BARRIERS AND FACILITATORS OF SCREENING FOR PROBLEM GAMBLING: PERSPECTIVES FROM AUSTRALIAN MENTAL HEALTH SERVICES

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Barriers and facilitators of responding to problem gambling: Perspectives from Australian mental health services

Despite high rates of comorbidity between problem gambling and mental health disorders, few studies have examined barriers or facilitators to the implementation of screening for problem gambling in mental health services. This exploratory qualitative study identified key themes associated with screening in mental health services. Semi-structured interviews were undertaken with 30 clinicians and managers from 11 mental health services in Victoria, Australia. Major themes and subthemes were identified using qualitative content analysis. Six themes emerged including competing priorities, importance of routine screening, access to appropriate screening tools, resources, patient responsiveness and workforce development. Barriers to screening included a focus on immediate risk as well as gambling being often considered as a longer-term concern. Clinicians perceived problem gambling as a relatively rare condition, but did acknowledge the need for brief screening. Facilitators to screening were changes to system processes, such as identification of an appropriate brief screening instrument, mandating its use as part of routine screening, as well as funded workforce development activities in the identification and management of problem gambling.

Keywords: screening; alcohol; barriers; assessment; mental health services; mental health disorders; gambling

Introduction

Previous studies consistently identify elevated rates of mental health disorders among individuals with gambling problems, and that mental health disorders are grossly over-represented in problem gambling treatment settings (Dowling et al., 2014; Dowling, Cowlishaw, et al., 2015). The most thorough examination of comorbid psychiatric disorders among treatment-seeking problem gamblers to date is a recently completed systematic review and meta-analysis (Dowling et al., 2015). The findings based on 36 studies (including three Australian studies) conducted between 1990 and 2011 were that approximately three-quarters of treatment seekers display co-morbid DSM-IV Axis I (clinical) disorders, with the most common being a current mood disorder (23.1%) and/or any substance use disorder (22.2%). A meta-analytic study on DSM-IV Axis II (personality) disorders from the same systematic search based on 15 studies meeting inclusion criteria (including two Australian studies), found that almost half of those seeking treatment for problem and pathological gambling had personality disorders, with antisocial (14.0%) and borderline (13.1%) personality disorders being commonly identified (Dowling, Cowlishaw, et al., 2015). Moreover, there is increasing evidence that problem gambling is over-represented in mental health populations (Cowlishaw, Hakes, & Dowling, 2016; Cowlishaw, Merkouris, Chapman, & Radermacher, 2014; Dowling, Jackson, Suomi, Lavis, Thomas, Patford et al., 2014).

Since only a minority of problem gamblers seek treatment, the early identification of those experiencing gambling-related harm is paramount, and health care professionals have a critical role to play. According to Berkson's bias (1946), individuals accessing treatment services are more likely to have co-morbid disorders and more severe problems than in the community, as the compounding effect of both mental illness and addiction can precipitate treatment seeking. This highlights the importance of routinely screening for gambling disorders among those seeking help for mental health problems.

In Australia and around the world, there have been attempts to integrate problem gambling screening into mental health services. These attempts have to a large degree been unreported, with the majority of literature reporting on the barriers to implementation in relation to screening by General Practitioners (GPs) in primary care settings (Achab et al., 2014; Corney, 2011; Rowan & Galasso, 2000; Sullivan, 2011; Sullivan, Arroll, Coster, Abbott, & Adams, 2000; Sullivan, McCormick, Lamont, & Penfold, 2007). These studies have identified issues that may apply to screening for problem

gambling in mental health services. At a systems level, there is generally no funding available to compensate for the additional time required to screen, assess and manage gambling problems (McCambridge & Cunningham, 2007; Sullivan, 2011). At the individual level, gambling is viewed as a low priority because of a reported lack of time (McCambridge & Cunningham, 2007; Sullivan et al., 2007), perceived low burden of disease (Sullivan, 2011), and a view that screening will not have an impact on service engagement or patient outcomes (Problem Gambling Research and Treatment Centre, 2011; Rowan & Galasso, 2000; Sullivan, 2011). Furthermore, many health professionals lack confidence that they have the necessary training, knowledge or skills to address gambling problems (Achab et al., 2014; Corney, 2011; Problem Gambling Research and Treatment Centre, 2011; Rowan & Galasso, 2000; Sullivan, 2011; Sullivan et al., 2000; Temcheff, Derevensky, St-Pierre, Gupta, & Martin, 2014; Tolchard, Thomas, & Battersby, 2007). Screening is also hampered by perceived lack of access to appropriate interventions or specialist referral services (Sullivan, 2011).

Given the limited research into screening for problem gambling among mental health patients outside of primary care, this study sought to investigate current practices within mental health services using in-depth interviews with mental health clinicians and managers. A qualitative approach was employed because this approach can provide a rich appreciation of clinicians and managers experiences of screening for problem gambling, beyond which may be gathered via a quantitative approach. While explorative, the study does build on previous research investigating screening by GPs that has found systematic and clinician-level factors influence willingness and capacity to screen for problem gambling. The current study extends this evidence and aims to identify common themes associated with the barriers and facilitators to screening for problem gambling within mental health services.

Method

Study sample

We recruited 30 key informants including clinicians (*n*=17) and managers (*n*=13) from six large adult (*n*=28) and child and youth mental health (*n*=2) services operating across 11 different sites in Victoria, Australia. These services included public community mental health, private mental health, emergency and crisis support and mental health community support services. Informants were recruited over the months of January and February 2015 via snowball sampling and were drawn from a concurrent quantitative study investigating attitudes towards screening in mental health services (citation removed

for peer review). Service managers were invited to participate in the study and were also asked to nominate clinicians who also might be interested.

The final sample included 19 females and 11 males. Participants were drawn from a broad range of services that included three public area mental health services which offer catchment-based inpatient and outpatient clinical care and case management; a state-wide mental health community support service which offers psychosocial rehabilitation, outreach and support; one community health service that provides general health and psychological support to clients with mental health issues and one private psychiatry outpatient clinic. Sixteen of the participating clinicians and managers were involved in a direct care role, including registered nurses (*n*=6), social workers (*n*=5), occupational therapists (*n*=3), a case worker (*n*=1) and a clinical psychologist (*n*=1). Twenty-four clinicians and managers were recruited from metropolitan services and six were recruited from regional areas across Victoria, Australia. The sample was drawn from the same six services that have recently been involved in a quantitative study of how mental health services respond to problem gambling (Manning et al., 2015). This study reported the mean duration of clinical practice was 12 years with a range of between 1 to 40 years. Just over 10% of clinicians had been provided training in how to respond to problem gambling. Clinicians from these services estimated that approximately 10% of their clients experienced gambling problems.

Procedure

Key informant interviews took place between January 2015 and October 2015. The average duration of each interview was 31 minutes (range 16-57 minutes) and these were digitally recorded and transcribed verbatim. The interview schedule focused on identification and management of problem gambling in community mental health services: “How do clinicians usually become aware that a patient has gambling problems?”, “What do you/your service do to identify patients with gambling problems?”, and “What sort of things impact on your/your service’s ability to identify gambling problems in patients?” A series of questions were also asked about the management, treatment and referral of problem gambling in their mental health setting: “What would you like your service to do to improve the way in which problem gambling is identified?”, and “What impacts on the ability of your service to manage gambling problems in patients?”

Clinicians and managers were provided with a $40 store voucher for participating. The study was approved by the Eastern Health Human Research Ethics committee (approval reference number: LR120/1314). The research protocol and Eastern Health ethics application was reviewed and approved by governing bodies, head offices or CEOs at other mental health services without formal ethics committees.

Data analysis

NVivo 10 software was used to conduct the thematic analysis (Braun & Clarke, 2006). Transcripts were read and re-read and initial codes developed. Codes were grouped by the first author into themes that were adjusted to capture new and emerging themes until the entirety of the dataset was coded. A second research assistant also coded one complete transcript and similar themes were identified. Disagreements in the final coding were ultimately resolved with input from the fifth author. Themes were then compared and contrasted with existing literature and finalised with input from the wider research team.

Results

The main barriers and facilitators to screening are presented on Table 1. Six themes emerged, which included competing priorities, importance of routine screening, access to appropriate screening tools, resources, patient responsiveness and workforce development.

INSERT TABLE 1 HERE

Competing priorities

Across all service settings, there was a consistent ranking of patient health priorities, whereby screening for gambling was not viewed as a high priority. This was because of a focus on immediate risk and service funding models and time pressures. For those working in emergency and crisis support services, gambling was viewed as something that was of minimal importance because it was not life threatening. Sometimes this was not intentional, but rather a reflection of being swept up in a crisis or

other acute situation. There was also a perception that gambling was not an acute issue, but rather a longer-term concern.

> *Usually because patients are presenting in crisis around risk issues, we're not usually focusing on the longer-term issues around whether it would be gambling.* (Female, Nurse)

Gambling may not have been viewed as an acute issue for many informants, but there were frequent reports that gambling was interrelated with mental and physical health, accommodation needs and alcohol and drug issues. Informants commented that gambling threatened to undermine the effectiveness of treatment approaches for other disorders. This became a priority when money that had been allocated to medication, housing, transport or other essentials had been spent on gambling.

> *Because I'm looking at prescribing medicine as a treatment, it's very important to make sure that that money can flow on and go on there.* (Male, Nurse)

There was also a perception that gambling was not as harmful as other behaviours and that, although it might be associated with spending money or small losses, it did not cause harm. It was reported that clinicians also ranked issues according to harm and or perceived need. One informant stated that alcohol and drug issues were higher on the list of priorities because of their potential interactions with medication.

Related to harms and risk was the perception that gambling was not a health issue. One informant noted that gambling had been part of their screening processes, but had been removed for this reason. Another informant reported patients also did not make the connection between gambling and mental health. It was not clear whether this informant also doubted the connection between gambling and mental health.

Multiple informants commented that gambling was not a priority issue at a systems level. Frequently, informants provided rankings as to the top and bottom issues that the agency and individual clinicians thought should take priority. Rankings were related to agency targets and the amount of funding attached to identifying or managing problem gambling.

> *So those are the things that are sort of targets for the workers to meet, whereas there is no target of following up around the gambling so that can probably get lost amongst the other assessments that are required. (Male, Intake manager)*

I don't think it's a high priority, no. We're more dealing with the impact of things like ice, alcohol, cannabis as well as general mental health. (Female, Nurse)

At the agency level, multiple informants indicated that gambling was not perceived as an important issue. Some informants commented that at this level, there was an emphasis on risk and symptom reduction and a focus on a traditional medical model. Informants stated that disorders perceived to be associated with greater risk were screened for first. High-risk conditions identified included schizophrenia, drug-induced psychosis, bipolar affective disorder, suicide, aggression, forensic history and alcohol and drug disorders.

Informants commented that there had recently been a greater focus on the screening and management of mental health conditions, including alcohol and drug issues. Gambling, however, had not been part of that discussion. Informants reported that this meant that there was limited momentum for gambling screening and identification in as much as limited support provided for training and education in problem gambling or even general awareness that it was a problem that should be addressed.

At a clinician level, there were repeated accounts of the difficulty in managing the scope of their current role and responsibilities. This was primarily related to workload issues and the amount of paperwork that was required (e.g., forms to complete) and there was a reluctance to increase this workload. Feeling over-burdened and that there was a lack of time was associated with role responsibility. Some informants indicated that gambling was not their core business and it was therefore not their responsibility to screen, identify or manage the problem.

The other issues aren't our issues. It sounds horrible but they're not. Once they're mentally stable, mentally well, they need to go out the door because we have patients coming. (Female, Service Manager)

Informants differed markedly in their perception of the prevalence of problem gambling in mental health services (i.e., very rare to very common). Multiple informants acknowledged that estimates of problem gambling in mental health were likely to be under-reported. This was because of a lack of focus on problem gambling and inadequate screening or assessment, but inadequate screening was in part due to a perception that gambling was not a common problem. Previous knowledge and experience regarding problem gambling informed some clinician's decisions to screen for gambling issues. For

these clinicians placing a priority on screening for problem gambling appeared to be influenced by their own expertise, level of experience and knowledge about problem gambling.

> *It's very ad hoc. It depends on the level of experience and knowledge about problem gambling.* (Female, Service Manager)

Importance of routine screening

Generally speaking, informants placed importance on routine and standard processes for screening to ensure that screening occurred. Processes were important not just to ensure patients were appropriately screened, but also to ensure screening continued to occur when there was staff turnover. It was reported that processes were in place for alcohol and to a lesser extent illicit drug screening, but not gambling. Unless gambling was included in mandatory screening, informants indicated that most clinicians would not ask about it.

> *If the question is not on the form - do they have a gambling problem - then we're not going to ask.* (Female, Service Manager)

Processes were also important to prompt clinicians to screen. A common reason reported for not screening was that they forgot or did not remember. Having an indicator or prompt to screen was seen as a helpful addition. Informants noted the importance of having gambling as part of routine screening so that clinicians would become accustomed to asking about it.

Whilst acknowledging the importance of screening for gambling, clinicians perceived the current screening and assessment process as a burden, with a reluctance to incorporate additional screening measures. Indeed, other informants reported that clinicians and patients were annoyed at the extensive and long screening and assessment process. The main concern here was that the addition of a screening tool for gambling would create more paperwork.

Access to an appropriate screening tool

Very few informants reported that a standardised tool for problem gambling screening was administered. While multiple informants said that they screened for problem gambling, prompting for the types of tools used revealed that they did not actually include questions related to gambling. For the

most part, current practice included an array of screening questions that had not been derived from a validated screening tool. For some services, there was not a formal tool, but rather a blank space that needed to be completed, with little guidance about how the clinician should approach the issue (e.g. how to introduce the topic, phrase the questions). Other agencies administered standardised tools for other mental health conditions (most often substance use) and appended additional questions related to gambling onto these tools.

There was also limited knowledge of validated screening tools. While there was broad agreement that screening tools were infrequently used to screen for problem gambling, informants were generally positive towards access to appropriate tools and resources. Multiple comments suggested direct questioning rather than indirectly eliciting information about gambling was preferred. In particular, questions that were brief, but quickly determined whether there was a gambling problem, were seen in a more positive light.

> *I feel okay asking those questions, but perhaps at times it might be useful having a structured screen on how it might be more useful, or otherwise I might go about it in ways that it could be measured, other than just simply asking.* (Male, Occupational Therapist)

Three informants commented that a screening tool similar to screens used for alcohol and drugs would be welcomed. Multiple informants suggested that a brief screen was preferred given time constraints, as well as time required for additional gambling screening.

Resources available

Informants reported that it would be helpful to have tools and resources to use once a problem had been identified. This included information on the harms and impact of gambling, strategies for change and where to seek further help. Furthermore, there was a call for resources that could be accessed by clinicians as well as patients. These resources would ideally guide discussions and provide information to support the person in seeking further resources and/or help for the gambling.

Having access to the right information was important. In addition to the person with the gambling problem, one informant noted it would be helpful to have a carer information resource. This included information on how to support the person with the gambling problem. Multiple informants indicated resistance to asking about problem gambling if they did not have tools and resources to respond if it were identified.

> *I think that I would need information to support my patient and to say to them look this is a service I know about, let's see what we can do and where to next. If a patient came to me and said I've got a gambling problem I'd go online and I'd say okay let's look, but it's not something that I would bring up if I don't have the information.* (Female, Service Manager)

In addition to resources, there was a call for increased access to expertise. However, this differed according to the location and focus of the service. The few that were located alongside a specialist gambling service (that provided assessment only) noted that they had access to expertise, but this expertise was more difficult to source in rural and other areas. One informant suggested up-skilling one person in their agency that could provide advice and support as needed. This informant went on to explain that the role could provide education for community teams as well as managers; specifically on what problem gambling is and how screening and assessments should be conducted. Overall, informants indicated a need for more support for clinicians in how to respond when problem gambling was identified.

Part of the reluctance to screen was the perception that identifying problem gambling would raise a whole range of issues that the clinician was not equipped to manage. When problem gambling was identified, there were concerns that the clinician would not know how to respond. This was in part related to confidence and having training in the identification and management of problem gambling.

> *You can just open up a can of worms. You want to know well what can I do with it anyway, where can I go with it and how can I help them. So why would you ask the question if you've got no follow on, so that's another thing. You'd want to know what to do with it.* (Female, Service Manager)

Patient responsiveness

Multiple issues impacted on perceived patient willingness to screen and be screened. These included a willingness to disclose a gambling problem and varying levels of readiness to change. Willingness to disclose was impacted by the timing of the interview (some patients did not disclose in the first interview because of embarrassment) and the screening process. Multiple informants stated that while patients initially denied that there was a problem, follow-up questioning identified that gambling was an issue. There was a view put forward by multiple informants that screening for problem gambling at

the first point of contact might not yield an honest response. The main reason provided was that sufficient time had not passed for rapport or trust to be developed. Some informants reported patients were reluctant to admit to a gambling problem or would under-report the extent of the problem until trust was established.

Perhaps the development of trust and rapport was related to the possible impacts of disclosure. If problem gambling was disclosed and harms identified then it was possible that other people would be notified or that the patient would be put on an administration order that usually meant someone else managing their finances.

> *They already have enough to deal with. Their own mental health issues and then on top of it they have gambling issues. Then if we take their rights away with their finances then they are fairly vulnerable.* (Female, Case Worker)

Conversely, other informants reported that they did not experience any difficulties with patients not disclosing gambling issues. These informants asked about gambling as part of a holistic approach to screening. That is, a comprehensive assessment was undertaken that included problem gambling. One informant noted that identifying the problem early for many is related to a sense of relief that the problem was no longer hidden. A critical issue when formal tools were not administered at the point of screening was that it made it more difficult for patients to later acknowledge or indicate that they had a gambling problem.

A positive screen for problem gambling did not necessarily mean that a patient would want to work on gambling issues. Multiple informants identified the relevance of readiness to change or the stage of change model to explain patient disclosure of problem gambling. Informants perceived that some patients who had screened positive to problem gambling or had disclosed that they gambled a large amount of money were not ready to do something about their gambling. Clinicians experienced this as an unwillingness to disclose the extent of their problem or not wanting to identify with having more than one problem.

> *Sometimes we pick up key issues we think are key issues and the patient says I don't want to deal with that. I'm here because I want to deal with X, so then you really have to respect what it is the patient is there for.* (Female, Service Manager)

Informants thought gamblers experienced high levels of shame and stigma about gambling, mental health issues more broadly and help-seeking. In terms of problem gambling, multiple informants reported stigma associated with gambling because it was potentially more of a hidden issue than disorders associated with substance use. One informant suggested that there was shame attached to problem gambling because the behaviour was viewed as 'stupid'.

> *There's a lot of shame attached to it and there's also a lot of thinking that it is something stupid that they've done. I've had patients tell me they would rather have a drug and alcohol problem, because you can actually see they have a problem.* (Female, Service Manager)

Indeed, comparisons were regularly drawn between gambling and alcohol and drug issues in terms of responsiveness to screening. One informant noted that patients would rather disclose that they were under the influence of alcohol than say that they had been gambling. Another social worker reported that they did not have any patients that wanted to discuss their gambling behaviours. The informant noted patients were open about their substance use, but secretive about their gambling behaviours. This informant attributed the difference to greater acceptance in the community of alcohol and drug issues than gambling problems.

Workforce development needs

Workforce development needs covered five main areas: (i) awareness of problem gambling, (ii) knowing the signs and how to introduce the issue, (iii) identification and application of appropriate screens, (iv) knowledge about how to assess, and (v) treatment/referral options. Overall, there were comments that training needed to be resourced and this training needed to be funded if it was to become a priority. There were various levels of confidence in identifying problem gambling with some informants indicating that a great deal of training would be required. Others however, reported that if they had access to appropriate tools then perhaps minimal training was needed.

> *Good training and then reminding people to ask, and not be scared to ask it, and some prompts, would be all you'd need, I think.* (Male, Service Manager)

The content of training requested also included how to raise the issue of problem gambling, how to screen for problem gambling (asking the right questions) and then what to do about it. Multiple informants mentioned the importance of making training specific and practical. The type of training requested was direct and to the point. There was more support for group training rather than a webinar

or audio-visual materials. Informants also requested in-service training that provided information and resources. This included resources that could be taken away and put into practice (rather than just information). Training for supervisors was also perceived as helpful in ensuring that gambling was routinely discussed. Training of supervisors was also deemed helpful in training new staff, especially in the administration of any gambling screening tools.

Multiple informants noted the importance of maintaining awareness of problem gambling in so much as providing training booster sessions. This could be in team meetings or other periodic events. In addition, to keeping gambling front of mind, one informant noted that with staff turnover there needed to be access to regular training. This included evaluation of whether training had an impact on identification of problem gambling. One informant noted that follow-up was important to ensure that training is not just a one-off session.

Discussion

This explorative study is the first to provide an in-depth exploration of the barriers and facilitators to screening for problem gambling in mental health services. Semi-structured interviews undertaken with 30 informants (clinicians and managers) in Victoria, Australia revealed six main themes. Barriers and facilitators included competing priorities, importance of routine screening, access to appropriate screening tools, available resources, patient responsiveness and workforce development needs. This study identified current practice for problem gambling screening in mental health and community services was for the most part ad-hoc or at the discretion of individual clinicians. Most informants were not aware of any available screening tools or any standardised means of assessing problem gambling.

Barriers to screening were multiple and inter-connecting. There was a focus on immediate risk, with gambling viewed as a longer-term concern or as an issue that was not related to mental health. There was a perception, based on clinical accounts, that problem gambling was a relatively rare condition, and this perception was reinforced through low rates of identification of problem gambling when non-standardized tools were used to assess the condition. Despite these barriers, many informants indicated a willingness to screen for problem gambling because it was known to impact on treatment for other conditions (e.g., money for medications), but reported competing priorities brought about by extensive requirements to screen for a range of physical and mental health issues resulting in limited time to consider other non-acute conditions. This is somewhat similar to previous studies involving

GPs that also identified a lack of time as a reason for not screening (McCambridge & Cunningham, 2007; Sullivan et al., 2007). The current study reported inadequate access to training and education resources leading to low confidence in identifying and managing problem gambling. This is also consistent with previous research investigating screening by GPs and their training needs, knowledge and skills (Achab et al., 2014; Corney, 2011; Problem Gambling Research and Treatment Centre, 2011; Rowan & Galasso, 2000; Sullivan, 2011; Sullivan et al., 2000; Temcheff et al., 2014; Tolchard et al., 2007).

Facilitators to screening were reported at a level of systems or agency as well as clinician and patient levels. Funding for identification and management of problem gambling in mental health services was a facilitator in terms of addressing competing priorities and raising the importance or profile of problem gambling among mental health patients. This is consistent with previous research investigating screening for problem gambling, with GPs also reporting that funding and resource constraints impact on screening (McCambridge & Cunningham, 2007; Sullivan, 2011). Facilitators also identified as helpful included the introduction of routine screening (at a systems level), resources to support clinicians and patients where problem gambling is identified, as well as funding for ongoing workforce development. However, clinicians were unaware of which screening tool to use, and there is clearly an urgent need to validate a brief screening tool that could be incorporated into routine screening within these settings. Many informants indicated a preference for a brief screening instrument that could reduce patient embarrassment associated with disclosing a problem.

Interestingly, similar barriers to screening were observed when attempts were first made to implement alcohol and drug screening within mental health services (Lubman, Hides, & Elkins, 2008); and community health services (Thomas & Staiger, 2012). Since then, there has been considerable investment in building mental health clinician capacity in responding to alcohol and drug issues across Australia, such as through the Victorian Dual Diagnosis Initiative (Thomas & Staiger, 2012; Thomas, Staiger, & Mccabe, 2012) as well as the Victorian Government's 'no wrong-door policy' (Roberts & Maybery, 2014). Such initiatives have seen an increase in mental health workforce capacity to deal with substance use issues, as well as greater utilisation of routine mental health screening across the alcohol and other drug sector (Lubman et al., 2008).

Clinical implications

The majority of informants acknowledged the benefit of having a valid and reliable screening tool to identify problem gambling, yet the inclusion of a new tool should take a number of factors into consideration. First, there needs to be an agreement at a systems level that a brief problem gambling screen is included within the minimum dataset and routine screening practices of mental health services. Given that datasets are often established at a local level (e.g., state or territory level), there is a need to identify, and make available to mental health services, brief screening tools that are easy to administer and can be incorporated into other existing screening tools. The current research also suggests that training should be provided, and that this should be repeated regularly given issues with staff retention. Given competing priorities, the screening tool and the training should be targeted and brief in terms of duration and complexity. This is consistent with research investigating brief screening for problem gambling in a range of clinical settings including alcohol and drugs and mental health (Brett et al., 2014; Goodyear-Smith et al., 2008; Rockloff, Ehrich, Themessl-Huber, & Evans, 2011; Stinchfield & McCready, 2014; Toce-Gerstein, Gerstein, & Volberg, 2009; Volberg, Munck, & Petry, 2011). Ideally training would include information on diagnostic criteria and characteristics of problem gambling which may go some way to addressing the low awareness of associated harms (e.g., suicidal ideation). When problem gambling is identified, clinicians need to be able to offer or refer to evidence-based brief interventions. These could be provided by mental health clinicians or alternatively via the growing number of online self-directed programs.

Study limitations

This qualitative study provides a great deal of information on the barriers and facilitators to problem gambling screening, but multiple limitations need to be considered. First, the study is limited to clinicians and managers employed in mental health services in Victoria, Australia, and it may be that these results are not applicable to other jurisdictions or countries. While we attempted to ensure that the sample was a broad representation of mental health service clinicians and managers, it is possible that volunteering informants had a particular interest in problem gambling and may therefore not be representative of the rest of the workforce. For example, the current study indicates that previous clinical experience in treating and/or assessing clients for problem gambling results in a greater

willingness and confidence to screen for problem gambling. Second, the current study employed a qualitative methodology because of its exploratory nature and the lack of previous research in this area. Future research should consider quantitative methods to determine rates of screening in mental health services as well as clinician attitudes more broadly to screening for problem gambling. Limitations associated with analysis include a lack of triangulation with other data sources (Mays & Pope, 2000). For instance, qualitative interviews with patients would have enabled us to compare common themes and corroborate and strengthen our interpretation of the data. While a form of analyst validation was undertaken to ensure that the interpretation of the data made sense, we did not share our interpretations of the qualitative data with, nor ask for feedback on our analysis from, clinicians and managers themselves. Mays and Pope (2000) point out that this kind of respondent validation can ensure that researcher interpretations correspond with participants. We did, however, attempt to ensure a diverse sample of clinicians and managers and our analysis does pay attention to differences in perspectives, which is another strategy for enhancing rigour in qualitative research (Mays & Pope, 2000). However, there are perspectives missing, including those of clinicians in primary health care and child and adolescent mental health services.

Despite these study limitations, the breadth of perspectives represented provide important insights into the barriers and facilitators of current responses to problem gambling within mental health services. The interviews explored the experiences of a diverse range of health care professionals, working at different levels in terms of leadership and case management and across a broad range of mental health settings and geographical sites. Despite sampling a range of clinicians and managers, consistent themes emerged, proving further confidence in the findings. In addition to highlighting the marked variability in current practice, the findings unveil some of the critical and practical challenges that must be addressed (e.g., embedding gambling questions into intake assessments, comprehensive clinician training), in order to meet the needs of this population.

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Table 1.

Summary of barriers and facilitators to screening for problem gambling

Domain	Barriers to screening	Facilitator to screening
Competing priorities	Agency and clinician focus on risk rather than longer-term issues; Prevalence of problem gambling perceived as low; estimates of prevalence based on current case load rather than evidence; Gambling not viewed as a mental health issue; Gambling viewed as a low priority issue across the service system (funding); Clinician over-burdened and limited time.	Funding to identify and manage problem gambling from within mental health services; Recognition of gambling as an underlying issue; awareness that gambling could impact on finances and engagement with treatment for other disorders; provide information on the harms associated with problem gambling.
Routine screening	Without routine screening clinicians were unlikely to screen for problem gambling; current number of screens for other mental health concerns	Routine screening would prompt clinicians to ask about problem gambling; An openness for inclusion of gambling in mandatory screens and assessments
Screening tools	Limited knowledge of valid tools; current screening not derived from valid instruments; time constraints	Readiness for a brief tool; direct questioning preferred by many clinicians;
Resources	Limited use or knowledge of appropriate resources	Provision of tools and resources and access to expertise;
Patient responsivity	Timing of interview could impact on willingness to disclose because of a lack of rapport; Potential impacts of disclosure in terms of patient rights; Screening may be positive for problem gambling but the patient is not ready to change; Patient embarrassment or shame hampers disclosure and a perceived willingness to engage in treatment	Routine screening may reduce embarrassment when gambling is assessed as part of a holistic interview; Disclosure may be associated with a sense of relief; if gambling not identified in initial screening it may not be addressed at a later stage;
Workforce development	Poor access to training or education; Clinician confidence to respond impacts on willingness to screen; less support for online training over group support; supervisors require training to support staff	Training needs to be resourced and funded; Demand for advice and training in the administration of appropriate screening tool/s; demand for resources that could be implemented following training; booster sessions should be provided.