Problem Gambling
&
(i) Financial Management
ii) CEP

ABACUS Counselling Training & Supervision Ltd

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Financial Management
(safety & money)

What is our role as PG counsellors?

Discuss

Financial Management (safety & money)

- Money management:
  - what basic financial knowledge should we have?
  - working with budgeters
- Safety management:
  - what can go wrong?
  - risk for us?
  - risk for client?

Money management

What basic financial knowledge should we have?

Without having to be a lawyer/budget advisor advantage of having some knowledge of the various options – discuss

- Bankruptcy
- No Asset Procedures
- Others
  - Summary Instalment Order
  - Compromise
  - Proposal

Money management

Working with budgeters

Our roles:

- Developing a connection with available budgeters (full budgeting option?)
- Disclosure agreement?
- Providing knowledge to budgeter of PG avoidance behaviour? Why?
- Having some basic understanding of budgeting? Why?
- When to refer?

Our safety

What can go wrong for us?

- Giving financial advice that is wrong
- Protection: Tell your client ‘This may apply but it is important to get advice from…..’
  - Official Assignee
  - Lawyer
  - Budgeter
- Assisting a client to avoid disclosure of ‘financial irregularities’ – you may become a party to the offence

Their safety

For our client

- Assist the client to protect their family, future, from their creditors
  - Need for advice from lawyers
- Clients with addictions can have diminished control over their money
  - Strategies to ‘distance themselves’ from their money
- Addressing credit card balances that have ‘maxed out’

Problem gambling and co-existing problems

Relationships of co-existing disorders

- AOD and MH are risk factors for each other
- Mental illness symptoms heightened with AOD use (head injury especially)
- MH problems become more problematic with AOD use
  - problems develop faster;
  - symptoms more intense and severe;
  - less responsive to treatment;
  - relapse more likely

Quote

"Working with people with co-existing mental health and addiction problems is one of the biggest challenges facing frontline mental health and addiction services in New Zealand and overseas. The co-occurrence of these problems adds complexity to assessment, case planning, treatment and recovery"

ALAC/MH Commission report, 2008

Co-existing issues to address

- “It underlines the complex causality of problems experienced by problem gamblers. Problem gambling may exacerbate other dependencies, and they in turn may exacerbate problem gambling”

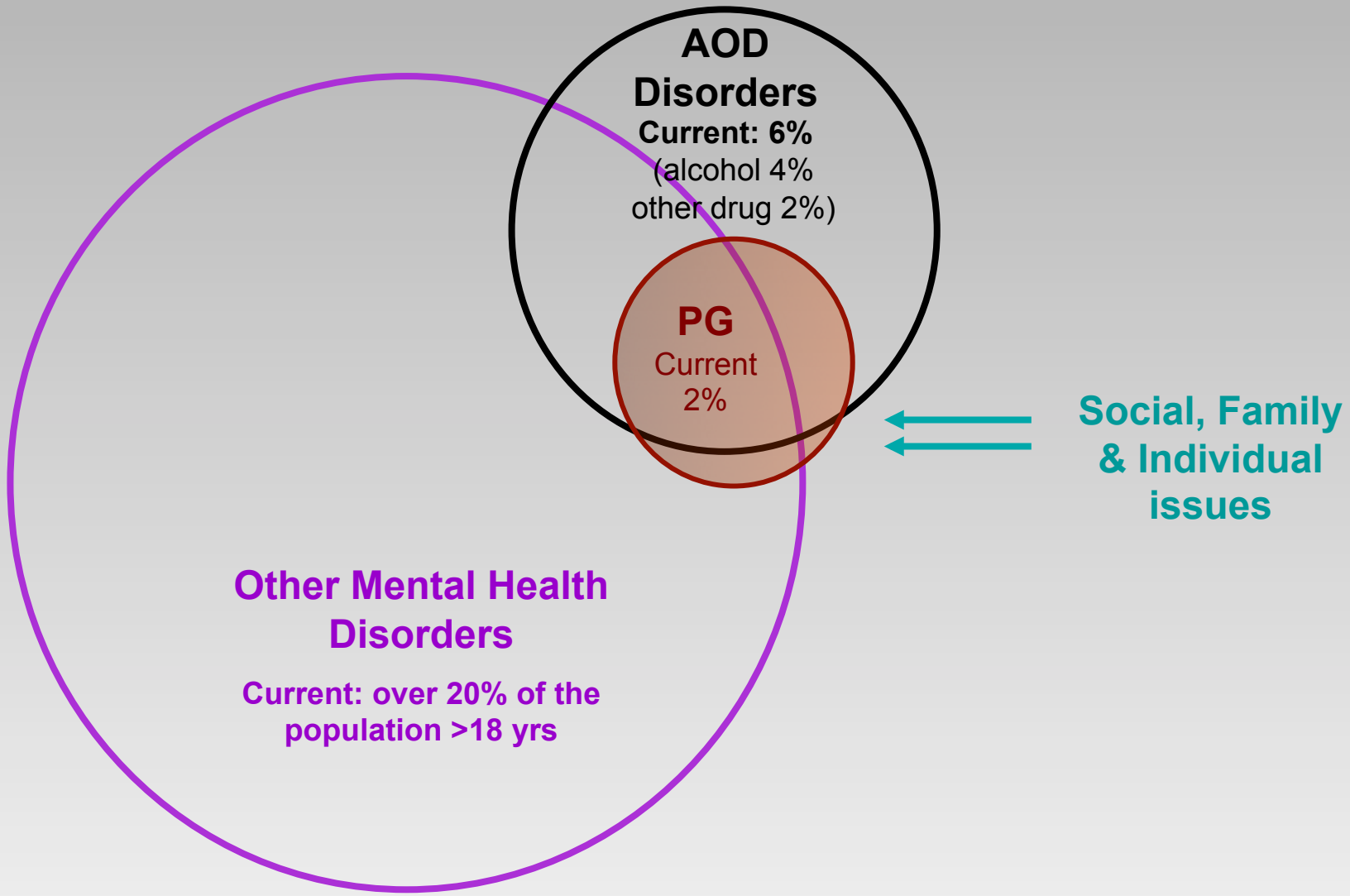
- “Counselling for problem gambling will need to also deal with these co-morbidities, and treatment for other dependencies may need to take into account secondary gambling problems that may not be transparent”

Australian Productivity Commission (1999)

ALAC/MH Commission Report (2008)

- Co-existing problems – are common, rather than exceptional, among people with serious mental health problems
- People with AOD and gambling problems have greater mental health problems than the general community, most commonly depression and anxiety
- Māori and Pacific people - higher mental health and substance-use disorders than the general population; also applies to problem gambling

Problem Gambling Embedded



Increased Risk in PG

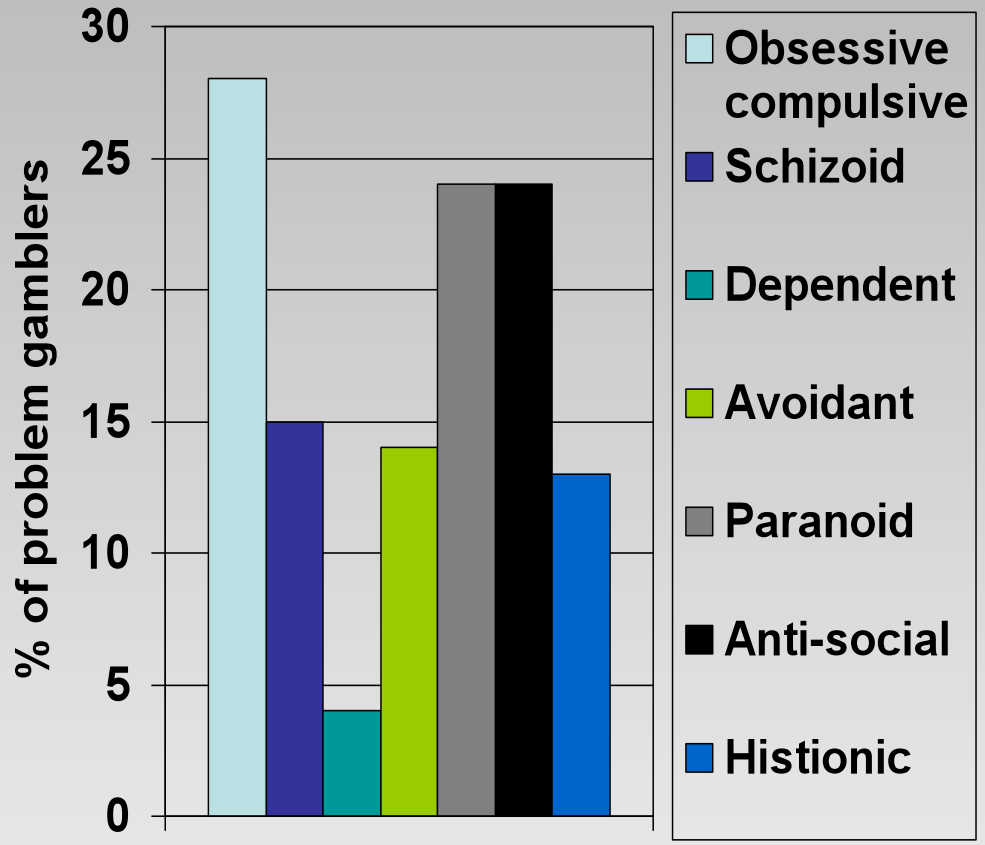
Disorder	General Population	PG (lifetime)
Depression (any affective)	8.3%	
Anxiety	14.6%	
Drug (abuse/dependence: not alcohol)	6%	
Alcohol (abuse/dependence)	13.5%	
ADHD	3-7%	
OCD	2.5%	
ASPD	3%	
Paranoid PD	0.5-2.5%	
Schizophrenia	1.5%	

Increased Risk in PG

Disorder	General Population	PG (lifetime)
Depression (any affective)	8.3%	49.6%
Anxiety	14.6%	41.3%
Drug (abuse/dependence: not alcohol)	6%	38%
Alcohol (abuse/dependence)	13.5%	73%
ADHD	3-7%	20%
OCD	2.5%	10-20%
ASPD	3%	23%
Paranoid PD	0.5-2.5%	25%
Schizophrenia	1.5%	3-5%

Personality Disorders high

Petry et al 2005



- Approximately one in four PGs may have OCD, Paranoid or Antisocial Personality Disorder (or more than one) Borderline?
- Personality disorders rare in general population (OCD 2%;ASPD 1-3%;Paranoid 0.5-2.5%;Schizoid ‘uncommon’)

Addictions and Co-existing Problems

People with gambling related problems are likely to meet criteria for other mental disorders:

- Almost all PG have another lifetime MH disorder (Kessler et al 2008)
- Co-existing mental health and addiction problems are associated with suicidal behaviour and increases in service use
- ‘Mental health and addiction services remain divided bureaucracies across discrete disorders’

ALAC/MH Commission report, 2008

MH disorders often pre-exist

Kessler et al 2008

- 96.3% of those meeting Pathological Gambling Disorder (PGD) criteria also met another psychiatric disorder (and two-thirds met 3 or more disorders)

- 74.3% of these experienced the other disorder prior to PGD
  - 42% had a substance use disorder (57% of SUD started before PGD)
  - 56% had a mood disorder (65% before PGD)
  - 60% had an anxiety disorder (82% before PGD)

Do PGs use AOD as self- medication?

- Temporary symptom reduction: arousal soothed; avoidance maintained; intrusive thoughts/memories controlled; fear calmed
- Lift sadness; increase energy/motivation
- Reduce preoccupation with delusions and intrusiveness of hallucinations – PG?
- Lack of alternative coping strategies- avoidance
- Psychophysical state made controllable

Self-medication? (Cont'd)

- Stimulants give high arousal and sensitise to stress
- Depressants reduce energy, motivation and cognitive clarity
- AOD users place themselves in dangerous or risky situations:
- Disinhibition, reduced impulse control, deterioration of judgement
- High-risk situations associated with 'drugs'
- PG affects health, job, finance, supports – PG isolated

Exercise: Co-existing Conditions

- Read the symptoms on your handout
- Check the cards on the floor with names of psychiatric disorders
- Stand by the card that you think matches the symptoms on your handout
- Be prepared to discuss the reasons for your choice with trainer and participants

Interventions
when coexisting conditions occur

So what should we treat?

- Many disorders very complex
- They are in addition to social needs
- But governmental approach is ‘make every door the right door’
- So could identify (screen) and refer
- Or identify and further briefly intervene (in addition to referral)
- Or have specialists on-site (brought in or base PG practitioners where these available)

What happens to MH in PGs?

Does part-addressing AOD/MH mean:

- If we focus almost solely on the gambling and are successful in reducing harm from gambling, do most (74.3%) clients with pre-existing disorders retain these now minus the gambling (and risk relapse from these?), or
- Do we assume addressing the gambling somehow also successfully addresses the client's pre-existing AOD/MH disorders?

Step: Identify coexisting issues

- Be aware of the increased risk for other health problems of PG clients – e.g. today's training may have raised awareness further
- Screen for asymptomatic conditions that commonly coexist
  - Depression
  - Alcohol
  - Suicidal ideation
- Discuss, assess and include in treatment plan (this may include referral)

Alcohol

AUDIT-C

- How often do you have a drink containing alcohol? (score: never=0, monthly or less=1, 2-4 times a month=2, 2-3 times a week=3, 4 or more times a week=4)
- How many drinks containing alcohol do you have on a typical day when you are drinking? (1-2=0, 3-4=1, 5-6=2, 7-9=3, 10 or more=4)
- How often do you have six or more drinks on one occasion? (never=0, less than monthly=1, monthly=2, weekly=3, daily or almost daily=4)

Alcohol

- AUDIT is the WHO screen used internationally – one drink is 10mls alcohol (small can beer, small/medium glass wine, one nip spirits)
- AUDIT-C used as standard screen in PG
- Looks at consumption only
- Other subscreens in the AUDIT look at symptoms of dependence and alcohol related problems
- Positive is 4 for women, 5 for men – can do an assessment using the full AUDIT

Drug use

- Standard brief screen in PG
- In the past 12 months, have you felt the need to cut down on your use of prescription or other drugs?
- A yes, answer is a positive
- Can offer a Severity of Dependence Scale screen (5 questions around self-concern about drug use over last 6 months)

Depression

Standard PG brief screen:

- In the past 12 months, have you often felt down, depressed or hopeless?
- In the past 12 months, have you often had little interest or pleasure in doing things?
  - A positive to either question may indicate depressed mood
- Signs, in addition to the above symptoms, include changes in weight, sleeping, thoughts of self harm, increased AOD use, increased agitation/or torpor, indecisiveness
- Sadness, tearful, agitated fixation on negative outcomes or expectations, hollow feeling, 'heavy' heart.

Depression

Interventions for depression include:

- Feedback to client of how depression may be interwoven with PG, AOD problems, social and legal problems arising from both, and others
- Motivating client to develop support, address debt, exercise, sleep, diet, social activities (especially ones from past), therapy such as CBT
- If severe depression, refer to medical specialist

Suicidal thoughts

Standard suicidality screen PG

Within the last 12 months, have you had thoughts of self harm or suicide?

1. None in last 12 months
2. Nust thoughts
3. Not only thoughts, but also a plan/
4. Have tried to harm myself in past 12 months

- Risk increases with each subsequent response – especially previous attempts
- High prevalence with PG and family
- High risk when PG, AOD and depression coexist

Suicidal thoughts

- Check if there is a policy for your organisation around this and apply this
- Prioritise safety if current thoughts of self harm – if respond ‘just thoughts’ check whether they are safe, and at subsequent opportunities
- If plan, treat with more concern, especially with AOD and depression issues – consider referral for possible antidepressant medication
- Be aware of CAT Team numbers

Guiding Principles for Co-existing Conditions TIP 42, 2005

- Adopt a recovery perspective (no wrong door)
- Adopt a multi-problem viewpoint (with AOD/MH of equal importance)
- Develop a phased approach to treatment – MI as front end (engagement/persuasion), active treatment/follow-up and relapse prevention, together with a “stages of change” approach

Guiding Principles for Co-existing Conditions TIP 42, 2005

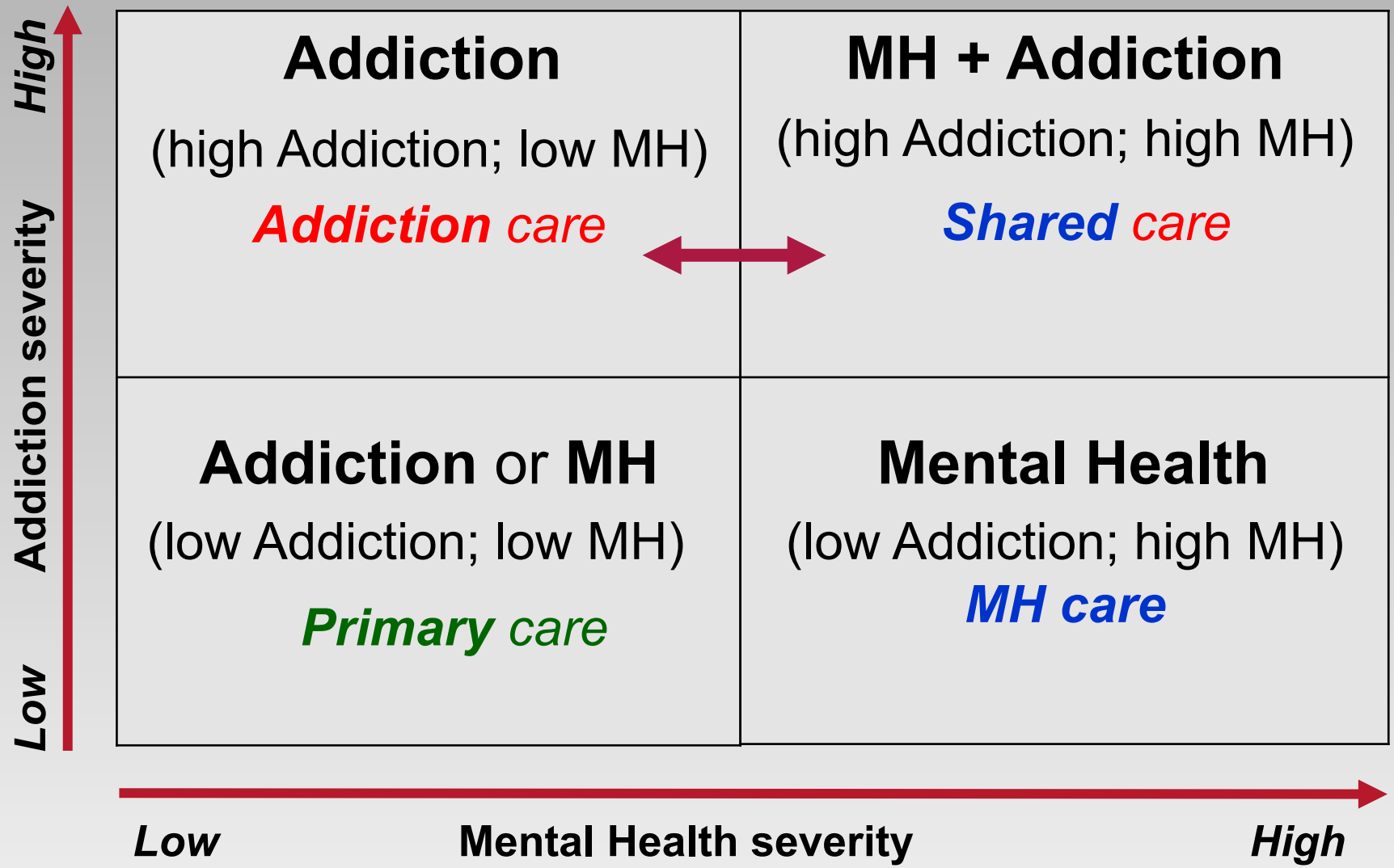
- Address specific real-life problems early in treatment
- Plan for client cognitive and functional impairment
- Use support systems to maintain and extend treatment effectiveness

12 Step Assessment Process

TIP 42, 2005

1. Engagement
2. Further info from whānau/friends/others
3. Screening (co-existing disorders/risk)
4. Determine severity of co-existing and appropriate service coordination
5. Determine level of care
6. Determine diagnosis
7. Determine disability and functional impairment
8. Identify strengths and supports
9. Identify cultural and linguistic needs and supports
10. Identify problem areas
11. Determine stage of change
12. Plan treatment

Involve MH support or not?
(Minkoff 2000)



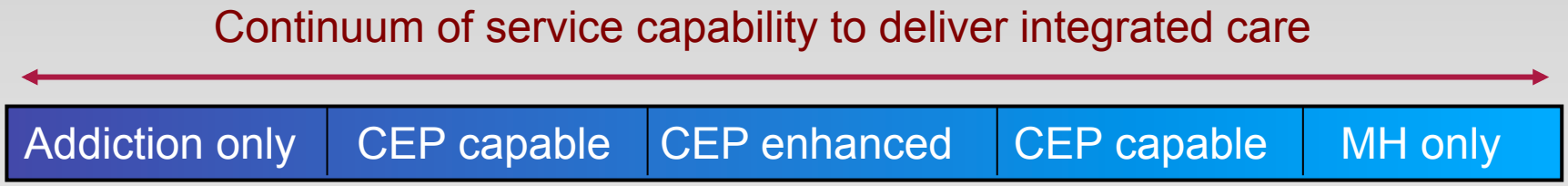
Exercise: Brainstorming

Mental Health (MH) includes AOD problems

PG High PG Low MH	**PG + MH** *(shared care)* High PG High MH
PG or MH *(either)* Low PG Low MH	**MH** High MH Low PG

When addiction & co-existing MH

- *Te Ariari o te Oranga: The Assessment and Management of People with Co-existing Mental Health & Substance Use Problems 2010* (MOH)
- *Integrated Solutions: Service Delivery for People with Co-existing Mental Health and Addiction Problems (MOH)*



Treatment Integration: Addictions/MH

- Aims to reduce gaps and barriers between services
- Integrates various treatments into a single treatment stream or package
- Adapts the various treatments to be consistent and not conflict with each other
- Need seamless, consistent, “accessible” approach to clients’ pathology, deficits and problems (including criminal offending issues)

Treatment Integration: Addictions/MH

- Single co-ordinating point for treatment
- Use compatible treatment models/concepts
- Harm minimisation approach
- Close liaison between all parties incl justice
- Deliver all treatments from one setting
- Close liaison between therapists, treatment agencies, and whānau/family

Cultural Issues

- In some cultures, depression is expressed in somatic terms, rather than sadness or guilt
- Examples: “nerves”, headaches; weakness, tiredness or imbalance (Asian); problems of the heart (Middle East).
- Māori and Pacific peoples: may be more spiritually based – may request traditional healing; family/ whānau context; some PI clients feel it may be a “curse”

Cultural Issues

- For some, may be irritability rather than sadness or withdrawal
- Differentiate between culturally distinctive experiences and hallucinations or delusions (which may be psychotic part of the depression)
- Don’t dismiss possible symptoms as always cultural
- How do these fit for youth culture?

MI Principles for Co-existing Conditions

- Focus on **empathy**
- Proceed very slowly to avoid **resistance**
- Expose or develop **discrepancy** very gently
- Build **self-efficacy**
    - support self-determination
    - encourage early small achievements

(Zuckoff & Daley, 2001)

MI Principles for Co-existing Conditions

- Co-existing MH problems exist with almost all those affected by PG
- AOD problems are MH problems, as are PG problems
- Some coexisting problems can be addressed without referral to MH services
- Others will require referral for best outcomes for the PG client
- Establishing relationships and knowledge about regional MH services will enable PG services to best assist their PG clients

Overview of CBT

CBT involves a consideration of 5 components to any problem:

1. Cognition (thoughts)
2. Mood (emotions)
3. Physiological reactions (e.g. physical sensations)
4. Behaviour
5. Environment

Overview of CBT

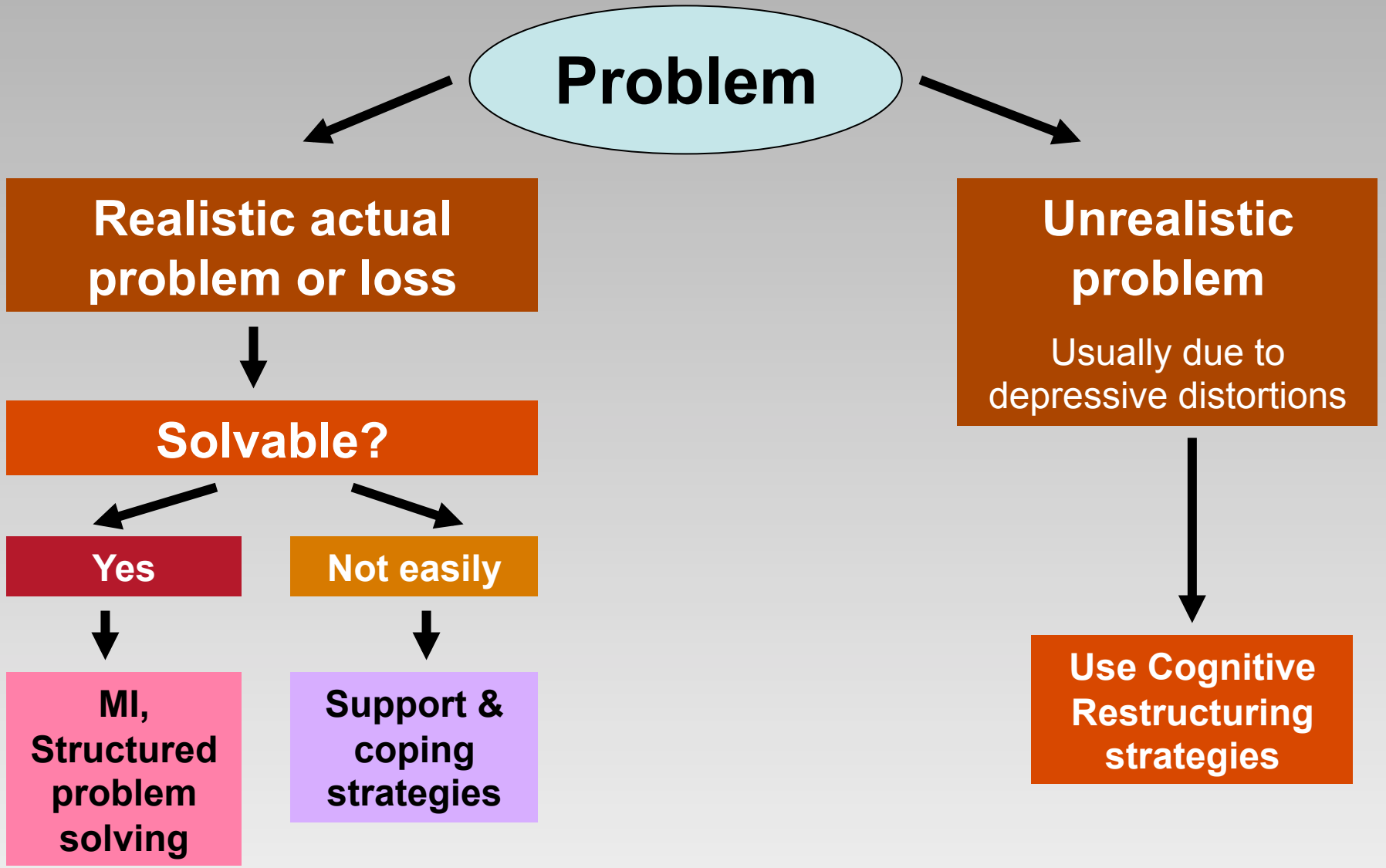
CBT therapist helps clients become aware of the relationships among the 5 areas:

1. To recognize how certain negative, unhelpful, or unrealistic thoughts can generate distress
2. Uncomfortable physical sensations
3. Maladaptive behaviour
4. Seemingly uncontrollable emotions that appear out of proportion to the situation
5. To understand how social and physical aspects of the environment can contribute to distress

Overview of CBT

- Once clients understand these connections, more helpful coping strategies are developed
- 3 main categories of coping strategies:
  - Problem solving
  - Social skills and support
  - Cognitive restructuring

CBT: 3 main problem categories



Addressing addiction issues with MH clients (CEP)

Possibilities are :

- serial – one problem treated before others
- parallel – both treated at same time but separate and distinct services, and
- integrated – addiction and MH problems addressed in a single service by the same health professionals

The integrated treatment model is widely considered superior for people with CEP

Summary

- Coexisting issues common for PG
- Youth have additional risk and impact
- Many MH issues are asymptomatic
- Brief interventions often very effective
- But be aware of own limits and need for further input from those with more knowledge
- Where possible integrate the coexisting MH issues into the treatment plan

end

Conclusion

- CEP is the rule rather than the exception
- Address cultural considerations, well-being, engagement, motivation, assessment, management, and integrated care
- Obtain information from a wide number of sources
- Match the speed and focus of the therapy to the ability of the individual tangata whaiora
- Work with other services to deliver the treatment plan, when these cannot be provided in-house