Treatment pathways for people with low, medium and high complexity/severity of problem gambling: a consensus paper

1. Purpose and Background

1.1 Purpose

The purpose of this paper is to present an outline of the consensus gained on the content and relationships between evidence-based treatment pathways for individuals with different levels of severity of problem gambling and other issues or complexity.

1.2 Background

GambleAware (GA) previously the Responsible Gambling Trust is the main commissioner of interventions and treatment for problem gamblers in the UK. GambleAware has a vision and strategic plan to develop a commissioned system of problem gambling interventions and treatment in the UK. Their vision is that consistent range of evidence-based interventions to help problem gamblers and their families should be available in every area in the country.

In 2015/16, GA embarked on a programme of work to create a commissioned system of interventions and treatment in the UK. This included consulting current providers on: strengths and weaknesses of the system; tiered systems of provision; 'stepped care models'; and the co-production of common screening and assessment tools. GA then embarked on a re-commissioning of the problem gambling treatment system in the UK, from current 'preferred providers' to support enable the development of a more structured, tiered and efficient gambling treatment system in each area within the UK.

In 2016/17 GA commissioned further work to support the development of the re-commissioned system, which involved consultation and co-production (with treatment providers, experts by experience and commissioners) of consensus agreement on treatment pathways, screening and placement tools.

Project a) Gaining consensus agreement with current providers on the content of evidence-based treatment pathways for the different levels of severity and complexity of service users and guidance on pathways for mild, moderate and high severity of problem gambling and complexity of need.

Project b) The development of a simple and accessible screening tool, and a simple Patient

Placement Criteria (PPC) model for problem gamblers. The screening and placement tool will be piloted and validity tested ready for implementation within the re-commissioned system. This consensus paper is the output from Project a).

1.3 Methods

Consensus was achieved over a 3 month period (December 2016 to March 2017) with the providers and commissioners of problem gambling services in the UK. The process involved a series of consultation events and surveys to gather feedback. At the time of writing, there was no formal mechanism for consultation with service users. Some 'expert by experience' input and feedback was garnered though service providers who declared they were from this background. GambleAware stated an aim to set up 'experts by experience' consultation mechanisms to inform future commissioning and developments.

2. Consensus on problem gambling treatment

2.1 The Principles

The following consensus principles emerged during the consultation exercise as underpinning problem gambling treatment systems.

- Individuals with a gambling problem located anywhere with in the UK should be able to quickly access help for their gambling problems through a variety of 'open doors' including the National Problem Gambling Helpline, on-line and via local services.
- Geography or an individual's characteristics (gender, ethnicity, language, religion, sexuality, socio-economic status, housing status etc) should not be a barrier to accessing free, advice, information, brief interventions or treatment for problem gambling
- Those with gambling problems have assets as well as difficulties and should be empowered by services to harness their assets in their recovery from problem gambling.
- The problem gambling treatment system in the UK should provide the least intrusive, most effective interventions first, to ensure cost-effectiveness and best use of resources.
- A range of interventions or Tiers should be available in each area in the UK, including: identification, advice screening and referral by mainstream services; open access specialist problem gambling interventions; structured community-based treatment for problem gamblers; and, a residential rehabilitation option with through care back to local community specialist problem gambling services.
- National common screening and triage processes will be embedded into the system which will help individuals and services identify problem gamblers and suggest an appropriate pathway for assessment and interventions to meet their level of needs.
- Each local area will provide evidence-based pathways for those with: mild needs; moderate needs and severe and/or complex needs relating to problem gambling and co-existing issues.

- local systems will have a 'stepped care' model with clear processes for 'stepping up' or 'stepping down' service users if more, or less intensive interventions are required to help them meet their goals.
- Mutual aid or self help is recognised as valuable to the system and is underdeveloped in many areas. GambleAware is committed to enable the development of a range of self help or mutual aid.

Interventions for the family or significant others of problems gamblers in their own right, was not covered by this work. It is the intention of GambleAware to undertake work to develop pathways for the family and significant others of problem gamblers in the future.

2.2 A Tiered system of Problem Gambling Treatment

The table below describes the consensus description of the Tiered system of problem gambling interventions and treatment in the UK.

Tier	Services	Interventions
Tier 1	Generic services such as primary care, citizens advice bureaux, debt management services, drug and alcohol services	Advice and information and signposting, Screening for problem gambling, Brief intervention (B) and referral
Tier 2	National Problem Gambling Helpline, on line and open access community based problem gambling services	Advice, information and signposting, Screening for problem gambling, brief intervention and extended brief intervention (BI/EBI) Aftercare such as recovery check-ups and open access groups Mutual aid
Tier 3	Community-based problem gambling services	Problem gambling assessment Care planning, review and discharge planning Evidence-based psycho-social interventions to address problem gambling, normally cognitive behavioural–based programmes* Prescribing interventions for non treatment responders Care co-ordination and joint work to address complex needs
Tier 4	Residential rehabilitation services	Respite care programmes Short term residential rehabilitation Long term residential rehabilitation
Note: A service provider may be commissioned provide one or several pathways of interventions, depending on their competence and commissioned remit eg all pathways in a geographical area.		

2.3 Problem Gambling pathways for service user users with different levels of severity and complexity

Problem Gambling pathways for service user users with different levels of severity and complexity			
Pathway	**Screening or assessment**	**Interventions**	**Aftercare**
Mild	Screening	1-3 sessions: brief interventions (BI), self help and guided self help	Information about mutual aid
Moderate	Assessment	4- 12 sessions: Recovery care plan with goals, recovery care plan review using self-monitoring. Interventions from extended BI to psycho-social interventions (normally cognitive behavioural based programmes*)	3 x monthly recovery check-ups Active referral to mutual aid Other aftercare groups/fora
Severe/ complex	Assessment including multi-agency	12 plus sessions Core: • Recovery care plan with goals, recovery care plan review, care co-ordination with other services • Extensive or intensive psycho-social interventions (normally cognitive behavioural based programme) Optional • Prescribing interventions for non-responders • Residential rehabilitation placement with pre and post residential support from community problem gambling services.	6 x monthly recovery check-up phone calls Active referral to mutual aid Other aftercare groups/fora

2.4 Definitions and explanatory notes on problem gambling pathways

Definitions and notes on problem gambling pathways
Screening
A brief screening is normally a one to a few standard questions to see whether an individual reaches a threshold that indicates they may have a problem in a particular area such as problem gambling.. A Triage screening in this context is a process involving administration of a slightly longer list of standard questions to briefly assess gambling and other problems and social capital and recommendation of a pathway for further intervention or assessment (if indicated).

Two bespoke screening tools are being developed and piloted for the problem gambling system in the UK. These are:
GAST-G brief screening tool for use by generic providers
GAST-S triage screening tool for use by problem gambling providers: this will include measures of problem gambling, other issues, well-being, and recovery capital or assets
The thresholds for suggested allocation to a mild, moderate and severe/complex pathways will be piloted.

Brief Intervention and extended brief intervention

Evidence-based models of Brief intervention and extended brief interventions should be provided such as those recommended by NICE for behaviour change (individual approaches) https://www.nice.org.uk/guidance/ph49
Brief intervention frameworks include FRAMES (Miller and Sanchez 1993)

Assessment

Assessment of problem is a process undertaken to diagnosis whether an individual has a gambling problem, explore the nature of that problem and provide the basis for planning an interventions or treatment for an individual. The assessment process would normally involve assessing history and severity of problem gambling (using validated measures), screening or assessment of other problems (such as debt, mental health, social situation etc), assessment of risks, taking socio-demographic details and exploring an individuals views concerning what they what and need. It is good practice to also explore an individuals assets and recovery capital.

Recovery care planning, review and discharge planning

All service users in structured treatment for addiction problems should have a recovery care plan, which is developed with the service user and which outlines treatment goals. Goals should be measurable and in small achievable steps that a service user can monitor and work towards. Recovery care plans should be regularly reviewed between the clinician and service users and adjustments made if required to ensure service users are enable to achieve their desired outcomes. Prior to discharge, it is good practice to develop discharge plans with service users that take into account planned discharge or drop-out scenarios, have contingency planning to prevent relapse and maximise return to treatment and maximise service users community support to help them achieve their desired outcomes.

Cognitive-behavioural based programmes *

Cognitive behavioural based programmes are currently the recommended form of psycho-social interventions recommended by the Monash Guidelines for Problem Gambling (2011) and NICE guidelines for behavior change (PH49 2014) and drug misuse (CG 51 2007).
Cognitive behavioural based programmes can include:

- Cognitive Behavioural Therapy (CBT);
- Rational Emotive Therapy (RET);
- Node-link mapping or cognitive mapping techniques;
- Motivational Interviewing and motivational enhancement therapy;
- Cognitive therapy, behaviour therapy/counseling;
- contingency management;
- skills training;
- relapse prevention;

- acceptance-based therapy;
- behavioural activitation eg alternative activities; and
- mutual aid.

General characteristics of the above include a focus on the 'here and now', systematic identification of thoughts and feelings and their impact on behavior (functional analysis) and time-limited interventions with goals. Client monitoring of behavior in between sessions and acquisition and utilisation of psychological & practical skills in between sessions.
Other techniques common in the treatment of problem gambling programmes are: self-exclusion strategies and money and debt management.
It is good practice for a service to have a detailed description or manual of its programme and ensure that staff are supervised to deliver the programme with 'fidelity' to the model.

There is emerging evidence of psychodynamic counselling for service user who do not respond to cognitive behavioural approaches.
Behaviour couples therapy focused on the significant other supporting the service user in their goals has been shown to be helpful to those with addiction problems

Individual and group programmes have been found to be effective in treating gambling problems. The therapeutic alliance between the therapist and service user where a shared view of the issues are developed and clinician empowers the client has shown to be an important factor in service user outcomes no matter what intervention deployed.

Prescribing interventions

There is evidence that Naltrexone can reduce gambling severity (Monash 2011) but should only be prescribed by a specialist doctor in addictions.

Mutual Aid

Mutual aid describes a range of types of self help from 12-step fellowship groups such as Gamblers Anonymous to cognitive-behavioural self help approaches such as SMART recovery. Mutual aid is recommended by NICE for those with substance misuse addiction and has been found to be helpful for problem gamblers (though less effective than practitioners delivered interventions in trials).

Recovery check-ups

Recover check-ups are brief motivational phone calls with those which have been discharged from treatment. They have been shown to be effective amongst those with other addiction problems in reducing risk of relapse and increasing help-seeking in those who have lapsed**.**

Competency to deliver psychosocial interventions

Services should ensure that staff are trained and competent to deliver the evidence-based psycho-social interventions provided by the service, including regular 'refresher training' if required.
Staff should be supervised to ensure they continue to deliver services in line with programme protocols with procedures in place to ensure staff keep 'fidelity' to the programme model.

Appendix 1

The consultation was in three phases:

A. A consultation exercise with current providers of problem gambling treatment and interventions was held on 2nd December 2016 led by Annette Dale-Perera. This involved detailed discussion and gaining consensus on a screening tool and the content of evidence-based pathways for different levels of severity and complexity of problem gambling service users.
B. A small group exercise was conducted to explore in detail some of the issues in relation to pathways and the draft screening and triage tools
C. A written consultation was issued on the draft pathways following the small group exercise. Results were then discussed with attenders of the National Clinician Network Forum meeting in early March 2017 to discuss any final issues on contention and finalise the consensus on the pathways

Detailed comments on Phase A and C are given below for commissioner's future reference.

Phase A

The consultation consisted of presentations to the whole group followed by the group being divided into 3 groups to discuss each issue, them writing down notes and then being brought back together to discuss emerging themes. All feedback was gathered and collated. Providers were enthusiastic and contributed well to the process. Detailed comments were gathered from treatment providers and these are presented in Appendix 1 with the results collated below.

A1. Screening/assessment feedback

To enable consultation on this area, Professor David Best had provided a series of slides to inform the discussion, which were presented by Annette Dale-Perera. The feedback on this area was:

1.1 Providers took a while to discuss the difference between a full assessment and a screening process. The group advised the screening tool be thought of as a triage tool in recognition that it was going to 'place' clients in one of a number of pathways where they could receive the correct level of further assessment and interventions.

1. 2 The group recommended a very short 1-3 question screening in addition to a longer 'triage screening' particularly for Tier 1 providers who were not gambling treatment specialists (e.g. the Citizens Advice Bureau (CAB) who were present). Therefore it was decided to have two versions of the screening instrument - one very short for Tier 1 services, and a second as a placement mechanism for specialist provision primarily for use through the helpline and for online self-assessment.

1.3 In terms of length of the triage tool, providers recommended something as short as possible – (2-3 pages) that is really easy for clients and staff to understand and score

1.4 In terms of domains – Providers they thought the list of domains on the slide was too long and they recommended a shorter list comprising:

a) a screening of gambling severity;
b) questions to establish complexity;
c) an assessment of assets - particularly positive relationships.
d) there was a split opinion about whether to include mental health screening. Some thought general 'wellbeing' screening was enough if there a means of identifying onward referral for

mental health assessment. Others recommended including validated mental health screening tools.

e) some thought it as important to capture Assess if this was a new or reoccurring problem as this may require different responses

1.5 Finally providers thought that the screening and triage tools should be available on-line for self administration, and undertaken by staff in telephone and face to face contact.

A2. Pathways for Low Need

2.1 The target group for low need would be those who do score above zero, but who score low on severity of gambling problem (eg a PGSI score of 1 or 2), low on complexity measures and/or high on assets. There also will be a group who score low on problem gambling but with other issues that are identified in this process and who will need referring on.

2.2 The general consensus on the low need pathways was that this pathway should contain the following elements:

a. a screening or self-diagnostic process to give the service user feedback on their problem, and access to materials to support resulting self-help
b. self-directed help and psycho-education materials (to: raise self awareness; techniques to enable the person to create strategies to minimize harm; debt management advice; sign-posting eg to mutual aid; information on how to manage behavior; tool to look at access, time and money spent on gambling: self exclusion techniques; techniques to block and avoid triggers, keeping a gambling diary etc)
c. 1 to 3 sessions of brief or extended brief interventions – in line with other behavioural BI/EBI guidance. Providers thought the session length could be led by setting (eg BI in generic settings such primary care or CAB) and the need/choice of the service user.
d. Providers thought some of the component parts of BI/EBI could include: discussion of screening results; goal-setting; practical help such as debt management advice; techniques outlined in the self-help materials above eg techniques to minimize harm, self exclude, avoid triggers, prevent relapse etc; trouble shooting key issues; and onward referral and sign-posting eg to mutual aid.
e. Some providers recommended an agreed follow-up phone call 4 to 6 weeks after the intervention to check progress.

2.3 In terms or delivery setting, providers thought these interventions could be delivered on-line, using telephone or telehealth (eg guided self help or a session), or face to face (groups and individual).

A3. Pathways for moderate need

3.1 The target group for moderate need would be those who score as having a problem gambling issue in relation to meeting 'caseness' of severity on PGSI (give score eg 3-7). The service user may also score as having a moderate degree of complexity though they may also have some assets. The Provider group recognized that there may be a broad range of service users within this group and that majority of service users they see would be in this group.

3.2 in relation to interventions, the moderate need pathway would consist of:

a. **Assessment** – taking into account, and not duplicating the triage
b. **An individualised care plan,** discussed with and agreed by the service user with recovery milestones of goals, which are reviewed with the service user. Referral to other services and case management was also discussed.

c. **4-12 psychosocial intervention sessions** with competent staff in a group or one to one and probably over as many weeks. The component parts of the sessions as suggested by the provider group were similar to those outlined above except they would be delivered in the context of an agreed number of sessions of structured psychosocial interventions "counselling or cognitive behavioural therapy based treatment". Component parts could include: debt and money management; asset-building and 'recovery management'; looking at triggers and cues and devising strategies to manage or avoid these; and relapse prevention. Family interventions were also recommended if appropriate for an individual service user such as Social behavior Network Therapy (SBNT) or Behavioural Couples Therapy (BCT);
d. **Facilitated access to Mutual aid during treatment**, having a mutual aid sponsor
e. **More extensive aftercare and recovery support** was recommended with the providers suggesting a wide range of interventions including: a recovery and aftercare system including follow-ups in each area; recovery check-ups, mutual aid (GA, SMART, peer groups) and a recovery drop-in if location allows; relapse prevention on-line with links to support groups; a recovery mentor/buddy/structured/vetted/risk managed system – build a hybrid support network; recovery interventions: mutual aid; follow-up phone calls; on-line forum/meetings; outreach; mentoring/sponsorship; access to an open support group (on-line or in person); and a resource pack to take away.

A4. Pathways for severe and/or complex needs

4.1 The target group for severe and/or complex need would be those who highly score as having a problem gambling issue (eg a PGSI, a score of 8 or above). The service user may also score as having a moderate or high degree of complexity, some may some low on assets.

4.2 in relation to interventions, the severe and/or complex pathway would consist of:

a. **A multi-agency approach** underpinned by relationships with other agencies (local authorities, mental and physical health, safeguarding services, substance misuse etc). How this will be managed will be determined by the balance of complexity and severity factors.
b. **Comprehensive assessment for problem gambling and referral for assessment of other needs** such as mental health with a joint working approach
c. **Detailed care planning and a tailored support plan with milestones and case management which co-ordinates across several agencies** either simultaneously or sequentially
d. **Increased frequency or intensity of interventions depending on the severity, complexity and functionality of the service users**. The intensity of interventions may include a range of activities in an individual or group 'programme' either in the community or residential rehabilitation unit – not just psychosocial interventions such as counseling, but life skills, activities etc.
e. **The care pathway** may involve
    - community-based pathways featuring greater intensity of interventions (several times a week) or a personal community day programme and/or several components to help address complex needs.
    - Community and residential rehabilitation pathway. The residential element may be short or longer term placement 'sandwiched' between community interventions prior to admission and 3-6 months community support post rehabilitation rehabilitation.
f. **Structured psychosocial interventions** may include the component parts outlined previously (eg relapse prevention) but either more frequently, or for longer, or in combination with interventions for other issues eg treatment for mental health. Providers commented "Longer

term process for complex clients – progess may be slower". This may involve more intensive case management and assertive community linkage?

g. **Family interventions** are also recommended if appropriate for an individual service user such as Social behavior Network Therapy (SBNT) or Behavioural Couples Therapy (BCT);
h. **Facilitated access to Mutual aid during treatment**, having a mutual aid sponsor

Draft Pathways Problem Gambling interventions and treatment: for consultation

Severe and/or Complex Pathway

- **Comprehensive assessment for PG and other issues** through multi-agency working
- **Detailed co-ordinated care planning and review** with milestones and case management which co-ordinates across agencies simultaneously or sequentially
- **Intensive and extensive community-based pathway** providing evidence-based interventions to address PG and other issues; address crisis; debt management; interventions to build assets and social support networks; mutual aid

OR

- **Community/Residential Rehabilitation pathway** including pre-rehab support and preparation, residential placement then community pathways as above.
- **Aftercare and Recovery check-ups**, ongoing access to aftercare support and mutual aid

Moderate Pathway

- **Comprehensive assessment of** PG
- **Individualised recovery care planning and review**
- **4-12 sessions of evidence-based psycho-social interventions** to address PG and related problems, interventions to build assets and social support
- **Facilitated access to Mutual Aid** during treatment,
- **Aftercare and Recovery check-ups**, ongoing access to aftercare support and mutual aid

Mild Pathway

- **Breif assessment**
- **A single session Breif intervention or extended brief interventions (up to 3 sessions)** with individually facilitated help to self manage, psycho-educational materials, goal setting and self monitoring,
- **Referal to Mutual Aid** during treatment,
- **1 x Recovery check-up**