

# **Betting on GPs' beliefs and attitudes toward problem gambling to improve screening procedure in general population: they have needs...**

Achab Sophia., Khan Riaz., Chatton Anne, Thorens Gabriel., Khazaal Yasser., Zullino Daniele Fabio

*University Hospitals of Geneva. Addiction Division. Department of Mental Health and Psychiatry.*

## **Abstract**

Pathological Gambling (PG) is an addictive disorder with harms related to the high psychiatric comorbidity and increased suicidal risk. Prevalence rates in general population range from 0.2% to 2.1%. Problem gamblers (PrG) are hard to attract to treatment programs for several proper reasons and for obstacles (e.g. accessibility). To address those obstacles, primary care (where the PrG prevalence seems to be 6.2%) has a crucial role to play (i.e. identifying and referring patients to specialized treatment programs) in the era of online gambling offer expansion. The present work aimed to collect data on resources in the field from GPs themselves, through a 24-item online questionnaire. Swiss French-speaking participants were asked about their screening practice and knowledge. The results state that the vast majority of them are aware of the existence and the potential impact of PrG on their patients. However, PrG screening is not systematic and their knowledge of adequate treatments or referral methods is scarce. GPs being central to health screening in general, targeted advice and training on short screening tools and better knowledge of when to refer to a specialist should be promoted and continued to empower the GP's management skills in a public health approach.

## **Keywords**

*Problem gambling, GPs, screening, belief, attitude.*

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## **Introduction**

Pathological Gambling (PG) is an addictive disorder [1] with harms related to the high psychiatric comorbidity and increased suicidal risk. Prevalence rates in general population are ranging from 0.2% to 2.1% [2-4] for pathological gamblers and from 0.6% to 5.5% for problem gamblers (PrG) [3, 5-8]. The prevalence seems to be more important (6.2%) in primary care services [9]. Problem gamblers are hard to attract to treatment programs, partly for feelings of shame and denial [10]. Only 0.4% to 3% of them seek help for their difficulties [11, 12] and a five year latent period is observed between the first symptomatic presentation and the first attempt to seek care [13]. Hence, general practitioners (GPs) as primary care providers have a crucial role to play in the early detection and intervention on PrG [14, 15]. There is a paucity of studies on the PrG management resources and screening practices of GPs. Fourteen years ago in Canada a structured national plan has been designed to evolve physicians in PrG management [16]. The needs (PrG resources available and awareness on their existence) have been studied in a sample of 54 physicians from the 800 contacted. Results showed a low awareness on PrG resources that have been considered by participants as insufficient to fulfill the needs [16]. Concern about the lack of knowledge, education and training in PrG and its perception as a non medical problem but rather as a character defect was raised as challenges and obstacles to GPs' involvement in PrG management [16]. An Australian paper [14] presented the way GPs can help in early detection and intervention and reported a pilot project that provided resources to GPs. Results from the 24 GPs (with referral experience in PrG) from the 51 that received information and material on PrG (e.g. importance, list of referral services, simple advice on the way to assist patients). The majority of participants were convinced of the role they can play in PrG management [14]. However, lack of knowledge was reported by almost half

of the sample (even if with referral experience in the field), and a difficulty to ask patients “out of the blue” if they gamble [14] .

Another awareness study of PrG in 180 health care providers (nurses, physicians, social workers)[17] showed that the vast majority are aware of the existence of PrG but only a minority are effectively screening their patients.

This study aims to evaluate interest and knowledge of GPs regarding PrG and the way they deal with it in their daily clinical practice.

## **Methods**

### *Sample*

Swiss GPs with a medical practice in the 6 French-speaking areas (FSAs) of Switzerland have been invited to participate anonymously to an online survey.

Participants were recruited between March and May 2011 via their physician’s regional association with e-mail informing about the study’s aims. The participants were directed through a web link to the questionnaire..

### *Measures*

A 24-item online questionnaire was developed for the study on Survey Monkey software. After socio demographical data (date of birth, gender, private practice duration, specialization and Swiss practice area), five items investigated participants’ beliefs on PrG (Table1). Then, participants were asked about their PrG screening practice (Table 2). They were presented a text-response item (to avoid oriented responses) to specify the PrG screening tools they use. They were also invited to estimate the rate of PrG and related debts issues in their active pool of patients seen by the GP. Practitioners were then asked the way they use to manage PrG and its financial consequences in their patients global management (Table2). The last section of the questionnaire consisted of items on the participants’ impression about their knowledge on PrG disorder, on the existing specialized local treatment network, and their estimated need for information and training (Table3). At the end of the questionnaire, responders were themselves screened for PrG, using the 2-items Lie-bet test [18] “*Have you ever felt the need to bet more and more money?*” and “*Have you ever had to lie to people important to you about how much you gambled?*”

### *Statistical analysis*

SPSS 18.0 (Statistical Package for the Social Sciences, IBM, Chicago, Inc.) software program was used to perform the statistical analyses. First, descriptive statistics were computed for the participants' characteristics (demographics and beliefs representation) and reported as medians, ranges and percentages. Before testing for associations between groups, adjacent categories were regrouped when appropriate into smaller categories in order to gain statistical power. Next, we used the Fisher exact tests for associations between level of knowledge of the topic (very satisfactory/satisfactory vs. insufficient/no knowledge) and screening for excessive gambling frequency (systematically/often vs. rarely/never) on one hand, level of knowledge of the topic (very satisfactory/satisfactory vs. insufficient/no knowledge) and the demand for more information and training (agree vs. disagree) on the other hand. Association between level of knowledge of PrG care network (very satisfactory/satisfactory vs. insufficient/no knowledge) and screening for excessive gambling frequency (systematically/often vs. rarely/never) as well as association between screening for excessive gambling frequency (systematically/often vs. rarely/never) and the self-reported interest on the topic were also assessed.

### **Results**

Four GPs' professional associations of the 6 French-speaking cantons of Switzerland accepted to relay the information on our study to their affiliates and 71 GPs agreed to participate in the survey. Respondents were mostly men (63.2%), with a median age of 53 years (range: 34-71) and a median age of 17 years of private practice as GP (range: 1-38). Almost all of them bear the FMH title of specialist in general and/or internal medicine.

Of the 71 participants, 69 (95.8%) filled out the questionnaires. However, three of them presented missing data on items related to gender, opinion on the best system care for PrG with debts, lie-bet tool, and self-reported knowledge on PrG and its care network. Four participants reported no need for information and another 6 no need for training on PrG.

Only descriptive results are presented in the Tables. Missing data is reported in the text and not in the Tables. This explains why for some items the percentage rates don't total up to 100%.

Concerning GPs' beliefs on PrG and financial debts (Table1) one participant did not report his opinion on the existence of a link between PrG and financial debts, even if the answer "*I don't know*" was possible. Items on PrG and debts' management presented missing data for 42 questionnaires (59%), PrG and debts screening items presented data for 18 questionnaires (25%) and 14 questionnaires (20%) had missing responses. Considering participants' beliefs, the great majority (99%) expressly recognized the potential addictive properties of gambling, 62% of them characterized PrG as an important or very important issue of concern in the French-speaking area of Switzerland and 69% of them showed a keen interest in PrG with all the financial harms that go along with it.

One participant screened himself positive for problem gambling according to Liebet items [18].

In GPs' daily practice (Table 2), while debts were often or systematically screened by 35% of the practitioners, this was not the case for PrG screening which, was often screened only by a minority of GPs (7%) during general history taking or discovered by chance with the occurrence of payment difficulties. Twenty-four percent (24%) of GPs estimate problem gamblers in a range of 1 to 30% of their patients whereas for 43% of them the proportion of indebted individuals lay between 5 to 40% of their patients.

One item of the questionnaire investigating PrG management by GPs leads to the followings: 52% of GPs referred their patients to a specialist; another 32% stated they didn't know what to do with these problematic patients and 3% do not address this issue at all. In turn, the responses for dept management showed that these proportions were 48%, 10% and 4% respectively. GPs promote a multidisciplinary approach to PrG treatment (80%) while 3% of them favor referral to private psychiatrists.

Regarding information and training status (Table 3), no knowledge at all or insufficient knowledge was reported by 79% of participants on PrG. The Fisher exact test comparing GP's level of knowledge of the topic (very

satisfactory/satisfactory vs. insufficient/no knowledge) and screening for problem gambling frequency (systematically/often vs. rarely/never) did not reach statistical significance ( $p=0.2$ ). Similarly there was no significant association between level of knowledge of the topic (very satisfactory/satisfactory vs. insufficient/no knowledge) and the demand for more information and training (agree vs. disagree) ( $p=0.5$ ). When comparing level of knowledge of PrG care network (very satisfactory/satisfactory vs. insufficient/no knowledge) and screening for excessive gambling frequency (systematically/often vs. rarely/never) we found no statistical significant difference between these groups ( $p=0.1$ ). Finally, no statistical significance was found between screening for PrG and interest on the topic ( $p=1$ ).

<b>Table1</b> Participants beliefs on excessive gambling	
Total sample (N=71)	(%)
<b>Excessive Gambling in Swiss French speaking area is</b>	
Not an issue	0.0
A minor issue	25.4
A major issue	57.7
A very major issue	4.2
I don't know	12.7
<b>Your interest on excessive gambling and gamblers' indebtedness is</b>	
Important	15.5
Medium	53.5
Low	25.4
Null	2.8
I don't know	2.8
<b>Do you think gambling could become excessive or addictive</b>	
Total agreement	93.0
Partial agreement	5.6
Partial disagreement	0.0
Total disagreement	0.0
I don't know	1.4
<b>Do you think gambling could lead to indebtedness</b>	
Total agreement	97.2
Partial agreement	2.8
Partial disagreement	0.0
Total disagreement	0.0
I don't know	0.0
<b>Does excessive gambling worsen indebtedness in the current economical context</b>	
Total agreement	63.4
Partial agreement	25.4
Partial disagreement	2.8
Total disagreement	0.0
I don't know	7.0

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**Table2** Participants attitudes toward excessive gambling

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Total sample (N=71)	(%)
Do you screen for excessive gambling	
Systematically	0.0
Often	7.0
Rarely	35.2
Never	31.1
I don't know	1.4
Do you screen for indebtedness	
Systematically	1.4
Often	33.8
Rarely	33.8
Never	8.5
I don't know	2.8
Your attitude towards excessive gambling is	
I refer to specialist	52.1
I treat it	7.0
I don't do anything	2.8
I don't know	31.8
Your attitude toward indebtedness is	
I refer to appropriate services	47.9
I include it in my treatment plan	21.1
I don't do nothing	4.2
I don't know	9.9
The best management of excessive gamblers is in referral to	
Specialized multidisciplinary centers (doctors, psychologists, social workers...)	80.3
Private psychiatrists	2.8
General GPs	4.2
Social services	1.4
I don't know	2.8

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<b>Table3</b> Self-reported knowledge on problem gambling	
Total sample (N=71)	(%)
<b>My knowledge on problem gambling is</b>	
Very satisfying	0.0
Satisfying	16.9
Unsatisfying	64.8
Null	14.1
I don't know	0.0
<b>My knowledge on problem gambling care network is</b>	
Very satisfying	0.0
Satisfying	21.1
Unsatisfying	45.1
Null	25.4
I don't know	4.2
<b>I desire more information on problem gambling</b>	
Total agreement	54.9
Partial agreement	31.0
Partial disagreement	4.2
Total disagreement	2.8
I don't know	1.4
<b>I desire more training on problem gambling</b>	
Total agreement	26.8
Partial agreement	50.7
Partial disagreement	8.5
Total disagreement	4.2
I don't know	1.4

## Discussion

To our knowledge, this is the first study specifically targeting GPs (regardless to their PrG referral experience) to investigate their beliefs, resources and practice related to PrG. Above all, in the era of expansion of online gambling, a risk factor for PrG with different clinical patterns in online problem gamblers.

The survey has been relatively well received by Swiss GPs' professional associations in the French speaking area with 66% of acceptance to relay the information and the link to the online questionnaire, and a majority of participants responded to the questionnaire. The sample consisted of 71 GPs. Data showed that the majority of GPs considered gambling as addictive and they believed in the importance of problem gambling in their area of practice, estimating furthermore



a high rate of PrG and related indebtedness in their own patients. These results are different from those of the Canadian sample of physicians [16] but similar to those from the Australian data [14]. This highlights the possible mentality changes this last decade regarding PrG status as a medical disorder and constitutes a better chance for GPs to be motivated to play a role in its management.

Nevertheless, screening practice was very low and PrG was often discovered by chance when patients experienced financial issues. In addition, GPs interested in PrG didn't differ significantly in screening from those who declared less or no interest in the field. This could be explained by the gap between beliefs and attitudes in a real practice setting. Even if GPs believe and take interest in PrG, they probably tend to prioritize managing other disorders, somatic and/or with short or medium-term vital risk or they could feel a lack of time in their consultation to include questions on PrG [19]. Furthermore, interest could be present but suitable and available resources and knowledge on PrG management could be lacking. This goes in line with the obstacles stated by the literature to be facing physicians' involvement (e.g. "lack of time" and "new problem recognized as having a low incidence rate")[16]. The economically symptomatic PrG (i.e. patient declaring financial issues or incidents of fee payment issues) could be a sign of alert of the disorder for the practitioner, but unfortunately where financial consequences are already present. This aspect could be addressed by renewed information on the vital risk of PrG (e.g. suicidal risk), and the importance of the early detection. GPs should also be trained and continuously trained to use basic and suitable PrG screening tools to detect patients before crisis-driven help seeking.

PrG management data also leads to interesting findings. Even if the majority of GPs knew the best treatment strategy for PrG, only half of them referred to PrG treatment systems, and more than 2/3 of them declared ignoring the local specialized network to refer patients to. This aspect could be addressed by a wider dissemination, through GPs professional associations, of the current accessible information about PrG local treatment systems. Internet could be an interesting, fast, cost-effective and easy to use vector to such information and training dissemination. Screening wasn't significantly different between those who

declared satisfaction from their knowledge and those who were unsatisfied. These correlation results are to take with caution regarding the small samples compared. What should be taken into account is the high rate (79%) of unsatisfied GPs from their knowledge on the disorder and the referring structures and the large majority of the sample declared needing more information (86%) and training (77.5%) on PrG and its management. This is a need that should be addressed by structured specific training and support strategies. Helplines for GPs and supervisions should be considered in addition to specifically designed training materials and settings (i.e. pre-graduate, post-graduate and continuous training). E-learning and distance supervisions (e.g. through e-mails or videoconferences) are emerging tools to build capacity that demonstrated efficacy in other fields in medicine [20-22].

The high rate of missing data concerned electively the second part of the questionnaire based on attitudes and knowledge. Taking into account that most of the participants answered to the beliefs, this could be explained by social desirability (i.e. difficulty to report the ignorance on a topic).

With the lack of information on the rate of participants from the panel sought (unknown proportion of affiliated doctors in each professional association at the time of the study), the representativeness of the sample here studied is hard to describe. Furthermore, the only data available is the number of 1183 of Swiss doctors (including GPs) in outpatient sector of the geographic areas concerned by our survey [16, 17, 23]. However, descriptive data are the most important contribution of our work. Validity of our results can be appreciated by some indirect indicators. Firstly, data on GPs' attitudes of PrG screening and knowledge are in with line previous studies [14]. Secondly, the proportion of probable PrG in the sample itself (1.5%) was situated in the range of the general Swiss population prevalence [5, 7]. Finally, even if the sample is moderate, a wide age range (34-70 years old) of GPs was represented. Participants, having done their medical studies at different periods in time, represent the panel of different considerations of the PrG as a disorder for the medical community the last decades.

## **Conclusion**

The results state that the vast majority of Swiss GPs that participated in the study are aware of the existence and the potential impact of PrG on their patients. But as

expected, the screening of PrG is not systematic and their knowledge of adequate treatments or referral methods is scarce. GPs being central to health screening in general and the pressures on them to screen almost all health issues, targeted advice and training (e.g. short screening tools, better knowledge of when to refer to a specialist) should be promoted to empower the GP's management skills in the context of a public health approach. This training and information should be periodically renewed to face new challenges (e.g. Internet as a vector of gambling accessibility but also information and training vector), and to know new management strategies. Our findings can be the first stepping stone in the implementation of such capacity building strategy for PrG early detection and intervention according to the local needs. Such strategy could be inspired by previous afterthoughts [14-16].

## Abbreviations

FMH: Foederatio Medicorum Helveticorum

FSAs: French Speaking Areas

GPs: General practitioners

PG: Pathological Gambling

PrG: Problem Gambling

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