Gambling with Lives Evidence to the House of Lords Select Committee on the Social and Economic Impact of the Gambling Industry

Gambling Disorder Treatment

This evidence describes expert by experience concerns regarding the treatment system for gambling disorder. The Gambling with Lives (GwL) families, bereaved by gambling related suicide, believe that lost family members who were suffering from gambling disorder would be alive today if they had been provided with appropriate referral and adequate treatment. GwL Trustees include people with Director level experience in NHS commissioning, Consultant NHS clinical (mental health) experience, and senior Civil Service research experience.

Following the deaths the GwL families have been through a process of attempting to learn about the current system and provision. Our standpoint has been to request information from the current commissioners and providers - Gamble Aware, GamCare and the NHS. We aim to collect evidence and to engage in constructive debate in order to improve services and save lives. To date our experience has been one of a systematic refusal to provide answers and documents from GambleAware and GamCare. In contrast the NHS have been collaborative, prompt and informative. However, it is also clear that the NHS and CQC have not had the remit or the political backing to take a systemic overview or to raise concerns about safety.

During the past two years we have raised concerns multiple times with Ministers, the APPGs on Gambling Related Harm and Suicide Prevention, NHS England, the CQC, the Gambling Commission, GambleAware and GamCare. We have become increasingly frustrated with the systematic refusal to listen to bereaved families and the organisational inertia that continues to fail to prevent deaths.

It has also become clear that Gamble Aware and GamCare continue to promote their organisations as “expert” commissioners and providers despite the safety concerns we and others have raised which we believe is inappropriate, undemocratic and clinically unethical.

This paper describes our broad conclusions and recommendations and follows the attempts to find answers. Although this paper details our concerns about the current system, of course as retired senior NHS professionals, we have ideas about solutions to contribute to the debate – but we leave those for a future paper.

Conclusion and recommendations

- At GwL we have come to the conclusion that the current system of treatment of gambling disorder in the UK has been and is still totally inadequate in commissioning, specification and provision and in our view this continues to result in avoidable deaths.
- GwLbelieves that only the NHS can provide the systematic pathway analysis, commissioning and clinical accountability for national treatment for such a prevalent and life-threatening condition. We believe that there is an urgent need for NHS England to set up a pathway working group to provide clear instruction to primary and secondary care about referral pathways and the nature of provision for disorder severity tiers. GwL will be writing to NHS England and DHSC to request that this is done.
- GwL believes that it is inappropriate and unethical for small charities funded by the industry that creates the life-threatening illness that they attempt to treat, to promote themselves as more expert than the NHS in pathway design, service commissioning and provision. We believe that if the NHS had the remit to develop a comprehensive system integrated with the existing robust structures, the true level of harm and need for services

would be revealed. It is difficult to avoid the conclusion that there may be vested interests at work in suppressing this information.

GwL believes that the services currently provided by GamCare and its sub-contractors, commissioned by GambleAware, do not meet the needs of people experiencing gambling disorder, and may be contraindicated given that most, possibly all patients currently referring are more than double the threshold for psychiatric diagnosis and treatment. In summary this is because:

- we have not been provided with evidence of assurance procedures, robust governance or adequate clinical quality control systems,
- we have not been provided with evidence that the GamCare Helpline (currently the main referral pathway mechanism) has triage criteria or staff with the competencies and clinical support required to fulfil the specification to screen and triage to appropriate treatment,
- specifications do not offer evidence of a model of gambling disorder that is compatible with the evidence based NHS model and that includes the nature of addiction to gambling, the role of the environment in the creation of the disorder, the need for abstinence or the risk of suicide
- there is evidence that the development of a coherent pathway design could be disrupted by lack of collaboration and that GamCare (currently the most highly funded provider in the system) may be acting as a rival provider to the NHS.
- the reliance on discretionary funding from the gambling industry appears to create an inappropriate dependence on the industry, constraining the charities for fear of losing funding, leading to the failure to be explicit about the full extent of harms, causes of harms and risk to life

1. The NHS

NHS commissioning and provision has been restricted to providing accommodation for one clinic in London until this year. Although specialist clinics are now being commissioned with funding from the NHS Long Term Plan (albeit minimally), this still does not include any systemic pathway plan that covers primary care including a complete failure to include systematic GP training. GP failure to diagnose gambling disorder has directly resulted in deaths and will feature in the inquest for Jack Ritchie for which Article 2 of the Human Rights Act is engaged.

A comprehensive NHS plan from primary to specialist care was indicated by the BMA scientific committee in 2007 (Ref 1). As far as we can see there has been a complete failure to implement these recommendations and this failure has cost many lives – probably thousands – including lives of family members of the GwL families.

The DCMS Consultation on proposals for changes to Gaming Machines and Social Responsibility Measures (October 2017) (Ref 2) presented information about apparently comprehensive provision in primary care (including a GP diagnostic tool), specialised mental health services and local authority addiction services as well as the IAPT programme. As far as we can see this information is not based on evidence of commissioning or service specification by DHSC. This information also seems to be based on a lack of recognition of the specialist requirements of services required to deliver treatment to life-threatening serious psychiatric conditions.

2. Gamble Aware and GamCare

Currently the main commissioning and provision is from the third sector – Gamble Aware and GamCare and in the view of GwL these organisations are not fit for purpose on multiple grounds. These include the following:

2.1 Lack of democratic accountability to the State.

The usual commissioning and governance systems that normally provide assurance on NHS treatment for life threatening conditions are not in place and there is no overview and scrutiny of the current gambling treatment system equivalent to the health service which is accountable to the Secretary of State for Health and Social Care. We have not received evidence that the following mechanisms of scrutiny are in place:

- Open Board meetings and published papers.
- Non-executive directors and governing bodies including lay members.
- Robust service user groups and voice.
- Public sector procurement processes and monitoring and scrutiny from commissioners.
- A Patient Advisory and Liaison Service to consult.
- Local Authority and elected members, through defined processes.
- Oversight by and accountability to the Care Quality Commission, NHS Improvement, NHSE, DHSC and ultimately Parliament.
- Ombudsman capable of overseeing treatment complaints
- An embedded culture of learning from mistakes in the interests of service improvement

So families who have lost family members have found that it is not clear who is accountable for treatment failures. GamCare is funded by GambleAware, which states it is a quasi-public sector body, following best practice in health and social care commissioning. GamCare states that it is the largest provider of support and treatment for those affected by gambling harms. However, it seems that GamCare is also a secondary commissioner. GambleAware passes money to GamCare, who then commission a variety of 'partners' to deliver treatment (it is not demonstrated what value is added by having GambleAware commission GamCare to commission others, what administrative costs this creates, and how accountability works between these two commissioners). That GamCare is not transparent regarding these commissioner and provider relationships and does not publish disaggregated statistics for different providers in its network, gives further concern regarding accountability arrangements. The provider network is extremely opaque with no clarity as to variation between providers in outcomes, quality and access.

In line with the requirements for transparency of public sector bodies Gamble Aware and GamCare should provide documents and data when requested. Instead, engagement with GwL has been characterised by generalised statements of intent, failure to provide evidence and increasingly aggressive defence of the status quo. Despite repeated requests, both organisations have declined to provide any evidence of any of the above mechanisms. We have not seen evidence of quality assurance, continuous improvement processes or involvement of people with lived experience, and there is no external validation of the generalised statements of reassurance provided. It would be helpful if these charities could provide evidence of being learning organisations by providing information on frequency of situations which have resulted in a change to algorithms and processes.

In the experience of families bereaved by suicide, it would appear no one is accountable or considers themselves responsible. Small charities with unreliable funding cannot be expected to provide the appropriate clinical governance and legal assurance necessary for national commissioning and provision on this scale and severity. GwL believes that the continued promotion of these organisations as appropriate and adequate for this task is unethical. It is a fact that you cannot run a national treatment system safety and effectively on c£10 million per annum, and making claims of competence, equivalence, quality and outcomes is at best naïve and dangerous. This is misleading the public and putting lives at risk.

2.2 Gambling Industry influence

Currently all gambling treatment third sector providers are reliant on gambling operator money. GamCare receives industry money from GambleAware and also directly from operators. This kind of discretionary funding leaves the treatment system subject to a lack of stability and creates a dependence and accountability only to the gambling industry.

There seems to be a reluctance to be transparent about the number of GamCare Board members who have links to or who have come from the gambling industry. This is not to disparage the individuals, but simply to note the lack of transparency and acknowledgement of potential conflicts of interest and it is hard not to feel vested interests are being defended at the expense of the people these charities are meant to serve. Currently GamCare has two Board members with a background in addictions, and the other five come from commercial backgrounds. Of course, commercial experience on a Board can be useful to charities particularly those dependent on raising money from industry. However, backgrounds in big business, finance, pharmaceuticals, oil and gas, leisure, alcohol and gambling are likely to influence worldview and consequently decision-making. Importantly, those that defend GamCare's existence are not suitably qualified to do so, from legal practices to individual consultants making profit themselves from gambling operators.

To be specific about GamCare Board links to the gambling industry:

- John Hagan has been GamCare Deputy Chairman, for 14 years, since 2006. He is a founding partner of the law firm Harris Hagan, whose is business is gambling law, compliance and regulation – for an industry notorious for lack of compliance. The firm's website provides quotes praising the firm for its 'understanding' of the Gambling Commission and what operators want. The website states: '*We view ourselves as a business within the gambling industry, which happens to be a law firm, rather than external advisors to the gambling industry. Our future success and sustainability is inextricably intertwined with that of the gambling industry*' (Ref 3)
- GamCare chairman Sir Ian Prosser was Chairman and CEO of Bass plc (Ref 4), brewery, hotel and pub business, which owned Coral the bookmakers.
- Dominic Harrison worked for Bass plc '*before joining Ladbrokes in 2002 as Commercial Director. He spent nearly a decade in the gambling sector becoming CEO of Gala Coral in 2008*'. (Ref 4) He worked with Neil Goulden, who was executive chair of Gala Coral, and chair of the Association of British Bookmakers while being chair of GambleAware – at the time the organisation attracted criticism for providing research it claimed did not support a reduction in FOBT stakes.

2.3 The Responsible Gambling Model

In the experience of GwL families GamCare and GambleAware have systematically refused to engage with expert by experience views on the reduction of stigma and the role of the "responsible gambling" model in increasing the risk of suicide. The model of gambling disorder promoted by both charities does not include the role of environment (including product characteristics and availability or industry practices) in initiating and progressing addiction and in triggering relapse. A cursory look at the GamCare website, including messages to those seeking help, information on treatment and training, self-help materials and Safer Gambling Standards for industry, are all within the framework of 'responsible gambling'.

Addiction is framed as an individual problem related only to personal psychology and relapse is seen as triggered by personal failures of impulse control. GwL families view this "individual responsibility" model as implicated in the deaths of their family members who in their suicide notes took sole responsibility for their addiction although they were addicted as children to products and in environments that they and their families were told were "safe".

GamCare continues to state publicly that for the organisation to comment on addictive products and predatory practices would be "campaigning". It is a strange position for a charity to take – to state that it has no comment on that which causes harm to its beneficiaries – no judgement about gambling industry practice and products which cause harm to those the organisation purports to treat and support. We believe that it is disingenuous to characterise this position (which in the past has included a formal Board position of neutrality on FOBTs) as "supportive" to addicts and as an attempt to minimise stigma and encourage people to seek treatment. Our view is that it is an attempt at sleight of hand to place this within the received therapeutic "non-judgemental" standpoint and to refuse to listen to the loud voices of bereaved families and recovering addicts which say that the opposite is the case. We all have attempted to tell these charities that a shared allocation of responsibility with industry and state and understanding of the role of addictive products and predatory practices would go much further to remove stigma and decrease the self-blame that characterises addictive suicidal ideation. Self-evidently gambling companies are accountable only to shareholders and have an ultimate commercial imperative. It is difficult to avoid the conclusion that the inappropriate structure of funding limits the ethos and actions of both charities and makes them unable to speak publicly about the role of addictive products and predatory marketing practices in the creation of the next generation of addicts and the increase in severity of addiction in the already addicted.

We note that the large gambling corporation GVC has funded GamCare and YGam to provide youth education. This education is also in the responsible gambling framework, unchallenging to industry and its extensive investment in normalising gambling, capturing and grooming a younger generation.

2.4 <u>Conflicts of Interest</u>

- GamCare accredits gambling companies with its Safer Gambling Standard. Gambling companies use a GamCare kitemark as endorsement of their 'safe' practice, for the very people who go on to be harmed, and then come to GamCare for treatment. It is hard to see how this does not constitute a conflict of interest. It appears GamCare has signed off operators in the past who have received substantial regulatory settlements, while some on the list of those currently accredited are likely to be met with dismay by Experts by Experience. (Ref 5)
- Gamble Aware's outline specification of gambling treatment services (Ref 6) clearly attempts to outline a National Treatment model containing all levels of treatment that mirror the stepped care model for mental health treatment tiers 2 – 4 while there is no evidence that the organisations have made adequate links into existing NHS systems.
- GwL believes that there is evidence of a clear conflict of interest in allowing GamCare to be commissioned to provide the National Helpline which is the main referral point into the system which now includes the NHS specialist clinics in London, Leeds and Manchester and others proposed as part of the DHSC long term plan. In the absence of a systemic NHS owned pathway and by serving as the primary point of triage and access to gambling treatment services, GamCare determines the triage system, the number of referrals into the partners the organisation commissions and the number of people who are able to access NHS treatment. The service proposal for the Leeds NHS clinic specifies the severity score which indicates psychiatric diagnosis and requires NHS referral. The severity score of service users currently accessing GamCare commissioned services is more than double this threshold. However, the NHS have recently confirmed in a letter to GwL (March 2020) that there have been no referrals into the Leeds clinic from the helpline.
- The apparent failure of GamCare to implement the GambleAware service specification for helpline provision and triage seems to provide further evidence of a conflict of interest surrounding the helpline. Although the Gamble Aware specification references a triage

and referral system it seems that the helpline advisors are not qualified or registered which would indicate competence to undertake the clinical steps necessary to screen including assess risk and refer on with appropriate clinical information. There seems to be confusion between the operation of a general helpline (which can be accredited by the Helplines Partnership) (Ref 7) and specialist mental health or clinical triage with crisis operating standards. The NHS runs a health helpline – NHS 111. This is not comparable with the GamCare helpline. NHS 111 has algorithms, follows NICE guidelines and has a pool of clinical advisors and senior clinical advisors. NHS111 is intertwined with the NHS pathway, so clinical decision making is prompt, efficient and responsive to risk, including risk of immediate harm. In conversations with GamCare there also seems to be a worrying confusion between management and clinical escalation and risk management – having a manager on call for helpline operators who are alone at home is not the same as NHS procedures which include at hand cover by senior clinicians.

- GwL have repeatedly asked for the triage criteria used by the helpline, for the suicide protocol used and for the number of referrals to which service. We have had no answers to these questions or evidence that people are getting the right care. GwL are concerned about current statements from GamCare that seem to reframe the triage criteria for referral into NHS service or GamCare commissioned partners as determined by case complexity rather than severity. As far as we are aware the PGSI severity scoring is an internationally researched and well recognised measure and that there is little justification in operating with a different triage process.
- GwL believe that the opaque nature of the helpline and refusal to provide triage criteria and evidence that staff are qualified to operate these is a risk to life.

2.5 Inadequate model of Gambling Disorder, failures of commissioning and continuous improvement

There seems to be a systematic refusal to recognise the life-threatening severity of gambling disorder in the commissioning by GambleAware and secondary commissioning and provision by GamCare. This includes:

- A service specification that does not refer to treatment of “addiction” or detail requirements for suicide risk assessment, crisis referral and management. Despite repeated requests in person and by letter GamCare continues to provide generic reassurance regarding safeguarding and suicidality but no assurance evidence of protocols, process or opportunities for learning. There has been a systematic refusal to provide data, for example, on safeguarding incidents, serious incidents, suicidality, complaints, suicide risk assessment tool and training. We have asked and not been provided with information on the number of referrals to emergency services. Given the published research on suicidality (Ref 8) it should be possible to calculate how many of the 30,000 contacts with the helpline should require referral into NHS crisis services which would enable an estimation of the effectiveness of helpline triage and pathway provision. It is difficult not to see the refusal to provide this information as evidence of a refusal to be subjected to service improving scrutiny.
- A treatment model specification that aims for “moderated gambling” that seeks to return addicts to “safe” gambling in contrast to the NHS evidence-based model which works with and aims for abstinence.
- Lack of systems for long term management and follow-up post discharge, which seem to be linked to characterisation of relapse as internally triggered rather than initiated by environmental influence such as advertising and predatory marketing of addictive products.

- Refusal to provide medium and long-term outcome data and failure to provide evidence of follow up procedures and long term case management.
- Failure to monitor deaths post treatment, initiate critical incident reviews and root cause learning from deaths.

It is difficult to avoid the conclusion that it might benefit the gambling industry to have treatment specified, commissioned and provided by charities that systematically fail to monitor the deaths that result from the condition and to recognise the life-threatening severity of the psychiatric condition induced by gambling on industrialised, repetitive, fast paced electronic products and that collude with industry favouring models of the illness.

2.6 Inadequate specification of levels of competence and training

As far as we can tell, there has been no external validation or accreditation of training and registration required for tiered specialist gambling disorder provision or validation of GamCare's internal induction and training. We understand that treatment practitioners in GamCare provider services have a professional qualification at NVQ 3 level. This is a level down from Improving Access to Psychological Therapies (IAPT), which has clear tiers and skills required for different tiers, and interventions against clinical need, as a national service with a genuinely stepped model. NVQ level 3 also does not indicate competence in the relevant modality. For example, being qualified as a mental health nurse does not mean one is qualified to provide Cognitive Behavioural Therapy (CBT) or other psychosocial interventions, any more than a medical doctor who has worked in paediatrics for ten years is fit to perform heart surgery.

GwL believe that it is essential to commission a specification of client need matched to clinical competence. This must include matching the qualifications and Continuous Professional Development (CPD) of each worker against the PGSI and CORE criteria of their client group.

GamCare have not provided information on training and competence of counsellors in in the providers they commission, or how as commissioner they assure themselves in this area. There is no evidence that a generic person centred counselling training plus minimal internal induction provides competencies to treat the psychiatric condition of gambling disorder with high levels of severity and suicidality.

3. Narrative of learning about the system and attempts to alert authorities

3.1 Initial Experts by Experience (EbE) experience

Our concerns were prompted by our families' reports about the treatment their sons had received, where they had sought help for their addiction to gambling. Broadly, there were two areas of concern – GP response and "specialist" services.

Our experience of the GP response was that GPs uniformly failed to diagnose gambling disorder although diagnostic tools for other addictions were sometimes administered (e.g. alcohol addiction). Occasional referral into IAPT also resulted in failure to diagnose gambling disorder with symptoms of anxiety, depression and suicidal ideation remaining unconnected to gambling activity and treated (unsuccessfully) as separate conditions.

Our families' experience of services marketed as specialist was generally that the service was poor, with a limited number of sessions offered, no follow up, and little availability. In particular, one lost son's experience was that the service told him he was cured and that he could return to limited gambling. He was not followed up post treatment. Although a critical incident review has been requested neither the local service nor Gamcare have been willing to undertake this process.

3.2 Attempts to find information and raise concerns

As a result of these concerns, we set about finding out more. We asked questions of GambleAware about how treatment was planned and funded, and asked Gamcare about the specific case referred to above. Although both GambleAware and Gamcare were willing to meet us, we had a limited response to our concerns, and both organisations either didn't respond or avoided many of our questions, and appeared uncomfortable with the challenges we posed.

The key issues we identified include:

- failure to recognise addiction as a problem, with no evidence that the service considered itself to be treating an addiction and no aim to help patients achieve abstinence
- failure to recognise the risk of suicide associated with gambling addiction, with no evidence of assessment of suicide risk
- staff not required to have experience or training in gambling addiction
- a weak service specification
- no evidence of quality assurance – such as audit – or accountability in the service

These concerns were – and are – based on the service specification used by GambleAware to commission the current service (Ref 6), and the guidance GamCare issued to its staff, and its subcontractor staff (no longer available online, GwL have a paper copy). The words "suicide" and "addiction" seem to be absent from these documents.

June 2018 GwL raised a concern and met with the CQC about lack of accountability and regulation of 3rd sector provision of gambling disorder treatment. Although Dr Paul Lelliott (CQC Deputy Inspector & Lead for Mental Health) expressed serious concern, it was clear that the CQC had no remit to raise the issue or the funding to undertake inspections. He wrote to GwL "I would not … want to raise your hope that there is a prospect of bringing such providers into the scope of regulation by CQC."

July 2018 GwL met with Gamble Aware's Director of Commissioning. We were not reassured by the response we received, which included a failure to provide information and a failure to implement agreed actions.

September / October 2018 a summary of our concerns (as summarised above) was sent to the Gambling Commission, and which we understand was used in a provider workshop in late 2018. GwL requested but was refused entry to the meeting.

December 2018 / January 2019 the Gambling Commission set up a meeting with GambleAware and Gamcare. Following that meeting we sent a letter summarising the meeting and again raising concerns about safety in detail. GwL received no response, including no provision of the information promised in the meeting (e,g. the suicide protocol and triage criteria)

January 2019 GwL raised a concern with NHS England's Director of Mental Health, Claire Murdoch by email about the safety of the treatment system and the failure to prevent deaths. GwL included reference to the meeting and communication with the CQC and its lack of remit and funding. We also referred to the lack of response and refusal to engage on the part of GambleAware and GamCare. Ms Murdoch responded with an honest response: "I don't have easy answers in the short term to some of the concerns you have raised" and directed us to the NHS Long Term Plan promise of specialist clinics. GwL appreciated this honesty but also raised the issue of siting the clinics within the current primary and secondary care NHS infrastructure which necessitates the development of a clear care NHS pathway and clinical training in the diagnosis and tier 2 & 3 treatment of gambling disorder. It was clear that there was no remit or political backing for the NHS to take a strategic view or to undertake due diligence investigations about the partnership with GambleAware and GamCare required by the NHS Long Term Plan. Since this letter we have raised this issue of the development of an NHS Care Pathway both with NHS England and DHSC and as far as we can see there remains no political remit for instructing this vital life saving piece of work.

June 2019 GwL wrote to the Chair of Gamble Aware, to escalate our concerns. In addition to repeating the issues raised in all the correspondence above we included the following concerns about GamCare treatment and services:

- Confused and limited understand of gambling disorder and lack of evidence base for counselling
- Severity of presentation, refusal to supply suicide protocol, triage criteria and care pathways into NHS evidence based treatment with the relevant risk management and governance
- Risk of discharge process and lack of follow-up of particular concern given the volatility of suicide risk and extreme risk of completed suicide on relapse
- Funding of GamCare in May 2019 of a further £3.9 million without a procurement exercise or standards review
- Risk that Gamble Aware and GamCare are seeking to compete with the NHS rather than collaborate.

July 2019 The response from the Chair of Gamble Aware was evidence that our concerns are not taken seriously and indeed indicated a thinly veiled hostility to any scrutiny. We received only generalised statements of an intention to collaborate with the NHS, commissioning objectives and a generalised assurance that gambling addiction is taken seriously. The letter did not include any attempt to provide evidence of these statements. The lack of publication of safeguarding procedures was admitted but dismissed as "detail". Particularly worrying was the apparent lack of understanding that treatment can be contraindicated if it is inappropriate or inadequate and can increase the risk of suicide. That this was followed by an invitation for GwL families to support promotion of GamCare services seemed to indicate a complacent indifference to the suicide risk and particularly the deaths of GwL family members that prompted these questions.

July 2019 We replied indicating our disappointment and restating all our concerns particularly noting again the safety concerns, the apparent rivalry and lack of collaboration with the NHS and the absolute failure to provide evidence of assurance and governance. We received no reply.

September 2019 In response to the evidence submitted to the APPG on Gambling Related Harm, GwL provided evidence of a list of discrepancies between that evidence and the experience of GwL members. We also submitted a list of questions and requests for evidence that the APPG could ask following the Gamble Aware and GamCare's failure to supply answers to GwL. We have written to the APPG secretariat to request that this evidence could be shared with the Lords enquiry.

January 2020 GwL wrote to the NHS Director of the Northern Gambling Service requesting assurance on safety and clinical models and requesting a response to the same scrutiny directed at Gamble Aware and GamCare.

March 2020 The NHS response was very reassuring about the quality and attention to risk of the NHS delivered services and demonstrates to us that many of the concerns we have raised about GamCare's services do not apply to the NHS clinics – including the application of NHS clinical quality standards to the service and recognition of the nature of the addiction and the risk of suicide.

However the response also indicates that our initial concerns about GamCare remain valid (through the lack of evidence to the contrary) and we are concerned that the NHS continues to face constraints in current ability to act to resolve the problems. The phrase used in response to each concern about GamCare governance and safety procedures is that the NHS "would expect" these to be in place. We do not think that "expectation" is the appropriate governance

mechanism given that lives are at risk. It is difficult to avoid the conclusion that if the NHS had conducted a due diligence process, it would not partner with GamCare due to lack of assurance about service quality and therefore patient safety.

In addition, a new specific concern is raised by the letter – the nature of the partnership with GamCare. It is evident from this letter, and from the specification for the GamCare Gambling Helpline (Ref 6), that there is no capability or expertise for assessment of needs of those who contact it – it is therefore unfit to act as the point where people can be triaged to either GamCare or NHS services. There is also no capability to assess for suicide risk.

The fact that there are no referrals from GamCare to the NHS service raises a further concern that GamCare appear to be acting as a rival provider. Although the presenting referrals are double the threshold for internationally recognised psychiatric diagnosis (with accompanying suicide risk), GamCare continue to refer only into partner 3rd sector providers who are commissioned to provide only generic counselling for mild to moderate severity, rather than co-operating to get people into the right treatment, despite the evident differences in competencies, qualifications and registration plus a remit from DHSC to collaborate.

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