Central and North West London NHS
NHS Foundation Trust

National Problem Gambling Clinic

Year End Activity Report
2012 to 2013

Wellbeing for life

Summary

- Referrals for all treatment episodes at the clinic numbered 736 in 2012-2013 – an increase of 22% over the 6.3 received in 2011-2012.
- Total numbers in treatment during this period 858, incorporating new presentations and ongoing cases

Psychological treatment for problem gamblers

- Referrals
  - 632 referrals received, an increase of 21% on 521 seen in 2011-12
  - No significant change in demographic profile – 'typical' client remains self-referred male, mid-30s, 'white' from London or South East England.
  - Self-referrals remain main source of referral (81%) – GP referrals halved over year
  - 116 individuals (18.4%) referred from outside of easy reach of clinic
- Assessments
  - 536 assessments offered, an increase of 39.7% on 2011-12
  - Wait times increased, but by 23%, less than increase in appointments offered
  - Use of bingo, fruit machines and lower age associated with non-attendance at assessment
  - No relationship between wait times and attendance at assessment
- Treatment
  - 356 new psychological treatment offers made, an increase of 42% on 2011-12
  - Higher proportion of treatment cases assigned to group CBT
  - Average wait times increased, but median wait times decreased
  - Waits for group treatment decreased, waits for individual CBT increased
- Outcomes
  - Planned discharges from treatment increased to 62% from 59% in 2011-2012 – 4.5% uplift in completed treatments
  - Treatment duration shorter on average by 1 week, average number of sessions offered increased
  - Treatment completers have significantly fewer gambling days, lose less money at treatment end and at 3 and 6 month follow-up periods
  - 60% of treatment completers achieve abstinence at treatment end – gains maintained at follow-up
  - 80-90% of treatment completers are less 'troubled' by gambling at end, 3 months and 6 months post discharge
  - High levels of depression and anxiety at assessment see substantial and sustained reductions at treatment end and 3 and 6 months post discharge
  - Over 95% of treatment completers provide favourable responses to satisfaction survey questions at treatment end

Family and carers service

- Service saw small reductions in referrals and assessment
  - Expected following loss of family psychotherapist to maternity leave
  - Psycho-educational groups remained well attended with very little decline in attendance

Money Advice Service

- Referrals to this service dropped by 50% following reduction in service offered by external provider
  - Attendance at sessions increased to 60% from 53% seen in 2011-2012

A. Total numbers in treatment 2012-2013

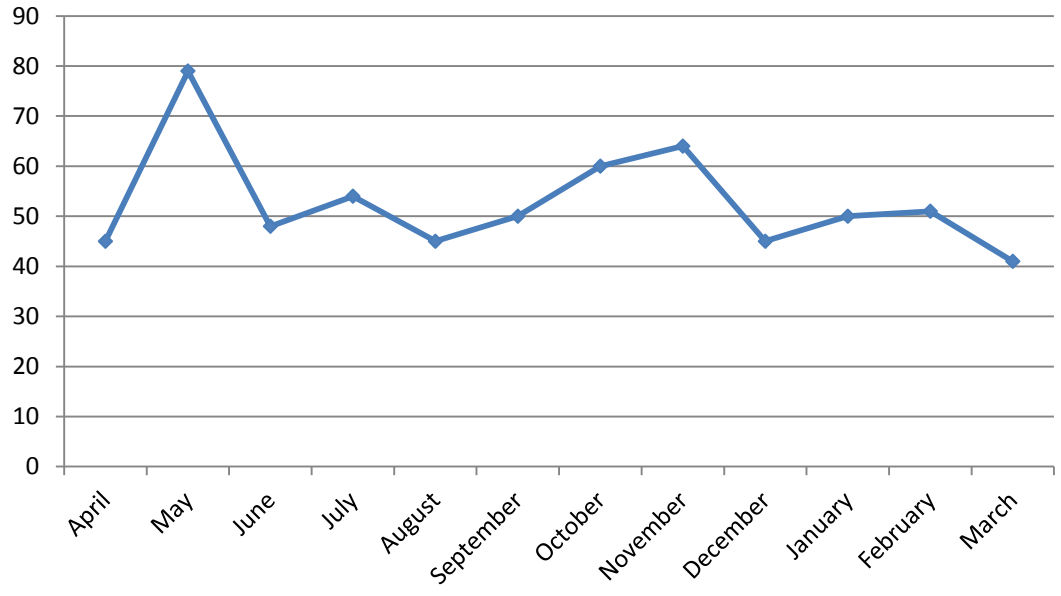
The term 'numbers in treatment' refers to the total number of treatment episodes managed by the service in any one period. This will include referrals to psychological treatment for problem gambling, family and carers support and financial money management. These figures are presented in the table below.

In treatment 2012-2013:	Total	New cases	Ongoing
	858	117	83
CBT treatment	693	632	61
Family and carers	88	66	22
Financial management	77	77	n/a

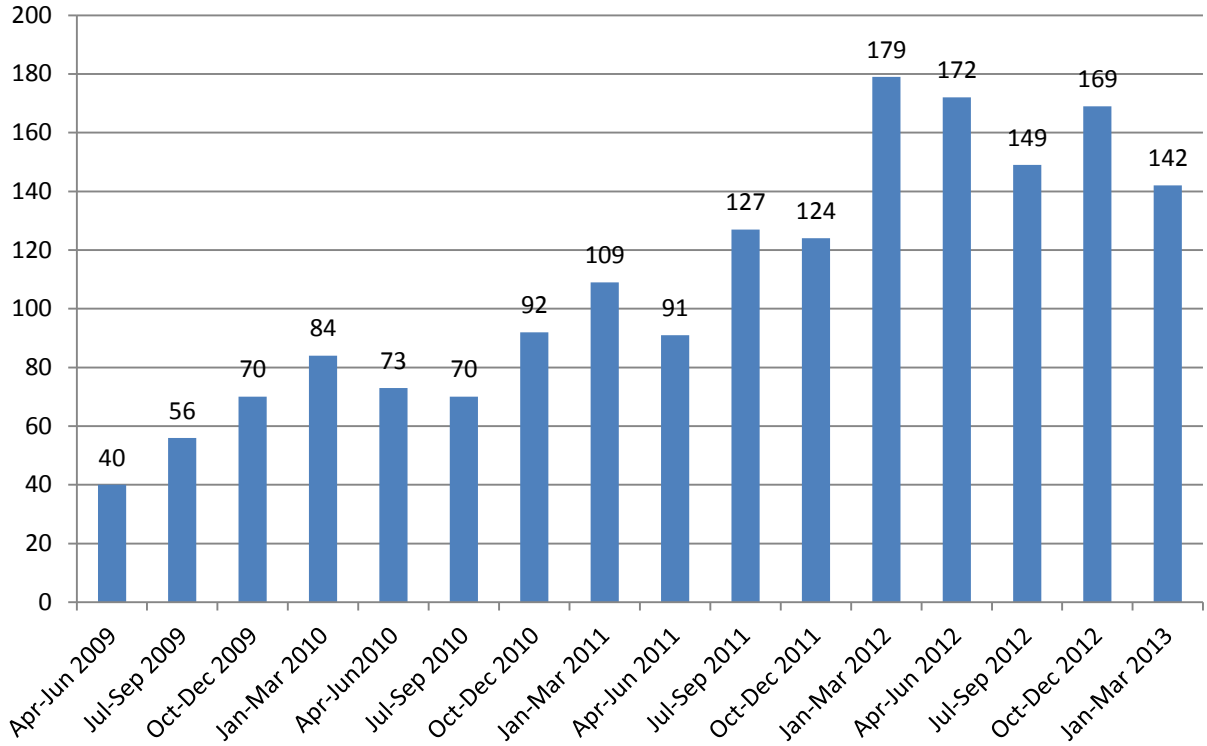
B. Psychological treatment for problem gamblers

1. Referrals

The year 2012-13 saw an increase of 21% in referrals of problem gamblers to the service compared with 2011-2012, from 521 to 632. The graph below displays the distribution of referrals throughout the year, with referrals peaking in May (79) and October and November (60, 64).



The pattern of increasing referrals follows that seen in previous years from 250 in 2009/10, 344 in 2010/11 and 521 in 2011/12. The graph below displays the referrals received by quarter over that time period.



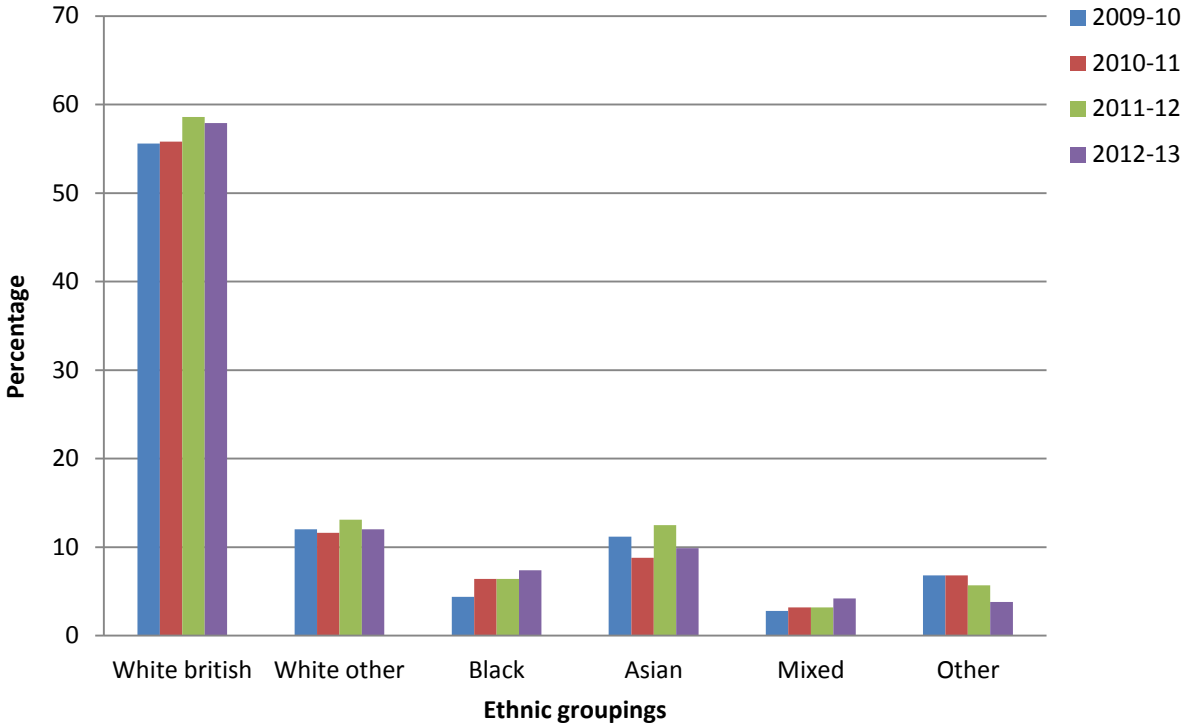
2. Demographic profile

2.1. Gender

In 2012-13 the percentage of referrals received from male problem gamblers was 92.6%. This compares with the figure of 92% for 2011-12. This figure has remained static over the past three years (2009/10 – and 2010-11 both 93.6%). This is despite the efforts of the service to increase the numbers of females attending. In the past year the clinic has trialled two different formats of groups for females run by female psychologists. However, rates of referrals remain low. We have attempted to publicise the issue in local and national media; however, understandably, we have found our female clients unwilling to discuss the issue openly. This is discussed further in section E (p21).

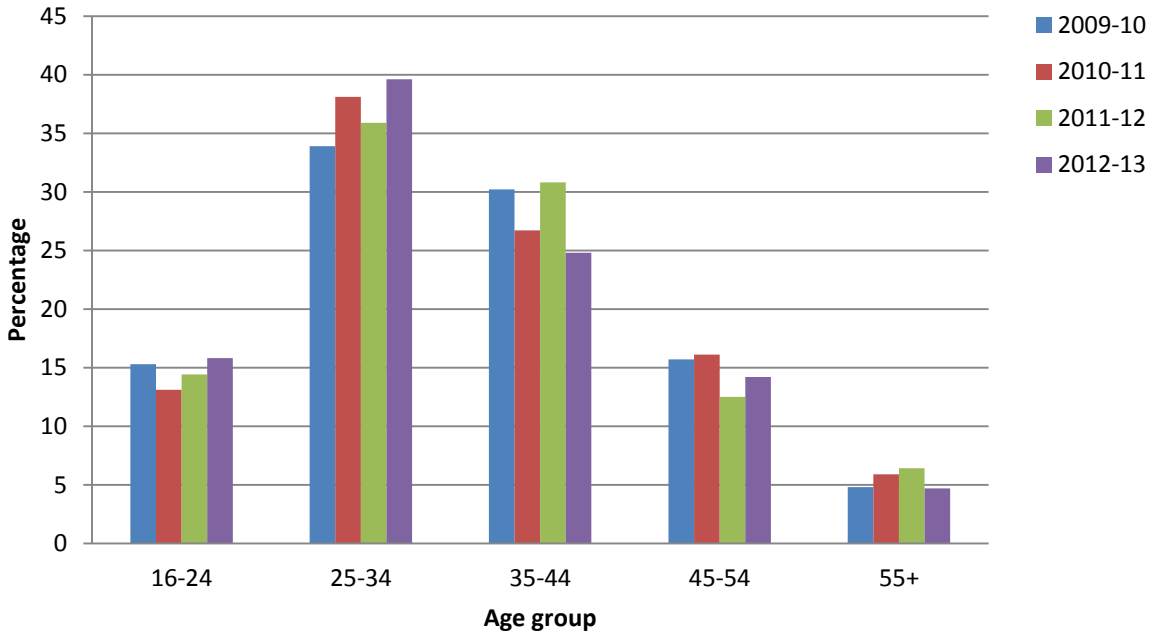
2.2. Ethnicity

The ethnic background of clients referred to the service has remained fairly static across the years. The graph below displays that as in previous the 'White-British' category remains by far the largest ethnic group that the clinic treats at 57.9% this year.



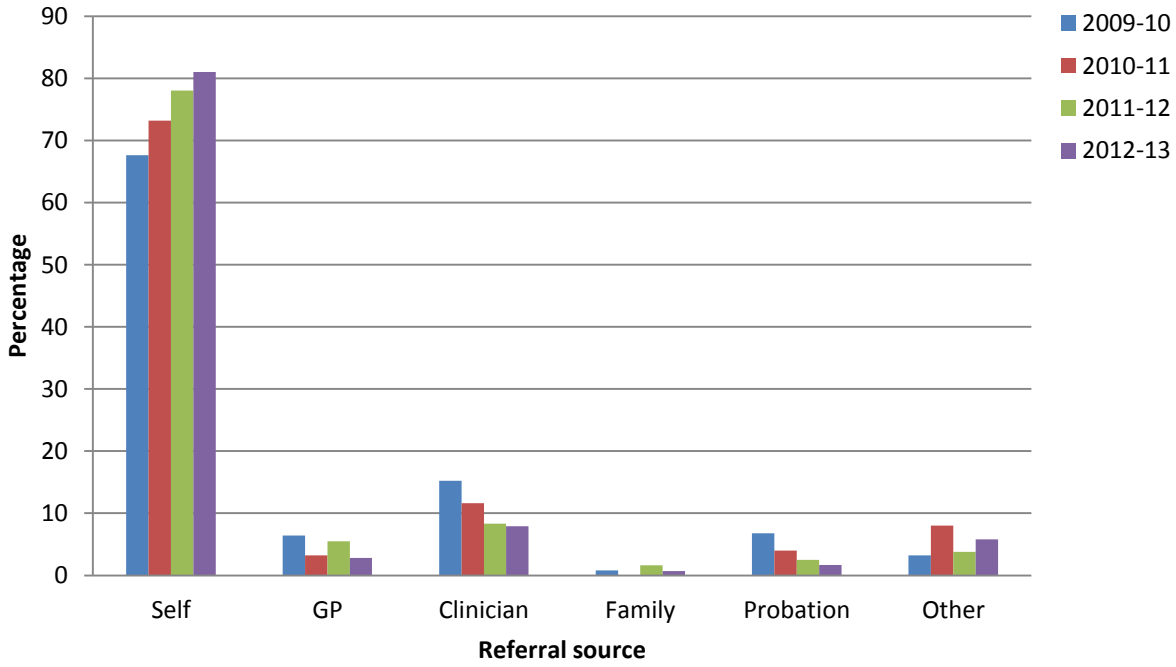
2.3. Age

The average age of clients referred in 2012-13 was 34.9 years. This revealed a slight drop from the average of 36 years seen in the previous year 2011-12. A break-down of the age groupings by years, in the graph below, reveals no consistent trends in the age of those referred. In past years the majority group referring to the clinic have consistently been in the 24-34 and 35-44 age groups and that picture is the same for this year with percentage figures of 39.6% and 24.8% respectively.



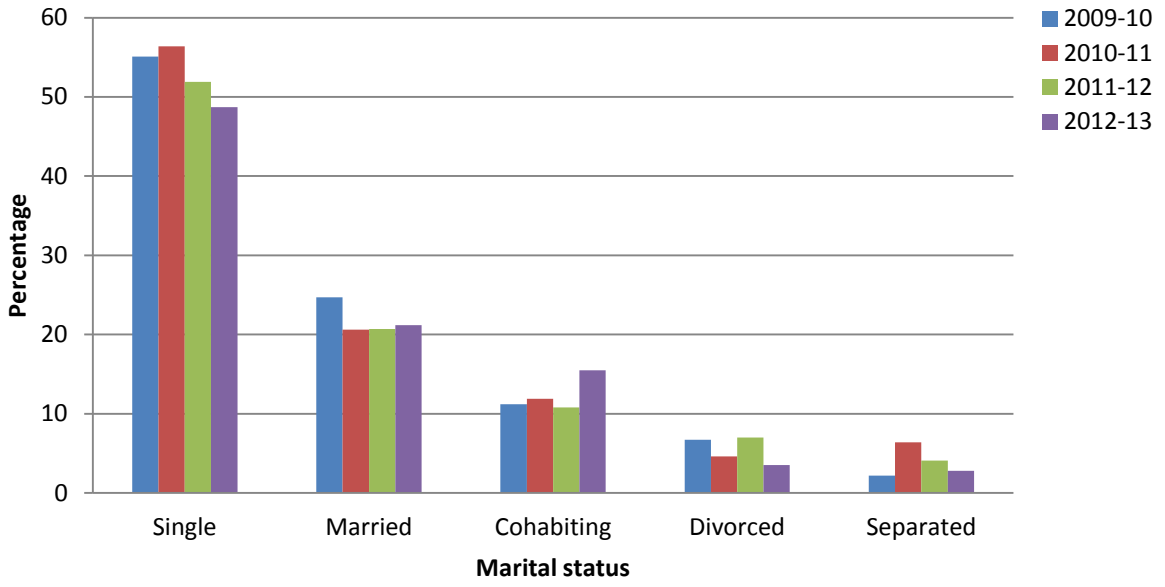
2.3 Source of referral

As in previous years self-referral remains the majority source of referrals at 81% this year, up from 78% in 2011-12. GP referrals also experienced a shortfall, down to 2.8% from 5.5% in 2011-12. The decreasing trend may be explained by the introduction of more evaluation questionnaires on the referral form; GPs and other clinicians may be more inclined to ask individuals to refer themselves. External agencies are required to provide a report, which may also motivate agencies to encourage self-referral. The graph below displays the percentage break-down of referral source in comparison with previous years.



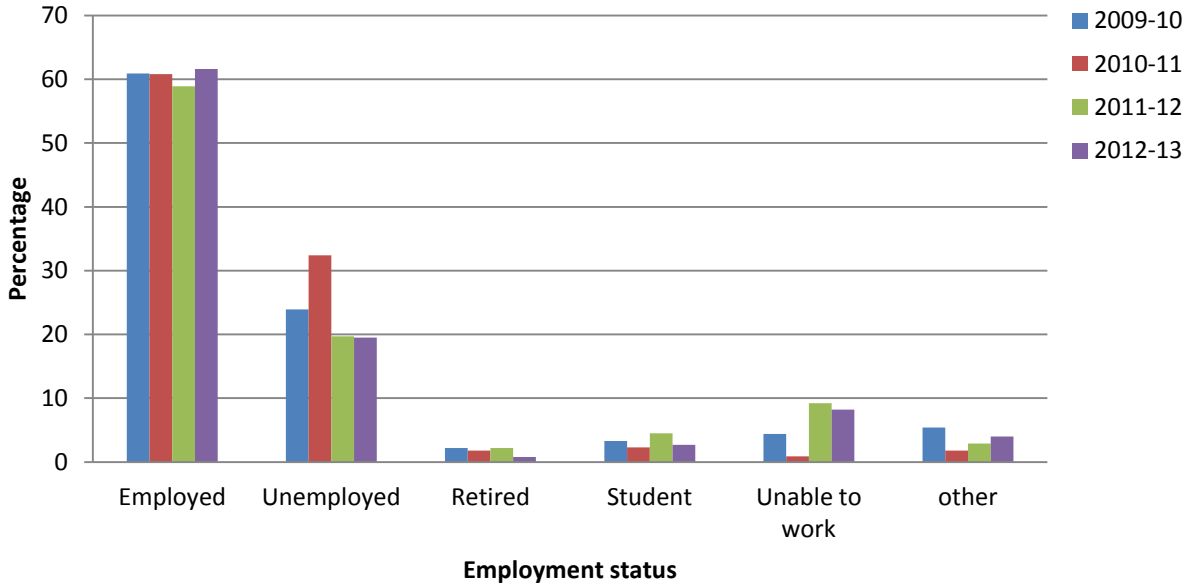
2.4 Marital Status

In the current year the largest marital status group was, as before, 'single, with 48.7% of referrals received. However, this category, along with 'separated', has shown a consistent decline over the past three years with no other sole grouping increasing noticeably. The graph below displays the previous four years percentage marital status data for comparison.



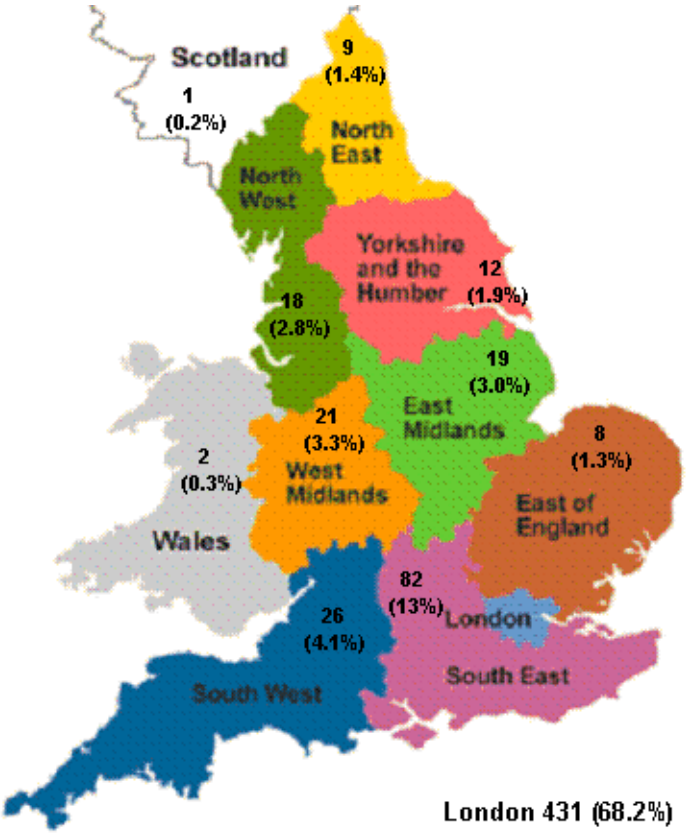
2.6 Employment status

Data on employment status reveals the category of 'Employed' being again the most popular category, at 61.6% in 2012-2013. As the graph below shows there has been little variation in employment status over the past four years. The category 'unable to work' was introduced in 2011, replacing two categories of 'disabled' and 'long-term sick'; it is likely that this category is not directly comparable over the four year period.



2.7 Region

As in previous years referrals for individuals residing in London and the South East dominated with 68.2% and 13% of referrals respectively, leaving a remaining 18.4% (116 referrals) coming from those not within easy reach of the clinic base. The map below indicates the regional location of referrals in the current year 2012-2013.



As the table below shows London and the South East have dominated referrals received in the last four years.

%	2009-10	2010-11	2011-12	2012-13
London	72.2	78.2	64.7	68.6
South East	11.3	16.1	16.3	13.0

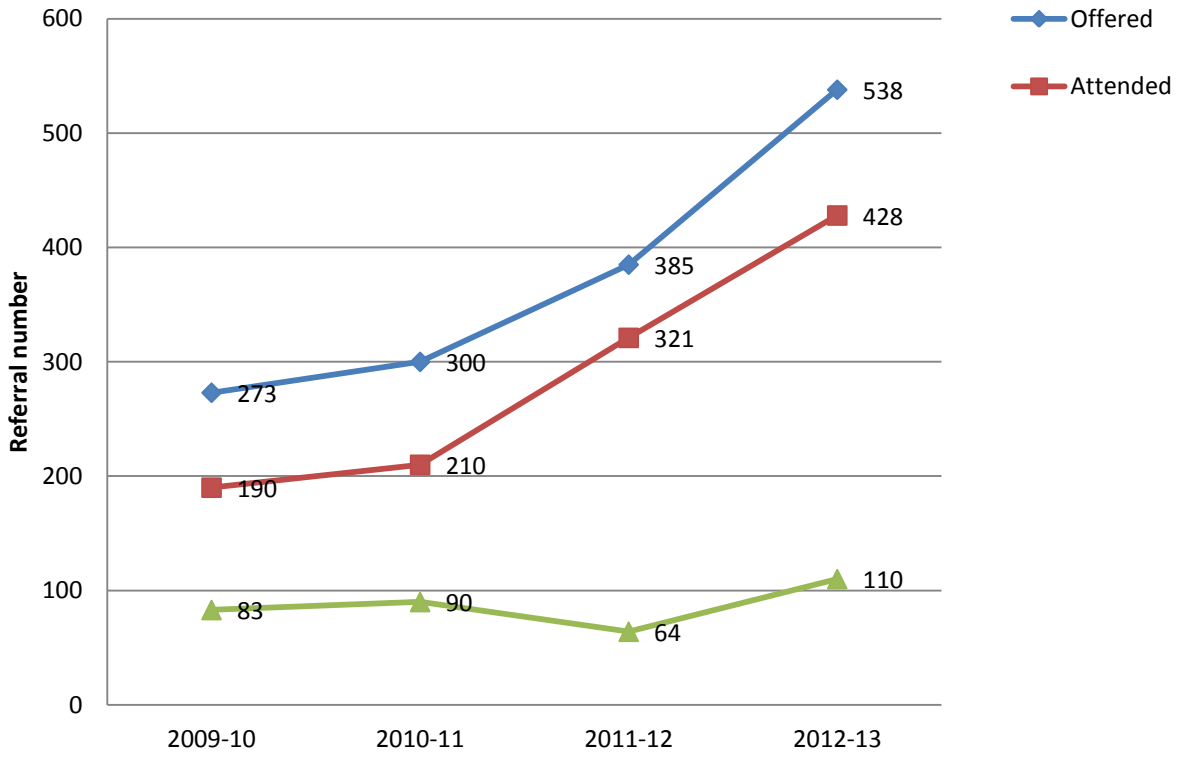
However, there have been regional variations in referrals received, as shown in the graph below. Referrals from Wales have dropped off in the current year; this is predominatly due to the clinic referring people on to the local CBT service which was opened in 2012. Referrals from all other regions have increased over the four year period. (East and West Midlands was collapsed to allow comparison with previous years, and Yorkshire and Humber included in 'North East' figures).


8
6
4
2
0
Percentage
2009-10
2010-11
2011-12
2012-13
South West
East
Midlands
North West
North East
Scotland
Wales
Regions

3. Assessments

3.1 Attendance

The number of initial psychological assessments offered by the service has increased this year by 39.7% over 2011-12. Since the 2009-10 period we have increased capacity for assessments by 97%. As the graph below indicates performance has improved also. In 2009-10 over 30% of referrals did not attend; in the 2012-13 period this figure was down to just over 20%.

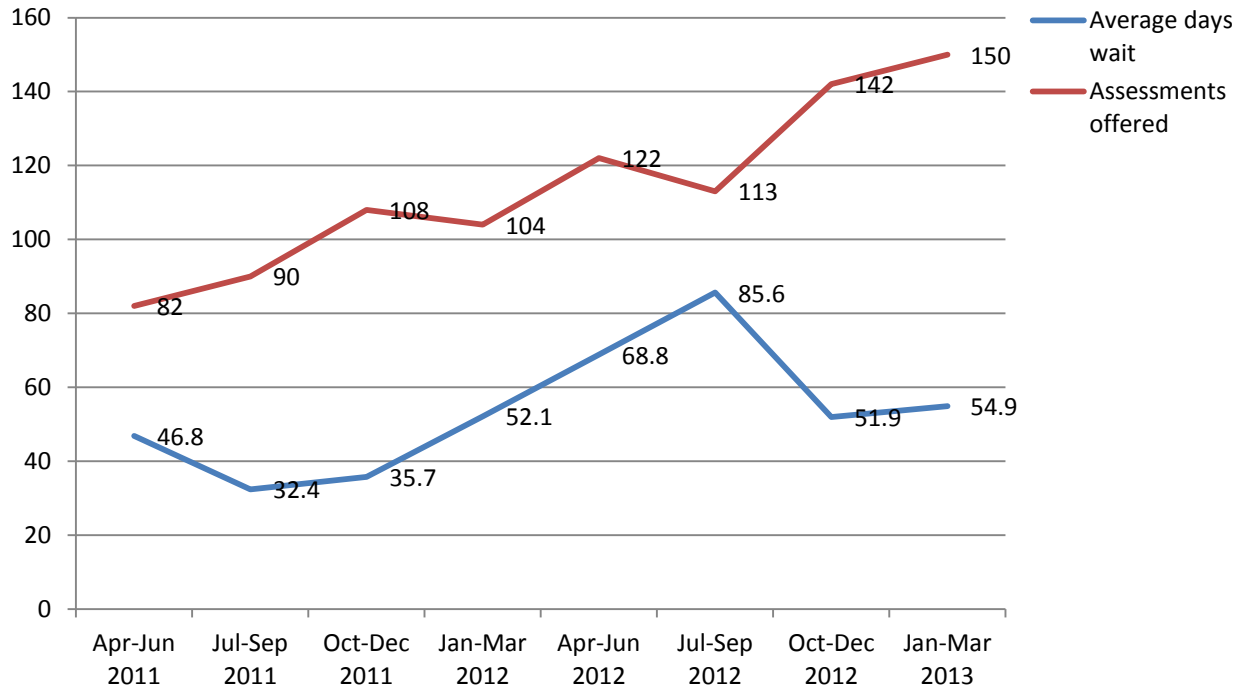


3.2 Wait times for assessment

As might be expected given the increased referral and assessment numbers wait times for assessment have increased from the 51.8 day average in 2011-12 to 63.6 days in the current period. This represents a 22.8% increase in wait times on average. However, in this same period assessments offered have increased by 39.7%, indicating that wating times have not increased in line with increased workload and performance is improving.

It is worth noting also that the last two quarters of this period saw a reduction in wait times, with a mean for the Oct 2012-Mar 2013 six month period being 53.5 days on average. This indicates that the yearly increase in assessment wait times seen in this report were the result of practices that the clinic has identified and succesfully changed during the course of the year.

The graph below displays the wait-times per quarter over the past two years; The red line indicates the number of assessments offered as a comparison to the wait-times. Data was not collected on wait-times in the previous periods.



As can be seen up until July - September 2012 there existed an approximately linear relationship between increased assessments and increased wait-times. Following concern in the clinic regarding wait-times intensive assessments days were provided in September and October to reduce waits. This resulted in decreases in wait-times in those periods, a decrease maintained in the last quarter of the year. Wait times now are at the level last seen in Jan-Mar 2012, when there were 50% fewer assessments being offered.

3.3 Predictors of assessment attendance

From the data collected at the referral stage there were several variables associated with non-attendance. As in previous years lower age of referrals was linked to non attendance (31.7 years x 35.9 years). Non-attendance rates were also higher in those who reported playing bingo and fruit machines in the last 30 days. No other demographic variables or severity variables collected at referral stage differed between those who attended and failed to attend.

3.4. Previous treatments

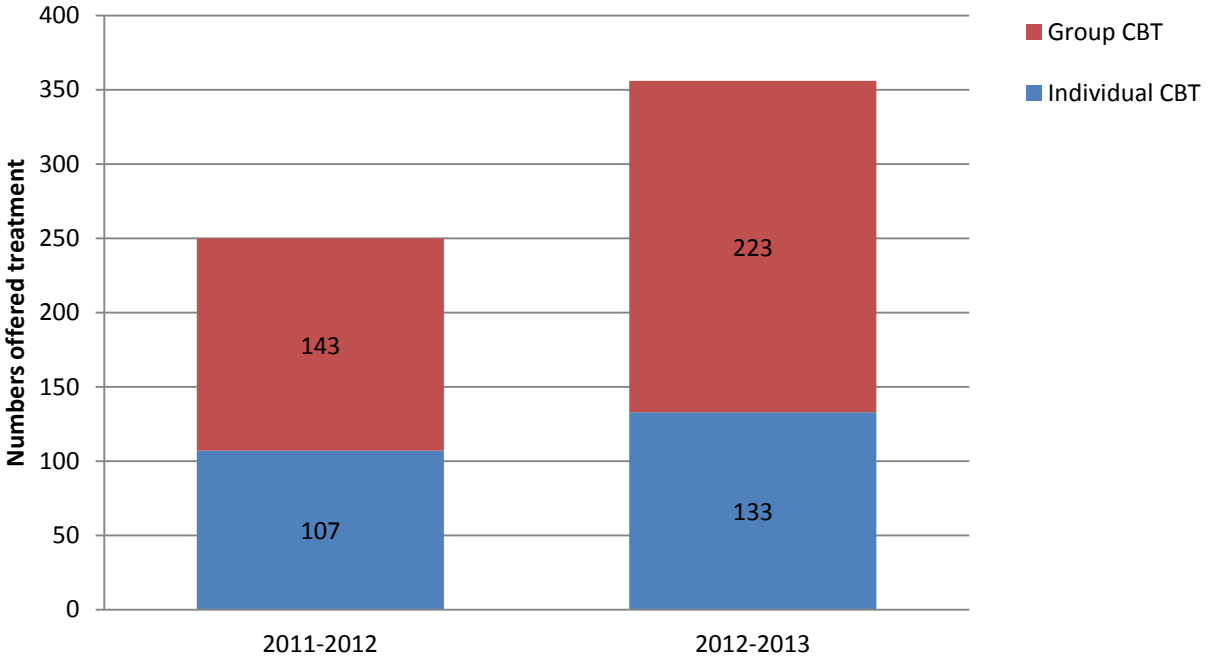
In 2012-2013 62.4% of assessed individuals reported having received any treatment for gambling problems prior to attending the NPGC, an increase from the 60.6% seen in 2011-2012. The table below shows the reported locations of prior treatment – individuals may have attended more than one treatment type.

%	Gamblers Anonymous	Gamcare	Gordon moody Association	Other
2011-2012	50	13.6	5.5	5.5
2012-2013	48.6	18.5	1.8	7.6

4. Psychological treatment episodes

4.1 Number of new treatment cases offered

In the year 2012-2103 new treatment cases for problem gamblers totalled 356. This represents an increase of 42% over the 2011-2012 figure of 250. In the current year 62.6% (223) of treatment cases were assigned to group CBT, compared with 57.2% (143) in 2011-2012, these proportions are displayed in the graph below.



The provision of group CBT has increased by 67% compared with 2011-2012, with individual CBT treatment offers increasing by 33%.

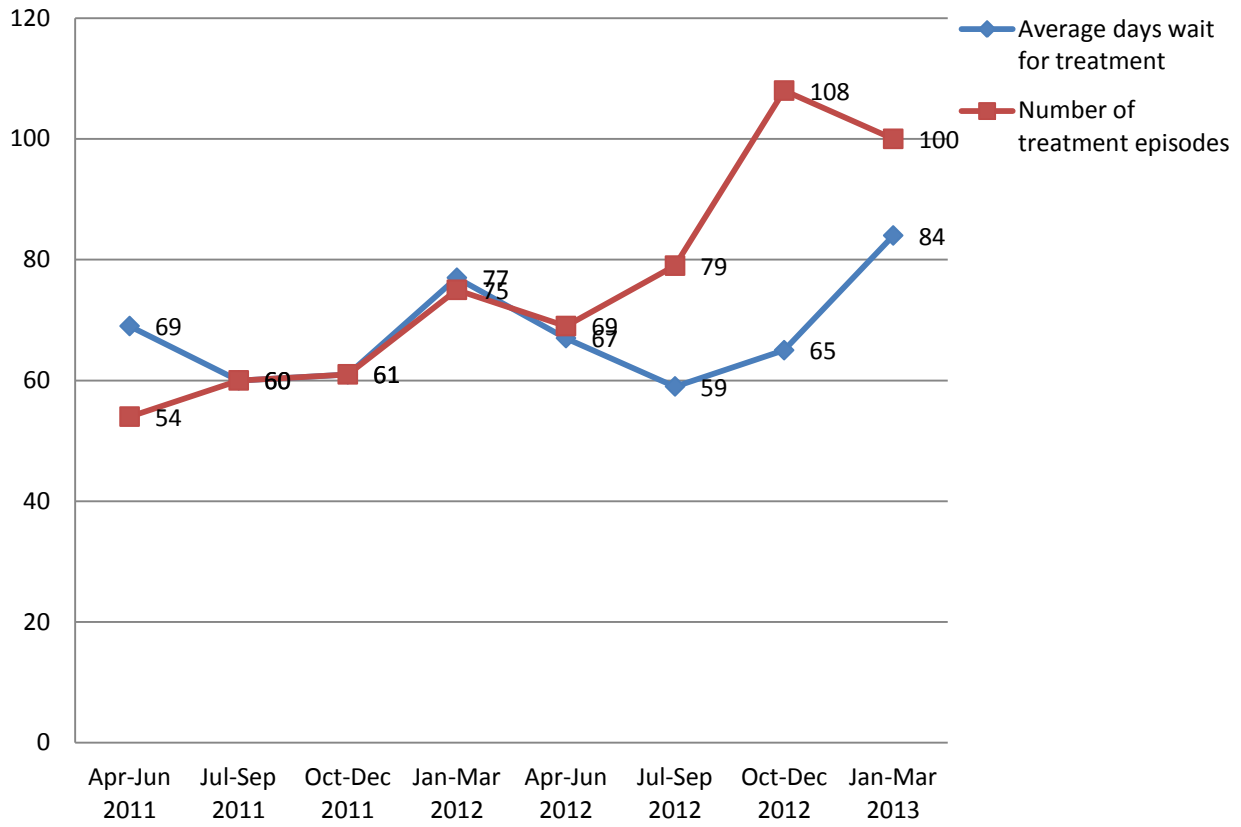
4.2 Wait times for treatment

The average waiting time between the point of assessment and the first treatment contact in 2012-2013 was 70.3 days. This was an increase of 8.5% from the average of 65.7 days seen in 2011-2012. However, the median wait time in days saw a drop of 7 days (2011-12 = 56 days; 2012-2013 = 49 days), suggesting the presence of outliers in the mean data.

Examining wait times for each treatment type, both individual and group CBT, reveals a decrease in wait times for group CBT from 2011-2012 to 2011-2013 and an increase in wait times for individual CBT. This data is displayed in the table below, with median data also included.

Wait times: Mean (median)	**Individual CBT**	**Group CBT**
2011-2012	90.8 (86)	47.2 (42.5)
2012-2013	115 (113)	43.8 (37)

Examining average wait times for treatment in relation to the number of new treament episodes offered reveals increases in performance over the past year. Whilst treatment episodes offered increased by 42%, average wait times increased by only 8.5%, and median wait times actually decreased. The graph below shows the trend in wait times relative to treatment episodes offered by quarter.

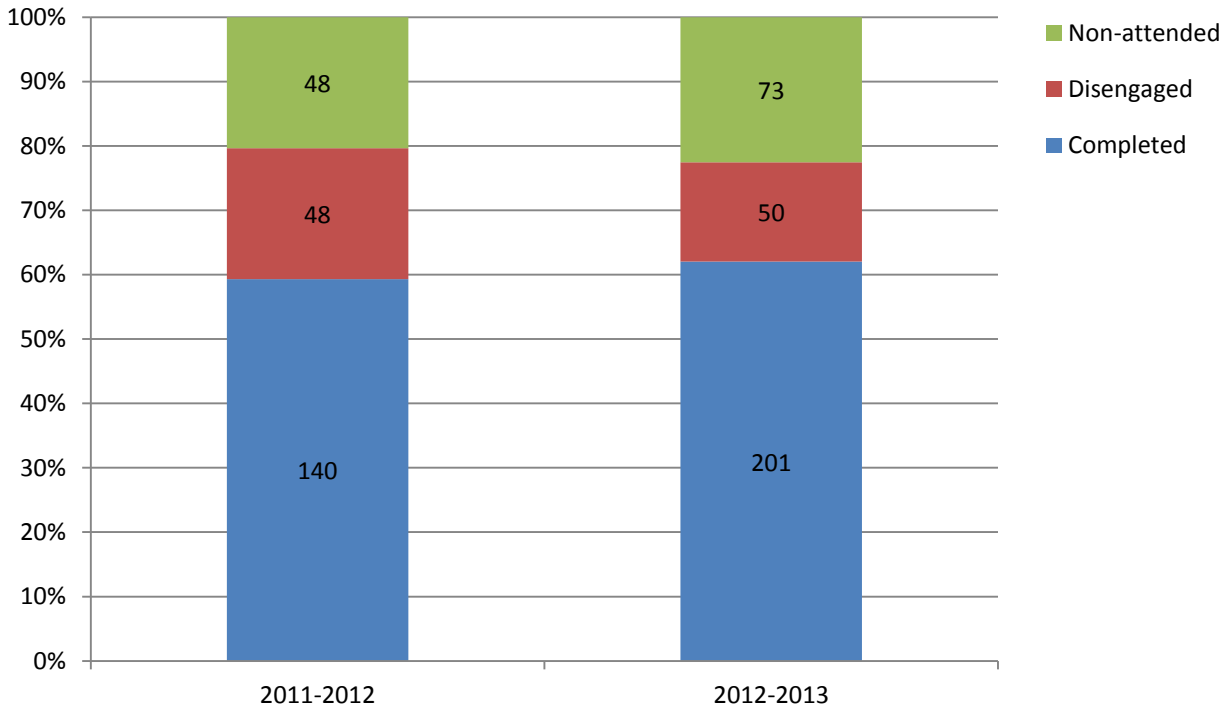


5. Psychological treatment outcomes

5.1 Discharges

The status at point of discharge is the method by which we establish the outcome of each individual treatment episode. A completed treatment episode means completion of the full allocation of sessions, or an agreement between clinician and client that no more sessions are required. This is known as a 'planned' discharge in CNWL addictions performance management reports. The clinic also distinguishes between those who have attended some sessions and then disengaged and those who attended assessment but did not attend any treatment, in both cases without informing us of the reasons why. Both of these categories are termed as 'unplanned' discharges.

In the year 2012-2013 the clinic achieved a figure of 201 planned discharges out of a total of 324 (62.0%); this is an increase of 43.6% over 2011-2012's figure of 140 planned discharges out of 236 (59.3%). The percentage figures reveal a 4.5% uplift in completed treatment episodes in 2012-2013 over the previous year. The graph below shows the completed, disengaged and non-attendance figures as a percentage of total discharges over the past two years.

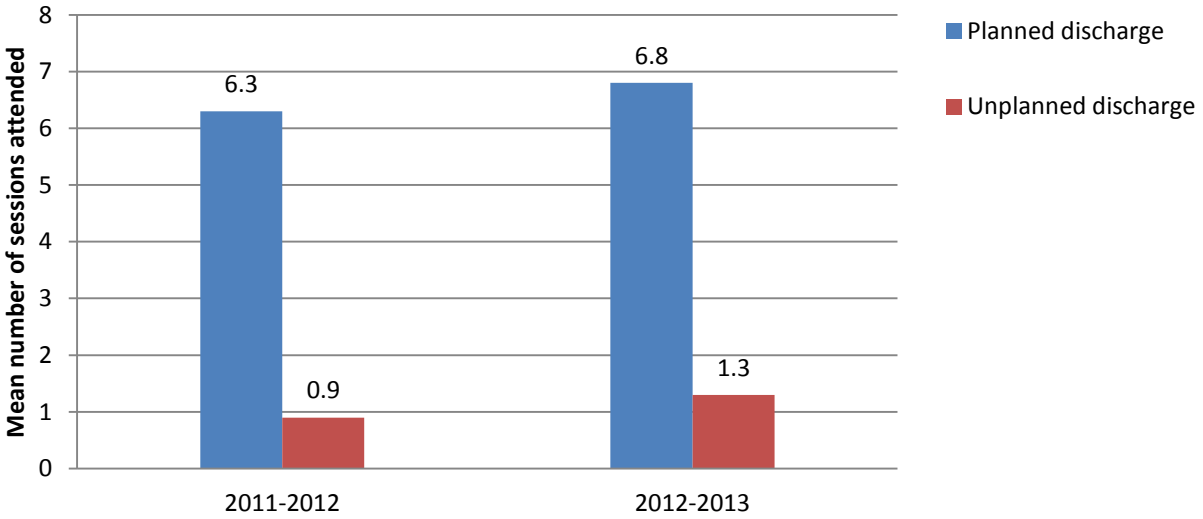


The graph reveals that in the 'unplanned' discharges (non-attended, disengaged) fewer clients in the current year, as a proportion, disengaged once they had commenced treatment but a slightly larger proportion did not attend any treatment sessions when compared with figures from 2011-2012.

5.2 Treatment duration

The mean duration of treatment in days in the year 2012-2013 was 52.7 days (median 49 days). This is a decrease from the 2011-2012 figure of 59.2 days (median 50 days).

The average number of sessions attended during treatement was 4.7 sessions (median 5), compared with 4.2 sessions in 2011-2012 (median 4). Treatment duration in terms of number of sessions is best understood in terms of planned and unplanned discharges, with slightly more sessions being attended on average in both categories in 2012-2013.



5.3 Primary gambling outcomes

Reporting of treatment outcome data in the year end report will take a similar format as that seen in the quarterly reports, with evaluation data from groups at assessment, treatment end and follow-up during the year being compared. Unlike the quarterly reports the follow-up data will be split into measures taken at 3 months and at 6 months, providing four time periods of data collection overall.

Our data reveals that good outcomes are achieved at treatment end, with significant reductions in objective measures of gambling days and amounts spent and subjective concern about gambling ('Troubled').

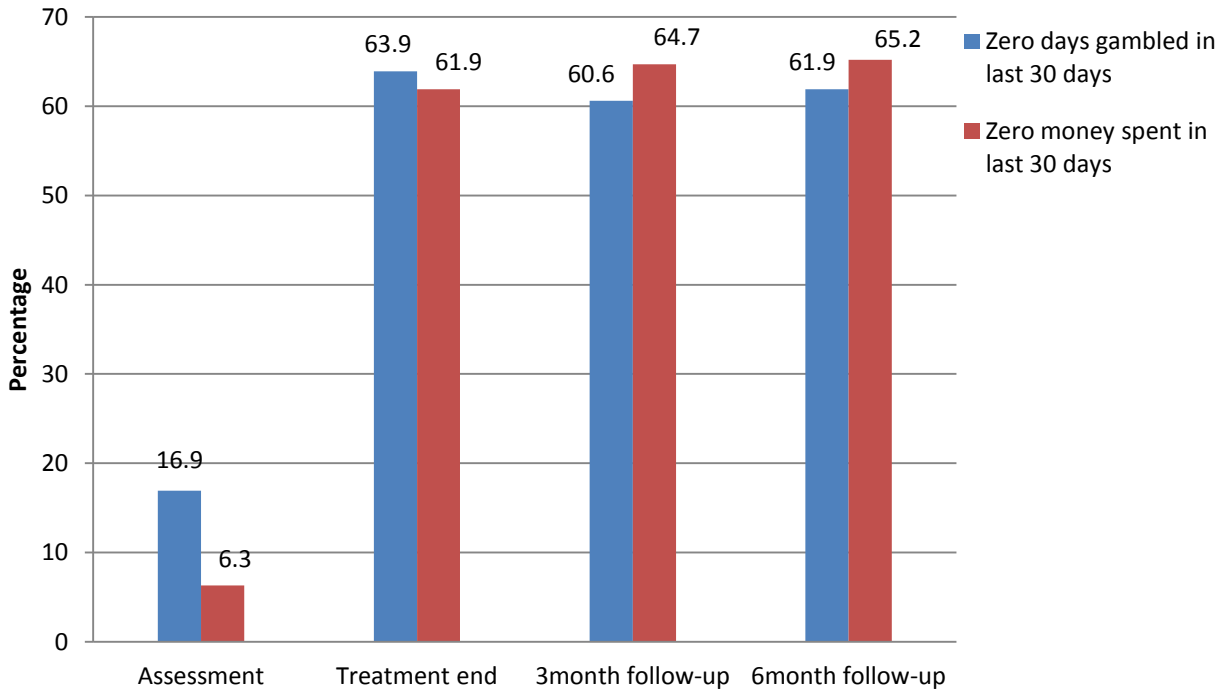
- The average days gambled figure at treatment end is just 20% of the assessment figure.
- Average amounts spent at treatment end stood at just 12% of the sums reportedly spent in the past 30 days at assessment, although the median figure is considered a better measure here due to the effect of outliers on the data.
- Scores on the Problem Gambling Severity Index (PGSI) see reductions, but also reflect the difficulties in utilising a 'past 3 months' screen at treatment end. This has been modified from April 2013 to assess past month only, in line with the other primary gambling measures.
- The majority of gains are maintained at 6 months post-discharge follow-up evaluations, barring days gambled only which sees a small uplift at 6 months.

The Table below displays the data on frequency and intensity of gambling behaviour.

	Baseline Assessment	Treatment end	Follow-up 3months	Follow-up 6 months
Average days gambled in last 30 days				
Mean (median) days	12.3 (10)	2.4 (0)	2.5 (0)	4.1 (0.5)
N	403	122	34	24
Average amount lost in last 30 days				
Mean (median) amount	£2129 (£1000)	£249 (£0)	£340 (£0)	£154 (£0)
N	396	120	33	21
'Troubled' by gambling in last 28 days*				
Considerably / extremely N (%)	274 (66.4)	14 (12.0)	7 (21.9)	2 (8.4)
N	412	117	32	24
Problem Gambling Severity Index (PGSI: 0-27)				
Mean score	19.8	9.9	6.6	4.9
'Caseness' - 8+ N(%)	411 (98.8)	61 (52.1)	13 (39.4)	6 (25.0)
N	416	117	33	24

* *Clients are asked to report how 'troubled or bothered' they are about their gambling on a 5 point scale; the top two categories on that scale are 'Considerably' and 'Extremely' and data for these is presented above.*

Whilst the NPGC does not offer a strictly abstinence based treatment – clients wishing to control gamble are accepted and treated – by far the majority of clients request abstinence. For this reason we would see a successful outcome as being one that achieves abstinence from gambling and maintains it at follow-up. Below are two graphs that represent success rates in these terms, namely those gambling no days and spending no money on gambling at each of the evaluation time points.



If we take this as a measure of 'caseness' then it can be said that we achieve and maintain success at above 60% of individuals who complete treatment, at treatment end and through to 6 months after discharge. This compares well with the 42% seen in the treatment end data from 2011-2012. As further comparison national data for mental health services in England and Wales also suggest a 'no caseness' rate at treatment end of 44%.[1]

5.4 Secondary outcomes

A. Depression & Anxiety

Depression and anxiety rates are high at assessment and far exceed national prevalence figures. The adult psychiatric morbidity survey suggest a figure of 17.6% for prevalence of any mental health condition (The Health & Social Care Information Centre, 2009, Adult psychiatric morbidity in England). As such it is important for us to establish that our treatment also supports reductions in the rates of mental health difficulties seen at assessment.

As with the primary gambling evaluation measures we see big decreases in rates of reported depression and anxiety from assessment through to 6 months post discharge. With the PHQ-9 measured depression there was a small uplift this year at the 6month follow-up, but numbers were small. Ongoing low mood and anxiety would be seen as a significant relapse indicator, so reductions in scores should also be seen as a success indicator in terms of reducing the risk of relapse post discharge.

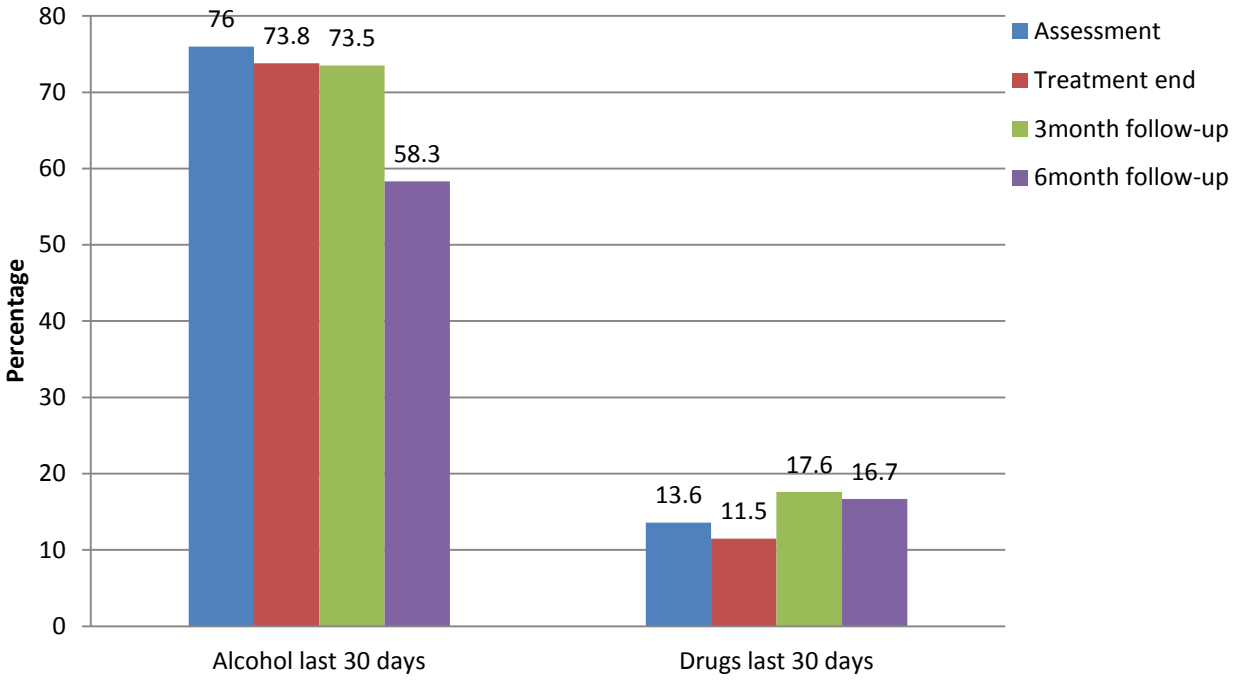
Depression: PHQ-9 (0-27)					
		Baseline Assessment	**Treatment end**	**Follow-up 3months**	**Follow-up 6months**
Caseness - 10+	N (%)	278 (66.6)	7 (5.9)	3 (8.8)	8 (33.3)
N		417	119	34	24

Anxiety: GAD-7 (0-21)					
		Baseline Assessment	**Treatment end**	**Follow-up 3months**	**Follow-up 6months**
Caseness - 10+	N (%)	219 (52.7)	11 (9.2)	7 (20.6)	4 (16.7)
N		415	119	34	24

B. Substance use

Substance use data is also collected by the clinic. It is considered important to understand changes in substance misuse as individual's progress through treatment. The graph below shows rates of alcohol and drug use in the populations assessed and changes in use patterns through treatment stages.

[1] NHS Health and Social Care Information Centre: IAPT Q3 KPI data, accessed from http://www.hscic.gov.uk/catalogue/PUB10442.



Prevalence rates for alcohol compare favourably with national estimates of alcohol use (87%; Adult Psychiatric Morbidity Survey 2009). It is reasonably clear that our treatment has little effect on rates of alcohol and substance misuse. However, it is also clear that problem gamblers who attend treatment at the NPGC do not switch to substance misuse on the cessation of their gambling habits.

C. Satisfaction with treatment

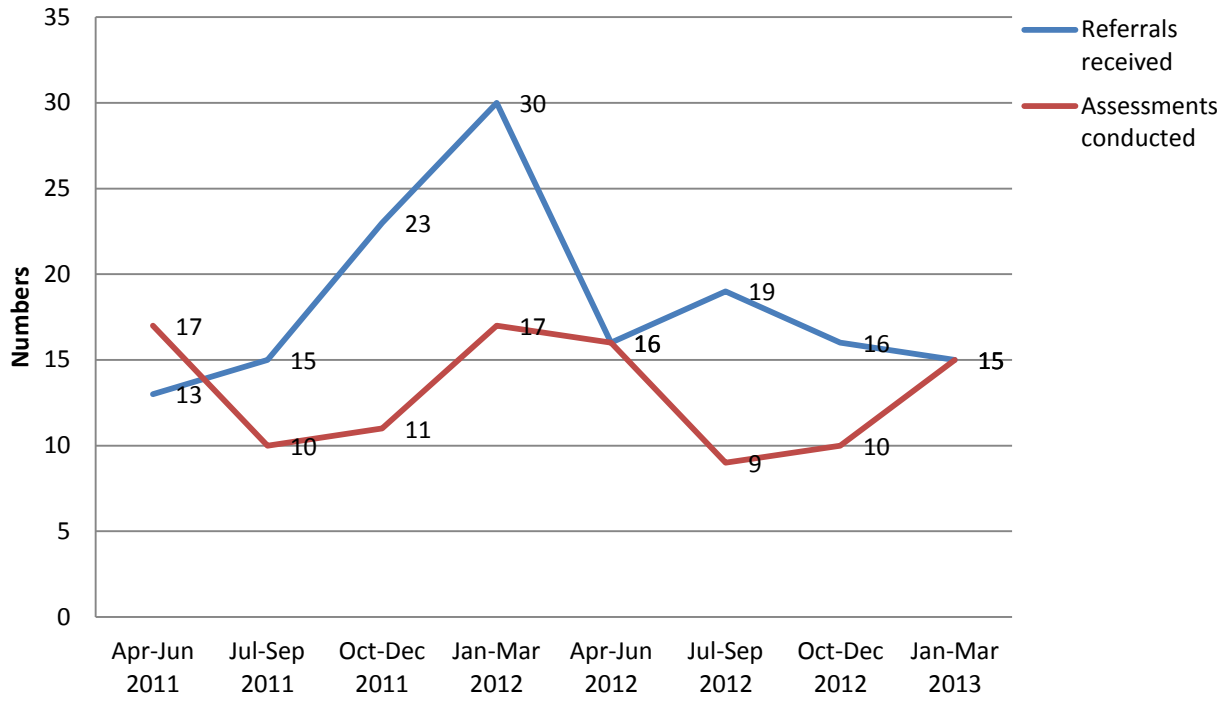
As noted in earlier quarterly reports the satisfaction measured changed in 2013 from a single question to a 5-item version of the Satisfaction with Therapy and Therapist Scale (Oei & Shuttlewood, 1999). The single item questionnaire revealed that 96.9% of clients were 'satisfied' or 'very satisfied' with their treatment at the final session (N=32). The results for the 5-item satisfaction scale are displayed below

Secondary outcomes: Satisfaction with therapy					
N = 34 (%)	**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
I am satisfied with the quality of the therapy I received	0	0	0	12 (35.3)	22 (64.7)
My needs were met by the programme	0	0	3 (8.8)	18 (52.9)	13 (38.2)
I would recommend the programme to a friend	0	0	0	11 (33.3)	22 (66.7)
I would return to the clinic if I needed help	0	1 (2.9)	1 (2.9)	13 (38.2)	19 (55.9)
I am now able to deal more effectively with my problems	0	0	3 (8.8)	13 (38.2)	18 (52.9)

Of the 34 responses received to date to the five questions, over 95% were in the 'Agree' or 'Strongly Agree' categories.

C. Family and carers support

Referrals to the family therapy service at the clinic were 66 in 2012-2013; this represents a reduction of 18.5% on the 2011-2012 totals of 81 referrals. Assessments conducted with families and carers totalled 50, a reduction of 9% on the figure of 55 seen in 2011-2012. The graph below represents the referrals received and assessments conducted by quarter since April 2011.



Attendance at the monthly psycho-educational Relative Connections group has remained strong at 78 attendees, representing a slight decline from the 82 seen in 2011-2012.

Reductions in activity in the family and carers work were expected given the loss of our single family psychotherapist to maternity leave half way through the year. However, the service managed resources so that the same level of support was available to family members and carers of problem gamblers.

D. Money Advice Service

In the year 2012-2013 money advice appointments were offered to 38 individuals. This is a decline from the figure of 77 seen in 2011-2012 and was expected given that the service provider, the Money Advice Service, halved the number of sessions offered to the clinic in this financial year. Of those appointments offered 60.5% were attended, closely mirroring the 'planned discharges' figure for treatment offers, and exceeding the 53% attendance seen in 2011-2012.

E. Targeted services

1. Women

A. Background

As noted above female problem gamblers have been poorly represented in the population attending the NPGC. For this reason a specific women's service was established at the start of 2012 with a separate pathway and treatment package. Initially, this package involved brief individual sessions with a psychologist prior to attendance at a rolling women's support group. Following poor attendance at this group a second group programme was established, more similar to that seen in the general treatment population at the NPGC, with a closed nine-session group run for women by female psychologists.

B. Referrals

As noted above referrals of females to the NPGC did not increase in the current year; this figure has remained static at around 7-8% since 2009.

Analysis of the demographic profiles reveals some interesting disparities. The females referring were, when compared to male clients, more likely to be:

- Older - 39.8 years vs. 34.5 years on average
- Of Asian ethnicity - 14.9% vs. 10.2%
- Divorced, separated or widowed – 15.1% vs. 6.9%
- Permanently unable to work – 23.9% vs. 7.2%
- Referred by a clinician or GP – 17.1% vs. 8.7%

The last two criteria here are suggesting that we are seeing a more severe client grouping, although no differences in severity of gambling or mood were detected between males and females on the referral form.

C. Assessments

47 Females were offered assessments in the year 2012-2013. Females who had referred were less likely to attend an offered assessment appointment (69.4%) compared with males (80.6%). The picture of a more severe group is continued when analysing the data from the assessment. As assessment females were more likely than men to:

- Rate themselves as 'extremely' bothered by their gambling – 80.6% vs. 56.2%
- Score in the 'severe' range for depression on the PHQ-9 – 45.2% vs. 19.4%
- Score in the 'severe' range for anxiety on the GAD-7 – 38.7% vs. 24.4%
- Be gambling frequently in last 30 days – 15.9 days vs. 12.1 days
- Have higher PGSI scores – 22.2 vs. 19.6

D. Outcomes

Females who attended assessment and were referred onto treatment were much less likely to result in a 'planned' discharge than men – 40% vs. 63.8% (N=30). Of note, 'planned' discharges were marginally higher with individual CBT than with group CBT – 41.7% for individual vs. 38.9% for group.

E. Summary

The clinic has over the past year established a specific pathway and intervention for female problem gamblers. Clearly, the difficulties inherent in advertising such a service in the media have been a major impediment to increased referrals. The initial group in early 2012 was also prefaced by a mailshot campaign to women's support services in the London area, including literature and posters. Although the numbers are currently small a picture is emerging of a population that differs in some ways to the male population, with the suggestion of a degree of increased severity. However, severity in male populations does not impact on assessment attendance or outcome. Over the next year we will retain a focus on specific services for women; as our data suggests a gender imbalance we are obliged under the Equalities act to continue to make efforts to redress this.

2. Black and minority ethnic gamblers

The clinic has amended its practice with regard to some BME clients, creating a separate pathway. It was considered that individuals who were unable to attend group CBT treatment for cultural or linguistic reasons were being required to wait longer for treatment. This is indirect discrimination. For this reason the clinic has now established a 'priority equalities' waiting list for individual CBT treatment for problem gambling for individuals who for equalities reasons are unable to attend the group programme. This wait time must not exceed the time that individuals would wait for group treatment, between 6 and 8 weeks post assessment.

The clinic has met with local groups to explore establishing a co-worked group for individuals of Chinese ethnicity. Unfortunately, differences in treatment approach have prevented this project from going forward at the time of writing. The clinic has taken on a Cantonese speaking psychologist, who has been able to work individually with Cantonese speaking clients. We shall explore further in the coming year projects with local community services for individuals of Chinese ethnicity to establish if support is required and welcomed locally for our service.

3. Young people

As noted above the data reveals an age discrepancy in attendance at assessments following referral. These discrepancies continue into treatment outcomes with lower rates of planned discharges in the 16-24 age grouping - 43.8% compared 65.2% for those aged 25 and over.

A. Non-attendance at assessment

In the 16-24 age group non-attendance at age group was associated with a single variable collected at the time of referral - higher scores on anxiety and depression measures (GAD2+PHQ2 – 9.3 in non-attenders vs.

7.8 in attenders). No other variables, including wait time were significantly different between those who did and did not attend.

B. Non-attendance at treatment

In the 16-24 age group there were no variables collected at assessment or referral that were significantly different between treatment episodes that ended in a planned or unplanned manner. Waiting times were no different also.

The gambling clinic has been operating a pathway in previous years whereby younger individuals were directed to individual treatment rather than group treatment. This was due to the sense that groups were predominantly populated by males in their 30's and 40's and younger clients appeared quieter and less involved in sessions. However, this entailed a longer wait for treatment and younger people were invited to groups if the team considered they responded favourably to the idea and appeared, at assessment, to be sufficiently mature and confident to engage in such work. Over the past year there was an equal split between those young people assigned to group or individual treatment; analysis of the outcome of treatment suggests a slightly higher successful outcome in terms of the planned discharge rate in those assigned to group over individual (47.8% vs. 43.5%).

D. Summary

The current strategy of having a different pathway into treatment for younger people, assigning them to individual CBT treatment over group, has been shown to have operational difficulties and poor outcomes. Operationally, increased waits due to age may be discriminatory. Outcomes reveal greater retention rates in group treatment. As a clinic we now need to rethink our approach to young people and this will most likely start with a survey, specifically designed for younger clients, that seeks to examine their reasons for non-attendance and collects ideas on how we can improve retention rates.