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

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ABACUS Counselling Training & Supervision Ltd

Literature	Findings	Comment
Gender differences in the presentation of observable risk indicators of problem gambling (2018) Authors: Delfabbro P, Thomas, A, Armstrong A. J Gambling Studies (2018) 34, 119-132 https://doi.org/10.1007/s10899-017-9691-5	• The authors noted that some countries' public health policies require staff in gambling venues to identify and assist people who may be experiencing gambling harm i.e. staff need to exercise a duty of care towards their patrons in respect of providing risks of gambling; where they can access help services for gambling harm; help patrons to find help is asked; and undertake required training • To assist this, researchers have identified behavioural indicators to identify those who may be gambling problematically • Warning signs have often related to the intensity and frequency of gambling; loss of control indicators; frequent attempts to obtain money to gamble; and display of unusual social and emotional signs around gambling • Some signs, the authors note, are not restricted to gambling harm and are less able on their own to assist in identifying problematic gambling, such as the length of time gambled, and how money is obtained by the person gambling. • Other signs, the authors note, are rare but are more likely to be displayed by gamblers experiencing harm, such as 'strong	• The 2019-2021 Gambling Harm consultation document notes, in accordance with the Gambling Act, that gambling environments provide opportunities to 'actively minimise harm, and individuals (can be) supported to recognise and seek support to minimise gambling harm' p41. The Sapere Research Group in their Gambling Harm Reduction Needs Assessment (2018) notes however, that venue staff are sometimes ill-equipped to prevent and minimise harm, and that opportunities to improve venue staff roles to identify and support gamblers experiencing harm are now timely (p90). • Venue staff have been reluctant to approach patrons exhibiting signs of harmful gambling because of adverse reactions, fears that regular gamblers will take offence and move to other venues, and that once approached, their behaviour will become even more

	emotional reactions and asking to borrow money at the venue' p.120. • The lead author has noted that statistically, if around five indicators are evident, then the probability of experiencing gambling harm is analysed at 90% likelihood (Delfabbro et al 2016), and such indicators may assist venue staff to identify those at risk and may be vital information for staff. • These warning signs, they noted, do not differentiate between men and women, and that so doing may assist in easier identification of such harm, and may encourage staff to intervene by using different ways to approach males verses females, chose a particular gender for the staff member approaching the person possibly experiencing harm to offer an intervention. • The authors noted that although gambling behaviour that may be resulting in harm may be similar across genders, gambling habits, motivations for gambling, and why harm develops may differ. Women gamble on a narrower range of gambling modes and are less likely to gamble upon games that require strategies, such as horses, casino tables, and sports. • Females develop problems more quickly ('telescoping') while men's gambling may start earlier in their lives; females are also more likely to report past childhood abuse, high levels of distress, and avoidant gambling to cope with emotions (which may be why EGMs are a more likely choice for those harmed by their gambling); males are more likely to gamble impulsively, and to use more alcohol and drugs. • N=1185 'regular' gamblers who gambled at least fortnightly that included N=338 people that were classified as experiencing gambling harm by the PGSI gambling screen with neither gender	furtive (Thomas et al, 2013). These concerns are best approached through training and awareness, and culture change. However, in NZ, there are legal obligations under the Gambling Act to identify and approach gamblers who may potentially be gambling harmfully, and therefore not only a duty of care exists but statutory legal obligations and penalties, if not complied with. The Australian authors note that compliance obligations as well as support should be provided to staff to meet their obligations in respect of gambling harm. This obligation is even further emphasised by harm minimisation requirements under the NZ Gambling Act. • However, the need in NZ to approach patrons who may be gambling harmfully may be under-exercised, because of the need in most circumstances to observe clear signs of harm. The authors have reported that time spent gambling and how gamblers obtain their money to gamble (presumably excluding requests to borrow from other patrons or venue) are not good discriminators of gambling harm from gambling without harm, however these are often a focus for those seeking to identify problematic gambling. These findings may further confuse and

	significantly different. People were recruited outside random gambling venues or responded to advertisements. • They noted that indicators of gambling harm were similar between genders, although there were several key differences or exceptions. • Emotional stress was more commonly displayed by females experiencing gambling harm, while males were more likely to display aggression towards the EGMs or to other people in the venue. • Females are more likely to display visible signs of distress (crying, signs of sadness or depression). • Male problem behaviour included striking or kicking EGMs, stand-over tactics to keep/obtain a preferred EGM, or being impolite to staff. Distress may be attributed to perception of skills or trying to beat an EGM with high expectations of winning, and therefore frustration/feeling cheated when unsuccessful. • However, the authors noted that many of these signs were displayed also by people not experiencing gambling harm, with the number of signs being more discriminatory i.e. more signs with gambling harm; also that females experiencing harm may be easier for staff to identify than males and staff may need to watch male gamblers longer to identify those males at-risk. • Males with gambling harm were more likely to try to display emotional distress as well as attempt to conceal their presence in venues, when compared with those not experiencing gambling harm; Females with gambling harm were more likely to show signs of anger, a decline in their grooming, as well as attempts to access credit to continue their gambling, when compared with those not experiencing harm.	dissuade staff from intervening, and suggest the need for greater clarification. • The findings of this research therefore provide needed evidence for signs suggesting an intervention is warranted, and also evidence that although most gender signs of gambling harm apply to both males and females, there are some gender-specific signs. • Including this evidence in staff training will support developing confidence to intervene, and to provide information to patrons about why their behaviour raises concerns, and the evidence that supports this. • Additional useful comments by the authors are that matching those intervening to gender-common signs may be appropriate. If males affected by gambling harm are more likely to be angry, aggressive to staff, and blame the venue, then a more mature male staff member may be more suitable, (although some female staff members may be willing and confident that their nurturing approach may de-escalate aggression). Similarly, if females experiencing gambling harm may be experiencing strong emotions because they are gambling to 'negate negative effect often arising from an extended history of emotionally distressing experiences and life events' p128 (cited

	• The authors posited that this additional gender-specific information would assist in refining venue policy and practice in identifying those people who were harmed by their gambling. • The authors suggested the need for adequate training of staff and 'unambiguous expectations regarding staff actions including consequences for non-compliance'.	McCormick et al 2012), then a female staff member may possibly be appropriate to intervene. • Overall, this research provides some evidence to support the presence of valid indicators and that intervention is appropriate, how indicators may vary across genders, and support for venue staff taking actions to address gambling harm in what may be a considerably under-utilised resource to reduce gambling harm.
Current suicidal ideation in treatment-seeking individuals in the United Kingdom with gambling problems Authors: Ronzitti S, Soldini E, Smith N, Potenza M et al Addictive Behaviors (2017) 74, 33-40.	• The authors noted that the WHO has identified suicide as one of the leading causes of death (WHO, 2014) accounting for 1.4% of all deaths (15th in ranking). Suicidal ideation was high amongst those experiencing severe harm from their gambling (17%-48%), or suicide attempts (9%-31%). • However, they noticed the wide disparity in the range of suicide ideation/attempts, whether it was current with the gambling, and whether coexisting problems may be the driver. • The aims of their study were to assess the prevalence of suicidal ideation and attempts in treatment-seeking people with gambling harm in the UK, identify the relationships between sociodemographic, clinical, and gambling-related variables and suicidality, and whether these variables may predict current suicidality in those seeking help for their gambling harm. • The authors collected data from N=903 help-seeking people with gambling harm who scored 8 or over in the PGSI screen (average score non-current suicidal ideation 18; average score current suicidal ideation 22), including sociodemographic data, anxiety, AOD use, and depression.	• There is a considerable volume of research to show that suicide risk and gambling problems coexist in NZ and elsewhere (Penfold, Hatcher et al 2006a & 2006b). • This research provides an important focus upon factors that increase the harm of gambling through raising the risk for suicide • The authors note that identification of current risk (e.g. within the last two weeks), past thoughts of suicide, depression and particularly anxiety, are factors to identify in presenting clients • Almost half of participating clients who were experiencing gambling harm reported currently thinking of suicide, with one in four having attempted suicide in the past. NZ has a high risk of suicide compared with other developed nations, and Maori being at particular risk (Coroner 2018). DSM5

	• 47% reported current suicidal data, and 62% had suicidal ideation at least once in their life. Of the latter lifetime suicidal ideation population, 23% had attempted suicide, 64% had only thoughts, 9% had a plan, and 3% had only self-harmed. • Women were more likely to have current suicidal ideation (64%) than men (45%), and were more likely to report coexisting anxiety and depression. • Of all participants, those with current suicidal ideation were also more likely not to be currently married (i.e. widowed, divorced, separated – 66%, or never married – 50%; versus 40% married). • Those with no current suicidal behaviour were more likely to be employed (57% versus 43% of those with current suicidal ideation). • Unexpectedly, the authors found no association between alcohol use and suicidal ideation in those experiencing gambling harm. • Those with current suicidal ideation reported a higher PHQ-9 score (depression) with an average 17.25 or moderate-severe depression range, while those without current suicidal ideation scored 8.58 (mild depression). • Those with current suicidal ideation were more likely to have higher PGSI scores (22 average versus 18 of those with non-current suicidal ideation), have more debt, lost a relationship, or job as a result of their gambling, higher anxiety, and were older. • The authors concluded that because almost half (47%) of clients reported current suicidal ideation (higher than most reported research), routine screening of presenting gambling harm clients was warranted. It was further concluded that structured assessments of suicide (rather than a single question) were needed.	identifies that 'about 17% have attempted suicide' p587. This figure is similar to the findings of this research (23% of the 62% who had suicidal thoughts in the past and current) and when this UK research is applied to NZ, an even higher risk may be present due to greater accessibility to gambling and higher identified risk for suicide in NZ. • Risk for suicide, gambling and alcohol use has previously been identified in NZ (Penfold et al, above), where 17.3% of hospitalised people who had made a serious suicide attempt were screened positive for problem gambling, a substantial prevalence taking into account the very low prevalence of problem gambling in NZ. Although alcohol was not identified as an additional risk factor in the Ronzitti research, other previous findings as well as the Penfold study, has found a considerable correlation of alcohol, gambling and suicide (Bischof et al, 2015, Hodgins et al 2006) • The authors noted the importance of routine screening for suicidal ideation. Screening for suicide is part of comprehensive assessment for clients presenting to treatment services in NZ. The authors indicate that those gamblers with higher PGSI scores and debt are at greater risk and again that risk should be addressed in the screening for suicide.

	• In addition, where gamblers experiencing harm also have anxiety, depression and substance use disorders, and particularly if suicidal ideation exists, therapy is needed to address these comorbid issues. • The authors also suggested that lifetime suicidal ideation is a more important risk factor or predictor of future suicidal ideation, and this was a stronger indicator than past suicide attempts, further emphasising the need to take a routine history of suicidality with clients affected by gambling harm. • Debt was also found to be a predictor of suicide by gamblers experiencing harm and financial counselling should be considered for individuals, especially for those with large debts. • Rather than focusing upon depression before the use of a suicide screen, the authors posited that the existence of anxiety potentiates the level of suicide risk, and the subgroup of gamblers experiencing harm with more anxiety symptoms and lifetime suicidal ideation may warrant a more intensive treatment programme (possibly medication and comorbidity management) to improve treatment outcomes and reduce suicide risk.	• Although screening for a wide number of correlating issues and disorders may be best practice, and may be a required practice in NZ gambling harm treatment, this evidence further highlights the importance of routine broad screening of every presenting client affected by their gambling. • This is also evidence for anxiety screening also to be routine, and that the CHAT screen be offered as an initial brief (2-3 minute) broad screen that covers anxiety, abuse, anger, smoking, exercise, and recreational drugs that are not required screening. • Overall, this research emphasises the complexity of gambling harm, its high comorbidity, and the need to routinely screen all clients, rather than 'pre-screen' by intuition.
The prevalence of problem gambling and gambling-related behaviours among older adults in Ontario (Sept 2018) Authors: van der Maas M, Mann R, Turner N et al J Gambling Issues, 2018, 39	• The authors noted that as the proportion of adults in the older age range increases, gambling remains a popular pastime, and as such, it is important to understand the implications that their leisure activities have for their physical and mental health. • The authors noted that although the participation in gambling and prevalence of gambling harm has been identified as lower than the general population, benefits of gambling can include organised bus transport to casinos and bingo. • They noted that gambling however, can have greater harm for older people, and loss of contemporaries, retirement, fixed	• The NZ Health Survey (2011/12) also noted lower risk of gambling harm for older adults (but above 15-24 years); however, issues that are not always addressed may be resilience to harm which may be lower amongst those older adults affected by gambling harm. • Older adults often have reduced health, have non-replaceable assets and limited income. Also the impact of lower losses may be greater because of these asset constraints.

DOI: 10.4309/jgi.2018.39.3	income, and illness may predispose some adults to gambling and experiencing gambling harm. The loss of money from gambling that is unable to be replaced may have greater impact on older persons than younger people experiencing gambling harm. • Previous general population research has identified males as being more likely to gamble and experience gambling harm, and this may be reflected in treatment that is biased towards males' needs. This may also continue towards types of stigma that prevent help-seeking being more focused upon male perceptions. • The authors noted concerns expressed by researchers around casinos offering free transport, lower cost food and alcohol, as well as music entertainment focused for older adults. • The authors focused upon three issues: 1) gambling prevalence of older adults, 2) gender differences for gambling and gambling harm for older adults, and 3) gambling behaviour, attitude and participation in gambling inducements, and perceptions of gambling harms and benefits. • N=2187 adults over 55 were surveyed around their gambling and related activities. 1.8% were identified as scoring 3 or over (moderate-severe gambling harm) on the PGSI, although a low number scored 8 or over. • No significant gender differences were identified in gambling harm, although there were gender differences in types of gambling participated in, attitudes towards gambling, and frequency of gambling. • Most common gambling was lottery (56.5% in last 12 months; instant draws 22%), charity draws (small draws 21%, large draws 32.5%), and EGMs (22.5%). Horse racing was relatively low at 3.6% (males 5.4%, females 2.1%).	• The study noted that the primary participation was lottery gambling, and that in NZ, the growth of lottery in the last report was 27% over the previous year, considerably higher than other gambling modes. • The focus of the report was casino gambling and noted that free services did enhance both the uptake and correlation with gambling harm for older gamblers. • However, although risk may be lower for gambling harm, help-seeking has been particularly low at 8% of those 65 and over (Sapere Research Group, 2018), the lowest age-related help-seeking cohort. • Reasons for low help-seeking may be shame, general attitude to help-seeking, or low motivation due to depression or anxiety. • Of importance may be that this cohort is growing quickly in numbers in NZ as the population ages, and the low prevalence of harm may be acting to divert attention towards other ages or affected populations with high risk for gambling harm. If the prevalence of harm is being under-estimated with this cohort (and low help-seeking may indicate this), targeted advertising may help to raise awareness and encourage help-seeking by this age group. • As lottery participation or expenditure increases, research is needed into whether

		older people are increasing participation and amount spent, especially when access to this gambling can be for low amounts, and is increasing in accessibility (continuous, multi-daily draws, multi-weekly draws, online options and multiple outlets. • This research does address a group that until now may be under-researched, yet may be seriously harmed when those that become desperate or commence gambling excessively may be unaware of the costs until too late, when ability to recover from excess losses are unlikely.
Effects of prevention and harm reduction interventions on gambling behaviours and gambling related harm: an umbrella review (2019) Authors: N McMahon, K Thomson, E Kaner, C Bambra Addictive Behaviors 2019, (90) 380-388.	• The authors noted that gambling harm is associated with a wide range of mental health problems, including substance use problems, and can affect families and others 'long after the gambling behaviour itself has ceased' p381. • The authors noted that the prevention paradox indicates that harm can occur to a larger number of low to moderate risk gamblers, as compared with smaller numbers experiencing severe harm, and that a preventative approach may be warranted to spread interventions across the entire population. In addition, they noted that there is a 'social gradient' in gambling harm, with those subjected to inequalities with income, accessibility, and density of EGMs, being more likely to be affected by gambling harm. • However, they noted further definitions and measures of both harms and low risk behaviour because other authors have suggested that the prevention paradox argument can be over-extended.	• This research demonstrates a new direction in research and focus upon a more public health model. • The limited effectiveness of individually focused research is noted by the authors as also having an unintended (at best) outcome of supporting a focus upon a small number of severely affected gamblers. • The limited effectiveness of current interventions may encourage more research and larger scale (public) research, although this should not replace research into clinical effective interventions for individuals and their families. The effectiveness outcomes of this study may also demonstrate the complexity of gambling harm, and need for

	• The authors posited that an umbrella review of systematically reviewed methodology would provide a 'unique opportunity to produce rapid and robust summaries of the evidence base for multiple intervention strategies', by evaluating the evidence for effective prevention and gambling related harm reduction. They also sought to identify the differential effects of the interventions across different socio-demographic groups. • The authors used the three strands of harm minimisation (supply reduction, demand reduction, and harm reduction) as well as the wheel of change measure (COM-B; capability, opportunity, motivation, behaviour) as their framework to measure effectiveness of interventions. • Evidence from 10 reviews of 55 studies was evaluated, covering a range of interventions. • Limitations were found with pre-commitment and limit-setting strategies in that although there was some evidence for effectiveness, reliance upon voluntary systems was not always adhered to (in 7 of 13 studies there were no positive effects). In addition, there were unintended consequences for high risk and gamblers experiencing harm with some studies, with higher limits being set, which are often exceeded. • Self-exclusion was often identified with positive effects limited to the exclusion period, however, 5 of the 11 studies found changes to gambling harm severity were not maintained once gamblers returned to gambling. Also, because self-exclusion is voluntary, many may not choose to act, while many that do (26%-60% of the studies) breached the exclusion at some stage. However, there were positive effects on gambling harm of improved psychological function, such as reduced anxiety and depression, and reduced family and work-related problems.	interventions both at the individual and public levels (rather than one or the other). • This does focus upon the limitation of the Reno Model for responsible gambling both in the difficulty as to motivation that gambling raises, as well as assumptions that choice to access services is a substantial discharge of obligations to reduce risk and provide support. • The need to focus upon at-risk gamblers, especially those where inequity occurs also supports new directions, not just in prevention, but perhaps in providing intervention for earlier stage harm (risk, moderate harm). • The suggestion that unintended consequences may occur though interventions (including those at earlier stages of harm) is an important point to consider in providing brief and intensive interventions. For example, self-motivated options may be ineffective if those harmed choose not to access them, and the percentages of these will be unknown – as such their effectiveness may only be assessed against those who have accessed or adopted the strategy, and effectiveness will therefore be unknown, but could be mistakenly supported as effective at face value. Also, where those at-risk or harmed choose self-

	• Less than half of the reviewed studies on youth programmes found positive effects (gambling or other problems). • There was some support for reduced EGM gambling hours allowed, smoking bans, personal feedback, removal of large note acceptors, restricting maximum bets, and removal of ATM cash machines. • The authors noted relatively low quality of evidence available and that the 'inverse evidence law' exists where least evidence exists for interventions most likely to succeed. Most research related to individually focused studies relative to supply and demand; the effect was less focus upon public reduction in gambling activity (particularly supply reduction interventions), and more on consumer protection. There was also a tension between individual self-control and responsibility, against simultaneously supporting liberalisation with reduced regulation, and that the focus upon the minority with gambling pathology shifts focus from what generates risk (where considerable power exists). • The authors noted what they viewed as a state-industrial gambling complex where governments who are involved in legislation and regulation of gambling are also reliant upon taxation and may also own the gambling business. They also noted concern for funding sources that may affect the direction and focus of research, and the need to be diligent in avoiding this influence. • They noted a gap in evidence around equity effects of interventions, with a social gradient in gambling behaviour and harm, as well as density of opportunities in poorer areas. The focus upon individual gambling may inadvertently increase inequities in behaviour.	actuated first steps - even when offered further steps, if less effective than the gambler may have wished - they may accept that they have discharged any obligation/accessed at the only level of effectiveness available. It is possible that those accessing early stage options (helplines and self-actuated online strategies) may have otherwise have contacted clinical services, and reduction in help-seeking statistics may be interpreted as reduced need. • This wholistic umbrella review of research provides an important bigger picture of research, effectiveness of interventions, and future focus of research and interventions. It is a timely reminder to review assumptions, possible biases, and perhaps shifting of approaches to reduce the greatest overall level of harm that occurs to the community through gambling harm. This is also a timely reminder of the focus of the innovative NZ Gambling Act.

Who uses self-exclusion to regulate problem gambling? A systematic literature review (2018) Authors: Motka F, Grune Sleczka P et al J of Behavioral Addictions 2018, 7(4), 903-916	• The authors stated that gambling harm was significantly increasing due to harm to individuals, the expansion of gambling internationally, and growth of online gambling (usually accessible at home or by smart phones) which is more accessible, anonymous, and concealable, while offering more flexible payment options. • They noted that self-exclusion programmes are insufficiently used (Fiedler 2014; Gainsbury 2014) and that rates of self-exclusion varied from 0.6% to 17% in Canada and Australia land-based, and 5.4% to 11% online. • They reviewed sociodemographic features and behaviours of self-excluders, their goals and motives, and whether they gambled online or terrestrially (land-based). Barriers as well as use of professional help by excluders were addressed. • 16 studies published in English and German language over a decade were reviewed. • Possible exclusion periods varied (e.g. 3months to 5 years e.g. Montreal; or lifetime (Missouri)), with possibility of required referral to treatment providers (Queensland) or by option (South Australia). Information around online exclusion was stated as being difficult to ascertain (however an example of Austrian casino exclusion offers 1-12 months). • Online gamblers were earlier age excluders (10 years younger). • Self-exclusion was mainly motivated by financial problems, then from fear of loss of control and impact for significant others. Mental health (to avoid suicide) was often a reason to self-exclude. • Approximately 20%-30% sought professional help for their gambling after a few months of self-exclusion, and more likely if harm was more severe and with goals of abstinence, however	• NZ options of multi-venue self-exclusion provides an important advantage. Also, the requirements of the Gambling Act in training of venue staff to approach, provide information and offer exclusion, or compulsorily exclude, addresses many of the findings in this research. • The importance of competent venue staff training is highlighted, providing a range of time exclusions appears to be important, although effectiveness of short-term exclusion balanced against possibly higher attractiveness of short term options has yet to be assessed. • Online options were restricted to just one study, and online gambling raises considerable difficulties when multiple online options remain unconnected and difficult to exclude. Site blockers self-installed may provide options but these can be easily side-stepped using alternative smart phones when urges over-ride. • Ease of, and awareness-raising of exclusion, offering of counselling at time of exclusion, further assessment at time of re-entry, improvements in venue staff training and motivation, all provide improvement options for self-exclusion in NZ, even with the advantages we appear to hold over many other countries.

	most self-excluders did not see treatment as necessary, whether land-based or online gambling. • Self-exclusion tended to occur at late stages of gambling harm severity, suggesting use of advertising to support self-exclusion as a means to regulate gambling at an earlier stage, prior to gambling pathology. Multiple-exclusion options, support of venue staff with appropriate information and privacy security are positive supports to exclusion. Improving staff competencies (to identify, intervene) and choice of exclusion periods were seen as important drivers of self-exclusion. Offering of counselling during the self-exclusion, as well as follow-up during the exclusion were seen as positive. • Barriers to self-exclusion (only available from land-based gamblers) were complicated procedures to exclude, lack of ability to exclude from all venues, little staff support, and lack of information on exclusion programmes. Embarrassment, privacy and confidentiality concerns, confidence that their breaches would be detected, and negative or unsupportive venue staff were also barriers. • In conclusion, the authors considered that targeted information (financial, role of significant others), simplifying exclusion processes, an early stage of gambling harm focus, choice of exclusion term, as well as promoting additional professional help for treatment of harm were important. For regulating impulse control, self-exclusion and professional help needed to be strongly connected.	