



High Stakes for Antisocial Gamblers

The following report is on a recent study that closely examined antisocial personality disorder among treatment-seeking pathological gamblers and its impact on their mental and physical health (Pietrzak, R. H., & Petry, N. M. (2005) reported in Wager Volume 11, number 5 – June 7 2006, <http://www.basisonline.org/wager/>

Researchers have examined the relationship between co-occurring psychopathology and gambling. However, relatively few studies focus on personality disorders and pathological gambling. Blaszczynski & Steel (1998) found that an overwhelming majority (93%) of pathological gamblers exhibited personality disorder(s).

Additionally, pathological gamblers with antisocial personality disorder (29%) had more severe gambling-related problems. The prevalence of antisocial personality disorder among pathological gamblers is as high as forty percent in some studies (e.g., Bland, Newman, Orn, & Stebelsky, 1993).

Two hundred and thirty-seven pathological gamblers participated in the study, they were at least 18 years old and diagnosed with pathological gambling.

The investigators administered the

- South Oaks Gambling Screen (SOGS), the antisocial personality module from the Structured Clinical Interview for DSM-IV



Personality Disorders,

- Addiction Severity Index (ASI), and the
- Brief Symptom Inventory (BSI)

The Addiction Severity Index assessed substance abuse problems and the Brief Symptom Inventory measured psychological distress.

To qualify for antisocial personality disorder, participants had to endorse six or more criteria: three or more for conduct disorder in adolescence and three or more for antisocial symptoms in adulthood.

Comparisons

To compare psychological symptoms of pathological gamblers with and without antisocial personality disorder, the investigators used general linear models controlling for other demographic variables (i.e., age, gender, substance abuse, and education). The models used ASI and BSI scores as dependent variables.

Results

The results showed that 16.5% of pathological gamblers were diagnosed with antisocial personality disorder (ASPD). As seen in Table 1, pathological gamblers with antisocial personality disorder reported more severe drug problems as well as medical problems. Antisocial pathological gamblers started using drugs at a younger age and were more likely to have used nicotine (89.7% versus 74.7%), marijuana (59.0% versus 26.8%), cocaine (53.8% versus 17.7%), heroin (28.2% versus 8.1%), amphetamines (25.6% versus 3.5%), hallucinogens (23.1% versus 2.5%), and sedatives (12.8% versus 2.0%) than pathological gamblers without ASPD.

Pathological gamblers with ASPD scored higher than gamblers without the disorder on three BSI subscales: paranoid ideation, somatization, and phobic anxiety. Additional analyses revealed that,

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NOTES FOR YOUR DIARY

CUTTING EDGE

Wellington 7-9 September

Early-bird registrations in by 7 August.

See Conference for more information and contact details.

MOANA HOUSE TRAINING DATES

Pacific Training September and October

Motivational Interviewing 17-18 & 19-20 October

Te Aka and Te Rea in 2007

Contact Claire Aitken 03 477-0842

www.moanahouse.org.nz

LOAD Meetings

check <http://www.adanz.org.nz>

On the Move in the AOD Sector

Changing Jobs – a message from Terry Huriwai, MoH

E ng āwaka, e ngā reo, e ngā karangatanga o te rohe, tenā koutou, tenā koutou.

He mihi mahana ki a koutou i roto tenei ao hurihuri. Ki a rātou kua wheturangtia, he mihi, he tangi he poroporoaki. Haere, haere hoki atu. Ki a tātou ngā kanohi ora, Tihei Mauriora!

For those who haven't heard already, this is just to let you know that my last day at the Ministry of Health was the 21st of July 2006. I started my new role the following week.

I will be contracted to Matua Raki (the Addiction treatment workforce development programme) as a project manager and I'll be working with Ian MacEwan to progress the Māori treatment workforce development projects in particular.

I just want to thank you all for the support I have received during my short time at the Ministry and I hope we will continue to work together down the track. I'll still endeavour to flick things of interest to you as they become available to me.

Again thank you all. Noho ora mai koutou katoa

New Contact Details

Terry Huriwai

Project manager

Matua Raki (Addiction Treatment Workforce Development programme)

Phone: 03 3640480, Cell: 0210327637, Email: terry.huriwai@chmeds.ac.nz

The ADA Connection team wish Terry good luck in his new endeavours with Matua Raki. It was nerve wracking to read that it was going to be his last day at the Ministry of Health and then a relief to read that his experience and talents were not going to be lost to the AOD and problem gambling sectors and that they will be well utilised at Matua Raki.

The people on his email list will miss seeing his messages with the always useful links and attachments to important information. It will be interesting to see what appears in our email in-boxes once Terry has settled into his new position.

VARIABLE	Pathological Gamblers with ASPD (n=39)	Pathological Gambler without ASPD (n=198)
	Mean (S.D.)	Mean (S.D.)
ASI composite scores		
Medical	0.56 (0.06)*	0.35 (0.03)
Drug	0.05 (0.01)*	0.02 (0.01)
Alcohol	0.10 (0.02)	0.10 (0.01)
Psychiatric	0.34 (0.04)	0.32 (0.02)
Family/Social	0.29 (0.04)	0.26 (0.02)
Legal	0.06 (0.03)	0.06 (0.01)
Employment	0.34 (0.04)	0.32 (0.02)
MEDICAL VARIABLES		
Days experienced medical problems in last month	15.6 (2.1)*	6.8 (0.8)
How important to get treatment for medical problems (scale 1-4)	2.6 (0.3)*	1.6 (0.1)
Bothered by medical problems in past month	64.1%	53%
DRUG VARIABLES		
Age first used any illicit drug	16.4 (0.8)*	19.6 (0.5)
Days of alcohol use in past month	3.9 (1.3)	3.7 (0.5)
Days of illicit drug use in past month	1.2 (0.6)	0.5 (0.2)
Groups Differ, *P<0.05		

TABLE 1 Adjusted Means for composite ASI scores and ASI Medical and Drug variables. Adapted from (Pietrzak & Petry, 2005)

compared to pathological gamblers without ASPD, gamblers with ASPD were younger, started gambling at a younger age, and endorsed more DSM criteria for pathological gambling. Pathological gamblers with ASPD also scored higher on the SOGS gambling screen and gambled more days in the past month. In stark contrast to gamblers without ASPD, antisocial gamblers were more likely to steal money to gamble in the past year.

Limitations

One limitation of the study is that the results may not be generalisable to all pathological gamblers, because the participants were seeking treatment for gambling related problems; most people with gambling problems do not seek treatment. The self reporting also is another limitation, because participants with ASPD might have been more likely to misreport, since "deceitfulness" is characteristic of the disorder.

This study not only highlights the significant prevalence of ASPD among pathological gamblers, but also suggests that pathological gamblers with ASPD are different from pathological gamblers without ASPD in terms of coping and health. These important differences among treatment-seeking pathological gamblers need to be considered and warrant comprehensive assessment efforts.

It is likely that differences between pathological gamblers with and without ASPD affect treatment compliance, involvement and outcome and that these two subtypes might require different types of treatment. Further research is needed to determine the nature of the relationship between pathological gambling and ASPD.

At one point, ASPD was an exclusion criterion for the DSM diagnosis of pathological gambling because the DSM assumed that if the two overlapped, pathological gambling was necessarily an expression of ASPD. However, empirical study is necessary to test this assumption and determine whether pathological gambling is an expression of ASPD, whether the two are distinct, or whether they both might be part of a larger disorder.

REFERENCES

- Bland, R. C., Newman, S. C., Orn, H., & Stebelsky, G. (1993). Epidemiology of pathological gambling in Edmonton. *Canadian Journal of Psychiatry*, 38(2), 108-112.
- Błaszczynski, A., & Steel, Z. (1998). Personality disorders among pathological gamblers. *Journal of Gambling Studies*, 14(1), 51-71.
- Pietrzak, R. H., & Petry, N. M. (2005). Antisocial personality disorder is associated with increased severity of gambling, medical, drug and psychiatric problems among treatment-seeking pathological gamblers. *Addiction*, 100(8), 1183-1193.

The Brooklyn Programme

The Brooklyn Programme approach is quite different from the evidence based approaches that are used in addiction treatment services. We present this article as an interest piece and for your consideration of its similarities and differences from our current approaches to addiction treatment and recovery principles.

In this Programme we seek to redefine the structures of experience in such a way that new options are not only available, but desirable.

A Self Enhancement Programme for Drug Treatment

The Brooklyn programme was created by Dr Richard M. Gray when he was the Substance Abuse Coordinator for the United States Probation Department, ED/NY. It developed over ten years of research into Jungian patterns, Neuro-Linguistic Programming and addiction studies, along with personal experience in the field, managing an addictions caseload.

A particular value of the Brooklyn Programme is that it is applicable across a wide spectrum of need. It is therefore useful for meeting the many dimensions of a client, not just that relating to their addictive behaviours.

Peter McHugh, who is currently a Guidance Counsellor at Waitaki Boys High School in Oamaru and also a Master Practitioner in Neuro-Linguistic Programming, has been using the programme successfully with students who have a wide range of behavioural issues. These boys were consistently facing disciplinary action and in many cases Peter witnessed first hand the increased social skill level and positive behaviour change the boys evidenced as they faced personal challenges in real life situations. Peter has used the Brooklyn Programme proactively also, most particularly with boys who want to reduce or give up smoking.

One of the bases of the Programme is that people are, for the most part, whole and healthy and that an essential element of overcoming addiction is realising that we all have the inner resources that we need to meet our present and future needs (albeit frequently hidden).

An important conceptual foundation of the Programme is that **human beings are systems**. People are integrated beings who grow and develop in an orderly, systematic fashion. This means that **people can be taught positive skills that will interact with each other and be taught in such a manner that the whole way of experiencing life can be transformed**. It is through this transformation of experience that we allow the individual to move beyond addictive patterns.

A Different Approach

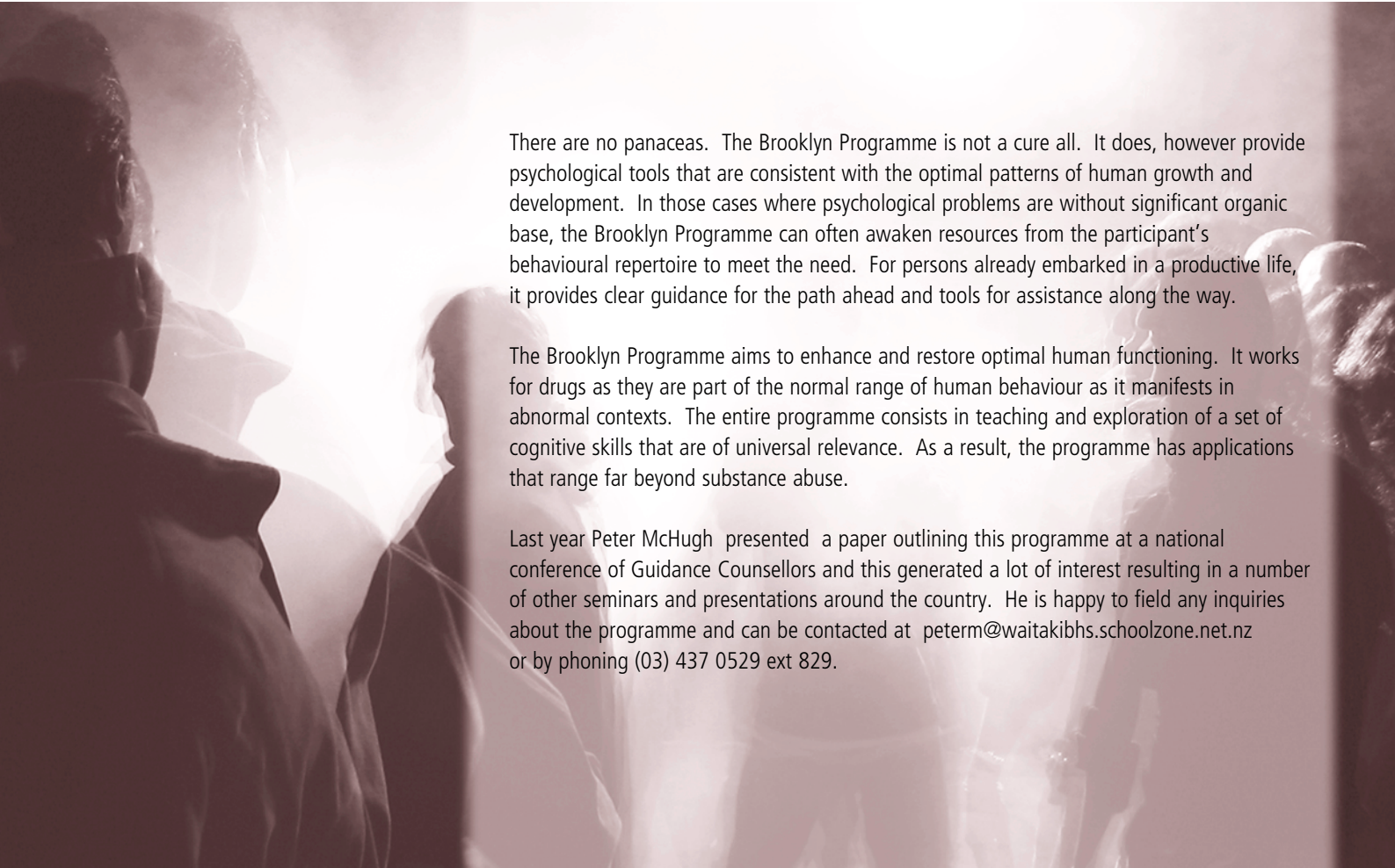
This is an indirect approach. Most of today's standard answers to addictions take a direct, head-on, allopathic stance that assumes that the addiction exists as a thing in and of itself and that by dealing with the issue, the urge, the triggers, the substance or chemical itself, we can solve the problem.

By contrast, the Brooklyn Programme's approach holds that addiction is an expression of systemic wholeness that answers very specific behavioural and emotional needs. It represents in each person a specific need for integration and balance for which no other answer is currently available. The addiction, as a single phenomenon, does not exist, except in a behavioural context.

There are certain affinities between this approach and the older, psychodynamic disease model in which addiction was viewed as a symptom of some other, more fundamental deficit or disease. In that model, elimination of the symptom i.e. addiction, would necessarily result in symptom substitution. It would follow from this perspective that the root problem must seek new expression in another object or behaviour.

In contrast, Dr Gray considers addiction not as a symptom, but as the best possible answer an individual has available for the problem(s) at hand, given the internal resources they have available at the time. (Internal resources are the useful and skillful ways we have of managing our thinking, feeling and behaviour.)





There are no panaceas. The Brooklyn Programme is not a cure all. It does, however provide psychological tools that are consistent with the optimal patterns of human growth and development. In those cases where psychological problems are without significant organic base, the Brooklyn Programme can often awaken resources from the participant's behavioural repertoire to meet the need. For persons already embarked in a productive life, it provides clear guidance for the path ahead and tools for assistance along the way.

The Brooklyn Programme aims to enhance and restore optimal human functioning. It works for drugs as they are part of the normal range of human behaviour as it manifests in abnormal contexts. The entire programme consists in teaching and exploration of a set of cognitive skills that are of universal relevance. As a result, the programme has applications that range far beyond substance abuse.

Last year Peter McHugh presented a paper outlining this programme at a national conference of Guidance Counsellors and this generated a lot of interest resulting in a number of other seminars and presentations around the country. He is happy to field any inquiries about the programme and can be contacted at peterm@waitakibhs.schoolzone.net.nz or by phoning (03) 437 0529 ext 829.

WORK FORCE DEVELOPMENT

Matua Raki: a request

Addiction & Mental Health Sectors

The National Addiction Treatment Workforce Development Programme is looking to improve treatment engagement in addiction issues for clients within mental health services, and in so doing improve their treatment outcomes. This focus is a priority as there are significant issues held in common between the addiction and the mental health sectors, and there are also a lot of people presenting to treatment services with both mental health and addiction needs (50 to 70%).

Case Management Links

There are mental health and addictions teams that provide services to people with co-existing problems. It seems that where teams are either co-located or work in collaboration through sessional arrangements there are strong case management links. This is often as the result of practitioners knowing each other, and respecting each others' abilities.

What are the Successful Ingredients?

We would like to identify teams where there are good processes for clients with co-existing mental health and addiction problems, to discover what are the successful ingredients, and if they can be replicated elsewhere. This might offer some modelling based on "what works".

The Request

If you work in one of these teams, please contact us through:

Ian MacEwan
Senior Project Manager
Matua Raki
(National Addiction Treatment Workforce Development Programme)
PO Box 25056, Panama St., Wellington
Tel. (04) 499 3083 / 021-345-125

Pacific Island Populations in NZ – some figures

People from the many and various islands in the Pacific having been settling in Aotearoa New Zealand for many decades now, and the 2001 census tells us that approximately 231,798 Pacific peoples make up 6% of the total population.

Our Pacific population is made up of a number of peoples from different island groups, most from Samoa, 50%; Cook Island 23%; Tongan, 16%; and Niuean 9%; smaller numbers are from Fiji, Tokelau and Tuvalu. Often included in the Pacific Island figures are people from Melanesia, including Papua New Guinea, Vanuatu and the Solomon islands and also the Micronesian islands such as Kiribati.

Most people from the Pacific islands were born in New Zealand, speak English as well as their own language, are young and live - if not in the Auckland and Manukau cities where 1 in 4 are from the Pacific islands then, in one of the other large New Zealand cities. The Pacific Drugs and Alcohol Survey 2003 (www.shore.ac.nz) has provided a picture of the patterns of alcohol and drugs use, including tobacco, kava, marijuana and other drugs, gambling and related harms. The survey collected information from 1103 Pacific people aged 13-65 years. There were 338 Samoan, 228 Cook Island Māori, 232 Tongan, 207 Niuean, 66 Fijian, and 32 Tokelauan. The following table shows figures that have been selected from the final report of the results from that survey.

	% of the Pacific sample	% Men	% Women	On average, compared with the total Pacific sample
Used Tobacco in the last year	37%	41%	33%	Samoan women smoked less, Cook Island women more
Used Tobacco in the last 30 days		38%	29%	and Tongan women 30-65 were less likely to smoke at all
Used Alcohol	57%	61%	51%	Cook Island Māori between 13-29 and Cook Island Māori women in all age groups were more likely to drink than the other Island groups
Frequency of use				Drink less than once every three days. Women less than once every four days; men just over once every two days
Typical quantity in one occasion				Six drinks for women, nine to ten drinks for men. Samoan women drank less overall.
Used Kava	23% had tried it 8% in last year	14%	3%	Those who did drink it did so more than twice a week and most often at a kava club.

Table 1: Selected figures from the final report of the results from Pacific Drugs & Alcohol Consumption Survey 2003 Final report.

From a speech last year the Hon Taito Phillip Field

“They [Pacific providers] have subject knowledge and the cultural expertise to ‘fofo’ or to massage the issues Pacific peoples face with alcoholism, drugs, gambling - whatever it may be.

Pacific providers work with Pacific models and Pacific values, they understand us and when we are in the budgeting office or talking to a counsellor about the things holding us back from achieving our fullest potential – we can work through our issues knowing that these people understand our cultural values and beliefs. Every population has its own history, culture, economic and social divisions. These influence the way people are exposed to specific risk factors. While alcohol and drugs have affected the Pacific community as a whole, each Pacific community is unique and

therefore to a degree, needs to be considered independently from other Pacific groups, taking into consideration their unique cultural values.

Historically in New Zealand a pan Pacific approach has been applied when considering and addressing Pacific health issues. However, it appears that Pacific communities are now highlighting the need for development of approaches specific to different Pacific groups.

It is therefore important to have Pacific providers playing an active role in delivering ethnic specific services...”

Value of Pacific Providers

Pacific Island peoples include the highest number of non-drinkers and drink less often but, those who do drink, do so heavily.

For many, including Pacific Island people it can be difficult approaching professional services for help to identify and treat problem gambling or use of alcohol and other drugs. Pacific providers play a huge role

in making effective treatment for Pacific Island people more accessible.

For information on what services are in your area call the Alcohol Drug Helpline 0800787797 or check the Addictions Treatment Directory www.addictionshelp.org.nz

5th International Conference on Drugs & Young People 2006

In May this year the Australian Drug Foundation and its Centre for Youth Drug Studies, in partnership with the Ted Noffs Foundation, hosted the 5th International Conference on Drugs & Young People, in Australia.

The theme for the 5thDYP was the culture and context of young

peoples' drug use across various settings.

Anni Watkin and Matt Matahaere both attended the 5DYP conference in New South Wales. Anni gives an over view of her experience at the conference followed by a condensed version of Matts talk.

Anni's Report

Held in Sydney Australia from the 24 to 26 May 2006

I was impressed with the range of speakers who were presenting at the conference, 215 abstracts including, Youth Panel and President, Juvenile and family Division, Supreme Court in Thailand.

Kim Boyce and I attended and gave a presentation at the conference on our experience working in the youth justice area. We challenged attendees to consider that the best thing we can do is offer the tools to young people to think about, in the hope that when they are in the right place in their lives they will pick them up.

The conference started with an opening with the people of the land. It wasn't long before I became aware that there were a lot of New Zealanders at the conference. The first day, I decided to circulate and network with participants from other lands. I would sit down, introduce myself and say where I was from, and then the response would be, "I'm from Rangiora, Ashburton, Auckland, Dunedin or Wellington". On the second day, I would look, listen and hearing an accent, introduce myself. Not that I dislike the NZ team; I wanted to find out what happens in other parts of our world.

After attending 2 workshops and listening to 2 Keynote speakers I

thought, "Wow New Zealand is operating some amazing initiatives".

What I learned from the conference was that there are lots of great things happening in different parts of the world and that in fact - New Zealand has initiated many of them. We are an innovative country!

The Youth Panel had one consumer and a selection of articulate, well presented young people. I always ask the same question, "Why do I not feel this is a true representation of the views of Young People." Because it isn't, and I think unless it is we should not do it.

Research-focused presentations were strongly represented and included service providers working with Native Australian young people. It struck me that we are leaders in supporting development of those to work with their own.

On the whole, the conference was an excellent opportunity to network and learn about Drug issues in other areas, and maybe what we can look forward to as far as trends; but in saying that I believe NZ issues often differ from those of other nations.

Anni Watkin, Manager of Youth and Cultural Development Soc, (YCD)

Matt's Talk

(BA Soc Anth, Pols) from Arai Te Uru Whare Hauora, a Community Maori Health and Social Service Provider, the facilitator for the CAYD/He Ara Tika project in Dunedin, Matt was one of the young people who spoke at the conference and this is a condensed version of his talk.

What Does It Mean...?

Matt began his presentation with a question "what does it mean to give those who we have been previously silenced, a voice?"

Having been born in the late 70s, Matt talked about how it was growing up in Invercargill, as his whakapapa indicates, the land of his ancestors, and also the southernmost city in Te Waipounamu - the South Island.

Although he had an extremely happy childhood growing up in the 1980s, Matt saw "Invercargill as... experiencing a particular type of

racial violence that was perceived as merely gang violence." He went on to describe the political climate of the time and the reforms that had an impact on Maori; how Maori were misrepresented in the media – either as happily homogenised into the general population or alternatively as those highlighted on the television show Crime Watch, as criminals.

As a teenager, Matt said he "...experienced a personal explosion ...an anger I had with the world. Angry at the bullsh*t I had been fed at school... at any institution that represented government." It was during this time that he identified with rappers such as Tupac, he still does – it is hard living in a 'white man's world'; particularly when your abilities and achievements are continually challenged by authority figures at school. Matt described becoming involved with drugs, criminal activity and binge drinking with all night parties being a regular thing and which continued through school.

"The scary thing for me now as I reflect on all of this, was that it was such normalised behaviour among many Maori around my age and unfortunately still is. ...I left school at sixteen without qualifications. Maori even now continue to receive tacit messages that we really aren't meant to achieve at school."

Negotiating the Barriers

A number of other events and experiences after moving to Auckland and getting involved in a trade course which included learning life-skills for Maori resulted in Matt gaining a BA with a double major – "I had developed a way to negotiate the barriers that many Maori youth continue to experience by shifting my consciousness to one of Maori potential... to see each barrier as a challenge, and success for Maori as normal."

Working in the Community - theories and models

Matt is now working at implementing Community Action Youth Alcohol and Drugs (CAYAD) and has the opportunity to work with Maori at a community level...

"I believe a key component of working with any community is that you need to come from that community. The reason is that you need to understand personally, the issues that that community is facing. This includes an understanding and awareness of the fundamental racism that pervades all levels of society and how this continues to impact on that community's development. ...what I disliked when talking with counsellors and community workers was they could never comprehend what it was like growing up Maori; you don't look like me, nobody will call you 'nigger', so how could you possibly understand."

These views were also related to the value of 'local thought' and the possible 'entanglements of the outsider's view' from Edward Said's theories as well as other theories that Matt had been immersed in at university. Not having lived the experience and to not feel the painful effects these can have, often leads to a reliance on deficit models of development.

Deficit models are those where people view 'others' as being in need because they are unable to perceive 'them' as like themselves – people with potential; at the worst extreme deficit ideas position others as somehow lesser people.

Ending at the Start

In the end it's about working in partnership with key stakeholders, other organisations and more importantly those for whom the benefits are intended. This will, of course, be about giving voice to those communities who more often than not are left out of the decision making. And it is at this point that Matt returned to the beginning of his presentation

What does it mean to give those who we have been previously silenced, a voice?

This is the real struggle of effecting community change; there is no overarching solution. It is a problem that is best left as a critical point of community work reflection because it must always be a marker to remind us that it is not only presumptuous, but arrogant, to imagine that we only ever have 'their' best interests at heart. No reira kai te mihi kai te mihi, tena koutou katoa



AUSTRALIAN AMPHETAMINE CONFERENCE

28 - 26 September 2006
Sydney Convention Centre Darling Harbour

The first Australasian Amphetamine Conference will tackle the ever-increasing problem of amphetamine use and the tangled community and societal impact.

In Australia and New Zealand comparatively high levels of amphetamine use and related problems are causing

unprecedented challenges to our health, social and law enforcement systems.

The focus of the Conference will be practical; engaging health professionals, law and order personnel, community workers as well as workers within the harm reduction and drug treatment fields.

For more information www.amphetamines.org.au

alcoholdrughelpline
0800 787 797 
He kai a te rangatira he korero