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policy paper

Addressing the Needs of Problem Gamblers With Co-Morbid Issues: Policy and Service Delivery Approaches

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Abstract

Most people with gambling problems have at least one co-occurring condition and many experience multiple co-occurring conditions simultaneously. In many Western jurisdictions, a specialist service response has developed, with separate agencies and workforces established to respond to gambling problems. Despite the number of co-occurring issues that occur alongside gambling, research is limited on the prevalence of problem gambling across some service systems, such as mental health and family service sectors. However, it is reasonable to conclude that significant numbers of people with gambling problems are currently engaged in other health and welfare service sectors. Partnership work with other service sectors is therefore vital to respond to the needs of these people. In Victoria, Australia, a partnership program was established in gambling help services to improve integration and co-ordination between gambling, alcohol and drug, family support, and mental health service sectors. From the experience acquired in developing the program, we seek in this article to outline the benefits and challenges of implementing a cross-sector approach in gambling treatment service systems and to recommend effective strategies to develop a cross-sector approach, including creating an authorising environment at the government policy level.

Keywords: problem gambling, health, co-morbidities, cross-sector collaboration, service delivery

Résumé

La majorité des personnes qui ont des problèmes de jeu présentent au moins un trouble concomitant et un grand nombre, plusieurs troubles concomitants. De nombreux pays occidentaux ont mis en place une structure d'intervention dédiée aux problèmes de jeu, constituée d'organismes et d'effectifs spécialisés. Malgré la

prévalence des troubles concomitants, toutefois, les problèmes de jeu ont peu été étudiés dans des secteurs comme la santé mentale ou les services aux familles. Néanmoins, il est raisonnable de supposer qu'un nombre important de personnes souffrant de problèmes de jeu consultent aussi certains services relevant de la santé et des services sociaux. La collaboration intersectorielle s'impose donc comme un moyen essentiel de répondre à leurs besoins.À Victoria, en Australie, un programme de partenariat a été mis sur pied par les services d'aide spécialisés dans les problèmes de jeu en vue d'améliorer l'intégration et la coordination des services dans différents secteurs d'intervention, soit le jeu, l'alcool et les drogues, le soutien aux familles et la santé mentale. S'inspirant de l'expérience acquise durant l'élaboration du programme, cet article vise deux objectifs : présenter les avantages et les défis d'une approche intersectorielle pour les services de traitement des problèmes de jeu; recommander des stratégies propices à sa mise en place, dont la création d'un contexte favorable sur le plan des orientations gouvernementales.

Co-Morbidities of Gambling

It is well established that people with gambling problems frequently experience co-occurring issues, including mental illness, substance abuse, family and relationship difficulties, health conditions, and social problems such as socio- economic disadvantage, homelessness, and crime (Miller, 2014). Problem gambling is highly associated with co-morbid substance abuse (Petry, Stinson, & Grant, 2005) and mental illness and has also been linked to suicide (Productivity Commission, 1999). Other risk factors associated with problem gambling include unemployment and coming from a lower socio-economic background (Delfabbro, 2011). In addition, emerging evidence suggests that problem gambling may be a specific risk factor for family violence (Suomi et al., 2013). Problem gambling has a much higher prevalence among people in prison (Turner, Preston, McAvoy, & Gillam, 2013) and in homeless populations (Nower, Eyrich-Garg, Pollio, & North, 2014) than it does in the general population.

Most problem gamblers have at least one co-occurring condition. In an online survey of 267 problem gamblers in treatment, less than 2% had not experienced one of the other health conditions studied, in addition to their problem gambling (Haw, Holdsworth, & Nisbet, 2013). Further, most people with gambling problems experience multiple co-occurring conditions simultaneously. A study of 15,000 problem gamblers in Victoria (Billi, Stone, Marden, & Yeung, 2014) found that less than 10% of problem gamblers had no co-occurring condition and nearly 40% of problem gamblers had four or more co-occurring issues (K.Yeung, personal communication, November 2014).

These figures support the view that in the area of health and addiction, co-morbidities should be understood to be the "expectation rather than the exception" (Minkoff & Cline, 2012).

Addressing Complexity in the Problem Gambling Service Sector

There is a huge variation in government health responses to problem gambling. Some approaches include no or limited gambling-specific services in which people with gambling problems are absorbed into self-help systems such as Gambler's Anonymous. Such models leave people with gambling problems to access the broader health and welfare system themselves in order to address co-morbid mental or physical health conditions. Other jurisdictions fund dedicated gambling treatment services with a specialist workforce to respond to people presenting with gambling problems. Services are usually a combination of clinical and financial counselling, self-exclusion, and community education and are often funded from some form of hypothecated tax or levy on gamblers' losses. Although there are many benefits of specialist responses to problem gambling, the clinical presentation of many people with multiple conditions requires a service response that is well integrated with other service sectors in order to better meet the multiple needs of clients.

Despite the number of co-occurring issues that may occur alongside gambling, research is limited on the prevalence of problem gambling in some service systems, such as mental health and family service systems (Miller, 2014). Nevertheless, it is reasonable to conclude that significant numbers of people with gambling problems are currently engaged in other health and welfare service sectors. Partnership work with other service sectors is therefore necessary in order to effectively respond to the needs of these people.

It is notable that the uptake of gambling-specific clinical services is often not high. In Australia, only up to about 10% of people with gambling problems access gambling help services (Delfabbro, 2011), a rate not dissimilar to rates in jurisdictions within Canada, the United States, and New Zealand. For clients with multiple issues, the complexity of their needs may hamper access to gambling help services. When problem gambling is identified in other service systems, it is not likely to be the most significant presenting issue. When there is no screening or assessment in other services, the problem may not be identified until well into treatment, because for some clients, the need to address the impact of the gambling may be more critical than the concerns about the underlying gambling behaviour (Department of Justice, 2008).

Problem gambling may be a low priority for the individual; where people with gambling problems are accessing other services, referral to gambling help services for this cohort is more likely to result in non-attendance or early dropout (Department of Justice, 2008). This means that the person affected by gambling is likely to miss out on help with their gambling issues, but not treating the gambling may also have a detrimental impact upon recovery in other areas (Miller, 2014). People with

gambling problems also face significant barriers to help seeking, most prominently community stigma and subjective pessimism regarding the effectiveness of treatment, such that help is not sought until a crisis point has been reached (Bellringer, Pulford, Abbott, DeSouza, & Clarke, 2008). Clients who do seek help tend to do so a considerable time following the initial recognition of the problem, by which time gambling and its associated problems may have become entrenched in these individuals and in their families. Gambling may be framed as a moral issue or a choice by the community, health providers, and affected individuals alike, rather than as an addiction. Such attitudes may underpin the low priority assigned to providing and accessing help for people experiencing problems with gambling.

Over the last 20 to 30 years in Australia and the United States, integrated dual diagnosis systems in the area of mental health and substance abuse have been developed and evaluated. Integrated treatment that simultaneously addresses mental health and substance use conditions is associated with lower costs and better outcomes such as reduced substance use, improved psychiatric symptoms and functioning, decreased hospitalisation, increased housing stability, fewer arrests, and improved quality of life (Drake et al., 2001). Integrated dual diagnosis programs are demonstrably more effective than non-integrated programs. By contrast, dual diagnosis clients in mental health programs that fail to integrate substance abuse interventions have poor outcomes (Drake et al., 2001).

The high co-morbidities between problem gambling, mental health, and substance abuse suggest it would be beneficial to include problem gambling in a dual diagnosis platform. Drake et al. (2001), for instance, note that dual diagnosis is a misleading term because the individuals in this group are heterogeneous and tend to have multiple diagnoses rather than a dual diagnosis. The classification of gambling as an addictive disorder within the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association, 2013) provides an added impetus for greater inclusion of gambling services within the broader health and mental health sector.

A recent meta-analysis of the prevalence of psychiatric co-morbidity in treatment-seeking problem gamblers recommends routine systematic screening and comprehensive assessment for co-occurring psychiatric disorders in those seeking treatment for gambling problems. Approaches include screening for multiple psychiatric disorders, or targeted screening for prevalent disorders such as alcohol and substance abuse disorders, mood disorders, and anxiety disorders. The clinical response of specialist gambling agencies to psychiatric co-morbidity should include appropriate referral pathways, or a workforce with adequate skills to appropriately manage these disorders (Dowling et al., 2015).

Systemic responses to addressing complexity in the population of people with gambling problems in Australia have been limited by the fact that historically, gambling help service systems have largely developed in relative isolation from the broader health and human services sector. Gambler's help agencies remain separately funded from alcohol and drug, mental health, and other welfare services, and the development of government policy pertaining to problem gambling service

delivery is often administered through departments (such as justice departments) that do not administer health and human services.

The National Drug Strategy 2010-2015 (Ministerial Council on Drug Strategy, 2011) emphasises the importance of partnerships and integrated service approaches with alcohol and other drug treatment, social welfare, income support, and job services; housing and homelessness services; mental health care providers; and correctional services. Gambling is not specifically mentioned in this strategy and is often neglected at a government policy level when partnerships in the broader health and welfare sector are considered. Without adequate incentives or government commitment to cross-sector integration of problem gambling treatment services, clients with gambling problems and complex co-occurring issues may be overlooked in service delivery responses.

A further area of concern is that the field of gambling utilises multiple terms to identify and describe a person who is experiencing acute levels of distress related to their gambling (e.g. problem gambler, pathological gambler). The same level of confusion exists for individuals who do not meet set diagnostic criteria (e.g. at-risk or recreational gamblers). This issue affects the literature related to gambling (Miller, 2014), but also applies to delivery of treatment services. In order to work effectively with other service areas, the funded gambling treatment service sector and other service sectors need to use consistent terminology to improve responses to people with gambling problems.

Advantages of Incorporating Cross-Sector Collaboration Approaches Into Gambling Treatment Service Systems

Given the evolution of a separate and specialist gambling service response in many jurisdictions, the challenge is to develop and deliver services that are better integrated and coordinated across the range of health and human service areas. Even for those gambling services that are co-located within other health and welfare agencies, integration cannot be assumed.

A substantial body of literature describes the benefits and challenges of cross-sector collaboration. Collaboration can be defined as "working across boundaries and in multi-organizational arrangements to solve problems that cannot be solved – or easily solved – by single organizations or jurisdictions" (O'Leary, 2014). Cross-sector collaboration is a more efficient and effective way of providing services to individuals and families with complex needs. It is widely accepted that collaboration can achieve outcomes that are more effective, efficient, and sustainable than can be realised if organisations work alone (Gray, Mayan, & Sanchia, 2009).

Cross-sector collaboration is increasingly assumed to be both necessary and desirable as a strategy for addressing many of society's most difficult public health challenges (Bryson, Crosby, & Middleton Stone, 2006):

> Problems like inadequate access to care, substance abuse, obesity, environmental hazards, and poverty go beyond the capacity of any single person, organization, or sector to solve. These problems are influenced by a variety of social, economic, environmental, and biological determinants … Only by combining the knowledge, skills, and resources of a broad array of people and organizations can communities understand the underlying nature of such problems or develop effective and locally feasible solutions to address them. (Lasker & Weiss, 2003)

At the service delivery level, cross-sector collaboration allows agencies and staff to better manage the complex needs of clients. Benefits of cross-sector collaboration for agencies include more efficient distribution of resources, an increase in staff morale resulting from a decrease in isolation, improved transfer of information between professionals resulting in more holistic and coordinated service delivery, and increased responsiveness of services to clients (Davidenko et al.).

It is already acknowledged in the mental health sector that government and organisational promotion of and incentives for cross-sector collaboration are needed, along with education for staff about co-morbidity and capacity, in order for agencies to support shared clients across sectors (Lee, Crowther, Keating, & Kulkarni, 2013).

Barriers to Cross-Sector Collaboration

Although cross-sector collaboration is necessary and desirable, research evidence indicates that it is not easy to achieve (Bryson et al., 2006). The literature on collaboration identifies a number of barriers that have an impact on the ability to implement partnership work effectively between problem gambling and other service sectors.

O'Leary and Gerard (2012) identify the following challenges in introducing collaborative approaches:

- *Relationship challenges:* difficulty achieving stakeholder buy-in, lack of communication, difficulty reaching consensus, turf wars
- *Resource challenges:* time, money
- *Organisational challenges:* reconciling shared mission and goals, different agency cultures, inadequate incentives, lack of leadership, lack of skills on how to collaborate effectively, lack of role clarity

Despite considerable interest and investment in partnership work, because it is difficult to build productive working relationships among people from different backgrounds, many partnerships do not survive their first year and others falter in the development of plans and interventions. It is therefore difficult to document the impact of partnerships in improving community health or service delivery (Lasker & Weiss, 2003).

Development of a Partnership Program in Victorian Problem Gambling Treatment Services

In 2008, the Department of Justice in Victoria (now the Victorian Responsible Gambling Foundation)[1] introduced a partnership development program into the delivery of problem gambling treatment services, with the aim of developing a more integrated response to problem gambling across different service sectors. The program requires gambling help services to develop collaborative partnerships between gambling help, alcohol and other drug, mental health, and family service sectors. It encourages innovative and flexible ways of responding to problem gambling to give clients the opportunity to maintain their primary therapeutic relationship with other services while still receiving a specialist problem gambling intervention. The program supports a "no wrong door" approach to service delivery. Flexible service responses include the following and are provided by all gambling help agencies in Victoria as part of their standard service delivery:

- Problem gambling outreach to agencies already engaged with clients
- Secondary consultations (or advice about problem gambling provided to clinicians in other sectors who require input from a problem gambling clinician in relation to their client's gambling)
- Single sessions with a problem gambling counsellor[2] in addition to the ongoing intervention with the clinician from another sector
- Co-counselling sessions in which a problem gambling counsellor and a counsellor from another area are involved in a session or a number of sessions together with the client
- Co-location in which problem gambling counsellors spend scheduled time within another agency or service on a weekly or fortnightly basis

In a survey of partnership development workers delivering this program in 2014,[3] the workers reported that they were effectively able to implement the following activities. Percentages refer to the proportion of workers reporting success in achieving these activities:

- establishing positive relationships with other agencies (94%)
- up-skilling staff in other services to provide problem gambling interventions (78%)
- providing secondary consultation (72%)
- uptake of screening questions in other service settings (61%)

[1]Until 2012 when the Victorian Responsible Gambling Foundation was established as an independent statutory authority under the Victorian Responsible Gambling Foundation Act (2011), responsibility for administration of problem gambling treatment was within the Victorian Department of Justice.
[2]Single session therapy is a structured process for meeting with a client that is focussed on achieving realistic and negotiated goals and maximising the value of one or more counselling sessions in recognition of the fact that many clients derive benefit from attending one or two sessions and may not want to attend more regularly (Young, Weir, & Rycroft, 2012).
[3]The survey was administered to 18 workers whose role was to specifically create partnerships between gambling help and alcohol and other drugs, mental health, and family service sectors. This was not a formal evaluation of the program; however, it provided insights into some of the difficulties in developing and sustaining partnerships with other service sectors.

The most difficult interventions for these workers to implement were as follows:

- providing specialist clinical interventions in other service settings (single session, co-counselling) (69%)
- co-location (62%)
- providing problem gambling-specific satellite or outreach services to agencies with the primary therapeutic relationship with the client (56%)

The partnership development workers identified the following main barriers and constraints to collaboration:

- lack of other sector understanding or recognition of problem gambling as an issue (67%)
- lack of engagement from other services (56%)
- lack of authority to approach other services (33%)
- limited peer support (feeling isolated) (33%)

Effective Strategies for Implementing a Cross-Sector Approach to Problem Gambling

The five principles below are based on the experience of implementing the partnership development program into gambling help services. They draw on the literature of cross-sector collaboration and have been developed specifically for the gambling help sector (The Bouverie Centre and the Victorian Responsible Gambling Foundation, 2014).

Summary of Principles to Assist Cross-Sector Collaboration

1. *Establishment of an authorising environment*: Government, organisational, and clinical leadership is needed to promote and reward collaborative practice and to establish incentives to facilitate integrated care.
2. *System integration* involves the interaction of different service components, including screening, assessment, and treatment planning (ideally across sectors), so that services are delivered in a more efficient and holistic manner, which ultimately benefits clients.
3. *Social capital* is about how people interact and the quality of relationships between individuals and organisations. Without sufficient time being invested in relationships between senior management, managers, and practitioners from different sectors, the necessary goodwill and motivation may not exist to sustain collaborative work.
4. *Co-location* can be a useful mechanism for facilitating collaborative work. However, there needs to be capacity for co-locating staff to participate in team case discussions, contribute to shared care plans, and retain professional supervision and connection to their core discipline. Merely sharing office space is not sufficient to achieve collaboration.

5. *Joint training* can help develop staff commitment to collaboration. Staff training programs can create a common language between services and help overcome barriers to cross-sector collaboration. Through training together, a "community of practice" can be fostered in which practitioners from different professional disciplines begin to see themselves as a team.

Creating an Authorising Environment

Lack of other sector understanding and engagement was identified by partnership development workers in the Victorian gambling help sector as a significant barrier to promoting partnership work. The creation of an "authorising environment" is a critical component in a three-pronged approach in which public sector organisations must (a) create public value, (b) be endorsed by the authorising environment, and (c) be operationally and administratively feasible. Crafting and implementing successful strategy in the public sector requires managers to maximise the degree of alignment among the three identified elements of public value, authorising environment and operational capabilities (Alford & O'Flynn, 2009).

Creating an authorising environment for cross-sector collaboration to occur in problem gambling requires commitment and innovation from government departments and may be hampered by insufficient resources devoted to collaborative goals. Unless government departments prioritise working across sectors to address problem gambling (e.g., through the development of memoranda of understanding at the government level), the needs of people with gambling and related co-morbidities may be overlooked by the broader service system.

However, even if collaboration across services is embraced at the government policy level, extensive barriers to collaboration at the service delivery (agency) level may still remain. Challenges include separate performance management systems, budget systems, and accountability requirements, particularly where agencies are answerable to different funding authorities (Davidenko, Goodyear, Weir, & Sundbery, 2014).

Skill Set for Cross-Sector Collaboration

Effective partnership work requires a specific skill set. Leadership has been identified as a strong predictor of partnership effectiveness (Gray et al., 2009), whereby successful partnerships "benefit from having boundary-spanning leaders who have backgrounds and experience in multiple fields, understand and appreciate different perspectives, can bridge diverse cultures, and are comfortable sharing ideas, resources, and power" (Lasker & Weiss, 2003).

Although much of the literature exploring collaboration in the public sector focuses on organisations, "important is who is representing an organization, agency, or jurisdiction at the table and whether they have the necessary skills to be an effective collaborator" (O'Leary, Yujin, & Gerard, 2012). In implementing the Victorian

partnership development program, clinicians identified not having the right skill set as a significant barrier that had an impact upon their confidence and ability to build capacity in other services to identify and screen for problem gambling. To address the issue of capabilities in Victoria, some gambling help agencies opted to employ workers who demonstrated skills and experience in capacity building work in addition to the existing clinical skill set within the organisation.

The principles outlined in this section have been expanded into a working eight-page document for use in guiding the development of cross-sector collaboration approaches and for the training of staff (The Bouverie Centre and the Victorian Responsible Gambling Foundation, 2014).

Sustaining the Benefits of Cross-Sector Collaboration as an Approach

Implementation science can provide insight into how to deliver sustained improvements in cross-sector collaboration. Thoughtful and effective implementation strategies at multiple levels are essential in implementing cross-sector collaboration, as every aspect, from system transformation to changing service provider behaviour and restructuring organisational contexts, may be fraught with difficulty.

Changes in skill levels, organisational capacity, and organisational culture require education, practice, and time to mature. However, change does not occur simultaneously or even in all parts of a practice or organisation (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). Implementing the changes required for gambling services to sustainably collaborate more effectively with other service sectors may demand considerable time and resources prior to measurable improvement of outcomes. Measurement of cross-sector collaboration outcomes is difficult and, although a number of tools have been developed, further work is needed in this area. In relation to the Victorian partnership development program, one clinician noted:

> Initially agencies appear confused as to why we are contacting them, often stating that they never see clients with problem gambling issues. After a second or third visit/call/discussion though, this stance has softened and agencies are beginning to report some clients with problem gambling or, more often, affected others as clients.

Conclusion

Most people with gambling problems have at least one co-occurring condition and many experience multiple co-occurring issues, including mental health, substance abuse, family and relationship issues, and social problems such as socio-economic disadvantage, homelessness, and crime (Miller, 2014). Although research is limited on the prevalence of problem gambling in some service systems, such as mental health and family services, in view of the multiplicity of issues experienced, it is

reasonable to conclude that a significant proportion of people with gambling problems are presenting to other service systems for assistance with other issues.

Gambling help services in many jurisdictions provide a specialist response; however, their separation from other health and human service delivery areas (even if located physically within other organisations) means integration can be challenging, reducing the ability to respond effectively to clients with multiple co-morbidities. A number of factors are necessary to facilitate effective collaboration between gambling help and other sectors, including the establishment of an authorising environment at the government policy level. A commitment to cross-sectoral and interdepartmental collaboration may be developed through memoranda of understanding. Consistency of terminology across sectors when referring to people with acute gambling problems, as well as those at risk of developing problems, would improve service responses. Providing staff with the relevant skill set to undertake capacity building work is also crucial to the success of partnership building so that gambling help services can work more effectively with other agencies to raise awareness of gambling as an issue and build referral pathways for clients with multiple co-morbidities. At an agency level, commitment to collaboration is needed from managers within the organisation in addition to clinicians, as leadership is an important predictor of partnership effectiveness (Gray et al., 2009).

The formation of successful partnerships across different sectors can be challenging. However, this process is vital to the creation of a service system capable of responding effectively to the significant number of gamblers with multiple and complex needs.

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