Report to the Ministry of Health
Feedback to MOH re Emerging Trends in National & International Literature

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Literature	Findings	Comment
Online self-guided interventions for the treatment of problem gambling Authors: Gainsbury S & Blaszczynski A (2011) International Gambling Studies, 11(3):289-308	• A minority of problem gamblers (PG) access formal treatment • Factors against help-seeking include a desire of PGs to manage their own treatment, shame, lack of awareness/denial, and concerns over confidentiality • The Internet is effective in providing health information, ability to self-assess, receive counselling through, and to receive support from, other PGs • Online PG programmes can provide as a further/alternative option for those PGs reluctant to access traditional options • Advantages of the Internet include ability to provide systematic CBT therapy, visual examples to correct skewed thinking such as probability of winning, accessibility, convenience, cost effectiveness, and anonymity/privacy • This research reviewed self-guided online	• The proportion of people with gambling problems who seek help is difficult to estimate, but has been estimated by the Productivity Commission (Gambling: Productivity Commission Inquiry Report No.50, Vol 1, Feb 2010) as between 8%-17%. This is based upon PGs in Australia estimated as 80,000 to 160,000 and 17,500 seeking help in a year. This may be very conservative, even for 4,000 family clients not being included in the estimation, as the Productivity Commission was reported in the media (Jan 21, 2012; Syndicate News) as stating problem gambling affects up to 5 million Australians, 'including friends, family, and employers of people with a gambling problem'. • Relatively low help-seeking by PGs and especially family members, may be in part addressed by offering this additional option, especially with the high uptake in NZ of Internet use

	interventions for PG • Evidence showed that although a new field, online self-guided interventions are effective, and offer an important additional option for treatment of PG • The authors noted that although there is some support for reducing PG prevalence, trends towards increased legalisation/availability, and new gambling forms, increased PG is anticipated • The Internet has increased real and virtual gambling (cards, roulette, pokies, sports and wagering) with new technologies such as interactive TV, 3G wireless phones/devices now enabling platforms that enable increased gambling • A review of 24 randomised studies appears to indicate that Internet based programmes for health/mental health are equal to or have greater effectiveness than face-to-face, brief interventions, educational and self-help options. A review of 9 addiction studies confirmed that online approaches were also effective with addictions. • Online programmes with some therapist contact (email, live chat, video conferencing, telephone) were possibly more effective in addiction reduction than self-directed programmes, but there were some mixed results • All stages of motivation can be provided for with online approaches, as well as severity; heightening perception of self-control, comfort,	• Online interventions appear to provide accessible help for those affected by online and other more traditional forms of gambling. More research is required to assess the effectiveness of behaviour change around PG, although limited research has been promising (Carlbring & Smit, 2008) • This paper provides an in-depth review of the evidence for self-guided online treatment of PG but also addresses the limited evidence for counsellor-assisted treatment for PG. Although specific research applying to PG is sparse, there is sufficient evidence for other addictions, and considerable evidence for online treatment for other mental health problems, that may generalise to PG. • With the authors' prediction of growth of PG with online accessibility of gambling increasing, intervention opportunities using the same medium appears to have merit.

	programme relevance, effectiveness, while reducing drop-out rates from treatment, and enabling multiple attempts to change behaviour • Stepped care frameworks are suitable for online delivery • Although youth PGs are reluctant help-seekers, they may relate to an online approach • They concluded that online PG programmes would be an alternative rather than a replacement, for face-to-face therapy, and also for an adjunct to face-to-face therapy such as those waiting for treatment, and for those exiting treatment	
Proposed gambling legislation by the Australian Federal Government (Jan 2012)	• A range of changes have been proposed by the Federal Australian Government to roll out between 2013-2016, dependent upon the outcome of a trial of pre-commitment for the maximum losses that they will accept during a session • If the trial of mandatory pre-commitment supports effectiveness to reduce gambling harm, estimated by the Productivity Commission to affect 5 million Australians (gamblers, family and others), then a range of requirements will be rolled out. These will be: o New gambling machines from 2013 must include an ability for the gambler to pre-commit o By Dec 2012, most gambling machines must be state-linked to a pre-commitment system	• Although many of the proposed Australian changes will be dependent upon the outcome of the pre-commitment trial, it would appear that other changes may proceed • In NZ, pre-commitment has been a possible future option, with this capability being built into some machines, should the DIA require this to be actioned • Some of the proposed changes currently exist in NZ, such as the mandatory training of some gambling machine venue staff; the Australian proposal may take this further in requiring all such staff to be trained, rather than being sufficient to ensure one trained staff member is present as is currently required in NZ; online Lotto in NZ does have pre-commitment currently. • Although a change of government may vary

	○ A $250 daily withdrawal limit on gambling venue ATMs other than casinos, by 1 Feb 2013 ○ Electronic warnings and cost of play displays on gambling machines by 2016 ○ Provision of 50 new financial counsellors for PG services and increased online help ○ Strengthening self-exclusion provisions ○ Training for staff in gambling machine venues ○ Banning live odds during sports coverage ○ Online sports betting companies offering credit will be prosecuted and inducements to gamble limited ○ Pre-commitment will also apply to online betting	this direction, the proposed changes cover a wide range of gambling modes, with a strong focus upon gambling machines, and the suggested changes have followed many of the recommendations of the Productivity Commission and an evidence-based review process. • The outcome of the trial on effectiveness of pre-commitment will be of interest, while the progress in instigating the other harm minimisation strategies (with or without a trial) will provide evidence that is relevant to the NZ environment
Guideline for screening, assessment and treatment in problem gambling (PGRTC) (2011) Authors: Clayton, Monash University ISBN Online: 978-0-9870540-0-5	• The Guideline summarises research and knowledge about PG and gives recommendations for screening, assessment and treatment • The presence of coexisting mental health disorders (MH) and problem gambling (PG) were estimated using a meta-analysis of eleven studies. Although prevalence rates varied across the studies for each of the MH, the weighted heterogeneity (error due to study differences) was moderate, so could be relied upon with some caution. • Coexistence of PG and different MH were 28%	• This is a timely summary of the state of problem gambling treatment in Australia and has substantial relevance for NZ. It addresses tertiary and secondary ends of PG treatment, rather than prevention, nor does it address family harm from PG. It was carried out as a Cochrane Review approach and categorises findings according to that body's approach • Recommendation categories range through A=evidence trusted to guide practice, B=trusted in most situations, C=some support but care required, and D=weak evidence and apply with caution; two further categories where evidence insufficient but has merit are: 1) consensus

	affected also by alcohol disorders, 23% depression, 10% bipolar, 58% substance use which includes alcohol, 17% illicit drugs, 60% nicotine, 37% anxiety, 11% generalised anxiety, 38% a mood disorder, and 29% antisocial personality disorder • They state however, that although understanding the functional relationship between PG and MH is critical in treatment, that these clients will have more severe problems, 'the presence of co-morbid psychiatric disorders and their implications for PG screening, assessment and treatment has received little attention' • Acknowledged research that between 7%-12% of pathological gamblers sought help or attended Gamblers Anonymous, and those seeking help were more likely to have 'much more severe gambling symptoms and are more likely to present with co-morbid conditions'. Research with these PGs may exclude therefore, the majority of PGs who didn't seek help (less severe, less likelihood coexisting MH problems) and that this is a bias of such research. • Targeted screening of PGs with coexisting MH is worthy of consideration • Screening of PGs is prudent for anxiety, depression, personality disorders, alcohol dependence, drug dependence, other impulse control disorders, and family violence. • Recommendations as to which screens to use	based=recommendation based on expert opinion as insufficient evidence available, and 2) practice point=practical advice and information based upon expert opinion • It is noted that due to lack of evidence, no evidence-based recommendations could be made regarding either screening or assessment. Only 4 studies met stringent criteria. Conclusions were therefore consensus-based which may reflect Australian views (experts Australian based but endorsed by the International Gambling Think Tank which does include NZ experts) • Although the focus was upon gambling harm, rather than Pathological Gambling, screens were assessed against DSM-IV criteria, which were stated to be the gold standard for pathological gambling. Screens assessed against other screens were regarded as less validated. There is a viewpoint held by many experts that DSM-IV criteria for Pathological Gambling is not a gold standard, and at best is a de-facto gold standard against with which care should be taken. For this reason a triangulation approach (comparison with a number of such lesser standards or measures) may be appropriate, especially as secondary PG criteria may not be represented in DSM-IV • Recommendations for PG treatment were based upon 34 randomised controlled trials (RCTS) which met strict inclusion criteria. The authors commented that research often didn't

	were based upon expert opinion (consensus-based) rather than research, as insufficient evidence was available. On this basis, 3 brief screens were the BBGS, the Lie-Bet, and the NODS-CLiP, one medium screen (PGSI) and 3 longer screens (SOGS, VGS, & PPGM)
	• Other consensus-based recommendations were:
	  ○ refer positives on brief screens for further assessment and treatment by trained specialists, and PG screening should occur in primary health settings where patients present for MH problems, and those in groups at-risk for PG
	  ○ adolescents and children with high risk of MH should be screened for PG
	• Evidence-based treatment recommendations are:
	  ○ Group or individual CBT be used for PG treatment (confidence level: B –use in most situations)
	  ○ Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET) be used for PG treatment (confidence level: B –use in most situations)
	  ○ Practitioner-delivered psychological interventions be used for PG treatment (confidence level: B –use in most situations)
	  ○ Practitioner delivered interventions preferred over self-help psychological
		account for the differences between different types of gambling, the effect of coexisting problems on PG, and the lasting effects of treatment over time. They posited that over time, relapse may be the rule rather than the exception.
		• The variation and complexities that PGs present with, and the fact that for many PGs, relapse may be difficult to avoid, may mean that more flexible measures of effectiveness may need to be considered when evaluating outcomes. In NZ, there is now a strong drive to address PG and coexisting problems, which may be the majority of presenting PGs. Yet, in much of the research around PG, PG with severe coexisting MH problems (CEP) may be excluded from the study. The lack of research into PG and CEP may suggest that this summary, while important and informative, may provide a starting point for future NZ-based CEP focussed studies rather than a basis upon which screens, assessment and treatment should be measured for NZ.

	interventions used for PG interventions (confidence level: B –use in most situations) ○ Group psychological interventions to reduce PG (confidence level: C –some support but use care) ○ Antidepressants should not be used as a treatment where PG alone exists (confidence level: B –use in most situations) ○ Naltrexone could be used to reduce PG (confidence level: C –some support but use care)	
The influence of depression and other co-occurring conditions on treatment outcomes for problem gamblers: a cohort study (2011) Authors: Smith D, Battersby M, Harvey P, Pols R, Baigent M & Oakes J. Medical J of Australia, 195(3), supplement 56-59	• Problem gamblers (n=127) referred for therapy for their gambling received up to 12 one-hour weekly therapy sessions • All PGs were from a single service and were primarily gambling machine players • PGs were assessed for co-occurring anxiety, depression, and alcohol problems • A CBT exposure to gambling programme identified the influence of co-occurring MH conditions on treatment outcomes • Assessments were conducted at 1, 3, 6 and 12 months. • PGs with higher depression were more likely to relapse during and after treatment. Although co-occurring anxiety and alcohol problems weren't statistically significant individually, they appear to have (negative) influence overall, although how they affected treatment for PG was unclear.	• This research continues to confirm the importance of identifying coexisting problems when screening and assessing PGs. • Although alcohol and anxiety appeared not to have a strong effect on the success of treatment, there appeared to be some negative effects that their coexistence may have contributed to treatment deficits • Depression clearly affected the treatment outcome and this suggests that identification, assessment and interventions in an integrated process (with the PG) is warranted, and that PG practitioners should have these competencies • This supports both the screening of all PGs for common coexisting MH conditions, and to a lesser extent, provides some support for screening those affected by MH for PG.

	• The authors recommended screening of all PGs for conditions such as depression and anxiety, and that MH patients be screened for PG for earlier identification and to enable better outcomes.	• This research is published in a medical journal and further supports the screening for PG and coexisting conditions in primary health services.
<u>Primary health and problem gambling research/articles</u>: 1) Problem gamblers in primary care: can GPs do more? Author: Sanju G & Gerada C (2011). (Editorial) British J of General Practice, April 2011. 2) GPs now have guidelines to manage gambling disorders (2011) Author: Wee L, www.responsiblegambling.org 3) Validation of a one item screen for problem gambling (2011) Author: Rockloff M, Ehrich J, Themessi-Hubur M, Evans L. J of Gambling Studies,	These three articles had relevance to primary health screening, assessment or interventions for PG 1) This article by the Chair of the Royal College of GPs in London and a consultant for Solihull Integrated Addiction Services is written and endorsed (as an editorial) by influential authors • The authors raised concerns that GPs may have low awareness of PG, which may be linked to their limited knowledge of identifying and intervening in PG. There may also be a perception that PG is a social or 'personal' problem, not a health problem. In primary settings, they say, PG goes largely unaddressed • PGs are described as having a wide range of co-morbidity (both physical and psychiatric) and should account for 6% of patients • Accurate and easy to use screens exist, while untreated PG will impact on the individual, their family, and society • GPs can provide brief interventions, including referral and appropriate treatment similar to alcohol/drug screening and referral a decade ago and now addressed through a national training programme. This is not available for PG	• Primary care provides an untapped opportunity to identify and intervene in PG, to follow up, and to address family issues that arise through PG. The high use of primary care services and resources that align with the CEP approach in NZ (e.g. use of the NZ CHAT screen) support this opportunity. • The three articles identify that there has been a recent increase in different parts of the world in developing this opportunistic intervention strategy that would align with NZ's own CEP approach • Further training is suggested for UK and Singapore primary health, and from a NZ perspective, is likely to include other health professionals in addition to GPs. The Singapore initiative appears to be further advanced, in that its Ministry of Health is leading the strategy • The development of the 1-question screen suggests that either restricting the question to 12 months may reduce its effectiveness, or that PGs do not readily accept they may have a problem. The NZ brief screen also uses this (approximate) question about whether gambling has been a problem and whether it is

27(4), 701-707	but shared care programmes should be developed for PG interventions • GPs should receive such training such as described in the British Medical Association publication *Gambling Addiction and its Treatment Within the NHS: a Guide for Healthcare Professionals* (2007). • While not suggesting all patients are screened for PG, those with psychosomatic symptoms, other psychiatric disorders (including substance misuse, depression, anxiety-spectrum disorders) and financial problems, should be. • The Lie/Bet is suggested because of its ease of use, or a 3-questions screen developed in Birmingham (Do you gamble; Do you experience problems with your gambling; Would you like to talk with someone about your gambling?) followed by referral to a specialist PG service • They refer to a pilot in Birmingham (funded by the South Birmingham Primary Care Trust and serviced by an alcohol/drug & gambling service; unpublished) that has been in operation since 2009 • The authors hope that this paper will help stimulate such strategies in this 'hidden' addiction. 2) Medical practitioners in Singapore now have guidelines from the Ministry of Health • The Director of Medical Services stated that the guidelines had been developed to assist detection, diagnosis and treatment of PG	current, but also incorporates the Lie/Bet screen. If the NZ screen is affected in the same manner, then substantial false negatives (an undesirable outcome for brief screens) may be occurring. • This last research raises the need to ensure that sensitivity is not compromised for the sake of brevity. • An additional factor relevant for NZ is that an embedded 2-question screen in the primary care CHAT tool has been validated, and although the second question also asks a similar question ('Has gambling sometimes caused you problems?'), the first question is designed for primary care settings ('Do you sometimes feel unhappy or worried after a session of gambling?), which has been found to be sensitive and therefore may influence a different response to the problem question. The NZ approach would be that all patients complete the multi-issue tool, and so avoid further false negatives through 'pre-screening' of patients by primary care professionals which, in the opinion of the UK leaders, may well fail to identify when to screen for PG without further training • Overall, the interest raised by health professionals who are associated with primary health provides a positive change of direction for the primary care sector providing help for PGs and their families.

	• PG had far-reaching consequences, including relationship breakdown, difficulties in work/studies, financial problems, physical and MH deterioration • All GPs would receive the guideline, although some considered more training would be required, as GPs focussed upon physical rather than MH issues • The opening of two large casinos in Singapore were contributing towards PG • Younger PGs were seeking help, suggesting preventative initiatives for adolescents were appropriate • Sports betting was a major problem. 3) A single question screen has been developed for primary settings (and research where longer screens not practicable; screen development Thomas et al , (2010) Monash University, unpublished; Thomas et al (2008) MJA 189(3), 135-6) • This study sought to replicate findings of acceptable comparison with the PGSI • A telephone survey (n=1292) found very high false negatives (79%) who were positive on the PGSI but negative on the 1-item screen 'for the last 12 months'. • The current study varied over the previous study in framing the 1-item in the past 12 months, similar to the PGSI time period • The authors however, concluded that, notwithstanding, that doubt existed whether PGs would self-identify their gambling as	

	problematic (the 1-item screen asks: Have you ever had an issue with your gambling?)	