Should GPs routinely screen for gambling disorders?

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DISORDERED GAMBLING

Gambling was reclassified from an impulse control disorder to a behavioural addiction in the DSM-5 (*Diagnostic and Statistical Manual*, 5th edn).[1] Conservative estimates indicate that approximately 1% of the UK population exhibit gambling behaviour that warrants a diagnosis of 'disordered gambling',[2] where disordered gambling refers to the useful term proposed in the DSM-5[2] re-classification encompassing 'problem', 'pathological', and 'compulsive' gambling.[1] The negative effects of disordered gambling can include mental health problems, financial crises, relationship breakdown, domestic violence, and self-harm or suicide, and tend to cluster with other high-risk behaviours such as smoking and drug taking.[3]

GAMBLING AND PRIMARY CARE

Disordered gamblers use NHS services extensively, being twice as likely to consult their GP, five times as likely to be hospital inpatients, and eight times as likely to have psychological counselling.[4] Despite over-representation in healthcare services, patients are reluctant to disclose when gambling has become problematic. Primary care is an established context for addressing high-risk behaviours, although previous research reported 97% of primary care, foundation, and mental health trusts in the UK did not provide specialist support for individuals seeking help for gambling problems, and only one trust offered dedicated specialist help for gamblers.[5] Although most individuals with gambling problems do not seek specialist services, they do access general health care, therefore GPs have the opportunity to identify gambling disorders and refer affected patients to appropriate services before they reach crisis point.

GP SURVEY

There are limited data regarding disclosure of gambling problems by patients and awareness of gambling-related symptoms and treatment options among GPs. A recent UK study determined the extent of gambling problems among patients attending GP services, and reported a gambling disorder in 5% of patients.[4] While reinforcing the potential for GP practices to be used for disorder detection, the study did not specially measure GPs' awareness of either gambling disorder symptoms or established care pathways for those experiencing the disorder.[4] To this end, data were collected via an online survey from 85 GPs (34 female) from across the UK. Responders had been a GP for an average of 14.67 years (standard deviation [SD] 9.58, range 1–40 years).

GPs were asked to estimate the percentage of patients who had disclosed gambling, smoking, alcohol, and drug problems over the previous 6 months. Estimates indicate that <1% of patients had disclosed gambling problems (mean 0.67, SD 2.30). By comparison, GPs estimated that approximately 25% of patients (mean 24.57, SD 23.80) admitted smoking, just under 10% disclosed alcohol-related problems (mean 8.09, SD 14.18), and approximately 5% disclosed drug problems (mean 4.90, SD 9.98). Therefore, GPs estimate that patients are less likely to disclose gambling problems than substance use disorders. However, approximately 25% of GPs thought gamblers would spontaneously disclose gambling-related issues, identifying a disconnect: GPs significantly overestimate the likelihood of gamblers discussing gambling problems unprompted. This overestimation may be related to the fallacious assumption that patients will be willing to talk about anything during consultation. A similar trend is noted in sexual health, which has also been recognised as a difficult topic for discussion in consultation.[6]

Additionally, GPs were presented with a range of non-physiological symptoms associated with disordered gambling and asked which symptoms they would identify as indicative of a gambling disorder, based on prior knowledge and experience. Over 75% of responders identified financial hardship, anxiety and depression, preoccupation with gambling, stress, lies to conceal extent of gambling involvement, and previous failed attempts to cut down on gambling as symptoms indicative of gambling problems. GPs confirmed that they would look out for, on average, 7.89 (SD = 2.66) of the 11 listed symptoms; it would therefore appear that, within our sample, GPs are able to identify gambling symptoms.

However, when asked to identify a care pathway for a gambler, the answers are less encouraging, ranging from an offhand 'not a GP problem', or a basic 'tell them to just stop', to referring to other appropriate services. Overall, only 35% of GPs surveyed were able to identify, from prior knowledge, a recognised gambling treatment provider.

DISCUSSION

As for other high-risk behaviours, primary care may provide an important environment for the early detection of gambling problems.[7] As spontaneous disclosure by problem gamblers is low, GPs need to routinely ask about gambling addiction, just as they do for substance abuse. Early detection prior to crisis-driven help-seeking could potentially reduce the severe mental and physical health issues associated with disordered gambling, thus reducing demand on NHS services. In a recent think tank policy report, it was estimated that disordered gambling costs the NHS hundreds of millions of pounds through use of primary and secondary mental health services and hospital inpatient care.[8] In the alcohol field, routine practice includes screening for instances and severity; for low-risk drinkers, brief intervention delivery is a cost-effective approach, whereas specialist referral is required for those who are alcohol dependent.[9] The same approach could be adopted for gambling, with significant cost implication for the NHS.

However, there are several points of contrast with substance use disorders that suggest the need for careful consideration of the role of GPs in identifying and addressing gambling disorders. For alcohol, severity dictates the level of intervention; in relation to gambling, however, there are no recognised strategies for identifying risk behaviours before serious harms have occurred (analogous to hazardous drinking), while existing screening tools are only suited for identifying disordered gambling (analogous to alcohol dependence). The Problem Gambling Severity Index (PGSI)[10] does offer a spectrum of harm categorisation; however, it was originally developed to measure general population problem gambling prevalence based on self-reported gambling behaviour rather than determinants of physiological or psychological harm, and may be too long to administer in a busy primary care practice. Shorter, more practical screening tools have been assessed for use in mental health services, although none in a UK population.[11]

Furthermore, on establishing the occurrence and severity of a gambling problem, GPs need to know the options available for treatment. Our pilot data suggest that, currently, this is not the case. It has been reliably demonstrated that psychological interventions for pathological gambling are consistently associated with favourable outcomes, both on a short- and long-term basis.[12] Specialist service referrals could include the National Problem Gambling Clinic in London, online and telephone counselling through GamCare, or intensive residential therapy at the Gordon Moody Association. However, the best efforts of these treatment providers notwithstanding, the geographical sparsity and location, infrequency of support groups, and intensity of residential treatment result in the existing infrastructure for specialist gambling support being inadequate for the likely increase in referrals should GPs routinely screen for disordered gambling.

CONCLUSION

Despite the increasing number of gamblers in the UK and the overuse of NHS services for associated physical and mental health harms,[2] external agency problem identification for problem gamblers is still very limited. As with alcohol and drug misuse, GPs can have a critical role in early detection of disordered gambling and in referral to enable early intervention before crisis point. However, in the absence of suitable identification and accessible intervention strategies for gambling, there are legitimate reasons for debate regarding the appropriate role of GPs.

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