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BRIEF REPORT

Gambling Disorder Treatment Referrals Within the Irish Mental Health Service: A National Survey Using Freedom of Information Requests

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Abstract
Gambling disorder is an increasingly recognised problem amongst healthcare professionals and the general public but there is little information on what services are provided within the Irish healthcare system for the disorder. The aim of the present study (adapted from a study in the UK by Rigbye and Griffiths [*International Journal of Mental Health and Addiction, 9*, 276–281, 2011] was to ascertain how referrals for gambling disorder are processed and what services are available for gambling disorder within the Irish healthcare system. Email requests for information on gambling disorder referrals were sent to the main super-catchment areas in Ireland known as Community Healthcare Organisations (CHOs) and part of the national Health Executive Service (HSE). Email requests were also sent to Primary Care services and Regional and Local Drug Task forces in Ireland. Each request asked a number of questions related to gambling disorder referrals (adapted from the study by Rigbye and Griffiths). Responses were received from seven of the nine CHOs (77.8%) and eight of the 24 Drug Task Forces (33.3%), as well as from Primary Care services. Four of the CHOs surveyed (50%) offered some form of service for gambling disorder as a part of their Community Mental Health Team (CMHT), most commonly through a Clinical Nurse Specialist (CNS) in Addictions. Referrals varied between 10 and 39 referrals in a 12-month period per CHO. Half of the Drug Task Forces surveyed offered a service for gambling disorder as part of their overall service and the majority offered onward referral to either a residential programme or a self-help organisation. Primary care services did not provide any specific services for gambling disorder. There is an evident need for a consistent and dedicated pathway for the referral and management of gambling disorder within the HSE.

Keywords Gambling · Gambling disorder · Gambling disorder treatment · Gambling in Ireland · Freedom of Information requests

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Gambling disorder has been defined as a behavioural addiction in the latest (fifth) edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association 2013), and has become an increasingly recognised problem amongst healthcare professionals and the general public in many countries worldwide (Calado and Griffiths 2016). This is due in part to increased knowledge and identification of gambling disorder, with the 2010 British Gambling Prevalence Survey (Wardle et al. 2011) estimating the prevalence of gambling disorder in the UK to be 0.9% of the adult population (approximately 450,000 people). More recent figures from a Northern Ireland study in 2016 showed the prevalence of gambling disorder to be 2.3%, higher than in Wales (1.1%), Scotland (0.7%) and England (0.5%) (Northern Ireland Statistics and Research Agency 2017). There is no such national prevalence data in Ireland currently, but a study from the Institute of Public Health in Ireland in 2010 estimated the number of individuals likely to have a gambling disorder at around 40,000 people (Institute of Public Health in Ireland 2010).

Gambling disorder has also become a recent topic of conversation in Ireland. In February 2018, the Gambling Control Bill 2013 was discussed by the Irish Government in order to regulate the expanding gambling sector which has emerged in recent years and to protect vulnerable adults and young people (Oireachtas 2018). The Irish Gambling Control Bill 2013 proposes a new and comprehensive framework for the regulation of gambling in Ireland (Department of Justice and Equality 2013) and has recently been referenced in both research publications (O'Gara 2017a) and national media coverage (O'Gara 2017b). The Irish Gambling Control Bill 2013 also makes provisions for funding of medical treatment services and scientific research into gambling disorder in Ireland (Department of Justice and Equality 2013). In addition to this, the Irish Medical Organisation (IMO), the national representative medical organisation linking all branches of the medical profession in Ireland, released a position paper on gambling disorder. They recommended that research be funded into the extent of gambling disorder and its effects on individuals and their families in Ireland (Irish Medical Organisation 2015).

Gambling disorder can have a multitude of negative medical and psychosocial effects on individuals and their families (Griffiths 2004). There is widespread literature on the effects that gambling disorder can have on mental health. Problem gamblers use gambling as a means to alleviate their current mood state, rather than using gambling as a leisurely pursuit (Wood and Griffiths 2015). People affected by gambling disorder can experience irritability, extreme moodiness, poor personal relationships, absenteeism from work, neglect of family, and financial difficulties (Griffiths 2004). A recent survey of online gambling in Ireland also suggested gambling disorder could be a significant problem in Ireland, with around 75% of the population surveyed stating that they had borrowed money or sold something to get money to gamble (Columb and O'Gara 2017). The same study also reported that 74.5% of respondents stated that gambling had caused financial problems for them and their household.

There are a number of self-help and voluntary organisations in Ireland offering support and information for people with gambling disorder. Organisations such as Gamble Aware Ireland, Problem Gambling Ireland, and Gamblers Anonymous offer information and advice around gambling disorder, as well as counselling services and other avenues for treatment should they be required (www.gambleaware.ie, www.problemgambling.ie, www.gamblersanonymous.ie). There are also a number of charitable organisations and private addiction services in Ireland that can offer treatment for gambling disorder in residential, inpatient, and outpatient settings (Problem Gambling Ireland 2016).

However, there is little information on what services are provided within the Irish healthcare system for gambling disorder. Furthermore, there is also little information on how mental health and addiction teams in Ireland manage referrals to their services for gambling disorder. A study by Rigbye and Griffiths (2011) (on which study the present study is adapted from) conducted a survey of gambling disorder services provided by the National Health Service (NHS) in the UK. Their study found that 97% of the NHS Trusts did not provide any service (specialist or otherwise) for gambling disorder (Rigbye and Griffiths 2011). Therefore, the aim of the present study was to ascertain how referrals for gambling disorder are processed in Ireland and what services are available for gambling disorder within the Irish healthcare system.

Methods

Between November 2017 and April 2018, email requests were sent to each of the nine Community Healthcare Organisations (CHOs) in Ireland. These CHOs are large organisations that offer a broad range of services outside the acute hospital system and include Primary Care, Social Care, Mental Health, and Health and Wellbeing services. These CHOs are further subdivided into 32 smaller regions operating at a local level known as Local Health Offices (LHOs) (Fig. 1). These CHOs and LHOs contain mental health teams covering specific regions known as Community Mental Health Teams (CMHTs). When an inadequate response or lack of response was received from a CHO, the Local Health Offices within the CHO were contacted individually.

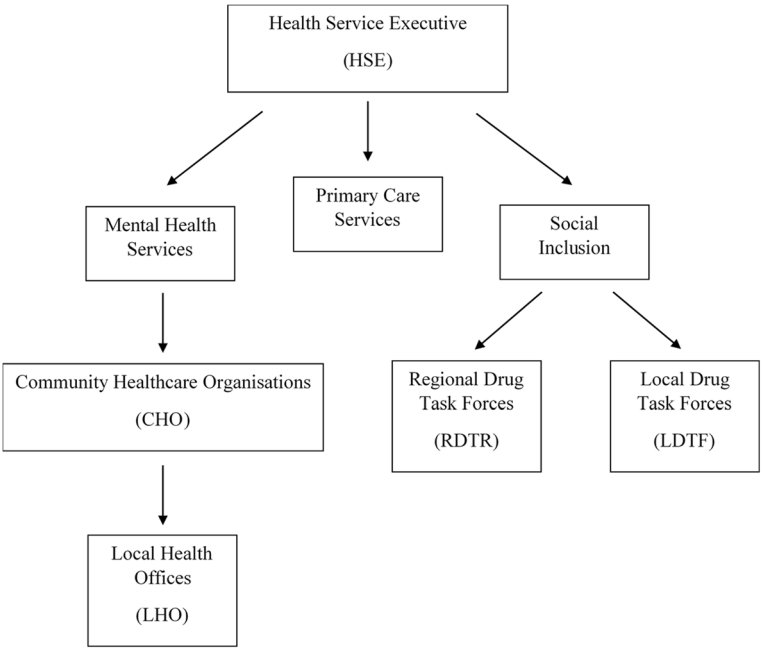

Fig. 1 Structure of the Health Service in Ireland

Email requests were also sent to the addiction service within the Primary Care Service and each of the 24 Regional and Local Drug Task Forces in Ireland in order to collate further information on direct referrals to these agencies within the HSE. The Regional and Local Drug Task Forces are responsible for implementing (i) 'National Drugs Strategy 2009–2016' (Department of Community Rural and Gaeltacht Affairs 2009) and (ii) 'Reducing Harm, Supporting Recovery 2017–2025' (Department of Health 2017) legislation across Ireland from an addiction perspective and would be an alternative route of referral to the CMHT within the HSE. Requests were made under the Freedom of Information Act 2014 (Minister for Public Expenditure and Reform 2014) where applicable or as a general request for information from the organisation. Each request asked the following questions, adapted from the study performed by Rigbye and Griffiths (2011).

(1) The different types of mental health service provided for gambling disorder (psychiatry input, counselling, etc.)
(2) Job title of each qualified mental health professionals within the service who offer treatment for gambling problems
(3) Number of gambling disorder specialists in the area
(4) Lowest age limit for referral to service
(5) Number of referrals to the service for possible gambling disorder (as primary reason for referral) in the past 12 months (if this information is to hand)
(6) Additionally, if the service does not provide treatment for gambling disorder/gambling disorder, where would the service refer these patients to?

Depending on the responses provided in the initial email, further email enquiries were made to the appropriate agencies (be it primary care services or addiction services in their area). The responses for these emails were then collated and analysed using descriptive statistics.

Results

Out of all the CHOs surveyed, email replies were received from seven of the nine services (77.8%). Of the remaining CHOs, the Local Health Offices within that CHO were contacted. Combined with the CHO results, this equates to responses from 28 of the 32 Local Health Offices within the HSE (87.5%). No data were collected from one CHO, so the results below are based on the remaining eight CHOs. In relation to services offered for gambling disorder, four of the CHOs surveyed (50.0%) offered some form of service for gambling disorder as a part of their general adult team. In most cases, this involved a referral to a Clinical Nurse Specialist in Addictions working within the MDT of the community mental health team. One CHO that offered detailed feedback on the local services provided by each team demonstrated that services can vary greatly within CHOs. As an example of this, only one of the local Community Mental Health Teams (CMHTs) within the CHO offered treatment for gambling disorder, with the other local teams within the CHO referring these patients to residential treatment facilities, primary care, or local self-help groups (for example, Gambler's Anonymous). Of note, two CHOs surveyed offered a comprehensive service for gambling disorder. Both CHOs had addiction counsellors treating gambling disorder as part of each of their community mental health teams, with one CHO stating that they had a service level agreement (SLA) to fund a residential treatment facility offering a 30-day treatment for gambling disorder.

Of the CHOs that did not offer services for gambling disorder, responses varied from referring patients to local addictions services, to primary care services, or offering no service in relation to gambling disorder. When referred to addiction services in these areas, there was no specific service available for gambling disorder but, if gambling disorder was identified as a co-morbidity in relation to another addiction, it would be treated in a similar fashion to other addictions. When referred to primary care services, patients were recommended to attend residential treatments and local counselling services in their area. Of note, when gambling services were not available in any form within the CHO, there was an addiction service present but the addiction counsellors therein did not provide any services for gambling disorder.

Responses were received from 8 of the 24 Regional and Local Drug Task Forces in relation to gambling disorder. Four of the Drug Task Forces offered a service for gambling disorder as part of their overall service. In all but one Drug Task Force, onward referral to either a residential programme or self-help organisation was offered to these patients. One Drug Task Force offered counselling, group work, key working, family support, structured day programmes, and aftercare for all addictions, with staff trained specifically in brief intervention for gambling disorder. Of the Drug Task Forces that did not provide services for gambling disorder ($n = 4$), it was reported that gambling disorder either did not fall under their remit or had not been identified as a major issue in their own internal audits of their service.

Primary care services stated that they were unaware of any general practitioners (GPs) specifically trained in gambling disorder and that there were no specific primary care services assigned to gambling disorder. They did offer comprehensive reading material as well as information around residential and self-help organisations around the country. One CHO and one Drug Task Force referred to treatment of patients aged under 18 years for gambling disorder. In each instance, these patients were referred to appropriate counselling services for addiction. Of the other CHOs offering services for gambling disorder ($n = 3$), these services were offered to patients over 18 years only.

Three CHOs offered data on the number of referrals received for gambling as the primary reason for referral. The number of referrals varied between 10 and 39 referrals in a 12-month period per CHO. However, there was a noted variation even within CHOs, with one district receiving 32 referrals compared to another district receiving two referrals within the same CHO for gambling disorder. One Drug Task Force also reported six referrals for gambling disorder as the main reason for referral. As a comparison, Saoirse, a specialist provider of addiction counselling and programmes (including gambling disorder), received 11 referrals for gambling disorder as the primary reason out of a total of 441 referrals in a 12-month period (2017).

Discussion

The aim of the present study was to ascertain how referrals for gambling disorder are processed in Ireland and what services are available for gambling disorder within the Irish healthcare system. The main finding of this study was that there are large discrepancies between services offered by the different CHOs for gambling disorder. Gambling disorder services range from each CMHT within a CHO having at least one member of the team with some training in offering services for gambling disorder, to offering no service for gambling disorder whatsoever. The 2006 Irish document ‘A Vision for Change’ states very clearly that the major responsibility for care of people with addiction lies outside the mental health system

(Department of Health and Children 2006). However, from the data above, most CHOs provided services to patients with substance misuse as part of either their addictions service or their general adult mental health teams. This suggests there is some infrastructure in place in terms of assessment and management of gambling disorder as part of overall service provision, but that there may not be the necessary training in place in order to assess and manage gambling disorder. There were also a number of teams without a dedicated clinical nurse specialist (or other discipline) in addictions.

Outside of the data collected from the CHOs, there were few treatment options available for gambling disorder. Primary care services did not provide any gambling-specific services and half of the Drug Task Force surveyed did not offer a service for gambling disorder. Interestingly, some of the responses indicated that gambling disorder had not been identified as a major issue in their own research of their service needs and that their services mainly focussed on substance addiction. This tallies with the study conducted by Rigbye and Griffiths (2011), in which they stated that some services would not class gambling disorder as a mental health issue. In contrast to this, there was some appetite for training in gambling disorder management, as evidenced by one Drug Task Force undertaking their own training in brief intervention for gambling disorder. This again highlights an evident need for consistent and dedicated pathways and information amongst providers of treatment in addiction services.

A small number of teams returned data on referrals for gambling disorder or gambling disorder in their area. One CHO received 39 referrals for gambling disorder, which was the largest number of referrals recorded in this study for one CHO. When looking at this as a percentage of total population in the CHO, this accounts for around 0.005% of the population (based on census results for this particular CHO) (Health Service Executive 2015). This is much lower than expected based on prevalence studies examining gambling disorder (Institute of Public Health in Ireland 2010). This suggests that a large number of people suffering with gambling disorder in Ireland are not being identified or accessing services within the Irish healthcare system.

The present study also highlighted the different directions that referrals take when they are referred to community mental health teams. Referrals that were not managed by the community mental health team were either referred to primary care services, addiction services, or advised to self-refer to residential treatment programmes and/or support organisations. There is a lack of consistency between CHOs in terms of where patients with gambling disorder are managed. As an example from this study, some clinical nurse specialists in addictions offer treatment for gambling disorder in specific CHOs and in other CHOs the service is not available, despite having clinical nurse specialists in addiction. This can cause confusion for general practitioners and mental health professionals making referrals for these patients. The study by Rigbye and Griffiths (2011) makes reference to this point, with their study indicating a lack of knowledge around where to refer patients for gambling disorder in the British NHS system.

The majority of CHOs that offered services to patients with gambling disorder offered the services to adults only. Only one CHO and one Drug Task Force offered services to patients under the age of 18 years. It is known from previous studies that rate of at-risk and gambling disorder to be 4% and 1.2% respectively in the adolescent (aged 14–18 years) population (Gonzalez-Roz et al. 2017), although a recent systematic review found a very wide range of problem gambling in adolescence ranging from 0.2% in Norway and Australia to 13% in Croatia (Calado et al. 2017). There is also evidence from population surveys in the UK that 12% of adolescents (aged 11–16 years) had gambled in the week prior to taking part in a national survey (Gambling Commission 2017). This could cause significant difficulties for this cohort because gambling disorder in adolescents has also been associated with delinquent

behaviours (Kryszajtys et al. 2018). There is no such prevalence data in an Irish adolescent population and further research in this area would be very beneficial to identify this cohort for early intervention and treatment.

There were some limitations noted in the present study. Whilst there were a large number of responses from the CHOs, there were relatively few responses from the Drug Task Forces. The low number of responses may not reflect the gambling services offered by these organisations. This is in contrast to the high number of responses from the CHOs, which is a strength of the present study. The study here was more focused on referrals to mental health teams in relation to gambling disorder, but there are many self-help and residential treatment facilities outside the remit of the HSE at which problem gamblers can attend. Further research into these facilities would likely add to the knowledge of prevalence and treatment of the gambling disorder population in Ireland.

Overall, the present study highlighted the evident need for a consistent and dedicated pathway for the referral of problem gamblers to services within the Irish HSE. At present, there is too great a disparity in how referrals of gambling disorder are processed which can lead to potential patients not being identified or treated. There is also a need for more specialist addictions input into the management of these patients as standard practice in order to reduce the morbidity in this patient cohort.

Compliance with Ethical Standards

Conflict of Interest MG's university currently receives funding from *Norsk Tipping* (the gambling operator owned by the Norwegian Government) for ongoing research. MG has received funding for a number of research projects in the area of gambling education for young people, social responsibility in gambling and gambling treatment from Gamble Aware (formerly the Responsibility in Gambling Trust), a charitable body which funds its research program based on donations from the gambling industry. MG also undertakes consultancy for various gaming companies in the area of social responsibility in gambling. The remaining authors (DC and COG) have no conflicts of interest.

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