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Help-seeking and help expectations for gambling problems at different severity levels

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Abstract

Background Treatment and help services for gambling problems range from formalised therapy to lower-threshold options such as helplines, digital health solutions and online self-help resources. Few people with gambling problems access these services. Lack of service reach may partly be explained by expectations and experiences on available services. Yet, little is currently known about what kind of services are expected and accessed by individuals gambling at different severity levels.

Objectives This study analyses help-seeking and help expectations amongst a sample of Swedish gambling helpline customers ($N = 108$).

Methods Data were collected using an online survey. The survey collected data on demographic characteristics, prior use of different support and treatment services for gambling, use of the national self-exclusion registry, and screened participants for gambling problem severity. The analysis compares expected and received services between individuals with gambling disorder and those gambling at lower severity levels.

Results Results show a wide range of expectations regarding help services, including psychological support, support with CSOs, and financial counselling. Expectations were similar across individuals with and without gambling disorder. However, in terms of received services, those with more severe gambling problems tended to receive more online and self-help services than those gambling at lower severity levels. Most help-seekers had self-excluded from gambling but continued gambling regardless.

Conclusions Our results suggest a mismatch between harm severity and types of received help. More effective prevention of gambling harm would reduce the burden on help services and allow better targeting of services to address individual needs of help-seekers.

1 Introduction

Gambling places a burden on public health. The ICD-11 and the DSM-5 both recognise Gambling Disorder (GD) as a mental health disorder that is characterised by persisting gambling behaviours [1, 2]. In population samples, harmful gambling is usually

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measured as prevalence of problem gambling. Problem gambling is estimated to affect 2.2% of men and 1.0% of women globally. 8.7% of adults globally engage in gambling at some risk level [3]. Alongside addictive use, gambling can also lead to other significant economic, mental, physical, and relationship harms and even suicidality [4, 5]. These harms accrue to those who gamble, but also to their families and communities.

The World Health Organisation [6] recently sounded alarm on the severe and global health consequences of gambling, highlighting the importance of effective prevention and treatment. It is therefore important to focus on how services to address gambling harms could be improved.

Currently, help services for gambling-related problems include formalised treatment and therapy but also a range of lower-threshold options such as helplines [7]. Digital health solutions are also becoming common, including online resources, tests, online therapy, and online health applications [8–10]. Yet, existing studies show that few individuals use any help services for gambling, even when these are available [11–13]. The choice not to seek help may depend on a range of personal and institutional barriers, such as shame, stigma, denial of problem severity, wanting to solve the problem alone, as well as lack of awareness of or access to services [14–17].

In addition, it is likely that individuals experiencing different severity levels of problem gambling may access help services differently and have different expectations of services. A systematic review on the prevalence of help-seeking for gambling problems showed that only 0.27% of people with low-risk gambling had ever sought help, compared to 3.73% of people gambling at moderate-risk levels and 20.63% of individuals with problem gambling [13]. However, the review did not differentiate results by help service type. Currently, little is known about what kind of services are accessed by individuals gambling at different severity levels, and what kind of services they expect when they do choose to seek help.

This brief report focuses on help-seeking and help expectations in a sample of Swedish gambling helpline customers ($N = 108$). Helplines are amongst the most frequently available and used help resource for gambling. A recent review found over 80 gambling helplines operating globally [8]. Most helplines offer a range of services, including motivational interviewing, counselling, treatment referrals and online resources [8]. Due to the range of services available, and status as a low threshold service for gambling harms, helpline customers are not a uniform group [18, 19]. Helpline customers are also likely to have diverging needs and expectations in terms of what kind of services they expect or receive.

Sweden is an appropriate context for studying different types of help services for gambling. Sweden is one of the most digitalised societies globally, also in terms of gambling consumption. In 2023, 63% of total Swedish gambling consumption took place in the competitive part of the market, i.e., online casino products and betting [20]. The Swedish online gambling market has grown rapidly since online markets were opened to licensed operators in 2019. At a population level, gambling is also causing important harm in Sweden. In 2021, 1.2% of the population were classified as having a gambling problem [21].

Sweden has a national gambling helpline, Stödlinjen, which was founded in 1999 and provides anonymous support to individuals with gambling problems and to their concerned significant others (CSOs). In 2023, 1200 individuals contacted the helpline for

counselling. 22,500 individuals used the online problem gambling screener, and more than 400,000 visits were recorded on the helpline web page [22]. In addition to the gambling helpline, municipalities and regions provide treatment options, both face-to-face and online. Unlike the anonymous gambling helpline, individuals seeking these treatments must identify themselves. Sweden also has a centralised self-exclusion registry, Spelpaus, that allows individuals to exclude from all licensed forms of gambling. Self-exclusion can be seen as an additional tool to help recovery [23].

In this paper, we ask what kind of services individuals contacting the Swedish gambling helpline have expected, and what kind of services they have received, depending on severity levels of gambling problems.

2 Methods

2.1 Data

We conducted a cross-sectional survey amongst Swedish helpline clients during 2022–2023. The initial dataset contained 227 observations, however, 119 participants left incomplete or empty answers, rendering a final sample of 108 participants who provided complete answers. The survey was available on the Stödlinjen website between December 2022 and October 2023. We included participants who sought support for their own gambling issues (excluding family members and other CSOs) and who visited the gambling helpline website during the data collection period.

Data were collected using an online survey that prompted respondents on demographic characteristics, prior use of different support and treatment services for gambling (including those provided by the helpline), expected services (defined as the kinds of services that help-seekers were looking for when contacting the helpline) and the use of the national self-exclusion registry (Spelpaus). The measures were developed for the purpose of this study. The lists of prior use and expected services reflected those offered by the Swedish national helpline and were created in collaboration with its counselors (see Supplementary Material 1). Self-exclusion was assessed with three items: current or prior use, selected time period (one, three, or six months, or until further notice), and gambling despite self-exclusion.

In addition, participants completed a self-report measure assessing gambling problem severity, i.e. the Gambling Disorder Identification Test (GDIT; available in the public domain; www.gditscale.com). GDIT is a comprehensive measure to assess diagnostic severity, including gambling behaviours, negative consequences/harms, and expenditure. The GDIT also assessed involvement in types of gambling associated with negative consequences, specifying both the gambling types (slots, poker, casino, sports betting, horse betting, bingo, lotteries, instant lotteries, and other types) and access mode (online or venue-based gambling). The GDIT has undergone extensive psychometric evaluations, demonstrating robust psychometric properties [24–27]. The scale has also been validated among Swedish helpline customers [26]. A key advantage of the GDIT over other gambling measures is its alignment with DSM-5 criteria. A total score of ≥ 20 indicates GD severity, while ≤ 19 represents diagnostic subthreshold gambling patterns.

- 0 points: non-gambling;
- < 15 points: recreational or at risk gambling;
- 15–19 points: problem gambling;
- 20–24 points: mild GD;

- 25–29 points: moderate GD;
- ≥ 30 points: severe GD.

All survey questions were answered after individuals had contacted the helpline, meaning they reported both the help they expected and the help they actually received at the same time.

2.2 Statistical methods

Results are presented descriptively and using inference tests. To test associations between help-seeking behaviours and dichotomised GD levels, we conducted logistic regressions with dichotomised GD level as an outcome variable and actual help-seeking behaviour in the helpline as the predictor variable.

For our study, we dichotomised our sample of 108 participants into two groups based on total GDIT scores: those reporting any degree of gambling disorder (GDIT 20+) were categorised as having GD ($N = 89$). Those experiencing lower severity gambling problems were categorised as 'sub-threshold GD' ($N = 19$).

Help-seeking behaviours were also dichotomised. Responses reporting having called, chatted, emailed or had repeated calls with the helpline were collapsed into the binary variable 'utilisation of counselling services' while responses indicating searching the website for information and testing gambling behaviours via a self-test were collapsed into 'utilisation of online services'.

3 Results

Table 1 shows our sample characteristics. Although our study was based on convenience sampling at the Swedish helpline, our data collection captured individuals gambling at varying severity levels. Our sample had significantly more men than women and a high proportion of individuals in employment. Table 2 presents results on how help-seekers in our sample found the gambling helpline. One third of participants had found the helpline using an internet search. Advertising and gambling company websites were also mentioned by approximately 10% of participants each.

Table 3 shows results on services that help-seekers were expecting to receive. Results show a variety of expected services amongst individuals with GD and individuals gambling at lower severity levels. On average, individuals reported 2.0 (SD = 1.5) expected services. In the full sample, the most reported expectations were to receive advice, support or motivation to change one's gambling behaviours (59.3%), and to obtain information about problem gambling or GD (47.2%). 20.4% participants sought advice or referrals on financial matters. 14.8% expected to receive assistance in disclosing their gambling behaviours to a concerned significant other. 29.2% of those with GD reported expecting psychological support. An important part of those gambling at lower severity levels (26.3%) also reported expecting 'other' types of services.

In terms of received services, we found that, overall, those gambling at lower severity levels had sought more prior help (26%) compared to those with GD (16%). However, both groups had similar levels of prior contact with the helpline (63.2% and 68.5%, respectively).

Table 4 shows results on the kinds of services that individuals in our sample had received. We found that online services were the most typical services received in the sample. Most study participants reported testing their gambling behaviours using the

Table 1 Background characteristics and gambling behaviours, *N* = 108

Variable	***N*** **= 108**
Gender, n (%)	
Women	35 (32.4)
Men	71 (65.7)
Not stated	2 (1.9)
Age, M (SD)	38.5 (14.2)
Born in Sweden, n (%)	89 (82.4)
Highest education, n (%)	
High school	61 (56.5)
University	24 (22.2)
Elementary school	11 (10.2)
Other	12 (11.1)
Source of income, n (%)	
Employment	81 (75.0)
Studies	9 (8.3)
Other	18 (16.7)
Net income in SEK (1 SEK ~ 0.09 EUR), median (IQR)	25,000 (12,500)
Gambling debts (yes), n (%)	69 (63.9)
Gambling variables	
GDIT total score, M (SD)	32.4 (13.9)
GDIT category, n (%)	
Non-gambling	1 (0.9)
Recreational or at risk gambling	12 (11.1)
Problem gambling	6 (5.6)
Mild Gambling Disorder	9 (8.3)
Moderate Gambling Disorder	16 (14.8)
Severe Gambling Disorder	64 (59.3)
Type of gambling, n (%)	
Online slots	76 (70.4)
Online betting	50 (46.3)
Online Lotteries	23 (21.3)

Table 2 How the participants found out about the helpline, *N* = 108

Variable, *n* (%)	
Via search engine on the Internet	36 (33.3)
Don't remember	31 (28.7)
Via gambling advertising	12 (11.1)
Link from a gambling company website	10 (9.3)
Link from a gambling company website directly to the Helpline's self-test	8 (7.4)
Was recommended by a friend/colleague/family member or similar	4 (3.7)
Was advised by a healthcare contact/self-help group or similar	3 (2.8)
Social media	2 (1.9)
Other	2 (1.9)

online self-test (48.2%) or seeking information via the website (41.2%). Moreover, we found that those with GD had lower odds of using counselling services compared to those gambling at lower severity levels (OR = 0.3, $p = 0.02$). In contrast, individuals with GD utilised online services to a greater extent than those gambling at lower severity levels. However, these differences were statistically inconclusive (OR = 2.7, $p = 0.14$).

Only 17.6% of our sample reported prior involved in problem gambling support or treatment outside of the helpline context. These services included treatment or internet-based treatment in public healthcare or private service provision (2.8–4.6%), as

Table 3 Expected service

Variable, *n* (%)	Full sample *N* = 108	Sub-threshold GD *N* = 19	GD *N* = 89
Information about gambling problems/disorder	21 (47.2)	7 (36.8)	44 (49.4)
Advice, support or motivation to change my gambling	64 (59.3)	9 (47.4)	55 (61.8)
Support to manage my mental health	28 (25.9)	2 (10.5)	26 (29.2)
Support in telling a loved one about my gambling	16 (14.8)	3 (15.8)	13 (14.6)
Referral or information about other support/treatment for gambling	20 (18.5)	4 (21.0)	16 (18.0)
Advice on financial matters or referral to financial advice	22 (20.4)	4 (21.0)	18 (20.2)
Other	17 (15.7)	5 (26.3)	12 (13.5)

Table 4 Received service at the helpline

Variable, *n* (%)	Total sample *N* = 108	Sub-threshold GD *N* = 19	GD *N* = 89
Spoke on the phone with a counsellor	14 (13.0)	6 (31.6)	8 (9.0)
Chatted with a counsellor	18 (16.7)	5 (26.3)	13 (14.6)
Contact with a counsellor via email	10 (9.3)	3 (15.8)	7 (7.9)
Verbally booked and then received a follow-up call with a counsellor at the appointed time	5 (4.6)	2 (10.5)	3 (3.4)
Searched for information via the website	45 (41.2)	3 (15.8)	42 (47.2)
Tested my gambling behaviours via the self-test	52 (48.2)	7 (36.8)	45 (50.6)
Other	27 (25.0)	7 (36.8)	20 (22.5)

Table 5 Previous help-seeking outside the helpline and self-exclusion status at spelpaus National registry

Variable, *n* (%)	*N* = 108
Treatment through healthcare	4 (3.7)
Internet treatment via healthcare	3 (2.8)
Support via Social Services	6 (5.6)
Support via self-help groups	6 (5.6)
Treatment via private service provision	6 (4.6)
Other	6 (5.6)
Self-exclusion	
Yes, currently	63 (58.3)
No	27 (25.0)
No, but I have used it previously	18 (16.7)

well as treatment and support via social services or through self-help groups (5.6%) (see Table 5).

In addition to helpline services and referrals, most individuals in our sample had used the Spelpaus self-exclusion registry (58.3%, with time-periods ranging from one month to until further notice). However, a significant proportion of these individuals also reported having gambled despite being enrolled in Spelpaus (76.2%).

4 Discussion

This brief research paper has investigated help seeking in terms of expectations and received services in a sample ($N = 108$) of Swedish helpline customers. We also compared help-seeking between those with GD and those gambling at lower severity levels. Our study has yielded several results that are important in further developing and targeting effective services to those who experience gambling-related problems.

First, our results have shown that individuals expect a range of different services when contacting helplines. Expected services range from help with changing gambling behaviours to psychological support, referrals to other treatment, financial counselling, or support in telling CSOs about the situation. This result suggests that individuals contacting gambling help services are knowledgeable about the range of services that are available to them [8]. At the same time, this finding attests to the wide range of service needs that individuals with gambling problems may have. Services should adapt to differing needs and harms attached to gambling problems and address these with appropriate treatment and help options. Our results showed that a significant number of help-seekers were also looking for 'other' types of services that are not currently offered by the helpline. These can include, for example, financial and family counselling.

Second, we found that while expectations regarding services were largely similar across our two groups of respondents, received services differed between the groups. Notably, those with GD had received significantly more online services than those gambling at lower severity levels. Conversely, those gambling at lower severity levels received more telephone counselling—both overall and in terms of recurring telephone contacts—than those with GD. This finding is somewhat surprising. Digital health services and online resources are intended as low-threshold and accessible options particularly for first-time help seekers (e.g [17]). Our result suggests that these online resources continue to be the main source of support also for those with more severe problems.

Online services can be more appropriate for some [10]. Some prior research also suggests that the choice to use online help resources for gambling may be related to perceived ability and desire to change [28]. In line with prior research on barriers to help-seeking, shame or willingness to solve the gambling issue alone may also explain the preference for online self-help resources [29]. However, it would be crucially important to investigate whether those with more severe gambling problems are, in fact, reluctant to make contact and therefore prefer online services, or whether their higher use of online services relates to a mismatch between service needs and services provided. This can have a major impact on how helpline services and other help infrastructure should be set up.

Third, and finally, our results showed that while most individuals in our dataset had signed up for the Swedish self-exclusion registry, over 77% of these individuals had continued gambling despite self-exclusion. Self-exclusions can be an important tool to reduce harmful gambling or GD symptoms, but the effectiveness of self-exclusions can also be reduced by factors such as lack of complete exclusion from all gambling offers [30]. In Sweden, over 120,000 individuals are already signed up to Spelpaus [31]. However, unlicensed offshore offers continue to be available to these individuals despite self-exclusion [32]. Self-exclusions have been identified as one of the most important reasons for Swedish individuals to seek gambling offers in the unlicensed market [32]. Our result therefore suggests that while self-exclusions can help some, they need to be implemented within the framework of a wider range of regulatory tools to reduce and prevent gambling problems within the licensed and the unlicensed markets.

4.1 Implications

Our results have implications on improving treatment services for problematic gambling. Help-seekers to helplines are not a uniform customer group. Instead, help-seekers

have diverging needs and expectations with regard to services. All help-seekers need to be screened for harm severity and expectations to match them with appropriate services. Some help-seekers may prefer online services due to anonymity and accessibility [10, 17]. However, internet-based help services can also be less appropriate for others. Online services include high levels of attrition as well as lack of personal contact with help professionals which may function as barriers to recovery [10].

It is important that appropriate help is matched with expectations and needs. Otherwise, it is possible that even when help is available, it might not reach those who need it the most. Helplines provide a range of different services to help-seekers, ranging from telephone counselling to online self-help resources [8]. These different services need to be referred and targeted according to customer group needs. Furthermore, the gambling field is currently developing at a fast pace. New products and commercial practices, particularly online, risk increasing harms globally [5]. Helplines and other help services need to stay vigilant in adapting services to emerging customer needs and expectations.

4.2 Limitations

Our study has been limited by a relatively small sample size. Our data collection was also based on convenience sampling. Whilst our data collection ran on the Stödlinjen website for almost a year, our sample consists of only a small minority of all individuals visiting the helpline online resources. Difficulties in recruiting more respondents may relate to continued stigma and reluctance to talk about gambling-related problems. It is possible that our sample is skewed towards individuals with more experience of different treatment and help services. Other limitations included the inability to specify the "Other" categories in free text due to a technical issue, and differences in response categories between prior and expected use of helpline services. As our data collection took place online, it is also possible that our data are skewed towards individuals seeking online services. Caution should therefore be used in interpreting our results.

However, helplines also provide unique access to individuals with experience of gambling problems and help services. This type of group would have been difficult to research otherwise. Despite possible skews in the sample, our analysis has produced new insight on the service expectations and needs of different help-seeker groups. Going forward, these promising new results call for additional research to further improve and target help services. In particular, it would be important to look at potential gender and age group differences in help expectations and forms of help received. Similarly, it would be important to consider the role of concerned significant others (CSOs) in future research. CSOs often play a crucial role in initiating help-seeking and are also impacted by gambling-related harm. Including their perspectives could provide valuable insights into their service expectations and needs.

5 Conclusion

This study has investigated help-seeking, expectations, and received services in a sample of Swedish gambling helpline customers. Our results have shown that individuals have a wide range of expectations with regard to help services. These expectations align with the harmful effects of gambling, including psychological support, support with CSOs, and financial counselling. Many of these expectations have also been met with received services. However, our results also show that those with more severe gambling problems

receive more online and self-help services than those gambling at lower severity levels. It is important that all individuals who experience gambling harm receive help and support. However, our results suggest that there may be a mismatch between harm severity and types of help received.

Gambling has negative impacts on an important part of the population. It is important to develop effective and well-targeted help and treatment interventions to support individuals and families dealing with problem gambling and gambling-related harms. At the same time, as also recently highlighted by the WHO [6], it is crucial to develop more effective strategies to prevent these problems and harms. More effective prevention is key to lessening the burden on the treatment system, allowing for better targeting and implementation of treatment based on individual needs.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12982-025-00853-7.

Supplementary Material 1

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Author contributions
V.M. wrote the main manuscript and was involved in conceptualization. H.W. was involved in conceptualization, data curation, data analyses, commented on the initial draft of the manuscript, and wrote the methods section and parts of the results section. O.M. was involved in conceptualization and commented on the initial draft. All authors contributed to the interpretation of the results and were involved in finalizing the manuscript.

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Data availability
The raw data supporting the conclusions of this article will be made available by the authors upon request, provided that the request complies with Swedish and EU laws governing the protection of identifiable data.

Declarations

Competing interests
The authors declare no competing interests.

Consent to participate
All data collection was anonymous and did not require informed consent. Participants were provided information about the study and their rights, but they were not asked to sign a form to give informed consent. The study received ethics approval from the Regional Ethics Board of Stockholm, Sweden (ref. no. 2022-03651-01). However, at the beginning of the survey, before participants proceeded to the measures, they were presented with a landing page. This page included a brief summary of the study and outlined the eligibility criteria for participation. Additionally, the landing page provided a link to detailed study information, covering the study procedure, data storage, and contact details for the responsible researchers. Before participants could begin completing the survey, they had to verify that they had read the study information and accepted the terms of participation. Participants also had the option to decline participation; these individuals were redirected to a page informing them that they had declined participation. This research was carried out in accordance with relevant guidelines and regulations.

Consent to publish
Not applicable.

Clinical trial number
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