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Collecting behavioural addiction treatment data using Freedom of Information requests

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Contributors' biographies

Dr. Mark Griffiths is a Chartered Psychologist and Professor of Gambling Studies at the Nottingham Trent University, and Director of the International Gaming Research Unit. He has spent over 25 years in the field is internationally known for his work into gaming and gambling. He has published over 430 refereed research papers, three books, 100+ book chapters, and over 1000 other articles. He has served on numerous national and international committees and gambling charities (e.g. National Chair of GamCare, Society for the Study of Gambling, Gamblers Anonymous General Services Board, National Council on Gambling etc.). He has won 13 national and international awards for his work including the John Rosecrance Prize (1994), CELEJ Prize (1998), Joseph Lister Prize (2004) and the US National Council on Problem Gambling Research Award (2009). He also does a lot of freelance journalism and has

appeared on over 2500 radio and television programmes. Dr Griffiths is an active blogger including his personal blog (<http://drmarkgriffiths.wordpress.com>) and one for Psychology Today (<http://www.psychologytoday.com/experts/dr-mark-d-griffiths-phd>).

Manpreet Dhuffar is completing her PhD at Brunel University and is an accredited Cognitive Behavioural and Sex Addiction Therapist with clinical experience in public and private sectors treating a range of mental health disorders and behavioural addictions. She has been commended for her innovative approach to cognitive behavioural research, and has been acknowledged by the BPS as a ‘Psychologist at 25’.

Relevant disciplines

Psychology (and social sciences more generally)

Academic level

Advanced undergraduate, Postgraduate

Methods used

Archival (Freedom of Information request) data; Quantitative research design;

Quantitative data collection; Qualitative data collection

Keywords

Freedom of Information Requests; Behavioural addiction treatment; Archival data collection; [British] National Health Service

Links to the research output

Rigbye, J. & Griffiths, M.D. (2011). Problem gambling treatment within the British National Health Service. *International Journal of Mental Health and Addiction*, 9, 276-281.

Griffiths, M.D. & Dhuffar, M. (2014). Treatment of sexual addiction within the British National Health Service. *International Journal of Mental Health and Addiction*, DOI 10.1007/s11469-014-9485-2.

Abstract

There is now a growing movement that views a number of behaviours as potentially addictive including many that do not involve the ingestion of a drug (i.e., behavioural addictions such as gambling addiction and sex addiction). As a consequence of being ‘medicalised’ and ‘pathologised’, such disorders have led individuals to seek treatment for their particular behavioural addiction. This case study examines a new method of collecting data on behavioural addiction treatment via the use of Freedom of Information (FOI) requests. More specifically, this case study briefly overviews two published studies that have used FOI requests to collate data on treatment of gambling addiction and sex addiction within the British National Health Service. It is argued that FOI requests for data have many advantages including almost 100% response rates (as organisations are legally required to respond to information requests), and nationally representative data that are highly objective.

Learning Outcomes

This case provides an overview of collecting data on the treatment of behavioural addiction within the British National Health Service and is designed:

- To give researchers an understanding of the methodological issues concerned when collecting data using Freedom of Information [FOI] requests.
- To give researchers a brief overview of the Freedom of Information Act in the UK and factors to take into account when making FOI requests for research purposes.
- To provide some specific examples (i.e., published research studies) of how FOI requests can and has been used to collect data.
- To understand the advantages and disadvantages of using FOI requests as a method of data collection.

Introduction

There is now a growing movement that views a number of behaviours as potentially addictive including many that do not involve the ingestion of a drug (such as addictions to gambling, sex, exercise, videogame playing and Internet use) (Griffiths, 2005a). As a consequence of being ‘medicalised’ and ‘pathologised’, such disorders have led individuals to seek treatment for their particular behavioural addiction. At present, there are numerous different methods that can be used to collect data about behavioural addiction and its treatment. However, this case study briefly examines a new method of data collection (i.e., using Freedom of Information [FOI] requests) that have been used in the last few years by the authors to collect data on whether such addictions are being treated within the British National Health Service. This case study briefly reviews two studies that used the method and briefly outlines the advantages, disadvantages, and uses.

Behavioural addiction treatment

The intervention and treatment options for the treatment of chemical and behavioural addiction include – but are not limited to – counselling and psychotherapies, behavioural therapies, cognitive-behavioural therapies, self-help therapies, pharmacotherapies, residential therapies, minimal interventions, and combinations of these, i.e., multi-modal treatment packages (Griffiths, 2009). There is also a very recent move towards surfing the Internet as a route for guidance, counselling and treatment (Griffiths & Cooper, 2003; Griffiths, 2005b; Griffiths, 2010a).

Treatment and support is provided from a range of different people (with and without formal medical qualifications), including specialist addiction nurses, counsellors, medics, psychologists, and psychiatrists. There are also websites and helplines to access information or discuss addiction problems anonymously, and local support groups where addicts meet other people with similar experiences (e.g., Alcoholics Anonymous, Gamblers Anonymous). Support is also available for friends and family members of addicts (e.g., Al Anon, Gam Anon). Many private and charitable organisations provide support and advice for people with addiction problems. Some focus exclusively on the help, counselling and treatment of a specific addiction (e.g., Narcotics Anonymous, Overeaters Anonymous), while others also work to address addictive behaviours across the spectrum. The method and style of treatment varies between providers and can range from comprehensive holistic approaches to treating the addiction (e.g., encouraging fitness, nutrition, alternative therapies and religious counselling), to an abstinence-based approach. Many providers also encourage patients (and sometimes friends and families) to join support groups while others offer confidential one-to-one counselling and advice.

Although there is a wide range of treatment options available for the treatment of addictive behaviours in the UK, many people's 'first port of call' is the National Health Service (NHS) because it is free at the point of delivery to every British citizen. Most NHS treatment programs focus on more traditional addictions (i.e., addictions to alcohol, nicotine, and various illicit drugs such as heroin). However, the NHS is increasingly being used to treat non-traditional (behavioural) addictions such as addictions to gambling and sex. One novel way that can be used to gain data about these non-traditional forms of addiction treatment is through the use of FOI requests.

Freedom of Information requests: A brief overview

In the United Kingdom, the Freedom of Information [FOI] Act 2000 is an Act of [British] Parliament that provides a public 'right of access' to information held by any public authority (e.g., government departments, local councils, health trusts, hospitals, educational establishments, the police, etc.). On January 1, 2005, the full provisions of the act came into force. On receipt of a FOI request, a public authority has two legal duties: (i) a duty to inform the person making the request whether or not it holds the information requested, and (ii) if it does hold that information, to communicate it to the person making that request.

Anyone can request information under the FOI Act irrespective of age, nationality, and where the person lives. There is no set format for anyone making a request and individuals do not need to make reference to the Act when making an FOI request.

Anyone can contact an organisation directly by letter, email, social media or verbally to make an FOI request. When making a request, the requesting person should include their name, contact address, and a description of the recorded information that is wanted (the more detailed the better). Furthermore, anyone requesting information

does not have to give reasons for their request.

Most FOI requests are free but in some cases the person asking for information might be asked to pay a small amount of money (e.g., photocopying, postage). Anyone requesting the information should receive the information asked for within 20 working days unless the organization provides a good reason as to why they cannot supply the information in the legally prescribed time period. Depending on the nature of the FOI request, the person can ask for all the information or just a summary. Information can be provided in a format of the requester's choosing (e.g., paper copies, electronic copies, audio formats) but may incur a charge depending upon amount and information format. Some information that a person requests may be deemed 'sensitive' and be unavailable to the general public. If this is the case, the organization has to tell the requesting individual why information has been withheld. Information requests may also be denied by the organization if the cost of collating the information exceeds £450. (Please note that all information in this section was taken from the UK GOV [website UK Government, 2013] on how to make an FOI request).

Studies using Freedom of Information requests to collect data on behavioural addiction treatment

To our knowledge, only two studies have ever been published that have used FOI requests to collate data relating to behavioural addiction treatment within the British NHS. The first was by Rigbye and Griffiths (2011) and examined the NHS treatment of gambling addiction. The second was by Griffiths and Dhuffar (2014) and examined NHS treatment of sex addiction. These will be briefly described.

NHS treatment of gambling addiction (Rigbye & Griffiths, 2011): Traditionally, problem gambling has not been viewed as a public health matter (Griffiths, 2007). Less than 1% of people in Great Britain have a gambling problem according to the most recent British Gambling Prevalence Survey (BGPS; Wardle, Moody, Spence, et al, 2011). The social and health costs of problem gambling can be large on both an individual and societal level. Personal costs can include irritability, extreme moodiness, problems with personal relationships (including divorce), absenteeism from work, family neglect, and bankruptcy. There can be adverse health consequences for both the gambler and their partner including depression, insomnia, intestinal disorders, migraines, and other stress-related disorders (Griffiths, 2007).

In the UK, a small number of private and charitable organisations provide support and advice for people with gambling problems. A few of these focus exclusively on the help, counselling and treatment of problem gambling. This includes approximately 180 chapters of Gamblers Anonymous, the charity *GamCare* that currently runs a national telephone helpline and also has a face-to-face counselling service, and *Gordon Moody Association* that has two residential treatment centres. There are also a few addiction treatment centres that primarily cater for alcohol and drug abuse (e.g., *Aquarius, Addiction Recovery Foundation, Connexions Direct, Priory*) but occasionally treat problem gamblers.

In 2006, the *British Medical Association (BMA)* commissioned a review on the issue of problem gambling and in 2007 they published their report *Gambling addiction and its treatment within the National Health Service* (Griffiths, 2007). The report noted that there were almost no treatment services available for problem gamblers within the NHS and that problem gamblers should be treated on the NHS just like other

addictions. Thirty months after the publication of the *BMA* report on problem gambling, Rigbye and Griffiths (2011) empirically assessed what gambling treatment services were being provided within the NHS for those with gambling problems.

In August 2009, 327 letters were sent to all Primary Care Trusts, Foundation Trusts and Mental Health Trusts in the UK requesting information about problem gambling service provision and past year treatment of gambling problems within their Trust using an FOI request. The data request was comprehensive and covered aspects of treatment provision including: (i) types of services offering problem gambling treatment; (ii) number and job title of qualified mental health professionals within each service who offer treatment for gambling problems; (iii) number of problem gambling specialists within the Trust; and (iv) lower age limit for referral to service. Also covered in the request for information was specific referral data for any individuals that had been referred for treatment of a gambling problem within each trust (by the end of July 2009) including: (i) number of referrals where problem gambling was the primary reason for referral; (ii) age of referrals; (iii) gender of referrals; (iv) type of treatment offered; (v) number of problem gamblers who attended first appointment; (vi) number of problem gamblers who never attended; (vii) number of problem gamblers who completed treatment; (viii) number of problem gamblers who dropped out of treatment part way through; and (ix) the number of problem gamblers who were still in treatment. All but two Trusts replied within the 20 day period.

Results showed that 97% of the Trusts (318 of the 327 responses) did not provide any service (specialist or otherwise) for treating those with gambling problems and/or that no referrals had been made to the Trust for anyone with a gambling problem in the

previous 12 months. Only one Trust offered dedicated specialist help for problem gambling. Some responses indicated that individuals with gambling problems would not be referred because problem gambling was not classed as a mental health problem. In some cases, the possibility of co-morbid treatment was identified. However, in these cases it was noted that problem gambling would not be recorded as the primary reason for referral to the service. Seven Trusts (2%) reported that they did not provide specialist problem gambling services, but did provide information about third party services to which people with gambling problems could be directed. Only one NHS Trust identified a specialist service for those with problem gambling.

The data obtained in this study highlights a number of issues. Although one specialist service has been set up since the publication of the *BMA* report in 2007, it would appear that the majority of problem gamblers in Great Britain are still unable to receive localised care for gambling problems within the NHS. Although the specialist service identified accepts referrals from anyone in the UK and endeavours to work with local support agencies for those affected by problem gambling, this does not fulfil the recommendations made by the 2007 *BMA* report that suggested that problem gambling, treatment services need to be available and accessible within the locality. There was some evidence that problem gamblers may get treatment via the NHS if that person has other co-morbid disorders as the primary referral problem (e.g., alcohol or drug addiction, other mental health problems, etc.).

NHS treatment of sex addiction (Griffiths & Dhuffar, 2014): Like gambling addiction, sex addiction has not been viewed as a public health matter. However, unlike problem gambling, there has never been a nationally representative study examining sex addiction in the UK so the prevalence of such a disorder is currently

unknown. In the UK, specific types of interventions offered for sexual addictions have been identified by the *Association for the Treatment of Sex Addiction (ATSAC)* who are a UK-based sexual addiction association and includes: psychosexual counselling, psychotherapy, cognitive-behavioural therapy, integrative cognitive-behavioural therapy closed-group therapy, SMART Recovery, Sex Addicts Anonymous (and similar groups such as Sexaholics Anonymous and Sex and Love Addicts Anonymous), internet-based services (e.g., online cognitive-behavioural therapy), and pharmacotherapy (e.g., anti-depressants).

Up until 15 years ago, there was only one (private) treatment service that provided treatment for problematic sexual addiction in Great Britain (i.e., The Marylebone Centre, London). *Relate UK* also offers psychosexual therapy for individuals or couples that are trying to overcome sexual addiction. Such services indicate that there is a clinical need for sexual addiction treatment although the number of people that require such services is unknown. Since sexual addiction and hypersexual disorder are not in either the DSM-V or the ICD-10, it is arguable that they remain generally unacknowledged within the infrastructure of the British NHS. Given these issues and concerns, Griffiths and Dhuffar (2014) investigated what treatment services were available within British NHS Mental Health Trusts that are currently provided for those who experience compulsive and/or addictive sexual behaviours. This was done in order to gain insight to whether or not sexual addiction is considered as a disorder that is diagnosed within the NHS.

In March and April 2013, a total of 58 letters were sent by email to all Mental Health Trusts (MHTs) in the UK requesting information about sexual addiction and treatment

of sexual addictions within their service over the past five years. The data were collected via FOI requests. As the NHS underwent major MHT and Service changes in April 2013, only Mental Health Services and those that had reached a Foundation¹ status were contacted.

The data request made by the research team was comprehensive and covered aspects of treatment as follows: (i) types of services offering problematic sexual addiction; (ii) number and job title of qualified mental health professionals within each service who offer treatment for sexual addiction, (iii) number of sexual addiction specialists within the MHT; and (iv) lowest age limit for referral. The request information also covered specific referral data for any individuals that had been referred in the past five years for treatment of a sexual addiction problem as follows: (i) number of referrals where sexual addiction was the primary reason for referral; (ii) age of referrals; (iii) gender of referrals; (iv) type of treatment offered; (v) how many clients attended first appointment; (vi) how many clients never attended, (vi) how many clients completed treatment; (vii) how many clients dropped out of treatment part way through; and (viii) how many clients were still in treatment (as of April 2013).

The results showed that 53 of the 58 responses to the information requests (91%) were that the MHT in question did not provide a specialist service for treating those with sexual addiction, were not commissioned to do so, and that no referrals were made to the MHT for anyone with a sexual addiction in the past five years. The results were also coded into whether the MHT (i) held and/or collated statistical information on the treatment for sexual addiction, (ii) stated that they did not provide

¹ An NHS Foundation Trust is part of the National Health Service in England and has gained a degree of independence from the Department of Health and local NHS strategic health authority.

services to treat sexual addiction and were not commissioned by the National Health Service to do so (and by implication do not treat it), and (iii), stated that they both neither collated or held such statistical information on sexual addiction and did provide such services to treat sexual addiction.

By coding in this way, further results demonstrated that (i) four of the 58 Mental Health Trusts (7%) specifically reported that they did not provide services to treat sexual addiction and were not commissioned by the National Health Service to do so, (ii) 24 Mental Health Trusts (41%) specifically stated that they did not provide services for sexual addiction and were not commissioned by the National Health Service to do so (and by implication do not treat it), (iii) 15 Mental Health Trusts (26%) specifically reported that they did not collate statistics on treatment for sexual addiction nor had the provisions to treat it, (iv) five of the 58 Mental Health Trusts provided information that they had treated sexual addiction within their service, (v) four out of 58 Mental Health Trusts (7%) confirmed that they did not provide specialist services for sexual addiction, but did provide information about other agencies that could be contacted for this information, and (vi) three out of the 58 Mental Health Trusts reported that cases of sexual addiction may have been referred to their service but it did not take primacy (i.e., possible co-morbidity with other disorders) or what actions would be taken if such a referral was made. The study also reported and coded the qualitative responses provided by each MHT (but are not reported here due to space constraints).

It was clear from the data collected via FOI requests that the majority of the Mental Health Trusts (MHTs) did not treat and/or acknowledge the existence of sexual

addiction. However, the study did highlight that the MHTs within the NHS view sexual addiction as a specialist service and therefore think that other dedicated services outside of the NHS structure should be treating it. Despite the general lack of treatment for sexual addiction, some services (n=5) had treated the disorder and acknowledged it as a clinical reality for some patients. There was also some suggestion from the data collected that sexual addiction may receive treatment via the NHS if co-morbidity with other disorders is present. However, the comorbid disorder may take primacy and leave sexual addiction as a secondary disorder, further increasing its marginalisation within NHS treatment.

The advantages and disadvantages of collecting data via Freedom of Information requests

As with all studies, there are a number of advantages and disadvantages with collecting data via FOI requests. Advantages include:

- The use of FOI requests via electronic mail (email) is an innovative and cost-effective way of collecting data to gain insight into marginalised disorders such as gambling addiction and sex addiction in the UK.
- Not only is there evidence of an email being sent but it is also less time-consuming. Traditional methods such as letters sent by 'snail mail' may get lost in transition, and secondly, an acknowledgment within 48 hours can be a small window for health trusts if responding through a postal letter. An FOI request via email also provides leniency for the health trust to ask for additional information that may be required in order to process the request efficiently.

- FOI request data provides a totally objective record of a person's behaviour and/or disorder (whereas those in self-report studies may be prone to social desirability factors, unreliable memory, etc.).
- FOI request data overcomes the problem of finding suitable participants as it provides an immediate data set. Participants do not even have to travel to participate in the study as their data are provided to the researchers.
- FOI request data usually have the potential to provide large national sample sizes although this depends on the behaviour being investigated.
- One of the most major advantages of using FOI requests to collect data is that response rates are typically close to 100% as those receiving FOI requests are legally obliged to respond. Both of the studies outlined above had 100% response rates (although a few of the health trusts replied after 20 working days).
- Because of the excellent response rate, the data arguably come from the most representative samples (although in treatment studies, those that turn up for treatment may be skewed to begin with).

FOI requests may also have disadvantages. The list below contains both general disadvantages in addition to limitations with collecting data on addiction populations using FOI data.

- Public authorities have the right to charge a fee for dealing with an FOI request. If the prescribed costs are greater than £450, then the authority is not obliged to comply with the request. In regards to the studies outlined above, there were a number of health trusts that calculated a fee for the number of

hours that would be put into filtering out files concerned with gambling and sexual addiction. As costs accumulated to more than the specified regulations, this resulted in some health trusts not providing requested and/or detailed information. Non-information may therefore give researchers and other stakeholders within the NHS a somewhat skewed view of whether gambling and/or sexual addiction is treated or not.

- FOI request data may not tell us nothing about *why* people engage in particular behaviours (whereas self-report data can provide greater insight into motivation).
- FOI request data may tell us nothing about the relationships between the behaviour under investigation and other behaviours (e.g. the relationship between gambling addiction and tobacco use or the relationship between sex addiction and eating disorders).
- It is also essential to highlight that stereotyping towards addictions as a whole remains, therefore, the misconception of gambling addiction and/or sex addiction may have resulted in professionals showing rigid or harsh attitudes towards individuals that suffer from these disorders. This may have also occurred among the health trusts from which the information was gathered.
- It may also be the case that gambling and/or sex addiction treatment might have been offered by private (i.e., non-NHS) providers that make it more attractive to suffering clients who are concerned about the confidentiality of their addictive behaviours.
- Using FOI data, the demand for such addiction services is unknown. The trusts that provided addiction treatment services for those with gambling and sex problems reported little data on their client numbers. The lack of provision

of such services can be multi-factorial including (but not limited to) client-related factors, cultural barriers, religious barriers, and provider-related factors such as lack of demand, lack of resources, lack of knowledge, and shortage of professionals.

- As FOI data collection may potentially be viewed as ‘secondary’, it is may be that individuals that enter health services may mask their struggle with gambling and/or sex addiction with other disorders that they feel are socially acceptable (i.e., depression and generalized anxiety).
- Data collected via FOI requests may be skewed. For instance, the lack of knowledge surrounding behavioural addictions in general may leads clinicians to typically screen for drug and alcohol usage as a form of coping in mental health disorders, thus marginalizing the presence of gambling and/or sex addiction.

Conclusions

This case study has highlighted that when it comes to studying behavioural addiction treatment (for gambling addiction and sex addiction) within the NHS, the use of FOI requests are a useful way to collect data on relatively rare behaviours. Researchers elsewhere are beginning to use FOI requests to collect other types of data such as how slot machines are designed in relation to gambling-inducing characteristics (see: Harrigan and Dixon [2009] who used the Canadian Freedom of Information and Protection of Privacy Act to gain gaming industry data about slot machine such as individual payout rates). As outlined above, the use of the FOI request methodology offer a number of advantages for researchers including an exceptionally high response rate. Although there are a number of disadvantages when compared to other more

traditional research methods (such as the information being too expensive to compile for those asking for such information), no data collection method is perfect. Clearly, the type of FOI data available to access depends on what types of data that organisations routinely collate. However, this case study has attempted to highlight that the collation of such data is not only possible, but is cost-effective and can lead to the collection of valuable data.

Exercises and Discussion Questions

- What advantages does collecting data via FOI requests have over other forms of data collection?
- To what extent is the use of FOI request data an invasion of people's privacy?
- How might FOI request methodologies be used to collect data on other types of human behaviour?
- What would be the advantages and disadvantages of using such methods on behaviours other than behavioural addictions?

Further Readings

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