

Why study Gamblers Anonymous (GA) in the UK?

1. One of the biggest sources of face to face help for problem gamblers



- Gambling Commission - 2 million adults are problem gamblers or 'at risk' of becoming a problem gambler (0.7 + 5.5% of sample) (See report by Connolly et al 2017)
- This is more than double the number who use opiate and/or crack cocaine – those drugs most associated with harm, according to the National Treatment Agency (Hay et al 2013).
- In the UK there were 288,000 individuals in contact with drug and alcohol treatment services in 2015-16 according to official statistics (PublicHealth England 2016).
- In contrast the single National Problem Gambling Clinic within the British NHS sees some 800 people per year.
- GAMCARE provided face to face help to 5,580 people in 2015/16 (via their own offer or via partner counselling agencies).
- Gamblers Anonymous - over 150 meetings every week (numbers per meeting not known though 10 to 20 is a reasonable estimate based on available information).

Why study Gamblers Anonymous (GA) in the UK?

One of the biggest sources of help for problem gamblers.

Both Gamcare and Gamblers Anonymous also have frequently used websites.

Part of the wider research has involved analysing posts to web forums

Gamcare - 'Recovery diaries' and 'overcoming problem gambling'. 47,000 posts.

Gamblers Anonymous - 'Share section' = 2400 threads and over 10,000 separate posts



Why study Gamblers Anonymous (GA) in the UK?

2. No published studies of GA in the last 25 years in the UK

Some of the earliest published studies of GA took place in Scotland and Wales.

1. Browne (1991) - A four part study of dropouts and continuers in GA in Glasgow. Minimal data reported on 232 consecutive attenders.
2. Turner and Saunders (1990) - Participant observation - 32 meetings over 12 months -Swansea. Sociological focus on processes of 'labelling', and 'rituals and ceremonies'.

Schuler et al (2016) .Gamblers Anonymous as a Recovery Pathway: A Scoping Review . Period 2002-2015. 14 of 17 studies were conducted in US or Canada. None in UK

Advisory Council on the Misuse of Drugs (ACMD) (2012) - there is a dearth of evidence surrounding recovery communities in the UK and more is needed to complement the existing largely US based studies.



'Twelve Step' Programmes

'Alcoholics Anonymous appears to be an effective clinical and public health ally that aids addiction recovery through its ability to mobilise therapeutic mechanisms similar to those mobilised in formal treatment, but is able to do this for free over the long term in the communities in which people live' (Kelly, 2017)

The nearest thing to a free lunch in public health terms?

Kelly, J (2017). Is AA religious, spiritual, neither? Findings from 25 years of mechanisms of behaviour change research. *Addiction*, 112, 929-936.



Access

ACCESS ALL AREAS

'Open' meetings and the GA culture.

Most GA meetings are 'closed' to non gamblers.

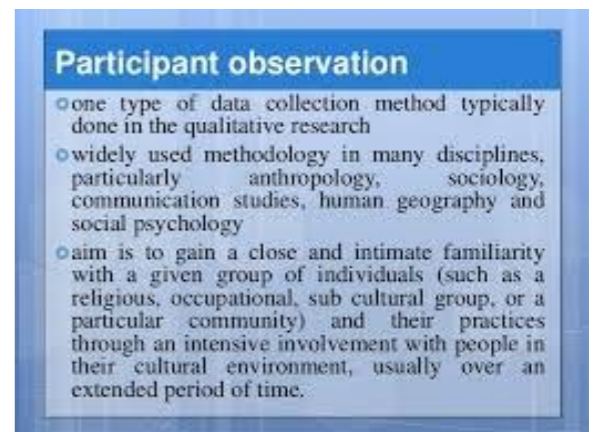
Some meetings are open to family members only on selected occasions when abstinence milestones are celebrated. e.g Medallions to recognise one year of abstinence.

The open meeting that I attended is unusual and the GA national organisation has been unhappy about the way that it operates. In the past they have threatened to 'delist' the meeting from national literature and websites.

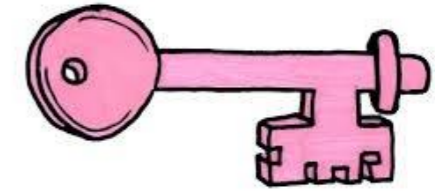


The project

- Exploratory study, with ethnographic methods -extended observations of a single GA meeting in one city in the North of England, supplemented with in depth one to one interviews with eight attenders.
- Individuals asked about their reasons for first attending GA, reasons for continuing to attend and in what specific ways they had found GA helpful.
- Over twenty separate meetings attended
- The number of participants ranged from 8 to 17 (the mean was 14).
- In total, there were 278 attendances over the course of twenty meetings.
- Of these some 10% were female (28), but these were mainly partners and family members of problem gamblers.
- It was notable that in the study period only four females attended who identified themselves as problem gamblers



Some key themes



From initial coding of the data, a number of emerging themes were considered. These were then shared with three of the most regular attenders at the observed meetings, reconsidered after feedback from those individuals, and a set of nine key themes were identified.

These were:

1. gender
2. the structure of meetings
3. the issue of money
4. the power of meetings and regular attendance
5. identity as a compulsive gambler and as a member of the GA community
6. support outside of meetings
7. dealing with co morbidities
8. suicide
9. crime and gambling (the latter was the major theme added after consultation with group members)

Selected themes. 1. Gender

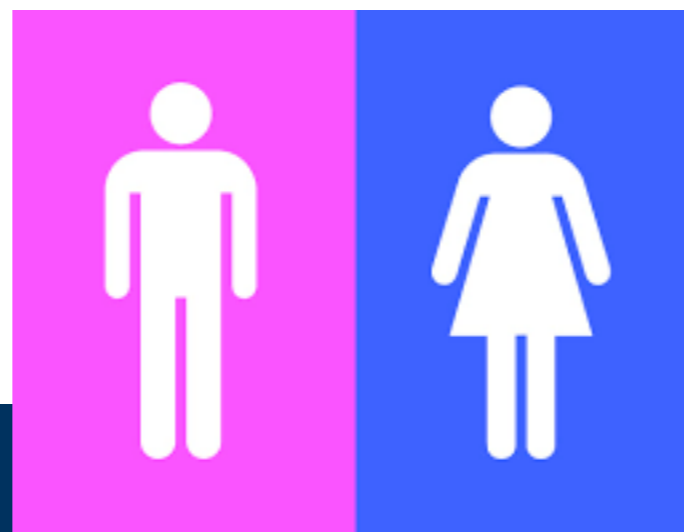
'women preferred' GA meetings in the USA since 1992 and the first such meeting in the UK in Manchester 2012

In the meetings that I observed, only four women attended with gambling problems of their own.

One typical example of a woman with . L described herself as the main carer for a child with significant disabilities, and suggested that her time playing bingo online was her only 'me time' and the only escape from the strains of her caring responsibilities.

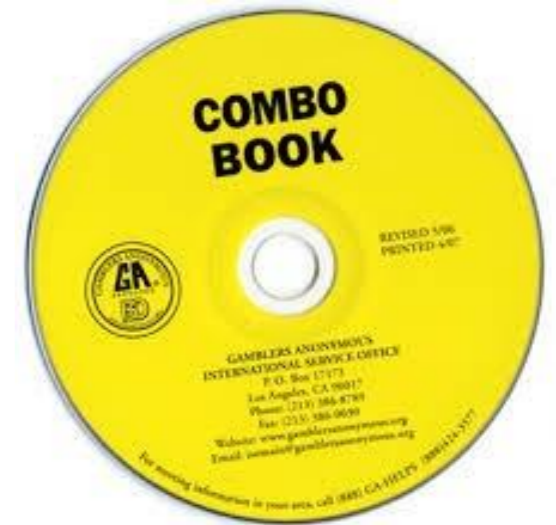
This echoes themes highlighted by Schull (2002) and others about the importance of caring roles in relation to women's gambling behaviours.

Most women attended as mothers/wives/supporters of male problem gamblers



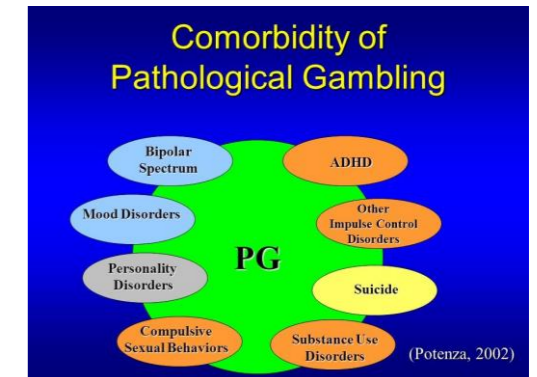
2. Structure of the meetings

1. My name is X and I am a compulsive gambler.
The date of my last bet was.....
2. Voluntary sharing. Questions from the chair person to individuals
3. Readings from GA literature - usually the 'combo' book described as a 'masterly exercise in concision' (Schuler et al 2016)
4. Little other reference to the 'twelve steps'



3.Co-morbidities

- One of the potential weaknesses of a mutual help process which relies on the experiences of the group members as the main source of expertise and which is focussed on a single issue is that any problem which is not related to the theme of the group can be downplayed or dismissed.
- This was particularly obvious in relation to comorbidities.
In a discussion of depression one GA member, after some obvious personal difficulty in disclosing it, acknowledged depression in himself. 'I think that I need to go to the doctor. I think that I am depressed.'
- A dismissive response followed from one of the experienced members. 'I don't think that you are depressed. It's still the addiction. You just need to follow the steps'. This is despite evidence in the meetings that specialist support may be very useful to GA attenders.
- Yet many problem gamblers have other problems. e.g half of problem gamblers also have major depressive disorder (Lorains et al 2011).



4. Suicide

- A recent study from the UK National Problem Gambling Clinic found that 28.7% of those who attended the clinic reported suicidal thoughts at their first assessment (Roberts et al 2017).
- This is more than *ten times* the reported rates of suicidal thoughts for the UK population as a whole.
- From observations at GA meetings references to suicidal ideations were noted were noted on twenty seven occasions. Ten references to actual suicide attempts were also noted.
- Again, it was notable that support from the GA community was helpful in this regard.



'One person described how he had driven his van to the top of a cliff and was close to driving it over the edge, mulling over the harm that he had caused to his family by the lies, theft and mood swings linked to his gambling, and the despair he felt at thinking about his debts and his inability to stop gambling. At that moment, a call to his mobile from another GA member came and he suggested that answering the phone at that moment may have saved his life'.

Conclusions and recommendations.

It would be helpful to have more data about those who attend GA and more longitudinal studies assessing outcomes and processes for both men and women.

Reiterating the reality that GA provides a good deal of the help which is actually available to problem gamblers in the UK, is of no cost to the state, and that state funding of treatment is likely to remain minimal in this era of austerity, it is suggested that this focus on GA should therefore be a priority for research funders and programmes.

For GA as an organisation, a more open stance towards guests and researchers would help in ensuring both that the benefits of their approach are more widely acknowledged and that the more useful aspects of their approach are refined and elucidated

Greater understanding and cross referral between GA and relevant mental health services would be helpful.

References

Advisory Council on the Misuse of Drugs (2012). *Recovery from drug and alcohol dependence: an overview of the evidence*. London. ACMD.

Browne, B.R. (1991). The selective adaptation of the Alcoholics Anonymous program by Gamblers Anonymous. *Journal of Gambling Studies*, 7 (3), 187–206.

Gamcare. *Annual Statistics 2015-16*. London. Gamcare.

Connolly, A. et al (2017). *Gambling behaviour in Great Britain in 2015 Evidence from England, Scotland and Wales*. London: Gambling Commission.

Hay, G., dos Santos, A. & Millar, T. (2013). *National and Regional Estimates of the Prevalence of Opiate and/or Crack Cocaine Use 2010-11*. London. Public Health England.

Kelly, J. (2017). Is AA religious, spiritual, neither? Findings from 25 years of mechanisms of behaviour change research. *Addiction*, 112, 929-936.

Lorains, F. K., Cowlishaw, S., & Thomas, S. A. (2011). Prevalence of comorbid disorders in problem and pathological gambling: Systematic review and meta-analysis of population surveys. *Addiction*, 106(3) 490-498.

Public Health England. (2016). *Adult substance misuse statistics from the National Drug Treatment Monitoring System 2015-16 (NDTMS)*. London: Public Health England.

Roberts, K. Smith, N., Bowden-Jones, H. and Cheeta, S. (2017) Gambling disorder and suicidality within the UK: an analysis investigating mental health and gambling severity as risk factors to suicidality. *International Gambling Studies* 17, 1. 51-64.

Schull, N. (2002). *Escape Mechanism: Women, Caretaking, and Compulsive Machine Gambling*. Working Paper No. 41, Berkeley: Centre for Working Families, University of California, Berkeley.

Turner, D.N., and Saunders, D. (1990). Medical relabeling in gamblers anonymous: The construction of an ideal member. *Small Group Research*, 21(1), 59-78.