



*Gambling Research Panel*

**GRP REPORT NO. 3**

# ***Best Practice in Problem Gambling Services***

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# Executive Summary

This project was commissioned by the Gambling Research Panel, which was established in May 2000 in Victoria with the enactment of the *Responsible Gambling Act 2000*.

## Purpose and Method

The purpose of the project was to:

- Analyse recent overseas and Australian research on successful problem gambling interventions;
- Consider a range of dimensions of service provision;
- Identify how services measure their own performance and achievements against these measures;
- Gain insight into the reasons for problem gambling, the reasons for contact with various types of services, take-up of various interventions, and perceptions of service effectiveness;
- Gain insight into service provision for third parties affected by problem gambling;
- Identify innovative, effective and culturally sensitive models of service delivery.

In conducting this research a number of activities were undertaken, including:

- Analysis of the literature relating to research on gambling service provision with a primary emphasis on sites and models of service delivery;
- Analysis of the literature relating to research on problem gambling treatment effectiveness as well as literature relating to treatment effectiveness more generally, with which to contextualise the problem gambling treatment literature;
- Consultations with researchers;
- Group and individual interviews with Gambler's Help service co-ordinators and individual and group interviews with gambling counsellors (n=40);
- Group interviews with Department of Human Services Head Office and regional staff responsible for Gambler's Help liaison (n=7);
- Focus group interviews with service users of both a 'self-help' program and Gambler's Help (n=19);
- Analysis of the Problem Gambling Research Program's data bank on counsellors who completed two questionnaires — the Counsellor Task Analysis (Problem Gambling) Questionnaire, and the Clinical Practice Evaluation Counsellor Questionnaire) (n=48);
- Analysis of the Problem Gambling Research Program's data bank on client outcome data (n=150);
- Trend analysis of reported outcomes of counselling as detailed in the Client and Services Analysis Reports published by the Victorian Department of Human Services;

- Interviews with managers and counsellors from a range of agencies providing services that may be accessed by people with gambling problems themselves, or accessed by those impacted upon by another person's gambling behaviour (n=20).

In order to contextualise findings on interventions presented in the report, two models are introduced:

- A model of influences on gambling behaviours and outcomes; and
- A model of inputs and outputs in relation to interventions.

## Service Models

There are no internationally established models of best practice in problem gambling services. Thus, a range of treatment programs available to problem gamblers, both within Australia and overseas, were reviewed in order to develop an understanding of best practice service models. Programs' organisational structure, theoretical orientation and treatment approach and techniques were examined with an emphasis primarily on describing sites of intervention and, to a lesser extent, forms of intervention.

The review of problem gambling intervention models indicates that there is a broad range utilising an equally broad range of theories of problem gambling causation, theories of intervention, target populations, and organisational auspices.

In the Australian context, community-based problem gambling service provision is the dominant model, but it is also the model least likely to have demonstrated with rigour the effectiveness of its interventions.

However, from the available data, we may conclude that community-based treatment models provide accessible support for problem gamblers and their family members experiencing gambling-related problems. A crucial dimension of these community-based programs is a multimodal approach to treatment acknowledging that problem gamblers and those affected by their behaviour need a range of interventions.

A major strength of the Gambler's Help model identified is its ability to provide a range of interventions at individual, couple, family and community levels through its community education function. The Gambler's Help model can address the need for modification of the problem gambler's actual gambling behaviour through behavioural, cognitive, and mixed interventions, and the need to ameliorate the harmful impacts of that gambling on family members through broader psychosocial interventions.

## Treatment Outcome Studies

A number of key methodological issues in the definition and measurement of treatment outcomes of problem gambling programs compromised them as guides to 'best practice'. These methodological issues include:

- Poorly delineated selection criteria and procedures for the inclusion of gamblers into treatment programs;
- Failure to take into account improvement in other areas of functioning in programs where criteria for success are based on whether or not the client abstained from gambling;
- Lack of distinction between treatment effects in relation to different forms of gambling;

- Varying levels of motivation to change in treatment populations, making generalisation of results problematical;
- Lack of reporting of data on client intervention rejection or attrition;
- Difficulty in identifying the impacts of primary interventions when a number of interventions are used simultaneously;
- Lack of clarity about whether reliable and valid measures of change are being used, or how concepts such as 'improvement' are measured;
- Lack of a clear-cut definition of what constitutes lapse or relapse in terms of gambling behaviour;
- Variation in post-treatment, follow-up intervals indicating lack of a system-wide approach to tracking the efficacy of interventions.

Given the limitations of reported outcome studies, the report's conclusions are broadly similar to those reached by the National Centre for Education and Training on Addiction (NCETA) team in their previous "Best Practice Interventions for Gambling problems: A Theoretical and Empirical Review" (March 2000), conducted for the Victorian Government. That is, that there appears to be support for a broad bio-psychosocial approach, using cognitive-behaviourally oriented approaches and multimodal approaches, delivered in community-based generalist agencies.

This broad bio-psychosocial approach should be applied to understanding the aetiology of problem gambling; the form of expression of problematic gambling; and the impacts of problematic gambling behaviours. There is also a need to identify specific targets for interventions, whether these interventions are pharmacological, cognitive, behavioural, or systemic in nature.

The implications of our review for service design are that services may be treatment-specific or multi-modal in orientation, but that interventions should be theory-driven, evidence-based and targeted.

Empirical outcome data reported provide an encouraging picture of treatment outcome for problem gamblers. It is not uncommon for two-thirds of treated cases to be reported as abstinent or controlled, according to counsellor's ratings of outcomes, and such behaviour change is often accompanied by more general improvement in psychosocial functioning. Slips without relapses are commonly reported. Although a bias towards publishing of positive reports must be considered, it appears that problem gambling must be considered a treatable behaviour disorder.

## Gambler's Help Counselling Practice

The review of Gambler's Help program counselling practice and theories in use revealed that a broad range of theoretical perspectives underpin the delivery of the Victorian problem gambling program. Counsellors incorporate a variety of therapeutic strategies and theoretical perspectives to inform their counselling practice with problem gamblers, with the majority of counsellors adopting an eclectic approach to counselling.

In examining Gambler's Help counselling practices in detail, the therapeutic relationship was the process variable that most consistently predicted positive outcome. In terms of intervention inputs and outputs, very few client characteristics had a statistically significant impact on counselling outcomes in the Gambler's Help program. As well, counsellor characteristics were found generally not to be predictive of client outcomes. The size of the Gambler's Help service and its level of funding were not shown to have an impact on outcomes achieved.

Gambler's Help problem resolution and post-counselling gambling behaviour compare very favourably with those attained by similar state-wide services, notwithstanding Gambler's Help lacking well-developed outcome measurements for quality assurance purposes.

It is suggested that this lack of standards for performance monitoring be addressed in the forthcoming review of Practice Standards in Gambler's Help commissioned by the Department of Human Services. The Gambler's Help Minimum Data Set (MDS), for example, contains only counsellors' ratings of their clients' outcomes, and is not a satisfactory basis for relating outcomes to inputs. An amended MDS could contribute to better service design and delivery.

## **Services other than Gambler's Help**

For services other than Gambler's Help, the key review finding is that there is a negligible amount of gambling-related service provision by this sector, despite anecdotal evidence to the contrary. There is a paucity of information available on service provision to people with gambling-related problems, and therefore almost no information on outcomes achieved.

Thus, it is recommended that state-funded services screen for gambling-related problems. However, compliance costs for these agencies should be taken into account before making this screening a requirement, and additional funding opportunities made available to agencies that can demonstrate they are meeting the needs of people with gambling-related problems.

Many respondents of services other than Gambler's Help, believed that work needs to be done to de-stigmatise problem gambling for those seeking services other than Gambler's Help such as emergency accommodation, mental health, legal, relationship and family support and 'generic' financial counselling.

On the available evidence, there is no indication that ethnic/indigenous specialist counselling services were attracting clients from these language communities or the Aboriginal community at a higher rate than if the services were not offered in these languages or without an indigenous focus. Neither was there evidence that culture-based counselling outcomes differ from other counselling outcomes.

## **Innovative Practice**

A number of innovative practices in problem gambling services, both within the Gambler's Help program and in the services other than Gambler's Help sector, were briefly reviewed on the basis that they represent types of practice not covered in the review of practice models. They may or may not represent 'best practice' — none have undergone rigorous evaluation. Recommendations are made that they be so evaluated.

## Recommendations

In order to establish a better evidence base to inform service design and funding decisions, better outcome measures need to be developed and incorporated into routine outcome reporting by funded agencies. Further, there is a need for the program to determine outcomes for those not completing the recommended intervention program. A system-wide evaluation framework would include post-intervention tracking of clients at intervals of three, six, 12 and 18 months to monitor the efficacy of interventions on problem gambling behaviour in line with international best practice:

1. Some minimal form of screening for gambling-related problems (with referral to Gambler's Help services where appropriate) be required of all services supported by funding and service agreements through the Victorian Department of Human Services.
2. A future mass media campaign addressing the issue of disclosure of gambling-related problems in agencies other than Gambler's Help, and that these services be given access to a budget to promote their services at a community and agency level to people with gambling-related problems.
3. The specialist indigenous and ethnic programs be evaluated to determine the success or otherwise of this specialist intervention in terms of accessibility, equity, and relevance as measured by culturally sensitive process and content and effective outcomes.
4. An Innovative Practice Fund be established, funded by the Community Support Fund and administered by the Department of Human Services with the assistance of an expert clinical practice and clinical research panel, to finance the development and evaluation of innovative practice to ensure that innovative practice is developed without penalty to agencies, in terms of needing to meet these development and evaluation costs from normal operating grants.
5. In pursuit of the objective of identifying possible best practice developments, the following research and development projects be given priority:
  - a. Evaluation of the single session and multiple sessions consultation models;
  - b. Assessment of the transferability and effectiveness of Gunner's 'spirals' model to other sites of clinical practice;
  - c. Evaluation of the G-mail intervention;
  - d. Evaluation of the Free Yourself Program;
  - e. Evaluation of the integrated gambling counselling/financial counselling model;
  - f. Evaluation of the Crown Customer Support Program.

# Chapter 1

## Introduction

### Project Background

This project was commissioned by the Gambling Research Panel of the Victorian Government.

The Gambling Research Panel (GRP) was established in May 2000 in Victoria with the enactment of the *Responsible Gambling Act 2000*.

Prior to the establishment of the GRP, the Victorian Casino and Gaming Authority (VCGA) auspiced a research committee through which gambling research was commissioned. This research focused on the social and economic impact of gaming. The Gambling Research Panel has now devised a research program through a consultative process. A document describing the program is available from the Panel's website (<http://www.grp.vic.gov.au>).

This report is Project 7 from the Panel's 2000–2001 program. The project's requirements included:

- Analysis of recent overseas and Australian research on successful problem gambling interventions;
- Consultation with relevant researchers and service providers representing the full spectrum of services that might be accessed by problem gamblers and those seeking early intervention for problem gambling;
- Consideration of a range of dimensions of service provision;
- Identification of how services measure their own performance and achievements against these measures;
- Gaining insight into the reasons for problem gambling, the reasons for contact with various types of services, take-up of various interventions (including self exclusion schemes) and perceptions of service effectiveness;
- Gaining insight into service provision for third parties affected by problem gambling;
- Identification of innovative, effective and culturally sensitive models of service delivery;
- Provision of a written report with appropriate policy recommendations.

The Victorian government planned for a Problem Gambling Services Strategy in 1993, to be implemented from 1994 funded through triennial grants from the Community Support Fund. Since the introduction some subsequent minor revision of service models has occurred, such as a re-badging of the primary program from 'BreakEven' to 'Gambler's Help' and G-Line re-named as Gambler's Helpline. The Strategy consists of a number of interrelated components, including:

- The Gambler's Help problem gambling counselling services located primarily in 'generic' agencies such as Community Health Centres, integrated in 2000–2001 with financial counselling services;
- Community education officers in each Victorian Department of Human Services (DHS) region;

- Mass media campaigns supplemented by community education initiatives;
- Provision of 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, originally located in the Victorian Casino and Gaming Authority (VCGA) and DHS. This research function has now transferred to the Gambling Research Panel, with a program development and evaluation research role assumed by DHS.

## Report Structure

Following an introduction to the purpose of the project, and a brief summary of the methodology employed, the report presents a comprehensive model of influences on gambling behaviours and outcomes. The model provides a clear policy and practice analysis and design framework and suggests there are a number of possible intervention targets to address problem gambling. These include:

- Restricting the supply of gambling products and modifying the characteristics of gambling products;
- Influencing the propensity to gamble, in terms of both initiating gambling or progressing to harmful levels of gambling;
- Addressing the outcomes and consequences of problematic gambling behaviour.

The report concerns itself mainly with interventions provided through a formal human services system that address levels of gambling propensity and the outcomes of problematic gambling. Other research commissioned and planned by the GRP will provide detailed information on the effectiveness of measures targeting the supply of gambling goods, particularly in terms of the distribution of electronic gaming machines (EGMs); and restriction of access to facilities through self-exclusion, for example. Other research recently commissioned and planned by DHS will assess the effectiveness of community education campaigns in influencing the propensity to gamble; and investigate the risk and protective factors as identified in our model.

The report continues in Chapter 2 with a review of problem gambling intervention models within Australia and overseas in order to develop an understanding of what might constitute best practice in terms of these broad models and program approaches. In keeping with a program description framework (Donovan & Jackson, 1991), the organisational structure, theoretical orientation and the treatment approach and techniques used, are briefly presented for a range of representative program types. The focus in this chapter is primarily on describing sites of intervention and to a lesser extent, forms of intervention.

Chapter 3 is an overview of a number of conceptual and methodological issues in the measurement of intervention effects, particularly the effects of 'therapeutic' interventions.

Chapter 4 discusses these methodological issues in detail, in relation to the outcomes of problem gambling intervention programs and methods of intervention ranging from the earlier (and now somewhat less popular) psychoanalytic interventions, through self-help programs, multimodal interventions, and pharmacological interventions.

Chapter 5 examines in detail the evidence relating to the design and effectiveness of the problem gambling service model in Victoria. The chapter presents evidence for the effectiveness of interventions delivered through agencies that stand outside the problem gambling-specific services model, and also presents some findings as to whether the Gambler's Help model is reflective of best practice (to the extent that 'best practice' can actually be specified).

In Chapter 6, examples of innovative practice are reviewed. These innovative practices are characterised by a lack of systematic evaluation but are, nevertheless, useful indicators for program and practice development in Victoria.

Chapter 7 presents a number of recommendations arising from these analyses of best practice.

## Overview of Project Methodology

In conducting this research a number of activities were undertaken. This chapter provides a summary only. Details of methodology are noted in the relevant chapters. Activities included:

- Analysis of the literature relating to research on gambling service provision with a primary emphasis on sites and models of service delivery;
- Analysis of the literature relating to research on problem gambling treatment effectiveness as well as literature relating to treatment effectiveness more generally, with which to contextualise the problem gambling treatment literature;
- Consultations with researchers;
- Group and individual interviews with Gambler's Help service co-ordinators and individual and group interviews with gambling counsellors (n=40);
- Group interviews with Department of Human Services staff responsible for Gambler's Help liaison (n=7);
- Focus group interviews with service users of both a 'self-help' program and Gambler's Help (n=19);
- Analysis of the Problem Gambling Research Program's data bank on counsellors who completed two questionnaires — the Counsellor Task Analysis (Problem Gambling) Questionnaire, and the Clinical Practice Evaluation Counsellor Questionnaire) (n=48);
- Analysis of the Problem Gambling Research Program's data bank on client outcome data (n=150);
- Trend analysis of reported outcomes of counselling as detailed in the Client and Services Analysis Reports published by the Victorian Department of Human Services;
- Interviews with managers and counsellors from a range of agencies providing services that may be accessed by people with gambling problems themselves, or accessed by those impacted upon by another person's gambling behaviour (n=20).

Prior to embarking on a detailed consideration of best practice in problem gambling services, problem gambling interventions need to be understood in terms of both their focus and intended outcome. This is discussed in some detail below.

## A model of influences on gambling behaviours and outcomes

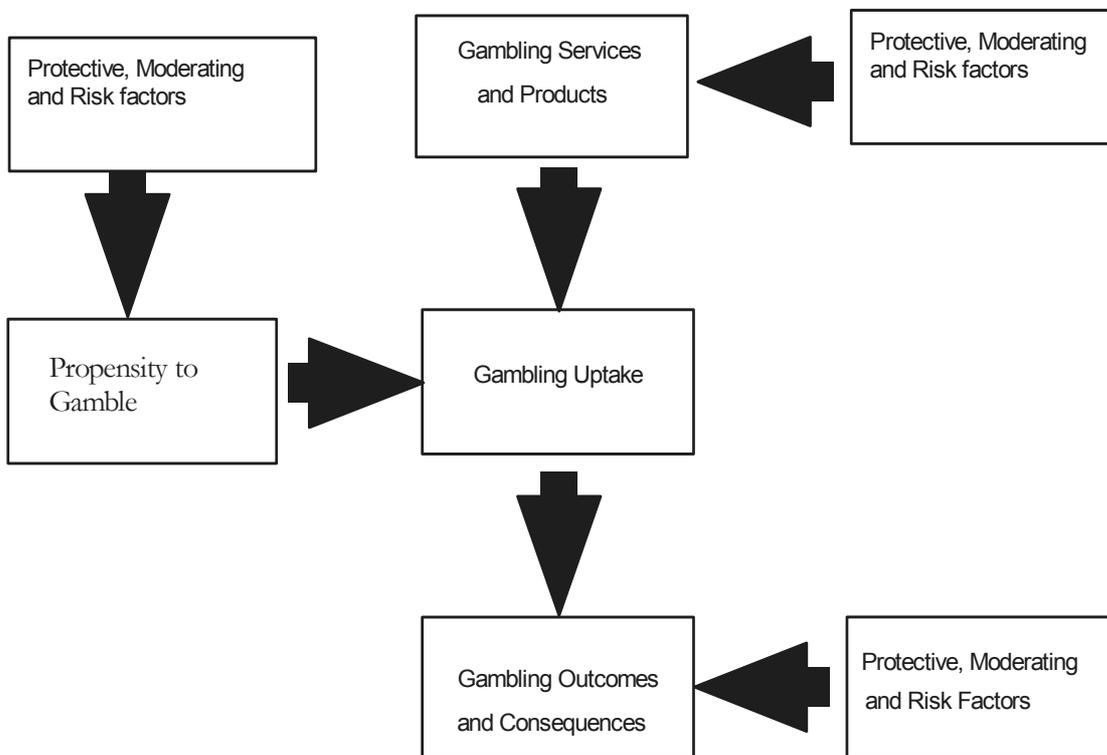
Interventions may be targeted at:

1. Restricting or modifying supply of gambling products, including modification of the properties of those products;
2. Influencing the propensity to gamble, either in terms of initiating gambling or progressing from social gambling to heavy or problematic levels of gambling;
3. Ameliorating the negative outcomes and consequences of problematic gambling, at the level of the individual, family or community.

The inter-relationship of these intervention targets is illustrated in Figure 1.

**Figure 1**  
**A Model of Influences on Gambling Behaviours and Outcomes**

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The model suggests that an individual's gambling uptake is influenced by varying intrinsic propensities to gamble and the availability of gambling products to that individual. It is further asserted that the outcomes and consequences of gambling are influenced by gambling uptake and that various protective, moderating and risk factors impact upon propensity to gamble, the availability of gambling products, and also the outcomes and consequences of gambling uptake upon gamblers, their families and the community.

## Propensity to Gamble

The model assumes that people vary in their propensity and desire to gamble. The propensity to gamble may be influenced by a variety of factors. These factors have been shown to include personality factors such as impulsiveness/impulse control and risk-taking. It may also be affected by other behavioural propensities. A common finding amongst people with gambling problems is that they also have other behavioural problems (Spunt, Dupont, Lesieur, Liberty, Hunt, 1998). Black and Moyer's (1998) US study has shown that people with more severe gambling problems frequently have substantial psychiatric problems. This does not necessarily mean that people in the 'normal' gambling range also have addictive and psychiatric co-morbidities or that all people with gambling problems have other behavioural problems. However the associations are of considerable interest.

Evidence for intrinsic factors affecting gambling behaviour is also provided by a fascinating study of 3,359 twin pairs (Eisen, Lin, Lyons, Scherrer, Griffith, True, Goldberg & Tsuang, 1998). According to Eisen and colleagues, familial factors, including both genetic inheritance and experiences shared by twin siblings, explained 62 per cent of variation in the study sample in the diagnosis of pathological gambling disorder and lower amounts of variance in the elevated but 'normal' ranges of gambling behaviour. This study may provide some evidence for a genetic predisposition or other biological influence (Bianco, Orensanz-Munoz, Biancojerez & Saiz-Ruiz, 1996) in conjunction with other familial social factors contributing to vulnerability to problem gambling.

Much of the research views the issues from a psychological and/or psychiatric framework, and thus focuses on the personal characteristics of the individual gambler. There is limited research from a sociological perspective on the social and contextual factors associated with the propensity to gamble, such as family or community factors. One factor found in overseas studies to be predictive of propensity to gamble is the family environment and exposure to gambling activity within that environment (Winters, Stinchfield & Fulkerson, 1993; Govoni, Rupcich & Frisch, 1996). Women, particularly those living in isolated communities, have also been shown to take up gambling at a higher rate than might otherwise be expected (Brown, Johnson, Jackson, Fook, Wynn & Rooke, 2000); Crisp, Thomas, Jackson, Thomason, Smith, Borrell, Ho & Holt, (2000). Women have also been demonstrated, in some studies, to progress to problematic levels of play at a rate faster than men (Grant & Kim, 2002)

There is little published data on the impact of cultural factors upon propensity to gamble, although some recent work addresses this (Cultural Partners Consortium, 2000; Yamine & Thomas, 2000). Personality is formed by the interplay of intrinsic genetic factors, social experiences and learning within and outside the family and the societal context. Cultural factors affect all of these components, but the relationships are complex. Specific cultural groups certainly have different preferences about gambling modalities, and it may be that different cultures have different propensities to gamble.

## Gambling Products

Gambling uptake and patterns are influenced by the availability of gambling products. In Victoria, prior to the introduction of electronic gaming machines, gambling opportunity was much more limited than at present. During the 1990s there has been a widespread liberalisation of access to gambling products across the state, particularly EGMs in clubs and hotels. The use of any product or service is affected by its availability, marketing and how well it meets the needs or expectations of its consumers.

The impact of geographical distribution of EGMs upon gambling uptake and rates of problem gambling has been reported in the Productivity Commission's report on Australia's Gambling Industries (1999). The report includes an analysis of data collected, by this report's authors, that shows a strong linear link between distribution of EGMs and the rates of new problem gamblers in Victorian regions. The Productivity Commission's study hypothesised a positive and statistically significant relationship between gambling-related problems and:

- accessibility to gambling, particularly the number of gaming machines; and
- average annual expenditure on gaming machines.

Government can impact upon the rates and distribution of gambling product uptake through regulating the distribution of gaming products and the nature of such products within its jurisdiction.

The nature of the gambling products as well as their distribution can also have important influences upon gambling service uptake. The availability of high denomination note acceptors, for example, has been the subject of review within many jurisdictions, including Victoria, and has been of considerable concern to both governments and the gambling industry because of its potential impact upon uptake of gambling services. Other contextual factors can impact upon uptake. For example, clock displays, the removal of Automatic Teller Machines (ATMs) from gaming areas, betting restrictions, the machine display of amounts wagered rather than units and enforced breaks in play are factors that have been hypothesised to impact upon rates of gambling uptake.

### **Gambling Uptake**

The model asserts that gambling uptake is influenced by both the personal characteristics of the gambler — i.e. propensity to gamble — and contextual factors such as the availability of services and products. Uptake can be modelled demographically and also spatially to examine uptake of different products and services by application of tools such as the Gambling Activity Index (GAI).

In Victoria, the site of the present study, about eighty per cent of adults gamble in any year, with figures ranging from a low of 75 per cent in 1992, the year that EGMs were introduced, to a high of 87 per cent in 1996 (Roy Morgan Research, 2000).

Participation in EGM play in the adult population has varied between a low of 13 per cent in 1992 (the survey was conducted three months after the introduction of EGMs) to a high of 15 per cent in 1994, coinciding with the establishment of a casino in June of that year. Participation rates for 1998 and 1999 were 13 per cent and 12 per cent respectively (Roy Morgan Research, 1999, 2000; Market Solutions, 1997).

A similar pattern is revealed by the participation rates in EGM play for those who gambled: 20 per cent in 1992, 41 per cent in 1994, 31 per cent in 1998, and 30 per cent in 1999 (Roy Morgan Research, 2000).

### **Protective and Risk Factors for Gambling Propensity, Uptake and Consequences**

Each of the major model elements — gambling propensity, uptake, and outcomes and consequences — has associated with it a set of related protective, moderating and risk factors. These factors need to be understood in order to be able to design appropriate interventions at each level and target services and assistance to those who most need them. The identification of risk and protective factors engenders the identification of potential interventions.

Propensity risk and protective factors relate to the social and demographic characteristics of gamblers and problem gamblers and their previous experiences of gambling. A considerable amount is known — from analysis of the research literature and data indicative of community gambling patterns, and from those presenting at problem gambling counselling services — about propensities to gamble and propensities for progression to problem gambling status.

The propensity to gamble and the propensity to become a 'problem gambler' might be addressed by targeting at-risk groups with appropriate communications through the mass media and other information networks. Although the effectiveness of this sort of intervention has been little studied in relation to gambling (Jackson, Thomas, Thomason & Ho, 2000), it has been widely demonstrated as effective in relation to a range of impulse-control-related and health-compromising behaviours (Budd, Gray & McCron 1982; Wallack 1984; Puska, Nissinen, Tuomilehto et al, 1985; Bracht & Kingsbury, 1990; Carleton, Lasater, Assat, Feldman & McKinlay, 1995).

The design of gambling products and their marketing and dissemination within the community have important impacts upon the uptake of gambling services (Blaszczynski, Sharpe & Walker, 2001). Government can regulate to change accessibility to services and product design and delivery. Venue caps or limits, the introduction of a gambling venue no-smoking policy, enforced breaks in play, low denomination note acceptors and other interventions have been trialled in an attempt to alter gambling uptake amongst targeted groups.

The outcomes and consequences risk factors include the social and financial resources that the gambler brings to their gambling activity. While gambling problems have important psychosocial elements, a major cause of identification of 'problem' gambling is that of insufficient money to pay all debts and fund everyday activities and the consequences of this inability to pay. There may be psychosocial consequences of problem gambling, such as poor interpersonal relationships and preoccupation with gambling to the exclusion of other important issues, but it is when the financial resources are insufficient to meet the requirements of the gambling activities, that the major identifiable problems and consequences become apparent (McCormack & Jackson, 2000).

If the person has low financial resources to meet the requirements of their gambling activities, this is a risk factor for negative consequences of the gambling. On the other hand, if the resources are substantial then this may be a protective factor. For example, it is noted that unemployed people appear at twice the expected rate in presentations to Victoria's BreakEven problem gambling services (Jackson, Thomas, Thomason, Holt & McCormack, 2000). While this may be a consequence of other factors, it is nevertheless the case that unemployed people do not have major resources to fall back upon to service their gambling requirements.

The development of a gambling problem and the associated potentially negative consequences of the problem take place over time, perhaps a very extended time period. Volberg's (1994) findings that problem gambling rates increase steadily with time in new gambling jurisdictions are probably reflective of this fact as well as issues such as market uptake.

Social and family supports, or the lack of them, also appear to be important protective and risk factors for negative outcomes of gambling activity (Ciarrochi & Reinert, 1993). For example, it is noted from the BreakEven Client and Service Analysis studies conducted for the Victorian Department of Human Services, that people who are divorced or separated generally appear at twice the expected rate in presentations to specialised problem gambling services (see Jackson, Thomas, Ross & Kearney, 2001, for example). While this may be either a cause or a consequence of the problem gambling, it is very well known from other research literatures that familial and community social supports are a key protective factor for adversity (Fobair & Zabora, 1995; McCubbin & McCubbin, 1996; Patterson, Garwick, Bennett & Blum, 1997).

This model shows the complexity of this field of study, and the multiple possibilities for intervention, designed to minimise the harms associated with problematic gambling. This model has been presented as a way of contextualising the types of intervention surveyed in the present study.

# Chapter 2

## Problem Gambling Intervention Models

### Introduction

The purpose of this chapter is to briefly review a range of different treatment programs available to problem gamblers both within Australia and overseas in order to develop an understanding of the best practice models in the field. The organisational structure, theoretical orientation and the treatment approach and techniques used, are briefly presented for a number of programs. The focus is primarily on describing sites of intervention and to a lesser extent, forms of intervention. Chapter 4 focuses more closely on forms of intervention.

The approach taken to treating gambling-related problems at the level of the individual and family is determined by the view taken of the 'causes' of problem gambling. As noted in Chapter 1, one may have views about community or societal factors that relate to gambling uptake or intensity and type of play that will predict to different responses such as policy and regulatory interventions or educative interventions. The scope of this report, however, is primarily concerned with interventions aimed at individual, family or small group level, and the identification of best practice in relation to these.

Broadly speaking, there are three main schools of thought that have dominated discussion about the causes and consequent required treatment of problem gambling: the 'medical' model, the 'behavioural' model and the 'cognitive' model (Petry & Armentano, 1999).

The medical model sees problem gambling as an addiction, akin to alcohol and substance dependence; as a compulsion; or as an impulse-control disorder, which must be treated by interventions appropriate for an illness, with the end goal being abstinence from all gambling (Hollander, Buchalter & DeCaria, 2000; Bianco C, Moreyra P, Nunes EV, Saiz-Ruiz J, & Ibanez A., 2001; Wedgeworth, 1998). The behavioural model, on the other hand, interprets problem gambling as a learned behaviour, motivated and/or reinforced by the personal experiences and social context of the gambler. Like any other problem of behaviour, the treatment focus is on 'unlearning' bad habits and learning how to minimise the harm arising from gambling through 'controlled gambling' (Petry & Roll, 2001). Abstinence, although theoretically consistent with this approach, is not usually specified as an endpoint. Cognitive theories of gambling suggest that problem gambling behaviours are maintained by irrational beliefs and attitudes about gambling.

Theories of gambling behaviour cover the realm of biological, sociological and psychological perspectives. Most theories, however, 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 & Silove, 1995). This eclecticism, in turn, is increasingly reflected in problem gambling intervention models.

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

The study undertaken by the US National Gambling Impact Study Commission (1999) supports this. The Commission found there very few studies to 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). This issue is reviewed more extensively in Chapter 4.

In attempting to make judgements about what constitutes best practice from a programmatic perspective, we need to recognise that the problem gambling treatment literature has also been dominated by theoretical and non-empirical studies, weakening the possibility of generalisation to different populations (Ciarrocchi & Richardson, 1989) or different sites of service delivery. As pointed out by Blaszczynski (1993) problems associated with sample selection have also restricted the ability to generalise across specific subgroups of gamblers.

The difficulty of evaluating the appropriateness of various treatment programs — for whom, at what level of problem intensity, for what type of problems, for what types of gamblers, in what mode of service delivery — is further complicated by the fact that there are 'no internationally established models of best practice in existence' (Elliott Stanford and Associates, 1998).

A range of problem gambling treatment models is presented below. This is an indicative list only, identifying broad types of service models and noting, where relevant, distinctive features of those service models and any evidence for including them as examples of 'best practice'. Included are community-based models that offer support and therapy for problem gamblers and their families; hospital inpatient and outpatient models; self-help and group therapy models; family-oriented treatment programs and a small group of 'miscellaneous' models. Some of these categories are obviously not mutually exclusive, and service models are presented in terms of their primary program design characteristics.

## Community-Based Models

Community-based centres reported in the literature are somewhat similar in nature to the Gambler's Help system of service provision in Victoria, in that free specialist support is available through generalist community-based organisations, such as community health centres, Relationships Australia, and the Wesley Central Missions in Sydney and Adelaide. These community-based models include:

1. The Guidance Centre for Gamblers and Relatives, Austria (Horodecki, 1992) started as the Gamblers Anonymous Association (GA) and gradually expanded into the Guidance Centre for Gamblers and Relatives. An independent non-profit organisation financed by donations and subsidies, the majority of funds come from the Casinos Austria AG and Lotto-Toto Gesellschaft, with a small contribution from the city of Vienna. The therapeutic team consists of one psychologist, one social worker and one psychiatrist. Clients can remain anonymous although about 90 per cent reveal their identities. Counselling is by professional consultants only, at no expense to the client or their family. The Centre's 'addiction model' for problem gambling proposes 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, 1992:116). Total abstinence from gambling is thought to be the first important step of therapy. In cases where problem gambling behaviour exists within a psychiatric illness, clients are referred to an appropriate institution for treatment. The majority of clients find out about the centre through the news media and received further information from a help-line or phone book.

Treatment provided includes:

- Individual/family/pair psychological counselling/psychotherapy (psychotherapeutic background); family therapy, solution-, goal-, and resource-oriented techniques, hypnotherapy (Erickson), behaviour therapy techniques;
- Financial, debts 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;
- Referral to an inpatient therapy scheme for gamblers;
- Leisure activities.

About 40 per cent of clients participated in individual/pair/family counselling only, and 60 per cent of clients participated simultaneously in group therapy. There were also three therapeutically led groups: one for gamblers, one for relatives, and one for gamblers and their relatives together, and one self-help group. Inpatient treatment has been conducted alongside drug and alcohol patients, with any further treatment after discharge being conducted at the centre. Financial, debts and social service counselling are thought in this model to be an integral part of the treatment program of problem gamblers. This counselling was conducted by social workers and adopted a social-therapeutic orientation. The organisation was also involved in a number of preventative strategies. Through publicity, the organisation has attempted to increase public awareness of the problems associated with gambling, and suggesting in addition, that gaming laws and regulations need to be re-evaluated.

2. The Compulsive Gambling Treatment Program, Greater Bridgeport Community Mental Health Center, United States (Miller, 1986).
3. The South Australian model of service provision (Elliot Stanford and Associates, 1998). This specialist BreakEven service exists within community agencies, with a number of rural and urban agencies including the Salvation Army, Anglicare, Wesley Central Mission, Relationships Australia and Adelaide Central Mission. This BreakEven program has an eclectic theoretical orientation, although with some emphasis on a cognitive behavioural approach to problem gambling counselling, and with a particular focus on financial counselling. This model also draws on a range of other intervention modalities such as the use of 12-step programs and relationship counselling. Evaluation of this program (Elliot Stanford and Associates, 1998) suggests that the program is achieving significant changes between intake and exit on three separate measures; an increase in financial and work satisfaction, a decrease in anxiety and depression levels, and a

decrease in suicidal ideation. The program is successful in attracting problem gamblers, family members, and friends.

Specialist services operate from a number of ethno-specific agencies in the Cambodian, Vietnamese and Chinese communities and within the Aboriginal community.

5. The Queensland BreakEven program, which was the forerunner in design terms of the Victorian BreakEven program. This community-based, client-centred program, operating within a regional framework from agencies such as Relationships Australia, Lifeline and Centacare, offers an eclectic mix of services as in the South Australian model, using an integrated financial counselling/problem gambling counselling orientation, along with a focus on relationships.
6. This range of approaches is mirrored in the organisation of services in Tasmania, with again, an eclectic multimodal orientation of working with problem gamblers, family members and friends using cognitive-behavioural therapy and family of origin work.

Community-based service models, such as these, appear to provide accessible support for individuals with problems with their own gambling and support for family members experiencing gambling-related problems. In addition, the multimodal approach to treatment adopted in this community model acknowledges the multifaceted nature of problem gambling behaviour in terms of impact. Aspects of the Victorian Gambler's Help program, as a prime example of a community-based model, are noted in Chapter 5.

## Hospital Inpatient and Outpatient Models

A range of hospital inpatient/outpatient models of treatment also exist. These include:

1. The Johns Hopkins Center for Pathological Gambling, United States (Poltzer, Morrow & Leavey, 1985). Following the enactment of the Maryland General Assembly House Bill 1311 for 'the purpose of providing a pilot project center for the treatment of pathological gambling' in 1978, the Drug Abuse Administration contracted the John Hopkins University, School of Health and Mental Hygiene to implement the program the following year. This was the first treatment centre for problem gamblers in the United States that was open to the general public. The centre was to be accessible to a large segment of the State population and it was proposed that the following services be provided: inpatient services, outpatient services, partial care services, consultation, education services, after care services, as well as preventative programs and rehabilitation services.

Two types of treatment programs were provided: an intensive residential treatment program and an outpatient program. The underlying therapeutic philosophy of the Center was that the most effective intervention for problem gamblers comprises an individual with a personal understanding of the problem, teamed with a suitably qualified counsellor. It was further proposed that 'abstention from gambling is a necessary first step which must be followed by personal growth and significant personality change' (Poltzer et al, 1985:132). The treatment procedure at the Center comprised an initial interview prior to intake which included a psychological assessment, statement of the problem, and assessment of the presence of problem gambling behaviour, followed by team crisis intervention, recovery plan negotiation and concurrent team-led group/family therapy.

The primary objective of the residential program was 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 Gamblers Anonymous. Couple and family therapy as well as legal and financial counselling were available in the belief that both play an important role in the treatment of problem gamblers.

2. The Psychiatric University Hospital, Homburg/Saar, Germany (Bellaire & Caspari, 1992) and an unspecified hospital inpatient program offering individualised programs (Schwarz & Lindner, 1992). Of 51 patients involved in the Homburg/Saar treatment program between 1980 and 1990 all were men, with 30 of these patients treated on an inpatient treatment program with the remaining 21 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 treatment population was divided into three clinical subgroups: (1) those with severe psychiatric conditions (e.g. schizophrenia, manic depression), (2) those with serious personality disorders, and (3) people with problems in their current relationships.

Treatments utilising the principles of client-centred therapy were widely used in the program and interventions included self-help groups, 'paradoxical intentions', and behaviour therapy, but because of their basic disorders, some other form of therapy was regarded as more appropriate for the majority of patients. Bellaire & Caspari (1992) make a number of recommendations for the treatment of problem gamblers who present with multiple problems: (1) a thorough psychiatric and neurological examination in order to begin appropriate treatment, (2) pharmacotherapy for patients who suffer from severe psychiatric disorders, (3) family therapy for patients with relationship problems, and (4) guidance in reactivating old interests in order to fill the time that has previously been spent gambling for patients with personality disorders. In essence, specifically targeted interventions within a multimodal program design.

3. The Behaviour Therapy Unit, Prince of Wales Hospital, then Liverpool Hospital, Sydney, Australia. (Blaszczynski, 1993). The Prince of Wales Behaviour 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 paraphilic behaviours and, from 1977, pathological gambling. Referral to the Unit came from health agencies and referral agencies including lawyers and prison probation and parole officers. Following the retirement of Professor Neil McConaghy the program relocated in part to the Academic Mental Health Unit, Liverpool Hospital under the directorship of Professor Alex Blaszczynski. Treatment practice was informed by McConaghy's (1980) Behaviour Completion Mechanism Model, and used imaginal desensitisation.

Hospital-based treatment programs are particularly common in the United States, having developed primarily 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.

## Self-Help Models

There are a small number of self-help models, which include:

1. Gamblers Anonymous, using a 12-step recovery process and abstinence treatment model based on the principles of Alcoholics Anonymous. Gamblers Anonymous accepts the disease model of problem gambling behaviour, proposing that gambling is 'essentially incurable' (Walker, 1992). 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).
2. The Free Yourself Program, Australia. This program is a self-help model developed by Gabriella 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. This program is described in more detail in Chapter 6, 'Studies in Innovation'.

## Group Therapy Models

A number of group therapy programs have been reported:

1. Haustein and Shurgers (1992) describe a treatment program designed for problem gamblers that involved individual and group therapy as well as a voluntary group program. Throughout the sessions the therapist guided the discussion towards three basic issues: What can the gambler do in their everyday life to make it as hard as possible for them to get to the slot machine? What had happened just prior to relapse? Parallel to these topics, the gamblers were asked exactly how they felt before, during and after gambling.
2. Taber and Chaplin (1988) have reviewed some of the group psychotherapy techniques, ranging from rational-emotive psychotherapy to Zen philosophy based treatments, in their work with problem gamblers. They propose that most pathological gamblers seem to have great potential to profit from short-term group psychotherapy, if a skilled professional manages the group, and if the group is homogenous with respect to the gambling problem.

## Family-Oriented Treatment Models

A range of family-oriented treatment models has been proposed. These include:

1. Treatment programs designed specifically to support the parents of problem gamblers (Heineman, 1989). 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.
2. Structured family intervention, also described by Heineman (1994). This method of intervention has been effective with people with problems with alcohol 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 model suggests 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. Therefore, attempts to encourage a person to seek treatment may be taken as threats and often brushed over 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.

This treatment model suggests also that 'compulsive gambling is a disease which therefore cannot be controlled, only arrested' (Heineman, 1994: 68). The problem is viewed as a 'family disease' and that '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, 1994:75). The intervention is thought to have been successful even if only one member of the intervention group remains in treatment.

3. Marital therapy approaches, both long-term (Bolen & Boyd, 1970) and short-term (Tepperman, 1985), as conducted at the Neuropsychiatric Institute of the University of California, Los Angeles.

## Miscellaneous Models

Other treatment models include:

1. An alternate treatment approach proposed by Walters (1994) described as a lifestyle interpretation of problem gambling activity based on work with incarcerated gamblers. This treatment model is guided by three primary objectives: to cease those lifestyle activities which lead to the problem gambling activity; to develop skills in order to manage gambling-related conditions, choices, and cognitions; and 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: (1) laying a foundation for change, (2) identifying approaches for change, and (3) establishing a non-gambling lifestyle by applying the new skills and knowledge to real-life situations and implementing an effective follow-up program.

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 such cognitive behavioural therapies 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.

2. A minimal intervention home-based self-help manual derived from a similar package developed for alcoholics, in response to the lack of available treatment facilities in Australia, by Dickerson, Hinchy and Legg England (1990). 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.
3. A residential therapy program from the UK (Griffiths, Bellringer, Farrell-Roberts, Freestone, 2001). The Gordon House Association (GHA) is the UK's only specialist and dedicated residential facility for problem gamblers. The therapeutic program is centred round a nine-month period of residency involving progression through a number of phases: initial assessment;

'Coping With Today' (phase one); 'Coping With Yesterday' (phase two); 'Coping With Change' (phase three), 'Coping With Tomorrow' (phase four), and 'Coping on My Own' (Phase Five).

## Conclusion

This review of problem gambling intervention models indicates that there is a large range of these intervention models, utilising an equally diverse range of:

- Theories of problem gambling causation;
- Theories of intervention;
- Target populations;
- Organisational auspices.

Although in the Australian context, community-based problem gambling service provision is the dominant model, it is also the model least likely to have demonstrated the effectiveness of its interventions in a rigorous sense, except in the case of Victoria, as detailed in Chapter 5. As is evident from the data presented in the following chapter on treatment outcome studies, as might be expected, more rigorous effectiveness studies are associated with more 'clinical' programs and with programs in which clinical researchers have been involved in design or implementation.

As noted earlier, from the evidence of the few studies available, community-based treatment models provide accessible support for problem gamblers and their family members experiencing gambling-related problems. A crucial dimension of these programs is that they adopt a multimodal approach to treatment, which acknowledges that problem gamblers need a range of interventions. These interventions deal with the gambling behaviour itself — behavioural and cognitive-behavioural approaches, along with interventions designed to ameliorate impact — financial counselling and relationship counselling, for example. The multimodal programs also address the impacts of gambling on families through relationship and family counselling and family education.

Support for this multimodal approach in program design has been evident for at least the last decade, as Cummings and Gambino's (1992) study of clinicians' perceptions of the critical tasks in the treatment of problem gamblers showed. This study revealed five major and three minor clusters of tasks that were viewed as the most important in the treatment of problem gamblers. The major task clusters were (1) self-help/social support, (2) crisis interventions, (3) behavioural resources for change, (4) psychodynamics of treatment, and (5) crisis severity. The minor task dimensions were (6) knowledge and training, (7) ethics and sensitivity to needs, and (8) confidentiality and regulations. Clinicians placed strong importance on developing support systems for clients while also dealing with crisis situations. Furthermore, it was shown that use of both behavioural and psychodynamic techniques were perceived to be of equal importance.

# Chapter 3

## Conceptualising and Measuring Therapeutic Effectiveness

### Introduction

The purpose of this chapter is to briefly review the research literature on therapeutic effectiveness and outcomes in general, in order to contextualise our review of the literature on intervention effectiveness specific to problem gambling. The chapter concludes with a brief note on some key methodological issues in the definition and measurement of treatment outcomes of problem gambling programs.

The debates over the complexities and difficulties involved in studying the outcomes of human service programs are numerous. This is particularly so in the exploration of the specific outcomes of counselling, which, whether delivered in the context of a residential program, community-based program, counselling-specific or multimodal program, forms the primary intervention in most problem gambling services targeting either the problem gambler themselves or those affected by that person's gambling. Further, the therapeutic and behaviour change models adopted by practitioners and researchers have important implications for where they look in terms of outcome measures. With different therapeutic goals and assumptions it may seem at first glance that different outcome measures may be implied by the different models. The concept of effectiveness is always relative to a context.

### Measuring Therapeutic Effect or Process?

Bergin and Garfield (1994) have noted that the central issue in outcome research is how to measure the changes that occur in people as a result of their participation in therapy. They suggest that the evidence for concluding that psychological treatments are of benefit to most clients is demonstrated in part by quantitative surveys of the literature that have used meta-analysis to summarise large collections of empirical data. Current research into the outcome of psychological treatments has shifted emphasis from establishing positive treatment effects to exploring what aspects of the process causes positive effects and what approaches work best with which clients.

Stubbs and Bozarth (1994) in their account of research on the outcomes of therapeutic practices argue that this research has occurred in phases corresponding to the shifts in our knowledge about these processes and their effects. The first phase they characterise as psychoanalytic with the publication of Freud's essay, 'Analysis Terminable and Interminable', in which he posed the questions: 'Is there a natural end to analysis?' and 'Can the analyst bring the analysis to this end?' According to Stubbs and Bozarth, the general optimism of the early research into the effectiveness of psychoanalytic psychotherapy was then replaced by a phase marked by Hans Eysenck's controversial research findings (that psychotherapy is no more effective than no psychotherapy). Eysenck's claim shocked the therapeutic community and, in an effort to explore and dispel the claim, a great deal of research in the psychotherapy field aimed to investigate the effectiveness of psychotherapeutic processes.

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

The most recent phase in research on psychotherapy outcomes is characterised by a renewed focus on the 'non specific' or 'common' factors within the therapeutic process that affect change. This focus, Stubbs and Bozarth (1994) believe, is the result of the inability of previous studies to strongly establish any specific factors such as therapist characteristics or client characteristics or particular techniques to have a significant impact on outcomes.

## Factors Contributing to Treatment Effects

Bergin and Garfield (1994) have argued that factors common across treatments account for substantial amounts of improvement found in people undertaking psychotherapy and that these factors are those dimensions of the treatment settings (therapist, therapy and client) that are not specific to any technique. They suggest that:

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

The most researched of the common factors is the therapeutic alliance between clients and workers and clients' readiness to change. Orlinsky, Grawe and Parks (1994) reinforce this in their extensive meta-analysis of process and outcome variables in psychotherapy. They conclude their study by stating that the quality of the patient's participation in therapy stands out on its own as the most important determinant of outcome. The therapeutic bond, especially as perceived by the patient, is importantly involved in mediating the process-outcome link. They suggest that the therapist's contribution towards helping the person achieve a favourable outcome is made mainly through empathic, affirmative, collaborative and self congruent engagement with the patient, and the skilful application of potent interventions. They conclude that:

*'These consistent process-outcome relations, based on literally hundreds of empirical findings can be considered facts established by forty plus years of research in psychotherapy ...'* (1994:361)

As well as there being questions about what constitutes the 'therapeutic mix', there is also the question of how much of the therapeutic intervention should be administered. In classical epidemiology the relationship between the amount of intervention and its effect is termed the dose response or dose-effect relationship. These brief interventions are an important characteristic of much problem gambling counselling practice, whether undertaken in specialised services or in more general contexts of service provision, other than in residential programs.

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

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

A number of studies have explored the relationship between the amount of counselling received and subsequent improvements in the client's well being. Since the publication of Howard, Kopta, Krause and Orinsky's (1986) influential paper on the dose-effect relationship in psychotherapy, the relationship between the number of therapy sessions and client improvements has been explored by a number of other authors with mixed results. All critiques of this work of Howard et al agree that there are problems generalising from the sample used to other treatment environments.

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

Given this mixed bag of findings it seems safe to assert that the dose-effect relationship is something that varies according to the individual matters involved and the nature of the research environment. As Steenbarger (1994:111) put it:

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

As Marjanovic (1995) has noted, in relation to problem gambling clients, the fact that many of them seek treatment when least able to afford the financial cost, indicates that prolonged psychoanalysis and privately provided or fee-for-service group therapy are often prohibitive treatment options. Consequently there is a need for a variety of treatment techniques which have shown to be both cost-effective and outcome effective, which tends to favour short-term interventions, where possible.

This relationship between outcomes achieved by problem gamblers and the number of counselling sessions attended has recently been reported (Crisp, Jackson, Thomas, Thomason, Smith, Borrell, Ho & Holt, 2001). This study analysed outcomes for 613 problem gamblers who began and completed treatment that involved at least one session of face-to-face counselling.

In examining the number of sessions attended by type of problem and degree of problem resolution, analysis of variance produced a main effect of degree of problem resolution in respect of the number of counselling sessions attended by those whose problems included financial issues ( $F(2,382) = 4.42, p < .05$ ), gambling behaviour ( $F(2,502) = 9.45, p < .05$ ), interpersonal problems ( $F(2,341) = 10.54, p < .001$ ), intrapersonal problems ( $F(2,377) = 6.54, p < .01$ ) and legal problems ( $F(2,210) = 5.26, p < .01$ ). Post hoc tests revealed that for each problem type, clients whose problems remained unresolved attended fewer counselling sessions than did those who achieved a degree of problem resolution. Interestingly, as the table below shows, problem resolution involved a reasonably small number of sessions.

**Table 1**  
**Mean number of counselling sessions attended by degree of problem resolution**

Problem	Unresolved	Partially resolved	Fully resolved	Statistical test
Problem which was primary reason for attendance	2.32	3.47	4.15	$F(2,509) = 35.59, p < .001$
Highest degree of problem resolutions	1.78	3.11	3.85	$F(2,593) = 36.57, p < .001$

Source: Crisp, B.R., Jackson, A.C., Thomas, S.A., Thomason, N., Smith, S., Borrell, J., Ho, W. & Holt, T.A., (2001) 'Is more better? The relationship between outcomes achieved by problem gamblers and the number of counselling sessions attended', *Australian Social Work*, 54, 3, 83–92

Before moving to Chapter 4, which identifies a large number of treatment outcome studies, it is worth noting briefly the distinction between efficacy and effectiveness, as these terms are sometimes used inter-changeably or inaccurately. An efficacy study has the essential feature of comparing an intervention to a comparison group under well-controlled conditions. A study of the effectiveness of a treatment is a study of how people fare under the actual conditions of interventions being delivered in agency settings.

This distinction is particularly pertinent if one looks, as we do in Chapter 4, at the therapeutic outcome literature, which has largely relied on research studies that occurred in environments that have not been 'naturalistic'. The findings that are presented in these efficacy studies do not necessarily translate to every day clinical settings or say much about what one could describe as effective practice. This problem was explored in some detail by Seligman (1995:996), who argued that:

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

# Chapter 4

## Treatment Outcome Studies

### Introduction

Having reviewed a range of service models in Chapter 2, we now turn to an extensive review of treatment outcome studies. The search procedure adopted for this review was as follows:

1. Review of all citations from the most extensive evaluation of problem gambling services undertaken in Australia to date, that of the Victorian Gambler's Help (BreakEven) program, with a particular emphasis on service design models (Jackson, Thomas, Thomason, Borrell, Crisp, Enderby, Fauzee, Ho, Holt, Perez & Smith, 2000) and intervention outcomes (Jackson, Thomas, Thomason, Borrell, Crisp, Ho, Holt & Smith, 2000; Jackson, Thomas, Thomason & Ho, 2000; Thomas, Jackson, Anderson & Kearney, 2000).
2. Search of major databases such as PsychLit, PubMed, Web of Science using the keywords 'problem gambling', 'pathological gambling', 'impulse control disorder', 'addiction', 'treatment', 'interventions', 'outcome', and 'effectiveness'.
3. Review of internet sites with particular reference to gambling research centres, such as the Ontario Problem Gambling Research Centre and the Alberta Gaming Research Institute to identify current treatment outcome research.
4. Review of libraries housing collections resulting from contracted searches such as the University of Lethbridge Library Gambling Treatment Research collection to check for gaps in our database search, if any.
5. Review of known collations of problem gambling treatment effectiveness literature. These included the National Centre for Education and Training on Addiction (NCETA) (2000) *Current 'Best Practice' Interventions for Gambling Problems: A Theoretical and Empirical Review*; the National Research Council's Committee on the Social and Economic Impact of Pathological Gambling (1999) review of treatment services; and el-Guebaly and Hodgins (2000) *Pathological Gambling: The biopsychological variables and their management, Interim Report*.

Prior to presenting our review of treatment approaches and outcomes, we need to note a number of key methodological issues in the definition and measurement of treatment outcomes of problem gambling programs which may compromise their ability to provide guides to 'best practice'. These include sample selection, specification of treatment objectives and treatment outcome criteria, attribution of treatment effects, the reliability and validity of measures of 'success', definitions of lapse and relapse, and, finally, the variation in post-treatment follow up intervals.

### Methodological Issues in Defining and Measuring Problem Gambling Program Treatment Outcomes

#### Sample Selection

Selection criteria and procedures for the inclusion of gamblers into treatment programs are often poorly delineated with samples characterised by 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. 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 & Custer, 1978; Lesieur & Blume, 1991).

Few studies distinguish treatment effect related to different forms of gambling.

Usually 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 EGMs is accompanied by a narrowing of attention acting as an emotional escape from daily stresses (Blaszczynski & McConaghy, 1989; Anderson & 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 & McConaghy, 1989).

Finally, respondents recruited from different treatment settings may vary in terms of motivation to change, thus making generalisation from one treatment site to another problematical in terms of predicting rate and magnitude of change.

### **Treatment Objectives**

Criteria of success based on the dichotomous global ratings of abstinence and non-abstinence typical of 'addictions'-oriented programs, 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 (1986) and Blaszczynski (1988), for example, have 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 problem 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 & Weeks, 1979; Rankin, 1982; Brown 1985; Blaszczynski, 1988).

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

### **Treatment Outcome Criteria**

Many studies do not present data on rejection (refusal to enter a program) or attrition (drop-out from programs).

It is difficult to glean the rate of rejection and attrition in many outcome studies but where available, 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 that 70 per cent had ceased attending by the tenth meeting. In Lesieur and Blume's (1991) study, 171 patients met the South Oaks Gambling Screen 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.

Excluding non-starters or drop-outs from statistical analyses results in an over-estimate of the likelihood of success. This tendency to ignore cases is equally pertinent when reporting on subjects lost to follow-up. 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 50–60 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 & Ramirez, 1984), and 52 per cent at five years follow-up (Blaszczynski, McConaghy & Frankova, 1991a).

### **Attribution of Treatment Effects**

It is sometimes difficult to identify the impacts of primary interventions in situations where a number of interventions are used simultaneously; for example, individual counselling and group therapy.

Indeed, in some of the multimodal programs noted in Chapter 2, there may not be a designated primary intervention, but a collection of interventions including individual counselling using a cognitive, behavioural or cognitive-behavioural approach for the person experiencing problems with their own gambling behaviour; couple or relationship counselling; individual counselling for the partner who is introduced to a range of coping, or impact-minimising strategies; group-work interventions for either or both problem gambler and partner; financial counselling and legal advocacy to reduce the stress caused by excessive debt, etc. In this sort of program, it is often difficult to identify with certainty what intervention or combination of interventions, performed by whom, had what effect.

### **Valid and Reliable Measures**

It is not always clear in studies whether reliable and valid measures of change are being used, or how concepts such as 'improvement' are measured.

Follow-up measures have most often relied upon semi-structured interview administered in person (Blaszczynski, McConaghy & Frankova, 1991a) or by telephone (Russo, Taber, McCormick & Ramirez, 1984; Lesieur & Blume, 1991) assessing not only gambling behaviour but changes in socio-demographic parameters such as 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 socio-demographic 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.

Gambling behaviour has generally been assessed by self-report measures. The reliability and validity of self-reporting, especially in relation to problematic gambling, where denial is common, can be questioned. It appears, however, that where therapy is independent of forensic issues, there is a high concordance between the respondent's self-report and confirmation through collaborative information obtained from their spouse or significant others (Taber, McCormick Russo, Adkins & Ramirez, 1987; Blaszczynski, McConaghy & Frankova, 1991a). This suggests that gamblers at follow-up are capable of providing accurate accounts of their behaviour.

### **Definition of Success on Discharge**

Few studies report on the status of the gambler at discharge preferring to provide assessments at six or twelve month's follow-up.

Much can happen in the intervening period between discharge and follow-up causing positive change independent of treatment received. In the clinical experience of one of the authors (Blaszczynski), 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 (1986) assessed discharge status but did not include follow-up, thereby 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.

### **Definition of Lapse and Relapse and Relationship to Treatment Failure**

There is no clear-cut definition of what constitutes lapse or relapse in terms of gambling behaviour.

Some people 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, while others substitute more innocuous forms of gambling. Should the latter cases be regarded as intervention 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.

### **Post-treatment Follow-up Intervals**

Post-treatment follow-up intervals vary in studies generally from six months to two years, although to adequately account for a full understanding of 'lapse' and 'relapse' behaviour, longer follow-up periods, say five years, may be more useful.

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 has to be determined 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 problem gambling, that extensive follow-up periods are employed in order to establish the robustness of interventions.

Having reviewed a range of methodological issues affecting the conceptualisation and measurement of outcome effectiveness in problem gambling programs which, the authors believe, may compromise their ability to provide guides to 'best practice', a number of treatment outcome studies are now examined in detail.

## Treatment Approaches and Outcomes

As Table 2 shows, a broad range of interventions has been employed in the treatment of problem gambling. Psychodynamic formulations appeared early last century, with behaviourally based interventions emerging in the 1960s. By the 1980s multimodal programs came into vogue while in the 1990s the emphasis shifted toward cognitive-behavioural interventions, cognitive interventions and, increasingly in the 2000s, psychopharmacological regimes, alongside multimodal and cognitive or cognitive/behavioural interventions.

**Table 2**  
**Problem Gambling Treatment Outcome Studies**

Author (bold denotes Australian study)	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, 1968	Aversive therapy	5	3 abstinent 2 abstinent with relapse episodes	< 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
Bolen & Boyd, 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	
Peck & Ashcroft, 1972	Satiation	5	80 per cent improved at treatment termination	Nil
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
Custer & Custer, 1978	Gamblers anonymous	150	42 per cent abstinent	Mean attendance 7 years 3 months
Dickerson & Weeks, 1979	Behavioural counselling	1	Controlled	15 months
Moskowitz, 1980	Lithium	3	2 reduced 1 unclear	Not specified
Griffiths, 1982	Hypnosis	1	Improved at termination	Nil
Greenberg & Rankin, 1982	Stimulus control, exposure and covert sensitisation	26	5 controlled 7 controlled with periodic relapse	9 months – 5 years

## Best Practice in Problem Gambling Services

Author (bold denotes Australian study)	Technique	Cases	Outcome	Follow-up
Greenberg & Marks, 1982	Covert sensitisation & cue exposure	7	3 reduced	Nil – 6 months
Rankin, 1982	Behavioural counselling	1	Controlled with brief relapses	2 years
<b>McConaghy, Armstrong, Blaszczyński &amp; Allcock, 1983</b>	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
Blackman, 1984	Outpatient couple and marital therapy	81	Gambling frequency lower	After average 65 sessions
Brown, 1985	Gamblers Anonymous	232	7.3 per cent abstinent	Retrospective 2 years
Tepperman, 1985	Conjoint group and marital therapy	20	10 dropped out 9 abstinent	3 years
Blackman, Simone, Thoms & Blackman, 1986	Outpatient unspecified	88	55 gambling less than once/week	At termination of treatment
Harrison & Donnelly 1987	Couple therapy	10	Higher marital satisfaction after 6 weeks	At termination of treatment
Taber, McCormick, Russo, Adkins & Ramirez, 1987	Multimodal	66	32 abstinent	6 months
<b>McConaghy, Armstrong, Blaszczyński &amp; Allcock, 1988</b>	Desensitisation versus relaxation	20 (1)	60 per cent improved	1 year
Franklin & Richardson, 1988	Multimodal	80	46 per cent abstinent	1 year
Stewart & Brown, 1988	GA outcome study	232	8 per cent abstinent after 1 year, 7 per cent after 2 years from first meeting	1 year and 2 years
Hudak, Varghese & Politzer, 1989	Multimodal	99	?	5 – 8 years
<b>Dickerson, Hinchy &amp; Legg-England, 1990</b>	Comparison of self help manual & manual plus interview	29	50 per cent abstinent 80 per cent controlled at 3 months No significant treatment differences	6 months
Toneatto & Sobell, (1990)	Cognitive therapy	1	Significant reduction	6 months
Arribas & Martinez, 1991	Cognitive behavioural	4	All improved	6 months
<b>Blaszczyński, McConaghy &amp; Frankova, 1991</b>	Imaginal desensitisation & other behavioural techniques	63	18 abstinent 24 controlled 21 uncontrolled	2 – 9 years
<b>McConaghy, Blaszczyński &amp; Frankova, 1991</b>	Imaginal desensitisation & other behavioural techniques	120	79 per cent improved	2 – 7 years
Lesieur & Blume, 1991	Multimodal	72	46 abstinent 26 gambling	6 – 14 months
McCormick & Taber, 1991	Multimodal	45	At 6 months 56 per cent abstinent. Maintained for 12 months	1 year
Zion, Tracy & Abell, 1991	Ga	43	40 resumed gambling; 60 per cent had spouses at Gam-Anon	
Sharpe & Tarrier, 1992	Cognitive behavioural	1	Improved on treatment termination	Nil
Schwartz & Lindner, 1992	Multimodal	112	71 per cent of 49 abstinent after 1 year; 62 per cent of 24 abstinent after 2 years	2 years
Bellair & Caspari, 1992	Multimodal psychiatric inpatient	51	3 resumed controlled gambling	?
Hollander, Frenkel, DeCaria, C. & Trungold, 1992	Clomipramine	1	Improved on treatment termination	Nil
Ciarrochi & Reinert, 1993	GA and Gam-Anon	86	Long term members had less open conflict and higher moral-religious emphasis	?
Haller & Hinterhuber, 1994	Carbamazepine	1	Improved	30 months
Bujold, Ladoucer, Sylvain & Boisvert, 1994	Cognitive	3	Two of three improved	9 months
Ladoucer, Boisvert & Dumont, 1994	Cognitive behavioural	4	All 4 adolescents abstinent at 6 months	6 months
Marjanovic, 1995	Cue-exposure	9	44 per cent improved	6 months
Echuburu, Baez & Fernandez-Montalvo, 1996	Comparison of cue-exposure, group cognitive and combined modality	64	69 per cent individual & 37.5 per cent of group improved after 6 months; 25 per cent of control group controlled after 6 months	6 – 12 months

Author (bold denotes Australian study)	Technique	Cases	Outcome	Follow-up
Stinchfield & Winters, 1996 Rhodes, Norman, Langenbahn, Harmon & Deal, 1997	Six-state funded multimodal programs	944 (368)	42 per cent abstinent 70 per cent improved No program differences	1 year
<b>Tolchard &amp; Battersby, 1996</b>	Desensitisation	75	81 per cent improved, but did not account for clients seen for fewer than 5 sessions	Nil
Henry, 1996	Emdr	22	?	Nil
Sylvain, Ladoucer, & Boisvert, 1997	Cognitive behavioural	29	71 per cent improved	6 months
Symes & Nicki, 1997	Cue-exposure	2	Both improved on treatment termination	Nil
Crockford & el Guebaly, 1998	Naltrexone	1	Improved on treatment termination	Nil
Ladoucer, Sylvain, Letarte, Giroux & Jaques, 1998	Cognitive	5	4 improved	6 months
Hollander, DeCaria, Finkell, Begaz, Wong & Cartwright, 2000	Fluvoxamine & placebo	10	Significant improvement in PG Clinical Global Impression Scale & on PG modification of Yale-Brown Obsessive Compulsive Scale	After 8 weeks of fluvoxamine and 8 weeks placebo
Kim, Grant, Adson & Shin 2001	Naltrexone & placebo	83	75 per cent of naltrexone treated patients statistically significantly improved cf 24 per cent on placebo	After 11 week naltrexone or placebo treatment
Kim & Grant, 2001	Naltrexone	17	Reduction in gambling frequency, amount lost, and clinician-rated CGI	After 6 weeks of treatment in open-label study
Ladoucer, Sylvain, Boutin, Lachance, Doucet, Leblond & Jaques, 2001	Cognitive	35 & 29 controls	86 per cent no longer met DSMIV criteria at treatment end Change maintained at 6 & 12 months	6 and 12 months
Breen, Kruegelbach & Walker, 2001	Cognitive inpatient	66	Significant . change in gambling-specific attitudes & beliefs	After 28 days of residential treatment
Hodgins, Currie & el-Guebaly, 2001	Motivational interview & workbook	102	Combined brief treatments more effective than single. Effect maintained at 12 months for those with less severe problems	12 months
Bianco, Petkova, Ibanez & Saiz- Ruiz, 2002	Fluvoxamine & placebo	32	Fluvoxamine not superior to placebo in total sample, but significant. Superior for males and younger participants	After 6 months treatment
Zimmerman, Breen & Posternak, 2002	Citalopram	15	Significant improvement on gambling related measures. For 9 completing, gains held for 12 weeks of treatment	After 12 weeks treatment

Below, we discuss the theoretical underpinnings of a range of approaches to intervention. These approaches include:

- Psychoanalytic formulations;
- Self-help programs;
- Behavioural treatments;
- Controlled gambling;
- Cognitive therapy;
- Multimodal interventions;
- Pharmacological approaches.

In addition to noting key conceptual formulations, we also review 64 outcome studies conducted to determine the effectiveness of this range of interventions. Not all references appearing in the discussion below are listed in Table 2. This applies where the reference primarily deals with an articulation of concepts rather than empirical analysis of intervention effects.

## Psychoanalytic Formulations

Early 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 (Israeli, 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).

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 populations, heterogeneous in terms of psychological state. 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. Thirty-three who completed full psychoanalysis and 12 who received partial psychoanalysis were reportedly 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.

Psychoanalytical formulations may in the future inform some work with couples, based on object relations theory (Drummond Street Relationships Centre, 2002), and some individual work with women, where the association between excessive gambling and a history of childhood sexual abuse is being explored.

## Self-help Organisations

As noted in Chapter 3, Gamblers Anonymous is the most 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-month abstinence rate of 7.5 per cent. Brown recognised that a stringent one to two-year abstinence 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 in hospital settings, and after discharge appear to do significantly better in terms of continued abstinence (Taber, McCormick, Russo, Adkins & Ramirez, 1987).

Zion, Tracy and Abell (1991), in examining the relationship between spousal involvement in GamAnon and relapse behaviours in pathological gamblers, found no significant difference in the relapse of those gamblers with or without a spouse in GamAnon. Spousal involvement in GamAnon did not influence the number of times the gambler relapsed, how long the gambler was abstinent before he/she relapsed, or the perceived degree of support. Compared with gamblers who relapsed, those who had not relapsed reported significantly higher past involvement with addictive-like behaviours for both self and spouse.

### **Behavioural Treatments**

The interest in the application of clinical behavioural techniques to 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, which can be unlearned through techniques based upon 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 problematic gambling patterns.

Most behavioural treatments have used operant or classical conditioning aversive techniques to counter-condition the arousal/excitement associated with gambling. The most frequent early form of aversion was electric shock in isolation (Barker & Miller, 1968; Goorney, 1968; Koller, 1972, McConaghy, Armstrong, Blaszczyński & 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 was later combined with rational emotive therapy (Bannister, 1977) and stimulus control and exposure (Greenberg & Rankin, 1982). Salzman (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 16 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.

It should be noted that most studies of behavioural interventions have failed to operationally define outcome criteria, and that under these circumstances, consideration of treatment effectiveness and successful outcome is often governed by an arbitrary choice of liberal versus stringent criteria. Overall, as the NCETA (2000) review argued, there is some evidence that imaginal desensitisation is superior to aversion therapy and that cue-exposure/response prevention therapies are producing improvement rates in terms of control, comparable with alcohol treatment programs using the same methods.

### **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 & 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. This was demonstrated in an Australian 2–9 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 socio-demographic measures, and did not differ from each other.

Russo, Taber, McCormick and Ramirez (1984) similarly found 21 per cent of their sample 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 & Frankova, 1991b).

Rosecrance (1989), in a different view of controlled gambling, rejected the medical model of gambling in favour of the notion that problem 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, which 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. There can only be conjecture on the potential usefulness of this approach for some gamblers, but it should not be dismissed on ideological grounds alone.

### **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 & Davis, 1986), erroneous perceptions (Griffiths, 1990; Coulombe, Ladouceur, Desharnais & Robin, 1992; Ladouceur, Sylvain, Boutin, Lachance, Doucet, Leblond & Jacques, 2001) and irrational thinking processes (Walker, 1992b).

Intrinsically, distorted cognitions may be interposed at any stage of the gambling cycle leading gamblers to:

- Believe, erroneously, they have a greater skill level or control over events/play than in actuality;
- Selectively recall wins in preference to losses leading to an over evaluation of success;
- Expect an impending win given 'near misses' or the probability that a losing streak is about to end;
- Maintain an over-valued belief regarding their luck;

- Accede to superstitious behaviours;
- Falsely believe that they possess special skills, knowledge or other attributes that provide them with a winning 'edge';
- Act from mistaken beliefs about randomness.

Recently treatment studies have emerged explicitly based on a cognitive theory of problem gambling. Ladouceur, Sylvain, Boutin, Lachance, Doucet, Leblond, and Jacques (2001), in a controlled clinical trial, evaluated the efficacy of a cognitive treatment package for pathological gambling. Sixty-six gamblers, meeting DSM-IV criteria for pathological gambling, were randomly assigned to treatment or wait-list control conditions. Thirty-five people completed treatment of up to 20 one-hour sessions (mean 11.03). Cognitive correction techniques were used first to target gamblers' erroneous perceptions about randomness and then to address issues of relapse prevention. The dependent measures used were the South Oaks Gambling Screen, the number of DSM-IV criteria for pathological gambling met by participants, as well as gamblers' perception of control, frequency of gambling, perceived self-efficacy, and desire to gamble. Post-test results indicated highly significant changes in the treatment group on all outcome measures, and analysis of data from six- and 12-month follow-ups revealed maintenance of therapeutic gains.

On percentage of change, 19 of the 35 people completing treatment improved by at least 50 per cent on the four dependent variables, compared with only two of 29 in the control group. In the treatment group 31 of the 35 participants completed the six-month follow up evaluation. Significant differences were found between the pre-test and six-month scores on DSM-IV: perception of control; desire to gamble; and self-efficacy perception. Of the treatment group, 28 participants completed the 12-month follow-up evaluation, and showed significant levels of retention of the treatment effects measured at completion of treatment and at six months. The authors suggest that this treatment outcome study shows that a cognitive treatment can significantly improve pathological gambling, as demonstrated by the fact that 86 per cent of the treated participants were no longer considered pathological gamblers, as measured by DSM-IV at the end of treatment. In addition, those completing treatment had greater perception of control of their gambling problem as well as an increased self-efficacy in high-risk gambling situations.

This study is important, in illustrating the effectiveness of theory-driven practice, and the effectiveness of a cognitive intervention targeting a specific cognitive error, namely the gambler's beliefs about randomness and their belief that they can control the outcome of random events.

Dickerson and Baron (2000) have also argued for specific targeting of interventions, particularly a focus on the construct of choice or subjective control over gambling. Despite the conceptual difficulties that may be associated with the variable of self-control, they suggest that these may be overcome because contemporary research into the addictive behaviours has demonstrated considerable success in the definition and measurement of control and related themes such as craving, restraint and temptation.

Several multimodal programs incorporate cognitive-behavioural techniques within their armamentarium but have not evaluated the specific contribution or effectiveness of the cognitive-behavioural techniques or of the cognitive component and the behavioural component specifically. 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 for 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, the results need to be interpreted with caution. The subject of this case study was atypical of gamblers in general, in 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 sub-scale 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 often been correlative. That a causal relationship exists remains to be clearly demonstrated over a range of studies. 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. Similarly, a clear and consistent relationship needs to be established between cognitive distortions and specific interventions in controlled trials, as in Ladoucer et al's 2001 study with 35 problem gamblers, referred to earlier, and to a lesser extent in Breen, Kruegelbach and Walker's (2001) study of a cognitive intervention in a residential setting.

### **Multimodal Therapies**

A potential criticism of some behavioural and cognitive 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 perceived available alternative option to obtain funds to meet financial commitments. Clearly, multimodal approaches with a focus on the insight, group therapy and personal development seem an attractive proposition in the holistic management of pathological gambling.

Blackman, Simone, Thoms and Blackman (1986) 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 at that time 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 dynamics underscoring 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 Taber, McCormick, Russo, Adkins and Ramirez (1987), in a Veteran's Administration hospital 52-bed alcohol treatment facility in which six beds were reserved for gamblers. They have also been evaluated 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, as noted in our previous description of program types.

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 & Ramirez, 1984), 124 gamblers were surveyed by mail questionnaire at 12 months 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) patients continuing contact with Gamblers Anonymous claimed abstinence compared to 9 (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, compared with non-abstainers.

In the subsequent comprehensive six-month prospective follow-up assessment conducted over the telephone (Taber, McCormick, Russo, Adkins & Ramirez, 1987), data were 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 were 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 were 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 followed up subjects remained abstinent since treatment with the figure increasing to 94.4 per cent if the more liberal criterion of overall improvement was used. The abstinence outcome rate for the 'worst case' scenario — 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 re-calculated 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 itself, and the educational component, as the most helpful.

Comparable positive outcome rates are found in the European literature. In an uncontrolled study on an initial cohort of 58 pathological gamblers also treated in an integrated alcohol addiction unit, Schwartz 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 intervention, 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 those with only gambling problems but was unspecified for dual/multiple problem patients.

The reported outcome rates appear somewhat inflated. Follow-up data were 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 so do 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, the multimodal programs reported appear effective in 20–50 per cent of cases over one to two years. Methodologically, all were uncontrolled studies with no random allocation of patients or blind ratings of outcome. Consideration was not given to reporting on outcomes for specific forms of gambling and an unacceptable proportion of subjects appeared to suffer primary substance abuse disorders. The prolific number of components constituting multimodal therapies precluded 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. Analyses of these interventions suggested that less costly and briefer methods of behavioural intervention needed to be explored.

Hodgins, Currie and el-Guebaly (2001) compared two brief treatments for problem gambling with a waiting-list control in a randomised trial. Eighty-four per cent of participants (n=102) reported a significant reduction in gambling over a 12-month follow-up period. Participants who had received a motivational enhancement telephone intervention and a self-help workbook in the mail, but not those who received the workbook only, had better outcomes than participants in a one-month waiting-list control. Participants who received the motivational interview and workbook showed better outcomes than those receiving the workbook only at three- and six-month follow-ups. At the 12-month follow-up, the advantage of the motivational interview and workbook condition was found only for participants with less severe gambling problems. Overall, these results were deemed to support the effectiveness of a brief telephone and mail-based treatment for problem gambling, and echo Dickerson, Hinchy and Legg-Englund's (1990) earlier study on the use of a self-help manual with and without interview.

### **Pharmacological Approaches**

Do pharmacological agents have a place in the management of problem gambling? From 1980 a number of case studies appeared in the 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 judgement in which analogies have been drawn between the manifestations of repetitive gambling behaviour and obsessive-compulsive disorders (Hollander, Frenkel, Decarcia, Trungold & Stein, 1992).

Moskowitz (1980) reported successful outcome in two of three pathological gamblers treated with 600 mg lithium carbonate T.D.S. 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 fleetingly referred to the cessation of gambling following 'usual neuroleptic therapy' in conjunction with 'sociotherapeutic activities' (1992:144) in three schizophrenic, two manic-depressive and one epileptic pathological gambler. 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 people with manic depression. The relative contribution of medication compared to group therapy was not ascertained.

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 & 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 not only of gambling (Hollander, Frenkel, Decarcia, Trungold & Stein, 1992) but also sexual paraphilic behaviours (Bianchi, 1990; Emmanuel, Lydiard & Ballenger, 1991; Perilstein, Lipper & Friedman, 1991), compulsive non-paraphilic sexual addictions (Stein, Hollander, Anthony, Schneier, Fallon, Liebowitz & Klein, 1992), kleptomania and bulimia (McElroy, Kech, Pope & Hudson, 1989), body dysmorphic disorder (Hollander & Wong, 1995), and trichotillomania (Winchel, Jones, Stanley, Molcho & 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 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) acknowledged that further replication was required on larger samples before any conclusive statement regarding the effectiveness of clomipramine could be offered. Recognising that gamblers may temporarily abate their gambling behaviour for periods of up to 12 months, longer follow-up periods would be required.

Figgitt and McClellan (2000) note, of the more recently used selective serotonin re-uptake inhibitor (SSRI), fluvoxamine, that it is both potent and that it has little or no effect on other monoamine reuptake mechanisms. They report that in randomised, double-blind trials, fluvoxamine 100–300 mg/day for 6–10 weeks significantly reduced symptoms of obsessive-compulsive disorder (OCD) compared with placebo. Response rates of 38–52 per cent have been reported with fluvoxamine, compared with response rates of 0–18 per cent with placebo. In patients with OCD, fluvoxamine had similar efficacy to that of clomipramine and, in smaller trials, the SSRIs paroxetine and citalopram and was significantly more effective than desipramine.

Maintenance therapy with fluvoxamine may reduce the likelihood of relapses in up to 67 per cent of patients with OCD. Fluvoxamine  $\leq$  300 mg/day for 6 to 8 weeks was as effective as imipramine in patients with panic disorder, and significantly more effective than placebo. In addition, treatment with fluvoxamine  $\leq$  300 mg/day for  $\geq$  8 weeks improved symptoms of a range of other conditions, in much the same way as clomipramine and fluoxetine. These conditions include social phobia (social anxiety disorder), post-traumatic stress disorder (PTSD), pathological gambling, compulsive buying, trichotillomania, kleptomania, body dysmorphic disorder, eating disorders and autistic disorder. Figgitt and McClellan (2000) suggest that large trials comparing the efficacy of fluvoxamine and other SSRIs in patients with anxiety disorders are now warranted. Fluvoxamine is associated with a low risk of suicidal behaviour, sexual dysfunction and withdrawal syndrome. Although comparative data are lacking, the tolerability profile of fluvoxamine appears to be broadly similar to those of other SSRIs.

Hollander, DeCaria, Finkell, Bagaz, Wong and Cartwright (2000) assessed the effectiveness and tolerability of fluvoxamine in the treatment of pathological gambling in a 16-week randomised double-blind crossover design that ensured that each participant received eight weeks of fluvoxamine and

eight weeks of a placebo. Fifteen gamblers entered the treatment program, with ten completing. They found that fluvoxamine resulted in a significant percentage improvement in overall gambling severity on the PG Clinical Global Impression (PG-CGI) scale. There was a significant treatment effect on gambling urge and behaviour as measured by the PG modification of the Yale-Brown Obsessive Compulsive Scale and PG-CGI scale improvement scores. Interestingly, they also found a significant interaction of treatment effect with the order of administration of the drug and placebo. Post hoc analysis, treating each phase as a separate trial, demonstrated a significant difference between fluvoxamine and the placebo in the second phase of the trial, but not in the first, indicating a reduction of early placebo effect. In terms of tolerability, fluvoxamine side effects were of only mild intensity and consistent with SSRI treatment and were not associated with early withdrawal from the study. Hollander et al suggest that the evidence from this study suggests that it is worth testing for persistence of effect over a longer period of time, with a more diverse group of gamblers.

Bianco, Petkova, Ibanez and Saiz-Ruiz (2002), in their pilot placebo-controlled study of fluvoxamine for pathological gambling did not find as positive a response as Hollander et al (2000). Thirty-two patients were treated for six months in a double-blind, placebo-controlled study of fluvoxamine 200 mg/day. Outcome measures included reduction in both money and time spent gambling per week. Longitudinal mixed effects models and treatment completers analyses were used for estimation and hypothesis testing. Fluvoxamine was not statistically significantly different from placebo in the overall sample. However, fluvoxamine was statistically significantly superior to placebo in males and in younger patients. Although the power of the study was limited by the high (59 per cent) placebo-response rate, fluvoxamine may be a useful treatment for certain subgroups of patients with pathological gambling. Again, further testing is warranted with a more diverse population of gamblers, with longer follow up times, than end of treatment.

As noted earlier, Figgitt and McClellan (2000) had reported that in patients with OCD, including sub-samples of people with disordered gambling, fluvoxamine had similar efficacy to that of clomipramine, paroxetine and citalopram. Zimmerman, Breen and Posternak (2002) recently evaluated the effectiveness of citalopram in the treatment of pathological gambling through an open-label trial for 12 weeks of 15 adults who had met the DSM-IV criteria for pathological gambling. Participants were rated at baseline and at 2-week intervals on measures of gambling severity and depression, and monthly on quality of life. At treatment end, patients reported significant ( $p < .05$ ) improvements on all gambling measures including the number of days gambled, the amount of money lost gambling, preoccupation with gambling, and urges to gamble. Thirteen (86.7 per cent) of the patients were rated as 'much improved' or 'very much improved' on a clinician-rated Clinical Global Impressions scale for gambling. Patients reported improvement in depression and overall quality of life. Patients with major depressive disorder (MDD) ( $n=8$ ) improved to approximately the same degree as patients without MDD ( $n=7$ ). For most patients, clinical improvement occurred during the first two weeks of treatment; for the nine patients who completed the entire 12-week trial, these gains were maintained.

From this study, it appears that the SSRI citalopram is an effective treatment for pathological gambling, and that this benefit was independent of its antidepressant properties. Future studies employing a control group will be important to determine more closely the extent of the response to non-specific factors of treatment. This is especially important given the high level of placebo response reported by Bianco et al (2002) and Hollander et al (2000).

As found in the Zimmerman et al (2002) trial, depressive symptoms are found in many, if not the majority of pathological gamblers although the direction of causality is not always clear (McCormick, Russo, Ramirez & Taber, 1984; Blaszczynski & McConaghy, 1988). Given the fact that clomipramine and fluoxetine, for example, 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. Crockford and el Guebaly (1998) report the effects of naltrexone on an alcohol-dependent EGM player also treated with fluoxetine for depression, who had been abstinent for one month (gambling) prior to being prescribed naltrexone. There was no relapse over the next month, and Crockford and el Guebaly suggest that the 'endogenous opoid system acts as a common pathway in regulating cravings'.

Further studies of naltrexone as a treatment for pathological gambling have confirmed the effects reported by Crockford and el Guebaly (1998). Kim and Grant (2001) report the results of a study designed to test the short-term efficacy and safety of naltrexone in the treatment of pathological gambling disorder. Seventeen subjects (seven men, ten women) who fulfilled DSM-IV criteria for pathological gambling disorder, and who were free from other Axis I diagnoses by Structured Clinical Interview for DSM-III-R screening, participated in a six-week open naltrexone flexible-dose trial. Gambling symptom change was assessed with the patient-rated Clinical Global Impression (CGI) Scale, the clinician-rated CGI and the Gambling Symptom Assessment Scale. Side effects were monitored weekly and liver function tests bi-weekly. Naltrexone reduced urges to gamble and gambling behaviour. The mean change in gambling frequency per week was 1.40 +/- 0.28 episodes per week; the mean change in dollars lost per week was \$66.95 +/- 13.77; and the mean change in clinician-rated CGI Improvement was 0.40 +/- 0.04. Of those who responded to the medication, the majority had done so by the end of the fourth week. Men responded to naltrexone as well as women. The average naltrexone dose required for effective symptom control was 157 mg/day and in terms of side effects, nausea was common during the first week (47 per cent). Obviously, further work is needed to assess the persistence of these effects over time.

In a further study, Kim, Grant, Adson and Shin (2001) reported on a double-blind naltrexone and placebo comparison study in the treatment of pathological gambling. Eighty-three subjects who met DSM-IV criteria were enrolled in a one-week single-blind placebo lead-in followed by an 11-week double-blind naltrexone or placebo trial. Naltrexone was started at 25 mg/day and titrated upward until maximum symptom improvement or 250 mg/day was achieved. Gambling symptom change was assessed with the patient-rated Clinical Global Impression (PG-CGI-PT), clinician-rated CGI (PG-CGI-MD), and the Gambling Symptom Rating Scale (G-SAS). Side effects were monitored weekly and liver function tests bi-weekly. Data from 45 patients completing the study were analysed. The 38 participants terminated from the study included a small number who developed intolerable side effects of the drug.

Interestingly, the largest group of those excluded from the study (n=22) were participants who showed improvement of 50 per cent or more on the Gambling Symptom Rating Scale during the first week placebo lead-in period. This ten-item self-rated scale asks for an 'average symptom' experienced during the last seven days. Items include urge to gamble, symptom severity, frequency and duration; frequency and duration of thoughts associated with gambling; frequency and duration of gambling behaviour; degree of excitement caused by imminent gambling act; subjective distress caused by gambling and personal trouble caused by gambling. Given what we understand about the nature of help-seeking and motivation to change (Prochaska & DiClemente, 1988; Prochaska, Velicer, Rossi, Goldstein, Marcus, Rakowski, Fiore, Harlow, Redding, Rosenbloom & Rossi, 1994) it is not surprising that over one-quarter of people recruited into a 'pathological gambling treatment study' via newspaper advertisements were able to report changes after the placebo lead-in week, simply on the basis of having made a commitment to change. Significant behavioural changes with minimal interventions are not rare in this area (Dickerson, Hinchey & Legg England, 1990; Crisp, Jackson, Thomas, Thomason, Smith, Borrell, Ho, & Holt, 2001; Hodgins, Currie, & el-Guebaly, 2001).

Using random regression analysis, Kim et al (2001) noted significant improvement in all three gambling symptom measures: patient-rated Clinical Global Impression,  $p < .001$ ; clinician-rated CGI,  $p < .001$ ; Gambling Symptom Rating Scale,  $p < .019$ . At study end, 75 per cent of subjects taking naltrexone were much or very much improved on both the PE-CEI PT and the PG-CGI-MD, compared with 24 per cent of those on placebo. In light of the comments above on motivation to change, it is worth noting that 64 per cent of those in the placebo group showed some improvement. The results of this study, again, suggest that naltrexone is effective in reducing the symptoms of pathologic gambling. In this study female participants outnumbered men nearly 2:1. Further studies are needed to determine how applicable these findings are to gambling populations varying by age, gambling type and duration of problem. Until further studies corroborate the present findings, their report should be interpreted cautiously.

As we can see, several types of medication have been demonstrated to be effective in some cases of pathological gambling: serotonin reuptake inhibitors; opioid antagonists; and mood stabilisers. The encouraging reports of the efficacy of clomipramine, fluoxetine and fluvoxamine in impulse control disorders suggests the possibility that repetitive, driven, or compulsive urges are characteristic features which may link pathological gambling, sexual paraphilias and obsessive-compulsive disorders. Such a proposition warrants further investigation for, if so, the reconceptualisation 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. Support for the use of naltrexone is suggested by its effect on other conditions in which 'urges' are the dominant characteristic such as alcoholism and bulimia nervosa.<sup>1</sup>

Additional developments in pharmacological approaches to the management of problematic gambling behaviour, and developments in the way we understand the role of memory and decision-making, for example, may also stem in the future from ancillary areas of research in which brain function is implicated in gambling-related behaviours. As an example, a recent study (Stout, Rodawalt & Siemers, 2001) on decision making in Huntington's disease (HD) reports on a laboratory-based simulated gambling task which had been used to quantify decision-making deficits in ventromedial frontal lobe damaged participants. They hypothesised that participants with HD would show deficits on this gambling task. For this study, 14 HD participants were asked to make 100 selections from four decks of cards with varied payoffs in order to maximise winnings of play money. They were compared to 22 participants with Parkinson's disease (PD) and 33 healthy controls. After an initial period in which participants had to learn contingencies of the decks, the HD group made fewer advantageous selections than the PD and control groups. In HD, the number of advantageous selections in the gambling task was correlated with measures of memory and conceptualisation but not disinhibition. Thus, people with HD may have had difficulties learning or remembering win/loss contingencies of the decks, or they may have failed to consistently take these into account in their card selections. Yet other studies, point to a greater understanding of the role of influences on decision making in gambling behaviours, such as Gehring and Willoughby's (2002) study of the rapid processing of monetary gains and losses and the riskiness of gambling choices following gains and losses.

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<sup>1</sup> The Responsible Gambling Council of Ontario recently reported in their 'Newscan' 4,20, May 24 2002, that tests are currently underway to determine if Nalmefene, an opiate-receptor blocker, could be marketed as a specific 'pathological gambler's pill'. ([www.responsiblegambling.org](http://www.responsiblegambling.org))

## Other Treatments

Other approaches to treatment have been suggested, including solution-focused brief therapy (Berg & Briggs, 2002) but as Berg and Briggs acknowledge, the approach to treatment was developed inductively in clinical practice, and has, as yet, not been subjected to rigorous pre- and post-test outcome studies of its effectiveness. Although evidence is now emerging on the clinical effectiveness of this approach (Gingerich & Eisengart, 2000; Macdonald, 2000), and its apparent cost effectiveness, there is no detailed evidence of its effectiveness with problem gamblers. Additionally, in support of multimodal interventions, there are suggestions that specific interventions, such as hypnosis, may prove effective when used in conjunction with other forms of intervention (Coman, Evans & Burrows, 1996).

## Conclusions on 'Best Practice' from Reported Studies

From this review of reported studies, our conclusions are broadly similar to those reached by the NCETA team in their theoretical and empirical review of 'best practice' interventions (NCETA, 2000). There appears to be support for a broad bio-psychosocial approach, using cognitive behaviourally oriented approaches and multimodal approaches delivered in community-based generalist agencies. This 'eclecticism' has been recognised also by McCown and Chamberlain (2000) in their extensive review of contemporary treatment strategies. In their case, however, they prefer to label it 'pragmatism', as they argue for multimodal treatment approaches, informed by a range of theories, to meet the variety of needs of people with a range of problems, at different levels of severity, in relation to a range of gambling modes .

Lopez Viets and Miller (1997:697), reviewing the findings of over 40 published problem gambling treatment outcome studies concluded that:

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

This is borne out in the review of materials presented here, although, as noted earlier in relation to methodological issues in gambling treatment outcome studies, some caution needs to be exercised in assessing actual rates of positive outcome by mode of intervention. This conclusion is not quite as pessimistic as that proposed by Oakley-Browne and Mobberly (2002) in their Cochrane Review report on interventions for pathological gambling. Oakley-Browne and Mobberly (2002), in keeping with Cochrane Review practice, conducted a systematic review and meta-analysis of randomised controlled trials (RCTs) of gambling treatments. As our review suggests, very few studies qualify for the rigorous definition used for a Cochrane Review. The authors were able to identify only four RCTs completed up to the time of their analysis. Although they concluded that there was a paucity of evidence for effective treatment of pathological gambling, they were able to show that behavioural or cognitive behavioural interventions were more efficacious than control treatments, both in the short-term and longer-term. Ladouceur, Sylvain, Boutin, Lachance, Doucet, Leblond, and Jacques' (2001) report of their controlled clinical trial of cognitive intervention is encouraging in this regard.

What emerges in the latest studies is support for a broad bio-psychosocial orientation to understanding:

- The aetiology of problem gambling;

- The form of expression of problematic gambling;
- The impacts of problematic gambling behaviours.

There is also a need to identify specific targets for interventions, whether these interventions are pharmacological, cognitive, behavioural, or systemic in nature. The implications for service design are that services may be both treatment-specific or multimodal in orientation, but that interventions should be theory-driven, evidence-based and targeted.

# Chapter 5

## Problem Gambling Services in Victoria

### Introduction

The analysis of the treatment outcome literature and our own research on outcomes, cited in Chapter 4, suggest that the model presented in Figure 2 is a useful way of thinking about intervention inputs and outputs. The model asserts that the outputs or outcomes of an intervention process are affected by four classes of factors. These include:

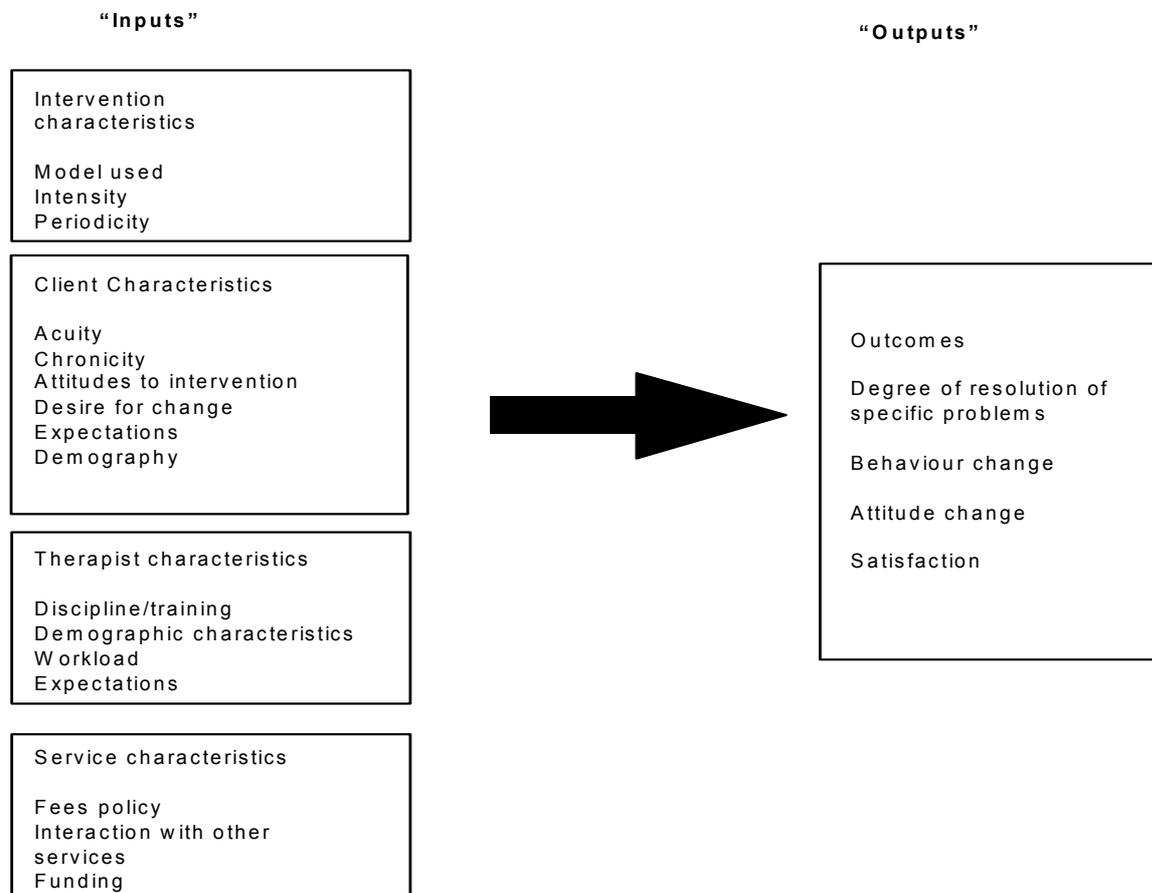
- Characteristics of the intervention, including the theoretical model used and features of the intensity and periodicity of the intervention — e.g. the number, timing and length of sessions;
- Client characteristics. Clients with more severe and chronic conditions may be harder to assist. Issues such as client attitudes to the interventions, the client's desire for change, their expectations of the intervention process and the outcomes it will produce and the demographic characteristics of the client may affect intervention outcomes;
- Therapist characteristics — the discipline and training of the therapist, their demographic characteristics, workload and expectations concerning the intervention process and the outcomes it will produce may affect intervention outcomes;
- Service characteristics and design: Certain service features may impact upon outcomes including charging policies and access and equity characteristics. How this service interacts with others and its funding arrangements and amenities may impact upon outcomes;

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

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

**Figure 2**  
**A Model of Intervention Inputs and Outputs**

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## Method

To provide an analysis of problem gambling services in Victoria and conduct this analysis with reference to the complexity of the practice, as reflected in the above model, a range of data collection methods was used. However, the data contained in this chapter, and in chapters 6–9, do not constitute an evaluation of problem gambling services. Rather, this report’s purpose is to make some judgements, using a variety of methods of enquiry, as to best practice in problem gambling services. Methods used in data collection for the following chapters included:

1. Review of all data pertaining to the effectiveness of the Gambler’s Help Problem Gambling Counselling Service, as reflected in the relevant volumes of the six-volume report series on the ‘Longitudinal Evaluation of the Effectiveness of Problem Gambling Counselling Services, Community Education Strategies and Information Products’, commissioned by the Department of Human Services, Victoria. These reports covered:
  - Service design and access (Jackson, Thomas, Thomason, Borrell, Crisp, Enderby, Fauzee, Ho, Holt, Perez & Smith, 2000);

- Counselling interventions (Jackson, Thomas, Thomason, Borrell, Crisp, Ho, Holt, & Smith, 2000);
  - Counsellor practice (Jackson, Thomas, Thomason, & Holt, 2000);
  - Natural recovery from problem gambling (Thomas, Jackson, Anderson & Kearney, 2000).
2. Review of outcome data as contained in the Problem Gambling Client and Services Analysis Reports, with particular reference to the trend data contained in the latest publicly available report (Jackson, Thomas, Ross & Kearney, 2001).
  3. Focus group interviews with 19 clients of Gambler's Help and the Free Yourself program. Questions used to guide discussion in the focus groups included:
    - What do you think affects a person's wish to gamble?
    - What would make someone go from being a regular gambler to being a problem gambler?
    - If you ran things what would you do to better protect problem gamblers?
    - Do you have experience of self-exclusion, and does it work?
    - What are the features of a good problem gambling service?
    - Do current problem gambling services give you what you need?
    - Is the aim of your involvement with a problem gambling program abstinence or control of gambling?
  4. Group and individual interviews with fourteen of the Gambler's Help program co-ordinators, the Gambler's Helpline and Gambler's Help Secretariat to gain their perspective as program managers on counselling practice generally as per the questions noted in point 4 below, 'best practice' theory and practice, and inter-agency co-ordination.
  5. Individual and group semi-structured interviews with an additional twenty-six Gambler's Help counsellors. Questions used in these interviews included:
    - What do you consider is meant by a 'successful' intervention with a person(s) with a gambling-related problem?
    - How do you currently measure success in your service?
    - What do you consider to be the key elements of 'successful' methods of intervention for people with gambling problems? Prompt included:
      - theoretical model;
      - individual/couple/family intervention orientation;
      - intervention intensity (actual vs. ideal number of sessions);
      - intervention timing in problem onset;
      - location of service delivery; e.g. centre based, outreach, home based.
    - Do the 'best' methods differ for different groups? Prompt included:
      - men/women;
      - people from different cultural backgrounds;

- type of gambling preferred;
  - severity of the gambling-related problem;
  - length of time the person has experienced the problem.
6. Group interviews with seven Department of Human Services Head Office and regional staff responsible for Gambler's Help liaison. These interviews explored issues such as service design, standards, staffing and outcome measurement in the Gambler's Help program.
7. Individual semi-structured interviews with twenty providers of services other than Gambler's Help, covering areas such as financial counselling, mental health, legal services, family support services, emergency services including accommodation services, and relationship counselling. Questions used in these interviews included:
- Does your program see people with gambling-related problems?
  - Do you routinely screen your clientele for gambling-related problems?
  - What proportion of your clientele is made up of people with gambling-related problems, and how do you know this e.g. what records are kept on problem type in your agency?
  - Do you offer any interventions specifically to people with gambling-related problems?
  - If yes, what is the target of these interventions e.g. gamblers themselves, partners, families?
  - How do you measure the 'success' of these interventions?

See Appendix 1 for details of those interviewed, in the categories specified in items 3, 4, 5, 6 and 7 of the above list.

## The Victorian Gambler's Help Program

### Introduction

The Victorian *Gaming Machine Control Act 1991* and its 1996 amendments provides for the establishment in the Public Account of the Community Support Fund, with the legislation requiring that 8.3 per cent of daily net cash balances from Electronic Gaming Machines in hotels be paid into the fund. The Minister for Gaming, under the provisions of the Act, may apply for money in the fund for a range of purposes including:

- Funding of research on the social impact of gambling, a function originally undertaken by the Victorian Casino and Gaming Authority, and after the enactment of the *Responsible Gambling Act 2000*, by the Gambling Research Panel;
- Sport and recreation clubs or programs and community services including financial counselling services, support and assistance for families in crisis, programs for prevention of compulsive gambling, programs for the treatment or rehabilitation of persons who are compulsive gamblers and government initiatives on youth homelessness;
- The promotion of arts and tourism (Auditor-General of Victoria, 1996:14).

One of the triennial grants provided by the Community Support Fund was for the implementation of a Problem Gambling Services Strategy (PGSS). The Victorian government implemented and developed the strategy from 1993, through a range of proposals by the Department of Human Services including the establishment of:

- Problem gambling counselling services, including problem gambling counselling services that are integrated with financial counselling services; and
- A range of counselling and support services that address family issues that may arise as a result of problematic gambling, through the establishment of state-wide family skills and regional family resource centres.

The strategy comprised a number of important and interrelated components including counselling services for those affected by problem gambling activity located in generalist agencies; gaming liaison and community education officers in each Department of Human Services region; a range of community education initiatives and media campaigns; a free, 24-hour telephone counselling and referral service; and a social research and evaluation program to provide information regarding problem gambling in the community and inform appropriate service responses.

Developments in the service model in recent years have seen a re-branding of the original BreakEven Problem Gambling Counselling Service as Gambler's Help and the G-Line telephone counselling service as Gambler's Helpline. Financial counselling was integrated into the Problem Gambling Services Strategy in 2000–2002, while discretionary funds were introduced in 1999–2000 and fully implemented by 2000–2001.

### **Existing Research on Treatment Practices and Intervention Outcomes of the Gambler's Help Counsellors**

The Victorian program has been subject to the most thorough review of any Australian program to date, through the Longitudinal Evaluation project noted in the introduction to this chapter. Data noted here were obtained from two sources in that study: interviews with 51 of the available 52 counsellors (98 per cent) and a Clinical Practice Evaluation (CPE) involving questionnaire data returned from 43 counsellors (83 per cent) (Jackson, Thomas, Thomason, Borrell, Crisp, Ho, Holt & Smith, 2000). Of 17 questions put to counsellors, three are 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 (e.g. reflective listening, imaginal desensitisation, free association, role-playing).

The survey of Gambler's Help program counselling practice and theories in use revealed that a broad range of theoretical perspectives underpin the delivery of the Victorian problem gambling program. 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 (of a possible 18 at the time, i.e. 83 per cent) by counsellor responses to the CPE questionnaire adopted an eclectic approach to counselling. This is consistent, as noted previously, with current trends in counselling and psychotherapy. Although a number of agencies did not specifically use the term 'eclectic', they described a spectrum of perspectives that informed their counselling practice with problem gamblers:

- Among the most influential contributions to counselling practice was cognitive behavioural therapy (CBT), mentioned by the majority of Gambler's Help agencies as a major component of their theoretical framework;
- The client-centred approach based on humanist psychology was also a major focus of counselling practice;
- Motivational approaches (particularly those informed by Prochaska and DiClemente, 1998) in terms of assessing the client's readiness to change, and systems theory are part of the theoretical framework of some Gambler's Help host agencies;
- Solution-focused therapy, narrative therapy and psychodynamic therapy were also mentioned by a number of Gambler's Help program providers;
- Among the less common 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 Gambler's Help counsellors pointed out that the issue of aetiology is particularly complex. 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 counsellors 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 counsellors 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', Gambler's Help 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 3 shows the most common therapeutic techniques and strategies employed by Victorian Gambler's Help counsellors.

**Table 3**  
**Most common therapeutic techniques used by Victorian Gambler's Help counsellors (n=43)**

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

Source: Jackson, A.C., Thomas, S.A., Thomason, N., Borrell, J., Crisp, B.R., Enderby, K., Fauzee, Y., Ho, W., Holt, T.A., Perez, E. & Smith, S. (2000) *Longitudinal Evaluation of the Effectiveness of Problem Gambling Counselling Services, Community Education Strategies and Information Products—Volume 1: Service Design and Access*. Melbourne: Victorian Department of Human Services. p 76

It is evident that the organisations implementing the Gambler's Help program have developed an eclectic orientation in their counselling of problem gamblers. A broad range of theoretical perspectives underpins the delivery of the service and influences counsellors' approaches to treatment. Cognitive-behavioural theories and psychosocial theories appear to be among the most influential contributions to counselling practice, which, as discussed in Chapter 4, is reflective of best practice in community-based services reaching a client base heterogeneous in terms of gambling type and severity.

We now turn to a brief review of data from the largest survey yet undertaken (n=150) of Gambler's Help clients (Jackson, Thomas, Thomason, Borrell, Crisp, Ho, Holt, & Smith, 2000). Questions concerning the following areas were included in the questionnaire distributed to clients:

- Service use, including specialist gambling-related services and more general services;
- Their state prior to counselling in terms of gambling, general life issues and readiness to change;
- Their rating for the period before and after counselling, how they felt about their current level of gambling, and if they would attribute any change that occurred to the actual counselling process;
- The counselling process itself (client suitability, therapeutic relationship including: bond, expectations/purposes, tasks/goals);
- Outcome (symptoms, life matters, other problems, satisfaction, termination factors).

The study found that there was a high level of positive — partial, full or satisfactory — resolution in all defined problem areas. In assessing the outcome of clients' gambling behaviours, 43 per cent had full or satisfactory resolution levels and 46 per cent experienced partial problem resolution. In

addition, it was noted that clients experienced the highest level of full problem resolution in relationship problems and problems with their physical health caused by their gambling activity.

Almost three-quarters (71 per cent) of clients felt that attending counselling at Gambler's Help impacted on their gambling activity in a positive way, with 45 per cent of these rating the impact as 'a great deal'. Two-thirds of respondents stated they gambled 'a lot less' after attending Gambler's Help. We have reported elsewhere, on a very similar group of Gambler's Help clients, that there is a statistically significant difference in number of counselling sessions attended, between those achieving full resolution of their primary problem and those achieving no resolution (Crisp, Jackson, Thomas, Thomason, Smith, Borrell, Ho & Holt, 2001). There is no significant difference in number of sessions attended to achieve full satisfaction, and number attended to achieve partial satisfaction. In all of these resolution states, however, the number of counselling sessions remains very small, with mean number of counselling sessions being 2.32 for non-resolved primary problem; 3.47 for partially resolved primary problem; and 4.15 for fully resolved primary problem.

These findings on problem resolution and post-counselling gambling behaviour compare very favourably with those attained in a similar state-wide service based on a stepped care approach, in Oregon (Moore, 2001).

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

This indicates a counselling process producing an effect of heightened understanding as well as problem resolution.

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

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

The study also found that the level of problem resolution was higher for problem gamblers in cases where no further contact has been planned; i.e. where the counsellor had terminated the counselling believing that counselling goals had been attained, as might be expected.

The earlier study of counselling effectiveness (Jackson, Thomas, Thomason, Borrell, Crisp, Ho, Holt, & Smith, 2000) revealed a diversity of expectations that counsellors had as to client outcomes, and it was not uncommon to find a diverse range of expectations from within the same agency. Consistent with a client-centred approach, the most frequently nominated expected outcome was that clients achieve their own goals, although this was nominated by less than one-third of all counsellors. Unspecified client change was the next most common expectation. Specific changes by clients which were the expectations of some counsellors, were reduction in amount of gambling and reduction of the harmful effects of gambling; resolution of emotional issues; and better family functioning.

### Key Findings on Counselling Outcomes and the Counselling Process

In the study reviewed, the therapeutic relationship was the process variable that most consistently predicted positive outcome.

Counsellors acknowledged this, describing the relationship as the basis from which the work becomes possible. Table 4 below shows the results of multiple regression techniques used to assess the impact of process measures, controlling for gender, age, and impact on a range of outcome measures. This table lists all the statistically significant outcomes of these analyses.

**Table 4**  
**Gambler's Help clinical practice evaluation sample: Statistically significant counselling outcome and process linkages (n=150)**

Outcome variable	Process Variables P<.05	Sig	Standardised (Beta)	Correlations	
				Zero-order	Partial
Percentage of problems fully resolved	Therapeutic relationship	.005	.262	.231	.265
	Number of sessions	.031	-.200	-.170	-.206
Percentage of problems fixed to satisfaction	Therapeutic relationship	.000	.349	.343	.352
	Gender	.052	-.179	-.136	-.181
Percentage of problems partly resolved	Number of sessions	.013	.227	.205	.229
Percentage of problems unresolved	Therapeutic Relationship	.000	-.480	-.485	-.481
Counselling had a positive impact on gambling activity	Therapeutic Relationship	.000	.620	.620	.621
Client was satisfied with counselling outcomes.	Therapeutic Relationship	.000	.349	.343	.352
	Actual Age	.006	-.208	-.243	-.254
Better self awareness	Therapeutic Relationship	.000	.370	.385	.374
Better understanding of the nature of their problem gambling behaviour	Therapeutic Relationship	.000	.467	.463	.456
Better ability to accept responsibility for the problems their gambling caused	Therapeutic Relationship	.000	.414	.420	.415
Better ability to communicate with others close to them	Therapeutic Relationship	.000	.462	.459	.463
Better ability to cope with stress	Therapeutic Relationship	.000	.429	.427	.429
Better self esteem	Therapeutic Relationship	.000	.432	.436	.437
Better self confidence	Therapeutic Relationship	.000	.384	.380	.394
	Gender	.008	-.243	-.230	-.250
Better ability to talk to others about sensitive issues	Therapeutic Relationship	.038	.196	.203	.198
Better knowledge of services available that can assist people with gambling related problems.	Therapeutic Relationship	.000	.355	.356	.362
	Gender	.034	.195	.193	.200

Source: Jackson, A.C., Thomas, S.A., Thomason, N., Borrell, J., Crisp, B.R., Ho, W., Holt, T.A., & Smith, S. (2000) *Longitudinal Evaluation of the Effectiveness of Problem Gambling Counselling Services, Community Education Strategies and Information Products—Volume 2: Counselling Interventions*. Melbourne: Victorian Department of Human Services. p 57

As this table illustrates, a number of process variables have a significant (at  $p < .05$  level) predictive relationship with the outcome variables, although the reported strength of the associations are weak to moderate. As indicated, the therapeutic relationship is consistently shown to be the variable most strongly associated with the outcomes achieved by clients. This finding is consistent with the literature reviewed earlier, exploring the linkage between process and outcome in counselling and psychotherapy in which the therapeutic relationship is often identified as the 'non-specific' factor most likely to have an impact on counselling outcome (Bergin & Garfield, 1994).

In addition to the major finding on the significance of the therapeutic relationship, the following aspects of the relationship between the counselling process and counselling outcomes were found:

- Counsellors with the highest rates of problem resolution used a mix of client-centred humanistic psychology, cognitive behaviour therapy techniques, and solution-focused counselling, in response to the diversity of the client base and variable need;
- A thorough psychosocial and readiness-to-change assessment of the client was a feature of the work of all counsellors achieving high levels of problem resolution;
- Client participation in goal setting and a realistic, timely and achievable set of goals characterise the goal setting of all counsellors achieving high levels of problem resolution;
- Counsellors achieving high levels of problem resolution used an eclectic mix of techniques in their work with clients. Decisions regarding which techniques to use were based on their initial assessment and goals as defined with the client. No particular technique stood out as the most valued or valuable;
- The review processes used by the counsellors vary. All counsellors achieving high levels of resolution, however, indicated the importance of celebrating client achievements no matter how small;
- Counsellors considered the counselling effort needed to be considered as a collaborative effort between them and the clients for it to work;
- The active ingredients for successful outcomes according to counsellors were a strong therapeutic relationship, client readiness to change, client ability to self reflect and finding the right fit between the client and the intervention;
- Conversely the factors counsellors considered hindered the achievement of these outcomes were: lack of relationship, lack of motivation on behalf of client, lack of alternative forms of leisure, co-morbidities, client unwillingness to disclose, and when gambling has become a central part of a persons self definition;
- Level of problem resolution is related to the number of sessions attended. The more sessions attended the more likely that the problem would be partially or fully resolved.

### **Key Findings on Counselling Outcomes and Client, Counsellor and Agency Characteristics**

Having detailed the centrality of the therapeutic relationship to the achievement of therapeutic outcomes, it is important to note briefly the impact of other factors on outcome, such as client, counsellor and agency characteristics. Very few client characteristics have been found to have a statistically significant impact on counselling outcomes in the Gambler's Help program to date (Jackson, Thomas, Thomason, Crisp, Ho, Holt & Smith, 2000). Clients' satisfaction with their current

level of gambling was the variable most consistently related to level of problem resolution. The number of presenting problems was related to a problem being unresolved or partially resolved. Older clients were less satisfied with their counselling outcomes. Clients in the action stage of readiness to change, at the end of the first counselling session, were more likely to resolve problems, increase life skills, and had a greater level of satisfaction with the outcomes of counselling. The level of an individual's debt did not impact in any significant way the level of problem resolution they achieved. Two-thirds of Gambler's Help clients who attended the service with gambling behaviour as their presenting problem, had a positive resolution of their problems by the time of case closure.

Key findings from Jackson, Thomas, Thomason, Crisp, Ho, Holt and Smith's (2000) analysis of the relationship of counsellor characteristics to client outcomes showed that overall, women counsellors had lower levels of clients with unresolved problems. Somewhat counter-intuitively, counsellors with high caseloads, measured by number of client contacts, had higher levels of client satisfaction with outcomes. Counsellor characteristics were, on the whole, not predictive of client outcomes.

In terms of agency characteristics, clients from non-metropolitan centres were more satisfied with the outcomes of counselling and reported a greater impact of counselling on their gambling behaviour and higher levels of problem resolution. The size of the Gambler's Help service and its level of funding did not impact outcomes achieved. In general, clients experienced Gambler's Help as particularly useful in the following ways:

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

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

Clients' major dissatisfaction with the service related to access issues such as availability of after-hours session times.

This has now been addressed to a great extent with a range of flexible service delivery models available in Gambler's Help services, as detailed in Appendix 2. This flexible delivery includes delivery of services from over 120 sites throughout the state, including after-hours individual and group counselling available as standard options in the Eastern, Northern and Western Regions.

### **Overview of Current Counselling Practice in Gambler's Help**

Counsellors interviewed provided a range of responses to the question 'What do you consider to be the key elements of 'successful' methods of intervention for people with gambling problems?' Cognitive behavioural therapy was very popular, but in accord with the general multimodal orientation taken, was never mentioned as a sole therapy. Other methods included behavioural therapy, motivation counselling, harm minimisation and psychodynamic approaches.

A somewhat new dimension has been added, however, with some counsellors noting as successful interventions, changing lifestyle patterns, diets and routine as well as developing a trusting and honest relationship with the client. Generally, it was agreed that no one therapy is the key to successful intervention. The following examples exemplify the diversity of answers:

*'Personally, I use CBT, motivational interviewing and a solution focus. These work with addictions. Others in this service use psychodynamic processes. I employ a systemic outlook ...'*

*'Too many conventional therapies focus on the problem. Gambling is NOT the key element of change. I challenge people to change routine, do something different. Delay of gratification, for example, on a cup of coffee. The key is, what can the person do to change their thinking pattern, not necessarily linked to gambling? What about underlying issues? To get to the core in my experience people's lives are made up of pieces: for example, relationship issues are one piece. If it is missing gambling can be used to fill the gap and make them feel good. So the key question is what do you fill with gambling? CBT is used, neurolinguistic programming remodel and refined on that science. I also believe that diet is major component to support mental strategies. Chemical imbalance, that is, endorphins etc. diet can play a big part. Stimulants, physical withdrawals, crave chemical balance. Venues are set up to stimulate chemicals, normal baseline chemistry changes and you become used to different balance, can crave to go back there ...'*

*'It depends on the client. I use a behavioural approach mostly and give people a chance to ventilate their story. When I go to the prison, many of the clients do not have the cognitive functions. I then use the Free Yourself Model. The findings have been working really well. People seem to appreciate hearing from an ex-problem gambler. It identifies the urge, separate from self and associated positive and negative feelings with the urges. We run a support group on the Free Yourself Model. The Free Yourself Model looks at the addictive process very well and it matches interventions ...'<sup>2</sup>*

As demonstrated in the 2000 study of counselling practice, a strong recognition persists that development of a relationship with the client is seen as a crucial factor in the intervention process:

*'Relationship with the client is the key. Create an environment where they are comfortable etc. Hold discussions in supported environment. We use a two-tiered system: level one intervention addresses gambling, level two, the sustained purpose of gambling. A variety of approaches are used, for example CBT, psycho dynamic, family therapy approach. It is really critical that counselling can look at underlying issues of behaviour, more sustained change happens around purpose of behaviour. For example, using an addictions approach, where gambling is not the problem but coping mechanisms are, give them more adaptive strategies ...'*

*'The relationship that develops between the counsellor and the client is key. All techniques are used, we have six different counsellors with different backgrounds and different models: CBT, start with behaviour, cognitive, anxiety, similarities of problem gambling behaviour and symptoms and anxiety as strategy. It depends on what the client brings with them, behaviour and circumstances. Can lead to see what is relevant ...'*

From financial counsellors interviewed, the view is somewhat different where the focus is primarily on financial impacts. Sometimes the partner or another family member are involved, not the actual gambler. This, it is suggested by these counsellors, usually happens when the gambler is in denial.

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<sup>2</sup> The Free Yourself Program is discussed in some detail in Chapter 6.

## Differential Diagnosis and Treatment

In surveying service providers, the question ‘Do the best methods differ for different groups?’ provoked a variety of responses, primarily concerning the central theme of client individuality. Some respondents offered observations of patterns they have encountered through therapy, such as what men, women, young, old people, and different cultural groups have as motivations for gambling and their preferred or ‘best’ method of intervention. These included:

*‘Men gamble for money reasons, however women gamble because of loneliness and young people gamble because of peers...’*

*‘Men prefer practical advice and solutions, whereas women prefer looking at background issues and young people respond to counsellors as friends and on their “wavelength”...’*

These and other observations reported, however, still do not provide a ‘recipe’ for therapy for any given group:

*‘It’s important to get to know the client and then select the best approach. The same behaviour can mean different things, for example, depression, sensation seeking, anxiety, “switch off”. Someone who sits in a pokie venue may be there for “time out” whereas the person sitting next to them may be looking for company. It is critical to look at purpose and their experiences of the world. Then be flexible in your approach ...’*

*‘It’s important to develop the relationship between counsellor and client, build on strengths, raise issues. Must be understanding of cultural differences; some cultures have very strong family orientation. Be aware and open to differences ...’*

*‘The aim is to match the best method to the client. Understanding their background is important, encouraging clients to be open and explore. For example, some GA, some self help, meditation. The goal is to find the solution for the client ...’*

*‘Clients have different backgrounds, for example, educational levels. Clients in prison have other issues with the criminal justice system. Sometimes work is done with partners or family members. The client is sometimes not the gambler, either partner or family member. The method depends on why the client is really there ...’*

It is important to note that while some of the counsellors believe that it depends on the type of person and their underlying issues as to how to approach therapy or intervention, a factor mentioned by others is the type of gambling the client has problems with. That is, intervention is directed to some extent by the modality of gambling:

*‘Definitely. Different types of gamblers, for example, pokie players versus TAB bettors. The reasons for gambling, for example, behaviour therapy works well with people who gamble to win. Others gamble for other reasons, such as victims of abuse or domestic violence — often need different methods to address these issues first ...’*

A number of counsellors from a range of services noted that some ethnic groups are not accessing the Gambler’s Help services. They reported that problem gambling is seen as something shameful, to be hidden, resulting in people from these communities not seeking help.

*‘Don’t get many referrals through the Iraqi population because it is denied and seen as unacceptable in their culture ...’*

The Aboriginal population can often be mistrustful of anything with government involvement, while NESB gamblers are reluctant to speak to a counsellor not from their own cultural background. The Springvale Chinese Mutual Assistance Association are trying to find the funding to hire a part-time Vietnamese-speaking counsellor as this is seen as an area of great concern. The current social

worker often refers to Gambler's Help Southern but knows of only one case where the person has acted on this recommendation.

Other Gambler's Help services, as detailed in Appendix 2 'Gambler's Help Sites', provide counselling in Mandarin/Cantonese, Croatian, Serbian, Macedonian, Slovenian, Greek, Polish, Arabic, Italian, Vietnamese and Spanish. There is no available evidence, however, that this specialised counselling service attracts clients from these language communities or the Aboriginal community at a higher rate than if the services were not offered in these languages or with an indigenous focus. Nor is there evidence that the counselling achieves different outcomes from the non-CALD focused counsellors.

There is an urgent need for the Department of Human Services to commission or conduct an evaluation of the effectiveness of these specialised counselling services.

### **Measuring Success and Ensuring Quality in Practice**

Gambler's Help counsellors, when previously surveyed on how they monitored their professional practice (Jackson, Thomas, Thomason, Crisp, Ho, Holt & Smith, 2000), nominated a range of methods and performance indicators with the most frequently mentioned being professional supervision, which was nominated by 80 per cent of the counsellors. Discussions with colleagues, whether from their own Gambler's Help program, employed elsewhere in the agency or in other agencies (including other Gambler's Help services) were also important in providing feedback to counsellors irrespective of whether this occurred informally or in formal settings such as case conferences and clinical settings.

Discussions and feedback from colleagues was as likely to be nominated as a method of monitoring practice as was feedback from clients as to their progress, which was nominated by slightly more than half of the counsellors.

This reliance on supervision and colleagues to provide feedback on practice performance is not unusual, but rather, a common feature of social workers' practice, but less of a feature of psychologists' practice. Mullen and Bacon (2001), for example, in a survey of 124 counselling staff in a large community-based welfare organisation, found that 45.5 per cent of social workers sought such supervision and consultation daily or a few times a week, compared with only 31.3 per cent of psychologists who sought supervision with that frequency.

Few counsellors in the 2000 study used any form of client survey, being more likely to rely on verbal reports from clients. Given the importance attached to external feedback, it is perhaps not surprising that less than one-third of counsellors reported engaging in some form of reflective process to assess their work, and only two considered their own job satisfaction to be a performance indicator.

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

Half the counsellors in the 2000 survey reported receiving professional supervision from outside the agency, mostly in addition to, but in some cases instead of, supervision from within the agency. External supervision was sought for a range of reasons including an inability of the agency to provide professional supervision, a desire to gain particular skills and as a pre-requisite for professional registration. For almost half the counsellors, supervision was an important component of their ongoing professional education. Importantly, by being a forum in which practice was open to scrutiny, supervision was not only a forum that fostered accountability but was perceived as helping to maintain professional standards.

In response to the question put to Gambler's Help counsellors and co-ordinators in the interviews conducted specifically for this report, 'How do you measure success in your service?' many counsellors reported this to be difficult, and sometimes impossible. The majority of counsellors reported that 'client self rating' was their means of gauging success, often combined with other external indicators such as scales; the extent of adoption of control measures such as self exclusion; continuing to attend counselling, and occasionally through formal evaluations:

*'When it is a problem, it is a problem interfering with their life, so when they are back in control as rated by the client, then this is successful. Also when they have achieved the goals that they have set, this could be anything including financial management. We do not have a formal evaluation ...'*

*'Because everyone is different and has a different story it is hard to have one measure of success. Approach each client and ask for feedback. Understand the client's goal and that they may have relapses but feel comfortable to come back. It is hard to predict the addiction pattern. Understand the nature of the problem and make positive experience of them ...'*

*'I don't have a measure of success. I take client feedback. I also think that when clients continue to attend counselling and begin to address their underlying issues. I do not tick the "case closed" box very often because people come back again ...'*

Measurement of outcomes as a specific aspect of quality assurance is one of the areas that is least well developed in the Gambler's Help program, with such lack of development seemingly at odds with the thoughtfulness and adherence to best practice (as far as best practice in community-based services can be determined), typical of the rest of the operations of the program.

Gambler's Help service co-ordinators interviewed for the present study identified a number of relevant issues relating to outcome measurement:

- The need for a consistent protocol across all sites regarding follow up procedures for a range of intervention modalities;
- Agreed definition on what constituted 'intervention' or 'episodes of treatment'. As one co-ordinator put it;

*'When does someone cease being a client? After three sessions, after ten, after ninety? ...'*

This latter point is important. It is clear that outcomes have to be measured against goals and that the appropriate time to measure goal attainment is when the effect of the intervention can be determined to have persisted.

The lack of specification of agreed-on methods for performance monitoring in Gambler's Help should be addressed in the forthcoming review of Practice Standards in Gambler's Help commissioned by the Department of Human Services. Standards, in this sense, would not specify in a prescriptive way the level of goal attainment in relation to clients that should be reached, but would, rather, specify

processes by which judgements of effectiveness would be made. See Appendix 3 for an indication of the form and content of such standards.

Methods for measuring 'success', other than client and worker self-report, are found in other community-based service models, but so are problems in follow-up. Walker, Blaszczynski, Sharpe and Enersen (2002), for example, report in their review of 130 counsellors in 75 agencies in New South Wales, that 42 per cent of counsellors follow-up all clients, while an additional 27 per cent follow-up those who gave permission to be followed up, those who completed treatment, or a random sample of clients. A range of follow-up methods is used, including telephone calls, structured interviews and re-assessment with initial screens. They note that 58 per cent of counsellors use the South Oaks Gambling Screen, although elsewhere Walker (2002) cautions against the use of screens that may not actually measure changes in the behaviour that was the focus of intervention. The majority of follow-ups are completed within six months, although they also note that one-third of counsellors do no follow-up after case closure.

Moore (2001) has also noted problems in follow-up in a state-wide program similar in many respects in design terms, to Gambler's Help in Victoria. Clients presenting with problems relating to their own gambling who complete the planned intervention, and who give written consent for follow-up are tracked at six and 12-months post-discharge. At six months 54.5 per cent of program completers indicated that they had 'never' gambled in the past six months, 20.0 per cent responded 'rarely' and 12.7 per cent indicated 'sometimes'. The corresponding 12-month follow-up figures were 56.5 per cent indicating never gambled in the previous six months, 12.9 per cent rarely and 11.3 per cent sometimes.

Other indicators of improvement associated with abstinence or reduction are noted in Moore's (2001:41) analysis, although there is no way of telling which effect is due to which outcome — abstinence or control. These include, with rates for those endorsing the item:

- Reduction of attempts at self-harm (8.7 per cent on admission, 7.3 per cent at six months, 2.8 per cent at 12 months);
- Reduction in the number of 'things for which I was ashamed' (92 per cent on admission, 54.5 per cent at six months, 58.3 per cent at 12 months);
- Reduction in losing more money than intended (94.6 per cent on admission, 41.8 per cent at six months, 38.2 per cent at 12 months);
- Reduction of suicidal ideation (40.2 per cent on admission, 14.5 per cent at six months, 5.8 per cent at 12 months).

Importantly, Moore also noted outcomes for those not completing the recommended intervention program. Such follow-up is strongly endorsed by Walker (2002) and the authors of the present Report. The rates at 90-day follow-up for non-completers, ascertained by telephone interview using a sixteen-item survey tool in response to the question, 'how frequently have you gambled since leaving the program,' were: 4.9 per cent responded 'always'; 17.6 per cent often; 29.6 per cent 'sometimes'; 24 per cent 'rarely', with 23.9 per cent indicating that they had not gambled at all since leaving the program. Almost half (45.5 per cent) of the non-completers said that they were gambling 'much less' than before treatment. Of those non completing, 62.5 per cent said that they found the intervention 'always' or 'often' helpful, with 83 per cent also saying that they would 'always' recommend the program to others.

## 'Best practice' by Providers of Services other than Gambler's Help

### Introduction

No comparable data exist for examining outcomes of counselling interventions achieved by services other than those in the Gambler's Help network, as exist for the Gambler's Help program. There is also little information even at a more descriptive level, of the range of service provision available to people with gambling-related problems, outside of the Gambler's Help network of services.

This chapter begins with a brief overview of existing data on the provision of services other than Gambler's Help and the use of other services by Gambler's Help clients, although it should be recognised that because of changes to the Gambler's Help program since the data reported were collected, this material should be treated with some caution unless advised differently in this report.

As Table 5 below shows, within the first two years of operation of the specialist service, 63.4 per cent of problem gamblers attending BreakEven/Gambler's Help services were concurrently receiving assistance from other health and human service organisations.

**Table 5**  
**Problem gambler clients attending Break Even/Gambler's Help services 1 July 1996 – 30 June 1997:**  
**Other services used concurrently (n=506)**

Other services used	Per cent
Family counselling or support	2.4
Financial counselling	14.6
Gamblers Anonymous/GamAnon	10.2
General health	5.6
Legal services	8.6
Material aid	5.9
Mental health professionals	10.6
Relationship counselling	3.5
Self help	23.0
Other	13.1
No other services	36.6

Source: Jackson, A.C., Thomas, S.A., Thomason, N., Crisp, B.R., Borrell, J., Ho, W., Holt, T.A. & Smith, S. (1999) *Needs and Gaps in Problem Gambling Service Provision: a Report to the Victorian Department of Human Services*, Melbourne: University of Melbourne Problem Gambling Research Program. p. 27

There are no comparable figures for any period later than this, although we might expect some changes. For example, with the integration of financial counselling services into Gambler's Help, there may be fewer problem gamblers seeking independent, concurrent financial counselling. The concurrent use of Gamblers Anonymous is an interesting phenomenon, and may reflect the fact that some clients preferred to operate from a clear abstinence model as an alternative to the overall harm-minimisation or controlled-gambling orientation of Gambler's Help, while at the same time, accessing professional counselling for matters related to their gambling behaviour, if not for the actual gambling behaviour itself.

Elements of the relationship between Gambler's Help and services other than Gambler's Help may be glimpsed through examining the routes by which people get to problem gambling counselling services, and the part played by other service providers in this referral process. Analysis of referral data for the year 1 July 1999–30 June 2000, the last date for which publicly available data are available, reveals that some problem gambler clients (3.4 per cent of men and 1.0 per cent of women) attended Gambler's Help 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, 14.0 per cent of problem gamblers cited family and friends as a source of referral.

However, the most common source of referral to Gambler's Help mentioned by problem gambler clients to counsellors was Gambler's Helpline, which contributed to the referral of nearly one-third (28.9 per cent) of all new clients in 1999–2000. We note that this is less than had been the case previously (37.1 per cent in 1997–1998, for example), but that a number of factors can affect this referral rate, particularly the impact of public education and mass media campaigns. For clients who were partners or family members of problem gamblers, other family and friends (23.3 per cent) were more likely and the telephone counselling service (18.8 per cent) was less likely to have been the source of referral than for problem gambler clients in 1999–2000. If we add 'media' (9.2 per cent) as a source of referral, however, and note that 'media' refers primarily to advertisements for Gambler's Helpline, then the combined rate is about the same for gamblers, and partners and others in this period.

Just over one per cent (1.1 per cent) of problem gambler clients reported in 1999–2000 that they had been directly referred to Gambler's Help by venue staff who had a responsible gambling function, whereas 1.3 per cent of family member clients reported this source of referral. The real figure is most likely higher than this, with some of these less formal referrals being reported by clients as 'self-referrals'.

### **Overview of Current Practice in Services other than Gambler's Help**

As noted in the discussion of method earlier in this chapter, a range of services other than Gambler's Help providers were interviewed to identify:

Twenty-six organisations were approached for interview. Six declined on the basis of believing that they provided no services to people with gambling-related problems, or were unable to produce evidence of doing so. These organisations included the two largest family therapy agencies in Melbourne and four associations of counsellors.

The key finding from this review of 20 services other than Gambler's Help is that there is a negligible amount of gambling-related service provision in this sector, despite anecdotal evidence to the contrary.

This finding stands in stark contrast to the findings of the 1998 'Needs and Gaps Survey' referred to in Table 5 above, and needs some explanation. This 'Needs and Gaps Survey' was designed to gauge the reach of both the gambling-specific program funded by the state, and the non-specialist services partially funded by the Community Support Fund on the basis that they were deemed to be providing services to people with gambling-related problems. This survey of 121 agencies yielded

102 who believed they were providing a service to people with gambling-related problems. The types of agencies providing such services are detailed in Table 6 below.

**Table 6**  
**Programs where gambling issues arose in non-PGSS funded services in the 1998 'Needs and Gaps Survey' (n=102)**

<b>Program type</b>	<b>Number of programs</b>
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

Source: Jackson, A.C., Thomas, S.A., Thomason, N., Crisp, B.R., Borrell, J., Ho, W., Holt, T.A. & Smith, S. (1999) *Needs and Gaps in Problem Gambling Service Provision: a Report to the Victorian Department of Human Services*, Melbourne: University of Melbourne Problem Gambling Research Program. p. 35

At the time of the Needs and Gaps Survey, Gambler's Help was operating from 18 major agencies using around one hundred sites. It is now certain that the agency sampling frame drawn up by the Department of Human Services captured many of these out-posted or co-located sites, and that what was being measured in this earlier survey was very effective penetration of Gambler's Help into the health and human service sector more broadly — not, as thought at the time, a co-existing 'generic' service sector working alongside Gambler's Help with people with gambling-related problems.

From the interviews and analysis carried out for this report, we believe that this interpretation is valid in relation to the present configuration of services. With Gambler's Help services now being offered from over 120 sites state-wide, through a network of health, family support and relationship counselling agencies, as described in Appendix 2, many service personnel interviewed suggested that there was little demonstrated need for additional services. In addition to the service's belief that they were not meeting a demonstrated need, a number of service providers raised issues concerning access and disclosure, as reasons for the apparent lack of interest by people with gambling-related problems from either using their services or disclosing their status as problem gamblers or as partners of problem gamblers.

A number of financial counselling services where it might be expected that people with gambling-related problems may refer, noted that gambling seemed to be more difficult for clients to disclose than other behaviours or experiences such as alcohol and other drug use, sexual abuse, sex work and domestic violence. This was also the case with both legal services and outreach homelessness services.

When asked about whether they screen clients for gambling problems, a number of respondents suggested that this would not be appropriate for a number of reasons:

- An already onerous assessment and data collection protocol (crisis accommodation and family support service);
- Risk of turning off clients who might otherwise access the service without disclosure (financial and legal rights service).

Others suggested that they could do so (mental health legal service), while at least one drug and alcohol family service noted that they presently screened clients for gambling problems. Odyssey House assesses clients at Carlton before admission to the therapeutic community at Plenty. There are two questions relating to gambling under the legal issues section of the assessment form. The first asks if the client has a gambling problem; the second asks if they have received treatment or counselling. After they are admitted to the House, all residents attend therapy groups but there are no specific sessions or groups related to gambling. Residents are expected to raise gambling as an issue in these general groups, if they wish.

As there was little information provided by service staff or managers on specific interventions for people with gambling-related problems, the issue of how success in interventions was measured became somewhat redundant. One counsellor from a service other than Gambler's Help offered an analysis of her measure of success:

*'When the client is not afraid to talk to everyone about it, part of the shame and guilt, being able to admit had problem, and talk openly about it ...'*

This is a very important point. Many respondents believed that considerably more work needs to be done to de-stigmatise problem gambling so that people needing a range of services other than Gambler's Help such as emergency accommodation, mental health, legal, relationship and general family support and 'generic' financial counselling feel able to access these services without disabling levels of guilt and shame.

Many of the services other than Gambler's Help surveyed for this study suggested that they refer to Gambler's Help, while some Gambler's Help counsellors also reported referring to other professionals;

*'Depends on client. Gambling is a symptom of underlying problem. Initial assessment is vital ...'*

*'It could be depression or personality disorder, you don't know until initial assessment. Then could use CBT psychodynamic, group therapy. If client is depressed, use CBT and maybe referral to GP or Psychiatrist ...'*

*'We need to do more work with underlying issues, abuse, grief etc. If beyond our confidence, then we refer ...'*

The view from one respondent who was not specifically a gambling counsellor and who was from a culturally specific group identified the need to understand and respect cultural issues:

*'The client recognising that it is a problem. Trust and rapport with the client is very important in Greek community. Being able to explore issues while maintaining respect and confidentiality. Counselling is not well understood in the Greek community so often have to explain that it will be an ongoing long-term thing ...'*

The issue of co-morbidity is also a prevalent and serious issue for some services. One drug and alcohol counsellor reported:

*'Sometimes it is difficult deciding which is the biggest issue, gambling or the drug and alcohol. Gambling is often secondary. In terms of best practice for drug and alcohol counselling, we look at gambling as a coping mechanism against further destruction. There are problems with counselling for specific things, for example if a person presents to a gambling counsellor and then discloses that they have been sexually abused, we see that sort of thing all the time, but would a gambling counsellor be able to deal with this? It is important to not just deal with behaviour ...'*

## 'Best practice': The Client's Perspective

Qualitative data in the form of detailed information provided by clients of Gambler's Help and the Free Yourself program in focus group discussions was formed into categories and analysed thematically (Cresswell, 1994). According to Patton (1990) there are two ways of representing the patterns to emerge from analysis of such data. First, the analyst can use the categories developed and articulated by the people studied to organise presentation of particular themes. Second, the analyst may also become aware of categories or patterns for which the people studied did not have labels or terms, and the analyst develops terms to describe these inductively generated categories. In this study, broad categories were suggested by the structure and purpose of the focus group interviews, while sub themes emerged from the data.

From detailed reading of the focus group transcripts, themes were identified until a point was reached where no new categories of behaviour could be identified. This is akin to the 'theoretical saturation' of Glaser and Strauss (1967). The following themes and sub-themes emerged with, inevitably, some overlap between them:

- Propensity to gamble;
- Causes of problem gambling;
  - Heredity or family background;
  - Personality type;
  - Early wins;
  - Escape;
  - Issues for women;
- Action clients would take to protect problem gamblers;
  - Leisure and entertainment-based strategies
  - Venue based strategies;
  - Advertising;
- Self exclusion;
- Features of a good problem gambling service;
  - Availability of group work as an intervention;
  - Staffing;
  - Interventions, particularly early intervention;

- Residential option;
- Service elements found to be unhelpful;
- Abstinence or control.

These themes are discussed in more detail below.

### Propensity to Gamble

Opinions were varied on whether gambling was more usually 'normal' behaviour with particular characteristics such as risk and escape:

*'Some people just love it. They love the adrenalin rush ...'*

*'I just love it because I love turning off from the world ...'*

*'You blank everything out ...'*

Participation in venue-based gambling, as distinct from lottery tickets and 'scratchies', for example, was often precipitated by crises or difficulties in other areas of life:

*'It wasn't really the money for me, it was crisis sort of for me. At the time I was seeing a girl and pretty involved and stuff and so when you're pretty involved you tend to let friends drift away a little bit so when I broke up with her my friends were sort of a bit distant and it was like, "Where do I go; what do I do?" and I just sort of went to the club. So it was somewhere to drink and stuff and I put a few coins in and then ...'*

*'Maybe you get a crisis and something happens and bang you play it to get through the crisis. ...'*

### Causes of Problem Gambling

Participants offered a range of reasons why people may develop gambling problems. These reasons included heredity or family background:

*'I grew up with it ... family ... mother, father, grandmother, uncle. You lived it and breathed it. It is hereditary in some people. I will go to my grave believing in that ...'*

Although there was quite a lot of disagreement about the role of personality, and whether such a thing as an 'addictive personality' existed and explained problem gambling for some people, one male problem gambler was in no doubt about the validity of this sort of explanation:

*'Well honestly in my situation I think that looking back at myself I am a compulsive person in a lot of regards. When I play sport I am full at it when I work I am full at it and it was a matter of time when I was introduced to gambling that I took the same attitude that I had with my work and my normal life and I just went at it full ball. And it is different to your work ... it is devastating because financially it ruins you. In my case I believe it my compulsive attitude towards when I pursue something I like I am full on ...'*

Another member of this group commented:

*'You get hooked it is the love of getting hooked. It's is a stupid thing but it is reality for some people ...'*

Some cited early wins as a cause of subsequent problematic play:

*'I used to work in the railways and I used to watch everyone else put fifty dollars, and it used to make me sick and I'm thinking, "Oh they're crazy", but I put five dollars in one day and all of a sudden I won fifty dollars. This was about 12 years ago and that was like, I don't know, a thousand dollars to you guys...I'm like "Oh my god", and so that's what sucked me in, and a lot of it was boredom and ... when I fought with my boyfriend or whatever reason you come up with and you just think, "Bugger it", and that's the addiction taking over but you reason it in your head, "I just won I won from five to fifty dollars". That's what got me — how easy is this; everybody can do it, you don't have to work again ...'*

*'That's what happened to me too. I won four hundred dollars and I was hooked — boom, just like that ...'*

Other clients mentioned gambling to escape:

*'In my case it wasn't money like it is different I felt like it distracted me from the world out there and I basically wanted that feeling again because I won big at times and it was never enough you know if I won big I wanted more and I wanted more of that feeling. I felt like I was like a drug addict wanting a fix that's that how I felt ...'*

*'That's what takes over after a while though isn't it you know the initial win might be the thing that starts you going um but then it is lots of other things that take over, you know, especially I live by myself just me and the dog and it's boredom you having a lousy day lots of things happen in my life. I went through lots of grief issues. It's a great way of hiding; it's a great way of having company that you don't have to talk to anybody if you don't want to ...'*

*'So you know there's a lot of aspects to it you know that gradually take over and then it becomes a miserable existence because you keep going. It's horrible ...'*

A number of clients noted that venues are perceived as safe places for women, which may encourage women to go to gambling venues rather than other entertainment venues:

*'It's a safe place to go for women. You could have sort of stayed in a public bar but for us it wouldn't have been quite safe ...'*

*'When I was growing up I was told that women never went to pubs alone and this particular night changed everything — the night we went from bingo to the pokies machine. I thought, "Oh you can come to hotels without having a man; oh that's wonderful", and that's what set it off for me ...'*

*'You know guys don't latch on to you like if you go to a public bar and you have a drink on your own. Can you imagine — they pounce! It's great no one talks to you but I feel really sad for women cause women haven't really got places to go on your own whereas a guy can go to a pub and just mix in and talk crap to other blokes, but women ...'*

### **What Clients Would Do to Protect Problem Gamblers**

Asked what they would do to protect problem gamblers if 'they ran things', focus-group members suggested a range of strategies. These included leisure and entertainment-based strategies, including provision of better youth services and provision of entertainment venues with a larger range of leisure opportunities:

*'I think that the whole attitude towards entertainment should change and ... we need to look at it and say, 'Hey we need entertainment venues. People don't want to do another arts and craft class, you know; we want have fun but we've got to go somewhere where it is safe', and look at really changing the attitude of venues and emphasise the ones that have no pokies. Make them advertise ... that women are*

*welcome you know we have live music at lunch time you know things like that would make a difference ...'*

Venue-based strategies included banning all gaming venues, reducing the number of venues, getting rid of all EGMs in venues, removing ATMs for venues, restricting opening hours; removing note acceptors, and training venue staff to identify problem gamblers and remove them:

*'A lot of the staff who work at the casinos probably know who the problem gamblers are. I don't know if they know all of them but I think they should know some of them. In a way there has got to be some way. I know it is just the first step if people who have a problem with gambling don't have complete access to these places until they have somehow dealt with their problems ...'*

Other suggestions included better practices regarding provision of cheques for paying winnings:

*'If you have a large win and you are waiting on a cheque they will take up to 25 minutes for that cheque and in that 25 minutes you can lose half of what is on that cheque. Because they say they have got to go out to the safe and get a cheque book and wait for the manager to come in and pay you so in that delay you have had a rush from a high win so you keep playing on another machine and you can give up to half of it back. So that is a ploy that they are using to get half their money back. Because to me you walk out to the safe and collect the chequebook and write the cheque it doesn't take 20 minutes ...'*

*'Sometimes you can't get it until the next day ...'*

Advertising of counselling services was mentioned, particularly with materials available in restrooms as in HIV and other blood-borne diseases materials:

*'And what I was saying too is maybe, you know, when that lady left her child in a car (at a venue) and it died and now on the back of each toilet door it says you can't leave children unattended. That's great but what if they had like, five forms of different gambling cards and brochures. When they have a gambling card (advertising a problem gambling service) it's normally near the gambling counter where you get your money and you feel like a right goose, "Oh I'll have twenty dollars of one", and trying to grab the card with fifteen people behind you. That's pretty embarrassing stuff so if you had them in the toilet — all five on the back of the doors ...'*

In relation to advertising as well group participants suggested providing more advertising to encourage people to seek help early:

*'There was one brilliant ad on television about a young apprentice kid who started gambling when he was 18 and all his mates were going out and he wouldn't go with them and he lost all his money and then he started stealing money from his workmates. That was a great ad; that was brilliant ...'*

*'If there is to be any advertising or forewarning it has got to be harsh it has got to be similar to the TAC (Transport Accident Commission) ads — graphic. And the fact is I remember watching a show in America about where they took in these problem juveniles into prisons and they exposed them to life sentenced prisoners and these kids come out and they changed their mindset straight away because these blokes in there were in for triple murders, rape, this and that and they said, "Look you come in here and you will be my little boy and you won't like it". The same thing with gambling ... Expose us to someone that says, "Listen this is the stark reality and don't joke around with it. This is what is going to happen to you" ...'*

In relation to self exclusion (as currently run), there was considerable doubt expressed as to its worth:

*'I self excluded myself for the very first time in six months from half a dozen (venues) but then I found my little car could travel further. So then when that time was up I would go up and got to a wider area. I self excluded myself three times over a period of 18 months ...'*

*'Anyone else who has self excluded? ...'*

*'Well there was two times that I have been into a place purposely. They didn't recognise me. They didn't notice. But there was one occasion where they did recognise me. They said, "Oh, I am sorry, I thought the self exclusion stopped last week" ...'*

*'I self excluded a long time ago myself from the casino but that had zero effect. I went back hundreds of times after that and I didn't really care ... There was a very low chance of being caught. And even if I was going to be caught they are all strangers there so I didn't care I just thought, "Oh well, if I am caught I am just going to be escorted out" ...'*

### Features of a Good Problem Gambling Service

Not surprisingly, many of the focus group participants, having experienced Gambler's Help, Gamblers Anonymous and other programs such as Free Yourself, had strong opinions on what features they wished to see in a problem gambling service, drawing both on their positive and negative experiences of these services.

Group work and contact with other problem gamblers through this group experience and in individual counselling was highlighted by a number of participants:

*'Being involved in a group and a one-on-one service. Being able to come to the group and being an equal with everyone ...'*

*'We are all here for the same reason ...'*

*'Oh I think being around people that are like you they have the same problems as yourself ...'*

*'They don't judge you ...'*

*'You don't judge them but you worry about them in a caring way ...'*

*'And talking about it and understanding and you are not on your own ...'*

*'I think the most important thing you see new people come into the group and it is always the same story and it doesn't change. It doesn't get far off track but that central way of thinking how they were all introduced and the kickstart and then the habit so and when you see new people come in after you have been here for six months or six years it is all the same situation ... I will be damned if I want to sit around for many more years doing this but I really appreciate the effect that I get from these groups because of the fact that that reinforces each time ...'*

For the Free Yourself participants, many noted the benefits of working in a 'therapeutic/commercial' restaurant and 'alternative space' enterprise:

*'It is just the spirit of the whole thing and the people that you are working with have the same problem as you. We just love to work together we have a lot of fun ...'*

*'But it is good because there are days when I have come in and I feel like. They know here I am either talking my head off or I am quiet. And usually when I am quiet I am either mad or I have just been to the pokies the day before or something and I have come in and just blown x amount of dollars and then I come in and say, 'I went to the pokies last night'. And they are not like non-gamblers, 'I don't get it. I think you are an idiot'. But these guys say, 'How are you doing now? Do you want to talk about it? Do you want to have a coffee? Do you want to keep busy? I know what it is like'. A big hug you feel all safe and you can open up ...'*

*'We know they are not judging ...'*

*'Yeah, there is no pointing and judging ...'*

Participants had strong views on who should staff the problem gambling services:

*'It's got to be someone who's been there ...'*

*'There's absolutely no doubt about it cause they know how you tick; they know how you think; they know your next step right before you even know it and that's the best thing about Free Yourself. Gabby has been there so she knows your next step. She's one step ahead of you all the time and to me that's the most important thing ...'*

Although we understand this sentiment, it is obviously impractical to ensure that problem gambling services' staff members have first-hand experience of problem gambling. What we understand people to be saying is that they expect counsellors to know the cognitive, affective and behavioural aspects of problematic gambling and respond sensitively to their clients with respect for the meaning of lapse and relapse and respect for the struggle to change.

Consistent with our review of the effectiveness of multimodal services, clients also endorsed this approach to the provision of interventions, again, in some cases emphasising the relevance of training or experience of counselling staff:

*'I think that the ideal service would sort of combine a lot of approaches to find out like an initial interview stage. I really think it be great to have a lot of people who have been there done that to get that rapport going. But, I mean, where we're lacking here is in general that there are underlying issues that they're are not trained to deal with, you know, and I believe to work to work together with professionals to be able to combine the academic approaches with self help's passionate support — I think that's where an ideal service would go to ...'*

Group members, as seen in the quote above, endorsed a service model that addresses those issues that many see made them vulnerable to gambling in the first place but also return to the question of counsellor competence:

*'It could also be like one of the things like you just said, you know, the night before your husband's funeral ... so there was grief involved there. With me there was grief issues involved. You can't cope anymore. I lost five family members in three years and enough was enough so it (EGM venue) was great place to bury myself ...'*

*'So I think probably most people would agree. I mean, that's pre gambling. I mean that's something I guess you feel you would want to address; have an opportunity to do that. So I guess that's where a professional counsellor type person could be of use, couldn't they? ...'*

*'And it has to be a very well checked out person because a friend of mine has just gone through a horrendous experience with a counsellor so you have to be able to have a person that has a good reputation and is associated with the counselling academy and all the rest of it; not somebody that does a few courses and hangs up a shingle ...'*

A small number of group participants argued strongly for a residential treatment facility:

*'All these services ... come for half an hour, come for an hour, and stuff like that you know. I am not at rock bottom at the moment but some people are at rock bottom and plenty of people don't even come to these groups. We have an addiction and that is why we are here and maybe we need to look at these services needing to be expanded into like we've got for drug rehabilitation. You go for three weeks or a month's time; you go into a centre and you spend your time and you face the problem. You are not put into temptation. You know even in three weeks, like you feel good. You feel great. Three weeks I haven't had to hit the pub but the temptation is right in front of you. And maybe we need to look at programs that are a month-long program, in-house, staying somewhere in like an addiction ...'*

*'But as I see it I think you need to be able to do when you do decide that you need help. I think you need to get it pretty quick ...'*

*'It is also to the point where, all right, if you did have those programs there would be so many wait lists for those too I am sure. But I am just saying if you did have those programs on offer to go and live in ... I know when I hit the bottom rung you have got the support of some of your friends and you haven't got the support of some of them. It is a real mix of who you have got the support from. But you need that support professionally as well ...'*

### **Service Elements Found to be Unhelpful**

A number of group participants were concerned to identify service elements that they found unhelpful. These included the perceived failure of the Gambler's Helpline to offer timely, relevant and 'trustworthy' assistance:

*'When I rang up — what a joke; absolute joke ...'*

*'They are a pathetic crowd ...'*

*'Get someone on there who has some idea of what they are talking about and don't go, "Well you've got to figure out why you gamble. Would you like to speak to a counsellor?" Well if I knew why I gambled I wouldn't go out and gamble again and there I am thinking I'm going to get sympathy and some sort of help and she's going, "Why do you gamble? You've got to figure what's missing in your life and you filled it in with gambling". Oh, there we go. How easy is that? Obviously I'm missing (deceased husband) so therefore knowing that, I won't gamble. What a bunch of idiots. Sorry ...'*

*'I was really annoyed because I'd just spent a thousand dollars I was in tears and this lady on the phone I think had obviously had no idea ...'*

It is clear that for these clients Gambler's Helpline was seen as a crisis line and not simply a means to receive counselling through a different modality, that is by telephone rather than face-to-face. We have commented elsewhere (Jackson, Thomas, Thomason, Borrell, Crisp, Enderby, Fauzee, Ho, Holt, Perez & Smith, 2000) on the need to clarify the purpose of telephone help lines, and, if these client's views are representative of the expectations people have of Gambler's Help, then it is clear that such a clarification still needs to be made and sold to the intended clients of such a service.

There was concern about waiting times to see counsellors, with clients believing Gambler's Help should be an 'on demand' service:

*'But I had a counsellor, a local counsellor, and I used to have to ring him and beg for an interview. I mean he didn't make an appointment to say come back and where we'll talk more about it and to see how you are going. He left it with me and said, "Ring me when you need me", and when I tried to get him he couldn't see me for a month ...'*

In discussion of specific interventions, there was a view expressed by some people about the seeming irrelevance of explanations about the odds of winning:

*'Gambler's Help, okay? In the end I threw my hands in the air and I thought, "What help am I getting?" All he gave me was a list of figures like, you know ... My mind was racing, "How am I going to cope?" I didn't want to look at all these figures. I mean, yes, they had bearing on it but I wanted him to talk to me to try to find out what I was doing. I didn't get that help. Then I went to Gamblers Anonymous and that was even worse! ...'*

### **Abstinence or Control**

Many members of the focus groups suggested that abstinence was the goal of their help-seeking:

*'I want to give it up totally ...'*

*'Go in there and not want to do it ...'*

*'I don't think you can keep it under control. Your addiction is there or the problem as you might call it. You couldn't go back and just put five dollars in ...'*

A number, however, thought that while abstinence might be the ultimate goal, controlled gambling was possible:

*'When I was gambling I didn't have any plan about it. I was thinking that you had to give up all together. But I think that sometimes some people can probably do it with a strategy. They can control it. I think it is possible to do that ...'*

*'I know that I could go to a venue now and know that I could put money in and I don't think it would bother me in the slightest ...'*

*'But I don't want to. I have just lost the whole thing about it ...'*

*'I mean, even bingo! I love bingo and I say I am never going to give up bingo but I haven't been this year. But I know that I can go; I have a choice but it is not like, "No I can't go". I have a choice, and I really learned from doing the program that I have a choice. In what I can do and what I want to do. My real choices. If I chose to go to bingo I will go. It is not going to rule my whole life and my family's life if I go to bingo a couple of times a year ...'*

*'Oh it has been at least three months since I gambled last but it hasn't been much of a problem in the last two months, roughly. I mean I have gambled but it hasn't been an obsession to the same extent that it was before although I have gambled too much. But I guess the actual difference it has made to my life is the fairly obvious thing to say, I suppose, is that gambling can easily become the worst problem. I know in my life I have got a few problems but gambling easy becomes the worst and by not gambling in the last few months and by it not being the kind of obsessional problem it's been the last couple of years, I guess it means I have got one less problem in life and it also allows me to focus more on other things ...'*

As part of the discussion on abstinence and control, a number of group participants made the case strongly for why it was worth it to them to give up gambling:

*'Can I say just quickly for me it is pretty simple. It is cut-throat because if I keep going I destroy my relationship, I destroy myself financially, I lose respect in the workplace which means I am no longer employable — I have become unemployable because the word gets around. You are seen around, this and that so there is no way known I am up against a wall. It is yes or no. Do you want to take this path or do you want to take that path and that is the way it has got to be for me. For me it is black and white and that is it no more, no less. Because I am shot I lose a person that I love so dearly, right? I have been divorced. I have got a partner who stuck by me through all this, my*

*mother has lent me money. If I let those people down I might as well do what a lot of people do in drastic situations and this is, take my life. That is the way I would go and at forty-seven I have got a lot of years to live still. And I am still fit and I don't want to go down that track. It is easy for me because I am up against a wall. Everyone is different but that is my situation ...'*

*'I reckon I am a little bit the same where I reckon by telling a few people that night I more or less I just feel a lot of shame about what I did and I don't want to I do feel ashamed and I don't think that is necessarily a negative thing but I feel ashamed of what I have become and how many people I have let down and really bullshitted. I guess the other flipside I think I can't stop completely on feeling the shame I guess what I am keen to do is follow these interests that I never find time to do because there is a race that day. And I guess I feel I want to start doing things that I became. I think when you gamble you become a "gunna". I am "gunna" do this and I am "gunna" do that and it just got to the stage, and I feel almost angry talking about it; there was so many things that I wanted to do by this stage that I haven't done and I guess there is anger. There is the shame of what I have done but also the anger that, yeah, I was going to do this that and the other. I don't think that it has gone but it is still there ...'*

## Conclusions on 'Best Practice' in Victoria's Problem Gambling Services

This review of practice in relation to problem gambling in Victoria suggests that a majority of counsellors in Gambler's Help have adopted an eclectic approach to counselling, consistent with current trends in counselling and psychotherapy. Cognitive behavioural therapy (CBT) has been identified by the majority of Gambler's Help agencies as a major component of their theoretical and practice framework, along with broad psychosocial approaches. This orientation is reflective of best practice in community-based services reaching a client base heterogeneous in terms of gambling type and severity, although as we have seen, some of the specific techniques are not always understood by the clients.

The counselling practice is informed by a range of beliefs about the possible causes of problem gambling behaviour, leading, apparently, to clear differential diagnosis and treatment. These beliefs include:

- Gambling as a way of managing problems in one's life, such as depression and stress;
- Gambling as an escape from problems, and possibly the result of boredom and loneliness;
- Unresolved grief and loss issues as underlying causes of problematic gambling;
- Attempts to chase losses;
- A range of other factors linked to personal or situational vulnerability.

The Gambler's Help program is producing high levels of positive — partial, full or satisfactory — resolution in all defined problem areas. For example, in one assessment of the outcome of interventions related to clients' gambling behaviours, 43 per cent showed full or satisfactory resolution levels, with 46 per cent experiencing partial problem resolution. These sorts of problem resolution rates are being achieved with relatively small numbers of counselling sessions, for example, a mean number of 4.15 counselling sessions for a fully resolved primary problem. Degree of resolution is related to number of sessions attended. Generally, the more attended, the better the resolution, although totals per episode of care remain small. These findings on problem resolution and post-counselling gambling behaviour compare very favourably with those attained in a similar overseas state-wide service based on a stepped care approach.

In examining Gambler's Help counsellor's practice, the therapeutic relationship was the process variable that most consistently predicted positive outcome. This is recognised by counsellors, who describe the relationship as the basis from which the work becomes possible. In examining the features of counsellors achieving higher rates of problem resolution, they:

- Use an eclectic mix of client-centred humanistic psychology, cognitive behaviour therapy techniques, and solution focused counselling, in response to the diversity of the client base and variable need;
- Undertake thorough psychosocial, and readiness to change assessment of clients;
- Involve client participation in goal setting and adopt a realistic, timely and achievable set of goals;
- Celebrate client achievements, no matter how small these are;
- Work with clients assessed as 'ready to change'.

More recently, a somewhat new dimension has been added to some counsellors' practice, with the adoption of a holistic approach including changing lifestyle patterns, diets and routine, typical of the Free Yourself Program.

In terms of the model of intervention inputs and outputs introduced in Figure 2, very few client characteristics have been found to have a statistically significant impact on counselling outcomes in the Gambler's Help program to date. As well, counsellor characteristics are, on the whole, not predictive of client outcomes. In terms of agency characteristics, clients from non-metropolitan centres are more satisfied with the outcomes of counselling and report a greater impact of counselling on their gambling behaviour and higher levels of problem resolution. The size of the Gambler's Help service and its level of funding have not been shown to have an impact on outcomes achieved.

Counsellors from a range of services have noted that some ethnic groups are not accessing the Gambler's Help services and suggest that problem gambling is seen as something shameful and to be hidden, thereby minimising help-seeking. There is no available evidence that ethnic/indigenous specialist counselling services attract clients from these language communities or the Aboriginal community at a higher rate than if the services were not offered in these languages or with an indigenous focus. Nor is there evidence that the counselling achieves different outcomes from the non-CALD focused counsellors. This is not to say that these effects may not be being achieved, but that there is no evidence of such achievement.

In terms of quality assurance measures adopted in Gambler's Help, there is a high level of reliance on clinical supervision. This reliance on supervision and feedback from colleagues on practice performance is not unusual, but rather, a common feature of social workers' practice, but less of a feature of psychologists' practice

In terms of measuring the success of interventions, the majority of counsellors reported that 'client self rating' was their means of gauging success, often combined with other external indicators such as scales; the extent of adoption of control measures such as self exclusion; continuation of attendance at counselling, and occasionally through formal evaluations.

Measurement of outcomes as a specific aspect of quality assurance is one of the least well-developed areas of the Gambler's Help program, with such lack of development at odds with the thoughtfulness and adherence to best practice (as far as best practice in community-based services

can be determined), typical of the rest of the operations of the program. As well as a general failure to adequately follow up completions, there is a need for the program to also follow-up to determine outcomes for those not completing the recommended intervention program.

Examining outcomes of interventions achieved by services other than those in the Gambler's Help network is hampered by the lack of any systematic data collection and analysis. There is also little descriptive information of the range of service provision available to people with gambling-related problems, outside of the Gambler's Help network of services.

The key finding, however, from the review of 20 services other than Gambler's Help, is that there is a negligible amount of gambling-related service provision in this sector, despite anecdotal evidence to the contrary. In terms of screening clients, a number of agencies have suggested that this would not be appropriate because of already having in place an onerous assessment and data collection protocol; and because of the risk of turning off clients who might otherwise access the service without disclosure. Other agencies believed, however, that they could introduce screening.

Many service providers other than Gambler's Help believe that much more work needs to be done to de-stigmatise problem gambling through media campaigns so that people needing a range of services other than Gambler's Help such as emergency accommodation, mental health, legal, relationship and general family support and 'generic' financial counselling feel able to access these services without experiencing disabling levels of guilt and shame.

# Chapter 6

## Studies in Innovation

### Introduction

This chapter briefly introduces a number of innovative approaches to practice in gambling services, and includes:

- Examples of Gambler's Help innovations, in terms of the development of:
  - The 'single session consultation', a method of working which pushes the boundaries of brief intervention;
  - Online counselling;
  - A theory of intervention, arising from clinical practice;
- The Free Yourself program, a holistic framework of intervention based on a self-help model, now being adopted in some Gambler's Help programs.

These descriptions of interventions are given, following the review of evidence on best practice provided to this point, as they represent types of practice not covered in this review, which may represent 'best practice', but which have not as yet undergone rigorous evaluation.

### Single Session Consultations

Single session consultations (SSCs) as a mode of counselling intervention in relation to problem gambling was developed at Gambler's Help Western in late 1995, but is now available at a number of other sites. The intervention consists of a 1.5–2 hour session with the gambler's family as the focus, involving a counselling team of four, with two counsellors conducting the session and the other two observing. The session itself consists of three parts — the session, a break and the message is videotaped.

The SSC mode of intervention was introduced as a means of maximising the impact of attendance for one session only, as the agency had determined that many clients only ever attended one session of a planned sequence of counselling sessions. This mode of counselling is offered to clients on first contact with the agency, as a choice, instead of the more usual ongoing counselling approach.

Based on systemic family therapy, and Prochaska & DiClemente's (1988) model of change, the SSC provides a forum for highly active exploration by the therapy team of what issues currently face the family: what strategies they have adopted to address the gambling-related problems; what has worked and not worked. The therapy team makes explicit suggestions for change, which are assessed and debated by the family, with the therapists using the form of assessment and negotiation as a vehicle for enhancing communication within the family about this often very painful arena of family (dys)functioning.

Families are followed up by telephone around one month after the intervention to determine if the intervention has made a difference to the way they are approaching this issue, and whether the session should be supplemented with ongoing counselling.

A small independent review of the intervention was conducted at Gambler's Help Western in 1997. This study reviewed 15 of the 32 SCCs held between April 1996 and March 1997 at follow-up that varied from one to 12 months (Gavan & Slowo, 1997). Those followed up in this study reported: high levels of understanding of the intent of the process; strong acceptance of the multiple therapist approach; and, high levels of satisfaction with both process and outcome. A number of respondents were able to clearly identify post-session improvements in lifestyle, adoption of more helpful strategies for coping and change, and some improvement in gambling behaviours. DSM IV scores pre- and post-session changed from a mean of 6 at assessment to 2 at post-assessment. All respondents noted that they would feel able to re-contact the program if they needed to.

The study was encouraging and indicates that this mode of counselling should now be rigorously evaluated for its clinical effectiveness.

## Online Counselling

Arising out of an analysis of reasons for the under-representation of young people as Gambler's Help clients, the Central and Northern programs developed a Youth Outreach Model, which proposed that although young people were reluctant to access gambling counsellors directly, they may be more comfortable contacting them indirectly, for example, through youth service providers. Following this development, Gambler's Help Central also began to consider other groups who did not readily access traditional counselling (e.g. Asians, the elderly, public figures, etc.) but who were nevertheless affected by gambling, and consideration was given to development of innovative modes of service delivery (Laidlaw, 1999; McCorriston & Laidlaw, 2000).

Previous work with by the agency with international students and student counsellors at Royal Melbourne Institute of Technology (RMIT) had indicated that students might utilise online support if/when they did not wish to present for face-to-face counselling. The students were apparently very familiar and comfortable with the idea of contacting their tutors by email when needing help with their studies so it was tentatively suggested that they might feel the same way about accessing help for personal problems via this method. The intervention was based on findings related to computer-mediated therapy, or the use of computers, to help build therapeutic relationships in remote areas (Sanders and Rosenfield, 1998); and the use of email as a particular vehicle for online counselling (Murphy and Mitchell, 1998).

In a submission to DHS in April 1999, Gambler's Help Central, supported by Gambler's Help Northern, proposed a six-month project to pilot an online support service for youth with concerns arising from gambling. It was suggested that the medium for support should be a web-based email service, which could be an access tool or adjunct to face-to-face counselling rather than a therapeutic modality in itself. Approval of the pilot led to the development of the G-mail intervention.

Strengths of the G-mail intervention were seen to be:

- Accessibility, particularly people who find it difficult to access a counselling service in person. This could include those: with limited physical mobility; living in geographically remote areas and/or with no counsellor nearby; with a disabling psychological disorder which makes venturing outside of the home very difficult (e.g. agoraphobia, social phobias); and, those who were pressured for time;
- Convenience, in terms of being able to send and receive emails at any time, and convenience in terms of users having time to think about, and possibly change, any emails they intend to send, thereby increasing their sense of control over what they reveal and the pace at which they do so;

- Anonymity, particularly as a means of coping with the shame of help-seeking for gambling-related problems;
- Provision of a permanent record of communications, benefiting clients because they can re-read positive feedback written about them by a counsellor and remind themselves of how much progress they have made and of what has helped them in the past. Another related benefit to clients is that it can ensure better counsellor accountability. Because each message sent by an email counsellor can be retained by the receiver, considerable responsibility is placed on the counsellor to choose his/her words carefully.

Perceived limitations of the G-mail approach centred around its effectiveness being largely unknown at the time; the lack of non-verbal information available to either counsellor or client; security and confidentiality of any information exchanged; the need for people to have ready access to computer and internet facilities; and the lack of appropriateness of email counselling for people whose presenting problem is suicidality, a violent relationship, an eating disorder, sexual abuse as a primary issue, and/or a psychiatric disorder which involves distortions of reality (Bloom, 1998).

Due to be launched originally in 2001, G-mail is now scheduled to commence operating in 2003. It is recommended that this intervention be evaluated as a model of adjunct service delivery, with particular relevance to rural and remote locations and hard to reach urban groups. See Chapter 7 for more detailed recommendations on this evaluation activity.

## Theory Building from Clinical Practice: Developing the 'Feedback Framework for Problem Gambling Development and Recovery'

The development of the 'feedback framework for problem gambling development and recovery' is an unusual example of innovative practice in that it exemplifies the practitioner as theorist. It was developed by a Gambler's Help counsellor to support his work in counselling (Gunner, 2002). The initial stimulus for the research was a desire to find a way of presenting to clients ideas about motivation to change from the model of change adopted to inform practice at the counsellor's agency (Prochaska & DiClemente, 1988), and to integrate other theories in use, such as Weinberg's (1995) theory of human pliancy, with its emphasis on 'compulsive habits'.

This experimentation produced a continuously evolving diagram of the development of problem gambling and recovery that was discussed with clients, known as 'Feedback Framework of Problem Gambling Development and Recovery'. From the outset, discussion of this evolving framework took place with clients and peers, contributing to its further development. Versions of the framework were presented at the Melbourne National Association of Gambling Studies (NAGS) conference in November 1997 (Gunner, 1997), the Brisbane Australian Family Therapy Conference in September 1998 and the Adelaide NAGS conference in November 1998 (Gunner, 1998).

The framework is a theory of problem gambling and recovery that, it is suggested, provides a practical basis for counselling interventions. It proposes that problem gambling is part of a system of intra-personal and interpersonal feedback loops. Some are amplifying loops and some are dampening loops. Some tend to increase the gambling while others tend to reduce it. A person develops gambling problems and recovers through the interaction of these feedback loops. The framework proposes feedback loops that tend to increase gambling, gambling losses, related worries and repression of the worries. It also proposes that a person becomes more of a gambler each time they are shocked by an event arising from their gambling, deny this shock and continue gambling. This is a movement around the downward spiral of problem gambling development. In an opposing

process, a person becomes less of a gambler each time they: (a) learn from these shocks and their urges to gamble; (b) take action to change their gambling; and (c) deal with the temptation to reverse the change. This is a movement around the upward spiral of recovery.

The framework appears to offer practical concepts and interventions for problem gambling counsellors and their clients, based on the solid foundations of systems theory (Maruyama, 1968) and recognised psychotherapists like Weinberg (1995) and Malan (1979).

The framework incorporates and supports cognitive behavioural ideas on relapse prevention as well as ideas derived from psychodynamic theory, suggesting that problem gambling can repress worries and become a defence against these worries; it provides a theoretical basis that encourages problem gambling counsellors to attend to their client's worries, from conscious boredom to unconscious dread. One of the more innovative features of the framework is its tentative prediction that chaos theory may be applied to problem gambling.

In practice, the framework provides a structure for understanding how cognitive therapy, behavioural therapy and psychodynamic therapy can influence problem gambling. It suggests that each therapy tackles problem gambling by breaking the amplifying loops underlying problem gambling in different places. Cognitive therapy strategies tackle the pro-gambling mentality, denial and self-tricking thinking, and thereby the gambling and the worries. Behavioural therapy strategies tackle the gambling behaviour, and thereby the ideas and worries. Psychodynamic therapy strategies tackle the dread, and thereby the ideas and gambling. One achievement of the framework, is this capacity to integrate various therapeutic theories within the one intervention, as psychodynamic theory is often seen to be in conflict with cognitive therapy and behavioural therapy.

Identifying that chaos theory applies to problem gambling is seen as an important aspect of the development of the framework because it is deemed to be a quite radical paradigm for understanding the world in that it challenges previous understandings of the tendency of a system to maintain a given organisation, of change, predictability and of the potential of even simple equations to generate complexity. In this context, the chaos perspective suggests that predicting the onset of problem gambling in an individual is inherently difficult. It is like predicting the emergence of a tornado except that forecasting problem gambling is more difficult. Where the key features of weather systems have been identified and are quantifiable, the key features of a person's gambling system are still debated, let alone set in equations and computer models.

The framework suggests that a key feature of problem gambling can be unconscious dread, which is not quantifiable. So, in gambling systems, it is very difficult to describe the conditions at a given time, let alone predict how these conditions will evolve over time. What the framework does predict is that in problem gambling systems, similar situations can lead to very different outcomes. So the framework, as a theory, limits people's ability to make predictions regarding an individual and problem gambling. Systems described by chaos theory can exhibit rapid, unexpected changes of state. This is consistent with the behaviour of problem gamblers who can swing rapidly from seriously tackling their problem in counselling to uncontrolled gambling. Such an inconsistency of behaviour is emphasised also in reversal theory.

Further work on the framework should investigate its transferability and utility; i.e. whether other problem gambling counsellors are motivated to use the framework, are able to learn it, are able to use it and integrate it into their practice.

## The Free Yourself Program

The Free Yourself Program is described by its creator (Byrne, 1999) as a positive, holistic, pro-active and effective approach to help people to deal with problem gambling. The program is based on an addictions framework with an abstinence goal, and aims to provide strategies that people can use 'in the moment' when the urge to go gambling threatens to become overpowering.

Based on Neuro-linguistic Programming, a major strategy taught in the program is for people to learn to become aware of the 'split' that occurs when a person develops a gambling problem, with one part wanting to give up the behaviour while the other part wants to continue the behaviour. The Free Yourself Program places a lot of emphasis on how to win what is described as an 'internal war' that takes place before the person engages in the gambling behaviour. The use of specific language patterns is designed to help the person to take back control of that part of themselves that does not want to stop gambling.

As a holistic intervention, the Free Yourself Program also incorporates the positive effects of diet, exercise and meditation or prayer, as well as exercises to strengthen what the program describes as the 'will-power muscle'.

The program was designed by Gabriella Byrne, following over four years of problematic poker machine play, which had led to employment, financial and relationship problems as well as suicidal ideation. Development of the program followed her use of a range of conventional therapy approaches such as GA, counselling, and hypnotherapy, and was an attempt to create a total 'lifestyle'-based intervention. The program includes:

- Individual sessions with a Free Yourself Program-qualified facilitator;
- Group Support Sessions, providing support for people using the Free Yourself Program. Telephone counselling, supplemented with the Free Yourself Program workbook;
- The Free Yourself Program workshop involving a seminar held over four weeks (two hours per week) teaching the Program's strategies to people directly or indirectly affected by problem gambling. After the four weeks, participants are encouraged to start a new group;
- The Free Yourself Program Facilitator Training (four hour) Workshop. In addition to training people who have directly experienced gambling-related problems, the workshop is designed to integrate the program into existing interventions, and is thought to be suitable for psychologists, social workers, psychotherapists, ministers, family lawyers, medical practitioners, youth workers, etc. who are involved in helping people with a gambling-related problem.

In addition, the Free Yourself Program has established a restaurant and entertainment facility in an outer suburb of Melbourne, to provide a supportive alternative venue for those not wishing to use venues with gambling facilities.

This program is important in that it involves a creative mix of elements of a self-help, peer-led program; an approach which targets total lifestyle (diet, exercise etc); and an approach which is seen to be useful as an adjunct, or integrated into 'professional' counselling practice. It is increasingly being adopted within the Gambler's Help program. To date, no formal evaluation of the effectiveness of the program, either in its 'pure' form or as integrated into professional counselling practice, has occurred, although submissions have been made to the Community Support Fund, for example, for funding for such an evaluation.

## Free Yourself Participant Perspective

A number of participants in the program, both male and female were interviewed for this study. They confirm strongly that the access afforded by its location and style as a 'therapeutic/commercial' venture makes it particularly relevant to them:

*'And so sometimes you don't need to have a constant focus on the problem. I think sometimes it is good to be able to take it away and get some input from other people ...'*

*'It's kind of free and easy. You can have it if you want it. But you don't have to have it ...'*

*'You don't have to come at 6.00pm every Monday night ...'*

*'You can do other things ...'*

*'You start to focus on other things in your life. You are not constantly aware and you know and that is what it is. The only problem is when you are driving down all the streets and you see all the big signs outside that is when you think, "I forgot about it, oh there it is". You know. It reminds you constantly ...'*

*'We found when we first had support group meetings that a lot of people find it very difficult because actually talking about it triggered the urge to go. I know I went to Gamblers Anonymous and I went gambling straight after. Because everyone was talking about it and that is when I start something like this I like to be able to help people if they feel the need to talk then that is there. But sometimes people talk in the kitchen about their boyfriends and their kids. And other stuff and it takes away that focus of the problem ...'*

*'We mainly talk about fruit and vegetables! ...'*

*'It sort of takes away from the sense that you are your problem. You are more than your problem ...'*

Program participants also strongly endorsed the behavioural change approach adopted:

*'I think with this program the strategies are absolutely excellent. They helped me enormously. What happens is you become so overwhelmed with everything. I gambled for about four years and you try to make it up; if you have to stop you think of all the things you missed out on all the things you have to pay and it is so overwhelming. So if you pick something out like with a strategy and do little things at a time then taking tiny steps it makes you appreciate it more. And eventually you know you are going to get there. That was a very important step for me ...'*

In terms of the importance of the holistic approach, participants uniformly agreed on its relevance:

*'Very, very important ...'*

*'You have got to re-program your mind really ...'*

*'You don't only have to reprogram your mind, you reprogram your body, because instead of sitting in front of a stupid idiot machine for hours on end you go for a walk ...'*

*'It is very hard to do that though ...'*

*'Or you visit somebody ...'*

*'I do one thing at a time. Dealing with the, "Come on play, come on play" ...'*

*'But most people don't do all the strategies at once because it is too much ...'*

*'Even going for a drive and appreciating things outside a venue room. You get out and realise things like there is fresh air. It is amazing that you drive along and the world looks different. Because you are not looking for the next one to say come on in. You are looking at the trees the flowers the houses. The scenery; the things that you have forgotten about ...'*

The authors believe that an evaluation of the effectiveness of an abstinence-focused, addiction-based model, which stands outside the 'mainstream' of problem gambling service provision in Victoria should be conducted, and funded according to the model outlined in Chapter 7.

## Conclusions on Innovative Practice

This chapter has described a number of examples of innovative practice in problem gambling services, both within the Gambler's Help program and in the services other than Gambler's Help sector. There are other examples, such as:

- The Crown Customer Support Centre (CCSC), as an example of an innovative responsible-gaming initiative by industry involving the establishment of a purpose-built facility within Crown Casino, providing patron support through professional counselling provided by Responsible Gaming Co-ordinators supported by venue staff acting as Responsible Gaming Liaison Officers;
- The integrated Gambler's Help and financial counselling model operating from a number of Gambler's Help sites.

What typifies all of these examples of innovative practice, however, is that none have been systematically evaluated, therefore no conclusions can be drawn as to whether any of them constitute 'best practice'. This matter is addressed in Chapter 7.

# Chapter 7

## Conclusion and Recommendations

### Introduction

A range of different treatment programs available to problem gamblers, both within Australia and overseas, were reviewed in order to develop an understanding of best practice service models in the field. The organisational structure, theoretical orientation and the treatment approach and techniques used were examined with an emphasis primarily on describing sites of intervention and to a lesser extent, forms of intervention. This review was undertaken from an explicit starting point — that there are no internationally established models of best practice in problem gambling services in existence.

### Service Models

Our review of problem gambling intervention models indicates that there is a large range of these, utilising an equally diverse range of theories of problem gambling causation, theories of intervention, target populations, and organisational auspices. Although in the Australian context, community-based problem gambling service provision is the dominant model, it is also the model least likely to have demonstrated the effectiveness of its interventions in a rigorous sense.

We may conclude, from the available data, that community-based treatment models provide accessible support for problem gamblers and their family members experiencing gambling-related problems. A crucial dimension of these programs is that they adopt a multimodal approach to treatment, which acknowledges that problem gamblers need a range of interventions. These interventions deal with the gambling behaviour itself such as behavioural and cognitive-behavioural approaches, along with interventions designed to ameliorate impact such as financial counselling and relationship counselling. These multimodal programs also address the impacts of gambling on families through relationship and family counselling and family education.

A major strength of the Gambler's Help model is its ability to provide a range of interventions at individual, couple, family and, indeed, community levels through its community education function. It can address the need for modification of the problem gambler's actual gambling behaviour through behavioural, cognitive, and mixed interventions, and the need to ameliorate the harmful impacts of that gambling on family members through broader psychosocial interventions.

### Treatment Outcomes

In our comprehensive review of treatment outcome studies, we noted a number of key methodological issues in the definition and measurement of treatment outcomes of problem gambling programs, which, we believed, may compromise their ability to provide guides to 'best practice'. These methodological issues were:

- Selection criteria and procedures for the inclusion of gamblers into treatment programs are often poorly delineated with samples characterised by heterogeneity of subjects;
- Few studies distinguish treatment effect related to different forms of gambling;

- Respondents recruited from different treatment settings may vary in terms of motivation to change, thus making generalisation from one treatment site to another problematical, in terms of predicting rate and magnitude of change;
- Criteria of success based on the dichotomous global ratings of abstinence and non-abstinence often 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;
- Many studies do not present data on rejection or attrition;
- It is sometimes difficult to identify the impacts of primary interventions, in situations where a number of interventions are used simultaneously;
- It is not always clear in studies whether reliable and valid measures of change are being used, or how concepts such as 'improvement' are measured;
- There is no clear-cut definition of what constitutes lapse or relapse in terms of gambling behaviour;
- Post-treatment follow-up intervals vary.

Bearing in mind these limitations, from our review of reported studies, our conclusions are broadly similar to those reached by the NCETA team in their previous theoretical and empirical review of 'best practice' interventions conducted for the Victorian government. That is, there appears to be support for a broad bio-psychosocial approach, using cognitive behaviourally oriented approaches and multimodal approaches, delivered in community-based generalist agencies.

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

In summary, what emerges in the latest studies reviewed is support for a broad bio-psychosocial orientation to understanding the aetiology of problem gambling; the form of expression of problematic gambling; and the impacts of problematic gambling behaviours. There is also a need to identify specific targets for interventions, whether these interventions are pharmacological, cognitive, behavioural, or systemic in nature. The implications of our review for service design are that services may be both treatment-specific or multimodal in orientation, but that interventions should be theory-driven, evidence-based and targeted.

## Problem Gambling Services

Our review of Gambler's Help program counselling practice and theories in use revealed that a broad range of theoretical perspectives underpin the delivery of the Victorian problem gambling program. Counsellors incorporate a variety of therapeutic strategies and theoretical perspectives to inform their counselling practice with problem gamblers, with the majority of counsellors adopting an eclectic approach to counselling.

Problem resolution and post-counselling gambling behaviour compare very favourably with those attained in similar state-wide services, and in an analysis of the counselling process, the most significant finding was that the therapeutic relationship was the process variable that most consistently predicted positive outcome.

Outcome measurement as a specific aspect of quality assurance is probably the least well developed area in the Gambler's Help program, with such lack of development, we believe, at odds with the thoughtfulness and adherence to best practice typical of the rest of the operations of the program.

This lack of specification of agreed-on methods for performance monitoring should be addressed in the forthcoming review of Practice Standards in Gambler's Help commissioned by the Department of Human Services for completion in mid-2003.

To establish a better evidence base upon which to inform service design and funding decisions, there needs to be developed better outcome measures and to incorporate the collection of these measures into routine reporting of outcomes by funded agencies through appropriate service standards. Further, there is a need for the program to determine outcomes for those not completing the recommended intervention program. The Gambler's Help Minimum Data Set, for example, contains only ratings from counsellors concerning the outcomes of their clients. This is not a satisfactory basis for relating outcomes to inputs. The MDS, with some amendment could be a superb evidence base to inform better service design and delivery.

The key finding from our review of services other than Gambler's Help is that there is a negligible amount of gambling-related service provision in this sector, despite anecdotal evidence to the contrary. There is a paucity of information available on the degree of service provision to people with gambling-related problems, and therefore negligible information on outcomes achieved.

Some minimal form of screening for gambling-related problems should be required of all services supported by funding and service agreements through the Victorian Department of Human Services. This requirement should take into account compliance costs for these agencies, and should also introduce funding opportunities for these agencies, if it can be demonstrated that they are meeting the needs of people with gambling-related problems.

Many respondents interviewed for this report, from services other than Gambler's Help believed that work needs to be done to de-stigmatise problem gambling so that people needing a range of services other than Gambler's Help such as emergency accommodation, mental health, legal, relationship and general family support and 'generic' financial counselling feel able to access these services without disabling levels of guilt and shame. Future mass media campaign should address the issue of disclosure of gambling-related problems in services other than Gambler's Help. Such agencies should be given a budget to promote their services at a community and agency level to people with gambling-related problems.

In examining Gambler's Help counsellor's practice in detail, the therapeutic relationship was the process variable that most consistently predicted positive outcome. In terms of our model of intervention inputs and outputs, very few client characteristics had a statistically significant impact on counselling outcomes in the Gambler's Help program. As well, counsellor characteristics were found generally not to be predictive of client outcomes. The size of the Gambler's Help service and its level of funding have not been shown to have an impact on outcomes achieved.

No available evidence was found that ethnic/indigenous specialist counselling services were attracting clients from these language communities or the Aboriginal community at a higher rate than if the services were not offered in these languages or with an indigenous focus. Neither was there evidence that the counselling achieved different outcomes from the non-CALD focused counsellors.

Specialist indigenous and ethnic programs should be evaluated to determine the success or otherwise of this specialist intervention in terms of accessibility, equity, and relevance as measured by culturally sensitive process and content and effective outcomes.

## **Innovative Practice**

A number of examples of innovative practice in problem gambling services, both within the Gambler's Help program and in the sector for services other than Gambler's Help were briefly reviewed. We noted that these descriptions of interventions were given as they represented types of practice not covered in the review of practice models, which may represent 'best practice', but which have not as yet undergone rigorous evaluation.

An Innovative Practice Fund should be established, funded by the Community Support Fund and administered by the Department of Human Services with the assistance of an expert clinical practice and clinical research panel, to finance the development and evaluation of innovative practice to ensure that innovative practice is developed without penalty to agencies, in terms of needing to meet these development and evaluation costs from normal operating grants.

In pursuit of the objective of identifying possible best practice developments, the following research and development projects be given priority:

- Evaluation of the single session consultation model;
- Assessment of the transferability and effectiveness Gunner's 'spirals' model to other sites of clinical practice;
- Evaluation of the G-mail intervention;
- Evaluation of the Free Yourself Program;
- Evaluation of the integrated gambling counselling/financial counselling model;
- Evaluation of the Crown Customer Support Program.

While there are undoubtedly other developments underway in Gambler's Help and in the industry, those noted above have been identified by the review team as requiring timely support through such an Innovative Practice Fund.

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# Appendices

## Appendix 1 Interviews Conducted

As noted in the ‘overview of project methodology’ section of Chapter 1, a range of people involved in the design, funding and implementation of the Gambler’s Help program were interviewed individually and in groups. These included:

- Managers, counselling staff and financial counsellors from metropolitan and regional Gambler’s Help services and the Gambler’s Help Services Secretariat;
- Department of Human Services Head Office staff and regional managers;
- Managers of agencies hosting Gambler’s Help programs.

These interviews covered areas such as policy, service models, practice standards and interventions. Those interviewed under these categories were:

Eddie Chapman (Council of Gambler’s Help Services)	Neil Mellor (Gambler’s Helpline)	Teresa Hall (Gambler’s Help Mallee)
Prue Sabelberg (Gambler’s Help Western)	Kathy Ryan (Gambler’s Help Barwon)	Bronwyn Rouse (Gambler’s Help Loddon Campaspe)
Chris Freethy (Gambler’s Help Southern)	Tim McCorriston (Gambler’s Help Central)	Bernie Durkin (Gambler’s Help Eastern)
Julie Nelson (Gambler’s Help Northern)	Colleen Lovell (Gambler’s Help Grampians)	David O’Brien (Gambler’s Help Southwest)
Marie Feeley (Gambler’s Help Gippsland)	Sarah Wooding (Gambler’s Help West Hume)	Leigh Barrett (DHS Head Office)
Faye Haskin Senior Agency Liaison Officer (DHS Southern Metro)	Brian Clarke Financial Counsellor (Gambler’s Help Central)	John Harnett Financial Counsellor (Gambler’s Help Central)
Dawn Martin Agency Liaison Officer (DHS Gippsland)	Lauren McGaw Program Advisor (DHS Barwon South West)	Ram Senguttuvan Agency Liaison Officer (DHS Eastern Metro)
Kathy Griffin Counsellor/Community Educator (Relationships Australia)	Eilee Mackie PG Counsellor (Upper Hume Community Health)	Peter Rinney Counsellor (Gambler’s Help Northern)
Frank Giggins Manager, Community Services (Bethany Community Support/ Gambler’s Help Barwon)	Jill McQualter Program Adviser (Loddon Mallee DHS)	Kath Johnson Manager, Primary Mental Health & Counselling Team (Community Health Bendigo)
Jill Candappa (Gambler’s Helpline)	Melissa Hamillton (DHS Hume)	Frank Johnson (Upper Hume Community Health)
Lindsay French PG Counsellor (Upper Hume Community Health)	Sarah Wooding (Gambler’s Help West Hume Shepparton)	Mike Butcher Senior Program Adviser (Loddon Mallee DHS)
Ailsa Stevenson (Gambler’s Help Barwon)	Gendal Atkinson (Gambler’s Help Colac)	Eileen Mackie (Gambler’s Help Wodonga)
Andrew Gunner (Gambler’s Help Western)	Frank Johnson (Gambler’s Help E. Hume)	Kay Tulloch (Gambler’s Help Mallee)
Colleen Lovell (Gambler’s Help Grampians)	John Laidlaw (Gambler’s Help Central)	Dianne Jenkin (Gambler’s Help Eastern)

Carol Henwood  
(Gambler's Help Horsham)

Clive Smee  
(Gambler's Help Southern)

John Flynn  
(Gambler's Help Gippsland)

Ray Meehan  
(Gambler's Help Swan Hill)

Anne Cox  
(Gambler's Help Broadford)

In addition a range of non-Gambler's Help service providers were interviewed regarding the extent to which they were involved in the provision of services to people with gambling-related problems. Those interviewed under this category were:

Kim Burns  
Program Manager, Young Women's  
Outreach, Hanover Welfare Services

Paul Linossier  
CEO  
McKillop Family Services

Gabriella Byrne  
Director  
Free Yourself

Anita Molivic  
SW Service Co-ordinator  
Hanover Southbank

Sophie Gardner  
Director  
Mental Health Legal Centre

Anne Tuohy  
Director  
Catholic Social Services

Leanne Acreman  
Director, Flagstaff Support Services  
Salvation Army

Marie  
Financial Counsellor  
Kildonan Child & Family Services

Kay Swinton  
Director  
Lifeworks

Tina Douvas  
Psychologist  
Australian Greek Welfare

David Maxwell  
Director  
Drummond Street Relationships  
Centre

Claudio Donissi  
Psychologist  
Cairnmiller

Carmel O'Brien  
Counsellor  
Doncare

Marilyn Webster  
Good Shepherd Youth and Family  
Services, Collingwood

Kylie Allen  
D&A Counsellor  
Bridge Centre, Salvation Army

Le Bui  
Social Worker  
Springvale Chinese Mutual  
Assistance Association

Jenny Lawton  
Director  
Carlton & Fitzroy Financial  
Counselling Service

Graeme Hall  
Odyssey House Drug and Alcohol  
Family Program

Carmel Stafford,  
Co-ordinator, Financial Counselling  
Program  
Good Shepherd Youth and Family  
Services, St Albans

Lyn Moran  
Director of Client Services  
Centrelink

A number of the non-Gambler's Help service providers contacted for interview, suggested after preliminary discussion that they believed they had no evidence of involvement with people with gambling-related problems by either their staff or Association members. These organisations were:

- Bouverie Family Therapy Centre;
- Williams Road Family Therapy Centre;
- Victorian Association of Psychoanalytic Therapists;
- Clinical Counsellors Association;
- Association of Solution Oriented Hypnotherapists;
- Association of Marriage and Family Counsellors.

In addition to interviews with service providers, three focus group sessions comprising nineteen people, were held with service users from the following services:

- Free Yourself, Lilydale (one group);
- Gamble's Help Southern, East Bentleigh (two groups).

## Appendix 2 Gambler's Help Sites

Region	Gambler's Help Agency	Outreach/Co-location Sites	Frequency	Agency/site features
City	Salvation Army (Melbourne Counselling Service) 69 Bourke St. Melbourne 3000 (PO Box 18137 Collins St East VIC 8003)	Lifeworks Relationship Counselling & Education Services Collins St City  Salvation Army (Melb. Counselling Service) West Melbourne		Mandarin/Cantonese  Financial counselling
Barwon	Bethany Family Support Inc. 1 Gibb St, North Geelong 3215 (PO Box 324 North Geelong 3215)	Drysdale Community Health Geelong  Surf Coast Community Health Torquay  Lorne Community Health  Barwon Prison	3-weekly/as needed  weekly  as needed  as needed	Croatian Serbian Macedonian Slovenian Financial counselling
Barwon Southwest	Colac Community Health Services Corangamite St, Colac 3250	Anglesea Community Health Centre  Otway Health & Community Services  Lorne Community House	as needed  as needed  as needed	Outside Colac, most clients seen by home visit
South West	Community Connections (Vic) Ltd. 135 Kepler Street, Warrnambool 3280 (PO Box 404)	Otway Community Health Portland  Community Connections Hamilton  South West Health Camperdown	1 day pw  1 day pw  1 day pw	Community Connections is independent multi-program agency with family & financial counselling, disability services
Eastern	Eastern Access Community Health 48 Warrandyte Rd, Ringwood 3134	Whitehorse Community Health Centre Box Hill  Camcare Camberwell  Camcare Ashburton  Migrant Resource Centre Oakleigh  Wavecare Glen Waverly  Eastern Access Community Health Ringwood	4 days pw pg 1 day pw fc  4 days pw pg 2 days pw fc After hrs 1 night pw  1 day pw  4 days pw pg .5 day pw fc After hrs 1 night pw After hrs self-directed support grp 1 night pw  1.5 days pw pg .5 day pw fc  2.5 days pw pg 1.5 day pw fc After hrs 2 nights pw After hrs therapeutic grp 1 night pw	50 per cent CALD focus for Chinese community in particular  50 per cent CALD focus for Greek community  .6 position to work with indigenous community in Eastern Region, centred on Yarra Ranges

Region	Gambler's Help Agency	Outreach/Co-location Sites	Frequency	Agency/site features
Eastern <i>(cont.)</i>		Valley Connect Yarra Junction	1 day pw pg	
		Anglicare Lilydale	1 day pw pg	
		Ranges Community Health Service Lilydale	1.5 days pw pg 1 day pw fc	
		Healesville Living & Learning Centre	1 day pw fc	
		Knox Community Resource Centre	3 days pw pg	
		Knox Towerpoint	1 day pw pg 2 days pw fc	
		Rowville Uniting Church Rowville	1 day pw pg	
		Manningham Community Health Centre Doncaster	2.5 days pw pg .5 day pw fc	
Gippsland	Anglicare Victoria Gippsland 65 Church St. Morwell 3840 (PO Box 959 Morwell 3840)	Anglicare Gippsland Warragul	3 days pw	These offices also provide outreach service to Sale, Lakes Entrance, Yarram, Orbost, Wonthaggi, Phillip Island, Moe, Fulham CC, Won Wron Prison  1 EFT NESB/indigenous specialist although all counsellors see NESB/indigineous clients  Support groups and/or women's groups available as necessary Polish worker
		Anglicare Gippsland Morwell	5 days pw	
		Anglicare Gippsland Bairnsdale	5 days pw	
		Anglicare Gippsland Leongatha	4 days pw	
Grampians	Relationships Australia (Vic) 116 Lydiard St North Ballarat 3350	Grampians Community Health Centre Ararat		
		Grampians Community Health Centre Stawell		
		Child & Family Services Daylesford		
		Child & Family Services Bacchus Marsh		
Horsham	Palm Lodge Rehabilitation 25 David Street (PO Box 501) Horsham 3400			
Wimmera	Wimmera Uniting Care 185 Baillie St Horsham 3400			
Central Highlands	Access Service Ballarat Inc. Child and Family Services 115 Lydiard Street North Ballarat 3350	As for Relationships Australia		



**Best Practice in Problem Gambling Services — Appendices**

Region	Gambler's Help Agency	Outreach/Co-location Sites	Frequency	Agency/site features
Mallee	Swan Hill Community Resource Centre 369 Campbell Street (PO Box 1049) Swan Hill 3585  Mallee Family Care Mildura Community Resource Centre 122 Ninth Street Mildura 3500 (PO Box 1870 Mildura 3502)	Robinvale Community Resource Centre  Kerang Community Resource Centre  Sealake  Ouyen	As needed  As needed	Residents from Sealake & Ouyen seen at main office or home visit
Northern	Banyule Community Health Centre Level 1, 444 Sydney Road Coburg 3058	Banyule Community Health Service West Heidelberg  Broadmeadows UnitingCare  Kildonan Family Services Lalor  Darebin Community Health Service Northcote  Eltham Community Health Service  Sunbury Community Health Service  Community Information Diamond Valley Greensborough  Yarra Community Health Service Richmond  Craigieburn Community Health Service  Victorian Aboriginal Health Service Fitzroy	3.5 days pw  1.5 days pw  4 days pw equiv 5 days incl 2 after hrs days for individuals and grps  1 day pw  1 day pw by appt  .5 day Saturday    1 day pw by appt  2 days pw	Counselling available in Greek, Arabic, Italian, Macedonian.  Also includes Indigenous Access Worker  Financial Counsellors available at Coburg, Northcote, Lalor, Broadmeadows West Heidelberg
Southern	Bentleigh Bayside Community Health Centre Gardeners Rd East Bentleigh (PO Box 30 Bentleigh East 3165)	Casey Community Health Service Berwick  Central Bayside Community Health Service Chelsea  Cranbourne Integrated Care Centre  Greater Dandenong Community Health Dandenong  Bentleigh Bayside Community Health Centre E Bentleigh	As needed	Counselling available in Arabic, Polish, Vietnamese, Cantonese/Mandarin, Greek

Region	Gambler's Help Agency	Outreach/Co-location Sites	Frequency	Agency/site features
Southern (cont.)		Bentleigh Bayside Community Health Service Highett  Frankston Health Care Centre  Good Shepherd Youth & Family Service Hastings  Casey Community Health Service Pakenham  Central Bayside Community Health Service Parkdale  South Central Migrant Resource Centre Prahran  Southern Peninsula CISS Rosebud  Inner South Community Health Service South Melbourne  Springvale Community Aid & Advice Bureau  Greater Dandenong Community Health Springvale	As needed       1 day pw	
Western	Isis Primary Care 1 Andrea St, St Albans 3021 (PO Box 147, St Albans 3021)	Isis Primary Care Altona Meadows  Isis Primary Care Copperfields Neighbourhood Centre Delahey  Isis Primary Care Deer Park  Western Region Community Health Service Footscray  Aust Vietnamese Women's Welfare Association  Djerrawarra Health Service Melton Flemington Community Centre  Quantin Binnah Community Centre Werribee  Werribee Support & Housing Co-op  Isis Primary Care Wyndham Campus  Werribee Dame Phyllis Frost Centre Deer Park (Women's Prison)	2 days pw  1 day pw  1 day pw incl after hrs  4 days pw  1 day pw  2 days pw  3 days pw   .5 day	Counselling available in Vietnamese, Spanish, and basic Arabic  2 financial counsellors including 1 Vietnamese speaking
Gambler's Help 24-hour telephone counselling service	Turning Point Telephone Services C/- 54-62 Gertrude St Fitzroy Vic 3065			

## Appendix 3

### Abbreviated Draft Problem Gambling Service Standards

The following represent the sorts of standards that might be appropriate for a service such as Gambler's Help with some indicative questions that might determine compliance.

*Staff involved in the delivery of problem gambling services should have appropriate qualifications and experience to deliver effective services.*

To evaluate the extent of compliance with this standard an agency would determine what the evidence was that staff held recognised qualifications relevant to the provision of problem gambling services and that staff engaged in a recognised ongoing program of professional development/continuing education.

*A systematic and comprehensive intake procedure should be used for all counselling service clients.*

To evaluate the extent of compliance with this standard an agency would determine what the evidence was that appropriate service and demographic data were collected and recorded using an accepted coding scheme and records system and that clients were provided with appropriate information about the range of services offered, other relevant services and referral options and complaints procedures?

*Effective evidence based counselling interventions should be selected and provided on the basis of an individual assessment of client need.*

To evaluate the extent of compliance with this standard there are a number of relevant indicators. An agency would determine what the evidence was that:

- A recognised method of assessment had been used to assess the nature and extent of the gambling related problems and the results recorded using an accepted coding scheme and records system;
- A recognised method of intervention had been selected based upon the best available evidence targeted at the identified profile of gambling and gambling related problems identified for the client;
- The selected intervention had been applied according to the initial and subsequent assessments of client need so as to provide the most effective client outcomes;
- A recognised discharge and disengagement protocol had been implemented for all clients.

*Effective evidence based Community Partnership and Education interventions should be selected and provided on the basis of an assessment of community need.*

To evaluate the extent of compliance with this standard, an agency would need to determine that:

- A recognised method of systematic needs assessment had been used to assess the client and Community Partnership and Education needs in problem gambling;
- A recognised method of education program design (based upon the best available evidence, targeted at the identified profile of gambling and gambling related problems identified for the client and the community) had been used to develop the Community Partnership and Education program;

- The Community Partnership and Education program had been applied according to the need assessment of the client and the community so as to provide the most effective outcomes.

Source: Renhard, R., Thomas, S., Jackson, A.C. (2003) Self-audit Protocol for Problem Gambling Service Standards, Melbourne: Australian Institute for Primary Care