Longitudinal Evaluation of the Effectiveness of Problem Gambling Counselling Services, Community Education Strategies and Information Products

Volume 2: Evaluation of the Effectiveness of the Counselling Interventions at BreakEven Problem Gambling Counselling Services

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Executive Summary

Background

The present project was commissioned by the Victorian Department of Human Services. The work described in this document has been performed by members of the Problem Gambling Program in the School of Social Work at the University of Melbourne supported by advice from a technical panel of local and international experts in problem gambling. The purpose of this component of the project reported in this document was to evaluate the effectiveness of the counselling interventions at BreakEven Problem Gambling Counselling Services.

In order to perform the evaluation, a series of linked activities was performed. These included:

- Literature analysis of the research on therapeutic effectiveness and outcomes in problem gambling.
- Analysis of the BreakEven Counselling Services' Minimum Data Set for the period July 1 1997 to June 30 1998 (n=3149).
- A retrospective survey of clients of the BreakEven Counselling Services who had a contact with a Service in the first quarter of 1998 (n=150).
- A prospective survey of clients who had attended their first counselling session at a BreakEven Counselling Service in July 1998 (n=43). Sixteen of these clients participated in a three-month follow-up data collection.
- Surveys of 48 BreakEven Counselling Service counsellors involving completion of two questionnaires (the Clinical Practice Evaluation Counsellor Questionnaire and the Counsellor Task Analysis Questionnaire).
- Individual interviews with counsellors.

Section 1 of the Report reviews the research literature on therapeutic effectiveness and outcomes. A short review of the history of therapeutic effectiveness research precedes a discussion of therapeutic effectiveness research specific to problem gambling. This is followed by a discussion of the conceptual underpinnings and theoretical models that have been used within the present project.

In Section 2 of this Report the methodologies used in the conduct of the various studies performed within the project, are presented along with a discussion of methodological issues of pertinence to the project. A third party recruitment method was required for the client studies, which involved BreakEven counsellors recruiting participants on behalf of the research team. While analyses are presented that support the conclusion that sample bias was not great, there are nevertheless significant concerns presented about the impact of the application of this recruitment method upon the validity of the findings in the two client studies presented in this Report. However, it is also noted that the BreakEven Minimum Dataset and the Counsellor Task Analysis were census or full population studies.

The following chapters present the outcomes of the research.

Summary of Key Findings

The Samples

The following demographic features characterise the group of clients who participated in the clinical practice evaluation. Two-thirds (61 per cent) of respondents were over 40, three-quarters were born in Australia, and three-quarters (77 per cent) had annual incomes below $31,148. The largest occupational grouping was clerical service workers (31.4 per cent).

In terms of gambling activity, the following features can be highlighted. The majority of CPE participants (approximately (70 per cent) gamble on Electronic Gaming Machines (EGMs). During this activity clients record the median number of hours spent per episode as three hours; the median amount of dollars spent per episodes as $100; the median number of episodes per month as eight episodes. This pattern resembles that of the sample population in the MDS 'problem gambler' population generally.

The above figures indicate that the average person attending BreakEven for counselling, as represented by the CPE study sample, spends around twenty-four hours a month playing EGMs and outlays around $800 per month on this play, or $9,600 per annum. On average the clients in the clinical practice evaluation sample spend around one-third (31 per cent) of their annual income on gambling. However, the median amount of debt recorded for this group was relatively low, at $2,500.

The current BreakEven Minimum Data Set uses the DSM-IV criteria for assessing the severity of a client's gambling-related problem. These ten items are described as 'maladaptive behaviours'. At the commencement of counselling three-quarters (76 per cent) of the clients participating in the clinical practice evaluation had five or more maladaptive behaviours. On the basis of client responses to these items the following conclusions can be drawn:

- Ninety per cent of clients are gambling as a way of escaping from problems or of relieving a dysphoric mood.
- Eighty per cent of these same clients chase losses, which is a recipe for financial difficulties.
- Seventy per cent of respondents lie to people close to them about their gambling.
- Sixty-nine per cent have had repeated unsuccessful attempts to control their gambling, which indicates that a client's decision to use a BreakEven counselling service occurs, in the main, after repeated attempts and failure at fixing their own problem.

Counselling Outcomes

In exploring the outcomes as reported by the clients participating in the clinical practice evaluation the following findings emerged:

- There was a high level of positive—partial, full or satisfactory—resolution in all defined problem areas. In assessing the outcome of clients' gambling behaviours, 43 per cent had full or satisfactory resolution levels and 46 per cent experienced partial problem resolution.
- Clients experienced the highest level of full problem resolution in relationship problems and problems with their physical health caused by their gambling activity.

Almost three-quarters (71 per cent) of clients felt that attending counselling at a BreakEven service impacted on their gambling activity in a positive way, with 45 per cent of these rating the impact as 'a great deal'. Two-thirds of respondents stated they gambled 'a lot less' after attending BreakEven Counselling.

The reported impact of counselling and its outcomes on clients' emotional well-being showed that respondents recorded a shift from the majority (69 per cent) being 'very poor' at the commencement of counselling to the majority being 'very good' (78 per cent) at the end of the counselling. Clients' level of understanding the nature of the problem, self-awareness, ability to accept responsibility for the problems their gambling had created and their awareness of services available to assist them were all improved as the result of counselling. This indicates a counselling process that produced an effect of heightened understanding as well as problem resolution.

The number and severity of maladaptive behaviours was also taken as a measure of counselling outcomes. Pre- and post-counselling measures of maladaptive behaviours indicated counselling had a positive effect of between 21–29 per cent improvement on clients in eight of the ten behaviours listed. This measure is used to indicate the severity of an individual's gambling problem, with those recording five or more maladaptive behaviours being considered 'pathological' gamblers. In a pre- and post-

counselling measure of clients participating in the clinical practice evaluation, the number of 'problem gamblers' reduced from 76 per cent to 37 per cent.

The team also used service satisfaction to indicate successful outcome. The level of service satisfaction expressed by participants in the clinical practice evaluation was high, as is normally the case in satisfaction studies in the health and human services. Clients were generally satisfied with the counsellors' treatment of them and were satisfied with the outcomes they received as a result of counselling. The large majority of clients indicated they would use the service again and that they would recommend it to others with gambling related problems.

A very small group of clients (n=16) participated in a longitudinal study of outcomes. The small numbers were a result of third party recruitment combined, with an inability on the part of the researchers to remind participants directly of the necessity for completion of their participation in the study. This resulted from the requirement for protection of client confidentiality. The study is reported, but with significant reservations expressed concerning the delivered sample. These clients were provided with a questionnaire at the end of their first counselling session and another, three months following completion of their counselling. The key findings of this study were:

- The level of unresolved problems after three months was reduced in all problem areas.
- The number of partially resolved problems reduced in all categories except in the area of gambling behaviour and financial problems.
- The number of problems fully resolved after the three-month period were greatest in the categories financial problems, legal problems and gambling behaviour.
- The number of problems fixed to the client's satisfaction increased overall with the greatest increase in the area of family related problems.
- In short there was a decrease in the number of unresolved or partially resolved problems, and an increase in the fully resolved and satisfactory resolutions.
- The psychosocial well-being of clients improved during the three-month study period with an average shift from fairly poor to quite good as rated by the clients.
- The mean number of maladaptive behaviours experienced by the clients in the three-month period being studied went from 5.4 behaviours to 3.3 behaviours.
- There was a reduction in the extent to which participants felt their gambling was a problem, from a fair amount to very little.
- Clients' level of satisfaction with the service did not change across the three-month period, even though their problems improved.

The report stresses caution in the use of these study data because of the small study sample size.

The BreakEven Minimum Data Set, which is a census study of all counselling participants, also provides information on the outcomes of sessions. The key findings from the MDS contact data was that the level of problem resolution is higher for problem gamblers in cases where no further contact has been planned, that is, where the counsellor has terminated the counselling.

Counselling Outcomes and the Counselling Process

A thorough investigation of the linkages between counselling outcomes and the counselling process was undertaken as part of the study. The key findings of this investigation were as follows:

- The therapeutic relationship is the process variable that can most consistently predict positive outcome.
- Counsellors with the highest rates of problem resolution are using a mix of client-centred humanistic psychology, cognitive behaviour therapy techniques, and solution focused counselling.
- A thorough psychosocial, and readiness to change assessment of the client is a feature of the work of all counsellors achieving high levels of problem resolution.
- Client participation in goal setting and a realistic, timely and achievable set of goals characterise the goal setting of all counsellors achieving high levels of problem resolution.
- Counsellors achieving high levels of problem resolution use an eclectic mix of techniques in their work with clients. Decisions regarding which techniques to use are based on their initial assessment and goals as defined with the client. No particular technique stands out as the most valued or valuable.

- The review processes used by the counsellors varies. All counsellors achieving high levels of resolution, however, indicated the importance of celebrating client achievements, no matter how small.
- All counsellors considered a strong therapeutic relationship to be essential in achieving positive outcomes. They describe this as the basis from which the work becomes possible.
- Counsellors considered the counselling effort needed to be considered a collaborative effort for it to work.
- The active ingredients for successful outcomes, according to counsellors, are a strong therapeutic relationship, client readiness to change, client ability to self-reflect and finding the right fit between the client and the intervention.
- Conversely, the factors counsellors considered hindered the achievement of these outcomes were: lack of relationship, lack of motivation on behalf of client, lack of alternative forms of leisure, co-morbidities, client unwillingness to disclose, and when gambling has become a central part of a persons self-definition.

Minimum Data Set Outcome/Process Links

These linkages were also explored using the Minimum Data Set contact data. The following was found:

- The level of problem resolution is related to the number of sessions attended. The more sessions attended the more likely that the problem would be partially or fully resolved.
- The findings seem to indicate a relatively high level of problem resolution, even though the actual number of sessions attended is relatively low.

Outcomes and Client Characteristics

A number of client characteristics were tested for their impact on counselling outcomes as reported by participants in the clinical practice evaluation. The following provides a summary of the key findings. Very few client characteristics had a statistically significant impact on counselling outcomes. This finding is consistent with current psychotherapy and counselling outcome literature (Bergin and Garfield, 1994).

Clients' satisfaction with their current level of gambling was the variable most consistently related to level of problem resolution. The number of presenting problems was related to a problem being unresolved or partially resolved. Older clients were less satisfied with their counselling outcomes. Clients in the *action stage* of readiness to change, at the end of the first counselling session, are more likely to resolve problems, increase life skills, and have a greater level of satisfaction with the outcomes of counselling. The level of an individual's debt does not impact in any significant way the level of problem resolution they achieve.

The linkage between client characteristics and outcomes was also tested using the Minimum Data Set for all BreakEven clients. The following findings were significant:

- Two-thirds of BreakEven clients who attended the service with gambling behaviour as their presenting problem, have a positive resolution of their problems by the time of case closure.
- Only age, annual income and living arrangement could discriminate between levels of problem resolution.
- Other demographic and gambling behaviour variables did not predict level of problem resolution. The outcomes achieved are not predicted by whether the client was a 'problem gambler' or 'partner and/or other'.

Outcomes and Counsellor Characteristics

A number of counsellor characteristics were tested for their relationship to client outcomes with clients participating in the clinical practice evaluation. The following were the key findings from this analysis:

- Women counsellors have lower levels of unresolved problems.
- Counsellors with high caseloads, measured by number of client contacts, have higher levels of client satisfaction with outcomes.
- The greatest number of full resolutions were achieved by counsellors who were not social workers or psychologists, but this could be an artefact of the rural/metropolitan division of services, as most of these counsellors are employed in rural areas (see below).
- Clients of psychologists and 'others' had higher levels of client satisfaction with the outcome of counselling.

Counsellor characteristics were also tested against outcomes as defined by the Minimum Data Set. For these clients, outcomes are, on the whole, unrelated to the particular breakdown of tasks that constitute their practice, as measured by the Counsellor Task Analysis (CTA). Counsellor characteristics are, on the whole, not predictive of client outcomes. This finding is consistent with current research in psychotherapy and counselling outcomes (Bergin and Garfield, 1994).

Outcomes and Agency Characteristics

A number of agency characteristics were explored for their impact on the outcomes achieved by clients participating in the clinical practice evaluation and via the Minimum Data Set. For clients participating in the clinical practice evaluation the following findings emerged from the analysis. Clients from non-metropolitan centres were more satisfied with the outcomes of counselling and reported a greater impact of counselling on their gambling behaviour.

The analysis of the Minimum Data Set showed that agency type impacts on the outcomes achieved by clients in respect to all outcome areas except gambling behaviour. Consistent with the clinical practice evaluation findings, the location of the agency impacted on outcomes, with country clients experiencing higher levels of problem resolution. The MDS analysis also indicated that agency type is related to outcomes, but this finding is most probably an artefact of the fact that a number of agency types are only found in the country. The size of the BreakEven service and its level of funding did not impact on outcomes achieved.

Client Comments

As part of the clinical practice evaluation clients were asked to list the factors they found most helpful and most unhelpful about BreakEven services, and to make any other comments they wanted to. The following were the key themes that emerged from the analysis of these responses.

Clients experienced the service as particularly useful in the following ways:

- The ability to talk to someone who understood the nature of the problem and did not judge them.
- That they could have confidence in the counsellors' concern for them.
- It provided them with a way to explore reasons for their behaviour.
- They felt confident of the counsellors' knowledge and professionalism.

Clients' major dissatisfaction with the service was clearly the lack of after-hours session times available.

Most clients who participated in the clinical practice evaluation considered attending counselling at a BreakEven service as a life-changing experience and considered it an essential service for them in a time of great crisis.

The counselling currently provided by BreakEven counsellors to clients of the service is producing successful outcomes that are consistent with other gambling treatment programs throughout the world.

The effectiveness of the service is not diminished by the often small number of sessions attended by clients, although there is evidence to suggest that the longer clients stay in counselling, the more positive outcomes are likely to be enhanced.

Clients who attend the service have often made repeated unsuccessful attempts to solve their problems themselves. The service is used when they can no longer manage the matter themselves.

Clients overwhelmingly identified the most helpful aspect of the service as being the level of knowledge counsellors had about the problem and the non-judgmental way in which counsellors provided their services.

Counsellors achieving the highest levels of problem resolution all worked collaboratively with clients to identify goals, for the work, that were realistic and achievable. Their work was also characterised by regular review and recognition of client achievements.

Recommendations

Service Provision

- Extension of service delivery hours to include after-hours session times for service users.
- Development of a more uniform counselling review process negotiated with clients and aimed at documenting gains made by clients during their time in counselling.
- Continued employment of a mix of practitioners in the field.
- Continue the mix of service delivery personnel in rural areas.
- The maintenance of an approach to counselling that makes central collaboration between client and counsellor in defining outcomes for the individual client. This approach is consistent with

the principles of harm minimisation as the guide for treatment rather than abstinence.

- The establishment of regular seminars for BreakEven workers, where up-to-date information on research and treatment techniques can be shared.

Research

We tender the following recommendations in the area of research:

- The present requirements for third party recruitment of participants into research and evaluation projects should be altered. This could be achieved by notification of clients at the outset of their service engagement of opportunities for participation in research and evaluation activities.
- A large-scale, prospective, randomised control study of intervention effectiveness should be conducted.
- To integrate into the current Minimum Data Set, more precise questions on gambling related spending and debt and to develop the questions on changes to gambling behaviour as a form of outcome.
- Research into the relationship between amount of play and negative impacts (a dose/impact relationship). This research would make a significant contribution to the design of education around the point where gambling becomes harmful.
- There should be a properly managed system for the dissemination of research information to BreakEven workers, enabling them to maintain their knowledge of research findings.

1 Literature Review on Therapeutic Effectiveness

1.1 Introduction

The purpose of this chapter is to review the research literature on therapeutic effectiveness and outcomes. A short review of the history of therapeutic effectiveness research precedes a discussion of therapeutic effectiveness research specific to problem gambling. This is followed by a discussion of the conceptual underpinnings and theoretical models that have been used within the present project.

The debates over the complexities and difficulties involved in studying the outcomes of human service programs are numerous. This is particularly so in the exploration of the specific outcomes of counselling and psychotherapy.

Further, the therapeutic and behaviour change models adopted by practitioners and researchers have important implications for where they look in terms of outcome measures. With different therapeutic goals and assumptions it may seem at first glance that different outcome measures may be implied by the different models. The concept of effectiveness is always relative to a context.

> …effectiveness derives from a variety of perspectives and assumptions, and itself-forms part of one or more of a range of different rhetorics—the language of value for money, say, or that of professional accountability, meeting customer demand, or maximising satisfaction (Cheetham, 1997:10).

This issue is discussed in more detail in the methodology section (Section 2) of this document.

The push to evaluate counselling or psychotherapeutic practice stems from many sources. These include:

- The desire of funding bodies purchasing services for agencies to be accountable for the spending of public money by demonstrating that their services are efficient and effective.
- The desire of professionals wishing to fulfil their ethical requirement to provide the best service possible to clients.
- The desire of researchers trying to establish the efficacy and effectiveness of particular therapeutic techniques.

The context in which the present study is undertaken is a complex one. Within the Victorian context, there is a legislative requirement to fund research into the social impacts of gambling on the community. This study constitutes a part of a broader research program. There is a wide interest amongst service purchasers, agencies and practitioners in understanding more about this new field of practice and what interventions work best. There is also a 'value for money' dimension, in that the funding body wants to know the cost-effectiveness of the services it funds.

Our responsibility was to design and implement a research program that builds upon the methodologies and findings of contemporary and comparable work being done throughout the world. As such, a

thorough literature review is the first step in meeting this responsibility.

The following discussion provides a broad overview of pertinent findings in the field of psychotherapy and counselling outcome research literature. We draw little distinction between the research that has occurred in the field of counselling effectiveness and the field of psychotherapy effectiveness. Many researchers have relied on the large volume of psychotherapy outcome research literature that exists to comment on and use as the basis for evaluating the outcomes of counselling practice.

1.2 The Nature of the Problem in Outcome Research

Bergin and Garfield have noted that:

> The central issue in outcome research is how to measure the changes that occur in patients as a result of their participation in therapy (Bergin and Garfield, 1994, p. 72).

It is now generally held that psychological treatments are of benefit to most clients:

> The evidence for this conclusion is demonstrated in part by quantitative surveys of the literature that have used the technique of meta-analysis to summarise large collections of empirical data (Bergin and Garfield, 1994, p. 144).

Current research into the outcome of psychological treatments has shifted emphasis from establishing positive treatment effects to exploring what aspects of the process causes positive effects and what approaches work best with which clients.

1.3 Historical Overview of Therapeutic Outcome Research

Stubbs and Bozarth (1994), in their account of research on the outcomes of therapeutic practices argue that this research has occurred in phases corresponding to the shifts in our knowledge about these processes and their effects.

The first phase they characterise as psychoanalytic with the publication of Freud's essay 'Analysis terminable and Interminable' (1937), where he posed the questions: 'Is there a natural end to analysis?' and 'Can the analyst bring the analysis to this end?' This paper of Freud's was a response to the push within his own circle for a shortening of the psychoanalytic treatment. Although Freud's thoughts were rather pessimistic regarding the end of analysis, Fenichel's studies at the Berlin Psychoanalytic Institute were showing a certain level of success.

According to Stubbs and Bozarth, the general optimism of the early research into the effectiveness of psychoanalytic psychotherapy was then replaced by a phase marked by Hans Eysenck's controversial research findings, that psychotherapy is no more effective than no psychotherapy. This claim shocked the therapeutic community, and in an effort to explore and dispel the claim, a great deal of research in the psychotherapy field was aimed at investigating the effectiveness of psychotherapeutic processes.

The next major phase coincided with the development of humanistic psychology. Carl Rogers argued that if a therapist showed the client empathic understanding, unconditional positive regard, and congruency, a positive outcome was assured. These attitudes became operationalised in research as *social influence variables* and dominated the research agenda during the sixties and seventies. In the late 1970s and early 1980s optimism in these factors as the cause of positive outcomes in therapeutic practices waned and the research effort was replaced with the idea that these core conditions are facilitative of change but not sufficient, on their own, to cause it.

The most recent phase in research on psychotherapy outcomes is characterised by a renewed focus on the 'non-specific' or 'common' factors within the therapeutic process that affect change. This focus is the result of the inability of previous studies to strongly establish any specific factors, such as therapist characteristics or client characteristics or particular techniques to have a significant impact on outcomes.

It is difficult to say why this research has failed to provide strong evidence for the expected relationships. It is argued later in this introductory section that many factors are in operation within the therapeutic context and that the complexity of this context and the many moderating influences operating may be the cause.

We now turn to a discussion of the gambling specific treatment outcome research literature.

1.4 Summary of Gambling Specific Treatment Outcome Literature

Lopez, Viets and Miller (1997), reviewing the findings of over forty published problem gambling treatment outcome studies concluded that:

> Empirical outcome data reported to date provide an encouraging picture of treatment outcome for pathological gamblers. It is not uncommon for two-thirds of treated cases to be reported as abstinent or controlled, and such behaviour change is often accompanied by more general improvement in psychosocial functioning. Slips without relapses are commonly reported. Although a bias towards publishing of positive reports must be considered, it appears that problem and pathological gambling are rather treatable behaviour disorders (Lopez, Viets and Miller, 1997, p. 697).

The most recent outcome study in the gambling field conducted by Toneatto, Dragonetti and Brennan at the Centre for Addiction and Mental Health Addiction Research Foundation Division Toronto (in press) reported the results of a comparative study of four treatment approaches. In this study they identified that three-quarters of the clients in their follow-up studies were either not gambling or gambling in a non-problematic way after treatment. In the same vein the same authors claimed that during the last decade of research on gambling treatment effectiveness it has been found that overall 'success' rates—measured in terms of abstinence from gambling or significant reduction in gambling activity—of between 60–80 per cent abstinence and 70–100 per cent reduction in gambling activity.

We consider that these conclusions are very optimistic in view of our own assessment of the published literature. Our view is confirmed by the many consultations with practitioners and experts that we have conducted as part of this research program. The rates and durability of resolution are normally much lower than those claimed above, in our view. Further, there are many methodological problems associated with conducting such studies and making such claims. The first of these is sampling bias. If we take Prochaska and DiClemente's findings that, at any one time, very small proportions of people with serious problems are engaged with therapeutic contexts, then those available for study may be a very select group, a small sub-sample of a large population. Second, most studies are obliged to rely upon self-report of the participants. There is cause for doubt about the accuracy of these reports in some contexts. Third, many of the studies suffer from well-known expectancy effects, such as Hawthorne and Rosenthal effects, which may be the source of much of the therapeutic gain rather than the specific features of the intervention program. This is a major interpretation problem in this field.[1]

In this vein, Lopez, Viets and Miller (1997) note that there are problems in generalising from the studies they summarised as they mostly employ mixed method approaches and it is difficult to establish what are the exact effective ingredients. This is the case also with the Toneatto, Dragonetti and Brennan study, where they could not control for the impacts of contact outside of treatment that the research participants may have had. This is a perennial problem with research into the effectiveness of treatments in community-based settings where it is difficult to control for extra-therapeutic variables and major variations in approach within the therapeutic context.

The current study context shares some of these difficulties. In the present context, a study of the therapeutic efficacy of particular techniques with the standard controls necessary for isolating the components of the counselling work that provide the impact or improvement was not operationally nor ethically feasible. In efficacy studies, it has often been found that it is 'non-specific factors' involved in treatment that account for most of the effective components of counselling and psychotherapy. These 'non-specific' factors include the therapeutic relationship, client readiness to change and client suitability to the treatment being employed (Bergin and Garfield, 1994).

The findings contained within this Report outline outcomes achieved by clients by summarising data collected from client and counsellor reports using survey methodology. The limitations of these studies are discussed in detail in Section 2. This project

[1] See also the detailed discussion on these issues in Volume 1 of this Evaluation Report series, particularly the material reproduced from Blaszczynski, A. (1993). *Juego patologico: una revision de los tratamientos. Psicologia Conductual*, 1: 409–440.

explored the relationship between these reported outcomes and various components of the counselling process. These findings are the result of a retrospective study of client experience and a longitudinal study of a small number of clients. Toneatto, Dragonetti and Brennan (in press) argue convincingly that outcomes reported some time after the experience of counselling, in the cool light of day, provide a more accurate evaluation of the impact of treatment. They conducted their follow-up at six months after treatment. This is recommended by other researchers in the field, such as Walker and Blaszcynski, who argue that six months is the minimum amount of time before which clients can reliably report on the outcomes of treatment and that more focus should be placed on studies up to two years after treatment.

Lopez, Viets and Miller (1994), in their summary of treatment outcome studies, identify certain areas as being under-specified in gambling treatment outcome research to date. The current study has gone some way to exploring these areas, particularly those related to the effect of the treatment setting, the mix of therapeutic methods being employed, the therapist's and client characteristics. In addition, the relationship between counselling outcomes and components of the counselling process has been comprehensively explored in the current study.

1.5 Research on 'Non-Specific' Factors in Counselling and Psychotherapy

Bergin and Garfield (1994: 163) have argued that:

> It appears what can be firmly said is that factors common across treatment are accounting for substantial amounts of improvement found in psychotherapy patients… they loom large as the mediators of treatment outcome. The research base for this conclusion is substantial and multidimensional, and we must attend to its import.

So what are these factors?

> They are those dimensions of the treatment settings (therapist, therapy and client) that are not specific to any technique (Bergin and Garfield, 1994: 149).

> Together these factors provide for a working endeavour in which the patient's increased sense of trust, security and safety, along with decreases in tension, threat and anxiety, leads to changes in conceptualising his or her problems and ultimately in acting differently by re-facing fears, taking risks and working through problems in interpersonal relationships (Bergin and Garfield, 1994: 163–4).

The most researched of common factors is the therapeutic alliance between clients and workers and clients' readiness to change. Orlinsky, Grawe and Parks (1994) reinforce this in their extensive meta-analysis of process and outcome variables in psychotherapy. They conclude their study by stating:

> The quality of the patient's participation in therapy stands out alone as the most important determinant of outcome. The therapeutic bond, especially as perceived by the patient, is importantly involved in mediating the process-outcome link. The therapists contribution towards helping the patient achieve a favourable outcome is made mainly through empathic, affirmative, collaborative and self-congruent engagement with the patient, and the skilful application of potent interventions… These consistent process-outcome relations, based on literally hundreds of empirical findings can be considered facts established by forty plus years of research in psychotherapy… (Orlinsky, Grawe and Parks, 1994: 361).

They go on to argue that:

> In designing future studies, researchers in particular should remember to control for the effects of process variables that have been found consistently related to outcome. These include… the overall quality of the therapeutic relationship, therapist skill, patient openness versus defensiveness, and treatment duration (Orlinsky, Grawe and Parks, 1994: 364).

The team took this recommendation seriously in the construction of the research program.

As well as what is in the 'therapeutic mix', there is also the issue of how much of it is to be administered. In classical epidemiology the relationship between the amount of interventions and its effects is termed the dose response or dose–effect relationship. We now review the research concerning this relationship in the context of brief interventions.

1.6 Brief Interventions and the Dose-Effect Relationship

Koss and Shiang (1994), in their account of brief therapies, argue that the therapeutic alliance in brief treatments is essential, as most approaches involve a high level of therapist activity whether this takes the form of directiveness or interpretations. They state that a number of studies have found that patient ability to reflect about their actions and therapeutic bond are associated with therapeutic realisations early in treatment. They isolated a number of related factors from the studies they reviewed that contribute to a positive outcome. These include:

- The client's expectation that therapy will create change and be useful.
- People's belief that they are receiving help.
- The client's readiness and motivation to change.
- Realistic role expectations.
- The client's involvement in the process of therapy.
- The client's openness to the process.
- The capacity of the client and counsellor to form a helping relationship.

Koss and Shiang go on to say that,

> It appears that the most important issue is not whether it is only the non-specific or the specific factors that create positive outcome, but which aspects of the relationship itself-must be present for a working collaboration to occur and what specific techniques must be maintained by the therapist within the context of the relationship (1994: 692).

A number of studies have explored the relationship between the amount of counselling and therapy received and improvements in the client's well-being. Since the publication of Howard et al's (1986) influential paper 'Dose-Effect Relationship in Psychotherapy', which identified a dose-effect curve that reported 75 per cent of clients improved by 26 sessions (six months, once-weekly work), the relationship between the number of therapy sessions and client improvements has been explored by a number of other authors with mixed results. All critiques of this work of Howard et al agree that there are problems generalising from the sample used to other treatment environments.

Kadera and Lambert (1996), in their more recent report on dose-effect relationships, found lower levels of improvement given the time in therapy than did Howard et al, They also they found that there was enormous variation between the impact of individual sessions, highlighting the misleading idea of a neat curve of progress that is implied in the original study. In Seligman's 1995 paper reporting the outcomes of a '*Consumer Reports*' study into the effectiveness of psychotherapy he argued that under the duration constraints of a natural treatment setting it appears that clients have higher improvement scores if they are in therapy for two years or more.

Given this mixed bag of findings it seems safe to assert that the dose-effect relationship is something that varies according to the individual matters involved and the nature of the research environment. As Steenbarger put it:

> I propose that the duration-outcome relationship in counselling/psychotherapy is mediated by a complex interplay of client, therapist and contextual factors that under certain conditions allow change to proceed very briefly and under others necessitate allocations of more extended time (1994: 111).

This is consistent with Blaszcynski's recent research, which indicates that there is a relationship between therapeutic efficacy and the type of problems being experienced by the client. It is not surprising that a lonely home carer going to play the pokies has different problems and would respond differently to therapy than a hyper-excited young man.

1.7 Efficacy and Effectiveness

It is pertinent to consider the distinction between efficacy and effectiveness for the purposes of the present research.

An *efficacy* study has the essential feature of comparing a therapy to a comparison group under well-controlled conditions. A study of the *effectiveness* of a treatment is a study of how patients fare under the actual conditions of treatment in the field.

This distinction is particularly pertinent if one looks at the therapeutic outcome literature, which has largely relied on research studies that occurred in environments that have not been 'naturalistic'. The findings that are presented in these efficacy studies do not necessarily translate to everyday clinical settings or say much about what one could describe as effective practice. This problem was explored in some detail by Seligman, who argued that:

> …in deciding whether one treatment, under highly controlled conditions works better than another treatment or a control group is a different question from deciding what works in the field.… efficacy studies are (not) the only, or even the best, way of finding out what treatments actually work in the field (1995: 996).

The activities described in this Report were focused on investigating the *effectiveness* of BreakEven counselling service rather than the *efficacy* per se of the techniques used by counsellors.

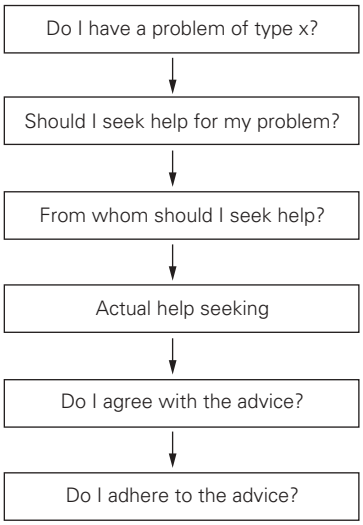
1.8 Conceptual Underpinnings for the Present Project

As a precursor to the presentation and discussion of the project activities and outcomes, it is important to discuss the conceptual models and the major research findings that have underpinned the development of the project design. As noted in the literature review presented in this Report, the progress of people through a therapeutic process is complex and often somewhat chaotic. There are many influences operating upon the process, including characteristics of the client, characteristics of the therapist, characteristics of the intervention and the service design in which it is delivered. Further, the change process may take place over an extended period and involve many fits and starts, resulting in highly varied outcomes.

In the field of behaviour change, Procahaska and DiClemente's work in their Model of Stages of Change stands apart as providing a theoretically and empirically convincing account of how people struggle with their addictions and the stages they progress through to achieve resolution of their problems. Our own work in the field of engagement with health services has shown that approximately 30 occasions of health symptoms occur for each consultation with a health practitioner. In health research, it is a well-demonstrated finding that many people do not seek to obtain health services when they have a health problem, even when the problem is serious (see, for example, Prochaska, DiClemente and Norcross, 1992; Thomas, Young, Dickens, Browning, Eckermann and Vafiadis, 1998).

There is a large body of literature in which researchers have set themselves the task of discovering why people do not seek services they ostensibly need. Discussion of this issue is assisted by consideration of the Health Action Model (Figure 1) developed by some of the present authors (see Thomas, Wearing and Bennet, 1991 or Thomas, 1996). This model is concerned with the steps taken by consumers in seeking services. It is directly pertinent to the present discussion. The steps in the model are shown below.

Figure 1 Health Action Model



The model asserts, in a similar fashion to the celebrated model proposed by Prochaska and DiClemente, that people with problems go through a series of steps before help is sought, and after it is initially and subsequently obtained. This is an active decision process, with fewer and fewer people reaching the later stages of the process. In an important paper, Prochaska, DiClemente and Norcross (1992), reviewed a large body of literature that had used their Model of Stages of Change in a wide variety of areas, including, alcohol, drug use and smoking. They concluded that at any one time most people with addiction or behavioural problems[2] were not engaged with services. They also concluded that resolution of the problems typically involved many unsuccessful attempts. These findings would be consistent with a large pool of people with problems, but a small pool of people actually engaged with

[2] It is not asserted that gambling is an addiction. However, the findings associated with help-seeking with addiction problems and help-seeking behaviour in the area of health problems may have some pertinence to the area of problem gambling.

services. On the other hand, this picture of a small pool of people seeking services is also potentially consistent with low rates of problem gambling within the community. We do not have sufficient knowledge of the situation as yet to eliminate competing explanations for it, but the available evidence would seem to support the notion of a large disengaged pool of people.

Thus, for the present work it is important to understand that most research in the fields of health service utilisation and the addictions show that at any one point most people with health and/or addiction problems are not actively engaged with a service at any one time. They are usually between abortive attempts to resolve their problems. We have made this argument in greater detail in one of the papers that has been prepared for this research program (Thomas et al, 1998). Thus, the reputedly high rates of problem resolution reported by groups, such as Toneatto's, need to be interpreted in this context. This has been an important contextual consideration in the design of the present study program.

A second major factor is the complexity of influences operating upon people in their gambling behaviour and the attempts of those who wish to modify it to do so. To explicate aspects of these influences, Thomas[3] has developed the following model of gambling outcomes and consequences, as presented below.

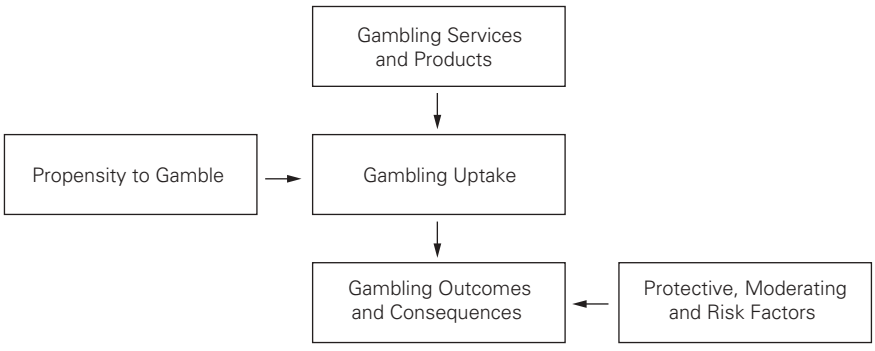
The model asserts that the gambling uptake for individuals is influenced by varying intrinsic propensities to gamble and the availability of gambling products and services to that individual. It is further asserted that the outcomes and consequences of gambling are influenced by gambling uptake and various protective, moderating and risk factors. We now turn to a discussion of the model elements.

1.8.1 Propensity to Gamble

In the model it is assumed that people vary in their propensity and desire to gamble. The propensity to gamble may be influenced by a variety of factors. These factors have been shown to include personality factors, such as impulsiveness/impulse control and take risks. It may also be affected by other behavioural propensities. A common finding amongst people with gambling problems is that they also have other behavioural problems. Spunt, Dupont, Lesieur, Liberty and Hunt's review in the November 1998 edition of *Substance Use and Misuse* provides a review of this literature. Black and Moyer's US study in the November 1998 issue of *Psychiatric Services* showed that people with 'pathological gambling' frequently have substantial psychiatric co-morbidities. Of course this does not necessarily mean that people in the 'normal' gambling range also have addictive and psychiatric co-morbidities, or that all people with gambling problems have other behavioural problems. However, the associations are of considerable interest.

Evidence for intrinsic factors affecting gambling behaviour is also provided by a fascinating study of twins reported in the September 1998 edition of *Addiction*. Eisen et al report the results of the study of 3,359 US twin pairs. According to these researchers, inherited factors explained 62 per cent of variation in the study sample in the diagnosis of pathological gambling disorder and lower amounts of variance

Figure 2 Model of Influences on Gambling Outcomes and Consequences



[3] Cultural Partners Consortium (2000). The impact of gaming on specific cultural groups: Stage 1 Report to VCGA. Melbourne: Thomas and Associates.

in the elevated but 'normal' ranges of gambling behaviour. This study may provide some evidence for inherited factors influencing propensity to gamble.

A factor that has also been found to be predictive of propensity to gamble is the family environment and exposure to gambling activity within that environment.

In terms of the impact of cultural factors upon propensity to gamble, there is little published data concerning this issue, although some recent work addresses this issue (Cultural Partners Consortium, 1999). We know that personality is formed by an interplay of intrinsic genetic factors, social experiences and learning within and outside the family and the societal context. Cultural factors affect all of these components, but the relationships are complex. It may be that different cultures have different propensities to gamble. We certainly know that specific cultural groups have different preferences about gambling modalities

1.8.2 Gambling Services and Products

While it might seem banal to note this factor, gambling uptake and patterns are, of course, influenced by the availability of gambling products and services. In the State of Victoria, ten years ago, access to gambling was strictly limited. There were no legal EGMs and no casino facilities. There has been a widespread liberalisation of access to gambling products and services, particularly over the last five years. The use of any product or service is affected by its availability, marketing and how well it meets the needs of its consumers. The Casino patron studies performed for the Victorian Casino and Gaming Authority examine these matters in some detail.

1.8.3 Gambling Uptake

The model asserts that gambling uptake is influenced by both the personal characteristics of the gambler, that is propensity to gamble, and the availability of services and products for them to exercise these propensities.

1.8.4 Protective, Moderating and Risk Factors

These factors refer to the social and financial resources that the gambler brings to their gambling activity. While gambling problems have important psychosocial elements, a major cause of identification of 'problem' gambling is that of insufficient money to pay all debts and fund everyday activities and the consequences of this inability to pay. Of course, while there may be psychosocial consequences of problem gambling, for example, poor interpersonal relationships with spouse and family, preoccupation with gambling to the exclusion of other important issues, it is when the financial resources are insufficient to meet the requirements of the gambling activities that the major identifiable problems and consequences become apparent.

If the person has low financial resources to meet the requirements of their gambling activities, this is a risk factor for negative consequences of the gambling. On the other hand, if the resources are substantial then this may be a protective factor. It is noted that unemployed people appear at twice the expected rate in presentations to BreakEven problem gambling services (Jackson et al, 1999). While this may be a consequence of other factors, it is nevertheless the case that unemployed people do not have major resources to fall back upon to service their gambling requirements.

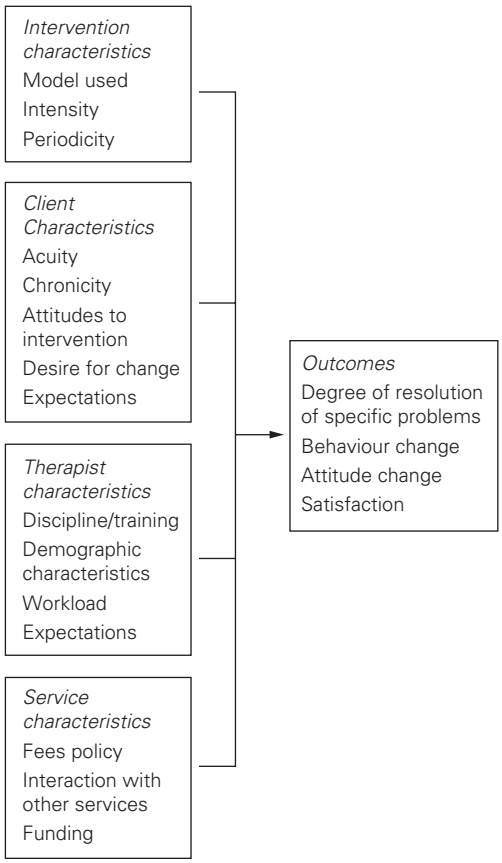
The development of a gambling problem and the associated potentially negative consequences of the problem takes time, perhaps a very extended time period. Volberg's findings, that problem gambling rates increase steadily with time in new gambling jurisdictions, are probably reflective of this fact as well as issues such as market uptake.

Social and family supports, or the lack of them, are also important protective and risk factors for negative outcomes of gambling activity. It is noted from the BreakEven Client and Service Analysis studies conducted for the Department of Human Services that people who are divorced or separated appear at twice the expected rate in presentations to problem gambling services. While this may be either a cause or a consequence of the problem gambling, it is very well known from other research literatures that social supports are a key protective factor for adversity.

1.9 A Model of Intervention Inputs and Outputs

The studies reported in this document rely upon an understanding or model of intervention inputs and outputs that also requires explication for the present discussion. The model is presented below.

Figure 3 Model of Intervention Inputs and Outputs



The model we have proposed asserts that the outputs or outcomes of an intervention process are affected by four classes of factors. These include:

1. **Characteristics of the Intervention.**
   These include the theoretical model used and features of the intensity and periodicity of the intervention, for example, the number, timing and length of sessions.
2. **Client Characteristics.**
   Of course, clients with more severe and chronic conditions may be harder to assist. Issues such as client attitudes to the interventions, the client's desire for change, their expectations of the intervention process and the outcomes it will produce and the demographic characteristics of the client, may affect intervention outcomes.
3. **Therapist Characteristics.**
   The discipline and training of the therapist, their demographic characteristics, workload and expectations concerning the intervention process and the outcomes it will produce may affect intervention outcomes.
4. **Service Characteristics and Design.**
   Certain service features may impact upon outcomes including charges policies. How this service interacts with others and its funding arrangements and amenities may impact upon outcomes.

Almost all of the published intervention studies in the health and human services literature focus on a very small subset of these variables and their interaction, for example, the relationship between client expectations and outcomes or demographic characteristics and their outcomes. However, there have been a small number of multivariate outcome prediction studies involving some of these classes of factors described above, especially in the area of physical and occupational rehabilitation. The discussion of the above model reminds us that we are looking at a very complex causal and associative web overlaying the person's engagement with a service designed to intervene an assist them with their gambling and its associated problems.

1.9.1 Intervention Outcomes

The inputs interact in complex ways to produce the intervention outputs. The measures of outcomes of interventions fall into several categories, the degree of resolution of specific problems, and changes in behaviour and attitudes. The experiences within the intervention program may also lead to varying levels of satisfaction with it.

We by no means underestimate the conceptual and methodological difficulties associated with outcomes measurement. The gambling field, perhaps even more so than other health and human services fields at present lacks crucial standardised outcome measurement tools, although work is underway in various jurisdictions and settings to address this problem. The present project has involved a major effort in the development of such tools in order to be able to address various research questions posed within the research program. We report upon some of these attempts later in this document.

1.10 Conclusions

We have offered the above discussion to provide a conceptual context for the activities we report in this document. We note that the engagement of people with gambling problems involves a complex web of causal and associative influences and connections played out in the person's life as they engage with

others within their family, work and with those who are engaged with them in assisting them. We note that in other help-seeking research that those engaged with services have been shown to represent the tip of an indeterminate iceberg, and that many people require assistance over an extended period to achieve satisfactory resolution of their problems. The complexity of intervention in this context requires a robust and systematic approach. One of the virtues of the present studies reported in this document and the research program within which it sits is that all of the classes of influencing factors discussed above have been subjected to systematic study. We do not underestimate the methodological and conceptual difficulties and complexities associated with such research. We now turn to a discussion of the project methodology.

2 Method

2.1 Introduction

This document reports the outcomes of analyses conducted on the following data sets:

- The BreakEven Counselling Services' Minimum Data Set for the period 1 July 1997 to 30 June 1998 (n=3149).
- A retrospective survey of clients of the BreakEven Counselling Services who had a contact with a Service in the first quarter of 1998 (n=150)
- A prospective survey of clients who had attended their first counselling session at a BreakEven Counselling Service in July 1998 (n=43). Sixteen of these clients participated in a three-month follow-up data collection.
- Surveys of 48 BreakEven Counselling Service counsellors, involving completion of two questionnaires (the Clinical Practice Evaluation Counsellor Questionnaire and the Counsellor Task Analysis Questionnaire).
- Individual interviews with counsellors.

A description of each data set and how it was collected now follows.

2.2 The BreakEven Counselling Services' Minimum Data Set

When the statewide network of problem gambling counselling services, known as 'BreakEven', was established in Victoria, in 1995, a requirement of the funded agencies was that statistical data about clients and their consultations be collected and pooled to form a Minimum Data Set (MDS). These data are, therefore, a census of all clients who present to these services. The MDS offers a unique opportunity to study gamblers who present to the designated problem gambling counselling services. Data from the period 1 July 1997 to 30 June 1998 were employed in the present study. This involved 3,149 participants. For a detailed discussion of the MDS and its characteristics, the refer to the various Client and Service Analysis Reports released by the Department of Human Services (see the Bibliography to this Report. Appendix H contains the MDS forms).

Between 1 July 1997 and 30 June 1998, 3,149 new clients registered with Victoria's problem gambling counselling services. As shown in Table 1, the clear majority of those presenting for services (79.6 per cent) were people who reported that they had problems with their own gambling behaviour. The retrospective sample is drawn from the group of clients presenting with their own gambling problem (that is, problem gambler). The Minimum Data Set analysis included in the report is based on the data from the 1997—1998 Minimum Data Set.

Table 1 New Clients: Client Status by Sex

Client Status	Male N	Female N	Persons N	Persons %
Self-identified gambling problem	1,223	1,233	2,456	79.6
Partner	129	307	436	14.1
Parent	23	50	73	2.4
Sibling	7	14	21	0.7
Other relative	12	37	49	1.6
Friend	11	17	28	0.9
Work colleague or employer	2	3	5	0.2
Other	9	8	17	0.6
Total	1,416	1,669	3,085	100.0

Unclassified missing data=64

2.3 Retrospective Survey of Clients of the BreakEven Counselling Services

A retrospective survey was conducted of clients of the BreakEven Counselling Services who had a contact with a Service in the first quarter of 1998 (n=150).

2.3.1 Retrospective Client Study Recruitment Methods

Clients who had a contact with a BreakEven Problem Gambling Service in the first quarter of 1998 were contacted via BreakEven counsellors for recruitment into the study. Counsellors were asked to forward questionnaires directly to clients. Each questionnaire was uniquely numbered, enabling subsequent matching with the MDS database for each respondent.

Of the 852 retrospective study questionnaires sent to BreakEven Counsellors, 318 were not distributed to clients, 384 were sent to clients but not returned and 150 were returned by clients. This produced a 28 per cent return rate amongst questionnaires distributed to clients and 18 per cent of all questionnaires distributed to services. The distribution of questionnaires by counsellors was employed because of confidentiality and ethical issues. There was considerable sensitivity on the part of counsellors concerning the methods of engagement with clients. It was not possible to send reminder notices to prospective participants because of these concerns, although counsellors were regularly contacted to track the progress of the data collection for this study. There was no direct contact between clients and the research team.

Of the 318 questionnaires not distributed to clients, a variety of reasons were advanced by services for their non-distribution. These included:

- Unwillingness of some workers to participate in the research at all because they considered the study to be a violation of client confidentiality.
- Inability to locate clients who had moved.
- A judgment that receipt of the questionnaire would cause stress to the client or damage client relationships with the worker, that is, participation would cause harm.

The overall low rates of distribution of questionnaires to clients were of considerable concern to the research team, as was the introduction, in some cases, of worker judgments into the distribution process. Notwithstanding these concerns, as discussed later, the extent of bias introduced into the sample by this third party recruitment method appears to be small from the available analyses.

2.3.2 Retrospective Client Study Survey Tool

A copy of the survey tool employed in the retrospective client study appears in Appendix A. The tool includes several scales, as well as stand-alone questions. Questions concerning the following areas were included in the retrospective client study questionnaire.

Service use (BreakEven and non-BreakEven)

Questions were asked of clients concerning their usage of BreakEven and other relevant gambling related services.

State prior to counselling (gambling and general life issues, readiness to change)

Questions derived from the DSM-IV diagnostic criteria for pathological gambling were asked of all clients. The criteria are widely used in the gambling literature as a means of assessing problem gambling behaviour. The questionnaire included a single question for clients to record their self-rating of the extent to which they felt ready to change at the beginning of counselling.

Gambling activity (prior and current)

Clients were asked to rate before and after counselling, how they felt about their current level of gambling and if they would attribute any change that occurred to the actual counselling process.

Counselling process (client suitability, therapeutic relationship including: bond, expectations/purposes, tasks/goals)

The therapeutic relationship can be conceptualised as being divided into three components—the working alliance, the transference relationship and the real relationship (Gelso and Carter, 1985).

The questions presented to clients in the questionnaire were grouped around three basic aspects of the alliance: the therapeutic bond, the roles and purposes (of each of the individuals involved, and the counselling process itself) and the goals and tasks developed as a result of worker–client collaboration (Horvath and Greenberg, 1989). In the client questionnaire, to investigate the working alliance component of the theapeutic relationship, we included the Therapeutic Relationship Scale developed by us for this project. We built on, and incorporated items from, those with a client version, such as the Working Alliance Inventory (Horvath and Greenberg, 1989); the Vanderbuilt Therapeutic Alliance Scale (Hartley and Strupp, 1983); the Barrett-Lennard Relationship Inventory (Empathy Scale) (Barrett-Lennard, 1962); and the Therapeutic Bond Scale (Orlinsky, Howard and Saunders, 1989). The development of the Therapeutic Relationship Scale is described in Appendix I. The questions in the questionnaire that form the Therapeutic Relationship Scale are numbered 23 to 46.

Outcome (symptoms, life matters, other problems, satisfaction, termination factors)

Clients were asked questions concerning the impact of counselling on the level of problem resolution for all presenting problems, client satisfaction and the quality of clients' life skills.

Within the questionnaire, the Client Satisfaction Scale developed by us was included to assess the clients' satisfaction with the services' process and outcomes. This scale was based on earlier work performed by us in the measurement of client satisfaction with health services (Steven, Thomas, Eckermann, Browning and Dickens, 1999). The questions 47 to 50 in the retrospective client study questionnaire (see Appendix A) correspond to this scale. The psychometric properties of the scale are reported in the above article.

Within the questionnaire, the Life Skills Scale developed by us was included to measure the impact of counselling upon the clients' life skills. The nine items of question 20 in the retrospective client study questionnaire (see Appendix A) form this scale. The psychometric properties of this scale are reported in Appendix I to this Report.

2.4 Prospective Survey of Clients

A prospective survey was conducted, in July 1998, of 43 clients who had attended their first counselling session at a BreakEven Counselling Service.

2.4.1 Prospective Client Survey Recruitment Method

The prospective sample was drawn from clients attending a first counselling session in July 1998. Clients were provided with a questionnaire by the counsellor at the end of the first counselling session. Three hundred questionnaires were sent to services for distribution to clients meeting the inclusion criterion. Of these, 43 questionnaires were returned unused and the remaining 257 were presented to clients by counsellors. Forty-three problem gamblers returned questionnaires to the research team. This represents a response rate of 17 per cent for questionnaires distributed to clients and 14 per cent of questionnaires distributed to services.

Of the 43 problem gamblers who returned questionnaires only 16 participated in a three-month follow-up study. This low return rate was disappointing and unsatisfactory. Feedback from counsellors indicated that they considered that clients often come in a 'state of crisis' and as such this may be an impediment to them completing such a questionnaire. We also believe that other factors came into play.

In other studies where we have used this type of longitudinal methodology, the identities of the participants have been known to us. We have been able to manage the process of engagement, with successful outcomes. The ethical and operational considerations that led to the present third party recruitment design led to high levels of protection for clients, but unsatisfactory recruitment outcomes.

We consider that the lack of incentives for participation for the longitudinal study participants was a factor in the low rates of participation. A feature of the BreakEven service delivery pattern is that rather high levels of problem resolution occur within relatively short periods. If a client considers that they

have resolved their issues for the moment, there is little incentive to perform an activity that reminds them of past problems. Second, because of confidentiality considerations, we were not able to provide incentives such as prizes for people to participate. Such incentives usually increase response rates substantially.

Notwithstanding these difficulties we have reported the outcomes of this study in the body of this Report, as it is a deliverable component of the project. This is not to minimise any critique of its limitations associated with the disappointing participant uptake resulting from the third party recruitment methodology.

2.4.2 Prospective Client Survey Tool

The Prospective Client Survey Tool mirrored the Retrospective Client Survey Tool discussed above with appropriate changes in tense. The Survey Tool appears in Appendix B.

An addition to the prospective version of the questionnaire was a complete version of Heather, Gold and Rollnick's (1991) Readiness to Change questionnaire. A copy of these questions is provided in Appendix B, questions 10–21. The psychometric properties of this tool are reported in the above article.

2.5 Surveys of BreakEven Counselling Service Counsellors

Surveys of BreakEven Counselling Service counsellors were conducted. These involved completion of two questionnaires (The Clinical Practice Evaluation Counsellor Questionnaire and the Counsellor Task Analysis Questionnaire) and individual interviews (n=48).

2.5.1 Recruitment Method

All counsellors employed in 1997–98 at the BreakEven Problem Gambling Counselling Services were recruited into the study. Following initial contact with service management, direct contact was made with all the counsellors. All but one participated in the surveys. This was, therefore, a census study of the 48 counsellors employed at the services at that time.

2.5.2 Counsellor Survey Tools

The studied involved the administration of two questionnaires to all BreakEven counsellors. These were:

- The Clinical Practice Evaluation Counsellor Questionnaire (Appendix D). The items included in the Questionnaire covered the following areas:
  - The relationship between theoretical frameworks and techniques used in practice.
  - The diagnostic decision making process used by counsellors.
  - An overview of the way counselling practice occurs within BreakEven services.
  - Counsellors' views on counselling outcomes.

The questionnaire content was developed on the basis of consideration of the literature review reported in Section 1 of this document and consultations with the counsellors and project researchers and advisors. No standard tool was available to cover the required content, so we devised our own questions. It is not intended that the responses to these questions constitute a scale and hence psychometric analyses are not provided for these items.

2.5.3 Counsellor Task Analysis Questionnaire (Appendix G)

The development of this tool, its psychometric properties and its application is described in detail in Volume 4 of the current Evaluation Report Series, and in Appendix I.

Individual interviews were conducted with all counsellors according to the schedule shown in Appendix F.

2.6 Further Considerations in the Study Methodology

There are several issues regarding the study methodology that require further explanation. The issues include how cross-referencing of study data was achieved and various discussion issues that have been raised in the process of the report review.

2.6.1 Cross-Referencing of Study Data

In the construction of the studies in the present project, cross-referencing of data collected within them was conducted. The Minimum Data Set database includes substantial information about the progress and process of counselling of BreakEven service client. It was considered to be advantageous to link this information with responses from the prospective and retrospective client surveys. This was achieved through the use of a unique matching identifier for each client. It should be noted that neither data set contains identifying information.

2.6.2 Time Since Last Counselling Session

It is important to understand that the study sample involved people who had engaged with the services in quite varying ways and at different times. As we shall demonstrate later, the diversity within the study sample characteristics closely matched the population from which they were drawn. We were in a very fortunate position in that the present studies drew participants from a study population for which the population parameters are well known, that is, people had attended BreakEven Problem Gambling Services. The characteristics of all people who attend these services are carefully logged.

The mean time since the last counselling session attended by the study participants was 3.3 months, with considerable individual variation around this mean. Thirty-six per cent of the study samples had been seen within the last month, 25 per cent between two and three months, 19 per cent between four to five months, 16 per cent between six to nine months and four per cent longer than nine months. Given the wide diversity in times since engagement, the issue arises as to whether these times may reflect people with differing levels of problem resolution and differing views of the intervention process and outcomes. If this were the case, then this might require the use of multivariate procedures to adjust for these effects.

In order to check for this possibility, many preliminary analyses were conducted. Analyses of the associations between time since last counselling session and the following factors were conducted using the appropriate statistical analyses:

- Satisfaction with outcomes achieved.
- Satisfaction with the counselling experience.
- Self-rated impact of BreakEven upon gambling.
- Self-rated levels of current gambling compared with prior to counselling.
- Self-rated resolution of problems associated with gambling behaviour.
- Selected demographic variables.

None of these analyses achieved statistical significance. Therefore, the time since counselling variable was not used as a covariate within the presented analyses. As described later in this Report, considerable analysis effort was invested to determine the level of match between the study sample statistics and the population parameters. A high degree of match was found, notwithstanding the relatively low response rates for some components of the program.

It should also be noted that little emphasis in these analyses is placed upon the concept of case 'closure' or 'drop-out'. Some studies of human services have foundered on this rock, in our view, quite unnecessarily. We do not make the assumption that 'closure' or 'drop-out' has occurred as a result of the passage of an arbitrary time interval since formal engagement has occurred with the services. As we have discussed in our review of the work of Prochaska and DiClemente, we consider that the best evidence to date shows that pattern of engagement with services of this nature is characterised by fits and starts over an extended time interval. A major procedural issue in the current context in assessing when closure has occurred is the fact that we were not able to independently contact clients because of confidentiality issues. Thus, if, as is very likely to occur, different services employ different formal criteria and/or apply them informally in different ways, then analyses based on case closure as an analysis criterion are suspect. In this context, tight definitions of closure and drop-out are fraught with major interpretation and procedural difficulties. Further, the enforcement of closure concepts based on arbitrary time intervals within such a diverse service delivery context may rely upon a commonality of approach between services that in practice simply does not occur.

2.6.3 Use of Summed Scores for Numbers of Problems in the Analyses

In the analyses presented of problem resolution in this Report, the problem resolution analyses have been based on a summed score derived from the eight problem resolution items. These problem areas are as follows:

1. Finances.
2. Interpersonal relationships.
3. Family.
4. Physical health.
5. Employment.
6. Leisure.
7. Intrapersonal issues.
8. Legal issues.

Each client has been rated in terms of the extent of resolution of each of the eight problems, thus providing a profile of the extent to which problems have been experienced and resolved.

In subsequent discussions of the utility of using summed scores to reflect the clients' outcomes it has been suggested that perhaps not all problems should be included in an overall measure of problem resolution for certain interventions. For example, if the intervention were Cognitive Behavioural Therapy, why should, for instance, issues associated with physical health and employment be included in the outcomes analysis? It might be argued that the focus should be on intrapersonal issues exclusively, if that approach were employed. If this suggestion were implemented then individual analyses would be employed perhaps with unique subsets of problem items used as the dependent measures within the analyses.

From a practical viewpoint, this would mean that analyses of overall effectiveness where different interventions were compared with each other would not be possible. A further practical issue is: how we would choose which items to include in the individual analyses? Is it the case, for example, that all therapists using CBT would argue that the impact of their intervention is confined to intrapersonal issues only? What if different therapists argued that although they used CBT, in one case they considered their intervention would have global effects across all areas but in another case, this was not their goal? Some therapists may have highly focused goals and achieve them well only within their chosen domain. Others may have broader goals. Yet both may use the same intervention techniques.

In an evaluation of this nature, therefore, we are comfortable with the application of a uniform set of evaluation criteria based on the summed scores, rather than the use of individual subsets for different interventions.

We consider that there are sound conceptual reasons as to why the outcome measures should be broadly based on all areas. The biopsychosocial model, which is at the heart of many accounts of human behaviour, argues for the connectedness of different facets of the human experience. It used to be the case, under biomedical models, that social and psychological factors and their relationship to physical health were separated. Yet the last two decades of health research have shown strong connections between these domains. We consider that it would run counter to the current conventional wisdom to separate client problems into single items or small subsets of items. It is well known that physical health is affected by finances, and that employment is related to health, and so on. There are many studies that have painstakingly examined these links.[4] This literature is beyond the scope of the present study, but to minimise these links by separating outcome measures into individualised subsets is not our preference, for the above reasons.

We consider that the above conceptual arguments are sufficient justification for the use of summed measures. However, this does not address the issue of whether it is psychometrically justified to sum the item scores into a single measure.

Accordingly, we report the outcomes of various psychometric analyses in Appendix I of this Report. These analyses show that this decision is psychometrically sound. We therefore report our analyses using the summed total scores based on the above considerations.

2.6.4 When is Behaviour Therapy Behaviour Therapy?

An important interpretational issue relating to the studies described in this Report is the fact the evaluation is based upon a natural experiment or comparison design. In a standard randomised control intervention study, one would randomly allocate clients to alternative interventions and then track progress. In the present context, this has not been possible because of the real-world constraints operating. We have carefully observed naturally occurring patterns of interventions and outcomes. However, we do not have a guarantee that what one counsellor terms behaviour therapy is the same as what the originators of the terminology or other counsellors may define as deserving that classification. Further, we do not have control over how clients may have gravitated towards different services and counsellors. We cannot assume that this process has been random. It may be biased in quite complex ways. We therefore draw the reader's attention to this feature of the research program and encourage the exercise of conservatism in the interpretation of the obtained data and findings.

[4] The reader is referred to the four volume series of the 'Handbook of health behaviour research' edited by David Gochman and published by Plenum in 1997 for a comprehensive discussion of these literatures.

2.7 Strengths and Limitations of the Clinical Practice Evaluation Methodology

The present study program has a number of strengths and limitations. We now discuss these.

Integration and Triangulation of Data Sets

The matching procedures employed in the present study permitted integration and triangulation of data concerning the same phenomena from a variety of different sources. This was a strength of the methodology.

The Census Nature of the BreakEven Minimum Data Set

The BreakEven Minimum Data Set is an ongoing census of all services provided to all clients in the BreakEven agencies. This is a definitive data set in terms of the data items included within it. Hence its inclusion is a strength of the present project methodology.

Control Issues

The establishment of a control group was not possible in the context of the current study. The prospective sample of clients who were followed up after three months to provide data concerning before and after-effects of counselling, although they cannot account for whether the client's improvement was due to experiences other than those associated with counselling contact (for example, via maturational or history effects). Although some control is given by exploring the relationship between a client's attendance at other services and outcome rates, the vast majority of clients did not report using any other service for their problem while attending BreakEven.

Self-Reported Data

All the client feedback for the clinical practice evaluation relied on the use of client self-reports regarding their experience and well-being. There is no simple way around the problem of potential inaccuracy of self-reports regarding emotional state and outcomes achieved, but as Seligman (1995: 965) argues:

> This is, however, an ever present inaccuracy even with an experienced diagnostician, and the correlation between self-report and diagnosis are usually quite high… Such self-reports are the blood and guts of a clinical diagnosis.

In the present study, we also were obliged to rely, to a certain extent upon counsellors', reports of their approaches and behaviour in counselling. Thus, if a counsellor said that they employed, for example, a Cognitive Behavioural approach, then they were taken at their word. While the counsellors obviously have a degree of sophistication in such judgments and descriptions, the particular implementations of certain approaches are likely to vary from one to the next. The classical way of resolving questions concerning the effectiveness of one intervention approach over another, the randomised control trial, was not available in this context. Thus comparisons between different therapeutic approaches in the context of the present study program to some extent relied upon professional judgments made by the counsellor respondents in describing and classifying their activities. The development of the Counsellor Task Analysis tool reflects these concerns, as it is necessary to objectively describe patterns of counsellor activity without heavily relying upon self-descriptions. Nevertheless, this is not entirely avoidable.

2.7.1 Sampling Bias

We now turn to a detailed discussion of the issues of sampling bias within the retrospective client survey sample. We have referred to the unsatisfactory nature of the third party recruitment protocol that we were obliged to employ because of confidentiality considerations within the present project. An important issue, therefore, is whether the sampling protocols delivered a biased sample to the study. In broad terms, we shall argue that on all of the major demographic and gambling activity criteria available to us from the Minimum Data Set, there is not substantive evidence for such bias to have occurred, while noting that other un-measured factors may have differed between the retrospective client survey study sample and the population from which it was drawn. We shall present analyses concerning the following variables and factors:

- Sex.
- Age.
- Country of origin.
- Individual and family income.
- Labour force status.
- Occupation.
- Type of gambling.
- Time and money spent on gambling.
- Patterns of gambling.

- Gambling-related debt.
- DSM-IV criteria for pathological gambling.
- Number of counselling sessions attended.

The following outline provides an overview of the demographic and gambling activity of the one hundred and fifty clients who participated in the clinical practice evaluation retrospective study. This group is compared with the characteristics of the 852 clients this sample was drawn from, noting any difference that may exist between the following groups within this sample:

- Clients who returned the questionnaire (n=150).
- Clients who were not sent the questionnaire (n=318).
- Clients who did not return the questionnaire (n=384).

This client population is also compared to the MDS records of self-identified 'problem gambler' clients, reported on in the *Client and Service Analysis Report Number 4 1997–1998* (Jackson et al 1998).

For each table, the data for some respondents was not available, hence some column totals do not equal the total number of respondents in the study population.

2.7.2 Sex

The clinical practice evaluation client questionnaire was only sent to service users who had designated themselves as 'problem gamblers'. (See Table 2)

The sample of clients who responded to the questionnaire was consistent with the overall profile of the client population they were drawn from. Measures of association showed no significant differences between groups (Cramer's V=0.052; p=0.331).

2.7.3 Age

The age profile of respondents varies somewhat from the BreakEven population the clients were drawn from. (See Table 3)

In order to establish the statistical significance of the association represented in the above table the correlation coefficient was computed. The Cramer's V was calculated for the table showing that the difference between groups within the clinical practice evaluation sample were significant (Cramer's V=0.128; p=0.002). Table 3 shows that the clients who participated in the clinical practice evaluation were, on the whole, older than the sample population in general, with 61.5 per cent of respondents being 40 or over, in comparison to 51.5 per cent who were not sent a questionnaire, and 47.7 per cent who did not return the questionnaire. A comparison of the mean age of each of the three groups reinforced this difference: evaluation participants (40.65 years); clients not sent a questionnaire (37.96 years); and clients who did not return a questionnaire (37.79 years). A comparison of means, on the MDS record of actual age of clients, also showed variance between groups, significant at (p=0.021), with a correlation coefficient of (eta=0.099).

Table 2 Clinical Practice Evaluation Clients by Sex

Sex	Returned % (N=150)	Not Sent % (N=318)	Not Returned % (N=384)	MDS Sample Total % (N=852)	MDS Problem Gambler Clients 1997–98 %
Female	46.6	47.8	52.5	49.7	50.2
Male	53.4	52.2	47.5	50.3	49.8
Totals	n=150	n=318	n=383	n=847	n=2,456

Table 3 Clinical Practice Evaluation Sample by Age Group

Age Group	Returned % (N=150)	Not Sent % (N=318)	Not Returned % (N=384)	Sample Total % (N=852)	MDS Problem Gambler Clients 1997–98 %
Less than 20	0.7	0.6	1.6	9	1.1
20–29	15.5	21.9	23.4	21.5	20.7
30–39	22.3	26.0	27.3	26.0	28.5
40–49	35.8	24.8	29.9	29.0	25.3
50–59	14.9	10.5	11.5	11.7	10.6
60 plus	10.8	16.2	6.3	10.7	13.8
Totals	n=148	n=315	n=384	n=847	n=2,455

2.7.4 Country of Origin

The percentage of questionnaire respondents who were born in Australia was similar to that of the BreakEven client population the sample was drawn from, at 78 per cent and 75 per cent respectively. There was little difference between groups of clients from this population—returned (78 per cent), not sent (72 per cent), not returned (77 per cent).

2.7.5 Weekly Income

The percentage breakdown of weekly individual income for clients who responded to the clinical practice evaluation questionnaire was almost identical to those for the BreakEven client population in general, with three-quarters of clients earning $32,000 or less per annum. There were no statistically significant differences between groups of clients within the CPE sample (Cramer's V=0.089; p=0.394). (See Table 4)

Similar to the result above for individual incomes, the weekly family income breakdown between the two groups of clients was closely related, with a high percentage (62 per cent) of clients having a family income of $32,000 or less per annum. There was no statistically significant difference between groups in the clinical practice evaluation (Cramer's V=0.095; p=0.323). (See Table 5)

2.7.6 Labour Force Status

The clients who responded to the clinical practice evaluation questionnaire had a similar labour force status break down to the 1997–98 MDS 'problem gambler' client population in general. There was no significant statistical difference between groups in the clinical practice evaluation sample (Cramer's V=0.065; p=0.514). (See Table 6 on following page)

2.7.7 Occupation

The occupational breakdown of respondents to the clinical practice evaluation is similar to that of the 1997–98 MDS 'problem gambler' client population. There were no statistically significant differences between the groups within the clinical practice evaluation sample in terms of their occupational groupings (Cramer's V=0.105; p=0.203). (See Table 7 on following page)

Table 4 Clinical Practice Evaluation Sample by Weekly Individual Income

Income	Returned % (N=150)	Not Sent % (N=318)	Not Returned % (N=384)	MDS Sample Population % (N=852)	MDS 'Problem Gambler' Client Population 1997–98 % (N=2,475)
$1,500 or more	2.8	1.4	1.6	1.7	1.7
$800–$1,499	7.6	4.5	7.0	6.2	6.3
$600–$799	12.5	7.7	10.8	10.0	12.3
$400–$599	22.2	24.1	24.3	23.8	23.1
$200–$399	23.6	22.7	24.5	23.7	23.8
$120–$199	20.8	24.1	16.7	20.1	19.2
Less than $120	10.4	15.4	15.1	14.4	12.7
Totals	n=144	n=286	n=371	n=801	n=2,243

Table 5 Clinical Practice Evaluation Sample by Weekly Family Income

Income	Returned % (N=150)	Not Sent % (N=318)	Not Returned % (N=384)	MDS Client Sample Population % (N=852)	MDS Clients 1997–98 % (N=2,475)
$1,500 or more	6.7	4.0	6.6	5.7	5.4
$800–$1,499	15.6	12.5	17.0	15.1	17.9
$600–$799	16.3	14.7	17.6	16.3	16.9
$400–$599	24.4	27.8	25.6	26.2	23.8
$200–$399	17.8	18.7	17.3	17.9	18.7
$120–$199	17.8	16.1	12.1	14.6	13.7
Less than $120	1.5	6.2	3.7	4.2	3.8
Totals	n=135	n=273	n=347	n=755	n=2,021

Table 6 Clinical Practice Evaluation Sample by Labour Force Status

Labour Force Status	Returned % (N=150)	Not Sent % (N=318)	Not Returned % (N=384)	MDS Client Sample Population % (N=852)	MDS 'Problem Gambler' Client Population 1997–98 % (N=2,475)
Employed full-time	43.5	39.1	42.6	41.4	41.4
Employed part-time	16.3	17.4	18.2	17.5	17.4
Unemployed, looking for work	14.3	11.4	13.2	12.7	12.7
Not in Labour force*	25.8	31.5	26.0	28.1	28.4
Totals	n=147	n=317	n=380	n=844	n=2,314

*Not in labour force means the person is retired or involved in home duties, etc.

Table 7 Clinical Practice Evaluation Sample by Occupational Group

Occupation	Returned % (N=150)	Not Sent % (N=318)	Not Returned % (N=384)	MDS Client Sample Population %	MDS 'Problem Gambler' Client Population 1997–98 % (N=2,475)
Manager/administrator	11.6	6.3	12.7	10.1	9.3
Professional	15.7	11.8	11.2	12.2	10.9
Associate/paraprofessional	11.6	7.8	10.3	9.6	9.1
Tradesperson	10.7	10.0	10.6	10.4	12.2
Clerical or service worker	31.4	31.8	29.0	30.5	29.9
Production or transport worker	5.8	9.3	8.2	8.2	9.3
Labourer	13.2	23.0	17.9	19.0	19.3
Totals	n=121	n=270	n=330	n=721	n=1,921

Missing Data = (N – n)

In terms of clients' demographic characteristics, statistically significant differences were only detected in the age of clients, with respondents to the clinical practice evaluation being slightly older than the general BreakEven population and others within the clinical practice evaluation sample.

2.7.8 Gambling Activity

The profile of clients returning the clinical practice evaluation questionnaire needs to be explored against the sample population they were drawn from and BreakEven 'problem gambler' clients in general, with respect to the extent of their gambling activity and their scores on the DSM-IV criteria for pathological gambling. Much of the therapy outcome literature notes problem severity as an important factor in achieving positive outcomes with clients. For the purposes of this study we will explore the respondents gambling behaviour, level of debt and severity of their problem using the DSM-IV criteria for pathological gambling.

2.7.9 Gambling Behaviour

The cohort of clients participating in the clinical practice evaluation of BreakEven services had a similar gambling behaviour profile as other groups within the sample and those 'problem gamblers' generally using BreakEven services during 1997–98.

Although there appears to be a difference in the types of gambling undertaken by the clinical practice evaluation respondents, other groups within the sample and 'problem gambling' clients from the MDS, with respondents to the clinical practice evaluation having higher percentages in most categories, none of these differences tested as statistically significant. This may be the result of the same sample size in some of the categories. (See Table 8)

As Table 9 illustrates, the respondents to the clinical practice evaluation are largely the same as those reported by the MDS in general. The CPE respondents spend slightly higher amounts on racing and card games. EGM play figures are identical for all groups.

2.7.10 Patterns of Gambling

The pattern of clinical practice evaluation respondents' gambling activity closely paralleled that of BreakEven clients generally. There was no statistically significant difference between groups (Cramer's V=0.071; p=0.652). (See Table 10)

The importance of these results is that they clearly indicate that the sample of BreakEven clients reported

Table 8 Clinical Practice Evaluation Sample by Type of Gambling During a Typical Gambling Episode

Type of Gambling	Returned % (n=150)	Not Sent % (n=318)	Not Returned % (n=384)	MDS Client Sample Population %	MDS 'Problem Gambler' Client Population 1997–98 % (n=2,475)
Lotto/Lottery/pools/Keno	5.4	5.0	4.2	4.7	3.9
Bet on races at TAB (off-course)	15.5	12.3	14.8	14.0	13.0
Bet on races (on course)	5.4	2.8	4.2	3.9	3.5
Electronic gaming machines	75.7	65.4	69.8	69.2	72.3
Bingo	3.4	1.6	1.6	1.9	2.8
Bet on card games	4.7	2.2	2.9	2.9	3.5
Numbers	0.7	1.9	1.8	1.6	1.8
Internet/online	0	0	0	0	0
Other kind of gambling	0	0.9	1.0	0.8	1.2
Not known	3.4	2.5	1.8	2.4	3.1

Table 9 Clinical Practice Evaluation Sample by Gambling Activity in Hours, Dollars and Episodes

	Median Number of Hours per Episode				Median Number of Dollars Spent per Episode				Median Number of Episodes per Month			
Type of Gambling	CPE 1	CPE 2	CPE 3	MDS	CPE 1	CPE 2	CPE 3	MDS	CPE 1	CPE 2	CPE 3	MDS
Lotto/lottery/keno	1	2	1	1	40	30	12.50	20	4	4	4	4
Bet on races TAB	3	2	2	3	150	100	100	100	7.5	8	10	8
Bet on races (on-course)	5.5	6	4	5	190	100	100	125	2.5	4	4	4
EGMs	3	3	3	3	100	100	100	100	8	8	8	8
Bingo	2	2	2.5	3	26	36	20	30	6	4	4	4
Bet on card games	4	4	4	4	500	500	200	400	5	4	5	5
Numbers	5	3		4	200	200		250	5	8		4

CPE 1=Participants in clinical practice evaluation=150

CPE 2=Clients who were not able to be sent an evaluation questionnaire=318

CPE 3=Clients who did not return evaluation questionnaires=384

MDS=All 'self-identified problem gambler' clients attending services in 1997–98=2,475

Table 10 Clinical Practice Evaluation Sample by Pattern of Gambling Activity

Pattern of Gambling	Returned % (n=150)	Not Sent % (n=318)	Not Returned % (n=384)	MDS Client Sample Population % (n=852)	MDS 'Problem Gambler' Clients 1997–98 % (n=2,475)
Ascending	21.7	22.1	24.8	23.3	23.1
Descending	14.0	13.6	13.7	13.7	15.0
Stable	21.7	20.3	19.1	20.0	20.6
Chaotic	16.1	18.8	12.0	15.2	16.2
Binge	7.7	5.9	7.4	6.9	6.4
Not currently gambling	18.9	19.2	22.8	20.8	18.7
Totals	n=143	n=271	n=350	n=764	n=2,131

on in the clinical practice evaluation are not significantly different from the general BreakEven 'problem gambler' client population, in respect to their gambling behaviour. This is important, as the severity of an individual's gambling behaviour can impact on the counselling outcomes possible for clients.

2.7.11 Gambling Related Debt

The clients who responded to the clinical practice evaluation have on the whole a lower level of debt than those generally attending BreakEven services, although their median debt level is similar. The difference in the mean between groups is largely the result of the impact of outliers on the data.

It is important to note that debt in this context does not refer to money lost playing, but rather money owing as a result of clients' gambling activity. There was no statistically significant difference between groups within the clinical practice evaluation sample (eta=0.003, p=0.470), in relation to debt levels. This again is a valuable finding, as it indicates that the sample of clients reported on in the clinical practice evaluation is not a group in more or less debt than most other clients, strengthening the ability of the findings to be generalised to the larger client population. (See Table 11)

2.7.12 DSM–IV Maladaptive Behaviours

As part of the Minimum Data Set clients are assessed at the beginning of counselling using the DSM-IV criteria for pathological gambling. The ten items listed in Table 12 are used to assess the severity of people's gambling related behaviours called maladaptive behaviours. If five or more of these maladaptive behaviours are present and no other psychiatric condition is present an individual meets the DSM-IV criteria to be classified as a 'pathological gambler'.

As Table 12 illustrates, the clinical practice evaluation respondents are representative of the BreakEven client population of 1997–98, with three-quarters of the client population fitting the criteria of five or more maladaptive behaviours and hence being designated as 'pathological gamblers', although there is a statistically significant difference between the groups within the clinical practice evaluation sample (eta=008, p=0.047). The mean number of maladaptive behaviours of each sample group are respondents, mean=6; not sent, mean=5.5; not returned, mean=6.1. There is a much lower percentage of clients with no maladaptive behaviours in respondents to the clinical practice evaluation than other groups within the sample. In this respect the respondents resemble the total 1997–98 client population more than the clinical

Table 11 Clinical Practice Evaluation Sample by Level of Gambling Related Debt

Level	Returned (n=150)	Not Sent (n=318)	Not Returned (n=384)	MDS Client Sample Population (n=852)	MDS 'Problem Gambler' Clients 1997–98 (n=2,475)
Maximum debt	85,000	1,000,000	1,000,000	1,000,000	2,000,000
75% quartile	8,000	10,000	10,000	10,000	8,250
Median debt	2,500	3,000	3,000	3,000	3,000
25% quartile	200	1,000	1,000	700	600
Minimum debt	0	0	0	0	0
Mean debt	9,362	16,580	21,120	17,222	14,140
Totals	n=93	n=167	n=215	n=475	(unknown)

Table 12 Clinical Practice Evaluation Sample by Number of Maladaptive Behaviours

Number of Maladaptive behaviours	Returned % (n=150)	Not Sent % (n=318)	Not Returned % (n=384)	MDS Client Sample Population	MDS Clients 1997–98 %
0	2.1	13.4	6.7	8.4	1.0
1	0.7	2.4	3.1	2.4	2.1
2	3.6	3.1	3.9	3.5	4.0
3	7.9	5.2	4.7	5.4	7.2
4	10.0	7.6	5.8	7.2	9.5
5	15.0	10.7	9.2	10.8	11.6
6	19.3	14.1	15.0	15.5	15.3
7	14.3	12.8	13.9	13.6	15.7
8	15.7	9.3	18.9	14.8	15.2
9	6.4	15.9	12.0	12.4	12.9
10	5.0	5.5	6.7	6.0	5.5
Totals	n=140	n=290	n=359	n=789	n=2,083

(Missing data = N – n)

practice evaluation sample population. This result is important, as it shows that the clients in the respondent sample are indicating as many, if not more, maladaptive behaviours than clients in the other groups. This strengthens the case that the sample clients are not those who had lower levels of problems so more positive outcomes.

As can be seen in Table 13, the pattern of maladaptive behaviours of respondents in the clinical practice evaluation is similar to that of MDS clients in general, and other groups within the evaluation sample.

2.7.13 Number of Sessions

The number of sessions attended was checked to ensure that the sample of respondents was attending counselling sessions at the same rate as the client population in general. The mean number of sessions attended for each group in the clinical practice evaluation sample was similar, with no statistically significant difference recorded (p=0.607, eta squared= 0.001); respondents: mean=6.76; clients not sent questionnaires: mean=6.94; clients who did not return questionnaires: mean=6.41; total sample population: mean=6.67. This finding indicates that clients reported on throughout the following analysis of service outcomes were using counselling with similar frequency to BreakEven clients generally.

2.8 Conclusions

The research program outlined involved a comprehensive set of linked studies to address the research and evaluation goals. The ability to link the data collections through data matching procedures was a particular strength of the project, as was the integration and triangulation of the studies.

However, the recruitment of participants using the third party recruitment methodology in this project has been shown to have strengths and weaknesses. In the present client studies, we were obliged to use counsellors as the recruitment agents for participants. This was a consequence of ethical considerations arising from the fact that most services do not obtain prior consent for their clients to participate in evaluation activities. This procedure provided very high levels of protection for clients. Unfortunately, it also resulted in lower rates of participation than were expected in the retrospective and prospective client studies within the program. Other data sources, such as the data derived from the BreakEven MDS and the counsellor task analysis were unaffected by this procedural consideration. Although analyses have been presented to demonstrate a close match between the characteristics of the study populations and the study samples in terms of a range of variables, the

Table 13 Clinical Practice Evaluation Sample by Type of Maladaptive Behaviour

Number of Maladaptive behaviours	Returned % (n=150)	Not Sent % (n=318)	Not Returned % (n=384)	MDS Client Sample Population	MDS Clients 1997–98 %
1. Preoccupied with gambling.	60.0	61.6	63.7	62.3	61.0
2. Needs to gamble with increasing amounts of money.	53.8	56.3	58.5	56.9	53.8
3. Has repeated unsuccessful efforts to control gambling.	68.9	77.6	74.7	74.6	74.5
4. Is restless or irritable when attempting to cut down.	47.2	61.4	62.2	59.0	56.8
5. Gambles as away ofescaping fromproblems.	90.3	86.0	81.0	84.5	86.4
6. After losingmoney chases losses.	80.0	83.1	82.4	82.2	80.8
7. Lies to familymembers, therapists or others.	69.6	77.3	80.0	77.1	77.3
8. Has committed illegal acts.	22.9	24.1	24.4	24.0	20.0
9. Has jeopardised relationships, job education.	59.3	61.9	61.5	61.3	58.8
10. Relies onothers to provide money.	55.6	59.2	62.7	60.1	58.3

lower than expected levels of recruitment must be considered in the interpretation of the prospective and retrospective client studies. On the other hand, the BreakEven MDS and Counsellor Task Analysis datasets were census or full population datasets.

We contend that in future evaluation studies more direct recruitment methods should be employed. This may require some changes in the ways in which services engage with their clients. They may need to alert them to the fact that for evaluation purposes they may be asked to assist in evaluating the services that they have received. Evaluation is now quite properly a routine feature of the service provision landscape. Of course, concerns about privacy and confidentiality must be addressed. In addition, the needs of the community in ensuring that publicly funded services provide high quality service must also be considered.

We now turn to a presentation of the project results.

3 Descriptive Analysis of Counselling Outcomes

3.1 Introduction

As outlined in the section on methods, several data sets were used to explore this topic. In establishing the effects of the agency's intervention on the client's problem a number of perspectives were taken into account. Through the analysis of the clinical practice evaluation questionnaires clients' views on the effects of their attendance at counselling are presented. This analysis explores the effects on a retrospective sample of clients (n=150) and on a very small (n=16) longitudinal sample of clients who responded to a questionnaire at the end of their first counselling session and three months later.

3.2 Outcome Measures Using the Retrospective Sample

It is important to note at the outset that, as the previous section on the data sets and sample shows, the retrospective sample seems to be a representative subset of 'problem gambler' clients attending BreakEven counselling services generally. As discussed earlier, in order to check if time since counselling may be an important covariate that ought be included in the forthcoming results presentation, many analyses were conducted. Analyses of the associations between time since last counselling session and the following factors were conducted using the appropriate analysis methods:

- Satisfaction with outcomes achieved.
- Satisfaction with the counselling experience.
- Self-rated impact of BreakEven upon gambling.
- Self-rated levels of current gambling compared with prior to counselling.
- Self-rated resolution of problems associated with gambling behaviour.
- Selected demographic variables.

None of these analyses achieved significance. Therefore, the time since counselling variable was not used as a covariate within the presented analyses. Keeping the necessary caveats in mind, outlined in the section on data limitations, one can infer the following findings to the BreakEven 'problem gambling' population generally.

A number of measures have been used to tap the effects of the agencies' counselling interventions. In the Clinical Practice Evaluation Client Questionnaire a series of questions were asked regarding the level of problem resolution over a number of areas. These areas include the impact of counselling on a number of life skills and the client's emotional state before and after counselling. The results of the client responses to these questions are described in detail in the following section.

3.3 Levels of Problem Resolution

In the data collection system used at BreakEven services workers report on the resolution levels of clients attending the services on a number of issues. These issues are gambling behaviour, financial issues, family issues, relationship issues, employment issues, physical health issues, leisure use issues, intrapersonal issues and legal issues. Counsellors

Table 14 Clinical Practice Evaluation Respondents Reported Level of Problem Resolution (n=150)

Problem Resolution	Got Worse	Unresolved	Partly resolved	Fully Resolved	Fixed to My Satisfaction	Total
Gambling activity	3% (4)	8%	46%	15%	28%	148
Financial issues	6% (8)	14%	46%	12%	23%	139
Family issues	5% (7)	10%	37%	21%	26%	135
Relationship issues	4% (5)	12%	30%	24%	31%	130
Employment	7% (7)	16%	18%	22%	37%	104
Physical health	3% (4)	11%	33%	23%	30%	124
Leisure use	4% (6)	13%	47%	12%	24%	139
Intrapersonal issues	4% (5)	14%	41%	17%	25%	137
Legal issues	4% (4)	5%	24%	30%	37%	93

can assess the level of problem resolution as unresolved, partially resolved or fully resolved. For the purposes of the clinical practice evaluation the same scale was given to clients with the addition of two new categories 'fixed to my satisfaction' and 'got worse'. The first, the 'got worse' category, was included as it is important to accept that some clients may feel their situation worsened as the result of counselling. The second category, 'fixed to my satisfaction', was created to provide clients with the opportunity to indicate that a problem may not have been fully resolved but that they were satisfied with the resolution reached as the result of counselling.

This scale was administered to a sample of problem gamblers who had used a BreakEven service between January and March 1998. The characteristics of this group of respondents have been outlined in detail in the previous section. Results of these responses are provided in Table 14.

Table 15 Clinical Practice Evaluation by Summary of Client Reported Change (n=150)

Problem Resolution	Got Worse %	No Change %	Positive Change %
Gambling activity	3	8	89
Financial issues	6	14	82
Family issues	5	10	84
Relationship issues	4	12	85
Employment	7	16	77
Physical health	3	11	85
Leisure use	4	13	83
Intrapersonal issues	4	14	82
Legal issues	4	5	90

On the basis of these client reports, BreakEven counselling would seem to be quite effective. This is particularly noteworthy, given the shortness of many of the interventions, with the mean number of sessions being six. It is important to note that the vast majority of clients come to the service having experienced a number of failed attempts to give up gambling. However, conclusive proof of positive effect would require a larger scale longitudinal study, across a range of different types of gambling problems. The results presented in this Report, however, do provide strong prima facie evidence that BreakEven counselling works well.

As Figure 4 and Table 15 graphically illustrate, the work undertaken in counselling at BreakEven services seems to have a strong positive impact on the problems clients attending the service experience. BreakEven counselling impacts clients' problems positively in at least three-quarters of the cases reported across all problem areas. The highest level of improvement reported was in the areas of legal issues (90 per cent) and gambling behaviour (89 per cent).

One of the constant indicators used in gambling treatment outcome literature to measure treatment effectiveness is the impact of the intervention on the actual gambling behaviour of clients. This is often measured in terms of abstinence or controlled gambling. In this study we have departed from this convention and asked clients to rate the level of problem resolution of the problems they experience as a result of their gambling, using their self-definitions. These findings need to be read and understood in this light. They represent client reports on the level of problem resolution as they have defined it.

Clients were asked directly to indicate the extent to which they considered receiving counselling from a BreakEven service had an impact on their gambling. As the graph above illustrates the majority or three-quarters of the clients who responded to the question noted the extent of the impact as a 'fair amount' or a

Figure 4 Clinical Practice Evaluation Respondents' Level of Problem Resolution

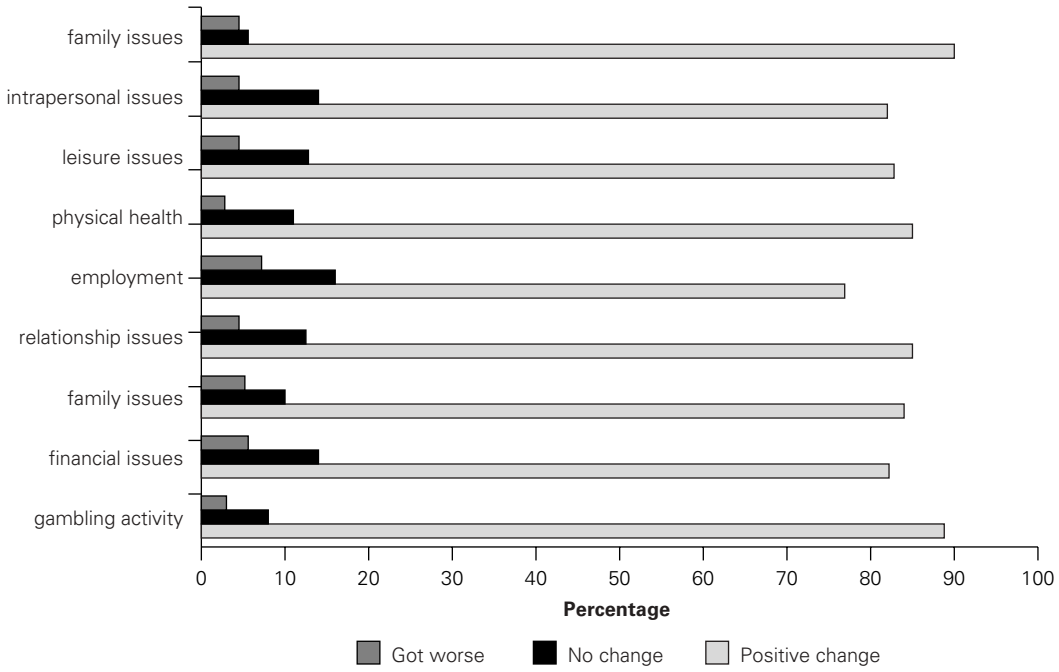
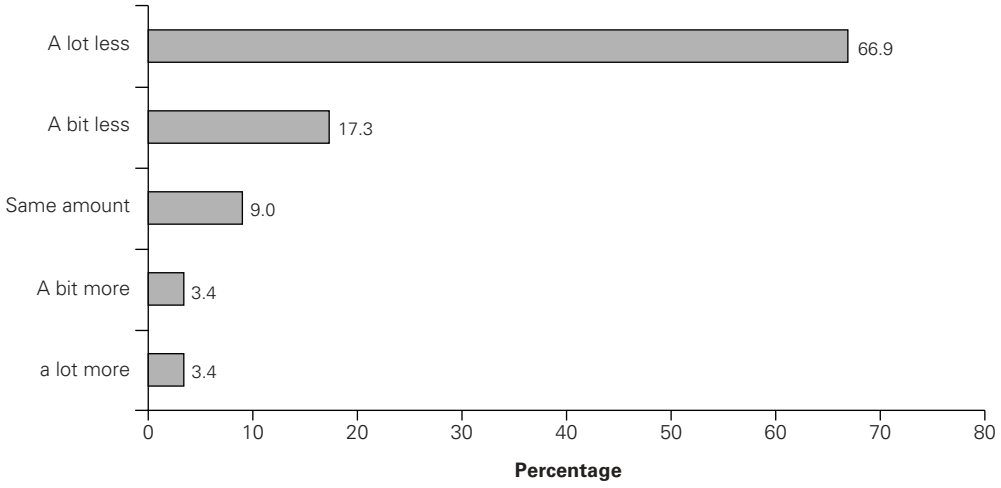


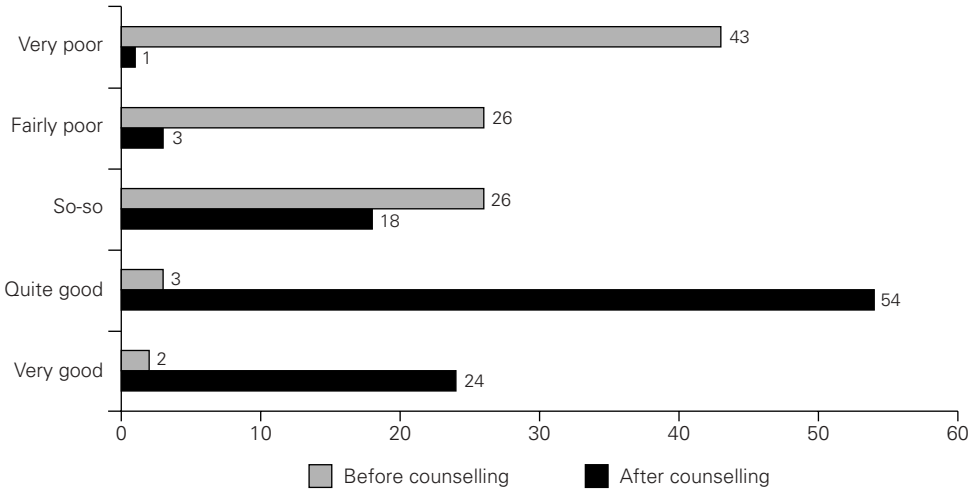
Figure 5 Clinical Practice Evaluation Respondents' Comparison of Current Gambling with Gambling Activity Prior to Attending BreakEven Counselling



'great deal'. Thus, in the opinion of clients the counselling they undertook at BreakEven directly changed their gambling behaviour.

As Figure 5 shows, two-thirds (67 per cent) of the respondents indicated that they gambled 'a lot less', with an additional (17 per cent) indicating they gambled 'a bit less'. Some respondents were more adversely affected, with three per cent each gambling 'a lot more' or 'a bit more'. Nine per cent of clients were gambling at the same level.

Figure 6 Clinical Practice Evaluation Respondents' Emotional State Before and after BreakEven Counselling



3.4 Emotional State Prior to and after Counselling

Clients were asked to report on their emotional state before and after counselling using the same scale, thus enabling a direct comparison of their responses. As Figure 6 illustrates peoples' emotional state improved dramatically after counselling. Prior to counselling the average description of emotional state was 'fairly poor'; after counselling this average response shifted to 'quite good'. Thus the emotional state of clients moved from the majority (69 per cent) being 'very poor' or 'fairly poor' prior to counselling to the majority (78 per cent) being 'quite good' or 'very good' after counselling.

3.5 The Impact of Counselling on Life Skills

The counselling process impacts in a number of ways on the ability of individuals to live full and productive lives. Many people experience emotional, relationship or financial breakdown and crises as a result of their gambling, and feel their lives are out of their control. They have often lost the ability to communicate effectively with their loved ones, they experience low self-esteem, and lack knowledge of the services and strategies available to assist them. The research team, rather than only defining the outcome of counselling in relation to levels of problem resolution, also considered it important to tap the improvement in life skills often associated with counselling experience. In this study clients were asked to indicate whether their skills in a number of areas were made better, worse or were not affected by the counselling process. These areas were:

- Self-awareness.
- Understanding the nature of problem gambling behaviour.
- Ability to accept responsibility for the problems their gambling caused.
- Ability to communicate with others close to them.
- Ability to cope with stress.
- Self-esteem.
- Self-confidence.
- Ability to talk to others about sensitive issues.
- Knowledge of services available that can assist people with gambling related problems.

Counselling received at BreakEven had a positive effect on a range of areas in respondents' lives. The large majority of clients experienced an improvement in their understanding of the nature of the problem they have (88 per cent), in accepting responsibility for the problems their gambling caused (84 per cent), their level of self-awareness (79 per cent), and in their knowledge of services available that can assist people with gambling related problems (71 per cent).

3.6 Level of Maladaptive Behaviours

When clients first attend counselling at a BreakEven service, counsellors undertake an assessment of their level of maladaptive behaviours using criteria set out in the DSM-IV. As a strategy for assessing the impact of counselling on clients' lives, clients were asked to assess themselves at the point in time they filled out

the questionnaire on the ten items listed in the DSM-IV criteria.

It is worth noting before presenting the findings in this section some of the difficulties that exist in using the findings of these different reporting sources.

The first problem is in the difficulty this creates for assessing the standards with which the different audiences reported activity. This raises the question of whether the assessment of a counsellor is going to differ significantly from a client report of their current activity. In the case of this client cohort it is difficult to state an answer to this question with any certainty.

Another problem with the use of these reports is the use of a primarily clinical tool for descriptive purposes, such as ours. The DSM-IV criteria are used to establish the clinical category 'pathological gambler'. We have, instead, taken the criteria as a list of 'gambling related behaviours' and asked clients to assess themselves on the basis of the statements provided. This again presents us with the ongoing problem of the reliability of client self-reports, addressed previously.

3.7 Type of Maladaptive Behaviour

Table 16 and Figure 7 (on the following page) outline the response of clients post-counselling in comparison to the worker assessment of their circumstances when they arrived at counselling.

3.8 Number of Maladaptive Behaviours

The number of maladaptive behaviours identified belonging to each client is used as an assessment of the 'pathological' nature of the client's gambling activity.

Table 17 Comparison of Client and Counsellor Reports of the Number of Maladaptive Behaviours for Clinical Practice Evaluation Respondents (n=150)

Number of Maladaptive behaviours	Counsellor Assessment of Clients Pre-Counselling		Client Self-Assessment Post-Counselling	
	N	%	N	%
0	3	2.1	22	14.7
1	1	0.7	21	14.0
2	5	3.6	21	14.0
3	11	7.9	18	12.0
4	14	10.0	12	8.0
5	21	15.0	12	8.0
6	27	19.3	12	8.0
7	20	14.3	10	6.7
8	22	15.7	9	6.0
9	9	6.4	8	5.3
10	7	5.0	5	3.3

(Missing cases=10)

Table 16 Comparison of Client and Counsellor Reported Maladaptive Behaviours for Clinical Practice Evaluation Respondents (n=150)

Maladaptive behaviours	Counsellor Assessment of Clients Pre-Counselling		Client Assessment of Themselves Post-Counselling	
	N	%	N	%
Preoccupied with gambling	87	60	50	35.7
Needs to gamble with increasing amounts of money	78	53.8	34	24.5
Has repeated unsuccessful efforts to control gambling	100	68.9	46	48.3
Is restless or irritable when attempting to cut down	67	47.2	44	31.2
Gambles as a way of escaping problems	131	90.3	97	66.4
After losing money chases losses	116	80	77	53.8
Lies to family members, therapists or others	101	69.6	69	48.6
Has committed illegal acts	33	22.9	28	19.7
Has jeopardised relationships, job education	86	59.3	51	35.4
Relies on others to provide money	80	55.6	42	30

Figure 7 Clinical Practice Evaluation Respondents' Pre- and Post-Counselling Measures of Maladaptive Behaviours

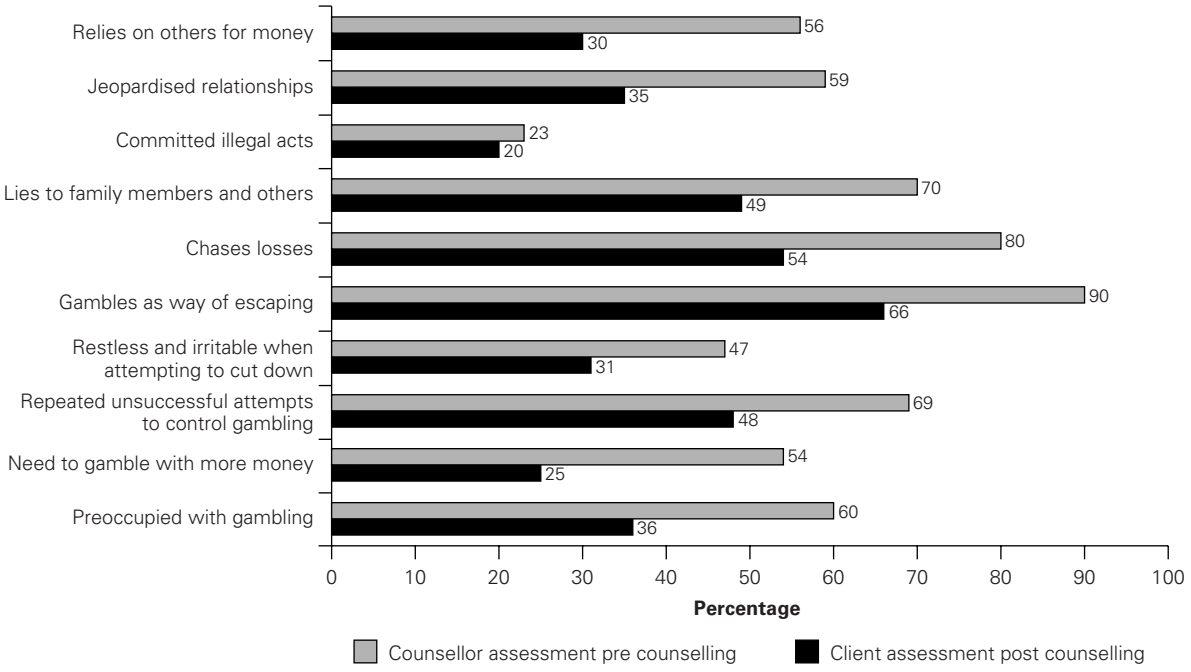


Figure 8 Clinical Practice Evaluation Respondents' Number of Maladaptive Behaviours Pre- and Post-Counselling

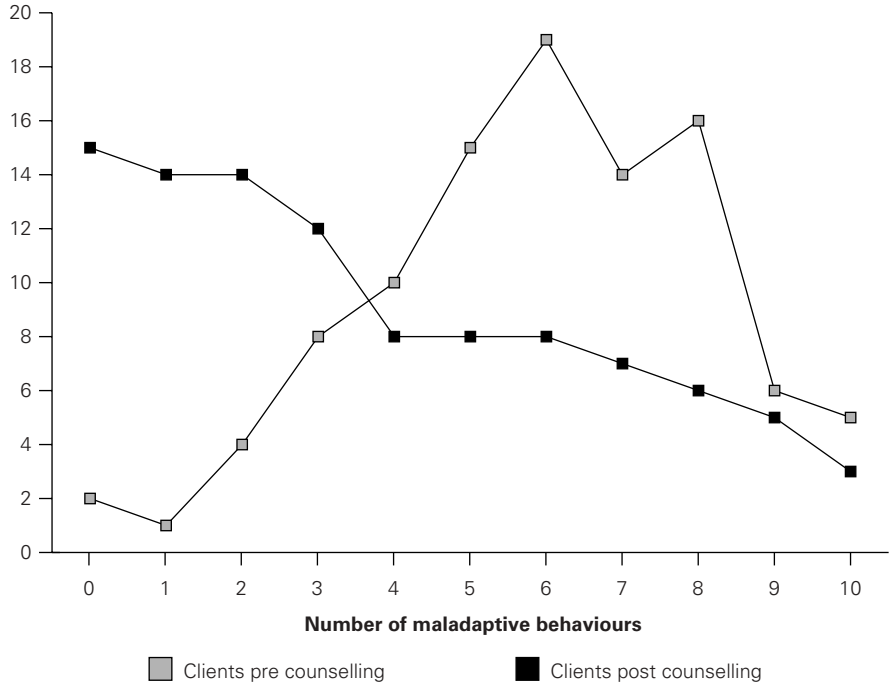


Table 17 and Figure 6 illustrates the difference between the workers' pre-counselling assessment of clients. Three-quarters (75.7 per cent) of these clients were 'pathological gamblers', with the client post-counselling self-assessment, which identified only a third (37.3 per cent) of the same client group as 'pathological gamblers'.

Of course the interpretation of these 'differences' requires careful consideration. The confounding factor in attributing the differences in ratings to improvement is that of the source of the ratings, that is, the client and the counsellor. It is not appropriate to interpret these differences simply as 'changes'. They may also reflect the differences in perceptions from the two different raters. From Tables 15 and 19 it would seem that in an aggregate sense clients might be using the rating scale more optimistically than the counsellors. As with any human judgment where there is no external gold standard referent, it is not possible to determine which sets of raters may be 'right' in their ratings. The reader therefore needs to interpret these 'differences' with appropriate caution.

3.9 Service Satisfaction

Another indicator of outcome used with respondents of the Clinical Practice Evaluation Client Questionnaire was *service satisfaction*. Clients were asked to indicate their level of satisfaction with the service they had received at BreakEven. A number of different aspects of service provision were presented, such as:

- The amount of time between contacting the service and being able to see a counsellor.
- The amount of time the counsellor spent with the client.
- The counsellor's treatment of the client's problems.
- The counsellor's ability to listen to the client's problems.
- The counsellor's willingness to answer the client's questions.
- The counsellor's knowledge about the problems facing the client.
- The counsellor's ability to help you with the client's problem.
- The way the counsellor focused on the issues the client presented to them.
- The outcomes the client received as the result of attending counselling.

Respondents were also asked how satisfied they were with the service overall.

As Table 18 shows, the vast majority of clients who responded to the evaluation questionnaire were satisfied with the service they received from BreakEven. They were most satisfied with the time the counsellor spent with them (92 per cent), the ability of the counsellor to listen to their problems (93 per cent), and the counsellor's willingness to answer their questions (93 per cent). They were predominantly satisfied, although at a slightly lower rate, with the outcomes they received as the result of attending counselling (73 per cent).

Table 18 Clinical Practice Evaluation Respondents' Level of Satisfaction with BreakEven Services

Level of Satisfaction with:	Very Satisfied	Satisfied	Neither	Dissatisfied	Very Dissatisfied	Totals
The amount of waiting time for an appointment	97 (65%)	36 (24%)	9 (6%)	5 (3.4%)	2 (1.3%)	149
The amount of time the counsellor spent with the client	102 (69%)	36 (24.2%)	5 (3.4%)	4 (2.7%)	2 (1.3%)	149
The counsellors treatment of the problem	101 (68.2%)	31 (21%)	8 (5.4%)	6 (4.1%)	2 (1.4%)	148
The counsellors ability to listen to clients problems	119 (80.4%)	19 (12.8%)	8 (5.4%)	2 (1.4%)	0 (0%)	148
The counsellor's willingness to answer the client's questions	109 (73.2%)	29 (19.5%)	8 (5.4%)	2 (1.3%)	1 (1%)	149
The counsellor's knowledge about the problems facing the client	96 (64.4%)	33 (22.1%)	9 (6%)	8 (5.4%)	3 (2%)	149
The counsellor's ability to help the client with their problems	85 (57%)	41 (27.5%)	12 (8%)	8 (5.4%)	3 (2%)	149
The way the counsellor focused on the issues the client presented	92 (62.2%)	37 (25%)	13 (8.8%)	4 (2.7%)	2 (1.3%)	148
The outcomes you achieved as the result of attending counselling	70 (47.3%)	38 (25.7%)	19 (12.8%)	13 (8.8%)	8 (5.4%)	148

As an additional measure of satisfaction with BreakEven Services, clients were asked to state if they would use BreakEven again if they had similar problems, and if they would recommend BreakEven to others. Over three-quarters (82 per cent) of clients said they would use the service again, and a significant (91 per cent) number of clients would recommend the service to others in similar circumstances to themselves.

3.10 Outcomes of a Three-Month Prospective Longitudinal Study of Clients

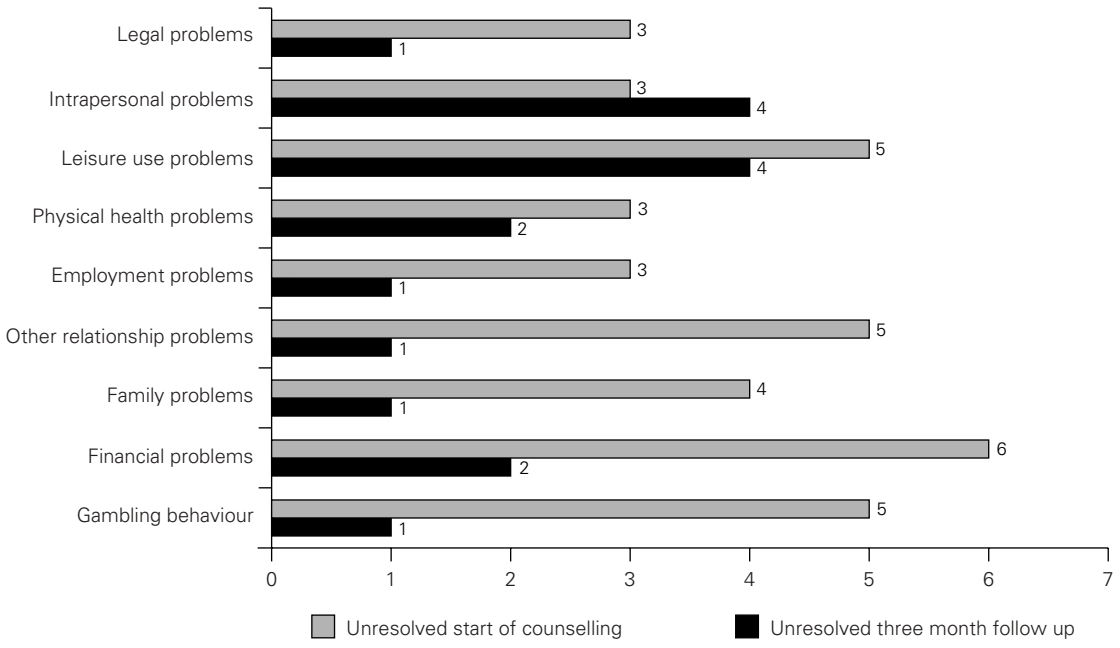
A prospective sample of clients was included as part of the analysis of the effectiveness of BreakEven counselling services. These clients were all clients new to the service and attending a first counselling session over the months July 1998 and August 1998. Counsellors asked these clients at the end of the first counselling session, if they would participate in the longitudinal study. In a study description clients were asked to participate in a follow-up study at three, six and eighteen months.

Three hundred questionnaires were distributed to BreakEven services, with the amount given to each service equivalent to the percentage of new registrations each service had recorded in the quarter January to March 1998. Of these three hundred questionnaires, 45 were not given to clients and 43 were completed and returned to the research team. One client declined permission to participate in the follow-up study. Forty-three clients were sent a three-month follow-up questionnaire. Of these, 16 clients responded and five questionnaires were returned to sender. As suggested earlier, it is unclear what the exact reason was for the low return rate, although feedback from counsellors suggested that the end of the first session is still a time of crisis for many clients and counsellors believed it would be unlikely that clients would feel up to completing such a questionnaire.

We have significant reservations about the utility of the third party recruitment methodology required in this study. While noting the necessity to preserve client confidentiality and not to disturb the client–counsellor relationship, the recruitment outcomes are clearly unsatisfactory.

Because of the very small sample size the following material has been presented in a descriptive form. No proper inferential analysis can be undertaken from this material. The following four figures illustrate the movement in the different levels of problem resolution at the commencement of

Figure 9 Clinical Practice Evaluation Longitudinal Study Respondents' Level of Unresolved Problems at End of First Counselling Session and Three-Month Follow-up



counselling and approximately three months after this first counselling contact for the sixteen clients who participated in the follow-up study.

3.11 Unresolved Problems

As shown in Figure 9, the level of unresolved problems at the end of the first session of counselling and three months following counselling are reduced in all areas but interpersonal problems. The level of unresolved problems are, proportionally, most reduced in the areas of gambling behaviour, financial problems and other relationship problems.

3.12 Partially Resolved Problems

As Figure 10 indicates, the number of partially resolved problems overall is reduced after the three-month period, with two notable exceptions. These are problems related to gambling behaviour and financial problems where there were slightly more partial resolutions in these areas after the three-month period.

3.13 Fully Resolved Problems

The level of full resolution to problems was greater in all areas after the three-month period. This was particularly the case with financial problems, problems with gambling behaviour and legal problems.

3.14 Problem Fixed to the Client's Satisfaction

There was an overall increase in the number of problems fixed to the client's satisfaction after three months, particularly in the area of family problems.

As Figures 9–12 indicate, from the end of the first session of counselling to the administration of the follow-up questionnaire the amount of unresolved and partially resolved problems decrease whilst the amount of fully resolved and problems resolved to the client's satisfaction increased. However, the very small sample size of this study must be considered in any interpretation of the results.

3.15 Psychosocial Index

A measure of the client's psychosocial well-being was developed by combining the client's responses to the following four statements:

- How would you describe your emotional state prior to counselling?
- How would you describe the state of your relationships prior to counselling?
- How would you describe the state of your financial position prior to counselling?

Figure 10 Clinical Practice Evaluation Prospective Study Respondents' Comparison of Problems Partially Resolved at End of First Counselling Session and Three-Month Follow-up

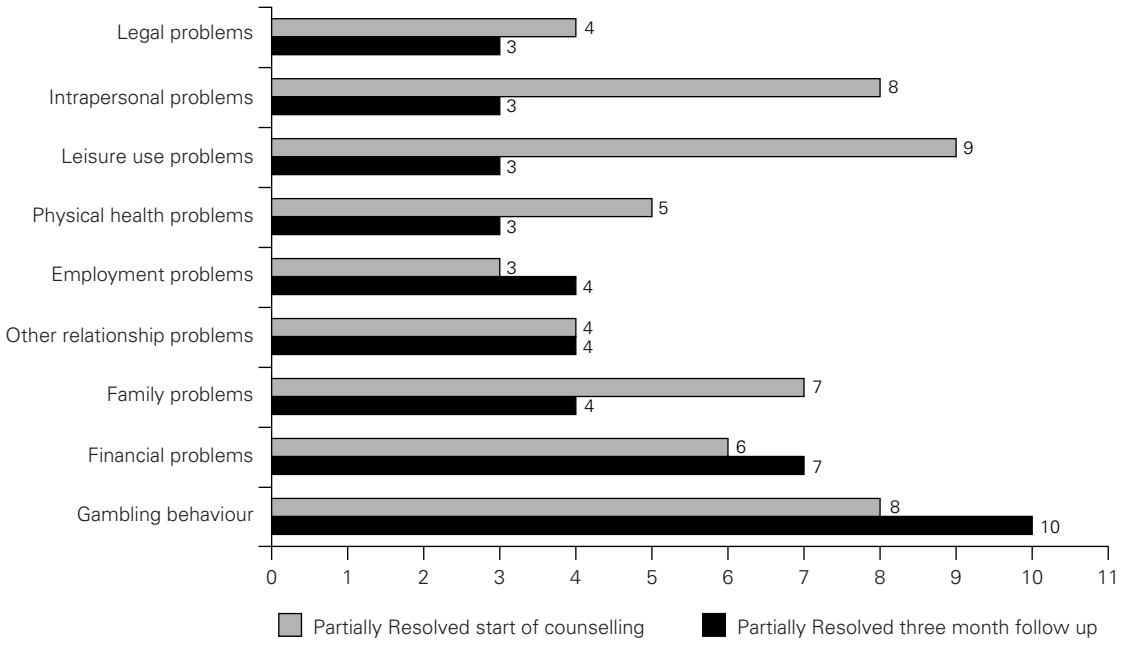


Figure 11 Clinical Practice Evaluation Prospective Study Respondents' Comparison of Problems Fully Resolved at End of First Counselling Session and Three-Month Follow-up

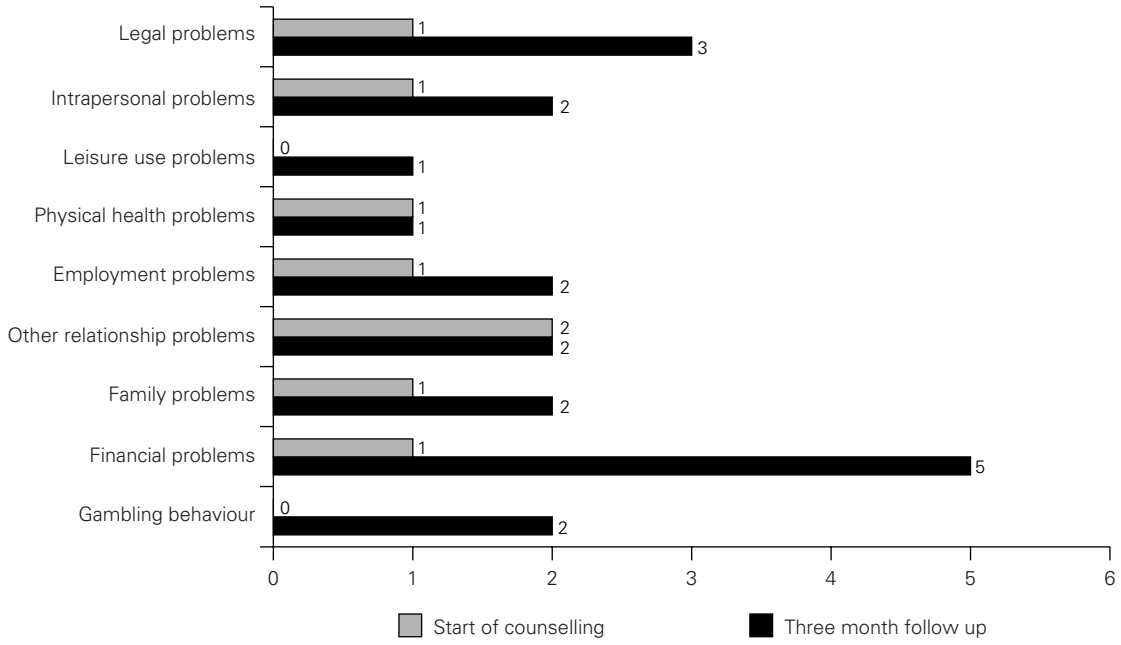
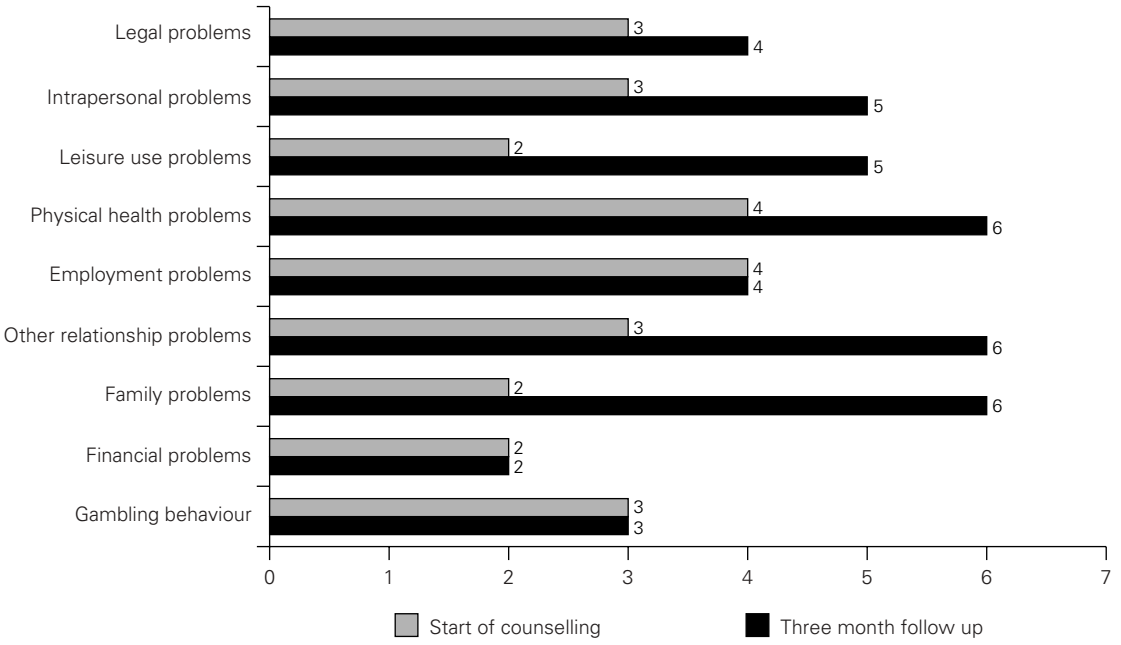


Figure 12 Clinical Practice Evaluation Prospective Study Respondents' Comparison of Problems Fixed to the Client's Satisfaction at End of First Counselling Session and Three-Month Follow-up



- How would you describe the state of your work life prior to counselling?

The follow-up measure used the same indicators but replaced 'prior to counselling' with 'after counselling'.

The range of the index was between 0–16, with 0 indicating 'very poor' and 16 indicating 'very good'. The mean position of clients on this index shifted from 6.14 ('fairly poor') after the first counselling session to 11.28 ('quite good') at the three-month follow-up.

3.16 Number of Maladaptive Behaviours

Clients were also asked to answer yes or no to a series of statements concerning the nature of their gambling problem. The ten statements, when applied clinically, are used as the basis of a diagnosis of pathological gambling using the DSM-IV criteria. In this non-clinical use of the statements they are used to indicate the number of maladaptive behaviours the client is involved in linked to their gambling activity. The following is the list of the ten statements that constitute this diagnostic tool.

1. I am preoccupied with gambling (this could include preoccupation with reliving past gambling experiences, handicapping or planning the next venture or thinking of ways to get money with which to gamble).
2. I need to gamble with increasing amounts of money in order to achieve the desired excitement.
3. I have repeated unsuccessful efforts to control, cut back or stop gambling.
4. I am restless or irritable when attempting to cut down or stop gambling.
5. I gamble as a way of escaping from problems or of relieving feelings of helplessness, guilt, anxiety or depression.
6. After losing money gambling, I often return another day to get even.
7. I lie to family members, therapists or others to conceal the extent of my involvement with gambling.
8. I have committed illegal acts, such as forgery, fraud, theft or embezzlement to finance gambling.
9. I have jeopardised or lost a significant relationship, job, or educational or career opportunity because of gambling.
10. I rely on others to provide money to relieve a desperate financial situation caused by gambling.

The positive responses to these statements are counted to provide an indication of the number of maladaptive behaviours each client has. In the longitudinal study this information has been captured at the beginning of counselling and after a three-month period.

The results of this analysis shows that the mean number of maladaptive behaviours recorded by the client at the beginning of counselling was 5.4 and after three months it had reduced to 3.3 ($t=2.6$, $p<0.05$). Thus most clients were up to two problems better off after counselling.

3.17 Gambling Activity

Clients were asked to indicate the extent to which their gambling was a problem for them using a five-point scale from 1 ('a great deal') to 5 ('not at all'). The mean response of clients shifted from 2.1 ('a fair amount') to 3.6 ('very little'). This indicates that there is a reduction in extent to which gambling is a problem for clients as the result of their counselling experience.

3.18 Level of Client Satisfaction

Clients were asked to report their level of satisfaction with the outcomes they achieved at the service and with the experience of counselling generally. Clients' scores on both these satisfaction measures did not vary. Thus the level of satisfaction the client felt was not directly affected by their level of problem resolution or level of psychosocial well-being.

3.19 Length of Time Since Counselling

The mean length of time since clients had used the service was four days for clients at the beginning of their counselling, and 30.43 days for clients responding to the follow-up. This means that, on average, clients in the sample had not attended the service for four weeks when they returned the follow-up questionnaire.

The above analysis of the longitudinal sample of clients indicates a distinct improvement on a number of outcome measures by clients across the time they attended counselling. Clients performed better on most outcome measures including the level of problem resolution, their psychosocial well-being, the number of maladaptive behaviours they exhibited

and a reduction in the extent to which they perceived their gambling to be problematic.

3.20 MDS Report of Outcomes

Counselling outcomes can be established in respect of each of the client's presenting problems. The table below provides details on the level of problem resolution across a range of presenting problems for clients defined as 'problem gamblers'. This is assessed at the time of their last contact session and by their intention to attend further counselling sessions. As may be anticipated, these data show a lower degree of resolution for clients who are intending returning for further counselling. Nevertheless, even those who intend to have further counselling sessions sometimes had achieved full resolution of some presenting problems.

The comparable data for partners and other clients are presented in Table 20. However, unlike problem gambler clients, for partners and others there is less of a marked difference in problem resolution rates between those intending to continue in counselling and those who intend ceasing counselling or for whom their intentions are unknown.

Table 19 MDS Reported 'Problem Gamblers': Progress Indicators at Last Contact by Plans for Further Contact

	Unresolved		Partially Resolved		Fully Resolved		Not an Issue	
	N	%	N	%	N	%	N	%
Further contact planned								
Financial issues	465	32.6	679	47.6	102	7.2	180	12.6
Employment and work related issues	288	22.3	262	20.2	61	4.7	683	52.8
Leisure use issues	418	30.8	580	42.7	73	5.4	286	21.1
Interpersonal related	509	35.4	612	42.6	82	5.7	235	16.3
Intrapersonal	455	31.3	793	54.5	77	5.3	129	8.9
Family issues	405	30.1	479	35.6	85	6.3	376	28.0
Legal issues	89	7.1	90	7.2	21	1.7	1,052	84.0
Physical symptoms	176	14.0	197	15.7	34	2.7	847	67.5
Further contact not planned or unknown								
Financial issues	112	19.7	248	43.6	101	17.8	108	19.0
Employment and work related issues	83	15.9	99	19.0	59	11.3	281	53.8
Leisure use issues	91	17.3	207	39.4	96	18.3	132	25.1
Interpersonal related	106	18.7	226	39.9	102	18.0	133	23.5
Intrapersonal	90	16.3	297	53.9	109	19.8	55	10.0
Family issues	92	17.6	183	35.0	96	18.4	152	29.1
Legal issues	33	6.8	28	5.8	25	5.1	400	82.3
Physical symptoms	42	8.6	72	14.7	45	9.2	330	67.5

Table 20 MDS Reported 'Partners and Others': Progress Indicators at Last Contact by Plans for Further Contact

	Unresolved		Partially Resolved		Fully Resolved		Not an Issue	
	N	%	N	%	N	%	N	%
Further contact planned								
Financial issues	66	26.4	98	39.2	8	3.2	78	31.2
Employment and work related issues	19	8.3	25	10.9	2	0.9	183	79.9
Leisure use issues	22	9.6	36	15.7	9	3.9	162	70.7
Interpersonal related	115	40.5	119	41.9	7	2.5	43	15.1
Intrapersonal	75	28.4	139	52.7	17	6.4	33	12.5
Family issues	76	29.9	97	38.2	7	2.8	74	29.1
Legal issues	12	5.3	12	5.3	0	0.0	203	89.4
Physical symptoms	11	4.9	27	12.1	2	0.9	183	82.1
Further contact not planned or unknown								
Financial issues	47	23.7	59	29.8	13	6.6	79	39.9
Employment and work related issues	11	6.6	4	2.4	7	4.2	145	86.8
Leisure use issues	14	8.3	16	9.5	7	4.2	131	78.0
Interpersonal related	61	29.5	73	35.3	20	9.7	53	25.6
Intrapersonal	51	26.2	98	50.3	22	11.3	24	12.3
Family issues	58	29.7	67	34.4	16	8.2	54	27.7
Legal issues	10	6.0	9	5.4	1	0.6	148	88.1
Physical symptoms	6	3.6	8	4.8	3	1.8	148	89.7

4 Outcomes and the Counselling Process

4.1 Introduction

The focus of this Section is to study the link between the program effects (outcomes) described in the previous chapter and the factors that characterise the intervention process (process variables).

Section 1 of this Report contains a discussion of the conceptual underpinnings of the models we have used to guide the study design and data collection. The relationships between outcomes and the intervention process are complex and many, and this is reflected in the volume of data presented within the present chapter.

To assist with the examination of these relationships, we had available to us, data from the Self-Completion Clinical Practice Evaluation Questionnaire in which clients provided their input to the evaluation. We also have available to us a linked set of Minimum Data Set data which, as the reader will recall, consists of information provided by the counsellor, albeit based upon their interpretation of information provided and their observations of the clients. It is important that the reader keeps in mind the two different sources of the data while interpreting the findings presented.

Different treatment characteristics were explored via the Clinical Practice Evaluation and the MDS. The following Section reports the results of these explorations separately, beginning with the analysis of the findings of the clinical practice evaluation, followed by the findings of the MDS analysis.

It is one thing to describe the impact of counselling on clients' problems and well-being, but a more complex matter to understand what the active ingredients in the counselling process are for clients. In other words, to get to the bottom of the question: What works for whom and why? In order to address this question and to discover more about the way programs effects are achieved, a profile of the counselling practice undertaken at BreakEven was undertaken, with particular reference to the links between this practice and the achievement of outcomes. The following list of factors that could affect the outcomes achieved by the clients will be explored. We also draw the reader's attention to the other volume in this Report series that is directly concerned with the Counsellor Task Analysis.

4.2 Characteristics of the Counselling Process Taken as Independent Variables

- **Client's readiness to change.** This variable was assessed using a direct question to clients asking the extent of their readiness to change at the commencement of counselling. Although the design of this item was informed by an appreciation of Prochaska and DiClemente's work, it is not claimed that this single item provides a full measure of the construct as postulated by these researchers. Because of the retrospective nature of this study cohort, we considered it not to be appropriate to ask extensive retrospective questions about past

intentions. We did not consider this to be methodologically sound. However, the Prochaska and DiClemente constructs were fully incorporated into the questions posed to the prospective study sample, which is reported later in this document.

- **The therapeutic relationship.** A series of questions were asked regarding the therapeutic relationship and a score produced by adding the scores of these individual questions (see Section 2 for details).
- **The number of sessions.** This information was taken from clients' MDS contact data where the number of contacts was counted.
- **Client satisfaction with the counselling process.** A small scale was used to assess clients' satisfaction with the counselling process based on a scale developed to assess client satisfaction with General Practitioners.
- **Techniques used by counsellors in their work.** These data were gathered from individual workers in open-ended, written accounts of their work that they provided as part of the clinical practice evaluation component of the study.
- **Theories of practice used.** These data were also collected as above (see Appendix D).

We have included as an appendix to this document a discussion of the development of various of the scales included within this study. We are satisfied with the psychometric properties of the tools that we used, but also note the difficulties confronting researchers in this field with respect to the paucity of standardised tools available concerning therapeutic process. Members of our team have indeed had a major involvement in the development of such tools, but much work remains to be done. In this project the best tools available have been utilised.

4.3 Counselling Outcomes Taken as Dependent Variables

- A measure of client reported problem resolution—the percentage of problems fully resolved, fixed to the client's satisfaction, partially resolved and unresolved.
- A measure of respondent's satisfaction with the outcomes they achieved.
- A measure of the client's gains in a range of life skills as the result of counselling.
- Self-awareness.
- Understanding of the nature of their problem gambling behaviour.
- The ability to accept responsibility for the problems their gambling caused.
- The ability to communicate with others close to them.
- The ability to cope with stress.
- Self-esteem.
- Self-confidence.
- The ability to talk to others about sensitive issues.
- Knowledge of services available that can assist people with gambling related problems.
- A client reported measure of the impact of BreakEven counselling on their gambling.
- Statistics were checked for their suitability for inclusion in analyses. A correlation matrix was created to measure the bivariate association between these series of outcome and process measures and their association with each other. Of the process variables, satisfaction with the process of counselling was dropped, as it was highly correlated with the therapeutic relationship ($r=0.745$). On further investigation it was felt that these two measures were in fact measuring the same phenomenon.
- The therapeutic relationship was moderately associated with all the outcome measures except percentage of problems partially resolved. The number of sessions was weakly negatively, associated with the percentage of problems fully and partially resolved. The outcome measures of percentage of problem resolution fixed to client satisfaction and partially resolved were significantly (at $p>0.01$), but moderately negatively related to one another. These associations were further tested using multiple regression techniques.

4.4 The Relationship Between Process and Outcome for the Retrospective Sample

Multiple regression techniques were used to assess the impact of the listed process measures, controlling for gender, age, and impact on each of the outcome measures mentioned. The Table 21 lists all the statistically significant outcomes of these analyses.

Table 21 Clinical Practice Evaluation Retrospective Sample—Statistically Significant Counselling Outcome and Process Linkages (n=150)

Outcome Variable	Process Variables p<0.05	Significant Difference	Standardised (Beta)	Correlations Zero-order	Partial	Part
Per cent of problems fully resolved	Therapeutic relationship	0.005	0.262	0.231	0.265	0.258
	Number of sessions	0.031	–0.200	–0.170	–0.206	–0.198
Per cent of problems fixed to satisfaction	Therapeutic relationship	0.000	0.349	0.343	0.352	0.346
	Gender	0.052	–0.179	–0.136	–0.181	–0.169
Per cent of problems partly resolved	Number of sessions	0.013	0.227	0.205	0.229	0.225
Per cent of problems unresolved	Therapeutic Relationship	0.000	–0.480	–0.485	–0.481	–0.476
Counselling had a positive impact on gambling activity	Therapeutic Relationship	0.000	0.620	0.620	0.621	0.615
Client was satisfied with counselling outcomes	Therapeutic Relationship	0.000	0.349	0.343	0.352	0.346
	Actual Age	0.006	–0.208	–0.243	–0.254	–0.206
Better self-awareness	Therapeutic Relationship	0.000	0.370	0.385	0.374	0.367
Better understanding of the nature of their problem gambling behaviour	Therapeutic Relationship	0.000	0.467	0.463	0.456	0.444
Better ability to accept responsibility for the problems their gambling caused	Therapeutic Relationship	0.000	0.414	0.420	0.415	0.411
Better ability to communicate with others close to them	Therapeutic Relationship	0.000	0.462	0.459	0.463	0.460
Better ability to cope with stress	Therapeutic Relationship	0.000	0.429	0.427	0.429	0.426
Better self-esteem	Therapeutic Relationship	0.000	0.432	0.436	0.437	0.429
Better self-confidence	Therapeutic Relationship	0.000	0.384	0.380	0.394	0.381
	Gender	0.008	–0.243	–0.230	–0.250	–0.230
Better ability to talk to others about sensitive issues	Therapeutic Relationship	0.038	0.196	0.203	0.198	0.195
Better knowledge of services available that can assist people with gambling related problems	Therapeutic Relationship	0.000	0.355	0.356	0.362	0.354
	Gender	0.034	0.195	0.193	0.200	0.186

As Table 21 illustrates, a number of process variables have a significant (at p<0.05 level) predictive relationship with the outcome variables, although the reported strength of the associations are weak to moderate. As indicated, the therapeutic relationship is consistently shown to be the variable most strongly associated with the outcomes achieved by clients. This finding is consistent with the literature exploring the linkage between process and outcome in counselling and psychotherapy in which the therapeutic relationship is often identified as the 'non-specific' factor most likely to impact counselling outcome. (Bergin and Garfield, 1994)

The following variables were inferred from the client responses:

- Percentage of problems fully resolved.
- Percentage of problems resolved to the satisfaction of the client.
- Percentage of problems partly resolved.
- Percentage of problems unresolved.

They were calculated over the full set of 'problems' explored in the client questionnaire. The response scale for these questions was a five-point one, including whether the problem had worsened, was unresolved, had partially or fully resolved and whether it had been resolved to the client's satisfaction. In Section 2 of this Report we present a discussion of the use of the summed scores in this Report. This is supplemented by further discussion in Appendix I. When we ran a factor analysis and calculated Cronbach alpha for the scales, we obtained a single factor solution and an alpha in excess of 0.8, indicating that this approach was psychometrically acceptable.

4.5 Profile of Treatment Techniques Used by Counsellors with High and Moderate Rates of Client Problem Resolution

Counsellors were sorted according to the level of resolution they achieved with clients. Some counsellors had less than three clients return questionnaires. These were excluded from the following analysis, as it was considered that only having one or two returns could not give a realistic picture of the work the counsellor had achieved with their clients. Counsellors were then grouped according to what percentage of the problems they dealt with that clients considered were fully resolved or fixed to their satisfaction. Two groups formed those with high rates of problem resolution and those with moderate rates of problem resolution.

A high level of problem resolution was considered to be a characteristic of counsellors who achieved full resolution on 45 per cent or more of problems they dealt with, across three or more cases. A moderate level was taken to be characteristic of those counsellors with less than 45 per cent of full resolution and high levels of partial resolution. The theories of practice, techniques and strategies used by these workers are described more fully below.

The following should not be taken as a recipe or as a foolproof set of active counselling ingredients, given some of the limitations of the data already outlined. Providing this is beyond the scope of the evaluation and can only be achieved by a controlled efficacy study of treatment approaches. Rather, it provides a profile of treatment approaches and interventions used by counsellors who have achieved these rates of problem resolution.

Of the 12 counsellors who achieved high-resolution levels with their clients, eight returned the counselling practice evaluation questionnaire. Of the 10 counsellors who achieved moderate levels of problem resolution, all returned their questionnaire. The following is a thematic analysis of these 18 returns.

Counsellors were asked to complete a Counselling Practice Evaluation Questionnaire that asked a series of open-ended questions about the following features of their counselling practice:

- The relationship between theoretical frameworks and techniques used in practice.
- The diagnostic decision making process used by counsellors.
- An overview of the way counselling practice occurs within BreakEven services.
- Counsellors' views on counselling outcomes.

The analysis in this section covers four areas of practice:

1. Counsellors' theories of practice and techniques used in counselling.
2. Counsellors' views on when gambling becomes a problem and the causes of problem gambling.
3. Counsellors' views on the place of the therapeutic relationship in their counselling practice.
4. Counselling review processes used by counsellors, and their perceptions regarding outcomes.

4.6 Resolution Levels and Counsellor Theories of Practice and Techniques

The common feature of the theoretical approaches adopted by the workers with high rates of problem resolution is that they used an eclectic mix of frameworks and chose frameworks to suit their clients' needs. Bergin and Garfield (1994) had noted this shift in the *Handbook of Psychotherapy and Behaviour Change*, where they identified a new trend towards eclecticism in the delivery of psychotherapeutic practices. This has already been highlighted in Section 1 of the Evaluation Report as a feature of existing problem gambling treatment models.

There are some similarities in the frameworks adopted by these workers. A combination of three approaches is most common (in no order of preference): Carl Rogers' model of client centred counselling; Cognitive Behaviour Therapy, with particular focus on changing false thinking and habitual behaviour; and solution-focused therapy. Two of the workers mentioned the use of Miller's motivational interviewing approach. Counsellors working with couples and family are primarily using systemic family therapy.

This finding was consistent with those achieving moderate levels of problem resolution, although the work of Miller and systemic family therapy were more prominent in this group. Two of the counsellors also mentioned the use of a Gestalt orientation.

4.7 Criteria Applied when Assessing the Counselling Needs of Clients

All eight counsellors stressed that they based their judgments on a thorough psychosocial assessment of the client, taking into particular account the client's coping or support resources—both internal and external. Counsellors also identified the need to identify the client's readiness and motivation to change, and what outcome they want regarding their gambling behaviour, that is, abstinence, control or no change. Only two mentioned the use of other diagnostic screening tools, these being the South Oaks Gambling Screen (SOGS) and Minnesota Multiphasic Personality Inventory (MMPI). Two counsellors also identified establishing and assessing the strength and potential of the therapeutic relationship.

Of counsellors achieving moderate levels of resolution, all mentioned taking some form of psychosocial assessment taking account of intra-pyschic and environmental factors, particularly the risk of suicide, readiness to change and social support networks available to the client. The client's view of their problem also is gained by most of the counsellors. A few counsellors used psychometric tests, such as G Map and the DSM-IV measure of depression.

4.8 Counsellor Processes Used for Setting Goals for Interventions with Clients

The setting of goals with clients is identified in the research literature as the process issue most strongly linked to achieving positive problem resolution. Counsellors with high levels of problem resolution all adopted a collaborative approach to defining goals with their clients, but they also stressed the importance of these goals being realistic, achievable and timely. One counsellor described how the goal setting process often helped clients gain greater insight into their problems.

Counsellors with moderate levels of resolution also adopted a collaborative approach to setting goals with clients, although the identification of goals as needing to be realistic and achievable was not so prevalent in their responses. Rapport building was seen by some counsellors as essential to being able to set goals with clients.

4.9 Counsellors' Decisions on which Techniques and Strategies they will Use with Clients

Although the techniques used by counsellors with high levels of problem resolution varied, all of them decided which ones to use by a combination of clinical experience, familiarity with approaches and practice wisdom. Some used assessment tools such G Map and MMPI; others assessed readiness to change and psychological mindedness of clients. Others stress the importance of dealing with immediate distress, described by one counsellor as 'damage control', prior to contracting with the client regarding treatment.

Counsellors achieving moderate levels of problem resolution identified a similar set of factors in deciding which techniques and strategies to use with clients. Some mentioned the use of their own supervision to make these judgments. Others suggested that the strength of the therapeutic relationship would impact on their decision to use certain techniques.

4.10 Examples of Counselling Techniques and Strategies Used

The techniques and strategies listed by counsellors, both those achieving high and moderate results, confirm the eclecticism of counsellor practice in BreakEven services. The decisions regarding the use of these techniques are based, as mentioned above, on a careful client assessment and the establishment of goals for the counselling work.

Counsellors achieving a high level of problem resolution are using the following techniques in their work, although as they were not asked to list how important or frequently applied these techniques were in their work, it is difficult to establish from this list the most effective treatments.

- Relaxation techniques: meditation, relaxation training.
- Cognitive/behavioural techniques: in-vivo exposure, imaginal desensitisation, cognitive restructuring, eye movement desensitisation, motivational interviewing.

- Client centered supportive counselling: active/reflective listening, reframing, summarising, rapport building, empathy, modeling relationships.
- Psychodynamic: interpretation, transactional analysis, psychodrama/role playing, confrontation, use of metaphors and narrative, normalising clients' experience.
- Educational: problem solving skills training, time management, assertiveness training, and anger management.
- Family therapy: Milan-style work with couples; systemic family therapy.[5]

The list of techniques used by counsellors achieving moderate levels of satisfaction is similar, although counsellors in this group also mentioned the use of diaries, genograms and eco-maps.

4.11 Referral of Clients for Additional Support

For counsellors with high and moderate resolution levels the decision to refer a client to another service is based primarily on the counsellor's assessment of their expertise and the scope of their counselling service delivery against the client's needs and ability of the client to help themselves.

4.12 Methods of Case Review

Most counsellors with high-resolution levels used a mix of informal session-based review and formal review of goals over a designated number of sessions. A number of counsellors spoke of using their own supervision to review progress that would then feed back to the client in their work with the client. A few counsellors re-administer psychometric tests they have used when assessing clients. Most of the counsellors mentioned the importance of celebrating achievements with clients as a way of marking these gains.

This profile remained consistent for counsellors with moderate levels of problem resolution. One counsellor described it well when speaking of the counselling having 'natural pauses' at which points it was necessary to review progress.

4.13 Resolution Levels and Counsellor Views of the Therapeutic Relationship

Both counsellors with high and moderate resolution levels considered the therapeutic relationship to be of the utmost importance in their practice.

When asked how they used the relationship counsellors' responses were similar irrespective of the level of their problem resolution. They all considered the therapeutic relationship to provide the basis from which the work could proceed in a positive manner and from which change could occur. They considered it essential to create a trusting and safe environment for clients to explore their behaviour, thoughts and feelings, and a platform from which different techniques and strategies could be worked out and the client's motivation to change built up.

Most counsellors understood the development of this trusting and safe environment as being the product of empathy, genuineness and congruence, as asserted by Carl Rogers in his development of the humanistic tradition in psychology. Counsellors also insisted that the counselling effort needed to be collaborative in order to be meaningful to clients.

4.14 Resolution Levels and Counsellor View of Outcomes

Counsellors were asked to indicate what they thought constituted a successful outcome, what factors they felt contributed to achieving these outcomes and what factors could hinder the achievement of successful outcomes. The findings below provide a thematic summary of counsellors' responses to these questions.

Irrespective of their level of problem resolution, counsellors believed that successful outcomes are gained when clients achieve the goals they set themselves and there has been an adjustment to their gambling activity, an improvement in the client's psychosocial functioning and an increase of insight into the problems they were experiencing.

Counsellors with high levels of problem resolution overwhelmingly identified a strong therapeutic relationship as central to gaining positive outcomes.

[5] For detail on intervention techniques used across all BreakEven sites, see Volume 1 of this Evaluation Report series.

They also identified the client's readiness to change, ability to self-reflect, finding the right 'fit' between the client and the intervention, the setting of clear and realistic goals and the provision of counselling by experienced, well-trained and supervised staff as important components of successful outcomes.

This list is similar to that of the counsellors with moderate levels of problem resolution, although they did not identify the relationship as the essential factor as with the counsellors mentioned above. They emphasised, rather, the client's motivation to change, suitability of the client to the counselling process and the quality of their social supports.

The factors listed by BreakEven counsellors are very consistent with Orlinsky, Grawe and Parks' (1994) findings from their meta-analysis of studies of the link between process-outcome factors in psychotherapeutic practice. The variables they found most robustly linked to outcome were:

- Patient suitability.
- Patient cooperativeness versus resistance: readiness to do the work, willingness to accept the therapist's ideas and instructions, acceptance of the direction of the counselling.
- Therapeutic bond/cohesion.
- Patient contribution to the bond.
- Reciprocal affirmation.
- Therapeutic realisations.

Counsellors were also asked to identify the factors that they considered hinder the achievement of positive outcomes. Essentially, the list is the reverse of the factors stated above and did not vary among counsellors. The factors listed consistently by all were:

- Lack of a strong relationship between counsellor and client.
- Lack of motivation on behalf of clients.
- Lack of alternative forms of leisure for clients.
- Comorbidity factors, such as mental illness, unemployment drug and alcohol addiction.
- Clients' unwillingness to disclose information.
- When gambling has become central to a person's social and familial life.
- The accessible nature of gambling venues.

Some workers mentioned intra-organisational inhibitors, such as lack of resources and ability to see clients immediately, lack of professional development opportunities and lack of information sharing between BreakEven counsellors.

4.15 Resolution Levels and Counsellor Definition of Problem Gambling

Counsellors were asked to record what they understood problem gambling to be and what they understood to be the causes of problem gambling. The point of these questions was to provide a description of the theories of causation applied by workers achieving high and moderate levels of problem resolution with clients.

Counsellors rated as achieving high levels of resolution essentially supported the idea that gambling becomes problematic when the activity causes harm to the gambler and/or others. The understanding of what constitutes 'harmful' varies between clients, and the work of counselling often includes the client and counsellor exploring these impacts. Counsellors also emphasised the compulsive dimension of problem gambling and the sense of gambling taking over an individual's life.

In outlining what they consider to be the causes of problem gambling, all counsellors agreed it was used as a way of coping with life stressors through avoidance, and was usually related to a client's sense of low self-esteem. Other factors they added as significant in the development of problem gambling are: having a large win early in gambling career, a person's cultural norms, co-morbidities, such as psychiatric problems and drug and alcohol use, and finally the availability of gambling opportunities.

4.16 Analysis of Counselling Process Variables and Treatment Characteristics Impacting on Outcomes: Minimum Data Set Cases

4.16.1 Number of Treatment Sessions

To explore the relationship between client outcomes and the number of counselling sessions attended, MDS data for the 613 problem gamblers whose cases were both opened and closed between 1 July 1996 and 30 June 1997 and who attended at least one session of face-to-face session of problem gambling counselling was examined.

Two (whether or not this was the primary presenting problem) X 3 (degree of problem resolution) analyses of variance (ANOVA) were conducted for each of the outcomes measures, with the number of sessions as

the dependent measure. As the distribution of the number of counselling sessions attended was positively skewed, this variable was logarithmically transformed for the purpose of analysis. Because three outcomes were entered into each analysis, it was necessary to follow-up a main effect of problem resolution with post hoc analysis (Bonferroni). Given previous findings that show that, for brief interventions, individual and group counselling is similarly effective (Piper and Joyce, 1996), separate analyses were not conducted according to whether clients were treated individually or not. Table 22 presents the mean scores for the number of sessions attended by type of problem and degree of problem resolution.

Analysis of variance produced a main effect of degree of problem resolution in respect of the number of counselling sessions attended by those whose problems included financial issues ($F(2,382)=4.42$, $p<0.05$), interpersonal problems ($F(2,341)=10,54$, $p<0.001$), intrapersonal problems ($F(2,377)=6.54$, $p<0.01$), legal problems ($F(2,210)=5.26$, $p<0.01$) and gambling behaviour ($F(2,502)=19.50$, $p<0.001$). Post hoc tests revealed that for each problem type, on average, clients whose problems remained unresolved attended fewer counselling sessions than did those who achieved a degree of problem resolution. However, with the exception of clients who sought help in relation to their gambling behaviour, for whom the number of sessions attended by those who achieved full resolution was greater than those who achieved partial resolution, there were no significant differences in the number of sessions attended by those who achieved full or partial problem resolution.

Given that most clients present to BreakEven counselling services with a number of problems for which they are seeking solutions, an overall measure of problem resolution could arguably provide a more comprehensive measure of problem resolution than examining the outcome measures for specific problems. Thus, three-way (degree of problem resolution) ANOVAs were performed for both the problem that was reportedly the primary reason for attendance, and for the problem with which individuals had achieved the greatest degree of resolution. The number of sessions attended by degree of problem resolution for each of these measures is presented in Table 23.

Analysis of variance revealed that the number of sessions differed significantly, according to degree of problem resolution achieved for the primary presenting problem ($F(2,509)=35.59$, $p<0.001$). Post hoc analysis revealed that clients whose primary problem remained unresolved attended fewer counselling sessions than did those who achieved

Table 22 Mean Number of Counselling Sessions Attended by Degree of Problem Resolution and if Problem was the Primary Reason for Attendance*

	Unresolved		Partially Resolved		Fully Resolved	
	Primary Problem	Other Problem	Primary Problem	Other Problem	Primary Problem	Other Problem
Outcome	*No.*	*No.*	*No.*	*No.*	*No.*	*No.*
Financial issues†	1.40	2.48	2.00	4.00	2.67	4.64
Interpersonal related¶	1.50	2.20	5.00	4.14	3.00	3.73
Intrapersonal‡	2.00	2.06	2.83	3.76	5.00	4.37
Legal issues‡	3.56	2.12	3.90	4.43	2.20	3.54
Gambling behaviour#	2.30	2.56	3.38	3.21	4.33	3.84

* [(n=613) 'self-identified problem gamblers', case opened and closed between 1.7.96 and 30.6.97, attended at least one session.]

† $p<0.05$

‡ $p<0.01$

¶ $p<0.001$

Table 23 Mean Number of Counselling Sessions Attended by Degree of Problem Resolution*

	Unresolved	Partially Resolved	Fully Resolved
Problem	*No.*	*No.*	*No.*
Problem which was primary reason for attendance†	2.32	3.47	4.15
Highest degree of problem resolutions†	1.78	3.11	3.85

* [(n=613) 'self-identified problem gamblers', case opened and closed between 1.7.96 and 30.6.97, attended at least one session.]

† $p<0.001$

partial or full of problem resolution. However, the number of sessions attended did not differ significantly between those who attained partial and full resolution of their primary presenting problem. When ANOVA was repeated with the highest degree of problem resolution entered into the analysis, there was again a significant difference in the number of sessions attended in respect of resolution achieved ($F(2,593)=36.57$, $p<0.001$). Post hoc analysis revealed that clients who fully resolved at least one presenting problem attended more counselling sessions than did clients who achieved only partial resolution of presenting problems and that these in turn attended more often than clients who resolved none of their presenting problems.

While the results presented here go some way to supporting the proposition that more counselling is correlated to better outcomes, it is important to remember that the mean number of sessions attended by those who fully resolved their problems remains low. This is not surprising, although, given the number of sessions attended by all clients attending BreakEven is low, with the majority of clients attending three sessions or less.

The resolution rates reported here are only for those clients whose cases were closed. However, many clients are not recorded as having a case closed because they still have an active file and will return to counselling if they need to, while others drop out of counselling before the case is closed. The resolution rates for these clients remain unknown. However, case closure is not a stable indicator of client change. For some clients, even a single session may be sufficient to start a process of change, on which they can continue to work on by themselves (Hoyt, 1995). Indeed, therapy is more likely to be brief when clients are highly aware of their problems and committed to change (Steenbarger, 1992). Hence we should not assume that cases which are only partially resolved at the end of counselling will remain somewhat unresolved (Hoyt, 1995).

4.17 Counselling Process

To explore the relationship between the counselling process and client outcomes we examined the 591 problem gamblers whose cases were both opened and closed between 1 July 1996 and 30 June 1997 who had sought to change their gambling behaviour, and for whom case closure data included an indication as to the extent of resolution achieved. The variables from the MDS, which are concerned with the counselling process, and which were considered to be potential predictors of treatment outcome in respect of gambling behaviour are presented in Table 24.

Table 24 Counselling Process Characteristics as Potential Predictors of Treatment Outcome Re: Gambling Behaviour

Primary reason for attendance (gambling behaviour or other).
Primary setting of intervention.
Assessment/referral as primary mode of intervention.
Systemic therapies as primary mode of intervention.
Supportive counselling as primary mode of intervention.
Cognitive behavioural therapy as primary mode of intervention.
Other therapy as primary mode of intervention.
Number of counselling sessions attended.
Use of other services while attending BreakEven.

Given that treatment outcome may well be predicted by an interaction between client characteristics and therapeutic features, the demographic, gambling behaviour and counselling process variables identified as predictors of outcome were entered into a stepwise Discriminant Function Analysis. Discriminant Function Analysis is used to predict group membership (dependent variable) from a set of predictors (independent variables). In the case of MDS, analyses were undertaken for each problem area and a number of analyses were run to test the ability of any of the external independent variables (such as client's gambling activity age or sex) to successfully predict outcome by group membership (such as whether the client gained no resolution, partial resolution or full resolution to their problem). The following definition outlines clearly the purpose of this analysis.

> The primary goals of Discriminant Function Analysis are to find the dimensions or dimension along which groups differ and to find classification functions to predict group membership (Tabachnick and Fidell, 1996, 509).

Six variables (excluding whether gambling occurs on electronic gaming machines), which accounted for 25 per cent of the variance, were identified as predicting degree of problem resolution for gambling behaviour. The results of this analysis are summarised in Table 25 on the following page.

Table 25 Variables Discriminating Between 'Problem Gamblers' with None and Some Problem Resolution (n=591)

Order entered	Predictor Variable	Wilks Lambda	Significant Difference of Wilks Lambda
1	Assessment/referral as primary mode of counselling	0.829	0.000
2	Number of problems associated with gambling	0.795	0.000
3	Annual income	0.765	0.005
4	Living situation	0.768	0.002
5	Age	0.759	0.034
6	Supportive counselling as primary counselling mode	0.758	0.041

Problem gamblers who achieved a positive resolution of their gambling behaviour were older (38.5 versus 34.9 years), had fewer problems associated with their gambling (4.2 versus 5.5), less likely to live alone (18 per cent versus 37 per cent) and had higher incomes than did those whose gambling behaviour did not change. Conversely, an absence of problem resolution was associated with attending BreakEven for assessment or referral elsewhere rather than ongoing treatment (42 per cent versus 12 per cent) or supportive counselling as the primary counselling mode (25 per cent versus 23 per cent).

5 Outcomes and Client Characteristics

5.1 Client Characteristics Impacting on Counselling Outcomes for CPE Retrospective Sample

Client characteristics obviously impact to some degree on the outcomes achieved by clients as the result of counselling. The following characteristics were assessed regarding their influence on clients' achieving certain levels of problem resolution.

- Demographic factors: age, gender, income.
- Readiness to change.
- Problem level using DSM-IV score, number of maladaptive behaviours.
- Actual gambling activity: debt level, EGM play in dollars, hours per episode and episodes.
- Client expectations of counselling.
- Psychosocial index—pre-counselling.
- Reason for attending BreakEven.
- Satisfaction with current level of gambling.
- Length of time since counselling.

This list of characteristics along with five measures of outcome were put into a correlation matrix to test for the strength of associations prior to selecting variables to include in a multiple regression analysis. The outcome measures included in the matrix were the percentage of problems fully resolved, partly resolved, unresolved, or fixed to the client's satisfaction, and the client's satisfaction with the outcomes they achieved.

It is important to reiterate the respective sources of the data used within the presented analysis. Matching of client IDs on the Minimum Data Set and the client responses to the clinical practice evaluation questionnaire permitted some analyses to be performed with data from both sources. This issue has already been canvassed in Section 2 of this Report.

Table 26 on the following page illustrates the results of this correlation matrix. Variables are only included if the association was significant at the $p<0.05$ level.

As shown in Table 26 the association between these variables was moderate to weak. A client's satisfaction with their current level of gambling was the variable most consistently related to the nominated outcome measures.

These variables were then entered into a multiple regression analysis for each outcome measure, controlling for sex, age and income.

As Table 27 on the following page illustrates, the client being satisfied with their current gambling activity is the independent variable with most predictive power for all the positive outcome indicators. Demographic variables were on the whole not predictive, although a client's age did slightly impact their satisfaction with the outcomes they received: the older, the less satisfied. Only one gambling activity variable, dollars spent per episode on EGM play, had any predictive power, and that was only a weak one for the outcome 'problem fixed to my satisfaction'. As indicated in Table 27, although a number of independent variables had statistically significantly predictive power on the nominated

Table 26 Clinical Practice Evaluation Retrospective Sample: Correlation Between Outcome Measures and Client Characteristics

Outcome measure	Client characteristics significantly associated, that is, p<0.05 (two-tailed) level	Significant Difference	r
Percentage of items fully resolved	Readiness to change	00.005	00.231
	Satisfaction with current level of gambling	00.006	00.227
Percentage of items partly resolved	Number of presenting problems	00.017	00.196
	Satisfaction with current level of gambling	00.000	–00.285
Percentage of items fixed to clients satisfaction	The amount of dollars spent per episode on EGM play	00.002	–00.189
	Satisfaction with current level of gambling	00.003	00.243
Percentage of items unresolved	Number of presenting problems	00.021	–00.189
Client satisfaction with the outcome of counselling	Age	00.004	–00.249
	Client readiness to change	00.000	00.290
	Satisfaction with the current level of gambling	00.000	00.392
	Presenting problem gambling behaviour	00.036	00.172

Table 27 Clinical Practice Evaluation Retrospective Respondents: Results of Regression Analysis on Outcome Measures and Client Characteristics

Outcome variable	Client Characteristics p<0.05	Significant Difference	Standardised (Beta)	Correlations *Zero-order*	*Partial*	*Part*
Per cent of problems fully resolved	Ready to change	0.009	0.231	0.258	0.236	0.227
	Satisfied with current level of gambling	0.037	0.231	0.203	0.189	0.180
Per cent of problems fixed to client's satisfaction	Dollars per episode playing EGMs	0.004	0.306	0.337	0.309	0.300
	Satisfied with current level of gambling	0.091	0.174	0.217	0.182	0.171
Per cent of problems partly resolved	Satisfied with current level of gambling	0.003	–0.260	–0.269	–0.270	–0.257
	Number of presenting problems	0.015	0.206	0.200	0.218	0.205
Per cent of problems unresolved	Number of presenting problems	0.018	–0.209	–0.218	–0.210	–0.208
Client was satisfied with counselling outcomes	Satisfied with current level of gambling	0.000	0.292	0.344	0.317	0.286
	Ready to change	0.001	0.280	0.334	0.306	0.275
	Age	0.011	–0.204	–0.255	–0.229	–0.201

dependent measures the actual association between variables and the impact of variables on one another were moderate to weak.

5.2 Readiness to Change in the Prospective Sample

When BreakEven counsellors were asked, in open-ended interviews held between November 1997 and May 1998, what they believed were impediments to effective counselling, one-third nominated client motivation or commitment to change. It was also suggested that clients may have unrealistic goals and expectations, drop out of counselling prematurely or may be unwilling to address underlying issues. Thus a more promising approach for predicting outcomes than considering individual characteristics may be to consider the individual's readiness to change.

As a result of their retrospective, cross-sectional and longitudinal studies of how people quit smoking, Prochaska and DiClemente (1983) identified a process of change involving a series of stages through which smokers invariably passed as they sought to seek smoking. Subsequent studies have suggested this model to be applicable to a far wider range of behaviours, including both the cessation of negative and acquisition of positive behaviours, addictive and non-addictive behaviours, legal and illegal actions, and socially acceptable and socially unacceptable practices (Prochaska et al, 1994). Those who have no plans to change and resist any suggestions that a change in their behaviour could be beneficial are said to be in *precontemplation* stage. Precontemplators by definition are unlikely to seek assistance and only engage with treatment agencies if there is an external imperative that must be placated. Once they begin to consider there may be advantages to changing, but have yet to make any commitment to doing so, individuals are said to have moved into the *contemplation* stage. This phase is characterised by a high degree of ambivalence as to whether or not they really need to make any changes. The intensive and overt efforts to modify behaviour constitute the *action* stage, which unless relapse occurs and the original behaviour is reinstated, is followed by the *maintenance*

stage, in which the effort turns to ensuring the changes are able to be sustained. In a later modification, a *preparation* stage was added to the stages of change model (Prochaska et al, 1994). This comes between contemplation and action and refers to the period in which the decision to change is made and a strategy as to how this may be effected is developed. It is at this stage that individuals are most likely to contact health and welfare providers, although some may do so at the contemplation stage as part of the process of deciding whether they really need to change.

The questionnaire given to new BreakEven problem gamblers clients at the end of their first session of counselling in July and August 1998, included an adapted version of the Readiness to Change Questionnaire (Heather, Gold and Rollnick, 1991) substituting 'gamble' for 'drink'. Forty-three self-identified problem gamblers returned the questionnaire to the research team. This is the 'prospective' sample of respondents, previously described in the project methodology in Section 2. The following analyses are based on these forty-three responses. The Readiness to Change Questionnaire is a 12-item instrument, in which respondents are asked to indicate on a five-point scale their level of agreement or disagreement with each statement. In the prospective sample, it was possible to include greater emphasis upon the Prochaska and DiClimente model, under the assumption that it would be possible to collect this information and track changes for the sample across the period of the study. In the retrospective sample previously reported, it did not make sense to ask respondents to speculate extensively about their states of mind in the core Model of Change items at varying times in the past. This would not have been methodologically sound. However, it was considered to be methodologically sound to do this prospectively, as we have done.

Four items are associated with each of the precontemplation, contemplation and action stages. Clients are assessed as being at the stage at which produce the highest score, or in the case of two stages having tied scores, at the later stage. Although this instrument fails to recognise either preparation or maintenance as distinct stages of change, it nevertheless provides an indication of an individual's readiness to change.

As may be expected, the majority of clients attending BreakEven were assessed as being at the action stage, although approximately one-third were contemplators. Although it is not uncommon for precontemplators to attend treatment settings at the behest of others, we found none. It may be that precontemplators are not inclined to voluntarily take time out to complete questionnaires that are part of an evaluation of problem gambling counselling services. Another possibility is that BreakEven counsellors are working very effectively with precontemplators such that by the end of the first session, they have moved from a state of precontemplation to contemplation or even action. Similarly, it is plausible that clients who were contemplators at the beginning of the first counselling session were now convinced of the need to take action.

Analysis of variance found no significant differences between problem gamblers assessed as contemplators from those assessed at the action stage when asked to rate on five point scales their emotional state ($F(1,37)=2.82$, n.s), state of relationships ($F(1,36)=0.05$, n.s), financial position ($F(1,37)=0.53$, n.s) or state of work life ($F(1,35)=0.87$, n.s) prior to attending counselling. Furthermore, there were no differences between the groups on either the number of items reported which concur with the DSM-IV criteria for assessing pathological gambling ($F(1,35)=3.09$, n.s) or a subjective rating concerning the extent to which respondents believed their current gambling was a problem ($F(1,37)=0.28$, n.s).

Nevertheless, contemplators were found to have a greater degree of dissatisfaction with their current level of gambling than were those at the action stage ($F(1,37)=7.39$, $p=0.01$) when the questionnaires were completed. This result initially might seem counter-intuitive, in that one might expect a greater degree of dissatisfaction from those who had decided to change their gambling than for those who are not sure whether or not they have a problem with their gambling. However, it may well be that those at the action stage had already taken steps to modify their level of gambling and were feeling pleased with their accomplishments to date. This is reinforced by the results of the maladaptive behaviour items, which identifies the majority of clients as having made repeated unsuccessful attempts to stop their gambling activity.

There is a range of expectations that problem gamblers may bring with them to counselling. Yet, with the exception of resolving a financial crisis ($\chi^2(1)=5.40$, $p<0.05$), which was twice as likely to be reported by contemplators, client expectations as to what they would achieve were not differentiated by readiness to change at a statistically significant level. The trends are, however, what might be expected. A person at the contemplation stage is more likely to have as a goal controlling their gambling rather than giving it up, which is more characteristic of those at the action stage. A problem gambler at the action stage is also nearly twice as likely as a contemplator to expect to work in counselling on one of the major consequences of their gambling behaviour, relationship problems. The results of these analyses are summarised in Table 28.

Table 28 Clinical Practice Evaluation Prospective Client Sample: BreakEven 'Problem Gambler' Clients: Expectations of Achievement when First Attended BreakEven (n=43)

	Readiness to Change Stage	
Expectation	Contemplation (%)	Action (%)
Give up gambling	66.7	82.6
Control gambling	46.7	26.1
Fix relationship problems	26.7	47.8
Deal with financial crisis*	73.3	34.8
Talk with someone about what is happening in life	73.3	65.2
To understand the reasons behind feelings and behaviour	60.0	60.9
To identify problems	80.0	56.5
To work out how to change problems	100.0	82.6

* $p<0.05$

Clients were asked to rate the level of resolution achieved on a scale with points 'got worse' (scored as 1), 'unresolved' (scored as 2), 'partially resolved' (scored as 3) and 'fully resolved/fixed to my satisfaction' (scored as 4). No client considered any problem to have worsened by attending BreakEven. Although there were few differences in respect of problem severity or the reasons they attended BreakEven, clients who were assessed as being at the action stage reported a greater degree of problem resolution in respect of gambling behaviour ($F(1,37)=9.52$, $p<0.01$), financial issues ($F(1,34)=4.78$, $p<0.05$), family relationship issues ($F(1,35)=10.09$, $p<0.01$), other relationships ($F(1,34)=18.32$, $p<0.001$), employment and work related issues ($F(1,26)=12.43$, $p<0.01$), physical health ($F(1,32)=17.48$, $p<0.001$), leisure use issues ($F(1,36)=30.00$, $p<0.001$), intrapersonal problems ($F(1,33)=4.47$, $p<0.05$), and legal issues ($F(1,25)=7.41$, $p<0.05$).

In addition to being asked about the extent of problem resolution, problem gamblers were also asked to indicate the impacts of counselling on other aspects of their life on a scale with the points 'got worse' (scored as 1), 'unresolved' (scored as 2) and 'got better' (scored as 3). Again, there were significant differences, with those at the action stage more likely to report improvements in self-awareness ($F(1,37)=5.20$, $p<0.05$), understanding the nature of problem gambling behaviour ($F(1,37)=7.44$, $p=0.01$), ability to accept responsibility for problems caused by gambling ($F(1,37)=5.75$, $p<0.05$), ability to communicate with significant others ($F(1,37)=10.50$, $p<0.01$), ability to cope with stress ($F(1,36)=4.66$, $p<0.05$), self-esteem ($F(1,37)=8.81$, $p<0.01$), and self-confidence ($F(1,37)=6.87$, $p<0.05$). However, readiness to change was not associated with changes in ability to talk with others about sensitive issues ($F(1,37)=3.35$, n.s), or knowledge of services available to people with problems associated with gambling ($F(1,36)=0.12$, n.s).

Consistent with being more likely to resolve problems and report positive impacts on other aspects of life, clients assessed at the action stage reported greater satisfaction with the outcomes achieved as a result of attending counselling than did contemplators ($F(1,34)=12.20$, $p=0.001$). However, contemplators reported similar levels of overall satisfaction with the counselling experience ($F(1,37)=1.33$, n.s). Nor did readiness to change differentiate the degree of satisfaction with specific aspects of the counselling process, such as the amount of time elapsed before the first appointment ($F(1,37)=1.92$, n.s), the length of the counselling session ($F(1,37)=2.41$, n.s), the counsellor's treatment of problems ($F(1,37)=1.85$, n.s), the counsellor's ability to listen ($F(1,37)=3.44$, n.s), the counsellor's willingness to answer questions ($F(1,37)=1.04$, n.s), the counsellor's knowledge about problems ($F(1,37)=2.10$, n.s), the counsellor's ability to help ($F(1,37)=0.88$, n.s) and the way in which the counsellor focused on the presenting issues ($F(1,37)=3.20$, n.s).

These findings seem to differ from those recorded earlier as part of the exploration of counselling process and outcomes for the retrospective sample of clients used in the clinical practice evaluation. This may be due to the sensitivity of the tests applied

heightening the results. The results reported in the current analysis are based on a scale used specifically for the purpose of identifying the clients' stage of change. The test used in the previous analysis was based on the clients' response to a single direct question regarding the extent to which the client considered themselves ready to change at the beginning of counselling.

5.3 Client Characteristics Impacting on Counselling Outcomes: Minimum Data Set

Potentially, several data items recorded in the Minimum Data Set may affect treatment outcomes, including clients' sex (Garfield, 1994), age (Beck, 1988; Dembo, Ikle and Ciarlo, 1983), marital status (Westhuis, Hayashi, Hart, Cousert and Spinks, 1998), access to social support (Barber and Crisp, 1995) and degree of problem severity (Garfield, 1994). However, there is little data to support a link between socio-economic factors and outcomes from counselling (Garfield, 1994) and even variables for which there may be some association are not supported unequivocally (Garfield, 1994).

To explore the relationship between client characteristics and the resolution of problem gambling we examined the data from 591 problem gamblers whose cases were both opened and closed between 1 July 1996 and 30 June 1997 who had sought to change their gambling behaviour, and for whom case closure data included an indication as to the extent of resolution achieved.

Counsellors were required to indicate, in their opinion, based on their interactions with the client, the extent of problem resolution achieved when the case was closed. Possible responses are that the issue remains unresolved, has been partially resolved or has been fully resolved. However, given that counselling may begin a process of change which clients can continue to work on by themselves (Hoyt, 1995), it should not be assumed that cases that are only partially resolved at the end of counselling will remain somewhat unresolved. Hence, for the purposes of these analyses, all clients who exhibited a degree of resolution in respect of their gambling behaviour were considered as a single group who had a positive outcome.

Two-thirds (64.8 per cent) of the 591 clients who sought help for problems associated with their gambling behaviour reported that they had a positive resolution of their problems by the time their case was closed. Demographic and gambling behaviour from the Minimum Data Set, which were considered to be potential predictors of treatment outcome in respect of gambling behaviour are presented in Table 29. Separate stepwise discriminant analyses were conducted for each of these groups of variables.

Table 29 MDS 'Problem Gambler' Client Characteristics as Potential Predictors of Treatment Outcome Re: Gambling Behaviour (n=591)

Demographic Characteristics
Age
Sex
Birthplace (Australia or overseas)
Annual income (less than $10,000, $10,000–$19,999, $20,000–$12,999, $30,000–$39,999, $40,000–$49,999, $50,000–$59,999, $60,000 or more)
Labour force status (employed or not employed)
Marital status (married or other)
Living situation (lives alone or with others)
Number of dependent children
Gambling Behaviour
Gambles on electronic gaming machines
Gambles at races
Gambles at TAB
Gambles on cards
Gambles on lotto
Gambles on bingo
Gambles on numbers
Number of maladaptive behaviours (DSM-IV criteria) (scores between 0 and 10)
Number of problems associated with gambling (scores between 0 and 9)

Three demographic variables (annual income, living situation and age) were identified as discriminating between none and some resolution of behaviour, although collectively they accounted for only nine per cent of the variance. When the process was repeated entering predictors relating to gambling behaviour, 10 per cent of the variance was accounted for by two variables (number of problems associated with gambling and gambles on electronic gaming machines).

Although a number of variables were identified as predicting resolution of gambling behaviour, our findings concur with previous studies, which have found that client characteristics are not necessarily good predictors of counselling outcome (Garfield, 1994; Clark, Landis and Fisher, 1990). Nevertheless,

it may be somewhat premature to argue that pursuing client variables is unlikely to improve our understanding of what might improve counselling outcomes (cf: Martin, 1990). The Minimum Data Set collects information on only a fraction of the more than 175 categories of client characteristics have been implicated with the outcomes of psychosocial treatments (Beutler, 1991). Variables that may also affect treatment outcome, which are beyond the scope of the Minimum Data Set, include locus of control (Ollendick and Murphy, 1977), level of reactance (Shoham-Salomon, Avner and Neeman, 1989) and readiness to change.

Not withstanding these limitations, the fact that client characteristics, either demographic or concerned with gambling behaviour, are poor predictors of changes in gambling behaviour should not necessarily be construed negatively. BreakEven was established as a generic service for all problem gamblers, and results here suggest that the program is not privileging some client groups by providing them with a more effective service than is provided to other groups.

5.4 Sex

If one sex comprises only a small proportion of an agency's clients, then not only does the agency develop less expertise in working with that group, but it may also set up its routine procedures and services to be most compatible with the needs of the majority group (Reed, 1985). However, in the case of BreakEven services, which attract similar numbers of male and female clients, an expectation that workers develop effective ways of working with clients of both sexes is warranted.

An effective service for both sexes may require different approaches for males and females. There has been limited recognition that females seeking treatment for problem gambling differ significantly from their male counterparts, with females more likely to report having been abused as a child, a suicide attempt and having a mother who is a compulsive gambler, and less likely to have been arrested (Ciarrochi and Richardson, 1989). However, most previous studies, which have included women in their samples, have failed to undertake gender analyses (Mark and Lesieur, 1992). For example, Zimmerman, Meeland and Krug (1985) compared their mixed sex sample of gamblers to a male-only control group. Like studies of client characteristics, studies concerned with the treatment of problem gamblers have rarely been gender sensitive, such as a major study of persons attending Gamblers Anonymous, which comprised an all male sample (Brown, 1986; 1987a; 1987b; 1987c).

Nevertheless, it should be noted that in the previous analyses presented within this Report, these did not identify client sex as a predictor of outcome. Interestingly, in the 1996–97 year, cases of male problem gamblers (47.9 per cent) were more likely to be formally closed than those of females (38.8 per cent) ($\chi^2(1)=12.29$, $p<0.001$). However, we draw the reader's attention to our previous discussion of case closure considerations. Case closure must not be confused with case resolution. Further, we have real doubts about the consistency of application of criteria for case closure across a wide set of agencies for whom these data pertain. In different agencies case closure may mean quite different things. Therefore we do not wish to overemphasise the utility of these results.

For the 1997–98 year, details of client outcomes were collected at each client contact, rather than when the case was formally closed. Table 30 presents details about the outcomes achieved at the last counselling session attended by problem gambler clients between 1 July 1997 and 30 June 1998. We calculated the numbers of clients who had achieved a rating of partially resolved or fully resolved in each of the problem items for males and females as the analysis groups. These are shown in Table 30. It was found that more females had positive outcomes in respect of financial ($\chi^2(1)=4.11$, $p<0.05$) and leisure ($\chi^2(1)=6.38$, $p<0.01$) issues. However, the magnitudes of effects, despite reaching statistical significance, are not especially large when one examines the actual rates shown in Table 30.

Table 30 BreakEven MDS 'Problem Gambler' Clients: Percentage of Positive Outcomes at Last Contact by Sex, 1 July 1997 to 30 June 1998

Positive Outcome Problem Category	Males (%)	Females (%)	N
Financial issues*	63.6	68.3	1,118
Employment and work related issues	55.7	57.1	475
Leisure use issues†	61.8	68.1	946
Interpersonal related	60.6	63.7	1,008
Intrapersonal	69.1	70.8	1,265
Family issues	60.8	64.4	833
Legal issues	58.9	53.7	161
Physical symptoms	57.2	63.9	341

* $p<0.05$

† $p<0.01$

5.5 Non-Problem Gambler Client Counselling Outcomes

The impact on partners and other family members of an individual's impaired functioning has long been recognised across a variety of problem areas, including alcohol dependence (for example, Crisp and Barber, 1995; Edwards, Harvey and Whitehead, 1973), depression (Feldman, 1976) heart attacks (Croog and Fitzgerald, 1978), renal failure (Streltzer, Finkelstein, Feigenbaum, Kitson and Cohn, 1976), and problem gambling (Abbott and Cramer, 1993). Partnerships may be severely strained (Lorenz and Yaffee, 1988) irrespective of the degree of financial hardship incurred, which is often substantial (Abbott and Cramer, 1993; Lorenz and Shuttlesworth, 1983). This in turn may the affect the relationships with others including family members and colleagues (Franklin and Thoms, 1989). The physical and mental health of family members may also be compromised (Lorenz and Yaffee, 1988).

BreakEven services were established with the aim of being available to all Victorians who are affected by problem gambling, including both problem gamblers and their significant others. Unlike some services for the family members of problem gamblers, it is not a requirement that the designated gambler is also in treatment (for example, Pixley and Stiefel, 1963). We therefore sought to examine whether BreakEven was able to provide similarly effective services for both problem gamblers and non-problem gambler clients. To that end we calculated the numbers of clients who had achieved a rating of partially resolved or fully resolved in each of the problem items for problem gambler and 'partners and other' groups. These are shown in Table 31.

Table 31 BreakEven MDS Clients: Percentage of Clients with Positive Outcomes at Last Contact Between 1 July 1997 and 30 June 1998 by Client Status

Positive Outcome Problem Category	Problem Gamblers (%)	Partners and Other Clients (%)	N
Financial issues	66.2	61.2	1,308
Employment and work related issues	56.5	55.9	519
Leisure use issues	65.3	65.4	1,024
Interpersonal related*	62.4	55.4	1,241
Intrapersonal	70.1	68.7	1,552
Family issues	62.9	58.3	1,030
Legal issues	57.3	50.0	186
Physical symptoms	61.5	70.2	388

* $p<0.01$

As Table 31 indicates, having a positive outcome was similarly likely for both problem gamblers and other clients of BreakEven, with the exception of interpersonal problems ($\chi^2(1)=6.54$, $p<0.01$), for which a positive outcome was reported more frequently for problem gamblers. However, the magnitude of the difference, despite reaching statistical significance, is rather modest.

6 Outcomes and Counsellor Characteristics

6.1 Counsellor Characteristics Impacting on Counselling Outcomes: CPE Retrospective Sample

The extent to which counsellor characteristics impact on the outcomes achieved in counselling is a much researched and debated topic. For the purposes of this study the following list of characteristics were tested for their impact on the outcomes achieved by workers.

- Counsellor demographic factors: age, sex.
- The length of time the counsellor has been working at BreakEven.
- The nature of the work performed by the counsellor, including:
  - The percentage of time spent in face-to-face contact with problem gambling clients, individuals and family members.
  - The number of client contacts they have in a fortnight.
  - The number of active cases.
  - The percentage of clients seen weekly.
  - Number of cases closed in the last six months.
- Counsellor's level of satisfaction with the content of the work they perform.

The research literature that could be used to support the selection of each of these characteristics is somewhat patchy. We therefore used our own expert judgment and knowledge of the literature to select the above set. They represent a significant battery of information about the characteristics of the counsellor and the context in which they deliver services.

These counsellor characteristics were explored against various inferred variables based upon the mean percentages of:

- Cases fully resolved.
- Cases resolved to the client's satisfaction.
- Cases partially resolved.
- Cases unresolved.
- Client satisfaction with the outcome of counselling.

A correlation matrix was produced to identify the pattern of relationships between the variables listed. There were only two statistically significant ($p<0.05$) relationships.

- A counsellor's sex with the percentage of unresolved problems which showed a moderate relationship $r=-0.415$, $p<0.05$. The result of a scattergram showed that women counsellors have lower levels of unresolved problems.
- The mean per cent of client satisfaction with the outcome achieved by counsellors with the counsellors' percentage of face-to-face contacts with individuals. This relationship was moderate to weak ($r=0.336$) significant at $p=0.049$ level. Counsellors who have a higher number of client contacts with individuals have a higher level of client satisfaction with the outcomes of counselling.

Multiple regression was not undertaken as the linkages between variables were too few and too weak to warrant one.

Because of the categorical nature of the variable identifying the professional background of counsellors (that is, social work, psychology, other) separate statistical tests were applied to explore the relationship between this variable and the outcomes achieved by counsellors. There was a moderate level of association between the professional background of counsellors and the mean percentage of full resolution achieved by counsellors (eta=0.471). A comparison of means identified counsellors trained in professions marked 'other' achieved better outcomes than social/welfare-trained workers, whereas social workers and psychologists were achieving similar results. It is clear that this difference is explained by the location of these workers. Workers trained in professions 'other' than social/welfare work and psychology work primarily in non-metropolitan areas and clients from these areas rated their outcomes higher than metropolitan clients. This is discussed in more depth in Section 7, when agency characteristics impacting outcomes are explored.

The only other association between counsellor characteristics and outcomes was a moderate one, between the mean percentage of client satisfaction with the outcome of counselling and the professional background of counsellors (eta=0.583). A comparison of means indicated that psychologists and others were gaining higher client reported rates of satisfaction than social workers.

Once these variables were put into a logistic regression analysis, controlling for counsellor age, sex and other counselling process variables, the strength of the associations between these counsellor characteristics and outcomes diminished and the impact reduced to insignificant levels (that is, $p>0.05$). It is important to note here that the power of the sample size will produce such an outcome. With small samples one would expect the null hypothesis to be proved, as it is not a sensitive enough test to assess the effect size. The small number of counsellors makes it difficult to assess the outcomes using statistical tests.

As already discussed in Section 4, the profile of counsellors work was similar irrespective of the levels of outcome their clients were achieving. This is also discussed in detail in Volume One of the Evaluation Report series, where a profile of the counselling undertaken at BreakEven services reveals broad similarities between services. Most workers, irrespective of their professional training or expertise, are using a combination of three or four basic frameworks to guide their counselling work with clients. These frameworks seem to provide the flattening effect indicated by the analysis in this chapter on counsellor characteristics.

6.2 Counsellor Characteristics Impacting on Counselling Outcomes: Minimum Data Set

Counsellors themselves may account for a portion of the variance in treatment outcomes not otherwise accounted for by variables that comprise the Minimum Data Set. While therapist impacts may be reduced by the provision of training and ongoing supervision (Crits-Christoph and Mintz, 1991), the ability of a client to effectively engage with one counsellor and not another may be somewhat idiosyncratic. Furthermore, as it is not uncommon for individuals in treatment to concurrently seek advice from a range of individuals other than their counsellor (Cross, Sheehan and Khan, 1980), any changes that do result between the initial and final counselling session cannot conclusively be attributed to the counselling process alone.

6.2.1 Outcome Measures Used in the Analysis

In order to explore the impact of counsellor characteristics on the outcomes they claimed to have achieved with their clients, a percentage of positive outcomes achieved by each counsellor were calculated. This was done by aggregating data pertaining to each of the outcome indicators from the MDS for the last session attended by each client between 1 July 1997 and 30 June 1998. To reduce the potential for skewed data which could occur if very small numbers of cases involving a particular problem were reported by counsellors, for each problem type the proportion of positive outcomes was calculated only for those counsellors for whom there were five or more cases reported. These data were then matched with statistical data obtained from the counsellors pertaining to themselves and their practice. This information was gathered during individual interviews with workers and from self-administered questionnaires.

6.2.2 Sex and Age of Counsellor

As at January 1998, there were 50 individuals employed as counsellors by the 18 BreakEven services across Victoria. Of these fifty counsellors, two-thirds were female (33) and one-third male (17). Overall there was a mean age of 40.50 years, with no significant age difference between the sexes ($F(1,45)=0.06$, n.s.). This age and gender profile is almost identical to that contained in a recently published study of Australian social workers (Cooper and Crisp, 1998).

ANOVAs were conducted to examine whether their sex was associated with the client outcomes achieved by counsellors.

Table 32 BreakEven Counsellors: Sex and Mean Percentage of Positive Outcomes at Last Client Contacts between 1 July 1997 and 30 June 1998

		Males	Females
Positive Outcome Problem Category	N	*Mean % of Positive Outcomes*	
Financial issues	49	64.3	66.3
Employment and work related issues	45	60.5	53.2
Leisure use issues	45	65.3	65.2
Interpersonal related	50	59.2	63.1
Intrapersonal	51	70.9	68.1
Family issues	49	60.0	63.3
Physical symptoms	39	61.4	63.7

As Table 32 indicates, sex did not account for the differences in the mean percentage of positive outcomes achieved by clients.

Correlation coefficients were then calculated to examine the relationship between counsellor's outcomes and their age.

Table 33 BreakEven Counsellors: Correlation Between Age and Percentage of Positive Outcomes at Last Client Contacts between 1 July 1997 and 30 June 1998

Positive Outcome Problem Category	r
Financial issues	0.24
Employment and work related issues	0.22
Leisure use issues	0.15
Interpersonal related	0.16
Intrapersonal	0.07
Family issues	0.19
Legal issues	0.10
Physical symptoms	0.26

As Table 33 reveals, these associations were weak, and none were significant.

6.2.3 Education and Training

When developing the BreakEven program, the Department of Human Services envisaged that the counsellors would be qualified either as social workers or psychologists. However, only two-thirds (68.0 per cent) of the counsellors employed in January 1998 held qualifications in these disciplines. The other field in which several counsellors were qualified was welfare studies (14.0 per cent). The remaining one-fifth of counsellors were qualified in a range of areas, including occupational therapy, psychiatric nursing, education, child care, or held generalist degrees in the social sciences. While such backgrounds initially appear somewhat diverse, all of the counsellors held qualifications that, since the late 1980s, would have enabled them to be employed by Department of Human Services' predecessor Community Services Victoria in its generic 'social welfare worker' positions.

Table 34 BreakEven Counsellors: Professional Training by Mean Percentage of Positive Outcomes at Last Client Contacts between 1 July 1997 and 30 June 1998

	Social Work or Welfare	Psychology	Other
Positive Outcome Problem Category	n=17	n=22	n=9
	Mean % of positive responses		
Financial issues	70.7	60.1	67.4
Employment and work related issues	61.7	52.2	46.6
Leisure use issues	71.0	59.5	65.2
Interpersonal related	66.9	56.9	62.9
Intrapersonal	77.0	61.2	72.5
Family issues	69.0	56.2	62.5
Legal issues	58.7	51.4	63.5
Physical symptoms	72.2	58.7	43.2

Due to the high degree of overlapping content between many social work and welfare courses and the small numbers of respondents, these courses were grouped together for the purposes of analyses. Despite the diversity of professional qualifications held by BreakEven counsellors, ANOVAs for each problem area failed to reveal any differences as to the proportion of positive outcomes achieved by the different professional groups. Thus, the percentage of positive responses achieved by a counsellor will not provide sufficient information to identify their professional training background.

Table 34 provides the mean percentage of positive outcomes for each problem area. It is important to

note that Table 34 needs to be read across the problem areas. The percentages provided for each problem area are the results for separate ANOVAs. The table must not be read down each column as indicating a statement of the results for each professional group that can be compared across problem areas. The small sample sizes in the study militate against the rejection of the null hypothesis. However, when one considers that this is essentially a census or population study, one could comment on the differences in percentages of positive outcomes between the different groups. However, there is an important confounding variable in that clients have not been randomly allocated to counsellors. It may be that more serious cases gravitate towards particular professional groups, for example, psychologists. Alternatively, the differences may be real. We cannot tell in the context of a natural comparison study; a well-implemented randomised control trail would be necessary.

These findings reflect a slightly different picture from the results of the analysis of the clinical practice evaluation sample of clients, where the professional background of a counsellor did impact on the number of fully resolved cases and the level of overall satisfaction the client felt for the service. There are explanations for this apparent inconsistency. First, different measures of positive outcome were used and with a sample size so small these differences could have important impacts on the results. Second, the clinical practice evaluation analysis used a percentage score for each level of resolution of counsellors with three cases or more. The MDS data were taken from workers working across five sessions or more with the one client, and data were grouped in problem categories, rather than as a percentage for the level of resolution. Both approaches are legitimate, but have uncovered different effects. This again highlights the difficulties that arise when applying these statistical tests to small samples. Also, the impact identified in the clinical practice evaluation study is due in the main to the effect of the location of the agency. (See Table 35)

As the level of highest qualification for which one has studied is potentially an indicator of the amount and level of counselling training, ANOVAs were performed to identify whether or not this variable was associated with the outcomes achieved by counsellors. This revealed a significant difference between groups as to the percentage of positive outcomes achieved for employment and work related issues ($F(3,37)$ 3.05, $p<0.05$). However, post hoc testing (Bonferroni) failed to identify where these differences occurred.

As problem gambling counselling has really only emerged as a new counselling speciality in Victoria since the emergence of the BreakEven service, despite many being highly qualified, few, if any, of the counsellors had received any specialist training to work with problem gamblers prior to their employment with BreakEven. Thus the introduction of the BreakEven program into Victoria was accompanied by a number of specialist training courses for the counsellors. Table 36 presents the difference in mean per cent of positive outcomes for counsellors trained or not.

Table 35 BreakEven Counsellors: Level of Highest Qualification and Mean Percentage of Positive Outcomes at Last Client Contacts between 1 July 1997 and 30 June 1998

Positive Outcome Problem Category	Masters (n=9)	Postgraduate Bachelors Degree, Post Graduate Diploma or Honours Degree (n=23)	Bachelors Degree (n=6)	Diploma, Associate Diploma or Other Non-Degree Qualification (n=8)
		Mean % of positive outcomes		
Financial issues	57.6	65.4	68.9	68.4
Employment and work related issues*	39.2	57.7	40.9	70.0
Leisure use issues	56.9	65.7	64.4	75.5
Interpersonal related	54.4	62.3	67.6	62.0
Intrapersonal	65.6	67.8	79.0	66.8
Family issues	51.5	62.6	63.4	68.1
Legal issues	39.0	60.3	45.2	60.3
Physical symptoms	44.7	61.6	58.7	77.6

* $p<0.05$

Table 36 BreakEven Counsellors: Attendance at Conferences or Training Programs Run by BreakEven or Specifically for BreakEven Workers by Mean Percentage of Positive Outcomes at Last Client Contacts between 1 July 1997 and 30 June 1998

	Attended BreakEven Training	
	Yes (n=41)	No (n=7)
Problem	*Mean % of positive outcomes*	
Financial issues	66.2	60.4
Employment and work related issues	55.8	53.9
Leisure use issues	66.4	64.8
Interpersonal related	61.4	66.8
Intrapersonal	68.3	76.4
Family issues	61.8	66.6
Legal issues	56.1	54.2
Physical symptoms	62.7	52.3

While the majority (87.3 per cent) of BreakEven counsellors report having attended these training programs, as Table 36 indicates, attendees did not report greater proportions of clients who had positive outcomes.

The lack of difference in outcomes achieved by counsellors who have attended training programs specifically for BreakEven workers from those who have not may well reflect a high degree of involvement in a range of other ongoing education activities, such as reading, attending professional conferences (for example, the National Association of Gambling Studies) and professional supervision. Therefore, rather than focus specifically on training programs provided for BreakEven workers, it would seem necessary to examine whether counsellors who have access to employer funded training programs have better outcomes than those who do not. (See Table 37)

ANOVAs revealed no differences in the outcomes between counsellors who had access to employer funded training programs from those who claimed these were not available to them. However, as many counsellors report contributing to the costs of their education on gambling issues by buying books or paying to attend additional conferences, and so on, this may account for the lack of differences revealed, as in fact there is little difference in 'training' actually consumed by the employer-supported and the self-supported groups.

Table 37 BreakEven Counsellors: Employer Funded Training Programs by Mean Percentage of Positive Outcomes at Last Client Contacts between 1 July 1997 and 30 June 1998

	Employer Provides Funding or Study Leave for Training	
	Yes (n=38)	No (n=8)
Problem	*Mean % of positive outcomes*	
Financial issues	66.5	55.6
Employment and work related issues	53.8	71.7
Leisure use issues	66.3	63.9
Interpersonal related	61.9	60.5
Intrapersonal	70.2	66.0
Family issues	61.0	68.1
Legal issues	57.2	50.0
Physical symptoms	61.3	78.8

6.2.4 Tasks Performed in Counselling

As Table 38 reveals, few of these correlations were significant, and even those that were significant were not highly correlated. Of the 160 correlations calculated only nine are statistically significant ($p<0.05$), with none at the ($p<0.01$) level. This number of 'significant' results is roughly what you would expect if the null hypothesis, of no correlation between tasks performed and positive outcomes at last client contact, is correct. This looks like random noise. However, because of the relatively small sample size (n=between 27 and 50) and the considerable variability in the data, the statistical power is not particularly strong and so no firm conclusions can be reached.

6.2.5 Counsellor Morale and Satisfaction

The ability of counsellors to effectively assist clients resolve their problems may also be affected by the resources available to them. Inadequate resources are likely to reduce morale. As the 'self' is often claimed by counselling professionals to be the primary tool they use in counselling, it therefore follows that any problems with morale could potentially impact on the counselling process.

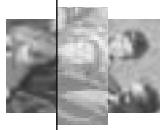


Table 38 BreakEven Counsellors: Correlations between Tasks Performed and Percentage of Positive Outcomes at Last Client Contacts between 1 July 1997 and 30 June 1998

Task	Financial Issues	Employment and Work Related Issues	Leisure Use Issues	Interpersonal Related	Intrapersonal	Family Issues	Legal Issues	Physical Symptoms
Assessment of other addictions	0.06	0.21	0.08	0.22	0.11	0.17	–0.11	0.15
Assessment of client eligibility	0.31*	0.11	0.20	0.23	0.31*	0.14	0.07	0.02
Assessment of client risk	0.21	0.25	0.33*	0.15	0.11	0.15	0.04	0.25
Assessment of problem impact	0.15	0.01	0.21	0.20	0.09	0.15	–0.02	0.03
Treatment goals	–0.06	–0.07	0.06	–0.01	–0.11	0.00	–0.28	–0.11
Facilitating effective client interventions	–0.01	0.04	–0.02	0.10	0.00	0.08	0.02	0.03
Establishing rapport	0.08	0.00	0.22	0.06	–0.13	0.03	0.00	–0.11
Teaching cognitive-behavioural strategies	0.11	–0.04	0.29	0.19	0.06	0.13	–0.20	0.20
Controlling gambling	0.06	0.00	0.20	0.14	0.00	0.21	–0.10	0.23
Maintaining treatment goals	0.26	0.17	0.35*	0.20	0.26	0.14	0.21	0.38*
Increasing awareness of non-gambling options	–0.04	0.06	–0.06	0.21	0.18	0.22	–0.15	0.22
Improving family relationships	–0.13	0.09	–0.14	0.01	–0.05	0.00	–0.04	0.03
Enhancing partner responses to gambling	0.21	0.21	0.14	0.27	0.21	0.32*	–0.01	0.24
Financial issues	0.02	–0.01	0.04	0.17	0.18	0.13	–0.25	0.15
Processes in resolving gamblers' problems	0.04	0.08	0.17	0.14	0.14	0.11	–0.41*	0.09
Linking clients with appropriate services	0.15	0.01	0.21	0.07	0.01	0.05	0.19	0.16
Referrals to medical practitioners	–0.08	–0.21	–0.01	–0.06	–0.07	–0.10	–0.19	–0.18
Community education and service promotion	0.08	–0.15	–0.06	0.00	0.01	0.04	–0.05	–0.10
Financial counselling education	0.05	0.05	0.08	–0.01	–0.16	0.12	–0.05	0.04
Research and policy development	–0.20	–0.29	–0.12	–0.30	–0.25	–0.35*	–0.24	–0.37*

* $p<0.05$

Table 39 BreakEven Counsellors: Satisfaction Levels

Level of Satisfaction	Content of Work (n=49)		Work Conditions (n=46)	
	N	%	N	%
Extremely unsatisfied	1	2.0	1	2.2
Quite unsatisfied	4	8.2	10	21.7
Neutral	2	4.1	4	8.7
Quite satisfied	22	44.9	20	43.5
Extremely satisfied	20	40.8	11	23.9

Counsellors were asked about their level of satisfaction with both the content of the work they perform and their working conditions. As can be seen from Table 39, the majority of staff claimed to be satisfied with both of these aspects, although there was clearly a greater degree of dissatisfaction with working conditions.

When asked to elaborate on these responses, working with clients was mentioned as a source of satisfaction by approximately two-thirds of counsellors. For some there was a sense of counselling being their chosen vocation, and they may well be happy in any position that involved counselling clients. Many, however, mentioned specific satisfaction with working with the particular clientele of BreakEven services, due to either or both the diversity of those presenting and the fact that many clients are seen to achieve their goals. For a number of counsellors involvement in a variety of tasks, including community education in addition to their counselling role, was a plus. However, there were others who resented these other tasks and would prefer that their duties were confined to counselling. Not surprisingly, given that persons drawn to counselling professions typically have a preference for working with people rather than numbers (Marlow, 1993), administration, including completion of the Minimum Data Set forms, was a source of dissatisfaction for several of the counsellors.

A second cluster of satisfying factors were concerned with the nature of professional practice, which was variously regarded as 'challenging', 'exciting' and 'enjoyable', with counsellors from a number of agencies remarking on having opportunities to be creative or innovative. An additional benefit of being part of a new service was the potential for professional development and learning new skills. The professional supervision they received was greatly appreciated by many counsellors who were receiving it, and desired by a number of (predominantly) sole workers who were receiving none. However, despite the many opportunities for professional development, a number of counsellors were concerned by the lack of a career structure within BreakEven. In most cases, a lack of career structure meant extremely limited, if any, opportunity for promotion, but for others the short-term nature of their employment contracts or the number of hours a week they were employed were of more immediate concern. Furthermore, although a few counsellors considered they were well paid, those who believed they were not sufficiently remunerated outnumbered them three-to-one.

The organisational structure was also important to many workers who, depending on their circumstances and personal predilections, either enjoyed a high degree of professional autonomy or being part of a professional team. Either way, it was important for counsellors to feel that the environment was regarded as being supportive of individuals and their style of work. Conversely, several counsellors who were the only BreakEven counsellor working from a location (either the only BreakEven worker employed by an agency or workers located at outposts) found their isolation problematic, especially if the BreakEven program was poorly integrated with the other programs in that setting. However, it may be difficult for counsellors to become integrated into other agencies if they are there for only a few hours a week or fortnight as part of an outreach service. Although some workers clearly enjoyed the challenge of providing a regional service, working from multiple sites and always having to carry papers and materials from one setting to another was certainly not a preferred style of working for a number of BreakEven counsellors.

Satisfaction levels with facilities and resources were quite mixed. While some differences may be a consequence of differential expectations, experiences also differed widely. Some reported having everything they required to do their work, including access to office equipment, cars and funds for professional development, whereas others complained that of the level of provision of these items being far from adequate. For example, one worker had been provided with a computer desk but no computer. Counsellors appreciated having their own office, but many report sharing offices and having to book an interview room when required,

and hope one was available. In one agency, it was reported that three counsellors shared a single counselling room and that on occasions when this was being used, other clients had been seen in the back yard. Several counsellors were concerned that the counselling spaces available to them were of a very poor standard, and inappropriate for a professional service. In some cases this was a matter of aesthetics, with offices that were physically unattractive. However, some counsellors found themselves working in spaces which they believed compromised client confidentiality either because the walls did not provide an adequate sound barrier, which could result in others overhearing confidential information, or because of an absence of reception staff. In at least one satellite setting it was not uncommon for people walking in off the street to interrupt a counselling session. Further problems with this particular setting included a lack of hot running water and an outdoor toilet. While many of the problems with buildings concerned satellite settings, there were also problems in some of the host agencies.

Correlation co-efficients were calculated to examine the relationship between counsellor's reports as to the percentage of clients with whom there were positive outcomes and levels of satisfaction with both the content of the work they perform and their working conditions. As Table 40 reveals, these associations were weak, and none were significant.

Table 40 BreakEven Counsellors: Correlation between Satisfaction Levels and Percentage of Positive Outcomes at Last Client Contacts between 1 July 1997 and 30 June 1998

Positive Outcome Problem Category	Level of Satisfaction	
	Content of work	Work conditions
Financial issues	–0.06	0.13
Employment and work related issues	–0.10	0.00
Leisure use issues	0.02	0.04
Interpersonal related	–0.12	0.17
Intrapersonal	–0.07	0.28
Family issues	–0.14	0.20
Legal issues	0.00	–0.19
Physical symptoms	–0.19	0.06

6.2.6 Counsellor Expectations Re: Outcomes

Interviews with counsellors revealed a diversity of expectations that counsellors have as to client outcomes. Interestingly, it was not uncommon to find a diverse range of expectations from within the same agency.

Consistent with a client-centred approach, the most frequently nominated expected outcome was that clients achieve their own goals, although this was nominated by less than one-third of all counsellors. Unspecified client change was the next most common expectation. Specific changes by clients which were the expectations of some counsellors, follow:

- Reduction in amount of gambling.
- Gaining awareness of their problem.
- Reduction of the harmful effects of gambling.
- Change in qualitative experience of gambling.
- Life more in control.
- Learning effective coping strategies.
- Dealing with life issues.
- Resolution of emotional issues.
- Effective family functioning.

As far as changes in the levels of gambling are concerned, despite the harm minimisation framework that supposedly underpins BreakEven, a number of counsellors expected their clients to become abstinent.

In addition to their expectations for clients, a number of counsellors had expectations in respect of their own performance. For a few, this involved setting objective targets, such as the proportion of clients who achieved a successful outcome from counselling (ranging up to 70 per cent), or the service becoming better known as reflected by an increase in client numbers. For others, it was the process rather than the outcome which was important, resulting in expectations around establishing rapport, clients having positive experiences in counselling, client satisfaction, and creating an environment where clients feel comfortable to re-present at a later date if necessary.

6.2.7 Quality Assurance Mechanisms

When asked how they monitor their professional practice, BreakEven counsellors nominated a range of methods and performance indicators, with the most frequently mentioned being professional supervision, which was nominated by eighty per cent. This represents almost all of those who reported receiving supervision. Discussions with colleagues, whether they be from BreakEven, employed elsewhere in the agency or in other agencies (including other BreakEven services), were also important in providing feedback to counsellors—irrespective of whether this occurred informally or in

formal settings, such as case conferences and clinical settings. Interestingly, discussions and feedback from colleagues was as likely to be nominated as a method of monitoring practice as was feedback from clients as to their progress, which was nominated by slightly more than half of the counsellors. Few counsellors used any form of client survey, being more likely to rely on verbal reports from clients. Given the importance attached to external feedback, it is perhaps not surprising that less than one-third of counsellors reported engaging in some form of reflective process to assess their work, and only two considered their own job satisfaction to be a performance indicator.

Although some counsellors claim to have used no performance indicators per se, many in fact mentioned mechanisms by which they were able to set benchmarks against which they could compare their work. The most common of these was involvement in ongoing professional education, either by reading or attending appropriate training courses. Also important was the ongoing statistical data collected for the Minimum Data Set and the extent to which clients continue to attend counselling and/or present for further counselling. Fewer workers mentioned their written case notes as providing a performance measure than did the number mentioning statistics.

Administrative procedures may be considered by some, but not all, counsellors from within a given agency to be a form of performance indicator. Such procedures included annual staff appraisals, reports submitted to the agency's management committee, setting work plans and determining the extent to which the aims were achieved, completing discharge summaries, as well as collecting statistical data and maintaining case notes. However, given that some of these administrative procedures are arguably measures of worker activity which provide little feedback on the quality of work, it is perhaps not surprising that many workers did not identify these as performance indicators.

Although the most frequently nominated quality assurance mechanism, professional supervision, occurs in a variety of ways within BreakEven overall, as well within individual agencies. Half the counsellors reported receiving professional supervision from outside the agency, mostly in addition to, but in some cases instead of, supervision from within the agency. External supervision was sought for a range of reasons, including an inability of the agency to provide professional supervision, a desire to gain particular skills and as a prerequisite for professional registration. Except for two counsellors, external supervision had to be paid for by either the counsellor or the agency. Two-thirds (16) of those receiving external supervision bore the cost themselves. A further three counsellors reported sharing the cost between themselves and the agency. Only four counsellors had their supervision costs paid in total by the agency.

There are a number of aspects to professional supervision, including 'helping supervisees to grow professionally', 'sharing knowledge with supervisees' and 'discussion of administrative matters' (Munson, 1993: 31). Not all of these will necessarily be provided in any one supervisory relationship, which may in part explain a number of counsellors having more than one type of supervision. However, for the most part, BreakEven counsellors discussed supervision only in respect of the categories of professional growth and obtaining information and advice about effective counselling strategies. For almost half the counsellors, supervision was an important component of their ongoing professional education. Importantly, by being a forum in which practice was open to scrutiny, supervision was not only a forum that fostered accountability, but was perceived as helping to maintain professional standards.

As for professional growth, this covers a range of counsellors' expectations from supervision, including being a forum to discuss issues or ideas or to review past work, and to provide constructive feedback, debriefing and support.

A few counsellors mentioned expectations that were about the process rather than the content of supervision. These were, that it was a safe environment where they would be listened to, trusted and respected. There were also expectations that it should be regular, relevant, and for the psychology graduates who were seeking registration as psychologists, that the supervisors have the appropriate accreditation.

Counsellors reported discussing a range of issues in supervision, with issues around cases and case management being the most common. While some tended to discuss only those cases where there were complex or difficult issues, some discussed all cases

in supervision. Another way in which counsellors use supervision is to focus on particular aspects of their work, such as assessment, referral or treatment and discuss issues, technique and strategies which may be pertinent. Theory and ethical issues were each identified by only a few counsellors as something they discussed in supervision. Whereas clinical concerns were the primary focus for some counsellors, a number reported using supervision to work through their own personal issues which arose from their practice.

Overall, supervision was primarily focused on the individual counsellor and their clinical work. Administrative issues were reportedly discussed in supervision by only a few counsellors, as were agency wide or overall program issues. The lack of administrative supervision is reflected by the fact that a number of counsellors were unaware of the agency procedures in the event of a traumatic incident, such as a suicide or violent attack on workers.

To examine whether use of professional supervision was associated with outcomes achieved with clients, each of the outcome indicators for counsellors were subjected to a 2 (internal supervision) X 2 (external supervision) analysis of variance.

Analysis of main effects revealed no effect on any of the outcome indicators of having either internal or external supervision. However, an interaction effect revealed in respect of outcomes achieved concerning leisure use issues ($F(1,39)=5.39$, $p<0.05$), such that the highest proportion of positive outcomes were achieved by counsellors who received external but not internal supervision (84.0 per cent) and the lowest by those who had both internal and external supervision (55.1 per cent).

Table 41 BreakEven Counsellors: Professional Supervision by Mean Percentage of Positive Outcomes at Last Client Contacts between 1 July 1997 and 30 June 1998

	Has Internal Supervision		Has External Supervision	
	Yes (n=38)	No (n=10)	Yes (n=25)	No (n=23)
Positive Outcome Problem Category	*Mean % of positive outcomes*			
Financial issues	66.3	68.5	66.6	68.1
Employment and work related issues	56.1	57.4	56.5	57.1
Leisure use issues*	65.1	75.5	69.6	70.9
Interpersonal related	61.7	66.3	62.6	65.5
Intrapersonal	68.9	72.8	70.6	71.0
Family issues	62.9	64.1	59.0	68.1
Legal issues	56.5	59.9	56.9	59.4
Physical symptoms	63.3	69.6	57.2	75.6

* $p<0.05$

7 Outcomes and Agency Characteristics

7.1 Agency Characteristics Impacting on Counselling Outcomes: Retrospective Sample

This chapter reports upon the impact of selected agency characteristics upon the counselling outcome measures used in the sequence of analyses presented in this Report. There is little work available in which these factors have been studied. The majority of intervention studies have focused on the characteristics of the interventions, generally with all other factors uncontrolled or randomised. Of course, randomisation does not remove the effects of the factors so treated, it just obscures them from our view. In any event, even if such work were available, it is likely to be of very limited utility for the present local context. The structure of service designs in other jurisdictions are likely to have very limited application to the local context, as are the results we will obtain from the analyses presented herein. However, they are likely to be of some utility to the funding body in this local context, which is why we have done them.

The following list of institutional characteristics was analysed for their impact on client reported outcomes of the counselling work undertaken at BreakEven services.

- The location of the program.
- The type of agency program is located in.
- The percentage of client contacts the agency had in 1997–98.
- The number of client returns received from each agency.
- Intra-agency support for professional development and education.

Outcome measures were created to test these factors. A score for each agency was produced by reducing the individual client scores for the percentage of problems fully resolved, fixed to the client's satisfaction, partially resolved, the impact of BreakEven on gambling and satisfaction with the outcomes of counselling—into an agency average score. Thus the following measures were used to assess outcome.

- Agency average score for problems fully resolved.
- Agency average score for problems fixed to the client's satisfaction.
- Agency average score for problems partially resolved.
- Agency average score for problems unresolved.
- Agency average scores for client satisfaction with the outcome of counselling.
- Agency average score for client reported impact of counselling on gambling activity.

Each variable was checked for its suitability for entry into regression analysis. All variables but the intra-agency support for professional development were suitable for analysis. This variable was not suitable because of its skewedness, as most agencies were supportive of their staff's training

A correlation matrix was produced to indicate the strength and the direction of the association between

the variables. The number of client returns and the percentage of client contacts in 1997–98 showed an almost exact fit ($r=0.919$), indicating that the number of client returns received almost mimics the number of client contacts from each service. This, linked with the demographic details provided in Section 2, indicates that the CPE sample reflected agency client numbers and was not skewed or disproportionate in this respect, which further strengthens the case for the sample being unbiased.

Only moderate associations were found to exist between some variables. Location of the agency, whether it was metropolitan or non-metropolitan, had a negative moderate association, with the average level of client satisfaction and the client reported impact of counselling on gambling activity, these being ($r=-0.530$) and ($r=-0.618$) respectively. These results indicate that clients from non-metropolitan services had higher levels of satisfaction with the outcome of counselling and reported greater impact of counselling on their gambling behaviour. The only other variables that showed a moderate and significant ($p<0.05$) association was the average percentage of problems fixed to a clients satisfaction and the type of service marked 'other'. Clients from agencies that were not either community health centres or family support agencies reported higher levels of problems fixed to their satisfaction.

7.2 Agency Characteristics Impacting on Counselling Outcomes: Minimum Data Set

BreakEven services have been located in a range of health and welfare agencies across Victoria. Whether or not these agencies achieve similar outcomes for clients is examined in the section below.

7.2.1 Agency Type

The successful tenders for provision of BreakEven services were a disparate mix of agencies in respect of the core services already provided. While half were community health centres, the remainder was primarily involved in the delivery of material aid, drug and alcohol or family support and relationship counselling. A breakdown of agency type is provided in Table 42.

Table 42 BreakEven Agencies Classified by Agency Type

Agency Type	Agencies
Community health centre	Banyule Community Health Service
	Bendigo Community Health Service
	Brimbank Community Health Service
	Colac Community Health Service
	East Bentleigh Community Health Service
	Goulburn Valley Community Health Service
	Lower Hume Community Health Service
	Maroondah Social and Community Health Centre
	Mitchell Community Health Service
Family support	Bethany Family Support
	Gippsland Family Services
	Mallee Family Care
	Relationships Australia
	South West Community Care
Material aid	Salvation Army
	Victorian Relief Committee
Drug and alcohol	Palm Lodge Rehabilitation Centre
	Western Region Alcohol and Drug Centre

Historically the dominant ethos of these types of agencies has been quite different which could potentially impact on clients and the outcomes achieved. As Table 43 shows, agency type did make a difference as to the outcomes achieved in respect of financial issues ($\chi^2(3)=83.71$, $p<0.001$), employment and work related issues ($\chi^2(3)=38.33$, $p<0.001$), leisure use ($\chi^2(3)=36.00$, $p<0.001$), interpersonal difficulties ($\chi^2(3)=102.08$, $p<0.001$), intrapersonal problems ($\chi^2(3)=89.32$, $p<0.001$), family issues ($\chi^2(3)=123.33$, $p<0.001$), legal issues ($\chi^2(3)=33.48$, $p<0.001$) and physical symptoms ($\chi^2(3)=53.28$, $p<0.001$). Although further research is necessary to ascertain the actual reasons why these results occurred, it may be that clients and or workers varied considerably between the agencies rather than agency practices or philosophies which produced these results.

7.2.2 Agency Location

Historically, health and welfare agencies in Victoria have had difficulties in recruiting qualified counsellors, although in recent years there have been efforts to remedy this situation (Fook, Ryan, Carew and van den Berk, 1991). Furthermore, the needs of urban and rural dwellers are not always identical, and clients from country areas would benefit from access to the range of additional services that most Australians can take for granted (Cheers 1991; Coleman, 1989), which may place additional pressures on BreakEven workers located outside the Melbourne

Table 43 BreakEven Agencies: Percentage of Clients with Positive Progress Indicators at Last Contact between 1 July 1997 and 30 June 1998 by Agency Type

	Community Health Centre		Family Support		Drug and Alcohol		Material Aid	
Problem	%	N	%	N	%	N	%	N
Financial issues*	70.0	1,541	68.9	511	75.4	61	43.6	303
Employment and work related issues*	62.5	698	60.6	221	56.7	30	37.1	178
Leisure use issues*	69.8	1,229	70.4	368	66.0	50	50.4	120
Interpersonal related*	67.6	1,644	62.6	479	66.7	60	36.8	296
Intrapersonal*	73.4	1,785	73.8	484	83.6	61	48.8	328
Family issues*	69.0	1,350	63.9	360	75.8	62	32.8	247
Legal issues*	68.5	248	58.8	85	84.6	13	30.0	60
Physical symptoms*	69.8	486	69.0	171	89.3	28	35.8	106

* $p<0.001$

Table 44 BreakEven Agencies: Percentage of Clients with Positive Progress Indicators at Last Contact Between 1 July 1997 and 30 June 1998 by Location of Agency

Problem	Melbourne Metropolitan Area		Rest of Victoria	
	%	N	%	N
Financial issues†	63.8	1,614	72.3	800
Employment and work related issues†	54.2	734	65.4	373
Leisure use issues†	63.6	1,257	75.0	628
Interpersonal related†	60.5	1,700	68.2	779
Intrapersonal†	67.6	1,859	77.8	799
Family issues†	60.7	1,372	70.5	647
Legal issues*	55.5	236	69.4	170
Physical symptoms*	61.5	517	73.7	274

* $p<0.01$

† $p<0.001$

metropolitan area. However, even if such services were provided clients may opt not to use them. In small communities, people may not want to seek the professional services of a local counsellor, either because of other pre-existing relationships they have with that person, or because of the dynamics in a small community, where being seen to have contact with a counsellor becomes community gossip. Consequently some rural clients have chosen to attend BreakEven services in an area different from that in which they live.

Given these known differences in the provision of counselling services to rural and urban clients, it was possible that different outcomes would be achieved by counsellors from the Melbourne metropolitan area from those based elsewhere. As Table 44 shows, differences were revealed with counsellors from the country reporting more positive client outcomes in respect of financial issues ($\chi^2(1)=17.67$, $p<0.001$), employment and work related issues ($\chi^2(1)=12.78$, $p<0.001$), leisure use ($\chi^2(1)=24.92$, $p<0.001$), interpersonal difficulties ($\chi^2(1)=13.35$ $p<0.001$), intrapersonal problems ($\chi^2(1)=28.51$, $p<0.001$), family issues ($\chi^2(1)=18.16$, $p<0.001$), legal issues ($\chi^2(1)=8.05$, $p<0.01$) and physical symptoms ($\chi^2(1)=11.86$, $p=0.001$).

7.2.3 Agency Inputs

Annual budget information was requested from all BreakEven services and supplied by 12 of the 18 agencies. These agencies reported receiving between $32,000 and $585,278 per annum to provide services and programs for persons affected by problem gambling.

The percentage of positive outcomes achieved by each agency was calculated by aggregating data pertaining to each of the outcome indicators from the MDS for the last session attended by each client between 1 July 1997 and 30 June 1998. To reduce the potential for skewed data, which could occur if very small numbers of cases involving a particular problem were reported by an agency, for each problem type the proportion of positive outcomes was calculated only for those agencies for which there were five or more cases reported. Correlation coefficients were then calculated to examine the relationship between the

annual budget for each BreakEven agency and the percentage of clients with whom there were positive outcomes. As Table 45 reveals, these associations were weak, and none were significant.

Table 45 BreakEven Agencies: Correlation Between Annual Budget and Percentage of Positive Outcomes at Last Client Contacts between 1 July 1997 and 30 June 1998

Positive Outcome Problem Category	r
Financial issues	–0.07
Employment and work related issues	0.00
Leisure use issues	–0.27
Interpersonal related	–0.02
Intrapersonal	–0.17
Family issues	0.11
Legal issues	0.10
Physical symptoms	0.08

As some BreakEven agencies are funded only to provide problem gambling counselling, and others are also funded to provide education and/or programs targeted at specific groups of clients, a measure other than the overall BreakEven budget may be a better measure of agency inputs into counselling. One method was to examine the effect of the number of counsellors employed by each agency on the client outcomes achieved. To do this, ANOVAs were performed to compare the percentage of client outcomes achieved by the seven agencies employing one BreakEven counsellor with the 11 who employ two or more counsellors, but no patterns or significant differences were revealed.

Table 46 BreakEven Agencies: Number of BreakEven Counsellors by Percentage of Positive Outcomes at Last Client Contacts between 1 July 1997 and 30 June 1998

Positive Outcome Problem Category	Number of Counsellors	
	One (%)	More than One (%)
Financial issues	65.9	69.0
Employment and work related issues	60.9	60.6
Leisure use issues	76.5	69.5
Interpersonal related	58.7	65.0
Intrapersonal	66.0	71.9
Family issues	63.6	64.3
Legal issues	57.6	63.5
Physical symptoms	72.7	66.4

8 Clients' Views on Service Helpfulness

8.1 Client Comments on Helpfulness of BreakEven Counselling: Retrospective Sample

Seventy-eight per cent of clients in the retrospective sample used the opportunity to comment on the helpfulness of BreakEven. The following is a thematic summary of these responses.

Clients' experiences of the helpful and unhelpful aspects of counselling were considerably uniform. One hundred and seventeen clients presented comments on the helpful aspects of the service, while only 26 commented on unhelpful aspects.

Irrespective of the agency the client attended, clients considered the following experiences as the most helpful for them:

- The opportunity to talk about their problems with someone who listened, was non-judgmental and understood the nature of gambling problems.
- The support and empathy they felt from the counsellors.
- The ability of the counsellors to explore with them the reasons for their gambling.
- The professionalism of the counsellors and their knowledge of the problems.

The same uniformity existed in the comments on aspects of the service that were unhelpful. The following themes emerged in the 26 clients who provided comments:

- There is a need for after-hours session times.
- A wish for counsellors to monitor the client's gambling activity more closely.

The comments concerning the second area of unhelpful service aspects were somewhat intriguing. It seems that some clients would welcome closer monitoring of their behaviour in order to promote adherence. It is difficult to imagine how this might be achieved in practice, but it is worthy of further consideration. Perhaps the use of diaries could be considered or other mechanisms of closer self-monitoring. In work in other settings, we have used diary methods to great effect. Most prospective GP patients who participated in our studies were staggered to learn that they had on average 30 symptom occasions before they consulted a GP. We suspect that when people are asked to estimate the volume of their turnover and losses in gambling activities that without accurate diary methods, these figures are likely to be aberrant.

Further comments made by clients in a general comments section highlight the varied role of the service from the extremes of life saver, for some, to someone feeling his counsellor was encouraging people to gamble because he was advocating controlled gambling. On this continuum most comments sit at the positive end where people largely felt their lives had changed in important ways as the result of attending counselling. The following quotes provide a flavour of these responses.

'I was grateful that the service existed and I could get to it. This lessened the damage I could have done.'

'The counsellor was very understanding and helpful in all ways. We worked on each problem, not everything at once. I was not made to feel guilty or stupid.'

'It has changed my life.'

'In general I think the service is excellent. Excellent professionalism—respectful of the individual. Essential that it is available widely on a continuing basis.'

'My counsellor has helped me see that there is a future for me. I don't feel alone anymore.'

'Not having to worry about the cost was great.'

'When I walked into the doors of BreakEven my life meant very little to me. I now have a very different attitude towards those around me and life in general.'

9 Study of Re-Presenters

9.1 Introduction

There is widespread agreement that problem gambling is a difficult behaviour to modify. It has been shown that reinstatement of the behaviour (relapse) can occur after months or years of abstinence (Brown, 1989; Marlatt, 1985). Problem gambling shares this characteristic with the addictions. So normal are relapses that Prochaska and DiClemente (1983) included this explicitly as part of the process in their model of stages of change. In their work with smokers, they found that individuals took an average of three attempts before achieving permanent extinguishment of the undesirable behaviour (Prochaska and DiClemente, 1988), and subsequent studies have suggested this model to be applicable to a far wider range of behaviours (Prochaska et al, 1994). Consequently, it is not unreasonable to expect that a proportion of clients at a problem gambling counselling service have sought help for this problem one or more times previously. Certainly this is the picture provided by counsellors. The short time intervals since the introduction of the BreakEven services and their utilisation by larger numbers of clients does not allow us to determine yet whether this picture is supported by the utilisation data within the Minimum Data Set. Certainly periods of rather short and intensive engagement with a service are a characteristic of the data collected and analysed to date.

From a treatment perspective, although it may be tempting to regard relapse as a failure of treatment, this approach fails to recognise efforts that clients have made to remain abstinent or keep their behaviour at a controlled and non-problematic level. An alternative perspective is to recognise that clients are only likely to return to seek further help from those individuals and agencies that they had found helpful on previous occasions. On such criteria, an agency with a sizeable proportion of re-presenting clients could arguably be regarded as being somewhat effective.

If, as DiClemente et al (1991) contend, each time clients take action to change they gain greater insight into the behaviour, then we might expect re-presenting clients to differ somewhat from first-time clients. This part of the evaluation study tested this proposition by comparing the statistical data collected from new and re-presenting clients of BreakEven services.

Between 1 August 1997 and 30 June 1998, 2,430 new clients registered with Victoria's problem gambling counselling services. However, registration data was also collected during this period from an additional 435 clients who reported having previously been a client of BreakEven. These re-presenting clients had either been registered prior to 1 July 1996, had attended previously without registration data being collected or were previously registered with a different identification number. As Table 47 on the following page shows, the clear majority of both new and re-presenting clients during this period were people who reported that they had problems with

their own gambling behaviour. Nevertheless, re-presenting clients (86.0 per cent) were more likely to identify themselves as problem gamblers than were new clients (78.1 per cent) ($\chi^2(1)=13.79$, $p<0.001$).

Table 47 BreakEven Client Registrations 1 August 1997 to 30 June 1998: Client Status by Type of Presentation

	Type of Presentation	
Client Status	New Clients No.	Re-Presenting Clients No.
Self-identified gambling problem	1,899	374
Partner	359	45
Parent	61	9
Sibling	20	1
Other relative	47	2
Friend	26	1
Work colleague or employer	5	0
Other	13	3
Total	2,430	435

9.2 Demographic Profile

9.2.1 Personal and Family Characteristics

Table 48 provides details of the personal and family characteristics of problem gamblers by type of presentation for whom registration data was collected between 1 August 1997 and 30 June 1998. Statistical tests reveal re-presenting clients as more likely to have been born in Australia ($\chi^2(1)=8.63$, $p<0.01$) and to have dependent children ($\chi^2(1)=5.42$, $p<0.05$). The household structure also differed for these two groups of clients ($\chi^2(5)=13.36$, $p<0.05$).

Table 48 BreakEven Problem Gambler Clients: Personal and Family Characteristics by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation	
Characteristic	New Clients	Re-Presenting Clients
Mean age (years)	38.2	38.9
Sex (%)		
Male	50.8	45.4
Female	49.2	54.6
Birthplace (%)†		
Australia	73.2	80.5
Overseas	26.8	19.5
Marital status (%)		
Never married	26.2	24.9
Married	41.2	40.5
De facto relationship	10.2	10.2
Separated, not divorced	8.2	8.0
Divorced	11.9	14.5
Widowed	2.3	1.9
*Household structure (%)**		
Couple with children	36.4	39.7
Couple without children	15.8	12.8
One parent family	9.4	13.0
Group/share household	13.8	9.0
Lives alone	15.9	17.7
Other	8.7	7.9
Has dependent children*	40.9	47.4

* $p<0.05$

† $p<0.01$

Unlike problem gamblers, the personal and family characteristics of partners and other clients were the same for both new and re-presenting clients.

Table 49 BreakEven Partner and Other Clients: Personal and Family Characteristics by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation	
Characteristic	New Clients	Re-Presenting Clients
Sex (%)		
Male	30.5	30.0
Female	69.5	70.0
Birthplace (%)		
Australia	77.5	80.3
Overseas	22.5	19.7
Marital status (%)		
Never married	9.6	3.3
Married	66.9	70.5
De facto relationship	11.5	11.5
Separated, not divorced	6.2	6.6
Divorced	4.6	4.9
Widowed	1.2	3.3
Household structure (%)		
Couple with children	53.7	62.3
Couple without children	24.8	16.4
One parent family	8.1	9.8
Group/share household	4.3	4.9
Lives alone	5.0	3.3
Other	4.1	3.3
Has dependent children	56.8	65.6

9.2.2 Income

The economic circumstances of new and re-presenting problem gambler clients also differed, with more re-presenting clients being in receipt of a pension or benefit ($\chi^2(1)=13.67$, $p<0.001$). This in part explains why they had lower individual ($\chi^2(1)=9.07$, $p<0.01$) and family ($\chi^2(1)=12.82$, $p<0.001$) incomes. Further details concerning the incomes of new and re-presenting problem gambler clients are presented in Table 50.

Table 50 BreakEven Problem Gambler Clients: Income Characteristics by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation	
	New Clients	Re-Presenting Clients
Characteristic	%	%
Receives pension or benefit†	31.1	41.1
*Weekly individual income**		
$1,500 or more	1.9	1.5
$800–$1,499	6.7	3.5
$600–$799	12.4	10.2
$400–$599	23.4	20.8
$200–$399	23.11	26.9
$120–$199	20.0	20.8
Less than $120	12.6	16.4
Weekly family income†		
$1,500 or more	5.8	3.1
$800–$1,499	18.9	13.6
$600–$799	16.9	17.0
$400–$599	23.6	23.5
$200–$399	18.0	21.6
$120–$199	13.2	15.4
Less than $120	3.5	5.9

* $p<0.01$

† $p<0.001$

As with the demographic characteristics, unlike problem gamblers, there were no differences between new and re-presenting partners and other clients in respect of income.

Table 51 BreakEven Partner and Other Clients: Income Characteristics by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation	
	New Clients	Re-Presenting Clients
Characteristic	%	%
Receives pension or benefit	24.8	20.3
Weekly individual income		
$1,500 or more	0.2	2.0
$800–$1,499	6.1	6.1
$600–$799	12.4	12.2
$400–$599	27.5	26.5
$200–$399	18.4	20.4
$120–$199	15.9	14.3
Less than $120	19.6	18.4
Weekly family income		
$1,500 or more	5.1	6.7
$800–$1,499	25.8	31.1
$600–$799	21.7	24.4
$400–$599	21.9	15.6
$200–$399	15.6	13.3
$120–$199	6.6	4.4
Less than $120	3.4	4.4

9.2.3 Labour Force Status

The differences in income between new and re-presenting problem gamblers reflect the differential labour force status between these two groups of clients ($\chi^2(3)=8.13$, $p<0.05$), with more new clients reportedly employed. However, for those problem gamblers who were employed, new and re-presenting clients had similar occupations.

Table 52 BreakEven Problem Gambler Clients: Labour Force Characteristics by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation	
	New Clients	Re-Presenting Clients
Characteristic	%	%
*Labour Force Status**		
Employed full-time	43.6	36.0
Employed part-time	17.6	19.1
Unemployed, looking for work	12.2	12.8
Not in the labour force	26.6	32.2
Occupation of employed clients		
Manager/administrator	9.9	6.2
Professional	11.0	10.1
Associate/paraprofessional	9.1	9.7
Tradesperson	12.6	8.8
Clerical or service worker	29.5	33.4
Production of transport worker	9.2	9.4
Labourer	18.8	22.4

* $p<0.05$

The difference in employment rates between new and re-presenting problem gambler clients raises some interesting questions for further research. One possibility is that problem gamblers who are not employed find it easier to attend counselling sessions at BreakEven and thus are more likely to return for further counselling should their gambling become problematic once again. Conversely, it may be that re-presenting clients are less employable than new clients; but even if this scenario was proven, we would still need to ascertain whether gambling has contributed to clients becoming unemployed or whether because they are unemployed clients have increased their involvement in gambling.

No differences were found in the labour force characteristics of new and re-presenting partners and others.

Table 53 BreakEven Partner and Other Clients: Labour Force Characteristics by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation	
	New Clients	Re-Presenting Clients
Characteristic	%	%
Labour force status		
Employed full-time	43.2	39.3
Employed part-time	18.2	26.2
Unemployed, looking for work	4.2	8.2
Not in the labour force	34.4	26.2
Occupation of employed clients		
Manager/administrator	11.4	18.0
Professional	16.1	18.0
Associate/paraprofessional	13.5	14.0
Tradesperson	11.4	16.0
Clerical or service worker	30.2	22.0
Production of transport worker	4.8	2.0
Labourer	12.7	10.0

9.3 Gambling Activity

9.3.1 Gambling Behaviours

Information gathered from the MDS Client Assessment Form summarises the type, frequency and intensity of problem gamblers' gambling activity. Clients were asked to provide information about: hours spent gambling and dollars spent gambling on most recent day of gambling by gambling type; and days spent gambling during a typical month by type of gambling. These data are available for 1,834 of the new, and 314 of the re-presenting, problem gamblers for whom registration data were collected between 1 August 1997 and 30 June 1998.

Logistic regression analysis was conducted to identify differences between new and re-presenting clients in respect of the forms of gambling which problem gamblers engaged in on their most recent day of gambling. This analysis, which is summarised in Table 54, revealed that new clients were 1.68 times more likely to report betting at the TAB than were re-presenting clients. However new and re-presenting clients were just as likely to be engaged in any of the other forms of gambling listed in Table 54, with gambling on electronic gaming machines (EGMs) by far the most common practice for the majority of clients irrespective of whether or not they have previously been a client of BreakEven.

Although the amount of money and time spent gambling varies between different types of gambling, as Table 55 indicates, problem gamblers report spending considerable amounts of time and money on most forms of gambling.

While the gambling behaviours of new and re-presenting clients are similar, Mann-Whitney U tests revealed a few significant differences between these groups of problem gamblers. New clients reported using EGMs more often ($U=121976.5$, $Z=-4.037$, $p<0.001$), whereas re-presenting clients played card games that went longer ($U=141.0$, $Z=-2.203$, $p<0.05$) and spent more money each time they played lotto or similar games ($U=195.0$, $Z=-1.991$, $p<0.05$).

Involvement in gambling can vary over time, and BreakEven attracts problem gamblers with wide ranging patterns of gambling. However, as Table 56 shows, the pattern of gambling was similar for both new and re-presenting clients.

Table 54 BreakEven Problem Gambler Clients: Types of Gambling on Most Recent Day of Gambling by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation			
	New Clients	Re-Presenting Clients		
Type of Gambling	%	%	Odds Ratio	95% Confidence Interval
Lotto/lottery, pools/keno	4.1	2.9	1.32	0.65–2.71
Bet on races at TAB (off-course betting)	14.0	8.9	1.68*	1.09–2.61
Bet at races (on-course betting)	3.8	1.9	1.77	0.75–4.17
Electronic gaming machines	75.7	76.1	1.21	0.89–1.65
Bingo	2.9	2.9	1.02	0.49–2.10
Bet on card games	3.7	2.5	1.41	0.66–3.02
Numbers	1.9	1.3	1.47	0.51–4.23
Other kind of gambling	1.3	1.0	1.23	0.36–4.18

* $p<0.05$

Table 55 BreakEven Problem Gambler Clients: Gambling Behaviour During a Typical Gambling Episode by Type of Presentation, 1 August 1997 to 30 June 1998

Type of Gambling	Median Number of Hours per Episode	Median Number of Dollars spent per Episode	Median Number of Episodes per Month
New Clients			
Lotto/lottery/pools/keno	1	15	4
Bet on races at TAB (off-course betting)	3	100	8
Bet at races (on-course betting)	5	125	4
Electronic gaming machines	3	100	8
Bingo	3	30	4
Bet on card games	4	400	5
Numbers	4	300	5
Other kind of gambling	3	200	6
Re-Presenting Clients			
Lotto/lottery/pools/keno	1	50	4
Bet on races at TAB (off-course betting)	3	100	8
Bet at races (on-course betting)	4	150	4
Electronic gaming machines	3	100	6
Bingo	3	30	4
Bet on card games	6	140	6
Numbers	3	100	4
Other kind of gambling	4	125	6

Table 56 BreakEven Problem Gambler Clients: Pattern of Gambling by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation	
	New Clients	Re-Presenting Clients
Pattern of Gambling	%	%
Ascending	23.5	21.5
Descending	14.8	17.4
Stable	20.2	21.9
Chaotic	16.6	14.5
Binge	6.0	7.4
Not currently gambling	18.8	17.4

9.4 Gambling Expenditure

The weekly amount of money problem gamblers report having access to for gambling purposes is presented in Table 57 on the following page. This revealed that new clients reported being able to access more money for gambling than re-presenting clients ($\chi^2(1)=29.04$, $p<0.001$).

Table 57 BreakEven Problem Gambler Clients: Access to Money for Gambling Purposes by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation	
	New Clients	Re-Presenting Clients
Access to Money %	%	
$1,500 or more	7.0	3.1
$800–$1,499	8.7	6.8
$600–$799	12.1	8.2
$400–$599	19.9	14.3
$200–$399	21.9	23.2
$120–$199	17.0	20.8
Less than $120	13.3	23.5

Problem gamblers report funding their gambling from a variety of sources. While for many, gambling is (at least partially) funded from the household budget, others require additional funds to pay for their gambling. These may be obtained by depletion of resources either by using savings or selling assets, borrowing money or engaging in illegal acts. Logistic regression was conducted to identify differences between new and re-presenting clients in respect of each of the potential sources of funding listed in Table 58 but none were revealed.

Re-presenting clients (2.30) reported using slightly fewer of these sources than did new clients (2.50) to fund their gambling ($F(1,2144)=4.85$, $p<0.05$). The extent of gambling related debts is reported in Table 59. A Mann-Whitney U test revealed no significant differences in the debt levels of new and re-presenting clients ($U=901123.00$, $Z=-.393$, n.s.).

Table 59 BreakEven Problem Gambler Clients: Total Amount of Gambling Related Debt by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation	
	New Clients	Re-Presenting Clients
Maximum debt	$1,000,000	$2,000,000
75% quartile	$8,000	$12,000
Median debt	$2,750	$3,000
25% quartile	$600	$500
Minimum debt	$0	$0
Mean debt	$13,064	$24,548

9.5 The Impact of Gambling Activity

9.5.1 Presenting Problems

Not surprisingly, gambling behaviour was the most common reason given by problem gamblers for attending BreakEven, irrespective of whether this was a new presentation or re-presentation. Indeed a logistic regression analysis, which is summarised in Table 60, revealed only one difference between new and re-presenting clients in respect of presenting problems. This was that re-presenting clients were 1.37 (1.0–0.73) times more likely to present with family issues than were new clients.

Table 58 BreakEven Problem Gambler Clients: Sources of Funds Used for Gambling by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation			
	New Clients	Re-Presenting Clients		
Sources of Funds	%	%	Odds Ratio	95% Confidence Interval
Budgeted leisure money	44.2	38.9	1.15	0.88–1.52
Deducted from normal household expenditure	81.0	80.9	1.00	0.73–1.36
Savings	47.3	42.0	1.15	0.88–1.50
Asset sales	9.2	7.3	1.11	0.69–1.80
Borrowed money from family and friends	32.5	28.7	1.11	0.84–1.48
Borrowed money from other sources	21.0	20.4	0.92	0.67–1.26
Illegal actions	11.0	8.0	1.40	0.90–2.18
Other	3.8	3.8	1.06	0.56–1.99

Table 60 BreakEven Problem Gambler Clients: Presenting Problem by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation			
	New Clients	Re-Presenting Clients		
Presenting Problem	%	%	Odds Ratio	95% Confidence Interval
Financial issues	56.5	58.0	.87	.67–1.12
Employment and work related issues	23.3	25.1	.84	.64–1.11
Leisure use issues	43.7	38.8	1.29	1.00–1.66
Interpersonal related	49.2	49.7	.98	.76–1.26
Intrapersonal	56.9	52.9	1.24	.96–1.61
Family issues	37.3	42.2	.73	.56–.95
Legal issues	10.1	8.6	1.29	.87–1.94
Physical symptoms	11.4	11.0	1.05	.72–1.53
Gambling behaviour	91.2	88.0	1.40	.97–2.03

Table 61 BreakEven Partner and Other Clients: Presenting Problem by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation			
	New Clients	Re-Presenting Clients		
Presenting Problem	%	%	Odds Ratio	95% Confidence Interval
Financial issues	34.5	23.0	2.78†	1.34–5.79
Employment and work related issues	4.3	11.5	0.37*	0.14–.99
Leisure use issues	3.8	9.8	0.37	0.12–1.11
Interpersonal related	63.5	70.5	0.53	0.28–1.01
Intrapersonal	46.1	42.6	10.28	0.70–2.32
Family issues	48.0	50.8	0.70	0.39–1.24
Legal issues	4.5	6.6	0.60	0.18–1.98
Physical symptoms	4.0	4.9	10.0	0.25–4.08
Gambling behaviour	21.7	24.6	0.76	0.40–1.47

* $p<0.05$

† $p<0.01$

Whether or not clients have attended BreakEven previously they typically present with several problems associated with their gambling. ANOVA revealed that the number of presenting problems was not significantly different between new clients (3.80) and re-presenting clients (3.74) ($F(1,2271)=0.20$, n.s.). As Table 61 shows, logistic regression revealed some differences between new and re-presenting partner and other clients in respect of presenting problems. New clients were 2.78 times more likely to present with financial problems whereas re-presenting clients were 2.70 (1.0/0.37) times more likely to present with employment and work related issues.

Like problem gamblers, there was no difference between new (2.30) and re-presenting (2.44) partners and other clients in respect of the number of presenting problems ($F(1,590)=0.55$, n.s.).

9.5.2 Maladaptive Behaviours

As previously noted in this Report, the client assessment form measures the extent to which gambling has become problematic by using the DSM-IV criteria to measure the type, frequency and intensity of gambling behaviours and their adverse affects, labelled as 'maladaptive behaviours'. Logistic regression was conducted to identify differences between new and re-presenting clients in respect of each of these maladaptive behaviours.

The number of maladaptive behaviours did not differ significantly between new clients (6.21) and re-presenting clients (6.27) ($F(1,1977)=0.19$, n.s.). If five or more of the maladaptive behaviours are present, and no other psychiatric condition is present, an individual meets the DSM-IV criteria to be classified as a pathological gambler. Although the

Table 62 BreakEven Problem Gambler Clients: Maladaptive Behaviours by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation			
	New Clients	Re-Presenting Clients		
Maladaptive behaviour	%	%	Odds Ratio	95% Confidence Interval
Preoccupied with gambling	60.8	57.9	.98	.72–1.32
Needs to gamble increasing amounts of money	54.4	50.0	.92	.68–1.24
Has repeated unsuccessful efforts to control gambling	73.5	81.8	1.83†	1.29–2.60
Is restless or irritable when attempting to cut down	56.2	55.9	.85	.62–1.15
Gambles as a way of escaping	86.4	89.2	1.35	.90–2.03
After losing money, chases losses	81.7	77.9	.72	.51–1.01
Lies to family members, therapist or others	77.7	76.7	.82	.59–1.15
Has committed illegal acts	20.1	20.7	.97	.70–1.34
Has jeopardised relationships, job, education, etc.	58.1	63.5	1.36*	1.01–1.81
Relies on others to provide money	57.9	60.2	1.01	.76–1.35

* p<0.05

† p<0.001

Table 63 BreakEven Problem Gambler Clients: Source of Referral by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation			
	New Clients	Re-Presenting Clients		
Source of Referral	%	%	Odds Ratio	95% Confidence Interval
Self-referral	27.9	47.3	0.57*	0.43–.77
Family or friends	13.7	10.7	10.47	0.99–2.18
Community agency	5.3	8.0	0.80	0.49–1.30
Media	8.7	6.7	10.28	0.80–2.04
Gamblers Anonymous	1.2	0.5	20.29	0.53–9.94
Other client of problem gambling counselling service	0.6	0.5	10.38	0.30–6.35
Problem gambling service staff	0.4	0.8	0.71	0.18–2.74
G-Line	43.1	22.5	20.46*	1.79–3.38
Other therapist	2.4	1.3	20.06	0.79–5.41
Legal service	1.9	1.6	10.43	0.57–3.56
Health service	3.2	3.2	10.25	0.64–2.44
Financial counsellor	1.3	2.4	0.64	0.29–1.44
Court order/correctional system	3.4	2.7	1.58	0.77–3.24
Other	4.5	4.5	1.22	0.68–2.17

• p<0.001

appropriateness of this criteria is open to question (Dickerson et al, 1997), the fact that 76.0 per cent of new, and 66.1 per cent of re-presenting, problem gamblers attending BreakEven report five or more of these behaviours, together with the findings reported in Table 60, suggests gambling has become a highly problematic behaviour by the time clients attend BreakEven.

9.6 Service Activity

9.6.1 Referral Source

The routes by which people get to problem gambling counselling services are quite varied and differ somewhat between new and re-presenting clients. As Table 63 shows, logistic regression revealed that re-presenting clients were 1.75 (1.0/0.57) times more likely to self-refer to BreakEven, whereas new clients

Table 64 BreakEven Partner and Other Clients: Source of Referral by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation			
	New Clients	Re-Presenting Clients		
Source of Referral	%	%	Odds Ratio	95% Confidence Interval
Self-referral	30.1	55.7	0.70	0.29–1.65
Family or friends	23.5	9.8	3.54*	1.19–10.57
Community agency	4.7	3.3	2.02	0.38–10.82
Media	7.3	11.5	0.82	0.30–.2.25
Self-help group	0.4	0.0	1712.00	0.00–>1000
Gamblers Anonymous	0.2	0.0	1.06	0.00–>1000
Other client of problem gambling counselling service	4.3	1.6	3.722	0.42–32.78
Problem gambling service staff	1.3	0.0	1812.67	0.00–>1000
G-Line	29.0	19.7	2.20	0.88–5.49
Other therapist	2.8	0.0	1520.67	0.00–>1000
Legal service	0.4	0.0	1712.00	0.00–>1000
Health service	2.4	4.9	0.81	0.20–3.37
Financial counsellor	0.8	0.0	1364.88	0.00–>1000
Court order/correctional system	0.4	0.0	1712.00	0.00–>1000
Other	3.8	0.0	1619.67	0.00–>1000

* $p<0.05$

were 2.46 times more likely to be referred to BreakEven by G-Line.

Logistic regression revealed that, unlike problem gamblers, self-referrals were similarly likely for new and re-presenting partners and other clients. New clients were 3.54 times more likely to be referred to BreakEven by family or friends, but otherwise the sources of referral were the same for both groups of clients. It is interesting to note that re-presenting partners and others are more likely to cite the media as a source of referral. This may reflect a role for the media, either in the form of advertising for G-line and BreakEven or in news coverage, in reinforcing the counselling service as an option, rather than in giving new information about the service as an option.

9.6.2 Service Inputs

Information about service inputs is collected on the Client Contact Form for each session of counselling attended. These data were available for 2,371 new (1,856 problem gamblers and 514 partners and others) and 422 re-presenting (364 problem gamblers and 58 partners and others) clients. As registration data are collected by some counsellors over the telephone, it is possible for clients to be registered but then never attend for counselling at a BreakEven service. This explains the slight discrepancy between the number of registered clients and the number of clients for whom contact data was available. In this study we will report on the service inputs recorded on the last contact that occurred between 1 August 1997 and 30 June 1998.

On the basis of their professional judgments, along with what is acceptable to clients, BreakEven counsellors may work with individuals (either problem gamblers or others) or with couples or family groups (which may or may not include problem gamblers). Yet, as Table 65 shows, despite the range of interventions available most problem gambler clients are seen on their own irrespective of whether they were new or re-presenting clients ($\chi^2(2)=3.31$, n.s.).

Table 65 BreakEven Problem Gambler Clients: Type of Intervention at Last Contact by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation	
	New Clients	Re-Presenting Clients
Type of Intervention	%	%
Individual	89.0	92.2
Couple	9.8	7.0
Family	1.3	0.8

Perhaps, not surprisingly, partners and other clients are far more likely to be treated as part of a couple or family than are problem gamblers. This is so for both new and re-presenting partners and other clients ($\chi^2(3)=5.06$, n.s.).

Table 66 BreakEven Partner and Other Clients: Type of Intervention at Last Contact by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation	
	New Clients	Re-Presenting Clients
Type of Intervention	%	%
Individual	51.4	63.2
Couple	37.4	28.1
Family	10.9	7.0
Self-help options	0.4	1.8

Problem gamblers who attend for counselling are treated with a variety of techniques by BreakEven counsellors, the most common being supportive counselling or cognitive behavioural approaches. There were no differences in the likelihood of any mode of counselling being used with new clients or re-presenting clients revealed by logistic regression. (See Table 67)

As with problem gamblers, counsellors use a variety of counselling modes to treat partners and other clients. However, logistic regression revealed these methods are used with similar frequency with partners and other clients irrespective of whether they are new or re-presenting clients. (See Table 68)

The use of similar therapeutic approaches with new and re-presenting problem gambler clients is understandable, given that similar issues were being addressed in counselling for both groups. As Table 69 shows, the only difference revealed by logistic regression was that counselling sessions with re-presenters were 1.32 (1.0/0.76) times more likely to address family issues.

As Table 70 shows, logistic regression revealed the focus of the last session to be similar for both new and re-presenting partners and other clients.

In addition to receiving counselling, approximately one-quarter of problem gambler clients were referred elsewhere at their last contact session. There was no difference in the likelihood of being referred between new (25.6 per cent) and re-presenting (23.9 per cent) problem gambler clients ($\chi^2(1)=0.47$, n.s.). New (24.9 per cent) and re-presenting (24.6 per cent) partners and other clients were also similarly likely to be referred elsewhere ($\chi^2(1)=0.00$, n.s.).

Table 67 BreakEven Problem Gambler Clients: Counselling Modes at Last Contact by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation			
	New Clients	Re-Presenting Clients		
Counselling Mode	%	%	Odds Ratio	95% Confidence Interval
Assessment/referral	27.9	22.3	1.29	0.98–1.70
Systemic therapies, structural family therapy, psychodrama, etc.	22.1	23.6	0.87	0.66–1.16
Supportive counselling	67.9	67.9	1.02	0.79–1.31
Psychodynamic therapies	1.7	1.1	1.64	0.57–4.70
Cognitive approaches	35.9	40.9	0.79	0.62–1.00
Other	11.0	14.3	0.75	0.53–1.05

Table 68 BreakEven Partner and Other Clients: Counselling Modes at Last Contact by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation			
	New Clients	Re-Presenting Clients		
Counselling Mode	%	%	Odds Ratio	95% Confidence Interval
Assessment/referral	29.9	32.8	0.82	0.44–1.53
Systemic therapies, structural family therapy, psychodrama, etc.	25.8	31.0	0.73	0.38–1.38
Supportive counselling	68.3	69.0	0.86	0.45–1.61
Psychodynamic therapies	1.6	0.0	121.84	0.00–>1000
Cognitive approaches	21.0	17.2	1.24	0.61–2.54
Other	8.5	8.6	0.91	0.34–2.46

Table 69 BreakEven Problem Gambler Clients: Focus of the Last Contact Session by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation			
	New Clients	Re-Presenting Clients		
Focus of Session	%	%	Odds Ratio	95% Confidence Interval
Financial issues	36.6	31.0	1.27	0.98–1.64
Employment and work related issues	22.4	20.6	1.04	0.77–1.39
Leisure use issues	32.7	32.4	0.93	0.72–1.20
Interpersonal related	49.7	48.9	1.03	0.82–1.30
Intrapersonal	62.0	57.4	1.20	0.95–1.52
Family issues	35.9	40.7	0.76*	0.60–0.97
Legal issues	7.5	7.4	1.03	0.67–1.58
Physical symptoms	7.8	6.9	1.10	0.70–1.73
Gambling behaviour	76.5	72.0	1.21	0.93–1.58

* $p<0.05$

Table 70 BreakEven Partner and Other Clients: Focus of the Last Contact Session by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation			
	New Clients	Re-Presenting Clients		
Focus of Session	%	%	Odds Ratio	95% Confidence Interval
Financial issues	30.9	19.0	2.08	0.98–4.42
Employment and work related issues	8.3	12.1	0.52	0.20–1.38
Leisure use issues	8.3	8.6	0.86	0.29–2.52
Interpersonal related	62.9	53.4	1.39	0.78–2.47
Intrapersonal	53.6	60.3	0.72	0.40–1.28
Family issues	47.2	53.4	0.79	0.45–1.37
Legal issues	6.8	5.2	1.26	0.36–4.38
Physical symptoms	2.7	1.7	1.76	0.21–14.79
Gambling behaviour	28.0	25.9	0.98	0.50–1.93

9.6.3 Service Outcomes

Counselling outcomes were established in respects of each of the client's presenting problems. Table 71 provides details as to the percentage of cases for which a positive outcome was achieved by problem gambler clients. Positive outcomes were those cases rated by counsellors where they believed the presenting problems were at least partially, if not fully, resolved.

Table 71 BreakEven Problem Gambler Clients: Percentage of Positive Outcomes at Last Contact by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation	
Positive Outcome Problem Category	New Clients %	Re-Presenting Clients %
Financial issues	65.9	67.4
Employment and work related issues*	54.5	65.5
Leisure use issues*	64.6	71.3
Interpersonal related†	60.6	69.7
Intrapersonal	69.2	74.1
Family issues*	61.4	68.8
Legal issues	56.1	66.7
Physical symptoms*	59.7	72.4

* $p<0.05$

† $p<0.01$

Interestingly, re-presenting problem gamblers were far more likely to have achieved positive outcomes than were new clients. Issues more likely to be resolved by re-presenters were employment and work related issues ($\chi^2(1)=5.89$, $p<0.05$), leisure use issues ($\chi^2(1)=3.93$, $p<0.05$), interpersonal issues ($\chi^2(1)=8.29$, $p<0.01$), family issues ($\chi^2(1)=4.59$, $p<0.05$) and physical symptoms ($\chi^2(1)=4.98$, $p<0.05$).

While there were fewer problems which had significantly different proportions of positive outcomes between new and re-presenting partners and other clients, where such differences were revealed, for interpersonal ($\chi^2(1)=4.91$, $p<0.05$) and intrapersonal ($\chi^2(1)=4.26$, $p<0.05$) issues, higher resolution rates were reported for re-presenters.

Table 72 BreakEven Partner and Other Clients: Percentage of Positive Outcomes at Last Contact by Type of Presentation, 1 August 1997 to 30 June 1998

	Type of Presentation	
	New Clients	Re-Presenting Clients
Outcome Indicator	%	%
Financial issues	60.2	66.7
Employment and work related issues	51.8	77.8
Leisure use issues	62.2	88.9
Interpersonal related*	53.2	71.8
Intrapersonal*	67.1	82.9
Family issues	57.8	64.5
Legal issues	46.2	75.0
Physical symptoms	67.3	80.9

* $p<0.05$

9.7 Discussion

The data presented in this portion of the study revealed a number of differences between re-presenting and new problem gamblers. However, there was also much in common between these two groups of clients. As such, it is important that counsellors assess each client individually rather than make assumptions about treatment on the basis of whether a client is new or a re-presenter. Interestingly, there were far fewer differences between new and re-presenting partners and other clients.

One set of differences, which cannot be ignored, is the differential rates of positive outcomes between new and re-presenting clients. One possible explanation for these differences in outcome may be that re-presenting clients had already made some progress on problems during a previous presentation, and thus the level of problem severity was lower than for new clients at the time of registration. Another possibility is that re-presenting clients have a greater commitment to the counselling process and work harder to achieve positive outcomes. Further research however is necessary to test the validity of both these propositions.

While this study adds to the relatively small literature on relapse and problem gambling (Brown, 1989), a major shortcoming of this cross-sectional study is the lack of longitudinal data from the re-presenting clients. Thus it is not clear the extent to which differences revealed in this study between new and re-presenting clients are due to the influence of previous episodes of treatment for the latter group, or inherent differences between those who present once only and those who present more often.

10 Discussion and Recommendations

10.1 Caveats and Cautions

Prior to discussion of the key findings, we remind the reader of several interpretation issues relating to the work presented in this Report. The reader is referred to Section 2, in which a detailed discussion of interpretation issues is presented. The highlights of these include:

- That the BreakEven MDS and Counsellor Task Analysis datasets were full population datasets.
- That significant recruitment problems were experienced in the retrospective and prospective client studies.
- That self-reports from both clients and counsellors are a significant component of the data available to the evaluation.

10.2 Summary of Key Findings

10.2.1 The Approach and Model

The conceptual approach taken to this work is outlined in detail in Section 1 of this document. We refer the reader to this discussion. Essentially our model asserts that there are complex linkages between the 'inputs' to problem gambling services and the 'outputs'. In our model the inputs are:

- Characteristics of the intervention.
- Client characteristics.
- Therapist characteristics.
- Service characteristics and design.

The outputs include:

- The degree of resolution of specific problems.
- Behaviour change.
- Attitude change.

We argue that while there has been much study of the relationship between these inputs and outputs that the field as a whole has had several flaws; these include:

- Most of the work has focused on only one or perhaps two input-output pairs.
- Much of it has been performed in other contexts and jurisdictions. We cannot be certain that these apply to the present one.

Our task has been to examine the complex web of inputs and outputs

10.2.2 The Samples

The data used in the following report were drawn from a variety of sources. The BreakEven Minimum Data Set contact forms and a client questionnaire that formed part of the clinical practice evaluation (CPE). The sample of clients reported on using the clinical practice evaluation questionnaire was found to resemble closely the larger sample of BreakEven clients it was drawn from and the BreakEven client population generally.

The following demographic features characterise the group of clients who participated in the clinical practice evaluation:

- Two-thirds (61 per cent) of respondents were over 40.
- Three-quarters were born in Australia.
- Three-quarters (77 per cent) had annual incomes below $31,148.

- The largest occupational grouping was clerical service workers (31.4 per cent).

In terms of gambling activity the analysis of the sample data found that:

- The majority of CPE participants (approximately (70 per cent) gambled on Electronic Gaming Machines (EGMs).
- The median number of hours spent by clients per episode was three hours.
- The median amount of dollars spent per episodes was reported as $100.
- The median number of episodes per month was eight episodes.

This pattern closely resembled that of the sample population in the MDS 'problem gambler' population generally. Thus the study sample is considered to be representative of the client population. Because of the availability of the MDS population data, we are able to make this statement with considerable authority.

10.2.3 Outcomes

In exploring the outcomes as reported by the clients participating in the clinical practice evaluation the following findings emerged. There was a high level of positive—partial, full or satisfactory—resolution in all defined problem areas. In assessing the outcome of clients' gambling behaviours, 43 per cent had full or satisfactory resolution levels and 46 per cent experienced partial problem resolution. Clients experienced the highest level of full problem resolution in relationship problems and problems with their physical health caused by their gambling activity.

Almost three-quarters (71 per cent) of clients felt that attending counselling at a BreakEven service impacted on their gambling activity in a significantly positive way, with 45 per cent of these marking the impact as 'a great deal'. The impact of counselling on respondents' gambling is further explained by two-thirds of respondents saying they gambled a lot less after attending BreakEven counselling.

The impact of counselling and its outcomes on clients' emotional well-being was sizeable, with respondents recording a shift from majority (69 per cent) being 'very poor' at the commencement of counselling to the majority being 'very good' (78 per cent) at the end of the counselling. Clients' level of understanding the nature of the problem, self-awareness, ability to accept responsibility for the problems their gambling had created and their awareness of services available to assist them were all improved as the result of counselling. This indicates a counselling process producing an effect of heightened understanding as well as problem resolution.

The number and severity of maladaptive behaviours was also taken as a measure of counselling outcomes. Pre- and post-counselling measures of maladaptive behaviours indicated counselling has a positive effect, of between 21–29 per cent improvement on clients in eight of the ten behaviours listed. This measure is used to indicate the severity of an individual's gambling problem with those recording five or more maladaptive behaviours being considered 'pathological' gamblers. In a pre- and post-counselling measure of clients participating in the clinical practice evaluation, the number of 'problem gamblers' reduced from 76 per cent to 37 per cent.

Service satisfaction was also used by the team to indicate successful outcome. The level of service satisfaction expressed by participants in the clinical practice evaluation was high. On the whole clients were very satisfied with the counsellors' treatment of them and were satisfied with the outcomes they received as a result of counselling. The large majority of clients indicated they would use the service again and that they would recommend it to others with gambling related problems.

A small group of clients (n=16) participated in a longitudinal study of outcomes. These clients were provided with a questionnaire at the end of their first counselling session and another, three months following completion of their counselling. The key findings of this study were:

- The level of unresolved problems after three months was uniformly reduced in all problem areas.
- The number of partially resolved problems reduced in all categories, except in the area of gambling behaviour and financial problems.
- The number of problems fully resolved after the three-month period were greatest in the categories financial problems, legal problems and gambling behaviour.
- The number of problems fixed to the client's satisfaction increased overall with the greatest increase in the area of family related problems.
- In short, there was a decrease in the number of unresolved or partially resolved problems, and an

increase in the fully resolved and satisfactory resolutions.

- The psychosocial well-being of clients improved during the three-month study period with an average shift from fairly poor to quite good as rated by the clients.
- The mean number of maladaptive behaviours experienced by the clients in the three-month period being studied went from 5.4 behaviours to 3.3 behaviours.
- There was a reduction in the extent to which participants felt their gambling was a problem, from a fair amount to very little.
- Clients' level of satisfaction with the service did not change across the three-month period, even though their problems improved.

We nevertheless note that because of the small sample size in this study, the above conclusions need to be treated with some caution. However, as discussed in Section 2, several of the other datasets reported in this document are full population or census datasets in which strong confidence can be rested.

The BreakEven Minimum Data Set also provides information on the outcomes of sessions. The key findings from the MDS contact data was that the level of problem resolution is higher for problem gamblers in cases where no further contact has been planned, that is, where the counsellor has terminated the counselling.

10.2.4 Counselling Outcomes and the Counselling Process

The evaluation of the effectiveness of BreakEven counselling services had two major purposes. The first, to provide a description of the outcomes being achieved by the service with its clients. The second, to explore the way these treatment outcomes were being achieved. Given this brief, it was essential that a thorough investigation of the linkages between counselling outcomes and the counselling process be undertaken as part of the study. The following section lists the key findings from the clients who participated in the clinical practice evaluation.

- The therapeutic relationship is the process variable that can most consistently predict positive outcome.
- Counsellors with the highest rates of problem resolution are using a mix of client centred humanistic psychology, cognitive behaviour therapy techniques, and solution focused counselling.
- A thorough psychosocial, and readiness to change assessment of the client is a feature of the work of all counsellors achieving high levels of problem resolution.
- Client participation in goal setting, and a realistic, timely and achievable set of goals characterise the goal setting of all counsellors achieving high levels of problem resolution.
- Counsellors achieving high levels of problem resolution use an eclectic mix of techniques in their work with clients. Decisions regarding which techniques to use are based on their initial assessment and goals as defined with the client. No particular technique stands out as the most valued or valuable.
- The review processes used by the counsellors vary. All counsellors achieving high levels of resolution, however, indicated the importance of celebrating client achievements, no matter how small.
- All counsellors considered a strong therapeutic relationship to be essential in achieving positive outcomes. They describe this as the basis from which the work becomes possible.
- Counsellors considered the counselling effort needed to be considered a collaborative effort for it to work.
- The active ingredients for successful outcomes according to counsellors are a strong therapeutic relationship, client readiness to change, client ability to self-reflect and finding the right fit between the client and the intervention.
- Conversely, the factors counsellors considered hindered the achievement of these outcomes were: lack of relationship, lack of motivation on behalf of client, lack of alternative forms of leisure, co-morbidities, client unwillingness to disclose, and when gambling has become a central part of a persons self-definition.

10.3 Minimum Data Set Outcome/Process Links

These linkages were also explored using the Minimum Data Set contact data. The following findings emerged:

- Level of problem resolution is related to the number of session attended. The more sessions

attended the more likely that the problem would be partially or fully resolved.

- The findings seem to indicate a relatively high level of problem resolution, even though the actual number of sessions attended is relatively low.

10.3.1 Outcomes and Client Characteristics

A number of client characteristics were tested for their impact on counselling outcomes as reported by participants in the clinical practice evaluation. The following provides a summary of the key findings. Very few client characteristics had statistically significant impact on counselling outcomes. This finding is consistent with current psychotherapy and counselling outcome literature (Bergin and Garfield, 1994).

Clients' satisfaction with their current level of gambling was the variable most consistently related to level of problem resolution. The number of presenting problems was related to a problem being unresolved or partially resolved. Older clients were less satisfied with their counselling outcomes. Clients in the *action stage* of readiness to change, at the end of the first counselling session, are more likely to resolve problems, increase life skills, and have a greater level of satisfaction with the outcomes of counselling. The level of an individual's debt does not impact in any significant way the level of problem resolution they achieve.

The linkage between client characteristics and outcomes was also tested using the Minimum Data Set for all BreakEven clients. The following findings were significant. Two-thirds of BreakEven clients who attended the service with gambling behaviour as their presenting problem, have a positive resolution of their problems by the time of case closure. Only age, annual income and living arrangement could discriminate between levels of problem resolution. Other demographic and gambling behaviour variables did not predict level of problem resolution. The outcomes achieved are not predicted by whether the client was a 'problem gambler' or 'partner and/or other'.

10.3.2 Outcomes and Counsellor Characteristics

A number of counsellor characteristics were tested for their relationship to client outcomes with clients participating in the clinical practice evaluation. The following were the key findings from this analysis. Women counsellors have lower levels of unresolved problems. Counsellors with high caseloads, measured by number of client contacts, have higher levels of client satisfaction with outcomes. Counsellors who were not social workers or psychologists achieved the greatest number of full resolutions, but this could be an artefact of the rural–metropolitan division of services, as most of these counsellors are employed in rural areas (see below). Clients of psychologists and 'others' had higher levels of client satisfaction with the outcome of counselling.

Counsellor characteristics were also tested against outcomes as defined by the Minimum Data Set. For these clients, outcomes are on the whole unrelated to the particular breakdown of tasks that constitute their practice, as measured by the Counsellor Task Analysis (CTA). Counsellor characteristics are, on the whole, not predictive of client outcomes. This finding is consistent with current research in psychotherapy and counselling outcomes (Bergin and Garfield, 1994).

10.3.3 Outcomes and Agency Characteristics

A number of agency characteristics were explored for their impact on the outcomes achieved by clients participating in the clinical practice evaluation and via the Minimum Data Set. For clients participating in the clinical practice evaluation the following findings emerged from the analysis. Clients from non-metropolitan centres were more satisfied with the outcomes of counselling and reported a greater impact of counselling on their gambling behaviour.

The analysis of the Minimum Data Set showed that agency type impacts on the outcomes achieved by clients in respect to all outcome areas except gambling behaviour. Consistent with the clinical practice evaluation findings the location of the agency impacted on outcomes, with country clients experiencing higher levels of problem resolution. The MDS analysis also indicated that agency type is related to outcomes by this finding is most probably an artefact of the fact that a number of agency types are only found in the country. The size of the BreakEven service and its level of funding did not impact on outcomes achieved.

10.3.4 Client Comments

As part of the clinical practice evaluation clients were asked to list the factors they found most helpful and most unhelpful about BreakEven services, and to make any other comments they wanted to. The following were the key themes that emerged from the analysis of these responses.

Clients experienced the service as particularly useful in the following ways:

- The ability to talk to someone who understood the nature of the problem and didn't judge them.
- That they could have confidence in the counsellors' concern for them.
- It provided them with a way to explore reasons for their behaviour.
- They felt confident of the counsellors' knowledge and professionalism.

Clients' major dissatisfaction with the service was clearly the lack of after-hours session times available.

Most clients who participating in the clinical practice evaluation considered attending counselling at a BreakEven services as a life changing experience, and considered it an essential service for them in a time of great crisis.

The counselling currently provided by BreakEven counsellors to clients of the service is producing successful outcomes that are consistent with other gambling treatment programs throughout the world.

The effectiveness of the service is not diminished by the often small number of sessions attended by clients, although there is evidence to suggest that the longer clients stay in counselling, positive outcomes are likely to be enhanced.

Clients who attend the service have often made repeated unsuccessful attempts to solve their problems themselves. The service is used when they can no longer manage the matter themselves.

Clients overwhelmingly identified the most helpful aspect of the service as being the level of knowledge counsellors had about the problem and the non-judgmental way in which counsellors provided their services.

Counsellors achieving the highest levels of problem resolution all worked collaboratively with clients to identify goals that were realistic and achievable. Their work was also characterised by regular review and recognition of client achievements.

10.4 Recommendations

10.4.1 Service Provision

- Extension of service delivery hours to include after-hours session times for service users.
- Development of a more uniform counselling review process negotiated with clients and aimed at documenting gains made by clients during their time in counselling.
- Continued employment of a mix of practitioners in the field.
- Continue the mix of service delivery personnel in rural areas.
- The maintenance of an approach to counselling that makes central collaboration between client and counsellor in defining outcomes for the individual client. This approach is consistent with the principles of harm minimisation as the guide for treatment rather than abstinence.
- The establishment of regular seminars for BreakEven workers where up-to-date information on research and treatment techniques can be shared.

10.4.2 Research

We tender the following recommendations in the area of research:

- The present requirements for third party recruitment of participants into research and evaluation projects should be altered. This could be achieved by notification of clients at the outset of their service engagement of opportunities for participation in research and evaluation activities.
- A large-scale, prospective, randomised control study of intervention effectiveness should be conducted.
- To integrate into the current Minimum Data Set more precise questions on gambling related spending and debt and to develop the questions on changes to gambling behaviour as a form of outcome.
- Research into the relationship between amount of play and negative impacts (a dose-impact relationship). This research would make a significant contribution to the design of education around the point where gambling becomes harmful.
- There should be a properly managed system for the dissemination of research information to BreakEven workers, enabling them to maintain their knowledge of research findings.

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Appendix A: Clinical Practice Evaluation Client Questionnaire—Retrospective Sample

University of Melbourne Problem Gambling Research Program
Clinical Practice Evaluation: Retrospective Study

Questionnaire for Break Even Clients

[Please complete the questionnaire and return in the envelope supplied.]
[The questionnaire should take about 20 minutes to complete]

Questionnaire identification number

☐☐☐☐☐☐☐☐☐

(Today's Date)

☐☐☐☐☐**1**☐**9**☐**9**☐

1) How did you initially find out about Break Even? ***(Please tick the appropriate box.)***

G–Line	❑		
		↳ **How did you find out about G-Line?**	
Family or Friends.	❑	Family or Friends.	❑
Other crisis service (lifeline, crisis line).	❑	Other crisis service (lifeline, crisis line).	❑
TV ads.	❑	TV ads.	❑
Radio ads.	❑	Radio ads.	❑
Newspaper ads.	❑	Newspaper ads.	❑
Telephone Book.	❑	Telephone Book.	❑
Other professional (eg. G.P., therapist/ counsellor/social worker, church leader)	❑	Other professional (eg. G.P., therapist/ counsellor/social worker, church leader)	❑
Financial Counsellor	❑	Financial Counsellor	❑
Advertising at a gambling venue.	❑	Advertising at a gambling venue.	❑
News Story (television, radio, newspaper, magazine).	❑	News Story (television, radio, newspaper, magazine).	❑

2) How would you describe your emotional state *prior* to counselling? ***(Please circle)***

Very poor Fairly poor So-so Quite good Very good

3) How would you describe the state of your relationships *prior* to counselling? *(Please circle)*

Very poor | Fairly poor | So-so | Quite good | Very good

4) How would you describe the state of your financial position *prior* to counselling? *(Please circle)*

Very poor | Fairly poor | So-so | Quite good | Very good

5) How would you describe the state of your work life *prior* to counselling? *(Please circle)*

Very poor | Fairly poor | So-so | Quite good | Very good

6) To what extent was your gambling a problem *prior* to counselling? *(Please circle)*

A great deal | A fair amount | Somewhat | Very little | Not at all

7) What services, if any, had you attended *prior* to Break Even to discuss the problems you were experiencing with your gambling? *(Please list in order of attendance if possible)*

Services	**List in order of attendance (ie. 1st, 2nd etc)**
Doctor (G.P.)	[ ]
Community Health Centre	[ ]
Life Line/Crisis Line	[ ]
Gamblers Anonymous (G.A.)	[ ]
Other Self Help Groups	[ ]
Therapist (non Break Even)	[ ]
Legal Service	[ ]
Financial Counsellor	[ ]
Other *(please describe)*	

_____

_____

8) Why did you decide to attend a Break Even service? Please select the reason that best describes your situation. *(Tick the most appropriate box/es.)*

a) ❑ To change my *gambling behaviour only*.

b) ❑ To change my *gambling behaviour because it was causing other problems*, such as:

- ❑ financial distress
- ❑ relationship problems
- ❑ family problems
- ❑ physical symptoms
- ❑ employment/work related problems
- ❑ anxiety or problematic changes in mood

c) ❑ To fix the other problems I was facing as a result of my gambling, *not my gambling behaviour*. Such as:

- ❑ financial distress
- ❑ relationship problems
- ❑ family problems
- ❑ physical symptoms
- ❑]employment/work related problems
- ❑ anxiety or problematic changes in mood

9) Are you presently gambling? *(Please circle)*

[YES] [NO]

10) How does your current gambling compare to your gambling activity *prior* to attending Break Even? *(Please circle)*

A lot more | A bit more | Same amount | A bit less | A lot less

11) How do you feel about your current level of gambling? *(Please circle)*

Very dissatisfied | Dissatisfied | Neither satisfied or dissatisfied | Satisfied | Very satisfied

12) To what extent did attending Break Even have an impact on your gambling? *(Please circle)*

A great deal | A fair amount | Somewhat | Very little | Not at all

13) In your opinion which of the following statements currently apply to you? (*Please tick the appropriate box)*

Statement	**YES**	**NO**
1) I am preoccupied with gambling [this could include preoccupation with reliving past gambling experiences, handicapping or planning the next venture or thinking of ways to get money with which to gamble]	❑	❑
2) I need to gamble with increasing amounts of money in order to achieve the desired excitement.	❑	❑
3) I have repeated unsuccessful efforts to control, cut back or stop gambling.	❑	❑
4) I am restless or irritable when attempting to cut down or stop gambling.	❑	❑
5) I gamble as a way of escaping from problems or of relieving feelings of helplessness, guilt, anxiety or depression.	❑	❑
6) After losing money gambling, I often return another day to get even.	❑	❑
7) I lie to family members, therapists or others to conceal the extent of my involvement with gambling.	❑	❑
8) I have committed illegal acts such as forgery, fraud, theft or embezzlement to finance gambling.	❑	❑
9) I have jeopardised or lost a significant relationship, job, or educational or career opportunity because of gambling.	❑	❑
10) I rely on others to provide money to relieve a desperate financial situation caused by gambling.	❑	❑

The urge to gamble

The following statements describe situations in which people sometimes experience an urge to gamble.

14) Imagine yourself in each of the following situations and then indicate on the scale how likely it is that you would gamble. *Circle the response that best describes your situation.*

Statement	**Definitely would not gamble**	**Probably would not gamble**	**Probably would gamble**	**Definitely would gamble**
When I feel lonely.	1	2	3	4
When I feel everything is going badly for me.	1	2	3	4
When something good happens and I need to celebrate.	1	2	3	4
When I am having problems at work.	1	2	3	4
When I want to celebrate a special occasion.	1	2	3	4
When I feel depressed.	1	2	3	4
When I begin to feel fed up with life	1	2	3	4
When I see or hear advertisements for gambling activities or venues.	1	2	3	4

When I am out and one of my friends starts to gamble.	1	2	3	4
When I need money.	1	2	3	4
When I feel tense and anxious.	1	2	3	4
When there is conflict in my home life.	1	2	3	4
When I am feeling bored.	1	2	3	4
When I am invited out to a venue where you can gamble.	1	2	3	4
When I want to feel sexy and glamourous.	1	2	3	4
To test my willpower by showing I could stop after a few plays.	1	2	3	4
When I am doing something I was in the habit of doing when I gambled	1	2	3	4
Answering questions relating to my gambling.	1	2	3	4

15) What did you hope to achieve when you first attended the Break Even service? ***(Please tick the appropriate box.)***

- ❑ To give up gambling.
- ❑ To control my gambling.
- ❑ To fix my relationship problems.
- ❑ To deal with my financial crisis.
- ❑ To talk to someone about what was happening in my life.
- ❑ To understand the reasons behind my feelings and behaviour.
- ❑ To identify what my problems were.
- ❑ To work out how to change the problems facing me.
- ❑ Other *(Please Describe)*

_____

_____

16) To what extent were your expectations changed as a result of counselling? ***(Please circle)***

Entirely different Significantly different Moderately different A little different Remained the same

17) To what extent were your expectations met as a result of counselling?

Completely As much as I needed Mostly Partially Not at all

18) At the end of counselling to what extent had your problems been resolved? ***(Please circle the most appropriate answer. Answer for all the areas that were affected by counselling even if it wasn't the focus of the counselling.)***

Problem Area	**Got Worse**	**Not Resolved**	**Partially Resolved**	**Fully Resolved**	**Fixed to my Satisfaction**
Gambling behaviour	1	2	3	4	5
Financial issues	1	2	3	4	5
Family relationship issues	1	2	3	4	5
Relationship issues with Others	1	2	3	4	5
Employment & work related issues	1	2	3	4	5
Physical health issues (headaches, backache, RSI, sleeplessness, drug taking)	1	2	3	4	5
Leisure use issues (loneliness, boredom)	1	2	3	4	5
Intrapersonal issues (mood swings, depression, anxiety, stress, self esteem)	1	2	3	4	5
Legal issues	1	2	3	4	5

19) Have you sought any assistance, from non Break Even services, for your unresolved problems? ***(Please Circle)***

[YES] [NO]

(a) If yes: where from?

(b) If no: why not?

20) In what ways did Break Even counselling impact on other aspects of your life? ***(Tick the appropriate box.)***

Aspects of Life	**Got Better**	**No Change**	**Got Worse**
1) Self awareness	❑	❑	❑
2) Understanding the nature of problem gambling behaviour	❑	❑	❑
3) Ability to accept responsibility for the problems my gambling caused.	❑	❑	❑
4) Ability to communicate with others close to me	❑	❑	❑
5) Ability to cope with stress	❑	❑	❑
6) Self-esteem	❑	❑	❑
7) Self-confidence	❑	❑	❑
8) Ability to talk to others about sensitive issues	❑	❑	❑
9) Knowledge of services available that can assist people with gambling related problems.	❑	❑	❑
Other (Please describe):			

_____

_____

21) How would you describe your emotional state after counselling? ***(Please Circle)***

Very poor Fairly poor So-so Quite good Very good

Your experience of the counselling process

The following questions relate to your experience of the counsellor and counselling process. Please circle the answer that best describes your experience. Remember your answers are anonymous and will not be seen by any Break Even worker.

22) To what extent did you feel ready to change your problem when you started counselling?

A great deal A fair amount Somewhat Very little Not at all

23) To what extent did you feel you could talk freely, openly and honestly with the counsellor about your thoughts, feelings and behaviour?

A great deal A fair amount Somewhat Very little Not at all

24) To what extent did you feel the counsellor understood the problems facing you?

A great deal A fair amount Somewhat Very little Not at all

25) To what extent did you feel the counsellor was concerned for your welfare?

A great deal A fair amount Somewhat Very little Not at all

26) To what extent did you feel the counsellor respected you as an individual?

A great deal A fair amount Somewhat Very little Not at all

27) To what extent did you feel confident in the counsellors ability to assist you with your problems?

A great deal A fair amount Somewhat Very little Not at all

28) To what extent did you feel the counsellor had enough knowledge to assist you with your problem?

A great deal A fair amount Somewhat Very little Not at all

29) To what extent did you feel supported by the counsellor?

A great deal A fair amount Somewhat Very little Not at all

30) To what extent did you feel clear about your role in the counselling process?

A great deal A fair amount Somewhat Very little Not at all

31) To what extent did you feel clear about the counsellors role in the counselling process?

A great deal A fair amount Somewhat Very little Not at all

32) To what extent did you feel clear about the purpose of the counselling sessions?

A great deal A fair amount Somewhat Very little Not at all

33) To what extent did you feel you and the counsellor shared an understanding of the purpose of counselling?

A great deal A fair amount Somewhat Very little Not at all

34) To what extent did you feel what you did in counselling sessions directly addressed the problems you had?

A great deal A fair amount Somewhat Very little Not at all

35) Prior to attending counselling to what extent did you feel confident that the counselling process could help you?

A great deal A fair amount Somewhat Very little Not at all

36) To what extent did you and your counsellor collaborate on setting goals for your counselling?

A great deal A fair amount Somewhat Very little Not at all

37) To what extent did you and your counsellor agree upon the goals and tasks for each session?

A great deal A fair amount Somewhat Very little Not at all

38) To what extent were clear goals set for the counselling?

A great deal A fair amount Somewhat Very little Not at all

39) To what extent did you feel you achieved the goals set for the counselling?

A great deal A fair amount Somewhat Very little Not at all

40) To what extent did you feel you and the counsellor shared a common view about the cause of your problem?

A great deal A fair amount Somewhat Very little Not at all

41) To what extent did you feel ready to accept the ideas that the counsellor put forward to you?

A great deal A fair amount Somewhat Very little Not at all

42) To what extent do you feel the sessions helped to clarify how you could change things?

A great deal A fair amount Somewhat Very little Not at all

43) To what extent did your work in counselling give you new ways of looking at your problems?

A great deal A fair amount Somewhat Very little Not at all

44) To what extent did your work in counselling give you an understanding of the kind of changes that would be good for you?

A great deal | A fair amount | Somewhat | Very little | Not at all

45) To what extent did the things you did in counselling help you accomplish the changes you wanted?

A great deal | A fair amount | Somewhat | Very little | Not at all

46) To what extent did attending counselling result in you realising things about yourself that you did not realise before?

A great deal | A fair amount | Somewhat | Very little | Not at all

Your level of satisfaction with the counselling service

47) Please note your level of satisfaction with the following aspects of the counselling service offered by Break Even. ***(Please circle the number that best describes your level of satisfaction.)***

How satisfied were you with:	**Very Satisfied**	**Satisfied**	**Neither Satisfied or Dissatisfied**	**Dissatisfied**	**Very Dissatisfied**
The amount of time between contacting the service and being able to see a counsellor.	1	2	3	4	5
The amount of time the counsellor spent with you.	1	2	3	4	5
The counsellor's treatment of your problem/s.	1	2	3	4	5
The counsellor's ability to listen to your problems.	1	2	3	4	5
The counsellor's willingness to answer your questions.	1	2	3	4	5
The counsellor's knowledge about the problems facing you.	1	2	3	4	5
The counsellor's ability to help you with your problems.	1	2	3	4	5
The way the counsellor focussed on the issues you presented to him/her.	1	2	3	4	5
The outcomes you achieved as the result of attending counselling?	1	2	3	4	5

48) Overall how satisfied were you with your counselling experience?

Very dissatisfied | Dissatisfied | Neither satisfied or dissatisfied | Satisfied | Very satisfied

49) Would you use Break Even again if you had similar problems? ***(Please circle)***

[YES] [NO] [UNSURE]

50) Would you recommend Break Even to others? ***(Please circle)***

[YES] [NO] [UNSURE]

51) How long is it since you received counselling? ***(please put a number in the appropriate box)***

Days [ ]
Months [ ]
Years [ ]

52) Why did you stop attending counselling? ***(please tick one box)***

- ❑ I still attend counselling when I need to.
- ❑ Problem/s resolved.
- ❑ Problem/s more manageable.
- ❑ Felt further counselling wouldn't help.
- ❑ Didn't like the counsellor.
- ❑ Counsellor thought I was ready to stop.
- ❑ Counsellor left.
- ❑ I didn't think the counselling I received was adequate.
- ❑ I am having a break to see how things go.

Other (please describe)

_____

_____

53) What did you find particularly helpful/unhelpful about the Break Even Counselling?

Helpful

_____

_____

Unhelpful

_____

_____

54) Any other comments you would like to make about the Break Even Service.

_____

_____

Thank you for your assistance in completing this questionnaire.

Please return it and your informed consent form in the postage paid envelope provided.

Appendix B: Clinical Practice Evaluation Client Questionnaire—Prospective 'Problem Gambler' Sample

University of Melbourne Problem Gambling Research Program
Clinical Practice Evaluation: Prospective Study

Client Questionnaire

[Please complete the questionnaire and return in the envelop supplied.]
[The questionnaire should take about 25 minutes to complete]

Questionnaire identification number

☐☐☐☐☐☐☐☐☐

[to be completed by the counsellor]

(Today's Date)

☐☐☐☐☐**1**☐**9**☐**9**☐

1) How did you initially find out about Break Even? ***(Please tick the appropriate box.)***

G–Line	❑		
		↳ **How did you find out about G-Line?**	
Family or Friends.	❑	Family or Friends.	❑
Other crisis service (lifeline, crisis line).	❑	Other crisis service (lifeline, crisis line).	❑
TV ads.	❑	TV ads.	❑
Radio ads.	❑	Radio ads.	❑
Newspaper ads.	❑	Newspaper ads.	❑
Telephone Book.	❑	Telephone Book.	❑
Other professional (eg. G.P., therapist/ counsellor/social worker, church leader)	❑	Other professional (eg. G.P., therapist/ counsellor/social worker, church leader)	❑
Financial Counsellor	❑	Financial Counsellor	❑
Advertising at a gambling venue.	❑	Advertising at a gambling venue.	❑
News Story (television, radio, newspaper, magazine).	❑	News Story (television, radio, newspaper, magazine).	❑

2) How would you describe your emotional state *prior* to counselling? ***(Please circle)***

Very poor Fairly poor So-so Quite good Very good

3) How would you describe the state of your relationships prior to counselling? (Please circle)

Very poor Fairly poor So-so Quite good Very good

4) How would you describe the state of your financial position *prior* to counselling? *(Please circle)*

Very poor Fairly poor So-so Quite good Very good

5) How would you describe the state of your work life *prior* to counselling? *(Please circle)*

Very poor Fairly poor So-so Quite good Very good

6) To what extent is your current gambling activity a problem? *(Please circle)*

A great deal A fair amount Somewhat Very little Not at all

7) How do you feel about your current level of gambling? *(Please circle)*

Very dissatisfied Dissatisfied Neither satisfied or dissatisfied Satisfied Very satisfied

8) What services, if any, had you attended prior to Break Even to discuss the problems you were experiencing related to your gambling? *(Please list in order of attendance if possible)*

Services	**List in order of attendance (ie. 1st, 2nd etc)**
Doctor (G.P.)	[ ]
Community Health Centre	[ ]
Life Line/Crisis Line	[ ]
Gamblers Anonymous (G.A.)	[ ]
Other Self Help Groups	[ ]
Therapist (non Break Even)	[ ]
Legal Service	[ ]
Financial Counsellor	[ ]
Other *(please describe)*	

_____

_____

9) Why did you decide to attend a Break Even service? Please select the reason that best describes your situation. *(Tick the most appropriate box/es)*

a) ❑ To change my *gambling behaviour*.

b) ❑ To change my *gambling behaviour because it was causing other problems*, such as:

- ❑ financial distress
- ❑ relationship problems
- ❑ family problems
- ❑ physical symptoms
- ❑ employment/work related problems
- ❑ anxiety or problematic changes in mood

c) ❑ To fix the other problems I was facing as a result of my gambling, *not my gambling behaviour*. Such as.

- ❑ financial distress
- ❑ relationship problems
- ❑ family problems
- ❑ physical symptoms
- ❑ employment/work related problems
- ❑ anxiety or problematic changes in mood

The following questions are designed to establish how you feel about your gambling right now. Please read each of the questions and decide whether you agree or disagree with the statements and circle the answer that best reflects your feelings.

10) I don't think I gamble too much.

Strongly Disagree Disagree Unsure Agree Strongly Agree

11) I am trying to gamble less than I used to.

Strongly Disagree Disagree Unsure Agree Strongly Agree

12) I enjoy my gambling, but sometimes I gamble too much.

Strongly Disagree Disagree Unsure Agree Strongly Agree

13) Sometimes I think I should cut down on my gambling.

Strongly Disagree Disagree Unsure Agree Strongly Agree

14) It's a waste of time thinking about my gambling.

Strongly Disagree Disagree Unsure Agree Strongly Agree

15) I have just recently changed my gambling habits.

Strongly Disagree Disagree Unsure Agree Strongly Agree

16) Anyone can talk about wanting to so something about gambling, but I am actually doing something about it.

Strongly Disagree Disagree Unsure Agree Strongly Agree

17) I am at the stage where I should think about gambling less.

Strongly Disagree Disagree Unsure Agree Strongly Agree

18) My gambling is a problem sometimes.

Strongly Disagree Disagree Unsure Agree Strongly Agree

19) There is no need for me to think about changing my gambling.

Strongly Disagree Disagree Unsure Agree Strongly Agree

20) I am actually changing my gambling habits right now.

Strongly Disagree Disagree Unsure Agree Strongly Agree

21) Gambling less would be pointless for me.

Strongly Disagree Disagree Unsure Agree Strongly Agree

The impact of gambling

The following questions try to capture and assess something of the impact of gambling on people's lives, both in terms of the problems it can cause and the distress it can cause.

We all know that when people gamble too much they run the risk of developing various problems. Unfortunately, an individual's gambling often causes problems for other people as well - especially that person's family and close friends.

22) Over the last month, to the best of your knowledge, have *other family members* experienced or feared *any of the following problems* as a result of your gambling?

Problems	Never	Not Often	Occa-sionally	Often	Always	Don't Know
Money for household running costs (eg food, rent, bills) spent on gambling	1	2	3	4	5	6
Money set aside for special family projects (eg major acquisitions, holidays) spent on gambling	1	2	3	4	5	6
Asking other family members or friends for loans of money	1	2	3	4	5	6
Household objects sold or pawned to pay gambling debts	1	2	3	4	5	6
Working (more) to overcome losses from gambling	1	2	3	4	5	6
Harassment by creditors or loan sharks	1	2	3	4	5	6
Involvement in legal processes (dealing with police, solicitors, barristers, court cases etc)	1	2	3	4	5	6
Eviction/homelessness	1	2	3	4	5	6
Considered moving to a new location to make a new start without gambling	1	2	3	4	5	6
Withdrawing from social contact with family or friends to avoid embarrassment	1	2	3	4	5	6
Loneliness	1	2	3	4	5	6
Being lied to or not told the whole truth (keeping secrets) by the gambler	1	2	3	4	5	6
Inability to trust the gambler	1	2	3	4	5	6
Arguments	1	2	3	4	5	6
Marital difficulties	1	2	3	4	5	6
An unsatisfactory sex life	1	2	3	4	5	6
Gambler is not capable of being a good parent	1	2	3	4	5	6
Negative impact on children's performance at school	1	2	3	4	5	6
Illness or other physical health problems	1	2	3	4	5	6
Depression (including suicidal thoughts or attempts)	1	2	3	4	5	6
Anxiety	1	2	3	4	5	6
Irritability (feeling edgy or cross)	1	2	3	4	5	6
Anger (feeling outraged, having angry outbursts)	1	2	3	4	5	6
Neglect (feeling neglected by the gambler)	1	2	3	4	5	6
Physical abuse	1	2	3	4	5	6
Verbal abuse	1	2	3	4	5	6

It is unlikely that all of the problems you have identified will effect you (or other family members) to the same extent. Some may cause extreme distress whereas others may cause little or no stress.

23) Over the last month, to the best of your knowledge, *how much distress* has each of the problems listed below caused other family members?

Problems	No Distress	Low Distress	Moderate Distress	High Distress	Extreme Distress	Don't Know
Money for household running costs (eg food, rent, bills) spent on gambling	1	2	3	4	5	6
Money set aside for special family projects (eg major acquisitions, holidays) spent on gambling	1	2	3	4	5	6

Problems	No Distress	Low Distress	Moderate Distress	High Distress	Extreme Distress	Don't Know
Asking other family members or friends for loans of money	1	2	3	4	5	6
Household objects sold or pawned to pay gambling debts	1	2	3	4	5	6
Working (more) to overcome losses from gambling	1	2	3	4	5	6
Harassment by creditors or loan sharks	1	2	3	4	5	6
Involvement in legal processes (dealing with police, solicitors, barristers, court cases etc)	1	2	3	4	5	6
Eviction/homelessness	1	2	3	4	5	6
Considered moving to a new location to make a new start without gambling	1	2	3	4	5	6
Withdrawing from social contact with family or friends to avoid embarrassment	1	2	3	4	5	6
Loneliness	1	2	3	4	5	6
Being lied to or not told the whole truth (keeping secrets) by the gambler	1	2	3	4	5	6
Inability to trust the gambler	1	2	3	4	5	6
Arguments	1	2	3	4	5	6
Marital difficulties	1	2	3	4	5	6
An unsatisfactory sex life	1	2	3	4	5	6
Gambler is not capable of being a good parent	1	2	3	4	5	6
Negative impact on children's performance at school	1	2	3	4	5	6
Illness or other physical health problems	1	2	3	4	5	6
Depression (including suicidal thoughts or attempts)	1	2	3	4	5	6
Anxiety	1	2	3	4	5	6
Irritability (feeling edgy or cross)	1	2	3	4	5	6
Anger (feeling outraged, having angry outbursts)	1	2	3	4	5	6
Neglect (feeling neglected by the gambler)	1	2	3	4	5	6
Physical abuse	1	2	3	4	5	6
Verbal abuse	1	2	3	4	5	6

24) What did you hope to achieve when you first attended the Break Even service? *(Please tick the appropriate box/es.)*

- ❑ To give up gambling.
- ❑ To control my gambling.
- ❑ To fix my relationship problems.
- ❑ To deal with my financial crisis.
- ❑ To talk to someone about what was happening in my life.
- ❑ To understand the reasons behind my feelings and behaviour.
- ❑ To identify what my problems were.
- ❑ To work out how to change the problems facing me.

Other (Please Describe)

25) In your opinion which of the following statements currently apply to you? ***(Please tick the appropriate box)***

Statement	YES	NO
1) I am preoccupied with gambling [this could include preoccupation with reliving past gambling experiences, handicapping or planning the next venture or thinking of ways to get money with which to gamble]	❑	❑
2) I need to gamble with increasing amounts of money in order to achieve the desired excitement.	❑	❑
3) I have repeated unsuccessful efforts to control, cut back or stop gambling.	❑	❑
4) I am restless or irritable when attempting to cut down or stop gambling.	❑	❑
5) I gamble as a way of escaping from problems or of relieving feelings of helplessness, guilt, anxiety or depression.	❑	❑
6) After losing money gambling, I often return another day to get even.	❑	❑
7) I lie to family members, therapists or others to conceal the extent of my involvement with gambling.	❑	❑
8) I have committed illegal acts such as forgery, fraud, theft or embezzlement to finance gambling.	❑	❑
9) I have jeopardised or lost a significant relationship, job, or educational or career opportunity because of gambling.	❑	❑
10) I rely on others to provide money to relieve a desperate financial situation caused by gambling.	❑	❑

26) To what extent were your expectations changed as a result of the counselling session? ***(Please circle)***

Entirely different Significantly different Moderately different A little different Remained the same

27) To what extent were your expectations met by the counselling session?

Completely As much as I wanted to Mostly Partially Not at all

28) At the end of the counselling session to what extent had your problems been resolved. ***(Please circle the most appropriate answer. Answer for the areas that were affected by the counselling even if they weren't the focus of the counselling.)***

Problem Area	Got Worse	Unresolved	Partially Resolved	Fully Resolved	Was Fixed to my Satisfaction
Gambling behaviour	1	2	3	4	5
Financial issues	1	2	3	4	5
Family relationship issues	1	2	3	4	5
Relationship issues with Others	1	2	3	4	5
Employment & work related issues	1	2	3	4	5
Physical health issues (headaches, backache, RSI, sleeplessness, drug taking)	1	2	3	4	5
Leisure use issues (loneliness, boredom)	1	2	3	4	5
Intrapersonal issues (mood swings, depression, anxiety, stress, self esteem)	1	2	3	4	5
Legal issues	1	2	3	4	5

29) Are you currently receiving assistance, from a service other than Break Even?

[YES] [NO]

30) Will you seek any assistance, from non Break Even services, for your problems? ***(Please Circle)***

[YES] [NO] [UNSURE]

(a) If yes: where from?

_____

_____

(b) If no: why not?

_____

_____

31) How did the Break Even counselling session impact on other aspects of your life? ***(Tick the appropriate box.)***

Aspects of Life	**Got Better**	**No Change**	**Got Worse**
1) Self awareness	❑	❑	❑
2) Understanding the nature of problem gambling behaviour	❑	❑	❑
3) Ability to accept responsibility for the problems my gambling caused.	❑	❑	❑
4) Ability to communicate with others close to me	❑	❑	❑
5) Ability to cope with stress	❑	❑	❑
6) Self-esteem	❑	❑	❑
7) Self-confidence	❑	❑	❑
8) Ability to talk to others about sensitive issues	❑	❑	❑
9) Knowledge of services available that can assist people with gambling related problems.	❑	❑	❑
Other (Please describe):			

_____

_____

32) How would you describe your emotional state after counselling? ***(Please Circle)***

Very poor Fairly poor So-so Quite good Very good

Your experience of the counselling process

The following questions relate to your experience of the counsellor and counselling process. Please circle the answer that best describes your experience. Remember your answers are anonymous and will not be seen by any Break Even worker.

33) To what extent did you feel ready to change your problem when you started counselling?

A great deal A fair amount Somewhat Very little Not at all

34) To what extent did you feel you could talk freely, openly and honestly with the counsellor about your thoughts, feelings and behaviour?

A great deal A fair amount Somewhat Very little Not at all

35) To what extent did you feel the counsellor understood the problems facing you?

A great deal A fair amount Somewhat Very little Not at all

36) To what extent did you feel the counsellor was concerned for your welfare?

A great deal A fair amount Somewhat Very little Not at all

37) To what extent did you feel the counsellor respected you as an individual?

A great deal A fair amount Somewhat Very little Not at all

38) To what extent did you feel confident in the counsellors ability to assist you with your problems?

A great deal A fair amount Somewhat Very little Not at all

39) To what extent did you feel the counsellor had enough knowledge to assist you with your problem?

A great deal A fair amount Somewhat Very little Not at all

40) To what extent did you feel supported by the counsellor?

A great deal A fair amount Somewhat Very little Not at all

41) To what extent did you feel clear about your role in the counselling process?

A great deal A fair amount Somewhat Very little Not at all

42) To what extent did you feel clear about the counsellors role in the counselling process?

A great deal A fair amount Somewhat Very little Not at all

43) To what extent did you feel clear about the purpose of the counselling sessions?

A great deal A fair amount Somewhat Very little Not at all

44) To what extent did you feel you and the counsellor shared an understanding of the purpose of counselling?

A great deal A fair amount Somewhat Very little Not at all

45) To what extent did you feel what you did in counselling sessions directly addressed the problems you had?

A great deal A fair amount Somewhat Very little Not at all

46) Prior to attending counselling to what extent did you feel confident that the counselling process could help you?

A great deal A fair amount Somewhat Very little Not at all

47) To what extent did you and your counsellor collaborate on setting goals for your counselling?

A great deal A fair amount Somewhat Very little Not at all

48) To what extent did you and your counsellor agree upon the goals and tasks for the session?

A great deal A fair amount Somewhat Very little Not at all

49) To what extent were clear goals set for the counselling?

A great deal A fair amount Somewhat Very little Not at all

50) To what extent did you feel you achieved the goals set for the counselling?

A great deal A fair amount Somewhat Very little Not at all

51) To what extent did you feel you and the counsellor shared a common view about the cause of your problem?

A great deal A fair amount Somewhat Very little Not at all

52) To what extent did you feel ready to accept the ideas that the counsellor put forward to you?

A great deal A fair amount Somewhat Very little Not at all

53) To what extent do you feel the sessions helped to clarify how you could change things?

A great deal | A fair amount | Somewhat | Very little | Not at all

54) To what extent did your work in counselling give you new ways of looking at your problems?

A great deal | A fair amount | Somewhat | Very little | Not at all

55) To what extent did your work in counselling give you an understanding of the kind of changes that would be good for you?

A great deal | A fair amount | Somewhat | Very little | Not at all

56) To what extent did the things you did in counselling help you accomplish the changes you wanted?

A great deal | A fair amount | Somewhat | Very little | Not at all

57) To what extent did attending counselling result in you realising things about yourself that you did not realise before?

A great deal | A fair amount | Somewhat | Very little | Not at all

58) Please note your level of satisfaction with the following aspects of the counselling service offered by Break Even. ***(Please circle the answer that best describes your level of satisfaction)***

How satisfied were you with:	**Very Satisfied**	**Satisfied**	**Neither Satisfied or Dissatisfied**	**Dissatisfied**	**Very Dissatisfied**
The amount of time between contacting the service and being able to see a counsellor.	1	2	3	4	5
The amount of time the counsellor spent with you.	1	2	3	4	5
The counsellor's treatment of your problem/s.	1	2	3	4	5
The counsellor's ability to listen to your problems.	1	2	3	4	5
The counsellor's willingness to answer your questions.	1	2	3	4	5
The counsellor's knowledge about the problems facing you.	1	2	3	4	5
The counsellor's ability to help you with your problems.	1	2	3	4	5
The way the counsellor focussed on the issues you presented to him/her.	1	2	3	4	5
The outcomes you achieved as the result of attending counselling?	1	2	3	4	5

59) Overall how satisfied were you with your counselling experience?

Very dissatisfied | Dissatisfied | Neither satisfied or dissatisfied | Satisfied | Very satisfied

60) Will you attend counselling again? ***(Please circle)***

[YES] go to 59 | [NO] answer part b | [UNSURE]

b) If No

Why won't you attend Counselling again?

- ❑ Problem/s resolved
- ❑ Problem/s more manageable
- ❑ Felt further counselling would not help

- ❑ Didn't like the counsellor
- ❑ It was clear that counsellor could not help me with my problem/s
- ❑ Counsellor thought I didn't need to return
- ❑ I didn't think the counselling I received was adequate
- ❑ I only came for a planned single session
- ❑ Other (please describe):

_____

_____

61) Would you recommend Break Even to others? ***(Please circle)***

[YES] [NO] [UNSURE]

62) How long is it since you received counselling? ***(Please put a number in the appropriate box.)***

Days [ ]
Months [ ]
Years [ ]

63) What did you find particularly helpful/unhelpful about the Break Even Counselling?

Helpful

_____

_____

Unhelpful

_____

_____

64) Any other comments you would like to make about the Break Even Service.

_____

_____

Thank you for your assistance in completing this questionnaire.

Please return it, and your informed consent form in the postage paid envelope provided.

Appendix C: Clinical Practice Evaluation Client Questionnaire—Prospective 'Partner and/or Others' Sample

University of Melbourne Problem Gambling Research Program
Clinical Practice Evaluation: Prospective Study

Client Questionnaire: Partner and/or Others

[Please complete the questionnaire and return in the envelope supplied.]
[The questionnaire should take about 25 minutes to complete]

Questionnaire identification number

☐☐☐☐☐☐☐☐☐

[to be completed by the counsellor]

(Today's Date)

☐☐☐☐☐**1**☐**9**☐**9**☐

1. How did you initially find out about Break Even? ***(Please tick the appropriate box.)***

G–Line	❑		
		↳ **How did you find out about G-Line?**	
Family or Friends.	❑	Family or Friends.	❑
Other crisis service (lifeline, crisis line).	❑	Other crisis service (lifeline, crisis line).	❑
TV ads.	❑	TV ads.	❑
Radio ads.	❑	Radio ads.	❑
Newspaper ads.	❑	Newspaper ads.	❑
Telephone Book.	❑	Telephone Book.	❑
Other professional (eg. G.P., therapist/ counsellor/social worker, church leader)	❑	Other professional (eg. G.P., therapist/ counsellor/social worker, church leader)	❑
Financial Counsellor	❑	Financial Counsellor	❑
Advertising at a gambling venue.	❑	Advertising at a gambling venue.	❑
News Story (television, radio, newspaper, magazine).	❑	News Story (television, radio, newspaper, magazine).	❑

2. How would you describe your emotional state *prior* to counselling? ***(Please circle)***

Very poor Fairly poor So-so Quite good Very good

3. **How would you describe the state of your relationships *prior* to counselling? *(Please circle)***

   Very poor Fairly poor So-so Quite good Very good

4. **How would you describe the state of your financial position *prior* to counselling? *(Please circle)***

   Very poor Fairly poor So-so Quite good Very good

5. **How would you describe the state of your work life *prior* to counselling? *(Please circle)***

   Very poor Fairly poor So-so Quite good Very good

6. **To what extent is your partner/relative/friend's current gambling activity a problem? *(Please circle)***

   A great deal A fair amount Somewhat Very little Not at all

7. **How do you feel about your partner/relative/friend's current level of gambling? *(Please circle)***

   Very dissatisfied Dissatisfied Neither satisfied or dissatisfied Satisfied Very satisfied

The impact of gambling

The following questions try to capture and assess something of the impact of gambling on people's lives, both in terms of the problems and distress it causes.

We all know that when people gamble too much they run the risk of developing various problems. Unfortunately, an individual's gambling often causes problems for other people as well - especially the person's family and close friends.

8. **During the last month have *you* or *other family members* experienced or feared *any of the following problems* as a result of someone else's gambling?**

Problems	Never	Not Often	Occa-sionally	Often	Always
Money for household running costs (eg food, rent, bills) spent on gambling	1	2	3	4	5
Money set aside for special family projects (eg major acquisitions, holidays) spent on gambling	1	2	3	4	5
Asking other family members or friends for loans of money	1	2	3	4	5
Household objects sold or pawned to pay gambling debts	1	2	3	4	5
Working (more) to overcome losses from gambling	1	2	3	4	5
Harassment by creditors or loan sharks	1	2	3	4	5
Involvement in legal processes (dealing with police, solicitors, barristers, court cases etc)	1	2	3	4	5
Eviction/homelessness	1	2	3	4	5
Considered moving to a new location to make a new start without gambling	1	2	3	4	5
Withdrawing from social contact with family or friends to avoid embarrassment	1	2	3	4	5
Loneliness	1	2	3	4	5
Being lied to or not told the whole truth (keeping secrets) by the gambler	1	2	3	4	5
Inability to trust the gambler	1	2	3	4	5
Arguments	1	2	3	4	5
Marital difficulties	1	2	3	4	5
An unsatisfactory sex life	1	2	3	4	5
Gambler is not capable of being a good parent	1	2	3	4	5
Negative impact on children's performance at school	1	2	3	4	5

Illness or other physical health problems	1	2	3	4	5
Depression (including suicidal thoughts or attempts)	1	2	3	4	5
Anxiety	1	2	3	4	5
Irritability (feeling edgy or cross)	1	2	3	4	5
Anger (feeling outraged, having angry outbursts)	1	2	3	4	5
Neglect (feeling neglected by the gambler)	1	2	3	4	5
Physical abuse	1	2	3	4	5
Verbal abuse	1	2	3	4	5

It is unlikely that all of the problems you have identified will effect you (or other family members) to the same extent. Some may cause extreme distress whereas others may cause little or no stress.

9. Over the last month *how much distress* has each of the problems listed below caused *you*?

Problems	**No Distress**	**Low Distress**	**Moderate Distress**	**High Distress**	**Extreme Distress**
Money for household running costs (eg food, rent, bills) spent on gambling	1	2	3	4	5
Money set aside for special family projects (eg major acquisitions, holidays) spent on gambling	1	2	3	4	5
Asking other family members or friends for loans of money	1	2	3	4	5
Household objects sold or pawned to pay gambling debts	1	2	3	4	5
Working (more) to overcome losses from gambling	1	2	3	4	5
Harassment by creditors or loan sharks	1	2	3	4	5
Involvement in legal processes (dealing with police, solicitors, barristers, court cases etc)	1	2	3	4	5
Eviction/homelessness	1	2	3	4	5
Considered moving to a new location to make a new start without gambling	1	2	3	4	5
Withdrawing from social contact with family or friends to avoid embarrassment	1	2	3	4	5
Loneliness	1	2	3	4	5
Being lied to or not told the whole truth (keeping secrets) by the gambler	1	2	3	4	5
Inability to trust the gambler	1	2	3	4	5
Arguments	1	2	3	4	5
Marital difficulties	1	2	3	4	5
An unsatisfactory sex life	1	2	3	4	5
Gambler is not capable of being a good parent	1	2	3	4	5
Negative impact on children's performance at school	1	2	3	4	5
Illness or other physical health problems	1	2	3	4	5
Depression (including suicidal thoughts or attempts)	1	2	3	4	5
Anxiety	1	2	3	4	5
Irritability (feeling edgy or cross)	1	2	3	4	5
Anger (feeling outraged, having angry outbursts)	1	2	3	4	5
Neglect (feeling neglected by the gambler)	1	2	3	4	5
Physical abuse	1	2	3	4	5
Verbal abuse	1	2	3	4	5

10. What services, if any, had you attended prior to Break Even to discuss the problems you were having? ***(Please list in order of attendance if possible)***

Services	**List in order of attendance (ie. 1st, 2nd etc)**
Doctor (G.P.)	[ ]
Community Health Centre	[ ]
Life Line/Crisis Line	[ ]
Gamblers Anonymous (G.A.)	[ ]
Other Self Help Groups	[ ]
Therapist (non Break Even)	[ ]
Legal Service	[ ]
Financial Counsellor	[ ]
Other *(please describe)*	

_____

_____

11. Why did you decide to attend a Break Even service? Please select the reason that best describes your situation. ***(Tick the appropriate boxes)***

a) ❑ To find out if my partner/relative/friend has a problem with gambling.

b) ❑ To find out what I could do about problems related to my partner/relative/friend's gambling: *(please note which ones)*

- ❑ financial problems
- ❑ relationship problems
- ❑ family problems
- ❑ physical symptoms
- ❑ employment/work related problems
- ❑ anxiety or problematic changes in mood

c) ❑ To talk to someone about how I was feeling?

d) ❑ To find out what I could do to change my partner/relative/friend's gambling behaviour.

12. What did you hope to achieve when you first attended the Break Even service? ***(Please tick the appropriate box/es.)***

- ❑ To change my partner/relative/friend's gambling.
- ❑ To fix our relationship problems.
- ❑ To deal with our financial crisis.
- ❑ To talk to someone about what was happening in my life.
- ❑ To understand the reasons behind my feelings.
- ❑ To identify what my problems were.
- ❑ To work out how to change the problems facing me.
- ❑ Other *(Please Describe)*

_____

_____

13. To what extent were your expectations changed as a result of the counselling session?) ***(Please circle)***

Entirely different Significantly different Moderately different A little different Remained the same.

14. To what extent were your expectations met by the counselling session. ***(Please circle)***

Completely As much as I needed Mostly Partially Not at all

15. At the end of the counselling session to what extent had your problems been resolved? ***(Please circle the appropriate number . Answer for the areas that were affected by the counselling even if they weren't the focus of the counselling.)***

Problem Area	Got Worse	Unresolved	Partially Resolved	Fully Resolved	Fixed to my Satisfaction
Gambling behaviour	1	2	3	4	5
Financial issues	1	2	3	4	5
Family relationship issues	1	2	3	4	5
Relationship issues with Others	1	2	3	4	5
Employment & work related issues	1	2	3	4	5
Physical health issues (headaches, backache, RSI, sleeplessness, drug taking)	1	2	3	4	5
Leisure use issues (loneliness, boredom)	1	2	3	4	5
Intrapersonal issues (mood swings, depression, anxiety, stress, self esteem)	1	2	3	4	5
Legal issues	1	2	3	4	5

16. Are you currently receiving assistance, from a service other than Break Even?

[YES] [NO]

17. Will you seek any assistance, from non Break Even services, for your problems? ***(Please Circle)***

[YES] [NO] [UNSURE]

(a) If yes: where from?

_____

_____

(b) If no: why not?

_____

_____

18. How did the Break Even counselling session impact on other aspects of your life?
(Tick the appropriate box.)

Aspects of Life	Got Better	No Change	Got Worse
1) Self awareness	❑	❑	❑
2) Understanding the nature of problem gambling behaviour	❑	❑	❑
3) Ability to accept responsibility for the problems my gambling caused.	❑	❑	❑
4) Ability to communicate with others close to me	❑	❑	❑
5) Ability to cope with stress	❑	❑	❑
6) Self-esteem	❑	❑	❑
7) Self-confidence	❑	❑	❑
8) Ability to talk to others about sensitive issues	❑	❑	❑
9) Knowledge of services available that can assist people with gambling related problems.	❑	❑	❑

Other (Please describe):

_____

_____

19. How would you describe your emotional state after counselling? ***(Please Circle)***

Very poor Fairly poor So-so Quite good Very good

Your experience of the counselling process

The following questions relate to your experience of the counsellor and counselling process. Please circle the answer that best describes your experience. Remember your answers are anonymous and will not be seen by any Break Even worker.

20. To what extent did you feel ready to change your problem when you started counselling?

A great deal A fair amount Somewhat Very little Not at all

21. To what extent did you feel you could talk freely, openly and honestly with the counsellor about your thoughts, feelings and behaviour?

A great deal A fair amount Somewhat Very little Not at all

22. To what extent did you feel the counsellor understood the problems facing you?

A great deal A fair amount Somewhat Very little Not at all

23. To what extent did you feel the counsellor was concerned for your welfare?

A great deal A fair amount Somewhat Very little Not at all

24. To what extent did you feel the counsellor respected you as an individual?

A great deal A fair amount Somewhat Very little Not at all

25. To what extent did you feel confident in the counsellors ability to assist you with your problems?

A great deal A fair amount Somewhat Very little Not at all

26. To what extent did you feel the counsellor had enough knowledge to assist you with your problem?

A great deal A fair amount Somewhat Very little Not at all

27. To what extent did you feel supported by the counsellor?

A great deal A fair amount Somewhat Very little Not at all

28. To what extent did you feel clear about the counsellors role in the counselling process?

A great deal A fair amount Somewhat Very little Not at all

29. To what extent did you feel clear about the purpose of the counselling sessions?

A great deal A fair amount Somewhat Very little Not at all

30. To what extent did you feel you and the counsellor shared an understanding of the purpose of counselling?

A great deal A fair amount Somewhat Very little Not at all

31. To what extent did you feel what you did in counselling sessions directly addressed the problems you had?

A great deal A fair amount Somewhat Very little Not at all

32. Prior to attending counselling to what extent did you feel confident that the counselling process could help you?

A great deal A fair amount Somewhat Very little Not at all

33. To what extent did you and your counsellor collaborate on setting goals for your counselling?

A great deal A fair amount Somewhat Very little Not at all

34. To what extent did you and your counsellor agree upon the goals and tasks for the session?

A great deal A fair amount Somewhat Very little Not at all

35. To what extent were clear goals set for the counselling?

A great deal | A fair amount | Somewhat | Very little | Not at all

36. To what extent did you feel you achieved the goals set for the counselling?

A great deal | A fair amount | Somewhat | Very little | Not at all

37. To what extent did you feel you and the counsellor shared a common view about the cause of your problem?

A great deal | A fair amount | Somewhat | Very little | Not at all

38. To what extent did you feel ready to accept the ideas that the counsellor put forward to you?

A great deal | A fair amount | Somewhat | Very little | Not at all

39. To what extent do you feel the sessions helped to clarify how you could change things?

A great deal | A fair amount | Somewhat | Very little | Not at all

40. To what extent did your work in counselling give you new ways of looking at your problems?

A great deal | A fair amount | Somewhat | Very little | Not at all

41. To what extent did your work in counselling give you an understanding of the kind of changes that would be good for you?

A great deal | A fair amount | Somewhat | Very little | Not at all

42. To what extent did the things you did in counselling help you accomplish the changes you wanted?

A great deal | A fair amount | Somewhat | Very little | Not at all

43. To what extent did attending counselling result in you realising things about yourself that you did not realise before?

A great deal | A fair amount | Somewhat | Very little | Not at all

44. Please note your level of satisfaction with the following aspects of the counselling service offered by Break Even. ***(Please circle the number that best describes your level of satisfaction.)***

How satisfied were you with:	**Very Satisfied**	**Satisfied**	**Neither Satisfied or Dissatisfied**	**Dissatisfied**	**Very Dissatisfied**
The amount of time between contacting the service and being able to see a counsellor.	1	2	3	4	5
The amount of time the counsellor spent with you.	1	2	3	4	5
The counsellor's treatment of your problem/s.	1	2	3	4	5
The counsellor's ability to listen to your problems.	1	2	3	4	5
The counsellor's willingness to answer your questions.	1	2	3	4	5
The counsellor's knowledge about the problems facing you.	1	2	3	4	5
The counsellor's ability to help you with your problems.	1	2	3	4	5

How satisfied were you with:	Very Satisfied	Satisfied	Neither Satisfied or Dissatisfied	Dissatisfied	Very Dissatisfied
The way the counsellor focussed on the issues you presented to him/her.	1	2	3	4	5
The outcomes you achieved as the result of attending counselling?	1	2	3	4	5

45. Overall how satisfied were you with your counselling experience?

Very dissatisfied Dissatisfied Neither satisfied or dissatisfied Satisfied Very satisfied

46. Will you attend counselling again? ***(Please circle)***

[YES] go to 45 [NO] answer part b [UNSURE]

b) If No

Why won't you attend Counselling again?

- ❏ Problem/s resolved
- ❏ Problem/s more manageable
- ❏ Felt further counselling would not help
- ❏ Didn't like the counsellor
- ❏ It was clear that counsellor could not help me with my problem/s
- ❏ Counsellor thought I didn't need to return
- ❏ I didn't think the counselling I received was adequate
- ❏ I only came for a planned single session
- ❏ Other (please describe):

_____

_____

47. Would you recommend Break Even to others? ***(Please circle)***

[YES] [NO] [UNSURE]

48. How long is it since you received counselling? ***(Please put a number in the appropriate box.)***

Days [ ]
Months [ ]
Years [ ]

49. What did you find particularly helpful/unhelpful about the Break Even Counselling?

Helpful

_____

_____

Unhelpful

_____

_____

50. Any other comments you would like to make about the Break Even Service.

_____

_____

Thank you for your assistance in completing this questionnaire.

Please return it, and your informed consent form in the postage paid envelope provided.

Appendix D: Clinical Practice Evaluation of Break Even Services—Counsellor Questionnaire

The following set of questions are aimed at providing an in depth look at the counselling work being undertaken at Break Even Services. The questions are open ended and require answers in a written format. This format has been selected to provided counsellors with the opportunity to have **time** to consider their counselling practice and then articulate it, a task we appreciate is often difficult to do in an on the spot interview session. It is important that you answer these questions carefully and in your answers reflect both the **range** of your practice and the **most typical features** of your counselling practice at Break Even.

The questions cover the following sections with a description of the purpose of the section provided at the beginning of each section.

Section 1: The relationship between theoretical frameworks and applied techniques in counselling practice.

Section 2: Diagnosis and its formulation. The diagnostic decision making process of counsellors.

Section 3: Management of cases and related issues. An overview of the way counselling practice occurs within Break Even services.

Section 4: Counsellors views on counselling outcomes.

If you require additional space please use the back of the sheets noting clearly the question to which the answer belongs. If you would like to prepare your response on the computer, and have email access please contact Serena Smith and she will forward you a copy. s.smith@socialwork.unimelb.edu.au.

If you have published any papers or articles outlining your work please feel free to attach them as supplements to your responses.

If you have any questions or queries please contact Serena Smith (Program Manager) Wednesday to Friday (03) 93449430 or Dr Beth Crisp (Research Fellow) (03) 9344 9417.

Please complete and return by 6th of November 1998

Name:

Agency:

Section One: Theoretical Orientation

This section aims at understanding something of the relationship between theoretical frameworks and applied techniques in counselling practice.

1. **Describe the theoretical orientation your counselling practice at Break Even is based on. (Please provide a descriptive overview of your theoretical framework, including the names of any influential individual's or books. Details of the actual techniques and strategies you use are asked for in question 8.)**

2. **Describe what you understand "problem gambling" to be.**

3. **Describe what you understand to be the cause(s) of "problem gambling".**

Section Two: Diagnosis and its Formulation

In this section we would like to understand the diagnostic decision making process of counsellors. We are interested in what counsellors therapeutic decisions are based on and how these relate to the material clients present with.

4. **What criteria do you apply when assessing the counselling needs of your client?**

5. **Describe the process you use for setting goals for your interventions with clients.**

6. **How do you decide which techniques and strategies you will use with clients?**

7. **How do you decide when and where to refer clients for additional support?**

Section Three: Management of a case and related issues

This section will provide an overview of the way counselling practice occurs within Break Even services. We are interested in exploring the "minutiae" of a counsellor's daily practice and the techniques and strategies they employ in that practice.

8. **Please provide specific examples of the techniques and strategies you use when counselling clients. (Examples: Reflective listening, imaginal desensitisation, free association, role playing.)**

9. Describe the techniques you understand to constitute Cognitive Behaviour Therapy.

10. To what extent do you consider the counsellor- client relationship important in your counselling practice. ***(Please circle your answer.)***

A great deal A fair amount Somewhat Very little Not at all

11. Describe how you use the counsellor–client relationship in your counselling practice.

12. Describe the techniques you use in ending counselling with a client.

13. Describe how you go about reviewing the progress of your counselling with clients.

14. In what ways does the work you do with re-presenters differ from that with new clients to the service?

Section Four: Counselling Outcomes

This section aims at developing a picture of counsellors' views regarding counselling outcomes; what they are and how they are achieved.

15. What do you consider to be a successful outcome in your counselling practice?

16. What factors do you consider contribute to achieving successful outcomes in counselling?

17. What factors do you think hinder the achievement of successful outcomes?

Please return in the enclosed reply paid envelope.

To: Serena Smith, Program Manager
Problem Gambling Research Program
School of Social Work, University of Melbourne,
Parkville, Victoria, 3052

Appendix E: Clinical Practice Evaluation Client Follow up Questionnaire—Prospective 'Problem Gambler' Sample

University of Melbourne Problem Gambling Research Program
Clinical Practice Evaluation: Prospective Study Follow Up

Client Questionnaire

[Please complete the questionnaire and return in the envelop supplied.]
[The questionnaire should take about 25 minutes to complete]

Questionnaire identification number

☐☐☐☐☐☐☐☐☐

(Today's Date)

☐☐☐☐☐**1**☐**9**☐**9**☐

1) How would you describe your emotional state after counselling? ***(Please circle)***

Very poor Fairly poor So-so Quite good Very good

2) How would you describe the state of your relationships after counselling? ***(Please circle)***

Very poor Fairly poor So-so Quite good Very good

3) How would you describe the state of your financial position after counselling? ***(Please circle)***

Very poor Fairly poor So-so Quite good Very good

4) How would you describe the state of your work life after counselling? ***(Please circle)***

Very poor Fairly poor So-so Quite good Very good

5) To what extent is your current gambling activity a problem for you? ***(Please circle)***

A great deal A fair amount Somewhat Very little Not at all

6) How do you feel about your current level of gambling? ***(Please circle)***

Very dissatisfied Dissatisfied Neither satisfied or dissatisfied Satisfied Very satisfied

7) Since going to Break Even have you attended any other services to get help for any of your gambling related problems? (*Please circle your answer.)*

Service		
Doctor (GP)	Yes	No
Community Health Center	Yes	No
Life Line/Crisis Line	Yes	No
Gamblers Anonymous (GA)	Yes	No
Other Self Help Groups	Yes	No
Therapist (non Break Even)	Yes	No
Legal Service	Yes	No
Financial Counsellor	Yes	No

The following questions are designed to establish how you feel about your gambling right now. Please read each of the questions and decide whether you agree or disagree with the statements and circle the answer that best reflects your feelings.

8) I don't think I gamble too much.

Strongly Disagree Disagree Unsure Agree Strongly Agree

9) I am trying to gamble less than I used to.

Strongly Disagree Disagree Unsure Agree Strongly Agree

10) I enjoy my gambling, but sometimes I gamble too much.

Strongly Disagree Disagree Unsure Agree Strongly Agree

10) Sometimes I think I should cut down on my gambling.

Strongly Disagree Disagree Unsure Agree Strongly Agree

12) It's a waste of time thinking about my gambling.

Strongly Disagree Disagree Unsure Agree Strongly Agree

13) I have just recently changed my gambling habits.

Strongly Disagree Disagree Unsure Agree Strongly Agree

14) Anyone can talk about wanting to so something about gambling, but I am actually doing something about it.

Strongly Disagree Disagree Unsure Agree Strongly Agree

15) I am at the stage where I should think about gambling less.

Strongly Disagree Disagree Unsure Agree Strongly Agree

16) My gambling is a problem sometimes.

Strongly Disagree Disagree Unsure Agree Strongly Agree

17) There is no need for me to think about changing my gambling

Strongly Disagree Disagree Unsure Agree Strongly Agree

18) I am actually changing my gambling habits right now.

Strongly Disagree Disagree Unsure Agree Strongly Agree

19) Gambling less would be pointless for me.

Strongly Disagree Disagree Unsure Agree Strongly Agree

20) Did you achieve what you hoped to achieve when you first attended the Break Even service?
(Please circle the appropriate answer.)

Yes	No	To give up gambling.
Yes	No	To control my gambling.
Yes	No	To fix my relationship problems.
Yes	No	To deal with my financial crisis.
Yes	No	To talk to someone about what was happening in my life.
Yes	No	To understand the reasons behind my feelings and behaviour.
Yes	No	To identify what my problems were.
Yes	No	To work out how to change the problems facing me.
		Other (Please Describe)

_____

_____

21) In your opinion which of the following statements apply to you, at this time?
(Please tick the appropriate box)

Statement	**YES**	**NO**
1) I am preoccupied with gambling [this could include preoccupation with reliving past gambling experiences, handicapping or planning the next venture or thinking of ways to get money with which to gamble]	❑	❑
2) I need to gamble with increasing amounts of money in order to achieve the desired excitement.	❑	❑
3) I have repeated unsuccessful efforts to control, cut back or stop gambling.	❑	❑
4) I am restless or irritable when attempting to cut down or stop gambling.	❑	❑
5) I gamble as a way of escaping from problems or of relieving feelings of helplessness, guilt, anxiety or depression.	❑	❑
6) After losing money gambling, I often return another day to get even.	❑	❑
7) I lie to family members, therapists or others to conceal the extent of my involvement with gambling.	❑	❑
8) I have committed illegal acts such as forgery, fraud, theft or embezzlement to finance gambling.	❑	❑
9) I have jeopardised or lost a significant relationship, job, or educational or career opportunity because of gambling.	❑	❑
10) I rely on others to provide money to relieve a desperate financial situation caused by gambling.	❑	❑

22) To what extent were your expectations changed as a result of the counselling session? ***(Please circle)***

Entirely different Significantly different Moderately different A little different Remained the same

23) To what extent were your expectations met by the counselling session?

Completely As much as I needed Mostly Partially Not at all

24) To what extent had your problems been resolved as the result of the counselling you received at Break Even. ***(Please circle the most appropriate answer. Answer for the areas that were affected by the counselling even if they weren't the focus of the counselling.)***

Problem Area	Got Worse	Unresolved	Partially Resolved	Fully Resolved	Was Fixed to my Satisfaction
Gambling behaviour	1	2	3	4	5
Financial issues	1	2	3	4	5
Family relationship issues	1	2	3	4	5
Relationship issues with Others	1	2	3	4	5
Employment & work related issues	1	2	3	4	5
Physical health issues (headaches, backache, RSI, sleeplessness, drug taking)	1	2	3	4	5
Leisure use issues (loneliness, boredom)	1	2	3	4	5
Intrapersonal issues (mood swings, depression, anxiety, stress, self esteem)	1	2	3	4	5
Legal issues	1	2	3	4	5

25) How did the counselling you received at Break Even impact on other aspects of your life? ***(Tick the appropriate box.)***

Aspects of Life	Got Better	No Change	Got Worse
1) Self awareness	❑	❑	❑
2) Understanding the nature of problem gambling behaviour	❑	❑	❑
3) Ability to accept responsibility for the problems my gambling caused.	❑	❑	❑
4) Ability to communicate with others close to me	❑	❑	❑
5) Ability to cope with stress	❑	❑	❑
6) Self-esteem	❑	❑	❑
7) Self-confidence	❑	❑	❑
8) Ability to talk to others about sensitive issues	❑	❑	❑
9) Knowledge of services available that can assist people with gambling related problems.	❑	❑	❑
Other (Please describe):			

26) How would you describe your emotional state after counselling? ***(Please Circle)***

Very poor Fairly poor So-so Quite good Very good

Your experience of the counselling process

The following questions relate to your experience of the counsellor and counselling process. Please circle the answer that best describes your experience. Remember your answers are anonymous and will not be seen by any Break Even worker.

27) To what extent did you feel ready to change your problem when you started counselling?

A great deal A fair amount Somewhat Very little Not at all

28) To what extent did you feel you could talk freely, openly and honestly with the counsellor about your thoughts, feelings and behaviour?

A great deal A fair amount Somewhat Very little Not at all

29) To what extent did you feel the counsellor understood the problems facing you?

A great deal A fair amount Somewhat Very little Not at all

30) To what extent did you feel the counsellor was concerned for your welfare?

A great deal A fair amount Somewhat Very little Not at all

31) To what extent did you feel the counsellor respected you as an individual?

A great deal A fair amount Somewhat Very little Not at all

32) To what extent did you feel confident in the counsellors ability to assist you with your problems?

A great deal A fair amount Somewhat Very little Not at all

33) To what extent did you feel the counsellor had enough knowledge to assist you with your problem?

A great deal A fair amount Somewhat Very little Not at all

34) To what extent did you feel supported by the counsellor?

A great deal A fair amount Somewhat Very little Not at all

35) To what extent did you feel clear about your role in the counselling process?

A great deal A fair amount Somewhat Very little Not at all

36) To what extent did you feel clear about the counsellors role in the counselling process?

A great deal A fair amount Somewhat Very little Not at all

37) To what extent did you feel clear about the purpose of the counselling sessions?

A great deal A fair amount Somewhat Very little Not at all

38) To what extent did you feel you and the counsellor shared an understanding of the purpose of counselling?

A great deal A fair amount Somewhat Very little Not at all

39) To what extent did you feel what you did in counselling sessions directly addressed the problems you had?

A great deal A fair amount Somewhat Very little Not at all

40) Prior to attending counselling to what extent did you feel confident that the counselling process could help you?

A great deal A fair amount Somewhat Very little Not at all

41) To what extent did you and your counsellor collaborate on setting goals for your counselling?

A great deal A fair amount Somewhat Very little Not at all

42) To what extent did you and your counsellor agree upon the goals and tasks for the session?

A great deal A fair amount Somewhat Very little Not at all

43) To what extent were clear goals set for the counselling?

A great deal A fair amount Somewhat Very little Not at all

44) To what extent did you feel you achieved the goals set for the counselling?

A great deal A fair amount Somewhat Very little Not at all

45) To what extent did you feel you and the counsellor shared a common view about the cause of your problem?

A great deal | A fair amount | Somewhat | Very little | Not at all

46) To what extent did you feel ready to accept the ideas that the counsellor put forward to you?

A great deal | A fair amount | Somewhat | Very little | Not at all

47) To what extent do you feel the sessions helped to clarify how you could change things?

A great deal | A fair amount | Somewhat | Very little | Not at all

48) To what extent did your work in counselling give you new ways of looking at your problems?

A great deal | A fair amount | Somewhat | Very little | Not at all

49) To what extent did your work in counselling give you an understanding of the kind of changes that would be good for you?

A great deal | A fair amount | Somewhat | Very little | Not at all

50) To what extent did the things you did in counselling help you accomplish the changes you wanted?

A great deal | A fair amount | Somewhat | Very little | Not at all

51) To what extent did attending counselling result in you realising things about yourself that you did not realise before?

A great deal | A fair amount | Somewhat | Very little | Not at all

52) Please note your level of satisfaction with the following aspects of the counselling service offered by Break Even. ***(Please circle the answer that best describes your level of satisfaction)***

How satisfied were you with:	**Very Satisfied**	**Satisfied**	**Neither Satisfied or Dissatisfied**	**Dissatisfied**	**Very Dissatisfied**
The amount of time between contacting the service and being able to see a counsellor.	1	2	3	4	5
The amount of time the counsellor spent with you.	1	2	3	4	5
The counsellor's treatment of your problem/s.	1	2	3	4	5
The counsellor's ability to listen to your problems.	1	2	3	4	5
The counsellor's willingness to answer your questions.	1	2	3	4	5
The counsellor's knowledge about the problems facing you.	1	2	3	4	5
The counsellor's ability to help you with your problems.	1	2	3	4	5
The way the counsellor focussed on the issues you presented to him/her.	1	2	3	4	5
The outcomes you achieved as the result of attending counselling?	1	2	3	4	5

53) Overall how satisfied were you with your counselling experience?

Very dissatisfied | Dissatisfied | Neither satisfied or dissatisfied | Satisfied | Very satisfied

54) Would you use Break Even again if you had similar problems? ***(Please circle)***

[YES] [NO] [UNSURE]

55) Would you recommend Break Even to others? ***(Please circle)***

[YES] [NO] [UNSURE]

56) How long is it since you received counselling? ***(Please put a number in the appropriate box)***

Days [ ]
Months [ ]
Years [ ]

57) Why did you stop attending counselling? ***(Please tick one box)***

- ❑ I still attend counselling when I need to.
- ❑ Problem/s resolved.
- ❑ Problem/s more manageable.
- ❑ Felt further counselling wouldn't help.
- ❑ Didn't like the counsellor.
- ❑ Counsellor thought I was ready to stop.
- ❑ Counsellor left.
- ❑ I didn't think the counselling I received was adequate.
- ❑ I am having a break to see how things go.
- ❑ Other *(please describe)*

_____

_____

Thank you for your assistance in completing this questionnaire.

Please return it and your informed consent form in the postage paid envelope provided.

Appendix F: Individual Counselling Staff Interview Schedule

Individual Counselling Staff Interview

Interviewers should note that this particular interview is complemented by:

- The *Counsellor Task Analysis*, which looks in detail at the range of tasks performed in relation to counselling, and which places this task information in the context of how frequently the tasks are performed and how important the counsellor believes the tasks to be.
- The *Clinical Practice Audit*, which 'walks' counsellors through case(s) to make explicit their clinical decision-making. This 'walkthrough' is preceded by a small number of questions asking staff to nominate their theories of practice (including theories of the aetiology of problem gambling).
- The *Staff Profile Questionnaire*, which would have been completed by counselling staff prior to this interview.

The focus of this interview, therefore, is primarily on the management of practice at both an organisational and at an individual level, and on worker's perceptions of their clients and practice.

Worker Name:

Agency:

Interviewer:

Section A: The Policy Context, Philosophy and Objectives of the Program

I would like to start by asking some general questions about the Break Even Program.

A.1 What do you believe led to the Program being established in the first place?

A.2 How would the Department of Human Services describe the main objectives of the Program?

A.3 Is there any difference between the DHS's objectives and what you see as the main objectives of the Program?

A.4 Are there any other agencies or services that you have a particular relationship with? These may include alcohol and drug agencies and domestic violence agencies, legal services, financial counselling services, for example.

Please list:

Section B: Workload Management And General Administration

B.1 What information would you routinely try to obtain over the first few interviews with a new client?
(NB: Mark all areas given without prompting with a "1". Then read through each category not given thus far by saying "would you also ask about _____ ?". Code these areas with a "2")

demographics: _____
social history: _____
gambling history: _____
financial status: _____
general medical history: _____
general psychiatric history: _____
current treatment or counselling received for problems other than gambling: _____
previous treatment or counselling received for problems other than gambling: _____
client's perception of problem: _____
client's treatment goals: _____
other/comments: _____

B.2 Does your Break Even program have a need to prioritise new cases?

YES NO

B.3 IF YES, how do you determine priorities? (e.g., are there any "high risk screening mechanisms" in operation). Describe:

B.4 Do you place a formal record of the assessment on the client's central file?

Never/Rarely/Sometimes/Usually/Always

B.5 Do you retain a formal record of the assessment on a personal file for this client?

Never/Rarely/Sometimes/Usually/Always

B.6 Would you routinely discuss a new intake assessment with anyone?

Never/Rarely/Sometimes/Usually/Always

B.7 How would this occur?

(a) ❑ At a group intake meeting with other staff.
(b) ❑ Individually, formally with a colleague or supervisor.
(c) ❑ Individually, informally with a colleague.
(d) ❑ Other (specify):

_____

B.8 How are cases allocated to a counsellor?

(a) ❑ Person doing assessment almost always takes them on.
(b) ❑ Informally passed on to colleagues depending on workload.
(c) ❑ Informally to colleagues depending on exact nature of the problem.
(d) ❑ Allocated at a group staff meeting *(see below)*.
(e) ❑ No set pattern.
(f) ❑ Other (specify):

_____

B.9 If (d): How are they allocated:

(1) ❑ According to current workloads.
(2) ❑ According to problem area/counsellor specialty.
(3) ❑ According to a roster.
(4) ❑ Other (specify):

_____

B.10 If (2), describe: are they allocated according to discipline (e.g., psychologist, social worker)? are they allocated according to the individual's skills, regardless of discipline? are other factors taken into account?

B.11 Apart from MDS requirements do you keep written records of every contact with clients?

YES NO

B.12 IF YES, do *you* keep records on:

(a) ❑ Every contact.
(b) ❑ Most contacts.
(c) ❑ Only significant contacts.

B.13 Are these records just for you, or do they go into a central file?

Personal only Central file only Both

B.14 Are client files kept by counsellors, or are they located in a central point in the office?

B.15 Who has access to your client's file if you are unavailable and information needs to be obtained?

B.16 In this counselling centre, are there differences in the work done by the various disciplines? For example, do social workers do a different kind of work, or carry different case loads, to psychologists?

Describe:

Section C: Supervision

The following questions cover issues relating to supervision of your professional practice.

C.1 What do you expect from professional supervision?

C.2 Do you receive any supervision at all for your work?

YES NO

C.3 If Yes: what aspects of your practice are covered in supervision?

C.4 If No: Would you like to receive some? Why don't you get any?

Then skip to C.8

C.5 If Yes:

(a) Do you have supervision in a group?	YES	NO
(b) If yes, is this compulsory for all counselling staff?	YES	NO
(c) Do you have supervision of ongoing cases individually?	YES	NO
(d) If yes, is this compulsory for all counselling staff?	YES	NO

C.6 How often and for how long do you have individual supervision:

C.7 How often and for how long do you have group supervision:

C.8 Does the centre hold formal case conferences (i.e., detailed discussion of a particular case)? If so, describe:

C.8a If yes, how is it decided who will present?

C.9 Are any formal mechanisms in place to ensure that all ongoing cases are reviewed at regular intervals?

YES NO If YES, describe:

C.10 Do you receive any formal supervision from outside Break Even?

YES NO

Describe:

C.10a If yes, who pays?

C.11 If you were unsure about your treatment of a client what would you do?

- ❏ Discuss with colleague from the same centre.
- ❏ Discuss with manager of the counselling program.
- ❏ Discuss with colleague from outside.
- ❏ Other (specify)

_____

C.12 In the event of a traumatic incident involving yourself (e.g., client suicide):

a) Are such incidents routinely documented (e.g, an via an incident report)?
b) Would some kind of debriefing routinely be provided?
c) Do you think you would want debriefing/support?
d) Would you prefer to receive debriefing/support from within or outside your agency?

C.13 Do you have any other comments on supervision of your professional practice?

Section D: Practice

D.1a On average, what percentage of your work time would be spent in the following activities?

Client related

Face to face client contact with problem gamblers: _____
Face to face client contact (with relatives/sig. others): _____
Telephone counselling: _____
Other client related activities: _____

Community Development

Contact with other agencies: _____
Contact with self help groups: _____
Community education/Promotion: _____

Service maintenance: _____

Other (specify):

_____

D.1b Do you find that this balance of work suits you? Please explain.

The following questions concern your counselling work.

D.2 Over the last two weeks, how many face-to-face contacts have you had with clients (including partners/families)? _____

D.2a Was that an average fortnight for you? **YES** **NO**

(NB: If last fortnight was not average, pick an average fortnight for the following questions)

D.2b What proportion of these were scheduled appointments? _____

D.3 Of these face-to-face contacts with clients, what proportion were:
(NB: not mutually exclusive and may overlap)

(a) Individual contacts: _____ %

(b) Individual contacts including family members: _____ %

(c) Group sessions: _____ %

(d) Were held away from the centre (e.g., client's home, another facility): _____ %

D.4 How many clients do you have currently that you would consider:

(a) active cases? _____

(b) open but inactive? _____

(Inactive is defined as the client having no scheduled appointments currently arranged and/or having no issues currently being worked on)

D.5 For what reasons would a case be considered open but inactive?:

D.6 Of the active cases, what proportion would you see: (NB: Provide options prior to obtaining figures)

(a) More than once a week: _____ %

(b) Once a week: _____ %

(c) Once a fortnight: _____ %

(d) Once a month: _____ %

(e) Less than once a month: _____ %

D.7 Of your active cases, what proportion do not have regular appointments but drop in when they need to? _____ **%**

D.8 In terms of attendance for scheduled appointments, what proportion of your current active cases:

(a) Attend regularly (few, if any, missed appointments): _____ %

(b) Attend irregularly (frequently miss appointments): _____ %

(c) Too early to say (have only seen once or twice): _____ %

D.9 If a client fails to attend for an appointment, do you make any effort to contact them?

YES NO

D.10 If yes:

(a) Telephone the client: _____

(b) "Pro-forma" letter to the client: _____

(c) Personal letter to the client: _____

(d) Other (describe):

_____

D.11 In the last six months, how many cases have you terminated from your own caseload? _____

D.12 Do you or the centre routinely follow up clients after termination?

YES NO

D.13 If YES, how:

D.14 In terms of your counselling work with clients, do you work from a particular therapeutic orientation?

- ❑ Cognitive-behavioural
- ❑ Psychodynamic
- ❑ Systemic family therapy
- ❑ Gestalt
- ❑ Structural family therapy
- ❑ Biopsychosocial
- ❑ Problem solving
- ❑ Eclectic
- ❑ Other (specify):

_____

D.15 How would you define a problem gambler?

The following questions relate to your professional practice more generally.

D.16 What are the five most frequent problems that cause problem gamblers or their families/partners to contact Break Even? (In order)

D.17 What are the five problem areas that take up most of your time? (In order)

D.18 What problem areas do you think your program is particularly successful in dealing with?

D.19 What problem areas do you think your program is not particularly successful in dealing with?

D.20 In general, how likely would you be to refer a client on to someone else either within the centre or outside for each of the following problems: Use the following scale:

0 = would definitely refer on
1 = would probably refer on
2 = might refer on
3 = would probably not refer on
4 = would definitely not refer on

	External referral
a: basic needs (food, housing, etc.)	_____
b: crisis intervention/management	_____
c: financial support, benefits, etc.	_____
d: alcohol/drug problems	_____
e: anger management	_____
f: employment issues	_____
g: legal problems	_____
h: family/relationship problems	_____
i: social activities, social isolation, etc.	_____
j: other psychiatric problems (e.g., depression, anxiety, etc.	_____
k: general ongoing support	_____
l: other (specify):	

_____

D.21 What are the positives *for you* of working with this client group?

D.22 What are the difficulties *for you* of working with this client group?

Section E: Monitoring of own work

E.1 Speaking generally, in what ways do you monitor your own professional practice?

E.2 What performance indicators are you using, if any, to evaluate your work specifically in the area of problem gambling?

E.3 In general terms, what are your expectations in relation to outcomes in your professional practice with problem gambling?

E.4 What are the constraints, if any, in achieving these outcomes?

E.5 What proportion of your service users with gambling related issues, if any, are involuntary? (Please give an approximation if you are not sure)

Section F: Worker Perceptions Re Gambling and Current Service Provision

F.1 What do you believe has been the impact, if any, of gambling industry advertising? Please elaborate.

F.2 What is your assessment of the efficacy of the DHS advertising in relation to problem gambling? Please elaborate.

F.3 In your view what would be the most effective way of preventing problem gambling?

F.4 How would you describe the relationship of your Break Even service with G Line?

F.5 How effective do you believe G Line is in terms of support to people phoning their service?

F.6 Do you believe that the service provided by G Line is well known in the community?

F.7 How do you think Break Even is seen by problem gamblers?

F.8 How do you think the program is seen by the general public?

Section G: Morale and Satisfaction

G.1 How satisfying is the content of the work you perform?

0 = Extremely unsatisfying
1 = Quite unsatisfying
2 = Neutral: neither satisfying nor unsatisfying
3 = Quite satisfying
4 = Extremely satisfying

G.2 Are there particular aspects that are satisfying/unsatisfying?

Satisfying:

Unsatisfying:

(Note for interviewers: indicators of instrumental satisfaction may include variety, complexity, if challenged, employment of the workers current skills and abilities, provision of opportunities for learning, worker control over pace and methods).

G.3 How satisfied are you with the working conditions offered by the organisation? For example, pay, career structure, hours, equipment, physical aspects, supervision, etc.?

0 = Extremely unsatisfied
1 = Quite unsatisfied
2 = Neutral: neither satisfied nor unsatisfied
3 = Quite satisfied
4 = Extremely satisfied

G.4 Are there particular aspects of the working conditions that are satisfying/unsatisfying?

Satisfying:

Unsatisfying:

G.5. Do you feel that you receive recognition for the work that you perform? (eg., praise for accomplishments, credit for work done, criticism, instrumental rewards such as increased pay, additional benefits, access to facilities and services etc).

G.6 Do you have any comments about the leadership provided by DHS for the Break Even program?

G.7 Are there any other issues that you think that a Review of this sort should be addressing?

Appendix G: Counsellor Task Analysis (Problem Gambling)—Final 108 Item Version

Developed by Problem Gambling Research Program
The University of Melbourne, Australia

Agency Code:

Worker Code:

Please read carefully

The survey asks you to describe the kinds of tasks you **personally** do on your job. To do this, you are required to make **two** ratings about each of the tasks. Each rating uses a 5-point scale. In using the two scales, you should make **both** ratings before moving on to the next task.

The first scale (**Scale A**) measures "**How Often**" you personally perform a task.

A. How often do you do this task?

Not Done	Seldom	Occasionally	Frequently	Almost Always
1	**2**	**3**	**4**	**5**

Starting on the next page, read each task and decide "**how often**", in the course of a **typical month**, you actually carry it out **yourself**. Choose the statement above one of the 5 circles that best describes how often you perform it and write the number corresponding to it in the box to the **left** of the task under the heading "**A. How Often?**". If you never carry out a task, you would put a "1" in the box. If you do it frequently, you would put a "4", and so forth.

The second scale (**Scale B**) measures "**How Important**" the task is to your job.

B. How important is it to your job?

Not Important	Somewhat Important	Moderately Important	Very Important	Extremely Important
1	**2**	**3**	**4**	**5**

Read the task and decide **how important** the task is to your job as it is defined within your agency or organisation. Choose the statement above one of the 5 boxes that best describes its importance and write the numbers corresponding to it in the box to the **right** of the task under the heading "**B. How Important?**"

Please include any tasks that was not included in this list which are important to your job in the blank rows at the end.

A. How Often?		B. How Important?
☐	1. Determine the urgency or risk in the individual's situation in order to decide if emergency services or routine handling and referral are required.	☐
☐	2. Observe individuals and gather information from appropriate sources in order to decide whether there is a need for specialist counselling or mental health treatment.	☐
☐	3. Interview client/family in order to gather information including gambling activities as part of a psychosocial assessment or to compile a social history.	☐
☐	4. Assess specific aspects of client and/or family life in order to determine the need for mental health or medical services.	☐
☐	5. Assess clients in order to determine eligibility for service and/or referral where appropriate.	☐
☐	6. Interview people, review applications and/or complete paperwork in order to determine initial or continued eligibility for services or financial help.	☐
☐	7. Obtain information from individuals, their relatives or significant others in order to carry out admission or intake procedures for treatment or services.	☐
☐	8. Ask specific questions relating to gambling when a client presents with symptoms of depression, insomnia, anxiety, and/or family conflicts without any mention of gambling.	☐
☐	9. Gather information to assess whether client has other addictions as well.	☐
☐	10. Observe individuals and gather information from appropriate sources in order to establish the existence of substance/alcohol abuse problems.	☐
☐	11. Gather information on gambling when evaluating other addictions affecting individuals and families.	☐
☐	12. Ascertain what functions gambling plays in the client's life.	☐
☐	13. Identify high risk situations in order to assess when gambling is most likely to occur.	☐
☐	14. Evaluate addictive behaviours including substance abuse, eating disorders or relationship addictions of gambler's partner in order to assess multiple addictions in families.	☐
☐	15. Inquire as to the drinking, gambling and/or drug use of each parent to assess family patterns of addictions.	☐
☐	16. Where either or both partners are found to have a sexual dysfunction or a sexual addiction, obtain more detailed sexual histories in order to refer to a sex therapist.	☐
☐	17. Interview client regarding employment in order to assess work impairment issues.	☐
☐	18. Use screening information in order to diagnose problem gambling and provide treatment or refer client to other sources.	☐

A. How Often?		B. How Important?
☐	19. Enable the client to recognise the problem and address it openly and positively within an established and trusted relationship.	☐
☐	20. Discuss treatment options with individuals in order to help them understand choices and/or resolve a particular problem.	☐
☐	21. Develop individual service plans in order to reflect the client's goals, strategies and time frames to achieve these goals, and evaluation of these outcomes.	☐
☐	22. Enable the client to analyse the benefits of continuing to gamble versus the costs of giving up gambling.	☐
☐	23. Ascertain whether abstinence or controlled gambling is the goal of the gambler.	☐
☐	24. Talk with individuals and/or relatives about problems in order to reassure, provide support, or reduce anxiety.	☐
☐	25. Encourage and help people to discuss their points of view, feelings, and needs in order to establish open and trusting relationships.	☐
☐	26. Express and demonstrate understanding of peoples' point of view, feelings, and needs in order to establish open and trusting relationships.	☐
☐	27. Confront people about unacceptable behaviour in order to reassure, provide support, or reduce anxiety.	☐
☐	28. Develop culturally appropriate intervention plans for clients in order to meet the needs of individual clients.	☐
☐	29. Use specific intervention techniques with individuals in order to improve behavioural functioning and adjustment.	☐
☐	30. Use a specific therapeutic method in a group situation in order to improve the adjustment and functioning of the group members.	☐
☐	31. Advocate on client's behalf in a manner that encourages self-determination and self-reliance.	☐
☐	32. Negotiate arrangements in relation to clients within the agency and with relevant agencies in order to ensure effective case management	☐
☐	33. Work with individuals, family members, or significant other, in order to prepare them psychologically and socially for movement from one living arrangement to another.	☐
☐	34. Work with individuals, family members and significant others in order to prepare them for termination of treatment, services, or financial help.	☐
☐	35. Schedule non-gambling activities in order to occupy the gamblers free time	☐
☐	36. Challenge client's beliefs regarding personal luck in order to get their thinking straight on the amount of money lost.	☐
☐	37. Suggest strategies to overcome the impulse to gamble when confronted with gambling related stimuli.	☐

A. How Often?		B. How Important?
☐	38. Teach client to set limits regarding number of gambling sessions in order to gain control of gambling.	☐
☐	39. Instruct clients to stop gambling when a predetermined amount of money has been lost.	☐
☐	40. Teach client to set limits regarding length of gambling sessions in order to gain control of gambling.	☐
☐	41. Encourage clients to seek support from spouse, family and friends in order to maintain treatment goals.	☐
☐	42. Assist gambler to find new friends who do not gamble in order to enable attention and energy be directed away from gambling.	☐
☐	43. Teach clients how to overcome "action" or arousal or excitement stage by encouraging the client to take breaks between sessions of gambling.	☐
☐	44. Advise clients that chasing ones losses in an attempt to get even will only produce irrational gambling and further losses.	☐
☐	45. Provide advice on how to overcome the need to raise money without resorting to gambling.	☐
☐	46. Suggest strategies for coping with sadness or depression that do not involve gambling.	☐
☐	47. Develop with client ways to celebrate occasions that do not involve gambling or gambling venues.	☐
☐	48. Teach client to set limits on the amount of money spent in order to gain control of gambling.	☐
☐	49. De-emphasise labelling client as a "problem gambler" in order to draw upon the client's awareness of the problem and his or her preparedness to change.	☐
☐	50. Advise clients to limit alcohol and drug consumption while gambling in order to gain control over gambling.	☐
☐	51. Teach clients self-monitoring skills in order that they may have greater control when gambling.	☐
☐	52. Instruct clients to keep a gambling diary of all monies spent and won from gambling in order to keep a record of the amount of money spent gambling.	☐
☐	53. Teach clients to reward themselves when they maintain their treatment goals.	☐
☐	54. Teach clients various relaxation techniques like muscular relaxation training, exercise and yoga in order to keep to keep the urge to gamble under control especially when they feel tense and irritable.	☐
☐	55. Encourage clients to change their gambling from games of luck to forms of games involving a degree of skill so as to minimise losses.	☐
☐	56. Teach client optimal strategies in order to maintain gains in the longer term.	☐

A. How Often?		B. How Important?
☐	57. Teach clients problem-solving skills which do not involve gambling.	☐
☐	58. Make clients aware of the possibility of relapse and suggest strategies to adopt should relapse occur	☐
☐	59. Interview each partner alone in order to establish a therapeutic bond with each.	☐
☐	60. Use specific intervention techniques to work with family members, individually or as a group, in order to strengthen the family as a unit.	☐
☐	61. Facilitate emotional healing between partners in order to assist the gambler to become more emotionally sensitive to partner's feelings and needs.	☐
☐	62. Resolve interpersonal conflicts through marital, family or group therapy in order to rebuild trust that has been destroyed.	☐
☐	63. Provide individual and family counselling to address the problem of gambling openly within an established and trusted relationship.	☐
☐	64. Assess and intervene directly in the dysfunctional couples system in order for a significant change to occur.	☐
☐	65. Facilitate partners, other family members and significant others to confront the gambler.	☐
☐	66. Include the partner and key significant others as early as possible in the assessment of a gambling problem.	☐
☐	67. Teach partners ways to reinforce non-gambling behaviours.	☐
☐	68. Encourage partners not to nag the gambler about their gambling as nagging is counter productive.	☐
☐	69. Teach partners appropriate responses in order not to reinforce . gambling behaviours	☐
☐	70. Analyse case background, consult with appropriate individuals, in order to arrive at a plan for services and/or financial help.	☐
☐	71. Provide specialist problem gambling financial counselling to individuals and families.	☐
☐	72. Assess client's financial situation in order to provide information regarding the legal implications of debt and government assistance, budgeting and negotiation with debtors.	☐
☐	73. Teach clients about money and budgeting in order to develop skills in the management of personal finances.	☐
☐	74. Develop a realistic family budget and a plan for financial restitution in order to enable the family to gain or regain control over finances.	☐
A. How Often?		**B. How Important?**

A. How Often?		B. How Important?
☐	75. Discuss with client the need to make restitution for incurred debts in order to teach gambler responsibility for his/her indebtedness including avoidance of further bailouts.	☐
☐	76. Suggest spouse assumes responsibility for family checking and savings accounts in order to avoid financial crises taking place.	☐
☐	77. Suggest to clients that access to cash must be limited in order to restrict gambling.	☐
☐	78. Advocate for individuals in order to persuade others that those people do qualify for services or financial help.	☐
☐	79. Start a legal process in order to protect the rights of an individual.	☐
☐	80. Testify or participate in court hearings in order to provide information on which legal decisions can be based.	☐
☐	81. Make contact with other units/agencies, by letters, memos, or phone calls, in order to refer people to appropriate services.	☐
☐	82. Put individuals in touch with people of similar backgrounds, cultures or ethnicity in order to make a move or change easier for them.	☐
☐	83. Establish contact between the service and local provider networks in order to create linkages and referral networks for people affected by problem gambling.	☐
☐	84. Refer individuals with gambling issues to GA and Gam-Anon recovery programs.	☐
☐	85. Refer client to a general practitioner or psychiatrist for treatment of depression or mood disorders.	☐
☐	86. Provide client with a self help manual in order to gain a better understanding of problem gambling.	☐
☐	87. Refer client to medical practitioner for treatment of health problems that are caused or exacerbated by gambling.	☐
☐	88. Educate spouse, parents, children and other family members about gambling.	☐
☐	89. Develop a marketing strategy in order to publicise and promote the gambling counselling service.	☐
☐	90. Educate individuals and groups of people about legal issues relating to debts.	☐
☐	91. Develop and initiate regional skill development workshops regarding problem gambling for health and community services industry personnel in order to identify and respond to the needs of problem gamblers.	☐
☐	92. Deliver education programs on problem gambling to gambling facilities in order to assist the gaming industry to respond to the needs of problem gamblers.	☐

A. How Often?		B. How Important?
☐	93. Deliver community education programs to the general public and the gaming industry in order to promote an awareness of problem gambling.	☐
☐	94. Collate and distribute information regarding gambling trends and problem gambling in order to maximise the impact of community education.	☐
☐	95. Promote the problem gambling counselling service amongst the gaming industry, service providers and the community in order to publicise its existence.	☐
☐	96. Explain service programs and policies to people in public appearances of various kinds in order to inform the general public about issues and programs.	☐
☐	97. Attend Financial Counselling Induction training and regular in-service training with the Financial and Consumer Rights Council.	☐
☐	98. Respond to request or inquiries from the community regarding the Financial Counselling Program.	☐
☐	99. Gather and analyse data about services provided to people in order to prepare statistics for periodic reports.	☐
☐	100. Review and analyse data about service needs and demands in order to establish workload and staffing requirements.	☐
☐	101. Take part or direct studies or research projects in order to increase the knowledge base of social work either in education or service provision.	☐
☐	102. Liaise with other services in the regional network in order to compare and analyse agency trends or issues in relation to problem gambling.	☐
☐	103. Develop, maintain and analyse client data consistent with the state wide format, and participate in any research projects regarding the service model.	☐
☐	104. Contribute to the agency's policy development, planning, monitoring and evaluation of the problem gambling counselling service.	☐
☐	105. Work with gambling facilities in order to assist them in developing policies, practices and procedures to deal with problem gamblers.	☐
☐	106. Identify and promote best practice models for problem gambling programs in order to provide an accountable, professional and accessible service to clients.	☐
☐	107. Participate in the development of educational and informative resources for the program.	☐
☐	108. Work with multicultural service providers in order to investigate culturally relevant and sensitive interventions for problem gambling.	☐
☐	Other (describe):	☐
☐	Other (describe):	☐
☐	Other (describe):	☐
☐	Other (describe):	☐

Appendix H: Minimum Data Set Data Collection Forms

CLIENT REGISTRATION FORM

PLEASE COMPLETE FOR EACH CLIENT. ALL QUESTIONS RELATE TO CLIENT *PRESENTING* FOR COUNSELLING

Client Identification Number

Agency Code OR name

Site Code OR name

Worker Code OR name

Today's date (d d m m y y y y)

1 Is this the client's first visit to this BreakEven service?
- ☐ 1 Yes
- ☐ 2 No. If registered prior to August 1997 please state **previous** agency code and **previous** client identification number

Previous Agency Code or Name

Previous Client Identification Number

2 Client's relationship to person with gambling behaviour. Please mark one box.
- ☐ 1 Self
- ☐ 2 Partner
- ☐ 3 Parent
- ☐ 4 Sibling
- ☐ 5 Other relative
- ☐ 6 Friend
- ☐ 7 Work colleague or employer
- ☐ 8 Other

3 Client gender
- ☐ 1 Male
- ☐ 2 Female

4 Age of client
- ☐ 1 Known. Please state ▶ _____ years
- ☐ 2 Unknown. Please estimate ▶ _____ years

5 Was the client born in Australia?
- ☐ 1 Yes
- ☐ 2 No. Please specify country of birth. ▼

6 Is the client an Aborigine or Torres Strait Islander? Mark one box only.
- ☐ 3 No
- ☐ 2 Yes, Aboriginal
- ☐ 1 Yes, Torres Strait Islander

7 Does the client speak a language other than English **at home**?
- ☐ 1 No
- ☐ 2 Yes. Please specify language. ▼

8 Does the client require an interpreter?
- ☐ 1 No
- ☐ 2 Yes. Please specify language. ▼

9 Does the client identify with a particular cultural group?
- ☐ 1 No
- ☐ 2 Yes. Please specify. ▼

10 What is the client's present marital status?
- ☐ 1 Never married
- ☐ 2 Widowed
- ☐ 3 Divorced
- ☐ 4 Separated, but not divorced
- ☐ 5 De facto
- ☐ 6 Married

11 Which **one** of the following **best** describes the client's current living arrangement?
- ☐ 1 Couple with children
- ☐ 2 Couple with no children
- ☐ 3 One parent family
- ☐ 4 Group/share household
- ☐ 5 Lone person household
- ☐ 6 Other

12 Is the client homeless? **Homeless refers to persons who have no home or permanent place to stay of their own (meaning they rented or owned it themselves) and no regular arrangement to stay at someone else's place.**
- ☐ 1 Yes
- ☐ 2 No

Questionnaire continues overleaf.

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13 Does the client have any dependants living with them? Dependants are children of the client who are under 15 yrs OR aged between 15 and 24 yrs and a full-time student.

- ☐ 1 No
- ☐ 2 Yes. Please specify number ▶ ☐☐

14 What is the client's current labour force status?

- ☐ 1 Employed 35 hours per week or more
- ☐ 2 Employed less than 35 hours per week
- ☐ 3 Unemployed. i.e. looking for work
- ☐ 4 Not in the labour force

15 Do any of the following descriptions apply to your client? Please mark all relevant boxes.

- ☐ 1 Voluntary worker
- ☐ 2 Home duties
- ☐ 3 Student
- ☐ 4 Retired
- ☐ 5 Not currently looking for work

16 Client's usual occupation. Mark one box only.

- ☐ 1 Manager or administrator
- ☐ 2 Professional
- ☐ 3 Associate/para professional
- ☐ 4 Tradesperson or related worker
- ☐ 5 Clerical or service worker
- ☐ 6 Production or transport worker
- ☐ 7 Labourer or related worker

17 Gross **individual** income of client. Please mark one box only

- ☐ 1 $1,500 or more per week
- ☐ 2 $800 - $1,499 per week
- ☐ 3 $600 - $799 per week
- ☐ 4 $400 - $599 per week
- ☐ 5 $200 - $399 per week
- ☐ 6 $120 - $199 per week
- ☐ 7 less than $120 per week

18 Gross **family** income of client. Please mark one box only.

- ☐ 1 $1,500 or more per week
- ☐ 2 $800 - $1,499 per week
- ☐ 3 $600 - $799 per week
- ☐ 4 $400 - $599 per week
- ☐ 5 $200 - $399 per week
- ☐ 6 $120 - $199 per week
- ☐ 7 less than $120 per week

19 Does the client receive a government **pension** or benefit? Please mark one box only.

- ☐ 1 No
- ☐ 2 Yes, age pension
- ☐ 3 Yes, disability support pension
- ☐ 4 Yes, sole parent pension
- ☐ 5 Yes, mature age allowance
- ☐ 6 Yes, newstart allowance
- ☐ 7 Yes, youth training allowance
- ☐ 8 Yes, sickness benefit
- ☐ 9 Yes, other

20 What is the client's presenting problem/s? Mark all relevant boxes.

- ☐ 1 Financial issues
- ☐ 2 Employment/work related issues
- ☐ 3 Leisure use issues
- ☐ 4 Interpersonal (relationship) related
- ☐ 5 Intrapersonal (anxiety, mood etc.)
- ☐ 6 Family issues
- ☐ 7 Legal issues
- ☐ 8 Physical symptoms
- ☐ 9 Gambling behaviour

21 Is the client legally bound to attend this session?

- ☐ 1 Yes
- ☐ 2 No

22 Who referred the client to your service? Please mark all relevant boxes.

- ☐ 1 Self referral
- ☐ 2 Family/friends
- ☐ 3 Community agency
- ☐ 4 Media
- ☐ 5 Self help group
- ☐ 6 Gamblers Anonymous
- ☐ 7 Other client of problem gambling service
- ☐ 8 Problem gambling service staff
- ☐ 9 G-Line
- ☐ 10 Other therapist
- ☐ 11 Legal service
- ☐ 12 Health service
- ☐ 13 Financial counsellor
- ☐ 14 Court order/correctional system
- ☐ 15 Other

The following information is required for geographic analysis only. It is not sufficient to identify individual clients and will not be used for this purpose.

23 Client's residential post code ☐☐☐☐

24 Name of suburb/town where client lives ☐

CLIENT ASSESSMENT FORM

FOR CLIENTS WITH GAMBLING BEHAVIOUR ONLY. COMPLETE AT REGISTRATION AND IF BEHAVIOUR CHANGES.

Client Identification Number

Agency Code OR name

Site Code OR name

Worker Code OR name

Today's date (d d m m y y y y)

1 Gambling behaviour during a typical gambling episode

	Hours per episode	Dollars spent per episode	Episodes per month
Lotto/scratch lotto/lottery/pools/keno			
Bet on races at TAB (off-course betting)			
Bet at races (on-course betting)			
Electronic gaming machine			
Bingo			
Bet on card games			
Numbers			
Other kind of gambling			
Internet/ On-line			
Not known			

2 Which pattern of gambling best fits the clients' behaviour?

- ☐ 1 Ascending
- ☐ 2 Descending
- ☐ 3 Stable
- ☐ 4 Chaotic
- ☐ 5 Binge
- ☐ 6 Not currently gambling

3 What is the total sum of money that the client has access to for gambling purposes? Access refers to monies which the client is willing to and capable of obtaining, legally and/or illegally, for gambling purposes.

- ☐ 1 $1,500 or more per week
- ☐ 2 $800 - $1,499 per week
- ☐ 3 $600 - $799 per week
- ☐ 4 $400 - $599 per week
- ☐ 5 $200 - $399 per week
- ☐ 6 $120 - $199 per week
- ☐ 7 less than $120 per week

4 Source of funds used for gambling.
Please mark all relevant boxes.

- ☐ 1 Budgeted leisure money
- ☐ 2 Deducted from normal household expenditure
- ☐ 3 Savings
- ☐ 4 Asset sales
- ☐ 5 Borrowed money from family or friend/s
- ☐ 6 Borrowed money from other source/s
- ☐ 7 Illegal actions
- ☐ 8 Other. Please specify. ▼

5 Total amount of gambling related debt $

6 In your estimation do the following statements typify your client's actions. May be completed with the client to raise awareness or may be completed by the interviewer independently of the client.

	Yes	No
Is preoccupied with gambling (e.g. preoccupied with reliving past gambling experiences, handicapping or planning the next venture or thinking of ways to get money with which to gamble)	☐ 1	☐ 2
Needs to gamble with increasing amounts of money in order to achieve the desired excitement	☐ 1	☐ 2
Has repeated unsuccessful efforts to control, cut back or stop gambling	☐ 1	☐ 2
Is restless or irritable when attempting to cut down or stop gambling	☐ 1	☐ 2
Gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g. feelings of helplessness, guilt, anxiety, or depression)	☐ 1	☐ 2
After losing money gambling, often returns another day to get even ('chasing' one's loses)	☐ 1	☐ 2
Lies to family members, therapist, or others to conceal the extent of involvement with gambling	☐ 1	☐ 2
Has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling	☐ 1	☐ 2
Has jeopardised or lost significant relationship, job, or educational or career opportunity because of gambling	☐ 1	☐ 2
Relies on others to provide money to relieve a desperate financial situation caused by gambling	☐ 1	☐ 2

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INDIVIDUAL CLIENT CONTACT FORM

PLEASE COMPLETE FOR EACH INDIVIDUAL CLIENT CONTACT. FOR GROUP SESSIONS USE GROUP CONTACT FORM

Client Identification Number

Agency Code OR name

Site Code OR name

Worker Code OR name

Today's date

d d m m y y y y

1 Is this the client's first visit to this BreakEven service? This is a transitional question for change of data collection systems.

- ☐ 1 Yes. Please complete client registration before continuing
- ☐ 2 No. If registered prior to August 1997 please state **previous** agency code and **previous** client identification number

Previous Agency Code or Name

Previous Client Identification Number

2 Venue that contact occurred in. Please mark one box only.

- ☐ 1 Financial counselling service
- ☐ 2 Health centre
- ☐ 3 Other health agency
- ☐ 4 Community agency
- ☐ 5 Telephone
- ☐ 6 Other

3 Nature of visit. Please mark one box only.

- ☐ 1 Initial visit - new client
- ☐ 2 Initial visit - re-presentation
- ☐ 3 Follow up visit
- ☐ 4 Planned final visit

4 Type of contact. Please mark one box only.

- ☐ 1 Scheduled contact
- ☐ 2 Unscheduled non-emergency contact
- ☐ 3 Unscheduled emergency contact

5 **Main** type of intervention during **this** contact. Please mark one box only.

- ☐ 1 Individual
- ☐ 2 Couple
- ☐ 3 Family
- ☐ 4 Self help options

6 Counselling mode. Please mark all relevant boxes.

- ☐ 1 Assessment/referral
- ☐ 2 Systemic therapies, structural strategic family therapy, psychodrama etc.
- ☐ 3 Supportive counselling, allowing clients to vent feelings and offer general supportive environment
- ☐ 4 Psychodynamic therapies; use of transference
- ☐ 5 Cognitive approaches/CBT/RET; analysis of beliefs through pattern restructuring; behavioural advice
- ☐ 6 Other. Please specify _____

7 Progress indicators

	Unresolved	Partially resolved	Fully resolved	Not an issue
Finances	☐ 1	☐ 2	☐ 3	☐ 4
Interpersonal relationships	☐ 1	☐ 2	☐ 3	☐ 4
Family	☐ 1	☐ 2	☐ 3	☐ 4
Physical health	☐ 1	☐ 2	☐ 3	☐ 4
Employment	☐ 1	☐ 2	☐ 3	☐ 4
Leisure	☐ 1	☐ 2	☐ 3	☐ 4
Intrapersonal (mood, anxiety etc)	☐ 1	☐ 2	☐ 3	☐ 4
Legal issues	☐ 1	☐ 2	☐ 3	☐ 4

8 What was the focus of this contact session? Mark all relevant boxes.

- ☐ 1 Financial issues
- ☐ 2 Employment/work related issues
- ☐ 3 Leisure use issues
- ☐ 4 Interpersonal (relationship) related
- ☐ 5 Intrapersonal (anxiety, mood etc.)
- ☐ 6 Family issues
- ☐ 7 Legal issues
- ☐ 8 Physical symptoms
- ☐ 9 Gambling behaviour

Questionnaire continues overleaf

PROBLEM GAMBLING SERVICES MINIMUM DATA SET JULY 1997

9 During this contact session did you refer the client to any other support services?
Please mark all relevant boxes.

- ☐ No
- ☐ Yes, family counselling or support services
- ☐ Yes, general health services
- ☐ Yes, self help services
- ☐ Yes, mental health professionals
- ☐ Yes, Gamblers Anonymous (G.A.)
- ☐ Yes, legal services
- ☐ Yes, financial counselling services
- ☐ Yes, relationship counselling
- ☐ Yes, material aid
- ☐ Yes other support services. Please specify ▼

10 Is the client planning further contact?

- ☐ Yes, further contact planned
- ☐ No, presenting problem/s unresolved
- ☐ No, presenting problem/s resolved.
- ☐ Not known

11 Contact time.

_____ minutes

If the client's registration details have changed dramatically please fill out a new client registration form.

If the client's assessment details have changed dramatically please fill out a new client assessment form.

GUIDELINES

CLIENT REGISTRATION FORM

The information provided by the Client Registration Form will be used to provide demographic information about the type of people using support services.

The Client Registration Form is to be filled in by staff on behalf of all clients. The Client Registration Form should be completed at the commencement of the client's contact with the service.

Every client is to be allocated a **client identification number**. Each subsequent Contact and Assessment Form for that client must contain the same unique identifier. No agency should have two clients with the same client identification number. The **agency code** is allocated by the Department of Human Services. The **site code** is allocated by the agency. Site codes are unique within each agency. The **worker code** is the individual worker's identification code. Worker codes are unique within each agency and allocated by the agency. Each worker has one identification code only. New workers should be allocated a new code. They should not use the previous position holder's code.

INDIVIDUAL CLIENT CONTACT FORM

The Client Contact Form is used to provide an overview of the nature of worker intervention for the duration of the client's contact with the service.

The Client Contact Form is to be filled in by staff. It is to be completed for each client for every non-group contact, including contact by telephone. Which telephone calls should be thus recorded is left to the discretion of the individual counsellor. This form relates to individuals who receive a direct service irrespective of their relationship with the gambler. Do not complete this form for group sessions.

GROUP CONTACT FORM

The Group Contact Form is used to provide an overview of clients involved in group work. This form is to be filled in by staff. One form per group session providing the client identification numbers for all participants.

CLIENT ASSESSMENT FORM

The Client Assessment Form will be used to provide an overview of gambling behaviour. It is not intended to present a comprehensive picture of 'problem gamblers'.

The Client Assessment Form is to be filled in by staff on behalf of all clients receiving a problem gambling service. The Client Assessment Form should be completed at the client's assessment visit. If the client's gambling behaviour, as noted on the Client Assessment Form varies during the course of the treatment a new Client Assessment Form should be completed.

PROBLEM GAMBLING SERVICES MINIMUM DATA SET JULY 1997

GROUP CONTACT FORM

PLEASE COMPLETE ONE FORM FOR EVERY GROUP CONTACT

Agency Code OR name

Site Code OR name

Worker 1 Code OR name

Worker 2 Code OR name

Please list the client identification numbers of all registered participating clients.

Client 1 Identification Number

Client 2 Identification Number

Client 3 Identification Number

Client 4 Identification Number

Client 5 Identification Number

Client 6 Identification Number

Client 7 Identification Number

Client 8 Identification Number

Client 9 Identification Number

Client 10 Identification Number

Client 11 Identification Number

Client 12 Identification Number

Client 13 Identification Number

Client 14 Identification Number

Client 15 Identification Number

Client 16 Identification Number

Client 17 Identification Number

Client 18 Identification Number

Client 19 Identification Number

Client 20 Identification Number

Client 21 Identification Number

Client 22 Identification Number

Today's date

d d m m y y y y

1 Number of unregistered **male** clients ▶

2 Number of unregistered **female** clients ▶

3 Venue that contact occurred in.
Please mark one box only.
- ☐ 1 Financial counselling service
- ☐ 2 Health centre
- ☐ 3 Other health agency
- ☐ 4 Community agency
- ☐ 5 Telephone
- ☐ 6 Other

4 What was the focus of this contact session? Mark all relevant boxes.
- ☐ 1 Financial issues
- ☐ 2 Employment/work related issues
- ☐ 3 Leisure use issues
- ☐ 4 Interpersonal (relationship) related
- ☐ 5 Intrapersonal (anxiety, mood etc.)
- ☐ 6 Family issues
- ☐ 7 Legal issues
- ☐ 8 Physical symptoms
- ☐ 9 Gambling behaviour

5 **Main** type of intervention during **this** contact.
Please mark one box only.
- ☐ 1 Therapeutic
- ☐ 2 Educative
- ☐ 3 On-going support
- ☐ 4 Self-help (worker assisted)

6 Contact time for the group.
minutes

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Appendix I: The Development of Measurement Tools used in the Melbourne University Problem Gambling Program

Measurement Tool Development for the University of Melbourne School of Social Work Problem Gambling Program

At the outset of the Problem Gambling Program, it was apparent that a significant effort would be required in the development of psychometrically robust tools for use within the program. This was due to the low availability of tools suited to the measurement tasks posed by the program design. Within the field of gambling research there has been quite a deal of controversy concerning measurement issues. Even the cornerstone of much gambling research, the South Oaks Gambling Screen has been the subject of trenchant, and in our opinion, justified criticism for its inadequacies. There is a significant research effort currently under way within Australia and internationally to develop new tools for use within the problem gambling field. We have had consultations with the Flinders Technology Group that has been engaged by the Victorian casino and Gaming Authority to develop a new measure of problem gambling. We await their work with interest. In sum, gambling research has very few standardised tools available to it.

To address this issue, the program methodologist, Professor Shane Thomas in conjunction with the other two program principals, Professor Alun Jackson and Dr. Neil Thomason developed standards to assist the Problem Gambling Programs in the development of measurement tools associated with the research program. The purpose of this activity was to provide methodological and statistical guidelines for the development of such tools. This document describes the standards and concludes with some discussion of their application to various tools developed within the program.

Measurement Tool Development Standards and Protocols Used Within the Problem Gambling Research Program

The methodology advocated for the development and validation of measurement tools in this document draws upon the principles and protocols proposed by De Villis (1991) in his seminal book on Scale Development.

De Villis (1991) advocates an eight-step process of scale development. Each of the steps is used as a heading for description of the scale development and validation procedures that has been followed in this project.

1. "Determine clearly what it is you want to measure"

Prior to the development of any tools, it is necessary to clarify exactly what it is that is going to be measured. In some situations, this is pursued by directly jumping in to the drafting of the measurement tool. Equally, it is often the case that there has not been sufficient precision in the exact purpose of the measurement tool. Discussion at this

stage in the tool development can save many hours in re-drafting of instruments where it is not the form of the actual items that is at issue but the underlying constructs that the different protagonists wish to measure. If different protagonists have different goals, then considerable and avoidable time will be spent in item redrafting.

2. "Generate an item pool"

The generation of an item pool can occur in a variety of ways. One good way is to derive each item from a statement of what the tool is intending to measure and to be ruthless about the degree of match with the goal statement for the measurement tool. This process can also be very usefully informed by analysis of the literature surrounding the target concepts. This review process may also reveal other similar tools, that are similar to the new tool under construction but that are not exactly what is desired from a content or methodological viewpoint. Another particularly effective way of developing items can be to do a content analysis of several related tools to identify the full range of the items included in similar tools and then use these content guides for the new tool.

3. "Determine the format for measurement"

An important design decision is the scale format of the items in the tool under development. As discussed in Polgar and Thomas (1995),[1] there are virtues associated with different types of response categories. The types of scale formats that are usually considered for use with measurement tool items are:

- Likert type.
- Forced choice.
- Dichotomous.
- Numerical rating scale.

Likert Scales

The Likert scale is normally a five point scale, with an intermediate position. This scale is usually considered to be an interval type scale, ie a scale that has the property of equal intervals between the scale points.[2] Examples of scale points on a Likert scale are:

- strongly agree.
- agree.
- neither agree nor disagree (undecided).
- disagree.
- strongly disagree.

Forced choice scales

A forced choice format does not include the middle category, thus forcing the respondent to choose a scale point on one side or the other of the undecided point. Examples of scale points on a forced choice scale are:

- strongly agree.
- agree.
- disagree.
- strongly disagree.

It has sometimes been claimed that forced choice scales cannot be considered to be interval data because of the lack of a central point. This runs counter to the many instances in the published literature where this has been implemented. A way of treating the data in coding is to code the responses as positive and negative, for example, strongly agree as +2, agree as +1, disagree as –1 and strongly disagree as –2, assuming that the neutral score if it had been included would have been 0.

The virtue of multiple scale points or categories is that they permit graded measurement of the attribute being rated or the question answered. However, there are several issues that arise from the gradation. A major problem with graded response scales is that people may interpret the scale points in different ways. There have been many studies of rating artefacts including acquiescent response mode (a propensity to choose middle ratings) and extreme response mode (a propensity to choose extreme items) that may introduce measurement error into scales.

There is also the issue of how graded the scales should be. Should it be 2, 3, 5, or 10 gradations? This involves a balance between the degree of precision desired in the measures and the extent to which the people completing the scale can make meaningful discrimination between the scale points. Let us now discuss dichotomous and numerical rating scales, the two extremes of the choice of numbers of scale points.

Dichotomous scales

Dichotomous scales or categories have only two scale points or categories, for example:

1 Polgar, S. & Thomas, S.A. (1995). *Introduction to research in the health sciences* (3rd ed.). Edinburgh: Churchill Livingstone.

2 In some statistical texts, it is claimed that checklist scores are inherently ordinal rather than interval in nature. While this degree of rigour is proposed by some theoreticians, in practice it is very unusual for such data to be treated as ordinal. Inspection of most social and behavioural research journals will reveal that such data are almost always treated as interval. Simulation studies of the statistical impact of violation of these assumptions has shown that the effect is minimal. Thus, for all intents and purposes, it is perfectly acceptable to treat data of this nature as intervally scaled.

- yes.
- no.

Dichotomous items have the virtue of reducing the need for arbitrary judgments of extent. There is lower ambiguity of scale points. This promotes greater validity and ease of use of the tool.

Numerical Rating Scales

Sometimes researchers will avoid the labelling of individual scale points by using a numerical rating scale, sometimes with labelled end points. For example, the following question illustrates this option.

On a scale from 0 to 10, with 0 indicating no pain and 10 indicating unbearable pain, your current level of pain.

The use of numerical rating scales permits a finer gradation of measurement. However, while the points are labelled, this does not avoid the issue that one person's six may be another person's seven. However, numerical rating scales are a perfectly respectable way of designing a rating scale.

4. "Have initial item pool reviewed by experts"

Review of the item pool that has been generated using the previous steps in the process is a particularly useful procedure. It is even better if the panel can sit together to do this task, although be ready for some protracted discussions. Hopefully, if the previous steps have been performed well, there will not be a great deal of discussion that arises from disagreements about the content of the tool at the fundamental measurement goal level.

5. "Consider inclusion of validation items"

In De Villis' exposition, the inclusion of validation items may be achieved in several different ways. Some psychological tests such as the MMPI have truth sub-scales where items that are demonstrably true or false are scored to form a measure of the truth of the responses. In other words, the inclusion of gold standard validation measures.

In most of the projects performed by us, there is no gold standard measure of the attributes in question. Therefore, this step is not especially useful in this context.

6. "Administer the items to a development sample"

It should be accepted that the first run of the scale is a development exercise. No matter how carefully the earlier steps have been implemented, there are statistical issues and logistic issues that cannot always be predicted at the design stage. It is sometimes useful to use a pilot with a small group of people drawn from the target population to trial the tool. The procedure is to administer it and then to interview them about ease of completion, understanding or confusion about items and so on.

7. "Evaluate the items"

Once the measurement tool has been administered to a reasonable sample[3] of respondents, there is a wide range of statistical techniques available to analyse the items of a scale. These are described below.

Item difficulty. Item difficulty is the proportion of respondents who "pass" a particular item. If the concept of "passing" an item is not applicable to the intent of the item, then item difficulty is not applicable.

Item scale correlations. In many instances, it is possible to derive a total score from the scale, e.g. using the numerical values assigned to the scale points on each item. If the score of each item is correlated with this total score, then this gives an indication of the contribution of the that item to the variability in the overall scale. It is generally considered that low item-scale total correlations are undesirable.

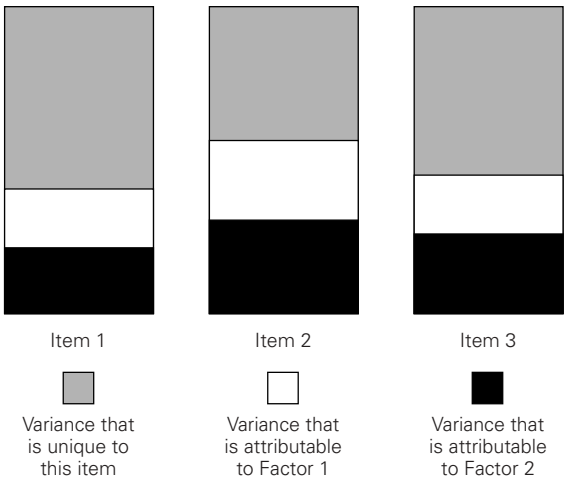
Coefficient alpha. Coefficient alpha or Cronbach's alpha is a measure of the homogeneity of the scale items. If all the items correlate highly, then alpha will assume a high value (close to 1.0). As De Villis notes, it is not necessarily the case that a high Cronbach alpha is always desirable if the goal of the scale is to measure a profile of relatively unrelated attributes. This might be applicable to psychometric tests, but is rarely applicable in other settings.

Criterion related validity correlations. These are very important measures of item validity. Each item score is correlated with a criterion variable e.g. whether the person passed all their course requirements. High correlations are generally desirable.

3 In terms of what is a reasonable sample, it is generally the case that multivariate analysis is to be employed in the analysis of the data. According to most authors, 10 cases per variable is a good standard to apply to determine the numbers of cases required. Thus if you have 20 items then 200 responses are desirable. Some authors advocate 5 cases per item but the reliability of the linear estimates in these cases is suspect. There is no specific answer as to what is a reasonable ratio. It depends upon how precise you want your statistical analyses to be. This is a value judgment not an iron-clad criterion.

Factor analysis. Factor analysis is a means of exploring the internal structure of multi item scales. First the correlation matrix of all items with all other items is constructed. This is then subjected to a mathematically complex but conceptually simple technique to discover whether there are sets of items that tend to correlate with each other and not other clusters of items. The assumption is that there are latent variables underlying the items which are partly measured by it. For example, it might be hoped that within a particular study that there is a single latent variable measured by all the items. Factor analysis reveals how many latent variables or factors are present in a set of items. Thus factor analysis may be used to study the internal structure of scales, to reveal how many factors there are. The factor structure may then be studied to see which items cluster with others and to interpret what this means in practical and measurement terms.

The following diagram shows what is achieved by factor analysis.



8. "Optimise scale length"

There are competing requirements for scale length. Long scales—that is—scales with many items that sample a wide range of aspects of the attribute(s) being measured, and may have higher validity. It is also known that in psychometric theory that scale length promotes greater reliability. The Spearman Brown formula is a means of actually estimating the effects of lengthening or shortening a scale upon its reliability. All other things being equal a longer scale may have higher validity and reliability than a shorter version of the same scale. However, this is by no means a certain outcome.

On the other hand, short scales have high practicability and the loss of reliability and validity may be negligible if the attribute being measured by the scale is tightly defined. In clinical settings, provided reliability and validity are not sacrificed, short scale length is very useful indeed, because of the very tight timelines that now operate in most clinical settings. In fact, the choice in these settings may not be between the use of a short scale and a long one but a short one and the abandonment of its use altogether. General Practitioners are busy people, so short scales are desirable without sacrifice of scale validity and reliability.

The shortening of scale length is achieved by deletion of poorly performing items. Poor performance of an item can be detected and defined by the following attributes:

Very low or very high item difficulty. If everyone passes or fails an item, then it is not useful as a means of discriminating between different target groups because it adds little discriminating information. Items with extreme difficulties also have low variances and covariances which means that their ability to predict or correlate with other variables is reduced.

Low correlations with criterion variables. Items that correlate poorly with a criterion variable should then be deleted from the scale as little or nothing is to be gained by collecting this information.

Another method of selection of items for deletion is low correlation with other items. In classical test theory, it is desirable that items correlate highly with each other in order that they are measuring the same attribute. In this study, the target attribute is need for services. Thus items with low correlations with other items are marked for deletion under this approach.

A variant of the above approaches is to conduct a factor analysis of the tool in order to see whether items tend to cluster together. In simple terms, the purpose of factor analysis is to determine whether there are factors or clusters of variables that are correlated with each other. In a situation where all items correlate highly, it is usual that the factor analysis yields a one factor solution meaning that the items are broadly measuring the same quality or attribute. However, other outcomes are possible. There may be several factors or latent variables that underlie the screening tool items. The items with high loadings on the main factor would be retained and

those with low loadings would be deleted. This is a more sophisticated version of selection of items with high inter-correlations and high covariances for inclusion in the scale and deletion of other items.

The above principles and practices are the classical methods of scale length optimisation and analysis of scale properties.

Application of the Standards to Scale Development Within the Problem Gambling Program

The above standards and protocols were developed for use within the Problem Gambling Program. We now discuss their application in selected examples of scale development within the program.

Client Satisfaction Scale

The satisfaction scale used in the client questionnaire was adapted from a patient satisfaction scale developed to measure a client's satisfaction with the service they receive from General Practitioner's (G.P.'s). The scale was chosen as it was a recently developed national scale looking at health consumers' experiences of and satisfaction with health service delivery (Steven, Thomas, Eckerman, Browning, Dickens, 1999).[4] Of the thirty nine item questionnaire only items exploring the interaction between doctor and patient were used, the technical items and accessibility items were not relevant in the context of the evaluation. The G.P. questionnaire consists of thirteen items that measure the interactive process that occurs between doctor and patient. Of these thirteen items seven were considered appropriate in the context of the evaluation of counselling services. The items dropped and items included are listed below with their original alpha values listed. In its original form the patient–G.P. interaction factor in the G.P. study accounted for 33.1 per cent of the variance of a total three factor variance of 44.4 per cent.

Table 1 Interaction items from satisfaction scale

Item: Are you satisfied with:	Alpha	Used/Not
The doctor's willingness to listen	.75	Yes
The doctor's ability to answer questions	.73	Yes
The respect shown you by the doctor	.72	No
The doctor's willingness to answer questions	.72	Yes
The explanation given by the doctor	.72	No
The doctor's concern about your problem	.70	No
The way the doctor examines you	.69	No
The notice the doctor takes of your wishes	.68	Yes
The doctor's willingness to spend time with you	.67	No
The doctor's ability to treat your problems	.66	Yes
The doctor's knowledge	.65	Yes
The advice given by the doctor	.56	No
The amount of time the doctor spends with you	.48	Yes

On the whole the items excluded from the counselling questionnaire had already been asked in slightly different forms in the relationship scale particularly the questions constituting the bond sub scale.

Table 2 on the following page provides the results of the factor analysis conducted on the counselling satisfaction questionnaire. It is also interesting to note the correlation coefficient for these items, all relationships were statistically significant at the (p>01) level.

As Table 2 indicates two clear factors emerged from the analysis. These factors accounted, over all, for 77 per cent of the variance in responses. This is consistent with other satisfaction questionnaire findings. (Steven et al., 1998). The first factor, counselling process items or interactional items were clearly the strongest. These findings are consistent with the G.P. study, this factor alone explained 64 per cent of the variance. An interesting addition is the second factor although this factor could correlate to the 'accessibility' factor in the G.P. study. This second factor concerning time, explained a further 12 per cent of the variance in responses. On the basis of this list of items it would appear that the interactional or process factors in counselling have a strong interrelationship. Although the trend in responses is similar between the G.P. study and the current study there are differences in detail. These differences could well be explained by the different scoring regimes used for each scale. The study scale used a fully anchored five point likert scale whereas the G.P. study used a three point scale.

4 Steven, I.D., Dickens, E., Thomas, S.A., Browning, C.J. & Eckermann, E. (1998). Preventative care and continuity of attendance. Is there a risk? *Australian Family Physician*, Suppl 1, S44-S46.

Table 2 Results of factor analysis of service satisfaction questions

Item: How satisfied were you with:	Factor 1 Counselling Process	Factor 2 Counselling Accessibility
The amount of time between contacting the service and being able to see a counsellor.	(.43)	.79
The amount of time the counsellor spent with you	(.55)	.68
The counsellor's treatment of your problem/s.	.93	
The counsellor's ability to listen to your problems	.83	
The counsellor's willingness to answer your questions.	.82	
The counsellor's knowledge about the problems facing you.	.86	
The counsellor's ability to help you with your problems.	.89	
The way the counsellor focussed on the issues you presented to him/her.	.89	
The outcomes you achieved as a result of attending counselling.	.80	
Overall how satisfied were you with your counselling experience.	.87	

Table 3 Results of factor analysis of Life Skills questionnaire questions

Item: In what ways did counselling impact on other aspects of your life.	Factor 1	Factor 2
Self awareness.	.79	
Understanding the nature of problem gambling behaviour.	(.55)	.46
Ability to accept responsibility for the problems their gambling caused.	.64	
Ability to communicate with others close to me	.77	
Ability to cope with stress.	.68	
Self esteem.	.79	
Self confidence.	.75	
Ability to talk to others about sensitive issues.	.59	
Knowledge of services available that can assist people with gambling related problems.	(.48)	.45

"The use of this scale may have meant that some patients with minor degrees of non satisfaction answered that they were satisfied, thus reducing the degree of sensitivity of the answer and thus the variance."(Steven et al., 1999: 348)

Life Skills Scale

A factor analysis was conducted to explore the relationship between items constituting the life skills scale. The results of the analysis are provided in Table 3. All but one correlation between items were statistically significant at the ($p > .01$) level.

As indicated by Table 3 two factors emerged in the analysis. In total they explained 61 per cent of the variance, with the first factor explaining 46 per cent and the second factor 15 per cent. The first factor appears to include all items that involve a development in skills of an individual relating to themselves in relation to others. The second factor appears more characterised by gaining some knowledge about something external to the individual client.

On the basis of the analysis provided above regarding the psychometric properties of the questionnaire, it would appear that the questionnaire is internally consistent and when compared with the results of similar tools used in the field produces consistent findings. Because of the lack of opportunity to pilot and test the questionnaire the author can not argue categorically that it is a reliable instrument. There are grounds for arguing the validity of the questionnaire is strong, in terms of its content, construct and criterion. It is the hope of the author that a similar structure or parts of it are used in further client evaluations of counselling practice so the reliability of the instrument can be further established.

Analysis of DSM-IV Items

Using a dichotomous 0/1 coding scheme, the DSM-IV items from the 1997/98 Minimum Data Set were subjected to factor and scale analysis using SPSS. The Cronbach alpha associated with a summed scale was found to be 0.87. Factor analysis revealed a single factor solution using Cattell's Scree Test. The Kaiser criterion, where all factors with eigenvalues of 1.0 or

greater are included, and would have yielded a two factor solution, but the first factor accounted for over 50 per cent of shared variation and the second less than 5 per cent. Our findings in these analyses are under preparation for publication.

Counsellor Task Analysis

The development of this scale is documented in the attached paper.

Numbers of Problems Resolved

In analysis of the problem resolution data, several inferred variables were constructed including numbers of problems resolved. These variables involved 0/1 coding derived from the five point coding scheme originally devised and reported.

For the sake of completeness, scale analysis was performed for both the full and coded scales. The Cronbach alphas for the collapsed and original scaling forms were .87 and .84 respectively. An alpha of .8 is generally considered to indicate highly acceptable levels of unidimensionality, so both forms qualified. The same two sets of data were subjected to factor analysis.

Factor analysis revealed a single factor solution using Cattell's Scree Test and the Kaiser criterion, where all factors with eigenvalues of 1.0 or greater are considered to be "meaningful" for both scale forms. Our findings in these analyses are under preparation for publication.

Scale analysis alone does not present a definitive argument for the acceptance of the utility of a measure. In the case of this scale, we have presented argument in the main body of this report for the logical integrity of the scale.

Conclusion

The above analyses provide examples of the outcomes of the development procedures followed in scale production within the program. You may be assured that a high standard of rigour has been applied to the development and implementation of the protocols. As we have outlined earlier in this document, the problem gambling area as with many other emerging fields is beset with a lack of standardised tools. A feature of the Problem Gambling program has been the development of many such tools for use within the research and evaluation activities engendered within the program. The outcomes of these activities will be the subject of a series of scientific publications from the program.

Development of an Instrument for the Analysis of Practice of Problem Gambling Counsellors[5]

Alun C. Jackson, Tangerine A. Holt, Shane A. Thomas, Neil Thomason, Beth R. Crisp[6]

Abstract

This paper describes the process of developing the Counsellor Task Analysis (Problem Gambling) instrument and the importance of an empirical examination of practice of problem gambling counsellors. The CTA (PG) aims to provide a broad overview of the complexity of the counsellor's role; specify the range of tasks they perform; and document the relationship between the frequency of task performance and the counsellor's beliefs about the importance of the tasks performed. The CTA (PG), was derived from a number of sources and consists of nine clusters of practice activity, addressed by 20 sub-scales, all of which demonstrated internal consistency. The CTA (PG) requires respondents to rate, using a five point scale, "how often" they performed each task, and "how important" it was to their job. It gives counsellors the opportunity to document their practice and theories in use when dealing with a problem gambler, a member of the problem gambler's family and the community at large.

Introduction

Following the legalisation of electronic gaming machines (EGMs) and a casino in Victoria, considerable attention has been given to issues relating to problem gambling and its treatment (Dickerson et al, 1997). The Department of Human Services' Problem Gambling Services Strategy which, funded through the Community Support Fund (created through a levy of 8.3 per cent of net hotel-based EGM profits), comprises a number of elements including the BreakEven Problem Gambling Counselling Services and a problem gambling research program designed to address issues arising from the social impacts of problem gambling.

This paper provides an overview of the development of a Counsellor Task Analysis (Problem Gambling) (CTA(PG)) instrument undertaken as part of an evaluation of the BreakEven Problem Gambling Counselling Service in Victoria. BreakEven provides a range of individual, couple and group counselling and gaming industry liaison services through eighteen agencies operating from 100 sites across the State of Victoria (Jackson, Thomas, Thomason, Borrell, Crisp, Ho, Smith, Holt, 1999).

Purpose of the CTA (PG)

Instruments that specifically measure counsellor practice related to problem gambling appear to be non-existent. The purpose of the CTA (PG) was to measure the frequency and importance of counselling activities performed by problem gambling counsellors with clients who have presented with issues relating to problem gambling, either their own or a family members'. As part of the service effectiveness evaluation the CTA (PG) was one method used for making explicit the details of counsellor practice. Other methods included a 'clinical practice evaluation' questionnaire, which aimed to obtain problem gambling counsellor views of what determined their practice and their 'theories in use'. Although we recognise the complexity of the issue of definition and measurement (Problem Gambling Research Program, 1999), the CTA (PG) attempts to operationalise the definition of problem gambling that is adopted in Victoria by the Victorian Casino and Gaming Authority and then Department of Human Services:

Problem gambling refers to the situation when a person's activity gives rise to harm to the individual player, and/or to his or her family, and may extend into the community (Dickerson, M., McMillen, J., Hallebone, E., Volberg, R. and Woolley, R., 1997).

Approaches to the Empirical Description of Human Service Work

Austin has suggested (1979, 1981) that human service work can be defined at various levels of functioning and has identified five major functions, including linkage, mobilisation, counselling, treatment and administration. In addition to defining human service

5 This study was commissioned by the Victorian Department of Human Services and funded by the Community Support Fund
6 Problem Gambling Research Program, University of Melbourne

work in terms of functions, job components, and major activities by observation and analysis of activity, the more 'subjective' aspect of the worker's perspective may be added.

Commonly known as task analysis studies, this sort of functional job analysis covers a range of analytic procedures used to describe human work in terms of tasks or activities which are usually described or identified in very abbreviated form, consisting of an active verb and its object, but typically not including the infinitive phrase which is characteristic of conventional job descriptions.

Functional job analysis has proven to be a useful tool for administrators and trainers because it quantitatively describes existing tasks which can be used to assess the fit between practice and purpose and to assess the utility of training programs. Some of the specific benefits of job and task analyses include clarification of job expectations, facilitation of workers' performance reviews, providing an information base for completing agency accountability reports, monitoring the relationship between work performed and the goals of the agency, and identifying the training needs of workers (Austin, 1981).

Tool Development Protocol

The development of the CTA (PG) measurement tool followed the principles advocated by De Villis (1992). These include:

- Determine what is to be measured.
- Generate an item pool.
- Determine the format for measurement.
- Have initial item pool reviewed by experts.
- Administer the items to a development sample.
- Evaluate the tasks.
- Optimise scale length.

As noted previously, the purpose of the CTA(PG) was to measure the frequency and importance of counselling activities performed by problem gambling counsellors with clients who have presented with issues relating to problem gambling. In order to ensure that all theoretical models and existing practice were captured in the development of the CTA (PG), an empirical approach was taken utilising both the qualitative and quantitative techniques from a number of sources, including:

- Borowski and Lagay's (1991) *Mapping Social Work Practice Questionnaire*.
- Teare and Sheafor's (1995) *Job Analysis Questionnaire (JAQ)*.
- Austin's (1981) supervisory management oriented approach to task definition.
- An in-depth literature review in the fields of problem gambling counselling and addictions counselling.
- Job descriptions from the BreakEven Problem Gambling Counselling Services.

Borowski and Lagay's (1991) 'Mapping Social Work Practice Questionnaire' (MSWPQ) was based on an earlier version of Teare and Sheafor's (1995) Job Analysis Questionnaire (JAQ). Minor changes were made to adapt the MSWPQ to the Australian context, resulting in 134 task statements. Thirty tasks which depict general social work practice were adopted from the Mapping Social Work Practice Questionnaire (Borowski and Lagay, 1991) and added to the CTA (PG). The format of frequency and importance in the CTA (PG), using a five-point scale, are similar to the American (Teare & Sheafor, 1995) and Australian (Borowski and Lagay, 1991) studies.

In order to gain an understanding of the core counselling activities of problem gambling counsellors, the CTA (PG) was designed to reflect many theoretical interventions, which were deemed relevant to practice context of these counsellors. There was a need to design an instrument that was inclusive of the range of practice, rather than exclusive. The interventions selected for inclusion were a combination of cognitive, behavioural, self-help treatment strategies and processes. These include motivational interviewing (Miller, 1983), thought stopping, cognitive restructuring; minimal interventions through self-help manuals (Glasgow & Rosen, 1978; Miller, Gribskov & Mortell, 1981; Orford & Edwards, 1977, Dickerson et al, 1990); relaxation therapy (Walker, 1992), control over cash money flow, alternate activities to gamble, long-term support and follow-up (Dickerson and Weeks 1979); controlled gambling therapies; group and individual psychotherapy Custer and Milt (1985); Gamblers Anonymous 12-step approaches (Gaudia, 1987).; and skills training including reducing nagging by the gambler's partner (McCrady, 1988), win therapy (Sartin, 1988).

Because the development of the instrument occurred within the context of the evaluation of the BreakEven Problem Gambling Counselling Service, problem

gambling counsellor's job descriptions were reviewed in consultation with BreakEven senior management.

Task statements were written up using the framework developed by Austin (1981) where the two most important elements of a task statement are:

- The action which the worker is expected to perform.
- The result expected of the worker action.

Based on this range of information an item pool was developed. The draft CTA (PG) instrument was circulated for comment among the members of the research team and experts in the field. The criteria that they used to critique the draft included clarity of the statements, comprehensiveness of the content and avoidance of technical jargon (Teare & Sheafor, 1995). Minor alterations were made to the CTA (PG) based on their feedback, and face validity was achieved.

One hundred and twenty-one possible task statements were included. The CTA (PG) required respondents to rate the task statements in relation to their current practice in the course of a typical month, using a five-point scale, "how often" they performed each task, from Not Done (scored as 1) to Almost Always (scored as 5). Simultaneously, counsellors were asked to rate the task statements as "how important" they were to their job. Responses could range from Not important (scored as 1) to Extremely important (scored as 5).

The 121 task statements thematically grouped into 9 clusters, representing a broad view of the counselling role in this service. These clusters include:

- Assessment.
- Treatment goals.
- General interventions.
- Family interventions.
- Gambling interventions.
- Interventions for related problems.
- Referral.
- Education.
- Research/policy.

Description of the CTA (PG) Clusters

Once the CTA (PG) clusters were thematically identified for their meaningfulness and homogeneity, care was taken in assigning cluster labels and descriptions. Meaningfulness meant that a cluster should only contain tasks that, from a practice point of view, could be connected logically to one another (Teare & Sheafor, 1995). Homogeneity was estimated statistically by measuring the internal consistency of the cluster using Cronbach's alpha (Cronbach, 1951).

Assessment
Assess case situation to determine need, risk, urgency and engage clients either in making use of services or preparing them for transition or termination.

Treatment Goals
Develop counselling goals for the outcomes of treatment. These may include change goals or choice goals.

General Interventions
Use basic helping skills like interviewing, questioning, counselling to assist individuals and/or families in understanding the problems they experience in social functioning and help then to examine possible options for resolving those problems.

Family Interventions
Use clearly defined formal treatment modes to help families to improve their social functioning or resolve social problems.

Gambling Interventions
Use a variety of therapeutic techniques and strategies with individuals and family members to improve their social functioning without or by controlling gambling.

Interventions for other Related Problems
Deliver a variety of services, which enables individuals, families, employers to cope with legal, financial and employment problems due to problem gambling.

Referral
Coordinate service planning with internal staff and providers from other agencies in order to provide any additional services that the client may require.

Education
Inform and educate individuals, the general public, gaming industry, and community agencies about problem gambling. In addition, engage in activities that strengthens one's own practice effectiveness and expand one's professional competence.

Research/policy
Collect, analyse and publish data so as to influence public opinion, public policy and legislation in the development of a knowledge base of accountable, professional and accessible counselling services for problem gamblers and their families.

Following the development of the CTA(PG), it was administered to the population of BreakEven problem gambling counsellors in Victoria.

Sample

The CTA (PG) was mailed to all 50 problem gambling counsellors from the 18 agencies auspicing the BreakEven Problem Gambling Counselling Service, along with a personal history questionnaire so that relevant demographic information could be obtained. Forty-nine replies were obtained from the BreakEven counsellors, representing a 98 per cent response rate. Being a population study, the sample is representative of the problem gambling counsellor population in the State of Victoria.

Table 1: Demographics of Counsellors in Problem Gambling

Gender	
Female	66%
Male	34%
Age	Mean 40.6 years
Professional Education	
Social Work	22.9%
Psychology	43.8%
Welfare Studies	14.6%
Occupational Therapy, psychiatric nursing, education	18.8%
Agency Type	
Community Health Centres	50%
Family Support	28%
Material Aid	11%
Drug and Alcohol	11%
Specialist Training Courses attended	87.3%

A demographic profile of the problem gambling counsellor appears in Table 1. Approximately 66 per cent of the counsellors were female. Overall the mean age for both male and female counsellors was 40.5 years. A little over two-thirds of the sample were qualified as either social workers or psychologists. Other qualifications which counsellors held were welfare studies (14 per cent) while the remaining one-fifth of the counsellors were qualified in a range of areas including occupational therapy, psychiatric nursing, education, childcare and social science generalist degrees. Additionally, a majority of counsellors (87 per cent) had attended specialist training courses in problem gambling counselling, held at the time of the introduction of the BreakEven program in the State of Victoria. Half of the BreakEven programs were located within community health centres, while 28 per cent of the BreakEven programs were located within family support agencies. The remaining programs were located within agencies which were primarily involved in the delivery of material aid (11 per cent) and drug and alcohol counselling (11 per cent). The CTA (PG) was re-administered after a 12-month period to track changes in counselling practice as the BreakEven program 'matures' or 'evolves'.

Factor Analysis of the Clusters

The task items in each cluster were entered into factor analysis to determine whether there were distinct subsets of tasks. The internal consistency of each of these scales was assessed. A principal components factor analysis with varimax rotation was carried out on each of the clusters with a minimum of a .4 loading being set as the criterion to determine the number of factors which emerged from their respective clusters. Inspection of the tasks in each factor revealed that some of the tasks within certain factors did not hang together as a meaningful construct. As a result those clusters were then re-analysed using a minimum of a .4 factor loading with a two-factor solution being set as criteria. However, the scales within the Gambling Intervention Cluster did not seem very interpretable. Consequently, factor analysis for this cluster was conducted using a minimum .4 factor loading with a four-factor solution set as criteria. An overall factor analysis of the 9 clusters resulted in 20 factors or sub-scales with a total of 107 items being retained in the CTA(PG). A full description of the CTA(PG) sub-scales together with the number of tasks, mean scores, standard deviations and alpha scores are presented in Table 2 on the following page.

Reliability Testing of the 20 Factors or Sub-Scales

The tasks which loaded on each factor were then subjected to a further measure of internal consistency reliability testing using Cronbach's alpha which is a frequently used index of homogeneity. An alpha value of .60 and above is considered to indicate an acceptable standard of internal consistency and anything below .5 is considered as 'unreliable' (Nunnally, 1978) The scales with their individual task statements, mean scores, task-to-total correlations, factor loadings and standard deviations for each task can be obtained from the Working Paper on the Development of the CTA(PG).[7] Ultimately, construct validity turns on how well a measure performs within

7 Available from the Problem Gambling Research Program, School of Social Work, University of Melbourne, Parkville, Victoria 3052, Australia.

Table 2: The Counsellor Task Analysis (Problem Gambling): Sub-scales, Tasks, Mean Scores, Standard Deviations and Alpha Scores

Sub-Scales	Number of Tasks	Mean Scores	Standard Deviations	Alpha
Assessment of other addictions	6	3.18	.84	.85
Assessment of Client eligibility	5	3.81	.90	.80
Assessment of Client risk	4	4.52	.52	.74
Assessment of Problem impact	3	3.39	1.33	.53
Treatment goals	5	4.41	.52	.65
Facilitating effective client interventions	6	3.20	.65	.67
Establishing rapport	5	4.10	.47	.63
Teaching cognitive-behavioural strategies	13	3.64	.76	.92
Controlling gambling	5	3.68	.85	.81
Maintaining treatment goals	3	3.78	.79	.62
Increasing awareness of non-gambling options	3	2.75	.79	.56
Improving family relationships	6	3.34	.68	.81
Enhancing partner responses to gambling	5	3.03	.68	.67
Financial issues	6	2.17	.91	.84
Processes in resolving gambler's problems	5	2.69	.52	.67
Linking clients with appropriate services	5	3.17	.61	.72
Referral to medical practitioners	2	3.02	.74	.63
Community education and service promotion	8	2.42	.78	.85
Financial counselling education	3	2.07	.84	.59
Research and policy development	9	2.72	.73	.81

a system of theoretical relationships (Nunnally, 1967; Rubin & Babbie, 1989).

Discussion

The CTA (PG) measures nine dimensions of the problem gambling counsellor's practice which resulted in 20 sub-scales. It takes into account not only the frequency of the tasks performed but also the importance of the task in relation to individual counsellor practice. Although the CTA (PG) is modelled on the JAQ (Teare & Sheafor, 1995), there are differences in its formulation and application. Unlike the JAQ which is 'model fair', that is, not oriented toward any particular model(s) of practice or any specific organisation of practice domain (Teare & Sheafor, 1995, 28-29) the CTA (PG) is directed towards gambling-specific and related services such as financial counselling, education, and family therapy.

Having developed the CTA (PG) for the purpose of a practice evaluation, we had to ensure that all relevant domains of social work practice were included. Three criteria—stability, meaningfulness, and homogeneity—were applied in selecting the ideal number of clusters and their identifying labels (Teare & Sheafor, 1995). Meaningfulness is where the tasks connected logically to one another within each cluster. The criteria of homogeneity meant that the tasks within each cluster were as similar as possible. The CTA (PG) tasks were identified into 9 hypothetical clusters of practice prior to data being obtained from the counsellors. Once the clusters were identified, labels were assigned according to the practice context or framework. Care was taken to assign tasks in each cluster according to the commonalities of that cluster. Stability as a criteria was evaluated after analysis of the CTA (PG) data was obtained.

Applicability

The content of the CTA(PG) was designed to reflect the formal models of practice intervention of problem gambling counsellors. It captures the practice of the problem gambling counsellor where clients represent a heterogenous group of men, women, older people, younger people, people from Anglo and Non–English Speaking Backgrounds with a wide array of clinical

diagnoses who live in a variety of geographical locations including rural, regional and metropolitan settings in Victoria (Jackson et al, 1999). The impact of these characteristics upon the utilisation of health services is an area of active research in Australia and elsewhere (Waddell & Petersen, 1994; Australian Institute of Health and Welfare, 1996). As the CTA(PG) is broadly applicable across a range of demographic and clinical strata, it should enable us to locate similarities and variations in practices across different agencies. In addition, we are able to compare the work profiles and practices of counsellors with different training backgrounds and determine whether there is any training effect on their practice.

Matched against outcome data the CTA (PG) may also be used to determine the relationship between tasks performed and their perceived importance, and outcomes achieved in specific problem areas that clients have sought help with.

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