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# An Evaluation of the GambleAware-Funded Treatment System (GAFTS)

# Phase One Report: **Exemplar gambling treatment system framework design**

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# Executive summary

This report covers Phase One of a two-phase programme commissioned by GambleAware and delivered by Leeds Beckett University. The overall programme aim is to deliver an objective, independent evaluation of the current GambleAware-funded treatment and support system. This a system-level evaluation not an impact evaluation of system components or services.

The programme brief dictates that this should be delivered in two phases as follows:
***Phase One:*** **Exemplar system framework design**: Establish an 'exemplar gambling treatment system' framework by reviewing the existing evidence-base, filling gaps in knowledge where possible through consultation with stakeholders, and initial network analysis to produce a treatment system map.
***Phase Two:*** **System evaluation**: To use these Phase One outputs to facilitate an in-depth evaluation of the system.

In order to fulfil the Phase One brief, we set four objectives which guided the choice of methodology utilised:

(1) To map the current GambleAware funded treatment system and the basic interconnections between system components – using **network analysis**.

(2) To review the existing evidence-base concerning effective treatment systems and to create an initial framework of exemplar gambling treatment system principles – using a **rapid literature review**.

(3) To use the initial framework to seek and crosscheck system stakeholder views on what a "good" gambling treatment system looks like – using **interviews with system stakeholders**.

(4) To synthesise the evidence-base and system stakeholder responses into a comprehensive exemplar gambling treatment system framework for use in Phase Two.

**Summary of methods**

**An initial network analysis** was conducted in order to provide a baseline understanding of the system under investigation. This analysis was intended to be a snapshot in time, which therefore did not take account of the dynamic and detailed characteristics of structure and interconnections between components, it highlighted the multi-level nature of the system (i.e. that not all components have a direct link with others).

The exemplar gambling treatment system framework was then developed iteratively in three stages. First, a **rapid review** of the academic and grey literature on treatment systems was conducted in order to develop an initial exemplar gambling treatment system framework, which comprised of six principles. Second, the framework was used alongside information gathered from system documentation and informal consultations with system managers and stakeholders to create an Interview Schedule, which was designed to capture information more specifically relevant to gambling treatment. **Semi-structured interviews** were then conducted with a range of system stakeholders including providers and commissioners in order to check the relevance of the framework principles and to fill gaps in the nascent evidence-base.

Third, the synthesis of accumulated information alongside previous and emerging commissioned research knowledge facilitated a further iterative framework development step resulting in a comprehensive version.

## The exemplar gambling treatment system framework

This includes **six core principles** (CPs), each with detailed definitions and descriptors. They are as follows:

CP1: Identification and understanding of treatment system requirements for the whole of the wider gambling environment (which may be termed a "gambleogenic" environment)[1]
CP2: Collaboration across the gambling treatment system
CP3: Governance, resources, and processes to ensure adequate infrastructure and system functioning
CP4: Attention to diversity and socio-structural status
CP5: Awareness and accessibility of the gambling treatment system and appropriate individualised treatment
CP6: Evidence-informed system design (including interventions and gambling insight)

The report concludes by summarising Phase One with reference to the four objectives, and then notes the limitations of Phase One work, principally the inability to take account of dynamic system changes and the lack of gambling-specific treatment system literature. Finally, it is proposed that the next step in the evaluation programme should be a Phase Two planning and consultation exercise which takes into account the dynamic and multi-level nature of the treatment system and potential

[1] "Gambleogenic" is a term we have coined following the use of the term "obesogenic" in the Government Office for Science 2007 report "Tackling Obesities". The use of the "-ogenic" suffix recognises that a public health condition may be influenced by a complex web of inter-connected and inter-relating factors, including both individual physiological and psychological traits and external influences, many of which are outwith the control of an individual, such as social norms, economic activity and industry behaviours. It also recognises the importance of considering the context in which the "core" treatment system operates, including its relationship with a wide range of sectors and stakeholders, including those that might not automatically see their contribution to the creation and implementation of an effective (gambling) treatment system.

challenges and risks associated with cross-sectional evaluations. This exercise will facilitate strategic decision making concerning the exact remit of Phase Two to ensure the impact of outputs are maximised, for the benefit of the treatment system and its stakeholders.

# 1 Introduction

## 1.1 Background

This report covers Phase One of a two-phase programme commissioned by GambleAware and delivered by Leeds Beckett University. The work was identified as one of the core strands in the Gambling Commission's Research Programme 2018-2022[2] to support the National Strategy to reduce gambling harms[3].

The overall programme aim is to deliver an objective, independent evaluation of the current GambleAware-funded treatment and support system. Following discussions between GambleAware (GA), the Gambling Commission (GC) and Leeds Beckett University (LBU) it was agreed that the objectives for the Evaluation of GA Funded Treatment System should be:

- Evaluate the GambleAware funded treatment system effectiveness
- Assess how the different services function together as a coherent national system, so that people get the treatment that best fits their needs
- Understand the wider inputs into the system (e.g. primary care, mental health, addictions, housing, debt advice), and
- Evaluate GambleAware commissioning against good practice in commissioning of services and provide evidence-based recommendations for system improvements to drive strategic design.

The project brief proposed that this would be addressed in two phases:

***Phase One:*** **Exemplar system framework design**: Establish an 'exemplar [4] gambling treatment system' framework by reviewing the existing evidence-base, filling gaps in knowledge where possible through consultation with stakeholders, and initial network analysis to produce a treatment system map.

***Phase Two:*** **System evaluation**: To use these Phase One outputs to facilitate an in-depth evaluation of the system.

This report summarises the Phase One research process and iterative development of knowledge and culminates in the presentation of a

[2] Gambling Commission Research Programme. Available: https://www.reducinggamblingharms.org/asset-library/Research-Programme-2018-22.pdf

[3] National Strategy to Reduce Gambling Harms. Available: https://www.reducinggamblingharms.org/asset-library/national-strategy-to-reduce-gambling-harms.pdf

[4] 'Exemplar' is defined as "a person or thing serving as a typical example or appropriate model"

comprehensive exemplar gambling treatment system framework that will underpin Phase Two evaluation.

## 1.2 Gambling treatment context

The work has taken place at a time of significant and on-going change in the treatment of problem gambling, including innovations led by GambleAware and individual providers, such as online CBT and pilots with primary care as well as the substantial increase in treatment capacity in the form of the new Northern Gambling Clinic/Hub. In addition, recently commissioned research has increased understanding of treatment need, and gaps in current provision (e.g. work conducted for GambleAware by NatCen[5] and ACT Recovery[6]). In addition, initiatives such as the BetRegret campaign[7] targeting sports betters aged 18-34, have resulted in changing public attitudes towards gambling and problem gamblers, indicated by media coverage highlighting associated mental health concerns and other comorbidities.

## 1.3 Phase One aim and objectives

Phase One aims to ensure that the more detailed Phase Two system evaluation can be carried out robustly, effectively and efficiently. To this end and in accordance with the Phase One brief, Phase One has four objectives:

(1) To map the current GambleAware funded treatment system and the basic interconnections between system components.
(2) To review the existing evidence-base concerning effective treatment systems and to create an initial framework of exemplar gambling treatment system principles.
(3) To use the initial framework to seek and crosscheck system stakeholder views on what a “good” gambling treatment system looks like.
(4) To synthesise the evidence-base and system stakeholder responses into a comprehensive exemplar gambling treatment system framework for use in Phase Two.

## 1.4 Phase One work components

In order to address objective (1) to map the current system, an initial network analysis was conducted to understand who is in the system and their

[5] NatCen Social Research: Treatment Delivery Gap Analysis: a needs assessment for treatment services (Workstream 3), seen in draft and Secondary Data Analysis of the Data Reporting Framework and the Health Survey for England (Workstream 2), seen in draft
[6] ACT Recovery: Gambling Treatment Services Needs Assessment Report for GambleAware, seen in draft
[7] See for instance: https://www.begambleaware.org/BetRegret/

interconnections (recognising that this would be a snapshot at a particular time) (see **Section 2** below).

To address objective (2), to review the existing evidence-base concerning effective treatment systems a rapid review of the academic and grey literature was conducted, and an initial draft framework of exemplar gambling treatment system principles was created (see **Section 3 below).**

To address objective (3), to ascertain system stakeholder views on what a "good" gambling treatment system looks like, the initial draft framework of system principles was used alongside information gathered from system documentation and informal consultations with system managers and stakeholders to create an Interview Schedule. Interviews were then conducted, and data were analysed to crosscheck interviewee responses against the initial framework and integrate additional gambling treatment-specific insight (see **Section 4 below**).

To address objective (4), to synthesise the iteratively developed knowledge base into a comprehensive framework, accumulated knowledge was collated and duplication of information across principles minimised in order to build the final comprehensive framework (see **Section 5 below**).

# *2* Mapping the current GambleAware Funded Treatment System

## 2.1 About the "System"

Before applying network analysis to the GambleAware Funded Treatment System (GAFTS), it was important to first establish the boundary of the system under investigation. Even though the GAFTS has connections with external organisations (such as industry, criminal justice system, social services, housing, employers), and there are other privately funded treatment services, the baseline network map only includes those directly funded by GambleAware within the treatment system. It is important to note that although some services, such as the Gordon Moody Association, are long-established providers, other components of the system are relatively recent (such as the Northern Gambling Service), whilst other parts are changing (such as the identity of the GamCare partners) and relationships between parts of the system are still evolving. Therefore, it is necessary to keep the boundaries under review and to update them regularly to maintain an accurate picture.

This preliminary network analysis is intended to provide an initial baseline understanding of the system under investigation. This initial network analysis will serve as a basis for a further and more robust analysis in Phase 2.

The data were collated from publicly available sources mainly GambleAware (2019) and GamCare (2019) annual reports, as well as the websites of providers in the funded treatment system.

## 2.2 Initial Network Analysis methodology

We have selected the Network Analysis approach[8] because it is a useful way of mapping and demonstrating the relationships and interactions between parts of a network, such as communications, funding or influences. The mathematical underpinning means, as the network develops, and with more data, we can provide deeper insight into the structure of the system.

## 2.3 Network map commentary

This initial system visualisation (see below) demonstrates the GAFTS funding system, with an arrow demonstrating the flow of funding. Funding flow was chosen as the data source for connections due to data availability, however, no reference has been made to funding amounts at this stage since specific funding amounts were not obtainable during this phase of research.

Whilst only an initial network, it is clear GamCare is central to the system, operating the majority of the current national treatment provision, as well as the national helpline, which plays a key role in the system. In a network sense, GamCare occupy a 'structural hole': without GamCare the system becomes two unconnected parts, which means GamCare is fundamental to the system structure.

This structure also means a service provider for GamCare is 2 steps away from GambleAware, unlike the National Health Service (NHS) Trusts (CNWL and Northern Gambling Service) and Gordon Moody, who are 1 step away: this may be significant in terms of the likelihood of direct contact and the strength of communications between these providers and other parts of the system.

Similarly, this structure suggests providers within the system are isolated from one another, meaning communication and collaboration (see Principle 2 of the final

[8] A very brief explanation of Network Analyses is included here for completeness and ease of reference for any reader unfamiliar with their uses. A network (or graph) describes a set of elements, termed nodes, that are connected through interactions and relationships, termed edges. Following Wasserman & Faust (2009) a graph is noted as $G = (V, L)$ comprised of a set of nodes $V$ (or vertices or actors) and a set of edges $L$ (or ties or links), or $L \in V \times V$. As some relationships follow direction (funding, resource flow, reporting) from node $i$ to $j$, then, $L_{ij} \in \{0,1\}$, with $L_{ij} = 1$ showing a relationship and $L_{ij} = 0$ where a relationship does not exist.

exemplar treatment system framework) is likely to be more difficult because they may not have direct interconnections with each other.

Further analysis is needed to fully understand the GAFTS from a systems perspective. To understand the system fully, the boundary needs to encompass the wider environment in which problem gambling exists. This will allow an analysis of how the GAFTS operates within the broader system, and how it interacts and overlaps with other sub-systems. As we know from network thinking, systems are often overlapping and nested.

## 2.4 Network map

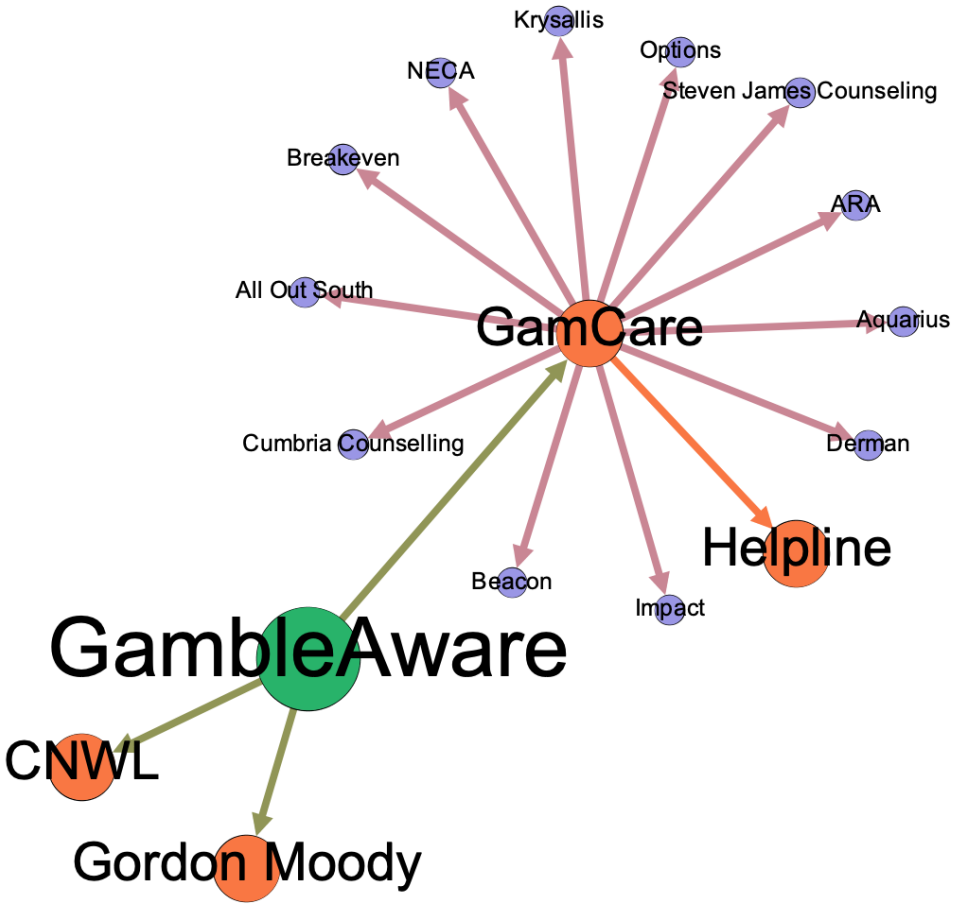


Figure 1. ***The 'Baseline' System Network based on 'Flow of Funding'***

# 3 A rapid review of academic and grey literature to develop an initial draft framework of exemplar gambling treatment system principles

## 3.1 Rapid review rationale

Due to constraints imposed by the schedule and resources available for Phase One, a rapid review of the existing evidence-base was deemed appropriate. There are no prescribed guidelines for rapid reviews (although guidelines for full systematic reviews have been used as a guide). The consensus is that flexibility is required within the process in order to meet the need for the review to be timely. Several studies have attempted to operationalise the steps or attributes common to rapid reviews (Watt *et al.,* 2008; Ganann *et al.,* 2010; Featherstone *et al.,* 2015). Their findings suggest that the majority of rapid reviews involve streamlined methods such as limiting the literature search and databases used, reducing inclusion criteria under certain parameters (e.g. language, date etc.), having one person screen the literature, and presenting the results as a narrative summary. Despite this streamlining, importantly it has been noted that rapid reviews do not generally offer any limitations compared with full systematic reviews and result in similar findings (Tricco *et al.,* 2015). Therefore, we applied the Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA-P) guidelines (Shamseer *et al.,* 2015) adapting them where necessary according to the flexible nature of the rapid review. The focus of the review was to establish an initial draft framework of core principles based on the following research question: What constitutes a 'good' (gambling)[9] treatment system?

## 3.2 Rapid review search strategy

To ensure an adequate search query, we used a two-stage procedure. First, we conducted a preliminary academic literature search for "gambling" 'AND' "treatment systems" using the *EBSCOHost* and *PsychINFO* databases. Since no relevant results were found, we broadened the search strategy and designed a search string based on key words identified by the research team (gambling OR gambling-related harm OR addiction OR addictive behaviour OR addictive harm OR psychological addiction OR substance OR alcohol) similarly a string search was used for treatment systems (addiction treatment OR treatment systems OR treatment system principles OR addiction system principles). Once initial searches yielded >1000 results for both, we began string searches iteratively combining the search strings (for example; gambling OR addiction AND treatment system OR treatment system principles). We then replicated the search strings using Google and Google Scholar to find 'grey'

[9] Before commencing the review, we were aware that there is very little or no previous research on gambling treatment system effectiveness.

literature concerning treatment system principles. Since the search terms were relatively broad, and given the time-pressures associated with the review, we applied strict screening criteria.

## 3.3 Rapid review screening process

The screening criteria were calibrated by the research team and resulted in a formal three-stage process: (1) title, (2) abstract, (3) full-text screening. Firstly, title screening excluded the following: (i) studies published before 2000; (ii) studies without treatment system and addiction search terms (included in our search query) in the title; (iii) studies written in a language other than English; (iv) articles not published by a reliable source. Subsequently, abstract screening involved excluding any literature that did not focus on treatment/healthcare/addiction treatment systems. Finally, full-text screening excluded any articles that did not meet any of the research question led inclusion criteria. Table 1 shows the screening process.

Table 1. Screening stages

| **Screening Stage** | **Criteria needed to carry forward.** |
|---|---|
| Title Screening<br><br>*Papers must meet all the screening criteria.* | • Published since 2000.<br>• Published in English language.<br>• Article title includes appropriate terms<br>• Article is published by a reliable source |
| | **N = 488** |
| Abstract Screening<br><br>*Papers must meet at least one of the screening criteria.* | • Article discusses gambling harm treatment<br>• Article discusses treatment systems.<br>• Article discusses healthcare systems.<br>• Article discusses addiction treatment. |
| | **N = 102** |
| Full-text Screening<br><br>*Papers must meet at least one of the screening criteria.* | • Provides empirical evidence or robust conceptual contributions for the following;<br>o Identifies gaps in treatment systems.<br>o Goes beyond service-level treatment.<br>o Identify population-level requirements<br>o Needs-base of treatment/healthcare systems.<br>o Shows effective collaboration between treatment/healthcare systems.<br>o Identifies effective management and processes of treatment systems.<br>o Explores client engagement, retention in treatment systems.<br>o Identifies key quality indicators for treatment systems.<br>o Offers insight into effective treatment system components |
| | **N = 59** |

The search strategy yielded 2236 results for articles, of which 1058 were duplicates. Of the 1178 remaining, 690 were excluded based on titles clearly being irrelevant, leaving 488 articles to be hand screened for relevance through abstract screening which excluded a further 386, leaving 102 results. The remaining academic and grey literature were full-text screened, which resulted in 59 relevant articles. For reference, these articles are listed in the 'rapid review references' section towards the end of the report.

## 3.4 Rapid review thematic analysis

Iterative thematic analysis of screened article content was conducted in order to establish the initial core principles of an exemplar gambling treatment system framework. One member of the research team led the initial analysis, firstly inductively coding common themes. Once emergent themes were identified they were shared with the wider project team alongside a narrative summary of article content. An iterative process of theme reduction was then initiated. This process followed a similar approach to the Delphi technique, and peer debriefing and member checking, which involves consensus forming through structured communications between a panel of experts or research team members. This meant that each member of the wider research team commented on, and refined each theme, followed by several rounds of group discussion until a consensus was reached. The agreed themes formed the core principles of the initial exemplar gambling treatment system framework.

## 3.5 Core principles (CPs) with brief narrative summaries

Six core principles of the initial exemplar gambling treatment system framework were established as a result of the rapid review process. The principles are presented below with brief narrative summaries.

**CP 1: Identification and Understanding of What is Required Across the Whole "Gambleogenic" Environment**

*Whole Systems Approach to understanding gambling treatment system requirements, understanding the full spectrum of gambling harm and required support throughout the system. The treatment system should achieve a population-level impact and have the capacity to reach multiple levels dependent upon individual needs.*

In relation to substance use treatment system design, Rush and Urbanoski (2019), identified the need for broad systems to address the full spectrum of issues related to substance use in order to achieve a population-level impact. This notion is further supported by additional studies which propose the need for a full spectrum, whole systems approach to treatment system design (Fleury, 2019; Rush *et al.,* 2019;

Urbanoski & Inglis, 2019). A system that understands all proposed risks, from acute to chronic and complex needs is required. Informed and coordinated system design allows for a reactive, dynamic and flexible approach to treatment (Babor *et al.,* 2019; Rush *et al.,* 2019).

Multiple studies addressed the need for a multidimensional continuum of collaborative, functionally integrated services within treatment systems supported by strong policies and shared agendas in order to meet the needs of individuals and populations (Room *et al.,* 2005; Strang *et al.,* 2012).

Gambling-specific research also emphasises the need for treatment services to understand the full spectrum of gambling harm, as well as individual and population need, and the tendency to seek help. Langham *et al.,* (2015) established a taxonomy of gambling harms in order to define and conceptualise the full range of associated issues. Itapuisto (2019) identified three help-seeking typologies, individualistic, multi-problematic and family-centric, suggests that aligning the understanding of problem gambling with treatment requirements will improve the offered support.

**CP 2: Awareness and Collaboration Within the Gambling Treatment System**
*Sharing best practice throughout the network in order to improve effectiveness. This collaboration across the system lies on a spectrum from just sharing communication in meetings to co-location and offering integrated services.*

Collaboration and sharing best practice between services or stakeholders and components within a treatment or healthcare system has been identified as a necessary strategy especially when the aim is integration and the achievement of common goals (Durbin *et al.,* 2004). Single service providers cannot alone address the full array of needs and challenges for successful treatment (Lesage *et al.,* 2008). Forms of collaboration sit on a spectrum stretching from communication to fully co-located or integrated services and can take place at the service or system level (Collins *et al.,* 2010; Kates *et al.,* 2011).

Classifications of collaboration have been identified within systems thinking literature. Brouselle *et al.,* (2010) proposed four classifications of collaboration; structural, functional, normative and cultural. Effective collaboration and communication can improve the accessibility of the treatment system, the timeliness of interventions, transitions within system, continuity of treatment care, and treatment outcomes (Babor *et al.,* 2005; Rush & Urbanoski, 2019).

Research has also identified barriers for collaboration, particularly in treatment systems that include multiple service components. Factors to consider include competing priorities, values, goals and defined outcomes for treatment, differences in training and knowledge base, lack of adequate or equal funding or pay, and stigma towards treatment and recovery (Babor *et al.,* 2005).

**CP 3: Resources and Processes to Ensure Adequate Infrastructure and System Functioning**

*The resources and processes required to ensure adequate infrastructure and system functioning. 3-fold looking at planning and funding, performance measurement & information management, and finally evidence-based practice and knowledge exchange. This is all interlinked across core principles.*

Effective system management and commissioning is integral to effective treatment system functioning (Smith et al., 2004). Establishing strategic direction is pivotal to create clear links between commissioning and achieving the outlined strategy. This includes reviewing strategic direction appropriately and guaranteeing clarity within commissioning and that it is 'fit for purpose'. This includes clarity on commissioning aims, responsiveness, relations with providers, and organisational fitness.

Performance management activities have increased within health care systems (Rush & Urbanoski, 2019; Ritter *et al.,* 2019b). They include an array of indicators and measures to monitor quality and promote accountability (Urbanoski et al., 2017), to explore structure (Roeg *et al.,* 2008), process (Garnick *et al.,* 2011) and investigate outcomes (McClellan *et al.,* 2007). To do this effectively Rush and Urbanoski (2019) argue for the use of a robust data infrastructure to understand previous performance and future performance alongside responsibility within the system.

Another key consideration in effective system management is sharing, promoting and building a strong knowledge and evidence base, and being accountable for the decisions made to advance system performance (Smith *et al.,* 2004).

**CP 4: Attention to Diversity and Socio-Structural Status in the Gambleogenic Environment**

*This includes age, sex, gender, sexual orientation, cultural background, socioeconomic status and immigration status, investigating the interplay between individuals and broader social structure and their access into the treatment system. Addressing issues including stigma, stress, discrimination, homelessness and criminalisation and their effects upon the gambling treatment system.*

According to Rush & Urbanoski (2019), attention to diversity and social-structural disadvantages is crucial to ensure effective and equitable treatment system design and service delivery. In substance use treatment systems, barriers to access have included poverty, all forms of marginalisation, stigma (Krieger, 2016) and the experience of trauma (Rush & Urbanoski, 2019). This interplay between individuals and social structures not only affects access into the system but also the likelihood of completing treatment (Brown, 2010; Guerrero et al., 2013; Majumder et al., 2016).

Research on gambling harm and access to treatment has revealed specific socio-structural issues affecting treatment success and recovery for individuals or populations including physiological and psychological health (Wardle *et al.,* 2018). income (Aldridge, 2019), ethnicity (Okuda *et al.,* 2016), homelessness (Guilcher *et al.,* 2016; Sharman, 2019) and criminality (Adolphe, 2019). In addition, Gainsbury *et al.,* (2014) found that a problem gambler's socio-structural status can reduce their motivation and ability to access help in the first place.

Sociodemographic characteristics need to be considered to ensure equity in treatment systems. Sex, gender, sexual orientation, age, ethnicity, faith, socio-economic status, immigration status among other cultural considerations have also been identified as potential barriers for treatment and must be considered within the treatment system in order to achieve a population-health approach to system design. Those with complex needs may require different approaches to treatment including their entry, transition, and retention within the system (Mitchell, 2012). Rassool (2006) identified a need to challenge negative attitudes and stigma surrounding complex needs or co-morbidities, tackling prejudices that may affect treatment and recovery.

**CP5: Accessibility of Gambling Treatment**
*Screening, assessment and individualised treatment across the network and understanding of where the individual should be going within the network. Also investigating the accessibility of the network from GPs, NHS and other referral opportunities.*

Systematic screening, assessment, and individualised treatment planning are necessary to improve detection and access, and to match people to evidence-based interventions across the continuum of care (Rush & Urbanoski, 2019).

The treatment system must be accessible for individuals, other primary health care (e.g. GPs) settings and health care systems (e.g. NHS), and communities and the general population (Babor et al., 2005). In order to ensure appropriate referrals the treatment system should seek to ensure there is wide ranging dissemination of information about available treatment services, including geographical location and access points (Ritter *et al.,* 2019b). Wieczorek *& Dabrowska,* (2020) discuss the specific requirement for improved awareness in what treatment is available for problem gamblers, especially for individuals with co-morbid problems. Yakovenko & Hodgins (2018) suggest that there is a need for system-level initiatives to address co-morbidity treatment and awareness of treatment at the policy level.

**CP 6: Evidence-Informed Interventions and Gambling Insight**
*Ensuring there is a treatment system that includes the right mix and duration of evidence-informed psychosocial and clinical interventions, intertwining lived experience, published research and professional experience.*

According to Rush & Urbanoski (2019) treatment systems should be designed to allow individual treatment plans to include the right mix of evidence-informed psycho-social and clinical interventions. More generally, evidence-based practice has been found to increase effectiveness and provide consistency across treatment systems. Glasner-Edwards & Rawson, (2010) provide recommendations to increase evidence-informed practice within addiction treatment, these include employing a stakeholder process approach, understand widely applicable, evidence-based skills, use established implementation methods, assess readiness for change, increasing access to training and resources and increasing exposure to evidence-based practices.

System managers/commissioners need to meet the challenge of integrating evidence from multiple sources including academic research on treatment and systems (Babor et al., 2019), those who work professionally within treatment systems, and those with lived-experience (clients, former clients and family or wider network of clients) (Nixon et al., 2016; Rush & Urbanoski, 2019). Dickson-Swift *et al.,* (2005) suggest the need to go beyond considering the viewpoint of the problem gambler to also include their social ties and network.

Babor *et al.,* (2019) highlight the risk of not taking an evidence-based approach in treatment system re(design) including deference to market-based solutions to health care. Westphal (2008) identified a lack of evidence base specifically for problem gambling treatment despite efforts to increase evidence-based practice (Patel *et al.,* 2013).

# 4 System stakeholder interviews

The aim of the stakeholder interviews was to utilise the framework drafted following the rapid review to seek and crosscheck system stakeholder views on what a "good" gambling treatment system looks like.

## 4.1 Data collection

Ethical approval was obtained through Leeds Beckett University's institutional ethical procedure[10], which follows the guidelines set by the learned society British Education Research Association[11]. Participants were given an information sheet

[10] Leeds Beckett University's Research Ethic Policy can be accessed here: https://www.leedsbeckett.ac.uk/staffsite/-/media/files/student-hub/research-ethics/tx_research_ethics_policy.pdf

[11] BERA's Research Ethics Guidelines can be found here: https://www.bera.ac.uk/publication/ethical-guidelines-for-educational-research-2018

that described the purpose of the interviews and the proposed procedure. It also made participants aware of their ethical rights including the right to withdraw their data at any time. It also asked participants to provide their informed consent before commencing. To protect confidentiality and anonymity, reference to personal details and job role within organisations has been omitted from this report. Data for this project is stored securely and used in accordance with the Data Protection Act 2018.

The prototype exemplar system framework was used alongside information gathered from system documentation and informal consultations with system managers and stakeholders to create the Interview Schedule, which was designed to capture information more specifically relevant to gambling treatment. For Phase One, it was intended that the interviews should test each principle for validity and completeness, and identify any additional information not already captured. A semi-structured approach was adopted to allow each interviewee to speak as much as possible in the time available, and to allow them to focus the discussion on the points they perceived as most important.

In collaboration with GambleAware, we identified a range of stakeholders with whom to discuss the draft principles. This included at least one person from GambleAware, Gambling Commission, the Advisory Board for Safer Gambling, and the funded providers (GamCare, NHS clinics and the Gordon Moody Association). For Phase One, we wanted to have sufficient and varied discussions to test the principles so that we could create the final framework, with the intention of engaging with a much larger number and more varied group of stakeholders in Phase Two (including those personally affected by problem gambling) and conducting more detailed analyses.

We approached potential interviewees and shared with them background information and asked them to complete consent forms, in line with our Ethics approval processes. In total, 15 core interviews were conducted (not including informal discussions with other stakeholders). The majority of the interviews were carried out via video conferencing technology, particularly once travel became an issue due to the COVID-19 pandemic. With participants' permission, interviews were digitally recorded, and field notes taken at the time of the interview.

## 4.2 Data analysis

The main aim of the analysis was to check the validity of the initial core principles developed in the draft framework (a deductive approach) so an adapted version of the framework method (Gale et al., 2013) was utilised. Field notes were the main data source, however digital audio recordings were also subject to a critical listening exercise in which salient audio extracts were transcribed verbatim.

An analytical framework was constructed based on the initial treatment system principles but also to allow for any new information to be coded as existing or new themes or sub-themes. A series of matrices were then developed, one representing each interviewee. This meant that the data was ordered in a systematic way that was grounded in the participants' own accounts, while oriented to the research objectives. The final analytic stage involved working through the charted data, drawing out the range of experiences and views, identifying similarities and differences and interrogating the data to validate existing knowledge and explore any emergent findings.

## 4.3 Key findings

With reference to objective (3), to use the initial framework to seek and crosscheck system stakeholder views on what a "good" gambling treatment system looks like, the overarching findings can be summarised as:

- The draft core principles do reflect people's views on what "good" looks like and there appears to be a great deal of agreement across stakeholders.
- Principle One (understanding the scope and content of a treatment system) is very general. Although it worked very well as an opening topic area, with many interviewees spontaneously discussing their perspective on the whole system, it should be redrafted to avoid overlap with other principles (e.g. with those on collaboration and on involvement with other sectors.
- The "system" is wider than the GambleAware-funded providers, and its exact definition and boundaries should be explored further.
- The "system" needs to reflect the needs of those in crisis (in whatever form this takes), whether those needs are met within the gambling treatment system or externally to it. This was not captured in the initial framework draft but was coded as a sub-theme within Principle One.

Because we found that all interviewee responses could be categorised within the existing framework of 6 core principles, the findings are summarised below in Table 4, by framework principle, what a gambling treatment system should include/do (themes), and additional detail (subthemes). Principle names were reviewed in light of themes and subthemes and small changes made where necessary to better reflect the emergence of more detailed and gambling-specific knowledge.

Table 4. Interview findings summary by framework principle

| **PRINCIPLE 1:** ***Identification and understanding of treatment system requirements for the whole of the wider gambling system environment*** | |
|---|---|
| **The system should (themes):** | **Additional points/points of detail to be reflected in Principle (sub-themes)** |
| Understand and reflect need | Should include an understanding of scale of need; clarify whom the system is trying to reach (diversity) and the appropriate balance between types of services required.<br><br>Should meet needs of those in crisis (particularly as it appears that mental health services are not able to meet these needs)<br><br>Should meet the needs of young people and "affected others[12]". |
| Have clear and agreed vision and goals | Noted that if individual organisations or components have different objectives, there is a risk that organisations will operate in silos and that the system will not be joined up.<br><br>Clients have differing objectives and the system needs to address this. |
| Have strong integration between elements, and clear pathways and relationships between each | Noted there was little reference to "tiers" and there does not appear to be a clear description of a tiered model or what is in each tier, or how clients enter or move between tiers. |
| Include education, prevention, recovery and rehabilitation as well as active treatment | Should include all of these elements, with "treatment" part of a continuum. |
| Learn from and reflect similarities and dissimilarities with other services | Many similarities with other addictions and other services, so some useful learning there.<br><br>Key to ensure gambling does not repeat errors made in development of other services.<br><br>Crucial that gambling's unique characteristics are understood and taken into account when considering adopting approaches from other sectors/services. |
| Strong awareness of the services available<br><br>Ease of access (a complex issue including both physical access and a sense of comfort about making an approach or having others aware that the client has a gambling problem) | Stigma is an issue, deterring people from seeking help.<br><br>Some groups may find it particularly hard to access the system (links with Principle 4 on diversity) |
| Support effective referrals and navigation around the system | Importance of an effective triage system, clarity about which clients go to which part of the system |

[12] Affected others is a term used by stakeholders to refer to families, carers, colleagues and anyone else impacted by the behaviours of problem gamblers

| | |
|---|---|
| | (particularly thresholds into the NHS) and clear pathways in and out of the system (links with Principle 5). |
| Link effectively with other services including clear pathways in and out | Relationships should be two-way.<br><br>Resources are needed to build these links. |
| Adequate resources (see also Principle 3) | Should include capacity to build links with other sectors. |
| Deliver quality: safe, effective, high quality, appropriate services, and be able to monitor and demonstrate this | Currently free and confidential, available in many locations and different formats (face-to-face, telephone, on-line etc.)<br>CQC and NICE involvement would be constructive.<br><br>Currently unclear what the template for services should look like.<br><br>Some issues around evidence-base.<br><br>Should be shaped by PWLE[13] (see also Principle 6).<br><br>Should build a network around the client, so wider than treatment element.<br><br>Should be longer term: more than a short-term intervention.<br><br>Should be innovative, including promoting research and expanding the evidence base (many respondents could talk about pilots being carried out). |
| Be responsive and offer choice | Many examples of how system currently delivers including range of approaches, range of times (including weekends, evenings; Helpline 24/7) and short response times.<br><br>More resources would enable choice to be increased and greater building up of consumer insight. |
| Be accountable (see also Principle 3 on Governance) | Welcomed actions to improve this including involvement of CQC. |
| Should have a workforce of the appropriate size and with the appropriate skills, qualifications and experience | Continuous Professional Development is key.<br><br>No clarity about what qualifications and skills are needed.<br><br>Importance of clarity about qualifications and skills needed.<br><br>Importance of capacity to support challenging *cases including people in crisis*. |

[13] People With Lived Experience

| | |
|---|---|
| | |

| **PRINCIPLE 2:** ***Collaboration across the gambling treatment system*** | |
|---|---|
| **The system should (themes):** | **Additional points/points of detail to be reflected in Principle (sub-themes)** |
| Promote and actively engage in collaboration<br><br>Collaborate at many levels and for many reasons:<br><br>Individual cases<br>So that the client can select the option that best meets their need<br>So that clients can move seamlessly from one part of the system to another<br>Development of processes and policies<br>Discussions about resources and resource use<br>Sharing ideas, innovations, best practice and updates on developments<br>Sharing activity and outcome data to inform service developments and understanding of need/outcomes | Collaboration should be systematic.<br><br>Effective collaboration requires clear agreement about which cases go to which provider.<br><br>Each part of the system should be aware of activities (pilots, studies etc.) that are underway in other parts of the system. |
| There should be structures in place to support formal strategic and operational collaboration | Communication and sharing of views should be two-way.<br><br>Data should be shared, and the system should enable this to happen. |
| Liaises and collaborates with a wide range of partners outside the immediate gambling treatment system | Liaison and collaboration need to be on an appropriate scale. |

| **PRINCIPLE 3:** ***Governance, resources, and processes to ensure adequate infrastructure and system functioning*** | |
|---|---|
| **The system should (themes):** | **Additional points/points of detail to be reflected in Principle (sub-themes)** |
| Have a managed, national approach, with a clear national strategy, so there is a clear plan with clear goals, resources are invested to deliver those goals and there is provision across the country. | System leadership is important otherwise the system would lack a clear direction, adequate resources and effective use of those resources. However, it was not clear who should provide that leadership, what exact form and remit it should have, which sector (for instance health or leisure) should take the lead and whether and how industry should be involved. |
| Governance should be robust, comprehensive and transparent, across the system | Broad agreement about the need for an effective system manager. |

| | |
|---|---|
| Clarity and transparency about decision-making, who should receive funding and why.<br><br>It should be clear how resources move around the system | There should be a process and criteria agreed and in place to identify which clients should be treated in which part of the system.<br><br>There may be differing views about any involvement of the gambling industry in providing funding. |
| There should be sufficient resources for the commissioning function and for the provision of services | Resource should be sufficient, able to deal with the range of cases and include resource to support engagement with partners outside the sector. |
| Data about a range of issues including uptake by group, performance measures including outcomes should be collected and used to inform the functioning and improvement of the system | Thought could be given to the creation of a common data set. |
| Governance including quality assurance is embedded and transparent, to provide accountability | All of the parts of the system need to have the appropriate skills and infrastructure to carry out all of the appropriate roles for governance, commissioning, audit, quality assurance and data analysis. |

| **PRINCIPLE 4: Attention to diversity and socio-structural status** | |
|---|---|
| **The system should (themes):** | **Additional points/points of detail to be reflected in Principle (sub-themes)** |
| Understand and shape engagement and services for specific groups so that it meets the needs of all those likely to require support<br><br>Have a detailed needs assessment, consumer insight and data systems to support the delivery of an approach that meets the needs of all groups including younger people, women, BAME groups and those with comorbidities<br><br>Be equitable and this should be reflected in the type of services on offer and where they are provided | Issues around equity should be taken into consideration.<br><br>There should be clear understanding of the issues facing different groups of clients/potential clients. |

| **PRINCIPLE 5: Awareness and accessibility of the gambling treatment system and appropriate individualised treatment** | |
|---|---|
| **The system should (themes):** | **Additional points/points of detail to be reflected in Principle (sub-themes)** |
| Ensure GPs are aware of the nature and scale of the problem | Some were aware that work is underway to encourage engagement with GPs, including on a range of pilots to engage primary care. |

| | |
|---|---|
| Encourage and enable GPs/primary care to make referrals including through a simplified assessment tool. | |
| Ensure clients are treated in the most appropriate part of the system and that the data system enables stakeholders to understand and track whether this is happening or not<br><br>Have clearly defined pathways and tiers<br><br>Include incentives (or at least not include disincentives) so that the components of the system work collaboratively and in an integrated way, so clients move smoothly to the most appropriate provider (and between providers, where appropriate) | It is key that there is clarity over which clients should go where across the system. The system should enable this to happen through a single point of access/triage[14]. |
| Ensure the public and other organisations are aware of the scale and nature of gambling problems, and know where and how to obtain support<br><br>Ensure that parts of the wider system are aware of the interconnections between gambling and other agendas, identify when a referral may be beneficial and know how to make a referral | It is agreed that many people who would benefit from support are not being referred into the system. A significant scale of action is needed to address this. |
| Ensure data systems are sufficiently detailed and robust to enable analysis and tracking to promote a seamless client journey from start to finish, and enable the system to understand how it is operating and support continuous improvement | Key that the data system can track how the client's journey is progressing.<br><br>The part of the system dealing with initial client contacts should make direct referrals to the relevant part of the treatment system. |
| Ensure that it can deliver appropriate support for its client group, by having the relevant capacity and skills, and the interconnections with other services for inward and onward referrals | This should include clients with additional needs, particularly urgent mental health issues of varying kinds. |

| **PRINCIPLE 6: *Evidence-informed system design (including interventions and gambling insight)*** | |
|---|---|
| **The system should (themes):** | **Additional points/points of detail to be reflected in Principle (sub-themes)** |
| Involve PWLE consistently and in a structured, supported way. | PWLE can contribute at all levels and stages, including to policy and service development, and as Peer Mentors or Peer Workers, actively engaging with service users. |

[14] The research team noted with interest that interviewees repeatedly stressed the importance of a single point of access, and made little reference to the concept of "any door is the right door". This point and its implications should be explored in greater depth in Phase Two.

| | |
|---|---|
| | The approach to involving PWLE should be joined up across the system to avoid repetition. |
| Utilise research, including into what works.<br><br>Generate more research. It is important that it is independent and objective, and relevant to gambling. | More research is needed, and that should be specific to gambling.<br><br>Everyone in the sector should be aware of the research that has been undertaken or is underway. |
| Utilise professional input, provided this is directly relevant and tailored to gambling | The input of those with experience of other sectors can be valuable: however, thought needs to be given as to what practices are truly relevant to gambling and its specific circumstances. |
| Use and manage information appropriately | The system should have sufficient and relevant information and use it effectively. |

# 5 Synthesis of emergent knowledge into updated framework

The last stage of Phase One involved the synthesis of all existing and new information contributing to our understanding of what a “good” gambling treatment system looks like into an updated version of the framework.

In order to do this, we first transposed interview findings concerning ideal aspects of a “good” system onto the respective principles of the framework where there was commonality across interviewee responses. The research team then reviewed the framework to ascertain where principles were discriminant. At this stage it was agreed that because system functions are integrated there will inevitably be crossover in the remit of each principle. Principle One, because of its generality, contained several aspects that duplicated the content of other principles. As a consequence, we conducted a review exercise that involved individual members of the research team reassigning content to more relevant principles or removing duplications. The research team reconvened to compare results and address any disagreements.

Finally, using the latest version of the framework as a guide we reviewed relevant GambleAware commissioned research conducted specifically in the context of GAFTS (NatCen & ACT Recovery Treatment Needs and Gap Analysis reports and ADP System Interrogation) in order to identify whether we could extract additional information that had not been captured during the prior Phase One stages. We then created a further comprehensive iteration of the framework to include all accumulated knowledge. The updated framework is shown in Table 5, below, with definitions and detailed descriptors.

It should be noted that at this stage the principles and descriptors should not be interpreted as criteria for evaluation. Phase One was concerned with the accumulation of existing knowledge. Phase Two will utilise the framework as a basis for the creation of evaluation criteria and further work will be necessary to determine the relative importance of each principle and associated criteria.

## 5.1 Updated framework

Table 5. Phase One exemplar gambling treatment system framework

***CP 1: Identification and understanding of treatment system requirements for the whole of the gambleogenic environment***

*Whole Systems Approach to understanding gambling treatment system requirements, strategically responding to the full spectrum of gambling harm and promoting a clear vision with shared goals and values in order meet identified need. The treatment system should adopt a recovery model to achieve individual-, group-, and population-level impact.*

*In particular, to understand the extent to which the system reflects these elements:*

**Whole systems approach to understanding treatment requirements**

- Elements are integrated and the pathways and relationships between each is clear
- Learns from and reflects similarities and dissimilarities with other treatment systems and services
- Addresses co-morbidity of other health issues within the system or through strategic links with external agencies
- There are effective links between services within and external to the system including clear pathways in and out (see also Principle 2 on Collaboration)
- There is strong awareness of the services available and models of care within and beyond the system to support effective referrals and navigation around the system (see also Principle 5)
- Organises and uses a variety of evidence to guide maintain, evaluate, and continually improve all aspects of treatment system provision (see also Principle 6)

**Strategically responding to the full spectrum of gambling harm**

- Is easy to access, is responsive, and offers service users choice
- Evidenced-based (tiered and stepped care) for service users with all levels of gambling severity and complexity, including those in crisis
- Structured to incorporate service user feedback and involving experts by experience
- Should have a workforce of the appropriate size and with the appropriate skills, qualifications and experience (including for effective commissioning and system management)
- Commitment to procure qualified workforce to enable delivery of the most effective treatment
- Structured to incorporate staff feedback and innovation
- There are adequate resources to deliver quality: safe, effective, high quality, appropriate services, and be able to monitor and demonstrate this to ensure accountability at all levels (see also Principle 3 on Governance)

**Promoting a clear vision with shared goals and values in order meet identified need**

- Understands and reflects need (including for all gambler profiles)
- Has clear and agreed vision and goals

**Recovery model to achieve individual-, group-, and population-level impact**

- Includes education, prevention, recovery and rehabilitation as well as active treatment
- Includes appropriate mix of evidence-based individual, group treatments delivered via a range of interfaces
- Adopts a recovery model that ensures continuing care and links to mutual aid or other services
- Includes involvement and support of affected others if appropriate
- Attention to equality and equity in access and treatment provision (see also Principle 4 on diversity and socio-structural status)
- Includes outreach and community engagement and with wraparound services
- Standards for engagement and retention of service users

***CP 2: Collaboration across the gambling treatment system***

*Sharing best practice throughout the network in order to improve effectiveness. This collaboration across the system lies on a spectrum from sharing information in meetings, to co-location, and offering integrated services.*

*In particular, to understand the extent to which the system reflects these elements:*

- Ensures there are structures in place to support formal strategic and operational collaboration
- Promotes and actively engages in collaboration within the system at many levels and for many reasons including:
    - Addressing individual cases
    - Development of processes and policies
    - Discussions about resources and resource use
    - Sharing ideas, innovation, best practice and updates on developments
    - Sharing activity and outcome data to inform service developments and understanding of need/outcomes
    - Enabling the client to understand the options available and select the option that best meets their needs
    - Enabling clients to move seamlessly from one part of the system to another
- Liaises and collaborates with a wide range of partners outside the immediate gambling treatment system
- Flexibility in treatment packages underpinned by commissioning arrangements that promote partnership and improved inter-agency working

***CP 3: Governance, resources, and processes to ensure adequate infrastructure and system functioning***

*The governance, resources, and processes required to ensure adequate infrastructure and system functioning. Including leadership, strategic planning and funding, (positive) system monitoring (including quality/performance), information management, and knowledge exchange.*

*In particular, to understand the extent to which the system reflects these elements:*

**Leadership, strategic planning and funding, (positive) system monitoring (including quality/performance)**

- Has a managed, national approach, with a clear national strategy and goals
- Formally commissioned system featuring planning based on need and priorities, formal procurement, and monitoring and evaluation of system performance against clear key performance indicators
- Governance is robust, comprehensive and transparent, across the system
- There is clarity and transparency about decision-making, who should receive funding and why, and how resources move around the system
- There are sufficient resources for the commissioning function and the provision of services
- Resources to develop integrated systems and recovery pathways, aftercare and ongoing support services
- system(s) and commissioner oversight of required care standards
- Has processes in place to ensure that appropriate service evaluation is a routine element of the commissioning cycle.
- Governance including quality assurance is embedded and transparent, to provide accountability

**Information management, and knowledge exchange**

- Clear KPIs and regular feedback on performance
- Data about a range of issues including uptake by group, performance measures including outcomes is collected and used to inform the functioning and improvement of the system
- Integrated case management system(s), performance management, and quality assurance
- Valid, reliable, clear, and useful data management framework to enable central monitoring of all aspects of treatment system quality and performance
- Clear requirements for data collection (including for screening, assessment, monitoring, and outcome measures) which do not adversely affect treatment processes

**CP 4: Attention to diversity and socio-structural status**

*The interplay between individuals and broader social structures and equity of access into the treatment system. For example, the extent to which the system understands whether treatment success is dependent on age, sex, gender, ethnicity, faith, sexual orientation, cultural background, socio-economic status or immigration status, and addresses inequities. Also, the extent to which the system takes account of characteristics that can be associated with gambling which may affect equity of access, e.g. mental wellbeing status, stigma, discrimination, homelessness, criminality etc.*

*In particular, to understand the extent to which the system reflects these elements:*

- A detailed needs assessment, consumer insight and data systems to enable understanding of the treatment needs and profiles of clients including those with specific characteristics (e.g., *age, sex, gender, ethnicity, faith, sexual orientation, cultural background, socioeconomic status, immigration status), including understanding how client* characteristics affect equity of access and effectiveness of treatment such as mental health status, stigma, discrimination, homelessness, criminality
- Uses this understanding to shape services for specific groups so that it meets the needs of all those likely to require support, including in the format and types of services on offer, and where and how they are provided
- Understands and meets the needs of under-represented groups including younger people, women, BAME groups and those with comorbidities (including poor mental wellbeing)
- Measures to overcome treatment barriers associated with stigma and shame
- Culturally adapted support for groups facing more barriers than others in accessing and completing treatment

**CP5: Awareness and accessibility of the gambling treatment system and appropriate individualised treatment**

*Accessibility and awareness of the treatment system and services. Awareness and accessibility of the treatment network for external referrals (e.g., from GPs, NHS, etc.). The extent to which the current system provides the mechanisms to facilitate appropriate individualised treatment pathways (i.e. screening, referrals, triage, individualised pathways, matched evidence-based treatment, consideration of comorbidities)*

*In particular, to understand the extent to which the system reflects these elements:*

**<u>Awareness and accessibility of the treatment network for external referrals (e.g., from GPs, NHS, etc.)</u>**

- Other organisations, and in particular GPs, are aware of the nature and scale of the problem
- GPs/primary care are encouraged and enabled to make referrals
- Ensure external referral agencies understand what constitutes unhealthy gambling activity (including common valid screening mechanisms)

- The public and other organisations are aware of the scale and nature of gambling problems, and know where and how to obtain support
- Awareness, screening and referral from allied health and social care services (e.g., drug and alcohol, mental health, debt agencies, etc.)

**Appropriate individualised treatment pathways (i.e. screening, referrals, triage, individualised pathways, matched evidence-based treatment, consideration of comorbidities)**

- Clients are treated in the most appropriate part of the system and the data system enables stakeholders to understand and track whether this is happening or not
- Data systems are sufficiently detailed and robust to enable analysis and tracking to promote a seamless client journey from start to finish, and enable the system to understand how it is operating and support continuous improvement
- There are clearly defined pathways and tiers[15]
- There are incentives (or at least no disincentives) for the components of the system to work collaboratively and in an integrated way so clients move smoothly to the most appropriate provider (and between providers, where appropriate)
- Parts of the wider system are aware of the interconnections between gambling and other agendas, identify when a referral may be beneficial and know how to make a referral
- Awareness within the system of pathways and models of care, including internal and external referral options and guidance
- The system can deliver appropriate support for its client group, by having the relevant capacity and skills, and the interconnections with other services for inward and onward referrals
- Considers barriers and enablers for initial and continued access to treatment and aftercare (e.g., personal, social, practical, and therapeutic)
- Locality of treatments available led by service user need rather than interests and competencies of providers

[15] The Research Team noted that there may be different interpretations of the terms "tiered" and "stepped": discussions so far focused on the importance of ensuring that a client entered the system at the most appropriate point within it, for instance reflecting the severity of their condition, and that interviewees also talked about the role of client choice. This should be explored in more detail in Phase Two.

***CP 6: Evidence-informed system design (including interventions and gambling insight)***

*The extent to which the current system allows for evidence informed evaluation of current operations and encourages innovation and change. This includes whether the treatment system includes the right mix and duration of evidence-informed psychosocial and clinical interventions, intertwining lived experience, published research and professional experience. It also could include the way in which evidence is sought, stored and utilised to inform all aspects of system design, e.g., information management, tiered pathways, etc.*

*In particular, to understand the extent to which the system reflects these elements:*

**Intertwining lived experience, published research and professional experience**

- Encourage innovative and forward thinking with research helping to create a more positive environment.
- Strategically generating and commissioning research that it is independent and objective, and relevant to gambling treatment.
- Utilising professional input, provided this is directly relevant and tailored to gambling
- Require provider organisations to actively engage in research studies and open up research opportunities for service users and PWLE in a structured, supported way.
- Demonstrates that information is provided to every service user about opportunities to be involved in research.
- Demonstrates that service users and PWLE are engaged in study design and development.
- Ensure information about research is available in accessible formats.
- Ensure induction of new employees at all levels includes discussion about research innovation and improvement and the use of evidence to inform service delivery and commissioning.
- Enable employees to have access to appropriate research related training and offer a range of research opportunities.
- Incentivise and reward staff to engage in research.

**Evidence is sought, stored and utilised to inform all aspects of system design**

- Evidence informed commissioning is systematic so that commissioning is based on robust evidence, knowledge and understanding of what works.
- Evidence, evaluation and research should be part of commissioning activity and should assist decision making, leading to more effective commissioning, better services, and improvements in service user outcomes.
- At all levels, an understanding of how information, knowledge, evidence (including research) informs practice and decision-making processes.
- Commissioners and providers of services have the tools, information, support and skills to make best use of information, knowledge and research to inform practice
- Has processes and structures for managing and routinely accessing relevant evidence including research evidence appraisals, service evaluation and grey literature to inform service redesign and commissioning policy.
- Can show how it uses information from system performance measurement to generate research priorities and questions.
- Can demonstrate that policy development has taken account of the underlying rationale and supporting evidence.

# 6 Conclusion

The aim of Phase One was to establish an 'exemplar gambling treatment system' framework by reviewing the existing evidence-base, filling gaps in knowledge where possible through consultation with stakeholders, and conduct an initial network analysis to produce a treatment system map.

To aid the focus of Phase One work we set four objectives. Below we summarise how these objectives were met:

(1) To map the current GambleAware funded treatment system and the basic interconnections between system components.

An initial network analysis was conducted in order to provide a baseline understanding of the system under investigation.

- While this analysis was a snapshot which does not take account of the dynamic and detailed characteristics of structure and interconnections between components, it highlighted the multi-level nature of the system, in that from a network perspective not all system components have a direct connection with one another.
- The current system structure has grown organically rather than being purposefully designed which means that it may not be optimal for "good" treatment system functioning. For example, the basic system map shows that the multi-level structure may make collaboration between system components more difficult.
- The use of network analysis in this Phase suggests that (alongside other research methods) it is a useful tool for treatment system evaluation.

(2) To review the existing evidence-base concerning effective treatment systems and to create an initial framework of exemplar gambling treatment system principles.

A rapid review of the academic and grey literature on treatment systems was conducted in order to develop an initial exemplar gambling treatment system framework comprised of six core principles.

(3) To use the initial framework to seek and crosscheck system stakeholder views on what a "good" gambling treatment system looks like.

The prototype exemplar system framework was used alongside information gathered from system documentation and informal consultations with system managers and stakeholders to create an Interview Schedule, which was designed to capture information more specifically relevant to gambling treatment. Interviews were conducted with a range of system stakeholders including providers and

commissioners (see Annex A). Overall, interviewee responses indicated that the six core principles described in the initial framework provided a valid categorisation tool for the key components of an effective gambling treatment system.

(4) To synthesise the evidence-base and system stakeholder responses into a comprehensive exemplar gambling treatment system framework for use in Phase Two.

Data collected during stakeholder interviews alongside further consultation with previous and emerging commissioned research facilitated a further iterative framework development step resulting in a comprehensive version presented in Table 5.

# 7 Limitations

It should be noted that the GAFTS is a dynamic system and our analyses and observations are cross-sectional (i.e. they were conducted at a single point in time). Therefore, we acknowledge that our findings may not reflect very recent system changes, such as changes to the treatment provider network.

The exemplar gambling treatment system framework was developed iteratively as we gathered more contextual data. Despite continuing efforts to extend the understanding of gambling and gambling treatment, the existing knowledge base is relatively small. There is no published literature about the components of effective gambling treatment systems. This means that although the framework reflects current understanding of the required components of a gambling treatment system, it should not yet be considered a fully developed evaluation tool. Nonetheless, the development of the framework is an important and necessary step towards the creation of system level criteria for effective gambling treatment and will be extremely valuable as a reference point for the system evaluation to be conducted during Phase Two. This evaluation will not only serve to highlight the necessary areas of the system that are in need of improvement but also identify best practice. As such, the nascent knowledge base concerning exemplar gambling treatment system components will develop, and in turn the framework will evolve further.

# 8 Next steps

Following completion of Phase One a planning and consultation exercise is required involving researchers and commissioners (as system managers) in order to determine the exact scope of, and priorities for, the Phase Two gambling treatment system evaluation.

This planning should be informed by the work conducted during Phase One, specifically the knowledge accumulated about the necessary components of a funded gambling treatment system and captured in the comprehensive final framework. It should also take into consideration recent and planned system changes and gambling research.

The exemplar system framework developed during Phase One is comprehensive and includes a wide range of components, and consequently a broad scope for system evaluation. Also, the treatment system is dynamic, and innovations are encouraged at all levels. Phase Two planning and consultation should therefore consider whether the evaluation priorities identified in the original programme brief remain the same. These priorities were:

- Evaluate the GambleAware funded treatment system effectiveness
- Assess how the different services function together as a coherent national system, so that people get the treatment that best fits their needs
- Understand the wider inputs into the system (e.g., primary care, mental health, addictions, housing, debt advice), and
- Evaluate GambleAware commissioning against good practice in commissioning of services and provide evidence-based recommendations for system improvements to drive strategic design.

One of the challenges of evaluation projects that take a cross-sectional approach (i.e. they assess effectiveness at a single point in time) is that they are often unable to take account of ongoing improvement initiatives and therefore when recommendations are presented, they may no longer be valid. The potential for this to occur is influenced by a number of additional factors, including the speed of the evaluation, the breadth of the evaluation, and the depth of the evaluation.

Another risk is that evaluation commissioners are presented with recommendations that they find difficult to implement, or difficult for them to judge whether their implementation has improved effectiveness. This risk is amplified when the focus of the evaluation is complex and multilevel like the funded gambling treatment system.

In order to maximise the impact of the Phase Two treatment system evaluation it is suggested that the planning and consultation exercise consider these challenges and risks, and more specifically:

- The balance between breadth, depth, and speed of evaluation i.e., an in-depth evaluation across all areas of the system will take longer, while there may be priority areas which require a less detailed and more timely evaluation that can lead to ‘quick wins’.
- The exemplar system framework includes areas of the system that may need improvement, but this is predicated on the prior enhancement of other

components (for instance strengthening communications between stakeholders, sharing updates on new developments). Identifying these cases early may benefit priority setting.

- The development of a formal mechanism for monitoring dynamic system changes as the initial focus of the Phase Two work. Such a mechanism would be based on the Phase One framework and allow for a rapid baseline assessment of system effectiveness. All efforts to improve system components could be individually or collectively evaluated by monitoring changes to these baseline metrics. A monitoring mechanism, if embedded properly, could assist system managers on an ongoing basis, and beyond the timeline of the current evaluation programme.
- The choice of evaluation methodology will depend on all other considerations to ensure it is fit for purpose.

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# Annexes

## Annex A: Interviewees

| **System Leaders (formal interviews)** | |
|---|---|
| Gamble Aware | 27th February 2020 |
| Gambling Commission | 8th April 2020 |
| ABSG | 12th March 2020 |
| **Level One Providers (initial chat and formal interviews)** | |
| GamCare | 28th February 2020<br>2nd March 2020<br>23rd March 2020 |
| Gordon Moody Association | 11th February 2020 |
| NHS Northern Clinic | Informal meeting 6th January 2020<br>3rd March 2020<br>6th April 2020 |
| NHS London Clinic | 5th March 2020 |