Problem gamblers and their families can be helped by their GP

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ABSTRACT

This paper describes a Practice Review Activity to provide interventions for problem gamblers and their families attending the practices of nine Auckland based general practitioners (GPs). GPs received a training manual and brief training to address patients' problem gambling issues. Patients were screened using the EIGHT gambling screen and for the effects of another's gambling using the COGS Screen. Those identified as screen positives were offered a brief intervention. Following one month of screening/interventions GPs participated in a focus group to discuss the process, followed by a second month of screening and follow-up individual key informant interviews. They found interventions for problem gamblers and their families became easier and their skills and confidence increased over time. In most cases they incorporated strategies into their practice to address problem gambling. However the time required to address gambling issues and the high level of co-existing depression, remained a concern.

Key words

Problem gambling screening, GPs, practice review activity

Introduction

Pathological Gambling Disorder is estimated to affect between 1% and 3% of the adult population, while a further unknown additional percentage of the population are affected by less severe, but still substantial, 'subclinical' gambling problems that impact upon the health of both the gambler and their families.[1,2] Problem gamblers experience financial problems as well as a high incidence of co-existing depression, anxiety and alcohol and drug problems.[3]

Problem gambling detection and intervention is attracting growing recognition as a legitimate role for pri-

mary health professionals in New Zealand[3-6] and overseas.[7-8] Those affected by problem gambling are often reluctant to access specialist services and usually do so at a late stage in the progression of the problem.[9-10] The potential has been recognised by the Ministry of Health:[2]

'There is the opportunity in primary care settings to provide an integrated package of service provision and to intervene at an earlier stage in the harm continuum, with screening and assessment for people with gambling problems and advice about healthier lifestyles. This will require workforce development in primary health care settings on screening and brief and early intervention.'[2]

A previous survey identified that GPs regarded problem gambling interventions as being within their mandate, including interventions for the family of problem gamblers, but there was less confidence in their ability to raise the issue with patients, and in their ability or training to intervene successfully.[4]

Methods

A practice review activity to provide interventions for patients affected by their own, or another's gambling, was approved by the Royal New Zealand College of General Practitioners, and was made available to GPs within an Auckland-based PHO participating in a substantial screening survey of patients for problem gambling; (paper in preparation). This qualitative paper reports the experiences and conclusions of the nine GPs who participated in the practice review activity and screening process.

The practice review activity involved training GPs to provide brief interventions for gambling problems: completion of a brief baseline questionnaire about problem gambling: attending a focus group to discuss the process and findings: and the completion of an outcome questionnaire. Much of the brief intervention training involved reading and applying strategies from a manual produced and provided by a problem gambling treatment specialist.[11]

Following this, problem gambling patients were identified by the Eight Gambling Screen,[12-13] and those affected by the gambling of another through the Concerned Others Gambling Screen (COGS).[14] GPs, at their discretion, provided a brief intervention to those identified patients. Interventions included the offer of feedback on the screening results, referral to a specialist treatment service, support, and addressing co-existing issues that may impact upon the gambling behaviour.

After approximately one month of screening, GPs discussed the process at a focus group and provided written comments, received feedback from the investigators (who were trained problem gambling treatment specialists), then continued screening and intervention process for approximately a further month. Final feedback was obtained from the GPs by written input and by individual key informant meetings with two of the investigators.

Results

Nine GPs, all practising in Auckland and belonging to the same Primary Health Organisation, elected to participate in the practice review activity. All received the manual, attended brief training and provided feedback at the focus group and key informant meetings.

Initial focus group feedback

Almost half of the GPs had not previously provided help for problem gambling patients, which may have been attributable to a range of factors, including the lack of overt symptoms. Several GPs indicated their surprise at the number of patients that were identified as affected by problem gambling. Some comments were as follows:

'I had not considered that, apart from one patient I knew about, that there were likely to be any problem gamblers within my practice.'

Key Points

- Patients were receptive to enquiries about gambling.
- Some GP surprise at numbers of patients with gambling problems.
- Most GPs felt their interventions were effective.
- Most GPs referred to specialist problem gambling treatment services.
- GPs intended to adopt strategies to identify problem gambling.
- GPs would prefer more training.
- The largest GP barrier was time required to address gambling issues including co-existing depression.

'I'm surprised at the level of problem gambling and family levels of affect.'

'I have never in 10 years previously seen anyone who has said they have a gambling problem.'

'My perception had been that very few Asian women gamble and I'm surprised in terms of there being a fairly even spread in terms of gender.'

However other GPs had expected problem gambling to be an issue for their patients:

'I'm not particularly surprised at the results; I expected quite a number of problem gamblers in this area (South Auckland).'

and...

'I'm not particularly surprised at the results, and I've taken the opportunity to discuss it with patients who were positive on the screens.'

All GPs responded that they found their patients receptive to their enquiries about their gambling, and most GPs felt they were able to help those experiencing gambling problems. Mostly GPs responded that they regarded themselves as legitimate help providers and considered that their

patients saw them as appropriate help-providers for problem gambling.

Most GPs would prefer to have more skills to intervene, and the majority intended to integrate strategies to address problem gambling into their practice. There were mixed responses as to whether patients with gambling problems should be referred to specialist treatment organisations, perhaps indicating responses to the problem were still being developed.

The largest barrier identified by the majority of GPs was that it was time-consuming to intervene with the identified, and patients invariably did not present for that issue. One stated:

'I was surprised by the number of depressed patients – most positives (for problem gambling) had to have a follow-up appointment.'

Another who was uncertain whether to incorporate problem gambling intervention strategies in their practice noted:

'Time (was a problem, and there was) – need to prioritise.'

Final key informant feedback

Most GPs responded that raising the issue of problem gambling with patients, and providing an intervention, had become easier over the period of the review activity. Some comments are as follows:

'I think the Pacific patients have been more willing to talk about their gambling than others.'

'Patients who were positive have not required very much in terms of information.'

'The majority of those who have been positive of the gambling screen have not considered that they have a problem and have not wanted to talk about it further. However, quite a number of patients have agreed to take away the information to read.'

This perception was less certain where the patient was a family member of a problem gambler, although half of the GPs believed interventions with family members had become easier over time.

'Those that scored positively on the family screen were less forthcoming.'

There was mixed support for the belief that patients saw enquiries about gambling as an appropriate enquiry for their GP to make:

'Patients with gambling or alcohol problems are very hard to identify and it isn't something they would want to talk with their family doctor about.'

In almost all cases, GPs believed their skills had increased in helping those affected by gambling problems, and had incorporated strategies into their practice to enquire about patients' gambling problems.

'I've offered patients the opportunity to be rung back to ask how they were progressing and if there was further help they wanted they could be connected with in respect of alcohol and smoking and am considering whether to offer this with problem gambling also.'

'I've placed a note on the patent's file to raise the issue again on the patient's return.'

'However, this is something I don't remember to do as often as I should – I need to be reminded.'

In most cases, GPs' strategies included referral of patients with gambling problems to specialist problem gambling treatment services.

'I've found those that scored positively on the gambling screen to have been quite open to discussing it further, and two agreed to seek counselling.'

Most GPs thought that identification of problem gambling issues amongst their patients was also a cue to check other issues that commonly co-existed with problem gambling.

'Many patients who would have identified as problem gamblers would have many other problems such as alcohol and other drugs.'

'I'm not surprised at the rate of depression that is showing up in the practice either.'

Most GPs believed they were instrumental in helping patients with problem gambling issues. However, it was a universally held view that providing an intervention for patients was time consuming, with some indicating that a further appointment had to be made for some patients to address both the presenting issue, and the identified gambling issues.

'I found it increased the workload for a 15 minute consultation markedly. It wasn't just a referral to specialist services.'

'The same old problem, an increasing amount to do and pressure to take less time. Frankly issues such as gambling have a hard road in the face of changing general practice. But is among the next wave of GP preventative care – perhaps improvement in the software we will use will prompt us to encompass them all.'

Conclusions

This qualitative pilot suggests that the Practice Review Activity increased the skills of the participating GPs and many had incorporated strategies into their practices to address problem gambling identified in their patients.

Despite initial surprise at the presence of gambling problems amongst their patients, and half having not dealt with gambling problems in the past, there was a perception that most patients were receptive to GPs' enquiries on the topic, although less so where the patient was a family member of a problem gambler.

The final key informant interviews and written GP comments provides evidence that the Practice Review Activity improved skills of raising the issue and providing interventions, together with checking for co-existing disorders.

Previous research[4] has called for more training for GPs to enable them to better help problem gamblers and their families. The Practice Review Activity reported here appears a successful way of improving the skills and attitudes of GPs. However the question of role legitimacy still needs further study.

The largest barrier appears to be insufficient time. This may have arisen because patients were identified with another issue (problem gambling) other than their presenting problem. In addition, depression was a common

co-existing problem. Where a longer consultation may be appropriate, or where the patient wishes the matter to be addressed 'in-house', problem gambling counsellors who could visit general practices to provide therapy would be a valuable resource and should perhaps be provided by PHOs.

The Gambling Act places responsibility on the Ministry of Health to minimise gambling-related harm, and the Ministry has identified within its strategic plan[2] that primary health care settings are important secondary intervention resources in minimising gambling-related harm. This study suggests that appropriately trained GPs would be able to provide this service.

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Competing interests

Sean Sullivan, none declared; Ross McCormick, The Goodfellow Unit (of which I am Director) has held two contracts for gambling research from the Problem Gambling Foundation in the past five years. This has involved appointing staff and teaching about problem gambling; Michael Lamont is Chair of the Mangere Community Health Trust and contracts his time to the Trust as its CEO. He also undertakes other contracting tasks with other organisations in NZ – particularly DHBs; Alison Penfold, none declared.

References

1. American Psychiatric Association. Diagnostic and statistical manal of mental disorders. 4th Edition. Washington DC: APA; 1994.
2. Ministry of Health. Preventing and minimising gambling harm: Strategic Plan 2004-2010. Wellington: Ministry of Health; 2005.
3. Sullivan S. Pathological gambling in New Zealand: the role of the GP. New Ethicals J. 2000; 3:8:11–18.
4. Sullivan S, Arroll B, Coster G, Abbott M, Adams P. Problem gamblers: do GPs want to intervene? NZMJ 2000; 113(1111): 204-7.
5. Sullivan S, Arroll B, Coster G, Abbott M. Problem gamblers: a challenge for general practitioners. NZ Family Physician 1998; 25:1:37–42.
6. Goodyear-Smith F, Arroll B, Sullivan S, Elley R, Docherty B, Janes R. Lifestyle screening: development of an acceptable multi-item general practice tool. NZMJ 2004; 117(1205) ISSN 1175-8716.
7. Potenza MN, Fiellin DA, Heninger GR, Rounsaville B, Mazure C. Gambling: an addictive behavior with health and primary care implications. J Gen Intern Med 2002; 17:721–732.
8. Unwin BK, Davis MK, De Leeuw JB. Pathologic gambling. Am Fam Physician 2000; 61:741-9.
9. Sullivan S, McCormick R, Sellman D. Increased requests for help by problem gamblers: data from a gambling crisis hotline. NZMJ 1997; 110:380-3.
10. Ministry of Health. Problem gambling intervention services in New Zealand: 2004 national statistics. Wellington: Ministry of Health; 2005.
11. Sullivan S, Penfold A, Goulding M, Cooke M. Staff manual on gambling intervention in primary health. Auckland: Abacus Counselling & Training Services Ltd; 2003.
12. Sullivan S. The GP eight gambling screen. PhD Thesis. Auckland: University of Auckland; 1999.
13. Sullivan S. A hidden curriculum: gambling and problem gambling among high school students in Auckland. Health Promotion J of Australia 2005: 16(3):201–206.
14. Sullivan S. What's up Doc? A project to assist problem gamblers and their families through their family doctor. A paper presented at the National Association of Gambling Studies Conference held at Canberra 26th-30th November 2003.

Cognitive impairment in older practising doctors

'As many as 8000 physicians in current practice are likely to have some form of cognitive impairment, and the existing medical literature provides little guidance. Only five articles on the subject have been published in the last two decades, according to the results of a study presented here at the annual scientific meeting of the American Geriatrics Society.

"Based on our own experience clinically of having cared for and evaluated physicians who either were suspected of, or turned out to have dementia, we started thinking about the problem of how you deal with this with respect to people who are actually still practicing clinical medicine," Greg A. Sachs, MD, told Medscape. Dr. Sachs is professor of medicine and chief of the Section of Geriatrics, Department of Medicine, at the University of Chicago Hospitals in Illinois. "When we went to do a formal literature review, we found that there was very little actually in print that directly addressed this."

Hyer R. Cognitive Impairment in Older Physicians May Be Widespread. Medscape Medical News. http://www.medscape.com/viewarticle/532007?src=mp (accessed 18 May 2006).