

Report to the Ministry of Health

Report from: ABACUS Counselling, Training & Supervision Ltd

Period covered: 8th August 2013 to 31st December 2013

Feedback to MOH re Emerging Trends in National & International Literature
ABACUS Counselling Training & Supervision Ltd

Literature	Findings	Comment
<p>Comorbid Axis 1-disorders among subjects with pathological, problem, or at-risk gambling recruited from the general population in Germany: Results of the PAGE study Authors: Bischof A, Meyer C, Bischof G, Kastirke N, John U, Rumpf H-J (2013) Psychiatry Research</p> <p>http://www.psychiatry.com/article/S0165-1781(13)00401-0/abstract</p>	<ul style="list-style-type: none"> The prevalence of psychiatric disorders for pathological gamblers during their lifetime has been found to be high (96.3%; Kessler et al 2008), while this elevated risk of psychiatric co-morbidity exceeds that of those affected by substance use disorders (Lorains et al 2011). In particular, elevated risk for these problem gamblers is high for substance use disorders, mood disorders, and anxiety disorders (Hodgins et al 2011) Because only a small minority of pathological gamblers seek help (Slutske 2006) and the majority of research is based upon these, sample selection bias may be occurring. In addition, with the release of DSM5 with less criteria, lesser cut-off for gambling disorder (formerly Pathological Gambling), the need for research that included sub-clinical levels of problem gambling was apparent Using a range of DSM-IV cut-offs, n=164 were interviewed from an eligible sample of N=1129 who had been categorised into at-risk problem gamblers (1-2 criteria), problem gamblers (3-4 criteria), and pathological gamblers (5-10 criteria). The comparison general population group comprised a random sample n=4075. The assessment of psychiatric disorders used the Composite Diagnostic Interview (CIDI) with a gambling section, and is based upon DSM-IV criteria. The lifetime rate of any psychiatric disorder within the 	<ul style="list-style-type: none"> Problem gamblers at different levels of gambling severity were all significantly more likely to be experiencing coexisting Axis-1 mental health problems than non-problem gamblers. Although this research results from problem gamblers in a German population, the high levels of co-existing mental health problems found reflect similar prevalence levels to non-German problem gamblers, suggesting the findings are generalisable to other populations, such as New Zealand. Of importance, is that this research also looks at problem gamblers who meet some of the criteria for Pathological Gambling ('sub-clinical problem gamblers'), although it is acknowledged that criteria for this lower problem gambler level is not well defined, especially with the advent of DSM-5 where lesser threshold criteria (4) are now required from fewer total criteria (9) for current diagnosis of Gambling Disorder (formerly Pathological Gambling). This research may align with the Co-existing Problem (CEP) initiative in NZ, in that high levels of coexisting problems appear to exist even for those with lower gambling criteria, with all the compared problems being elevated for each of the three problem gambling levels, and even the lowest (1-2 criteria).

	<p>gambling categories was high across all three, with pathological gamblers identified at 93.6% (85.1% without tobacco dependence), problem gamblers 88.5% (86.5% without tobacco), and at-risk gamblers at 81% (74.6% without tobacco). This compared with a lifetime psychiatric rate of 35.7% for the general population, which included tobacco dependence (22.9% without tobacco dependence as a disorder). Substance use disorders were highest lifetime disorders (at-risk 65.1%, problem 75%; pathological 87.2%), compared with 25.8% for the general population; mood disorders were also elevated (at-risk 49.2%, problem 46.2%, pathological 46.8%) compared with 12.3% for the general population. Anxiety disorders were also elevated across all problem gambling categories (23.8% at-risk, 32.7% problem, 38.3% pathological) compared with 6.5% for the general population. These higher levels of risk for all of the gambling problem levels were maintained across the range of drugs (alcohol, tobacco, and illicit drugs); alcohol disorder (general population 8.3%; at-risk 44.4%; problem 61.5%; pathological 61.7%), tobacco dependence (general population 20.9%; at-risk 54%; problem 48.1%; pathological 68.1%) and illicit drugs (general population 1.2%; at-risk 17.5%; problem 11.5%; pathological 19.1%)</p> <ul style="list-style-type: none"> • The high rates of pathological gamblers having at least one life-time comorbid disorder (93.6%) is a similar rate to that in at least one other large study (96.3%; Kessler et al 2008) • Contrary to the researchers' expectation, psychiatric comorbidity was high for those gamblers meeting only one or two pathological gambling criteria. They posited that individuals with psychiatric disorders may be 'particularly vulnerable to developing gambling problems.' Gambling may be a dysfunctional 'coping strategy to handle psychological strains' and this view was supported by other research identifying that loneliness and low social support were 	<ul style="list-style-type: none"> • It is possible that this research may be interpreted as those with existing mental health problems being more at risk for subclinical or clinical problem gambling (and Kessler et als' (2008) findings suggest this may be over half of clinical problem gamblers), but even if so, this still provides important information for treatment that supports the CEP initiative. Treatment should take into account the need to assess all presenting clients for coexisting mental health problems, and should proactively provide advice and motivation for those affected by subclinical problem gambling in respect of the likelihood of other coexisting mental health issues (including other addictions). These levels of coexisting problems were very similar in subclinical gamblers to gamblers with severe gambling problems. • One of the few differences between the severity gambling levels of the participants was that subclinical problem gamblers were likely to have had more school education. • These findings, notwithstanding that subclinical gamblers are less defined, support the high need for treatment resources for subclinical and clinical problem gamblers, and that these resources should also target coexisting mental health problems. The CEP initiative fits appropriately within this finding, with broad screening, assessment and integrated treatment across mental health issues when identifying all levels of problem gambling.
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	<p>gambling problem risk factors.</p> <ul style="list-style-type: none"> The authors concluded that the results showed that 'especially impaired decision-making and a dysfunctional executive system are associated with pathological gambling' and that even problem gamblers with one or two criteria for gambling disorder have a high risk for co-morbid disorders, which has implications for treatment. 	
<p>An overview of and rationale for changes proposed for Pathological Gambling in DSM-5</p> <p>Authors: Petry N, Blanco C, Auriacombe M, Borges G, Bucholz K, Crowley T, Grant B, Hasin D, O'Brien C (2013) Journal of Gambling Studies DOI 10.1007/s10899-013-9370-0</p>	<ul style="list-style-type: none"> The 5th revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was released this year (May 2013) with several changes to the diagnosis of pathological gambling DSM is, with the World Health Organisation manual (ICD-10), the primary classification system for diagnosing psychiatric disorders, and is published by the American Psychiatric Association (APA) The previous manual, DSM-IV, was released in 1994, and apart from a text review in 2000, has remained unchanged for 19 years Changes to the 2013 DSM-5 criteria for pathological gambling includes the change in name to a less pejorative 'Gambling Disorder' More importantly and marking a more fundamental change, has been the shifting of problem gambling from an impulse 'catchall' section (Impulse Disorders Not Categorised Elsewhere) to the sole 'behavioural' addiction in a new category 'Substance-Related and Addictive Disorders', which also contains the substance use (e.g. alcohol) disorders (SUDs) The authors advise that the reviewers were influenced by data emerging 'that gambling and substance use disorders have common underlying genetic vulnerabilities and both are associated with similar biological markers and cognitive deficits'. The further referred to effective treatments for gambling and SUDs are similarly based, while gambling 	<ul style="list-style-type: none"> APA states that DSM provides accurate and consistent diagnosis of mental health disorders through defining criteria for them. It also enables researchers to compare treatments, risk factors and causes, prevalence and incidence of mental health disorders. Problem gambling has been a challenge for DSM, commencing in 1980 (DSM-III) when the first description of pathological gambling was as 'an impulse disorder which caused chronic financial loss and met three out of seven criteria'. This was followed by the review of DSM in 1987 when criteria increased to nine, and any four would meet the diagnosis. With the advent of DSM-IV in 1994, criteria increased to ten, with any five meeting the diagnosis. The new DSM-5 released in 2013 has reduced criteria to nine, of which, any four meets the diagnosis of its new, less pejorative description, 'gambling disorder'. It also is no longer regarded as an impulse disorder, and sits within the category of Substance-related and Addictive Disorders as the only behavioural addiction under the sub-category 'Non-substance-Related Disorders'. Its inclusion is accepted because of there being sufficient evidence that 'gambling behaviours activate reward systems similar to those activated by drugs of abuse and produce some behavioural symptoms that

	<p>disorder and SUDs are more closely aligned than other psychiatric disorders</p> <ul style="list-style-type: none"> • One criterion of the 10 previously in DSM-IV referring to the committing of illegal acts to finance gambling has been removed, as it was less likely to be admitted to by problem gamblers (compared with the other 9 criteria), while it may only apply to the most severe level of gambling disorder. Up to 40% of those meeting pathological gambling as a disorder would acknowledge illegal acts, compared with 60% and above of the remaining criteria, and those that did would admit many of the remaining criteria, making the 'illegal' criterion of limited effect • Previously, the pathological gambling diagnosis did not refer to the criteria as being necessarily co-occurring, although generally, most of the research addressed this. Criteria for gambling disorder must now occur in the same 12 month period. • Some criteria (preoccupation with gambling, and gambling when distressed) are now required to occur more than once or twice, with the requirement that they occur 'often' • The threshold for gambling disorder has reduced from five out of ten criteria in DSM-IV, to four out of nine in DSM-5. Research has found that diagnostic accuracy improved through this reduction. Although some researchers suggested reduction to three criteria, with the knowledge that some people meeting these reduced criteria would be experiencing gambling problems, the APA was reluctant to make changes that would substantially increase the base rate of the disorder without strong empirical evidence. However, the researchers concluded that clinicians should intervene with those who met less than four criteria for gambling disorder, and also acknowledged the need for more research into sub-diagnostic gambling problems (etiology and consequences of these lesser criteria, and 	<p>appear comparable to those produced by substance use disorders'.</p> <ul style="list-style-type: none"> • There are also now various subcategories of gambling disorder. The first is that there may be periods when the criteria are met, and others when the symptoms may subside. This would be required to occur more than once, and this type of gambling disorder would be regarded as Episodic. Where the criteria were continuously present, the type of gambling disorder would be regarded as Persistent. Secondly, where the criteria for gambling disorder were met, and all criteria were in remission for at least three months but less than twelve months, then gambling disorder would be categorised as 'In early remission'. Where this remission extended for twelve or more months, this gambling disorder would be categorised as 'In sustained remission'. Finally, there are now three levels of severity for gambling disorder: Mild (4-5 criteria met), Moderate (6-7 criteria met), and Severe (8-9 criteria met). • Although each of the nine criteria have equal weighting in the diagnosis of gambling disorder (an unlikely outcome), DSM-5 does indicate that preoccupation with gambling and chasing losses are criteria more likely to be present with mild gambling disorder, while jeopardising relationships/careers and requiring bailouts are more likely to occur with severe gambling disorder. It is also stated that those who present for treatment of their gambling disorder are more likely to meet moderate to severe gambling disorder, and of these, about 17% will have attempted suicide (down from 20% in DSM-IV). • Although many of the above issues describe important changes to DSM, some were not
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	<p>whether their condition differs from the ‘four or more’ criteria), especially as many more will confirm less than four criteria than confirm more, and these ‘subthreshold gambling problems can result in personal and societal harm’.</p> <ul style="list-style-type: none"> • Those meeting five or more criteria for pathological gambling under DSM-IV are highly likely to meet four or more criteria under DSM-5 • Benefits of moving gambling disorder to its new category with SUDs should enhance screening for gambling disorder in SUD services, especially with the high comorbidity between them, and enhance treatment opportunities for problem gambling • Finally, there still remains a need for a ‘gold standard’ screen for problem gambling. 	<p>canvassed in the article, probably due to size constraints and that at the time of publication, DSM-5 had not been released.</p> <ul style="list-style-type: none"> • Several issues raised do, however, have important influence in the use of this important manual, which is the primary mental health disorder categorisation tool in NZ. Firstly, the authors note support for a sub-clinical level of gambling disorder was not approved because of the lack of evidence, resulting in not meeting the requirements of APA. There is a ‘Mild’ subcategory for gambling disorder and this may be taken by some to be a de-facto sub-clinical condition for problem gambling. However, one must meet the full criteria of the disorder even for a mild level of gambling disorder, while research indicates (see Bischoff et al 2013 above) that even people with a single criterion for pathological gambling are very likely to also have coexisting mental health disorders. As research (Kessler et al 2008) suggests that problem gambling is highly likely to include many conditions (similar to a syndrome), and as stated in DSM-5 that only those with moderate to serious gambling disorder are likely to seek help, this appears to be a lost opportunity to provide help to ‘mild’ problem gamblers who are experiencing considerable harm. DSM-5 does, however, acknowledge that ‘Individuals with gambling disorder have high rates of comorbidity with other mental disorders, such as substance use disorder, depressive disorders, anxiety disorders, and personality disorders’. Recent research by Weinstock et al, 2013 – reference below) concluded that ‘subclinical gamblers experience significant adverse consequences’).
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<p>Gamblers Anonymous: overlooked and underused?</p> <p>Authors: George S, Ijeoma O, Bowden-Jones H (2013)</p> <p>Advances in Psychiatric Treatment, 19, 23-29</p> <p>doi:10.1192/apt.bp.111.009332</p>	<ul style="list-style-type: none"> • The authors state that Gamblers Anonymous (GA) is the least used of the 12-step addiction support approaches, and this may in part be attributable to health professionals' lack of awareness and knowledge (in their region, UK) of gambling addiction and its treatment (including GA). • GA is based upon the earlier principles and steps of Alcoholics Anonymous. • The principles that guide GA include: that the fellowship programme is free of fees; that it is based upon a disease model, where recovery or control is possible (but not cure); total abstinence is the goal (rather than control) and must be pursued lifelong as a way of life; it requires belief in a higher power that is spiritual but not religious (and in fact has no affiliation with religion or socio-political views, but encourages personal and spiritual growth); with anonymity a 	<ul style="list-style-type: none"> • This appears to be an important reminder for those working in the problem gambling field that clients may have ongoing access to a support (and therapeutic) programme post-treatment, that may be effective and accessible. • At first instance, the wording and focus may appear off-putting for a growing secular population in which harm reduction rather than solely abstinence as a goal is widely accepted. However, the limited research conducted in the last decade suggests GA clients have more favourable outcomes, while the design overall of the programme appears to align itself with arguably the most efficacious form of therapy, CBT. Earlier research suggests GA is more suited to severely affected problem gamblers, which

	<p>key aspect, and a focus upon repeatedly working through the programme's 12 steps.</p> <ul style="list-style-type: none"> • The 12-steps consist of admitting powerlessness over gambling, believing in a higher power needed to restore normal thinking and living, passing control of will and lives to the higher power, making a 'searching and fearless moral and financial inventory', admitting to self and another of their wrongs, being ready to have these 'defects of character' removed and asking a God of their understanding to remove them, listing those harmed and be willing to make amends, then doing so directly unless that would cause harm, continuing with the personal inventory and promptly admitting wrong, seeking knowledge through prayer and meditation, and following making all these efforts, take the message to other compulsive gamblers. • Meetings are usually held weekly over 1-2 hours, with members chairing meetings in rotation. Members 'therapy' is attendees being encouraged to talk about their past gambling, their past and current life, and the effects of their GA attendance. A 20-question GA screen may be asked of new-comers, with seven positives identifying 'compulsive gambling'. This screen has been found to have high diagnostic efficacy. • Each meeting concludes with the serenity prayer ('God grant me the serenity to accept the things I cannot change, courage to change the things I can, and the wisdom to know the difference') • Outcomes include goal orientation ('way of life'), fostering of friendships, and 'bonds built on empathy and shared understanding' together with familial-like socialising opportunities • After 90 days of abstinence with regular attendance at GA, the member is seen as reaching a plateau or stability, and is expected to provide support back to GA. The first will be to 	<p>in turn, fits with the evidence-based DSM-5 findings (above) that therapy is more likely to be sought out by moderate to severely affected gamblers (rather than early stage, mildly affected gamblers).</p> <ul style="list-style-type: none"> • This research article is written by UK authors, but the limited research and the GA programme itself (although initiated in the US) is world-wide. Processes are similar and structure follows the steps and processes in the Orange Book. • NZ situations may require further therapist support, expansion of chapter numbers, and education and motivation of clients to provide a further ongoing option for problem gambling clients. Currently, there are only 19 GA chapters throughout NZ, with just 4 in Auckland, with no Gam-Anon or Gam-A-Teen chapters operating. This may compare with 38 operating in the mid-1990s when some funding was directed towards the employment of a GA member in a treatment service, and alignment with the gambling helpline to establish new chapters when consenting callers from a particular region agreed. The employed GA member would then attend the first few sessions in the new chapter and mentor members in the processes. Approval was obtained to move the NZ regional office from Australia to NZ and the treatment service then provided the Orange and Little Blue Book (and other resources) to each of the chapters. The reduction of chapter numbers eventually to half following the cessation (1997) of the treatment service providing the helpline suggests that either the GA programme has become less relevant, or the programme itself requires support to attain and maintain a critical size. • There is evidence that in NZ, problem gamblers may
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	<p>out-reach to those problem gamblers who are not members (or members in need) and who are experiencing problems – a ‘12-step call’ made in person. The expectations are not to sell the programme, or overwhelm with information, but to explain it and share their experiences. The second will be a longer term commitment to another member to adhere to the programme and attain recovery. This may include encouraging attendance, explaining the programme, and being empathetic and supportive during crises. This obligation is seen as helpful to both the member and sponsor, with the understanding that it will be the GA programme rather than the sponsor’s qualities that ensure success.</p> <ul style="list-style-type: none"> • Literature includes the Combo Book (or called The Orange Book or GA Bible) and the Little Blue Book which has readings for each day of the year. • Alongside GA are the sister fellowships of Gam-Anon, for spouses and friends of compulsive gamblers, and Gam-A-Teen, for children of compulsive gamblers • The authors note that there is little robust published evidence on the effectiveness of GA despite its history (commenced 1957) because of its valuing of anonymity, so no records are kept. Information that is available is exclusively self-reports and subjective/self-selection, fluctuating membership, and of accepted outcome measures/success. • The authors reviewed the limited range of evaluations of GA. Early studies identified high drop-out rates after the first session, and surveys of these indicated that they considered their gambling to be less problematic, considered they could utilise self-control, did not wish to abstain, had underlying inferiority issues, and reported the GA group as unsympathetic when slips occurred (Brown 1987). Another study noted relatively low abstinence rates after one year 	<p>be amenable to a programme operated and driven by those affected by gambling. A recent study (MOH 2013) identified that a barrier to help-seeking by problem gamblers is that the majority (59%) may prefer to resolve their gambling issues on their own. This was followed by a barrier of being too ashamed to disclose issues (44%); although attending GA may be seen to be shaming, and may not necessarily be seen as self-therapy, the strong fellowship focus, socialising and normalising may overcome these barriers.</p> <ul style="list-style-type: none"> • Therapists can apply to attend chapter sessions as an observer, and this, together with knowledge of the programme, supportive attitude, and client education about GA, may all result in the establishment of a highly cost-effective ongoing support programme for problem gamblers (and their families). Problem gambling is a persistent and recurrent disorder, suggesting the need for ongoing support for an acknowledged enduring and often relapsing disorder. GA may be an important option that may also provide better outcomes when integrated into a therapeutic treatment plan. • For GA to be an effective option, a strategy may have to be established to educate therapists, while supporting the establishment of further chapters. Formative evaluation may also play a part to compensate for the low level of evidence available. However, this paper provides a start for consideration of this low cost, long established option.
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	<p>(8%) and in the second year of GA (7%), with high drop-out rates after the first meeting (22%-41%; Stewart & Brown 1988). Brown concluded that GA was better suited for severe gamblers and for those who experienced few relapses. Later research in Australia (Oei & Gordon, 2008) assessed a range of variables of the GA programme and concluded that meeting attendance and social support increased abstinence outcomes, while stronger gambling urges and distorted cognitions increased relapse outcomes. Petry (2003) noted in her research that 53.8% of treatment-seeking problem gamblers had attended GA prior to treatment, and these were older, had more severe gambling problems, larger debts, and fewer concurrent alcohol or other drug problems, but more severe family, social or psychiatric problems than the non-GA attenders. These clients were more likely to engage with treatment, and also more likely to re-engage with GA following treatment. Importantly, these 'GA clients' were more likely to be abstinent from gambling during treatment. Overall, Petry concluded that these 'GA clients' appeared to have more positive outcomes and these may have been impacted by GA attendance. Toneatto (2008) compared GA twelve steps with CBT principles and concluded that aside from linguistic differences, the underlying principles were similar and that GA was an intervention that can be offered alongside other psychological interventions. Other early research also concluded that GA outcomes can be improved by clients attending psychological therapy for their gambling behaviour.</p> <ul style="list-style-type: none"> • The authors concluded that there were myths that may deter gamblers or therapists engaging (e.g. male orientated (20% may be female); little emotional investigation) that appeared to be unsupported, while research remained sparse and may not be robust, but that therapists needed to know about GA in order to offer it to clients, and that GA appears to be an 	
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	effective treatment for gambling addiction. Importantly, GA appears to be compatible with other therapies such as CBT for gambling addiction.	
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