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Jacobs Journal of Addiction and Therapy

Review Article

Provision of Treatment Services for Gambling Addicts in England: The Present and the Future

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Received: 07-30-2014

Accepted: 07-31-2014

Published: 08-04-2014

Introduction

In this mini review I will look at the current treatment provision for gambling addiction in England and its funding streams and commissioning mechanisms, and then suggest a model that, in my view, can be a better way forward. I will then briefly discuss some strategic changes that have to take place if this new proposed model is to work well. Although the discussion here is limited to England, principles discussed here might apply to other regions/countries.

Problem gambling is estimated to affect between 360,000 and 451,000 people in Britain – around 0.9% (an increase of 0.3% in the past 3 years) of the adult population; and a further 7.3% of Britain's adult population are deemed at risk of developing problem gambling in the future [1]. The consequences of problem gambling to the individual, family and society are wide – ranging. Problem gamblers suffer from high rates of psychiatric comorbidity including depression, anxiety, substance misuse and personality disorders [2]. Excessive gambling can often result in financial losses leading to debts and bankruptcy, and the person with the gambling problem may also have to commit crime to fund the gambling addiction. Moreover, Lobsinger and Beckett [3] estimated that for every pathological gambler, between 8 and 10 others are also directly affected including family, friends and colleagues.

Treatment services for England's gambling addicts: The present

Treatment provision for problem gamblers across England is grossly inadequate. There is only one specialist NHS – based service, the National Problem Gambling clinic (funded indirectly by the gambling industry), and apart from this the bulk of treatment is provided by non-statutory third sector agencies or peer fellowships – Gam Care and Gamblers Anonymous (GA) respectively. Gam Care [4] is a non-governmental organisation and that 'provides support,information and advice to anyone suffering through a gambling problem.' Other non-statutory treatment providers include Gamblers Anonymous [5], a self-help group network modelled on Alcoholics Anonymous but operating on a considerably smaller scale across the UK and the Gordon Moody Association, offering only limited residential and online help [6].

Commissioning and funding of gambling treatment services in England: The present

Almost all treatment provision England is almost exclusively provided through the non-statutory or voluntary sector, and largely funded voluntarily by the gambling industry via the Responsible Gambling Trust (RGT). 'The Responsible Gambling Trust is the leading charity in the UK committed to minimizing gambling-related harm. As an independent national charity funded by donations from the gambling industry, the Responsible Gambling Trust funds education, prevention and treatment services and commissions research to broaden public understanding of gambling-related harm' [7]. RGT also fulfils the function of commissioning these, either themselves or through sub-contracted agencies. Or in other words, the Government keeps well clear of any responsibility or commitment to its problem gambling population, estimated to be around 1% of the adult population.

Although beyond the remit of this discussion, we will briefly allude to two key ethical issues here. One is the ethical dubiousness of the Government position to consider providing treatment for gambling disorders differently from other health disorders. Considering parallels with alcohol or tobacco treatment provision: Would it be considered appropriate or even acceptable if the alcohol/tobacco industries were to exclusively fund treatment of alcohol disorders and smoking cessation/ smoking - related problems, with the Government (NHS) playing no role?. In not funding gambling treatment services, the Government is not only failing to acknowledge problem gambling as a health problem (which is now established beyond doubt – i.e. problem gambling is a public health problem) but the Government is also, as a consequence, gratefully letting the industry fund treatment services, and shamelessly accepting this 'blood money'.

The future

A call for integration of gambling addiction treatment into existing drug and alcohol treatment services

I call upon the Government, partly for ethical reasons touched upon above, and also due to the opportunity this presents to take over the role and responsibility for commissioning gambling treatment services in the England. In the sections below I suggest what I believe are feasible strategic and operational ways to do this, without huge additional investments.

Helping England's problem gamblers: Strategy and policy solutions

I will answer this question in two parts: first, I will look at the strategic changes that are required; and then I will suggest how these strategic aims can be operationalized to the level of service provision.

In my view, the first change that needs to happen at a strategic level is to move Government responsibility for governing/regulating gambling activities (and subsequently for treating problem gambling) from the Department of Culture, Media and Sport (DCMS) to Department of Health (DoH). Maybe apart from those in the industry, most of those in the health sector and even those with a remote interest in the health of the population would argue that gambling cannot be viewed merely as a sport; it clearly has the potential to be a health problem. Again, drawing parallels with other legal addictive activities (alcohol use or smoking), would many argue for alcohol use being considered a 'sport' instead of a health problem? So rightly, the remit for gambling treatment provision should sit within the DoH. Given the amount of monies received in taxes by the Government from the gambling industry, I see no legitimate excuse for the Government not to re-invest some of that into providing treatment to those with gambling problems.

Second, the commissioning of gambling treatment services should sit within Public Health England, along with other addictions (alcohol and drugs). As there already exists the infrastructure/commissioning framework for the commissioning of alcohol and drug services throughout the country through Drug and Alcohol Action Teams (DAATs), there would need to be minimal extra effort and investment required to make this transition/change. It was not in the very distant past that many of the DATs (of which there are approximately 150 in England) incorporated the commissioning of alcohol services as well and evolved/changed to DAATs. In our view, now DAATs need to take on the local/ regional commissioning of gambling treatment services and change to maybe Addictions Action Teams. And in regions where DAATs have been de-commissioned, local public health departments (that sit within local Councils) can take responsibility for this.

Lastly, if treatment for gambling addiction is to be delivered successfully and if the practice is to take off effectively (as I have proposed, if they are to be commissioned through the DoH, through DAATs/ PH departments, one needs to question whether we need national specialist agencies/ providers, to retain exclusive control over service provision? Devolution through AATs (or whatever other shape the future local commissioning bodies are likely to take) to local areas/regions, we believe, will be a much better way to go about commissioning treatment services rather than centralised, specialist providers. Having specialist treatment agencies is a good idea, provided they are the only treatment services available because the alternative would be no treatment provision at all – and this is acceptable at present, as there are no alternatives. But if our earlier – noted strategic shifts are to happen (i.e. move to DoH, PHE and AATs) and once local addiction treatment services start delivering gambling treatment services as well, we do not see a major role for specialist treatment centres.

It follows logically from the above that, at an operational level, gambling treatment service delivery would be through what are currently the community drug and alcohol teams or services. As these services currently treat drinkers and drug users, there are no obvious obstacles to them taking over service provision to gamblers as well. This is not to say that current drug and alcohol workers would not require additional training and support, and it goes without saying that there will also need to be some investment toward additional worker/therapist capacity. But given that the basic infrastructure for delivery of drug and alcohol services exist, to piggy back gambling treatment services on to these, in our view, would not require vast amounts of additional investment – provided the desire, motivation and drivers are there in the first place. Orford et al [8] studied the attitudes of staff working in drug and alcohol treatment services in England towards integrating gambling treatment service provision and found that the results were 'moderately encouraging.' Components of attitudes studied included motivation, support, self-esteem, satisfaction, legitimacy, and knowledge and skills.

They found that with the exception of knowledge and skills, staff expressed 'moderately positive' attitudes in all of the other 5 areas. Hence they concluded that 'British substance misuse services are appropriate locations for the development of services for problem gamblers', provided that the knowledge and skills gap of staff is adequately addressed.

Yet another crucial operational issue here is who should provide these treatment services? – NHS agencies or non-NHS third sector agencies? Statutory and non-statutory agency/agencies partnership models are increasingly being recognised as a good way forward. My own experience in providing services for alcohol and drug misusers lends further support to such a model in demonstrating cost effectiveness, patient – centeredness and sustainability. Other significant benefits of such an integrated model of service delivery include joined up care pathways, efficient care co-ordination and a seamless service.

Conclusion

It is evident from the above that it is high time the landscape of gambling treatment services changed in England. The current treatment provision is inadequate and funded exclusively through 'industry' money. I call for a more sustainable and ethically robust mechanism for funding, commissioning and providing of treatment services to England's gambling addicts.

Conflict of interest

Dr Sanju George is a member of the Responsible Gambling Strategy Board in England, and also authored a faculty report on gambling addiction for the Royal College of Psychiatrists, UK in 2014. The views expressed here are not the Board's or the College's.

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