FINAL REPORT

Problem Gamblers: General Practitioners' Perception of Self-Competency in Detection and Intervention.

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Executive summary

This questionnaire study was conducted with the aim of assessing whether general practitioners (GPs) believe that early intervention, as well as identification, of problem gambling falls within their role responsibility, whether GPs possess the knowledge and skills to detect problem gamblers, and whether GPs are conscious of, and willing to utilise, available referral pathways. In order to answer these questions, 155 GP practices in Tasmania were contacted and 2000 questionnaires were delivered to 72 consenting practices. In spite of dedicated efforts in following up practices, only 37 completed questionnaires from 28 practices were received and analysed. This poor response rate is a limitation of this study and hence the data should be treated with caution. GPs, rather than believing that problem gambling falls within their role responsibility, believe that gambling is not a serious problem, does not fall within conventional medicine, and is a lifestyle or moral issue under the control of the problem gambler rather than the GP. GPs are not confident of their skills in detecting problem gamblers and indeed very few of them even attempt to do so. Although at least half of the GPs indicated that they were aware of referral channels and some of them were able to name potential referral pathways, their responses to the attitude and knowledge questionnaire indicated that they were not confident in their knowledge of referral channels and practices. Very few GPs indicated that they had seen or detected a problem gambler over the previous year and very few had referred a problem gambler to one of these services in the year prior to the survey. It is clear that GPs may benefit from education regarding not only detection of problem gambling and referral pathways for problem gamblers once detected but also regarding the role of the GP in addiction and its processes.

Background

Although approximately two per cent of the Australian population can be classified as pathological gamblers, research indicates that only a small percentage of these will seek external assistance, despite serious legal, social, and financial ramifications of continued gambling (Productivity Commission, 1999). Disclosure of maladaptive gambling behaviour is typically instigated by a state of extreme crisis produced by financial difficulties, legal retribution, deterioration of mental/physical health, suicidality, and/or disintegration of familial/interpersonal bonds (Hodgins & el-Guebaly, 2000; Productivity Commission).

Of the possible available outlets for disclosure or detection of pathological gambling (for example, kin, friends, health professionals, gambling helpline, and support group), general practitioners (GPs) are in a unique position due to their recurring, long-standing contact with patients (Potenza, Fiellin, Heninger, Rounsaville, & Mazure, 2002). The Australian Medical Association's Position Statement on problem gambling (1999) instructs GPs to: (i) be aware of problem gambling and its negative impact on physical and mental health, (ii) discuss gambling during lifestyle risk assessment, and (iii) undertake psycho-social assessment when maladaptive gambling behaviour is conjectured. However, Christensen, Patsdaughter, and Babington (2001) found that although health care providers in America were conscious of problem gambling, only 30% had asked patients presenting with stress-related symptoms about a gambling problem. Similarly, Sullivan, Arroll, Coster, Abbott, and Adams (2000) reported that while 72% of surveyed New Zealand GPs indicated need for their involvement in treatment, only 53% were confident broaching the topic of gambling, 38% were aware of referral pathways, and 19% conveyed confidence in their ability to intervene. GPs reported readiness to intervene may be undermined by low rates of proactive inquiry regarding gambling problems and limited knowledge of potential referral pathways or intervention strategies.

Aims of the project

Given that there is data indicating that although GPs in New Zealand and America are conscious of problem gambling, at least to a limited extent, they are less likely to use this knowledge to act upon their awareness, there is a clear need to establish the beliefs of the Australian GP population in these matters.

The aim of this project was to assess the level of knowledge regarding problem gambling in Australian GPs. We aim to answer the following questions:

1. Do GPs believe that early intervention, as well as identification, of problem gambling falls within their role responsibility,
2. Do GPs possess the knowledge and skills to detect problem gamblers, and
3. Are GPs conscious of, and willing to utilise, available referral pathways?

Method

Participants

Participants were 37 GPs practising in the State of Tasmania, Australia. Of the 37 participants, 19 were male (1 non response) with the mean age between 45 and 49 (see Figure 1), the most common age group was between 50 and 54 (24%) and the majority of GPs' ages fell between 45 and 60.

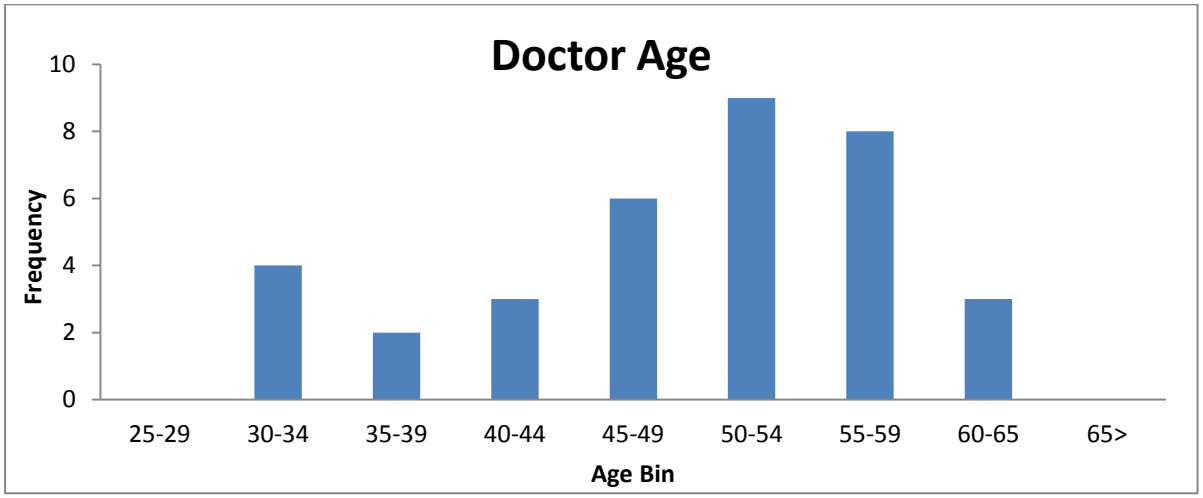

Figure 1: Respondent self-reported ages

Participation was most common from Launceston (postcode 7250: 22%) followed by Hobart (postcode 7000: 14%). Respondents had graduated with their medical degree between 1971 and 2010 with the mean graduation year being 1988 reflecting the average age of the respondents.

Materials

The questionnaire (see Appendix A) consisted of four sections. The first section, Demographics, asked participants to indicate their sex, age, professional status, and provide details regarding their personal gambling habits. In the second section participants were asked a series of open and closed questions regarding the number of patients consulted with gambling problems, typical characteristics and symptoms of problem gambling, referral processes, training in detection and intervention, and frequency of inquiry by GP of patients regarding gambling behaviour. In the third section, participants were asked to respond to 27 statements concerning gambling on a five point scale from strongly disagree (1) to strongly agree (5). The statements were developed and utilised by Sullivan et al. (2000) in their New Zealand study on GPs and their willingness to intervene in problem gambling. Several questions were revised to reflect Australian content. In the final section, participants were asked to provide any feedback or comments regarding the process of detecting and intervening in problem gambling as a GP.

Procedure

The Practice Managers of 155 operating practices in Tasmania were contacted and asked to distribute information sheets and questionnaires to GPs in their practices. Two thousand questionnaires were distributed by hand to the 72 Practice Managers who agreed to distribute the questionnaires to their GPs across the state of Tasmania. Up to six follow-up phone calls and up to three follow-up visits were made to consenting Practice Managers and this resulted in completed surveys being received from 28 practices. Completed

questionnaires were collected from the practices or mailed to the researchers in reply paid envelopes. The questionnaires were anonymous and took approximately 15 to 20 minutes to complete. The study had ethical approval from the Human Research Ethics (Tasmania) Network.

Design

This study was a questionnaire study and the data was analysed using either parametric (means and standard error), non-parametric (median and range) or frequency analyses (percentages) depending on the measures used. The attitude questionnaire was also analysed using factor analysis.

Summary of Results

Thirty seven questionnaires were returned from the 2000 questionnaires. Thus the response rate, although every effort was expended to increase the rate, at approximately two per cent was extremely poor. Table 1 shows the distribution and return of all questionnaires.

Table 1. Distribution of questionnaires and responses.

Description	Number
Operating GP practices in Tasmania contacted	155
GP practices in Tasmania agreed to participate	72
Number of practices returned completed surveys	28
Number of practices returned uncompleted surveys	46
Did not agree to participate	65
Completed surveys returned	37
Follow up survey permission forms returned	14

Demographic Questions

Respondents estimated seeing between 200 and 12,000 patients, with a mean of 3,523 (SE = 497), the most common estimate was patient numbers between 0 and 1,000 patients per year (see Figure 2); this data is skewed to the right with patient numbers median at 2,850 (see

extended results in Appendix B). Ten of the 37 respondents (27%) reported this range of patients. This result in itself warrants discussion as it is somewhat unexpected considering the time it would take to see 1000 patients in a year given a mean consultation time of approximately 16 minutes. If GPs were working a 48 week year and if they see 1000 patients in this year then this amounts to them working less than six hours per week. Therefore, caution should be used when interpreting these results as representative of GPs working in Tasmania as a whole. Given the poor overall return rate, perhaps the majority of GPs completing the survey were working part-time and perhaps these results reflect the nature of general practice in Tasmania with response rates to surveys lower for more time-poor practitioners.

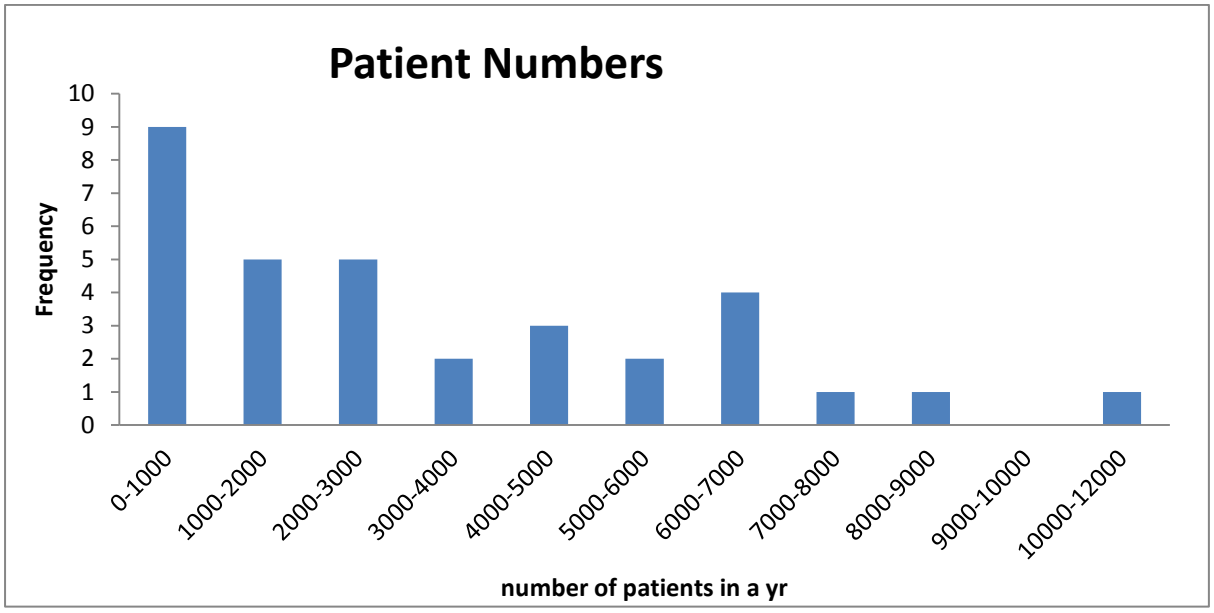

Figure 2. Respondent estimate of number of patients seen in last year.

Table 2 shows the results from questions six through eight. Respondents estimated approximately 17.2% (range 3-50%) of patients who they had seen in the past year had suffered from anxiety or depression, and on a scale from 1 to 100, GPs ranked, on average,

the likelihood of them asking these patients a question about gambling at 12.5, with only one GP rating their likelihood of asking above 50.

Table 2. Mean (standard error) number of patients in different categories seen by respondents (with percentage of total patients seen) and likelihood of asking about gambling.

Description	Responses (*n*) Total n = 37	Mean (SE)
Q 6. Number of patients with Anxiety or Depression in last year	35	577 (SE = 132)
Mean percentage of total patients seen (range)		17.2% (3-50%)
Scale of 1-100 how likely to ask Anxiety and Depression sufferers about gambling	36	12.5 (SE = 3)
Q 7. Numbers of patients with high drug or alcohol use in the last year	34	177 (SE = 40)
Mean percentage of total patients seen (range)		6.2% (0.1-50%)
Scale of 1-100 how likely to ask High drug or alcohol patients sufferers about gambling	36	18.5 (SE = 4.1)
Q 8. Number of patients with gambling difficulties in the last year	31	15 (SE = 7)
Mean percentage of total patients seen (range)		0.42% (0-2.5%)
Percentage of patients with gambling difficulties who presented with gambling as primary problem	29	16% (SE = 6)

Respondents estimated that approximately 6% of patients (range 0.1-50%) who they had seen in the last year had reported difficulties with high drug or alcohol use, and on a scale from 1 to 100, GPs ranked, on average, the likelihood of them asking these patients a question about gambling at 18.5, with only five GPs rating their likelihood of asking above 50.

One-quarter (26%) of respondents reported that they had seen no patients with gambling problems in the past year. The remainder reported seeing a median of five patients (range 1-200) during this time. On average approximately 0.42% of total patients (range 0-2.5) seen in the last year had suffered gambling difficulties. Among those who had seen

patients with gambling problems (n=29), a majority (69%) indicated that patients did not present with gambling as their primary problem.

Respondents reported a mean consultation time of 16 minutes (SE = 0.79), and a median of 15 minutes (range 5-30). As can be seen in Table 3, a large majority of respondents (97%) reported that they discussed lifestyle issues (not typically about gambling) with patients even though they were not the presenting issue. The majority of respondents (78%) indicated they would ask more questions if they had longer consultation times, however, 84% of respondents indicated that longer consultation times are not realistic.

Table 3. Percentage of respondents responses regarding lifestyle questions, consultation times, and gambling.

Description	Percentage
Q10. I do ask/discuss lifestyle issues with patients when these are not the presenting issue (Yes)	97%
Q11. I would ask more questions if I had longer consultations (Yes)	78%
Q12. Are longer consultation times realistic (No)	84%

Gambling among GPs

All respondents indicated they had not gambled in the last week and only 19% indicated they had gambled in the last year. Of those respondents who reported gambling in the last year (n=7), the average amount spent in the past year on gambling was $38.50 (SE=15.5) with a median of $20 (range $5 to $124). No GP surveyed reported spending money in an electronic gaming machine (Questions 14a, 15a and 16a).

Gambling among patients

Over one-half of respondents (57%) reported that no patients had consulted with them regarding a gambling problem in the past year. Among those who did have patients consult with them during this time (n=15), the median number of patients was two (range 1-40). Two

GPs reported that single patients had consulted with them regarding a gambling problem in the past week.

When gambling problems were considered regardless of the reason for consultation (Question B2), two-fifths (39%) of respondents indicated they had not seen any patients with a gambling problem in the past year. Among those who did report seeing patients with a gambling problem (regardless of reason for consultation), the median number of patients was five (range 1-100). Four respondents reported seeing patients with a gambling problem in the past week regardless of the reason for consultation, with a median of 1 patient (range 1-5) patients seen during this time.

When considering the number of patients who disclosed a gambling problem in the last year (Question B3), two-fifths (40%) indicated that no patients had disclosed a gambling problem during this time. Among those who reported that patients had disclosed a gambling problem (n=23), the median number of patients was two (range 1-50). Two GPs reported that single patients a disclosed a gambling problem to them in the last week.

When respondents were asked to consider how many patients they had specifically asked about gambling problems in the past year (Question B4), almost one-half (47%) indicated that they had not asked any patients about gambling. Among those who had asked patients about gambling (n=17), the median number of patients was 10 (1-100). Five respondents indicated that they had asked patients about gambling problems in the past week, with a median of 1 patient (range 1-5) reported during this time.

Characteristics of problem gamblers

Respondents were asked to indicate the typical demographic characteristics of problem gamblers whom they had contact with in the last year. Those who responded (n=20)

indicated that the problem gamblers were typically female (50%) or less commonly male (35%). One-half (50%) indicated that typical ages ranged from 40-60 years and one-fifth (20%) indicated that ages ranged from 20-40 years (20%). Problem gamblers were reported to be either retired (30%), employed on a full-time or part-time basis (30%) or unemployed (15%).

Problem gamblers were reported to present with a range of physical and psychological symptoms conditions. Among those who commented on physical symptoms (n=17), the most common symptoms included insomnia (29%), heart palpitations/chest pain (24%), pain/tension (18%), and variable/multiple symptoms (18%). In addition, one-fifth (18%) indicated that they did not typically present with physical symptoms. Among those who commented on psychological symptoms (n=24), the most common symptoms were anxiety (79%), depression (45%), stress (13%) and relationship problems (17%).

Referral services and training

Over one-half of respondents (56%) indicated that they are aware of possible referral channels for problem gambling. Among those who were aware of possible channels (n=20), the most commonly known channels were: psychologist (55%), gamblers anonymous (35%) gambling hotline/helpline (35%) gambling support services/DHHS (15%), and local counselling services such as Breakeven and Relationships Australia (15%).

In an average year, three-fifths (60%) of respondents reported that they had not referred any patients to referral services, one-fifth (20%) had referred single patients, and the remainder (20%) had referred 2 or more patients. No problem gamblers were referred by respondents to a further service in the week prior to the survey.

Participants were asked for suggestions to improve the availability of referral services and communication between referral services and GPs. Among those who commented (n=21), over three-fifths (67%) indicated that increased awareness or knowledge of referral

services was required, with some suggestions (n=6) pertaining to the need for hardcopy resources (flow charts, contact details, posters, handouts, referral guidelines), with others (n=4) suggesting that face-to-face contact with referral services (e.g., clinical presentations, education sessions) would be appropriate.

Three of the 37 respondents (8%) indicated they had taken part in training in problem gambling and interventions, with two of these three having completed formal training online or through a problem gambling awareness program. Among those who commented (n=31) on the interventions they favoured to combat addictions (e.g., alcohol, gambling, drug), the most common response was psychological therapy (61%), followed by support group (26%), counselling (23%), and pharmacotherapy (13%).

Among those who responded (n=34) a large majority (88%) indicated that they would utilise complementary resources about gambling identification and intervention if they were available. In addition over three-fifths (69%) of those who responded (n=35) indicated that they would be likely to attend if complimentary professional training in identification and intervention for problem gambling was provided. Respondents (n=18) indicated they would like such training to provide skills/information on detection/identification (40%), interventions (35%) and services (35%).

Patient Assessment

When asked how often they include questions about gambling as part of a patient's life history one-half of the sample responded 'never' (51%) or 'sometimes' (49%). When asked whether they (n=36) would ask "Have you ever had an issue with your gambling?" when patients presenting with anxiety, depression, or experiencing difficulties with high drug or alcohol use, 69% (n=25) indicated they would.

When asked whether it would be realistic for receptionists to give patients a lifestyle survey including the question "Have you ever had an issue with your gambling?", over one-half (56%) of respondents indicated this would be realistic. When asked about the form that referral to gambling information should take, the most common responses were, a computer printout (40%), followed by factsheet (34%) and pamphlet (31%). Novel suggestions provided by respondents included a website and mobile phone application.

Participants were asked to give qualitative feedback regarding the detection of and intervention in patient's problem gambling from a GPs perspective. These comments are contained in full in Appendix B, Table B15, and include suggestions regarding use of a lifestyle questionnaire and encouraging greater public awareness.

Attitude Questionnaire

The final section of the survey was a 29 question questionnaire where respondents rated on a five-point scale whether they strongly disagreed (1) or strongly agreed (5) with statements dealing with perceptions of their vocation (see Table 4). Strongest disagreements were to the statements "Doctors have no mandate to intervene in lifestyle practices" (M = 1.38), "Doctors should seldom refer patients to non-medical professionals" (M = 1.59) and "Undergraduate medical students can't be taught interpersonal skills" (M = 1.62). The statements which were most strongly agreed to included "When it comes to their own gambling behaviour, doctors are the same as other people" (M = 4.24), "Doctors can influence their patients' health and lifestyle practices" (M = 4.24), "It is part of my job to help people who can't cope" (M = 4.11) and "I do not have the training to identify and help people who have difficulties with their gambling" (M = 3.43).

Table 4. Means and Standard Errors for responses to the Attitude Questionnaire

Question	Mean	SE
Undergraduate medical students can't be taught interpersonal skills.	1.62	0.14
Doctors have no mandate to intervene in lifestyle practices.	1.38	0.08
Doctors can influence their patients' health and lifestyle practices.	4.24	0.19
Public health education has only worked with well educated people.	2.22	0.19
Doctors should seldom refer patients to non-medical professionals.	1.59	0.15
It is part of my job to help people who can't cope.	4.11	0.17
I could be at risk of losing my patient if I inquired about their gambling.	1.95	0.16
Doctors lose control of their patients' management when they refer them to self help organisations.	1.78	0.14
Doctors have little role in supporting a family where a member has a gambling problem.	1.86	0.19
Patients expect a prescription to result from their visit to the doctor.	2.62	0.18
Doctors should make time to inquire about their patients' gambling.	3.22	0.19
I have some difficulties seeing problem gambling as within a doctor's mandate.	2.51	0.20
Doctors have little part to play in the treatment of gambling problems.	2.42	0.18
It is more acceptable for doctors who gamble regularly to ask patients about their gambling.	1.76	0.17
Viewing problem gambling at any stage as an addiction is hard for me to accept.	1.76	0.14
People with problems around gambling are often weak and self-indulgent.	2.00	0.15
People could alter their gambling behaviour if they really want to.	2.95	0.19
Fear of incapacity or death is the only real motivator for behaviour change.	1.68	0.12
The only viable goal for problem gamblers is abstinence.	3.27	0.21
When it comes to their own gambling behaviour, doctors are the same as other people.	4.24	0.13
Problem gambling is a much less serious problem than alcohol use or illicit drug taking.	2.11	0.15
I don't feel confident asking patients about their gambling.	2.76	0.20
I do not have the training to identify and help people who have difficulties with their gambling.	3.43	0.23
I would find it difficult to know what to do next if a patient told me they had concerns about their gambling.	2.51	0.21
I wouldn't know where to refer patients with gambling problems.	2.73	0.20
I know how to find out whether patients are thinking about changing their gambling habits.	2.92	0.18
I feel it is intrusive to ask patients about their gambling.	2.54	0.19
I am satisfied with the availability of referral services for problem gambling.	2.61	0.15
I am satisfied with the level of communication from referral agencies post-referral.	2.45	0.16

NOTE: 1 = strongly disagree, 5 = strongly agree

In order to summarise these results more efficiently, a factor analysis was carried out on the items from the Attitude Questionnaire. The number of participants is insufficient for this analysis to be considered sound, but the communalities were high despite the small sample size, suggesting that the outcome may be indicative of the results that would be obtained with a more satisfactory sample. A scree plot indicated that a four-factor solution was optimal, and so four factors were extracted using principle components, which were then subject to an orthogonal (varimax) rotation. The loadings for items on the four factors are shown in Table 5.

The first factor identified (F1) appears to tap in to the notion that gambling is not a serious problem and also a lack of confidence regarding where to find and utilise information regarding referral processes for gambling. The second factor (F2) revolves around the notion that gambling is a moral or lifestyle issue which individuals could control if they wished to. The third factor (F3) relates to ideas of disciplinary integrity of medicine, a lack of enthusiasm for utilising processes that are outside of conventional medicine, and a belief that gambling is not relevant to medical practices. Finally the fourth factor (F4) relates to social aspects of practice, a reluctance to engage in discussion about gambling with patients, and a belief that abstinence is the only solution (thus linking gambling to other addictions). Correlations were calculated between these four factors and demographic information such as age, number of patients seen with gambling problems, etc. The only significant correlations (r = .35) was between Factor 4 and how much the GP had spent on gambling in the last year indicating that GPs who spent more money on gambling themselves were more likely to show a reluctance to talk to patients about their gambling.

Table 5. Item loadings for each of the factors extracted by the Factor Analysis

Item	F1	F2	F3	F4
Problem gambling is a much less serious problem than alcohol use or illicit drug taking.	.738			
I wouldn't know where to refer patients with gambling problems.	.736			
I could be at risk of losing my patient if I inquired about their gambling.	.683			
Undergraduate medical students can't be taught interpersonal skills.	.602			
I do not have the training to identify and help people who have difficulties with their gambling.	.595			
I would find it difficult to know what to do next if a patient told me they had concerns about their gambling.	.569			
I know how to find out whether patients are thinking about changing their gambling habits.	-.646			
It is part of my job to help people who can't cope.	-.478			
It is more acceptable for doctors who gamble regularly to ask patients about their gambling.		.835		
People with problems around gambling are often weak and self-indulgent.		.687		
Viewing problem gambling at any stage as an addiction is hard for me to accept.		.682		
I am satisfied with the availability of referral services for problem gambling.		.655		
Doctors have no mandate to intervene in lifestyle practices.		.654		
People could alter their gambling behaviour if they really want to.		.611		
I am satisfied with the level of communication from referral agencies post-referral.		.311		
Doctors should seldom refer patients to non-medical professionals.			.704	
I have some difficulties seeing problem gambling as within a doctor's mandate.			.686	
Public health education has only worked with well-educated people.			.658	
Doctors have little part to play in the treatment of gambling problems.			.589	
Doctors have little role in supporting a family where a member has a gambling problem.			.533	
Doctors lose control of their patients' management when they refer them to self-help organisations.			.371	
Doctors can influence their patients' health and lifestyle practices.			-.730	
I don't feel confident asking patients about their gambling.				.717
Patients expect a prescription to result from their visit to the doctor.				.701
The only viable goal for problem gamblers is abstinence.				.609
When it comes to their own gambling behaviour, doctors are the same as other people.				.557
I feel it is intrusive to ask patients about their gambling.				.541
Doctors should make time to inquire about their patients' gambling.				.501
Fear of incapacity or death is the only real motivator for behaviour change.				.417

Discussion

Of the 72 practices who agreed to participate in this survey only 28 practices returned completed surveys, with 37 respondents completing the survey hence the results should be treated with caution as they cannot be seen as representative of the GP population in Tasmania. Among those GPs who did complete the survey, one-quarter had seen no patients with gambling problems in the last year and the remainder had seen 5 patients on average (range 1-200). A majority of those who had seen patients with a gambling problem (69%) reported that the patients had not presented with gambling as their primary problem. In addition, almost one-half of respondents (47%) indicated that they had not asked any patients about gambling in the past year. Thus while gambling problems represent a serious lifestyle issue which contributes to physical and psychological health problems, it is likely that gambling problems often go undetected by GPs.

When patients consulted GPs regarding Anxiety or Depression, GPs were unlikely to ask about gambling. However GPs surveyed clearly indicated that common psychological manifestations of problem gambling include anxiety and depression. Indeed when the presenting issue is not related to lifestyle issues, 97% of respondents indicated they would still ask about or discuss lifestyle issues with their patients. However, almost one-half of GPs had not asked any patients about gambling in the past year. This suggests that gambling, within the framework of lifestyle issues, is not generally a high priority for GPs, despite respondents believing that they can influence their patients' health and lifestyle practices and strongly disagreeing that they have no mandate to intervene in lifestyle practices. It is possible that they are more likely to ask about lifestyle issues that relate to physical health (e.g., smoking, drinking, exercise and diet), rather than those which might relate to gambling (e.g., social relationships, financial issues). The time taken for any single consultation seems to preclude GPs asking more lifestyle questions.

None of the respondents surveyed indicated they had gambled in the last week and only 19% in the past year, however GPs agreed that they are the same as other people in regard to gambling behaviour. Although the numbers of respondents are small in this survey, these two results are at odds with each other as, given the rate of gambling behaviour in Australia (two in every three adult Australians participated in some form of gambling during 2012), it would be expected that at least some of the respondents would have gambled in the previous week. The average adult in Australia spends $1,641 on gambling per year; the average reported by the respondents is lower at $38.50 per year. It is possible that the sample is again, not representative of GPs or that GPs do have a lower prevalence of gambling compared to the general population. Further research would be required to examine this.

Although over one-quarter (26%) of the respondents reported that they had seen no patients with a gambling problem in the last year, others reported seeing an average of five patients a year with a gambling problem, equating to approximately 0.42 of total patients (range 0-2.5%). The estimate of total numbers of problem gamblers is relatively consistent (albeit slightly lower) compared to the Productivity Commission report from 2010 (Productivity Commission, 2010) in which it was reported that between 0.5 to 1% of the Australian population suffering significantly from gambling with a further 1.4% to 2.1% at moderate risk. However, given that many GPs did not report seeing any patients with a gambling problem, it is likely that there is considerable variability among GPs in terms of their willingness or ability to detect and assess gambling problems. Furthermore, many patients do not present with gambling as a primary issue. For example, the number of patients who ‘specifically consulted’ GPs or ‘specifically disclosed’ a gambling problem was substantially lower, with larger proportions of GPs reporting no patients within the past year and among those who did, an average of two patients was reported in the past year. It is also clear that patients do not typically present with gambling as a primary issue, thus it is likely

that GPs can play an important role in detecting and approaching the issue of gambling with their patients.

Just over one-half of GPs surveyed were aware of referral channels for problem gambling and the most commonly known were gamblers anonymous, hotlines, and helplines, with a number of GPs indicating it would be appropriate to refer patients to psychologists. Three-fifths (60%) of respondents had not referred any patients to a referral service, 20% had referred a single patient and 20% had referred 2 or more patients. However, among those who reported that at least one patient had consulted with them regarding a gambling problem in the past year, 73% reported referring at least one patient to further services during this time. Many GPs are apparently aware of a lack of knowledge of appropriate referral pathways as they clearly indicated that to improve the availability of referral services and communication channels between GPs and referral services; increasing awareness of services, in house training and referral guidelines/flowcharts could be beneficial. The fact that only three out of 37 respondents indicated they had completed any training in problem gambling and interventions and only two of these were formal training, suggests that a greater need for structured training either in house or with online tutorials may be required. The majority of GPs surveyed indicated they would use information about problem gambling identification and interventions if it were available. However, when asked whether they would attend complementary training only 69% indicated they would be likely to attend. Only half of the GPs responded to a question on what would constitute beneficial training material; detection identification, interventions and information on services being suggested. Respondents indicated they would like such training to provide skills/information on detection, identification, interventions, and services.

Using a five-point Likert scale (from strongly disagree to strongly agree) GPs were asked to respond to questions such as: “I do not have the training to identify and help people

who have difficulties with their gambling" (GPs strongly agreed with this particular statement). Respondents clearly also believe that lifestyle practices are within their mandate, as when asked "Doctors have no mandate to intervene in lifestyle practices" and when asked "I have some difficulties seeing problem gambling as within a doctor's mandate" they strongly disagreed. These questions specifically address the first aim of this survey ("Do GPs believe that early intervention, as well as identification, of problem gambling falls within their role responsibility"). Clearly there is strong evidence to suggest that GPs do believe that their job involves discussing and influencing the lifestyle practices of their patients, while at the same time they seem to acknowledge there are impediments to their role in early intervention and identification. Perhaps this reflects the perceived importance of problem gambling within the framework of the health system overall; problem gambling is potentially not an issue which has been addressed in practitioner training given the age demographic of the majority of these respondents and the relative recent research on problem gambling. However, GPs surveyed acknowledge the potential for harm in problem gambling by disagreeing with the statement "Problem gambling is a much less serious problem than alcohol use or illicit drug taking".

The question of whether GPs possess the knowledge and skills to detect problem gamblers is difficult to assess. As previously mentioned respondents strongly agreed with the statement "I do not have the training to identify and help people who have difficulties with their gambling", however respondents have indicated they are able to identify potential physiological manifestations of problem gambling. Even though it was the most common psychological manifestation reported only a small number of respondents indicated anxiety as a psychological symptom. Anxiety is often strongly associated with financial difficulty, which in turn has the potential to be highly influenced by problem gambling. Respondents surveyed were aware that anxiety may be a strong indicator of problem gambling, and stated

that they have the skills to identify and diagnose anxiety. Based on the logic in this example, GPs seem to believe that they have both the training and the skills to identify potential problem gamblers in spite of the general theme of responses to questions regarding psychological and physiological manifestations of gambling being no-response or don't know.

Addressing the question of whether GPs are conscious of, and willing to utilise, available referral pathways there are several key pieces of evidence. Firstly, as previously mentioned just over half the GPs surveyed indicated that they were even aware of referral channels for problem gambling and over one third of GPs were not (or did not name them. Indeed, the response to the question "I wouldn't know where to refer patients with gambling problems" being effectively neither agreed to nor disagreed with supports the suggestion that many GPs are not aware of referral possibilities. This suggests that there is a significant lack of knowledge of the availability of support services for problem gambling, despite GPs being able to list a number of suitable support programs and services for addiction. Although many respondents were unaware of available services, GPs on the whole indicated that they would have no problem referring patients to referral services.

The questionnaire designed to investigate knowledge and attitudes of GPs with regard to gambling indicated some commonalities with the responses to the earlier questions in the survey and as indicated above, some contradictions. Although this data should be treated cautiously given the small number of participants in the study, the four factors identified by the factor analysis conducted on this data indicate that GPs are not confident about their knowledge regarding referral processes for gambling, that gambling is a lifestyle issue under the control of the patient, that gambling is not relevant to medical practice and that GPs are reluctant to discuss gambling with their patients.

Conclusions

The response rate for this survey was very low in spite of extensive efforts to improve it. The low response rate is, in itself, interesting. It is possible that GPs who completed the form thought they knew about gambling (although the survey results do not support this view) and those who did not complete the survey, in spite of opportunity, did not do so because they were aware that they were not knowledgeable about gambling.

Recommendation: To provide incentives for GPs to complete surveys, research participation could be embedded in the Professional Development Environment. Alternatively GPs could be paid an honorarium to complete surveys

Overall, GPs in the main do not see many people with gambling difficulties and although they do ask lifestyle questions of patients, they do not generally include questions about gambling in this process arguing that short consultations times preclude this. In general, GPs are not confident about their knowledge regarding referral processes for gambling. In addition, they believe that gambling is a lifestyle issue under the control of the patient and that gambling is not relevant to medical practice. Possibly as a result of these beliefs and in particular their lack of confidence in the area, GPs are reluctant to discuss gambling with their patients. Although the numbers of respondents are small, the factor analysis is reliable and valid and suggests that some GPs have inappropriate and incorrect views on the relationship between gambling and addiction.

Recommendation: To increase knowledge concerning all aspects of gambling behaviour, a training course led by an effective trainer who is well versed in contemporary evidence based knowledge concerning all aspects of gambling could be conducted. Pre-test and post-test measures could be taken to assess any increase in knowledge and any change in attitude following the course.

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Appendix A Questionnaire

Gambling Questionnaire

Please answer the following questions as accurately as you can. We understand that for many of these questions you will only be able to provide an approximate answer, this is fine.

A. Demographic Questions

1. I am male / female *(please circle)*
2. Please circle the range (in years) within which your age falls:
   25-29 30-34 35-39 40-44 45-49 50-54 55-59 60-65 65>
3. What is the postcode of your professional practice? _____
4. In what year did you graduate from medical school? _____
5. In the past year, can you estimate how many patients you saw? _____
6. In the past year, can you estimate how many patients were having difficulties with anxiety or depression? ___
   a. For these patients, on a scale from 0 to 100, how likely are you to ask if they have difficulties with gambling? _____
7. In the past year, can you estimate how many patients were having difficulties with high drug or alcohol use? _
   a. For these patients, on a scale from 0 to 100, how likely are you to ask if they have difficulties with gambling? _____
8. In the past year, can you estimate how many patients you saw were having difficulties with gambling? _____
   a. For these patients, please estimate what percentage presented with gambling difficulties as their primary problem_____
9. How long is your average consultation? _____minutes_____
10. Do you ask/discuss lifestyle issues with your patients when these are not the presenting issue? Yes / No
11. Would you ask more questions if you had a longer consultation time? Yes / No
12. Is a longer consultation time realistic? Yes / No
13. Have you gambled in the last week? Yes / No
    If yes:
    a. How much have you spent on gambling in the last week (dollars):_____
14. Have you gambled in the last year? Yes / No
    If yes:
    a. Approximately how much have you spent on gambling in the last year (dollars):_____
15. Have you used Electronic Gaming Machines in the last week? Yes / No
    If yes:
    a. How much have you spent on EGMs in the last week (dollars):_____
16. Have you used Electronic Gaming Machines in the last year? Yes / No
    If yes:
    a. Approximately how much have you spent on EGMs in the last year (dollars):_____

B. Gambling Survey

1. How many patients in the last year/week have consulted you regarding their gambling problem? **Year? _____Week?_____**
2. How many patients in the last year/week would you have you seen who have a gambling problem (regardless of their reason for consulting you)? **Year? _____Week? _____**
3. In a year/week, on average how many patients disclose a gambling problem? **Year? _____ Week? _____**
4. In a year/week, on average how many patients would you ask if they have a gambling problem? **Year? _____ Week? _____**
5. What are the typical demographic characteristics of problem gambler with whom you have had contact within the last year? (e.g., gender, age, occupation):_____
   _____
   _____
6. What physical symptoms do these problem gamblers typically present with:
   _____
   _____
   _____
7. What psychological symptoms do these problem gamblers typically present with:
   _____
   _____
   _____
8. Are you aware of the possible channels of referral for problem gambling? Yes / No
   If yes:
   a. Please list two or three of these channels:
      _____
      _____
9. In an average year/week, how many problem gamblers would you refer to such services? **Year? _____ Week? _____**
10. Have you referred a problem gambler on to further services in the last week? Yes / No
    If yes:
    a. To which services did you refer such patients:
       _____
       _____
11. What do you believe could be implemented to improve the availability of referral services and/or the communication between GP and referral services?
    _____
    _____
    _____
12. Have you received any training in problem gambling identification and/or intervention? Yes / No
    If yes:
    a. How many courses have you completed?_____
    Please answer the following questions with respect to the last training course you completed.
    b. What was the training? _____
    c. Who was the training conducted by? _____
    d. How long ago was the training (*in years; please detail in months if training was within the last year*)? _____

e. What motivated you to undertake the training?
_____

f. What skills/information did the training provide you with?
_____
_____

13. With addictions (e.g., alcohol, gambling, drug), what interventions do you favour?
_____
_____
_____
_____

14. If complimentary resources about problem gambling identification and intervention were available, would you be likely to use them? Yes / No
15. If complimentary professional training in identification and intervention for problem gambling was provided, would you be likely to attend? Yes / No
If yes:
    a. What skills/information would you like the training to provide?
    _____
    _____
16. How often do you include questions about gambling as part of a patient's life assessment *(please circle)*? Always Mostly Sometimes Never
17. The screening question "Have you ever had an issue with your gambling?" is suggested for use in primary care practice. With regard to this question:
    a. Would you ask the question for patients presenting with anxiety, depression, or experiencing difficulties with high drug or alcohol use? Yes / No
    b. The suggestion has been made that receptionists give patients a "lifestyle survey" including the gambling question while they are in the waiting room. In your opinion is this realistic? Yes / No
    c. What form should referral to gambling information (either self-help or Gamblers Help counselling services) take? *(please circle the most relevant one*)
        i. Computer prompt
        ii. Computer printout,
        iii. Pamphlet
        iv. Fact sheet
        v. Other (please describe) _____

C. Please now rank the following statements on a scale from strongly disagree to strongly agree by ticking the appropriate box.

		Strongly Disagree				*Strongly Agree*
1.	Undergraduate medical students can't be taught interpersonal skills.	☐	☐	☐	☐	☐
2.	Doctors have no mandate to intervene in lifestyle practices.	☐	☐	☐	☐	☐
3.	Doctors can influence their patients' health and lifestyle practices.	☐	☐	☐	☐	☐
4.	Public health education has only worked with well educated people.	☐	☐	☐	☐	☐
5.	Doctors should seldom refer patients to non-medical professionals.	☐	☐	☐	☐	☐
6.	It is part of my job to help people who can't cope.	☐	☐	☐	☐	☐
7.	I could be at risk of losing my patient if I inquired about their gambling.	☐	☐	☐	☐	☐
8.	Doctors lose control of their patients' management when they refer them to self help organisations.	☐	☐	☐	☐	☐
9.	Doctors have little role in supporting a family where a member has a gambling problem.	☐	☐	☐	☐	☐
10.	Patients expect a prescription to result from their visit to the doctor.	☐	☐	☐	☐	☐
11.	Doctors should make time to inquire about their patients' gambling.	☐	☐	☐	☐	☐
12.	I have some difficulties seeing problem gambling as within a doctor's mandate.	☐	☐	☐	☐	☐
13.	Doctors have little part to play in the treatment of gambling problems.	☐	☐	☐	☐	☐
14.	It is more acceptable for doctors who gamble regularly to ask patients about their gambling.	☐	☐	☐	☐	☐
15.	Viewing problem gambling at any stage as an addiction is hard for me to accept.	☐	☐	☐	☐	☐
16.	People with problems around gambling are often weak and self-indulgent.	☐	☐	☐	☐	☐
17.	People could alter their gambling behaviour if they really want to.	☐	☐	☐	☐	☐
18.	Fear of incapacity or death is the only real motivator for behaviour change.	☐	☐	☐	☐	☐
19.	The only viable goal for problem gamblers is abstinence.	☐	☐	☐	☐	☐

		Strongly Disagree				*Strongly Agree*
20.	When it comes to their own gambling behaviour, doctors are the same as other people.	☐	☐	☐	☐	☐
21.	Problem gambling is a much less serious problem than alcohol use or illicit drug taking.	☐	☐	☐	☐	☐
22.	I don't feel confident asking patients about their gambling.	☐	☐	☐	☐	☐
23.	I do not have the training to identify and help people who have difficulties with their gambling.	☐	☐	☐	☐	☐
24.	I would find it difficult to know what to do next if a patient told me they had concerns about their gambling.	☐	☐	☐	☐	☐
25.	I wouldn't know where to refer patients with gambling problems.	☐	☐	☐	☐	☐
26.	I know how to find out whether patients are thinking about changing their gambling habits.	☐	☐	☐	☐	☐
27.	I feel it is intrusive to ask patients about their gambling.	☐	☐	☐	☐	☐
28.	I am satisfied with the availability of referral services for problem gambling.	☐	☐	☐	☐	☐
27.	I am satisfied with the level of communication from referral agencies post-referral.	☐	☐	☐	☐	☐

D. Do you have any feedback regarding the detection of and intervention in patient's problem gambling from a medical practitioner's perspective? (e.g., what do you think are the best ways to increase identification of gambling? What do you think would be the best intervention for gambling problems?)

The Gambling Support Program would like to know if you would be amenable to a follow-up survey on rates of intervention and estimates of outcomes for patients you have spoken to about their gambling difficulties. If you would like to be involved in this please provide contact details below:

Name: _____

Contact phone number: _____

Contact email address: _____

Please detach this page and return it separately directly to the Gambling Support Service at

The Coordinator

Gambling Support Program

Disability and Community Services

Department of Health and Human Services

PO Box 125

Hobart, Tasmania, 7000

Appendix B. Full Results

Table B1. Summary of Survey Distribution and Collection

Description	Number
operating GP practices in Tasmania were contacted	155
GP practices in Tasmania agreed to participate	72
number of practices returned completed surveys	28
number of practices returned uncompleted surveys	46
Did not agree to participate	65
Completed surveys returned	37
Follow up survey permission forms returned	12

- Of these 155, we are not calling anymore to 18 practices due to:
    - the practice is closed
    - the practice manager has not returning our calls on 3+ occasions (11 practices)
    - emailed information and the practice manager told us they will call us if any GPs want to participate (said don't call them)
    - practice said 'maybe' to participation but not to contact them until after March
    - practices affected by bushfires

Summary of Descriptive statistics

SECTION A

- 39 participants, 19 males and 19 females, 1 non response. Age range (Figure 1). Mean age between 45-49. Mode and median 50-54.

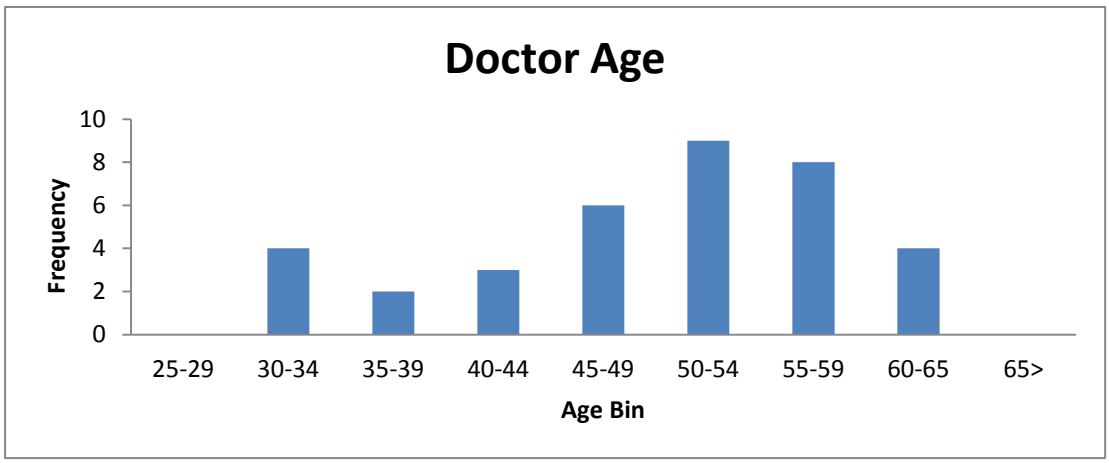

Figure B1: Doctor age range

Table B2. Participant demographics

Description	Number
Most common postcode	7250 (8)
Second most common postcode	7000 (5)
Mean graduation year	1988
Median graduation year	1986
Mode graduation year	1980
Minimum graduation year	1971
Max graduation year	2010
Mean patients last year (estimate)	3523 (SE = 497)
Median patients last year (estimate)	2850
Mode patients last year (estimate)	1000
Min patients last year (estimate)	200
Max patients last year (estimate)	12000

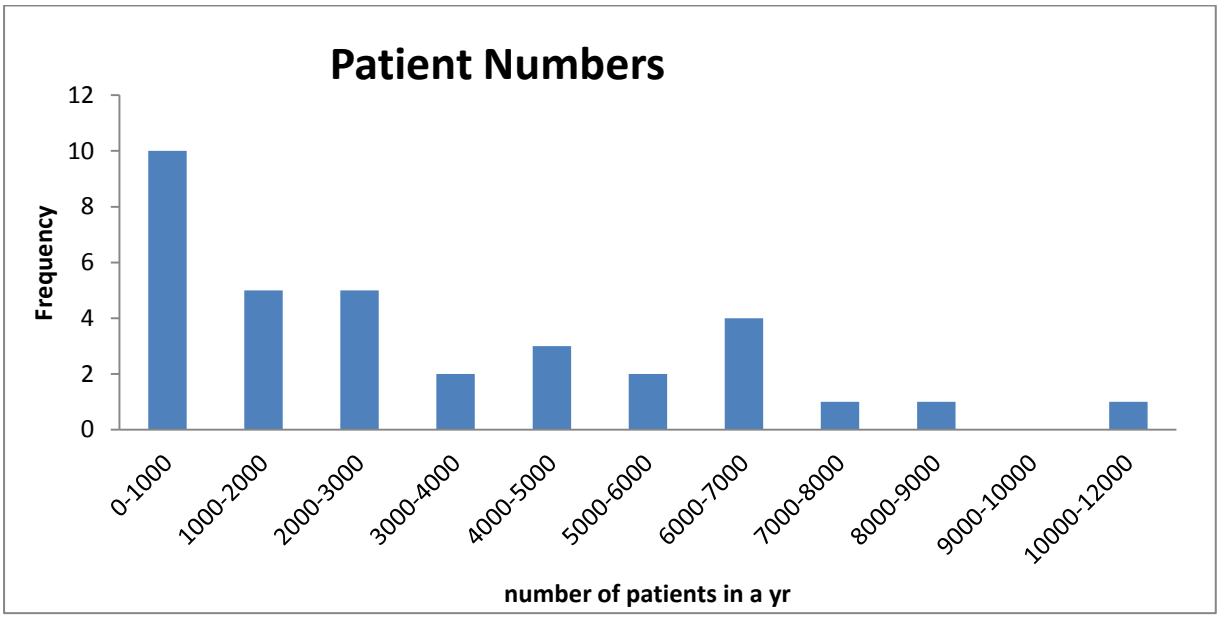

Figure B2: medical practitioner patient numbers

Table B3. Responses to Questions A6 - A16.

Description	Number
Estimate numbers of Anxiety or depression patient in last year	577 (SE = 132)
Above number is as a percentage of total patients seen	16.38%
Scale of 1-100 how likely to ask Anxiety and Depression sufferers about gambling	12.5 (SE = 3)
Estimate numbers of High drug or alcohol patients	177 (SE = 40)
Above number is as a percentage of total patients seen	5.02%
Scale of 1-100 how likely to ask High drug or alcohol patients sufferers about gambling	18.5 (SE = 4.1)
In the Past yr how many patients having difficulties with gambling	15 (SE = 7)
Above number is as a percentage of total patients seen	.43%
Percentage of patients with gambling difficulties who presented with gambling as their primary problem	16 (SE = 6)
Description	**Number**
Mean of how long is your average consultation (minutes)	16 (SE = .79)
Median of how long is your average consultation (minutes)	15
Mode of how long is your average consultation (minutes)	15
Description	**Number**
I do ask/discuss lifestyle issues with your patients when these are not the presenting issue	97%
I would ask more question if you had longer consultations	78%
Are longer consultation times realistic (No)	84%
Have you gambled in the last week/year (No)	100/81%
Description	**Number**
Mean Approx amount spent on gambling last year	$38.5 (SE = 15.5)
Median Approx amount spent on gambling last year	$20
Mode Approx amount spent on gambling last year	$20
Number of responses to this question	7
Have you used Electronic Gaming Machines in the last week/year (No) 35 responses	100%/100%

SECTION B

Table B4. Means and Standard errors for Questions B1-B4

Question	Mean	SE	% of average patients seen	Max	Min
QB1Year: How many patients in the last year have consulted you regarding their gambling problem? (n=35)	3	1.3	0.09	40	0
QB1 Week: (n=31)	0.06	0.04		1	0
QB2 Year: How many patients in the last year would you have seen who have a gambling problem (regardless of their reason for consulting you? (n=31)	8.35	3.5	0.22	100	0
QB2 Week: (n=27)	0.29	0.19		5	50
QB3 Year: On average how many patients disclose a gambling problem? (n=35)	3.88	1.16	0.11	50	0
QB3 Week: (n=28)	0.07	0.05		1	0
QB4 Year: On average, how many patients would you ask if they have a gambling problem? (n=32)	11.4	3.9	0.31	100	0
QB4 Week: (n=28)	0.35	0.2		5	0

Table B5. Demographics of Problem Gamblers as indicated by Respondents and Respondents responses.

female	10
male	7
20-30	2
30-40	2
40-50	6
50-60	4
retired	6
non-responses	15
employed	2
unemployed	3
ptime	1

All Responses
Female, 70's, retired
Male 40's
Female, working, clerical, age 30-45
Female, middle aged, unemployed (just become)
female 40-60's
Male, middle aged, 40-60yrs, middle class working, none professional
Female, early thirties, single parent, p/t employment
Male 50's
Female, middle aged and older, middle class
>60yrs, female, pensioner
40-70yo
female, 25-35; male 25-45 (unemployed)
Female, 67, retired farmer, anxiety, chronic pain
any type
I am not aware that I directly have any pts with gambling problems. I see families affected.
usually male
mid-old age; pensioner
Male, 18-30years of age
Female, over 60, pensioner
substance use, financial concerns, relationship issues, middle aged, male, wealthy or pensioner extremes

What physical symptoms do these problem gamblers typically present with (number mentioned, see Table B6):

Table B6. Physical symptoms of problem gamblers and individual responses

non-responses	7
Anxiety	4
Insomnia	3
Tremors	1
Nausea	1
Palpitations	1
Tension n shoulders	1
Alcohol abuse	2
Chronic pain	1
Reflux	1
Depression	1
Chest tightness or pain	2
Back/shoulder pain	2
N/A or ? or don’t know	9
nil	4
variable or multiple	3

All Responses
Variable
Relationship difficulties
Anxiety, Insomnia, tremors
Anxiety type symptoms- insomnia, nausea, palpitations
alcohol misuse, chronic pain
reflux, depression
varied
n/a no problem gambler identified
?
Depression; Chest tightness
symptoms of anxiety
stress related
back pain, shoulder pain
multiple medical problems, often poorly controlled
n/a
often nil
Don't know
stress and anxiety
Don't know
mostly none
Chest pain, tiredness
increased heart rate and blood pressure, insomnia

- The psychological symptoms which problem gamblers typically present with (see Table B7).

Table B7. Psychological Problems seen in problem gamblers.

Anxiety	19
Depression	11
guilt	1
insomnia/sleep	3
variable or multiple	2
other (shame, guilt, alcohol, marriage breakdown)	7
non -responses	5
n/a or don't know	7

- Are you aware of the possible channels for referral: 59% yes
- List two or three of these channels (see Table B8):

Table B8. Channels for referral mentioned.

gamblers anon or hotline or helpline	14
psychologist	12
relationships australia	1
breakeven	1
drug and alcohol service	1
DHSS	2
tasmanian website	1
non response	14
% of responders B8 who didn't name 2 or more services	37%

- In an average year/week how many problem gamblers would you refer to such services: mean = 2 (SE = 0.85)/mean = 0.05 (SE = 0.05), responses 30/22. As a percentage of average patient seen in the year 0.05%.
- Have you referred a problem gambler on to further services in the last week: 100% No, 34 responses.

- What do you believe could be implemented to improve the availability of referral services and/or the communication between GP and referral services (see Table B9):

Table B9. Methods to improve availability of referral services.

Actual responses:
Have not used so?
Simple flow chart for desk top
unsure
A knowledge of what services are available
list of recourses with phone numbers and contact person
Big health warning signs on poker machines, lotto outlets, on-line gambling sites, direction to services available
increased awareness of services available
One A4 sheet of tips, signs of gambling, referral services
nil
internet referrals
Awareness of the referral services
knowledge about it
Someone coming to talk to us at the practice
Service providers could come to surgery and educate us on what they have to offer
Clinical presentation to practice
Better resourcing for the services involved
Information about services available
more advertisements and handouts
Posters in the lobby, and more routine enquiries
nil
More awareness resources
Better recognition by me
I believe to prevent the problem is the best approach
There should be good communication between GP and referral services
Set referral guidelines

- 3 doctors reported training in problem gambling and intervention (see Table B10).

Table B10. Training and intervention undertaken

What was the training	Who was the training conducted by	How long ago was the training	What motivated you to undertake the training	What skills/information did the training provide you with
attended meetings				
Online educ. Activity	Online	3 years	No previous training	Early recognition; education of the patients; mgmt options available
In house service	Breakeven	1 year	Relevant to our practice	Detection of gambling

- With addictions (e.g., alcohol, gambling, drug), what interventions do you favour (number mentioned, see Table B11):

Table B11. Favoured interventions and all responses

Intervention	Number Mentioned
follow-up	3
support group	8
psychological therapy	15
counselling	7
CBT	4
pharmacotherapy	4
non response	5

All Responses
Regular follow up, it takes time; support network, e.g. AA; specific psychological therapies; A team effort; If possible, active involvement of family/loved ones
Psychological therapy/support
Personal Intervention/counselling & support + drug & alcohol
Counselling
As with all addictions this depends entirely on the voluntary involvement of the patient. We basically depend on the patient to SEEK help.
1. Address underlying problem (if any), 2. harm minimisation/safe withdrawal, 3. motivational interviewing/CBT, 4. Referral to appropriate service if not making headway
Depends on the patient- psychological intervention of CBT; medications; psycho social support/groups

Psychology; family/social supports; drug & alcohol counselling/services- public, holyoake; harm minimisation strategies; aa +na
Specialised support where available; private psychologist if not suitable
Psychological first, then medication then output followup or psychological ongoing
Total abstinence; Withdrawal management; confinement as needed.
Alcohol & drug- referral to alcohol & drug services; Gambling- referral to psychologist and support services
DASC; Psychologist
Counselling
Ref to specialised centres
Counselling- drug & alcohol service; Pharmacotherapy
Better efforts to prevent the problems; government policy on gambling is a disgrace and surveys such as this should be directed at politicians, not GPs.
Psychological treatment
Referral drug & alcohol service
alcohol, drug
Discussion with patient & family & referral to services they will accept. Financial counselling. For family, limit setting on bank accounts, etc. Narcotics Anonymous, Gamblers Anonymous.
inpatient intensive therapy
counselling; inpatient treatment; treat related psychological illness
Information; Referral to services as available & acceptable to pt; medication/therapy for underlying psych problems if present
Nil specific; deal with underlying issues, i.e. depression and treat; drug and alcohol services
Specialiset program. Primary care linked to these.
Psychological counselling; Medication as appropriate
Alcohol & drug service program; CBT- psychological
for alcohol and drug- drug and alcohol unit
psychological (e.g., CBT); medication
referral to psychologist, psychiatrist, AA
withdrawal, substitution,CBT,abstinance

- If complimentary resources about problem gambling identification and intervention were available, would you be likely to use them: yes 88%, 34 responses
- If complimentary professional training in identification and intervention for problem gambling was provided, would you be likely to attend: yes 69%, 35 responses
- What skills/information would you like the training to provide (number mentioned see Table B12):

Table B12. Skills/Information liked

Skill/Information	Number who mentioned this
detection identification etc	8
interventions	7
basic counselling	2
prevalence	2
information on services	7
non-response	17

- How often do you include questions about gambling as part of a patient's life assessment: 19 – never, 18 – sometimes, 0 – mostly, 0 – always.
- "Have you ever had an issue with your gambling?" is suggested for use in primary care practice. Would you ask the question for patients presenting with anxiety, depression, or experiencing difficulties with high drug or alcohol use: yes 69%, 36 responses.
- The suggestion has been made that receptionists give patients a "lifestyle survey" including the gambling question while they are in the waiting room. In your opinion is this realistic? 56% yes, 36 responses
- What form should referral to gambling information (either self-help or Gamblers Help counseling services) take (see Table B13):

Table B13. Suggestions for referral to gambling information

Response		Freq
1	computer prompt	9
2	computer printout	14
3	pamphlet	11
4	fact sheet	12
5	other describe	3

Other suggestions: referral letter, website, phone number, mobile phone app

Table B14. Responses to Attitude Questions				
Question	**Mean**	**SE**	**Med**	**Mod**
Undergraduate medical students can't be taught interpersonal skills.	1.62	0.14	1	1
Doctors have no mandate to intervene in lifestyle practices.	1.38	0.08	1	1
Doctors can influence their patients' health and lifestyle practices.	4.24	0.19	5	5
Public health education has only worked with well educated people.	2.22	0.19	2	1
Doctors should seldom refer patients to non-medical professionals.	1.59	0.15	1	1
It is part of my job to help people who can't cope.	4.11	0.17	4	5
I could be at risk of losing my patient if I inquired about their gambling.	1.95	0.16	2	1
Doctors lose control of their patients' management when they refer them to self help organisations.	1.78	0.14	2	1
Doctors have little role in supporting a family where a member has a gambling problem.	1.86	0.19	1	1
Patients expect a prescription to result from their visit to the doctor.	2.62	0.18	3	3
Doctors should make time to inquire about their patients' gambling.	3.22	0.19	3	4
I have some difficulties seeing problem gambling as within a doctor's mandate.	2.51	0.20	2	2
Doctors have little part to play in the treatment of gambling problems.	2.42	0.18	2	2
It is more acceptable for doctors who gamble regularly to ask patients about their gambling.	1.76	0.17	1	1
Viewing problem gambling at any stage as an addiction is hard for me to accept.	1.76	0.14	2	1
People with problems around gambling are often weak and self-indulgent.	2.00	0.15	2	1
People could alter their gambling behaviour if they really want to.	2.95	0.19	3	3
Fear of incapacity or death is the only real motivator for behaviour change.	1.68	0.12	2	1
The only viable goal for problem gamblers is abstinence.	3.27	0.21	3	3
When it comes to their own gambling behaviour, doctors are the same as other people.	4.24	0.13	4	5
Problem gambling is a much less serious problem than alcohol use or illicit drug taking.	2.11	0.15	2	2
I don't feel confident asking patients about their gambling.	2.76	0.20	3	4
I do not have the training to identify and help people who have difficulties with their gambling.	3.43	0.23	4	4

I would find it difficult to know what to do next if a patient told me they had concerns about their gambling.	2.51	0.21	2	2
I wouldn't know where to refer patients with gambling problems.	2.73	0.20	2	2
I know how to find out whether patients are thinking about changing their gambling habits.	2.92	0.18	3	3
I feel it is intrusive to ask patients about their gambling.	2.54	0.19	3	3
I am satisfied with the availability of referral services for problem gambling.	2.61	0.15	3	3
I am satisfied with the level of communication from referral agencies post-referral.	2.45	0.16	3	3

1 = Strongly Disagree → 5 = Strongly Agree

Table B15. Responses regarding detection of an intervention in patient's problem gambling
Do you have any feedback regarding the detection of and intervention in patient's problem gambling from a medical practitioner's perspective? (e.g., what do you think are the best ways to increase identification of gambling? What do you think would be the best intervention for gambling problems?)
It's an awareness issue; I just don't think about it!
I think media campaigns are the way to go. GP's have a minimal role in detection. Maybe can help a little with intervention. It's a social issue needing a sociological solution.
Detection and intervention at really not the GP's domain. Occasionally I have patient brought by a parent or spouse for help but NEVER approached cirectly by the patient- Like smoking it is up to the patient to seek help.
Should be part of normal practice. Public health approach- 1. i.e. Make it more difficult to gamble, 2. address underlying issues, 3. promotion of service available with good evidence base
Not sure- people are even better at hiding a gambling problem than a drinking problem I feel.
Find it hard to translate statistics into practice, have never had anyone confess to having a gambling problem when I have asked (yet see lots of credit card debt, lots of financial stress, lots of drugs and alcohol abuse.)
Information sheet as said before. Clear, free referral services. Website for patients.
It is usually part of a bigger set of problems but the financial incapacity causes more problems in physical and mental health.
no comment
I don't have a big clinical load- not a typical GP
Including it as part of lifestyle questionnaire
no
Institute a lifestyle questionnaire for patient to bring in to consultation. Ask as a standard history item & specifically in presentations of mood disorders.
GPs deal with a variety of public health issues daily. Gambling is one of them. The public health response to gambling is poor.
Screening as we do for alcohol & tobacco. I could use skills for identifying & treating gambling problems. My husband and I were both raised to see even school raffles as unacceptable gambling. I feel fine with alcohol/tobacco treatment.
It comes up in conversation with family but if it comes up in conversation with the patient then the setting is usually as part of a wider mental health problem.
I suspect the problem is well hidden. I can recall just a few cases over a twenty- five year period in general practice- and I was told of the gambling by a spouse! I recognise that people presenting with anxiety and depression need to be asked about gambling.
Reduce the Gambling venues and or make it illegal. Prevention better than treatment
Lifestyle screening questionnaire