The University of Sydney

FINAL REPORT

Problem Gamblers Receiving Counselling or Treatment in New South Wales

Sixth Survey
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A Report for
The Casino Community Benefit Fund Trustees

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EXECUTIVE SUMMARY

Each year since 1997, an annual survey has been conducted of problem gambling counselling in New South Wales. The sixth such survey was completed in November and December of 2002. The survey was based on a face-to face interview with 144 problem gambling counsellors of a total of 167 counsellors who provide services in relation to problem gambling. The results of the survey were compared with those in previous years to determine the direction of trends in the provision of services for problem gamblers. The conclusions may be summarised as follows:

- Approximately N= 834 individuals were counselled face-to-face in a given week in relation to problems caused by excessive gambling. This is an increase of 16% over the numbers of individuals counselled per week at a similar time in the previous year. The numbers of counsellors increased in the same period of time by 13%.

- The profile of problem gamblers remains similar across years: male (59%), from Sydney (58%), Anglo-Australian (66%), aged 39 years, and with the primary problem being excessive gambling on electronic gaming machines (87%). Of the problem gamblers counselled, 88% were seen individually and 12% in a family or group context;

- 29% of referrals were made by the G-Line telephone counselling and referral service, an increase of 3% or more over previous years. The increase is likely to be associated with television advertising of the G-Line service which occurred at the same time as the survey;

- The numbers of clients on waiting lists for treatment (N=15) remains low and stable. The vast majority of individuals seeking counselling help receive an appointment within seven days;

- Usage of services, defined as the number of client sessions provided as a proportion of the total number of sessions available, has increased from 46% in 2001 to 63% in 2002. Usage would be as high as 69% if all clients kept their appointments. Thus usage of the services is increasing and the availability of appointment times for new clients is decreasing.

- 96% of the counsellors interviewed assess the level of problem gambling. The most commonly used assessment is the South Oaks Gambling Screen (31%).

- 36% of counsellors provide treatment for problem gambling according to a manual of treatment.

- 65% of counsellors report using multiple treatment methods in helping individuals cut back and stop gambling.

- Only 30% of counsellors adopt a single treatment approach to problem gambling. 37% of counsellors describe themselves as 'eclectic' implying that the treatment approach used is matched to the needs of the client. A further 16% report using

cognitive behavioural methods. 23% provide no label for the treatment approach favoured.

- Following treatment, the clients of 69% of counsellors are followed up to determine whether the treatment received has been effective. 48% of follow-ups are conducted within six months of the completion of treatment. However, 31% of counsellors have no follow-up evaluation after treatment.

BACKGROUND

In New South Wales, individuals who have problems caused by excessive gambling can seek help from a network of agencies across the State. The majority of these agencies are funded by grants from the Casino Community Benefit Fund (CCBF). CCBF funded agencies offer services which are free to the client. Other agencies and individuals also provide help, some on a fee for service basis, others at no cost to the individual.

The numbers of problem gamblers who seek help from the full network of services available (CCBF funded and other funded) provide an index of the size of the gambling problem in New South Wales. Since 1997, annual surveys of agencies providing services for problem gamblers have been conducted to determine the numbers of individuals seeking help and their demographic profile. The surveys also report on the usage of the services available and the means by which problem gambling is assessed and treatment success is evaluated.

Previous surveys have not reported on the treatment approaches used by counsellors and therapists to help individuals cut back and stop gambling. Understanding the variations in treatment methods is a pre-requisite to evaluating treatment effectiveness and moving to a greater understanding of how problem gambling can be alleviated.

The Sixth Survey was commissioned by the CCBF to be conducted towards the end of 2002. The survey replicates the methods and aims of previous surveys but includes an attempt to catalogue and differentiate the different treatment approaches being used in New South Wales.

Aims of the sixth survey

In relation to problem gamblers seeking face-to-face counselling, the aims of the sixth survey are:

(1) To report the number of gamblers treated in a seven day period;
(2) To report the number of gamblers with appointments for the next seven days;
(3) To report the number of gamblers who are waiting to begin treatment and the length of time in days that they have been waiting;
(4) To provide a demographic description of clients receiving treatment;
(5) To specify the extent to which different sources of referral are used by clients;
(6) To estimate the actual number of clients treated as a percentage of maximum number of clients who can be treated each week;
(7) To make an assessment of the G-line (NSW) service as a referral mechanism for problem gamblers.
(8) To compare current usage patterns with those reported in previous years;
(9) To report on the assessment procedures used;
(10) To report whether outcome evaluation programs are in place.
(11) To report the different treatment approaches being used to help gamblers cut back and stop gambling.

METHOD

The method of the previous five surveys was followed closely. Surveys of this kind do not seek to draw a random sample and infer the characteristics of the population. Rather, an attempt is made to include every problem gambler receiving counselling or treatment for excessive gambling and to describe the characteristics of that group. Since it is not possible to guarantee that every problem gambler receiving treatment is included in the survey, the characteristics of the full population are extrapolated from the group of problem gamblers for whom the required information is available. The more closely the population of problem gamblers surveyed approaches the population of problem gamblers receiving treatment, the more accurate will be this extrapolation. Thus, the method of identifying the population of problem gamblers receiving treatment is an important aspect of the accuracy of the demographic profiles that are subsequently described. The method described was given ethical clearance by the Human Ethics Committee of the University of Sydney.

Locating Relevant Agencies and Individuals

The approach taken in the survey was to identify all of the agencies and individuals in New South Wales whose primary purpose is to provide counselling and treatment services to problem gamblers. In relation to locating all problem gamblers receiving treatment, this approach fails in two important ways. First of all, some problem gamblers will receive help from agencies where the primary concern is not problem gambling. Secondly, some problem gamblers will receive help from problem gambling agencies that are not able to provide the requested information or which, although able to provide the information, choose not to do so. Although little can be said about the numbers of individuals receiving help from secondary services for problem gambling, the number of primary agencies for whom data is not available will be reported in table 1.

The full list of agencies and individuals providing services for problem gamblers was constructed based on reference to a number of different sources. The starting list was set at the agencies and individuals contacted in the fifth survey conducted in 2001. This list was extended by adding agencies and individuals for whom information was available from:

- a complete list of agencies funded by the CCBF and supplied by the CCBF Branch of the Department of Gaming and Racing;
- an unofficial list of agencies and individuals compiled by Ron Mac and supplied free of charge to gambling agencies in New South Wales;
- information supplied by counsellors during their interviews for the 2002 survey in answer to a question which asked of any other services for problem gamblers in their neighbourhood, suburb or township.

The full list of agencies that participated in the survey is listed in Appendix A.

Summary of contacts and successful interviews

Table 1 shows the numbers of counsellors on the survey list, the numbers contacted and the numbers interviewed. Reasons for failure to interview are also listed.

Table 1:
Interview status of the counsellors scheduled for inclusion in the survey

Counsellor Interview Status	N
Full list of all counsellors providing services for problem gamblers	167
Counsellors who were interviewed	147
Counsellors who were not interviewed	20
• Could not be contacted in the survey period - status unknown	(4)
• On holidays during the survey period	(8)
• No suitable time could be arranged for the interview	(2)
• Maternity leave, sick leave	(3)
• Declined to be interviewed	(3)

Altogether, 147 counsellors of a complete list of 167 were interviewed. The proportion of counsellors not interviewed (12%) is larger than in earlier surveys. Fifteen counsellors had either taken leave of one kind or another during the survey period (n=11) or did not answer their telephones despite repeated calls (n=4). These numbers are comparable with earlier surveys as a percentage of the full list of counsellors. Furthermore, counsellors who are absent for any reason can be assumed to have made arrangements for the care of their clients during their absence. For example, other counsellors at the agency may have taken on a temporary increased load. A further five counsellors either declined to participate (n=3) or did not make a time at which they would be available for interview (n=2). The absence of this number of counsellors from the survey decreases the total number of clients for whom data is available. However, it is likely that the demographic breakdown of clients in treatment will be relatively unaffected.

Conduct of Survey and Interviews

The interviews were conducted by seven interviewers. All were experienced interviewers and five took part in the fifth survey conducted in 2001. The interviewers were trained in conducting the structured interview to minimise variations in actual interviewing procedures. The inclusion of a new section on the therapy used with problem gamblers necessitated that all interviewers take part in the preliminary training session.

Agencies funded by the CCBF received a letter from the Chairperson stating the purpose of the survey and requesting the cooperation of counsellors. Agencies not funded by the CCBF received a letter from the research team. All counsellors received copies of an information sheet giving further information about the survey and were requested to give signed consent to participate in accordance with the ethical approval granted by the Human Ethics Committee of the University of Sydney.

Counsellors were contacted by telephone to arrange a suitable time for an interview. It was the intention of the research team that all interviews would be conducted face-to-face. Altogether, 147 counsellors were interviewed. Of these, 138 interviews were conducted face-to-face and nine were conducted by telephone. In all nine interviews conducted by telephone, the small number of clients seen in the previous week and the large distances of travel involved, precluded the use of the face-to-face technique.

Interview Questions

The interview questions fall into six parts. Part A contains questions concerning the demographic details of all clients counselled, in relation to problem gambling, in the seven days prior to the day of the interview. ‘Counselling a client’ included face-to-face contact with the client alone or within a family or group context, telephone counselling, and counselling via the internet. However, nearly all analyses in the report are based on face-to-face contact only. Part B contains questions concerning the demographic details of clients for whom there are appointments in the next seven days following the day of the interview. Part C includes questions concerning the current caseload of the counsellor and the capacity of the counsellor to provide a service to clients. Capacity is conceptualised as the maximum number of clients that can be offered a service that meets the counselling standards of the counsellor. Part D concerns the extent to which the gambling and associated problems are assessed prior to treatment. Counsellors were asked to nominate the screening devices used. Part E includes questions concerning the process whereby the counsellor determines whether the help given to the client has been successful in achieving its goals. Finally, in part F a set of questions was included which related to the goals, expectations and nature of the treatment provided to the gambler. The full interview schedule is shown in Appendix B. The questions in parts A, B and C were also asked in all previous surveys and form the basis for measuring change over time. Questions in parts D and E were included in 2001. The questions in part F have not been included in previous surveys.

Rationale for the treatment section of the interview

The Sixth Survey is required to provide data on the kinds of treatment approaches being used by counsellors in New South Wales. There are several reasons why this task is difficult. First of all, there is no established lexicon of treatments and typology of treatment approaches. Secondly, treatment approach names, such as 'cognitive behavioural therapy', are fuzzy sets that can be understood in a strict sense of excluding all but treatments that meet specific criteria (for example, have both cognitive restructuring and behaviour therapy components) or in a loose sense that includes a wide range of different approaches that only share in common the fact that cognitive change is expected to occur (for example, modified problem solving techniques). Furthermore, it is possible that some actual treatment approaches are mislabelled by the proponent. Finally, the actual treatment approach used may not be that which the therapist reports. For example, a therapist may report using behavioural therapy, whereas the actual sessions might more properly be classified as a form of psychotherapy.

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The implication of these problems is that the straightforward approach of asking the counsellor to give a label to the treatment method used should be avoided as the sole means of classifying the approach used. A method by which a treatment approach is classified according to a set of explicit criteria would be preferred over self-reported labels. In this survey, treatment approach is classified by two questions concerning (a) the nature of excessive gambling, and (b) the main processes by which a gambler can be helped to cut back or stop gambling. The category of treatment determined by this approach was then validated against the procedure used in counselling the last client seen and the self-reported label supplied by the counsellor or therapist for the treatment.

Three broad treatment categories were defined on theoretical grounds:
- methods aimed at reducing addiction to gambling ("addiction");
- methods aimed at changing cognitions about gambling ("cognition");
- methods aimed at decreasing outside pressures to gamble ("escape").

The central notion of addiction to gambling is that there is something so attractive or rewarding about gambling that the individual finds it difficult to control the urge to continue. The urge to gamble is physiologically based. Problem gamblers may have more powerful urges or may have impaired control over normal urges. The task of the counsellor is to help reduce the strength of urges or to increase the ability of the individual to control the urges. Thus, the therapist will focus on the triggers to gambling and ways in which these triggers may be avoided. Frequent relapse is expected and the process of gaining control will be a relatively slow one.

The central notion of the cognitive theory of gambling is that the individual believes, despite all the evidence to the contrary, that money will be won. The individual does not believe that gambling outcomes are truly random. Rather, the individual engages in magical thinking or believes in personal luck. The individual remains optimistic about recovering money that has been lost. The therapist will focus on changing the erroneous beliefs and positive attitudes of the gambler on the assumption that the gambling behaviour is caused by irrational cognition.

The central notion of the escape theory of gambling is that the gambling is not engaged in for itself (the excitement or the money) but because it fulfils an important role of allowing the individual to escape from aversive situations elsewhere in life. The individual is pushed into gambling rather than pulled into gambling. Thus, the therapist will focus on the resolution of problems elsewhere in the life of the gambler on the belief that this will reduce the motivation to gamble. Problem solving skills, social skills and coping skills will be important areas for change in the individual.

These categories do not enable treatment approaches to be categorised unambiguously. A therapist may believe that all three processes contribute to excessive gambling. Nevertheless, the process that is ranked most important in bringing about change in the problem gambler does enable an unambiguous categorisation of the therapy. Furthermore, the rank order of processes deemed important by the therapist provides a means of assessing the homogeneity of the treatment approach used.

RESULTS

The results of the survey are presented in two sections. In the main report, results from all counsellors are included whether or not they are employed by agencies funded by the CCBF. In Appendix C, similar information is provided based solely on the data provided by counsellors from CCBF funded agencies.

All Problem Gambling Counsellors in New South Wales

Numbers of Problem Gamblers in Treatment

Counsellors in NSW provided services for 851 individuals in relation to gambling problems within a one-week period. Of those individuals 16 were counselled over the telephone and one by written correspondence. Ninety-nine gamblers and their relatives and friends were seen in a group therapy context. For comparison with previous surveys, telephone and internet counselling data have been omitted from the analysis. Figure 1 shows the numbers of individuals receiving face-to-face counselling across the years 1997 - 2002. During a one-week period, counsellors provided services face-to-face for 834 individuals in relation to gambling problems. This is an increase over the comparable figures for the years 1997 (N =154), 1998 (N = 310), 1999 (N = 558), 2000 (N = 686) and 2001 (N=717).

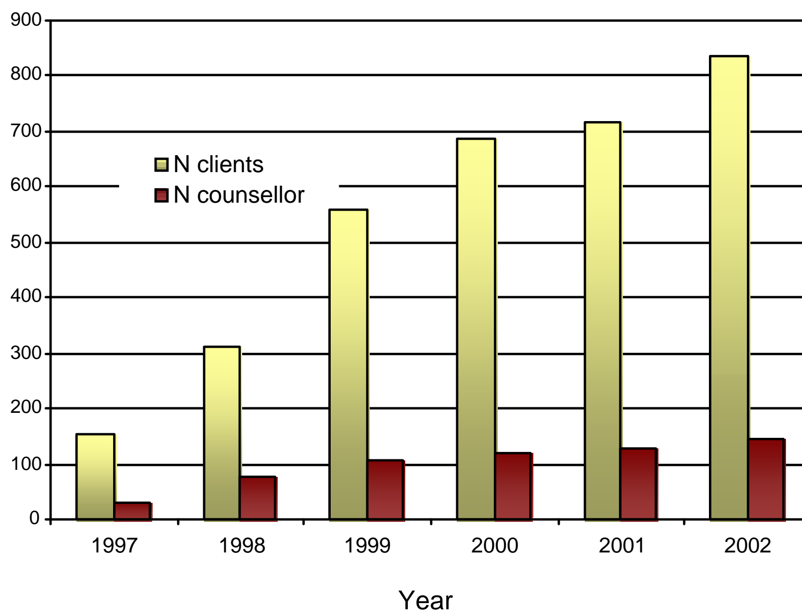

Figure 1: The numbers of individuals receiving face-to-face counselling in relation to problem gambling in NSW (tall columns) and the numbers of counsellors (short columns).

The Different Types of Service Provided

Problem gamblers and their families can receive a range of services from counsellors. Previous surveys have demonstrated that a large majority of the individuals seeking help receive either treatment for excessive gambling behaviour or counselling aimed at ameliorating the problems caused by excessive gambling. Within that context, the majority of counsellors may be classified as providing services aimed at alleviating a gambling addiction. A minority of counsellors are trained in financial counselling and provide a service in relation to helping the gambler cope with the debts incurred by excessive gambling. In table 2, a distinction is made between a service that is primarily financial counselling and other kinds of services. Similarly, a small number of individuals with legal training provide legal advice and representation for problem gamblers. In table 2, these services are referred to as 'legal'. All other services for problem gamblers are categorised as 'addiction'. Counsellors may also provide help for individuals who hold some relationship to the problem gambler. Typically, the individual belongs to the family of the problem gambler. Such counselling is identified as "relationship" in table 2. Finally, in table 2 a distinction is made between counselling a client individually and counselling two or more clients together (group counselling).

Table 2:
The different kinds of counselling to problem gamblers and their families

	1997		1998		1999		2000		2001		2002	
	N	%	N	%	N	%	N	%	N	%	N	%
Individual												
Addiction	115	75	238	77	360	65	459	67	487	68	591	71
Financial	16	10	31	10	69	12	38	6	49	7	66	8
Relationship	23	15	32	10	56	10	31	5	63	9	62	7
Legal[1] there is not footnote for this									19	2	15	2
Assessment	0	0	9	3	7	1	10	1	2	<1	0	0
Other	0	0	0	0	0	0	0	0	1	<1	0	0
Total	154	100	310	100	492	88	538	79	621	86	734	88
Group[2]												
Addiction							106	15	62	9	58	7
Relationship							42	6	34	5	42	5
Total	n/a	n/a	n/a	n/a	66	12	148	21	96	14	100	12
Overall Total	154	100	310	100	558	100	686	100	717	100	834	100

Note: Group counselling was included with addiction counselling in 1997 and 1998

Table 2 shows that the numbers of gamblers and related others counselled individually has continued to rise across years. By comparison, the numbers of individuals receiving counselling in groups has decreased slightly from 2001 to 2002.

The demographic characteristics of problem gamblers receiving face-to-face counselling

Table 3 shows the gender, location (rural or Sydney), mean age and ethnic background of problem gamblers counselled face-to-face in a one-week period prior to the day of interview. The data for previous years is provided for comparison.

Table 3:

Problem gamblers seen individually in face-to-face sessions in the last seven days

Number of clients receiving counselling		1997	1998	1999	2000	2001	2002 N=672
		%	%	%	%	%	%
Gender	Male	80	65	61	62	63	59
	Female	20	35	39	38	37	41
Location	Sydney	79	73	54	55	62	58
	Rural	21	27	46	45	38	42
Average age	All	37	38	39	38	39	39(1)
Ethnicity	Anglo-Australian	71	71	76	68	57	66(1)
	Other English	9	4	4	4	10	6
	NESB non-Asian	15	17	11	21	21	16
	Asian	3	4	6	5	9	8
	Islander	1	2	2	1	<1	1
	Aboriginal	0	1	1	1	3	3
	Other	1	1	0	0	0	0
Type of gambling	Racing	17	12	11	8	6	5(1)
	Machines	74	79	83	88	85	87
	Casino	6	6	5	2	6	3
	Numbers	0	2	1	1	<1	<1
	Stockmarket	0	0	0	<1	<1	0
	Multiple	3	1	0	0	2	4
	Sports betting	-	-	-	<1	<1	<1
	Other					<1	<1

(1) Note Percentages are calculated excluding the category 'unknown'; age n=1, ethnicity n=5, type of gambling n=5)

Results for the label applied to gamblers seeking treatment (compulsive, pathological, problem) are not presented for 2002 since a large and growing number of counsellors state that they do not have a label for the clients for whom they provide services. This trend is consistent with a widely held view in Australia (Dickerson, 2002) that the boundaries between different types of gamblers are arbitrary markers in continuous measures rather than defined by discrete features. Figure 2 shows the demographic trends.

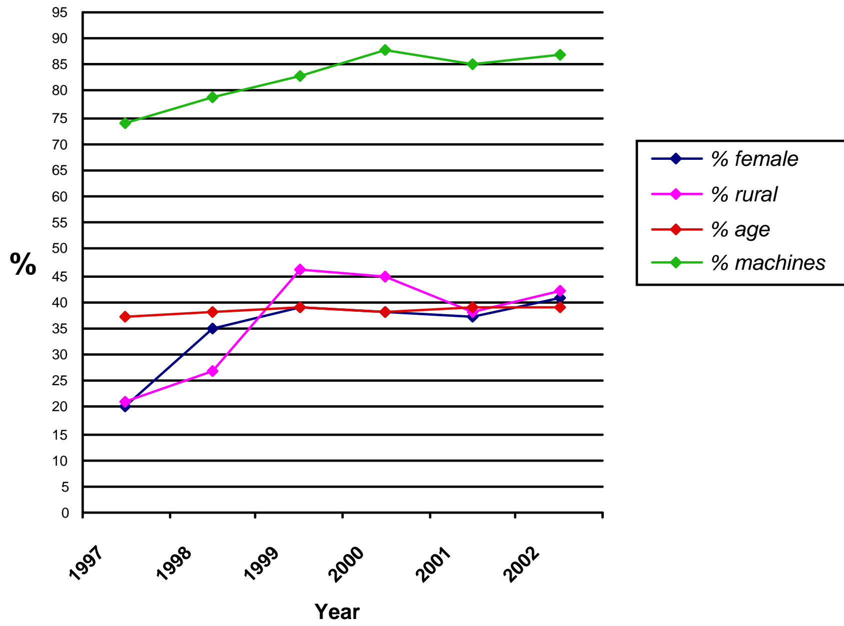

Figure 2: Demographic trends on problem gambling

Characteristics of problem gamblers with appointments for consultation in the next seven days

A similar analysis may be made of clients with appointments in the next seven days. Since many of the clients with appointments in the coming week will be clients counselled in the previous week, it can be anticipated that the same demographic trends shown in table 3 will be repeated in table 4.

Table 4:

Problem gamblers with face-to-face appointments for the next seven days

Number of clients receiving counselling		1997 %	1998 %	1999 %	2000 %	2001 %	2002 N=481 %
Gender	Male	75	66	57	61	64	57
	Female	25	34	43	39	36	43
Location	Sydney	91	72	58	54	59	61
	Rural	9	28	42	46	41	39
Average age	All	38	39	39	38	40(1)	39(1)
Ethnicity	Anglo-Australian	67	67	77	72	63(1)	65
	Other English	10	5	3	7	7	5
	NESB non-Asian	15	17	12	15	22	18
	Asian	3	7	6	3	6	8
	Islander	2	1	1	1	<1	1
	Aboriginal	0	1	1	2	2	3
	Other	3	2	0	0	0	0
Type of gambling	Racing	24	10	10	9	6(1)	5(1)
	Machines	67	83	85	90	86	87
	Casino	9	6	5	1	4	3
	Numbers	0	1	0	0	1	<1
	Stockmarket	-	-	-	0	<1	0
	Multiple	-	-	-	0	2	4
	Sports Betting	-	-	-	-	<1	<1
	Other	-	-	-	-	<1	<1

Note: Assessments (where it was unknown whether the client was a problem gambler) were excluded from the 2000, 2001 and 2002 analyses (2002 assessments n=56). (1) Percentages are calculated excluding the category 'unknown' (in the 2002 analysis: age n=11, ethnicity n=9, type of gambling n=9)

Source of referral of problem gambling clients: The role of G-Line

Problem gamblers and their families may be referred to counselling through a variety of sources. Of particular interest is the share of referrals made by the G-Line telephone referral agency. Table 5 shows the categories of referral sources for all clients seen in face-to-face counselling in the last seven days or with appointments in the next seven days.

Table 5:
Source of referral for all clients treated in a seven-day period in 2002

Source of Referral	Last Seven Days N	Last Seven Days %	Next Seven Days N	Next Seven Days %
Telephone Referral				
• G-line	245	29	213	32
• Lifeline	9	1	3	<1
Gambling Related Agencies				
• Another gambling agency	41	5	32	5
• Other counsellor within agency	19	2	18	3
• Gambling industry	37	4	29	4
Non-Gambling Agencies				
• Medical	38	5	32	5
• Parole service	21	3	17	3
• Police	0	0	0	0
• Legal agent	9	1	9	1
• Employer	2	<1	0	0
• Church	3	<1	2	<1
• Another non-gambling agency	128	15	81	12
Advertising				
• Advertising	73	9	42	6
• Telephone books	27	3	18	3
• Internet	1	<1	1	0
Individuals				
• Self	30	4	18	3
• Family or friends	104	12	77	11
• Another client of the agency	25	3	19	3
Other	3	<1	2	<1
Not known	19	2	57	8
Number of clients	834	100	670	100

Of considerable interest is the increase in referrals made by G-line which result in clients receiving help from agencies. The share of referrals attributed to G-line in 2002 is 29% compared with 20-26% over the preceding years. At the time of the survey, advertisements highlighting gambling problems were shown on television specifying G-line as a source of help. It is likely that the increase in G-line referrals is a result of this campaign. Figure 3 shows the increasing proportion of G-line referrals. Note that the G-line referral service was not implemented until after the 1997 survey. Prior to 1998 the main telephone referral service was Lifeline.

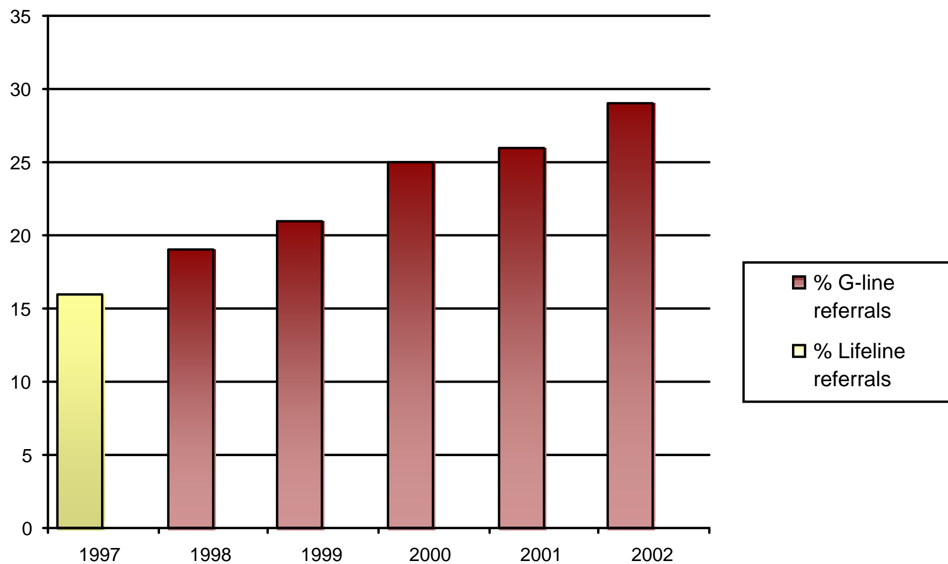

Figure 3: G-line referrals expressed as a percentage of referrals

Waiting Lists

After the prospective client has contacted a counsellor, it is important that an appointment is made as soon as possible. The counsellors interviewed were asked whether, in the last week, they had been unable to make an appointment to see a prospective client because all their appointment times were full. A waiting list was defined by the prospective client having to wait more than seven days before an appointment time became available. Table 6 shows the extent to which counsellors have waiting lists compared across the years 1997-2002.

Table 6:
The presence of waiting lists for problem gambling clients

	1997	1998	1999	2000	2001	2002
Number of Counsellors	31	78	105	120	130	147
Counsellors with waiting lists	7	3	4	3	6	7
Number of clients waiting	22	24	9	5	21	15

It is clear that the number of counsellors with waiting lists remains small and relatively few problem gamblers and their families must wait longer than seven days before an appointment time can be made available.

Capacity and usage of services

Capacity refers to the number of clients that counsellors can see in one week while maintaining their counselling standards. Usage refers to the number of clients actually seen in the week preceding the interview. Percentage usage refers to the total number of clients counselled expressed as a percentage of total capacity. Percentage usage across time is shown in figure 4. The data labelled 'rural' refers to all agencies which operate outside the ABS Sydney region.

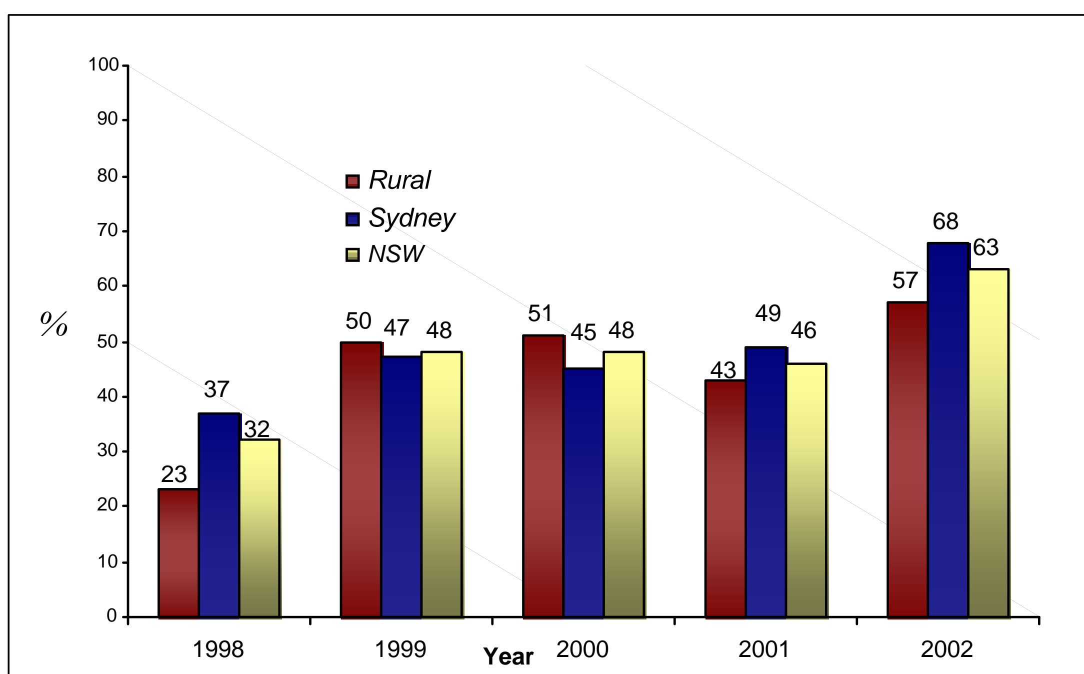

Figure 4: Usage of services as a percentage of capacity.

Percentage usage increased from 46% in 2001 to 63% in 2002.

This large increase in usage can be explained as the conjunction of two factors: a large increase in the numbers of clients presenting for services and a decrease in the capacity of agencies to provide those services. Whereas the number of clients increased by 16% from 2001 to 2002 the capacity of the system of services available decreased by 11%. The explanation for the decrease in capacity needs further investigation. Since capacity is estimated by each counsellor as the maximum number of clients that can be seen whilst maintaining counselling standards it is possible that the decrease in capacity may reflect changing circumstances. For example, if the duties of counsellors increase then the hours available for face-to-face counselling would be expected to decrease. An indication of whether such a trend is present can be obtained by comparing the capacity of CCBF funded counsellors for whom the employment hours did not change. Seventeen Counsellors were identified as having the same employment hours in 2002 as in 2001. The capacity for these counsellors decreased from the 2001 survey to the 2002 survey by 11%. This result is consistent with the assumption that counsellor's duties are increasing.

Although 63% usage suggests that the system of services available to problem gamblers is not overloaded, care should be taken to distinguish between availability and usage. Usage refers only to the extent to which services are actually used. Unfortunately, a significant proportion of appointments do not result in service delivery. A Prospective client may not arrive for a scheduled appointment (a 'no show'). However, the appointment time must be reserved despite the no show and is thus not available for other prospective clients. Thus 'availability' may be defined as the availability of a counsellor for an increased number of appointments over and above those used by clients ('usage') and those reserved for prospective clients ('no shows'). Availability has not been calculated in previous surveys. Calculated as a percentage of the maximum number of appointments which can be made while maintaining quality of services, availability was 38% in areas of New South Wales outside Sydney, and 24% for services within Sydney. Availability for the State was 31%. While this figure indicates some ability to meet increased demand, two factors suggest caution: demand may not be spread evenly across agencies and counsellors; and, usage in 2002 has shown a definite increase.

It should be noted that no show rates vary markedly across agencies. In some cases the nature of the operation of the agency precludes the possibility of a no show (for example, in-patient programs and drop in centres). When such agencies are omitted the no show rate across counsellors is 10%.

Assessment of the severity of problem gambling

There are two major reasons for assessing problem gambling prior to counselling and treatment: (a) planning the counselling/treatment approach; and (b) evaluating the effectiveness of the counselling or treatment provided. The major approaches to assessment are the South Oaks Gambling Screen (Lesieur & Blume, 1987) and the Diagnostic and Statistical Manual of the American Psychiatric Association (1994) commonly known as the SOGS and DSM-IV. Other approaches are also available and include the Twenty Questions used by Gamblers Anonymous (GA20), the

Maroondah Assessment Profile (1999) (G-Map), and, more recently, the Victorian Gambling Screen (Tolchard & Battersby, 2001) and the Canadian Problem Gambling Index (Wynne, 2002). Additionally, problem gambling may be assessed by structured, semi-structured or unstructured interviews. Assessment by structured interview is typically based on the DSM-IV criteria. An example is the Structured Clinical Interview for Pathological Gambling (SCIP). Table 7 shows the frequency with which counsellors reported using different approaches in the assessment of problem gambling.

Table 7 shows that a large majority of counsellors (96%) assess the severity of problem gambling prior to treatment. The South Oaks Gambling Screen is used by 31% of counsellors and remains the most widely used type of assessment. 'Unstructured interview' refers to the technique of assessing gambling severity based on information elicited during the initial counselling session in an unstructured format. A total of 32 counsellors use this approach in preference to a questionnaire or structured set of questions. 4% of counsellors do not use any kind of assessment.

Table 7:
Tests used to measure problem gambling

Assessment	N
South Oaks Gambling Screen SOGS	
Lifetime	17
Revised	42
Modified	10
Chinese	2
DSM Criteria	
DSM Criteria-Questionnaire	36
SCIP –Structured Interview	19
Other Questionnaires	
G-map	14
Gamblers Anonymous 20 Questions	11
Agency questionnaire	13
Intake questionnaire only	5
Victorian Gambling Screen	3
NODS	2
Gambling Symptoms Assessment Screen	3
Other Questionnaire	7
Other Interview	
Unstructured interview	32
Structured interview	4
No Assessment	10

Problem gambling is frequently associated with depression. In some cases, there may be suicidal ideation or a suicidal tendency. Counsellors may determine risk of suicide in an unstructured format or they may use a structured set of questions. Table 8 shows the approaches used.

Table 8:
Method of assessing suicidal tendency

Assessment	N
Determined by interview	
Structured interview	4
Unstructured interview	81
DSM	3
Inferred from Gambling Questionnaire	
• Beck Depression Inventory	1
• Depression, Anxiety and Stress Scale	6
• Agency Questionnaire	11
• Intake Questionnaire	18
• Lifeline Questionnaire	3
• Wesley Questionnaire	6
• Other Questionnaire	8
No Assessment	6
Total	**147**

Problem gambling may also be associated with a wide range of other clinical problems. According to some writers, problem gambling is frequently symptomatic of an addictive personality. There is some support for a link between excessive alcohol consumption and loss of control in gambling (Baron & Dickerson, 1994).

Table 9:
Assessment of Comorbidities

Assessment	N
Formal Assessment	
DSM criteria	10
Depression Anxiety and Stress Scale	21
Beck Depression Inventory	4
DAST-20 (Drug Abuse Substance Test)	6
AUDIT (alcohol screen)	9
Short form 12 well being scale (SF-12)	5
Other Questionnaires	3
Agency Questionnaire	15
Intake questionnaire	14
Structured Interview	3
No Formal Assessment	
Unstructured interview	47
No assessment	31

Since problem gambling is sometimes not the primary cause of problems, it is appropriate for assessment to be made on a range of comorbid conditions. Table 9 shows the extent to which such assessment is conducted.

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The majority of counsellors do not formally assess a wide range of clinical conditions other than problem gambling. Among the assessments available, the DASS questionnaire measuring depression, anxiety and stress is the most widely used. The majority of counsellors who do not use a questionnaire, rely on their own judgement of appropriate questions to ask. However, approximately 18% of counsellors do not make any assessment of any comorbid conditions.

Approach to treatment

The data reported in this section refers to the treatments provided by counsellors to help individuals to reduce their excessive levels of gambling. Thus counsellors who only provide help in overcoming the problems caused by excessive gambling and who do not treat the excessive gambling itself are not included. For example a financial counsellor who only provides counselling in relation to debt management would not be included. However a financial counsellor who treats both the excessive gambling in addition to the management of debt would be included. Treatment approaches are frequently set out in manuals. The presence of a manual can be expected to inhibit unintended deviation from the basic treatment strategy. While some treatment approaches might be imported from other problem areas such as substance abuse, it is also possible that best strategies for alleviating problem gambling are still to be developed. Nevertheless, manuals describing treatment procedures are available (e.g. Blaszczynski et al,1999; Milton, 2001) and a wide range of self-help manuals have

also been written. Table 10 shows the extent to which manualised treatment approaches are used in New South Wales.

Table 10:
Use of a manual to guide treatment

Q "Do you use and follow a written manual?"		**N**
YES		48
NO		59
OTHER:	sometimes	7
	more or less use manual as a guide but don't follow it	16
	set procedure which is not written down (but could be)	5
	Total	135

The problem gambler seeks help from the counsellor in controlling the excessive gambling. The goal for treatment may be to bring the gambling under the personal control of the individual, or to reduce gambling to a low level of involvement, or to enable the individual to stop gambling altogether. The decision on treatment goals may be made by the client, may follow from the theoretical stance of the counsellor, or may be negotiated by the counsellor with the client. Table 11 shows the extent to which the treatment goals are set by the counsellor or client.

Table 11:
The setting of treatment goals

Q As a goal for counselling, do you give the gambler a choice of controlling or stopping gambling		**N**
YES	Counsellor lets the client set the goal	68
NO	Counsellor sets the goal	12
OTHER	Irrelevant to counselling	0
	Counsellor and client negotiate goals	55
	Wait and see what happens	0
	Total	135

The counsellor or therapist may hold the view that one approach is best for helping all gamblers. Alternatively, the counsellor or therapist may use different approaches with different gamblers. Table 12 shows the distribution of counsellors across single and multiple treatment options. The majority of counsellors and therapists do not use a single approach but a mixture of approaches tailored to the needs of the client. Many of these described their approach as 'eclectic'.

Table 12:
Use of single or multiple treatment approaches

Q Do you have a single treatment approach to helping the gambler cut back or stop gambling?		**N**
YES	Cognitive Behavioural Therapy	13
	Cognitive Restructuring	4
	Other	24
NO	Two methods	6
	Multiple methods	88
	Total	135

The treatment approach used by a therapist or counsellor can be conceptualised as an interaction between the service provider and the client that brings about certain processes of change in the gambler whereby the level of gambling involvement decreases and possibly ceases. Provided that the primary process of change can be accurately described, the treatment approach can be derived. 'Escape' explanations of excessive gambling explain the gambling behaviour primarily as an escape from pressures and aversive situations elsewhere in the individual's life. Processes of change will involve reducing the impact of those problems or giving the client the skills to deal with those problems more effectively. 'Addiction' to gambling explains heavy involvement in terms of powerful urges from within the individual which are difficult to control. Similarly to drug addictions, the gambler craves the excitement and action involved and has impaired ability to limit the level of involvement. Processes of change will involve decreasing the excitement or attractiveness of gambling and increasing the ability of the gambler to control the gambling urges. Cognitive explanations of gambling assume that the central motivation for gambling is winning money. Despite the evidence to the contrary, the individual believes that winning is imminent through erroneous perceptions and cognitions about gambling. Processes of change involve changing beliefs about and attitudes toward gambling. Table 13 shows the categorisation of treatment approaches according to the primary process of change. The 'not specified' category refers to responses where several processes were given but all were given equal weight.

Table 13:
Treatment categories determined by the primary process of change

Treatment Category (based on primary process of change)	**N**
Escape	61
Addiction	33
Cognition	28
not specified	12
no response	1
Total	135

For a large proportion of counsellors and therapists, the primary process of change is one of enabling the clients to cope better with problems elsewhere in their lives. Nevertheless, table 13 presents a clearer picture of therapy than might be the case. Since many counsellors and therapists report using different treatment approaches

according to the needs of the client, it is likely that different processes of change will be assumed to be operating for different clients. Furthermore, cognitive behaviour therapy assumes that both cognitive and addiction processes are operating. For this reason, the treatment approach was also analysed by considering the three main processes of change operating. The treatment categories become 'pure escape' , 'pure addiction, and 'pure cognition' where all three processes fall in the same category, 'escape plus' where two processes indicate escape as the main cause of gambling (two items) and mixed where all three processes are represented. Table 14 shows the breakdown into pure and mixed categories.

Table 14:
The frequency with which counsellors fall into different treatment categories based on the three main processes of change

Treatment categories based on the three main processes of change	N
Pure treatment processes	
escape	16
addiction	2
cognition	3
Modal treatment processes	
escape	46
addiction	23
cognition	11
Mixed treatment processes	21
Not specified	12
No response	1
Total	135

Table 14 shows the frequency with which counsellors use different treatment approaches. It does not necessarily represent the emphases should this be emphasis? in treatment since counsellor hours vary from a small number up to forty hours per week. Using the capacity of each counsellor as an indication of the extent to which a particular treatment approach is used yields estimates of the availability of sessions where different treatment approaches are used. The most common treatment approach on a sessional basis is with therapies that fall in the escape category (45% of all available sessions). Treatment approaches based on the addiction process account for 22% of all available sessions. Treatment approaches based on cognitive theory account for 13% of sessions. 15% of available sessions involve a mix of all three treatment approaches. The remaining 5% were of counsellors did not specify which treatment approach they used.

Treatment approaches typically have labels. Thus, 'cognitive behaviour therapy' (CBT) is the label for a treatment approach which assumes that both behaviour change and cognitive change must occur. Brief definitions for commonly used therapy labels are:

- Behaviour Therapy (BT)
  Any approach which seeks to modify behaviour through learning theory mechanisms. Learning theory is understood to include the processes of social learning theory in addition to conditioning. (Marlene, 2002)

- Cognitive Therapy (CT)
  Any approach which assumes that the maladjusted behaviour is caused by erroneous cognitions. By inducing more accurate cognition, the behaviour will cease. (Ladouceur & Walker, 1996).

- Cognitive Behavioural Therapy (CBT)
  Any approach which seeks to modify both behaviour and cognitions at the same time. Consists of elements of BT and CT. (Sharpe & Tarrier, 1993).

- Client Centred Therapy

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  An approach which assumes the individual can overcome behaviour problems through their own resources given a caring, accepting, genuine relationship with the counsellor. (Rogers, 1951).

- Narrative Therapy
  An approach which views gambling as a bad habit. Clients provide a narrative account of their lives and gambling's role. Understanding the pattern and role of gambling in one's life enables the client to re-author life with solutions to gambling. (Munn, 1999).

- Solution Focussed Therapy (SFT)
  An approach which assumes that the client already uses a number of both unsuccessful and successful strategies to control their behaviour. By helping the client identify and utilise the successful strategies and reduce the utilisation of the unsuccessful strategies behavioural problems may be overcome. (O'Connell, 1998)

- Problem-solving Therapy
  The premise of this approach is that behavioural problems are the result of poor problem-solving skills. By teaching the client to solve problems in general, the client can then use these skills to find effective solutions to any behavioural problem in his or her life. (Nezu, 1986)

Each counsellor/therapist was invited to give details of the last session with a problem gambler where the goal of the session was to bring about a change in the gambling behaviour of the client. The counsellor/therapist was also asked to provide a label for the approach they favoured in helping individuals cut back their gambling. Given the definitions of therapy above, it is possible to estimate the proportions of counsellor/therapists using different approaches. However, many counsellor/therapists do not appear to have a preferred treatment approach. A significant proportion of these describe their approach as eclectic. This appears to mean that the approach used is adjusted to the client and is quite variable from one client to the next. Table 15 shows the distribution of named therapies. A named therapy is assumed to be consistent with the processes of change if the label, processes of change, and details of session are consistent.

Table 15:
Named therapies in relation to named processes

Label for Therapy	escape	addiction	cognition	mixed	Not Specified	Total
Cognitive Behaviour Therapy	7	6	5	2	2	22
Cognitive Therapy	0	0	4	0	0	4
Client Centred Therapy	3	6	0	1	1	11
Solution Focused Therapy	3	1	0	2	0	6
Motivational Interviewing	0	0	0	2	0	2
GA Twelve Steps	0	1	0	0	0	1
Narrative Therapy	1	0	0	0	0	1
Systemic	1	0	0	0	0	1
Rational Emotive Therapy	1	0	0	0	0	1
Holistic	2	2	0	0	0	4
Eclectic	29	4	2	14	1	50
No label provided	15	5	3	0	8	31
No information provided	-	-	-	-	1	1
Total	62	25	14	21	13	135

Table 15 shows that the two major approaches used by counsellors and therapists are either cognitive-behavioural or eclectic. The category 'eclectic' includes both counsellor therapists who use a small number of labelled therapies and counsellor/therapists who did not list the therapy types that they call on. Given the fact that there is not yet sufficient evidence to favour any one approach over any others, the heterogeneity of therapeutic approaches would be expected.

Evaluation of treatment effectiveness

Although gambling may cause a wide range of problems which may form the focus of counselling, the primary aim of treatment of the individual who is exhibiting excessive gambling is likely to involve helping the individual to cut back or stop gambling. Where the counsellor or therapist is attempting to help clients to control or to cease their gambling, follow-up assessment of post treatment gambling behaviour can provide important information concerning the effectiveness of the approach used. Ideally, all clients entering treatment are followed up independently of whether the treatment is completed. Table 16 shows the numbers and percentages of counsellors who evaluate treatment effectiveness by follow up procedures.

Table 16:
Numbers and percentage of counsellors using different approaches to the evaluation of treatment effectiveness.

Assessment	N	%
Conduct follow-up on all clients	75	51
Follow-up clients who give permission	23	16
Follow-up clients that complete treatment	0	0
Follow-up sample of clients	3	2
• Random sample	(1)	(<1)
• Counsellor chosen sample	(2)	(1)
Don't conduct follow-ups	46	31
Number of counsellors	147	100

Follow-up may range in quality from a telephone call asking about whether or not the individual is still gambling through to structured interviews and re-assessment with the initial screens. In the data presented in table 16, no distinctions are made between these different approaches to follow-up assessment.

Evaluation of treatment effectiveness might occur at any time after treatment. Since relapse into gambling following treatment is a common problem, the greater the latency of follow-up, the greater the confidence that treatment effects will be maintained. Table 17 shows the interval between treatment and final follow-up. In a small number of cases counsellors conduct multiple follow-ups at different times. Only the latency of the final follow-up is included in the analysis.

Table 17:
The length of time following completion of treatment
at which follow-up evaluation is conducted

Time interval to follow up	N
One month or less	11
1 – 3 months	5
Three months	14
3 – 6 months	13
Six months	27
Nine months	7
Twelve months	19
Two years	4
Follow-up at variable time	1
No follow-up	46
Number of counsellors	147

Table 12 shows that approximately 50% of follow-ups are completed within six months following treatment.

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