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session

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Session III: Critical issues in treatment

Brief interventions for problem gambling

Presenter: David Hodgins

(Introduction.) **Ken Winters**: We are glad to be able to present to you Dr. David Hodgins, professor of psychology at the University of Calgary in Alberta, Canada. He's going to speak to us on the topic of brief interventions for problem gambling.

David Hodgins: Brief and self-directed treatments are an exciting area of development in the treatment of gambling and other addictions. I want to start by providing a context: brief treatments have an important role to play in supplementing and complementing more formal treatment options—they are a way to broaden our treatment system and have the potential to help greater numbers of people. This figure, adapted from other public health areas, provides a schematic of an ideal treatment system. The population of individuals that we call problem or pathological gamblers can be divided into two groups. The larger group, perhaps 90 percent of people with gambling problems, are "not ready to change." For those individuals we have started to develop public awareness campaigns to try to get them ready to acknowledge and address their problems. As well as these campaigns, we can also work through family members to encourage insight, and provide opportunistic interventions for individuals when they seek help for related problems with mental or physical health or even finances. The goal is to get people "ready to change." For people who are ready to change, we need to offer a range of interventions consisting of different levels of structure and intensity. These interventions should include outpatient counseling and residential programs. As well, the options should include brief treatment and encouragement for people to recover

"naturally." There is a set of hypothetical factors that can be used to match people to the treatment that is most likely to be effective—for example, severity of problem is a likely matching factor (people with more severe problems need more structured treatments). Other potential factors are social support and comorbidity (people with less social support or greater comorbid problems need more structured treatment). The model also suggests that if people do not perform well at one level of intervention, they should step up to a more intensive treatment format (hence the treatment title, "Stepped Care Model").

I am interested in the self-change and brief intervention aspects of the model. We know that rates of natural recovery are high among people with gambling problems. Our research also shows that people do not move quickly into natural recovery—most often they have lengthy and serious problems before they become ready to change; however, they do reach this state of readiness without treatment. The question that we had was, "What can we do to promote this natural recovery process so that it happens earlier?"

We have reported a two-year follow-up of people who were provided with a telephone-workbook self-recovery program. The participants were recruited through the media and were eligible to participate if they believed they had a gambling problem but wanted to quit on their own without treatment or Gamblers Anonymous (GA). The workbook was brief and simple and provided cognitive behavioral strategies. The telephone aspect involved one motivational call from a psychologist at the beginning of the project. The psychologist spent 20 to 40 minutes talking to the participants about their reasons for change, their ambivalence about changing, and their previous efforts to change their bad habits. Despite the brevity of the intervention, by 24 months almost 40 percent of participants were abstinent and most were significantly improved.

That is just one example of a brief intervention. Currently, we are conducting a replication study to better understand who benefits from this approach (i.e., the matching factors). We also do not know much about what exactly helps people: the workbook, the motivational interview, or some other therapeutic ingredient. One of my doctoral students, Kate Diskin, is doing a study looking specifically at the effects of a motivational intervention. The goal of her project is to identify people who were showing some concern regarding their gambling, who would be willing to volunteer to come in to assess the effectiveness of two different ways of interviewing people with gambling problems. So when people came in, they were randomly assigned to one of two groups.

One group received a more traditional clinical interview, where they were interviewed about their gambling and filled out some

questionnaires about their gambling, and so forth.

The other group provided the same information, but a motivational interviewing style was used. Therefore, both groups were similar in the sense that they talked about the pros and cons of their problem, and their previous efforts to change, and so forth.

Although Kate is in the process of analyzing the results, it's very clear that over a 12-month follow-up, the participants who had the motivational style of interview showed much better outcomes in terms of their gambling, compared to participants who had the more traditional clinical interview.

Remember, these weren't people that were seeking treatment, or even seeking a change in their gambling. They just identified themselves as having some concern over their gambling. Kate isn't necessarily meaning to package this as an intervention, but it really does underscore the importance of motivational processes in brief interventions.

And that's one of the major points I want to make today—that my working hypothesis is that brief interventions are going to be more effective if there are clear motivational properties associated with those interventions.

Let's look at some of the other research that has been conducted. This is a table of some of the trials that I'm aware of. The first one is the one I described—promoting self-recovery in a dual package. There is good evidence of its effectiveness.

The second one is Kate's study that I just described—the single-session motivational interview. And, again, there is good evidence of its effectiveness.

The third trial on the list, the relapse-prevention booklets, is another trial that we conducted. The rationale for the trial was to do some follow-up work with a group of people who had quit gambling. We found, not surprisingly, that people who involved themselves in some sort of recovery group—mostly GA, but not exclusively GA—had better outcomes than those who did not attend support groups.

We found that only about a quarter of the people we were following were actually attending the groups and, therefore, these had better outcomes. However, most people, roughly 75 percent, were not attending the groups.

Then our question was, "If people aren't willing to attend these support groups, can we provide them with some kind of information concerning relapse, so that they will have better outcomes? Can

we provide them with something that they will perceive as treatment, that will supply them with information that will help with their outcomes?"

So, we designed a series of relapse-prevention booklets. Basically, we sent one per month to people and each booklet was on a different topic: "Helping with Your Finances" and "Dealing with Urges," and various other topics on relapse prevention. We found, frankly, lukewarm results. There was some suggestion that it was somewhat helpful, but there were not strong outcomes in that particular study. So, that's a relapse-prevention brief intervention.

The fourth one on the list is a study by Ellie Robson in Edmonton, who did a trial where she targeted people who were problem gamblers, not pathological gamblers. So I think they scored three and four on the SOGS and she provided them with various options.

One was a self-help package. She found similar results, with some being positive, but not really strong results overall.

And then the final one on the list is another project that we did in our group where we developed a brief intervention for concerned significant others, for family members and friends of people with gambling problems, where the gambler wasn't doing anything to address his or her problem. We knew that family members were calling help lines looking for help. When we interview successfully recovered gamblers, they tell us that families are very important influences on recovery. And so we asked, "Can we provide some self-help materials that will be useful to these family members? Can these materials help them feel better about, cope better with, and maybe be more effective in dealing with the gambling problem?"

The results of that trial were somewhat positive, but again, somewhat lukewarm. So what I'm presenting here, if you look at the rank ordering of the strength of the evidence, is that interventions—and mainly the brief interventions that have a clear focus on motivational properties—are the most effective.

The relapse-prevention booklets and Ellie Robson's program have some focus, but not as clear a focus as the top two. So my working hypothesis is that if we're going to be effective in offering brief interventions, it's not the information that we provide in the form of strategies, it's more the focus on the motivation that's going to be the important therapeutic ingredient.

And that's a hypothesis that we need to further investigate. Let me just summarize here that I'm arguing that there is a clear role for brief interventions in our treatment systems. We need to be

creative in how we fit those interventions into the system, though, because we shouldn't be offering them to people who are already saying, "I want to go for treatment."

We need to find ways of offering them opportunistically to people who don't want to go to treatment. I don't know that we have clear evidence at this point of who does well.

We have a large, ongoing project where we're replicating this self-recovery study and we're collecting a lot more information about the participants as a way of identifying who does well in this brief intervention approach. We're assuming that severity will be one of those factors. It will be most effective with people who have relatively less severe problems.

Ellie Robson is also replicating her study with a stronger scientific design, while specifically targeting early-stage problem gamblers, so that will be very informative. Nancy Petry also has an ongoing brief intervention trial, which will be helpful. And then there's Kate's trial as well. So I think, with these various approaches, with their similarities and differences, we'll be in a better position to understand who does well a year or so from now.

Finally, just let me restate my hypothesis that a motivational focus is important and needs to be a clear part of our efforts to develop brief interventions. Thank you.

Ken Winters: Excellent. So we are at the middle of the triangle there, of the brief intervention section and, as David said, it might be a treatment approach that's better targeted to those with mild to moderate problems. Although, a good question is, to what extent can we stretch this out perhaps for the continuum?

There might be some severe-end cases for which a brief intervention is what's needed, at least for a kick start. Probably more on that during the discussion section.

[End of session.]

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