# BETKNOWMORE UK

# DON'T GAMBLE WITH HEALTH

# PILOT PROJECT

Evaluation report for GambleAware

Final: 07 December 2017

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# EXECUTIVE SUMMARY

Don't Gamble with Health (DGWH) is a pilot harm-minimisation project based in Islington, north London, delivered by BetKnowMore UK. The team works with high street betting shop staff in the local area to improve their understanding of gambling-related harm, to raise awareness of support available to customers at risk and provide support service to customers who are at risk or are problem-gamblers.

Project monitoring data[1] shows that, since the beginning of the pilot in October 2016:

- 59 licensed betting offices (LBOs) in Islington set up a customer referral process with support from the project team. This number covers all the betting shops in the borough
- 17 DGWH workshops and training sessions exploring gambling-related harm and raising awareness of the service have been delivered
- 112 people, frontline and corporate staff from the booking industry and partner originations, have been trained
- 95 clients have been referred to the service or approached it independently, drawing on the information available in the local betting shops and other community organisations.

Stakeholder (partner and industry organisations and customers) feedback about the project and the service it offers was overwhelmingly positive. The following features emerged as distinctive about the project and contributing to its effectiveness:

- The project team is highly proactive and go an extra mile to engage their clients and sustain their engagement with treatment
- The team responds rapidly to any referrals and staff try to make the referral process easy for clients
- The project approach is positive and holistic
- The approach is highly client-focused and bespoke to their needs and experiences

[1] Information provided by the project team on 3 November.

- BKM team works effectively with local partners to identify people at risk of gambling-related harm and offer better support to existing customers through signposting to relevant services
- The project staff have an in-depth and practical understanding and/or experience of gambling-related harm which they translate into tools and resources that underpin their training and support services
- They develop a trusting relationship with their clients which they see as one of the factors that helps customers sustain their engagement and assists their treatment
- The service aims to empower each of their clients and support their recovery through tools that they can then use independently to help them control their gambling behaviour and achieve their own personal goals.

Assessment of the project processes (such as client referral and assessment, staff training, safeguarding) suggests that they are effective overall. During the next stage of the project implementation, the project team needs to prioritise and consistently monitor cost-effectiveness of its work and refine its evaluation and monitoring systems so that the team has the evidence it needs to inform the project's future development.

The available evidence suggests that the project has achieved some impressive outcomes for many of its clients and the majority of its training participants. For example,

- Virtually all participants of the training delivered by the project team observed improvements in their understanding of gambling-related harm and their ability to recognise 'red flags' in customer behaviour. They also reported feeling more confident to assist people with gambling problems.
- The vast majority of the clients who engaged with the service formally considerably improved their ability to successfully manage their gambling behaviour. Such customers who had completed their treatment for problem gambling made particularly impressive progress.

At the same time, evidence of outcomes for customers who accessed lower tiers of support, associated with shorter and more informal engagement, was limited.

The evaluation team's overall conclusion was that the project offers a valuable service for which there is a need.

When considering scaling up, we recommend starting the process by focusing on developing the team capacity, and scoping and partnership building in any prospective new areas. Alongside this development work, the team will be able to test any adaptations to the service with customers in Islington and gather the additional evidence they need to inform the development and growth of the project.

# 1. INTRODUCTION

## Background and context

Don't Gamble with Health (DGWH) is a project based in Islington, north London, which has been running as a pilot since October 2016. The project is delivered by a social enterprise company called BetKnowMore (BKM) UK and is sponsored by GambleAware. The project has two distinct sides to it. The first strand involves the project team working with licenced betting offices (LBOs) staff in the local area to improve their understanding of gambling-related harm and support available to customers at risk. The other strand of the project provides the delivery of support service to customers who are at risk of gambling-related harm or are problem-gamblers.

The project was conceived with the view of improving access to and take-up of support amongst people who experience harm associated with their gambling behaviour. The project team referred to British and international research[2] suggesting that only around 10 per cent of people with gambling problems undergo treatment, whilst the majority of gamblers, some of them with strong addiction symptoms, do not access support. The team said that the main barriers preventing people who could benefit from help to come forward were lack of awareness of support mechanisms, complexity of referral and slow response within some of the existing services and negativity and stigma associated with gambling as common barriers preventing people who could benefit from help to come forward. The team wanted to address these barriers with their project.

Making the project and the service it offers visible to local community members who might need support, via posters, referral cards and training for staff in LBOs became a significant part of it. Over the first year of the project delivery, people at risk were signposted to the DGWH support service by LBO staff through a project-specific referral mechanism and representatives of other local organisations supporting vulnerable members of community, or they approached the team themselves, typically after seeing information about the project in LBOs.

[2] E.g. Wardle, H., Seabury, C., Ahmed, H., Payne, C., Byron, C., Corbett, J. & Sutton, R. (2014). Gambling behaviour in England and Scotland: Findings from the Health Survey for England 2012 and Scottish Health Survey 2012. London: NatCen; Volberg, R. A., Nysse-Carris, K. L., & Gerstein, D. R. (2006). California problem gambling prevalence survey. Final Report.; Slutske, W. S., Blaszczynski, A., & Martin, N. G. (2009). Sex differences in the rates of recovery, treatment seeking, and natural recovery in pathological gambling: results from an Australian community-based twin survey. Twin Research & Human Genetics, 12(5), 425–432; Suurvali, H., Hodgins, D., Toneatto, T., & Cunningham, J. (2008). Treatment seeking among Ontario problem gamblers: results of a population survey. Psychiatric Services, 59(11), 1343–1346.

The support service is delivered in tiers.

- **Tier One** – information sharing and signposting to non-gambling services
- **Tier Two** – informal 1:1 mentoring, advice and signposting
- **Tier Three** – structured mentoring, counselling, group, tailored and holistic support
- **Tier Four** – intensive care planning and signposting to other specialist agencies, including residential and intensive interventions.

Tiers 1 and 2 are described as brief interventions. Typically, they take form of informal meetings in neutral places (such as cafes) or phone engagement with people who call the project helpline, usually to share their concerns about their own or their loved one's gambling behaviour. Face-to-face or over the phone, these conversations tend to be bespoke and fully driven by the needs and concerns of each individual client. Tier 3 offers a more structured support through mentoring and group therapy. Tier 4 is dedicated to clients with complex and multiple needs and typically involves counselling support.

## Evaluation aims

GambleAware commissioned Chrysalis Research to carry out an independent evaluation of the pilot phase of the DGWH project.

In accordance with the GambleAware funding requirements for all their harm-minimisation projects, the project team has put in place their own systems for measuring effectiveness and impact of their work. As external evaluators, Chrysalis Research were asked to:

- Conduct a critical review of the monitoring and evaluation systems and measures set up by the BKM team and to provide recommendations about how these can be improved
- Perform an evaluation of the progress and achievements of the project, in terms of
    - developing better understanding of gambling-related harm (GRH), and
    - minimising such harm
- Assess the likely scalability of the project.

## Methods and evidence base

This report draws on a range of primary and secondary evidence. In accordance with the specification for this research, where possible, the evaluation team worked with the evidence gathered by the project team. Specifically, the evaluation team:

- Scrutinised all paper-based client records available during the data collection stage (86 customers in total)
- Performed analysis of the workshop feedback data, collated by the project team
- Examined relevant organisation documentation and policies, specifically those related to keeping customers safe.

In addition to the review of the evidence and documents supplied by the project team, Chrysalis Research carried out a range of interviews to inform this evaluation. These were with:

- The project team – a total of eight group and individual interviews with a range of BKM staff and volunteers, two of whom were former BKM clients
- One local authority representative (licensing team)
- Two partner organisations working with vulnerable clients in the area
- Betting industry representatives – senior staff from:
    - three different major betting shop operators. Interviewee roles included an area manager and two heads of retail compliance.
    - the Association of British Bookmakers.

## The report structure

This report comprises six sections. Following the introduction, we offer an overview of the project evaluation and monitoring systems. Understanding the nature and quality of the existing evidence is also essential to put the remainder of the project findings into context. Further observations about the evaluation and monitoring systems are included throughout the report to ensure clarity and specificity of the points being made.

Next, we consider the concept of GRH, as it is perceived and understood in the context of this project.

The two sections that follow provide an overview of findings related to effectiveness of the processes and project outcomes to-date.

The report concludes with a discussion about scalability of the project.

### Reporting note

Throughout this report we present percentages rounded to the nearest whole number. This sometimes means that totals can appear to be one or two percentage points out. For example, the sum of 55.4% and 44.4% would appear as 55+44=100, since 99.8 rounds to 100.

## Acknowledgements

Chrysalis Research would like to thank the project team for all their support during the data collection stage and for their willingness to open their systems and data to external scrutiny.

# 2. OVERVIEW OF THE PROJECT SELF-EVALUATION AND MONITORING SYSTEMS

**In this section we provide an overview of the project evaluation and monitoring systems, as reviewing this was one of the evaluation aims.**

BKM collects a lot of evidence about its clients and their treatment process but the monitoring and evaluation data collection has been affected by two factors that limit its effectiveness at this stage:

- **Evidence** captured for each individual client is often **determined by the nature and level of their engagement**. The project team is aware that completing forms can be negatively perceived by customers (and available project and wider evidence supports this view) and can lead to disengagement if done prior to building trusting relationships. This results in little evidence being available about Tier 1-2 clients whose engagement with the service is typically brief. Equally, the sheer nature of the service means that clients can 'disappear' half way through the treatment process. This can happen for a variety of reasons (one of which is the success of the treatment meaning clients see no further need to continue with it), this is usually beyond the project team's control. All this can lead to incomplete client records and make monitoring impact and effectiveness of the service problematic.
- There has been **continued effort to refine monitoring and evaluation systems throughout the pilot year**. Whilst this has led to some undeniable successes (e.g. direct feedback from clients about their experience of the programme now being captured via BKM's own forms, 2B and C), the process has also resulted in multiple instances of parallel forms and data capture instruments being used, making any cross-project analysis difficult, time-consuming and in some cases not possible.

As soon as a client is referred to BKM, their contact details are recorded and their paper-based file is opened. Gradually, assessment and then subsequently monitoring information is added, accompanied by mentor or counselling notes of all meetings and other communications with the client. These are added to the client file on an ongoing basis, usually immediately after a meeting or remote exchange with the client.

## Background information about clients

Fairly detailed background information, covering aspects such as age, gender, ethnicity, employment and income, gambling history, habits and preferences, was captured for virtually all clients involved in more structured support (Tiers 3 and 4) but was rarely available for Tier 1 and 2 clients.

Where background information was captured, it was gathered through different forms (BKM initial referral form and forms 1A and B, RGT DRF, GAST-S) which created instances of evidence duplication or conflicts as far as individual clients were concerned and made amalgamation of evidence across the entire client base complex or sometimes impossible.

## Outcomes data

Two types of outcomes were fairly consistently tracked by BKM team – those related to **gambling behaviour** and clients' **emotional and mental health**.

PGSI (problem gambling severity index), usually in its fuller (nine questions) form, is used at the assessment stage with Tier 3 and 4 clients and then one or more times (depending on each clients' engagement with their treatment) during, at the end of and where possible after the treatment. All PGSI records are kept in the client file and used for progress summary in the BKM Aftercare Form where this is completed.

Core-10, a brief assessment and outcome measure, widely used in the evaluation of counselling and the psychological therapies in the UK, has been adopted by BKM team to monitor their Tier 3 and 4 clients' emotional and mental health and wellbeing. The tool is designed to gauge the clients' state with regards to for example anxiety, depression, trauma and everyday functioning.

Unlike the PGSI score which appeared to be the only universally used assessment and measurement approach used across all clients, there were several instances of alternative instruments being used to assess the state of client mental health. Examples of these included the APT anxiety scale and Mood-Depression Assessment questionnaire. These were typically used for Tier 4 clients by their counsellor and their use was understandable and justified from the point of view of the individual client treatment, but it created instances of incomplete datasets across the programme as they were used instead of Core-10.

Despite the consistency with which PGSI and Core-10 were used in assessments of client outcomes the timing when the measurements were taken makes the dataset less reliable. For example, for some clients there were instances of weekly or fortnightly assessments using both or one of the forms, for other clients there were only two assessments, captured six or more months apart. In

some instances, the differences in timing were explained by the course of a client treatment. For example, a client might disengage and then reengage with the treatment several weeks or months later and successfully complete it. Within this evaluation, every effort was made to ensure client datasets were directly comparable (i.e. measurements were taken at similar points – beginning, mid-stage and end of their treatment). Nonetheless, it is important to state that the were some ambiguous records, for example, when not all the outcome assessment tools in the file were dated.

There were many other positive outcomes for clients, which were occasionally visible in mentoring and counselling notes and emerged during project team and other stakeholder interviews, but these were not captured systematically. There were some instances of missed opportunities, for example, some aspects of the GAST-S tool, frequently used by the project team at baseline stage, could also be used towards the end of the treatment to gauge distance travelled. More recently, attempts were made to assess (via BKM form 2B in particular) client outcomes in a range of areas, including mental, physical and financial wellbeing, education and employment. This represents a move in the right direction but the form itself needs revising as it can be misinterpreted. Specifically, 'affected' appears to be interpreted both positively and negatively by the clients who completed it. The phrasing in the form is also unnecessarily conservative, asking clients to assess whether their experience of gambling-related harm deteriorated during the treatment period (e.g. 'During the mentoring programme gambling has put me in debt'), and making it difficult to capture improvements (e.g. 'By taking part in the programme I have been able to pay off some of the old debts') in their state, behaviour and perception of themselves.

## Process data

Overall, there was less emphasis on process data within the project evaluation and monitoring systems compared to outcomes data and where this was collected, this was relatively recent meaning the evidence set was still small.

Lack of useful process data might come across as a bit of a surprise, given how detailed mentoring and counselling notes are. What they tend to capture however is client experiences between the sessions and their emotional and mental (and some cases also physical) state during the session. In mentor /counselling notes or otherwise, it was rarely possible to see what strategies or tools worked well at supporting improvements in reducing gambling-related harm. Absence of this kind of process data creates two interconnected challenges that need to be addressed going forward:

- It makes attribution of impact to the service difficult. This is because a number of clients receive support from multiple agencies. For example, there was evidence of one client attending Gambling Anonymous groups at the same time as benefitting from structured support from the project. It is also important to acknowledge individual clients' own ability to overcome their

addiction and control their behaviour. Therefore, if there is a noticeable improvement in client PGSI but no evidence explaining what had helped the client gain control of their gambling behaviour or evidence of client explicitly linking improvements to BKM service, attribution of such improvement to DGWH project is far from straightforward.

- It makes it virtually impossible to adapt the service, including improving its efficiency, in an evidence-informed way. For example, in order to decide which elements of the service are essential and which can be reduced or removed to increase efficiency and cost-effectiveness, it is essential to know what truly helps clients and makes the service distinctive and what is a 'nice to have', i.e. non-essential, and /or an element of the programme that can be better performed by other organisations or parallel services.

Overall, BKM collects a wide range of monitoring and evaluation evidence, some of it very detailed. It is important to note that the bulk of the available evidence is consistent with the results-based or outcomes-focused approach to evaluation and monitoring, which is widely recognised[3] as superior but also a lot more challenging to put in place. Alongside these achievements, there is a small number of aspects of the project (Tiers 1 and 2 of the service in particular) where until now evidence collection focused mainly on inputs and outputs. Assessing outcomes for customers accessing service informally and for a brief period of time is notoriously difficult and is a challenge for many services and charities offering such support. Nonetheless, the project team should develop appropriate data collection mechanisms for gathering evidence of outcomes for Tier 1 and 2 customers so that there is a clear picture of impact of the project on *all* the customers who access BKM support as part of the project.

Similarly, there are some instances of inconsistencies in data collection. Most of these are understandable for a new and constantly evolving service, but they need to be addressed prior to scaling up the approach to other geographical areas.

To improve service monitoring and evaluation systems, going forward, we recommend**:**

- **Developing** a fit-for-purpose and appropriate **approach for capturing outcomes data for Tier 1 and 2 clients**. This might take form of asking 1-2 questions at the end of the initial phone conversation with a client or asking their permission to follow up electronically with a short feedback form. Viewing the initial meeting or phone conversation as a stand-alone instance of support and gathering evidence about it is essential, given that this is the point where many clients decide that they have received all the information they need and disengage from further support. Important to emphasise here that data collection tools used with Tier 1 and 2 clients should be appropriate to the level of support offered. They might for example capture

[3] E.g. Kuzek, J. & Rist, R. (2004) Ten Steps to a Results-Based Monitoring and Evaluation System. – Washington, The International Bank for Reconstruction and Development /The World Bank.

improved awareness of risky behaviours, awareness of support available or improvements to clients' wellbeing linked to feeling listened to and understood.

- **Determining precise points** when **assessment** tools are used. These should not be too close to each other. Frequent measurements can lead to poor quality data due to research fatigue amongst clients and they take up valuable time during and after sessions with clients. The intervals between assessment points should be realistic in terms of clients being able to change their attitude and behaviour. They should also take into account the number of sessions within this period during which a client is offered support, i.e. its intensity. In addition, care should be taken when using some of the tools, particularly doing so frequently. For example, frequently using Core-10 which contains questions about suicidal plans, might be detrimental to client emotional health and wellbeing.
- Wherever possible, **using the same forms and scores across all clients** to capture evidence about particular outcomes. BKM has been gradually moving towards developing their own forms, following a period of trialling various off-the-shelf alternatives, and this should be further encouraged. The team should decide what data they need and agree on the tools that would capture it most effectively.
- Capturing **other outcomes** for clients in a systematic way. Given that these might differ between clients, it might be helpful to use an adaptive system, first determine the relevant areas of impact for each client and then perform a further assessment to determine its extent.
- Ensuring that some of the evaluation tools focus on gathering useful **process data**. This might be clients commenting on the extent to which the service supported specific improvements in their state and behaviour and scoring specific elements of the service in terms of their relevance and usefulness.
- Prior to introducing new tools and systems, **reviewing existing ones to spot redundant, duplicate or irrelevant data**. The associated data collection tools can then be removed to create staff capacity and client time to gather new /additional evidence.
- Gradually **digitising client records**. This would simplify monitoring across clients, would correct simple errors such as undated records or incorrect calculations of scores.

As monitoring and evaluation systems are one of our research foci, we provide further insight related to their specific aspects in the relevant sections of this report.

# 3. GAMBLING-RELATED HARM IN THE CONTEXT OF THE PROJECT

**Building the evidence and analysis presented in the interim evaluation report, this section offers an overview of the evidence about gambling-related harm as it is experienced by the project clients.**

The interim evaluation report (submitted on 29 September 2017) articulates in some depth how gambling-related harm can have multiple manifestations. For example, one of the core pieces of research in this area[4] identifies eight domains of gambling-related harm – health, emotional or psychological distress, financial, performance, relationship, criminal activity or neglect of responsibilities, cultural and life course (generational and intergenerational) harms.

It is clear from the available evidence that in their work, the project team encounter the full range of these manifestations and they attempt to mitigate as many of them as possible. Yet, it was the (perceived) inability of clients to control their own gambling, and the state of their mental and emotional health and wellbeing that have emerged as the main types of harm that the project is trying to target.

Below we provide a brief overview of the level of harm that is experienced by clients with regards to these two parameters at the time when they access the DGWH services.

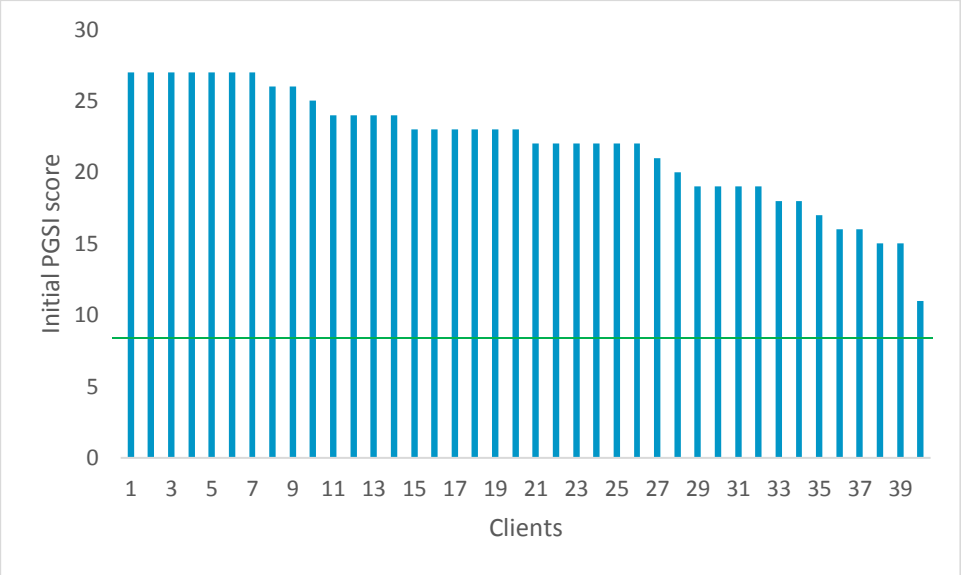
## Ability to control gambling behaviour

The initial PGSI assessments indicate that the vast majority of the customers for whom such assessments were completed could be classified as problem gamblers as their PGSI scores were well above the score of eight. The level of severity is high, with the average score being 22.

[4] Browne, M., Langham, E., Rawat, V., Greer, N., Li, E., Rose, J., Rockloff, M., Donaldson, P., Thorne, H., Goodwin, B., Bryden, G. & Best, T. (2016) Assessing gambling-related harm in Victoria: A public health perspective. Victorian Responsible Gambling Foundation, Melbourne.

**Figure 1: Distribution of the initial PGSI scores across the project client base**

Source: Full PGSI assessments across all tiers; base 40.




The specific elements of the PGSI score that emerged as highest across the entire client base were around customers recognising they had lost more than they could afford, them feeling guilty and acknowledging that their gambling was problematic.

Additional evidence captured by the project team reveals that at the time when they are referred to the project, many customers gamble every other day or more often. They spend a considerable amount of time gambling and lose a noticeable proportion of their income. The vast majority of those who completed the relevant forms stated that they felt unable to control their gambling behaviour and that their urges to gamble were too strong for them to cope with.

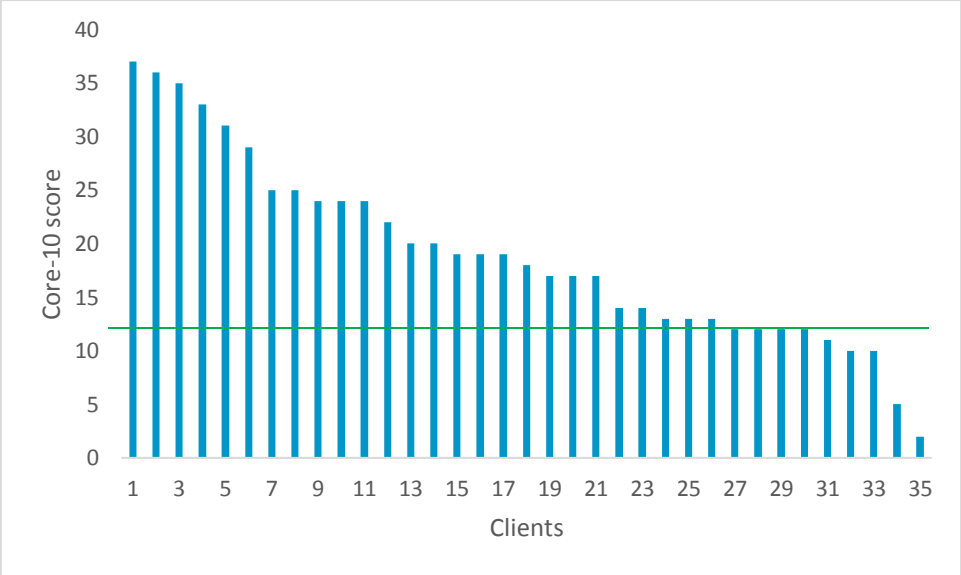
## Mental and emotional health and wellbeing

Many customers were in a state of distress or despair when they first approached the service or were referred to it by for example betting shop office staff. For some clients, such state was caused by the sheer amount of money they had lost (for example their entire months' wages) or the importance of the money they had lost (money reserved to pay the rent or buy their child's birthday present). It is often at this point of distress and despair that people with gambling problems decide to ask for help and access support.

More in-depth assessments (Core-10 scores) revealed additional and more serious health and wellbeing concerns for customers. The average score was 19 and the vast majority of scores were well above the 10-11 mark which is when a client is considered to be healthy or in a low level of distress. Scores above 25 indicate severe distress and are often linked with complex health issues.

**Figure 2: Distribution of the initial Core-10 scores across the project client base**

Source: Core-10 assessments across all tiers; base 35.




Overall, with the initial assessment practices being relatively strong, the project has been contributing to developing better understanding of gambling-related harm. To further enhance this, and to enable the team to use their evidence to better match levels of treatment, specific strategies and tools to clients, the project team should also be systematic about capturing fine-grained and specific *descriptive* evidence of harm being experienced by clients, particularly those treated informally (Tiers 1 and 2). Such descriptive evidence should be gathered alongside PGSI and Core-10 data, or where these are not possible for clients engaging informally, as a minimum level of evidence gathered about this dimension of the project.

# 4. PROJECT ACTIVITIES AND PROCESSES

**This section explores the effectiveness of the project processes.**

## Project outputs at a glance

According to the project monitoring data, since the beginning of the project in October 2016:

| | |
|---|---|
| **59** | LBOs in Islington set up customer referral process with support from the project team. This number covers all the betting shops in the borough. |
| **17** | DGWH workshops and training sessions exploring gambling-related harm and raising awareness of the D service have been delivered. |
| **112** | People, frontline and corporate staff from the booking industry and partner originations, have been trained |
| **95** | Clients have been referred to the service or approached it independently, drawing on the information available in the local betting shops and other community organisations. |

In addition, the project team has been working on developing partnerships with organisations in the borough that support clients who might be experiencing gambling-related harm so that they can be signposted to the service or those who can provide additional support to DGWH clients, for example around housing, debt management, mental health issues, drug or substance abuse.

Recent additions to the service also include a workshop programme and drop-in sessions for clients. A support offer for 'affected others' is currently being developed.

## Service reach and customer engagement

### Referral

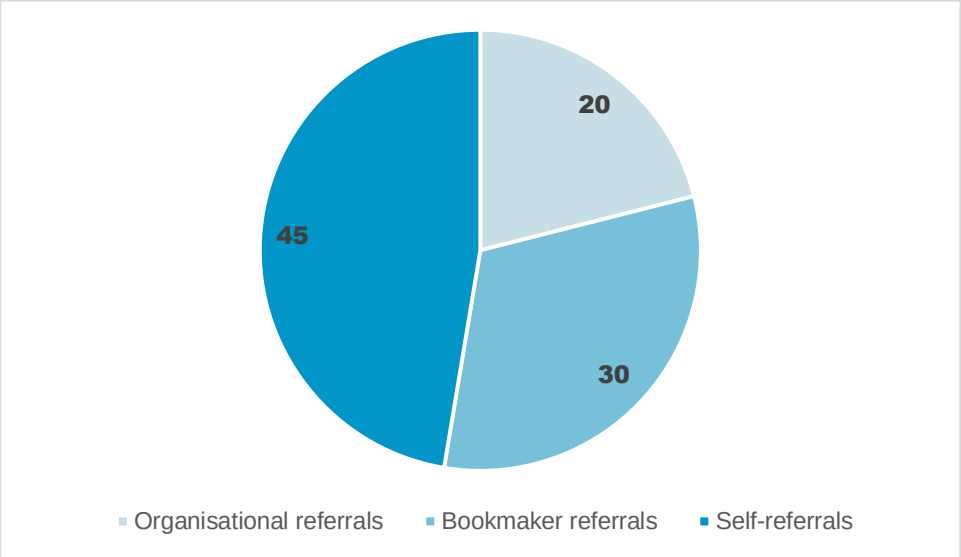
As indicated above, the project team has been working with all betting shops in Islington and a referral process is now in place. Similarly, partnerships with other local organisations, such as SHP

(Single Homeless Project[5])and iCope (Islington Psychological Therapies and Wellbeing Service), have led to new clients being identified and referred to the project.

The current customer base referral distribution is presented in Figure 3 below.

**Figure 3: Customer referral breakdown**

Source: BetKnowMore monitoring information (3 November 2017); base 95.




## Speed of referral

The project team have a target to respond to calls, to collect the referral cards and make an initial contact with customers within 48 hours. It was not possible to verify whether this was achieved in all cases. The team's monitoring processes indicate that 48-hour response rate was achieved in all instances of client (self) referral. Analysis of the client records generally supports the statement about the speed of response from the team. There were multiple examples when the team were able to initiate a discussion with a client, including setting up a meeting in the area, within hours and sometimes minutes, following a referral. Documentary analysis suggests, that in most cases, the initial assessments were performed within 1-2 days from the date indicated on the referral card. In other cases, it was clear that the initial conversation (for example over the phone) was near instant, but the assessment meeting took place several days later. At the same time, not all clients were referred via a referral postcard which meant that it was not possible to verify the speed of the team's response in these cases.

Overall, there was no evidence across the entire dataset suggesting any delays in response to referrals and there was a lot of positive evidence indicating prompt response from the project team.

[5] https://www.shp.org.uk/

## Reaching vulnerable population groups

Given that there is a lot of evidence about gambling-related harm affecting particularly strongly some of the more vulnerable members of the society, consideration needs to be given to the extent to which the service is reaching such customers.

Due to the informal nature of their engagement with the service, little information about background characteristics of Tier 1-2 clients, particularly those who engaged with the project in its early stages, was available. There was only a handful of records that were sufficiently complete to enable analysis so it is not possible to represent the complete picture of the project clients and their needs. Instead, we will summarise some key patterns in the data related to Tier 3 -4 clients and those who enrolled very recently.

- **Five** out of 34 clients for whom records were available were in **supported accommodation or at risk of becoming homeless**. Furthermore, a similar number lived with friends, not having a home of their own.
- Out of the 26 clients for whom information about their employment was available, **nine were not in employment**. Five were unemployed and four were in receipt of benefits due to a long-term illness.
- Out of 37 clients for whom the relevant information was available, **16 had mental health problems**, most typically anxiety, stress and depression. There were several clients with personality and bipolar disorders.
- **10** out of just under 40 clients for whom the relevant information was available had a history or were recovering from **substance and/or alcohol abuse.**
- **Four** out 37 clients had a history of **breaking the law in the past** (linked to gambling or substance abuse).

**Client case study 1**

The client was referred by a partner organisation called New Horizon.

The client has been gambling for four years, since he was 18. He feels that his gambling behaviour has caused a lot of damage to his relationships with family and friends. He is currently homeless. Lost his job due to gambling and is currently unemployed, with several thousand pounds' worth of debts. Some of the money is owed to loan sharks. He has been diagnosed with anxiety and paranoia; there is a risk of mental health degradation due to cannabis. He is not eating properly which risks affecting his physical health.

Most of DGWH clients are men, as is to be expected for a project focused on betting shops' customers, with only a few women taking up the support offer, some of them as 'affected others'. The client base is very diverse as far as ages and ethnic background are concerned.

Even though incomplete due to the nature of the available evidence, the brief analysis presented above indicates that the service does reach and support some of the most vulnerable members of the society. Yet, many of the people whom it supports are those who have not yet attracted attention of health, social or similar services. They are people in employment, in a relationship or with families, etc. Yet, many of them risk becoming vulnerable as they struggle to manage the consequences of their problem gambling, gradually or rapidly moving towards a crisis point.

**Client case study 2**

The client, now in his thirties, has been gambling for 12 years. He is in full time employment. He lives with friends. Currently in treatment for substance abuse (cocaine).

It took a few years till he was able to admit a problem but hasn't been able to stop. Mounting debts and desperate to stop, though still sees gambling as a way to make money. He is ready to stop and has accepted the need for support.

Whilst incomplete in terms of all customer records having the relevant information, there is quite strong evidence that the service engages large numbers of people who had not previously considered asking for help to positively change their gambling behaviour. Most of them had tried – unsuccessfully – to tackle their problem gambling and its consequences on their own.

## Systems around staff competence and client safety

The project team is fully committed to ensuring client safety and offering them the highest standard of service. As an example of this commitment to quality and high standards, when launching their mentoring service for example, the team went through an accreditation process with NCVO and received the approved provider standard.

> *[As far as we are aware], we're still the only organisation in the UK that has [this accreditation] for gambling support. To achieve it, we had to go through a process of self-assessment, reflection on our working practices, ensuring that our policies were in place, all our systems were in place. That was a really important process for us.*
>
> **DGWH project team member, BKM**

The process of self-evaluation and improvement of systems and policies is ongoing. For example, work is currently underway on refining policies around suicide prevention and introducing new procedures on adult safeguarding. Staff receive training around potential risks and safeguarding

issues, including from external specialist organisations. All staff have to have a Disclosure and Barring Service (DBS) check in order to be allowed to work with clients.

An extensive, project-specific training programme has been put in place for the network of volunteers that has been growing around the project, to support its client and community work.

## Stakeholder experience of the service

According to the partner organisation and industry interviews carried out by the evaluation team, and the analysis of the feedback about the training and – increasingly – service for the customers, captured by the project team, all these stakeholder groups' experiences of the service have been extremely positive.

### Customers

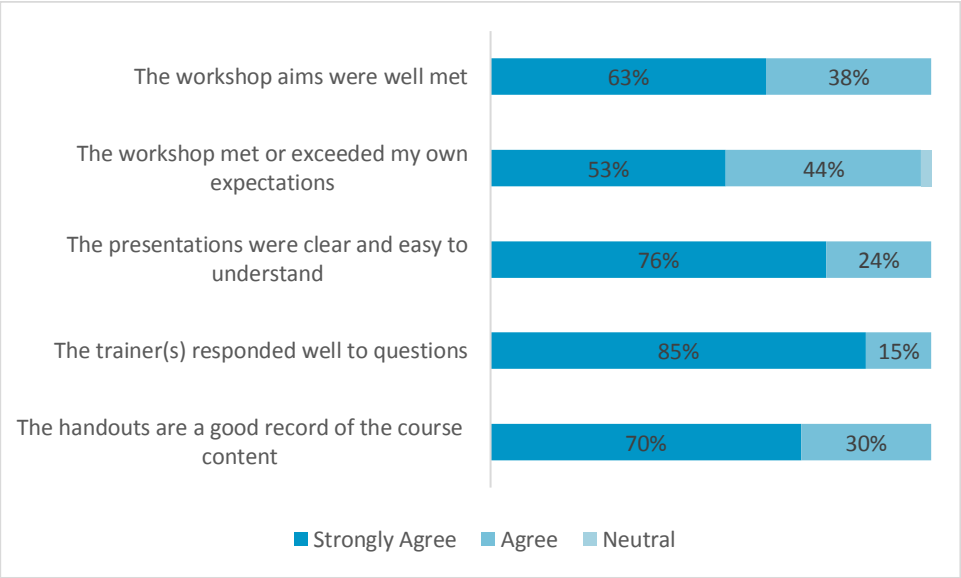
BKM only recently started collecting customer feedback about the service and support they have received, when they have completed their treatment. All the clients who provided such feedback (10 people in total) stated the programme was highly effective in helping them gain control over their gambling behaviour. They highlighted that staff were always there when they needed support, they were 'good at their jobs' and kept them motivated and informed about their treatment. The clients rated their experience of the treatment as positive. All the clients who provided their feedback said they would recommend the programme to others.

### Workshop training participants

Workshop participants feedback was similarly universally positive about their experiences of the project, as Figure 4 illustrates.

**Figure 4: DGWH workshops – participants feedback**[6]

Source: BetKnowMore workshop evaluation forms; base 88.




All participants stated that the workshops met their aims and expectations, praising the clarity of the presentation, quality of the session facilitators and presenters and quality of materials in particular. In their comments, the training participants consistently described as 'informative', 'illuminating', 'insightful' and 'valuable'. Some of them referred to it as 'unique'.

> *A very good workshop and insight into a potential gambler's mind.*
>
> **DGWH training participant**

Case studies and real-life accounts of people experiencing gambling-related harm were identified as a potentially powerful aspect of the training.

> *Hearing [a volunteer, former project client] speak about [their] personal experiences with gambling was a big eye-opener. I think having this incorporated into the workshop really helped in seeing the other side of gambling.*
>
> *It was great to hear first-hand experience. It allows me to get a deeper understanding of how a customer with a problem thinks, which will help me review policies and procedures from their point of view.*
>
> **DGWH training participants**

Analysis of participants' comments about possible areas for further improvement reveals that the majority of those who left comments would like to have longer sessions or more of them, focusing on gambling-related harm and helping customers at risk. Other suggestions included requests for

[6] At the beginning of the project, a different workshop evaluation form was used. It was not possible to merge the data captured through the two different forms, so only feedback captured through the later form was included in the analysis presented in the chart.

the resources to be emailed to participants electronically and suggestions about simplifying some of the terminology being used in the session. One participant commented that the views of those working in the industry should also be surfaced during the session to ensure a comprehensive overview of gambling-related harm and how problem gambling affects people.

## Industry and partner organisations

Similar to previous stakeholder groups, local authority, industry and partner organisations' representatives were unanimous in their praise of the project, commenting on both the training being offered to them and their staff, and the service for people experiencing gambling-related harm that was at the heart of the project.

> *Staff were impressed with the practical approach and with the BKM team's knowledge of the industry. Sometimes you get a counsellor who has never seen inside of a betting shop and doesn't really know what it's like. BKM was very different. But it's not just the training offered to our staff, it's the support service behind it that is the most important part of it all. BKM can see people quickly, they can have those conversations in the right forums and in the right way.*
>
> **Head of Retail Compliance, one of the major betting shop operators**

Reiterating many of the favourable comments provided by their staff, the interviewed industry representatives also spoke about the positive and balanced attitude – to customers with gambling problems and to the industry – that characterised the project approach as something that they found particularly helpful.

> *I've been to training [focused on responsible gambling issues, delivered by other organisations] and you walk away from those trainings feeling 'I ruin all these people's lives, our industry's awful and so on'. BetKnowMore take a more [holistic and balanced] approach. They're not trying to say you people are awful or anything like that. Their approach doesn't just look at the gambling problem, it looks at why people have got a gambling problem. It recognises that sometimes it isn't a case of stopping [people gamble] altogether, but it's a case of helping them control it, and it seems like they respond to people that need the help a lot quicker.*
>
> **Area manager, one of the major betting shop operators**

When reflecting on potential further development areas, betting shop operators spoke about the need for advanced notice prior to any staff training so that they have sufficient time to put in place cover for multiple colleagues. Another consideration expressed by all three interviewed industry representatives was around staff turnover within their organisations, meaning continuing need for new training opportunities for staff, as well as refresher sessions for previous training participants. Overall, all operators wanted to be in a position to deliver subsequent training internally, drawing on BKM resource, practical knowledge and harm-minimisation expertise.

## Key and unique features of the project

The available evidence suggests that there are a number of features which, taken together, make the DGWH project effective. They also distinguish it from other similar or parallel projects and services.

These features are:

- The project team are highly **proactive and go an extra mile to engage** their clients and sustain their engagement with the treatment. For example, the project team go to their clients rather than expecting their clients to come to them for an initial meeting. Typically, this means meeting clients at a place that is most suitable for them, but can also mean, according to a partner organisation interview respondent, going to customer homes which have rat infestation issues.
- The team **respond rapidly** to any referrals and try to make the referral process easy for clients.
- The project approach **is positive and holistic**. To help deal with the stigma and shame often linked with gambling, within the project it is viewed and presented as a lifestyle choice and health issue similar to for example drinking. When people can engage in both these activities in appropriate and well-managed ways, they do not lead to harm and are socially acceptable.
    - The positive nature of the approach is also visible in the service offering suitable alternatives to problem-gambling activity. Consistent with many modern behaviour change theories, this means that in order to sustainably remove or minimise a negative behaviour feature, people need to have a positive alternative. Within the context of the project, this might be about helping a client to fill up the time previously occupied by gambling with new activities, enjoyable to the individual and contributing to their wellbeing, e.g. music-making or sport participation.
    - The holistic nature of the approach is also manifested in the team trying to assess what, alongside gambling, negatively affects their clients' wellbeing and support them in addressing that. Such issues are diverse and personal to each client. Examples include loneliness, unemployment or accommodation that is inconsistent with healthy living.
- The approach is highly **client-focused and bespoke** to their needs and experiences. This might mean that anything from the content of the mentoring sessions, to where and when they take place, to the signposting and information that is given to them is individualised and unique to the client.
- BKM team **works with local partners** to identify people at risk of gambling-related harm and offer better support to existing customers through signposting them to relevant services.

- The project staff and volunteers that support them have an **in-depth and practical understanding and/or experience of gambling-related harm** which they translate into tools and resources that underpin their training and support services. Not only does this make everything they do feel authentic to all stakeholders, it also helps them build rapport with their clients. For some customers, feeling so desperate that they are unable to believe that their situation can change for the better, members of staff who have been able to successfully overcome their gambling problems become an inspiration and a real-life embodiment of what is possible.
- Mentors and other staff develop **a trusting relationship** with their clients which they see as one of the factors that helps customers sustain their engagement and assists their treatment.
- The service aims to **empower** each of their clients and support their recovery through **tools** that they can then use independently to help them control their gambling behaviour and achieve their own personal goals.

It is important to note that the bulk of the evidence that underpins and supports the above-mentioned features comes from the project team and partner and operator organisations staff (both at the level of corporate colleagues and those who work in LBOs).

At the same time, there is little feedback from *clients* about effectiveness of the different elements and features of the service. For example, one of the recently introduced monitoring and evaluation forms (BKM 2B) attempts to gauge just that, but the nature of responses indicates that greater degree of support for respondents, for example through prompts, or differently framed questions are needed to isolate the 'active ingredients'. For example, the most common response to the question about what helped them get their gambling behaviour under control is 'mentoring'. It is however unclear which precise element of it is meant (it might be the trusting relationship that they have with their mentor, or the frequency and structure of sessions, or the tools being used, etc). In several instances it appears that by 'mentoring' clients refer to the entire service they had received.

Similarly, whilst there is evidence that some of the clients had previously accessed support from other services, there is no data about what they found distinctive about the project and why it ultimately helped them, as appeared to be the case.

Capturing such evidence from clients will be important in further developing and refining the service as well as improving the team's clarity about the specificity of their offer when compared against other services.

## Value for money considerations and increasing efficiency and cost-effectiveness of the service

Value for money i.e. whether the optimum amount of resource is used to achieve the intended outcomes, is a difficult assessment to perform in the context of the project for a number of reasons. External stakeholders believed that the unique nature of the service made any comparisons virtually impossible.

Another reason was the fact that it is a *service*, trying to create an environment in the local community where those who need help, come forward and get the help they need, as opposed to an easily countable set of sessions or similar. A considerable amount of effort and resource is dedicated to secure and, in some cases, sustain client engagement. To provide a close-to-immediate response to a (self) referral, the project team have to be on standby and in a position to act quickly in order to engage people who realise they experience harm at the time when this happens. For many problem gamblers, whilst a period of despair during which they might ask for help passes, they return to their excessive gambling practices, refusing to acknowledge that their behaviour is causing harm to them and those around them, thus moving further towards a crisis point. The project team believes that in order to reach those who otherwise would not engage with support services, fast response is essential.

This should not preclude the team from looking at increasing the cost-effectiveness of their work, by spotting opportunities to offer fast response in an increasingly less resource-intensive way. Similarly, sustaining client engagement in some instances is extremely costly for the project. In many client files there were records of clients cancelling or rescheduling sessions at short notice, being very late or not turning up at all. The team prides itself on being different from other support services where one instance of such behaviour might lose a client their treatment and support opportunity, and not giving up on their clients just because they are difficult. At the same time the extent to which irresponsible behaviour from clients is accommodated puts strain on the project resources.

The project team needs to review its practices and decide on the approaches and practices that would allow their clients an occasional slip-up but at the same time require them to take ownership and responsibility from the outset. This would be consistent with the general empowerment approach used by the team when working with DGWH customers. Additional allowances could be made for a small number of clients with particularly complex needs, for example those with diagnosed mental health problems, but the team needs to be clear how many such clients it could afford to support without jeopardising the resource allocated for the rest of their work.

The project team has already started their work on identifying ways of being more cost-effective. One of the new systems that is being put in place will ensure there is clarity from the beginning – amongst the entire team and with each of the clients – about the volume of support they would be

offering. A precise number of sessions has been identified, along with the approximate period of time over which they would be delivered. This contrasts with some of the early practices when vulnerable clients with very complex needs would continue drawing on the team support for months, with a very large number of one-to-one sessions and other forms of support being given to them. The new, sharper and more defined approach is expected to reduce the level of resourcing required to support each individual client, at the same time as ensuring that they gradually move towards being empowered to support their own recovery and do not become dependent on the project team and the trusting relationships they develop with their mentors and other staff.

Other areas being explored by the project team with the aim of increasing cost-effectiveness include:

- Strengthening the remote support (phone helpline) elements of the service
- Scrutinising when some client needs can be better supported by other dedicated organisations – more effective sign-posting and multi-agency working in the area
- Exploring cascade training ('train the trainer') approaches as opposed to training all LBO and partner organisation staff directly.

The latter is very important in the context of high staff turnover amongst LBO staff, in London in particular, meaning that additional training is frequently required in the same LBOs that had already been trained as part of the project.

With the initial period of the project set-up now out of the way and the service in operation, improving cost-effectiveness is rightly one of the team's priorities, particularly in the context of potential growth and scale up of the service into other geographical areas. Going forward, it is important to sustain cost-effectiveness checks within strategic and operational planning for the project and service delivery. Given the project team's strong commitment to offering as comprehensive a support service as possible to their clients and going the extra mile for them, introducing a system for routinely considering cost-effectiveness and performing comparisons with similar services or their parts is advisable. The latter (performing comparisons for individual elements of the service) might be easier to achieve, as for example workshop / training costs and mentoring or counselling costs as part of addiction support services are widely available[7]. These might offer useful yardsticks when reviewing cost effectiveness and value for money of the project and its processes. To ensure a degree of externality and independence when performing such checks, this role might be for example performed by one of BKM board members or its trustees.

[7] For example, a quick internet search suggests that a one-day awareness workshop (typically these last around 6-7 hours in total) on issues such as self-harm can be commissioned by organisations to be delivered for a team of up to 15 of their staff on their premises for approx. £600-700 plus the trainer's expenses.

# 5. PROJECT REACH AND OUTCOMES

**This section considers outcomes for the two main strands of the project activity – its direct support to customers and its training for staff from industry and partner organisations.**

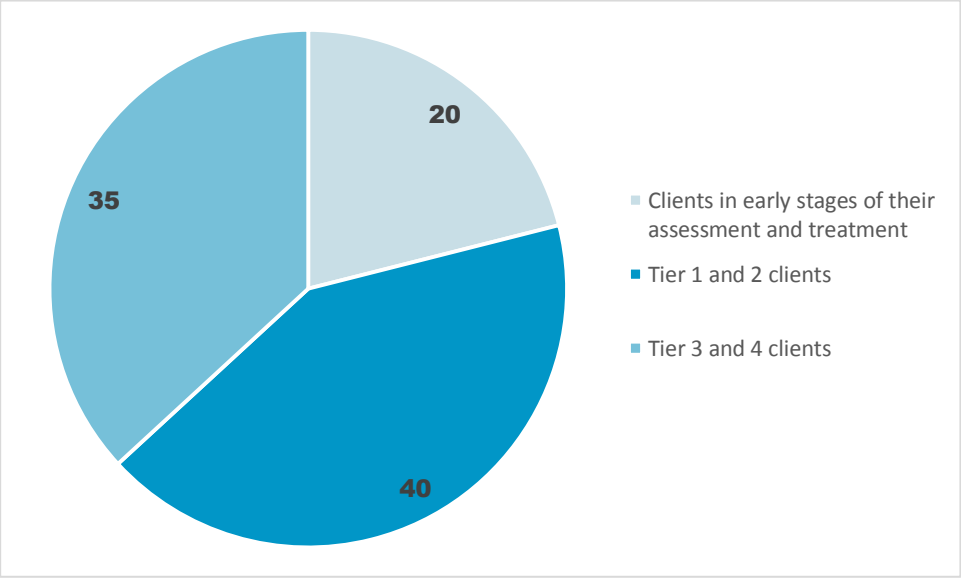
## Customers

By early November 2017, BetKnowMore engaged with 95 customers. Twenty of them[8] were in their early stages of treatment and assessment. For approximately half of these clients only initial assessment data was available. The remainder were recently referred clients and their assessments were in the process of being completed during the reporting stages of this evaluation. No outcomes data was available for these customers, so they were excluded from impact analysis.

Below we offer a breakdown of the current customer base, outlining the numbers of customers who recently approached the service and those who are treated through informal, short term (Tiers 1 and 2) or more formal (Tiers 3 and 4) interventions.

**Figure 5: Customer breakdown**

Source: BetKnowMore monitoring records, checked 3rd November 2017




[8] Clients with reference codes ABB75-ABB95.

Tier 1-2 and Tier 3-4 customer engagement with the service and the evidence about their outcomes differ considerably so they are presented separately below.

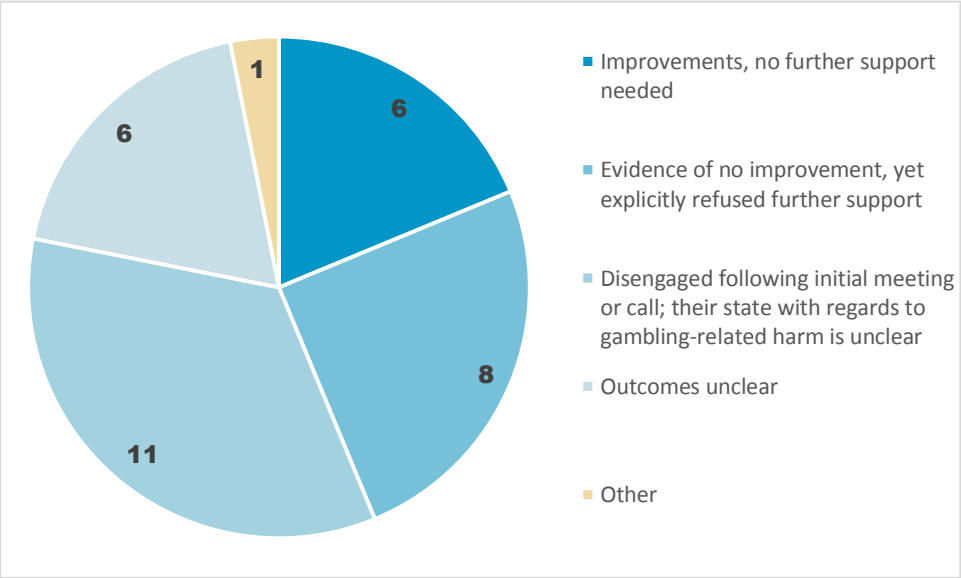
## Tier 1-2 client outcomes

Of the 40 clients recorded as Tier 1- 2 customers, 32 had brief meetings or a phone conversation with the project team. Despite their efforts, the project team was unable to reach eight clients due to incorrectly provided contact details or these customers' reluctance to engage despite being (self)-referred.

According to the interviews with the project team, within their brief and informal interactions with Tier 1 and 2 customers they discuss client experiences of gambling and explore their concerns about negative consequences of their gambling and offer information and advice. It is important to acknowledge that little evidence about the nature of support within Tier 1 and 2 is documented. Notes that do exist are often brief, unspecific and vague. For example, reports like 'discussed gambling-related harm with the client', make it impossible to determine the nature of client needs, support provided and its outcomes. As a result, there is virtually no evidence of improved outcomes for clients, intensified by the fact that, due to the nature of their engagement with the service, for the vast majority of such clients, the formal evaluation tools adopted by the project team (such as PGSI or Core-10 scores) are either not used at all or only used at the assessment stage.

**Figure 6: Service outcomes for Tier 1 and 2 customers**

Source: Tier 1 and 2 customer records, clients who engaged with the service beyond referral, base 32.




Our analysis of Tier 1 and 2 client records also suggests that when working with these customers the project team might be focusing too much on trying to formalise their engagement with these

customers to offer them greater support and evaluate it. This potentially results in missing opportunities for offering high-quality informal, light-touch support to clients and capturing evidence about it. The team should ensure that brief interventions are seen as stand-alone support routes and are monitored accordingly. For example, this might take form of a few feedback questions at the end of a call to the project helpline or an informal meeting, or a very short follow-up survey to customers who agree to be contacted. The questions should focus on capturing customer feedback about the extent to which the support and information was helpful. It is unrealistic to expect behaviour change in the context of providing customers with information and signposting and the project should not be judged for not achieving this. At the same time, lack of concrete evidence about the nature of harm experienced by the customers who access informal support, the exact nature of that support and how it benefits them, is unhelpful and needs to be addressed.

## Tier 3-4 client outcomes

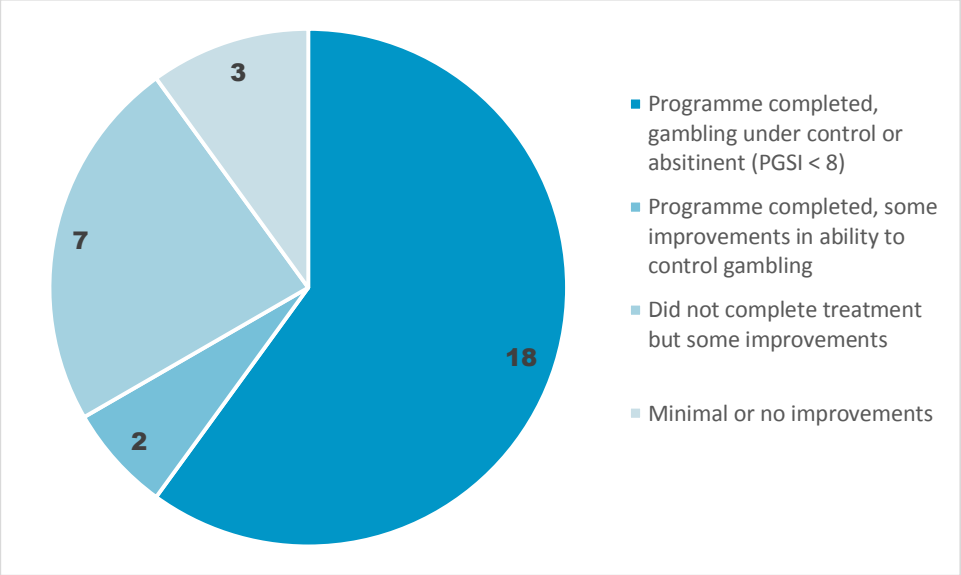
A considerably greater range and volume of evidence was available for clients who engage with the service more formally, i.e. Tier 3 and 4. The main emphasis was on supporting customers to gain control over their gambling behaviour and on attending to their emotional and mental health and wellbeing.

### Clients' ability to control their gambling

Evidence about distance travelled with regards to their ability to successfully manage their gambling behaviour, including being abstinent from gambling, was available for 30 Tier 3-4 clients. The vast majority (27 out of 30 clients) considerably improved their ability to successfully manage their gambling behaviour, assessed by PGSI, regardless of whether they completed their treatment or not.

**Figure 7: Overview of impact on gambling behaviour for Tier 3-4 clients**

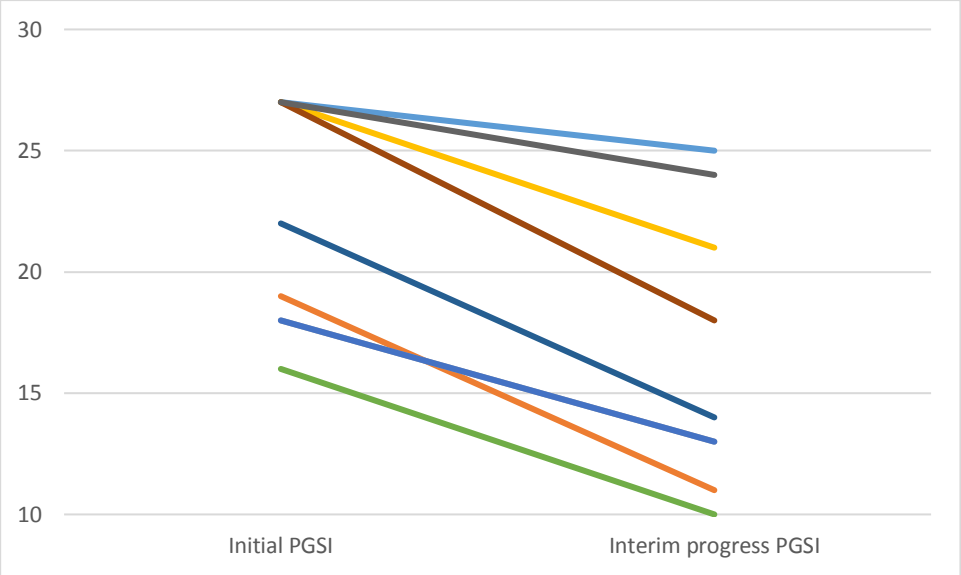
Source: Tier 3 and 4 customer records, clients for whom initial, interim and if relevant end-of-treatment PGSI scores were available, base 30.




Improvement was slightly less for those who did not complete their treatment by the time of analysis and reporting. Some of these customers were continuing their treatment, some moved out of the area and were unable to continue, others disengaged. In several instances those who disengaged reported that their gambling was under control, even though this was not captured via PGSI assessments.

**Figure 8: Improvement in PGSI scores for Tier 3-4 clients who did not complete treatment[9]**

Source: Tier 3 and 4 customer records; PGSI assessment scores, base 9.




NB: For two clients their PGSI scores improved from 18 to 13, so these lines overlapped on the chart.

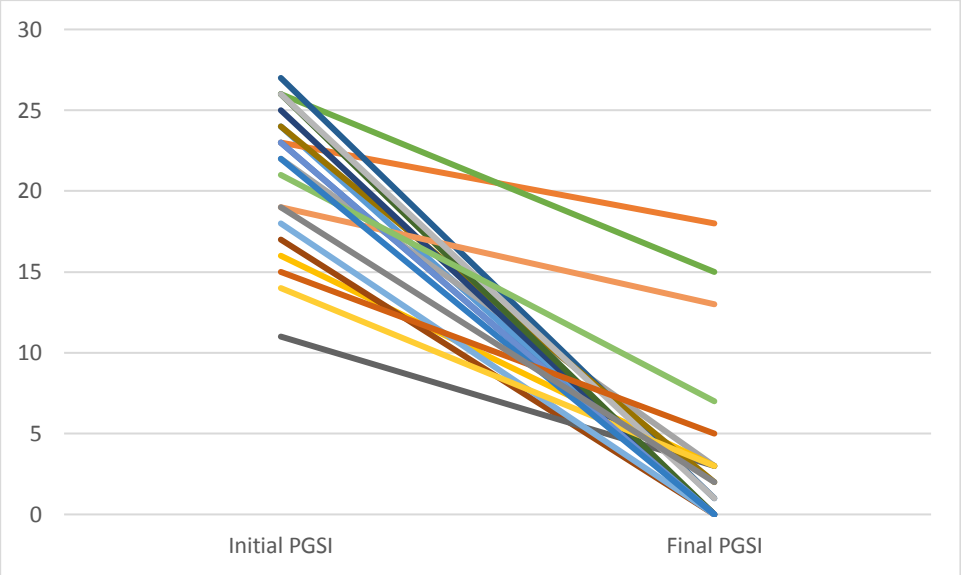
On average client PGSI scores improved by approximately 6 points. Nonetheless, none of these customers scored below eight points on the PGSI scale, which is considered a borderline for identifying problem gamblers.

The situation was very different for those Tier 3 and 4 customers who had *completed* their treatment for problem gambling. These customers make impressive progress, PGSI score reductions from ≥ 24 to ≤3 were common. On average, customer PGSI scores improved by 17 points. Importantly, the vast majority (18 out of 22) of the clients who completed Tier 3-4 treatment also scored below eight points on the PGSI score, suggesting that they were able to gain control over their gambling behaviour. Most of these customers became abstinent, the remainder continued to gamble within limits that they and those around them considered appropriate and manageable. For the clients who accessed the service at the very beginning of the project, there was evidence that these positive outcomes were sustained over a period of several months.

[9] These were the following customers: ABB19, ABB23, ABB28, ABB38, ABB40, ABB41, ABB46, ABB48, ABB63.

**Figure 9: Improvement in PGSI scores for Tier 3-4 clients who completed treatment[10]**

Source: Tier 3 and 4 customer records; PGSI assessment scores, base 21.




Recent changes to the evaluation processes also provide additional evidence about clients' ability to control their gambling.

Overall, the evidence about the impact in this area for Tier 3 and 4 clients was strong and highly positive for the majority of the clients.

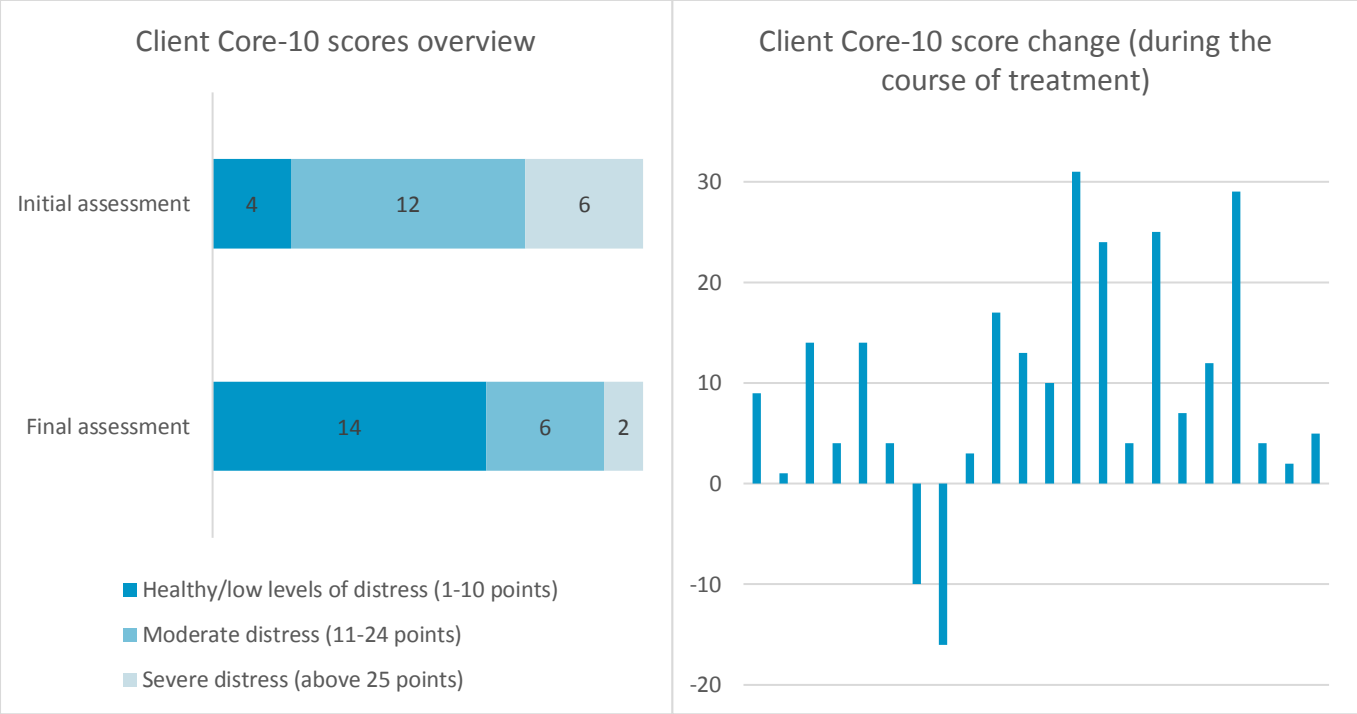
## Improvements in client emotional and mental health and wellbeing

For most Tier 3 and 4 clients, assessments of the emotional and mental state of their clients was performed at multiple points during their engagement with the service, using Core-10 scores. Analysis of the data captured through these assessments reveals a positive picture overall (See Figure 10).

[10] These were the following customers: ABB2, ABB7, ABB10, ABB12, ABB14, ABB16, ABB20, ABB21, ABB22, ABB35, ABB37, ABB39, ABB42, ABB43, ABB45, ABB47, ABB49, ABB54, ABB55, ABB58, ABB68.

**Figure 10: Change in client Core10 scores during the course of treatment (Tier 3-4 clients)[11]**

Source: Tier 3 and 4 customer records; Core 10 assessment scores, base 22.




During the course of their treatment, the signs of anxiety and depression, thoughts of self-harm and other negative manifestations have considerably diminished for the majority of the clients. This is particularly impressive given the complex nature of many clients' needs, ranging from prior mental and physical health conditions to co-morbidity issues.

The project team and the evidence they have collected were clear that sometimes client paths to success can be far from easy and straight. There were for example instances when abstinence from gambling achieved through the treatment or other events taking place in clients' lives during its

**Client case study 3**

The client is a train driver, doesn't use drugs or alcohol. When he approached the service, he stated that he had good income but spent half his salary on gambling. His partner of 31 years did not know about the extent of the debts that he had due to gambling. He said that he was tired of lying, cheating and hiding.

The client has responded positively to mentoring treatment and became abstinent. At this stage, the project team picked up that his core-10 scores remained high and he was offered counselling to help him with issues around confidence and emotional stability. He had to take some time off work and was treated for depression. He continued to be supported as Tier 4 client until he was able to return to work and his emotional and mental state had sufficiently improved.

[11] These were the following customers: ABB2, ABB7, ABB10, ABB12, ABB14, ABB16, ABB19, ABB23, ABB28, ABB35, ABB38, ABB39, ABB42, ABB45, ABB46, ABB47, ABB48, ABB54, ABB55, ABB58, ABB67, ABB68.

period, led to low mood, signs of depression and other mental health issues. The team's attention to addressing such problems, despite gambling being no longer problematic, was noticeable in a number of instances and shows their commitment to seeing their clients' health and wellbeing as a priority for the approach. These efforts also made sure that their achievements around helping clients control their gambling behaviour were sustained, i.e. there were no relapses.

### Improvements in other aspects of customers' lives

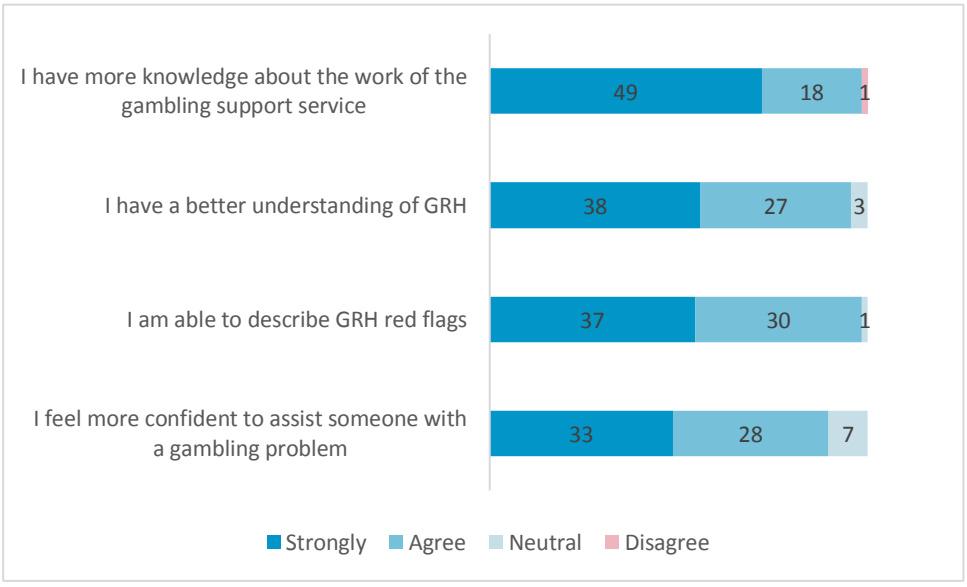
There was extensive evidence about improvements to other aspects of clients' lives and wellbeing (including their physical health, financial wellbeing, employment, relationships, etc.) as a result of them engaging with the service at Tier 3 and 4. However, these were not systematically recorded and were only occasionally visible in notes for individual client as well as being prominent in the interview data. To a significant extent, this can be explained by the fact that client needs are all different and so are the benefits that they gain from the service. Going forward, it is however, important to put in place a system that systematically captures such additional benefits for clients as without it the picture of the overall impact of the service is incomplete.

## Industry and partner organisations and their staff

Available evidence suggests that the workshops and awareness raising events delivered by the project team were very beneficial to people working in the gambling industry and partner organisations staff who attended them.

**Figure 11: Learning and development benefits for the workshop participants**

Source: BetKnowMore workshop evaluation forms, where responses to the outcomes questions were provided, base 68



Many participants and their managers commented that the workshops improved staff ability to deliver good customer service, by spotting those who were experiencing harm from their gambling or were at risk of doing so.

All industry representatives involved in this research and the LBO staff who left their feedback about the workshops, stated that the training was helpful in deepening their understanding of gambling-related harm and how to minimise it in their shops. Many of them had previous training around these issues yet they found the training, its vivid real-life examples of harm in particular, 'eye-opening'.

Industry representatives spoke above their members of staff's improved ability to handle potentially challenging conversations with their customers correctly, 'using the right terminology, so that [they] are not for example inadvertently using words that may offend somebody'. At the same time, they stressed that there needs to be a support service that their staff can refer customers to.

> *There is a need for BKM and there is a need for more BKM. We are not experts. We are told by the experts about the types of behaviour we should look out for but essentially, we are only a conduit between those who look like they might need help and those who can help. We can never be anything more than that because we are not experts, not clinicians.*
>
> **Head of Retail Compliance, major betting shop operator**

Overall, raising awareness of gambling-related harm amongst various organisations and individuals in the local area was reported by the interviewed stakeholders as one of the main outcomes of the project. Stakeholders commented that the project enabled them to move beyond 'newspaper headlines', to develop a clearer understanding of gambling-related harm and how the industry is trying to tackle it.

> *There's been a lot of obviously controversy around betting shops, and a lot of our local authorities, our councillors had concerns with those. The project [helped us] get an insight from the people that are actually dealing with the problem gamblers to get behind the headlines… We get very little if any people approaching us [about support around gambling] … Gambling problems are very much under reported and under the radar. What we're trying to do is get behind that to see to what extent gambling harm is prevalent in Islington, which is the 4th or 5th most deprived borough in London.*
>
> **Local authority licencing team, senior member of staff**

# 6 CONCLUSIONS: SCALING UP CONSIDERATIONS

Whilst the number of people with problem gambling in our society might be relatively small, some studies[12] suggest it can cause as much harm to people and their wellbeing as substance and alcohol abuse. Yet, few people who experience gambling-related harm access help and support[13] to help minimise harm to them and those around them. In this context, there is clearly a need for a service that can reach more people affected by gambling-related harm and help them minimise it.

There is also a need for the type of service offered by the project within the gambling industry. There is a growing understanding that betting shop operators' success as businesses is more sustainable when their customers gamble responsibly, and that bookmakers have to share the responsibility of spotting and helping their customers who might be at risk. Our evidence suggests, that despite the support available to them within their organisations, frontline staff benefit from the additional inputs that the training offered through the project offers them, enabling them to better spot customers at risk. At the same time, the industry representatives recognised that their staff's ability to help customers at risk after they spotted them was limited. They appreciated the value of having a fast-response local support service that people can be referred to.

DGWH therefore offers a valuable service for which there is a need.

Evidence gathered and analysed for the purposes of this evaluation indicates that many core elements of the service, such as referral processes and work with partner and industry organisations, the training for LBO staff and structured support to customers (Tier 3 and 4) are highly effective. Evidence about the effectiveness of more informal support (Tier 1 and 2) is currently limited. The project monitoring and evaluation systems and possibly the approach of working with Tier 1 and 2 customers need to be refined to rectify that. Taken as a whole, the approach appears to be working in addressing the needs of clients at risk of gambling-related harm and the gambling industry.

[12] E.g. Wardle, H., Seabury, C., Ahmed, H., Payne, C., Byron, C., Corbett, J. & Sutton, R. (2014). Gambling behaviour in England and Scotland: Findings from the Health Survey for England 2012 and Scottish Health Survey 2012. London: NatCen.

[13] E.g. Browne, M., Bellringer, M., Greer, N., Kolandai-Matchett, K., Rawat, V., Langham, E., Rockloff, M., Palmer du Preez, K., & Abbott, M. (2017). Measuring the burden of gambling harm in New Zealand.

In this context, scaling the project up appears an obvious next step. We see two possible routes here.

- Trying to scale up the project in exactly the same form as it currently operates poses questions about the team's capacity and resourcing of the work. There was a lot of evidence that many of the project strengths are tightly linked with its core team, their personal experiences, their skills and expertise and their attitude to customers. There is currently no evidence that would suggest that rapidly increasing the size of the team is possible without compromising the quality of the service. This would need careful planning and checks when being implemented. Equally, project resourcing would need careful thought, as the project costs associated with moving into new geographical area are likely to be higher than working locally.
- Adapting the service in ways that would address questions about the project capacity and resourcing is certainly possible and is something that the project team is keen to consider. However, any adaptations to the key elements to the project approach need to be informed by evidence and such process-related evidence is currently limited. For example, based on the available evidence we cannot say whether increasing the prominence of remote support as a way of helping customers is likely to be as effective in securing outcomes for customers as meetings with them. It will be important to test new elements of the service with customers and to strengthen process-related evidence base for the project prior to scaling up an adapted service.

Taking all of the above into account, we recommend starting the process of scaling up the service by focusing on developing the team capacity, scoping and partnership building in any prospective new areas. The latter emerged to be an important factor for the successful operation of the project. This would also give the team some time to test any adaptations to the service with customers in Islington and gather the additional evidence they need to inform the development and growth of the project.

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