Report to the Ministry of Health

Feedback to MOH re Emerging Trends in National & International Literature

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Literature	Findings	Comment
Venue Staff knowledge of their patrons' gambling and problem gambling. Authors: Delfabbro P, Borgas M & King D (2012). Journal of Gambling Studies, 28, 155-169. doi 10.1007/s10899-011-9252-2	○ The aim of this study was to compare gambling venue staff assessment of problem gambling with self-reported (screen) assessment by patrons of gambling venues in order to estimate the effectiveness of gambling staff interventions with at-risk or problem gamblers. ○ In many gambling venues around the world staff are required to identify possible problem gambling by patrons. In South Australia where the research occurred, compulsory training is required. ○ There are some visible indicators of problem gambling. ○ Little or no research has occurred as to the effectiveness of this intervention. ○ This research covered seven small to moderate venues in Adelaide with typically 30 gambling machines each and n=303 patrons participated. ○ Patrons provided information on their attendance and completed a gambling screen (PGSI) and venue staff were asked to independently assess	○ This research is an important indicator for effectiveness of the need for monitoring of this 'coal-face' opportunity to identify both early and established problem gambling in NZ. ○ Although the research is in Australia and did not include casinos, and training requirements may vary from those required under the NZ Gambling Act and its regulations, this appears to have considerable relevance to NZ. ○ Staff training is compulsory in NZ for categories of class 4 gambling (gambling machine), some class 3 (racing, sports), and casino staff, which includes the requirement to identify possible problem gamblers and intervene. There are fewer gambling machines per site in NZ than in the Australian study. ○ This study only addresses the effectiveness

	these patrons. ○ Only regular patrons were included in the analysis. Staff had seen 76% the patrons participating on a weekly basis, and 18% fortnightly. ○ Of patrons who were screened as no risk or low risk, staff categorised 90% 'correctly' but considered 10% as having some problems (moderate risk or problem gamblers). However, of those screened as having some risk for problem gambling, only 24% were 'correctly' categorised by staff, with a further 76% being false negatives. ○ Venue staff assessed some patrons at-risk for gambling problems but at a lower level than screen findings, while one-off assessments by staff were not sufficiently accurate to effectively identify problem gamblers. ○ The study canvassed the evidence for valid observable problem gambling symptoms and noted that Schellinck & Shrans (2004) identified several indicators that provided a high confidence for problem gambling existing (e.g. gambling more than 3hrs and borrowing gambling money), although some symptoms were less observable (e.g. feeling depressed). In another, Hafeli & Schneider (2006) identified 39 possible indicators of problem gambling and these have been used in Swiss casinos. In 2007 (Delfabbro et al), indicators from the 2004 study were put into the categories raised in the 2006 study (frequency/intensity of gambling; overt attempts to obtain additional funds for gambling; social behaviours - e.g. isolation,	of identification of possible problem gamblers, and this categorisation is imprecise. ○ There is evidence that overt indicators of problem gambling exist, and that staff can identify regular gamblers. The noting over time of symptoms may avoid the high false negative finding that this study identified through asking at a single point for staff to categorise patrons. ○ A further question is whether the PGSI is a correct or accurate identifier of problem gambling. With the difficulty of categorising problem gambling (there is no 'gold standard') as well as the absence of full validation of this screen for NZ, the accuracy or generalisation of these findings to NZ cannot be confirmed. ○ However, it would appear that there is a likelihood that staff will under-estimate problem gambling, and that especially when a negative response may be elicited when an intervention occurs, it is possible that a high majority of problem gamblers may have their gambling unaddressed. ○ A review of this study by The WAGER (Vol. 16(7)) drew attention to some limitations of the study: use of more than one screen may reduce error, larger venues provide a wider range of gambling and may provide differing results, and only a small percentage

	rudeness; emotional responses, and inappropriate attributions/reaction to losing). Three or more symptoms or indicators over time were highly likely (over 90%) to identify a problem gambler. Problems in using this approach included that several hours of observation may be required, and that a relatively small amount of time was spent by staff close to the gamblers during shifts. Multiple sessions of observation were suggested in order to address these barriers, and such a strategy was used by the Swiss. ○ The authors concluded that for these staff and gambling patrons, staff were not able to differentiate between problem gamblers and others based upon their observations. The authors recommended that possible symptoms be logged over time for this subset of gamblers and combined with technology that may recognise at-risk patterns of gambling.	(unknown) of patrons who were approached agreed to participate. It concluded that although staff ratings of patron problem gambling were found to be unreliable, it was unclear as to whether this was attributable to poor training or time restraints of staff in venues. It noted that bartenders have also been found to have difficulty in identifying intoxicated patrons (Brick & Erickson 2009) which may have more observable indicators, and therefore, for gambling, reliance only upon observable indicators may be too great an expectation. ○ The WAGER review does raise valid concerns. However, it suggests changes to future research that may resolve these issues. Additional screens will result in the possibility of identifying increased prevalence of problem gambling to one or other of the screens, but will result in increased (at least) moderate risk being identified, a laudable aim for harm minimisation strategies. If training inadequacies are contributing to low identification, this may also provide a part solution to the problem. Also, although low participation rates may have affected results, an argument may be that less problematic gamblers participated who may have been more open to disclosing their level of problematic gambling than severe problem gamblers as has been suggested by

		(Australian) Productivity Commission research (1999, 2010). If so, it is possible that some generalisation of the results may have been restricted, but there may be difficulty in enlisting more severe problem gamblers, although this will possibly be offset by more severe and greater numbers of indicators of problem gambling for this group, assisting with staff identification. ○ As few problem gamblers initiate help for their behaviour, interventions by staff of gambling venues provide an important health promotion strategy to develop, especially when the NZ Gambling Act focuses upon this approach. With many thousands of gambling venue staff in NZ required to receive training to identify possible problem gambling and to intervene to provide information and consider exclusion, this comprises by far the largest workforce for potential intervention opportunity for at-risk gamblers. ○ Similar research in NZ may promote strategies to address early and effective interventions, through problem gambling definition/identification and optimising a culture to monitor and intervene when problem gambling symptoms develop that aligns with the aim of the Gambling Act. Such research could include casinos as well as class 4 venues, to ascertain the degree to which the findings of this research translate

		to the relatively similar NZ environment. This could follow-up with identifying the effectiveness of such interventions, once risk has been identified.
A Swedish mutual support society of problem gamblers. Author: Per Binde (2011) International Journal of Mental Health and Addiction doi: 10.1007/s11469-011-9335-4	○ Mutual support organisations have been available in Sweden for 20 years and may be the primary help or support for gambling problems in that country. ○ The paper reviews the background of these support organisations and meeting processes. ○ It is posited that, in addition to support they provide for gambling problems at all stages of recovery, they provide a narrative of the etiology of the problem which gives insight and assists in guiding recovery. ○ Gamblers Anonymous (GA) is a support organisation that may attract many affected by problem gambling, but research is limited because of anonymity and closure to non-problem gamblers, while any research participants are self-selected (making control groups difficult, or estimating the number of attendances to comprise a treatment). GA has found difficulty in establishing a foothold in Sweden. Nevertheless, the author notes that GA plus cognitive-behavioural therapy has been found to be more effective than either intervention alone (Gomes & Pascual-Leone 2009; Hodgins & el-Guebaly 2010; and others). ○ These support societies are considered to be valuable additions or alternatives to professional therapy. The largest support society in Sweden for	○ This paper provides an important alternative for post-treatment (or treatment) that is under-addressed in NZ. ○ GA has far fewer chapters in NZ than in the past and appears to be poorly attended when compared with other 12-step groups such as AA. This appears to be the situation also in Sweden, although AA and GA members may disagree with the author's view that help and information is not generally part of the AA/GA approach, when the 12th step specifically refers to this. ○ Although clients are offered, post-treatment, the opportunity to reconnect should problems arise, this may be less utilised when support, rather than therapy is sought. Self-help groups can offer ongoing socialisation for gamblers over the long term, and a step towards recovery between 'problem' and 'in-recovery' status. ○ In addition, relatively few problem gamblers seek help, and a support organisation that is immediately accessible (some PG therapy may require waiting), and does not imply 'a disorder' exists, may attract many PGs who would not otherwise seek therapy. ○ GA does have the requirement that it not

	problem gambling (PG) is the National Association of Gambling Addicts (*in Swedish*, SBRF). ○ Meetings of the SBRF include group sharing, without religious or 12-step processes. Following Swedish organisation culture, meetings are fully democratic, receive state and municipal funding. Unlike GA, SBRF is an active social organisation engaging in social gambling policies, and is often consulted by the Swedish government. The SBRF also is active communally, offering lectures to schools and workplaces. There is no anonymity required and members are encouraged to interact in policy issues. Guests with an interest in its activities are invited to attend. Unlike 12-step groups, experience and knowledge of its members is provided to others. SBRF members can be problem gamblers or family members. Volunteers assist to run open drop-in services, and these volunteers are problem gamblers with 6-month's abstinence from gambling. ○ The Gothenburg (pop half million) SBRF chapter has a membership of 200 and a staff of 20. A typical process is assessment with DSM (average 7/10 criteria of members suggesting severe PG), planning to address acute issues (eg. evictions, employment dismissal, legal debt issues), then a prompt invitation to attend open meetings which extend to families. Impediments to attending may be the need for acute psychiatric help, or being under 17 years of age. Usually, three meetings occur each week, with average total attendance of	accept financial support from others (i.e. it is self-funded by its members), and because financial problems are usually a consequence of problem gambling, this may be a barrier to maintaining GA services. This was successfully addressed in the past in NZ when the Compulsive Gambling Society provided an establishment support service, became the NZ representative of GA, provided GA literature and funded a recovering gambler as a mentor, until 1997. ○ Currently in NZ, some of this ongoing support is provided by the Gambling Problem Helpline; however, face to face meetings with others affected by gambling may provide a stronger socialisation recovery strategy, and thereby an important additional support tool. ○ This study suggests a comprehensive alternative through funding that can provide an important ongoing support for problem gamblers and their families that may not be currently available in the NZ treatment provision. ○ Although costs are not detailed, it would appear that much of the human resources are provided by volunteers, and funding is shared between state and metropolitan services. ○ By membership of a peer service that interacts with the community, ownership and a sense of belonging may be an additional

	54 a week. Attendees are assigned (for variation) to groups of 6-8 who meet in separate rooms. Specific disclosures are kept confidential, but issues without names are unrestricted. Specific sums of losses are not discussed, as impacts vary and large losses may glorify gambling, but emotions and social impact disclosures are encouraged. Meetings are 2 hours and sharing in turn, starts. A 15min break after an hour enables groups to mingle. ○ Youth groups meet separately on a different day and attract 6-10 members and varies, in that reminders of meetings are given by phone, email, Facebook, or other electronic means, and meet Saturdays afternoon/evenings for social activities. ○ An example of attendance profile (excluding invited guests) has been 70% male PGs, 9% female PGs, 14% female relatives, 7% male relatives. Most problems were electronic gambling machines (EGMs), live and internet poker, internet casinos, casino games, and sports betting. ○ The meetings provide a response to often, poor social lives of PGs, while youth may not have socialised in the past, and this provides an opportunity to create new identities rather than as 'a gambler', as well as educational and occupational choices. ○ Meetings enhance self-esteem, assist to reduce family stress, give a sense of progress, promote socialising, and give release to emotional stress. It promotes motivation and highlights PG as a topic to be addressed. It provides insight to erroneous	benefit to those that the health promotion services provide through PG treatment services. ○ This approach described may address the low help-seeking level of families for treatment, the similar low help-seeking by young people affected by gambling (their own or their parents), and improve the level of help-seeking of problem gamblers, for which research indicates 85% or more do not seek help (PC, 1999, 2010). In addition, providing an ongoing lower step for those who have received treatment may improve resilience, provide important ongoing socialisation, education and focus, and assist to de-stigmatise problem gambling, through its peer-initiated outreach and public education strategies. ○ This Swedish approach appears to expand upon GA (and Rational Recovery groups that may address gambling) by becoming a broad support service for those affected by gambling. Its relevance and generalisation to NZ may be uncertain although the profile of SBRF members may not be too inconsistent with NZ expectations: far greater numbers of males seek GA groups, EGMs are the main gambling mode described, and the Swedish population is relatively small. ○ In Sweden, the average level of PG severity of SBRF members appears high, and a NZ

	thinking, and an opportunity for narrative perspective (e.g. addiction, escape) understanding of why the gambling became problematic, and 'a solution'. ○ Although support groups are differentiated from therapy, some consider they may have shared features (Toneatto 2008) – emotionally charged, a healing setting, schemes for recovery, and procedure for resolving problems.	approach may emphasise family and those experiencing more moderate PG. ○ An ongoing watch of this initiative and discussion of its cloning to NZ may be an important initiate in attaining the aspirations of the spirit of the NZ Gambling Act.
Disordered gambling among higher-frequency gamblers: who is at risk? Authors: Hodgins D, Schopflocher C, Martin C, el-Guebaly N, Casey D, Currie S, Smith G & Williams R (2012) Psychological Medicine, 42, 2433-2444 doi:10.1017/S0033291712000724	○ Not all frequent gamblers develop gambling problems (PG). This research sought to identify which risk factors would predict heavy involvement and which would predict problem gambling- i.e. what differentiated frequent gamblers with gambling problems from those without gambling problems. ○ The authors noted that the Pathways Model of gambling addiction (Blaszczynski & Nower 2002) identified three pathways to addiction, each initially triggered by behavioural conditioning. Pathway one will be less severe PG where frequent gamblers will meet PG criteria (at least intermittently) with little impairment of control. Pathway two will be mood dysregulated PGs, and pathway three will be antisocial, impulsivist type PGs. ○ The authors state that an implicit assumption in the Pathways model is that all highly frequent gamblers	○ This research provides important evidence that some frequent gamblers may not be inevitably affected at some time by PG. ○ They have also provided information that has clarified or supported two common PG models, the Pathways model and the General Addiction Theory. ○ The findings that cigarette smoking has strong associations with PG; as does alcohol or other drug use, childhood trauma, and mental health conditions generally; all assist as indicators for PG or preventative measures, and as enquiry for the purpose of treatment plans for presenting PGs. ○ These issues are at least correlative and can't be concluded as causative of PG. Other studies have identified similar coexistence of

	will inevitably develop at least, the least severe PG (pathway one) through being behaviourally conditioned. They also posit that this does not always occur. ○ The primary aim of the research was to identify differences between high frequency gamblers who were not PG and those who were. Secondly, to distinguish between PGs and non-PGs who were not highly frequent gamblers. ○ N=1372 participants were enlisted to complete a battery of assessment instruments and provide demographic data. Recruitment rate was low (5%-10% of all). High frequency gambling was defined as gambling at least weekly on other than lottery. ○ Findings were able to differentiate between high frequency PGs and high frequency non-PGs which previous research had been less effective in doing. ○ High frequency PGs who were PGs were more likely to (one or more) smoke cigarettes, more likely to be dependent upon alcohol or other drugs, have higher anxiety or depression levels, have higher impulsivity and antisocial traits, or have experienced childhood trauma. In addition, as all mental health indicators were associated with PG amongst the high frequency gamblers, this (having a mental health condition) was identified as a vulnerability factor for PG. ○ The association of childhood trauma with PG was support for Jacob's (1986) General Addiction theory, which states that those usually either hyper, or hypo-aroused, who are affected by childhood	other mental health (CEP) issues with PG (e.g. Kessler et al 2008), and that addiction plus coexisting mental health problems will adversely affect onset, severity, recovery, and relapse of both the addiction and the coexisting issues (e.g. Todd 2010). ○ In NZ, the approach for PG treatment is to test for coexisting issues, and integrate them into treatment plans. The findings for cigarette smoking, anxiety and childhood trauma being important factors coexisting in PG, and that in their absence (and of the other factors identified) frequent gambling can exist without PG, suggests an important focus of enquiry in treatment and prevention (including relapse prevention). ○ The findings suggest that these factors may be systematically addressed in all presenting PG clients, and that strategies be incorporated in treatment plans. PG treatment practitioners can qualify as smoking cessation practitioners, and provide information, subsidised prescriptions, and support for smoking cessation with PG clients. Addressing childhood trauma through referral or in-house (if such competencies exist), addressing anxiety and depression through cognitive and/or behavioural approaches, and referral to general practitioners for medical interventions where required, and alcohol or other drug

	trauma, will have a higher risk for early onset of addictions that enable the person to dissociate, e.g. PG or alcohol/other drug use. ○ The presence of a large group of non-problem highly frequent gamblers (n=76 vs 60 PGs) was said to mitigate against pathway one of the model, although certain forms of gambling (those including electronic gambling machines) were more likely to be PGs, and the Pathways model may be valid for frequent gamblers who use EGMs (with or without other gambling modes). ○ Factors such as gender, intelligence, exposure to gambling, and excitement seeking, were found to influence gambling involvement, but not necessarily PG. ○ The authors concluded that PG policies (treatment or prevention) should focus upon these identified vulnerable groups, and if so, outcomes may be expected to be more successful.	interventions, are all possible and within the CEP approach used by addiction practitioners in NZ.