Theme 7: Responding to co-occurring harms

In responding to co-occurring gambling and substance use harms, there are a range of interventions that may be appropriate at different points in time and in different contexts.

Within the service setting the response is most likely to be treatment and / or harm reduction interventions to support those experiencing harm from their own gambling and substance use or, in specific contexts, from somebody else's gambling or substance use. There are a wide range of therapies and strategies that are suitable for those who are experiencing co-occurring gambling and substance use harms.[1]

GAMBLING	SUBSTANCE USE
Brief intervention	Brief intervention
Withdrawal (non-medical)	Withdrawal (medical or non-medical)
Counselling (e.g. CBT, MI)	Counselling (e.g. CBT, MI)
Support for affected family and friends	Support for affected family and friends
No residential rehabilitation currently available for gambling in the ACT	Residential rehabilitation
Pharmacotherapy (naltrexone – off label)	Pharmacotherapy (acamprosate, naltrexone and disulfiram – alcohol; methadone, buprenorphine and buprenorphine / naloxone – opioids)
Peer support / lived experience educators in non-peer service setting (there are no peer-led gambling support services currently available in the ACT)	Peer support / peer treatment support in non-peer or peer-led service-setting
Mutual-help / peer-led groups (e.g. Gamblers Anonymous, SMART Recovery)	Self-help / peer-led groups (e.g. Alcoholics Anonymous; SMART Recovery)
Harm prevention strategies	Harm reduction strategies
Relapse prevention	Relapse prevention

7

The intervention type will depend on the service setting and the needs, goals and expectations of the service user. Many of the interventions that are routinely used for those experiencing harms from only gambling or only substance use can be effectively applied or adapted to those experiencing co-occurring harms. Where the needs of a service user cannot be accommodated within the specific service setting, it may be appropriate to discuss options to another service or program. In all cases, interventions for co-occurring harms should be person-centred and oriented towards meeting the holistic health and wellbeing needs of the individual within the broader context of public health imperatives.

A PERSON-CENTRED APPROACH IS ONE THAT TREATS SERVICE USERS AS INDIVIDUALS AND AS EXPERTS IN THEIR OWN LIVES.

Figure 7.1 Person-centred approaches

PRINCIPLES OF PERSON-CENTRED APPROACHES

1. Respectful: Treating each person with respect and recognising their inherent worth.

2. Individualised: Tailoring care to the specific needs and preferences of each person.

3. Holistic: Considering the person's physical, emotional, social, and spiritual well-being.

4. Transparent: Working with the person to make informed choices about their care.

5. Empowering: Supporting the person to take control over their lives and their health in ways that are sustainable into the future

6. Co-ordinated: Recognising that people may have multiple needs and working with other services to ensure they are able to access appropriate support.

7. Collaborative: Recognising the importance of involving family, friends, and carers in the person's care where appropriate and in consultation with the individual.

Person-centred approaches are inherently multi-disciplinary and draw on expertise from a diverse range of sources including medical specialists; psychologists, counsellors and other therapists; social workers; alcohol and other drug workers; financial counsellors; peer workers and others with lived experience of gambling and / or substance use harm.

ACT Spotlight: Just 1.5% of gamblers in the ACT reported ever wanting any sort of help for issues related to their own gambling.[2]

BRIEF INTERVENTIONS

Brief interventions are most suitable for people at risk of experiencing harms or who are experiencing mild to moderate harms. A brief intervention can be undertaken at any point in the treatment process but is often used when an individual has first been identified as at risk of experiencing harms, through routine screening. Repeating brief interventions whenever possible rather than focusing on a single session, will improve efficacy.[3]

It is not necessary to be an expert in gambling and / or substance use to provide a brief intervention. A basic understanding of risks and harms and a working knowledge of simple interventions to reduce harm, including referral options, are the essential requirements. For example, those providing brief interventions for harmful use of alcohol need to know basic facts and effects about alcohol, standard drink measures, low risk drinking advice for men and women, basic tips for cutting down and stopping (including risks associated with this) and knowledge of specialist agencies to which to refer people.

Regardless of the approach to brief intervention, there are key elements that apply in all contexts. These can be summarised by the acronym FRAMES:

F **Feedback**: Provide feedback about personal risk or level of current harm, as indicated by the screening process.

R **Respect**[1]: Always respect the person's autonomy. You can empower a person to make positive choices but the decision to do so is ultimately theirs.

A **Advice**: Increase the person's awareness of the costs and consequences of their behaviour and provide advice to support change.

M **Menu**: Outline the menu of options or strategies to support positive change; help with goals and action planning if appropriate to the person.

E **Empathy**: Listen and reflect; maintain rapport; use a communication style grounded in empathy.

S **Self-efficacy**: Convey optimism and strengthen the person's self-efficacy and capacity for change.

[1] In a traditional FRAMES approach the R stands for 'Responsibility'. Recognising the way in which the concept of responsibility has been framed by industry (e.g. through the 'gamble responsibly' narrative) and contributes to increased stigma, a decision was made by the Expert Committee to use the word 'Respect' in its place, while retaining the same ideas about service user autonomy.

WITHDRAWAL

Withdrawal (also known as detoxification or detox) is the process of stopping or cutting back, on gambling or on using alcohol or other drugs. Withdrawal can result in symptoms indicative of physical dependence and / or psychological dependence.[4]

The reward or pleasure effects of both gambling and substance use involves activation of the brain's dopamine and opioid signalling system. Dopamine is a neurotransmitter inside the brain that reinforces sensations of pleasure and connects those sensations to certain behaviours or actions.

Withdrawal from gambling

Most people who experience gambling harms report restlessness and irritability when attempting to cut down or limit their gambling. A significant 65% report at least one withdrawal-like symptom (e.g. insomnia, headaches, stomach upset / diarrhea, loss of appetite, etc.)[6] There are no specific withdrawal programs available for people in the ACT who are experiencing harms from gambling. However, educating service users about the likelihood of withdrawal-like symptoms is important in managing the process and identifying appropriate interventions.

Withdrawal from substance use

Experience of withdrawal from substance use varies significantly depending on the substance and factors such as length of use, general health of the individual and the support environment. In some cases, medical supervision is required for safe withdrawal.

MEDICATION CAN BE AN IMPORTANT COMPONENT OF WITHDRAWAL MANAGEMENT

PHYSICAL DEPENDENCE OCCURS WHEN A PERSON COMES TO RELY ON THE PHYSIOLOGICAL RESPONSES TO GAMBLING OR SUBSTANCE USE IN ORDER TO FEEL 'NORMAL'.[4, 5]

PSYCHOLOGICAL DEPENDENCE OCCURS WHEN A PERSON BELIEVES THEY NEED THE SUBSTANCE OR BEHAVIOUR TO FUNCTION, EITHER IN PARTICULAR SITUATIONS OR MORE GENERALLY.[4, 5]

HOME-BASED WITHDRAWAL	OUTPATIENT WITHDRAWAL	RESIDENTIAL WITHDRAWAL
Experience of withdrawal from substance use varies significantly depending on the substance and factors such as length of use, general health of the individual and the support environment. In some cases, medical supervision is required for safe withdrawal.	Outpatient withdrawal is similar to home-based withdrawal. However, rather than medical professionals attending the person's home, regular visits to a hospital or community-based withdrawal unit will be made by the person undergoing withdrawal.	Residential withdrawal provides a safe, secure and supportive environment for people to withdraw from drugs and / or alcohol.

All three types of withdrawal are available, for at least for some substances, in the ACT.

COUNSELLING

There are a wide range of counselling approaches that may be utilised in a treatment setting for people experiencing gambling and / or substance use harms.[1] Two approaches that are backed by evidence of efficacy in regards to both gambling and substance use harm are cognitive behavioural therapy (CBT) and motivational interviewing (MI).[7, 8]

Clinical guidelines recommend individual or group CBT and motivational interviewing delivered by trained practitioners. While evidence for other treatments is limited, clinical consensus suggests mindfulness-based therapies, solution-focused brief therapy, interpersonal psychotherapy, narrative therapy, acceptance and commitment therapy, dialectical behaviour therapy, and family interventions may also be effective.

Cognitive Behavioural Therapy

CBT is a goal-oriented form of psychotherapy in which a trained clinician supports a service user to identify negative patterns of thought or behaviour and to develop a range of skills to put in place more positive approaches. CBT can be offered in individual or group settings, using face-to-face or online delivery.

Motivational Interviewing

MI is a technique to help service users identify what may be causing ambivalence about change and to enhance their commitment to achieving identified goals.

SUPPORT FOR AFFECTED FAMILY AND FRIENDS

Appropriate psycho-social interventions for affected family and friends can be critical in ensuring that the service user has the support to enact long-term change and achieve their treatment and harm reduction goals.

ACT Spotlight: In the ACT affected family and friends can access information, speak to counsellors or attend support groups by contacting Family Drug Support or Relationships Australia / ACT Gambling Support Service (AGSS).

PHARMACOTHERAPY

Pharmacological interventions may be recommended as part of a holistic treatment plan in consultation with a prescribing healthcare provider.

DRUG / BEHAVIOUR OF CONCERN	RECOMMENDED MEDICATION
Alcohol	Diazepam Acamprosate[9] Naltrexone[9] Disulfiram[9]
Cannabis	There are no specific pharmacotherapies listed by the TGA for managing cannabis withdrawal (medication may be recommended for symptomatic relief)
Opioids	Methadone Buprenorphine Buprenorphine/naloxone Buprenorphine long-acting injections (LAI)
Methamphetamine and cocaine	No specific pharmacotherapies for managing withdrawal. Short-term medication use may be recommended for symptomatic relief, including benzodiazepines and atypical antipsychotics*
Gamma Hydroxybutyrate (GHB)	Diazepam Diazepam and baclofen
Gambling	Naltrexone[10]

Unless otherwise indicated, this information has been adapted from https://www.health.nsw.gov.au/aod/professionals/Publications/clinical-guidance-withdrawal-alcohol-and-other-drugs.pdf *Some atypical anti-psychotics have been associated with an increased risk of developing a gambling disorder.

PEER SUPPORT

Peer workers and lived experience workers can play an important role within the service setting. Workers who have experienced co-occurring harms and are able to bring that experience to their work practice, provide a model of hope and can be critical in enlisting and retaining individuals in treatment. Peer workers and lived experience workers may liaise with services to ensure co-occurring gambling and substance use harms are appropriately addressed, referrals are suitable and meet the needs and expectations of the service user, and broader needs of the service user are met wherever possible. Importantly, peer workers and lived experience workers play a role in improving systems and in reducing the stigma (including self-stigmatisation) and discrimination that can present a barrier to accessing support.

ACT spotlight: ATOD peer workers can be found in many ATOD services in the ACT but are primarily located at the Canberra Alliance for Harm Minimisation and Advocacy (CAHMA), the ACT's peer-led drug and alcohol service. Gambling support peer workers are located at the ACT Gambling Support Service (AGSS).

MUTUAL-HELP / PEER-LED GROUPS

Participation in community-based programs such as mutual-help or peer-led groups can assist individuals through support, accountability and structure. Such group interventions—if offered alongside other forms of support—can be helpful for some service users.

ACT Spotlight: In the ACT there are a number of mutual help / peer led groups available for individuals experiencing gambling or substance use harms, as well as groups for affected family and friends.

HARM PREVENTION STRATEGIES / HARM REDUCTION STRATEGIES

There are a number of different harm reduction and harm prevention strategies that may be useful tools to support better health, social and economic outcomes for people experiencing co-occurring gambling and substance use harms. These strategies can sit at a social policy level (for example, strategies to manage online sales of alcohol, decriminalisation of small quantities of illicit drugs or a reduction in the number of EGMs) or at an individual level (for example needle and syringe programs [NSPs] or bet / loss limits).

For information about services, visit the ACT Alcohol, Tobacco and Other Drug (ATOD) Program Directory

https://directory.atoda.org.au/

HERE IS SOME ADVICE YOU MIGHT PROVIDE TO YOUR SERVICE USERS ON REDUCING OR PREVENTING HARMS

GAMBLING	SUBSTANCE USE
• Set time limits • Set loss limits • Avoid gambling venues • Utilise self-exclusion where available – including online self-exclusion (BetStop) • Avoid drinking alcohol or using drugs when gambling • Participate in events that don't involve gambling • Request activity statements when using EGMs • Speak to a Gambling Contact Officer (GCO) on the floor at your gambling venue • Understand the relative harms of different forms of gambling and consider lower risk activities	• Limit alcohol and drug use to certain times of the day and avoid driving • Alternate alcoholic beverages with water • Swap drinks to low / no alcohol options • Take daily thiamine if you are drinking at higher-risk levels • Set a daily / event limit • Participate in activities not involving drugs or alcohol • Consider alternatives to injecting drug use and become familiar with vein health • Engage in safer injecting, such as using 'fit packs' and avoid sharing needles • Test your drugs (CanTEST) • Access at-home naloxone if you or a loved one is at risk of opioid overdose (or if you are not testing your illicit drugs) • Use safer smoking equipment such as steel implements (avoid plastic or aluminium)

THE MODEL YOU USE AND THE ORDER OF TREATMENT MAY DEPEND ON THE SPECIFIC TREATMENT NEEDS AND CIRCUMSTANCES OF THE SERVICE USER

Sequential treatment: The service user is treated for one condition first, which is followed by treatment for the other condition.

Integrated treatment: Gambling and substance use are treated simultaneously (usually by the same service provider) in a way that is mutually re-enforcing

Parallel treatment: Gambling and substance use are treated at the same time but independently of each other

Historically, there has been a preference for treating co-occurring harms sequentially. Within this model, substance use would typically be treated first and gambling addressed only after the service user has exited ATOD treatment. More recently, there has been an emphasis on integrated treatment, services, and systems within a broader push to acknowledge and respond to co-occurring issues around mental health and substance use. While the evidence on outcomes related to order of treatment remains inconclusive, there would appear to be some advantages to an integrated treatment model, particularly around avoiding disengagement and promoting consistent treatment objectives.[11, 12]

ADDRESSING BARRIERS TO TREATMENT

In the ACT, service users at ATOD services were asked about issues that had made it difficult to access ATOD services in the previous five years.[13] Notwithstanding the fact that those who answered had, in fact, overcome or partially overcome these barriers in order to access the service, a number of issues were identified.

Figure 7.2 What makes it hard to access ATOD services

Fear of being stigmatised or judged

Lack of support from family or friends

Someone I know might find out

The service or other people told me the waiting list was too long

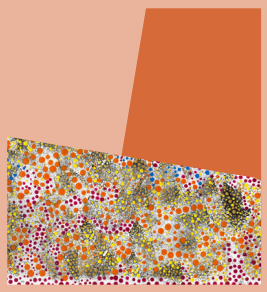
Caring or other responsibilities

Couldn't smoke at the service

Financial situation

Couldn't get to the service

Note: For each question, non-responses have been excluded. Where relevant, 'prefer not to say' is not reported - for further details see main report



Knowledge point: There are a range of different interventions for gambling and substance use, and no 'one-size-fits-all'.

Practice point: Brief Interventions are an important starting point. Utilise the FRAMES method – feedback, respect, advice, menu, empathy, and self-efficacy and follow up with the most appropriate support for the service user.