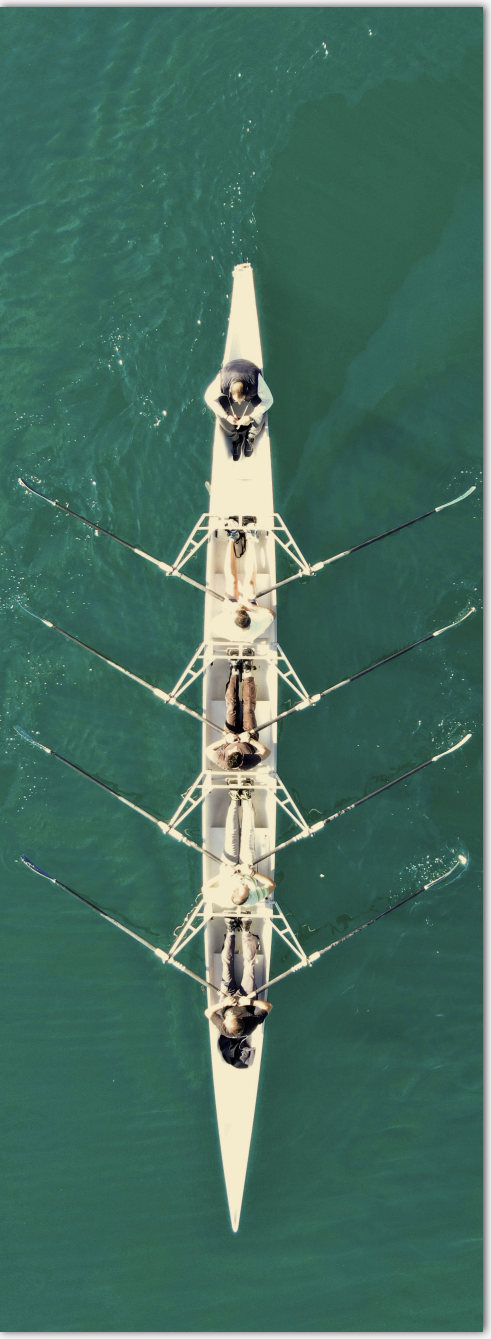
THE TAVISTOCK INSTITUTE OF HUMAN RELATIONS

GambleAware

Factors Influencing Multi-Agency Working to Address Gambling-Related Harms in Great Britain

Mobilising Local Systems Funding Programme

March 2025



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EXECUTIVE SUMMARY

Multi-agency working is essential in addressing gambling-related harms (GRH), yet challenges remain in achieving effective partnerships across sectors. This learning digest explores factors that support or hinder multi-agency working, drawing insights from interviews with different stakeholders of the Regional Boards across England, Scotland, and Wales, established as part of GambleAware's Mobilising Local Systems (MLS) funding programme. Findings are contextualised within broader research on multi-agency collaboration to inform future improvements.

Interviews and research highlight four key factors influencing effective multi-agency working to address GRH:

Persistence and relationship building
Successful engagement relies on identifying key stakeholders, building trust, and maintaining long-term collaboration. Overcoming initial resistance and securing 'champions' within organisations is critical.

Overcoming barriers to more co-operation
Challenges include structural, cultural, logistical and financial barriers, and differing organisational priorities. Addressing these barriers requires stronger coordination and joint working agreements.

Situating GRH in the wider public health agenda
Showing the relationship between, and the impact of, GRH on other public health concerns (e.g., mental health, financial insecurity, homelessness, drugs and alcohol) and linking it with the wider determinants of health improves engagement from agencies unfamiliar with GRH.

Making the case for addressing GRH
Demonstrating the scale and impact of GRH using local data and harnessing lived experience is key to gaining commitment from statutory services. This can be enhanced by highlighting existing working relationships with other public health teams or well-respected organisations locally to encourage others to get involved.

This learning digest conceptualises multi-agency working via a four-level model ranging from basic collaboration (Level 1) all the way up to full integrated service delivery (Level 4). While the MLS funding programme has helped to improve information-sharing between Regional Board members, more needs to be done going forward to encourage more cross-agency referrals (Level 2), deeper joint working (Level 3) and fully integrated service delivery (Level 4) to address GRH.

To ensure the continued progress of Regional Boards in advancing multi-agency collaboration, three key areas should be considered:

1 **Strengthening engagement:** For multi-agency working to be successful, Regional Board members need to ensure they include a variety of relevant stakeholders. Together, they need to develop a compelling offer that aligns with the priorities of potential partners rather than presenting the need to address GRH as an additional burden. Engagement strategies should be data-driven, strategically targeted, and informed by lived experience to increase relevance across different sectors.

2 **Effective leadership:** Strong leadership is central to advancing multi-agency working and securing long-term commitment from partners. Leadership in this context is not only about driving strategic direction but also about adopting proactive and confident approaches to collaboration. Regional Board members need to be willing to take risks and explore new engagement opportunities to position GRH within wider policy and public health agendas building on the support of GambleAware and other strategic partners.

3 **Organisational effectiveness:** Ensuring that Regional Boards operate effectively is essential to initiating and sustaining multi-agency collaboration. Board members must be able to demonstrate how they are using evidence and data to identify needs effectively while maintaining structured governance and accountability.

1. Introduction

This learning digest explores the enablers and barriers to multi-agency working in the GRH field. This aligns with the objectives of the MLS funding programme, which aims to strengthen partnerships between the National Gambling Support Network (NGSN) and other stakeholders, including the NHS, local authorities, and other Voluntary, Community & Social Enterprises (VCSEs).

The NGSN, commissioned by GambleAware, consists of voluntary sector treatment providers delivering prevention, early intervention, and treatment and support services to help individuals directly and indirectly affected by GRH.

The MLS funding programme is split into two phases with some overlap between the two: Phase 1 ran from February 2024 to March 2025, and Phase 2 from around January 2025 to March 2026.

Phase 1 focused on regional integration and collaboration via the Regional Boards, while Phase 2 focuses on the delivery of a range of pilot projects incorporating new models of prevention, support and referral pathways for people experiencing gambling harms or strengthening opportunities for multi-agency collaboration.

Methodology

This digest draws on qualitative data gathered through semi-structured interviews conducted between December 2024 and January 2025 with 30 key stakeholders involved in the setup and operation of Regional Boards.

Participants included representatives from NHS services, public health teams, VCSEs, gambling treatment providers, national GRH organisations and researchers/consultants. The interviews were recorded and thematically analysed, with findings triangulated against existing research on multi-agency working in other sectors.

In addition to interview data, this digest incorporates insights from Regional Board meetings and reflections from three learning events, facilitated by the Tavistock Institute acting as an independent learning and evaluation partner, held to discuss early successes and challenges in developing multi-agency approaches across England, Scotland, and Wales.

2. Insights from Wider Research on Multi-Agency Working

Multi-agency working has emerged as a key approach for addressing complex social issues across various sectors, including children's social care, adult social care, substance misuse, and mental health (Morris, 2018).

It refers to the collaboration of professionals and organisations from different sectors, including public health agencies, social care providers, and VCSEs to provide comprehensive services to individuals with multifaceted needs (Bagnall et al., 2024).

This aligns closely with place-based approaches, which seek to integrate services at a geographical level, ensuring they are tailored to the specific needs of communities (Taylor & Buckly, 2017). Place-based approaches are inherently dependent on multi-agency collaboration, as they require different agencies to coordinate their work, align funding streams, and deliver services in a way that maximises local impact.

The growing emphasis on place-based approaches reflects a heightened awareness of the critical role that communities and local environments play at national, regional, and local levels in shaping individual health and well-being (Buck et al., 2018).

This shift towards place-based working has been further reinforced by the introduction of Integrated Care Boards (ICBs) and Integrated Care Systems (ICSs), which are designed to operate within smaller geographic areas, strengthening partnerships at the local and neighbourhood level to ensure more coordinated and responsive service delivery (NHS England, 2021; 2022).

For more than a decade now, there has been a growing consensus that GRH is a public health issue, rather than simply an issue of individual choices and individual health (Johnstone & Regan, 2020). Addressing it requires a broad, multi-sector approach that brings together statutory and non-statutory partners to integrate data and evidence at a place-based population level, ensuring interventions are targeted according to local need.

Given the strong correlation between the wider determinants of health, including social, economic, and environmental factors, and gambling harms, there is a need to prioritise those experiencing higher levels of disadvantage (Public Health England, 2018). Achieving this cannot happen without joined-up approaches that operate at a local, regional, and national level, ensuring that clear pathways and strategies for preventing and reducing harm are embedded across sectors.

Multi-agency working remains essential in driving this agenda forward, ensuring that responses to gambling harm remain integrated, evidence-led, and aligned with wider public health strategies.

The following four-level model (see Table 1) of multi-agency working demonstrates how agencies move from informal collaboration (Level 1), via more coordinated collaboration (Level 2) and more advanced service coordination (Level 3) to fully integrated multi-agency service delivery (Level 4), reflecting place-based good practices seen in health, social care, and criminal justice partnerships worldwide.

Table 1. Description, characteristics and examples of each of the four levels of the model

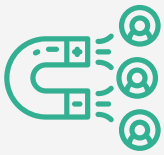
Level	Description	Characteristics	Examples
Level 1: Networking & Information-Sharing (Basic Collaboration)	Agencies share information and ideas but operate independently.	•Informal meetings and networking events •Knowledge exchange but no structured joint work •Services remain separate	A local forum (such as a Regional Board) where charities, public health and NHS professionals discuss challenges related to gambling harms.
Level 2: Referral & Coordinated Pathways (Intermediate Collaboration)	Agencies refer service users to each other but still work separately.	•Formal referral agreements •Service pathways mapped between organisations •Some shared training but no co-location	A debt service charity referring a client experiencing financial distress to a gambling harm treatment provider.
Level 3: Joint Working & Service Coordination (Advanced Collaboration)	Agencies actively coordinate their services for shared service users.	•Regular case meetings and joint assessments •Multi-agency teams working together •Some shared funding models	A social care team working alongside gambling treatment and drugs and alcohol services to provide wraparound support for vulnerable individuals.
Level 4: Integrated, Place-Based Approaches (Full Integration)	Services are fully integrated, often co-located, with shared governance structures.	•Multi-disciplinary teams delivering services in tandem •Shared case management systems •Joint commissioning and pooled budgets •A holistic, person-centred approach	A one-stop community hub where housing, mental health, GRH and financial support services operate together under a single governance structure.

2.1 Key Enablers of Multi-Agency Working from Wider Research

Drawing on wider research in the UK and overseas, four key enablers can be identified as central to effective multi-agency collaboration.

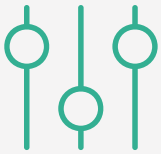
2.1.1. Working relationships and leadership

Successful multi-agency working relies heavily on strong leadership and effective working relationships (Broussine, 2004; Charles et al., 2021). At the most basic level, collaboration begins with networking and informal information sharing (Level 1), where agencies start building relationships and exchanging best practices. However, for multi-agency partnerships to move beyond this stage, leadership must drive closer integration across services (Frost & Robinson, 2016), including:



Senior leadership engagement Research indicates that strategic buy-in from senior leaders is crucial in fostering trust between agencies (Bagnall et al., 2024).

Place-based leadership models
The success of place-based approaches, such as Community Planning Partnerships in Scotland, depends on agencies forming long-term relationships with local communities (Stansfield et al., 2020).



Embedding relationships at different levels
Successful collaboration requires not just strategic or board-level engagement but also frontline staff working together through joint training and secondment opportunities (Alderwick et al., 2021).

When strong leadership is absent, fragmentation occurs, and agencies struggle to work towards common goals (Huxham & Vangen, 2013). Moving up the multi-agency collaboration levels requires embedding these leadership principles into formalised referral pathways (Level 2) and coordinated service delivery (Level 3).

2.1.2. Communication and information sharing

Effective communication and data sharing are essential for multi-agency working to succeed (Alderwick et al., 2021). At Level 1, informal knowledge exchange lays the groundwork for deeper collaboration. As services begin referring clients between organisations (Level 2), communication becomes more structured, requiring clear protocols and shared or compatible digital infrastructures.

Moving into Level 3 and Level 4 of multi-agency working, information-sharing systems become more advanced, leading to joint decision-making and integrated data platforms that enable place-based service delivery (Local Government Association, 2019). Co-located services improve communication, as seen in the Age-Friendly Cities initiative, where multi-agency hubs facilitated stronger collaboration (Buffel et al., 2024; Flores et al., 2019).

However, research highlights that incompatible IT systems, different professional terminologies (including the use of distinct jargon, acronyms, or sector-specific language that may not be familiar to others outside their field), and legal restrictions often hinder collaboration (Auschra, 2018; Kantar Public, 2021).

2.1.3. Governance structures

Effective governance mechanisms are needed to formalise multi-agency relationships, ensuring collaboration is sustainable and not dependent on individual goodwill (Dayson et al., 2022). In contrast, poor governance, such as short notice for meetings and lack of reimbursement for attendance, has been found to discourage long-term collaboration (Harden et al., 2016). The higher the level of collaboration (Levels 3 and 4), the stronger the governance frameworks must be (Alderwick et al., 2021).

Moving through the levels, multi-agency governance shifts from informal networks (Level 1) to structured partnerships (Level 4), ensuring agencies can deliver place-based solutions effectively. The Integrated Care Systems (ICS) in England are an example of this, with several agencies operating under a single strategic plan to improve local service delivery (NHS England, 2021).

2.1.4. Funding

Financial constraints are a major barrier to multi-agency and place-based working (Glasby et al., 2011; Local Government Association, 2019). When agencies compete for the same limited funding, it undermines trust and collaboration (Baker et al., 2022). The transition from network-based collaboration (Level 1) to Levels 2, 3 or 4 depends heavily on whether long-term core funding is in place that encourages cooperation.

Shared funding arrangements such as the Better Care Fund in the UK enable joint commissioning of services (Alderwick et al., 2021; NHS England, 2024), while multi-year funding cycles support Level 3 and Level 4 initiatives, ensuring that services can scale up from simple referrals to fully co-located, place-based services.

3. Key Factors Influencing Multi-Agency Working in the GRH sector

This section explores what factors are associated with facilitating or hindering multi-agency working in the GRH sector, including: persistence and relationship-building, making the case for GRH, situating GRH within the broader public health agenda, and overcoming barriers to cooperation. These are illustrated with quotes from qualitative interviews with 30 key stakeholders involved in the setup and operation of Regional Boards, including NGSN treatment providers, VCSE treatment and support providers, statutory services, and other national stakeholders.

3.1. Persistence and relationship-building

Reflecting the findings from wider research on multi-agency working (Bagnall et al., 2024; Frost & Robinson, 2016), establishing effective relationships with other services was seen as a pre-requisite for developing more intensive forms of collaboration in the GRH sector. However, establishing initial connections with stakeholders in other organisations can be challenging due to a range of factors, including a lack of awareness about GRH, competing organisational priorities, and scepticism regarding the effectiveness of multi-agency approaches. However, as multiple interviewees highlighted, persistence is key to overcoming these barriers:

> “I’ve knocked on doors and I’ve rung the bell, and I’ve kicked the gate, and eventually you get there, but it does require persistence” (NGSN provider)

Building relationships takes time, and sustained follow-up is often required to convert initial interest into active participation.

As research in health and social care has demonstrated (Alderwick et al., 2021), another significant factor in facilitating collaboration is often the identification of ‘champions’ within organisations – key individuals who can support GRH initiatives and help drive engagement from within.

> I think one of the key learnings around building multi-agency systems is that it takes time, and it takes people in other organisations to be really vocal and to almost act as ambassadors for gambling harms as a topic” (National stakeholder)

Such ‘ambassadors’ or ‘champions’ located in local authorities, the NHS or other settings can serve as internal advocates, lending credibility to GRH efforts and encouraging links with other organisations, including NGSN providers.

> So, I don’t think at the moment you could achieve multi-agency working without having somebody in a local authority who really cares about gambling harms or in a local grassroots charity or criminal justice setting who is really committed – so we’re really reliant on individuals” (National stakeholder)

Examples of this include providers developing links with the CEO of a VCSE locally who encouraged others to attend Board networking events, or with a public health official who promoted the delivery of GRH activities among other services.

The importance of informal relationship-building was also highlighted. Several interviewees noted that successful collaborations often begin with informal conversations, networking opportunities, and trust-building activities rather than formal partnership agreements.
One participant observed, *“the best conversations happen when there’s no agenda – when people feel comfortable just talking about what they do and where they see links”* (NGSN provider).

These informal interactions can help lay the foundation for more structured collaboration over time, echoing findings from multi-agency research in other sectors which have shown that unstructured meetings can foster deeper collaboration over time (Huxham & Vangen, 2013).

3.2. Making the case for addressing GRH

One of the main challenges in advancing multi-agency collaboration in addressing GRH was seen to be making a compelling case for why organisations should prioritise this issue. Many organisations operate in environments where multiple pressing concerns – such as mental health, homelessness, and substance misuse – compete for attention and resources. As several interviewees pointed out, without a strong case for action, addressing GRH can be seen as a lesser priority.

> In a public health world, drug and alcohol has been around for forever, hasn't it? And mental health to a certain extent, and healthy eating … we have talked about these things time and time again. So, the messaging has been regurgitated millions of times, and it's almost as though gambling still feels very new and very unspoken, and a bit of a hidden one" (Statutory service)

One board used MLS Phase 1 funding to organise a large conference involving more than 150 health, social care, criminal justice, education professionals and other key stakeholders. This was used to highlight the value of using a community place-based approach to address GRH and to show how it links with other public health concerns.

Evidence plays a crucial role in demonstrating the scale and impact of GRH. Several interviewees reported that stakeholders were more likely to respond once they were presented with relevant research, local data, or case studies that illustrate the connection between gambling harms and other social issues. One participant noted, *"They might not reply the first time, but if you then say, 'OK, now there's a new study that shows this is a growing issue,' they start to listen"* (NGSN provider).

However, a lack of region-specific data has made it difficult to persuade some organisations of the relevance of GRH to their work. One interviewee observed, *"There's a gap in the evidence base, especially in Scotland. A lot of the research is focused on England, and that makes it harder to demonstrate local need"* (VSCE provider). To address this, some Regional Boards have actively engaged in data collection efforts, partnering with universities and public health teams to generate localised reports.

In addition to research evidence, peer influence was highlighted as a powerful tool for driving engagement. When a respected agency within a region takes action on GRH, others are more likely to follow suit.

> I mean, you know, if you get a local authority to sign up to something, all the other local authorities are like meerkats: 'How come they've got that [NGSN provider] logo on there?'" (NGSN provider)

This suggests that highlighting the involvement of other public health teams or well-respected organisations or networks can encourage broader participation.

Lived experience is another critical component in making the case for GRH. Several interviewees stressed the importance of meaningfully involving individuals with lived experience of gambling harm (including affected others) via partner organisations or working in operational or strategic roles for Regional Board members to help bring to life the nature and scale of the issue. One provider explained, *"We had someone with lived experience speak at our event, and you could see the impact – it went from an abstract issue to something real"* (NGSN provider).

Others also noted that centring lived experience of GRH when making links with other stakeholders can be an effective way to leverage change. Indeed, Boards that incorporated lived experience into their board meetings, networking events and engagement strategies reported higher levels of interest and commitment from partner organisations. Others also noted that making links with senior leaders in local authorities with a strong personal commitment to addressing GRH can be an effective way to leverage change: *"You get that buy-in from that single human who has a little bit of influence, and that makes all the difference"* (NGSN provider).

Despite these efforts, some organisations were said to remain resistant to engaging with GRH. Several interviewees pointed out that GRH are still viewed as a niche issue, outside the remit of many public health and social care agencies or not a serious issue in the area: *"I've spoken to [some local politicians] where they're like, 'Well, it's not happening in my area'"* (VCSE provider). Other organisations perceive it as a lesser concern compared to, for example, drug and alcohol addiction. One interviewee observed, *"There's still this belief that gambling isn't as serious as substance misuse, so we have to work harder to change that perception"* (NGSN provider). This illustrates the need for continued awareness-raising efforts, based on relevant local evidence and data.

3.3. Situating GRH in the wider public health agenda

One of the key barriers to multi-agency working is that many organisations see GRH as outside their remit, as not a major issue in their area or that it does not align with their core priorities. However, by framing GRH as a broader public health issue such as mental health, financial stability, family wellbeing, homelessness prevention or drugs and alcohol, and linking it with the wider determinants of health stakeholders are more likely to engage.

Several interviewees highlighted that organisations were more likely to be receptive when GRH was framed in such a wider context: *"If you're offering something that connects to what they already do, that might bring more people along"* (VCSE provider). This reflects the findings of wider research, which shows that public health issues gain greater traction when they are framed within broader policy agendas (Stansfield et al., 2020; Randolph, 2016).

This means that it can be easier to engage other organisations in Board meetings, events or even just informal conversations by highlighting the links between GRH and wider public health concerns. For instance, this could involve linking GRH to mental health concerns, by highlighting that many individuals experiencing GRH also struggle with anxiety, depression, or other mental health conditions and vice versa.

Similarly, gambling can also often lead to financial insecurity and problem debt. By framing GRH as a contributing factor to financial hardship, organisations working in debt advice, social security, and employment services may be more inclined to collaborate.

This strategy was highlighted by one interviewee: *"We showed them how gambling harm fits into their existing work rather than presenting it as something extra"* (NGSN provider). This was done by one Board by highlighting how addressing gambling harms can help organisations meet their existing goals, providing training and support to build confidence, and using local statistics to demonstrate the cost of ignoring gambling-related issues in relation to, for example, employee absences. This approach not only reduced resistance but also increased engagement by demonstrating shared goals.

Another way of embedding GRH in existing agendas is to highlight its impact on families, children, and relationships. As Langham et al. (2016) have shown, gambling does not just affect the individual who is gambling; it has wider repercussions, including domestic conflict, and can lead to adverse childhood experiences (ACEs) for children (Suomi et al., 2023).

One Regional Board used the MLS Phase 1 funding to organise a series of roundtable events across the region involving local councils, prisons, housing associations and several other key potential partners such as regional Citizens Advice offices and various local community organisations. The aim was to create a safe place, where lived experience, affected others, experts and those with knowledge of related subjects could share their insight and bring to life the far-reaching effects of GRH across various themes (including LGBTQ+, armed forces, neurodiversity, money & finance, and ethnic minorities).

In another local area, the key focus in the first year of the MLS funding programme has been on raising awareness of GRH across key services within public health, but there has also been a 'ripple effect' to other services in the authority. This has involved: *"working with staff in Early Help teams, the CAB [Citizen's Advice Bureau] and the DV [Domestic Violence] team – and raising awareness that gambling does not just affect the person who is doing the gambling but the whole family around that person"* (Statutory service).

Cross-sector partnerships may also be key to embedding GRH into wider agendas. Some Regional Board members have successfully linked their work on GRH with other existing multi-agency forums. One example shared by an interviewee involved integrating such discussions into a cross-sectoral network focused on education: *"While the focus is on gambling, their sessions also include topics such as mental health or homelessness, so people with less of a focus on gambling are also motivated to attend as they're interested in the link with mental health or, say, low attainment at school"* (VCSE provider).

3.4. Overcoming barriers to more co-operation

Despite efforts to promote multi-agency working in the GRH sector, several persistent barriers hinder effective collaboration – reflecting the findings of the wider literature (see Section 3).

These barriers include structural, cultural, logistical and financial challenges, all of which can undermine trust, reduce engagement, and hinder multi-agency cooperation. Addressing these obstacles requires strategic approaches that align with best practices in multi-agency collaboration.

One of the most frequently mentioned challenges was the fragmented nature of services and governance structures. Siloed systems across sectors (including, for example, children's social care, adult social care, the NHS, and the GRH sector) can make cross-agency collaboration difficult. One interviewee described the problem: *"Different services have different priorities and reporting structures, so even when there's willingness to collaborate, it's hard to align decision-making processes"* (NGSN provider). Coupled with this, unclear governance and administrative structures in local areas, including the Regional Boards, can lead to conflicts over leadership and accountability within the GRH sector.

To address this, interviewees emphasised the need for appointed roles, clearly defined goals, responsibilities, and governance frameworks that establish transparent decision-making processes and reduce duplication. Even when governance structures are in place, cultural differences between organisations can still hinder collaboration, including a lack of shared administrative or operational infrastructure to support ongoing communication and Board engagement.

Additionally, technological limitations such as a lack of shared data systems were cited as barriers to effective co-ordination and collaboration – reflecting findings from the wider research literature (Kantar Public, 2021). One stakeholder explained: *"We don't have a common database, so everyone is working with their own figures. That makes it hard to track progress or spot trends"* (NGSN provider).

Lack of government funding, as well as competition for funding, remain significant challenges for multi-agency collaboration and a more place-based approach in addressing GRH (see Section 3). Many organisations rely on the same limited pool of funding, leading to competitive rather than collaborative behaviours among Regional Board members.

One interviewee expressed frustration: *"It's not healthy when everyone is chasing the one pot of funding"* (NGSN provider). This competition can create reluctance to share information or resources with other Board members, particularly if providers fear losing out on financial support.

> If our organisation has got a particular USP [unique selling point] that's going to safeguard your charity and the income and the people you help, you're not really going to share it with people who are going to be competitors" (NGSN provider)

Lack of funding for GRH services was also said to be exacerbated in many areas by lack of capacity of local authority staff to make links or develop partnerships in the light of funding cuts and other competing demands for resources.

> So, for example, if a local public health team has got someone off sick, someone on maternity leave and the council doesn't fund them very well, you know you can say as much as you like" (NGSN provider)

Several interviewees emphasised that the best way to overcome this barrier was to engage local authorities with an open 'offer' of support – such as the offer of free resources, training or advice to raise awareness of GRH among local authority staff.

Such an approach was said to facilitate collaborations with providers working in other sectors, particularly if they lacked the resources to deliver GRH services on their own:

> Very often with [NGSN treatment provider], it's me asking them: 'Can you do this?' and them just saying 'Yeah'. And it's not them coming back and saying: 'Well, yeah, we'll come and deliver some training. But will you do this, or will you promote this in return?'" (Statutory service)

A significant issue reported by several interviewees relates to the current GRH funding landscape. GambleAware is currently the leading independent charity and strategic commissioner of gambling harms education, prevention, treatment and research. The organisation receives money via a voluntary levy from gambling operators and regulatory settlements from the Gambling Commission in relations to industry fines. However, there is a common misperception that association with GambleAware funding equals an alignment with gambling operators themselves and some feel that such funding is *"tainted by its association with the gambling industry. Some are more willing than others and some are just a definite: 'No go!'"* (NGSN provider).

However, there was evidence from some interviewees that some Regional Board members have managed to break down this barrier by working closely with key contacts acting as 'champions' in local authorities or the NHS, and by demonstrating the quality of their offer. As one public health official noted:

> I'll be honest with you, I think because of the relationship that I've got with [NGSN provider] and the work that they've done that has kind of gone above and beyond what other partners have done, I think that has really kind of settled any doubt that anyone might have as to how impartial they are" (Statutory service)

4. Conclusions and Recommendations

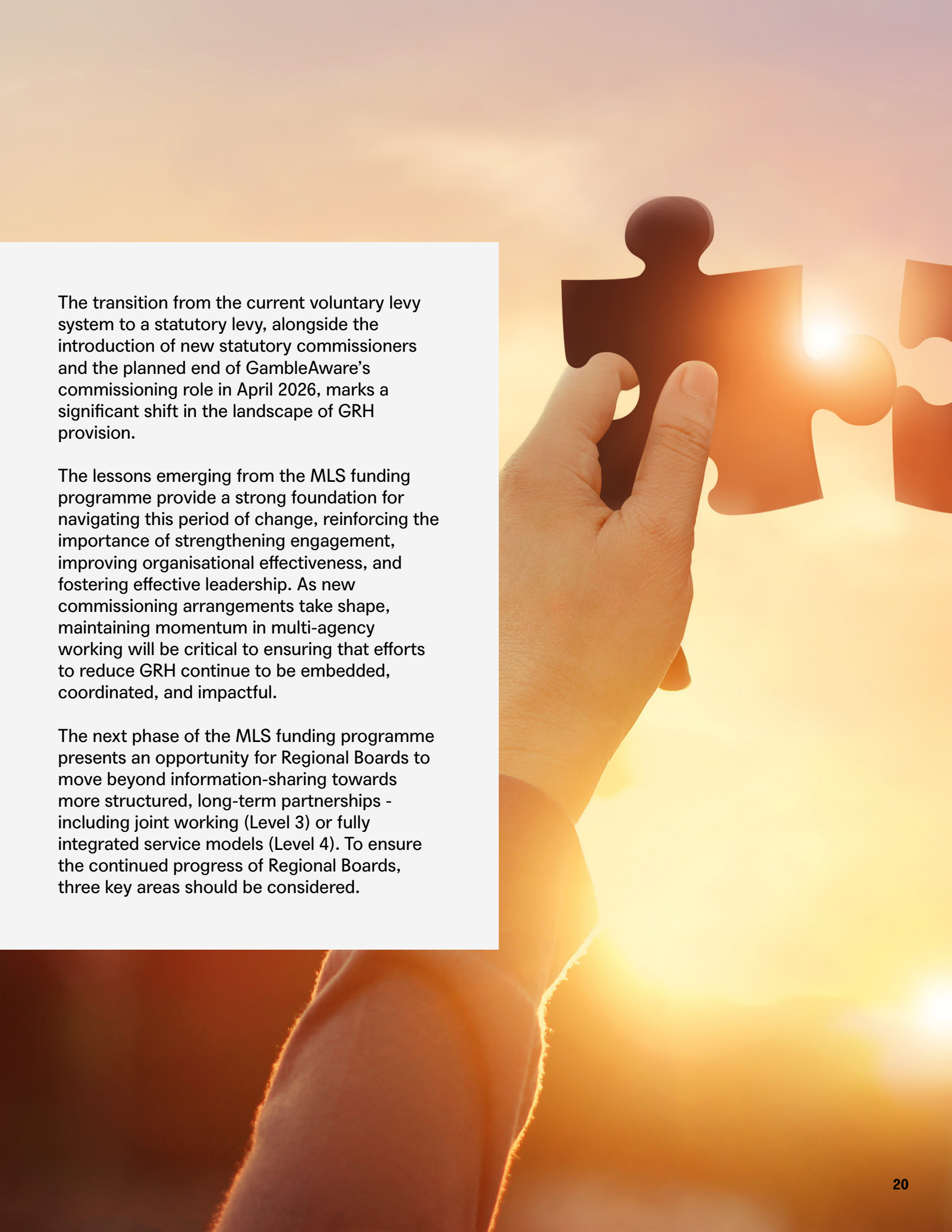
The first phase of the MLS funding programme has highlighted the potential for multi-agency working in tackling GRH, while also identifying key challenges that must be addressed to create more sustainable and integrated partnerships. Findings from this learning digest reinforce that effective multi-agency collaboration relies on:

- Building and maintaining relationships over time, securing buy-in from key stakeholders.
- Demonstrating the relevance of GRH within broader public health and social care priorities.
- Embedding GRH within existing structures rather than positioning it as an isolated issue.
- Overcoming structural, cultural, and technological barriers that hinder collaboration.

The transition from the current voluntary levy system to a statutory levy, alongside the introduction of new statutory commissioners and the planned end of GambleAware's commissioning role in April 2026, marks a significant shift in the landscape of GRH provision.

The lessons emerging from the MLS funding programme provide a strong foundation for navigating this period of change, reinforcing the importance of strengthening engagement, improving organisational effectiveness, and fostering effective leadership. As new commissioning arrangements take shape, maintaining momentum in multi-agency working will be critical to ensuring that efforts to reduce GRH continue to be embedded, coordinated, and impactful.

The next phase of the MLS funding programme presents an opportunity for Regional Boards to move beyond information-sharing towards more structured, long-term partnerships - including joint working (Level 3) or fully integrated service models (Level 4). To ensure the continued progress of Regional Boards, three key areas should be considered.



4.1 Strengthening engagement

For multi-agency working to be successful, Regional Board members need to ensure they include a variety of relevant stakeholders. Together, they need to develop a compelling offer that aligns with the priorities of potential partners rather than presenting the need to address GRH as an additional burden. Engagement strategies should be data-driven, strategically targeted, and informed by lived experience to increase relevance across different sectors. Key areas for consideration include:

1. Expanding multi-agency representation within Regional Boards and engaging champions in organisations that are already committed to addressing GRH.

2. Developing an 'offer' rather than an 'ask' – including what training or support Board members can provide to other services often struggling with limited resources.

3. Framing GRH in ways that highlight financial impacts, links to wider public health strategies, and multi-sectoral benefits.

4. Using local data and lived experience to strengthen the case for engagement and demonstrate how GRH intersects with other areas of social need.

5. Leveraging existing networks and events – rather than creating additional demands on partner organisations, Regional Board members should consider how they can integrate GRH into established statutory sector events and multi-agency forums.

4.2 Effective leadership

Strong leadership is central to advancing multi-agency working and securing long-term commitment from partners. Leadership in this context is not only about driving strategic direction but also about adopting proactive and confident approaches to collaboration. Regional Board members need to be willing to take risks, explore new engagement opportunities to position GRH within wider policy and public health agendas – with the support of GambleAware and other strategic partners. Key areas for consideration include:

1. Pushing boundaries with proactive engagement – exploring new spaces for discussion and collaboration, such as political conferences, national health forums, and sector-wide leadership events..

2. Strengthening relationship management – revisiting previous engagement efforts, re-establishing connections with statutory bodies, and seeking new champions to drive GRH forward within other services or organisations.

3. Understanding their sphere of influence – recognising external challenges but maintaining focus on what is within an organisation's control, including clarifying internal roles, responsibilities, and organisational objectives.

4.3 Organisational effectiveness

Ensuring that Regional Boards operate effectively is essential to initiating and sustaining multi-agency collaboration. Board members must be able to demonstrate how they are using evidence and data to identify needs effectively while maintaining structured governance and accountability. Key areas for consideration include:

1. Improving data literacy and evidence use – identifying available data sources (including social media insights) to assess local needs.

2. Embedding structured governance frameworks – ensuring Regional Boards have clearly defined terms of reference, decision-making processes, and shared accountability mechanisms.

3. Tracking progress and effectiveness – developing mechanisms to evaluate multi-agency initiatives and demonstrate tangible outcomes to funders and stakeholders.

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