Subjects with gambling-related problems requiring treatment

Gambling disorders affect 0.2–5.3% of adults worldwide, although measurement and prevalence varies according to the screening instruments and methods used, and the availability and accessibility of gambling opportunities. A significant percentage of gamblers develops clinically relevant gambling problems, but only 10% seek treatment in clinic-based programs.

A large body of evidence indicates that pathological gambling (PG) is more likely among males, singles or divorcees, non-natives, people unemployed, with alcohol abuse, nicotine dependence, and is highly comorbid with other mental disorders and substance or alcohol dependence. PG is indeed strongly associated with a range of psychiatric conditions, such as personality disorders, mood and anxiety disorders, and other impulse control disorders, suggesting that treatment for one condition should involve assessment and possible associated treatment for comorbid conditions.

	Subjects (680)				Before/After PG Univariate Analysis	
	Before PG	%	After PG	%	OR	95% CI
Substance dependence	54	7.9	19	2.8	2.84	1.68–4.79
Alcohol dependence syndrome	50	7.4	10	1.5	5.0	2.54–9.86
Mental disorders	167	24.6	43	6.3	3.88	2.78–5.43
Schizophrenia and other functional psychoses	29	4.3	1	0.2	29.0	3.95–212.89
Mania and bipolar affective disorders	24	3.5	4	0.6	6.0	2.08–17.29
Depression	83	12.2	17	2.5	4.88	2.90–8.23
Neurotic and somatoform syndromes	63	9.3	9	1.3	7.0	3.48–14.07
Personality and behavioral disorders	43	6.3	15	2.2	2.87	1.59–5.16
Other psychic disorders	29	4.3	4	0.6	7.25	2.55–20.62

Tab. 1. Substance dependence, alcohol dependence, and mental disorders before/after pathological gambling.

In Italy, PGs can seek treatment in Services Dedicated to Drug Addicts (SERD), or in Community Mental Health Centers (HC) or in Hospital wards (HOS). In these three different public settings, treatment is covered by the National Health Service and is voluntary.

We analyzed data of people with a first diagnosis of PG in Northern Italy (2000/2016), and the findings of our study highlight a growing demand for treatment addressed not only to addiction units, but also to psychiatric and hospital services. Many of these patients had already been treated for mental health problems before, but their percentage remained constant over time. Most are males, aged from 40 to 50 years, 13% were born abroad, and 40% have a comorbid disorder: one in three suffers from mental disorders (especially depression), 11% from drug-dependence, and 9% from alcohol-dependence syndrome.

As regards socio-economic status, we should point out the low level of education, the high presence of unemployed or retired subjects, and married or formerly married people. Men,

especially non-natives, were younger and showed a higher frequency of drug-dependence. On the other hand, women were older, with a higher prevalence of retirees, widows, and other mental disorders.

For some authors, this may suggest a paradoxical effect, whereby problem gamblers with co-morbid disorders seek treatment at mental health or addiction services to manage their co-morbid psychopathology rather than at specialist gambling agencies for their gambling problems. This implies that co-morbid psychiatric conditions may be of more concern than the gambling problem or that gamblers are more aware of their co-morbid symptomatology than their gambling symptomatology. An alternative explanation is that the social acceptability, public awareness, and accessibility of mental health or addiction services may be higher than gambling services.

Furthermore, our study found that most subjects were diagnosed with mental disorders (7 years on average) before being diagnosed with PG.

Therefore, it is likely that this long delay in PG diagnosis confirms the tendency, reported by recent research, to under-recognize PG in mental health settings and indicates the need to reinforce referral pathways, screening abilities, and integrated treatment approaches across primary care, mental health, and addiction services. In this regard, since brief assessment tools have been successfully developed for primary care and mental health settings, it should be both appropriate and straightforward to include such an effective screening in clinical interviews, in order to increase the opportunities for earlier PG identification and timely interventions.

Last but not least, the profile of clients with a diagnosis of mental disorders, substance-dependence, or alcohol-dependence before PG showed a strong mutual relationship between these previous disorders, with no correlation with the period of the first admission.

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Publication

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