HOUSE OF LORDS

Select Committee on the Social and Economic Impact of the Gambling Industry

Corrected oral evidence: Social and Economic Impact of the Gambling Industry

Tuesday 10 March 2020

3.25 pm

Watch the meeting

Members present: Lord Grade of Yarmouth (The Chair); Lord Butler of Brockwell; Lord Filkin; Lord Foster of Bath; Lord Layard; Lord Mancroft; Lord Smith of Hindhead; The Lord Bishop of St Albans; Baroness Thornhill; Lord Trevethin and Oaksey; Lord Watts.

Evidence Session No. 19 Heard in Public Questions 209 - 218

Witnesses

I: Jill Britton, Trustee, GamCare; Anna Hemmings, Chief Executive, GamCare; Matthew Hickey, Chief Executive, Gordon Moody Association; Dr John McAlaney, Trustee, Gordon Moody Association.

USE OF THE TRANSCRIPT

1. This is a corrected transcript of evidence taken in public and webcast on www.parliamentlive.tv.

Examination of witnesses

Jill Britton, Anna Hemmings, Matthew Hickey and Dr John McAlaney.

Q209 **The Chair:** Thank you very much for helping us with our inquiries, as they say, although hopefully in a more positive sense here. I will read a general health warning, which I do for every session. A list of Members' interests relevant to the inquiry has been sent to you and is available. This session is open to the public, is being recorded and is accessible via the parliamentary website. A verbatim transcript will be taken of the evidence and put on the parliamentary website. A few days after this session, you will each be sent a copy of the transcript to check for accuracy. It would be helpful if you could advise us of any corrections as quickly as possible thereafter. After this evidence session, if you wish to clarify or amplify any points made during your evidence or have any additional points to make, you are welcome to submit supplementary evidence to us.

For the record, could you say who you are and who you represent? Thank you.

Anna Hemmings: I am the chief executive of GamCare.

Jill Britton: I am a trustee of GamCare.

Matthew Hickey: I am interim chief executive of the Gordon Moody Association.

Dr John McAlaney: I am a trustee of the Gordon Moody Association.

Q210 **The Chair:** The acoustics in these rooms are very unreliable, so it is best to speak up a bit and not rush your words. It is important to hear everything that you have to say. We do not want to miss anything..

I will kick off with the first question. Do not all feel obliged to answer every question. Only chip in if you feel that you want to contradict or have a different point of view, otherwise we will be here for longer than you would like, and certainly longer than we would.

One of the things that interests us is whether you have undertaken any analysis of the gambling activities undertaken by those who contact your treatment services. In your experience, which gambling activities are most prevalent? In your opinion, which are most likely to lead to gambling-related harms? There is an awful lot in that question. I do not know who would like to go first.

Anna Hemmings: It might be useful to give a little bit of context first. I am sure that you are all aware that GamCare has been established for 23 years and is the largest national provider of support and treatment, as well as education and prevention, around gambling harms. I have been its CEO since January 2018. Prior to that, I have a long history of working in addictions and other areas of health and social care.

To move to your question, we routinely analyse what our data shows us and publish that analysis annually, usually in the autumn. The most

helpful figures that I can give you are from the National Gambling Helpline, which we operate, because these are at the largest volume: we receive over 30,000 calls to the helpline per year.

The Chair: Was that 30,000 calls?

Anna Hemmings: Yes. Of callers, around 55% gamble online and 45% offline. The online group is mainly a combination of sports betting, casinos and slots. With offline gambling, we are mainly talking about people in betting shops, with very small cohorts in casinos and other offline venues.

The Chair: Forgive me: do the offline gambling figures take account of the change in the FOBT regime?

Anna Hemmings: Our most recent full-year dataset is for 2018-19, which was around the time that the change happened. We will have more information when we come to the end of this year.

The Chair: Sorry to interrupt your flow. Would you expect the 55:45 online-offline gap to increase as a result of the FOBT intervention?

Anna Hemmings: It is too early to say. We have seen a significant shift towards online gambling over the past five years anyway. This is probably reflective of all our lives being lived online more and the availability and accessibility of online gambling.

The other thing that I wanted to mention is that we see that not all groups gamble in the same way. For example, women and, as you might expect, young people are more likely to gamble online than in land-based settings. However, black and minority ethnic groups gamble more in land-based settings and do not gamble so much online. There is variation depending on the cohort you look at.

You also asked about harms. We look at three variables: the person, the product and the environment.

The Chair: By product, do you mean the operator's product that they are consuming?

Anna Hemmings: Yes, the product that they are gambling on—for example, casino or sports betting. We know that certain types of product are higher risk: size of stake and speed of play are key factors. Equally, the individual is important as well and everybody's circumstances contribute to how they experience gambling harms. For example, a single, wealthy male might be able to afford greater losses and have it have less impact in his life than a woman with caring responsibilities on a low income.

Personal characteristics are also important to consider, as is the environment. In a land-based setting such as a betting shop, you can see whether somebody is becoming stressed or distressed or spending a long time there, whereas people often gamble online alone and often feel that

they become very isolated, which I think contributes to some of the mental health harms that we see.

The Chair: Could you expand on that? Why do you think that the sense of isolation and being alone with the screen increases somebody's propensity to gamble beyond their means?

Anna Hemmings: I am not necessarily saying that it means that people gamble beyond their means, but it is a very solitary experience. If somebody uses drugs or drinking, you can often see an obvious change in their behaviours—for instance, you can see if somebody is drunk. That often prompts someone to ask whether someone is all right or there are issues with their drinking. Our service users have told us that they thought that their partner was having an affair or had another family because they seemed distracted and preoccupied and never had any money. It is not as easy to spot the signs of somebody gambling. When somebody is doing that on their own with a device at all hours of the day and night, they become very immersed in that world and feel very isolated.

Lord Mancroft: Thank you. I am perplexed by that slightly. In the world of drink and drugs, one of the real problems is that people do not spot it; the last person to know that someone's partner is drinking is their husband or wife, and the last people to know that a child is taking drugs are their parents. That does not seem to be right to me.

On the other side of the coin, some of the greatest fortunes in Britain have been lost on the gambling tables in casinos in public and still are and have been recently. That it is the isolation of one or denial of another does not seem to stack up. That seems to be a subjective judgment.

Matthew Hickey: I will add something. To give you a little bit of context about the Gordon Moody Association, it has been operating for nearly 50 years—we celebrate our 50th year next year. In that time, we have supported those most in crisis. They are beyond breaking point and contemplating suicide: 99% of the people who we support are on the cusp of committing suicide.

In the past year, we have supported 650 people. If you came in and asked them about their gambling addiction, they would all say that it is the hidden addiction. They have got away with nobody knowing about it for a very long time, some of them for 20 years or more. The difference between gambling and drug or alcohol addiction is that you can see a physical change in somebody with the latter. That is why gambling is more hidden and why it is a lot easier for an individual gambling online or doing small stakes but very regularly in betting shops across a conurbation to get away with hiding it from everybody. The residents that we support would very easily tell you that they have hidden it for a long time.

The Chair: I would like to come back to Ms Hemmings. In your experience, which is considerable in this field, are you defining problem

gamblers as people compelled to gamble beyond their means, which therefore causes all kinds of related havoc in their lives, or are there problem gamblers who gamble within their means? Is that a useful distinction?

Anna Hemmings: It could be either. There are lots of harms related to spending beyond your means and accumulating debts, but there are also harms related to time, preoccupation and being away from your family. Money is one of a number of measures.

The Chair: It is not the only measure.

Anna Hemmings: It is not. It is about that combination of the personal circumstances, the product and the environment.

Lord Butler of Brockwell: I have one supplementary question. Is your sample bound to be biased in that self-declared people come to your organisations? For example, children probably do not feature much among the problem gamblers that you see. I wonder whether your samples are not completely representative of the problem.

Anna Hemmings: As I said, our samples are data from the National Gambling Helpline. People phone it when they are concerned about their gambling. In that sense, it is a very particular cohort. It is not representative of all gamblers.

Matthew Hickey: Similarly, all the people coming to us are self-referring because they are in the most crisis.

Q211 **Lord Layard:** I want to ask you about treatment. As you say, only 3% of problem gamblers are getting treatment, which is not at all satisfactory. Could you say something about why that is the case? Moreover, what do we do about it? This is a mental health problem. What is the role of the NHS? Should it not be taking the main burden, or should your organisations? What is the relation and the division of labour between you and the NHS?

Anna Hemmings: To take the first part of your point, you are right about penetration: around 3% of problem gamblers currently come forward for treatment. There are two key points that we need to consider. I touched on one about the isolation that gamblers experience and the stigma that people often feel about having those sorts of issues. It is hard to come forward for treatment, a bit like how it is hard to talk about mental health problems more generally. We have seen lots of promotion around accessing treatment for that.

The other issue is investment. To give you some context, the funding for drug treatment—not alcohol treatment—is around £450 million every year in this country. When I started at GamCare in January 2018, the turnover of the whole charity was around £4 million, which is around 100 times less. I am not saying that we need the same funding as drug treatment; it is a different area of work. However, we have to be realistic about the fact that we need considerably more investment. Treatment

being available and visible in your local community legitimises this as a problem. People often find it very difficult to come forward. We absolutely need investment in treatment services and to address some of the issues that people experience around things such as isolation. I will talk later about some of the things that we are doing to make treatment more accessible and raise awareness.

You asked about whether the NHS should be involved. We work very collaboratively with the NHS, and we are delighted that it is extending its provision in this field and opening a number of new clinics over the next few years. We sit on a strategic planning group about that, and we are looking very closely at who should come to voluntary sector services and who is best treated by the NHS. The NHS works best for those people with the most complex needs. If you look at all areas of health and social care, there is usually a mix: a combination of a thriving voluntary sector and NHS treatment. It is important that we have both in this sector and work together to develop them over the coming years.

Lord Layard: Are you pressing the NHS or the public health system to do more about this? The following is roughly true: 1% of the population are problem gamblers, 1% are drug addicts and 1% are drink addicts. As you said, drugs and drink are a major chunk of activity in the public sector. Who is pushing the Government to take the same attitude to gambling?

Anna Hemmings: The answer is complex, because there are a number of different factors: there is much more political awareness and much more in the media about the issues. The architecture—the likes of GambleAware and the Gambling Commission—is hopefully pushing it forward.[1] We are working very collaboratively on that as well. We want to see significant growth in the treatment available.

Lord Filkin: Can I just pick up on that? It is clearly an issue of importance to us. Has anybody done an analysis of the services needed, for whom and at what cost? We need to be a bit clearer than saying just that we need more. Clearly, 3% looks trivial. Has this been done by you, the NHS or any of the policy units?

Anna Hemmings: The Gambling Commission regularly completes a health survey that gives us the prevalence estimates that we have to work with. My understanding is that there is significantly more needs assessment work under way. That is being led by a number of different organisations. I agree that you are right that we need a better understanding of need and of what works and for whom.

Lord Filkin: Who can give us that with gambling? We clearly want to have an understanding of the scale of the problem, the policy argument for dealing with it, which bits of the problem to deal with, and what that

[1] The witness subsequently explained that this referred to a tripartite agreement between the Gambling Commission, Gamble Aware and the Advisory Board for Safer Gambling.

implies for supply, resource and cost.

Anna Hemmings: If you are looking at something that would be available for this Committee, the research has not yet been done in full. I am sure that you have access to all the research that has been done.

Lord Filkin: Has nobody done a needs assessment of the treatment required for gamblers with problems or problem gamblers?

Anna Hemmings: My understanding is that that research is under way with GambleAware.

Lord Layard: For people with depression or anxiety disorders who were not suicidal 15 years ago, there was no psychological treatment available on the NHS. That situation has now been changed through a major national programme, IAPT. Do you think that something similar ought to be recommended by us, for example, to be developed within the NHS?

Anna Hemmings: As I said, I think that it will be about a combination of voluntary sector and NHS providers. As a treatment provider, we are not a research organisation, which is why I cannot necessarily give you the answers about prevalence.

Lord Layard: The IAPT is delivered through a mixture of providers, including voluntary ones such as yourselves. Would that not be what you would most like to happen? How will you get this money? You will not be able to get a large quantity through a levy. You are going to get it only through the NHS, are you not? Am I wrong?

Matthew Hickey: As someone very new to running a charity in this sector, it is very evident that there are lots of players doing their own bits. What is really needed is a huge amount of collaboration across the voluntary and public sectors to bring it all together. There is a great opportunity to do exactly what you are talking about here: to raise awareness and improve the funding streams coming through. We will get that only through collaboration. Through that, we will each learn the gaps are, as you mentioned before, and drive forward what is required for the future.

Lord Filkin: That seems a little bit hopeless. One would have expected by now that a consortium of charities would have made a very powerful case about the treatment services needed, as they would for mental health, or that the regulator or the department itself would have done it. It sounds as if none of the three bits has done that where they could have. Is that correct?

Anna Hemmings: I will take you back to my point about investment. As a charity offering treatment, our priority has been to grow the treatment services available and raise awareness of those services.

Lord Filkin: I am asking a policy question, not a supply question.

Jill Britton: We have not had funds available to us to do policy work. Funding-wise, we are a very small charity. In my normal job, I am a strategic commissioner. I have worked in policy and commissioning for a long time. I have seen various organisations undertake this type of work to develop what the strategic approach should be, to undertake the strategic needs assessment and to drive and collaborate on a national treatment system. You are right that that work has not been done. I do not think that there has been that opportunity before now.

There are a number of organisations that could take that forward such as Public Health England, NHS England or one of the big commissioning charities in the gambling arena. Any one of them could, but whichever did would need to involve everyone and collaborate on finding out the prevalence and how we reach people. There is not a national dataset that we can go to and say, "This many people have come forward." GamCare has the biggest dataset, but it is only of people coming directly to us. Other harm will be hidden in different sectors, just as it has been and is as they start to grow in this way.

Lord Filkin: Thank you. It would be a good idea, would it not?

The Chair: Yes, it would be. Baroness Thornhill?

Q212 **Baroness Thornhill:** We have sort of touched on my question quite a bit. As somebody who attended the funeral of a lifelong gambler literally yesterday and sat there, looked around and thought that probably only about half a dozen people in that packed crematorium chapel knew of his secret life, I absolutely get the fact that it is hidden. Is that part of the problem? If our recommendations will be around research, funding and all that, and all the evidence seems to say that people seek help in crisis, how do we get upstream and get more proactive intervention? As you said, this is lifelong and can go on for years. We have even had families of people who have lost loved ones, and a question asked was, "At what point could somebody have intervened and made a difference?" That seems to be a really cloudy area. What do we need to break that pattern to get in before and more proactively?

Anna Hemmings: Any loss of life is absolutely tragic. You are absolutely right that it is to be avoided at all costs. We need to be reaching people much earlier. I will talk about a couple of areas: raising awareness and the accessibility of services.

It is important to raise awareness in numerous different ways. There are obviously marketing materials—online materials and physical leaflets and posters—being in the appropriate places for people to see them and understand that help is available and that gambling can become problematic.

Training other professionals is also really important. If you go to your GP and say that you are depressed because you are in debt, do they ask about gambling? Do debt advisers ask about it? Over the past couple of years, we have trained around 20,000 professionals with the view to

trying to encourage them to ask a question. Working in partnership with other organisations is also important. To give you an example, we are working closely with the Samaritans and organisations such as Citizens Advice, where people may also present with gambling issues.

The other thing is about education. Young people receive education about other risky behaviours such as smoking, drinking and sex. However, they have not often received education around gambling. Our youth education programme goes into schools and has trained over 16,000 young people over the past couple of years, as well as youth-facing professionals. This is around raising their awareness and understanding, as well as developing their critical thinking skills, so that they gamble safely in the event that they do so as adults.

The Chair: I have a small point for clarification. Are you allowed to market your services in betting shops or online on the operators' services, or do they not like you putting posters up in the betting shops?

Anna Hemmings: We are allowed to. The National Gambling Helpline number is usually but not necessarily consistently available on operator websites.

The Chair: What determines whether it is available? Is it discretionary on their part? If they say, "No, we are not going to", do you push back?

Anna Hemmings: Yes, we would. I said that because there is a large volume of operators. It is about ensuring that it is represented in the right places so that it is easily accessible for anyone who needs it.

Dr John McAlaney: There are some opportunities available for online gambling that are not available for offline gambling, especially around identification and prevention. The amount of data that an online operator gets can be extensive. From that data, we can potentially predict when someone will become problematic. There is a lot of opportunity with online data to identify and almost prevent rather than intervene. That requires operators to facilitate that process.

Matthew Hickey: We have learned that the people coming to us for our residential supports—those most in crisis—are doing so to break the cycle that they are in. They are stepping out of their normal lives and coming to stay with us for 14 weeks. By the time that they have been through that, they will have rebuilt a lot of the tools that they need to deal with what they are dealing with. We have also developed a short-term, one-week intensive programme, so that people can take that leap of breaking the cycle through a shorter-term programme. It has been piloted over the past year and has worked very well for men and women who have had the opportunity to see if they can sort themselves out over a shorter period.

Baroness Thornhill: Are these people pre-crisis?

Matthew Hickey: No, these people are in crisis.

Anna Hemmings: I will touch on some of the accessibility points, because they are also really important in catching people earlier. Our helpline previously ran from 8 am to midnight and has now gone 24-hour, which is really important because you need to be there in the moment that people choose to seek help. We now get calls throughout the night as well as during the day. We have also moved to making outbound calls on our helpline so that we can give a call back if people want that and interact very quickly with them.

An important thing that we have done is to implement warm transfers with self-exclusion schemes, as well as with Barclays and some gambling operators. If they have somebody on the phone, they can transfer directly to our helpline without having to give out the number and hope that the person calls back. That means that there is no fallout.

You may have read in the papers about an initiative that we have embarked on with NatWest: it has made rooms available in its high street banks for us to see people for treatment, which means that we can be more local and accessible in a very discreet place. We have also launched a form of computerised cognitive behavioural therapy treatment so that people do not even have to leave the house to access treatment—they can do it online on the computer. We do that with calls back from therapists so that there is also some human support.

It is really important that, at the very moment that somebody is able to express a problem—hopefully, a good professional will ask them—they can access the support that they need. We have improved the ways that that can happen.

Q213 **Lord Mancroft:** You have talked about access and some of the other things. Can we talk about the effectiveness of treatment? I know that you do not research because you have said that. How do you know that the treatment that you provide is effective? Mr Hickey, you talked about having one-week and 14-week programmes. Those are pretty different. How do you know that one work and the other does not? Do they both work? Are these treatment programmes effective for all people equally, such as men and women, people of ethnic minorities and different sorts of people? How do you know that that is all working?

Anna Hemmings: GamCare offers treatment directly and via a network of partners around the country. We and our partner network, Gordon Moody and the NHS clinic all use the same measures at the start of treatment, as well as throughout and at the end of it. To the end of February, we had had more than 10,000 people in our treatment system this year, which is up more than 20% on the same period last year. We find that 75% complete that treatment episode successfully. When they finish it, they have significantly reduced gambling and improved quality of life. Our two measures are on the severity of gambling and quality of life. Of people who have used our treatment services, 90% would recommend them to their friends and family.

We measure very carefully. You asked about different cohorts and who does well. It is really important to offer choice to people. The setting, choice of gender of worker and so on are also important in encouraging some of those underrepresented groups, such as women, and black and minority ethnic communities, into treatment.

Lord Mancroft: You talked about the response of people leaving treatment and the percentage affected. It would be pretty depressing if the treatment had not worked on the day that they left. What about three months, six months or a year later? How do you know? That is the measure that we are really looking for, is it not?

Matthew Hickey: I will come in here. We know that we are successful with those people that we support. Of those, 74% of people complete the programme and 91% would recommend it to a friend, which are very comparable results to GamCare. The key thing with us is that we also run a number of sessions for ex-residents: they can come in and support the current residents through peer-to-peer support. We have to keep closing the book on people attending because they all want to come back and tell their story about the difference that being through our programme has made to their lives. At the moment, we are gathering that information anecdotally. We have a raft of people who have dealt with and are coping with their issues.

There are people who slip up. They come back to us and get additional support, which may well be a little bit more support from one of our therapists who has been assigned to them, or, in extreme cases, they may well come back for another 14-week session with us. The key thing is that we have developed that relationship and almost grown an alumni group who are thankful for the difference that we have made to their lives. We really need to build more on that for those stories where we have changed people's lives.

The Chair: Are you of the view that there is no such thing as a cure? If somebody has been through the course and treatment and has begun to get it under control in a way that they did not when they came in, will they always be a problem gambler under the surface and it is a matter of how they control it? Alcoholics Anonymous always says, "You are always an alcoholic; you just do not drink."

Matthew Hickey: From the people that I have spoken to and the evidence that we have, we have given them the tools to cope with what they have to deal with. We have got to the underlying issues of why they gamble. We have understood what in their history has got them to the point where they have started gambling. They may well have come from a gambling family, or there could have been separation in their family or violence in their childhood. There is a whole range of mechanisms and things that have happened in their past that have led them to where they are.

The Chair: Is that empirical? If someone has come from a wonderfully stable background, had a wonderful education, never wanted for anything

and had the perfect life, are they still capable of being a problem gambler?

Matthew Hickey: Yes, they are. However, from the evidence that we have gathered from our work with the University of Lincoln in 2017, the evidence is that there are triggers.

The Chair: Is there always a trigger?

Matthew Hickey: There is always a trigger in there of some description, whether they are coming from an affluent or lower socioeconomic background.

The Chair: Is that a common thread?

Matthew Hickey: From what we have seen, it is.

Baroness Armstrong of Hill Top: I wanted to ask about women. You have told us that women are more likely to gamble online than in other forms. What proportion of the people in treatment are women and what is their access? For a lot of the women who I have worked with, a 14-week residential course is simply not on the cards. Could you tell me about the point at which most women are accessing services, whether we call them treatment, support or whatever? What is the overall balance?

Anna Hemmings: At the moment, the majority of calls to the National Gambling Helpline and the majority of those in treatment are men. We are seeing the number of women getting in touch with us growing. It is really important to talk about this in two ways: women as gamblers and as affected others—women are often affected by someone else's gambling. We have a national programme at the moment reaching out to women, both as gamblers and affected others, and working very closely with women's organisations to raise awareness and encourage access to treatment.

The women who we are seeing through that programme talk about what I would describe as layers of stigma. They already feel that gambling is somehow less legitimate because it is not a substance-based issue, but they also feel like it is a male issue. Those things compound access to treatment and make them feel that it is harder to come forward. Getting their stories out there, raising awareness and the visibility of women throughout treatment and using their lived experience is really important.

Lord Mancroft: What is the objective of treatment? In your case, Mr Hickey, if you have people coming who want to commit suicide, they leave not wanting to. That is an objective, but it is presumably not the same at GamCare. What is the objective? What is the goal that you are trying to reach?

Anna Hemmings: The objective is that people reduce their gambling or stop altogether. That is guided a little bit by what the individual wants, and we will work with them through treatment to achieve their goals. It is usually about stopping gambling and addressing some of the underlying

issues that might be affecting them, as well as resolving some of the practical concerns, such as addressing money and relationship issues, getting back into work if they are not in work, and getting their lifestyle to a point where they feel that they have the tools to continue not gambling and that they are in a better place with their quality of life.

Matthew Hickey: We deliver the same types of tools as well. We talk about the advice that we give to individuals around their health and the legal situations that they may well be in, as well as around their careers, debt and housing. Some of the people who we have seen have been kicked out of their homes and have nowhere to live. They have been sofa surfing and sleeping on the streets. They are at breaking point, in that they have been totally kicked out of life. They come to us. We have a halfway house—but we do not call it that—where those individuals can go on from our residential support into another home where they have security around them so that they do not go back into their old routeways. We can give them the advice following on from the 14 weeks so that they can rebuild their lives, as well as their lives with their families.

The Lord Bishop of St Albans: Before I come on to education, I will ask a short supplementary on this. I think that GamCare has a controlled gambling model, is that right?

Anna Hemmings: No, that is not right.

The Lord Bishop of St Albans: Do you have the abstinence model, the same as the NHS?

Anna Hemmings: To explain this a bit more fully, one of the characteristics of addiction is ambivalence. People will quite often take a long time to come to a point of acceptance that they cannot continue with their particular activity. People will sometimes present saying that they want to reduce their gambling, not stop it. That is not always realistic. We sometimes have to do a lot of work to get somebody to a point where they understand that. For disordered gamblers, it is not realistic to gamble in a reduced way in the future. If you were talking about much earlier intervention and the at-risk cohort, there is maybe more of a possibility of returning them to safer gambling. For the people who we see at the moment with very severe gambling, it is probably not a realistic goal.

Q214 **The Lord Bishop of St Albans:** That leads absolutely on to the education question that I want to ask. GamCare puts a lot of stress on the importance of educating young people about gambling and related harms. However, some of the evidence that we have heard has been fairly sceptical. For example, Professor Jim Orford, who researches in this area, said, "Unfortunately, education is one of the weakest forms of prevention … it meets with limited success … At best, it is naive. Worse, gambling education may well be counterproductive … Education has its place but needs to be planned with care". Could you say a little bit about your views on the role of education and what it can do and do well?

Anna Hemmings: I imagine that a reason for those comments might be that it is very difficult to directly attribute behaviour change to an education intervention over the longer term. We know that young people receive education about drinking, smoking, sexual health, mental health and so on. To my mind, gambling does not at the moment have parity of esteem with other health and social care issues. If we are providing education around those, why would we not around gambling?

Education needs to be done in the right way. For example, we know that education based on fear is not effective. Think back to the HIV/AIDS campaign in the early 1990s: it was based on fear and was not so effective. It is really important that we work with what works in education. We have had the youth education programme that we run externally evaluated to ensure that it is raising young people's awareness, knowledge and understanding of what problem gambling might look like.

The Lord Bishop of St Albans: I think you mentioned 16,000 young people earlier. Are these who you are talking about?

Anna Hemmings: Yes, they are.

The Lord Bishop of St Albans: Do we have any follow-up evidence about how effective that has been with those 16,000, compared with young people who have not received it?

Anna Hemmings: We do not have a comparative with people who have not received it, but we have had it externally evaluated and it is effective at raising awareness in those young people. The other thing that has happened more recently is that gambling is now included in PSHE guidance.[2] We also work with other education charities, such as YGAM, and Fast Forward in Scotland, to co-ordinate what we are doing.

Q215 **Lord Butler of Brockwell:** Can I put to you the criticisms that the previous chief executive made of GamCare? I hope you do not mind. This was a story in the *Sunday Times*. He was very outspoken and said that the organisation was "not fit for purpose". Can you tell us what was behind those criticisms and what your reaction to them has been?

The Chair: I wonder if the trustee should answer.

Jill Britton: We will both answer, but Anna will start.

The Chair: It is entirely up to you.

Anna Hemmings: We refute the allegations in the strongest terms and are concerned about the impact that they may have on our beneficiaries. I have talked a lot about the work that we are delivering, our education, and our accessibility such as broader helpline and treatment offers. It

[2] The witness subsequently clarified that gambling would become a compulsory part of the PSHE curriculum from September 2020.

might also be useful to touch on some of the changes that we have made from a governance perspective.

For example, we introduced a new model of care from April 2018, which is a new way of working with our service users. We have had external reviews of our board governance and an external safeguarding review. We have reviewed all our policies, processes and systems, and we have increased the frequency of our reporting around performance and quality. The quality side covers things such as safeguarding, incidents, compliments, complaints, staff training and so on. We have reviewed our staff training and it is considerably more robust. A wider range of mandatory training is in place for all staff. As I have said, we are working very closely with the NHS. In particular, we are also working with the Care Quality Commission, which inspects hospitals and care homes, to develop an inspection framework for gambling treatment services. That will provide additional external assurance that we are offering safe, effective and well-led services.

Jill Britton: From a trustee's position, we absolutely refute those allegations. He was with us on an interim basis for a short period. To strengthen the governance of the organisation, we have had almost a complete change in our executive since then, not only with Anna but other appointments. We also established a clinical committee, a sub-committee of the board, that ensured that we were gathering the evidence to substantiate what we knew that we were delivering, which was quality, safe care.

The Chair: Would those changes have happened without these criticisms?

Jill Britton: These changes happened from around 2017.

Lord Butler of Brockwell: The Chair is suggesting that the fact that you have thought it necessary and right to make those improvements suggests that you agree that there was a basis for the former chief executive's criticisms.

Jill Britton: I do not agree that there was a basis. We did not necessarily have processes to evidence the work that we were doing, but all the care that we were delivering was safe and responsible and that there was supervision of staff, et cetera. However, we perhaps did not have the right reporting mechanisms to evidence all that to the board and committees. We now have that. We have done a number of deep dives, external reviews of our safeguarding, et cetera, as any organisation would to look at where it can improve on a continuous basis. I have not found the organisation to be unsafe in any way. As I have said, I commission NHS organisations for mental health. That is my job, so I think that I would know what I am looking for. There is also a consultant psychiatrist on the committee and, until very recently, a pharmacist.

Lord Butler of Brockwell: While we are dealing with this, I will put one final criticism to you. Gambling with Lives said that "the service is

unsafe". A particular criticism was that you have a conflict of interest because if people come to you, you recommend the services that you run to them.

Jill Britton: We absolutely refute that. People come through the helpline and we recommend them to a range of services from there, including NHS partners and some of our partners that work elsewhere. That is how the organisation has been structured. We also refer to Gordon Moody and all the gambling organisations that are currently available. We do not pick and choose. We do it across the board.

The Chair: We will have Lord Watts and then Lord Foster.

Lord Watts: I know that criticism is often difficult to take, but it seems to me that you have accepted that you did not review and assess what you were doing. To me, that seems fairly fundamental: you do not know what you are doing if you do not assess and review. You have only just started to do that. It seems to me that some of criticism that that was not in place earlier is probably justified. You say that you have addressed those issues now, but do you accept that there is a failure in the system if you have not done those two things?

Jill Britton: I did not say that we had not done them. I think that we had not done them as robustly as we could. It is a reflection of all organisations that you can make improvements. It was also some considerable time ago. I absolutely think that we are a different organisation now from the one that we were when Simon was around.

Lord Foster of Bath: This will be very quick. You say that there has been enhanced training for staff. One of the concerns that we had expressed to us in a previous session was that some of your counsellors received only two days' worth of training and that that was wholly inadequate. Has that now changed?

Anna Hemmings: There is no specialist training to work in gambling treatment. Over time, that will need to change with specific qualifications. We provide staff with the training that they need to deliver our model of care depending on their role, and we require them to have qualifications in related fields. On our helpline, the level of qualification that we ask for is in excess of other helplines such as NHS 111 and so on. We provide supplementary in-house training around our model of care, and we have numerous mandatory trainings for staff around things such as safeguarding, data protection and so on. Importantly, we have a very strong system of supervision and appraisal in place. Staff receive regular supervision. Their work is reviewed in the sense that we record all helpline calls and look at the quality of them all the time. We are also looking for our staff to continuously improve the range of competencies that they demonstrate in their roles.

Q216 **Lord Smith of Hindhead:** I should mention for the record that I know Anna Hemmings. My question relates more to funding than anything else. We accept that gambling care is a very difficult and complex area, but we

also all understand that a great deal of the funding that you both receive comes directly or indirectly from the gambling industry via GambleAware and that it may come directly from the industry in the future because there has been a change in the regulations around how money can be given to you. Do you have any concerns about taking funds from the gambling industry to help those with gambling issues?

Before you answer that, having looked at some accounts, I will ask the GamCare team a question. At the moment, you get about 78% to 80% of your funding from GambleAware each year. If you get more money from other parts of the industry, will that contribution from GambleAware decrease?

Anna Hemmings: There are a few questions in there. In a general sense, we take a pragmatic view of funding coming via the industry. There has not been statutory funding available for gambling treatment, so the only way that we have been able to do the work that we have been doing is with funds that have come directly—or usually indirectly, through GambleAware—from gambling operators. The majority of our funding comes from GambleAware and we have a good relationship with it. Especially for people receiving treatment, it is good for there to be a sort of buffer, if you like, of the funding coming via a third-party organisation. It is also important that an organisation—GambleAware in this case—has the overview of the full numbers in treatment across all our different organisations. Can you repeat the second part of the question?

Lord Smith of Hindhead: I will put the question in a different way. At the moment, you get 78% to 80% of your funding from GambleAware. A new regulation will be introduced that will enable you to get funding from other sources that may not have been quite so open in the past but now will be. If you get additional funding from those new sources, will GambleAware continue to provide you with the significant funds to do the work that it already provides?

Anna Hemmings: I would certainly like to think so. We are in a grant agreement with GambleAware and we are entering the final year of that from April. We are talking to it about what the future looks like.

Lord Smith of Hindhead: When does the grant agreement that you have at the moment come to an end?

Anna Hemmings: It ends in March 2021.

Lord Smith of Hindhead: Is there any restriction in that agreement that restricts the amount of money that you might get from any other source?

Anna Hemmings: There is in the sense that GambleAware reserves the right to reduce its grant to us pound for pound if we use alternative funds to fund treatment.

Lord Smith of Hindhead: So GambleAware gives you 80% of your money, but it will reduce its amount if you get money from elsewhere.

Does that not rather restrict the amount of money that you can raise and how many people you can care for?

Anna Hemmings: That clause stems from a different time in this field. It is really quite dated now.

The Chair: Has that clause ever been exercised?

Anna Hemmings: No, it has not been.

Lord Smith of Hindhead: It would not have been, because they would not have been able to get their money from elsewhere until now.

Anna Hemmings: Equally, I think that GambleAware recognises the current situation. We have had very productive discussions with it about how that would be managed going forward if it were to happen.

Lord Smith of Hindhead: Is that clause in the grant arrangements currently in place that come to an end in X amount of time?

Anna Hemmings: It is. However, as I say, it has never been exercised.

Lord Smith of Hindhead: I am trying not to be difficult about this, because it strikes me from what you have said that you provide a huge amount of help: you are the country's leading provider of help to people with gambling and gambling-related issues. However, somehow, under your financial structure, GambleAware put you in a position in which there is a limit to the amount of funding that you can receive, which will limit or restrict the amount of care and help that you can give. I would like to see you get a lot more money so you could help a lot more people. That is simple arithmetic to me.

Jill Britton: In our recent conversation with GambleAware, we have all recognised that the situation has largely changed and that there is money available from different sources through the Gambling Commission's preferred provider list, et cetera. At this point, we have agreed to look at that clause again, because none of us think that it is helpful anymore. We all want to get more money coming into this sector to help the people who really need it.

Lord Smith of Hindhead: That is the funding issue, which the first questions were about. You spoke about funding and said that you could provide the help up to the amount of money that you have. It just strikes me that some of the arrangements that may have been and may still be in place have slightly restricted the amount of funding that you have had and therefore the amount of help that you can give.

Anna Hemmings: I understand your point, but that has not been our experience to date, in the sense that our services have grown and we have worked very productively with GambleAware. We have an indication that what you say will not be the case going forward.

Lord Smith of Hindhead: Do you have a similar relationship with

GambleAware?

Matthew Hickey: Yes, we have a similar arrangement.

Lord Smith of Hindhead: Is it the same thing? If it gives you some money and you get the money from elsewhere, does it reduce the amount pound for pound?

Matthew Hickey: It is not quite that. My understanding is that it is funding us to deliver certain services in certain locations and we are not allowed to go out and ask for additional funds to support those services. GambleAware basically fund us 100% of what it costs us to deliver those services.

Lord Smith of Hindhead: Are you allowed to go out or not?

Matthew Hickey: We are not allowed to ask for additional funds to deliver the services that it funds, but we are allowed to go out and secure additional funding to deliver other services if we so wish. We are allowed to fundraise in other areas. For example, it funds us to deliver our services in Beckenham and Dudley. If we wished to open a service in the east Midlands, we could fundraise for it quite easily.

Lord Smith of Hindhead: But you cannot fundraise for things that it already does to extend the services that you offer?

Matthew Hickey: If we asked it to fund us more to deliver more in Beckenham and Dudley, there would be a very open and positive conversation and it would be willing to deliver more funds.

Lord Smith of Hindhead: Hypothetically, it would be, but you have not asked it.

Matthew Hickey: That is correct.

Lord Smith of Hindhead: We do not know that.

Matthew Hickey: From the informal conversations that we have had with it, there is not an issue there. The key thing to say is that we have a positive relationship with GambleAware about funding opportunities.

Lord Smith of Hindhead: I am sure that you do, but it sounds a bit strange to me that, as organisations providing care, you are somehow curtailed from your fundraising because of your relationship with your biggest fund contributor. It seems most odd and, I would suggest, not particularly healthy.

The Chair: We understand that, given that you are—in the nicest possible way—supplicants to GambleAware, your main source of funding, this is not the forum in which you would particularly prefer to be critical.

Lord Smith of Hindhead: We are not asking you to be. However, as a Select Committee, we need to have the information so that we can come up with recommendations. Thank you very much indeed for answering.

Q217 **Lord Foster of Bath:** I think that you have already made it very clear that the help for people with gambling problems is nowhere near as great as that for people with alcohol and drug problems. You have told us that you do not quite know what the level of need is, but that various assessments are going on, and that it has not been helped by the inadequacy of the data. That was a starting point. Lord Smith is now saying that you should have more money and you said that more needs to come into the sector. Where do you think that that money should come from? Should it predominantly be from the gambling companies themselves? If so, how should it come? Should it continue to be in the form of the voluntary levy or should we move to a compulsory one? If it is compulsory, ought it to be a smart levy based on the level of problems that particular products create?

Anna Hemmings: To pick up on the investment issue, it can sometimes feel contradictory to suggest that there is a need for investment when the full scale of need is not understood in a detailed way. We need to progress and take things forwards anyway. We know things from other disciplines: for example, 17% or 18% of dependent drinkers access treatment, and the figure is much higher for drug users. There are some comparators there that we could use as a reasonable barometer.

Where funding comes from is very much a matter for the Government and the regulator to decide. For us, it is about investing in treatment and delivering the services that we need to deliver, as well as on the other side in education and prevention activities. How that increased funding is delivered is a matter for others.

The Chair: Would you like to comment on that question?

Dr John McAlaney: Speaking as an academic, I think that there are some barriers. In addiction research, having accepted funding from an operator or the alcohol industry can have an impact on your career. There are probably a lot of academics who would be very happy to receive funding from industry but might not want to do so. That may be a factor in why there is less research in this area than others.

Lord Filkin: You have indicated that 3% of problem gamblers get treatment and about 17% or 18% of people with alcohol problems do. You are helpfully suggesting that a fivefold increase would bring parity between gambling and alcohol problems. Am I putting words in your mouth, or is that a fair benchmark that we should be thinking about?

Anna Hemmings: It probably is a fair benchmark, but I would add that there are some unknowns. For example, we do not know for sure how many gamblers would want treatment were it available.

Lord Filkin: I will ask that question differently. Is the figure 3% because they are the only ones expressing demand or because there is only that much supply? I was not clear.

Anna Hemmings: We need considerably more work to raise awareness because it very difficult for people to identify the issue. We need much

more supply and investment in treatment. It needs to be available locally to wherever people live. Alongside that, we also need more awareness of the issue.

Matthew Hickey: I concur with that wholeheartedly. The awareness of our organisation, gambling addictions and the opportunity to support those dealing with gambling addictions is low. Therefore, the supply is low. With an increase of awareness and supply, we should be able to tackle more.

Lord Filkin: You are implying that the demand is low.

Anna Hemmings: I would not say that demand is low. To give you an example, we had received 35,000 calls to our helpline from April to the end of February. In the previous year, over the same period that number was 27,000. We have more than 10,000 people in the treatment system, compared with around 8,000 over the same period in the previous year. Numbers are growing, and quite quickly. We would say that that is a good thing, because people are so underrepresented in treatment at the moment.

The Chair: Before I come to Baroness Armstrong, do you think that that is a function of better "marketing" by your organisation or is the demand just growing?

Jill Britton: It is a combination. There is better marketing, but we have also had additional funding this year to bring on slightly different bits of treatment, such as our work with the Leeds clinic, et cetera. Every time that we have expanded, there has not been any problem with filling those gaps. It is a bit like the old adage: if you build it, they will come. At the moment, the availability of treatment is low compared with what we think the problem is.

The Chair: Would you agree with that?

Matthew Hickey: Yes. We have a waiting list of people wanting to come into our services. They are phoning up daily, wanting to come in today, and we do not have the space to put them in.

The Chair: We will have Baroness Armstrong and then Lord Layard briefly before we come to Lord Watts.

Baroness Armstrong of Hill Top: Gordon Moody provides treatment at the far end. How many of the people that you get have already been through other, non-residential forms of treatment? There is a big debate—I should not say argument—in the other addiction treatment services about the role of residential treatment. It is sort of seen as being at the far end when people have been through other forms of treatment.

Matthew Hickey: It is the far end. The residents that we have will have been through some CBT through their doctor. They may well have phoned the GamCare helpline and had support in other areas. Because they have not broken the cycle of their addiction through coming into a

residential opportunity, they have not been able to overcome what they are dealing with. To get to us, they have tried things and failed, and they have needed to break that cycle of addiction by coming into residential care.

Baroness Armstrong of Hill Top: Are you the only people providing that sort of residential? For example, would the NHS clinics not be providing that?

Matthew Hickey: We are the only specialist residential gambling addiction charity.

The Chair: Lord Layard? You are fine. Lord Watts?

Q218 **Lord Watts:** Gordon Moody's written evidence seems to suggest that research just leads to more research. Do you think that research should be carried out closer to the gambling activity itself? If you agree, can you explain how research closer to the gambling industry could be carried out, and do you have any concerns about gambling operators being able to influence that research?

Dr John McAlaney: Speaking from my day job, I agree. There is often a gulf between academic research and real-world impact. This is a bigger issue and not specific to gambling. There are some unique aspects of gambling. I mentioned previously that there can be hesitation by researchers to engage with operators because of concern around conflict of interest or perceived bias. With online gambling there are opportunities for researchers to get data directly from gambling operators—that can be anonymised—as a way for us to see real-life, quick and objective data. We can also use that to advise operators on how to deliver intervention and prevention in intelligent and interactive ways.

Land-based gambling is trickier. Because of the stigma and social shame, it can be hard for a researcher to engage with someone in a gambling shop, for example. If you are standing there as a researcher, holding your clipboard, it is quite off-putting. There can be opportunities that have not really been taken advantage of yet. If the research will be working with operators, which I think that it has to be, there are ways to avoid some of those potential issues: you need to have a very transparent and clear agreement about what exactly the research is doing, how exactly you are independent as an academic and, for example, how you have a right to publish your results without it being vetoed by the operator. There is a lot of possibility. However, because of some concerns, this is not being exploited as well as it could be.

Lord Watts: Would that problem be resolved if, for example, the levy went to a body that then commissioned the research? We have heard this before. It seems quite difficult for academics to be involved in anything controversial. They seem to avoid it in any way possible.

Dr John McAlaney: As an academic, if you accept funding from certain operators, you will not be invited to certain conferences and will be excluded from certain things. If it was a levy, it would come back to the

point around buffering: if there was a bit of a gap between where the money came from and the academic research, that would encourage more research.

Lord Watts: Would that bit then get over the problem of working closer to the gambling establishments where people are gambling anyway?

Dr John McAlaney: Yes, I think so.

Lord Watts: Would it be seen as different than at present?

Dr John McAlaney: I think that it would be seen to be more objective and less biased, which would encourage more research.

The Chair: There is one word that I would like to understand a bit better, which has recurred throughout our evidence sessions: it is stigma. Is the stigma that the gambler feels ashamed that they cannot control something that they know is destructive, or is it a social stigma? I do not quite understand. I accept that there is some kind of stigma, but I wish that we could define it a bit more from your experience of what it is.

Anna Hemmings: There is stigma involved in lots of health and social care issues. We have seen the big campaign about the importance of talking about mental health issues and how people find that very difficult. I suppose that this is a little similar. As I said, we find that people experience stigma in a range of different ways. Some people find it very difficult because gambling is not a substance-based addiction, while others find it difficult because they have caring responsibilities and are frightened that their children might be taken away from them. This is usually very unlikely, but people have fears about it. As I said, women feel embarrassed because they think that gambling is a male problem. We have to get over these hurdles and to the point where people can talk more openly and ask what gambling looks like in our families, homes, workplaces and communities more generally. That is the argument that has been made about mental health that we need to be talking about it more. Equally, we need to be talking about gambling behaviours more.

Matthew Hickey: I totally agree.

The Chair: You do not need to answer this now. Subsequent to this session, which is now coming to a close, it would be very helpful to get any thoughts from you about how the Gambling Act 2005 or the explosion and availability of online gambling—or both—have led to an increase in harm and demand for the sorts of services that you supply. If you cannot quantify it and it is just anecdotal, do not worry. It would be particularly good from you because you have a much longer history—files going back 50 years, as it were.

On behalf of the Committee, I thank you all for your candour and the help that you have given us in reaching some conclusions about what is clearly a problem. We have to find ways to improve how we deal with these things as a nation. We hope that this Committee will make that contribution. Your contribution is invaluable in that process.

Matthew Hickey: If any of you would like to come out and meet any of our service users at any of our sites, you would be more than welcome to come to talk to them.

The Chair: Thank you. I think that it is unlikely, as we are nearly at the end of evidence sessions.