Treatmen t Seeking Among Ontario Problem Gamblers: Results of a Population Survey

Helen Suurvali, B.A.
David Hodgins, Ph.D.
Tony Toneatto, Ph.D.
John Cunningham, Ph.D.

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 level of gambling problems. 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 3% 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)

Ms. Suurvali and Dr. Cunningham are affiliated with Social, Prevention, and Health Policy Research and Dr. Toneatto is with the Clinical Research Department at the Centre for Addiction and Mental Health, 33 Russell St., Toronto, Ontario, Canada M5S 2S1 (e-mail: helensuurvali@canh.net). Dr. Hodgins is with the Department of Psychology, University of Calgary, Calgary, Alberta, Canada.
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, x^2=304.4, df=3, p<.001; for treatment not including self-help materials, x^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

<table>
<thead>
<tr>
<th>Severity</th>
<th>Access treated self-help materials (N=68)</th>
<th>Access treated only (N=28)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>CLiP lifetime ≥1</td>
<td>824</td>
<td>9</td>
</tr>
<tr>
<td>At-risk gambler</td>
<td>235</td>
<td>12</td>
</tr>
<tr>
<td>Problem gambler</td>
<td>89</td>
<td>21</td>
</tr>
<tr>
<td>Pathological gambler</td>
<td>57</td>
<td>26</td>
</tr>
</tbody>
</table>

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.
time 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 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.

**Acknowledgments and disclosures**

This study was supported by the Ontario Problem Gambling Research Centre, Guelph, Ontario. The telephone interviews in this study were conducted by staff of the Institute of Social Research, York University, Toronto, Ontario. The authors report no competing interests.

**References**


Submissions for Datapoints Column Invited

Submissions to the journal’s Datapoints column are invited. Datapoints encourages the rapid dissemination of relevant and timely findings related to clinical and policy issues in psychiatry. National data are preferred. Areas of interest include diagnosis and practice patterns, treatment modalities, treatment sites, patient characteristics, and payment sources. The analyses should be straightforward, so that the figure or figures tell the story. The text should follow the standard research format to include a brief introduction, description of the methods and data set, description of the results, and comments on the implications or meanings of the findings.

Datapoints columns, which have a one-page format, are typically 350 to 400 words of text with one or two figures. The maximum total word count—including the title, author names, affiliations, references, and acknowledgments—is 500. Because of space constraints, submissions with multiple authors are discouraged; submissions with more than four authors should include justification for additional authors.

Inquiries or submissions should be directed to column editors Amy M. Kilbourne, Ph.D., M.P.H. (amy.kilbourne@va.gov), or Tami L. Mark, Ph.D. (tami.mark@thomson.com).