GAMBLING, ALCOHOL & OTHER DRUGS

Prevalence & Implications of Dual Problem Clients

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Gerry Kaplan
Coordinator of Research
& Information Systems

Bob Davis
Prevention & Education
Consultant, Gambling Program

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CHAPTER ONE
BACKGROUND AND METHODOLOGY

1) BACKGROUND:

The Addictions Foundation of Manitoba provides services to individuals experiencing problems regarding their use of chemicals,[1] and those with gambling problems. Clients with chemical problems receive treatment through either residential or non-residential treatment programs. Clients experiencing problem or pathological gambling receive services through the AFM's non-residential Gambling Program.

This study has set out to explore the following questions:

- What is the prevalence of dual problems among the AFM's various client populations? 'Dual problems' describes an individual experiencing problems both with chemicals ***and*** problem or pathological gambling.
- How do clients with single and dual problems resemble one another? In what ways do they differ? and
- What are the associated treatment implications?

2) METHODOLOGY:

This study seeks to describe AFM clients in three subsets: those solely experiencing gambling problems; those solely experiencing problems with chemicals; and those experiencing both. The first task, then, was to develop these three subsets, based on information collected from AFM's client population.

All AFM clients complete a set of assessment forms upon entering treatment. Forms completed by clients seeking treatment for gambling problems include a set of questions referred to as the **CAGE**. The CAGE Questionnaire, which has been in use since the early 1970s, is not intended to be used as a diagnostic instrument. Instead, the CAGE is a prescreen scale consisting of four questions, which is designed to reflect potential problems of a chemical nature. The sensitivity of the CAGE as a prescreen instrument is well-documented.[2] The scale includes the following four questions:

1) Have you ever felt the need to **C**ut down on your drinking or drug use?
2) Have you ever felt **A**nnoyed by criticism of your drinking or drug use?
3) Have you ever had **G**uilty feelings about your drinking or drug use?
4) Have you ever had a morning **E**ye-opener?

A minimum of two positive responses to any of these question is indicative of potential

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[1] The term ***chemical*** refers to either alcohol and/or other drugs.

[2] See **Ewing, JA., Detecting Alcoholism: The CAGE Questionnaire**, JAMA, 1984, Vol. 252, 14; Pages 1905 to 1907; or **Mayfield D. et al, The CAGE Questionnaire: Validation of a New Alcoholism Screening Instrument**, American Journal of Psychiatry, 1974, 131:10, pages 1121 to 1123.

problems related to the use of chemicals. Gambling clients providing two or more positive responses on the CAGE are 'flagged' for possible chemical problems.

In order to screen clients in treatment for chemical problems who may also have gambling problems, the AFM created a hybrid scale, which modified three of the **CAGE** questions, along with two questions taken from the original **DSM-III.**[3] The result, referred to as the **Manitoba Gambling Pre-Screen (MGPS)**, consists of the following five questions:

1) Have you ever felt the need to cut down on your gambling?
2) Have you ever felt annoyed by criticisms of your gambling practices?
3) Have you ever had guilty feelings about your gambling?
4) Have you ever borrowed money from friends, family members, or from work to help finance your gambling?
5) Have you ever gambled more than you intended?

Positive responses to two or more of these questions is considered indicative of a possible gambling problem. As with the CAGE, this scale is not considered to have diagnostic properties. Instead it is used solely as a prescreen. The only validated instrument available, as a gambling assessment instrument, as of this writing, is **the South Oaks Gambling Screen (SOGS).**

Beginning To Validate The Manitoba Gambling Pre-Screen:

The current process of validating the MGPS is preliminary, involving correlating results from the MGPS with results from the SOGS, where clients completed both scales upon entering the Gambling Program. Correlations were undertaken at two levels.

First, we employed the formal breaks established for both scales (i.e. for the SOGS clients' scores were divided into three categories: clients scoring 0-2; clients scoring 3-4; and clients scoring 5+. In terms of the MGPS, clients' scores were divided into two categories, those scoring 0-1 'Yes' responses and those scoring 2+ 'Yes' responses.) This resulted in a high level of correlation ($N=232$; Chi-Square=232.0; $df=2$; $p<.00001$).

Since 99.1% of all gambling clients were assessed as 'probable pathological gamblers' based on the SOGS (i.e. scores of 5+) and 99.6% of these same clients had two or more 'Yes' responses to the MGPS, a second attempt was made which provided more discrete breaks in the results of both scales.

In terms of the MGPS, greater distinction was made regarding the number of 'Yes' responses received (ranging from 1 to 5). In terms of the SOGS, five breaks were defined (scores of 0-2; 3-4; 5-10; 11-15; and 16+). Results from this correlation were equally encouraging ($N=232$; Chi-Square=288.33; $df=16$; $p<.00001$) (Figure 1).

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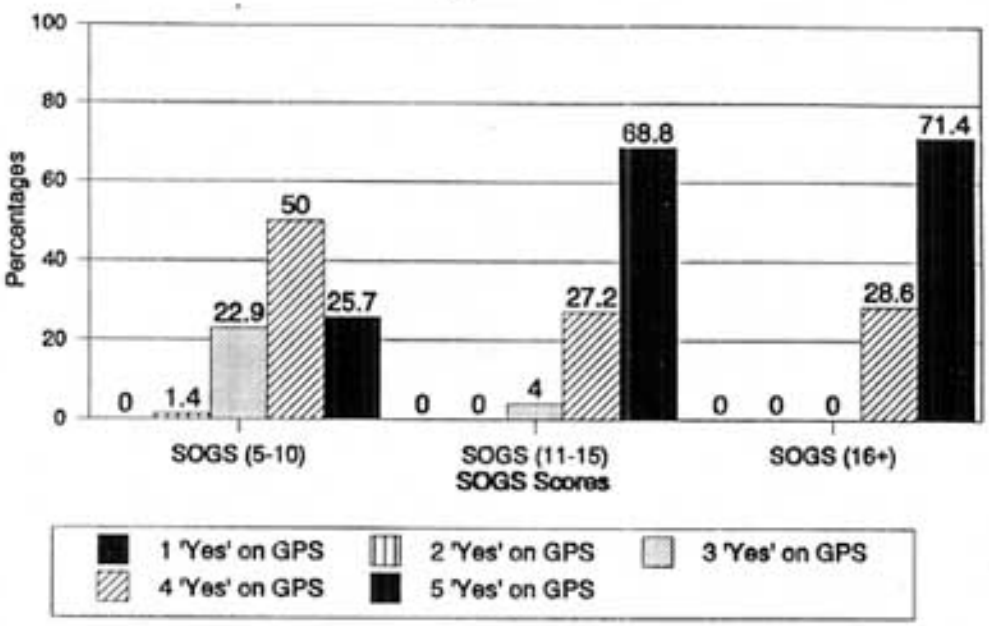
[3] The ***DSM-III*** was developed by **the American Psychiatric Association** in 1992. The AFM currently uses the **pathological gambling diagnostic criteria** included in the ***DSM-IV***.

Figure 1 Correlating SOGS Results With Manitoba Gambling PreScreen Results



N=70, 125, 35. Only two clients scored under 5 on theSOGS. Those scoring from 0 to 4 are omitted from this chart.

While there is no formal research regarding the validity and reliability of the Manitoba Gambling Pre-Screen, there are preliminary findings that appear to indicate the potential usefulness of the MGPS, at least in terms of clinical populations.[4]

Developing The Study Sample:

Three study populations were derived for this study, spanning two AFM programs: Adult Treatment Programs, for clients with chemical problems, and the Gambling Program. The three populations include:

- Clients indicating problems solely with chemicals (based on clients in the Adult Treatment Program scoring 0-1 'Yes' responses on the ***MGPS***);
- Clients indicating problems solely with gambling (based on clients in the Gambling Program scoring 0-1 'Yes' responses on the ***CAGE***); and
- Clients indicating problems both with chemicals and with gambling.

[4] **The AFM** encourages researchers and therapists to use the MGPS, and to test the validity and reliability of this prescreen on both clinical samples and within the general population. We would be very interested in receiving any test results which may arise, including anecdotal reports regarding the usefulness of this scale. If interested, please contact the **AFM's Research Unit** at (204) 944-6243.

This last category includes Adult Treatment[5] clients who answered 'Yes' to two or more of the questions in the MGPS and Gambling Program clients who answered 'Yes' to two or more of the CAGE questions. These scales, along with a range of additional questions, are included in the AFM's intake and assessment forms. Clients from each program respond to both the CAGE and the MGPS. Data from these forms are scanned and transferred to ***SPSS***[6] for analysis. Given the completeness of the various datasets at the time when this analysis was undertaken, the decision was made to use the 1995-96 dataset for clients in the Gambling Program and the 1996-97 dataset for clients in Adult Treatment Programs.

As well, to ensure the 'cleanest' possible data, only clients who answered ***all*** of the four CAGE questions and ***all*** of the five MGPS questions were included in this study. All other clients were excluded from this study. A total of 3,016 clients attended both programs during these reporting periods. Of these, this study tracks the **1,134** clients who completed all of these questions: **342** from the Gambling Program and **792** from Adult Treatment Programs. This reflects completion rates of **40.3%** and **36.5%** respectively, for these two programs. The total sampling frame is described in the figure on page 5.

Rates Of Dual Problems Are Similar Across Programs:

Based on the methodology described above, almost identical rates of dual problems have been discovered for clients attending programs for chemical treatment and those attending for their gambling problems. Specifically, **36.3%** of the gambling clients in this study provide indications of problems with chemicals, while **34.6%** of the clients in this study attending chemical treatment programs provide indications of problem gambling.

In terms of the three study subsets then, the client distribution is as follows:

SUBSET	N	%
Gambling Problem Only	218	19.2
Chemical Problem Only	518	45.7
Dual Problems	398	35.1
TOTALS	**1,134**	**100%**

Process For Developing This Study:

Once the study sample was developed, frequencies and crosstabulations were produced for all questions contained in the various assessment forms. The findings

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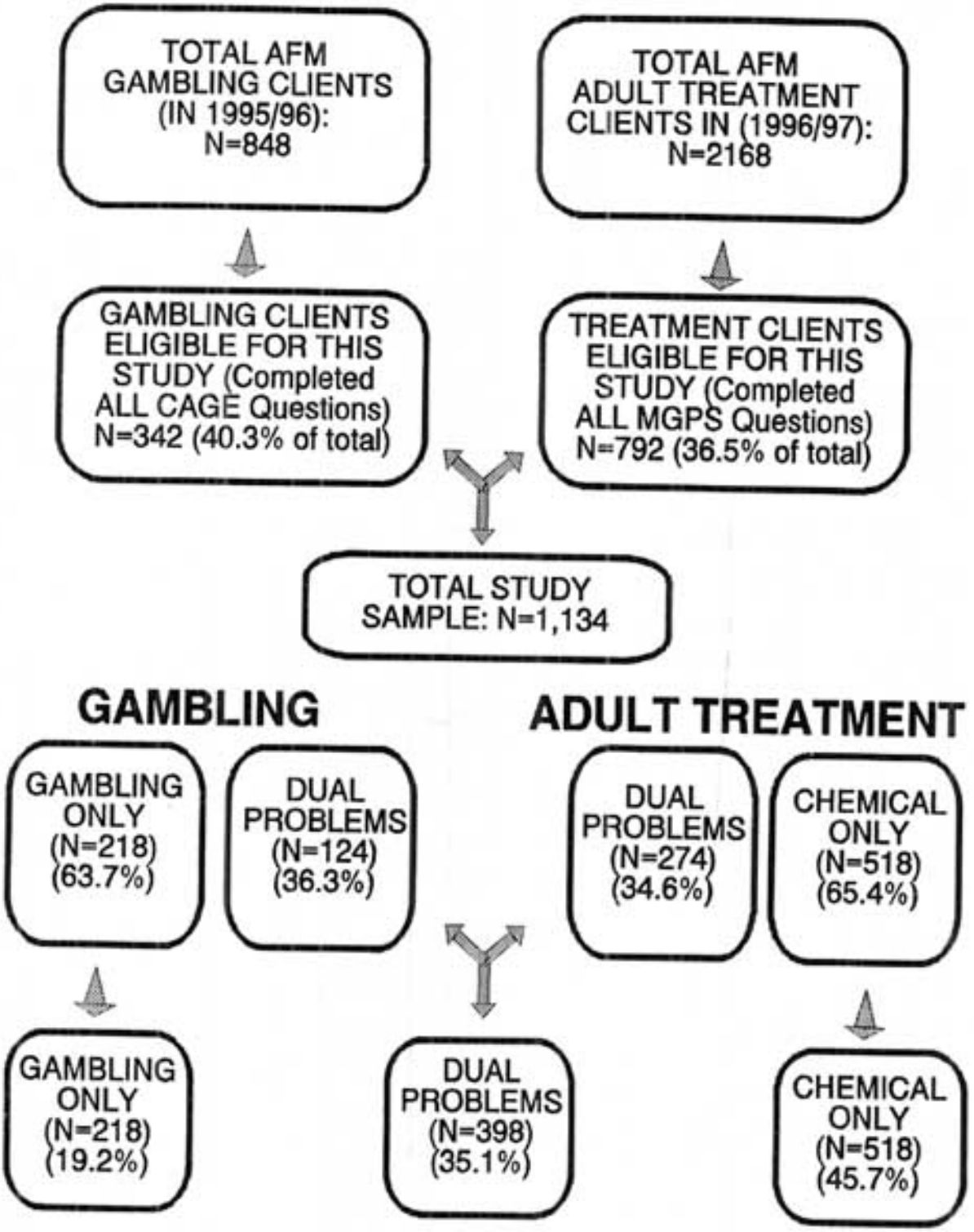
[5] Includes clients with alcohol and/or other drug problems, in the AFM's **Residential Treatment Program**, **Day Treatment Program** and **Community-Based Programs**

[6] ***The Statistical Package for the Social Sciences*** (for ***Windows***) is used for data processing. The design, processing and verification of scannable forms is completed through ***Teleform***.

SAMPLING FRAME



DISTRIBUTION OF STUDY SAMPLE

were then presented to Gambling Program staff, who assisted in culling data of lesser programmatic significance.[7] These staff also provided the researchers with implications of these data, from a treatment perspective. Notes were taken, which have been incorporated into this report.

3) STUDY LIMITATIONS:

There are two important limitations to this study. First, our ability to designate clients in AFM chemical treatment programs who also provide indications of gambling problems is based on the outcome of ***the Manitoba Gambling Pre-Screen***. While the AFM has had positive outcomes with this scale, including informal anecdotal reports from counsellors and community collaterals, and while initial test results correlate positively with results taken from ***the South Oaks Gambling Screen***, no additional formal testing of this scale's validity and reliability has been undertaken to date. However, further testing is planned. It should be noted that the five questions included in the MGPS were selected on the basis of counsellors' experience with gambling clients. That is, consideration was given to those factors or questions most indicative of problem gambling when deciding which questions to include in this scale.

The second limitation pertains equally to the SOGS, CAGE and MGPS. All three scales rely on client self-reporting. It is generally established that clients can tend to minimize the severity of their situations. As a result, under-reporting on some of the items in these scales may be expected.

4) TECHNICAL NOTES

4.1) Data Sources:

Data for this study are derived from the AFM's client-based information system. The system combines several functions into a single process, including: client tracking; the development of client profiles based on demographic characteristics, social indicators, addictions-related activities and the consequences of those activities, along with standardized scales and scoring keys for proprietary diagnostic instruments. The system also facilitates the collection of client satisfaction measures and outcome data.

In addition to client-tracking forms, all clients entering treatment complete a set of intake and assessment forms. There are core questions that are asked of clients in all AFM programs. As well, each program also has its own set of questions germane to the issues and needs specific to that program. All forms are scannable, using ***Teleform*** as the software for this purpose. Once the forms have been verified, data are transferred directly into ***the Statistical Package for the Social Sciences*** (***SPSS***) for analysis. The data included in this study are derived from these forms. In terms of clients attending an adult treatment program for their chemical problems, the forms used include **the Adult Treatment Intake Form**, the **Adult Treatment Assessment Form** and **the Adult Treatment Information Form**. Clients attending the Gambling Program completed the AFM's **Gambling Program Intake Form** and **Assessment Form**.

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[7] Gambling Treatment staff participating in this group process included **Eva Golden**, M.Ed., CGC; **Debra Kostyk**, MSW, CGC; and **Sharon MacDonald**, RN, RPN, CGC.

4.2) Statistical Analysis:

This study uses ***Chi-Square*** as a measure of association. Measures of association show the direction and/or magnitude of a relationship between two or more variables. However, measures of association cannot denote causation.

Chi-Square is used when comparing ***nominal variables***. Examples of nominal variables include gender, ethnicity, hair colour, and so on. In these instances, there are no inherent empirical values which are associated with the variable (for example, *brown* hair as opposed to *red* hair): there is nothing indicating that one hair colour has more inherent 'value' than another.

Chi-Square itself is defined as a test of statistical significance based on a comparison of the observed cell frequencies of a ***crosstabulation***, or ***contingency table***, with frequencies that would be expected under the ***null hypothesis*** of no relationship. Where the resulting data conform to the ***expected distribution*** of cases across the cells of the contingency table, it is assumed that there is no statistical relationship between the variables being examined. That is, one variable is not seen to affect the other. Where the actual distribution of cases varies from the expected distribution of cases across this table, a relationship between the variables under review is assumed.

In order to test whether there is a ***significant*** statistical relationship between the variables under review, two additional factors must be examined. These include the ***Degrees of Freedom*** (df) associated with this table, and its ***level of probability*** (p).

Degrees of Freedom is a factor of the construction of the contingency table. It is derived by calculating the number of rows in the table (minus 1) by the number of columns in that table (minus 1). The formula then reads df=(r-1)(c-1). A two-by-two contingency table would have 1 degree of freedom (2-1)(2-1). Similarly, a four by five contingency table would have 12 degrees of freedom (4-1)(5-1). Degrees of freedom is an important element in this analysis, in that it refers to the potential for cell entries to vary freely, given a fixed set of marginal totals (ie column and row marginals).[8] The importance of reporting degrees of freedom along with Chi-Square and probability is that, the higher the degrees of freedom, the larger the value of Chi-Square required in order for statistical significance to occur.

Probability asks the question: how ***likely*** is it that the relationship observed in the sample data could be obtained from a population in which there was no relationship between the two variables? If it can be shown that this probability is very high within the general population then, even though a relationship exists in that larger sample, it is concluded that the two variables are not related. As a minimal standard, probability must be at least **.05** or less ($P < .05$) in order for there to be a finding of a statistical significance. That is, in order for the data to be considered significant, it would be expected that the results which were obtained would occur, where there was no relationship between the variables being analyzed, less than five times out of a hundred. This is a minimum standard. In social science research, there is a grey area

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[8] For a more in-depth explanation of ***Degrees of Freedom*** see Bohrnstedt and Knoke, pps 118-121.

in which borderline correlations are said to exist. This includes probabilities of .06 through .09. Where these occur the results are presented in a qualified format.

Throughout this study we have found probabilities that read ***<.00001***. This is interpreted as meaning that the likelihood of obtaining the observed distribution by chance or sampling error is *less than one in one hundred thousand.*

CHAPTER TWO
THE STUDY FINDINGS

1) CLIENT CHARACTERISTICS:

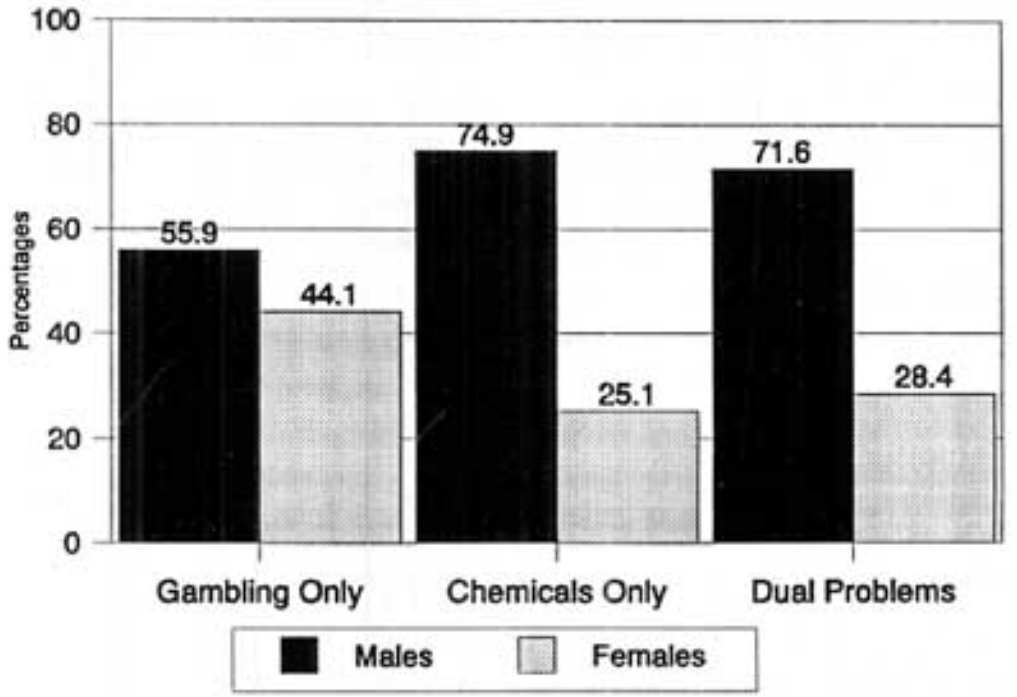
The first section of this chapter compares some of the demographic characteristics of clients with problems solely with chemicals, those with problems solely with gambling, and those with dual problems.

1.1) Demographics:

Gender:

Clients solely with gambling problems were more evenly distributed by gender than were those with either chemical problems or dual problems (Figure 2). In this instance, **44.1%** of the gambling only group were female, compared with **25.1%** of the chemicals only group and **28.4%** of those with dual problems. These differences are considered statistically significant (N=1094; Chi-Square=26.37; df=2; p <.00001).

Figure 2 Gender By Type Of Problem



N=213; 494; 387

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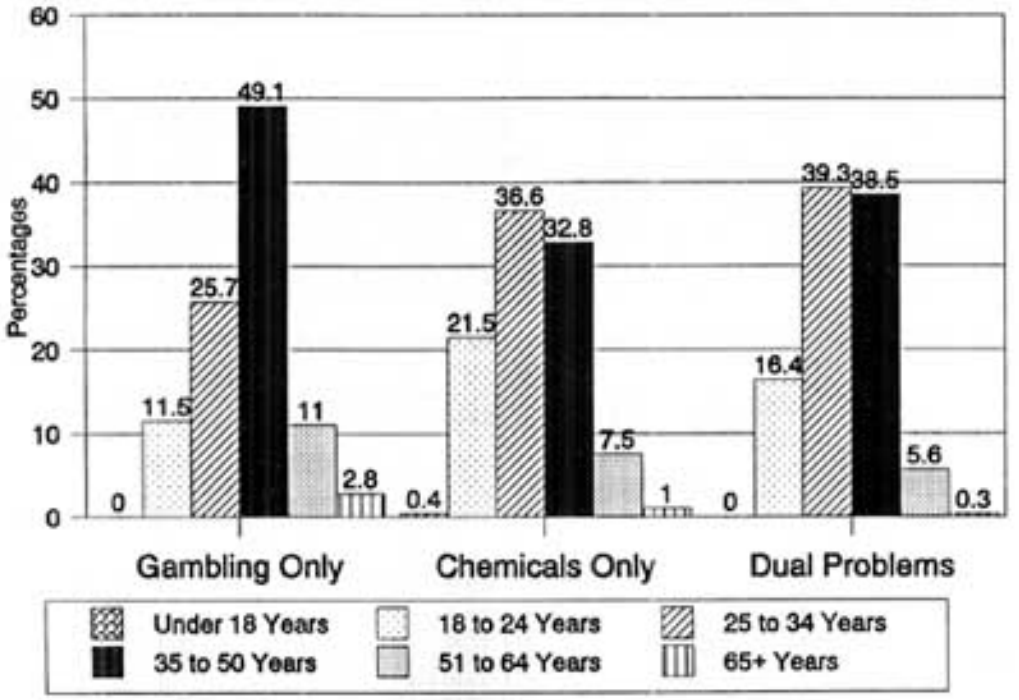
Age:

Clients experiencing either sole problems with chemicals or those with dual problems reflect very similar ages, as compared with those solely with gambling problems (Figure 3). In terms of the former, there was a fairly even distribution between clients 25 to 34

years of age and those 35 to 50 years of age. However, in terms of the latter group, almost half of those with problems related solely to gambling were 35 to 50 years of age. This same group also had a somewhat larger percentage of clients ages 51 to 64 years. These differences are considered statistically significant (N=1073; Chi-Square= 42.68; df=2; p=.00001).

Figure 3 Age By Type Of Problem



N=218; 478; 377

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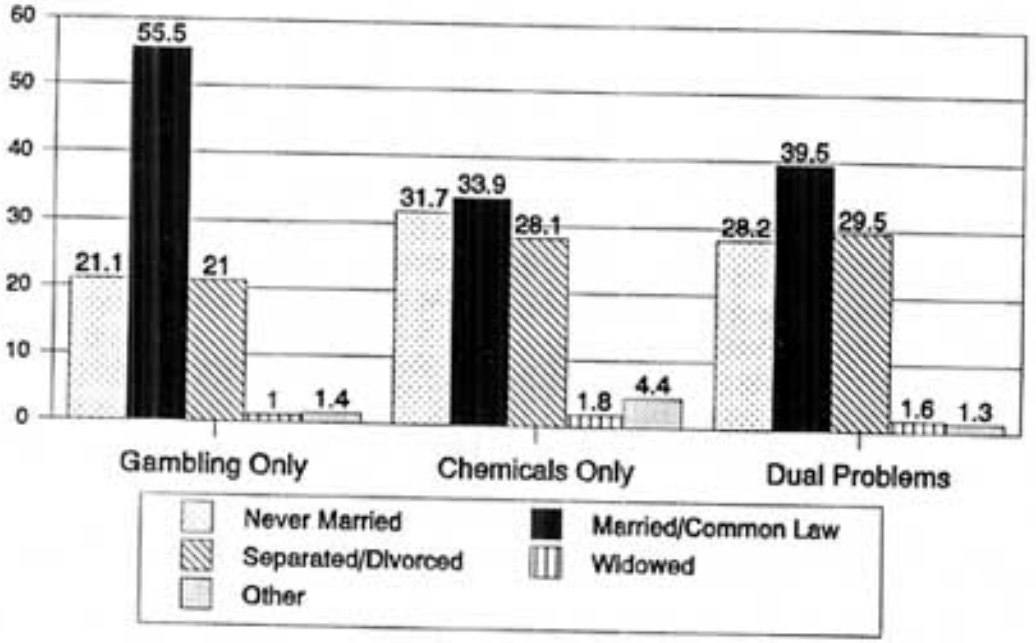
Marital Status:

Gambling only clients were significantly more likely to be married than were their counterparts (Figure 4). **Fifty-five percent** of the gambling only group were married, compared with **33.9%** of those with chemical problems and **39.5%** of the dual problem group. The latter two groups were more likely to have never been married, and to be separated or divorced, as compared with the gambling group. These differences are considered statistically significant (N=1084; Chi-Square=48.84; df=2; p <.00001).

Education:

Clients in the gambling only group were significantly more likely to report at least a complete high school education than were their counterparts (Figure 5). In this case, only **5.0%** of the gambling only group had less than a grade nine education and none of these clients had an incomplete high school education. Conversely, **20.8%** of the chemicals only group had less than a grade nine education, while another **35.1%** reported an incomplete high school education. In addition, **21.4%** of the dual problem group had less than a grade nine education, and just under another **23.6%** reported

Figure 4 Marital Status By Type Of Problem



N=209; 495; 380

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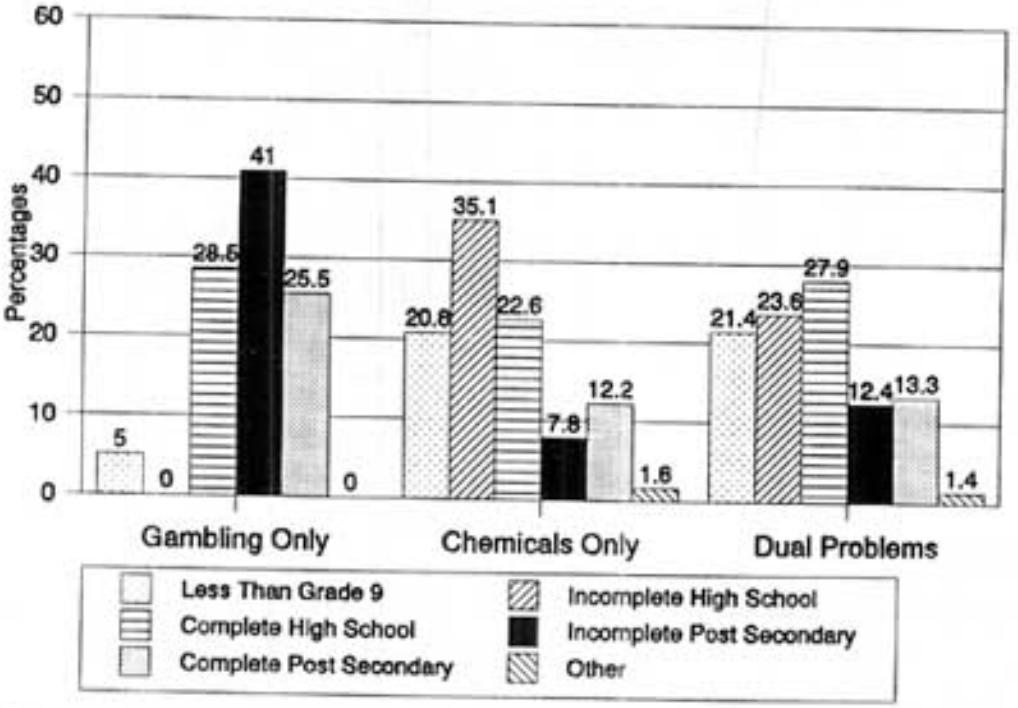
Figure 5 Education By Type Of Problem



N=200; 501; 369

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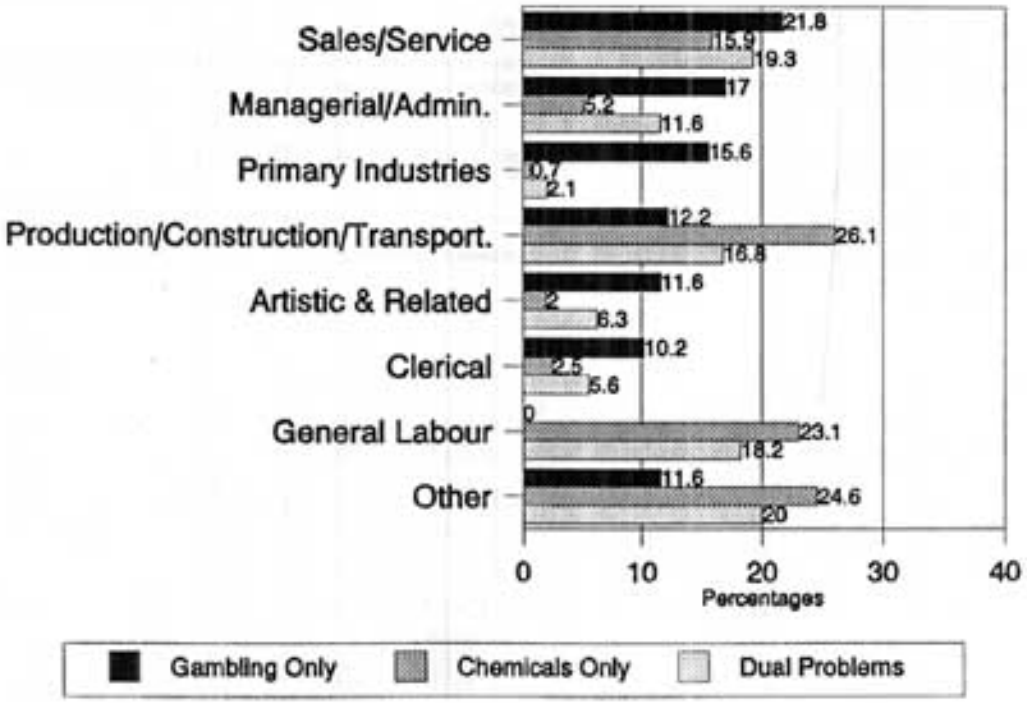
incomplete high school. Forty-one percent of the gambling only group had some post secondary education, while **25.5%** reported a complete post secondary education. In terms of some post secondary education, this was reported by **7.8%** of the chemicals only group, and **12.4%** of the dual problem group. Finally, **12.2%** of the clients in the chemicals only group, and **13.3%** of those in the dual problem group, reported a complete post secondary education (N=1070; Chi-Square=224.21; df=10; p <.00001).

Occupations:

Occupations varied significantly across the three client populations (Figure 6). Those solely with gambling problems were more likely to be employed in sales or service industries (**21.8%**); be in managerial or administrative positions (**17.0%**); or be employed in the primary industries (**15.6%**). None were employed in general labour. Clients with problems with chemicals were most likely to be employed in production, construction or transportation industries (**26.1%**); general labour (**23.1%**); or other occupations (**24.6%**). Finally, those exhibiting problems with both chemicals and gambling were generally employed across a broader range of occupations. This includes sales and service (**19.3%**); general labour (**18.2%**); production, construction or transportation industries (**16.8%**); and other occupations (**20.0%**) (N=835; Chi-Square=174.89; df=14; p<.00001).

Figure 6 Occupation By Type Of Problem



N=147; 403; 285

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1.2) Indicators Of Client Stability:

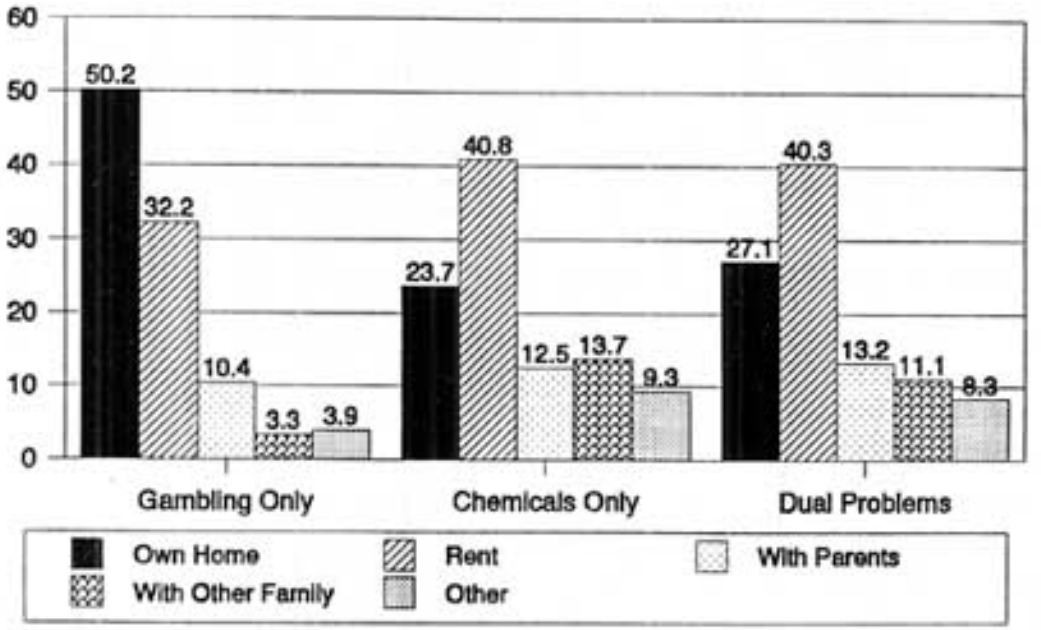
There are several social characteristics of AFM clients that are collectively viewed as

indicators of stability. These include: living arrangements; numbers of residences during the previous twelve months; employment status; number of jobs held during the preceding five years; and household income.

Living Arrangements:

Clients with only gambling problems were significantly more likely to own their own homes than were those with chemical or dual problems (Figure 7). **Half** of the gambling only group owned their own homes (**50.2%**), compared with **23.7%** of those with chemical problems and **27.1%** of those with dual problems. Clients with chemical problems and those with dual problems, were more likely to rent than were those in the gambling only group (**40.8%**, **40.3%** and **32.2%**, respectively). The former two groups were also more likely to live with other family members (**13.7%**, **11.1%** and **3.3%**, respectively) (N=1088; Chi-Square=68.26; df=10; p <.00001).

Figure 7 Living Arrangements By Type Of Problem



N=211; 497; 380

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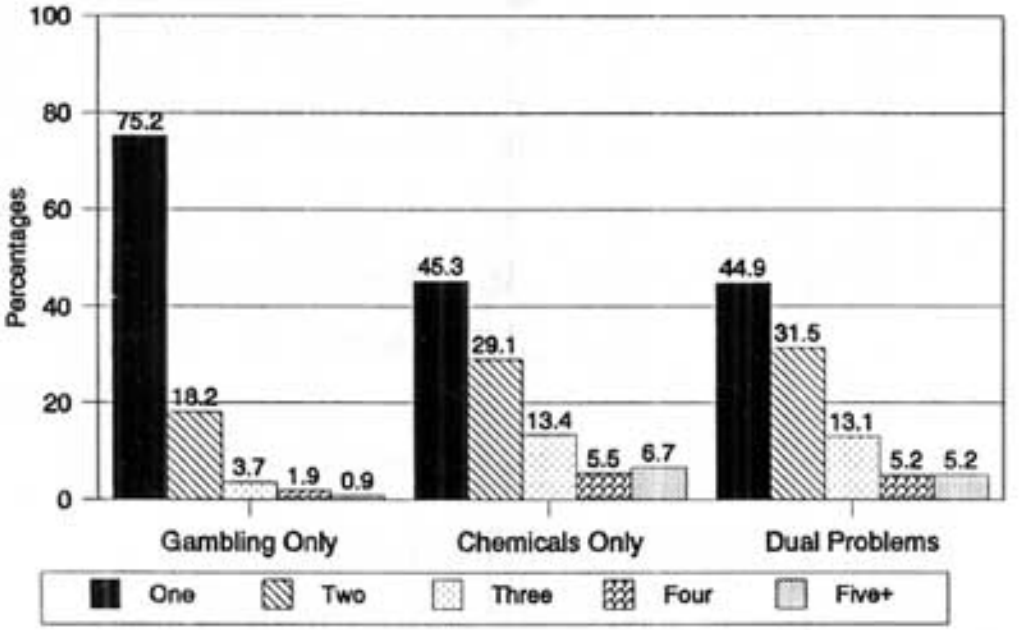
Number Of Residences:

One primary indicator of stability is the level of transiency. Clients with only gambling problems were significantly more likely to report residing in one residence during the year preceding entering treatment (Figure 8). In this instance, **75.2%** the gambling group reported living in one residence during this period, with another **18.2%** reporting one move. In contrast with this finding, **45.3%** of the clients with chemical problems of reported living in one residence during the preceding year, while **29.1%** reported one

move; **13.4%** reported two moves, and **6.7%** reported five or more moves. In terms of those with dual problems, **44.9%** reported living in the same residence during the preceding year, **31.5%** reported one move; **13.1%** reported two moves; and **5.2%** reported moving five or more times (N=1101; Chi-Square=68.30; df=8; p <.00001).

Figure 8 Number Of Residences Past 12 Months By Type Of Problem



N=214; 506; 381

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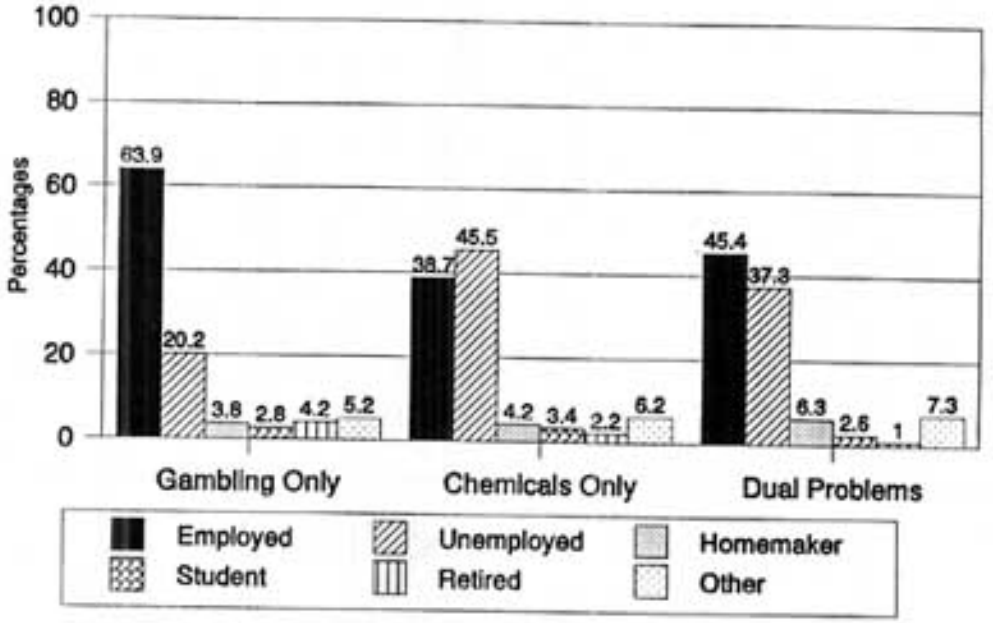
Employment Status:

Almost two-thirds of the gambling only group reported being employed at the point when they entered treatment (**63.9%**), while another **20.2%** were unemployed (Figure 9). This is compared with employment rates of **38.7%** of the chemicals only group and **45.4%** of the dual problem group. Conversely, **46.5%** of those with only chemical problems reported being unemployed, as did **37.3%** of those with dual problems. Other employment categories were generally consistent across these three groups (N=1098; Chi-Square=58.21; df=14; p <.00001).

Number Of Jobs Held Past Five Years:

Gambling only clients also showed the greatest stability in terms of the number of jobs held for the five years preceding treatment (Figure 10). In this case, all of these individuals have been employed at least once during this period, **56.4%** have held the same job, **20.8%** have had two jobs, and **22.8%** have held three or more jobs. This is compared with the chemicals only group, of which **11.3%** did not work during this five year period, **34.3%** held one job, **18.1%** held two jobs, and **59.1%** held three or more

Figure 9 Employment Status By Type Of Problem



N=214; 506; 381

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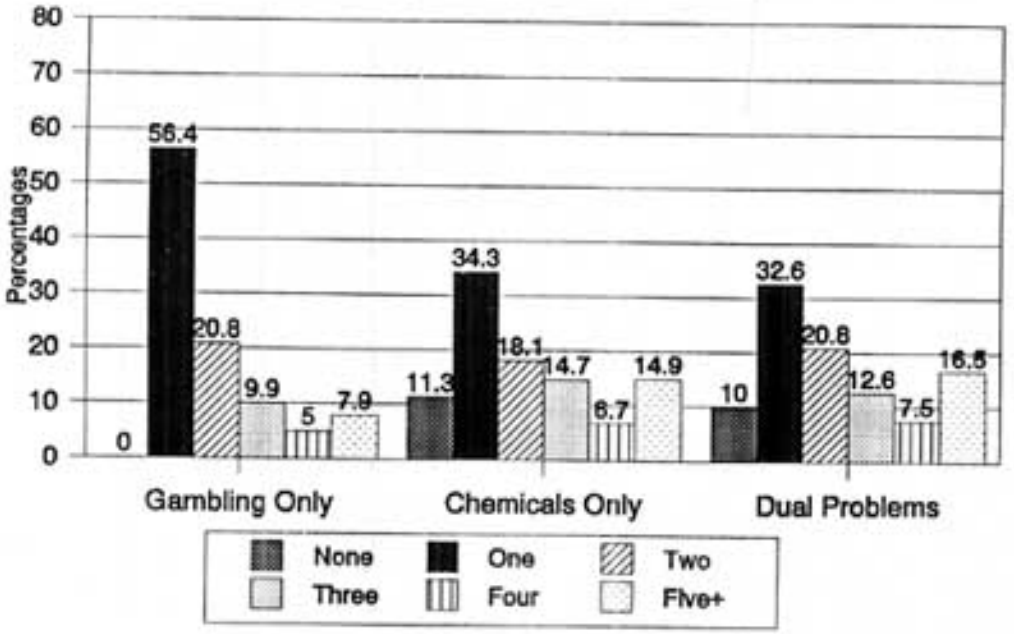
Figure 10 Number of Jobs Past 5 Years By Type Of Problem



N=202; 504; 389

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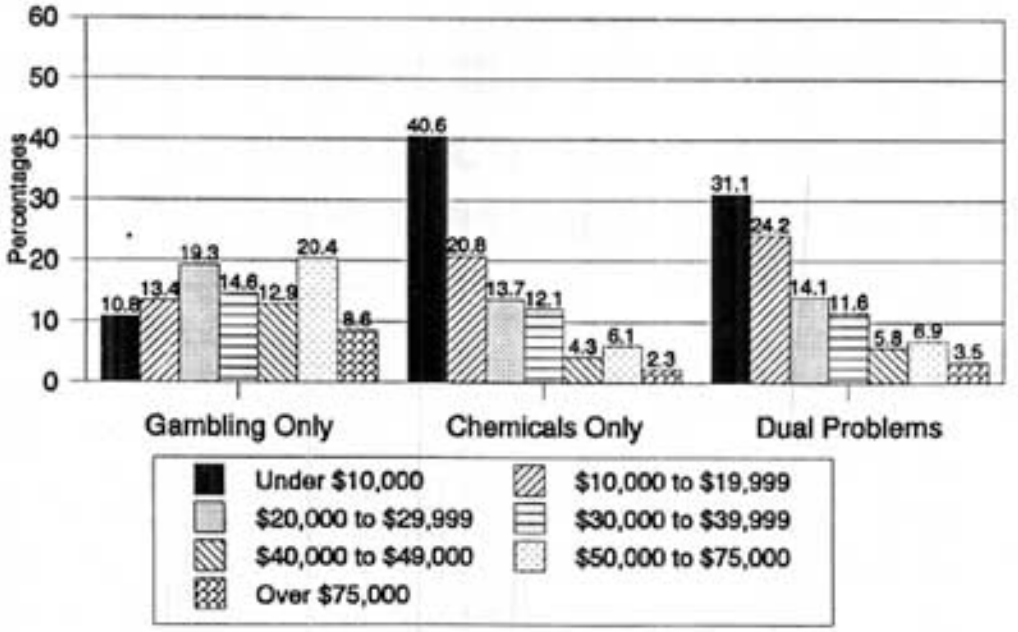
jobs. The percentage breakdown for the dual problem group was very similar to the one describing clients solely with a chemical problem (N=1095; Chi-Square=57.15; df=10; p <.00001).

Annual Household Income:

Not surprisingly, based on the previous data, clients' household incomes vary significantly across these three groups (Figure 11). The household incomes of clients with only gambling problems reflects a somewhat standard distribution. In this instance, **10.8%** of these clients reported household incomes under $10,000; **13.4%** reported incomes of $10,000 to $19,999; **19.3%** reported incomes of $20,000 to $29,999; while **20.4%** reported incomes ranging from $50,000 to $75,000, and **8.6%** reported incomes exceeding $75,000. The income profiles of both those with only chemical problems, and those with dual problems, reflects a downward trend, with the lowest incomes predominating. This was most dramatic regarding clients with only chemical problems. Four out of ten of these clients (**40.6%**) reported household incomes under $10,000, while another **20.8%** reported incomes between $10,000 and $19,999. Only **8.4%** of these individuals reported household incomes exceeding $50,000.

Figure 11 Household Income By Type Of Problem



N=186; 394; 318

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In terms of clients with dual problems, **31.1%** reported incomes under $10,000, with another **24.2%** reporting incomes ranging from $10,000 to $19,999. Just over **ten percent** of these clients had household incomes exceeding $50,000 (N=898; Chi-Square=107.06; df=18; p <.00001).

1.3) Summary:

The fact that there were demographic differences between clients attending the AFM's gambling program and those seeking help for problems with chemicals is already well-documented.[9] This study has demonstrated that the characteristics of clients with chemical problems applies to those with dual problems as well.

There may also be cohort effects regarding client stability. That is, individuals who are better-educated are more likely to be employed than those with incomplete high school. They may also be more likely to work in fulfilling positions, thereby increasing their likelihood of remaining in a position over time. Along with stable employment they are more likely to have higher household incomes and to own their own homes. With more positive living conditions, they are more likely to stay in one residence over time.

1.4) Implications For Treatment:

A common question in the addictions field is whether or not all addictions are essentially the same in nature. The study data have shown there are differences in terms of demographic characteristics among individuals who seek treatment at the AFM, based on the type of problems they are experiencing. This may suggest the need for a range of treatment modalities that best suit the characteristics of those clients presenting for help. For example, social stability appears to be higher among gambling clients and lower among the chemical only and dual problem clients. These differences can have relevance as to how treatment providers will deliver services to these clients.

Implications Of Marital Status:

AFM gambling treatment staff have found, generally, that gambling clients who are married tend to seek help in order to: attempt to fix the problem before the family finds out about the gambling; out of fear of losing their family; or because the family has given the gambler an ultimatum. Given that gambling clients generally appear more likely to have intact families, the AFM has implemented a more integrated program for gambling clients and their spouses.

Keeping these families connected with the treatment program is important. For example, AFM treatment staff report that the gambling clients who remain in treatment tend to be the ones with families encouraging them to stay. Involvement of spouses or significant others at the outset of treatment has several additional benefits.

- Gambling Program treatment staff can provide family members with information about gambling addiction and offer emotional support. Spouses are often in the paradoxical situation of having to *let go* emotionally of the gambler's problem, but at the same time *take control* financially.

- It is not realistic to expect gambling clients to accurately relay information about the addiction and recovery to their families.

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[9] See **AFM Gambling Clients: Two Profiles**, the Addictions Foundation of Manitoba, 1996

- It is reported that gambling clients have a greater likelihood of staying in treatment if their spouses are also involved in treatment. In this sense the family becomes an ally to the treatment team.

- Unnecessary future deterioration of relationships can be minimized. Conventional wisdom in the addictions field has suggested that clients and spouses often need to disentangle emotionally from one another before recovery can occur. Our experience has shown that concurrent spousal involvement is an asset and should occur sooner rather than later.

- Finally, there is a group of clients that may have little or no family support. At the very least they are not married or in a common-law relationship. To maintain these clients in treatment, it may be necessary to use surrogates to the support that a family network would otherwise provide these individuals.

Social Stability:

The data have shown that there are marked differences between gambling only clients on the one hand, and chemical only and dual problem clients on the other, with regard to the indicators of social stability. This includes clients' education, occupation, employment stability/record, income, and housing. In terms of content and process, the AFM treatment program has evolved to its present state based on the characteristics of existing clients. For example:

- Increased stability appears to make the majority of gambling only clients candidates for outpatient treatment.

- Educational materials and didactic sessions used in treatment sessions must be compatible with clients' education levels and cognitive abilities. The two client groups with gambling problems (i.e. gambling only and dual problem clients) may have differing levels of comprehension and ability to think abstractly: dual problem clients may be effected by chemically-induced cognitive impairment. Treatment staff may need to adapt educational materials if the presence of a chemical problem has effected clients' comprehension levels.

- The majority of gambling only clients are employed. Therefore, greater flexibility on the part of service providers in offering evening and weekend services may be required, in order to accommodate the work schedules of these clients, and to encourage their continued participation in treatment.

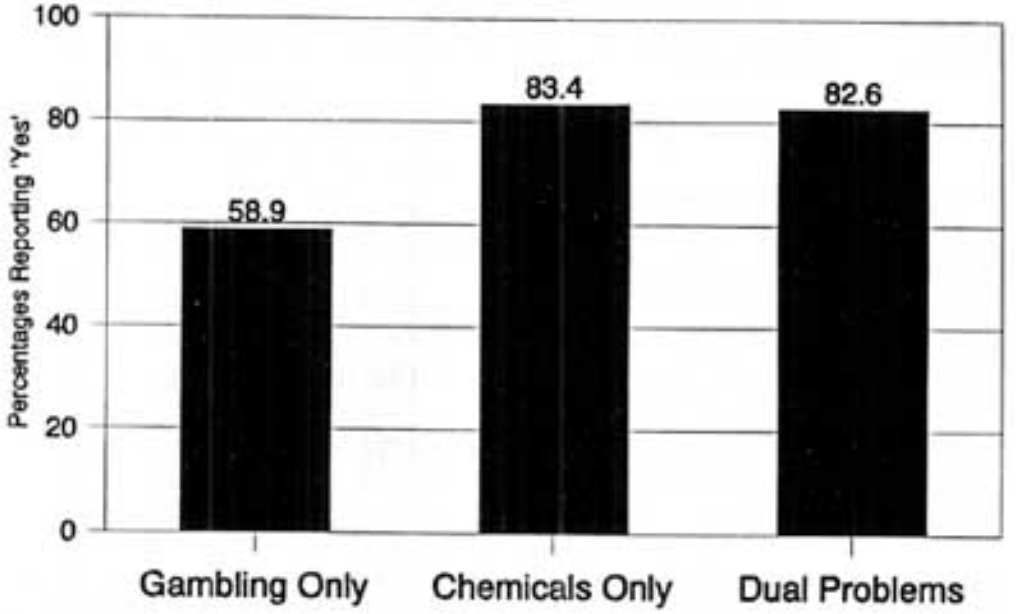
2) CLIENT CONSUMPTION:

2.1) Tobacco Consumption:

Clients in the gambling-only group were significantly less likely to report smoking tobacco than were their counterparts, although rates of tobacco consumption still exceed that reported by the general population (Figure 12). While the rate of tobacco consumption among those with chemical problems only was **83.4%**, and **82.6%** of the clients with dual problems reported smoking tobacco, the rate for those solely with gambling problems was **58.9%**. These differences are considered statistically

significant (N=1106; Chi-Square=58.89; df=2; p <.00001). This is compared with a rate of **27.0%** for the general population across Canada.[10] The Manitoba rate is **27.3%**.

Figure 12 Whether Clients Smoke Tobacco By Type Of Problem



N=209; 507; 390

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2.2) Drugs Of Choice:

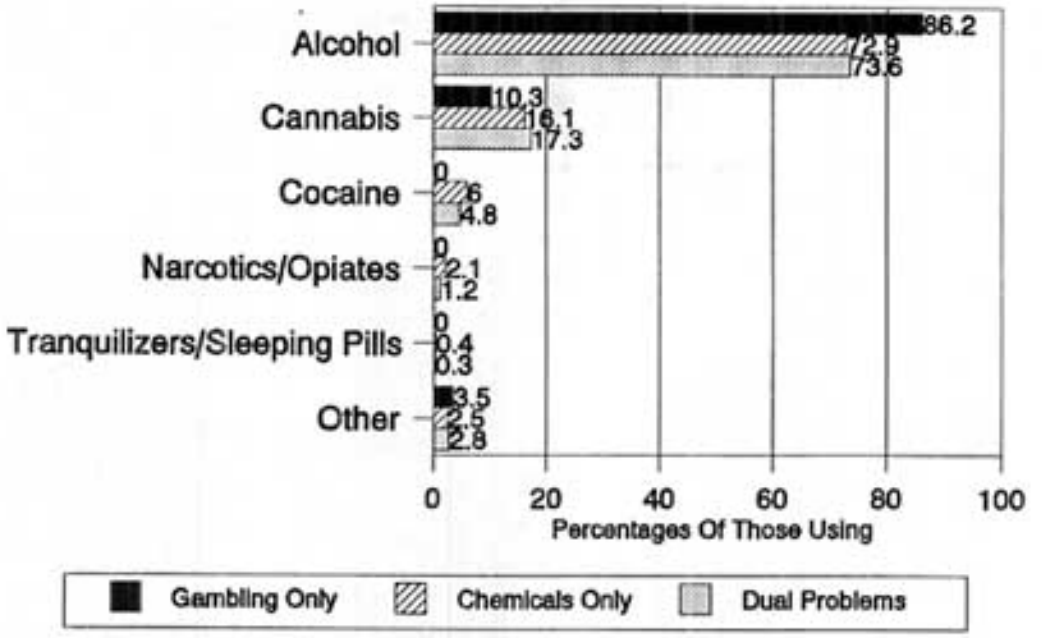
There were no significant differences regarding drugs of choice selected by clients, across these three groups (Figure 13). In all instances, alcohol was the most frequently cited drug of choice among those reporting the use of chemicals. This was consistently followed distantly by cannabis (N=842; Chi-Square=12.07; df=20; p=.91).

2.3) Drugs Consumed During The Preceding Forty-Five Days:

While there were no differences regarding what clients defined as their primary drugs of choice, there was a significant difference in the extent to which they reported consuming varied substances during the forty-five days preceding entry into treatment. This analysis examined the consumption of the four most frequently used substances: alcohol, cannabis, cocaine and tranquillizers or sleeping pills. Those with gambling as their sole problem were consistently least likely to report the consumption of each substance, while rates of consumption were very similar between the remaining two groups (Figure 14). These results are considered statistically significant (see table).

[10] **Canadian Profile: Alcohol, Tobacco and Other Drugs**; published by the Canadian Centre on Substance Abuse and the Addictions Research Foundation of Ontario, 1997, Pps 63 & 76

Figure 13 Primary Drug Of Choice By Type Of Problem



N=29; 483; 330

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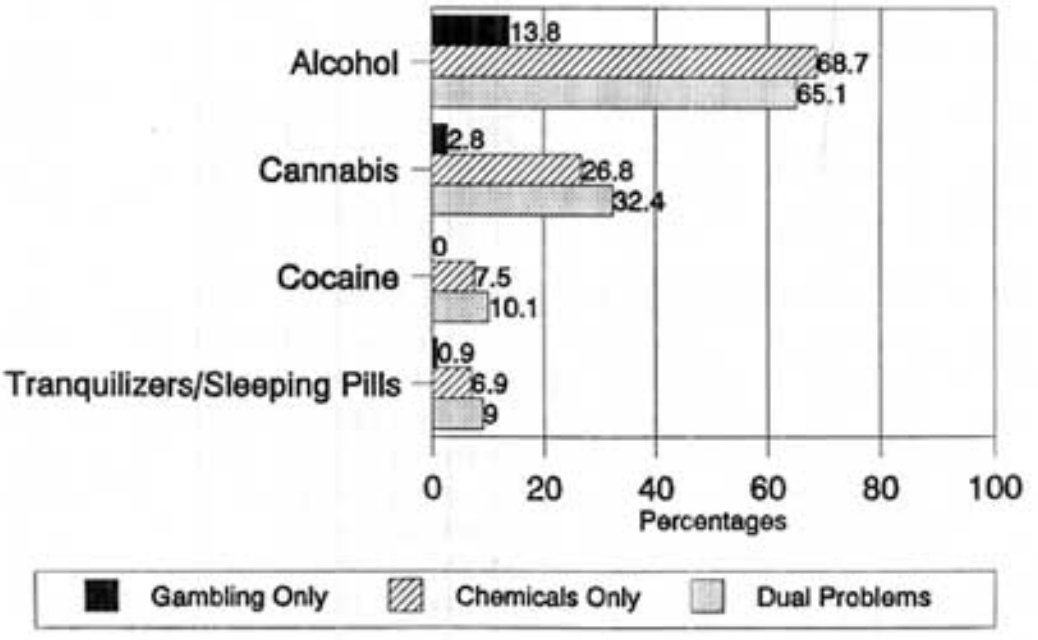
Figure 14 Drugs Used Past 45 Days By Type Of Problem



N=218; 518; 398

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Substances Used Correlated With Problem-Type	N	Chi-Square	df	p
Alcohol	1134	205.79	2	<.00001
Cannabis	1134	71.33	2	<.00001
Cocaine	1134	22.42	2	.00001
Tranquillizers/Sleeping pills	1134	15.54	2	.00042

2.4) Treatment Implications:

Drug Use During The Preceding 45 Days:

Clients with only gambling problems were most likely to report that alcohol was their primary drug of choice (**86.2%**). However, they were also least likely to report any alcohol consumption during the 45 days prior to admission (**13.8%**). Based on AFM Gambling Program treatment staff observations, gambling clients are often involved in very high frequency gambling just prior to admission, to the exclusion of most other activities, including alcohol consumption. The implication appears to be that the extent to which alcohol is a problem for some of these clients may be higher than the data indicate. To rule out a possible coexisting alcohol problem which may be non-apparent (because excessive gambling has precluded any other high risk behaviour), a more extensive alcohol consumption history may be required.

While rates of the pre-admission use of other drugs by chemical and dual problem clients was fairly even, the latter were slightly more likely to report the consumption of cannabis, cocaine, and tranquilizers or sleeping pills prior to admission. Service providers who encounter individuals with recent multiple drug use, other than alcohol, are advised to screen for a coexisting gambling problem. Given their recent history of pre-admission chemical use, dual problem clients have an increased likelihood of intoxication and/or withdrawal, and cognitive impairment. In these circumstances, where the effect of chemical usage is more apparent, the gambling problem (of a dual problem client) can be missed and, therefore, not addressed.

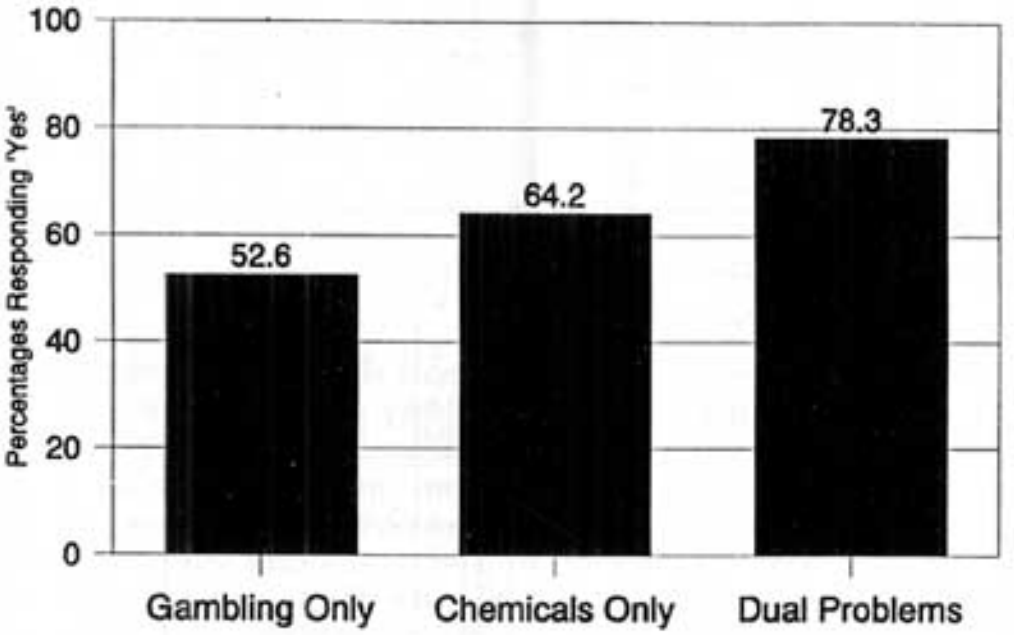
3) FAMILY OF ORIGIN ISSUES:

A number of questions asked at the point of intake relate to clients' experiences as children. The first asks clients whether someone in their family had a problem with alcohol, other drugs or gambling, when they were growing up. Clients with dual problems were most likely to report a family history or these problems (with **78.3%** reporting that this was the case). These were followed by clients with chemical problems only (**64.2%**), and gambling problems only (**52.6%**) (Figure 15). These differences are considered statistically significant (N=837; Chi-Square=24.89; df= 2; p <.00001).

The Effect of Gender:

There were some variations in responses when this question was analyzed by client gender (Figure 16). First, females were consistently more likely to report being affected

Figure 15 When Growing Up Did A Family Member Have A Chemical/Gambling Problem?



N=57; 466; 314

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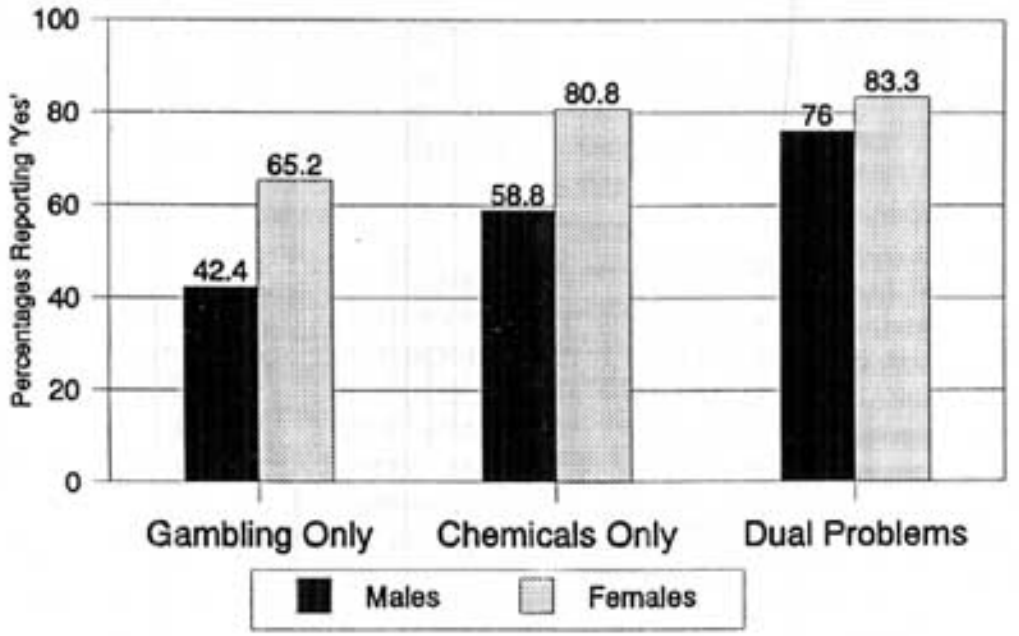
Figure 16 Did Family Member Have Problems With Chemicals/Gambling? By Problem & Gender



N=33/23; 325/120; 217/90

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by someone else's alcohol, drug or gambling problem than were males. However, when comparisons were made across the three study groups, the resultant differences are statistically significant when it comes to males in this study, but not for the females.

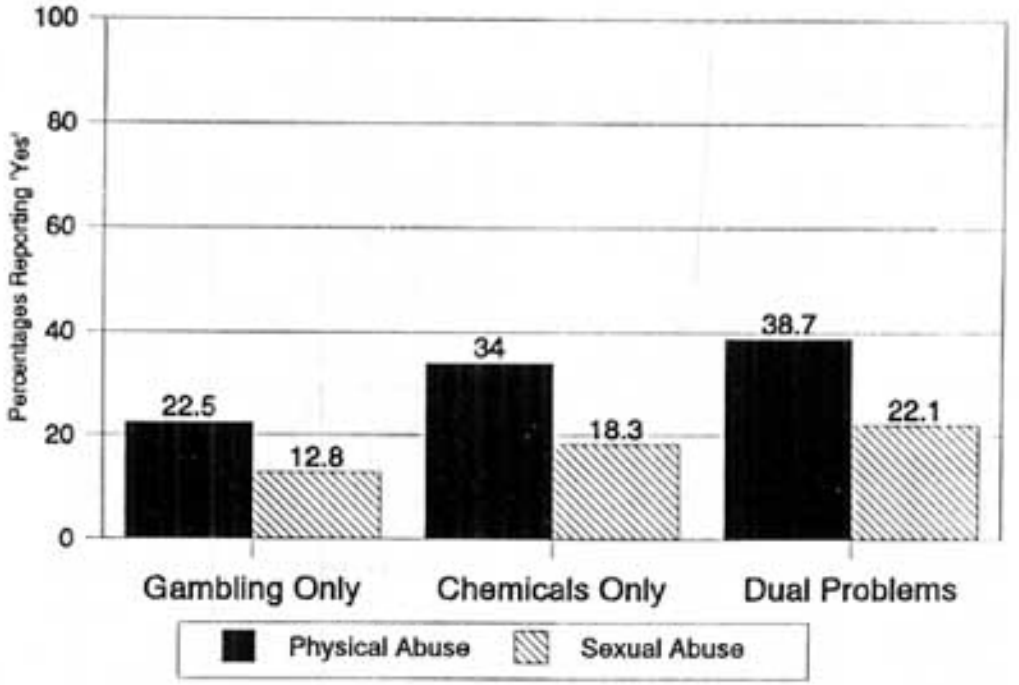
For males, **76.0%** of those with dual problems reported that someone in their family of origin had a chemical or gambling problem, compared with **58.8%** of those with only chemical problems and **42.4%** of those with only gambling problems (N=575; Chi-Square=24.25; df=2; p=.00001).

In terms of the females, **83.3%** of those with dual problems were affected by someone else's chemical or gambling problem, compared with **80.8%** of those with only chemical problems, and **65.2%** of those with only gambling problems. These differences are ***not*** considered statistically significant (N=233; Chi-Square=3.85; df=2; p=.15).

3.1) History Of Abuse:

Clients with dual problems were significantly more likely to report experiencing physical and sexual abuse than were their counterparts (Figure 17). In terms of those with dual problems, **38.7%** experienced physical abuse at one time, and **22.1%** experienced sexual abuse. Those numbers drop somewhat regarding clients with only chemical problems (**34.0%** reporting physical abuse and **18.3%** reporting sexual abuse). Clients with only gambling problems were least likely to have experienced either form of abuse (**22.5%** reporting physical abuse and **12.8%** reporting sexual abuse).

Figure 17 History Of Abuse By Type Of Problem



N=122/22; 299/130; 288/131

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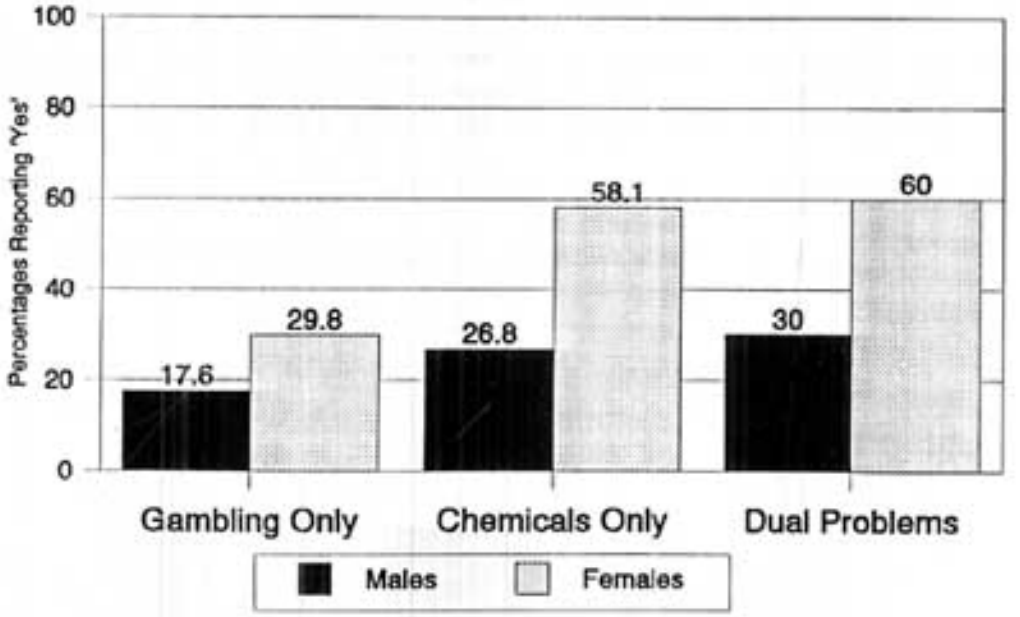
Abuse Experienced By Problem Type	N	Chi-Square	df	p
Physical Abuse	1134	16.78	2	.00023
Sexual Abuse	1134	8.03	2	.018

The Effect of Gender:

i) Physical Abuse:

There was a correlation between gender and reports of physical abuse, by type of problem. In all cases, regardless of gender, clients with dual problems were most likely to report physical abuse, followed by those with only chemical problems, and gambling only clients (Figure 17.1). In all cases, however, female clients were generally twice as likely to report physical abuse than were male clients.

Figure 17.1 History Of Physical Abuse By Gender And Type Of Problem



N=119/94; 370/124; 277/110

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In terms of the males in this study, **17.6%** of the clients with only gambling problems reported experiencing physical abuse at some time, compared with **26.8%** of those solely with chemical problems, and **30.0%** of those with dual problems. These differences are considered statistically significant (N=766; Chi-Square=6.51; df=2; p=.038).

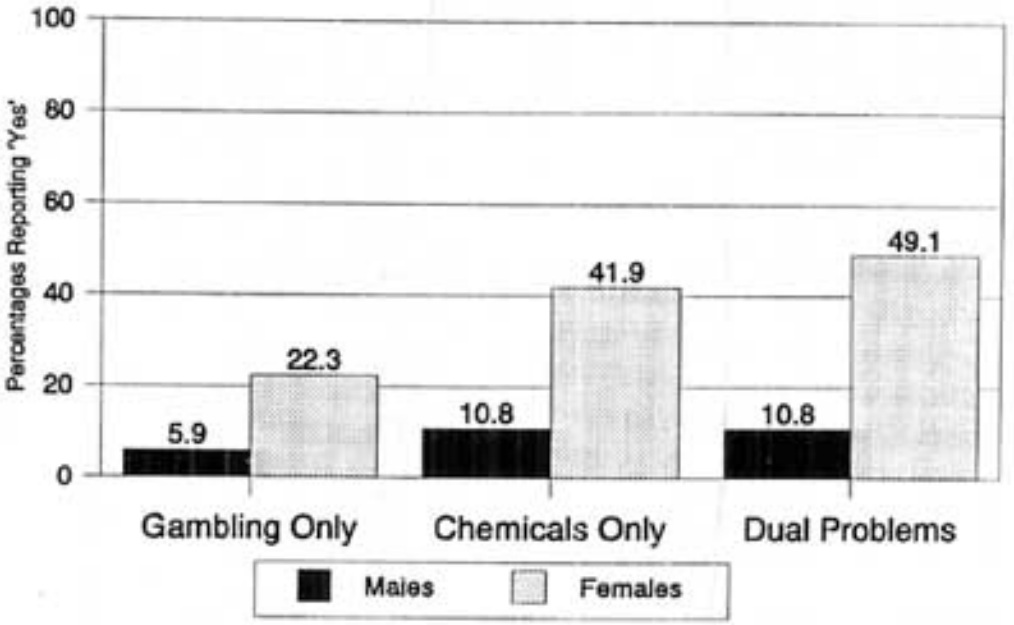
In terms of female clients, differences were more significant. About thirty percent of the

females in this study (**29.8%**) with only gambling problems reported being physically abused at some time, compared with **58.1%** of those with chemical problems only and **60.0%** of those with dual problems (N=328; Chi-Square=22.94; df=2; p=.00001).

ii) Sexual Abuse:

Gender differences were more pronounced when it came to reports of clients being sexually abused than they were with regard to physical abuse (Figure 17.2). In terms of male clients, no significant differences emerged across the three study groups with regard to sexual abuse. Sexual abuse was reported by **5.9%** of the male clients with only gambling problems, and **10.8%** of both those with only chemical problems and those in the dual problem group (N=766; Chi-Square=2.71; df=2; p=.26).

Figure 17.2 History Of Sexual Abuse By Gender And Type Of Problem



N=119/94; 370/124; 277/110

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Differences were much more significant when it came to the females in this study. First, females were much more likely to report having been sexually abused than were males. In addition, there was extensive variation in responses, for females, across the three study groups. Specifically, **22.3%** of those in the gambling problem group reported having been sexually abused, compared with **41.9%** of those with only chemical problems and **49.1%** of those with dual problems. These differences are considered statistically significant (N=328; Chi-Square=16.16; df=2; p=.00031).

3.2) Treatment Implications:

The number of clients reporting a family history of chemical or gambling problems, and

a personal history of physical or sexual abuse, was lowest among gambling only clients and highest among the dual problem clients. The current trend in addiction treatment is to match clients to appropriate treatment based on individual client needs. The data demonstrate that dual problem clients, although demographically similar to chemical only clients, are more likely to have family and abuse issues that may require specialized, and/or more intense, treatment. Although further research is required, this preliminary study supports the need for programs tailored to the specific life situations of gamblers' spouses and other family members. Anecdotal reports from the spouses of problem gamblers suggest there are two types of family clients.

- The first type is one for whom the gamblers' problem has just been discovered. Just under half of the gambling only clients appear to be in this category. There was no prior indication of a gambling problem, nor is there a family history of addiction. For the spouses of these gamblers, the gambling problem quite literally came out of no where. These spouses often require short term, practical, self-protection skills regarding family finances, problem-solving, and contracting with the gambler.

- The second type of family client is one for whom their gamblers' problem is part of a long history of marital and premarital problems, apparently including addiction and abuse. Three-quarters of the dual problem clients fall in this category. There is also an indication of a history of addictive behaviour within their families of origin. In addition to practical problem-solving skills, the spouses of these gamblers may also benefit from longer term, insight-oriented individual or family counselling.

4) VIOLENT BEHAVIOUR:

Clients were asked two questions regarding violent behaviour. The first asked them whether they have a history of violent behaviour. The second asked whether they behave violently when using chemicals.

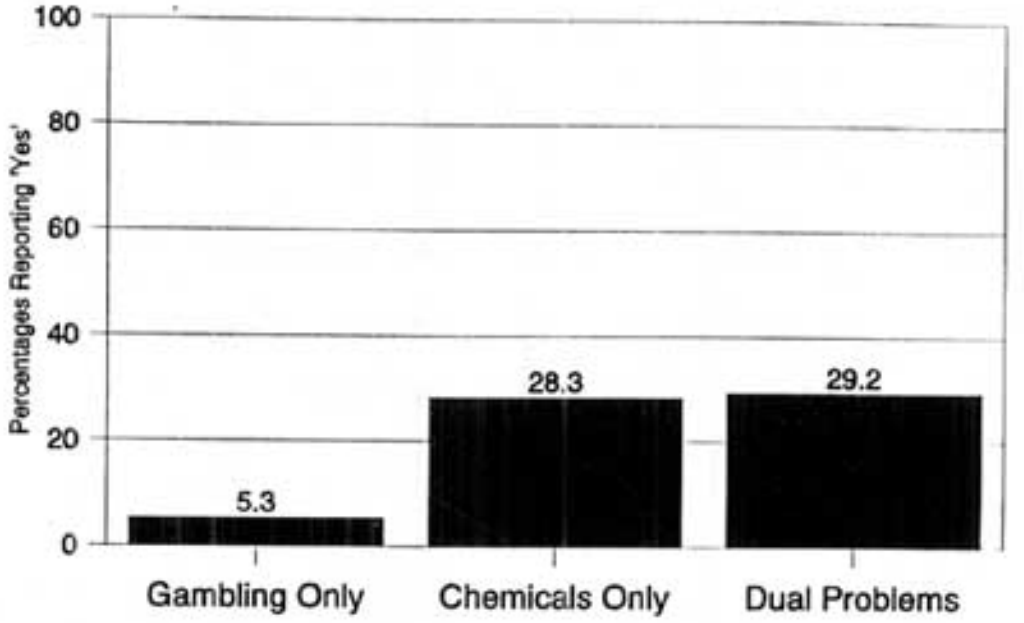
i) A History Of Violent Behaviour:

A history of violent behaviour was significantly more widely reported by clients with chemical problems and those with dual problems (Figure 18). Only **5.3%** of the clients with only gambling problems reported a history of violence, compared with **28.3%** of those with chemical problems, and **29.2%** of those with dual problems (N=987; Chi-Square=49.48; df=2; p <.00001).

ii) Violence Under The Influence:

A smaller percentage of clients with gambling problems reported being violent while under the influence (**2.5%**), than did those reporting violence behaviour in general (see previous data). However, clients with only chemical problems, and those in the dual problem group, were more likely to report being violent while under the influence, than they were to report violent behaviour in general (35.4% and 38.4%, respectively) (Figure 19) (N=973; Chi-Square=90.68; df=2; p <.00001). In both instances, rates of violence, and violence while under the influence, were negligible for gambling clients, but higher and similar for the remaining client groups.

Figure 18 Did Clients Have A History Of Violent Behaviour? By Type Of Program



N=207; 431; 349

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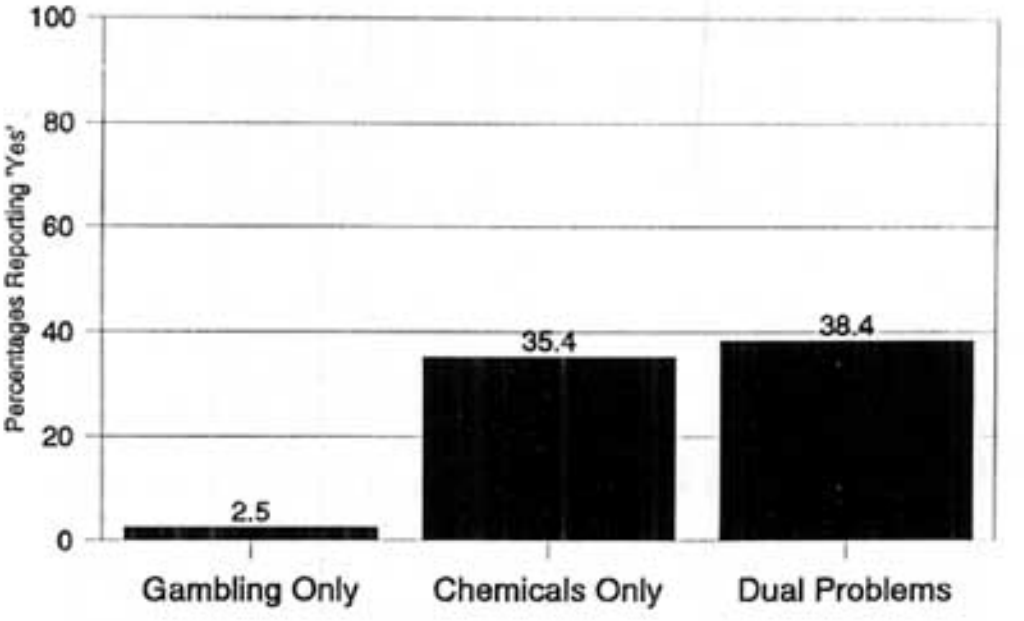
Figure 19 Did Clients Have History Of Violent Behaviour Under The Influence?



N=201; 426; 346

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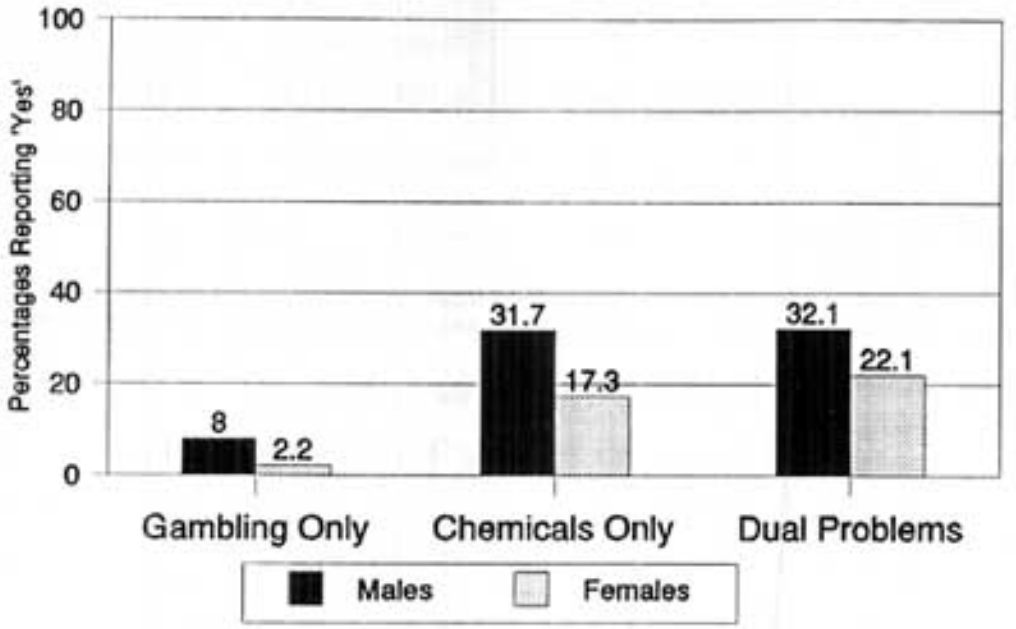
The Effect Of Gender:

In all cases, males were more likely than females to report violent behaviour, regardless of the type of problem they present. However, when it comes to violence while under the influence, these differences were much less pronounced across the three study groups (Figures 20 & 21). In addition, previously described patterns were consistent by gender. That is, clients with only gambling problems, regardless of gender, were least likely to report violent behaviour, or violence while under the influence, while the rates of both were very similar for clients with only chemical problems and those with dual problems within gender categories.

Figure 20 History Of Violent Behaviour? By Problem & Gender



N=113/89; 312/98; 243/95

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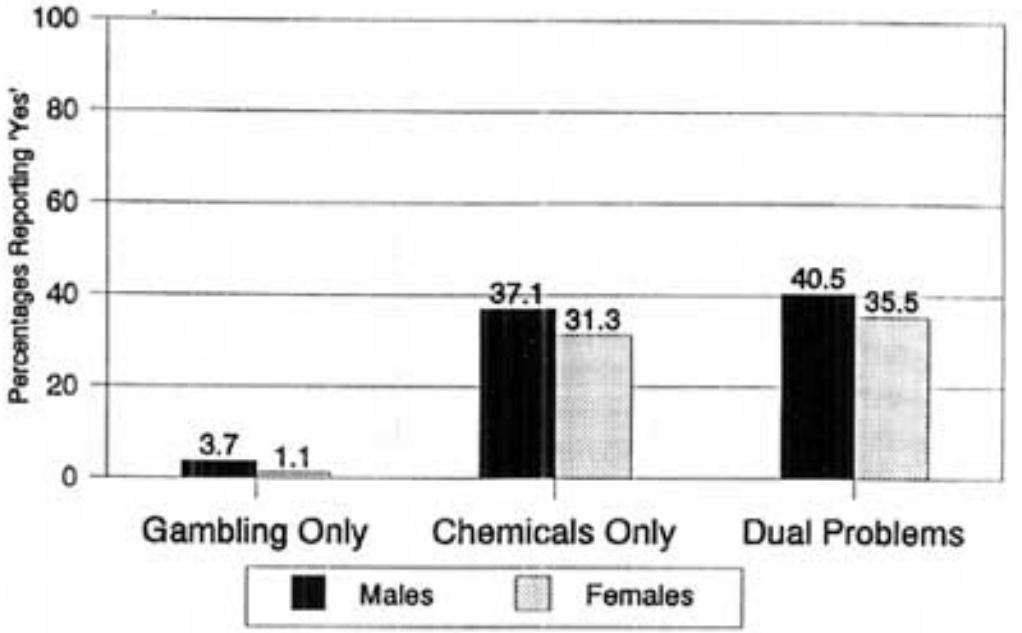
4.1) Implications For Treatment:

Clients with dual problem, and those with only chemical problems, had the higher reported incidence of violent behaviour. This was particularly true of male clients. Two treatment implications follow:

- Treatment programs that treat dually addicted clients should be aware that they may have potentially more volatile clients within this population. For example, dual problem clients were six times more likely to report a history of violence than were the gambling only clients. Where this population is included with clients who only have gambling problems, consideration should also be given to the safety of all clients and staff.

Figure 21 History Of Violent Behaviour While Under The Influence? By Problem & Gender



N=108/88; 310/96; 242/93

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Gender	Violence By Problem Type By Gender	N	Chi-Square	df	p
Males	History Of Violence	668	26.76	2	<.00001
	Violent Under The Influence	660	50.52	2	<.00001
Females	History Of Violence	282	16.12	2	.00032
	Violent Under The Influence	277	35.51	2	<.00001

- When dual problem clients are involved in treatment, anger management, controlling aggression, and attention to appropriate problem-solving skills, may be relevant for this client population.

5) CLIENT MENTAL HEALTH & SUICIDAL IDEATION:

The last area of inquiry included in this study relates to mental health issues and clients' suicidal ideation.

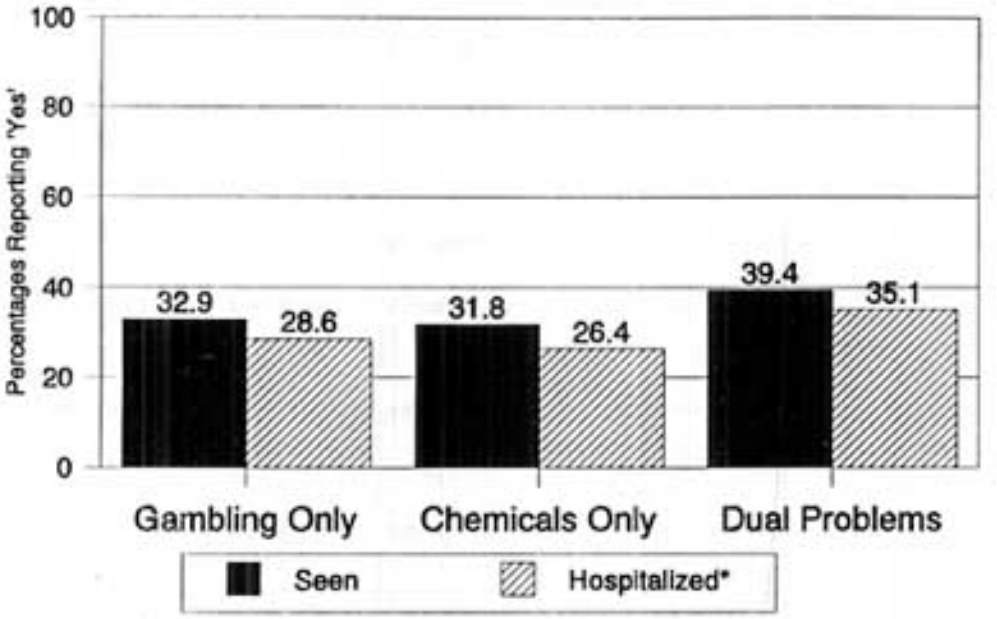
5.1) Mental Health Issues:

Clients were asked whether they had ever been seen for emotional or mental health

issues or problems. This was followed by asking those who were seen whether they were also hospitalized for these same problems.

Almost **forty percent** of the clients with dual problems reported having been seen for emotional or mental health problems (Figure 22). The rates with which this was reported by the clients with single problems (either chemical or gambling) was fairly consistent, with **32.9%** and **31.8%** of the clients in the gambling only and chemical only groups (respectively) reportedly being seen. While the findings appear to indicate that those with dual problems were more inclined to seek professional help for their mental health issues than were their counterparts, only borderline significance resulted from this analysis (N=976; Chi-Square=5.19; df=2; p=.07).

Figure 22 Had Clients Been Seen Or Hospitalized For Emotional/Mental Problems?



N=213/70; 415/144; 348/148
(*Percentages of those who had been seen)

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When a correlation was undertaken regarding rates of hospitalization for mental health problems, by type of problem, no significant differences emerged (N=362; Chi-Square=2.77; df=2; p=.25).

The Effect Of Gender:

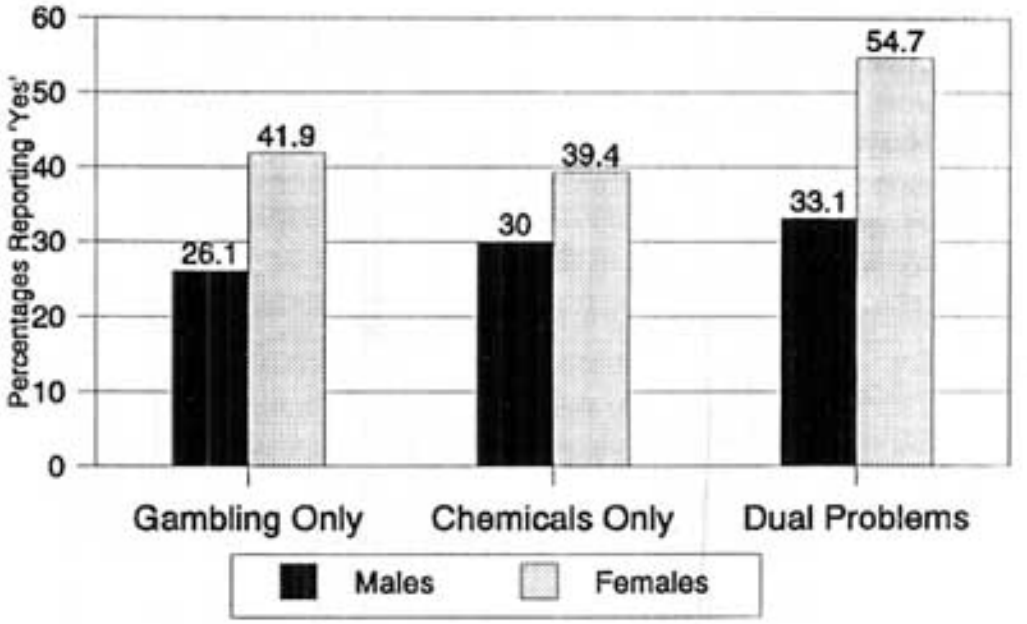
Being Seen For Mental Health Problems:

Females were much more likely to report having been seen for emotional or mental health problems than were their male counterparts, regardless of which of the three study groups they were in (Figure 23). When analysis was undertaken by gender, across each of the three study groups, there was no significant difference in the extent to which males reported being seen. In this instance, **33.1%** of the males in the dual

group reported being seen for emotional or mental health problems, compared with **26.1%** of those with only a gambling problem and **30.0%** of those with only a chemical problem (N=654; Chi-Square=1.84; df=2; p=.40).

Rates for females were suggestive of differences between these groups, although they are only considered to have borderline statistical significance. In this case, **54.7%** of the females in the dual problem group had been seen for an emotional or mental health issue, compared with **41.9%** of those with a gambling problem and **39.4%** of those with a chemical problem (N=287; Chi-Square=5.23; df=2; p=.07).

Figure 23 Clients Been Seen For Emotional/ Mental Problems? By Problem & Gender



N=115/93; 297/99; 242/95

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Being Hospitalized For Mental Health Problems:

Differences emerged regarding clients who were hospitalized for mental health problems, by gender. Females with dual problems were more likely to be hospitalized than were males (**41.7%** and **31.6%**, respectively). This trend was reversed with regard to clients with only gambling problems (**21.6%** and **34.4%**). Finally, the distribution was fairly even with regard to those with only chemical problems (**25.0%** and **28.1%**).

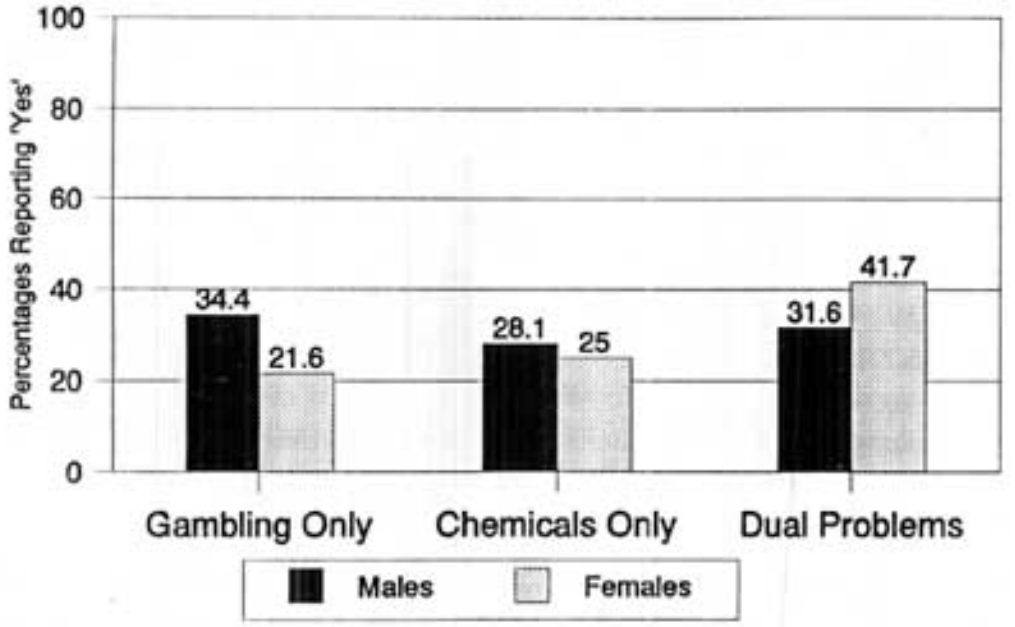
The Effect Of Gender:

Analyzing these data by gender, across the study groups, differences between males and females again emerged. First, no significant differences appeared by type of problem regarding male clients (Figure 24). Hospitalization for mental health problems

was reported by **34.4%** of those in the gambling problem group, who were seen for mental health problems; compared with **28.1%** of those in the chemical problem group and **31.6%** of the dual problem group (N=223; Chi-Square=0.53; df=2; p=.77).

For the females in this study, those in the dual problem group were more likely to be hospitalized for their mental health problems than were their counterparts, although these differences reflect only borderline significance. Hospitalization was reported by **21.6%** of the females in the gambling problem group, who had been seen for mental health problem; compared with **25.0%** of those in the chemical problem group; and **41.7%** of those in the dual problem group (N=129; Chi-Square=4.85; df=2; p=.09).

Figure 24 Hospitalized Because Of Emotional Or Mental Problems? By Problem & Gender



N=32/37; 96/44; 95/48

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5.2) Suicidal Ideation:

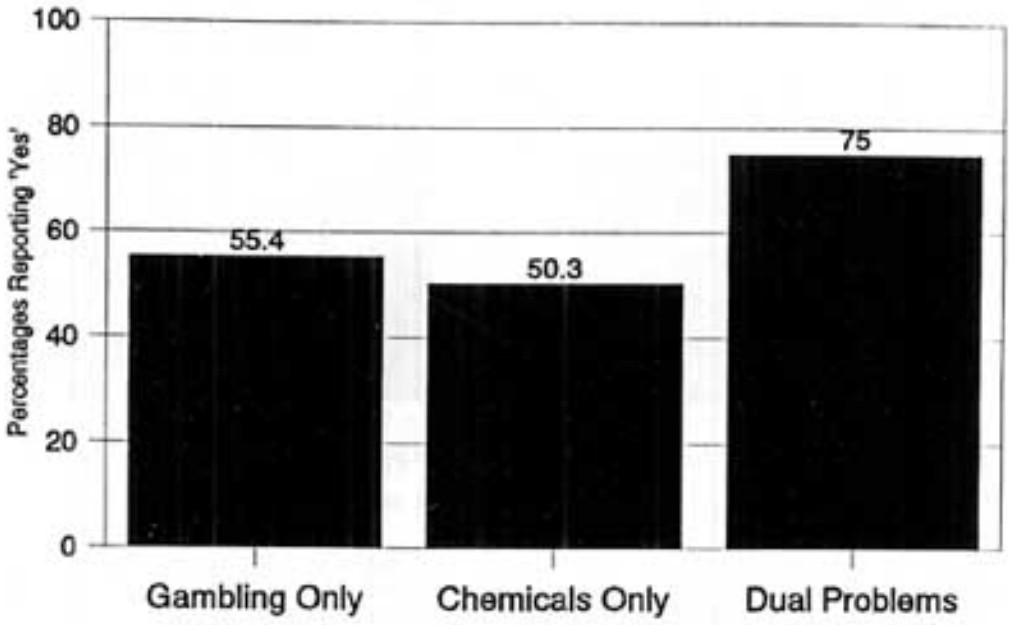
The AFM asks all clients questions regarding suicidal ideation as part of the client assessment process. Some relate to precursors of suicide: thinking life is not worth living and having thoughts of suicide. Some relate to whether clients have ever attempted suicide and, if so, whether they were *under the influence* at the time. From the data, it appears that the existence of dual problems increased the likelihood that clients may both consider and attempt suicide.

Thinking That Life Is Not Worth Living:

While a high percentage of all clients in this study reported ever feeling that 'life is not

worth living,' clients with dual problems were significantly more likely to do so (Figure 25). This was reported by **75.0%** of the clients with dual problems, compared with **55.4%** of those with only gambling problems and **50.3%** of those with only chemical problems (N=974; Chi-Square=51.41; df=2; p=<.00001).

Figure 25 Clients Ever Felt Life Is Not Worth Living? By Type Of Problem



N=193; 429; 352

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Thinking About Committing Suicide:

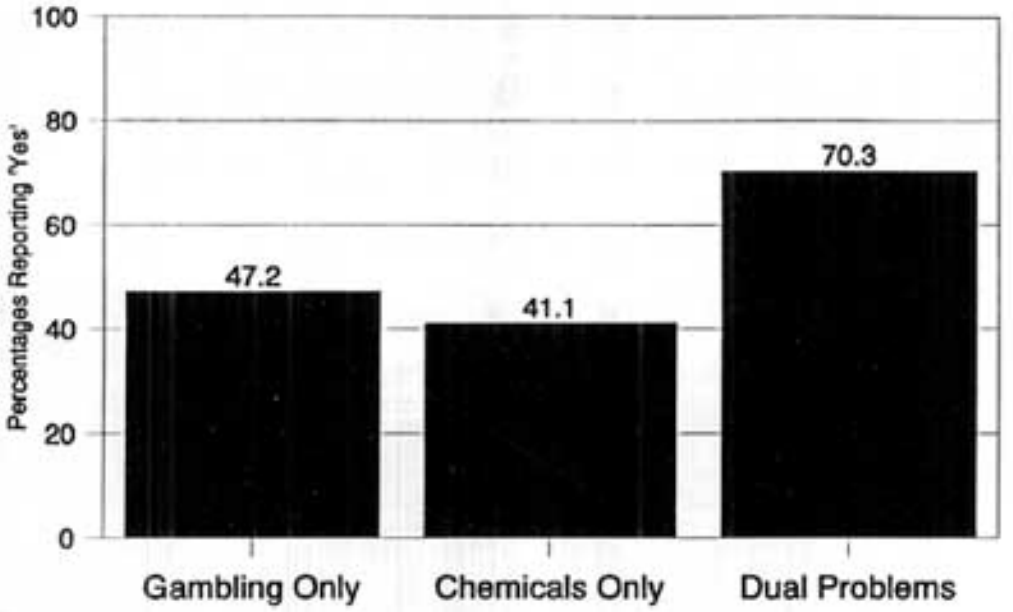
This same trend was present in terms of those reporting ever having thought about committing suicide (Figure 26). Of those clients with dual problems, **70.3%** reported they had thought about committing suicide at some time in their lives. This is compared with **47.2%** of the clients with only gambling problems, and **41.1%** of those with only chemical problems. Again, while thoughts of suicide were high for clients in all three study groups, it was significantly higher for those with dual problems (N=973; Chi-Square=68.84; df=2; p<.00001).

The Effect Of Gender:

Life Is Not Worth Living:

Females in both the gambling only and chemical only groups were more likely to have reported feeling that 'life was not worth living' than were their male counterparts. However, males and females in the dual problem group appeared equally likely to report this feeling (Figure 27).

Figure 26 Have Clients Ever Thought Of Committing Suicide? By Type Of Problem



N=195; 428; 350

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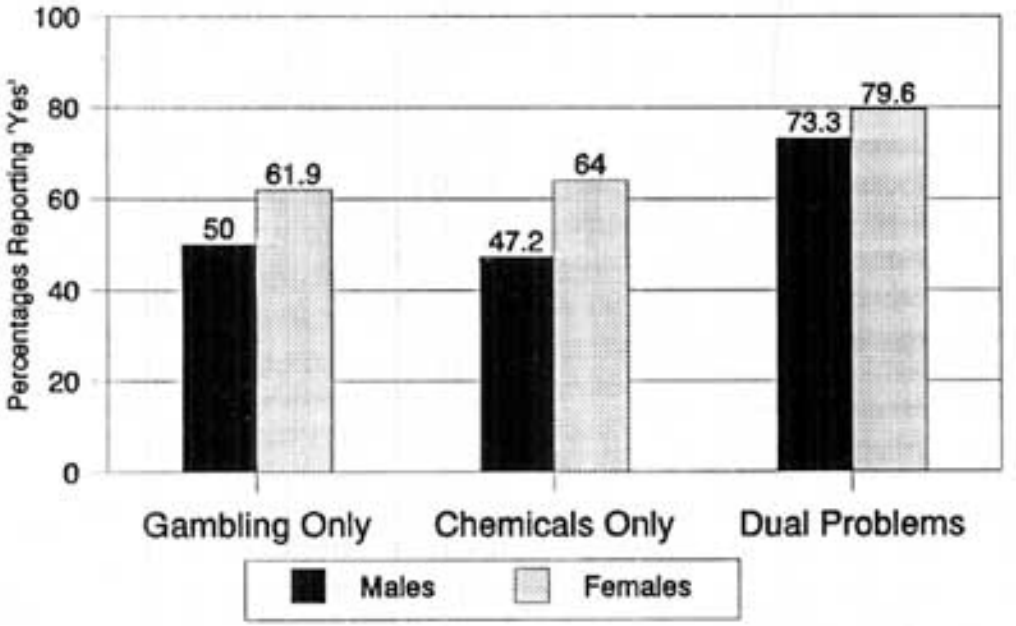
Figure 27 Had Clients Ever Felt Life Is Not Worth Living? By Problem & Gender



N=104/84; 309/100; 243/98

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'Life Not Worth Living' By Gender	N	Chi-Square	df	p
Males	656	40.30	2	<.00001
Females	282	8.25	2	.016

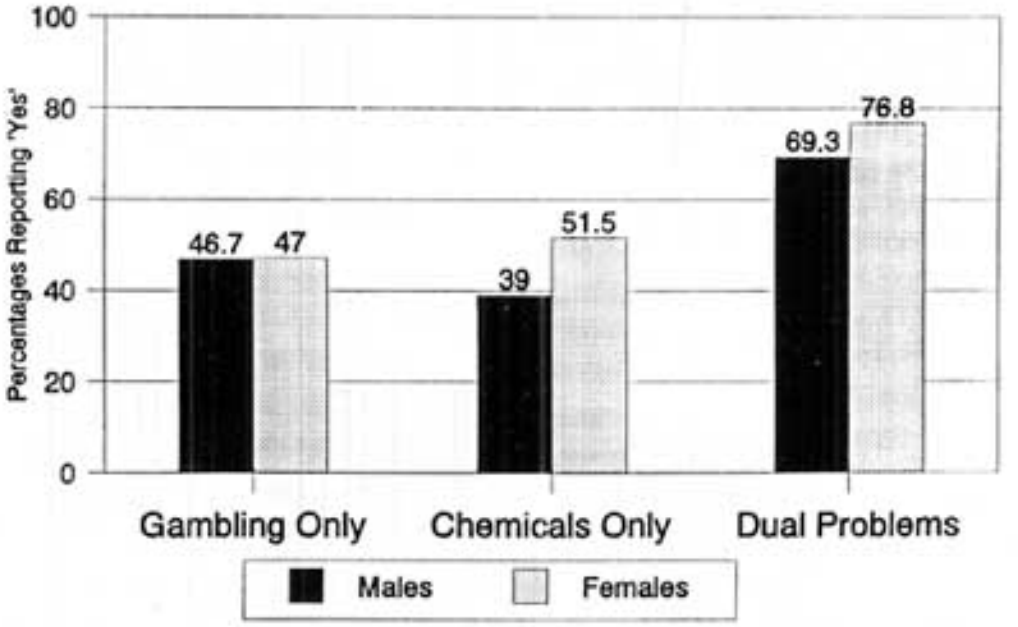
Analyzing gender *across* the three study groups, both males and females in the dual problem group were significantly more likely than their counterparts to have felt that 'life is not worth living.' In terms of males, **73.3%** of those in the dual problem group reported this feeling, compared with **50.0%** of those with only gambling problems and **47.2%** of those with only chemical problems.

In terms of females, this feeling was reported by **79.6%** of those in the dual problem group, compared with **61.9%** of those with gambling problems and **64.0%** of those with chemical problems.

Having Thoughts Of Suicide:

The distribution of males and females who have thought of suicide was virtually identical for clients with gambling problems and, to a lesser extent, with regard to the dual problem clients (Figure 28). In terms of the former, **46.7%** of males solely with gambling problems have thought of suicide compared with **47.0%** of the females. In terms of the dual problem group, **69.3%** of the males in this group have thought of suicide, compared with **76.8%** of the females. Only within the group of clients solely

Figure 28 Had Clients Ever Thought Of Committing Suicide? By Problem & Gender



N=107/83; 308/99; 241/99

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Thoughts of Suicide By Gender	N	Chi-Square	df	p
Males	656	50.90	2	<.00001
Females	281	20.17	2	.00004

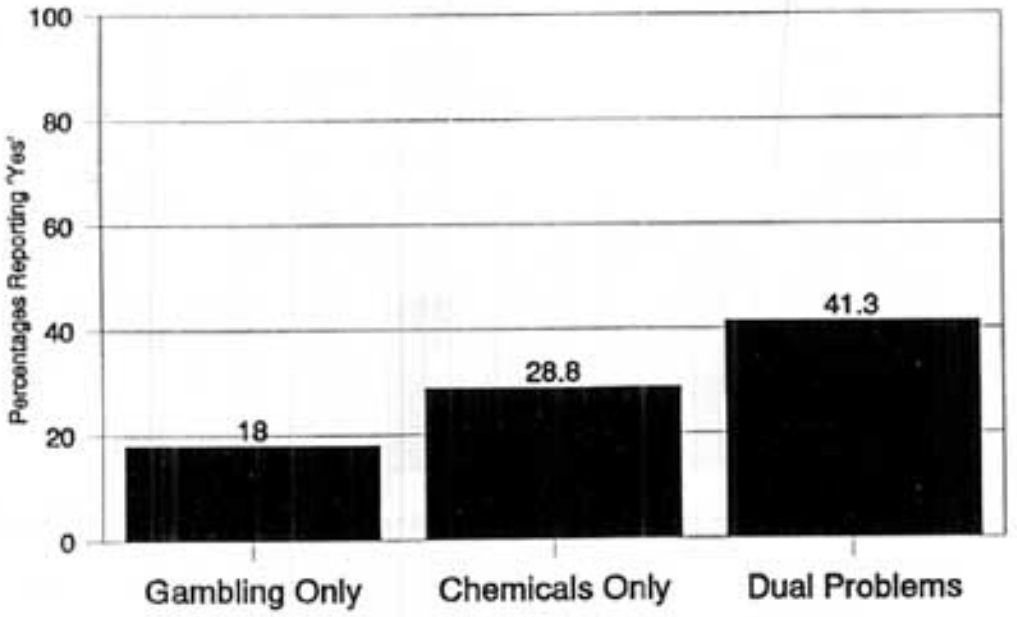
with chemical problems were there notable differences (**39.0%** of the males had thought of suicide compared with **51.5%** of the females).

However, analyzing these data by gender *across* the three groups, clients with dual problems were again significantly more likely to have thought of suicide than were their counterparts. Regarding male clients, **69.3%** of the dual problem males had thought of suicide, compared with **46.7%** of clients with only gambling problems and **39.0%** of those with only chemical problems. In terms of the females, **76.8%** of those in the dual problem group had considered suicide, compared with **47.0%** of those with gambling problems and **51.5%** of those with chemical problems.

5.3) Reported Suicide Attempts:

Clients reporting thoughts of suicide were asked whether they had ever attempted suicide. Consistent with previous findings, clients in the dual problem group were most likely to report attempting suicide (Figure 29). Just over **forty percent** of the dual problem clients, who had thought of suicide, had attempted suicide. In contrast, suicide

Figure 29 If Clients Considered Suicide Did They Attempt It? By Type Of Program



N=122; 299; 288

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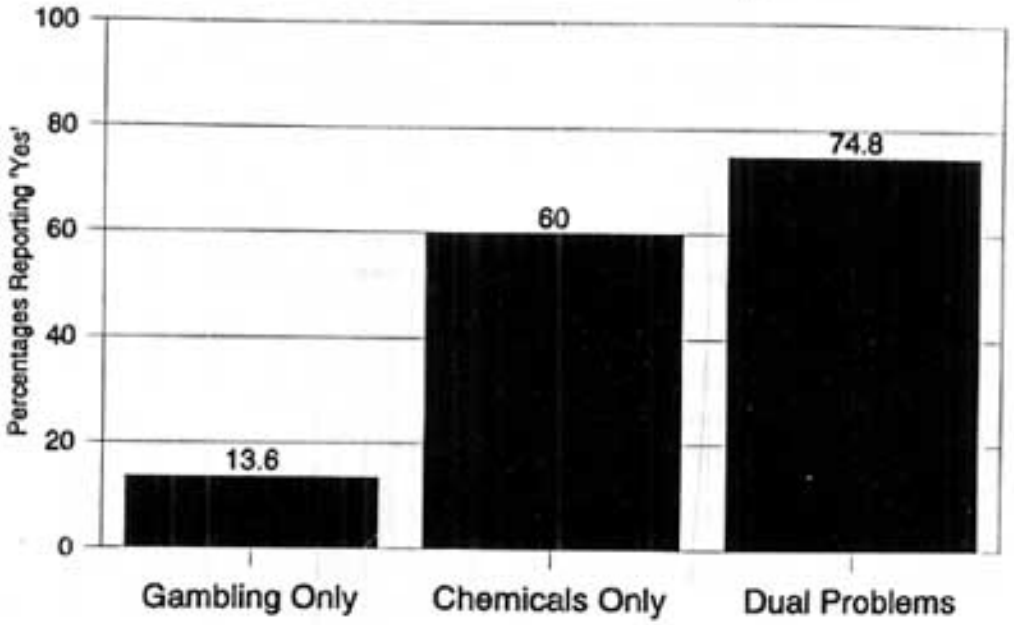
attempts were reported by **18.0%** of those with only gambling problems, who had thought of suicide, and **28.8%** of those with only chemical problems (N=709; Chi-Square=23.87; df=2; p=<.00001).

5.4) Being Under The Influence:

Clients with only gambling problems, who had attempted suicide, were less likely to have been under the influence during a suicide attempt than were other clients (Figure 30). Approximately **three-quarters** of the clients in the dual problem group, who had attempted suicide, were under the influence at the time of the last attempt. The number was somewhat lower for those with chemical problems (**60.0%**). However, only **13.6%** of the gambling clients, who had attempted suicide, were under the influence at the time (N=283; Chi-Square=31.42; df=2; p=<.00001).

Figure 30 Of Those Attempting Suicide, Were They Under Influence At The Time? By Problem



N=22; 130; 131

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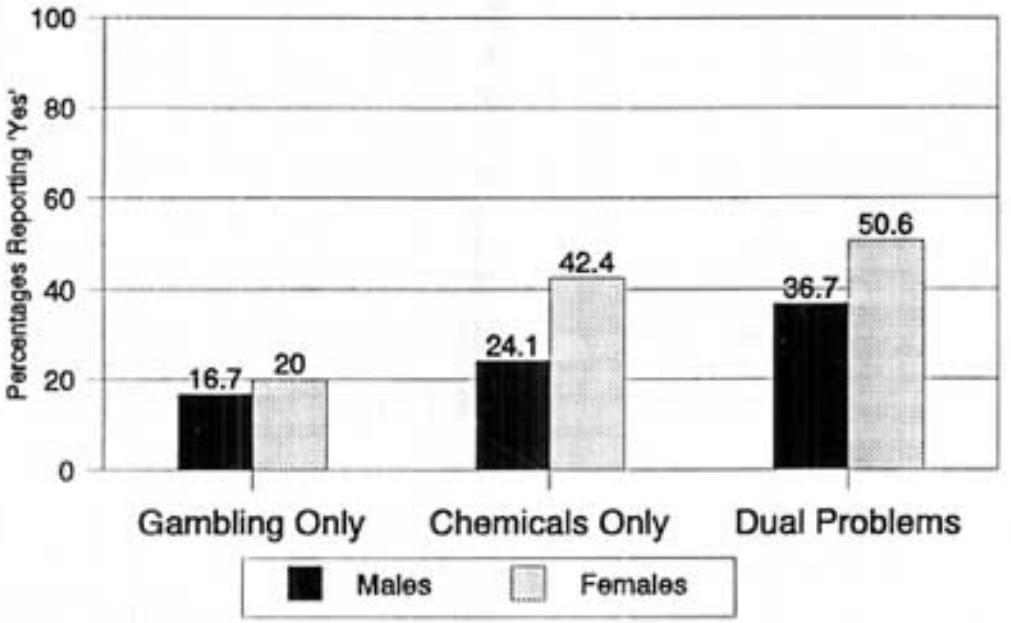
The Effect Of Gender:

Suicide Attempts:

With the exception of clients with gambling problems, of those individuals who had thought about suicide, females were more likely than males to attempt suicide (Figure 31). However, when comparisons were made across the three study groups, clients in the dual problem group were significantly more likely to attempt suicide than were their counterparts, while those solely with gambling problems were least likely to do so.

Figure 31 If Clients Considered Suicide Did They Attempt It? By Problem & Gender



N=60/60; 203/85; 196/85

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Having Attempted Suicide, Of Those Who Had Thought About It, By Gender	N	Chi-Square	df	p
Males	459	12.52	2	.0019
Females	230	14.20	2	.0008

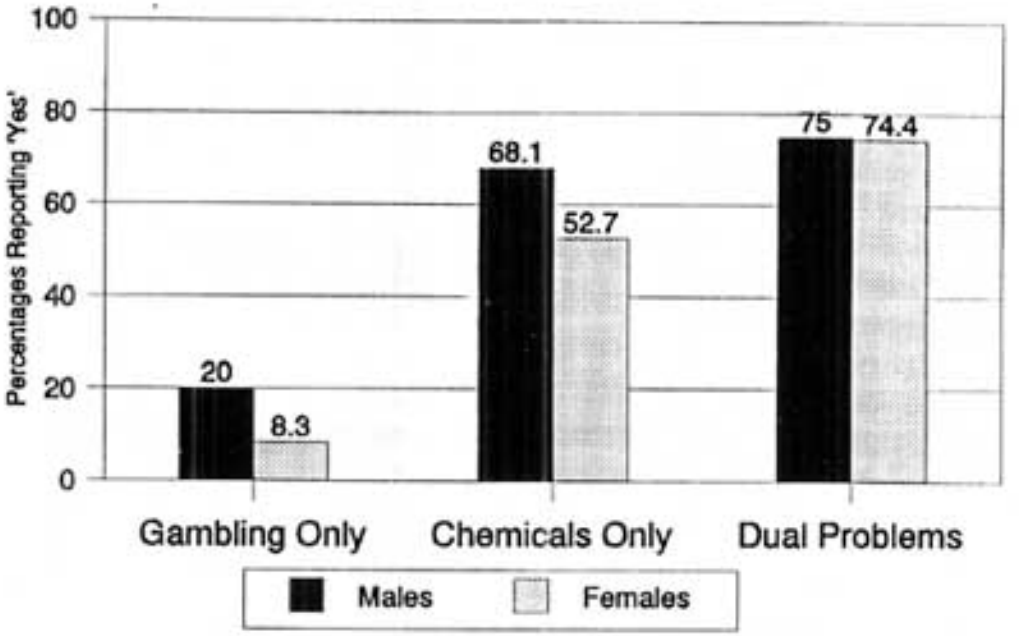
Being Under The Influence At The Time Of The Suicide Attempt:

This question provided varied results when analyzed by clients' gender (Figure 32). First, there was virtually no difference in responses by gender, within the dual problem group. In this instance, **75.0%** of the males and **74.4%** of the females within this group, who had attempted suicide, had done so while under the influence. Males and females responded somewhat differently within the other two groups.

Once again, in terms of males in this study, **75.0%** of those in the dual problem group, who had attempted suicide, were under the influence at the time, compared with **68.1%** of those with chemical problems. **Twenty percent** of the males with gambling problems were under the influence when they attempted suicide (n=10).

Variations in responses were even more pronounced for the females. **Three-quarters** of the females in the dual problem group, who attempted suicide, were under the

Figure 32 Of Those Attempting Suicide, Were They Under The Influence? By Problem & Gender



N=10/12; 69/55; 84/43

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influence at the time. In terms of females with only chemical problems, **52.7%** were under the influence during the suicide attempt. However, this applies to only **8.3%** of those with gambling problems (n=12).

These differences, by gender, are considered statistically significant for both males and females in this study.

Under The Influence At The Time Of The Last Suicide Attempt By Gender	N	Chi-Square	df	p
Males	163	12.59	2	.0018
Females	110	17.25	2	.00018

5.5) Implications for Treatment:

In all instances in which data regarding mental health and suicidal ideation were analyzed, dual problem clients report a higher incidence of problems. For example, three quarters of the dual problem clients *have felt life is not worth living*, while forty-one percent have who have thought of suicide have actually attempted suicide. Some treatment implications related to these findings are provided below:

- Because a greater percentage of gambling and dual problem clients seen for a mental health problem are eventually hospitalized, it would appear that these groups may be harder to stabilize. Treatment providers need to pay attention to mental health issues and suicidal ideation among clients with dual gambling and chemical problems.

- Alcohol and drug treatment programs that also treat dual problem clients are advised to give more attention to these clients because of the apparent increased pathology in that group.

- Alcohol and drug treatment centres are advised to screen clients for a coexisting gambling problem because of the potential increased suicide risk among clients with dual problems.

- Treatment providers should have suicide protocol in place. There is also a need for staff training regarding crisis management and suicide prevention, particularly in settings where dual problem clients are being treated.

CHAPTER THREE
STUDY SUMMARY & CONCLUSIONS

1) SUMMARY OF THE FINDINGS:

This study examined three groups of AFM clients: those with only gambling problems, those with only chemical problems and those experiencing both types of problems. The study's overall goal was to explore the degree to which the types of problems clients experience correlate with selected demographic characteristics and social indicators. While tests of association such as Chi-Square do not denote causation, this study did identify some associations which appear to have implications for treatment. This applies not only to those clients in treatment for their gambling problems; it also speaks to the needs of clients receiving treatment for chemical problems who have a concomitant (and possibly unrecognized) gambling problem.

1.1) Demographics:

We have found, consistently, that clients who experience only gambling problems are significantly different from both those with only chemical problems and those with dual problems. Put another way, dual problem clients closely resemble clients with only chemical problems. This was true in terms of:

- **Gender,**
- **Age,**
- **Marital Status,**
- **Education,**
- **Living Arrangements,**
- **Number of Residences Past 12 Months,**
- **Employment Status,**
- **Number of Jobs Past 5 Years, and**
- **Household Income**

To summarize, a significantly larger percentage of clients with only gambling problems tended: to be female; to be 35 to 50 years of age; to be married; to have a complete high school education, generally with some post-secondary education; to work in the sales or service sectors, management or administrative positions, or primary industries; to own their own homes; to have lived in the same residence for the preceding year; to be employed; to have worked in the same job for the past five years; and to have an annual household income exceeding $30,000.

Differences With Other Jurisdictions:

The demographic profile of AFM gambling clients appears to differ dramatically from that of gambling clients in some other jurisdictions. In terms of the latter, the profile of the gambling clients in those jurisdictions tends to mirror that of clients seeking help for chemical problems. One theory for these differences is that Manitoba has a treatment program dedicated solely to working with problem gamblers, whereas other jurisdictions appear to be more generalist: counsellors with mixed caseloads. It is hypothesized that middle class clients, where there is solely a problem with gambling, may be more likely to attend a dedicated gambling treatment program. If this hypothesis is true two questions immediately arise:

- Are generic treatment programs appropriate for clients where a gambling problem has emerged and no other addictions or family dysfunction are apparent?

- What alternate treatment modalities should be used for these individuals?

1.2) Consumption:

Clients with only gambling problems were least likely to have consumed either alcohol, cannabis or other drugs during the forty-five days prior to entering treatment. Conversely, two-thirds of the clients with chemical and dual problems had consumed alcohol during this period, while cannabis was consumed by one quarter of the chemicals only group, and one-third of the dual problem group. Ten percent of the dual problem group also consumed cocaine during this time frame.

1.3) Family Of Origin:

Clients with dual problems were most likely to report family of origin issues, including a family history of addiction and a history of physical or sexual abuse, while those with only gambling problems were least likely to do so. While causation cannot be determined, there appears to be a clear association between types of problems experienced by clients and their family histories.

1.4) Violent Behaviour:

Clients with only gambling problems were significantly less likely to report having violent behaviour, and behaving violently 'while under the influence,' than were their counterparts. Rates of violent behaviour were virtually identical for clients with only chemical problems and for those with dual problems.

1.5) Client Mental Health & Suicidal Ideation:

Mental Health:

There were no significant differences between the three study groups, in terms of their either being seen for emotional or mental health problems, or being hospitalized as a result of these problems. Rates were consistent across the three groups of clients.

Suicidal Ideation:

Dual problem clients were significantly more likely to report the primary indicators of suicidal ideation than were their counterparts. This includes feeling that 'life is not worth living,' having thoughts of suicide, or attempting suicide. Of those clients who had attempted suicide, those with dual problems were most likely to report making these attempts while they were 'under the influence,' followed by clients with only chemical problems. Very few of the clients with only gambling problems, who had attempted suicide, were under the influence at the time.

Once again, these data cannot establish causation. However, it may be that the presence of a gambling problem, ***in addition to*** a problem with alcohol and/or other drugs, has a cumulative effect on these individuals, leading to higher rates of suicidal ideation.

II) IMPLICATIONS OF THE FINDINGS:

What follows are some initial thoughts on possible implications of the findings in this

study. They are not designed to be exhaustive or conclusive, but are merely a first attempt to view the data from a programmatic context.

2.1) Implications Of Marital Status:

Clients' marital status may have implications for treatment. This stems from the assumed stability and support that can come from a marital and/or family system, and the need to ensure that supports are in place for clients who do not have family systems they can rely on. Emphasis may need to be centred on providing support and education to the family and spouse of the gambling client on the one hand, while seeing them as allies to the treatment team on the other.

2.2) Implications Of Varied Social Stability:

Clients with only gambling problems are most likely to possess the indicators of social stability explored through this study. This includes: educational attainment, occupation, employment record, household income and housing.

- From the demographic data, it appears that clients with only gambling problems, given their relative stability and links to the community, are candidates for outpatient treatment.

- Given the varied levels of educational attainment, it is important that materials and sessions are tailored to clients' reading abilities.

- Given that these clients tend to be engaged in generally stable employment, there should be flexibility in offering treatment during weekends and evenings to accommodate their work schedules.

2.3) Implications Of Client Consumption:

Clients with dual problems are as likely to consume alcohol prior to treatment as are clients with only chemical problems. They are slightly more likely to consume cannabis and cocaine. The effects that drug use can have on cognitive abilities should be reflected through the materials that are used in treatment, as well as counsellors' expectations of these clients. That is, allowances, regarding client cognitive abilities, may need to be made for clients in gambling programs where dual problems are a factor.

2.4) Implications Of Family History:

Two types of family gambling clients have been identified through this study: those for whom the gambling problem is part of larger set of problems (including chemical problems, a family history of addiction and a history of physical or sexual abuse), and those for whom the gambling problem is the sole problem and an apparent divergence from the family's general functioning. Accordingly, a variety of treatment strategies for family members has been identified.

Where family of origin issues to do not apply, an emphasis on information and strategy sessions for family clients may be the more appropriate response. Where clients experience both gambling and chemical problems, it appears that traditional

approaches to family treatment are also indicated. This could include longer-term, insight-oriented individual and/or family counselling sessions, in addition to the information and strategy sessions referred to above.

2.5) Implications Of Violence:

Clients with dual problems are significantly more likely to report violent behaviour, and behaving violently 'while under the influence,' than are those with only gambling problems. The implications regarding this finding are two-fold:

- When gambling programs treat dual problem clients, staff should be aware of the potential volatility of these individuals and take steps to ensure the safety of both the other clients and staff.

- In instances where dual problem clients are being treated, consideration should be given to including anger management and the development of appropriate coping and problem-solving strategies in the treatment process.

2.6) Implications Of Suicidal Ideation:

Clients with dual problems appear to represent a significantly greater suicide risk than do clients with a single problem. Based on these findings it is incumbent upon addictions programs to screen for both chemical ***and*** gambling problems. With regard to chemical addictions programs, it is clear that the presence of a secondary problem must be determined. Similarly, programs working solely with pathological gambling clients should screen for problems associated with alcohol or other drug problems.

More specific implications include the need to establish protocol related to clients who may represent a suicide risk, and ensuring that staff are trained in suicide prevention and crisis management and/or that community resources are available and readily accessible to assist in this regard.

3) CONCLUSIONS:

This preliminary study has demonstrated that there is an apparent relationship between the types of problems clients experience and a number of important characteristics and social indicators. Based on the findings, it is clear that consideration has to be given to the range of problems that clients experience. Chemical treatment programs should consistently screen their clients for gambling problems and vice versa. Where dual problems exist, a plan should be put in place to address these. The findings also spell out the varied needs of family gambling clients: a single approach to working with the families of gamblers seems contraindicated.

This study has identified numerous instances in which clients with only gambling problems are significantly different from other addictions clients. This includes not only the demographic differences noted earlier, but also their life experiences and social indicators such as violence and suicidal ideation. Clients with dual problems were also seen to have a unique set of needs that may require more intensive interventions. Consideration of these differences should be taken into account when designing and developing programs and services, and staff training initiatives.

To a lesser extent, this study has highlighted the impact that a dedicated gambling program may have on the types of clientele it attracts. This observation is based on the demographic profile of AFM Gambling Program clients, compared to those of other jurisdictions. It is admittedly speculative in nature.