# Is Gambling in the Mix?

## Identifying and responding to gambling in your client group

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BANYULE
Community Health

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# Section 1

## Introduction

With the support of the Victorian Responsible Gambling Foundation (VRGF), Banyule Community Health Gambler's Help North & North Western modified and trailed a fidelity instrument to measure adherence to problem gambling evidence based clinical processes in the areas of service integration, screening, assessment and treatment of people who have problem gambling behavior. Often those adversely affected by problem gambling do not disclose their problems and remain concealed within the mental health (MH) and alcohol and other drug (AOD) service systems.

### Purpose

The purpose of this manual is to provide a framework to assist with integration and practices associated with increasing the capacity of staff employed and volunteering in health and welfare agencies to identify, assess and treat problem gambling in their client group, regardless of their service orientation or area(s) of expertise.

Specifically, this manual has been developed to;

- provide a tool which will quickly and easily identify strengths and opportunities within an agency's ability to recognise and respond effectively to people with co-occurring problem gambling;
- identify areas of improvement in screening for, assessing and treating problem gambling; and
- offer practical advice and strategies about how to make improvements.

### Rationale

The co-occurrence of mental health concerns; substance misuse; problem gambling, relationship difficulties and other interrelated issues are common when working with people in health and welfare settings[1, 6].Given high rates of co-occurring complex issues, it is likely that the health and welfare workforce will be working with people with problem gambling behaviour. Many people with problem gambling behavior wait until they have major problems (financially, mentally and socially) before they seek help [2]. While screening for gambling has been implemented more broadly particularly in the addictions field, many cases go undetected [3].

It is well understood that disclosing a range of personal issues and difficulties both past and present can be painful particularly when there is stigma, shame or trauma associated[1]. It may take some time and the development of a trusting relationship with a clinician before such information is shared. Where disclosures are **not** made, there are likely to be other indicators that a person's situation is more complicated than being made known [4]. It is important therefore that clinicians have some basic training and understating in the prevalence and common symptoms of problem gambling in order to recognise it when it is hidden, and processes in place to support help seeking behaviour.

Current state and federal health policies value and promote integrated healthcare service delivery. Treatment outcomes are shown to be better when co-occurring conditions are treated simultaneously rather than sequentially or in parallel[5]. In 2014 the Victorian Responsible Gambling Foundation released a background paper [6] identifying the need to strengthen cross-sector relationships and developed practice guidelines to provide a framework to do so [10].

This resource has been developed to increase the capacity of healthcare services to integrate Gamblers Help services, screen for, assess and treat problem gambling alongside the conditions they have presented for, and offers practical guidance towards integrated care for this issue.

## Background

Although awareness of problem gambling is rising, the community generally has little understanding of the behavior. Research shows that problem gambling is highly stigmatised and that people with the behavior often experience feelings of significant shame and guilt [1]. In this context it is not surprising that there are low levels of help seeking around problem gambling [6].

The DSM-5 [15] has recently reclassified problem gambling to now sit within the addictive disorder category. The move reflects research findings regarding the similarities between problem gambling and substance related disorders including common symptoms, comorbidity, physiology and treatment approaches needed [7]. Benefits of the reclassification may include a shift in conceptualising the behaviour as a form of addiction, which is better understood by the community, in broad terms. There are many commonly experienced, yet less pathologised, "unwanted behaviours" and urges such as cravings for common substances like sugar and caffeine, undertaking excessive exercise, fixation on use of devices, difficulty resisting shopping/buying/spending - all of which have the potential to cause harm (physiological, emotional, financial and within relationships). Understanding problem gambling behavior as having similarities to other common addictive behaviours may lead to some reduction in the stigma surrounding it.

Another likely strength of understanding problem gambling as an addictive behaviour is the existence of a workforce who screen, assess and treat substance addiction who are trained to assist with relapse prevention, managing cravings and harm minimisation approaches, which are transferable to the treatment of problem gambling [8]. Motivational Interviewing and Cognitive Behavioural Therapy are also effective treatments for problem gambling and are commonly used interventions across psychological services, drug and alcohol and mental health treatment services [11]. Many health and welfare services that work with people towards making significant changes in their lives will also be familiar with the change process, the Stages of Change model [9] and stage-matched interventions.

Often when multiple issues are disclosed or identified there can be a tendency for clinicians to prioritise the presenting issue that the agency is funded to work with (eg. relationships, substance use) and refer out to external agencies for treatment of co-occurring conditions. Such practices may require people with complex issues to:

- Attend multiple appointments with a variety of agencies
- Attend multiple assessment appointments, frequently re-iterating their personal history
- Compartmentalise their goals for each treatment type, treating each issue as separate from one another
- Adhere to the requirements of treatment or follow recommendations from a number of clinicians, simultaneously (parallel treatment).

While such an onerous treatment regime tends to jeopardize engagement and be unsustainable for people with multiple and complex issues, it is still a commonplace response by clinicians and agencies to people with multiple treatment needs. Attempts to enable access often include the addition of service coordination whereby an additional worker assists with collaborative treatment planning. Although this can be enormously beneficial for a person accessing multiple services, care coordination usually only leads to better client outcomes when agencies are committed to working in partnership and where processes to support collaborative care are embedded within agency practice frameworks [3,5,10].

# Section 2

## Frameworks for working with multiple issues

Alongside our recognition that many people accessing the public health system have multiple and sometimes complex health needs sits the parallel reality that recovery does occur and that people are able to make considerable improvements and overcome significant challenges over time. In order for health and welfare agencies to he helpful in this process, service delivery needs to be positioned in a number or ways.

### Comprehensive Continuous Integrated System of Care Model

The work of Minkoff and Cline has influenced many improvements in service integration, both locally and internationally and the pair continue to advocate for systems of care that are both welcoming to the range of issues people bring to the table, and hopeful that positive change can occur.

Together they have developed a suite of tools and templates which are underpinned by a fundamental belief that systems which are welcoming and engaging, client centered, integrated and hopeful will facilitate better outcomes for individuals and families with multiple and complex issues [13].

The Minkoff and Cline Comprehensive Continuous Integrated System of Care (CCISC) model is an evidence-based model underpinned by the following 8 principles:

1. Co-occurring issues are an expectation, not an exception.
2. A recovery partnership is an empathic, hopeful, integrated, strength-based relationship.
3. All people with co-occurring conditions are not the same, so different parts of the system have responsibility to provide co-occurring capable services for different populations.
4. When co-occurring issues are present, each issue is considered to be primary.
5. Recovery involves moving through stages of change and phases of recovery for each co-occurring issue.
6. Progress occurs through adequately supported and rewarded skill-based learning for each co-occurring issue.
7. Recovery plans, interventions, and outcomes must be client centered and individualised. There is no one program or intervention for everyone.
8. CCISC is designed so that all policies, procedures, practices, programs, and clinicians become welcoming, recovery oriented, and co-occurring-capable in order to help the individual or family make progress toward achieving their recovery goals [13].

### No Wrong Door Approach

It is well known that the more marginalized, disadvantaged and unwell people are, the less likely they are to receive the support they need, when they need it. The No Wrong Door (NWD) approach to service delivery appears throughout much state and federal health policy, particularly those oriented to comorbidity and complexity. Most definitions both locally and abroad describe a NWD oriented service as one that:

- Undertakes responsibility (by all staff) to identify and address health and other stated/identified needs no matter where a person presents for assistance;
- Prioritises, and proactively welcomes people with multiple and complex needs into care;
- Provides proactive support for access to treatment, where the initial agency is unable to provide the treatment;
- Provides follow-up to ensure that links are made and that appropriate care has been delivered should other agencies be referred to [14].

## Cross Sector Collaboration

In 2014 the Victorian Responsible Gambling Foundation (VGRF) released practice guidelines for cross-sector collaboration in acknowledgement of the high prevalence of co-occurring issues and need for integrated and collaborative responses from the service system [6]. Underpinning the guidelines is the belief that there is a strong inter-relatedness between co-occurring issues and that for best possible client outcomes, these issues require simultaneous treatment within an integrated coordinated environment.

The VGRF's cross-sector collaboration practice guidelines provide guidance about how agencies can position themselves, maximise opportunities for collaboration, partnership and integration. The guidelines center on the following 5 principles:

1. Begin by creating an authorising environment – supporting and enabling collaborative practices.
2. System integration is essential – working with others in the system to provide more efficient and holistic care.
3. Social capital provides fuel – developing relationships and partnerships within services and across sectors and all levels.
4. Co-location can be a useful mechanism for facilitating collaborative work – providing opportunities for formal and informal information sharing between services.
5. Joint training can help develop staff commitment to collaboration – providing opportunities for staff to come together will increase understanding of each other's services and more incidental occasions for relationships to build [6].

This framework is intended to provide a set of tools to add to the VRGF guidelines by providing Gambler's Help staff with the opportunity to gather base line data to assist with the design of the planned based activity requirements. Moreover, it allows Gambler's Help Services to identify and report on any impact or changes to the service system/s as a result of the capacity building activities.

# Section 3

## Building your agency's capacity to respond to problem gambling

### Detecting the gaps and making improvements

Over the past two decades several tools have been developed in the addictions field to measure strengths and identify opportunities within complex healthcare systems for the recognition of and responses to people with co-occurring mental health and problematic substance use concerns (dual diagnosis). Use of these tools at intervals has contributed to improvements in service delivery, integration and efficiency.

The ***Expect Gambling in the Mix*** tool (below) is an adapted abridged version of the Dual Diagnosis Capability in Addiction Treatment (DDCAT) toolkit [5] and can be used to identify areas for improving service integration, screening, assessment and treatment for clients with co-occurring gambling. The DDCAT has been in development since 2003 and is an evidence based fidelity tool for measuring agency ability to provide responsive and integrated care for dual diagnosis clients.

## How to use the tool

### Collecting information and evidence

In order to conduct the audit, there are 3 ways in which information is gathered:

1. Structured staff conversation/meeting – staff from various levels of the organisation are invited to participate
2. File auditing – evidence of routine documentation in client files
3. Search of agency documentation (policies, procedures, strategic planning, training calendars etc.).

The greatest benefit of using this tool is the conversation it generates among staff. Most of the information needed to identify areas of strength and service gaps will be brought forth through conversation, as will ideas be generated for ways to make improvements.

Efficacy in use of the tool is enhanced where it is lead by external agents or by others within the agency such as quality assurance staff, who may be more impartial. Workers enquiring into their own program have been shown to rate their performance as higher than it actually is. This is not to say that the tool cannot be implemented internally where that is the most practical way forward [5].

### Scoring

Scores are allocated from 1 to 5 and the below guide can be used to make a decision about where the agency rates. Agencies using the tool for the first time should expect to have very low scores, particularly if there has been very little contact with Gambler's Help (GH) services. Common recommendations for ways to improve scores are listed within the tool and are centered on the broad themes of coordination, consultation, collaboration and integration.

Scores of 3 indicate capability when working with co-occurring problem gambling. Scores above 3 indicate that the agency has moved beyond being capable and looks further out into the system, working towards collaborative practice and integrated service delivery [5].

| Score | Definition |
|---|---|
| 1 | Agency focusses primarily on its areas of expertise and provides minimal support for co-occurring issues. |
| 2 | The agency makes some attempts made to coordinate services however there is an absence of routine practice. |
| 3 | The agency is able to work with co-occurring issues for most clients however has a greater capacity to work with its area of expertise. |
| 4 | There is evidence of efforts to improve upon basic capability and attempts are being made towards integrated service delivery. |
| 5 | The agency has the ability to work with people with co-occurring gambling equally as with other conditions. |

# Expect Gambling in the Mix:

Detecting and treating the barriers to working with co-occurring gambling

| Area 1.Service Integration | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | Score |
| 1.1 | Coordination and Collaboration with Gambler's Help (GH) | No documented evidence of formal coordination or collaboration. Minimal coordination | Vague, undocumented or informal relationships or consultation with GH staff | Formalised and documented coordination or collaborations with GH | Formalized coordination and collaboration exists with the availability of GH staff, or staff exchange programs (variably used). There is evidence of collaboration some informal components consistent with Integration. | GH support and treatment is integrated within the program, or there is routine use of GH staff or staff exchange programs/co location | |
| 1.2 | Routine expectation of and welcome treatment for problem gambling (PG) | Service does not expect PG and refer out for support for this issue | Documented evidence that refers only to target population (eg admission criteria, target population) but have informal procedure for links to PG support | Focus is on target population, but will usually provide/coordinate treatment for PG, and there is some documented evidence of this | Program is defined as being able to treat co-occurring conditions and staff informally expect and treat co-occurring disorders regardless of severity. Not well documented overall. | Clinicians and program expect and treat co-occurring problem gambling regardless of severity, well documented. | |
| 1.3 | Display and distribution of literature and educative materials | No Gamblers Help material displayed or distributed | Available but not routinely available or distributed | Gamblers Help material available in waiting areas, client orientation materials etc but distribution is less than for service specific health issue(s) | Routinely available with equivalent distribution as service specific health issue. | Routinely and equivalently available and included information about the interaction between co-occurring issues such as gambling and mental health/substance use | |
| 1.4 | All clinicians have basic training in attitudes, prevalence, common signs and symptoms, detection, screening and assessment for co-occurring disorders. | Clinicians have not had any training (0%) | Variably trained, no systematic agency training plan or individual staff member election (1-24% of clinical staff trained). | Certain staff trained, encouraged by management and with systematic training plan (25-50% of clinical staff trained). | Many staff trained and monitored by agency strategic training plan (51-79% of clinical staff trained). | Most staff trained and periodically monitored by agency strategic training plan (80% or more of staff trained). | |

| Suggested ways to improve service integration for problem gambling | |
|---|---|
| 1.1 | • Develop an understanding of the range of services offered by GH<br>• Contact your local GH service and establish clear lines of referral<br>• Consider opportunities to co-locate GH services, including staff rotation/swap<br>• Communicate and document how referrals can be made to GH |
| 1.2 | • Review language used to describe your service and modify (where required) to convey inclusiveness of other co-morbid conditions. Words and phrases such as recovery, holistic care, towards better health and wellbeing & client centred care, may be useful to broaden the shared understanding towards a bio psychosocial model of health<br>• Detailed documents such as intake and assessment tools, procedure manuals, resource guides should document common conditions as problem gambling |
| 1.3 | • Material is made available for GH resources alongside other health and wellbeing material<br>• Material is distributed to the same level as other health materials |

| | |
|---|---|
| | • Materials are easily found |
| 1.4 | • Staff have access to basic training regarding the prevalence of problem gambling in the community and the rates of comorbidity with other common conditions as; substance misuse, mental health concerns and relationship breakdown.<br>• GH training to be routinely and regularly offered/accessed.<br>• GH training to be built into agency training calendar. |

| Area 2. Screening and Assessment | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | Score |
| 2.1 | **Routine screening methods for problem gambling** | No screening in place | Ad hoc screening depending upon clinician knowledge/ awareness. | Generic screening conducted routinely | Standardised or formal screening too/instruments in place, used variably | Standardised or formal screening tools/instruments used routinely | |
| 2.2 | **Routine assessment if screened positive for problem gambling** | No Assessment conducted (though may be referred to GH services following screen) | Included in assessment or ad hoc depending on clinician, not routine | Formal standardised assessment is offered (in-house or referral) and documented in 50-69% of client records | Formal standardised assessment is offered (in-house or referral) and documented in 70-89% of client records | Standardised or formal integrated assessment is routine and is documented in 90% of client records | |
| 2.3 | **Comorbid conditions reflected in medical record** | Collection of service specific health information only | Standard form collects service specific health information. Problem gambling information collected ad hoc | Routine documentation of comorbid conditions and history recorded in client file. | Specific section in client record dedicated to history and chronology of comorbid conditions | Specific section in record devoted to history and chronology of comorbid conditions and interaction between them is examined and documented. | |

| Suggested ways to improve Screening for co-occurring gambling | |
|---|---|
| 2.1 | • Enter a screening question to your agency screening tool<br>• Screen all clients accessing your service |
| 2.2 | • Include screening questions to assessment tools as some may not have disclosed during the screening process<br>• Include more detailed assessment for PG in your agency assessment tool<br>• Establish referral and secondary consultation process where problem gambling is evident for the client or their families/significant others<br>• Secondary consultation should be utilised where clinicians are treating PG alongside other conditions and also where a client does not wish to be referred to a PG counsellor/additional service provider. |
| 2.3 | • Allocation of dedicated space in medical records for comorbid conditions<br>• Documentation in medical record about the interrelationship between co-occurring conditions<br>• Documentation in the medical record regarding the client's stage of change in relation to each co-occurring condition (eg preparation stage for management of mental health issues, pre-contemplation for substance use, contemplation for reducing gambling behaviour etc.) |

| Area 3. Treatment | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | Score |
| 3.1 | Treatment plans | Address service specific health issue only, not PG | Variable by individual Clinician – some may address problem gambling | Co-occurring conditions are listed in the treatment plan. Service specific health issue treated as primary, problem gambling as secondary. | Treatment plans focus on all comorbidities as equal | Address comorbid conditions as primary, and list these in plan consistently with specific details about the concurrent treatment for all co-occurring conditions. | |
| 3.2 | Assess and monitor interactive courses of comorbid disorders. | No attention or documentation of progress with comorbid conditions. | Variable reports of progress with comorbid conditions. | Clinical focus in client file (treatment plan/review or progress note) on comorbid conditions. | Treatment monitoring and documentation reflecting equivalent in-depth focus on both disorders is available but variably used. | Treatment monitoring and documentation routinely reflects clear, detailed and systemic focus on change in Co-occurring conditions. | |
| 3.3 | Education is provided to clients and families/significant others about PG and its interaction with other comorbid issues as substance use, mental ill health and domestic violence | No education provided | Variably provided, ad hoc depending upon clinician | Generic format and content, and delivered in individual and/or group formats. Routinely offered | Specific content for specific comorbidities, and delivered in individual and/or group formats. Variably offered. | Specific content for specific co-morbidities, and delivered in individual and/or group formats routinely. | |
| 3.4 | Specialised interventions to facilitate use of peer support | Peer support not known or advertised | Used variably or infrequently for peer support regarding service specific health issue primarily | Variably offered or referred to for PH, not routinely | Routinely offered and access is routinely facilitated. Some co-occurring focus | Present or offsite, facilitated and integrated into program, routinely facilitated and utilised and documented with co- occurring focus. | |

| Suggested ways to improve treatment for co-occurring gambling | |
|---|---|
| 3.1 | • All clinicians expect to treat PG and consider it with the same importance as other presenting issues when developing a treatment plan.<br>• Treatment is made available for PG either within the agency or via secondary consultation and referral<br>• Treatment for PG is listed in the client treatment plan |
| 3.2 | • Ongoing monitoring of co-occurring conditions is listed in case notes and treatment plan reviews<br>• Provision of collaborative care is made available and documented in the treatment plan (records of secondary consultation, adjunct treatments as group/peer programs etc. is recorded) |
| 3.3 | • Education sessions are made available to outline the inter-relationship between PG behaviours and other common co-occurring issues<br>• Education sessions are designed and delivered in collaboration with GH services<br>• Educations sessions are tailored to meet the needs of the client group and also their family members and significant others<br>• Sessions can be delivered individually or in a group setting |
| 3.4 | • Peer support groups are advertised and access is facilitated<br>• Peer support is offered routinely by all clinicians<br>• Where peer support is provided by the agency, there is a co-occurring focus |

# Section 4

## Useful links to further information

For more information regarding your local Gambler's Help Services

gamblershelp.com.au

For more information about the Dual Diagnosis Capability in Addiction Treatment toolkit

ddcattoolkitversion4.com

For more information about the Comprehensive Continuous Integrated System of Care (CCISC) Model

www.ziapartners.com

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