ROYAL COLLEGE OF PSYCHIATRISTS

RAPID EVIDENCE REVIEW OF EVIDENCE-BASED TREATMENT FOR GAMBLING DISORDER IN BRITAIN

Dr Henrietta BOWDEN-JONES, Consultant Addiction Psychiatrist, National Problem Gambling Clinic, Central and North West London NHS Foundation Trust, London
Professor Colin DRUMMOND, Chair, Addictions Faculty, Royal College of Psychiatrists and Professor of Addiction Psychiatry, King's College London.
Professor Shane THOMAS, Professor of Primary Care Research, Monash University, Australia.

PURPOSE OF PAPER

The Royal College of Psychiatrists' Faculty of Addictions has been asked by the Department of Health in England to provide a rapid review of evidence-based treatment for gambling disorder in the UK to inform policy considerations on matters such as the future level of NHS involvement in the delivery of care for this disease, and the potential need for psychotropic medication for the hundreds of thousands of people affected by the illness.

PREVALENCE OF PROBLEM GAMBLING IN BRITAIN

The rates of Gambling disorder in the UK have been reported as ranging from between 0.5 to 0.9 per cent over the last decade (British Gambling Prevalence Survey 2007 and 2010 and Health Survey for England 2012).

This figure amounts to there being about 300,000 problem gamblers in the UK at any one time.

From the work conducted by GambleAware there is now evidence that of the 300,000 people gambling pathologically, 8,000 (2.7%) are in treatment at any one time, although this figure does not include any patients treated in the private sector. This compares to around six per cent of problem drinkers and 50 per cent of class A drug misusers in treatment in England (Public Health England, 2016).

Despite gambling disorder being recognised internationally as a mental disorder, it has not as yet become a core NHS mental health service responsibility. Problem gambling issues often present with both physical and psychiatric comorbidities, pointing to a need for the illness to be seen as both a physical and mental health issue, and also a social issue.

NATIONAL PROVISION OF TREATMENT FOR GAMBLING DISORDER

In England, gambling policy is overseen by the Department for Culture, Media and Sport rather than the Department of Health or Public Health England. At present there is little formal NHS involvement in the field of pathological gambling, either in apportioning funds or in overseeing treatment provision.

The primary role in determining national treatment provision rests with GambleAware (formerly known as The Responsible Gambling Trust). This is the charity set up by the gambling industry to apportion funds to treatment, research and prevention at national level, rather than this being the role of a government body, such as NHS England.

There are 19 treatment services in England and one national helpline providing interventions for the treatment of problem gamblers. The geographical distribution of services is informed neither by the prevalence rates of problem gambling, nor by a needs assessment to guide strategic commissioning. Access to services is therefore highly variable across England.

GamCare is the largest non-statutory treatment provider, with a London base and 17 partner agencies across the UK. Gordon Moody is the only residential treatment service for pathological gamblers.

The National Problem Gambling Clinic is currently the only designated NHS provider of treatment for gamblers, supported by both GambleAware and Central and North West London NHS Foundation Trust.

Data from all the treatment providers is collected by GambleAware. This information reflects not only the demographics of the treatment-seeking population but also the type of treatment they receive, as well as drop-out rates and non-attendance data.

EVIDENCE BASE FOR TREATMENT

Up until 2010 the evidence base for treatment of problem gambling at international level was outlined in the Australian National Health and Medical Research Council (NHMRC) guidelines developed by Monash University: Guideline for screening, Assessment and treatment in problem gambling, published in 2011. The principal author of these guidelines is Prof Shane Thomas. **(See Appendix).**

The process was scientifically rigorous and the results have informed clinical practice across the world, and continue to do so. There is not yet an equivalent publication for the period 2010 to 2016, but the most relevant studies have been included here. The Monash Guidelines are currently being updated to take into account any new research published since the original guidelines were published. The current guidelines based their recommendations on 34 randomised controlled trials reported in 37 articles.

There are currently no NICE guidelines for the treatment of pathological gambling which is why in the UK, as elsewhere, clinicians and services have been referring to the Monash Guidelines.

It is a widely held view amongst treatment providers and regulators in the problem gambling sphere that if NICE were to produce clinical guidelines on the diagnosis and management of gambling disorders, this would be beneficial for patients across the UK. It would also help to clarify the responsibility of the NHS for treatment provision.

PSYCHOLOGICAL INTERVENTIONS

The NHMRC Guidelines state that Cognitive Behavioural Therapy (CBT) was found to be more effective than no intervention, and that treatment either in individual or group delivery should be used to reduce problem-gambling behaviour, problem-gambling severity and distress caused by problem gambling. The CBT should be delivered ideally by CBT-trained professionals and the therapy ideally should be manual-guided.

There was insufficient evidence available at the time to determine whether CBT was superior to other psychological treatment modalities.

Motivational Interviewing and Motivational Enhancement Therapy were also found to be more effective than no treatment intervention in the reduction of gambling problems. Both of these treatment modalities should ideally be delivered by a trained clinician and a manualised structure should be used.

Practitioner-delivered treatment interventions were found to be more effective in reducing problem gambling symptoms than self-help groups.

Group psychological interventions could be used to reduce gambling behaviour and gambling severity in problem gamblers, although the evidence for this is currently limited.

The NHMRC guidelines suggested that studies are needed to assess whether there is evidence for inpatient treatment for gambling disorder. As no studies on this particular topic were included, the NHMRC guidelines could not make any recommendations.

A further area in need of research was linked to whether abstinence-based programmes are more effective than those without a total abstinence goal. However, as with alcohol dependence it is appropriate to continue to work with gamblers who are not currently committed to an abstinence goal rather than denying them access to treatment.

MEDICATION

Naltrexone can be used to reduce gambling severity in problem gamblers. It should be prescribed by an experienced practitioner, with appropriate skills and training, and careful consideration must be given within the clinical encounter to contraindications.

Antidepressant medication should not be used to reduce gambling severity in people presenting with problem gambling alone. It is however appropriate to prescribe Selective Serotonin Re-uptake Inhibitors (SSRIs) in people with comorbid depression and gambling disorder, but there is no evidence that this improves gambling outcomes.

RECOMMENDATIONS

The Royal College of Psychiatrists recommends the following:

1. Randomised controlled trials assessing the impact of psychological therapies and medication should be conducted in the UK rather than allowing US-based studies alone to inform clinical practice. The experiences of gambling-related harm and the use of gambling-related products and treatment provision differ widely from country to country, so it would be preferable to base national recommendations on UK-based research.

2. Gambling disorder is a mental disorder that needs to be regarded as an addiction like any other, with significant levels of harm to the individual and to society. Treatment services for problem gambling should have parity of esteem with other mental disorders, in particular alcohol, drug and tobacco addiction, and should be a core element of addictions treatment provision within the NHS.

3. Naltrexone, as the treatment intervention of choice for treatment-resistant pathological gamblers, should be made available to all patients whose lives are affected negatively by their illness.

4. NICE Guidelines for the treatment of gambling disorder are required to address a pathology that affects almost half a million people in England but has not been sufficiently prioritised by the NHS.

5. Training in identifying and treating problem gambling symptoms should be a component of all medical school curricula and the postgraduate psychiatry training curriculum.

December 2016

References

British Gambling Prevalence Surveys 1997, 2000, 2007 Wardle H et al, NatCen Social Research for the Gambling Commission.

Health Survey for England 2012, Craig R, Mindell, J (eds) The Health and Social Care Information Centre, London.

Public Health England (2016) Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2015 to 31 March 2016. PHE, London

National Health and Medical Research Council (2011), Guidelines for Screening, Assessment and treatment in Problem Gambling. Australian Government publication, available at: www.nhmrc.gov.au

APPENDIX

National Health and Medical Research Council (NHMRC) Guidelines

What is the 'Guideline for Screening, Assessment and Treatment in Problem Gambling'?

This document is the first guideline to address problem gambling in Australia and provides recommendations to guide practice, patient and policy decisions for screening, assessment and treatment of problem gambling. The guideline summarises the research and the current state of knowledge, and has been based on the best available evidence up to March 2010. Several recommendations for practice were made, but only where there was sufficient high-quality evidence available.

What does the guideline recommend?

There are three categories of recommendation in the guideline: evidence-based, consensus-based, and practice points.

There are seven evidence-based recommendations in the guideline, all of which relate to treatment. Each recommendation is associated with a Grade, which indicates the level and quality of evidence upon which it is based. Each recommendation should be read in conjunction with practice points, which are available in the guideline.

For screening and assessment, in the absence of sufficient high-quality evidence, there are three consensus-based recommendations and three practice points.

An electronic version of the guideline (3.1mb) is available here. It can also be obtained from the NHMRC Clinical Practice Guidelines Portal.