AGENDA

Meeting: Health Committee

Date: Wednesday 13 March 2024

Time: 2.00 pm

Place: Chamber, City Hall, Kamal Chunchie Way, London, E16 1ZE

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Members of the Committee

Dr Onkar Sahota AM (Chair)

Caroline Russell AM (Deputy Chair)

Emma Best AM

Andrew Boff AM

Krupesh Hirani AM

A meeting of the Committee has been called by the Chair of the Committee to deal with the business listed below.

Proper Officer: Mary Harpley, Chief Officer
Tuesday 5 March 2024

Further Information

If you have questions, would like further information about the meeting or require special facilities please contact: Diane Richards, Committee Officer; Email: diane.richards@london.gov.uk. For media enquiries please contact: Anthony Smyth, Communications Officer;
Email: anthony.smyth@london.gov.uk. If you have any questions about individual items please contact the author whose details are at the end of the report. If you have a public enquiry please contact the City Hall Public Liaison Unit on 020 7983 4000.

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Certificate Number: FS 80233

Agenda
Health Committee
Wednesday 13 March 2024

1 Apologies for Absence and Chair's Announcements

To receive any apologies for absence and any announcements from the Chair.

2 Declarations of Interests (Pages 1 - 4)

Report of the Executive Director of Assembly Secretariat

Contact: Diane Richards, diane.richards@london.gov.uk

The Committee is recommended to:

(a) Note the list of offices held by Assembly Members, as set out in the table at Agenda Item 2, as disclosable pecuniary interests;

(b) Note the declaration by any Member(s) of any disclosable pecuniary interests in specific items listed on the agenda and the necessary action taken by the Member(s) regarding withdrawal following such declaration(s); and

(c) Note the declaration by any Member(s) of any other interests deemed to be relevant (including any interests arising from gifts and hospitality received which are not at the time of the meeting reflected on the Authority's register of gifts and hospitality, and noting also the advice from the GLA's Monitoring Officer set out at Agenda Item 2) and to note any necessary action taken by the Member(s) following such declaration(s).

3 Minutes (Pages 5 - 44)

The Committee is recommended to confirm the minutes of the meeting held on 1 February 2024 to be signed by the Chair as a correct record.

4 Summary List of Actions (Pages 45 - 54)

Report of the Executive Director of Assembly Secretariat

Contact: Diane Richards, diane.richards@london.gov.uk

The Committee is recommended to note the completed, closed and outstanding actions arising from its previous meetings.

5 Action Taken Under Delegated Authority (Pages 55 - 120)

Report of the Executive Director of Assembly Secretariat

Contact: Diane Richards, diane.richards@london.gov.uk

The Committee is recommended to note the recent action taken by the Chair under delegated authority, in consultation with party Group Lead Members, namely to agree the report on eating disorders, as attached at Appendix 1.

6 Responses to Committee Outputs (Pages 121 - 126)

Report of the Executive Director of Assembly Secretariat

Contact: Diane Richards, diane.richards@london.gov.uk

The Committee is recommended to note the response from the Mayor of London to the Committee's letter on trauma-informed approaches to youth violence, as attached at Appendix 1.

7 Question and Answer Session with the GLA Health Team (Pages 127 - 130)

Report of the Executive Director of Assembly Secretariat

Contact: Tim Gallagher, tim.gallagher@london.gov.uk

The Committee is recommended to:

(a) Note the report as background to putting questions to invited guests and note the subsequent discussion; and

(b) Delegate authority to the Chair, in consultation with party Group Lead Members, to agree any output arising from the discussion.

8 Date of Next Meeting

The London Assembly's Annual Meeting, due to take place in May 2024, will decide which committees to establish for the 2024/25 Assembly Year and a timetable of meetings for those committees.

9 Any Other Business the Chair Considers Urgent

GREATERLONDONAUTHORITY LONDONASSEMBLY

Subject: Declarations of Interests

Report to:	**Health Committee**
Report of:	**Executive Director of Assembly Secretariat**
Date:	**13 March 2024**
Public Access:	**This report will be considered in public**

1. Summary

1.1 This report sets out details of offices held by Assembly Members for noting as disclosable pecuniary interests and requires additional relevant declarations relating to disclosable pecuniary interests, and gifts and hospitality to be made.

2. Recommendations

2.1 **That the list of offices held by Assembly Members, as set out in the table below, be noted as disclosable pecuniary interests;**

2.2 **That the declaration by any Member(s) of any disclosable pecuniary interests in specific items listed on the agenda and the necessary action taken by the Member(s) regarding withdrawal following such declaration(s) be noted; and**

2.3 **That the declaration by any Member(s) of any other interests deemed to be relevant (including any interests arising from gifts and hospitality received which are not at the time of the meeting reflected on the Authority's register of gifts and hospitality, and noting also the advice from the GLA's Monitoring Officer set out at below) and any necessary action taken by the Member(s) following such declaration(s) be noted.**

3. Issues for Consideration

3.1 The Monitoring Officer advises that: Paragraph 10 of the Code of Conduct will only preclude a Member from participating in any matter to be considered or being considered at, for example, a meeting of the Assembly, where the Member has a direct Disclosable Pecuniary Interest in that particular matter. The effect of this is that the 'matter to be considered, or being considered' must be about the Member's interest. So, by way of example, if an Assembly Member is also a councillor

of London Borough X, that Assembly Member will be precluded from participating in an Assembly meeting where the Assembly is to consider a matter about the Member's role / employment as a councillor of London Borough X; the Member will not be precluded from participating in a meeting where the Assembly is to consider a matter about an activity or decision of London Borough X.

3.2 Relevant offices held by Assembly Members are listed in the table below:

Assembly Member Interests

Member	**Interest**
Marina Ahmad AM	
Lord Bailey of Paddington AM	Member, House of Lords
Elly Baker AM	
Siân Berry AM	
Emma Best AM	Member, London Borough of Waltham Forest
Andrew Boff AM	Congress of Local and Regional Authorities (Council of Europe)
Hina Bokhari AM	Member, London Borough of Merton
Anne Clarke AM	Member, London Borough of Barnet
Léonie Cooper AM	Member, London Borough of Wandsworth
Unmesh Desai AM	
Tony Devenish AM	Member, City of Westminster
Len Duvall AM	
Peter Fortune AM	
Neil Garratt AM	Member, London Borough of Sutton
Susan Hall AM	Member, London Borough of Harrow
Krupesh Hirani AM	
Joanne McCartney AM	Deputy Mayor
Sem Moema AM	Member, London Borough of Hackney
Caroline Pidgeon MBE AM	
Zack Polanski AM	
Keith Prince AM	Member, London Borough of Havering
Nick Rogers AM	
Caroline Russell AM	Member, London Borough of Islington
Dr Onkar Sahota AM	Congress of Local and Regional Authorities (Council of Europe)
Sakina Sheikh AM	Member, London Borough of Lewisham

3.3 Paragraph 10 of the GLA's Code of Conduct, which reflects the relevant provisions of the Localism Act 2011, provides that:

- where an Assembly Member has a Disclosable Pecuniary Interest in any matter to be considered or being considered or at

  (i) a meeting of the Assembly and any of its committees or sub-committees; or

  (ii) any formal meeting held by the Mayor in connection with the exercise of the Authority's functions

- they must disclose that interest to the meeting (or, if it is a sensitive interest, disclose the fact that they have a sensitive interest to the meeting); and

- must not (i) participate, or participate any further, in any discussion of the matter at the meeting; or (ii) participate in any vote, or further vote, taken on the matter at the meeting

UNLESS

- they have obtained a dispensation from the GLA's Monitoring Officer (in accordance with section 2 of the Procedure for registration and declarations of interests, gifts and hospitality – Appendix 5 to the Code).

3.3 Failure to comply with the above requirements, without reasonable excuse, is a criminal offence; as is knowingly or recklessly providing information about your interests that is false or misleading.

3.4 In addition, the Monitoring Officer has advised Assembly Members to continue to apply the test that was previously applied to help determine whether a pecuniary / prejudicial interest was arising - namely, that Members rely on a reasonable estimation of whether a member of the public, with knowledge of the relevant facts, could, with justification, regard the matter as so significant that it would be likely to prejudice the Member's judgement of the public interest.

3.5 Members should then exercise their judgement as to whether or not, in view of their interests and the interests of others close to them, they should participate in any given discussions and/or decisions business of within and by the GLA. It remains the responsibility of individual Members to make further declarations about their actual or apparent interests at formal meetings noting also that a Member's failure to disclose relevant interest(s) has become a potential criminal offence.

3.6 Members are also required, where considering a matter which relates to or is likely to affect a person from whom they have received a gift or hospitality with an estimated value of at least £50 within the previous three years or from the date of election to the London Assembly, whichever is the later, to disclose the existence and nature of that interest at any meeting of the Authority which they attend at which that business is considered.

3.7 The obligation to declare any gift or hospitality at a meeting is discharged, subject to the proviso set out below, by registering gifts and hospitality received on the Authority's on-line database. The gifts and hospitality database may be viewed online.

3.8 If any gift or hospitality received by a Member is not set out on the online database at the time of the meeting, and under consideration is a matter which relates to or is likely to affect a person from whom a Member has received a gift or hospitality with an estimated value of at least £50, Members are asked to disclose these at the meeting, either at the declarations of interest agenda item or when the interest becomes apparent.

3.9 It is for Members to decide, in light of the particular circumstances, whether their receipt of a gift or hospitality, could, on a reasonable estimation of a member of the public with knowledge of the relevant facts, with justification, be regarded as so significant that it would be likely to prejudice the Member's judgement of the public interest. Where receipt of a gift or hospitality could be so regarded, the Member must exercise their judgement as to whether or not, they should participate in any given discussions and/or decisions business of within and by the GLA.

4. Legal Implications

4.1 The legal implications are as set out in the body of this report.

5. Financial Implications

5.1 There are no financial implications arising directly from this report.

List of appendices to this report:

None

Local Government (Access to Information) Act 1985

List of Background Papers: None

Contact Information

Contact Officer:	Diane Richards, Committee Officer
E-mail:	diane.richards@london.gov.uk

MINUTES

Meeting: Health Committee

Date: Thursday 1 February 2024

Time: 10.00 am

Place: Chamber, City Hall, Kamal Chunchie Way, London, E16 1ZE

Copies of the minutes may be found at:
www.london.gov.uk/about-us/london-assembly/london-assembly-committees

Present:
Dr Onkar Sahota AM (Chair)
Caroline Russell AM (Deputy Chair)
Emma Best AM
Andrew Boff AM
Krupesh Hirani AM

1 Apologies for Absence and Chair's Announcements (Item 1)

1.1 There were no apologies for absence.

2 Declarations of Interests (Item 2)

2.1 The Committee received the report of the Executive Director of Secretariat.

2.2 **Resolved:**

That the list of offices held by Assembly Members, as set out in the table at Agenda Item 2, be noted as disclosable pecuniary interests.

3 Minutes (Item 3)

3.1 **Resolved:**

That the minutes of the meeting held on 29 November 2023 be signed by the Chair as a correct record.

4 Summary List of Actions (Item 4)

4.1 The Committee received the report of the Executive Director of Assembly Secretariat.

4.2 **Resolved:**

That the completed and outstanding actions arising from previous meetings be noted.

5 Action Taken Under Delegated Authority (Item 5)

5.1 The Committee received the report of the Executive Director of Assembly Secretariat.

5.2 **Resolved:**

That the recent action taken by the Chair under delegated authority in consultation with party Group Lead Members be noted, namely to agree the Committee's letter to the Mayor of London on trauma-informed approaches to youth violence, as attached at Appendix 1 of the agenda report.

6 Health Impacts of Gambling in London (Item 6)

6.1 The Committee received the report of the Executive Director of Assembly Secretariat as background to putting questions to the following invited guests with lived experience of gambling harm:

- Tom Fleming, Communications Manager, Gambling with Lives;
- Dean Frost;
- Tracey O'Shaughnessy; and
- Colin Walsh, Lived Experience Manager, GamCare.

6.2 A transcript of the discussion is attached at **Appendix 1**.

6.3 During the course of the discussion, the Communications Manager, Gambling with Lives, agreed to:

- Supply relevant data regarding women experiencing, and seeking help for, gambling addiction; and
- Share data regarding the impact of the advertising ban on levels of gambling harm in Norway.

6.4 **Resolved:**

(a) That the report and discussion be noted.

(b) That authority be delegated to the Chair, in consultation with party Group Lead Members, to agree any output arising from the discussion.

7 Health Committee Work Programme (Item 7)

7.1 The Committee received the report of the Executive Director of Assembly Secretariat.

7.2 **Resolved:**

That the work programme be noted.

8 Date of Next Meeting (Item 8)

8.1 The next meeting of the Committee was scheduled for 13 March 2024 at 2.00pm in Committee Rooms 2&3, City Hall.

9 Any Other Business the Chair Considers Urgent (Item 9)

9.1 There were no items of business that the Chair considered to be urgent.

10 Close of Meeting

10.1 The meeting ended at 12.31pm.

Chair Date

Contact Officer: Diane Richards, Committee Officer; Email: diane.richards@london.gov.uk

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London Assembly Health Committee – 1 February 2024

Transcript of Agenda Item 6 – Health Impacts of Gambling in London

[During the course of the meeting, the Chair, Dr Onkar Sahota AM noted that some of the content may be triggering for listeners and urged anyone who may be affected to seek help, for instance through the Samaritans.]

Dr Onkar Sahota AM (Chair): That brings us to today's main item. I would like to extend a warm welcome to our panel of guests joining us to discuss the health impacts of gambling in London. Now I am going to ask the guests to introduce themselves and I will start with you, Colin.

Colin Walsh (Lived Experience Manager, GamCare): Thank you. Hi, everybody. I am Colin Walsh I have my own experience of gambling harm and recovery, and I am also Lived Experience Manager at GamCare who delivers support and treatment across greater London area and operate the National Gambling Helpline.

Dr Onkar Sahota AM (Chair): Thank you. Tracy.

Tracy O'Shaughnessy: Hi, my name is Tracy, and I am an 'affected other'. I support other women like myself through peer support with GamFam, as well as 'affected others' that have been impacted by crime through GamLEARN and I also work with women with thrivin' together, which is a space for women run by women impacted by gambling harm.

Dr Onkar Sahota AM (Chair): Thank you. Dean.

Dean Frost: My name is Dean Frost, a London cab driver by trade, and a recovering compulsive gambler. I have not had a bet for seven and a half years. I am a regular attendee of Gamblers Anonymous (GA), and I also work for a charity called GamFam. We provide support and help for people that are struggling with gambling. That includes the gambler, and it includes the 'affected others', i.e. mums, dads, husbands, and wives. Currently, we run about 18 meetings a week and hopefully growing. We provide support and hopefully help people overcome their addiction.

Dr Onkar Sahota AM (Chair): Thank you. Tom.

Tom Fleming (Communications Manager, Gambling with Lives): Hi, my name is Tom. I have my own lived experience of gambling harm and I am also the communications manager for a charity called Gambling with Lives that was set up by families bereaved by gambling-related suicide. We now support families bereaved by gambling-related suicide. Thank you.

Dr Onkar Sahota AM (Chair): Thank you to all of you for coming along and contributing to our investigation. Each Assembly Member will have a lead off question and other Assembly Members will come in if something comes to their mind or they want some clarification. This is more like a conversation; we want to get knowledge from you and learn from your experiences and your experiences of the people you are helping to overcome the gambling addiction. Can I start off, can you please tell us about your own experiences of gambling harms and how this impacted on you and those close to you? Any one of you can start.

Tom Fleming (Communications Manager, Gambling with Lives): I am happy to go first.

Dr Onkar Sahota AM (Chair): OK, Tom, thank you.

Tom Fleming (Communications Manager, Gambling with Lives): My experience of gambling harm was direct, it was from my own experiences of gambling. It was always through football. I was probably 17 when I placed my first bet, but it was not a case for me of instant addiction and I did not really see it as a problem then. The problem really probably started in my mid to early 20s I would say. I had recently moved to London, and I was in quite a low-paying job, therefore I was spending a lot of time at home, and I was thinking about ways that I could potentially make money. I was watching a lot of football, always been a really avid football fan, still am, and there is obviously a lot of gambling advertising and football sponsorship on the shirts, around the stadiums, adverts at half time and things like that.

I started to think that it would be a reasonable way to supplement my income because I did not have a great deal of money to go out therefore friends were going out on weekends, and I was probably spending a lot of time at home. There is probably five to six televised games of football on at the weekend, money was the motivation for starting, but it ended up taking so much more from me. Over a period of about two, two and a half years it just intensified. Things started to fall apart in other areas of my life, work, friendships, relationships, and it took me to a really, really bad place, to the point where I just could not stop. I am quite a well-rounded, sensible individual. I am not vulnerable in any sense of the word I would say. I have not had addiction issues in the past, but I just could not stop this. I remember feeling terrible because of all the messages and things that you see out there on the adverts about, "When the fun stops, stop" or "Take time to think".

Therefore, I thought, "Why me? Why am I the only person that cannot stop? Everybody else is having a great time and they can control it, but I cannot." Therefore, it took me to a really bad place mentally. I did not lose a huge amount of money. I do not know but it was definitely not life-changing, it was probably under £10,000, therefore, enough to be able to pay off and it was on credit cards at the time. But the damage it did to me was really to my mental health, as I said, it just took me to a really dark and miserable place, to be honest, because I blamed myself because I could not stop, and I did not realise that the gambling is a really addictive thing and there is a lot of things that the gambling industry do that get you addicted and keep you addicted. I did not realise all that at the time. I do now.

I just could not stop. I tried. I went to see a doctor, they diagnosed me with depression, which I now think definitely came about as a result of the gambling, but they saw it the other way around. They saw it as I was anxious and depressed, so I took to gambling as a means to escape that, however I have never been anxious or depressed before that or since that. It took me to a really bad place. Fortunately, my rock bottom was that I would say it was bad and it was bad, but there is up to 496 gambling-related suicides a year, thankfully it did not take me there, but it did take me to a really bad place.

Thankfully, I was able to stop in the end. I used a tool called GAMSTOP, which is an overarching self-exclusion tool. You can self-exclude with individual operators, but, because there are so many of them, I would go through a process of, after a weekend of gambling, basically feeling awful on a Sunday night and thinking I am never going to do this again, I am going to block myself with one, and then Tuesday, Wednesday comes about and it is like, OK, I am going to open an account with this other one and I am not blocked with that. But then I found GAMSTOP, which is a tool that just applies to all licenced gambling operators in the UK and I had a bit of therapy at the time that was not gambling related, but that was a good place to discuss it. As I said, the general practitioner (GP) was not much help, but I was able to stop and sustain my recovery since then and here I am today.

Dr Onkar Sahota AM (Chair): First of all, Tom, thank you very much for that very powerful personal testimony. I just want to say to any listeners who are who are listening that we may be discussing topics of suicide, and if anyone finds any topics triggering then help is available 24 hours through agencies like the Samaritans. I just want to highlight this to any listeners who are listening.

Tom, I just want to know, what made you go to a GP, was it yourself taking yourself to a GP, or was it members of your family intervening and encouraging you to do so? What was the trigger for you to go to a GP?

Tom Fleming (Communications Manager, Gambling with Lives): It was myself. Members of my family and friends, and my partner at the time, did not know that I was gambling to the extent that I was. People knew that I would like a bet, a bit of a cliched phrase, but they did not know the extent. You see, just going back to the advertising, it is always like a fun social activity, but for me it was sitting in the toilet at work and doing it or it was not nice, it was not fun. Therefore, I went to the doctor essentially because I was not sleeping, and I felt really depressed. I did have fleeting thoughts about suicide and things like that, therefore I thought it was the best course of action to go and see a doctor and see if there was anything they could do for me.

Dr Onkar Sahota AM (Chair): That is very useful is that you had insight into something was wrong in your own self that you needed to get help and you sought the help, so that was an important thing that you had the insight into your own issues. Thank you. It is good opportunity to bring in other guests. Dean.

Dean Frost: Please pause me because I can talk about gambling and recovery and addiction for ages. It is the only thing I know. If someone asked me to come and talk for three or four hours about addiction, gambling addiction, the power of addiction, and recovery, I could talk about it for hours, therefore please pause me and stop me if I go on for too long.

I started gambling when I was a kid, not compulsively, but I was more attracted to the fruit machines as a young boy. Brought up in caravan sites and holiday homes at the weekend. Other kids would go off to play computer games, I would be attracted to fruit machines. It probably should have been a warning then, but my gambling really took off about a year before I became a London cab driver. I had a big win, I had a win on a horse called the Touch of Frost, it won at 33 to one for a fiver and I am thinking, "When I become a cab driver, I am going to take these betting shops to the cleaners, and I can make this a career". How wrong did I get that. Two years into being a cab driver, I was in and out of betting shops all day long, every day. I was robbing Peter to pay Paul, taking loans out, lying to my partner, lying to my mum and dad, lying to friends. If friends were asking me to come out at the weekend, especially when I was in my 20s, when I was full of life, "Do you want to come out?" I would say, "I will be out" and come Saturday I would not be out, I would have no money, I would be in the cab working to try to fund and finance my gambling.

My gambling was all done in betting shops, horses and dogs, maybe occasionally football. I did not really enjoy football betting because it took too long for me to get the result. I wanted the result within five minutes or two or three minutes. However, I do understand, I can see now the power of football betting today because it is 'in play', the way that they have designed it to suck people in, to be involved in the game in that very moment. Rather than back in 20 years ago you would have a bet on a football game, you could only find out whether you had won or lost at the very end. Today, the gambling companies through the phone are pulling people in to play 'in play'. Thankfully I stopped seven years ago, I did not get involved in downloading anything on my phone, I have never done really any online gambling. Mine was done in betting shops, but the space I work in today is for a charity GamFam. I did a poll last night and 14 out of 15 it was all online betting; therefore, we are seeing the change.

As a London cab driver, I drive around London, I am seeing betting shops close, but that does not mean it is a good thing, it just means that everything has gone online. The only thing I have seen an increase is in the slot machine arcades that are open 24/7. They have started to increase in London, but betting shops not. As I say, and I will finish on this, I can talk forever. I have just sat on the Docklands Light Railway (DLR), I have just sat on the Elizabeth line from where I live. I have sat in a compartment, eight out of 10 people in my compartment were on their phone. The next I got on DLR, and I looked at the next eight people, six out of eight were on their phone. I am not saying everyone is gambling, but obviously there is a problem with the enticement of commercialism, advertising, gambling, shopping, no one is putting cash over the counter anymore and that is what we are seeing is an increase in gambling because of the phone. They do not have to go to a casino, do not have to go to a betting shop. I am meeting people along the way that are laying under their covers and gambling, do not even get out of the house, they do not even have to walk down the street to place a bet, but I am talking about others now.

I have stopped for seven years. I lied to my wife. When I used to walk indoors, my wife would go to me, "How has your day been?" I used to think, "If only you knew." I had been at a betting shop for eight hours, 10 hours. "How has your day been?" The devastation, I probably still feel it now, there is still a disconnect from me and my partner, or she would occasionally remind me. We are on a better path now and we have a good relationship, we have a bit of banter and a bit of a laugh about it, but every day I gambled was a millimetre away from my wife. If I gambled for 10 days, 20 days, that gap between me and my wife got greater. Recovery hopefully brings us back. The devastation is relationships, finances, numb, do not even feel. A big part of it, I was talking on a meeting last night, a big reason that people struggle in recovery is dealing with feelings and emotions. The gambling maybe takes us away.

I will finish on this, many people want attachment, I wanted attachment to gambling, it probably took me away from everyday life, living life on life terms. I have learned to live with life-on-life terms and face what comes along, but there is no doubt that the advertising and the power of the industry is probably luring a lot of people back in when they want to remove themselves. It is too powerful. It is devastating and I enjoy working in the space I work in. I work with people at their wits end, but there clearly obviously needs to be more awareness, more education. But I do enjoy what I do working with people, but it is devastating because last night people losing their jobs, in trouble with the law. I took a meeting last night, I see the devastation, the result of where gambling can take people, and the very end is suicide. With that, I have rambled on too long. I call it ramblers anonymous, that is what we call it, Gamblers Anonymous (GA), ramblers anonymous.

Dr Onkar Sahota AM (Chair): Thank you very much for sharing your story. You said, if I got it correct, that it was about seven years ago that you addressed your problems. Was it you going to seek help yourself or was it some member of the family who prompted you?

Dean Frost: Just to let you know, from 2000 to 2017 I struggled on and off. I went to lots of meetings and when I went to meetings, I stopped gambling, when I stopped going to my GA meetings, I went back gambling. It shows that I need to maintain my recovery. This time around my wife, I went indoors after being out of work in the cab for two hours, I walked back indoors, and she said, "What are you doing back already, you only left for work two hours ago?" She saw it in my face, and she said, "You have been gambling again". I went back on my own accord, but really my wife pushed me and said, "If you do not go back to meetings or go and get some support or help, counselling, therapy, this relationship is finished". Therefore, a combination of I did want to stop, but a prompt of, "This relationship is over if you do not take action". Therefore, a bit of both.

Dr Onkar Sahota AM (Chair): Some of the themes you raise, we will explore them in a bit more detail. Some of them we have dropped, but we will pick them up later on. Tracy.

Tracy O'Shaughnessy: Hi, everyone. My journey is slightly different because I am an 'affected other'. I have been an 'affected other' all my life from substance misuse, I lost my sister to heroin addiction six years ago, and my partner has been a gambling addict for 36 years. He has only been in recovery for two and a half I believe. As an 'affected other', life is very isolating. There is a lot of stigma and shame attached to being with an addict, living with an addict, and you are judged by everyone around you, even the people that love you, your friends, your family. You begin to feel quite ostracised, and as a woman particularly - and I support just women; I am not hating on men, I just literally can only go from my own experience - I hear the same stories over and over of women suffering in silence for years. I was that person.

Often women do not reach out for help until they reach a crisis point. My own journey has been one of mental health issues. My mental health suffered massively. I isolated myself. I stopped talking to friends about what was going on in my life because it was just, they cared but there was very much, "Why do you not just leave?" Where am I going, with what money? Because, as you are probably aware, gambling addiction is a money-orientated addiction. You could give a gambler £50,000 and they could do that in a day. If you gave a heroin addict £50,000 and said, "You need to take £50,000 worth of heroin today", that person is going to die. There is the difference. Where am I going? There was nowhere to go.

I found myself very isolated and alone. I could not reach out to anyone. I was afraid I would lose my children. It affected my job. I eventually went to my GP, and I left with antidepressants, which were not particularly helpful. Six months later, I went back, and I was given antipsychotics for post-traumatic stress disorder (PTSD) and was told, "I do not know anything about gambling addiction. If it was a substance misuse, I would probably be able to help you." I support lots of women and I hear these stories every single day. I supported a lady just a couple of weeks ago who, after 18 months of coming to groups and understanding gambling harm and wanting to help her marriage and support her husband moving forward, finally went to the GP for some help and came away with contraceptive pills. She was told, "Now is probably not a good time to have a baby when you live with an addict". That is what us women are up against.

Women in this space are stigmatised. There is that "Why are you with an addict? Think about your children." I talk a lot about domestic abuse and people are quite shocked about that, but domestic abuse and violence is growing among 'affected others' and gambling harm. I would say probably a third of the women that I support are experiencing some form of domestic abuse, coercive abuse, emotional, psychological abuse, and of course financial abuse, and in a lot of cases neglect, because there is no money, there is no food, they are experiencing food poverty, fuel poverty, the list goes on. As I said before, I generally find that - and myself included - I did not reach out until I had a crisis, and that crisis was that my partner committed a crime due to his gambling. There I was again on my own, one wage coming in, trying to juggle everything, the pressures of that are huge.

As an 'affected other' we become everything, we become a housekeeper, we become the earner, we become an accountant, because, as many on the panel will tell you, one of the first things is take control of the finances, reduce the chances of them gambling and relapsing. You are holding that space constantly. This is all on women's shoulders. There needs to be more understanding and support for women affected by gambling harm. My partner is 14 months bet-free, the longest period of his life, and I do not take anything for granted. Each day as it comes. There are strategies in place that we work through together and I hope that, through supporting some women and my journey is their journey, I am no different just because I am in a position of offering that support.

I am also working alongside GamLEARN, who offer support for those who have committed a crime due to their gambling, and I support 'affected others' in that journey. It is isolating and people need to wake up because

mental health crisis, women, literally, I am speaking to people that have had no heating for a week or cannot afford to feed their children, and I am trying to get in contact with food banks and things. Again, social housing, currently social housing does not see gambling harm as a domestic abuse issue. It is not prioritised. I have been told myself, "If it was a substance misuse, we could help you. Gambling, sorry, do not know."

That is just the beginning of the journey, but I really hope that people in this space, because once again I am the only woman here in quite a male-dominated space, and, from my own experience, 'affected others' are very much an afterthought. I understand that the gambler is important, that they need treatment and recovery, but without us often that does not happen because we are the ones holding it together. There needs to be more focus on us and our journeys and the part that we play and there needs to be more help out there for women by women and that that is received properly and supported properly. Ask us what that looks like. Do not just create a space and go, "There you go". As my very learned friend Faye once said, women are not just 'small men'. Thank you.

Dr Onkar Sahota AM (Chair): Thank you, Tracy, for again sharing that very powerful personal experience and how it has impacted upon you. In my other life, I am a GP and therefore I identify with some of the issues from them. Were you able to get help for your partner through your GP? Were you able to get them engaged with that or was that a difficult task?

Tracy O'Shaughnessy: That is not my responsibility; it is his responsibility to want to get well, and for me I had to focus on myself and what I call my own recovery, because I feel I am in recovery. I have been harmed; I have been affected, and therefore my recovery started prior to his. I reached out for help for myself, despite whether he was engaging in recovery or not. I am powerless over his addiction. That is his journey and not mine. If we can be on it together then that is great, and we can support each other through that. It does not always happen. Most of the women that I am supporting currently, their partners are still actively gambling, therefore that is a whole different ball game. But in regards of going to the GP, no, he did not. Not that I am aware of anyway.

Dr Onkar Sahota AM (Chair): OK, thank you. We will pick up some of the issues that you raised in later discussions.

Tracy O'Shaughnessy: Thank you.

Dr Onkar Sahota AM (Chair): Colin?

Colin Walsh (Lived Experience Manager, GamCare): Thank you. Hi, everybody. A bit like Dean mentioned, I will try to keep this a relatively condensed version of my experience of gambling harm, because all of us can probably talk for the full session if we were given the space to. Feel free to ask any questions or if you want me to go into any detail on any more parts of this.

I started gambling in my late teens as I was growing up. I had a fairly normal childhood, if that makes sense, it was normal to me anyway, some exposure to gambling, a bit like Dean, in the arcade at the seaside I was probably a bit more fixated on the opportunities to win money than probably was normal at that age, but I did not feel like I grew up surrounded by gambling harm, but gambling was certainly normalised, as it is in in wider society. I was always intrigued by it. As I got a little bit older, went to university, started working, the time I had, the freedom, the opportunity to gamble increased, access to money increased, and I started to gamble problematically. Looking back now, I did not see it that way at the time, looking back now I had an issue with gambling from a pretty young age, probably late teens, early 20s, but did not do anything about it for quite a long time.

It continued to escalate through early work and early career and my gambling was in-person initially on sports, but then transitioned to online and beyond just sports gambling. It would be initially a bit like Tom mentioned, it might be sports I knew something about, I thought I knew a lot about football or different sports, but then it would go to horses or dogs or anything, sports I did not know anything about. Then online it would go to online casino, online slots. We see how big that is as a market these days. That has grown hugely over recent years and it is a real rabbit hole. I used to spend hours and hours gambling, but I did not realise. I do not know if you have ever been on your phone, looking on social media for 10 minutes and it turns into an hour. Imagine you are spinning wheels or spinning a wheel every 10 seconds, 20 seconds, 30 seconds, that adds up very quickly and the harm really can escalate. It did for me.

My gambling was always hidden, therefore at the time I never saw it as a problem, I did not think I had an issue with gambling, but I never told anybody about it. I never showed it. People knew that I liked to bet a little bit, but I always hid the scale of it, which shows that deep down I clearly knew that it was not right. That is the guilt and the shame and the stigma. I could not see it at the time, it is only now I look back and think that is why I hid it, because it is not right, it is not normal. I talk to my kids now and encourage them to be completely open and tell me what is going on because I know where it can take you.

In my mid to late 20s I had my own business, I did a management buyout, had a business with two other people, 20 staff working for us, pretty successful to the outside world. That gave me more time, more freedom and opportunity, I did not have a boss, more money. To the outside world, I was really successful. I was married, started a family, had a nice house, nice cars, nice holidays, and I guess, like a peacock in some ways, wanted the world to see how successful I was. However, the reality, I was a really different person. A lot of that lifestyle was built on debts, on loans, on credit cards, on overdrafts, and I know that the world has changed, you can no longer gamble on credit cards, but very much you can still live on credit cards. I do not think that stops the issue.

I started to take money from the business to fund my gambling because I was getting more and more desperate to continue, and in the belief, I guess, that a big win would come and sort it all out. There is never a win big enough. My mental health was suffering even though I did not see it at the time. My self-care was not great. I was not really sleeping. It is hard to see it when you are in the midst of the addiction of experiencing gambling harm. It is really when I stopped and looked back with even only a little bit of hindsight, I could see that for a long period of time I do not know how I survived if I am really honest.

I missed years of my kids growing up when they were younger. That is the bit I really regret because the money side of things was significant, but I cannot get the time back, and that is the bit that still stays with me now. Money-wise, we do not always talk about numbers when we talk about gambling harm because there is not a threshold, it is always relative to somebody's circumstances. I would never want there to be like you have to experience this much debt before you have an issue with gambling, that is not true. But we have to talk about our own experiences. For me, on one of my online accounts, I had maybe 10 - 15 online accounts, I staked over £900,000 in one month, in the last month of my gambling. I had multiple accounts and gambled in person every day, but I did not think I had a problem. I thought I had a money problem that I kept running out of it before I got that big win. That is a lot of money, nobody can afford to gamble that amount and that is not normal behaviour.

I was getting more and more desperate to keep those plates spinning I suppose and, like I said, there were moments of clarity - I will come on to that perhaps later in the session - but I did not see it, I thought I could not live a different way, I had gambled for 15 years, 20 years, I did not see that I could. To me it was just my life, I did not see there was a different way of living. I could not see a life without gambling being part of it. I

did not know anybody else, I thought I was the only person in the world that was living like that, going through that. I did not know there were other people who had walked similar paths and now lived a different way and were in a better place. Yet it was still hidden. My wife, we had been married at the time for seven years, eight years, been together for like 15 years, she knew there was something, but did not know what it was. Tracy, I do not know how common you find it, but she thought I might have been having an affair or something like that because I was distracted, I was not there, I was not present.

Tracy O'Shaughnessy: Yes.

Colin Walsh (Lived Experience Manager, GamCare): In some ways I was, but not with a person, with gambling. Everybody is different, but there is real commonality in a lot of stories. It got to the point where it was just not sustainable anymore and that the lies were getting more and more extreme to try to cover up the gambling. Eventually, those plates that had been spinning started to fall and I got to the point where I had a few choices I suppose, it is either to reach out and seek support, keep lying and make up some other ridiculous claims to try to continue to gamble, or to take myself out of the equation. Tom spoke earlier about gambling-related suicide and how common that is. I think it is underreported if I am honest. There are more than that, just from people I know and how much of it we have seen. I am still here, and I am in a good place, therefore I am grateful that I chose the option I did.

Dr Onkar Sahota AM (Chair): Colin, thank you very much for sharing your very powerful story and also you talked about this internal conflict that you knew that you knew something wrong, or something was uncomfortable, and you had an external life. What triggered you to get help? What was that that said, "I now need help; I really have a problem"? This had been going for many years since, you said, your late teens, but you tolerated it for some time but then something shifted in your thinking. I wonder what that was and what was that?

Colin Walsh (Lived Experience Manager, GamCare): At times in my journey, I look at it a bit like a roller coaster if you if you want to imagine it that way, there were some moments of clarity where there is a bit of calm on the roller coaster and you think I cannot do that anymore, that is not healthy. I tried to stop by myself. I tried to reduce gambling by myself or tried to cut it down at times, maybe exclude or put limits on one of those online accounts like we talked about earlier and think I cannot do that. But then I would convince myself a few days later that it was not as bad as it was. I had a lot of online accounts, I used to get a lot of the emails and promotions and things from different operators. There were moments of clarity along that journey, but it never got bad enough that I thought I now have to tell my wife the truth otherwise she just would not believe any more lies.

I had not told anybody. The first person I told was my son, who was one at the time, on a beach in Wales, and I found it easier to talk to him because he was one and he did not understand what I was saying, but that was like the first time the words had ever come out of my mouth that I had an issue with gambling and talking to him around not knowing what would happen next. I did not know where I would be a week later, whether I would still be in the family, whether I would still be in his life, whether I would still be here, but starting to talk about it made it easier.

After I spoke to him, I only told him that recently, he was quite proud that he was the first person I told. He is 13 now. After I told Charlie, I really took that window of opportunity and thought I need to commit to something. I reached out for support and talking therapy and group support worked for me. Through that, through talking about it, I could unpick some of the things that were going on in my head. In some ways gambling was not the problem. Gambling was how the problem manifested in me. In a different life it could have been different. I could unpick some of that and work on my own mental health through peer support and

groups. I met other people who had walked similar paths and their stories were different to mine, but a lot of similarity. I started to see that there is a different way and put some abstention in my life and quite quickly realised that my life is better without gambling being part of it.

Dr Onkar Sahota AM (Chair): Thank you for that. Obviously, you had a point of insight at some point that, "What I am doing is not right for me at least and I am going to get some help", therefore there was some element of insight in yourself. Thank you for that. I am going to ask my colleagues now to come in and first is Assembly Member Andrew Boff.

Andrew Boff AM: Thank you. When you first tried to access treatment, I wonder if you could tell us about that and how you get to that, perhaps an epiphany, perhaps a point of decision where you realise there is an issue, was it easy to access services? Did you know how to? Did you know where to go? What was your experience? Perhaps Mr Fleming.

Tom Fleming (Communications Manager, Gambling with Lives): This would have been going back to 2017, I googled "help gambling addiction" and, although I cannot remember it specifically, I remember not coming out of that feeling particularly enlightened or empowered to get any help. Then I made an appointment with my GP and went to the GP and explained everything that was happening, explained about the gambling, they did not ask, I had to bring that up, and I listed all the symptoms that I was --

Andrew Boff AM: Sorry, who is this to?

Tom Fleming (Communications Manager, Gambling with Lives): To my GP. As a result, they put me on antidepressants. I do understand the focus on treatment here, but I do not think treatment is necessarily the answer to this, although it is clearly very important, I am not saying otherwise. I do not think treatment is the answer to the crisis that is caused by gambling at the minute. I do understand the realms of this session, but the point that I would make is that we need to look at why do so many people need treatment. There was a study out last year that found up to 1.44 million adults harmed by gambling in the UK. That is directly harmed. As Tracy's testament too, for those people who are harmed, there will be other people harmed.

I quoted earlier the Public Health England (PHE) study from 2021 that was updated last year that estimated up to 496 gambling suicides a year. Just recently, in the last few days, there has been some more stats that have come out that have shown the gambling profits, particularly online, are continuing to grow. We know that 86 per cent of online gambling profits come from 5 per cent of customers, those who are suffering harm, therefore those profits that are growing means more harm. I am not sure if you saw the taxpayer list was published other day, the highest taxpayers, in the top four highest taxpayers in the UK were Peter and Denise Coates of Bet365 and Fred and Peter Done of Betfred. They make up two of the top four highest taxpayers.

GAMSTOP, the tool that I mentioned earlier that I used to stop, their sign-ups increased last year, therefore everything is going up. Although treatment is clearly needed and there are a lot of people out there in need of treatment, we need to look more at wider regulation and at the industry itself essentially.

Andrew Boff AM: Can I just to ask on that point, when you went to your GP, he prescribed antidepressants. Did he prescribe any other therapies or assistance? Was there anything or that was the only thing in the toolbox as far as he was concerned?

Tom Fleming (Communications Manager, Gambling with Lives): Correct, yes. I was seeing a therapist at the time for something unrelated. He recommended that I use that as an avenue to explore things.

Andrew Boff AM: Without revealing anything confidential at the time, you did say to that GP, was it that you were depressed or was it that you had a gambling issue? If you do not want to answer that is fine.

Tom Fleming (Communications Manager, Gambling with Lives): No, no, of course. I went and I outlined the problems that I was experiencing and how I was feeling and the insomnia and anxiety and depression, etc, and then I did not necessarily go and say, "I have a gambling problem", but I mentioned it and the dots seemed clear as day there in hindsight to connect, but they certainly did not at the time.

Andrew Boff AM: Mr Frost.

Dean Frost: I am not a man with data; I just have lived experience. Therefore, 20 years ago it was just a straightforward phone call to GA, to a helpline, and someone directed me to the closest meeting to where I lived or where I was working. Very fortunately in London there is a meeting every night of the week, but there are parts of the UK where there are no or very few GA meetings.

Andrew Boff AM: How did you find them?

Dean Frost: I cannot remember.

Andrew Boff AM: Can you remember, did you know they existed?

Dean Frost: It was probably just off the website. That was my source of recovering and the support I just got straight on the phone. However, I do understand that there is the shame and embarrassment and the blockage. There is a lot of blockage to people that are making that first effort to ring someone up or go on the internet or get into contact. There is plenty of charities out there providing support today, but what I would say is I noticed on the London Underground that Alcoholics Anonymous (AA) is advertised and I know it is down to AA maybe to approach London Underground to advertise, but there is not much in the way of posters or support for gambling charities. It is something that I have recognised in the last few months on the Underground. There is a blockage for some people whether they want to get support, but I was comfortable ringing up. That was my first port of call.

Andrew Boff AM: If you do not mind, I am going to skip, and I will come back to you. Your experience is quite different. Mr Walsh, how did you know what services, and what was your experiences with those services? Mr Frost's sounds like it was a very positive one, straight away as soon as he made that contact.

Colin Walsh (Lived Experience Manager, GamCare): I was going to touch on this earlier. I did my own research to find it myself. I do not think education around gambling harm, certainly, when I was at school, it was a different world to the one we live in today. I went to a good school. I was given a good academic education, but a very poor life education, if that makes sense. I was not particularly financially literate. Mental health was not a thing that was discussed. It is a good thing the world has changed and evolved since then, but when I needed support, I went online, and I found the helpline that was available.

I also went to GA alongside talking therapy because, like I said, that was the peer support option that was available to me. There are others available today that are funded, and it is a good thing that they are because having both that professional support to be able to unpack the things that were going on in my life as well as support from other people that were outside of my family and gave me that safe space, was a good thing. I needed it quickly as well. I think that is the thing. I talked earlier about those moments of clarity; I needed that support then. Had I had to wait for it, it would have been a very different outcome. It is something that I did want to talk about if given the opportunity and my microphone is on, so I have that opportunity really.

Going to the GP is interesting because not a lot of people do it. Certainly, if you look at the data, not a lot a people go to their GP currently to talk about gambling and if people do go to their GP - I wonder if the Chair might be able to answer my question? If I was to come to Dr Sahota and say that I present with some of the issues that we have talked about already, I would likely get prescribed with anti-depressants. If I started to talk about suicidal ideation, I might get signposted to talking therapy. How long would that take currently? Ballpark.

Dr Onkar Sahota AM (Chair): Access varies throughout London. I think we could get access within a couple of weeks to you for talking therapies.

Colin Walsh (Lived Experience Manager, GamCare): Yes. It is interesting. Certainly, I know other people who have waited months and had I had to wait that long, I would not be here.

Andrew Boff AM: What was the first agency that you went to, if you do not mind?

Colin Walsh (Lived Experience Manager, GamCare): It was through the GamCare Support Network. That was the first agency, but it is the time to access that I think is amazing. It is not really talked about, and it is where the third sector works brilliantly with the National Health Service (NHS). We talk about a "no wrong door" approach. I think part of the issue is people do not even know what those doors are. We all gamble in slightly different ways. We all recover in slightly different ways. Therefore, having multiple options to find what is right for me is really important. Through the third sector now, if I was to call the helpline today, I would be speaking to somebody in two days and would be waiting less than a week for my first appointment. That is amazing and that is why it is important to tie all of this together, so the GPs know where to signpost to or the organisations know where to signpost to. We do not have the conversation about gambling because people do not know what to do.

There is support out there and yes, it needs more funding, and it needs sustainable funding, but also, we need to raise awareness. That is the bit Tom [Fleming] was talking about. There are two things to this: a societal change is needed in how we look at gambling and how we talk about gambling, but we also need to support the people who are impacted and ensure their treatment is not forgotten. I think the societal piece is the longer term, but people are calling the helpline today and people are reaching out today. I am a bit of a data geek as well, Dean [Frost], sorry, but I did a data request before coming here. In quarter three of this financial year - October to December [2023] - there was an increase of 20 per cent in people accessing support in Greater London year-on-year. It has increased 20 per cent from last year to this year. That is a significant change. There was a press release out yesterday; people calling the helpline has increased 39 per cent - I think that was in December [2023]. The awareness we are raising is seeing people start to reach out for support.

Andrew Boff AM: It is always difficult at times like this when the services become more apparent to know whether or not there is an increase or whether the people already there suddenly have that service available and therefore you get the increase. Time will tell. Ms O'Shaughnessy, your experience is slightly different. How did you know where to go? What was your first experience of the support?

Tracy O'Shaughnessy: Again, there was nothing for me. Today still I hear stories of women - or 'affected others' - who feel that, as I said earlier, they hit some form of crisis point, and that can be suicidal thoughts. I have been that person where I did not see any way out for myself. For me, I came into it from a substance misuse pathway, to be fair, because that is what I knew. I thought I would reach out and see if somebody could help me through that pathway because I was so isolated. I did not know anybody else like me. There was no one to talk to. There was nothing. I could not find anything. Going through Narcotics Anonymous (NA) I

then obviously found GA, but the thought of going to a Families Anonymous group and walking into a room full of people,

it was very challenging for me. Also, obviously, childcare is an issue. I still have that now with women who struggle to come to groups and get support because of childcare. Again, there can often be domestic abuse issues. I have had women attend meetings sitting in their car for fear of their partner finding out that they are reaching out for help. For me, it took a long time. I tried a GP, as I said earlier, obviously Google. Eventually I found someone on social media who had an Instagram account and I messaged him and said, "I need help because I'm in a really bad way". He was actually a gambler, not an 'affected other', and he pointed me in the direction of GamFam.

Andrew Boff AM: Sorry. Just to be clear in my mind, through NA that dealt with some of the symptoms of substance abuse --

Tracy O'Shaughnessy: Yes, but not with gambling.

Andrew Boff AM: Not with gambling.

Tracy O'Shaughnessy: There was no support there for me.

Andrew Boff AM: Right.

Tracy O'Shaughnessy: Nothing. They put me in touch with GA and again, I got a leaflet because there was not a meeting in my area.

Andrew Boff AM: What was your experience with the GP?

Tracy O'Shaughnessy: With my GP or with GA?

Andrew Boff AM: Actually, I think you alluded to it earlier; it was just anti-depressants.

Tracy O'Shaughnessy: GP, basically, anti-depressants, followed by anti-psychotics for PTSD, followed by, "I don't have any gambling harm training, so I can't help you".

Andrew Boff AM: It was the story of somebody else on Instagram that alerted you --

Tracy O'Shaughnessy: Yes, who was actually a gambler. I reached out to him, and he put me in touch with the charity GamFam that support groups for 'affected others' and that was like - I cannot even begin to tell you - it completely changed my life.

Andrew Boff AM: I have a feeling how you are all going to answer this: do you think the current provision of support and treatment services for people suffering gambling harm in London is sufficient? Bearing in mind you are probably going to say, "No", how can they be improved? Mr Frost, yours was the most positive - as far as I could see - experience of seeking assistance and getting it fairly straight away.

Dean Frost: Yes, for London. Obviously, there are more meetings in London than any other part of the country. For Londoners, it is just probably breaking down the stigma or the shame of just making that phone call for many people. For GA there is support. I think there are 14 charities in this space right now that are mostly funded by the industry. There is support, but I do not really see many adverts. You just have to go on

Google and find the charity or support network and it is then down to that person to reach out. I have no experience of doctors because I never went to the doctor. All I can say right now is there are 15 NHS Gambling Clinics and the feedback we are getting is that maybe the length of time that people are waiting to get support is too long.

With the likes of GA or GamFam, we run three meetings a week. Therefore, the most someone will have to wait is 48 hours to get to a meeting. Most of the people get a phone call with me straightaway if they ring me and I can answer there and then. With GamFam they can get support straightaway. The problem with the NHS - and it is not a criticism, but just a fact - is that it is two, three or four weeks before a doctor or consultant can see someone to put them in the right direction. In that space of time, someone could have lost £50,000 or £100,000, maybe a relationship, maybe a job, or maybe committed a crime.

There is support out there, but it is a big barrier for the individual with the shame. In London, there is support but it is just that people have to do their research. The last bit I would say is the common thing with GamFam - I work for GamFam and Tracy works for GamFam - it tends to be the partners or the loved ones reaching out and not the gambler. That is really common. I do not know the statistic on that, but it would be far more than the gambler. It is the family members that are the ones that really want the support and the gamblers maybe lagging behind a little bit before they are ready to hold their hands up and admit defeat. The last bit I would say is that it is down to the pain of the individual. I have to be in enough pain or have had enough emotional damage, physical damage or financial damage. I have to say, "I've had enough". That is all I am going to say.

Andrew Boff AM: Yes. Mr Fleming, what is your view of the current level of support?

Tom Fleming (Communications Manager, Gambling with Lives): On a simple level, no, there is not enough treatment and support available. If we are talking about clinical support, as Dean mentioned, I believe there are now 15 NHS Gambling Clinics in the UK and obviously London was home to the first, but - and a small caveat here that obviously, as we covered in our written submissions to the consultation, data can be difficult, hard to extrapolate and potentially unreliable - if you look at the potential treatment pool of London, which could be around 200,000 people experiencing gambling harm, then clearly there is not enough support. Not everybody within that 200,000 would need treatment because there are varying levels within that, but one clinic is simply not enough to treat all those people. Therefore, no, there is not enough.

Andrew Boff AM: The Government has proposed a statutory levy --

Tom Fleming (Communications Manager, Gambling with Lives): Correct.

Andrew Boff AM: -- that will increase the level of funding available. Do you think that will have a substantial effect?

Tom Fleming (Communications Manager, Gambling with Lives): Yes, we hope it will. I think that will bring in funding of around £100 million a year, which is clearly a welcome step, but if you think about what you are up against in the gambling industry and the potential treatment pool, it could do with improving, certainly. It is a lot of money, but it is not a huge, huge, huge amount of money when you are talking about a national rollout of clinics, treatment, and research. Education also falls under that I believe.

Andrew Boff AM: Mr Walsh, this extra amount of money that may be available, how do you think that should be spent?

Colin Walsh (Lived Experience Manager, GamCare): That is a big question. Can I go back to the last one in London, first?

Andrew Boff AM: Yes, please.

Colin Walsh (Lived Experience Manager, GamCare): Thank you. I work at GamCare which is part of the National Gambling Support Network (NGSN). If you split Great Britain (GB) up into 10 regions, the NGSN provides support across GB. Part of my remit is to advocate for anybody with lived experience. We have heard four different stories today from four different people. I am not there to talk about just my experience. It would be wrong to do that, but it is to give a platform to the people who access support and ensure that our services across GB, and specifically in London, are developed based on people's real experiences and are accessible. I work alongside the team that deliver support across Greater London and make sure that that is on the helpline that is 24/7 and people who deliver support everyday by video calls, by phone calls or in person in our office in Farringdon or in the community, like at Haringey. I think in the first of these sessions there was some discussion around the great work that has been done in Haringey. I know there is a new project in Westminster and in Wandsworth.

We have a partnership with NatWest. One of the issues across Greater London is just the cost of having the space. If we wanted to deliver support in person anywhere, that costs a lot of money to do that. Therefore, we have a partnership with NatWest that I do not think is talked about a lot, but it is a thing. NatWest let us use their spaces. If that could be done on a broader scale, that would make services a lot more accessible. There is also then the education and awareness that these services are there and are available. They are free and available to anybody. They are not just for people who gamble. They are for people impacted by other people's gambling. They are for family and friends, and we also link up to - you talked about - GAMSTOP and GamFam. We can get those tools to give people that lifejacket when they are drowning. A lot of that is financial; that is how the gambling comes out. We cannot wave a magic wand and make it go away but we can link in with StepChange or PayPlan. It is the right thing to do to get people as much support as is available.

We need to keep working on that collaboration as a sector. Dean, you talked about the number of organisations in this space. Ultimately, all of those organisations want the same thing, which is support for people impacted by gambling harm. We go about it in different ways. That is normal and again, that "no wrong door" approach means that people need different things. Some people need to talk to somebody to work it out one-to-one. Some people need to go to a meeting and talk it through in a group space. Some people do not want to talk to anybody, they want to block gambling on their phone and block access to accounts. That is perfectly normal, but just awareness of what these things are does not exist. We all probably live in a little bubble where we think everybody knows about these things. When I talked to somebody on a train yesterday, or on a tube or in a cab, it is amazing how many people know somebody who is impacted by gambling, but they do not know what is out there for support.

Andrew Boff AM: Mr Frost alluded to earlier about advertising. I am not aware of any. Is that something you feel could help? I apologise. I saw this question and I thought, "I am in danger of treading onto the next one". I apologise for that. Awareness moves into the next question. Tracey, you almost answered this, so it is almost a redundant question; do you think GPs are trained enough to deal with this? I am guessing you are going to say, "No" because of your experiences.

Tracy O'Shaughnessy: No. Absolutely not. It is a bit like with the NHS in that it is a bit of post code lottery and I think what needs to happen - not just with GPs, but with other organisations across London, and the police especially - is it needs to be looked at. Blanket training and awareness need to be given right across the board - right across - because to a degree it is endangering people's lives not having this knowledge. When a

woman goes to a GP and is unwell mentally, emotionally, physically, and there is fear and violence at home on occasions, to be told, "I don't really know. I've got nothing really to offer you" you come away thinking, "I'm really on my own here. I'm really on my own".

Again, with police I had an occasion, unfortunately, 12 months ago where my partner had a little lapse in his recovery and decided that he was going to take his own life. I had no choice but to phone the police. The police arrived - three lovely female officers - at 5am. Two of them were straight out of training and not one of them had gambling-harm trained experience. Not one of them. I had to explain what had happened, that he was in recovery for gambling. He had emailed somebody in his support group that he had made a plan to end his life that day and they had no idea. Therefore, the answer is yes, there needs to be lots of awareness around it. There needs to be referrals. GPs need to know where to pinpoint 'affected others'. They need to be able to say, "There is this. Try this". Until I met and spoke to people like myself, I was in a bad place and I deal with women all day every day that are in that space. It is really harmful. Women are fearful of losing their children and their homes. They are stigmatised by their own families. They are judged, "Why are you still there? Why have you not left? Why are you doing this?"

Actually, no, is the answer. There needs to be a lot more training and awareness with all sectors. Even within social housing and social services, I have come across that recently. I spoke to a social worker on behalf of somebody that I am supporting. She had no idea around gambling harm. I will not even start about probation and prison because we will be here until next week. We would have to do another whole meeting. Seriously, it is beyond ridiculous. I will just touch on this; I was supporting somebody recently whose partner had committed a crime, and the judge asked a question regarding gambling harm and the probation officer had no idea. The judge locked eyes with me. I nodded to say, "Yes" and so the judge actually asked the probation officer to come over and ask me the question. If I was not there -- this really has to be looked at right across the board.

Andrew Boff AM: Thank you very much. I will hand back because, Caroline [Russell AM], is continuing on the questioning.

Dr Onkar Sahota AM (Chair): I am seeing three themes here. Of course, they are related to each other, but there are people who have gambling problems who have the insight, and they can go and seek help themselves. There is another group that have a gambling problem, but they do not have an insight into that and then there are the affected ones: their partners and their families. Therefore, there are three separate populations that are existing there. The ones that say, "I have a problem and I need help" are on a much easier pathway because if you realise you have a problem you will take some action to do something about it. The challenge for the NHS and certainly for me sitting here as a doctor is that the people who are affected when they come and see me, how do I help them when the person who may be a cause of their problem are not in the room and are not prepared to come to terms with that realisation? That is the real challenge for me and for the services. I just put that out as an observation. Over to you, Assembly Member Russell.

Caroline Russell AM (Deputy Chair): Thank you and thank you all of you for your testimony. It has been incredibly powerful, and I feel like I am learning a lot - I think we are all learning a lot - from what you are sharing with us. We are hugely grateful. Yes, thinking about the advertising of gambling products and public health information, Dean [Frost], you talked about how AA are advertised on the underground, but there does not seem to be any gambling support. Tracy [O'Shaughnessy], you have just described the absolute lack of information amongst so many different agencies particularly around the harm for 'affected others' and the need for more information from the police, probation officers, housing support and all those different areas. Colin [Walsh], you talked about the normalisation of gambling in childhood and the seaside arcades. That is a tiny little thing that seems quite harmless - a bit of seaside fun - but that is like the tail end of something that

is much bigger and very much more addictive and harmful. Tom [Fleming], you talked about football. Football: a healthy thing, watch a football match, support a team and yet there is this gambling that is absolutely integral to the whole culture around football, like stuff on the shirts. It is this very harmful thing that is wrapped up in something that could just be about supporting your local team. You have all given really clear evidence about how gambling can be so present in people's lives and the lack of information. My first and opening question is: what role do you think that the advertising of gambling products has in encouraging people to gamble and potentially experience gambling-related harms? I am going to start with you, Tracy.

Tracy O'Shaughnessy: I think advertising is very impactful. From a mother's point of view, I know that I have had many women who have been impacted by gambling harm; a mother has come up against the issue of wanting to buy their child football kit. Why would you want to buy your child a football kit that has gambling advertising on it when their parent is a gambler, and they cannot afford to put food on the table? I was sharing with my colleagues previously that I have a five-year-old granddaughter who came to me the other day because she wanted to play a game that she had seen and she described it as being, "Pink and bubbly, nanna. You know the one". I did not know and then I realised it was a Bingo advert that she had seen on the television (TV) and my heart sank. I am aware of how much advertising there is on trains and buses. As you know, many children are encouraged to get themselves to school on London transport and I just feel personally that it starts at a young age.

We have heard these amazing people here talking about arcades and seaside trips with parents and it just becomes normalised. It becomes part of childhood and that is dangerous because there are games and children have access to things 24/7. They are playing games on their phone and low and behold suddenly an advert comes up; you can buy coins, or you can buy something, and it is that gateway in. It is very impactful. From an 'affected other', it is really triggering. I find it really triggering if I am watching sport with my partner or whatever, and if an advert comes on, I automatically think, "Oh God, is he feeling like [gambling]?" It is that anxiety constantly that we cannot just sit down and enjoy something as a family.

I do not know about you, but if I see an advert for a nice skin cream, I am going to want it. Advertising is there because it is enticing us to buy something. That is what it is there for. They know what they are doing, and it does impact 'affected others' massively. It is very triggering. It is very traumatising and with children, if you are impacted yourself by gambling harm through your partner, your brother, your father or whatever, it is really difficult. I think that is something that really does need to be addressed, massively.

Caroline Russell AM (Deputy Chair): Can I just say something? You just mentioned if you are impacted by the gambling of your father, your brother, or your partner. Do many women gamble? What are the statistics?

Tracy O'Shaughnessy: Yes. These guys are better with the statistics, but recently I was invited up to Scotland as the only 'affected other' that was invited to talk about the impacts of gambling harm and there is not a lot of difference. Tom will probably know, but the statistics are not that different in regard to gamblers, but I believe that the statistics are much lower for women gamblers reaching out for help because again, there is that stigma as a mother or as a grandmother. It is a very different journey for a woman. It is a very different journey because we are expected to be maternal and holding it all together and being the housewife and having a career and all of those things and low and behold, this is going on as well. I know that for some of the women that I spoke to there and women that I spoke to in this space, menopause is another big impact and that needs to be looked into. I have spoken to lots of women that turned to gambling during their menopause. Also, during COVID-19, a lot of first-time mums were isolated, and services were closed down, like mum and baby groups. You could not go and sit around other mums and hand the baby over. There are these adverts, "We are the community. Join the community." That was a big outreach and a big thing for a lot of women. I have spoken to a lot of women. That is when their journey started. It is huge.

Caroline Russell AM (Deputy Chair): Thank you.

Tracy O'Shaughnessy: Thank you for asking that question, actually. Thank you.

Caroline Russell AM (Deputy Chair): That is really helpful. Just going back to the initial question, Tom, do you want to add anything? Also, do you have any actual stats on the women and men? That would also be useful.

Tom Fleming (Communications Manager, Gambling with Lives): Sure. I do not actually have any of that data to hand, but I can supply it afterwards.

To Tracy's point, I am sure you will have all noticed the recent uptick in gambling products that are specifically marketed at women. Tracy referenced the game that was pink and bubbly.

Tracy O'Shaughnessy: Yes, it was bingo, yes.

Tom Fleming (Communications Manager, Gambling with Lives): Yes, like Foxy Bingo, these kinds of things. Gambling products are increasingly marketed at women. I mentioned earlier that the charity I work for supports families that have lost loved ones to gambling-related suicide. We do support a mum who lost her daughter to gambling-related suicide, so this is not a male-related problem. There is a split, although I cannot provide any specifics off the top of my head.

Just to a wider point about advertising in football, personally for me, football was huge. Gambling is embedded in football, is it not? There was a study out that found, if you watch a televised game of Premier League football, you can see gambling logos 3,500 times, which is insanity, really. It is hard to get your head around. It is on the shirt fronts. It is on the sleeves. It is on the advertising boards around the perimeter of the pitch. If you are watching a championship game, you are watching a Sky Bet Championship game. If you are watching Stoke City, you are watching them play at the Bet365 Stadium. I know last year the Premier League did agree a voluntary front-of-shirt ban on gambling sponsors, but that actually is not going to make a great deal of difference because most of the logos are not on the front of the shirts. They are already beginning to shift to the sleeves and the pitch-side advertising. That is huge.

Also, in my own experience, it perhaps was not a case of seeing an advert and rushing out and putting a bet on because you have seen that advert, although perhaps when I was gambling and self-excluding with some operators, maybe I would see a new operator and think, "I have not got an account with them yet. I am going to sign up." But the two problems with me with advertising are the framing of gambling and the problems that come from it as an individual responsibility issue and the health messaging - the so-called health messaging, should I say - that appears at the end of the adverts, things like, "Take time to think", and "When the fun stops, stop". They frame it as something that you should be in control of, but these are addictive products. Can you imagine somebody saying that to someone who was in recovery or addicted to drugs or alcohol, "Just stop. Just don't have another drink. Just don't take any more drugs"? I had not thought of that! That is a huge problem. All the adverts frame gambling as an individual responsibility problem. To really understand that gambling harm comes from gambling products, not people, is huge. That realisation would be really useful for people before they sort of got to the point where they needed treatment, to my earlier point.

Also, it just creates a sense of normalisation, just the fact that it is constantly there. Just to draw on my own experience, having grown up around football and then after 2005 when the Gambling Act opened the floodgates for advertising, with that surrounding me at that point in my life, I thought, "This cannot be

something that can harm me because it is on TV all the time." That really added to me blaming myself, essentially.

Caroline Russell AM (Deputy Chair): Yes, the responsibility for the harm should sit with the gambling providers.

Tom Fleming (Communications Manager, Gambling with Lives): Exactly, the people who design these products and push them and give you offers. Exactly, the source of gambling harm is gambling products and not people.

Caroline Russell AM (Deputy Chair): Yes. Dean?

Dean Frost: I have got some stats, but I made the stats up last night. No, I did not make them up, but we had a meeting last night. We had 15 people in our group, which is a self-help peer support group. We have been going for three years and for the first meeting we had one lady on it and then she dropped away, and it was just purely men for the next two and a half years. Last night we had five women in the group and 10 men. I asked them the question what their prominent gambling was. For the men it was generally sports betting. A couple did say they did online roulette and slots. For all five women, it was online bingo, online casino and online slots, most probably referencing what Tracy and Tom spoke about how the products are marketed to certain groups.

I have never thought about the advertising for me because I was lured in by the win. As a cab driver, I always remember seeing adverts going, "If you have a first goal scorer and Arsenal to win 3-nil, if you put £10 on, you will win £200 back." I probably did fall for some of that or get lured in by some of that in the windows.

I just want to bring up this. It is nothing to do with gambling, but it is related. There is a greater issue as well looking at designers and the technology industry. Forget the gambling. We have got Facebook, Google and YouTube. If you mention the word 'gambling' and you are watching a YouTube video, the likelihood is you are going to get a gambling advert thrown up in between.

I remember watching Panorama in 2018. It was about whistleblowers in Silicon Valley and talking about the dopamine hit that people get when they get likes, retweets or some sort of response online. Facebook, it is said [on the programme], was built to be addictive to children. Whistleblowers confess Facebook is like a slot machine. Who knows? They may be partnered up with gambling. But just using Facebook alone, they want people to stay on their site, and that is clearly what the gambling companies want.

In some of my experiences, I want to talk about my daughter. It is quite common. Young girls play a game called Roblox where you walk around your own house, and you create a living room. My daughter will go, "Can I have a fiver, Dad? Can I put some new clothes on a character?" Over a period of a year, they will build up their own house. What we find is that a lot of young boys will play a game called Fortnite. Within those two games, Fortnite has a loot box that creates a dopamine hit when someone wins maybe a new gun, a prize or a number of points on their virtual score. That taps into the dopamine hit. They get that rush that they like. With the girls, I noticed a number of years ago my daughter was playing Roblox very innocently. She shows me it has the wheel of fortune. I remember the TV show, Wheel of Fortune. You turn the wheel around and you get 400 points, 500 points, a new dress or a new crown for your character.

A greater area to look at is the technology companies. I am a cab driver. I know Shoreditch and Hoxton and Dalston, the creative part of London. What are they doing inside these buildings?

Caroline Russell AM (Deputy Chair): That is like an evolution of those seaside slot machines, which were a normal part of a childhood trip to the seaside. I remember paying those shove penny games and whatever at the seaside. It was a once-a-year thing. You might have 10p or whatever in 2p bits to use. But, yes, because it is on all our phones, it is becoming --

Dean Frost: Prepping the future consumers, the future --

Caroline Russell AM (Deputy Chair): Yes.

Dean Frost: I know a bit. I have friends who work in the gambling industry, and they are profiling people. The phones are profiling youngsters, working out what their likes are, what their interests are. Are they going to be addictive? Can we lure this one in in later life?

The final thing I want to share is, as a cab driver, last week I picked someone up from a company called King, which is in Wardour Street. It has been bought out by Microsoft. It is the designer of Candy Crush. He was telling me he is involved in the French and German markets, where they still sell the computer games in the box. The UK market does not sell them anymore. The UK market is not interested in that. In France and Germany, they still sell a game in a box. He said the main driver for many of these organisations is to get people in a game on their phone and continuously buy in the game, you know, whether you buy some more credit for more games or, as I say, going back to Roblox, put £5 into my daughter's account so she can buy a dress for her character. The interest is keeping people in it. He said, "We actually do not want to build these games in boxes. It is not very valuable for us. It is not cost-effective. We want people to be buying in the app." What does that tap into? Anyway.

Caroline Russell AM (Deputy Chair): Thank you. That gives a good sense of what is coming down the tracks as well. Colin, do you have anything extra to add just on that overall problem of, yes, the advertising and how harmful you think that is?

Colin Walsh (Lived Experience Manager, GamCare): Thanks, Caroline. Yes, a few things. The gaming link is an interesting one. The bulk of the profits these days for gambling operators comes from online slots. There is a clear link from game mechanics to online slots to harm.

I do have some of the data, actually. Last year, there were 52,000 calls to our helpline in 2023. Around 30 per cent of those were from women. When I say 'calls', that is calls and chats as well. I do not have the breakdown of whether they were women who were seeking support for their own gambling or for other people. That [people seeking support] sounds great.

But at the same time, there are probably some not-so-great stats behind it as well. Around 13 per cent of people who have alcohol or substance misuse issues are seeking support. For gambling, that is below five per cent. For women who are gambling, we think it is around one per cent.

Also, we talked about support groups and peer support groups. Talking from personal experience, women are less likely to walk into a mixed GA meeting - you would probably find that, Tracy, from what you have seen - just because it is generally a male-dominated space, and it is a difficult thing to do. I do not know the numbers, but more women are likely to go to their GP, for example, than men and more women are likely to call the helpline because it is individual, and it can be a gender-considered approach.

On sports, I agree with everything that has been said and so I do not need to say it again. All I would say on top of it is that sportspeople who have been impacted by gambling harm - and there has been a high-profile

case in London very recently - should not be forced to endorse a gambling organisation in their work. That happened yesterday in a match, for example. Also, there should be probably an immediate ban on non-UK-regulated gambling operators advertising. If you watch a football match, you see some very strange companies that you have probably never heard of or ever seen. Usually, they are international gambling or crypto-type organisations. They advertise in the UK because gambling is illegal in their home countries, but the Premier League is streamed all around the world. That should not be allowed. We do not need that.

I also wanted to talk about Transport for London (TfL).

Caroline Russell AM (Deputy Chair): That was going to be my next question. Let me frame this up because, in our last meeting, we discussed one of the levers that the Mayor has, which is adverts on the TfL network. We talked to [Dr] Tom Coffey [OBE], who is the Mayor's Health Advisor. He said that there was a bit of a problem. How do we define harmful gambling? He said the GLA has asked the Government and public health partners to develop a definition of harmful gambling. He emphasised, "We are keen not to ban the advertising of all gambling, only harmful gambling."

From what we are hearing today, it sounds like the idea of non-harmful gambling is probably a bit of an oxymoron. Do you think it is possible to distinguish between harmful gambling advertising and non-harmful gambling advertising?

Colin Walsh (Lived Experience Manager, GamCare): Do you want me to start on that?

Caroline Russell AM (Deputy Chair): Yes. Why do you not start, Colin, since you raised TfL?

Colin Walsh (Lived Experience Manager, GamCare): Yes. It is fair to say that some gambling products are more harmful than others. We talked about a lot of profits coming from slots. People still experience harm from the lottery, which might be at the other end of the continuum, if you like. However, it is not the products they advertise; it is the organisations and so it is impossible to make a distinction there.

I know there has been some research commissioned that was inconclusive, but we all see the harm that gambling can cause. That is why it was researched. That is why it was a manifesto pledge. I think I am fairly rounded these days. I did not used to be, but I have changed. People get frustrated when politicians make promises or officials make promises that are just not delivered on. I understand that sometimes you might not be able to deliver exactly what was promised on, but explain why and then say, "We cannot do all of this, but we are going to do something rather than nothing."

This is my personal opinion rather than that of my employer. I do not even know if I have said it out loud before and so here we go. For me, on TfL, if you cannot ban the advertising, charge a premium for it. Charge gambling operators or other organisations that are in industries that cause harm a premium and, with that premium, give space to other organisations like AA, like GA, other organisations that are represented here today or that represent awareness campaigns or harm reduction. It is expensive to advertise. We all work for charities that are funded on pretty small budgets, certainly compared to the £14.2 billion gross gambling yield that the gambling industry makes every year.

Caroline Russell AM (Deputy Chair): You mean TfL could charge double and give that equivalent advertising space to the --

Colin Walsh (Lived Experience Manager, GamCare): To awareness campaigns and support organisations in Greater London. I was on the Elizabeth line yesterday and all the way down the escalator was a brand-new

gambling campaign that was the full length of that escalator. It is not right. Everybody is seeing that. That is a way of really saying, "We think you are doing harm." I am sure gambling operators will still pay it because they make a lot of money, and they want customers.

Caroline Russell AM (Deputy Chair): It would have to be that the advertising given to the awareness and support networks would need to be of equivalent status and prominence.

Colin Walsh (Lived Experience Manager, GamCare): For me, yes. We also have started to see some of the operators - there are always some responsible - have safer gambling messaging at the bottom of an advert, but that is still a gambling advert. It is not just gambling. You see it with alcohol, for example, where alcohol brands are advertising alcohol-free or zero per cent. That is still the alcohol brand advertising. Whether it would work I do not know, but it is a way that organisations like ours can really raise that awareness because it is a big part of the issue.

Caroline Russell AM (Deputy Chair): Yes. Actually, they need to pay even more than they pay for the advertising that they are buying because they have to pay for the development of the adverts for the products to provide to support to people that are as grabby as the bubbly pink and green adverts that catch people's eye. There needs to be the same prominence of promotion to the support networks if we are going to say, "We are going to ignore the harm, but you have to pay all this extra."

Colin Walsh (Lived Experience Manager, GamCare): As an idea, that sounds amazing to me. It would work.

Caroline Russell AM (Deputy Chair): In an ideal world, would you prefer to see the adverts just gone?

Colin Walsh (Lived Experience Manager, GamCare): Yes, if they can deliver on that pledge, then great. If not, then take steps towards it and say, "Here is an alternative."

Caroline Russell AM (Deputy Chair): OK. Let me hear from everyone else, just briefly. Would you prefer to see adverts for gambling completely gone on TfL and do you have views on this other halfway house option?

Dean Frost: Yes, it would be a good idea to remove all advertising. There is enough advertising in this world. You only have to turn the TV on, scroll through your social media, turn on the radio if you listen to Talksport. Even other radio stations are advertising gambling. For me, just an appetite for change, an appetite for raising awareness about gambling addiction rather than promoting gambling. It is straightforward for me: no advertising and more raising awareness of the potential harms of gambling and raising awareness.

Caroline Russell AM (Deputy Chair): Yes. Tracy?

Tracy O'Shaughnessy: Yes, the same for me, to be fair. This might sound a bit extreme, but it is like you would not advertise your local heroin dealer, would you? For me as a person, it has impacted me the same.

Also, there could be some issues around not everybody taking money from the industry in this space. If it is going to be the case, then there are going to be organisations within this space that are not going to benefit from that because they do not benefit from industry-funded organisations. It should just be a straight ban. We have evidence here and we could have 1,000 people outside here telling you their stories of how they have been harmed. What more evidence do you need?

Caroline Russell AM (Deputy Chair): That is very powerful, Tracy. That is very powerful. Tom, did you want to add anything on this?

Tom Fleming (Communications Manager, Gambling with Lives): Yes. Just to build on Tracy's point about not advertising heroin, some online slot and casino-style games have been found to have addiction and at-risk rates of 45 per cent, which is higher than heroin. That is fully referenced in our submission. That builds on the point I was going to make and sort of made earlier about gambling harm coming from gambling products. There is no such thing as a safe or harmless gambling operator because they are all selling products like these and they are all trying to, essentially, get people onto these. If you sign up for a football bet that you see an advert for on the Tube, within a week you have free slots and free spins. They want you to use these because they are available 24/7 and they are the most profitable and the most addictive. I say get rid of them all.

Caroline Russell AM (Deputy Chair): Thank you. The other piece is going back to what Dr Tom Coffey [OBE, Mayoral Health Advisor] told us, which is that it is not clear what is harmful and what is not harmful and surely, we have to allow the non-harmful adverts.

Tom, you just mentioned some research that you have submitted in your submission into the harm of advertising gambling, which I look forward to seeing when that comes around to the Committee Members. Do you think it would be good for the Mayor to commission research into the impact of gambling advertising on the transport network, specifically in London?

Tom Fleming (Communications Manager, Gambling with Lives): It certainly could not hurt to have the data, but we are at a point where we do not really need any data and research. We know that advertising increases consumption. The gambling industry spends £1.5 billion a year on advertising - obviously, that is not on TfL but in the country as a whole - to increase consumption and they are increasing consumption of a harmful product. It is harmful. Yes, to answer your question, sort of, but also there is more than enough to act on. We do not need to commission more.

Caroline Russell AM (Deputy Chair): Thank you. That is very clear. There is more than enough evidence for the Mayor to be able to take action. Chair, back to you.

Dr Onkar Sahota AM (Chair): Thank you. Emma, did you want to come in?

Emma Best AM: Yes, please. Thank you. I just wanted to build on that point quickly that Caroline was making around the harmful and unharmful. I suppose what Tom Coffey was meaning by unharmful was maybe things like the People's Postcode Lottery and the National Lottery, I would presume.

Is it worthwhile to protect those adverts in order to continue having the conversation about harmful or unharmful or do you think just trying to answer that question is not necessary, really? Perhaps if you want to answer it quickly but just to get your thoughts. Tom, you look ready, or Colin?

Tom Fleming (Communications Manager, Gambling with Lives): Yes. Just briefly, I mentioned that continuum earlier but, even if you look at the [National] Lottery, for example, the Lottery is changing to a new provider, if that is the right word for it. There is a scale within the Lottery. There is the main draw and there are also scratch cards. We have seen real issues. People struggle. If people have issues with scratch cards, it is difficult to ban yourself from the corner shop or Tesco or Sainsbury's or any other scratch card retailer. They are there at counters at petrol stations, etc. There are online instant wins that are closer to online gambling than they are to the Lottery. That is one organisation, but it offers a range of products.

I heard Lord Foster [of Bath, Chair, Peers for Gambling Reform] speaking about this really recently at the GambleAware conference around how there is scope to still levy the Lottery, even though it has not really been considered. He speaks really well on it.

Emma Best AM: Is there any point in trying to define harmful and unharmful?

Tom Fleming (Communications Manager, Gambling with Lives): We have quite a skewed perspective, I suppose, have we not? For me, it is difficult because the companies rarely advertise the product.

Emma Best AM: Dean?

Dean Frost: On Tuesday, I put it out to a WhatsApp group with 120 gamblers, people in recovery or people who are still struggling. I just did some control questions, what you gambled on, what was harmful and what was not. I will be honest. It came back quite inconclusive because it was all over the place: in-play football, bingo, slots, casinos. For me, I would gamble on anything. Once I am in addiction, I will gamble anything.

The final thing I would say is that the common thing I am getting back from people - and it is scientific or with research - is that certain products are more enticing and more addictive than others and are designed to be addictive. Rather than maybe asking us, find out what they are designing to be addictive. It was my point in what I said about Facebook. Let us go back to the designers. What are you designing? How are you designing it? Who are you targeting? Are you trying to entrap people? Does that make sense?

Emma Best AM: To be clear, the Mayor is not pursuing the ban at the moment because there is not a clear definition on what is harmful and what is not harmful. That is the reason for doing it because then how do you judge what is harmful or not harmful? My question really is: the thing that is holding back a TfL advert ban on gambling is that there is not a definition of harmful and so is it worthwhile to just not have a definition and pursue a gambling ad ban in toto?

Dean Frost: Yes.

Emma Best AM: That is my question. Just to be clear, that is where I am coming from. Do you see any merit in trying to explain what is harmful and what is unharmful? Tracy?

Tracy O'Shaughnessy: No. It should be a total ban. You do not need to spend more money and waste time on research. We are the research. It is as simple as that, really. To me, it is just constantly moving the goalposts.

Emma Best AM: Thank you. That is what I wanted to see your views on. Colin, you brought in an interesting point around the premium for space but, to be clear, the Mayor has massive powers over the TfL estate and does give out free advertising each year. We have asked this in a previous question, and I do not want to ask the basic question, "Do you think the Mayor should give free advertising to charities", because the answer would be yes, but you can surprise me by saying no if you would like.

However, what I am more interested in on that question is, having confirmed that you think that is a good idea, if there was that free advertising - and, Tom, you raised this point earlier that there is no point in just saying, "Stop" - what content would actually be helpful in that free advertising, not just something that says, "Please stop"?

Tom Fleming (Communications Manager, Gambling with Lives): Yes. You need independent public health messaging about the risks of gambling, which would be about things like products and the mental health risks. There are actually other local authorities that have already done campaigns similar to this. The Greater Manchester Combined Authority (GMCA) and Yorkshire and the Humber have run really effective city-wide campaigns with public health messaging that actually address the source of the problem and do not continue that individual responsibility narrative, which is quite harmful, as I have covered.

Emma Best AM: Do you think it is worth focusing more on the personal harms and the public health safety message or the outreach and where people should go or does there need to be a moderate balance of both?

Tom Fleming (Communications Manager, Gambling with Lives): In an ideal world, it would be early intervention and prevention, but we do not live in an ideal world and so there does need to be a balance because there are clearly a lot of people out there who need signposting to help.

One of the projects that my charity has worked on and just completed is a resource hub called Chapter One, which is live at chapter-one.org, which is a hub, essentially, for independent information. It has training on there for GPs and for other professionals and intermediaries, like you mentioned, so that they can spot the signs of gambling harm. Yes, definitely something like Chapter One should be advertised.

Emma Best AM: Would free advertising be helpful, just to be clear?

Tom Fleming (Communications Manager, Gambling with Lives): Yes, absolutely.

Emma Best AM: Thank you. That was all my questions, Chair, unless anyone wanted to add anything.

Colin Walsh (Lived Experience Manager, GamCare): Yes, can I jump in briefly? I assume the free advertising is something like what Dean mentioned, the old AA poster. I doubt we would get the full banner all the way down the Elizabeth line on rotation. If that is given away for free, yes, please, can we have that tomorrow?

Emma Best AM: This Committee could always try to argue for it. Whether the Mayor would be up for doing that is perhaps another question.

Colin Walsh (Lived Experience Manager, GamCare): It is that awareness. Push for the ban but, I reckon if that cannot happen, do something. Do not do nothing. Have harm reduction campaigns, awareness campaigns and signposting as well, like the 'No Wrong Door' programme. People do not know where to go. There are four or five organisations we have talked about today. There are many others out there.

My last point is you have the opportunity to regionalise it across Greater London as well and signpost it. We have talked about the national or fairly national organisations. There are some really good pockets of local work out there, like in Haringey. Signpost to that because, while we live in a world where everything is connected, a lot of things are online. We also live in the world that we see every day. Make it local. Make it real.

I do not want to take this on too weird a tangent from a licensing perspective, but I was talking to someone last week who lives in Romford. I do not know if any of you know South Street in Romford, but he was saying that he stood on one spot the day before and he could see six places he could gamble from standing in one spot. Four of them were bookmakers. Two of them were adult gaming centres and so arcades, essentially.

Are they the kind of high streets that we want people to live in and that we want the next generation to grow up in? No. That despite all of the harm that we have talked about being online. It is all around us.

Emma Best AM: Thanks. Yes, I used to work at The Moon and Stars in Romford and so I know it very well.

Dr Onkar Sahota AM (Chair): Assembly Member Hirani, did you want to come in?

Krupesh Hirani AM: Thank you. It is just on the theme of advertising and probably more pertinent to Tom because it is in relation to football directly. One of the growing practices that we have seen is on podcasts or YouTube podcasts - there is one I watch quite regularly, Stick To Football, and it is sponsored by Sky Bet - in terms of looking at how the industry can combat maybe some of the online advertising on podcasts. This show is also, almost inexplicably, sponsored by a gambling company as well in bits where you cannot even skip the ads in between segments or before or after a show ends on YouTube.

Is there more than the industry can be doing with social media providers as well to look at advertising where it is inescapable?

Tom Fleming (Communications Manager, Gambling with Lives): I am sure there is, yes. One of the things that we as a charity have been calling for is a complete ban on all gambling advertising and, definitely, football is a really common route in. Yes, there is certainly more, but I do not have the specifics to my mind other than a complete blanket ban.

Krupesh Hirani AM: Just on that, celebrities and ex-football players have a huge influence and a huge reach as well. Is there anymore that individuals can be doing to limit what they are doing, which is effectively promoting advertising?

Tom Fleming (Communications Manager, Gambling with Lives): Yes, there should be a ban on celebrity endorsements for gambling. There were some guidelines brought in by the Advertising Standards Authority the year before last [2022], I believe, but they turned out to be quite murky and they were quite easy to get around because they were mainly focused on young people and celebrities or stars who might appeal to young people. That vagueness in the rules created a bit of leeway and we ended up with people like Harry Redknapp [former football manager and player] still advertising gambling because he does not appeal to young people and perhaps even Peter Crouch [former football player] because their careers ended some time ago.

Yes, there needs to be much more stringent rules in place that cannot be got around so easily because celebrity endorsement is huge, especially in football. I know José Mourinho [Portuguese football manager] was doing it while he was still a manager. It is huge. If you are growing up and you see one of the most respected managers of all time, probably, endorsing a product, you are going to think that is fine. It really needs to be addressed.

Colin Walsh (Lived Experience Manager, GamCare): Tom, I know the stuff you did with Clive Tyldesley [television sports broadcaster] at Gambling with Lives was really interesting. I heard him speak a few times before on that story. He was somebody who chose to step away from what he did as a presenter not because he had been impacted by gambling harm himself but because he saw it was wrong. He just felt it was not the right thing to do. I do not know if you want to talk on that, but I thought it was really interesting.

Tom Fleming (Communications Manager, Gambling with Lives): Yes, he approached one of our campaigns. We have a campaign called The Big Step, which is a campaign to kick all gambling adverts out of football. Clive Tyldesley got in touch because, as you said, Colin, he was working for Talksport at the time and

part of the commentator's duty there was to read out odds before the game. He felt uncomfortable with it and so he got in touch with a colleague of mine and has since met with the charity. He hosted an event for us at the Labour Party conference this year and you can tell that he has had a journey and so it is possible for people to - an expression I often use - have the curtains pulled open and see the full picture. Yes, that was a good example. Thanks for that.

Andrew Boff AM: Just a small detail. Did you say chapterone.com was the website?

Tom Fleming (Communications Manager, Gambling with Lives): Chapter-one.org.

Andrew Boff AM: Org. That is where I went wrong. Thank you.

Tom Fleming (Communications Manager, Gambling with Lives): No problem.

Dr Onkar Sahota AM (Chair): Emma?

Emma Best AM: Thanks. The next section of questioning is around the actions that we want taken that we have not really covered already. We will go through a couple of the different responsible authorities, but perhaps we will start with the Government. I know Andrew mentioned earlier one of the bits of the white paper. I do not know if anybody has any further comments on the actions taken, especially in relation to more of these checks that are going to start happening and being triggered, whether these are good steps, whether the limits are in the right place and what anybody on the panel thought about that. Colin?

Colin Walsh (Lived Experience Manager, GamCare): I do not mind starting. Certainly, GamCare workers have submitted a response on this already, but, for me personally, the checks are meaningless until there is a single customer view. If there is a limit from me on one account, there are no limits to how many accounts I can have. The daily limits or weekly limits or monthly limits that are talked about are per account, not per person. Until there is a stage when that is possible, I do not see how they are going to have significant impact. They will stop perhaps the occasional person.

It is one of my frustrations, really. We hear of the super extremes. I talked earlier about the kinds of numbers that I gambled when I was gambling. That is the kind of thing we hear about, but that is not the bulk of the people who are experiencing harm. It is at lower levels; people are just leading rubbish lives because they are gambling all their wages. That is one of them.

Emma Best AM: Just to say - and you can correct me - my understanding was that this was going to bring together the online gambling stakeholders so that it would be more cross-platform sharing of that.

Colin Walsh (Lived Experience Manager, GamCare): There is an ambition to move towards a single customer view. The technology does not exist for that to happen currently.

Emma Best AM: OK, but it is an ambition, though, of the paper. Where do we need to move to make that happen, then?

Colin Walsh (Lived Experience Manager, GamCare): As I understand it, that is still four or five years away from being a thing. It is not possible currently. There is a pilot that sits with GAMSTOP, if I am right, but it is not within the white paper to say that this has to happen.

Emma Best AM: Is there anything that brings that four- to-five-year wait closer? Is there anything that you are suggesting in terms of that single customer view?

Colin Walsh (Lived Experience Manager, GamCare): Yes. It is not my field of expertise, but I guess a desire to do it from the operators and collaboration across that sector. Generally, I would hope they would want to be better. We want harm to be reduced.

Yes, until that exists from a technical perspective, any limit is only operator specific. Even within an operator - name one - an operator might have five or six different brands. You can gamble up to that limit with each of those brands, as I understand it, and that does not account for in-person gambling on South Street in Romford.

Emma Best AM: Thanks. Maybe we have the wrong panel, but I am interested because this mandatory data sharing is a big part of the new Bill and I have questions about you not thinking that that is implementable, but I do not want to question you too much. That would not be fair. Does anyone else want to say anything about the Bill?

Dean Frost: It is not really my expertise. I am generally someone who works with people who are right at the bottom. A friend of mine works as an analysis guy on data. He sits at home, keeping an eye on betting. This is with horses and dogs and sports betting, not online betting. He was telling me on Sunday that he can stop someone in time very quickly if he knows they are going to be a winner and they are going to be in profit, but if they are a potential loser and he has the data and past experiences of others, he will recognise that that person will be a winner. It will cancel them out straight away. If they were £10,000 down today but he knew that in time he was going to win, he would still block him, even though that person has given £10,000. It is through certain ante-post betting, which is a bit deeper. That is the power that one person can have. They can ban a potential future winner. If you are going to give money away, they will allow you to carry on.

Emma Best AM: All right. What do you think was missing from the Bill or could be improved in the Bill? Tom?

Tom Fleming (Communications Manager, Gambling with Lives): Advertising was conspicuous by its absence. It was barely even touched upon. The Premier League's decision to have a voluntary ban - which is not really a ban if it is voluntary - from two years from now was lip service and possibly jumping before they were pushed. Advertising was the biggest thing left out of the white paper.

Emma Best AM: Thanks. Yes, a voluntary ban sounds as much of an oxymoron as you can get, really. Tracy, did you want to add anything to that?

Tracy O'Shaughnessy: There is not really anything for me to add to that, to be fair.

Emma Best AM: OK. In terms of the Mayor of London and the ways in which he might be able to do more to help, we have covered the TfL estate and advertising there. Is there anything else that you think we can think about? Dean?

Dean Frost: Does he have the power to have a strong partnership with football clubs? If football clubs are happy to advertise gambling, is there a partnership so that the same football clubs can raise awareness about the dangers and a very powerful message from football clubs? Is there any possibility of that, specifically with the London clubs?

Emma Best AM: Yes. There is a really obvious partnership between the Olympic Stadium and West Ham and the convening powers the Mayor has along with the London Legacy Development Corporation (LLDC). Those convening powers probably stretch to all London Premier League and Championship clubs as well and so that is not a direct power but certainly a convening power, if that is what you are suggesting, and is something that would make a good recommendation.

Dean Frost: As a London cab driver, I know a little bit about Tufton Street and Old Queen Street where the lobby groups are. Who funds a lot of it? Looking at all those vested interests, whether it be politicians or policymakers, there are people driving the industry to be more accessible to more people. Look at who funds and who drives the lobby groups and who is behind the lobby groups. I drive around in my cab. I am aware of a lot of stuff.

Dr Onkar Sahota AM (Chair): You heard it first on the Health Committee.

Emma Best AM: Yes.

Dean Frost: The last bit I would like to say as well is a different subject, but you just spoke about COVID. So many people during COVID took up lots of addictions. According to The Cable News Network (CNN), 52 per cent of addicts returned to their addictions during lockdown. Moving forward, if there was ever another lockdown, God forbid, would there be something put in place for people to give them support? That is a report from CNN. That is another subject.

Emma Best AM: Yes, perfect. Thanks. Anyone else on the panel, looking specifically at the Mayor of London and his remit? Tom?

Tom Fleming (Communications Manager, Gambling with Lives): Yes, just to stress that there should be city-wide public health messaging campaigns and signposting healthcare professionals and intermediaries towards Chapter One, where they can train themselves on how to spot the signs of gambling disorder and refer to the appropriate place.

Emma Best AM: Thanks. Colin?

Colin Walsh (Lived Experience Manager, GamCare): Thank you. For me, really, look at some of the best practice that is out there. In my notes, I have some headlines of the work done in Haringey. They train and educate professionals from local public health services to identify and respond and support people who are impacted by gambling harm; clarifying and strengthen referral pathways to GamCare adult support services or other support services, not just GamCare. People might want residential support. People might want peer support. Other services are out there. They raise visibility of support available, increase accessibility of face-to-face support by having those safe spaces that are in local communities, increase collaboration between those local services and gather the data to evidence the impact of it. It is really good, and it should be done across London.

The other one for me is signposting and recognition of gambling harm alongside alcohol and substance misuse. Generally, people talk about gambling harm being 20 or 30 years behind drug and alcohol services. That is not OK. Let us shorten that gap. A lot of organisations have alcohol policies and substance misuse policies. Very few have safer gambling policies. People do not know what to do. They do not know.

When I came in this building - which is really impressive, by the way - I did not know where the toilets were. I was a bit nervous and so I wanted to find a toilet. I had to look for those signposts. Without that, I would

have just been wandering around aimlessly. Have that signposting to show people what that path can look like.

Emma Best AM: Tracy, would you like to come in as well?

Tracy O'Shaughnessy: For me, just reiterating everything that everyone has said, really. I would like to see blanket training included with the Metropolitan Police [Service] (MPS). There is a lot of work that needs to be done around that, to be fair. That is really important because not just from the gambler's perspective but for an 'affected other'. If you are in any sort of situation, whether it is - as I have touched on before - domestic abuse or mental health or whether it is the gambler themselves, to then be confronted by an organisation that you are reaching out for help from, and they have nothing to give is quite challenging. Again, just going back to what Tom said, healthcare referrals, making sure that those support networks are there for 'affected others' and focusing more on us.

We are important. We are here. We are not an afterthought. We are here. It affects us. They say on average for every gambler there are six 'affected others'. I would double that. It is a lot more. It is wider. It affects everybody. It affects in-laws. It affects siblings. It affects children. The list goes on. That support is just not there.

Women particularly want women-only spaces. Women find it incredibly difficult to reach out for help when they are possibly expected to go into a group meeting or whatever with men. They may be coming from a domestic violence situation. We want that support. We want spaces for women by women.

Colin rightly said the difference between substance misuse support and signposting. I am somebody who has come from both paths, unfortunately. It is huge. I cannot even begin to tell you the difference. I was really shocked when I reached out for help because I did not have those issues when I reached out for help as somebody affected by somebody's drug misuse. Especially with training across the board, the Mayor really needs to get up to speed with that.

Emma Best AM: It is a really important point you raise about the MPS and the training and to emphasise that at the end, not least because of the situation that you explained earlier, but there are a number of violent incidents in betting shops and things like that. Just to think that if the police officers do not understand the addictions that might be fuelling those is quite remarkable, really. It is a really important point you raise.

Tracy O'Shaughnessy: I know this from my experience. I am using my own experience. I was actually cautioned and questioned when the police came and when they arrested my partner. I was treated like I was complicit to his crime, "Well, you must know. You must know." This is something that really impacted me because they then left because they did not find whatever it was, they were looking for. As they left me at half past six in the morning, they said, "Well, you do know he's got a gambling addiction." What if I did not? What if that was the first time that I was finding out that my life was about to be turned upside down? There was no duty of care. They just left me with that.

That is my own story and I hear that repeated constantly from women whom I support. They ring up for help. There has been some violence, or something has happened. That support is just not there because they go, "I do not know. What is it about? He took the money?" It is bigger than that. Do not minimise this. Do not do that. It is really harmful.

Particularly for me, it is the training within the MPS and services outside of that as well, as I have said, social services, domestic violence organisations that I speak to on a daily basis. Still a lot of them do not have that gambling harm training. That really seriously needs to be looked at. Yes, that is my bit. Thank you.

Emma Best AM: Thank you, Tracy.

Dean Frost: Could I just finish off, sorry? No one has mentioned this. I am sure it is on all of our minds. Also, go into schools, colleges and universities. Over the last few years, I have met many people who have gone to university and within the first few weeks their grant has gone, and they do not even finish their degree. Look at education at an early age. It could be junior football clubs and talking to parents. A lot of the parents probably do not know what is going on with the phones. While their child is playing Roblox or Fortnite, they do not realise what is actually on that device and what may be potentially luring them a bit later down the line. Maybe there could be a big education campaign in London or around the country raising awareness about the dangers of gambling and the harms it can cause.

Emma Best AM: Yes. You are doing online safety now in schools from reception, basically, and gambling is part of that online safety, right?

Dean Frost: I am old enough to remember when we got taught to cross the road, but now it is stuff that I never had in 1989. I am giving my age away now.

Emma Best AM: Yes, of course. Colin, did you want to say something?

Colin Walsh (Lived Experience Manager, GamCare): Yes, just one more from me and it builds on Tracy's point as well. Really engage with people with lived experience of harm. Hear those stories. That is what makes it real. We talk a lot about data and stats, and I have had a few numbers written down, but each one of those numbers is somebody's life. It is their family's life and their partner's and their kids' and their parents'. Hear some of those stories from people across London who have been impacted. That is what makes it real. They are the things people remember.

Emma Best AM: In terms of putting that into a recommendation, would that be for the Mayor of London to have some sort of forum or a summit event? Is that what you mean?

Colin Walsh (Lived Experience Manager, GamCare): Yes, just hearing those stories from people and not hearing the organisations in this space that all do different things. Hear from the people who have had support from these organisations. Hear just how valuable is the work that all of us do. It saves lives. It changes lives. It sometimes has to pick up the pieces for those people left behind, which is really sad, and so let us not let it get that far or let us do our best to not let it get that far.

Emma Best AM: One final question I had is the one where we as a Committee clearly have the most limited powers, but we could still make recommendations. It is in terms of the gambling industry. "Stop existing" might be your recommendation, but is there anything that you could specifically think that we could be asking or lobbying for from the Assembly through this work?

Tom Fleming (Communications Manager, Gambling with Lives): Yes. It definitely should not stop existing, in my opinion, anyway. They just need to, essentially, clean up their acts, to use a better phrase. They make the majority of their profits from harm. That needs to change. This harm does not happen by accident. It happens because of their products, because of their practice, things like marketing misleading offers, things like cross-selling. They need to stop that. Unfortunately, for them, that would mean essentially

a hit to their bottom line because they make most of their profit from harm. That needs to stop. However, that would get a lot of kickback because they are private businesses whose aim is to make money.

Emma Best AM: Can you briefly describe cross-selling for me?

Tom Fleming (Communications Manager, Gambling with Lives): Sure. Cross-selling would be where, say, I am on the train on the way back today and I see an advert that says, "Sign up with X and X and get a £5 free bet when you put £10 on." I am in there because I am football better and I am with that gambling operator. Then they will start to cross-sell me towards different products. They might be sending you offers to get you in, for example, for things like online casinos and online slot games. They have essentially converted a sports better to an online casino better, which is the most dangerous and addictive product. It is a very common route in that I talk to people about. They come in through football because it is the hook that gets people in. Once they are in and they have the data and they are profiling you and are profiling your age and your characteristics and things, they will push you across to the more addictive and dangerous products.

Emma Best AM: Thanks. Does anyone have any other specific recommendations or things we should take on board about the gambling industry and the things it could do to, as Tom said, clean up its act?

Colin Walsh (Lived Experience Manager, GamCare): For me, I guess less industry-specific but more awareness. Do not stop learning about what else is out there and what support is out there from the organisations. I know GAMSTOP was mentioned earlier. At GamCare, we run a partnership called TalkBanStop, which is with GamCare, GAMSTOP and Gamban. We are hosting an event at the House of Lords on 28 February [2024], where Lord Foster [of Bath, Chair, Peers for Gambling Reform] is speaking. I am sure I can get any of you on the invite list if you want to come along. It is great to liaise with the organisations and find out why they exist and how they have come together to support people.

I agree with Tom that campaigning against the gambling industry does not have an end goal that we can achieve, but what we need to do is just make it be better and ensure that fewer people are harmed and that those who are get the best support.

Emma Best AM: Is there perhaps one thing that one online provider or betting shop has done that is best in field and everybody else should do?

Colin Walsh (Lived Experience Manager, GamCare): The seatbelt has never been invented for gambling, unfortunately. If it was, would they share it? They probably should. That does not exist. Practices are very slowly changing but technology is also quite quickly changing. Yes, that seatbelt that saves millions of lives a year does not exist in gambling.

Dr Onkar Sahota AM (Chair): Assembly Member Hirani?

Krupesh Hirani AM: Thank you. It might have been Tom in one of the earlier exchanges who mentioned the Gambling Act and Colin mentioned licensing laws as well. Do you feel that it is time that legislation was reviewed?

Tom Fleming (Communications Manager, Gambling with Lives): It just has been reviewed, the Gambling Act. It was reviewed and the white paper was published in April of last year [2023]. There was the reform side and the industry side and so a lot of the things that were included ended up being a little bit watered down. A lot of the nuts and bolts and the details went out to consultations, which are undergoing and are yet to be announced. Although no actual reforms have been enacted yet, the Gambling Act itself has been reviewed.

Krupesh Hirani AM: Last week, a couple of cabinet members from Brent Council in my area wrote to the Government explaining about the harms of operators on high streets in the [London] Borough of Brent and calling for more powers for local councils to make decisions that are right for local communities. Is that something that you would like to see? Dean, you alluded to some of the newer types of betting shops, the slot machine shops and the gaming shops that are popping up on high streets.

Dean Frost: Centrally in London, certain streets that I used to go and gamble on, those betting shops have disappeared, but they have been replaced or there are more slot machines and casinos and 24/7 arcade types of premises. I have forgotten the question now.

Krupesh Hirani AM: Do you feel that councils should have more powers in controlling what goes into high streets?

Dean Frost: Yes, without a doubt because I am sure, once again, the people who own the betting shops and these organisations are targeting certain high streets, maybe knowing that people have less money and are more needy. Yes, without a doubt, councils, governments, whoever is making policies, yes.

Krupesh Hirani AM: Just because it is not an area that we have discussed much in terms of the slot machine and arcade types of shops, do any other panellists want to come in with any thoughts on those?

Colin Walsh (Lived Experience Manager, GamCare): I know there was a YouGov survey last year that talked about people using betting offices, arcades and slot centres as warm banks. Off the top of my head and so do not quote me - but I am conscious this is recorded and minuted - one in six who gamble harmfully use those kinds of establishments as warm banks. That is horrific. Also, you see on any high street in any part of London the concentration of gambling establishments in the more deprived areas. That tells you something in itself. You do not need the research to tell you why that happens. It just does not feel right.

I would also just add the protections that we have talked about today are getting better. Things like GAMSTOP and Gamban are great for online gambling. In-person needs to go some way to catch up the same technology. Whilst there are national schemes, they are not quite as effective as the feedback that I get from other people. It is hard to stop yourself. If you think about that broader question of what gambling is, we are not just talking about betting on the horses or in a casino or in an arcade. Add the Lottery. Add scratch cards and those slot machines that might be in pubs. It is all around.

Dean Frost: Just regarding the protection, not on the street but online, this is another one that I have. I have little polls from people in the recovery community. Where is it? Did betting companies, online or onsite, ever do affordability checks on you or question your gambling? Nine said yes and 15 said no, which means 15 had been allowed to continue to gamble irresponsibly without control.

Colin Walsh (Lived Experience Manager, GamCare): Sorry, just to come back in with one more that I meant to mention from me, on the licensing side, it is not a world I fully understand but I know the basics of the aim to permit scheme. Is that the right approach when it comes to high risk? We talk about high-risk areas on the TfL estate in advertising. The same principles can apply when it comes to bricks and mortar buildings that cause harm.

Dr Onkar Sahota AM (Chair): Assembly Member Russell?

Caroline Russell AM (Deputy Chair): Thank you. Yes, I have just a few things I want to pick up on that go back a little bit though. We have talked quite a lot about gender and the different experience of men and women. I am just wondering. London is a very diverse city. We have huge numbers of different communities. I just wondered. Are there differences amongst different communities within London? Tracy?

Tracy O'Shaughnessy: Yes, from an 'affected other's' perspective, definitely. What I have seen is a rise in women coming forward from the Muslim faith. Particularly within Islam, gambling is classed as haram. It is a very closed community. It is a huge cultural issue rather than a religious issue if that makes sense. Particularly, we are trying to reach out to that community specifically, but it is very difficult for most of those women that I speak to.

I spoke to one just yesterday at length. I can touch on this because my daughter actually converted to Islam and so I understand her journey. She just cried for about 10 minutes and said, "You are the first person who has actually heard me", because she went to her local mosque, and she was told that she was bringing shame against her husband and that she must never speak about it again. There is a huge issue here. There is a huge community of women that we are not reaching particularly. That is just one area that I would like to focus on moving forward.

Caroline Russell AM (Deputy Chair): That also points to having information about gambling on buses, the Tube, places where people travel?

Tracy O'Shaughnessy: Absolutely. I support another lady whose husband is, again, from the Muslim community. He will not go for any help at all because of the shame and stigma attached to that. He is worried his family will find out. That is just a couple of examples from both sides there.

Yes, it is something particularly within the organisations that I work with. We are looking at ways to reach those women particularly because it is something that I am really aware of. How do we approach that safely and delicately?

Caroline Russell AM (Deputy Chair): We have heard about the barriers to seeking help anyway because of the shame and the stigma, which we heard about at the very beginning of this session, but then if you have another overlay on top of that, then that makes it --

Tracy O'Shaughnessy: Absolutely. I do find that women from those particular communities struggle even more. For example, a lady just recently could not reach out for help. She really struggled with her mental health and just cannot talk about it to anyone else. As you say, positive advertising and signposting is a way for these particular women to be able to go, "That could be me", using advertising that looks like them - do you know what I mean - because it is relatable.

Caroline Russell AM (Deputy Chair): Culturally competent advertising?

Tracy O'Shaughnessy: Absolutely. It has to be relatable.

Caroline Russell AM (Deputy Chair): Yes. Thank you. OK. I have got a couple of other things I wanted to pick up on. Sorry, I am just scribbling things down here.

We have talked a lot about the development of online gambling. There is another online product, which is cryptocurrency. I just wonder if you are aware of evidence or experience of products and services that have

financial risks that are similar to gambling like cryptocurrency and whether that is also influencing gambling behaviour. Is there anything that anyone wants to throw in on that? Tom, you look like you might have.

Tom Fleming (Communications Manager, Gambling with Lives): Yes. I recall there was some news in the last year or so about a rise in people seeking help for crypto-related issues, but in itself cryptocurrency is just an asset, no matter how volatile or speculative. It in itself is just there. It is the way it is marketed. Again, there are clear parallels with gambling with the gamblification of the apps and the checking all the time. There is a crossover, but that is probably more in the marketing of the product as opposed to in the product itself, if that makes sense.

Caroline Russell AM (Deputy Chair): Yes. I suppose I am just thinking, if we are talking about controls on marketing gambling, whether there should be additional controls that relate to products like cryptocurrency and whether there is crossover into the gambling harm space.

Dean Frost: I have actually experienced a few more people in the last year joining our recovery community and being involved in crypto. I worked during lockdown. There was no cab work and so I went and worked on a building site over in Slough with a lot of young builders. A lot of them spent a lot of their time on their phones. They were looking at their phones definitely after one o'clock and so they were involved in the forex trading in the American markets. They were also heavily involved in crypto, and they could not stop looking at their phones and their trades going up and down. As far as I am concerned, if there is an unhealthy relationship that they are consumed by and cannot concentrate on their day, then crypto is a problem.

Again, I use the example of people in the back of the cab. I asked a banker last week what he thought of crypto. He said, "I do not even get involved." He had a nice big house. He worked in the City of London. I assume he was doing well for himself. He said, "If I do not understand the product, I do not get involved." Probably the likelihood is we have lots of young people thinking that they can get rich quickly and, likely, it is not going to happen. As far as I am concerned, crypto needs to be put in with other forms of gambling.

Caroline Russell AM (Deputy Chair): Yes. Colin, you looked like you were going to say something.

Colin Walsh (Lived Experience Manager, GamCare): Yes, I agree with that. I know people we have supported at GamCare who have suffered harms through crypto trading because no specialist support exists and so they see the parallels and come to gambling support services. Crypto companies advertise those short 24-hour high returns, which are essentially parallels to gambling. It is also not regulated as gambling. We are not strictly funded to do all of this. Whether we should be is an entirely different question, but anybody who has probably walked the paths that we have can really see those parallels. It is certainly not something I would ever consider doing because I see it very much as gambling myself.

Caroline Russell AM (Deputy Chair): Yes. Thank you. My final question. We heard just earlier - and I cannot remember who it was who talked about it now - that there was some good practice in Haringey in terms of training people well and making sure that all the different agencies that might encounter someone experiencing gambling harm might come into contact with, all the people that Tracy has been mentioning, contact with police or with social workers or with housing support.

Are there any good examples of places where gambling advertising has already been removed or banned that has not been mentioned so far today? Is there anything that you are aware of that is tip-top good practice that London should be having a look at?

Tom Fleming (Communications Manager, Gambling with Lives): When you say "place", how loosely are we drawing that term?

Caroline Russell AM (Deputy Chair): City, country, town, village.

Tom Fleming (Communications Manager, Gambling with Lives): I know there are countries that have banned gambling advertising in Europe or certainly put severe restrictions on it. Belgium, Spain, Italy and Norway have some form of restriction. I do recall seeing, although I cannot quote, the Norway example. After X amount of time either banning or restricting, they saw harm levels go down. I can try to dig that out and forward that over to someone because I appreciate that that is quite vague.

Caroline Russell AM (Deputy Chair): That would be really helpful.

Tom Fleming (Communications Manager, Gambling with Lives): I will make a note of that.

Caroline Russell AM (Deputy Chair): It is always good to tell the Mayor to look to a particular place for examples of other practice.

Tom Fleming (Communications Manager, Gambling with Lives): Yes, I agree. We need to look outside of the UK for this. There is a researcher in Bristol, [Dr] Raffaello Rossi [Lecturer in Marketing, University of Bristol], who is great on social media and advertising. I have seen his presentations a few times. We have some of the most lax gambling advertising legislation in Europe. Yes, there is precedent for bans in sport. We would not be the first to do this. There is some practice elsewhere.

Caroline Russell AM (Deputy Chair): Thank you very much indeed. Back to you, Chair.

Dr Onkar Sahota AM (Chair): Thank you. Thank you to all members of the panel. If you think of something, particularly on the issues raised by my colleagues, if you can send the information to the secretariat, it would be very helpful, and we will of course pick it up. Thank you very much for sharing your very personal experiences and thank you to all the Committee Members for dealing with this matter so sensitively. I just have to finish on a few bits of formal business and then you will be free to go.

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GREATERLONDONAUTHORITY LONDONASSEMBLY

Subject: Summary List of Actions

Report to:	**Health Committee**
Report of:	**Executive Director of Assembly Secretariat**
Date:	**13 March 2024**
Public Access:	**This report will be considered in public**

1. Summary

1.1 This report updates the Health Committee on the progress made on actions arising from previous meetings.

2. Recommendation

2.1 **That the Committee notes the completed, closed and outstanding actions arising from its previous meetings.**

3. Summary List of Actions

Actions Arising from the Meeting Held on 1 February 2024

Item No:	Item Title	Responsible Person	Action(s)	Status
6.	Health Impacts of Gambling in London Part 2	Communications Manager, Gambling with Lives	• Supply relevant data regarding women experiencing, and seeking help for, gambling addiction; and • Share data regarding the impact of the advertising ban on levels of gambling harm in Norway.	Completed. See **Appendix 1**.

Item No:	Item Title	Responsible Person	Action(s)	Status
6.	Health Impacts of Gambling in London Part 2	Senior Policy Advisor	That authority be delegated to the Chair, following consultation with party Group Lead Members, to agree any output arising from the discussion.	In progress.

Actions Arising from the Meeting Held on 29 November 2023

Item No:	Item Title	Responsible Person	Action(s)	Status
6.	Health Impacts of Gambling in London	Greater London Authority (GLA) Group Director of Public Health	To confirm the amount the GLA Group is spending on the Transport for London (TfL) estate for public health messages regarding gambling.	Completed. See **Appendix 3**.
6.	Health Impacts of Gambling in London	Deputy Chair, GambleAware	To confirm whether TfL has offered advertising space to GambleAware for positive messages about preventing or treating gambling addiction.	Completed. See **Appendix 2**.
6.	Health Impacts of Gambling in London	Senior Policy Advisor	That authority be delegated to the Chair, following consultation with party Group Lead Members, to agree any output arising from the discussion.	In progress.

Actions Arising from the Meeting Held on 21 September 2023

Item No:	Item Title	Responsible Person	Action(s)	Status
6.	Eating Disorders in London Part 2	Senior Policy Advisor	That authority be delegated to the Chair, following consultation with party Group Lead Members, to agree any output arising from the discussion.	Completed. See **Agenda Item 5**.

Actions Arising from the Meeting Held on 29 June 2023

Item No:	Item Title	Responsible Person	Action(s)	Status
6.	Eating Disorders in London	Senior Policy Advisor	That authority be delegated to the Chair, following consultation with party Group Lead Members, to agree any output arising from the discussion.	Closed. See above.

Actions Arising from the Meeting Held on 25 May 2023

Item No:	Item Title	Responsible Person	Action(s)	Status
10.	Trauma-informed approaches to youth violence	National Clinical Director for Violence Reduction, NHS England	To provide the NHS England guidance for measuring outcomes from trauma-informed programmes within emergency departments and hospital environments.	Ongoing. Followed up on 8 February 2024.

Actions Arising from the Meeting Held on 20 March 2023

Item No:	Item Title	Responsible Person	Action(s)	Status
6.	Healthy Eating Habits	Senior Policy Advisor	That authority be delegated to the Chair, following consultation with party Group Lead Members, to agree any output arising from the discussion.	In progress.

4. Legal Implications

4.1 The Committee has the power to do what is recommended in this report.

5. Financial Implications

5.1 There are no financial implications arising from this report.

List of appendices to this report:

Appendix 1 – Response from the Communications Manager, Gambling with Lives, dated 9 February 2024

Appendix 2 – Response from the Deputy Chair, GambleAware, dated 19 February 2024

Appendix 3 – Response from the GLA Group Director of Public Health and Deputy Statutory Health Adviser, dated 23 February 2024

Local Government (Access to Information) Act 1985

List of Background Papers:

None

Contact Information

Contact Officer:	Diane Richards, Committee Officer
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Appendix 1

Response to follow up request for information from the 1 February 2024 meeting of the Health Committee

Request for information:

During the course of the discussion, the Communications Manager, Gambling with Lives agreed to:

- Supply relevant data regarding women experiencing, and seeking help for, gambling addiction; and
- Share data regarding the impact of the advertising ban on levels of gambling harm in Norway.

Response:

Good afternoon,

Please see the information on the follow-ups, as requested by Dr Sahota [AM]:

- Evidence that advertising restrictions can help prevent harm: https://www.sciencedirect.com/science/article/abs/pii/S0160252713001040?via%3Dihub
- Norway drop in harm post advertising ban (I appreciate correlation isn't causation so 'concrete' evidence in this area can be hard to find): https://focusgn.com/survey-shows-notable-drop-in-gambling-harm-in-norway
- Women suffering gambling harm directly/ looking for help – accurate data problematic in this area but NHS Health Survey from 2021 have it that about 20/25% of people classed as 'problem gamblers' are women – so between 60,000 and 280,000. A GambleAware study from 2022 estimated a million women are at risk of harm. Whatever the number, it's definitely on the rise and women are seen as a huge growth market.

Hope this is helpful and thanks again,

Tom

Tom Fleming

Communications Manager

Gambling with Lives

Sent by email on 9 February 2024

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Appendix 2

Response to follow up request for information from the 29 November 2023 meeting of the Health Committee – Health Impacts of Gambling

Request for information:

During the course of the discussion, Members requested that the Deputy Chair, GambeAware, confirm whether TfL has offered advertising space to GambleAware for positive messages about preventing or treating gambling addiction.

Response:

Dear Committee Members,

Here is a comment from the Director of communications at GambleAware:

> *Thanks for following up - no we haven't had any free space from TfL, but would love to open up the conversation with them .*
>
> *Given the impact of their HFSS ban, and the fact that Londoners are twice as likely to experience gambling harms - I think we could collaborate on something really interesting/impactful.*

Given the positive response perhaps TfL could be encouraged to contact GambleAware via Alexia Clifford.

Best wishes

Sian

Sian M Griffiths CBE
Deputy Chair
GambleAware

Sent by email on 19 February 2024

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MAYOR OF LONDON

Dr Onkar Sahota AM
Chair of the Health Committee
London Assembly
City Hall
Kamal Chunchie Way
London E16 1ZE

(sent by email)

Date: 23 February 2024

Dear Onkar,

Thank you for the invitation to contribute to the Health Committee meeting on Wednesday 29 November 2023. It was a pleasure to meet with you and the members of the Committee to discuss the Health Impacts of Gambling in London

During the course of the discussion, I agreed to provide the Committee with further information. I have set out my response to your requests below:

To confirm the amount the GLA Group is spending on the Transport for London (TfL) estate for public health messages regarding gambling.

I have explored this with Group organisations and can confirm that there have been no bookings from the GLA Group on the Transport for London (TfL) estate for public health messages regarding gambling, and as such no spend.

Yours sincerely,

Vicky Hobart, BSc, MSc, FFPH
GLA Group Director of Public Health and Deputy Statutory Health Adviser

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GREATERLONDONAUTHORITY LONDONASSEMBLY

Subject: Action Taken Under Delegated Authority

Report to:	**Health Committee**
Report of:	**Executive Director of Assembly Secretariat**
Date:	**13 March 2024**
Public Access:	**This report will be considered in public**

1. Summary

1.1 This report outlines recent action taken by the Chair of the Health Committee in accordance with the delegated authority granted by the Health Committee.

2. Recommendation

2.1 **That the Committee notes the recent action taken by the Chair under delegated authority, in consultation with party Group Lead Members, namely to agree the report on eating disorders, as attached at Appendix 1.**

3. Background

3.1 At its meetings on 29 June 2023 and 21 September 2023, the Committee discussed eating disorders with invited guests and resolved that:

Authority be delegated to the Chair, in consultation with party Group Lead Members, to agree any output from the meeting.

4. Issues for Consideration

4.1 Following consultation with party Group Lead Members, on 29 February 2024, the Chair of the Health Committee agreed the Committee's report on eating disorders, as attached at **Appendix 1**.

5. Legal Implications

5.1 The Mayor of London's statutory responsibilities in relation to health matters, as set out in the GLA Act 1999, are to develop a strategy which sets out "proposals and policies for promoting the reduction of health inequalities between persons living in Greater London". The GLA Act 1999 defines health inequalities as inequalities between persons living in Greater London "in respect of life expectancy or general state of health which are wholly or partly a result of differences in respect of general health determinants" and also goes on to define "health determinants". The Mayor of London has no statutory role in the commissioning of any health services or health service provision.

5.2 The Committee has the power to do what is recommended in the report.

5.3 Officers confirm that the recommendations contained in the report fall within the Committee's terms of reference.

6. Financial Implications

6.1 There are no financial implications arising from this report.

List of appendices to this report:

Appendix 1 – Eating Disorders Report, published 29 February 2024

Local Government (Access to Information) Act 1985

List of Background Papers:

Member Delegated Authority Form 1542 [Health Committee – Eating Disorders Report]

Contact Information

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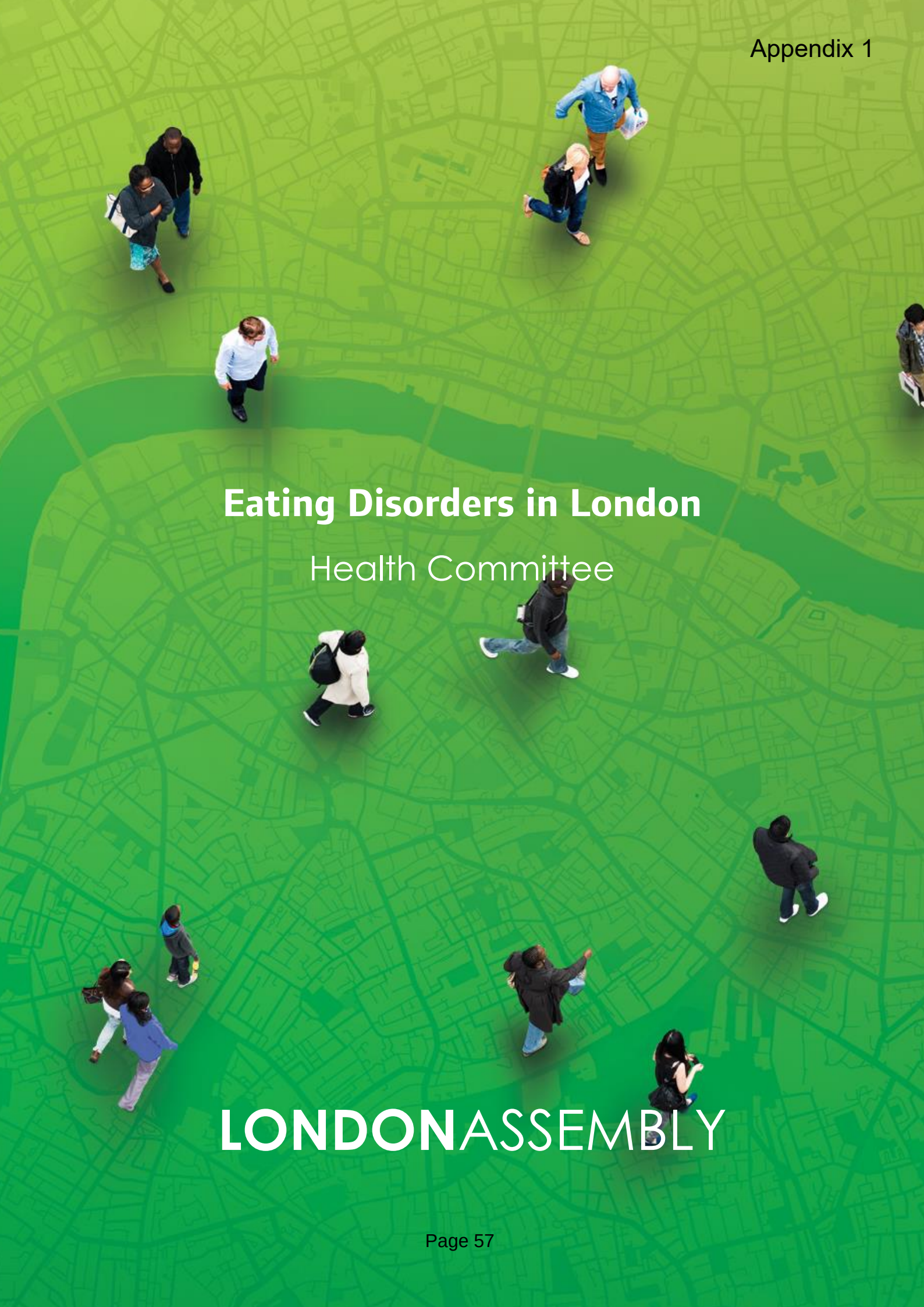

Eating Disorders in London

Health Committee

LONDONASSEMBLY

Health Committee

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Contents

Foreword

Dr Onkar Sahota AM
Chair of the Health Committee

Up to six per cent of the UK population may suffer from an eating disorder in their lifetime. In severe cases, eating disorders have devasting impacts on the lives of individuals and their loved ones.

Many people suffer in silence with an eating disorder for too long. Some may not recognise their symptoms at first, while others may feel reluctant to come forward and seek help due to the stigma associated with the condition. People who do not fit prevalent stereotypes of an eating disorder sufferer may find it even harder to reach out for support, particularly men, older people and people from certain minority ethnic groups.

Given that people may be initially reluctant to seek help, it is crucial that when they do, they are met by informed health practitioners supported by robust systems to deliver the specialist help required.

However, this is often not happening in London.

The London Assembly Health Committee has found that many people face significant barriers to access treatment amidst over-stretched services struggling to meet increased demand. As an experienced GP, I was particularly concerned to hear that some people in London have found their GP to be ill-informed and insensitive to their experiences. The Committee also heard that some GPs failed to make necessary referrals to specialist services.

Those that are able to secure referrals then face services that are facing significant capacity pressures. Referrals to specialist eating disorder services have more than doubled in London since 2016, for both children and adults. Simultaneously, the Committee was told that services in London do not have sufficient staff to safely deliver the care that is required.

It is in this context that we see inconsistent waiting times. Last year, 61 per cent of adults accessed services within four weeks of being referred but performance between trusts differed widely. Some adults have waited over three years to start treatment in London after being first referred.

Improvements to waiting times for children and young adults have also stuttered in the past two years and services in London are failing to meet national waiting time standards for children and young adults. For those stuck on waiting lists, the Committee was told there is almost no support provided. People told us how their condition deteriorated dangerously while waiting, unsupported, for treatment to begin.

The findings set out in this report highlight how over-stretched services are not able to provide the kind of tailored, long-term, integrated support that is required to address both the underlying causes, and health impacts, of eating disorders.

However, I am not without optimism. London is home to some of the most effective and innovative eating disorder services in the country, staffed by dedicated and expert professionals. The Committee makes several recommendations which it thinks can harness the assets present in London to deliver improvements to eating disorder services across London.

I would personally like to thank all those that provided evidence to the Committee. I am particularly grateful to the many people with direct experience of eating disorders who shared their views via public meetings, private meetings and the Committee's survey. This report is far richer for their contributions. I hope the powerful testimonies within this report, alongside the Committees recommendations, can help spur action to ensure London leads the way in the delivery of accessible and effective treatment for eating disorders.

Executive summary

In June 2023, the London Assembly Health Committee launched an investigation into eating disorders in London, following reports that referrals for eating disorder services have increased in recent years and performance against waiting time standards dropped during the COVID-19 pandemic. The aim of this investigation was to understand what is driving the increase in referrals, how services are responding to this additional demand and to explore people's access to, experiences of, and outcomes from treatment services.

The Committee held two formal meetings with expert guests, including clinicians, people with experience of living with an eating disorder, and representatives from the Greater London Authority and NHS England. It also held a private session with people with lived experience of being affected by an eating disorder and received 112 responses to its survey from those with experience of an eating disorder, supporting a family member or friend with an eating disorder or those working with those experiencing an eating disorder.

The Committee is grateful to all those who shared their expertise to inform this investigation. Many people shared their personal stories of having an eating disorder or supporting a loved one with an eating disorder, and this evidence has been hugely valuable to the Committee's work.

This report highlights several concerns around the increasing prevalence of eating disorders in London and the pressures faced by services to respond to this demand. Too many people and their families are not able to get the care and treatment they desperately need. This report identifies major issues related to barriers to securing referrals, waiting times for services, quality of care, management of discharges and the paucity of support in the community.

The key findings made in this report include:

- The demand for eating disorder services in London has increased in recent years and was accelerated by COVID-19. However, some GPs could benefit from updated training on eating disorders and many people struggle to access referrals to specialist services.

- Whilst NHS funding for eating disorder services is at its highest ever level[1], services in London have struggled to cope with the demand. Performance on waiting times has worsened, with people stuck on long waiting lists, often with their symptoms getting worse and with little interim support.

- Some services are left to prioritise only the most severely ill people and are reportedly going against clinical guidance by using body mass index (BMI) as a threshold for determining who should and shouldn't have access to services.

- Excellent care is available in parts of London, but work is needed to provide consistent access to the best care possible for all Londoners.

[1] NHS England, Children and young people's eating disorders programme

- Resources of community groups and voluntary sector organisations are not currently being harnessed effectively to support those with mild to moderate symptoms.

- The absence of positive support networks for young people leads some to engage in 'pro-eating disorder communities' online, which may encourage and accentuate existing eating disorders.

- Eating disorders have a devastating impact on families and yet there is little support provided to families and carers of people with eating disorders.

The report makes 12 recommendations for change, which are detailed below. The Committee acknowledges that the ability to enact many of these recommendations falls outside the direct powers of the Mayor and the GLA. However, the Committee believes the Mayor can play a role in working with the NHS to help address the challenges that services face, improve standards of care and expand existing good practice to improve outcomes for people with eating disorders in London. We have therefore focused on how the Mayor could most fruitfully intervene and influence the services, in order to make a real difference to the lives of Londoners affected by eating disorders.

Recommendations

Recommendation 1

The Mayor should work with NHS England (London), including through the London Health Board, to advocate for the adoption of training on eating disorders across all GP practices in London.

Recommendation 2

The Mayor should request that NHS England (London) explores the feasibility of establishing self-referral routes for adult eating disorder services across London and the likely number of referrals that would be generated, so that the service set up can meet the needs of the patients self-referring.

Recommendation 3

The GLA Health team should work with NHS trusts across London to ensure that: all people on waiting lists for eating disorder services are provided with clear information and resources; and additional interim support is commissioned for those on waiting lists who are at higher risk.

Recommendation 4

The Mayor should lobby NHS England (London) to ensure that health services are not rejecting nor prioritising patients for treatment for an eating disorder on the sole basis of BMI, as stipulated in NICE guidelines.

Recommendation 5

The GLA Health team should work with NHS England (London) to conduct a London-wide audit of available eating disorder services, to identify and address any gaps in provision for particular eating disorders, such as binge-eating disorder and avoidant/restrictive food intake disorder.

Recommendation 6

The Mayor should request that NHS England (London) supports the roll-out of specialist care pathways across NHS trusts in London for people with autism suffering from an eating disorder.

Recommendation 7

The Mayor should request that NHS England (London) reviews how the Improving Access to Psychological Therapies workforce can be utilised across London to provide better access to talking therapies for people with eating disorders.

Recommendation 8

The Mayor and the GLA Public Health Unit should design and deliver a public awareness campaign on eating disorders across London, with the aim of addressing stigma and improving signposting to support services.

Recommendation 9

The Mayor should work with relevant partners to ensure that Thrive LDN and Good Thinking provide good, easily accessible and up-to-date information to help people with an eating disorder understand options for treatment and services available in London.

Recommendation 10

The Mayor should raise awareness of the existing legislation that exempts schools from including calories on menus, to support schools that may believe they are required to display calorie information.

Recommendation 11

The Mayor should take steps to support those experiencing eating disorders when using cafes and restaurants on GLA and TfL premises, ensuring that relevant exemptions to calorie labelling on menus are applied. This could include doing more to promote the option of providing a menu without calorie information.

Recommendation 12

The Mayor should bring together the GLA Health Team, NHS England (London) and Feast to review how NHS trusts engage with and support families impacted by eating disorders; and identify areas where additional support can be provided.

About eating disorders in London

About eating disorders

According to the National Institute for Health and Care Excellence (NICE), "eating disorders are characterised by persistent disturbance of eating or eating-related behaviour which leads to altered intake or absorption of food and causes significant impairment to health and psychosocial functioning."[2]

According to the NHS, examples of eating disorders include:

- Anorexia nervosa – trying to control your weight by not eating enough food, exercising too much, or doing both
- Bulimia – losing control over how much you eat and then taking drastic action to not put on weight
- Binge eating disorder – eating large portions of food until you feel uncomfortably full
- Avoidant/restrictive food intake disorder (ARFID) – avoiding certain foods or limiting how much you eat or both.[3]

The NHS states that people may develop eating disorders due to a combination of psychological, biological, genetic and social factors.[4] The Committee heard that there are a wide range of possible contributing factors, including genetic causes and environmental triggers. The Committee is not in a position to provide a comprehensive summary of the causes of eating disorders, although this report does discuss some potential causes or contributing factors that were raised by guests.

Some people with eating disorders may not have all the recognised symptoms from a particular disorder or may experience symptoms from more than one disorder, which can make it more complicated to get a formal diagnosis.[5] For example, atypical anorexia carries the same symptoms of anorexia nervosa but without being underweight.[6] According to the NHS, the most diagnosed eating disorder is "other specific feeding or eating disorder" – a diagnosis given in circumstances where an individual's symptoms do not exactly fit those expected for any single eating disorder.[7]

Beat, a UK-based eating disorder charity, has estimated that 1.5 million people across the UK are suffering from an eating disorder at any one time, and that six per cent of the population suffer from an eating disorder in their lifetime.[8]

[2] National Institute for Health and Care Excellence, Eating disorders: What is it?, July 2019
[3] NHS, Overview – Eating disorders [Last accessed 09/02/24]
[4] NHS, Overview – Eating disorders [Last accessed09/02/24]; Mind, Eating problems [Last accessed 26/05/23]
[5] Mind, Eating problems [Last accessed 01/06/2023]
[6] Beat, Anorexia nervosa [Last accessed 01/06/23]
[7] NHS, Overview – Eating disorders [Last accessed 26/05/23]
[8] London Assembly, Health Committee – transcript, 29 June 2023 p.1

According to the NHS Health Survey for England 2019, four percent of all adults in England may have an eating disorder. [9]

Treatment for eating disorders in London

NHS eating disorder services offer a range of treatment options. Care may involve any of the following:

- monitoring of weight, mental and physical health
- psychoeducation about the disorder
- cognitive behavioural therapy
- other forms of individual, group or family therapy
- dietary counselling
- guided self-help programmes
- involvement of family in care plans.[10]

Where there are concerns that someone is seriously unwell or underweight, that person may be admitted to a specialist clinic or mental health hospital and receive additional support and medication.[11] Admissions may be planned for the purpose of medical stabilisation, symptom interruption and weight restoration. Urgent or unplanned admissions may be made with the purpose of weight restoration.[12]

There are eight NHS trusts currently delivering specialist eating disorder services in London (see table one). Each of the five Integrated Care Boards in London have at least one child and adolescent service, and one adult service in their area.

Table 1: Eating disorder services in London

ICB	Provider	Children and adolescent/ adult
North Central	Central and North West London NHS Foundation Trust	Children and adolescent; and adults
	Royal Free London NHS Foundation Trust	Children and adolescent
	Barnet, Enfield and Haringey Mental Health NHS Trust (St Anne's Hospital)	Adults
North East	East London NHS Foundation Trust	Children and adolescent; and adults
	North East London NHS Foundation Trust	Children and adolescent; and adults

[9] NHS, Health Survey for England, 2019, 15 December 2020. The SCOFF scale was used to determine whether someone had a possible eating disorder, but this does not provide definitive diagnosis. See notes included in dataset for further information on SCOFF.
[10] NICE, Eating disorders: recognition and treatment, 16 December 2020
[11] Mind, Eating problems [Last accessed 01/06/2023]
[12] NICE, Eating disorders: recognition and treatment, 16 December 2020

North West	West London NHS Trust	Children and adolescent; and adults
South East	South London and Maudsley NHS Foundation Trust	Children and adolescent; and adults
South West	South West London and St George's Mental Health NHS Trust	Children and adolescent; and adults

Private providers also operate in London and will sometimes receive referrals from the NHS where it has insufficient inpatient capacity. Providers include Priory Group, Cygnet, Ellern Mede and Schoen Clinic.[13]

Mayoral powers and the role of the GLA

The Mayor is required through the Greater London Authority Act 1999 to publish a health inequalities strategy that contains proposals and policies for the reduction of health inequalities in London.[14]

There is no reference to eating disorders in the Mayor's Health Inequalities Strategy (HIS) or the HIS Implementation Plan 2021-24.[15] However, there are objectives within the strategy that the Committee believes have clear relevance to issues related to eating disorders, including:

- "Mental health becomes everybody's business. Londoners act to maintain their mental wellbeing, and support their families, communities and colleagues to do the same
- No Londoners experience stigma linked to mental ill health, with awareness and understanding of mental health increasing city-wide."[16]

Whilst the Mayor has no formal powers related to the delivery of health services, the GLA Act 1999 also states that the Mayor's strategy must "describe the role to be performed by any relevant body or person for the purpose of implementing the strategy". A relevant body includes any NHS trust or NHS foundation trust which delivers services within London.[17]

This report therefore identifies areas where we believe the Mayor and GLA can take action, both within their current powers and by using their role to influence and work alongside health delivery partners. The Committee also expects this report will be considered as evidence to inform the next Mayor's Health Inequalities Strategy implementation plan.

[13] Written evidence – Royal College of Psychiatrists. Published alongside report.
[14] UK Government, Greater London Authority Act 1999
[15] GLA, Health inequalities strategy, September 2018. GLA, Health Inequalities Strategy Implementation Plan 2021-24, 9 December 2021
[16] GLA, Health inequalities strategy, September 2018
[17] UK Government, Greater London Authority Act 1999

About the investigation: evidence and methodology

Meetings

This investigation sought to understand the prevalence of eating disorders in London, and people's access to, experiences of and outcomes from, treatment.

The Committee held three evidence sessions as part of this investigation. It held a formal session on 29 June 2023 to hear evidence on the causes and prevalence of eating disorders in London and how people could access treatment. The following guests attended:

- Hope Virgo, Author and Campaigner and person with lived experience
- Dr Karina Allen, Consultant Clinical Psychologist, Eating Disorders Outpatients Service - South London and Maudsley NHS Foundation Trust
- Andrew Radford, Chief Executive, Beat Eating Disorders
- Jazz Bhogal, Assistant Director, Health, Education and Youth, GLA

It held a second formal session on 21 September 2023 to hear evidence on people's access to, experiences of and outcomes from eating disorder services in London. The following guests attended:

- Emma Christie, Head of Mental Health, NHS London
- Dr Brian Sreenan, Consultant Psychological Lead for Disordered Eating, NHS East London Foundation Trust
- Dr Agnes Ayton, Consultant Psychiatrist, Oxford Health NHS Foundation Trust
- Dr Ashish Kumar, Clinical Director Child and Adolescent Mental Health Services (CAMHS) Mersey Care NHS Foundation Trust and Chair Faculty of Eating Disorders, Royal College of Psychiatrists
- Dr Victoria Chapman, Consultant Child and Adolescent Psychiatrist, Royal Free CAMHS
- Jessica Griffiths, National First Episode Rapid Early Intervention for Eating Disorders (FREED) Co-lead, South London and Maudsley NHS Foundation Trust, eating disorders therapist and person with lived experience.

Evidence gathered from these sessions has been used throughout this report and attributed to guests. Full transcripts and recordings of these sessions are publicly available.[18]

Finally, the Committee also held a third evidence session in private with three guests with lived experience on 21 September 2023. Two guests had experience of supporting their child to access eating disorder services in London, and one guest had direct experience of accessing treatment for an eating disorder in London.

Evidence gathered from this session is used throughout this report but is not attributed to guests, to ensure that they are not identifiable. The Committee has also not published a

[18] London Assembly, Health Committee – transcript, 29 June 2023; London Assembly, Health Committee – transcript, 21 September 2023.

transcript from this meeting and some quotes have been modified to remove any detail (such as specific areas in London, ages, BMI and NHS trusts) that could be used to identify guests.

The Committee is grateful to all those who provided oral evidence to its investigation.

Written evidence

The Committee also received nine responses to its call for written evidence. The Committee refers to these responses throughout the report and has published all responses it received.[19] The questions asked in the call for written evidence are included in Appendix A of this report. The Committee is grateful to the following organisations who provided written evidence to its investigation:

- Autistica
- Beat
- Carney's Community
- Family Mental Wealth
- Goldsmiths, University of London
- Jessika Morgan-McNeil
- Local Dental Committee Confederation
- Marc Terry
- Royal College of Psychiatrists.

Survey

The Committee was keen to hear from people with experience of eating disorders and eating disorder services in London. As part of this, the Committee launched a survey to allow Londoners to inform its work. The survey used mostly open text box questions to allow respondents to share as much or as little as they would like to, and in acknowledgement that the survey is not representative of all experiences of eating disorders in London. The Committee is grateful to staff at eating disorder charity Beat who advised on the phrasing of survey questions.

The Committee received 112 complete responses to its survey. The survey was open to anyone who wanted to respond; many respondents had personal experience of an eating disorder (75), experience supporting someone else with an eating disorder (33) or working with people with an eating disorder (16).

Most respondents' experiences related directly to London. 55 respondents had experience of adult eating disorder services in London and 24 had experience of Child and Adolescent Mental Health Services (CAMHS) in London. Other respondents had either not accessed eating disorder services or had accessed services outside of London.

[19] Written evidence published alongside report.

Respondents with personal experience of eating disorders were predominantly female (69), with only small numbers of men (3) and non-binary people (2) responding. Most respondents with personal experience of eating disorders were between the ages of 18 and 34 (see table below).

Most respondents who were supporting someone with an eating disorder described the person they supported as being female (28), compared to male (0) and non-binary (2). Most people being supported were either children or young adults between the ages of 18-24 (table below).

	Age of respondents with a direct experience of an eating disorder	**Age of people being supported by respondents**
Under 18	4	9
18-24	22	12
25-34	23	6
35-44	10	5
45-54	10	0
55+	4	0

The Committee has published the survey questionnaire and responses alongside the report. Responses to the survey are used throughout this report. Please note responses have been edited to remove any information that may be used to identify respondents.

As the survey is not a representative sample, experiences described may not be representative of all Londoners with an eating disorder, their experience of services or of supporting or working with those with an eating disorder.

The Committee is grateful to all those who responded to the survey.

Freedom of information responses

The Committee sent Freedom of Information (FOI) requests to NHS trusts that deliver specialist eating disorder services in London.

The Committee requested information on:

- referral numbers for adults and children since 2016-17, including rejected referrals
- demographic information of referrals for adults and children, including gender, age and ethnicity
- waiting times for adult referrals, including longest waiting times since 2016-17.

The Committee has published all information received by Trusts alongside this report.

Chapter one: seeking support for an eating disorder

Recognising symptoms and seeking treatment

Before seeking treatment for an eating disorder, people must first acknowledge that they are unwell. However, the Committee heard how many people suffer in silence with their eating disorder for some time before seeking treatment. For example, one respondent to the Committee's survey stated: "I have experienced disordered eating for 35 years but was only diagnosed with anorexia 8 years ago". Another stated: "I have been living with anorexia for almost ten years and only sought support this year".

The reasons why people may take some years to seek treatment are varied. One respondent to the Committee's survey suggested they simply did not know they had an eating disorder, as they had never been told what eating disorders were:

> "I realise I struggled a while ago […] however, there was absolutely no messaging or education about eating disorders at the time. In schools or the community. So I had no skills or knowledge to understand what was happening to me, or that what I was going through was a problem. The only way I realised something was wrong was when I opened my A Level Psychology textbook and found the diagnostic criteria for anorexia nervosa, and thought… is this me?"

One survey respondent with personal experience of eating disorders described the "guilt, stigma and shame" that surround eating disorders. Other respondents suggested that they struggled to reach out for help for their eating disorders:

> "Many people, like myself, would not mention it [eating disorder] to anyone."

> "Fear of asking for help, I present well on the surface but continue to struggle with eating disorders behind closed doors."

A guest at the Committee's private meeting told the committee that they first developed an eating disorder when they were 17 years old but they were not diagnosed until they were 29. Beat has found that it takes adults on average almost two years to seek help after first recognising the signs of an eating disorder.[20] Beat says more advice and guidance is needed so that families, carers, schools and others can help to spot signs of eating disorders and help those affected to seek treatment earlier.[21]

The Committee also heard evidence that certain groups of people may face additional barriers in recognising their symptoms and seeking support. For example, respondents to the Committee's survey suggested there was an inaccurate but prevalent stereotype that eating

[20] Beat, Delaying for years, denied for months
[21] Beat, Best practice in ensuring early intervention for eating disorders, September 2022

disorders only affected "young, white females", "middle class white women", or "silly teenage girls".

Respondents said such stereotypes caused additional barriers for people such as men, people from ethnic minority groups and older people to access help. One respondent stated: "I strongly feel my race (black) means I am overlooked and not fitting in narrow definitions of who has an ED [eating disorder]". Another respondent stated that it was considered strange to be a man in his 30s suffering from an eating disorder.

The NHS Health Survey for England 2019 suggests four per cent of all adults in England may have a possible eating disorder, and that prevalence is higher amongst women (five per cent) than men (three per cent). The survey indicates prevalence is highest amongst women aged 25-34 (9 per cent) and 35-44 (8 per cent), followed by girls and young women aged 16-24 (7 per cent).[22] In London, data provided to the Committee through FOI requests shows that the vast majority of adult referrals received by London eating disorder services in 2022-23 were for women (6,180 compared to 626 men).[23]

However, guests stressed that men, minority ethnic groups and LGBTQ+ people may be underrepresented in both treatment figures and prevalence estimates.[24] Dr Agnes Ayton, Consultant Psychiatrist, Oxford Health NHS Foundation Trust, described "a significant gap of accessing services for men, ethnic minorities and other minority groups".[25] Dr Ashish Kumar, Clinical Director CAMHS Mersey Care NHS Foundation Trust and Chair Faculty of Eating Disorders, Royal College of Psychiatrists, said:

> "There are estimated 1.25 million people with eating disorders in the population. We are reaching out to only a fraction of them. As a result, there is a huge number of people with eating disorders in the community who are not accessing our services. Among the people who try to access our services, are we catering to males, are we catering to ethnic minorities, and are we building our team to cater to their needs? Is there capacity? Is there training? I do not think so".[26]

The Committee also heard that people who have different types of eating disorders, or atypical symptoms, face additional barriers in accessing support. One respondent described the "misunderstanding of varying degrees of disordered eating". Other respondents stated that particular eating disorders were poorly understood – including binge eating disorder, ARFID and

[22] NHS, Health Survey for England, 2019, 15 December 2020. The SCOFF scale was used to determine whether someone had a possible eating disorder, but this does not provide definitive diagnosis. See notes included in dataset for further information on SCOFF.
[23] London Assembly Health Committee analysis of Freedom of Information request data received from Trusts. Published alongside report.
[24] London Assembly, Health Committee – transcript, 29 June 2023 pp.3 – 4, 26 and 29
[25] London Assembly, Health Committee – transcript, 21 September 2023, p.17
[26] London Assembly, Health Committee – transcript, 21 September 2023, p.17

orthorexia.[27] One respondent with experience of supporting someone else with an eating disorder cited a lack of understanding of how much eating disorders "vary and present themselves in different people."

The Committee is concerned that this lack of understanding of different types of eating disorders makes it less likely some people will recognise their symptoms as an eating disorder or receive an appropriate response from services. One respondent suggested such misunderstanding "is truly harmful because it leads to less understanding about them and thus less aid to those suffering from these eating disorders."

Approaching GPs for support

When people do reach out for support for an eating disorder, they are likely to first approach their GP. The Committee heard some positive examples of GPs responding to people presenting with eating disorders. A respondent to the Committee's survey said that their GP "reacted without judgement and with compassion and urgency, making a referral to specialists quickly". Another stated that "they were very supportive and helped me to access support/go on a waiting list very quickly".

Unfortunately, much of the evidence received by the Committee suggests respondents feel that many GPs are not providing an appropriate response to patients presenting with eating disorders and failing to make referrals to specialist services. For example, a guest at the Committee's private session said their GP would not take their concerns for their daughter seriously: "I had been going privately because the GP kept on saying, 'Oh, it is a phase', or, 'Yes, she is a little bit underweight but she will grow out of it'."

A respondent to the Committee's survey, who had also sought support for their child's eating disorder, reported a similar response from their GP: "I've taken my child to the GP when [they were] very young and we felt we were not listened to and our concerns were dismissed with 'It's just a phase! They're going to grow out of it'." Other respondents with direct experiences of seeking support reported dismissive responses from GPs:

> "I was turned away as a teenager when my Mum first took me to the GP. Despite having lost a considerable amount of weight, the GP told my Mum that I was okay and just to encourage me to 'eat a bit more'. My health continued to decline over the following months and following our next visit to the GP nine months later I was taken straight to A&E for a week long admission."
>
> "GP brushed it off, said the numbers don't add up and that I have a healthy BMI now and accused me of not telling the truth. This was after so long of trying to bring the courage to reach out."

[27] Beat describes orthorexia as: an unhealthy obsession with eating "pure" food. It notes that this is not currently recognised in a clinical setting as a separate eating disorder, so someone who visited the doctor with the symptoms would not be officially diagnosed with "orthorexia",

The Committee heard that some GPs may simply lack knowledge or training around eating disorders. For example, a guest at the Committee's private session found GPs to be poorly trained in relation to eating disorders, when they had sought support for their child:

> "I think a lot of the issues that we have with eating disorders is that the GP is the first point of contact and in my experience, where I have been going through this nightmare now for nearly seven years, I would say the large proportion of the ones that I have met are very inexperienced and say very unhelpful things to the patients".

Some respondents to the Committee's survey suggested their GP was well-meaning but lacked appropriate training:

> "While my GP was supportive and listened, she had very little knowledge or understanding about eating disorders and often would recommend things that are not suitable for someone with an eating disorder, particularly around weight and exercise."

> "GP's have been very supportive, but not very knowledgeable, I've often had to tell them exactly what I need rather than being able to rely on them for advice."

The evidence reflects the findings of both the Parliamentary and Health Service Ombudsman (PHSO) in 2017, and the Public Administration and Constitutional Affairs Committee (PACAC) in 2019, that GPs and other medical professionals need to be better trained to ensure they are responding to eating disorders appropriately.[28][29] In 2023, the PHSO said there were still issues with training for medical professionals on eating disorders.[30]

Andrew Radford, Chief Executive, Beat said that "retraining in GPs once they have qualified is incredibly difficult because they are so busy and there are so many of them". He suggested that the most effective way to address this is "by equipping the ill person with the information that they need and the assertiveness" to push for a referral when they go to their GP.[31]

Jessica Griffiths is the national FREED Co-lead, and also co-chaired the PHSO's Delivery Group in response to the 'ignoring the alarms' report. She said efforts had been made to improve education of doctors but that "it has been so difficult to cause change in that area because there is no mandate" and training remains optional for medical schools.[32] She suggested there was a role for the Mayor's London Health Board to push for adoption of available training across London:

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[28] PHSO, Ignoring the alarms: How NHS eating disorder services are failing patients, 6 December 2017. N.b 'Ignoring the alarms' was published by the PHSO following its investigation into the death of Averil Hart from anorexia. It found that Averil's death would have been avoided if the NHS had cared for her appropriately. The report expressed singificant concern with the national provision of eating disorder services.
[29] PACAC, Ignoring the alarms follow up, 18 June 2019. N.b PACAC published a report to examine what progress had been made against the PHSO's 'Ignoring the alarms' recommendations.
[30] PHSO, Urgent action needed to prevent eating disorder deaths, 27 February 2023
[31] London Assembly, Health Committee – transcript, 29 June 2023 p.20
[32] London Assembly, Health Committee – transcript, 21 September 2023, p.3

> "There is excellent GP training, medical training, training for whole teams, but actually unless someone takes responsibility for implementing that in the boroughs of London, how do we know? That training is not going to be taken up. I would call up, once again, the [London] Health Board to present and say, 'How can we hold our primary care colleagues and our trusts to account and encourage that eating disorder training and make it widely available and accessible and give the clinicians the time they need to complete it?' That is absolutely vital. We need accountability".[33]

The Committee heard that other healthcare professionals also lacked training to identify and respond to eating disorders effectively. Dr Agnes Ayton told the Committee that "the assessment of knowledge during undergraduate and postgraduate training for doctors is still very limited […]. I would say it is still an ongoing issue in terms of training of primary care staff".[34] Dr Ashish Kumar told the Committee that "There has been a lack of a coherent approach to training the medical workforce and other workforces like nursing colleagues and also psychologists, psychotherapists, trained CBT therapists and so on. That needs to improve".[35]

In response to the Committee's call for evidence, Nick Pollard, co-founder and Director of Family Mental Wealth, a social enterprise working to improve mental health provision for young people through family-based support, discussed the need for all healthcare professionals and allied health professionals to be aware of eating disorders:

> "It is not just specialist clinicians who can, and should, contribute to the prevention and management of eating disorders. ALL healthcare professionals and allied health professionals will come across people with eating disorders in their day-to-day clinical work, and have the opportunity to contribute to the NHS aspiration to 'make every contact count'. For example, the early symptoms of an eating disorder may first be identified by a dentist, pharmacist, or physiotherapist – if they have the vital knowledge to spot the signs."[36]

In written evidence to the Committee, the Local Dental Committee Confederation, a group representing NHS dentists, stated that "the effect of eating disorders on oral health is clear and dentists and their team will be ideally placed to recognise the signs of eating disorders when providing dental care". It recommended that "training needs to be provided to dentists and their team to ensure every contact counts with referral pathways from dentists to eating disorder support put in place through local training hubs".[37]

[33] London Assembly, Health Committee – transcript, 21 September 2023, p. 13
[34] London Assembly, Health Committee – transcript, 21 September 2023, p.6
[35] London Assembly, Health Committee – transcript, 21 September 2023, p.13
[36] Written evidence – Family Mental Wealth. Published alongside report.
[37] Written evidence – Local Dental Committee. Published alongside report.

Recommendation 1

The Mayor should work with NHS England (London), including through the London Health Board, to advocate for the adoption of training on eating disorders across all GP practices in London.

Options for self-referral

Given the challenges presented to people in accessing referrals to specialist services through their GP, it may be necessary for people to make self-referrals. People can make self-referrals to Child and Adolescent Mental Health Services (CAMHS) in London. A guest at the Committee's meeting described making a self-referral for their child following "horrendous" experiences with GPs, and a respondent to the Committee's survey also stated that they accessed treatment for their child through "self-referral as our doctors were very unhelpful".

The Committee also received a survey response from an individual who had referred themselves to adult services. However, the Committee understands that self-referral is not an option for most adult eating disorder services in London. Some respondents to the Committee's survey with personal experience of an eating disorder, specifically called for self-referral options to be made available for adult eating disorder services:

> "It would be great to be able to self-refer as the GP makes referral SO hard, both in terms of their lack of compassion and in terms of them focusing on weight over and above all other difficulties."
>
> "I feel that those diagnosed with eating disorders should be able to self-refer to services, particularly given how difficult it is accessing GP appointments."
>
> "I personally feel that people should be able to self-refer to eating disorders services, particularly as GPs are not specialists in this area and yet they are the gatekeepers."

The Committee is concerned that the lack of self-referral for adult services may mean some people are not able to access the treatment they require, particularly in cases where GPs may not be making appropriate referrals.

Dr Karina Allen, Consultant Clinical Psychologist, Eating Disorders Outpatients Service – South London and Maudsley NHS Foundation Trust, told the Committee that:

> "Self-referral would be something to be thinking about and how much we can promote this as a way for people to access they support they need. Hope [Virgo] talked about GPs, who are overworked and overrun anyway, that may not be in a position to spot an eating disorder and promote early referral. Children and young people's eating disorder services allow self-referral and family-referral. At the moment, however, almost no

eating disorder services are set up that way. It would be something that might facilitate greater access."[38]

Recommendation 2

The Mayor should request that NHS England (London) explores the feasibility of establishing self-referral routes for adult eating disorder services across London and the likely number of referrals that would be generated, so that the service set up can meet the needs of the patients self-referring.

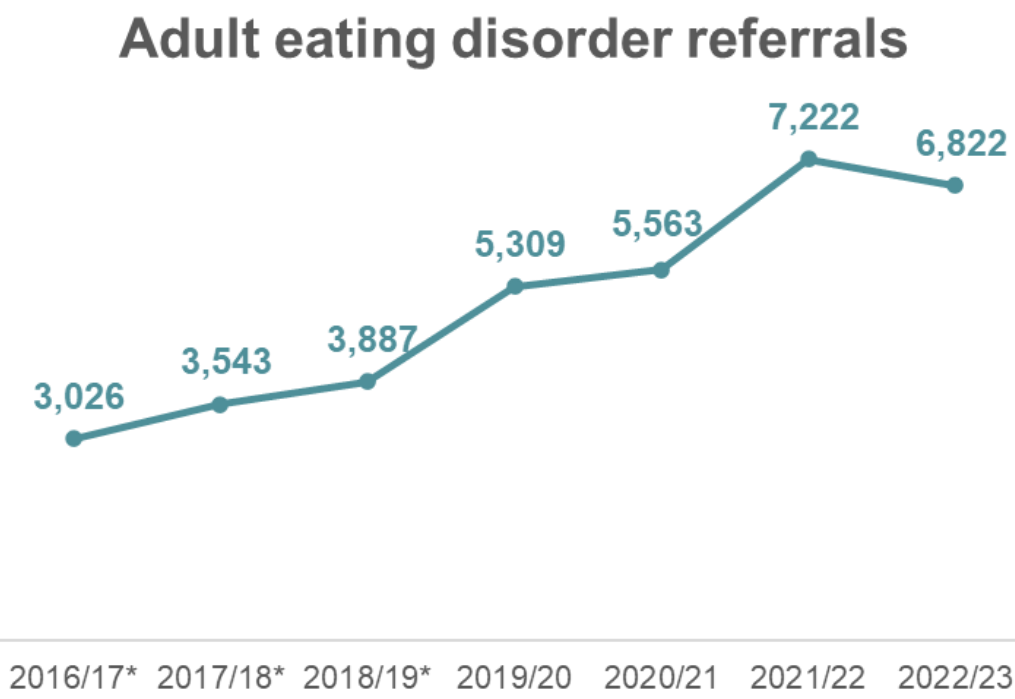
[38] London Assembly, Health Committee – transcript, 29 June 2023 p.20

Chapter two: accessing treatment in London

Referrals to specialist services

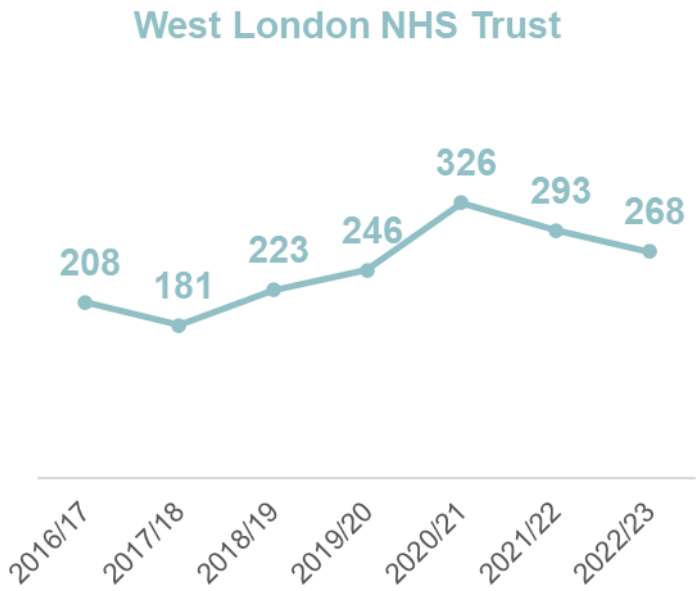
Referrals to specialist eating disorder services in London have increased significantly amongst both children and adults in recent years.

In 2022-23, Freedom of Information (FOI) data obtained by the Committee from seven NHS mental health trusts shows that adult services in London received 6,822 referrals. Among the six trusts that provided information for each year requested, there was a 56 per cent increase in referrals between 2016-17 and 2022-23. This increase varied significantly among Trusts, for example North East London NHS Foundation Trust saw the highest increase of 227 per cent. A breakdown of the information by Trust is provided below.



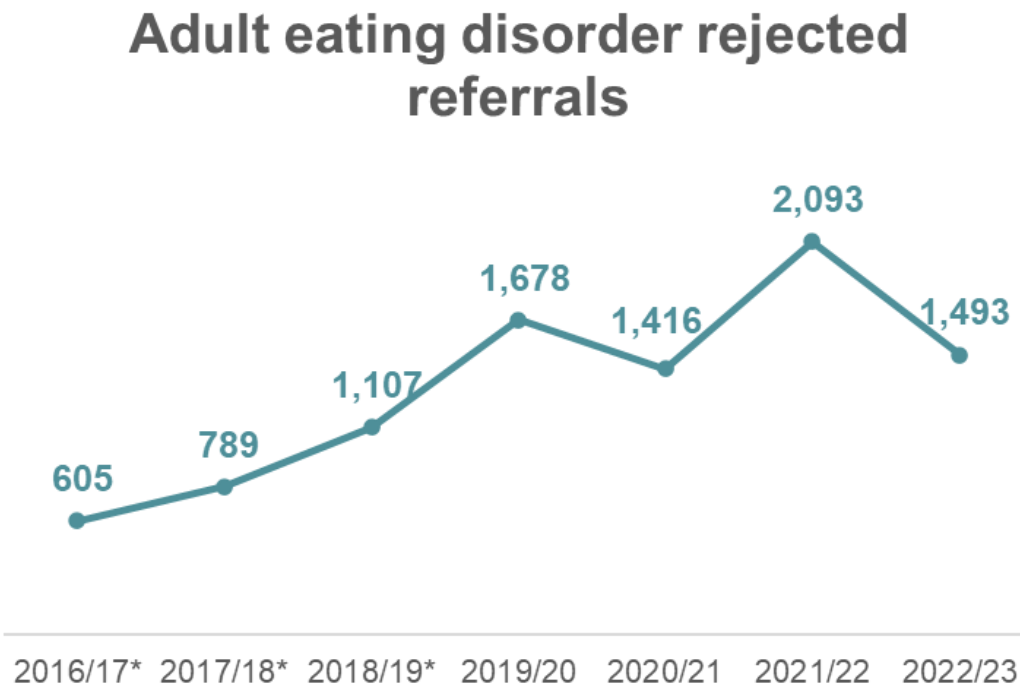
Source: London Assembly Health Committee analysis of Freedom of Information data from Trusts
**One trust was not able to provide information between 2016/17 and 2018/19, therefore numbers for these years may be higher, and any percentage increases calculated have excluded figures from this trust for accuracy. Please note the Committee is aware of a cyber incident for the most recent year of information in relation to reporting of children and young people waiting times that impacted the reliability of some data. While it is not clear what impact this may have on this information, the Committee is cautious about commenting on a decrease in referrals in the last year as a result. One trust provided information for adults in calendar rather than financial years, which is reflected in the breakdowns below.*


Barnet, Enfield and Haringey Mental Health NHS Trust
1,228
1,323
1,277
1,274
1,284
1,586
1,298
2016/17
2017/18
2018/19
2019/20
2020/21
2021/22
2022/23
Central and North West London NHS Foundation Trust
1,237
1,198
1,748
2,106
2016/17
2017/18
2018/19
2019/20
2020/21
2021/22
2022/23
East London NHS Foundation Trust
168
168
172
244
245
276
321
2016/17
2017/18
2018/19
2019/20
2020/21
2021/22
2022/23
North East London NHS Foundation Trust
410
728
865
1,006
1,260
1,756
1,340
2016/17
2017/18
2018/19
2019/20
2020/21
2021/22
2022/23
South London and Maudsley NHS Foundation Trust
659
774
836
851
824
1,078
975
2016
2017
2018
2019
2020
2021
2022
South West London and St George's Mental Health NHS Trust
353
369
514
451
426
485
514
2016/17
2017/18
2018/19
2019/20
2020/21
2021/22
2022/23



Source: Freedom of Information data received from Trusts by the London Assembly Health Committee

Six of seven Trusts were able to provide information related to the number of rejected referrals for at least some of the years requested. In 2022/23, there were 1,493 rejected referrals. Trusts noted various potential reasons for rejected referrals, including capacity, administration error, duplicate or inappropriate referrals. Among Trusts that provided information for each year since 2016/17, there was an 88 per cent increase in rejected referrals.

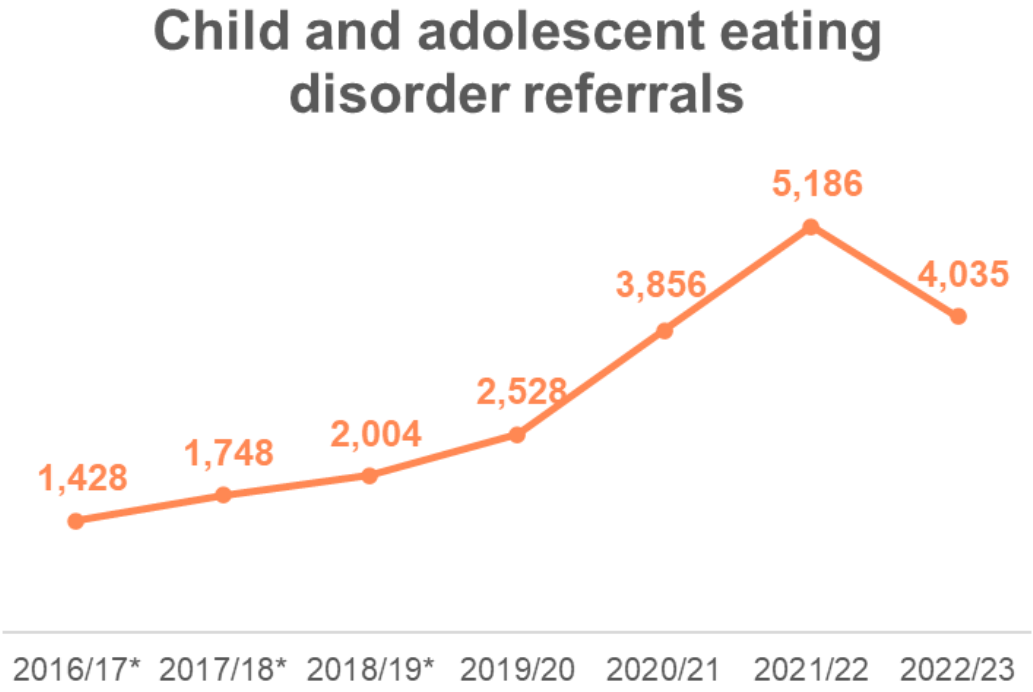


Source: London Assembly Health Committee analysis of Freedom of Information data from Trusts
**One trust was not able to provide information between 2016/17 and 2018/19, therefore numbers for these years may be higher, and any percentage increases calculated have excluded figures from this trust for accuracy.*

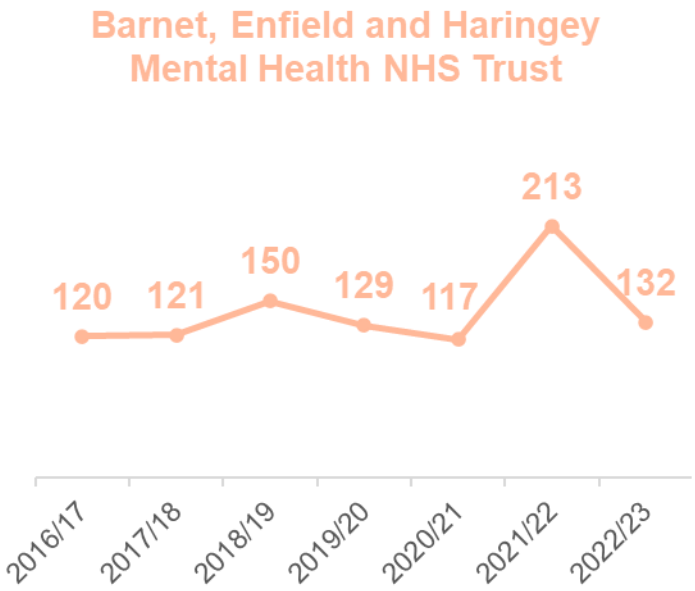
Eating disorder referrals to child and adolescent services in London

In 2022-23, child and adolescent services in London received 4,035 referrals. Among the seven trusts that provided information for each year requested, there was a 158 per cent increase in referrals between 2016-17 and 2022-23.

All trusts that provided information for each year requested reported an increase in referrals for children and adolescents between 2016-17 and 2022-23. North East London NHS again saw the highest increase in referrals, of 377 per cent. Royal Free London NHS Foundation Trust, East London NHS Foundation Trust and South London and Maudsley NHS Foundation Trust all saw referrals to child and adolescent services more than double.



Source: London Assembly Health Committee analysis of Freedom of Information data from Trusts
**One trust was not able to provide information between 2016/17 and 2018/19, therefore numbers for these years may be higher, and any percentage increases calculated have excluded figures from this trust for accuracy.*
Please note the Committee is aware of a cyber incident for the most recent year of information in relation to reporting of children and young people waiting times that impacted the reliability of some data. While it is not clear what impact this may have on this information, the Committee is cautious about commenting on a decrease in referrals in the last year as a result.


Barnet, Enfield and Haringey Mental Health NHS Trust
120
121
150
129
117
213
132
2016/17
2017/18
2018/19
2019/20
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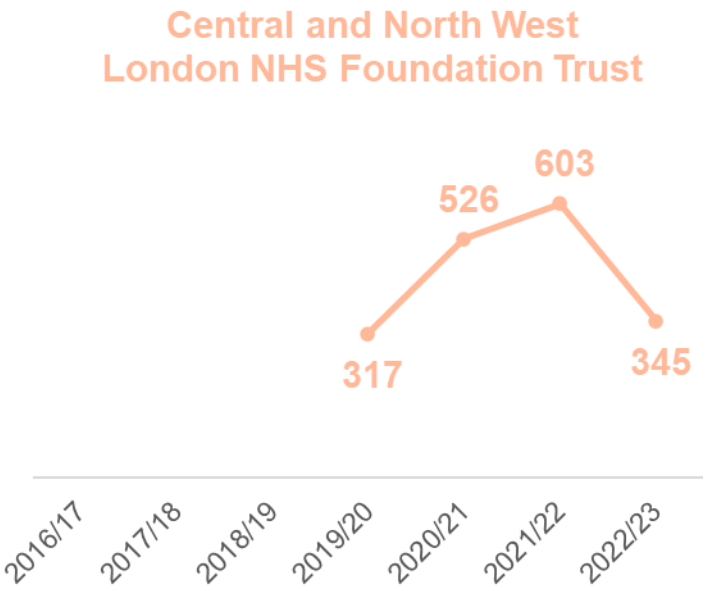
2021/22
2022/23


Central and North West London NHS Foundation Trust
317
526
603
345
2016/17
2017/18
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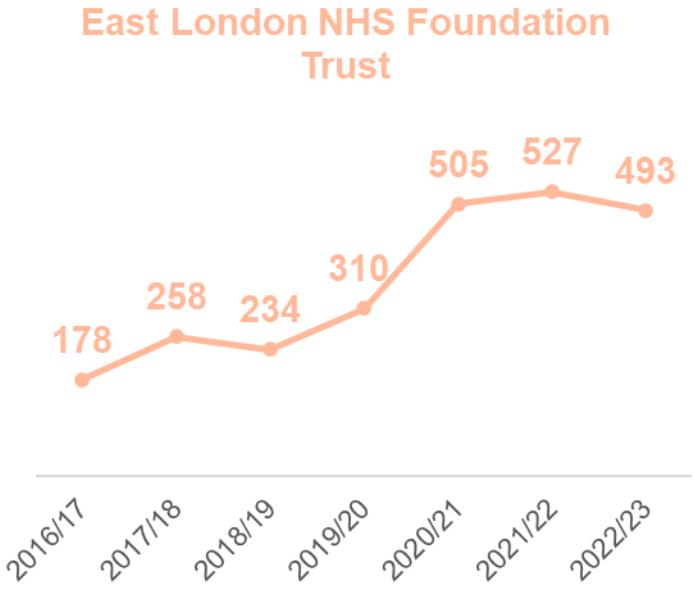
East London NHS Foundation Trust
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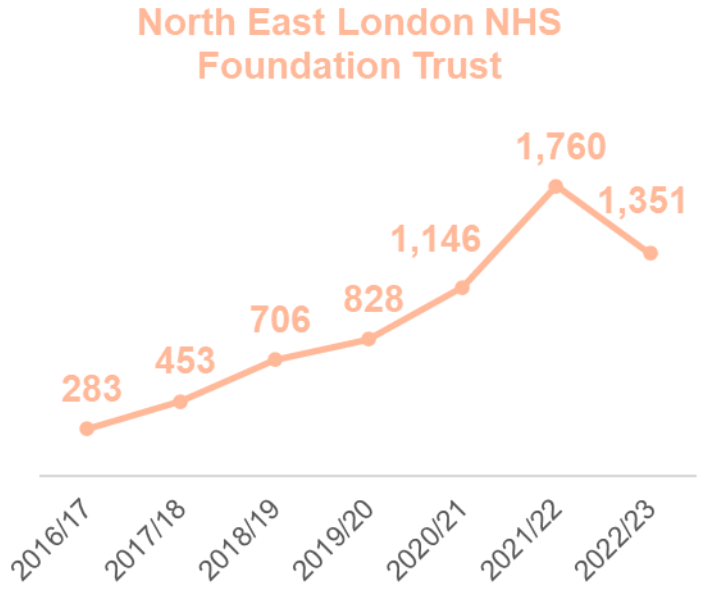
2022/23


North East London NHS Foundation Trust
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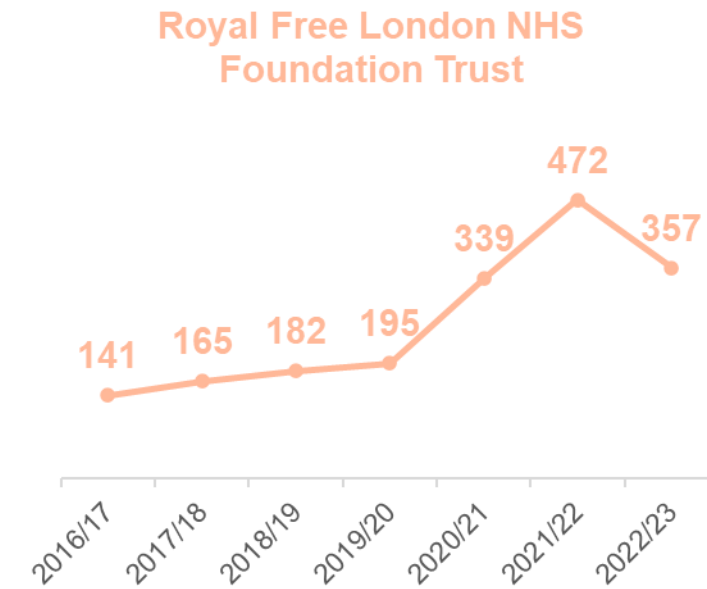
Royal Free London NHS Foundation Trust
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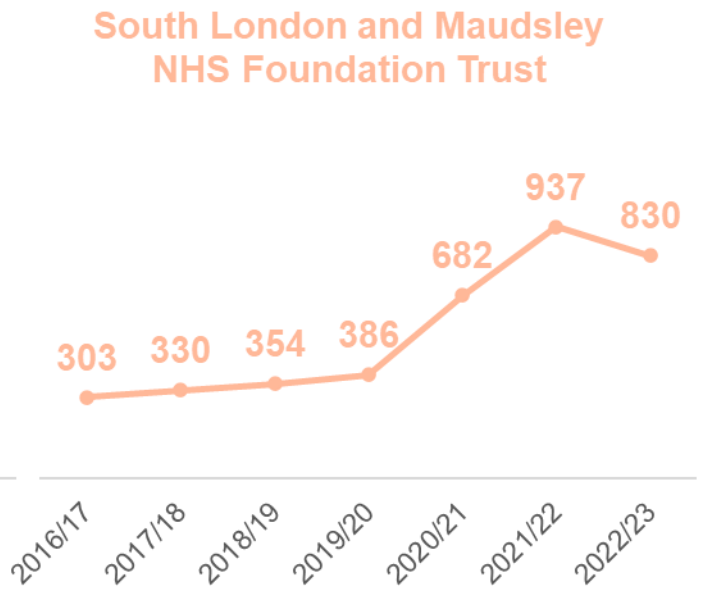
2022/23


South London and Maudsley NHS Foundation Trust
303
330
354
386
682
937
830
2016/17
2017/18
2018/19
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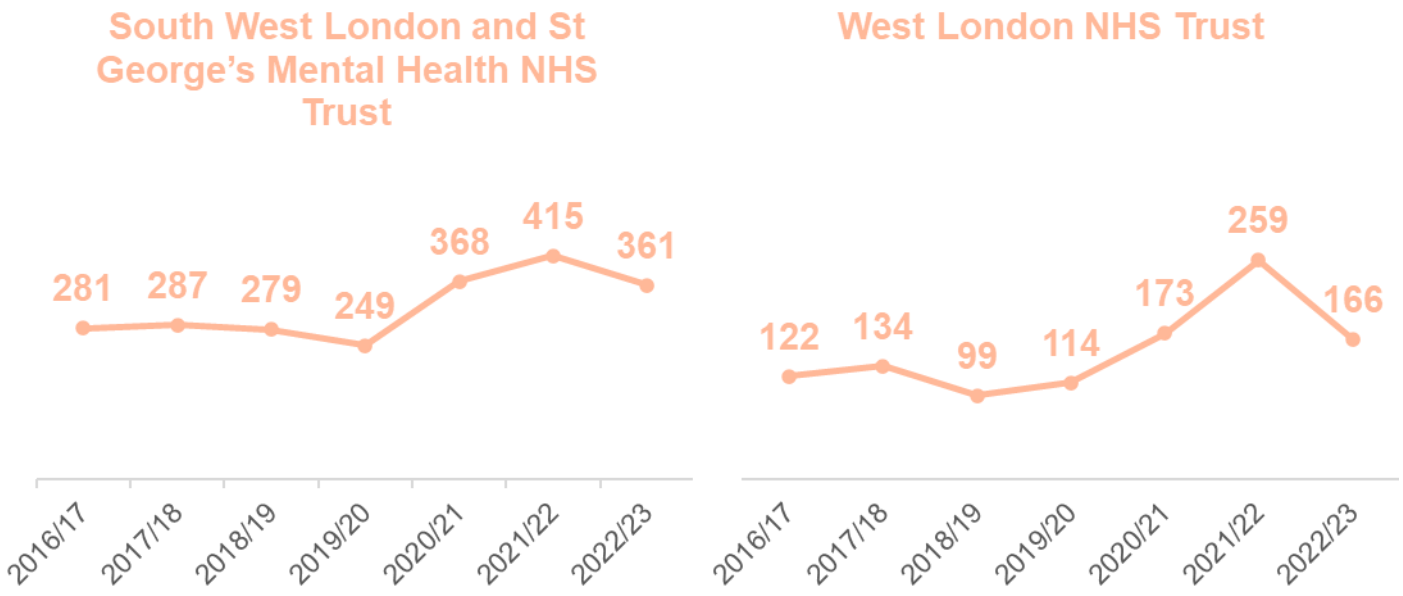
2020/21
2021/22
2022/23



Source: Freedom of Information data received from Trusts by the London Assembly Health Committee

The Committee notes this worrying increase in referral figures. However, as detailed in the previous section, it has also received compelling evidence that people are struggling to receive referrals to services at all. The Committee is therefore concerned that these referral figures represent just the tip of the iceberg, with many people in London struggling with eating disorders but not currently in treatment or unable to access treatment.

NHS waiting times

Since 2014, efforts have been made by the Government and the NHS to improve the speed at which children and young people referred to services can access treatment. Alongside an investment of £150 million into eating disorder services nationally, new waiting time standards were established stating that children and young people should receive treatment within four weeks from their first contact with a designated healthcare professional for routine cases, and within one week for urgent cases.

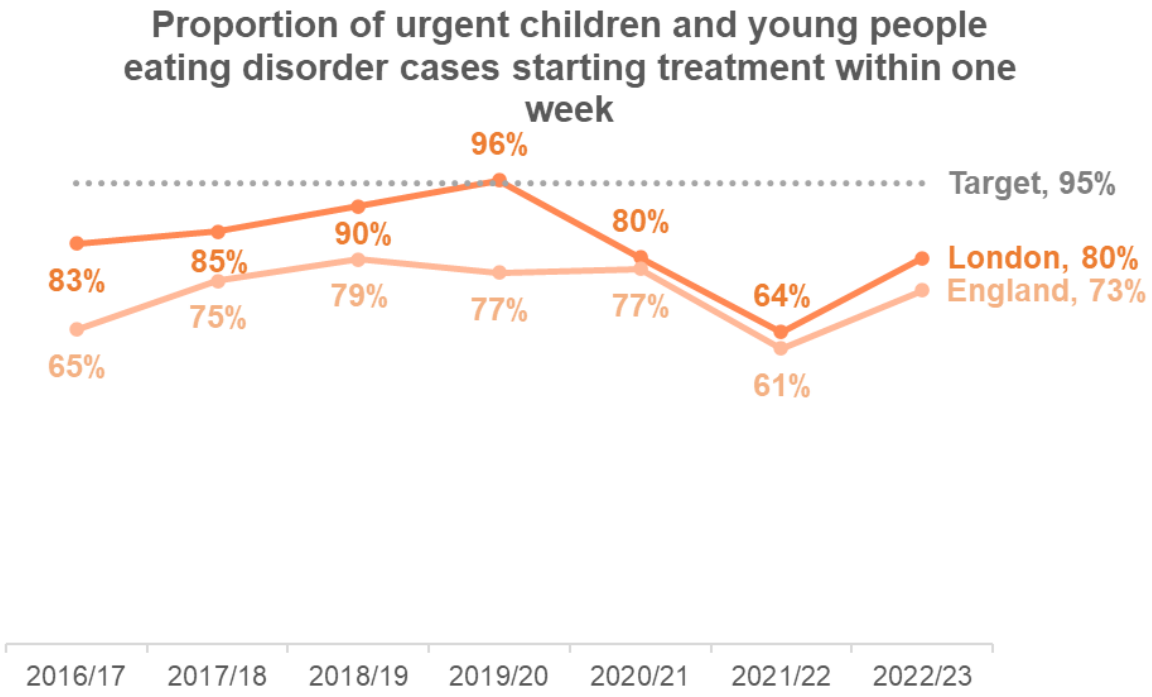
The Government set a target of waiting time standards being met in 95 per cent of all cases by 2020.[39] Further investment was committed in the 2019 NHS Long Term Plan to allow the NHS to "maintain delivery of the 95 per cent standard beyond 2020/21".[40]

Improvements in waiting times for children and young people were achieved across England and in London between April 2016 and March 2020 (see graphs below), where on average across the quarters London hit the target of 95 per cent of urgent cases starting treatment

[39] NHS England, Access and Waiting Time Standard for Children and Young People with an Eating Disorder, July 2015
[40] NHS England, Long Term Plan, January 2019

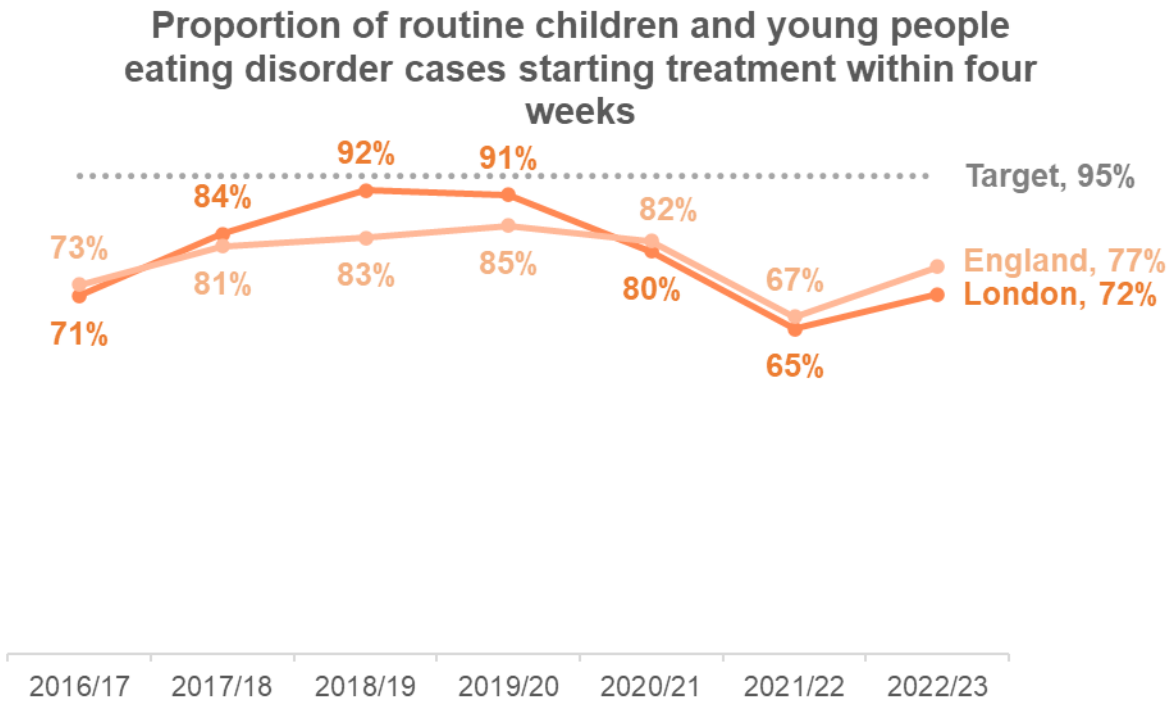
within one week.[41] Of those children and young people who started treatment following an urgent referral in London in 2016-17, 83 per cent started their treatment within a week of first making contact with a healthcare professional. This increased to 96 per cent in 2019-20. Similar improvements were seen in routine cases. London has generally performed better than England as a whole.

However, this improvement was not sustained from 2020-21. In 2021-22 of those children and young people who started treatment following an urgent referral only 64 per cent started treatment within a week. Guests told the Committee that performance against waiting time standards was impacted by the COVID-19 pandemic. This is discussed further in chapter 3. Performance appears to have improved in 2022-23, though this data should be treated with caution due to a cyber-attack which impacted reporting for this year.[42]



Source: London Assembly Health Committee analysis of NHS England, Children and Young People with an Eating Disorder Waiting Times[43]

[41] NHS England, Children and Young People with an Eating Disorder Waiting Times
[42] NHS England, Children and Young People with an Eating Disorder Waiting Times
[43] NHS England, Children and Young People with an Eating Disorder Waiting Times



Source: London Assembly Health Committee analysis of NHS England, Children and Young People with an Eating Disorder Waiting Times[44]

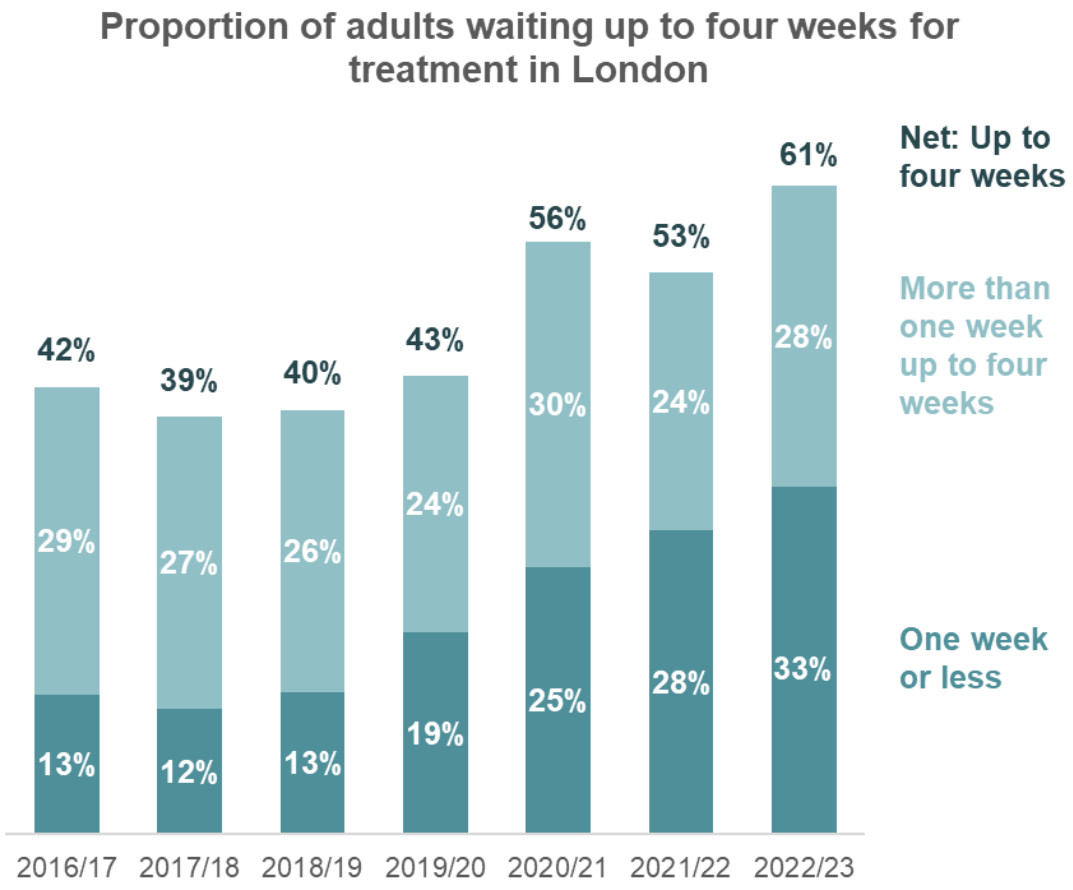
Waiting time standards have not been implemented for adult services. Therefore, trusts have not been required to report on waiting times for adults to access services following referrals.

However, the Committee has received data on waiting times for adults from NHS trusts in London through FOI requests. Six of seven trusts were able to provide data in response.

The Committee's analysis found that, in 2022-23, 61 per cent of adults referred for treatment started it in four weeks or less, including 33 per cent who started treatment within one week. This shows an improvement in waiting times since 2016-17, when around 42 per cent of patients started treatment within four weeks, and only 13 per cent of people started treatment within a week. This improved access to treatment has been achieved despite an increase in the number of patients being referred.

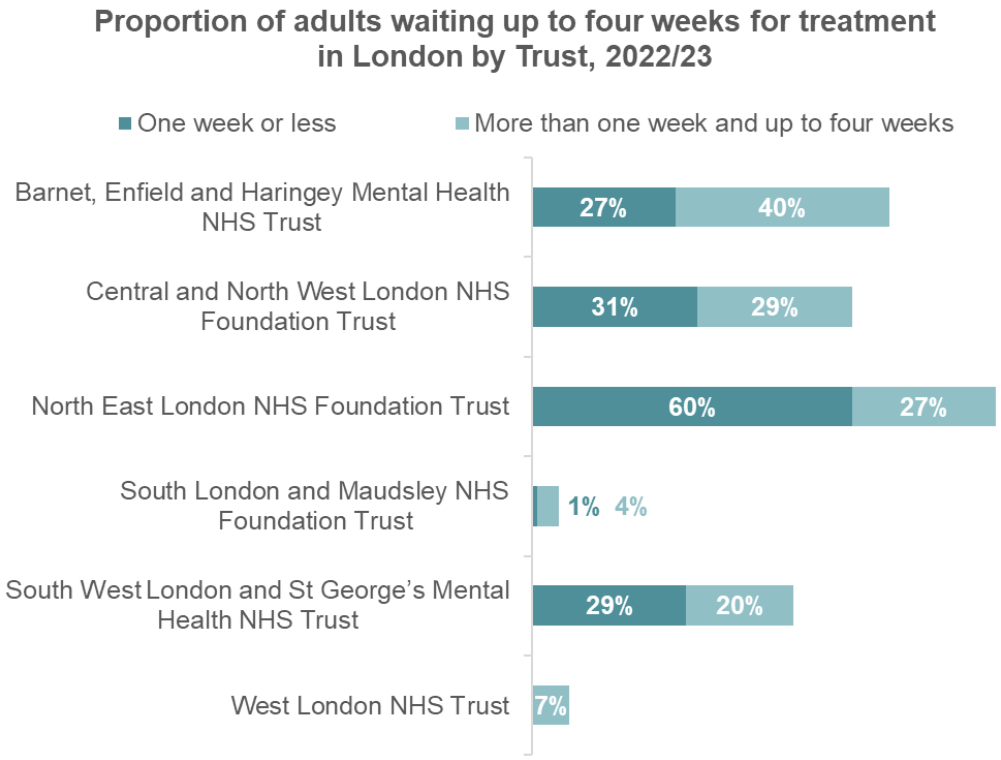
The Committee's analysis of information, provided by Trusts and published by the NHS, suggests that the proportion of adults waiting 12 weeks or more has not decreased in recent years in the same way it has for children and young people. In 2022-23, 18 per cent of adults waited 12 weeks or more, compared to approximately 4 per cent for children and young people across both urgent and routine cases.[45]

[44] NHS England, Children and Young People with an Eating Disorder Waiting Times
[45] The Committee notes that this data was affected by a cyber incident in 2022-23



Source: London Assembly Health Committee analysis of Freedom of Information data received from Trusts. One Trust was not able to provide information before 2019-20.

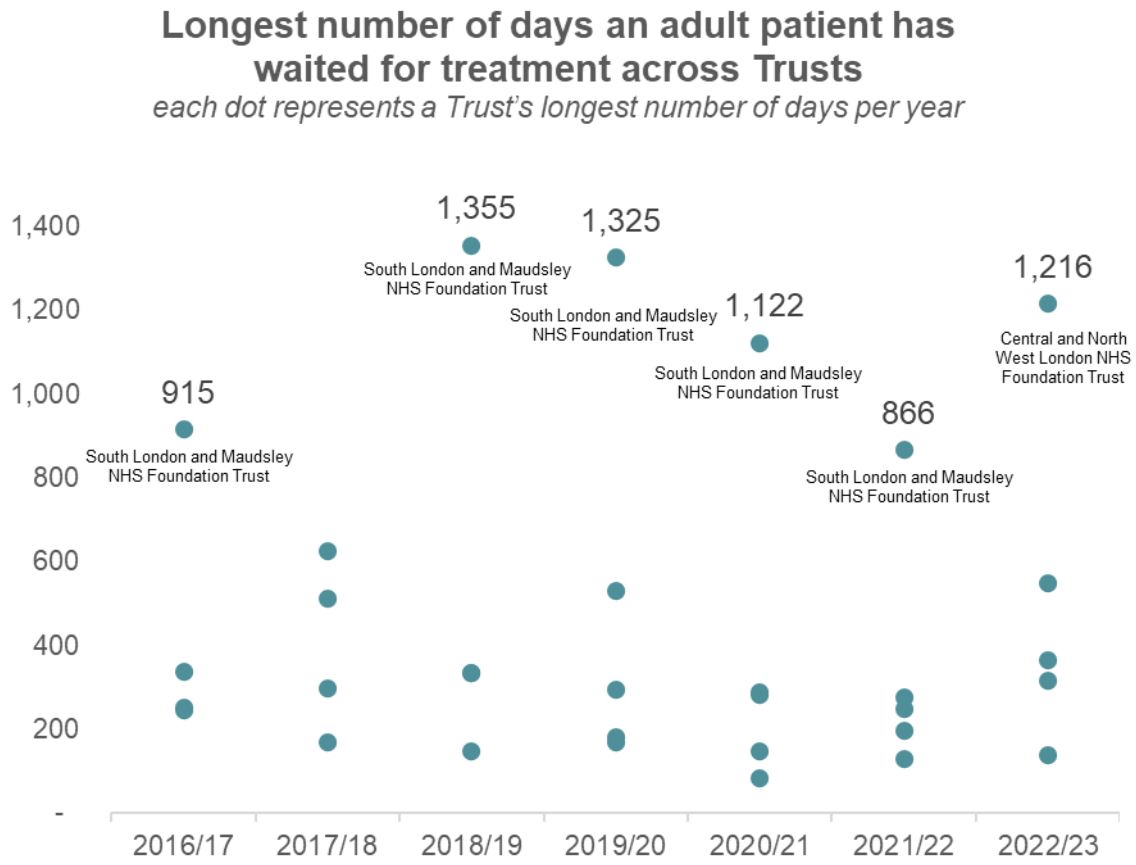
Source:



Freedom of Information data received from Trusts by the London Assembly Health Committee

Additionally, there was significant variation between Trusts. Last year, 60 per cent of adult patients in one trust started treatment within a week of referral, significantly higher than the average across trusts, with the second highest being 31 per cent.

The Committee also asked Trusts about the longest number of days that an adult patient has waited for eating disorder treatment for each year since 2016-17, and found significant variation (as outlined in the graph below). The longest number of days waited by adult eating disorder patients amounted to over three years in total, with four of five Trusts providing information having a patient waiting over a year for treatment. One Trust reported a wait of 1,355 days for a patient starting treatment in 2018-19, and another reported a wait of 1,216 days for a patient before starting treatment just last year. The Committee notes that there may be a range of reasons for variation among Trusts. It also notes that the longest wait times are not necessarily reflective of the average wait times, which are considerably lower. In 2022-23, the lowest average waiting time for a Trust was 65 days and the highest was 198 days.



Source: Freedom of Information data received from Trusts

Impact of waiting times

Some respondents to the Committee's survey, including both people with experience of CAMHS and adult services, said the process from referral to assessment and treatment was fast and effective:

> "Fast referral, assessment, diagnosis, treatments and intervention. All staff were very caring and supportive."

> "I received a lot of support during my diagnosis and was able to access inpatient treatment promptly."

> "Once I was referred to CAEDS [child and adolescent eating disorder services], I had an assessment within a few weeks. It was very well organised and I felt validated. I was diagnosed on the day with anorexia nervosa and recommended treatment."

However, many other respondents had waited significant periods of time to access treatment, including some waiting over a year. Some respondents said they had opted to pay for private treatment due to challenges in accessing NHS treatment, with one stating that "waiting lists were so long we had to re-mortgage the house to pay for private treatment."

Several respondents to the Committee's survey stated that their health deteriorated whilst waiting to access care, including some who described the perverse incentive to get more unwell to access services faster:

> "In the period of waiting for an assessment and then waiting for treatment my symptoms and weight drastically worsened. Waiting for an assessment and treatment made my eating disorder worse. I felt I needed to be good enough at my eating disorder to get help / be taken seriously."

> "Being told there was an 18 month wait for any treatment, and it being made clear that even that wouldn't be sufficient to help me recover was soul destroying. The clear message was that I had to get dangerously ill before I would actually get any access to the level of support I needed."

The Committee heard that even short waits for services can be extremely challenging for people, particularly if people have come forward to seek support for the first time. One respondent described how they felt: "You've opened the wounds but don't have a plan, which can worsen the anxiety." Another respondent who waited two months following diagnosis to start treatment said: "Those two months were incredibly challenging for me, navigating an eating disorder diagnosis but being in a sort of standstill point where I didn't know what to do, was angry, confused and really lost."

One respondent, who supported their child to access services, described the challenges they and their child faced waiting six weeks to access CAMHS after their first assessment:

> "This may not seem like a long time but it felt like we were descending into hell. Whilst my daughter's weight was within the low but 'normal' range for most of this waiting period, her mental state declined very sharply. She seemed terrified of all foods and barely left her room."

Dr Brian Sreenan, Consultant Psychological Lead for Disordered Eating, NHS East London Foundation Trust said that being placed on a long waiting list could also impact someone's outcomes from treatment. He said that services can miss opportunities to support people while they have the motivation to get better, and that "people stay on waiting lists for months, if not years, and that motivation to change can dwindle, so people are caught in the trap for even longer".[46]

Dr Ashish Kumar described how long waiting lists can worsen physical health and make it more challenging for patients to engage in therapy. He said, "As a result of this waiting, what

[46] London Assembly, Health Committee – transcript, 21 September 2023, p.20

happens is that these patients become worse and worse […] if your brain is starved and if you are offering them therapy, they are not going to engage as they would engage if they were properly nourished".[47]

At the Committee's private meeting with people with lived experience, guests described experiencing waits of between five to eight months to access services in London after the initial referral. One guest described how this wait negatively impacted their mental health:

> "From being referred in January to being properly diagnosed in May, it was then early October when I started the sessions. That period between May and October, I felt completely suicidal the whole time. That was one of the reasons why anorexia has the highest mortality rate."

The same guest went on to say that they received no support while they were on the waiting list:

> "There was absolutely nothing [in the way of support]. My GP, nothing, and I just felt like I have never felt so mentally unwell in my entire life as I did. When I finally got in, there was such a sense of relief and my therapist was great, I cannot fault her. I think I was very lucky. But that period between May and October, I look back and I think I am really quite surprised that I did not do something to really hurt myself then. It was just too much."

Dr Brian Sreenan confirmed that little support was provided to people on waiting lists: "The reality is not a lot is given when it comes to an eating disorder perspective". He added:

> "There are handouts and psychoeducation given to people. In terms of people turning to other ways of regulating their emotions, through self-harm or other things like that, there are other services that people can access whilst waiting, like home treatment teams or crisis services across NHS trusts. There are some initiatives in other areas of the country where there are podcasts being made for people who are on waiting lists and some educational videos and books that people can be supported to read through. The staffing level is that chronic that people cannot be supported."[48]

Some respondents to the Committee's survey also noted the lack of support for people on waiting lists, including one respondent who said the lack of support provided whilst on waiting lists ultimately undermined the effectiveness of the treatment they eventually received:

> "I had to wait a year for treatment without any support. Once I did have the treatment it was good and useful however It was given to me too late and therefore it was even harder to take in because I had become even more unwell throughout the time I was left unsupported."

[47] London Assembly, Health Committee – transcript, 21 September 2023, p.4
[48] London Assembly, Health Committee – transcript, 21 September 2023, p. 20

Another respondent urged for there to be "more support when on the waiting list". They stated that services should not "just drop people off the cliff face when they've told you really personal things to be assessed and leave them for years without any hope or help."

Recommendation 3

The GLA Health team should work with NHS trusts across London to ensure that: all people on waiting lists for eating disorder services are provided with clear information and resources; and additional interim support is commissioned for those on waiting lists who are at higher risk.

BMI thresholds for accessing services

National Institute for Health and Care Excellence (NICE) guidance on the recognition and treatment of eating disorders states that "unusually low or high BMI or body weight" should be taken into account when deciding to refer people for assessment. However, it states that these factors should not be used on their own to determine whether people are offered treatment or whether people should be admitted to day patient or inpatient care. Instead, the guidance states that BMI or body weight must be considered alongside a range of other physical and mental health indicators.[49]

London clinical experts also told the Committee that BMI alone is not an appropriate measure to assess someone's need for treatment, since it does not take into account the severity of mental ill health of each patient. Dr Brian Sreenan said that "somebody can have a normal BMI, but be psychologically extremely unwell and vice-versa as well".[50] Dr Karina Allen, Consultant Clinical Psychologist, Eating Disorders Outpatients Service - South London and Maudsley NHS Foundation Trust, told the Committee that to determine access to services, clinicians required "a whole picture of someone's mental health and someone's physical health". [51]

However, it is not clear that NICE guidance is always followed in London. For example, several respondents to the Committee's survey stated that they had been turned away from treatment due to their BMI or body weight not being deemed low enough to require treatment:

> "I was refused treatment because my weight wasn't low enough."
>
> "the biggest barrier for early treatment was weight/BMI not being low enough to access treatment."
>
> "my BMI not being low enough for treatment."

[49] NICE, Eating disorders: recognition and treatment, 16 December 2020
[50] London Assembly, Health Committee – transcript, 21 September 2023, p.20
[51] London Assembly, Health Committee – transcript, 29 June 2023, p.19

Hope Virgo, author and campaigner and person with lived experience, also told the Committee that she knew of cases – both nationally and in London – of people being turned away from services if their BMI was not deemed low enough to require urgent care.[52]

The Committee heard a range of evidence to suggest that significant capacity pressures within eating disorder services in London are creating pressures whereby BMI or body weight is used as an indicator of immediate risk to determine who should have priority access to services.

For example, Dr Brian Sreenan stated that "people with certain BMIs jump the queue and get seen exceptionally fast compared to their fellow residents".[53] This is reflected in the experience of some survey respondents, who suggested they were essentially fast tracked after losing a significant amount of weight:

> "I only got help when I was severely underweight, when I was only a little underweight the GP and crisis team didn't care."
>
> "The only reason things moved so fast was due to my extremely low weight. if it hadn't been for that, I assume I would have been dismissed or put on a waiting list."
>
> "they suddenly sped things up when I lost a lot of weight."

Dr Brian Sreenan described the "perverse incentive" this creates for people seeking referrals or on waiting lists "to become more and more unwell in order to get treatment".[54] A guest with experience of supporting their daughter also suggested that this was the case, stating that "we are all standing around waiting for this patient to become so chronically ill". They described how their child reacted to being turned away from services:

> "When they are then told that, 'We cannot give you a place at the moment', those words mean, 'You are not ill enough', and therefore my daughter would come out of those meetings going, 'You see, I am not ill', and then go completely down the pan. But why are we waiting for that to happen?"

One guest told the Committee that "throughout the country, you have to get to a certain weight, which is wrong, because if you get to that certain weight it is just that much harder to get them back". Another guest told the Committee of the limitations of using weight or BMI to determine access to services:

> "the first time I went for my weigh-in at [London NHS eating disorder service] I was just marginally below the healthy BMI, just within the underweight category, then for five weeks I was hugging the bottom line of the weight, therefore technically I was fine. I was not fine at all […] I think the whole thing around weight is unhelpful. But BMI just possibly needs to be scrapped".

[52] London Assembly, Health Committee – transcript, 29 June 2023, p.18
[53] London Assembly, Health Committee – transcript, 21 September 2023, p.20
[54] London Assembly, Health Committee – transcript, 21 September 2023, p.20

Whilst the Committee acknowledges the capacity pressures facing eating disorder services in London, we are concerned that the use of BMI or body weight to prioritise patients' access to services can lead to further deterioration of physical and mental health amongst highly vulnerable people. This deterioration will only create further pressures for services downstream, leading to more patients with increasingly severe and complex issues needing treatment.

In January 2022, the Mayor stated that he was "deeply concerned by reports that Londoners are being turned away from care or treatment" and said that "NHS England and Improvement and Healthy London Partnership[55] are working with adult eating disorder services to ensure that AED pathways remove any barriers to access such as weight or BMI."[56]

Emma Christie, Head of Mental Health, NHS London said that "the BMI threshold should never be the sole basis for a decision about access to services" but said that "there will be scenarios where, to all intents and purposes, from a service user's experience, they do feel like they are being excluded".[57] Dr Karina Allen told the Committee that some services in London may use BMI as a criterion when they have been specifically commissioned only to treat moderate to severe eating disorders. However, she said: "The fact that we have patients being stratified off based on BMI or other somewhat arbitrary criteria around severity is far from best practice".[58]

The Committee is also concerned about the wider impact that the use of BMI and body weight on determining access to treatment can have in reinforcing the stigma and misunderstanding experienced by many people who have an eating disorder but are not underweight. Several respondents cited this stigma in their responses:

> "If you do not look thin enough people don't believe there is anything wrong. People also think eating disorders are limited to starvation or bulimia and are not aware of all the other ways it can impact you."

> "I have experienced a severe and life threatening eating disorder however I have never been underweight. Because of this fact I have not been believed, it has taken longer to receive treatment, I have been dismissed by healthcare professionals, I have been refused GP checkups. Eating disorders are not weight disorders."

> "I think if someone is a healthy weight then eating disorders remain stigmatised and untreated, leaving those affected unsupported and suffering in silence."

> "You have to fit a stereotype (really low weight etc) to get any help. There is a lot of fatphobia within ED services."

[55] Healthy London Partnership was established by the NHS in 2015 and is now known as Transformation Partners in Health and Care. It provides consultancy support to NHS London agencies to assist with transformation programmes.
[56] London Assembly, MQT – Eating disorders in London (2), 24 January 2022
[57] London Assembly, Health Committee – transcript, 21 September 2023, p.21
[58] London Assembly, Health Committee – transcript, 29 June 2023, p.19

One respondent, who was caring for their child with an eating disorder, expressed their fear that BMI or weight measurements could prove a barrier to their child accessing services:

> "As a mother I fear they will turn her away due to her BMI being too high and then fear she will lose weight and then be sent to palliative care. She's on a waiting list to have an assessment and I fear the assessment could potentially harm her if they refuse to offer her treatment. She will interpret this as being "too fat" and not ill enough."

Several survey respondents called for BMI and weight to be scrapped as measure to determine access to treatment. For example, one respondent stated that "weight and BMI should not be indicators for treatment." Another urged that services "DO NOT base qualification on low BMI" and another stated that "BMI should NOT be a criteria for entering treatment." One respondent, who stated that BMI and weight should not be used to determine access to treatment, also stressed that an eating disorder "is a MENTAL HEALTH DISORDER, NOT a weight disorder."

Recommendation 4

The Mayor should lobby NHS England (London) to ensure that health services are not rejecting nor prioritising patients for treatment for an eating disorder on the sole basis of BMI, as stipulated in NICE guidelines.

Chapter three: capacity pressures facing services in London

Workforce challenges

The Committee heard concerning evidence that there are significant workforce challenges within eating disorder services in London. While guests stressed that capacity pressures were felt nationally, Dr Karina Allen suggested some pressures may be heightened in London:

> "There are some areas of the country that are faring worse than London, but London has a large population, so that is where London is more vulnerable. When demand goes up, the services really struggle to keep up so that is where London is perhaps facing a particular pinch point in recent years as the demand has increased and services have not been able to respond to meet that".[59]

Andrew Radford told the Committee that the single biggest issue impacting eating disorder services nationally is workforce challenges.[60] Dr Allen told the Committee that "almost all of the eating disorder services in London do not have the staffing levels available to safely provide the care required".[61] She said staffing services in London has become "extremely difficult":

> "Historically, London did better than some areas of the country at recruiting and retaining clinicians in NHS services, but that has changed over recent years both in terms of the cost-of-living crisis but also with patterns of hybrid and remote working. People are no longer needing to be based in London in the way they once were and this is contributing to more geographical diversity in where people are choosing to base themselves. London has been particularly hard-hit by recruiting and retaining clinicians in the eating disorder services that need them".[62]

Dr Victoria Chapman, Consultant Child and Adolescent Psychiatrist, Royal Free CAMHS, described the challenge of staff retention in London CAMHS:

> "There is a limited number of trained staff within the workforce for children and adolescents and they tend to just move from one team to another. What results is that teams get left without enough staff and then cannot meet the needs of their patients.

[59] London Assembly, Health Committee – transcript, 29 June 2023 p.28
[60] London Assembly, Health Committee – transcript, 29 June 2023 p.26
[61] London Assembly, Health Committee – transcript, 29 June 2023 p.2
[62] London Assembly, Health Committee – transcript, 29 June 2023 p.25

> Training and thinking about a sustainable workforce is really important in eating disorders."[63]

Dr Brian Sreenan described similar challenges faced by adult services in London:

> "In adult services we are robbing Peter to pay Paul all over the place. People just go from one service to another but there is no new blood coming into the system that will actually help us reach the targets and the huge demand that is placed on the system."[64]

A respondent to the Committee's call for evidence, who currently works with the Eating Disorders Day Unit at South West London & St. George's Mental Health NHS Trust, wrote:

> "Capacity to accept patients can be limited due to there not being enough staff for the referral rate. There is also not enough occupational therapists in eating disorder services […]. As an Occupational Therapist myself working on a day unit I often cannot do half the things I would like to do, simply because I am the only OT and have to split my time between other generic tasks".

In written evidence, the Royal College of Psychiatrists said that there were 78 eating disorder consultant psychiatrists in post in England in 2021, of which 16 were in London. This was the same number of consultants as reported in 2019. The evidence stated that there were three vacant substantive consultant posts in London in 2021.[65]

The Committee is concerned that workforce challenges are negatively impacting experience of and outcomes from treatment. We heard evidence that workforce pressures were being exacerbated by a high turnover of staff, and leading to an overreliance on inexperienced or temporary healthcare staff.

For example, one survey respondent shared that they had felt their community eating disorder team to be "inexperienced and unprepared to deal with anorexia, making comments and doing absolutely nothing when my weight was dropping to dangerous levels." Another respondent described their care as "a mixture of good and terrible both in the same establishment" and stated that agency staff were inexperienced and held unkind attitudes. Another respondent described their experience of seeing an inexperienced dietitian:

> "Initially I saw a dietician who was 'new' to working with people with eating disorders. She seemed to find it impossible to help me reduce my fear of food and see it as a positive thing. Instead she was hyper fixated on portion sizes and documenting my eating habits, which in itself led me to reduce further, become more controlled and fear food even more. There were so many comments she made that were really unhelpful and damaging towards someone with anorexia and showed her lack of experience in this area".

A guest at the Committee's private meeting said their child had not received good care from "bank and contracted staff":

[63] London Assembly, Health Committee – transcript, 21 September 2023, p.5
[64] London Assembly, Health Committee – transcript, 21 September 2023, p.15
[65] Written evidence - Royal College of Psychiatrists. Published alongside report.

> "I want to say that there are fantastic people in the NHS. But there is a lot of bank and contracted staff who should not be working within the health service and it is very dangerous. As far as I am concerned, they are not qualified - maybe on paper - but they are not the right people to be in that vicinity and they should not be anywhere near the patients".

The same guest suggested the reliance on temporary staff was related to the high turnover of staff, which they attributed in part to poor working conditions:

> "This is a massive issue and when you talk to a lot of people, which I did at the unit, about why they wanted to go, it was not because they did not like their job, it was because of the logistical nightmare of being underpaid, which we keep hearing all the time in the NHS, and also all the red tape that came with the job. It was not the job that they first took on".

The Royal College of Psychiatrists, in written evidence, stated:

> "The workforce is experiencing burnout, high turnover, and leaving for the private sector as take-home pay is higher and the risk and workload are at a lower risk. This has a negative impact on training and research, as well as on the stability of NHS services".[66]

Funding of services

Several respondents to the Committee's survey argued that eating disorder services in London did not receive sufficient funding. One respondent who has supported someone with an eating disorder perceived services to be "hopelessly under-resourced even though there are dedicated individuals trying their best in a service not fit for purpose." One respondent with experience of accessing adult services in London stated that "the funding provided to eating disorder services by the government is wholly inadequate."

Some respondents said that additional funding for services could help to improve access to, and outcomes from, services. For example, a respondent to the survey who works with those with eating disorders called for "more funding for NHS services to expand our provisions and remit". Other respondents with personal experience of accessing services in London said there should be:

> "More funding for treatment to reduce waiting lists, wider availability for treatment - not just for patients at their deepest lows."

> "More funding for NHS ED services, which would mean more eating disorders could be caught earlier, improving prognoses significantly."

NHS England has received additional funding for child and adolescent eating disorder services in recent years. Following new waiting time standards introduced from 2014, £150 million was invested in children and adolescent eating disorder services nationally. Further investment was

[66] Written evidence - Royal College of Psychiatrists. Published alongside report.

committed in the 2019 NHS Long Term Plan to allow the NHS to "maintain delivery of the 95 per cent standard beyond 2020/21".[67]

Guests welcomed this additional investment in child and adolescent services. However, Dr Ashish Kumar expressed concern that "sometimes the money which was intended for children's eating disorder services has not reached the front line".[68] He referred to work conducted by Beat, on behalf of the All Party Parliamentary Group on Eating Disorders, which found that in 2019-20 only a small proportion of the additional funding for eating disorder services was actually spent. Beat estimated that in London, only 17 per cent of additional funding allocated for 2019-20 was actually spent.[69] Beat suggests that challenges in recruiting staff to eating disorder services may have contributed to the underspend.

Guests also suggested that while child and adolescent services had received significant additional investment in recent years, adult services had not benefitted from investment. Dr Brian Sreenan told the Committee "there is a huge gap in the amount of funding that adult services get compared to children services".[70] Dr Ashish Kumar said additional funding was needed in adult eating disorder services: "On one hand, we have a very good example of improved care in children's eating disorders, but there is a disparity in adult eating disorder services".[71]

Dr Agnes Ayton told the Committee that the additional funding placed into children and adolescent services was partly intended to ensure early interventions and "reduce the number of people who will have an eating disorder in adulthood". However, she said that this has created a "a two-tier system when a 17-year-old can wait a week for an urgent assessment and then an 18-year-old has six months to a year of waiting time".[72]

Emma Christie told the Committee that alongside additional investment for children and adult services, "there has been significant additional investment in eating disorder specialist pathways for adults through our Community [Mental Health] Transformation Programme".[73]

Availability of services across London

Some responses to the Committee's survey indicated inconsistent service provision across London, which led to some people travelling long distances to access care:

> "Unfortunately treatment was almost impossible as I was expected to travel quite a distance and I have other health issues that made this very difficult and so I didn't carry on for long as no other provision could be made."

> "distance from eating disorder clinic to where I live [was a barrier to accessing services]. Had to travel from Walthamstow to Barking minimum twice a week for months on end."

[67] NHS England, Long Term Plan, January 2019
[68] London Assembly, Health Committee – transcript, 21 September 2023, p.4
[69] Beat and APPG on Eating Disorders, Short-changed: Funding for children and young people's community eating disorder services in England in 2019/20, May 2021
[70] London Assembly, Health Committee – transcript, 21 September 2023, p.15
[71] London Assembly, Health Committee – transcript, 21 September 2023, p.4
[72] London Assembly, Health Committee – transcript, 21 September 2023, p.5
[73] London Assembly, Health Committee – transcript, 21 September 2023, p.2

Another respondent described a "postcode lottery" of available services in London. Another respondent, who works with people with an eating disorder, noted that there were: "Challenges of the geographical vastness of London, different boroughs being larger than others. Lack of service support in some boroughs vs others. Can be a postcode lottery."

The Committee also heard that some people lost access to services when they moved away from London, for example to attend university. One respondent said that, "despite improvements", people accessing eating disorder services when they turn 18 or move between areas "frequently fall through gaps." They said there should be more flexibility when people move between London boroughs. Another respondent suggested there should be a "cross London solution" or that NHS services should be better joined up.

This was similarly highlighted in written evidence from Goldsmiths, University of London, which included views from members of the Central London Self Help Support Group for Adults with an Eating Disorder:

> "The lived experiences of people with an ED in London reveals that where they are located is often contingent as to whether they receive the support they need. In some cases, there are lengthy waiting lists with wait times of over a year for adult services. This can be compounded if someone moves to a new borough. This has meant that some people have lost their place on the waiting list as they need to be referred to a service within their new borough. This could mean a further delay in receiving treatment".[74]

Guests also told the Committee that provision of support for different types of eating disorder services across London was inconsistent.[75] For example, Andrew Radford told the Committee that some trusts do not commission services for binge eating disorders, and Dr Brian Sreenan said that not all trusts in London accepted referrals for avoidant/ restrictive food intake disorder (ARFID). [76]

Recommendation 5

The GLA Health team should work with NHS England (London) to conduct a London-wide audit of available eating disorder services, to identify and address any gaps in provision for particular eating disorders, such as binge-eating disorder and avoidant/restrictive food intake disorder.

The impact of COVID-19

The Committee heard how COVID-19 has been associated with a significant increase in demand for eating disorder services. Dr Karina Allen told the Committee how consequences of the COVID-19 pandemic could have caused triggers for people who were already vulnerable to an

[74] Written evidence - Goldsmiths, University of London. Published alongside report.
[75] London Assembly, Health Committee – transcript, 29 June 2023 p.28
[76] London Assembly, Health Committee – transcript, 29 June 2023 p.26; London Assembly, Health Committee – transcript, 21 September 2023, p.7

eating disorder, including the stress of the pandemic itself, people losing structure in their day, uncertainty and loss of control, lack of social support, and food shortages.[77]

A guest at the Committee's private session said: "I think a lot of people had an eating disorder were really experiencing hell [during COVID-19 lockdowns]. I was really noticing in my own behaviours a lot of stuff I was struggling with". [78]

Dr Karina Allen also said that fewer people sought support for eating disorders under a time of great pressure for the NHS, effectively creating a backlog of demand: "We were all being told to protect the NHS, so there was a drop in referrals or people seeking help for an eating disorder initially. There was an avalanche later on, with services opening up again, which we have still not caught up on".[79]

Andrew Radford said Beat helped four times as many people each month during the height of COVID-19 than it had before the pandemic.[80] Jessica Griffiths said: "The general consensus is that eating disorder rates have increased across the pandemic generally across the age range."[81]

Dr Victoria Chapman told the Committee of the additional pressures CAMHS experienced during COVID-19: "In CAMHS eating disorder services in London, towards the end of the pandemic, there was a two-and-a-half times increase in the number of referrals to some services across London in our service".[82] She said that this heightened demand increased pressure on services and negatively impacted performance against waiting time standards for children and adolescents: "the pandemic has had a huge impact and some of the Access and Waiting Time Directive key performance indicators have not been met".[83]

Emma Christie said: "Coming out of the COVID period, the most obviously impacted service line seems to be children's and young people's eating disorders with really significant increases in demand. We could see that in the access standard data, which had been holding steady at 95 per cent across both routine and urgent cases for a number of years and suddenly, as colleagues reflected it dropped."[84]

The Committee also heard that services saw an increase in severity of cases during and following the pandemic. Dr Victoria Chapman said that CAMHS services saw an "increase in very unwell young people who needed a lot of support and admissions to paediatric wards".[85] Emma Christie also observed an "ongoing trend" of children and young people becoming sicker and needing more intensive support. She suggested this increase in severity negatively impacted routine referral times, as sicker patients were prioritised.[86]

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[77] London Assembly, Health Committee – transcript, 29 June 2023
[78] Health Committee private meeting with people with lived experience
[79] London Assembly, Health Committee – transcript, 29 June 2023, p.15
[80] London Assembly, Health Committee – transcript, 29 June 2023, p.15
[81] London Assembly, Health Committee – transcript, 21 September 2023, p.9
[82] London Assembly, Health Committee – transcript, 21 September 2023, p.8
[83] London Assembly, Health Committee – transcript, 21 September 2023, p.5
[84] London Assembly, Health Committee – transcript, 21 September 2023, p.8
[85] London Assembly, Health Committee – transcript, 21 September 2023, p.4
[86] London Assembly, Health Committee – transcript, 21 September 2023, p.8

Both Dr Victoria Chapman and Emma Christie said additional funding and investment has gone into children's services to support the response post-COVID, and that this has improved response times. However, Dr Victoria Chapman warned that demand "is still above pre-pandemic levels", which she suggests may stem from "a gradual year on year increase in presentations for eating disorders that has been going on longer than the pandemic".[87]

[87] London Assembly, Health Committee – transcript, 21 September 2023, p.8

Chapter four: improving quality of care

Positive and negative experiences of treatment in London

The Committee heard varied accounts of people's experiences in accessing eating disorder services in London, including inpatient and outpatient care across both CAMHS and adult services.

Some respondents described very negative experiences. Respondents variously described their experience of treatment as "poor – just poor"; "poor therapists, poor care/ treatment, poor therapy, poor access to support. overall, a bad experience"; "Diabolical. I never reached a healthy weight. There was no treatment as such. No care in the community. I became a revolving door patient, readmitted many times".

Other respondents to the survey indicated that they felt services to be impersonal and to have lacked compassion. One respondent described their treatment as "one size fits all rather than focusing on individual needs". Other respondents suggested that they lacked input into the treatment they received:

> "The mode of therapy and person working with me was out of my control. I was told what therapy I would get without any discussion with me. I was then told it has to be online even though I have issues with cameras".
>
> "Staff often had quite a paternalistic attitude towards patients and our views, although rarely punitive. It was only occasionally that I felt that my asserting my views and needs where taken as a being obstructive and held against me, it was more often that I was ignored or patronised".
>
> "Recovery requires a holistic, compassionate and person centred approach to care. I'm sad to say that this was never achieved in the NHS. I am now accessing private therapy and dietetic support, as I could not wait the 12 months that my local service wait list required. This has shown me that care can be supportive and encouraging, firm and yet person centred."

The same respondent described their overall experience of treatment in NHS services as "disjointed, traumatic, and bewildering" and said that:

> "I experienced numerous changes (e.g., changing therapists 3 times in 6 months, around a time when I was also admitted to inpatient treatment). I was transitioned from a general child mental health ward (with no specialist support for EDs) on my 18th birthday to an adult ED ward far away from home. This was terrifying".

Other respondents described receiving interrupted treatment due to services not being joined up within the NHS, transitions being poorly managed between services or other issues such as high staff turnover. One respondent stated that "I have found treatment fragmented and mostly ineffective", while another described it as "a long and confusing process". One respondent gave a detailed description of their experience of supporting their child through CAMHS in London, highlighting in particular the challenges they faced in accessing support for

physical health complications associated with their child's eating disorder through CAMHS. The respondent called for changes to how CAMHS supports children:

> "CAMHS to offer more than one hour a week of support, to be more flexible, tailoring their protocols according to the needs of the patient and carer - perhaps with more intense interventions early on, with home visits and input from dieticians. Have cast iron communications between GP surgeries and specialist services so that they each know what their roles and responsibilities are, providing eating disorders training to staff at GP surgeries".

The Committee heard from several other people with very positive experiences of treatment. For example, one respondent described treatment as "difficult and daunting… But the service also saved my life so I am grateful". Another respondent, who described their experience of treatment as **"**very good", reported having a great deal of agency in their treatment:

> "I was given as much agency as possible in treatment and decisions and the treatment plan revolved around me personally. I was seen regularly and further intervention provided when lower levels didn't suffice".

Other respondents praised various aspects of the care they received in London:

> "I was put on an Outpatient waiting list, but about 6 months later, was offered a 16 week group course at the Maudsley hospital, with individual sessions between the group sessions. This was extremely beneficial for me, and even though I'm still recovering, I'm gradually getting better".

> "I speak very highly of the care I received as an inpatient, day patient and outpatient".

> "They were amazing, I had 1-1 therapy and group therapy, generous amount of sessions 20+ and I honestly wouldn't be where I am today without it. Invaluable support that I know isn't on offer in every borough. Feel very lucky that I was living where I was when I realised and reached out for help".

Some respondents to the Committee's survey described positive experiences of being supported by excellent and caring healthcare staff in the NHS. One respondent described a nurse supporting them as "empathetic, experienced, encouraging and supportive". Other respondents also spoke highly of healthcare staff:

> "the staff I've seen so far have all been really nice and haven't said anything triggering to me […] ED services actually kind of make me want to get better".

> "I felt very comfortable and able to open up as the lady I spoke to was lovely".

> "The therapist was the kindest person and was always very understanding and empathetic which made me feel safe and comfortable to discuss my experiences with an eating disorder".

A guest at the Committee's private meeting described their NHS therapist as "amazing". They said: "It is a massive challenge, recovering as an adult because no one can force you to be there. Therefore, it is really delicate the way they approach it. I was referred for 12 weeks of cognitive behavioural therapy and I found it really effective".

The Committee notes that London has hosted some examples of excellent practice, such as the First Episode Rapid Early Intervention for Eating Disorders model (FREED) which was founded at the South London and Maudsley Trust (see below). The current challenges faced in London are also not unique to other parts of the UK.

Good practice: FREED

The First Episode Rapid Early Intervention for Eating Disorders model (FREED) was developed by the eating disorders unit at South London and Maudsley Trust and King's College London in 2014.[88] FREED aims to improve services to young people aged between 16 and 25 who have had an eating disorder for less than three years.[89] FREED has improved treatment outcomes, including reductions in waiting times for accessing treatment and improving outcomes from treatment.[90] Subsequent studies appear to support the findings from the initial trial.[91] FREED has since been rolled out to several eating disorder services across England.[92]

Dr Ashish Kumar described FREED as a "fantastic model". A respondent to the survey with experience of supporting their child stated that "FREED take concerns seriously" and praised the quick referral and expertise of the staff. Dr Ashish Kumar said access to the FREED intervention "has been quite patchy across London services" and recommended for greater investment to provide more consistent access to FREED. [93]

The 2017 'Ignoring the alarms' report by PHSO identified several failings in how NHS eating disorder services were working nationally, including around the management of referrals between services; the management of hospital discharge; and the level of support offered by specialist adult eating disorder services.[94]

In February 2023, the PHSO again raised concerns about eating disorder services nationally, stating: "People with eating disorders are being repeatedly failed by the system and radical changes need to be made to prevent further tragedies". It said little progress had been made since the publication of its 2017 report, and added that it had received 234 complaints related to eating disorders since April 2019.[95]

Guests also told the Committee that there were national challenges. Andrew Radford told the Committee that there is nowhere in the UK that is "meeting the need and doing it in a way that gets people into and through treatment quickly".[96] Dr Allen said "I do not think again there are many areas in England where you could say that there is an eating disorder service that is

[88] FREED, The Maudsley Story
[89] FREED
[90] FREED, What is FREED
[91] Early intervention in psychiatry, The First Episode Rapid Early Intervention for Eating Disorders - Upscaled study: Clinical outcomes, 29 March 2021
[92] FREED, The Maudsley Story
[93] London Assembly, Health Committee – transcript, 21 September 2023, p.18
[94] PACAC, Ignoring the alarms follow up, 18 June 2019
[95] PHSO, Urgent action needed to prevent eating disorder deaths, 27 February 2023
[96] London Assembly, Health Committee – transcript, 29 June 2023 p.28

perfectly matching the needs of the local community".[97] Dr Ashish Kumar said: "Many of the recommendations of the PHSO report, which came out in 2017, have not been implemented, unfortunately".[98]

Care for the most unwell patients

The Committee also heard examples of eating disorder services in London struggling to provide care for the most seriously ill patients, for example children and young people who do not necessarily want to cooperate with treatment. One respondent described their experience of supporting someone else through treatment as "very stressful and often felt hopeless". They said: "The person was very resistant to treatment and it felt like the system wasn't equipped to deal with someone who wouldn't cooperate as often they would be discharged early due to these issues."

A respondent to the survey who supports their child with an eating disorder also highlighted how eating disorder services were not set up to provide treatment for patients who self-harmed or were at risk of making attempts to take their own life. They stated: "We found the eating disorder ward unable to cope with my daughter's suicide attempts when regaining weight". They said that when their child was then transferred to an "adolescent psych ward" the parents were told the ward "couldn't support her eating as they're 'not an eating disorder ward' and let her skip meals". The respondent also said they had "consulted a range of private facilities, but were told our daughter was too ill and risky for them".

Another respondent stated: "I was told that binging and self harm meant I could not be treated as an inpatient". [Following an incident of self harm] I was not allowed on the ward for a week. Leaving me with no support when I was most at risk". They said that their experience of services had left them with trauma and that when they developed further disordered eating in later years, they avoided seeking any help due to their previous experience.

Length of care and managing discharges

Some survey respondents shared experiences of being discharged from services when they felt the underlying causes of their eating disorder had not been addressed. They suggested that the focus of services was primarily on weight restoration and there was not enough support provided to address the underlying causes of the condition, which increased the likelihood of people being readmitted:

> "My daughter was discharged from services before making a full recovery".
>
> "As soon as you have weight restored they want to discharge you, which is when your mental state is most fragile and the time you need more support not less. This often leads to relapse and so you keep going round in circles".
>
> "Often the time limited nature of treatments will get you to a minimum healthy weight and then discharge you when although physically stable, mentally you are struggling more than you were before treatment. Sadly this just means rapid deterioration and going round in circles being re-referred and discharged".

[97] London Assembly, Health Committee – transcript, 29 June 2023 p.28
[98] London Assembly, Health Committee – transcript, 21 September 2023, p.7

> "Overall emphasis on weight restoration and discharge. Very little or no Psychological Therapy leading to relapses I feel as the root of ED is never addressed".

Other respondents shared positive experience of their treatment but said the support was simply not provided for long enough, and with very limited step-down support offered for people who are discharged from services: "The service provided therapy, physical monitoring but I feel there was not enough focus on long term mental health recovery which is not sustainable to just focus on physical health".

Some respondents called for services to better support people towards longer term recovery. One respondent stated that services should aim to "Help someone strive for full recovery not a partial recovery still driven by an eating disorder" and another stated that "the door shouldn't be closed after discharge and only opened if you experience a full relapse. Help and support around building life after a long illness, such as help with getting a job". The Committee heard how integrated care models could be adopted more widely across London to achieve better care pathways (see below).

Good practice: integrated care models

The integrated cognitive behaviour treatment (I-CBTE) model, trialled by Oxford and Marlborough NHS Trust, combines a planned 13-week admission to hospital with the goal of full weight restoration; seven weeks of 'stepped down' day treatment; and a further outpatient treatment over a total period of 40 weeks.[99] Dr Agnes Ayton told the Committee that "people who received I-CBTE Model had 70 per cent recovery rate as opposed to five per cent in treatment as usual. The readmission rates were 15 per cent instead of about 50 per cent with treatment as usual".[100] The Royal College of Psychiatrists has encouraged commissioners and NHS mental health providers to consider implementing this model in their areas.[101]

Emma Christie said that while she was not aware that the specific ICBT-E model had been adopted anywhere in London, there was a focus on providing strong integration across inpatient and community settings in London.[102] Jessica Griffiths also told the Committee that "many of the eating disorder services within London" are "implementing an integrated care model", including two integrated care models for treating anorexia nervosa: Maudsley Anorexia Nervosa Treatment for Adults (MANTRA); and Specialist Supportive Clinical Management (SSCM). [103]

[99] Journal of Eating Disorders, Integrated enhanced cognitive behavioural (I-CBTE) therapy significantly improves effectiveness of inpatient treatment of anorexia nervosa in real life settings, 8 July 2022
[100] London Assembly, Health Committee – transcript, 21 September 2023, p.16
[101] Oxford Health NHS Foundation Trust, New integrated treatment could transform the lives of adults with life-threatening anorexia nervosa, 1 March 2022
[102] London Assembly, Health Committee – transcript, 21 September 2023, p.16
[103] London Assembly, Health Committee – transcript, 21 September 2023, p.14

Experience of people with autism accessing eating disorder services

The Committee also heard that there is particular concern around unmet need amongst people in London with autism. In response to its call for evidence to support this investigation, Autistica – an autism research and campaigning charity – highlighted that those with autism are more likely to be impacted by eating disorders but many people will not have been identified as autistic when accessing services:

> "Eating disorders are especially prevalent amongst autistic people, with as many as one in five women in anorexia services meeting diagnostic criteria for autism. In many cases, this group are not identified as autistic until long after eating disorders take hold, often involving an admission to inpatient services. In July 2022, there were almost 8,000 people on the waiting list for an autism assessment in London, the vast majority of whom were much longer than the recommended 13 weeks, and the backlog is rising fast".[104]

Guests told the Committee that prevalence of eating disorders may be high amongst autistic people, but services do not always know how to effectively support people with autism. Dr Victoria Chapman told the Committee:

> "The patients that sometimes become extremely ill and need admission to specialist eating disorder units often with children and young people have undiagnosed autism spectrum disorder (ASD). They have not had the assessment. Maybe they are still on the waiting list. They need a specific treatment pathway. As a result, quite often they get stuck in inpatient units without having the diagnosis and are very complex to treat. There is a gap there and it is very important that you mention the fact that the diagnosis and treatment of ASD is very important for these patients. I personally see the patients that maybe get detained under section, who spend maybe up to a year or more in inpatient units, often have that diagnosis but have not been treated".[105]

One respondent to the Committee's survey with personal experience of accessing treatment in London stated that they were told by services that they were "probably autistic" but could not access an autism assessment through the NHS. Another respondent stated that they had "difficulties getting autism diagnosis/assessment within the NHS" and that they felt this impacted their treatment outcomes, "trying to treat the eating disorder without trying to understand what may be contributing to it is not only traumatising but is ineffective and a waste of time and resources".

The Committee also heard that even for people who have had an autism assessment, eating disorder services in London can be inflexible to their additional needs. One respondent to the survey stated that "autism was not considered during treatment". Jessica Griffiths said:

> "I was speaking to someone with lived experience last week who has autism and had so many hospital admissions. Because the inpatient ward was not appropriate for her needs and her accessibility needs and treatment adaptations, it really developed into a place where she lost trust in her treatment team and it became traumatic to go to the very place where she needed that support and treatment. There is a lot more we need to

[104] Written evidence – Autistica. Published alongside report.
[105] London Assembly, Health Committee – transcript, 21 September 2023, p.6

> learn about autism and eating disorders. We know there is a huge crossover and there is a lot more we could do to support people better."[106]

Jessica Griffiths praised the work of the Pathway for Eating Disorders and Autism (PEACE), a specialist pathway for people with eating disorders who also have autism, based at the South London and Maudsley Trust. She said: "There has been new research conducted that I believe is coming out in the next couple of years but we are trying to replicate that model in other trusts in London to ensure that actually there are specialised pathways for people who are autistic".[107] In its written evidence, Autistica also called for more tailored interventions for eating disorders in autistic people.[108]

Recommendation 6

The Mayor should request that NHS England (London) supports the roll-out of specialist care pathways across NHS trusts in London for people with autism suffering from an eating disorder.

Improving access to psychological therapies

Dr Brian Sreenan told the Committee that funding tends to be channelled into specialist services to support people with more severe symptoms, but that people who are at the mild to moderate end of the spectrum can be neglected or struggle to access treatment.[109] He said there was potential for eating disorder services to work more closely with the Improving Access to Psychological Therapies (IAPT) workforce, to provide access to talking therapies for people at the mild to moderate end of the spectrum.

One respondent to the survey, who works with adults with eating disorders in London, stated that: "The largest access to psychological treatments is provided via IAPT /Talking Therapies", but that "Eating Disorders is largely 'excluded' from this offer". Dr Brian Sreenan said that in East London, work had taken place to better integrate IAPT capacity with eating disorder services and suggested this should be rolled out more widely:

> "The results coming out of our IAPT or talking therapies services in primary care are really excellent not only in terms of recovery rates for eating disorders but also in terms of the measures that their KPIs are based on and so the depression and anxiety measures, too. It seems to be killing two birds with one stone. I would really like to see that - maybe with the convening powers that this Assembly has - to really think more deeply with the talking therapies services as to why they cannot extend their provision for people with eating disorders".[110]

Emma Christie expressed interest in following this up. She said there is work ongoing in London to integrate talking therapies with community services more effectively. She said: "We are aware that there will be people at a milder, earlier stage in their experience of an eating disorder that would definitely benefit from being able to access our talking therapy services".[111]

[106] London Assembly, Health Committee – transcript, 21 September 2023, p.7
[107] London Assembly, Health Committee – transcript, 21 September 2023, p.6
[108] Written evidence – Autistica. Published alongside report.
[109] London Assembly, Health Committee – transcript, 21 September 2023, p.10
[110] London Assembly, Health Committee – transcript, 21 September 2023, p.10
[111] London Assembly, Health Committee – transcript, 21 September 2023, p.11

Recommendation 7

The Mayor should request that NHS England (London) reviews how the Improving Access to Psychological Therapies workforce can be utilised across London to provide better access to talking therapies for people with eating disorders.

Chapter five: improving support in the community

Prevention and education

The Committee heard that improved education around eating disorders could help more people to spot the signs of an eating disorder and recognise their own symptoms, or symptoms in loved ones. Jessica Griffiths said "there are so many people whom people with eating disorders come into contact with, so many clinicians, school, workplace. All of those people need to have an awareness of how to talk to someone with an eating disorder and how to spot them and the treatment pathway, too".[112]

Several respondents to the survey called for greater efforts to raise awareness in schools, colleges and universities to help identify and address eating disorders at an earlier stage:

> "For teenagers many begin by skipping lunch at school so prevention and intervention in schools could be highly effective. Good early intervention could stop symptoms from worsening and avoiding the need for more intensive treatment".

> "Better education for schools and colleges and universities - what to look out for, how to help, how to talk to someone they are concerned about, how to foster a positive culture in their environment". [113]

One respondent said "having some sort of a programme at schools to deliver informative lessons about eating disorders would be incredibly useful [...] having a space devoted to talking about eating disorders, in a non-triggering and sensitive way of course, would really help to not only widen the understanding and awareness of eating disorders, but also aid students struggling from eating disorders". Emma Christie said NHS London had supported the rollout of mental health support teams in schools, and providing them with the resources to spot early signs of eating disorders.[114]

Other respondents highlighted the importance of public education in specifically addressing the common misunderstandings about eating disorders, for example that "the only symptom of an eating disorder is weight control" or that you "have to be underweight to have anorexia". Others suggested there should be efforts to promote where people can seek help if they have an eating disorder, including in offline spaces such as transport networks, local newspapers and library noticeboards.

In written evidence, Carney's Community, a South London youth charity, said there should be "more discussions about eating disorders at school and in the media (including social media).

[112] London Assembly, Health Committee – transcript, 21 September 2023, p.14
[113] See also R53, R98 and R54
[114] London Assembly, Health Committee – transcript, 21 September 2023, p.11

There should be more safe spaces where people can speak to trusted adults about things like eating disorders".[115]

Some respondents also suggested there should be training provided in workplaces to support people to identify eating disorders amongst loved ones, and know how to approach them to discuss their condition:

> "Inform family members of how to best approach a loved one with an eating disorder".
>
> "Education in schools and workplaces on how to initiate conversations and help support with someone who they suspect to have an eating disorder. Making referral pathways clear, accessible and well advertised so that people may self-refer or refer others".
>
> "Creating awareness of what an Eating Disorder is, and sharing what those who live with one go through. Psycho education at schools around Eating Disorders Family support and education on how best to manage their loved ones with an Eating Disorder".

The Mayor's HIS sets out an objective that "No Londoners experience stigma linked to mental ill health, with awareness and understanding of mental health increasing city-wide". This is a welcome goal, but it is clear that many people with eating disorders in London do face stigma and that there is widespread misunderstanding and lack of awareness surrounding eating disorders.

Recommendation 8

The Mayor and the GLA Public Health Unit should design and deliver a public awareness campaign on eating disorders across London, with the aim of addressing stigma and improving signposting to support services.

The Mayor's HIS also sets out an objective that "Mental health becomes everybody's business. Londoners act to maintain their mental wellbeing, and support their families, communities and colleagues to do the same". The Mayor's HIS commits to action towards this objective through Thrive LDN and the Good Thinking website. Jessica Griffiths told the Committee that information on eating disorders should be more prominently available through Thrive LDN.[116]

Recommendation 9

The Mayor should work with relevant partners to ensure that Thrive LDN and Good Thinking provide good, easily accessible and up-to-date information to help people with an eating disorder understand options for treatment and services available in London.

[115] Written evidence – Carney's Community. Written evidence published alongside report.
[116] London Assembly, Health Committee – transcript, 21 September 2023, p.10

Calorie labelling on menus

The Committee also heard how some other efforts to promote healthy eating could have the unintended consequence of triggering or worsening people's eating disorders. In particular, the Committee heard opposition to the introduction of legislation in April 2022 that requires large food businesses, such as restaurants, cafes and takeaways to add calorie labels to the food they sell.[117]

The Government's stated aim of the legislation was to "ensure people can make more informed, healthier choices when it comes to eating food out or ordering takeaways".[118] A Public Health England survey from 2018 found that 79 per cent of people agreed with the statement that "menus should include the number of calories in food and drinks".[119]

However, guests at both formal meetings and several survey respondents highlighted the negative impact experienced by people with eating disorders from legislation requiring certain restaurants and cafes to include calories on menus. Andrew Radford, Dr Karina Allen and Hope Virgo all criticised the evidential basis for using calories as a metric of healthy eating.[120] Guests also said that detailing calories on menus was harmful to people with eating disorders. Hope Virgo described the impact it had on her:

> "When the calories came out on the menus, while I was in a good space in my recovery, I did find it triggering and difficult to go out for dinner. It meant that a lot of the conversations that were happening with your friends and around the restaurants were around the lowest calorie option, what they were going to have, people saying things like, "I can have this, it has got 1,000 but I went to the gym today", or something like that, which is not helpful if you have had an eating disorder or you are in recovery or if you are in the grips of it as well."[121]

Some respondents to the Committee's survey described the harm they experience from seeing calories on menus:

> "My greatest challenge has been the introduction of calorie content to restaurants and cafes. This isn't just on menus but on the walls. It's impossible to not see and there have been so many times that I have been too overwhelmed and had to leave or to ask for menus without calories where people give you horrible looks or say they don't have them. This has caused me so much harm".

Dr Karina Allen suggested restaurants could work within the current legislation to have two menus available – one with calorie labelling and one without. She also suggested that calorie

[117] DHSC, Tackling obesity: empowering adults and children to live healthier lives, 27 July 2020
[118] DHSC, New calorie labelling rules come into force to improve nation's health, 6 April 2022
[119] Public Health England, Calorie reduction: The scope and ambition for action, March 2018, p.70
[120] London Assembly, Health Committee – transcript, 29 June 2023, p.17
[121] London Assembly, Health Committee – transcript, 29 June 2023, p.17

labelled menus should not be the default option.[122] Andrew Radford agreed that people should have to opt-in for a calorie labelled menu, rather than it being the default option.[123]

Andrew Radford expressed concern that schools use calorie labelling on menus, despite being exempt from doing so in the legislation.[124] Hope Virgo also suggested that some schools use calorie labelling on their menus.[125]

We note in this context that at London's City Hall itself, calorie labelling is used on some menus at the public café, despite it being potentially exempt under the legislation as dishes are on the menu for less than 30 consecutive days.[126] In response to a question in July 2022, The Mayor stated that he was "pleased to note that the regulations include a provision which allows businesses to provide a menu without calorie information at the request of the customer".[127] The Committee believes there is scope for the Mayor to do more to promote this option in cafes and restaurants on GLA and TfL premises.

The Committee believes that further evidence gathering is needed nationally to determine the extent to which calorie labelling has helped the wider population to make more informed decisions about their calorie intake when eating out, and whether any changes to the legislation should be made in light of this.

Recommendation 10

The Mayor should raise awareness of the existing legislation that exempts schools from including calories on menus, to support schools that may believe they are required to display calorie information.

Recommendation 11

The Mayor should take steps to support those experiencing eating disorders when using cafes and restaurants on GLA and TfL premises, ensuring that relevant exemptions to calorie labelling on menus are applied. This could include doing more to promote the option of providing a menu without calorie information.

Community support services

The Committee was informed of opportunities to improve the provision of lower-intensity support in the community for those people with less severe symptoms. For example, Andrew Radford said that people at the earliest stages of their eating disorder may benefit from support from peer workers or from guided self-help support delivered by people who are not clinicians. He said this could be more effective and cheaper, and could help to prevent people from

[122] London Assembly, Health Committee – transcript, 29 June 2023, p.14
[123] London Assembly, Health Committee – transcript, 29 June 2023, p.17
[124] London Assembly, Health Committee – transcript, 29 June 2023, p.16
[125] London Assembly, Health Committee – transcript, 29 June 2023 p.7
[126] UK Government, The Calorie Labelling (Out of Home Sector) (England) Regulations 2021
[127] Mayor of London, MQT 2022/2306: No Calorie Menu Options, 21 July 2022

presenting to specialist services down the line, when they have more complex and serious symptoms.[128]

Dr Karina Allen said there is an "enormous gap" in available support for people dropping down from NHS care and that there needed to be more support like "recovery groups and recovery spaces" in the community for people discharged from NHS treatment.[129] Andrew Radford also described an "enormous dropdown from what you receive on an NHS service when perhaps you are acutely unwell to what is available in the community" and said there needed to be more "stepdown options from NHS Care".[130]

The Committee heard that a lack of options for engaging in positive communities both online and offline could also be contributing to the existence of more dangerous eating disorder 'communities' online. For example, many young people are exposed to content on social media that advocates an eating disorder as a desirable lifestyle choice, rather than a symptom of an illness.[131] The Committee was encouraged to consider the reasons why young people engage with online 'communities' of pro-ana (content advocating anorexia nervosa symptoms) and pro-mia (content advocating bulimia symptoms) content. Andrew Radford explained:

> "The Pro-Ana and Pro-Mia sites, the environments where people are then encouraged to be better at having anorexia or better at having bulimia, are horrible environments. However, often they are also places where people will go to those environments and then they will go to a safe space as well and then they will come to Beat's online groups and they move around between those things. They are getting something out of it."[132]

In September 2023, the Government passed the Online Safety Act, which is designed to protect young people and vulnerable adults from harmful content online. Whilst Ofcom will ultimately be responsible for regulating this content, it is hoped that this will have a positive impact on reducing the extent to which young people can access pro-ana or pro-mia content.

Respondents to the Committee's survey also highlighted the lack of community-based options for care, particularly for those who are looking to step down from specialist treatment but may need continued informal support. One respondent with experience of accessing services in London said that "finding appropriate support outlets, outreach, support groups and general service access is very poor to none".

Another respondent said: "there is a huge lack of support for those who are moving towards recovery but still finding things difficult and need help". They said that "the door shouldn't be closed after discharge and only opened if you experience a full relapse".

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[128] London Assembly, Health Committee – transcript, 29 June 2023 p.25
[129] London Assembly, Health Committee – transcript, 29 June 2023 p.8
[130] London Assembly, Health Committee – transcript, 29 June 2023 p.33
[131] Internet Matters, In their own words: the digital lives of schoolchildren, 2019; Centre for Countering Digital Hate, Deadly by design, 15 December 2022; BBC, Instagram eating disorder content 'out of control', 20 March 2019
[132] London Assembly, Health Committee – transcript, 29 June 2023, p.8

Other respondents, with experiences of accessing services and/or caring for others or working with people with eating disorders, said there should be more "community-based services in all boroughs" and "more informal ways of seeking short term support or advice".

Andrew Radford also said there is an opportunity for the NHS to take better advantage of voluntary sector resource and support, and that England was lagging behind Scotland in how it engages with the voluntary sector to provide nonclinical support. He pointed to an example of how Beat had helped provide a cost-effective peer-led NICE-compliant treatment for people with binge eating disorders in Scotland.[133]

Emma Christie said there have been good examples of the NHS commissioning voluntary sector support, including support for parents and carers in relation to eating disorders.[134]

Dr Victoria Chapman said she does not refer patients to voluntary sector services often, partly because the severity of risk of people being supported is difficult to delegate out. However, she suggested the voluntary sector could play a role in helping to educate people, for example outreach into schools and "supporting schools understanding how to manage their whole health policy with eating and nutrition".[135] Jessica Griffiths suggested voluntary sector support could be better harnessed to provide "community support for those from different cultural backgrounds".[136]

Dr Brian Sreenan said that "involving third sector organisations is fantastic and there is massive resource there and massive skills and intelligence there. However, he said voluntary sector organisations should not be relied upon to deliver eating disorder treatment, and any support provided by external organisations "needs to be an adjunct to NHS provided NICE evidenced based care".[137]

Working with families

The Committee heard that it was important that where possible, clinicians should involve carers and families in the care plan for someone with an eating disorder. Dr Ashish Kumar said:

> "Who is around the patient, who could listen to them and their inner feelings? Who could take them to a variety of appointments or help? This illness thrives on secrecy. […] That is quite an important part, which has not been tapped very well – how to train and educate parents and carers about eating disorders and engage them in the treatment we offer. They are a vital resource of the whole picture".[138]

Dr Karina Allen told the Committee that "involving families, carers or close others in the support of someone with an eating disorder is best practice and really important for the individual with

[133] London Assembly, Health Committee – transcript, 29 June 2023 p.31
[134] London Assembly, Health Committee – transcript, 21 September 2023, p.22
[135] London Assembly, Health Committee – transcript, 21 September 2023, p.23
[136] London Assembly, Health Committee – transcript, 21 September 2023, p.25
[137] London Assembly, Health Committee – transcript, 21 September 2023, p.23
[138] London Assembly, Health Committee – transcript, 21 September 2023, p.24

an eating disorder and also for the family members being supported as well".[139] Andrew Radford stated that families "can be incredibly powerful at understanding the illness, supporting the treatment, encouraging their loved one to get in, to stay on the course, stay in treatment and stay healthy afterwards".[140]

Dr Ashish Kumar said there were examples of initiatives that sought to bring families into treatment, including family therapy models and 'triangle', which involves bringing parents and carers into treatment plans.[141]

Jessica Griffiths said more needed to be done to support and upskill people in the community to be able to support those with eating disorders:

> "We need to look after them. We need to skill them up. We need to provide them support. We need to work together. None of us can do this on our own. We are a partnership, supporting our carers, supporting those people who are in treatment themselves, understanding that we are better together. There are lots of resources that we can provide for our family members in the community, such as in schools. You could do a carers workshop, understanding eating disorders. There are lots of things you can do in community groups and youth clubs to raise awareness and skill up our community".[142]

Hope Virgo praised the service provided by Feast, a charity set up to support people caring for those with an eating disorder. She said there needed to be "wider education for parents and carers within schools, within our communities".[143]

Guests also told the Committee that carers and families themselves experience a great deal of pressure when supporting loved ones with an eating disorder. Jessica Griffiths said that "carers and family members are likely to develop their own mental health issue; 50 per cent of them from supporting someone with an eating disorder".[144]

Andrew Radford said that "eating disorders tear families apart in so many different ways" and endorsed NICE guidelines that state that families "should be offered an assessment of their own wellbeing and offered support if they need it".[145] Research published by Cambridge University in March 2022 found that the experiences of family members of those with eating disorders did not meet the published guidance.[146]

Respondents to the Committee's survey with experience of supporting someone with an eating disorder in London said there was a lack of support for families:

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[139] London Assembly, Health Committee – transcript, 29 June 2023 p.15
[140] London Assembly, Health Committee – transcript, 29 June 2023 p.8
[141] London Assembly, Health Committee – transcript, 21 September 2023, p.23
[142] London Assembly, Health Committee – transcript, 21 September 2023, p.22
[143] London Assembly, Health Committee – transcript, 29 June 2023 p.19
[144] London Assembly, Health Committee – transcript, 21 September 2023, p. 21
[145] London Assembly, Health Committee – transcript, 29 June 2023 p.33
[146] Cambridge University Press, The experiential perspectives of siblings and partners caring for a loved one with an eating disorder in the UK, 24 March 2022

> "A lot more support is also required so that families can give the best chances for their loved ones to overcome these issues."

> "Basically, by default, as a single mother of three children I've been left to care for my acutely ill and risky child on my own at home with no real practical help including from social services."

It is apparent that friends, families and carers play an essential role in supporting people impacted by eating disorders and it is widely acknowledged that families should be involved in treatment plans. However, it appears families themselves currently do not receive the level of support they need, in order for them to be able to best help their loved ones.

Recommendation 12

The Mayor should bring together the GLA Health Team, NHS England (London) and Feast to review how NHS trusts engage with and support families impacted by eating disorders; and identify areas where additional support can be provided.

Other formats and languages

If you, or someone you know needs this report in large print or braille, or a copy of the summary and main findings in another language, then please call us on: 020 7983 4100 or email assembly.translations@london.gov.uk

Chinese

如您需要这份文件的简介的翻译本，
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Email 与我们联系。

Hindi

यदि आपको इस दस्तावेज का सारांश अपनी भाषा में
चाहिए तो उपर दिये हुए नंबर पर फोन करें या उपर दिये
गये डाक पते या ई मेल पते पर हम से संपर्क करें।

Vietnamese

Nếu ông (bà) muốn nội dung văn bản này được dịch sang
tiếng Việt, xin vui lòng liên hệ với chúng tôi bằng điện
thoại, thư hoặc thư điện tử theo địa chỉ ở trên.

Bengali

আপনি যদি এই দলিলের একটা সারাংশ নিজের ভাষায় পেতে চান,
তাহলে দয়া করে ফো করবেন অথবা উল্লেখিত ডাক ঠিকানায় বা
ই-মেইল ঠিকানায় আমাদের সাথে যোগাযোগ করবেন।

Greek

***Εάν επιθυμείτε περίληψη αυτού του κειμένου στην γλώσσα
σας, παρακαλώ καλέστε τον αριθμό ή επικοινωνήστε μαζί
μας στην ανωτέρω ταχυδρομική ή την ηλεκτρονική διεύθυνση.***

Urdu

اگر آپ کو اس دستاویز کا خلاصہ اپنی زبان میں
درکار ہو تو، براہ کرم نمبر پر فون کریں
یا مذکورہ بالا ڈاک کے پتے یا ای میل
پتے پر ہم سے رابطہ کریں۔

Turkish

Bu belgenin kendi dilinize çevrilmiş bir özetini
okumak isterseniz, lütfen yukarıdaki telefon
numarasını arayın, veya posta ya da e-posta
adresi aracılığıyla bizimle temasa geçin.

Arabic

ال حص ول عل ى مل خص له ذا ال مس تن د ب ل غ ت ك،
ف ر ج اء ال ات ص ال ب ر ق م ال ه ات ف أ و ال ات ص ال عل ى
ال ع ن وان ال ب ر ي دي ال ع ادي أ و ع ن وان ال ب ر ي د
ال إ ل ك ت ر ون ي أ ع لاه.

Punjabi

ਜੇ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਦਾ ਸੰਖੇਪ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲੈਣਾ
ਚਾਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਇਸ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ ਜਾਂ
ਉਪਰ ਦਿੱਤੇ ਡਾਕ ਜਾਂ ਈਮੇਲ ਪਤੇ 'ਤੇ ਸਾਨੂੰ ਸੰਪਰਕ ਕਰੋ।

Gujarati

જો તમારે આ દસ્તાવેજનો સાર તમારી ભાષામાં
જોઈતો હોય તો ઉપર આપેલ નંબર પર ફોન કરો
અથવા ઉપર આપેલ ટપાલ અથવા ઈ-મેઈલ સરનામા
પર અમારો સંપર્ક કરો.

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GREATERLONDONAUTHORITY LONDONASSEMBLY

Subject: Responses to Committee Outputs

Report to:	**Health Committee**
Report of:	**Executive Director of Assembly Secretariat**
Date:	**13 March 2024**
Public Access:	**This report will be considered in public**

1. Summary

1.1 This report outlines the recent responses received to Health Committee outputs.

2. Recommendation

2.1 **That the Committee notes the response from the Mayor of London to the Committee's letter on trauma-informed approaches to youth violence, as attached at Appendix 1.**

3. Background

3.1 At its meeting on 25 May 2023, the Committee discussed trauma-informed approaches to youth violence with invited guests and delegated authority to the Chair, in consultation with party Group Lead Members, to agree any output from the meeting.

3.2 The Committee's letter to the Mayor of London can be found on the GLA website here.

4. Issues for Consideration

4.1 The Mayor of London responded to the Committee on 15 February 2024 regarding trauma-informed approaches to youth violence, as attached at **Appendix 1**.

4.2 The Committee is asked to note the response received.

5. Legal Implications

5.1 The Committee has the power to do what is recommended in the report.

6. Financial Implications

6.1 There are no financial implications to the Greater London Authority arising from this report.

List of appendices to this report:

Appendix 1 – Response from the Mayor of London (trauma-informed approaches to youth violence), dated 15 February 2024

Local Government (Access to Information) Act 1985

List of Background Papers:

None.

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MAYOR OF LONDON

Dr Onkar Sahota AM
Chair
London Assembly Health Committee
Onkar.Sahota@london.gov.uk

Our ref: MGLA051223-1463

Date: 15 February 2024

Dear Onkar,

Thank you for your letter regarding the London Assembly Health Committee's investigation into trauma-informed approaches to youth violence in London.

First, I would like to thank the Committee for undertaking this important piece of work. I agree that trauma-informed approaches have great potential for supporting young people who have been impacted by or who are at risk of being impacted by violence.

I established London's Violence Reduction Unit (VRU) in 2019 to take a public health approach to tackling violence and its causes. As our understanding of trauma-informed practice grows and becomes more systematically embedded across the London system, I hope the VRU will be considered an innovative leader in this area.

Please find my response to the recommendations in the annex below. Thank you again for investigating this very important issue.

Yours sincerely,

Sadiq Khan
Mayor of London

Annex

Mayor of London's response to the recommendations of the London Assembly Health Committee's investigation on trauma-informed approaches to youth violence in London

Recommendation 1
The GLA Public Health Unit and London Violence Reduction Unit should make their framework on trauma-informed practice publicly available, and support its implementation through proactive engagement with London health and care services and the Metropolitan Police Service, to increase understanding of trauma and ensure strong take-up amongst front-line practitioners.

The Mayor recognises the importance of a London-wide definition and approach to trauma-informed practice.

The London VRU, supported by the GLA Group Public Health Unit, is currently in the process of commissioning a qualitative research piece mapping trauma-informed and trauma-responsive practices related to violence prevention across the capital. Linking to the Serious Violence Duty, this commission and associated research will focus specifically on Local Authorities, the Metropolitan Police Service (MPS), and London NHS Integrated Care Boards (ICBs).

The specific aims of the research, focusing on the three sectors identified above, will be to:

- Collaboratively establish a definition of trauma-informed that is contextualised for London.
- Provide the VRU with a broad understanding of the current landscape of trauma-informed and trauma-responsive practice.
- Develop a suite of promising practices that can be shared across the sector and support the growing evidence base for trauma-informed work in the violence reduction field.
- Generate a roadmap or framework through which organisations across London can understand and progress on their journey towards being trauma-responsive.
- Ensure the development of the evidence base relating to the impact of trauma-informed and trauma-responsive practices on violence reduction and beyond.

Once this piece of work has been completed, it will be made publicly available and shared with the services named above to support a consistent take-up of this approach.

Recommendation 2
The London Violence Reduction Unit should create and maintain an online library of evidence on the impact of trauma-informed approaches to reducing youth violence.

The London VRU is working closely with the NHS London Violence Reduction Programme, which is currently developing the Violence Reduction Academy, which will identify, synthesise and promote evidence-based models of violence reduction in health and social care, sharing the latest research and supporting wider implementation across the capital.

The London VRU is establishing its evidence hub to link into and complement the academy's resources. Building on the VRU's existing published research and evaluations, the hub will include learning and best practices from across the VRU's programmes while signposting to relevant external resources. The first iteration of the hub is scheduled for spring 2024.

Recommendation 3

The London Violence Reduction Unit should share with the Committee the latest information about the Behavioural Insights Team's evaluation of the hospital-based youth work programme and the work carried out by Social Finance Limited to support delivery organisations. This information should include the key objectives, plans for implementation and timescales of the work.

The Behavioural Insights Team and Social Finance Ltd started work with the VRU in October 2023 as the Evaluation and Learning Partners, respectively, for the Hospital-Based Youth Work Programme.

They will work together closely on several aspects of the programme, particularly in the design and implementation of the Hospital-Based Youth Work Programme Data Framework (until March 2024), which will be an essential foundation for the evaluation of the service.

Social Finance Ltd will also provide active contract management for all the VRU's Hospital-Based Youth Work providers until March 2025, supporting them through:

- Reactive troubleshooting: helping delivery partners identify and resolve issues as soon as possible.
- Incremental improvements: continual sharing of learnings across sites and providers.
- Systems reengineering: scoping throughout the programme for opportunities for system-wide change.

This will ensure the successful delivery of the hospital-based youth work service as well as the learning and implementation of improvements for the VRU and partners throughout the contract period.

The Behavioural Insights Team is tasked with delivering a series of evaluation packages. This includes:

- A robust impact evaluation looking at both individual and organisational-level outcomes. This will look at both self-reported and objective measures (for example, looking at hospital readmissions and police data).
- A performance and process evaluation to explore the implementation of the programme and the impact of the learning partner.
- An evaluation of the cost-effectiveness of the programme.

The Behavioural Insights Team will work closely with Social Finance throughout the programme to ensure that the data being collected is of sufficient detail and quality to support a robust evaluation of impact.

The Behavioural Insights Team will produce an interim report in December 2024 and a final report in December 2025.

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Subject: Question and Answer Session with the GLA Health Team

Report to:	**Health Committee**
Report of:	**Executive Director of Assembly Secretariat**
Date:	**13 March 2024**
Public Access:	**This report will be considered in public**

1. Summary

1.1 This report provides background for the Health Committee question and answer session with the Greater London Authority (GLA) Health Team.

2. Recommendations

2.1 **That the Committee notes the report as background to putting questions to invited guests and notes the subsequent discussion.**

2.2 **That the Committee delegates authority to the Chair, in consultation with party Group Lead Members, to agree any output arising from the discussion.**

3. Background

3.1 In 2018, the Mayor published his Health Inequalities Strategy (HIS).[1] This was updated in the HIS Implementation Plan 2021-24, which was published in December 2021.[2] In April 2023, the GLA published the 2022 annual report for the HIS, which provides the most recent update on progress in implementing the strategy.[3]

[1] Mayor of London, The London Health Inequalities Strategy, September 2018
[2] GLA, Health Inequalities Strategy Implementation Plan 2021-24, 9 December 2021
[3] GLA, Progress report 2022: Health Inequalities Strategy

3.2 The HIS Implementation Plan contains six 'key commitments', which each fall under one of the five themes of the HIS. The themes and key commitments are:

- **Healthy Children:** To expand the School Superzones pilot programme across London with a target of 50 by 2024;
- **Healthy Minds:** By 2025, London will have a quarter of a million wellbeing champions supporting Londoners where they live, work, learn and play;
- **Healthy Places (1):** London will be a net zero carbon city by 2030 and will have the cleanest air of any major world city, meeting legal and health requirements by 2050. In the interim, the GLA aims to be on a path to zero pollution, meeting the World Health Organisation's interim target for PM2.5 (10ug/m3) by 2030;
- **Healthy Places (2):** To lead the campaign to make London a Living Wage City, targeting accreditation of an additional 1,600 employers, lifting at least 48,000 people onto the real Living Wage and putting £635m in Londoners' pay packets;
- **Healthy Communities:** To support London action on tackling structural racism as a determinant of health – by organisations in their commitment to be anti-racist; and
- **Healthy Living:** By 2041 all Londoners will do at least the twenty minutes of active travel each day that they need to stay healthy.[4]

3.3 In April 2022, the Mayor established a new GLA Group Public Health Unit (PHU). The PHU works across the GLA and the wider GLA Group, and aims "to ensure that prevention, resilience and tackling health inequalities are part of each organisation's strategy and planning".[5]

3.4 The Mayor also has an important leadership role in supporting public health and the delivery of health services in London. According to the GLA, the Mayor "brings together partners to protect and improve the health of the city. Although he is not responsible for health and care service delivery, the Mayor champions, challenges and collaborates with the NHS and other health partners on behalf of Londoners".[6]

4. Issues for Consideration

4.1 This meeting will examine:

- The actions taken by the Mayor to implement the Health Inequalities Strategy Implementation Plan during the current Mayoral term, and in particular the six 'key commitments';
- What impact these commitments have had in addressing health inequalities in London;
- How the Mayor has allocated spending on health issues over the course of this Mayoral term;
- What impact the GLA Group Public Health Unit has had since its formation in April 2022, and how it has contributed to a 'health in all policies' approach across the GLA Group;
- How the Mayor has worked with partners and used his leadership role to promote good health and drive up standards in health services in London; and

[4] GLA, Health Inequalities Strategy Implementation Plan 2021-24, 9 December 2021
[5] GLA, GLA Group Public Health Unit
[6] Mayor of London, Champion, challenge, collaborate

- What progress has been made by the Mayor on some of the key issues that the Health Committee has investigated over the course of the Mayoral term.

4.2 Members will hold a public meeting with the following invited guests:

- Jazz Bhogal, Assistant Director of Health, Children and Young Londoners, GLA;
- Dr Tom Coffey OBE, Mayoral Health Advisor;
- Professor Kevin Fenton, Regional Director for London, Office of Health Improvement and Disparities, Regional Director of Public Health, NHS London, and Statutory Health Adviser to the GLA;
- Vicky Hobart, GLA Group Director of Public Health & Deputy Statutory Health Advisor; and
- Emma Pawson, Head of Health and Wellbeing / Programme Director for Free School Meals, GLA.

5. Legal Implications

5.1 The Committee has the power to do what is recommended in the report.

6. Financial Implications

6.1 There are no direct financial implications to the GLA arising from this report.

List of appendices to this report:

None.

Local Government (Access to Information) Act 1985

List of Background Papers:

None.

Contact Information

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