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

Volume 1: Service Design and Access

State Government
Victoria

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

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Acknowledgments

Principal Investigators

Professor Alun Jackson, Head, School of Social Work, University of Melbourne

Professor Shane Thomas, Principal Research Fellow, School of Social Work, University of Melbourne

Dr Neil Thomason, Department of History and Philosophy of Science, University of Melbourne

Technical Consulting Team

Associate Professor Alex Blaszczynski, Deputy Director of the Psychiatry Research and Teaching Unit; Director, Impulse Disorders Unit, University of New South Wales

Professor Jan McMillen, Executive Director, Australian Institute of Gambling Research, University of Western Sydney

Dr Michael Walker, Senior Lecturer, Psychology Department, University of Sydney

Research Staff

Jennifer Borrell, Senior Research Assistant

Beth Crisp, Research Fellow

Kate Enderby, Senior Research Assistant

Dr Yasmine Fauzee, Research Fellow

Wei-Ying Ho, Senior Research Assistant

Tangerine Holt, Senior Research Assistant

Eva Perez, Senior Research Assistant

Serena Smith, Research Fellow

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Introduction

The purpose of the evaluation reported in the present series of reports was:

> To measure the effectiveness, accessibility and accountability of problem gambling counselling and liaison services and community education strategies for problem gamblers and their families and the broader community, purchased by the (Victorian) Government through funds made available from the Community Support Fund.

This Report, Volume One of a five-volume Evaluation Report series, details issues arising from an analysis of service access, including program reach, eligibility, physical access, program objectives, and the relationship of the BreakEven counselling service to other service providers, including the G-Line telephone counselling and referral service.

The Problem Gambling Services Strategy

Since 1993 the Victorian Government has had a Problem Gambling Services Strategy in place, consisting of a number of important and interrelated components:

- Counselling services for those affected by problem gambling activity, including:
  - Specific problem gambling counselling services.
  - Problem gambling counselling services that are integrated with financial counselling services.
  - A range of counselling and support services that address family issues that may arise as a result of problematic gambling, through the establishment of statewide family skills and regional family resource centres.
- Gaming liaison and community education officers in each Department of Human Services region.
- Community education.
- Media campaigns.
- A problem gambling reference group chaired by the Department.
- G-Line, a free, 24-hour telephone counselling and referral service.
- A research program to provide information about problem gambling in the community and to inform appropriate service responses.

The counselling services purchased (BreakEven) were located in generalist agencies, predominantly Community Health Centres, and the definition of problem gambling as a public health issue and the promotion of community health is a feature of the practice of the BreakEven program host agencies. The service is offered from 18 agencies operating from around 100 sites.

The Department of Human Services has been very successful in selecting host agencies with objectives that support and facilitate the implementation of the objectives set for the BreakEven program. The unique features of the BreakEven program are complemented by the backdrop of other services provided by the host agencies.

Access and Program Reach

A major issue in determining the reach of the BreakEven program is the difficulty of measuring prevalence, that is, what proportion of the eligible population of problem gamblers and others affected by their gambling is being seen by the program. Information obtained from existing measures, such as the South Oaks Gambling Screen (SOGS) and the Diagnostic and Statistical Manual (DSM) (IV edition) criteria for 'pathological gambling', is considered imprecise for a range of reasons, including:

- These gambling screens have typically been designed for and tested with clinical populations (those currently seeking or receiving treatment within organised and/or clinical settings). They have not been designed or validated for use in random sampling of adults and gamblers in the general population.
- The causal relationship between problem gambling and the associated criteria, as measured by SOGS or the DSM-IV, are often difficult to determine.

The consensus seems to be that the combined prevalence of problem and pathological gambling within an adult community averages out to approximately two per cent, which, based on an adult population in Victoria of 3.26 million, gives a pool of potential problem gambling clients of 65,200 adults.

This Report presents data on approximately 8,500 people, of whom around 6,000 were problem gamblers seen by the 18 BreakEven problem gambling counselling agencies in Victoria. The discrepancy between the suggested potential client pool and actual clients is explored, particularly from the perspectives of measurement and models of help-seeking in this population. In the absence of international benchmarks on program reach, except for a suggestion that three per cent is likely, there is reason to suppose that, at 11 per cent, BreakEven has attained a good reach. If all of the services funded through the Problem Gambling Services Strategy that attract clients with gambling related problems are considered, including generalist family service and support agencies and financial counselling agencies, then it is obvious that the reach of the Strategy, as distinct from the BreakEven program alone, is much greater, but indeterminate as yet.

The ability of the BreakEven services to both attract women and, if they complete treatment, to be more likely to resolve their problems than male clients, suggests they present an attractive model of service delivery for female problem gamblers. Female problem gamblers may be attracted by the fact that these services are community-based and are housed in existing agencies which women may already have relationships with, such as community health centres. For women who are concerned about being stigmatised if others learn of their gambling, these agencies provide discreet venues for counselling. Discretion is further enhanced by clients attending BreakEven services being able to discuss either their own gambling behaviour or that of a significant other. This is in stark contrast to many overseas services that have been developed in treatment settings in which males predominate, such as Veterans centres.

The barriers to accessing mainstream problem gambling counselling services for people from non-English speaking backgrounds (NESBs) include lack of knowledge of available services, language barriers, cultural barriers to recognising problems and seeking appropriate assistance, and lack of culturally relevant and sensitive services. Therefore people may miss out on getting the assistance available to them. The need for support of NESB groups is particularly high. The introduction of the Innovative Service Model for people of Non-English Speaking Backgrounds, although in its early days, has increased access to problem gambling support services for people from these communities.

In terms of how people find their way to BreakEven, over 37 per cent have been referred by the G-Line telephone counselling and referral service. Family and friends recommend attendance for about one eighth of new clients. BreakEven clients also access a range of other services—before, during and after their BreakEven counselling episode. For almost half of the clients who used other services prior to accessing BreakEven, Gamblers Anonymous was the first place they sought help for their gambling-related problems. Doctors (15.2 per cent) and financial counsellors (10.6 per cent) were also common first points of contact for people seeking help.

This information is particularly useful in terms of future service planning. It may be necessary for BreakEven to strengthen communication with particular agencies or services, in order to assist

people in accessing the BreakEven service more efficiently. For example, it is evident that Gamblers Anonymous is a significant first *and* second point of contact for people seeking help for problem gambling. It would be useful for the BreakEven program to have an effective system of communication with Gamblers Anonymous for the purpose of efficient referral, but the complexities of this are evident given the widely divergent theories of intervention used by BreakEven and Gamblers Anonymous.

Surprisingly few referrals to BreakEven were found to come through financial counsellors. Further analysis would be valuable in determining the extent of indebtedness of problem gamblers and the extent to which the financial aspect of problem gambling is a motivator for seeking help. In addition, the counselling practices of financial counsellors working with problem gamblers should be examined.

The Report notes that the 18 locations of the BreakEven service around Victoria are based on division of resources by Department of Human Services regions, with consideration of the number of Electronic Gaming Machines (EGMs) and people aged 18 years and over in each region. These 18 locations are supplemented by a multitude of satellite sites within each region. A number of BreakEven personnel and service providers have questioned whether the distribution of these sites is equitable and/or effective. A key factor in assessing the accessibility of the service is an understanding of the extent to which problem gamblers seek help from agencies in the same area as where they live and/or gamble. It would be difficult to plan service provision by population and EGM criteria if there is a lot of movement between where the problems are caused and where they are addressed. There does not yet appear to be sufficient information, however, to be able to determine the pattern of where people live, gamble and seek help.

Treatment Models in BreakEven

A great deal of the problem gambling treatment literature describes clinical trials of various methods of treatment (efficacy studies), which in many cases have not been systematically translated into treatment programs. Of those established treatment programs that appear in the published literature, very few are accompanied by controlled effectiveness studies. In addition, as many reported treatment programs are multimodal in nature, it is difficult to determine which elements have been particularly effective. We note that, to date, a great deal of the treatment literature related to programs, such as the BreakEven program has been dominated by theoretical and non-controlled and small sample studies, weakening the possibility of generalisation to different populations. What is needed is evaluation of controlled *therapeutic efficacy* studies of specific treatment techniques and evaluation of the *long-term effectiveness* of treatment programs. Treatment follow-up studies and replication of reported findings are also needed before the effectiveness of some of these programs can be adequately assessed.

The difficulty of evaluating the appropriateness of various treatment programs is further complicated by the fact that there are no internationally established models of best practice in existence. Despite a lack of detailed empirical evidence, we suggest that community-based treatment models provide accessible support for individuals and family members experiencing gambling-related problems. In addition, a multimodal approach to treatment acknowledges the multifaceted nature of problem gambling behaviour.

It is evident that in problem gambling treatment programs worldwide there has been some move towards:

- Taking a broad-based approach to the explanation and treatment of problem gambling behaviour.
- Using eclectic treatment approaches.
- Focusing on delivering a client-centred service to problem gamblers.

The different models reviewed for comparative purposes for this evaluation show variation in terms of the nature of the population being treated, the broad structure of the organisation or program, the theoretical orientation of treatment, and the therapeutic interventions employed, resulting in a number of very distinct, often incomparable treatment programs.

As with the overseas models described in this Report, very few of the Australian programs have been evaluated. Some have not been evaluated at all and others are in the preliminary stages of evaluation. For this reason, the present evaluation of BreakEven should contribute to setting a benchmark against which other programs, both overseas and within Australia, can be assessed.

This evaluation shows that organisations implementing the BreakEven program have developed an eclectic orientation in their counselling of problem gamblers. Cognitive-behavioural theories and psychosocial theories appear to be among the most influential contributions to counselling practice. Moreover, BreakEven counselling is multimodal in nature, as a wide variety of therapeutic strategies are employed, with a predominantly client-centred focus.

Therefore, the BreakEven program displays a number of the features characteristic of what may be deemed to be 'best practice' in *community-based* treatment of problem gambling in terms of its overall design of a specialist service delivered from generalist multi-program agencies, and in terms of its detailed interventions.

Issues to be Addressed

One major issue identified in the analysis of access and design of BreakEven is the relationship with the G-Line telephone counselling and referral service. A significant difference in understanding between G-Line staff and BreakEven counsellors as to the purpose of the G-Line service was identified. G-Line staff, and a majority of callers, see G-Line as a *counselling* service, delivered by telephone. BreakEven counsellors see G-Line as a *referral* service and, more particularly, as a referral service for BreakEven. While G-Line staff consider referral to BreakEven as only one of the treatment options open to them, BreakEven counsellors view G-Line as a primary source of referral for them. This divergent understanding impacts significantly on the number and type of clients that G-Line refers to BreakEven. This apparent mismatch of expectations as to the role that G-Line plays and its relationship with BreakEven suggests an urgent need for the Department of Human Services to clarify what it intends the level and nature of interaction between the two services to be.

1 Introduction

The purpose of the evaluation reported here is:

> To measure the effectiveness, accessibility and accountability of problem gambling counselling and liaison services and community education strategies for problem gamblers and their families and the broader community, purchased by the (Victorian) Government through funds made available from the Community Support Fund. (Tender Brief, p. 14.)

The Evaluation Report series includes five volumes:

1. **Volume One** details issues arising from an analysis of service access, including program reach; eligibility; physical access; program objectives; and the relationship of the BreakEven counselling service to other service providers, including the telephone service G-Line. In addition, the BreakEven service is located within a theoretical and practice context nationally and internationally in order to assess it in terms of best practice models.
2. **Volume Two** covers an evaluation of service effectiveness, and uses data from the Minimum Data Set collected from all BreakEven services and data from a Clinical Practice Evaluation.[1] This includes an analysis of the effects of the organisations' intervention in clients' problems and their well-being, explication of the way these effects were achieved, and clients' satisfaction with the interventions.
3. **Volume Three** contains an evaluation of community education strategies and information products made available through the Problem Gambling Services Strategy.
4. **Volume Four** describes the development of the Counsellor Task Analysis (Problem Gambling) instrument and reports on its psychometric properties and an application of it to the work of the BreakEven counsellors.
5. **Volume Five** reports the findings of a study undertaken by the research team on natural recovery from problem gambling and examines the implications of this study for professional counselling practice.

Activities undertaken in order to report on service design and access include:

[1] As part of the standard operating procedures for the problem gambling counselling service, client details are collected at the point of registration, assessment, each client contact and case closure. Counsellors collect this information by completing forms, either during the interview with a client or afterwards. These forms constitute the Problem Gambling Services Minimum Data Set (MDS). The MDS was established in 1995 to provide information for a range of purposes. These include:

- To assist the service provider with case management and assessment.
- To assist agencies in their service planning.
- To monitor, at a regional and statewide level, trends in gambling activity and its effects.

A full description of the MDS is provided in *Client & Service Analysis Reports 1, 2, 3, 4 & 5.*

- A brief policy and historical overview of gambling legislation and history in Victoria.[2]
- Interviews with BreakEven Problem Gambling Counselling Service coordinators (n=15) and host organisation CEOs (n=15) in order to provide a detailed program description following a model proposed by Donovan and Jackson (1991).
- In-depth interviews (n=51) and a clinical practice evaluation questionnaire (n=43) to BreakEven counsellors.
- Analysis of the Minimum Data Set in order to compare BreakEven program reach and access with studies of other Australian and overseas programs.
- Review of published data on program models and treatment effectiveness in order to compare the BreakEven program model with 'best practice' models of problem gambling intervention.
- Survey by questionnaire of G-Line counsellors in order to profile their characteristics, intervention approaches, and perception of the purpose of G-Line and its relationship to BreakEven (n=10).
- A 'snapshot' client survey conducted at G-Line involving telephone interviews with G-Line clients to identify client impressions and usage of the G-Line service (n=39).
- Survey of family support and financial counselling programs to determine the extent to which they provided services to people with gambling-related problems (n=121).

This Report begins with a brief overview of the policy and legislative developments in relation to gambling in Victoria, which provides the backdrop to the need for, and establishment of, the BreakEven service. This is followed by an outline of the Department of Human Services' Problem Gambling Services Strategy (PGSS).

1.1 Overview of Trends in Gambling Policy and Legislation

In social policy terms, there are few areas as complex as gambling. McMillen (1997) has suggested that gambling policies have to strive for a balance between the social protection of citizens, economic development and the integrity of gambling operations. The way these inter-related aspects of gambling policy are balanced goes to the heart of people's beliefs about what constitutes good government. Gambling policy is read as a powerful message about the importance placed on their quality of life; the value placed on the protection of vulnerable individuals; and the weight government gives to the interests of 'ordinary' individuals, families and communities relative to the interests of business and revenue generation.

The complexity of gambling policy makes it a highly contested area of policy that incorporates a number of elements, any one of which is contentious in its own right. One such element is the presence of strong moral objections to legalised behaviour that is seen to challenge core values (that is, the challenge of gambling to the values of thrift and reward for effort). Also present are debates about the:

- Role of government in the supply and regulation of the 'product' (what government should run itself; what it should allow to be offered in a regulated market; whether it allows industry self-regulation or requires external government regulation).
- Reasons why, if many people are able to cope with gambling behaviours, some people are not able to cope and thereby cause harm, both to themselves and to others.
- Most appropriate form of containment of problems arising from people's inability to cope (what sort of services should be funded by government to address the problems; and what should be offered by these services).
- Relative costs and benefits to the community of the behaviours, particularly as, through the regulatory process, high levels of revenue accrue to government.

Until 1953, Victoria's approach to gambling was one of prohibition, with the exception of gambling for the purpose of raising funds for church-based welfare services. However, in 1953 a campaign by the Anglican and Wesley churches to resist government moves to introduce a State lottery was defeated and in 1954 a private corporation, Tattersall's, was awarded a licence to run regular lotteries in Victoria. This was followed by the government establishment of the Totaliser Agency Board (TAB) in 1961, which

[2] For greater detail on this history, see McMillen, J., Jackson, AC, Johnson, D., O'Hara, J., Woolley, R (1999) *Australian Gambling Comparative History and Analysis*, Melbourne: Victorian Casino and Gaming Authority, p. 242.

was the direct result of a Victorian State Government Royal Commission into off-course betting. The Commission was established to explore the revenue collection potential of off-course betting, as well as to investigate illegal gambling operations that had thrived despite State opposition.

Following this Royal Commission, the Victoria Police's Gaming Squad was strengthened to eliminate the TAB's illegal competition (Birch, 1996: 36). This marked a significant shift in Victorian Government gambling policy, as it was for the first time overtly guided by the objective of collecting revenue via gambling taxes. In effect, this reflected a shift from a prime role of gambling regulation for the social protection of citizens to that of government as an economic stakeholder.

Recent decades have seen a growing tolerance and liberalisation of gambling in Victoria, particularly in terms of legalisation and an increase in public legitimacy. In 1972 the Victorian Government made two significant moves towards the liberalisation of gambling. It lifted the law that banned the advertising of lotteries on television and radio and licensed Tattersall's to run Tattslotto. The next major shift occurred in 1985 when TAB agencies were allowed to open in hotels. However, the most notable shifts in gambling policy, infrastructure and activity in Victoria have occurred in the present decade.

In the 1990s there was a dramatic increase in gambling infrastructure and expenditure in Victoria. This increase has been in marked comparison to other states and territories, even though several of them have also seen a burgeoning in gambling activity. The passage of various Acts of Parliament has enabled strong growth in the numbers of Electronic Gaming Machines (EGMs) in hotels and clubs and the establishment of Crown Casino in central Melbourne.

Most notable among recent gambling legislation in Victoria is the *Gaming Machine Control Act 1991* (Vic) and the *Casino Control Act 1991* (Vic). These Acts, in conjunction with the *Casino Management Agreement Act 1993* (Vic) and the *Gaming and Betting Act 1994* (Vic), establish the framework for the regulation of gaming activities in the State. They include the stipulation that 20 per cent of EGMs be located outside the Melbourne statistical division and that the statutory maximum number of EGMs allowed in the State be 42,500, excluding those in the Casino. There are 2,500 EGMs located in the Casino precinct.

EGMs were introduced in Victoria in 1992, with Tabcorp and Tattersall's as the two licensed gaming operators. In 1996 a Ministerial Direction placed a ceiling on the number of EGMs allowed to operate in venues other than the Casino (currently set at 27,500), until more comprehensive research could be undertaken on behalf of the Victorian Casino and Gaming Authority (VCGA) into the social and economic impact of gambling.

The Casino Control Act established the general framework for the regulation of casino activities in the State and paved the way for the opening of Melbourne's temporary Crown Casino in June 1994 and the permanent casino at Southbank in May 1997.

The Gaming Machine Control Act provided for 8.3 per cent of the total daily net cash balances (the total amount wagered less the sum of all winnings paid out) derived from EGMs in hotels to be paid into a public account fund, the Community Support Fund. In early 1996 the weekly revenue of the Fund was $1.2 million, equivalent to annual revenue of $62 million (Auditor General of Victoria, 1996).

1.2 Economics of Gambling in Victoria

In Victoria, gambling is the third highest source of government revenue after payroll tax and stamp duty, equalling liquor, tobacco and petrol taxes combined. Total revenue from gaming increased from $401.722 million in the year 1992–93 to $1,036.122 million in 1996–97. Total revenue from EGMs, video gaming machines (VGMs) and Club Keno increased from $10.918 million in 1991–92 to $629.010 million in 1996–97. During this same period, gambling taxation revenue from racing, a more traditional form of gambling in Australia, decreased from $174.160 million to $121.317 million.

During the 1990s there was a rapid rise in the proportion of household income per capita spent on gambling. Per capita gambling expenditure in Victoria has increased from $309.16 in the financial year 1991–92 to $804.71 in 1996–97. Much of this increase can be traced to gambling on electronic gaming machines, as per capita expenditure on this form of gambling increased from $9.90 to $424.96 per annum in the same period (Tasmanian Gaming Commission, 1998).

Expressed as a percentage of household income in Victoria, gambling expenditure rose from 1.35 per cent

in 1991–92 to 3.21 per cent in 1996–97; and for gaming (gambling excluding racing) it rose from 0.74 per cent to 2.71 per cent in the same period. This can be compared with the rise in the percentage of household income allocated to gambling for the whole of Australia, which went from 2.07 per cent to 3.03 per cent in the same period (Tasmanian Gaming Commission, 1998).

VCGA research carried out in 1997 (Maddern and Golledge, 1997) indicates that the increased household expenditure on newly introduced forms of gambling has come from the use of savings, rather than the diversion of spending money from other retail forms (though local shifts in spending patterns cannot be captured in the aggregate statistical analyses employed). This is consistent with a study of gambling taxation in Australia in which a survey of Victorians showed that 75 per cent of gambling was financed by reducing household savings or increasing debt (Smith, 1998). Australian Bureau of Statistics data (1999) indicate that Victoria experienced a higher growth in net gambling takings between 1994–95 and 1997–98 at 57 per cent, than the Australian increase at 41 per cent. The net takings from gambling in Victoria ($3,266 million in 1997–98) accounted for 30 per cent of the total net takings for gambling nationwide. This proportion of net takings was higher than the State's proportion of the Australian population (25 per cent), illustrating that Victorians spent disproportionately more on gambling than Australians, as a whole.

1.3 Problem Gambling Services Strategy

One of the triennial grants provided by the Community Support Fund was for the implementation of the Problem Gambling Services Strategy (PGSS). The Victorian Government has been developing and implementing such a Strategy since 1993, consisting of a number of important and interrelated components, including:

- Counselling services for those affected by problem gambling activity, including:
  - Specific problem gambling counselling services.
  - Problem gambling counselling services that are integrated with financial counselling services.
  - A range of counselling and support services that address family issues that may arise as a result of problematic gambling, through the establishment of statewide family skills and regional family resource centres.
- Gaming liaison and community education officers in each Department of Human Services region.
- Community education.
- Media campaigns.
- A problem gambling reference group chaired by the Department.
- G-Line, a free, 24-hour telephone counselling and referral service.
- A research program to provide information about problem gambling in the community and to inform appropriate service responses.

A Problem Gambling Services Strategy obviously needs to be underpinned by a definition of 'problem gambling'. The Department of Human Services, in establishing the Strategy, made one of the earliest attempts to describe problem gambling in terms of the economic, social and personal costs for individuals, and in some instances, their families. The Department defined a problem gambler as:

> A person who is spending their time and money gambling in such a way that may be harmful to them and potentially to those around them. Diagnostic measures used to identify problem gambling and pathological gamblers include the South Oaks Gambling Screen (SOGS) and the American Psychiatric Diagnostic and Statistical Manual (DSM-III-R and DSM-IV 1992).

The issue of definition and measurement of problem gambling is a crucial one, as without consensus on both of these, it is not possible to make any judgment on the first evaluation question addressed in this Report, that of the program reach of the BreakEven service. A later section in this Report, Evaluation of Service Access, reviews some approaches to definition and measurement as a prelude to commenting on program reach.

The following section discusses the nature of the BreakEven service.

2 Description of the BreakEven Program

The following analysis reviews and describes the *program objectives* of the BreakEven service, and also of the host organisations, as reported by program coordinators and counsellors. This analysis examines the way in which the program objectives, as stated by program coordinators and counsellors are linked to, and reflect, the program objectives as set out by the Department of Human Services.

The original tender brief inviting applicants to apply for funding to provide problem gambling services in Victoria, to begin in 1995, outlined the objectives of the service. The project brief called for agencies to provide:

- Problem gambling counselling services.
- Gambling facility liaison services.

The *Specialist Problem Gambling Counselling Service Model* would comprise the following:

- An addiction counselling/family therapy/relationship counselling component, including both individual and group counselling.
- Aspects needing to be explored during counselling, including: low self-esteem, anxiety, stress, triggers for relapse, relapse prevention/management, behaviour change, employment and legal issues, communication and relationship difficulties, family and personal history.
- A gambling facilities liaison service component.
- A professional training component.
- Service promotion/marketing activities.
- The Problem Gambling Counselling Service was to incorporate a range of theoretical approaches, which focus on the psychosocial needs of individuals and their families.
- A *strong program linkage* between the problem gambling service, financial counselling and other relevant services (such as drug and alcohol counselling).
- A demonstrated relationship between the overall strategic directions of the host agency and the problem gambling program.

These program objectives, as specified by Department of Human Services, will be used to review BreakEven counsellors' practice in the Approaches to Problem Gambling Treatment section of this Report.

The data relating to *explicit* program objectives for the present analysis were obtained from interview schedules of BreakEven coordinators and counsellors. Of 19 questions in the schedule, four were relevant for the purpose of this particular analysis. The following open-ended questions were examined:

- How would you describe the central purpose of your host organisation?
- How would you describe the central purpose of the BreakEven program?
- How do you view the link between the purpose of your host organisation and the aims of the BreakEven program?
- Please describe any broad aims for intervention adopted by your program? (for example, harm minimisation, controlled gambling, abstinence, support, etc).

The information gained from these questions is used in the following sections to describe the BreakEven program and how it is delivered by the various host organisations.

2.1 Distribution of BreakEven Services

2.1.1 Rationale for Host Organisations Selected

An important objective of the PGSS is to ensure that services are provided to clients where they need them. Thus in accordance with its mandate to provide statewide services, Department of Human Services allocated funds for the establishment of problem gambling services in each of its nine regions.

At the local level, the need for BreakEven services has been established primarily through anecdotal evidence. There has been no imperative on auspicing agencies to establish service need in order to receive funding for a BreakEven service. This fact raises an important question regarding the relationship between service need and service provision.

Indeed, it should not even be assumed that the services that successfully tendered to provide the BreakEven service in their region considered gambling to be a major problem. While some agency directors indicated that their agency's decision to tender for the BreakEven service was based on an anecdotal notion of need within the community for such a service, others were motivated to tender by the need to expand their base of service provision as other funding sources contracted.

Coordinators of BreakEven services and host agency directors report that in many agencies the first year of operation involved a great deal of work with communities identifying the need that exists within them. However, this has been more difficult in local communities where gambling activity is seen to provide positive outcomes, such as essential income for social groups and entertainment for residents. Irrespective of the original impetus to establish a problem gambling counselling service in their agency, the directors of agencies which host BreakEven services, at interview, now generally agree that the services are needed and that the impact of problem gambling is quite visible in their communities.

2.1.2 Location of BreakEven Services

The establishment of BreakEven services was not based on any specific local analysis of need within the community. Rather, it was based on the assumption that increased opportunities to gamble, through the introduction of electronic gaming machines (EGMs) in a community, may increase the number of 'problem gamblers' in that community. In contrast to some other Department of Human Services-funded programs in which money is primarily apportioned to regions on the basis of population size, the number of EGMs and the population aged 18 and over in each region were both considerations in the location of BreakEven services. As demonstrated in the table below, there may be some limitations to this funding model, due to the ratio of problem gambling clients to EGMs ranging from 1:10.7 to 1:24.0 as at 30 June 1997. (See Table 1)

That the ratio of machines to clients is in some regions more than double that in other regions may warrant further examination. One possibility is that the number of problem gamblers is directly associated

Table 1 Department of Human Services Regions: New Problem Gambling Clients from 1 July 1996 to 30 June 1997 and Electronic Gaming Machines (EGMs) at 30 June 1997

Region	Number of New Problem Gambling Clients	Number of EGMs	Ratio Problem Gambling Clients to EGMs
Eastern	177	3,887	1:22.0
Northern	178	4,268	1:24.0
Southern	263	6,016	1:22.9
Western	397	4,675	1:11.8
Barwon South West	138	2,142	1:15.5
Gippsland	92	1,809	1:19.7
Grampians	89	1,045	1:11.7
Hume	83	941	1:11.3
Loddon Mallee	103	1,109	1:10.8
Total	1,520	25,892	1:17.0

with the number of EGMs below an as-yet-unknown threshold of EGMs. Increasing the number of EGMs beyond that threshold may not result in a corresponding increase in the number of service users. With the exception of the Western region, which includes Melbourne's central business and leisure precincts, this theory is to some degree supported by the data in the table above.

A second explanation for the data in the table above concerns the possibility that problem gamblers do not necessarily seek services in the same region in which they live or gamble. Problem gamblers may register with any BreakEven service in the State, and while many no doubt register in the region in which they live, services in the centre of Melbourne are likely to be more attractive to some clients than those in residential and rural areas (Crisp, 1998). It is well known that people from rural areas often use services outside their local community if they have a problem that they consider to be sensitive and potentially stigmatising (Regan, 1997), which may include problem gambling. This has been shown in the case of Vietnam Veterans, for example, who often travel some distance to consult a counsellor from the Vietnam Veterans Counselling Service, or use a 1800 telephone number, rather than consult with a local rural-based service (Jackson, Creamer and Ball, 1994). This would in part explain the higher ratio of clients to EGMs in the Western region when compared to the other metropolitan regions.

Clients may also use EGMs in regions other than where they seek services. This was especially an issue for workers in the Hume region who noted that there were approximately 2,500 EGMs in New South Wales that were within 10 km of their region's northern border. Moreover, because the venues over the border have been established far longer than those in Victoria, it is thought likely that many of the clients presenting to BreakEven in this region have had much longer regular exposure to EGMs than clients elsewhere in Victoria. This concurs with Volberg's (1994) contention that problem gambling prevalence increases the longer gambling opportunities are readily available and easily accessible.

In addition to considering the distribution of clients and services between regions, the distribution of services *within* regions was commented on in several interviews with BreakEven personnel. In order to fulfil tender requirements and provide services for either an entire Department of Human Services region or a significant proportion of such, most BreakEven services provide counselling services not just at one site, but at a variety of locations where they are hosted by other agencies or organisations. By June 1998 BreakEven services were provided from approximately 100 sites across the State. Nevertheless, several informants including agency directors, BreakEven coordinators and counsellors suggested that some areas within their region were better serviced than other areas. The development of these satellite services therefore appears to be influenced by expressed needs. In at least one region, the locations of satellite services seem to be determined by the pleas of other agencies to have a BreakEven counsellor regularly attend their agency, rather than by a strategic planning exercise.

Some rural counsellors indicated that due to the area they cover, it is not possible to visit some sites more than once a fortnight, whereas for metropolitan counsellors, attendance at each site serviced each week is the norm. It was therefore predicted that clients in rural areas would be seen less frequently than clients in the Melbourne metropolitan area. However, analysis of data provided by counsellors concerning how often they see clients found no difference between metropolitan counsellors and their colleagues in the rest of the State ($F(5,43)=0.42$, n.s.).

One implication arising out of the fact that many counsellors work from multiple sites and/or are employed part-time, is the very limited opportunity to provide drop-in facilities. From interviews with the counsellors, with one exception, the majority of client contacts involved scheduled appointments, and 60 per cent reported appointments for all client contacts.

2.2 Objectives of the Counselling Service

Coordinators' and counsellors' responses regarding the central purpose of the BreakEven program were essentially the same. All respondents saw their primary function as assisting people experiencing difficulties with their gambling activity. The following points detail the major explicit objectives of the BreakEven service:

- Provide direct services to address the harmful impacts of problem gambling, by providing counselling and support to people experiencing gambling-related problems.

- Educate and provide information to the community about the harmful effects of gambling activity, as well as advocate for preventative strategies.
- Liaise with members of the gaming industry to establish communication between gambling facilities and gambling support services.
- Provide well-managed, accessible, accountable and professional services.
- Provide professional education and training.

2.2.1 Broad Aims for Intervention

The following points outline coordinators' responses to the question, 'Please describe any broad aims for intervention adopted by your program'. The major themes described closely resemble the objectives of the BreakEven program described above by BreakEven coordinators and counsellors. The major themes that emerged in coordinators' responses were:

- Gambling related aims:
  - Harm minimisation
  - Abstinence or control.
- Counselling strategies:
  - Client-centred/supportive approach
  - Motivational considerations.

2.3 Integration of BreakEven with Host Agencies

2.3.1 Purpose of the Host Agency

Of the 15 agency coordinators who returned the questionnaire, the majority provided a brief response regarding the *purpose* of their agency. Because of the differing nature of a number of the agencies (for example, Victorian Relief Committee compared with Relationships Australia), some responses varied greatly. However, two clear themes did emerge from coordinators' responses as to the purpose of their agency:

To Foster Community Health

Because the majority of Victorian BreakEven programs exist within community health centres, gambling-related problems are situated within a social model of health that is aimed at:

> Working with the community to address health needs in a responsive and innovative way. It encompasses promoting the physical, social and emotional health and well-being of its constituent community through prevention, early detection and intervention.

Therefore, the promotion of community health emerged as a common purpose of the various BreakEven program host agencies. Included in this broad objective were activities such as facilitating the development of personal skills, knowledge and health; strengthening community action; and creating a supportive environment in order to bring people together to learn from one another.

Although this broad objective was considered important to all agencies, a number of agencies had more specific aims as their primary function. Two agencies, for example, are aimed at providing assistance to people experiencing difficulties related to the problematic use of drugs and alcohol. Similarly, Relationships Australia provides relationship counselling and mediation as their primary function, which is reflected in their description of 'central purpose'.

To Provide Counselling, Community Education, and Family Support

The provision of counselling and family support was seen as an important function of the BreakEven program host agencies. The majority of coordinators mentioned counselling and the provision of family support as a primary role of their agency, and a number of respondents also commented that community education was among their primary roles. Illustrative of this focus is the following description by one respondent:

> …programs that assist family members to value their strengths and skills, overcome difficulties and make choices for their futures.

For a number of agencies, support to families was also provided in the form of financial and/or legal information and assistance.

2.3.2 Linkage between the Purpose of the Host Agency and BreakEven's Objectives

All BreakEven coordinators provided a positive response to the question regarding the link between the purpose of the host agency and the aims of the BreakEven program. All respondents noted that the link was particularly strong and the objectives were compatible. Some coordinators only provided a one word response to the question, such as 'excellent', 'intimate' or 'closely linked', whereas others elaborated on the connection. Coordinators' responses

varied only in terms of the primary function of their host agency.

To some extent this degree of synergy is not surprising. These agencies had to tender to host the BreakEven program. Central to tendering for the role was the requirement to demonstrate their compatibility with the objectives of BreakEven.

2.4 BreakEven in a National Context

As noted in the first two sections of this Report, the BreakEven Problem Gambling Counselling program forms one part of a Problem Gambling Services Strategy (PGSS), which may be seen itself to be part of a larger policy and program environment concerned with the regulation of gambling opportunity and its impacts. In Victoria, 11 BreakEven services were funded, beginning in the 1993–94 financial year, at a cost of $4,143,000, to form the Compulsive Gambling Program. This also included funds for the operation of G-Line and funding of the Victorian Council on Problem Gambling (VCPG) to provide community and professional education. In the 1994–95 financial year, fifteen regional and three statewide financial counselling services were added as a component of the strategy. In the 1995–96 financial year the VCPG was allocated $1,007,500 to deliver a community education media campaign through television, radio and print.

In the same financial year, over $14 million was allocated to a range of initiatives to strengthen the Strategy. These included funding of an additional five BreakEven services, integrated financial counselling and problem gambling counselling services; NESB-targeted programs and a research strategy. This research strategy was to be complementary to that developed by the Victorian Casino and Gaming Authority (VCGA).[3] The VCGA was established under the Gaming and Betting Act 1994, with responsibility for regulating casino, gaming machine and wagering activities in Victoria.

The Gaming Machine Control Act 1991, together with other relevant legislation, set out the general framework for regulation of gaming activities in Victoria. The Act provided for crime prevention measures, specifies probity standards for the granting of licenses, provided for gaming operators as a buffer between manufacturers and venues, and specified on-line monitoring, technical standards and inspection of operations. This Act set out the returns to each of the parties involved in gaming, that is, the split of gaming revenue between Government, gaming operators and venues, and includes measures designed to reduce adverse social impacts of gambling. There was also provision for the funding of social programs, such as the PGSS from a proportion of gaming revenue, so that the costs are borne by electronic gaming machine (EGM) users in general rather than the wider community.

Victoria, therefore, had an integrated program of development of problem gambling counselling services, community education and research from an early stage in the development of gaming opportunity, particularly as related to electronic gaming. This is in contrast to other states (McMillen, 1996; Dickerson, 1995).

2.4.1 Queensland

In many areas of policy development in relation to gambling, Victoria had followed Queensland's example. In 1991 the Queensland Government passed the *Gaming Machine Act*, which established a comprehensive and rigorous regulatory regime to permit gaming machines in Queensland clubs and hotels. An independent statutory watchdog authority (the Machine Gaming Commission) was appointed to safeguard the public interest, with specific functions to license venues and key industry participants, and to mediate the relationship between the Government and industry. From 1991 to 1997 a proportion of hotel gaming revenues was directed to a Charities and Rehabilitation Levy, administered by the Department of Family Services. These funds were intended for the establishment of community support services, and funded the establishment of BreakEven centres specifically to assist people with gambling problems. In 1993 five 'resource centres' were opened in Brisbane, Gold Coast, Rockhampton, Toowoomba and Townsville with an additional centre opening in Cairns in 1997. These centres are supplemented by at least eight additional outreach services. These BreakEven services were auspiced by either Relationships Australia, Centacare or Lifeline.

In 1996 an additional Gaming Machine Community Benefit Levy was introduced, based on a sliding scale

[3] For a review of the VCGA research and its outcomes for 1996–97, see Victorian Casino and Gaming Authority (1997) *Summary of Findings: 1996/97 Research Program*, Melbourne: Victorian Casino and Gaming Authority.

(0.5–1 per cent), which recognised the ability of clubs to contribute. Hotels also contributed to the fund through re-allocation of 0.5 per cent of the existing Charities and Rehabilitation Levy. This Community Benefit Fund was administered by a secretariat in the Department of Family, Youth and Community Services that assessed applications for funding from community groups for capital works and equipment.

Since the introduction of gaming machines, problem gambling had emerged as a growing concern, with research suggesting that gaming machines had a significant impact (Department of Family Services and Aboriginal and Islander Affairs, 1994). In 1998, a Problem Gambling Advisory Committee was established to advise on remedial policies. Following the election of the Beattie Government this committee has been supported by a Responsible Gambling Secretariat and a trial program with a Gambling Help Line has been introduced. Unlike Victoria, however, where no BreakEven Secretariat is funded, the Department of Family, Youth and Community Services, since 1993, has funded a liaison and support network, the BreakEven Network. The purpose of this Network is to provide a forum for BreakEven services to coordinate, plan and share information regarding service delivery and policy development.

2.4.2 South Australia

As noted in Section 4 of this Report, a Gamblers Rehabilitation Fund (GRF) was established in response to the introduction of EGMs in South Australia in 1994, and was allocated $1.5 million 'to initiate programs to deal with gambling addiction', and to provide support for the families of problem gamblers (Elliot Stanford and Associates, 1998: 14). The payment package, 'Smart Play', attempted an integrated program model, in allocating funds based on a split of funds into direct services, specialist services, coordination, training and research; specific allocation of direct service funds between metropolitan and rural locations; and a specific allocation within specialist services to focus on Aboriginal people and intensive addiction therapy.

The basic premise of this model of service response to problem gambling was to fund large organisations that had the capacity to provide services across a comprehensive and integrated range of functions including community education and prevention strategies.

The Elliot Stanford and Associates (1998) evaluation of the GRF model noted that the model was based on providing a full range of services in response to problem gambling, including face-to-face education, information dissemination, mass communication promotions, advocacy, community development, preventative strategies, screening, and early and minimal intervention strategies. It concluded that, overall, it was a good model. One deficiency noted, which has been more systematically addressed in Victoria, was the lack of a distinct research agenda forming part of the GRF planning process, and the lack of research to establish effective pathways and evidence-based practice.

2.4.3 New South Wales

The history of gambling availability in New South Wales is different from that of other States in one main respect: poker machines were legalised for use in registered clubs from 1956 onwards, although poker machines in clubs had had a semi-legal status since the 1920s. The impact of legal poker machines was twofold: poker machine manufacturers in New South Wales became market leaders in the development of the machines and the general public became accustomed to the poker machine gambling. By 1959, there were 1,100 Clubs in New South Wales, and the club system was stable through the income generated by poker machine play. Card machines were introduced in the early 1980s and were legalised for use in hotels. Although popular at first, by 1988 the new video poker machines had swept past both card machines and the older spinning reel machines in popularity.

The increasing attractiveness of poker machines over a period of 30 years was parallelled in New South Wales by an increasing percentage of problem gamblers with poker machine gambling as their major problem. The available data suggests that approximately 20 per cent of problem gamblers receiving treatment in New South Wales between 1976 and 1980 had poker machine gambling as their major problem, whereas in 1999, the percentage had risen to 83 per cent (Walker, 1999; Walker and Sturevska, 2000).

Services for Problem Gamblers Prior to 1995

The year 1995 marked an important change in the funding of services for problem gamblers in New South Wales. Prior to that date, the only funding provided by government sources was sufficient for

two counselling positions: one at Lifeline (run by Wesley) and one at Centacare. From 1970, Dr Clive Allcock was treating compulsive gamblers within the hospital system and from approximately 1980 a unit under Neil McConaghy operated at the Prince of Wales Hospital, where the main treatment provider was Alex Blaszczynski. Both Allcock and Blaszczynski were interested in controlled trials to develop effective treatments and from their work, Imaginal Desensitisation became the treatment of choice. Although Lifeline (Mitchell Brown) and Centacare (Reg Murray) were aware of the work of Blaszczynski and Allcock, they did not follow the lead and preferred counselling and problem solving approaches. Subsequently, Allcock became interested in cognitive therapy as an approach to treatment. Thus, by 1995, there were quite distinct approaches to the treatment of problem gambling already in place. Throughout this period, Gamblers Anonymous was the main source of help for problem gamblers and GamAnon the main source of help for family and friends of the problem gambler. It was estimated that in 1997, approximately 150 problem gamblers were being seen each week by counsellors, whereas approximately 550 gamblers were attending GA meetings each week (Walker, 1997).

Development of Services After 1995

In 1995, the Darling Harbour Casino opened and two per cent of gross revenue was allocated to funding gambling research and treatment of problem gambling. The Casino Community Benefit Trust Fund was established to oversee the allocation of funding to ensure quality services were available to problem gamblers in New South Wales. A small number of new services were funded in 1996, but interest in obtaining funding grew to such an extent that new mechanisms were required to process applications. Thus, at the end of 1996, a panel of experts was formed to advise the CCBF on the development and funding of services for problem gamblers. Applications were invited from agencies that wished to set up gambling treatment services, and the panel set about developing a strategy to ensure high quality services were available throughout New South Wales. The panel recommended against setting up a centralised BreakEven network similar to those in Queensland, Victoria and South Australia, on the grounds that diversity in treatment approaches should be encouraged, at least until more was known about which treatment programs are effective and which are not.

In terms of a strategy for providing services, a two-stage process was recommended, according to which a short-term policy would be implemented immediately, and a long-term policy implemented within two to five years. The short-term policy consisted of funding a wide range of services for a period of eighteen months, with the primary directive being geographical coverage. Thus, areas of Sydney without services, such as Penrith, and major rural centres in New South Wales, were to be provided with services. By September 1997 there were 23 agencies providing services for problem gamblers, most of which were funded by the CCBF. Funding rounds in 1998 and 1999 increased the number of agencies providing services to problem gamblers to 66. By 1999, counselling services were seeing approximately 550 clients each week (Walker, 1999). The second stage of the strategy involved setting up large scale integrated services involving addiction, financial, relationship and legal counselling services within the one centre, and the provision of multilingual counselling especially within Sydney and outreach services, especially within the country areas. Unfortunately, the reference panel was disbanded at the end of 1997 and little progress has been made with Stage 2 of the recommended strategy.

Characteristics of the Funded NSW Services, 1999

Unlike other states, there is no BreakEven umbrella organisation identifying problem gambling services. This is a deliberate policy to avoid the risk of negative labelling of such agencies and to promote a diversity of approaches to the problem.

G-Line operates in New South Wales, but, in distinction to other states, it is now operated by High Performance Health of Sydney rather, than the Addiction Research Institute of Melbourne. While there are expected to be advantages to having a local telephone referral agency (in terms of liaison with service providers and knowledge of location and access), it is too early at this time to evaluate the transition to HPH.

There are few integrated services in New South Wales of the kind operating in Queensland, Victoria and South Australia, where addictions and financial counsellors operate side by side. Exceptions include the Wesley Gambling Counselling Service (which also

provides legal advice to problem gamblers), Centacare and a number of larger agencies in rural centres.

Research programs on treatment methods are funded at the University of Sydney and the University of New South Wales.

Programs of in service training of counsellors have been funded and are provided by Wesley and by Liverpool Hospital. These training programs range from half-day workshops to integrated programs extending over several days. The University of Sydney has been funded to provide training and resources for the assessment of problem gamblers.

Provision of services for non-English speaking ethnic minorities has primarily followed the direction of specialist services set up in community centres rather than bilingual counsellors in mainstream agencies.

In New South Wales, several counsellors in a variety of settings provide services for problem gamblers without funding by the CCBF. Dr Clive Allcock is a representative of this group.

Counselling of the problem gambler takes on average six sessions of between one and one-and-a-half hours, typically on the basis of one session per week. Eighty-three per cent of clients have poker machines as the main cause of excessive gambling, 60 per cent are men, and 55 per cent reside in Sydney, and the average age is 39 years (Walker, 1999).

The majority of counsellors assess their clients with either the DSM-IV criteria or the South Oaks Gambling Screen.

In general, clients are not followed up after treatment. The main data relevant to effectiveness of treatments are provided by specialist research programs, such as the one operating at the Liverpool Hospital.

2.5 Conclusions

From this brief review of services in a number of other jurisdictions it could be argued that, in terms of comprehensiveness of design and integration of the components, one might expect to form part of a problem gambling services strategy, Victoria's development is more advanced than a number of other states. This is particularly the case when Victoria is compared with New South Wales, but somewhat less so when compared with South Australia and Queensland.

The Department of Human Services has been successful in selecting host agencies with objectives that support and facilitate the implementation of the objectives set for the BreakEven program. Coordinators and counsellors report a strong program linkage between the aims of the BreakEven problem gambling program, and the purpose and aims of other programs within their agency. It is evident that the BreakEven program exists within a broad organisational context, focused on promoting general health and well-being within the community, and that its unique features are complemented by the backdrop of services provided by the host agencies. Later sections of this Report will show how this auspicing by generalist family support and counselling agencies guides the theoretical perspective and treatment responses they select.

The following section will evaluate the accessibility of the BreakEven service to those experiencing problems with their gambling behaviour. In order to do so, the chapter includes discussion about the issues involved in attempting to define and measure the prevalence of 'problem gambling'.

3 Evaluation of Service Access

As has been outlined in the Introduction to this Report, gambling availability, expenditure and acceptance have grown rapidly in Victoria within the last decade. This evaluation is to assess the effectiveness of one of the State-funded services set up to deal with the negative consequences of this growth, BreakEven Counselling Services, in meeting the level of problem gambling need in the community.

In order to assess how well BreakEven is reaching the 'problem gambling population', we need define what we mean by problem gambling behaviour and how it can be measured in the general adult population. These questions have occupied many researchers, practitioners and policy makers, and the answers they have come up with have major implications for problem gambling treatment programs and how their efforts are evaluated.

3.1 Defining and Measuring Problem Gambling

3.1.1 Range of Problem Gambling Prevalence Estimates

It is impossible to assess the extent to which a service is accessible to those who need to access it without some idea of the size of the population of potential clients and how this population relates to the numbers currently accessing the service. There is now substantial literature on the prevalence of problem and pathological gambling within the community, but some uncertainty remains as to the actual rates and scope of the problem within communities due to methodological differences in definition and measurement.

For a discussion of the various definitions of problem and pathological gambling see Dickerson, McMillen, Hallebone, Volberg and Woolley (1997: 11–29). In this Report, we have adopted the definition proposed by Dickerson et al (1997: 106):

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

This broad definition of 'problem gambling' includes behaviour that some writers have categorised as 'pathological gambling'. In this Report, the term 'problem gambling' will be used to represent this spectrum of behaviours.

Buhringer and Konstanty (1992) studied the prevalence of users of slot machines in the Federal Republic of Germany in a face-to-face interview study of 7,643 respondents. They found that 10.2 per cent of the population were active gamblers and that 0.7 per cent were 'intensive' gamblers who had used slot machines for five hours or more per week in the previous three months. While the authors provided no indication as to the extent to which gambling was problematic, findings from other research would suggest that this was the case for several of their respondents. For example, Abbott and Cramer (1993) performed a study of 420 randomly selected adult Nebraskans concerning their gambling activities.

Through their telephone interviews, they found that six per cent of respondents who reported having gambled in the past year indicated they had experienced negative effects from either their own, or another person's gambling.

Ladouceur (1991) studied the prevalence of pathological gambling in a telephone survey of 1,002 randomly selected residents of Quebec using the standard lifetime prevalence version of the South Oaks Gambling Screen (SOGS) (Lesieur and Blume, 1987). This uses questions phrased to assess lifetime prevalence (that is, 'Have you ever?'). Ladouceur found what he terms the 'current' prevalence of pathological gamblers to be 1.2 per cent, with another 2.6 per cent being problem gamblers. In a later study of 1,471 Quebec college students, Ladouceur, Dube and Bujold (1994a) once again using the standard SOGS instrument, found that 2.8 per cent of the students were pathological gamblers and that 5.8 per cent were problem gamblers. Major differences were found in the rates for males and females.

Volberg and Steadman (1988; 1989) have studied a range of samples of communities in the United States over a period of years, using the standard lifetime prevalence form of the SOGS. The 1988 study, involving the telephone interview of 1,000 randomly selected New York respondents, found problem gamblers made up 2.8 per cent of the sample and that a further 1.4 per cent were pathological gamblers. Their 1989 study of 1,750 New Jersey and Maryland residents, again using randomly selected telephone interviews, found problem gambling rates of 2.8 per cent in New Jersey, 2.4 per cent in Maryland and pathological gambling rates of 1.4 per cent in New Jersey and 1.5 per cent in Maryland. In a later paper Volberg (1994) reviewed the public health implications of her findings. She noted that:

> In states where legal gambling has been available for less than 10 years, less than 0.5 per cent of the adult population were classified as probable pathological gamblers. In states where legal gambling has been available for more than 20 years, approximately 1.5 per cent of the adult population were classified as probable pathological gamblers. Together these data support the long standing contention of treatment professionals and researchers that increasing the availability of gambling will contribute to an increase in the prevalence of gambling related problems in the general population. (Volberg, 1994: 239).

Thus, according to Volberg, problem and pathological gambling prevalence rates are affected in quite important ways by systemic variables, including the time period since the introduction of widespread legalisation of gambling modes. Volberg's assertions are supported by Emmerson and Laundergan's (1996) study of the changes in the prevalence of gambling and problem gambling over a four-year period in the state of Minnesota. Their 1990 sample consisted of 1,251 respondents and the 1994 survey consisted of 1,028 telephone interviews using randomly selected numbers. The SOGS-M modification of the SOGS was employed whereby the questions are rephrased to reflect a time period of the last year over which the target behaviours are exhibited, rather than the lifetime of the respondents. In 1990, 11.3 per cent of respondents were classified as gamblers 'with some difficulties', 1.6 per cent as gamblers with 'increasing negative consequences' (often the group that the term 'problem gambler' is applied to) and 0.8 per cent fell into the category of probable 'pathological' gamblers. In 1994, the figures were 15.8 per cent, 3.2 per cent and 1.2 per cent respectively for each group, suggesting a growth in the sizes of these groups over the time period of the study.

The Nova Scotia Department of Health (Focal Research, 1998) in 1997–98 commissioned a survey of 711 regular video lottery (VL) gamblers and 400 randomly selected adults from the general adult population of the province. The purpose of the survey was to obtain data in order to benchmark the behaviours, motivations and characteristics of VL gamblers, which would then be directly applied to the design of Problem VL Gambling treatment strategies and harm minimisation initiatives in Nova Scotia. The study is one of the more unusual as it did not use any of the conventional screens to identify problem gamblers, like the SOGS or DSM-IV. Such screens were not used because they were perceived to have the following weaknesses:

- The information obtained from SOGS and DSM-IV is descriptive rather than actionable, making it difficult to translate into treatment strategies.

- The appropriate cut-off points to minimise false positives are unclear and ill defined.
- These gambling screens have typically been designed for and tested with clinical populations (those currently seeking or receiving treatment within organised and/or clinical settings). They have not been designed or validated for use in random sampling of adults and gamblers in the general population.
- The causal relationship between problem gambling and the associated criteria, as measured by SOGS or the DSM-IV, are often difficult to determine.
- They do not provide information on the characteristics of 'normal' or typical VL gambling and, therefore, on what differentiates problem from non-problematic VL gambling.

Instead, the study used three independent measures:

- A Derived Multi-Item Attitude Score of 16+ on six key statements associated with problem VL gambling (based on pilot testing).
- A rating of 5 or higher on a 10-point scale, where 1 means your VL gambling is not at all a serious problem, and 10 means your VL gambling is a serious problem (self-designated score).
- Respondent indication that they had ever spent more time or money VL gambling than they should, and that the problem was still unresolved or only partially resolved (self-designated score).

Respondents had to qualify on at least two of the three measures to be considered problem VL gamblers. The use of self-selection of membership in the problem VL gambler category was used on the grounds that those who *felt* their VL gambling was problematic should also be considered in an analysis of problem gambling, regardless of whether they qualified on other behavioural or attitudinal measures. Their inclusion was based on a belief that those who reported that they were having 'problems' were more likely than other VL gamblers to seek assistance and/or information from the various support and service providers in Nova Scotia. They were also seen as the individuals most likely to benefit from assistance, given that they already recognised that VL gambling was problematic for them.

These three measures resulted in 16 per cent of the 'regular' VL gamblers in the survey (those who gambled on VLs on average more than once a month) being classified as problem gamblers, giving a current problem VL gambling prevalence for all adults in Nova Scotia of 0.92 per cent. When the additional nine per cent of the survey sample who indicated that they had had problems with their VL gambling but had subsequently resolved them are included, the prevalence for past and present (that is, lifetime) problem gambling rises to 2.8 per cent of all adults in Nova Scotia. Interestingly, the study found no significant differences between the sample of regular VL gamblers and the general population, in terms of the percentage of adults involved in VL gambling in Nova Scotia, even though very different sampling techniques were employed. This suggests that the VL gambling 'population' closely resembles the general adult population in Nova Scotia.

Gambling may also be problematic among minors. Ladouceur, Dube, and Bujold (1994) found in a survey of 1,230 primary school children in Quebec that 40 per cent of the respondents gambled at least once a week. Fisher (1992) studied the rates of pathological gambling in a sample of 467 British children. The study involved a written questionnaire that included items derived from the DSM-IV (American Psychiatric Association, 1994) definition of pathological gambling, which had been adapted to increase their relevance to juveniles. The questions were asked in the present tense so that the target behaviours were current. Sixty-two per cent reported gambling on fruit machines and of these, nine per cent were classified as problem gamblers. This gives a total population pathological gambling percentage for the children of 5.6 per cent, a somewhat troubling result.

3.1.2 Issues Regarding these Problem Gambling Prevalence Estimates

The prevalence estimates cited in the above papers are affected by the type of prevalence estimate used and the definitions adopted to define problem and/or pathological gambling. Furthermore, when discussing the prevalence of pathological and problem gambling, there can be considerable imprecision as to what is meant by 'prevalence' and the type of prevalence being described. In standard epidemiological terminology (for example, Christie, Gordon and Heller, 1987) the incidence of a condition within a population is the number of new cases occurring within a specified time interval. *Point prevalence* is the number of cases that have the condition within the population at a specified point in time, whereas

period prevalence is the number of cases that have the condition over a specified period of time. Lifetime prevalence, for example, is the number of cases within a population that will have the condition over the lifetimes of the individuals comprising the population. These prevalence definitions and their associated values within populations are quite different and it is important that the quotations of prevalence data include a clear specification of which type of prevalence is being quoted.

In the context of tools designed to measure the prevalence of problem or pathological gambling, the use of terminology, such as 'Have you ever?' performed the target behaviour is assessing a period prevalence over the person's lifetime to date. The use of terminology, such as 'Have you in the last six months?' performed the target behaviour is attempting to assess the period prevalence over six months. The use of terminology, such as 'Are you currently?' is assessing a point prevalence for the particular moment at which the question is being asked. Of course, these different terminologies will yield widely different prevalence results. The SOGS-M where the respondent is asked about target behaviours over a 12-month period may yield quite different results from the standard SOGS, where lifetime 'Have you ever?' questions are asked. If, on the other hand, problem and pathological gambling are a life-long affliction, then the questions may well yield the same results for point, period and lifetime prevalence. Emmerson and Laundergan's (1996) study using the SOGS-M did, after all, yield 1994 problem and pathological gambling rates of 3.2 per cent and 1.2 per cent, which are very similar rates to Volberg and Steadman's lifetime rates.

Knowing the point prevalence or the 12-month period prevalence of problem gambling is very important for problem gambling service planning. Problem gambling services based on the assumption that lifetime rates of problem gambling represent the numbers of people that currently require services may have vast over-capacity. This is because lifetime prevalence is sometimes substantially greater than point prevalence. Knowledge of the prospective pool of people who require services is informed by the incidence data (that is, new cases) and period prevalence data where the period corresponds to the planning period for the service. Thus, in most instances, 12-month period prevalence and 12-month incidence data would provide a sound basis for service planning and estimation of prospective client numbers. Of course, not all prospective clients turn into actual clients. Lifetime prevalence data that are yielded by tools, such as the standard SOGS do not provide a sound basis for service planning where the point or 12-month period prevalence is the required data.

In addition to concerns about the imprecise quotation of prevalence data without specifying the type of prevalence being quoted, a further issue is the use of epidemiological principles and terminology in the problem gambling literature. In medical epidemiology, in many instances, there is an incontrovertible test for the presence of the condition for which the prevalence is being estimated. Thus, with discussions of conditions such as HIV, while there may be some uncertainty concerning population prevalence because of sampling difficulties, the existence of the target condition in individuals can, in principle, be readily determined by the appropriate test. However, problem and pathological gambling measures involve the use of social constructs and self-reports by the affected population. Furthermore, there may be measurement error induced through considerable incentive to conceal problems. In this vein, Walker (1992) has issued a number of warnings about the use of instruments, such as the SOGS to measure the prevalence of problem and pathological gambling, based on concerns about the accuracy of self-reporting.

The use of self-report measures to determine HIV positive status would be seen in mainstream medical epidemiology as quite odd, whereas in the problem gambling literature, the use of self-report measures is quite routine. The use of prevalence rates and other quantitative estimates should not mask the fact that problem and pathological gambling are arguable social constructs that do not have the same tightness of definition that the occurrence of diseases may have. This means that measurement error and erroneous classification decisions may affect prevalence estimations of the rates of problem and pathological gambling in ways that they do not for conditions with tighter tests and criteria (not to mention physical 'evidence' of a disease). Thus, estimates of the prevalence of problem and pathological gambling need to be considered carefully in the context of exactly what type of prevalence is being quoted.

What is needed for service planning is information about current (and anticipated) experience of the problem, and to this end, the SOGS has been modified in some studies so that questions are asked about the last six or 12 months. In addition to this modification, a higher cut-off score (10 or more) has been proposed for use of the scale in Australia, and the scale has been treated as identifying people *at risk* of gambling related problems, rather than, as in the US, the identification of 'pathological gamblers'. Dickerson et al (1997) recommend that Australian studies be interpreted in such a way (with a current timeframe and a score of 10 or more), with the result that we arrive at the conservative figure of about 1.5 per cent of the adult population at risk of being problem gamblers. This is an extremely conservative figure that could go to four per cent, with the addition of people scoring over 5 on the SOGS. This figure is especially conservative given that it is based on state and national surveys carried out, in general, before the rapid expansion of gambling, or, in the case of the first national survey (Dickerson, 1996), was conducted in 1991, just at the time of legalisation of EGMs in Victoria.

Knowing the approximate number of people in a specific adult population who may be experiencing problems with their gambling is critical to assessing the program reach of a problem gambling treatment service.

3.2 Program Reach

These previous studies have indicated that the combined prevalence of problem and pathological gambling within an adult community averages out to approximately 1.5 per cent, which fits with Dickerson et al's 'recommended' prevalence rate for the Australian environment. Based on an adult population in Victoria of 3.26 million (Australian Bureau of Statistics, 1997), this would give a pool of potential problem gambling clients of 48,900 adults. The Productivity Commission Report (1999), reworking somewhat data from these previous studies, suggests that in taking the different populations into account the weighted average prevalence rates of studies undertaken prior to their National Gambling Survey is 1.8 per cent. Using a score of 5 or more on SOGS, the Productivity Commission suggests, from their National Gambling Survey, a problem gambler prevalence rate for Victoria of 2.14 per cent of the adult population (Productivity Commission, 1999, Volume 1:6.46). Using the HARM scale, a measure of gambling-related harm similar to the Novia Scotia study previously discussed, the Productivity Commission estimates prevalence for Victoria of 2.05 per cent. If we take the Victorian prevalence figure to be a conservative two per cent, then our pool of potential problem gambling clients is around 65,200 adults.

For the 18 BreakEven problem gambling counselling agencies in Victoria, we know from the Minimum Data Set of all client registrations in this program that the total number of people seen by BreakEven is 8,562 (excluding some data from one agency, not available at the time of preparation of this Report). Of these, 5,493 were problem gamblers and 1,202 were partners and others. The gambling status of the remaining 1,867 clients has not been reported on a registration form. However, 111 of these 1,867 clients had an assessment form. This means that they are likely to be problem gamblers. Hence, the total number of problem gamblers seen by BreakEven, to date, is 5604, or, more reasonably, if an estimate of the number of problem gamblers seen by the one BreakEven agency for which there is no data is included, 6,000.

If we compare these two sets of estimates, 65,200 versus 6,000, we have an almost eleven to one ratio. How can this discrepancy be explained?

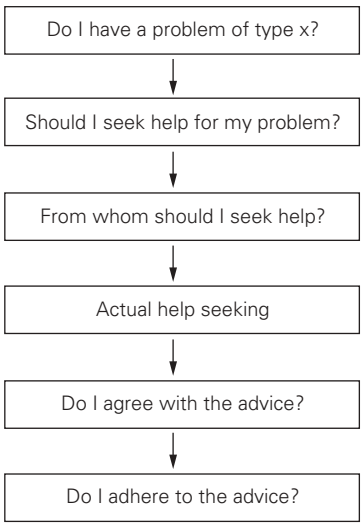
3.2.1 Explaining the Discrepancy

The fact that there is a major discrepancy between the numbers of people attending problem gambling services and the potential number of people with gambling problem, as predicted by the application of prevalence rates to populations, should not be dismissed as a result of incorrect estimates. It is possible that the 'low' numbers of clients presenting to problem gambling services is due to low service uptake. In other words, there may well be large numbers of people with problems who do not present to services for a variety of reasons.

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, 1997). 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 proposed by some of the present authors. This model is concerned with the steps taken by health consumers in seeking health care.

Figure 1 Health Action Model



The model asserts that people with problems go through a series of steps before help is sought. This is an active decision process, with fewer and fewer people reaching the later stages of the process. While we do not wish to enter into the vexed debate about whether gambling is best viewed from an addictive behaviours perspective, it is certain that if gamblers wish to modify their target behaviour, they need to progress though a change process similar to the one proposed by Prochaska and DiClimente (Prochaska et al, 1992; 1994), which has been widely used in a variety of contexts. In this Model of Stages of Change to addictive behaviours, individuals are said to pass through five stages of change:

1. **Precontemplation**—periods when there is no intention to change.
2. **Contemplation**—when change is considered but there is no firm commitment to altering behaviour.
3. **Preparation**—a transition phase between contemplation and action, when a decision has been made to take action sometime within the next month.
4. The **action** phase—when individuals actively modify their behaviour and/or environment to overcome their problems.
5. After making changes, the task of maintaining these changes and preventing relapse is the task of the **maintenance** phase.

Prochaska et al (1992) make a number of important points based on their literature review of the many studies that have been performed using their model. They argue that a common finding is that small numbers of all people with demonstrable addictive problems register for treatment. They argue that this is because they are in the earlier stages of change prior to seeking help. They also argue that relapse in attempting change is the rule rather than the exception in a whole range of human behaviours and that many people may attempt self-help rather than professional help.

If Prochaska et al's results are applied to the present context, then it is indeed possible that the 11:1 ratio of potential clients to actual clients observed in the Victorian context is accurate. Our own studies in the health actions research context (Thomas et al, 1997) have shown, using health diary methodologies, that people consult medical practitioners on average once per 29 symptom occurrences. The rate of 29 symptoms per presentation suggests a vast discrepancy between actual and potential clients, with most individuals choosing to seek outside assistance only on those occasions when they regard it as absolutely essential.

Other studies, such as Brown's (1986; 1987a; 1987b; 1987c), have shown similar difficulties in people with gambling problems maintaining their desired behaviour changes. Brown's seminal study of Gamblers Anonymous dropouts illustrates the difficulties associated with behaviour change for many problem and pathological gamblers. Furthermore, the provision of services for significant others may in fact affect the behaviour of problem gamblers, even if they do not attend treatment themselves (Barber and Crisp, 1995). The Nova Scotia Department of Health study (Focal Research, 1998) of video lottery (VL) gambling, for example, found that six per cent of all adults in Nova Scotia had sought assistance or information for help in controlling VL gambling at some time, and that approximately 84 per cent of these adults accessing problem gambling support and services were friends or relatives of a problem gambler.

3.2.2 Comments on the Prevalence Rate Used in this Report

In this Report, we have adopted the broad, harm-based definition of problem gambling crafted by the Department of Human Services. It is important to note that this definition could be considerably more inclusive than that used in many of the prevalence studies mentioned above, which tend to concentrate on identifying people who cross the threshold of clinical definitions. With this important warning in mind, we have assumed a potential problem gambling population of two per cent, or 65,200 adult Victorians.

However, this prevalence does not take account of any differences in prevalence that might occur between males and females, or different ethnic, income and age groups. This level of detail is beyond the scope of this Report and, indeed, may require the collection of more comprehensive, and comparable, data than that collected at present by problem gambling service agencies.

Furthermore, this prevalence should not be seen as static. The international research suggests that prevalence changes as the local gambling market matures and it is therefore possible that Victoria's prevalence range may alter once the recent major expansive phase has passed. This is all the more reason to advocate the regular calculation of the point or the 12-month period prevalence of problem gambling for service planning and evaluation.

The literature also suggests the need to appreciate that with problem gambling, we are talking predominantly about self-reports by the affected population, in an area that owes much to the prevailing social constructs, attitudes towards and awareness of the issue. Therefore the likelihood that affected people will use a problem gambling service is guided by their awareness and acceptance that they have a problem, their knowledge that services exist to help them, and their willingness and ability to access these services. It is within this context that the BreakEven service operates.

Compared with other estimates of help seeking in problem gambler populations, however, the Victorian BreakEven result is very good. In New Zealand the figure of three per cent has been proposed as the proportion of problem gamblers who will seek help (Smith, 1993). We have been unable to locate any similar estimate, but note that this three per cent estimate has subsequently been adopted as a working figure for estimating service need in New South Wales, for example (Dickerson, Allcock, Blaszczynski, Nicholls, Williams and Maddern, 1996; Walker, 1997) and Oregon (Volberg, 1997). The Productivity Commission National Gambling Survey found that 'perhaps 1 in 5 gamblers with severe problems obtain counselling whereas around 1 in 14 with less severe problems receive help' (Productivity Commission, 1999, Volume 2:17.32). As BreakEven works with clients with a wide range of severity of gambling-related problems, having a help-seeking population of 11 per cent of those who might have a need for the service is a good result, comparatively, even though in theory we aim at 100 per cent recruitment of those with the targeted problem.

3.3 Access to the BreakEven Service

There would seem to be little point in developing services if potential clients cannot access them. To be accessible a service must be:

> …one where a user can be in direct contact with the service (and, often, a service provider) where, and at a time which is convenient for the user, more or less as the need arises. Potential users know that the service exists, what it can provide, and how it can be accessed (Cheers, 1992: 13).

Factors affecting accessibility include the following:

- Geographical location of service (including proximity to public transport).
- Client ability to access the building where the service is located (that is, the provision of ramps, lifts, disabled toilets, etc for disabled clients).
- Hours of opening.
- Languages spoken by staff.
- Availability of interpreters.
- Provision of child care.
- The ability of the agency to provide culturally sensitive services.
- Client fees and charges.
- Agency policies.
- Philosophical orientation of agency and/or agency staff.
- Style of service delivery.
- Client perceptions of discrimination (by staff, other clients, or if known by others to be a client of a service).

- Client beliefs about being a service user.
- Overall demand for service (is there a waiting list, or so little demand the agency no longer provides the required service?).
- Government policies and funding priorities.

The purpose of the following analysis is to evaluate the *accessibility* of the BreakEven service as *perceived by service users.* This analysis will involve examination of:

- Geographical access.
- Anti-discriminatory practice.
- Clients' referral source.
- Whether or not clients used another service prior to accessing BreakEven.
- The type of services used by clients prior to making contact with BreakEven.
- The referral source of those clients who used other services prior to accessing BreakEven.
- Clients' satisfaction with the time elapsed before being seen by a BreakEven counsellor.
- Whether or not clients would use the service again
- Whether or not clients would recommend the service to others.

The data for the present analysis were obtained from the Clinical Practice Evaluation (CPE) Retrospective Study of BreakEven clients. One hundred and fifty BreakEven clients returned the survey. Further information regarding the *referral sources* of all new clients presenting to the BreakEven service between July 1997 and June 1998 was obtained from the *Client and Service Analysis Report No. 4: Analysis of Clients Presenting to Problem Gambling Counselling Services* (Department of Human Services, 1999).

3.3.1 Geographical Access

The distribution of BreakEven host agencies has been described earlier in this Report. Table 2 shows the distribution of registered sites at which BreakEven services are provided, along with details about the adult population, the number of EGMs in each local government area and the ratio of adults to EGMs in each local government area.

Table 2 shows that BreakEven services are provided in most municipalities in the Melbourne metropolitan area, and where they are not, are available in one or more adjacent municipalities. BreakEven services are also provided in most of the major population centres in rural Victoria and in rural localities that have sizeable numbers of EGMs. Many other communities also host BreakEven services.

Table 2 Electronic Gaming Machines, Population Aged 18 and Over and BreakEven Sites by Local Government Area

Local Government Areas with Department of Human Services Regions	Population Aged 18 and Over at August 1996[a]	Number of EGMs at June 1997[b]	Ratio of EGMs to Population Aged 18 and Over	Registered Sites of Breakeven Services at January 1999
Eastern Metropolitan Region				
Boroondara (C)	144,590	276	1:524	Ashburton, Camberwell
Knox (C)	130,793	837	1:156	Ferntree Gully, Knox, Rowville
Manningham (C)	103,759	538	1:192	Doncaster
Maroondah (C)	91,323	391	1:233	Ringwood
Monash (C)	152,552	924	1:165	Oakleigh (2), Syndal
Whitehorse (C)	135,472	619	1:218	Box Hill
Yarra Ranges (S)	130,805	302	1:433	Lilydale, Yarra Junction
Regional total	**889,294**	**3,887**	**1:228**	
Northern Metropolitan Region				
Banyule (C)	112,594	594	1:189	West Heidelberg
Darebin (C)	121,794	1,037	1:117	n/a
Hume (C)	116,030	653	1:177	Broadmeadows (2), Craigieburn, Sunbury
Moreland (C)	130,093	808	1:161	Coburg
Nillumbik (S)	54,417	147	1:370	Eltham
Whittlesea (C)	101,893	575	1:177	Lalor
Yarra (C)	65,148	454	1:143	Richmond
Regional total	**701,969**	**4,268**	**1:164**	

continues

Table 2 Electronic Gaming Machines, Population Aged 18 and Over and BreakEven Sites by Local Government Area (cont.)

Local Government Areas with Department of Human Services Regions	Population Aged 18 and Over at August 1996[a]	Number of EGMs at June 1997[b]	Ratio of EGMs to Population Aged 18 and Over	Registered Sites of Breakeven Services at January 1999
Southern Metropolitan Region				
Bayside (C)	80,933	366	1:221	n/a
Cardinia (S)	40,599	166	1:244	Pakenham
Casey (C)	143,533	675	1:212	Berwick, Cranbourne, Endeavour Hills
Frankston (C)	103,971	541	1:192	Frankston
Glen Eira (C)	113,392	659	1:172	East Bentleigh
Greater Dandenong (C)	126,179	1,129	1:111	Dandenong (2), Springvale (2)
Kingston (C)	122,438	916	1:133	n/a
Mornington Peninsula (S)	110,409	784	1:140	Hastings, Rosebud
Port Phillip (C)	73,092	389	1:187	South Melbourne, St Kilda
Stonnington (C)	84,298	391	1:215	n/a
Regional total	**998,844**	**6,016**	**1:166**	
Western Metropolitan Region				
Brimbank (C)	149,131	722	1:206	Deer Park, St Albans
Hobsons Bay (C)	74,166	455	1:163	Altona Meadows, Williamstown
Maribyrnong (C)	59,031	757	1:77	Footscray
Melbourne (C)	48,560	1,191	1:40	Kensington, Melbourne (2), West Melbourne
Melton (S)	39,167	195	1:200	Melton
Moonee Valley (C)	104,849	850	1:124	Moonee Ponds, Niddrie
Wyndham (C)	73,901	505	1:146	Werribee
Regional total	**548,805**	**4,675**	**1:117**	
Barwon South West Region				
Colac-Otway (S)	19,764	133	1:148	Colac
Corangamite (S)	16,963	49	1:346	Camperdown
Glenelg (S)	19,907	121	1:164	Portland
Greater Geelong (C)	175,409	1,310	1:133	Drysdale, North Geelong
Moyne (S)	15,865	0	n/a	n/a
Queenscliff (B)	3,193	35	1:91	n/a
Southern Grampians (S)	17,159	99	1:173	Hamilton
Surf Coast (S)	16,713	115	1:145	Torquay
Warrnambool (C)	26,777	280	1:95	Warrnambool (2)
Regional total	**311,750**	**2,142**	**1:145**	
Gippsland Region				
Bass Coast (S)	20,147	234	1:86	Phillip Island
Baw Baw (S)	32,984	140	1:235	Warragul
East Gippsland (S)	37,893	336	1:112	Bairnsdale, Lakes Entrance, Orbost
French Island	54	0	n/a	n/a
South Gippsland (S)	24,083	142	1:169	Leongatha
Wellington (S)	39,815	284	1:140	Sale
Regional total	**222,540**	**1,809**	**1:123**	

continues

Table 2 Electronic Gaming Machines, Population Aged 18 and Over and BreakEven Sites by Local Government Area (cont.)

Local Government Areas with Department of Human Services Regions	Population Aged 18 and Over at August 1996[a]	Number of EGMs at June 1997[b]	Ratio of EGMs to Population Aged 18 and Over	Registered Sites of Breakeven Services at January 1999
La Trobe (S)	67,564	673	1:100	Morwell
Grampians Region				
Ararat (RC)	11,095	83	1:133	Ararat
Ballarat (C)	76,509	594	1:128	Ballarat
Golden Plains (S)	13,157	0	n/a	n/a
Hepburn (S)	13,427	80	1:167	Daylesford
Hindmarsh (S)	6,573	0	n/a	n/a
Horsham (RC)	17,323	140	1:123	Horsham
Moorabool (S)	21,943	60	1:365	Bacchus Marsh
Northern Grampians (S)	13,002	88	1:147	n/a
Pyrenees (S)	6,578	0	n/a	n/a
West Wimmera (S)	4,931	0	n/a	n/a
Yarriambiack (S)	8,303	0	n/a	n/a
Regional total	**192,841**	**1,045**	**1:184**	
Hume Region				
Alpine (S)	18,157	77	1:235	n/a
Delatite (S)	22,494	136	1:165	n/a
Greater Shepparton (C)	51,902	300	1:173	Shepparton
Indigo (S)	13,680	0	1:270	n/a
Mitchell (S)	24,931	92	1:270	Broadford, Seymour
Moira (S)	24,714	25	1:622	n/a
Murrindindi (S)	12,452	20	n/a	n/a
Strathbogie (S)	8,797	30	1:293	n/a
Towong (S)	6,123	20	1:306	n/a
Wangaratta (RC)	25,037	99	1:252	n/a
Wodonga (RC)	29,187	142	1:205	Wodonga
Regional total	**237,474**	**941**	**1:252**	
Loddon Mallee Region				
Buloke (S)	7,596	0	n/a	n/a
Campaspe (S)	33,320	100	1:333	Echuca (2), Kyabram
Central Goldfields (S)	12,321	109	1:113	Maryborough
Gannawarra (S)	11,920	0	n/a	n/a
Greater Bendigo (C) Eaglehawk, Heathcote, Kangaroo Flat	81,338	479	1:169	Bendigo, Bendigo Prison,
Loddon (S)	8,585	0	n/a	Inglewood, Wedderburn
Macedon Ranges (S)	32,368	75	1:431	Gisborne, Kyneton
Mildura (RC)	45,416	224	1:202	Mildura
Mount Alexander (S) Tarrengower Prison	15,934	30	1:531	Castlemaine, Loddon Prison,
Swan Hill (RC)	20,393	92	1:221	Swan Hill
Regional total	**269,191**	**1,109**	**1:242**	
State Total	**4,372,708**	**25,892**	**1:168**	

[a] Source: Australian Bureau of Statistics, 1996.

[b] Source: Dickerson et al, 1997.

3.3.2 Meeting Demand for Problem Gambling Counselling Services

An issue raised by a number of counsellors was their belief that the numbers of client contacts reported significantly underestimates their actual activity levels. Most counsellors indicated that a considerable proportion of appointments made (mean=18.6 per cent, maximum=50 per cent) are not kept, resulting in lower client numbers than actual contacts. The majority of counsellors attempted to follow-up clients who failed to keep appointments (61 per cent followed up new clients, 79 per cent followed up existing clients), indicating that time and effort were expended on these clients.

There was a strong feeling from counsellors that it was important that if new clients were not seen promptly, the likelihood of them not keeping their appointment was greatly accentuated. Despite this, waiting lists were a fact of life in several agencies, especially when fluctuating demand was at its peak.

With the number of new clients in 1997–98 being equal to the combined total of the two previous years, one agency claimed to have provided services to almost twice as many clients during this period than the number specified in their funding agreement with Department of Human Services that they should provide service to. This agency was one of four rural agencies suggesting that there was sufficient client demand to employ more than the 0.5–1.5 EFT counsellors that they currently employed and that in relation to these agencies, waiting lists were indicative of understaffing. For other agencies, the presence of waiting lists does not necessarily mean that agencies are unable to service the number of clients requiring problem gambling counselling in their region. Instead, it relates to a discrepancy between client preferences and the services that are on offer. For example, counsellors in agencies which have several satellites report that while there may be a three week wait for counselling at the delivery point closest to a client's home, counselling may be available much sooner elsewhere in the region. In such cases, clients may be offered the choice between an immediate appointment that involves some travel, or a later appointment closer to home.

While demand may fluctuate between service delivery points within a region, the demand for after-hours appointments remains a constant in those regions where they are provided. Almost 60 per cent of problem gambler clients attending BreakEven services in 1997–98 were employed. Counsellors from the few agencies that offer after-hours counselling report a strong demand for evening sessions and suggest that if more after hours counselling was available, service usage by employed persons may be even higher.

The lack of after-hours services is not unanticipated and may in part reflect decisions by Department of Human Services to locate BreakEven services in existing community agencies, such as community health centres, few of which are open outside of office hours. While G-Line is able to provide crisis counselling on a 24-hour a day basis, and some BreakEven counsellors even refer their clients to G-Line for immediate tension relief outside office hours, alternative strategies for providing an after-hours, ongoing counselling service may be required. One way of ensuring the availability of counselling sessions outside office hours could be to include the number of evening sessions offered as one of the performance indicators in the service agreements with the auspicing agencies.

3.3.3 Anti-Discriminatory Practice

Specific efforts or policies may be required to increase access to services for specific groups which have tended to be systematically marginalised either by society (Industry Commission, 1995) or by service providers (Hughes and Mtezuka, 1992). Efforts may also be required to attract potential clients who, for whatever reason, do not believe the service is applicable to them. In the case of BreakEven services, which have a mandate to provide services to all persons affected by problem gambling, the ability to attract female problem gamblers, gamblers from non-English speaking backgrounds and individuals affected by someone else's gambling are arguably critical requirements of anti-discriminatory practice.

Sex

Females, who comprise the majority of service users at most health services (Australian Institute of Health and Welfare, 1996; Cockerham, 1997), are more than twice as likely as males to seek help from a counsellor at some point in their life (Collier, 1982). This difference, however, should not necessarily be interpreted as evidence that females have a greater need of such services, but may reflect sex differences in help-seeking behaviours.

In stark contrast to most other forms of counselling, overseas samples of problem gamblers in treatment found in the research literature are made up predominantly of males (for example, Ciarrochi and Richardson, 1989; Taber, McCormick, Russo, Adkins and Ramirez, 1987). Volberg (1994) found that the proportion of male clients in treatment programs in five American states ranged between 86 per cent and 93 per cent. Similarly high proportions of males have been attending Gamblers Anonymous in both Australia (Wootton, 1995) and America (Johnson, Nora and Bustos, 1992). This is despite population data that suggest men and women are equally likely to gamble in both countries (Hraba and Lee, 1996; Lindgren, Youngs, McDonald, Klenow and Schriner, 1987; Maddern and Golledge, 1997).

Given that prevalence studies indicate that up to half of all problem gamblers are female (Hraba and Lee, 1996), it seems that male problem gamblers are more likely to be in treatment than females (Volberg, 1994). There are many reasons why this may be so. Females who seek assistance from health or welfare professionals are unlikely to be routinely assessed for gambling problems (Downing, 1991; Mark and Lesieur, 1992). Thus only those who disclose their gambling as problematic, without prompting, have any chance of entering treatment (Lesieur, 1989). The paucity of women in treatment may also reflect the program design failing to take account of needs and issues that are predominantly of concern to women, for example, child care, sexual assault and domestic violence (for example, Copeland, 1997; Doshan and Bursch, 1982; Kravetz and Jones, 1988; Reed, 1985). Whether programs that are specifically designed for men can be readily adapted for women is questionable. Women who enter treatment programs designed for men may find that program staff do not have the expertise or resources to deal with problems which are specific to their sex (Reed, 1985).

The ability of the BreakEven services both to attract women and, if they complete treatment, to be more likely to resolve their problems than male clients, suggests they present an attractive model of service delivery for female problem gamblers. Female problem gamblers may be attracted by the fact that these services are community-based and are housed in existing agencies which women may already have relationships with, such as community health centres. For women who are concerned about being stigmatised if others learn of their gambling, these agencies provide discreet venues for counselling (Thomas, 1995). Discretion is further enhanced by clients attending BreakEven services being able to discuss either their own gambling behaviour or that of a significant other. This is in stark contrast to many overseas services that have been developed in treatment settings in which males predominate, such as Veterans centres (Mark and Lesieur, 1992). Furthermore, for female clients, especially those with dependent children, counselling on a non-residential basis may be a more feasible option than entering residential treatment (for example, Doshan and Bursch, 1982; Kravetz and Jones, 1988).

Ethnic Background

Approximately one-quarter of BreakEven clients (24.4 per cent) were born overseas, from a wide range of countries. This proportion is consistent with ABS 1996 Population Census data that found 27.5 per cent of Victorians were not born in Australia.[4] As shown in Table 3, over half of those born overseas (61.1 per cent) were born in Europe.

To protect the confidentiality of the clients among the very small numbers of clients born in many countries, the data in Table 3 for most countries has been aggregated into geographical regions. Thus while it is possible that 'problem gamblers' from various countries may be over-represented, as is often suggested, comparison of the regional data with Census data reveals BreakEven clients to be similar to the profile of the general population of Victorians.

However, recent work by Thomas and Yamine (2000) has shown very high rates of problem gambling within specific cultural groups in Victoria. The four cultural groups within this study were Arabic speaking, Chinese speaking, Greek speaking and Vietnamese speaking respondents. When one considers that the representation of cultural groups within the BreakEven client population matches that of the general population, this implies that the uptake of BreakEven services by people from these cultural groups is much lower that that within the Anglo community.

[4] The following information on ethnicity has been drawn from Jackson, et al (1998). Analysis of Clients Presenting to Problem Gambling Counselling Services July 1997 to June 1998: Client and Service Analysis Report No. 4.

Table 3 New Clients of BreakEven Service: Birthplace

Birthplace	Persons N	Persons %
Australia	2,299	75.6
New Zealand	47	1.5
Polynesia	8	0.3
Other Oceania and Antarctica	4	0.1
Oceania and Antarctica	2,358	77.5
Southern Europe	187	6.1
United Kingdom and Ireland	178	5.9
Western Europe	47	1.5
Eastern Europe	34	1.1
Europe and the former USSR, nfd	8	0.3
Europe and Former USSR	454	14.9
South East Asia	73	2.4
The Middle East and North Africa	55	1.8
North East Asia	30	1.0
Southern Asia	26	0.9
Africa (excluding North Africa)	26	0.9
North America	11	0.4
South America, Central America, Caribbean	9	0.3
Total	3,042	100.0

Missing data=107

Given that clients born in Australia, New Zealand, the United Kingdom and North America comprised 83.3 per cent of all clients, the data presented in Table 4 which indicate that English is the main language spoken at home for 85.3 per cent of clients is hardly surprising. While the remaining clients speak a wide range of languages, only 40 (1.3 per cent) required an interpreter. None of the 45 (1.5 per cent) clients who identified themselves as Aboriginal or Torres Strait Islanders primarily spoke an indigenous language at home. The slightly higher proportion of Aboriginal and Torres Strait Islander clients compared to all Victorians at the 1996 Census (0.5 per cent), may be due to the outreach work that has been conducted by some BreakEven services with Aboriginal communities.[5]

Table 4 New Clients of BreakEven Service: Language Spoken at Home

Language	Persons N	Persons %
English	2,432	85.3
Language other than English:		
Northern European Languages	17	0.6
Southern European Languages	175	6.1
Eastern European Languages	95	3.3
South West Asian and North African Languages	39	1.4
Southern Asian Languages	10	0.4
South East Asian Languages	35	1.2
Eastern Asian Languages	39	1.4
Australian Indigenous Languages	0	0.0
Other Languages	9	0.3
Total Languages other than English	419	14.7
Total	2,851	100.0

Missing data=298

As part of its Problem Gambling Service Strategy, the Department of Human Services funds a number of services for people from non-English speaking backgrounds (NESB). There are nine specialist services in Victoria, covering specific geographical regions. The majority of the services operate from existing BreakEven services. For the purposes of this

Table 5 Organisations that Provide NESB Services

Region	Organisation	NESB Group
Northern Melbourne	Kildonan Child and Family Service in conjunction with Broadmeadows CARE	Turkish, Arabic, Macedonian and Vietnamese
Eastern Melbourne	Maroondah Social and Community Health Centre*	Indo-Chinese, Italian and Greek
Western Melbourne	Brimbank Community Health Service, and Australian Vietnamese Women's Welfare Association*	Turkish and Former Yugoslav State Vietnamese and Indo-Chinese
Southern Melbourne	East Bentleigh Community Health Centre*	South East Asian
Loddon-Mallee	Bendigo Community Health Service*	Different groups
Hume	NEWomen Goulburn North Eastern Women's Health Service	Koori women
Gippsland	Anglicare Gippsland*	Different groups
Grampians	Ballarat Children's Home	Different groups

* NESB service operates from the existing BreakEven program.

[5] In this report, Aboriginal and Torres Strait Islander communities have not been included in the definition of 'ethnic communities'. Rather, they are distinguished as 'Indigenous communities'.

Report these services are described briefly below.[6] The following organisations provide NESB services in different regions throughout Victoria.

All agency coordinators indicated that there is a significant demand for NESB services within their particular region. One agency identified a significant proportion of NESB clients who had accessed the service for 'superficial assistance', but who did not attempt to address the underlying causes of their financial difficulty. It was suggested that the existing BreakEven service was not attracting this particular group, and that the current NESB service model should employ ethno-specific workers to target these communities. A study of the gambling and help-seeking behaviours of selected Asian cultural communities in Western Australia (AIGR, 1999) agrees that 'there is a gap between the level of help-seeking behaviour of members of Asian cultural communities and the number of presentations of individuals from Asian backgrounds at BreakEven centres'. The study found that one of the main reasons for this shortfall 'was the lack of a formal program within BreakEven (WA) dealing with culturally diverse clients'. Until further, specific research is undertaken, it is uncertain to what degree other NESB communities are experiencing the same barriers.

Similarly, a number of agencies highlighted the difficulty of attracting people to the service because of the social stigma attached to 'problem gambling'. There is thought to be a great fear within the Vietnamese community, for example, that 'shameful family matters' will become known to others. Furthermore, in many Asian communities counselling itself is seen as negative, 'often associated with mental deficiency or personal inadequacy' (AIGR, 1999). Therefore, community education efforts are required before the strong demand for counselling and early intervention is apparent.

Agencies funded to provide NESB services within Victoria utilise a broad range of strategies in delivering the program. Program coordinators identified what they thought to be the most effective and efficient method for delivering the service, as well as a number of inefficiencies and gaps in the current NESB service provision model. Working and collaborating with key ethno-specific agencies was thought to be a key activity in developing and promoting the service. The Western Australian study (AIGR, 1999), for example, found that 'most individuals from Asian communities seeking assistance with gambling-related problems presented first at an appropriate ethnic organisation rather than a mainstream gambling counselling service'. Communication with these agencies aids community development and assists those people who would not usually come in contact with the mainstream BreakEven service.

Ethno-specific workers access ethnic communities in a variety of different ways: radio and TV interviews, information booths at cultural festivals, information sessions with small groups, focus groups, and distribution of written material in the appropriate languages. In addition to providing problem gambling and financial counselling, workers engage in community consultation and education activities, and provide self-help booklets and literature. A number of agencies have outpost workers who operate from ethno-specific agencies, in order to further assist people in obtaining the help and support they need. In some cases, telephone counselling is made available for people in remote areas.

However, program coordinators highlighted a number of gaps in service delivery. There is thought to be some difficulty in recruiting workers from particular cultural groups (for example, South East Asian). This problem has hindered the development of NESB programs in particular regions. There is also some concern about how particular ethnic groups regard the counselling model, and the relevance of the West's model of financial counselling. For example, it was suggested that the Arabic community does not value the 'counselling' model of intervention, as it is associated with 'illness'. It was also suggested that some ethno-specific agencies that lack knowledge of the problem gambling service may not refer clients from their community, restricting access to the service for these people. Other perceived gaps included lack of resources for financial education, need for 'responsible gambling' advertisements in appropriate languages, and a Koori awareness program (one coordinator specified the need for services for Koori women).

[6] The following information was obtained from interview schedules of agencies hosting Innovative Service Models for NESB Communities Experiencing Problem Gambling and Financial Management Difficulties.

The barriers to accessing mainstream problem gambling counselling services for people from NESBs include lack of knowledge of available services, language barriers, cultural barriers to recognising problems and seeking appropriate assistance, and lack of culturally relevant and sensitive services. Therefore, people may miss out on getting the assistance available to them. In this way, the need for support of NESB groups is particularly high. The introduction of the Innovative Service Model has increased access to problem gambling support services for people from NESB.

Access by People Affected by Others' Problem Gambling

Although BreakEven services have a mandate to provide counselling to all persons *affected* by problem gambling, media campaigns advertising the existence of problem gambling counselling services across Victoria have primarily been aimed at problem gamblers. Nevertheless, Table 6 indicates that persons other than problem gamblers are increasingly identifying BreakEven as a potential support for themselves, with the proportion of clients presenting because of the gambling of others almost doubling from 11.9 per cent in 1995–96 to 20.4 per cent in 1997–98.

Table 6 Number of New BreakEven Clients: Client Status by Year of Registration

	1997–98		1996–97		1995–96	
Client Status	Male	Female	Male	Female	Male	Female
Self-identified gambling problem	1,223	1,233	813	694	581	560
Partner	129	307	46	140	37	88
Other	64	129	24	70	5	24
Total	1,416	1,669	883	904	623	672

Although many writers have in the past assumed that the partners of problem gamblers are invariably female (for example, Ciarrocchi and Richardson, 1989; Gaudia, 1987; Greenberg and Rankin, 1982; Lorenz, 1989; Lorenz and Shuttlesworth, 1983), the client data from the MDS challenge this assumption. This no doubt reflects the fact that similar numbers of male and female problem gamblers attend BreakEven services.

Male reluctance to seek help may be coupled with agency initiatives that are primarily focused on women (Forster, 1996). Such factors include the availability of appointments. Given that only a few BreakEven services offer appointments out of office hours and many male partners are employed, it may be that male partners have greater difficulties in linking up with BreakEven.

3.3.4 Referral to BreakEven from Other Services

The routes by which people get to problem gambling counselling services are quite varied. Some problem gambler clients (6.8 per cent of males, 4.3 per cent of females) attend BreakEven services to fulfil legal orders that they receive counselling for issues associated with their gambling. While the majority may not have a legal requirement to attend, pressure from significant others to seek help is not uncommon. In fact, 12.6 per cent of problem gamblers cited family and friends as a source of referral. However, the most common source of referral to BreakEven mentioned by problem gambling clients was the G-Line telephone counselling and referral, which contributed to the referral of one-third of all new clients (37.1 per cent). Interestingly, given the high incidence of financial problems and some attempts to integrate problem gambling counselling with financial counselling services, only 1.3 per cent of clients were referred to BreakEven by financial counsellors.

One-quarter (28.8 per cent) of clients were reportedly self-referred. This concept of self-referral is a difficult one. While clients may be urged by others to seek help for their gambling-associated problems, unless an actual referral is made, the client is regarded as self-referred. Self-referral data, therefore, should not be taken in itself as evidence of insight or motivation. Conversely, if a client self-refers to an agency that deems BreakEven to be a more suitable agency to deal with the client's problem, and informs the client of this, then a referral from another health or welfare service is recorded, even though the client initiated the original contact. The sources of referral for problem gambler clients are presented in detail in Table 7.

Table 7 New Clients: Problem Gamblers: Source of Referral by Sex

	Males (n=1,223)	Females (n=1,233)	Persons (n=2,456)	
Source of Referral	N	N	N	%
G-Line	471	449	920	37.1
Self-referral	301	404	705	28.5
Family or friends	167	144	311	12.6
Media	86	107	193	7.8
Community agency	66	70	136	5.5
Court order/correctional system	54	20	74	3.0
Health service	32	42	74	3.0
Legal service	29	13	42	1.7
Other therapist	22	28	50	2.0
Gamblers anonymous	18	6	24	0.0
Financial counsellor	17	16	33	1.3
Problem gambling service staff	8	4	12	0.5
Other clients of problem gambling service	3	11	14	0.6
Self-help group	0	0	0	0.0
Other	60	49	109	4.4

This information can be compared to the sources of referral for the *Clinical Practice Evaluation (CPE)* client cohort (discussed in detail in Volume Two of the Evaluation Report). This group also accessed the BreakEven service in a variety of ways. Sources of referral for this client cohort are presented in Table 8.

Table 8 Clinical Practice Evaluation Client Cohort: Problem Gamblers: Source of Referral (n=149)

Person's Source of Referral	N	%
G-Line	65	43.3
Family or friends	18	12.0
Other professionals	14	9.3
TV advertisements	13	8.7
Advertising at gaming venue	13	8.7
Newspaper advertisements	7	4.7
Crisis service	6	4.0
Telephone book	5	3.3
Financial counsellor	3	2.0
News Story	3	2.0
Radio advertisements	1	0.7
Prison	1	0.7

Missing Data=1

Although the sources cited in Tables 7 and 8 are not identical, it is possible to compare across a number of different sources of referral in order to establish whether the CPE client cohort is representative of the greater population of BreakEven clients.

Table 8 shows that almost half (43.3 per cent) of this group found out about BreakEven via the G-Line telephone counselling service. This is consistent with the findings for all new clients presenting to BreakEven services between July 1997 and June 1998 (shown in Table 3), which shows that G-Line contributed to the referrals of one-third (37.1 per cent) of all new clients. Similarly, family and friends (12.0 per cent) were also among the most common source of referral for this group, as with all new clients (12.6 per cent).

If the figure for financial counsellors (2.0 per cent) is included with 'other professionals' (9.3 per cent), it is evident that other professionals were a source of referral for 11.3 per cent of this client cohort. If we then examine Table 7, it is evident that 'other professionals' contributed to 8.5 per cent of referrals for all new clients when the figures for those who cited health services (3.0 per cent), legal services (1.7 per cent), problem gambling service staff (0.5 per cent), other therapists (2.0 per cent) and financial counsellors (1.3 per cent) are combined. Hence, it is apparent that the CPE client cohort is typical of the greater population of BreakEven clients. Other common sources of referral for the CPE client cohort were television advertisements (8.7 per cent) and advertising in gaming venues (8.7 per cent).

Referral of People from non-English Speaking Backgrounds

Coordinators' reports suggest that NESB clients are attending services other than those funded under the Innovative Service Models for NESB Communities Experiencing Problem Gambling and Related Financial Management Difficulties Program. However, most agencies have in place formal referral relationships with other related agencies, increasing the likelihood that NESB clients will receive the assistance that is available to them. Furthermore, program coordinators and staff have reported a significant increase in the number of people with gambling-related issues accessing their organisations since the NESB programs were established.

NESB clients are being referred from a variety of different organisations, including emergency relief programs, other welfare agencies, migrant resource centres, legal aid, psychiatrists, physiotherapists and the G-Line telephone counselling service. Many clients are also reportedly self-referred. A number of coordinators commented that clients were self-

referred, having attended discussion groups in the community, as well as through exposure to problem gambling advertising material.

Where the NESB service is provided by an agency that does not host the BreakEven service, such agencies still tend to have strong links with the BreakEven program in their region. Agencies also have strong referral relationships with a wide variety of other organisations and professionals. These include generalist family services, government departments, corrections services, migrant services, solicitors, doctors, alcohol and drug services, mental health services and disability services.

Agencies for NESB clients use a number of different protocols for referral to and from other agencies. The Ballarat Children's Home, for example, has procedures in place whereby a specific worker is allocated the referred client and this worker then takes responsibility for the client case and for liasing with the referring worker, or agency. Within specific programs, referral to and from agencies also occurs directly. For example, a referral to or from BreakEven counsellors to the financial counsellor is direct once permission has been given by the client to speak with the worker concerned. This system has been seen to work well. Another agency commented that the financial counsellor is responsible for case management as they are best placed to access necessary financial and housing support services for the client group.

3.3.5 Use of Other Services Prior to Attending BreakEven

Although there are 18 BreakEven services throughout inner city, suburban and rural Victoria, BreakEven is not necessarily the first point of contact for people seeking help for gambling-related problems. In fact half (50.7 per cent) of the clients surveyed stated that they had been to another service to discuss their gambling problems prior to attending BreakEven. This group cited a variety of different sources of referral to BreakEven. The sources of referral for problem gambler clients who used other services prior to attending BreakEven are presented in detail in Table 9.

Table 9 Other Service Use: Problem Gamblers: Source of Referral to BreakEven (n=76)

Person's Source of Referral	N	%
G-Line	25	32.9
Family or friends	13	17.1
Other professionals	9	11.8
TV advertisements	6	7.9
Advertising at gaming venue	6	7.9
Newspaper advertisements	5	6.6
Crisis service	5	6.6
Telephone book	3	3.9
Financial counsellor	2	2.6
News Story	1	1.3
Radio advertisements	1	1.3
Prison	n/a	n/a
Total	76	100.0

Missing Data=1

Of those people who had used other services, a number of different sources of referral to BreakEven were cited. As with all new clients and the CPE client cohort, the most common referral source was the telephone counselling service G-Line, mentioned by one-third (32.9 per cent) of those clients who had accessed another service prior to BreakEven. Not surprisingly, other professionals (17.1 per cent) were a common source of referral, consistent with the figures for all new clients and the CPE population. Another common referral for those people who used other services prior to BreakEven was advertisements in gaming venues (11.8 per cent). This finding is also comparable to the findings for all CPE clients (8.7 per cent).

The relatively high proportion who cited gaming venue advertisements as their source of referral to BreakEven can be traced to the work of the CEGFLOs (Community Education and Gaming Facility Liaison Officers). As part of the gaming liaison work and education of gaming facility staff, advertising material outlining the problem gambling services available is distributed. The substantial proportion of people who cited advertising material as their source of referral to BreakEven is also evidence of the work of Convenience Advertising, a company under contract to Department of Human Services, providing advertising material such as that found on the back of toilet doors in gaming venues.

The high proportion of people who were referred from G-Line is an indication of the success of community education programs and the G-Line service in Victoria. This is discussed in more detail in Section 3 of this Report.

Of the 50.7 per cent of CPE clients surveyed who stated that they had used another service prior to attending BreakEven, the number of services used prior to accessing BreakEven varied and is presented in Table 10.

Table 10 Number of Services Used Prior to BreakEven (n=77)

Number of Services Used	N	%
1	37	48.0
2	22	28.6
3	11	14.3
4	5	6.5
8	2	2.6
Total	77	100.0

Of the 77 people who used other services prior to accessing BreakEven, more than three-quarters (76.6 per cent) attended one or two other services. Only a small proportion of people surveyed had attended four or more other services. BreakEven clients cited a range of different services from which they sought help prior to attending BreakEven. Table 11 details the different services accessed by clients.

Table 11 reveals the most common service used prior to BreakEven was Gamblers Anonymous, which was mentioned by more than half (57.9 per cent) of the 76 clients surveyed. Interestingly, one-third (31.6 per cent) of these clients saw a doctor about their gambling-related problems before attending BreakEven.

Such findings provide direction for the future planning of problem gambling services. Provision of information about problem gambling to other service providers, and increased communication between BreakEven and other organisations, appears to be paramount to the effective treatment of problem gamblers. An example of where this is already happening is with the Australian Medical Association (AMA, NSW) providing doctors with information about identifying problem gambling symptoms and referring clients to appropriate treatment services. Community education strategies such as this may be an effective means of increasing awareness of the BreakEven service in Victoria, resulting in a greater degree of accessibility and referral to appropriate treatment services.

Table 11 Other Services Used Prior to BreakEven (n=76)

Type of Service	N	%
Gamblers Anonymous	44	57.9
Doctor	24	31.6
Therapist	20	26.3
Crisis service	19	25.0
Financial counsellor	18	23.7
Community health centre	12	15.8
Legal service	7	9.2
Self-help group	6	7.9

Missing Data=1

Patterns of Service use Prior to Accessing BreakEven

Further information about problem gamblers' help-seeking behaviour and the accessibility of the BreakEven service can be obtained by tracking people's movements through other services and identifying whether any clear patterns of service use exist. Examination of the different combinations and patterns of services are also important in terms of future planning, and targeting appropriate services for intervention and education about problem gambling and referral. Table 12 details the patterns of service use of those people who used other services prior to accessing BreakEven. Only those people who used between one and three services have been included in Table 12, as this group constitutes more than 90 per cent of those people who used other services prior to accessing BreakEven. Additionally, three clients did not specify their order of service use, one client did not respond to the question and seven clients made contact with more than three services. These cases have been included as missing data.

Table 12 Patterns of Services Use Prior to Accessing BreakEven (n=66)

Person Case	Point of Contact First (n=66)	Second (n=31)	Third (n=11)
1	GA		
2	T		
3	GA	T	
4	CL		
5	T	FC	
6	LS		
7	GP	CL	GA
8	SH	FC	
9	GA		

Person Case	Point of Contact First (n=66)	Second (n=31)	Third (n=11)
10	LS		
11	CHC		
12	GA		
13	CL		
14	GA	T	CL
15	T	GA	
16	GA	CL	CHC
17	GP	CL	T
18	GA		
19	GA		
20	GA		
21	CL	GA	
22	GA		
23	FC	T	
24	CL	GA	
25	T	CL	
26	CHC		
27	GA	GP	CHC
28	GA		
29	GP		
30	FC		
31	GA	T	
32	T	SH	
33	GA		
34	GA		
35	GA		
36	T	GP	
37	CL	GP	
38	GA	SH	
39	GP		
40	GA		
41	GA		
42	GA		
43	FC		
44	GP	GA	T
45	GA	T	GP
46	GA		
47	GA	FC	GP
48	GP	GA	
49	GA		
50	SH		
51	FC		
52	GP	T	
53	GA		
54	GA		
55	GA		
56	FC	CL	
57	GA		
58	CHC	GP	LS
59	GA	FC	
60	Other	FC	GA
61	GP	T	
62	GP	CL	FC
63	FC		
64	CL	SH	
65	FC	GP	
66	GP		

Missing data=11

Service type codes:
CHC=Community health centre
GA=Gamblers Anonymous
SH=Self-help group
CL=Crisis Line/Life Line
GP=Doctor
T=Therapist
FC=Financial counsellor
LS=Legal service

Table 12 reveals that there are no *clear* patterns of service use among those people who accessed other services prior to attending BreakEven. Of the 66 cases presented in Table 12, more than half (53.0 per cent) used only one service prior to BreakEven. Therefore, in as much as there is some pattern among these people, they used the one same service (for each service type) prior to attending BreakEven. Of the remaining 31 people who used two or three other services prior to BreakEven, there were 28 different combinations of service use. That is, there were only three cases where two people had followed the same path to BreakEven. Table 13 shows the path taken to BreakEven by these 66 clients.

Table 13 shows that for almost half (43.9 per cent) of the clients who used other services prior to accessing BreakEven, Gamblers Anonymous was the first place they sought help for their gambling-related problems. Doctors (15.2 per cent) and financial counsellors (10.6 per cent) were also common first points of contact for people seeking help.

Therapists and crisis services were common second points of contact for people seeking help for gambling-related problems, followed closely by doctors, Gamblers Anonymous and financial counsellors. Only 11 of the 66 clients presented in Table 12 sought help from a third service before accessing BreakEven. Service use among this group was fairly evenly distributed between the different service types, with one or two people using each service as a third point of contact, except for self-help

groups which were not cited as a third contact point by any of these people.

Table 13 Service Use at Different Points of Contact (n=66)

	Point of Contact			
	First) (n=66		Second) (n=31	Third (n=11)
Service Type	N	%	N	N
Gamblers Anonymous	29	43.9	5	2
Doctor	10	15.2	5	2
Financial counsellor	7	10.6	5	1
Crisis service	6	9.1	6	1
Therapist	6	9.1	7	2
Community health centre	3	4.5	0	2
Self-help group	2	3.0	3	0
Legal service	2	3.0	0	1

This information is particularly useful in terms of future service planning. It may be necessary for BreakEven to strengthen communication with particular agencies or services, in order to assist people in accessing the BreakEven service more efficiently. It may be necessary to target problem gambling interventions at particular services and common first points of contact. For example, it is evident that Gamblers Anonymous is a significant first *and* second point of contact for people seeking help for problem gambling. Thus BreakEven ought to establish an effective system of communication with Gamblers Anonymous for the purpose of efficient referral. This system would also benefit Gamblers Anonymous in terms of utilising BreakEven as a referral resource for clients. Similarly, doctors, who are also a common first and second point of contact, may require more information about the nature and diagnosis of problem gambling, as well as referral details for specialist problem gambling services.

3.3.6 Client Satisfaction with Access

Clients' perceptions of service accessibility will be reflected in their level of satisfaction with the time that it took to receive help from BreakEven and the quality of the help they received. Table 14 details clients' level of satisfaction with the service they received from a BreakEven counsellor.

Table 14 reveals that nearly two-thirds (64.7 per cent) of clients surveyed were very satisfied with the time it took before they were seen by a BreakEven counsellor. When those clients who stated that they were satisfied (24.0 per cent) are included, the figure rises to more than three-quarters (88.7 per cent).

In addition, more than three-quarters (82.0 per cent) of clients said that they would use the service again, and an even higher proportion (90.7 per cent) commented that they would recommend the BreakEven service to other people.

Table 14 Client Satisfaction with Service

Level of Satisfaction	N	%
Very satisfied	97	64.7
Satisfied	36	24.0
Neutral	9	6.0
Dissatisfied	5	3.3
Very dissatisfied	2	1.3
Total	149	99.3

Missing data=1

3.3.7 Challenges for Service Delivery

As already suggested, in contrast with most health and welfare services at which females comprise the majority of service users, and many overseas gambling treatment programs which have predominantly male clientele, similar numbers of males and females have attended a BreakEven service to address issues associated with their gambling. While such data suggest the model of service delivery adopted to be attractive to a range of clients, there may still be some challenges to address.

The only indication in the data collected from BreakEven personnel that suggested any duplication of services came from one of the four agencies in the Barwon South West region. Personnel in this region suggested that the multiple agencies providing services in that region may be duplicating agency infrastructures, although there was no suggestion that client services were being duplicated. However, there were several factors identified which counsellors, program coordinators, and/or agency directors believed impinged on their ability to provide an optimal service:

- A lack of statewide coordination between BreakEven services and the criminal justice system.
- A lack of community support for many BreakEven clients, which manifests itself in a range of ways, such as misconceptions as to the nature of problem gambling.
- The ability to offer clients a choice of interventions beyond individual counselling.
- Perceptions by potential and/or actual clients about whether BreakEven can offer their desired

degree of confidentiality and anonymity, especially in rural settings.

There was general agreement that client numbers had increased markedly in response to the *media campaigns* that advertised the availability of G-Line and counselling services for problem gamblers. Nevertheless, there was a perception in some agencies that the agencies were not fully tapping the need that exists within their community, and believed that increased funding for more community education and gaming liaison officer positions was seen as one way of overcoming this. Alternately, a number of BreakEven counsellors believed that if they had greater opportunity for speaking publicly about problem gambling and its effects, they would be more likely to reach people who may be experiencing the effects of problem gambling but who are not currently using the service.

Several counsellors expressed concerns about the Department of Human Services-funded statewide media campaign. In particular, it was felt that advertisements in which individuals in acute crisis are seen ringing G-Line may be failing to attract clients to counselling at an earlier stage, when it may be possible to avert crises. It was also suggested that the negative portrayal of problem gamblers in these advertisements could accentuate the stigma and act as a deterrent to contacting BreakEven services. Furthermore, as the media campaign emphasised G-Line, potential clients may be unaware that regionally-based counselling services exist. Some direct advertising of the BreakEven service was seen as likely to reduce the slippage of potential clients, many of whom now have to telephone G-Line, receive the information on BreakEven and then contact BreakEven. These issues are discussed more fully in Section 3 of this Report.

Despite these reservations expressed by counsellors, for clients who responded to the client questionnaire, the media campaign played a significant role in leading them to contact BreakEven. Approximately one-fifth of our client sample said they had heard about BreakEven from advertising on television (7.4 per cent), on the radio (0.7 per cent), in newspapers (3.7 per cent) or in gaming venues (9.6 per cent). Advertising also played a significant role in alerting clients to the existence of G-Line, through whom 43.7 per cent subsequently heard of BreakEven. Of the clients who knew of G-Line, over half had gained this knowledge from advertising on television (29.2 per cent), on radio (2.8 per cent) and at gaming venues (26.4 per cent).

A further challenge for service delivery relates to the physical setting in which counselling is conducted. Several counsellors were concerned that their counselling spaces were of a very poor standard, and inappropriate for a professional service. In some cases this was a matter of aesthetics, with offices being physically unattractive. However, some counsellors found themselves working in spaces that they believed compromised client confidentiality. This was because either the walls were not soundproof, which could result in others overhearing confidential information, or due to an absence of reception staff in at least one satellite setting, people often walked 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 auspicing agencies, such as counsellors sharing offices and having to book an interview room when required.

3.3.8 Ability to Meet Client's Broader Needs

One indicator of the extent to which clients feel that BreakEven is able to assist them in resolving their gambling problems is the extent to which clients return for subsequent appointments, or re-present for further treatment. Details relating to the nature of the last visit during the 1997–98 year are presented in Table 15.

Table 15 Clients Attending BreakEven Services from 1 July 1997 to 30 June 1998: Nature of Last Contact by Client Status

Nature of Contact	Problem Gamblers		Partners/ Others		Persons	
	N	%	N	%	N	%
Initial visit—new client	571	22.9	274	44.8	845	27.2
Initial visit—re-presentation	81	3.3	23	3.8	104	3.4
Follow-up visit	1,670	67.1	288	47.1	1,958	63.1
Planned final visit	167	6.7	27	4.4	194	6.3
Total	2,489	100.0	612	100.0	3,101	100.0

Table 15 reveals that partners and others (44.8 per cent) were twice as likely to be new clients on an initial visit than were problem gamblers (22.9 per

cent), who were far more likely to be attending a follow-up session. Re-presentation rates were similar for both groups, as was attending for a planned final visit.

As mentioned previously, G-Line is the first point of contact for many of those seeking help with problems associated with gambling. In the main, BreakEven counsellors felt that there was a positive relationship between the two services. Counsellors in country areas were more likely to have concerns with the quality of service provision from BreakEven, with some reports of G-Line not referring clients to the closest BreakEven service. The relationship between G-Line and BreakEven is discussed further later in this Report.

There were concerns expressed that the effectiveness of BreakEven services is in part determined by the availability of additional support services which clients may require. The relationship between BreakEven and other areas of human service provision will be addressed in the next section.

3.3.9 Use of Other Services Subsequent to Attending BreakEven

Due to the nature of issues raised in counselling, there are times when BreakEven counsellors feel it is more appropriate to refer clients to other services. In order to delineate between the associated issues they deal with, and those they refer on. BreakEven gambling counsellors were asked to rank 11 presenting problems from 'would probably refer on' (scored as 0) to 'would definitely not refer on' (scored as 4). The ratings for each of these presenting problems were entered into a within subjects design multi-variate analysis of variance (MANOVA). This produced a significant effect of ($F(10,38)=11.80$, $p < .001$) indicating that the likelihood of counsellors referring on varied according to the presenting problem. Table 16 lists the items entered into this analysis in declining likelihood that the counsellors would work with these problems themselves.

Table 16 BreakEven Counsellors: Mean Likelihood of Referral for Presenting Problems

Problem	Mean Likelihood Of Referral
Family/relationship problems	2.57
Social activities/social isolation	2.31
Anger management	2.16
Crisis intervention	1.88
Employment issues	1.55
Other psychiatric problems	1.47
Alcohol and drug problems	1.45
Financial support/benefits	0.78
Legal problems	0.65
Basic needs (food, housing)	0.63

What is not known is whether the extent to which counsellors are likely to refer clients on for assistance with particular problems is due to the counsellors' skills and resources to work with those problems or the availability of other services to refer clients to. Nevertheless, we know that referrals to other services from BreakEven do occur. Referrals emanating from the last contact session are detailed in Table 17.

Table 17 BreakEven Clients from 1 July 1997 to 30 June 1998: Referrals to Other Support Services at Last Contact by Client Status

	Problem Gamblers (n=2,347)	Partners and Others (n=595)	Persons (n=2,942)	
Type of support service			N	%
Financial counselling services	135	44	179	6.1
Gamblers Anonymous	57	11	68	2.3
General health services	45	11	56	1.9
Family counselling or support service	19	11	30	1.0
Mental health professionals	39	6	45	1.5
Self-help services	35	9	44	1.5
Material aid	33	6	39	1.3
Legal services	30	16	46	1.6
Relationship counselling	18	10	28	1.0
Other support services	177	30	207	7.0

Although referral is always an option, counsellors took this action on only one-fifth (20.7 per cent) of all last contacts. As can be seen in Table 18, the number of referrals to other services was similar for both problem gamblers and partners and other clients. As to the majority of clients for whom no referral was made, the Minimum Data Set is unable to distinguish whether this was because the counsellors believed themselves competent to deal with a client's issues or due to a paucity of other services.

Table 18 BreakEven Clients from 1 July 1997 to 30 June 1998: Number of Referrals to Other Support Services at Last Contact by Client Status

No. of referrals	Problem Gamblers N	Problem Gamblers %	Partners and Others N	Partners and Others %	Persons N	Persons %
0	11,867	79.5	465	78.2	2,332	79.3
1	391	16.7	108	18.2	499	17.0
2	75	3.2	20	3.4	95	3.2
3	11	0.5	2	0.3	13	0.4
4 or more	3	0.1	0	0.0	3	0.1

While referrals to other services may be part of the process of terminating treatment with a client, referrals to other services can happen at any stage of the treatment process. Table 19 presents the total number of referrals made to other services during the 1997–98 year, with financial counselling being the most frequent referral.

Table 19 All BreakEven Client Contacts from 1 July 1997 to 30 June 1998: Referrals to Other Support Services by Client Status

Type of support service	Problem Gamblers (n=9,181) N	Partners and Others (n=1,543) N	Persons (n=10,724) N	Persons (n=10,724) %
Financial counselling services	568	99	667	6.2
General health services	193	17	210	2.0
Gamblers Anonymous	185	20	205	1.9
Self-help services	129	16	145	1.4
Mental health professionals	123	21	144	1.3
Material aid	111	11	122	1.1
Legal services	106	32	138	1.3
Family counselling or support service	68	21	89	0.8
Relationship counselling	63	16	79	0.7
Other support services	574	64	638	5.9

3.4 Conclusions

The 18 locations of the BreakEven service around Victoria are based on division of resources by Department of Human Services region, with consideration of the number of EGMs and people aged 18 years and over in each region. These 18 locations are supplemented by a multitude of satellite sites within each region. Comments by BreakEven personnel and service providers question whether the distribution of these sites is equitable and/or effective as they perceive that many have resulted from ad hoc demands, rather than a strategic or needs assessment approach. This perception will presumably lessen with a re-tendering of the services and the provision by Department of Human Services of explicit decision criteria for selection of service sites.

A key factor in assessing the accessibility of the service is an understanding of the extent to which problem gamblers seek help from agencies in the same area as where they live and/or gamble. It would be difficult to plan service provision by population and EGM criteria if there is a lot of movement between where the problems are caused and where they are addressed. There does not yet appear to be sufficient information to be able to determine the pattern of where people live, gamble and seek help.

In terms of using the BreakEven service, G-Line clearly plays a major role in the referral of new clients as well as clients who have accessed other services prior to BreakEven. A considerable number of the BreakEven clients surveyed had used other sources of help, either for referral or for treatment. This emphasises the need to distribute information about accessing BreakEven to a wide range of service providers in the community, to ensure that they recognise the 'signs' of a gambling problem and know who to refer their client to. The survey results indicate that the existing publicity and education efforts are having good effect.

Surprisingly few referrals to BreakEven come through financial counsellors. Further analysis would be valuable in determining the extent of indebtedness of problem gamblers and the extent to which the financial aspect of problem gambling is a motivator for seeking help. In addition, the counselling practices

of financial counsellors working with problem gamblers should be examined. This may go some way towards explaining the very low levels of cross-referral between BreakEven and the financial counselling service providers.

The most common service used prior to BreakEven is Gamblers Anonymous (GA). The nature of this service is discussed in the following section, but at this stage it is worth mentioning that there is little data available for analysis from this private service. Hence it is difficult to determine:

- The number of clients that GA has.
- The proportion of callers to G-Line who are referred to GA instead of BreakEven and why.
- Why some problem gamblers choose GA over BreakEven and why some leave GA to use BreakEven (and doubtlessly vice versa).
- What sort of impact BreakEven's education campaigns have had in increasing awareness of problem gambling and thereby increasing the client base of GA.

It is important to recognise when evaluating BreakEven's program reach that BreakEven is not the only problem gambling counselling service available in Victoria. Another specialist problem gambling service, GA, with quite a different understanding of the issue and how it should be treated, is treating an undefined proportion of the pool of problem gamblers and interacting with BreakEven in a complex way. For some people with gambling problems, GA will be the service of choice. For other people with problems related to gambling, the agencies which are accessed by BreakEven clients en route to BreakEven will provide all the assistance that they require and they will, therefore, not need to make a subsequent referral to BreakEven. For others, as noted later in this Report, an agency other than BreakEven will be used for counselling, with no subsequent referral to BreakEven.

The brief assessment of program reach in the previous section is of program reach for BreakEven in particular. It does not detail, however, the reach of all programs accessed by people with gambling related problems and therefore no assumption should be made that the non BreakEven clients go untreated. It also suggests that the reach of the Problem Gambling Services Strategy is far greater than the reach of the BreakEven program alone. A question that needs continued attention is, 'Why, when faced with real choice of service, and similar problems, will one agency be more attractive to potential clients than another?' Part of the answer to this will be the part played by the client's perception of the treatment given in the various services and the compatibility of the underlying philosophy and theory of problematic gambling behaviour with the client's own belief system.

The following section will examine a range of problem gambling treatment models from overseas and Australia, in order to place the Victorian BreakEven model in both a national and international context.

4 Approaches to Problem Gambling Treatment

4.1 Introduction

The approach taken to treating gambling-related problems is determined by the view taken of the 'causes' of problem gambling. Broadly speaking, there are two main schools of thought that have dominated discussion about the causes and consequent required treatment of problem gambling: the 'medical' model and the 'behavioural' model.

The medical model sees problem gambling as an addiction, akin to alcohol and substance dependence, which must be treated by interventions appropriate for an illness, with the end goal being abstinence from all gambling. The behavioural model, on the other hand, interprets problem gambling as a learnt behaviour, motivated and/or reinforced by the personal experiences and social context of the gambler. Like any other behaviour problem, the treatment focus is on 'unlearning' bad habits and learning how to minimise the harm arising from gambling through 'controlled gambling'.

The purpose of this chapter is to review the range of different treatments available to problem gamblers both within Australia and overseas in order to evaluate the appropriateness of the Victorian BreakEven model of service provision and develop an understanding of the *best practice models* in the field. The chapter is divided into three sections. The first section provides a discussion of some key methodological issues in the measurement of outcomes in the treatment of problem gamblers. The second section outlines a range of established treatment programs. The organisational structure, theoretical orientation and the treatment approach and techniques used, are presented for each program described. The final section is a thorough review of treatment outcome studies of specific treatment techniques for problem gamblers. The section concludes with a discussion of how Victoria's BreakEven service fits into this treatment schema.

Theories of gambling behaviour cover the realm of biological, sociological and psychological perspectives. Most theories have focused on only one aspect of gambling behaviour. More recently there has been a move toward taking an *eclectic* approach to explain the development, maintenance and persistence of gambling behaviour (Blaszczynski and Silove, 1995). At the same time, problem gambling intervention models are increasingly developing an eclectic approach to the treatment of problem gamblers.

There is now a broad range of interventions in use, as well as a growing number of *multimodal* treatment programs that utilise a range of different therapeutic techniques and strategies. Treatment programs are increasingly developing a *client-centred* orientation, in that the needs of the client are the focus of treatment, 'not the models and methods of the helper' (Egan, 1994). This paradigm shift reflects an appreciation of the multifaceted nature of problem gambling behaviour.

To date, a great deal of the treatment literature has described clinical trials of various methods

of treatment (efficacy studies), which in many cases have 'not been systematically translated into treatment programs' (Blaszczynski and Silove, 1995). Furthermore, of those established treatment programs that appear in the published literature, very few are accompanied by controlled effectiveness studies.

The study undertaken by the National Gambling Impact Study Commission (1999) supports this notion concluding that few studies exist that measure the effectiveness of different treatment methods and those that do exist 'lack a clear conceptual model and specification of outcome criteria, fail to report compliance and attrition rates, offer little description of actual treatment involved or measures to maintain treatment fidelity by the counsellors, and provide inadequate length of follow-up' (National Gambling Impact Study Commission, 1999: 4–15).

The problem gambling treatment literature has also been dominated by theoretical and non-empirical studies, weakening the possibility of generalisation to different populations (Ciarrocchi and Richardson, 1989). As pointed out by Blaszczynski (1993) problems associated with sample selection have also restricted the ability to generalise across specific subgroups of gamblers.

What is required is controlled *therapeutic efficacy* studies of specific treatment techniques and evaluation of the *long-term effectiveness* of treatment programs. Treatment follow-up studies and replication of reported findings are also needed before the effectiveness of any formal treatment program can be adequately assessed. To date, these essential features of a comprehensive evaluation of problem gambling treatment have been somewhat overlooked.

The difficulty of evaluating the appropriateness of various treatment programs is further complicated by the fact that there are 'no internationally established models of best practice in existence' (Elliott Stanford and Associates, 1998). A comprehensive review of 'best practice models' of problem gambling treatment is therefore limited in part to:

- A description of the formal treatment programs which appear in the published literature.
- A review of successful treatment techniques.

The following section examines a number of key methodological issues in the definition and measurement of treatment outcomes of problem gambling programs. These issues include sample selection, treatment objectives, treatment outcome criteria, definition of success rate on discharge, the definition of lapse and relapse and their relationship to treatment failure, and post-treatment follow-up intervals.

This section is reproduced with permission from the author from Blaszczynski, A. (1993). *Juego patologico: una revision de los tratamientos. Psicologia Conductual*, 1: 409–440. We believe that this review paper is an excellent review of problem gambling treatment effectiveness and related methodological issues. The review provides an evidence-based context for the description of problem gambling treatment programs that follows later.[7]

4.2 Methodological Issues

4.2.1 Sample Selection

Selection criteria and procedures for the inclusion of gamblers into treatment programs are often poorly delineated. Samples are characterised by their heterogeneity of subjects. Many studies report the presence of co-existing primary Axis I psychiatric disorders, usually psychoactive substance abuse, and/or fail to ascertain whether therapy for gambling was the primary reason for referral.

The presence of alcohol abuse, personality disorder and criminal behaviours in impulse control disorders, such as sexual addictions and paraphilias, is a predictor for poor response to treatment and relapse (see reviews by Marshall, Jones, Ward, Johnston and Barbaree, 1991; Marshall and Eccles, 1991). In pathological gambling, high rates of substance abuse, psychopathology and criminality are also observed. Depending on the sample population, the rate of dual substance abuse addictions in pathological gamblers ranges between four per cent and 39 per cent (Custer and Custer, 1978; Lesieur, Blume and Zoppa, 1986). In Blaszczynski and McConaghy's (1992) sample of 306 pathological gamblers, 50 per cent admitted to gambling-related, and a further 18 per cent to non-gambling related, criminal offences, and 15 per cent also met criteria for diagnosis as antisocial personality disorder. The presence of psychiatric co-morbidity holds important implications for the suitability and type of therapeutic intervention, and the prospect for successful treatment outcome, especially for gamblers displaying personality disorders and dual addictions.

[7] All references cited in the Blaszczynski paper appear in the references section of this Evaluation Report.

There is also a need to report separate outcome data for gamblers engaged in different forms of gambling. Horse race, poker-machine (slot-machine), video draw poker machines, sports gamblers, casino and card players are all typically combined into a heterogenous group. No attempt is made to distinguish those participating exclusively in one form as compared to multiple forms of gambling. There is no justified *a priori* reason to assume that factors influencing aetiology and persistence in gambling apply equally to all forms of gambling. In fact, empirical evidence points to the contrary view. For example, participation in low-skill games, such as slot machines, is accompanied by a narrowing of attention acting as an emotional escape from daily stresses (Blaszczynski and McConaghy, 1989; Anderson and Brown, 1984). On the other hand, high-skill games of cards and horse racing contribute to an elevation of mood in dysphoric/depressed gamblers (Blaszczynski and McConaghy, 1989). There is a need to take into account selected forms of gambling in developing appropriate intervention strategies for gamblers.

4.2.2 Treatment Objectives

An agreed treatment package for pathological gambling does not exist but most individual and group based treatment programs hold the belief that abstinence is the only viable treatment goal or criteria of success. Historically, two influential factors have contributed to this belief.

Gamblers Anonymous, a self-help organisation modelled on the principles and format of Alcoholics Anonymous lobbied the psychiatrist Dr Robert Custer to establish with Dr Alida Glen the first formal hospital treatment program for pathological gamblers. This commenced in 1972 at the Veteran's Administration Hospital in Brecksville, Ohio (Nora, 1989; Weisbroat, 1991). Regular attendance at Gamblers Anonymous meetings became an integral and mandatory part of the program leading other American (Russo, Taber, McCormick and Ramirez, 1984; Nora, 1989) and some Australian (Allcock—personal communication) programs to follow suit.

Gamblers Anonymous espouses the philosophy that 'compulsive gambling is an illness progressive in its nature, which cannot be cured but can be arrested' (Gamblers Anonymous, 1977). Implicit in this disease model is the belief that participation in any form of gambling will invariably lead to loss of control and resumption of pathological habits.

The other influential factor has been the acceptance of pathological gambling as an addictive disorder (Dell, Ruzicka and Palisi, 1981; Ferrioli and Ciminero, 1981; Dickerson, 1984; Meyer, 1992; Blaszczynski, Buhrich and McConaghy, 1985; Nora, 1989; Horodecki, 1992; Schwartz and Lindner, 1992). This is reflected in DSM-III-R's decision to model its diagnostic criteria (American Psychiatric Association, 1987) after that of psychoactive substance abuse (Lesieur and Rosenthal, 1991).

Reference to reinforcing 'hits' (Anderson and Brown, 1984), dependence (Moran, 1970), dissociative states (Jacobs, 1988), tolerance (Anderson and Brown, 1984; Dickerson, 1984), withdrawal symptoms (Wray and Dickerson, 1981) and similarities in personality profiles between addicts and gamblers (Blaszczynski, Buhrich and McConaghy, 1985) has lent further credibility to the concept of gambling as an addiction. Schwartz and Lindner (1992) claim that pathological gambling is only infrequently a symptom of a neurotic disorder.

The acceptance of the addiction model has resulted in the integration of American gambling treatments into existing substance abuse programs located in drug and alcohol addiction centres (Russo, Taber, McCormick and Ramirez, 1984; Gambino and Cummings, 1989; Shaffer, 1989; Lesieur and Blume, 1991). A similar trend is also becoming evident in European countries (Schwartz and Lindner, 1992). It comes as no surprise, therefore, to find that treatment objective of abstinence demanded by addiction centres have been eagerly and uncritically extended to pathological gambling.

However, criteria of success based on dichotomous global ratings of abstinence and non-abstinence fail to take into account significant improvement in other areas of functioning including reduced frequency, urge, ability to control gambling once initiated, and improved social, financial and interpersonal functioning. Taber, McCormick, Russo, Adkins, and Ramirez (1987), Blackman, Simone, Thoms and Blackman (1989) and Blaszczynski (1988) found that gamblers showed clear signs of post-treatment improvement in many areas even though they continued gambling albeit at reduced levels.

It is apparent that despite one or more lapses gamblers may continue to regard themselves as abstinent over the longer timeframe. To suggest a lapse constitutes treatment failure because it violates

the criteria of abstinence is excessively rigid and has the potential to lead the gambler to regard such lapses as a total failure causing them to lose motivation to reinstate control (Blaszczynski, 1988). The offer or option of controlled gambling as an alternative outcome may have an added advantage of enticing borderline motivated gamblers into treatment at a much earlier stage of their career. Lower treatment rejection and attrition rates may be achieved for gamblers who find complete cessation difficult or its notion unacceptable (Dickerson and Weeks, 1979; Rankin, 1982; Brown 1985; Blaszczynski, 1988).

Success should also be considered where pathological gambling associated with the primary form of gambling ceases but participation continues in other benign minor forms.

4.2.3 Treatment Outcome Criteria

The effectiveness of any treatment regime can be assessed by due reference to three indices:

1. Rejection and attrition rate.
2. Success rate on discharge.
3. Rate of relapse over long term follow-up periods.

Rejection is classified as the refusal to enter a program or give consent to participate in a research project. Attrition, also referred to as 'drop-out', relates to the failure to complete or comply with treatment requirements, or the premature discharge from treatment because of disciplinary reasons.

It is difficult to glean the rate of rejection and attrition in many treatment studies, but where available, exceedingly high rates have been reported. In Bergler's (1957) series of psychoanalytically treated gamblers, 20 out of 80 patients refused treatment, with a further 15 subsequently discontinuing giving an attrition rate of 43 per cent. Greenberg and Rankin (1982) noted 50 per cent of 26 gamblers prematurely ceased treatment. Similarly, Brown (1985) found that 22 per cent of Gamblers Anonymous members ceased attending after just one meeting, and altogether 70 per cent by the tenth meeting. In Lesieur and Blume's (1991) study, 171 patients met the South Oaks Gambling Screen (Lesieur and Blume, 1987) criteria for pathological gambling. Three patients had declined consent to participate, 44 were not interviewed and five patients were later excluded in the interview phase leaving a final attrition rate of 30 per cent. Gambino and Cummings (1989) surveyed 16 centres providing treatment facilities for gamblers and found that less than 75 per cent of the patients described in 11 of these centres had successfully completed treatment. In Blackman, Simone, Thoms and Blackman's study (1989), 155 entered treatment, with admission data recorded on 128, out of an initial population of 179 seeking outpatient assistance.

Excluding non-starters or drop-outs from statistical analyses results in an overestimate of the likelihood of success. This tendency to ignore cases is equally pertinent when reporting on subjects lost to follow-up. Unfortunately, 100 per cent response rates are rarely achieved in follow-up studies, and this is no less the situation in pathological gambling. It would appear that apart from Taber, McCormick, Russo, Adkins and Ramirez (1987) who achieved a rate of 86 per cent from a sample of 66 gamblers at six months, follow-up data is generally obtained on approximately 50 per cent to 60 per cent of subjects initially treated and irrespective of the length of follow-up; 60 per cent at two months to two years (Koller, 1972), 48 per cent at 12 months (Russo, Taber, McCormick and Ramirez, 1984), and 52 per cent at five years follow-up (Blaszczynski, McConaghy and Frankova, 1991a). Lesieur and Blume (1991) report a follow-up of 60.5 per cent on their final sample of 119 patients but as discussed in the previous paragraph, the rate drops to 42 per cent if calculations include the 171 patients initially screened.

4.2.4 Success Rate on Discharge

Success rate on discharge and at follow-up is determined by the definition of success used. Success may be defined stringently as complete abstinence from any form of gambling activity no matter how innocuous, or liberally as significantly reduced gambling with an associated subjective sense of control.

Follow-up measures have relied upon semi-structured interview administered in person (Blaszczynski, McConaghy and Frankova, 1991a) or by telephone (Russo, Taber, McCormick and Ramirez, 1984; Lesieur and Blume, 1991) assessing not only gambling behaviour but changes in sociodemographic parameters. Improvement is taken to include not only significant reductions in the frequency and amount gambled relative to one's disposable income, decreased subjective urges and increased sense of control over gambling, but also improved indices of lifestyle functioning reflected by enhanced marital and familial relationships, lower debt or increased available income, employment stability and physical

health. However, the utility of such sociodemographic measures will depend upon pre-treatment level of dysfunction and the degree of reversibility of problems. Gambling may lead to irreconcilable marital differences or substantial debts that continue to exert an effect on quality of life despite cessation of gambling.

Telephone interviews are less than satisfactory but, given the scarcity of available treatment centres, present the only realistically viable means of patient contact over widespread geographic distance.

Gambling behaviour has generally been assessed by self-report measures. The reliability and validity of self-report and psychometrically derived reports on pathological gamblers characterised as they are, by deceit and lying, can be questioned. But it would appear that where therapy is independent of forensic issues, there is a high concordance between the patient's self-report and confirmation through collaborative information obtained from their spouse or significant others (Taber, McCormick Russo, Adkins, and Ramirez, 1987; Blaszczynski, McConaghy and Frankova, 1991a). This suggests that gamblers at follow-up do provide accurate accounts of their behaviour.

Taber, McCormick, Russo, Adkins and Ramirez (1987) used a Time Line Follow Back Month method, a procedure in which each day over the immediate preceding month was rated according to the degree of involvement (frequency and extent) in gambling. These same authors also utilised a Gambling Behaviour Survey to record days abstinent, expenditure, time spent gambling, ancillary behaviours and number and type of treatment sessions received post discharge. Such measures appear useful.

Batteries of standardised psychometric tests tapping symptoms of psychopathology or personality characteristics have also been used to reflect response to treatment. These have included the Minnesota Multiphasic Inventory, Beck Depression Inventory, Millon Multiaxial Clinical Inventory, Eysenck Personality Questionnaire, Spielberger's State Trait Anxiety Inventory and the Symptom Checklist-90.

Few studies report on the status of the gambler at discharge preferring to provide assessments at six or twelve months follow-up. Much can happen in the intervening period between discharge and follow-up causing positive change independent of treatment received. In the authors' experience, gamblers at discharge have reported no perceived change in urge to gamble but at one month and after exposure to gambling cues have come to recognise significant positive changes in their behaviour and emotions. Alternatively, others have reported good response only to find themselves gambling within a short period. Blackman, Simone, Thoms and Blackman (1989) assessed discharge status but did not include follow-up diminishing the value of their study.

Discharge assessments allow for the determination of outcome predictors. For example, McConaghy, Armstrong, Blaszczynski and Allcock (1983; 1988) found high-state anxiety scores at one month but not pre-treatment predicted failure to respond to a behavioural treatment, Imaginal Desensitisation. It is therefore important that discharge status be considered.

4.2.5 Relapse

One of the major problems in assessing response to treatments relates to the definition of lapse and relapse and their relationship to treatment failure. It is clear that some patients fail to respond to treatment and continue to engage in unchanged levels of uncontrolled gambling. Others exhibit periods of gambling against a background of abstinence. Are these to be also regarded as failures?

Blaszczynski, McConaghy and Frankova (1991b) have shown that lapses do not invariably lead to a resumption of pathological gambling habits. Nine of 18 gamblers classifying themselves as abstinent at follow-up described an average of 1.89 lapses lasting a mean of 22 weeks over an average of five years. These gamblers resumed abstinence after their lapse.

Indices of frequency, amount gambled or duration are, in themselves, poor criteria in defining relapse. Gamblers may gamble relatively frequently but with minuscule amounts or on innocuous forms of gambling. Alternately, others may manifest infrequent lapses but lose substantial amounts when they do so, or gamble over prolonged periods. As will be discussed later, significant positive response to treatment as measured by changes in sociodemographic data is frequently observed in gamblers who manifest brief periods of lapses.

There are no clear-cut guidelines at this stage but the matter does warrant further clarification.

4.2.6 Follow-up Periods

Post-treatment follow-up intervals are generally of the order of six months to two years, although one five-year mean interval has been reported (Blaszczynski, McConaghy and Frankova, 1991a). Clinical data suggests that gamblers may experience lengthy periods of abstinence or reduced gambling, especially if access to gambling outlets is restricted. Others, as mentioned above, exhibit sporadic episodes of gambling but are able to resume abstinence. It remains to be seen whether there will be an increase in the frequency of lapses over the much longer term resulting in a return to prolonged uncontrolled gambling. Therefore, it is imperative, given the nature of pathological gambling, that extensive follow-up periods are employed in order to establish the robustness of interventions.

While pre-treatment demographic and psychometric comparisons between follow-up and gamblers not followed up suggest the two populations do not differ on critical variables (Taber, McCormick, Russo, Adkins and Ramirez, 1987; Blaszczynski, 1988; Lesieur and Blume, 1991), it cannot be assumed that the same applies in respect of actual response to treatment. It is prudent to classify those gamblers not followed up as treatment failures. A recommended practice is to calculate outcome rates both as a proportion of followed-up only, and of the combined groups of gamblers who were and were not followed up, to provide upper and lower estimates of outcome (Blaszczynski, McConaghy and Frankova, 1991a; Lesieur and Blume, 1991).

As noted previously, the preceding section on methodological issues was reproduced with permission from Blaszczynski, A, (1993), 'Juego patologico: una revision de los tratamientos' in *Psicologia Conductual*, 1: 409–440.

A review of the literature on *problem gambling treatment models* is now presented. Although the purpose of this information is to develop an understanding of the *best practice models* in the field it must be pointed out that the following programs simply represent a range of different approaches but are not a comprehensive list of treatment programs available. The following section describes various *forms* of treatment offered in a number of different countries including Australia, England, America, Canada, Germany and Austria.

4.3 Problem Gambling Treatment Models

4.3.1 Community-Based Treatment Models

There are a number of community-based treatment centres around the world that offer support and therapy for problem gamblers and their families. These centres are somewhat similar in nature to the BreakEven system of service provision in Victoria, in that free support is available through *generalist* community-based organisations. However, *specialist* community-based services also exist. The following is an overview of types of community-based treatment centres overseas and within Australia.

Guidance Centre for Gamblers and Relatives, Austria

The problem gambling treatment model in Vienna evolved over an eight-year period into a treatment centre for problem gamblers (Horodecki, 1992). What started as the Gamblers Anonymous (GA) Association gradually expanded into what is now known as the *Guidance Centre for Gamblers and Relatives*. It is an independent, non-profit organisation, financed by donations and subsidies. The majority of funds come from Casinos Austria AG and Lotto-Toto Gesellschaft, with a small amount of money donated by the City of Vienna. The therapeutic team consists of one psychologist, one social worker and one psychiatrist. Clients can remain anonymous, however approximately 90 per cent reveal their identity. Counselling is only given by professional consultants and at no expense to the client or their family.

The Centre has adopted an addiction model of problem gambling, proposing that 'pathological gambling is a symptom of a basic psychological disturbance in the broadest sense, as well as an autonomous illness with its own dynamic rules' (Horodecki, 1992). Consequently, total abstinence from gambling is thought to be the first important step of therapy. Where psychiatric co-morbidity exists, the client is referred to an appropriate institution for treatment. The majority of clients finds out about the Centre through the news media and receives further information from a help line or phonebook.

The Centre utilises a multimodal treatment approach. The range of therapeutic interventions offered include the following (Horodecki, 1992):

- Individual/family/couple psychological counselling:
  - Psychotherapy (psychotherapeutic background).
  - Family therapy (solution focused, goal oriented, and resource-oriented techniques).
  - Hypnotherapy (Erickson).
  - Behaviour therapy techniques.
- Financial, debt and social service counselling (social worker).
- Psychiatric consultations.
- Group therapy possibilities:
  - Therapeutically-led slow-open group for gamblers.
  - Therapeutically-led slow-open group for relatives.
  - Self-help group for gamblers without a therapist.
  - Autogenous training and communication training are sometimes arranged.
- Referral to an inpatient therapy scheme for gamblers.
- Leisure activities.

About 40 per cent of clients participate in individual/couple/family counselling, and 60 per cent of clients participate in counselling and group therapy simultaneously. There are three therapeutically-led groups and one self-help group. At the time of writing, nine clients had been referred to the inpatient therapy program, with the diagnosis of gambling addiction accepted by the insurance scheme. Treatment was conducted in conjunction with drug and alcohol patients, and any further treatment after discharge was conducted at the Centre. Financial, debt and social service counselling are thought to be an integral part of the treatment program of problem gamblers. These sessions are conducted by social workers and adopt a social–therapeutic orientation.

The Centre is also involved in a number of preventative strategies. Through publicity, the Centre has attempted to increase public awareness of the problems associated with gambling, and believes that gambling laws and regulations need to be re-evaluated. This model of service provision incorporates many of the features identified in the literature as being essential in the treatment of problem gamblers, such as a variety of therapeutic treatment techniques, support for family and relatives, financial and social service counselling, psychiatric consultation and preventative activities. In addition, the Centre acknowledges the need for personal development, including leisure activities and social skills training as part of the multimodal approach.

However, no information on treatment efficacy is available. Therefore, it is difficult to assess the effectiveness of the model. Furthermore, the cost-effectiveness of implementing an all-encompassing treatment centre, such as this may be prohibitive.

Compulsive Gambling Treatment Program, Greater Bridgeport Community Mental Health Center, United States

Another community-based treatment program is the Compulsive Gambling Treatment Program at the Greater Bridgeport Community Mental Health Center (US), which provides individual outpatient treatment for problem gamblers. This program is a specialist program within a generalist organisation. Miller (1986) proposes that during the recovery stage, gamblers mourn the loss of their former gambling activity, provoking grief responses similar to those experienced with other types of loss, and that individual outpatient treatment is an effective form of intervention for dealing with this loss. The therapy is based on well-known principles of crisis and loss and can easily be learnt and applied by clinicians who treat problem gamblers.

There are four phases in this individual outpatient treatment program, which correspond to the phases of the grief reaction in response to abstinence (see Miller, 1986). The four phases of treatment are:

1. Working with clients who have not yet made a commitment to abstinence.
2. Working with people who have attempted to stop gambling but who have not made a firm commitment to a life of abstinence.
3. Therapy with those people who are becoming increasingly committed to ceasing gambling and who are working through the later stages of mourning and acceptance.
4. Working with clients who have accepted their commitment to abstinence, but who are not yet fully in touch with this reality.

The second phase of treatment involves crisis intervention techniques. The third phase utilises goal-directed therapy, and the final stage of treatment

applies the principles of analytical, existential, and client-centred therapy. Miller (1986) suggests that:

> Throughout all four phases of treatment, the therapist must attempt to understand just what the gambler gives up by not gambling in order to help with commitment and adjustment to a life of abstinence.

Emphasis is placed on the client/therapist relationship as essential to the effectiveness of treatment. It is thought that 'a manipulative and/or adversarial relationship is not apt to prove effective', and that the therapist should be 'authentic and involved' (Miller, 1986). Although a thorough account of treatment process at the Center is provided, no information on the long-term effectiveness of the program is available.

The South Australian Model of Service Provision, Australia

The Gamblers Rehabilitation Fund (GRF), established in response to the introduction of EGMs in South Australia in 1994, has been allocated $1.5 million 'to initiate programs to deal with gambling addiction' and to provide support for the families of problem gamblers (Elliot Stanford and Associates, 1998). The payment package, called Smart Play, includes funding for the rehabilitation of problem gamblers, information on gambling, and promotion of a controlled gambling approach. Following a tendering process, the GRF committee developed an allocation model based on:

- A split of funds into direct services, specialist services, coordination, training and research.
- A specific allocation of direct service funds between metropolitan and rural locations.
- A specific allocation within specialist services to focus on Aboriginal people and intensive addiction therapy.

The basic premise of this model of service response to problem gambling in South Australia is to fund large organisations that have the 'capacity to provide services across a comprehensive and integrated range of functions' (Elliot Stanford and Associates, 1998). This is based on the belief that larger service bases can provide a more efficient system for information exchange. Furthermore, it is anticipated that the multifunctional, hands-on experience of these service bases will provide an effective means of implementing community education and prevention strategies.

There is a range of alternative support services in South Australia for individuals with gambling-related problems, including private clinicians, generalist agencies, such as the financial counselling services provided by Department of Human Services, and the BreakEven services funded by the GRF. The policy specifications are limited to 'information, brief and longer term periods, financial counselling, and enhancement of social and life skills and relationship counselling' (Elliot Stanford and Associates, 1998). The policy does not detail any specific counselling or treatment approaches. It is suggested that at the time of policy development there were no internationally established models of best practice in existence. However, the model supports an eclectic approach to the treatment of problem gambling activity within the BreakEven services. Included in this eclectic approach are individual and group counselling, behavioural-cognitive psychotherapy techniques, financial counselling, and 12-Step programs.

The South Australian model of problem gambling treatment has recently been evaluated. The definition of effectiveness adopted for the purpose of evaluating the BreakEven program in South Australia was:

> An estimate of the relationship between the outcomes described in the program objectives of the GRF and the actual outcomes achieved by the individual recipients of the service (Elliot Stanford and Associates, 1998).

The evaluation report suggested that the BreakEven service providers in South Australia have been successful in their efforts to attract those people with gambling-related problems. Furthermore, the report proposed that the quantitative results were supported by client feedback, and that clients of the BreakEven program reported that their experience with the service had been very positive.

An evaluation of access to services was also undertaken. A number of information sources about the BreakEven network were cited by clients of these services. The most commonly cited source of information was family and friends, followed by the phonebook, a community agency, brochures, advertising and talks, and BreakEven staff (Elliot Stanford and Associates, 1998). These sources accounted for more than 78 per cent of all information sources. The more uncommon information sources included the Casino, a legal adviser, hotel or club staff, Smart Play, and medical practitioners.

The evaluation of access identified a range of disadvantaged groups and 'the status of current planning or services to address their disadvantages' (Elliot Stanford and Associates, 1998). Among these were people from non-English speaking backgrounds (NESB). In 1997 the GRF provided funds for the Wesley Uniting Mission and three Asian/Australian community organisations to provide support for NESB communities. However, it is suggested that there is little evidence to assess whether the current model of service provision has adequately addressed the needs of this group. There is thought to be a range of issues relating to the current system of service provision for this disadvantaged group (Elliot Stanford and Associates, 1998):

- The issue of *critical mass* of the smaller Asian/Australian services resulting in access problems (for example, the need to employ part-time staff).
- An absence of specialist expertise (of both workers and the management of Asian/Australian organisations) in relation to problem gambling.
- The level of referral of NESB clients to mainstream services and training of mainstream workers, as well as joint case management with mainstream services, has not been achieved at the expected level.

The evaluation report suggests that a new approach is required to address the needs of NESB communities. This may involve negotiating an agreement with a large NESB organisation, such as the Migrant Resource Centre (MRC), to assist in providing this service. Workers would be based in the community and supported by the MRC.

The GRF model was thought to clearly reflect the initial Ministerial statement of purpose 'to help protect the lives and well-being of families of addicted gamblers' and the target of individuals and families 'who are in difficulty as the result of their gambling addiction' (Elliot Stanford and Associates, 1998). The model is based on providing a full range of services in response to problem gambling, including face-to-face education, information dissemination, mass communication promotions, advocacy, community development, preventative strategies, screening, and early and minimal intervention strategies. It was concluded that, in essence, this was a good model.

However, there were still a number of deficiencies identified in the model. There appeared to be a lack of clarity among service providers of the fundamental purpose of the GRF. Some providers saw their role as laying somewhere within the continuum of harm minimisation through gambling with controls to abstinence from gambling. A number of recommendations were made with respect to improvements to the model. In addition to the introduction of G-Line, there was seen to be a need to assist people with 'minor' gambling problems, including those individuals who may not directly approach a specialist BreakEven service. There was also argued to be the potential to create other non-clinical approaches, including self-help programs, broad-based community education, and the training of generalist human service workers in brief interventions for problem gambling.

Conclusions on the Community-Based Models

Given the lack of empirical evidence of outcome, it seems reasonable to suggest that community-based treatment models, such as those described above, provide accessible support for individuals and family members experiencing gambling-related problems and multimodal approach to treatment acknowledges the multifaceted nature of problem gambling behaviour.

4.3.2 Hospital Inpatient/Outpatient Models

Problem gambling is referred to as 'pathological gambling' in the United States, and its symptoms are outlined in the DSM-IV manual (American Psychiatric Association, 1994). This view of problem gambling as an impulse control disorder, and the close affinity between the Gamblers Anonymous and Alcoholics Anonymous models of treatment, has resulted in a number of medical model, hospital-based treatment programs (Jackson, Blaszczynski, Thomason, Walker and McMillen, 1998).[8]

Johns Hopkins Center for Pathological Gambling, United States

A well-known specialist treatment centre is the Johns Hopkins Center for Pathological Gambling. The 1978 session of the Maryland General Assembly enacted House Bill 1311 for 'the purpose of providing a pilot

[8] This information has been drawn from a Tender Proposal for Department of Human Services produced by Jackson et al, 1998.

project center for the treatment of pathological gambling' (Politzer, Morrow and Leavey, 1985). Therefore, in August 1979, the Drug Abuse Administration contracted the Johns Hopkins University, School of Health and Mental Hygiene to implement the program. The contract, for US$98,900, established the first treatment centre for problem gamblers in the United States that was open to the general public. The Center was to be accessible to a large segment of the state population and was proposed to provide the following services:

- Inpatient services.
- Outpatient services.
- Partial care services.
- Consultation.
- Education services.
- After care services.
- Preventative programs.
- Rehabilitation services.

The Center provides two types of treatment. The first is an intensive residential treatment program and the second is an outpatient program. The Center takes a medical model approach to the explanation of gambling behaviour, believing that pathological gambling is an illness. The underlying therapeutic philosophy of the Center is that the most effective intervention for problem gamblers comprises an individual with a personal understanding of the problem, teamed with a suitably qualified counsellor. There are no reasons given for this claim. The treatment procedure at the Center is based on an initial interview prior to intake, which includes a psychological assessment, statement of the problem and assessment of the presence of problem gambling behaviour. This is followed by team-based crisis intervention, negotiation of a recovery plan and concurrent team-led group or family therapy.

Clients may also be involved in the residential program. The primary objective of the residential program is to educate the client about the illness, initiate rehabilitation and to eventually refer the clients for two years of outpatient work with a private practitioner and/or GA. Couples and family therapy, as well as legal and financial counselling, are available in the belief that both play an important role in the treatment of problem gamblers (Politzer et al, 1985).

The Center reports impressive success rates, with 80 per cent of patients abstinent six months after completion of the residential program and 90 per cent of patients abstinent six months after completion of treatment in the outpatient program.

Psychiatric University Hospital, Homburg/Saar, Germany

A number of hospital-based treatment programs are also available in Germany. Between 1980 and 1990, 51 problem gamblers were evaluated and treated at the psychiatric university hospital of Homburg/Saar in Germany (Bellaire and Caspari, 1992). All 51 patients involved in the treatment program were men. Thirty patients were part of an inpatient treatment program and the remaining 21 were treated as outpatients. The majority of patients (43 of the 51) did not attend treatment of their own volition, but were referred by family members or other authorities. The sample was divided into three clinical subgroups:

1. Those with severe psychiatric diseases (for example, schizophrenia, manic depression).
2. Those with serious personality disorders.
3. Those with problems in their current relationships.

The focus of treatment differed between each of the groups, although the principles of client-centred therapy were used in all three groups. Twenty-two patients in the sample attended self-help groups, and in general were not satisfied with the treatment they received. They reported that the meetings were irregular and often did not take place at all. One patient was treated with a technique known as *paradoxical intentions*. This approach was not successful. In fact the patient's gambling losses increased and his financial situation worsened. Only two patients in the study were treated with behaviour therapy. Because of their basic disorders, some other form of therapy was regarded as more appropriate for the majority of patients. Three patients in the sample achieved controlled gambling, with their wives controlling the amount of money they spent on gambling.

Of all patients in the sample, six of the 21 inpatients and 16 of the 30 outpatients dropped out of treatment. There appears to be complexities in treating clients who present with multiple problems. The authors make a number of recommendations for the treatment of such clients:

- A thorough psychiatric and neurological examination is essential in order to begin appropriate treatment.

- Pharmacotherapy is crucial for patients who suffer from severe psychiatric disorders.
- Patients with relationship problems need some form of family therapy.
- Patients with personality disorders need guidance in reactivating old interests in order to fill the time that they had previously spent gambling.

The treatment approach presented by Bellaire and Caspari (1992) does not offer promise for the hospital-based treatment of problem gamblers. Although the study provided a detailed account of the diagnosis and range of possible therapy techniques available for hospital-treated problem gamblers, the researchers only provide the tentative results described above. Controlled efficacy studies are required in order to establish the long-term value of this approach.

Another German study described the treatment process of 58 male gamblers in a hospital inpatient program in Germany (Schwarz and Lindner, 1992). Details of the treatment hospital (that is, name and location) were not provided. The treatment program provided an individual inpatient treatment plan tailored to the needs of each client. However, the main purpose of the study was to determine the validity of a diagnostic test that aimed to differentiate between harmless gambling behaviour and addiction to gambling. A control group of 54 patients with other addictions was used in the study. The authors point out that in 1985, when inpatient treatment of pathological gamblers began, very few clinicians had experience in treating problem gamblers, and there were few diagnostic instruments available. The authors support an addiction-based model of problem gambling behaviour suggesting that:

> Like other addictions, it focuses on the addictive substance, an inability to abstain, loss of control and a pattern of relapse (Schwarz and Lindner, 1992).

It was proposed that 'a real addiction therapy does not exist', and therefore therapy was based on 'a pragmatic, compensatory and multidimensional concept'. Furthermore, the treatment aimed at ' the elimination or at least improvement of all physical, psychological and social symptoms that were diagnosed' (Schwarz and Lindner, 1992). This multidimensional approach to treatment is thought to be the most viable approach at present due to the relatively unknown nature of the effectiveness of specific treatment techniques. Therefore, different forms of therapy were employed, including medical interventions, group therapy, individual treatment, occupational therapy, work therapy, hydrotherapy, sports and gymnastics, autogenic training, family group therapy, health education and general lifestyle discussions. The program was available to problem gamblers, as well as to other addicts. However, gamblers also attended a weekly group therapy session aimed specifically at the needs of gamblers.

The authors point out that relapse statistics of gamblers who have undergone treatment hardly exists in Germany. However, the present study provided some guide as to the success of the 58 patients involved in the treatment program. It was suggested that relapse information could only be collected for some of these patients, as the first follow-up should not take place earlier than one year after the end of treatment. Of the 49 patients followed-up one year after treatment 29 were abstinent, 12 had relapsed and eight patients could not be reached. Of the 25 patients followed-up at two years 13 were abstinent, eight had relapsed and three could not be reached. It was concluded that inpatient treatment of pathological gamblers was an effective form of intervention, and that:

> The pragmatic, compensatory and multidimensional therapy applied, which included a special group therapy for gamblers, individual treatment, and family treatment, was crowned with success (Schwarz and Lindner, 1992).

It was noted that the involvement of gamblers in the program was beneficial to the alcoholics, as the gamblers tended to be more outgoing and act as role models for the alcoholics.

The Behaviour Therapy Unit Program, Sydney, Australia[9]

The Behaviour Therapy Unit

The Prince of Wales Behaviour Therapy Unit and Pathological Gambling Therapy Unit was located in a general hospital 40-bed psychiatric unit in Sydney. Headed by Professor Neil McConaghy, the Unit specialised in the treatment of sexual paraphiliac behaviours and, since 1977, pathological gambling. Referral to the Unit came from health agencies and

[9] This description of The Behaviour Therapy Unit Program is taken from Blaszczynski, A. (1993), and is reproduced here with permission.

referral agencies including lawyers and prison probation and parole officers. Recently, following the retirement of Professor Neil McConaghy, the program has relocated in part to the Academic Mental Health Unit, Liverpool Hospital, under the directorship of Professor Alex Blaszczynski.

Assessment Procedure

Patients admitted to the program initially completed a psychiatric assessment interview. Diagnosis was made according to DSM-III and later DSM-III-R criteria and other Axis I disorders noted. Apart from active psychosis, there were no other exclusion criteria. Not always, but where practicable, treatment was delayed until completion of legal proceedings for gamblers involved in criminal offences. This step was taken to ensure genuine motivation.

The Unit was principally research oriented. Subjects accepted for treatment were assessed on the morning of their admission into the week behavioural program. A second interview using a semi-structured gambling history schedule was administered, together with a battery of psychological measures. The interview covered significant demographic data and details of the past and current gambling behaviour patterns, and the adverse impact of gambling on various facets of their lifestyle and health. The battery of psychological tests included measures of anxiety (Spielberger's State Trait Anxiety Inventory), depression (Beck Depression Inventory), point in time symptomatology (Symptom Checklist-90), sensation seeking (Zuckerman's Sensation Seeking Scale) and boredom proneness (Sundberg and Farmer's Boredom Proneness Scale). Other instruments were included for various research projects as demanded, for example, a semi-structured interview diagnosing antisocial personality disorder and exploring the relationship between crime and gambling (Blaszczynski and McConaghy, 1992).

Particular focus was placed on eliciting qualitative descriptions of emotional and environmental stresses experienced immediately prior to the emergence of pathological gambling. It became apparent that, while some were able to provide detailed descriptions, most could not clearly separate the transition from controlled to uncontrolled behaviours. Denial of the problem and the gradual pace of deterioration were prominent reasons for this. In hindsight, many report the signs of problem gambling well before it has come to be acknowledged as a problem.

Behaviour Completion Mechanism Model

McConaghy (1980) advanced a Behaviour Completion Mechanism Hypothesis to account for the processes maintaining repetitive driven behaviours. Based on the experimental findings of the Russian neurophysicists, McConaghy cogently argued that the central nervous system built up a neuronal of all habitual behaviours commencing from the initial stimuli provoking arousal through to the completion of the act. If the behaviour was not completed when the individual was driven to act on his urges, either through his own efforts to cease acting or when prevented externally, a noxious state of tension would develop. This was experienced as so sufficiently aversive as to compel him to carry out the act to its conclusion. As gambling is associated with high levels of arousal, and therefore, if not completed when stimulated to act would produce a greater level of compulsive drive.

Gamblers describe a preoccupation with gambling following exposure to relevant cues. Attempts to avoid gambling engender feelings of tension, irritability and depression. These continue until the gambler is compelled to complete the behavioural sequence by actually placing a bet. The resultant reduction in their physical and emotional state acts as a negative reinforcer while the excitement generated by the act of gambling serves as a positive reinforcer. Thus the gambling cycle is doubly reinforced. Through second order conditioning, subjects learnt that gambling reduced tension levels generated by other stresses. Negative emotional states of anger, frustration, anxiety and depression acted as cues to stimulate gambling.

McConaghy further suggested that Imaginal Desensitisation would give subjects control over their driven behaviours by reducing their level of arousal so that the Behaviour Completion Mechanism no longer provoked uncontrollable levels of tension.

Imaginal Desensitisation

With Imaginal Desensitisation the standard procedure consisted of fourteen sessions administered in three daily twenty-minute sessions over five days. Each session was separated by a period of no less than two hours. Two sessions were conducted on the first day following their detailed assessment interview.

Each patient provided descriptions of four scenes in which he was stimulated to gamble, but did not do so. A typical scene was:

> You have had a trying day where nothing had gone right for you. You feel tense and angry. On the way home you decide to drive to the betting shop to place a few bets. As you are walking toward the entrance you start to feel bored with the idea of spending your time gambling. You decide not to enter, but return home to your wife.

Sessions were conducted in a quiet room with the patient reclining on a comfortable bed. At the commencement of each session, subjects were given five minutes of progressive muscle relaxation instructions. They were then asked to signal by raising the index finger of their right hand, when they felt relaxed. On so doing, they were asked to visualise themselves performing the first behaviour described in each scene and to signal when they were feeling relaxed. After 20 seconds, they were asked to visualise the next scene in the sequence and so on until the scene was completed. They were then requested to blank their minds and concentrate on a further one to two minutes of relaxation prior to the next scene in the series being presented.

Occasionally, patients requested the session to be audiotaped, to allow extension of treatment in-vivo. This led the author to set up a research project developing and evaluating a cost-effective audiotaped version of the technique for home-based use.

Treatment Outcome

To test the Behaviour Completion Mechanism hypothesis and the effectiveness of Imaginal Desensitisation, a series of comparative treatment evaluative studies were carried out (Blaszczynski, 1988; Blaszczynski, McConaghy and Frankova, 1991a). Subjects were randomly allocated to receive either Imaginal Desensitisation or an alternative therapy, either a standard aversive therapy procedure, relaxation therapy, and brief or prolonged in-vivo exposure to gambling cues. Where possible, collaborative evidence of response to treatment was obtained from significant others and blind ratings carried out by a psychiatrist in several of the studies. Follow-up was conducted at one month and one year intervals. Subjects failing to respond to one form of treatment were allocated to an alternative type and for statistical purposes were recorded as treatment failures.

Results indicated Imaginal Desensitisation to be an effective form of therapy. In the first study (McConaghy, Armstrong, Blaszczynski and Allcock, 1983), Imaginal Desensitisation produced a superior response compared to aversive therapy. At one-year follow-up seven of the ten Imaginal Desensitisation treated subjects reported abstinence but only two of the ten administered aversive therapy did so. McConaghy, Blaszczynski and Frankova (1991) evaluated the response to the various behavioural treatments over an average five-year follow-up period. Outcome data were obtained on 63 of 120 gamblers initially treated. Twenty-six of the 33 who received Imaginal Desensitisation reported controlled or cessation of gambling compared with 16 of the 30 who received one of the other behavioural techniques referred to earlier.

Of the sample of 63 subjects followed-up over five years, 14.2 per cent achieved abstinence. Utilising a more liberal criteria of abstinence, that is, no episodes of gambling in the immediate month preceding follow-up interview and for the majority of the post-treatment period, the figure increased to 28.6 per cent.

Thirty eight per cent described themselves as controlled gamblers. Controlled gambling was defined as spending no more than $10 per week. Controlled gambling was associated with improved social and financial functioning, better interpersonal relationships with spouse, and a trend for better relationships with other family members.

Combining the abstinent and controlled gamblers gives an overall success rate of 66.6 per cent, a figure slightly lower than achieved by other studies. However, the one-week program involving one therapist and 14 hours treatment time represents a highly cost-effective approach in the management of pathological gambling compared to extensive 30-day inpatient admissions with considerable investiture of therapist ancillary staff time.

Treatment of Associated Gambling-Induced Problems

It is recognised that pathological gamblers suffer a diversity of problems, many induced by financial strains resulting from their gambling. Deception on the part of the gambler leads to a breakdown of trust and the emergence of marital and family discord. The ability to maintain employment is compromised and two-thirds engage in criminal acts leading to legal proceedings.

Treatment programs should be individually tailored to target specific variables contributing to loss of

control or relapse. Specific components, not necessarily applicable to all gamblers or critical to recovery, may include:

- Stimulus control techniques to avoid exposure to gambling cues, situations or contact with other gamblers to reduce the risk of relapse.
- Stress management techniques to enhance or substitute more appropriate coping skills. Relaxation therapy may lower arousal and reduce anxiety.
- Antidepressant medication where dysphoric mood is primary.
- Cognitive therapy to correct dysfunctional beliefs, attitudes and expectations regarding gambling. A primary emphasis should be placed on relapse prevention.
- Marital therapy where loss of trust has emerged and resultant suspiciousness creates conflict. The gambler often reacts with anger to continual questioning and gambles in retaliation.
- Restitution of debt is desirable. Budgeting skills and acceptance of responsibility over repaying debts is important, but in some unfortunate cases, restitution is realistically not feasible. Where pressure to meet financial obligations is severe, the urge to return to gambling and to chase losses becomes insurmountable.
- Substitution of adaptive leisure pursuits, preferably engaged in at times incompatible with gambling.
- Addiction counselling for gamblers with substance abuse problems is important for some but it must be borne in mind that the majority of gamblers do not exhibit substance dependency. Psycho-education in addictive processes and psychotherapy and counselling may assist.
- Continued attendance at Gamblers Anonymous. This has been shown to be associated with maintenance of abstinence. Referral of spouses to GamAnon for support should be considered. Benefit may be gained, if not to the gambler, then certainly for the spouse in helping deal with her own emotional difficulties.

The Imaginal Desensitisation technique itself is designed specifically to target the urge to gamble and is considered the ideal core around which these treatment components can be drawn. Imaginal Desensitisation's primary purpose is to reduce the drive to gamble, the excessive physical tension and arousal, and the persistent preoccupation to gamble evoked by attempts made not to gamble. The technique requires minimal training and can be administered by less qualified staff under supervision. Audiotaped versions can be utilised for those, who because of geographical, cost or employment reasons are unable to attend inpatient programs.

Additional difficulties affecting the gambler can be addressed by the therapist or outside resources utilised in a cost-effective manner. Agencies specialising in marital therapy centres, financial counselling services and stress management programs can provide added expertise where resources are lacking. As McConaghy, Armstrong, Blaszczynski and Allcock note:

> …in the light of the high social cost of compulsive gambling, and the good response of the majority of subjects treated, it would seem desirable that inexpensive treatments similar to those used in this study [Imaginal Desensitisation] should be available to compulsive gamblers (1988:383).

Conclusions on Hospital-Based Models

Hospital-based treatment programs are particularly common in the United States, having developed out of an 'addictions' view of problem gambling behaviour. This view is not as widely supported in Australia, therefore few hospital inpatient/outpatient models of problem gambling treatment have been implemented. Whether or not this model is a viable option in Victoria is largely dependent on researchers' and clinicians' perceptions of the cause(s) of problem gambling behaviour.

4.3.3 Self-Help/Group Therapy Models

Gamblers Anonymous

Gamblers Anonymous is thought to be the only widely known self-help organisation specifically established for problem gamblers. Since its first meeting in 1957 Gamblers Anonymous has expanded to include 8,000 members in 380 worldwide chapters (Gamblers Anonymous, 1984; cited in Blaszczynski, 1993). Since this time, a number of other approaches have achieved recognition, although self-help and group therapy models are still widely available and a common form of treatment for problem gamblers.

The 12-step recovery process and abstinence treatment objectives of Gamblers Anonymous are modelled on the principles of Alcoholics Anonymous.

Gamblers Anonymous accepts the disease model of problem gambling behaviour, proposing that gambling is 'essentially incurable' (Walker, 1992a). Hence therapy is seen as an ongoing process. According to the Gamblers Anonymous model of treatment 'no member can afford to relax their guard against the urge to gamble', and therapy can only be successful if the gambler makes a sincere commitment to stop gambling (Walker, 1992a).

The first stage of the process involves the gambler completing a 20-item questionnaire. If the person responds positively to seven or more of these questions, they are considered to be a problem gambler and are admitted to the group. Positive responses to these questions are thought to form the basis for the 'main step towards accepting the true state of affairs concerning the gambling' (Walker, 1992a). This first step involves standing up at the first meeting and stating, 'I am a compulsive gambler'. The person is also encouraged to discuss the extent of their gambling problem.

Gamblers Anonymous believes that problem gambling can be overcome, and that with the support of the group, abstention from gambling can be achieved. Support goes beyond the meetings, as members are provided with the names and numbers of others members who they are able to contact if they are overcome by the urge to gamble. The personal stories of members are known as 'therapies' and are told repeatedly in order to strengthen individuals' decision not to gamble. Gamblers Anonymous meetings focus on the 12 steps of therapy which are based on those used in Alcoholics Anonymous (see Walker, 1992a).

The therapeutic effectiveness of Gamblers Anonymous remains unknown, as there is yet to be a controlled study of its effectiveness. Walker (1992a) points out that from the Gamblers Anonymous perspective, the best chance for a life of abstention lies in regular attendance at meetings. In this way, the success rate is 100 per cent for those members who attend meetings for the rest of their lives. It is suggested that this approach to measuring the effectiveness of treatment is inadequate, as no living member has successfully completed treatment based on this criterion. Walker (1992a) suggests a number of other barriers to measuring the effectiveness of Gamblers Anonymous. These being:

- Anonymity—no case records are kept and no objective evaluation is undertaken.
- Sample bias—any person voluntarily attending and who meets the 20 question criteria is accepted as a member. Some people attend multiple meetings and membership of a particular group changes over time, therefore comparison with a control group is not possible.
- Abstention—the criterion for success in Gamblers Anonymous is complete abstention. Of those people who drop out and/or return to gambling, there is no measure of the effects of therapy. Some of those who drop out after a few meetings may have gained the insight to maintain a controlled, acceptable level of gambling activity.

Despite these barriers a number of researchers have provided participant observational reports and carried out systematic observations of Gamblers Anonymous attendance rates (see Self-Help Organisations in Treatment Outcome Studies section).

Individual and Group Therapy in Germany

Haustein and Shurgers (1992) present a treatment program designed for problem gamblers which involves individual and group therapy as well as a voluntary group program. Through individual therapy with a number of problem gamblers, the group therapy sessions developed. Twenty-seven of the 60 gamblers involved in the three-year program participated in the voluntary group setting. Participation in the groups was irregular, and the average attendance was five or six people per session. Treatment approaches employed in the groups varied between therapist-supported self-help and psychoanalytically based group therapy. The weekly sessions were held in the therapist's office, 'with a kind of family atmosphere, the gamblers obviously felt comfortable and came regularly' (Haustein and Shurgers, 1992). Throughout the sessions the therapist guided the discussion towards three basic issues:

1. What can the gambler do in their everyday life to make it as hard as possible for them to get to the slot machine?
2. What had happened just prior to relapse?
3. Parallel to these topics, the gamblers were asked exactly how they felt before, during and after gambling.

This method of focusing on only three practical points of behaviour change proved to be a successful approach to treatment, with many of the clients

changing their gambling habits. A number of participants had success through controlled gambling, and about half either stopped gambling completely or greatly reduced their time spent gambling. The authors provided only these tentative results.

Group Therapy in the United States

Group therapy with problem gamblers is gaining increasing popularity. Taber and Chaplin (1988) reviewed some of the group psychotherapy techniques used in their work with problem gamblers. Their treatment techniques range from rational–emotive psychotherapy to Zen philosophy-based treatments. The authors proposed that:

> …most pathological gamblers seem to have great potential to profit from short-term group psychotherapy if the group is managed by a skilled professional and if the group is homogenous with respect to the gambling problem (Taber and Chaplin, 1988).

The review is based mainly on the field experience of the first author, who has worked on a number of gambling treatment programs attached to Veterans Administration Medical Centres. Building on a learning theory background, Dr Taber has employed a number of effective therapy methods including rational-emotive therapy, values clarification, Zen philosophy, Gestalt therapy and cooperation with self-help groups. Although the author supports a group processes model of problem gambling treatment, he acknowledges the need for some problem gamblers to have individual treatment. The paper presented focuses mainly on describing the many therapeutic and anti-therapeutic beliefs and behaviours expressed by problem gamblers, and the way in which they affect the group process. The effectiveness of various therapeutic techniques is not described.

Free Yourself Program, Australia

The Free Yourself Program is a self-help approach developed by Gabriela Byrne, a former problem gambler (Productivity Commission, 1999). Free Yourself aims to free people of their 'addiction' to gambling, based on improving their physical, mental and spiritual well-being. The Program was developed as an alternative to approaches used by Gamblers Anonymous and conventional problem gambling counselling.

4.3.4 Family-Oriented Treatment Programs

Treatment for Parents of Problem Gamblers, United States

Many studies have acknowledged the role of family and friends in the diagnosis and treatment of problem gambling (Heineman, 1989; Heineman, 1994; Horodecki, 1992). Heineman (1989) goes a step further by examining treatment programs designed specifically to support the parents of problem gamblers. Included in these treatment techniques are education, family therapy, conjoint sessions, combined group therapy, parent group and after care. The author describes each mode of treatment, however, no information about treatment effectiveness is provided. Heineman suggests that self-help through GamAnon is a particularly valuable means of returning sanity to peoples' lives (Heineman, 1989). This study was conducted at a treatment agency on Long Island, New York.

Structured Family Intervention, United States

Another study by Heineman (1994) describes a model of problem gambling treatment that employs *structured family intervention*. This method of intervention has been effective with alcoholics for twenty years and is now being used with problem gamblers. The preliminary goal of the intervention is to get the gambler into treatment. This short-term focus is thought to be the necessary first step in helping the problem gambler and their family deal with the many and varied effects of problem gambling. The underlying premise of this important first step is the need to help the client 'see and accept enough reality so that, however grudgingly, the need for help can be accepted' (Johnson, 1987; cited in Heineman, 1994).

It is suggested that self-directed interventions are problematic in the sense that those intervening (family members and friends) are not trained in the often difficult task of confronting someone about their gambling problem (Heineman, 1994). Therefore, attempts to encourage a person to seek treatment may be taken as threats and often disguised with reassurance or lies about the extent of the gambling problem. In this way, it is thought that intervention at the family level is a positive first step towards helping not only the problem gambler, but also those family members who are affected by the problem gambling activity.

The structured family intervention technique takes a medical model approach to the explanation of problem gambling, suggesting that 'compulsive gambling is a disease which cannot be controlled, only arrested' (Heineman, 1994). The problem is viewed as a family disease and 'because family members are often in more pain than the gambler, ethically, the primary purpose of any professionally led family intervention should be to get *someone* into treatment' (Heineman, 1994). Family intervention begins with a phone call to a treatment agency from a family member or friend. The intervention is thought to have been successful even if only one member of the intervention group remains in treatment. However, no specific measures of treatment effectiveness were described in the paper.

Marital Therapy, Neuropsychiatric Institute of the University of California, Los Angeles, United States

Marital therapy has also been used to treat gamblers. Blaszczynski (1993) points out that this approach is not indicated for unmarried gamblers and that there is no evidence to suggest that marital dysfunction is the cause rather then the effect of pathological gambling. Furthermore, it needs to be determined whether improved marital relationship leads to a reduction in pathological gambling behaviour.

Favourable outcomes in response to conjoint marital therapy was reported by Bolen and Boyd (1970), although empirical data was not provided. Of nine couples involved in the treatment, one was discharged for irregular attendance and replaced by another couple. On completion of the 12-month therapy, three had ceased gambling and five were described as 'near cessation'. The follow-up time, however, was not specified.

Tepperman (1985) conducted a study of the effectiveness of short-term group therapy with male 'pathological gamblers' and their spouses compared with Gamblers Anonymous attendance. It was proposed that short-term conjoint group therapy would 'enable the working through process' and help make problem gamblers less defensive about their gambling problem. It was further suggested that this treatment technique would improve the marital relations of problem gamblers and open up the lines of communication between the problem gambler and their spouse (Tepperman, 1985).

All participants were active members of Gamblers Anonymous and GamAnon. A clergyman who was trained in Rogerian-style counselling and had extensive experience in leading Alcoholics Anonymous groups conducted the therapy sessions. He was also familiar with the 12-Step Recovery Program and focused on one step per session. The program was conducted at the Neuropsychiatric Institute of the University of California, Los Angeles.

Of the twenty people from each group, ten from both failed to complete sessions. An informal follow-up at three years showed nine conjoint therapy patients in continued attendance with Gamblers Anonymous, whereas the remainder had ceased attending and assumed to have reverted to gambling.

4.3.5 Other Treatment Models

A Lifestyle Model of Treatment

An alternate treatment approach proposed by Walters (1994) describes a lifestyle interpretation of problem gambling activity. This treatment model is guided by three primary objectives:

1. To cease those lifestyle activities which lead to the problem gambling activity.
2. To develop skills in order to manage gambling-related conditions, choices and cognitions.
3. To implement an effective follow-up and support program.

Walters describes an approach for managing a gambling lifestyle therapeutically. The three stages of the intervention include:

- Laying a foundation for change.
- Identifying approaches for change.
- Establishing a non-gambling lifestyle by applying the new skills and knowledge to real-life situations, and implementing an effective follow-up program.

The lifestyle approach to treating problem gamblers is based on work with incarcerated gamblers. An underlying assumption of the theory is that drug abuse, crime and gambling are, to a certain extent, correlated. Hence, the model may not be effective for those individuals with gambling-related problems only. However, the second stage of the intervention involves behavioural treatment techniques common to many behavioural intervention programs. This stage of establishing a vehicle for change suggests a variety of activities that are designed to 'expand the client's repertoire or social, coping, thinking, and general life skills'. Included in these activities are cognitive behavioural therapies such as cue-control, substitution, limiting access to gambling

opportunities, cognitive reframing and rational restructuring. In this way, lifestyle theory provides a broad range of possible therapy techniques that may be effective for a range of individuals.

Minimal Intervention Treatment, Australia[10]

In response to the lack of available treatment facilities in Australia, Dickerson, Hinchy and Legg England (1990) evaluated a minimal intervention home-based self-help manual derived from a similar package developed by Robertson and Heather (1983) for alcoholics. Component ingredients of this manual included training in self-monitoring, functional analysis of gambling behaviour, goal/limit setting, self reinforcement and maintenance of long-term gains. Recruitment of subjects was by media advertising and directed toward individuals 'gambling too much' (Dickerson, Hinchy and Legg England, 1990, p. 19). Subjects were randomly allocated to a manual only or manual plus interview group. Demographic parameters suggested the sample to be similar in many characteristics to first time attendees at Gamblers Anonymous.

The proportion of subjects aiming for abstinence as opposed to reduction was not clearly specified in the study. Calculations suggested that 10 subjects held reduction as their goal and the remaining 11, abstinence. At three months follow-up 100 per cent of those aiming for abstinence achieved their goal but this figure reduced to 50 per cent by six months. The proportion maintaining subjectively acceptable levels of reduction in their gambling or the number experiencing relapse was obscure, but only two subjects were described as reporting increased gambling since initial contact.

In other ways that problem gambling is being addressed, the American Gaming Association (AGA) which represents a wide range of casinos has, among other efforts to address problem and pathological gambling, created the *Responsible Gaming Resource Guide* (second edition), which lists programs and efforts in each state to assist problem and pathological gamblers. In addition to such private sector efforts a number of non-profit treatment groups have emerged throughout the United States in response to problem gambling. The National Council on Problem Gambling (NCPG) acts as a national coordinating body for its 34 state affiliates, as well as for other treatment organisations and self-help groups (National Gambling Impact Study Commission, 1999). Its purpose is to distribute information about problem and pathological gambling and to promote the development of services for those people with gambling related problems. Among the services provided by the NCPG are a nationwide help line and a referral resource database. Funding comes from membership fees, affiliate fees, grants, and private contributions (National Gambling Impact Study Commission, 1999).

Table 20 summarises a number of Australian and New Zealand problem gambling program models. All of the information presented in the table has been provided by staff from each of the agencies and programs mentioned. This is followed by a review of treatment outcome studies in the field.

[10] The description of Dickerson, Hinchy and Legg England's (1990) program is taken from Blaszczynski, A. (1993), and is reproduced here with permission.

Table 20 Models of Problem Gambling Programs in Australia and New Zealand

State	Organisation/ Treatment Approach	Organisational Structure	Theoretical Orientation	Client Base	Approach/therapeutic Strategies Used	Evaluation of Service
South Australia	Community-based programs Flinders Medical Centre Program	South AustraliaSpecialist BreakEven programs exist within community agencies zoned geographically. There are four rural and five suburban agencies, which include: • The Salvation Army • Anglicare • Wesley Central Mission • Relationships Australia • Adelaide Central Mission. Also, specialist services within a number of ethnic community agencies; Aboriginal, Cambodian, Vietnamese, Chinese. Hospital inpatient treatment offered within the Anxiety Disorders Unit.	Eclectic orientation. Particular focus on financial counselling. Cognitive behavioural approach.	Problem gamblers. Family members. Friends.	Financial counselling. Cognitive-behaviour therapy. Narrative therapy. Relationship counselling. Psychotherapy. 12-step programs. Grief/depression issues addressed. Focus on addressing life issues.	Recent evaluation (Elliot Stanford & Associates, 1998) suggested that the South Australian BreakEven program had successfully attracted problem gamblers to the service. Tentative results suggest that there were significant changes between treatment intake and exit data on three separate measures, indicating improvements in financial and work satisfaction, a decrease in anxiety and depression levels, and suicidal ideation.
Queensland	Community-based programs	Specialist BreakEven programs exist within three community-based counselling agencies, which cover specific regions. These agencies include: Relationships Australia. Lifeline. Centre Care	Eclectic orientation. Cognitive-behavioural approach. Systemic theory. Psychodynamic theory.	Problem gamblers. Family members. Friends.	Therapy is client-centred. The most commonly used strategies include: • Cognitive behavioural therapy. • Systemic therapy. • Psychodynamic therapy. • Assessment of readiness to change. • Marriage/relationship issues addressed. • Cash control, safety net procedures.	An evaluation of problem gambling services is currently underway. The study is similar in nature to the present evaluation of Victorian services.
Tasmania	Community-based programs	Specialist BreakEven program exists within three community-based counselling agencies covering specific regions. Agencies include: • Relationships Australia. • Anglicare. • Gambling and Betting Anonymous (GABA).	Eclectic approach. Psychotherapeutic orientation.	Problem gamblers. Family members. Friends.	Therapy is client-centred. Traditional psychotherapy. Cognitive-behavioural therapy. Family of origin work. Some gestalt therapy.	A recent evaluation (yet to be released) suggests that the Tasmanian services have been effective in treating problem gamblers.

continues

Table 20 Models of Problem Gambling Programs in Australia and New Zealand (cont.)

State	Organisation/ Treatment Approach	Organisational Structure	Theoretical Orientation	Client Base	Approach/therapeutic Strategies Used	Evaluation of Service
New South Wales	Community-based agencies Impulse Control Research Clinic Gambling Program University of NSW at Liverpool Hospital, Sydney Blaszczynski & Silove (1995)	There are as many as 40 services in NSW funded by the Casino Community Benefit Fund, which is the central funding agency for problem gambling services. The majority of which are generalist community-based agencies. Includes funding for a number of specific ethnic community agencies: Asian, Arabic, Chinese. Hospital-based treatment also available (described below). Problem gambling treatment program exists within the Impulse Control Research Clinic, Psychiatry Research and Teaching Unit, University of NSW at Liverpool Hospital.	The theoretical orientation of treatment varies greatly depending on the focus of the host agency or program (for example, financial counselling, legal service, general family support). Cognitive behavioural orientation including Relapse prevention techniques.	Problem gamblers. Family members. Friends. Problem gamblers.	Therapeutic interventions used vary enormously between the different services, although most counselling treatment involves: • Problem solving therapy. • Supportive counselling. Hospital based treatment (described below) distinctly different from that of community agencies. Treatment incorporates cognitive behavioural sessions in combination with Imaginal Desensitisation (ID). Standard procedure consists of individual or group therapy program. Group programs are one-and-a-half hour weekly sessions over six weeks. Imaginal desensitisation sessions are recorded on audio cassette and distributed for self-directed home practice; two to three sessions per day over five days.	The trustees of the Casino Community Benefit Fund require that agencies report on a regular basis on the progress of their programs. No formal evaluation at this stage. A number of studies have been carried out to evaluate the effectiveness of behavioural treatments for problem gamblers. Results indicated ID to be an effective form of therapy. Blaszczynski, McConaghy & Frankova (1991) reported that 66.6% of clients who had received behavioural treatment had either ceased or controlled their gambling behaviour, over an average five year follow-up period.
Western Australia	Community-based program	Centre Care is the problem gambling treatment service in Western Australia.				
New Zealand	Problem Gambling Purchasing Agency	NZ government does not fund treatment of problem gambling as part of its core health service. The gambling industry trust contracts to the Problem Gambling Purchasing Agency (PGPA), as a private company to purchase services. In the first year of operation services were purchased from three organisations. These were: 1. The gambling problem help line. 2. The Compulsive Gambling Society. 3. The Salvation Army. Other organisations are contracted to provide services to Maori, Pacific Island people.	Eclectic orientation.	Problem gamblers. Family members.	There is a wide range of therapeutic strategies used.	Evaluation of the central purchasing model to be conducted in the coming fiscal year.

The following section is reproduced with the permission of the author from Blaszczynski, A, (1993), 'Juego patologico: una revision de los tratamientos' in *Psicologia Conductual*, 1, 409–440. This paper provides an excellent review of problem gambling treatment effectiveness.

4.4 Treatment Outcome Studies

As shown in Table 21, a broad range of interventions has been employed in the treatment of pathological gambling.

Psychodynamic formulations appeared in the early turn of this century with behavioural-based interventions emerging in the 1960s. By the 1980s multimodal programs came into vogue, while in the 1990s the emphasis is shifting toward cognitive-behavioural interventions and the possibility of psychopharmacological regimes.

Table 21 Techniques Used in the Treatment of Pathological Gambling

Author	Technique	Cases	Outcome	Follow-up
Bergler, 1957	Psychoanalysis	60	80 patients 60 treated 45 successes	not specified
Victor and Krug, 1967	Paradoxical intention	1	1 abstinent	not specified
Barker and Miller, 1966, 1968, 1969	Aversive therapy	5	3 abstinent 2 abstinent with relapse episodes	? months – 2.5 years
Goorney, 1968	Aversive therapy	1	abstinent	2 years
Seager, 1970	Aversive & supportive therapy	16	5 abstinent 6 relapsed	6 months – 3 years
Boyd & Bolen, 1970	Marital group	9	3 abstinent 5 near cessation	nil
Kraft, 1970	Systematic desensitisation	1	failure	1 year
Cotler, 1971	Aversive & covert sensitisation	1	relapsed	
Koller, 1972	Aversive therapy	20	5 abstinent 1 virtually ceased	6 months – 2 years
Bannister, 1977	Rational emotive therapy & covert sensitisation	1	1 abstinent	2.5 years
Dickerson & Weeks, 1979	Behavioural counselling	1	controlled	15 months
Moskowitz, 1980	Lithium	3	2 reduced 1 unclear	not specified
Greenberg & Rankin, 1982	Stimulus control, exposure and covert sensitisation	26	5 controlled 7 controlled with periodic relapse	9 months – 5 years
Greenberg & Marks, 1982	Covert sensitisation & cue exposure	7	3 reduced	nil – 6 months
Rankin, 1982	Behavioural counselling	1	controlled with brief relapses	2 years
McConaghy, Armstrong, Blaszczynski & Allcock, 1983	Aversive therapy and Imaginal Desensitisation	10 10	2 controlled 7 controlled	1 year
Russo, Taber, McCormick & Taber, 1984	Multimodal	124	33 abstinent 13 reduced with periodic abstinence	1 year
Tepperman, 1985	Conjoint group and marital therapy	20	10 dropped out 9 abstinent	3 years
Taber, McCormick, Russo, Adkins & Ramirez, 1987	Multimodal	66	32 abstinent	6 months

continues

Table 21 Techniques Used in the Treatment of Pathological Gambling (cont.)

Author	Technique	Cases	Outcome	Follow-up
Blackman, Simone, Thoms & Blackman, 1989	Outpatient unspecified	88	55 gambling less than once/week	at termination of treatment
Toneatto & Sobell, (1990)	Cognitive therapy	1	significant reduction	6 months
Blaszczynski, McConaghy & Frankova, 1991a	Imaginal desensitisation & other behavioural techniques	63	18 abstinent 24 controlled 21 uncontrolled	2 to 9 years
Lesieur & Blume, 1991	Multimodal	72	46 abstinent 26 gambling	6 to 14 months
Schwartz & Lindner, 1992	Multimodal	58	13 abstinent 8 relapsed 3 no data	2 years

4.4.1 Psychoanalytic Formulations

Psychoanalytic explanations of pathological gambling emphasised the sexual equivalence of the gambling situation and considered gambling an expression of an underlying psychoneurosis related to a regression to pre-genital psycho sexual phases (von Hattinger, 1914; Simmel, 1920; LaForgue, 1930; Kris, 1938).

Simmel (1920) regarded gambling to be a regressive infantile conduct and an attempt to obtain longed-for erotic satisfaction. Others emphasised satisfaction of primitive superego demands (Menninger, 1938), a question addressed to destiny (Reik, 1942) and as a provocation to fate (Fenichel, 1945).

Freud (1928) equated gambling to a compulsive neurotic state. Gambling was the manifestation of an addiction with masturbation considered the 'primal addiction for which all later addictions are substitutes.' (Herman, 1976: 94). Freud did not intend his analysis to apply to all gamblers, but his writings lay the foundation for subsequent psychodynamic descriptions and treatment (Israel, 1935; Greenson, 1947; Eissler, 1950; Lindner, 1950; Galdston, 1951; Harkavy, 1954; Bergler, 1936, 1943, 1957; Fink, 1961; Harris, 1964; Niederland, 1967; Herman, 1976; Greenberg, 1980).

Harris summarised the varying psychoanalytic positions by stating 'only minor alterations are necessary to fit all hypotheses into the basic theoretical structures proposed by Freud' (1964: 517). The characteristic components were:

- That gambling was an unconscious substitute for pre-genital libidinal and aggressive outlets associated with unresolved Oedipal conflicts.
- That the wish for punishment emerged as a reaction to guilt associated with indulgences in forbidden impulses.
- That gambling provided a medium for repeated re-enactment but not resolution of these conflicts.

Psychoanalytic explanations are inherently weak and considered doubtful as a useful explanation of the pathogenesis of pathological gambling (Cornish, 1978; Rosecrance, 1985). The effectiveness of psychodynamic treatments is difficult to evaluate. Little credibility can be apportioned to the myriad of single case reports on a heterogenous population of neurotic, personality or mood-disordered patients exhibiting co-existing gambling problems. Generally, treatment goals have been unspecified and no measure of gambling severity or outcome described (Bergler, 1943; Greenson, 1947; Matussek, 1955; Harris, 1964).

Only Bergler (1957) reported on an appreciable sample of 80 patients selected from a larger pool of referrals. Sixty patients actually commenced, with fifteen subsequently discontinuing. Treatment extended over 12 to 18 months, at which time 33 who completed full, and 12 partial, psychoanalysis were repeatedly cured and fifteen had symptom removal. Taken as a proportion of those who commenced treatment, 75 per cent achieved successful outcome. But this represents less than one fifth of the initial total pool of referrals.

4.4.2 Self-Help Organisations

As discussed previously Gamblers Anonymous is the only widely known self-help organisation for problem gamblers. Despite the many barriers to examining its effectiveness, a number of researchers have provided participant observational reports and carried out systematic observations of Gamblers Anonymous attendance rates.

Scodel (1964) and Cromer (1978) provided participant observational reports outlining relevant processes

emerging within the group structure but emphasised the inherent difficulties in identifying the crucial therapeutic ingredients underpinning positive outcome. Insight or personality changes did not emerge in the context of attendance (Scodel, 1964).

Custer and Custer (1978) surveyed 150 Gamblers Anonymous members attending the First International Conference on Gamblers Anonymous. The mean period of attendance at Gamblers Anonymous meetings was seven years and three months. Forty-two per cent reported no gambling since attending, 32 per cent one lapse, 10 per cent two lapses, and 16 per cent more than two lapses.

Brown (1985) carried out a systematic five-year retrospective and a three-month prospective study of Gamblers Anonymous attendance rates. In the retrospective phase of the study, only 7.3 per cent of members met the required criteria of two-year abstinence. Results revealed that 22.4 per cent of the initial total cohort of 232 gamblers dropped out after one meeting, with 70 per cent so doing by their tenth meeting. Reducing the period of abstinence to one year did not alter the success rate.

In the prospective phase, Brown (1985) observed a 50 per cent attrition rate by the third week of attendance, with a 12 months abstinence rate of 7.5 per cent. Brown recognised that stringent one- to two-year abstinent rate potentially underestimated the full impact of Gamblers Anonymous, noting that those dropping out after even one meeting may well have benefited considerably from that experience.

Variables that influence gamblers to attend Gamblers Anonymous in preference to hospital-based programs have not been fully explored. Nevertheless, the proportion of gamblers who participate in Gamblers Anonymous meetings during treatment and after discharge do appear to do significantly better in terms of continued abstinence (Taber, McCormick, Russo, Adkins and Ramirez, 1987).

4.4.3 Behavioural Treatments

Twenty-five years have elapsed since the first behavioural alternatives in treatment first appeared in the literature. The interest in the application of clinical behavioural techniques to pathological gambling emanated partly from a case report in *The Times*, 2 April 1968, of the use of biological interventions in the management of a case of compulsive gambling. The rationale and use of leucotomy to treat the 'compulsive' component of gambling met with heated criticism and was followed by a series of descriptions of the effectiveness of less invasive behavioural modification procedures.

The underlying assumption of behavioural approaches is that gambling is a learnt maladaptive behaviour that can be unlearnt through techniques based on principles of learning. Dickerson (1979) extended Skinner's operant conditioning model to postulate the presence of two available reinforcers: money won, reinforced on partial reinforcement schedules, and excitement associated with cognitions and environmental stimuli reinforced on a fixed interval schedule to account for observed betting shop behaviours, such as delayed placement of bets. Anderson and Brown (1984) suggested a two-factor neo-Pavlovian model emphasising the classical conditioning of environmental cues and autonomic/cortical arousal, together with the negative reinforcement associated with a reduction in aversive emotional states produced by the narrowing of attention and distraction from awareness of life problems, in accounting for the maintenance of pathological gambling patterns.

Most behavioural treatments have used operant or classical conditioning aversive techniques to counter-condition the arousal/excitement associated with gambling. As shown in Table 20, the most frequent form has been electric shocks in isolation (Barker and Miller, 1968; Goorney, 1968; Koller, 1972, McConaghy, Armstrong, Blaszczynski and Allcock, 1983) or in conjunction with supportive therapy (Seager, 1970) or covert sensitisation (Cotler, 1971). Covert sensitisation in which aversive imagery is substituted for electric shock stimuli has been combined with rational emotive therapy (Bannister, 1977) and stimulus control and exposure (Greenberg and Rankin, 1982). Salzmann (1982) reported the only use of a chemical substance, apomorphine, in an aversive therapy paradigm, while Greenberg and Rankin (1982) supplemented exposure to gambling cues with a rubber-band technique (in which self-inflicted pain is produced by snapping a rubber band over the wrist).

Implied in the majority of these reports is the adoption of abstinence as the desired treatment goal. However, abstinence had been achieved for a period prior to a relapse but later regained after further intervention. For example, Barker and Miller (1968) instigated a series of studies in which in-vivo electric aversive therapy was used to treat five gamblers.

Favourable response was achieved over 12 to 30 months in three cases, with positive outcome following booster sessions in response to an episode of relapse in the remaining two.

Seager (1970) treated sixteen gamblers with abstinence as the stated aim. At 12-months five were free of gambling, two improved, and one showed minor gambling. Four ceased treatment prematurely. Koller (1972) treated 20 gamblers but reported outcome on only 12 who were assessed and followed-up over two months to two years. Five reported cessation and one virtual cessation of gambling. Overall, Koller concluded that aversive therapy effectively modified gambling in 75 per cent of his patients. Greenberg and Rankin (1982) treated 26 gamblers at two hospitals with stimulus control, in-vivo exposure and/or covert sensitisation and rubber band aversive therapy. There was no random assignment to treatment group. Five patients attended only one session and 50 per cent dropped out prior to completion of therapy. Follow-up conducted over nine months to four years revealed that five (19 per cent) had gambling 'well controlled', seven (27 per cent) controlled with periodic relapse, and the remainder continued gambling.

Sadly, most studies have failed to operationally define outcome criteria. Under these circumstances, consideration of treatment efficacy and successful outcome is governed by arbitrary choice of liberal versus stringent criteria.

4.4.4 Controlled Gambling

The prospect of controlled gambling has been largely ignored despite Dickerson and Weeks' (1979) successful application of behavioural counselling in a single case study of a 40 year old male with a three-year history of recurrent uncontrolled gambling. Controlled gambling, that is one dollar wagered weekly compared to $20 to $2,000 pre-treatment, was maintained over a 15 months follow-up interval. Comparable results were achieved by Rankin (1982) using a similar approach in the treatment of a 44 year old gambler with a 20 year history. Except for three lapses, control was reputedly maintained 'for almost all of the two-year follow-up period' (p. 186).

Rankin (1982) and others (Greenberg and Rankin, 1982; Bacuum, 1985; Blaszczynski, 1988) have questioned the validity of regarding episodes of relapse as indicative of treatment failure without adequately taking into account frequency or intensity of gambling characteristic of such relapse episodes.

Contrary to expectation, controlled gambling does not appear to increase the probability of relapse into uncontrolled gambling. In a two to nine-year treatment outcome study on 63 of 120 pathological gamblers on whom data was successfully obtained Blaszczynski, McConaghy and Frankova (1991b) classified 18 abstinent gamblers into two groups: those reporting complete abstinence, or those abstinent with intermittent relapse episodes over the follow-up period. Relapse was defined as an episode of, or period of excessive gambling accompanied by subjective sense of loss of control. The mean number of reported relapses was 1.89. Prolonged periods of abstinence were regained after lapses. Results indicated that both groups improved significantly on post-treatment psychological and sociodemographic measures, and did not differ from each other.

Russo, Taber, McCormick and Ramirez (1984) similarly found 21 per cent of their sample who reported abstinence in the month preceding follow-up interview had earlier experienced gambling lapses without resurgence of pathological gambling behaviour patterns. Lapses may be beneficial in enhancing the learning process of identifying and subsequently coping with or avoiding situation and emotional determinants leading to gambling relapse (Blaszczynski, McConaghy and Frankova, 1991b).

4.4.5 Specific Controlled Gambling Treatment Strategies

Rosecrance (1989) rejected the medical model of gambling in favour of the notion that pathological gambling was the expression of poor gambling strategies in play. He offered an interesting and highly innovative alternative to clinical management, a controlled gambling treatment program that placed reliance on active gamblers in the mode of peer counsellors. The primary aim of his approach was to replace defective with sensible gambling strategies learnt through exposure to those tactics employed by experienced gamblers. While no empirical evaluation of such an approach has been undertaken, Rosecrance provided anecdotal evidence of its efficacy. He interviewed more than fifty gamblers attending Dr Howard Sartin's handicapping school for horse race gamblers in Southern California. An unspecified number met DSM-III criteria for pathological gambling.

In Sartin's school, gamblers were encouraged to share skills to develop effective betting strategies. This did

not extend to, or imply, that gambling skills were pooled to maximise selection of winners. 'Most' of the fifty gamblers managed '…participation in an acceptable manner.' (Rosecrance, 1989: 157), but no outcome measures or follow-up periods were described. Therefore, one can only conjecture at this stage on the potential usefulness of this approach for some gamblers, but it should not be dismissed out of hand on ideological grounds alone.

4.4.6 Cognitive Therapy

Cognitive theories have been proposed to explain the apparent contradictions manifested in pathological gambling behaviour. These have variably emphasised notions of the illusion of control (Langer, 1975), biased evaluation (Gilovich, 1983; Gilovich and Davis, 1986), erroneous perceptions (Griffiths, 1990; Coulombe, Ladouceur, Desharnais and Robin, 1992) and irrational thinking processes (Walker, 1992b).

Intrinsically, distorted cognitions may be interposed at any stage of the gambling cycle, leading the gambler to erroneously believe themselves to have a greater skill level or control over events/play than in actuality, to selectively recall wins in preference to losses, leading to an over-evaluation of success, to expect an impending win given 'near misses', or the probability that a losing streak is about to end, to maintain an over-valued belief regarding his luck, accede to superstitious behaviours, or to falsely believe in that they possess special skills, knowledge or other attributes that provide them with a winning 'edge'.

Evidence favouring cognitive distortions has not been as yet formally translated into treatment studies. Several multimodal programs incorporate cognitive-behavioural techniques within their armamentarium but have not evaluated their specific contribution or effectiveness.

Bannister (1977) concurrently applied rational emotive therapy, covert sensitisation and Valium in the case of a 46 year old married male sports gambler. Cognitive interventions were designed to enhance a sense of internal locus of control, to correct self-statements that abdicated responsibility over his own behaviour, and to engender the link between gambling and its negative impact. However, excessive internality or externality in terms of locus of control has not been demonstrated in gamblers. Johnson, Nora and Bustos (1992) found no relationship between relapse and locus of control scores.

Toneatto and Sobell (1990) used Beck's model in modifying gambling-related assumptions and beliefs in a 47 year old male with a 26 year history of gambling. Ten weekly sessions led to a significant reduction in frequency from seven gambling sessions per month to three episodes over the six-month follow-up period. The absence of pre- and post-treatment measures precluded an assessment of the presence of change and its nature in cognitive activity. Although encouraging, results need to be interpreted with caution. The subject was atypical of gamblers in general, presenting for treatment for an alcohol addiction problem with a co-existing history of indecent assault and exposure. Gambling appeared incidental to his primary disorder. He did meet DSM-III criteria but had made no prior attempt to cease gambling and '…expressed an interest in learning to curb his gambling…' (1990: 498). In addition, sensation-seeking subscale scores were elevated compared to those for pathological gamblers reported in other studies.

While studies have established the presence of cognitive distortions, perceptions and beliefs in gamblers, the association shown has been shown to have correlation. That a causal relationship exists remains to be demonstrated. Walker (1992b) aptly notes that gambling may serve to maintain irrational thinking styles rather than the reverse. Cognitive distortions are yet to be shown to co-vary with indices of gambling severity and to be absent in non-pathological gamblers.

The majority of gamblers commence gambling prior to age 20 years but maintain controlled levels for many years before succumbing to pathological cycles. It is relevant, therefore, that cognitive theorists explain what factors generate cognitive distortions and the process leading to the transition from normal to dysfunctional cognitions.

4.4.7 Multimodal Therapies

A potential criticism of behavioural techniques is that they target only the specific reduction in the frequency of gambling without addressing significant ancillary issues. Although their aetiological significance is obscure, co-existing problems of depression, substance abuse, marital discord, legal action and employment problems are important, but tend to be neglected on the presumption that they are secondary to the gambling. These are expected to improve without direct intervention if gambling

ceases. However, emotional stresses produced by the effects of gambling may themselves act as risk factors in persistence at gambling or in precipitating relapse episodes. This is pertinent where co-morbid substance abuse disorders exist and where disinhibition caused by alcohol may affect self-control resulting in impulsive or binge episodes. Financially, pressing debts may also prompt further gambling as the only available alternative option to obtain funds to meet financial commitments.

Clearly, multimodal approaches with a focus on the insight, group therapy and personal development seems an attractive proposition in the holistic management of pathological gambling.

Blackman, Simone, Thoms and Blackman (1989) described outcome data on 88 out of 155 pathological gamblers treated on an outpatient basis between 1983 and 1985. Their program is unique in being one of few that considered gambling an impulse control disorder rather than an addiction. Apart from recommendations to attend Gamblers Anonymous, details of the treatment were not elucidated. The length of treatment was not mentioned. The focus, however, was on uncovering dynamic underscoring lack of impulse control.

At termination of treatment 61 per cent reported a gambling frequency of less than once per week. Thirty-one per cent perceived a nil or slight level of severity in respect of their gambling at this time. No follow-up period was specified.

Multimodal treatments have been evaluated in America by Russo, Taber, McCormick and Ramirez (1984); and by Taber, McCormick, Russo, Adkins and Ramirez (1987) in a Veteran's Administration hospital 52-bed alcohol treatment facility with six beds reserved for gamblers; by Lesieur and Blume (1991) in a private psychiatric chemical dependency hospital; and in Germany by Schwartz and Lindner (1992), also in an inpatient addiction unit.

Russo and his colleagues' program consisted of a 30-day highly structured inpatient stay, in which, with the exception of daily group psychotherapy and regular essential attendance at Gamblers Anonymous, patients were integrated in the multidisciplinary based alcohol program. Education on addictions and health and peer-counsellor support was provided. Interested family members were involved in treatment, usually through means of telephone discussions. Post-discharge living arrangements, professional follow-up and vocational training were arranged appropriately as part of formal discharge plans.

In their first report (Russo, Taber, McCormick and Ramirez, 1984) 124 gamblers were surveyed by mail questionnaire at 12 month post-discharge. Returns were obtained from 60 respondents, 33 (55 per cent) of whom reported complete abstinence and 13 (21 per cent) overall reduced gambling but abstinence during the immediate preceding month. In total, 91.5 per cent showed a reduction in gambling behaviour over pre-treatment levels. Not surprisingly, successful outcome was correlated with continued assistance and support. Thirty-six (70.2 per cent) of patients continuing contact with Gamblers Anonymous claimed abstinence, compared to nine (37.5 per cent) of the 24 who terminated contact. Abstainers exhibited more improvement on social, interpersonal and financial parameters and a reduction in depression than non-abstainers.

In the subsequent comprehensive six month prospective follow-up assessment conducted over the telephone (Taber, McCormick, Russo, Adkins and Ramirez, 1987), data was collected on 57 of 66 gamblers. Results indicated that periodic abstinence was achieved by 38 (67 per cent) and complete abstinence by 32 (52 per cent) of patients over the follow-up interval. Number of days gambling and per weekly expenditure showed a significant decline from 15.7 days and $738 to 4.74 and $70 respectively. However, it appears that mean values were calculated using 56 subjects as the figure for the denominator. If 52 per cent were completely abstinent then including zero values for the days and expenditure gambled for these subjects would artificially reduce the mean figure. It is suggested that the reported figure for these two variables is misleading and in actuality is much higher. Nevertheless, this does not detract from the value of the study. Except for two cases, collateral support from 46 informants confirmed the reliability of subjective responses. In the other two, the informant differentially reported abstinence when the subject claimed to be gambling.

Improved pre- to post-treatment ratings were evident on Psychiatric Status Schedule summary scales measuring subjective distress, behavioural disturbance, impulse control, reality testing, wage earner role, alcohol abuse and suicide self-mutilation. However, normative data was not provided making it

difficult to assess whether improvements were in the non-pathological range. As found earlier, continued attendance at Gamblers Anonymous correlated with positive outcome.

Lesieur and Blume (1991) reported on the outcome of 72 patients at six to 14 months following completion of a combined alcohol, substance abuse and compulsive gambling treatment program. The study was conducted in three phases. In the initial phase a cohort of 172 patients were screened using the South Oaks Gambling Inventory. In the second phase, 124 of those scoring greater than five on this instrument were subsequently interviewed. Errors in group allocation excluded five subjects leaving 119 subjects. In the third phase, follow-up data was obtained on 72 of these.

Of the 72, 19 (26 per cent) considered the gambling to be primary, with 17 (24 per cent) and 30 (50 per cent) considering alcohol or dual substance addictions respectively to be the main presenting problem.

The multimodal program consisted of individual and group psychotherapy, education on the impact of alcohol, drugs and gambling, family counselling, attendance at Alcoholics, Narcotics and Gamblers Anonymous meetings and psychodrama. Special groups for health professions, law enforcement agencies and employee assistance programs were offered with post discharge continuity of care achieved through weekly group, individual or family sessions as required.

Results were consistent with those of Taber and colleagues, in that 64 per cent of subjects followed up remained abstinent since treatment, with the figure increasing to 94.4 per cent if the more liberal criteria of overall improvement was used. The authors report that the abstinence outcome rate for the 'worst case' scenario, that is assuming that those of the 119 not followed-up were failures, is reduced to a still positive 38.7 per cent. Given that the follow-up period was greater than seven months for only 22 per cent of the sample, and that success rates reduce over time, this figure needs to be interpreted with caution. However, to be excessively critical, the final figure of 72 represents only 42 per cent of the original sample screened, and if the abstinence rate is recalculated as a percentage of the total of 171 subjects to take into account attrition, the overall success rate is reduced to 27 per cent.

Importantly, no substitution of one addiction for another was noted in the gambling group. Only 9.7 per cent of the sample indicated that the program as a whole was beneficial, with 51 per cent singling out group therapy as the most useful contributor to outcome. Fifteen per cent considered the disease concept and the educational component as the most helpful.

Comparable positive outcome rates are found in the emerging European literature. In an uncontrolled study on an initial cohort of 58 pathological gamblers also treated in an integrated alcohol addiction unit, Scwhartz and Lindner (1992) reported an abstinence rate of 71 per cent in 49 subjects followed-up at 12 months, and 62 per cent for 25 subjects at 24 months follow-up. Patients were exposed to such therapies as medical, group therapy, individual treatment, occupational therapy, work therapy, hydrotherapy, autogenic training, sports and gymnastics, family group therapy, cognitive therapy, and health education. Treatment duration was four months for sole gambling addicted but unspecified for dual/multiple-addicted patients.

The reported outcome rates appear inflated. Follow-up data was not obtained on eight of the 49 subjects at 12 months, and three of the 25 at 24 months. Statistically, the outcome figure was calculated by deriving the percentage of abstinent subjects as a proportion of the respective 41 and 22 followed-up subjects, and not on the 49 and 25 subjects originally sampled. By including the eight and three non-successfully followed-up subjects as treatment failures the outcome rate is reduced to 59 per cent at 12 months and 52 per cent at 24 months.

To provide an even more accurate account, the remaining nine patients who discontinued or were discharged from the program for disciplinary reasons should also be included as failures in calculating outcome rates. Five were described as discharged on the basis of gambling during the treatment phase. To do so reduces the overall twelve months success rate to 50 per cent and 22 per cent respectively.

Although 83 per cent of the total sample reported gambling on German-style slot machines, it is not clear how many presented for treatment of a primary gambling problem. An unspecified proportion was identified on screening at intake into the addiction program. Of the sample, 64 per cent had dual or

multiple addiction problems, with only 36.2 per cent reporting gambling as their sole presenting disorder.

In summary, multimodal programs appear effective in 20 per cent to 50 per cent of cases over one to two years. Methodologically, all are uncontrolled studies with no random allocation of patients or contain blind ratings of outcome. Consideration is not given to reporting on outcomes for specific forms of gambling, and an unacceptable proportion of subjects appear to suffer primary substance abuse disorders. The prolific number of components constituting multimodal therapies precludes identification of the salient ingredients contributing to improvement. Given the expense associated with the length of treatment and the manpower utilised, the cost-benefit of employing such resources for such gains as are achieved needs to be evaluated. Less costly and briefer methods of behavioural intervention need to be explored.

4.4.8 Pharmacological Approaches

Do pharmacological agents have a place in the management of pathological gambling? A number of case studies have appeared in the recent literature describing the effective use of medication in the control of pathological gambling. The rationale for such use has not been theory-driven, but based on attempts to simply block reinforcing affective 'thrill' components inherent in gambling (Moskowitz, 1980), or on innovative clinical judgment in which analogies have been drawn between the manifestations of repetitive gambling behaviour and obsessive-compulsive disorders (Hollander, Frenkel, Decarcia, Trungold and Stein, 1992).

Moskowitz (1980) reported successful outcome in two of three pathological gamblers treated with 600 mg lithium carbonate TDS. The outcome of the third case report was not clearly elucidated, and it was not clear as to whether abstinence or reduced gambling was achieved by subjects over the unspecified follow-up periods.

However, evidence that manifest pathological gambling behaviours coincided with cyclical episodes of affective excitability and impulsivity suggested the possibility that the pathological gambling was secondary to a primary diagnosis of manic-depressive illness. Therefore, the utility of Lithium Carbonate in pathological gamblers in general not displaying evidence of a cyclical affective disturbance remains uncertain.

Bellaire and Caspari (1992) fleetingly referred to the cessation of gambling following 'usual neuroleptic therapy ' in conjunction with 'sociotherapeutic activities' in three schizophrenic, two manic-depressive and one epileptic pathological gamblers. Medication type was not specified and it remained questionable as to the primary diagnosis of this sub-sample of patients. Gambling appeared directly related to the manic phase in the case of the two manic depressives. The relative contribution of medication compared to group therapy was not ascertained by the authors.

Certain similarities in the nature of obsessive-compulsive disorders and repetitive impulse control disorders have led a number of authors to speculate on the possibility that impulse control disorders including gambling (Hollander, Frenkel, Decarcia, Trungold and Stein, 1992) are in some way related to a dimension of impulsivity/obsessive-compulsive disorders rather than a disorder of addiction. This speculation has prompted the use of obsessive-compulsive medications, such as the serotonin re-uptake blockers clomipramine and fluoxetine in the management of not only of gambling (Hollander, Frenkel, Decarcia, Trungold and Stein, 1992) but also sexual paraphiliac behaviours (Bianchi, 1990; Emmanuel, Lydiard and Ballenger, 1991; Perilstein, Lipper and Friedman, 1991), compulsive non-paraphiliac sexual addictions (Stein, Hollander, Anthony, Schneier, Fallon, Liebowitz and Klein, 1992), kleptomania and bulimia (McKelroy, Kech, Pope and Hudson, 1989), and trichotillomania (Winchel, Jones, Stanley, Molcho and Stanley, 1992).

Hollander, Frenkel, Decarcia, Trungold and Stein (1992) administered clomipramine to a 31 year old female poly-gambler with a 12-year history of excessive gambling. Although some features of an obsessive-compulsive personality were noted, their severity did not merit a DSM-III-R (American Psychiatric Association, 1987) label of obsessive personality disorder. In this well-conceived single case double-blind placebo-controlled design, pathological gambling was reduced by week three and discontinued by week ten, in response to 125–150 mg/day doses of clomipramine. Minimal improvement in gambling behaviour occurred over the initial ten-week placebo phase. With the exception of one lapse at week 17, abstinence was maintained under open 175 mg/day clomipramine treatment for the duration of the one-month follow-up interval.

While these results appear encouraging, Hollander, Frenkel, Decarcia, Trungold and Stein (1992) acknowledge that further replication is required on larger samples before any conclusive statement regarding the effectiveness of clomipramine can be offered. Recognising that gamblers may temporarily abate their gambling behaviour for periods of up to twelve months, longer follow-up periods are required.

However, depressive symptoms are found in the majority of pathological gamblers although the direction of causality remains unknown (McCormick, Russo, Ramirez and Taber, 1984; Blaszczynski and McConaghy, 1988). Given the fact that clomipramine and fluoxetine are robust anti-depressants (Stahl, 1992), it is necessary to exclude the possibility that the effectiveness of these medications may act through their mood altering properties.

These encouraging preliminary reports of the efficacy of clomipramine and fluoxetine in impulse control disorders suggests the possibility that repetitive, driven, or compulsive urges are characteristic features that may link pathological gambling, sexual paraphilias and obsessive-compulsive disorders. Such a proposition warrants further investigation for, if so, the re-conceptualisation of pathological gambling away from an addictive disorder to that of a variant of an 'obsessive-compulsive' illness may prove a more fruitful avenue of pursuit especially in respect of treatment.

As noted earlier, the foregoing section is reproduced with permission from Blaszczynski, A (1993), 'Juego patologico: una revision de los tratamientos' in *Psicologia Conductual*, 1: 409–440.

4.5 The Victorian BreakEven Program

4.5.1 Treatment Practices of Victorian BreakEven Counsellors[11]

The information relating to counsellors' practices was obtained from the Clinical Practice Evaluation (CPE) Counsellor Questionnaire survey of BreakEven Services. Of 17 questions, three were considered relevant for the purpose of the present analysis. The following open-ended questions were examined:

- Describe the theoretical orientation of your counselling practice.
- Describe what you understand to be the cause(s) of 'problem gambling'.
- Please provide specific examples of the techniques and strategies you use when counselling clients (for example, reflective listening, Imaginal Desensitisation, free association, role-playing).

The survey of BreakEven program *counselling practice* and *theories in use* revealed that a broad range of theoretical perspectives underpin the delivery of the Victorian problem gambling program. BreakEven counsellors incorporate a variety of therapeutic strategies and theoretical perspectives to inform their counselling practice with problem gamblers. The majority of the 15 agencies represented by counsellor responses to the CPE questionnaire adopt an eclectic approach to counselling. This is consistent with current trends in counselling and psychotherapy. Although a number of agencies did not specifically use the term 'eclectic', they did describe a spectrum of perspectives which inform their counselling practice with problem gamblers:

- Among the most influential contributions to counselling practice is cognitive behavioural therapy (CBT), mentioned by the majority of BreakEven agencies as a major component of their theoretical framework.
- The client-centred approach based on the humanist psychology, developed by Carl Rogers, is also a major focus of counselling practice.
- Motivational approaches (particularly those informed by Prochaska and DiClemente) in terms of assessing the client's readiness to change, and systems theory are part of the theoretical framework of some BreakEven host agencies.
- Solution-focused therapy, narrative therapy and psychodynamic therapy were also mentioned by a number of BreakEven program providers.
- Among the more uncommon contributions to counselling practice were chaos theory, attachment theory and feminist theory.

Counsellors' perceptions of the causes of problem gambling behaviour were reviewed in order to gain an understanding of the beliefs that influence the theoretical orientation and practice of treatment. Many BreakEven counsellors pointed out that the issue of aetiology is particularly complex.

[11] This section contains only a brief description of counsellor practice. A detailed analysis of the relationship between counselling practice and counselling effectiveness is contained in Volume Two of this Evaluation Report series.

There were some difficulties in reviewing counsellors' responses to this question as many offered *possible* causes of problem gambling, while others took a more philosophical approach, questioning the causal relationship between gambling activity and problematic behaviour. Despite this, counsellors provided a variety of possible causes of problem gambling behaviour:

- A number of workers responded that problem gambling is a way of managing problems in one's life, such as depression and stress.
- Similarly, gambling was thought to be an escape from problems, and possibly the result of boredom and loneliness.
- A number of agencies also mentioned grief and loss issues as underlying causes of problematic gambling.
- It was also suggested that problem gambling behaviour is the result of attempts to chase losses, the desire for a particular social image, the result of gambling industry promotion and social/familial factors.

In response to the question, 'Please provide specific examples of the techniques and strategies you use when counselling clients', BreakEven counsellors described a wide range of techniques. It was not uncommon for counsellors within the same agency to use very different techniques, with perhaps only a few strategies being utilised by more than one person.

Table 22 shows the most common therapeutic techniques and strategies employed by Victorian BreakEven counsellors.

Table 22 Most Common Therapeutic Techniques Used by Victorian BreakEven Counsellors (n=43)[12]

Therapy techniques	No, of Counsellors Utilising Technique
Cognitive Behavioural Therapy	
Role-playing	11
In-vivo exposure	11
Imaginal desensitisation	7
Challenging irrational beliefs	7
Humanist Psychology	
Reflective listening	32
Relaxation techniques	16
Provision of information/education	12
Motivational interviewing	11
Solution focused therapy	9
Confrontation	8
Circular questioning	8
Narrative therapy	7
Families/couples counselling	6

Table 22 shows that even the most commonly used strategies are still only employed by a relatively small number of counsellors. Apart from reflective listening, which was mentioned by 32 counsellors, all other techniques were used by fewer than 16 of the 43 counsellors. This information further supports the increasingly multimodal nature of the treatment of problem gamblers within the Victorian BreakEven program.

It is evident that the organisations implementing the BreakEven program have developed an eclectic orientation in their counselling of problem gamblers. That is, a broad range of theoretical perspectives underpins the delivery of the service and influences counsellors' approach to treatment. Cognitive-behavioural theories and psychosocial theories appear to be among the most influential contributions to counselling practice. Moreover, BreakEven counselling is multimodal in nature, as a wide variety of therapeutic strategies are employed, with a predominantly client-centred focus. It is evident that the 15 host agencies reviewed have adopted similar approaches to treating problem gamblers within the Victorian BreakEven program.

4.6 The Victorian BreakEven Program Compared to Other Approaches

The preceding sections have shown the wide range of problem gambling treatment models. The different models vary in terms of the nature of the population being treated, the broad structure of the organisation or program, the theoretical orientation of treatment, and the therapeutic interventions employed, resulting in a number of very distinct, often incomparable treatment programs.

However, a number of important observations can be made with respect to the present status of problem gambling treatment. It is evident that there has been a move towards:

- Taking a broad-based approach to the explanation and treatment of problem gambling behaviour.

[12] For a comprehensive list of the therapeutic techniques and strategies employed by Victorian BreakEven counsellors see Appendix A.

- Using eclectic treatment approaches.
- Focusing on delivering a client-centred service to problem gamblers.

These developments in service provision reflect the identification of the multifaceted nature of problem gambling, the diversity of the problem gambling population, and the varying degrees of problem severity among gamblers. The recent *Productivity Commission Inquiry Report* (1999) supports this notion suggesting that there is a wide range of counselling and treatment services available to assist people affected by problem gambling and that such services can differ in relation to the form of help, the types of problems being addressed, and the nature of the counselling/treatment provided.

The Commission's Survey of Counselling Services sought information on the approaches or techniques used by agencies to treat problem gamblers, and were given the general impression that as many agencies appear to be using modern types of treatment like cognitive-behavioural therapy (CBT) as are using more traditional supportive counselling approaches. However, the report points out that there is some debate as to what are preferred types of treatment for problem gamblers.

Furthermore, although behaviour modification techniques and cognitive techniques are currently favoured interventions for problem gambling treatment there appears to be a degree of scepticism among clinicians and researchers as to whether these approaches are actually being used by counsellors. Walker (1998: 18) comments that:

> With few exceptions, counsellors and therapists are not using these approaches. When asked about their approach, many counsellors responded that they talk to their client and from their experience know what to say. (But) client-centred counselling has been shown to be relatively ineffective across a wide range of problems.

However, results of the Commission's *Survey of Counselling Services* appear to suggest a generally more favourable picture, with a high proportion of the agencies reporting the use of cognitive, and cognitive-behavioural techniques. It is concluded that the application of different treatment approaches remains uncertain, because as Walker has suggested, the issue of treatment is a complex one and possibly one that is not accurately described by any data:

> The problem is knowing what actually occurs in therapy. An agency may say that it uses CBT but we do not know how strictly the criteria for CBT are being met…CBT is a 'buzz' word in therapy currently and most counsellors will have heard the term and have some understanding of what is involved. But whether their understanding is sufficient to categorise their own therapy is another matter.

4.7 Difficulties in Evaluating Treatment Services

It is evident that a number of comprehensive treatment programs exist, but that many also neglect some important features in the treatment of problem gambling behaviour, such as preventative strategies and education strategies. Many of the programs reviewed did not offer a comprehensive overview of treatment. Therefore, the effectiveness and appropriateness of different models of treatment are difficult to assess. The absence of treatment outcome and follow-up data severely hinders a thorough evaluation of problem gambling treatment models. Many studies have failed to report cases dropped from treatment or not included in follow-up studies, and in some instances they have been ignored in reporting outcome findings (Lopez, Viets and Miller, 1997). It is evident that more comprehensive and consistent reporting of research findings is required before we can gain a thorough understanding of the *best practice models* in the field.

The evaluation of various treatment programs is further complicated by the fact that there are 'no internationally established models of best practice in existence' (Elliott Stanford and Associates, 1998). There is no consensus on the best method and organisational setting for treating problem gamblers, making it difficult to assess the appropriateness of various programs. Blaszczynski et al (1999) highlight the complexity of establishing best practice in the problem gambling field as follows:

> There is a consensus that problem gambling is a treatable condition. Research suggests that the process leading to problem gambling involves a complex, dynamic interaction between ecological, psychophysiological, developmental, cognitive, and behavioural components. All these elements should be addressed within a treatment strategy if

successful treatment is to be achieved. However, there is no single intervention modality that is the 'gold standard' or best practice in the management of problem gambling.

The study commissioned by the Nova Scotia Department of Health (Focal Research, 1998) supports this notion by concluding 'that there will not be any single treatment solution in addressing problem… gambling. Prevention, intervention and treatment strategies will have to be as varied as the many factors impacting and contributing to problem… gambling.' Similarly the US *National Gambling Impact Study Commission Report* (1999) points out that according to therapists and other professionals in the field, pathological gambling is a difficult disorder to treat (National Gambling Impact Study Commission, 1999). As with substance abuse, treatment for pathological gambling is a costly, time-consuming effort, often without quick results and with a high degree of re-occurrence. Furthermore, given the lack of information about the root causes of the disorder and the relatively new awareness of the phenomenon, at least on a large scale, no single treatment approach has been devised.

4.8 Conclusions

It is perhaps not surprising, therefore, that the overseas and Australian programs reviewed in this Report share many similar features and appear to be consistent in providing problem gambling treatment that is predominantly *eclectic* in orientation, *client-centred* and *multimodal* in nature. As with the overseas models described, very few of the Australian programs have been evaluated. Some have not been evaluated at all and others are in the preliminary stages of evaluation. For this reason, our evaluation of BreakEven may contribute to setting a benchmark against which other similar programs, both overseas and within Australia, can be assessed. Volume 2 of this Evaluation Report series provides an evaluation of treatment effectiveness and therapeutic outcomes, and provides a good overview of a community-based model for the treatment of problem gamblers. It is important to note that for the most part, problem gambling treatment within Australia is consistent among the various States and Territories. The majority of programs (excluding the hospital-based treatment programs) are *specialist* programs that exist within *generalist* community health centres and are broad-based in nature.

Despite the many difficulties in making an informed judgment of what constitutes 'best practice' it is clear that a number of successful therapy techniques have been used in treatment with problem gamblers, many of which are accompanied by controlled efficacy studies. Therefore, it may be necessary to look to these clinical findings in order to gain an understanding of the essential features and most successful approaches to the treatment of problem gambling behaviour. Blaszczynski (1993) suggests that treatment outcome studies have shown that more than half the number of pathological gamblers treated in outpatient, inpatient or community settings respond positively with abstinence or controlled gambling irrespective of whether the treatment is behavioural or multimodal in nature.

Future research of problem gambling treatment must focus on evaluating established treatment programs. Research is required to evaluate the long-term effectiveness of various treatment models and the therapeutic efficacy of the treatment techniques employed. Many of the established treatment programs that appear in the published literature lack outcome and follow-up data. These oversights must be addressed in future research.

A comprehensive evaluation of treatment programs would include an examination of:

- The long-term effectiveness of established treatment programs.
- The therapeutic efficacy of a variety of treatment techniques.
- The accessibility of the treatment program for those individuals that the program aims to target.
- Evaluation of the cost-effectiveness of the program.

The following section will examine the relationship between the BreakEven program and the telephone counselling service G-Line.

5 G-Line and BreakEven

The following section outlines the nature and objectives of the G-Line telephone counselling service. It is succeeded by data about the G-Line service and how it interacts with the BreakEven service from the perspective of G-Line counsellors, BreakEven counsellors and problem gambling clients who have called the G-Line service.

5.1 The Value of Telephone Counselling

> Intuitively, the concept of the hotline is a good one. It provides a relatively economical method of dispensing helping services to greater portions of the community than could be reached by conventional services. It utilises a large, potentially invaluable source of manpower, the volunteer non-professional, enabling a minimum number of professionals, serving in administrative and consulting capacities, to serve a maximum number of people. The hotline makes help information, advice, comfort, and counselling available around the clock, most importantly when most agencies are normally closed. It is a free service regardless of the caller's socioeconomic status, yet it is without the welfare or charity stigma. It offers anonymity and freedom from both legal and bureaucratic 'red tape'… the hotline transcends geographical barriers where seconds make a life or death difference and offers an acceptable form of help to many persons who would not ordinarily come into a helping agency. The hotline appears so valuable that, in the absence of any hard evidence to the contrary, most people are content to assume that it offers an effective service. It is in this atmosphere that hotlines have become what is perhaps the fastest growing helping service in the country (Rosenbaum and Calhoun, 1977).

The literature refers to many theoretical and practical arguments for the establishment of telephone counselling services. Telephone counselling services offer a legitimate and useful alternative to existing service models, especially in terms of 'their non-institutional and generally non-professional orientation' (Hornblow, 1986). Telephone counselling services have numerous roles in providing a legitimate alternative to face-to-face service provision (Hetzel, et al, 1993). The most obvious advantages to the client are the accessibility of such services and their role in offering support, guidance and information as a preventative intervention. To service providers, such programs are cost-effective and meet a clear and growing need in the community.

The growth of telephone counselling services reflects many of the characteristics of the community mental health movement: a challenge to institution-oriented care, a move away from patterns of accountability dependent on a professional hierarchy, an affirmation of caring resources within the community at large, and a recognition of the need to provide support and intervention as close as possible to a point of personal crisis (Hornblow, 1986). A review of the literature identifies several persuasive arguments in support of such services:

- Logistical efficiency: addressing the problems of increased funding cuts and lengthening waiting lists. They also provide a low cost service to clients, increase the service options available and are designed to reach as many people as possible (Rosenbaum and Calhoun, 1977).
- Accessibility: reaching groups who do not use more traditional mental health services or who have been dissatisfied with past attempts to contact more traditional helping services, better meeting the needs of minority groups in the community and those geographically isolated, enabling clients to seek help anonymously, filling the gap left by more conventional services, operating for extended hours and utilising volunteer counsellors who may better reflect the socio-economic characteristics of the callers (McCord and Packwood, 1973; Apsler and Hoople, 1976; Enright and Parsons, 1976; O'Donnell and George, 1977; Iscoe, Hill, Harmon, and Coffman, 1979; Stewart and Glenwick, 1992; Regan, 1997).
- Benefits to clients: providing the caller with more control over confidentiality and the amount of information they provide, reducing feelings of isolation and despair in the home-bound, providing an immediate service for those who need crisis intervention and offering help before a problem has a chance to worsen into pathological behaviour (Hetzel et al, 1993; Rosenbaum and Calhoun, 1977).
- Adjunct to other services: providing a valuable adjunct to other services and a pathway into the complex systems of professional care. Because they are crisis oriented, they may also act as a `holding point' for people in crisis, and are increasingly being utilised as a diagnostic preventative tool in health agencies.

The purpose and operation of G-Line is outlined below.

5.2 Overview of the G-Line Service

The material in this section combines information produced by the Australian Research Institute in a publication entitled *G-Line Crisis Counselling and Referral Service for People Affected by Problem Gambling*, and an interview conducted with the National Director of G-Line, Kate Earl.

The underlying philosophy of G-Line is to acknowledge the need for 'people affected by problem gambling behaviour [to]… have equitable access to professional, non-judgmental, anonymous, confidential and high quality telephone counselling services including service referral and information provision' (Addiction Research Institute, 1998). Ms Earl adds to this description of the philosophy a commitment to data collection, which will in the long-term assist the client group being served. The definition of problem gambling, which has been officially adopted by G-Line, is that proposed by Dickerson, et al (1997):

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

The G-Line service model contains four essential elements, outlined in Table 23, which are: referral, access to G-Line, problem identification, and service delivery.

Table 23 Service Model of G-Line

Referral Source	Access to G-Line	Problem Identification	Service Delivery
Self Family/friends Gambling venue Service provider Print media Electronic media Other	Via National G-Line Call Centre: 1800 telephone TTY telephone Internet	Crisis management Identify problem Assess needs Collect caller details	Direct Services: • Crisis management • Individual telephone • Counselling Indirect Service: • Referral • Information

Table 24 Funding Arrangements for G-Line Services Nationwide

State	Commencement Date	Funding Body/Source
New South Wales	August 1997	Department of Gaming and Racing (Casino Community Benefit Fund)
Western Australia	August 1997	Lotteries Commission of Western Australia
Queensland	September 1998	Community Funding and Support Branch, Families, Youth and Community Care
Victoria	October 1994	Office of the Family Department of Human Services (Community Support Fund)
Tasmania	October 1996	Tasmanian Gaming Commission (Community Support Levy)
South Australia		Contract Management Community Services Division, Family and Community Services

G-Line in Victoria is funded by the Department of Human Services using monies from the Community Support Fund. Table 24 depicts the arrangements in place for all states and territories.

5.2.1 Staffing of G-Line

All staff at G-Line are paid. There is a pool of counsellors from which additional staff can be arranged if the need arises. There is a minimum of two counsellors on duty at any one time. Their job description specifies that telephone counsellors are required to:

- Provide a telephone crisis counselling and referral service for those affected by problem gambling behaviour in Victoria, New South Wales, Tasmania, Queensland, Western Australia and South Australia.
- Recognise and assess additional caller issues, including violence, morbidity and psychiatric issues.
- Enter data and collate call frequency information.
- Act on duty of care for coworkers by providing informal debriefing.
- Attend and contribute to ongoing professional development seminars.

The training of staff begins as soon as they are appointed to the service. The basic model adopted is an experiential one. Initially the staff member is given selected reading on problem gambling and then takes part in a series of supervised counselling shifts. The number of shifts is normally six but can be increased or decreased depending on the level of skill, confidence and experience of the trainee. The supervised sessions involve both a supervisor and trainee sitting at the one phone, with only one person ever taking a call. During these initial shifts, which last four hours, the trainee commonly does not take calls but rather observes and discusses the counselling session at the conclusion with the supervisor. Trainees are not paid during this period, their formal employment only takes place when they are able to take calls unsupervised. At the end of this series of supervised sessions the trainee meets with the Administrator and National Director to discuss their progress and whether they are ready to begin work. If they are not, the trainee is advised to undertake further training and experience elsewhere.

The service requires that all staff take part in ongoing professional development and group supervision. The purpose of professional development as an ongoing aspect of the service is to 'ensure and maintain a high standard of service delivery' (Addiction Research Institute, 1998).

There are four main sources of internal evaluation for G-Line, which comprise reports to the funding body, feedback received from BreakEven services, feedback received from clients and collegial evaluation.

The feedback received from BreakEven services takes the form of feedback sheets from the client. Client feedback received is formally recorded. All complaints are responded to and go through the National Director. Feedback received from group telephone counselling is also recorded and responded to.

The quality of counselling is also informally evaluated through 'collegial supervision'. Debriefing takes place in the counselling room where there is an exchange of ideas and where monitoring takes place. Supervision of this kind has immediacy as it takes place in the counselling environment. It is also a 'transparent' system. If there are concerns with the approach or style of counselling, colleagues will raise it directly with the counsellor concerned or report to the Director who will look into the matter.

The Professional Development Working Group is also an important part of 'collegial supervision'. This Working Group is comprised of the most experienced counsellors and those with an interest in supervision.

The group conducts supervision in small groups of four to five people where case scenarios are discussed. Counsellors report on their approach to a given case and other counsellors provide comments and input (Appendix B includes the G-Line information brief).

Evaluation takes place from the initial training phase to become a counsellor and continues as an ongoing part of staff development. Feedback forms are received from trainee counsellors and are used to establish what they think about working with other counsellors. This assists in determining whether the trainee is suitable for the particular environment at G-Line of working in close proximity to others, rather than counselling in isolation.

5.2.2 Profile of G-Line Counsellors

A Survey was conducted of G-Line counsellors in order to compile a profile that identifies their characteristics, working approaches and perceptions. The main aim of the Survey was to obtain information on:

- The counsellors' education, training, level of experience as a telephone counsellor, age, sex and country of birth, etc.
- Counsellors' views of their role.
- Any issues arising in counselling clients with gambling related problems.
- Counsellors' views on the function of BreakEven.
- Counsellors' understanding the role of G-Line.

Questionnaires were given to G-Line for distribution to counsellors. Researchers also handed copies of the questionnaire to those counsellors who were on duty during the one-week period of a Client 'Snapshot' Survey (which is discussed later in this section). Interviews were not conducted, in the interests of confidentiality, and to enable the counsellor sufficient time to reflect on their responses to the questionnaire.

However, only 10 counsellors participated in the survey, out of a total of 40 counsellors currently employed by G-Line. The response rate was disappointing and greatly limits the usefulness of the data in making generalisations. Nonetheless, an attempt has been made to draw attention to some interesting aspects of the counsellors' responses.

Professional Qualifications and Specialist Training

Nine of the 10 respondents had qualifications in psychology. Five indicated that they were probationary psychologists and two were registered psychologists. Nine of the respondents had also received specialist problem gambling training. All ten respondents indicated that they had received specialist telephone counselling training. Only five had received cross-cultural communication training.

Employment with Other Organisations

Seven of the respondents indicated that they were currently employed elsewhere. Agencies where counsellors were employed included BreakEven (three respondents) and the Anti-cancer Council of Victoria Quit Campaign (three respondents). Other positions cited included private practice as a psychologist, university tutor, university research assistant, and counselling.

Supervision

Seven respondents indicated that they received supervision for their counselling practice at G-Line. One indicated having had received supervision outside of G-Line. Another indicated that they have as yet had no supervision as a result of difficulties in accessing peer supervision due to work clashes. This respondent made the comment that there is no one 'on the spot' except at peer level.

Counsellor Self-Assessment

Six counsellors indicated that they assessed the quality of their counselling at G-Line through informal means. Two counsellors stated that they used formal means and two indicated that they used both informal and formal means in assessing the quality of their counselling. It should be noted that responses to this question are to some extent ambiguous, as respondents may have had differing interpretations of what 'formal' and 'informal' assessment entails. The respondents mentioned numerous means of assessing their counselling performance, including: client response to the counselling session, reflection with colleagues, reflection with a supervisor outside G-Line, and self-reflection.

Suggested Improvements to G-Line

Counsellors provided numerous suggestions as to how the G-Line service could be improved. Comments included:

- More feedback on the data collected by counsellors, such as the basic number of calls taken from each state and territory, and number of calls missed.
- An expansion of G-Line's service role, in terms of offering a call-back/follow-up service with some callers. According to this approach, a caller may

get linked up with a particular counsellor who provides them with ongoing support, in much the same way as face-to face counselling.

5.2.3 Counsellors' Opinions of the Cause(s) of Problem Gambling

Counsellors were aware that numerous interactive factors play a role in the development of problem gambling and that there is no single cause. Because of this, there can be differences according to the sex of the client, their cultural background and their age.

Generally counsellors felt that problem gambling was largely an individual's response to either problems in their life, such as financial difficulties, relationship break-ups, loss of a job or bereavement. In this context gambling is a means of 'avoidant' coping or escapism to relieve stress, anxiety, loneliness, boredom or depression. The problem is exacerbated when an addictive behavioural response develops and the individual is no longer able to control their level of gambling.

Problem gambling was also described as a learnt behaviour, through intermittent reinforcement, pleasure-seeking behaviour, and risk-taking behaviour. Other explanations included social cognitions that acknowledge the role played by social influences such as cultural norms and family history of gambling amongst influential peers. The relationship between social influences and individual cognitions, such as erroneous beliefs about gambling, was also identified. Personality traits, such as impulsiveness, low tolerance and frustration, were also cited as factors to take into account when considering the cause of problem gambling.

5.2.4 Theoretical Approaches and Counselling Techniques

The theoretical orientation adopted by counsellors in their counselling practice at G-Line is varied. Most adopt an eclectic approach, incorporating numerous theoretical approaches. Examples include cognitive-behavioural, motivational counselling, Gestalt and experiential therapies, and solution-focused approaches. Specific examples of the most frequently used techniques and strategies cited by counsellors at G-Line include: exploration and expression of emotions, prioritising needs, informing of support services, building motivation for clients to change, listening, empathy, challenging cognitive distortions, collaborative development of a quitting/cutting down plan, goal setting, psycho-education, interpreting, affirming, and questioning.

5.2.5 Building Rapport with Clients

Counsellors build rapport with callers through a range of techniques, which includes: voice tone; open questions that encourage the caller to talk and explore; active/emphatic and reflective listening; demonstrating a non-judgmental understanding for their situation; exploring the problems associated with gambling; adopting a non-judgmental manner, which involves summarising and helping clients to tease out their feelings; inviting, encouraging, matching, remaining focused on the caller; 'sitting with the distress'; challenging the client when appropriate; commending callers on taking the positive step of calling; and adopting a comfortable pace which allows the caller to be in control of the content without premature interruptions.

Several techniques are employed by counsellors for ending a call with clients who have received counselling. Techniques cited include: summarising the counselling session, giving referrals, checking that the caller is satisfied with the counselling session and giving them encouragement. Summarising the counselling session involves giving the client an overview of what has transpired and of the steps that now need to be taken. Referrals provided at the conclusion of the call are to BreakEven if face-to-face counselling is required, and to other services as appropriate. The client is also reminded that they are welcome to ring G-Line again if they need to. Encouraging comments are made about the positive step the client has taken in contacting G-Line and to wish them well for road that lies ahead.

5.2.6 Client Referral Practices

Counsellors outlined several methods employed to assess their clients' referral needs, including:

The Counsellor's Assessment of Need

Information is gathered on the caller's needs and their access to resources. The counsellor also prioritises needs, such as material aid, financial counsellor, emergency, face-to-face counselling, etc. The decision may be based on safety reasons for the caller or for others in the caller's life. This assessment takes into account the severity of the problem, and the caller's capacity for following through.

Caller Participation in the Assessment of Referral Needs

This involves the counsellor discussing with the client directly what services they think would be most useful. This is preceded by an overview of the services available.

Discussion of the Use of Referral Information

Through discussion with the client, the counsellor examines the pros and cons of different services; explores the caller's past experiences with referrals and their expectations; creates a plan of how the caller will use the referral information; and discusses the likely barriers to use of certain referrals.

Counsellors were asked where they would refer clients with gambling related problems who presented with a range of specified issues which included: crisis intervention, financial supports, alcohol/drug problems, anger management, employment issues, legal problems, family/relationship problems, social activities/social isolation, and psychiatric problems. Counsellors indicated that they utilise a wide selection of community-based and government services. Services cited include: CaT, Victoria Police, CrisisLine, CareRing, LifeLine, the Salvation Army, material aid, emergency relief, CreditLine, financial counsellor, Community Health Service, Centrelink, Community Legal Centre, Relationships Australia, self-help groups, Neighbourhood House, general practitioners, psychiatrists, psychologists, the Community Mental Health Service, GamAnon and BreakEven.

5.3 G-Line as a Referral Source to BreakEven

According to data obtained through analysis of the 1997–98 BreakEven minimal data set, the most common source of referral to BreakEven mentioned by problem gambling clients was G-Line, which contributed to the referral of one-third (37 per cent) of all new clients. Table 25 presents the sources of referral mentioned by problem gambling clients of BreakEven.

Table 25 Problem Gamblers' Source of Referral to BreakEven

Source of Referral	N (n=2456)	%
G-Line	920	37.1
Self-referral	705	28.5
Family or friends	311	12.6
Media	193	7.8
Community agency	136	5.5
Health service	74	3.0
Court order/correctional system	74	3.0
Other therapist	50	2.0
Legal service	42	1.7
Financial counsellor	33	1.3
Gamblers Anonymous	24	1.0
Other client of problem gambling service	14	0.6
Problem gambling staff	12	0.5
Self-help groups	0	0.0
Other	109	4.4

G-Line, self-referral and family and friends were also the most commonly cited sources of referral to BreakEven for partners and other clients. However, family and friends (20.6 per cent) were more likely and G-Line was less likely (26.3 per cent) to have been the source of referral for problem gambler clients than for partners and other clients of BreakEven. Table 26 details the sources of referral for partners and other clients.

Table 26 Partners' and Others' Source of Referral to BreakEven

Source of Referral	N (n=629)	%
G-Line	196	31.1
Self-referral	166	26.3
Family or friends	130	20.6
Media	46	7.3
Community agency	27	4.3
Health service	24	3.8
Court order/correctional system	16	2.5
Other therapist	15	2.4
Legal service	7	1.1
Financial counsellor	4	0.6
Gamblers Anonymous	2	0.3
Other client of problem gambling service	2	0.3
Problem gambling staff	2	0.3
Self-help groups	1	0.2
Other	23	3.6

According to data obtained through the Clinical Practice Evaluation and reported earlier in this Report (see the Referral to BreakEven from Other Services section), 43.3 per cent of clients find out about BreakEven through G-Line.

5.3.1 Reasons for Referring Callers to Services Other than BreakEven

Nine respondents indicated that they do refer clients to services other than BreakEven, even though the clients may have problem gambling counselling

needs. The main reasons given included: client requests for services they feel more comfortable with (for example they may prefer a self-help group such as Gamblers Anonymous, psychologist, hypnotherapy, etc), BreakEven services are not available locally (five responses) and if other problems are identified as being of principle concern, such as clients with psychiatric problems.

The main reasons given by respondents for why referrals *are* made to BreakEven were: to continue treatment and ongoing support where it was believed the caller could benefit from face-to-face counselling; or if the client requests a referral to specialist counselling for gambling-related problems.

5.3.2 G-Line Counsellors' Perceptions of BreakEven

Eight of the ten comments made by counsellors regarding the *relationship* between G-Line and BreakEven were predominantly positive, although some also noted that difficulties can, and do, arise. The positive comments referred to a good working relationship between the services, which was variously described as 'complementary', 'cordial', 'integrated', 'strong and supportive'.

The negative comments indicated that there can, at times, be some animosity and tension between the two services. A comment was also made that G-Line can sometimes be blamed if BreakEven is not receiving sufficient numbers of clients. A further comment referred to different issues arising from the maintenance of 'boundaries' and issues surrounding client dissatisfaction.

With regard to counsellor perceptions of the *effectiveness* of BreakEven, two counsellors felt unable to comment on the effectiveness of the service; four respondents were clearly positive; and the remaining four respondents indicated that they had heard both good and bad reports about BreakEven. However, it should be noted that an absence of positive feedback cannot necessarily be construed as indicating a problem with BreakEven services, as clients who may have been satisfied with the service may not require further assistance from G-Line.

Positive comments received from clients about BreakEven referred to the usefulness and appropriateness of the service and the good relationships formed with individual counsellors.

Negative comments referred to: problems with the initial phone call in terms of the quality of the receptionist; failure of calls to be returned; disappointment that underlying issues were not dealt with in the counselling session and the obverse of this, concern that underlying issues were focused on rather than directly addressing the gambling problem; dissatisfaction with the face to face component; the need for support between appointments; appointments being missed by counsellors; difficulties encountered in finding the right counsellor; complaints about the poor quality of the premises; and complaints about the lack of counsellors from linguistically and culturally diverse backgrounds.

With regard to the negative feedback received, it needs to be acknowledged that in some cases complaints may reflect that face-to-face counselling is simply not appropriate for certain clients. Clients more predisposed to telephone counselling may therefore hold more negative views of their experiences encountered with face-to-face counselling. A further consideration is that a client may have been assisted by a service in ways that are not immediately obvious to them, and as such, may fail to appreciate the value of a service they have received.

The following section provides the views of BreakEven counsellors on the G-Line and BreakEven service relationship.

5.4 The Relationship of G-Line to BreakEven

The information presented in this section has been obtained from the BreakEven Counsellor Survey. The purpose of this section is to examine counsellor impressions of the nature of the relationship between BreakEven and G-Line. The data were obtained from 51 interview schedules of BreakEven counselling staff. The interview schedule was devoted to 'worker perceptions regarding gambling and current service provision', and the data were obtained from counsellors' responses to three questions:

1. How would you describe the relationship of your BreakEven service with G-Line?
2. How effective do you believe G-Line is in terms of support to people phoning their service?
3. Do you believe that the service provided by G-Line is well known in the community?

5.4.1 BreakEven Counsellor Perceptions of the Relationship between the BreakEven and G-Line Services

In response to the question 'How would you describe the relationship of your BreakEven service with G-Line?' respondents tended to provide differing interpretations of the meaning of the question. Some (seven respondents) provided more of a personal perspective than organisational perspective with comments like: '[I] don't have a lot to do with them personally'. There was also a tendency to provide responses that contained the counsellor's general attitude towards G-Line rather than a specific assessment of the nature of the working relationship between the services.

However, the responses were generally favourable regarding the nature of the contact between G-Line and BreakEven. There were 26 responses (51 per cent) that were clearly positive. Comments tended to focus on G-Line being a good source of clients through referral, and a useful contact for referral for support services out of hours.

Only four respondents made negative comments. These comments referred to a lack of communication, and frustration with clients being incorrectly referred to the wrong geographical areas.

Two respondents appeared to be undecided on the nature of the relationship between the two services, and provided responses that noted both positive and negative aspects of the relationship.

Nine respondents indicated that they had little or minimal contact with G-Line, although they did not necessarily see this as negative. Some respondents seemed to believe that only limited contact was necessary. Four respondents indicated that there had been no contact at all between the two services.

The data obtained from the BreakEven Counsellor Survey indicate that counsellors generally hold a positive perception of the relationship between G-Line and BreakEven. There is also a positive attitude towards the effectiveness of G-Line as a support service for problem gamblers and regarding the level of awareness in the wider community of its role and functions. However, the data on effectiveness, although generally positive, also contained a number of concerns with the level of consistency in the quality of counselling provided.

5.5 G-Line 'Snapshot' Client Survey

The G-Line Victoria 'Snapshot' Client Survey was conducted over a one-week period between 1–7 March 1999. The main aim of the survey was to identify client impressions and usage of the G-Line service. Three researchers from the University of Melbourne Problem Gambling Research Program were based at the G-Line premises during different day and evening shifts. Counsellors used their discretion as to whether a client was suitable to be interviewed, in terms of their level of distress at the time of calling the service. The counsellor then briefed the client on the aims and objectives of the Survey, assured them of its confidentiality and passed the phone over to the researcher. The counsellor moved away from the console during the interview but remained on-call in case the client wished to be returned to the counsellor. The researcher then conducted a 10–15 minute interview with the client.

As with the disappointingly small sample size of counsellors, the sample size for the client survey was 39 respondents out of a total of 343 Victorian clients who contacted the G-Line service during the period under investigation. This sample of 11 per cent of the total callers during the week under investigation does limit the extent to which the data obtained can be useful in drawing generalisations and trends.

The client group comprised two main types, namely, problem gamblers, of which there were 32 respondents (82 per cent), and friends/relatives/colleagues of problem gamblers, of which there were seven respondents (18 per cent). These two groups were further distinguished by whether they received counselling or received information only from the counsellor.

5.5.1 Service Use

The majority of callers first found out about G-Line through community education campaigns run through television (13 respondents) and through materials distributed or on display at gambling venues. This highlights the value of community education strategies, which seek to contact their target group through their own environmental setting. For further details on this aspect see Volume 3 of this Report.

Other sources raised by 21 callers in total included advertisements in newspapers, listings in the phone

book, public transport, material in libraries and the guide to local health services. Five respondents received professional referrals from practitioners or community agencies.

With regard to problem gamblers, 79 per cent of callers were using the service for the first time, with the rest indicating that they had used the service previously. Similarly, 71 per cent of friends/relatives/colleagues were calling G-Line for the first time, with the rest indicating that they had called the service previously.

Of those callers who had indicated that they had utilised the service previously, four indicated that they had used the service on 10 to 15 occasions, while another four indicated that they had used the service one or two times previously.

5.5.2 Other Sources of Assistance Sought by Callers

The majority of problem gamblers (91 per cent) indicated that G-Line had been the only service from which they had sought help for a gambling-related problem. Only nine per cent of problem gamblers indicated that they had sought assistance elsewhere. Five friends/relatives/colleagues of problem gamblers had sought assistance elsewhere, and only two indicated that G-Line had been their only source of assistance.

Of those callers who indicated that they had sought assistance elsewhere, one indicated that they had used LifeLine, four had used Gamblers Anonymous and one had used a financial counsellor. The majority of callers (95 per cent) indicated that they had not used BreakEven; only two respondents indicated that they had used the BreakEven counselling service.

5.5.3 Client Problem Level

Callers were asked to rate their or their friend/relative/colleague's current financial position, their work life and their state of family relationships as being either very good, quite good, so-so, poor, or very poor. These ratings are summarised in Table 26.

Table 26 shows that in terms of their *current financial position*; 82 per cent of callers failed to give a clearly positive response to their financial position. The data thus suggest that clients contacting G-Line are entering a stage where their finances are less than secure.

With regard to their *current work life*, 43 per cent of respondents had a positive outlook on their current work life. However, if the ratings from very poor, poor, and so-so are combined, 57 per cent of callers did not clearly provide a positive response to the state of their current work life. This figure suggests that clients contacting G-Line are entering a stage where their problems with gambling are beginning to infringe on their work life in some way.

The ratings for the state of callers' *current family relationships* were also spread across the scale. The total of clearly positive ratings then is 54 per cent. On the other hand, a total of 46 per cent of callers who rang the service during the period under investigation did not have a strong sense of security about the state of their family relationships.

It appears then from these ratings that callers contacting G-Line are in a position where there is a level of insecurity in their lives with regard to their current financial position, their work life, and the state of their family relationships.

Table 27 Rating of the Extent of Clients' Problems According to their Current Financial Position, Work Life and the State of their Family Relationships

Rating	N	%
Current Financial Position (n=38)		
Very poor	11	29
Poor	5	13
So-so	15	40
Quite good	7	18
Very good	–	–
Work Life (n=26)		
Very poor	4	15.0
Poor	6	19.0
So-so	7	23.0
Quite good	9	35.6
Very good	2	7.7
State of Family Relationships (n=39)		
Very poor	5	12.8
Poor	5	12.8
So-so	8	20.5
Quite good	13	33.0
Very good	8	20.5

In terms of whether callers considered themselves or their friend/relative/colleague to be in a *state of crisis* when the call to G-Line was made, 33.3 per cent of callers stated that they were in a state of crisis, whilst 66.6 per cent indicated that they were not in a state of crisis. However some callers found this question a difficult one to answer because of the relative nature of the term 'crisis'. It appeared to be that 'crisis' was

seen by some to be on par with 'suicidal'. Nevertheless, the finding is an interesting one as it suggests that for two-thirds of the callers, G-Line is seen as delivering counselling by a different mode, that is, acting as a telephone counselling service, *not* as a crisis intervention service.

With regard to the *general emotional state* of callers when they rang G-Line, 28 per cent stated it was very poor, 31 per cent stated that it was poor, and 22 per cent stated that it was so-so. If these ratings are combined, 81 per cent of callers were emotionally unsettled at the time when they contacted G-Line. This finding does provide a clear sense that the majority of callers contact G-Line are in a heightened state of emotional need.

The vast majority of callers indicated that their gambling related problem was of concern to them when they contacted the G-Line service, with 58 per cent stating it was the source of a great deal of concern, and 39 per cent stating that it was the source of a fair amount of concern.

When asked the extent to which their crisis had been reduced as a result of the counselling they had received, 60 per cent of problem gamblers stated it had been reduced a fair amount, 30 per cent stated very little and 10 per cent stated not at all. The majority of callers in this survey then felt that their level of need had in some way been lessened as a result of the counselling they had received. This still leaves 40 per cent of callers who were left to some extent unsatisfied by their counselling experience.

5.5.4 Counselling Process

To understand the nature of the counselling process,[13] respondents were asked to rate several questions on therapeutic bond and therapeutic outcome. These findings are summarised in Table 28 and Table 29 below.

Table 28 Client Rating of the Therapeutic Bond with the Counsellor

Rating	N	%
Extent to which clients felt they could talk freely, openly and honestly with the counsellor about their thoughts, feelings and behaviour (n=34)		
A great deal	24	70.6
A fair amount	8	23.5
Very little	2	5.9
Not at all	–	–
Extent to which clients felt that the counsellor understood the problems facing them (n=33)		
A great deal	24	72.7
A fair amount	7	21.0
Very little	7	6.0
Not at all	–	–
Extent to which clients felt the counsellor was concerned for their welfare (n=32)		
A great deal	21	65.6
A fair amount	9	28.0
Very little	1	3.0
Not at all	1	3.0
Extent to which clients felt the counsellor respected them as an individual (n=34)		
A great deal	25	73.5
A fair amount	9	26.5
Very little	–	–
Not at all	–	–
Extent to which clients felt confident in the counsellor's ability to assist them with your problems (n=32)		
A great deal	19	59.0
A fair amount	13	37.5
Very little	1	3.0
Not at all	–	–
Extent to which clients felt the counsellor had enough knowledge to assist them with the problem (n=31)		
A great deal	17	54.8
A fair amount	11	35.5
Very little	3	9.6
Not at all	–	–
Extent to which clients felt supported by the counsellor (n=34)		
A great deal	21	62
A fair amount	12	35
Very little	1	3
Not at all	–	–

The findings on the level of therapeutic bonding overwhelmingly demonstrate a high level of client satisfaction with the counselling process. With regard to the extent that callers felt they could express themselves freely, 71 per cent stated 'a great deal'. In terms of the extent to which the counsellor was seen to understand the problems faced by the caller, 72.7 per cent stated 'a great deal'. Callers' perceptions of the extent to which counsellors were concerned for their welfare was also high, with 66 per cent stating 'a great deal'. Again, a high ratings were given for the extent to which callers felt respected by the counsellor, with 74 per cent giving a rating of 'a great deal'. Callers also clearly felt supported by the

[13] Note: Five respondents did not answer the questions regarding therapeutic bond and therapeutic outcome as they received information only.

counsellor with 87.5 per cent providing a rating of 'a great deal'.

The rating decreased a little when callers were asked to rate the extent to which they were confident in the counsellor's ability to assist them, with 59 per cent stating 'a great deal'. In terms of the extent to which callers felt that the counsellor had enough knowledge to assist them with their problem, 54.8 per cent stated 'a great deal'.

Table 29 Client Rating of the Therapeutic Outcome of the Counselling Session

Rating	N	%
Extent to which the counselling gave the client new ways of understanding their problems (n=32)		
A great deal	11	34.0
A fair amount	16	50.0
Very little	4	12.5
Not at all	1	3.0
Extent to which the counselling gave the client an understanding of the kind of changes they could make (n=32)		
A great deal	8	25.0
A fair amount	19	59.0
Very little	5	15.6
Not at all	-	-
Extent to which the counselling reduced the client's concern about their problem (n=30)		
A great deal	7	26.6
A fair amount	14	43.3
Very little	7	23.3
Not at all	2	6.6

Ratings provided by callers regarding the therapeutic outcome were a little more tentative in comparison to the responses given to the therapeutic process, which is to be expected. Likewise, the Nova Scotia Health Department study conducted by Focal Research (1998) found that when the problem gamblers in their sample sought professional help, 'they report[ed] mixed results from sources, such as Gamblers Anonymous and the Gamblers Help Line'.

In terms of the extent to which the counselling gave callers new ways of understanding their problems, 50 per cent stated 'a fair amount'. With regard to the extent to which counselling gave the caller an understanding of the kind of changes they could make, 59 per cent stated 'a fair amount'. Last, in reference to the extent to which the counselling reduced the caller's concern about their problem 43.3 per cent stated 'a fair amount'.

5.5.5 Referral Information

Apart from the counselling provided, referral information forms an indispensable part of the service provided by G-Line. Of all the callers who participated in the survey, 79.5 per cent had received referral information from counsellors. When asked how useful they thought the referral information they were given would be, the majority (54 per cent) stated 'a great deal', 39 per cent stated 'a fair amount', and seven per cent stated 'very little'. In all then, clients seem to consider the referral information they received would be useful to some extent in addressing their problems.

5.5.6 Overall Client Satisfaction

In terms of overall satisfaction with their counselling experience, 68 per cent of callers stated that they were very satisfied, 30 per cent stated that they were satisfied and two per cent stated that they had no view. It appears then that there is a very high level of client satisfaction with the counselling service currently provided by G-Line.

5.5.7 Suggestions for Improving G-Line

Twelve callers made a range of suggestions for ways to improve the service provided by G-Line:

- **Expanding the role of G-Line**, by introducing an advocacy function, providing positive reinforcement to gamblers who are making progress with their problem, introducing a self-help component, active involvement in community education programs at venues, a 'call-back' facility, and the presence of specialist legal advice.
- **Adopting an advocacy function**, by taking a role in stopping the development of gambling venues. It was thought that G-Line could develop a policy or politically oriented direction to better represent the interests of the clients it serves.
- **Providing encouragement and positive reinforcement**, by enabling clients who are making progress with their problems to ring the service to share their success, which they may be unable to do with family and friends. This would broaden the role of the service to one of positive reinforcement for achievements made rather than one of predominantly crisis intervention.

- **Introducing the self-help model**, based on the idea that problem gamblers would benefit from having the opportunity to be counselled by people who have gone through similar hardship and have successfully met the challenge. It was suggested that through the introduction of some counsellors who are reformed ex-gamblers clients could be inspired by their example.
- **Expanding G-Line's activities in the area of community development**, through community education programs at venues, especially if programs were placed within the gaming machines. This would give the gambler messages about the amount of time and money that has been spent, and suggestions that a rest period is advisable.
- **Providing a call-back option**, so that callers have the opportunity, if they wish, to leave a contact number and to access the same counsellor, as is possible with Quit Line.
- **Improving the quality of counselling** including: the need for the client to be able to express all they want to; the need for counsellors to be more understanding, supportive and approachable; the need for counsellors to ask the caller how they might be able to regain control over their lives, rather than give advice which may not be appropriate; and the need for counsellors to reassure the client that they are listening.
- **Avoiding placing callers on hold**, especially when people are feeling desperate.
- **Minimising background noise**.
- **Providing more information about the referral service**, as one caller felt a bit unclear about the nature of the service. Another client stated that the referral information was not convenient to them, with regard to the location and time of operation.

5.6 Conclusions

These findings about the G-Line service and how it relates to the BreakEven service suggest that most of the callers connect with the therapeutic process offered by G-Line. They appear, however, to be more guarded about the outcomes of the process.

There also seems to be a significant difference in understanding between G-Line staff and BreakEven counsellors as to the purpose of the G-Line service. G-Line staff, and a majority of callers, see G-Line as a *counselling* service, delivered by telephone. BreakEven counsellors see G-Line as a *referral* service and, more particularly, as a referral service for BreakEven. It follows then, that while G-Line staff consider referral to BreakEven as only one of the treatment options open to them, BreakEven counsellors view G-Line as a primary source of referral for them. This divergent understanding impacts significantly on the number and type of clients that G-Line refers to BreakEven, and therefore, our ability to assess the effectiveness of BreakEven's reach and response.

This apparent mismatch of expectations as to the role that G-Line plays and its relationship with BreakEven suggests an urgent need for the Department of Human Services to clarify what it intended the level and nature of interaction between the two services to be.

6 Survey of the Non-Problem Gambling Specialist Services Funded by the Problem Gambling Service Strategy

This section reports findings from a survey of family support and financial counselling programs not funded by the Problem Gambling Service Strategy (PGSS).

6.1 Where Problem Gamblers are Presenting

Most (89.3 per cent) of the agencies surveyed indicated that their services were being used by people whose gambling was problematic and/or the significant others of problem gamblers. As Table 30 indicates, gambling problems are being identified in non-PGSS services in all nine Department of Human Services regions. However, care is needed when interpreting this table not to infer greater problems in some regions, as the proportion of respondents from each region is reflective of the regional distribution for the first mailout.

Almost half of these agencies (43.1 per cent) had data collection systems that enabled identification of gambling-related problems. Agencies that could readily identify clients with issues associated with gambling (98.1 per cent) were significantly more likely to be aware of having clients with gambling issues than agencies that do not record this data (82.6 per cent) ($\chi^2(1)=7.40$, $p<.01$).

What we do not know is whether people with gambling problems are more likely to present to those services that keep statistical information about gambling issues. While it is possible that agencies have begun to collect statistical data about problem gambling because they have identified this as an issue that affects a proportion of their clients, it is equally plausible that counselling staff in agencies that have decided to collect data are more attuned to problem gambling as an issue and hence more likely to probe for the existence of gambling-related issues.

Table 30 Non-Problem Gambling Specific Programs at which Problem Gamblers and Others Affected by Problem Gambling Attend: Number by Department of Human Services Regions

Region	Programs with Problem Gambler Clients	Programs without Problem Gambler Clients	Total Respondents
Eastern	25	2	27
Northern	16	3	19
Southern	16	1	17
Western	15	0	15
Barwon South West	7	1	8
Gippsland	8	0	8
Grampians	8	1	9
Hume	9	4	13
Loddon Mallee	4	1	5
Total	108	13	121

The identification of gambling issues may also be affected by staff training. Whereas half (50.5 per cent) of the agencies that identified problem gambling-affected clients had provided staff with specialist training on gambling issues, only one agency (8.3 per cent) that claimed not to have clients affected by gambling had provided such training.

Problem gambling issues arise in a wide variety of programs offered by community agencies. Of the 108

responding agencies that indicated they had contact with people affected by gambling, 102 provided information concerning the programs at which these individuals presented. This information is presented in Table 31.

Table 31 Programs Where Gambling Issues Arise in Non-Problem Gambling Specific Funded Services (n=102)

Program Type	Number of Programs
Family support/family counselling	65
Financial counselling	53
Problem gambling counselling	25
Emergency relief/material aid	21
Housing/accommodation	13
Crisis intervention	4
Alcohol and drug treatment	4
In-home support	4
Domestic violence	3
Social work	3
Mediation	2
Mental health service	1
Legal service	1
Ethno-specific service	1
Medical	1
Community education programs	1
Other	13

In a study of agencies that are funded to provide family support and/or financial counselling services, it is not surprising that gambling issues are most likely to arise in these particular programs. Low numbers of clients presenting with gambling issues in other program types may simply reflect the range of co-located programs within an agency and it may be that surveys of agencies that provide the other services listed would identify several clients with gambling problems.

In non-Problem Gambling Specific funded services at which problem gambling has been identified, the proportion of clients attending who have gambling issues ranges from less than one per cent to 100 per cent, with a mean of 12.7 per cent (SD=16.9). This range is presented in Table 32.

Table 32 Non-Problem Gambling Specific Funded Agencies that have Identified Clients with Gambling Issues: Actual or Estimated Percentage of Clients with Gambling-Related Problems

Percentage of Clients	Number of Respondents	Percentage of Respondents
Under 5	26	27.5
5–10	38	40.1
11–15	9	9.5
16–20	8	8.5
21–25	3	3.2
26–30	4	4.2
Over 30	7	7.5
Total	95	100.0

Having a high proportion of clients who are identified as having gambling issues does not necessarily mean these agencies are duplicating the work of BreakEven. As previously discussed, BreakEven clients typically have many problems for which they seek assistance.

The demand for services at these agencies in late 1997 by people affected by problem gambling was perceived to be increasing (50.0 per cent) or at about the same levels as in late 1996 (47.8 per cent). Only 2.0 per cent of agencies that worked with people affected by problem gambling felt demand had decreased over that time. This increased demand is consistent with an increase of 37 per cent in the number of BreakEven clients between 1995–96 and 1996–97.

6.1.1 Agencies at which Problem Gamblers are Not Presenting

The 13 agencies that were not aware of clients presenting with gambling-related problems were asked for the reasons why they believed such clients were apparently not attending their agency. Eight indicated that problem gambling just was not presenting itself as an issue, though this could be an artefact of the way client-related data are collected, for example no category for identifying this exists in their data system. Only one rural agency considered that gambling was not a problem in their community.

6.2 Access to BreakEven Services

Irrespective of whether problem gamblers were using their service, respondents were asked whether they perceived any barriers that might restrict their clients from using BreakEven problem gambling counselling services. The accessibility of problem gambling counselling was an issue for 13 respondents,

especially those in rural areas where the current part-time availability of a local BreakEven counsellor was considered inadequate. There may well also be untapped need for gambling counselling in country areas where there is no BreakEven service, as it cannot be assumed that clients can travel to where the counsellors are located. As one respondent noted 'travel and distance can be an issue as there is no public transport available'.

While distance is important, it is only one of several factors that affect client access to services (Crisp, 1998). In the case of problem gambling counselling services, eight respondents from non-PGSS funded services considered that more education, promotion and/or information dissemination is required:

> More education is needed so people feel okay about accessing the services. We think that we probably see a lot of people who tend to hide their gambling difficulties—particularly women. Group work/self-help/child-care is needed.
>
> Appears to be an ongoing need for TV advertising—so that those recognising need for support are able to be linked directly to the appropriate service.
>
> A more proactive/outreach approach would result in greater utilisation [of problem gambling counselling services].

A small minority (four respondents) considered that the perceived philosophy underpinning BreakEven could act as a disincentive to people with gambling issues requiring support. For example, it was suggested that:

> …some gamblers do not like the BreakEven principle of controlled gambling and want to give it up completely.

Such comments indicate that some respondents were unaware that a harm minimisation approach can include abstinence if that is a client's chosen goal (Heather and Tebbutt, 1989).

Native speakers of English may be slightly over-represented at BreakEven. The 85.3 per cent of BreakEven clients in 1997–98 who reported English as the language they spoke at home is higher than the 79.2 per cent of Victorians aged five years and over at the 1996 Census who spoke a language other than English. However, as these two sets of data do not collect identical information, the differences are possibly more apparent than real. Nevertheless, the non-PGSS funded agencies were asked about the perceived access to BreakEven services for clients whose first language is not English. Almost half (42.6 per cent) of those who answered this question indicated one or more issues that they felt needed addressing. These barriers to service are listed in Table 33.

Table 33 Non-Problem Gambling Specific Funded Services: Barriers Identified to Accessing Problem Gambling Counselling Services for Clients whose First Language is Not English (n=92)

Barrier	Number of Respondents	Percentage of Respondents
Cultural reasons	15	16.3
Access to interpreters	11	12.0
Understanding role of service or options	10	10.9
Stigma, re: mental illness or failure	9	9.8
Lack of bilingual workers	7	7.6
Unavailability of BreakEven counsellors	4	4.3
Discussing personal issues via interpreters	2	2.2
Other	12	13.0
None	8	8.7
Don't know	8	8.7
Not an issue/not applicable	34	37.0

Of the respondents who replied to this question, 37 per cent did not consider barriers for clients whose first language was not English to be an issue or applicable to their agency. The most commonly cited issues that were thought to act as barriers to NESB clients were: cultural reasons, access to interpreters, understanding of the role of the service or options available and community stigma in relation to mental illness or failure.

The 'other' category included such responses as: the opinion that counselling services should be in ethno-specific agencies, fear of protective involvement in child neglect issues by service users, an ethic of not seeking help outside the family and extended family group, generational issues, feelings of alienation from formal processes, lack of gambling education on the television, the cultural issue of the head of the house/father having a gambling problem and other family members feeling powerless to access any income for basic needs, and unconventional methods of borrowing that make it difficult for workers to negotiate on behalf of service users.

Although fewer than half of the respondents for this study indicated specific barriers to service, more than three-quarters (78.3 per cent) identified measures, which if implemented, they believed would result in increased usage of problem gambling counselling services by NESB individuals, with the most prominent measure being greater use of promotional materials in languages other than English. Their suggestions are listed in Table 34.

Table 34 Non-Problem Gambling Specific Funded Services: Measures Suggested to Increase Usage of Problem Gambling Counselling Services by Clients whose First Language is Not English (n=92)

Measure	Number of Respondents	Percentage of Respondents
Promotional materials in languages other than English	37	40.2
More counsellors who speak languages other than English	21	22.8
Outreach work through ethnic specific agencies	17	18.5
Greater access to interpreters	8	8.7
Culturally sensitive service provision	6	6.5
Cross-cultural training of problem gambling counsellors	3	3.3
Placing problem gambling counsellors in ethno-specific agencies	1	1.1
Increased accessibility of BreakEven workers	1	1.1
Other	17	18.5
Not applicable	20	21.7

Some of the 'other' suggestions as to how increased use of problem gambling services may be achieved were as follows:

- Multilingual workers employed who may not have educational qualifications due to rurality and a lack of access opportunities. Support workers to obtain educational qualifications—access for clients.
- Education in school re the consequences of gambling. Enforce age rules in gambling venues. Make gambling less available and less promoted.
- Shopfront agencies that offer other services to people of NESB like sensitive community aid bureau.
- Improve intake procedures to BreakEven counsellors.
- Counselling within our home.
- More research needed—different models of counselling need to be developed.
- Training of TIS (Telephone Interpreting Service) staff in gambling related issues.
- Conduct groups of similar language and an interpreter with the facilitator.

Since this study was completed, each Department of Human Services region has tendered with one or more community agencies to provide Innovative Service Models for Non-English Speaking Background Communities Experiencing Problem Gambling and Financial Management Difficulties, although it should be noted that in five regions, this will be provided in part or completely by one of the mainstream BreakEven services. As these additional services come on stream, we will be able to determine the extent to which they are successful in overcoming some of these perceived access barriers.

Apart from people from a non-English speaking background, older people and small business people with gambling-related debts were identified as groups in the community who may not be particularly well served by BreakEven services as they are currently operating.

While it is clear that those involved in financial counselling and family support work identified a number of factors which may impinge on potential clients' ability to access services, there was nevertheless some acknowledgment that irrespective of how the service was delivered, many individuals who would clearly benefit from them would not contact a problem gambling counselling service:

> I think the services that are provided for gambling are comprehensive and relevant, however, I find it difficult to encourage people to go to them as they are often in denial about the problem.

6.3 Relationship between BreakEven and Other Agencies

Coordination and cohesion of service delivery between programs was raised as an issue by nine respondents. In particular, it was felt that greater coordination was required between problem gambling and financial counselling services. Respondents from both financial counselling and family support agencies raised this concern. One respondent proposed that a problem gambling counsellor be required to form part of a family support team. Nevertheless, almost one third of

respondents reported that they had referral arrangements with BreakEven. Nine per cent of respondents reported having referral management arrangements with a financial counselling service and eight per cent noted arrangements with a 'problem gambling counsellor' (which could include BreakEven). Table 35 outlines these referral management arrangements.

Table 35 Non-Problem Gambling Specific Funded Agencies: Arrangements for Management of Referrals Involving Gambling Issues (n=105)

Referral Management Arrangements	Number of Respondents	Percentage of Respondents
Referral to/arrangements with BreakEven	33	31.4
Referral to/arrangements with financial counsellor	10	9.5
Referral to/arrangements with problem gambling counsellor (may include BreakEven)	9	8.6
Referral to other services as necessary	9	8.6
Client encouraged to/must refer themselves	7	6.7
No sharing of information without client's permission	3	2.9
Referral to G-Line	2	1.9
Referral to/from Gamblers Anonymous	2	1.9
Arranged at case management	2	1.9
In process of developing formal protocols	2	1.9
Cross-referral within agency	2	1.9
Arrangements with psychiatric services	1	1.0
Arrangements with legal service	1	1.0
Referral to counsellors/psychologist	1	1.0
Other	15	14.3
None	15	14.3
No formal arrangements	12	11.4
Not applicable	6	5.7

Although somewhat less common than referral protocols, 15% of respondents reported having arrangements for joint case management with BreakEven services. Further details of these are provided in Table 36.

Table 36 Non-Problem Gambling Specific Funded Agencies: Arrangements for Joint Case Management with BreakEven (n=93)

Joint Case Management Arrangements	Number of Respondents	Percentage of Respondents
Arrangements with BreakEven	14	15.1
Arrangements made on case by case basis	9	9.7
Internal case management referrals	5	5.4
Currently drafting formal protocols	4	4.3
Via case management meetings with other agencies	4	4.3
Joint case management meetings require client participation	3	3.2
Formal arrangements invoked when several agencies involved	1	1.1
Other	11	11.8
None in relation to gambling specifically	10	10.8
No formal arrangements	28	30.1
Not applicable	17	18.3

6.4 Resourcing of Other Agencies to Deal with Gambling Issues

Five respondents considered that financial counselling services needed greater resourcing to meet the needs of people with gambling-related issues, while one noted the extra demand being placed on emergency relief services. As one respondent noted, it is:

> …ridiculous that financial counselling has received only a modest increase in the funding of hours of service in Victoria and that their clients can wait anywhere for two to six weeks for a first appointment.

Similar concerns were held by respondents from family support agencies:

> …lack of resources in allied services to adequately deal with gambling issues.

Approximately 14 per cent of all respondents in this survey of family support and financial counselling programs considered that more generalist, holistic services were required to meet the needs of people with gambling issues. This would involve training workers not specialising in this area, including financial counsellors, in order to identify gambling issues when they are present in clients accessing their programs.

6.5 Conclusions

The majority of agencies, across the nine Department of Human Services regions, funded as non-specialist problem gambling services by the Problem Gambling Service Strategy nonetheless identified that they see people they define as problem gamblers or as significant others of problem gamblers. Furthermore, there appears to be some correlation between the agencies that have data collection systems that recognise gambling-related problems and those that are aware of having clients with such problems. A similar correlation is evident in the agencies that provide staff with specialised training in gambling issues. More data are required before a judgment can be made as to what this greater awareness among some agencies means for service planning and funding.

The survey results show that people with gambling-related problems are presenting to a wide range of family support and/or financial counselling services. This further strengthens the suggestion already made earlier in this Report that a greater number and broader variety of agencies may need to be targeted or continue to be targeted for information about identifying and treating problem gambling. In addition, greater cohesion and coordination of service delivery between programs was seen as a priority by a number of these agencies.

These agencies themselves also identified a number of barriers they perceived to their clients accessing designated problem gambling counselling services. Not surprisingly, the list of barriers they noted is similar to that compiled by BreakEven counsellors, provided earlier in the report. However, a small number of these non–Problem Gambling Specific agencies suggested that the BreakEven philosophy, as they understood it, of controlled gambling, was a deterrent to those gamblers who were seeking to cease gambling. They also added older people and small businesspeople to the list of groups within society that need targeted information about the sources of help for gambling-related problems.

Further research would therefore seem warranted as to the extent to which the clients presenting to these non-designated problem gambling counselling services perceive their gambling behaviour as a secondary problem, or symptom, of a more critical, primary problem. This may explain why they have accessed these agencies, as opposed to BreakEven or G-Line. Conversely, it may be that those who access BreakEven or G-Line may consider their gambling to be their main problem, or the cause of any of their other problems, which is why they accessed these services. A greater understanding of this relationship between perceived hierarchy of need and order of services accessed would assist in identifying what type of information needs to be targeted at what type of people and agencies. It would also provide an insight into the contribution the PGSS is making to reach the wider pool of potential problem gamblers.

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Appendix A: List of the Therapeutic Techniques and Strategies Employed by BreakEven Counsellors

Note: Where a number appears in a bracket, this denotes use of the therapeutic strategy by that number of people within the particular agency. Where no number appears, this denotes use of the strategy by one person only. The number which appears with the agency name, indicates the number of workers from that particular agency who stated the specific therapeutic strategies used in counselling with problem gamblers.

Victorian Relief Committee (1)

- Problem solving skills training.
- Role playing.
- Summarising.
- Progressive muscle relaxation (tape).
- Imaginal desensitisation.
- In-vivo exposure.
- Education (handouts, diagrams).
- Assertiveness training.
- Reframing.
- Time management training.
- Cognitive behavioural therapy.
- Immediacy.
- Advice giving.
- Urge control through delaying gratification.
- Metaphors/analogies.
- Challenging irrational beliefs.
- Interpretations.
- Reflective listening.

Salvation Army (2)

- Identification of socio-biological changes.
- Imaginal desensitisation.
- Relaxation procedures.
- Allowing clients to "vent".
- Confrontation.
- Paraphrasing/summarising.
- Immediacy.
- Advice giving.
- Feedback.
- Reflective listening.
- Metaphors.
- Narrative approach.
- Solution focused therapy.
- Eye movement desensitisation.
- Exploration of family, cultural, value and belief systems.
- Imaginal rehearsal.
- Hypnosis.
- Problem solving strategies/training.
- Reframing.
- Reflection of meaning.
- Attending behaviours (i.e. microskill based).
- Silences.
- Interpretation.
- Role playing.
- Education/information provision.
- Rapport building.
- Knowing client as a whole person.
- Motivational interviewing.
- Cognitive behavioural therapy.
- Challenging.
- Hypnotherapy.

Maroondah Social and Community Health Centre (6)

- (4) Reflective listening.
- (2) Imaginal desensitisation.
- couples counselling.
- Reframing to highlight client strengths.
- Creating new narratives that are more accurate to the clients struggle.
- Observational tasks. For example, to observe the behaviour of other gamblers.
- (2) Behavioural tasks. For example, to gamble in certain ways.
- (2) Cognitive behavioural therapy. For example, to challenge unrealistic thoughts.
- Interpretations. For example, to linking gambling to everyday stresses.
- (2) Education. For example, about how pokies work.
- Identifying positive small changes to build on.
- Exposure therapy.
- Positive imagery techniques.
- Unconditional regard.
- Circular questioning.
- Relaxation.
- Self-talk.
- (2) Use of humour.
- Gestalt techniques.
- (3) Use of G-MAP.
- Allowing clients to "vent".
- (2) Paradoxical interventions.
- Keeping diary.
- Creating awareness of interactions within the family and social environment in order to create opportunities for change.
- (2) Role-playing.
- Coaching techniques including rewards for positive progress based on transference.
- Motivational techniques.
- Scaling questions.
- Miracle questions.
- Empty chair, paper, white-board.
- Provision of information.
- Modelling of non co-dependent relationships.
- Supportive counselling.
- Confrontation when appropriate.

Banyule Community Health Service (3)

- Positive connotations. For example, "you are a man who enjoys challenges."
- (2) Reflective listening.
- Conversation which normalise a person's situation.
- Milan style conversation with couples.
- Provision of information about useful thinking. For example, "I must not gamble".
- Questions about the future.
- Family of origin work.
- Decisional balance.
- Progressive muscle relaxation.
- Relaxation induction.
- Monitoring feelings, thought, behaviours.
- Challenging irrational beliefs.
- Role-playing.
- Questionnaires where appropriate.
- Miracle questions.
- Didactic presentation.
- Solution focused therapy.
- Systematic therapy.

Brimbank Community Health Service (6)

- (4) Reflective listening.
- (2) Confrontation.
- Role-playing.
- (3) Action techniques.
- Purpose focus therapy.
- Empty chair.
- (4) Reflective team work.
- (3) Role reversal.
- Cross-cultural counselling.
- (4) Circular questioning.
- Art therapy & techniques.
- Reframing.
- Externalising the problem.
- Challenging the victim.
- (2) Narrative therapy.
- (2) Solution focus therapy.
- (2) Neutrality.
- Systemic therapy.
- Cognitive behavioural therapy.
- Ritualisation with couples.
- Family therapy.
- Mirroring.
- Positive connotations.
- (2) Writing clients stories.
- Relabelling.
- Chain reversal.
- Provocative therapy.
- (2) Motivational intervening.
- (2) Purpose focus.
- Paying attention to small change.
- Psychodrama.

- Coaching.
- Education.
- Goal setting.
- Encourage clients to be aware of their own "self-tricking thinking".
- Transactional analysis.
- Gestalt therapy.
- Single session therapy.

East Bentleigh Community Health Centre (9)

- (2) Imaginal desensitisation.
- Free association.
- (2) Interpretation.
- Encourage differentiation between thoughts and feelings.
- Active listening.
- (2) Meditation training.
- (5) Relaxation training.
- (2) Motivational interviewing.
- (2) Reframing.
- Analogies.
- Present centred approach.
- Client centred listening and clarifying.
- (2) Connecting stories back to the clients experience and to the present situation.
- Gestalt role-play experiment: two chain work.
- (2) Breaking down language to further clarify an experience. i.e. "What is an urge?".
- Developing skills e.g. communication, assertiveness, problem solving.
- Directives.
- (2) Self-monitoring e.g. keeping a diary.
- Tracking for news of difference.
- Eliciting concerns, normalising, depathologising.
- Awareness training to allow clients to track their own processes.
- (2) Training in active listening.
- Create a place of support, respect and safety.
- Offer self exclusion from venues strategy.
- Limit access to funds.
- Supportive psychotherapy.
- Miracle question.
- Guided imagery.
- Objective construction.
- Empty chair work.
- Free association.
- Harm minimisation strategies.
- (8) Empathy skills:
  - (8) Reflective listening.
  - Understanding, normalising feelings.
  - Identifying feelings.
  - Working on counsellor relationship.
  - Conveying hope.
  - Encouraging motivation.
  - Focusing on strengths.
  - Encouraging positive behavioural change.
  - Identifying underlying conflict issues.
  - (4) Offering support, exploration, education.
  - (2) Confrontation.
- Teaching gambling strategies:
  - Responsible gambling.
  - Controlling cash/limit setting.
  - Using motivational/positive self-talk.
- (3) Cognitive behavioural therapy:
  - (2) REBT.
  - Cognitive restructuring.
  - (4) Exploring habits of thought and behaviours. i.e. irrational thoughts.
- Discuss alternative activities to gambling.
- Client self-monitoring.
- Self-talk.
- Enhancing self-image.
- Developing supportive networks.
- Relapse prevention.
- Self-help material to read.
- Homework setting.
- Provide strategies for non-gambling family members.
- Assisting the client with rewarding.
- Encourage the client to tell their story.
- Completion of genogram.
- Evaluate the main issues.
- Discuss how to manage each issue.
- (2) Create contract, plan and commit to goals.
- Family therapy technique.
- (4) Role playing.
- Gestalt therapy techniques.

Bethany Family Support (2)

- Counselling microskills.
  - (2) Reflective listening.
  - Maintaining congruence.
  - Reframing.
- Cognitive behavioural techniques.
- (2) Use of diary.
- Emotional release techniques.
- Solution focused.
- Circular questioning.
- Use of A, B, C model.
- Genograms, ecomap, time lines.

- Relaxation activities.
  - Scripts.
  - Tapes for home use.
- Imaginal Desensitisation.
- In-vivo desensitisation.
- Challenging irrational beliefs catastrophising.
- Solution focused therapy.
- Relationship counselling techniques.
- Family therapy systems strategies.
- Relapse prevention strategies.
- Decisional balance sheet.
- Exploring consequences of behaviour.
- Metaphors.
- Motivational interviewing.
- Narrative techniques.
- Scaling technique with moods.
- Modelling.
- Exploring options and choices.
- Exploring costs and benefits of gambling.
- Explore times when there was no problem.

Western Region Alcohol and Drug Service (1)

- Consciousness raising e.g. "Why do I gamble?".
- Stimulus control e.g. coping with the urge to gamble.
- Pragmatic relief; allowing clients to express feelings, grief, and loss.
- Assertiveness training.
- Communication skills training.
- Continued use of summarising.
- Imagery.
- Rehearsal.
- Role-playing.
- Relaxation training.
- Positive self-talk training.
- Positive self-talk training.

Anglicare Gippsland (5)

- (2) Identifying how clients have "learned" to behave when they experience anxiety.
- Helping clients become aware of the processes of experiencing anxiety.
- Imagery.
- Helping clients understand and change the way they react to stressful situations.
- (3) Use of micro-skills.
- Unconditional positive regard.
- Stress management, empathy.
- (3) Relaxation techniques.
- Visual strategies: genograms, eco-maps, family systems.
- Change processes.
- (4) Reflective listening.
- Circular questioning.
- Keeping diary.
- Self-exclusion form gambling venues.
- Encourage clients to have conjoint counselling.
- (3) Visualisation.
- (2) Metaphors.
- (2) Reframing.
- Transference.
- Behaviour modification techniques.
- Cognitive behavioural therapy:
  - (2) Challenging irrational thoughts and behaviours.
  - Cognitive restructuring.
- Anxiety management.
- Education.
- (2) Ratings schedules.
- Role-playing.
- Modelling.
- Nutrition management.
- Deconstructive questioning.

Relationships Australia (2)

- Crisis management.
- (2) Motivational counselling/interviewing.
- Provision of self-help information.
- Referral to financial counsellor.
- Relationship counselling.
- Improving communication and conflict management skills.
- Strengthening clients sense of self and sense of power.
- (2) Reflective listening.
- Reframing.
- Teaching skill acquisition.
- Modelling.
- Psychodynamic therapy.
- Questioning.
- Empowering.
- Active listening.
- Probing, summarising, challenging.
- Problem solving.
- Role-playing.

Palm Lodge (1)

- Reflective listening.
- Empathising.
- Encouraging.
- Basic understanding.
- Educating.

- Narrative therapy.
- Externalising.
- Demystification of the process.
- Appropriate use of humour.
- Timing.
- Grounding.
- Black and white model e.g. goal setting.

Upper Hume Community Health Service (1)

- Finance management.
- Teach stress management techniques.
- Reflective listening.
- Applied systems therapy.
- Family therapy.
- Narrative style therapy.
- Solution focused therapy.
- Reframing.
- Externalising.
- Find exceptions to the dominant plot.
- Develop the clients landscape of action and identity.
- Help clients re-story their lives.
- Develop a stronger sense of self.
- Circular questioning.
- Use of genogram.
- Map/territory split.
- Use of metaphors.
- Cognitive behavioural therapy.
- Communication and assertiveness training.
- Teach stress management.
- Relaxation techniques.
- Provide reading material.

Goulburn Valley Community Health Service (1)

- Reflective listening, reframing, summarising.
- Empathy techniques including:
  - Probing.
  - Attending to body language.
  - Attending to other non-verbal communication.
  - Maintain unconditional acceptance of the client
  - Non-judgemental attitude.
  - Open-ended questions.
- Get clients story and interests.
- Generate options.
- Address contradictions.
- Guided visualisation.
- Progressive muscle relaxation.
- Controlled breathing.
- Positive affirmations.
- Information/education.
- Discourse analysis.
- Challenge when appropriate.
- Identify motivation.
- Immediacy and transference.
- Goal setting.
- Brainstorming.
- Miracle question.
- Role-playing.

Bendigo Community Health Service (1)

- Reflective listening.
- Motivational interviewing.
- Role-playing.
- Assertiveness training.
- Use of metaphors.
- Challenging.
- Anger management.
- Cognitive behavioural therapy.
- Solution focused therapy.
- Visual representation.
- Relaxation techniques.

Mallee Family Care

The Mallee Family Care worker did not respond to the question regarding specific therapy techniques used in BreakEven counselling.

Appendix B (Part 1): G-Line Evaluation Instructions for Researchers

Victorian G-Line Evaluation

Background

The Victorian G-Line Evaluation is being conducted through the University of Melbourne as part of the Problem Gambling Research Program. This Program has been an extensive 3-year study, which has sought to examine problem gambling counselling services, community education strategies and information products in Victoria.

In order to evaluate the effectiveness of Victorian G-Line operations a 'snap shot' survey will be conducted over a one-week period from 8.00 am to midnight from 1/3/1999 to 7/3/1999. Three researchers will be involved in the Survey; one researcher will be based at the premises at a time. Two surveys will be conducted, a client survey and a counsellor survey.

Client Survey

The Client survey will seek to identify the impressions and usage of the service through the use of a questionnaire to be administered at the conclusion of each counselling session.

Counsellor Survey

A survey will also be conducted of G-Line counsellors over the same period. Counsellors will be given questionnaires to fill in and return them in supplied, reply paid envelopes by Wednesday 10 March. Researchers on duty are to answer any questions counsellors may have or be referred on to Yasmine Fauzee (please only give BH contact phone number as provided below).

Time Period

The survey will be conducted over a one-week period beginning on Monday 1/3/1999 and will end on Sunday 7/1/1999.

Time Schedule

See attachment already provided

Location

Level 3
21 Victoria Street
Melbourne

Please note that the details of the location are to be kept *confidential*, as they are not publicly available.

Ms Kate Earle
G-Line National Director
Phone: 9663 7677
Fax: 9662 4677

Transportation

For evening shifts taxis can be provided if required. Researchers need to make their own bookings and pay the charge up front. Please obtain a receipt and you will be reimbursed through the Problem Gambling Research Program.

Procedure

There will be one Researcher based at the premises per shift. The Researcher on duty will be required to conduct client interviews and answer any questions which counsellors may have regarding the counsellor survey questionnaire.

Client evaluation

At the conclusion of a counselling session the counsellor will pass on the phone to the Researcher to begin the interview.

At the beginning of the interview the Researcher should:

- Thank the client for their agreement to participate in the Survey.
- Check that the client has not already been surveyed during the week, if they have already been surveyed they will not be required to participate a second time.
- Check that they are Victorian clients, if they are not Victorian they are not required to participate in the survey.

During the interview:

- Because clients have just received counselling and may be already stressed it is essential that the interviewer be gently spoken, friendly, calm and supportive in tone when speaking with the client.

At the conclusion of the interview the Researcher should:

- Thank the client for their participation.
- Ask whether they would like to be passed back on to the counsellor.

Research Instrument

There will be 3 versions of the questionnaire designed for the following client types:

(i) Problem gamblers, and friends/relatives of problem gamblers who received counselling.
(ii) Problem gamblers, and friends/relatives of problem gamblers who have received information only.
(iii) Professional inquiries from agencies.

Each version will be similar in content and adapted to the different client types. The questionnaires are currently being refined in cooperation with G-Line. Attached is the current version 23/2/99 for (i) above. Multiple copies of the questionnaires will be kept on the premises in Kate Earle's office.

Form A
For G-Line Counsellor to Complete

Victorian G-Line Evaluation
The Problem Gambling Research Program, the University of Melbourne

'G-Line is currently being evaluated for its effectiveness. We are asking if clients would be willing to participate in a short interview over the phone with a researcher at the conclusion of the counselling session. All information obtained will be treated with strict confidence. You need not provide any personal details, and need only answer questions you feel comfortable to answer. At the conclusion of the interview the Researcher will ask if you would like to be put back on to me. Would you like to take part in the study?'

(i) 'Have you been surveyed previously through this service this week?'

Yes
`Thank you for your participation. You will not be required to be interviewed a second time.'

No
↳ Go to (ii)

(ii) Are you Victorian?

Yes
Please fill out the following information and pass this form and the client onto the researcher. Thank you.

No
'Thank you for your interest. You will not be required to be interviewed as the Survey is only looking at Victoria.'

Client Information

Please record the following details about the client and then pass the form and client onto the Researcher.

Client Call Number:

Gender:

Age:

Employed/unemployed:

Identity:

Nature of call:

Reason for call:

Form B
For researcher to complete

Victorian G-Line Evaluation
The Problem Gambling Research Program, the University of Melbourne

'Thank you for agreeing to participate in this Survey. This survey has been designed to evaluate the effectiveness of the G-Line telephone counselling service in order to ensure it meets the needs of its clients. All information you provide will be treated in strict confidence and used to assist in improving G-Line.'

I. Ascertaining Client Type

(a) Do you personally have a gambling related problem?

Yes
└► Go to (d)

No
└► Go to (b)

Note: use questionnaire 1.

(b) Are you a friend, relative or colleague of someone who has a gambling related problem?

Yes
└► Go to (d)

No
└► Go to (c)

Note: use questionnaire 2.

(c) Are you making an inquiry on behalf of a client?

Yes
└► Begin interview

No
└► Go to (g)

Note: use questionnaire 3.

(d) Did you receive counselling?

Yes

No
└► Go to (f)

(f) Did you receive information only?

Yes
└► Begin interview

No
└► Please describe the type of assistance you received.

Note: omit questions 9 & 10.

(g) What was your reason for contacting G-Line?

Note:

- If a client type emerges which we have not foreseen please use your judgement on how to proceed and contact Yasmine during normal working hours to arrange for an adapted questionnaire.
- **Please ensure that this form is attached inside the questionnaire cover with the paper clips provided.**

Appendix B (Part 2): G-Line Client Evaluation Survey

I. Service Use

1. How did you find out about G-Line?

2. Is this the first time you have used G-Line?

   Yes

   No
   ↳ How many times have you used G-Line in the past?

3. Is G-Line the only service that you have sought help for a gambling related problem?

   Yes

   No
   ↳ Where else have you sought help?

4. Have you ever used a Break Even Problem Gambling Counselling Service?

   Yes

   No

II. Problem Level

5. We are interested in knowing the extent of people's problems when they contact G-Line. Please answer the following questions.

Statement	Very poor	Poor	So-so	Quite good	Very good
How would you describe your current financial position?	1	2	3	4	5
How would you describe your work life?	1	2	3	4	5
How would you describe the state of your family relationships?	1	2	3	4	5
How would you describe your general emotional state when you rang today?	1	2	3	4	5

6. How would you describe the extent to which your gambling related problems were of concern to you at the time when you rang this service?

   A great deal A fair amount Very little Not at all

7. When your rang this service would you describe yourself as being in a state of crisis?

   Yes No

   ↳ Proceed to question 8.

---

8. To what extent has your crisis been reduced as a result of the counselling you received?

   A great deal A fair amount Very little Not at all

III. Counselling Process

Note for Researcher: Omit questions 9 and 10 below for clients which received information only from the counsellor.

9. Therapeutic Bond

(a) 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 Very little Not at all

(b) To what extent did you feel that the counsellor understood the problems facing you?

A great deal A fair amount Very little Not at all

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

A great deal A fair amount Very little Not at all

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

A great deal A fair amount Very little Not at all

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

A great deal A fair amount Very little Not at all

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

A great deal A fair amount Very little Not at all

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

A great deal A fair amount Very little Not at all

10. Therapeutic Outcome

(a) To what extent did the counselling give you new ways of understanding your problems?

A great deal A fair amount Very little Not at all

(b) To what extent did the counselling give you an understanding of the kind of changes you could make?

A great deal A fair amount Very little Not at all

(c) To what extent did the counselling reduce your concern about your problem?

A great deal A fair amount Very little Not at all

11. Referral Information

(a) Did you receive referral information?

Yes
↳ Go to (b)

No
↳ Go to question 12.

(b) How useful is the referral information you were given?

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

12. Overall how satisfied were you with your counselling experience?

Very satisfied | Satisfied | No view | Dissatisfied | Very dissatisfied

IV. Suggestions for Improving G-Line Service

13. Do you have any suggestions on how the G-Line service could be improved?

_____

_____

Thank you very much for your help with this survey. Would you like me to put you back on to the counsellor?

G-Line (Victoria)
Client Evaluation Survey
Questionnaire No. 2
Relatives, Friends or Colleagues of Problem Gamblers

The Problem Gambling Research Program
School of Social Work
The University of Melbourne, Australia
March 1999

I. Service Use

1. How did you find out about G-Line?

2. Is this the first time you have used G-Line?

   Yes No

   ↳ How many times have you used G-Line in the past?

3. Is G-Line the only service that you have sought help for your relative, friend or colleagues gambling related problem?

   Yes No

   ↳ Where else have you sought help?

4. Have they ever used a Break Even Problem Gambling Counselling Service?

   Yes No

II. Problem Level

5. We are interested in knowing the extent of people's problems when G-Line is contacted. Please answer the following questions about your relative, friend or colleague.

Statement	Very poor	Poor	So-so	Quite good	Very good
How would you describe their current financial position?	1	2	3	4	5
How would you describe their work life?	1	2	3	4	5
How would you describe the state of their family relationships?	1	2	3	4	5
How would you describe their general emotional state when you rang today?	1	2	3	4	5

6. How would you describe the extent to which their gambling related problems were of concern to you at the time when you rang this service?

   A great deal A fair amount Very little Not at all

7. When your rang this service would you describe your friend, relative or colleague as being in a state of crisis?

   Yes No

III. Counselling Process

Note for Researcher: Omit questions 8 and 9 below for clients which received information only from the counsellor.

8. Therapeutic Bond

(a) 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 Very little Not at all

(b) To what extent did you feel that the counsellor understood the problems facing you?

A great deal A fair amount Very little Not at all

(c) To what extent did you feel the counsellor was concerned for your friend, relative or colleagues welfare?

A great deal A fair amount Very little Not at all

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

A great deal A fair amount Very little Not at all

(e) To what extent did you feel confident in the counsellors ability to assist you with your friend, relative or colleagues problems?

A great deal A fair amount Very little Not at all

(f) To what extent did you feel the counsellor had enough knowledge to assist you with your friend, relative or colleague's problem?

A great deal A fair amount Very little Not at all

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

A great deal A fair amount Very little Not at all

9. Therapeutic Outcome

(a) To what extent did the counselling give you new ways of understanding your relative, friend or colleagues problems?

A great deal A fair amount Very little Not at all

(b) To what extent did the counselling give you an understanding of the kind of changes they could make?

A great deal A fair amount Very little Not at all

(c) To what extent did the counselling reduce your concern about their problem?

A great deal A fair amount Very little Not at all

10. Referral Information

(a) Did you receive referral information?

Yes
↳ Go to (b)

No
↳ Go to question 12.

(b) How useful is the referral information you were given?

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

11. Overall how satisfied were you with your counselling experience?

Very satisfied | Satisfied | No view | Dissatisfied | Very dissatisfied

IV. Suggestions for Improving G-Line Service

12. Do you have any suggestions on how the G-Line service could be improved?

_____

_____

Thank you very much for your help with this survey. Would you like me to put you back on to the counsellor?

G-Line (Victoria)
Client Evaluation SURVEY
Questionnaire No. 3
Professional Inquiries

The Problem Gambling Research Program
School of Social Work
The University of Melbourne, Australia
March 1999

I. Service Use

1. How did you find out about G-Line?

2. Is this the first time you have used G-Line?

   Yes No
   → How many times have you used G-Line in the past?

3. Is G-Line the only service that you have sought help for clients with a gambling related problem?

   Yes No
   → Where else have you sought help?

4. Have you ever used a Break Even Problem Gambling Counselling Service?

   Yes No

II. Problem Level

5. We are interested in knowing the extent of people's problems who utilise G-Line.
   Please answer the following questions regarding your client.

Statement	Very poor	Poor	So-so	Quite good	Very good
How would you describe your client's current financial position?	1	2	3	4	5
How would you describe your clients work life?	1	2	3	4	5
How would you describe the state of your client's family relationships?	1	2	3	4	5

6. Is your client currently in a state of crisis?

   Yes No

III. Counselling Process

Note for Researcher: Omit questions 7 to 9 below for clients which received information only from the counsellor.

7. To what extent did you feel confident in the counsellors ability to assist you?

   A great deal A fair amount Very little Not at all

8. To what extent did you feel the counsellor had enough knowledge to assist you?

   A great deal A fair amount Very little Not at all

9. Overall how satisfied were you with the service provided?

   Very satisfied Satisfied No view Dissatisfied Very dissatisfied

10. Referral Information

(a) Did you receive referral information?

Yes
↳ Go to (b)

No
↳ Go to question 11.

(b) How useful is the referral information you were given?

A great deal A fair amount Very little Not at all

IV. Suggestions for Improving G-Line Service

11. Do you have any suggestions on how the G-Line service could be improved?

Thank you for your participation in this survey. The findings will be included in a report to be produced by the Problem Gambling Research Program, through the University of Melbourne to be released later this year.

Note: If the interviewee has further inquiries give them the contact number of the Problem Gambling Research Program: 9344 9425

Appendix B (Part 3): G-Line Counsellor Questionnaire

G-Line (Victoria)
Counsellor Questionnaire Survey
Problem Gambling Research Program

School of Social Work
The University of Melbourne
Phone: 9344 9425
March 1999

First name: _____

Surname: _____

Age: _____

Gender: _____

1. Please indicate your professional qualification(s) and level.

_____

_____

2. Have you had problem gambling specialist training?
   Yes No

3. Have you had telephone-counselling specialist training?
   Yes No

4. Have you had cross-cultural communication training?
   Yes No

5. a) Are you currently employed elsewhere? Please circle your response.
   Yes No

b) If yes, where are you employed and what is your position?

6. What are the positives for you of working with people with gambling related problems?

7. What are the negatives for you of working with gambling related problems?

8. a) Do you receive supervision for your counselling practice at G-Line? Please circle your response.
   Yes No

   b) If no, where do you receive supervision?

9. a) How do you assess the quality of the counselling you do at G-Line? Please circle your response.
   Formal means Informal means

   b) Please describe your means of assessing your counselling.

10. How satisfying is the content of the work you perform? Please circle your response.
    Extremely Quite Neutral Quite unsatisfying Extremely unsatisfying

11. What aspects are particularly satisfying or unsatisfying?

12. From your experience, what do you understand to be the cause of problem gambling?

13. What is the theoretical orientation that you adopt in your counselling practice at G-Line?

14. Please provide specific examples of most frequently used techniques and strategies you use in your counselling at G-Line.

15. How do you build rapport with counselled callers?

16. How do you finish a call with counselling clients?

17. How do you assess the clients referral needs?

18. Where would you refer clients with gambling related problems who presented with the following issues?

a) Crisis intervention

b) Financial support, benefits, etc.

c) Alcohol/drug problems

d) Anger management

e) Employment issues

f) Legal problems

g) Family/relationship problems

h) Social activities, social isolation, etc.

i) Psychiatric problems (e.g. depression, anxiety, etc)

j) General ongoing support

k) Other (please specify)

19. When do you refer clients to Break Even?

20. a) Do you refer clients to services other than Break Even if they have problem gambling counselling needs? Please circle your response.

Yes No

b) If yes, why?

21. How would you describe the relationship of G-Line with Break Even?

22. How effective do you believe Break Even is in supporting the clients who use their service?

23. What client feedback have you had, if any, about the quality of the service provided by Break Even?

24. Work Environment

(a) Are you satisfied with the physical environment within which you work at G-Line? Please circle your response.

Yes No

(b) Please comment on what you are satisfied or dissatisfied with about the physical environment within which you work.

(c) Are you satisfied with the personal and professional supports you receive at G-Line? Please circle your response.

Yes No

(d) Please comment on what you are satisfied or dissatisfied with regarding the personal and professional supports you receive at G-Line.

25. Do you have any comments you would like to make as to how G-Line services can be improved?

Thank you for your participation in this Survey. Please return this questionnaire in the supplied prepaid envelopes by Wednesday 10 March 1999 to:

Problem Gambling Research Program
School of Social Work
The University of Melbourne
Parkville Victoria 3052


State Government
Victoria
Community
Support Fund