Problem gamblers: do GPs want to intervene?

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Abstract

Aim. To survey GPs' attitudes towards problem gamblers and knowledge to successfully intervene.
Methods. 100 GPs, randomly selected for gender and geographical distribution, were anonymously surveyed by questionnaire through the Royal New Zealand College of General Practitioners.
Results. 80 GPs responded (80% of those surveyed). There was strong support (85%) for problem gambling being within a GP's mandate, for involvement in treatment of problem gambling (72%) and for their having a role in supporting a family where a member has a gambling problem (80%). There was less confidence in: raising the issue of gambling with patients (53%), in knowledge of resources (38%) and in having the necessary training to intervene (19%).
Conclusions. GPs see problem gambling as a legitimate role for their intervention, however, they have concerns around their competency and knowledge of resources. The provision of undergraduate and postgraduate training may assist to remove barriers to an accepted role in primary health.

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Pathological gambling is a chronic, progressive disorder that can affect not only the gambler's and their family's finances, but also their mental and physical well-being.[1-3] Prevalence of the disorder may be growing as a consequence of the greater availability of opportunities to gamble.[4,5] Although gambling is widespread, there are few specialist treatment providers available in New Zealand, with those available being largely sited in city centres.[5] GPs could provide treatment that is presently difficult to access for many. In addition, GPs could add a further treatment dimension through case-finding and early intervention.

Studies of intervention by GPs in alcohol misuse cases have found factors that may determine whether a doctor intervenes include: acceptance of role legitimacy,[6] knowledge about the problem,[7,8] perception of one's own skills to deal with it,[8] empathy with the patient,[9] willingness to intervene,[6] available time/incentives to deal with the problem,[7,10] motivation and work satisfaction.[10] It appears the greatest barriers to intervention may be perceptions of one's own skills, availability of resources (time, training, support, materials, screens, referral services, government support) and concerns of role legitimacy.[11,12] Overseas, there appears to be support for intervention by family doctors in problem gambling[3,12,13] but concern exists around underestimation of the disorder.

> "When we consider that compulsive gambling is an addiction that can destroy families and waylay a healthy future for our youth, it becomes clear that primary care physicians should take careful notice of the problem and its magnitude, just as we do with smoking, drinking, and other diseases that have a psychosocial element".[12]

The aim of this study was to ascertain whether intervention in problem gambling was considered a legitimate role for New Zealand GPs; ascertain their attitudes towards the issue, their knowledge of resources and their confidence in intervening, should a patient be identified with such a problem.

Methods

Questionnaires were distributed to 100 GPs throughout New Zealand, selected randomly by the Royal NZ College of General Practitioners generated from their database of current practitioners using factors of gender and GP distribution throughout the country.

Currently, more than 90% of practising GPs hold some form of membership of the College (personal communication). A numbering system allowed the GPs to remain anonymous so as to enhance candour, however an option allowed for disclosure should they desire research feedback. General demographic information was requested including GPs' age group and gender.

GPs were asked about attitudes towards prevention and intervention generally; their role in helping problem gamblers; knowledge of problem gambling; and their perceived skills around successful intervention in this disorder. Thirteen of the 27 questions were modelled on those of an alcohol study involving GPs,[6] a further ten from a similar study involving nurses[14] and a final four involved additional aspects on gambling (role/knowledge).

A second request was sent (through the College) eight weeks later to those GPs who had not replied to the first mail-out. GPs were asked to rate their response to various statements by ticking one of the boxes headed 'strongly agree', 'agree', 'neither agree nor disagree', 'disagree', or 'strongly disagree'. For analysis, agree/strongly agree and disagree/strongly disagree were collapsed.

Results

80 of the 100 GPs (80%) replied to the two requests (58 replied to the first request, 22 to the follow-up), and two were returned as uncollected. All responses received were eligible for inclusion. 27 (34%) requested information about the study and disclosed their names and/or addresses.

Responses to the 27 questions were divided into categories that covered: general attitude towards prevention/intervention, beliefs as to GPs role in the disorder, knowledge, and perception of their own skill to intervene.

General attitude towards prevention and intervention. GPs held positive attitudes to their roles in counselling patients, in influencing or intervening in patients' lifestyle practices and in referring patients to non-medical professionals (see Table 1).

Table 1. General attitude of GPs surveyed towards prevention and intervention.

Question asked	agree %(n)	no opinion %(n)	disagree %(n)
Undergraduate medical students can't be taught interpersonal skills *	6%(5)	5%(4)	89%(70)
Doctors have no mandate to intervene in lifestyle practices	6%(5)	10%(8)	84%(67)
Doctors can influence patient health and lifestyle practices	85%(68)	6%(5)	9%(7)
Public health education has only worked with well educated people	22%(17)	28%(22)	51%(41)
Doctors should seldom refer patients to non-medical professionals	1%(1)	8%(6)	91%(73)
It is part of my job to help people who can't cope	90%(72)	9%(7)	1%(1)

* one reply missing. NB percentages rounded and may not add to 100%.

Beliefs about the role of GPs concerning problem gambling. GPs indicated a high acceptance of legitimacy in intervening in patients' gambling problems, in supporting a problem gambler's family and involving themselves in treatment programmes for problem gamblers. There was less support for GPs' screening of patients' gambling behaviour (34%), with more than half having no opinion on the matter. This was not based upon fear of alienating the patient (see Table 2).

GPs' knowledge and opinions about problem gambling. A high proportion of GPs viewed problem gambling as an addiction. A majority (51%) viewed problem gambling as an issue as serious as drug/alcohol problems. However, considerable proportions of GPs expressed no opinion in questions about problem gamblers' self indulgence (39%) and ability to self change (31%) (see Table 3).

GPs perceptions of their own skills around gambling. Greater variation in opinions occurred in this section of the questionnaire. Majorities replied that they would not lack confidence in asking patients about their gambling (54%) or that they would not feel it intrusive to do so (53%). However, few expressed confidence in their training to successfully intervene (19%) or knew where to refer patients with gambling problems (38%), although a bare majority (53%) expressed they would know 'what to do next' if a patient disclosed a gambling concern (see Table 4).

Table 2. Beliefs of GPs surveyed about the role of GPs around problem gambling.

Question asked	agree %(n)	no opinion %(n)	disagree %(n)
I could be at risk of losing my patient if I inquired about their gambling	16%(13)	16%(13)	68%(54)
Doctors lose control of their patients' management when they refer them to self help organisations	18%(14)	18%(14)	65%(52)
Doctors have little role in supporting a family where a member has a gambling problem	6%(5)	14%(11)	80%(64)
Patients expect a prescription to result from their visit to the doctor	28%(22)	19%(16)	53%(42)
Doctors should make time to inquire about their patients' gambling	34%(27)	56%(45)	10%(8)
I can accept problem drinking may be within a doctors' mandate but I have some difficulty in seeing problem gambling that way	8%(6)	8%(6)	85%(68)
Doctors have little part to play in the treatment of gambling problems*	10%(8)	18%(14)	72%(57)
It is more okay for doctors who gamble regularly to ask patients about their gambling	9%(7)	14%(11)	78%(62)

*One reply missing. NB: percentages rounded and may not add to 100%.

Table 3. Knowledge and attitudes about problem gambling by GPs surveyed.

Question asked	agree %(n)	no opinion %(n)	disagree %(n)
Viewing problem gambling at any stage as an addiction is hard for me to accept	4%(3)	8%(6)	89%(71)
People with problems around gambling are often weak and self indulgent	13%(10)	39%(31)	48%(38)
People could alter their gambling behaviour if they really want to	49%(39)	31%(25)	19%(15)
Fear of incapacity or death is the only real motivator for behaviour change	10%(8)	19%(15)	71%(57)
The only viable treatment goal for problem gamblers is abstinence	52%(41)	33%(26)	16%(13)
When it comes to personal gambling, doctors are the same as other people*	79%(62)	15%(12)	5%(4)
Problem gambling is a much less serious problem than problems around alcohol and drugs	20%(16)	29%(23)	51%(41)

*2 replies missing. NB: percentages round and may not add to 100%.

Age and Gender of GPs compared with responses. Age and gender of GPs were compared in responses to key questions concerning: mandate (GPs having a part to play in gambling problems), seriousness of problem gambling compared with alcohol and drugs, attitude towards problem gamblers (weak and self indulgent?) and training to identify/help problem gamblers (where to refer). Questions were analysed separately by ordinal logistic regression with age (as a categorical variable) and gender as explanatory variables. There was no significant difference for any of these questions between GPs of differing ages or gender.

Discussion

Three-quarters (75%) of those with opinions supported inquiring about their patients' gambling, however, less than one in five believed they had the training to identify and help those patients with gambling problems. There

was an implied willingness to counsel, which conflicted with the relatively low rates of diagnosis by GPs of psychological disorders reported in New Zealand publications.[15,16] Further uncertainty was reflected around the response to a patient's disclosure of a gambling concern, with over one-third responding that they would not know what to do. Almost one-half of GPs would not know where to refer problem gamblers for help. This may be compounded by patients' uncertainty around the relevance of disclosing their problem gambling behaviour to their GP.[15] The mandate for GPs to deal with problem gambling was strongly affirmed. However, there was a clear lack of confidence expressed or implied around training to intervene with problem gamblers.

Table 4. Perceptions of GPs surveyed of their own skills around problem gambling.

Question asked	agree %(n)	no opi nion %(n)	disagree %(n)
I don't feel confident asking patients about their gambling	18%(14)	30%(24)	53%(42)
I do not have the training to identify and help people who have difficulties with their gambling	55%(44)	26%(21)	19%(15)
I would find it difficult to know what to do next if patients told me they had concerns about their gambling	37%(29)	11%(9)	53%(42)
I wouldn't know where to refer patients with gambling problems	48%(38)	14%(11)	38%(31)
I know how to find out whether patients are thinking about changing their gambling habits*	16%(13)	24%(19)	59%(47)
I feel it is intrusive to ask patients about their gambling*	11%(9)	34%(27)	54%(43)

*one reply missing. NB: percentages rounded and may not add to 100%.

GPs viewed problem gambling as a serious disorder. Although suicidal behaviour is elevated in this disorder,[1,2,5] somatic symptoms are not apparent and identification difficulties may deter many GPs.

Many GPs saw abstinence as the only viable option for problem gambling, but one-third held no opinion, possibly indicating uncertainty around treatment. This appeared to support the conclusion of a desire to intervene, but a lack of training to do so when applied to problem gambling.

The study indicated a strong general desire of GPs towards intervention and prevention, and to intervene in lifestyle practices. Almost three-quarters of GPs stated that, in general, patients could be motivated even when not faced with life-threatening or incapacitating consequences, suggesting a willingness to focus on early intervention, and implying confidence that they could be effective at this stage. However, only one-third agreed GPs should inquire (screen generally) about gambling, with most (56%) having no opinion. This may be a consequence of the lack of confidence earlier expressed around identifying problem gambling (Table 4) and may suggest the need for resources such as a brief screen.

A large number of GPs responded that they held no opinion on questions. This response could indicate either uncertainty, reluctance to state an unpleasant viewpoint, lack of interest in the question, or even a lack of sufficient knowledge about the subject to express an opinion either way. Lack of interest appeared to be inconsistent with the expressed strong mandate to deal with problem gambling and the many (one-third) requests for results of the survey. Reluctance to express an opinion would also seem inconsistent with the anonymous format and high response rate (80%).[17]

Many of the 'no opinion' responses may be attributable to uncertainty, due to ambivalent or as yet undetermined attitudes and a lack of knowledge about the subject. Further qualitative research, beyond the scope of this anonymous study, may be required to secure a conclusion.

The focus of the study was upon identification and brief intervention. Time involvement, cost recovery and ongoing management of problem gamblers were not considered in the survey. Sample questions analysed indicated that responses did not vary with age or gender of the GPs, however, care should be taken in light of the relatively small sample sizes overall.

There is little published research upon the readiness of GPs to intervene in problem gambling issues,[3,15] and the data on intervention in alcohol abuse/dependence may have relevance.[18] A recent New Zealand study of GPs' intervention around alcohol misuse found role legitimacy, perceived competency and level of support; such as lack of available time and financial incentives from government to practice prevention (eg counselling), to be the highest barrier to intervention.[11] Attitudes towards alcohol problems or knowledge of the disorder were not found to be key factors in whether or not the GP would intervene.[15,16] Barriers that mitigated against intervention were: lack of training in brief interventions, lack of screening resources and of counselling materials. In contrast, patients' recognition of their GP's role in this field (ie role endorsement) would encourage intervention. GPs have often been reluctant to screen for alcohol abuse/dependence.[6,8] Barriers to GP intervention in patients' alcohol problems[6-11] may also be applicable to problem gambling patients, as may solutions to remove or mitigate these barriers.

In conclusion, this study has indicated that GPs, irrespective of age or gender, do see problem gambling as a medical issue and that they have a mandate to intervene when such issues arise. There is concern about having the necessary skills, knowledge, or resources available to intervene successfully, and this concern may remain a barrier to their involvement in screening or treatment of problem gambling patients. The development of resources such as a brief problem gambling screen, as well as undergraduate and postgraduate training may encourage intervention. The raising of patient awareness of problem gambling as a health issue and of GPs' willingness to intervene may also enhance intervention, and this may be assisted by information in waiting rooms indicating that problem gambling is a health issue.

Minimal interventions have been proven to be effective treatments in the allied field of alcohol abuse.[7,19] Early intervention through screening or encouraging help-seeking behaviour may reduce long term harm to the gambler and their family's quality of life. GPs can provide a readily accessible gateway to help for the problem gambler and their family. It would appear that GPs are willing but that deficits of resource and confidence may be barriers to intervention when patients' health is adversely affected by gambling.

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