Report to the Ministry of Health

Feedback to MOH re Emerging Trends in National & International Literature

Report 09 covering 1st July 2014 to 31st December 2014

ABACUS Counselling Training & Supervision Ltd

Literature	Findings	Comment
Pathological and problem gambling in substance use treatment: a systematic review and meta-analysis Authors: Cowlishaw S, Mercouris S, Chapman A (2014) Journal of Substance Abuse Treatment Vol 46 (2), 98-105 doi:10.1016/j.jsat.2013.08.019	• This paper reviewed (meta-analysis) the presence of gambling disorders (pathological gambling and problem gambling: GD) in substance use (AOD) treatment. • Many important factors arise: whether the AOD and GD coexist, or occur at different times in the person's life, whether one condition increases the risk of the other, whether they impact upon treatment for either, whether they increase risk for relapse, and whether other conditions are more likely to coexist as a result (e.g. mood disorders and personality disorders) • The systematic survey applied to studies of patients accessing substance use treatment services, both residential and community programmes, over 18 years of age, and included general addiction treatment services although those with PG as their primary addiction were excluded (as were non-English and involuntary participation studies). • The meta-analysis indicated on average 14% (one	• Pathological and problem gambling (PG) and AOD problems in AOD treatment have been found to be strongly linked, with up to 50% of AOD clients also affected by PG (Weinstock, Blanco, Petry, 2006). Similar links have been found in NZ* • Competency requirements in NZ recognise that AOD practitioners should have knowledge, skills, and appropriate attitude to address co-existing PG amongst their clients (and similarly PG practitioners with AOD affecting their clients)** • However, there is little evidence as to what competence current AOD practitioners possess, and as to whether there is a systematic approach to these clients in screening, brief or minimal interventions, or strategies to avoid transfer of addictions (increase in severity of a secondary addiction)

	in 7) AOD patients also were affected by problem gambling, with 23% (one in 4) affected by some gambling issues from a broader perspective. Some findings have identified levels of PG as high as 50% in substance use treatment populations (Weinstock, Blanco, & Petry, 2006). Methodological reasons may explain the wide variation (e.g. definition of PG, community vs residential participants) • There were limitations in ascertaining whether these problem gambling issues coexisted with the AOD problems, or may have occurred sometime during the person's lifetime when AOD issues were not experienced. • The authors noted that the higher likelihood of PG and AOD problems coexisting may indicate several possible explanations. These include that PG and AOD may result from 'shared determinants, such as common genetic vulnerabilities'; that one may increase the risk for the other, or AOD may impair judgement and promote risk-taking (such as gambling); that financial losses through gambling may increase stress, with consequential AOD problems; financial stressors may erode support and thereby increase AOD relapse. It was posited that AOD in most cases would precede PG. • The authors concluded that 'the findings suggest a strong need to identify and manage gambling comorbidity in substance use treatment, whether these PG interventions are minimal, brief, but should be adjunctive to the treatment of AOD'.	• This research supports the need for identification and coexisting treatment of PG as an adjunctive issue. This will accord with Te Ariari (2010) coexisting approach, where addictions and other mental health issues (including other addictions such as PG) coexist. *Sullivan S, Steenhuisen R (2006) The CADS/ABACUS Problem Gambling Screening Project: gambling problems commonly co-exist in AOD clients. In Adamson SJ & Schroder R (eds). NZ Addiction Treatment Research Monograph. Research Proceedings from the Cutting Edge Conference, September 2006. Sellman D, Adamson S, Robertson P, Sullivan S & Coverdale J (2002) Gambling in mild-moderate alcohol-dependent outpatients. J Substance Use & Misuse 37(2):199-213 ** Parsonage P, Sullivan S, DAPAANZ, Matua Raki (Program) (2011) Addiction intervention competency framework: a competency framework for professionals specialising in problem gambling, alcohol, and other drug and smoking cessation intervention. Wellington, DAPAANZ

Decision-making deficits in patients diagnosed with disordered gambling using the Cambridge Gambling task: the effects of substance use disorder comorbidity. Authors: Zois E, Kortlang N, Vollstadt-Klein S, Lemenager T, Beutel M Mann K & Fauth-Buhler M (2014) Brain and Behavior, Vol 4 (4), pages 484-494 doi: 10.1002/brb3.231	• This paper reports decision-making amongst a range of groups (disordered gamblers (DG), health controls (HC), and other with DG and substance use disorders, and compares deficits, using a measure of the Cambridge Gambling Task. • Decision-making refers to a cognitive process, involving the pre-frontal cortex, where future consequences should be assessed prior to the action (in this case, gambling). The authors refer to deficits in both DGs and those affected by alcohol or other drugs (AOD) where there is a preference by AOD-affected people to 'prefer immediate profit even in the face of negative future outcome'. They noted that DGs appear unable to anticipate negative consequences that accompany their risky choices with consequential problems and appear to have a lack of insight into the task (gambling rules that may be disadvantageous to the player), rather than a neuro-pyschological dysfunction particular to problem gamblers. They also state that DGs often appear to regard their decisions as being correct • The authors noted that there were several components of decision-making that had not been previously differentiated in research, such as risky or rational choice, betting behaviour, reaction time, risk adjustment, and decisions made outside of the learning context. Any or all of these may be impaired in AOD and/or DG affected people. Previously, research noted that decision-making was impaired for both DGs and AOD affected people, but the level of impairment between the two	• This study has important implications for treatment. Whereas many of the people affected by their gambling may be also nicotine dependent, there has been a tendency to treat this nicotine use as a parallel addiction, with little evidence that it impacted upon the gambling. • These findings that nicotine may cause more severe gambling, with poorer decision making, support the requirement to integrate the screening for intervention and treatment planning, as well as training implications for PG practitioners. The ability to be qualified for, and be able to provide a prescription for reduced cost nicotine replacement therapy, to relate the smoking to the gambling in an appropriate manner, and to motivate clients to address coexisting smoking, is an important finding. • Addressing smoking in an integrated manner may raise the need to consider modification of the stand alone ABC model for smoking cessation, which may otherwise clash with the harm reduction model used in gambling therapy.

	did not differ significantly. However, because of the high overlap between AOD and DG, as high as 60% (Lorains et al, 2011), and in DGs for alcohol dependence (73%), and tobacco use (60%) (Petry, 2005), there was lack of clarity in whether the decision deficits were due to AOD or DG. • The aim of this study was to clarify the reasons for these deficits. Several subgroups of gamblers (n=80) were compared with a 'healthy control' group of (n=108). The subgroups comprised of DG only, DG with coexisting tobacco smoking, DG and alcohol dependence, and DG with alcohol dependence and smoking. • Findings were clear, that all DGs made irrational choices on the task. Those with DG only, DGs who were smokers, and DGs who were alcohol dependent and smokers, all had decision-making deficits when compared with the healthy non-DGs (i.e. controls), whether they smoked or not (n=32 were smokers, n=76 were non-smokers), amongst the healthy controls. • The DG and alcohol-dependent group were also more likely to develop their gambling problems at a later age. • The DGs who were alcohol dependent and smokers, were significantly more likely to also have elevated betting, which differed from all the DG and control groups. • The possible rationale by the authors is that DGs with alcohol dependence would have improved executive functioning of their pre-frontal cortex once	

	they were in remission from alcohol use (these clients were), however, with the addition of smoking, this improvement was delayed by the nicotine dependence. They also concluded that outside of treatment, the combined effects of alcohol and smoking on the DG would be greater expenditure on gambling, as well as more severe long-term consequences, such as higher debts. • Their finding supported a unitary model of addictions, sharing the same vulnerability mechanisms, and that the DG behavioural addiction was appropriately placed with other addictions in the new DSM5 Manual. • The authors concluded that 'gambling diagnosis accompanied by alcoholism and nicotine dependence represent a more challenging group of DGs with implications for treatment and therapy.' This compared with those affected by DG only, 'who seem to be intact when it comes to risk-taking behaviour, as opposed to previous findings' (where all subgroups were combined) • DGs who were smokers were more impulsive, but DGs who were alcohol dependent and smokers, were also liked with more aggressive gambling behaviour. • They also concluded that the relationship between DGs and controls' decision making and pre-frontal cortex dysfunction were indirect, suggesting psychosocial interventions focussing upon impulsive behaviour were best. • They also concluded that DGs who smoked	

	appeared to be associated with greater gambling severity, supporting previous findings (Oetry & Oncken, 2002) and this had implications for this more vulnerable group, with direct implications also for treatment course and outcome.	
The 'light drugs' of gambling? Non-problematic gambling activities of pathological gamblers Authors: Thege B & Hodgins D (2014) International Gambling Studies, Vol 14 (1) Doi: 10.1080/14459795.2013.839732	• This paper addresses whether gambling modes identified by problem gamblers which were stated as non-problematic, were able to be continued once the problematic gambling mode had been addressed • N=169 gamblers who had recently quit problematic forms of gambling were enlisted through media announcements. Most (84%) identified non-problematic forms of gambling that they continued to participate in. Of the gamblers with one or more 'non-problematic' modes of gambling, most had one (45%); 28% had two, 10% three, and 1% had four. • The authors noted that identification of gambling as 'non-problematic' was often perceived by other gamblers as indicative of poorer clinical outcomes (e.g. a lack of insight by gamblers, or continuing participation in an at-risk environment) • Findings were continued participation in these perceived non-problematic modes, following cessation of identified problem causing gambling modes, 'generally did not predict worse outcomes' as measured by acceptable scales, or increased time and money spent on gambling on these identified non-problematic modes • The only exceptions were bingo (with only one of 14 outcome variable (amount of money spent in last	• This paper has interest for the NZ environment. Many practitioners may be uncertain as to whether abstinence from all gambling may be best practice in encouragement, while a harm minimisation approach may not only encompass reduced playing of the problematic gambling mode, but also, whether or not advice can be given around other non-problematic modes • Gamblers attending groups or Gamblers Anonymous may be philosophically opposed to other gambling, while those with coexisting alcohol problems may feel conflicted when different advice is given for alcohol (cease use) as opposed to gambling (change use). • The difficulty is identifying what specific skills or supports will protect continuing gamblers, especially when transfer of addiction, and similar issues exist (betting upon uncertainties, chances of a large win (Lotto), continued focus upon gambling and others). The advantages may be that gambling in less problematic modes may still result in losses, but may be manageable, and may be an 'acceptable' treatment alternative to ceasing all gambling.

	three months)) and casino gambling (where several indicators or higher risk occurred) and confirming that casino gambling has higher risk factors for problem gambling, even if perceived as benign. • The findings by the authors were that problem gambler perceived non-problem gambling modes were not inherently harmless or harmful. More appropriate is the individual concerned, although they usually were correctly able to discern whether a mode of gambling was problematic or not for them • The authors also suggested that continued gambling by problem gamblers on perceived non-problematic gambling modes (following ceasing their gambling on problematic modes) 'cannot be seen as signs of poor insight and lack of acknowledgement of problems'. • This conclusion cannot, however, be generalised to all problem gamblers, as the participants were those who had been motivated sufficiently to successfully end their problematic gambling, and gamblers who were pre-contemplative or early contemplative (in terms of readiness to quit) may have 'less self-awareness, and might be less conscious about the harmfulness of their gambling activities'. • Participants were also asked to give their viewpoints generally about the risk of various modes of gambling. There was general agreement that gambling machines and casino gambling was problem-causing, while lotteries, scratch tickets,	• This paper provides some evidence that this alternative is possible, and is useful information for practitioners to provide to a gambler, should they be uncertain around living with the absence of gambling. Lotto provides enjoyment for the majority of the population and belonging may be an important desire for gamblers in recovery. Also, self awareness raising can be an important goal in managing this strategy of alternative gambling. • Of importance, may be the rapid changing complexity of gambling modes and that rather than concrete categorisation, yhere should be monitoring of their gambling and self-awareness. For example, although in this study, lotteries were stated by recovering gamblers as the least problematic, this may change when in NZ Lotto and Instant Kiwi become more easily accessible online, and jackpots increase in size and regularity. Instant Kiwi may, if provided online electronically, resemble more gambling machines than paper scratchies. Similarly, sports and racing have mixed opinions amongst the participants in the study. In NZ there are dedicated TV channels, online credit gambling, and 24 hour live racing/sports events. • The importance of this study is that an open mind is considered in working alongside

	bingo, raffles and family gambling was least problematic. Racing and sports betting were middle risk (although some chose risk and others non-risk for horse racing). • The authors therefore considered that they would recommend limited access to gambling machines and casino gambling to recovering gamblers. • However, the authors concluded that there was some support for gamblers who wish to quit or remain in remission for their gambling problem/s, that they may be able to 'continue involvement in some types of gambling', and that 'eliminating problem causing gambling activities might be a 'good enough' goal for pathological gamblers. Complete abstinence from all gambling may not be necessary and this may be a characteristic of pathological gambling that may differentiate it or distinguish it from substance disorders. • Nevertheless, advice should be given regarding moderate casino games and gambling machines as ongoing gambling choices, even if these have not previously been the problematic gambling mode.	gamblers in their therapy and that this paper suggests that agreeing to trial another mode of gambling is not a dangerous, unprofessional option to discuss with an uncertain client.
Characteristics and help-seeking behaviours of internet gamblers based on most problematic mode of gambling Authors: Hing N, Gainsbury S, Blaszczynski A (2015)	• The authors sought to differentiate from previous on-line gambling studies to identify problem gambling differences between land-based and on-line gambling, and whether this was associated with their help-seeking. • Their hypothesis was that on-line gamblers would be less likely to access help for their gambling problems, and if they did, then on-line help would be preferred	• This study has some relevance for NZ being similar to Australia, with many gambling access similarities. • Although the findings suggest less problems with on-line gamblers, many on-line gamblers may also access land-based gambling, and although these on-line gamblers appeared to be less problematic, factors such as unlimited access, credit betting (cards), lack of

J Medical Internet Research Vol 17(1) Jan doi: 10.2196/jmir.3781	• N=620 Australian problem gamblers participate through advertising, assessed by the PGSI, with a Kessler 6 screen to identify levels of distress • Findings were that on-line gamblers were less likely than land-based gamblers to seek help. They were also more likely to be male, younger than land-based gamblers, have lower distress, and more likely to be experiencing problems with sports and racing • Both on-line and land-based gamblers were not likely to access on-line help for their gambling, however land-based gamblers were more likely to access land-based help when compared with on-line gamblers • The authors concluded that 'more targeted and innovative efforts may be needed to increase access to gambling help by problem Internet gamblers'. However, their lower distress and lower problem gambling screen scores suggest a lower need for help.	monitoring by venues, with a growing range of gambling opportunities, all raise questions around why lower risk was found with on-line gamblers • The conclusions raised by the authors that more targeted and innovative efforts be available on-line for both land-based and on-line gamblers are timely, with the previous findings that most problem gamblers would prefer to address their own problems (rather than seek expert help; i.e. self-directed treatment) suggesting the need for stepped online help that can be initially self accessed and delivered.
Problem gambling Author: Thomas S (2014) Australian Family Physician 43(6) June, 362-4	• This is a brief paper reviewing the clinical issues for General Practitioners (GPs) detecting and treating problem gambling • It is noted that 1% of adult Australians are affected by problem gambling and a further 4% are at significant risk. Problem gambling often coexists with serious mental health problems and this has a clinical importance. The author notes that there are national guidelines in Australia around problem gambling that recommend that GPs screen for gambling problems and they have an important role	• It is notable that although the author notes that GPs have a low level of screening, the supports for screening through professional guidelines appear to be relatively strong and perhaps more evident than in NZ medical professional bodies • GPs provide an important source for both early and intensive treatment (through referral) and may be under-utilised as a resource. The CHAT screen developed as a brief broad combined screen that includes

	in this. These guidelines include the National Health & Medical Research Council as well as the Australian Medical Association that both support and recommend problem gambling screening. • Brief screening tools (some one-question) are available and developed specifically for GPs. • However the author notes that there are 'currently very low rates of treatment' by GPs, and seeks to advise GPs that there are effective and lasting treatments (CBT and Motivational Interviewing) available in specialist problem gambling treatment services	two validated gambling questions has been gradually taken up in NZ and elsewhere, and can provide an important solution as to whether to screen for problem gambling (at which point a screening decision has been made, with high risks for false negatives), the possible reason for low GP intervention in Australia.
Psychological treatments for gambling disorder Authors: Rash C & Petry N (2014) Psychology Research & Behavior Management Vol 7, 285-295	• The authors reviewed the research evidence for psychological treatment of problem gambling • Several treatment options were considered, including self-help, peer support, brief, intensive, and motivational options • They identified that peer support programmes improved when these were combined with professional treatment, but that there was limited engagement in peer programmes, and when so, retention in these programmes was limited • The authors noted that self-directed interventions were preferred by some gamblers and could be beneficial to them, but also noted that if therapists were also involved in the self-directed options (telephone or other contact options) then the self-directed options would be enhanced, even if the therapist involvement was relatively minimal • The authors noted that self-directed options also	• This American study has several important applications to NZ problem gambling treatment. • Although peer treatment options are usually applied to AA or GA/GamAnon (Gamblers Anonymous/Family of problem gamblers), in NZ, with AOD treatment combinations of peer and practitioners, interventions have successfully been provided in outreach treatments (e.g. Phoenix) and these approaches could be extended to problem gamblers and their families • Although CBT is the most likely approach in the USA, in NZ, it is more likely to be Motivational Interviewing, which has benefits not only for at-risk gamblers, but also severe gamblers • An important finding was the option of self-help strategies, with the brief involvement of

	assisted in removing barriers to problem gamblers' treatment seeking, and by doing so, increased help-seeking by problem gamblers substantially • Brief approaches and those based in motivational processes provided options for a wider range of clients, including those at-risk for problem gambling, those with established gambling problems, and those who would otherwise not seek treatment from practitioners • Of intensive therapies for problem gambling, the authors noted that no one therapeutic approach emerges as best, although they noted that CBT may be the most likely approach that practitioners applied. Specific treatment approaches for problem gambling required more systematic evaluation before there could be evidence to support a specific approach as 'best practice'.	practitioners. This suggests that providing telephone, text, or on-line practitioner support such as the specialist helpline for problem gamblers and their families, where counselling as well as resource referral could be provided, is useful. This paper, however, does emphasise the benefits are through opportunistic treatment provision, over resource referral. • Self referral options appear to be relatively rare in NZ, and the opportunity to develop online self-help options alongside problem gambling advertising to raise awareness of their availability, appears to be supported. Currently, the referral to a helpline appears to be second stage (direct to practitioner, even if brief) opportunity, while a first stage (self screen, information and options, self-applied strategies) may be less utilised. The researchers emphasise the extension to self-help options may increase help-seeking by problem gamblers, which is currently relatively low.