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# Self-management and the treatment of gambling addiction: A rationale

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**Self-management programs are now a well-accepted approach to assisting people with chronic and complex health conditions to manage their illness and their lives more comprehensively, and, as a result, enjoy better quality of life and health outcomes. Such approaches have now been developed for a wide range of chronic conditions and many programs are generic in that they are not illness-specific. This paper explores the possibility of peer education and self-management as the next frontier in the treatment of gambling addiction and asks whether the expert patient approach that has been shown to be successful in the management of chronic disease might gainfully be applied to the treatment of problem gambling.**

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Self-management and peer education programs are being explored in many countries today as a means of improving patient life and health outcomes and reducing the incidence of preventable hospital admissions from complications associated with chronic and complex health conditions. People with a range of chronic health conditions are being educated and supported to manage their symptoms, medication and lifestyle and to improve their quality of life and health status.

This improvement translates into a reduction in the need for medical intervention, hospital admissions and specialist involvement in the management of chronic illness. Further to the successful management of chronic conditions, it is possible to provide education, lifestyle and support programs that prevent the onset of illness in the first instance. These strategies are particularly relevant for younger age groups who are currently experiencing earlier onset of lifestyle-related illness than has been the case in previous generations.

In addition to the documented rise in the incidence of chronic illness in Australia, we are now also becoming more aware as a society of another growing chronic health-related problem; this problem is gambling addiction and in particular, addiction to gaming machine or poker machine gambling. While gambling addiction is often co-morbid with a range of other chronic conditions including depression, anxiety and even drug dependence, it is a socially determined condition that can be managed and cured. Cognitive behavioural therapy (CBT), and in particular graded exposure to gambling stimuli, is proving to be a successful strategy for helping patients overcome their urge to gamble. Early work in this field is now demonstrating that people with an uncontrollable urge to gamble can learn to overcome their problem through a short treatment program and consequently carry on a normal life, free of the debilitating urge to gamble.

While this treatment regimen is good news for problem gamblers, the logistics of implementing such a service to all those who might benefit from or need it (some suggest that more than 2% of the population have serious gambling problems) presents a major challenge for service providers. Insufficient trained therapists and the difficulties of distance and time mean that it is not possible for therapists to meet the demand for their services, especially in rural and remote areas. Clearly other solutions must now be found; some of which are already being employed such as videoconferencing, phone links and web-based services, but there is still an enormous unmet need for problem gambling treatment programs in the community.

By adapting the self-management peer education approach to chronic illness management for the treatment of gambling addiction, new programs could be tailored to suit a peer-led self-management context in which peer educators could be trained to support people with gambling problems and take on the role of self-management coach in the therapy process.

## Background to self-management

It has been shown in research in Australia and elsewhere that for many chronic health conditions, patients can be educated and supported to manage their symptoms, medication and lifestyle to improve their quality of life and health status (Battersby et al. 2007; Fuller et al. 2004; Harvey 2006; Harvey et al. 2008). This improvement translates into a reduction in the need for medical intervention, hospital admissions and specialist involvement in the management of chronic conditions condition (Petkov et al. 2007). Further to the successful management of chronic conditions, it is possible to provide education, lifestyle and support programs that can prevent the onset of chronic conditions in the first instance (Harvey, 2001c; Harvey & Docherty 2007).

As a result of self-management programs and more coordinated systems of chronic illness care it is now possible for many diabetics, for example, to manage their illness effectively and improve their day-to-day quality of life (Bodenheimer et al. 2002; Frith et al. 2001; Lorig et al. 2000; Tuomilehto et al. 2001; Wagner 2000, 2004; PricewaterhouseCoopers 2005). Other chronic conditions, including asthma, cardiovascular disease and mental illness can be managed in the same way through educating and empowering patients with the knowledge necessary for them to help themselves. The chronic care model is also driving organisational change through health services (Harvey, 2001a, 2001b) and divisions of general practice (Dennis et al. 2008) and it underpins major reforms in the health industry (Martin & Peterson 2008). In addition to the success of self-management and other initiatives for people with advanced chronic conditions, indications are that the suite of chronic care support programs now available and being promoted around the world as a strategy for improving health outcomes and health systems efficiency should focus, for best effect, more on early intervention and prevention (Holmes et al. 2008; Harvey 2006) and even on education of school age cohorts (Harvey & Staker 2009).

## Key self-management principles

Self-management programs have emerged as adjuncts to structured systems of chronic illness care through which patients can learn to manage the key elements of their condition to produce improved quality of life and reduce the need for hospital admissions. The Coordinated Care Trials across Australia, for example, which were designed to improve the coordination and management of care for people with complex chronic conditions, showed that some patients are more receptive to this approach than others, and that, in the short term at least, better coordination of care can reduce demand for services for patients who have a recent history of hospital admissions (Battersby et al. 2005, 2007). A patient's ability or inclination to self-manage was a key factor in achieving positive outcomes through these trials and consequently the Australian Government embarked upon a national chronic disease self-management initiative; the Sharing Health Care program. This program also demonstrated the short-term benefits of self-management strategies for patients with complex health care needs (Fuller et al. 2004; Harvey et al. 2008; PricewaterhouseCoopers 1999).

In essence, the success of self-management programs consists of the ability of people to work together to help themselves; for trained peer educators to encourage others to learn how to manage their conditions and their lives more effectively by taking back responsibility for and control of aspects of their health care, which have historically been out of their control and in the hands of the health industry. These major changes in the way chronic illness care is managed have, according to Glasgow, "... come about for multiple reasons, including the greatly enhanced data on the effectiveness of diabetes self-management, the significance of psycho-social factors in diabetes and the increasing penetration of diabetes empowerment and other evidence-based self-management approaches" (Glasgow et al. 2008, p. 1046).

### The six key principles of self-management

- Take an active part in decision-making with the GPs and health professionals when managing their condition(s)
- Learn about and understand the nature of the condition
- Follow an agreed treatment plan (i.e. care plan)
- Monitor symptoms associated with the condition(s) and take appropriate action to manage and cope with the symptoms
- Manage the physical, emotional and social impact of the condition(s) on the life of patients and carers
- Adopt a lifestyle that promotes health and does not worsen the symptoms or the impact of the condition (Battersby 2003; Harvey & Docherty 2007, p. 189; Von Korff et al. 1997; Harvey 2005)

The notion of consumers taking back control of their lives and their health in this way is quite new; although, as outlined above, this is driven as much by system need as individual initiative and is having the effect of putting people back in charge of their lives in a new and exciting way. For many aspects of people's lives and health need—for which they have hitherto relied solely upon their GP or the hospital system to manage—people are now finding they are able to do this for themselves. Diabetics monitor their blood sugar levels and manage their diets themselves with input from diabetes educators. Asthma patients manage their medication and monitor their condition closely without direct medical input, and mental health patients are also becoming more responsible for the day-to-day management of their illness.

The American Association of Diabetes Educators (AADE) cited a similar list of key skills and behaviours to ensure sound self-management. They have identified seven self-care behaviours in the literature (Glasgow et al. 2008):

- Expert consensus and clinicians in practice
- Healthy eating
- Being active
- Monitoring
- Medication taking
- Problem solving reducing risk
- Healthy coping

### Extension of the self-management concept

Self-management in its many forms and permutations is about the individual learning how to deal with aspects of their lives that have progressively been institutionalised by one system or another; health, for example. In this process, and as our lives become increasingly complex, more and more aspects of our daily lives are influenced by outside institutions. We no longer service our own cars, we are not able to manage the power provisions to our house, we don't grow and manage many components of our food production processes (Singer & Mason 2006) and we are even losing control of the preparation, cooking and presentation of food. Similarly, health care has become the preserve of highly specialised and highly trained professionals and quite removed from the individual. Our health management, like the management of the modern car, has become a technical business which is mostly out of the hands of the consumer.

All these modern trends notwithstanding, it is possible for individuals to take back control of aspects of their lives that have been lost to institutions because we either do not have the time or the space to manage these things or because they have become, like our cars, too technical for the average person to contemplate. At the hard end of the spectrum in health self-management, patients learn to take over some of the monitoring and management aspects of their chronic conditions such as diabetes monitoring and dietary intake. However, the process extends far beyond this to individuals learning early in their lives about how best to manage lifestyle choices in order to reduce the risk of conditions such as diabetes from manifesting in the first place. In this context, self-management is about individuals taking more

ownership of and responsibility for the way they live and work and as such, the self-management process is part of all aspects of our lives, including the management of adverse conditions such as heart disease, asthma, mental health conditions and addictive behaviours such as problem gambling, to list a few.

### Problem gambling

Gambling addiction, and in particular addiction to gaming machines or poker machines, has become a major social health problem in Australia and other developed countries in recent years (Stinchfield et al. 2007; Chene 2005):

*It is estimated that there are at least 290,000 people in Australia with a gambling problem, and that for every one person with a gambling problem there are between 5 and 10 others who are negatively affected. This equates to more than 2 million Australians being affected by problem gambling.*

(THE OFFICE FOR PROBLEM GAMBLING 2008, FACT SHEET 1)

Gambling addiction is also often co-morbid with a range of other chronic illnesses including depression, anxiety and drug dependence and is considered to be a chronic condition and axis one diagnosis within the Diagnostic and Statistical Manual of Mental Disorders (DSM4) classification of mental illness (American Psychiatric Association 1994). It is a socially constructed and determined condition that can be managed and even 'cured' (Gega et al. 2004). In any event, the nature of the condition means that gambling addiction, as well as being treated effectively through CBT approaches, could also be managed, it is postulated, through a combination of professional treatment, peer education and self-management strategies.

Cognitive behavioural therapy (CBT), and in particular graded exposure to gambling stimuli, is proving a successful strategy for helping patients overcome or master their urge to gamble. Early work is demonstrating that people with an uncontrollable urge to gamble can learn to overcome this urge through a short treatment program and be able to carry on a normal life, free of the debilitating urge to gamble. Evidence suggests that people who have allowed gambling to dominate their lives to their detriment are able to resume normal, gambling free lives and no longer be troubled by a gambling problem (Commonwealth of Australia 2000; Tolchard & Battersby 2000; Toneatto 2002; Toneatto & Ladouceur 2003).

While this successful therapist-based treatment regimen is good news for problem gamblers, the logistics of implementing such a service for all those who need it (some suggest that more than 2% of the population have serious gambling problems) presents a challenge (The Office for Problem Gambling 2008). Insufficient trained therapists and the difficulties of distance and time mean that it is not possible for therapists to meet demand for their individual or even group therapy clients. Clearly other solutions need to be found, some of which are already being employed, such as videoconferencing, phone links and web-based services, but even with these innovations there is still an enormous unmet need for gambling therapy and support services in the community.

Given the success of self-management programs in other spheres of health care treatment and management (Battersby et al. 2007, 2008; Harvey et al. 2008; Fries 2003; Lorig et al. 2001), it is therefore reasonable to extend the principles and practices of self-management in chronic illness to the treatment and ongoing self-management of problem gambling. Models exist for this type of approach and could be used as a guide for the development and implementation of peer education and self-management approaches to the treatment of gambling addiction. While it is important for trained therapists to initiate and oversee the therapy process, it is possible—as in the case of diabetes management—that people once familiar with the clinical process could be trained to lead others through a self-management approach to treatment and ongoing support. Trained peer leaders could therefore assist others to learn the basic skills required to help them manage their urge to gamble.

As in the management of other chronic conditions, the interface between where specific clinical intervention ends and a self-management program begins will need to be delineated, but potentially such approaches could lead to a much wider application of gambling treatment programs for those in need of such services. An additional potential benefit also exists, as in other chronic condition management programs, where peer education approaches to health-related problems are more accessible and much more user-friendly than programs run purely by health professionals. Given that the stigma associated with gambling problems is probably more pronounced than that associated with chronic conditions such as diabetes, the peer education and support process would mean that many more people in need of help would feel confident to participate in such programs.

Further, while early research suggests that structured approaches to treatment and exposure therapy can assist people to overcome their urge to gamble and regain control of their lives, it is reasonable to assume—as is the case in other more generic self-management initiatives—that consumers are more likely to respond positively to peer-led approaches than to those promulgated entirely by health professionals (Fuller 2004). Certainly, during the establishment of the South Australian State-wide Gambling Therapy Service, consumer groups and health professionals alike have been engaged regularly through presentations and talks given by reformed gamblers—consumer consultants.

The opportunity now presents itself, therefore, for program leaders to tailor an approach to the treatment and management of gambling addiction that puts the consumer in the centre of the process and draws on the experience of peer leaders and educators to assist in the rehabilitation process, as is now the case for people with a range of other chronic and complex illnesses.

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