Position statement 45
Problem gambling
September 2017

Authorising Committee/Department: Board
Responsible Committee/Department: Faculty of Addiction Psychiatry
Document Code: PS45 PPP Problem gambling

Purpose
The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is concerned that problem gambling is having a significant and deleterious impact on vulnerable individuals, their family/whānau, support networks and beyond. Furthermore, the stigmatisation of problem gambling continues to act as a barrier to individuals accessing the support they need. The RANZCP advocates that at the basis of any response to problem gambling must be a respect for the person, their behavioural disorder and its treatments.

Key messages
- The rise of interactive and online gambling is having devastating consequences; new gamblers are more easily recruited online and gambling sites are accessible 24 hours per day.
- Approximately 90% of people diagnosed with problem gambling have at least one other mental health diagnosis.
- The stigmatisation of problem gambling continues to act as a barrier to individuals accessing the support they need.
- Electronic gaming machines (EGMs) are associated with higher risks than other forms of gambling and the RANZCP supports changes that would restrict the number of EGMs, reduce the maximum bet and limit the jackpots on EGMs.
- Increased investment in research into evidence-based screening, assessment, treatment and early intervention in the field of problem gambling is required and particularly, evidence-based models for regulation of interactive and online gambling.
- Increased funding of evidence-based services for the screening, assessment, treatment and early intervention of people experiencing problem gambling is also required.

Definition
The Australian Ministerial Council on Gambling defines problem gambling as ‘difficulties in limiting money and/or time spent on gambling which leads to adverse consequences for the gambler, others, or for the community’ (SA Centre for Economic Studies, 2005). In New Zealand, the Gambling Act 2003 defines gambling-related harm as ‘harm or distress of any kind arising from, or caused or exacerbated by, a person’s gambling; and includes personal, social, or economic harm suffered – by the person; or by the person’s spouse, civil union partner, de facto partner, family/whānau, or wider community; or in the workplace; or by society at large’ (Ministry of Health, 2010).

Pathological gambling was first included as a disorder in the International Classification of Diseases (ICD) in 1977 and is included in the ICD-10 under impulse disorders (WHO, 1990). The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) included...
gambling disorder as a new category on behavioural addictions, reflecting research findings to suggest that gambling disorder is similar to substance-related disorders in clinical expression, brain origin, comorbidity, physiology and treatment (APA, 2013).

The phrases ‘pathological gambling’ and ‘problem gambling’ are often used interchangeably, with the term ‘pathological’ more frequently used in the United States and ‘problem’ more common in Australia and New Zealand. ‘Problem gambling’ is also sometimes used to describe an intermediate or subclinical form of the disorder ‘pathological gambling’. The term ‘pathological’ is considered to be pejorative by some who prefer the term ‘problem’ to describe addictive gambling behaviours as points along a continuum (Thomas, 2011). For the purposes of this position statement, the phrase ‘problem gambling’ is used to describe the disorder.

Evidence

In Australia it is estimated that there are approximately 115,000 people experiencing problem gambling and 280,000 who are at moderate risk (Productivity Commission, 2010). Problem gamblers are those who have the most serious difficulties due to gambling behaviours, including relationship breakdown, depression, suicidal ideation, suicide, illegal activity, poverty and bankruptcy (SA Centre for Economic Studies, 2005). In New Zealand, problem gamblers are estimated to make up 0.3% of the population, with moderate-risk gamblers at 1%. There can be considerable harm to others as a result of gambling and it is estimated that approximately 1 in 40 New Zealanders are negatively affected by other people’s gambling (Ministry of Health, 2012). One third to one half of people with gambling problems and their family members reported family violence in the preceding 12 months (Dowling et al., 2014).

Young people are particularly vulnerable to problem gambling. Research from Canada, the United States, the United Kingdom, Norway and Australia shows that 63–82% of teenagers (12–17 years of age) gamble each year, 4–7% of adolescents exhibit serious patterns of pathological gambling and 10–15% are at risk of either developing or returning to a serious gambling problem (Monaghan et al., 2008).

The relationship between cultural background and problem gambling is complex and it is unclear whether being from a culturally and linguistically diverse community is a risk factor for problem gambling (Victorian Responsible Gambling Foundation, 2015). In Australia, some studies have shown that problem gambling is associated with non-English speaking backgrounds (School for Social and Policy Research, 2006); however, other research has shown lower rates of problem gambling in individuals born outside of Australia (Davidson and Rodgers, 2010). Several studies have demonstrated an increased risk of problem gambling for Aboriginal and Torres Strait Islander peoples (Sproston et al. 2012; South Australian Department of Families and Communities, 2012) and Māori (Ministry of Health, 2012). Lower socio-economic status is also a risk factor for problem gambling (Victorian Responsible Gambling Foundation, 2015).

Electronic gaming machines (EGMs) are associated with higher risks than other forms of gambling and the risk of problem gambling increases significantly with the frequency of playing EGMs. In 2010, it was estimated that among people who play EGMs weekly or more, around 15% are problem gamblers and a further 15% are at moderate risk. Regular EGM players spend on average $7000–8000 per annum with most people significantly underestimating their spending (Productivity Commission, 2010). The RANZCP supports changes that would reduce the maximum bet and limit the jackpots on EGMs and recommends restricting the number of EGMs in venues relative to the damage caused.

The RANZCP recognises that the rise of interactive and online gambling is having devastating consequences for some individuals and families (Financial Counselling Australia, 2015). New gamblers are more easily recruited online, especially young people who are highly involved in web-based activities (Lejoyeux, 2012). In addition, online gambling sites are accessible 24 hours per day and do not require the person to leave their home. The difficulties experienced by existing problem gamblers are also exacerbated by engagement with interactive gambling. New screening and prevention measures are required to respond to this phenomenon. More research is required into evidence-based responses to problem online gambling. Further, the RANZCP supports...
legislative change to bring the laws of Australia and New Zealand up-to-date with the changing online landscape.

Comorbidity is common with problem gambling. Approximately 90% of people diagnosed with problem gambling have at least one other mental health diagnosis and approximately 30% have three or more diagnoses. The most common comorbidities are substance use disorder (57.5%); antisocial personality disorder (28.8%); alcohol use disorder (28.1%) and depression (23.1%) (Thomas, 2011). Suicidality is an important concern for those experiencing gambling problems (Petry and Kiluk, 2002) particularly those with greater gambling severity (Ledgerwood and Petry, 2004). Psychiatrists have an important role in identifying and diagnosing problem gambling as well as any other underlying, comorbid mental illness. In some instances these will be a consequence of the gambling behaviour and will improve when gambling is controlled or ceased. In other cases, gambling may be a way of managing pre-existing mental health issues. For instance, research suggests that mood and anxiety disorders may often precede gambling problems for some people, but others may develop depression as a result of the financial and relationship stress arising from gambling (Lorains et al., 2010).

Less frequent comorbidities include psychiatric illnesses such as mania, hypomania and schizophrenia. In cases of mania and hypomania, gambling behaviour may be part of the mood disorder episode. Gambling is sometimes used by the individual as a way of managing the symptoms of psychiatric illness, for example the negative symptoms of schizophrenia. Rarely, symptoms of schizophrenia such as delusional ideas and command hallucinations may precipitate gambling behaviour. In some cases, pathological gambling can also develop following dopamine agonist treatment for Parkinson’s disease (Djamshidian et al, 2011).

Problem gamblers present to general practitioners more often than average, for both physical and mental health issues (VRGF, 2014). Physical symptoms such as migraine, hypertension and other stress-related problems can be associated with gambling. Other issues include family and social problems, such as emotional problems, financial difficulties, relationship stress or family violence (Dowling, 2014).

Despite the links between problem gambling and health, governmental responsibility for problem gambling is separated from health in every Australian jurisdiction. This is at odds with the situation in other countries like New Zealand where the Gambling Act 2003 requires an ‘integrated problem gambling strategy focused on public health’ including prevention measures, treatment services, independent research and evaluation. Accordingly, the New Zealand Ministry of Health has developed a strategic plan with eleven objectives designed to meet these requirements. This approach has the advantage of aligning the responsibilities for problem gambling and health so as to enable an effective, evidence-based response to problem gambling and associated mental health issues.

Despite increasing research into problem gambling, there is a dearth of evidence-based treatments partly due to people with comorbidities often being excluded from being test subjects in research trials. As approximately 90% of all people with problem gambling have comorbidities, research must often be undertaken with the small cross-section of people presenting with problem gambling as their only mental health problem and therefore they may not be representative of the majority of problem gambling cases (Thomas, 2011).

Like other mental health conditions, gambling is typically a relapsing–remitting condition, with reported relapse rates around 75% (Hodgins et al., 2007). Although relapse rates can be high even with treatment (Hodgins and el-Guebaly, 2004), most people accessing treatment do report reductions in gambling involvement (Productivity Commission, 2010).

Free, confidential, 24/7 helplines are available in every state and territory in Australia (1800 858 858) and in New Zealand (0800 654 655), providing counselling information and referral for gamblers and concerned family members. Self-help booklets and printed service information are also available from these helplines. Free online services (e.g., gamblinghelponline.org.au) are also available and appear to be attractive to those who experience high levels of shame and stigma. Accessed most often by young men, 70% of people accessing this service have never previously accessed treatment (Rodda and Lubman, 2014).
Recommendations

Areas for development

- There should be increased investment in research into evidence-based screening, assessment, treatment and early intervention in the field of problem gambling. There is also a need for improved training of psychiatrists and other practitioners in relation to problem gambling.
- There should be adequate funding for evidence-based treatment programs and facilities to meet the level of need in the community. Given the very high social and financial cost of gambling in Australia and New Zealand, funding for such initiatives would have very high potential for return on investment.
- Mental health and problem gambling should be aligned within state and territory government portfolios to enable an effective, evidence-based response to problem gambling and the associated mental health issues.
- The RANZCP also recognises the contribution of online betting and interactive gambling to problem gambling. Research is specifically required into evidence-based models for regulation of interactive and online gambling, incorporating consumer protection and harm-minimisation features. All jurisdictions in Australia and New Zealand must work together collaboratively to develop comprehensive guidelines and legislation that encompass the growing online market.
- The RANZCP supports changes that would reduce the maximum bet, limit the jackpots on EGMs and restrict the number of EGMs in venues in order to address the associated psychosocial harms (see, for example, Rockloff et al., 2014; Productivity Commission, 2010).

Screening and assessment

- Given the high levels of comorbid problem gambling and additional mental health problems, screening by mental health practitioners for problem gambling should be routine. Conversely, screening for other mental health issues, including the risk of suicide, is important among individuals presenting with gambling problems. A disclosure of problem gambling may not be volunteered by patients without prompting, so direct questions may be necessary.
- Screening for problem gambling should be done as part of an initial assessment, followed up with a more comprehensive assessment when the individual feels able to complete this (Problem Gambling Research and Treatment Centre, 2011). If problem gambling is identified, further assessment, treatment and/or referral to a specialised service should be undertaken as appropriate.

Psychological treatment

- There is limited evidence in the area of problem gambling treatment; however, some psychological approaches have been shown to have a positive effect in reducing gambling severity and psychological distress. These include:
  - cognitive behavioural therapy (CBT), incorporating cue exposure and response prevention (Battersby et al., 2008), in an individual or a group setting
  - motivational interviewing and motivational enhancement therapy
  - practitioner-delivered psychological interventions
  - various e-mental health interventions (Rodda, Lubman and Dowling, 2016)
  - Gamblers Anonymous (Problem Gambling Research and Treatment Centre, 2011).
- Psychiatrists and other practitioners may wish to consider one or more of these approaches when treating problem gambling.

Pharmacological treatment

- There is growing evidence for the use of naltrexone in the treatment of problem gambling, although definitive research is still required (Grant et al., 2014). The RANZCP recommends
careful consideration of the following prior to initiating pharmacological treatment for problem gambling:

- Prescription of naltrexone should be made as part of a holistic treatment plan. This should occur after having considered all the appropriate checks and measures, in dialogue with the person and taking into account the full range of contraindications.

- Naltrexone is approved for the treatment of alcohol dependence and as adjunctive maintenance therapy for patients formerly dependent on opioids by the Therapeutic Goods Administration in Australia and the Medicines and Medical Devices Safety Authority in New Zealand (Revia 2016; Naltraccord, 2014).

- The use of naltrexone for problem gambling is therefore ‘off label’ in both Australia and New Zealand. The usual, appropriate precautions must be taken when prescribing in this manner and issues such as costs should be discussed. The RANZCP’s Professional Practice Guideline 4: ‘Off-label’ prescribing in psychiatry should be referred to for more information (RANZCP, 2016).

**Advertising and endorsement**

- There is strong evidence to demonstrate the link between the advertising of gambling activities and increases in problem gambling behaviour. The RANZCP recommends the limitation of television and online advertisements for betting and gambling and the prohibition of television advertisements for gambling during designated children’s viewing times.

- The RANZCP supports the prohibition of sports commentators talking about odds and the restriction of gambling advertisements at sporting events.

- ‘Host responsibility’, including trained staff, is encouraged to ensure that companies offering gambling create a safer environment for problem gamblers.

- Organisations external to the gambling industry should be cognisant of the importance of engaging with the industry only in such a manner that does not contribute in any way to the harm of problem gambling. With regards to this matter, the RANZCP commits to being mindful when selecting venues for events and avoiding those which are suggestive of support of the industry and engaging with the industry in a purely advisory role with the aim of harm reduction.

**References**


Gambling Act 2003 (NZ).


South Australian Department of Families and Communities (2006) Gambling prevalence in South Australia. Adelaide, Australia: South Australian Department of Families and Communities.


Disclaimer
This information is intended to provide general guide to practitioners, and should not be relied on as a substitute for proper assessment with respect to the merits of each case and the needs of the patient. The RANZCP endeavours to ensure that information is accurate and current at the time of preparation, but takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.