When Maria Bellringer first asked me to do a presentation at the Think Tank, she wanted me to just discuss brief screens for PG. The request to discuss “other activities that are commonly measured” came later. In thinking about the logic of my remarks, I felt that it made more sense to talk about the “other activities” first. Mostly because it doesn’t make sense to administer a problem gambling screen unless you already know that someone gambles. So I’ve taken the liberty of changing the order of the topics today.
Considerations

• Policy decisions about legalising gambling rest on up-to-date information about participation & PG prevalence
• Collecting survey data is expensive
• Importance of international comparisons
• Embedding gambling “modules” in larger health surveys can contribute to emerging knowledge of etiological pathways

• In gambling surveys, it is typical to assess peoples’ self-reported participation level in gambling and to then examine the intensity of gambling participation as this relates to things such as demographic characteristics, gambling availability, gambling attitudes, and problem gambling status.
• Despite the frequency of this practice, we do not yet have a standard way of measuring gambling participation.
• Furthermore, there is very little research investigating the most reliable and valid way of assessing gambling participation or the intensity of gambling involvement.
• As often happens, there are several of us working on different ways to assess gambling involvement.
• I’m not going to talk about that work but instead have tried to indicate on this slide why that work has been undertaken.
• In the work that Rob Williams and I are doing to develop an internationally-accepted Gambling Participation Instrument, we are looking at several important characteristics:
  • Validity and reliability
  • Broad agreement from different stakeholder audiences
  • Comprehensiveness
  • Consistency with historical assessments as well as how revenues are categorized
  • Generalizability across population subgroups, cultures & countries, different kinds of studies
• Flexibility to add unique forms of gambling in different contexts
• Efficiency
• Considerations specific to gambling
  • Which activities
  • Time frame
  • Dimensions (time, location, modality)
  • Frequency and expenditures
In this slide and the next one, I want to share two recent examples of short gambling screens that have been considered in the US.

This example is a module that I was asked to create for the General Social Survey. The GSS is a bi-annual national survey that has been ongoing since the 1980s.

Data is collected by NORC at the University of Chicago. The GSS is mostly an attitudinal survey but there is a process for adding brief modules looking at emerging issues such as gambling.

The guidelines for adding modules include the stipulation that it can only include 2-7 questions.

As you can see, I decided to forego any assessment of lifetime participation or expenditures in order to stay within the GSS guidelines.

Unfortunately, even this short module (which was to be followed by a brief screen for PG) was rejected for inclusion in the GSS in 2010.
• In an exercise that I undertook for the Kansas Department of Health, I looked at the magnitude of differences in gambling participation rates based on asking a single question about gambling participation compared to multiple questions.
• I did this by looking at surveys carried out within a few years of each other within specific jurisdictions.
• At the top, we have three surveys carried out in the 1970s and 1980s.
• In the mid to late 1990s, we had three national US surveys that obtained very different rates of gambling participation based on the number of questions asked.
• Finally, you can see differences across several different surveys in the state of Iowa.
• The take-away here is that a single global question yields past-year gambling participation rates that are 30-60% lower than when multiple—and more specific—questions are used.
• There are probably several reasons for lower endorsement of global questions about gambling participation compared with multiple questions about specific activities.
  • These include comprehension difficulties
  • Differing tacit definitions of what constitutes “gambling.”
  • The most likely reason is that the use of a single global question about gambling requires respondents to self-identify as a “gambler,” a label that even people who regularly play the lottery or gamble at casinos are reluctant to apply to themselves (Suurvali, Cordingly, Hodgins, & Cunningham, 2009).
This example is from a survey that actually did include some gambling-related items in Kansas in 2009.

The Brief Risk Factor Surveillance System survey is an annual national survey funded jointly by the Centers for Disease Control and Prevention (CDC) and the individual states.

There is a core set of questions that all of the states must include.

Then there are a number of pre-approved modules that states can include.

Finally, there is some room for states to add modules focused on issues of specific concern to them.

Gambling modules have been added to the BRFSS in several states at various different times.

In MA, a gambling module was added to the BRFSS several times, including most recently in 2008 and 2013.

The 2008 MA module is identical to this set of items from Kansas in 2009.

It will probably be no surprise that the overall rate of gambling participation assessed in this way is significantly lower than when participation in specific gambling activities is assessed.

Also no surprise that the problem gambling rate based on the two questions was under-reported.
Assessing Problem Gambling

• Widespread assumption that PG is a robust phenomenon that can be measured in populations & clinical settings
• Pragmatic demands for relatively brief, easily administered measures to assess extent, degree of PG in range of settings
• Many definitions of PG have been proposed
• All of most recent efforts have included
  – Loss of control
  – Negative or adverse consequences

• While you read the points on the slide, I’m going to talk a bit more free-form.
• There are a lot of reasons why we need brief screens for PG
  • In population research, it is particularly important to consider respondent burden, impact on response rates, and survey costs.
  • In other settings, there are other important considerations.
Several brief screens and short-form measures for problem gambling have been developed over the last decade.

A significant limitation to all of these short-forms is that they are each derived from a single instrument and validated against this same instrument.

Even more critically, all of these short forms are taken from problem gambling measures which themselves have only modest correspondence to classifications obtained in subsequent clinical interviews.

This is important because brief screens are often intended for use by clinicians rather than for use in population surveys.

It is important to understand that different screens may work differentially well (or poorly) in populations with different base rates of PG.

For example, where you have extremely high rates of PG, one or two items may be enough.

In populations with relatively low rates of PG, brief screens may not work very well.

But can they be used to understand “harm” more generally?
This is a list of all of the brief screens for problem gambling of which I am aware.

I have listed them by the number of items rather than in chronological or alphabetical order.

Several of these screens are reduced sets of PGSI items.

- This includes the PGSI Short Form (Britain)
- Also the SRGS (Sweden)

The three NODS brief screens are all based on DSM-IV criteria.

Only the AGRI Short Screen includes items selected from several different problem gambling screens.

Importantly, the PGSI Short Form and the AGRI Short Screen used the clinically validated samples that we used to develop the PPGM to establish validity and reliability.


I just want to finish up by mentioning a project that is underway in Victoria to test brief PG screens in a mental health setting.

I have included a list of the brief screens that are being tested in this study.

But I am hoping that others here at the Think Tank might be able to tell us a bit more about what they have done so far since I have been an international adviser to the research team at Turning Point rather than a closely involved investigator.

### Brief PG Screens Tested in MH Setting in Victoria

- PGSI short form (3 items)
- PGSI short form (4 items)
- NODS-CLiP (3 items, modified to PY)
- NODS-PERC (4 items, modified to PY)
- NODS-CLiP2 (5 items, modified to PY)
- Lie-Bet (2 items)
- BBGS (3 items)
- AGRI short screen (2-5 item versions tested)