
Executive Summary

Overview and major conclusions

The Ministerial Council on Gambling has nominated seven national research priorities for gambling research. The National Gambling Research Program Working Party oversees the research agenda. This report has been prepared in response to the first of the seven national research priorities for gambling research: *National definitions of problem gambling and consistent data collection*.

The project involved two major tasks:

- A literature review of definitions of problem gambling and gambling-related harm and gambling screens and measurement instruments; and
- Obtaining feedback on the material developed in the literature review.

The literature review comprises Chapters 2 to 7 of this report. In order to obtain comments in a semi-structured form, the literature review was widely circulated with a “Call for Comments” on particular questions. The “Call for Comments” is reprinted in this report following the Executive Summary. Feedback on the material developed in the literature review and in response to the “Call for Comments” is summarised in Chapter 8. Our conclusions with respect to the elements stakeholders would prefer to see in a national definition of problem gambling and their views with respect to gambling screens and instruments are presented in Chapter 9.

On the basis of the feedback that we received — the majority of which suggested the definition should contain reference to both gambling behaviours and to harms — we recommend that the following definition of problem gambling be adopted as the national definition:

“Problem gambling is characterised by difficulties in limiting money and/or time spent on gambling which leads to adverse consequences for the gambler, others, or for the community.”

Reference to “difficulties in limiting money and/or time spent on gambling” implies a continuum of gambling behaviours from those who have no difficulty (including non-gamblers) to those who have extreme difficulty so that no direct reference to a continuum need be incorporated into the definition. Our view is that the proposed definition is shorter and sharper and therefore has more impact (without being any less useful) than a definition that incorporates reference to a continuum.

The following table describes the relevance of the proposed national definition to the principal foci of stakeholders’ gambling-related work. It also sets out - where necessary - the shortcomings - of the definition from the perspectives of some groups of stakeholders.

Our view is that it will be impossible to find a definition that will be acceptable to all stakeholders, particularly in the light of many Australian stakeholders resistance to a medical or pathological approach to problem gambling. Nonetheless, many stakeholders are of the view that there should be a national definition of problem gambling.

Implications of the national definition to different stakeholders

Stakeholder	Principal focus of gambling-related work	Appropriate Measure	Relevance of national definition
Psychological Researchers	<ul style="list-style-type: none"> • Differentiation of problem from problem gamblers • To obtain adequate score variability for analyses • Focus on causes of gambling and behaviour 	SOGS, VGS, DSM-IV	<ul style="list-style-type: none"> • Behavioural element is most important • The focus is on the causes of excessive gambling as indicated by expenditure patterns and its causes whether behavioural, cognitive or physiological
Social workers/ Counsellors	<ul style="list-style-type: none"> • Identifying problem gamblers • Monitoring change due to interventions • Community education 	SOGS, VGS, CPGI	<ul style="list-style-type: none"> • Initial interest in the harms requiring immediate attention • Secondary need to monitor changes in behaviour over time • Educate community about links between gambling behaviour and adverse consequences
Clinical Psychologists	<ul style="list-style-type: none"> • Identify problem gamblers • Identify problematic behaviours, cognitions and situations • Monitor change due to interventions 	SOGS, VGS, CPGI Gambling Urges	<ul style="list-style-type: none"> • Interest in the behavioural component of definition, i.e., the causes of excessive behaviour
Psychiatrists/ Medical practitioners	<ul style="list-style-type: none"> • Diagnosis of underlying pathology • Require confirmation that pathology is absent or present 	DSM-IV	<ul style="list-style-type: none"> • Behavioural and harm element of definition only symptomatic of underlying problem • Definition only underscores the need for screening prior to formal diagnosis
Sociologists	<ul style="list-style-type: none"> • Identify social causes of problem gambling • Identify broader community impacts • Cultural and social meaning and function of gambling • Understand group behaviour and environmental experiences 	Attitudinal surveys Qualitative methods Observational methods	<ul style="list-style-type: none"> • Focus on individual behaviour in definition may not capture broader social influences • Need to supplement standard psychometric measures with studies of social environment, developmental experiences, function of gambling within social groups

Stakeholder	Principal focus of gambling-related work	Appropriate Measure	Relevance of national definition
Geographers	<ul style="list-style-type: none"> • Identify spatial distribution of harm • Relationship between behaviour and gambling opportunities 	SOGS, CPGI, VGS	<ul style="list-style-type: none"> • Both harm and behavioural element are important
Regulators	<ul style="list-style-type: none"> • To reduce harm • Efficacy of policy and regulation of gambling products on behaviour 	CPGI, VGS, SOGS	<ul style="list-style-type: none"> • Both harm and behavioural component is important • How does regulation reduce excessive time and money spent on gambling and the associated harms?
Educators	<ul style="list-style-type: none"> • To reduce harm • To draw attention to the risks of gambling and problematic behaviours • Increase awareness 	<i>SOGS, GA-20</i> VGS CPGI	<ul style="list-style-type: none"> • Both harm and behavioural elements are important
Judiciary	<ul style="list-style-type: none"> • To identify acceptable explanations for offending • Are there grounds for mitigating sentences based on diminished capacity, impaired judgment? 	DSM-IV	<ul style="list-style-type: none"> • The definition does not imply a pathology sufficient to influence court decision-making concerning the mental state of defendants • Any measure encapsulating the definition would be considered a screening tool requiring more formal diagnostic testing
Social policy/ Government services	<ul style="list-style-type: none"> • To reduce harm • To design appropriate services to assist those who are adversely affected 	VGS	<ul style="list-style-type: none"> • The harm component of the definition is most important
Industry	<ul style="list-style-type: none"> • To identify those who appear to be gambling excessively to their detriment • Venue and product innovations to encourage responsible gambling 	SOGS VGS CPGI	<ul style="list-style-type: none"> • The behavioural element is most important
Epidemiologists	<ul style="list-style-type: none"> • To identify the prevalence of problem gambling 	CPGI	<ul style="list-style-type: none"> • The harm and behavioural elements of the definition could both be used to identify problem gamblers

A number of stakeholders suggested it might be useful to have separate definitions for problem gambling and pathological gambling. We see merit in this proposal but a definition of pathological gambling would need to be the subject of a separate research project focused on the needs of stakeholders who are required to make clinical diagnoses.

The general consensus was that there is a need for a consistent measurement tool in Australia to allow comparisons across States and Territories and across time.

The CPGI (with refinements to clarify the cut-off points) is the preferred measurement tool for population-level research. The SOGS may also need to be used to allow for comparisons with previous studies. Both the SOGS and the DSM-IV are accepted as useful tools for counselling and assessment purposes.

In the short-term, the best option is to continue to use current measures but to combine them with other instruments that capture elements for items that appear to be missing or inappropriate (e.g., for younger or older people, Indigenous persons and persons with ethnic backgrounds). Also, many existing items in current measures are not suitable because the prevalence rate of the items is either too high or too low.

In the longer-term, there are greater opportunities to refine existing measures so that they are better able to capture the critical elements of problem gambling. One possible starting point might be to develop a measure that clearly differentiates between harm and problematic behaviour in two separate subscales. That is, a person would be classified as a problem gambler if they displayed behaviours that indicated difficulties in the ability to limit time and money on gambling, and if they experience significant harms associated with their gambling. *A measure that clearly differentiates between harm and problematic behaviour in two separate subscales would be able to classify people in more than one way to identify those who were at future risk, currently at risk, or already experiencing significant problems. This would be consistent with the proposed national definition of problem gambling.*

In our view (and that of the majority of stakeholders who provided us with feedback), the inclusion of behaviour in the national definition is important because it recognises the practical realities of regulation and clinical interventions, and may also encourage a greater focus on the continuum model of gambling.

By including reference to behaviour as well as to harm in the definition of problem gambling we have suggested above, we do not wish to imply that gamblers should be seen as being to blame for their problems, or that concern with broader regulatory, policy or accessibility issues are any less important. Instead, by shifting some of the emphasis away from harm, we hope that this will encourage greater interest in research into gambling in general; in particular, research into the experiences and characteristics of those who gamble without developing harms. This may prove a very useful step towards enhancing our understanding of problem gambling.

The literature review

Defining problem gambling

Nomenclature

There are a plethora of terms used to describe ‘problem’ gambling in the literature – ‘problem’, ‘pathological’ and ‘compulsive’ being the most common - but ‘addictive’, ‘excessive’, ‘disorderly’, ‘Level 2’ and ‘Level 3’, ‘at-risk’, ‘in-transition’, ‘degenerate’ and ‘potential pathological’ are also used.

‘Problem gambling’ is frequently used, particularly in North America, to denote a level of gambling, which is at an earlier stage, or which leads to fewer problems than the later stage or more severe problems experienced or caused by those gamblers who are clinically diagnosed as ‘pathological gamblers’.

In Australia, the term ‘problem gamblers’ tends to encompass gamblers who are experiencing problems but who do not meet the diagnostic criteria and gamblers who are clinically diagnosed as problem or pathological gamblers.

Conceptualising problem gambling

Many definitions of problem gambling tend to fall into one of a number of categories: problem gambling as a medical disorder/mental health problem, as an economic problem, as lying on a continuum of gambling behaviour, expressed in terms of harm to the individual and to others, and as a social construct. However, these categories are not mutually exclusive. For example, one could look at the development of problem gambling using a continuum model and in reference to problematic behaviours. A national definition of problem gambling that meets the needs of all stakeholders in a diverse range of contexts will probably need to be referenced to both individual gambling behaviours and to harms and so may draw on several of the following conceptualisations of problem gambling.

A. Medical disorder/mental health approach

The primary definition in the medical disorder/mental health approach is the American Psychiatric Association DSM-IV (1994) definition:

“... persistent and recurrent maladaptive gambling behaviour that disrupts personal, family and vocational pursuits”

The United States National Research Council (1999, pp. 20-21) referred to widespread support in the United States and in the research literature for pathological gambling defined as:

“[a] mental disorder characterised by a continuous or periodic loss of control over gambling, a preoccupation with gambling and with obtaining money with which to gamble, irrational thinking, and a continuation of the behaviour despite adverse consequences”.

Definitions that characterise problem gambling as a medical disorder/mental health problem underpinned by diagnostic criteria:

- allow for clinical diagnosis;
 - are useful for measurement, research and replication;
 - may be useful for planning public policy; and
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- gamblers are not held responsible for their gambling problems, but are encouraged to work towards recovery once diagnosed.

Against accepting a definition based on the medical disorder/mental health approach:

- there is dispute as to whether a dichotomy exists between problem gambling and non-problem gambling,
- there is little evidence for underlying pathology;
- cultural, social and environmental factors are not taken into account;
- it does not serve the needs of those who are not diagnosed as problem gamblers and yet have gambling-related problems; and likewise,
- it does not serve the needs of service providers.

B. *Gambling and problem gambling as an economic activity*

Most gambling problems, although not all, are the result of gamblers spending beyond their means. The term most often used to define problem gambling when it is characterised as an economic activity is excessive gambling. A typical definition is Blaszczynski, Walker, Sagris and Dickerson's (1997, pp. 6-7) definition:

“Excessive gambling is used to describe a level of gambling expenditure that is considered to be higher than can be reasonably afforded relative to the individual's available disposable income and as a result produces financial strain”.

Although gambling beyond one's means may not be sufficient to define problem gambling, this aspect of problem gambling is the one that is almost always the source of other problems associated with problem gambling. It is usually financial problems that distinguish so-called problem gamblers from other gamblers whose gambling behaviours might otherwise be identical. Thus, any definition of problem gambling, if it is to be of much use to any stakeholders other than clinicians who need only deal with individual behaviours, must incorporate this aspect of problem gambling. Certainly, spending beyond one's means is the aspect that many self-identified problem gamblers use to classify themselves as such.

C. *Gambling and problem gambling as a continuum*

Many of those who do not favour the medical disorder/mental health approach to problem gambling view gambling as a continuum ranging from social or recreational gambling where there are no adverse impacts through to problem gambling where gambling leads to adverse consequences for the individual, his or her family, friends and colleagues, or for the community through to pathological gambling where the adverse consequences tend to be more severe and the pathological gambler is defined in relation to some diagnostic criteria. Although it did not put forward its own definition of problem gambling, viewing problem gambling as a continuum is the approach favoured by the Productivity Commission.

Dickerson (1991, quoted in O'Connor, Ashenden, Raven, Allsop, Peckham and Quigley 1999, p. 2) defined problem gambling in terms of a continuum as follows:

“Problem gambling is essentially a behaviour that will present in varying degrees and forms. That is, gambling involvement rests on a continuum from occasional non-problematic use through to extreme over-involvement, with a host of related problems that may be accompanied by a sense of impaired control”.

In the continuum approach to problem gambling, the threshold for determining that a person is a problem gambler depends on judgements as to what levels of severity are policy relevant.

Definitions of problem gambling based on the continuum approach are:

- broad enough to encompass all those who could be identified as having a gambling problem;
- focussed on adverse consequences rather than underlying pathology;
- contextually based (i.e., they take into account cultural, social and environmental factors); useful for intervention from the perspective of service providers; and
- the way in which problem gamblers themselves tend to talk about problem gambling behaviours.

However, problem gambling defined in terms of a continuum:

- leads to difficulties for diagnosis, objective measurement, research and replication; and
- may not provide a sound basis for planning public policy.

D. Problem gambling defined in terms of harm

In recent years, Australian researchers and practitioners have tended to favour defining problem gambling in terms of the harms it gives rise to for the individual and to any other persons affected by that individual's gambling behaviour. The primary harm-based definition used in Australia is that of Dickerson, McMillen, Hallebone, Volberg and Woolley. (1997, p. 106):

“ ‘Problem gambling’ refers to the situation when a person’s gambling activity gives rise to harm to the individual player, and/or to his or her family, and may extend into the community”.

A very similar harm-based definition was developed by the Canadian Inter-Provincial Task Force on Problem Gambling (Ferris and Single, 1999) to underpin the development of the Canadian Problem Gambling Index (CPGI) which is used in Queensland.

Harm-based definitions, although broader than definitions based on a clinical approach, can:

- encompass a clinical approach if desired;
- distinguish social gambling from problem gambling,
- be referenced both to individual behaviours and to the impacts on others;
- be contextually based,
- underpin eclectic approaches to dealing with problem gambling, and
- be useful from the perspectives of service providers and for monitoring service usage.

Definitions based on harm, however, have been criticised because of their lack of precision. Making a harm-based definition operational is difficult. Harm-based definitions:

- use subjective criteria;
 - are inadequate for measurement, replication and research;
 - cannot be used to research innate characteristics or causes of problem gambling; and
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- support only limited measures in assessing the assistance required by individual gamblers from a public policy planning perspective.

Socio-cultural aspects of problem gambling

Many studies have found that problem gamblers are most likely to be young, male, unmarried, unemployed, less educated and have other co-morbidities such as mental health problems and alcoholism. Problem gamblers favour continuous forms of gambling: electronic gaming machines, casino gaming, and to a lesser extent TAB gambling. More women have sought assistance with gambling-related problems as electronic gaming machines have become more widespread.

There is some evidence that the prevalence of problem gambling is higher among non-Caucasians and Indigenous groups, but these groups are less likely to access gambling support services because of the shame attached to burdening people outside the family with problems felt by persons in some cultures, and because of a lack of culturally appropriate and language-specific support services.

A Western Australian study (Tan-Quigley, McMillen and Woolley, 1998) found that definitions of social gambling and problem gambling are culturally specific, deeply entrenched and not subject to easy modification. This characterisation of problem gambling is supported by many other studies into the socio-cultural aspects of problem gambling. Ethics of a particular community, positive and negative views with respect to gambling, whether a particular community is collectivist or individualistic all affect attitudes to gambling and the ways in which various communities deal with problem gambling.

Defining harm

In Australia, problem gambling is now generally defined in terms of its social impacts rather than with reference to individual behaviours. Current definitions of gambling-related harms tend to be couched in general terms. The *New Zealand Gambling Act 2003* contains a specific definition of harm that encompasses broader social impacts:

“Harm-

- (a) means harm or distress of any kind arising from, or caused or exacerbated by, a person’s gambling; and
- (b) includes personal, social, or economic harm suffered-
 - (i) by the person; or
 - (ii) the person’s spouse, partner, family, whanau, or wider community; or
 - (iii) in the workplace; or
 - (iv) by society at large”.

The Queensland Government Treasury’s (2002, p. 3) definition of problem gambling also contains within it a definition of harm:

“... a range of adverse consequences where:

- the safety and wellbeing of gambling consumers or their family or friends are placed at risk, and/or
- negative impacts extend to the broader community.”

The above definitions of harm are so imprecise that it may be almost impossible to make them operational. Harm is such a subjective concept dependent on value judgements, social norms, cultural mores and environmental factors that it is unlikely that a precise definition of gambling-related harm to suit the needs of all stakeholders is possible. Most stakeholders use lists of harms with reference to (in some cases) mental health problems, relationships (spousal, family, friends, work colleagues), financial problems, employment outcomes and legal problems.

List of potential harms might suggest strategies that need to be in place to assist those experiencing harms, but of themselves, they do not contribute to a definition of gambling-related harm that can be used for the purposes of measurement, prediction and evaluation.

Harm minimisation, harm reduction and responsible gambling

In very recent years there has been a shift toward the concepts of harm minimisation or harm reduction and responsible gambling that reflects a shift towards viewing problem gambling as a community health issue. A typical definition of harm reduction is the following definition adapted by the Canadian Public Health Association from the definition used by the Canadian Centre on Substance Abuse:

“Harm reduction refers to a policy or program directed towards minimizing or decreasing the adverse health, social and economic consequences of gambling behaviour for individuals, families, communities and society. A harm reduction strategy does not require abstention from gambling”.

Some stakeholders are, however, critical of the concepts of harm minimisation and harm reduction because of the vagueness of the notion of harms.

The *New Zealand Gambling Act 2003* (p. 22) defines responsible gambling as follows:

“responsible gambling means lawful participation in gambling that is-

- (a) Lawful, fair and honest; and*
- (b) conducted-*
 - (i) in a safe and secure environment; and*
 - (ii) without pressures or devices designed to encourage gambling at levels that may cause harm; and*
 - (iii) by informed participants who understand the nature of the activity and do not participate in ways that may cause harm.”*

Often, as above, it is the legislation, rather than the literature that comes closest to providing “definitions” (albeit imprecise) of gambling-related harms, harm minimisation or harm reduction and responsible gambling.

Measurement of problem gambling

Ideally, problem or pathological gambling assessments should be underscored by theoretical principles and a clear definition of the construct.

The purposes of assessment

Assessments have 4 principal functions: identification, classification, description and therapeutic.

- *Identification*: screening vs. diagnosis. Screening involves the identification of people who might have gambling problems whereas diagnosis involves the formal classification of positive cases.
- *Classification*: cases vs. non-cases, levels of problem severity, current risks vs. future or predicted risk. Measures can categorise people as having the disorder or not having the disorder, indicate the severity of the problem, and/ or identify those currently or at future risk of becoming positive cases.
- *Description*: Problem gambling behaviour vs. consequences. Assessments can describe the problems caused by gambling, or the behaviour itself.
- *Therapeutic*: Problem assessment and index of therapeutic change. Assessments can identify the problems affecting gamblers so as to identify the most appropriate intervention or services. They can also be used to measure the effectiveness of these interventions.

Characteristics of effective measures

Measures need to be assessed in terms of their reliability, validity, practicality, applicability and comparability.

- *Reliability* refers to the consistency or stability of measurement (test-retest) or internal consistency of the measure.

Validity

- *Internal Validity* refers to the extent to which the assessment measures what it is supposed to measure. Validity is confirmed using a variety of indicators or appraisals. These include: construct validity, classification accuracy, the appropriateness of validation samples, dimensionality, external validation, concurrent validity and item variability.
 - *Construct validity* is influenced by the choice of theoretical model governing the definition of problem gambling (e.g., medical pathology, psychological habit, social or cultural phenomenon), whether one adopts a categorical or continuum model, and definition (whether problem gambling is defined in terms of its behaviour, consequences or both).
 - *Classification accuracy* refers to the level of sensitivity and specificity. Sensitivity refers to the probability of being able to identify true cases and avoid false negatives. Specificity refers to the ability to avoid misclassifying non-cases (i.e., false positives).
 - *Appropriate validation samples*: Many assessment methods were validated using comparison samples that were too dissimilar to the problem gambling sample, so it is unclear whether the problems identifiable with problem gamblers are merely symptoms of regular gambling.
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- *Dimensionality*: A coherent definition of gambling should yield measurement items that all tap into the same underlying construct.
- *External validation*: Problem gambling scores should correlate with known comorbidities or correlates of problem gambling (e.g., anxiety and depression).
- *Concurrent validity*: Newly developed assessments should be highly correlated with existing measures.
- *Item variability*: Items should be selected so as to avoid items with very high or very low base-rates. If the base-rate is too high, the items may not be true indicators of problem gambling, whereas if too low, they will not be able to assess the varying degrees of problem gambling and possibly lead to the exclusion of positive cases.
- *Practicality*: Practical assessments are those which are short, easy to administer, which require no training, and which are cost-effective.
- *Applicability*: This refers to the extent to which the assessment can be applied in different populations. The principal contexts identified included: community prevalence studies, research involving gamblers, clinical diagnosis and therapeutic change. The appropriateness of an assessment is also influenced by demographic factors such as gender, age, socio-economic status and culture. Items in some scales may be less applicable for specific subgroups. Problematic examples include borrowing items, those referring to employment, marital relations and specific forms of financial transactions. These items may not be entirely suitable for administration to older samples, indigenous people, or women from more patriarchal cultures.
- *Comparability*: The historical usage of certain measures may encourage their continued use because of the need to obtain comparative longitudinal data.

Review of measures

DSM classification

The DSM classification for pathological gambling was first established in 1980 (DSM-III), modified in 1987 (DSM-III-R), and again in 1994 (DSM-IV). The DSM-III classification referred predominantly to the consequences of gambling, but was subsequently modified to address criticisms relating to the middle-class bias inherent in a number of the 7 criteria. The DSM-III-R classification was modelled on the criteria for alcohol addiction and included items relating to cravings, tolerance and withdrawal. The DSM-IV classification clarified the wording of the DSM-III-R and placed greater emphasis on the mood altering affects of gambling.

The DSM-IV focuses predominantly on pathological behaviours and significant consequences and yields lower prevalence rates than other measures. Nonetheless, the DSM-IV does not appear to measure a unitary phenomenon. In effect, it brings together two different classes of item: one group that refers to the pathology, and another that relates primarily to the consequences of excessive gambling.

A bi-axial model for problem gambling

	<i>Severity of Gambling Consequences</i>	
	<i>Low</i>	<i>High</i>
Low impaired control / Behavioural "pathology"	(A) Non-problematic gambling	(B) Gamblers in treatment + regaining control
High impaired control / Behavioural "pathology"	(C) Early stage problem gambling	(D) Late stage problem gambling

Several psychometric versions of the DSM-IV have been developed, including: a 10-item version by Fisher (2000), a 20-item version by Winters, Specker and Stinchfield (1997), 10 item version by Stinchfield and Winters (1996) and the 17-item NODS version used in recent North American prevalence studies. The best validated psychometric version of the DSM-IV is the 10-item Stinchfield and Winters (1996) version. The DSM-IV focuses predominantly on pathological behaviours and significant consequences and yields lower prevalence rates than other measures.

The emphasis on a traditional pathology or dependence model in the DSM-IV means that it is inconsistent with the theoretical approaches favoured by Australian researchers. Evaluation studies reveal that its criteria are not sufficiently variable or inclusive enough to make it suitable for community prevalence studies or to assess clinical change. It is best used as a diagnostic tool in clinical settings. The current cut-off score of 5 is too high and should be reduced to 4 out of 10 criteria. The psychometric versions of the DSM-IV have reasonably good psychometric properties.

South Oaks Gambling Screen (SOGS)

The 20-item SOGS (Lesieur and Blume, 1987) is the most widely used measure in the world and is based on DSM-III-R criteria. It was extensively validated when developed, but never against an appropriate comparison sample or using a community sample. A third of the items in the SOGS relate to consequences, 50 per cent to borrowing money, and the remainder relate to attitudes and behaviours. The SOGS does not appear to be grounded in a clearly defined theoretical framework.

Positive features of the SOGS include its ease of administration, availability of a cut-off score (usually 5+ for pathological gambling), and breadth of items. It has good internal consistency, reliability, and concurrent validity, but classification rates are poorer in community samples. It also does not appear to have a clear dimensional structure because of the mixture of different items.

Negative features include its over-representation of "softer" attitudinal and behavioural items that often lead to an excessive number of false positives, particularly when the measure is used in community prevalence studies.

SOGS appears to be appropriate to use to screen clients in clinical settings and as a measure to be included in research studies.

The Victorian Gambling Screen (VGS)

The VGS is the only measure of problem gambling developed in Australia (Ben-Tovim, Esterman, Tolchard and Battersby, 2001). It was appropriately validated and shown to have

good reliability, classification rates, dimensionality and concurrent validity. The principal subscale “harm to self” comprises 15 items scored on 4-point scales (range 0-60). Scores of 21 or higher indicate problem gambling.

The VGS shares some of the negative features of the SOGS: its inclusion of many “soft” items and the lack of a clear theoretical framework. A recent validation study of the VGS (McMillen, Marshall, Wenzel and Ahmed, 2004) confirmed the positive qualities described above, but found that the cut-off score of 21 is too high and suggested a reduction to 15.

The Canadian Problem Gambling Index (CPGI)

The CPGI was specifically developed as a measure of community prevalence (Ferris and Wynne, 2001). The initial validation study indicated that it had good psychometric properties. The CPGI is a 9-item scale with a score range of 0-27 with 8+ indicating severe problems. It has been validated in Canada, Europe and in two Australian studies. The measure typically yields lower prevalence rates than the SOGS.

Positive features include its ease of administration and brevity, and availability to classify varying degrees of severity. Possible negative features include its limited use in clinical settings or in research studies, as well as its inclusion of two of the least useful SOGS items (criticism and guilt associated with gambling).

Recent Canadian research suggests that the CPGI is possibly too similar in content to the SOGS and may therefore also give rise to false positives in community samples.

Other problem gambling instruments

A large number of other less widely used instruments were reviewed:

- *The Eight-Screen* (Sullivan, 1999) is a brief 8-item screening measure that can be used in medical or applied settings.
 - *The Gamblers Anonymous Twenty Questions (GA-20)* is a useful screening device, but lacks a clear theoretical rationale. The GA-20 requires further validation before being validly used in large-scale prevalence surveys or as an indicator of therapeutic change.
 - *The Scale of Gambling Choices* (see Baron and Blaszczynski, 1995) is a useful Australian measure of impaired control, which has good psychometric properties and concurrent validity. Some concerns have been raised about the redundancy of the items and interpretation.
 - *The Lie-Bet Scale* (Johnson, Hamer, Nora, Tan, Eisenstein and Engelhart, 1997) is a 2-item measure of problem gambling with limited validity testing.
 - *The Addiction Severity Index (ASI-G)* (Lesieur and Blume, 1992) is a modified version of the index used for other substance disorders. This has acceptable psychometric properties and provides a quantitative index of problem severity based on the frequency and intensity of gambling.
 - *The Yale-Brown OCD scale* is a psychiatric measure used to measure the strength of gambling-related compulsions and obsessions (see Hollander, DeCaria, Finkell, Begaz, Wong and Cartwright, 1998, 2000; Zimmerman and Breen, 2000). The construct validity of this measure has been questioned given the dissimilarities between problem gambling and conventional obsessive compulsive disorders.
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- *The Gambling Urges Scale* (Raylu and Oei, 2004) measures the strength of gambling-related urges and appears to be a useful complement to the Scale of Gambling Choices. However, there is some concern about the appropriateness of the validation sampling.
- *The Cumulative Signs Method* (Culleton, 1989) is a harm-based measure that identifies problem gamblers using 5 categories of harm, including personal, interpersonal, financial, vocational and “hard signs”. Very little validation information is available concerning this method of assessment.
- *The HARM measure* (Productivity Commission, 1999) included a list of indicators of significant gambling problems that was used to validate the result of the SOGS in the 1999 national Australian survey. The scale has good face validity, but has not been subject to psychometric testing.
- *The G-Map* is an 85 question survey instrument designed to profile gamblers in Victoria. The instrument generates 17 descriptors or factors. This instrument is problematic in that there appears to be some overlap between “factors” and it does not appear to have been subjected to rigorous statistical testing.
- *The Gambling Interview Schedule (GIS) or Gambling Behaviour Interview* (Stinchfield, Govoni and Frisch, 2001) is a 32 item measure that was used in a validation study of the DSM-IV criteria. The results from this study were promising, although the scale lacks a clear theoretical focus, and has many items that appear to yield excessively high rates of endorsement.

Literature review of usage patterns

An extensive literature search was undertaken using academic search engines (e.g., PsychINFO, Sociofile, Medpubs), internet searches, conference proceedings and Government and research agencies (1999-2004). Searches focused on keywords pathological + gambling + measures. Over 150 publications were included in the review and profiled according to academic area, sample type, measure used and country of origin. Most articles were in the fields of psychology and psychiatry and published in psychology or gambling studies journals. Most studies have involved the administration of measures in treatment or clinical settings.

The SOGS is the most widely used measure in the world and has been used across all contexts: clinical assessment, prevalence and research studies. The SOGS is considered an acceptable measure for research purposes.

Clinical assessment tends to involve the DSM-IV as the first choice.

The choice of measure for prevalence research depends upon the country. Canada clearly now favours the CPGI, North America favours the SOGS and the NODS (psychometric version of the DSM-IV classification), whereas Australian researchers may be shifting towards using the CPGI or a combination of SOGS and CPGI to ensure comparability with previous Australian studies (McMillen, 2003). The DSM-IV is preferred in Europe and Asia.

Feedback on material developed in the literature review

1. Definitions

Industry responses

- There is a need to be clear about the objectives for having a national definition of problem gambling.
- A single definition may not suit all purposes.
- There is perhaps a need for two definitions: one definition for pathological gambling where the condition would be capable of clinical diagnosis, underpin treatment, and which might contain reference to mental health problems; and another definition for problem gambling which would underpin education, intervention and policy making.
- Several industry responses, although not all, favour the conceptualisation of problem gambling as a continuum.
- There is no clear agreement across industry responses as to the elements that should be included in a definition of problem gambling.

Government/public policy-makers

- Some responses favoured retaining “loss of control” in the definition as a key element of problem gambling; others did not as it suggests both that “external forces” are operating to affect people’s behaviour and a link to mental health problems.
- Several responses suggested there is no need to have reference to the “causes” of problem gambling included in the definition.
- On the whole, government and policy makers seem to view a definition of problem gambling that takes account only of gambling-related harms as sufficient.
- No government/policy maker response regarded the concept of gambling-related harm as being too vague to be of practical use.
- Several responses viewed the definition put forward for comment as acceptable; one thought it lacked impact and another argued that a short pithy definition is required.

Researchers

- Key researchers did not respond to our “Call for Comments”. They would probably argue that their views are adequately represented in the literature review.
- The researchers who did make responses think “loss of control” is an important element of problem gambling although Allcock suggests the term be replaced by “difficulties in limiting time and/or money spent on gambling”.
- Some think the concept of gambling-related harm is vague; others do not.
- Several responses are of the view that the definition should include reference to what might be termed the “seduction” of electronic gaming machines.

Counsellors and service providers

- A person with a gambling problem should not be characterised as a problem gambler, i.e., don’t define the person in relation to the activity.
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- Reference to illness, addiction and mental health problems should not be in the definition.
 - Some counsellors think it would be useful to have separate definitions for pathological and problem gambling.
 - Loss of control, compulsion and preoccupation are key aspects of problem gambling.
 - Counsellors favour the continuum approach as it is useful for education, to identify ‘at-risk’ gamblers, and to implement early intervention and more targeted intervention strategies according to where people are on the continuum.
 - Counsellors consider it very important that the definition contain reference to both behaviours and harms.
 - A definition based on “harm” alone is not a practical definition from the perspective of working with gamblers who have problems to change their behaviours.

Comments on socio-cultural aspects

- The term “problem gambling” cannot be translated into many languages.
- CALD counsellors and service providers do not favour the notion of a single definition.
- CALD counsellors and service providers do favour the continuum approach to problem gambling because of its inclusiveness (*everyone* fits somewhere on the continuum), and because of its usefulness with respect to strategies to address problem gambling from community education for non-gamblers and recreational gamblers, to early intervention strategies for ‘at-risk’ gamblers, to more targeted intervention strategies for problem and pathological gamblers.
- A national definition should include reference to both behaviours and harms.
- Building prior relationships with most people from ethnic communities and with Indigenous Australians is very important before talking to them about their gambling behaviours and takes time.
- Many persons with CALD backgrounds who have gambling problems don’t know how to, or are too scared to access help services.
- Research is “way-underestimating” the prevalence of problem gambling in CALD and Indigenous communities.
- Counselling needs to be culturally and linguistically appropriate for CALD and Indigenous communities.

2. *Screens and instruments*

Feedback from Victoria

- A single consistent instrument across agencies is likely to be very useful to obtain useful comparative information.
 - There is value in being able to use psychometric assessments in counselling.
 - Counsellors should receive training in how to administer psychometric instruments.
 - Counsellors reported using the SOGS, DSM-IV, CPGI and G-Map, but no standard measure was used across agencies.
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Feedback from South Australia

- The SOGS is the predominant measure used by South Australian counselling agencies.
- The SOGS is useful as a tool to track client progress.
- The VGS is used by Flinders Medical Centre (who designed it).
- Instruments need to be tailored to meet the needs of specific cultural communities and consultation should be undertaken to avoid inappropriate questions.

Views from New South Wales

- The SOGS remains the most commonly used measure in NSW counselling agencies, and the DSM-IV the second most widely used.
- The SOGS and DSM-IV were generally seen as useful, but there was a perceived need to develop shorter measures for public health surveys and to supplement these measures with other indicators of community harm.

Views from Queensland

- The CPGI is the preferred measurement tool in Queensland, although no specific measure is mandatory for assessments conducted by problem gambling services.
- The CPGI is considered consistent with the Government's public health approach to gambling and interest in the social effects of problem gambling.
- The CPGI does not avoid the weaknesses of any psychometric instrument; namely, its reliance on self-report and inability to document the broader community-level factors contributing to problem gambling.
- There are many perceived advantages to using a two-part approach to measuring problem gambling, ie., where problematic behaviour and the harms associated with the behaviour are separated. However, it may be difficult to develop any objective measure of gambling-related harm.

Views from Tasmania

- SOGS is the most widely used measure in Tasmania for both population surveys and the assessment of gamblers by counselling agencies.
 - Measures based on harm alone were seen as too subjective and therefore problematic.
 - A measure reliant only on behaviour is also undesirable because some people have the capacity to expend considerable time and effort on gambling without incurring any significant harms.
 - A two-part survey that defines gambling either in terms of harm, behaviour, or both would be preferred.
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View from Western Australia

- The SOGS is the most widely used assessment tool in Western Australian counselling agencies.
 - It has therapeutic value and allows international comparisons (although not with current Canadian research- Authors).
 - The SOGS may not be entirely suitable for use in Indigenous communities.
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Call for Comments

Definitions of problem gambling and gambling-related harm

- Q.1 Should a national definition of problem gambling contain reference to any or all of the following:
- addiction, illness or mental health problems;
 - loss of control;
 - a preoccupation with gambling;
 - spending beyond one's means;
 - problem gambling residing on a continuum of gambling behaviours; and
 - adverse impacts upon the gamblers' personal life, family relationships, vocational pursuits, and the wider community?
- Q.2 From your professional perspective, which of the above elements of problem gambling most closely reflects your experiences with dealing with problem gamblers? Would incorporation of these elements into a national definition of problem gambling help you in your work with problem gamblers? How?
- Q.3 Is the concept of gambling-related harm too vague to be of any practical use?
- Q.4 A national definition of problem gambling that meets the needs of all stakeholders and so can be used for diagnosis, objective measurement, replication, research, service provision and public policy planning in a diverse range of contexts will probably need to be referenced to both individual gambling behaviours and to harms. Whilst no single definition is likely to suit all purposes, do you think a definition along the lines of the following would be suitable as a national definition in the Australian context? Why or why not?

“Problem gambling is characterised by a preoccupation with gambling which leads to a continuous or periodic loss of control over time and/or money spent on gambling resulting in adverse impacts for the gambler, and perhaps for his or her family, his or her vocational pursuits and which may extend into the wider community”.

Measures of problem gambling

For service providers / counsellors and other practical users of gambling measures

- Q.1 What measure or measures are you currently using to identify whether your client has a gambling problem?
- Q.2 What are the best and worst features of the measure(s) you are using?
- Q.3 Thinking about the measures you are using now: What items or questions do you think are the best indicators that a person has a problem? AND Which ones are least helpful?
- Q.4 What general aspects of problem gambling are left out of current gambling assessments, and should be included?
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- Q.5 Are there any items that are not appropriate for women, for people of different ages, or for people from other cultural backgrounds (e.g., Indigenous)? What aspects of their gambling are not being captured by existing measures?
- Q.6 Is problem gambling best measured by looking at the problems caused by gambling (e.g., legal, financial) or by looking at behaviours (e.g., chasing losses)?
- Q.7 Would it be useful to design a measure that classifies problem gamblers using a 2-part survey: one part that looks at problematic behaviour and another that looks at the consequences of the behaviour?
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