

Report to the Ministry of Health

Feedback to MOH re Emerging Trends in National & International Literature

Period covered: 1st January 2016 to 31st June 2016

ABACUS Counselling Training & Supervision Ltd

Literature	Findings	Comment
<p>Mood and anxiety Disorders are the most prevalent psychiatric disorders among pathological and recovered gamblers (June 2016)</p> <p>Authors: Tony Toneatto & Sabina Pillai</p> <p>Mental Health Addiction (2016) 14.217. doi: 10.1007/s11469-016-9647-5</p>	<ul style="list-style-type: none"> • Pathological (or now Gambling Disorder) and problem gamblers ('PGs') are commonly affected by psychiatric disorders, and particularly mood and anxiety disorders. • The authors noted that little is known of the rates of this co-pathology in either those PGs who are actively gambling, or those who have recovered from their gambling harm • The authors sought to compare the rates of lifetime and concurrent psychiatric comorbidity in these gamblers using a community (as opposed to treatment) sample of PGs • The authors noted that a large epidemiological study (NESARC; Petry 2005) had identified that 49.6% of pathological gamblers were affected by mood disorders and 41.3% were affected by anxiety (major depressive Episode 37%, dysthymia 13%, panic disorder 18%, phobias 23.5% and GAD 11%), significantly above those without PG. In addition, alcohol (73%) and other drug use disorders (38%) were also common. Other studies have noted that PG is associated with any mood, bipolar, GAD, PTSD and AOD (Chou & Afifi 2011) while a recent study (Abdollahnejad et al 2014) identified that approximately two-thirds of pathological gamblers were affected by a mood or anxiety disorder together with a further type of disorder, usually AOD. In this recent sample, 26% were diagnosed with depression and 16.4% reported suicidality. This compared with gamblers who were not gambling pathologically – 18% with depression and 1.5% suicidality. • In treatment seeking PGs who were outpatient psychiatric patients, current coexisting disorders were major depression disorder (52.5%), social phobia (42.5%) panic disorder (40%), PTSD (22.5%) and phobias (20%) were common (Zimmerman et 	<ul style="list-style-type: none"> • Although co-existing mental health problems are known to be high amongst problem gamblers, little was known around whether these persisted post-treatment for PGs, and whether those in recovery may naturally recover from these co-existing disorders once gambling had been successfully addressed • Participants were obtained from the general populations (through advertisement) rather than treatment populations and may be more generalisable in findings taking into account that probably less than 10% of PGs seek treatment. • High levels of depression and anxiety initially suggest that these are issues to be addressed in PG treatment, and the findings that these do not abate following resolution of the PG would suggest that addressing these coexisting issues within PG treatment may be important. • Also, it appeared that AOD issues increase as possibly a 'transfer' of addiction, and that escape from problems may be a focus rather than the learning of other coping skills. • The very broad range of co-existing problems, which include high levels of sexual abuse, suggest the need for the formulation of treatment plans that take into account a wide range of issues, as well as the need to address risk for alcohol and other drug substitution following PG treatment

	<p>al 2006). Pathological gamblers had on average three current and five lifetime mental health disorders. Over their lifetime these pathological gamblers who were also mental health patients had lifetime rates of 76% for major depression, and 38% hypomania</p> <ul style="list-style-type: none"> • Recent research with PGs using CBT found the existence of coexisting anxiety and mood disorders did not adversely impact upon PGs therapy for their PG harm (Smith et al 2015) • The authors noted that despite this knowledge about treated PGs there was little information about comorbid mental health issues in recovered PGs. Matched groups of RGs and PGs were compared. • Recovered gamblers (RGs) were positives on the lifetime SOGS screen but had not had gambling problems for one year, while PGs were positives on DSM-IV. • RGs' current prevalence of Major Depressive Disorder was 24% and GAD 12% compared with lifetime levels of 36% for Major Depression, 34% adjustment disorder, phobias 24% and PTSD 24%. • RGs had lower rates of phobia and adjustment disorder than current PGs but RGs had higher rates of substance abuse than PGs. • Overall, current rates of coexisting mental health disorders remained similar and high for both RGs and PGs. The authors concluded that 'these findings suggest that resolving the gambling problem does not necessarily eliminate concurrent emotional disorders'. They further concluded that either the concurrent problems pre-existed the gambling problems or that the gambling is linked to the co-existing problems by some third factor such as personality disorders, or demographic variables. Also, one quarter of the RGs and one-third of PGs reported being victims of sexual abuse and trauma • The authors also concluded that not treating the co-existing disorders appears not to affect the PG recovery although may remain a risk for PG relapse 	<ul style="list-style-type: none"> • This research is a timely reminder of the need to screen for and address these co-existing problems, and that the stressors caused by PG may not be the primary factors for the presence of these issues. • In addition, it is clear that following recovery (or there being a lower level of gambling harm) there still exists high levels of mental health issues and that even those with moderate levels of PG may have much higher than population prevalence levels of mental health disorders. • This research raises the importance of screening those with moderate gambling problems as well as those meeting Gambling Disorder criteria. It may also explain much of the rationale behind high rates of relapse with problem gamblers. Also, the increased AOD problems with recovering gamblers indicate the possibility of 'switching' addictions and the need to address these issues within treatment formulation.
Factors associated with suicidal risk among a French cohort of problem gamblers seeking treatment (2016)	<ul style="list-style-type: none"> • The authors sought to 'identify specific profiles of problem gamblers (PGs) with suicidal risk according to sociodemographic, clinical and gambling characteristics'. • It was noted that the most serious adverse consequences of problem gambling, suicidal behaviour, is high, with 20% of 	<ul style="list-style-type: none"> • The importance of this paper is the high levels of suicidal behaviour that occurs with PG treatment populations, even higher than previously considered. • The importance of identifying both depression

<p>Authors: M Guillou-Landreat, A Guilleux et al Psychiatry Research, 240 (2016), 11-18</p>	<p>pathological gamblers estimated as attempting suicide within their lifetime - 3.4 times that of the general population; 49.2% of pathological gamblers had experienced suicidal ideation (Moghaddam et al 2015)</p> <ul style="list-style-type: none"> • Further, of pathological gamblers seeking treatment, 12% had in the past attempted suicide (Ledgerwood & Petry, 2004) • Few studies identified the underlying risk factors for suicidal behaviour in PGs • Problem gamblers (N=194 gamblers meeting 3 or more DSM-IV criteria; pathological gambling and risk for it) attending an outpatient problem gambling treatment facility. • 40.2% were identified with a current risk for suicide and 21.65% had attempted suicide in the past, reporting 'serious family and financial damages'. • The authors noted that suicide attempts amongst their participants were considerably higher (21.65%) than that of pathological gamblers in the general population (18.3%; Moghaddam et al 2015) or previous treatment seeking pathological gamblers (12%; Ledgerwood & Petry 2004) • The most significant PG comorbidities for suicide risk were mood and anxiety disorders, with mood disorders having affected over half of the PGs. Aligning with depression and AOD findings, coexisting or pre-existing depression (to PG) was identified as the major indicator of suicidal behaviour • Unlike previous research, the authors noted that anxiety disorders had not, until this study, been a strong predictor of suicidal behaviour • A third strong predictor of suicidal behaviour is the perception that the person believed that they had little or no control over their ability to stop gambling. Previous research identified that PGs with suicidal behaviour had significantly higher gambling craving than those PGs without suicidal behaviour. The authors noted that this predictive factor was 'very consistent and easy to identify in PGs seeking treatment'. They concluded that self efficacy training would be a valuable focus in reduction of suicide behaviour. • Other risk factors were being unemployed, living alone, family conflicts, severe financial damages, longer gambling history, illegal gambling behaviour and low standard of living. Suicide risk 	<p>and anxiety issues in presenting clients, as well as matching these with those believing they have low control over their gambling is an important new understanding.</p> <ul style="list-style-type: none"> • In NZ assessment tools, control over gambling is identified, as is depression. However, use of a broad depression questions or questions such as those used in the CHAT (two questions) may provide an important tool for identifying high risk for suicidal behaviour.
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	<p>was also (unexpectedly) higher in the female PGs and in (marginally) older PGs. Although AOD problems were higher (56% of participants; 6 times higher than the general population) surprisingly, AOD was not associated with suicidal behaviour. Neither was ADHD or impulsivity higher amongst those at risk for suicidal behaviour.</p> <ul style="list-style-type: none"> • The authors concluded that the provision of ‘therapy designed for PGs should aim at increasing the self-efficacy and self-confidence of the PG and giving him/her individual strategies to enact changes in his/her life’. 	
<p>Single-session interventions for problem gambling may be as effective as longer treatments: results of a randomized control trial Author: T Toneatto Addictive behaviors (2016) 58-65</p>	<ul style="list-style-type: none"> • The author noted that evidence-based problem gambling (PG) treatment was more likely to be multi-modal in that it combined cognitive, behavioural and motivational elements. • CBT has often provided the most effective outcomes with long-term improvements in the range of 50%-75%. • Some advantages of combining motivational and CBT have been reported while some very brief interventions often delivered in a single session may be as effective as these longer sessions (e.g. Larimer et al 2012; 60-90 min Motivational Interviewing (MI) session as effective as 6 CBT intervention) and provision of CBT-based manuals to PGs can also reduce treatment length when combined with MI, and even MI in a single session (e.g. Diskin & Hodgins 2009) • Several studies had found that different therapeutic approaches were each as effective as the other (e.g. Gunartne 2009; addition of CBT to Behavioural treatment no greater effect than Behavioural treatment alone) as have non-cognitive approaches (Korn & Shaffer 2004) • The author also noted that there was a high attrition (drop out and relapse) rate for PGs in treatment, while even in longer treatments there was a ‘brief duration of contact’ between the PG and treatment system. He also noted that PGs often preferred briefer treatments. • In this study PG participants were randomly assigned to one of four treatments (6 sessions of cognitive therapy; behaviour therapy, motivational therapy; or a single session intervention) • Participants were followed up at 12 months post-therapy and were assessed upon gambling frequency, money expended gambling, and severity of gambling harm 	<ul style="list-style-type: none"> • This possibility of an effective brief intervention approach for PG may have considerable interest when costs of effective treatment remain an important factor, as well as treatment drop-out and relapse remaining high in this client population. • However, the author notes that the outcomes were not exceptional and classed them as ‘a C-grade’ and that the design of the research (not to vary from the assigned therapy may have at time ‘precluded the most effective clinical response’). He further notes that ‘in community based treatment, interventions would be more flexible and responsive to the client’s clinical needs’. In clinical studies where treatment presenting clients are invited to participate in research, a ‘treatment as usual’ group can often address this factor. • The presence of a number of additional contacts does describe this minimal intervention group as more than a single session approach. For example the clients were screened by telephone as to whether they were eligible, then assessed in a separate base-line assessment session before being allocated to a treatment condition. Following this they were contacted by telephone at 30 days ‘post-treatment assessment’ and then at 12 months. In addition the minimal group received a ‘manual’ of the other intervention

	<ul style="list-style-type: none"> • Participants with at least one-DSM PG criteria and not having received treatment, were recruited by advertisement in Canada, and were not affected by severe mental health or psycho-social factors (e.g homeless, suicidal). A separate assessment session provided a baseline, then they received one of the interventions (randomly assigned) and a 12 month follow-up assessment (as well as a 30 day post-treatment check). Over 80% met criteria for pathological gambling with 6-7 DSM criteria • Cognitive therapy intervention focused upon identification and cognitive restructuring of gambling related distortions, weakening their core belief of their predictability, or controllability of their outcomes. Behavioural therapy was action based (e.g. avoiding socialising with gamblers or venues, urge-coping, reinforcing other behaviours that were incompatible with gambling and improving social connections outside of gambling. MI was appropriate to the PGs' stage of change and focused upon commitment to change gambling behaviour, identifying core values and consequences of gambling. Each were delivered over six one-hour sessions over 8-10 weeks. • The one-session Minimal Intervention consisted of a single 90 minute session comprising sharing of assessment data, summarised handouts of the three longer intervention approaches were handed in a book to these clients and information on these and 'common-sense and practical advice' also provided to these clients. • Following treatment, the average PG symptoms reduced from 6-7 down to 3-4, and pathological gambling from 80% of participants down to 43%. • All interventions showed improvements at 12 months, although the author noted there was room for improvement in all interventions. Most had preferred a non-abstinent gambling outcome for their treatment in this community sample, however only about 5% were gambling daily at the 12 month point. Participants expressed similar treatment satisfaction for the one-session intervention as for the other sessions. • The author noted that gambling may be best viewed as a syndrome in which behavioural, cognitive and motivational systems interact, and therefore it may be expected that each of the longer interventions would be similarly effective. 	<p>approaches which the other interventions did not, and the single session at 90 minutes was presumably longer than each of the six sessions in the other interventions. Each of these factors can be described as aspects of 'treatment' (including assessments) and the single session could not be described as the only treatment received</p> <ul style="list-style-type: none"> • Nevertheless, even with two sessions (one assessment orientated and the other a longer treatment session at 90 mins), and the takeaway manual, this is a very brief intervention. The content of the session is interesting, as being described as didactic, it does not appear to ascribe to usual therapeutic approaches, such as motivational interviewing (MI). Other research (Hodgins) has supported an MI single session intervention for PG, while workbooks are often comprehensive and use CBT and MI as well as information, and have known effectiveness. • Whether a 'single' session approach using a workbook plus either CBT, MI or other approach is more effective than this current research is yet to be determined. This does however, again raise the importance of meeting the PG's desires regarding brevity (in some cases), what should be included in a first session which may be the only session (through client disengaging), and whether a manual should accompany all treatment.
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	<ul style="list-style-type: none"> • The author noted that such a single session programme could be supported by a manual, booster sessions as needed, and on-line assistance as required. The findings supported the MI single session plus workbook previous findings (Diskin & Hodgins 2009) and that the high drop-out/relapse rates with PGs could be matched with this brief approach using a comprehensive coping skill approach in a session together with supplementary assistance as required. • The author did accept that the absence of a non-treatment group did not exclude the possibility that PGs may have improved without treatment. However, the author concluded that the study supported consideration of a brief focused intervention for PGs. 	
<p>Child maltreatment and problem gambling: a systemic review Authors W Lan, P Sacco, K Downton et al Child Abuse & Neglect 58 (2016) 24-38</p>	<ul style="list-style-type: none"> • The authors sought to identify the influence of maltreatment of children and its impact upon their developing gambling problems in adulthood. In addition authors identified the risk that adult gamblers posed in abusing or neglecting their own children. Twelve studies were reviewed in this analysis. • They noted that this was the first systematic review of the association between childhood maltreatment and adult problem gambling. • They identified a moderate, but significant association between the two, and included physical and sexual abuse, neglect and psychological maltreatment. However, it is possible that coexisting issues may be the influencing (mediating) factors in the development of problem gambling by these PGs who were maltreated as children. This research was unable to ascertain the causal nature of the maltreatment and later problem gambling. • In addition, there was evidence suggesting that PGs are more likely to 'physically abuse, punish harshly, and neglect their children' but this evidence was insufficient to require that treatment providers ask about abuse and neglect, especially as this may raise the need to mandatorily report such findings to child protection services. • The authors concluded that the data intuitively raises ethical support for such enquiries but that further research may be required to convince PG practitioners to make such enquiries. They believe that for practitioners who work with maltreated children, enquiries of parents about their gambling behaviour is warranted. 	<ul style="list-style-type: none"> • Although the findings are not definitive, this paper provides further information around the risk for harm to children that can arise directly or indirectly from PG. • There is moderate evidence for the association for both the child developing problems through gambling (e.g. as a dysfunctional way to address harm received as a child (escape), and/or from modelling parents' gambling) and for current harm through neglect as has arisen in previous research. This does indicate the need for more research due to the relative paucity of evidence for this important impact, especially as NZ law (Vulnerable Childrens Act 2014) requires identification of risk and policies to minimise harm where children may be at risk. • Provision of evidence for PG practitioners to screen or make enquiries about current harm may influence this being effected, despite the reluctance of practitioners to ask questions that may be detrimental to their engagement with their clients.

<p>Neural and psychological underpinnings of gambling disorder: a review Authors: J Grant, B Odlaug & S Chamberlain Progress in Neuro-Psychopharmacology & Biological Psychiatry 65 (2016) 188-193</p>	<ul style="list-style-type: none"> • The authors note that problem gambling (PG) is highly correlated with other mental health disorders and that this offers a basic review of the neural and psychological underpinnings of PG • They note that 50%-60% of PG is heritability and that neurochemical systems (dopaminergic, glutamatergic, serotonergic, noradrenergic and opioidergic) may be structurally or functionally abnormal • Also, personality traits such as disinhibition and personality disorders occur with PGs • By reviewing this research the authors identified that more findings are required to ascertain whether these dysfunctions in cognitions and personality factors may impact upon treatment outcome and course of the development of gambling disorder 	<ul style="list-style-type: none"> • Of interest is the advent of imaging of the brain which is beginning to provide biological evidence for interventions and possibility of medical interventions. For example, they refer to the impact of the opioid system with the benefit of partial agonists and antagonists (e.g. Naltrexone) in the treatment of PG. Also, coexisting anxiety disorders were evident in over 70% of PGs with a personality disorder, suggesting there may be other issues that impact on PGs with personality disorders.
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