
5 Counselling and treatment support services

Key points

- Only a small share of people experiencing problems seek professional help. The available data suggests that around 17 500 people attended gambling help services in 2007-08.
- Most clients of help services have either 'hit rock bottom' or are coming close.
- Social stigma associated with having a problem, denial of a problem and believing they can handle the problem themselves are the main reasons why gamblers do not seek professional help.
- Interventions should cover the full continuum of gambling problems and not just focus on 'treatment'.
 - Governments should place greater emphasis on community awareness, to encourage earlier help-seeking and interventions by family and friends.
 - Pathways for referral would be improved by better informing general practitioners and other front-line professionals.
- People experiencing problems with gambling can recover without professional help, and the evidence suggests that many do. Relatively low cost interventions have the capacity to increase self-recovery.
- Outcome studies show that the majority of clients appear to benefit from treatment (irrespective of its form). And, while cognitive behavioural therapy has the most empirical support, no one style of intervention is necessarily best practice.
- There would be benefits in having a minimum standard of specific training for problem gambling counsellors.
- Funding sources for gambling help services currently are too narrow in coverage of gambling forms.
- Nationally consistent data is much needed. Coordination of the collection of data would be highly desirable.

A main element of the policy response by governments to problem gambling is to provide counselling and treatment support to people experiencing problems with

gambling, as well as to family or friends who may be affected. All state and territory governments in Australia provide free treatment services, including:

- 24 hour gambling helplines (a national 1800 number) offering counselling, information and referral services
- websites providing information, online counselling, self-help material and tools
- face to face counselling, including intensive clinical therapy, financial and relationship counselling, and group support.

The states and territories also fund community education and research activities (appendix J).

The key question for this chapter is whether these services achieve their objectives and the extent to which there is scope to improve them. Help services are important to achieving good outcomes but are also costly for governments (and therefore taxpayers). In 2007-08, around \$48 million was spent on specialist gambling counselling and support services, community education and research.

This chapter assesses:

- the capacity of the services to reach problem gamblers and what governments can do to enhance this (section 5.1)
- the effectiveness of the ‘treatments’ used to assist problem gamblers, and whether there are preferred approaches (section 5.2)
- whether there are benefits in increasing the qualifications or training of counsellors (section 5.3)
- the appropriate nature and degree of coordination of specialist services and the wider health system (section 5.4)
- the adequacy of funding arrangements (section 5.5).

The need for better evidence as a basis for decision-making about help services is a key theme (section 5.6).

5.1 Reaching the target population

A first step in improving the reach of services is an understanding of:

- how many people seek help (or do not)
- their motivations for doing so (or not)
- the nature and extent of their problems.

Relatively few people with problems seek help

Only a small share of people experiencing problems with gambling seek formal help from counselling and treatment services. While it is difficult to know the 'exact' number, client data collected by the states and territories suggest that around 17 500 people attended gambling counselling and treatment services in 2007-08 (appendix J). The data, however, are not strictly comparable (some jurisdictions collect data on 'all' clients, others on 'new' clients, some include clients attending gambling financial counselling). This estimate also excludes people seeking help from privately provided or voluntary gambling help services (such as Gamblers Anonymous and private psychiatrists) and those seeking help from generic community services as well as financial and relationship counselling agencies.

Based on there being between 90 000 and 170 000 problem gamblers, and excluding clients seeking help for someone else's gambling problem (around 4 000 people), this suggests a help seeking rate of between 8 and 15 per cent.

Low rates of help-seeking by people experiencing problems with gambling are not unique to Australia. Internationally, around 6-15 per cent of people experiencing problems with gambling are reported to seek help from problem gambling services (Slutske 2006, Suurvali et al. 2008).

Who does seek help?

Data collected by the states and territories suggests that:

- Most of those seeking formal help are experiencing problems primarily with electronic gaming machines (EGMs), or they identify EGMs as the principal preferred form of gambling activity.
- Most people seeking help have been experiencing problems for some time. Data collected in both NSW and Tasmania, show the most commonly reported length of time experiencing problems with gambling is 2 to 5 years (25 per cent in NSW and 32 per cent in Tasmania). Seventeen per cent of males and 12 per cent of females in NSW report having experienced problems for more than 15 years.
- Most clients do not receive prolonged periods of treatment. NSW, for example, reported a session-to-client ratio of 4 in 2007-08, with 30 per cent of problem gambling clients and 49 per cent of financial counselling clients receiving only one counselling session during the reporting period.
- Many people seeking help for gambling problems also have co-morbidities. In NSW, for example, of those clients presenting for counselling, 43 per cent reported having at some stage been diagnosed with anxiety, 55 per cent with

depression, 29 per cent with alcohol problems and 19 per cent reported problems with other drugs.

Additional client profile information is provided in appendix J.

What triggers help-seeking?

People experiencing problems with their gambling often do not seek professional help until a ‘crisis’ occurs — financial ruin, relationship break down, court charges or attempted suicide — or when they hit ‘rock bottom’. As one gambler said:

Recognition that I had a gambling problem came the day I went to buy some groceries and found there was no money in my account. The trigger ... was serious threats by my family to quit dealing with me. (quoted in McMillian et al. 2004, p. 155)

The evidence from counselling services is consistent with this:

... those clients who do seek help often do so some considerable time after they first recognise the problem, by which time gambling and its associated problems have reached crisis point and much damage has been done. (Department of Justice 2008, p. 8)

By the time people experiencing harm as a result of their own or someone else’s gambling find their way to counselling they are usually in a very distressed state. Of 249 Gambling Care clients whose files were active in the 07/08 financial year, 87 (34 per cent) had indicated they had seriously considered suicide and 17 (7 per cent) that they had attempted suicide as a result of their problems with gambling. A small but steady number found themselves before courts for the first time as a result of offences related to their problem gambling and we usually have at least one client serving a custodial sentence as a result of crime solely related to problem gambling. (Gambling Care, Lifeline Canberra, sub. 123, p. 1)

Studies looking at reasons for seeking help for gambling consistently find ‘hitting rock bottom’, financial and relationship difficulties, negative emotions, work and legal difficulties and physical health, as the main reasons for seeking formal help (Suurvali 2009, table 5.1). For example, Evans and Delfabbro’s study of 77 problem gamblers (61 had sought professional help), found help seeking to be largely crisis-driven rather than being motivated by a gradual recognition of problematic behaviour. They observed:

The majority of gamblers interviewed only sought help when they were on the verge of physical or psychological breakdown, and/or when they were facing financial ruin. This was evident not only in the nature of motivational items endorsed, but also in the range of items endorsed, indicating that the negative effects of gambling had already affected multiple areas of the person’s life. (2005, p. 149)

Table 5.1 Studies looking at help-seeking behaviour of people experiencing problems with gambling

<i>Study</i>	<i>Method</i>	<i>Results</i>
Evans and Delfabbro (2005), Australia	77 gamblers — 61 had sought professional help, 16 relied on self-help strategies. A questionnaire (with both open and closed-ended questions) was used to find out what factors motivated professional help seeking and self-help methods. Gamblers were also asked to rank key barriers to help seeking.	Help seeking found to be largely crisis-driven rather than being motivated by a gradual recognition of problematic behaviour. The main obstacles to seeking help were found to be psychological. Problem gamblers consistently endorsed two issues — (i) they were in denial, or were embarrassed if friends or family found out, and (ii) believed they would eventually regain control on their own, or would be able to gamble their way out of difficulties. Factors such as a lack of awareness of services and dissatisfaction with services were endorsed by relatively few.
McMillian, et al. (2004), ACT, Australia	Semi-structured interviews with representatives from a variety of cultural communities and a small sample of problem gamblers and their families.	A variety of factors prompted help seeking. For the majority, a problem recognised as serious when it impacted on finances and relationships. Found ‘shame and stigma’ and ‘failure of others to understand the problem’ as obstacles to seeking help. Inadequacy of services on offer was also reported as an obstacle.
New Focus Research (2004), Victoria, Australia	Longitudinal study of problem gamblers, loved ones and providers of problem gambling services.	Main reasons for seeking help — ‘hitting rock bottom’ financially (36 per cent) and emotionally (15 per cent), pressure by family member/loved one (17 per cent).
Rockloff and Schofield (2004), Australia	1203 Central Queenslanders (598 women, 605 men) aged 18+ completed a telephone survey.	Identified 5 potential barriers to treatment — availability, stigma, cost, uncertainty and avoidance. People with greater gambling difficulties were more concerned with the availability, effectiveness and cost of treatment.
Hodgins and el-Guebaly (2000) Calgary, Canada	Comparison of resolved (n=43) and active pathological gamblers (n=63)	Obstacles — embarrassment/pride (50 per cent), no problem/no help needed (50 per cent), unable to share problem (49 per cent) and stigma (53 per cent). 82 per cent of gamblers said that wanting to handle the problem on their own was moderately important. Ignorance of available treatment/lack of treatment options were also identified as obstacles.
Pulford, et al. (2009a,b) New Zealand	Structured multi-modal survey — users of a national gambling helpline + gamblers from general population	Financial concerns most frequently reported reason for seeking help, also psychological distress, problem prevention, rational thought, physical health, relationship issues. Barriers included pride (78 per cent of help seeking (HS) and 84 per cent of non help-seeking (NHS) participants), shame (73 per cent HS, 84 per cent NHS), and denial (87 per cent NHS).

A study of problem gamblers who employed largely self-help methods to overcome their difficulties, also found that the only significant predictor of professional help seeking was the degree of severity of gambling problem. The help seekers' DSM-IV score was significantly higher than for those receiving minimum or no professional treatment (Hodgins and el-Guebaly 2000). These findings are consistent with the Commission's previous national gambling survey (PC 1999) — 1 in 5 gamblers with SOGS scores of 10+ had sought help, compared with 1 in 14 gamblers with scores in the 5-9 range.

In terms of the evidence as to why people experiencing gambling problems *do not* seek formal help, the main reasons appear to be:

- feelings of guilt, shame and embarrassment
- denial and
- believing that they can resolve their gambling problems without professional help (table 5.1).

Issues and dilemmas about help seeking

Given what we know about *when* people experiencing problems with their gambling seek professional help and the reasons *why* they do not seek formal help, key policy questions are:

- Is it possible to identify and help people experiencing problems with their gambling earlier? Can we do better than having an 'ambulance at the bottom of the cliff'?
- Can policy measures lessen the stigma attached to having a gambling problem?
- Are there ways by which government action can help people help themselves?

Can we do better than the 'ambulance'?

Many participants called for more of a public health approach to problem gambling, with a focus on addressing problems earlier. UnitingCare Australia, for example, said:

Responding to gambling harm requires an integrated range of responses, best described by application of a 'public health' approach to reducing gambling harm. Over the past decade, most focus on reducing gambling harm has been through the provision of tertiary level services focussed on individuals with gambling problems. These services are very important. However, improved use of primary and secondary responses, including public education and other risk reducing strategies will increase the reach, timeliness and effectiveness of the overall harm minimisation effort. (sub. 238, p. 7)

As shown in figure 5.1, gambling problems lie along a continuum of increasing severity. The public health model focuses on the prevention of problems associated with gambling and promotion of wellbeing generally. This is in contrast to the medical approach which focuses on the *treatment* of the relatively small group of people suffering severe harm from gambling. As Shaffer and Korn put it:

By understanding the distribution and determinants of gambling problems in the general population and among the subgroups, there is opportunity to develop effective strategies to protect the vulnerable people, foster healthy gambling where appropriate, and improve the quality of community life. (2002, p. 204)

Under the public health model, strategies are applied across the continuum of problems, including identifying the behavioural and environmental factors that could lead to future problems.

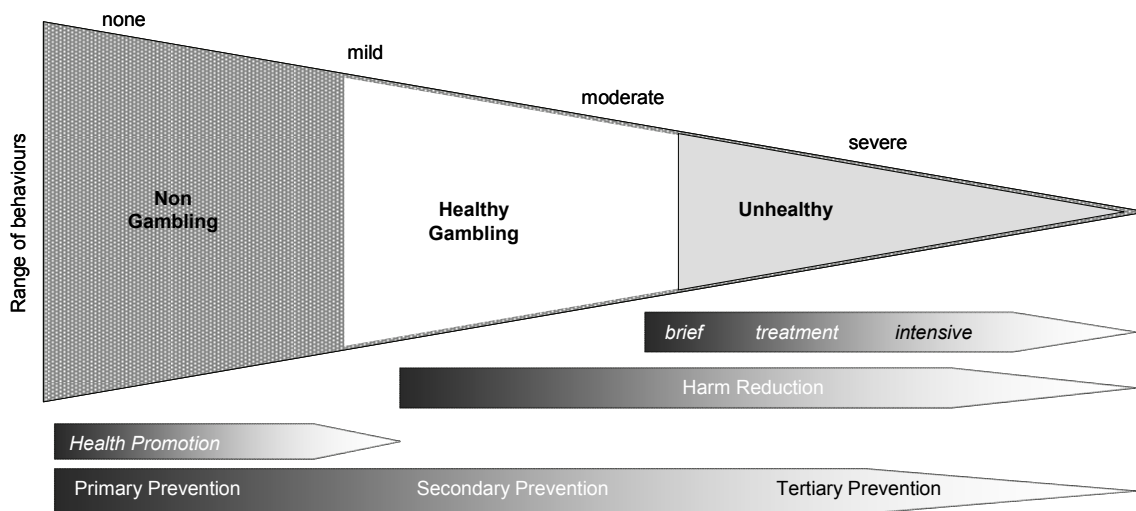
- Primary prevention activities are aimed at preventing individuals in the general population from developing gambling problems (such as public awareness-raising campaigns, service provider awareness).
- Secondary prevention activities seek to limit harm in the early stages of problem development (such as through intervening early).
- Tertiary prevention activities are about treating or reversing the effects of problem gambling.

Raising community awareness about gambling and help services available

Public awareness, education and training are a key focus of the *National Framework on Problem Gambling 2004-08*. All states and territories have in place strategies for raising community awareness about gambling and help services. Information is provided by various means:

- media campaigns
- gambling awareness weeks
- gambling websites
- problem gambling information material (printed in various languages)
- school education material.

Figure 5.1 **Gambling problems lie on a continuum**



Source: Korn and Shaffer (1999)

And, some states and territories have adopted a public health approach to gambling. For example, the Victorian Government’s ‘Problem Gambling Community Awareness and Education Strategy’ is built around three core principles — building community resilience to problem gambling, raising awareness of risks and promoting services for those who need help. Similarly, Queensland’s ‘Responsible Gambling Strategy’ covers early identification and prevention, consumer protection and rehabilitation initiatives.

Community awareness campaigns have the advantage of reaching a large proportion of the population. Campaigns based at the whole population can help the community better understand gambling problems (and this can reduce the stigma associated with having a gambling problem) and make more informed choices about gambling. What is evident from interventions targeting general populations in other areas (such as tobacco), is that sustained campaigning over an extended period of time is generally required before population-wide changes in behaviour become evident. In the case of tobacco, behavioural changes took over 40 years to occur.

In order to reduce ‘harm’ associated with gambling, awareness campaigns need to induce behavioural change. This is very difficult to do. Gambling awareness campaigns have little impact if people are not obliged to attend to the information or have no intrinsic interest in it (Williams et al. 2008). This suggests targeting campaigns at gamblers at risk and enhancing their ability to recognise ‘at risk’ behaviours and adopt control strategies.

Because financial loss is one of the main reasons gamblers seek help, Pulford et al. (2009b) suggest that campaigns that demonstrate increasing levels of financial loss and hardship over time could be particularly valuable as viewers/readers/listeners could conceptualise a continuum of financial loss. A recent review of help-seeking studies also found ‘fear of future consequences’ and a desire to prevent gambling problems from becoming more serious, to be key reasons for gamblers quitting or reducing their gambling (Suurvali et al. 2009). This suggests that gamblers are able to see where their gambling is leading them and to take action before they reach ‘desperation point’. Suurvali et al. (2009) suggested that:

Awareness and educational messages could feature, in addition to information meant to support and assist gamblers in crisis, positive statements about the benefits of reduced gambling involvement targeting heavier gamblers who have not yet experienced or acknowledged serious harms from their gambling.

In another recent study where recovered gamblers were asked how they would help active problem gamblers to cease or reduce gambling, one third suggested awareness-raising strategies, such as pointing out the negative consequences of problem gambling and arousing cognitive dissonance between what the individual wants to achieve and what continued gambling would lead to (Toneatto et al. 2008).

Overall, the evidence suggests that campaigns that focus on the threat of future financial loss could promote earlier and increased rates of formal help seeking behaviour.

Because of the ‘invisibility’ of the symptoms of problem gambling, campaigns that make the community aware of the sorts of behaviours that are indicative could also promote earlier help seeking. People in contact with those experiencing problems with gambling may not know what they can do to help and what services are available. Again, this suggests targeting, this time at those likely to encounter people showing early signs of distress (partners, friends, colleagues, general practitioners and financial counsellors).

There is evidence that family and friends can play an important role in:

- identifying problematic behaviours (they are often aware of gambling problems, but not always the extent of the problems)
- helping those concerned with strategies to control their gambling and
- referring those concerned to help services (box 5.1).

Box 5.1 **Family and friends can play an important role**

- In a Victorian longitudinal study of problem gamblers, their loved ones and service providers, the majority of problem gamblers stated that their families and loved ones were aware of their gambling problems, although they were not aware of the extent of the problems (New Focus Research, 2004).
- Client data on referral to counselling services also shows that family, friends and neighbours are an important referral source to gambling help services. For example, 16 per cent of clients in NSW services reported family/friend/neighbour/partner as the most recent referral source. In Victoria and Queensland, around 8 and 6 per cent respectively, were referred to counselling services by family and friends in 2007-08 (appendix J).
- A study of problem, recovering and recreational gamblers across Glasgow found that close friends and family often played a key practical role in identifying services, applying pressure of various kinds and accompanying gamblers to counselling sessions (Anderson et al. 2009). Friends and family were also found to take an active role in helping participants stop or control their gambling including accompanying them when they went out, taking control of the gambler's finances (holding credit cards, managing and allowance), reminding gamblers what there was to lose by gambling (holidays, treats for children).

There is also some evidence that campaigns to raise awareness of problem gambling issues lead to increases in the number of calls to gambling help lines and in the number of clients accessing counselling services:

- The year one evaluation of the Gambling Hangover Campaign (NSW), which targeted young males but also friends/family of young males with gambling problems, showed that there was high awareness and approval for the campaign among the target group. Half of the young men surveyed recalled the advertisement as 'attention getting', 'modern' and 'thought provoking'. Calls to G-line were up by an average of around 5 per cent and an estimated 85 new clients sought RGF-funded face-to-face services, citing the campaign as the reason for seeking help then (RGF, sub. 38, p. 5).
- An evaluation of public awareness initiatives undertaken during *Responsible Gambling Awareness Week* in Victoria found that over 27 per cent of gamblers had heard about the week and all of them could recall the key messages. There was also a 50 per cent increase in visits to the problem gambling web site the following week and a 6 per cent increase in the number of calls to the Gambler's Help Line during the week (Victorian Government, sub. 205, attachment 3).
- An earlier Victorian longitudinal study testing recall of a state-wide campaign found that, prior to commencing the campaign, 43 per cent of the community were aware of support services. Six months after the completion of stage III,

71 per cent had become aware of the support services. A significant increase in the number of people using both counselling services and G-line was also reported (Jackson et al. 2000)

- An evaluation of a Gambling Awareness Media Campaign undertaken in Tasmania in 2003 targeted at people who gamble and those who know someone who gambles or might be affected by another person's gambling, found that there was an increase of 52 per cent in first time callers to Gambling Helpline Tasmania and a significant increase in awareness of gambling support services.

Abbott et al. commenting on awareness campaigns internationally also concluded that they can be effective in raising awareness and increasing the number of gamblers seeking help (evidence also supported by awareness campaigns for tobacco and alcohol):

Evidence suggests that effective problem gambling awareness campaigns targeting adults can lead to measureable increases in awareness of community services, in the number of calls to help lines and in the number of first-time clients seeking help. Systematic reviews of mass media campaigns for tobacco and alcohol support the effectiveness of such approaches, particularly in combination with other strategies at the national and local levels. (2004, p. 23)

The evidence of a relationship between social marketing aimed at raising awareness about common signs of problem gambling and awareness of help available and increased help-seeking behaviour, suggests that more emphasis on community awareness would encourage earlier help seeking and interventions by family and friends. That said, more evaluations of campaign outcomes and assessment of cost effectiveness are needed to get a better sense of what works, the reasons why and the cost.

Community awareness campaigns can be relatively high-cost strategies. Raising awareness about gambling problems and help services available during a particular week of the year (each of the states and territories engage in community awareness activities during Responsible Gambling Awareness Week) is one way of limiting costs. The introduction of a national help line number and national on-line counselling and support program also provides the opportunity for jurisdictions to work together to more cost-effectively develop national awareness campaigns.

Improving pathways for referral

Improving referral pathways between gambling counselling services and other professionals who are likely to encounter people experiencing problems with gambling — such as general practitioners, financial counsellors and community

groups — is another way of encouraging earlier help seeking and intervention. As Morgan, Multicultural Problem Gambling Services, said:

We also need to work with the health services and their intake systems. Clients ring up presenting with problems like depression or psychosomatic symptoms, they don't ring to say they have a gambling problem. (NSW Problem Gambling Roundtable, 2008, p. 9)

Abbott et al. also said:

The majority of health and related professionals who have contact with problem gamblers are probably unaware that they do so. This is because practitioners who have most frequent contact with members of the community, including problem gamblers, are medical doctors, nurses and other professionals working in primary health and community settings. (2004, p. 51)

Professionals who could routinely be encountering people experiencing problems with gambling should be able to recognise and refer the person to gambling counselling services. But, the evidence suggests that few health professionals screen for problem gambling (Tolchard et al. 2007). Equipping professionals with information, a screening tool and appropriate referral options (including where to access self-help material and online counselling), is likely to be a low cost strategy that could increase opportunities for earlier intervention among people who are not actively seeking formal help.

Some states are already pursuing strategies in this area. For example:

- *The Early Intervention Prevention Community Engagement Strategy for Problem Gamblers in NSW, A Communication Framework 2009-2011*, includes strategies such as presentations at key seminars and conferences of partner members by problem gambling experts, the distribution of kits to partner members that contain information about problem gambling and gambling help, and articles in partnership newsletters.
- The Office of Problem Gambling has undertaken a project to engage with the South Australian Division of General Practice and their member GPs to identify, design and test resources to assist GPs in identifying high and medium risk gamblers and engage with them in confidence and offer therapeutic responses (SA Government, sub. 225, p. 50).

Internationally, medical associations have devised policy statements and toolkits to guide medical practitioners in the treatment of problem gamblers and their families. In 2007, the British Medical Association released protocols for the treatment of gambling addiction within the United Kingdom National Health Service. Some jurisdictions in the United States have also provided clinical protocols to help health professional screen for and treat problem gamblers.

Thomas et al. (2008) argued that the standard diagnostic tools for problem gambling are too time-consuming for routine use in primary care practice (a New Zealand study where a practice review activity was trialled found ‘time’ to be an issue, Sullivan et al. 2006). Thomas et al. suggested a one-item screening test — ‘Have you ever had an issue with your gambling?’ — for use in primary care practice. They found that answers to this question closely predicted answers to the full Canadian Problem Gambling Index. Thomas et al. also recommended screening patients presenting with anxiety and depressive symptoms or high drug or alcohol use (because of the high co-morbidity of these conditions, section 5.4).

At the Ministerial Council of Gambling meeting in July 2009, the Ministers agreed to develop a national screening tool to help gamblers and service providers identify risky gambling behaviour before it becomes too entrenched. The screening tool is to contain questions to help individuals self assess and enable doctors, financial counsellors and other support services to be able to identify if a person is at risk of becoming a problem gambler (MCG 2009b).

Overall the evidence suggests that equipping health professionals and counsellors with information and a brief problem gambling screening test (for inclusion in general mental health and financial risk assessments), would be a relatively low cost strategy that could result in earlier intervention. Screening could be targeted towards at-risk groups (such as those presenting with anxiety, depression, high drug or alcohol use).

Partnerships between counselling services and venues could also be strengthened. Given that people experiencing problems with their gambling are most likely to be found in venues, this is an obvious place to be identifying problem gamblers and providing them with information about counselling. Garvin from Star City Casino suggested that observing people’s behaviour is more effective than brochures and signs:

Brochures, signs on the wall, et cetera, aren’t necessarily the best way to cut through. The best way is to observe behaviour and make direct contact, and then offer the assistance that people need. (NSW Problem Gambling Roundtable, 2008, p. 16)

The industry has sought to better equip venue staff to identify problem gamblers and provide them with appropriate information about help services (chapter 8). The national principles for the conduct of responsible gaming machine activity in clubs and hotels state that information and support should be provided to patrons seeking help and those that have been identified by staff as potentially having a problem with gambling. Also that:

- venues should act promptly to assist persons to self-exclude if requested

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- venues should display problem gambling help information in the gambling area and venue more broadly
 - venues have a responsibility to train their staff in problem gambling issues
 - specifically trained contact officers should be available in venues to provide referral information or assist with undertaking exclusion
 - venues should monitor suspected problem gamblers and take reasonable steps to offer them assistance
 - venues should not knowingly allow problem gamblers to gamble in their venues (MCG 2009b).

Visits to venues by Commission staff lent support to the proposition that people experiencing problems with gambling can be identified in venues and that they may not always be approachable. That said, they may be more approachable at particular times/places, such as when at the cashier or when claiming a cheque.

While venues are required to ‘monitor suspected problem gamblers and take reasonable steps to offer them assistance’, there are no penalties or consequences for ‘knowingly’ allowing problem gamblers to continue to gamble in venues. The Hunter Council on Problem Gambling said:

Occasions of contact with the local gambling industry (eg Clubs and hotel managers, venue staff) have suggested that there is an attitude amongst some in the industry that gambling treatment services are a threat to their business and revenue. This leads us to wonder if the responsibility, awareness and commitment for responsible gambling practices is truly being communicated, supported and displayed by all staff within gambling venues. (sub. 111, p. 4)

Delfabbro, while acknowledging the difficulties associated with identifying and approaching gamblers in venues, also noted that:

There is nothing to prevent staff members from providing information, advice, or support to patrons in an informal way, e.g., information packs could be provided to all gamblers in the venue whether they were showing warning signs or not, or staff members could post promotional information on notice boards that draws attention to the warning signs. ... Such information packs could include short gambling checklists such as the 8 Screen or SOGS, and counselling referral information, including the availability of counselling services on-site. (2008b, p. 172)

The issue of incentives and challenges for venue staff to intervene is discussed further in chapter 8.

There is evidence that some clients learn about counselling services in the venues. Client data for G-line (NSW) shows that the most common means of learning about the help line is gambling venue notices/stickers. G-line was also the most

commonly reported ‘recent referral source’ for government-funded counselling services in that state accounting for around 22 per cent of referrals in 2007-08. In Queensland around 8 per cent of callers to Gambling Help Line in 2007-08 nominated poster/venue notices as the source of referral and around 3 per cent said gaming venue/casino staff. Around 8 per cent of clients of counselling services in Queensland nominated venue staff as a source of referral of help services (appendix J). Venue brochures and signs are further examined in chapter 6.

Counsellors and community educators taking a more proactive approach in venues (including approaching gamblers who appear to have a problem with their gambling) could be better than relying on venue staff to make information available. Counsellors do not face the same disincentives to intervene as venue staff. As one client of a counselling agencies said:

I would like counsellors to be more available when I felt I needed help (at the club). I would have sought help sooner. (PC survey of clients of counselling services)

There would appear to be value in involving problem gambling counsellors in interviews with individuals seeking self exclusion. This may improve formal help seeking and, where the gambler does not want formal help, there may be opportunity to provide brief intervention and self-help material (as discussed later there is some evidence that these work). Under a pilot program in Victoria, gambling help staff attended self-exclusion interviews and assisted in the management, monitoring and ongoing support of people choosing to exclude from gaming venues. Around 60 per cent of those participating in the pilot elected to use the treatment pathway services. Self-help materials were provided to those not wanting to engage in formal help services.

Funding for counselling and treatment services should allow for counsellors/community educators to take a proactive role in venues, including being involved in interviews with gamblers seeking self exclusion, as this could facilitate earlier help seeking. Counsellors could also provide brief interventions and self-help material to people who do not want to engage in formal help services.

Lessening the stigma attached to having a gambling problem

On-line self-help services and internet therapy are strategies for getting around the reluctance of problem gamblers to seek face-to-face help for their problems with gambling. Further advantages of internet therapy are that clients can access counselling at any time or place convenient to them and such interventions are likely to be more attractive to young people. As noted by Monaghan, minimal

therapist input is required and the limited evidence suggests that it is an effective form of treatment for people who would not otherwise have sought formal help:

Internet therapy has emerged as a new and innovative treatment option that enables clients to access a cognitive-behavioural therapy program, with minimal therapist input, at any time and place convenient to them. Although evidence in the field of Internet therapy is scarce, a review of the literature is being completed by myself and Professor Alex Blaszczynski, which suggests that this may be a very effective treatment intervention that is appropriate for those who would not otherwise seek treatment. (Monaghan, sub. 58, p. 6).

There is some evidence that problem gamblers will use interventions that do not require direct contact with a counselling agency (including computerised expenditure summaries and self-help books). In a study of 50 people using an online support group (known as 'GAweb'), 70 per cent said they had previously avoided attending face-to-face programs because of concerns related to stigma. And, those in the group who were not attending a treatment program or Gamblers Anonymous appeared to have higher levels of concern about stigma than those receiving formal help (Cooper 2004).

In late 2008, the Ministers from each Australian jurisdiction signed a Memorandum of Understanding to undertake a three year trial of a national on-line gambling counselling service. The national on-line 24 hour gambling counselling service recently began operating (end of August 2009). The new online program offers both live counselling and email support. The use of national on-line counselling services should be monitored and the program evaluated. On-line counselling is discussed further in chapter 12.

Placement of help material also matters

Given that the stigma associated with having a gambling problem is a barrier to seeking help, where gambling help service material is placed within venues will matter. Visits to venues by Commission staff found that it was not unusual for help service material to be only placed in prominent locations within venues (such as the front counter), although in some venues pamphlets and contact cards about help services were more discretely located (such as in bathrooms, see chapter 6). Locating information on gambling help services discretely would be more effective, would not impact on the recreational gambler and involve no additional cost.

Encouraging recovery without formal treatment

While not a lot is known about the ‘natural recovery’ of problem gamblers, what is known is that:

- more people experiencing problems *do not* seek formal help than those who do
- greater problem severity and co-existing problems increase the likelihood of using treatment. Natural or untreated recovery is the pathway chosen by gamblers with less severe problems (Hodgins and el-Guebaly 2000, Toneatto et al. 2008 and Suurvali et al. 2008)
- people experiencing problems with gambling can recover without professional treatment. Slutske (2006), for example, using data from two large US surveys, found that around one-third of gamblers recovered without formal treatment (box 5.2). As Suurvali et al. (2009) said ‘formal treatment ... is not a prerequisite for resolution, even among gamblers with severe problems’.

Given the importance of natural recovery, it is important that those gamblers who choose to resolve their own problems have access to self-help material and support. The evidence suggests that self-help material and brief treatments can indeed be effective in reducing the severity of gambling (box 5.3).

Self-help and brief interventions are less expensive than extended periods of counselling and likely to appeal to a much wider group of problem gamblers. Such interventions also have the advantage of avoiding the perception of stigma associated with dealing with others. While such interventions are currently available — for example, the new national online gambling help service provides self-help material and email support — there would appear to be scope to further promote these options. Health professionals, counsellors and venue staff could refer gamblers not only to face-to-face counselling but also make them aware of other help options. Awareness campaigns promoting help services could also promote the full range of help options available.

Box 5.2 Recovery without formal treatment

The few studies that have looked at 'natural recovery' have found that many people experiencing problems with gambling recover without formal treatment from counsellors.

- One Canadian study found that four out of six people reporting gambling problems recovered without treatment (Hodgins et al. 1999).
- A more recent US study looking at the rates of recovery, treatment seeking and natural recovery, found that 36-39 per cent of individuals with DSM-IV pathological gambling disorders in two large and representative surveys (the Gambling Impact and Behaviour Study and the National Epidemiological Survey on Alcohol and Related Conditions), had not experienced any gambling-related problems in the past year, even though only 7-12 per cent had ever sought either formal treatment or attended Gamblers Anonymous. The author concluded that:

The finding that roughly one-third of individuals with a history of pathological gambling recover from the problems suggests that pathological gambling does not always follow a chronic or persisting course. (Slutske 2006, p. 301)

- The most common pattern found in the National Epidemiological Survey, characterised by just over 60 per cent of pathological gamblers was one episode of problem gambling lasting one year or less, although some gamblers reported several episodes of problem gambling across their lifetime.
- Another recent study found that untreated recovery defined the pathway chosen by the moderate or mild problem gamblers and this group more closely resembled the behaviourally conditioned problem gambler. Recovering gamblers were found to employ strategies that were generally practical, problem-focused and cognitive-behavioural in nature, including avoiding gambling venues, adopting gambling-incompatible lifestyles, reducing access to money and recall of gambling-related negative consequences. The authors concluded that:

The development of easily accessible resources (e.g. books, tele-counseling, manuals, work-books, online, CDs/DVDs, chat rooms) for gamblers interested in self-recovery may be necessary to assist the vast majority of problem gamblers, who will never seek formal or professional assistance. (Toneatto et al. 2008, p. 119).
- A review of five prospective studies of gambling behaviour among non-treatment samples found *no* evidence to support the assumptions that:
 - individuals cannot recover from disordered gambling
 - more severe gambling problems are less likely to improve than individuals who have less severe gambling problems
 - individuals who have some gambling problems are more likely to worsen than individuals who do not have gambling problems.
- The authors concluded that 'individuals with some gambling problems experience considerable movement in and out of more severe and less severe levels of gambling disorder, and, often, considerable movement out of more severe levels without a return to those levels' (LaPlante et al. 2008, p. 59).

Box 5.3 **Some evidence that self-help and ‘brief treatments’ work**

Self-help methods have been proven to be effective in reducing the severity of gambling.

- A study comparing gamblers provided with a self-help manual with a group provided with the manual plus a telephone interview found that the manual only group reduced their weekly gambling sessions and weekly dollars wagered group for six months after receiving the manual while the manual-plus interview group showed the reduction for only three months (Dickerson et al. 1990).
- Hodgins et al. (2001), comparing outcomes of a group that received a self-help book with a group that received a self-help book and a motivational interview, found that at the 12 months follow-up there were no significant group differences. In both groups, 25 per cent of gamblers reported abstinence and an additional 58 per cent reported a significant reduction in their gambling.
- A 24 month follow-up of the same groups found both groups doing well — 77 per cent were improved and 37 per cent reported 6 months of abstinence. The motivational intervention group, however, were found to have gambled fewer days, lost less money and had lower South Oaks Gambling Screen scores compared with the group just receiving the workbook (Hodgins et al. 2004).

There is also some evidence that the length or intensiveness of treatment may not be important in terms of outcomes. A recent randomised trial of brief interventions (Petry et al.), where problem gamblers were assigned either to assessment only, 10 minutes of brief advice, one session of motivational enhancement therapy (MET) or one session of MET plus three sessions of cognitive behavioural therapy — found that relative to assessment only, brief advice was the only intervention that significantly decreased gambling behaviour between baseline and week six. Brief advice was also associated with clinically significant reductions in gambling at nine months. The authors concluded:

These results suggest the efficacy of a very brief intervention for reduction of gambling among problem and pathological gamblers who are not actively seeking gambling treatment. (2008, p. 318)

DRAFT RECOMMENDATION 5.1

Building on existing initiatives, governments should:

- ***place greater emphasis on campaigns that (i) highlight potential future financial losses associated with problem gambling and (ii) make the community aware of behaviours indicative of problem gambling, to encourage earlier help-seeking and interventions by family and friends***

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- *provide information and a one-item screening test, as part of other mental health diagnostics, for optional use by health professionals and counsellors to assist them to recognise and refer people experiencing gambling problems. Screening should be targeted at high-risk groups, particularly those presenting with anxiety, depression, high drug and alcohol use*
 - *with subsequent evaluation of the effectiveness of this measure*
 - *promote self-help and the option for brief treatments, as such relatively low cost interventions can increase self-recovery of people experiencing problems with gambling.*

5.2 Effectiveness of treatment and support

What treatments for problem gambling?

A number of different factors are thought to come into play in how and why people develop gambling problems. The main theoretical models for understanding problem gambling include the mental disorder or medical addiction model, cognitive, behavioural and escape theories of gambling, and problem gambling as a social problem. Three treatment modes emerge from these theoretical models:

- The *medical model*, which sees problem gambling as an addiction, or as an impulse-control disorder which needs to be treated as an illness.
- The *behavioural model*, which interprets gambling as a learned behaviour, motivated and/or reinforced by the personal experiences and social context of the gambler. The treatment focus is on ‘unlearning’ bad habits and learning how to minimise the harm arising from gambling through controlled gambling. Abstinence is not usually specified as an endpoint.
- The *cognitive model*, which posits that problem gambling behaviours can be explained by irrational beliefs and attitudes about gambling. The gamblers think erroneously that they will win money and recoup losses despite personal experience. Problem gamblers have heightened expectations of winning and illusions of control over the outcome of a game (Jackson et al. 2003, IPART 2004).

There has been a move away from focusing on one aspect of gambling behaviour towards diverse approaches to explaining how and why gambling problems develop. Blaszczynski and Nower said:

At the moment, there is no single conceptual theoretical model of gambling that adequately accounts for the multiple biological, psychological and ecological variables contributing to the development of pathological gambling. (2002, p. 487)

Blaszczynski and Nower's (2002) pathways model of problem and pathological gambling seeks to integrate the complex array of biological, personality, developmental, cognitive, learning theory and ecological determinants of problem and pathological gambling. It contends that there are three distinct subgroups of gamblers manifesting impaired control:

- behaviourally conditioned problem gamblers
- emotionally vulnerable problem gamblers
- antisocial, impulsivist problem gamblers.

The model further assumes that the different subtypes require different types of interventions:

From a clinical perspectives, each pathway contains different implications for choice of management strategies and treatment interventions. (Blaszczynski and Nower 2002, p. 496)

The main therapeutic approaches used for problem gambling include behavioural therapy, cognitive therapy and cognitive-behavioural therapy (CBT). Other approaches include pharmacotherapy and brief interventions. Multimodal approaches to treatment are commonly used. Shaffer and Korn said:

Although it has unique elements, pathological gambling has many signs and symptoms shared with other disorders (e.g. anxiety, depression, impulsivity), consequently, disordered gambling is best thought of as a syndrome. From this perspective, the most effective treatments for gambling problems will reflect a multimodal 'cocktail' approach combined with patient-treatment matching. These multidimensional treatments will include combinations of psychopharmacology, psychotherapy, and financial, educational and self-help interventions, such treatment elements are both additive and interactive to deal with the multidimensional nature of gambling disorders. (2004, p. 198)

Overall, the evidence suggests that there are subtypes of gamblers with varying treatment needs. This is reflected in a variety of treatment techniques employed by counsellors (box 5.4). A survey of Victorian counsellors (Jackson et al. 2000) found that 83 per cent adopted an eclectic approach. The Commission's 1999 survey of counselling services found that a high proportion of agencies used cognitive and CBT techniques.

People experiencing problems with gambling also often require services (such as financial and relationship counselling) in addition to therapeutic counselling to address the impacts of gambling on their finances and relationships. Client data collected by Gambler's Help services in Victoria, for example, showed that:

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- 62 per cent of problem gamblers present to specialist problem gambling services with financial issues
 - 45 per cent with family issues
 - 56 per cent with interpersonal-related issues (Department of Justice, 2008).

Box 5.4 Counsellors employ a variety of treatments

South Australian Government

The Statewide Gambling Therapy Services provides treatment using a CBT approach and a graded exposure program to treat people with gambling problems. This approach enables clients to overcome their urge to gamble and return to a normal life without gambling. ... Cognitive therapy is usually offered in combination with behavioural strategies including problem solving, social skills training, self-monitoring and stimulus control. (sub. 225, p. 48)

Tasmanian Government

Counselling is based around cognitive behavioural therapies although counsellors can utilise other therapies they deem appropriate. (sub. 224, p. 34)

Jackson et al.

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. (2003, p. 7)

What works?

As counselling and treatment support are the main interventions for people experiencing problems with gambling, a key policy issue is whether the interventions work. Do they have a positive effect on gambling behaviour? Are some interventions more effective than others?

This section looks at what we know about the efficacy of the various support and treatments for problem gambling from the literature. The evidence base on what makes for effective treatment of problem gambling is not strong. As Toneatto and Ladouceur, on reviewing the literature of treatment for pathological gambling, said:

Although the history of gambling treatment extends for several decades, there is a surprising lack of reliable knowledge of what constitutes effective treatment for problem gambling. (2003, p. 284)

In part, this is because many of the studies of gambling treatment outcomes suffer from methodological flaws, including:

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- small sample sizes
 - poorly-defined criteria and procedures for the inclusion of gamblers into treatment programs
 - varying levels of motivation among treatment populations, making generalisation of results problematic
 - a lack of standardised measures for gambling diagnostic criteria and outcomes measures
 - variable training of counsellors
 - treatments involving multi-disciplinary approaches (particularly where there are issues of co-morbidity). It can be difficult to distinguish between impacts of primary interventions when other interventions are being used simultaneously
 - lack of clear outcome measures (abstinence, reduced gambling)
 - variations in follow-up intervals (many studies cover relatively short periods, three-six months after treatment) and a lack of long-term outcome data (Walker 2005, Blaszczynski 2005, Battersby et al. 2008).

Psychological treatment

Most gambling treatment outcomes studies, irrespective of the type of treatment provided (behavioural, cognitive, or a combination of treatment) report that the majority of people receiving treatment respond to and benefit from treatment (with abstinence or controlled gambling). Pallesen's meta-analysis review of psychotherapeutic treatments of pathological gambling (covering 22 studies involving 1434 subjects) concluded that:

The results from the present meta-analysis indicate that psychological interventions for pathological gambling are associated with favourable outcomes, both on a short-and long-term basis, and that the results seem robust. (Pallesen et al. 2005, p. 1421)

Treatment is also often reported to be accompanied by more general improvement in psychosocial functioning (Jackson et al. 2003). What is less clear is for how long clients benefit from treatment. That said, the studies generally show that the probability of relapse increases with time. It is also unclear how treated clients compare with comparable problem gamblers who do not receive professional treatment.

There is a lack of evidence from randomised clinical trials with good follow-up assessments. As Delfabbro, commenting on the quality of evaluations of gambling treatments puts it:

Very few meet the gold standard criteria set out by the American Psychological Association; namely, the use of a randomised design with a control group. (2008 p. 186)

Reviews of the controlled treatment literature (Pallesen et. al 2005, Oakley-Browne et al. 2000, Toneatto and Ladouceur 2003, Toneatto and Millar 2004, Korn and Shaffer 2004), while noting methodological flaws in many of the studies, find behavioural interventions (imaginal desensitization strategies) and cognitive-behavioural interventions to be effective treatments for problem gambling in the short term (table 5.2). The best evidence and support, however, is for cognitive-behavioural treatment approaches (even when it is delivered via manuals and involving only minimal therapist contact, Toneatto and Ladouceur 2003). The results on CBT for gambling are consistent with the evidence for the efficacy of CBT for other clinical conditions.

That said, most of the studies using controlled interventions have been for cognitive and behavioural therapies. As Korn and Shaffer said:

... the existing randomized clinical trials have limited their focus to cognitive and behavioural therapies. ... the absence of a randomized trial does not mean that other treatment approaches have little or no utility. Rather, this evidence simply is the best available research supporting these methods. (2004, p. 17)

Some recent studies, however, have found conflicting results with CBT failing to produce superior outcomes compared with other less costly methods such as gamblers anonymous and brief interventions. For example, Toneatto and Dragonetti (2008), examining the effectiveness of an eight-session CBT and a modified gamblers anonymous program among 126 problem or pathological gamblers, found that treatment outcomes of CBT did not differ significantly from those of the gamblers anonymous group, in terms of gambling frequency, abstinence rates and money wagered at 12 month follow-up.

Treatment with medication

The pharmacological approach to treating gambling problems is relatively new and includes three main classes of drugs: opiate antagonists (naltrexone and nalmefene); antidepressants and mood stabilizers. A recent meta-analysis involving 16 pharmacological treatment studies found that pharmacological treatments were more effective than no treatment/placebo (Pallesen et al. 2007). The magnitude of effect sizes at post-treatment, however, was found to be lower in studies using a placebo-control compared with those without controls. No differences in outcomes between the three classes of drugs were found.

Table 5.2 Reviews of psychotherapeutic and pharmacological treatments of pathological gambling

<i>Study</i>	<i>Method</i>	<i>Findings</i>
Pallesen, et al. (2005)	A quantitative meta-analytical review of psychotherapeutic treatments of pathological gambling. 22 studies including involving 1434 subjects.	At post-treatment, psychological treatments were found to be more effective than no treatment, an overall effect size of 2.01. At followed-up (averaging 17 months), the corresponding effect size was 1.59. Effect sizes were found to be higher in randomised controlled trials.
Oakley-Browne, Adams and Mobberley (2000)	4 randomised controlled trials of psychological treatments were identified (Echeburúa, Baez, & Fernandez-Montalvo 1996, McConaghy, Blaszczyński & Frnakova, 1983, McConaghy et al 1988, Sylvain, Ladouceur & Boisvert, 1997). The data were entered into the Cochrane Review Manager software. Relative risk analyses were conducted for the dichotomous outcome of controlled vs. uncontrolled gambling.	The experimental interventions, behavioural or cognitive behavioural therapy were found to be more efficacious than the control interventions in the short term (relative risk 0.44, 95 per cent confidence interval 0.24-0.81). Also long-term treatment with BT/CBT to be more efficacious than the control treatments, but statistical significance sensitive to statistical model used for meta-analysis.
Petry, et al. (2006)	Randomly assigned gamblers to 3 groups (1) referral to Gamblers Anonymous (GA), (2) GA plus a CB workbook, (3) GA + 8 sessions of individual. Assessments at baseline, 1, 2 (post treatment), 6 and 12 months later. Large sample (n=231), reasonable follow-ups.	Gambling reduced in all 3 groups, but benefits of CBT emerged both during the treatment with some effects maintained through follow-up. Individual CBT improved some outcomes compared with CB workbook.
Toneatto and Ladouceur (2003)	Criteria was randomisation to an experimental group and at least 1 control group, included 11 studies.	Cognitive-behavioural studies received the best empirical support.
Toneatto and Millar (2004)	Review of controlled clinical trials where subjects were randomised to either psychological or pharmacologic treatment.	Cognitive-behavioural and pharmacological treatments possibly efficacious, but specific treatment modality still limited. Cognitive-behavioural treatments found most effective. Found no compelling evidence for the efficacy of any drug except naltrexone.
Pallesen et al. (2007)	Qualitative review on studies of pharmacological interventions from 1966-2006. 16 studies met criteria, total of 597 subjects	Pharmacological interventions found more effective than no treatment, overall effect size of 0.78% (95% CI 0.64-0.92). Effect lower in studies using placebo/control conditions. No differences in outcome between antidepressants, opiate antagonists, mood stabilizers.

While the authors concluded that pharmacological interventions for pathological gambling ‘may be an adequate treatment alternative in pathological gambling’, they also noted that psychological interventions appear to yield greater improvements than pharmacological ones (overall effect size of 0.78 for pharmacological treatments compared with 2.01 for psychological interventions, Pallesen et al. 2005, p. 357). But, because of differences in the use of control conditions and the outcome measures between nonpharmacological and pharmacological treatment studies, the authors concluded that it was unclear whether nonpharmacological treatments were really more effective than pharmacological treatments for pathological gambling (Pallesen et al. 2007).

FINDING 5.1

Gambling treatment outcome studies report that, irrespective of the type of treatment provided, most clients benefit. Although cognitive behavioural therapy is the approach with the most empirical support, no one style of intervention is recommended as best practice.

Outcomes from government-funded gambling counselling services

While limited, client outcome data collected from gambling counselling services show that the majority of people who seek formal help are able to better manage their gambling problems following counselling and treatment. For example, telephone follow-up surveys conducted by G Line (NSW) of clients of funding counselling services (conducted at intervals of one, three and six months, up to December 2008) found the proportion of respondents saying they ‘can now manage their gambling’ in the affirmative to be 84 per cent at one month, 93 per cent at three months and 90 per cent at six months.

Results from a number of counselling agencies in NSW also show significant decreases in clients’ involvement in gambling, and in gambling-related problems, following treatment. The following are two examples:

- The University of Sydney Gambling Treatment Clinic (where the therapy is an intensive form of cognitive therapy involving 10 one hour sessions on average) reported the following outcomes, based on a sample of 190 problem gamblers treated by counsellors:
 - 54 per cent of clients were abstinent from gambling
 - 94 per cent of clients had decreased gambling significantly
 - 100 per cent of clients no longer met DSM-IV criteria for pathological gambling.

These results were maintained for two years after treatment and were based on data for the 60 per cent of clients that could be followed up (RGF 2008).

- Follow-up data collected by the Hornsby Drug, Alcohol and Gambling Services, in relation to gambling clients who were seen between October 2005 and November 2006 — at an average of 9 months after initial presentation — found that:
 - SOGS scores had reduced from 9.61 to 3.75
 - average weekly gambling expenditure had fallen from \$1 677 to \$262
 - there was an improvement in measures for depression (5.6 to 3.5), anxiety (5.6 to 4) and stress (6.8 to 4.4) (NSW Government, sub. 247).

Results from an earlier longitudinal evaluation of the Gambler’s Help program in Victoria, also found high resolution levels among clients. According to pre and post counselling measures, the number of ‘pathological gamblers’ fell from 76 to 37 per cent. The evaluation also found the degree of resolution to be related to the number of sessions attended with a mean number of 4.15 sessions for a fully resolved primary problem (box 5.5).

DRAFT FINDING 5.2

Outcome and client follow-up data following treatment, while limited, show significant decreases in clients’ involvement in gambling and their gambling-related problems.

5.3 Counsellors’ qualifications and service standards

The effectiveness of counselling and treatment services obviously also depends on the training and experience of counsellors. Some participants raised concerns about the qualifications of problem gambling counsellors and variability among counsellors in their knowledge about the nature of gambling activities and technologies. For example:

Many counsellors are holding minimal qualifications. The counselling field of problem gambling has attracted those from a range of welfare sectors and whilst not belittling their interest or expertise in the welfare sector this area of work requires considerable skills in working with mental health, and other co morbid issues. It is not an area of work for those with minimal qualifications or skills and the failure to recognise this places both staff and clients at risk. (Roberts, sub. 89, p. 2)

Box 5.5 **Some evidence from counselling and treatment services**

A Longitudinal Evaluation of the Gambler's Help program in Victoria (survey of 150 clients) found:

- 43 per cent of clients had full or satisfactory resolution levels (clients received the highest level of full problem resolution in relationship and physical health problems caused by their gambling activity)
- 46 per cent of clients experienced partial problem resolution
- 71 per cent of clients felt attending counselling impacted on their gambling in a positive way, 45 per cent indicated the impact as 'a great deal'
- in all resolution states the number of sessions attended was low — 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
- 69 per cent rated their emotional wellbeing as being 'very poor' when commencing counselling and 78 per cent rated themselves as 'very good' at the end of counselling
- counselling had a positive effect on maladaptive behaviours — on the DSMIV criteria for pathological gambling between 21-29 per cent improvement on clients in 8 of the 10 behaviours. The number of 'pathological gamblers' reduced from 76 to 37 per cent according to pre and post counselling measures
- the therapeutic relationship was the process variable that most consistently predicted positive outcomes (Jackson et al. 2000).

A more recent Victorian study (New Focus Research 2004) found that of the problem gamblers who sought help:

- 90 per cent were satisfied with the service. Between 88-95 per cent were satisfied with the ease of contacting the service, the frequency of contact provided, the waiting time and length of sessions and treatment.
- the factors that made the service effective were thought to include the availability of group and individual counselling, ease with which counsellors could be contacted in an emergency, and the quality of the relationship with the counsellor.

Counsellors providing gambling treatment services have a range of qualifications — from diploma to postgraduate qualifications in social work, mental health, drugs and alcohol, psychology and psychiatry. Some counsellors also have specific training in problem gambling.

Because of high co-morbidities among people experiencing problems with gambling, counsellors need skills in clinical diagnosis. In a submission to the IPART report, the University of Sydney Gambling Treatment Clinic argued that

‘best practice’ involves employing clinical psychologists in the treatment of problem gambling.

Since many individuals with gambling problems also have other clinical problems, it is essential to assess the nature of these problems and to determine whether the gambling is the primary problem or secondary. Accurate clinical diagnosis depends on supervised training of the kind provided in postgraduate clinical psychology programs. (Walker et al. 2003, pp. 9-10)

Base level training for counsellors, however, need not include specific training in gambling. Given the key role that counsellors play in correcting misconceptions that problem gamblers may have, it would seem essential that counsellors understand how gambling works. As Abbott et al. said:

Whilst most of the cognitive-behavioural techniques used in the treatment of problem gambling are shared with other addiction treatment approaches, treatment of problem gambling does include some unique elements. (2004, pp. 21-22)

This suggests that counsellors providing gambling help services (regardless of their base level qualifications) should have a minimum level of training specific to problem gambling. A Massachusetts Think Tank (Massachusetts Council on Compulsive Gambling 2001) also concluded that entry level staff should have problem gambling specific training regardless of other credentials. A further suggestion was a requirement of at least 24 hours of relevant gambling-specific continuing education every two years.

Some states and territories already have in place a minimum level of training specific to problem gambling. NSW, for example, has recently developed a minimum qualification — the Diploma of Problem Gambling Counselling — for problem gambling counsellors working in Responsible Gambling Fund (RGF) funded services. The Diploma consists of 13 units that are nationally accredited general community service competencies and 3 specially developed problem gambling competencies. In September 2008, the Diploma of Problem Gambling Counselling was accredited for 5 years by NSW Vocational Education and Training Accreditation Board. The RGF also funds a state-wide training service, the Centre for Community Welfare Training to provide training for workers in RGF-funded gambling counselling and support services:

The service provides gambling-specific training plus generalist courses dealing with mainstream topics relevant to the work undertaken in gambling counselling services such as ‘measuring client outcomes in problem gambling services and ‘cognitive therapy for excessive poker machine play’. It also provides generalist courses dealing with mainstream topics relevant to the work undertaken in gambling counselling services such as alcohol and other drugs. ‘Counselling and therapy’ and ‘management and governance’. (NSW Government, sub. 247, p. 66)

Victoria's Centre for Problem Gambling Treatment and Research also provides training for new and existing staff working in gambling services (Victorian Government, sub. 205).

Given the need for clinical knowledge for the application of therapies — including the 'unique elements' involving in treating problem gambling — and for dealing with co-morbidities, there appears to be grounds for a minimum level of competency training for problem gambling counsellors. A national minimum level of training for problem gambling counsellors would be expected to improve the quality of services, as well as promote greater consistency across the states and territories in the standard of treatment provided.

Some participants also raised questions about the service standards that are in place suggesting that under current arrangements the result is inequitable services for clients and a lack of confidence in service competencies. The Australian Casino Association, for example, recommended a national system of accreditation for problem gambling service providers (sub. 214).

Accreditation is an approach that is adopted in other health and community service policy areas and is aimed at achieving minimum standards of performance. As noted by IPART (2004), accreditation does not of itself guarantee quality, but it does provide a useful framework for encouraging the development of a quality culture. NSW is currently rolling out an accreditation system for counselling services for RGF-funded counselling services (as recommended by IPART):

The purpose of the accreditation process is to ensure that a continuous quality improvement cycle is incorporated into the management and dealing of services, resulting in better outcomes for service users. ... Many funded services have achieved, or are nearing the point of achieving, accreditation with all on track to achieve accreditation by 2009. (NSW Government, sub. 247, p. 66)

A national accreditation system would provide a consistent standard of service across Australia and a national framework for continuous improvement. That said, a national accreditation system would not come without costs to service providers (and ultimately tax-payers). There is also the question of whether the same objectives could be achieved by way of a national minimum level of training for counsellors and requirements for initial assessments, evaluations and follow-ups linked to the collection of a minimum national data set (section 5.6).

The Commission seeks feedback on the need for a national accreditation system for problem gambling service providers.

Governments should work together to establish a national minimum standard of training for problem gambling counsellors.

5.4 Co-ordination with other health services

Many clients who present for help with gambling problems are also dealing with other health or behavioural issues. A Victorian survey found that the majority of problem gambling clients experienced between four and seven other issues in addition to their gambling (KPMG 2008).

A study by the Problem Gambling Research and Treatment Centre in Victoria into the risk and protective factors associated with problem gambling, found that in the problem gambling group:

- 36 per cent had a ‘severe mental disorder’
- the rate of ‘likely hazardous alcohol use’ was 50 per cent
- the risk of depression was 71 per cent
- the rate of daily smoking was 57 per cent.

The study concluded that ‘problem gamblers not only need treatment for their gambling but also for a range of other problems’ (Thomas and Jackson 2008, p. ix).

A number of submissions emphasised the importance of managing clients who are grappling with other issues and taking a case-management approach (as in other areas of health). Others called for the greater integration of problem gambling services with other health services, arguing that this would improve outcomes and reduce the stigma attached to having a gambling problem:

Services to assist people affected by problem gambling (individual gamblers, their families and communities) need to go beyond psychological or financial counselling to address the multitude of contributing factors which precipitate different experiences of problem gambling. It is encouraging that gambling support services in Victoria, for example, will be located in community centres with a range of health and social professionals. (McMillen sub. 223, p. 7)

The fact that problem gambling remains in the portfolio of the Office of Liquor, Gaming and Racing as opposed to NSW Health or another Community Service department is a clear lack of understanding of the nature of the disorder and its significant health impacts. ... clients are unable to access a case management approach to their co-morbid issues and unlike a community health service where collaborative co-working relationships between therapeutic interventions are common, much of the

counselling is conducted without integration with other services. (Roberts, sub. 89, p. 3)

As many people experiencing problems with gambling require access to other health and community services (such as housing and accommodation support), there needs to be a co-ordinated approach to care and flexibility to cater for individual needs. The evidence points to the importance of co-ordination between specialist gambling services and services in the areas of alcohol and drugs, mental health services, financial and family services.

At the July 2009 Ministerial Council on Gambling, the Ministers agreed to work together to provide better linkages between front-line Commonwealth and state-based gambling support services, to better support problem gamblers (MCG, 2009b). The Commonwealth funds a range of services which problem gamblers access, including Emergency Relief, Supported Accommodation Assistance Program and Commonwealth Financial Counselling and income support payments.

State and territory governments could also establish stronger linkages between gambling counselling services and other health and community services. In Victoria, gambling services are co-located with other health and community services. This model has the potential to not only facilitate more of a case-management approach for clients presenting with multiple issues, but also reduce the stigma associated with accessing gambler's help services. Victoria has also sought to better integrate gambling help services with the broader health and care sector, via Primary Care Partnerships (PCPs) and Integrated Health Promotion (IHP).

A key component of PCP's is service coordination. Service coordination is a statewide vision to align practices, processes, protocols and systems through functional integration. Working within PCPs enables Gambler's Help to liaise with relevant agencies in a cohesive and coordinated way so that problem gamblers receive a seamless and integrated service. Service coordination elements include initial contact, initial needs identification, assessment and care planning.

...IHP provides a framework for achieving collaborative partnerships across sectors that can facilitate the delivery of individual and population wide health promotion interventions for problem gamblers. (Victorian Government, sub. 205, p. 79)

Central to this collaborative approach is the collection of a consistent set of information and the use of secure electronic systems to share consumer health and care information between agencies (box 5.6).

Victoria also provides funding for a specialist portfolio service program with dedicated specialist positions that work in collaboration with mental health services, alcohol, and drug services and family services.

A co-ordinated approach is more likely to ensure continuity of care and achieve better overall outcomes for people experiencing problems with gambling who are also dealing with other issues. It could also minimise total costs of care, by reducing the need for multiple assessments.

Box 5.6 Primary Care Partnerships — secure electronic system a key building block

The Victorian Primary Care Partnership Strategy is focused on building relationships between agencies, better co-ordination and an integrated approach to health promotion. Membership of PCPs include hospitals, community health, local government, divisions of GPs, mental health, drug treatment and disability services.

Central to achieving better coordination of services is the use of secure electronic systems including:

- Service Coordination Practices — the manual gives service providers agreed sharing practices for coordination of services and sharing of consumer health and care information.
- Service Coordination Tool Templates are used to document consumer information, identify consumer needs, coordinate care planning and make referrals.
- Agencies are able to access information about other services using electronic service directories.
- Electronic referral means that, with consent, consumer health and care information can be shared quickly and securely.

Source: www.health.vic.gov.au/pcps/about/index.htm#strategy

DRAFT RECOMMENDATION 5.3

Governments should work to provide stronger formal linkages between gambling counselling services and other health and community services.

5.5 Funding of gambling help services

Funding for problem gambling services generally occurs through mandatory levies and voluntary contributions. While funding arrangements for problem gambling vary, in a number of jurisdictions levies are imposed on only parts of the gambling industry (appendix J). For example:

- in New South Wales, the Responsible Gambling Fund derives its income from a levy (set at a rate of 2 per cent of the casino's gaming revenue) paid by the operator of the Sydney Casino.

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- in Victoria, under the *Gambling Regulations Act 2003*, net gaming revenues from hotels with gaming machines are subject to an additional tax of 8.33 per cent. The additional tax payable by hotels does not apply to club venues provided clubs make a community benefit contribution of at least 8.33 per cent of their net gaming revenues (Victorian Government, sub. 205).

A number of submissions raised the issue of the ‘narrowness’ of funding sources:

We wish to acknowledge the valuable contribution many Clubs make to community groups and activities. However, we suggest that all gambling venues (Clubs, pubs, TAB agencies) should be directed to contribute part of their gambling revenue to their local gambling treatment services as an acknowledgement of where this revenue comes from, and also to demonstrate recognition of problem gambling as a serious issue affecting our communities. (Hunter Council on Problem Gambling, sub. 111, p. 4)

Since 1999 there has been a commitment to provide specialist treatment services to those affected by problem gambling in NSW. This is funded from \$12 million provided by the Star City Casino revenue (2%). Unlike our neighbours in NZ, StarCity is the only contributor to this fund and all other gambling activities are not required to make contributions. (Roberts sub. 89, p.1)

Since all gambling forms contribute to the need for problem gambling services, the whole industry should contribute to the funding of gambling counselling and treatment support services. That said, given that gaming machines are the main source of gambling problems, they should be a proportionately large source of funding, regardless of venue type.

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Governments should ensure that, existing funding mechanisms for help services are based on greater contributions from those gambling forms found to involve the greatest social harms.

The *adequacy* of funding was also a concern for some participants. For example:

... there is still very minimal funding going towards problem gambling services when compared to the taxation revenue collected by state governments. ... Counsellors have expressed concerns to me about the lack of funding available to them to service the needs of people in the community with a gambling problem. Given that so little is received by each individual service provider by way of grants, agencies often lack the resources to advertise their services in a way that adequately reaches the community. (Xenophon, sub. 99, p. 6)

And some participants considered the need to expand funds to cover primary and secondary measures. Relationships Australia (SA), for example, said:

...in the pool of funds currently directed to managing gambling here in SA needs to be larger to adequately meet the primary, secondary and tertiary public health needs. ... It

may be that Gambling Rehabilitation Funds are directed to tertiary and some secondary responses, and that primary interventions are funded through different, Health or Welfare funding. (RASA sub. 203, p. 28)

If governments are to place greater emphasis on strategies to encourage earlier help-seeking, promote self-help options and establish better data collections (section 5.6), additional funding for problem gambling services will be required (at least initially).

Some participants considered that there was a conflict of interest in funding arrangements.

The counsellors who treat gamblers and their families receive funding from the Responsible Gambling Fund or equivalent. Open criticism of the industry that funds their work is not likely. The counsellors prefer to work with the situation and do what they can. (David, sub. 56, p. 12)

The GRF also has a strong industry presence on its Committee — apparently to reflect the co-contribution funding arrangements. This is akin to the tobacco industry directly funding lung cancer research and having a role in the scope and direction of that research (Xenophon, sub. 99, p. 6)

Given the potential for competing incentives with industry involvement in funding arrangements, there is merit in an independent body having responsibility for the funding of counselling and treatment support services and for evaluating the effectiveness of the services (governance issues are discussed further in chapter 14).

5.6 Building a better evidence base

A better evidence base is needed to answer basic questions about the effectiveness of counselling and treatment services and to ensure that government funded services are accountable. Better monitoring and evaluation of services are also required to inform future planning and direction of gambling help services. A number of participants were also of this view (box 5.7).

The Commission's attempts to gather data about clients seeking help across Australia revealed the absence of a *nationally consistent* data set for gambling help services. The Commission's 1999 report, pointed to the need for a national minimum data set that collected data on clients of problem gambling counselling agencies using an identical set of definitions across the jurisdictions. While there has been agreement among jurisdictions on the need for more consistent data (a number of jurisdictions have sought to improve their data sets and the jurisdictions have agreed to a data dictionary), Australia is still a long way off having a national minimum data set.

Box 5.7 **A better evidence base — participants' views**

The Australasian Casino Association called for:

... the development of a comprehensive national data set to be used as a tool that it utilised by problem gambling service providers as well as being a means of providing feedback to counselling services, industry and the community on a regular basis. (sub. 214, p. 4)

Relationship Australia (SA) said:

RASA is constantly looking to improve our data collection. We have found that we are interested in data that is not required to be collected for reporting purposes and are thus mid process updating our data collection categories and processes. A state or national integrated framework that agencies could input to and access from would be very useful, particularly in relation to client outcomes and methodologies used. (sub 203. p. 29)

UnitedCare Australia:

... there is limited formal evaluation of gambling help services to quantitatively determine service effectiveness. The valuations need to be undertaken to determine effectiveness and to identify areas of improvement. (sub. 238 p. 8)

Senator Xenophon:

The efficacy of gamblers' rehabilitation services needs to be assessed on a rigorous and systematic basis and this could best be carried out by a national research body that is independent of governments, industry and any other vested interests. In particular it needs to be established how many people with a gambling problem are currently receiving help, and of those, how many have been helped to break free of their problem. (sub. 99, p. 7)

Because data are not collected in a common format (if collected at all), aggregation of client numbers and characteristics is difficult, as is undertaking comparisons across jurisdictions. Greater compatibility in terms of what data are collected and recorded would build the evidence base on clients attending help services and allow a more robust comparison of clients across problem gambling services in Australia. There is also variation in the extent to which jurisdictions make data publicly available — and thus available to assist service providers, researchers and the community more generally.

A national data set would not preclude jurisdictions and service providers from collecting data specific to their needs, but it would ensure that minimum uniform data are available nationally. The Commission's proposed research centre (chapter 15) ideally should coordinate the collection of a national dataset on gambling help services. The Australian Institute of Health and Welfare is another option: it currently coordinates and publishes national datasets in a number of health areas, including a national collection of publicly funded treatment episodes in alcohol and other drug treatment agencies.

Outcome data and follow-ups

Client data also provide only limited outcome and follow-up information needed to assess the effectiveness of interventions in reducing gambling problems. To allow for an accurate measure of client change following counselling, a standardised interview should be conducted both pre and post treatment. Follow-up assessments should be routinely carried out at regular intervals after counselling is completed (for up to two years). Data should also be collected on:

- the nature and severity of the problems with which gamblers present, including co-morbidities
- the type of interventions provided
- the number of treatments provided to individual clients
- the level of counsellor training.

In some jurisdictions, outcome measures are already collected. In South Australia, pre and post measure testing has been required by services since 2004. Victoria has recently put out a revised approach to Gambler's Help Performance Management that involves collecting baseline client data, performance outcome measures and client satisfaction surveys, and all RGF-funded counselling services in NSW are required (since July 2008) to conduct structured client follow-ups. However, a more structured approach to evaluating outcomes and conducting follow-ups from counselling and treatment support services within and across jurisdictions would help build the evidence base on the effectiveness of gambling counselling services. A set of outcome measures (agreed to following consultation between the jurisdictions) should form part of the national data set.

New Zealand's service-user statistics provide a guide in terms of outcome measures that might be used (Ministry of Health, 2008). Three measures — SOGS-3M score, a measure of how much money is spent, and a test of the client's assessment of the degree of control they have over gambling — are collected at assessment and repeated at follow-up. The Gambling Treatment Clinic at the University of Sydney has also developed a Structured Clinical Interview for Problem Gambling that uses the DSM-IV criteria, and measures time and money spent on gambling and assesses the level of debt of the client.

The collection of assessment data and information on treatment variables, such as the type of interventions provided, the number of sessions and counsellors qualifications, should be routinely undertaken by counselling agencies. There may, however, be value in an independent body undertaking follow-ups. In New Zealand, the telephone counselling service conducts the follow-ups of clients and assesses progress against outcome criteria. This model has also been used in NSW. This

model avoids any possible problems associated with counselling services following up their own clients and has the added advantage that it ensures funding is made available specifically for follow-up of clients.

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A nationally consistent and publicly available dataset, including agreed outcome measures, would improve the evidence base on gambling help services. The collection of data could be coordinated by the Commission's proposed gambling policy research centre (draft recommendation 15.3) or the Australian Institute of Health and Welfare.

There is also currently very little tracking of clients. Jackson et al., looking at new and re-presenting clients concluded that:

... distinguishing between first treatment contact and subsequent entry to treatment is clinically relevant, and that the examination of problem gambling from a treatment career perspective is deserving of further attention. (2008, p. 618)

What this suggests is that there would be value in having individual identifiers to link records and to reactivate a closed case if a client re-presents for help. Such linkages would provide more information about relapses and could also mean better case management of clients. The use of individual identifiers, including issues around confidentiality, warrants further investigation.

Areas for further research

There are a number of areas where further research is required to address gaps in knowledge about interventions to assist problem gambling. There is a particular need to know more about the effectiveness of early interventions in:

- preventing or reducing the likelihood of groups at risk from developing gambling problems and ensuring they have the information to make informed choices, and
- educating the public about the visible signs of problem gambling.

Specifically, more evaluations of community awareness campaigns are required to get a better sense of what works and why, and additional research is needed to determine the effectiveness of self-help options and brief interventions.

Essential questions about the efficacy and effectiveness of treatment for gambling problems still need to be answered. More standardised randomised controlled trials with extended follow-up periods are required. Future outcome evaluations should attempt to overcome the methodological issues that have weakened the evidence

base and have sufficiently long follow-up periods. The critical period in judging whether the effectiveness of treatment for problem gamblers is considered to be two or more years after the completion of treatment. Walker recently said:

If we are serious about helping problem gamblers, it has to be help, not for six months or twelve months, but for life. We need research to determine approaches to helping people to quit gambling for life. The available evidence suggests that we help problem gamblers quit for six months; we need to do better than that. (NSW Problem Gambling Roundtable, 2008, p. 17).

Longitudinal research on clients and problem gamblers more generally could shed further light on the effectiveness of counselling, natural recovery and relapse. Long term effectiveness is also critical in terms of assessing cost effectiveness.

Further research is also needed to establish what clinical variables have an impact on treatment efficacy.