Assessment – including Tools

ASSESSMENT

This Kit has been funded by the Gamblers Rehabilitation Fund and developed by the South Australian Government in conjunction with General Practice SA, Professor Alun C Jackson (University of Melbourne), Associate Professor Paul Delfabbro (University of Adelaide) with assistance from the Gambling Help Services, the gambling industry and the Independent Gambling Authority.

Overview

Ask

General practice is well placed to screen for problem gambling – but the process needs to be short and effective. Traditional problem gambling screening and assessment tools are lengthy and often complicated. To be effective, a tool needs to have a high psychometric performance in terms of high sensitivity and more importantly, high specificity in order that time is not wasted inappropriately referring patients or clients for assessment. Recently, the Problem Gambling Research and Treatment Centre, a joint initiative of the University of Melbourne, Monash University and the Victorian Government, developed a single item screening tool perfect for a busy general practice (Thomas et al., 2008).

When consulting with 'at risk' patients or clients ask a simple screening question:

Have you ever had an issue with your gambling?

Or

Has anyone in your family ever had an issue with gambling?

If the patient or client answers yes to the screening question…

Assess

If the patient or client answers 'yes' to the screening question, general practice should undertake an assessment or refer for a more thorough assessment by an appropriately trained specialist practitioner in problem gambling. If the preference is to assess the patient within the practice setting a General Practitioner, Practice Nurse or Mental Health Clinician could administer one of several simple assessment tools, such as the Canadian Problem Gambling Index OR the patient or client could complete a self-assessment such as the 'Eight Gambling Screen'. Both tools are included in the following pages.

Reference

Thomas, SA, Piterman, L, & Jackson, AC, (2008), 'What do GPs need to know about problem gambling and what should they do about it?', *Medical Journal of Australia.*189, 3, 135-6.

Assessment

Written for general practice by Professor Alun C Jackson, 2009

Introduction

Earlier in the history of problem gambling diagnosis and research, the South Oaks Gambling Screen was the dominant measurement tool. The SOGS consists of 26 items of which 20 are actually scored. However, in recent years the Canadian Problem Gambling Inventory has replaced the SOGS as the tool most widely chosen for use in gambling research studies and in clinical settings. The CPGI involves a lengthy and comprehensive collection of information but most researchers now use a subset of the tool in the form of a nine-item index known as the Problem Gambling Severity Index. The CPGI categorizes respondents into four groups: non-problem; low risk; moderate risk and problem gambling groups. The CPGI has been shown to have good construct validity and reliability in psychometric testing.

While the DSM-IV "measure" of problem gambling has also been used widely in both gambling research and in clinical practice, actually DSM is not really a measurement tool at all. It is a set of diagnostic criteria. However, some researchers use the set of 10 criteria developed by the American Psychiatric Association for the diagnosis and classification of problem gambling as if it were a measure. In order to achieve a positive diagnosis of problem gambling under DSM, the patient being assessed must score positively on at least 5 of the 10 criteria.

The DSM gambling criteria are used by clinicians to assist their diagnosis of problem gambling whereas tools such as the CPGI and SOGS are self-report measures. Although they are used virtually interchangeably in discussions of the measurement of problem gambling, these tools actually reflect very different measurement philosophies and practices.

A brief assessment measure developed for general practice is the Eight Gambling Screen-Early Intervention Health Test. This can be given to clients as a self-completion test.

Eight Gambling Screen
Early Intervention Gambling Health Test

1. **Sometimes I've felt depressed or anxious after a session of gambling**

☐ yes, that's true ☐ no, I haven't

2. **Sometimes I've felt guilty about the way I gamble**

☐ yes, that's so ☐ no, that isn't so

3. **When I think about it, gambling has sometimes caused me problems**

☐ yes, that's so ☐ no, that isn't so

4. **Sometimes I've found it better not to tell others, especially my family, about the amount of time or money I spend gambling**

☐ yes, that's true ☐ no, I haven't

5. **I often find that when I stop gambling I've run out of money**

☐ yes, that's so ☐ no, that isn't so

6. **Often I get the urge to return to gambling to win back losses from a past session**

☐ yes, that's so ☐ no, that isn't so

7. **Yes, I have received criticism about my gambling in the past**

☐ yes, that's true ☐ no, I haven't

8. **Yes, I have tried to win money to pay debts**

☐ yes, that's true ☐ no, I haven't

If you answer **YES** to **4** or more questions gambling may be causing you problems in your life.

For an online version of this Tool – go to http://www.acts.co.nz/Eight_Screen.php

Reference

Sullivan, S (1999), *The GP eight gambling screen,* PhD thesis, University of Auckland.

Adult assessment tools

Since its development (Lesieur et al., 1987), the South Oaks Gambling Screen (SOGS) has been used extensively in both population prevalence studies and in clinical measurement. Schaffer, Hall and Vander Bilt (1997), for example, in their review of pathological gambling prevalence studies, noted that the SOGS had been used in over half of the 152 studies identified, as the measure of pathological gambling.

The SOGS has been reviewed extensively (Productivity Commission, 1999; Stinchfield, 2002) and some concern has been expressed about its use as a population prevalence measure of problem (or pathological) gamblers, mainly because it was initially developed as a clinical tool to identify probable pathological gamblers. The SOGS demonstrated good reliability and validity, and high correlation with the DSM–III-R criteria for pathological gambling (r=.94) (not surprisingly though, because the SOGS was based on the DSM-III-R, and the SOGS was able to accurately classify Gamblers Anonymous members (98.1 per cent), university students (95.3 per cent) and hospital employees (99.3 per cent).

Taken out of the clinical context, there is concern that the SOGS may yield a high false positive score in population studies. Concern has also been expressed that excessive weight is given to items concerned with borrowing money, with nearly half of the 20 equally weighted items dealing with sources of funding gambling.

Both SOGS and DSM–IV combine items relating to the characteristics of gambling, such as ‘chasing losses’, and items relating to the consequences of gambling, such as ‘missing important social engagements’. It has been suggested (Thomas et al., 2003) that the SOGS may not be sensitive to the social and material contexts of the player, including culturally diverse contexts, and may be better used as a screen prior to validation of problem gambling status by application of DSM–IV or clinical interview, as appropriate.

Compared with the SOGS, the Canadian Problem Gambling Index (CPGI) is more theory-based, designed specifically for community studies, and is better able to distinguish between sub-types of problem gamblers in general population surveys.

In the development of the Canadian Problem Gambling Index, Ferris and Wynne (2001; 2001) took nine scored items from a variety of sources - SOGS, DSM–IV, expert opinion—that were the strongest predictors of problem gambling (validity) and that showed stability in test/re-test (reliability) to construct a Problem Gambling Severity Index. The PGSI includes two domains: problem gambling behaviours, with 5 scored items, and adverse consequences, with 4 scored items. These dimensions, with their associated variables, indicators and Index items are detailed in Figure 1.

Adult assessment tools (cont.)

Figure 1: PGSI scored items by category

Dimension	Variables	Indicators	PGSI scored items
Problem gambling behaviour	Loss of control	Bet more than could afford	1. How often have you bet more than you could really afford to lose?
	Motivation	Increase wagers	2. How often have you needed to gamble with larger amounts of money to get the same feeling of excitement?
	Chasing	Return to win back losses	3. How often have you gone back another day to try to win back the money you lost?
	Borrowing	Borrow money or sold anything	4. How often have you borrowed money or sold anything to get money to gamble?
	Problem recognition	Felt problem	5. How often have you felt that you might have a problem with gambling?
Adverse consequences	Personal consequences	Criticism	6. How often have people criticised your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?
		Feelings of guilt	7. How often have you felt guilty about the way you gamble or what happens when you gamble?
		Negative health effects	8. How often has your gambling caused you any health problems, including stress or anxiety?
	Social consequences	Financial problems	9. How often has your gambling caused any financial problems for you or your household?

The responses are 'never' scored 0; 'sometimes' scored 1; 'most of the time' scored 2; and 'almost always' scored 3. This results in a score of between 0 and 27. Unlike the dichotomous classification of the SOGS, there are four classification categories in the PGSI: 0 = non-problem gambler, as distinct from a non-gambler; 1-2 = a low risk gambler; 3-7 = a moderate risk gambler; with 8+ = a problem gambler.

To date, the CPGI has been used in a Canada-wide gambling survey and in the provinces of Manitoba in 2001 and in 2006, Ontario in 2001 and in 2005, Saskatchewan, Alberta, British Columbia in 2002 and in 2007, New Brunswick, Newfoundland and Labrador, Nova Scotia, and Prince Edward Island (see Table 1 for details of these Canadian studies). It has also been used in the Queensland Household Gambling Surveys of 2001, 2003/4 and 2007, and in a number of other states and Territories including Victoria in 2003 and in 2007, Northern Territory and South Australia in 2005, New South Wales in 2006, and Tasmania in 2007.

In the Gamblers Anonymous GA20, a range of questions cover attitudes and feelings (for example, 'Have you ever felt remorse after gambling?'), gambling behaviours (for example, 'Did you ever gamble until your last dollar was gone?', 'Have you ever gambled to escape worry or trouble?') and consequences (for example, 'Did you ever lose time from work due to gambling?').

Adolescent assessment tools

Two assessment tools based on the adult versions discussed above - the SOGS-RA and the Diagnostic Statistical Manual-IV-Multiple-Response-Adapted for Juveniles - have been specifically adapted or developed for adolescent gambling research and intervention and are discussed briefly below.

The SOGS-RA is a revised version of SOGS developed in order to more accurately assess adolescent gambling problems. It is a 16-item scale (although only 12 items are scored) that assesses gambling behaviours and gambling related problems during the past 12 months. SOGS-RA scaled items assess negative behaviours and feelings as a result of gambling involvement. The items include lying about gambling, gambling more than planned, conflict with family and friends, and borrowing/stealing to gamble in the last 12 months.

In keeping with a risk continuum framework, three levels of severity are identified: no problem gambling, at-risk gambling and problem gambling. No problem gambling is a SOGS-RA score of 0–1. At-risk gambling is a SOGS-RA total score 2–3. Problem gambling is defined as a SOGS-RA score of 4 or more. Adding information on gambling activity to these scores (Poulin, 2002) problem gambling consists of a SOGS-RA score of 2 or more combined with weekly gambling or daily gambling, regardless of the SOGS-RA score. The internal consistency reliability of the SOGS-RA was found to be .80 (Winters et al., 1993).

Reviews of the SOGS-RA (Wiebe et al., 2000; Rossen, 2001; O'Neil et al., 2003) have identified a number of issues with it:

- Because the rate and severity of gambling among females is low, the psychometric properties could not be determined for females in the original testing.
- Items do not appear to equally contribute to the total score. If some items are better indicators of problem gambling, it is possible that these items should be more heavily weighed.
- One study Ladoucer et al., 2000) found, in using the SOGS-RA with 9 to 11 year old children, that they did not understand over one quarter of the items, although it should be noted that the scale was never intended for use with children of this age. This finding on lack of understanding, however, has also been found with year 9 to 11 students.
- There is a lack of attention to preoccupation with gambling, when clinical experience has shown (Deverensky et al., 2000) that preoccupation should be in any gambling screen, from their clinical experience.

The DSM-IV-J (Fisher, 2000) is a 12-item screen for measuring 'pathological' gambling during adolescence modelled after the DSM-IV criteria for diagnosis of adult 'pathological' gambling. The DSM-IV-J internal consistency reliability was reported to be .78. Each endorsed item is given a score of 1, with a total score of 4 or greater being the scoring criteria for severe gambling problems. An individual who receives a score between 1 and 3 has some gambling-related problems and a score of 0 has no gambling-related problems. The weaknesses of this screen are that it has not fully validated and has not been used extensively or in large scale samples.

Derevensky and Gupta, (Deverensky et al, 2000) in comparing the DSM-IV-J, the SOGS-RA and the GA20 questions with year 12 and 13 adolescents, found that the DSM-IV-J was the most stringent gambling screen, while the GA20 was the least conservative, in classifying more adolescents as having higher levels of problematic behaviour, than the other two screens.

One point worth noting from the comparative study is that the majority of adolescent gamblers with some problems and probable pathological gamblers, regardless of screening instrument used consistently underestimated the severity of their own problems.

The Canadian Problem Gambling Index
(Ferris et al., 2001)

In the last 12 months how often have you [or have for item 7]?

1. Bet more than you could really afford to lose?
2. Needed to gamble with larger amounts of money to get the same feeling of excitement?
3. Gone back another day to try and win back the money you lost?
4. Borrowed money or sold anything to get money to gamble?
5. Felt that you might have a problem with gambling?
6. Felt that gambling has caused you health problems, including stress and anxiety?
7. People criticized your betting or told you that you have a gambling problem, whether or not you thought it was true?
8. Felt your gambling has caused financial problems for you or your household?
9. Felt guilty about the way you gamble or what happens when you gamble?

Scoring:
0 = Never, 1 = Sometimes, 2 = Most of the time, 3 = Almost always.

Scores of 8 or more are deemed to indicate problem gambling.

Reference
Ferris, J., & Wynne, H J. (2001), *the Canadian Problem Gambling Index*, Ottawa: Canadian Centre on Substance Abuse.

References

Derevensky, JL and Gupta, R (2000), 'Prevalence estimates of adolescent gambling: a comparison of the SOGS-RA, DSM-IV-J and the GA20 questions', *Journal of Gambling Studies,* vol. 16, no. 2–3, pp. 227–51.

Ferris, J and Wynne, H (2001), *The Canadian problem gambling index: user manual,* Report to the Canadian Inter-Provincial Task Force on Problem Gambling.

Ferris, J and Wynne, H (2001), *The Canadian problem gambling index final report,* Report to the Canadian Inter-Provincial Task Force on Problem Gambling.

Fisher, S (2000), 'Developing the DSM-IV criteria to identify adolescent problem gambling in non-clinical populations', *Journal of Gambling Studies,* vol. 16, no. 2–3, pp. 253–73.

Ladoucer, R., Bouchard, C, Rheaume, N, Jaques, C, Ferland, F, Leblond J (2000), 'Is the SOGS an accurate measure of pathological gambling among children, adolescents and adults?', *Journal of Gambling Studies,* vol. 16, no. 1, pp. 1–21.

Lesieur, HR and Blume, SB (1987), The South Oaks Gambling Screen (SOGS): a new instrument for the identification of pathological gambling: *American Journal of Psychiatry,* vol. 144, no. 9, pp. 1184–8.

O'Neil, M, Whetton, S and Duerrwald, K (2003), *Measurement of prevalence of youth gambling in Australia: report on review of literature, final report to department of family and community services,* South Australian Centre for Economic Studies, Adelaide.

Poulin, C (2002), 'An assessment of the validity and reliability of the SOGS–RA', *Journal of Gambling Studies,* vol. 18, no. 1, pp. 67–93.

Productivity Commission (1999), 'Australia's gambling industries',www.pc.gov.au/ inquiry/gambling/finalreport/index.html.

Rossen, F (2001), *Youth gambling: a critical review of the public health literature,* University of Auckland.

Schaffer, HJ, Hall, MN and Vander Bilt, J (1997), *Estimating the prevalence of disordered gambling behaviour in the United States and Canada: a meta-analysis,* Harvard Medical School, Division of Addictions Boston.

Stinchfield, R (2002), 'Reliability, validity, and classification accuracy of the South Oaks Gambling Screen (SOGS)', *Addictive Behaviours*, vol. 27, no. 1, pp. 1–19.

Thomas, SA, Jackson, AC and Blaszczynski, A (2003), *Measuring problem gambling–evaluation of the Victorian gambling screen,* Gambling Research Panel, Melbourne.

Wiebe, JMD, Cox, BJ and Mehmel, BG (2000), 'The south oaks gambling screen revised for adolescents (SOGS-RA): further psychometric findings from a community sample', *Journal of Gambling Studies,* vol. 16, no. 2–3, pp. 275–88.

Winters, KC, Stinchfield, R and Fulkerson, J (1993), 'Toward the development of adolescent gambling problem severity scale', *Journal of Gambling Studies,* vol. 9, pp. 371–86.