

Problem Gambling: A local treatment “audit” Sheffield City Council

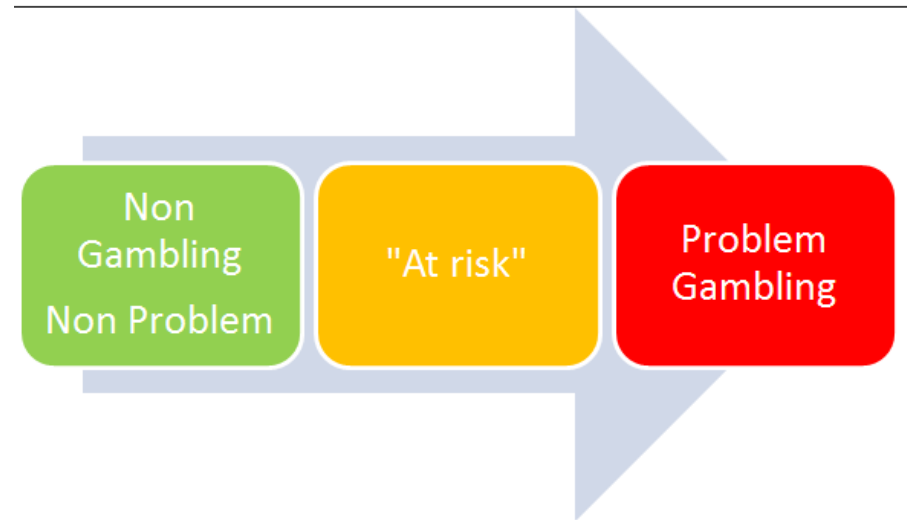
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Sheffield City Council



A legal activity on a spectrum of harm...

- **Non-problem** includes “non-problem” gamblers and non-gamblers (Shaffer et al, 1999)
- **At risk** represents gamblers with sub-clinical levels of gambling problems (Shaffer et al, September 1999)
- **Problem gambling** is gambling to a degree that compromises, disrupts or damages family, personal or recreational pursuits (Lesieur and Rosenthal, 1991). In DSM-V problem gambling is designated as a “Gambling Disorder” which can be mild, moderate or severe and episodic, persistent, or in remission
<http://www.ncpgambling.org/wp-content/uploads/2014/08/DSM-5-Diagnostic-Criteria-Gambling-Disorder.pdf>



The estimated size of the problem...

	Leeds Beckett (Kenyon et al, 2016) estimates applied to Sheffield	Gambling Commission (2015) estimates applied to Sheffield
Problem Gambling	1.6% ~ 7377 (18+)	0.8% 16+ ~ 3785 (16+)
At risk gambling	5-6% 23054-27655 (18+)	
Problem and at risk gambling	7-8% 32276 – 36886 (18+)	

16+ 473145,
18+ 461086

(2017, ONS
mid-year
estimates)



Alcohol (drinking above 14 units) prevalence of **25.3%** & binge drinking **17.9%**

Smoking prevalence in Sheffield of **17.0%**

Gambling **0.8% or 1.6%**

Opiate & crack use in Sheffield **~1%**
(9.76 per 1,000 population 15-64 yr olds)

The “audit”

- “Quick and dirty” aimed to get some rapid local knowledge on ability of community organisations to **identity, treat and refer** problem gamblers in Sheffield
- Community organisations sampled were those most likely to be in contact with problem gamblers due to co-morbidity (mental health, addictions, youth)
- 5 salient questions with Y/N/DK possible responses + a free text box distributed and returned electronically – easy to issue, complete & analyse
- Asked for support from NHS and Local Authority Commissioners to reach community settings and from the Local Medical Committee and Clinical Commissioning Group to reach GPs – stakeholder “buy in” is important
- 31 responses so not generalisable, but aimed to identify gaps and shape further local discussion, priorities and action

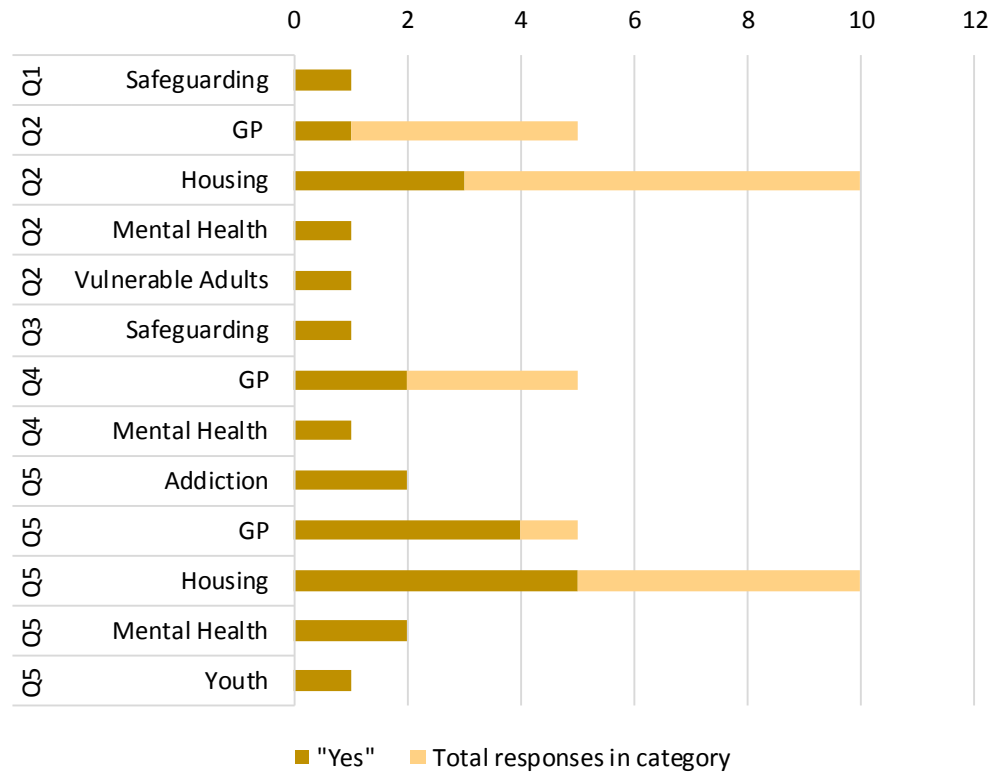
The questions



Ref	Audit question
Q1	In the past 12 months has your service received any information or training (online, face to face, fact-sheets) about problem gambling? Not including this service audit information
Q2	Does your service ask question(s) about gambling as part of routine assessment and care planning?
Q3	Does your service use a recognised screening tool to identify and/or assess the severity of problem gambling e.g. Bet/Lie, GA-20, PGSI?
Q4	(Clinical providers only) Does your service offer efficacious treatment for problem gambling e.g. Cognitive Behavioural Therapy?
Q5	Does your service know where to refer problem gamblers for effective treatments, debt or peer support?

Referrals was the main positive response...

"Yes" responses to audit questions by service type



Most of those surveyed had not received training in problem gambling, and did not ask or screen for gambling.

Community organisations were confident in referring problem gamblers but these were not all **“appropriate” referrals** to organisations knowledgeable & skilled to help problem gamblers

What Sheffield did next...

- **Work with key stakeholders**

A loosely constituted multi-stakeholder “task & finish” group & when required to pragmatically progress local priorities. Not all stakeholders are represented. Unstructured is not “good enough” for everyone (status of group?).

- **Agree local priorities**

Local priorities arising from the audit were agreed by the multi-stakeholder group through a transparent, interactive process of idea generation and ranking.

- **Manage expectations #austerity**

The staff capacity for this is limited – ½ a day of Public Health time per week. There is no budget for this work. There is a stark contrast with investment of resources to address other “addictions” which is not easily understood by stakeholders.

- **Acknowledge limited sphere of influence**

Local Authorities sphere of influence is local but we shouldn't underestimate the opportunities to influence regionally & nationally e.g. DCMS consultations, collaborations with the LGA, PHE, Gambling Commission, ADsPH

Local priorities from the audit

Option	Desired outcome	Red, Amber, Green
Option 1 - Technical training to advice staff (Newport CAB)	Frontline advice agencies are confident that they have the knowledge and skills to address problem gambling as part of financial inclusion or debt management including housing arrears.	Amber
Option 2 –Screening tool training e.g. Lie/Bet, GAST-G, GAST-S	Problem gamblers are given the opportunity to disclose problems through being asked screening questions as part of routine assessments. Problem gamblers who are already receiving specialist support are able to gauge the degree of the problem through more advanced screening tools.	Amber
Option 3 – Clinical training (protected learning initiative)	Frontline clinical staff working with mental health, suicide prevention and addictions are confident that they have the skills, knowledge and techniques which are known to be effective for addressing problem gambling.	Amber
Option 4 – Referral pathway	<p>Problem Gamblers receive appropriate referrals</p> <p>Service providers do not have to process inappropriate referrals</p> <p>Delays in reaching help are reduced through eliminating inappropriate referral.</p> <p>Self -help and mutual aid are visible</p> <p>Family and carer support are visible</p>	Amber
Option 5 – Good practice guidelines	There is a shared local understanding about the best ways of managing presentations/disclosures of problem gambling – counselling and debt support are offered concurrently	Amber
Option 7 – invite Krysallis to speak to Sheffield about what they offer	Local providers understand the local offer commissioned by Gamcare	Green