

Co-existing Conditions with Problem Gambling Clients

ABACUS Counselling, Training and Supervision Ltd



Quote

“Working with people with co-existing mental health and addiction problems is one of the biggest challenges facing frontline mental health and addiction services in New Zealand and overseas. The co-occurrence of these problems adds complexity to assessment, case planning, treatment and recovery”

ALAC/MH Commission report, 2008

Co-occurring MH conditions & addictions

Mental health and addiction issues commonly co-exist, causing significant impairment or distress:

<i>MH Disorders</i>	<i>Addictions</i>
Schizophrenia	Alcohol
Bipolar	Cannabis
Major depression	Cocaine
PTSD	Opiates
OCD	Benzodiazepines
Complicated grief	Amphetamines
Anxiety	Methamphetamine
Personality disorders	Problem Gambling

Co-existing issues to address

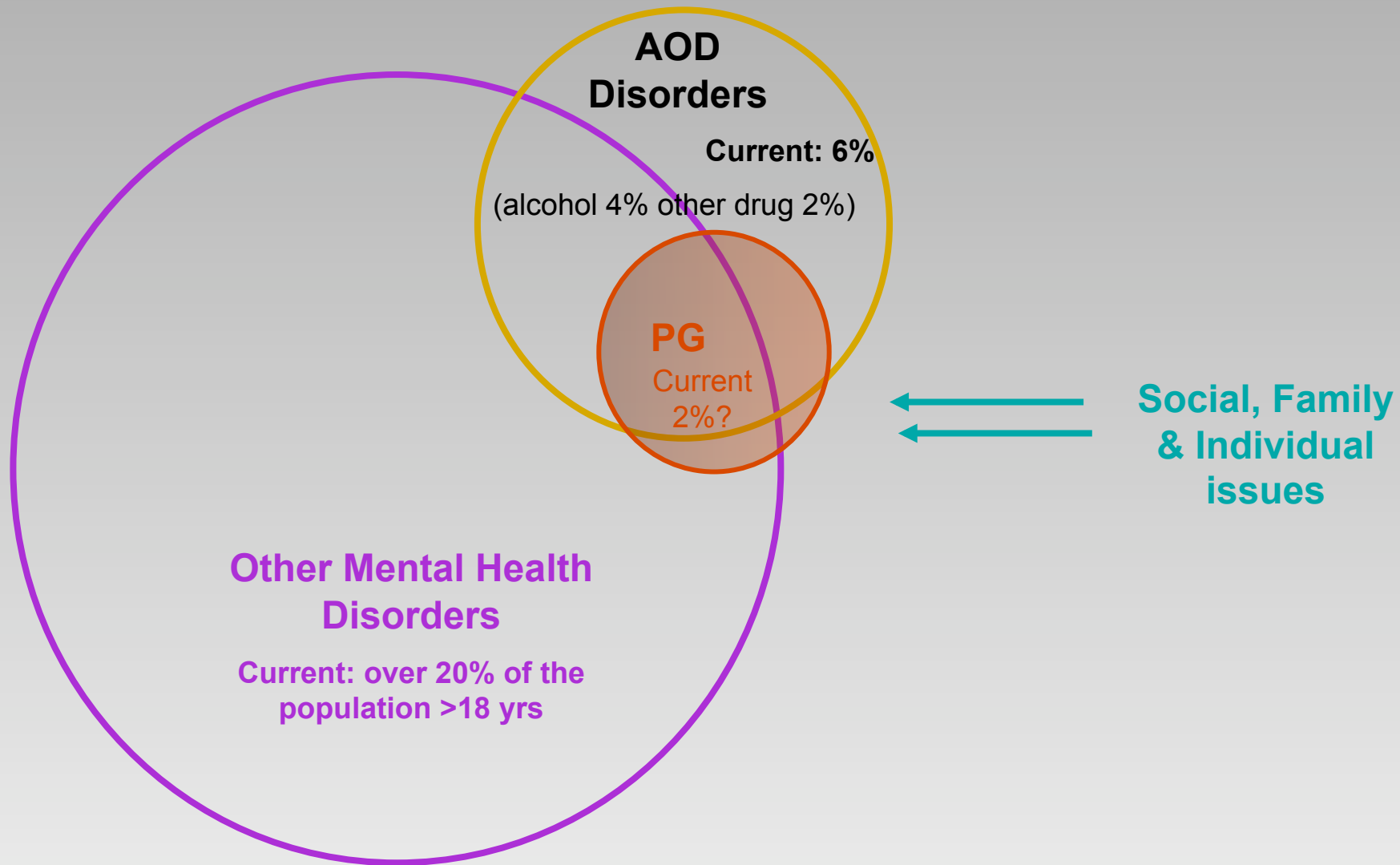
- “It underlines the complex causality of problems experienced by problem gamblers. Problem gambling may exacerbate other dependencies, and they in turn may exacerbate problem gambling”
- “Counselling for problem gambling will need to also deal with these co-morbidities, and treatment for other dependencies may need to take into account secondary gambling problems that may not be transparent”

Australian Productivity Commission (1999)

ALAC/MH Commission Report (2008)

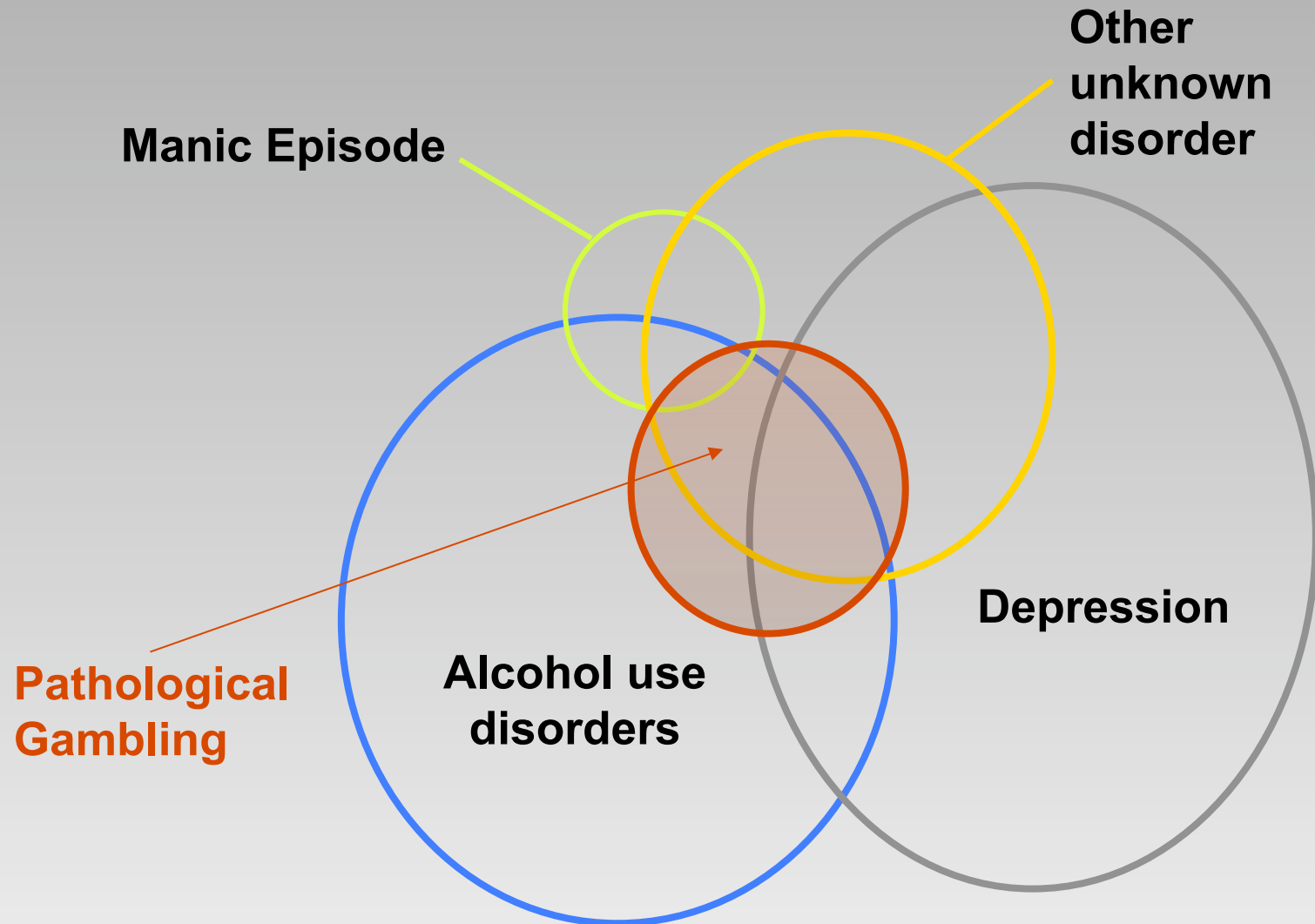
- Co-existing problems – are common, rather than exceptional, among people with serious mental health problems
- People with AOD and gambling problems have greater mental health problems than the general community, most commonly depression and anxiety
- Māori and Pacific people - higher mental health and substance-use disorders than the general population; also applies to problem gambling

Problem Gambling Embedded



‘Pathological Gambling may not be a single phenomenon’

Shaffer et al 1997



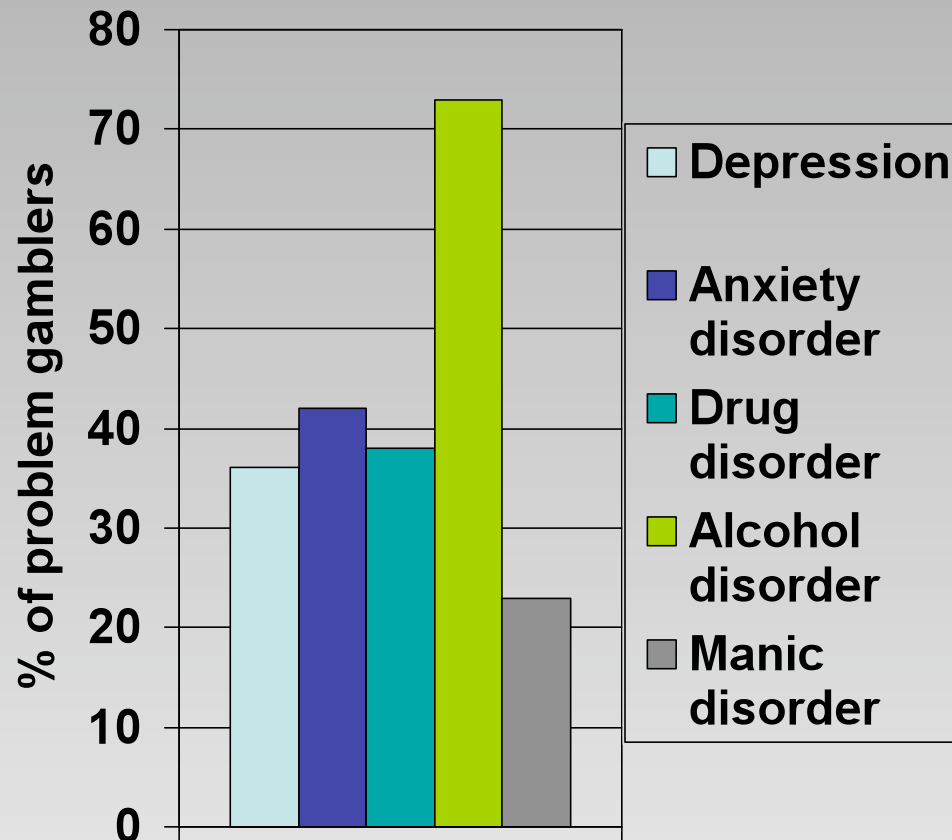
Exercise 1: Prevalence of Co-existing Disorder in PG

- One person from the audience will hold up the co-existing disorder to PG and the audience will assist by identifying the expected prevalence with PG – a continuum 0%-80% will be placed on the floor
- Two members of the audience will assist by standing at each the lowest and highest prevalence points with PG suggested by the audience
- The person with the co-existing disorder card will stand equidistant between them – what confidence is there that they are close to the correct prevalence?

Increased Risk in PG

Disorder	General Population	PG (lifetime)
Depression (any affective)	8.3%	49.6%
Anxiety	14.6%	41.3%
Drug (abuse/dependence: not alcohol)	6%	38%
Alcohol (abuse/dependence)	13.5%	73%
ADHD	3-7%	20%
OCD	2.5%	10-20%
ASPD	3%	23%
Paranoid PD	0.5-2.5%	25%
Schizophrenia	1.5%	3-5%

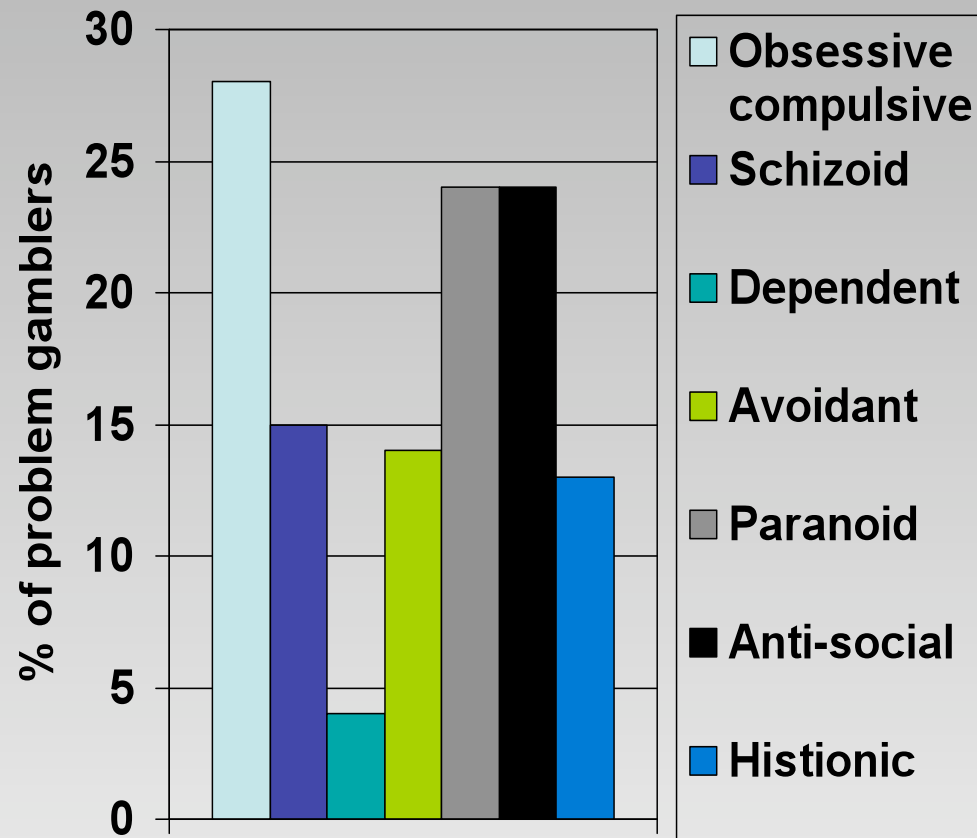
Mental Health disorders common



- Findings from n=195 PG
- AOD problems may occur in $\frac{3}{4}$ of PGs
- Anxiety in over 40% of PGs
- NB Manic disorder seems very high at over 20% (and Depression usually 60%+ in other research)

Personality Disorders high

Petry et al 2005



- Approximately one in four PGs may have OCD, Paranoid or Antisocial Personality Disorder (or more than one) Borderline?
- Personality disorders rare in general population (OCD 2%; ASPD 1-3%; Paranoid 0.5-2.5%; Schizoid 'uncommon')

Addictions and Co-existing Problems

People with gambling related problems are likely to meet criteria for other mental disorders:

- Almost all PG have another lifetime MH disorder (Kessler et al 2008)
- Co-existing mental health and addiction problems are associated with suicidal behaviour and increases in service use
- ‘Mental health and addiction services remain divided bureaucracies across discrete disorders’

ALAC/MH Commission report, 2008

MH disorders often pre-exist

Kessler et al 2008

- 96.3% of those meeting Pathological Gambling Disorder (PGD) criteria also met another psychiatric disorder (and two-thirds met 3 or more disorders)
- 74.3% of these experienced the other disorder prior to PGD
 - 42% had a substance use disorder (57% of SUD started before PGD)
 - 56% had a mood disorder (65% before PGD)
 - 60% had an anxiety disorder (82% before PGD)

Exercise 2: Barriers & Solutions

In groups of 4:

1. Identify as many barriers as you can think of affecting those with PG and a (or several) co-existing MH conditions
2. What might be the effect of each?
3. Brainstorm possible solutions to each of these

Relationships of Co-existing Conditions

- A primary psychiatric illness precipitates or leads to substance abuse
- Use of substances makes the mental health problems worse or alters their course
- Intoxication and/or substance dependence leads to psychological symptoms
- Substance misuse and/or withdrawal leads to psychiatric symptoms or illnesses (UKDH 2002: 7)
- Problems develop faster; symptoms more intense and severe; less responsive to treatment; relapse more likely

Parallels with problem gambling?

Do PGs use AOD as self- medication?

- Temporary symptom reduction: arousal soothed; avoidance maintained; intrusive thoughts/memories controlled; fear calmed
- Lift sadness; increase energy/motivation
- Reduce preoccupation with delusions and intrusiveness of hallucinations – PG?
- Lack of alternative coping strategies- avoidance
- Psychophysical state made controllable

Self-medication? (Cont'd)

- Stimulants give high arousal and sensitise to stress
- Depressants reduce energy, motivation and cognitive clarity
- AOD users place themselves in dangerous or risky situations:
- Disinhibition, reduced impulse control, deterioration of judgement
- High-risk situations associated with 'drugs'
- PG affects health, job, finance, supports – PG isolated

Exercise 3 Co-existing Conditions

- Read the symptoms on your handout
- Check the cards on the floor with names of psychiatric disorders
- Stand by the card that you think matches the symptoms on your handout
- Be prepared to discuss the reasons for your choice with trainer and participants

What happens to MH in PGs?

Does part-addressing AOD/MH mean:

- If we focus almost solely on the gambling and are successful in reducing harm from gambling, do most (74.3%) clients with pre-existing disorders retain these now minus the gambling (and risk relapse from these?), or
- Do we assume addressing the gambling somehow also successfully addresses the client's pre-existing AOD/MH disorders?

So what should we treat?

- Many disorders very complex
- They are in addition to social needs
- But governmental approach is 'make every door the right door'
- So could identify (screen) and refer
- Or identify and further briefly intervene (in addition to referral)
- Or have specialists on-site (brought in or base PG practitioners where these available)

Guiding Principles for Co-existing Conditions

TIP 42, 2005

- Adopt a recovery perspective (no wrong door)
- Adopt a multi-problem viewpoint (with AOD/MH of equal importance)
- Develop a phased approach to treatment – MI as front end (engagement/persuasion), active treatment/follow-up and relapse prevention, together with a “stages of change” approach

Guiding Principles for Co-existing Conditions

TIP 42, 2005

- Address specific real-life problems early in treatment
- Plan for client cognitive and functional impairment
- Use support systems to maintain and extend treatment effectiveness

12 Step Assessment Process

TIP 42, 2005

1. Engagement
2. Further info from whānau / friends / others
3. Screening (co-existing disorders/risk)
4. Determine severity of co-existing and appropriate service co-ordination
5. Determine level of care
6. Determine diagnosis

12 Step Assessment Process

TIP 42, 2005

7. Determine disability and functional impairment
8. Identify strengths and supports
9. Identify cultural and linguistic needs and supports
10. Identify problem areas
11. Determine stage of change
12. Plan treatment



Referral: AOD, Mental Health, or both?

(Raistrick 2004)

AOD (high AOD; low MH)	MH + AOD <i>Shared care</i> (high AOD; high MH)
AOD or MH <i>Either care</i> (low AOD; low MH)	Mental Health (low AOD; high MH)

1.11

Exercise 4 Brainstorming

MH or Mental Health includes AOD problems

PG High PG Low MH	PG + MH Shared Care High PG High MH
PG or MH Either Low PG Low MH	MH High MH Low PG

Brainstorming Exercise

- List 4 AOD/MH services in your area that you could either refer PGs to, or services you could work with your PG clients with MH conditions
- Could this quadrant model work for your PG clients who had AOD/MH conditions?
- How could you ensure this process could work for these clients?

DISCUSS

Issues of Stigma in Treatment

- People with co-existing problems are doubly stigmatised for both mental health problems and addictions, which makes it more difficult to get help/engage with treatment
- Concerted efforts recently to de-stigmatise mental illness, but little done toward society understanding causes of addictive behaviours & journey to recovery
- Society ascribes character defects to people with addictions such as moral failure and weakness of will



Issues of Stigma in Treatment

- Addiction is often linked in people's minds with criminality
- There is often a tacit belief that “addicts” invite and deserve discrimination, despite clear evidence that addictions have a neurobiological basis, the effect of which, erodes free will
- Little recognition by society that addictions are chronic health conditions for which there are proven, successful interventions

ALAC/MH Commission report, 2008

Treatment Integration: Addictions/MH

- Aims to reduce gaps and barriers between services
- Integrates various treatments into a single treatment stream or package
- Adapts the various treatments to be consistent and not conflict with each other
- Need seamless, consistent, “accessible” approach to clients’ pathology, deficits and problems (including criminal offending issues)

Treatment Integration: Addictions/MH

- Single co-ordinating point for treatment
- Use compatible treatment models/concepts
- Harm minimisation approach
- Close liaison between all parties incl justice
- Deliver all treatments from one setting
- Close liaison between therapists, treatment agencies, and whānau/family

Cultural Issues

- In some cultures, depression is expressed in somatic terms, rather than sadness or guilt
- Examples: “nerves”, headaches; weakness, tiredness or imbalance (Asian); problems of the heart (Middle East).
- Māori and Pacific peoples: may be more spiritually based – may request traditional healing; family/whānau context; some PI clients feel it may be a “curse”

Cultural Issues

- For some, may be irritability rather than sadness or withdrawal
- Differentiate between culturally distinctive experiences and hallucinations or delusions (which may be psychotic part of the depression)
- Don't dismiss possible symptoms as always cultural

MI Principles for Co-existing Conditions

- Focus on **empathy**
- Proceed very slowly to avoid **resistance**
- Expose or develop **discrepancy** very gently
- Build **self-efficacy**
 - support self-determination
 - encourage early small achievements

(Zuckoff & Daley, 2001)

MI Principles for Co-existing Conditions

- Co-existing MH problems exist with almost all those affected by PG
- AOD problems are MH problems, as are PG problems
- Some coexisting problems can be addressed without referral to MH services
- Others will require referral for best outcomes for the PG client
- Establishing relationships and knowledge about regional MH services will enable PG services to best assist their PG clients