

Knowledge Notes

Brief Self-directed Gambling Treatment

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Background

Gambling Disorders are recognized mental health disorders affecting between 1 and 3% of the population. They are associated with significant personal, social and family impairment as well as significant financial consequences. They are also associated with concurrent substance abuse, depression and anxiety disorders (Petry & Weinstock, 2007) and elevated risk of suicidal ideation, attempts and suicide (Hodgins, Mansley & Thygesen, 2006). Treatment services are available from Alberta Health Services (both outpatient and residential services) and reviews of treatment outcome studies conducted in Canada and elsewhere conclude that cognitive-behavioural treatment is effective (Hodgins & Holub, 2007). This review focuses on a promising new brief treatment for gambling disorders. This treatment has been identified as an evidence-based intervention by the US Substance Abuse and Mental Health Services Administration.

Objectives

To summarize evidence pertaining to Brief Self-directed Gambling Treatment (BSDGT).

Brief Self-directed Gambling Treatment (BSGT)

BSGT was developed in recognition of the fact that only a small proportion of individuals who are suffering problem with gambling seek formal face-to-face treatment. In jurisdictions with fully developed and accessible face-to-face treatment, at most 10% of pathological gamblers attend treatment. At the same time, there is evidence that some of these individuals recover naturally and prefer this route to recovery. BSGT is designed to enhance the likelihood and success of “self-directed” recovery. The treatment involved very brief telephone contact in the form of a motivational interview (20 to 40 minutes) after which clients are sent by mail a copy of a 40 page self-help workbook. Clients are recruited through media announcements or through contact with a gambling helpline service.

Method

Three randomized trials provide evidence of the efficacy of BSGT. Two of these trials test the telephone – mailed self-help workbook treatment specifically and the other trial assessed a face-to-face version. In each of these trials, specific behavioral outcomes included gambling frequency and expenditures as primary outcomes and gambling problem severity as a secondary outcome.

Results

Trial 1 (Hodgins, Currie, & el-Guebaly, 2001) randomly assigned 102 individuals with gambling problems to one of three conditions: BSGT, workbook only, and waiting list control. The initial report followed individuals for 12 months, with interviews at three, six, and 12 months (85% follow-up rate). Participants in the BSGT were more likely to have significantly reduced days of gambling and expenditures at 3, 6 and 12 months. Similar results were also found in a further 24 month follow-up (78% follow-up rate; Hodgins, Currie, el-Guebaly, & Peden, 2004).

Trial 2 (Hodgins, Currie, Currie & Fick, 2009) provided a replication and extension of the above design with a larger sample size (N = 314). Individuals with gambling problems were randomly assigned to one of four conditions: BSGT, workbook only, wait list control and a BSGT condition with extended telephone contact in the form of 5 monthly booster calls. Results of a 12 month follow-up (85% follow-up rate) showed an advantage of the two BSGT conditions over the workbook only and wait list control groups. There was no added advantage of the booster calls over BSGT with a single telephone contact.

The BSGT telephone intervention uses a motivational interviewing model that encourages clients to identify and resolve their ambivalent feelings amount changing their gambling involvement and to voice commitment to change. A detailed analyses of audio tapes of these telephone contacts provided support for therapeutic effectiveness of this model. Strength of commitment identified by blinded raters of the sessions correlated with gambling outcomes in the follow-up year (Hodgins, Ching & McEwan, 2009).

Trial 3 (Diskin & Hodgins, 2009) assessed a face-to-face session of the BSGT. Participants (N = 81) were randomly assigned to receive a face-to-face motivational interview about their gambling concerns or a structured clinical interview. Participants in both groups received the self-help workbook. Results showed an advantage for the motivational interview on frequency of gambling and expenditures.

Although this research supports the efficacy of the intervention, further research by independent researchers is necessary. It is particularly important to demonstrate that BSGT is successful in increasing treatment uptake. Does it attract individuals who otherwise would not seek treatment or would delay seeking treatment? Does it successfully broaden our treatment system? How should we advertise this option to attract the most suitable candidates? Evidence from the alcohol field suggests that individuals with less severe problems self-select these self-directed options but this has not been demonstrated for gambling disorders

Conclusions: Brief Self-directed Gambling Treatment Availability

The Self-directed Gambling Treatment program has been implemented in a number of jurisdictions, most recently by the New Zealand Problem Gambling Helpline. A web version is available in Sweden and is also being developed for Ontario. In Alberta, the telephone support is not available but Alberta Health Services has published the self-help workbook under the title *Becoming a Winner*. This workbook is 40 pages and includes a variety of personalized exercises to help with motivation and to help with developing behavioral strategies for reducing or quitting gambling.

References

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