Report to the Ministry of Health

Feedback to MOH re Emerging Trends in National & International Literature

Report No. 01 covering 1st July 2010 to 31st December 2010

ABACUS Counselling Training & Supervision Ltd

Literature	Findings	Comment

Time and money spent gambling and the relationship with quality of life measures: A national study of New Zealanders
Authors: Lin E-Y J Lin, Casswell S, Easton B, Huckle T, Asiasigaga L, You R Q
(2010) Journal of Gambling Issues, 24: 33-53
	• A telephone survey of 7,010 NZ adults identified impacts of gambling by comparing gambling participation levels with quality of life measures in a quantitative study
	• This research considered the range of social impact upon all gamblers, and not only focussed upon problem gamblers
	• Those with higher gambling losses reported significant quality of life costs in:
	  ○ Poorer physical health
	  ○ Poorer mental health
	  ○ Relationships
	  ○ More negative self feelings
	  ○ Poorer quality of life
	  ○ Lower satisfaction with life
	  ○ Lower living standards
	  ○ Study performance
	• Time spent on gambling machines was identified as the greatest risk for quality of life for these gamblers, and overall, the main contributor to inferior mental well-being were the playing of
		• Loss compared with income was a prime measure of impact variable, yet acknowledge that gamblers have been found to inconsistent estimate gambling losses. Further, in the 1999 Australian PC, it reported one study of problem gamblers stating less than 30% would respond truthfully to an enquiry about their gambling
		• The authors acknowledge that as the survey was conducted only through telephone landline, this may have under-estimated the extent of problem gambling as ethnicities with higher risk for gambling problems and lower socio-economic status (Māori, Pacific) are less likely to have landlines and instead use cell-phones or no phones. Also, that quality of life reductions for problem gamblers may have been greater than found in the research
		• A broader measure of impact was used rather than a problem gambling screen, and

	electronic gambling machines • 2.4% of the population (extrapolating these findings) were estimated as have an (self-reported) inferior state of mental well-being as a result of gambling. Further, gambling may be the cause of between 4.3% and 7.6% of severe mental health problems • Participants were selected from 15 to 80 years of age (mean age participants 43 yrs), males to females participated 3:4, had lived in NZ at least 12 months, with an over-sampling of Māori, Pasific and Asian/Korean ethnic groups. • Some forms of gambling were associated with positive impact upon quality of life (racing and housie, and to some extent EGMs in casinos)	therefore comparisons of problem gambling measures with other quantitative studies is restricted. However, the focus was wider than problem gamblers and with a broad range of fields of well-being impact differences were identifiable e.g. that some forms of gambling had positive aspects to well-being • A finding that loss to income ratio appeared to be associated with poor standard of living yet have no association with participants' view of their financial situation was difficult to explain, and it was suggested that the latter may have been more open to denial because of self esteem issues. A further explanation may be the unintentional minimisation of losses, or over-estimation of winnings often identified with problem gamblers, or perhaps all gamblers • Despite the identified problems encountered in this study the attribution of high gambling losses with a number of fields of well-being provides further support for addressing wider issues than the gambling behaviour in treatment interventions, as many of these issues will not remedy themselves within a short period of time (if at all) should the client be able to reduce or stop their gambling. These outstanding issues of loss of well-being, should they persist after addressing the gambling, appear to be prime reasons for relapse. As a NZ study, this provides

		important evidence for the costs of high gambling losses to not be confined to financial issues alone
Pathological gambling recovery in the absence of abstinence Authors: Slutske W, Piasecki T, Blaszczynski A, Martin N (2010) Addiction, 105(12), 2169-2175	• Most treatment identifies abstinence as a goal for problem gambling or as a definition of successful treatment • Most recovery from problem gambling is achieved without treatment. In USA and Australian survey studies more than 80% of recoveries occurred without treatment. Those seeking treatment for problem gambling are therefore unrepresentative of those with gambling problems. • Therefore, in order to research whether recovery from problem gambling requires abstinence, participants should include those who have achieved recovery naturally (i.e. without treatment) • 4,764 participants from the Australian Twins Registry Cohort were interviewed by telephone and a DSM based gambling screen (NODS) used. A lifetime prevalence of pathological gambling of 2.2% was identified. • Problem gambling recovery was defined as the absence of any DSM (NODS) symptoms in the last 12 months after being positive on the lifetime NODS. Some 44 participants met this recovery compared with 28 who met pathological gambling criteria in the last 12 months and a further 32 who met one to four criteria (some problems). Of the last two problem categories,	• In NZ, a harm minimisation approach that includes controlled gambling as well as abstinence is offered to clients. As such the conclusions around provision of the option as a client-centred approach is not unusual. • What is perhaps of more interest is the high proportion of clients who have recovered from problem gambling without seeking treatment i.e. 36 of 44 (82%). The 8 who were treated were similar in gambling behaviour to those naturally recovering, as were the 60 pathological and problem gamblers when the recovered gamblers were problematic gamblers in the past. • What may be of more concern are the reasons the 82% of recovery gamblers (and presumably most or all of the 60 current problem/pathological gamblers) did not seek treatment. If none of the 60 current problematic gamblers have sought treatment, then just under 35% (36 of 104) participants have naturally recovered, and perhaps of more concern, just 7.7% have sought treatment. • This percentage of naturally recovered gamblers is low compared with the study of Abbott et al (1999) but as with that study reinforces findings of Hodgins and others

	58 of the 60 had at least five criteria prior to the last 12 months. The average years of symptom free for problem gambling for the recovery group was 4.7 years with 93% symptom free for two or more years. Only eight of the 44 recovery group had sought treatment (i.e. 82% natural recovery) • 90% of the recovery group gambled in the past year, on an average of 3.6 gambling activities (a total of 55 hours spread over 54 days and consuming 7% of their income). Of modes of gambling for the recovery group, many were higher risk e.g. gambling machines 62%, track racing 52%, and casino table games 31%. This was a substantial reduction (days, hours and % income) compared to the pathological and problem gambling groups. The recovery group had similar past figures to the gambling groups. • Findings were some gambling was not inconsistent with recovery, and the offering of controlled gambling rather than abstinence may increase treatment seeking. • Many clients who at first seek controlled gambling may after accessing treatment change or transition to abstinence(Dowling et al 2007)	that many problem gamblers choose not to access treatment, and perhaps indicate reluctance even higher than those affected by alcohol and other drugs • This research suggests that further research is required into what skills those who naturally recover possess compared with those who continue problematic gambling behaviour over long periods of their lives. It is suggested by the authors that alternatives be offered to encourage treatment access, and whereas these currently occur in NZ, further thought may be given to stepped treatment processes that Hodgins and others suggest may provide briefer alternatives to intensive therapies (a current brief intervention research project is currently underway in NZ and may provide evidence for this alternative).
Predictors of problem gambling severity in treatment seeking gamblers Authors: Hounslow V, Smith D, Battersby M, Morefield K	• Problem gambling (PG) severity can be influenced by certain factors, such as co-existing mental health problems (including personality traits), gambling related thoughts, substance use, and the gender of the person. • PG severity has also correlated with being male, personality traits such as impulsivity, personality	• Although many of these findings are raised in other studies (e.g. Blaszczynski & Nower 2002 pathways model), and may possibly differ from those problem gambler who don't seek help, this study provides important confirmation that problem gamblers present with a range of issues that should be

(2010) International J Mental Health & Addiction DOI 10.1007/s11469-010-9292-3	disorders, cognitions, and substance use • Relatively few problem gamblers seek treatment with an estimated 10% in South Australia with motivations ranging from financial concern (loss or hardship), psychological distress, physical health issues (Delfabbro 2008; Pulford et al 2009). Issues of shame, denial, and stigma also are issues to be addressed. • The participants completed a wide range of tests, including DASS21 Depression Anxiety and Stress Scale, The Trait Anxiety Inventory, the Gambling Urge Scale, AUDIT alcohol test and social, functional, sensation seeking and gambling cognitions tests. • The DASS identified 37.5% were extremely depressed, 22.8% extremely anxious, and 20.5% extremely stressed. Also, 30.7% reported harmful or likely dependent alcohol use (AUDIT). • 51% had been affected by problem gambling for more than 5 years. • N=127 problem gamblers seeking treatment completed baseline measures which were analysed • Findings indicated that gambling urge, gambling related cognitions/thoughts, and depression were significant predictors of gambling severity • High levels of anxiety and stress were also found • Results are said to have implications for practitioners in assessment and treatment planning – for example a CBT programme requiring cognitive therapy, cue exposure, or cue	reflected in the treatment offered. Participants in this study may reflect more closely NZ clients, and the gambling environment in South Australia may be more similar than others in Northern Hemisphere research. • Treatment that does not meet needs may result in early withdrawal of clients from the service. Stabilisation of depression may be an important focus, as well as alcohol misuse for at least one-third of PG clients because of its depressive effects, amongst other reasons. Anxiety issues also suggest relaxation training (and/or anxiolytics) should be part of many PG treatment plans. Addressing urges to gambling have been a regular treatment model in South Australia and this research provides support for that approach. • The NZ approach in screening for alcohol misuse (AUDIT-C), depression (brief 2-item screen), and suicidal ideation, and other tests, cover many of the identified drivers of severe depression of this study. Direct tests of urge are not included but could be implied from the gambling screen items associated with urge or cognitions, and could be addressed with specific urge reduction strategies included in the treatment plan (e.g. CBT imaginal desensitisation). • This study is a timely reminder that the

	response and response prevention techniques, may result in adherence problems for highly impulsive treatment seeking gamblers. • Severity of problem gambling symptoms were found to be significantly predicted by depression, gambling urge, and gambling related cognitions. The was some indication that urge to gamble precipitate gambling cognitions, suggesting that treatment focussing upon reducing the urge may reduce gambling thoughts (which lead to gambling). CBT urge control is an example of such treatment. The lack of correlation found between sensation seeking and gambling severity was surprising for the researchers. • When coexisting mental health problems exist, problems that arise from gambling may abate as gambling is treated; however, if these predate the gambling they may influence the gambling and may require equal allocation of treatment with the gambling to enable full recovery and avoid relapse. • Treatment programmes should address strong urges to gamble, distorted cognitions, high depression, and increased suicidal ideation. The presence also of high stress and anxiety may also result in high treatment attrition rates.	current roll-out of Te Ariari (Todd 2010) may be applicable to many, and probably most PG clients presenting to services often present with severe mental health issues, and that treatment planning should seek to meet and address these issues.
Subtyping study of a pathological gamblers sample Authors: Alvarez-Moya E, Jimenez-Murcia S,	• Pathological gambling may result from an underlying addiction syndrome (predictable signs/symptoms that vary and need not be always present). This variability may suggest subcategories of pathological gambling, each	• WAGER critiqued the study for its self-report assessment basis, that all participants were help-seeking for their gambling, that criteria for pathological gambling may not have been confirmed for all, and that the criteria may

Aymami M, Gomez-Pena M, Granero R, Santamaria J et al (2010) The Canadian J of Psychiatry, 55(8), 498-506	with their own idiosyncrasies • N=1171 patients from a hospital seeking treatment for their gambling participated (after excluding 148 for severe psychiatric disorders, 97 incomplete data, and 160 refusals) • Participants self-completed a personality assessment inventory (TCI-R), a gambling screen (SOGS) and Pathological Gambling DSM criteria, a mental health self completed inventory (SCL-90-R) and a substance use scale (SUDS module of SCID-I) • An analysis of the personality assessment identified 4 subgroups with subgroup 1 having the highest clinical and pathological gambling scores, while subgroup 4 had the lowest for these (subgroups 2 and 3 fell between) • Type 1 is 'disorganised and emotionally unstable', with schizotypal personality traits, high impulsivity, alcohol and substance abuse, and early onset • Type 2 is schizoid (e.g. socially aloof and avoidant), high harm avoidance, and exhibits alcohol abuse • Type 3 is sensation seeking, impulsive, sensitive to rewards, but without psychopathology • Type 4 is high functioning, without psychopathology or substance abuse • Different treatments are suggested for the varying needs of each Type of pathological gambler	reflect disorders that overlap with pathological gambling rather than aspects of pathological gambling • Unfortunately a substantial number (n=148) of pathological or at least problem gamblers seeking help were needed to be excluded because of the severity of their coexisting problems, which may or may not have fallen into type 1 or 2 categories. Severe mental health issues are often found to coexist with problem gambling (Petry 2005) and whether the strong symptoms of these mental health disorders were influenced by these gambling categories may have been an important support or otherwise for this categorisation hypothesis • Nevertheless, the study does note that coexisting problems may raise the need for alternative treatments and the search for underlying similarities that may inform best practice treatment is important • Some similarities to Nower & Blaszczynski (2003) Pathways Model is noted, where three subgroups are identified with differing underlying psychopathology and level of needs.

Subtyping pathological gamblers based upon impulsivity, depression, and anxiety Authors: Ledgerwood D & Petry N (2010) Psychology of addictive behaviors DOI: 10.1037/a0019906	• Examination of the Pathways Model subtypes (Nower & Blaszczynski, 2003) and whether each would benefit from different treatment was examined • N=229 problem gamblers seeking treatment for their gambling were allocated into the three different Pathway categories depending upon their depression, anxiety and impulsivity. The categories were behaviourally conditioned (BC), antisocial impulsive (AI) and emotionally vulnerable (EV) problem gamblers. • BC problem gamblers develop through repeated exposure to gambling and the reinforcement schedules of the gambling, other gambling issues (e.g. near misses) and access/habituation to gambling. Increased arousal/excitement and potential to win together with perception of greater control over gambling outcomes are also important factors. Many of these symptoms common to the other categories, however BC have less severe gambling problems and unlikely to have substantial psychological problems before the gambling problems than the other two categories. This group fluctuates between heavy and pathological gambling, and may be most likely to reduce harm through treatment • Emotionally vulnerable (EV) gamblers have similar precursors as BC, but use gambling to reduce psychological pain. They have poor emotional coping skills, their depression/anxiety pre-exists their gambling, and use gambling to	• This study has important implications for the triaging of treatment for problem gambling, although all participants me the criteria of pathological gambling by design. There was a range of mild to severe problem gambling, and findings may be restricted to this reduced problem gambling continuum i.e. may not apply to sub-clinical levels of problem gambling where brief interventions may be appropriate and effective. • The approach of the CBT therapy appeared to address the gambling behaviour and its symptoms, and not the co-existing mental health issues that existed in both the EV and AI gamblers. The Pathways Model refers to the pre-existence of many of these mental health problems to the gambling problems, and they would expect to necessarily abate as the gambling problems reduced. CBT was described as a suitable treatment for altering adverse moods associated with gambling, although the mood focus of the CBT intervention was not described in the study. • In NZ, the addiction and coexisting problems (CEP) strategy is being rolled out, with mental health issues (other than the addiction) specifically addressed in an integrated approach (and vice versa for present mental health clients identified with addictions). This appears to be a more intensive and focussed approach to the most

	reduce the psychological pain. Biological vulnerabilities underlie (e.g. neurotransmitter deficiencies) the gambling behaviour, and addressing the negative effect (depression and anxiety disorders) as well as the gambling may require longer treatment to stabilise. • Antisocial impulsive (AI) gamblers are the more disturbed subtype, having similar emotional vulnerability and elevated psychopathology as EV gamblers, but more emotional dysregulation (e.g. antisocial personality disorder or borderline personality disorder). AI gamblers will have high trait impulsivity and neurological dysfunction alongside the psychological problems which will lead to gambling problems. Higher risk for criminal activities, alcohol and drug problems, and antisocial traits will exist, resulting in higher attraction to arousal and excitement. Treatment must not only the gambling but these widely ranging issues which will result in attention problems, treatment compliance issues, requiring both intensive and impulse control therapies, with outcomes for change being less positive. • The authors noted that although several studies had assessed aspects of the Pathways Model, this may be the first to assess how these subtypes respond to treatment • They hypothesised that low anxiety/depression gamblers would experience lower gambling pathology and psychiatric problems (BC), high anxiety and/or depression but lower impulsivity	intensive intervention in this study (GA referral and 8 CBT sessions for gambling). • The study also comprised pathological gamblers who elected treatment (as the authors noted), and it is possible that problem gamblers in the community who have not elected treatment may have more severe problems on average, while milder (non-pathological) gamblers did not participate by design. Further, treatment for these may include motivational interviewing to increase motivation for treatment, and include non-specialists who may opportunistically identify gambling problems. The authors did suggest further research in community settings so as to further test the Pathways Model, however the NZ, the CEP model allows for such opportunistic screening (subject to adoption of a broad screen regularly applied e.g. CHAT screen) with an integrated approach by both addiction and mental health specialists where severe conditions coexist. • The Pathways Model provides a challenging hypothesis for categorising the characteristics and needs of problem gamblers. Hounslow et al (2010) and Alvarez-Moya et al (2010) above describe the interest currently expressed in categorisation of problem gambling with a view to best practice treatment, allocation of resources, and perhaps more importantly but

	gamblers would experience greater psychopathology and coping difficulties (but fewer legal/antisocial symptoms)(EV), and AI gamblers would be characterised by high impulsivity, anxiety and/or depression, greater legal problems, higher rates of anti-social personality disorder, greater personal/family addiction, psychopathology, and earlier gambling. BC would be expected to have the best treatment response, EV respond well to individual CBT because of its emphasis upon altering cognitions and adverse moods, but with slower recovery, while AI would have the least effective outcome from treatment. • Participants were recruited from advertisements who met pathological gambling criteria n=229, and randomly assigned to one of three treatment conditions: 1) Gamblers Anonymous (GA), 2) GA referral plus CBT workbook, or 3) GA referral and 8 session of individual CBT. A one-year follow-up occurred. • Support was found for the Pathways Model categorisation, although EV gamblers appeared not to have poorer emotional coping skills than BC. • Treatment outcomes: BC was more likely not to meet pathological gambling criteria, indicating they were more likely to be in recovery following treatment. However, the rate of improvement appeared to be the same for each of the categories – although as both EV and AI	less addressed, stepped approaches to treatment that identifies and addresses early stage gambling problems. • The authors conclude that their study identifies that the strongest predictor of outcomes is the severity of gambling exhibited by the gambler (i.e. more severe gambling requiring more time and resources), with sub-typing of problem gamblers still assisting in our knowledge of how such gambling problems develop, and how they progress. • Of interest was that treatment for problem gambling assisted even the most severe problem gambler also affected by other psychopathology, but still remained at a higher gambling problem level having started higher at treatment commencing. The more holistic NZ approach would address the range of issues (and not restricted to gambling), ensuring that every door was the right door, with an overall goal of well-being. Such approach appears to treat problem gambling as integrated within other mental health issues, which requires either highly qualified problem gambling treatment providers capable of addressing severe mental health issues that co-exist (unusual competencies) or an overall health approach that draws mental health and addictions into the same treatment opportunity, which the NZ CEP strategy does. This differs

	gamblers started with more elevated problem gambling, these problems still remained at a more elevated level (albeit reduced) following treatment than BC gamblers. This improvement by AI gamblers is not predicted by the Pathways Model. Neither was the expected higher improvement for EV gamblers using CBT; although CBT was positive for all groups. • The authors concluded that the Pathways categorisation of pathological gamblers for the purpose of different treatment was not warranted. The concluded that the same findings for the large MATCH clinical study (1997) that matching patients to specific treatments based upon their presenting symptoms had little benefit. • The authors did note their participants were treatment-seeking, and that these may differ from those who don't	substantially from a specialist addiction approach, and allocation of resources needs, and expands the opportunity for interventions.