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Promoting Cross-Sector Collaboration and Input into Care Planning Via an Integrated Problem Gambling and Mental Health Service

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Abstract

Although problem gambling and mental illnesses are highly comorbid, there are few examples of integrated problem gambling and mental illness services. This has meant that it is unclear whether such services are needed, why they may be used, and how they operate to support clients who are affected by the comorbidity and the clinicians who are providing care. This study reports on data collected via telephone questionnaire-assisted interviews of 20 clients and 19 referrers who had accessed one such Australian integrated problem gambling and mental illness program between July 2014 and June 2016. Data revealed that clients were often referred in the context of psychiatric or psychosocial crisis, or when clinicians encountered clients who were not making progress and wanted a second opinion about diagnosis and treatment. Improved management of illness symptoms or gambling behaviour was a commonly reported benefit, and a number of clients reported gaining a feeling of reassurance and hope following assessment as a result of a deeper understanding of their issues and available treatment options. Access to dual-specialist expertise on problem gambling and mental illness may therefore enhance treatment planning, management during crises, and cross-sector collaboration to improve access to care and its impact on people who are experiencing comorbidity.

Keywords: gambling, mental health, comorbidity, integrated care, user feedback

Résumé

Bien que le jeu problématique et les maladies mentales aient un taux élevé de comorbidité, il existe peu d'exemples de services intégrés pour le jeu et la maladie

mentale. En d'autres termes, il n'est pas clair si de tels services sont nécessaires, à quelles fins ils peuvent être utilisés et la manière dont ils fonctionnent pour aider les clients touchés par cette comorbidité et les cliniciens qui leur fournissent des soins. La présente étude a rendu compte des données recueillies lors d'entretiens assistés par un questionnaire téléphonique menés auprès de 20 clients et de 19 répondants qui avaient eu accès à l'un des programmes australiens intégrés de lutte contre le jeu problématique et la maladie mentale entre juillet 2014 et juin 2016. Les données révèlent que les clients étaient souvent recommandés à d'autres services dans le contexte d'une crise psychiatrique ou psychosociale ou lorsque les cliniciens rencontraient des clients qui n'avaient pas fait de progrès et qui souhaitaient obtenir un deuxième avis sur le diagnostic et le traitement. Une gestion améliorée des symptômes de la maladie ou du comportement de jeu constituait des avantages souvent rapportés, et un certain nombre de clients ont déclaré avoir ressenti du réconfort et de l'espoir après une évaluation, en raison d'une meilleure compréhension de leurs problèmes et des options de traitement disponibles. L'accès à une double expertise en matière de jeu problématique et de maladie mentale peut donc améliorer la planification du traitement, la gestion de crise et la collaboration intersectorielle afin d'améliorer l'accès aux soins et l'incidence des soins pour les personnes souffrant de cette comorbidité.

Introduction

In a recent article, Martyres and Townshend (2016) argued for the importance of addressing comorbidity in problem gamblers. Problem gambling and mental illnesses are commonly comorbid. In outpatients seeking treatment for mental illness, approximately 6% experience problem gambling (Haydock, Cowlishaw, Harvey, & Castle, 2015; Manning et al., 2017), far higher than the 0.8% of adult Australians in the general population who experience it (Hare, 2015). Personality disorder (e.g., 14% with antisocial personality disorder) and mental illness (e.g., 58% with substance use and 38% with mood disorders) are also highly prevalent in treatment-seeking problem gamblers (Dowling et al., 2014, 2015).

Mental illness can be a contributor to and a consequence of problem gambling (Shaffer & Korn, 2002). Social consequences of problem gambling can be catastrophic and include loss of employment, relationship breakdowns and isolation, and severe financial debt (Browne et al., 2016). These consequences make a person vulnerable to psychological distress or exacerbate symptoms of an existing illness (Yakovenko, Clark, Hodgins, & Goghari, 2016). Mental illness can also increase gambling behaviour and related harm. Gambling can be used to escape social isolation and negative affective states or to improve mood in people with affective or psychotic disorders (Quilty, Watson, Toneatto, & Bagby, 2017; Yakovenko et al., 2016). Delusional beliefs about control of gambling outcomes can increase gambling urge and frequency. Riskier gambling-related decision making and reduced sensitivity to negative feedback

can also accompany schizophrenia and borderline personality disorder (Pedersen, Goder, Tomczyk, & Ohrmann, 2017; Schuermann, Kathmann, Stiglmayr, Renneberg, & Endrass, 2011), increasing the potential for harm when they engage in gambling.

The response of mental health services to problem gambling, or of problem gambling services to mental illness, is affected by multiple factors. A study in which mental health clinicians in public, private, or nongovernmental services were interviewed reported that routine screening for problem gambling rarely occurred (Rodda, Manning, Dowling, Lee, & Lubman, 2018). This was thought to be due to problem gambling often being seen as a low priority and to limited expertise or confidence among mental health clinicians in identifying or responding to problem gambling. In addition, at the client level, help seeking in people experiencing problem gambling is often low, affected by a range of factors, including shame, stigma, and pessimism about the potential for improvement or not viewing the comorbid issue as a priority, reducing the likelihood of mental health clinicians identifying problem gambling (Harvey, 2013; Rodda et al., 2018). Experience with mental illness is variable in gambling clinicians, in particular affecting their capacity to treat people at risk for suicidality or experiencing psychosis. This has led to recommendations for stepped-care approaches that enable gambling clinicians to work more closely with specialist mental health services for clients with severe mental illness (Dowling et al., 2015). Psychiatric comorbidity may also negatively affect problem gambling treatment compliance and success through increased dropout rates from gambling treatment or increased gambling participation during treatment (Melville, Casey, & Kavanagh, 2007; Smith et al., 2011). At a systems level, the separation of funding and management of gambling services from health and human services may perpetuate differing service attitudes, and different processes for referral and eligibility between services may affect access (Davidenko, Goodyear, Weir, & Sundbery, 2014). The result can be that people with comorbidity may not simultaneously receive care that addresses all of their needs.

Different approaches are available for achieving the recommended concurrent treatment of problem gambling and mental illness (Dowling et al., 2015; Martyres & Townshend, 2016). More research has examined approaches to addressing comorbid psychiatric illness and substance use, or to addressing comorbid psychiatric and physical illness, than to addressing comorbid problem gambling and mental illness; however, findings are relevant to the latter. Three broad approaches have been identified (Ivbijaro, Enum, Ali Khan, Sai-Kei, & Gabzdyl, 2014; Mangrum, Spence, & Lopez, 2006). In many settings, each issue is treated in parallel by different clinicians or services. Integrated treatment programs, however, involve one clinician or team with dual-specialist expertise, which enables them to concurrently treat both issues. Integrated care can also be achieved through cross-service collaboration to deliver joint input to assessment, care planning, and treatment enabled through such practices as co-location, a common health record, and shared values related to the importance of concurrently addressing comorbidity (Ivbijaro et al., 2014). Integrated care (via dual-specialist clinicians or effective cross-service collaboration) can improve outcomes. For example, a study that randomly assigned people with substance use and mental health disorders to integrated or parallel treatment found that integrated treatment produced greater reductions in

psychiatric hospitalization and arrest (Mangrum et al., 2006). Integrated care may also improve outcomes for clients with problem gambling and mental illness (Davidenko et al., 2014). Clients can access all needed care in one location with fewer appointments, as care planning considers and treats the causes and consequences of both issues, and clinicians are knowledgeable in or able to access consultation to address behavioural consequences (e.g., self-harm, aggression, financial loss) of both issues. Cross-service collaboration can also benefit staff through decreased isolation, improved transfer of information, and more holistic practice (Martyres & Townshend, 2016).

Few previous examples of dual-specialist problem gambling and mental illness services have been identified (Lubman et al., 2017). Although services such as the South Australian Gambling Therapy Service advocate the potential benefit of concurrently treating depression (Smith et al., 2011), the primary focus is specialist problem gambling treatment. Martyres and Townshend (2016) described a partnership program implemented within problem gambling treatment services. This program funded problem gambling services to establish collaborative partnerships (via outreach, secondary consultation, co-location, and co-counselling sessions) with mental health, addiction, and family services. Partnership development workers who delivered the program reported it to be successful in establishing positive relationships with other agencies, up-skilling staff, and increasing the uptake of gambling screening within partner services.

Commencing in 2010, a state-wide Problem Gambling and Mental Health Program (PGMHP) was established to provide a dual-specialist problem gambling and mental illness service staffed by a part-time psychiatrist and two part-time allied health clinicians or nurses. Referred clients were assessed and, if required, given a brief intervention (mostly over less than 1 month). Types of brief intervention included gambling and/or mental illness psychoeducation, suggestions to change medication with progress reviewed, help in accessing ongoing problem gambling counselling or specialist mental health care or establishing venue self-exclusion; family intervention; and motivational interviewing to enhance readiness for treatment. Clinicians in specialist problem gambling or mental health services across the state were provided with education and consultation to build capacity and enhance cross-sector collaboration. With few such dual-specialist problem gambling and mental illness services, we conducted the present study to gather experiential feedback from clients and referrers about their PGMHP contact. This study had three aims: (a) to explore why people were referred, (b) to measure how they rated different aspects of the contact, and (c) to explore perceived benefits of referral or aspects of the PGMHP that could be improved.

Method

Design and Participants

This study conducted a telephone questionnaire-assisted interview of clients who underwent an assessment by a clinician from the PGMHP between July 2014 and

June 2016, as well as their referrers. Referrers could be mental health or gambling clinicians, primary care clinicians, or a friend or family member. Fifty-one clients had been assessed by the service between July 2014 and June 2016; however, 22 were unable to be contacted via their preferred mode of communication. Of the 29 who were contacted and invited to participate, 20 completed an interview (39% of all eligible clients) and nine declined. Thirty-eight people had referred a client for a PGMHP assessment during the study period. Eighteen were unable to be contacted, as they had left their former workplace, were on extended leave, or did not respond to their invitation. Of the 20 who were contacted, 19 completed an interview (50% of all eligible referrers) and one declined to participate. The reason that invited clients or referrers declined participation was not recorded.

Procedure

This study was approved by a hospital ethics committee (#364/16). Eligible clients and referrers were contacted via telephone by a clinician who had not been involved in assessment and were invited to take part in the feedback project. If they chose to participate, they were provided with a Participant Information Statement and a time was scheduled to complete a telephone interview. In completing the interview, the interviewer read the questions to each participant and wrote their responses onto a questionnaire verbatim. Participating clients were mailed a $10 reimbursement voucher following completion of the interview.

Measure

Client and referrer questionnaires were developed by the research team. Both measures were piloted with potential participants to ensure face validity and suitability of items. The referrer questionnaire contained 13 forced-choice items and four open-ended items. Forced-choice items asked referrer participants about the following: their role; where they live or work; how they had contact with the PGMHP; the number of clients referred during the 2-year study period; how feedback was received; the overall rating of PGMHP helpfulness, assessed with an 11-point scale from 0 (*not at all*) to 10 (*extremely*); and seven statements about their contact experience with PGMHP, rated with a 5-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*; see Table 1). Open-ended questions were as follows: “For what reasons have you referred someone for an assessment by a PGMHP clinician?”, “How would you describe our referral and assessment process?”, “In what way or ways has referral of clients for an assessment been helpful for you as a clinician or for your clients?”, and “How could the PGMHP improve how it supports you as a referrer and your clients?”.

The client questionnaire contained 13 forced-choice and three open-ended items. Client participants were additionally asked what they did in relation to post-assessment recommendations, but these data will be reported on in a future paper. Forced-choice items asked client participants about the following: age, gender, and postcode of where they lived (which was coded as being in a metropolitan or regional location); who had referred them for assessment; how they had received

feedback following the assessment; overall rating of PGMHP helpfulness by using an 11-point scale from 0 (*not at all*) to 10 (*extremely*); and seven statements about their experience with PGMHP contact, rated by using a 5-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*; see Table 1). Open-ended questions were as follows: "Why did you choose to undergo an assessment with a PGMHP clinician?"; "Overall, what has been most helpful in your contact with the PGMHP?"; "What, if anything, should the PGMHP improve about how it helps clients?"

Table 1
How Clients and Referrers Rated Aspects of Their PGMHP Experience

Group	Item	Mean (*SD*)[a]	*n* (%) at least "agree"
Clients (*n* = 20)	After being referred, I was able to complete an assessment with a PGMHP clinician in a timely manner	4.4 (0.7)	18 (90%)
	I found it easy to access the PGMHP or attend to complete the assessment	4.4 (0.6)	19 (95%)
	I had a better understanding of my gambling and/or mental health issues after completing an assessment	4.0 (1.0)	17 (85%)
	Following contact with the PGMHP clinician, I felt more hopeful that I had a plan to manage my mental health and/or gambling issues	4.2 (0.8)	18 (90%)
	I received the type of help that I expected	4.1 (0.7)	16 (80%)
	I would recommend that others who are experiencing gambling and mental health issues access the PGMHP	4.7 (0.5)	20 (100%)
	Through completing a PGMHP assessment, I was able to access treatment that was helpful for me	4.2 (1.1)	17 (85%)
Referrers (*n* = 19)	I have found it easy to access support from the PGMHP for my clients	4.4 (0.7)	17 (89%)
	My referred clients have been happy to access the PGMHP for an assessment	4.3 (0.6)	18 (95%)
	I have been kept updated about the progress and outcome of a referral for a PGMHP assessment	3.9 (1.1)	14 (74%)
	Advice or recommendations given by a PGMHP clinician have been relevant to my clients' problems	4.4 (0.6)	18 (95%)
	I would recommend that other clinicians who have clients with more complex gambling and mental health issues refer them to the PGMHP for an assessment	4.6 (0.6)	18 (95%)
	The reasons for referring clients for a PGMHP have been satisfactorily addressed	4.3 (0.5)	19 (100%)
	Undergoing an assessment with a PGMHP clinician has helped to improve the outcomes for referred clients	4.0 (0.8)	15 (79%)

Note. PGMHP = Problem Gambling and Mental Health Program
[a] Rated by using the following scale: 1 = strongly disagree, 2 = disagree, 3 = uncertain, 4 = agree, 5 = strongly agree

Analysis

Descriptive statistics were used for continuous or categorical data. Qualitative responses were analysed thematically by using the six-stage thematic approach proposed by Braun and Clarke (2006). This approach involved familiarization with responses, generation of initial codes, collation of codes into potential themes, review of themes in relation to coded extracts and the entire data set, defining and naming themes, and reporting on outcomes. Thematic coding was cross-checked by a second researcher as a means of enhancing reliability. The proportion of clients and referrers who provided a response that was consistent with identified codes and subthemes was also calculated.

Results

As shown in Table 2, the mean age for clients was 47 years, and slightly more females than males participated. More clients and referrers were living in metropolitan than in regional areas, and most referrals came from problem gambling counsellors, with fewer from mental health or primary care clinicians. Six (32%) referrers had referred only a single client for assessment, whereas four (21%) had referred two to three clients, and nine (47%) had referred at least four clients for assessment.

As shown in Table 1, clients' and referrers' ratings of aspects of their contact with the PGMHP were consistently high. Only one client or referrer did not agree or strongly agree that they would recommend others who were affected by problem gambling and mental health issues to access the PGMHP.

Figure 1 shows the mean overall rating of helpfulness of the contact with the PGMHP. Ratings were again consistently high, with 50% of clients rating this as 10 (extremely helpful). There was no significant difference in the ratings of clients and referrers, $t(37) = 0.48$, $p = .64$.

Table 2
Client and Referrer Characteristics

Variable	Clients (n = 20)	Referrers (n = 19)
Age at assessment, mean (*SD*)	46.9 (13.4)	-
Male gender, *n* (%)	11 (55%)	-
Residential location at assessment, *n* (%)		
Metropolitan Melbourne	12 (60%)	13 (68%)
Regional Victoria	8 (40%)	6 (32%)
Referrer, *n* (%)		
Problem gambling counsellor	16 (80%)	16 (84%)
Mental health clinician	3 (15%)	3 (16%)
General practitioner	1 (5%)	0 (0%)

Note. SD = standard deviation

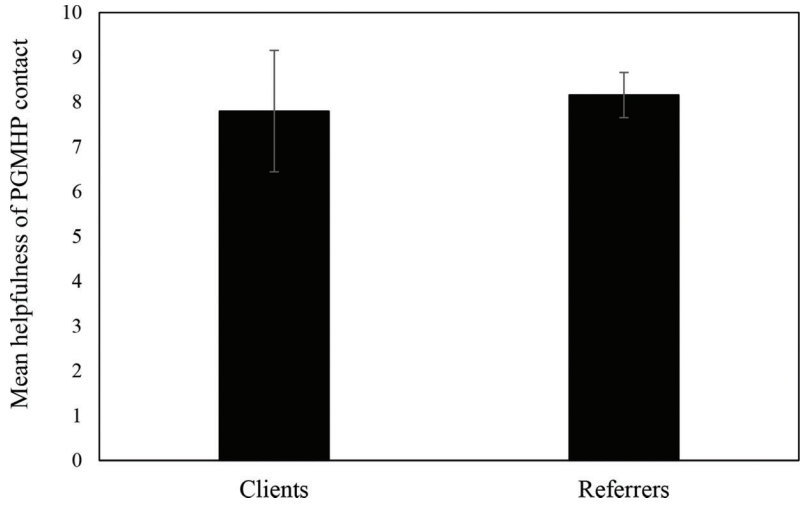

Figure 1. Mean client (n = 20) and referrer (n = 19) rating of overall helpfulness of Problem Gambling and Mental Health Program (PGMHP) contact from 0 (*not at all*) to 10 (*extremely*). Note: error bars represent the 95% confidence interval.

Five subthemes summarized what clients and referrers reported as the reasons for referral (see Table 3). Among clients, these reasons included for advice or support in a time of crisis with severe gambling behaviours or significant psychosocial complications (40%); for assessment and management of mental health issues (35%), which included assessment of new symptoms, clarification of diagnosis, and management advice; to gain insight into their problem gambling (33%); to explore management options for problem gambling (25%); and for further advice because they had exhausted all known options for management (20%). Referrers reported having made referrals for assessment and management of mental health issues,

Table 3
Reasons for Referral

Client (n = 20)	Referrer (n = 19)
For increased support during crisis or significant psychosocial consequences of problem gambling (40%)	For assessment and management of mental health issues (68%)
For assessment and management of mental health issues (35%)	For specialist gambling and mental health assessment for comorbid or complex illness (32%)
To gain further insight into problem gambling (33%)	For biological, psychological, and social management of problem gambling (26%)
To explore management options for problem gambling (25%)	For clients unable to make changes, having exhausted available options for management (26%)
For further management of ongoing gambling, having exhausted available options for treatment (20%)	For a risk assessment to determine safety of client and problem gambling staff (5%)

which in particular involved seeking diagnostic clarification or medication review (68%); for specialist assessment of comorbid gambling and mental health issues, or complex illness (32%); and for biological, psychological, and social management of problem gambling (26%). The complexity of caring for some of this population was shown through the referrers seeking referrals for help with clients who were unable to make changes, having exhausted available options for management (26%), as illustrated in the following quotes: "*My client was stuck and relapsing after work in counselling*" and "*We were feeling stuck, my client had been in counselling for years.*"

One referrer requested assessment of aggression risk for a client with a known forensic history to determine the safety of the client and of counselling staff to participate in ongoing treatment (5%).

The aspects of the service that clients found most helpful were summarized by six subthemes (see Table 4). The most frequent benefit noted by clients was management recommendations for problem gambling (50%), which included specific suggestions that had made a significant impact, such as the "*suggestion of counselling*" and "*specifically, the suggestion of voluntary administration,*" which involved supporting a client to appoint a financial administrator to limit the client's access to money that was impulsively spent on gambling. Other subthemes deemed as most beneficial were gaining insight into the gambling and/or mental health issues (40%), with responses such as "*taking the time to discuss and realize the significance of my gambling*" and "*gaining understanding of my gambling and mental health issues,*" *as well as*

Table 4
Beneficial Aspects of the Service

What the client felt was most helpful (n = 20)	How referrers felt the service benefitted them (n = 19)	How referrers felt the service benefitted the client (n = 19)
Recommendations for management of problem gambling (50%)	Access to expertise in mental health and gambling (84%)	Access to a specialist service (68%)
Gaining insight into their reasons for gambling and/or mental health issues (40%)	Validation and reassurance of the work being done already by clinicians and counsellors (37%)	Alternative strategies to assist client (21%)
Assessment and management of mental health issues (35%)	Improved engagement with clients (32%)	Validating the client's experience (21%)
Felt listened to and understood, or reassured (30%)	Support and guidance when client is not progressing (11%)	Improved engagement following mental health treatment (11%)
Unsure (5%)		Help to address gambling issues (5%)
Unhelpful (5%)		Client encouraged to access further psychiatric care (5%)

assessment and management of mental health issues (35%), which included "*peace of mind about a mental health diagnosis*" and "*medication advice.*" Responses such as "*I felt empowered to help myself,*" "*having someone to talk to so I wasn't doing it by myself,*" and having been given "*reassurance and hope*" exemplified the subtheme of feeling listened to and understood, or reassured (30%). Less frequently reported were indecision about a helpful aspect (5%) and a feeling that the service had been unhelpful (5%), in which participants stated that they had "*disagreed with the wording on the report and chose to ignore the suggestions*" for management.

Table 4 also shows the benefits that referrers perceived for themselves and clients. The most beneficial aspect for referrers was the access to expertise in both mental health and gambling (84%), with examples including having "*a medical perspective,*" "*a multi-disciplinary team,*" and "*support when outside of my level of expertise.*" This was followed by validation and reassurance of the work that clinicians and counsellors had been doing (37%), which was particularly helpful for those with complex clients or clients requesting a second opinion, as shown in the following quote: "*It allowed me to show my client their progress from an outsider's perspective*."

Improved engagement with clients (32%) was also achieved, illustrated with the following quotes: "*building rapport by being able to respond to an expressed need,*" and "*improved engagement following mental health treatment.*" Two referrers said it was helpful to get input when the client was not progressing: "*stuck in progress but not engaging with their general practitioner or local psychiatric service.*"

The most frequently reported beneficial aspect for clients was access to a specialist service in problem gambling and mental health (68%). Most beneficial was "*access to a psychiatrist who understands gambling*" or to a psychiatrist "*where gambling would be predominant in the assessment*." Other frequent subthemes of benefits were alternative strategies given in management suggestions (21%) and validation of the client's experience (21%), as, having received feedback from clients, they "*felt listened to, and understood.*" Referrers saw improved engagement in therapy following the treatment of mental illness (11%), and some felt that the help in addressing gambling issues was most beneficial (5%). A final benefit involved the experience of having a positive encounter with psychiatry (5%), with a client "*being able to engage with ongoing psychiatric follow-up after a positive experience through the program.*"

Five subthemes summarized what clients suggested could be improved. Eight clients said there was nothing to improve. The most frequent improvement suggestion was to offer additional follow-up (40%), including monthly in-person reviews or phone follow-up: "*Follow-up would be helpful to assess how the recommendations are going*".

Two clients suggested providing further education about the health consequences of gambling and how to get help, for example, by "*holding seminars*" or "*pop-up booths outside venues for people who may not realize that they are in need of help yet.*" Improved communication with clients (10%), for example, by sending the report to clients, and improved access for clients in regional areas (5%) was also suggested.

For referrers, improving access was the most common recommendation (37%) in order to "*expand geographically*" and "*reinstate regional outreach to facilitate joint assessments,*" or to "*employ more clinicians and grow the service.*" Referrers also suggested providing additional follow-up (16%) in the form of further reviews with clients, or by following up with referrers over the phone after the assessment. Also suggested were changes to the referral process (16%), for example a "*dedicated phone referral line*" or an "*email rather than a fax referral*," and report provision (16%), including "*faster provision of reports*" and "*sending the report to all health providers involved in the client's care*." Further education was also recommended about the PGMHP or how to respond to problem gambling and mental illness comorbidity for counsellors and clinicians (11%), for example "*online modules that would also help to promote what the service can offer,*" and reinstatement of residential gambling treatment (5%). One referrer said there was nothing to improve.

Discussion

This study explored how clients and referrers experienced an integrated problem gambling and mental illness service by examining why people were referred, how they rated aspects of their experience, and what was perceived to be beneficial or in need of improvement. The questionnaire-assisted telephone interview revealed overall a high level of client and referrer satisfaction. Most clients (95%) and referrers (89%) agreed that the service was easy to access. Most clients agreed they had a better understanding of their issues (85%) and felt more hopeful (90%) following assessment. Most referrers (95%) agreed that the advice was relevant and they would recommend other clinicians to refer clients with complex gambling and mental health issues for assessment. Highlighting the complexity of the problems of many referred clients, clients in particular felt that referral was initiated for support during a crisis, and referrers felt that referral was initiated for support when clients were not making progress or engaging with other services. Being able to access a specialist in both gambling and mental health was a key benefit for clients and referrers, exemplified by statements such as "seeing a psychiatrist who understands gambling." Other reported benefits were being given specific recommendations for gambling management, management of mental health issues, gaining insight, and receiving validation. For referrers, validation referred to support and endorsement of the work they had been doing, and for their clients, it referred to an outside perspective of progress they had made. For clients, this meant taking the time to discuss their issues and gain a deeper understanding and a feeling of reassurance and hope. Improving access, particularly in regional locations, and expanded options for post-assessment follow-up were the most commonly suggested improvements.

Study data summarizing why people were referred highlights why the capacity to access dual-specialist services such as the PGMHP may be beneficial. Referral was often in the context of crisis, complexity, or a lack of progress in therapy. Increased complexity and a requirement for clinicians to possess a greater diversity of assessment and treatment skills is common in the treatment of people with comorbid mental health and addiction issues (Flynn & Brown, 2008). Concerns

regarding forensic risk, mental state deterioration potentially requiring hospitalization, and capacity to make financial or living decisions were among the reasons for referral. The multidisciplinary nature of the team staffed by experienced mental health and addiction clinicians meant that they had broad expertise related to risk assessment and management, mental health and problem gambling diagnosis, and treatment planning and delivery to work with referrers, clients, and their families in responding to crises or identifying and addressing barriers to ongoing treatment engagement.

Given the urgency with which many referrals needed to be assessed, timely access was a priority. To enhance this timeliness, system integration was promoted through negotiation with individual services about how support was provided (e.g., visiting outreach clinics occurring onsite, regular onsite case discussions, joint education provision to a local specialist mental health services, or didactic education for staff). The use of direct clinician intake and varied methods of engaging referrers, clients, and family members in joint assessment and care planning by using various methods (e.g., videoconference, assessment conducted onsite at the referring service, joint therapy delivery involving the referrer and client) has also occurred to simplify access and enhance continuity of care (Martyres & Townshend, 2016). These methods are similar to approaches recommended by Savic, Best, Manning, and Lubman (2017), who proposed that cultivating positive interagency relationships was particularly important for promoting integrated care. Facilitated linkage also occurred for some clients, with PGMHP clinicians sourcing and assisting access to required services. Highlighted in the study data was that many clients were helped to access specialist mental health services; however, many clients referred from primary care or mental health services were similarly assisted to access problem gambling treatment. Some clients were said to be agreeable to accessing the PGMHP while not engaging with their own local public mental health service or general practitioner. It may be that equal focus on problem gambling is a less confronting entryway into ongoing psychiatric care.

Specific gaps in the service were identified, notably, improving access to the program by expanding the size of the program and access in regional areas. While the number of participating clients (40%) and referrers (32%) from regional areas showed the value of regional outreach as an integral part of the PGMHP model, this has fluctuated across the years due to changes in funding. This was certainly acknowledged in areas of improvement for the service and in suggestions to strengthen regional outreach, as access can be geographically difficult even for those in outer metropolitan regions, not just in regional areas. Improvements to system integration via faster provision of reports and sending of reports to all those involved in a client's care were also suggested, as well as changes to the referral system to offer a single entry point responded to by a PGMHP clinician. These changes were all implemented following receipt of feedback.

Study findings support the benefit of the adopted service model and add to a little-researched area of collaborative care among mental health and problem gambling services. Some of the benefits reported in collaborative mental health and substance use services are mirrored in these results, in particular regarding access to care for

complex clients (Flynn & Brown, 2008). In the design and delivery of the service, factors recommended for the promotion of integrated or collaborative care were considered, including an authorizing environment (government policy and funding promotes collaboration), system integration (e.g., through co-location or joint training), enhancing clinician awareness of and response to comorbidity (e.g., through training, resource provision, supervision), and addressing client barriers to addressing comorbidity (e.g., illness acuity, risk of causing harm to self or others, shame; Lee, Crowther, Keating, & Kulkarni, 2013; Rodda et al., 2018; Savic et al., 2017). Many of these factors were present or pursued to enhance integration of care provision with the primary care providers (problem gambling counsellors and primary care and mental health clinicians), but also to build collaboration between referrers and other specialist services (e.g., broader addiction or specialist mental health) required to provide ongoing specialist care for identified comorbidities.

A number of limitations were evident. A primary limitation was that only 39% of eligible clients and 50% of referrers participated. It is possible that the responses provided were not representative of the overall population experience of contact with the PGMHP. However, given that a broad range of positive aspects were reported, as well as areas for service improvement, this study is likely to have described the most meaningful aspects of client and referrer experience. Most clients and referrers originated from problem gambling services. How mental health clinicians or clients had experienced contact with the integrated service model was, therefore, explored in less detail, highlighting that this as an area for future exploration. Confidence among mental health clinicians in screening for gambling issues and limited expertise in responding to problem gambling has been identified as a barrier (Rodda et al., 2018). Accessing training and client-specific assessment and advice on managing gambling in mental illness clients through integrated services such as the PGMHP will likely build clinician capability and confidence in screening for and responding to problem gambling. The extent to which this was achieved for referring mental health clinicians is, however, unclear. Further exploration of changes in clinical outcome measures achieved by clients who were assessed and offered brief intervention by the PGMHP would also be needed to determine the nature and extent of mental health and gambling and the social impacts of service contact.

Conclusion

Clients with comorbid problem gambling and mental illness were often referred to an integrated service, either in the context of clinical or psychosocial crisis, or when clinicians felt stuck or wanted advice on how to work with clinical complexity. The PGMHP offered a multidisciplinary clinical team that used outreach, a dedicated intake clinician and delivery of capacity building via joint assessment, and input into case discussions and didactic clinician education to enhance the accessibility, reach, and collaborative delivery of care for clients and referrers. Client and referrer feedback were in most cases positive about how helpful the contact with the PGMHP was. Primary areas for improvement related to growing the availability and reach of the PGMHP, particularly in regional areas, and the capacity to continue to offer

support to referrers and referred clients beyond the period of assessment and brief intervention. What remains unknown is whether clients' and referrers' satisfaction translates into positive clinical and psychosocial outcomes for clients, highlighting a need for further research.

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