Online peer support for gambling harms in Great Britain

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Executive Summary

Background

Gambling-related harm remains a significant public health issue in Great Britain, yet reported rates for formal help-seeking are persistently low. Stigma, shame, limited service availability, practical barriers, and concerns about privacy deter many people from accessing formal support. These barriers disproportionately affect groups such as women, minoritised communities, people with caring responsibilities, and those experiencing co-occurring mental health difficulties.

Online peer support has emerged as an increasingly prominent form of help within this context. Delivered through forums (such as Reddit), messaging platforms (such as WhatsApp), social media groups (such as groups on Facebook), and online meetings (such as group meetings hosted by service providers like Gordon Moody), it enables people affected by gambling harms to connect with others who share lived experience. These spaces offer anonymity, flexibility, and accessibility, allowing individuals to engage at their own pace and in ways that feel manageable.

Despite widespread use, the evidence base for online peer support in gambling contexts has been limited. This programme of research was designed to address that gap, providing an integrated examination of how online peer support is accessed, experienced, and perceived, and how it fits within the wider gambling harm support system.

Approach

This synthesis draws together findings from four complementary research strands:

1. **Rapid Evidence Assessment (REA):** A structured review of existing literature on online peer support from the past 10 years, including gambling-specific studies and relevant evidence from mental health and drug and alcohol use contexts.
2. **Qualitative Interviews:** In-depth interviews with 24 people (14 males and 10 females, aged from 20s-50s) with lived experience of gambling harm and 24 service providers (16 males and 8 females, aged from 20s-60s) involved in delivering or overseeing online peer support.
3. **Quantitative Survey:** A survey of 520 respondents, examining patterns of online peer support use, engagement behaviours, motivations, perceived benefits and challenges, and relationships with gambling harm severity (measured using the 9-item Problem Gambling Severity Index, and the 7-item Gambling Harm Severity Index).
4. **Forum Analysis:** A thematic and content analysis of naturally occurring posts from public online gambling harm peer forums (two housed within support service provider websites, and one within a gambling harm focused subsection of a general online discussion forum), focusing particularly on help-seeking behaviour and responses during periods of distress and suicidality over the past 12 months.

Together, these strands provide both depth and breadth, capturing lived experience, service delivery perspectives, behavioural patterns, and real-world interactions.

Key Findings

The role of online peer support

Online peer support occupies a distinctive position within the gambling harm support landscape. It is most often used alongside other forms of help, rather than replacing them, although for a minority it represents the primary or only source of support. Its core value lies in connection with others who understand gambling harm through lived experience, which - qualitative interview data informs us - helps reduce shame, normalise recovery, and foster hope.

Modes of engagement

Engagement with online peer support for gambling harm is varied, non-linear, and frequently indirect. Many people benefit through passive or low-visibility engagement (such as reading posts or observing discussions), which survey data showed to be a common behaviour, and which was consistently reported as meaningful and legitimate by qualitative interview participants. Active engagement takes diverse forms, including posting, messaging, attending online meetings, and providing support to others. People often move fluidly between different formats and levels of involvement as needs and circumstances change.

Accessibility and availability

Online peer support lowers practical and psychological barriers to help-seeking for gambling harm. Survey and qualitative interview data converged in demonstrating that participants valued its flexibility, anonymity, and availability outside standard service hours. Within interviews, participants shared how synchronous formats (such as messaging groups and live online meetings) were particularly valued for providing real-time emotional containment during moments of distress or heightened risk.

While online peer support has the potential to widen access to support for gambling harm, engagement and benefit are not evenly distributed. Digital literacy, financial constraints, and lack of culturally or demographically specific spaces may limit accessibility for some groups. Women-only spaces were consistently identified by interview participants as particularly valuable, and there is a need for greater attention to inclusion and representation. Some highly valued modalities of online peer support, such as one-to-one support, are constrained by availability, such that some users would continue to engage with them for longer, if resources allowed.

Crisis and safeguarding

People who experience gambling harm sometimes turn to online peer support during periods of acute distress, including crisis-level situations. While peer responses can offer empathy and validation, this research highlights limits to what peer-led spaces can reasonably provide in relation to crisis management for gambling harm. Expressions of need are often indirect or ambiguous – such as forum posts where people describe suicidal ideation or intent euphemistically – meaning that approaches relying solely on explicit crisis language may miss individuals at risk.

It is also important to acknowledge the potential burden carried by individuals providing peer-support to others, particularly in formalised, responsible “peer supporter” roles. We heard from those working in service provision, and those with experience of online peer support delivery, how

training, boundaries, and appropriate support are important safeguards to mitigate against the challenges of providing peer support. These challenges include emotional burnout and boundary management for peer supporters, and the risk of unsafe or harmful interactions for users.

These tensions underscore the importance of proportionate safeguarding and clarity about the role of online peer support within wider support systems.

Implications

The findings suggest that online peer support should be understood as a flexible, relational resource within a broader ecosystem of gambling harm support. Evaluations that focus only on visible participation risk underestimating reach and impact. Clearer positioning of online peer support within the system (by service commissioners and providers), appropriate safeguarding expectations, and support for peer supporters are critical for sustainability and safety.

Limitations and Future Research

The programme focused on perceived benefits and experiences rather than direct measurement of outcomes. Future research should examine the impact of online peer support on recovery trajectories and wellbeing, ideally through longitudinal and comparative designs (e.g. comparing online peer support with online professional support, or with face-to-face peer support). There is also a need for research focused on under-represented groups and on how different online peer support models interact with formal services over time.

Conclusion

Online peer support plays a meaningful and distinctive role in responding to gambling harms in Great Britain – characterised by features including potential for anonymity and 24-7 availability. When appropriately supported and integrated, it can extend the reach of the support system, offering accessible, responsive, and relational forms of help that complement formal provision.

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1. Introduction and background

1.1 Brief contextual background and rationale for the work

Gambling-related harm is increasingly recognised as a significant public health issue, encompassing a wide range of adverse consequences that extend beyond gambling behaviour itself, including financial hardship, psychological distress, relationship breakdown, and reduced quality of life[1,2]. Findings from the 2023 *Gambling Survey for Great Britain Annual Report* (a nationally representative cross-sectional household survey of adults in England, Scotland and Wales) demonstrate that gambling harms are not confined to individuals classified as 'problem gamblers' (with scores on the Problem Gambling Severity Index (PGSI) of 8+), but are experienced across the risk spectrum, including among those reporting low (PGSI scores of 1+) and moderate risk gambling behaviours (PGSI scores of 3+). Despite the scale and distribution of harm, engagement with formal support services remains limited, and only a small minority of individuals experiencing gambling-related harm report accessing treatment or professional support, even where harms are ongoing or severe[3].

Significant barriers to support include perceived stigma, lack of insight into harms, doubt about the relevancy or appropriateness of services, and inaccessibility.[4] Stigma, in particular, plays a significant role in limiting help-seeking for gambling-related harm.[5,6,7] Accounts from individuals affected by gambling harm consistently highlight the presence of multiple forms of stigma, including anticipated, enacted, and internalised stigma.[8,9] In parallel, research examining public attitudes suggests a general reluctance to engage socially with people who have experienced gambling-related difficulties,[10] pointing to the broader presence of social stigma surrounding gambling harm.

Beyond acting as a social barrier, stigma can itself be harmful, as it is closely linked to psychological distress[11] and poorer quality of life.[12] Gambling-related harm can also have profound consequences for interpersonal relationships, further reinforcing isolation and barriers to recovery. Financial secrecy, repeated breaches of trust, and attempts to conceal gambling behaviour can place considerable strain on relationships with partners, family members, and friends. Over time, these

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dynamics may lead to conflict, emotional distance, and, in some cases, relationship breakdown.[13,14,15] Experiences of shame and fear of judgement can further inhibit open communication, making it difficult for individuals to seek understanding or support.[16] As trust deteriorates and relationships become strained, informal sources of support may be lost, reducing social connectedness at a time when it may be most needed and increasing vulnerability to ongoing harm.

Against this backdrop, online peer support has emerged as an increasingly important form of help, offering a potentially more accessible, less stigmatising, and more flexible alternative to formal services. Online peer support can be understood as support delivered through digital platforms by individuals who have personally experienced a particular challenge or difficulty, offered to others facing similar situations. This working definition is informed by wider conceptualisations of peer support in the health and mental health literature as a system of mutual support between people with lived experience, grounded in respect, shared responsibility, and reciprocal engagement (drawing on Mead et al., 2001)[17] as well as more recent definitions of digital or online support as peer-to-peer support delivered via Internet-enabled technologies.[18]

These interactions can take a variety of formats, ranging from asynchronous discussion forums to synchronous chatrooms, structured video-based meetings, social media groups, or private messaging channels via platforms such as WhatsApp, Discord, or Telegram. A central feature of these environments is that they permit users to engage on their own terms: anonymously or pseudonymously, at a pace they choose, and in ways that accommodate varying levels of comfort with disclosure.

Although research on online peer support specifically for gambling harms to date has been limited, a broad evidence base across related domains such as mental health,[19] physical health conditions,[20] and parenting[21] provides important insights into why peer-led spaces can be particularly valued. People consistently identify shared experience as a unique and defining strength of peer support. Lived experience knowledge often feels more authentic, credible, and emotionally resonant than advice from professionals.[22] Users describe feeling more understood by people who have "been

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there," which can reduce feelings of isolation and create a sense of solidarity or collective identity.[23] These environments may facilitate disclosures that feel too risky, shameful, or exposing in formal clinical settings, especially when perceived power imbalances or professional boundaries act as barriers to openness.[24]

Evidence from mental health contexts suggests that peer support can reduce isolation, normalise difficult emotions, and enhance self-efficacy and hope.[25,26] Seeing others make progress, even when imperfect or non-linear, can help individuals recognise that change is possible, while also providing practical strategies for managing cravings, distress, or relapse. The structural characteristics of digital peer support, especially its flexibility, anonymity, and asynchronous availability, may be particularly important for people who are cautious, fearful of judgement, or dealing with complex life circumstances.[27] Online spaces allow users to observe before participating, to tailor their disclosure, and to engage at moments that feel safe or manageable.

These potential benefits can be contextualised through a range of theoretical frameworks. The helper-therapy principle[28] suggests that helping others can promote a sense of purpose, competence, and self-worth; social comparison theory[29] illuminates how observing others' successes or struggles can shape motivation: upward comparisons can instil hope, while downward comparisons may validate one's progress or resilience; and social learning theory emphasises the power of learning behaviours through peer observation.[30] A recent review draws together evidence of how these theories can inform our understanding of online peer support for mental health,[31] which can, intuitively, be extrapolated to understanding online peer support for gambling harms.

However, online peer support is not without risks. Studies across various domains have documented challenges such as inconsistent or absent moderation, exposure to triggering content, the circulation of misinformation, and hostile or exclusionary interactions.[32,33,34] The blurred boundaries and unstructured nature of some online peer support spaces can also place emotional pressure on participants, for example, when individuals in distress turn to forums for immediate safety or crisis

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support.[35] These risks do not negate the value of online peer support but underscore the need to understand the conditions under which benefits are enhanced or undermined.

Despite the dearth of empirical research on gambling-specific online peer support,[36] such support is widely available across Great Britain. Third-sector organisations such as GamCare, Gordon Moody, and Gamblers Anonymous UK offer structured or semi-structured online groups, while large self-organised peer communities operate on platforms such as Reddit and Facebook. These spaces may attract people who do not engage with formal services, including individuals who face significant stigma, lack privacy, have caring responsibilities, or live in regions where in-person services are limited – patterns that are consistent with wider evidence on digital help-seeking and online peer support in mental health and addiction contexts.[37,38,39,40]

Given the potential reach of these communities, and the vulnerability of the populations they serve,[41] there is need for empirical evidence to inform the optimisation of such online peer support, supporting safe, fair, and effective service provision.

1.2 Goal of the current programme of research

This programme of research brought together four complementary studies to build an integrated understanding of how individuals affected by gambling harms access and experience online peer support. We sought to learn who uses online peer support, how it is used, why individuals choose to engage with it, and what their experiences of it are – building an in-depth picture of how online peer support operates in practice.

This included examining the types of support for gambling harm people seek, observe, and provide within peer-led online spaces; the ways individuals engage with different formats such as forums, messaging groups, online meetings, and one-to-one support; and the perspectives of both people with lived experience of gambling harm and service providers involved in delivering or overseeing these forms of support. Particular attention was given to understanding the perceived benefits of online peer support, alongside the challenges, risks, and limitations that may arise through engagement.

Our ultimate aim was to help inform decisions about the development, delivery, and governance of online peer support for gambling harms, supporting the design of provision that is accessible, safe, and appropriately integrated with other forms of support.

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1.3 Overview of the research strands

Strand 1: Rapid evidence assessment

A rapid evidence assessment, synthesising existing research on online peer support for gambling harms, drawing on supplementary evidence from adjacent fields such as mental health and substance use. This was conducted across major databases (PubMed, Scopus, Web of Science, EBSCOhost and Google Scholar), and covered literature published within the last 10 years.

Strand 2: Qualitative interviews

In-depth interviews with individuals with lived experience of gambling harm (*n* = 24) and with gambling harms service providers (*n* = 24), to generate in-depth insights into experiences of using and providing online peer support, including perceived benefits, risks, and challenges.

Strand 3: Quantitative survey

A cross-sectional survey of *n* = 520 people, examining patterns of online peer support use across different demographic groups and levels of gambling-related harm, alongside participants' reported experiences of use and perceived benefits and challenges.

Strand 4: Forum data analysis

A text-based analysis of naturalistic data from three publicly accessible online peer support forums focused on gambling-related harms, including two UK-based service-provider forums and a large general discussion platform with a dedicated gambling support sub-community, examining help-seeking behaviours, expressions of distress, peer responses, and community dynamics through content and thematic analysis, covering posts from the last 12 months.

2. Rapid evidence assessment

2.1 Overview

The REA was conducted to provide a timely yet rigorous overview of the existing research on online peer support for gambling-related harm. Its purpose was to establish what is currently known (and what is unknown) about the role, mechanisms, benefits, and risks of online peer support. Although peer support is well-established in other areas of mental health and addiction,[42,43,44] far less is known about its online forms in the context of gambling harm. The REA therefore aimed to map and synthesise the available evidence to inform the design and interpretation of the empirical studies within this programme of work.

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2.2 Method

The review followed a structured and transparent method consistent with established REA guidance.[45] Searches were conducted across major health, psychology, and interdisciplinary databases (PubMed, Scopus, Web of Science, EBSCOhost and Google Scholar) in November 2024. Keywords and search terms were constructed around two primary concepts: online peer support (terms included online peer support, digital peer support, virtual peer support, online support groups, internet-based peer support, web-based peer support, social media support, web chat, online forum, online mutual aid and e-support), and gambling harms (gambl*, addict*, disord*, problem, harm, recovery, treatment, support and pathological). A pilot search retrieved very few papers on online peer support for gambling harm, so, given there are a number of parallels between treatment experiences for different kinds of addiction,[46] a decision was made to include the broader areas of online peer support for substance and alcohol harm (using the search terms addiction, substance addiction, substance use disorder, alcohol addict*, alcohol use disorder, drug addict*, behavioural addiction, substance dependency, alcohol dependency, alcohol abuse, drug abuse, problem drinking).

Inclusion criteria focused on empirical research (qualitative, quantitative, mixed-methods, reviews) that examined any form of digital peer support (such as online forums, chatrooms, mutual aid communities, and social media groups) used by people affected by gambling harm. Only studies published in English, and within the last 10 years, were included, in order to prioritise evidence reflecting contemporary digital platforms, technologies, and patterns of online engagement, which have evolved rapidly over the past decade.

Following title and abstract screening, retained studies were subjected to a structured relevance and rigour assessment to determine their suitability for inclusion in the synthesis. Papers were first scored for basic relevance, including methodological type, topical focus (e.g. gambling versus other addictions), geographic scope, recency, and the extent to which online peer support constituted a central focus. Studies were then assessed against the review research questions, evaluating the extent to which they provided substantive insight into engagement with online peer support, perceived benefits, and challenges. To address concerns regarding "insufficient weight of evidence", a binary weight-of-evidence screening process was applied, whereby papers were required to meet baseline criteria for methodological transparency and rigour in order to be retained. These criteria included, for example, a clear statement of aims, appropriate and justified sampling or data selection strategies, transparent and suitable methods of data collection and analysis, explicit consideration of ethical issues, adequate presentation of evidence to support conclusions, and critical discussion of limitations. Papers failing to meet one or more of these baseline criteria were excluded from the final synthesis. While no formal quality appraisal tool was applied, consistent with REA guidance, this structured screening process ensured that only studies providing a minimum

[45] Crawford, C., Boyd, C., Jain, S., Khorsan, R., & Jonas, W. (2015). Rapid Evidence Assessment of the Literature (REAL©): streamlining the systematic review process and creating utility for evidence-based health care. *BMC Research Notes*, *8*(1), 631. https://doi.org/10.1186/s13104-015-1604-z

[46] Grant, J. E., & Chamberlain, S. R. (2020). Gambling and substance use: Comorbidity and treatment implications. *Progress in Neuro-psychopharmacology & Biological Psychiatry*, *99*, 109852. https://doi.org/10.1016/j.pnpbp.2019.109852

standard of evidential robustness and relevance were included (full methodological details are reported in a separate paper which is under review).[47]

Figure 1 summarises the screening and study selection process, and key insights from the rapid evidence assessment are summarised in

[47] Penfold, K. L., Nicklin, L., L., Devonport, T., Orchard, L., Chadwick, D., Huntington, C. & Lloyd, J. (under review). *Online peer support for gambling harms: A rapid assessment of the existing research evidence*. Manuscript under review.

Table **1**.

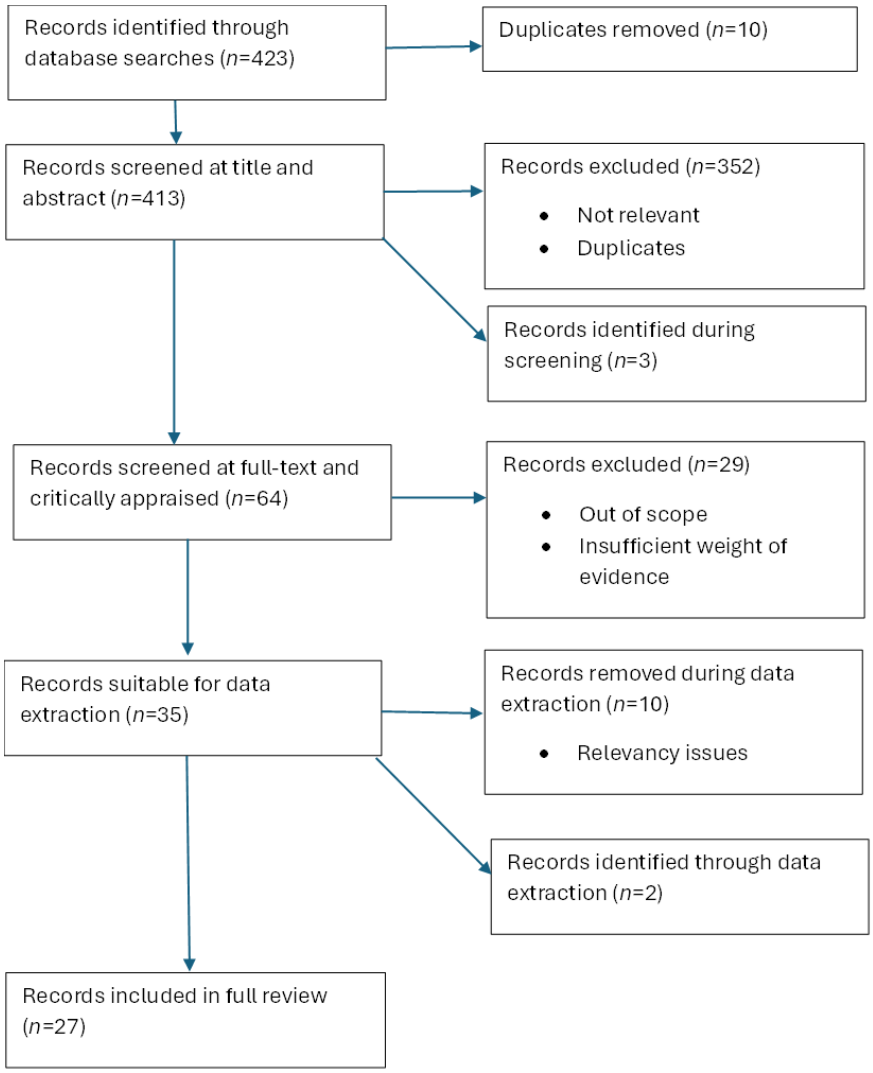

Figure 1: PRISMA flowchart: screening process

2.3 Summary of existing literature on online peer support for gambling harms

Only four studies specifically related to gambling harm were retrieved from the search, though these studies offer valuable, highly relevant insights. Bradley & James[48] conducted a correlated topic modelling analysis of data scraped from online gambling harm support forums to examine what people discuss within these spaces. They identified ten topics grouped into four overarching themes: negative emotions, recovery resources, gambling products, and financing gambling. The most prominent discussions centred on negative emotions associated with gambling, including pain and distress, suggesting that many users turn to forums to articulate and share emotional experiences. Recovery resources shared within the forums included both formal and informal forms of support, such as creative uses of online communities to exchange helpful content and inspire positive change. While the study did not explicitly examine the motivations or benefits underlying these patterns, the

[48] Bradley, A., & James, R. J. (2021). Defining the key issues discussed by problematic gamblers on web-based forums: a data-driven approach. *International Gambling Studies*, *21*(1), 59-73. https://doi.org/10.1080/14459795.2020.1801793

findings illustrate how forums function as spaces for emotional expression, information exchange, and experiential sharing, highlighting the potential emotional and informational functions of online peer support. Ferentzy and colleagues[49] situate these digital interactions within a broader historical and conceptual account of online mutual aid for problem gambling, drawing on both a review of the literature and qualitative interviews with two current members of Gamblers Anonymous, and one non-member who is "nonetheless very active in employing up to date technology to coordinate recovery options for problem gamblers" (pp. 24). Their work highlights how the digital environment has increasingly become a meaningful extension of traditional peer support, offering opportunities for enhanced accessibility, anonymity, and flexibility, while also raising concerns about moderation, cohesion, and the preservation of core mutual aid principles in online spaces.

Penfold and Ogden's[50] qualitative study of people who attended Gamblers Anonymous (*n* = 21) during the COVID-19 pandemic showed that individuals continued to value the sense of shared understanding, emotional resonance, and mutual encouragement when meetings moved online. Participants described both benefits, such as increased convenience and reduced social anxiety, and challenges, such as reduced intimacy and the loss of certain rituals central to Gamblers Anonymous culture. In a related qualitative study, Penfold and Ogden[51] explored people who gamble's (*n* = 10) experiences of a broader range of interventions for gambling harm alongside online peer support, and identified how meaningful support is shaped not only by the modality of delivery but also by relational dynamics, perceptions of authenticity, and the ability to connect with others who have lived experience.

These studies reveal how people actively engage with online peer support for emotional validation, practical guidance, and shared identity, while also underscoring the role of digital platforms in sustaining community and offering accessible pathways into recovery. They also highlight important considerations around safety, cohesion, and the maintenance of supportive norms in online environments, pointing to the need for further research to evaluate the challenges, as well as the benefits of gambling-specific digital peer support.

2.4 Summary of selected findings from the wider online peer support literature

Findings from the wider online peer support literature highlight several consistent themes in how people engage with and experience digital recovery communities. In the interests of space, selected references are provided within this section, but readers seeking greater detail can refer to the forthcoming full literature review paper.

A central feature across studies is the sharing of personal experiences. Users of online forums for substance use and alcohol harm frequently disclose their struggles in anonymous, non-judgemental environments, which facilitates emotional expression, reduces isolation, and fosters a sense of solidarity grounded in shared lived experience.[52] These interactions appear to support the

[49] Ferentzy, P., Sanchez, S., & Turner, N. E. (2019). Technology and mutual aid for problem gambling: the past and the future. *Journal of Concurrent Disorders*, *1*(2), 20. https://doi.org/10.54127/usqz5590

[50] Penfold, K. L., & Ogden, J. (2022). Exploring the experience of Gamblers Anonymous meetings during COVID-19: a qualitative study. *Current Psychology*, *41*(11), 8200-8213. https://doi.org/10.1007/s12144-021-02089-5

[51] Penfold, K. L., & Ogden, J. (2022). Exploring gamblers' experiences of problem gambling interventions: A qualitative study. *Cogent Psychology*, *9*(1), 2138805. https://doi.org/10.1080/23311908.2022.2138805

[52] Peart, A., Horn, F., Petukhova, R., Barnett, A., & Lubman, D. I. (2024). Web-Based Forums for People Experiencing Substance Use or Gambling Disorders: Scoping Review. *JMIR Mental Health*, *11*(1), e49010. https://doi.org/10.2196/49010

development of collective identity and can enhance motivation for change, offering a buffer against the negative effects of self-stigma and improving self-efficacy and well-being.[53]

Another core feature is the exchange of practical advice and experiential knowledge. Participants routinely seek and offer strategies for managing urges, coping with risk, navigating finances, and accessing professional and informal resources.[54,55] This reciprocal support can reinforce users' sense of agency, and became particularly valuable during COVID-19, when access to face-to-face services was restricted.[56] Online spaces also support relationship-building: for some individuals they maintain connections originally formed offline, whereas others use them to expand social networks and develop new sources of belonging.[57]

Patterns of engagement vary, with "lurking" emerging as the most common participation style. For example, one study described how "lurking" afforded participants the opportunity to gain information and reassurance from similar people, while also allowing them to maintain secrecy about continued substance use or an ambivalence towards change, highlighting the complex role of observational engagement in online peer support environments.[58] Another study, using a social network analysis of Reddit, showed that online communities often comprise a highly active central group surrounded by more peripheral members (who seldom post), with the network operating as an interconnected system.[59] The anonymity afforded by online spaces plays an important though complex role. While it can reduce stigma-related barriers to help seeking and facilitate honest disclosure,[60] it can also reduce trust, and raise privacy concerns, and can both reduce accountability[61] and (for small groups) increase it.[62]

Motivations for using online peer support are diverse and goals include receiving or providing mutual support; enhancing self-awareness; and achieving moderation, maintenance or abstinence in substance use.[63] In some communities, such as those adopting a "radical acceptance" stance, users initially join to continue their substance use, yet discussions still tend to prompt reflection on behaviour change.[64] Online spaces also function as important sources of information, with

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[53] Bliuc, A. M., Doan, T. N., & Best, D. (2019). Sober social networks: The role of online support groups in recovery from alcohol addiction. *Journal of Community & Applied Social Psychology*, *29*(2), 121-132. https://doi.org/10.1002/casp.2388

[54] Greiner, C., Chatton, A., & Khazaal, Y. (2017). Online self-help forums on cannabis: A content assessment. *Patient Education and Counseling*, *100*(10), 1943-1950. https://doi.org/10.1016/j.pec.2017.06.001

[55] Sinclair, J. M., E. Chambers, S., & C. Manson, C. (2017). Internet support for dealing with problematic alcohol use: a survey of the soberistas online community. *Alcohol and Alcoholism*, *52*(2), 220-226. https://doi.org/10.1093/alcalc/agw078

[56] Krentzman, A. R. (2021). Helping clients engage with remote mutual aid for addiction recovery during COVID-19 and beyond. *Alcoholism Treatment Quarterly*, *39*(3), 348-365. https://doi.org/10.1080/07347324.2021.1917324

[57] Bunting, A. M., Frank, D., Arshonsky, J., Bragg, M. A., Friedman, S. R., & Krawczyk, N. (2021). Socially-supportive norms and mutual aid of people who use opioids: An analysis of Reddit during the initial COVID-19 pandemic. *Drug and Alcohol Dependence*, *222*, 108672. https://doi.org/10.1016/j.drugalcdep.2021.108672

[58] Chambers, S. E., Canvin, K., Baldwin, D. S., & Sinclair, J. M. A. (2017). Identity in recovery from problematic alcohol use: A qualitative study of online mutual aid. *Drug and Alcohol Dependence*, *174*, 17–22. https://doi.org/10.1016/j.drugalcdep.2017.01.009

[59] Urbanoski, K., Van Mierlo, T., & Cunningham, J. (2017). Investigating patterns of participation in an online support group for problem drinking: a social network analysis. *International Journal of Behavioral Medicine*, *24*(5), 703-712. https://doi.org/10.1007/s12529-016-9591-6

[60] Davey, C. (2021). *Online sobriety communities for women's problematic alcohol use: A mini review of existing qualitative and quantitative research. Frontiers in Global Women's Health, 2,* 773921. https://doi.org/10.3389/fgwh.2021.773921

[61] Penfold, K. L., & Ogden, J. (2022). Exploring the experience of Gamblers Anonymous meetings during COVID-19: a qualitative study. *Current Psychology*, *41*(11), 8200-8213. https://doi.org/10.1007/s12144-021-02089-5

[62] Sinclair, J. M., E. Chambers, S., & C. Manson, C. (2017). Internet support for dealing with problematic alcohol use: a survey of the soberistas online community. *Alcohol and Alcoholism*, *52*(2), 220-226. https://doi.org/10.1093/alcalc/agw078

[63] Davey, C. (2021). *Online sobriety communities for women's problematic alcohol use: A mini review of existing qualitative and quantitative research. Frontiers in Global Women's Health, 2,* 773921. https://doi.org/10.3389/fgwh.2021.773921

[64] Lustig, A., & Brookes, G. (2022). Construction of group norms in a radical acceptance online forum for heavy alcohol users: A corpus-based discourse analysis. *International Journal of Drug Policy*, *109*, 103862. https://doi.org/10.1016/j.drugpo.2022.103862

individuals sharing both formal guidance and informal, peer-generated knowledge.[65] Some peers use online peer support as a space to make behavioural contracts.[66]

Across the literature, a wide range of social and therapeutic benefits are reported, including increased trust, reassurance and perceived safety,[67] greater coping skills,[68] confidence and personal agency,[69] reduced loneliness,[70] and access to robust social support networks.[71] Receiving supportive messages can improve mood,[72] and engagement with peers can encourage help-seeking for formal treatment.[73] Online mutual aid also appears to support sober identity development,[74] and provide a sense of purpose.[75] Evidence for behavioural outcomes is mixed but promising, and includes shifts toward moderation or abstinence, and reductions in cravings for drugs and alcohol,[76,77,78] although causation cannot be conclusively inferred.[79]

[65] Chambers, S. E., Canvin, K., Baldwin, D. S., & Sinclair, J. M. (2017). Identity in recovery from problematic alcohol use: A qualitative study of online mutual aid. *Drug and Alcohol Dependence*, *174*, 17-22. https://doi.org/10.1016/j.drugpo.2022.103862

[66] Penfold, K. L., & Ogden, J. (2022). Exploring the experience of Gamblers Anonymous meetings during COVID-19: a qualitative study. *Current Psychology*, *41*(11), 8200-8213. https://doi.org/10.1007/s12144-021-02089-5

[67] Bunting, A. M., Frank, D., Arshonsky, J., Bragg, M. A., Friedman, S. R., & Krawczyk, N. (2021). Socially-supportive norms and mutual aid of people who use opioids: An analysis of Reddit during the initial COVID-19 pandemic. *Drug and Alcohol Dependence*, *222*, 108672. https://doi.org/10.1016/j.drugalcdep.2021.108672

[68] Krentzman, A. R. (2021). Helping clients engage with remote mutual aid for addiction recovery during COVID-19 and beyond. *Alcoholism Treatment Quarterly*, *39*(3), 348-365. https://doi.org/10.1080/07347324.2021.1917324

[69] Manning, V., Roxburgh, A. D., & Savic, M. (2023). Piloting the integration of SMART Recovery into outpatient alcohol and other drug treatment programs. *Addiction Science & Clinical Practice*, *18*(1), 52. https://doi.org/10.1186/s13722-023-00406-w

[70] Chambers, S. E., Canvin, K., Baldwin, D. S., & Sinclair, J. M. (2017). Identity in recovery from problematic alcohol use: A qualitative study of online mutual aid. *Drug and Alcohol Dependence*, *174*, 17-22. https://doi.org/10.1016/j.drugalcdep.2017.01.009

[71] Krentzman, A. R. (2021). Helping clients engage with remote mutual aid for addiction recovery during COVID-19 and beyond. *Alcoholism Treatment Quarterly*, *39*(3), 348-365. https://doi.org/10.1080/07347324.2021.1917324

[72] Vogel, E. A., & Pechmann, C. (2021). Application of automated text analysis to examine emotions expressed in online support groups for quitting smoking. *Journal of the Association for Consumer Research*, *6*(3), 315-323. https://doi.org/10.1086/714517

[73] Bunting, A. M., Frank, D., Arshonsky, J., Bragg, M. A., Friedman, S. R., & Krawczyk, N. (2021). Socially-supportive norms and mutual aid of people who use opioids: An analysis of Reddit during the initial COVID-19 pandemic. *Drug and Alcohol Dependence*, *222*, 108672. https://doi.org/10.1016/j.drugalcdep.2021.108672

[74] Chambers, S. E., Canvin, K., Baldwin, D. S., & Sinclair, J. M. (2017). Identity in recovery from problematic alcohol use: A qualitative study of online mutual aid. *Drug and Alcohol Dependence*, *174*, 17-22. https://doi.org/10.1016/j.drugalcdep.2017.01.009

[75] Manning, V., Roxburgh, A. D., & Savic, M. (2023). Piloting the integration of SMART Recovery into outpatient alcohol and other drug treatment programs. *Addiction Science & Clinical Practice*, *18*(1), 52. https://doi.org/10.1186/s13722-023-00406-w

[76] Bunting, A. M., Frank, D., Arshonsky, J., Bragg, M. A., Friedman, S. R., & Krawczyk, N. (2021). Socially-supportive norms and mutual aid of people who use opioids: An analysis of Reddit during the initial COVID-19 pandemic. *Drug and Alcohol Dependence*, *222*, 108672. https://doi.org/10.1016/j.drugalcdep.2021.108672

[77] Schwebel, F. J., & Orban, D. G. (2023). Online support for all: Examining participant characteristics, engagement, and perceived benefits of an online harm reduction, abstinence, and moderation focused support group for alcohol and other drugs. *Psychology of Addictive Behaviors*, *37*(2), 228. https://doi.org/10.1037/adb0000828

[78] Naserianhanzaei, E., & Koschate-Reis, M. (2022). Effects of substance use, recovery, and non–drug-related online community participation on the risk of a use episode during remission from opioid use disorder: Longitudinal observational study. *Journal of Medical Internet Research*, *24*(8), e36555. https://doi.org/10.2196/36555

[79] Kirkman, J. J. L., Leo, B., & Moore, J. C. (2018). Alcohol consumption reduction among a web-based supportive community using the hello Sunday morning blog platform: observational study. *Journal of Medical Internet Research*, *20*(5), e196. https://doi.org/10.2196/jmir.9605

Table 1: Key insights from the rapid evidence assessment

Domain	Key Findings
Evidence Base	• Only 4 gambling-specific studies were retrieved. • Most evidence comes from alcohol, drug, or smoking contexts. • Designs predominantly observational/cross-sectional; longitudinal work is rare. • Demographic reporting is limited; where available, samples narrow and not representative.
How People Engage	• Engagement centres on storytelling/disclosure and advice-seeking/giving. • Lurking is the most common participation style. • Communities often have small active core and a large quieter (but connected) periphery.
Social, Emotional & Therapeutic Benefits	• Social benefits: reduced loneliness; solidarity; expanded/maintained social networks. • Emotional benefits: reassurance; validation; increased confidence, agency, and hope; development of a sober/recovery identity; purpose through helping others. • Therapeutic benefits: accountability; coping skills; support for behavioural contracts; sustained engagement with treatment; motivation to reduce harm or abstain. • For gambling: improved access, frequency of attendance, and recovery encouragement.
Anonymity & Accountability	• Enabling effects: reduces stigma barriers; encourages honest disclosure. • Challenges: concerns about privacy/trust; reduced accountability; easier disengagement. • Mixed outcomes: increased accountability reported in some small/cohesive online groups.
Behavioural Outcomes	• Some reductions in alcohol consumption associated with online support engagement. • Engagement in diverse online communities linked with lower opioid relapse risk. • For gambling, direct behavioural evidence is very limited and user experience is mixed. • Causality cannot be established due to design limitations.
Gambling-Specific Online Support	• Online Gamblers Anonymous increased accessibility and continuity during COVID-19. • Reported benefits: convenience, novelty, social contact, psychological contracts. • Reported limitations: weaker relational depth; passive engagement; altered group dynamics; high dropout; trust/privacy concerns. • Some online spaces reinforced gambling (e.g. via social comparisons).
Gaps & Inequities	• No studies examined experiences of minoritised / disproportionately harmed communities. • Many studies lack basic demographic data. • Insufficient research on: platform design, moderation, ethics, safeguarding and crisis management, long-term outcomes, how online support fits within wider recovery ecosystems.

2.5 Key conclusions and implications

This rapid review of the evidence identified a number of gaps in the literature that directly informed the wider research programme. With very few gambling-specific studies, and even fewer exploring lived-experience perspectives, our interview study was designed to capture in-depth accounts of how people use and interpret online peer support within a gambling harms context. The lack of attention to risks such as triggering content, inconsistent moderation, and negative group dynamics within the gambling harms online peer support literature shaped the inclusion of targeted questions on safety and harm across both the interviews and the survey. A further gap concerned the lack of work examining how online peer support interacts with formal treatment pathways, prompting the programme to explore service navigation, barriers, and blended support models. Finally, because previous studies tended to examine single platforms in isolation, the programme sought to understand how people use a variety of online peer support spaces. Both the interviews and the survey included questions about a wide array of online peer support modalities, facilitating a more comprehensive understanding of the online peer support ecosystem for gambling harm.

3. Qualitative Interview study exploring people's experiences and perceptions of online peer support

3.1 Overview

This qualitative interview study explored how people with lived experience of gambling harm, and service providers working in gambling support settings, understand and experience online peer support. While the findings from this work package are reported in full in a standalone GambleAware report,[80] this section provides a focused summary of the key themes most relevant to the present programme of work. In particular, it highlights perceived benefits and challenges of online peer support, unpacks how and why particular aspects of online peer support are valued, and identifies areas of convergence and tension between lived experience and service-provider perspectives, all of which inform interpretation of the survey and forum analysis findings presented elsewhere in this report.

3.2 Methods

Procedure for recruiting and interviewing participants

A total of 48 people took part in the interviews, comprising 24 participants with direct lived experience of gambling harm and 24 service providers (SPs) who work in gambling support settings. Although lived experience was not required for SPs to take part, most reported having such experience. Participants were recruited through multiple routes, including social media postings, support-service mailing lists, organisational contacts, and word-of-mouth referral. Individuals who expressed interest were directed to an online participant information sheet and digital consent form (hosted on Qualtrics). Once consent was provided, interviews were scheduled at a time that suited each participant. Ethical approval for the study was obtained from the School of Psychology ethics committee at the University of Wolverhampton (Reference: *1124KPUOWPSY*), and the study was conducted in line with British Psychological Society ethical principles.

Interviews were carried out remotely between January and June 2025 by researchers from the University of Wolverhampton and Magenta Research Ltd. All conversations took place over secure video-conferencing software (MS Teams), were audio-recorded with participants' permission, and transcribed verbatim. Interview duration ranged from 30 to 120 minutes, with most lasting around an hour. A semi-structured guide was used, enabling researchers to adapt the sequence of questions and draw on prompts to explore topics in greater depth when appropriate. Further details of the questions can be found in the authors' accompanying qualitative report.

Procedure for analysing the interview data

Data were analysed using reflexive thematic analysis following Braun and Clarke's[81] guidelines. Each transcript was examined line by line and coded inductively by two researchers: KP coded all interviews with lived experience participants, and CH coded all service provider interviews. The analysis was grounded in an interdisciplinary perspective, incorporating input from team members with professional expertise as well as lived experience of gambling harm (including affected others).

[80] Lloyd, J., Penfold, K., Huntington, C., Chadwick, D., Devonport, T., Meredith, J. & Orchard, L. (2025). *Online peer support for gambling harms: Perspectives from people with lived experience and service providers [report].* GambleAware: London.
[81] Braun, V., & Clarke, V. (2021). Thematic analysis: A practical guide. https://doi.org/10.53841/bpsptr.2022.28.1.64

We approached the analysis from a predominantly '*critical realist*' perspective, which meant recognising that our interpretations were inevitably shaped by our own backgrounds, worldviews, and lived experiences. At the same time, we acknowledged that the world exists beyond our own views, and we sought to identify the underlying factors influencing participants' experiences

Early in the analytic process, 5 members of the research team reviewed one randomly selected transcript from each participant group to compare coding decisions and discuss initial interpretations. After the first round of coding, potential themes were developed and then refined collectively through team discussions, which facilitated critical reflection and adjustment of theme names and definitions. To further strengthen rigour, a summary of emerging findings and example quotations was presented to the lived experience panel via a remote meeting and slide deck, allowing the panel to comment on clarity, accuracy, and relevance. Input from our lived experience advisors enhanced our confidence in the credibility and relevance of the themes that were identified, and afforded us greater insight into how these aligned with the panel's own experiences.

3.3 Findings

Key over-arching findings

Online peer support was consistently described as a highly accessible, relational form of help that sits alongside, rather than in place of, formal services for gambling harm. Across both lived experience and service provider accounts, its distinctive value lay in the opportunity to connect with others who "understand" gambling harm first hand. Sharing experiences, hearing others' recovery stories, and engaging in mutual encouragement helped to reduce shame and isolation, foster hope, and support identity reconstruction in recovery. For many participants, these spaces were not just informational resources but communities where they could feel seen, accepted, and less alone.

A central mechanism underpinning this value was synchronous connectivity. Real-time communication via instant messaging platforms (such as WhatsApp) was perceived as uniquely powerful. It enabled immediate emotional containment during urges to gamble or moments of crisis, provided a sense of constant presence, and functioned as a safety net between or after formal interventions. Knowing that someone was available "right now" was often described as stabilising and, at times, lifesaving. At the same time, participants highlighted that asynchronous spaces (such as forums) could offer lower-pressure entry points and allow gradual engagement, especially for those initially anxious about sharing.

These benefits, however, were dependent on how spaces were designed and managed. Both the lived experience participants and the service providers highlighted risks in poorly moderated or entirely informal settings, including exposure to triggering content (such as discussion of gambling wins), misinformation, boundary breaches, and hostile or exploitative behaviour (such as scams or trolling). Service providers, many of whom also had lived experience, emphasised that while lived experience is a critical asset, it is not a substitute for training in facilitation, safeguarding, and risk management. Effective online peer support was seen as requiring clear boundaries, proportionate moderation, and robust safeguarding protocols to protect both users and peer supporters.

Finally, the findings underscored that "one size doesn't fit all" in online peer support. Recovery trajectories were described as non-linear, with individuals moving in and out of peer spaces as needs and circumstances changed. People differed in their preferred formats (text-only vs video, group vs

one-to-one), desired level of structure, and length of engagement. Women-only and, potentially, culturally specific groups were viewed as particularly important for safety, representation, and comfort among under-served groups. Taken together, the data suggest that online peer support is most effective when it is flexible, inclusive, and user-led, offering diverse, co-designed options that can adapt over time, while being underpinned by appropriate training, moderation, and integration with wider support systems.

Findings from interviews with people with lived experience

Participants with lived experience described online peer support as a relational, accessible, and often transformative component of recovery from gambling harm. Three major themes captured how these spaces supported healing, where they posed risks, and the critical role they played in accessibility and crisis prevention. A cross-cutting mechanism - synchronous connectivity - underpinned all themes.

Theme 1: Healing Through Connection

Participants consistently emphasised the centrality of connection with others who shared similar experiences. A strong sense of community and belonging was described across platforms such as WhatsApp, online meetings, forums, and even social media spaces like TikTok. This countered isolation, secrecy, and shame commonly associated with gambling harm, helping individuals feel understood, accepted, and supported. These reciprocal networks, marked by regular check-ins, informal contact, and mutual encouragement, played a central role in sustaining recovery for gambling harms.

For some, safe spaces such as women-only groups were crucial, allowing people to discuss gendered or sensitive issues more freely. A few participants, particularly those from minoritised ethnic groups, noted that while many spaces were welcoming, they did not always see their cultural experiences reflected. This highlighted the need for more culturally specific groups to ensure that community and connection are accessible to all.

Participants also valued being understood and reducing isolation, repeatedly describing how interacting with people who “truly got it” reduced feelings of stigma and made emotional disclosure easier - helping participants process longstanding difficult emotions. Learning from the successes of others further strengthened motivation: recovery stories provided hope, reframed gambling harm as surmountable, and offered practical, credible guidance.

Theme 2: When Support Spaces Become Unsafe

Despite their benefits, online peer support spaces could also become distressing or unsafe. Triggering or harmful content included discussions of gambling wins, graphic disclosures, or emotionally overwhelming narratives – which were especially destabilising for individuals early in recovery. This kind of content was encountered particularly in unmoderated forums or WhatsApp groups where there was potential for inappropriate behaviour (such as late-night off-topic content) that would not occur in more structured offline environments. Unmanaged or poorly managed spaces risked amplifying vulnerability and undermining recovery efforts.

A small number of participants described negative interactions and online harassment, including scams, verbal abuse, and “Zoom bombing.” This refers to a situation where uninvited individual(s)

join and disrupt an online meeting, e.g. through sharing offensive or inappropriate content or insulting/harassing the attendees. These incidents damaged trust, created fear and uncertainty, and in some cases caused groups to collapse entirely. These accounts highlighted the need for robust safeguarding, moderation, and role clarity within online peer support environments.

Theme 3: Accessibility and Crisis Prevention

Online peer support was frequently described as a gateway to recovery for gambling harms, providing an accessible entry point for people who were not ready or did not feel able to seek formal help. Anonymity, privacy, and flexibility allowed individuals to disclose gambling harm at their own pace. Many described online peer support as bridging the gap between isolation and professional services, helping them build confidence, normalise recovery, and reduce feelings of shame.

Participants also emphasised the value of online peer support as a safety net. The constant availability of messaging groups, chatrooms, and global online meetings meant support was accessible at any time, including late at night or during moments of acute vulnerability. This round-the-clock presence provided reassurance and helped prevent relapse by enabling immediate connection with others who could de-escalate urges or distress.

Online peer support also played a key role in crisis prevention. Participants described moments where intense gambling urges or emotional crises were interrupted through rapid, empathic responses from peers. Immediate support helped individuals regain control, avoid relapse, and remain anchored in recovery routines. For some, ongoing engagement with online peer groups worked preventatively, helping them recognise early warning signs and maintain emotional stability.

Overarching Theme: Instant support, constant connection

Cutting across all themes was the central importance of synchronous connectivity, the real-time availability of peers through instant messaging platforms and online meetings. This immediacy enabled rapid emotional containment, fostered belonging through continuous interaction, and provided practical support in moments of risk. It also intensified vulnerabilities in poorly moderated spaces, illustrating how the same mechanisms that make online peer support uniquely effective can also create opportunities for harm when safeguards are absent. Overall, synchronous connectivity functioned as the core mechanism through which online peer support alleviated isolation, sustained motivation, and created a sense of ongoing companionship throughout recovery of gambling harms.

Findings from interviews with service providers

This section summarises the key themes from interviews with gambling harm service providers who work for services that also provide online peer support options. Many held lived experience themselves, but their perspectives here focused on their professional roles supporting others. Themes reflect how service providers understand access to, engagement with, and experiences of online peer support.

Theme 1: Navigating Access to Online Support

Service providers described how people come into online peer spaces through a variety of routes, including signposting by GPs or the NHS; the National Gambling Helpline; or “by chance”. Overall public awareness of online support was described as poor, especially compared with pervasive

gambling advertising, and peer word-of-mouth and online communities were seen as important informal routes in. The importance of readiness to engage was also emphasised; service providers observed that help-seeking often began only after reaching "rock bottom", when people recognised the extent of harm and were psychologically ready to accept support. At that point, the immediacy and anonymity of online groups were especially valuable, but providers still needed to gauge whether someone was ready for group participation or better suited to one-to-one work to ensure the individual gained the maximum benefit, and that the wider group were not, for example, disrupted by the presence of someone who was not yet ready for a group environment.

Service providers also highlighted that the same digital features that make support convenient and private (e.g. removing geographic and financial barriers) can also exclude those with low digital literacy, limited access, or discomfort with online formats, and can make it harder to manage risk when someone abruptly goes offline.

Theme 2: Modes, Preferences, and Structures of Support

This theme emphasised that there is no single "right" way to deliver online peer support and that services must adapt to varied needs and preferences. Providers described deliberately offering multiple formats including text chat, video groups, one-to-one coaching, moderated forums, and encouraging people to experiment and "find what works for them", with collaboration across organisations used to signpost to the best fit. For instance, peer supporters offering low-intensity online support might signpost clients to more structured interventions, led by professionals with training in psychological or therapeutic interventions.

The importance of client autonomy over engagement was noted. Progressive, self-paced engagement (such as being able to join groups with camera off, listening first, then gradually using mic and video) was seen as key to facilitating initial access and retention, and boundaries were deemed important, so one person's behaviour did not negatively affect others. On structure, for example, providers argued that semi-structured groups with topics, ground rules, and facilitated turns prevent domination or drift, while still allowing informal chat and humour. On scheduling, it was noted that flexible, co-designed scheduling across times and time zones, and around high-risk periods (e.g. holidays), could help maintain accessibility. Overall, providers saw effective online peer support as balancing structure with flexibility.

Theme 3: Evolving and Individualistic Recovery

Service providers conceptualised recovery as dynamic, personal, and intertwined with identity. Recovery was described as non-linear, and, as such, engagement with online peer support naturally ebbs and flows. Stepping back can indicate stability rather than disengagement, while returning after a relapse reflects courage. Providers argued that online peer support must remain open and flexible, enabling people to reconnect when needed without judgement. Individual differences in engagement over time were also observed; while some people dipped in and out as needed; others became deeply embedded, seeing long-term involvement as central to wellbeing.

Lived experience was a uniquely powerful connector, and seeing people with shared experience further along in recovery offered tangible evidence of the potential for change. Providers also recognised that cultural or demographic similarity could strengthen connection. Although they noted that current participation in UK online peer support remains demographically narrow, with

women and people from minoritised ethnic and religious backgrounds described as underrepresented, there were accounts of highly-valued women-only spaces within online peer support. Service providers explained how these facilitated sensitive or gender-specific discussions, and offered a protective and empowering space for women who faced barriers to joining mixed groups – for instance due to feeling unsafe or unable to speak freely in male-dominated environments.

Theme 4: The Role of Peer Supporters

Providers discussed the complexities of delivering online peer support, especially when they themselves had lived experience of gambling harm. They noted that online peer support carries inherent risks for users and providers, necessitating clear professional limits, respectful behaviour, and explicit ground rules to maintain trust and safety. Without these, unregulated spaces risk harmful over-involvement, emotional exhaustion, or inappropriate interactions. Providers also stressed that peer supporters must be personally ready before taking on such roles.

Practical safeguarding requirements mentioned included the need for two facilitators in live groups, crisis-management protocols, robust follow-up when someone leaves a group meeting abruptly, and active moderation of forums to address harmful content. Safeguarding was seen as essential to maintaining trust and preventing harm, even though risk cannot be eliminated entirely.

Service providers also noted the importance of appreciating the limits of lived experience and recognising where formal/professional skills may be required. Providers cautioned that personal recovery stories can unintentionally be presented as the "correct" path and noted that many clients have complex needs requiring skills beyond experiential insight. They advocated for combining lived experience with training, supervision, and evidence-based practices such as motivational interviewing and group facilitation.

Overarching Theme: One Size Doesn't Fit All

Service providers accounts emphasised that online peer support is most effective when it is flexible, person-centred, and tailored. Engagement varied widely by personal history, demographics, stage and severity of gambling harm, and individual goals, and preferences for format, structure, and interaction differed, as did the balance of benefits and challenges. For providers, this meant offering varied, well-signposted options, while maintaining enough structure and safeguarding to ensure that online peer spaces remain safe, inclusive, and responsive to users' changing needs.

3.4 Key conclusions and implications

This strand of the research highlights that online peer support occupies a distinctive and highly valued role within the wider gambling harm support landscape. Participants with lived experience and service providers consistently described its core strengths as immediacy, accessibility, and the authenticity of shared lived experience. Synchronous forms of support, in particular, were perceived as offering emotional containment, practical guidance, and, at times, crucial interruption during moments of heightened risk or distress. For many interviewees, online peer communities functioned as a bridge into recovery, while for others they represented a sustained, long-term resource that reduced shame, fostered belonging, and supported identity change.

At the same time, both lived experience participants and service providers emphasised that the benefits of online peer support are contingent on how spaces are designed, facilitated, and governed. Poorly moderated or informal environments risk exposing users to triggering content, misinformation, boundary breaches, or hostile interactions. Service providers, many of whom also had lived experience, were clear that while shared experience is a critical asset, it does not substitute for training in facilitation, safeguarding, and risk management.

Several service providers expressed particular concern about how crisis-level distress, including suicidality, can be identified and supported in online settings where traditional safeguarding mechanisms (such as referring clients in crisis to one-to-one professional therapeutic support) are constrained. These concerns directly informed our decision to undertake a focused analysis of suicidal disclosures in public online forums, reported in Section 5, to examine how such moments manifest and are responded to in practice.

A further consistent finding was that no single model of online peer support meets all needs. Recovery trajectories are non-linear and highly individual, with people moving in and out of peer spaces as circumstances change. Preferences varied in relation to format, structure, intensity, and group composition, with women-only and potentially culturally specific spaces viewed as especially important for safety and inclusion among some groups. These findings underscore the importance of offering flexible, person-centred, and well-signposted options that allow people to engage in ways that feel appropriate to their stage of recovery, while remaining underpinned by clear boundaries and safeguarding.

Some limitations of this qualitative strand should be noted. Although the interview sample was substantial for qualitative research and included both lived experience participants and service providers, it necessarily reflects the perspectives of individuals who were willing and able to take part in in-depth interviews. As such, some experiences - including those of people who disengaged early, were less connected to services, or had more negative experiences - may be under-represented. In addition, the findings reflect participants' accounts and perceptions rather than direct observation of behaviour within online peer spaces. These limitations are partly addressed by the complementary components of this research project: the survey, reported in the next section, provides broader coverage of patterns and experiences across a larger sample, while the forum analysis, reported in Section 5, examines naturally occurring interactions and responses in situ.

Taken together, this qualitative strand provides important insights into how online peer support is experienced, valued, and sometimes questioned by those closest to its delivery and use. It helps to clarify the perceived mechanisms through which it can support recovery, as well as the conditions under which it may introduce risks. These insights are synthesised with evidence from the survey and forum analyses in the integrated synthesis (Section 6), where implications for policy and practice are considered alongside the wider literature.

4. Survey study investigating experiences and perceptions of online peer support

4.1 Overview

An online survey was conducted with 520 people (62% male; 37% female, 1% other, mean age 41.3 years (SD = 11.0)) with direct personal experience of gambling harms. It explored who engages with online peer support, how and why they use it, and what benefits and challenges they experience. This quantitative component complemented the in-depth qualitative interviews, allowing for greater breadth of insight, through examination of patterns of use across a larger group of participants with a variety of demographic characteristics.

4.2 Method

Recruitment

Participants were adults (18+) with self-reported lived experience of gambling harms (indicated via a yes/no response), living in the UK. Prior use of online peer support was not a prerequisite. Recruitment initially used community advertising with a shopping voucher incentive, before moving to Prolific - a widely used online research platform with incentives managed by the service provider - shown to produce high-quality, reliable data.[82]

Procedure

After providing informed consent, participants completed the survey which was presented using routing logic to ensure they received only relevant questions. For instance, questions on perceived benefits, challenges, and motivations were completed only by participants who had used online peer support. Average completion time was around 15 minutes. Attention checks were included throughout the survey to identify inattentive or inauthentic responses. See Appendix 8 for full details. Fewer than five cases were excluded from analysis due to failing data-quality checks, while a larger block of automated responses was excluded based on response patterns that clearly indicated inauthenticity.[83]

Ethical considerations

The study received ethical approval from the University of Wolverhampton School of Psychology Research Ethics Committee (reference: 0925JLUOWPSY) and was conducted in line with British Psychological Society ethical principles. Participants were provided with detailed information about the study before providing informed consent. Relevant support resources (such as the GambleAware website, National Gambling Helpline, and Mind website) were signposted at the beginning and end of the survey. Data were processed in accordance with GDPR requirements.

[82] Douglas, Benjamin D., Patrick J. Ewell, and Markus Brauer. "Data quality in online human-subjects research: Comparisons between MTurk, Prolific, CloudResearch, Qualtrics, and SONA." *PLOS One* 18.3 (2023): e0279720. doi.org/10.1371/journal.pone.0279720

[83] A block of approximately 450 responses was received within a short time frame and was quantitatively, qualitatively, and temporally distinct from preceding authentic responses. These responses were definitively identified as mass automated submissions through pattern analysis rather than attention checks, many of which were passed by the automated responses. In combination with attention checks used to screen non-automated responses, this provided high confidence that all inauthentic responses were excluded and authentic responses retained. Following this issue, the survey recruitment method was changed to Prolific for the remainder of data collection, where safeguards are in place to prevent automated responding and ensure participants are genuine individuals.

Measures

Participants first indicated whether they had engaged in a range of online peer support activities (e.g. forums, online meetings, or one-to-one peer support). Those with current or past experience completed follow-up questions on patterns of use, including duration, frequency, typical engagement, reasons for discontinuation (where relevant), and overall satisfaction. Participants with experience of online peer support also reported when they typically engaged, the balance between active and passive use, and their use of other forms of gambling harm support, including whether these were accessed before, after, or alongside online peer support.

In the absence of validated measures specific to online peer support in gambling, several survey instruments were adapted from established tools used in online health, peer support, and digital literacy research, with adaptations refined in collaboration with the lived experience panel to ensure relevance and clarity. Motivations for engaging with online peer support were assessed using an adapted version of the Health Online Support Questionnaire (HOSQ),[84] with a parallel version completed by participants with no prior experience to capture potential future motivations. Participants with online peer support experience also completed adapted measures assessing perceived benefits and challenges, and the types of support received (emotional, informational, practical, and affiliative- based on the Online Social Support Scale[85]). All participants completed measures of digital health literacy (an adapted version of the e-health literacy use scale; e-HLUS)[86] and technology acceptance (with a brief, 4-item bespoke scale, detailed in full in Appendix 1, section 5, including items such as 'I think it would be easy to access and participate in online peer support'), as well as validated gambling harm scales: the Problem Gambling Severity Index (PGSI),[87] administered using a retrospective "worst period" timeframe,[88] and the 7-item Gambling Harms Severity Index (GHSI-7),[89] which captures harms experienced in the past three months.

Reliability checks were conducted on all adapted or novel scales. Cronbach's alpha values are reported in Appendix 8, but almost all were either good (>.8) or excellent (>.9). One scale (the technology acceptance scale) had an 'adequate' value of .78, and one subscale within a larger scale (the e-HLUS) had a slightly low but still acceptable Cronbach's alpha of .69, but no analyses reported here rely on that specific subscale.

A comprehensive account of the measures and procedure can be found in Appendix 1, and full item wording for the survey in Appendix 2.

[84] Mattsson, S., Olsson, E. M. G., Alfonsson, S., Johansson, B., & Carlsson, M. (2015). Measuring use of health-related support on the internet: development of the health online support questionnaire (HOSQ). *Journal of Medical Internet Research*, *17*(11), e266. https://doi.org/10.2196/jmir.4425

[85] Nick, E. A., Cole, D. A., Cho, S. J., Smith, D. K., Carter, T. G., & Zelkowitz, R. L. (2018). The online social support scale: measure development and validation. *Psychological Assessment*, *30*(9), 1127. https://doi.org/10.1037/pas0000558

[86] Stephan, J., Gehrmann, J., Dehner, J. C., Stullich, A., & Richter, M. (2025). Development and validation of the eHealth Literacy and Use Scale (eHLUS) to measure medical app literacy. *Public Health*, *240*, 27-32. https://doi.org/10.21203/rs.3.rs-4377708/v1

[87] Ferris, J. A., & Wynne, H. J. (2001). *The Canadian problem gambling index* (pp. 1-59). Ottawa, ON: Canadian Centre on substance abuse.

[88] Li, E., Browne, M., Rawat, V., Langham, E., & Rockloff, M. (2017). Breaking bad: Comparing gambling harms among gamblers and affected others. *Journal of Gambling Studies, 33(1),* 223-248. https://doi.org/10.1007/s10899-016-9632-8

[89] Close, J., Statton, R., Collard, S., Wheaton, J., Davies, S., Martin, I., Pinto, C., Conway, M., Walsh, C., & Browne, M. (2025). Development and Validation of the Gambling Harms Severity Index (GHSI-10) and the GHSI for Affected Others (GHSI-AO-10): Measurement Instruments for People Experiencing Gambling Related Harms and Affected Others. *PsyArXiv*. https://doi.org/10.31234/osf.io/w8fb6_v1

4.3 Findings

Who uses online peer support?

As 91.5% of the sample (n=476) had used at least one form of online peer support, we do not present direct demographic comparisons between users and non-users, as statistical contrasts between highly unbalanced groups would be unreliable and potentially misleading.[90] Instead, we summarise the demographic characteristics of participants who had used online peer support.

The 476 participants with experience of online peer support reflected a broad demographic mix. Most identified as male (61.7%), with just under two-fifths identifying as female, and a small number identifying as another gender. Ages ranged from 19 to 74 years (mean = 41.1, SD=10.9). The majority were heterosexual (88.9%), and most identified as White (83.2%), with additional representation from Black (8.4%), Asian (5.5%), and other ethnic groups. Approximately 63% were partnered, with the remainder single (29%) or widowed. Caring responsibilities were common: 43.9% cared for children, and 17.2% for another adult.

Educational attainment was relatively high, with over two-thirds having Higher Education qualifications, and over 85% were in full- or part- time employment. Income was widely distributed, but most participants were within middle-income bands. Participants also lived across urban, town, and rural settings, and in a mix of owner-occupied, private rented, and social housing. One-third reported a long-term physical or mental health condition.

While the convenience sampling strategy means these demographic patterns cannot be taken as representative of online peer support users across Great Britain, they indicate substantial diversity among those engaging with online peer support in this sample. Before examining differences in how people from different demographic backgrounds and gambling harm histories engage with online peer support, we first summarise how common different forms of online peer support were within the sample.

Overview of online peer support engagement

Over 90% of participants (476/520) had engaged with at least one form of online peer support for gambling harm at some point, and 63.1% (328/520) were currently engaging in at least one form of online peer support at the time of the survey. The number of types of support reported ranged from 0 to 9 (out of the maximum of 9 support types enquired about), but most had experience of between one and four types (this range cumulatively accounted for over two-thirds of the sample). Current users estimated, on average that around three-quarters of their engagement was in the form of indirect interaction (mean = 74.8%, SD = 25.3), and one-quarter (mean = 24.3%, SD =24.4) involved direct interaction.

By far the most common form of engagement was the reading of online peer support forums, closely followed by posting on forums, and using social media support groups.[91] More intensive/direct forms of online peer support (attending online meetings, using a recovery-focused WhatsApp group,

[90] We do return briefly to the non-user group later in the Results, for example when summarising their intentions to use online peer support in future; their demographic characteristics are also summarised descriptively in Section [X], but no inferential comparisons are made.

[91] We did not ask specifically whether these were dedicated gambling harm related support forums or general forums where support with gambling-related harm was available, so we are unable to identify what proportion of respondents were using each type of support forum.

and receiving 1:1 support online) were less common, but not rare, with between 23% and 33% of the sample reporting having used them. The least common forms of online peer support engagement were the 'helper' roles, with 12-15% of the sample having provided 1:1 support to others, moderated forums, or led/facilitated online group meetings. Figure 2 illustrates what proportion of the sample reported current, past, and future engagement with each type of support, and Table 6 (in Appendix 3) presents the exact proportions numerically. Please note that participants were not required to specify what kind of forums they used in these questions, so forum engagement encompasses both dedicated and non-dedicated gambling support platforms.

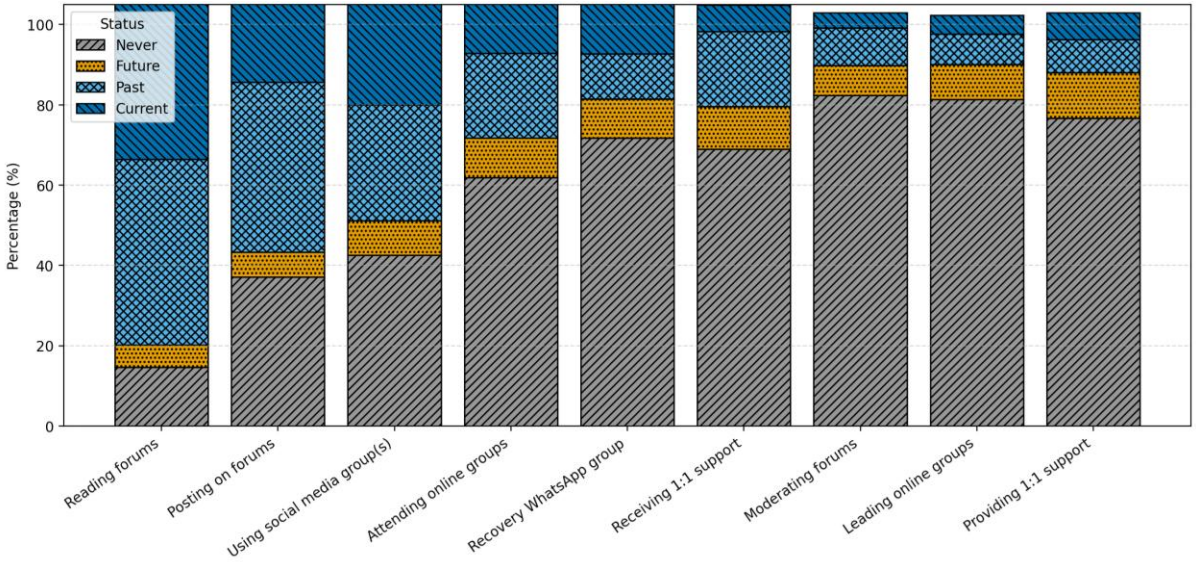

Figure 2: Visual representation of patterns of usage across different forms of online peer support for gambling harms

Relationships between gambling harms history and patterns of peer support usage

In order to see whether gambling harm severity was associated with using different kinds of online peer support, we first created mutually exclusive engagement categories of current, past, future, and never, for each type of support.[92] We then examined differences in both recent gambling harm (SGHS; past 3 months) and worst-ever historical harm (PGSI worded to ask about 'worst ever' time) across the nine forms of online peer support, using Kruskal-Wallis tests.[93]

For recent gambling harm (SGHS), analyses showed significant differences across engagement categories for reading forums, posting on forums, using WhatsApp groups, receiving 1:1 support online, and providing 1:1 support online (all p-values <.001 – see Table 7 in Appendix 3 for full details of statistical tests). Across these modalities, people who had never engaged generally reported the lowest recent harm scores, while current or future users showed higher harm. No significant differences were found for attending online peer support meetings, using social media groups, moderating forums, or leading support groups. Figure 3 summarises these visually, with lighter cells

[92] To create mutually exclusive categories to allow for statistical analysis without violating key requirements of the tests, those who currently used a form of support were classed as "Current" users regardless of any other selections; those who did not report current use but indicated previous use were classed as "Past"; those who did not report current or past use but planned to use the support in future were classed as "Future" users; and only respondents who selected "Never" and no other category were classed as "Never" users.
[93] This non-parametric test was chosen because the data were not normally distributed, and it is suitable for comparing differences between multiple independent groups on ordinal or continuous variables

depicting lower harm scores, and darker cells depicting higher scores. Rows with an asterisk indicate support modalities in which significant differences across engagement categories were observed.

Error! Reference source not found.: Mean (SD) SGHS scores, compared across history of engagement categories for each type of online peer support. *Cells show the mean (SD) SGHS score within each engagement group, with darker shading indicating higher mean harm. Rows marked with * indicate support types where the Kruskal–Wallis test showed an overall difference across engagement categories. Because some groups were small and uneven in size, post-hoc pairwise tests were not carried out, so these results should be interpreted descriptively rather than as firm conclusions.*

For worst-ever harm (historic PGSI), analyses showed significant differences in PGSI scores across engagement categories for online peer support meetings, WhatsApp groups, receiving 1:1 support online, leading groups, and providing 1:1 support (all p-values <.001 - see Table 7 in Appendix 3). These findings are visualised in Figure 4, where lighter cells again indicate lower scores, and asterisks indicate significant differences across categories for a particular support modality. Although Kruskal–Wallis tests do not identify which specific categories differ from one another,[94] inspection of the heatmaps indicates that current and future users of these more intensive support modalities tended to report higher PGSI scores than those who had never used them. No significant PGSI differences were found for reading or posting on forums, using social media groups, or moderating forums.

***Error! Reference source not found.*: Mean (SD) PGSI scores, compared across history of engagement categories for each type of online peer support.** *Cells show the mean (SD) PGSI score within each engagement group, with darker shading indicating higher mean harm. Rows marked with * indicate support types where the Kruskal–Wallis test showed an overall difference across engagement categories. Because some groups were small and uneven in size, post-hoc pairwise tests were not carried out, so these results should be interpreted descriptively rather than as firm conclusions.*

Demographics patterns in online peer support usage

The nonparametric statistical tests we carried out to compare demographics between users and non-users of each online peer support type identified just three statistically significant patterns. Participants with higher educational qualifications were more likely to read online forums than those with lower qualifications ($\chi^2(2, N \approx 440) = 10.69$, $p = .0048$, Cramer's V = .11), This effect size is small, meaning the difference, while statistically significant, was not particularly pronounced. However, it is consistent with the observation that 71.1% of forum readers held higher-level educational qualifications compared with 55.8% of non-readers (and low education was less common among readers: 11.6% vs 24.7%). Participants who led online peer support groups were more likely ($\chi^2(1, N \approx 440) = 4.63$, $p = .032$, Cramer's V = .10) to report having a health condition than those who did not lead groups (46.8% vs 32.1% for non-leaders). Finally, ethnicity was associated with providing 1-to-1 peer support ($\chi^2(1, N \approx 440) = 5.03$, $p = .025$, Cramer's V = .11), with minority ethnic participants making up a larger proportion of providers than non-providers (25.0% vs 14.1%).

All other demographic comparisons were non-significant, indicating that online peer support engagement was largely consistent across age, gender, ethnicity, education, income, and health

[94] Follow up post-hoc pairwise tests were not conducted because Kruskal–Wallis tests were used in an exploratory context to identify whether any differences existed across engagement categories. Given substantial imbalance and small cell sizes in several categories (particularly 'future' and 'current' users for some modalities), post-hoc comparisons would have low statistical power and yield unstable estimates. Instead, descriptive patterns are presented in heatmaps and interpreted cautiously

status. Given the exploratory nature and the interest in identifying potential demographic patterns across multiple online peer support types, p-values are presented without correction for multiple comparisons. The few significant results that were observed should, therefore, be interpreted cautiously.

Health literacy and technology acceptance among users and non-users of online peer support

Participants who had ever used online peer support scored significantly higher than those who had never used it, on self-reported measures of both digital health literacy (eHLUS scores; $U = 6{,}982.50$, $Z = -3.44$, $p < .001$, $r = .15$) and technology acceptance ($U = 3{,}843.50$, $Z = -7.04$, $p < .001$, $r = .31$).[95] In other words, those who engaged with online peer support tended to report greater confidence in using digital health information and more positive attitudes towards technology than those who had never used it. Given the small size of the never-user group (n=44), these comparisons should be interpreted as exploratory.

How do people use online peer support?

As already summarised in the overview of engagement, the most common way to use online peer support is to engage with 1-4 types, with low-commitment options like online peer support forums being the most-commonly used. Here, we elaborate further on the specific ways in which each type of support was typically used.

Frequency, duration and timing of engagement

Typical usage patterns for each type of support are summarised in Table 2, with detailed distributions of duration, frequency, time spent per session, and planned future use for each online peer support modality available in Appendix 3 (

[95] Differences between participants who had ever used online peer support and those who had never used OPS were examined using Mann–Whitney U tests, due to non-normal distributions and unequal group sizes. Effect sizes were calculated as $r = Z / \sqrt{N}$.

Table ***8***; Table 9; Table 10; and Table 11).

Reading online forums - the most widely used modality - was characterised by long-term, frequent engagement in relatively short sessions. Most forum readers reported using forums for one year or longer, engaging at least weekly, spending less than 30 minutes per session, and intending to continue long-term. We did not capture whether this involved single or multi-forum use. Posting on forums, engaging with WhatsApp groups, and using social media support groups showed broadly similar patterns, with predominantly long-term engagement, frequent use, short sessions, and generally long-term intentions to continue.

By contrast, engagement with online peer support group meetings and one-to-one online peer support was more variable. These modalities were used by smaller subsets of participants and involved longer sessions, alongside more mixed patterns of frequency and duration. Intentions to continue were also less uniform, particularly for one-to-one support, where uncertainty about future use was more common. The subsequent section on discontinuation explores reasons underlying these patterns.

Moderating forums, leading or facilitating online peer support groups, and providing one-to-one peer support were the least common forms of engagement but involved the highest levels of time commitment among those who participated. Participants in these roles most often reported long-term, frequent engagement, sessions lasting over one hour, and strong intentions to continue.

Table 2: Typical patterns of engagement across types of online peer support (amongst current users)

Online peer support type	Typical duration of use	Typical frequency of use	Typical time per session	Typical intention to continue
Reading forums (n=243)	Long-term (≥1 year; ~80%)	Weekly or more (~88%)	<30 min (~57%)	Long-term/no plan to stop (~79%)
Posting on forums (n=118)	Long-term (≥1 year; ~74%)	Weekly (~56%)	<30 min (~60%)	Long-term (~70%)
Using social media groups (n=143)	Long-term (≥1 year; ~62%)	Weekly or more (~60%)	<30 min (~55%)	Long-term (~66%)
Joining online group meetings (n=71)	Mixed (no single dominant category)	Weekly to monthly	≥1 hour (~40%)	Long-term (~63%)
Using WhatsApp groups (n=70)	Long-term (≥1 year; ~63%)	Weekly or more (~74%)	<30 min (~58%)	Long-term (~71%)
Receiving 1:1 online peer support (n=34)	Short–medium term (≤11 months; ~58%)	Monthly / ad hoc	30–60+ min (~52%)	Mixed / uncertain
Moderating forums (n=19)	Long-term (≥1 year; ~69%)	Weekly or more (~72%)	≥1 hour (~61%)	Long-term (~75%)
Leading/facilitating OPS groups (n=24)	Long-term (≥1 year; ~73%)	Weekly (~68%)	≥1 hour (~65%)	Long-term (~78%)
Providing 1:1 online peer support (n=35)	Long-term (≥1 year; ~70%)	Weekly (~66%)	≥1 hour (~59%)	Long-term (~74%)

Entries reflect the most-commonly reported category among participants who had used each type of online peer support (OPS). Percentages are rounded to whole numbers and are intended to provide an indicative summary rather than a full distribution. Detailed category-level frequencies are reported in Appendix 3.

The most common time of day for engaging with online peer support among current users (N = 328) was the evening (6pm–midnight). Around 80% reported sometimes accessing online peer support

during this period, with 73% identifying it as their most frequent time of use. Afternoon engagement (12pm–6pm) was reported by approximately 35%, with around one in five indicating this as their primary time of use. Morning use (6am–noon) was reported by around 20%, and overnight use (midnight–6am) by 10–15%, although fewer than 10% identified either period as their typical time of engagement.

Use of other forms of support alongside online peer support

Most participants used online peer support alongside other forms of gambling harm support – most commonly, self-help tools such as self-exclusion schemes or online resources (62%) and support from friends and family (58%). Some used it alongside services including helplines (16%), face-to-face peer support (16%), professional online support from gambling harm specialists (15%), support from non-specialist professionals such as GPs or general therapists (14%), and professional face-to-face specialist support (11%). Residential treatment was reported by a small minority (3%). Online peer support was most often used alongside these services rather than before or after them, though some participants did use other support (particularly support from friends and family or self-help tools) before online peer support, and some showed the opposite direction.

Notably, 14% reported using online peer support *without* engaging with any other form of gambling harm support, i.e. it was their sole source of support. Given that our list of possible support sources covered a comprehensive array of options, the fact that approximately 1 in 7 participants were using *only* online peer support and none of these other modalities is an important finding, discussed further in Section 6.

Reasons for discontinuation of online peer support (by modality)

Reasons for stopping engaging with each type of online peer support are summarised in

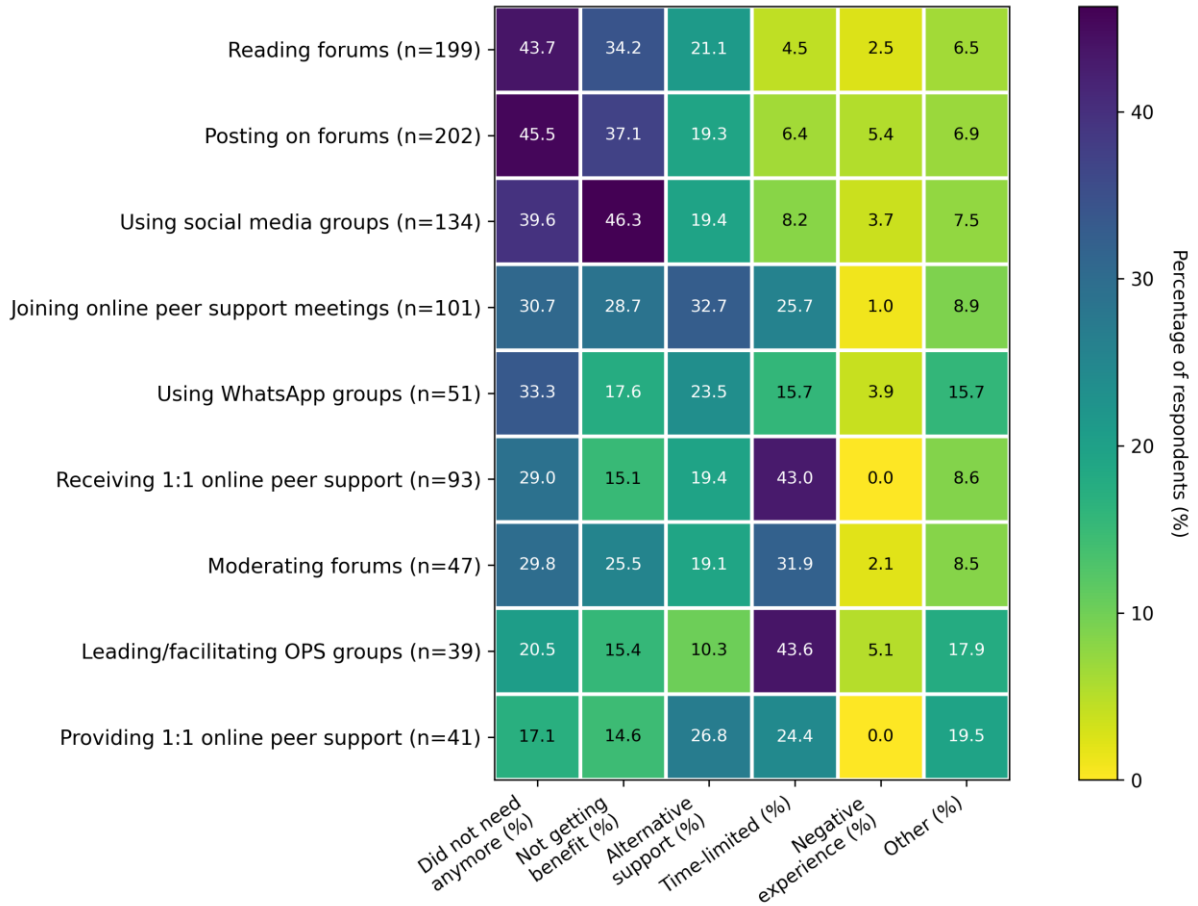

Figure ***3***, for those who reported only past (and not current) engagement.

Across modalities, discontinuation was usually driven by shifting needs or perceived lack of usefulness, rather than due to experiencing negative effects. For the three largest, more informational modalities (reading forums, posting on forums, and using social media groups), around 40–46% of past users reported that they no longer needed the support, and a similar proportion said they were not getting enough benefit. A smaller subgroup (roughly 10–33%) reported switching to alternative forms of support, indicating that stopping one online peer support modality sometimes reflected a transition to another format rather than disengagement.

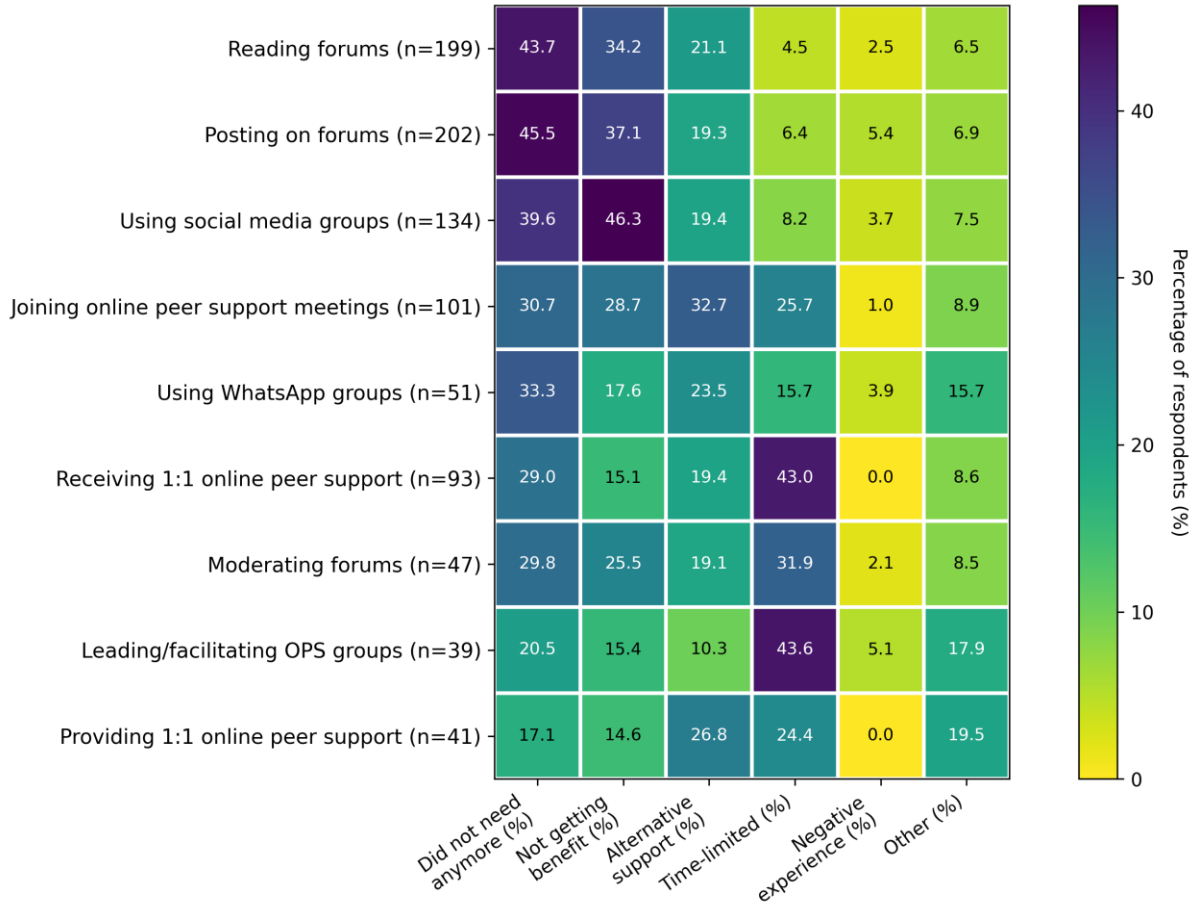

Figure 3: Reasons for discontinuing engagement with each type of online peer support, amongst those who engaged previously but not currently. *NB: numbers do not sum exactly to 100% as categories were not mutually exclusive.*

For more structured or time-limited support, availability played a substantial role. 43% of former 1:1 recipients and 44% of former facilitators stopped because the support was only available for a defined period, as did about a third of former moderators and a quarter of those who had used online meetings. Reasons for discontinuing WhatsApp groups and online meetings were more mixed, with reasons dispersed across no longer needing support, moving to alternative support,[96] and limited availability.

Free-text elaboration on "other" reasons for discontinuation, endorsed by 7–20% depending on modality, reflected a wide range of practical or personal circumstances, such as lack of time, health issues, leaving social media platforms, or group inactivity. Negative experiences were the least frequent reason for discontinuation across all support types, reported by <6% of past users. In rare instances where negative experiences were described in free-text responses, they included hostile interactions, judgemental comments, or feeling emotionally overwhelmed.

[96] This survey item did not capture the type of support transitioned to, simply that the participant 'started using an alternative kind of support'.

Why do people use online peer support?

To understand participants' motivations for engaging with online peer support, we examined responses to a set of items assessing agreement with different potential reasons for use. Figure 4 summarises mean endorsement scores across 18 motives, grouped into reading-based and interacting-based objectives, based on the validated factor structure for the Health Online Support Questionnaire (HOSQ).[97] Reading-based objectives are primarily informational, whereas interacting-based objectives focus around drawing on social relationships and others' opinions, for things like compassion or feedback – as can be seen from the items with blue and green bars, respectively, in Figure 4.

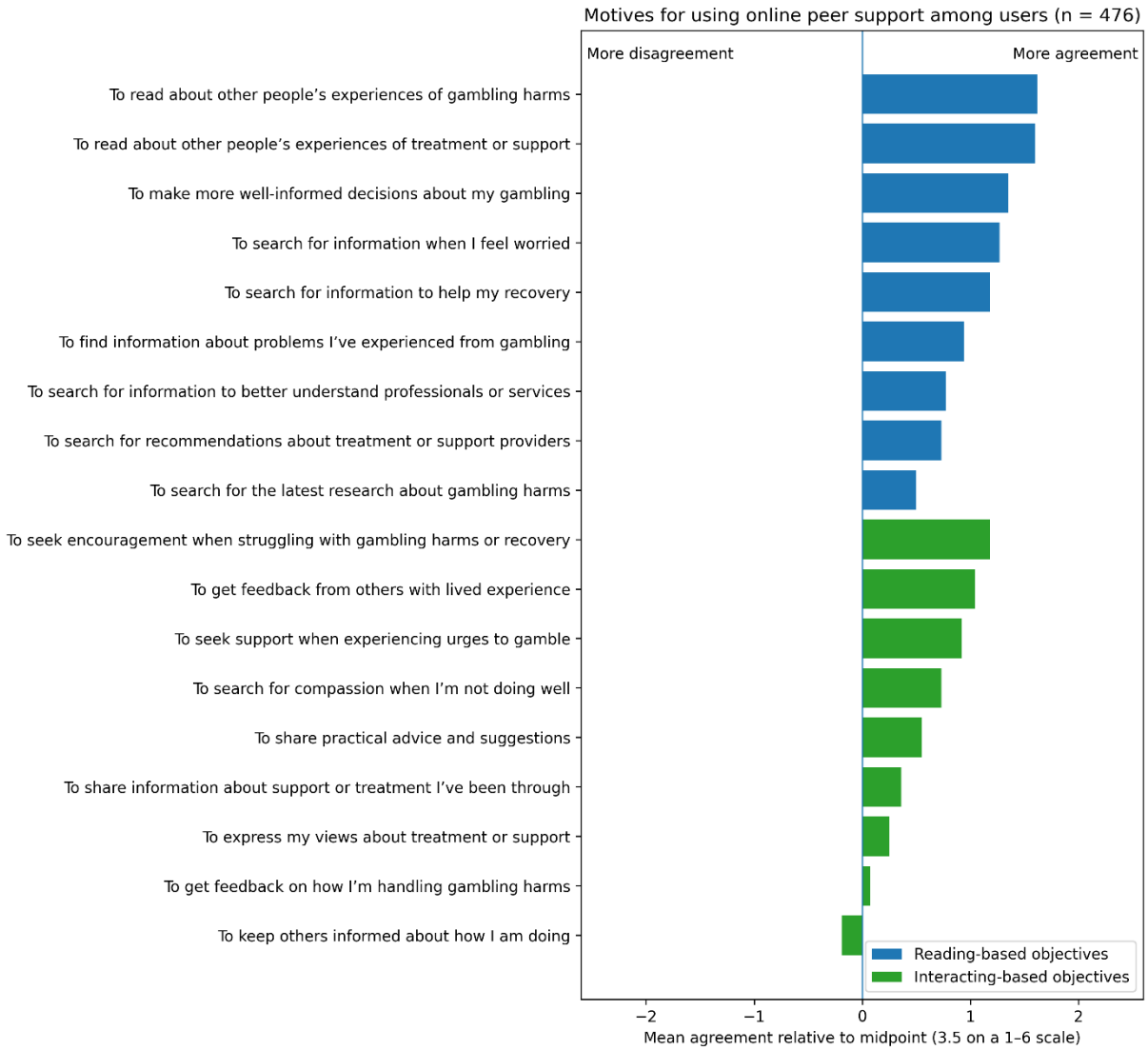

Figure 4: Endorsement of motives for using online peer support modalities amongst those reporting any experience of usage (n=476)

[97] Mattsson, S., Olsson, E. M. G., Alfonsson, S., Johansson, B., & Carlsson, M. (2015). Measuring use of health-related support on the internet: development of the health online support questionnaire (HOSQ). *Journal of Medical Internet Research*, *17*(11), e266. https://doi.org/10.2196/jmir.4425

To examine whether motivations differed between users and non-users of specific online peer support modalities, Mann–Whitney U tests compared reading-based and interacting-based motive scores between participants who had ever used each type of support and those who had not (

Table ***3***). False Discovery Rate corrections were applied within each family of tests.

Reading-based motives were generally endorsed more strongly than interacting-based ones. The highest ratings related to using online peer support to read about other people's experiences of gambling harms and of treatment or support. Participants also commonly reported using it to help inform their own decisions, to search for information when worried, and to seek information relevant to recovery. Taken together, these patterns suggest that online peer support often functions as an informational and reflective space for users.

Interacting-based motives were also widely endorsed, though typically at slightly lower levels. Many reported using online peer support to seek encouragement when struggling, to receive feedback from others with lived experience, or to obtain support during urges to gamble. In contrast, motives involving more outward communication, such as expressing opinions or keeping others informed, were less strongly endorsed. This suggests that users tend to engage more as information- or support- seekers than as active contributors.

Interacting-based motives were significantly higher among ever-users than never-users for nearly all types of online peer support, with the exception of reading forums. Differences were largest for more socially embedded formats, including online meetings, WhatsApp groups, and 1:1 peer support, and smaller for activities such as posting, moderating, or leading groups. This indicates that engagement in more active forms of online peer support is associated with stronger social and emotional motivations.

Reading-based motives showed a more selective pattern. Higher information-seeking motivation was observed among users of forums, online meetings, WhatsApp groups, and those receiving 1:1 support, although effect sizes were small. There were no significant differences in reading motives when comparing those who did and did not engage in interactive roles such as posting, moderating, leading groups, or providing 1:1 support.

Overall, these findings suggest a distinction between information-oriented and interaction-oriented motivations for engaging with online peer support. While information-seeking appears to underpin engagement with several forms of support, more interaction-focused motivations are characteristic of those who engage in higher-intensity and more socially embedded modalities.

Table 3: 'Reading' & 'interacting' motives for using online peer support: Comparisons between those who have ever and those who have never used each type of support

Online peer support type reported (ever)	Motives subscale	Dir	U	n(never)	n(ever)	p	p(FDR)	r
Reading forums	Reading	↑	5422	33	441	.014	.036	0.11
	Interacting	~	6765	33	441	.500	.500	0.03
Posting on forums	Interacting	↑	19872	156	318	.001	.001	0.16
	Reading	~	23654	156	318	.411	.462	0.04
Using social media groups	Interacting	↑	20007	199	275	.001	.001	0.23
	Reading	~	24479	199	275	.050	.090	0.09
Joining OPS online group meetings	Interacting	↑	13295	302	172	.001	.001	0.41
	Reading	↑	20667	302	172	.001	.005	0.17
Using WhatsApp groups	Interacting	↑	11405	353	121	.001	.001	0.35
	Reading	↑	18227	353	121	.016	.036	0.11
Receiving 1:1 online peer support	Interacting	↑	13757	347	127	.001	.001	0.29
	Reading	↑	17749	347	127	.001	.005	0.15
Moderating forums	Interacting	↑	9301	408	66	.001	.001	0.19
	Reading	~	11788	408	66	.104	.134	0.07
Leading/facilitating OPS groups	Interacting	↑	7515	411	63	.001	.001	0.25
	Reading	~	12592	411	63	.726	.726	0.02
Providing 1:1 online peer support	Interacting	↑	8684	398	76	.001	.001	0.27
	Reading	~	13144	398	76	.070	.105	0.08

Dir: Direction of effect. ↑ = Ever-users scored higher than never-users (significant after FDR, p(FDR) < .05). ~ = No significant difference after FDR. p = Asymptotic two-tailed p-value from the Mann–Whitney U test. p(FDR) = p-value after Benjamini–Hochberg False Discovery Rate correction (Q = .05), applied separately to the nine reading-motive tests and the nine interacting-motive tests. r = Effect size, calculated as $|Z|/\sqrt{N}$, where Z is the standardised test statistic and N is the total sample size across both groups.

What do people think of online peer support?

Levels of overall satisfaction

Overall satisfaction with online peer support, visually summarised in Figure 5, was high among the 476 participants who had used online peer support. We did not specify whether they should indicate their satisfaction with solely the experience, or the outcome, or both – this was open to individual interpretation. Around three-quarters of respondents reported being satisfied, more than satisfied, or very satisfied. Only a small minority (2.5%) reported being not at all satisfied, and the remainder (22.9%) were partially satisfied.

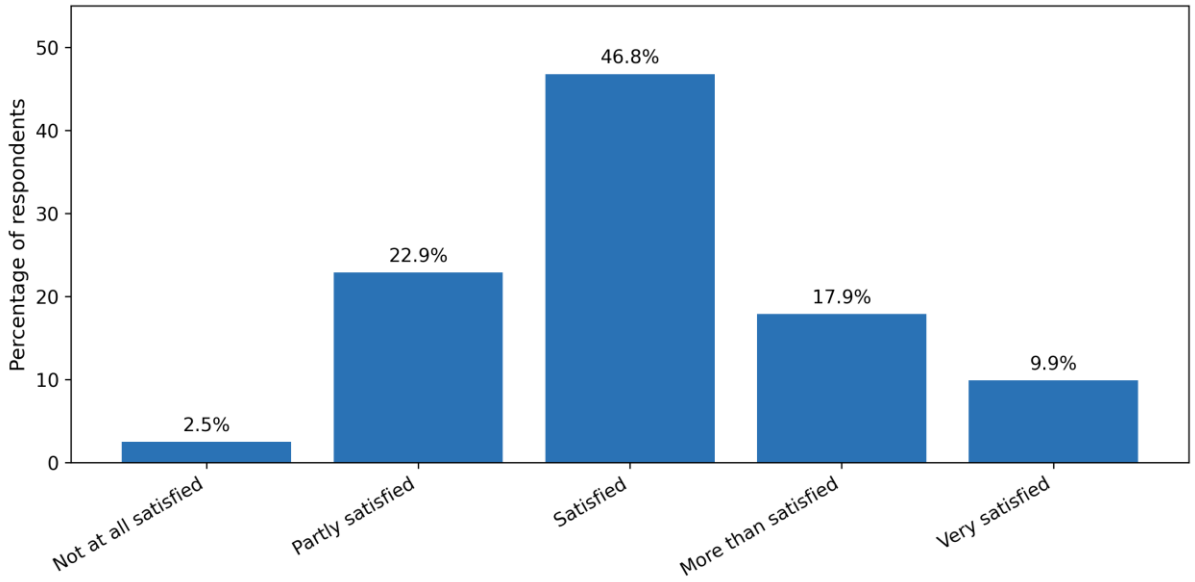

Figure 5: Overall satisfaction with online peer support (n= 476 participants who [had/] used it)

Satisfaction across different demographic groups

Exploratory nonparametric analyses (reported in full in Appendix 3, Table 12) of satisfaction ratings across key demographic groups identified that satisfaction differed modestly by household income, with participants in higher income groups reporting slightly higher satisfaction scores than those in lower income groups (Kruskal–Wallis $H(2) = 6.72$, $p = .035$), and a weak positive correlation observed between satisfaction and household income (Spearman's $\rho = .10$, $p = .029$). Satisfaction was also higher among participants who reported caring for children under the age of 16 compared to those without such responsibilities (Mann–Whitney $U = 23059.5$, $p = .005$). No significant differences in satisfaction were observed by education level, relationship status, ethnicity, presence of a health condition, or other caring responsibilities (all $p > .05$), and age was not significantly correlated with satisfaction.

Overall, satisfaction with online peer support appeared broadly consistent across demographic groups, with only small subgroup differences observed, which should be interpreted cautiously, given the exploratory nature of these analyses and the number of comparisons conducted.

Perceived benefits and challenges

Participants who had used online peer support endorsed a range of perceived benefits, alongside some challenges, on the 8-item measure developed based on the Online Peer Support Group Experiences Questionnaire[98]. The proportion of people endorsing each type of benefit and challenge is presented in Table 4.

Overall, challenges were reported by a minority of users and most commonly related to emotional burden (e.g. feeling overwhelmed by others' experiences), negative interactions, or difficulties

[98] Tan, Y. T., Rehm, I. C., Stevenson, J. L., & De Foe, A. (2021). Social media peer support groups for obsessive-compulsive and related disorders: understanding the predictors of negative experiences. *Journal of Affective Disorders*, *281*, 661-672. https://doi.org/10.1016/j.jad.2020.11.094

managing time or boundaries when engaging with online peer support. Although not widely reported, these challenges remain important to acknowledge.

Benefits were endorsed more frequently than challenges across all items. The most-commonly reported benefits related to feeling less alone, feeling understood by others with lived experience, and gaining encouragement or reassurance, while practical benefits such as receiving advice or information were also frequently endorsed.

Table 4: Benefits and challenges of online peer support

	% endorsing (≥ sometimes)
Benefits	
Felt validated by online peer support	76.0%
Felt a sense of acceptance or belonging	78.7%
Felt relief or hope for recovery	81.3%
Received helpful advice about tools, resources or information	84.5%
Challenges	
Felt anxious, distressed, angry, guilty or frustrated as a result	10.5%
Experienced bullying or harassment	6.5%
Been removed, blocked, or banned	4.0%
Use worsened gambling harms	2.7%

Percentages reflect respondents who reported experiencing each outcome "sometimes", "often", or "very frequently".

Consistent with these patterns, scores on the adapted Online Social Support (OSS)[99] scale indicated moderate to high levels of perceived support amongst online peer support users. Mean scores were highest for informational support (M = 7.25/10, SD = 1.79) and affiliative or belonging-based support (M = 7.15/10, SD = 2.00), followed by emotional support (M = 6.81/10, SD = 1.90) and instrumental or practical support (M = 6.81/10, SD = 2.05). Together, these findings suggest that online peer support was most-commonly experienced as a source of shared understanding, information, and social connection, while also presenting challenges for some users.

4.4 Conclusions and implications

This quantitative survey provides a detailed picture of how people experiencing gambling harms engage with online peer support, the forms this support takes, and how it is perceived by users.

Engagement with online peer support was common, varied, and typically embedded within broader patterns of informal and self-directed support, with a minority using it alongside professional treatment or services. While use of online peer support in isolation was less common than using it alongside other forms of support, it was not negligible. This positioning of online peer support within the wider support landscape highlights opportunities for integration and signposting within broader gambling harm pathways.

[99] Nick, E. A., Cole, D. A., Cho, S. J., Smith, D. K., Carter, T. G., & Zelkowitz, R. L. (2018). The online social support scale: measure development and validation. *Psychological Assessment*, *30*(9), 1127. https://doi.org/10.1037/pas0000558

Most participants engaged with lower-intensity, primarily informational modalities such as reading or posting on forums, often over extended periods and in short, frequent sessions. More intensive forms of online peer support, including online meetings, messaging groups, and one-to-one peer support, were used by smaller subsets of participants, involved longer sessions, and were more closely associated with higher levels of recent or historical gambling harm.

The findings highlight the informational role of online peer support, with common motivations related to learning from others' experiences, understanding recovery or treatment options, and informing one's own decision-making. While social and emotional support were important for users of more interactive modalities, many participants appeared to engage primarily for knowledge, reassurance, and validation rather than direct outward-facing interaction. This reinforces the need to recognise passive engagement as a legitimate and potentially beneficial form of use.

Overall experiences of online peer support were predominantly positive, with most users reporting moderate to high satisfaction. While our questions about satisfaction did not prompt participants to specify whether they were satisfied with the *experience* and/or the *outcomes* of online peer support, there were strong perceptions of informational and affiliative support, and perceived benefits such as reduced isolation, validation, and hope for recovery. This suggests participants were likely satisfied with both the experience and its impact on their wellbeing, and potentially their gambling recovery, but further research to explore this explicitly would be of value.

Reported challenges, including emotional overwhelm or negative interactions, were comparatively uncommon, and very few participants indicated that online peer support had worsened their gambling harms. Nevertheless, 2.7% of participants did report that online peer support had worsened their gambling harms at least sometimes, so it will be important for service providers, and service users, to recognise that using this form of support is not completely risk-free. The importance of safeguarding processes within online peer support is discussed further in Section 6.

Where engagement with online peer support had ended, this most often reflected changing needs, reduced perceived usefulness, or transitions to other forms of support rather than negative experiences. For one-to-one support and facilitator roles, discontinuation frequently reflected time-limited availability rather than lack of benefit, suggesting that longer-term access to these forms of online peer support may be welcomed.

The findings raise equity and access considerations. Engagement with online peer support within our sample was associated with higher digital health literacy and more positive attitudes towards technology. This suggests that people with lower digital confidence may be less likely to use, and therefore benefit, from online peer support. Slightly higher satisfaction among higher-income participants further indicates that socioeconomic factors may shape experiences and perceived benefits, even where access appears broad. In contrast, satisfaction was somewhat higher among participants with caring responsibilities for children, highlighting the value of flexible and accessible support for those balancing recovery with caring roles.

Taken together, these results suggest that online peer support plays a meaningful and multifaceted role within the gambling harm support landscape, functioning as a flexible, user-driven resource that can meet different needs at different stages of harm and recovery. However, several limitations should be noted. The online convenience sample is subject to self-selection bias and may under-

represent those with lower digital literacy or access, or over-represent those with positive experiences of online peer support. This limits representativeness and comparisons between users and non-users. The cross-sectional design precludes causal inference; and some subgroup analyses were exploratory with limited statistical power. All measures were self-reported and subject to recall and social desirability biases. Longitudinal and mixed-methods research will be important to build on these findings, examine outcomes over time, and better understand for whom, and under what circumstances, online peer support is most beneficial.

5. Analysis of real online peer support interactions

5.1 Overview of study rationale

This section details our analysis of naturalistic text data from online peer support forums, focusing on posts in which individuals disclosed suicidal thoughts or feelings. This focus was informed by consistent concerns raised across the rapid evidence assessment, qualitative interviews, lived experience panel consultations, and survey findings regarding safeguarding vulnerable individuals in online peer support environments.

Service providers expressed particular concern about the challenges of recognising and responding to suicidal distress in anonymous online spaces such as forums, where follow-up and escalation options are limited. Several questioned whether forum-based peer support is well suited to supporting people experiencing acute crisis. Participants with lived experience similarly described encountering suicidal expressions in online forums and noted the emotional difficulty of managing such content. Survey findings indicating that forums were among the most-commonly used forms of online peer support for gambling harms (see Figure 2 in Section 4) further underscored the importance of examining how suicidal distress is communicated and responded to in these settings.

Against this backdrop, the forum analysis examined patterns of help-seeking, communication, and response within posts disclosing suicidality, using a combination of quantitative and qualitative approaches. This enabled examination of how distress is expressed during moments of acute risk, how peers and moderators respond, and the challenges and opportunities for supporting safety within publicly accessible, peer-led environments.

5.2 Methods

We analysed posts from three publicly accessible online peer support forums focused on gambling-related harms, including two UK-based service-provider forums and a large general discussion platform with a dedicated gambling support sub-community. The non-gambling-specific forum is large and frequently used, receiving over 1,000 posts per week, while the forums housed within gambling support provider websites receive considerably fewer posts (from a few dozen to a few hundred per week). All three forums were moderated by at least one individual. Forum names are not disclosed in line with the project's ethical approach to data processing.

Posts were identified using systematic keyword searches designed to capture disclosures of suicidality in the context of gambling harm, including terms commonly used to avoid online moderation controls (such as 'kms' (an abbreviation of 'kill myself'); and 'unalive'). Searches were restricted to posts from the preceding 12 months as a feasibility-driven decision, to constrain the

sample size and focus on the most contemporary examples of online communication. All retrieved posts were screened and classified as eligible, ineligible, or uncertain. Posts indicating explicit or clearly implied current suicidality were included in the final dataset (n = 73). An additional 79 posts were initially classified as potentially relevant but remained ambiguous following independent review by two coders and were therefore excluded, as it could not be determined with sufficient confidence whether they reflected current suicidality. Ambiguous cases were reviewed by multiple coders to increase confidence in the specificity of the final sample, rather than to maximise inclusivity. As a result, it is possible that some posts referring to suicidality in more indirect or ambiguous terms were excluded; however, this approach ensured that all included posts unambiguously met the inclusion criterion.

A structured codebook guided analysis, capturing both post characteristics and engagement features (e.g. number and timing of responses, moderator involvement), alongside indicators of help-seeking and suicidality. A subset of posts was double coded, with the codebook refined iteratively. Inter-rater agreement, after initial discussions and revision of the codebook, was extremely high (>99%), with disagreements resolved through consensus.

Descriptive statistics were used to summarise engagement patterns, including volume and timing of responses. Group comparisons were conducted using non-parametric Mann-Whitney U tests, reflecting the non-normal and highly skewed distribution of key engagement variables.

During the first attempt at deductive coding using the codebook, while most codes worked well, it became clear that help-seeking could not be reliably captured using simple, mutually exclusive categories. A supplementary qualitative analysis was therefore conducted across all posts to examine how distress and need were communicated, attending to tone, framing, and communicative intent. Posts could be assigned multiple overlapping codes to reflect the complexity of help-seeking in practice.

A further qualitative analysis was undertaken for a purposively selected subset of 11 complete threads to explore the range and character of peer and moderator responses. Threads were chosen to include responses to short, medium and long original posts; with examples including a range of levels of engagement (i.e. a few with comparatively high, medium, and low numbers of responses, respectively); and to encompass several threads from each of the three forums. This analysis focused on identifying the functions and styles of responses, including empathetic engagement, validation, sharing of lived experience, practical guidance, signposting, and risk-management behaviours. Coding was refined collaboratively within the research team.

A detailed description of forum selection, search strategy, screening procedures, codebook development, and inter-rater reliability protocols is provided in Appendix 4: Detailed methods for forum analysis.

5.3 Content analysis findings

Overview of the Dataset

A total of 73 posts containing explicit or clearly implied current suicidality in the context of gambling harm were included in the analysis. All posts were publicly accessible and authored by individuals

discussing or seeking support in relation to gambling-related distress. This dataset formed the basis for both quantitative and qualitative analyses.

Of the 73 posts, one originated from a public forum hosted by a UK gambling-support service, seven from a second UK service-provider forum, and the remainder from a large international publicly accessible general discussion forum with a dedicated gambling-support sub-community. While the first two are UK-based and the latter is international, all forums can be accessed globally, and therefore encompass international perspectives. The small number of posts identified on service-provider forums likely reflects moderation or community policies that discourage or remove content referencing self-harm. Given the very limited number of posts from these forums, no comparisons were made across forum types; instead, all posts were treated as a single pooled sample of public online peer support interactions.

Post length ranged from 7 to 656 words (M = 166, SD = 155). Most posts (94.5%) received at least one reply from other forum users and/or a moderator or administrator,[100] with the number of replies ranging from 0 to 48 (M = 11.7, SD = 12.0). The number of distinct responders (i.e. responders with different usernames, presumably representing different individuals) ranged from 0 to 41 (M = 8.6, SD = 8.9). Figure 6 illustrates the distribution of replies across posts, highlighting substantial variability in engagement and a small number of highly active threads.

Initial replies were often received relatively quickly: the median time to first non-automated reply was 64 minutes. However, response times varied considerably (M = 339 minutes, SD = 606), reflecting wide differences in timing and visibility across posts.

Most posts contained explicit references to suicidal thoughts, reflecting the screening criteria used to identify posts in which suicidality was clearly identifiable. Explicit disclosures are therefore over-represented in the dataset and should not be interpreted as indicating that most online disclosures of suicidality are explicit in nature.

[100] Moderators are usually community members in voluntary roles focused on keeping discussions safe and on-topic, welcoming users, and addressing guideline breaches. Administrators typically have organisational or technical responsibilities, such as setting policies, managing accounts, and supporting moderators. In practice, the roles often overlap and vary by forum size, resources, and protocols. In our sample, moderator posts on the large international forum were mostly automated 'bot' messages linking to general resources, whereas administrator posts on gambling-specific forums were personalised responses from named staff, combining both administrative and moderating functions.

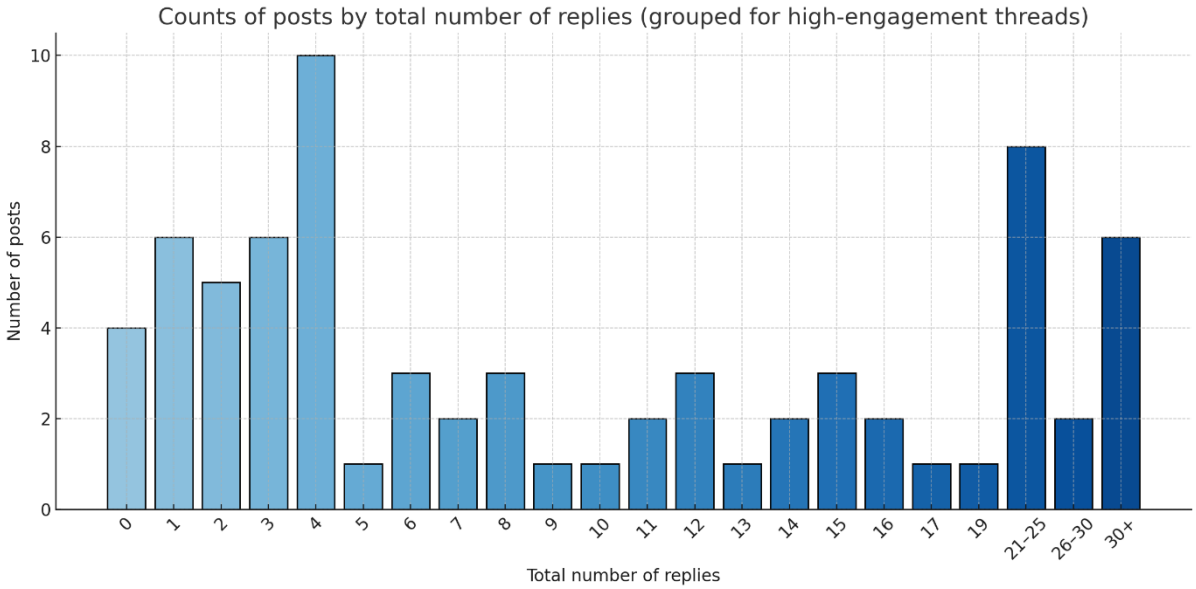

Figure 6: Number of posts by total number of replies received. *Bars show the number of posts that received each possible number of replies (e.g. 0, 1, 2, etc.), illustrating the variability in engagement and the small number of highly active threads.*

Engagement Patterns

Relationship between post characteristics and engagement

Longer posts received significantly more replies – as indicated by a statistically significant correlation (Spearman $\rho = .24$, $p = .044$). Faster initial replies were associated with higher overall engagement, shown by strong negative correlations between time to first reply and both total replies ($\rho = -.52$, $p < .001$) and number of distinct responders ($\rho = -.51$, $p < .001$).

Nature of suicidal disclosure and engagement

Engagement did not differ significantly according to the recency or specificity of suicidal expression: Comparisons across different forms of suicidal expression (e.g. current versus recent past thoughts; presence versus absence of stated plans) showed no statistically significant differences in number of replies, time to first reply, or number of distinct responders.

When comparing posts that contained explicit near-future suicide plans with those that did not, descriptive statistics indicated higher mean numbers of replies and distinct responders for the former. However, these differences were not statistically significant for either total replies ($U = 660.5$, $n_1 = 20$, $n_2 = 53$, $p = .107$, $Z = 1.61$, $r = .19$) or number of distinct responders ($U = 654.0$, $n_1 = 20$, $n_2 = 53$, $p = .126$, $Z = 1.53$, $r = .18$). Time to first reply could not be compared because some posts received no non-automated replies, resulting in no available timing data. Excluding these cases would have restricted the analysis to only those posts that received responses, thereby biasing the comparison.

Only two posts involved implicit suicidality without concurrent explicit disclosure. These received fewer replies and slower responses, but the very small number of cases precludes meaningful statistical comparison.

In other words, the explicitness or specificity of suicidal disclosure was not a reliable predictor of engagement within forum threads.

Moderator involvement

Moderators or administrators posted replies in 14 threads (19% of the dataset). These were most common in the gambling-specific service forums (all of which received a response from a moderator or administrator, with all but one being personalised). Moderator responses within the non-gambling-specific forum were, by contrast, more sporadic, and almost all automated. Threads with moderator involvement received, on average, significantly more replies (Mann–Whitney U = 248.5, $n_1 = 14$, $n_2 = 59$, p = .021, Z = –2.30, r = .27) and involved more distinct responders (U = 241.0, $n_1 = 14$, $n_2 = 59$, p = .016, Z = –2.41, r = .28) than threads without moderator input. It is not possible from the data to determine whether the moderator responses acted as a catalyst to greater activity, or whether posts receiving moderator responses received greater engagement across the board for unrelated reasons, e.g. because of features of the original post, or in response to thread activity. Two posts (2.7%) received only a moderator reply (which was automated in nature), with no engagement from peers. These posts were relatively short (83–110 words). These findings indicate that while it can be associated with greater response volume, moderation does not consistently generate peer interaction and may in some cases be linked with response inactivity.

Help-seeking approaches and responses

Approximately half of the posts (51%) were coded as explicitly or implicitly seeking help. The others, despite disclosing suicidality, did not ask other forum users for help, nor imply that they were seeking support. Help-seeking posts had lower mean numbers of replies (M = 10.0 vs. 13.5) and distinct responders (M = 7.3 vs. 10.1) compared with posts that did not seek help. These differences were not statistically significant for total replies (U = 532.0, $n_1 = 37$, $n_2 = 34$, p = .266, Z = –1.12, r = .13) or for distinct responders (U = 538.0, $n_1 = 37$, $n_2 = 34$, p = .296, Z = –1.04, r = .12), but do indicate that explicit help-seeking did not reliably predict faster or more extensive engagement.

5.4 Qualitative forum analysis findings

Ways in which support was requested

Across the full dataset, posts were often made at points of acute distress (e.g. "*It's the middle of the night and I feel completely hopeless")*, when gambling-related harms had escalated and individuals felt overwhelmed or unable to cope. This context shaped how distress and help-seeking were communicated in the forum posts described here. Through a supplementary inductive qualitative analysis of all 73 help seeking posts, five 'themes' were identified that capture the ways in which individuals expressed distress and sought support. The analysis was data-driven, with themes developed iteratively from close engagement with the posts rather than being pre-specified. Below the themes are presented with illustrative quotations. These quotations are paraphrased from the original text to preserve anonymity whilst still capturing the essence of what was being said. At least two researchers checked each paraphrased quote to increase confidence that it retained the original meaning, without being traceable to the original post.

Theme 1. Direct help-seeking

Many users explicitly reached out for immediate support, often using urgent and emotive language. Posts included direct pleas for advice, requests for reassurance or safety, and appeals for someone to respond or engage with them. Some users framed their messages as crisis signals, using SOS-style language to convey desperation and an inability to cope alone.

> *"PLEASE, PLEASE, PLEASE point me in the right direction… THIS IS MY SOS."*

Other explicit requests included asking for others to share similar stories, to join in with protesting against gambling operators, or give advice on specific scenarios, as well as occasional material requests, such as asking for money. These posts illustrate how forums function as accessible spaces for seeking rapid emotional support, practical guidance, and connection grounded in shared lived experience.

Theme 2. Indirect help-seeking

Alongside explicit appeals for support, many users engaged in more indirect forms of help-seeking, often describing difficulties without directly asking for help. Posts detailing escalating losses, repeated relapses, recurring urges to gamble, and a growing sense of losing control appeared to function as implicit requests for support. These accounts allowed users to invite understanding, validation, or guidance indirectly, while maintaining a degree of emotional distance.

> *"My children are being dragged down with me… I've even borrowed money from people I never imagined I would… I can't afford basic things"*.

Indirect help-seeking often conveyed vulnerability without specifying what kind of response was desired, leaving peers to interpret whether emotional support, advice, or reassurance was being sought.

Theme 3. Storytelling and reflective posts

Many posts took the form of extended narrative accounts in which users described their gambling histories, personal circumstances, and the progression of harm over time. These posts often traced a trajectory from early engagement with gambling through escalation, loss of control, and accumulating consequences, including financial, relational, and emotional harm. Rather than focusing on an immediate request for support, these narratives appeared oriented toward making sense of what had happened and how the individual had reached their current situation.

> *"I've done this seven times this year… I smoke my salary the day I get it, then I tell myself I'll stop, and it just happens again."*

In these posts, recounting past experiences and patterns of behaviour appeared to serve a reflective function, allowing users to articulate insight, regret, or recognition of repeating cycles. While not always framed as help-seeking, such narratives often conveyed vulnerability and a desire to be heard and understood by others with shared experience, suggesting that storytelling itself functioned as a form of engagement and connection within the forum.

Theme 4. Suicidal disclosure as a form of help-seeking

In some posts, expressions of suicidality appeared to function as a way of signalling the severity and urgency of distress rather than as a direct request for intervention. Suicidal thoughts, intent, or

references to attempts were woven into broader narratives of gambling harm, communicating that individuals were at a critical point and struggling to cope.

> *"It would be easier if I just wasn't here… everything looks so dark just now."*

In a small number of cases, users disclosed having made a suicide attempt, while others invoked the possibility of harming themselves to convey the immediacy of their situation. These expressions illustrate how, for some individuals, forums became a space to articulate extreme emotional pain when they may not have felt able to access support elsewhere. In this sense, suicidal communication operated as a form of help-seeking oriented toward eliciting connection, intervention, or acknowledgement during moments of acute distress.

Alongside these narrative disclosures, a small number of posts consisted of extremely brief messages—sometimes only a few words long—in which users expressed a desire to end their lives with little or no contextual detail. These posts suggest that some individuals reached out during moments of intense distress with limited capacity to elaborate their situation, using the forum as an immediate outlet for signalling crisis.

Theme 5. Accounts of hope

Some forum users posted accounts of tentative hope, using these narratives as a way to both document moments of progress and quietly seek support and affirmation from others. In one example, a poster described feeling that they had reached their "first sign of hope" after months of secrecy, fear, and suicidal thoughts, and shared this openly in order to "make someone else feel less alone." Although they emphasise that they still face significant challenges and shame, they use the forum to express a fragile sense of optimism, urging others: "when you think you've got no way out, please don't give up." By posting this story, the user not only provides encouragement to others but implicitly seeks ongoing connection and validation, using hope-sharing as a way of sustaining motivation and signalling their desire to keep moving forward with support from the community.

Ways in which support seeking was responded to

Within the 11 complete threads analysed, 5 included responses from moderators or admins, and 6 consisted of responses solely from other forum members. Multiple response types often co-occurred within the same thread. Four overlapping themes capture the main ways in which suicidal disclosure was responded to in these online peer environments. In line with reflexive thematic analysis principles,[101] frequencies of response types are not reported, with emphasis placed on patterns of meaning rather than counts.

Theme 1. Emotional responses to distress

Many responses centred on acknowledging the poster's distress and offering empathy, reassurance, and emotional support. These replies often explicitly validated the intensity of the poster's feelings, normalised emotional reactions to gambling harm, and emphasised shared experience within the community. Expressions of care and concern were common, particularly in early replies, and appeared aimed at reducing isolation and conveying that the poster was not alone.

[101] Braun, V., & Clarke, V. (2021). *Thematic Analysis: A Practical Guide*. London: SAGE.

"It's understandable to feel anger, sadness, despair… you made a bad choice, but you can decide what you do next."

At the same time, emotional engagement varied in quality. Some responses minimised the poster's distress or reframed it as disproportionate, particularly in relation to perceived financial losses. A small number of replies adopted overtly confrontational or hostile tones, criticising the poster's behaviour or character rather than responding to their expressed distress.

"Here's the blunt take you probably won't like… pull yourself together. The money is gone…"

These responses illustrate the uneven emotional climate of peer-led spaces, where supportive and invalidating reactions can coexist.

Theme 2. Advice-giving and guidance

Advice-giving was a prominent response across threads, regardless of whether the original poster had explicitly asked for advice. Suggestions ranged from practical strategies (e.g. installing blocking software, restricting access to money) to broader reflections on responsibility, mindset, or long-term recovery. Many users drew on their own lived experience, using personal stories to warn, motivate, or reassure.

"You can't undo what's already happened, but you can choose what you do next."

While some guidance was clearly supportive and tailored, other advice was unsolicited, prescriptive, or poorly aligned with the poster's stated needs. In some cases, conflicting advice appeared within the same thread, reflecting differing beliefs about what constitutes effective recovery. These patterns highlight both the value of experiential knowledge and the challenges of subjective advice in peer settings. While we did not specifically focus on the role of the moderator within these threads, and not all threads were moderated, it is of interest to note that moderators did not tend to pass comment on other forum users' responses, so questionable advice sometimes went unchallenged. For instance, one thread within the non-gambling-specific forum included the controversial advice to replace gambling with an alternative, "less harmful" addiction, and the auto-moderator response that came after this comment did not reference or challenge it. However, moderator responses – including automated ones - did universally direct the original poster to reputable sources of information and resources.

Theme 3. Online community dynamics

Beyond direct responses to the original poster, some replies focused on regulating the interactional norms of the thread itself. Defensive exchanges or disagreements sometimes strained the supportive intentions of the space, and some users responded by challenging dismissive or hostile comments, correcting misinformation, and defending the legitimacy of the poster's distress. These responses helped maintain a supportive ethos and signalled shared expectations about acceptable behaviour.

"Why minimise his reaction just because your experience is different?"

Other interactions revealed tensions within the community, including post-hijacking (where another user redirects the discussion towards their own issues instead of engaging with the author's), disagreements between commenters, and assumptions about the poster's identity (e.g. defaulting to

male gender). Some replies explicitly reinforced the limits of what the forum could offer, clarifying that financial assistance or professional intervention were outside the scope of the community. These dynamics illustrate how peer forums rely on informal social regulation to balance openness, support, and boundary maintenance.

Theme 4. Crisis response and safety promotion

When posts included references to suicidality or acute emotional risk, responses often shifted toward urgency and safety. Users expressed concern, discouraged self-harm, and prioritised signposting to external crisis services, trusted contacts, or emergency support. Many replies emphasised the importance of seeking help beyond the forum, particularly where immediate risk was perceived.

> *"If you're in immediate danger, please contact emergency services or reach out to the Samaritans right now."*

Moderation practices were also visible within these threads. Some platforms deployed automated crisis messages containing standard signposting information, while others involved personalised moderator replies. The balance between automated and human moderation varied by forum, and in some cases automated messages appeared – which did not receive peer engagement. These responses underscore both the importance and the limitations of safety-oriented interventions within peer-led online spaces.

5.5 Conclusions and Implications

This analysis provides naturalistic insight into how suicidality linked to gambling harms is disclosed and responded to within publicly accessible online peer support forums. It illuminates how online peer support operates during moments of crisis within one of the least formally supervised support environments.

A central finding is that forums are sometimes accessed at points of extreme distress, when individuals feel overwhelmed and unable to cope. Posts described financial collapse, shame, isolation, and a perceived lack of alternatives, with the forum used as an immediate outlet for expressing distress. This mirrors concerns raised by service providers and people with lived experience across other strands of the programme, and demonstrates that forums are not only spaces for reflection or recovery-oriented discussion, but can also function as sites of crisis disclosure.

Help-seeking within these environments was variable and often indirect. Many posts containing suicidal content did not explicitly ask for help, instead embedding distress within narratives, reflections, or brief statements of intent. Explicit disclosures did not reliably result in faster or more extensive engagement, and some posts with clear expressions of suicidality received limited or no peer responses. Engagement appeared to be shaped less by the severity or explicitness of suicidal expression and more by contextual factors such as timing, narrative detail, and early visibility. Faster initial replies were associated with higher overall engagement, suggesting early responses may influence how support unfolds - raising questions about chance and equity in who receives support.

Qualitative analyses highlighted the breadth of ways in which distress was communicated and responded to. Storytelling emerged as a central mode of expression, supporting emotional release,

sense-making, and indirect help-seeking. Expressions of suicidality sometimes appeared to signal urgency rather than function as direct requests for intervention. Alongside crisis disclosures, tentative accounts of hope or progress indicated that forums can also function as spaces for sustaining motivation and mutual encouragement even during times of crisis.

Responses were equally heterogeneous. Many offered empathy, validation, and shared lived experience, reinforcing the forum's potential as a source of emotional and affiliative support. However, some responses minimised distress, adopted confrontational tones, or offered unsolicited and sometimes conflicting advice. These patterns reflect both the strengths and risks of peer-led spaces.

Moderator involvement was associated with higher overall engagement, but did not consistently initiate peer responses, and a small number of posts received only automated moderator replies. Automated responses provide essential signposting and risk management, but may also shape subsequent peer engagement. The low number of suicidal posts identified on service-provider forums further suggests that organisational context and moderation practices influence what distress becomes visible in public spaces. Based on publicly available information, posts on the service-provider forums we analysed do not appear to require moderator approval before publication. However, both platforms use active moderation (including editing or removing posts that breach community guidelines), and state clearly that the forums are not intended to function as crisis services.

These findings have several implications. Publicly accessible forums are already functioning as crisis spaces for some people experiencing gambling harms, and this reality needs to be acknowledged in policy and practice. Safeguarding approaches that rely primarily on explicit crisis language may miss some vulnerable users; even within this focused analysis, many individuals communicated distress indirectly (e.g. expressing that 'nothing matters anymore', in the context of other clues that they were feeling emotionally vulnerable and hopeless), suggesting this challenge is likely more pronounced in the wider forum environment. Patterns of engagement also indicate that early responses may shape the trajectory of support, highlighting the importance of considering how peer, moderator, and automated responses interact during moments of acute distress.

Limitations of this study include the fact that analysis reflects only publicly visible interactions; private messages, offline follow-up, and moderated or removed content were not accessible. While we sorted posts by recency and attempted to screen all posts from the past 12 months, it is also possible there may also have been algorithms that influenced visibility of posts. The study may also be subject to cultural and linguistic bias. The keyword-based search strategy necessarily prioritised commonly used English-language expressions of distress, meaning that culturally specific or less familiar ways of articulating distress may not have been captured. The focus on posts with clearly identifiable suicidality also limits insight into earlier or more ambiguous expressions of distress. Finally, the small number of posts from service-provider forums constrains conclusions about differences in moderation practices.

Nonetheless, this study demonstrates that online peer support forums play a complex and consequential role in responding to suicidality linked to gambling harms. They can offer rapid and accessible support, but with variability in response quality and safeguarding capacity. These findings

align with concerns raised elsewhere in the programme and inform the integrated synthesis that follows.

6. Integrated Synthesis Across Work Packages

The distinctive role of online peer support within the gambling harm support system

This programme of research indicates that online peer support for gambling harms is a distinctive form of help that typically occupies a complementary position within the wider support system. It was most often used alongside other forms of support rather than as an alternative, with around 3 in 5 people we surveyed using it in conjunction with self-help tools or support from friends and family, and a smaller proportion using it alongside professional gambling harms support (around 1 in 7) or support from other professionals (another 1 in 7). However, it did represent the only source of support engaged with for around 1 in 7 people.

The value of online peer support was closely tied to the authenticity of shared lived experience. Interview participants emphasised the importance of connecting with others who understood gambling harm first-hand, and who could offer empathy, validation, and hope grounded in personal experience rather than professional expertise alone. This helped reduce shame, normalise recovery, and support the development of a recovery-oriented identity. These findings align with wider literature on face-to-face peer support and lived experience in relation to fields spanning mental health,[102] substance use disorder,[103] and gambling.[104]

Beyond these shared mechanisms, online peer support was perceived as offering distinctive advantages in accessibility and flexibility. Interview accounts highlighted how online formats can lower practical and psychological barriers to engagement, including stigma, geography, cost, scheduling, and hesitancy to disclose difficulties. Again, this mirrors findings from wider literature on online peer support.[105] The ability to engage gradually or at lower intensity (for example, through camera-off participation) was described as particularly valuable. Survey findings showed that online peer support is used flexibly across times of day and durations, fitting around caring responsibilities and other commitments. However, there was some evidence that people with lower digital literacy or fewer financial resources were less well served, pointing to important equity considerations. This is consistent with observations in other online peer support settings.[106,107]

[102] Fortuna, Karen L., Phyllis Solomon, and Jennifer Rivera. An update of peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Quarterly* 93.2 (2022): 571-586. https://doi.org/10.1007/s11126-022-09971-w

[103] Stanojlović, M., & Davidson, L. (2021). Targeting the barriers in the substance use disorder continuum of care with peer recovery support. *Substance Abuse: Research and Treatment*, *15*, 1178221820976988. https://doi.org/10.1177/1178221820976988

[104] Penfold, K. L., & Ogden, J. (2024). The role of social support and belonging in predicting recovery from problem gambling. *Journal of Gambling Studies*, *40*(2), 775-792. https://doi.org/10.1007/s10899-023-10225-y

[105] Mirbahaeddin, E., & Chreim, S. (2024). Transcending technology boundaries and maintaining sense of community in virtual mental health peer support: a qualitative study with service providers and users. *BMC Health Services Research*, *24*(1), 510. https://doi.org/10.1186/s12913-024-10943-y

[106] Lepore, S. J., Rincon, M. A., Buzaglo, J. S., Golant, M., Lieberman, M. A., Bauerle Bass, S., & Chambers, S. (2019). Digital literacy linked to engagement and psychological benefits among breast cancer survivors in Internet-based peer support groups. *European Journal of Cancer Care*, *28*(4), e13134. https://doi.org/10.1111/ecc.13134

[107] Peng, R., Chang, J., Zhu, Y., Feng, H., & Cao, Z. (2025). Unlocking the Power of Peer Support in Digital Use and Digital Health Interventions for Older Adults: A Scoping Review. *Journal of Advanced Nursing*. https://doi.org/10.1111/jan.16963

Immediacy also emerged as a defining characteristic – something that has also been highlighted in the wider online peer support literature as a potential benefit of online peer support.[108] Participants described the value of synchronous formats, such as messaging groups and live meetings, in providing real-time emotional containment during moments of distress. The forum analysis complements this by illustrating how online spaces – including both specialised and general support forums - can generate rapid peer responses, sometimes within minutes, particularly when posts gain early visibility. Together, these findings suggest that online peer support can bridge temporal gaps between formal appointments and operate outside standard service hours, while also raising questions about how risk and crisis are managed within peer-led environments (explored further below).

How people seek, signal, and engage with support online

This research found that engagement with online peer support was varied, non-linear, and often indirect. People moved in and out of peer spaces as needs, circumstances, and stages of recovery changed, and many participants described not only help-seeking but also the formal and informal provision of support to others – something that was particularly common amongst those who had experienced high levels of gambling harm historically, before recovery.

Passive forms of engagement, such as reading posts or observing discussions, were frequently reported and experienced as meaningful forms of support. For some, indirect posting or story-sharing felt safer than explicit help-seeking; for others, reading without contributing enabled continued connection while limiting exposure. This indicates that visible or direct participation is not a prerequisite for benefit, and that low-visibility engagement can play a legitimate role in recovery. It can also represent a low-barrier entry into online peer support that some people make use of before progressing to more interactive forms of online peer support. Similar patterns have been observed in the wider online peer support literature,[109] where varied reasons why people may prefer to engage passively have been identified.[110]

Where people did actively engage, they communicated distress and sought support in nuanced ways. Analysis of naturalistic forum data provided one lens via which to examine how such patterns play out in public, text-based peer spaces. Expressions of distress, including disclosures of suicidality, were sometimes explicit and other times implied, and were often embedded within broader narratives or conveyed in brief, fragmented ways. Responses were equally variable, and even when help was explicitly asked for, the type of support or advice offered did not always align well with what was requested. This is broadly similar to the pattern of responses observed in a study of threads encompassing suicidality in online forums more generally.[111]

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[108] Lim, Z., Lim, S. Y., Lu, S., & Gutman, L. M. (2025). Barriers and Enablers to Young People's Posting, Responding, and Reading Behaviors on Mental Health Forums Using the Behavior Change Wheel: Qualitative Study. *JMIR Human Factors*, *12*, e71549. https://doi.org/10.2196/71549

[109] James, T. L., Calderon, E. D. V., Bélanger, F., & Lowry, P. B. (2022). The mediating role of group dynamics in shaping received social support from active and passive use in online health communities. *Information & Management*, *59*(3), 103606. https://doi.org/10.1016/j.im.2022.103606

[110] Fullwood, C., Chadwick, D., Keep, M., Attrill-Smith, A., Asbury, T., & Kirwan, G. (2019). Lurking towards empowerment: Explaining propensity to engage with online health support groups and its association with positive outcomes. *Computers in Human Behavior*, *90*, 131-140. https://doi.org/10.1016/j.chb.2018.08.037

[111] Bjärehed, J., Grönberg, H., & Jarlvik, E. (2023). The different faces of online support: A thematic analysis of responses to help-seeking related to depression and suicidal ideation in public online forums. *Cyberpsychology: Journal of Psychosocial Research on Cyberspace*, *17*(5), Article 5. https://doi.org/10.5817/CP2023-5-5

While forums were one of the most-commonly used forms of online peer support, many participants particularly valued the sense of community derived from synchronous, immersive formats such as online group meetings, or one-to-one peer support. People often used more than one form of online support, and it could come before, during, after, or in place of, other forms of support, with no consistent directional pattern. Service providers emphasised that readiness to engage fluctuates, and that online peer support allows people to approach help in ways that feel manageable at a given point in time. While there is a paucity of existing literature exploring online peer support use longitudinally, there is some evidence to suggest that users favour this kind of flexible engagement over time.[112]

Overall, these findings indicate that help-seeking within online peer support is a dynamic process, shaped by individual circumstances and the affordances of different platforms.

Safeguarding, crisis, and the limits of peer support

Online peer support was frequently described as a resource that people turn to during periods of acute distress, including moments of crisis. This reflects the accessibility and immediacy of online peer spaces, as well as the barriers that some individuals experience in accessing formal services at times of heightened need. At the same time, concerns about the suitability of online peer support for responding to crisis-level distress, including complexities around roles and responsibilities and boundary setting, were raised consistently across qualitative interviews and lived experience panel discussions. Accounts highlight a central tension: online peer support is often used in crisis because it is available and approachable, but its capacity to manage acute risk is limited. A detailed dissection of this tension, and discussion of how crisis is conceptualised and managed in online peer support spaces for mental health, can be found within the wider literature.[113]

Concerns about safeguarding included the challenges of recognising and responding to crisis-level distress. While peer responses could offer empathy and validation, this was not always found. Importantly, as interview participants explained, challenges can differ across moderated and unmoderated online spaces. Professionally moderated forums or groups may remove suicidal content (as seen in some forums' policy statements) or redirect users disclosing suicidality to crisis services as part of safeguarding processes, offering clearer pathways for risk management but potentially constraining open discussion. Unmoderated spaces, while they can be experienced as less restrictive and more authentic, tend not to provide equivalent safeguards. This means that peers can be left carrying responsibility for responding to acute risk without formal support, and the quality and appropriateness of responses can vary. Furthermore, our forum analysis suggests that approaches to moderation, safeguarding, and service design that rely primarily on explicit crisis language or direct requests for help are likely to fail to identify and support some individuals experiencing acute distress. The challenges of effectively moderating online forums where self-harm or suicidality are disclosed have received recent attention within the wider literature, where this issue, alongside others, is highlighted.[114]

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[112] Smit, D., Vrijsen, J. N., Broekman, T., Groeneweg, B., & Spijker, J. (2022). User engagement within an online peer support community (depression connect) and recovery-related changes in empowerment: longitudinal user survey. *JMIR Formative Research*, *6*(11), e39912. https://doi.org/10.2196/39912

[113] Tucker, I. M., & Lavis, A. (2019). Temporalities of mental distress: Digital immediacy and the meaning of 'crisis' in online support. *Sociology of Health & Illness*, *41*, 132-146. https://doi.org/10.1111/1467-9566.12943

[114] Haime, Z., Kennedy, L., Grace, L., & Biddle, L. (2025). Experiences of moderation, moderators, and moderating by online users who engage with self-harm and suicide content. *Digital Society*, *4*(1), 8. https://doi.org/10.1007/s44206-025-00166-x

Taken together, evidence across the programme of research suggests that online peer support can play a meaningful role during periods of distress, but that its strengths in accessibility and immediacy are accompanied by limits in relation to crisis management and safeguarding. These tensions are not unique to gambling harm contexts and have been identified in wider research on online peer support and digital mental health.[115,116] Rather than positioning online peer support as an appropriate or inappropriate response to crisis, the findings point to the importance of understanding how it is used in practice and how it sits alongside other forms of support.

The following section draws on these findings to consider their implications for policy, practice, and the optimisation of online peer support for gambling harms.

7. Implications

This programme of research provides a detailed picture of how online peer support for gambling harms is used and experienced, and of its place within the wider support landscape. The implications outlined here draw directly from the findings across the four strands and are intended to inform policy, commissioning, and practice, while recognising the diversity of online peer support models and contexts.

Implications for understanding demand and engagement

Engagement with online peer support extends well beyond active or visible help-seeking, with passive and intermittent modes of access commonly reported as meaningful forms of support. This suggests that low-visibility engagement plays a legitimate role in recovery and should not be assumed to be peripheral or indicative of limited benefit.

This has implications for how online peer support is conceptualised and evaluated. Approaches that focus primarily on posting frequency, attendance, or volume of interaction to evaluate uptake or effectiveness may underrepresent both reach and perceived value. Alternative metrics such as number or duration of site visits, or number of reads or 'likes' that existing social media or forum posts receive, could be of value to provide additional information about engagement. The findings also show that individuals often move fluidly between different forms of online support, and between online and offline provision, as needs and circumstances change. Understanding online peer support as a flexible and shifting resource, rather than a bounded intervention, may therefore offer a more accurate basis for planning and interpretation.

Implications for crisis, safeguarding, and escalation

Online peer support is not only used at lower levels of harm, but also by those experiencing more severe difficulties. Some use occurs at times of distress or crisis, regardless of whether spaces are designed for this purpose - reflecting the accessibility of online peer environments at times of heightened need. However, there are clear limits to what peer-led online spaces can reasonably provide in relation to crisis management and safeguarding.

[115] Bjärehed, J., Grönberg, H., & Jarlvik, E. (2023). The different faces of online support: A thematic analysis of responses to help-seeking related to depression and suicidal ideation in public online forums. *Cyberpsychology: Journal of Psychosocial Research on Cyberspace*, *17*(5), Article 5. https://doi.org/10.5817/CP2023-5-5

[116] Haime, Z., Kennedy, L., Grace, L., & Biddle, L. (2025). Experiences of moderation, moderators, and moderating by online users who engage with self-harm and suicide content. *Digital Society*, *4*(1), 8. https://doi.org/10.1007/s44206-025-00166-x

As our qualitative analysis of ways of seeking help within online forum posts demonstrated, expressions of need were often indirect, ambiguous, or embedded within broader narratives, complicating recognition and response. Safeguarding approaches that rely primarily on explicit crisis language (for example, direct references to suicidality) or overt requests for help may fail to capture some users at risk, and automated moderator responses may miss nuances in the poster's situation. These findings raise questions about expectations placed on online peer support and highlight areas for consideration when tailoring training and support for those facilitating or moderating spaces.

While this study did not explore the role of artificial intelligence in any detail, beyond observing the frequency of automated moderation, the rapid growth in generative AI is likely to bring both potential benefits and challenges for online support for gambling harms, that will require further investigation. Algorithms influencing forum post visibility, for instance, while not considered in the current study, could be beneficial for exposing passive users to most relevant content, but could also lead to some posters receiving reduced engagement.

Implications for the design and delivery of online peer support

The findings indicate that different online peer support formats, including forums, messaging groups, live meetings, and one-to-one support, are valued in different ways and at different points in recovery. No single model emerged as universally superior; rather, diversity and choice were key.

How online peer support is structured and facilitated shapes users' experiences, as well as providers' confidence in the safety and adequacy of support. The findings point to the importance of considering how best to train and support those providing peer support in formalised roles – something that wider research has begun to explore.[117] In addition to safeguarding their wellbeing, this may also influence user experience and the sustainability of provision.

Implications for system integration and commissioning

Across the programme, online peer support was most often used alongside other forms of help rather than as a replacement for them, although in some cases it functioned as the primary or only source of support available. This reinforces the importance of understanding online peer support as one component within a wider ecosystem of provision, while also recognising that it may, at times, be drawn on as a standalone response to gambling harms.

For commissioners and policymakers, the findings point to the value of clarity around how online peer support is positioned within the broader support system, including roles, responsibilities, and boundaries. In particular, the research underscores the importance of considering how online peer support connects with formal services, crisis provision, and other sources of help, and how responsibility for safeguarding is distributed across the system. Greater clarity in these areas may help ensure that online peer support is appropriately supported and integrated, in ways that recognise its benefits while also acknowledging and compensating for its limitations.

[117] Collins-Pisano, C., Johnson, M., Mois, G., Brooks, J., Myers, A., Muralidharan, A., ... & Fortuna, K. (2021). Core competencies to promote consistency and standardization of best practices for digital peer support: focus group study. *JMIR Mental Health*, *8*(12), e30221. https://doi.org/10.2196/30221

8. Recommendations

Key recommendations arising from this research are summarised in

Table ***5***, with a more detailed version mapping these to the evidence base, available in Appendix 5. In considering these recommendations, it is worth noting that online peer support extends beyond commissioned and formally moderated services, including informal, community-led, and self-organised spaces. As a result, the capacity of policymakers and service providers to implement these recommendations across all forms of online peer support is necessarily constrained. The recommendations should therefore be understood as most directly applicable to commissioned, supported, or facilitated provision, while remaining relevant as guiding principles more broadly.

Table 5: Summary of recommendations

Theme	Recommendation (summary)
Positioning and resourcing	Maintain and strengthen online peer support as a core component of the gambling harm support system.
	Where expansion is considered, ensure it is proportionate and accompanied by appropriate support and safeguards, such as crisis management protocols or sufficient staffing.
Understanding engagement	Recognise passive, intermittent, and low-visibility engagement as potential pathways to interactive engagement, but also as legitimate forms of use in themselves.
	Avoid reliance on volume-based participation metrics as proxies for impact.
Crisis and safeguarding	Do not position online peer support as a substitute for formal crisis services.
	Review safeguarding approaches to ensure they do not rely solely on explicit crisis language or direct requests for help.
	Ensure clear, visible, and proportionate escalation pathways to external crisis support.
Supporting peer supporters	Provide appropriate training, guidance, supervision, and role clarity for peer supporters in formal or semi-formal roles.
User experience and access	Support provision of multiple online peer support formats to enable tailored engagement.
	Promote user autonomy, including the option for passive or intermittent engagement.
	Provide clear guidance and proportionate technical support to reduce participation barriers and ensure an equitable experience for all users.
System integration	Be explicit in commissioning about intended role, remit, and limits of online peer support.
	Support closer alignment between online peer support and other gambling harm services, while respecting peer-led distinctiveness.

9. Limitations and directions for future research

The limitations of each component study are described in detail within the relevant sections of this report. In addition to these strand-specific considerations, several cross-cutting limitations should be noted when interpreting the findings of the programme as a whole.

First, while participants consistently described a range of benefits associated with engagement with online peer support, the evidence presented here may under-represent views of those with negative experiences of online peer support. It is also based on self-reported experiences and perceived value, rather than direct measurement of outcomes. While these are valid and valuable insights, the findings cannot speak to the objectively measured effectiveness of online peer support in terms of

recovery trajectories, wellbeing, or harm reduction, nor to how its impacts compare with other forms of support.

Second, although the programme brought together multiple methods to strengthen understanding, each strand necessarily captures only part of the online peer support landscape. The forum analysis focused on public, text-based spaces; the qualitative interviews reflect the perspectives of individuals willing and able to participate; and the survey provides breadth but limited insight into individual change over time. Together, these approaches offer complementary perspectives, but they do not capture all forms of online peer support in equal depth, particularly informal, private interactions.

These limitations point to clear directions for future research. Longitudinal studies following individuals over time would be valuable in understanding how engagement with online peer support interacts with changing needs, stages of recovery, and use of other services. Comparative research examining different models of online peer support, and their relationship to offline and clinical provision, would further strengthen the evidence base.

10. Conclusions

This programme of research set out to build an integrated understanding of how people affected by gambling harms access and experience online peer support, drawing together evidence from surveys, qualitative interviews, analysis of online forums, and a rapid evidence assessment. Taken together, the findings provide a grounded account of how online peer support operates in practice, and of its place within the wider gambling harm support landscape.

Across the four strands, online peer support emerged as a valued and widely used resource, characterised by accessibility, immediacy, and the relational strengths of shared lived experience. Engagement was varied, non-linear, and often indirect, with people moving in and out of different online spaces over time and engaging in ways shaped by their circumstances and stage of recovery. These patterns challenge narrow conceptions of help-seeking and highlight the importance of recognising passive and intermittent forms of engagement as meaningful.

At the same time, the research underscores clear limits to what online peer support can reasonably be expected to provide, particularly in relation to crisis management and safeguarding. While online peer spaces are often used during periods of acute distress, expressions of need may be ambiguous or indirect, and peer-led environments lack the infrastructure required for sustained crisis intervention (e.g. they tend not to be embedded within escalation pathways that can easily refer users to personalised, professional support provision). Understanding both the strengths and the limits of online peer support is therefore essential to its safe and effective integration within the broader support system.

Overall, the programme contributes to a more nuanced evidence base on help-seeking for gambling harms in the digital age. By grounding analysis in lived experience, service provision, and observed online interactions, the research provides a robust foundation for informing decisions about the development, delivery, and governance of online peer support, while remaining attentive to variability, risk, and the realities of how people seek support in practice.

Appendices:

Appendix 1: Detailed survey methods

Overview

This survey examined who engages with online peer support for gambling harms, how they use it, their motivations, and perceived benefits and risks. Because no validated online peer support specific measures exist for gambling contexts, several measures were adapted from established instruments used in online health, peer support, and digital literacy research. All adaptations were refined through consultation with our lived experience panel to ensure they were clear, logical, and relevant.

Recruitment

Participants were recruited via two routes:

1. **Initial convenience sampling via open link (n = 55 authentic responses):**
   The survey link was circulated through community groups, social media, and professional gambling support networks, incentivised by a £10 shopping voucher for completed surveys where attention and authenticity checks were passed. A total of 55 authentic responses were obtained over a period of approximately 10 days, in Oct-Nov 2025. At a clearly defined point, the link was accessed by automated bots, generating >500 inauthentic responses within a short period. All inauthentic cases were excluded based on (a) failed attention checks, (b) duplicate IP/device data, and (c) patterned response behaviour. Following this, the open link was closed.
2. **Prolific Academic (n ≈ 465 authentic responses):**
   The remaining sample was recruited via Prolific, using pre-screeners to target adults with any prior gambling experience. Participants were paid £3.50, which corresponded to an hourly rate in the "great" range according to Prolific guidelines and aligned with ethical expectations for fair compensation.

Procedure

Participants accessed an online information sheet which included support resources and detailed information about the survey content, data processing and storage, and contact details for the research team, before providing digital informed consent. They then completed the survey (~15 minutes depending on conditional routing). At the end, participants received a debrief reiterating support resources for gambling harms and mental health.

Voucher payments (or Prolific credit) were issued only after authenticity checks were passed. Personal data for voucher distribution were stored separately from survey responses, linked only by a unique anonymised code. To avoid excluding any genuine participants from compensation but also protect data quality, we applied stricter criteria for analytic online peer support inclusion than for payment. A small number of respondents (fewer than five) therefore received compensation but were excluded from analysis due to borderline validity concerns (e.g., failing one of multiple attention checks).

Ethical approval

Ethical approval was obtained from the University of Wolverhampton's School of Psychology Research Ethics Committee (Reference: 0925JLUOWPSY). An amendment approving the switch to Prolific recruitment was submitted and approved during data collection. Data were processed in accordance with GDPR, with all identifying information removed from the analytic dataset.

Measures

All items are reproduced with their exact phrasing in Appendix 2. Below we summarise the measures used, reliability statistics for adapted scales, and which participants received which items and scales.

1. Engagement with Online Peer Support

Participants reported their engagement with nine online peer support modalities:

1. Reading online forums
2. Posting in online forums
3. Using social media support groups
4. Attending online peer-support meetings
5. Being a member of WhatsApp groups
6. Receiving one-to-one peer support online
7. Moderating online forums
8. Facilitating online support group meetings
9. Providing one-to-one peer support online

For each support type, participants indicated whether they currently used it, had used it previously, had never used it, and/or would like to use it in the future.

Participants who reported current online peer support use received follow-up questions tailored to each form of support they reported using. These asked about duration of use (with response options of <1 week; 1-3 weeks; 1-3 months; 4-6 months; 7-11 months; 1-2 years and >2 years), frequency of engagement (with response options of daily or almost daily; once or twice a week; once or twice a month; every 2-3 months; a few times a year; and once a year or less), typical session length (<15 minutes; 15-30 minutes; 31-60 minutes; 1-2 hours; 2-3 hours; and >3 hours). They were also asked how long they intended to continue using the form of online peer support, with response options covering timeframes of 'a few weeks'; 'a few months'; and 'a year or more'; as well as the options 'just trying it out/no plan to continue'; 'I don't plan to stop'; and 'not sure yet'.

Participants who reported past (but not current) online peer support use were asked about duration of use (with the same response options as current users saw), and reasons for discontinuation (e.g., no longer needed, insufficient benefit, time-limited availability, switching to alternative support; with optional free-text for negative experiences).

All participants with any online peer support experience also reported when they typically used online peer support. This included indicating what time(s) of day they used it, with response options of morning (6am-noon); afternoon (12pm-6pm); evening (6pm-midnight); and overnight (midnight-

6am)), as well as what time of day they used it most often (choosing from the same options). They were also asked to estimate their proportion of active vs. passive engagement with the two summing to 100%, and to indicate their overall satisfaction with online peer support (on a 5-point Likert-type scale with options ranging from 'not at all satisfied' to 'very satisfied'). The active/passive engagement and satisfaction items were adapted from Tan et al., 2021).

2. Integration with Other Support Services

Participants were asked about their use of other forms of support for gambling harms, including services such as helplines, residential treatment, structured therapy, support groups, and self-exclusion tools. Response categories were drawn from GambleAware's Annual Treatment and Support Survey.

Participants who had used both online peer support and at least one other form of help were asked an additional follow-up question about sequencing. They indicated whether the other support was accessed before, after, or during their period of online peer support use. This enabled exploration of how online support fits within broader help-seeking pathways.

3. Motivations for Using Online Peer Support

Participants with any experience of online peer support completed an adapted version of the Health Online Support Questionnaire (HOSQ; Mattsson et al., 2015). The measure consists of 18 items capturing two types of motivations:

- Reading-based objectives (e.g., searching for information, learning from others' experiences), and
- Interacting-based objectives (e.g., sharing practical advice, receiving encouragement or compassion).

All items were reworded so that references to "health" and "patients" were replaced with terminology relating to gambling harms and online peer support. Participants rated each item on a 5-point Likert-type scale ranging from "strongly disagree" to "strongly agree". Following the structure of the original scale, subscale scores and a total motivation score were calculated by summing the relevant items. The adapted scale had good internal consistency (Cronbach's alphas were .93 for the full scale; .88 for the reading subscale; and .91 for the interacting subscale's (all n's = 474)).

Participants who had never used online peer support completed a parallel 18-item version adapted specifically for this study. Wording was modified to assess hypothetical motivations for future online peer support use (e.g., "I would use online peer support to…"). This allowed examination of potential facilitators and barriers to uptake among online peer support non-users. Scores were calculated using the same approach as for the user version. Internal consistency of the adapted scale was again, good: Cronbach's alphas were .95 (full scale); .93 (reading subscale); and .93 (interacting subscale) (n's = 43-44).

4. Perceived benefits, challenges, and social support

(a) Benefits and challenges of online peer support

Participants with any online peer support experience completed an 8-item measure adapted from the Online Peer Support Group Experiences Questionnaire (Tan et al., 2021). Four items reflected positive experiences - such as feeling validated, gaining a sense of belonging, feeling hopeful about recovery, and receiving helpful advice - while four captured negative experiences such as harassment, being blocked or banned, worsening gambling harms, or experiencing difficult emotions (e.g., distress, guilt, or frustration).

Participants responded on a 5-point scale from "never" to "very often". Positive and negative experience scores were calculated by summing the relevant items, with higher scores indicating more frequent experiences.

Both subscales had good internal consistency; Cronbach's alphas were .84 and .90 for the positive and negative experiences subscales, respectively (n's = 474-475).

(b) Online social support

An adapted 8-item version of the Online Social Support Scale (Nick et al., 2018) assessed four domains of support within online peer support environments:

- Emotional support,
- Affiliative or belonging-based support,
- Informational support, and
- Practical or instrumental support.

Items were revised to ensure relevance to gambling harms (e.g., references to health conditions replaced with gambling-related terminology). Participants rated each item on a 5-point agreement scale. Subscale and total support scores were computed using summed item scores. The scale had good internal consistency, with Cronbach's alphas of .95 for the full 8-item scale; .84 for the emotional support subscale; .85 for the affiliative/belonging subscale; .80 for the informational support subscale; and .89 for the practical/instrumental support subscale (n's = 476).

5. Technology acceptance and digital health literacy

(a) Technology acceptance

To assess attitudes toward online peer support as a digital tool, all participants completed a brief 4-item scale developed for this study. Items captured:

- Perceived usefulness of online peer support,
- Perceived ease of access and use,
- Social influence (e.g., whether important others would encourage online peer support use), and
- Facilitating conditions (e.g., whether participants felt they had the necessary knowledge and resources).

Each item was rated on a 5-point Likert-type scale. A total technology acceptance score was calculated by summing the items. Internal consistency was acceptable with a Cronbach's alpha of .78.

(b) Digital health literacy

Digital literacy was measured using 16 items adapted from the eHealth Literacy and Use Scale (eHLUS; Stephan et al., 2025). Items assessed three domains from the original scale: information literacy, engagement, and autonomous use. An additional domain captured interactional digital health literacy, using two adapted items from the Our Digital Health project and the eHEALS (Norman & Skinner, 2006).

Participants responded on a 5-point agreement scale. Subscale scores and a total literacy score were computed by summing the relevant items. Internal consistency was moderate to good, with Cronbach's alpha of .87 (n=518) for the full scale; .89 for the information literacy subscale; .83 for the engagement subscale; .69 for the autonomous use subscale; and .89 for the interactional subscale (all n's = 519-520).

6. Gambling Harm Severity

Two validated measures of gambling harm were administered to all participants:

- The Problem Gambling Severity Index (PGSI; Ferris & Wynne, 2001). Following Li et al. (2017), the timeframe was adapted so that participants were asked to respond with reference to the period when gambling had caused them the most harm. Participants rated each item on a 4-point scale from "never" to "almost always". Scores across the nine items were summed to yield a total PGSI score (possible range: 9–36). Internal consistency was very good (Cronbach's alpha = .91, n=518)
- The seven-item Short Gambling Harms Scale (SGHS; Close et al., 2025). This measure captures harms experienced over the past three months, with items rated on a 4-point frequency scale ("never" to "very often"). Responses were summed to produce a total SGHS score (range: 7–28). Internal consistency was very good (Cronbach's alpha = .94, n=517)

Using both measures allowed us to examine both historical peak harm severity and more recent or ongoing harms, while minimising repetition for participants.

7. Attention Checks

To ensure data quality - particularly important given the use of financial incentives - the survey included several embedded attention checks based on recommended formats (Oppenheimer et al., 2009; Meade & Craig, 2012). For example, they were asked 'which of the following is a type of fruit…' and required to choose the correct item from the options of 'apple'; 'table'; 'cat'; and 'pen'. These required participants to select a specific response option or demonstrate careful reading of the item. Participants were informed in the information sheet that attention checks were included.

To avoid excluding any genuine participants from compensation but also protect data quality, we applied stricter criteria for analytic inclusion than for payment. A small number of respondents (fewer than five) therefore received compensation but were excluded from analysis due to borderline validity concerns (e.g., failing one of multiple attention checks).

8. Conditionality and Flow

Routing logic was used to minimise participant burden and ensure relevance:

- Only participants who had used online peer support received questions about online peer support experiences, benefits and harms, social support, and the online peer support user version of the HOSQ.
- Only participants who had never used online peer support received the hypothetical HOSQ.
- Follow-up questions about reasons for stopping online peer support, patterns of use, and interactions with other support forms were presented only when triggered by previous responses.
- All participants received the gambling harm measures, technology acceptance scale, digital health literacy items, demographic questions, and attention checks.

A full copy of the survey wording, item list, with annotations on routing logic, is provided in Appendix 2.

Appendix 2: Full survey wording

Note: text in bold italics is explanatory text for the reader of this report, and was not presented to participants.

Types of online peer support (and other support) engaged with, patterns of usage, and overall satisfaction

What experience do you have of the following kinds of online peer support…

	I do this at the moment	I have done this in the past	I have never done this	I would like to do this in the future
Reading online forums	☐	☐	☐	☐
Posting on online forums	☐	☐	☐	☐
Being in a social media support group (e.g. a Facebook group)	☐	☐	☐	☐
Joining online peer support meetings	☐	☐	☐	☐
Being in a Whatsapp support group of people in recovery	☐	☐	☐	☐
Having one-to-one support online from a peer supporter or recovery coach	☐	☐	☐	☐
Moderating online forums	☐	☐	☐	☐
Facilitating or leading online peer support groups	☐	☐	☐	☐
Providing one-to-one support to others as a peer supporter, sponsor, or recovery coach online	☐	☐	☐	☐

For any options where current (or current + previous) engagement is ticked, the following questions were presented (with the type of support populating the bracketed section):

How long have you been […]?

- ☐ Less than 1 week
- ☐ 1-3 weeks
- ☐ 1-3 months
- ☐ 4-6 months
- ☐ 7-11 months
- ☐ 1-2 years
- ☐ More than 2 years

How often do you spend time […]

- ☐ Daily or almost daily
- ☐ Once or twice a week
- ☐ Once or twice a month
- ☐ Every 2-3 months
- ☐ A few times a year
- ☐ Once a year or less

How much time did you typically spend […], on a day when you did this?

- ☐ Less than 15 minutes
- ☐ 15–30 minutes
- ☐ 31–60 minutes
- ☐ 1–2 hours
- ☐ 2–3 hours
- ☐ More than 3 hours

How long do you plan to use [type of support]

- ☐ Just trying it out / no plan to continue
- ☐ For a few weeks
- ☐ For a few months
- ☐ For a year or more
- ☐ I don't plan to stop
- ☐ Not sure yet

For any options where only previous engagement is ticked, the following questions were presented:

How long did you use […] for?

- ☐ Less than 1 week
- ☐ 1-3 weeks
- ☐ 1-3 months
- ☐ 4-6 months
- ☐ 7-11 months
- ☐ 1-2 years
- ☐ More than 2 years

Why did you stop using [type of support] – please select all that apply.

☐ I did not need it anymore
☐ I was not getting any benefit from it
☐ It was only available for a set period of time
☐ I started using an alternative kind of support
☐ I had a negative experience with it
[please tell us a bit more about what happened_____]

General follow up questions – presented if participant reported currently using any type of online peer support)

At what times of day do you usually access online peer support?
☐ Morning (6am-noon); ☐ afternoon (12pm-6pm); ☐ evening (6pm-midnight); ☐ overnight (midnight-6am).

Which time of day do you use online peer support most often? (same categories as above).
☐ Morning (6am-noon); ☐ afternoon (12pm-6pm); ☐ evening (6pm-midnight); ☐ overnight (midnight-6am).

Of the total time you spent on online peer support in the past week, approximately what percentage of your time:

- Involved direct interaction, such as posting, commenting, sending messages or joining group meetings: ____ %
- Involved indirect interaction, e.g. browsing, reading posts, or liking content without posting: ____ %

(Percentages should add up to 100%.)

How satisfied are you overall with your experience of online peer support?
Not at all satisfied / Partly satisfied/ Satisfied / More than satisfied/ Very satisfied

All participants receive this question about desirable forms of online peer support:

Is there any kind of online peer support you aren't aware of but would like to see made available?
_____

Questions about other support – presented to all participants

What other kinds of support have you accessed for gambling harms?

N/A ☐ None
A ☐ Support or treatment helpline
B ☐ Support from friends and family
C ☐ Self-help tools (e.g. self-exclusion schemes, online resources)
D ☐ Face-to-face peer support (e.g. in-person group meetings)
E ☐ Residential treatment
F ☐ Professional online support from gambling harms specialist (e.g. online counselling or therapy)
G ☐ Professional face-to-face support from gambling harms specialist (e.g. face-to-face counselling or therapy)
H ☐ Support from other professionals (e.g. GP or general therapist)

For any items that are ticked, if someone had also mentioned having used online peer support, they were asked:

Where did X fit with your use of online peer support? ☐ I used online peer support first, then […]
☐ I used […] first, then online peer support
☐ I used both at the same time

Reasons for and ways of using online peer support

Health Online Support Questionnaire (HOSQ) (Mattson et al., 2015) – adapted for our study. The exact version below was presented to anyone who currently uses/has used online peer support, prefaced with 'I use online peer support for gambling harms…' An adapted version was presented to anyone with no current/prior use, prefaced with the alternative wording of 'I would consider using online peer support for gambling harms…'

I use online peer support for gambling harms…	Strongly disagree	Disagree	Slightly disagree	Slightly agree	Agree	Strongly agree
1. To search for information that can help me recover from gambling harms	☐	☐	☐	☐	☐	☐
2. To share information about support or treatment that I've been through	☐	☐	☐	☐	☐	☐
3. To read about other people's experience of gambling harms treatment or support	☐	☐	☐	☐	☐	☐
4. To be able to make more well-informed decisions regarding my gambling	☐	☐	☐	☐	☐	☐
5. To seek support from others when I am experiencing an urge to gamble	☐	☐	☐	☐	☐	☐
6. To share practical advice and suggestions regarding gambling harms	☐	☐	☐	☐	☐	☐
7. To search for information that enables me to better understand treatment providers	☐	☐	☐	☐	☐	☐
8. To search for encouragement from others when I'm having difficulties with gambling harms/recovery	☐	☐	☐	☐	☐	☐
9. To express my opinion regarding treatment or support for gambling harms	☐	☐	☐	☐	☐	☐
10. To read about other people's experience of gambling harms.	☐	☐	☐	☐	☐	☐
11. To search for compassion when I'm not doing well	☐	☐	☐	☐	☐	☐
12. To get feedback from others with lived experience of gambling harms	☐	☐	☐	☐	☐	☐

13. To search for /recommendations about treatment or support providers who are experienced in gambling harms	☐	☐	☐	☐	☐	☐
14. To search for information when I feel worried	☐	☐	☐	☐	☐	☐
15. To keep others informed about how I am doing	☐	☐	☐	☐	☐	☐
16. To get feedback from others on how I'm handling gambling harms	☐	☐	☐	☐	☐	☐
17. To search for the latest research regarding gambling harms	☐	☐	☐	☐	☐	☐
18. To find information about whether problems that I've experienced from gambling are cause for concern	☐	☐	☐	☐	☐	☐

Benefits and harms: Participants who had used some form of online peer support (currently and/or previously) received the bespoke 8 items below, loosely based on domains mentioned (and response options used) in the Online Peer Support Group Experiences Questionnaire (Tan et al., 2021)

The next set of questions ask about both positive and negative experiences that people may have had when using online peer support. Please tick the box to show how often you have experienced the following:

	Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very frequently**
I have experienced bullying or harassment in an online peer support context	☐	☐	☐	☐	☐	☐
I have been removed, blocked, or banned from an online peer support space	☐	☐	☐	☐	☐	☐
Using online peer support has worsened my gambling harms	☐	☐	☐	☐	☐	☐
I have felt anxious, distressed, angry, guilty or frustrated as a result of online peer support	☐	☐	☐	☐	☐	☐
I have felt validated by online peer support	☐	☐	☐	☐	☐	☐
I have felt a sense of acceptance or belonging through online peer support	☐	☐	☐	☐	☐	☐
I have felt relief or hope for recovery through online peer support	☐	☐	☐	☐	☐	☐
I have received helpful advice about tools, resources or information through online peer support	☐	☐	☐	☐	☐	☐

All participants received the adapted version of a measure of digital health literacy (e-HLUS; Stephan et al., 2025) below:

Now we are going to ask you how you feel about 'digital health tools'. By this, we mean any kind of online tool you might use to access help, support, or advice. This might include forums, apps (e.g. whatsapp), websites, or video calling software. Please rate how much you agree or disagree with the statements below

.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Digital health tools can generally help improve my health.	☐	☐	☐	☐	☐
I find it appealing that I can use digital health tools independently.	☐	☐	☐	☐	☐
I am motivated to use digital health tools in everyday life.	☐	☐	☐	☐	☐
Using digital health tools is easy to integrate into my daily life.	☐	☐	☐	☐	☐
I always have access to the necessary hardware (e.g., smartphone, PC) to use digital health tools.	☐	☐	☐	☐	☐
I always have access to stable and reliable internet.	☐	☐	☐	☐	☐
I know how to use the internet to get answers to my health-related questions.	☐	☐	☐	☐	☐
I know where to find useful health information on the internet (e.g., NHS).	☐	☐	☐	☐	☐
I am able to critically evaluate information related to my health.	☐	☐	☐	☐	☐
I can distinguish reliable from questionable information and sources regarding my health on the internet.	☐	☐	☐	☐	☐
I feel confident using digital devices (smartphone, PC, etc.).	☐	☐	☐	☐	☐
I am able to use digital health tools without help from others.	☐	☐	☐	☐	☐
If I need help using apps or digital technology, I can always get support from my social environment.	☐	☐	☐	☐	☐
I think my data is sufficiently protected when using digital health applications.	☐	☐	☐	☐	☐
I can show other people health information I have found online. For example, a friend, family member or a professional	☐	☐	☐	☐	☐
I can discuss the health information I have found online with other people. For example, a friend, family member, or a professional.	☐	☐	☐	☐	☐

This bespoke 4-item scale measuring technology acceptance was presented to all participants:

The next questions ask you how you feel about the idea of using online peer support – remember this can include any kind of online support from people with lived experience.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I believe using online peer support would help me cope with or manage gambling-related problems.	☐	☐	☐	☐	☐
I think it would be easy to access and participate in online peer support	☐	☐	☐	☐	☐
People whose opinions I value would encourage me to use online peer support.	☐	☐	☐	☐	☐
I have the resources and knowledge I would need to make effective use of online peer support.	☐	☐	☐	☐	☐

The following bespoke 3 item measure of social relationships within online peer support was presented to those who use/have used at least one form of online peer support.

This section of the questionnaire is to assess your relationships with people whom you met through online peer support for gambling related harms. Please think about the **online** relationships that you have developed through these online peer support groups and answer the questions below. If you think you have not built any online relationships, please select "no relationship".

	No relationship	Not at all	A little	Moderately	Very much
How positive a role do people you have met though online peer support groups play in your life?	☐	☐	☐	☐	☐
How significant are these online relationships to your life?	☐	☐	☐	☐	☐
How responsible do you feel for the well-being of people you have met though online peer support groups?	☐	☐	☐	☐	☐

The following 8 item measure, an adapted version of the Online Social Support Scale (Nick et al., 2018) was presented to those who had used online peer support.

These next questions ask you about the social relationships you may have experienced within online peer support settings. Please rate how often each of these things apply to you **when using online peer support**…

When using online peer support…	Never	Sometimes	Rarely	Pretty often	A lot
People encourage me	☐	☐	☐	☐	☐
People make me feel good about myself	☐	☐	☐	☐	☐
I connect with people who have had similar experiences to me	☐	☐	☐	☐	☐
People make me feel like I belong	☐	☐	☐	☐	☐
People give me helpful advice	☐	☐	☐	☐	☐
People help me, by saying what they would do.	☐	☐	☐	☐	☐
People have offered me the practical help I need	☐	☐	☐	☐	☐
I have been able to get assistance from others	☐	☐	☐	☐	☐

Gambling harms severity

The following 9 items are the PGSI (Ferris & Wynne, 2001), using a retrospective "worst period" timeframe following recommendations by Li et al. (2017) was presented to all participants

In this section we will ask about difficulties you may have experienced, related to gambling. We'd like you to reflect on the time when gambling was causing you the most problems. At that time…

1. Did you bet more than you could really afford to lose?
2. Did you need to gamble with larger amounts of money to get the same excitement?
3. When you gambled, did you go back another day to try and win back the money you lost?
4. Did you borrow money or sell anything to get money to gamble?
5. Did you feel that you might have a problem with gambling?
6. Did gambling cause you any mental health problems, including stress or anxiety?
7. Did people criticise your betting or tell you that you had a gambling problem, regardless of whether or not you thought it was true?
8. Did your gambling cause any financial problems for you or your household?
9. Did you feel guilty about the way you gambled or what happened when you gambled?

[Response options: Never / Sometimes / Most of the time / Almost always]

The 7-item Gambling Harms Severity Index (GHSI-7 Close et al., 2025, The Gambling Harms Scale Initiative: Accessing the GHSI Tools) with past 3 months as the reference period was presented to all participants.

Many people face challenges with gambling, and support is available.
Over the last 3 months, in relation to gambling, how often have you noticed changes in your...
[response options = Not at all / occasionally (e.g. once or twice a month) / sometimes (e.g. once or twice a week) / Frequently (e.g. most days).

… Mood and feelings. Such as feeling down, stressed, shameful or anxious.
… Physical wellbeing. Such as eating poorly, losing sleep or being less physically active.
... Day to day finances. Such as issues with paying bills, borrowing money or using up savings
… Hobbies, work and study. Such as losing focus, getting things wrong or missing work.
… Family and loved ones. Such as tensions or being less involved with loved ones.
… Social life and community connection. Such as feeling judged, stigmatised, lonely or cut off.
… Secrecy. Such as hiding losses from loved ones or borrowing money without asking.

Demographics – all participants received these questions

Now we would like to ask you some questions about your demographics and other personal characteristics. This is to help us understand more about whether people with different characteristics and circumstances have different experiences of gambling harms support.

1. What is your age? _____

2. What is your gender?
    - Male
    - Female
    - Non-binary
    - Prefer to self-describe: _____
    - Prefer not to say

3. What is your ethnic group?
    - White
        - English, Welsh, Scottish, Northern Irish or British
        - Irish
        - Gypsy or Irish Traveller
        - Roma
        - Any other White background [write-in]
    - Mixed or multiple ethnic groups
        - White and Black Caribbean
        - White and Black African
        - White and Asian
        - Any other Mixed or multiple ethnic background [write-in]
    - Asian or Asian British
        - Indian
        - Pakistani
        - Bangladeshi
        - Chinese
        - Any other Asian background [write-in]

- Black, Black British, Caribbean or African
  - Caribbean
  - African
  - Any other Black, Black British or Caribbean background [write-in]
- Other ethnic group
  - Arab
  - Any other ethnic group [write-in]
- Prefer not to say

4. Which of the following best describes your sexual orientation?
   - Heterosexual or straight
   - Gay or lesbian
   - Bisexual
   - Other sexual orientation [write-in]
   - Prefer not to say

5. What is your current relationship status?
   - Single (never married or never registered a civil partnership)
   - Married or in a civil partnership
   - Divorced or formerly in a civil partnership which is now legally dissolved
   - Widowed or surviving civil partner
   - Living with partner
   - Other [write-in]
   - Prefer not to say

6. Do you care for any children under 16 - either as a parent, guardian, or unpaid carer?

- *Yes*
- *No*
- *Prefer not to say*

7. If yes, how many children under 16 do you care for? _____

8. Do you have any other caring responsibilities?
   - Yes, I provide regular unpaid care to a family member, friend, or neighbour
   - No
   - Prefer not to say

9. Have you been a resident in the UK for less than 12 months?
   - Yes
   - No
   - Prefer not to say

10. What is the highest level of qualification you have completed?
    - No formal qualifications
    - GCSEs or equivalent
    - A-Levels or equivalent
    - Higher education (e.g., HND, degree)
    - Postgraduate qualifications (e.g., Master's, PhD)
    - Prefer not to say

11. What is your current employment status?
    - Employed full-time
    - Employed part-time
    - Self-employed
    - Unemployed and seeking work
    - Unemployed and not seeking work
    - Retired
    - Student
    - Looking after home or family
    - Long-term sick or disabled
    - Other _____

12. What is your total household income before tax and deductions?
    - Less than £10,000
    - £10,000–£19,999
    - £20,000–£29,999
    - £30,000–£39,999
    - £40,000–£49,999
    - £50,000–£59,999
    - £60,000–£69,999
    - £70,000 or more
    - Prefer not to say

13. How would you describe the area where you live?"
    ☐ Major urban area (city)
    ☐ Minor urban area (town or small city)
    ☐ Village
    ☐ Hamlet or isolated rural area

14. What type of accommodation do you live in?
    - Owner-occupied
    - Private rented
    - Social rented
    - Living rent-free
    - Other [write-in]
    - Prefer not to say

15. Do you have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more?
    - Yes
    - No
    - Prefer not to say

16. Please tick any of the following conditions, diagnoses or health conditions that apply to you (tick as many as apply):
    - Cognitive/Developmental (e.g. learning difficulties, an intellectual disability, or a traumatic brain injury).
    - Neurodivergence (e.g. autism, ADHD or ADD, or another neurodivergent condition)
    - Communication difficulties (e.g. difficulty reading or spelling; speech or language problems; dyslexia).
    - Sensory conditions or disabilities (e.g. hearing, visual, or other sensory conditions).

- Physical disability (e.g. mobility, spinal cord injury, cerebral palsy, or any other physical disability)
- Psychological/Emotional condition (e.g. depression, anxiety, OCD, severe mental illness).
- Health and nervous system conditions (e.g. chronic health condition, dementia or Alzheimer's disease, motor neuron disease, Parkinson's disease, stroke, aphasia, multiple sclerosis).

If one or more of the above conditions are checked, the following 2 questions were presented:

- How often do the conditions you have selected above interfere with your use of technology and online activities (like using social media, online gaming etc.)?
- How often do the conditions you have selected above interfered with your use of online peer support?

Never/Occasionally/Sometimes/Often/Always

Attention / authenticity checks- these were inserted at roughly equal intervals throughout the survey, for all participants.

"To show you are paying attention, please select 'Agree' for this question."
(Response options: Strongly Disagree → Strongly Agree)

"Which of the following options is a type of fruit?"
(Response options: Apple / table / cat / pen)

"To show you are paying attention, please select 'neither agree nor disagree' for this question."
(Response options: Strongly Disagree → Strongly Agree)

"What is two plus two? Please enter the answer as a number in the box" _____

"Were you able to answer the questions in this survey honestly and attentively?"
(Response options: Yes / No)

Appendix 3: Additional detail on quantitative survey data

Table 6: Summary of usage of different forms of online peer support[118]

	N (%) of participants using each form of support…				
	Current	Past	Never	Future	Ever[119]
Reading forums	243 (46.7%)	240 (46.2%)	76 (14.6%)	29 (5.6%)	442 (85%)
Posting on forums	118 (22.7%)	220 (42.3%)	193 (37.1%)	32 (6.2%)	320 (61.5%)
Using social media support group(s)	143 (27.5%)	149 (28.7%)	221 (42.5%)	45 (8.7%)	277 (53.3%)
Attending online peer support group meetings	71 (13.7%)	110 (21.2%)	322 (61.9%)	51 (9.8%)	172 (33.1%)
Using a recovery WhatsApp group	70 (13.5%)	58 (11.2%)	373 (71.7%)	51 (9.8%)	121 (23.3%)
Receiving 1:1 peer support online	34 (6.5%)	97 (18.7%)	359 (69.0%)	55 (10.6%)	127 (24.4%)
Moderating online forums	19 (3.7%)	49 (9.4%)	428 (82.3%)	39 (7.5%)	66 (12.7%)
Leading/facilitating online peer support groups	24 (4.6%)	40 (7.7%)	423 (81.3%)	45 (8.7%)	63 (12.1%)
Providing 1:1 peer support online	35 (6.7%)	43 (8.3%)	399 (76.7%)	59 (11.3%)	76 (14.6%)

[118] Total scores across categories do not sum to exactly 100%, due to categories not being mutually exclusive

[119] This category was calculated post-hoc to create a simple measure of actual usage to date, with mutually exclusive categories; any participant who had used the form of support, either in the past or currently, and regardless of whether or not they had future intentions, was classified as 'ever' having used them. Any participant who had never used, even if they had future intentions, was classified as 'never' having used.

Table 7: Differences in gambling harm by engagement with online peer support

Online peer support modality	Outcome	H (df=3)	p-value	Significant	Effect size (ε^2)
Reading forums	SGHS (recent harm)	11.34	.010	Yes	.02
Posting on forums	SGHS	10.31	.016	Yes	.01
Social media groups	SGHS	19.17	<.001	Yes	.03
Online OPS meetings	SGHS	7.68	.053	No	.01
WhatsApp-type groups	SGHS	88.13	<.001	Yes	.17
Receiving 1:1 peer support	SGHS	71.40	<.001	Yes	.13
Moderating forums	SGHS	—	—	—	—
Leading peer support groups	SGHS	—	—	—	—
Providing 1:1 peer support	SGHS	—	—	—	—
Reading forums	PGSI (worst-ever)	3.45	.327	No	.00
Posting on forums	PGSI	1.35	.717	No	.00
Social media groups	PGSI	5.76	.124	No	.01
Online OPS meetings	PGSI	57.52	<.001	Yes	.11
WhatsApp-type groups	PGSI	88.13	<.001	Yes	.17
Receiving 1:1 peer support	PGSI	71.40	<.001	Yes	.13
Moderating forums	PGSI	7.82	.050	Marginal	.01
Leading peer support groups	PGSI	36.10	<.001	Yes	.06
Providing 1:1 peer support	PGSI	52.18	<.001	Yes	.10

Note: Table summarises the results of Kruskal-Wallis tests comparing SGHS and PGSI across online peer support engagement categories: Never, Past, Current, Future. Nonparametric tests used due to non-normal distributions and unequal group sizes. Post hoc tests were not conducted as analyses were descriptive and exploratory. Empty cells appear for three variables where Kruskal–Wallis tests were not conducted due to cell sizes within engagement categories being too small to permit reliable estimation.

Table 8: Duration of use of online peer support, by online peer support modality

Online peer support type	Short-term (≤ 3 months)	Medium-term (4–11 months)	Long-term (≥ 1 year)	N (users)
Reading forums	10%	10%	80%	441
Posting on forums	14%	12%	74%	318
Using social media groups	18%	20%	62%	275
Joining OPS online group meetings	32%	29%	39%	172
Using WhatsApp groups	17%	20%	63%	121
Receiving 1:1 online peer support	33%	25%	42%	127
Moderating forums	15%	16%	69%	66
Leading/facilitating OPS groups	13%	14%	73%	63
Providing 1:1 online peer support	16%	14%	70%	76

Percentages are calculated within users of each OPS modality and may not sum to 100 due to rounding. Duration categories were collapsed into short-term (≤3 months), medium-term (4–11 months), and long-term (≥1 year) to aid interpretability.

Table 9: Frequency of use of online peer support, by online peer support modality

Online peer support type	Frequent (weekly or more)	Occasional (monthly / every 2–3 months)	Infrequent (few times a year or less)	N (users)
Reading forums	88%	9%	3%	441
Posting on forums	56%	28%	16%	318
Using social media groups	60%	25%	15%	275
Joining OPS online group meetings	42%	38%	20%	172
Using WhatsApp groups	74%	18%	8%	121
Receiving 1:1 online peer support	35%	40%	25%	127
Moderating forums	72%	18%	10%	66
Leading/facilitating OPS groups	68%	22%	10%	63
Providing 1:1 online peer support	66%	24%	10%	76

Percentages are calculated within users of each OPS modality and may not sum to 100 due to rounding. Frequency categories were collapsed into frequent (weekly or more), occasional (monthly or every 2–3 months), and infrequent (a few times a year or less) to aid interpretability.

Table 10: Typical time spent per session using online peer support, by online peer support modality

Online peer support type	Short (<30 minutes)	Medium (31–60 minutes)	Long (>1 hour)	N (users)
Reading forums	57%	25%	18%	441
Posting on forums	60%	22%	18%	318
Using social media groups	55%	27%	18%	275
Joining OPS online group meetings	18%	42%	40%	172
Using WhatsApp groups	58%	24%	18%	121
Receiving 1:1 online peer support	21%	36%	31%	127
Moderating forums	16%	23%	61%	66
Leading/facilitating OPS groups	14%	21%	65%	63
Providing 1:1 online peer support	18%	23%	59%	76

Percentages are calculated within users of each OPS modality and may not sum to 100 due to rounding. Time spent categories were collapsed into short (<30 minutes), medium (31–60 minutes), and long (>1 hour) to aid interpretability.

Table 11: Planned future use of online peer support, by modality (current users only)

Online peer support type	Short / uncertain	Medium-term (months)	Long-term (≥1 year / no plan to stop)	N (current users)
Reading forums	11%	10%	79%	347
Posting on forums	15%	15%	70%	235
Using social media groups	14%	20%	66%	192
Joining OPS online group meetings	16%	21%	63%	120
Using WhatsApp groups	12%	17%	71%	93
Receiving 1:1 online peer support	28%	22%	50%	86
Moderating forums	12%	13%	75%	52
Leading/facilitating OPS groups	11%	11%	78%	47
Providing 1:1 online peer support	13%	13%	74%	54

Percentages are calculated within current users of each OPS modality and may not sum to 100 due to rounding. Planned future use categories were collapsed into short/uncertain, medium-term (a few months), and long-term (≥1 year or no plan to stop) to aid interpretability.

Table 12: Results of nonparametric tests comparing overall satisfaction scores across key demographic categories

Demographic variable	Groups compared	Test	N	Test statistic	p-value	Effect size
Age (continuous)	—	Spearman's ρ	456	ρ = .04	.369	ρ = .04
Household income	Low / Medium / High	Kruskal–Wallis	438	H(2) = 6.72	.035	ε^2 = .01
Education level	Low / Medium / High	Kruskal–Wallis	440	H(2) = 0.54	.765	ε^2 = .00
Relationship status	In relationship / Not	Mann–Whitney U	456	U = 23465.0	.162	r= .07
Caring for children <16	Yes / No	Mann–Whitney U	466	U = 23059.5	.005	r= .13
Other caring responsibilities	Yes / No	Mann–Whitney U	467	U = 15594.5	.855	r= .01
Ethnicity	White / Minority ethnic	Mann–Whitney U	473	U = 14782.5	.659	r= .02
Health condition	Yes / No	Mann–Whitney U	464	U = 24071	.982	r= .00

Notes. Overall satisfaction was measured on a five-point ordinal scale. Nonparametric tests were used throughout. Kruskal–Wallis tests were applied for variables with three categories; Mann–Whitney U tests for binary variables; and Spearman's rank correlations for continuous variables. Analyses were exploratory and p-values are reported unadjusted for multiple comparisons.

Appendix 4: Detailed methods for forum analysis

Forum Selection

Three publicly accessible online forums were selected for analysis. Two were associated with established UK national gambling support providers, and one was a large international general-interest discussion platform hosting anonymous, topic-specific sub-communities. Only posts from the gambling harms support sub-community were included. All content analysed was publicly viewable without registration.

Search Strategy

Systematic searches were conducted within each forum using a set of keywords and phrases indicating suicidality (e.g., *suicid**, *"can't go on"*, *"want to die"*, *kill*, *kms*, *unalive*). Terms commonly adopted online to bypass content filters were included. Searches were restricted to posts from the preceding 12 months. No gambling-related terms were required, as all posts originated from forums explicitly focused on gambling harm. Each keyword/string was searched separately using the forum's internal search tools. All retrieved posts ("hits") were screened for relevance by at least one researcher.

Screening Process

Posts were initially categorised as *yes*, *no*, or *maybe* for inclusion:

- **No:** Posts where keywords were used in a non-suicidal context, or where neither the keyword nor surrounding text suggested suicidality. Obvious automated or commercial posts were also excluded.
- **Maybe:** Posts referring to another person's suicidality; historical suicidality no longer causing distress; or ambiguous phrasing that might imply but did not clearly indicate current suicidal thoughts.
- **Yes:** Posts containing explicit or clearly implied references to current suicidality, including brief statements or titles alone.

A low threshold for *maybe* classifications ensured that potential inclusions were not prematurely excluded. All *maybe* posts were reviewed by a second coder. Disagreements were resolved through majority decision among three coders. Posts categorised as *yes* formed the final corpus (n = 73); *maybe* posts (n=79) were not included due to sufficient sample size.

Codebook Development

A structured codebook was developed to capture both observable and interpretative features of each post.

Objective codes included:

- Word count
- Number of responses and unique responders
- Dates of posts and replies
- Time to first response (from users and moderators)
- Number and nature of moderator/administrator responses (generic vs. personalised)

Subjective codes (binary yes/no) captured presence or absence of:

- Explicit/implicit references to suicidal thoughts or plans (current, recent, distant past)
- Mentions of past attempts
- Explicit denial of suicidal intent
- Use of trigger warnings or help-seeking tags
- Whether the poster sought help (explicitly or implicitly)

- Whether help was offered to others
  A free-text field captured the type of help sought.

Operational definitions were included in the codebook and embedded as cell comments to support coder consistency.

Inter-Rater Reliability Procedures

Objective measures were coded by one researcher. Subjective codes were distributed across three coders. To assess inter-rater reliability and refine the codebook:

- 27 posts were double-coded in two batches.
- Percent agreement was used, as highly skewed distributions made Cohen's Kappa inappropriate.

Wave 1 reliability metrics:

- Initial agreement = 87.4%.
- Discrepancies led to clearer definitions of "current" vs. "recent" suicidality[120], and simplification of help-seeking codes.
- After revisions, agreement reached 100% on the first batch.

Wave 2 reliability metrics:

- Agreement = 99.9%, with remaining discrepancies resolved through discussion.

Following reliability checks, the remaining 46 posts were single-coded, with coders instructed to raise uncertainties for team consensus.

[120] Posts were coded as 'current' when suicidality was described as occurring at the time of making the post. i.e. referenced in the present tense - e.g. 'I am feeling suicidal', 'I want to kill myself', 'I can't stop thinking about ending things. 'Recent' referenced thoughts/feelings of suicide that were within a short period of time ago, e.g. days/weeks of making the post, but that were described in the past tense (e.g. 'last week I was thinking of ending it all'.

Appendix 5: Mapping of recommendations

Recommendation	Primary evidence strands	Rationale / evidential basis
Maintain and strengthen online peer support as a core component of the gambling harm support landscape.	Survey; qualitative interviews; lived experience panels	Online peer support was widely used and valued, most often alongside other forms of help, and in some cases as the primary or only support accessed.
Where expansion of online peer support is considered, ensure this is accompanied by appropriate support and safeguards.	Qualitative interviews; forum analysis	Evidence indicates widespread use and limits in crisis management and safeguarding capacity, highlighting risks of un-resourced expansion.
Recognise passive, intermittent, and low-visibility engagement as legitimate forms of use.	Survey; qualitative interviews	This kind of engagement (e.g. reading without posting) was commonly reported and experienced as meaningful support.
Avoid reliance on volume-based participation metrics as proxies for impact.	Survey; qualitative interviews	Engagement was non-linear and fluid, meaning posting frequency/attendance doesn't capture full reach or benefit.
Do not position online peer support as a substitute for formal crisis services.	Qualitative interviews; lived experience panels; forum analysis	Participants and providers emphasised that peer-led spaces lack the infrastructure and authority required for sustained crisis intervention.
Review safeguarding approaches to ensure they do not rely solely on explicit crisis language or direct requests for help.	Forum analysis (core); qualitative interviews	Expressions of acute distress were often indirect or narrative-based, even in definitively suicidal posts, risking missed need if explicit language is prioritised.
Ensure escalation pathways to external crisis support are visible and accessible.	Qualitative interviews; forum analysis	Given inevitable crisis use, clear escalation pathways support safer responses without unrealistic expectations on peer supporters.
Ensure peer supporters in formal or semi-formal roles have access to training, guidance, and supervision.	Qualitative interviews (lived experience and service providers)	Service providers stressed that lived experience alone does not substitute for training, particularly around safeguarding and boundaries.
Clarify role boundaries for peer supporters.	Qualitative interviews; lived experience panels	Boundary ambiguity was associated with emotional burden, safeguarding uncertainty, and sustainability concerns.
Support provision of multiple online peer support formats to allow tailored engagement.	Survey; qualitative interviews	Different formats were valued at different stages of recovery, with no single model meeting all needs.
Promote user autonomy in how and when online peer support is used.	Survey; qualitative interviews	Fluctuating, self-directed engagement was common and often purposeful rather than indicative of disengagement.
Provide clear guidance and proportionate technical support to reduce barriers to participation.	Survey; qualitative interviews	Digital literacy and access issues were reported as barriers for some users, potentially shaping who benefits from online peer support.
Be explicit in commissioning about the intended role, remit, and limits of online peer support.	All strands (synthesis)	Lack of clarity risks both under-supporting peer provision and over-expecting it to compensate for gaps elsewhere in the system.
Support closer alignment between online peer support and other gambling harm services, while respecting peer-led distinctiveness.	Qualitative interviews; lived experience panels	Alignment across services was often informal or uneven, with clearer links seen as supporting safer navigation without professionalising peer support.

This table is intended to demonstrate the traceability of recommendations to the empirical evidence and implications presented in the report. Many recommendations draw on multiple strands of evidence, reflecting the integrated nature of the programme of research.