Gambling-Related Harm Programme 2021-24:
Yorkshire and the Humber Association of Directors of Public Health (Y&H ADPH)

Workforce Training Needs Assessment Survey: Results and Key Themes (June 2023)

Background and Introduction

Improving access to both workforce education, training and information and support on gambling-related harms (GRH) for frontline professionals who support people who gamble or Affected Other's, has been a topic repeatedly raised by members of the Y&H GRH Community of Improvement (COI); a collaborative regional forum which aims to prevent and reduce gambling-related harms across Yorkshire and the Humber.

A review into existing training and resources was conducted, which did not identify any packages or resources of sufficient quality for rollout across the region. Training identified highlighted links to gambling industry funding and it was not possible to guarantee that these provided a holistic and balanced view of gambling-related harms and their solutions, or that there was evidence of their effectiveness.

As part of the 3-year gambling-related harms YH ADPH funded programme* one of the programme workstreams focuses on the development and access to "*to good quality training, to meet needs of staff in frontline services regionally, who are best placed to intervene early and discuss gambling harms, leading to better identification of need and access to support".* Under this workstream, a regional training planning group was established to support strategic direction and development of a bespoke regional gambling-related harms training package.

Led by the Y&H ADPH GRH programme leads, membership to this group consists mainly of Y&H local authority gambling leads, with input from Office for Health Improvement and Disparities (OHID) Y&H Workforce Development, with group activity also informed by ongoing national work by the OHID Addiction and Inclusion team.

This work is to improve training for healthcare professionals on gambling-related harms in response to the 'Jack Ritchie: Prevention of future deaths report' (March 2022).

As part of initial discussions to improve access to gambling harms information and knowledge for local frontline services, the training planning group agreed to disseminate a training needs survey to further understand any gaps in knowledge and training and how these might be addressed. This included identifying any additional resources that may be helpful to support practice.

Aim

The aim of this training needs assessment was to understand current knowledge on gambling-related harms and identify the training needs of frontline professionals in the Yorkshire and the Humber (Y&H) region, who may be in a position to raise the topic of gambling harms with individuals and provide advice or support.

These results will be used to inform and shape the development of a regional training offer for frontline professionals who may support people who gamble or Affected Others as part of the Y&H GRH funded programme.

Survey Approach

Once questions were agreed and confirmed, the survey platform 'Jotform' was used to build and disseminate the survey across the region. The survey was shared for completion to training planning group members to disseminate to local areas via both an online link and fillable PDF version (to provide an offline option for potential issues accessing the online format).

All raw survey data was collated to a Microsoft Excel spreadsheet available to a private account on Jotform, downloadable and accessed only by the Health and Wellbeing Support Manager, supporting the funded programme team. This spreadsheet was saved on a password protected area on Microsoft Teams only accessible by the funded programme team. Where appropriate and requested, local responses to the survey were shared with training planning group members, for specific local area intelligence where useful. (Names, organisations and emails were removed to maintain anonymity of individual responses).

Data was anonymised apart from emails that were voluntarily provided by participants who wished to be kept updated on further training developments in the programme. These emails were saved separately and also password protected on the Microsoft Teams location accessed only by the funded programme team.

i. Target population

Survey dissemination was targeted at gambling related-harm frontline professionals as identified by the training planning group members. Professionals included any frontline role that may intervene or provide information or support to people who may gamble or may be affected by it (known as 'Affected Others'), as part of their service or day-to-day role. (This excluded specialist services providing gambling harms treatment as their main focus, or clinical settings e.g. in primary care.)

Additional staff groups who would benefit from a greater understanding of gambling-related harms due to relevance to their organisational objectives or remit were also included and agreed by the training planning group.

The list of services and groups for survey dissemination are below:

(this is not an exhaustive list)

- Substance misuse services and recovery community
- Carer's support
- Wellbeing services
- Community and voluntary sector (including charities)
- Adult education providers (including universities and colleges)
- Student services (including student unions)
- Financial support providers (such as Citizens Advice)
- Employers and sector skills councils
- Local sports clubs and associations
- Services working with inclusion groups
- Community policing and Liaison and Diversion services
- Early intervention services

- Mental health support.

Each local authority lead in the training planning group led engagement and survey dissemination in their local area with these staff groups.

ii. *Survey topic areas*

The questions and structure of this survey were jointly developed by members of the training planning group. As part of survey development, similar previous survey examples were shared to learn from best practice. During group planning meetings, survey questions and topic areas were discussed and agreed by group members to appropriately fit the desired survey aim outcomes.

Questions in the survey covered the following areas:

- Information on the professional's role and organisation
- Understanding current knowledge and previous training completed on gambling-related harms (including any training accessed through 'Making Every Contact Count')
- Identifying preferences for potential delivery formats and durations, and any enabling factors to support engagement with a potential training offer
- Gaining insight on how training would be used and identifying any supplementary resources that may support practice.

To note:

The scope of the target population to support in this programme is adults who gamble and Affected Others. Training specific for professionals working in treatment and intervention services or supporting children and young people specifically will be out of scope of training that is developed.

Some local authority areas in the Yorkshire and the Humber region are not represented in the results and development of this training needs assessment. In some areas, the timing of this survey did not fit local plans due to ongoing pre-existing commitments. However, interest in future developments were expressed.

Summary of Results and Key Themes

The survey was open for completion between 6th-21st April (inclusive) 2023.

In total, there were **111** survey responses from across the Y&H region.

The following sections will provide a summary of results, separated into the three sections of the survey on **roles and organisations, previous skills and knowledge and training considerations.**

Full quantitative data and supporting charts can be found in Appendix 1.

Section 1: Roles and Organisations

The first section of the survey asked individuals about their role and organisation, including locations where people work and a brief description about their role.

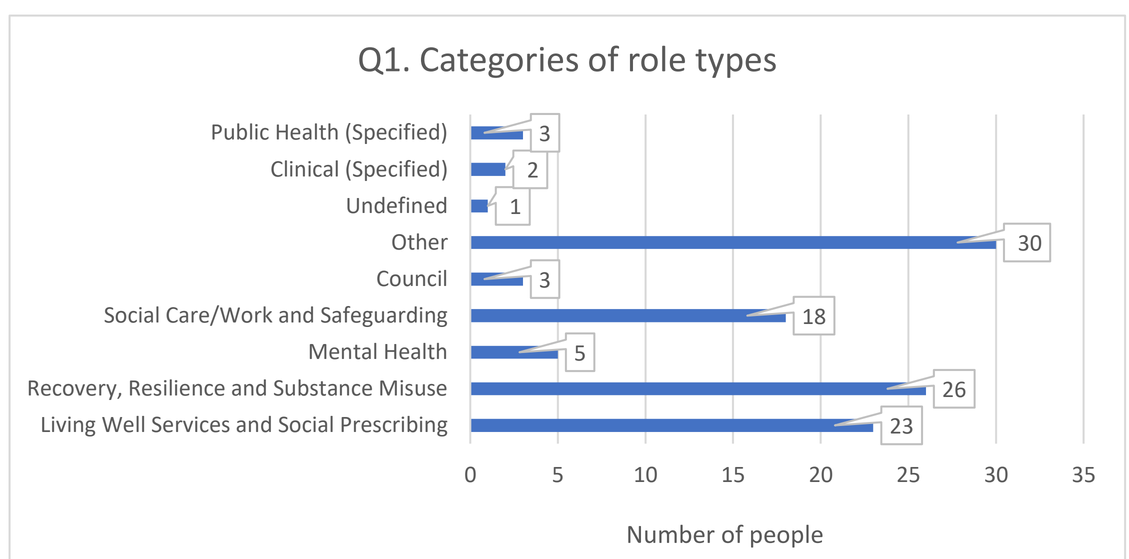
The table below shows the number of responses from locations across the region.

Three participants chose options covering the whole Y&H region, two stated they work UK wide (one including Northern Ireland), and four participants worked in more than one location in the region.

Location in the region	Number of responses
Barnsley	13
Bradford	27
Doncaster	3
Kirklees	4
North East Lincolnshire	18
North Lincolnshire	1
Sheffield	18
Wakefield	10
Y&H wide	3
>1 Y&H location	4
UK and NI	2
York	8

Questions 1 and 3 asked participants about their job titles and organisations, including a description of the outline of their role. Results showed a variation of role types and descriptions, including administrative roles, safeguarding and clinical roles (some within medical settings) and health promotion-based work, such as reducing alcohol intake and weight management. Some of the most common roles included were social prescribers, health trainers/health adviser roles and social workers.

This has been categorised in the pie chart below, grouping roles into different service areas:



As the chart shows, outside of living well/social prescribing and recovery services, most participants fell into the 'other' category. This 'other' category included administrative roles, charity specific roles (including director level and strategic level roles) and Human Resources.

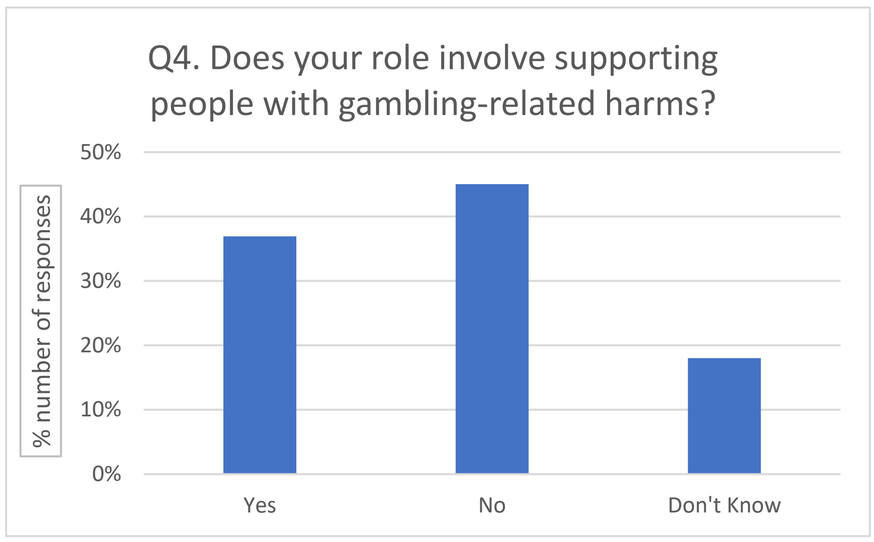
In the 'social care' category, a number of roles involved a remit of supporting children and young people; despite this population group being stated as out of scope at the start of this survey.

When asked to provide a description of their role, most responses involved the use of 'support' in their descriptions, with a main theme of promoting positive health behaviours (such as smoking cessation) and reducing unhelpful ones. Other common roles were focused around supporting recovery and providing therapeutic support, such as through counselling or mental health support.

Although highlighted in the 'out of scope' criteria at the start of the survey, a number of respondents specified working with and supporting children and young people, with some overlap of working with families overall.

Organisations and roles were largely based in local communities. The majority of roles were in live well/wellbeing and recovery services. Other organisations included councils (although this was low in the frequency of responses). Due to differences in commissioning within local areas, it is likely that where services sit within health structures and organisational systems will differ; with some based in community services and some within local authorities.

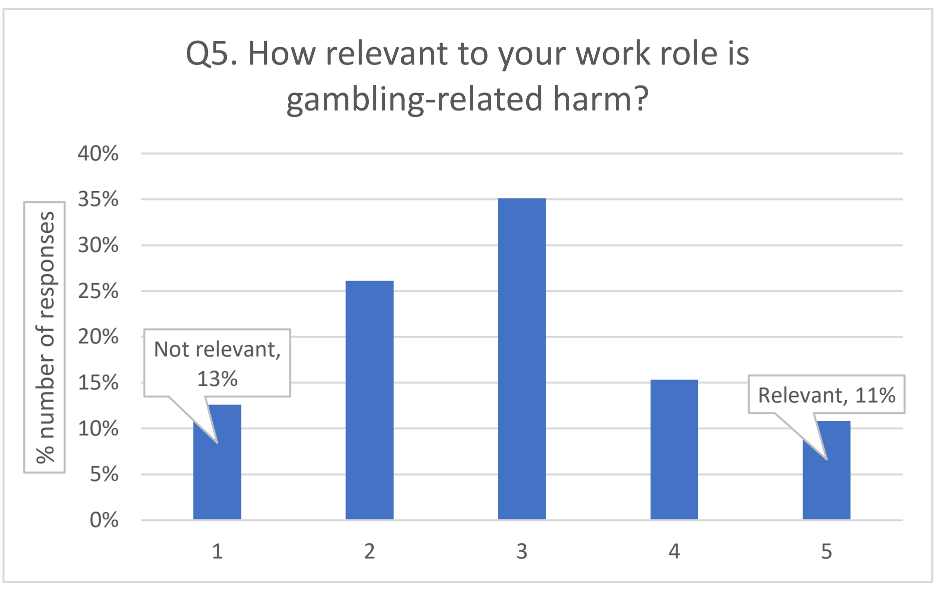
Q4 asked participants to state whether supporting people with gambling-related harms was part of the remit of their role. Findings are shown in the bar chart below:



45% of respondents (50 participants) stated their role did not involve supporting people with gambling harms, compared to 37% of people who answered 'yes'. 18% (20 people) answered 'don't know'. For those answering yes, these roles were largely frontline facing support roles involving one on one engagement with service users/clients (mainly from recovery and social prescribing services). This correlates to what we may expect from individuals answering yes to this question, as these roles overall provide therapeutic or targeted support as part of the nature of their role.

Those answering 'no' included health trainers and social care-based roles which are were still client facing, but when cross-referencing to the description of their role in Q3, outlined specific areas of focus in their role (such as support around substance misuse, or other areas of health improvement or promotion).

In addition, those also answering 'no' included roles which were not front facing such as Human Resources and some administrative roles, which we may expect from roles such as these that are not service/client facing with providing support.



When asked how relevant gambling related harms was to their role (on a scale of 1-5, not relevant to relevant) the highest number of responses sat in the middle of having 'some' relevance, with 35% of responses (39 people). Those answering '3' onwards were mainly from recovery, resilience, or social care/work services.

39% of participants (43 people - close to half of overall respondents) felt gambling harms was either 'not relevant' or of 'low' relevance to their role. When looking at the roles of these respondents, these were largely based in non-traditional supportive face to face roles (such as HR and administrative roles) which may be argued could be less relevant to gambling-related harms with less face-to-face service user contact.

A reasoning behind the high response rate to 'low relevance' could be linked to confidence and/or awareness on the link to gambling-related harms to an individual's specific role, where the connection might not be clear or seen as relevant (resulting in the shift towards 'low relevance' seen in these answers).

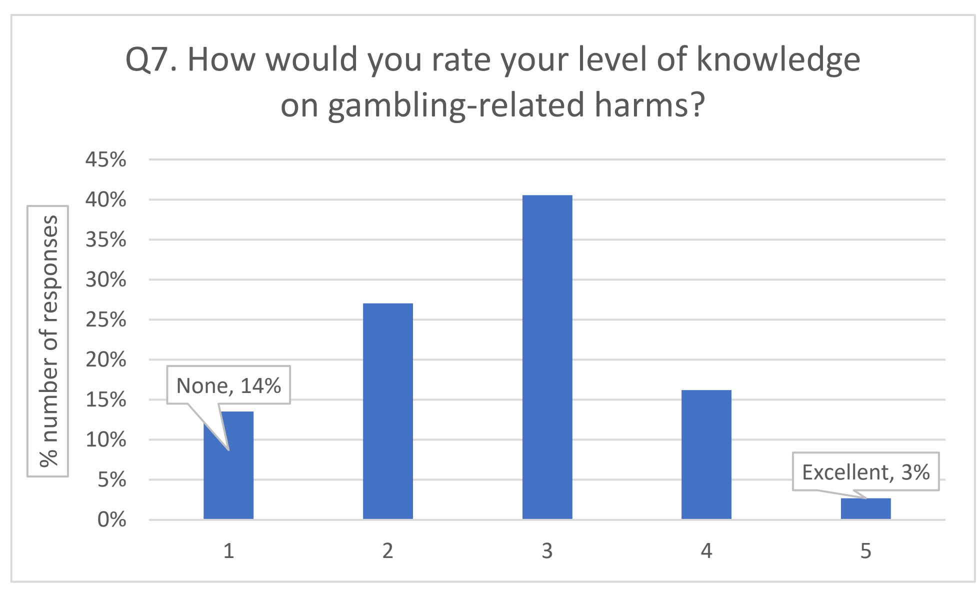
Training may provide clarity or greater understanding to the relevance of gambling-related harms to certain roles which could result in changes in responses to this question over time. This could be measured through surveys pre and post training, analysing any changes to responses to this question following an individual's undertaking of training.

When asked about the relevance of gambling-related harms to organisational objectives (on a scale of 1-5, not relevant to relevant), similar to Q5, Q6 shows a similar cluster of most responses sitting in the middle of 'some' relevance; 34% of responses (38 people).

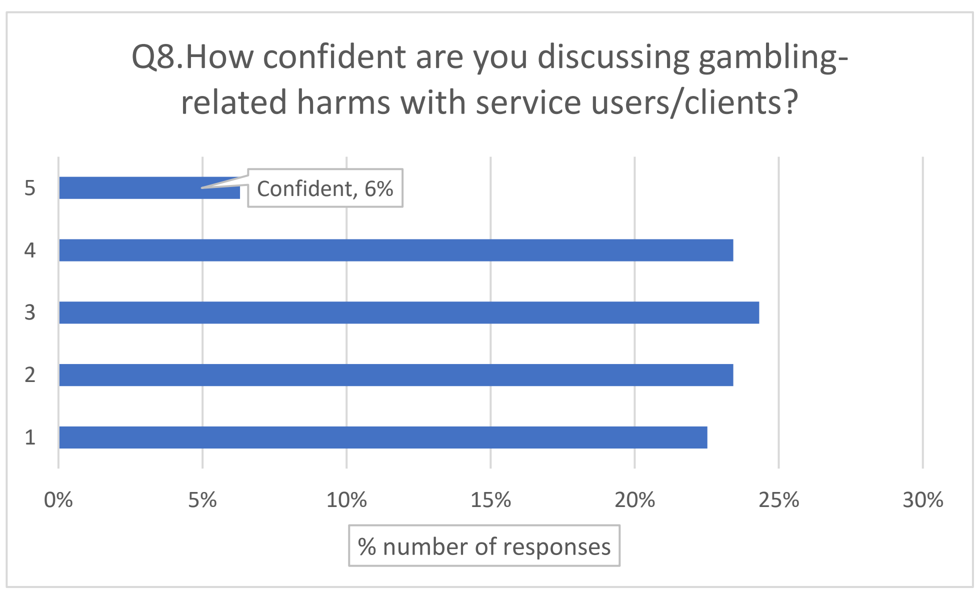
Unlike Q5 however, there is a shift of higher levels of responses towards a greater relevance of gambling-related harms to organisational objectives, with 43% of responses noting 'high' or 'very high' relevance. Those scoring '3' onwards in this question were from similar services as outlined in Q5, who answered '3' or higher identifying the relevance of gambling-related harms to their role. This may be interpreted as those understanding the relevance of gambling-related harms to to their role showed similar confidence on relevance their organisational objectives.

Interestingly, when comparing the answers of those scoring 1 (not relevant) or 2 (low relevance) in Q5 against their responses to Q6, over half of these respondents identified greater relevance of gambling-related harms to their organisation. This highlights that although these participants may not have identified relevance of gambling-related harms to their specific role, they could identify the relevance as part of their wider organisation.

Section 2: Overall knowledge, skills and previous training

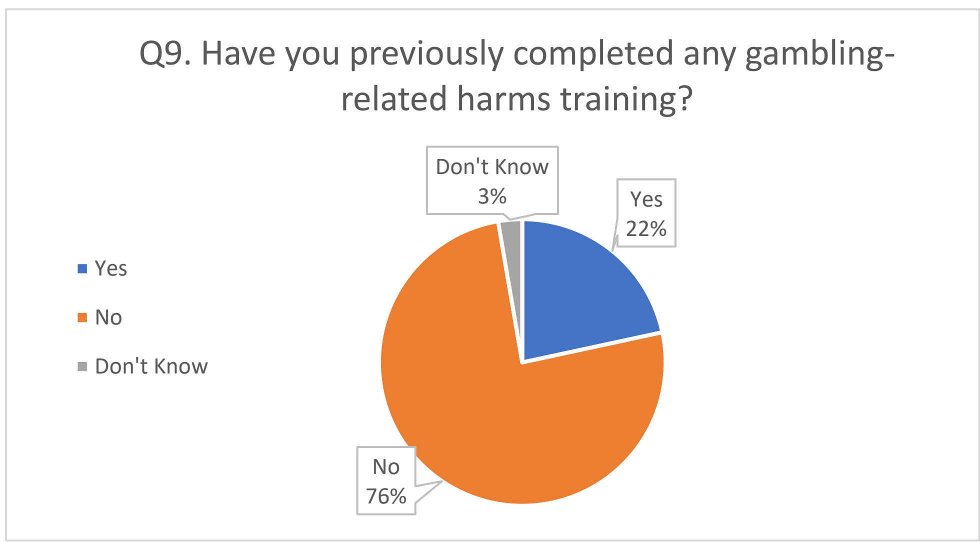


When asked how individuals would rate their own knowledge on gambling-related harms (1-5, none to excellent), 41% of responses (45 individuals) lay somewhere in the middle. 41% of participants were towards the lower end of the scale on having 'none' or 'low' levels of gambling-related harm knowledge, with only 3% of participants (3 people) holding an excellent level of knowledge. Those in the 'excellent' category included individuals affiliated to a charity whose specific purpose is to reduce gambling-related harms (specific to children and young people), so their answer to this question would be as expected given the nature of their role related to their organisation.

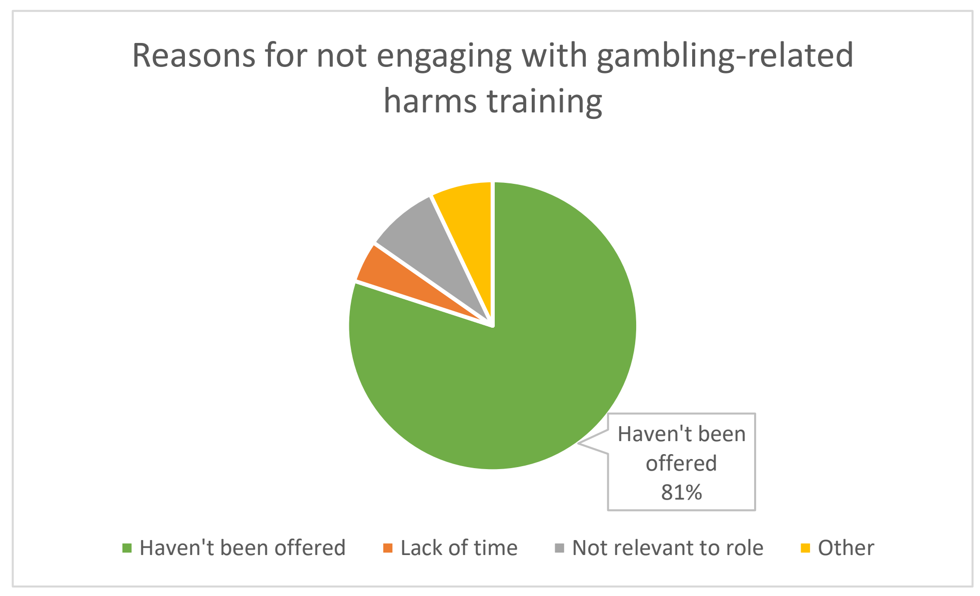


Confidence levels on discussing gambling-related harm with service users/clients gave a relatively even spread of responses from fairly confident to not confident, with only 6% of participants (7

people) at the highest end of the scale at confident. Those answering 'confident' were mainly at more senior positions (directors or founders), mainly from charitable organisations.



An overwhelming number of responses were seen for Q9 with 76% of participants (84 out of 111 people) having not previously completed any training, with only 22% (24 people) having previously taken part in gambling-related harms training. This question included completion of any 'Making Every Contact Count' training. A variety of roles were included in both those answering yes and no, meaning no specific conclusions can be drawn about particular roles answering this question as expected or predicted.



As a follow-on question, participants who had not completed training were asked why. From the multiple-choice options (where only one could be selected), the highest chosen option from 81% of

people (68 individuals) was that they had not been previously offered gambling related-harms training.

A small number of free text responses to not having completed training were given. These reasons varied and included; not having considered training as part of their role and having to prioritise other aspects of workload meaning training could not be completed.

'Cost-too expensive' was an additional multiple-choice option which was not chosen as a reason by any survey respondents.

Previously Completed Training – Content and Application

For the 22% that had completed training when asked to describe its content, most training completed was through 'Making Every Contact Count' (MECC), with YGAM as another highly rated option. Most participants had taken part in training within the last 1-2 years. The majority of individuals in these roles were from recovery and based roles and health improvement backgrounds, including supporting with substance misuse recovery and health promotion (e.g. smoking cessation, healthy eating and weight management).

Most responses simply stated the name of the training provider (i.e. MECC). Additional detail included in free text responses described training as 'brief' with content largely described as providing basic understanding and introductions to gambling (sometimes phrased as 'gambling addictions' and another response using 'problem gambling'). Patterns and causes for gambling harms and the effects on Affected Others were also included, as well as information on signposting.

For those that had completed training, 71% of these individuals stated they had used this training as part of their day-to-day role. When asked 'how', most responses were linked to awareness (being mindful on the use of terminology, stigma and triggers to be aware of) signposting, referrals and screening, including increased confidence or knowledge on when appropriate to raise discussions with service users. Some respondents had applied training to developing training materials and in commissioning.

29% of participants did not apply completed training to their role.

The main reason given was:

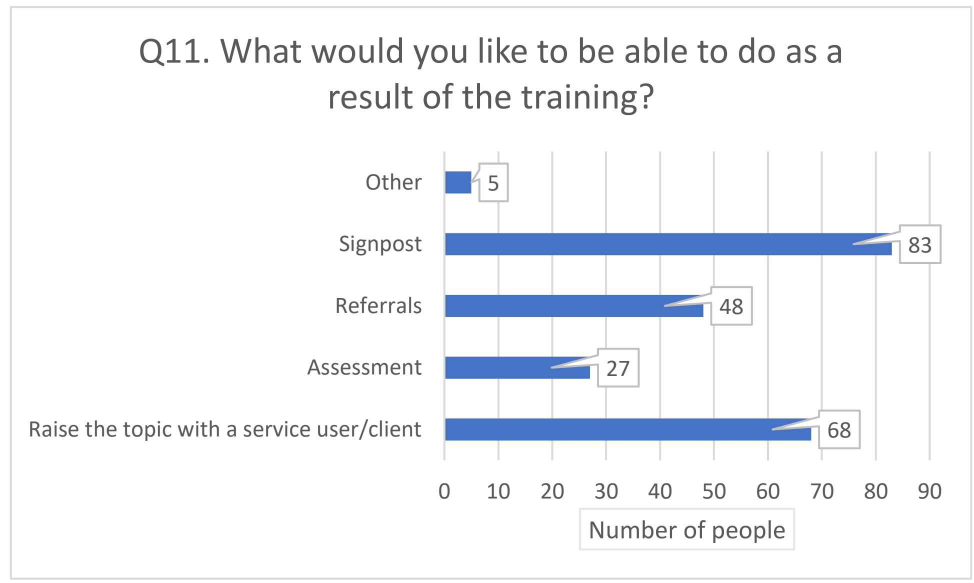
- due to a lack of relevance of this training to their role
- or not having encountered a client/service user that has raised gambling-related harms as a concern.

Other respondents stated their role did not involve face to face interactions where this training may be used.

Section 3: Training Needs (Content, Delivery and Materials)

86% of those completing the survey (96 people) expressed wanting to improve their knowledge/skills on gambling related harms.

For those that did not want to improve their knowledge and skills, (14% of participants, 15 people), the main reason given was that training would not be relevant to their role. Additional responses for some were that they did not require further information on their existing knowledge of gambling harms, while another response expressed that this area had not yet come up when engaging with service users/clients.

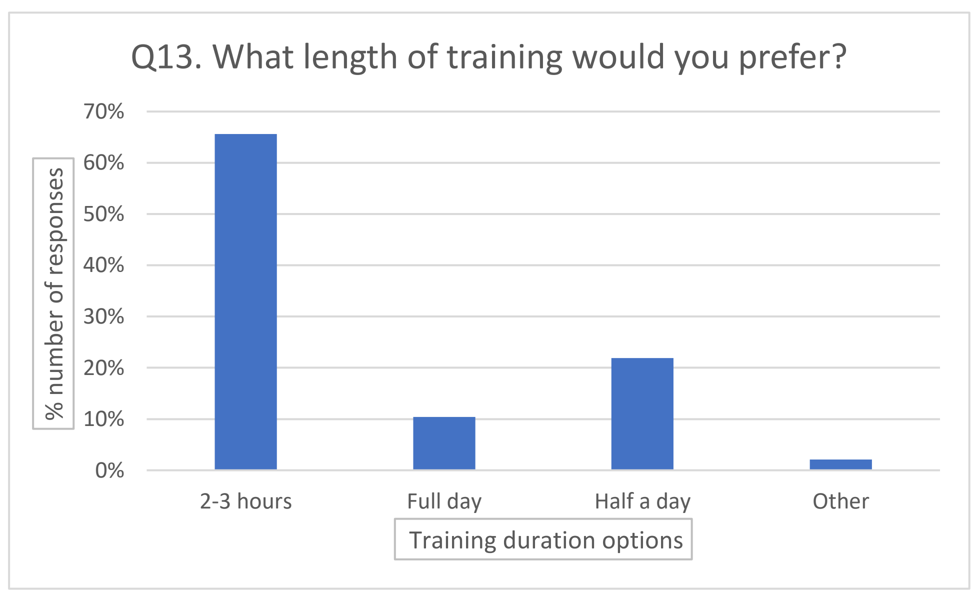


Q11 asked participants what they would like to be able to do as a result of the training. (This question was an open multiple-choice, allowing participants to choose as many of the options as preferred). Signposting received the highest number of votes, (chosen 83 times). Raising the topic with a service user/client received the second highest number of votes, chosen 68 times.

The raw data also showed that the option of 'assessment' was the only category chosen consistently alongside other multiple-choice options. This may indicate that individuals wanted to gain other skills (such as referring or signposting) alongside assessing individuals for gambling-related harms.

Reasons given outside of the multiple-choice options were; understanding brief or structured interventions for people who gamble, coaching to support other staff members and training for staff to understand the risk and impacts of gambling on children. (The latter option being out of scope of this survey and programme training development).

Most people preferred the option of taking part in online training; chosen by 43 people. As with Q11, this was also a multiple-choice question, allowing for more than one choice. One participant stated they would like training to engage all methods listed.



The majority of participants 66% (63 people) opted for a preferred training length of 2-3 hours. A full training day received the lowest response rate of 10% (10 responses).

Two participants expressed wanting shorter training times than those listed. One individual stated up to an hour/less would be preferred due to capacity reasons, and another for 1 to 1.5 hours, with both reasoning this could work well for those that are time poor who may have a preference for

dipping in and out of e-learning. Having the option to speak to a training course facilitator alongside this option was also suggested as a way to support e-learning.

Is there anything that would make it easier for you to access training? (Q14)

Of those wanting training, 76% (73 people) did not have anything specific that would make it easier to access training, answering ‘no’.

23% (22 participants) selected ‘yes’ to this question. The majority of these respondents stated training being online or through e-learning would support accessing training. Most did not include further explanation, but for those that did, being able to engage at a time suitable to them around their workload was mentioned, as well as having sufficient notice of online training to be able to attend. (A small number of respondents highlighted training in the local area would support attending training, especially if this was face to face). Where face to face training was mentioned, the accessibility of venues either close to public transport options or a local venue was also raised as a facilitator to attend training in person.

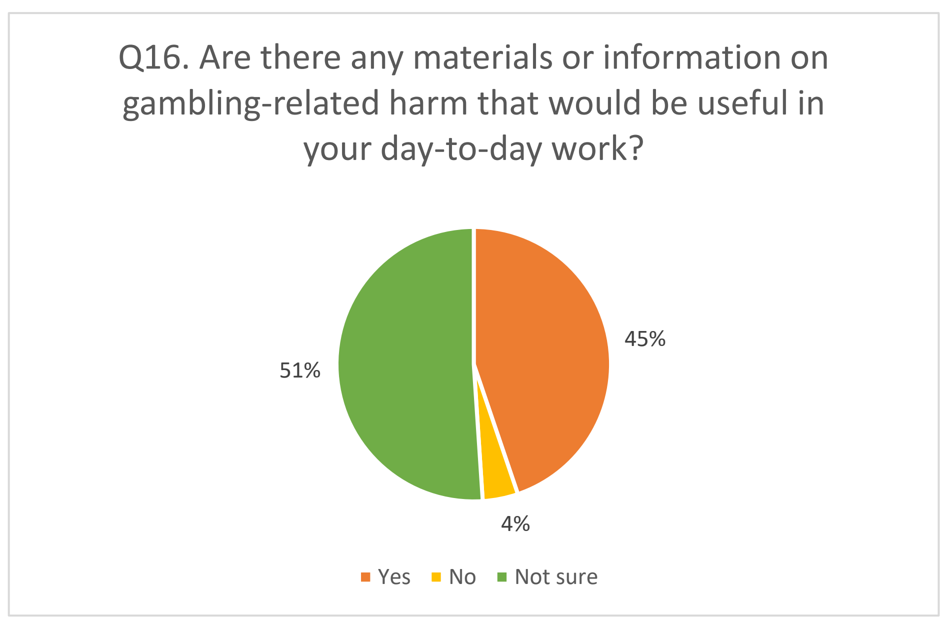
One response voiced combining gambling-related harms training with other related topic areas (not outlined in the response) would be beneficial due to a lack of time and resource for them as a smaller organisation to attend training on multiple topic areas. The response highlighted training should be person-centred, combining support needs an individual may need/face in addition to gambling.

Do you expect any barriers to applying the knowledge or skills to your role? (Q15)

79% (88 participants) did not anticipate any barriers to applying their knowledge/skills as a result of undertaking training. For those that did (3%, 3 people) felt that the clients/service users they support would be the barrier to applying training. Additional detail (i.e. on how individuals may be a barrier) was not outlined in these responses.

(An additional barrier around confidentiality was noted by a participant. The response given was in relation to confidentiality when supporting children and young people, and difficulties with managing this with their parents. This response was not included in the full analysis of results from this survey as children and young people are a population group outside of the scope of this training programme.)

When asked what would help to overcome these barriers, greater knowledge on how to approach the topic with a service user and greater knowledge on managing confidentiality were given. This however was in relation to confidentiality between parents and professionals when supporting children and young people (which as mentioned is a population outside of the scope of this programme).



On the final question of the survey, when asked if any additional resources or materials would be useful as part of day-to-day work, most responses fell under 'not sure' - 51% of responses (49 people) - closely followed by 'yes' (45% of responses, 43 people).

For those choosing that felt that additional materials would be helpful, signposting options came up overwhelmingly as a theme in free text. Further detail given was around understanding on organisations to refer to (such as charities), as well as a need to understand support available in local areas and online information. A 'summary sheet' was suggested in a response as a potential way to support this.

Assessment tools and methods of being kept up to date with services and updates on gambling-related harms were also mentioned.

To conclude the survey, an 'additional comments' free-text box was provided, which generated several responses. Overall, the importance and prominence of gambling-related harms was commonly raised, with training being a good way to address this in the event service users/clients need further support.

Limitations

It is important to consider some limitations as part of the results of this survey. Firstly, as this survey was disseminated solely to the Yorkshire and the Humber region, the results are not indicative of the national scale of training needs, and thus should not be extrapolated outside of the region. It is also true that results are not generalisable of needs across the whole Y&H region (although there is a strong representation from local areas across the region), especially when considering the sample size of this survey and that responses were not received from all service groups targeted for survey engagement. In addition, although efforts were taken to disseminate this survey to relevant staff groups within the region through the training planning group leads to their locally established networks, this relied on a snowball effect to reach certain services. As a result, not all services with potential to intervene on gambling-related harms in their day-to-day role may have been engaged, and these results may not speak to the specific needs of some service areas.

This survey was also disseminated during the Easter holiday break of April 2023 with a short turnaround in an aim to keep in line with programme timelines, which may have contributed to a lower response rate due to staff groups not being able to complete this survey in the timeframe given. This includes services that were not represented in the survey results, such as community policing. Moreover, the survey was shared via email and may have also missed professionals working in more informal support settings, who may support people who gamble or Affected Others. However, anecdotal feedback from other gambling-related harm professionals across the region (not represented in the training planning group) provides some confidence in the main themes of these results.

The questions on this survey were developed and structured solely by members of the training planning group (with a background knowledge of gambling related harms) but the perspectives of those with lived experience were not captured when developing questions. This may be something to consider in future surveys.

Analysis of this data was completed by one individual (due to low capacity in the programme team) meaning interpretation of particularly the qualitative results was subjective, based on the interpretation of one individual. This was managed by discussing results with the project lead.

Conclusion: What do these results tell us?

In conclusion, this training needs assessments survey has highlighted several key themes which can provide guidance and evidence towards the development of a bespoke regional training package. The results of this survey provide a starting point to explore the training needs of professionals who might work with gambling-related harms (or who are likely to support individuals in this space as part of their role). As such, the results of this work raises further questions for local areas in the region which may require follow up engagement or exploration (for example, to understand low response rates from certain services) to identify specific needs for local areas.

Key themes and conclusions of this survey were:

- Individuals indicated mixed feelings about the relevance of gambling-related harms to their role, but overall most participants identified more relevance of gambling-related harms to their organisation. This may suggest differing perceptions of supporting gambling-related harms within an individual role in comparison to perceptions of an organisation.

- A low number of people (6% of individuals) identified as feeling 'confident' discussing gambling-related harms. These respondents were mainly in management and oversight roles of either other staff members or teams supporting service users/clients, or held senior roles in organisations whose specific remit was on supporting gambling-related harms.

- 76% of survey participants had not previously completed gambling-related harms training. The main reason identified in results was that participants had 'not been offered training'. This may link to perceptions around responsibilities on who requires specific knowledge in supporting individuals with gambling-related harms and thus training.

- Most people were not sure what materials or information on gambling-related harms would be useful in their day-to-day work, perhaps highlighting a high level of uncertainty around knowledge of available materials and options.

- The majority of respondents (66%) interested in training preferred a duration of 2-3 hours. 43% of these individuals preferred this training to be online.

- Although out of scope of this programme, support for children and young people was a frequently occurring theme from several respondents.

Next steps

The results of this training needs assessment survey will be shared with the funded programme training planning group and used to shape and guide the development of a training package for the region. Where appropriate, these results will also be shared with national OHID leads for ongoing national training work.

If you have any questions or queries about the results of this survey, please contact Abi Brown:
abi.brown@dhsc.gov.uk

This work was completed on behalf of the Yorkshire and the Humber Association of Directors of Public Health (Y&H ADPH) by the programme's training planning group:

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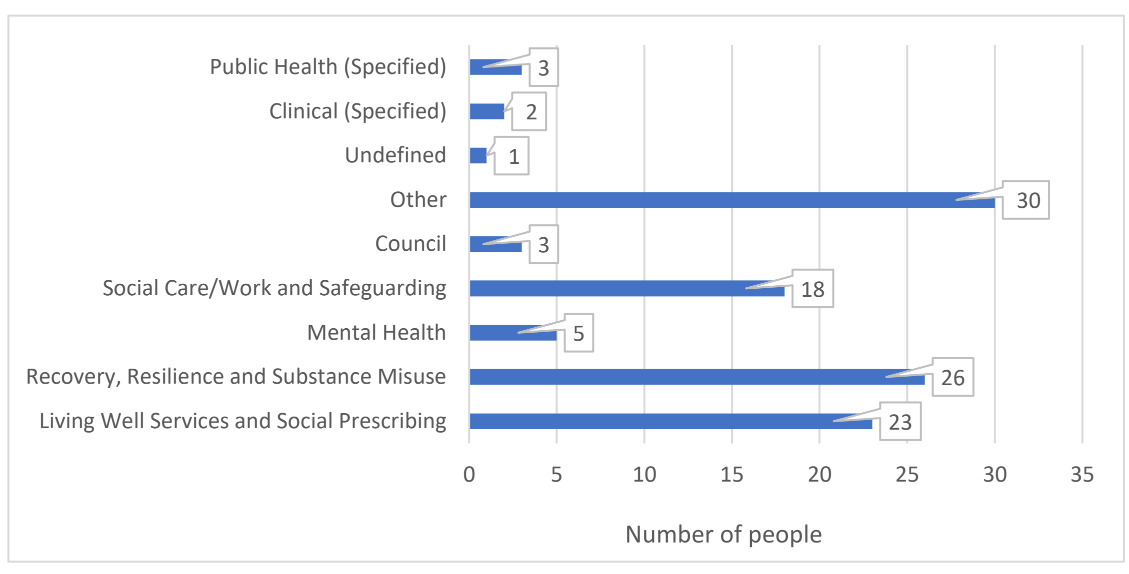
- **Abi Brown** (OHID Yorkshire and Humber Health and Wellbeing Team)
- **Chris Sharp** (OHID Yorkshire and Humber Health and Wellbeing Team)
- **Laura Fairbank** (Barnsley Public Health Team)
- **Nasar Ahmed** (Bradford Public Health Team)
- **Sarah Exall** (Bradford Public Health Team)
- **Priti Gohil** (Kirklees Public Health Team)
- **Caroline Temperton** (City of Doncaster Council Public Health Team)
- **Mike Hardy** (North East Lincolnshire Council Public Health Team)
- **Jessica Brooks** (Rotherham Public Health Team)
- **Maureen Hanniffy** (Sheffield Children's Safeguarding Partnership)
- **Chris Wathen** (Wakefield Council Public Health Team).

** ADPH Yorkshire and Humber have received funding in the form of a regulatory settlement from a UK gambling operator to support this programme of work. Regulatory settlement funds are payment in lieu of a financial penalty the Gambling Commission might otherwise impose for breach of a licence condition. The project remit was approved by the Gambling Commission with no involvement of the UK gambling operator. There has been no industry involvement in any part of this research or the related programme. More information on this type of funding can be found here: What are Regulatory Settlement funds? (gamblingcommission.gov.uk)*

Appendix 1: Quantitative analysis data

Q1. Categories of role types

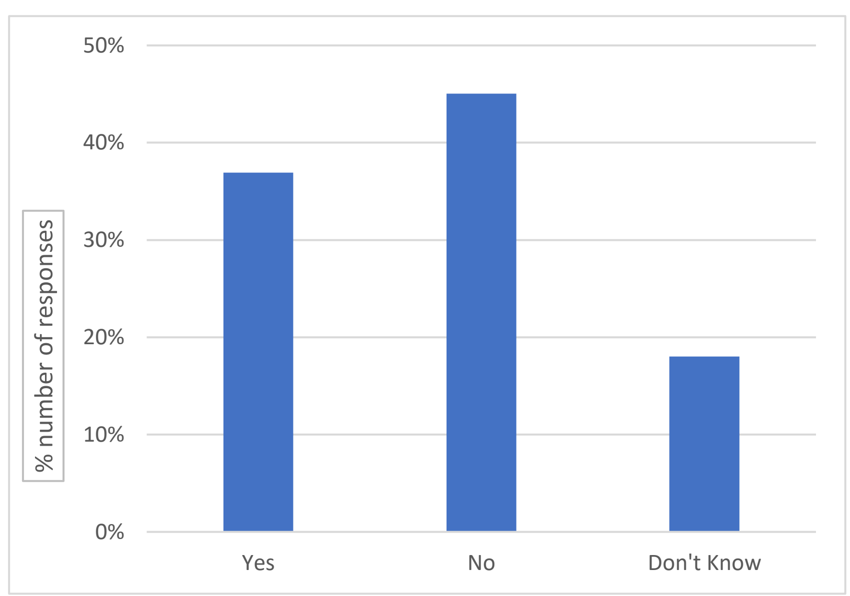


Question 2)
What location(s) does your role cover?

Location in the region	Number of responses
Barnsley	13
Bradford	27
Doncaster	3
Kirklees	4
North East Lincolnshire	18
North Lincolnshire	1
Sheffield	18
Wakefield	10
Y&H wide	3
>1 Y&H location	4
UK and NI	2
York	8

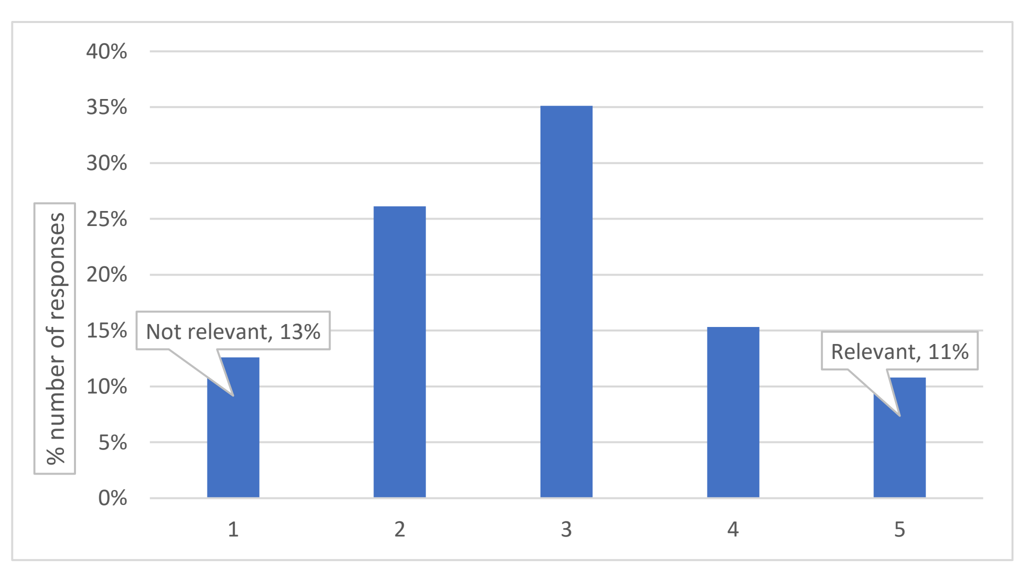
Question 4)

Does your role involve supporting people with gambling-related harms?



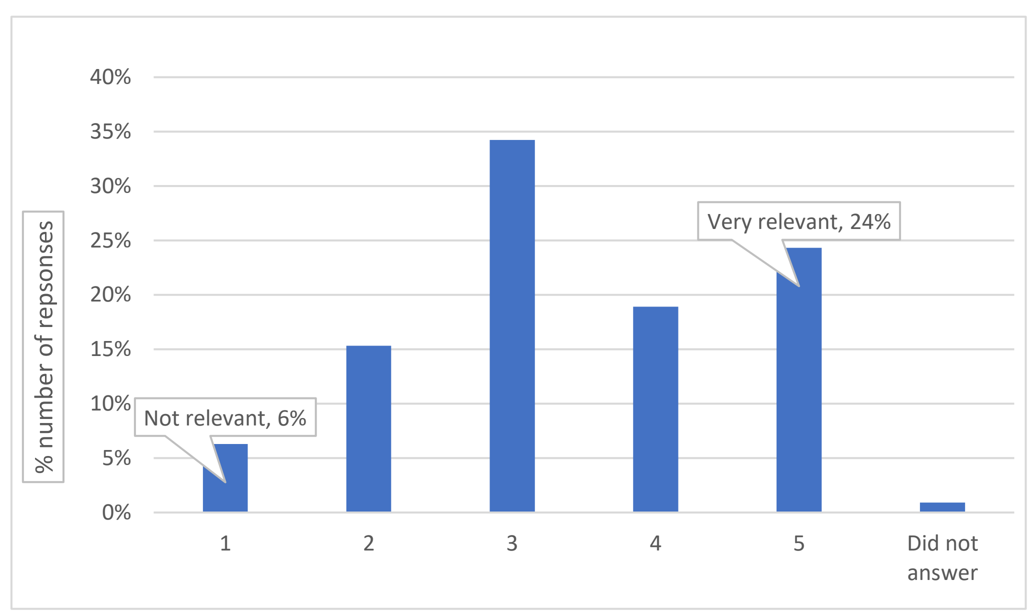
Question 5)

How relevant to your work role is gambling-related harm?



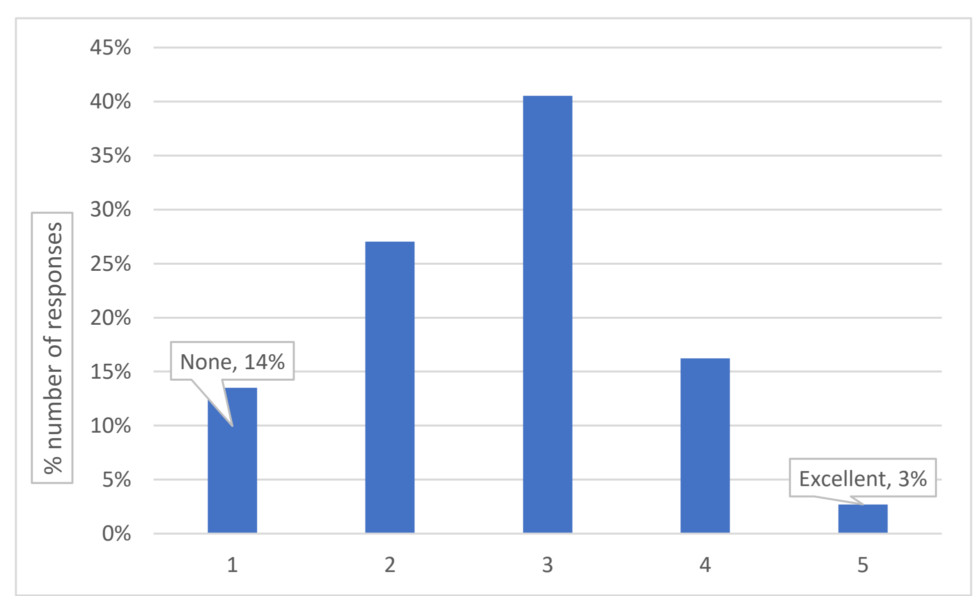
Question 6)

How relevant to your organisation's objectives is the impact of gambling harms?



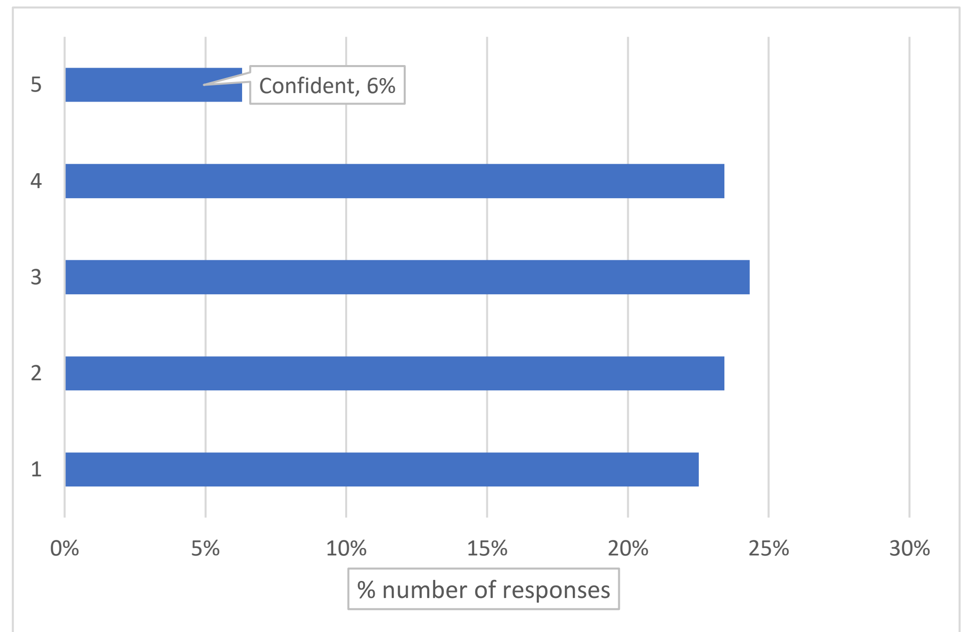
Question 7)

How would you rate your level of knowledge on gambling-related harms?



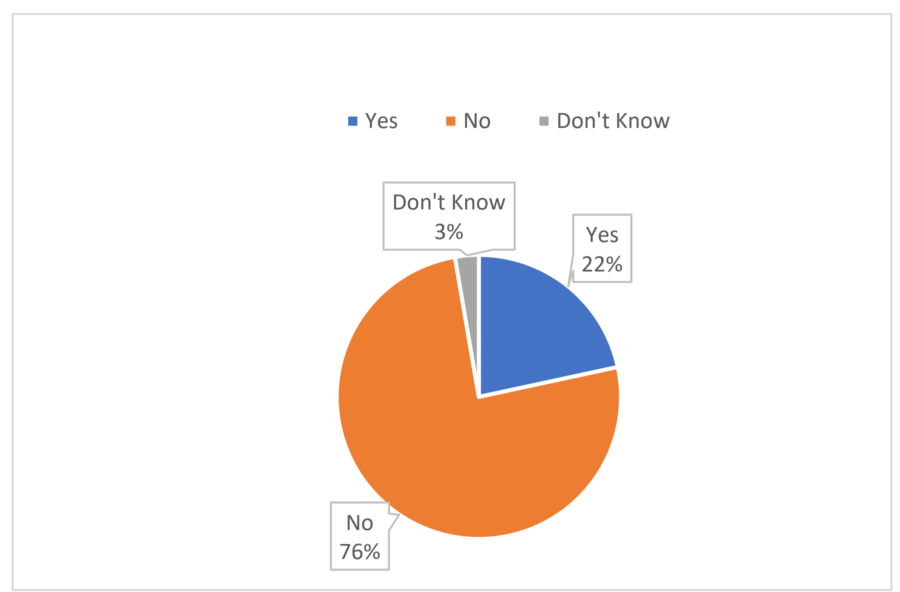
Question 8)

How confident are you discussing gambling-related harms with service users/clients?

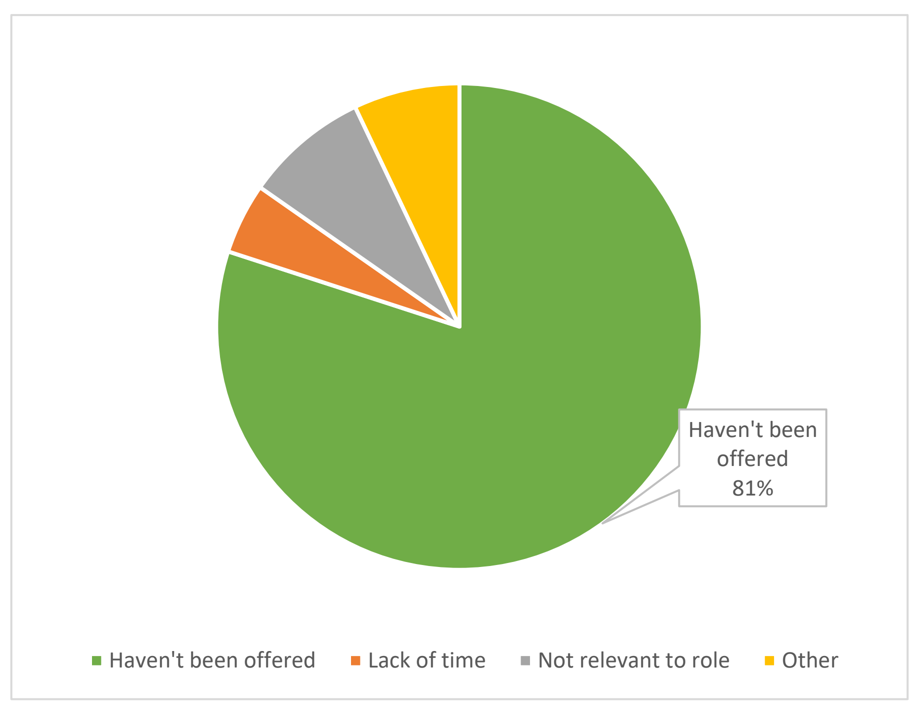


Question 9)

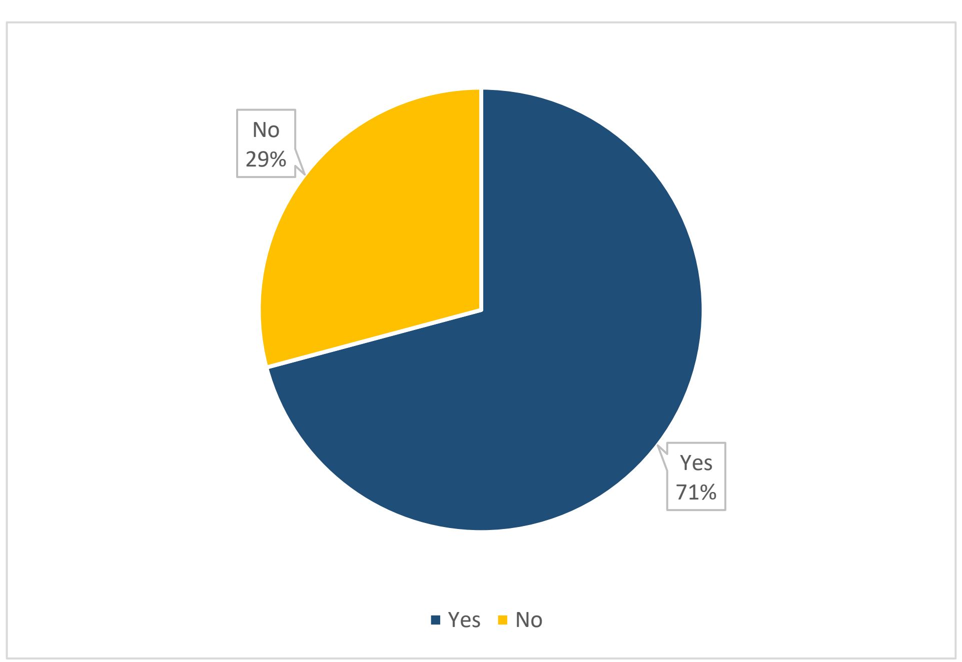
Have you previously completed any gambling-related harms training (including 'Making Every Contact Count'?)



If no, please tell us why:

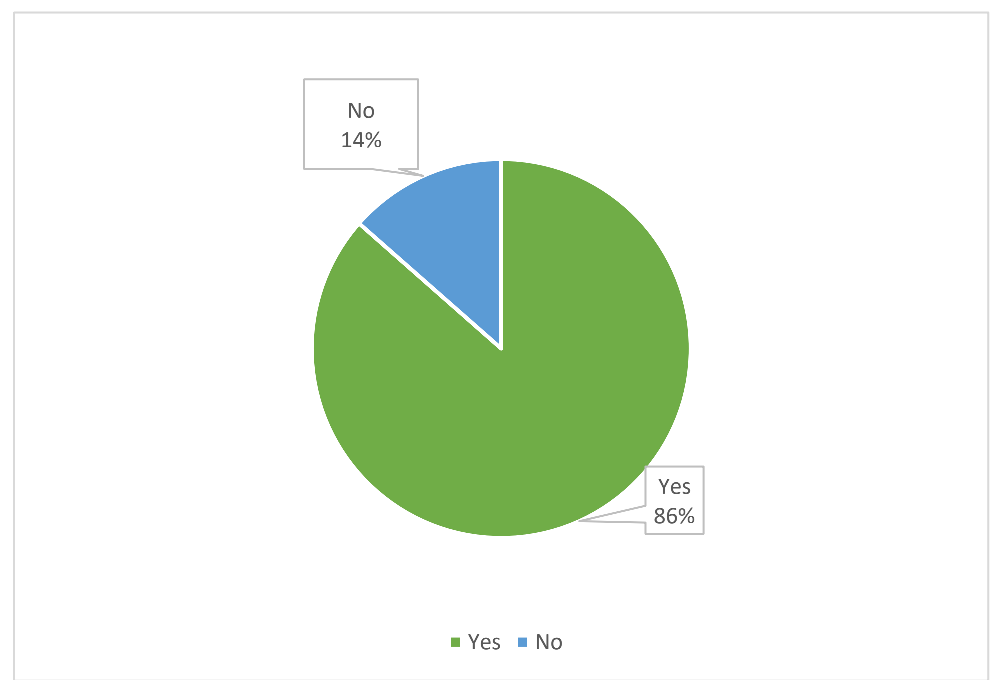


Have you used this training in your day to day?



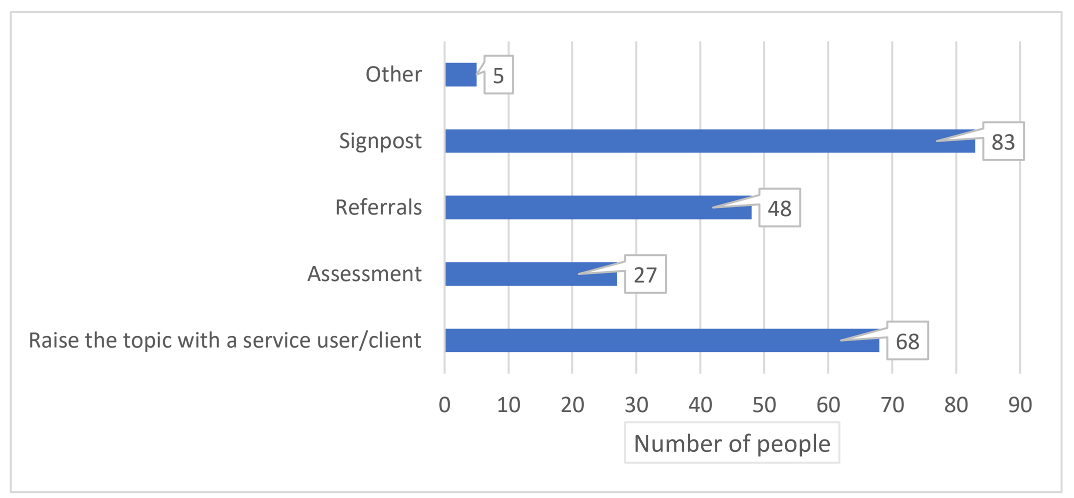
Question 10)

Would you like to improve your knowledge/skills on gambling-related harms?



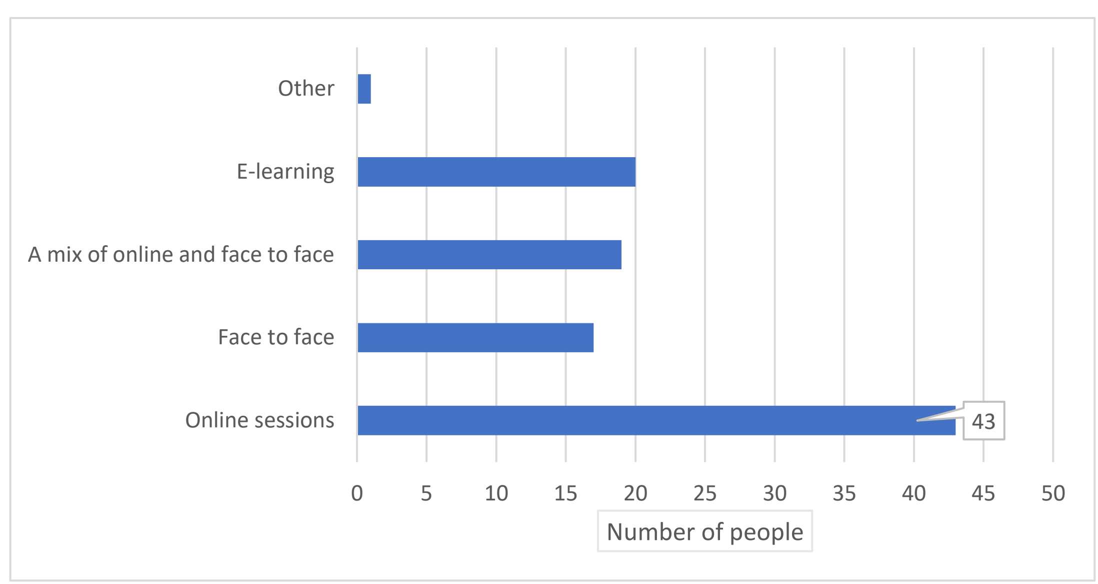
Question 11)

What would you like to be able to do as a result of the training? (please select all that apply)



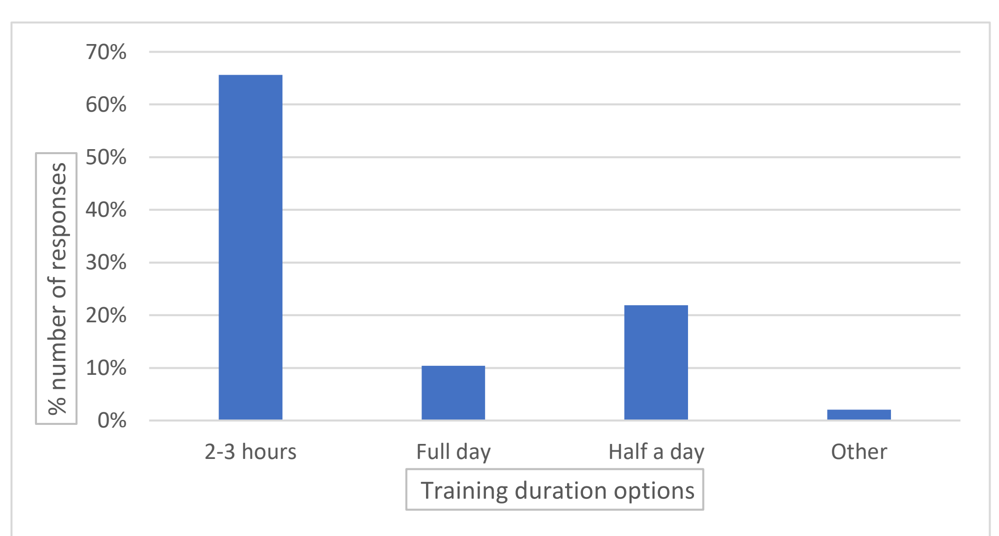
Question 12)

How would you prefer to take part in training?



Question 13)

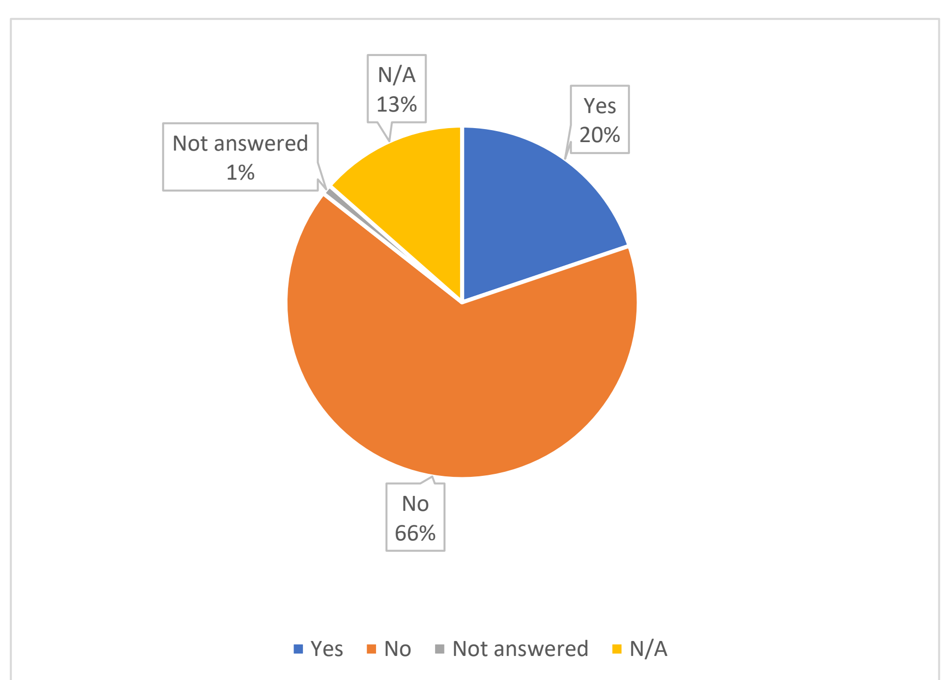
What length of training would you prefer?



Question 14)

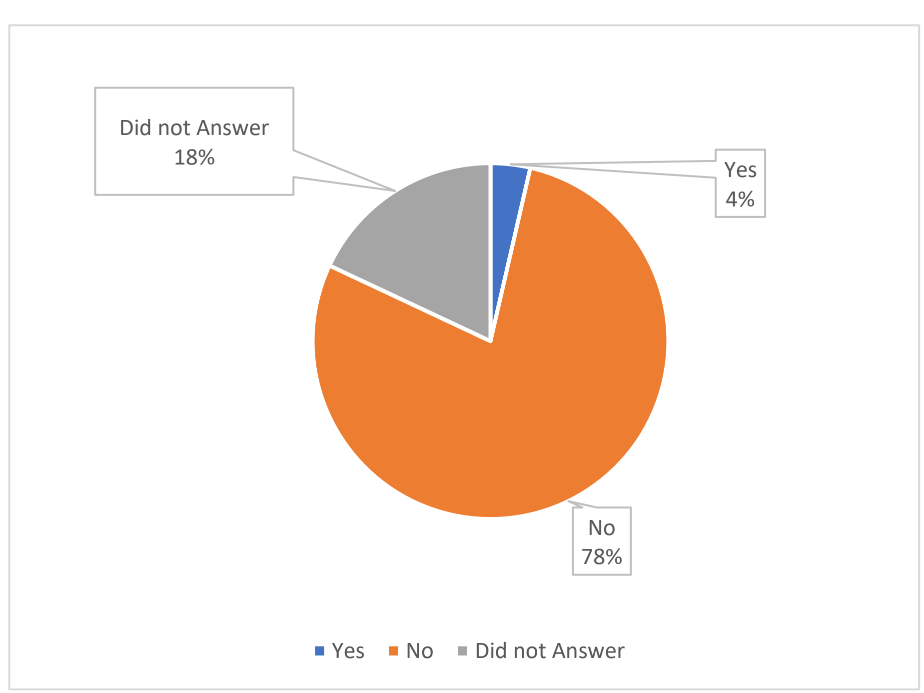
Is there anything that would make it easier for you to access training?

(N/A encompasses those who answered 'No' to Question 10)



Question 15)

Do you expect any barriers to applying the knowledge or skills in your role?



Question 16)

Are there any materials or information on gambling-related harm that would be useful in your day-to-day work?