators, linked to changes made to services.

**Figure 9. Staff perceptions of the impact of changes made to services they offer**




*B6. How would you assess the impact of the changes that have been made to improve the quality of services offered by your provider organisation in the last 12 months? Would you say that... Base: All staff (134)*

**Figure 10. Reasons why staff think that services have improved as a result of changes made to service delivery at their organisation**




*B6a. What makes you say that services have improved as a result of changes made to service delivery at [provider organisation] in the last 12 months? Base: Staff who think services have improved (89). Responses under 10% not included.*

**However, in depth interviews and provider documents, there was no mention of gathering evidence of the impact of changes.** Therefore, providers may need further guidance on how to objectively measure whether changes have led to a genuine improvement (such as gathering data pre and post change).

## Claim 3: Providers have treatment pathways with mechanisms of referral for individuals with local non-gambling specific services

Based on the evidence, there is **high confidence that this claim has been met across the NGSN**. The evidence suggests that NGSN providers signpost service-users to local non-gambling specific services. In this context, signposting could mean sharing the contact number of a local support organisation with service-users or simply giving them the name of a local support organisation. This signposting can reportedly occur at various points in a service-user's journey through the service and is based on the service-user's non-gambling specific needs. NGSN stakeholders mentioned that signposting rather than making a more formal referral (e.g. a written referral including a transfer of information on service-users' history and support needs) allows service-users to reflect on whether they want to reach out to the signposted organisation and to make their own decision. For example, stakeholders noted that signposting to financial or debt advisors is preferable to making a formal referral. They also pointed out that signposting would be preferred over a formal referral by some non-gambling services.

When describing typical referral pathways through the NGSN, **frontline practitioners from all case study providers reported referring service-users to local non-gambling specific services**, including to services offering financial advice, housing support and relationship counselling. Similarly, frontline practitioners reported high confidence in referring service-users to external organisations in the provider survey.[30]

[30] Provider survey - 79-93% agreed that they feel confident referring service-users to external organisations for support for relationship help, finances and resources, support with mental health or

There was some evidence in provider documents of **'step down' referral pathways between NGSN providers and other support services**. These documents stated that a service-user can be referred for lower-level community-based support, for example as part of their long-term recovery support following residential or intensive support (and specifically mentioned referral pathways between the NGSN provider and these community-based organisations). Customer journey maps shared by case study providers also showed **external referrals as a step in the service-user journey**.

*"Service-user signposted to DrinkAware, Sexaholics Anonymous. Service-user also signposted to Pheonix Futures for substance misuse."*

**Provider Document**

Formal agreements for safeguarding referrals were also evidenced in provider documents, however this may fall out of scope of treatment pathways.

*"We have several structured referral pathways for statutory services which are non-gambling services that we use, including Multi Agency Safeguarding Hub (MASH) pathways, Mental Health crisis intervention pathways and MARAC (Multi Agency Risk Assessment Conference) for domestic abuse."*

**Provider Document**

For context, it should be noted that there is ongoing work and funding allocated to further improve partnerships between local non-gambling services and facilitate more integrated support (e.g. MLS funding programme).

To summarise, according to this evidence **service-users are referred to local non-gambling services according to need across the NGSN**. This often takes the form of signposting, particularly in circumstances where this is beneficial to empower service-users.

## Claim 4: All providers have tailored the treatment and support services they provide based on evidence of need

**The evidence indicates that we can conclude with high confidence that this claim has been met**: there was sufficient evidence that support has been tailored to individual needs and the needs of groups, based on service-user feedback or research on need. However, there is evidence to suggest that services could be further tailored to the needs of people from minority ethnicity communities.

**Provider staff felt that services were tailored to needs of individuals and groups, and were able to provide examples of these cases**. Results from the provider survey showed that the vast majority (94%) of staff agreed that services are tailored to the needs of individual service-users. A majority of staff also agreed that support is tailored to the needs of different groups, as shown in Figure 11, with some slight variation and lowest levels of agreement for tailoring of services to the needs of people from ethnic minorities (specifically South Asian and Black Caribbean or Black African communities).

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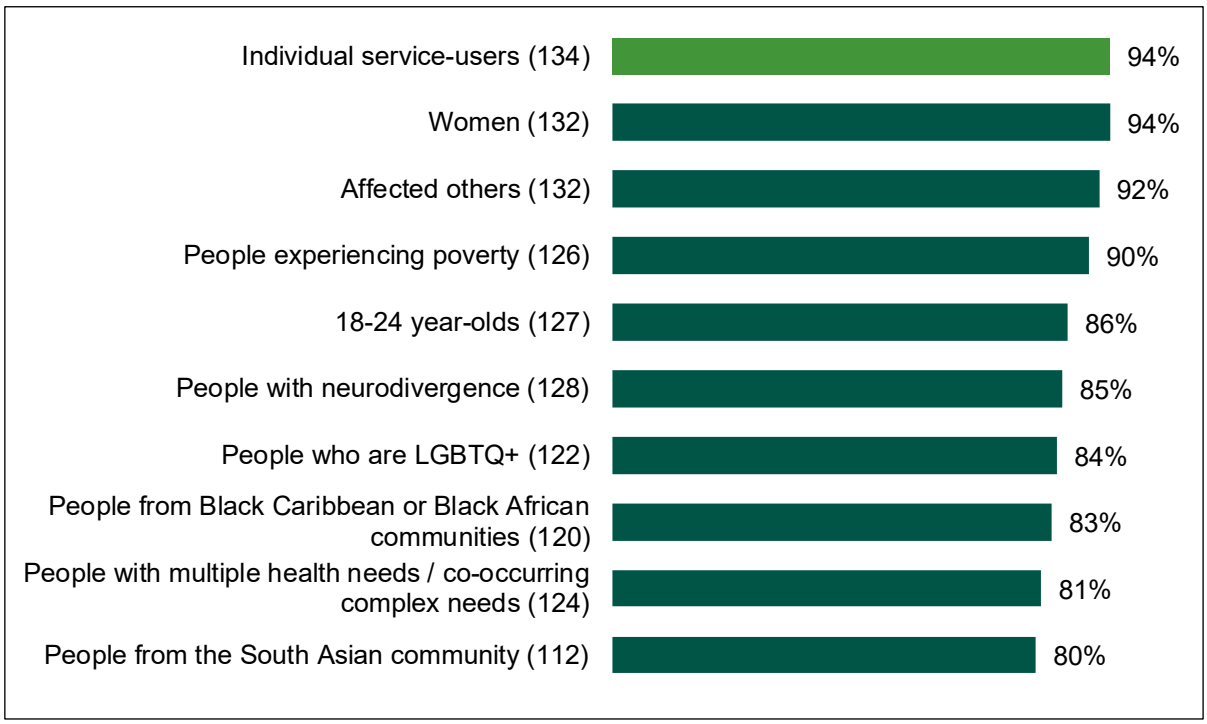
emotional wellbeing, help with other dependencies (e.g. drug or alcohol), legal and advocacy help, support for domestic abuse, crisis services (between). 62% agreed that they feel confident referring service-users to faith and community organisations. Base: Frontline practitioners (109)

**Figure 11. Extent of agreement that services are tailored to the needs of different groups of service-users**




*B3. To what extent do you agree or disagree that the services provided by your provider organisation are tailored to the needs of... Base: Staff at provider organisations which have provided support to individuals in that group in the last 12 months (in brackets in chart labels)*

In depth interviews, frontline practitioners from case study providers discussed several ways in which **services had been tailored to the needs of individual service-users**: including development of trauma-informed care plans, adapting mode of delivery to service-users' learning styles, and pairing service-users with lived experience peer supporters and matched counsellors. Provider documents also included case studies of service-users who were offered different types of support based on their unique needs, and referral pathways which depend on an initial assessment of service-user needs.

*"We have now introduced the VARK (Visual Aural Read Kinaesthetic) learning styles as well, so that helps. So, you know you might be visual, but I might be [a different style] ... it's just making sure we adapt for each service-user that comes in."*

**NGSN Provider Leader**

**Spotlight: Adferiad – Inspection report evidencing that services are tailored to service-user needs**

In 2024, the Care Inspectorate Wales inspected Adferiad's residential facilities. Through the report, **several cases of services being tailored were given as evidence for an overall high performing service**:

- "A variety of therapeutic sessions are offered, and people can choose which sessions they attend"
- "The service considers people's personal wishes, aspirations and desired outcomes as well as any risks and specialist need when designing their care and support"
- "People's language and cultural needs are catered for where possible"

In depth interviews and the provider survey, frontline and leadership staff also gave examples of ways in which **support had been tailored to the needs of particular groups or communities**. Examples included providing bespoke groups for certain communities (for example, women), adapting support materials to be more accessible to individuals with ADHD and Autism, providing training for practitioners on the needs of specific groups (such as South Asian communities, armed forces, and individuals with neurodivergence), and printing information in different languages.

*"By increasing awareness among staff [through training/ cultural competency groups], we can offer more personalised and appropriate support to service-users, leading to better engagement and outcomes."*

**NGSN Frontline Practitioner**

Breakeven took this one step further by employing counsellors who speak different languages. In a Contribution Analysis workshop, some leadership staff expressed that more could be done to make service-users from different backgrounds feel represented, **indicating that tailoring services to diverse needs is a persistent priority.** Some frontline and leadership staff who completed the survey also expressed that there is always more tailoring to be done, as the gambling harms landscape is constantly changing. In the provider survey, when staff were asked what aspect of the NGSN they felt could be improved, the most commonly mentioned theme **was tailoring of support for diverse groups/needs (17%), despite acknowledging that steps are already taken to tailor support (see Figure 16 in the appendix).**

*"I think that the work undertaken over the last 12-18 months has seen a real improvement in service offer and evaluation of this. There will be further work needed in the years ahead as the gambling itself continues to evolve and we must be strong enough to evolve and adapt our services to meet changing needs."*

**NGSN Frontline Practitioner**

Furthermore, in the provider survey some staff expressed that **support could be tailored to a wider variety of groups across the system,** instead of multiple providers having bespoke services for the same group (women, for example). There could be opportunity for a more collaborative, system-level

approach to tailoring support, to avoid duplication of work between providers and ensure that a range of underserved groups are adequately supported.

*"While its great there are 5 different women's groups, some differentiation rather than repetition would be fantastic. More neurodiversity, LGBTQIA+ groups and services."*

**NGSN Frontline Practitioner**

**Although there is a range of evidence that services have been tailored to the needs of individual service-users, DRF data indicates that tailoring services has not expanded the reach of the NGSN to people in minority ethnic communities**. In recent years, the ethnic profile of NGSN service-users has not changed: in 2018/19 nine out of ten (90%) of service-users were from a White ethnic background, with the next most reported ethnic backgrounds being Asian or Asian British[31] (5%), and Black or Black British (3%). Six years later in 2024/25, the proportion of White service-users was unmoved at 90%, and the proportion of Asian or Asian British (5%), and Black or Black British (3%) service-users was also exactly the same.[32] These findings indicate that tailoring of services to certain groups does not necessarily lead to an uptake of services amongst those groups. Therefore, there may need to be an intermediate step in the Theory of Change between providers delivering services that reflect the needs of communities, and individuals in need of support accessing services.

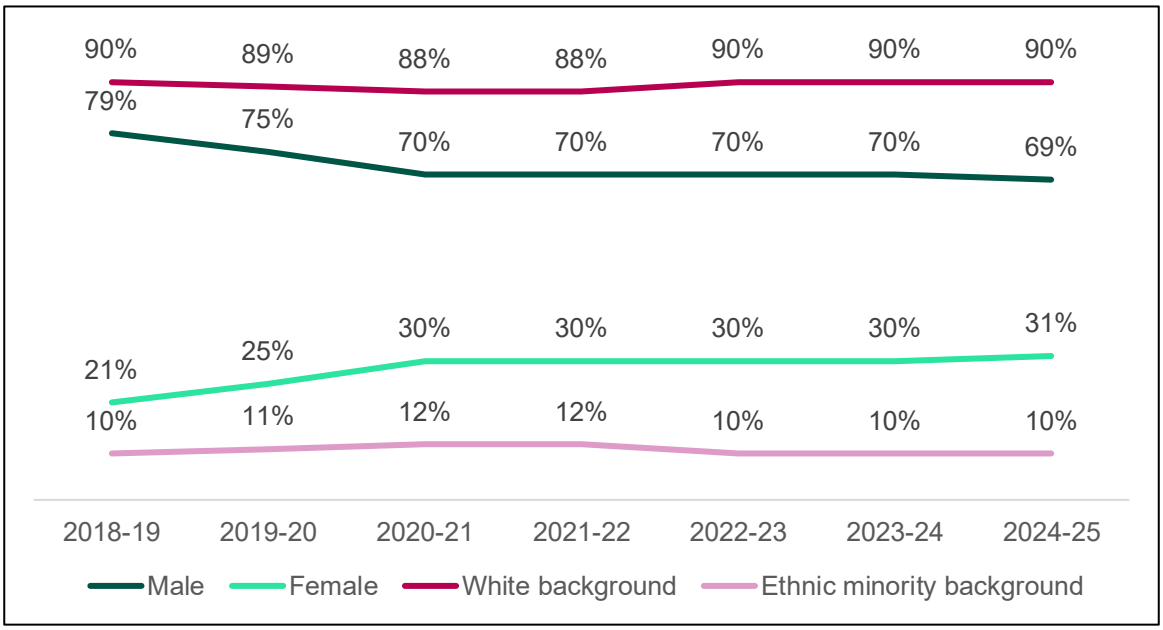
**This issue is not a new one, and GambleAware have funded several programmes to tackle this (among other objectives).** According to an initial learning report from the Improving Outcomes Fund (IOF), providers have attempted to encourage uptake of services among women and minority communities, despite the challenges of stigma, cultural barriers, and lack of trust. The main strategies used were community-based engagement, trust-building measures (like taking the time to build individual relationships and ensuring the right language is used to suit community norms), embedding lived experience in the support provided, innovative practices (such as social media storytelling to reach younger and more diverse audiences) and system-level adaptations (including advocacy for longer-term funding to allow sustained engagement).

**Since the IOF is a relatively recent funding programme, more time will be needed to gauge the full impact of these strategies; but initial findings are promising.** An evaluation of the Community Resilience Fund also found that several subgroups are underserved by the NGSN. This research identified several strategies to encourage uptake, tailored to the groups in question. These strategies focused both on making the support more relevant to these groups and on developing effective awareness-raising activities. Finally, the Aftercare Programme helped improve engagement activities to better reach marginalised communities, through adapting service-delivery to be more inclusive and trauma-informed, whilst diversifying delivery methods (e.g. online support) to help reach underserved groups. An evaluation of the programme recommended that it could be further improved by including trained staff with lived experience of gambling harms and shared cultural backgrounds in delivery teams.

[31] 'Asian or Asian British' is defined as service-users who are Bangladeshi, Indian, Pakistani, Chinese, or other Asian group.
[32] Annual Statistics from the National Gambling Treatment Service (Great Britain) 2018-19 (2019); Annual Statistics from the National Support Network (Great Britain) 2024/2025 (2025)

**Positively, the gender mix is now less dominated by men than it was five years ago, suggesting that services may have been adapted to better meet the needs of women**. In 2018/19, 79% of service-users were male and 21% were female. By 2024/25, this has changed to 69% male and 31% female.[33]

**Figure 12. Gender and ethnic background of service-users in NGSN treatment from 2018 to 2024**




*Source: Annual Statistics from the National Gambling Treatment Service (Great Britain) 2018-19 to 2024-25*

[33] Annual Statistics from the National Gambling Treatment Service (Great Britain) 2018-19 (2019); Annual Statistics from the National Support Network (Great Britain) 2024/2025 (2024)

# 7. Economic effectiveness of the NGSN system

## Key findings

This chapter details the findings of an evaluation of the economic effectiveness of the NGSN system compared with care without the presence of NGSN services. This includes the development of an economic model which has been used to assess the cost effectiveness of NGSN services compared with not using the NGSN services. The primary outcomes of the model are incremental costs and Quality Adjusted Life Years (QALYs), the incremental cost-effectiveness ratio (ICER), the net monetary benefit (NMB), and the net health benefit (NHB).

- The base-case model results estimated that NGSN services are cost-effective to the NHS for both people who gamble and affected others. For people who gamble, NGSN services are estimated to be cost saving and health improving, saving £497 per person and producing 0.15 additional QALYs per person over a 2-year time period. This is driven by a reduction in hospitalisations, fewer GP appointments, and decreased prevalence of depression.

- For affected others, NGSN services are estimated to be cost incurring but health improving over a 2-year time period, incurring £530 per person but producing 0.10 additional QALYs per person, remaining within the National Institute for Health and Care Excellence (NICE) cost-effectiveness threshold of £20,000 per QALY gained, meaning that NGSN services are considered good value for money. This is primarily driven by reduced depression severity.

- When societal costs are included for the population of people who gamble, cost savings increase substantially to £2,771 per person. The additional cost savings stem from a reduction in criminal activity, a reduction in homelessness, and a reduction in unemployment.

### Interpreting the results

| Result | Interpretation |
|---|---|
| Incremental results | These demonstrate the difference in costs and QALYs when having the NGSN compared with having no NGSN.<br><br>An ICER is calculated by dividing the difference in total costs (incremental cost) by the difference in the chosen measure of health outcome or effect (incremental effect) to provide a ratio of 'extra cost per extra unit of health effect' for the more expensive therapy versus the alternative. |
| Net monetary benefit (NMB) | This is a summary statistic that represents the value of an intervention in monetary terms when a willingness-to-pay threshold for a unit of benefit (QALYs in this case) is known.<br><br>A positive NMB indicates that an intervention is cost effective for the given willingness-to-pay threshold.<br><br>A negative NMB indicates that it is not cost effective. |

| | |
|---|---|
| Net health benefit (NHB) | This is a summary statistic that represents the impact on population health of introducing the intervention.<br><br>A positive NHB implies that overall population health would be increased as a result of the intervention.<br><br>A negative NHB implies that the health benefits of the intervention are not sufficient to outweigh the health losses that arise from the healthcare that ceases to be funded elsewhere, to fund the intervention. |

## NGSN operating costs

The costs of providing services were established by obtaining cost information from providers for the 2023/24 financial year, through GambleAware.

### Tier 1

As the costs of Tier 1 are currently unknown, these were set to zero in the base case and explored in two-way sensitivity analysis. This type of sensitivity analysis involves changing two parameters simultaneously to determine the impact on the results. We varied the treatment multiplier (effectiveness of Tier 1) and the cost of Tier 1, to explore the effect on NMB, to see how effective and how low the cost of Tier 1 would need to be to produce a positive NMB.

The treatment multiplier works by assuming that a certain proportion of people from each PGSI/CORE-10 severity group[34] move up or down by one severity group dependent on the direction of the multiplier. For example, a treatment multiplier of 1.0 would mean no change in severity group from receiving treatment. A treatment multiplier of 1.2 would mean that 20% of the cohort in each severity group would move down a severity group (e.g. 20% of people with PGSI score 8+ would move to PGSI score 3 to 7). A treatment multiplier of 0.8 would mean that 20% of the cohort in each severity group would move up a severity group (e.g. 20% of people with PGSI score 3 to 7 would move to PGSI score 8+).

Furthermore, one of the estimated benefits of Tier 1 interventions is that identifying and engaging with people earlier means that they may require less intensive treatment. Therefore, we compared the difference in benefit between Tier 3 and Tier 4 treatment to estimate the willingness to pay for identifying people needing treatment earlier, which may then need less intensive treatment. This was done by calculating the NMB for costs and QALYs associated with Tier 3 compared with Tier 4. This represents the willingness-to-pay for every one person accessing Tier 3 services who may have required Tier 4 services without access to Tier 1 interventions. Since there is a lack of effectiveness data for economic outcomes of Tier 1 interventions, this scenario helps to identify the potential value, through utilising the theory of change. Further details and the results of this analysis are provided in the full technical report, attached in Appendix C: Link to economic model technical report.

[34] By severity group, for PGSI this is referring to risks associated with gambling behaviour. For CORE-10, this is referring to the severity of psychological distress, as measured by both scales.

### Tiers 2 and 3

Due to limited data on costs of intervention tiers, multiple assumptions were made to calculate the costs of service provision. Two options for costing the treatment tiers were used. The first option assumed the same cost for Tiers 2 and 3, as this is calculated from the total financial budget data provided by GambleAware. Using this method, Tiers 2 and 3 were estimated to cost £584.25 per person. It is important to consider that the treatment tiers are all allocated the same cost here and costs are not correlated by differences in proportion receiving treatment in each tier.

An alternative option for costing the three tiers was provided, using the same costing method for Tier 2 but alternative methods for Tier 3. The cost for Tier 3 was estimated by calculating the costs of individual resources used in Tier 3 treatment, such as clinical staff time, and administrative time required for referral, assessment, and treatment. Hence, this alternative approach can be described as a 'bottom-up' costing approach, by costing each of the individual components of Tier 3 care. Costs were inflated to the 2023/24 cost year (the most recent cost year available for health data at the time of writing). Using this method, the cost of Tier 3 was estimated to be £751.18 per person.

### Tier 4

The cost of Tier 4 was calculated from Gordon Moody 2023 budget and the total number of applicants in 2022/23. This cost was also inflated to the 2023/24 cost year. This cost was estimated to be £5,068.17 per person.

## Cost and health benefit ratios, regionally and nationally

### Overview

The results of the analysis are provided below. Threshold analysis was conducted to calculate the economically justifiable price (EJP) of each treatment tier per person, to produce a positive net monetary benefit. The EJP determines what the maximum cost of each treatment tier could be to still be considered cost effective. This analysis was conducted for Tier 2, 3 and 4 for people who gamble, and for Tier 3 and 4 for affected others. Due to a lack of regional effectiveness data, it was not possible to say if one provider was more cost-effective than another.

### Results: People who gamble

**For those who gamble, NGSN services are estimated to save £497 per person and produce an additional 0.15 QALYs per person.** Scaling this up to 9,140 people in this population who accessed NGSN services (Tier 2 to Tier 4) in 2023/24, this gives a total cost saving of £4,539,181, and 1,404 additional QALYs. Regardless of the cost-effectiveness threshold used, the incremental cost-effectiveness ratio (ICER) comparing the NGSN with no NGSN is dominant (the intervention is both cost saving and produces more health), with a positive NMB (£3,570) and NHB (0.18 QALY) per cohort. Reduction in costs were driven by a £1,107 saving per person in hospitalisations (£10,116,062 for the whole cohort), a £194 saving per person from a decreased prevalence of depression (£1,771,621 per cohort), and an £84 saving per person from fewer GP appointments (772,245 per cohort). This outweighed the £888 per-person cost attributed to providing NGSN services (£8,120,746 per cohort). Further details of this can be found in the economic technical report.

### EJP: People who gamble

Table 5 presents the results of the threshold analysis for Tiers 2, 3, and 4 for people who gamble. It presents the estimated current cost per person for each treatment tier and the EJP (i.e. the maximum

per-person cost that would still result in the NGSN being cost effective). **Base-case treatment costs for Tier 2 and Tier 3 currently fall under the EJP, making the costs economically justifiable. The base-case treatment costs for Tier 4 do not fall under the EJP, making the cost not economically justifiable when looking at a time horizon of two years.** However, over a 5 year time horizon, Tier 4 becomes cost-effective due to a higher EJP, reflecting the higher up-front costs of Tier 4 services, but potential for benefits to continue in the longer-term.

Tier 2 and Tier 3 base-case treatment costs are around 5.5 and 6.7 times lower than their associated EJP respectively. This means that even if there were large shocks to costs for these tiers, and the treatment costs were to substantially increase, they would likely still be considered cost effective.

**Table 5. Economically justifiable price of treatment tiers for people who gamble**

| Treatment tier | Base-case treatment cost per person | EJP |
|---|---|---|
| Tier 2 | £584 | £3,200 |
| Tier 3 | £715 | £4,800 |
| Tier 4 | £5,068 | £4,500 |

### Results: Affected others

**For affected others, NGSN services are estimated to be cost incurring at £530 per person but produce more health (0.10 QALYs per person).** Scaling this up to 1,119 people in this population who accessed NGSN services (Tier 3 and Tier 4 only) in 2023/24, this gives an additional 110 QALYs. This results in an ICER value of £5,373. The increase in health is driven by a reduction in depression severity. This also results in cost savings but is still outweighed by the cost of the intervention. This cost incurrence falls within the threshold of what would be considered cost effective according to the National Institute for Health and Care Excellence (NICE) of £20,000 per QALY gained, and so the cost incurrence is considered justifiable. The NMB and NHB are both positive, at £1,442 and 0.07, respectively.

### EJP: Affected others

Table 6 presents the results of the threshold analysis for Tiers 3 and 4 for affected others. It presents the estimated current cost per person for each treatment tier and the EJP (i.e. the maximum per-person cost that would still result in the NGSN being cost effective). **The base cost of Tier 3 falls under the EJP, making the cost economically justifiable.** Given that the cost is around 3.4 times lower than the EJP, the cost effectiveness of Tier 3 for affected others should be resilient to cost increases.

**Table 6. Economically justifiable price of treatment tiers for affected others**

| Treatment tier | Base case treatment cost per person | EJP |
|---|---|---|
| Tier 3 | £715 | £2,400 |
| Tier 4 | £5,068 | £2,500 |

### Limitations

Regional differences could not be explored based on the available data. This is because only national-level statistics were available for PGSI and other measures used for the economic modelling, even if the costs could be stratified by region. In addition, some providers only provide a particular Tier of service, and quality in provision could differ between providers, beyond just cost differences.

Therefore, based on the information available, it was not possible to consider a regional breakdown that was economically meaningful.

## Recommendations for improving data quality for economic evaluation

### Short term

We would recommend that treatment commissioners require providers to collect EQ-5D data for people engaging with NGSN services. This measure is recommended by NICE as the preferred measure of health-related quality of life (HRQoL) in adults for use in cost-utility analysis. Currently, the only utility decrements (loss of quality of life measure) available in the literature for PGSI use the SF-36 questionnaire.[35] These utility values were used in this analysis and are still useful measures of health. However, EQ-5D is the gold standard measure in the UK. Collecting EQ-5D would also allow for future research to create a mapping algorithm between CORE-10 and EQ-5D, if data are available for both measures.

Other outcome measures that would be useful to capture for use in economic evaluations are PHQ-9 and the General Anxiety Disorder-7 (GAD-7). Both measures have been linked to economic outcomes in previous studies, including not just health-related quality of life, but also other economic outcomes such as healthcare resource use.[36]

Our evaluation also encountered some other data quality and availability issues that could be addressed in the future. There were no data available on Tier 1 costs. Additionally, we did not have separate costs for Tier 2 and Tier 3 services and so had to make assumptions about the average costs of these services combined. Therefore, we would recommend that treatment commissioners collect more detailed cost data on these services.

Furthermore, as highlighted in the limitations, we were unable to analyse regional differences in service provision due to a lack of available data on regional outcome measures, including PGSI scores. Therefore, we would recommend stratifying data collection by region in the future.

### Long term

At present in the existing literature, there is no evidence that links CORE-10 to robust economic outcomes. Therefore, in the long term, we would recommend further research to be commissioned by centralised research bodies, such as the National Institute for Health and Care Research (NIHR) to link CORE-10 to economic outcomes, including resource use. This research could then be used to estimate an associated cost by CORE-10 score. This research is likely to require data linkage through electronic health records of people engaging with the NGSN service. This would provide a more holistic picture of the impact of the NGSN and allow for more clinically meaningful extrapolation of economic outcomes. If EQ-5D is found to lack sensitivity to changes in CORE-10, then future research may also be useful to perform direct elicitation of health by CORE-10 scores. These

[35] https://www.rand.org/health-care/surveys_tools/mos/36-item-short-form.html
[36] Catarino, A., Harper, S., Malcolm, R., Stainthorpe, A., Warren, G., Margoum, M. *et al.* (2023) "Economic evaluation of 27,540 patients with mood and anxiety disorders and the importance of waiting time and clinical effectiveness in mental healthcare." *Nature Mental Health*, 1(9), pp. 667–678.

elicitation methods are likely to involve time-trade off,[37] or other similar methods to elicit health-related quality of life.

[37] York Health Economics Consortium (2016) “Time Trade-Off [online].” York: York Health Economics Consortium. Available at: https://yhec.co.uk/glossary/time-trade-off/ (Accessed: 23 July 2025).

# 8. Conclusions and recommendations

## Conclusions

This evaluation has identified that the National Gambling Support Network (NGSN) is operationally, clinically and economically effective. There are clear pathways to further enhance its impact, consistency, and long-term sustainability, building on the existing initiatives that support the NGSN's effectiveness.

### Operational Effectiveness

The NGSN benefits from a strong foundation of committed providers and a shared ambition to reduce gambling harms. Collaboration between providers is already evident and plays a vital role in operational success. There is an opportunity to build on this by continuing to strengthen mechanisms such as working groups and informal learning exchanges, helping to embed more systematic knowledge sharing and service coordination across the network.

Referral pathways are in place, and action underway to further streamlining them should make it easier for service-users to access the most appropriate support. Increased strategic allocation of resources could help to reduce duplication in some regions and address gaps in others. Enhanced visibility of available services would also support more informed choices for service-users. The evaluation has found that the Model of Care principles are generally reflected in service delivery, and there may be potential to deepen their integration, particularly in relation to lived experience and self-determination, by promoting consistent application across the network.

### Clinical Effectiveness

The NGSN is well-positioned to expand its reach to underserved groups, including ethnic minorities, LGB+ individuals, and younger adults. While tailored services are already being delivered, there is scope to further combine this with targeted awareness-raising and engagement to help ensure that these services are taken up by those who need them most. Promising work is underway in this area through the Improving Outcomes Fund and Community Resilience Fund.

Eligibility criteria and referral mechanisms were found to vary across providers, and greater alignment of these could potentially improve access, especially for younger people and those seeking higher-tier support. Long-term recovery support provision is perceived as a valuable part of the service-user journey, and there is an opportunity to ensure consistency in its availability and emphasis across the network.

### Economic Effectiveness

Economic analysis has demonstrated the likely economic benefits of the NGSN services. For people who gamble, the NGSN is more effective and less costly than having no NGSN services, with savings driven by reduced hospitalisations, fewer GP appointments, and decreased prevalence of depression.

Current costs for Tier 2 and Tier 3 are substantially below their economically justifiable prices, suggesting that their cost effectiveness is resilient to future treatment cost increases. For affected others, the NGSN is cost effective, primarily due to savings from reduced depression severity. Tier 3 treatment for affected others was considered economically justifiable, with cost effectiveness also predicted to be resilient to cost increases. Tier 1 treatment for both populations was also considered

cost effective in many scenarios, particularly for affected others, although evidence was limited for Tier 1.

## Recommendations

### For NGSN Commissioners

1. Continue to invest in strengthening relationships between providers and local services
    - Continue to fund and support collaborative multi-agency working (e.g. MLS fund)
2. Continue to strengthen referral pathways into and between services
    - Provide a standardised contract template to streamline inter-provider referral agreements.
3. Further clarify long-term recovery support expectations across the network
    - Define a consistent minimum standard for long-term recovery services to ensure equitable support for all service-users.
4. Reduce the risk of duplication and promote service diversity
    - Review funding allocations to reduce overlap in services and encourage a broader range of support options, including long-term recovery support.
5. Support economic evaluation and outcome monitoring
    - Invest in research linking CORE-10 and other outcome measures (e.g. EQ-5D, the new Gambling Harms Severity Index) to economic impact, enabling more robust evaluation of service effectiveness.

### For NGSN Providers

1. Continue prioritising and tailoring awareness-raising to minoritised groups
    - Continue and expand awareness-raising efforts, ensuring they are led or co-led by individuals from the target communities to improve engagement and trust.
2. Continue to improve inter-provider collaboration
    - Foster stronger relationships between service teams to encourage timely referrals and reduce service fragmentation.
3. Support economic data collection
    - Begin collecting EQ-5D, PHQ-9, and GAD-7 data where feasible to support future economic evaluations and align with NICE guidance.
4. Continue to improve communications around the contribution of Lived Experience

- Consider being more open and transparent about the ways in which Lived Experience informs current service delivery (while protecting the anonymity of individuals with lived experience within the organisation), to boost trust, buy-in and confidence in services.

# 1. Appendix

## Appendix A: Further detail on methodology

### Provider survey

We originally received 151 survey completes across 13 providers, but it was decided to filter out responses from 4 providers because those providers declined to participate in the survey at an organisational level. We included 134 survey responses across 9 providers of around 15 minutes. Survey questions were mostly, mostly single and multicode questions, with two open text responses, and included routing towards modules relevant for leadership/practitioners. The survey was an opportunity for individuals working for NGSN organisations to tell us what they thought was working well and what could potentially be improved in how the NGSN operates, and in their organisation's delivery. A census approach of provider leadership, management and frontline practitioners gave us a breadth of evidence required to answer our research questions and was feasible given the staff population size.

Topics covered in the provider survey included views on participants' own skills and experience, tailoring of support to service-user needs, confidence in referral pathways, NGSN governance structure, and the embedding of Model of Care principles.

We took an organisational sampling approach as working with provider leadership showed staff members that we had their 'buy-in' and encouraged staff responses. Provider leadership were encouraged to promote the survey link via email communications (1 invite, and 2 reminders), staff newsletters and in staff meetings. This supported efficient administration, because it removed the need for Data protection Impact Assessments (DPIA) with each provider and the transfer of staff details to us for survey administration.

We maximised response rates and ensured accessibility by including definitions and examples in question wording to aid question understanding. We also ensured anonymity of responses and reporting in aggregate form so individuals who participated could not be identified.

Once providers confirmed the number and profile of staff within their organisation, we weighted the data and conducted descriptive analysis by overall responses and role type.

**Table 7. Sample composition**

| **Type of role** | **Number of respondents** |
|---|---|
| Senior leadership | 16 |
| Clinical services | 87 |
| Outreach services | 30 |
| | |
| **Support tier offered** | |
| Tier 1 | 47 |
| Tier 2 | 86 |
| Tier 3 | 78 |
| Tier 4 | 8 |

### Provider case studies

We conducted case study research with four providers that offer a range of support to aid comparisons of views and experiences of the NGSN. This approach was chosen as it was illustrative and aided in-depth exploration of our operational and clinical effectiveness research questions.

We recruited GamCare, Betknowmore, Beacon Counselling Trust and Adferiad for our case studies as there was a variety of experiences across providers of community outreach, clinical treatment, the National Gambling Helpline and regional and national support.

We initially reached out to leadership at potential case study organisations to ask for their participation. Once they had agreed to take part, they recommended practitioners or other members of staff to speak to for the practitioner focus group. This sampling approach helped us to efficiently gain relevant staff details and send out invites to these individuals.

Case studies included a 60-minute paired leadership discussion and a 90-minute group discussion with up to 6 frontline practitioners. All sessions were conducted virtually to increase accessibility for participants.

### Participatory Systems Map (PSM) Development

#### Overview

PSM was proposed for use in the scoping phase to explore and capture the complexity of systems of interest and use this to inform the overall evaluation design and delivery. The method engages stakeholders in exploring the complexity of the system they work in. It promotes a shared understanding of the context which the evaluation is operating in and, through making complexity explicit, it is intended to make it easier to identify what is important and where efforts should be focused. By using PSM, CECAN Ltd aimed to explore the factors affecting the operational effectiveness of NGSN.

#### Approach

- **Participatory Systems Mapping (PSM) workshop:** We hosted a two-and-a-half-hour in-person workshop, with two GambleAware staff and eight provider representatives, to brainstorm factors that affect the NGSN system's ability to reduce harm among people experiencing harm from gambling. Results informed the development of draft Participatory Systems Maps.

- **Participatory Systems Mapping (PSM) supplementary mapping interviews:** We also gathered input from two additional GambleAware staff, and two PCGS representatives, who were unable to attend the in-person workshop, across three virtual follow up sessions.

- **Participatory Systems Mapping (PSM) validation workshop:** The draft PSMs were presented to stakeholders (one GambleAware staff member and seven provider representatives) in a one-and-a-half-hour online session, to gather additional evidence to produce a single map.

# Appendix B: Key modelling assumptions

**Table 8. Key modelling assumptions**

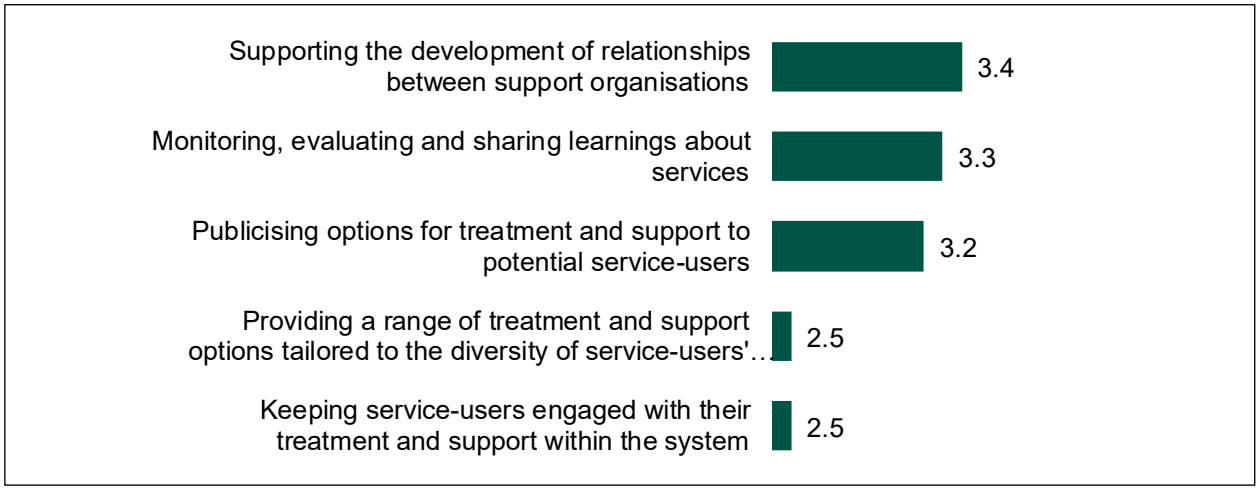
| Assumption | Justification | Likely impact on results |
|---|---|---|
| **Affected others included in the model using PHQ-9 as a proxy for CORE-10 scores.** | This is due to limited data on costs and health outcomes linked to CORE-10 score. This exploratory analysis was discussed with clinical experts to validate the assumptions used. | This may result in an under- or over-estimation of the impact on affected others through use of the services. It is difficult to estimate the direction of the bias for this assumption. Various sensitivity analysis will be run to provide a range of estimates, given this assumption. |
| **PGSI is the most appropriate measure to track treatment benefit for the economic analysis of those who are gambling.** | Previous literature has highlighted that PGSI is the most common measure within economic analysis. Furthermore, there is a substantial range of literature stratifying costs and health outcomes by PGSI. We acknowledge that PGSI may be limited to capture true effectiveness. However, at this time, we believe this is the most appropriate measure of benefit for the economic analysis. | If PGSI is less sensitive to improvements in wellbeing that may stem from intervention, then the model may underestimate the true treatment effect. We believe that future evidence should look to stratify economic outcomes by alternative metrics, such as PHQ-9, CORE-10 or GAD-7. Further detail will be provided in Phase 2 and 3 on future evidence generation. |
| **Alcohol and substance misuse are not included in the model.** | In the literature, correlation rather than causation between these behaviours has been found, suggesting a shared causal factor. | This may underestimate the impact of services to support people at risk from gambling. However, it is preferable to make a more conservative estimate than to potentially overestimate the true impact. |
| **Impact of aftercare is not included in the model.** | Insufficient evidence base for aftercare and the impact it may have on recurrent gambling in the literature. | This is a limitation, as the model will underestimate the continued benefits of aftercare. As above, it is preferable to make a more conservative estimate in the absence of evidence. |
| **The age of T1 service-users is the same as T3-T4.** | Absence of data for Tier 1 in the DRF. | This assumption will have limited impact to the model results as the model does not have a lifetime time horizon. |

## Appendix C: Link to economic model technical report

NGSN Evaluation - Final Economic Tech

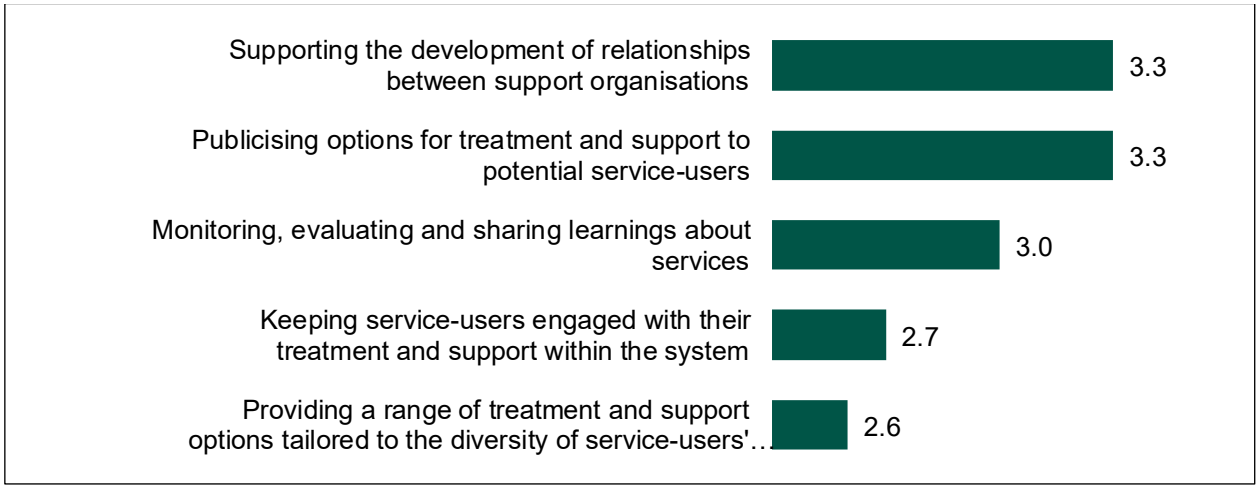
## Appendix D: Further charts and tables

**Figure 13. Mean ranking of success of PSM factors intended to reduce gambling harms: regionally**



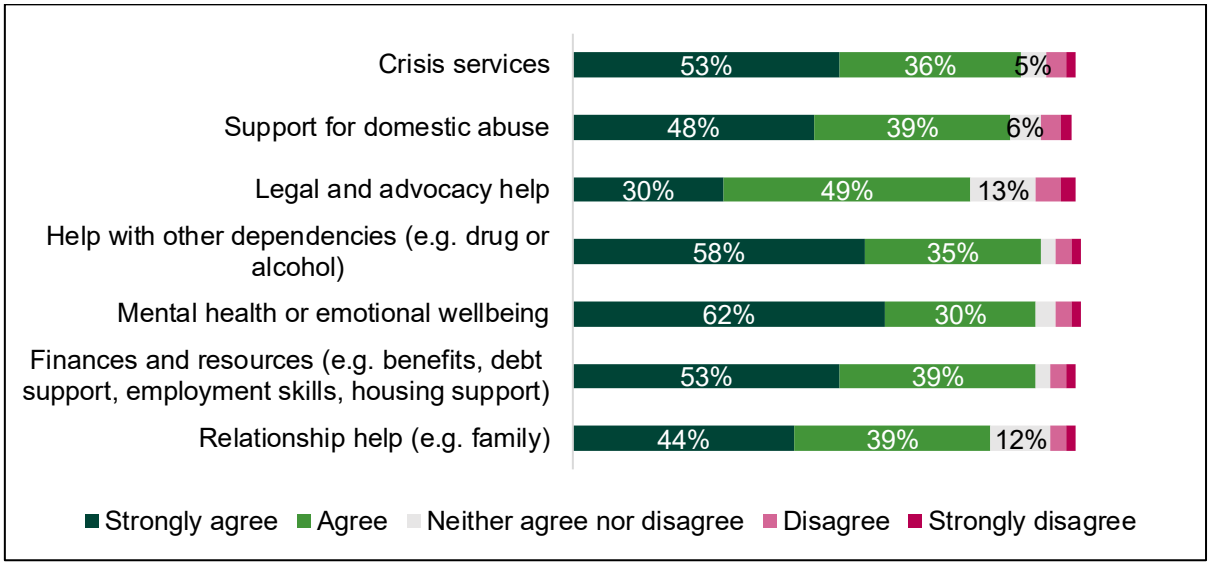

*C3. Please rank the following factors from 'most successful' to 'least successful', by typing a '1' next to the activity you think the NGSN is doing most successfully, and a '5' next to the activity you think the NGSN is doing least successfully, in the region(s) where [provider organisation] delivers services. Base: all staff excluding those who selected 'don't know' (115).*

**Figure 14. Mean ranking of success of PSM factors intended to reduce gambling harms: nationally**



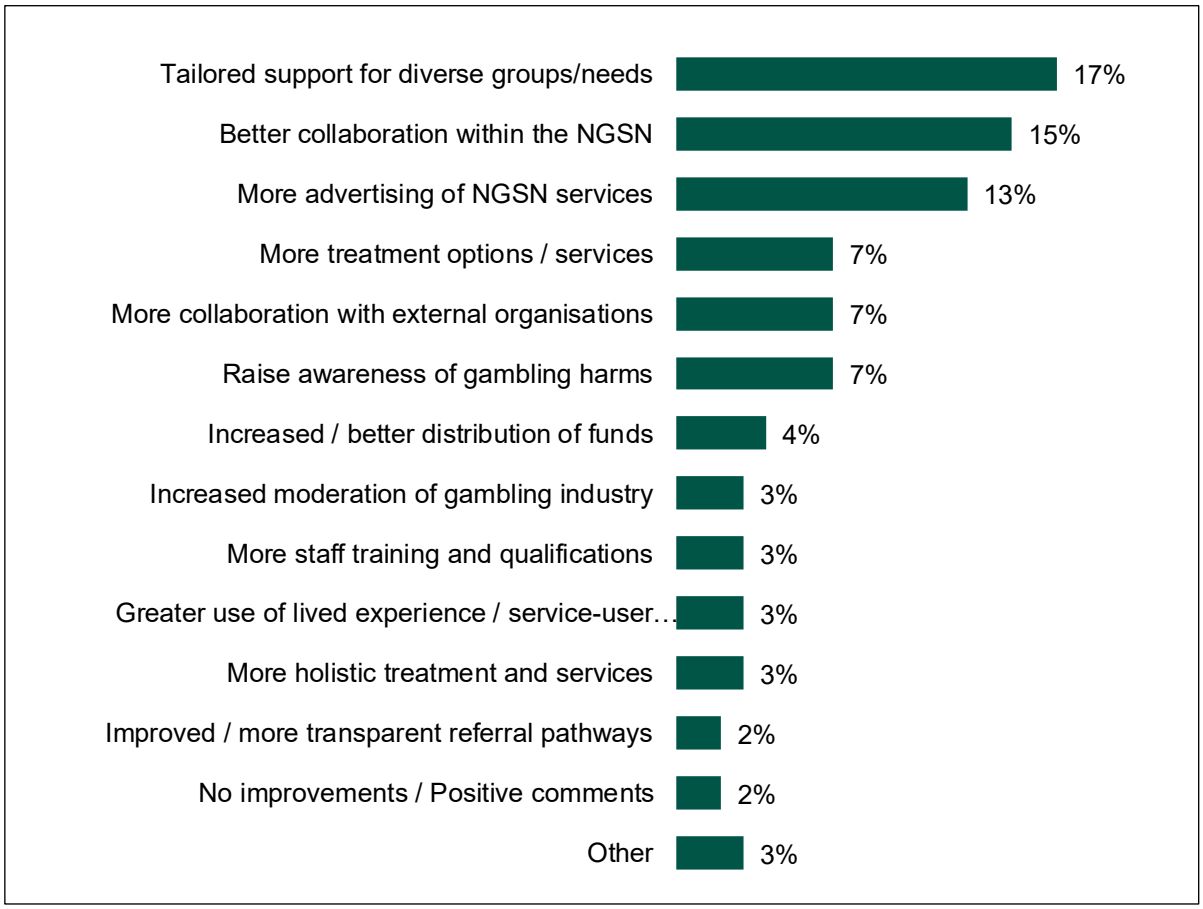

*C4. Please rank the following factors from 'most successful' to 'least successful', by typing a '1' next to the activity you think the NGSN is doing most successfully, and a '5' next to the activity you think the NGSN is doing least successfully, in the whole of Great Britain. Base: all staff excluding those who selected 'don't know' (96).*

**Figure 15. Agreement with statements relating to confidence referring service-users to external organisations for support for…**




*B8. To what extent do you agree or disagree that you feel confident referring service-users, where needed, to organisations outside of the NGSN for support for.... Base all frontline staff (109).*

**Figure 16. Ways in which staff believe the NGSN could be improved to reduce gambling harms in Great Britain**




*C7. Please provide any feedback you'd like to share on how the NGSN could be improved to reduce*

*gambling harms in Great Britain in the box below. Base all staff (134). 'Don't know' (45%) not included in chart.*

**Table 9. Gender of NGSN service-users (DRF)**

| Category | Frequency | Valid Percent |
|---|---|---|
| Male | 4790 | 65% |
| Female | 2457 | 33% |
| Male-to-female / Transgender female | 5 | 0% |
| Genderqueer | 3 | 0% |
| Non-listed category | 2 | 0% |
| Not know or refusal | 91 | 1% |

*Gender. Base: all records in DRF dataset between 01/10/23 – 30/09/24 (7348)*

**Table 10. Ethnic background of NGSN service-users (DRF)**

| Category | Frequency | Valid Percent |
|---|---|---|
| White | 6241 | 85% |
| Black | 199 | 3% |
| Asian | 393 | 5% |
| Mixed | 152 | 2% |
| Other | 11 | 0 |
| Not known or refusal | 352 | 5% |

*Ethnic background. Base: all records in DRF dataset between 01/10/23 – 30/09/24 (7348)*

**Table 11. Age of NGSN service-users (DRF)**

| Category | Frequency | Valid Percent |
|---|---|---|
| 18 to 24 | 548 | 7% |
| 25 to 34 | 2523 | 34% |
| 35 to 44 | 2249 | 31% |
| 45 to 54 | 1084 | 15% |

| | | |
|---|---|---|
| 55 to 64 | 731 | 10% |
| 65 or over | 200 | 3% |
| Not known or refusal | 13 | 0% |

*Age. Base: all records in DRF dataset between 01/10/23 – 30/09/24 (7348)*

**Table 12. Sexual Orientation of NGSN service-users (DRF)**

| Category | Frequency | Valid Percent |
|---|---|---|
| Lesbian, gay or homosexual | 137 | 2% |
| Heterosexual | 4256 | 58% |
| Bisexual | 55 | 1% |
| Other | 7 | 0% |
| Not known or refusal | 2890 | 39% |

*Sexual orientation. Base: all records in DRF dataset between 01/10/23 – 30/09/24 (7348). Please note that 3 records were missing.*

**Table 13. Religious affiliation of NGSN service-users (DRF)**

| Category | Frequency | Valid Percent |
|---|---|---|
| No religion | 2549 | 35% |
| Christian | 848 | 12% |
| Buddhist | 17 | 0% |
| Hindu | 38 | 1% |
| Jewish | 11 | 0% |
| Muslim | 153 | 2% |
| Sikh | 27 | 0% |
| Other religion | 87 | 1% |
| Unrecognised code | 16 | 0% |
| Not known or refusal | 3599 | 49% |

*Religious affiliation. Base: all records in DRF dataset between 01/10/23 – 30/09/24 (7348). Please note that 3 records were missing.*

**Table 14. Region of NGSN service-users (DRF)**

| Category | Frequency | Valid Percent |
|---|---|---|
| London | 758 | 11% |
| North East | 445 | 6% |
| North West | 1258 | 18% |
| Yorkshire & The Humber | 504 | 7% |
| East Midlands | 494 | 7% |
| West Midlands | 601 | 8% |
| East of England | 897 | 13% |
| South East | 1080 | 15% |
| South West | 522 | 7% |
| Scotland | 163 | 2% |
| Wales | 394 | 6% |
| Northern Ireland | 6 | 0% |

*Region. Base: all records in DRF dataset between 01/10/23 – 30/09/24 (7348). Please note that 226 records were missing.*

**Table 15. Ethnic minority background - share of total demand for treatment/support (Treatment and Support Survey 2024)**

| | Total count | Ethnic minority background count | % share of people who gamble who want treatment/support accounted for by ethnic minorities (share of total demand) |
|---|---|---|---|
| Net: Want any treatment or support | 960 | 305 | 32% |

**Table 16. Ethnic minority background - share of total need for treatment/support (Treatment and Support Survey 2024)**

| | Total count | Ethnic minority background count | % share of people with PGSI 8+ accounted for by ethnic minorities (share of total need) |
|---|---|---|---|
| PGSI score 8+ | 742 | 224 | 30% |

**Table 17. Muslim background - share of total demand for treatment/support (Treatment and Support Survey 2023)**

| | Total count | Muslim background count | % share of people who gamble who want treatment/support accounted for by Muslims (share of total demand) |
|---|---|---|---|
| Net: Want any treatment or support | 625 | 41 | 7% |

**Table 18. Muslim background - share of total need for treatment/support (Treatment and Support Survey 2023)**

| | Total count | Muslim background count | % share of people with PGSI 8+ accounted for by Muslims (share of total need) |
|---|---|---|---|
| PGSI score 8+ | 535 | 41 | 8% |

**Table 19. Aged 18-24 - share of demand for treatment/support (Treatment and Support Survey 2024)**

| | Total count | Aged 18-24 count | % share of people who gamble who want treatment/support accounted for by people aged 18-24 (share of total demand) |
|---|---|---|---|
| Net: Want any treatment or support | 960 | 226 | 24% |

**Table 20. Aged 18-24 - share of total need for treatment/support (Treatment and Support Survey 2024)**

| | Total count | Aged 18-24 count | % share of people with PGSI 8+ accounted for by people aged 18-24 (share of total need) |
|---|---|---|---|
| PGSI score 8+ | 742 | 169 | 23% |

**Table 21. Regional share of demand for treatment/support (Treatment and Support Survey 2023)**

| | Total | NE | NW | YORKS | EM | WM | EAST | LDN | SE | SW | WLS | SCO |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Net: Want any treatment or support (count) | 625 | 27 | 76 | 50 | 41 | 57 | 38 | 211 | 45 | 26 | 26 | 27 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Net: Want any treatment or support (share) | 100% | 4% | 12% | 8% | 7% | 9% | 6% | 34% | 7% | 4% | 4% | 4% |

**Table 22. Regional share of need for treatment/support (Treatment and Support Survey 2023)**

| | Total | NE | NW | YORKS | EM | WM | EAST | LDN | SE | SW | WLS | SCO |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PGSI score 8+ (count) | 535 | 21 | 69 | 38 | 30 | 62 | 31 | 162 | 43 | 20 | 27 | 31 |
| PGSI score 8+ (share) | 100% | 4% | 13% | 7% | 6% | 12% | 6% | 30% | 8% | 4% | 5% | 6% |

**Table 23. LGB+ share of demand for treatment/support (Treatment and Support Survey 2023)**

| | Total count | LGB+ count | % share of people who gamble who want treatment/support accounted for by LGB+ people (share of total demand) |
|---|---|---|---|
| Net: Want any treatment or support | 625 | 73 | 12% |

**Table 24. LGB+ share of total need for treatment/support (Treatment and Support Survey 2023)**

| | Total count | LGB+ count | % share of people with PGSI 8+ accounted for by LGB+ people (share of total need) |
|---|---|---|---|
| PGSI score 8+ | 535 | 68 | 13% |

**Table 25. Proportion of service-users that self-referred into NGSN treatment, split by treatment tier**

| Self-referral | | | | | |
|---|---|---|---|---|---|
| | | Tier 2 only | Tier 3 only | Tier 4 only | Tier 2 and 3 only |
| Not self-referral | Count | 245 | 2770 | 370 | 1550 |
| | % within Tier | 51% | 78% | 57% | 73% |
| Self-referral | Count | 234 | 764 | 277 | 564 |

| | | | | | |
|---|---|---|---|---|---|
| | % within Tier | 49% | 22% | 43% | 27% |

*Base: all records in DRF dataset between 01/10/23 – 30/09/24 (7348)*

**Table 26. Proportion of service-users referred into NGSN treatment through National Gambling Helpline, split by treatment tier**

| National Gambling Helpline | | | | | |
|---|---|---|---|---|---|
| | | Tier 2 only | Tier 3 only | Tier 4 only | Tier 2 and 3 only |
| Not referred by National Gambling Helpline | Count | 271 | 1459 | 623 | 798 |
| | % within Tier | 57% | 41% | 96% | 38% |
| Referred by National Gambling Helpline | Count | 208 | 2075 | 24 | 1316 |
| | % within Tier | 43% | 59% | 4% | 62% |

*Base: all records in DRF dataset between 01/10/23 – 30/09/24 (7348)*

**Table 27. Proportion of service-users with caring responsibilities for children, split by treatment tier**

| | | Tier 2 only | Tier 3 only | Tier 4 only | Tier 2 and 3 only |
|---|---|---|---|---|---|
| Yes | Count | 62 | 1161 | 331 | 723 |
| | % within Tier | 13% | 33% | 51% | 34% |
| No | Count | 110 | 1676 | 272 | 1070 |
| | % within Tier | 23% | 47% | 42% | 51% |
| Not known or refusal | Count | 307 | 694 | 44 | 321 |
| | % within Tier | 64% | 20% | 7% | 15% |

*Base: all records in DRF dataset between 01/10/23 – 30/09/24 (7348)*

**Table 28. Proportion of service-users in employment, split by treatment tier**

| | | Tier 2 only | Tier 3 only | Tier 4 only | Tier 2 and 3 only |
|---|---|---|---|---|---|
| Working | Count | 317 | 2368 | 306 | 1440 |
| | % within Tier | 66% | 67% | 47% | 68% |

| | | | | | |
|---|---|---|---|---|---|
| Not working | Count | 120 | 985 | 303 | 504 |
| | % within Tier | 25% | 28% | 47% | 24% |
| Not known or refusal | Count | 42 | 181 | 38 | 170 |
| | % within Tier | 9% | 5% | 6% | 8% |

*Base: all records in DRF dataset between 01/10/23 – 30/09/24 (7348)*

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