Senate enquiry into the Prevention and treatment of problem gambling 2012

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This submission is written from the perspective of the Director of the Statewide Gambling Service in South Australia (Professor Malcolm Battersby) and Director of the Flinders Gambling Research (Assoc Professor Peter Harvey) which focusses on prevention and treatment of disordered gambling.

Gambling Help Services are providing a valuable service to the community and, if our service is a relevant guide, some people who are adversely affected by gambling are being helped, through the current resourcing formulae to overcome their problematic gambling behaviour. However, it is not known whether services are delivering effective outcomes with what therapeutic interventions because of a) a lack of agreed outcome measures, b) lack of data collection programs ie information technology systems c) clinical staff who are trained to use these systems d) management, administrative and data management staff to manage the outcome measurement system such that it not only measures individual client outcomes before, at end of treatment and follow up, that such data can be aggregated across a whole service and can be fed back to clients, and staff for quality improvement purposes. These elements have been incorporated into the Statewide Gambling Therapy Service in South Australia and will be described in more detail below.

Before providing this detail there are some general issues which need to be described.

Diagnosis, prevalence and conceptual issues

The methods for determining the prevalence of problem gambling, and indeed deciding what problematic gambling actually is, are questionable, for example, prevalence surveys relying on phone interviews using computer aided telephone interview techniques and fixed line telephone numbers may not be sampling the population in a truly representative manner and people with gambling problems may be underestimated. The measurement tool used by most states and territories ie the Canadian Problem Gambling Index is flawed, ie underestimates or wrongly estimates problem gamblers. A review of available instruments is required including the Victorian Gambling Screen which was commissioned by the Victorian Government yet discarded in favour of the Canadian instrument based on one flawed study (McMillan et al). The author of this report, Prof Malcolm Battersby was part of the Flinders University team who was commissioned to produce the VGS hence there is a potential conflict of interest although there is no financial conflict and the instrument is in the public domain.

Amongst the many conceptual issues in relation to definition and diagnosis of problem gambling , the categorisation of gamblers as low, moderate or high risk is very questionable given that the person either has a problem with gambling or not ie the person is not ‘at risk’, but either has no problem, a small, medium or severe problem. This clinical understanding (the purpose of using a screening tool is to detect those who have a clinical problem) is the same as that applied to medical or mental illness paradigms and what has probably led to the avoidance of such terms or concepts because the field has been dominated by psychology and social

sciences who in many cases have a philosophical or discipline problem with a person having problem gambling described as a 'mental illness'. Similar conceptual issues are reflected in the entire gambling treatment area. Because problem gambling has been defined as a mental disorder in the American Psychiatric Association Diagnostic Manual DSM IV-R as pathological gambling, it is treated by gambling therapy clinicians with mental health training in Australia, similarly to anxiety disorders or depression, ie there are clinical diagnostic criteria and validated screening tools for anxiety disorders and depression with cut off scores either giving specificity and sensitivity for correctly allocating the diagnosis, or cut offs for severity levels, mild, moderate or severe eg the Beck Depression scale. Gambling should be treated similarly with scales which measure severity not risk. Risk implies a much more theoretical and less real situation than severity and underestimates the implications of the problem in terms of its seriousness and consequences for the individual, their family and the community.

The APA has recently proposed that pathological gambling be moved into a new classification of behavioural addictions. The authors of this report agree that there is sufficient evidence of the genetic and clinical presentation similarities with other substance addictions to justify this recommendation. This would allow pathological gambling to be seen as a more serious disorder with the victim having less blame and stigma than exists currently.

Implications for non-acceptance of Problem or Pathological gambling as a mental disorder

Gambling Help services are described simply as that ie 'help', they are rarely described as treatment or therapy services. From this conceptual and philosophical point a cascade of service delivery problems arise. Organisations and staff providing the services do not need the structures or skills to make a diagnosis, provide a full mental health and psychosocial assessment, do not need to provide evidence based therapy services. The implication is that staff do not need undergraduate or post graduate qualifications or specific cognitive behavioural skills or qualifications and are therefore less expensive to employ. This is not to say that many staff in these organisations cannot provide financial and other counselling services which may benefit clients but this is far from being able to deliver evidence based therapy skills for 'treatment'.

Inadequate recognition of problem gambling as a mental disorder is at the core of the governments' lack of consistency and definitive action to address the treatment of problem gambling. This is reflected in the number of variety of government departments responsible for problem gambling treatment across Australia, including Justice, Families and Communities, and Health. The gambling help services should be managed by health and/or mental health services because it is clear that a) problem or pathological gambling is a medical or psychiatric diagnosis ie it has distress, dysfunction and disability with all or more consequences of other severe mental illnesses including family, social occupational breakdown and suicide b) mental health professionals with or without drug and alcohol skills should be employed rather than counsellors who have general rather than specific therapeutic skills.

Long term outcomes of treatment or counselling

There is limited definitive evidence about the longer term efficacy of the myriad counselling and therapy options available, yet governments continue to fund a wide range of programmes to support people with gambling problems. The SGTS has gained ethics approval for all clients to be approached to give informed consent for longitudinal data collection for 5 years beyond the treatment commencement. Over 95% of clients give this consent. This means that there is an accumulating data base now over 1000 clients with the opportunity to contact these clients years later to determine the impacts of the treatment program and other interventions and naturalistic events contributing to gambling outcomes.

Prevention

Much has been made of the machine functionality (pre-commitment technology) and upper limits of spend ie $1 maximum in recent political attempts to address prevention. In addition to

these laudable attempts, reduction in machine numbers only achieved in SA, and reduction in venue numbers would clearly contribute to the prevention of problem gambling. If the enquiry is interested in on-line gambling, legislation restricting access to minors, restricting access to local and overseas based gambling sites would assist prevention.

Conflict of interest and double standards

State governments have conflicts of interest in maintaining the income from gaming machines whilst providing treatment or help services to ameliorate the damage. They cannot fully address the prevention and treatment of problem gambling whilst they also receive income from the machines. If any policy advancements in prevention and treatment are to be made, state governments will need to completely separate the management of income from managing the prevention and harm from machines, through the establishment of fixed percentages to the prevention, treatment and research area by and independent statutory authority.

In terms of the next phase in prevention ie public awareness much more needs to be done. Previously successful advertising campaigns in Vict and SA have been withdrawn with reductions of people seeking help whilst revenues continue to increase. Comparison with the frequency and potency of tobacco and gambling warning and help seeking advertisements reveals a much less vigorous attitude by governments. I would recommend a mandatory national percentage of gambling revenue goes into marketing and awareness campaigns and banning advertisements which are deliberately misleading eg suggesting that gambling on pokies is going to solve a financial problem or escape from life's worries. An example of the sort of ad which hits hard at the harm done by tobacco is the ' that's not all you are coughing up' (blood on a handkerchief). A similar ad – that's not all you are coughing up – showing effects on self and family would convey the same messages. Similar bans on encouraging gambling as for smoking should be introduced. Whilst smoking kills over many years of use, problem gambling kills in a few short years for some people through suicide. Wider harm is caused by problem gambling than other addictions or mental illnesses because of the financial losses which affect all members of a family.

Treatment and Research

The **Statewide Gambling Therapy Service (SGTS)** was established in 2007 following the development and testing of a cognitive behavioural therapy (CBT) treatment programme for people with gambling problems over 11 years as the intensive treatment service in SA. Professor Malcolm Battersby developed the programme at Flinders University based on his work on exposure therapy in the UK in anxiety disorders. This approach to treating gambling addiction employs a graded exposure (behavioural therapy) programme in conjunction with cognitive therapy to challenge the thought processes of addicted gamblers.

The CBT model used by SGTS has its origins in a number of treatment initiatives developed at Flinders University through the Master of Mental Health Sciences programme including the use of individual and group therapy programmes and an on-line videoconferencing programme for remote rural communities (1, 2). A key principle of this treatment is the reduction of the urge to gamble through graded exposure to gambling related cues. Early outcomes suggest that if the urge to gamble can be extinguished through the graded exposure treatment programme, relapse to problematic gambling is less likely (3-7). The process of cure is similar to that used with phobias where the client exposes themselves in a graded way with mild anxiety from pictures of the feared object to eventually approaching the real feared object. Staying in the situation for 20-40 minutes results in a reduction of the urge or anxiety. Repeating the same task daily results in eventual extinguishing of the urge to gamble. Many clients report eventually becoming bored by the venue, the machines and the idea of gambling. This approach is considered counterintuitive by some counsellors who concentrate on teaching clients ways of avoiding or thinking about gambling triggers. In these types of therapies, clients use will power which may

work for weeks of months but the client reports being continually pre-occupied with the thought of gambling and vulnerable to relapse.

SGTS provides a complete mental health assessment on presentation and a range of treatment and support options including an inpatient programme with additional clinical support and treatment for clients with co-morbid conditions, on-line support, peer support, and relapse prevention strategies involving family support and self-help groups. Collaboration and cross-referral between treatment agencies providing financial and family counselling services also complement the range of options available to people seeking help for their gambling problems.

To date, numerous papers and reports have been produced by **SGTS** and the **Flinders Centre for Gambling Research (FCGR)** on the processes and outcomes of treatment programmes for people with gambling disorders. These works are beginning to form a more robust evidence base for the efficacy of the CBT treatment approach to disordered gambling as this body of work, including book chapters, treatment manuals, journal articles and presentations chart patients' journeys through treatment (8) and document short and longer-term treatment outcomes (2, 4-6, 8-15). Our annual reports show that of those who seek treatment, 15-20% do not attend their first appointment, of those who attend, 68% complete 4 or more treatment sessions. Of these over 80% achieve their treatment goals and have statistically and clinically significant reductions in gambling behaviours. We are not aware of any other services nationally or internationally that achieve this retention rate in therapy and the treatment outcomes for a real world clinical service as compared to an experimental research study.

In addition to the regular outpatient treatment programme offered by SGTS, an inpatient programme has been developed for clients with complex co-morbid mental health conditions and, although a small programme in the scheme of things, this programme provides significant benefits for this patient group (11, 16). SGTS, in collaboration with the Flinders Centre for Gambling Research is also exploring relapse prevention strategies and the application of peer-led, self-management programmes to assists recovered gamblers to prevent relapse to problematic gambling following treatment (3, 17). The service is also diversifying its treatment options to include clients from culturally and linguistically diverse (CALD) and Aboriginal communities (18, 19) with programme adaptations, bi-lingual educational materials and a new treatment manual now in place for Vietnamese people with gambling problems.

Currently the FCGR is working on a number of studies exploring the efficacy of behavioural, cognitive and cognitive behavioural therapy in the treatment of disordered gambling. An initial randomised controlled trial conducted through the FCGR is looking at the benefits of pure exposure therapy compared with pure cognitive therapy (20) and a larger study is being developed in collaboration with Professor Ladouceur from Laval University in Canada and Professor Abbott in Auckland, NZ, to investigate the relative merits of a number of other treatment options for people experiencing gambling disorders.

The developments outlined above go part of the way to answering the key questions emerging in the field of gambling addiction, treatment, relapse and prevention and ongoing support. As outlined in the introductory section of this submission, there are many grey areas in relation to the gambling industry and the associated phenomenon of disordered gambling that researchers are now beginning to address.

Service delivery models

Current service delivery models are a mixture of services with a combination of gambling help lines, non government organisations providing financial counselling and a range of therapy approaches . The alternative approach is to use evidence where available from the gambling literature and where this is inconclusive use the anxiety disorders and depression literature on interventions and their delivery at a population level to model gambling therapy services. The most rigorous example is the NHS Improving Access to Psychological Therapy Services in the

UK. The National Institute of Clincal Excellence (NICE) recommended the brief cognitive and behavioural therapy approaches for anxiety and depression in a stepped care model ie from low intensity to high intensity with adjunct social prescribing for social isolation and signposting to community services eg unemployment, marital, financial counselling. New(community members) and existing therapists were trained in a one year national curriculum to the low intensity counsellors and existing cognitive behavioural psychologists and other health professionals were trained to be high intensity therapists. Ie when a person was too complicated for brie – 5-10 sessions they were 'escalated' to high intensity therapy. These services have been provided across the UK to over 110,000 people. A key element of the model is that all clients have outcome measures taken at each session using an electronic data management system called PC-MIS (York University). Data completion rates of over 95% have been achieved. Outcomes have been impressive with over 50% of those attending achieving recovery.

Recommendations: issues which require urgent attention in regards to treatment services

1. The most serious issue is the incidence of attempted self-harm and completed suicides. Only one Australian study has measured completed suicides and another self-harm, both in Victoria. We are aware of many suicides amongst clients seeking help in a range of help services but many go unrecorded publically. There is an urgent need to understand the full impact of gaming machines in terms of self-harm and completed suicides. This should be accompanied by a suicide and self-harm recognition, assessment, triage and brief intervention education program for venue staff, counselling and therapy services.

2. There should be a national training program for therapists or counsellors which teaches in a rigorous way at least a graduate certificate level those with mental health qualifications mental health assessment with a gambling focus, anxiety and depression assessment and management similar to that provided by the Master of Mental Health Science course at Flinders University a course for non- psychologists in evidence based psychological therapies.

3. There is a need to develop an interactive on-line either client alone or therapist assisted cognitive behavioural therapy program which includes urge reduction methods in addition to the traditional cognitive approaches.

4. Explore stepped care models for service delivery including the adjunct use of technology with email, text messaging, on-line education and therapy, on-line therapy groups.

5. Gambling help services should be transferred to state and territory health or mental health services.

6. Models of peer support including peer education and peer treatment models should be developed and tested

7. Specific services should be provided for special needs groups with high prevalence of problem gambling ie Aboriginal and mental illness populations ie people with long term mental illnesses usually being case managed in mental health services and receiving social security benefits.

8. Improve collaboration between gambling help services and the wider community health sector in order to provide more effective and efficacious treatment pathways for problem gamblers

Research

- better matching of treatment interventions to the person to the needs and stages of addiction of those with problem gambling

- clearer analysis of what forms of treatment work for which groups of people, for how long and at what cost

- a much better understanding of the stages in the development of addictive behaviours in relation to gambling, cycles of treatment and relapse

- a move beyond self-reported outcome measures in problem gambling treatment including the use of physiological measures and more direct methods for collecting data on the rates of use and impact of gaming technologies upon the consumer as discussed by Shaffer (21)

- an extension of research enterprise beyond the clinical / treatment focus and into the arena of public policy and the wider social determinants of health and wellbeing in relation to the impact of gambling upon individuals, families and communities…ie the pathways to problem gambling need further investigation beyond a psychological paradigm and to include psychosocial and socioeconomic perspectives

- the relationship between co-morbid conditions such as anxiety, depression and substance abuse, and gambling disorders to be further investigation

Consumer contribution

Problem Gambling

I struggled with gambling on poker machines for many years until seeking the specific treatment offered at the Statewide Gambling Therapy Service (SGTS) The harm I have encountered over these years has been significant, including the following:

- financial hardship resulting in significant anxiety and depression
- relationship problems
- significant restrictions to my lifestyle
- many failed attempts to overcome my problems gambling behaviours

Treatment

I was referred to the SGTS in 2009 to be assessed for the treatment program. It was determined that I was suitable for the program. I completed the treatment and was placed in follow up. During this time I regained control over my life. It was a different approach that I had been struggling with over the years. Rather than learning ways to keep myself safe and avoid gambling I learnt to overcome this destructive behaviour. The difference between this program and other services where I had sought support for my problem was that my urges to gamble have gone and through the graded exposure program I can now enter a gaming venue, carry cash and save money. I have now been involved in supporting other clients to stay with their program to gain the benefits.

In summary I want to highlight the importance of this program and hope that it can be made available to other problem gamblers.

Heather: client of the Statewide Gambling Therapy Service

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