National Centre for Social Research

# Exploring the relationship between gambling behaviour, suicidality, and treatment and support

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# Contents

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# Content warning

Please note that sensitive content is discussed throughout this report, including experiences with suicidality, gambling harms, and childhood abuse. Some readers may find this distressing. Support is available from The National Gambling Helpline or Samaritans.

# Glossary of key terms

**List of abbreviations**

| Abbreviation or acronym | |
|---|---|
| APMS | Adult Psychiatric Morbidity Survey |
| CBT | Cognitive Behavioural Therapy |
| CI | Confidence Interval |
| GESS | Gambling Experienced Stigma Scale |
| GHSI-10 | Gambling Harms Severity Index |
| GSR | Government Social Research |
| LEP | Lived Experience Panel |
| LGB | Lesbian, Gay, Bisexual |
| LGBTQ+ | Lesbian, Gay, Bisexual, Transgender, Queer and other sexual orientations and gender identities not explicitly listed |
| NIHR | National Institute for Health and Care Research |
| NHS | National Health Service |
| ONS | Office for National Statistics |
| OR | Odds Ratio |
| PGSI | Problem Gambling Severity Index |
| PIP | Personal Independence Payment |
| REC | Research Ethics Committee |
| RIM | Random Iterative Method |
| SBQ-R | Suicide Behaviors Questionnaire-Revised |
| SRA | Social Research Association |
| S-WEMWBS | Shorter Warwick-Edinburgh Mental Wellbeing Scale |

## Glossary of terms

| Term | Definition |
|---|---|
| **Binary Regression** | A type of statistical analysis used to model the relationship between a binary (having two possible outcomes) dependent variable and one or more independent variables. The model estimates the probability of the occurrence of one of the two outcomes as a function of the independent variables, providing insights into how these factors influence the likelihood of the event. |
| **Categorical variable** | Also known as discrete or qualitative variable(s). These are variables which can take on a set number of values. For example, category of PGSI score, such as low, medium or high. |
| **Confidence Interval** | A statistical tool that is used to estimate the true value of a population parameter. It provides an interval within which we are fairly certain the true value lies. |
| **Dependent variable** | Also known as the outcome variable. Regression models estimate the relationship between a single dependent variable of interest and the independent variables. For example, we can use suicidality as a dependent variable to understand to what extent suicidality is explained by factors like income and gender. |
| **Descriptive statistics** | Statistics that summarise and describe features of a dataset such as the mean, range, and distribution of values for variables. This report largely uses frequency tables and crosstabulations. |
| **Gambling** | Any kind of betting, gaming, or playing lotteries. Gaming means taking part in games of chance for a prize, betting involves making a bet on the outcome of sports, races, events or whether or not something is true, and lotteries involve a payment to participate in an event in which prizes are allocated on the basis of chance (such as raffles and sweepstakes). |
| **Gambling Experienced Stigma Scale (GESS)** | A way of measuring the amount of gambling-related stigma someone has experienced. GESS is a validated 13-item scale. |
| **Gambling harms** | The preferred term within this research, “gambling harms” refers to any adverse impacts from gambling on the health and wellbeing of individuals, families, communities, and society. This can include impacts on people’s resources, relationships, and health. |
| **Independent variable(s)** | Also known as the explanatory variable(s) or predictor variable(s). These are variables included in regression models to explain or predict changes in the dependent variable. For example, age, disability status, and education level. |
| **Kessler Psychological Distress Scale (K10)** | A widely used self-report screening tool designed to measure non-specific psychological distress. The scale consists of 10 questions assessing the frequency of anxiety and depressive symptoms over the past four weeks. |

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| | Each question is scored on a scale from 1 (“none of the time”) to 5 (“all of the time”), with higher total scores indicating greater levels of distress. |
| **Recovery support** | Recovery from gambling harms is not a concept which is clearly defined and agreed on, but a person-centred view can focus on factors such as empowerment, pursuing goals, hope, openness to others, and enhanced wellbeing.[1] Therefore, throughout the report we use ‘recovery support’ to refer to any kind of support to realise these factors, and ‘longer term recovery support’ to refer to this concept longer term including after other forms of treatment and support. |
| **Odds Ratio (OR)** | A statistical measure used to compare the odds, or likelihood, of an event occurring in two distinct groups. An OR greater than one indicates that the event if more likely to occur in the specified group, while an OR less than one suggests the event is less likely to occur. An OR equal to one implies there is no difference in the odds between the two groups. An OR describes how the odds of an outcome compare between two groups: an odds ratio of *x* means the odds are *x* times the odds in the comparison group, not that the outcome is *x* times more likely to occur. |
| **p-value** | Used as a measure of statistical significance. Low p-values indicate results are very unlikely to have occurred by random chance. p<.05 is a commonly cited value, indicating a less than 5 per cent chance that results obtained were by chance. Research findings can be accepted with greater confidence when even lower p-values are cited, for example p<.01 or p<.001. |
| **Problem Gambling Severity Index (PGSI)** | An index of “problem gambling” which gives scores from 0–27. The measure is widely used and in the UK is used in the Health Survey for England, Scottish Health Survey, and the Welsh Problem Gambling Survey. However, it should be noted that a public health approach to gambling harms has moved away from this conceptualisation because definitions of “problem gambling” stem from a mix of risk factors and outcomes and are inappropriate proxies of harm.<br><br>We will refer to different PGSI levels using either the score bandings or the terminology “level of problems with gambling” as shown below:<br>**PGSI score of 0: Those experiencing no reported problems with their gambling** (*often referred to in wider literature as “non-problem gamblers”*).<br>**PGSI score of 1-2: Those experiencing a low level of problems with their gambling** (*often described in wider literature as being at “low risk” of negative consequences and loss of control*). |

[1] Mansueto, A., Challet-Bouju, G., Hardouin, J.-B., & Grall-Bronnec, M. (2024). Definitions and assessments of recovery from gambling disorder: A scoping review. *Journal of Behavioral Addictions, -1(aop).*

| | |
|---|---|
| | **PGSI of 3-7: Those experiencing a moderate level of problems with their gambling** (*often described in wider literature as being at "moderate risk" of negative consequences and loss of control*).<br>**PGSI of 8+: Those experiencing a high level of problems with their gambling** (*defined in the PGSI as being gambling which leads to negative consequences and a possible loss of control*).<br>**PGSI of 3+: Those experiencing problems with their gambling.** *In wider literature, those considered "moderate risk" are also labelled as being "at-risk" of negative consequences and loss of control. We have excluded those considered at "low risk" of problem gambling, as their wellbeing and experience of harms is closer to people who do not gamble than to people who are experiencing a moderate or high level of problems with their gambling.*[2] |
| **Relapse** | Also known as "lapse", this term in the context of gambling harms relates to the reoccurrence of gambling participation after previous experiences of harm, or the reoccurrence of gambling harms. This term has been used in this report when used by participants to describe their own experiences. |
| **Shorter Warwick-Edinburgh Mental Wellbeing Scale (S-WEMWBS)** | A shortened 7-item scale that assess mental wellbeing over the last two weeks. Therefore, this report refers to this as a measure of "current mental wellbeing". The response categories are on a scale of 1–5. |
| **Statistical significance** | A way to quantify whether results from analysis are likely to be due to random chance. A statistically significant result or difference at the 95% level means we can be 95% confident that this was caused by something other than chance alone. All findings presented here are statistically significant unless otherwise stated. Statistical significance is usually represented by a p value or confidence interval. Findings are henceforth reported based on statistical significance thresholds of 5% represented by a p value of p=.05. |
| **Stigma** | A social process though which difference between individuals is labelled, with negative stereotyping following from this difference. *Experienced Stigma* refers to people's reported experience of stigma from others. *Internalised Stigma or Self-stigma* describes when people believe the negative stereotypes associated with a stigmatised label are true, apply these to oneself, and modify their own behaviour as a consequence. *Structural stigma* describes systematic stigma in policies and institutional practices. |
| **Suicidality** | In this report, the term suicidality is a collective term used to refer to thinking about dying by suicide (suicide/suicidal ideation), and/or attempting to die by suicide (expressed collectively as "experiencing suicidality"). The term does not encompass experiences of self-harm. |

[2] Ipsos UK. (2023). *Problem Gambling Severity Index – Full Technical Report.* On behalf of GambleAware. Available at: https://www.gambleaware.org/our-research/publication-library/articles/problem-gambling-severity-index-full-technical-report/ [Accessed on: 25th September 2025]

# Executive Summary

This research has drawn on a nationally representative survey of people who gamble, conducted in October 2024, consisting of 11,646 respondents, interviews with people with experience of gambling harms and suicidality (suicidal ideation and/or attempt), and interviews with stakeholders involved in the provision of treatment and/or support for gambling. It has explored whether and how different types of gambling relate to suicidality, the influence of demographic and contextual factors on this risk, and treatment and support experiences of those affected, including critical points for intervention. The specific research aims were:

1. To understand whether and how different types of gambling behaviours affect suicidal ideation or behaviour.
2. To explore whether and how the risk of suicidal ideation or attempt (among those with experience of gambling harms) is influenced by demographic or other contextual factors (e.g., feelings of stigma, presence of other associated mental health problems).
3. To explore effective interventions for people experiencing suicidal ideation and/or attempt and gambling harms. This includes:

    - Examination of the critical points of intervention where individuals with experience of gambling related harms choose either to seek or not seek support and/or treatment for suicidal ideation and/or attempt.

    - Exploration of risk and protective factors and the interplay between them which can influence the effectiveness of treatment for gambling or suicidal ideation.

**Summary of findings**

*The relationship between gambling, mental health and suicidality*

Overall, one in five (22%) people who reported high levels of problems with gambling (PGSI 8+) had attempted suicide in their lifetime, and most of this group (66%) linked their latest suicide attempt to gambling. Our research indicated that the pattern of gambling participation most associated with suicidality among people who reported gambling in the last 12 months was combination of gaming and 'other' gambling, with over one in three (37%) people in this category of gambling participation reporting suicidal ideation in their lifetime. However, when stratifying for PGSI scores, the relationship between patterns of play and suicidality was not statistically significant for people experiencing high levels of problems with their gambling (PGSI 8+). Our qualitative data showed a complex relationship between gambling harms and suicidality. For some, gambling to cope with difficult life events (such as bereavement) or poor mental health (such as low mood, or suicidality), led to gambling harms. However, in other cases, gambling harms occurred following changes in financial circumstances or gambling patterns. For some, gambling harms such as financial losses, debt and housing insecurity, then contributed to suicidality through people feeling hopelessness and unable to see a way out of their situation.

We identified from interviews that efforts to stop or reduce gambling could be a high-risk point for experiencing suicidality. While some participants highlighted that stopping gambling had a positive effect on their mental health, others experienced negative impacts on their mental health and suicidality. This was particularly evident in relation to experiencing the urge to gamble after deciding to stop, and the worry that they may never be able to stop gambling (alongside the concern that gambling harms will continue), which made people with lived experience feel trapped and contributed to suicidal ideation. Restarting gambling again (referred to by some as the experience of "relapse") after going through sometimes long periods of treatment could also relate to feelings of being defeated or lonely which was also a key risk point for suicidal ideation or actions.

Overall, we identified several key factors which could lead to experiences of suicidality among those experiencing gambling harms:

- Significant experiences of gambling harms, such as financial harm and housing insecurity, contributed to suicidality when they left people feeling stuck and lacking options;

- Compounding experiences of gambling harms (for example experiencing financial harms alongside relationship harms and loneliness) resulted for some in cumulative stress which could subsequently lead to suicidality;
- Ongoing urges to gamble when trying to stop could result in suicidality as these experiences could lead people to feel hopeless, trapped and worried about the future;
- Restarting gambling after previously stopping could result in people feeling shame, loneliness or like they would always experience gambling harms, which could then lead to suicidality.

*Demographic and contextual factors impacting experiences with suicidality among people experiencing gambling harms*

Demographic factors among those who gamble, such as **age**, **gender**, **ethnicity** and **social grade**, were associated with prevalence of lifetime suicidal ideation and/or attempt, although this relationship was not significant among people who experienced high levels of problems with gambling (PGSI 8+). However, identifying as **lesbian, gay, bisexual or another sexual orientation**, or having a **disability** were associated with an increase in the odds of lifetime experience of suicidality among people who gamble, and this relationship was significant even when stratifying by experience of problem gambling. People who gambled and identified as **lesbian, gay, bisexual or another sexual orientation**, had 1.69 times the odds of having experienced suicidal ideation and more than twice the odds (OR: 2.30) of having attempted suicide, compared to people who identified as heterosexual. **Disability** was assessed by asking participants if their day-to-day activities were limited by a health problem or disability (with response options as “no”, “a little”, or “a lot”). Participants who reported that their day-to-day activities were limited “a lot” had 1.73 times the odds of experiencing suicidal ideation and nearly four times the odds (OR: 3.92) of having previously attempted suicide compared to people who reported no disability. Our findings emphasise the importance of treating suicidality as a potential co-occurring experience for all people who are experiencing harm from gambling, while also identifying that some groups experience higher prevalence of suicidal ideation and/or attempt (people identifying as LGBTQ+ and disabled people). However, though there are some patterns among different groups and associated factors (e.g., housing insecurity and debt), gambling harms and suicidality affect a broad range of people.

There were mixed findings when examining the relationship between gambling harms, suicidality and experiences of **gambling stigma**. People who experienced problems with their gambling (PGSI 3+) and had “high” or “very high” gambling stigma had 1.52 times the odds of having attempted suicide compared to people with “low” gambling stigma. However, the relationship between **gambling stigma** and suicidal ideation among people who experienced problems with their gambling (PGSI 3+) was not statistically significant. People with lived experience of suicidality and gambling harms described how they felt gambling stigma was more harmful than stigma related to suicidality, emphasising that they found that people understood experiences with suicidality more easily and they could more easily relate to feelings of depression or feeling “low” as these are common experiences. Despite this, while in recovery, people with lived experience continued to find it challenging to discuss mental health problems with other people.

*Treatment and/or support experiences and needs among people experiencing suicidality and gambling harms*

NHS mental health services were the most accessed form of treatment or support by survey participants with experience of suicidality who had tried to reduce their gambling. 39% of people who had ever attempted suicide and 34% of people who had ever experienced suicidal ideation reported accessing NHS mental health services for help with gambling, including counselling or therapy both online and face to face. Among those who had tried to reduce or stop gambling and linked their latest suicide attempt to gambling, the most common form of treatment and/or support accessed was private mental health services (42%). Interviews with people with lived experience and stakeholders identified that experiences of significant gambling harms, including suicidality, and returning to gambling after a period of abstinence were key points at which people sought treatment and/or support.

Those experiencing gambling harms and suicidality often had complex personal circumstances which could result in complex support needs (e.g., support for gambling harms and suicidality alongside support needs related to housing or debt). In some circumstances, this could influence the effectiveness of some types of treatment, due to this group being more likely to be in a state of distress or in vulnerable circumstances. This could mean that for some individuals, community-based or group therapies were less appropriate. Experiences of self-stigma and wanting to hide experiences with gambling and suicidality due to shame could act as a barrier to treatment and/or support as well as influencing how people interacted with it. In general, there were no clear findings on which specific types of treatment or support were the most appropriate, as this varied between

people due to the impact of individual factors, including personal preferences and severity of current experiences with gambling harms and suicidality.

When discussing continued recovery after formal treatment, people with lived experience and stakeholders emphasised the importance of cultivating support and recovery networks (either personal networks or networks facilitated through treatment and/or support or lived experience organisations), emphasising that change is hard to sustain when attempting to do so alone. Participants felt that long-term gambling support reduced suicidal ideation. It did this both by lowering the risk of 'relapse' and reminding them of their recovery options, so they no longer saw suicide as the only way out. These findings add weight to existing evidence on the benefits of longer-term recovery programmes for those who have experienced gambling harms. A recent evaluation of ten 'aftercare'[3] programmes funded in the UK to provide long-term recovery support found that outcomes for service users included increased self-confidence, improved self-image, enhanced mental health and wellbeing, reduced isolation, and strengthened relationships with friends and family.[4]

**Recommendations for service provision**

Overall, this research has shown the importance of considering suicidality within gambling harms support provision, given that one in five (22%) people who reported high levels of problems with gambling (PGSI 8+) had attempted suicide in their lifetime, and most of this group (66%) linked their latest suicide attempt to gambling. The following recommendations for service provision and policy are based on our own analysis, as well as recommendations made by participants in our research:

- **Suicidality should be considered a potential co-occurring experience among all those experiencing gambling harms** – Our data has shown that although demographic factors, such as age, gender, ethnicity and social grade, were associated with suicidality, this relationship was not significant among people who experienced high levels of problems with gambling (PGSI 8+). This emphasises the importance of screening for suicidality among all those experiencing significant gambling harms, regardless of background. However, our research has also identified that among people who gamble, disabled individuals and those from lesbian, gay, bisexual or other sexual orientations are at higher risk of experiencing suicidality and therefore, there may be higher levels of support needs for these groups. Identity-safe pathways for these groups should be considered (for example, optional affinity groups such as women's or LGBTQ+ groups). Data to identify these groups can be hard to collect in some services due to apprehension among service users about sharing personal information, particularly with brief interventions. To support data collection, services should include clear explanations of the purpose of collecting data and data protection measures.

- **Services supporting people with gambling harms and/or mental health should ensure that dual-screening and assessment is undertaken for both gambling harms and suicidality on first contact, including within gambling support services, primary care mental health, emergency departments and crisis lines and ensure onward referral processes are embedded consistently** – Our research has shown the frequent and complex relationship between gambling harms and suicidality. Comprehensive screening and risk assessment is an essential first step for supporting people holistically. Services should use validated screening tools for both suicide risk and gambling harms, such as the Gambling Harms Severity Index (GHSI-10), and, where needed, provide staff training.[5]

- **People experiencing gambling harms and suicidality are likely to have complex and unique support needs which may necessitate being addressed holistically, and long term** - Our research has shown that gambling harms and suicidality are closely intertwined (e.g., gambling-related distress can both contribute to, and arise from, suicidal thoughts and behaviours), suggesting that support which considers gambling harms, mental health, or suicidality in isolation may not be as effective. Our research has also emphasised the role of wider social factors (e.g., debt and housing insecurity) which closely

[3] The term 'longer term recovery' is used throughout the report to reference support provided throughout the duration of recovery from gambling harms, including following other formal forms of treatment and support. The term 'aftercare' has been used here to accurately represent the cited evaluation.

[4] Ipsos UK. (2025). *Evaluation of the Aftercare Funding Programme Interim report 2 (Phase 2)*. Available at: https://www.ipsos.com/sites/default/files/ct/news/documents/2025-07/aftercare-evaluation-phase-2-report_final-april-2025.pdf. [Accessed on: 25th September 2025]

[5] 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.

interrelate to gambling harms and suicidality. These should, therefore, also be considered as part of holistic support plans and offered within gambling support services where possible. Both those with lived experience and stakeholders emphasised the importance of long-term support for this group, describing the role of long-term support networks (including peer support) in mitigating suicidality longer-term through reminding people of routes to recovery. Longer term recovery support should be structured and include time-specified check-ins.

- **Challenges when trying to stop gambling (e.g., not being able to stop when trying to) as well as experiences of "relapse" (taking part in gambling or experiencing gambling harms again after a period of abstinence or lower harm) are key risk moments for experiencing suicidality** – Our qualitative findings showed how these moments could lead to feelings of "defeat" related to the view that gambling harms would be everlasting or insurmountable. These findings align to wider suicidality research which has modelled suicidal behaviour and highlighted the role of defeat, humiliation and the sense of entrapment in contributing to suicidal ideation. [6] These moments are therefore particularly vital for the provision of support and should be considered within support plans for those accessing support. The risk of suicidality during the experience of "relapse" also emphasises the importance of long-term treatment access and support networks, including for those in "recovery" who are no longer experiencing acute gambling harms. Support plans should include a "return to gambling participation" response plan which should be shared in circumstances where clients are referred between services.

- **Continued efforts to address stigma and discrimination related to both gambling harms and suicidality are vital to support those experiencing gambling harms and suicidality and improve access to and experiences of treatment and/or support** – Our research found that experience with both gambling stigma and stigma related to suicidality influenced access to and experiences of treatment and/or support, including making it more challenging for people to discuss their experiences with friends, family, and treatment providers. Addressing gambling stigma is a particular priority. People with lived experience felt that gambling stigma was more harmful than suicide stigma, emphasising that they found that people understood experiences with suicidality more easily whereas negative perceptions about people who gambled were more common. Staff supporting those experiencing gambling harms and suicidality should be trained in suicide and gambling-specific stigma reduction (including training relating to using non-judgemental language and recognising how stigma impedes disclosure).

- **Suicidality as a result of gambling harms should be considered more broadly as a public health priority** – Our research indicates that experiences of suicidal ideation and suicide attempts are higher among people experiencing harms from gambling than among people who do not gamble or gamble without harms. Suicide is currently recognised as a priority in the government's recently announced 10-year health plan and suicide prevention strategy, and we recommend that gambling harms should be treated as a risk factor along with self-harm, and harm related to alcohol and drug use.[7,8] Additionally, wider prevention and awareness campaigns should cover the link between gambling harms and suicidality and signpost to support access, including providing resources for people experiencing harm related to other people's gambling.

[6] O'Connor, R. & Kirtley, O. (2018). *The integrated motivational–volitional model of suicidal behaviour.* Philosophical Transactions of the Royal Society of London. Series B, Biological Sciences. 5;373(1754).
[7] Department for Health and Social Care. (2025). Fit for the future: 10 Year Health Plan for England. Available at : https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future/fit-for-the-future-10-year-health-plan-for-england-accessible-version [Accessed on: 24th October 2025]
[8] Garratt, K., Kirk-Wade, E., Gajjar, D., Danechi, S. (2025). Suicide Prevention Policy. Available at: https://commonslibrary.parliament.uk/research-briefings/cbp-10090/ [Accessed on: 24th October 2025]

# 1. Introduction

## 1.1 Background to the report

Suicide is a serious global health issue, with around 703,000 people dying by suicide each year,[9] and many more people experiencing suicidal ideation. The 2023/24 Adult Psychiatric Morbidity Survey (APMS) shows that prevalence of suicidal thoughts and suicide attempts in England has increased from 2000 to 2023/24. The proportion of 16-74 years olds reporting suicidal ideation in the past year increased from 3.8% to 6.7%, and suicide attempt reports increased from 0.5% to 1.0%.[10] Researchers have long recognised that it is difficult to predict who might be at risk of suicidality, as suicide is a complex and sensitive issue with complex ethical implications for research.

People who experience gambling harms are at a higher risk for suicidality compared to people who do not gamble or people who gamble without harms. The 2023 Annual Great Britain Treatment and Support Survey shows a correlation between those with higher PGSI scores and increased risk of suicidal ideation: 10% of those with PGSI score of 1-2 were categorised as being high risk, 18% of those with PGSI score 3-7, and 44% of those with PGSI score 8+ (compared to 8% of the general public).[11] Gambling harms are the adverse impacts from gambling on the health and wellbeing of individuals, families, communities, and society. These harms impact people's resources, relationships, and health.[12] The 2007 APMS in England reported a prevalence of 19% for past-year suicidal ideation and 4% past-year suicide attempt in individuals experiencing gambling harms (compared to 6.7% and 1.0% for past-year suicidal ideation and suicide attempt respectively in individuals not experiencing gambling harms).[13]

Studies have demonstrated a bi-directional relationship between gambling and suicidal ideation and/or attempt, with evidence showing that each is capable of exacerbating the other over time. The UK NICE clinical guidelines explicitly recognise that distress related to experiences of gambling and gambling harms can be a risk factor for subsequent suicidality.[14] More recent studies have also demonstrated a link between gambling problems and suicidal ideation and behaviour in the general population,[15] young adults,[16] and people receiving treatment both in Great Britain and internationally.[17,18] These studies found that even after accounting for factors like substance use, depression, anxiety, and impulsivity, the connection between gambling and suicide remained strong. Studies have also suggested that people might gamble to escape negative thoughts, a state known as "dark flow". [19] In this way, escaping psychological distress through gambling can become a self-reinforcing cycle. However, there is a lack of long-term studies from Great Britain and internationally, leaving gaps in our

[9] World Health Organization. (2022). *World Suicide Prevention Day 2022.* Available at: https://www.who.int/campaigns/world-suicide-prevention-day/2022. [Accessed on: 25th September 2025]
[10] NHS England. (2025). *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/24.* Available at: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-attempts-and-self-harm - key-findings. [Accessed on: 12th November 2025]
[11] Gosschalk, K., Webb, S., Cotton, C., Gunstone, B., Bondareva, E. and Zabicka, E. (2024). *Annual GB Treatment and Support Survey 2023.* YouGov on behalf of GambleAware. Available at: https://www.gambleaware.org/media/pxmnarjh/gambleaware_2023_treatment-and-support_report_final_0.pdf. [Accessed on: 12th November 2025]
[12] Gambling Commission. (2020). Problem gambling and gambling-related harms. Available at: https://www.gamblingcommission.gov.uk/statistics-and-research/publication/problem-gambling-vs-gambling-related-harms [Accessed on: 20th October 2025]
[13] Wardle, H., John, A., Dymond, S. & McManus, S. (2020). *Problem gambling and suicidality in England: secondary analysis of a representative cross-sectional survey.* Public health, 184, 11–16.
[14] NICE guideline NG248 (2025). Gambling-related harms: identification, assessment and management. Available at: Recommendations | Gambling-related harms: identification, assessment and management | Guidance | NICE [Accessed on: 21st November 2025]
[15] Wardle, H., John, A., Dymond, S. & McManus, S. (2020). *Problem gambling and suicidality in England: secondary analysis of a representative cross-sectional survey.* Public health, 184, 11–16.
[16] Wardle, H. & McManus, S. (2021). *Suicidality and gambling among young adults in Great Britain: Results from a cross-sectional online survey*. The Lancet Public Health, 6(1), e39–e49.
[17] Karlsson, A. & Håkansson, A. (2018). *Gambling disorder, increased mortality, suicidality, and associated comorbidity: A longitudinal nationwide register study.* Journal of Behavioral Addictions, 7(4), 1091–1099.
[18] Sharman, S., Murphy, R., Turner, J. & Roberts, A. (2022*). Predictors of suicide attempts in male UK gamblers seeking residential treatment.* Addictive Behaviors, 126, 107171.
[19] Dixon, M., Gutierrez, J., Larche, C., Stange, M., Graydon, C., Kruger, T. & Smith, S. (2019). *Reward reactivity and dark flow in slot-machine gambling: "Light" and "dark" routes to enjoyment.* Journal of behavioral addictions, 8(3), 489-498.

understanding of the complex mechanisms and processes involved in the relationship between gambling harms, suicidal ideation and behaviour.

People experiencing gambling harms through various forms of gambling participation face specific challenges. Gambling behaviour and experiences of harm are often stigmatised, which leads to unfair perceptions about and behaviour towards individuals who experience gambling harms, stemming from the idea that gambling is a mark of shame or disgrace.[20,21] Furthermore, for those with experience of gambling harms, this is seldom recognised by professionals and the majority of people experiencing gambling harms do not access gambling-specific treatments or services.[22]

Certain groups are at particular risk of stigmatisation and/or discrimination due to demographic or other personal characteristics, including women experiencing severe harms, single people, those with parental responsibilities (particularly mothers), people from minoritised ethnic communities in Great Britain, people living in financial hardship and people experiencing difficulties with drug and/or alcohol use alongside gambling harms.[23] Similarly, stigma surrounds suicidal ideation and behaviour.[24] Suicide-related stigma has been shown to be associated with higher levels of suicide risk, poor mental health, and lowered help-seeking.[25] While the stigma related to gambling and suicide is well-documented, less is known about how these issues interact and the impact of stigma on individuals and their access to support. There are wider gaps in knowledge about experiences with treatment and support among this group in Great Britain, including pathways (and barriers) to access, and best practice within services for supporting this group.

Wider research on gambling harms has shown that certain marginalised or minoritised communities, such as men who identify as gay, bisexual, or another sexual orientation and minoritised ethnic communities, are more likely to engage in gambling activities that are associated with harms (such as electronic gambling machines, animal racing, and sports betting).[26,27] However, most research on suicidality and gambling harms has focused on adult males, especially those aged 40–45, who are the main at-risk group.[28] This leaves gaps in knowledge about women, sexual and gender minorities, minoritised ethnic communities, and people with long-term physical and mental health conditions or disabilities. Additionally, there is limited information on how different gambling patterns, such as types and frequency of gambling, affect various population groups, which may support identification of risk patterns or points of intervention.[29]

Building on these existing research gaps, our research aims were:

1. To understand whether and how different types of gambling behaviours affect suicidal ideation or behaviour.

[20] Hing, N., Russell, A., Gainsbury, S. & Nuske, E. (2016*). The Public Stigma of Problem Gambling: Its Nature and Relative Intensity Compared to Other Health Conditions*. Journal of Gambling Studies, 32(3), 847–864.
[21] Shipsey, F., Martin, A., Brearley-Bayliss, H., Bennetto, R., Cohen, E., Dinos, S., Lloyd, J., Penfold, K., Nicklin, L. & Chadwick, D. (2025). *Stigmatisation and discrimination of people who experience gambling harms: quantitative analysis*. NatCen on behalf of GambleAware. Available at: https://www.gambleaware.org/our-research/publication-library/articles/stigmatisation-and-discrimination-of-people-who-experience-gambling-harms-quantitative-analysis/ [Accessed on: 3rd September 2025]
[22] Bennett, M., Spencer, S., Hill, S., Morris, S., McManus, S., & Wardle, H. (2025). Gambling behaviour. In Morris, S., Hill, S., Brugha, T., McManus, S. (Eds.), *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4.* NHS England.
[23] Shipsey, F., Martin, A., Brearley-Bayliss, H., Bennetto, R., Cohen, E., Dinos, S., Lloyd, J., Penfold, K., Nicklin, L. & Chadwick, D. (2025). *Stigmatisation and discrimination of people who experience gambling harms: quantitative analysis.* NatCen on behalf of GambleAware. Available at: https://www.gambleaware.org/our-research/publication-library/articles/stigmatisation-and-discrimination-of-people-who-experience-gambling-harms-quantitative-analysis/ [Accessed on: 3rd September 2025]
[24] Carpiniello, B. & Pinna, F. (2017). *The Reciprocal Relationship between Suicidality and Stigma. Frontiers in psychiatry*, 8 (35).
[25] Wyllie, J. M., Robb, K. A., Sandford, D., Etherson, M. E., Belkadi, N., & O'Connor, R. C. (2025). *Suicide-related stigma and its relationship with help-seeking, mental health, suicidality and grief: scoping review*. BJPsych open, 11(2), e60.
[26] Bailey, L., Zeeman, L., Sawyer, A. & Sherriff, N.S. (2023). *LGBTQ+ People and Gambling Harms: A Scoping Review*. Brighton. University of Brighton. Available at: https://www.gambleaware.org/media/lnvgv0j0/lgbtqplus-people-and-gambling-harms-full-report.pdf [Accessed on: 2nd October 2025]
[27] Bramley, S., Norrie, C., Wardle, H., Manthorpe, J. & Lipman, V. (2020). *Gambling-related harm among recent migrant communities in the UK: Responses to a 21st century urban phenomenon.* NIHR Policy Research Unit in Health and Social Care Workforce, Policy Institute at King's, King's College London and London School of Hygiene & Tropical Medicine. Available at: Bramley_et_al_2020_Migrant_gambling_report.pdf [Accessed on: 1st October 2025]
[28] Andreeva, M., Audette-Chapdelaine, S. & Brodeur, M. (2022). *Gambling-Related completed suicides: A scoping review*. Addiction Research & Theory, 30(6), 391–402.
[29] Forrest, D., McHale, I., Dinos, S., Ashford, R., Wilson, H., Toomse-Smith, M. & Martin, A. (2022). *Patterns of Play: Extended Executive Summary Report*. Available at: https://natcen.ac.uk/publications/patterns-play [Accessed on: 25th September 2025]

2. To explore whether and how the risk of suicidal ideation or attempt (among those with experience of gambling harms) is influenced by demographic or other contextual factors (e.g., feelings of stigma, presence of other associated mental health problems).
3. To explore effective interventions for people experiencing suicidal ideation and/or attempt and gambling harms. This includes:

    - Examination of the critical points of intervention where individuals with experience of gambling related harms choose either to seek or not seek support and/or treatment for suicidal ideation and/or attempt.
    - Exploration of risk and protective factors and the interplay between them which can influence the effectiveness of treatment for gambling or suicidal ideation.

## 1.2 Overview of methods

This study comprised of a quantitative and qualitative strand. The quantitative strand involved an online survey with 11,646 people who gamble, and the qualitative strand comprised of six interviews with stakeholders who work at organisations delivering treatment and/or support for gambling, and 12 interviews with people with lived experience of gambling and suicide. The study was approved by NatCen's internal research ethics committee. Figure 1 below provides an outline of data collection and analysis methods with the full details provided in Appendix A.

**Figure 1: Outline of data collection and analysis methods**

| Survey with people who gamble | Interviews with stakeholders | Interviews with people with lived experience |
|---|---|---|
| The survey was conducted by YouGov with **11,646 people** who gamble, who were sampled from YouGov's online panel in **October 2024.** | Six interviews were conducted with stakeholders involved in the provision of treatment and/or support for gambling, taking place from **December 2024 to February 2025**. | 12 in-depth interviews were conducted with people who have experience of gambling harms and suicidality, taking place from **May to August 2025**. |
| The survey included questions on:<br>• Gambling experiences and patterns of gambling participation.<br>• Experiences of suicidality.<br>• Gambling stigma.<br>• Experiences of treatment and/or support. | Interviews aimed to gain insight into the relationship between gambling harms and suicidality. Interviews focused on:<br>• Gambling behaviours.<br>• Risk and protective factors for suicidality, such as demographic and contextual factors.<br>• Factors related to treatment and/or support, including barriers and enablers.<br>• The role of gambling and suicidality related stigma. | Interviews included the creation of a timeline of gambling experiences, gambling harms, and suicidality. Participants were also asked for their views and perceptions of:<br>• Factors that protect or put them at greater risk of experiencing suicidality.<br>• The role of gambling and suicidality related stigma.<br>• Experiences of treatment and/or support. |

**Data management and analysis**

The survey was weighted to be representative of the population of people who gamble in Great Britain. In addition to descriptive statistics, we carried out a variety of statistical tests (including chi-squares) using SPSS to examine where the effects observed in the data, such as differences in suicidality, were statistically significant. This study employs an exploratory regression analysis, which is intended to identify potential relationships and generate hypotheses for future research rather than to confirm specific theoretical expectations. To minimise

overfitting in this exploratory context, only variables where the relationship with suicidality was significant ($p<.05$) were included in a binary logistic regression to quantify the impact on the odds of suicidal ideation and suicide attempt. We conducted the analysis on the relationship between gambling, mental health, demographic factors and suicidality among people who gamble using the entire dataset. To look at the relationship between stigma and access to treatment and/or support and suicidality among people experiencing harms from gambling, we used a sub-set of the data including only people with PGSI 3+ (see Appendix A for further information). Interviews with stakeholders and people with lived experience were analysed using the Framework approach to qualitative analysis. This is a case and theme-based approach to qualitative data analysis developed by NatCen. Further details on both quantitative and qualitative analysis can be found in Appendix A.

In the main body of the report, percentages presented in figures have been rounded to the nearest whole-number. As a result of the rounding, the sum of percentages in the figures may not always total 100%. In the appendix tables, percentages were rounded to one decimal point. Where the original variable offered options such as “Prefer not to say”, “Not applicable”, or “Don’t know”, these response categories were retained to accurately represent respondent choice but treated as missing and not included in the analysis stage. Given the categorical nature of most variables and the relatively small proportion of responses treated as missing, this approach was deemed the most transparent and least bias-prone.

**Measurement of gambling harms**

The Problem Gambling Severity Index (PGSI) which measures gambling problems over the last 12 months was selected for analysis in this study as a proxy measure for gambling harms.[30] Both PGSI total scores (0–27), and standard PGSI categories (groups) of scores (0, 1–2, 3–7, 8+) are well known and understood by the research and policy communities. However, researchers have highlighted that the PGSI is an inappropriate proxy measure of gambling harms due to the measure including an “ill-defined mix of risk factors and outcomes” (i.e. a mix of behaviours and harms) among other disadvantages.[31] Despite this, the research team decided to use PGSI due to it being a widely understood measure and for the purpose of performing categorical analyses using PGSI groupings.

**Measurement of suicidal ideation and attempt**

Suicidal ideation was assessed using a modified item from the Suicide Behaviors Questionnaire-Revised (SBQ-R)[32] and suicide attempt was measured using a modified question from the Adult Psychiatric Morbidity Survey (APMS).[33] Participants were asked if they had personally experienced feelings of suicide or considered taking their own life in any way. The answer options were “No”, “Yes, it was just a brief passing thought”, “Yes, I had a plan to take my own life but did not want to try it”, and “Yes, I had a plan and wanted to take my own life”. Participants who answered any variation of “Yes” to this question were considered as having experienced suicidal ideation and were routed to a question asking if they had ever made an attempt to take their life (“Yes” or “No”). All participants had the option to answer “Prefer not to say” to this question. A derived variable for suicidality was then created with mutually exclusive categories (no suicidality, suicidal ideation (no attempt), suicidal ideation and attempt). Participants who had attempted suicide were further asked how important gambling was in their latest suicide attempt (4-point Likert scale).

**Language**

In this report, **"suicidal ideation"** (sometimes referred to as suicidal thoughts), refers to having thought processes, ideation, or ruminations about the possibility of dying by suicide or intentions to attempt suicide. **"Suicide attempt"** refers to behaviours or actions taken in an attempt to die by suicide. In line with recent developments in suicide research literature, we note that suicidal ideation and attempt represent distinct but

[30] Ferris, J. & Wynne, H. (2001). *The Canadian problem gambling index: final report*. Ottawa. Available at: https://www.greo.ca/Modules/EvidenceCentre/files/Ferris et al(2001)The_Canadian_Problem_Gambling_Index.pdf [Accessed on: 24th September 2025]

[31] Close, J., Martin, I., White, G., Lau, R. & May, J. (2023). *Frameworks and Measurement of Gambling Related Harm: A Scoping Study*. NatCen and the University of Plymouth on behalf of GambleAware. Available at: https://www.gambleaware.org/media/0e3n2ggk/frameworks-and-measurement-of-grh_final_for-publication.pdf [Accessed on: 25th September 2025]

[32] Osman A., Bagge C., Gutierrez P., Konick L., Kopper B., Barrios F. (2001) The Suicidal Behaviors Questionnaire-Revised (SBQ-R): validation with clinical and nonclinical samples. Assessment. 8(4):443-54

[33] NHS England. (2025). *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/24.* Available at: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-attempts-and-self-harm - key-findings. [Accessed on: 18th November 2025]

related experiences.[34,35,36] Some of our findings do not allow for clear differentiation between these experiences, as participants would refer to suicidal experiences in general without distinguishing between suicidal ideation or suicide attempt. Therefore, **"suicidality"** is used as a collective term to encapsulate experiences of suicidal ideation and/or suicide attempt where breakdown by either ideation or attempt is not appropriate or accurate.

Within our quantitative data, we categorised participants into three distinct groups: those who gambled and experienced no lifetime suicidality, those who gambled and had experienced suicidal ideation (without attempt), and those who gambled who had experienced both suicidal ideation and suicide attempt. When reporting on quantitative data, "people who experienced suicidal ideation" refers to those who reported suicidal thoughts without having attempted suicide, while "people who experienced suicide attempt" refers to those who reported experiencing both suicidal ideation and suicide attempt.

We have used the term "**stakeholders**" to refer to interview participants who were involved in the provision of gambling treatment and/or support. The phrase "**people with lived experience**" is an abbreviated term used in the report to refer to interview participants who have lived experience of gambling, gambling harms, and suicidality.

## 1.3 Structure of the report

The report is arranged in the following chapters:

- **Chapter 2** reports on the relationship between gambling, mental health and suicidality.
- **Chapter 3** explores demographic and contextual factors, including experiences of stigma, and how they impact experiences with suicidality among people who experience gambling harms.
- **Chapter 4** discusses treatment and/or support needs and experiences for people who experience suicidality and gambling harms.
- **Chapter 5** includes a summary of findings, limitations, recommendations and areas for future research.
- **Appendix A** provides full details of the methodology, and the survey questionnaire.
- **Appendix B** provides the survey data tables.

[34] Klonsky, D., May, A., & Saffer, B. (2016). *Suicide, Suicide Attempts, and Suicidal Ideation*. Annual review of clinical psychology, 12, 307–330. Available at: https://pubmed.ncbi.nlm.nih.gov/26772209/ [Accessed on: 13th November 2025]

[35] Leo, D., Goodfellow, B., Silverman, M., Berman, A., Mann, J., Arensman, E., Hawton, K., Phillips, M. R., Vijayakumar, L., Andriessen, K., Chavez-Hernandez, A. M., Heisel, M., & Kolves, K. (2021). *International study of definitions of English-language terms for suicidal behaviours: a survey exploring preferred terminology*. BMJ open, 11(2). Available at: https://pubmed.ncbi.nlm.nih.gov/33563622/ [Accessed on: 13th November 2025]

[36] Nock, M., Borges, G., Bromet, E., Cha, C., Kessler, R., & Lee, S. (2008). *Suicide and suicidal behavior*. Epidemiologic reviews, *30*(1), 133–154. Available at: https://pubmed.ncbi.nlm.nih.gov/18653727/ [Accessed on: 13th November 2025]

# 2. The relationship between gambling, wellbeing, and suicidality

This chapter explores the relationships between gambling, wellbeing, and suicidal ideation or suicide attempt among people who gambled in the last 12 months (explored in our survey) and people with experiences of both gambling harms and suicidality (explored in qualitative interviews). It begins by examining the prevalence of suicidal ideation and attempts among individuals who participate in gambling, and how different gambling behaviours influence the risk of suicidality. The chapter then explores the complex relationships between mental health challenges (which we found to be a key related factor), experiences of gambling harms, and suicidality.

### Chapter two: Key findings

- One in five (22%) people who reported high levels of problems with gambling (PGSI 8+) had attempted suicide at some point in their lifetime, and most of this group (66%) linked their latest suicide attempt to gambling.
- Among people who reported high levels of problems with gambling (PGSI 8+), different patterns of play (such as betting, gaming, "other" gambling and combinations of these categories) were not significantly associated with suicidality.
- People who reported gambling in the last 12 months and low current wellbeing in the last two weeks (as measured by the Shorter Warwick-Edinburgh Mental Wellbeing Scale) had nearly three times the odds (OR: 2.82) of having ever experienced suicidal thoughts and had 1.71 times the odds of having ever attempted suicide, compared to those who reported high current wellbeing.
- In line with findings from previous studies, we found complex multi-directional relationships between gambling harms, wellbeing and suicidality.
- People with lived experience and stakeholders highlighted that gambling harms, such as significant losses, debt and homelessness, could leave people feeling stuck and subsequently increase the risk of suicidal ideation and/or suicide attempt.
- People with lived experience described how using gambling to cope with difficult life events or poor mental health sometimes caused or exacerbated the gambling harms, in turn impacting suicidality. In other cases, people with lived experience reported gambling harms, with impacts on suicidality, following increases in gambling frequency and/or losses.
- While some people with lived experience highlighted that stopping gambling had a positive effect on their mental health, others reported negative impacts on suicidality. When people experienced challenges refraining from gambling, or when restarting gambling and experiencing harms once again after previously stopping, they described feeling trapped and unable to see a future without gambling harms.

## 2.1 Prevalence of suicidal ideation/ attempts among people taking part in gambling

This section examines the prevalence of suicidal ideation and attempts among individuals who participated in gambling, drawing on both survey and interview data. It begins by exploring how experiences of suicidality vary according to the severity of gambling problems, as measured by PGSI scores. Subsections 2.1.1 and 2.1.2 then explore the relationship between suicidality and different types of gambling.

Three out of ten (32%) people who had gambled in the last 12 months reported lifetime suicidal ideation – without attempts, while one out of ten (9%) survey participants reported suicide attempts[37] (Appendix Table B.1). Our findings are based on a weighted sample of 11,646 people in Great Britain who had gambled in the 12 months leading up to the survey. These figures are slightly higher than recent general population estimates. The 2023/4 Adult Psychiatric Morbidity Survey (APMS) estimated that the lifetime prevalence of suicidal ideation and suicide attempts among the English adult population is 25% and 8%, respectively – based on a weighted sample of 6,981 adults aged 16 and over.[38] However, this comparison should be approached with significant caution as both surveys have different samples and methodologies.

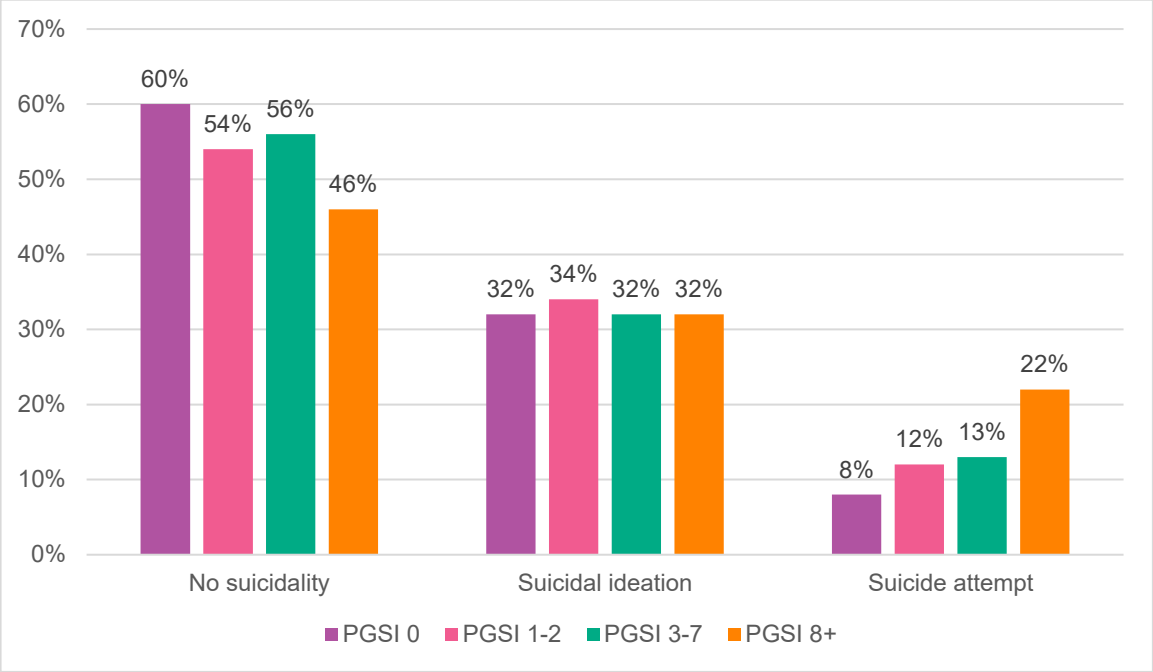
There was no statistical difference between the odds of having ever experienced suicidal ideation among people who reported no problems with gambling (PGSI 0) and people who reported any problems with gambling (PGSI scores of 1-2, 3-7 and 8+)[39] (Appendix Table B.24).

However, among people who gamble, there was a stronger association between reporting any problems with gambling (PGSI scores of 1-2, 3-7 and 8+) and lifetime occurrence of suicide attempt, compared with reporting no problems with gambling (PGSI 0). To illustrate, people experiencing high levels of problems with their gambling (PGSI 8+) had twice the odds of having ever attempted suicide compared to people with no problems with gambling (PGSI 0) (OR: 2.01, 95% CI 1.349–2.994, p=.001) (Appendix Table B.25).

The prevalence of lifetime suicidality within each PGSI score category further illustrated the association between experiencing high levels of problems with their gambling (PGSI 8+) and lifetime suicide attempt (Figure 2 and Appendix Table B.1). More than one in five (22%) people who reported high problems with gambling (PGSI 8+) experienced a suicide attempt at some point in their life, compared to less than one in ten (8%) of those who experienced no reported problems with their gambling (PGSI 0).

[37] To measure suicidality among people who gambled in the last 12 months, we created three mutually exclusive categories: “no suicidality”, “suicidal ideation” (no attempt), and suicide ideation and attempt – referred to as “suicide attempt”.
[38] NHS Digital. (2025). *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4: Data tables Data set, Part of Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4*. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/data-sets. [Accessed on: 25th September 2025]
[39] PGSI scores of 1-2 OR:1.16 (95% CI 0.99-1.35, p=.060). PGSI scores of 3-7 OR: 1.11 (95% CI 0.89-1.39, p=.337). PGSI scores of 8+ OR:1.26 (95% CI 0.92-1.73, p=.15).

**Figure 2: Lifetime suicidality, by PGSI score, among people who gamble**




Base: n=11,129

Among survey participants who attempted suicide (n=1,011), gambling was considered "somewhat" or "very important" in their most recent suicide attempt by the majority of people experiencing high levels of problems with gambling (PGSI 8+) (66%), compared to 7% of people who experienced a moderate level of problems with their gambling (PGSI 3-7), 4% of people who experienced a low level of problems with their gambling (PGSI 1-2), and 1% of people who reported no problems (PGSI 0) (Appendix Table B.2). Due to the low number of people who linked their latest suicide attempt to gambling, it was not possible to establish if that relationship was statistically significant.

## 2.1.1. Patterns of gambling participation

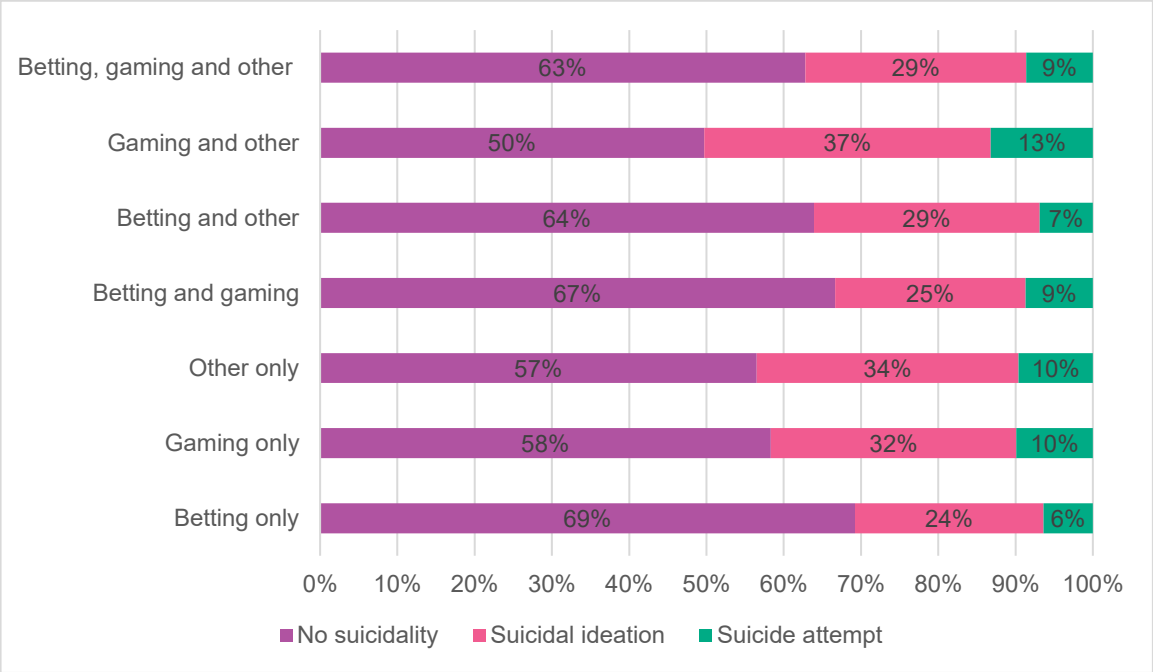
To explore patterns of gambling participation, we categorised survey respondents' activities into seven distinct groups based on their reported behaviours in the 12 months leading up to the survey:[40]

- **Betting** which includes wagering on events external to the gambling environment, such as sports matches.
- **Gaming** which encompasses activities where outcomes are generated within the gambling environment, including bingo, casino games, poker, slots, and instant wins.
- **"Other" gambling** covers lotteries, loot boxes, and miscellaneous gambling types. Although the creation of this group supported an exploration of different experiences between those taking part in betting and gaming, the heterogeneous nature of activities in this group makes interpretation more challenging.
- **Combinations of these categories** – betting and gaming, betting and other, gaming and other, and gaming, betting and other – reflect the diverse ways individuals engage in multiple gambling activities.

[40] The distinction between betting and gaming has been used based on a previous study exploring online gambling: Forrest, D., McHale, I. G., Dinos, S., Ashford, R., Wilson, H., Toomse-Smith, M. & Martin, A. (2022). *Patterns of Play: Extended Executive Summary Report*. NatCen on behalf of GambleAware. Available at: https://www.gambleaware.org/our-research/publication-library/articles/patterns-of-play-extended-executive-summary-report/. [Accessed 25th of September 2024]

Figure 3 and Appendix Table B.3 illustrate how the pattern of gambling participation most associated with suicidality among people who reported gambling in the last 12 months was the combination of gaming and 'other' gambling, with over one in three (37%) people in this category of gambling participation reporting suicidal ideation in their lifetime. However, when stratifying for PGSI scores, the relationship between patterns of gambling participation and suicidality was not statistically significant (p=.072) for people experiencing high levels of problems with their gambling (PGSI 8+) (Appendix Table B.3).

**Figure 3: Lifetime suicidality by pattern of gambling participation, among people who gamble**




Base: n=11,126

Among all people who gambled, our regression model confirmed that engaging in gaming and "other" gambling activities was more strongly associated with having ever experienced suicidal ideation compared to betting alone (OR: 1.64, 95% CI 1.26–2.13, p<.001). In addition, other patterns of gambling participation more closely linked with having ever experienced suicidal ideation than "betting only" include spending money solely on "other" gambling (OR: 1.63, 95% CI 1.32–2.02, p<.001) and combining betting with "other" gambling (OR: 1.34, 95% CI 1.06–1.69, p=.015), as outlined in Appendix Table B.24. However, the odds of reporting suicide attempt did not differ significantly between individuals who spent money on "betting only" and those who engaged in other patterns of gambling participation (Appendix Table B.25) and further research is needed to understand these patterns.

Among survey participants who had previously attempted suicide (n=1,012), people who spent money on gaming (by itself or combined with other gambling activities) reported more often than those taking part in other activities that gambling was "somewhat" or "very important" in the most recent attempt. People who spent money only on "other" gambling were the group least likely to consider gambling important in their most recent suicide attempt (2.6%) (Appendix Table B.4). Due to the low number of people who linked their latest suicide attempt to gambling, it was not possible to establish if that relationship was statistically significant.

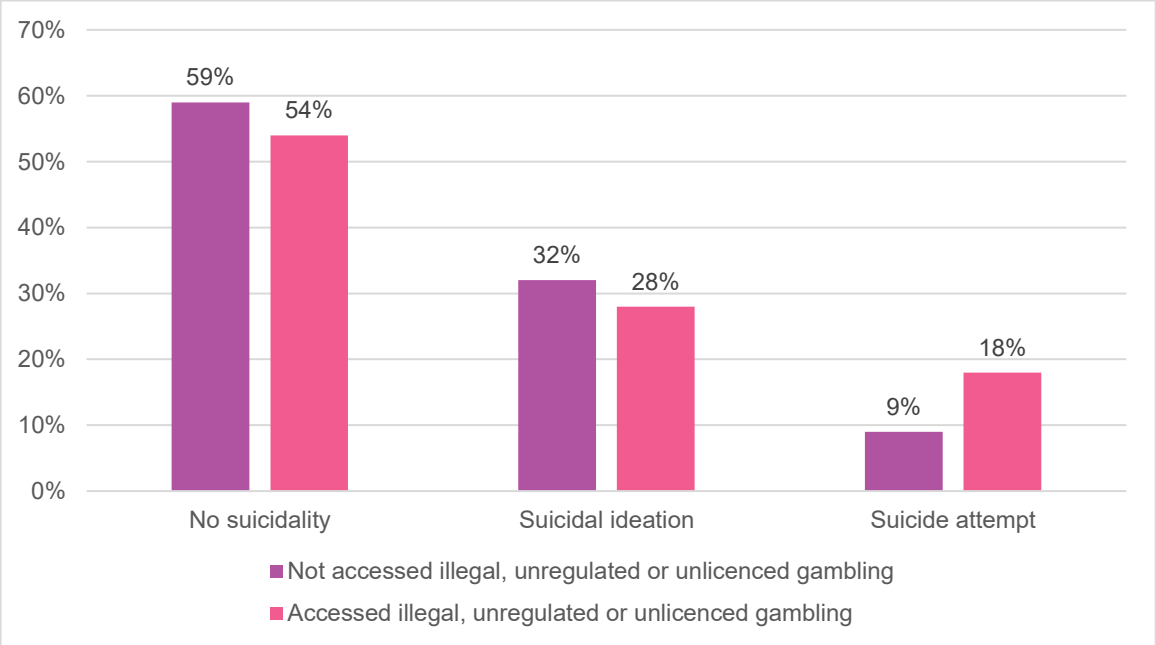
The survey measured lifetime experience of suicidality, while patterns of gambling participation were measured within the last 12 months and gambling frequency (discussed in section 2.1.3) was measured within the last four weeks. However, according to our interview participants, gambling behaviours often changed over time due to wider factors such as living situations, financial circumstances, and self-imposed restrictions on gambling participation. Consequently, a limitation is that survey participants who experienced suicidality more than 12 months before taking part may have engaged in different gambling patterns at that time, and the frequency of engaging in these patterns at the time of experiencing suicidality was unknown.

People with lived experience and stakeholders interviewed did not directly associate one or more specific patterns of gambling participation with higher risk of suicidality. However, online gambling was associated in some cases with higher spending due to its availability and the ease with which individuals could "lose control" over money spent. Furthermore, fixed odds betting machines, slots, roulette and betting at the racetracks were also described by participants as "addictive". In turn, interview participants linking gambling harms and financial losses to suicidality, in many cases due to experiences of gambling harms being significant (as discussed in section 2.2.2). Our findings reinforce the wider literature, where substantial financial losses and the use of electronic gambling machines in halls or bars were associated with suicidality.[41] However, casino games or betting on sports were not found to be independently associated with suicidality.

## 2.1.2. Illegal, unregulated or unlicensed forms of gambling

Our survey asked people who gamble to self-report whether they had ever accessed illegal, unregulated or unlicenced gambling, such as using gambling sites not registered on GAMSTOP. Participants were reassured that all responses were confidential and one in twenty people (5%) answered that they had accessed illegal, unregulated or unlicensed gambling. Participants were given the option to respond 'Don't know' or 'Prefer not to say', which only accounted for 2.7% and 0.6% of responses respectively (Appendix Table B.5). Among people who gambled in the last 12 months, illegal, unregulated or unlicensed gambling was most prevalent among people experiencing high levels of problems with their gambling (PGSI 8+).[42] Almost one in five (18%) people who engaged in illegal, unregulated or unlicenced gambling reported lifetime suicide attempt, compared to one in ten (9%) people who did not report this gambling behaviour (Appendix Table B.5).

**Figure 4: Lifetime suicidality by lifetime access to illegal, unregulated or unlicensed gambling, among people who gamble**




Base: n=10,806

There was a significant relationship (p<.001) between the use of illegal, unregulated or unlicenced gambling and participants linking their latest suicide attempt to gambling. Among survey participants who attempted suicide, gambling was considered "somewhat" or "very important" in their most recent suicide attempt by the majority of

[41] Bischof, A., Meyer, C., Bischof, G., John, U., Wurst, F. M., Thon, N., Lucht, M., Grabe, H.-J., & Rumpf, H.-J. (2016). "Type of gambling as an independent risk factor for suicidal events in pathological gamblers". *Psychology of Addictive Behaviors*, 30(2), 263–269.
[42] The relationship between illegal, unregulated or unlicensed gambling and suicidality was statistically significant, but we have not included this variable in the regression model because PGSI score has already been included in our model.

people who engaged in any illegal, unregulated or unlicenced gambling (67%), compared to only 3% of people who did not (n=980, Appendix Table B.6).

### 2.1.3. Frequency of gambling behaviours

Using survey data, we examined the link between suicidality and frequency of gambling (in the four weeks leading up to the survey).[43] We report the highest frequency at which people spent money on each pattern of gambling participation (on betting, on gaming, or on "other" gambling) and it should be noted that this may underestimate how frequently some participants spent money across multiple patterns of gambling participation. It should also be noted that the survey measured frequency of gambling engagement within the last 4 weeks, whereas suicidality was measured over people's lifetime, which limits the conclusions which can be drawn from the comparison.

Descriptive statistics found significant relationships between betting frequency and suicidality ($p<.001$), gaming frequency and suicidality ($p<.001$), and "other" gambling frequency and suicidality ($p<.001$). Among people who engaged in gaming every day in the last four weeks, one in five (20%) reported having ever experienced suicidal ideation, and over one in four (27%) reported having ever attempted suicide. Additionally, among those who engaged in "other" forms of gambling every day in the last four weeks, one in four (26%) reported having ever experienced suicidal ideation, and one in five (21%) reported having ever attempted suicide. Lastly, among people who engaged in betting every day in the last four weeks, 19% reported lifetime suicidal ideation and 15% reported lifetime suicide attempts (Appendix Tables B.7, B.8 and B.9).

## 2.2 The relationship between gambling harms and mental health

This section explores the complex relationship between gambling harms, mental wellbeing, and suicidality. It starts by presenting quantitative findings on current mental wellbeing and lifetime prevalence of suicidal ideation and/or attempts among individuals who gambled in the last 12 months. Quantitative findings are followed by qualitative insights into people's journeys with gambling harms and suicidality.

### 2.2.1. Associations between lifetime suicidality and mental wellbeing

Mental wellbeing was measured using the Shorter Warwick-Edinburgh Mental Wellbeing Scale (S-WEMWBS), capturing subjective wellbeing over the two weeks prior to the survey. The data presented in this section therefore reflects mental wellbeing in the two weeks leading up to the survey, rather than lifetime mental illness (whereas suicidality was measured over people's lifetime), which limits the conclusions which can be drawn from the comparison.

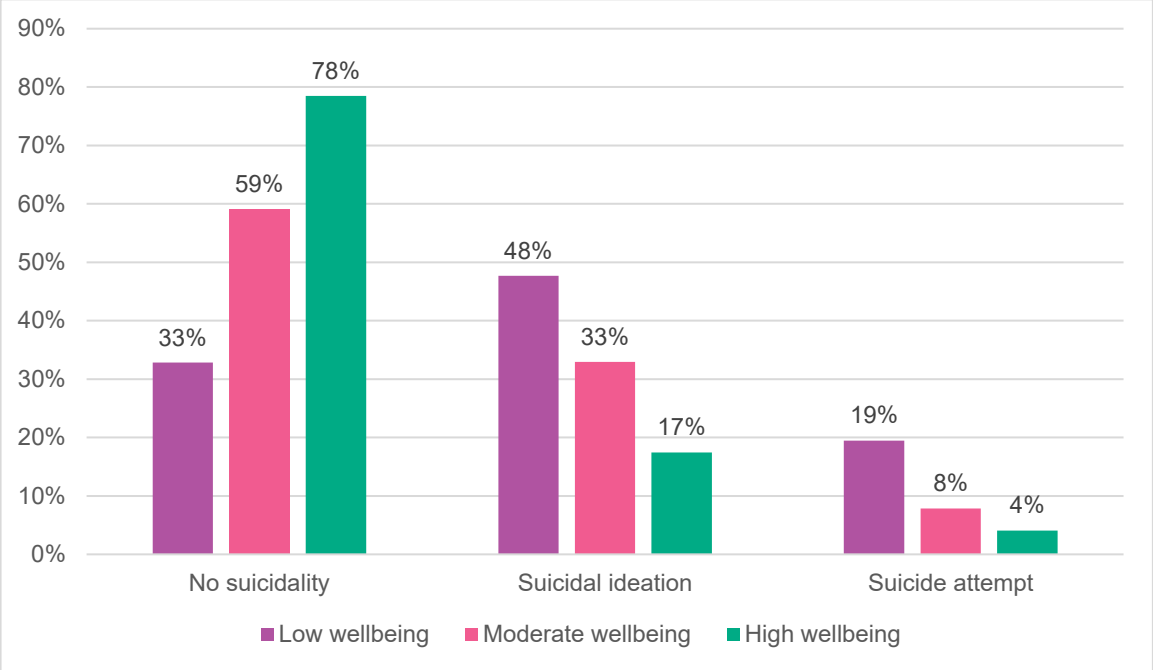
Low current mental wellbeing was associated with higher prevalence of having ever experienced suicidal ideation and/or suicide attempts (as shown in Appendix Tables B.24 and B.25). People with low current mental wellbeing at the time of the survey had almost three times the odds (OR: 2.82, 95% CI: 2.39–3.33 $p<.001$) of having ever experienced suicidal ideation compared to those with high current mental wellbeing (Appendix Table B.24). They also had nearly twice the odds (OR: 1.71, 95% CI: 1.30–2.25, $p<.001$) of having ever attempted suicide compared to participants who had high current mental wellbeing (Figure 5 and Appendix Table B.25). However, due to the time-frame mismatch in these measures, causality should not be inferred.

Nearly one in four (23%) people with current high mental wellbeing and who experience high levels of problems with their gambling (PGSI 8+) reported having attempted suicide, compared to 4% of the wider group of people who gambled who reported current high mental wellbeing and suicide attempt (Appendix Table B.10). Due to the limitations above, causality cannot be inferred from these findings. However, one possible explanation for this association is that people who experienced suicide attempts and high levels of problems with their gambling (PGSI 8+) may have used gambling to cope with or escape from difficult emotions, therefore improving their current mental wellbeing. Using gambling to cope and escape from negative emotions was reported by interview

[43] Frequency was categorised into six distinct groups: "Never or not in the past four weeks"; "Once in the past four weeks", "About once a fortnight", "About once per week", "A few times per week", and "Every day".

participants and will be explored in the next section, which describes the journey of people who experienced gambling harms with mental wellbeing and suicidality.

**Figure 5: Lifetime suicidality, by current mental wellbeing (measured by S-WEMWBS), among people who gamble**




Base: n=11,130

## 2.2.2. Participants' journey with gambling harms and suicidality

This section examines people's pathways into experiencing both gambling harms and suicidality. It details the experiences of some participants using gambling to manage difficult life events and mental health issues, as well as the effects of experiencing gambling harms, such as significant losses, on suicidal ideation and/or suicide attempt. Lastly, it explores how efforts to reduce or stop gambling can influence mental health and suicidality.

In line with lived experience accounts presented below, stakeholders highlighted that experiencing gambling harms alongside past traumatic events including adverse childhood experiences or bereavement, drug and alcohol use, and/or mental health issues, such as depression and anxiety, could increase the risk of suicidality. In many cases, mental health issues or having experienced trauma, such as sexual abuse, were reported to predate gambling harms – which was believed to exacerbate the risk of suicidal ideation due to pre-existing stress.

*"[My team] generally find[s] that where there's suicidal ideation, it exists more so with pre-existing mental health and wellbeing concerns and that these are then greatly exacerbated by their gambling. So, where we see young people come in and there's never been any kind of mental health worries or concerns, they are less likely to express suicidal ideation to us […]"* (Stakeholder)

However, other stakeholders highlighted the difficulty in determining whether mental health issues or gambling harms had occurred first. At the same time, stakeholders also reported working with people who experienced mental health issues such as depression as the result of taking part in gambling. This complex interplay between gambling harms, mental health and suicidality will be explored in depth for the remaining of this chapter.

Consistent with stakeholder accounts, interviews with people with lived experience showed a complex interplay between gambling harms and suicidality. They emphasised the existence of past trauma and/or mental health challenges in childhood and/or adolescence. Some participants stated that they had survived childhood abuse or neglect, or that they struggled with mental health challenges during their time at school – including anxiety,

depression, and suicidal ideation due to bullying. However, others did not report or could not recall mental health issues before they began gambling.

**The use of gambling to cope with negative emotions or life events among people with lived experience**
The use of gambling to manage life challenges was described by people with lived experience and stakeholders. Gambling was presented as a means to "escape from" or cope with difficult emotions and circumstances – including childhood trauma, complicated relationships, bereavement, or mental health challenges among people experiencing gambling harms and suicidality.

*"So, from what they gathered when I was in my treatment I started gambling to escape from normal life because there was a lot of trauma, a lot of upset in my life. So, I would use gambling to kind of hide from what was really going on in the world around me and with my family and everything."* (Woman with lived experience, aged 18–39)

In cases when gambling was used to escape or cope with negative emotions or life events, participants typically experienced harm from their gambling. Difficult life events which, alongside gambling, were reported to negatively impact suicidality included: relationship issues (such as abuse from a partner, partner infidelity, difficult relations with parents), bereavement, struggling after the birth of a child, and unexpected health problems affecting them or their loved ones. In some circumstances, participants reported how the combination of these factors alongside gambling became overwhelming, and contributed to suicidality:

*"[T]hat was the last time I've done everything like that [attempted suicide], because I realised, I was very ill from having my little boy and I was trying to deal with the counselling from my childhood trauma, the gambling stuff, having a little boy, the divorce."* (Woman with lived experience, aged 40+)

Experiences related to poor mental health, ranging from low mood and low self-esteem to suicidality, and gambling were also described by people with lived experience as reinforcing each other in a negative cycle, where people used gambling to cope with mental health challenges, and experienced mental health challenges due to gambling harms – sometimes alongside wider experiences of low self-worth, loneliness, and/or harm related to substance use. For example, one participant compared their gambling to "self-harm" as a means to cope with suicidality and low self-esteem.

*"I wasn't present, which then was a downward cycle because I felt useless and pointless, so then I'd gamble, which then I'd feel useless and pointless and annoyed, so then I'd gamble. [...] Yes, it were just domino effect, I guess, one thing, then another, and it all just led back to gambling unfortunately."* (Man with lived experience, aged 18–39)

**Other pathways into gambling harms among people with lived experience**
Conversely, some people with lived experience did not reference gambling as a coping mechanism. Instead, they described how additional money or additional time available for gambling caused an increase in gambling frequency and/or substantial losses, leading to suicidal ideation and/or a suicide attempt.

**The impact of gambling harms on suicidality among people with lived experience**
Regardless of the reason for taking part in gambling, participants described how the gambling harms they experienced caused or exacerbated the risk of suicidality. In line with the accounts from people with lived experience, stakeholders also reported that clients' experiences of gambling harms sometimes left them feeling stuck and lacking options and therefore resulted in or exacerbated suicidality.

*"I think [suicidality] - thoughts, actions were very much prominent when I was gambling. In the worst spots of my gambling, that's why I was - that's where it really got to that point."* (Man with lived experience, aged 18–39)

Financial harms from gambling were often specifically linked by participants to suicidality. The pressures of substantial financial losses, loss of career or business, homelessness, food insecurity, and debt, were reported to leave participants in a "dark place", feeling hopeless, stressed, unable to see options, and generally unable to discuss or share the burden with family or friends (see section 3.2, exploring gambling and suicidality stigma). In some cases, participants highlighted that experience of a particularly severe financial harm (for example,

housing insecurity or a substantial financial loss) was the biggest contributor to their poor mental health, including to them experiencing suicidality.

*"[I]f you've experienced the pressure being in massive debt has on you, and keeping secrets from family and friends, you can realise people think there's no other way out. The only option is, if I'm dead I've got no debt; my debts are all gone."* (Man with lived experience, aged 40+)

Some participants who experienced financial harms and hopelessness reported how the high-risk, high-reward mentality around gambling impacted their experiences of suicidal ideation, when deciding to challenge themselves to either win back money to recoup losses, or to end their own life.

*"So, to do with when I challenged myself; win the money back or take your own life, that's a very gambling... That risk and reward thing, it's very much within that statement, it's very high-risk gambling, very extreme gambling so that sort of mentality to your own life […]."* (Man with lived experience, aged 18–39)

Lastly, some participants highlighted the interconnectedness between their finances and other areas of their life, such as their independence, and other's trust and respect towards them. Experiences of financial harms alongside relationship harms (including stress related to the impact of gambling on loved ones, loneliness, and/or low self-esteem) had significant impacts on suicidality due to the cumulative stress of experiencing multiple gambling harms at the same time.

*"[I]s when those [suicidal] thoughts were probably the most loud. That's when I spent all of my money. I sold everything that I had. My relationship was ending, and I just didn't want to be here anymore because everything was just falling apart […] I didn't have any support because everybody would just see me as being an issue rather than somebody that had a problem."* (Woman with lived experience, aged 18–39)

**The impact of reducing/stopping gambling among people with lived experience**

For participants with lived experience who had previously reduced or stopped gambling, interviews explored the impact of their journey with gambling participation, harms and suicidality. For some participants, stopping or "controlling" gambling had a positive effect on their mental health, primarily due to improved finances which alleviated stress, and increased time and money available for social activities with family and friends.

*"You're not going to be chasing the money that you've lost. You're just going to want to spend that time having fun with other people and improving relationships and being out in the world"* (Woman with lived experience, aged 18–39)

On the other hand, stakeholders felt that some of their clients who relied on gambling to manage their emotions could be at higher risk of suicidality if they stopped gambling, as they might seek alternative coping mechanisms, including self-harm.[44]

Additionally, participants with lived experience described two key moments which increased the risk for them of suicidal ideation and/or suicide attempt. Firstly, participants described how stopping or reducing gambling could be challenging due to ongoing desires to gamble. These challenges made some participants feel trapped and unable to envision a future without gambling harms, contributing to ongoing suicidal ideation.

*"I think the first time I had suicidal thoughts, I would have been [in my mid-twenties]. That was through gambling. I couldn't see a way out. I couldn't stop. I didn't know a way out."* (Man with lived experience, aged 40+)

Secondly, restarting gambling participation again (referred to by some as the experience of "lapse" or "relapse") after going through sometimes long periods of treatment, left some participants feeling defeated, lonely or ashamed. This was related to the belief they would not be able to stop or "control" gambling in the long-term, making people with lived experience feel that there was no "way out" of experiencing gambling harms. These

[44] Our use of the term self-harm in this context refers to non-suicidal self-injury.

moments sometimes led to their most dangerous experiences in terms of suicidality. In some cases, "relapse" occurred due to the continued reliance on gambling to cope with negative emotions or life events, including everyday challenges.

*"That [suicide thought] was the most - I suppose, the most real it became, and that obviously was straight after... That was after maybe second or third relapse."* (Man with lived experience, aged 18–39)

These findings align to wider suicide research which has examined suicidal behaviour and highlighted the role of defeat, humiliation and the sense of entrapment in contributing to suicidal ideation.[45]

[45] O'Connor, R. & Kirtley, O. (2018). *The integrated motivational–volitional model of suicidal behaviour.* Philosophical Transactions of the Royal Society of London. Series B, Biological Sciences. 5;373(1754).

# 3. Demographic and contextual factors impacting experiences with suicidality among people who gamble

In this chapter, demographic and contextual factors associated with suicidality among people who gamble are explored. This is followed by an exploration of how gambling and suicide stigma interact with experiences of suicidality among survey participants who reported a moderate to high level of problems from gambling (PGSI 3+) and people with lived experience. The chapter brings together data from the survey with people who gamble, as well as interviews with stakeholders and participants with lived experience of gambling harms and suicidality.

### Chapter three: Key findings

- Among those who gamble, demographic factors, such as age, gender, ethnicity and social grade, were associated with suicidality, although this relationship was not significant among people who experienced high levels of problem with gambling (PGSI 8+).
- The odds of experiencing suicidal ideation were higher for those who gamble who identified as lesbian, gay, bisexual or other sexual orientation, or reported having a disability. This relationship was significant even when stratifying by experience of “problem gambling” (PGSI 8+). People who gambled and identified as lesbian, gay, bisexual or other, had 1.69 times the odds of having experienced suicidal ideation and had more than twice the odds (OR: 2.30) of having ever attempted suicide.
- Participants who gamble and reported that their day-to-day activities were limited “a lot” due to a health problem or disability had 1.73 times the odds of having experienced suicidal ideation and had nearly four times the odds (OR: 3.92) of having attempted suicide compared to people who reported no disability. Participants who gambled and reported that their day-to-day activities were limited “a lot” due to a health problem or disability had 1.73 times the odds of having experienced suicidal ideation and had nearly four times the odds (OR: 3.92) of having attempted suicide compared to people who reported no disability.
- Our analysis also pointed to a strong association between loneliness and suicidality, even when stratifying by experience of “problem gambling” (PGSI 8+). People who gambled and reported feeling “often or always” lonely had nearly seven times the odds (OR: 6.82) of having experienced suicidal ideation and nearly four times the odds (OR: 3.88) of having ever attempted suicide compared to people who reported “never” feeling lonely.
- There were mixed findings when examining the relationship between gambling harms, suicidality and experiences of gambling stigma. People who experienced problems with their gambling (PGSI 3+) with “high” or “very high” gambling stigma had 1.52 times the odds of having attempted suicide compared to people with “low” gambling stigma. However, there was no statistically significant relation between gambling stigma and suicide ideation among this group.
- Interviews with stakeholders and people with lived experience showed how both gambling and suicide stigma could lead to hiding gambling, gambling harms and experiences of suicidality. This could further lead to isolation, increasing risk of suicidality.
- Suicide stigma and gambling stigma could lead to a negative loop of negative self-talk (worsening emotional state) and using gambling as a coping mechanism (worsening gambling harms), in turn increasing the risk of suicidality.

## 3.1 Demographic characteristics

While this section explores various demographic (age, gender, ethnicity) and contextual (social grade, disability) factors, it is important to note that people’s experiences do not exist in isolation. Experiences of both gambling

harms and suicidality take place in their social and political environment, which will influence their experiences with gambling harms and suicidality, as well as wider factors related to experiences of stigma. This environment can be influenced by people's identity, whether race, age, disability, social class, and creates an inequitable context in which they exist.[46]

While most demographic and contextual factors that were explored in the survey are significantly linked to suicidality, those relationships were not significant among people experiencing a high level of problems with their gambling (PGSI 8+). This emphasises the importance of treating suicidality as a potential harm for all people who are experiencing problems with gambling, a view also held by stakeholders, who felt that suicidality as a result of gambling harms could affect anyone.

> *"It's [suicidality among people experiencing harms from gambling] across the board. You would just say it absolutely cuts through the genders and the ages [...] It feels like it could be anybody at any time, really."*
> (Stakeholder)

### 3.1.1. Age

Overall, age was associated with having ever experienced suicidal ideation among people who gamble, although this relationship was not statistically significant (p=.388) for people experiencing high levels of problems with their gambling (PGSI 8+) when stratifying for PGSI scores (Appendix Table B.11). As this study reports on lifetime experiences of suicidality, it is possible that older people may appear more likely to have experienced suicidal ideation or attempt due to there being a cumulative opportunity for these experiences to occur over time. However, our findings show that lower age groups had higher odds of having ever experienced suicidality compared to those aged 65 and older. This aligns with previous findings in the 2023/24 APMS, which highlighted that higher reporting of suicidal thoughts and/or attempts might be explained by generational differences, variations in recall, perception and willingness to report, along with healthy-survivor effect.[47]

People who gambled aged 25-34, 35-44 and 55-64 had the highest odds of having ever experienced suicidal ideation compared to people aged over 65 (around 1.7 times). People aged 45-54 had 1.6 times the odds of having ever experienced suicidal ideation compared to people aged over 65. (Appendix Table B.24).[48] Analysis showed similar results for people who gamble and who had ever attempted suicide. Those aged 25-34 and 35-44 had nearly twice the odds of having ever attempted suicide compared to people over 65. Those aged 45-54 had 1.8 times the odds of having ever attempted suicide compared to people over 65 (Appendix Table B.25).[49]

Crosstabulations by age groups further illustrate the association with suicidality, with one in four (25%) people over 65 who gambled reporting lifetime suicidal ideation compared to over a third of people aged 25-64 (35% of those aged 25-34, 36% of those aged 35-44, 35% of those aged 45-54, and 33% of those aged 55-64). More than one in ten people (11%) aged 25-54 also reported having ever attempted suicide (compared to 5% of people aged over 65) (Figure 6 and Appendix Table B.11).

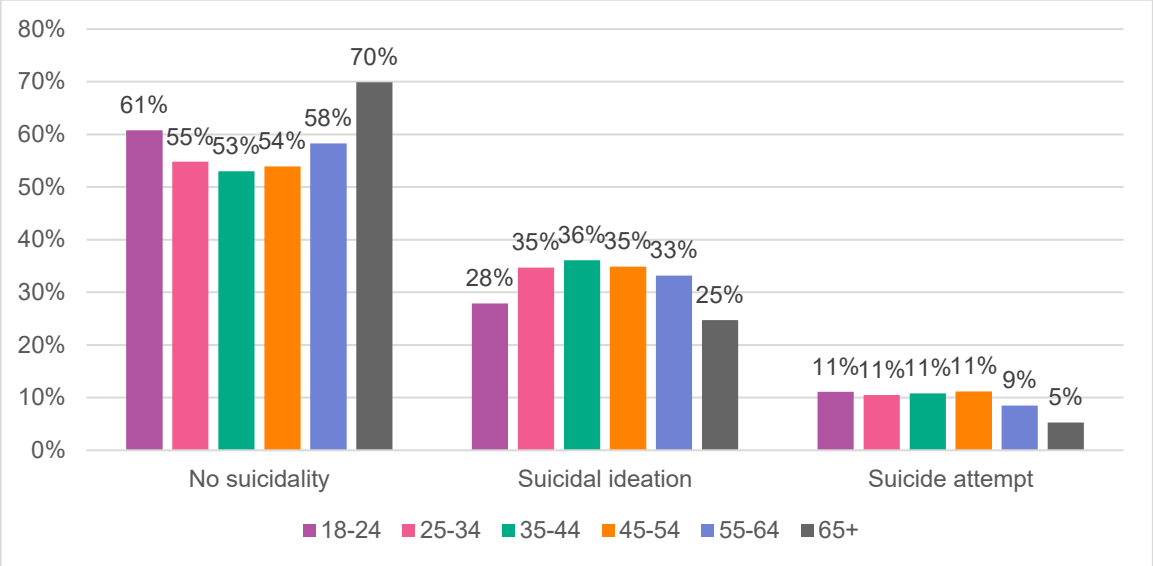
[46] Martin, I., Trégan, F., Bennetto, R., Cottis Black, O., Brearley-Bayliss, H., Sawdon, E. & Dinos, S. (2024). Gambling Harms and Inequalities in Great Britain: Experience of communities Experiencing Marginalisation, Isolation or Criminalisation: A Scoping Series. London. NatCen on behalf of GambleAware. Available at: https://www.gambleaware.org/media/2efgzn5h/gambling-harms-among-marginalised-communities.pdf [Accessed on 24th September 2025]

[47] NHS England. (2025). *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/24.* Available at: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-attempts-and-self-harm - key-findings. [Accessed on: 12th November 2025]

[48] 25-34 OR=1.78 (95% CI: 1.52-2.09, p<.001) / 35-44 OR=1.75 (95% >CI: 1.50-2.04, p<.001) / 45-54 OR=1.66 (95% CI: 1.44-1.93, p<.001) / 55-64 OR=1.71 (95% CI: 1.48-1.99, p<.001)

[49] 18-24 OR=1.57 (95% CI: 1.22-2.03, p<.001) / 25-34 OR=1.91 (95% CI: 1.50-2.43, p<.001) / 35-44 OR=1.91 (95% CI: 48-2.47, p<.001) / 45-54 OR=1.77 (95% CI: 1.36-2.32, p<.001)

**Figure 6: Lifetime suicidality, by age, among people who gamble**




Base: n=11,131

Interviews explored the role of age in experiences of suicidality and gambling harms. Participants with lived experience and stakeholders held the perception that younger age could be associated with risk taking behaviour, which played a role in participation in drinking, gambling, and even suicidality. For instance, one participant described how heavy drinking during nights out in their 20s was connected to gambling participation and ongoing harms.

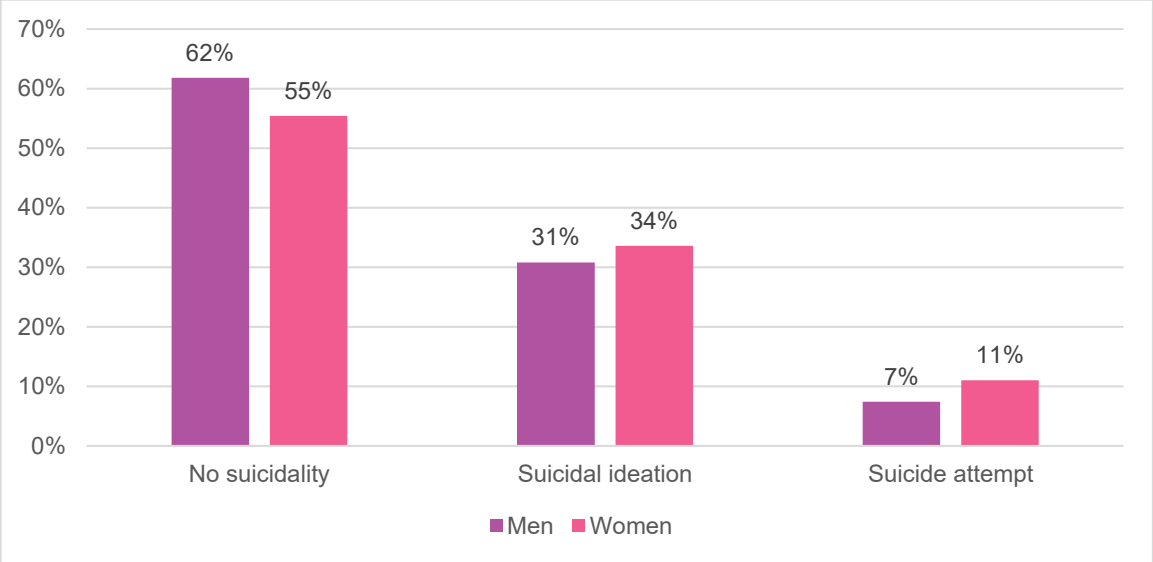
## 3.1.2. Gender

A gender variable provided with the cleaned and weighted dataset from YouGov included participants coded to "female" or "male", with no missing data. The questionnaire itself allowed participants to self-describe if their gender identity did not match with their sex at birth (n=81).[50] Women who gambled had 1.39 time the odds of having ever attempted suicide (95% CI 1.19–1.61, p<.001) compared to men who gambled, although there was no statistical difference in relation to having ever experienced suicidal ideation (Appendix Tables B.24 and B.25). This aligns with findings from previous research with the general population which show women are more likely than men to have ever made a suicide attempt.[51]

More than one in ten women (11%) who took part in the survey reported having ever attempted suicide, compared to 7% of men (see Figure 7). However, this relationship was not significant among people experiencing a high level of problems with their gambling (PGSI 8+), suggesting that unlike the pattern within the wider population, both men and women are equally at risk (p=.308) (Appendix Table B.12).

[50] 6,507 people did not answer this question, therefore the 'gender' variable provided by YouGov was used.
[51] Butt, S., Randall, E., Morris, S., Appleby, L., Hassiotis, A., John, A., McCabe, R. & McManus, S. (2025). *Suicidal thoughts, suicide attempts and non-suicidal self-harm*. In Morris, S., Hill, S., Brugha, T., & McManus, S. (Eds.), *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4*. NHS England.

**Figure 7: Lifetime suicidality, by gender, among people who gamble**




Base: n=11,126

Men with lived experience highlighted the role of their gender when describing gambling as a way to cope with negative emotions and poor mental health. Men felt that this was linked to their upbringing and how they were taught not to cry or show emotions, which led to gambling as a way to cope with their emotions. They linked this experience of harms from gambling to worsening mental health and a pathway to suicidal ideation and suicide attempts.

*"'Men are men, man up,' I think there's a lot more pressure on men of a certain age not to talk about mental health and how they're feeling."* (Man with lived experience, aged 40+)

## 3.1.3. Other demographic characteristics

**Ethnicity**

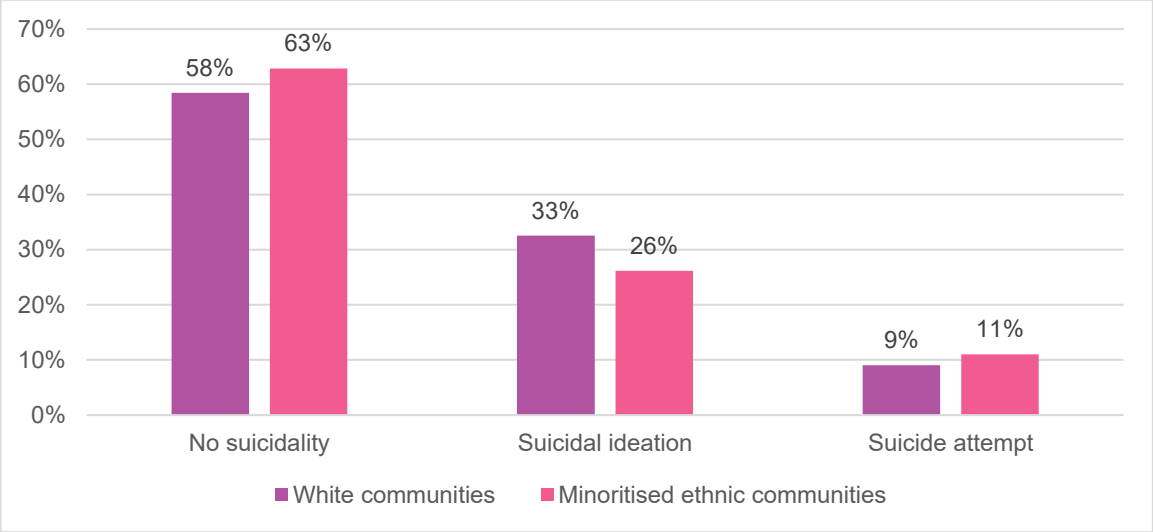
Ethnicity was grouped into two groups: people from White communities (n=10,193) and people from minoritised ethnic communities (n=837).[52] This was due to the small sample sizes among specific minoritised ethnic groups, meaning that it would be difficult to conduct meaningful analysis on those groups (Appendix Table A.2). While acknowledging that not all members of minoritised ethnic communities will share the same experiences, there is also strength in grouping people from minoritised ethnic communities to understand their collective experiences of social exclusion and marginalisation. These merged group analyses highlight that it is important for future work to expand on this with larger and more diverse samples.

Among people who gambled, those from minoritised ethnic communities had significantly lower odds of having ever experienced suicidal ideation compared to those from White groups (OR: 0.66, 95% CI 0.55–0.79, p<.001; Appendix Table B.24). There was no significant relationship between ethnicity and experience of lifetime suicide attempt (Appendix Table B.25).

One in three (33%) White people who gambled reported lifetime suicidal ideation, compared to just over one in four (26%) people from minoritised ethnic communities (see Figure 8). The crosstabulations showed that this relationship was not significant for participants with no reported problems from gambling (PGSI 0) and participants experiencing a high level of problems with their gambling (PGSI 8+) (Appendix Table B.13).

[52] For the purpose of the analysis presented here, 'White communities' includes 'White British', 'White Irish', 'Gypsy or Irish Traveller', 'Any other White background'. 'Minoritised ethnic communities' includes 'Mixed or multiple ethnic groups', 'Asian or Asian British', 'Black, Black British, Caribbean or African', and 'Other ethnic groups'.

**Figure 8: Lifetime suicidality, by ethnicity, among people who gamble**




Base: n=11,030

Stakeholders interviewed who ran treatment and/or support services for gambling harms reported that a majority of their service users were from a White British background, unless they specifically targeted minoritised ethnic communities. Stakeholders felt that stigma as a barrier to treatment and/or support (explored further in 4.1.4) was a significant issue among some minoritised ethnic communities (particularly Muslim communities), related to religious beliefs with gambling being taboo for some. People with lived experience generally did not perceive that their ethnicity had any impact on their gambling or suicidality experience, with 11 out of 12 participants identifying as White or White British. In some cases, White men associated their ethnicity, alongside their gender, with the cultural expectation of not showing emotion, which they felt contributed to gambling and drinking behaviours.

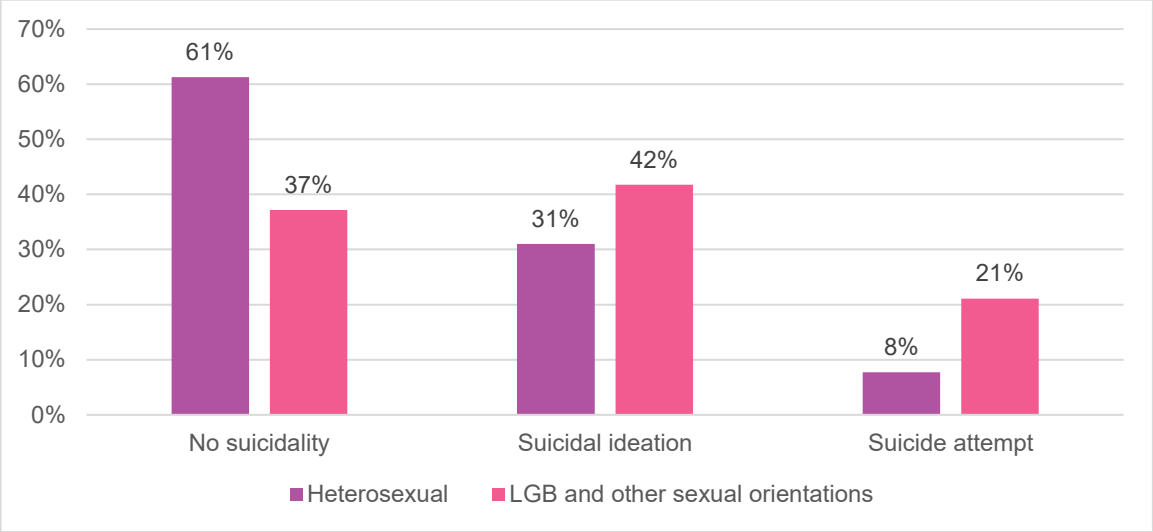
**Sexual orientation**

Sexual orientation was combined into two groups for analysis: heterosexual (n=9,616) and lesbian, gay, bisexual and other sexual orientations (n=1,109), due to small sample sizes among some groups (e.g., other sexual orientations). People who identified as lesbian, gay, bisexual or other sexual orientation had 1.69 times the odds of having ever experienced suicidal ideation (95% CI: 1.45–1.98, p<.001) and had more than twice the odds of having ever attempted suicide (OR: 2.30, 95% CI: 1.91–2.77, p<.001), as shown in Appendix Tables B.24 and B.25.

Crosstabulations by sexual orientation further showed the association with suicidality, with people who gambled and identified as lesbian, gay, bisexual or another sexual orientation reporting higher lifetime suicidal ideation (42% compared to 31% of heterosexual people) and lifetime suicide attempts (21% compared to 8%) (see Figure 9). The relationship between sexual orientation and suicidality was significant even when stratifying by experience of gambling problems (Appendix Table B.14). These findings align to previous research showing that in the general population, those identifying as LGBTQ+ are at higher risk of experiencing suicidality.[53]

[53] Office for National Statistics. (2025*). Self-harm and suicide by sexual orientation, England and Wales: March 2021 to December 2023.* Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/mentalhealth/bulletins/selfharmandsuicidebysexualorientationenglandandwales/march2021todecember2023. [Accessed on: 25th September 2025]

**Figure 9: Lifetime suicidality, by sexual orientation, among people who gamble**




Base: n=10,725

Stakeholders reported that the majority of their service users were either heterosexual, or that they did not collect data on sexual orientation. Among participants with lived experience, there was some limited evidence that identifying as lesbian, gay, bisexual or another sexual orientation was associated with experiences of discrimination and feelings of stigma and shame that exacerbated gambling harms and suicidality, particularly through isolation.[54]

"*Sexuality, very confused because I felt I was gay, but couldn't be gay because of the prejudice with my family and friends. […] Well, I'd just say that the discrimination and lack of help and support, no one to talk to about it. […] It was just I really felt on my own, and obviously, with all these problems and no hope of rehousing, I felt desperate."* (Woman with lived experience, aged 40+)

## 3.1.4. Wider social or environmental factors

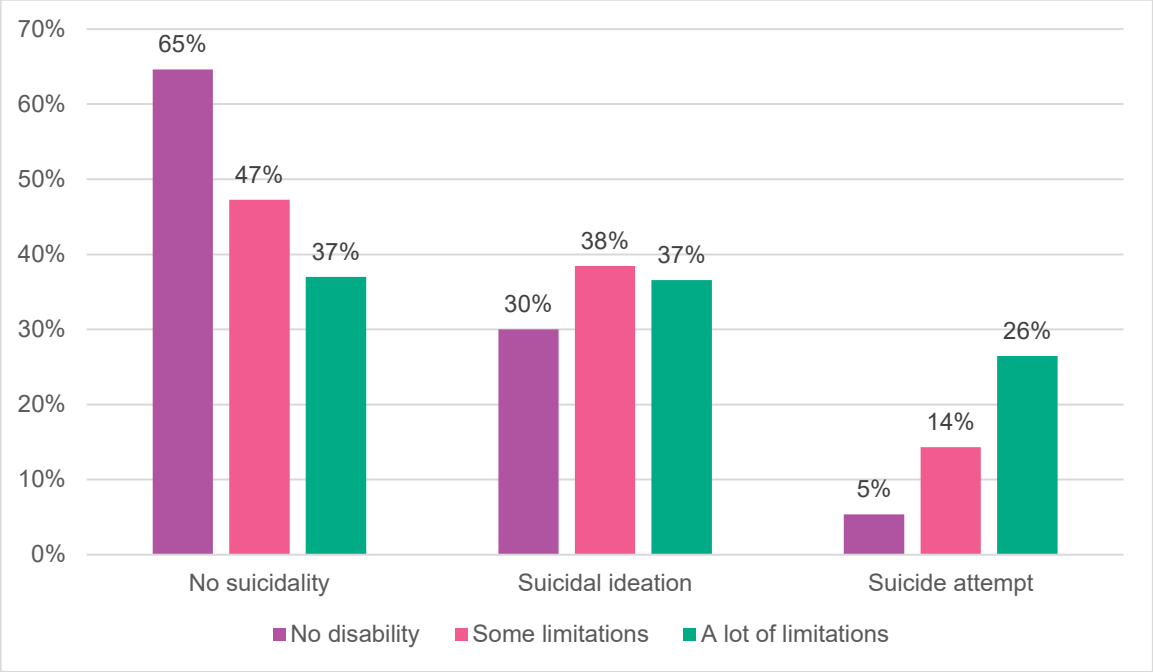
**Disability**

Disability was assessed by asking participants if their day-to-day activities were limited by a health problem or disability (with response options as "no", "a little", or "a lot"). Participants who reported limitations had nearly twice the odds of having ever experienced suicidal ideation (OR: 1.77, 95% CI: 1.56–2.00, p<.001) and nearly three times the odds of having ever attempted suicide (OR: 2.62, 95% CI: 2.20–3.12, p<.001) compared to people who reported no limitations (Appendix Tables B.24 and B.25). Participants who reported a lot of limitations to their day-to-day activities also had nearly twice the odds of having ever experienced suicidal ideation (OR: 1.73, 95% CI: 1.46–2.05, p<.001) and four times the odds of having ever attempted suicide (OR: 3.92, 95% CI: 3.24–4.75, p<.001) compared to people who reported no limitations.

Crosstabulations further illustrate the relationship between disability and lifetime experience of suicidality. One in twenty people (5%) who gambled and reported no limitations in their day-to-day life had ever attempted suicide, compared to 14% of those who reported some limitations and 26% of those who reported a lot of limitations (see Figure 10). This relationship was significant even when stratifying by experience of problems with gambling (Appendix Table B.15). These findings align to previous research showing that in the general population, disabled people are at higher risk of experiencing suicidality.[55]

[54] Only 1 of out 12 interview participants identified as lesbian, gay, bisexual or another sexual orientation.
[55] Office for National Statistics. (2023*). Sociodemographic inequalities in suicides in England and Wales: 2011 to 2021*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/sociodemographicinequalitiesinsuicidesinenglandandwales/2011to2021 - :~:text=Disabled%20people%20had%20much%20higher,4.69)%20(Figure%207). [Accessed on: 25th September 2025]

**Figure 10: Lifetime suicidality, by disability, among people who gamble**




Base: n=11,054

Disability was not discussed by stakeholders as a risk factor for gambling harms or suicidality, except to note that a large number of their service users received high-level Personal Independence Payment (PIP). Among participants with lived experience who also had a disability, gambling was highlighted as an accessible way to seek out stimulation. Financial harms from gambling could further be exacerbated if their disability also impacted their employment and income.

> *"I had a really bad car accident, which meant that I had to live with my mother, who is my biggest trigger. I couldn't move my neck. Couldn't do anything. I couldn't do any hobbies, nothing. All I could do was be on the internet, and that's when I got into internet gambling and online casinos, and that's what killed me, financially, everything."* (Woman with lived experience, aged 40+)

Some participants also mentioned previously undiagnosed neurodiversity, mostly attention deficit hyperactivity disorder (ADHD), which they linked to "dopamine seeking" and impulsive behaviours, as a risk factor for their gambling harms and suicidality. One participant mentioned that starting ADHD medication reduced their desire to gamble as well as the "negative overthinking" which led them to suicidal ideation.

**Social Grade**

Socio-economic status was assessed by classifying participants into two social grade categories based on the NRS Social Grade system.[56] This classification is based on occupation and education. The "middle class" category includes people in higher managerial, administrative, and professional occupations and those with higher education. The "working class" category includes people employed in skilled, semi-skilled, and unskilled manual occupations, as well as people who are unemployed.

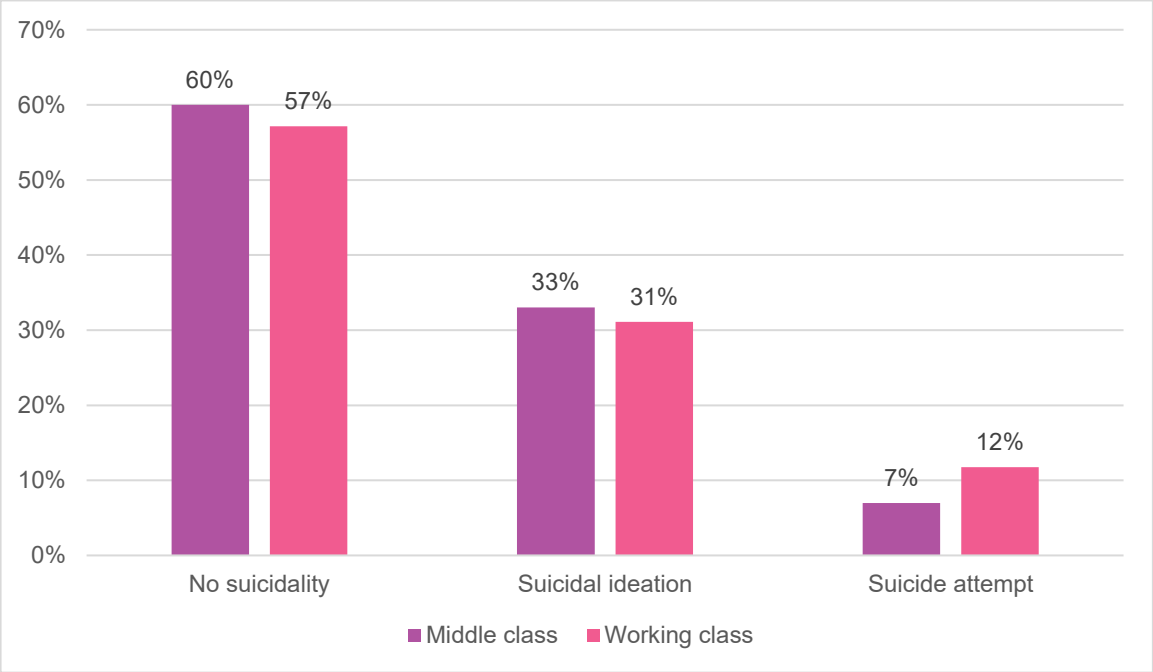
There was a significant statistical relationship between social grade and suicidality among people who gamble. Within our sample, people within the "working class" category had significantly lower odds of having ever experienced suicidal ideation (OR: 0.86, 95% CI: 0.78–0.95, p=.002, Appendix Table B.24) compared to "middle

[56] National Readership Survey. (2019). *Social Grade.* Available at: https://nrs.co.uk/nrs-print/lifestyle-and-classification-data/social-grade/ [Accessed on: 25th September 2025]

class" category but had higher odds of having ever attempted suicide (OR: 1.37, 95% CI: 1.18 –1.59, p<.001, Appendix Table B.25).

Crosstabulations further illustrate the relationship between social grade and suicidality, with one in three "middle class" people (33%) reporting having ever experienced suicidal ideation (compared to 31% of "working class" participants) and one in fifteen (7%) having ever attempted suicide (compared to 12% of "working class") (see Figure 11). This relationship was not statistically significant among people who experienced a high level of problems with their gambling (PGSI 8+) (Appendix Table B.16).

**Figure 11: Lifetime suicidality, by social grade, among people who gamble**




Base: n=11,128

While interviews did not cover the concept of social grade or class, stakeholders discussed how financial harms from gambling (such as bankruptcy, job loss, or harassment from debt collection agencies) could increase suicidality, which could be perceived by some as a mechanism of escape from financial challenges. This was also discussed by participants with lived experience, where financial losses affected their mental health and self-perception, leading to suicidality (as discussed in section 2.2.2). This could be further exacerbated when gambling harms lead to loss of employment (for instance if people committed fraud to finance gambling activities).

Additionally, stakeholders mentioned housing instability linked to gambling harms such as financial harms or relationship breakdown as a risk factor for suicidality. Participants described how housing instability could have a significant impact on mental health and wellbeing, pushing people further into gambling as a way to cope with poor mental health and leading to a viscous cycle between gambling harms and suicidality.

Conversely, people with lived experience and stakeholders highlighted that addressing financial harms from gambling, for example with a debt repayment plan, and support accessing employment or secure housing, could act as a protective factor against suicidality.

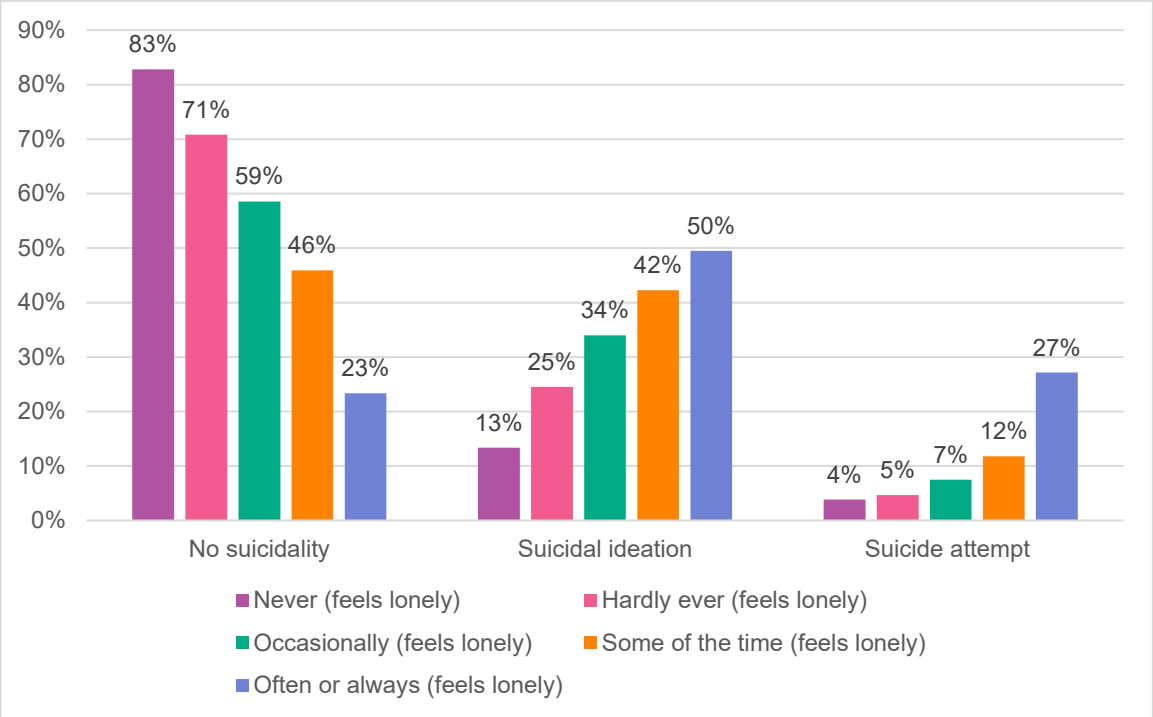
*"Even when people are in debt, where people, maybe they've got things in place already, a charity to help them manage that debt, or they've already reached out to the companies that they owe money to, and they've got a plan. That generally I think is quite stabilising for people and reduces that risk [of suicidality], even if they do have debt."* (Stakeholder)

**Loneliness**

Quantitative analysis also identified an association between loneliness and lifetime suicidality among individuals who gamble and those experiencing gambling harms. However, it should be noted that the survey measured current loneliness, whereas suicidality was measured over people's lifetime, which limits the conclusions which can be drawn from the comparison. Among people who gamble, half of those who reported feeling lonely "often or always" reported having ever experienced suicidal ideation (50%), and over one in four (27%) had ever attempted suicide (see Figure 12). This was much higher than among people who reported "never" feeling lonely (13% had ever experienced suicidal ideation and 4% had ever attempted suicide). The relationship between loneliness and suicidality was significant even when stratifying by experience of problems with gambling (Appendix Table B.17).

Higher frequency of recent loneliness was associated with a higher prevalence of lifetime suicidal ideation. People who reported feeling lonely "some of the time" and "often or always" had nearly four (OR: 3.89, 95% CI: 3.21–4.72, p<.001) and seven (OR: 6.82, 95% CI: 5.37–8.66, p<.001) times the odds of having ever experienced suicidal ideation compared to people who reported "never" feeling lonely (Appendix Table B.24). They had also nearly twice (OR: 1.82, 95% CI: 1.31–2.53, p<.001) and four times the odds (OR: 3.88, 95% CI: 2.74–5.49, p<.001) of having ever attempted suicide compared to people who reported "never" feeling lonely (Appendix Table B.25). These findings are consistent with previous research among the general population which has shown a relationship between loneliness and suicidality.[57]

**Figure 12: Lifetime suicidality, by how often people feel lonely, among people who gamble**




Base: n=11,125

Participants with lived experience highlighted three mains ways that loneliness intertwined with their experiences of gambling harms and suicidality.

They described how loneliness – sometimes caused by gambling stigma and relationship harms (such as hiding gambling from loved ones), or the loss of support networks due to the death of someone close to them – could lead to increased gambling harms and subsequently suicidality. This was due to participants experiencing harms

[57] Shoib, S., Amanda, W., Saeed, F., Ransing, R., Bhandari, S., Armiya'u, Y., Gürcan, A. & Chandradasa, M. (2023*). Association Between Loneliness and Suicidal Behaviour: A Scoping Review.* Turkish Journal of Psychiatry, 34(2), 125-132.

and suicidality after using gambling to cope with feelings of loneliness (generally alongside low mood), and/or due to participants struggling with experiencing gambling harms on their own, without support from others.

*"So, yes, I think it's that feeling of being alone in it, contributing to the suicidal thoughts and me gambling more, I suppose. But then obviously that vicariously leads to suicidal thoughts again."* (Man with lived experience, aged 18–39)

Relatedly, some people with lived experience described withdrawing from friends, family and/or their partner due to their gambling (for example, using all available time for gambling or keeping gambling a secret due to concerns about being stigmatised), which was associated with higher risk of suicidality due to isolation.

*"Yes, I became very alone. […] That's how it felt. I was more of a negative to society rather than a positive. So, there was no point in carrying on. Because of the isolated, secretiveness, that's the only voice I heard. I had no voice saying, 'Actually, [Name], you could do this, you could do that.' There was no positivity coming in there. It was all negativity because it was all coming directly from me."* (Man with lived experience, aged 40+)

Lastly, participants sometimes experienced suicidality as a direct result of loneliness. For example, participants described experiencing suicidal ideation related to feelings of loneliness after moving to a new location, or after a relationship breakdown. They subsequently used gambling to cope with these feelings of isolation.

**Other social factors**

Stakeholders and participants with lived experience outlined several other social factors which could exacerbate or protect against suicidality among people who experience gambling harms.

While family relationships, and especially the presence of children, were generally perceived as a protective factor against suicidality, the added caring responsibilities (for instance with a new child) or the loss of access to children as a result of gambling harms was linked by participants to higher risks of suicidality. Family and relationship breakdown, including divorce, as well as life-changing events, such as bereavement, was mentioned as both the cause and the result of gambling harms, and in both situations, could result in increased suicidality.

*"I could not stop. There was nothing in my life that was more important than making me want to stop, including my child. I couldn't comprehend that I'd had this child and I was actually seeing it as an inconvenience that I had to now look after something, and it was stopping me from gambling. […] [My children] are the reason why I wouldn't do those things, but to think at that moment in time the gambling was more important than them it's just horrendous."* (Woman with lived experience, aged 40+)

# 3.2 Stigma

This section is focused on the interaction between stigma related to both gambling and suicidality. This section brings together both survey and interview data to explore, in turn, the prevalence and impact of gambling stigma and stigma around suicidality.

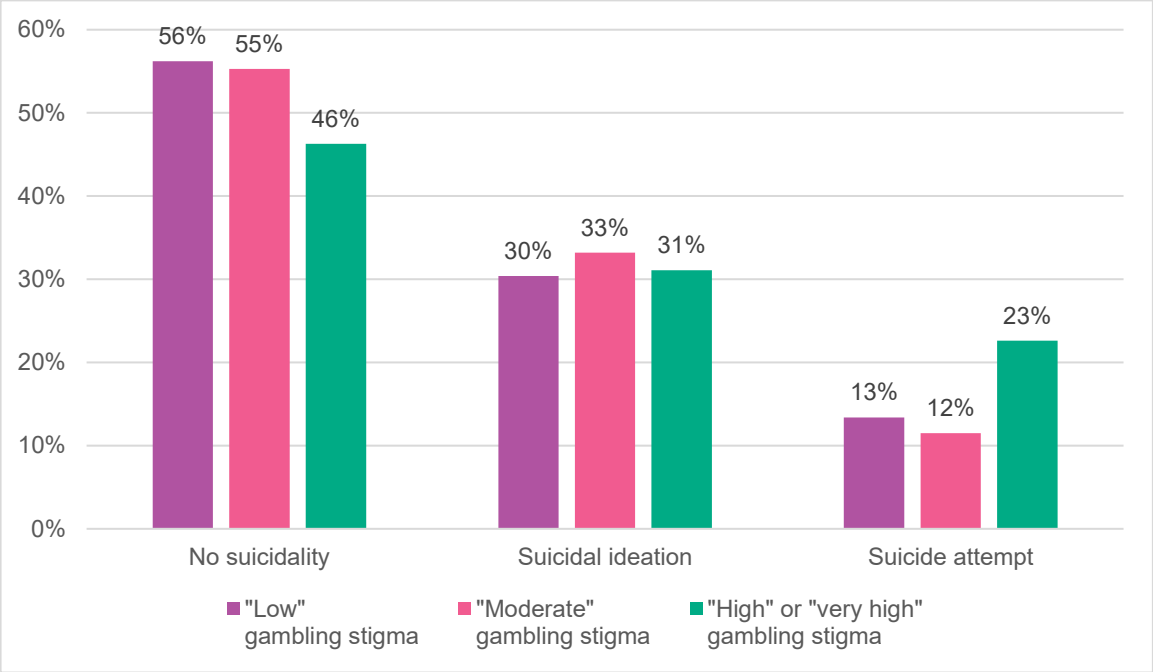
## 3.2.1. Gambling stigma

For survey participants experiencing problems with their gambling (PGSI 3+), we explored the links between gambling stigma and experiences of suicidal ideation and/or suicide attempt. Gambling stigma was measured using the Gambling Experienced Stigma Scale (GESS), a 13-item scale which provides a way of measuring the amount of gambling-related stigma someone has experienced.

Among people who experienced problems with their gambling (PGSI 3+) and had reported "high" or "very high" gambling stigma had 1.91 times the odds of having ever attempted suicide compared to people with "low" gambling stigma (95% CI: 1.27–2.87, p=.002), as shown in Appendix Table B.25. However, there was no statistically significant relation between gambling stigma and suicidal ideation among this group (Appendix Table B.24).

Crosstabulations further illustrated the relationship between gambling stigma and suicidality, with nearly one in four people (23%) who reported “high” or “very high” gambling stigma having ever attempted suicide, compared to 13% of people who experienced “low” gambling stigma (Figure 13 and Appendix Table B.18).

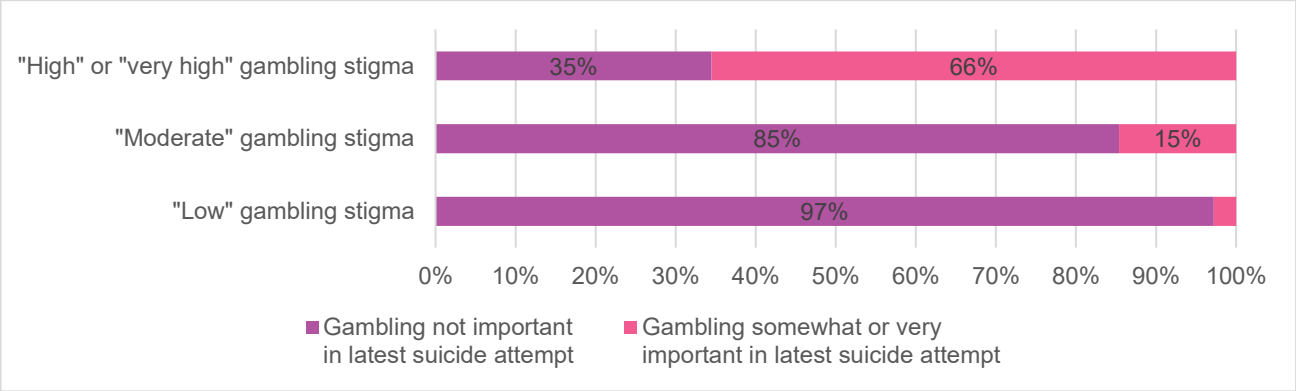
**Figure 13: Lifetime suicidality, by gambling stigma, among people experiencing problems with gambling (PGSI 3+)**




Base: n=1,184

Among survey respondents who had experienced problems with gambling (PGSI 3+) and had attempted suicide, two-thirds (66%) of people who had experienced “high” or “very high” gambling stigma reported that gambling was important to their latest suicide attempt. This was much higher than among people who experienced “low”[58] or “moderate” (15%) gambling stigma (Figure 14 and Appendix Table B.19).

**Figure 14: Importance of gambling in latest suicide attempt, by gambling stigma, among people experiencing problems with gambling (PGSI 3+)**




Base: n=194

The survey found that among people who reported that gambling was an important factor in their latest suicide attempt, 76% reported that other people judging their gambling was a ‘very important’ or ‘somewhat important’

[58] Figure suppressed as there are below five cases.

factor in their decision and 79% of people reported that shame or guilt related to gambling was a 'very important' or 'somewhat important' factor in that decision (Appendix Table B.28). In line with these findings, people with lived experience and stakeholders described how gambling stigma, both from other people (experienced stigma) and from oneself (self-stigma), could result in hiding gambling behaviours which in some cases negatively impacted suicidality due to increased isolation.

People with lived experience and stakeholders described how shame around gambling behaviour, low self-worth, and negative self-talk increased the risk of suicidality, which aligns with previous research findings.[59] Both stakeholders and participants with lived experience described how both concealing gambling from loved ones and being judged for gambling by family and/or friends could place those experiencing gambling harms at higher risk of suicidality. Participants felt there was a lack of understanding around gambling harms, and those with lived experience described experiencing judgement from friends and family as a result, being told to "just stop gambling" and to "get over it". Reasons for shame and low self-worth included lying to their friends and/or family about financial harms from gambling (including hiding the true reasons for asking for money and/or stealing from family and/or friends) and a desire to gamble despite gambling harms impacting them and those close to them.

*"[W]hen you know you need to stop it's like that's when your self-worth is on the floor and your mental health is in tatters because you've been doing it and you're lying to people and you're being deceitful. That all contributes to that ultimate thing of feeling suicidal […]"* (Man with lived experience, aged 18–39*)*

## 3.2.2. Suicide stigma

Wider research has shown how people living with mental health conditions experience stigma and discrimination due to their mental health at the structural level (for example, due to legal discrimination), at the interpersonal level (for example, negative attitudes and social exclusion) and individually, in the way they see themselves.[60] Our findings align with this; participants with lived experience described experiencing negative stereotypes around suicide being "selfish", shame around experiencing suicidality, and subsequently hiding suicidality from others.

Interviews with stakeholders and people with lived experience showed that suicide-related stigma could create a cycle of negative self-talk, leading to low self-esteem, and increasing the risk of suicidality. In some cases, people with lived experience felt that suicide stigma had a less severe personal impact than gambling stigma, emphasising that they found that people understood experiences with suicidality more easily and they could more easily relate to feelings of depression.

Similar to our findings around gambling stigma, people with lived experience sometimes concealed their experiences around suicidality. This happened due to a lack of awareness and/or negative comments around suicidal ideation and/or suicide attempt from family, friends, treatment and/or support providers. Additionally, a common theme among people with lived experience was their reluctance to upset others by sharing their experiences with suicidality, which they believed to be too much of a burden to put other people, often because they had not disclosed the extent of the gambling harms they were experiencing.

For people with lived experience, hiding experiences of suicidality at the same time as experiencing suicide stigma in the form of negative comments from others and/or self-stigma in the form of negative self-talk worsened feelings of isolation, increasing the risk of suicide:

*"There's nothing I'd done before or nothing I could do after that would benefit society. Therefore, there's no point in carrying on. That's how it felt. I was more of a negative to society rather than a positive. So, there was no point*

[59] Shipsey, F., Martin, A., Brearley-Bayliss, H., Bennetto, R., Cohen, E., Dinos, S., Lloyd, J., Penfold, K., Nicklin, L., & Chadwick, D. (2025). *Stigmatisation and discrimination of people who experience gambling harms: quantitative analysis.* NatCen on behalf of GambleAware. Available at: https://www.gambleaware.org/our-research/publication-library/articles/stigmatisation-and-discrimination-of-people-who-experience-gambling-harms-quantitative-analysis/ [Accessed on: 25th September 2025]

[60] Thornicroft, G., Sunkel, C., Aliev, A., Baker, S., Brohan, E., Chammay, R., Davies, K., Demissie, M., Duncan, J., Fekadu, W., et al. (2022). *The Lancet Commission on Ending Stigma and Discrimination in Mental Health*. The Lancet. 400;10361 *(1438–1480)*. Available at: www.thelancet.com/journals/lancet/article/PIIS0140-6736(22)01470-2/fulltext.[Accessed on: 23rd October 2025].

*in carrying on. Because of the isolated, secretiveness, that's the only voice I heard."* (Man with lived experience, aged 40+)

People with lived experience also reported feeling isolated, ashamed, guilty and/or experiencing low self-worth due to hiding suicidality (due to suicide stigma) and gambling (due to gambling stigma). To cope with these and other negative emotions, people with lived experience sometimes increased their gambling, which in some cases led to increased experiences of gambling harms and higher risk of suicide (as discussed in section 2.2.2).

## 3.2.3. Interrelationship between suicide stigma and gambling stigma

Our analysis found a complex interplay between gambling stigma and suicide stigma. People with lived experience of both gambling and suicide stigma sometimes highlighted that gambling stigma (while actively gambling) was more severe. In some cases, they described suicide as more widely understood than gambling due to generational shifts in more openly discussing mental health, and stated that because many people have experienced low moods, suicide was more relatable to people who had not experienced suicidality:

*"[W]hen I talk about the suicide, people are concerned, supportive, genuine, and want to help, and try and understand. Everyone's felt low at some point, and everyone's felt differently and had different experiences. Everyone can relate to feeling sad […] Not everybody can relate to the gambling […]"*
(Man with lived experience, aged 18–39)

In addition, reaching a point of suicidal ideation or attempt was described as a "crisis state" by people with lived experience, to a greater extent than experiencing gambling harms, which they felt accumulated over time. Participants with lived experience felt that gambling could cause harm to the friends and family of someone who gambles, whether or not they were aware of gambling (e.g., through financial harms like increasing debt). However, with suicidality, they felt that the harm to friends and family did not feel like it had occurred until the point of attempting suicide.

People with lived experience sometimes reported that it was easier to discuss past experiences of gambling harms to support others on their gambling journey, compared to finding it challenging to discuss mental health problems publicly:

*"I wouldn't really like to talk about it [mental health and suicidality] that much [...] it's not a part I want to go, hey, that's what I did. That's the past."* (Woman with lived experience, aged 40+)

# 4. Treatment and support experiences and needs among people experiencing suicidality and gambling harms

This chapter discusses experiences related to treatment and/or support among those experiencing gambling harms and suicidality. This includes formal treatment options and informal forms of support, such as from family and friends. Firstly, we explore the prevalence of accessing treatment and/or support, the types of treatment and/or support commonly used and describe the reasons why people seek treatment. Lastly, we explore enablers and barriers to accessing and benefiting from treatment and/or support that relate to people's experiences around gambling and suicidality. The chapter brings together data from the survey with people who gamble, as well as interviews with stakeholders and participants with lived experience of gambling harms and suicidality.

## Chapter four: Key findings

- NHS mental health services were the most accessed form of treatment or support by survey participants with experience of suicidality. 24% of people who had attempted suicide and 19% of people who had experienced suicidal ideation reported accessing NHS mental health services for help with gambling, including counselling or therapy both in person and face to face.
- People with experience of suicidality and gambling harms who took part in the survey and interviews frequently sought and accessed treatment and/or support. It was common to access more than one form, which included, for those with lived experience who took part in interviews, formal and informal support.
- Among those who experienced gambling harm, associated moments of crisis – including experiences with suicidality – created critical points to access and engage with support. These however were moderated by peoples' readiness to access treatment and support and make changes.
- Those experiencing gambling harms and suicidality often had complex personal circumstances which could result in complex support needs and, in some circumstances could prevent people accessing support and influence the effectiveness of some types of treatment, such as group interventions.
- Experiences of one-to-one therapy were mixed. Some participants found that it supported their recovery from gambling harms and suicidality through being able to address complex psychological needs and provided them with tools to regulate emotions and behaviour. Where participants did not find one-to-one therapy helpful, this was attributed to being unable to explore the co-occurrence of gambling and mental health issues and not forming a good therapeutic relationship.
- Experiences of self-stigma and wanting to hide gambling and suicidality due to shame could act as a barrier to treatment and support as well as influencing how people interacted with it.
- Formal aftercare/longer-term recovery support or sustained support networks long-term supported participants to mitigate suicidal thoughts as they could remind people of routes to recovery and support them to no longer see suicide as the only option when thinking about gambling and gambling harms.

Throughout this chapter, all survey findings relate only to people experiencing both problems with gambling (PGSI 3+) and who have attempted to stop or reduce their gambling in the 12 months leading up to the survey. Stakeholders and people with lived experience discussed factors that both enable and act as barriers to

accessing treatment and/or support, and the effectiveness of that support. These included practical factors (including location, cost, and delivery of services), how people perceive the effectiveness of treatment, and experiences of gambling stigma, in particular related to gender diversity in support settings and the balance between visibility and stigma in community settings. Previous research has identified these factors as key barriers to treatment and/or support for those experiencing gambling harms more generally and it is clear that those who also experience suicidality have many similar experiences to the general population of people experiencing gambling harms. We have focused this chapter on factors and experiences related to both gambling harms and suicidality.[61,62,63]

# 4.1 Journeys accessing treatment and/or support

The majority (59%) of people experiencing problems with their gambling (PGSI 3+) and who tried to reduce their gambling in the past year had accessed treatment and/or support for gambling (Appendix Table B.20.a). There was, however, no significant relationship between access to treatment and/or support in the past year and experience of lifetime suicidality (Appendix Table B.20.a). Among those respondents who had attempted suicide, 90% of those who reported that gambling was somewhat or very important in their latest suicide attempt had accessed treatment and/or support while 35% who reported that gambling was not important had done so ($p<.001$, Appendix table B.20.b). However, these findings should be approached cautiously due to time-frame mismatch; treatment and/or support accessed was only measured for the last year, whereas suicidality was measured over people's lifetime. This relationship may also reflect that those who have greater support needs seek treatment and/or support more readily.

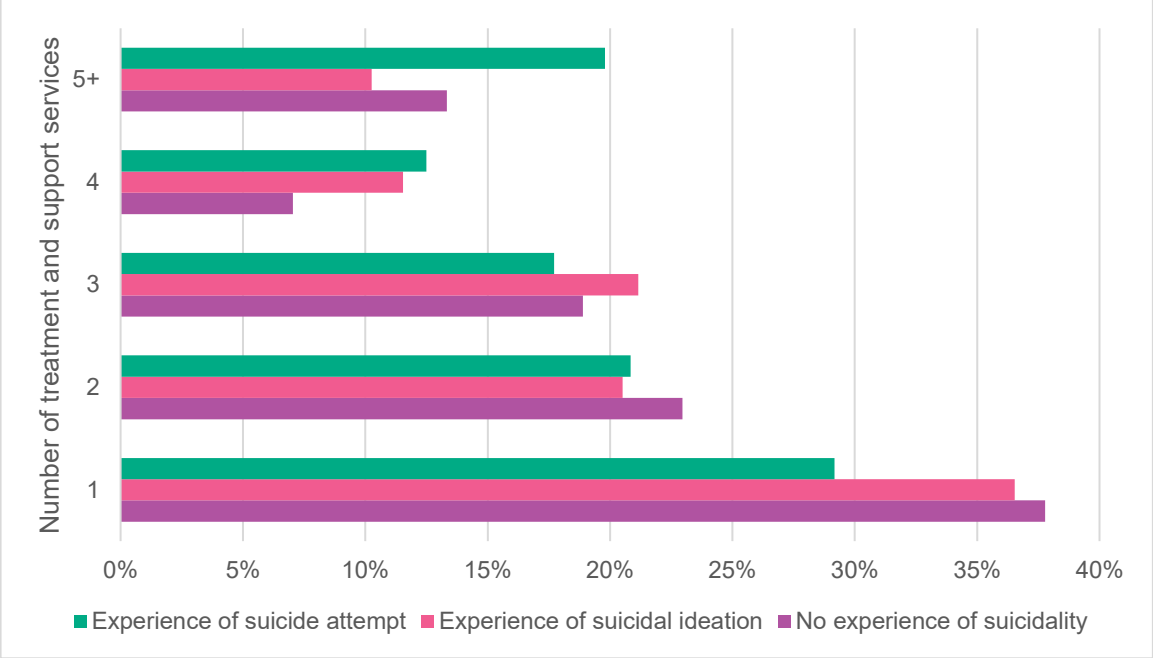
Among those who had tried to reduce or stop gambling and had accessed treatment and/or support, people had most commonly accessed only one form of treatment and/or support, regardless of experience of suicidality. However, a greater proportion of those who had experienced suicidality had accessed multiple forms of treatment and/or support; 20% of those who had ever attempted suicide, 10% of those had ever experienced suicidal ideation, and 13% of those with no experience of suicidality accessed five or more treatment and/or support services (Figure 15 and Appendix Table B.21).

[61] Lloyd, J., Penfold, K., Nicklin, LL., Martin, I., Martin, A., Dinos, S. & Chadwick, D. (2025). NatCen, the University of Wolverhampton, and Liverpool John Moores University on behalf of GambleAware. *Stigmatisation and discrimination of people who experience gambling harms in Great Britain: Synthesis report.* Available at: https://www.gambleaware.org/media/qapn2wxq/synthesis-report_formatted_final.pdf [Accessed on: 1st October 2025]

[62] Brown, G., Trebilcock, J. & Harding, N. (2023). *Lived experience of gambling, gambling related harms, and crime within ethnic minority communities*. Available at: https://howardleague.org/wp-content/uploads/2023/04/Howard-League_Report_Lived-experiences-of-gambling-gambling-related-harms-and-crime-within-ethnic-minority-communities_-April-2023.pdf [Accessed on: 25th September 2025]

[63] Kerr, J., Lynch-Huggins, S., Thompson, B., Dinos, S., Khambhaita, P. & Windle, K. (2019). NatCen on behalf of GambleAware. *A Needs Assessment for Treatment and Support Services.* Available at: https://www.gambleaware.org/media/onhapfnn/a-needs-assessment-for-treatment-and-support-services.pdf [Accessed on: 1st October 2025]

**Figure 15: Number of types of treatment and/or support services accessed in the last year, by lifetime suicidality, among people experiencing problems with gambling (PGSI 3+) who have tried to reduce their gambling and had accessed services**




Base: n=522

All interview participants with lived experience had accessed treatment and/or support at some point in their journey with gambling and had often accessed multiple forms when seeking support for both mental health and gambling harms.

All interview participants also had sources of treatment and/or support available to them at the time of the interview, to ensure that they could safely participate in the research.[64] The limitation of this approach is that our qualitative findings presented in this chapter do not include the voices of people who have not accessed treatment or support. This limitation is discussed further in our concluding chapter.

## 4.1.1. Types of support accessed

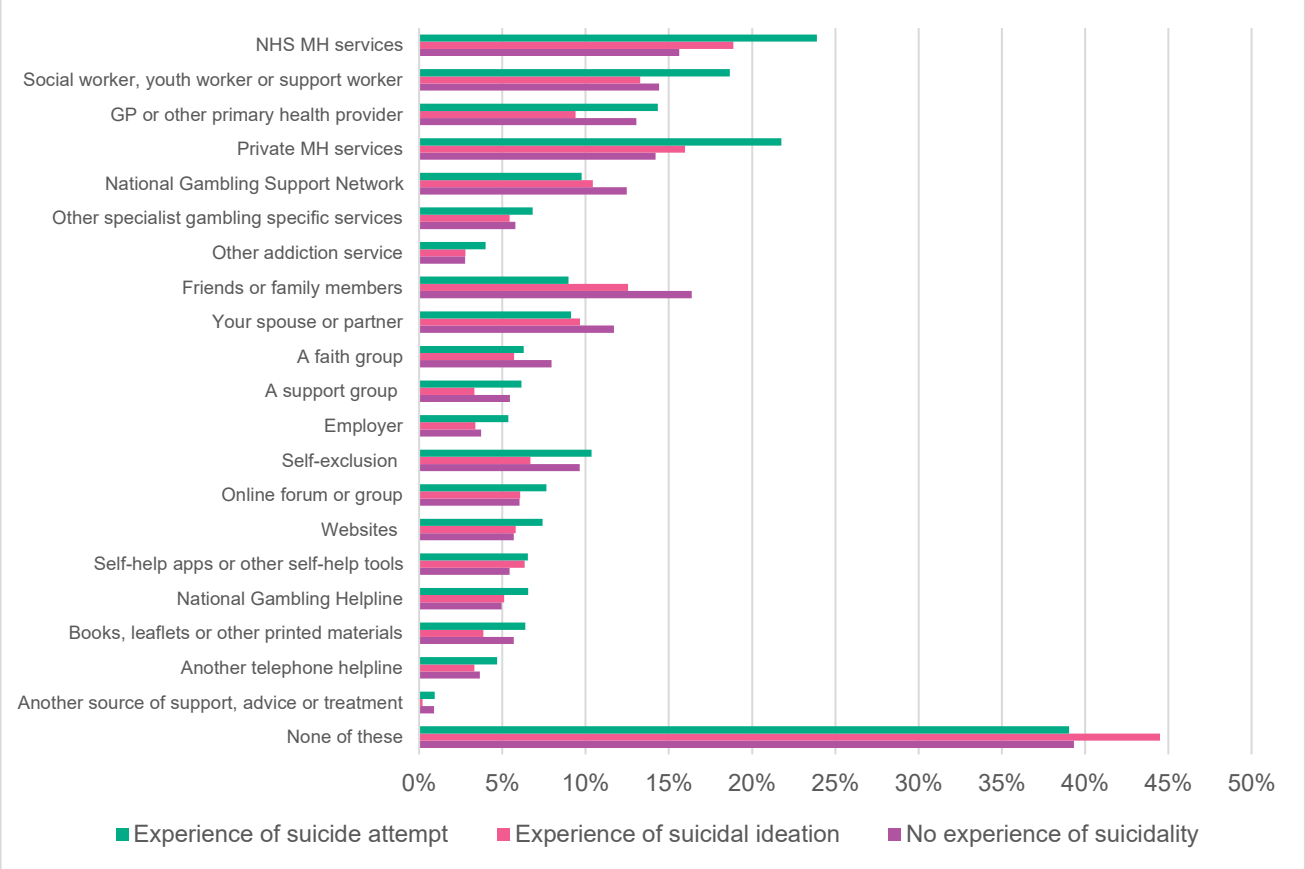
The following section examines the types of treatment and/or support services accessed by people with experience of gambling harms and explores in what way this was influenced by suicidality. Overall, participants who accessed treatment and/or support for gambling used a variety of services, including more formal and structured treatments and more informal support.

Although a proportion of people experiencing problems with their gambling (PGSI 3+) and who tried to reduce their gambling in the past year did not access any form of treatment and/or support, the types of services accessed among those who did varied for those with and without experiences of suicidality – as detailed in Figure 16 (Appendix Table B.22.a). NHS mental health services were the most accessed form of treatment or support by survey participants with experience of suicidality. 24% of people who had ever attempted suicide and 19% of people who had ever experienced suicidal ideation reported accessing NHS mental health services for help with gambling, including counselling or therapy both online and face to face. 16% of people who had no experience of suicidality had accessed this form of treatment. Similarly, 16% of people with no experience of

[64] Please refer to Appendix B for further details on qualitative recruitment and ethical considerations.

suicidality had accessed support from their family and friends. Comparatively, 13% of those who had ever experienced suicidal ideation and 9% who had experience of suicide attempt reported doing so.[65]

**Figure 16: Types of treatment and/or support services accessed in last year, by lifetime suicidality, among people experiencing problems with gambling (PGSI 3+) who have tried to reduce their gambling**




Base: n=887

The most common form of treatment and/or support accessed among those who experienced problems with their gambling (PGSI 3+) who tried to reduce or stop gambling and linked their latest suicide attempt to gambling was private mental health services (42%). The most commonly accessed form of treatment and/or support for those who reported that gambling was not important in their latest suicide attempt was self-exclusion (11%), although the majority (65%) had not accessed any support (Appendix Table B.20.b).

Participants with lived experience who took part in interviews commonly accessed multiple different forms of treatment and/or support – both for their experiences of gambling and those related to their mental health and experiences of suicidality. The types of services accessed were often similar across people with lived experience; support from family, GP services, and residential support were all common. While some participants reported that suicidality, especially a suicide attempt, prompted them to seek treatment and/or support for their mental health and gambling, others reported having sought treatment and support for gambling at various points throughout their journey.

Those with lived experience had often also accessed informal forms of support which generally involved support from family and friends – sometimes earlier on in their journey and preceding access to more formal treatments. Other forms of support which were commonly accessed were support groups, for example Gamblers

[65] In response to the question in the survey asking which treatment and support services respondents had accessed, those participating could select all options that applied to them. Therefore, people could select more than one type of service or support and percentages for all are greater than 100%.

Anonymous, and gambling-specific helplines. Self-exclusion tools were often used before and then alongside formal treatment, such as counselling interventions, group and individual support, and residential treatment services. Furthermore, some participants had accessed treatment services multiple times and tried different types or sources of support prior to finding one, or several, that were effective for them (discussed further in section 4.2).

As well as treatment and/or support which had a specific focus on gambling, some participants with lived experience had also accessed NHS services for support with their mental health, including experiences of suicidality. This was commonly through their GP or specific mental health teams and included being prescribed medication. Some of those interviewed additionally described receiving support for suicidality involuntarily in a hospital setting and on an emergency basis following suicide attempts. Contrary to experiences around gambling specific treatment and/or support, which were often accessed in conjunction with one another, involuntary support for suicidality often occurred in isolation, without facilitating longer term support or treatment. For instance, some people had the opportunity to access NHS mental health crisis or psychiatric services but ultimately declined to do so. The barriers people faced accessing mental health services are discussed in section 4.1.4.

## 4.1.2. Reasons for seeking treatment and/or support

Interviews with people with lived experience and stakeholders identified that experiences of significant gambling harms, including suicidality, and returning to gambling after a period of abstinence were key points at which people sought treatment and/or support.

People with lived experience and stakeholders agreed that experience of significant gambling harms often led people to seek treatment and/or support – while also being a risk factor for suicidality.[66] Stakeholders described that these 'significant' experiences often involved financial harm, for example becoming in debt and having experiences with debt collectors. Stakeholders specifically described how these significant experiences of harm created pressure and left people at a point of crisis or "rock bottom", leading people to feel that they had limited options other than seeking support.

*"Then I was at rock bottom because I thought there's no way of me getting back from this if I'm not… I couldn't get any lower. Then that's where I were [sic] broken, speaking on the phone, crying to strangers, ringing everybody, saying, 'I need help. Help me, please […]"* (Man with lived experience, aged 18–39)

Participants with lived experience further explained how significant gambling harms created feelings of worthlessness, being stuck, and feeling overwhelmed. Such experiences both led people to, and exacerbated, suicidality, which in turn prompted people to seek support, for example using helplines.

Participants with lived experience described that gambling after a period of abstinence could result in a sense of desperation and vulnerability which then led to them seeking treatment and/or support. In addition, people with lived experience both sought treatment and were treated involuntarily through NHS emergency services following a suicide attempt. This, however, did not often facilitate access to longer term support, which participants cited as being due to them wanting to hide their gambling, feeling ashamed, or services not providing appropriate support, for instance providing only physical treatment or brief periods of support after discharge from hospital.

Stakeholders noted that these moments of crisis with gambling harms, including suicidality, relied on internal motivation and readiness to make self-motivated changes in order to access treatment and/or support. Participants with lived experience explained that they sought treatment when they felt ready to reach out and address the gambling harms they were experiencing and had made their own decision to do so.

*"I think a lot of people who have gambled will say it doesn't matter how many times people tell you, you have to stop, you have to do it yourself. You have to want to do it yourself. There was not a single person who could tell*

[66] The impact of significant and escalating gambling harms on suicidality is discussed in Chapter 2.

*me that I had to stop gambling or else that would have made me change my mind. It had to be my decision."* (Woman with lived experience, aged 40+)

Without this, people can go through a process of reaching out for support during moments of distress – sometimes several times – and then disengaging. This, however, places the onus on individuals and it is essential to acknowledge that barriers such as stigma and structural barriers may disproportionately affect some people and groups. It is therefore essential to overcome these barriers to ensure equitable access.

## 4.1.3. Enablers and barriers to accessing treatment and/or support

Several key factors impacted access to treatment and/or support for those experiencing suicidality. These were often individuals' support networks, complex personal circumstances of individuals accessing the support, stigma, risk thresholds of services themselves, and the responsiveness and accessibility of services.

**Support networks**

People with lived experience and stakeholders identified that an individual's support network impacted their access to treatment and/or support. Family and networks were seen by stakeholders as playing a key supportive role in many cases, such as by researching support options and making referrals. In some instances, experiences with suicidality encouraged people with lived experience to confide in their family about gambling harms, which enabled their access to further support (see section 4.1.2).

*"It's a kind of, let's look at other options, so that's when I decided to tell my partner – well, wife – tell my close family members. I cut all ties with anybody I'd linked to gambling. I got in touch with [gambling-specific treatment service], so I decided to get help rather than try to solve everything on my own, if that makes sense*." (Man with lived experience, age 40+)

However, in other cases, family and support networks could act as a barrier. Some people with lived experience, described being dismissed when they tried to discuss their experiences of gambling with their family, and for other people, stigma prevented them from confiding in family and friends (see section 3.2).

**Complex personal circumstances**

Furthermore, complex personal circumstances such as mental health issues, housing instability, and substance use were cited as key barriers to accessing treatment and/or support. People with lived experience highlighted that housing instability specifically contributed to this, particularly when attempting to access residential treatment where not having secure housing was a barrier due to safeguarding processes. Having insecure or temporary housing exacerbated experiences of suicidality as the environment could feel unsafe and increase low mood. Stakeholders, however, reported that while complex personal circumstances can prevent people from accessing support in the community, those who are able to access residential treatment may experience a reduced influence of these factors, such as a relief from pressures of daily living, leading to a chance to address and reduce suicidal ideation.

*"[I]f we brought them into somewhere which is safe, secure, three meals a day, accommodation, we cook, clean, and everything for you, you just need to look after yourself, then mentally, you have the chance of breaking that suicidal thought pattern".* (Stakeholder)

**Stigma**

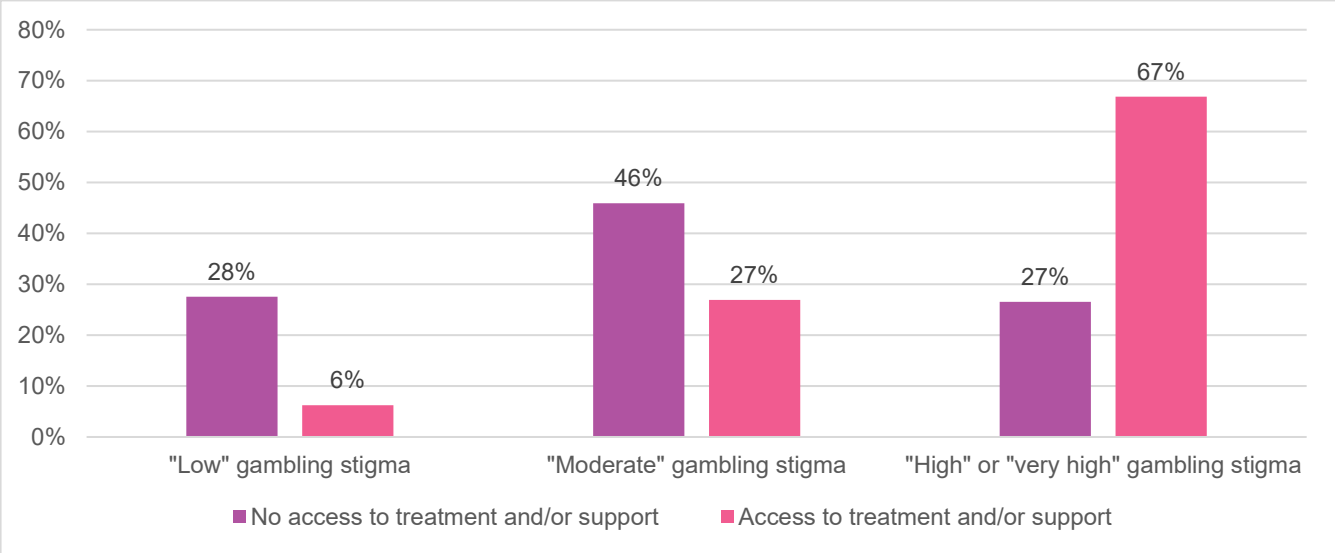
Interview participants and stakeholders indicated that stigma related to both gambling and suicide, was a barrier to accessing treatment and/or support. For instance, people with lived experience mentioned that self-stigma, driven by feelings of shame and wanting to prevent other people from finding out about their experiences, prevented them from accessing support through community mental health services following a suicide attempt.

*"I didn't want people to find out what had happened, really. The element of shame around it."* (Man with lived experience, aged 18–39)

Furthermore, stakeholders noted that people from minoritised ethnic communities face particular barriers to treatment and/or support due to stigma. They identified that it was important to increase the visibility and

peoples' awareness of services to aid access to treatment and/or support. However, they also acknowledged that this did not completely address feelings of shame associated with gambling and not wanting to be seen attending treatment among minoritised ethnic communities. This contradicts our survey findings, where gambling stigma was higher among people who had accessed treatment and/or support to reduce or stop their gambling than among people who had not accessed treatment and/or support (Figure 17 and Appendix Table B.23). Participants with lived experience who took part in interviews did not identify that experiences of stigma led to increased access to treatment and/or support and therefore did not provide additional insight into this. However, previous evidence on gambling harms more broadly suggests that stigmatisation and discrimination are associated with psychological distress, negative impacts on mental health, relationships, and occupational opportunities and those who experience more gambling harms are more likely to access treatment and/or support.[67] As discussed in the following section on enablers and barriers to effective treatment and/or support, stigma further impacted peoples' experiences once they gained access to services.

**Figure 17: Use of treatment and/or support services, by gambling stigma, among people experiencing problems with gambling (PGSI 3+) who have tried to reduce their gambling**




Base: n=956

### Risk thresholds

People with lived experience and stakeholders identified that support services themselves enabled or created barriers, depending on their referral procedures, risk thresholds, and approach to managing suicidality. Gambling, mental health, and social support services' thresholds for risk of suicide attempt and response to this reportedly differed between services and was not uniform, which influenced whether or not people with these experiences could access them. In the case of residential gambling support, stakeholders discussed how suicidality could enable access more quickly or easily, with the aim of managing risk by providing treatment and a safe environment, as soon as possible.

Some services, including NHS mental health services, were reported to have thresholds for risk and complexity that restricted access to people with suicidal ideation or behaviours. For example, stakeholders noted that some services do not offer support to people experiencing suicidality where their risk is too high at the point of access due to needing these circumstances to be more stable prior to accessing treatment. Stakeholders, however, did not know the processes of those organisations referred to. Conversely, people with lived experience noted that suicidality was a barrier to accessing support through the NHS due to their experiences of both suicidality and gambling being deemed not severe, frequent, or recent enough.

[67] Lloyd, J., Penfold, K., Nicklin, LL., Martin, I., Martin, A., Dinos, S. & Chadwick, D. (2025). *Stigmatisation and discrimination of people who experience gambling harms in Great Britain: Synthesis report.* NatCen, the University of Wolverhampton, and Liverpool John Moores University on behalf of GambleAware. Available at: https://www.gambleaware.org/media/qapn2wxq/synthesis-report_formatted_final.pdf [Accessed on: 1st October 2025]

*"[I]f somebody has made an attempt and it is simply because they're hopeless, helpless, got nowhere to go, we wouldn't then say, no, you can't come in. We would be right, okay, let's bring you in as soon as possible. Almost like control the controllable. We can't control everything else, but you're actually more safer [sic] in our care than you are out in the community. But there are some services that would deem that too risky and would want a period of stability. But how do they get a period of stability […] when their life is just chaotic?"* (Stakeholder)

*"If you mention suicide with the [NHS mental health service], they'd go, 'No, we can't help you. You're too complicated.'"* (Woman with lived experience, aged 40+)

At the same time, people with lived experience and stakeholders explained that NHS services, particularly GPs, often lacked knowledge and understanding about gambling and gambling harms. For example, participants reported missed opportunities from GPs and other professionals to ask about problems with gambling, unlike the common practice of asking about drug or alcohol misuse, and/or to direct people to appropriate gambling support. This aligns with previous research, which shows that gambling harms are rarely recognised by professionals.[68] Instead, participants found it extremely helpful to be referred to a counselling service specialising in addiction or gambling.

*"I would not be able to pinpoint a single place locally that I could go to, other than my GP, but what do they know? They don't know anything about gambling harm. I sit in the waiting room when I take my children for jabs and things. There's not a single thing on any of their noticeboards about gambling harm, nothing. Weight loss, yes. Mental health, yes. Support groups for mums, yes. Nothing about gambling."* (Woman with lived experience, aged 18–39)

**Responsiveness and accessibility of services**

Lastly, people with lived experience and stakeholders highlighted the importance of services being accessible at the point when people with experiences of gambling harms and suicidality are ready to access treatment and/or support. Participants with lived experience highlighted that information about treatment and/or support for gambling was easily available online, albeit only when they actively searched for this themselves. In addition, people with lived experience noted that it was important to them when experiencing suicidality and gambling harms that support, specifically helplines and support groups, was available 24 hours. In some instances, they felt that at times when they were experiencing suicidal ideation, having instant access to support and some form of human connection was important, and these experiences were not always during regular working hours.

*"Definitely instant connection […] I'd think, oh God, I feel this is making me have suicidal ideation. Not one of the times when I attempted to take it. If I knew that I could have picked up that phone and a human being would talk to me then, a bit like a gambling Samaritans line, because a lot of the lines, even GambleAware and GamCare, it's instant."* (Woman with lived experience, aged 40+)

Relatedly, short waiting times for assessments and treatment were considered by stakeholders as being important to maintain the internal motivation of people who seek treatment and/or support.

*"Then I think we've noticed - as a service - when people have stopped, it's really important to keep that momentum going, I guess, so they're not waiting too long for support, because I think sometimes, that, waiting too long, again, people lose that motivation."* (Stakeholder)

For some people with lived experience, services were quick to respond after they were referred. However, where people experienced long waits to access support and services did not contact them when planned, participants found this distressing, felt uncared for, and felt that services were lacking in empathy when they felt vulnerable due to gambling harms and suicidality.

[68] Bennett, M., Spencer, S., Hill, S., Morris, S., McManus, S., & Wardle, H. (2025). Gambling behaviour. In Morris, S., Hill, S., Brugha, T., McManus, S. (Eds.), *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4.* NHS England.

## 4.2 Enablers and barriers to effective treatment and/or support

This section presents findings on the role of personal motivation, emotional regulation tools, complex needs and stigma in the effectiveness of treatment and/or support for gambling harms and suicidality. In general, the most appropriate form of treatment and/or support for people with lived experience of gambling harms and suicidality was influenced by a wide range of individual factors, with no clear findings on the most appropriate types of support.

As discussed in the previous section, people with lived experience and stakeholders emphasised that people experiencing gambling harms needed sufficient personal motivation to participate in treatment and recovery. Stakeholders described some participants in treatment as being "ambivalent" towards their recovery, and having not fully decided whether they wanted to change their gambling behaviour. In the case of suicidality, stakeholders felt that participants could be in a state of distress, which could preclude them from engaging with community-based or group therapies. However, stakeholders recognised that personal motivation needed to be balanced with effectively reaching those experiencing gambling harms and suicidality before they experienced high levels of harms.

Stakeholders and people with lived experience also identified how complex needs (multiple overlapping personal issues, such as gambling harms, latent mental health issues, substance use issues and material deprivation) could impact the efficacy of treatments. Stakeholders felt that holistic treatment approaches which address these overlapping issues should be provided as a best practice to address complex needs. People with lived experience also described their general material conditions outside of treatment as directly determining its efficacy. Participants reported that holistic treatment approaches (for example support with severe financial harms caused by gambling such as bankruptcy and homelessness), were often essential components to their treatment and important to their recovery:

*"[Suicidal thoughts] didn't stop until I got housed, really permanently… I needed stability… You can be told all the time in the world, do activities, make yourself feel better. If your home life is you haven't got a tap and you can't make a cup of tea… it's very hard"* (Woman with lived experience, aged 40+)

Both people with lived experience and stakeholders further identified stigma from both gambling and suicidality as a barrier to the effective treatment of gambling harms and suicidality. Some participants described suicidality stigma as interacting with gambling harms stigma, for example not wanting to discuss suicidal ideation that was occurring as a result of financial harm and criminality during treatment. People with lived experience described finding it difficult to open up about their experiences of suicidality and not having the means to effectively communicate how they were feeling with others.

People with lived experience and stakeholders discussed the positive and negative elements of different treatment approaches for people experiencing both gambling harms and suicidality, including one-to-one therapy, group support, and residential treatment.

**One-to-one therapy**

Participants had mixed experiences with one-to-one therapy, with efficacy being predicated on the ability of therapy to address underlying trauma and gambling harms concurrently. Some participants with lived experience found that one-to-one therapy allowed for both self-exploration of underlying psychological issues impacting gambling harms and suicidality, especially experiences of trauma, and also provided the tools for emotional regulation which helped to reduce their reliance on gambling. Practices learned in therapy, such as mindfulness and cognitive behavioural therapy (CBT), were described as both a way to limit gambling activity and mitigate mental health issues and experiences with suicidality. Some participants highlighted how learning how to talk openly about suicidal ideation gave them a voice and allowed them to release "mental pressure".

*"[O]ne-to-one talking did help me a fair bit because it allowed me to explore why I was gambling in the first place and what it was... How it was serving me. I think gambling, I suppose, can be seen as a medication and it's like, why am I actually taking this medication? Is it actually going to help me anymore?"* (Man with lived experience, aged 18–39)

Some participants with lived experience described having partially positive experiences of one-to-one therapy. In these instances, one-to-one therapy helped participants to either better understand their mental health, including suicidality, or helped to reduce their gambling, but not both of these things concurrently. Some participants were able to better understand their personal psychology and relationships but were not able to stop or reduce their gambling. For others, one-to-one therapy was oriented around the practicalities of reducing gambling but did not allow for exploration of underlying or co-occurring mental health issues, including suicidality. Some participants also found that not being able to form a good connection with their counsellor was an obstacle to them being able to address their experience of gambling harms and suicidality.

**Group support**
People with lived experience felt that group settings could be very effective environments for recovery. Participants reported that it was helpful to be in a non-judgemental environment where the focus was not solely on them and where people had similar experiences of gambling and suicidality. Being in an environment where they did not feel judged reduced feelings of self-stigma and made it easier to discuss suicidality. Some participants highlighted the helpful aspects of Gamblers Anonymous (GA) meetings in particular, which was described as having a culture of honesty that enabled some participants to share their experiences of suicidality which they had previously kept secret from family and friends, or when receiving support.

Those experiencing gambling harms and suicidality often had complex personal circumstances which could result in complex support needs. In some circumstances, this could influence the effectiveness of some types of group treatment, due to this group being more likely to be in a state of distress or vulnerability. This could mean that for some individuals, community-based or group therapies were less appropriate. Participants also reflected on the effect that gender played in group therapies and highlighted the importance of both mixed-gender and gender-specific support groups. For instance, some male interview participants with lived experience shared that they were not comfortable openly discussing gambling or mental health issues with women. Conversely, women with lived experience highlighted instances where they were the only woman in a group setting and where they felt as though they had to “act like a man to fit in”. In these instances, they also felt they were not able to discuss their gendered experiences of life and health more generally. This exacerbated feelings of low self-worth and not fitting in in the group setting.

**Residential support**
For participants who had experienced high levels of gambling harms, residential treatment was often the preferred option and some participants described how residential treatment allowed a holistic support approach which included receiving support for both their mental health and gambling. Stakeholders reflected on what facilitated effective treatment in a residential setting, emphasising the importance of making people with lived experience comfortable, both socially and physically. Physical comfort included ensuring comfortable beds, a pleasant residential setting and sufficient privacy, as to not be overheard in therapy sessions. Social comfort included creating a good atmosphere for clients, where they do not have to fear embarrassment and fostering community and communication between clients. Stakeholders felt as though all of these aspects reduced the risk of suicidality for those in residential treatment.

*“We want them to feel comfortable to share uncomfortable things […] environment is key. If somebody feels comfortable in their physical environment and with their peers… then you’ve got the perfect setup […] They'll probably say they'd learn as much from playing pool […] and conversations[…] than in any session with a therapist[…] that’s the beauty of being in a residential setting[...] it dramatically brings [suicidal ideation] down” (Stakeholder)*

Some people with lived experience felt there was room for support services to work together better and that this would help address the complex needs of those seeking support for gambling harms. Both stakeholders and people with lived experience felt that NHS and local services were not properly resourced. Counselling received through a GP was singled out as being the least effective, with participants describing their experience as a “tick-box” exercise and not a sufficient assessment of their needs around mental health and suicidality.

## 4.2.1. Longer term recovery

When discussing continued “recovery” after treatment, stakeholders emphasised the importance of longer term recovery to sustain progress made during treatment. Some stakeholders who provided residential treatment,

recognised that their programmes were primarily concerned with addressing gambling behaviour and suicidality during the residential stay and that attention was needed on preparing people for post-treatment life and the risk of being "triggered by everyday" occurrences. To this end, people with lived experience and stakeholders emphasised the importance of cultivating a recovery network to continue one's recovery after treatment. Having a strong support network, made up of family, friends, gambling support organisations and broader community was seen as a way to diminish the likelihood of "relapse" and further gambling harms.

*"Speak to people and it will help, and get a support network. There's nothing worse than being alone because you're never going to be able to get out of it yourself, unfortunately, you're not. The multiple, two, three times that I'd stopped, there was a reason I went back, and that's because I did it on my own."* (Man with lived experience, aged 18–39)

Having a support network was also seen as a way to mitigate against future experiences of suicidality, given that "relapse" was described as a significant risk factor in suicidality (see Chapter 2). Participants with lived experience described family and friends supporting them to keep busy through days out or by making time to do activities. Participants also described personal benefits from engaging with a wider community, such as religious congregations.

Gambling support organisations also provided the opportunity to build relationships and ongoing peer support to maintain an enduring recovery. Participants with lived experience stated that this helped them go through difficult life circumstances such as divorce and bereavement, or more frequent triggers for gambling such as pay day. Participants also pointed to the value of forms of longer-term recovery support such as periodical check ins from support organisations following treatment. Some participants felt this kept them "accountable" during their ongoing recovery. Participants felt as though continued gambling support from such organisations mitigated suicidal ideation through preventing them from seeing suicide as the only option when thinking about gambling and gambling harms.

# 5. Conclusion and recommendations

## 5.1 Summary of findings

This research has drawn on a nationally representative online survey of people who gamble, conducted in October 2024, consisting of 11,646 participants, interviews with people with experience of both gambling harms and suicidality, and interviews with stakeholders involved in the provision of treatment and/or support for gambling. This exploratory research was intended to build evidence to fill current research gaps and idea key areas for further research, including related to gambling harms support services. This study has several strengths, including the survey being a large and nationally representative sample, and the use of validated measures of suicidality and gambling stigma. In line with previous research,[69] it has re-iterated the complex multi-directional relationships between gambling harms, mental health, and suicidality. It has provided further exploration of the complex multi-directional pathways between these experiences. It has also identified several key factors which could lead to experiences of suicidality among those experiencing gambling harms which has allowed us to identify critical points for intervention. This research has also added to the evidence base on the experiences of different demographic groups. It has shown that although age, gender, ethnicity and social grade are associated with suicidality among people who gamble, the relationship is not significant among people who experience high levels of problems with gambling (PGSI 8+). Importantly it emphasises that those experiencing gambling harms who identify as LGBTQ+ or are disabled have a higher prevalence of suicidal ideation and/or attempt. This research has also helped to close the evidence gap around people's experiences of treatment and support, and has informed emerging best practice for supporting individuals affected by both gambling harms and suicidality. Findings from qualitative interviews have also added insights on evidence gaps in relation to treatment and support.

The following section summarises these key findings, before discussing limitations and recommendations for future research, service provision and policy.

**The relationship between gambling, mental health and suicidality**

Overall, one in five (22%) people who reported high levels of problems with gambling (PGSI 8+) had attempted suicide in their lifetime, and most of this group (65%) linked their latest suicide attempt to gambling. Our research indicated that the pattern of gambling participation most associated with suicidality among people who reported gambling in the last 12 months was combination of gaming and 'other' gambling, with over one in three (37%) people in this category of gambling participation reporting suicidal ideation in their lifetime. However, when stratifying for PGSI scores, the relationship between patterns of play and suicidality was not statistically significant for people experiencing high levels of problems with their gambling (PGSI 8+). Our qualitative data showed a complex relationship between gambling harms and suicidality. For some, gambling to cope with difficult life events (such as bereavement) or poor mental health (such as low mood or suicidality), led to gambling harms. However, in other cases, gambling harms occurred following changes in financial circumstances or gambling patterns. For some gambling harms, such as financial losses, debt and housing insecurity, then contributed to suicidality through people feeling hopeless and unable to see a way out of their situation.

We identified that efforts to stop or reduce gambling could be a high-risk point for experiencing suicidality. While some participants highlighted that stopping gambling had a positive effect on their mental health, others experienced negative impacts on suicidality. This was particularly evident in relation to experiencing the urge to gamble after deciding to stop, and the worry that they may never be able to stop gambling (alongside the concern that gambling harms will continue), which made people with lived experience feel trapped and contributed to suicidal ideation. Restarting gambling again (referred to by some as the experience of "relapse")

[69] Dixon, M.J., Gutierrez, J., Larche, C., Stange, M., Graydon, C., Kruger, T. & Smith, S. (2019). *Reward reactivity and dark flow in slot-machine gambling: "Light" and "dark" routes to enjoyment.* Journal of behavioral addictions, 8(3), 489-498.

after going through sometimes long periods of treatment could also relate to feelings of being defeated or lonely which was also a key risk point for suicidal ideation or suicide attempts.

Overall, we identified several key factors which could lead to experiences of suicidality among those experiencing gambling harms:

- Significant experiences of gambling harms, such as financial harm and housing insecurity, contributed to suicidality when they left people feeling stuck and lacking options;
- Compounding experiences of gambling harms (for example experiencing financial harms alongside relationship harms and loneliness) resulted for some in cumulative stress which could subsequently lead to suicidality;
- Ongoing urges to gamble when trying to stop could result in suicidality as these experiences could lead people to feel hopeless, trapped and worried about the future;
- Restarting gambling after previously stopping could result in people feeling shame, loneliness or like they would always experience gambling harms, which could then lead to suicidality.

These findings align to wider suicidality research which has modelled suicidal behaviour and highlighted the role of defeat, humiliation and the sense of entrapment in contributing to suicidal ideation.[70]

**Demographic and contextual factors impacting experiences with suicidality among people experiencing gambling harms**

Demographic factors, such as **age**, **gender**, **ethnicity** and **social grade**, were associated with suicidality, although this relationship was not significant among people who experienced high levels of problem with gambling (PGSI 8+). Identifying as **lesbian, gay or bisexual or another sexual orientation**, or having a **disability** was associated with an increase in the odds of lifetime experiences of suicidality among people who gamble, and this relationship was significant even when stratifying by experience of problem gambling (PGSI 8+). People who gambled and identified as **lesbian, gay, bisexual or another sexual orientation**, had 1.69 times the odds of having ever experienced suicidal ideation and more than two times the odds of having ever attempted suicide (OR: 2.30). **Disability** was assessed by asking participants if their day-to-day activities were limited by a health problem or disability (with response options as “no”, “a little”, or “a lot”). Participants who reported that their day-to-day activities were limited “a lot” had 1.73 times the odds of having ever experienced suicidal ideation and had nearly four times the odds (OR: 3.92) of having ever attempted suicide compared to people who reported no limitations. Our findings emphasise the importance of treating suicidality as a potential co-occurring experience for all people who are experiencing harm from gambling, while also identifying that some groups experience higher prevalence of suicidal ideation and/or attempt (people identifying as LGBTQ+ and disabled people). Although there are some patterns among different groups and associated factors (e.g., housing insecurity and debt), gambling harms and suicidality affect a broad range of people.

There were mixed findings when examining the relationship between gambling harms, suicidality and experiences of **gambling stigma**. People who experienced problems with their gambling (PGSI 3+) and had “high” or “very high” gambling stigma had 1.52 times the odds of having attempted suicide compared to people with “low” gambling stigma. However, the relationship between **gambling stigma** and suicidal ideation among people who experienced problems with their gambling (PGSI 3+) was not significant. People with lived experience (those who had experiences of suicidality and gambling harms) described how they felt gambling stigma was more harmful than stigma related to suicidality, emphasising that they found that people understood experiences with suicidality more easily and they could more easily relate to feelings of depression or feeling “low” as these are common experiences. Despite this, while in recovery, people with lived experience continued to find it challenging to discuss mental health problems with other people.

**Treatment and/or support experiences and needs among people experiencing suicidality and gambling harms**

NHS mental health services were the most accessed form of treatment or support by survey participants with experience of suicidality who had tried to reduce their gambling. 39% of people who had attempted suicide and

[70] O'Connor, R. & Kirtley, O. (2018). *The integrated motivational–volitional model of suicidal behaviour.* Philosophical Transactions of the Royal Society of London. Series B, Biological Sciences. 5;373(1754).

34% of people who had ever experienced suicidal ideation reported accessing NHS mental health services for help with gambling, including counselling or therapy both online and face to face. Among those who had tried to reduce or stop gambling and linked their latest suicide attempt to gambling, the most common form of treatment and/or support accessed was private mental health services (42%). Interviews with people with lived experience and stakeholders identified that experiences of significant gambling harms, including suicidality, and returning to gambling after a period of abstinence were key points at which people sought treatment and/or support.

Those experiencing gambling harms and suicidality often had complex personal circumstances which could result in complex support needs (e.g. support for gambling harms and suicidality alongside support needs related to housing or debt). In some circumstances this could influence the effectiveness of some types of treatment, due to this group being more likely to be in a state of distress or in vulnerable circumstances. This could mean that for some individuals, community-based or group therapies were less appropriate. Experiences of self-stigma and wanting to hide experiences with gambling and suicidality due to shame could act as a barrier to treatment and/or support as well as influencing how people interacted with it. In general, there were no clear findings on which specific types of treatment or support were the most appropriate, as this varied between people due to the impact of individual factors, including personal preferences and severity of current experiences with gambling harms and suicidality.

When discussing continued recovery after formal treatment, people with lived experience and stakeholders emphasised the importance of cultivating support and recovery networks (either personal networks or facilitated through treatment and/or support or lived experience organisations), emphasising that change is hard to sustain when attempting to do so alone. Participants felt that long-term gambling support reduced suicidal ideation. It did this both by lowering the risk of 'relapse' and reminding them of their recovery options, so they no longer saw suicide as the only way out. These findings add weight to existing evidence on the benefits of longer-term recovery programmes for those who have experienced gambling harms. A recent evaluation of ten 'aftercare'[71] programmes funded in the UK to provide long-term recovery support found that outcomes for service users included increased self-confidence, improved self-image, enhanced mental health and wellbeing, reduced isolation, and strengthened relationships with friends and family.[72]

## 5.2 Limitations

Despite the strengths of this study, there are also limitations that must be acknowledged. The survey was relatively long in duration, and as with all extensive surveys, it is possible that some participants' attention, energy, or motivation may have waned before the end of the survey, impacting the validity of their responses. Although the large and nationally representative sample allowed identification of relationships between variables, the cross-sectional nature of the methodology design did not allow for interpretation of causal relationships from our quantitative data alone. Timeframe mismatch between measures also limited the conclusions that could be drawn from analysis; suicidality was measured over people's lifetime whereas some of our measures captured current experiences, for example with gambling frequency, mental wellbeing and loneliness. Another limitation is that the base sizes for some analyses were small. This sometimes necessitated the consolidation of several categories into one to allow for statistical analysis and to preserve the anonymity of participants. For example, all minoritised ethnicity groups were merged into a single category. This limited our ability to draw nuanced conclusions about factors such as ethnicity, and it is important to note that minoritised groups are heterogeneous and will not necessarily share the same experiences.

Similarly, although qualitative sampling for interviews with people who had experiences of gambling harms and suicidality allowed analysis of intersectional experiences and allowed exploration of women's experiences (often missing in previous studies), these experiences are unlikely to be exhaustive and instead reflect only the experiences of those sampled, to the exclusion of experiences and identities which were not captured extensively in the sample (for instance, those identifying as lesbian, gay, bisexual or another sexual orientation and people from minoritised ethnic backgrounds). The focus of this project, both for interviews with stakeholders

[71] The term 'longer term recovery' is used throughout the report to reference support provided throughout the duration of recovery from gambling harms, including following other formal forms of treatment and support. The term 'aftercare' has been used here to accurately represent the cited evaluation.
[72] Ipsos UK. (2025). *Evaluation of the Aftercare Funding Programme. Interim report 2 (Phase 2).* Available at: https://www.ipsos.com/sites/default/files/ct/news/documents/2025-07/aftercare-evaluation-phase-2-report_final-april-2025.pdf [Accessed on: 24th September 2025]

and those with lived experience has been on the perspectives of those working within, and with experience of support from "gambling focused" treatment and/or support, rather than broader mental health support. While this has provided valuable insights, experiences related to accessing mental health support for suicidality while experiencing gambling harms, may provide important perspectives which were not captured. All interview participants with lived experience had accessed treatment and/or support at some point in their journey with gambling harms and all had sources of treatment and/or support available to them at the time of the interview, to ensure that they could safely participate in the research. The limitation of this approach is that our qualitative findings presented in this chapter do not include the voices of people who have not accessed treatment or support, and our research may therefore have not sufficiently captured barriers to treatment and/or support within this population, or experiences of alternative journeys such as experiences of self-help (e.g., self-exclusion and blocking software).

## 5.3 Recommendations for future research

Based on our limitations outlined above and our findings we have identified several areas which would benefit from further exploration:

- Our research found higher risk of suicidality among those who gambled and identified as lesbian, gay, bisexual or other sexual orientation, and disabled individuals. These groups were not fully captured in our interviews, and it would therefore be beneficial to conduct further qualitative research with these groups to explore any specific drivers and experiences of suicidality and gambling harms.
- Our research identified high-risk points for experiences of suicidality among those experiencing gambling harms, including experiences of multiple harms or 'relapse' and recommended dual screening for gambling harms and suicidality within support services. Further research could build on these findings and develop a gambling specific risk-assessment framework for suicidality which considers specific stressors related to gambling harms.
- There were several measures which were not included in our survey but were identified in our qualitative strand as important; in particular, it would be beneficial to conduct future quantitative analysis using data on religion and experiences of stigma related to suicidality. Further quantitative research could also use a measure of gambling harms such as the Gambling Harms Severity Index (GHSI-10).[73] Our research used the PGSI which is a measure of "problem gambling" but conducting further analysis using a gambling harms measurement tool would allow more robust measurement of gambling harms and allow exploration of patterns related to types of harm (e.g., financial vs social harm) and the ways that these interrelate with suicidality.[74]
- Our research identified that longer term recovery support and sustained support networks are key to supporting those with experience of suicidality and gambling harms long term, including through any experiences of "relapse" which were identified as a risk point for further experiences of suicidality. Although covered in our interviews, this was not explored in depth and further qualitative research with those with lived experience of gambling harms and suicidality who are in "recovery" to explore long term support needs would be beneficial. Further research on the topic of recovery after treatment could focus on which particular modalities of longer-term recovery support are the most successful in aiding an endured recovery from suicidality and gambling harms, and the role of wider contextual factors, for example the strength of therapeutic relationships. Particularly, further research should focus on what type of support works best when people experience a return to gambling (or "relapse").

## 5.4 Recommendations for service provision

Overall, this research has shown the importance of considering suicidality within gambling harms support provision, given that one in five (22%) people who reported high levels of problems with gambling (PGSI 8+) had

[73] 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.
[74] Close, J., Martin, I., White, G., Lau, R. & May, J. (2023). *Frameworks and Measurement of Gambling Related Harm: A Scoping Study*. NatCen and the University of Plymouth on behalf of GambleAware. Available at: https://www.gambleaware.org/media/0e3n2ggk/frameworks-and-measurement-of-grh_final_for-publication.pdf [Accessed on: 25th September 2025]

attempted suicide in their lifetime, and most of this group (65%) linked their latest suicide attempt to gambling. These recommendations for service provision and policy are based on our own analysis, as well as recommendations made by participants in our research:

- **Suicidality should be considered a potential co-occurring experience among all those experiencing gambling harms** – Our data has shown that although demographic factors, such as age, gender, ethnicity and social grade, were associated with suicidality, this relationship was not statistically significant among people who experienced high levels of problems with gambling. This emphasises the importance of screening for suicidality among all those experiencing gambling harms, regardless of background. However, our research has also identified that among people who gamble, disabled individuals and those from lesbian, gay, bisexual, and other sexual orientation backgrounds are at higher risk of experiencing suicidality and there may therefore be higher levels of support needs for these groups. Identity-safe pathways for these groups should be considered (for example optional affinity groups such as women's or LGBTQ+ groups). Data collection activities to identify these groups can be hard to collect in some services due to apprehension among service users about sharing personal information, particularly with brief interventions. To support data collection, services should include clear explanations of the purpose of collecting data and data protection measures.

- **Services supporting people with gambling harms and/or mental health should ensure that dual-screening and assessment is undertaken for both gambling harms and suicidality on first contact, including within gambling support services, primary care mental health, emergency departments and crisis lines and ensure onward referral processes are embedded consistently** – Our research has shown the frequent and complex relationship between gambling harms and suicidality. Comprehensive screening and risk assessment is an essential first step for supporting people holistically. Services should use validated screening tools for both suicide risk and gambling harms (such as the Gambling Harms Severity Index (GHSI-10)) and where needed provide staff training.[75]

- **People experiencing gambling harms and suicidality are likely to have complex and unique support needs which may necessitate being addressed holistically, and long term** - Our research has shown that gambling harms and suicidality are closely intertwined (e.g., gambling as a coping mechanism for suicidality), suggesting that support which considers gambling harms, mental health and suicidality in isolation may not be as effective. Our research has also emphasised the role of wider social factors (e.g., debt and housing insecurity) which closely interrelate to gambling harms and suicidality. Debt, housing, and legal support should also be considered as part of holistic support plans and offered within gambling support services where possible. Both those with lived experience and stakeholders emphasised the importance of longer-term recovery support for this group, describing the role of long-term support networks (including peer support) in mitigating suicidality longer-term through reminding people of routes to recovery. Longer term recovery support should be structured and include time-specified check-ins.

- **Challenges when trying to stop gambling (e.g., not being able to stop when trying to) as well as experiences of "relapse" (taking part in gambling or experiencing gambling harms again after a period of abstinence or lower harm) are <u>key risk moments</u> for experiencing suicidality** – Our qualitative findings showed how these moments could lead to feelings of "defeat" related to the view that gambling harms would be everlasting or insurmountable. These findings align to wider suicidality research which has modelled suicidal behaviour and highlighted the role of defeat, humiliation and the sense of entrapment in contributing to suicidal ideation. [76] These moments are therefore particularly vital for the provision of support and should be considered within support plans for those accessing support. The risk of suicidality during the experience of "relapse" also emphasises the importance of long-term treatment access and support networks, including for those in "recovery" who are no longer experiencing acute gambling harms. Support plans should include a "return to gambling participation" response plan which should be shared in circumstances where clients are referred between services.

[75] 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.
[76] O'Connor, R. & Kirtley, O. (2018). *The integrated motivational–volitional model of suicidal behaviour.* Philosophical Transactions of the Royal Society of London. Series B, Biological Sciences. 5;373(1754).

- **Continued efforts to address stigma and discrimination related to both gambling harms and suicidality are vital to support those experiencing gambling and harms and suicidality and improve access to and experiences of treatment and/or support** – Our research found that experience with both gambling stigma and stigma related to suicidality influenced access to and experiences of treatment and/or support, including making it more challenging for people to discuss their experiences with friends, family and treatment providers. Addressing gambling stigma is a particular priority. People with lived experience felt that gambling stigma was more harmful than suicide stigma, emphasising that they found that people understood experiences with suicidality more easily whereas negative perceptions about people who gambled were more common. Staff supporting those experiencing gambling harms and suicidality should be trained in suicide and gambling-specific stigma reduction (including training relating to using non-judgemental language, and recognising how stigma impedes disclosure).
- **Suicidality as a result of gambling harms should be considered more broadly as a public health priority –** Our research indicates that experiences of suicidal ideation and suicide attempts are higher among people experiencing harms from gambling than among people who do not gamble or gamble without harms. Suicide is currently recognised as a priority in the government's recently announced 10-year health plan and suicide prevention strategy, and we recommend that gambling harms should be treated as a risk factor along with self-harm, and harm related to alcohol and drug use.[77,78] Additionally, wider prevention and awareness campaigns should cover the link between gambling harms and suicidality and signpost to support access, including providing resources for people experiencing harm related to other people's gambling.

[77] Department for Health and Social Care. (2025). Fit for the future: 10 Year Health Plan for England. Available at : https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future/fit-for-the-future-10-year-health-plan-for-england-accessible-version [Accessed on: 24th October 2025]
[78] Garratt, K., Kirk-Wade, E., Gajjar, D., Danechi, S. (2025). Suicide Prevention Policy. Available at: https://commonslibrary.parliament.uk/research-briefings/cbp-10090/ [Accessed on: 24th October 2025]

# Appendix A: Methodology

## Research aims and research questions

Building on identified research gaps, this project was guided by the following research aims:

1. To understand whether and how different types of gambling behaviours affect suicidal ideation or behaviour.
2. To explore whether and how the risk of suicidal ideation or attempt (among those with experience of gambling harms) is influenced by age, sex, ethnicity / cultural background, or other contextual factors (e.g., feelings of stigma, presence of other associated mental health problems), while paying attention to what can be learned about protective factors.
3. To explore effective interventions for people experiencing suicidal ideation and/or attempt and gambling harms. This included:
    - Examination of the critical points of intervention where individuals with experience of gambling related harms choose either to seek or not seek support and/or treatment for suicidal ideation and/or attempt.
    - Exploration of risk and protective factors and the interplay between them which can influence the effectiveness of treatment for gambling or suicidal ideation.

The **quantitative** research strand aimed to address the following research questions:

- **QT1**: What are the gambling-related determinants (risk and protective factors), if any, for suicidality based on different types of gambling behaviours and experiences of stigma?
- **QT2**: What are the demographic drivers (risk and protective factors) of suicidality among different groups who gamble?
- **QT3**: How do factors related to gambling behaviours, demographic characteristics and feelings/experiences of stigma interact with suicidal ideation and attempt?
- **QT4**: What are the gambling-related determinants (risk and protective factors), if any, of suicidality for different groups experiencing gambling harm?

The **qualitative** research strand aimed to address the following research questions:

- **QL1**: What are the individual, social and environmental determinants of suicidal ideation and/or behaviour among different groups experiencing gambling harm?
- **QL2**: How do gambling-related and wider suicide ideation and/or behaviour determinants interrelate among different groups of people experiencing gambling harm?
- **QL3**: What are the barriers and enablers for those experiencing suicidal ideation/ attempt and gambling harms in seeking/accessing/completing support and treatment?
- **QL4**: What are the critical points for effective intervention for people experiencing suicidal ideation and/or attempt and gambling harm from the perspective of treatment staff and those experiencing gambling harms?
- **QL5:** What are the (self-)perceptions of individuals who gamble and experience suicidal thoughts in relation to stigma?

# Advisory Group and Lived Experience Panel

A Lived Experience Panel (LEP) was recruited to provide guidance and input throughout the project. In line with best practice, the research team discussed and agreed with the LEP the scope, tasks, and responsibilities of the panel and overall contribution to the research study.

The four panel participants had experienced, at some point in their lives, direct harms from gambling and suicidal ideation and/or suicide attempt. We conducted the panels via videoconferencing at five timepoints throughout the project: (1) at project inception, to introduce the study, agree the research process and gain the panel's perspective on questionnaire development; (2) prior to qualitative fieldwork with stakeholders to gain the panel's perspectives and input into the design of participant-facing materials and topic guides; (3) prior to qualitative fieldwork with people with lived experience to gain the panel's perspective on participant-facing materials, topic guides and ethical considerations, including the safety plan; (4) during the analysis and interpretation stage to present key themes from the interviews and discuss recommendations; and (5) at the dissemination stage.

In accordance with the National Institute for Health and Care Research's (NIHR) recommendations, and in order to acknowledge the time and effort required, panel members were remunerated for their time, at a rate of £75 for two hours to cover each engagement (up to 90 minutes) and preparation (30 minutes). We supplied accessible materials before each session to facilitate preparation. We requested feedback from the panel on their involvement in the research.

# Quantitative strand

## Dataset

**Data**
The analysis presented here is drawn from YouGov's survey on gambling and suicidality, conducted for NatCen. The research team developed the survey questionnaire and conducted light-touch desk review to explore evidence on best practice / previous approach for questions that were not validated scales. Following fieldwork in October 2024, YouGov provided NatCen with a cleaned dataset, including weights, for analysis.

The dataset was a sample of adults (18+), weighted to be representative of the GB population who gamble (n=11,646). The sample was made up of people who had gambled in the last 12 months. Please see Appendix Tables A.1 and A.2 below for a breakdown of the sample characteristics, including by PGSI score.

**Appendix Table A.1: Composition of the sample by relationship to gambling harms (PGSI score)**

| PGSI Category | Unweighted base | Weighted base |
|---|---|---|
| PGSI: 0<br>People experiencing no reported problems with their gambling | 7,975 | 9,084 |
| PGSI: 1–2<br>People experiencing a low level of problems with their gambling | 1,372 | 1,281 |
| PGSI: 3–7<br>People experiencing a moderate level of problems with their gambling | 1,130 | 699 |
| PGSI: 8+ | 1,169 | 582 |

| | | |
|---|---|---|
| People experiencing high levels of problems with their gambling | | |
| Total | 11646 | 11646 |

## Appendix Table A.2: Demographic characteristics of the sample provided

**Age**

| | Age 18–24 | Age 25–34 | Age 35–44 | Age 45–54 | Age 55–64 | Age 65+ |
|---|---|---|---|---|---|---|
| Unweighted base | 643 | 2213 | 2196 | 2185 | 1945 | 2464 |
| Weighted base | 530 | 2110 | 2131 | 2235 | 2009 | 2630 |

**Sex**

| | Men | Women |
|---|---|---|
| Unweighted base | 6,134 | 5,512 |
| Weighted base | 5,973 | 5,673 |

**Sexual orientation (combined)**

| | Heterosexual | LGB and other sexual orientations | Prefer not to say |
|---|---|---|---|
| Unweighted base | 9,954 | 1,178 | 499 |
| Weighted base | 9,992 | 1,168 | 474 |

**Ethnicity (grouped)**

| | White groups | Mixed | Asian | Black | Other | Prefer not to say |
|---|---|---|---|---|---|---|
| Unweighted base | 10,455 | 381 | 304 | 348 | 39 | 118 |
| Weighted base | 10,637 | 309 | 275 | 269 | 35 | 119 |

**Ethnicity (combined)**

| | White communities | Minoritised ethnic communities | Prefer not to say |
|---|---|---|---|
| Unweighted base | 10,455 | 1,072 | 118 |
| Weighted base | 10,637 | 889 | 119 |

**Disability**

| | 'Yes, limited a lot' | 'Yes, limited a little' | 'No' |
|---|---|---|---|
| Unweighted base | 1,346 | 2,088 | 8,110 |
| Weighted base | 1,264 | 2,070 | 8,221 |

**Social grade**

| | Middle Class | Working class |
|---|---|---|
| Unweighted base | 6,264 | 6,242 |
| Weighted base | 5,382 | 5,404 |

**Weighting**
The dataset was weighted by YouGov to allow for generalisability of the findings, using Random Iterative Method (RIM) weighting, whereby weights were recalculated iteratively until the required level of accuracy reached. The dataset was weighted to be representative of the population of all UK adults aged 18+. Weights were also applied across the demographic characteristics of age, gender, and geography on the basis of ideal weighting from Statistics UK.

# Variables

Our dataset contains variables regarding participants' level of gambling harms. We used the Problem Gambling Severity Index (PGSI) as a proxy measure for levels of gambling harms and used a PGSI score of 3+ as an indicator of gambling harms as it represents moderate and high levels of problems with gambling. We also asked questions regarding; gambling-related stigma, mental wellbeing, loneliness, suicidality and accessing treatment and/or support. In these instances, we used validated measures or questions from extant surveys when available. We also included a range of demographic variables which YouGov already holds on their panel.

The specific scales we used are detailed below:

**Problem Gambling Severity Index (PGSI)**
This widely used 9-item scale is routinely included in gambling and gambling harms research. It is asked of people who have gambled in the last 12 months. Response options are scored on a range from 0 to 3: 0 = "Never", 1 = "Sometimes", 2 = "Most of the time", 3 = "Almost always". Those who answer "Never" to all nine items score 0 and are classed as "experiencing no reported problems with their gambling", those who score 1–2 total are classed as "experiencing a low level of problems with their gambling", those who score 3–7 total are classed as "experiencing a moderate level of problems with their gambling", and finally those who score 8–27 are classed as "experiencing high levels of problems with their gambling".[79] To ensure the internal consistency of the PGSI in our sample, we calculated Cronbach's alpha, which was found to be 0.878, indicating a high level of reliability.

**Gambling Experienced Stigma Scale (GESS)**
A 13-item scale that assesses individual thoughts of people who gamble, about their own experiences of stigma (experienced stigma). The response categories are on a scale of 1-4 from "Strongly Disagree", to "Somewhat Disagree", "Somewhat Agree", and "Strongly Agree". Stigma scores were combined in four groupings of experience of stigma: "low" (score of 13-19), "moderate" (score of 20-29), "high" (score of 30-39) and "very high"

[79] Abu, B. (2025). *Problem Gambling Severity Index (PGSI): A Comprehensive Guide*. ResRef. Available at: https://resref.com/problem-gambling-severity-index-pgsi-guide/. [Accessed on: 12th November 2025]

(score of 40-52).[80] Wherever the GESS categories were analysed in this report, people experiencing a "high" or "very high" level of gambling stigma were combined into a single category to ensure there was a large enough sample size to make accurate estimates. To ensure the internal consistency of the GESS in our sample, we calculated Cronbach's alpha, which was found to be 0.965.

**The Warwick-Edinburgh Mental Wellbeing Scale (S-WEMWBS)**
A shortened 7-item scale that assesses mental wellbeing over the last two weeks. We applied and registered to use this measure and were granted a non-commercial license. The response categories are on a scale of 1–5 from "None of the time" to "All of the time". As this is a shortened version of the scale, we followed the University of Warwick's score cut points to sort scores into "low" (score of 7-19), "moderate" (score of 20-27) and "high" (score of 28-35) wellbeing categories.[81] Categories for "low", "moderate", and "high" wellbeing were created using cut-off scores representative of plus or minus one standard deviation in the UK general population sample. To ensure the internal consistency of the S-WEMWBS in our sample, we calculated Cronbach's alpha, which was found to be 0.942.

**ONS direct loneliness measure**
We used the ONS' single item direct measure of loneliness which is, "How often do you feel lonely?". Response ranges are scored on a range from 1= "Never", 2 = "Hardly ever", 3 = "Occasionally", 4 = "Some of the time", 5 = "Often/always".

**Questions on suicidal ideation and attempt**
Two items were used from this survey to create derived variables for suicidal ideation and suicidal attempt. Suicidal ideation was assessed using a modified item from the Suicide Behaviors Questionnaire-Revised (SBQ-R)[82] and suicide attempt was measured using a modified question from the Adult Psychiatric Morbidity Survey (APMS).[83]

Participants were asked if they had personally experienced feelings of suicide or considered taking their own life in any way. The answer options were "No", "Yes, it was just a brief passing thought", "Yes, I had a plan to take my own life but did not want to try it", and "Yes, I had a plan and wanted to take my own life". Participants who answered any variation of "Yes" to this question were considered as having experienced suicidal ideation and were routed to a question asking if they had ever made an attempt to take their life ("Yes" or "No"). All participants had the option to answer "Prefer not to say" to this question. A derived variable for suicidality was then created with mutually exclusive categories (no suicidality, suicidal ideation (no attempt), suicidal ideation and attempt.

Participants who had attempted suicide were further asked how important gambling was in their latest suicide attempt (4-point Likert scale).

**Patterns of Gambling Participation**
In this report, patterns of gambling participation refers to the type of gambling products that people engage with and/or the gambling activities that people partake in. A non-exhaustive list of gambling activities includes; sports betting (online or in-person), casino games, bingo, lottery and gambling machines. We grouped patterns of gambling participation into three categories:

[80] Ipsos UK. (2024). *Measuring Gambling Related Stigma: A secondary analysis of two validated scales.* On behalf of GambleAware. Available at: https://www.gambleaware.org/media/uiloznhy/measuring-gambling-related-stigma-a-secondary-analysis.pdf [Accessed on: 24th September 2025]
[81] University of Warwick. (2025). *WEMWBS: How it works*. Available at: https://warwick.ac.uk/services/innovations/wemwbs/how/ [Accessed on: 25th September 2025]
[82] Osman A., Bagge C., Gutierrez P., Konick L., Kopper B., Barrios F. (2001) The Suicidal Behaviors Questionnaire-Revised (SBQ-R): validation with clinical and nonclinical samples. Assessment. 8(4):443-54
[83] NHS England. (2025). *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/24.* Available at: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/suicidal-thoughts-suicide-attempts-and-self-harm - key-findings. [Accessed on: 18th November 2025]

- Gaming: this refers betting on gaming outcomes which are generated within the gambling environment (e.g., by the roulette wheel). Gaming covers a range of gambling activities, such as bingo, live and virtual casino games, poker, slot machines, and instant wins.
- Betting: this refers to betting on events external to the gambling environment (such as results of sport matches). Betting covers both online and in-person betting on football, horses, and other sports.
- Other: this refers to all other gambling activities such as lotteries, loot boxes and "other".

## Data preparation

For the purpose of analysis, the following derived variables were created of the above variables (see Table A.3). This included measures and demographic variables:

**Appendix Table A.3: Data management and derived variables**

| Scale | Derived Variables | Notes |
|---|---|---|
| PGSI **(Problem Gambling Severity Index)** | PGSI_category | |
| S-WEMWBS **(Mental Wellbeing)** | WEMWBS_category | 5-point Likert scales. We have produced a total score and classified in categories based on WEMWBS statistical analysis (below average, average and high wellbeing). |
| Loneliness | Loneliness_frequency | 5-point Likert scale.<br>0 'Never'<br>1 'Hardly ever'<br>2 'Occasionally'<br>3 'Some of the time'<br>4 'Often / always' |
| Pattern of play | PoP_combined | Gambling activity was grouped into betting, gaming and other (including lotteries). |
| Frequency of gambling | Frequency_betting_PoP<br>Frequency_gaming_PoP<br>Frequency_other_PoP | Maximum frequency for combined pattern of play was derived. This might underestimate frequency of gambling, as it did not add if participant took part in multiple activities. |
| Suicide ideation | Suicide_ideation | Created a binary variable:<br>0 'No'<br>1 'Yes' |
| Suicide attempt | Suicide_attempt | Created a binary variable:<br>0 'No'<br>1 'Yes' |
| Suicidality | Suicidality_grouped | Created a new variable from suicide ideation and suicide attempt with mutually exclusive categories.<br>3 groups |

| | | |
|---|---|---|
| | | 0 ‘No suicidality’<br>1 ‘Suicidal ideation (no attempt)<br>2 ‘Suicidal ideation AND attempt’ |
| Latest suicide attempt linked to gambling | Suicide_gambling_influence | 2 groups:<br>0 ‘No’<br>1 ‘Yes’ |
| GESS | GESS_categories | 4-points Likert scale (‘Strongly disagree’, ‘Disagree’, ‘Agree’, ‘Strongly agree’). We have produced a total score and classified in categories based on GA report |
| Services accessed | Treatment_accessed | Derived variable 2 groups:<br>0 ‘No’<br>1 ‘Yes’ |
| Age | Age_category | 6 groups:<br>1 '18–24'<br>2 '25–34'<br>3 '35–44'<br>4 '45–54'<br>5 '55–64'<br>6 'over 65'. |
| Ethnicity | ethnicity_grouped | 2 groups:<br>1 'White communities<br>2 'Minoritised ethnic communities |
| Gender | Linked_gender | 2 groups<br>1 ‘Men’<br>2 ‘Women’ |
| Sexual orientation | Linked_sexuality | 2 groups:<br>1 ‘Heterosexual’<br>2 ‘LGB and other sexual orientations’ |
| Disability | Linked_disability | 3 groups:<br>1 ‘Yes, limited a lot’<br>2 ‘Yes, limited a little’<br>3 ‘No’ |
| Social grade | Social_grade | 2 groups:<br>1 ‘Working class’<br>2 ‘Middle class’ |

## Analysis

Descriptive statistics and binary logistic regression were applied in providing the analyses in this report.

Where the original variable offered options such as “Prefer not to say”, “Not applicable”, or “Don’t know”, these response categories were retained to accurately represent respondent choice but treated as missing for analytic purposes. Given the categorical nature of most variables and the relatively small proportion of missingness, this approach was deemed the most transparent and least bias-prone.

The first set of analyses constituted of weighted cross tabulation statistics to assess if there was an association between suicidality and different gambling behaviours (PGSI score, patterns of gambling participation, frequency of gambling), demographics (such as age and gender) and social factors (such as disability or experience of loneliness), feelings/experiences of gambling stigma and access to treatment and/or support. Significance testing of the relationship between variables was assessed by conducting Pearson chi-square test of independence. To look at the relationship between stigma, access to treatment and/or support and suicidality among people experiencing harms from gambling, we used a sub-set of the data including only people who experienced problems with their gambling (PGSI 3+). To control for inflated Type I error due to multiple pairwise comparisons, we applied a Bonferroni correction. The adjusted p-values are reported in the appendix tables to indicate which column proportions differ significantly from one another at the Bonferroni-corrected $\alpha = .05$ level.

Where there was a statistically significant relationship with suicidality, a binary logistic regression was carried out to assess the effect of PGSI score, patterns of gambling participation, age, gender, ethnicity, sexual orientation, disability, social grade, loneliness, current mental wellbeing, and gambling stigma on the likelihood of suicidal ideation and suicide attempt (see Appendix Tables B.24 and B.25). We tested for multicollinearity and found that the Variance Inflation Factors (VIF) were all below 5, indicating that multicollinearity was not a concern. The study employed an exploratory regression analysis, which was intended to identify potential relationships and generate hypotheses for future research rather than to confirm specific theoretical expectations. To minimise overfitting in this exploratory context, only variables where the relationship was significant were included. The pool of independent variables was based on theoretical underpinnings that guided our data collection.

# Qualitative strand

This section outlines the qualitative methods used in the study, including recruitment and data collection for interviews with stakeholders, and for interviews with people with lived experience of gambling harms and suicidality. Lastly, it describes the approach to qualitative analysis, detailing how interview data was managed and interpreted.

## Recruitment and data collection

**Fieldwork with stakeholders**

We conducted six semi-structured interviews with stakeholders working at organisations delivering treatment and/or support for gambling between December 2024 and February 2025.

Our recruitment approach involved desk research to identify treatment and/or support organisations with varied areas of expertise and from different geographical areas. Organisations were then invited to participate via email from either NatCen or GambleAware. Stakeholders from these organisations who expressed interest were invited to a short screening call, which provided further information about the research, answered any questions that potential participants had, and found a suitable time for interview. The screening call was also used as an opportunity to alert participants to the sensitive nature of the research topic.

Our final sample included stakeholders:

- working for the NHS, and for third sector organisations; working in different geographical areas across England and Wales.
- with experience providing face-to-face (including residential) and online treatment and/or support, group- and individual-based interventions.

- with experience working with different groups of people, such as women, minoritised ethnic communities, and young people.

The six interviews with stakeholders were approximately 60-minutes long and took place on Microsoft Teams at a time convenient to our participants. Interviews used a topic guide[84] which was designed to explore stakeholders' organisational roles and the types of services they provide; to gather their views on the impact of different gambling behaviours on suicidality; to identify risk and protective factors for suicidal ideation and behaviour; and to understand how people with experiences of gambling harms and suicidality access and engage with treatment and/or support. Finally, we gathered stakeholders' reflections and recommendations on improving current treatment and/or support provision, and their recommendations on the terminology to use when interviewing people with lived experience.

**Fieldwork with people with lived experience**

Between April 2025 and August 2025, we recruited for and conducted 12 semi-structured interviews with people who had lived experience of gambling harms and suicidality. Our recruitment strategy involved reaching out to organisations that provide treatment and/or support for gambling harms, as well as those offering mental health services, and engaging with networks of individuals with lived experience. These organisations were provided with briefing information detailing the nature and objectives of our interviews, including guidance on how they could assist in the recruitment process. We requested that these organisations disseminate information about our research to the individuals they support. Additionally, organisations providing treatment and/or support were asked to conduct debriefing sessions with participants following the completion of interviews. We asked organisations to invite people with lived experience to contact the NatCen research team directly and express their interest in participating.

Our recruitment materials for people with lived experience clearly stated that we were conducting interviews with people who have experienced both gambling harms and suicidal thoughts and/or behaviour. We outlined our study aims, introduced NatCen as the organisation conducting the research, and provided detail on what participation will entail, including the focus of the screening call and the interview, the voluntary nature of taking part, confidentiality and anonymity, and how their data would be used. Given the research topic, we included at the end of the document the contact details of support organisations in gambling, financial support, and personal and emotional support.

Once participants contacted us expressing interest in the study, a screening call lasting approximately 30 minutes was arranged. During this call, we provided more information about the study and answered any questions participants had. We also asked questions about their experiences with gambling harms and suicidal ideation or behaviours, as well as their demographic characteristics, to determine their eligibility for participation. We included individuals with lifetime experience of gambling harms, and lifetime experience of suicidality, and did not explore the connections between the two as part of our screening call. To reduce any risks related to participation, individuals who experienced suicidal ideation and/or suicide attempt in the month leading up to the screening call were not invited to interview. In the second half of the screening call, we developed a safety plan with participants, and discussed relevant sources of support and actions that the research team and the participant could take to prevent and mitigate risks to their wellbeing during and after the interview.

For those who were eligible and agreed to participate, the interviews were scheduled to last approximately 90 minutes and were conducted at a time convenient for the participant. Interviews took place online via Microsoft Teams, or over the telephone with a NatCen researcher. To thank participants for their time, they received a £50 Love2Shop voucher for participating. Our quotas and achieved sample are outlined in Table A.4.

[84] The topic guide is a structured outline of themes and prompts used during interviews to guide the conversation and ensure that all relevant subjects are covered consistently across interviews. At NatCen, topic guides are used flexibly to accommodate the responsive nature of qualitative research, allowing interviewers to adapt the order and focus of discussion based on the participant's responses.

**Appendix Table A.4 Achieved sample for interviews with people with lived experience**

| Characteristics | | Quotas | Completed |
|---|---|---|---|
| Age | 18–39 | 6 | 4 |
| | 40+ | 6 | 8 |
| Sexual orientation | Heterosexual | 8 | 11 |
| | LGB and other sexual orientations | 4 | 1 |
| Ethnicity | White communities | 6 | 11 |
| | Minoritised ethnic communities | 6 | 1 |
| Gender | Male | 5 | 8 |
| | Female | 5 | 4 |
| | Prefer not to say / non-binary | 2 | 0 |
| Country | England | N/A[85] | 7 |
| | Scotland | N/A | 3 |
| | Wales | N/A | 1 |

To reach these quotas, we contacted over 50 organisations and networks providing gambling or mental health support and/or treatment. These included organisations and networks providing support locally and/or working with specific groups, such as women, people who identify as LGBTQ+, or people from minoritised ethnic communities. At the same time, our engagement emails stated that we are hoping to reach adults with different demographic characteristics – across age, gender, sexuality, ethnicity, religion and geographic region. However, as noted above, one of the limitations of our qualitative sampling has been the inability to capture extensively

[85] Participants' country of residence was not a primary recruitment category for this research project, so we did not aim to recruit to pre-determined quotas. However, it was monitored with the aim to achieve as much diversity as possible across the countries in Grate Britain.

experiences from specific groups, especially people identifying as LGBTQ+ and people from minoritised ethnic communities.

These semi-structured interviews were conducted using a topic guide designed to explore participants' experiences with gambling harms and suicidal ideation or behaviours. Our interviews have not explored experiences (if any) where gambling was neither a contributing factor to suicidality nor a way to cope with negative emotions and circumstances, including suicidality (for example, suicidality before starting to gamble). The guide covered a range of areas including personal and social circumstances influencing gambling and mental health, experiences of stigma related to gambling and suicidality, access to and engagement with support services, and critical points in their journey with gambling harms, suicidality, and treatment. Additionally, participants were invited to share their recommendations for effective treatment and/or support, with an option to create a timeline of their experiences to illustrate the context and meaning attached to specific events.

## Qualitative analysis

With participants' permission, interviews were audio recorded and transcribed verbatim for analysis purposes. Interview data was managed and analysed using the "Framework" approach, a case and theme-based approach to qualitative data analysis developed by NatCen.[86] Key topics emerging from the data were identified through familiarisation with the transcripts. An analytical framework was developed and matrices relating to the different thematic issues were produced. The columns in each matrix represented sub-themes or topics while rows represented individual participants/stakeholders. Data was summarised in the appropriate cell. The final analytical stage involved working through the charted data, drawing out the range of experiences and views, and identifying similarities and differences.

Where applicable, verbatim interview quotations are provided in this report to highlight key findings in participants' own words. The value of qualitative research is in revealing the breadth and nature of the phenomena under study.[87] Therefore, we do not quantify participants' views and experiences. The findings of the qualitative research contained in this report are based on the views of those who took part in the research; as such, their views may not be exhaustive.

# Ethics

The project received approval from our internal Research Ethics Committee (REC) in June 2024, ahead of recruitment and data collection. This process is aligned with the guidance provided by the Government Social Research (GSR) and the Social Research Association (SRA). The role of the NatCen REC is to identify any concerns and propose solutions to ensure that each study obtains fully informed and voluntary consent, respects participants' autonomy, privacy, and dignity, considers diversity and accessibility requirements, maximises benefits, and minimises personal and social harm. This includes harm to participants, organisations to which participants belong, wider social groups with an interest in the topic, researchers, and anyone who opted out.

We employed a clear and non-coercive recruitment approach. All survey and interview participants were provided with clear and accessible information about the study before deciding whether to participate. This included the aims and objectives of the study, the funder, what participation would involve – including the topics that will be explored, the voluntary nature of taking part, how the data would be used, confidentiality and anonymity measures, and plans for dissemination.

On our online survey, our research team collaborated with YouGov to contribute to their information sheet and privacy notice, ensured that the appropriate consent policies were in place, and that participants were signposted to support services.

We implemented a staged consent process for all interviews. Participants received detailed information about the study well in advance of the interview. Researchers discussed the key information before the interview

[86] Ritchie, J., Lewis, J., Nicholls, C. M. & Ormston, R. (Eds.). (2013). *Qualitative research practice: A guide for social science students and researchers*. Sage.
[87] Ritchie, J., Lewis, J., Nicholls, C. M. & Ormston, R. (Eds.). (2013). *Qualitative research practice: A guide for social science students and researchers*. Sage.

started, ensuring participants fully understood the aims, objectives, voluntary nature of the study, and our safeguarding policy. It was made clear to participants that they could change their mind about taking part, stop the interview at any point, take a break, or skip any questions or topics without providing an explanation. At the end of each interview, participants were asked if they wanted to redact any part of their contribution and they were also informed of the timeframes for withdrawing their participation, which was allowed until analysis started.

In addition, to ensure the experiences of a diverse group of people with lived experience were heard, we asked organisations supporting our recruitment to disseminate the study information to various demographic groups across age, gender, sexual orientation, ethnicity, religion, and geographic regions, including England, Scotland, and Wales. To enable participation, we offered interview participants a choice between telephone or videocall interviews (Microsoft Teams) and had the capacity to provide technical support as needed, with the assurance that only audio would be recorded during video interviews. Interviews were scheduled at a time and date convenient for participants, and accessibility needs were checked with participants as part of our screening calls. Interviews were conducted in English, and participants with lived experience were given the option to have someone with them for emotional or language support, such as a family member or friend.

Ensuring the safety and wellbeing of participants who shared their personal experiences with gambling harms and suicidality was a primary concern throughout our study. This applied to both survey participants and interview participants with lived experience. The Lived Experience Panel and Advisory Group reviewed our recruitment and data collection materials, as well as the list of organisations we signposted participants to, so as to ensure they were appropriate and sensitive.

To protect the safety and wellbeing of our researchers, we ensured that everyone on our research team was comfortable contributing to the project. This included clearly communicating at every stage of the research that anyone on the research team could opt out (either of the project or specific tasks) without any negative consequences. Every researcher completed external suicide awareness training[88] and several internal briefings sessions, which included a training session about safeguarding policy, strategies to manage challenging interview dynamics (including participants becoming upset), and the mental health support available at NatCen.[89]

The research team put in place additional steps to ensure the wellbeing of interview participants with lived experience of both gambling harms and suicidality, including but not limited to:

- We asked if and when potential participants had last experienced suicidality (using questions updated from the Adult Psychiatric Morbidity Survey) and assessed psychological distress at the time of the screening call (using the Kessler Psychological Distress Scale)[90] and did not invite to interview anyone who had experienced suicidality in the month leading to the screening call. Risk to participants' wellbeing was assessed both as part of the screening calls, and before each interview.
- We worked with potential participants to identify relevant sources of support and actions that the research team and participants could take to prevent and mitigate risks to their wellbeing during and after the interview. This safety planning occurred as part of the screening calls.
- After each discussion with our team, participants received the contact details of a range of organisations specialised in gambling support, financial support, and personal and emotional support after the screening call and after the interview.
- For participants with more recent experiences who were still in contact with treatment and/or support organisations, we encouraged and supported them to arrange with a member of staff to check in approximately an hour after they completed the interview.

[88] Researchers who conducted qualitative interviews completed Suicide Awareness training (SafeTALK) facilitated by the North East London Health & Care Partnership, and additional members of the team completed the Zero Suicide Awareness (ZSA) Suicide Awareness training.
[89] Team members were encouraged to attend debriefs with senior members of the team following interviews with people with lived experience. While being required to maintain confidentiality outside the project team, the project team had access to wider support from their manager, NatCen's wellbeing champions and mental health first aiders, and the Employee Assistance Programme from Health Assured (providing confidential support to employees).
[90] The Kessler Psychological Distress Scale (K10) is a widely used tool for measuring psychological distress, consisting of 10 questions that assess emotional states over the past four weeks.

# Questionnaire

NatCen Gamblers and Suicidality

*Base: All*
*Question type:* ***Multiple***

**[G1]** Which, if any, of these have you spent money on in the _past 12 months? Please tick all that apply.

| | | | |
|---|---|---|---|
| <1> | Tickets for the National Lottery Draw, including Thunderball and EuroMillions and tickets bought online | <10> | Betting on horse or dog races – in person |
| <2> | Tickets for any other lottery, including charity lotteries | <11> | Betting on football – online |
| <3> | Scratch cards | <12> | Betting on football – in person |
| <4> | Gaming machines in a bookmakers | <13> | Betting on other sports – online |
| <5> | Fruit or slot machines | <14> | Betting on other sports – in person |
| <6> | Bingo (including online) | <18> | Loot boxes (e.g., paid for mystery prizes within video games) |
| <7> | Gambling in a casino (any type) | <15> | Any other type of gambling |
| <16> | Online casino games (slot machine style, roulette, instant wins) | <99 xor> | None of the above |
| <17> | Online poker | <98 xor> | Don't know |
| <9> | Betting on horse or dog races – online | | |

*#skip logic:*
***exit status=screenout if G1.has_any([99,98])***

*Base: All gamblers (P12M)*
*Question type:* ***Grid***

**[MH1]** Short Warwick-Edinburgh Mental Wellbeing Scale (S-WEMWBS)[91]

*Base: All gamblers (P12M)*
*Question type:* ***Scale***

[91] This is a seven-question scale. Due to non-commercial licence agreement with Warwick University, the measure is not included in the report.

**[MH2]** Please select the number (0-10) that best describes how much distress you have been experiencing over the last week, including today.

*Please rate how much distress you've been experiencing on a scale of 0 to 10 where 0 is no distress and 10 is extreme distress.*

Range: No distress 0 ~ 10 Extreme distress

*Base: All gamblers (P12M)*
*Question type:* ***Single***

**[MH3]** How often do you feel lonely?

| | |
|---|---|
| <1> | Often/always |
| <2> | Some of the time |
| <3> | Occasionally |
| <4> | Hardly ever |
| <5> | Never |

*Question type:* ***Text***

The next set of questions is about gambling.

*Base: All gamblers (P12M)*
*Question type:* ***Grid***

**[G3]** In the past 4 weeks, how often, if at all, have you spent money on any of the following activities?

| | | | |
|---|---|---|---|
| -[G3_1] | Tickets for the National Lottery Draw, including Thunderball and EuroMillions and tickets bought online | -[G3_9] | Betting on horse or dog races – online |
| -[G3_2] | Tickets for any other lottery, including charity lotteries | -[G3_10] | Betting on horse or dog races – in person |
| -[G3_3] | Scratch cards | -[G3_11] | Betting on football – online |
| -[G3_4] | Gaming machines in a bookmakers | -[G3_12] | Betting on football – in person |
| -[G3_5] | Fruit or slot machines | -[G3_13] | Betting on other sports – online |

| | | | |
|---|---|---|---|
| -[G3_6] | Bingo (including online) | -[G3_14] | Betting on other sports – in person |
| -[G3_7] | Gambling in a casino (any type) | -[G3_18] | Loot boxes (e.g., paid for mystery prizes within video games) |
| -[G3_16] | Online casino games (slot machine style, roulette, instant wins) | -[G3_15] | Any other type of gambling |
| -[G3_17] | Online poker | | |

| | |
|---|---|
| <1> | Not in the past four weeks |
| <2> | Once in the past 4 weeks |
| <3> | About once a fortnight |
| <4> | About once per week |
| <5> | A few times per week |
| <6> | Every day |

*#option display logic:*
***[G3_1] - If [G1] - Tickets for the National Lottery Draw, including Thunderball and EuroMillions and tickets bought online is selected***
***And [G3_2] - If [G1] - Tickets for any other lottery, including charity lotteries is selected***
***And [G3_3] - If [G1] - Scratch cards is selected***
***And [G3_4] - If [G1] - Gaming machines in a bookmakers is selected***
***And [G3_5] - If [G1] - Fruit or slot machines is selected***
***And [G3_6] - If [G1] - Bingo (including online) is selected***
***And [G3_7] - If [G1] - Gambling in a casino (any type) is selected***
***And [G3_16] - If [G1] - Online casino games (slot machine style, roulette, instant wins) is selected***
***And [G3_17] - If [G1] - Online poker is selected***
***And [G3_9] - If [G1] - Betting on horse or dog races – online is selected***
***And [G3_10] - If [G1] - Betting on horse or dog races – in person is selected***
***And [G3_11] - If [G1] - Betting on football – online is selected***
***And [G3_12] - If [G1] - Betting on football – in person is selected***
***And [G3_13] - If [G1] - Betting on other sports – online is selected***
***And [G3_14] - If [G1] - Betting on other sports – in person is selected***
***And [G3_18] - If [G1] - Loot boxes (e.g., paid for mystery prizes within video games) is selected***
***And [G3_15] - If [G1] - Any other type of gambling is selected***
***[if 1 in G1 and 2 in G1 and 3 in G1 and 4 in G1 and 5 in G1 and 6 in G1 and 7 in G1 and 16 in G1 and 17 in G1 and 9 in G1 and 10 in G1 and 11 in G1 and 12 in G1 and 13 in G1 and 14 in G1 and 18 in G1 and 15 in G1]***

*Base: All gamblers (P12M)*
*Question type:* ***Single***

**[G2]** Have you ever accessed any forms of gambling which are illegal, unregulated, or unlicensed, for example using gambling sites not registered on GAMSTOP?

GAMSTOP helps you control your online gambling. Once registered you will be prevented from using gambling websites and apps run by companies licensed in Great Britain, for a period of your choosing.

All answers that you provide are entirely confidential.

| | |
|---|---|
| <1> | Yes |
| <2> | No |
| <98 xor> | Don't know |
| <999 fixed xor> | Prefer not to say |

*Base: All gamblers (P12M)*
*Question type:* ***Open***
*#integer Only*
*#SPD Category: health*

**[G4]** Thinking back, what age were you when first gambled (e.g., placed a bet, played the lottery, bingo, or slot machine)?

Range: 0 ~ 100
Not Sure

*Base: All gamblers (P12M)*
*Question type:* ***Dyngrid***

**[Q5]** Answer the following questions when thinking about your gambling behaviour over the past 12 months.

| | |
|---|---|
| -[Q5_1] | Have you bet more than you could really afford to lose? |
| -[Q5_2] | Have you needed to gamble with larger amounts of money to get the same feeling of excitement? |
| -[Q5_3] | When you gambled, did you go back another day to try to win back the money you lost? |
| -[Q5_4] | Have you borrowed money or sold anything to get money to gamble? |
| -[Q5_5] | Have you felt that you might have a problem with gambling? |
| -[Q5_6] | Has gambling caused you any health problems, including stress or anxiety? |
| -[Q5_7] | Have people criticized your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true? |
| -[Q5_8] | Has your gambling caused any financial problems for you or your household? |

-[Q5_9] Have you felt guilty about the way you gamble or what happens when you gamble?

<1> Never

<2> Sometimes

<3> Most of the time

<4> Almost always

*Question type:* ***Text***

The following section contains questions on the topic of suicide.

If you feel that you are in need of immediate support in relation to the issues discussed in this section, please contact NHS Choices on 111 (available 24 hours a day, 365 days a year, and free). Alternatively, please go to, or call, your nearest Accident and Emergency (A&E) department and tell the staff how you are feeling. If you feel that you need support with harms experienced as a result of gambling, please contact The National Gambling Helpline on 0808 8020 133 (free, 24/7). You can also contact your GP or The Samaritans on 116 223 (free, 24/7).

*Base: All gamblers (P12M)*
*Question type:* ***Multiple***

**[S1_new]** At any point in the past, have you personally experienced feelings of suicide or considered taking your own life in any way?

<1 xor> No

<2> Yes, it was just a brief passing thought

<3> Yes, I had a plan to take my own life but did not want to try it

<4> Yes, I had a plan and wanted to take my own life

<999 fixed xor> Prefer not to say

*Base: All gamblers (P12M)*
*Question type:* ***Single***
*#Question display logic:*
***if S1_new.has_any([2,3,4])***

**[S2]** Have you ever made an attempt to take your own life?

<1> Yes

<2> No

<999 fixed xor> Prefer not to say

*Base: All gamblers (P12M) who have attempted suicide*
*Question type:* ***Single***
*#Question display logic:*
***If [S2] - Yes is selected [if S2 == 1]***

**[S3]** When answering the question below, please think about the most recent time you attempted to take your own life.

How much of a factor, if any, was your gambling in your decision to attempt to take your own life?

<1> Very important

<2> Somewhat important

<3> Not very important

<4> Not at all important

<999 fixed xor> Prefer not to say

*Base: All gamblers (P12M) who said gambling was important factor in decision to attempt suicide*
*Question type:* ***Grid***
*#Question display logic:*
***If [S3] - Very important or Somewhat important, is selected [if S3 in [1,2]]***

**[S4]** Below are some reasons that people may have for attempting to take their own life.

For each of these factors, please indicate how important, if at all, each was in your decision to attempt to take your own life on the most recent occasion…

-[S4_1] I had lost all hope that things could get better in the future

-[S4_2] I needed to get out of an impossible situation because of gambling and it felt like there was no way to recover

-[S4_3] It seemed like the only way to deal with my problems

-[S4_4] I felt that other people were judging me because of gambling

-[S4_5] I felt shame or guilt because of gambling

<1> Very important

| | |
|---|---|
| <2> | Somewhat important |
| <3> | Not very important |
| <4> | Not at all important |
| <999 fixed xor> | Prefer not to say |

*Question type:* ***Text***

The previous questions covered thoughts and feelings about self-harm and suicide. We know that these can be sensitive topics to address. If you need to talk to someone, there are links to sources of support in your information sheet and at the end of this survey.

The final part of the survey includes a few more questions on the topics of gambling, self-harm and suicide.

*Base: All gamblers (P12M)*
*Question type:* ***Dyngrid***
*#row order: randomize*

**[B1]** For each statement, please mark whether you strongly disagree, disagree, agree, or strongly agree.

| | | | |
|---|---|---|---|
| -[B1_1] | I feel the need to hide my gambling from my friends | -[B1_8] | I sometimes have the thought that I deserve the bad things that have happened to me in life because I gamble |
| -[B1_2] | I sometimes have the thought that I've negatively impacted my life by gambling | -[B1_9] | I feel the stress in my life is what causes me to gamble |
| -[B1_3] | Most people would always suspect that I'd returned to gambling, even if I didn't gamble anymore | -[B1_10] | Others view me differently in terms of my morals because I gamble |
| -[B1_4] | People have insulted me because of my gambling | -[B1_11] | I avoid situations where another person might have to depend on me, due to my gambling |
| -[B1_5] | I have the thought that I should be ashamed of myself for my gambling | -[B1_12] | I don't think I can be trusted because I gamble |
| -[B1_6] | People can tell that I gamble by the way I look | -[B1_13] | Once they know I gamble, most people will take my opinion less seriously |
| -[B1_7] | Others think I am not worth the investment of time and resources because I gamble | | |

| | |
|---|---|
| <1> | Strongly disagree |
| <2> | Disagree |
| <3> | Agree |
| <4> | Strongly agree |

*Base: All gamblers (P12M)*
*Question type:* ***Dyngrid***
*#row order: randomize*
*#SPD Category: health*

**[B2]** For each statement, please mark whether you totally disagree, disagree, agree, or totally agree.

| | | | |
|---|---|---|---|
| -[B2_1] | Most people would willingly accept a relative or a friend of a person who committed suicide as a close friend | -[B2_8] | Most employers will hire a person who has attempted suicide if he or she is qualified for the job |
| -[B2_2] | People believe that a person who committed suicide was just as intelligent as the average person | -[B2_9] | Most employers will pass over the application of a person who has attempted suicide in favour of another applicant |
| -[B2_3] | Most people believe that a person who committed suicide was just as trustworthy as the average person | -[B2_10] | Most people in my community would treat a person who has attempted suicide just as they would treat anyone |
| -[B2_4] | Most people would accept a relative or a friend of a person who committed suicide as a teacher of young children in a public school | -[B2_11] | Most people would be reluctant to date a person who has attempted suicide |
| -[B2_5] | Most people feel that suicide is a sign of personal failure | -[B2_12] | Once they know a person is a person who has attempted suicide, most people will take his/her opinion less seriously |
| -[B2_6] | Most people would not hire a relative or a friend of a person who committed suicide to take care of their children even if he/she is healthy | -[B2_13] | Most people think that a person who has attempted suicide has a mental illness |
| -[B2_7] | Most people think less of a person who committed suicide | | |

| | |
|---|---|
| <1> | Strongly disagree |

| | |
|---|---|
| <2> | Disagree |
| <3> | Agree |
| <4> | Strongly agree |

*Base: All gamblers (P12M)*
*Question type:* ***Multiple***

**[T1_new]** In the past 12 months, have you attempted (either successfully or unsuccessfully) to stop gambling, or reduce your level of gambling?

| | |
|---|---|
| <1> | Yes – I have tried to stop gambling completely |
| <2> | Yes – I have tried to reduce the amount of **time** I spend on gambling |
| <3> | Yes – I have tried to reduce the amount of **money** I spend on gambling |
| <4> | Yes – I have tried to reduce the number of **different types of gambling activities** I gamble on |
| <5> | Yes – I have tried to reduce my frequency of gambling in certain situations (e.g., gambling alone, gambling after midnight, gambling when drinking alcohol) |
| <6> | Yes – I have tried to reduce my gambling in another way (open [T1_open1]) [open] please specify |
| <7 xor> | No |
| <98 fixed xor> | Don't know |
| <999 fixed xor> | Prefer not to say |

*Base: All gamblers (P12M) who attempted to stop or reduce level of gambling in P12M*
*Question type:* ***Multiple***
*#row order: randomize*
*#Question display logic:*
***if T1_new.has_any([1,2,3,4,5,6,98])***

**[T2]** Which, if any, of the following did you use to help you reduce or stop your gambling? Please select all that apply.

| | |
|---|---|
| <1> | Self-excluded from gambling companies' websites (via GAMSTOP), premises or a specific product |
| <2> | Set spend, loss or deposit limits on the amount of money I spent gambling |

| | |
|---|---|
| <3> | Set reminders, limits, or a 'time out' to control the time I spent gambling |
| <4> | Used blocking software to stop me accessing gambling websites |
| <5> | Asked my bank to block payments to gambling companies |
| <6> | Took a break from online websites without using a specific gambling management tool |
| <977 fixed xor> | None of these |
| <999 fixed xor> | Prefer not to say |

*Question type:* ***Multiple***
*#Question display logic:*
***if T1_new.has_any([1,2,3,4,5,6,98])***

**[T3]** In the last 12 months, which, if any, of the following have you used for support, advice or treatment with cutting down your gambling? Please tick all that apply.

**Treatment**

| | | | |
|---|---|---|---|
| <1> | GP or other primary health provider | <11> | Your employer |
| <18> | Mental health services (e.g., counsellor, therapist) – NHS (online and face-to-face) | <12> | Books, leaflets or other printed materials |
| <20> | Mental health services (e.g., counsellor, therapist) – Private (online and face-to-face) | <13> | Websites (e.g., GambleAware, Citizen's Advice, GamCare) |
| <3> | Social worker, youth worker or support worker | <14> | Online forum or group |
| <22> | National Gambling Support Network | <23> | National Gambling Helpline |
| <21> | Other specialist gambling specific services (e.g., AnonyMind, Therapy Route, a rehabilitation centre) | <24> | Another telephone helpline |
| <5> | Other addiction service (e.g., drug or alcohol) | <16> | Self-help apps or other self-help tools |
| | **Support and advice** | | |
| <8> | A support group (e.g., Gamblers Anonymous) | <17> | Self-exclusion (e.g., blocking software or blocking bank transactions) |
| <19> | A faith group | <95 fixed> | Another source of support, advice or treatment (open |

| | | | |
|---|---|---|---|
| | | | [Q7_open]) [open] please specify |
| <9> | Your spouse/partner | <99 fixed xor> | None of these |
| <10> | Friends or family members | | |

*Question type:* ***Pdl***
*#Question display logic:*
***if not pdl.sexuality and updated***

**[sexuality]** Which of the following best describes your sexuality?

| | |
|---|---|
| <1> | Heterosexual |
| <2> | Gay or lesbian |
| <3> | Bisexual |
| <4> | Other |
| <5> | Prefer not to say |

*Question type:* ***Pdl***

**[ethnicity_new]** What ethnic group best describes you? Please select one option only. (We ask the question in this way so that it is consistent with Census definitions.)

| | | | |
|---|---|---|---|
| <1> | English / Welsh / Scottish / Northern Irish / British | <11> | Bangladeshi |
| <2> | Irish | <12> | Chinese |
| <3> | Gypsy or Irish Traveller | <13> | Any other Asian background |
| <4> | Any other White background | <14> | African |
| <5> | White and Black Caribbean | <15> | Caribbean |
| <6> | White and Black African | <16> | Any other Black / African / Caribbean background |
| <7> | White and Asian | <17> | Arab |
| <8> | Any other Mixed / Multiple ethnic background | <18 fixed> | Any other ethnic group |

| | | | |
|---|---|---|---|
| <9> | Indian | <19 fixed> | Prefer not to say |
| <10> | Pakistani | | |

*Question type:* ***Pdl***
*#Question display logic:*
***if not pdl.profile_work_stat or pdl.profile_work_stat.last > months(6) and updated***

**[profile_work_stat]** Which of these applies to you?

| | |
|---|---|
| <1> | Working full time (30 or more hours per week) |
| <2> | Working part time (8–29 hours a week) |
| <3> | Working part time (Less than 8 hours a week) |
| <4> | Full time student |
| <5> | Retired |
| <6> | Unemployed |
| <7> | Not working |
| <8> | Other |

*Question type:* ***Pdl***
*#Question display logic:*
***if not pdl.profile_education_level or pdl.profile_education_level.last > months(12) and updated***

**[profile_education_level]** What is the highest educational or work-related qualification you have?

| | | | |
|---|---|---|---|
| <1> | No formal qualifications | <11> | GCE A level or Higher Certificate |
| <2> | Youth training certificate/skillseekers | <12> | Scottish Higher Certificate |
| <3> | Recognised trade apprenticeship completed | <13> | Nursing qualification (e.g., SEN, SRN, SCM, RGN) |
| <4> | Clerical and commercial | <14> | Teaching qualification (not degree) |
| <5> | City & Guilds certificate | <15> | University diploma |

| | | | |
|---|---|---|---|
| <6> | City & Guilds certificate - advanced | <16> | University or CNAA first degree (e.g., BA, B.Sc, B.Ed) |
| <7> | ONC | <17> | University or CNAA higher degree (e.g., M.Sc, Ph.D) |
| <8> | CSE grades 2–5 | <18> | Other technical, professional or higher qualification |
| <9> | CSE grade 1, GCE O level, GCSE, School Certificate | <19> | Don't know |
| <10> | Scottish Ordinary/ Lower Certificate | <20> | Prefer not to say |

*Question type:* ***Pdl***
*#Question display logic:*
***if not pdl.profile_gross_household or pdl.profile_gross_household.last > months(6) and updated***

**[profile_gross_household]** Gross HOUSEHOLD income is the combined income of all those earners in a household from all sources, including wages, salaries, or rents and before tax deductions. What is your gross household income?

| | | | |
|---|---|---|---|
| <1> | under £5,000 per year | <10> | £45,000 to £49,999 per year |
| <2> | £5,000 to £9,999 per year | <11> | £50,000 to £59,999 per year |
| <3> | £10,000 to £14,999 per year | <12> | £60,000 to £69,999 per year |
| <4> | £15,000 to £19,999 per year | <13> | £70,000 to £99,999 per year |
| <5> | £20,000 to £24,999 per year | <14> | £100,000 to £149,999 per year |
| <6> | £25,000 to £29,999 per year | <15> | £150,000 and over |
| <7> | £30,000 to £34,999 per year | <16> | Don't know |
| <8> | £35,000 to £39,999 per year | <17> | Prefer not to answer |
| <9> | £40,000 to £44,999 per year | | |

*Question type:* ***Pdl***
*#Question display logic:*
***if not profile_marital or pdl.profile_marital.last > months(6) and updated***

**[profile_marital]** What is your current marital or relationship status?

| | |
|---|---|
| <7> | Divorced |

| | |
|---|---|
| <2> | In a civil partnership |
| <5> | In a relationship, but not living together |
| <4> | Living with a partner but neither married nor in a civil partnership |
| <1> | Married |
| <3> | Separated but still legally married or in a civil partnership |
| <6> | Single |
| <8> | Widowed |

*Question type:* ***Pdl***
*#Question display logic:*
***if not pdl.disability or pdl.disability.last > months(12) and updated***

**[disability]** Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

| | |
|---|---|
| <1> | Yes, limited a lot |
| <2> | Yes, limited a little |
| <3> | No |

*Question type:* ***Single***

**[q_gender_identity_census_2021]** Is the gender you identify with the same as your sex registered at birth? (This question is voluntary.)

| | |
|---|---|
| <1> | Yes |
| <2> | No (open [q_gender_identity_census_2021_open]) [open] Optional: enter gender identity |

*Question type:* ***Text***

It's up to you how you answer this question.

Select "Yes" if:
you identify as female and your sex registered at birth was female you identify as male and your sex registered at birth was male

Select "No" if:
your gender identity is different to the sex recorded on your birth certificate when you were born, for example if you're transgender or non-binary

If you answered "No", please enter the term you use to describe your gender. This is also voluntary, so you can leave it blank if you prefer.

*Question type:* ***Text***

Thank you very much for taking the time to complete this survey and share your experiences and views with us. If you have been affected by the content of this survey, a list of support services is provided in the Information Sheet.

# Appendix B: Data tables

**Appendix Table B.1: Lifetime suicidality, by PGSI score, among people who gamble**

| PGSI category | Weighted bases (N=) | No suicidality | Suicidal ideation | Suicide attempt |
|---|---|---|---|---|
| PGSI 0 | 8,728 | 60.2%$_{a}$ | 31.9%$_{b}$ | 7.8%$_{c}$ |
| PGSI 1-2 | 1,217 | 54.4%$_{a}$ | 34.0%$_{a, b}$ | 11.6%$_{b}$ |
| PGSI 3-7 | 663 | 56.0%$_{a}$ | 31.5%$_{a}$ | 12.5%$_{b}$ |
| PGSI 8+ | 521 | 46.4%$_{a}$ | 31.9%$_{a}$ | 21.7%$_{b}$ |
| Total | 11,129 | 58.7% | 32.1% | 9.2% |
| *Weighted bases (N=)* | | *6,532* | *3,576* | *1,021* |

Base: GB adults aged 18 and over who had gambled in the past 12 months (n=11,129)Significance test: Pearson Chi-Square 144.804 (6, N=11,129), p<.001

Bonferroni Correction: Each subscript letter denotes a subset of suicidality categories where the column proportions do not differ significantly from each other at the .05 level.

**Appendix Table B.2: Importance of gambling in latest suicide attempt, by PGSI score, among people who gamble**

| PGSI category | Weighted bases (N=) | Not important | Somewhat or very important |
|---|---|---|---|
| PGSI 0 | 678 | 99.1%$_{a}$ | 0.9%$_{b}$ |
| PGSI 1-2 | 140 | 96.4%$_{a}$ | 3.6%$_{b}$ |
| PGSI 3-7 | 82 | 92.7%$_{a}$ | 7.3%$_{a}$ |
| PGSI 8+ | 111 | 34.2%$_{a}$ | 65.8%$_{b}$ |
| Total | 1,011 | 91.1% | 8.9% |
| *Weighted bases (N=)* | | *921* | *90* |

Base: GB adults aged 18 and over who had attempted suicide in their lifetime and had gambled in the past 12 months (n=1,011)

Significance test: Pearson Chi-Square 501.477 (3, N=1,011), p<.001

Bonferroni Correction: Each subscript letter denotes a subset of suicidality categories where the column proportions do not differ significantly from each other at the .05 level.

**Appendix Table B.3: Experience of suicidality, by patterns of gambling participation and PGSI score, among people who gamble**

| PGSI category | Pearson Chi-Square | Patterns of gambling participation | Weighted bases (N=) | No suicidality | Suicidal ideation | Suicide attempt |
|---|---|---|---|---|---|---|
| PGSI 0 | 72.987 (12, N=8729) | Betting only | 433 | 70.0%$_{a}$ | 24.5%$_{b}$ | 5.5%$_{b}$ |
| | P<.001 | Gaming only | 161 | 66.5%$_{a}$ | 28.6%$_{a}$ | 5.0%$_{a}$ |
| | | Other only | 5,870 | 58.1%$_{a}$ | 33.4%$_{b}$ | 8.5%$_{b}$ |
| | | Betting and gaming | 87 | 67.8%$_{a}$ | 25.3%$_{a}$ | 6.9%$_{a}$ |
| | | Betting and other | 1,254 | 66.1%$_{a}$ | 27.8%$_{b}$ | 6.1%$_{b}$ |
| | | Gaming and other | 480 | 52.9%$_{a}$ | 37.3%$_{b}$ | 9.8%$_{a, b}$ |
| | | Gaming, betting and other | 444 | 66.4%$_{a}$ | 28.6%$_{a, b}$ | 5.0%$_{b}$ |
| PGSI 1-2 | 57.273 (12, N=1217) | Betting only | 132 | 71.2%$_{a}$ | 24.2%$_{b}$ | 4.5%$_{b}$ |
| | P<.001 | Gaming only | 48 | 52.1%$_{a}$ | 37.5%$_{a}$ | 10.4%$_{a}$ |
| | | Other only | 483 | 46.6%$_{a}$ | 37.1%$_{b}$ | 16.4%$_{c}$ |
| | | Betting and gaming | 34 | 76.5%$_{a}$ | ** | ** |
| | | Betting and other | 215 | 56.3%$_{a}$ | 33.5%$_{a}$ | 10.2%$_{a}$ |
| | | Gaming and other | 127 | 44.1%$_{a}$ | 42.5%$_{b}$ | 13.4%$_{a, b}$ |
| | | Gaming, betting and other | 178 | 64.6%$_{a}$ | 30.3%$_{a, b}$ | 5.1%$_{b}$ |
| PGSI 3-7 | 39.182 (12, N=663) | Betting only | 70 | 67.1%$_{a}$ | 25.7%$_{a}$ | 7.1%$_{a}$ |
| | p<.001 | Gaming only | 33 | 54.5%$_{a}$ | 33.3%$_{a}$ | ** |
| | | Other only | 153 | 41.8%$_{a}$ | 38.6%$_{b}$ | 19.6%$_{b}$ |
| | | Betting and gaming | 45 | 68.9%$_{a}$ | 28.9%$_{a}$ | ** |
| | | Betting and other | 94 | 55.3%$_{a}$ | 37.2%$_{a}$ | 7.4%$_{a}$ |
| | | Gaming and other | 93 | 46.2%$_{a}$ | 34.4%$_{a, b}$ | 19.4%$_{b}$ |
| | | Gaming, betting and other | 175 | 66.3%$_{a}$ | 24.0%$_{b}$ | 9.7%$_{a, b}$ |
| PGSI 8+ | 19.735 (12, N=518) | Betting only | 39 | 59.0%a | 20.5%a | 20.5%$_{a}$ |
| | p=.072 | Gaming only | 32 | 31.3%a | 37.5%$_{a}$ | 31.3%$_{a}$ |
| | | Other only | 90 | 33.3%a | 41.1%$_{b}$ | 25.6%$_{a, b}$ |
| | | Betting and gaming | 54 | 57.4%$_{a}$ | 25.9%$_{a}$ | 16.7%$_{a}$ |
| | | Betting and other | 38 | 57.9%a | 31.6%$_{a}$ | ** |
| | | Gaming and other | 86 | 44.2%$_{a}$ | 30.2%$_{a}$ | 25.6%$_{a}$ |
| | | Gaming, betting and other | 179 | 49.2%$_{a}$ | 30.7%$_{a}$ | 20.1%$_{a}$ |
| Total | 110.277 (12, N=11,127) | Betting only | 674 | 69.3%$_{a}$ | 24.3%$_{b}$ | 6.4%$_{b}$ |
| | p<.001 | Gaming only | 274 | 58.4%$_{a}$ | 31.8%$_{a}$ | 9.9%$_{a}$ |
| | | Other only | 6,596 | 56.5%$_{a}$ | 33.9%$_{b}$ | 9.6%$_{b}$ |
| | | Betting and gaming | 220 | 66.8%$_{a}$ | 24.1%$_{b}$ | 9.1%$_{a, b}$ |
| | | Betting and other | 1,601 | 64.0%$_{a}$ | 29.2%$_{b}$ | 6.9%$_{b}$ |
| | | Gaming and other | 786 | 49.7%$_{a}$ | 37.0%$_{b}$ | 13.2%$_{b}$ |
| | | Gaming, betting and other | 976 | 62.9%$_{a}$ | 28.5%$_{b}$ | 8.6%$_{a, b}$ |
| *Weighted bases (N=)* | | | 11,127 | 58.7% | 32.1% | 9.2% |

Base: GB adults aged 18 and over who had gambled in the past 12 months (n=11,127)

** Base is <5

Bonferroni Correction: Each subscript letter denotes a subset of suicidality categories where the column proportions do not differ significantly from each other at the .05 level.

**Appendix Table B.4: Importance of gambling in latest suicide attempt, by pattern of gambling participation, among people who gamble and had attempted suicide**

| Pattern of gambling participation | Weighted bases (N=) | Not important | Somewhat or very important |
|---|---|---|---|
| Betting, gaming and other | 84 | 63.1%$_a$ | 36.9%$_b$ |
| Gaming and other | 104 | 82.7%$_a$ | 17.3%$_b$ |
| Betting and other | 111 | 96.4%$_a$ | 3.6%$_b$ |
| Betting and gaming | 19 | 68.4%$_a$ | 31.6%$_b$ |
| Other only | 624 | 97.4%$_a$ | 2.6%$_b$ |
| Gaming only | 27 | 70.4%$_a$ | 29.6%$_b$ |
| Betting only | 43 | 83.7%$_a$ | 16.3%$_a$ |
| Total | 1,012 | 91.1% | 8.9% |
| *Weighted bases (N=)* | | *922* | *90* |

Base: GB adults aged 18 and over who had attempted suicide in their lifetime and had gambled in the past 12 months (n=1,012)

Significance test: Pearson Chi-Square 154.411 (6, N=1,012), p<.001

Bonferroni Correction: Each subscript letter denotes a subset of suicidality categories where the column proportions do not differ significantly from each other at the .05 level.

**Appendix Table B.5: Experience of suicidality, by illegal, unregulated or unlicenced gambling, among people who gamble**

| Illegal, unregulated or unlicenced gambling | Weighted bases (N=) | No suicidality | Suicidal ideation | Suicide attempt |
|---|---|---|---|---|
| Not accessed illegal, unregulated or unlicenced gambling | 10,242 | 59.0%$_a$ | 32.4%$_a$ | 8.6%$_b$ |
| Accessed illegal, unregulated or unlicenced gambling | 564 | 53.5%$_a$ | 28.2%$_a$ | 18.3%$_b$ |
| Total | 10,806 | 58.7% | 32.2% | 9.1% |
| *Weighted bases (N=)* | | *6,341* | *3,480* | *985* |

Base: GB adults aged 18 and over who had gambled in the past 12 months (n=10,806)

Significance test: Pearson Chi-Square 60.269 (2, N=10,806), p<.001

Bonferroni Correction: Each subscript letter denotes a subset of suicidality categories where the column proportions do not differ significantly from each other at the .05 level.

**Appendix Table B.6: Importance of gambling in the most recent suicide attempt, by illegal, unregulated or unlicenced gambling, among people who gamble and had attempted suicide**

| Illegal, unregulated or unlicenced gambling | Weighted bases (N=) | Not important | Somewhat or very important |
|---|---|---|---|
| Not accessed illegal, unregulated or unlicenced gambling | 878 | 97.5%$_a$ | 2.5%$_b$ |
| Accessed illegal, unregulated or unlicenced gambling | 102 | 33.3%$_a$ | 66.7%$_b$ |
| Total | 980 | 90.8% | 9.2% |
| *Weighted bases (N=)* | | *890* | *90* |

Base: GB adults aged 18 and over who attempted suicide in their lifetime and had gambled in the past 12 months (n=980)

Significance tests: Independence: Pearson Chi-Square 451.056 (1, N=980), p<.001

Bonferroni Correction: Each subscript letter denotes a subset of suicidality categories where the column proportions do not differ significantly from each other at the .05 level.

**Appendix Table B.7: Lifetime suicidality, by frequency of gambling activities, among people who bet**

| Frequency of betting | Weighted bases (N=) | No suicidality | Suicidal ideation | Suicide attempt |
|---|---|---|---|---|
| Never or not in the past four weeks | 8895 | 56.2%$_a$ | 34.2%$_b$ | 9.6%$_b$ |
| Once in the past four weeks | 462 | 61.9%$_a$ | 28.6%$_a$ | 9.5%$_a$ |
| About once a fortnight | 320 | 65.0%$_a$ | 27.8%$_a$ | 7.2%$_a$ |
| About once per week | 676 | 71.9%$_a$ | 23.1%$_b$ | 5.0%$_b$ |
| A few times per week | 594 | 72.7%$_a$ | 21.0%$_b$ | 6.2%$_b$ |
| Every day | 182 | 66.5%$_a$ | 18.7%$_b$ | 14.8%$_a$ |
| Total | 11,129 | 58.7% | 32.1% | 9.2% |
| *Weighted bases (N=)* | | *6,531* | *3,577* | *1,021* |

Base: GB adults aged 18 and over who had gambled in the past 12 months (n=11,129)

Significance test: Pearson Chi-Square 147.990 (10, N=11,129), p<.001

Bonferroni Correction: Each subscript letter denotes a subset of suicidality categories where the column proportions do not differ significantly from each other at the .05 level.

**Appendix Table B.8: Lifetime suicidality, by frequency of gambling activities, among people who game**

| Frequency of gaming | Weighted bases (N=) | No suicidality | Suicidal ideation | Suicide attempt |
|---|---|---|---|---|
| Never or not in the past four weeks | 9602 | 58.3%$_{a}$ | 32.8%$_{b}$ | 8.8%$_{a}$ |
| Once in the past four weeks | 509 | 58.3%$_{a}$ | 32.6%$_{a}$ | 9.0%$_{a}$ |
| About once a fortnight | 250 | 62.0%$_{a}$ | 26.8%$_{a}$ | 11.2%$_{a}$ |
| About once per week | 349 | 62.5%$_{a}$ | 26.6%$_{a}$ | 10.9%$_{a}$ |
| A few times per week | 327 | 64.5%$_{a}$ | 24.8%$_{b}$ | 10.7%$_{a, b}$ |
| Every day | 92 | 53.3%$_{a}$ | 19.6%$_{a}$ | 27.2%$_{b}$ |
| Total | 11,129 | 58.7% | 32.1% | 9.2% |
| *Weighted bases (N=)* | | *6532* | *3576* | *1021* |

Base: GB adults aged 18 and over who had gambled in the past 12 months (n=11,129)Significance test: Pearson Chi-Square 57.557 (10, N=11,129), p<.001

Bonferroni Correction: Each subscript letter denotes a subset of suicidality categories where the column proportions do not differ significantly from each other at the .05 level.

**Appendix Table B.9: Lifetime suicidality, by frequency of gambling activities, among people who engage in 'other' gambling**

| Frequency of 'other' gambling | Weighted bases (N=) | No suicidality | Suicidal ideation | Suicide attempt |
|---|---|---|---|---|
| Never or not in the past four weeks | 3,092 | 57.9%$_{a}$ | 33.1%$_{a}$ | 9.1%$_{a}$ |
| Once in the past four weeks | 2,845 | 55.9%$_{a}$ | 35.5%$_{b}$ | 8.5%$_{a}$ |
| About once a fortnight | 1,142 | 57.4%$_{a}$ | 32.0%$_{a}$ | 10.5%$_{a}$ |
| About once per week | 2,831 | 62.3%$_{a}$ | 29.1%$_{b}$ | 8.6%$_{a, b}$ |
| A few times per week | 1,133 | 60.5%$_{a}$ | 29.3%$_{a}$ | 10.2%$_{a}$ |
| Every day | 84 | 52.4%$_{a}$ | 26.2%$_{a}$ | 21.4%$_{b}$ |
| Total | 11,127 | 58.7% | 32.1% | 9.2% |
| *Weighted bases (N=)* | | *6,531* | *3,576* | *1,020* |

Base: GB adults aged 18 and over who had gambled in the past 12 months (n=11,127)
Significance test: Pearson Chi-Square 54.377 (10, N=11,127), p<.001
Bonferroni Correction: Each subscript letter denotes a subset of suicidality categories where the column proportions do not differ significantly from each other at the .05 level.

**Appendix Table B.10: Lifetime suicidality, by mental wellbeing (S-WEMWBS) and PGSI score, among people who gamble**

| PGSI category | Pearson Chi-Square | S-WEMWBS category | Weighted bases (N=) | No suicidality | Suicidal ideation | Suicide attempt |
|---|---|---|---|---|---|---|
| PGSI 0 | 836.988 (4, N=8,728) p<.001 | Low wellbeing | 1,495 | 32.8%$_a$ | 49.8%$_b$ | 17.4%$_c$ |
| | | Moderate wellbeing | 5,128 | 60.4%$_a$ | 32.6%$_a$ | 7.0%$_b$ |
| | | High wellbeing | 2,105 | 79.3%$_a$ | 17.6%$_b$ | 3.1%$_c$ |
| PGSI 1-2 | 130.520 (4, N=1,217) p<.001 | Low wellbeing | 262 | 31.3%$_a$ | 43.5%$_b$ | 25.2%$_c$ |
| | | Moderate wellbeing | 738 | 55.6%$_a$ | 35.6%$_a$ | 8.8%$_b$ |
| | | High wellbeing | 217 | 78.3%$_a$ | 17.1%$_b$ | 4.6%$_b$ |
| PGSI 3-7 | 83.330 (4, N=664) p<.001 | Low wellbeing | 163 | 30.1%$_a$ | 46.6%$_b$ | 23.3%$_b$ |
| | | Moderate wellbeing | 373 | 58.2%$_a$ | 31.1%$_a$ | 10.7%$_a$ |
| | | High wellbeing | 128 | 82.0%$_a$ | 14.1%$_b$ | 3.9%$_b$ |
| PGSI 8+ | 15.658 (4, N=521) p=.004 | Low wellbeing | 164 | 37.8%$_a$ | 36.6%$_a$ | 25.6%$_a$ |
| | | Moderate wellbeing | 254 | 47.2%$_a$ | 34.3%$_a$ | 18.5%$_a$ |
| | | High wellbeing | 103 | 58.3%$_a$ | 18.4%$_b$ | 23.3%$_{a, b}$ |
| Total | 1064.434 (4, N=11,130) p<.001 | Low wellbeing | 2,084 | 32.8%$_a$ | 47.7%$_b$ | 19.5%$_c$ |
| | | Moderate wellbeing | 6,493 | 59.2%$_a$ | 32.9%$_a$ | 7.9%$_b$ |
| | | High wellbeing | 2,553 | 78.5%$_a$ | 17.4%$_b$ | 4.1%$_b$ |
| *Weighted bases (N=)* | | | | *6,531* | *3,578* | *1,021* |

Base: GB adults aged 18 and over who had gambled in the past 12 months (n=11,130)

Bonferroni Correction: Each subscript letter denotes a subset of suicidality categories where the column proportions do not differ significantly from each other at the .05 level.

**Appendix Table B.11: Lifetime suicidality, by age and PGSI score, among people who gamble**

| PGSI category | Pearson Chi-Square | Age | Weighted bases (N=) | No suicidality | Suicidal ideation | Suicide attempt |
|---|---|---|---|---|---|---|
| PGSI 0 | 179.679 (10, N=8,730) | 18–24 | 219 | 59.8%$_{a}$ | 29.2%$_{a}$ | 11.0%$_{a}$ |
| | p<.001 | 25–34 | 1,271 | 53.8%$_{a}$ | 37.5%$_{b}$ | 8.7%$_{a, b}$ |
| | | 35–44 | 1,502 | 53.5%$_{a}$ | 36.9%$_{b}$ | 9.7%$_{b}$ |
| | | 45–54 | 1,700 | 56.0%$_{a}$ | 34.5%$_{b}$ | 9.5%$_{b}$ |
| | | 55–64 | 1,681 | 60.7%$_{a}$ | 31.8%$_{a}$ | 7.4%$_{a}$ |
| | | 65+ | 2,357 | 70.7%$_{a}$ | 24.2%$_{b}$ | 5.1%$_{b}$ |
| PGSI 1-2 | 27.726 (10, N=1,216) | 18–24 | 101 | 64.4%$_{a}$ | 28.7%$_{a}$ | 6.9%$_{a}$ |
| | p=.002 | 25–34 | 325 | 60.9%$_{a}$ | 28.9%$_{b}$ | 10.2%$_{a, b}$ |
| | | 35–44 | 258 | 52.7%$_{a}$ | 34.1%$_{a}$ | 13.2%$_{a}$ |
| | | 45–54 | 237 | 46.4%$_{a}$ | 38.4%$_{a, b}$ | 15.2%$_{b}$ |
| | | 55–64 | 153 | 44.4%$_{a}$ | 41.2%$_{b}$ | 14.4%$_{a, b}$ |
| | | 65+ | 142 | 59.2%$_{a}$ | 34.5%$_{a}$ | 6.3%$_{a}$ |
| PGSI 3-7 | 34.418 (10, N=663) | 18–24 | 73 | 65.8%$_{a}$ | 31.5%$_{a, b}$ | 2.7%$_{b}$ |
| | p<.001 | 25–34 | 197 | 63.5%$_{a}$ | 26.4%$_{a}$ | 10.2%$_{a}$ |
| | | 35–44 | 164 | 51.8%$_{a}$ | 34.8%$_{a}$ | 13.4%$_{a}$ |
| | | 45–54 | 111 | 45.9%$_{a}$ | 33.3%$_{a, b}$ | 20.7%$_{b}$ |
| | | 55–64 | 64 | 37.5%$_{a}$ | 46.9%$_{b}$ | 15.6%$_{a, b}$ |
| | | 65+ | 54 | 70.4%$_{a}$ | 20.4%$_{a}$ | 9.3%$_{a}$ |
| PGSI 8+ | 10.616 (10, N=522) | 18–24 | 101 | 56.4%$_{a}$ | 21.8%$_{b}$ | 21.8%$_{a, b}$ |
| | p=.388 | 25–34 | 222 | 44.1%$_{a}$ | 34.2%$_{a}$ | 21.6%$_{a}$ |
| | | 35–44 | 105 | 49.5%$_{a}$ | 32.4%$_{a}$ | 18.1%$_{a}$ |
| | | 45–54 | 61 | 39.3%$_{a}$ | 34.4%$_{a}$ | 26.2%$_{a}$ |
| | | 55–64 | 22 | 31.8%$_{a}$ | 40.9%$_{a}$ | 27.3%$_{a}$ |
| | | 65+ | 11 | ** | ** | ** |
| Total | 209.551 (10, N=11,131) | 18–24 | 494 | 60.9%$_{a}$ | 27.9%$_{a}$ | 11.1%$_{a}$ |
| | p<.001 | 25–34 | 2,015 | 54.8%$_{a}$ | 34.7%$_{b}$ | 10.5%$_{b}$ |
| | | 35–44 | 2,029 | 53.0%$_{a}$ | 36.1%$_{b}$ | 10.8%$_{b}$ |
| | | 45–54 | 2,109 | 53.9%$_{a}$ | 34.9%$_{b}$ | 11.2%$_{b}$ |
| | | 55–64 | 1,920 | 58.3%$_{a}$ | 33.2%$_{a}$ | 8.5%$_{a}$ |
| | | 65+ | 2,564 | 69.9%$_{a}$ | 24.7%$_{b}$ | 5.3%$_{c}$ |
| *Weighted bases (N=)* | | | | 6,532 | 3,577 | 1,022 |

Base: GB adults aged 18 and over who had gambled in the past 12 months (n=11,131)

** Base is <5

Bonferroni Correction: Each subscript letter denotes a subset of suicidality categories where the column proportions do not differ significantly from each other at the .05 level.

**Appendix Table B.12: Lifetime suicidality, by gender and PGSI score, among people who gamble**

| PGSI category | Pearson Chi-Square | Gender | Weighted bases (N=) | No suicidality | Suicidal ideation | Suicide attempt |
|---|---|---|---|---|---|---|
| PGSI 0 | 52.7 (2, N=8,727) | Men | 4,209 | 63.4%$_{a}$ | 30.5%$_{b}$ | 6.0%$_{c}$ |
| | p<.001 | Women | 4,518 | 57.2%$_{a}$ | 33.2%$_{b}$ | 9.5%$_{c}$ |
| PGSI 1-2 | 36.4 (2, N=1,218) | Men | 709 | 60.4%$_{a}$ | 32.0%$_{b}$ | 7.6%$_{c}$ |
| | p<.001 | Women | 509 | 46.0%$_{a}$ | 36.9%$_{b}$ | 17.1%$_{c}$ |
| PGSI 3-7 | 11.238 (2, N=662) | Men | 450 | 59.1%$_{a}$ | 31.1%$_{a, b}$ | 9.8%$_{b}$ |
| | p=.004 | Women | 212 | 49.1%$_{a}$ | 32.5%$_{a, b}$ | 18.4%$_{b}$ |
| PGSI 8+ | 2.357 (2, N=519) | Men | 358 | 48.9%$_{a}$ | 30.4%$_{a}$ | 20.7%$_{a}$ |
| | p=.308 | Women | 161 | 41.6%$_{a}$ | 34.8%$_{a}$ | 23.6%$_{a}$ |
| Total | 64.978 (2, N=11,126) | Men | 5,726 | 61.8%$_{a}$ | 30.8%$_{b}$ | 7.4%$_{c}$ |
| | p<.001 | Women | 5,400 | 55.4%$_{a}$ | 33.6%$_{b}$ | 11.0%$_{c}$ |
| *Weighted bases (N=)* | | | | *6,530* | *3,576* | *1,020* |

Base: GB adults aged 18 and over who had gambled in the past 12 months (n=11,126)
Bonferroni Correction: Each subscript letter denotes a subset of suicidality categories where the column proportions do not differ significantly from each other at the .05 level.

**Appendix Table B.13: Lifetime suicidality, by ethnicity and PGSI score, among people who gamble**

| PGSI category | Pearson Chi-Square | Ethnicity | Weighted bases (N=) | No suicidality | Suicidal ideation | Suicide attempt |
|---|---|---|---|---|---|---|
| PGSI 0 | 4.491 (2, N=8,645) | White communities | 8,237 | 60.1%$_{a}$ | 32.1%$_{a}$ | 7.8%$_{a}$ |
| | p=.106 | Minoritised ethnic communities | 408 | 63.7%$_{a}$ | 27.2%$_{a}$ | 9.1%$_{a}$ |
| PGSI 1-2 | 13.982 (2, N=1,210) | White communities | 1,046 | 52.4%$_{a}$ | 35.9%$_{b}$ | 11.7%$_{a, b}$ |
| | p=.001 | Minoritised ethnic communities | 164 | 67.7%$_{a}$ | 22.6%$_{b}$ | 9.8%$_{a, b}$ |
| PGSI 3-7 | 16.348 (2, N=660) | White communities | 527 | 52.0%$_{a}$ | 34.2%$_{b}$ | 13.9%$_{b}$ |
| | p<.001 | Minoritised ethnic communities | 133 | 71.4%$_{a}$ | 21.1%$_{b}$ | 7.5%$_{b}$ |
| PGSI 8+ | 0.121 (2, N=515) | White communities | 383 | 47.0%$_{a}$ | 31.1%$_{a}$ | 21.9%$_{a}$ |
| | p=.941 | Minoritised ethnic communities | 132 | 45.5%$_{a}$ | 32.6%$_{a}$ | 22.0%$_{a}$ |
| Total | 15.521 (2, N=11,030) | White communities | 10,193 | 58.4%$_{a}$ | 32.5%$_{b}$ | 9.1%$_{a}$ |
| | p<.001 | Minoritised ethnic communities | 837 | 62.8%$_{a}$ | 26.2%$_{b}$ | 11.0%$_{a}$ |
| *Weighted bases (N=)* | | | | *6,480* | *3,535* | *1,015* |

Base: GB adults aged 18 and over who had gambled in the past 12 months (n=11,030)

Bonferroni Correction: Each subscript letter denotes a subset of suicidality categories where the column proportions do not differ significantly from each other at the .05 level.

**Appendix Table B.14: Lifetime suicidality, by sexual orientation and PGSI score, among people who gamble**

| PGSI category | Pearson Chi-Square | Sexual orientation | Weighted bases (N=) | No suicidality | Suicidal ideation | Suicide attempt |
|---|---|---|---|---|---|---|
| PGSI 0 | 235.192 (2, N=8,453) | Heterosexual | 7,643 | 62.7%$_a$ | 30.6%$_b$ | 6.7%$_c$ |
| | p<.001 | LGB and other sexual orientations | 810 | 38.4%$_a$ | 43.3%$_b$ | 18.3%$_c$ |
| PGSI 1-2 | 61.590 (2, N=1,160) | Heterosexual | 1,009 | 57.4%$_a$ | 33.6%$_b$ | 9.0%$_c$ |
| | p<.001 | LGB and other sexual orientations | 151 | 31.1%$_a$ | 40.4%$_b$ | 28.5%$_c$ |
| PGSI 3-7 | 11.277 (2, N=634) | Heterosexual | 560 | 57.9%$_a$ | 30.9%$_{a, b}$ | 11.3%$_b$ |
| | p=.004 | LGB and other sexual orientations | 74 | 40.5%$_a$ | 36.5%$_{a, b}$ | 23.0%$_b$ |
| PGSI 8+ | 10.363 (2, N=478) | Heterosexual | 404 | 49.0%$_a$ | 31.2%$_{a, b}$ | 19.8%$_b$ |
| | p=.006 | LGB and other sexual orientations | 74 | 32.4%$_a$ | 32.4%$_{a, b}$ | 35.1%$_b$ |
| Total | 329.003 (2, N=10,725) | Heterosexual | 9,616 | 61.3%$_a$ | 31.0%$_b$ | 7.7%$_c$ |
| | p<.001 | LGB and other sexual orientations | 1,109 | 37.2%$_a$ | 41.7%$_b$ | 21.1%$_c$ |
| *Weighted bases (N=)* | | | | *6,304* | *3,443* | *978* |

Base: GB adults aged 18 and over who had gambled in the past 12 months (n=10,725)
Bonferroni Correction: Each subscript letter denotes a subset of suicidality categories where the column proportions do not differ significantly from each other at the .05 level.

**Appendix Table B.15: Lifetime suicidality, by disability and PGSI score, among people who gamble**

| PGSI category | Pearson Chi-Square | Disability* | Weighted bases (N=) | No suicidality | Suicidal ideation | Suicide attempt |
|---|---|---|---|---|---|---|
| PGSI 0 | 526.568 (4, N=8,684) | A lot of limitations | 834 | 39.3%$_a$ | 37.4%$_b$ | 23.3%$_c$ |
| | p<.001 | Some limitations | 1,545 | 50.0%$_a$ | 37.4%$_b$ | 12.6%$_c$ |
| | | No disability | 6,305 | 65.5%$_a$ | 29.9%$_b$ | 4.6%$_c$ |
| PGSI 1-2 | 99.537 (4, N=1,208) | A lot of limitations | 136 | 30.9%$_a$ | 41.2%$_b$ | 27.9%$_c$ |
| | p<.001 | Some limitations | 211 | 38.4%$_a$ | 41.7%$_b$ | 19.9%$_b$ |
| | | No disability | 861 | 61.7%$_a$ | 31.4%$_b$ | 7.0%$_c$ |
| PGSI 3-7 | 77.039 (4, N=655) | A lot of limitations | 85 | 35.3%$_a$ | 27.1%$_a$ | 37.6%$_b$ |
| | p<.001 | Some limitations | 117 | 41.9%$_a$ | 41.0%$_b$ | 17.1%$_b$ |
| | | No disability | 453 | 63.6%$_a$ | 29.8%$_b$ | 6.6%$_c$ |
| PGSI 8+ | 60.861 (4, N=507) | A lot of limitations | 94 | 26.6%$_a$ | 30.9%$_a$ | 42.6%$_b$ |
| | p<.001 | Some limitations | 84 | 26.2%$_a$ | 45.2%$_b$ | 28.6%$_b$ |
| | | No disability | 329 | 57.8%$_a$ | 28.6%$_b$ | 13.7%$_c$ |
| Total | 783.178 (4, N=11,054) | A lot of limitations | 1,149 | 37.0%$_a$ | 36.6%$_b$ | 26.5%$_c$ |
| | p<.001 | Some limitations | 1,957 | 47.3%$_a$ | 38.4%$_b$ | 14.3%$_c$ |
| | | No disability | 7,948 | 64.6%$_a$ | 30.0%$_b$ | 5.4%$_c$ |
| *Weighted bases (N=)* | | | | *6487* | *3556* | *1011* |

Base: GB adults aged 18 and over who had gambled in the past 12 months (n=11,054)

* Disability was assessed by asking participants if their day-to-day activities were limited by a health problem or disability (with response options as ‘no’, ‘a little’, or ‘a lot’)

Bonferroni Correction: Each subscript letter denotes a subset of suicidality categories where the column proportions do not differ significantly from each other at the .05 level.

**Appendix Table B.16: Lifetime suicidality, by social grade and PGSI score, among people who gamble**

| PGSI category | Pearson Chi-Square | Social grade | Weighted bases (N=) | No suicidality | Suicidal ideation | Suicide attempt |
|---|---|---|---|---|---|---|
| PGSI 0 | 49.684 (2, N=8,727) | Middle class | 4,751 | 61.2%$_{a}$ | 32.8%$_{a}$ | 6.0%$_{b}$ |
| | p<.001 | Working class | 3,976 | 59.1%$_{a}$ | 30.9%$_{a}$ | 10.0%$_{b}$ |
| PGSI 1-2 | 30.649 (2, N=1,217) | Middle class | 646 | 57.4%$_{a}$ | 35.8%$_{a}$ | 6.8%$_{b}$ |
| | p<.001 | Working class | 571 | 51.0%$_{a}$ | 32.0%$_{a}$ | 17.0%$_{b}$ |
| PGSI 3-7 | 10.063 (2, N=663) | Middle class | 336 | 60.7%$_{a}$ | 30.4%$_{a, b}$ | 8.9%$_{b}$ |
| | p=.007 | Working class | 327 | 51.1%$_{a}$ | 32.7%$_{a, b}$ | 16.2%$_{b}$ |
| PGSI 8+ | 0.903 (2, N=521) | Middle class | 284 | 44.7%$_{a}$ | 33.5%$_{a}$ | 21.8%$_{a}$ |
| | p=.637 | Working class | 237 | 48.5%$_{a}$ | 30.0%$_{a}$ | 21.5%$_{a}$ |
| Total | 75.262 (2, N=11,128) | Middle class | 6,017 | 60.0%$_{a}$ | 33.0%$_{a}$ | 7.0%$_{b}$ |
| | p<.001 | Working class | 5,111 | 57.2%$_{a}$ | 31.1%$_{a}$ | 11.7%$_{b}$ |
| *Weighted bases (N=)* | | | | *6,532* | *3,576* | *1,020* |

Base: GB adults aged 18 and over who had gambled in the past 12 months (n=11,128)
Bonferroni Correction: Each subscript letter denotes a subset of suicidality categories where the column proportions do not differ significantly from each other at the .05 level.

**Appendix Table B.17: Lifetime suicidality, by how often people feel lonely and PGSI score, among people who gamble**

| PGSI category | Pearson Chi-Square | Loneliness level | Weighted bases (N=) | No suicidality | Suicidal ideation | Suicide attempt |
|---|---|---|---|---|---|---|
| PGSI 0 | 1,124.395 (8, N=8,727) | Never (feels lonely) | 1,269 | 83.0%$_{a}$ | 13.4%$_{b}$ | 3.6%$_{b}$ |
| | p<.001 | Hardly ever (feels lonely) | 2,768 | 71.2%$_{a}$ | 24.3%$_{b}$ | 4.5%$_{c}$ |
| | | Occasionally (feels lonely) | 1,990 | 58.5%$_{a}$ | 35.0%$_{b}$ | 6.5%$_{a}$ |
| | | Some of the times (feels lonely) | 1,923 | 45.9%$_{a}$ | 43.8%$_{b}$ | 10.3%$_{b}$ |
| | | Often or always (feels lonely) | 777 | 23.9%$_{a}$ | 52.0%$_{b}$ | 24.1%$_{c}$ |
| PGSI 1-2 | 173.680 (8, N=1,216) | Never (feels lonely) | 87 | 83.9%$_{a}$ | 12.6%$_{b}$ | ** |
| | p<.001 | Hardly ever (feels lonely) | 302 | 69.2%$_{a}$ | 25.5%$_{b}$ | 5.3%$_{b}$ |
| | | Occasionally (feels lonely) | 325 | 57.8%$_{a}$ | 34.2%$_{a, b}$ | 8.0%$_{b}$ |
| | | Some of the times (feels lonely) | 363 | 44.9%$_{a}$ | 41.3%$_{b}$ | 13.8%$_{b}$ |
| | | Often or always (feels lonely) | 139 | 19.4%$_{a}$ | 46.8%$_{b}$ | 33.8%$_{c}$ |
| PGSI 3-7 | 87.167 (8, N=664) | Never (feels lonely) | 40 | 77.5%$_{a}$ | 12.5%$_{b}$ | ** |
| | p<.001 | Hardly ever (feels lonely) | 136 | 70.6%$_{a}$ | 24.3%$_{b}$ | 5.1%$_{b}$ |
| | | Occasionally (feels lonely) | 196 | 65.8%$_{a}$ | 26.0%$_{b}$ | 8.2%$_{b}$ |
| | | Some of the times (feels lonely) | 202 | 48.0%$_{a}$ | 37.1%$_{b}$ | 14.9%$_{a, b}$ |
| | | Often or always (feels lonely) | 90 | 20.0%$_{a}$ | 50.0%$_{b}$ | 30.0%$_{b}$ |
| PGSI 8+ | 37.350 (8, N=518) | Never (feels lonely) | 12 | 75.0%$_{a}$ | ** | ** |
| | p<.001 | Hardly ever (feels lonely) | 65 | 63.1%$_{a}$ | 27.7%$_{a, b}$ | 9.2%$_{b}$ |
| | | Occasionally (feels lonely) | 138 | 50.7%$_{a}$ | 29.7%$_{ab}$ | 19.6%$_{ab}$ |
| | | Some of the times (feels lonely) | 208 | 45.7%$_{a}$ | 35.1%$_{ab}$ | 19.2%$_{a, b}$ |
| | | Often or always (feels lonely) | 95 | 27.4%$_{a}$ | 32.6%$_{a}$ | 40.0%$_{b}$ |
| Total | 1,468.723 (8, N=11,125) | Never (feels lonely) | 1,408 | 82.8%$_{a}$ | 13.4%$_{b}$ | 3.8%$_{b}$ |
| | p<.001 | Hardly ever (feels lonely) | 3,271 | 70.8%$_{a}$ | 24.5%$_{b}$ | 4.7%$_{c}$ |
| | | Occasionally (feels lonely) | 2,649 | 58.6%$_{a}$ | 34.0%$_{a}$ | 7.5%$_{b}$ |
| | | Some of the times (feels lonely) | 2,696 | 45.9%$_{a}$ | 42.3%$_{b}$ | 11.8%$_{b}$ |
| | | Often or always (feels lonely) | 1,101 | 23.3%$_{a}$ | 49.5%$_{b}$ | 27.2%$_{c}$ |
| *Weighted bases (N=)* | | | | *6,528* | *3,575* | *1,022* |

Base: GB adults aged 18 and over who had gambled in the past 12 months (n=11,125)
** Base is <5

Bonferroni Correction: Each subscript letter denotes a subset of suicidality categories where the column proportions do not differ significantly from each other at the .05 level.

**Appendix Table B.18: Lifetime suicidality, by gambling stigma, among people experiencing problems with gambling (PGSI 3+)**

| GESS category | Weighted bases (N=) | No suicidality | Suicidal ideation | Suicide attempt |
|---|---|---|---|---|
| Low stigma | 276 | 56.2%$_a$ | 30.4%$_a$ | 13.4%$_a$ |
| Moderate stigma | 416 | 55.3%$_a$ | 33.2%$_a$ | 11.5%$_b$ |
| High or very high stigma | 492 | 46.3%$_a$ | 31.1%$_a$ | 22.6%$_b$ |
| Total | 1,184 | 51.8% | 31.7% | 16.6% |
| *Weighted bases (N=)* | | *613* | *375* | *196* |

Base: GB adults aged 18 and over who had gambled in the past 12 months and were experiencing problems with gambling (PGSI 3+) (n=1,184)
Significance test: Pearson Chi-Square 24.001 (4, N=1,184), p<.001
Bonferroni Correction: Each subscript letter denotes a subset of suicidality categories where the column proportions do not differ significantly from each other at the .05 level.

**Appendix table B.19: Importance of gambling in latest suicide attempt, by gambling stigma, among people experiencing problems with gambling (PGSI 3+)**

| GESS category | Weighted bases (N=) | Not important | Somewhat or very important |
|---|---|---|---|
| Low stigma | 36 | 97.2%$_a$ | ** |
| Moderate stigma | 48 | 85.4%$_a$ | 14.6%$_b$ |
| High or very high stigma | 110 | 34.5%$_a$ | 65.5%$_b$ |
| Total | 194 | 58.8% | 41.2% |
| *Weighted bases (N=)* | | *114* | *80* |

Base: GB adults aged 18 and over who had gambled in past 12 months, were experiencing problems with gambling (PGSI 3+), and had attempted suicide (ever) (N=194)
Significance test: Pearson Chi-Square 62.670 (2, N=194), p<.001
** Base is <5
Bonferroni Correction: Each subscript letter denotes a subset of suicidality categories where the column proportions do not differ significantly from each other at the .05 level.

**Appendix Table B.20.a: Treatment and/or support accessed in last year among people experiencing problems with gambling (PGSI 3+) who had tried to reduce their gambling**

| Suicidality | Weighted base (N=) | No access to treatment and support | Access to treatment and support |
|---|---|---|---|
| No suicidality | 447 | 39.4%$_a$ | 60.6%$_a$ |
| Lifetime suicidal ideation | 283 | 44.5%$_a$ | 55.5%$_a$ |
| Lifetime suicide attempt | 158 | 39.2%$_a$ | 60.8%$_a$ |
| Total | 888 | 41.0% | 59.0% |
| *Weighted bases (N=)* | | *392* | *564* |

Base: GB adults aged 18 and over who had gambled in the past 12 months, had attempted to stop or reduce their gambling in the last year, and were experiencing problems with gambling (PGSI 3+) (n=888)

Significance test: Pearson Chi-Square 2.143 (2, N=888), p=.342

Bonferroni Correction: Each subscript letter denotes a subset of suicidality categories where the column proportions do not differ significantly from each other at the .05 level.

**Appendix Table B.20.b: Treatment and/or support accessed in last year among people experiencing problems with gambling (PGSI 3+) who have tried to reduce their gambling and had attempted suicide**

| Suicidality | Weighted base (N=) | No access to treatment and support | Access to treatment and support |
|---|---|---|---|
| Gambling not important in latest suicide attempt | 85 | 64.7% | 35.3% |
| Gambling somewhat or very important in latest suicide attempt | 73 | 9.6% | 90.4% |
| Total | 158 | 39.2% | 60.8% |
| *Weighted bases (N=)* | | *62* | *96* |

Base: GB adults aged 18 and over who had gambled in the past 12 months, had attempted to stop or reduce their gambling in the last year, were experiencing problems with gambling (PGSI 3+), and had attempted suicide (ever) (n=158)

Significance test: Pearson Chi-Square 50.039 (1, N=158), p<.001

**Appendix Table B.21: Number of treatment and/or support services used in last year, by lifetime suicidality, among people experiencing problems with gambling (PGSI 3+) who had tried to reduce their gambling and accessed treatment and/or support**

| Number of treatment services used | Weighted bases (N=) | No suicidality | Suicidal ideation | Suicide attempt |
|---|---|---|---|---|
| 1 | 187 | 37.8% | 36.5% | 29.2% |
| 2 | 114 | 23.0% | 20.5% | 20.8% |
| 3 | 101 | 18.9% | 21.2% | 17.7% |
| 4 | 49 | 7.0% | 11.5% | 12.5% |
| 5+ | 71 | 13.3% | 10.3% | 19.8% |
| *Weighted bases (N=)* | *522* | *270* | *156* | *96* |

Base: GB adults aged 18 and over who had gambled in the past 12 months, had attempted to stop or reduce their gambling in the last year, accessed treatment and/or support, and were experiencing problems with gambling (PGSI 3+) (n=522)

**Appendix Table B.22.a: Type of treatment and/or support used in last year, by lifetime suicidality, among people experiencing problems with gambling (PGSI 3+) who had tried to reduce their gambling**

| Treatment Accessed | Weighted bases (N=) | No Suicidality | Suicidal ideation | Suicide attempt |
|---|---|---|---|---|
| NHS MH services | 161 | 15.6% | 18.9% | 23.9% |
| Social worker, youth worker or support worker | 131 | 14.4% | 13.3% | 18.7% |
| GP or other primary health provider | 107 | 13.0% | 9.4% | 14.3% |
| Private MH services | 143 | 14.2% | 16.0% | 21.8% |
| National Gambling Support Network | 101 | 12.5% | 10.4% | 9.8% |
| Other specialist gambling specific services | 52 | 5.8% | 5.4% | 6.8% |
| Other addiction service (e.g., drug or alcohol) Support and advice | 27 | 2.8% | 2.8% | 4.0% |
| Friends or family members | 123 | 16.4% | 12.5% | 9.0% |
| Your spouse or partner | 94 | 11.7% | 9.7% | 9.1% |
| A faith group | 62 | 8.0% | 5.7% | 6.3% |
| A support group (e.g., Gamblers Anonymous) | 43 | 5.4% | 3.3% | 6.1% |
| Employer | 35 | 3.7% | 3.4% | 5.4% |
| Self-exclusion (e.g., blocking software or blocking bank transactions) | 78 | 9.6% | 6.7% | 10.4% |
| Online forum or group | 56 | 6.0% | 6.1% | 7.7% |
| Websites e.g., GambleAware, Citizens Advice, GamCare | 53 | 5.7% | 5.8% | 7.4% |
| Self-help apps or other self-help tools | 53 | 5.4% | 6.3% | 6.5% |
| National Gambling Helpline | 47 | 5.0% | 5.1% | 6.6% |
| Books, leaflets or other printed materials | 46 | 5.7% | 3.9% | 6.4% |
| Another telephone helpline | 33 | 3.7% | 3.3% | 4.7% |
| Another source of support, advice or treatment | 6 | ** | ** | ** |
| None of these | 363 | 39.3% | 44.5% | 39.0% |
| *Weighted bases (N=)* | *887* | *447* | *282* | *158* |

Base: GB adults aged 18 and over who had gambled in the past 12 months, had attempted to stop or reduce their gambling in the last year, and were experiencing problems with gambling (PGSI 3+) (n=887)
** Base is <5

**Appendix Table B.22.b: Type of treatment and/or support used in last year, by lifetime suicidality, among people experiencing problems with gambling (PGSI 3+) who had tried to reduce their gambling and had attempted suicide**

| Treatment Accessed | Weighted bases (N=) | Gambling not important in latest suicide attempt | Gambling somewhat or very important in latest suicide attempt |
|---|---|---|---|
| NHS MH services | 38 | 9.9% | 40.7% |
| Social worker, youth worker or support worker | 29 | ** | 35.3% |
| GP or other primary health provider | 23 | 5.4% | 25.1% |
| Private MH services | 34 | ** | 41.6% |
| National Gambling Support Network | 15 | ** | 20.5% |
| Other specialist gambling specific services | 11 | ** | 14.2% |
| Other addiction service (e.g., drug or alcohol) Support and advice | 6 | ** | 6.4% |
| Friends or family members | 14 | 9.0% | 8.5% |
| Your spouse or partner | 14 | 7.8% | 10.8% |
| A faith group | 10 | ** | 10.7% |
| A support group (e.g., Gamblers Anonymous) | 10 | ** | 8.2% |
| Employer | 8 | ** | 10.2% |
| Self-exclusion (e.g., blocking software or blocking bank transactions) | 16 | 10.7% | 10.1% |
| Online forum or group | 12 | ** | 13.8% |
| Websites e.g., GambleAware, Citizens Advice, GamCare | 12 | ** | 13.8% |
| Self-help apps or other self-help tools | 10 | ** | 11.4% |
| National Gambling Helpline | 10 | ** | 12.9% |
| Books, leaflets or other printed materials | 10 | ** | 9.5% |
| Another telephone helpline | 7 | ** | 9.0% |
| Another source of support, advice or treatment | ** | ** | ** |
| None of these | 61 | 64.6% | 9.1% |
| *Weighted bases (N=)* | *157* | *84* | *72* |

Base: GB adults aged 18 and over who had gambled in the past 12 months, had attempted to stop or reduce their gambling in the last year, were experiencing problems with gambling (PGSI 3+), and had attempted suicide (ever) (n=157)
** Base is <5

**Appendix Table B.23: Use of treatment and services in last year, by gambling stigma, among people experiencing problems with gambling (PGSI 3+) who had tried to reduce their gambling**

| Access to treatment and support | Weighted bases (N=) | Low stigma | Moderate stigma | High or very high stigma |
|---|---|---|---|---|
| No access to treatment and support | 392 | 27.6%$_a$ | 45.9%$_b$ | 26.5%$_c$ |
| Access to treatment and support | 564 | 6.2%$_a$ | 27.0%$_b$ | 66.8%$_c$ |
| Total | 956 | 15.0% | 34.7% | 50.3% |
| *Weighted bases (N=)* | *956* | *143* | *332* | *481* |

Base: GB adults aged 18 and over who had gambled in the past 12 months, had attempted to stop or reduce their gambling in the last year, and were experiencing problems with gambling (PGSI 3+) (n=956)Bonferroni Correction: Each subscript letter denotes a subset of suicidality categories where the column proportions do not differ significantly from each other at the .05 level.

**Appendix Table B.24: Lifetime suicidal ideation: binary logistic regression**

| Variable | Value | Odds ratio | 95% Confidence interval (CI) Lower | Upper | Significance (p-value) | df |
|---|---|---|---|---|---|---|
| PGSI | PGSI 0 | | | | 0.180 | 3 |
| | PGSI 1-2 | 1.157 | 0.994 | 1.347 | 0.060 | 1 |
| | PGSI 3-7 | 1.114 | 0.893 | 1.390 | 0.337 | 1 |
| | PGSI 8+ | 1.259 | 0.918 | 1.727 | 0.152 | 1 |
| Pattern of gambling participation | Betting only | | | | 0.000 | 6 |
| | Gaming only | 1.278 | 0.902 | 1.810 | 0.168 | 1 |
| | Other only | 1.633 | 1.322 | 2.016 | 0.000 | 1 |
| | Betting and gaming | 0.955 | 0.631 | 1.445 | 0.828 | 1 |
| | Betting and other | 1.335 | 1.059 | 1.685 | 0.015 | 1 |
| | Gaming and other | 1.635 | 1.258 | 2.125 | 0.000 | 1 |
| | Betting, gaming and other | 1.215 | 0.943 | 1.565 | 0.132 | 1 |
| S-WEMWBS | High wellbeing | | | | 0.000 | 2 |
| | Moderate wellbeing | 1.710 | 1.507 | 1.940 | 0.000 | 1 |
| | Low wellbeing | 2.817 | 2.385 | 3.328 | 0.000 | 1 |
| Age | 65+ | | | | 0.000 | 5 |
| | 55–64 | 1.714 | 1.478 | 1.988 | 0.000 | 1 |
| | 45–54 | 1.664 | 1.437 | 1.927 | 0.000 | 1 |
| | 35–44 | 1.747 | 1.499 | 2.037 | 0.000 | 1 |
| | 25–34 | 1.781 | 1.517 | 2.090 | 0.000 | 1 |
| | 18–24 | 1.254 | 0.965 | 1.629 | 0.091 | 1 |
| Gender | Men | | | | | |
| | Women | 1.037 | 0.943 | 1.140 | 0.454 | 1 |
| Ethnicity | White communities | | | | | |
| | Minoritised ethnic communities | 0.657 | 0.545 | 0.792 | 0.000 | 1 |
| Sexual orientation | Heterosexual | | | | | |
| | LGB and other sexual orientations | 1.691 | 1.448 | 1.975 | 0.000 | 1 |
| Disability | No disability | | | | 0.000 | 2 |
| | Some limitations | 1.765 | 1.560 | 1.997 | 0.000 | 1 |
| | A lot of limitations | 1.731 | 1.463 | 2.047 | 0.000 | 1 |
| Social grade | Middle class | | | | | |
| | Working class | 0.862 | 0.784 | 0.946 | 0.002 | 1 |
| Loneliness | Never (feels lonely) | | | | 0.000 | 4 |
| | Hardly ever (feels lonely) | 1.917 | 1.597 | 2.303 | 0.000 | 1 |
| | Occasionally (feels lonely) | 2.769 | 2.294 | 3.342 | 0.000 | 1 |
| | Some of the times (feels lonely) | 3.892 | 3.213 | 4.715 | 0.000 | 1 |
| | Often or always (feels lonely) | 6.815 | 5.366 | 8.656 | 0.000 | 1 |
| GESS | Low gambling stigma | | | | 0.002 | 2 |
| | Moderate gambling stigma | 0.805 | 0.689 | 0.941 | 0.007 | 1 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | High or very high gambling stigma | 0.665 | 0.500 | 0.884 | 0.005 | 1 |

Base: GB adults aged 18 and over who had gambled in the past 12 months and who had not attempted suicide (n=9,475)

**Appendix Table B.25: Lifetime suicide attempt: binary logistic regression**

| | | | 95% Confidence interval (CI) | | | |
|---|---|---|---|---|---|---|
| **Variables** | **Value** | **Odds ratio** | **Lower** | **Upper** | **Significance (p-value)** | **df** |
| PGSI | PGSI 0 | | | | 0.001 | 3 |
| | PGSI 1-2 | 1.347 | 1.078 | 1.682 | 0.009 | 1 |
| | PGSI 3-7 | 1.460 | 1.072 | 1.989 | 0.016 | 1 |
| | PGSI 8+ | 2.010 | 1.349 | 2.994 | 0.001 | 1 |
| Pattern of gambling participation | Betting only | | | | 0.428 | 6 |
| | Gaming only | 0.756 | 0.434 | 1.316 | 0.323 | 1 |
| | Other only | 1.177 | 0.826 | 1.678 | 0.367 | 1 |
| | Betting and gaming | 1.004 | 0.543 | 1.856 | 0.990 | 1 |
| | Betting and other | 1.013 | 0.681 | 1.507 | 0.950 | 1 |
| | Gaming and other | 1.019 | 0.675 | 1.539 | 0.927 | 1 |
| | Betting, gaming and other | 1.001 | 0.659 | 1.519 | 0.997 | 1 |
| S-WEMWBS | High wellbeing | | | | 0.000 | 2 |
| | Moderate wellbeing | 1.340 | 1.054 | 1.703 | 0.017 | 1 |
| | Low wellbeing | 1.711 | 1.301 | 2.251 | 0.000 | 1 |
| Age | 65+ | | | | 0.000 | 5 |
| | 55-64 | 1.531 | 1.032 | 2.272 | 0.034 | 1 |
| | 45-54 | 1.771 | 1.355 | 2.315 | 0.000 | 1 |
| | 35-44 | 1.912 | 1.483 | 2.465 | 0.000 | 1 |
| | 25-34 | 1.910 | 1.499 | 2.434 | 0.000 | 1 |
| | 18-24 | 1.572 | 1.220 | 2.026 | 0.000 | 1 |
| Gender | Men | | | | | |
| | Women | 1.388 | 1.193 | 1.614 | 0.000 | 1 |
| Ethnicity | White communities | | | | | |
| | Minoritised ethnic communities | 0.887 | 0.677 | 1.161 | 0.381 | 1 |
| Sexual orientation | Heterosexual | | | | | |
| | LGB and other sexual orientations | 2.296 | 1.905 | 2.769 | 0.000 | 1 |
| Disability | No disability | | | | 0.000 | 2 |
| | Some limitations | 2.617 | 2.196 | 3.119 | 0.000 | 1 |
| | A lot of limitations | 3.919 | 3.236 | 4.746 | 0.000 | 1 |
| Social grade | Middle class | | | | | |
| | Working class | 1.368 | 1.179 | 1.587 | 0.000 | 1 |
| Loneliness | Never (feels lonely) | | | | 0.000 | 4 |
| | Hardly ever (feels lonely) | 1.157 | 0.828 | 1.618 | 0.393 | 1 |
| | Occasionally (feels lonely) | 1.412 | 1.010 | 1.973 | 0.044 | 1 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Some of the times (feels lonely) | 1.820 | 1.308 | 2.531 | 0.000 | 1 |
| | Often or always (feels lonely) | 3.880 | 2.741 | 5.491 | 0.000 | 1 |
| GESS | Low gambling stigma | | | | 0.005 | 2 |
| | Moderate gambling stigma | 0.830 | 0.650 | 1.059 | 0.133 | 1 |
| | High or very high gambling stigma | 1.519 | 1.059 | 2.179 | 0.023 | 1 |

Base: GB adults aged 18 and over who had gambled in the past 12 months (n=10,525)

**Appendix Table B.26: Lifetime suicidal ideation, by gambling stigma, among people experiencing problems with gambling (PGSI 3+): binary logistic regression**

| | | 95% Confidence interval (CI) | | | | |
|---|---|---|---|---|---|---|
| **Variables** | **Value** | **Odds ratio** | **Lower** | **Upper** | **Significance (p-value)** | **df** |
| GESS | Low gambling stigma | | | | .468 | 2 |
| | Moderate gambling stigma | 1.107 | 0.789 | 1.554 | .556 | 1 |
| | High or very high gambling stigma | 1.231 | 0.880 | 1.722 | .225 | 1 |

Base: GB adults aged 18 and over who had gambled in the past 12 months and were experiencing problems with gambling (PGSI 3+) and had not attempted suicide (n=988)

**Appendix Table B.27: Lifetime suicide attempt, by gambling stigma, among people experiencing problems with gambling (PGSI 3+): binary logistic regression**

| | | 95% Confidence interval (CI) | | | | |
|---|---|---|---|---|---|---|
| **Variables** | **Value** | **Odds ratio** | **Lower** | **Upper** | **Significance (p-value)** | **df** |
| GESS | Low gambling stigma | | | | .000 | 2 |
| | Moderate gambling stigma | 0.847 | 0.534 | 1.342 | .479 | 1 |
| | High or very high gambling stigma | 1.907 | 1.269 | 2.865 | 0002 | 1 |

Base: GB adults aged 18 and over who had gambled in the past 12 months and were experiencing problems with gambling (PGSI 3+) (n=1,183)

**Appendix Table B.28 Importance of gambling-related factors in decision to attempt suicide, among people experiencing problems with gambling (PGSI 3+) who had attempted suicide**

| **Gambling-related factors** | **Weighted bases (N=)** | **Not important at all** | **Not very important** | **Somewhat important** | **Very important** |
|---|---|---|---|---|---|
| I felt that other people were judging me | 77 | 6.6% | 17.4% | 37.8% | 38.3% |
| I felt shame or guilt because of gambling | 79 | ** | 16.0% | 36.4% | 42.3% |

Base: GB adults aged 18 and over who had gambled in the past 12 months, were experiencing problems with gambling (PGSI 3+) and had linked their latest suicide attempt to gambling (n=79)
** Base is <5