Barriers to Accessing Treatment for Problem Gambling

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Contents

Introduction

Over the past decade, prevalence studies conducted in British Columbia have indicated that up to 4.6% of the general population could be at risk for developing a gambling problem with 0.4% of the population experiencing severe problems (Ministry of Public Safety and Solicitor General, 2003). The population of British Columbia in 2005 slightly exceeded 4.2 million, suggesting that over 17,000 people could be experiencing a severe problem with gambling. However, problem gamblers are underrepresented among those seeking access to gambling treatment services.

Counseling is the primary method of problem gambling treatment and, in the 2005-2006 fiscal year, problem gambling counseling services in British Columbia admitted 1,115 clients (Gaming Policy and Enforcement Branch, 2006). While this number represents a 25 percent increase from the 900 clients served the year before and three times the number of clients served in 2000, a large number of problem gamblers and potential problem gamblers are not accessing services. In recognition of this disparity, the Gaming Policy and Enforcement Branch has identified and addressed several barriers to accessing treatment, such as the availability of qualified counselors in every region within British Columbia and by having more flexibility with respect to the time, location, and language that counseling services can be accessed. The toll-free Problem Gambling Help-Line in British Columbia has also seen an increase in calls. More specifically, in 2001-2002, the help-line received 900 calls specific to problem gambling, while in 2005 they received 5,830 calls (Gaming Policy and Enforcement Branch, 2006). Still, the large disparity between the estimated 17,000 problem gamblers in the province of British Columbia and the 1,100 clients accessing counseling services indicates that barriers to accessing treatment continue to exist. This review will explore the typical barriers to access faced by mental health and substance abuse clients and draw parallels with the problem gambling population.

Barriers to Treatment

Research in the field of mental health and substance use problems indicates a number of consistent reasons as to why members of the population do not seek treatment for their particular problems. When considering the mental health literature, Olfson, Guardino, Struening, Schneier, Hellman, and Klein (2000) identified a number of different barriers that prevent people from accessing treatment; the most common, held by slightly more than three-quarters of the sample (77 percent) was that they thought they could handle the situation on their own. Additional barriers were that: treatment would not help (46 percent); it was too expensive (36 percent); and concern about the reaction they might receive from friends and family (4 percent). The researchers noted that the decision to seek treatment may ultimately result when people reach ‘rock bottom’ or the point when they can no longer manage the problem(s) on their own (Olfson et al., 2000).

Research also suggests similar findings for those who have problems with alcohol and drugs. Cunningham and Breslin (2004) supported this notion with their study of 1,086 Canadians with a lifetime diagnosis of alcohol abuse or dependence. Only slightly more than one third (36 percent) of their sample, mainly those with severe alcohol problems, accessed services, most commonly

by talking to a medical doctor or attending a self-help group, such as Alcoholics Anonymous. In their review of individuals who abuse multiple substances, Sobell, Ellingstad, and Sobell (2000) found that the most commonly identified barriers to treatment included fear of stigmatization or labelling, negative beliefs or prior experiences with treatment, the perception that treatment was not relevant to their problems or that it would not help them, and privacy or a disinclination to share their problems with others.

Both the mental health and substance abuse literature is replete with examples of barriers to accessing treatment, and researchers in the gambling field have begun to draw comparisons between the two fields. Hodgins and el-Guebaly (2000) designed a checklist created from items found in the substance abuse literature and explored their relevance to problem gambling using a sample of 106 Canadian problem gamblers. An overwhelming majority of the sample (82 percent) agreed that a significant barrier to treatment was the desire to handle the problem on their own. Other barriers included: embarrassment or pride (50 percent); the perception that they did not have a problem or that no help was needed (50 percent); ignorance of the availability of treatment (55 percent); an inability to share problems (49 percent); and stigma (53 percent).

Tavares, Martins, Zilberman, and el-Guebaly (2002) argued that because this checklist was based on the substance abuse literature, there was a possibility that the methodology failed to identify those barriers that might be unique to problem gamblers. Tavares et al. (2002), therefore, employed the Reasons for Delaying Treatment Scale in which they asked their respondents to identify why they chose not to seek treatment even though they were aware of their gambling problem. They classified the answers into four main factors and identified two of these – (1) chasing losses and lonely efforts for self-control and (2) shame and secrecy – as the best predictors of the number of years spent problem gambling. The other two factors for not seeking treatment included lack of practical resources (time, money, and transportation) and a general lack of a readiness to change.

The results found by Hodgins and el-Guebaly (2000) and Tavares et al. (2002) have been supported by additional studies. In a survey of video lottery gamblers in Nova Scotia, 60 percent of problem video lottery players, while aware of the availability of treatment for their gambling problem, chose not to access treatment services (Nova Scotia Department of Health, 2001). The most common reason given for the failure to seek treatment was their belief in their ability to resolve this problem on their own. Again, this view was endorsed by 60 percent of those who had not accessed treatment. Other common reasons given included: the belief that it was a personal issue (16 percent); concern about confidentiality and disclosure in a group setting (16 percent); the thought that the gambling service providers would not help or would not understand (16 percent); the thought that their problem was not serious enough to warrant treatment (12 percent); feeling ashamed or embarrassed (12 percent); and not being ready to access help or to admit their problem (12 percent). Nearly one quarter (24 percent) of the sample of problem gamblers reported a lack of awareness of any gambling treatment services in Nova Scotia, while only 16 percent stated that they had accessed formal services (Nova Scotia Department of Health, 2001).

Rockloff and Schofield (2004) found five factors associated with barriers to treatment. These factors included: (1) availability (concerns regarding availability and effectiveness of treatment); (2) stigma (blame or other negative social labels being placed on the gambler); (3) cost (the

monetary costs of treatment); (4) uncertainty (lack of knowledge regarding treatment availability or methods); and (5) avoidance (related to attitudes towards seeking treatment). Those with a more severe gambling problem (as defined by a higher abridged-South Oaks Gambling Screen score) were more likely to indicate the availability and cost factors, whereas older gamblers were more likely to identify stigma as a key factor for not seeking treatment. Men were slightly more concerned with stigma and avoidance factors than their female counterparts. In general, those with more education showed less agreement with all the factors, with the exception of the avoidance factor. In other words, the more educated the individual was the more likely they were to seek treatment

It is also important to note that the number of women engaging in gambling activities has increased (Boughton, 2002). However, female gamblers tend to seek treatment at a much lower rate than do males. Given that female gamblers differ from male gamblers, the Ontario Ministry of Health funded a Centre for Addiction and Mental Health study to specifically examine female gamblers. In this study of 365 female gamblers, nearly all (90 percent) indicated that they had never accessed any form of treatment for their gambling problem. Consistent with other studies, slightly less than three quarters of the sample (73 percent) stated that their failure to access treatment was due to the belief that they should be able to deal with their problem on their own (Boughton, 2002). Additional barriers to accessing services included financial pressures and gambling hooks, such as hoping for the big win that would solve all their problems. Furthermore, slightly more than one third of women (38 percent) were not aware of available problem gambling services, while more than half (57 percent) worried that accessing treatment would mean that they would have to abstain from gambling altogether.

While some people arrive at the sudden realization that they cannot handle their problem on their own, and the severity of the problem is a clear predictor of accessing services, individuals who experience a sudden change in their personal lives, such as a divorce, bankruptcy, mental instability, or loss of a job, are also more likely to seek treatment. In considering the financial and/or employment effects of problem gambling, Lesieur (1998) found that between 18 to 28 percent of males and 8 percent of females who attended Gambler's Anonymous programs had declared bankruptcy and that between 21 to 36 percent of those participating in Gambler's Anonymous had lost a job due to their gambling behaviour. Although the short-term nature of the study was insufficient to establish whether bankruptcy or loss of a job served as a catalyst for treatment seeking behaviour, it is possible that one of the effects of the sudden financial instability was that these individuals became more open to treatment.

Lesieur (1998) also documented that between 47 to 52 percent of pathological gamblers also receive a diagnosis of substance abuse. This introduces the possibility that problem gamblers who access treatment may not be doing it primarily to deal with their gambling behaviour, but because of a substance use problem. This possibility is supported by Roberts and Ogborne (1999) who noted that only 30 percent of substance abuse programs in Canada screen their clientele for gambling problems.

Natural Recovery

A substantial part of the literature on problem and pathological gambling discusses the "natural recovery" of gamblers. The natural recovery hypothesis suggests that some problem gamblers may spontaneously recover from their addiction. While research has consistently identified a desire to resolve the problem on one's own as a barrier to treatment access, a study of video lottery players in Nova Scotia (2001) suggested that there may be some validity to this perspective. According to this study, nearly two thirds (60 percent) of problem video lottery players recognized the availability of treatment programs, but did not access these services. The primary reason for this was the belief that they could resolve their problem without the aid of formal treatment. Further analysis suggested that almost half of the problem players who held this belief also indicated that they had actually resolved their problems with gambling. While there was no way to validate the participants' claims, the researchers interpreted these findings to suggest that approximately one quarter of all problem gamblers who resolved their problems, did so without any contact with formal treatment services (Nova Scotia Department of Health, 2001). The authors further concluded that formal treatment or support services are not accessed until a player depletes all their financial and emotional resources and hits "rock bottom". This conclusion is supported by Ladd and Petry (2002) who argued that problem gamblers seeking treatment likely reach an unusual threshold of severity and consequences before accessing treatment.

The ability to naturally recover from problem gambling has only recently gained support. The view that addiction is not a self-curing disease was shared by many, including a former Director of the National Institute on Drug Abuse, who claimed that "left alone, addiction only gets worse, leading to total degradation, to prison, and ultimately to death" (Sobell, Ellingstad, & Sobell, 2000: 750). Sobell and colleagues also refer to an argument suggested by disease model advocates that the ability to cease addictive behaviours on one's own suggests a lack of actual addiction. Yet Hodgins and el-Guebaly (2000) argued that recovery from addiction without the aid of formal treatment services has become progressively more recognized as a common process. In their study of 106 resolved and non-resolved problem gamblers, slightly more than half (53 percent) who had resolved their gambling problems reported that they did not access any treatment (compared to 63 percent of non-resolved gamblers). For more than four fifths of these individuals (82 percent), the central reason for not accessing treatment was a desire to handle the problem on their own. The two main actions taken to resolve their gambling problem included stimulus control and adoption of new activities. However, slightly more than one quarter (28 percent) indicated that they found treatment involvement to be helpful in maintaining their recovery.

While many pathological gamblers appear to naturally recover from their problems, research also indicates that access to treatment can often depend on the severity of the gambling problem. In effect, as the gambling problem becomes more severe, the pathological gambler is more likely to access treatment services, whether it be professional services or self-help groups, such as Gamblers Anonymous. Hodgins and el-Guebaly (2000) identified only one variable that discriminated between problem gamblers who did and did not access treatment, namely the severity of the gambling problem. According to these researchers, gamblers who reported

moderate or greater levels of treatment experienced more problem gambling criteria, as defined by the DSM-IV, than did problem gamblers who did not access treatment.

Furthermore, in a study of pathological gamblers using two United States national surveys, Slutske (2006) documented a strong association between pathological gambling symptoms over one's lifetime and the likelihood of treatment seeking. According to this research, a large majority of recoveries occurred without treatment. However, as the number of symptoms experienced over the lifetime increased from 5 to 10, there was a generally corresponding increase in the proportion of those who sought treatment. For example, at five symptoms, only 6 percent of the sample sought treatment, whereas approximately three quarters (76 percent) of those experiencing 10 symptoms sought treatment. Therefore, there appears to be a connection between treatment seeking and level of severity of a mental health problem. Cunningham and Breslin (2004) identified that 36 percent of 1,086 Canadians with a lifetime diagnosis of alcohol abuse or dependence had accessed services, and that addiction services were more likely to be used if the individual had a severe alcohol problem. It should be kept in mind, however, that, for this study, services was defined rather broadly to include things like speaking to a religious leader as well as attending inpatient or outpatient services. Although the most common service accessed was talking to a medical doctor (29.7 percent) followed by attending a self-help group (12.3 percent), and talking to a psychiatrist, psychologist, social worker, rabbi, priest, minister, counsellor, or other (8.1 percent), only 7.3 percent of the sample reported attending inpatient or outpatient services.

In a similar study of alcohol abuse and dependence in which 50 percent of the sample had accessed treatment services, Cunningham, Lin, Ross, and Walsh (2000) identified two main populations of alcohol users. The first group was made of people who often accessed treatment and were characterized by fairly significant alcohol problems which they had experienced for a relatively long period of time. The second group was composed of those who appeared to have resolved their alcohol problems without accessing treatment services, but who continued to drink at a moderate level. This latter group of alcohol users appeared to experience a problem with alcohol that was less severe and of shorter duration than that of the treatment seekers.

However, natural recovery studies have generally been impeded by a lack of longitudinal research. It is not fully clear whether problem gamblers who naturally recover are able to maintain this recovery over the long-term. Thus, whereas studies of cognitive behavioural treatment have been able to demonstrate long-term success, this is not substantiated for natural recovery. Therefore, despite the fact that a large portion of problem gamblers appear to naturally recover from their problems, resources should continue to be directed toward treatments that show successful improvements in achieving and maintaining both cognitive and behavioural changes in those with gambling problems.

Public Awareness

While a commonly cited barrier to treatment in the research literature is the desire to deal with the problem on one's own, an additional barrier is the lack of awareness among the target population of the availability of problem gambling treatment services. Therefore, attempts to increase public awareness of treatment availability should be undertaken. Public awareness techniques are common to the field of gaming as a preventative technique. For example, in March of 2006, the Gaming Policy and Enforcement Branch introduced a gambling awareness campaign targeting 18 to 24 year olds in an attempt to increase awareness of the problem gambling program and the toll-free Help Line. To achieve their goal, advertisements were placed in transit buses and shelters, on websites oriented to youth, in washrooms, and in college and university newspapers. Furthermore, in an attempt to increase awareness of how to access services, Responsible Gaming Information Centres (RGIC) were piloted in two lower mainland casinos. The RGICs were staffed with Responsible Gaming Officers who were present during the peak casino hours to provide information, assistance, and referrals for problem gambling related concerns.

In Ontario, the Mental Health and Addiction Branch administered a $250,000 public awareness campaign directed towards increasing problem gambling awareness (Sadinsky, 2005). The three month campaign utilized advertisements on and in transit vehicles, in bus shelters, and in community papers. However, an evaluation of the campaign provided only moderate support for its success, and the Branch concluded that although the increase in cost would be substantial, a more far-reaching media campaign would be necessary to improve the success of the campaign. Similarly, the Manitoba Gaming Control Commission (2006) conducted a province-wide media campaign advertising on the radio and in movie theatres, washrooms, newspapers, bus shelters, transit buses, and coffee newsletters. While a post-campaign evaluation indicated that 85 per cent of the respondents did not recall the advertisements, recall was higher for the advertisments on transit buses and in shelters than for the other media.

Health literacy refers to self-control over one's health and the seeking out of health-related information and resources. Specifically, it refers to one's capacity to seek out, understand, and use information and services related to health (Friedman and Hoffman-Goetz, 2006: 352). In a study conducted by the Nova Scotia Department of Health (2001) with problem video lottery players who were able to identify a source of support for their problem, the majority identified either the Help-Line or Gambler's Anonymous. Thus, the researchers concluded that when gamblers reject the use of formal services, it may be because they are only aware of the availability of the Help-Line and Gambler's Anonymous. Such gamblers fail to seek out alternative options for dealing with their problems which suggests that an increase in public awareness of other available options, for example individual counseling, may be necessary. An increase in awareness of available programs would have a direct impact on health literacy by improving the range of resources available to those experiencing problems with gambling who are seeking help for their problem.

The purpose of public awareness campaigns have been identified as twofold: (1) to raise awareness regarding problem gambling and the corresponding available services; and (2) to reduce the incidence of problem gambling. A review of North American public awareness campaigns provided some insight into the most common practices and identified those perceived

to be the most effective (Wynne Resources, 1999). Many of the techniques employed were consistent across multiple agencies, however, the conclusions with respect to which techniques were most effective tended to differ. For the Minnesota Institute of Public Health, while the internet was noted to be an effective tool, radio campaigns were found to be the most effective with a consistent increase in calls to their problem gambling helpline following media campaigns involving on-air interviews with problem gambling counselors. The Addictions Foundation of Manitoba found that brochures were the least effective measure as people tended not to read them, and that repetition of advertising is essential, especially on television, but also other mediums, such as radio and newspapers.

The Minnesota Institute also identified longevity of advertising as an important component. Some organizations indicated that simple production of brochures was not sufficient, but that physically bringing brochures to particular communities was a necessary component for increasing public awareness (Wynne Resources, 1999). For example, the Addictions Foundation of Manitoba recognized that members of the senior population, while at risk for developing gambling problems, would not come to them for information regarding problem gambling. Therefore, they developed brochures specifically for the senior population and put them on display in personal care homes catering to senior populations. Similarly, in an attempt to gain access to the Filipino and Chinese communities, multi- language brochures were displayed in community social clubs and problem gambling information was delivered on ethnic radio stations (Wynne Resources, 1999).

The various organizations emphasized the importance of personal contact as opposed to simply creating brochures. Given this, the methods of communication identified as being most effective included telephone help-lines, television and radio campaigns involving interviews with problem gamblers or with problem gambling counselors, and using the internet to disseminate information on problem gambling (Wynne Resources, 1999). However, in considering these findings, it is important to note that none of the responding organizations conducted formal evaluations of these various methods. The informal methods of evaluation tended to include measures like: tracking requests for materials, information, and presentations; receiving verbal and/or written participant feedback; requests from the media; and web-site hits, with the most common evaluation being tracking calls to the hotline.

Of the 21 organizations who participated with this study, only three indicated that they had employed an external program evaluation and two indicated internal program evaluation, although no evidence of these evaluations were provided. An additional five organizations evaluated the effectiveness of their public awareness campaigns through assessment of the numbers of persons who presented for treatment (Wynne Resources, 1999).

Conclusion

While a number of recent research studies have suggested that a large proportion of problem gamblers fail to access treatment, the most consistent reason given was a desire to achieve recovery on their own. Research from the field of natural recovery indicated that many problem gamblers are, in fact, able to achieve this goal without accessing formal treatment. However, research also indicated that as the severity of the gambling problem increases, so does the likelihood that the problem gambler will come into contact with treatment service providers.

In raising public awareness about the availability of problem gambling services, public awareness campaigns should include a focus on the ability of the problem gambler to maintain control over their recovery, while, at the same time, utilizing formal services to assist them in their progress. Many problem gamblers who never accessed treatment indicated that they desired to keep their problems private, that they feared the stigmatization of others, and that they preferred to recover on their own. Thus, the message to problem gamblers must be that successful professional help is available in multiple forms, such as through individual counseling if they fear disclosure in a group setting or through group counseling if they desire the support of others experiencing similar problems. Problem gamblers must become aware not only of the more commonly known services, such as Gambler's Anonymous and the Problem Gambling help line, but also of the availability of inpatient and outpatient services and the flexibility of time, location, and language offered by these programs. While a number of problem gamblers may continue to recover naturally from their addiction, others fail to access treatment simply due to a lack of awareness of service availability or a misconception that it is irrelevant to their particular problem (Nova Scotia Department of Health, 2001). Thus, efforts must be undertaken to further increase levels of awareness surrounding the availability of problem gambling services, ideally using methods, such as advertising on radio, television, transit, and from with gambling establishments. As the severity of the gambling problem appears to be related to treatment seeking, advertising problem gambling services should consider emphasizing the wide range of services available to encourage those with a wide-range of severity of gambling problems to further develop their health literacy.

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