Treatment Seeking Among Ontario Problem Gamblers: Results of a Population Survey

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Objective: **This study examined help seeking for gambling concerns among people with different levels of gambling problems.** ***Methods:*** **Ontario adults who had gambled more than $100 (N=4,217) and who screened positive for a possible gambling problem (N= 1,205) were classified according to gambling problem severity and asked about their experiences with gambling treatment.** ***Results:*** **Only 6% of gamblers had ever accessed a service, including a self-help group or self-help materials. With self-help materials excluded, only 3% of gamblers (from 1% of those who met only the initial CLiP screening criteria to 53% of those with pathological gambling) had sought treatment for gambling.** ***Conclusions:*** **Few gamblers sought treatment for gambling problems; greater problem severity was associated with greater likelihood of using treatment, with self-help materials used most often. Further research is needed on why treatment seeking is low and on the effectiveness of self-help resources in reaching gamblers with problems in earlier stages. (*Psychiatric Services* 59:1343–1346, 2008)**

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Despite the existence of effective treatments for problem gamblers (1,2), in North America few problem gamblers ever seek treatment. Data from two large national surveys in the United States, the Gambling Impact and Behavior Study (GIBS) done in 1998–1999 and the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) conducted in 2001–2002, were analyzed for prevalence of treatment seeking among pathological gamblers (3,4) whose problems were diagnosed according to *DSM-IV.* The GIBS used the National Opinion Research Centre DSM-IV Screen for Gambling Problems (NODS) to make the *DSM-IV* diagnosis, whereas the NESARC used the Alcohol Use Disorder and Associated Disabilities Interview Schedule–IV. With the GIBS, 7% of participants with a history of pathological gambling had ever sought treatment (defined to include self-help groups as well as help from professionals). No gamblers with symptoms falling below the threshold of pathological gambling reported having sought treatment. With the NESARC, 10% of participants with evidence of pathological gambling at some time in their lives had ever sought treatment or attended Gamblers Anonymous meetings.

Some states in the United States also have conducted surveys on the prevalence of gambling problems. The largest survey was done in California between October 2005 and April 2006 (5). Of respondents who were rated as problem or pathological gamblers on the NODS, approximately 10% said they had ever sought professional help for a gambling problem or had been to a Gamblers Anonymous meeting.

In this study, we aimed to conduct a representative survey of the adult population in Ontario, Canada, to assess the proportion of people with different levels of gambling involvement who had accessed treatment during their lifetime.

Methods

We conducted a random-digit-dialing telephone survey of the Ontario population, age 18 and older, between September 2006 and August 2007. We selected respondents in two stages. First, we randomly selected households in Ontario with active telephone numbers. Then, within each chosen household, we selected the respondent age 18 or older with the most recent birthday. To be eligible, a potential respondent had to be able to speak English. Residents in all regions of Ontario, with the exception of those living in institutions, were included in the survey. Verbal informed consent was provided by each potential participant before the interviewer began to ask the survey questions. The study was approved by the Research Ethics Board at the Centre for Addiction and Mental Health.

We conducted a total of 8,467 interviews; this translated into a response rate of 52% of eligible persons. The mean±SD age of persons interviewed was 46±16.3 years. Forty-five percent of the respondents (N=3,665) were men. Roughly 8% of the respondents reported Asian origins, approximately 3% mentioned African or Caribbean descent, 2%

mentioned an Aboriginal background, and the rest were of Caucasian background. (All percentages are weighted.)

The survey comprised two sections: a brief screen to identify respondents with possible gambling problems and a detailed core survey administered to those identified in the screen. In the initial screen, we asked respondents if they had ever in their lifetime spent more than $100 on any kind of gambling activity. If they said yes (N=4,217), we presented them with the three CLiP questions (addressing control, lying, and preoccupation in relation to gambling) from the NODS-CLiP (6). A score of 1 or more on the CLiP has been found to be a reliable brief indicator of problem and pathological gambling as assessed by the longer NODS (6). The NODS has been shown to have strong validity and reliability (7) and has been validated for use in Canada (8). Anyone who scored 1 or higher on the lifetime CLiP (N=1,205, or 15% of the total sample) was presented with the core gambling survey, which included the complete lifetime NODS. The remainder of the respondents skipped to the demographic items at the end of the survey.

On the basis of the answers to the lifetime NODS questions, we classified these 1,205 respondents into four groups according to the lifetime severity of their gambling problems: those who met the criteria of the CLiP screen but did not qualify for the NODS categories (N=824, or 10% of the total sample), those who met criteria for lifetime at-risk gambling by having a NODS score of 1 or 2 (N=235, or 3% of the total sample), those who met criteria for lifetime problem gambling by having a NODS score of 3 or 4 (N=89, or 1% of the total sample), and those who met criteria for lifetime pathological gambling by having a NODS score of 5 or higher (N=57, or <1% of the total sample).

We then asked core survey respondents if they had ever sought help for gambling concerns. Separate questions were asked about the various types of help currently available in Ontario: Gamblers Anonymous, telephone helpline for gamblers, inpatient or residential treatment, assessment or outpatient services, family or marital counseling, mental health professionals (physician, psychiatrist, psychologist, or social worker) seen at their private office, minister (or priest, rabbi, or clergy or spiritual leader), self-help materials from the Internet or in print, and other.

We examined the proportions of the persons in each gambling severity group who had ever accessed treatment for gambling concerns. We weighted the data (using weights based on age and sex distributions in Ontario census data) before doing the analyses, in order to make the results more representative of the general adult population of Ontario. Unless otherwise stated, all percentages presented in this brief report are weighted values; sample sizes are presented as unweighted values.

Results

Table 1 presents lifetime treatment use among respondents with different levels of lifetime gambling problem severity. Treatment use among gamblers was rare, ranging from 6% (N=68) for any type of service, including self-help materials, to 3% (N=28) if self-help materials were excluded. The likelihood of having ever used treatment services, whether or not self-help materials were included, increased significantly with severity of gambling problems as assessed by the NODS-CLiP and NODS (for treatment including self-help materials, χ^2=304.4, df=3, p<.001; for treatment not including self-help materials, χ^2=206.1, df=3, p<.001). When self-help was not included, none of the gamblers who met only the CLiP screen criteria, 10% of the problem gamblers, and 29% of the pathological gamblers reported treatment for gambling issues. When self-help was included, 1% of the gamblers meeting only the CLiP screen criteria reported using treatment. However, 25% of problem gamblers, and 53% of pathological gamblers reported using treatment services, including self-help resources.

The core survey asked questions about each of several possible types of assistance for gambling problems. Gamblers who had accessed help for gambling concerns were most likely to have chosen self-help, either on the Internet or as printed material. Of 107 lifetime episodes of treatment or self-help contacts reported (some respondents used more than one source of help), 49% (unweighted percentage, N=52) involved Internet or printed self-help resources. Fifteen gamblers (14% of the 107 contacts with assistance) reported having attended Gamblers Anonymous meetings, and nine (8%) had used a telephone helpline. Eight gamblers (7% of the 107) had seen a physician, psychiatrist, psychologist, social worker, or other professional at the professional's private office; seven (7%) had gone to a minister, priest, rabbi, member of the clergy, or other spiritual leader; six (6%) had attended assessment or outpatient services; six (6%) had attended family or marital counseling in regard to their gam-

Table 1

Lifetime treatment use for gambling concerns according to severity of lifetime gambling problem among 1,205 gamblers interviewed in Ontario[a]

		Accessed treatment or self-help materials (N=68)		Accessed treatment only (N=28)[b]	
Severity	N	N	%	N	%
CLiP lifetime ≥1[c]	824	9	1	0	—
At-risk gambler	235	12	5	5	2
Problem gambler	89	21	25	7	10
Pathological gambler	57	26	53	16	29

[a] Percentages are weighted to be representative of the population of Ontario, Canada.

[b] Not including self-help materials

[c] Possible scores on the measure of control, lying, and preoccupation related to gambling range from 0 to 3, with scores of 1 to 3 indicating a possible gambling problem.

bling; and two (2%) had been in inpatient or residential treatment for the problem.

Discussion

The proportions of gamblers with lifetime treatment use in our study are higher than those found in other North American survey studies. Of these, the California survey is most similar to ours in its use of the NODS to assess *DSM-IV*–defined pathological gambling and in asking separate questions about specific sources of help (9). In our study, 18% of combined problem and pathological gamblers had used treatment (including Gamblers Anonymous but not including self-help materials) at some time in their lives, whereas the corresponding proportion in California was 10% (5). Possible explanations for the difference could have to do with differences in availability and accessibility (including cost and insurance coverage) of gambling-specific treatment and with overall changes over the past ten years in gambling treatment usage.

Although lifetime use of gambling treatment services by problem or pathological gamblers was higher in our study than in other North American gambling surveys, it was much lower than the lifetime use of treatment services (including self-help groups but excluding self-help materials) by Ontarians with a lifetime diagnosis of alcohol abuse or dependence (the latter proportion is 36%, which itself reveals a rather low penetration of the population that could possibly benefit from treatment) (10). The number of initiatives to help gamblers with problems has greatly increased in Ontario in the past 12 years (11). Nonetheless, treatment resources for people with alcohol problems have been readily available for much longer, and there has been considerably more time for public awareness and acceptance of these resources to grow. Gamblers may be struggling with more, different, or in some cases, more daunting obstacles to seeking treatment compared with people with alcohol problems.

The limitations of our study are the fact that it relied solely on self-report, potential problems with recall of lifetime gambling-related events and treatment episodes, possibilities for error inherent in telephone interviews (such as miscommunication from difficulties hearing), fairly low response rate, and too small numbers of treated gamblers in the various gambling severity groups for more in-depth analyses. Beyond these limitations, however, our results indicate that the low use of treatment services among problem and pathological gamblers found in earlier U.S. survey-related studies (3–5) was also true in Ontario. Our results showed that almost three-quarters (71%) of pathological gamblers in Ontario had never sought treatment from professionals or attended Gamblers Anonymous meetings. Even when the use of self-help resources online or in print form was included, almost half (47%) of Ontario pathological gamblers had never tried to access help for their gambling. Gamblers with less severe gambling problems were much less likely to have gone for treatment or to have relied on self-help materials than were gamblers with the most severe gambling problems, although there is some suggestion that gamblers with less severe problems who want help may be especially drawn to self-help materials. There was little evidence, though, that Ontario gamblers were seeking early intervention, before their problems had become too serious.

The relatively frequent use of self-help resources underscores the value of providing a range of treatment options. There is a growing body of literature supporting the effectiveness of brief interventions for gambling problems offered by telephone or the Internet and in the form of self-help workbooks (12–14). Problem and pathological gamblers themselves express considerable interest in these alternative forms of treatment (15), and for some gamblers, accessing self-help resources—for example, on a Web site—could make it easier for them to subsequently seek face-to-face help (14).

Conclusions

More work needs to be done to find out why more gamblers are not taking advantage of available treatment resources. Future research needs to examine the barriers to seeking treatment, both objective and perceived, encountered by gamblers at different levels of problem severity, as well as the triggers that motivate them to take the step of actually seeking help. The role of natural recovery should also be studied. Also useful would be more exploration of the effectiveness of reaching problem and pathological gamblers through self-help resources, including those available through the Internet. With greater understanding of these topics, we can gain a better idea of how to provide useful assistance to a greater proportion of people with gambling problems, especially before their problems become too severe.

A sizeable proportion of Ontario adults with gambling problems had never accessed any kind of treatment. However, gamblers with more severe gambling problems were more likely to have used treatment. The proportion of gamblers at all levels of problem severity who sought help was considerably greater when self-help materials were included among the possible treatment sources. More research needs to be done to identify the barriers that prevent many gamblers from seeking help and to develop strategies that will permit these barriers to be overcome.

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References

1. Hodgins DC, Holub A: Treatment of problem gambling, in Research and Measurement Issues in Gambling Studies. Edited by Smith G, Hodgins DC, Williams RJ. New York, Elsevier, 2007
2. Toneatto T, Ladouceur R: Treatment of pathological gambling: a critical review of the literature. Psychology of Addictive Behaviors 17:284–292, 2003
3. Cunningham J: Little use of treatment among problem gamblers. Psychiatric Services 56:1024–1025, 2005
4. Slutske WS: Natural recovery and treatment-seeking in pathological gambling: results of two US national surveys. American Journal of Psychiatry 163:297–302, 2006

5. Volberg RA, Nysse-Carris KL, Gerstein DR: 2006 California Problem Gambling Prevalence Survey Final Report. Chicago, University of Chicago, National Opinion Research Center, Aug 2006. Available at www.adp.ca.gov/OPG/reports.shtml

6. Toce-Gerstein MT, Volberg RA: The NODS-CLiP: A new brief screen for problem and pathological gambling. Paper presented at the International Symposium on Problem Gambling and Co-Occurring Disorders, Mystic, Conn, Oct 2004

7. Gerstein D, Hoffman J, Larison C, et al: Gambling Impact and Behavior Study: Report to the National Gambling Impact Study Commission. Chicago, University of Chicago, National Opinion Research Center, Apr 1999. Available at cloud9.norc.uchicago.edu/dlib/ngis.htm

8. Hodgins DC: Using the NORC DSM Screen for Gambling Problems as an outcome measure for pathological gambling: psychometric evaluation. Addictive Behaviors 29:1685–1690, 2004

9. Volberg RA, Nysse-Carris KL: 2006 California Problem Gambling Prevalence Survey Appendices. Chicago, University of Chicago, National Opinion Research Center, Aug 2006. Available at www.adp.ca.gov/OPG/reports.shtml

10. Cunningham JA, Breslin FC: Only one in three people with alcohol abuse or dependence ever seek treatment. Addictive Behaviors 29:221–223, 2004

11. Rush B, Moxam RS: Treatment of Problem Gambling in Ontario: Service Utilization and Client Characteristics January 1, 1998 to April 30, 2000. Toronto, Centre for Addiction and Mental Health, Drug and Alcohol Treatment Information System, July 2001. Available at www.gamblingresearch.org/download.sz/Ont%20treatment%20survey.pdf?docid=2986

12. Hodgins DC, Currie S, el-Guebaly N, et al: Does providing extended relapse prevention bibliotherapy to problem gamblers improve outcome? Journal of Gambling Studies 23:41–54, 2007

13. Hodgins DC, Currie S, el-Guebaly N, et al: Brief motivational treatment for problem gambling: a 24 month follow-up. Psychology of Addictive Behaviors 18:293–296, 2004.

14. Cooper G: Exploring and understanding online assistance for problem gamblers: the Pathways Disclosure Model. eCommunity: International Journal of Mental Health and Addiction 1:32–38, 2004

15. Cunningham JA, Hodgins DC, Toneatto T: Problem gamblers' interest in self-help services. Psychiatric Services 59:695–696

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