The University of Sydney

Problem Gamblers Receiving Counselling or Treatment in New South Wales

DRAFT REPORT

Eighth Survey 2004

A Report for
The Casino Community Benefit Fund Trustees

Prepared by:

Walker, M., Shannon, K., Blaszczynski, A. & Sharpe, L.
University of Sydney Gambling Research Unit

Financial assistance for this project was provided by the
New South Wales Government from the Casino Community Benefit Fund.
The views expressed in this report, however, are solely those of the authors.

EXECUTIVE SUMMARY

The Eighth Annual Survey was funded by the Casino Community Benefit Fund (CCBF) to meet four aims:

- to determine whether the numbers of people seeking help for problem gambling in New South Wales has continued to increase as in previous years;
- to provide State-wide demographic information on problem gamblers receiving face-to-face counselling in the survey period;
- to report assessment procedures, treatment methods, and evaluation methods currently used for problem gambling in New South Wales;
- to provide data against which the web-based CCBF Client Data Set can be validated.

An attempt was made to locate and interview all individuals who counsel problem gamblers and their families in relation to gambling problems. The majority of interviews (79%) were conducted in November, 2004. The counsellors were asked about individuals counselled in the preceding week and about appointments for the following week. Altogether, 184 counsellors provided information on 806 individuals counselled in the previous week. Of these, 567 were problem gamblers who received face-to-face counselling. This number is a decrease on the numbers for 2002 (N=672) and 2003 (N=634). The decreasing number of problem gamblers occurs in the context of an increase in the number of counsellors from 2002 (N=147) to 2004 (N=184). Only one agency reported a waiting list for individuals seeking help.

The demographic characteristics of problem gamblers receiving counselling have remained relatively constant from year to year. Thus, in 2004 the profile consisted of:

- more males (63%) than females (37%);
- more in Sydney (58%) than outside Sydney (42%);
- a mean age of 42 years (a trend from 39 years in 1998);
- 77% English-speaking-background, 13% combined non-English-speaking-European-background, 7% Asian background, and 2% Aboriginal Australian;
- having poker machines as the primary cause of problems (86%); wagering on horses and dogs (8%), casino games excluding machines (2%), and sports betting (2%);
- 30% of all referrals made by G-Line.

Counsellors rely heavily on the established methods of problem gambling assessment. Approximately equal numbers of counsellors use a version of the South Oaks Gambling Screen or a method based on the DSM-IV criteria. Counsellors do not report using the newly developed screens such as the Canadian Problem Gambling Index (N=2) and the Victorian Gambling Screen (N=2). Of the counsellors who treat problem gambling (excluding financial and legal counsellors), 20% do not assess the level of problem gambling.

Counsellors are roughly equally divided concerning whether the primary cause of problem gambling is escape from problems elsewhere in the lives of the individuals (43%) or addiction to the excitement of the gambling itself (32%). Many counsellors believe that problem gambling has multiple causation and 37% employ multimodal treatment strategies. Nevertheless, the predominant approach to treatment is to work with the individual on solving the problems in the life of the individual that are

driving him or her to seek gambling as an escape. Of those counsellors treating problem gambling, 57% do not use a treatment manual at all compared with 17% who report following a written manual. The remainder sometimes refer to a manual.

An important aspect of helping individuals to stop gambling excessively is evaluation of whether or not the treatment has been beneficial. 74% of counsellors report attempts to conduct follow-up evaluations on at least of some of their clients and 55% report attempting to evaluate all clients treated. However, the majority of evaluations are short term (within six months). Only 13% of counsellors report conducting follow-up evaluations more than six months after treatment.

BACKGROUND

Problem gambling is widespread in Australia. The best estimate of the prevalence of this problem is that 2.3% of the adult population is affected (Productivity Commission, 1999). Not all problem gamblers seek treatment from health professionals. Some individuals who reach excessive levels of gambling involvement stop gambling without any professional help whatsoever (Hodgins & El-Guebaly, 2000). Nevertheless, a considerable number of problem gamblers do seek help in ending their excessive gambling and in coping with the problems caused by gambling. In New South Wales, approximately six million dollars is spent annually by the State Government in providing services for problem gamblers and approximately eighty percent of problem gamblers seeking help receive counselling from those services (Annual Survey, 2004).

Since 1997, annual surveys of the numbers of problem gamblers receiving counselling or treatment in New South Wales have been commissioned by the Casino Community Benefit Fund. In general, the numbers of individuals receiving face-to-face counselling in a one week period has been increasing across the seven years in which data has been gathered. Figure 1 shows this trend based on data reported in the Annual Survey for 2003.

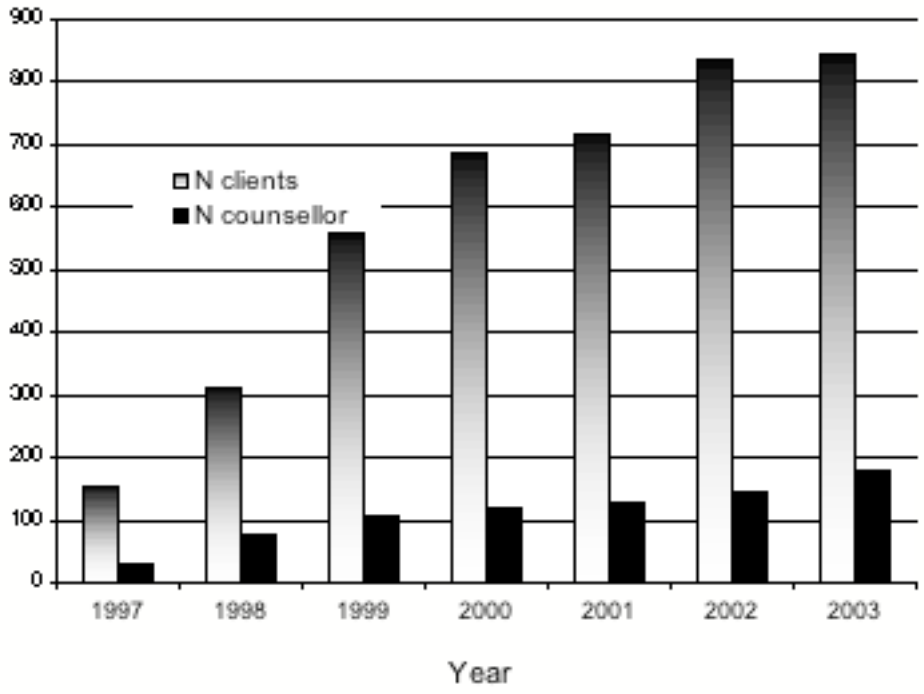

Figure 1: The numbers of individuals receiving face-to-face counselling in relation to problem gambling in NSW (tall columns) and the numbers of counsellors providing those services (short columns).

The Annual Surveys provide information on the demand for services and whether the number of services funded by the State Government is in step with that demand. Such knowledge is important in a time of change, when services are being used to an increasing extent.

An eighth annual survey in 2004 was planned to provide answers to a range of questions. First of all, figure 1 shows that, within the context of increasing numbers of problem gamblers, there may be evidence of a decrease in the rate at which numbers are increasing. For the first time, since 1997, the numbers of individuals counselled in relation to problem gambling did not increase across consecutive years. It is possible that the curve in figure 1 will continue to climb thereby exposing the datum for 2003 as a temporary variation. Alternatively, the curve may continue to plateau suggesting that the need for more services has decreased. Thus, the first question that this survey is intended to answer is whether or not the numbers of individuals afflicted by problem gambling and requiring counselling have continued to increase.

In 2003, a client data set (CDS) was constructed. Throughout New South Wales, agencies funded by the CCBF are required to maintain records of counselling sessions provided and submit these to the Department of Gaming and Racing. In 2004, the submission of client and session data was streamlined by enabling counsellors to use a web-based system to record sessions with clients. The advantages of a client data set with automatic collection of data are numerous. Importantly, the number of new clients treated each year can be assessed accurately. However, the accuracy of the client data set depends on the quality of the data entered. In some agencies, each counsellor enters his or her own data whereas in other agencies, a manager or research assistant enters the data. The second question relevant to the Eighth Annual Survey, concerns the reliability of the CDS data. For a one week period, the data collected by the CDS overlaps the data collected by the Annual Survey. In the Annual Survey the sessions with clients are reported by the counsellor in a face-to-face interview validated by diaries and client files. In the CDS data is entered directly by computer. If the two different methods of data collection yield similar numbers, then confidence in the results obtained by the CDS will be heightened.

Whereas both the CDS and the Annual Survey provide information concerning the demography of problem gambling, the CDS does not record the methods used to assess clients, treat clients or evaluate effectiveness of services. Although some information on assessment and treatment effectiveness is obtained in reports by agencies to the funding body, there is no systematic analysis or collation of data across the agencies. Thus, the Eighth Annual Survey is designed to answer a third set of questions concerning the profile of assessment methods in New South Wales, the different kinds of interventions applied to help clients stop gambling excessively, and the means by which agencies attempt to measure whether their interventions are effective.

Finally, the annual surveys attempt to provide data describing the treatment of problem gambling in face-to-face counselling for the whole of New South Wales. By comparison, the CDS provides data only for those services funded by the State Government.

METHOD

Locating counsellors who provide services for problem gambling

A full list of all services for problem gamblers and their families funded by the CCBF was provided for the survey by the Department of Racing and Gaming. For services not funded by the CCBF, the list compiled in the previous survey (Seventh Annual Survey, 2003) provided a starting point. All agencies from these combined lists were contacted and the relevant counselling staff interviewed. As part of the interview, each counsellor and agency was asked to supply any information available on other services for problem gamblers in the area. Although there is no way of knowing whether all relevant services have been contacted, it is highly unlikely that any primary service for the treatment of problem gambling has been omitted. At the same time, it may well be the case that some counselling of problem gamblers occurs in the context of health and welfare services for target groups where the primary presenting problem is other than gambling. It is assumed that the numbers of problem gamblers lost from the total in this way is relatively small.

Counsellors consenting to be interviewed

Counsellors, employed by auspicing bodies funded by the CCBF, participated as part of their contractual agreement with the CCBF. Counsellors not employed with CCBF funding were approached initially by letter and then by telephone requesting participation. Table 1 shows the numbers of counsellors participating in the survey and the reasons for non-participation of the remainder.

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	194
Counsellors who were interviewed	184
• CCBF funded counsellors	146
• Non-CCBF funded counsellors	38
Counsellors who were not interviewed	10
• Could not be contacted in the survey period - status unknown	2
• On leave during the survey period	4
• No suitable time could be arranged for the interview	2
• Declined to be interviewed	2

Time period in which the survey was conducted

Consistent with earlier surveys, all interviews were scheduled for November 2004. Interviews with CCBF funded counsellors were conducted at this time. However, for administrative reasons, the interviews with non-CCBF funded counsellors were conducted in February 2005.

The interview structure and content

The survey protocol is shown in Appendix 1. Consistent with previous surveys, each interview included questions by the interviewer in six domains concerning:

- clients counselled in the seven days preceding the day of interview;
- clients with appointments in the next seven days after the interview;
- maximum counselling load and waiting lists of the counsellor;
- the methods of assessing clients before treatment;
- the treatment approach directed towards ending excessive gambling;
- the method by which effectiveness of treatment is evaluated.

All interviews were conducted face-to-face with four exceptions where large distances were involved. Interviewers were instructed to seek evidence (for example, the existence of client files or diary entries) validating the numbers of clients counselled and sessions provided.

Interviewer training

The interviewers consisted of postgraduate students with training in interview techniques. Where possible, interviewers with experience in the surveys conducted in previous years were recruited. All interviewers received step-by-step training in the interview administration and one supervised practice interview with a problem gambling counsellor.

RESULTS

Consistent with previous reports of the Annual Survey data, the results provided in the main body of the report are those for all counsellors interviewed in New South Wales and thus provide the population data for the State. Tables based on data provided only by CCBF funded counsellors is shown in Appendix 2.

Numbers of clients receiving counselling

Table 2:
The numbers of clients counselled categorised by funding source and mode of counselling.

Counselling modality	CCBF funded		Other funded		Total	
	N	%	N	%	N	%
Number of Counsellors	146	79	38	21	184	100
Number of Clients (1 week)	714	89	92	11	806	100
Problem Gamblers (1 week)	587	88	82	12	669	100
Face-to-face counselling	669	88	90	12	759	100
• Individual	532	86	86	14	618	100
• Group	137	97	4	3	141	100
Counselling at a distance	45	96	2	4	47	100
• Telephone	45	96	2	4	47	100
• Internet	0		0		0	0

Table 2 shows that altogether 806 clients were counselled in a one week period by the 184 counsellors interviewed. Of the 806 clients, 669 (83%) were problem gamblers and 137 were significant others in the problem gambler's life. Most counselling was conducted face-to-face (95%) in a one-on-one situation (81%). Figure 1 shows the comparison across years of the number of clients (problem gamblers and associated others) counselled in a one week period. The question of whether or not client numbers have continued to increase appears to be answered by the data shown in figure 1. The number of clients has not continued to increase. If the years in which client numbers increased (1997 to 2003) are approximated by the line of best fit, then the number of clients actually counselled in 2004 is significantly lower than the expected number based on extrapolation of the line of best fit. Furthermore, counsellor numbers show no evidence of decrease. Thus, the ratio of clients to counsellors in 2004 (4.1) is lower than the ratio in 2003 (4.7). There are various possible explanations for this change which are examined in the discussion.

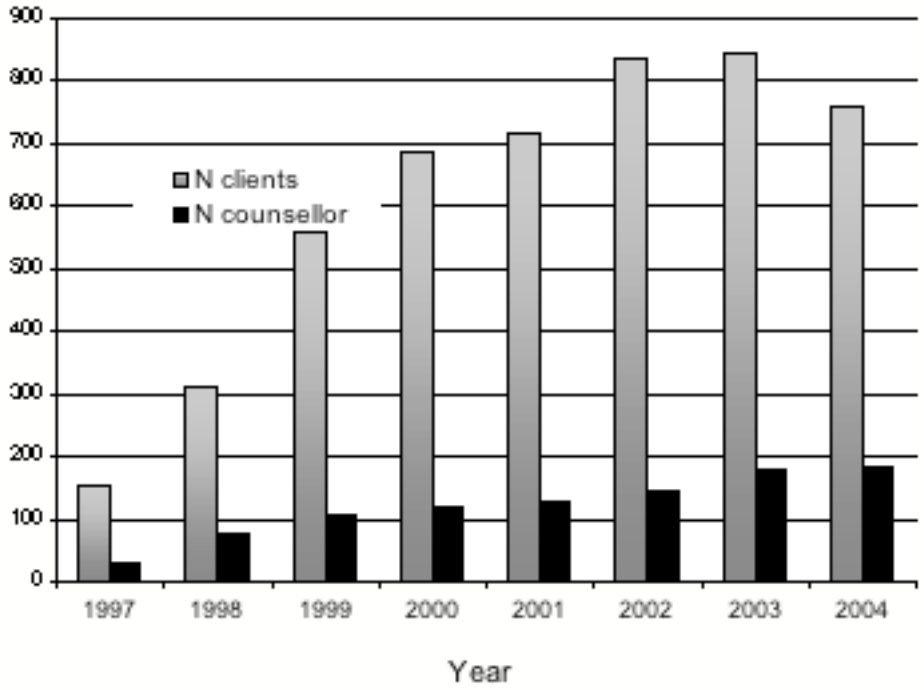

Figure 1: The trend in numbers of clients counselled face-to-face in relation to problem gambling in a one week period.

The different kinds of services provided for problem gamblers

Table 3:
Types of counselling provided for gamblers and their families (%)

	1997 N=154	1998 N=310	1999 N=558	2000 N=686	2001 N=717	2002 N=834	2003 N=843	2004 N=759
Individual								
Addiction	75	77	65	67	68	71	69	66
Financial	10	10	12	6	7	8	4	8
Relationship	15	10	10	5	9	7	7	7
Legal	-	-	-	-	2	2	2	<1
Court assessment	0	3	1	1	<1	0	0	0
Total individual	100	100	88	79	86	88	82	82
Group								
Addiction	-	-	-	15	9	7	12	13
Relationship	-	-	-	6	5	5	6	5
Total group	-	-	12	21	14	12	18	18

Note: Group counselling numbers were combined with addiction counselling numbers in 1997 and 1998

All counselling of individuals other than problem gamblers is categorised as 'relationship'. Thus table 3 shows that 12% of all counselling sessions is with individuals who are not the problem gambler but are affected by the gambling. It follows that 88% of counselling involves problem gamblers. Eight percent is financial counselling and less than one percent is legal advice.

Demographic profile of problem gamblers receiving counselling

Table 4:
Problem gamblers seen individually in face-to-face sessions in the last seven days

N clients receiving counselling		1998 %	1999 %	2000 %	2001 %	2002 N=672 %	2003 N=634 %	2004 N=567 %
Gender	Male	65	61	62	63	59	59	63
	Female	35	39	38	37	41	41	37
Location	Sydney	73	54	55	62	58	54	58
	Rural	27	46	45	38	42	46	42
Average age	All	38	39	38	39	39	40	42
Ethnicity	Anglo-Australian	71	76	68	57	66	64	71
	Other English	4	4	4	10	6	8	6
	NESB non-Asian	17	11	21	21	16	17	13
	Asian	4	6	5	9	8	7	7
	Islander	2	2	1	<1	1	2	<1
	Aboriginal	1	1	1	3	3	2	2
	Other	1	0	0	0	0	0	0
Type of gambling	Racing	12	11	8	6	5	7	8
	Machines	79	83	88	85	87	86	86
	Casino	6	5	2	6	3	1	2
	Numbers	2	1	1	<1	<1	<1	<1
	Sports betting	-	-	<1	<1	<1	<1	2
	Stockmarket	0	0	<1	<1	0	<1	0
	Multiple	1	0	0	2	4	4	2
	Other				<1	<1	1	<1

Note % is calculated excluding 'no data' cases: gender=1, age=1, ethnicity n=1, type of gambling n=6 (for 2004).

The data in table 4 show that within the inherent variability, from year to year the profile of problem gamblers has remained relatively constant across the years 1997-2004. Male problem gamblers receiving counselling continue to exceed female problem gamblers (63% compared to 37%); a majority of problem gamblers reside in Sydney (58%), and the average age is approximately forty years, although a slow trend towards older clients may be worthy of closer inspection. A majority of clients have an Anglo-Australian background (71%). In terms of the likelihood that an

individual will have problems with gambling, the major type of gambling involved is poker machine play (86%). Compared to poker machines, other forms of gambling are associated with low levels of reported problems: racing (8%), casino games excluding poker machines (2%), and sports betting (2%). The year 2004 is the first year in which the proportion of problem gamblers with sports betting as the main cause of problems has risen above one percent.

Problem gamblers with appointments in the coming week

Table 5:
Problem gamblers with appointments for the next seven days

Number of clients with appointments		1998 %	1999 %	2000 %	2001 %	2002 N=481 %	2003 N=531 %	2004 N=527 %
Gender	Male	66	57	61	64	57	63	60
	Female	34	43	39	36	43	37	40
Location	Sydney	72	58	54	59	61	63	61
	Rural	28	42	46	41	39	37	39
Average age	All	39	39	38	40(1)	39(1)	39(1)	41(1)
Ethnicity	Anglo-Australian	67	77	72	63(1)	65	68	68
	Other English	5	3	7	7	5	8	8
	NESB non-Asian	17	12	15	22	18	16	13
	Asian	7	6	3	6	8	5	6
	Islander	1	1	1	<1	1	1	<1
	Aboriginal	1	1	2	2	3	2	4
	Other	2	0	0	0	0	0	0
Type of gambling	Racing	10	10	9	6(1)	5(1)	8(1)	5(1)
	Machines	83	85	90	86	87	84	90
	Casino	6	5	1	4	3	4	2
	Numbers	1	0	0	1	<1	0	<1
	Stockmarket	-	-	0	<1	0	<1	0
	Multiple	-	-	0	2	4	3	<1
	Sports Betting	-	-	-	<1	<1	<1	2
	Other	-	-	-	<1	<1	<1	0

Note: New clients, where it was unknown whether the client was a problem gambler, were excluded from the analyses.

Appointments for the next seven days provide results closely similar to those for the prior seven days. This would be expected since a majority of clients are the same from one week to the next. The number of appointments in 2004 was similar to that in 2003, providing further evidence that client numbers may not be continuing to increase from one year to the next. Of the appointments, 9% are new clients.

Source of Client Referral to Problem Gambling Services

An individual who seeks help in relation to gambling-related problems must make contact with a service in order to receive help. For example, such an individual may search for problem gambling counselling in the local telephone book. As a means of making counselling immediately available to the person who requires it, the CCBF funds a telephone counselling and referral service (G-line). Signs posted in venues and other forms of advertising are means by which individuals can contact G-line. G-line then may refer the individual to specific services located nearby the individual's home address. In practice, individuals seeking help learn of the available services through a wide range of avenues (see table 6). Analysis of reported source of referral is particularly relevant to the evaluation of the G-line initiative. Figure 3 shows the proportion of client referrals accounted for by G-line across the years 1998-2004. The value for 1997 is prior to the establishment of G-line.

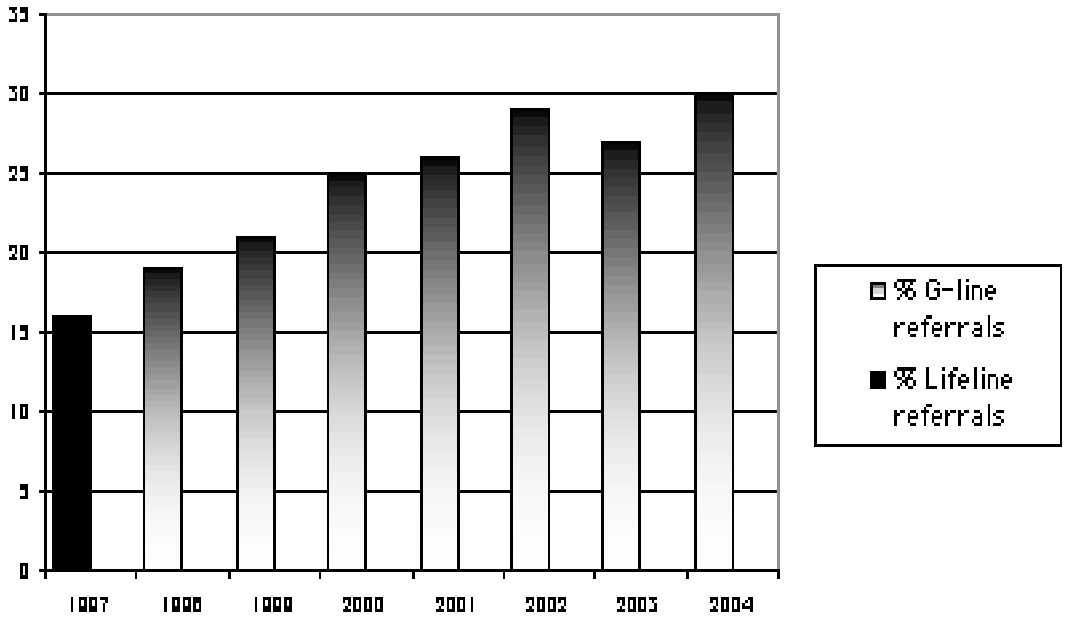

Figure 3: G-line referrals expressed as a percentage of referrals
Note: The G-line referral service was not implemented until after the 1997 survey. Prior to 1998 the main telephone referral service was Lifeline

Table 6 shows that G-line (NSW) (referred to hereafter as 'G-line') is the largest single source of client referrals to problem gambling agencies. G-line was established in 1997 to provide a telephone number which could be advertised throughout New South Wales as a source of help for individuals experiencing gambling-related problems. One of the main reasons initially for the annual surveys was an attempt to monitor the success of the G-line initiative.

Table 6:
Source of Client Referral to Problem Gambling Services

Source of Referral	Last seven days			Next seven days		
	all %	N	%	all %	N	%
Telephone Referral	**30.6**			**28.5**		
• G-line [1]		230	30		207	28
• Lifeline		2	<1		2	<1
Advertising	**9.2**			**9.6**		
• Advertising [2]		47	6		46	6
• Telephone books		18	2		20	3
• Internet		4	<1		4	<1
Individuals	**16.6**			**18.5**		
• Self		12	2		12	2
• Family or friends		105	13		112	15
• Another client of the agency		10	1		12	2
Gambling Related Agencies	**12.6**			**12.2**		
• Another gambling agency		59	8		45	6
• Other counsellor within agency		12	2		18	2
• Gambling industry		26	3		27	4
Non-Gambling Agencies	**23.4**			**20.4**		
• Medical		11	1		16	2
• Parole service		24	3		23	3
• Police		2	<1		0	0
• Legal agent		12	2		6	<1
• Employer		16	2		16	2
• Church		6	<1		6	<1
• Other non-gambling agency		106	14		83	11
Other	**1.1**	8	1	**0.6**	4	<1
Not known	**6.5**	49	6	**10.2**	75	10
Number of clients	**100**	759	100	**100**	733	100

Note: The advertising category excludes G-line advertisements and also excludes advertising of agencies by gambling venues (categorised under 'industry').

Usage and capacity of available counselling services

Capacity is defined as the maximum number of client-sessions that a counsellor can provide in a week while maintaining his or her standards of counselling. It is an estimate of load based on each counsellor's appraisal of own capacity, client profile, and the nature of the service offered. By contrast, usage refers to the actual number of sessions delivered. Availability refers to the number of counselling slots remaining after appointments are subtracted from capacity. To calculate availability, the maximum number of sessions is reduced by the actual number of sessions provided face-to-face and by the number of 'no shows' since the counsellor must be available for a client's appointment whether or not the client actually keeps the appointment. Availability can then be expressed as a percentage of capacity. When a counsellor reaches capacity, the number of additional clients over and above capacity will either be referred to another service or will be placed on a waiting list.

Figure 4 shows usage as a percentage of capacity averaged across counsellors. With the exception of 2002, usage remains relatively constant at just under 50%.

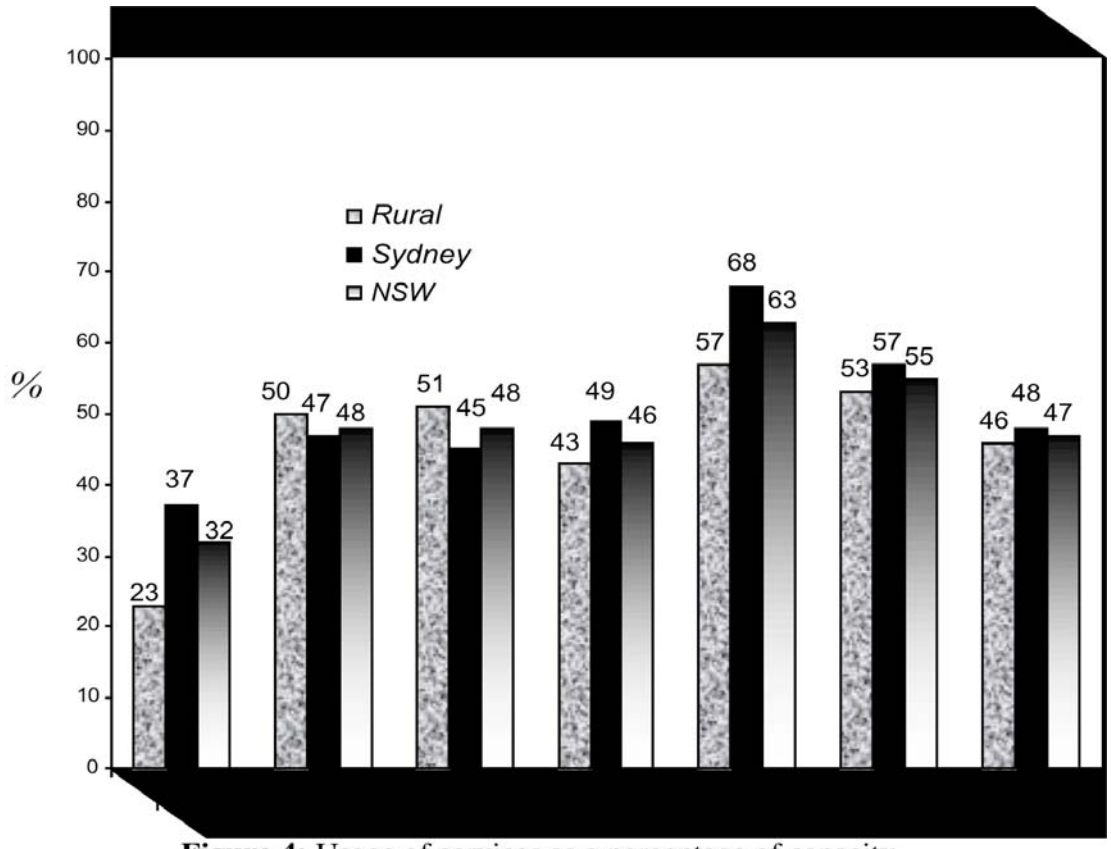

Figure 4: Usage of services as a percentage of capacity.

Table 7:
Usage of services and presence of waiting lists for problem gambling clients

	1997	1998	1999	2000	2001	2002	2003	2004
Usage (% of capacity)	-	32	48	48	46	63	55	47
Availability (% of capacity)	-	-	-	-	-	31	34	44
Number of Counsellors	31	78	105	120	130	147	181	184
Counsellors with waiting lists	7	3	4	3	6	7	8	5
Number of clients waiting	22	24	9	5	21	15	20	7

Table 7 shows the availability of counsellors across the State and the extent to which waiting lists exist for problem gambling services. Availability across the State has increased from 34% in 2003 to 44% in 2004. Availability figures for Sydney and the rest of the State were 41% and 49% respectively. The number of clients on waiting lists has declined from the levels reached in 2001-2003.

Assessment of problem gamblers

One of the important roles of a counsellor in relation to a client involves assessment of the severity of the gambling problem.

Table 8:
Methods used to assess problem gambling

Assessment	N
South Oaks Gambling Screen	
Lifetime	7
Revised	36
Modified	32
DSM Criteria	
DSM Criteria-Questionnaire	18
SCIP –Structured Interview	36
Other Questionnaires	
G-map	29
Gamblers Anonymous 20 Questions	12
Agency questionnaire	22
Victorian Gambling Screen	2
Gambling Symptoms Assessment Screen	6
Canadian Problem Gambling Index	2
Other Questionnaire	15
Other Interview	
Unstructured interview	12
Structured interview	18
No Assessment	31

Two methods have widespread use throughout the world in this regard: The South Oaks Gambling Screen (SOGS) and the criteria of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM). Table 8 shows the frequency with which different methods are used to assess problem gambling.

The total number of methods used exceeds the number of counsellors because some counsellors use multiple methods. The important entry in table 8 is number of counsellors (N=31), who do not assess their clients in any way. Table 9 shows the methods used to assess risk of suicide. In all of the following tables relating to the treatment and assessment of problem gamblers, the financial and legal counsellors were excluded from the analysis, on the basis that they would not be expected to assess problem gambling severity or provide treatment (financial counsellors n=24, legal counsellors n=3).

Table 9:
Method of assessing suicidal tendency

Assessment	N
Determined by interview	
• Structured interview	34
• Unstructured interview	65
• SCIP	3
Inferred from Gambling Questionnaire	
• Beck Depression Inventory	4
• Depression, Anxiety and Stress Scale	16
• Agency Questionnaire	5
• Intake Questionnaire	5
• Other Questionnaire	19
• Lifeline	4
No Assessment	5

Frequently, clients seeking help with gambling problems have other problems as well. These additional problems are comorbid with the gambling problem. Comorbid problems may require referral based on a careful assessment of the nature of the problem experienced by the client. Counsellors were asked whether and how they assess for comorbidities. The results are shown in table 10. Approximately one third of counsellors rely on unstructured interview methods. Such methods generally have no known reliability or validity. Without valid and reliable assessment methods, it may not be possible to determine when a referral should be made or to whom such a referral should be directed.

Table 10:
Assessment of Comorbidities

Assessment	N
Formal Assessment	
DSM criteria	11
Depression Anxiety and Stress Scale	32
Beck Depression Inventory	13
Beck's Hopelessness Scale	2
Beck's Anxiety Scale	3
DAST-20 (Drug Abuse Substance Test)	1
AUDIT (alcohol screen)	5
Substance Abuse Subtle Screening Inventory	3
State-trait Anxiety Index	2
Severity Alcohol Index	2
Personality Assessment Inventory	3
Other Questionnaires	18
Agency Questionnaire	11
Intake questionnaire	5
Structured Interview	9
No Formal Assessment	
Unstructured interview	53
No assessment	28

Treatment approaches used by counsellors to stop excessive gambling

Counsellors were asked whether they set goals for treatment and whether the goal was abstinence or control. A majority of counsellors allowed either abstinence or control depending on the choice of the client (table 11). In general the goal of treatment was negotiated by the counsellor with the client (table 12).

Table 11:
The type of counselling goal

Q "What is the goal for counselling?"	**N**
Abstinence	36
Control	11
Either depending on the client	109
No set goal	0
No response	1
Total	**157**

Table 12:
The setting of treatment goals

Q "How do you set the treatment goal?"	**N**
Counsellor lets the client set the goal	45
Counsellor sets the goal	21
Counsellor and client negotiate goals	89
No response	2
Total	**157**

Counsellors were asked whether or not they followed a treatment manual. A majority of counsellors reported they did not follow a manual for treatment (table 13). However, the absence of a manual does not imply the absence of a theoretical orientation to treatment. The majority of counsellors (74%) reported that they did have a predominant theoretical orientation to treatment (table 14).

Table 13:
Use of a manual to guide treatment

Q "Do you use and follow a written manual?"		**N**
YES		27
NO		89
OTHER:	sometimes	9
	more or less; use manual as a guide but don't follow it	28
	set procedure which is not written down (but could be)	3
No response		1
	Total	**157**

Table 14:
The presence of a predominant theoretical orientation towards treatment

Q "Do you have a predominant theoretical orientation towards treatment?"	**N**
YES	116
NO	40
No response	1
Total	**157**

Analysis of Orientation to Treatment

A theoretical orientation towards treatment follows from a set of beliefs about why a person gambles excessively. As suggested in the Annual Survey for 2003, there are three distinct principles which might explain excessive gambling. Since there are many more treatment methods than these three principles, it follows that treatment methods may be grouped together under theoretical principles.

The first such principle involves escape. According to this view, it is not that the attraction to gambling is so strong but rather that gambling is a convenient escape from problems elsewhere in the individual's life. For example, the individual may have a painful and unhappy relationship with the spouse and may seek respite from the pain involved by gambling for excessive periods of time.

A second principle assumes that gambling excessively is intrinsically linked to excitement. All gambling is designed to be exciting but may be especially so for certain individuals. According to this view, for some individuals gambling is like a drug and the individual becomes addicted to the thrills of gambling. For example, an individual may intend to play a poker machine for only a short period of time. However, the gambling itself is so consuming that possible restraining factors are set aside and the gambling continues to an excessive extent.

Finally, the attraction may not be the excitement as such but the anticipation of winning. If the individual is trying to win money then it follows that mistaken beliefs about gambling are held. Despite the fact that gambling is designed to take money from the gambling public, the excessive gambler remains optimistic that a big win is nearby. Gambling to excess occurs in pursuit of this win. Thus, according to this view the excessive gambling follows from erroneous cognitions held by the individual about gambling.

Depending on the theoretical orientation of the counsellor, so the appropriate form of treatment is determined. If the predominant cause of excessive gambling is escape then the appropriate interventions involve the client coping better with the problems which drive the need to escape. For example, if the individual who gambles to escape a painful relationship with a spouse can resolve the relationship problems, then the need to gamble excessively is decreased.

If the predominant cause is addiction to excitement then treatment may involve both learning how to cope with urges to gamble and weakening or avoiding the stimuli that trigger gambling behaviours. For example, the individual may learn more constructive activities that compete with the urge to gamble and at the same time learn strategies for avoiding gambling triggers such as the sight of the gambling venue, avoiding gambling advertisements and ensuring that spare cash is not readily available.

Finally, if the predominant cause is erroneous expectations of winning then the appropriate treatment will involve a change to more realistic thinking and expectations. For example, close analysis of the type of gambling involved will show that winning in the long term is impossible. Thus, treatment methods might typically involve education about the expectations of different gambling strategies and the reality of a gambling industry based on gamblers' losses.

It is, of course, possible that all three principles are involved in excessive gambling and that one principle is dominant in one client and a different principle is dominant in another. A counsellor who holds such a view might try to discover the mix of factors associated with excessive gambling in each client and then try to devise interventions that are appropriate for the circumstances. Such an approach is frequently labelled multimodal.

In the interview, counsellors were asked to choose from a list, the factors most associated with excessive gambling. The counsellors were asked to rank the factors from the most important to the least important. The factors available in the list were divided between the three principles of escape, addiction and erroneous cognition. Thus, each counsellor could be categorised according to the three principles by the factor chosen as the most important explanation of excessive gambling. The results of such an analysis are shown in table 15.

Table 15:
Treatment categories determined by the primary process of change

Treatment Category (based on primary process of change)	**N**
Escape	66
Addiction	50
Cognition	38
not specified	0
no response	3
Total	**157**

It is clear from table 15 that the most popular treatment category based on the assumed primary process of change is escape. Interestingly, the three-way categorisation scheme adopted accounted for all but three descriptions provided by 157 counsellors. This adds support to the three-way categorisation scheme as a valid and useful conceptualisation of the diverse field of treatment methods. Such a system of classification is likely to facilitate investigation of the effectiveness of different treatment methods.

Categorising a counselling approach based on the main factor causing the gambling may lead to errors. For example, when the counsellor holds a more complex view involving the interplay of multiple factors then categorisation on three main factors is likely to be more accurate than categorisation based on a single factor. For this reason a second analysis was conducted using the three highest ranked factors. If all three processes belong to the same category of treatment (ie. escape, addiction and cognition) then the result is labelled a "pure treatment process". If two out of the three processes belong to the same treatment approach, then the result is labelled a "modal treatment process". All other cases are referred to as "mixed treatment processes". For example, a counsellor who nominates the three main factors involved in excessive gambling as: (1) reducing the excitement or arousal associated with gambling; (2) giving the gambler the skills to deal with the urge to gamble and (3) directing the gambler to attend to opportunities to pursue alternatives would be categorised as having a pure addiction treatment approach. A counsellor who nominates two of these factors would be categorised as using a modal addiction approach. A counsellor who nominates only one of these factors together with one factor from escape and one factor from cognition would be categorised as having a mixed treatment approach. The results of this analysis are shown in table 16.

Table 16:
The frequency with which counsellors fall into different treatment categories based on the three main processes of change

Categories of explanation based on three main processes	**N**
Pure treatment processes	
escape	26
addiction	5
cognition	2
Modal treatment processes	
escape	48
addiction	29
cognition	13
Mixed treatment processes	31
Not specified	0
No response	3
Total	**157**

When categorisation of treatment is based on the three main processes assumed to be operating, the percentage of pure problem formulation and treatment approach is only 21%. A further 20% of counsellors are identified as using mixed treatment processes (a multimodal treatment strategy). The majority of counsellors are identified as using a modal treatment approach involving elements from two treatment categories.

Asking a counsellor to select the main factors causing excessive gambling does not necessarily translate into an appropriate treatment strategy. It is important to examine more closely the interaction between the counsellor and the client in a given case to determine whether the theoretical causes and the treatment provided are consistent. Each counsellor was asked to describe the program for a recent client who had completed treatment. The counsellor was asked to explain how he or she formulated the problem and the approach used to help the individual cut back or stop gambling. Unlike previous questions, the responses of counsellors could not be categorised without some form of content analysis. Content analysis was achieved by training interviewers to recognise the principles of escape, addiction, and erroneous cognition in the case description provided by the counsellor and then make a judgement at the end of the interview.

Table 17 shows the consistency of problem formulation and treatment approach based on counsellor descriptions of single cases. The category ‘escape treated as escape’ refers to a counsellor formulation in terms of the client escaping to gambling from problems elsewhere in their life and a treatment approach involving working with the client towards solutions to the identified problems. Similarly, the categories ‘addiction treated as addiction’ and ‘cognition treated as cognition’ refer to consistent problem formulations and treatment approaches. Alternatively, a counsellor may identify multiple causes of gambling in the case formulation but adopt a specific treatment approach (escape, addiction, cognition). These categories are identified as involving multiple causes and a single treatment approach (eg. ‘multi-cause treated as escape’). Again, the counsellor may identify multiple causes and adopt a variety of different treatment methods. In this case the treatment approach is identified as ‘multi-cause treated as multimodal’.

Table 17:
Treatment approach as a function of problem formulation

	N
Singular cause	
escape treated as escape	70
addiction treated as addiction	7
cognition treated as cognition	7
Multiple causes	
multi-cause treated as escape	4
multi-cause treated as addiction	3
multi-cause treated as cognition	0
Multi-cause treated as multimodal	57
Not specified	6
No response	3
Total	**157**

When single cases are analysed, nearly 50% of counsellors formulate the problem in terms of escape and treat the gambling problem appropriately for that formulation. The other major category involves identifying multiple causes and using a multimodal treatment strategy. Thus, at the level of single cases there is a degree of coherence in formulation and treatment which is not present at the more general level of identifying causative processes and deriving treatment approaches.

Evaluation of the effectiveness of treatment after elapsed time

Counsellors were asked whether their clients were assessed for continued gambling and problem gambling at some period of time after completion of treatment.

Table 18:
The length of time following completion of treatment
at which follow-up evaluation is conducted

Time interval to follow up	N
Less than 1 month	7
1 month	18
1 – 3 months	20
Three months	2
3 – 6 months	21
Six months	28
Nine months	1
Twelve months	12
Two years or more	4
Follow-up at variable time	3
No follow-up	41
Total	**157**

Table 18 shows the extent to which treatment effectiveness is evaluated by problem gambling counsellors. Financial and legal counsellors were excluded from the analysis on the basis that these counsellors would not normally be expected to provide a treatment for the excessive gambling.

Assessment following completion of treatment may involve all clients beginning treatment, all clients completing treatment, or a sample of these groups. For comparison with the results of published trials, evaluation of all clients entering treatment is the preferred option.

Tables 18 and 19 show that a majority of counsellors do undertake evaluation of clients following treatment (74%) and that the evaluation is based on the full set of clients entering treatment (55%).

Table 19:
Numbers and percentage of counsellors using different approaches to the evaluation of treatment effectiveness.

Assessment	N	%
Conduct follow-up on all clients	86	55
Follow-up clients who give permission	13	8
Follow-up clients that complete treatment	3	2
Follow-up upon clients request	0	0
Follow-up sample of clients	13	8
• Random sample	2	1
• Counsellor chosen sample	11	7
Don't conduct follow-ups	42	27
Total	**157**	**100**

DISCUSSION

Previous surveys in New South Wales have shown a marked increase from one year to the next in numbers of problem gamblers receiving treatment. One of the major reasons for conducting the Eighth Annual Survey was to determine whether the number of individuals seeking counselling in relation to problem gambling has continued to rise. In the Seventh Survey conducted in 2003, there was some evidence that the rapidly increasing numbers of individuals seeking help was beginning to slow. The 2004 results are consistent with the conclusion that the numbers of cases of problem gambling have levelled off. This apparent end to increasing numbers year by year cannot be explained by a decline in the services available. The numbers of counsellors providing services in relation to problem gambling have continued to increase. Furthermore, the decline in rate of increasing numbers is present in the data provided by both CCBF and non-CCBF-funded counsellors. Assuming that the shape of the curve shows a real levelling out effect, rather than a chance fluctuation, then two explanations might be considered: (a) that counselling effectiveness is increasing; or, (b) that the comprehensiveness of network of services available to problem gamblers has reached a stable level.

It may be the case that the treatments provided by counsellors are becoming increasingly effective. The improvement in treatments available may be causing the rate of ending excessive gambling to exceed the incidence of new cases. If it is the case that most counsellors continue in the same line of work for many years (ie. low employment mobility) then the years of experience of the population of counsellors would be expected to be increasing. If that increasing experience is associated with more effective counselling, then increasing numbers of clients may be giving up on gambling excessively. Without effectiveness data on the treatments provided by counsellors, little more can be said about this possibility.

The second possible explanation is that the increasing numbers of clients in previous years were associated with the expansion of counselling services into new areas and the strengthening of services in existing areas. An increasing network of services would provide greater accessibility to services up to a point. Once a state-wide network of services was in place, increasing accessibility would no longer be an important factor driving client numbers higher. If this explanation has some validity, then the case for further expansion of services is weakened.

In other respects, the results of the Eighth Annual Survey are similar to those obtained in previous surveys. Poker machines continue to be the main cause of problem gambling. Consistent with the population distribution of New South Wales, more problem gamblers are counselled in Sydney than in the combined non-Sydney regions. Males continue to outnumber females in attending counselling services. Large changes to the demographic features of problem gambling would not be expected from one year to the next.

The dominant conceptualisation of the cause of problem gambling is that the behaviour is an escape from other problems in the life of the individual. Treatment frequently focuses on the resolution of these problems using a multimodal treatment plan.

References

American Psychiatric Association (1995). *Diagnostic and Statistical Manual of Mental Disorders (4th ed.)*. Washington, DC.

Hodgins, D.C. El-Guebaly, N. (2000). Natural and treatment-assisted recovery from gambling problems: A comparison of resolved and active gamblers. *Addiction, 95*(5), 777-789.

Productivity Commission (1999). *Australia's gambling industries*. Canberra: Commonwealth of Australia.

Walker, M.B. (2000). *Problem Gamblers Receiving Counselling or Treatment in New South Wales: Fourth Survey*. Report to the Casino Community Benefit Fund Branch.

Walker, M., Shannon, K., Blaszczynski, A, Sharpe, L. (2003). *The Seventh Annual Survey of Problem Gamblers Receiving Treatment in New South Wales*. Report to the Casino Community Benefit Fund Branch.

Appendix 1 **Counsellor Interview Schedule 2004**

Name of Service Provider (Agency):_____
(Counsellor Name &
Agency Name & Address) _____

Date of interview:_____ Interviewer: _____

Counsellor's Weekly Hours of Employment:_____ Counselling Hours:_____
(Please specify number of hours dedicated specifically to gambling counselling & related activities (eg. Writing up of case notes etc.)

Gamblers Currently Receiving Treatment

(Last 7 days; kept appointment/phone/self-help)

___ / ___ / ___ to ___ / ___ / ___

	Gender	Age	Ethnicity	Source of Referral	Counselling Service	Type of gambling	Other Agency	Suburb / Or P/C
1.								
2.								
3.								
4.								

	Gender	Age	Ethnicity	Source of Referral	Counselling Service	Type of gambling	Other Agency	Suburb / or P / Code
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								
16.								

NB: Validation required, e.g., log or other record.

Gamblers Currently Receiving Treatment

(Next 7 days; have appointment)

___ / ___ / ___ to ___ / ___ / ___

	Gender	Age	Ethnicity	Source of Referral	Counselling Service	Type of gambling	Other agency	Town / Suburb Or P / C
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

NB: Validation required, e.g., record of appointment in diary.

How many gamblers are you currently treating (est.)? N= ____
[i.e. -what is your current case load?

What is your capacity in terms of the maximum number of problem gamblers that you can treat adequately per week? ____

Gamblers Currently on Waiting List

Number of days since they asked for treatment until today is:

1. _____	2. _____	3. _____	4. _____	5. _____
6. _____	7. _____	8. _____	9. _____	10. _____
11. _____	12. _____	13. _____	14. _____	15. _____
16. _____	17. _____	18. _____	19. _____	20. _____
21. _____	22. _____	23. _____	24. _____	25. _____

N= _____

Assessment

Do you assess the severity of problem gambling? Y/N
If Y, how (List names of tests or screens eg SOGS, DSM-IV)

_____

Do you assess whether or not there is a risk of suicide? Y/N
If Y, how (List names of tests or screens; indicate ad hoc)

_____

Do you assess any clinical conditions other than problem gambling? Y/N
If Y, which ones and how are they assessed?

_____

Evaluation

Does your agency (or do you) follow up the clients you have counselled to see if their gambling has decreased? Y/N
If Y, do you attempt to follow-up all of your clients? Y/N
If N, what proportion do you attempt to followed up _____ and how are they selected?

_____

If Y, when is the follow up conducted (how long after counselling has finished?) _____ (weeks/months/years)
How is the level of gambling and associated problems assessed at follow up?
(a) assessed by response to letter of enquiry
(b) assessed by general enquiry over telephone
(c) assessed by questionnaire (List questionnaires)

_____

(d) assessed in other ways (List ways)

_____

Treatment Interview

I'd like to ask you some questions now about how you help a gambler to cut back or stop gambling

1. What is the goal for counselling?

___ Abstinence

___ Control

___ Either depending on the client

___ No set goals (skip to question 3)

2. How do you set the treatment goal?

___ Counsellor lets the client set the goal

___ Counsellor sets the goal

___ Counsellor and client negotiate goals

3. Do you use and follow a written manual?

___ Yes-Details _____

_____

[Obtain copy if possible]

___ No

___ Sometimes [Details above]

___ More or less- use manual as a guide but don't follow it closely [Details above]

___ Set procedure which is not written down (but could be)

4. Is there a systematic sequence of components or strategies that you use with each client?

___ Yes (Skip to Question 5)
___ No
___ For some gamblers YES and for others NO

5. Do you deal with issues as they arise, session by session?

___ Yes
___ No

6. Do you have predominant theoretical orientation towards treatment?

___ Yes- Name of approach _____
___ No

7. Thinking about the main process of helping the gambler cut back or stop, which of the following is the main or central process operating?
   [If there are several processes operating, focus on the main one (mark as 1), then the others in order of importance (2, 3 etc)]

   (a) ___ extinguishing the gambling response by conditioning processes
   (b) ___ reducing the excitement or arousal associated with gambling
   (c) ___ reducing problems elsewhere in the gambler's life
   (d) ___ increasing the gambler's problem-solving skills in general
   (e) ___ increasing the gambler's social skills in general
   (f) ___ changing the gambler's constructs about him/her self as a gambler
   (g) ___ directing the gambler to attend to opportunities to pursue alternatives
   (h) ___ educating the gambler about gambling probabilities and risks
   (i) ___ convincing the gambler that they can't win at gambling
   (j) ___ making salient the harm the gambler is causing family and friends
   (k) ___ working through the grief and guilt that is driving the gambling
   (l) ___ giving the gambler the skills to deal with the urge to gamble
   (m) ___ showing the gambler gambling strategies that are less dangerous
   (n) ___ showing the gambler how gambling is being used as avoidance

8. Choose a client with whom they have recently completed treatment. Briefly describe the treatment given (ie how they tried to help the client cut back and stop gambling)

_____
_____
_____
_____
_____
_____

Appendix 2

Table 1:
The different kinds of counselling to problem gamblers and their families at CCBF agencies

	2001		2002		2003		2004	
	N	%	N	%	N	%	N	%
Individual								
Addiction	441	66	525	69	502	69	440	66
Financial	49	7	63	8	25	3	41	6
Relationship	63	9	59	8	54	7	45	7
Legal	19	3	15	2	20	3	6	<1
Assessment	2	<1	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0
Total	574	86	662	87	601	82	532	79
Group								
Addiction	58	9	56	7	88	12	100	15
Relationship	32	5	39	5	45	6	37	6
Total	90	14	95	13	133	18	137	21
Overall Total	664	100	757	100	734	100	669	100

Table 2:
Problem gamblers seen individually in face-to-face sessions in the last seven days at CCBF agencies

Number of clients receiving counselling		2001 N=511 %	2002 N=603 %	2003 N=547 %	2004 N=487 %
Gender	Male	63	59	59	63(1)
	Female	37	41	41	37
Location	Sydney	63	60	56	56
	Rural	37	40	44	44
Average age	All	39	39	41	42(1)
Ethnicity	Anglo-Australian	57	64	65	70(1)
	Other English	9	6	7	7
	NESB non-Asian	21	16	17	13
	Asian	10	9	7	7
	Islander	<1	1	2	<1
	Aboriginal	3	4	2	2
	Other	0	0	0	0
Type of gambling	Racing	6	5	8(1)	7(1)
	Machines	84	86	86	86
	Casino	6	3	1	2
	Numbers	<1	1	<1	<1
	Stockmarket	<1	0	<1	0
	Multiple	2	4	3	2
	Sports betting	<1	<1	<1	2
	Other	<1	<1	1	<1

Note: Percentages are calculated excluding the category 'unknown'; gender n=1, average age n=1, ethnicity n= 1, type of gambling n=4)

Table 4:
Problem gamblers with face-to-face appointments for the next seven days at CCBF funded agencies

Number of clients receiving counselling		2001 N=416 %	2002 N=449 %	2003 N=478 %	2004 N=463 %
Gender	Male	64	58	63	60
	Female	36	42	37	40
Location	Sydney	58	61	64	60
	Rural	42	39	36	40
Average age	Full sample (yrs)	39	39	40	41(1)
Ethnicity	Anglo-Australian	63	64	67(1)	67(1)
	Other English	7	5	7	9
	NESB non-Asian	22	18	18	13
	Asian	6	8	5	6
	Islander	<1	1	1	<1
	Aboriginal	2	4	2	4
	Other	0	0	0	0
Type of gambling	Racing	6	5	9(1)	4(1)
	Machines	86	86	84	90
	Casino	4	4	4	2
	Numbers	1	<1	0	<1
	Stockmarket	<1	0	<1	0
	Multiple	2	4	2	1
	Sports Betting	0	<1	<1	2
	Other	<1	<1	<1	0

Note: New Clients (where it was unknown whether the client was a problem gambler) were excluded from the analysis (2003 assessments n=34). (1) Percentages are calculated excluding the category 'unknown' (age n=10 ethnicity n=11, type of gambling n=6)

Table 5:
Source of referral for all clients treated in a seven-day period in 2003 at CCBF agencies

Source of Referral	Last seven days			Next seven days		
	all %	N	%	all %	N	%
Telephone Referral	**31.9**	213	32	**29.8**	197	30
• G-line [1]		1	<1		1	<1
• Lifeline						
Advertising						
• Advertising [2]	**8.5**	40	6	**8.8**	41	6
• Telephone books		13	2		14	2
• Internet		4	<1		4	<1
Individuals						
• Self	**17.5**	10	2	**18.3**	11	2
• Family or friends		97	14		100	15
• Another client of the agency		10	2		10	2
Gambling Related Agencies						
• Another gambling agency	**12.5**	56	8	**12**	45	7
• Other counsellor within agency		11	2		15	2
• Gambling industry		16	2		19	3
Non-Gambling Agencies						
• Medical	**23.2**	9	1	**20.6**	11	2
• Parole service		21	3		20	3
• Police		2	<1		0	0
• Legal agent		10	2		5	<1
• Employer		16	2		16	2
• Church		5	<1		6	1
• Other non-gambling agency		92	14		78	12
Other	**6.4**	2	<1	**10.5**	1	<1
Not known		41	6		69	10.4
Number of clients	**100**	669	100	**100**	663	100

Note: The advertising category excludes G-line advertisements and also excludes advertising of agencies by gambling venues (categorised under 'industry').

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

	2001	2002	2003	2004
Number of Counsellors	130	133	153	146
Counsellors with waiting lists	5	7	7	3
Number of clients waiting	18	15	16	5

Table 8:
Tests used to measure problem gambling at CCBF agencies

Assessment	N
South Oaks Gambling Screen	
SOGS	7
Lifetime	32
Revised	24
Modified	
DSM Criteria	
DSM Criteria-Questionnaire	17
SCIP –Structured Interview	36
Other Questionnaires	
G-map	27
Gamblers Anonymous 20 Questions	8
Agency questionnaire	17
Intake questionnaire only	2
Victorian Gambling Screen	2
NODS/NORC	3
Gambling Symptoms Assessment Screen	3
Canadian Problem Gambling Index	2
Other Questionnaire	9
Wesley Questionnaire	2
Other Interview	
Unstructured interview	11
Structured interview	10
No Assessment	23

Note: Financial and legal counsellors were excluded from the analysis, as they did not complete the treatment interview (financial counsellors n=12, legal counsellors n=3)

Table 9:
Method of assessing suicidal tendency at CCBF agencies

Assessment	N
Determined by interview	
• Structured interview	27
• Unstructured interview	51
• SCIP	3
Inferred from Gambling Questionnaire	
• Beck Depression Inventory	3
• Depression, Anxiety and Stress Scale	13
• Agency Questionnaire	5
• Intake Questionnaire	5
• Other Questionnaire	19
• Lifeline	3
No Assessment	5

Note: Financial and legal counsellors were excluded from the analysis, as they did not complete the treatment interview (financial counsellors n=12, legal counsellors n=3)

Table 10:
Assessment of Comorbidities at CCBF agencies

Assessment	N
Formal Assessment	
DSM criteria	8
Depression Anxiety and Stress Scale	23
Beck Depression Inventory	12
Beck's Hopelessness Scale	2
Beck's Anxiety Scale	2
DAST-20 (Drug Abuse Substance Test)	1
AUDIT (alcohol screen)	4
Substance Abuse Subtle Screening Inventory	2
State-trait Anxiety Index	2
Severity Alcohol Index	2
Personality Assessment Inventory	2
Other Questionnaires	14
Agency Questionnaire	11
Intake questionnaire	4
Structured Interview	7
No Formal Assessment	
Unstructured interview	43
No assessment	25

Note: Financial and legal counsellors were excluded from the analysis, as they did not complete the treatment interview (financial counsellors n=12, legal counsellors n=3)

Table 11:
The type of counselling goal used by counsellors at CCBF agencies

Q "What is the goal for counselling?"	**N**
Abstinence	32
Control	9
Either depending on the client	89
No set goal	0
No response	1
Total	**131**

Note: Financial and legal counsellors were excluded from the analysis, as they did not complete the treatment interview (financial counsellors n=12, legal counsellors n=3)

Table 12:
The setting of treatment goals by counsellors at CCBF agencies

Q "How do you set the treatment goal?"		**N**
YES	Counsellor lets the client set the goal	33
NO	Counsellor sets the goal	19
OTHER	Counsellor and client negotiate goals	77
No response		2
	Total	**131**

Note: Financial and legal counsellors were excluded from the analysis, as they did not complete the treatment interview (financial counsellors n=12, legal counsellors n=3)

Table 13:
Use of a manual to guide treatment by counsellors at CCBF agencies

Q "Do you use and follow a written manual?"		**N**
YES		25
NO		69
OTHER:	sometimes	7
	more or less use manual as a guide but don't follow it	27
	set procedure which is not written down (but could be)	2
No response		1
	Total	**131**

Note: Financial and legal counsellors were excluded from the analysis, as they did not complete the treatment interview (financial counsellors n=12, legal counsellors n=3)

Table 14:
The presence of a predominant theoretical orientation towards treatment at CCBF agencies

Q "Do you have a predominant theoretical orientation towards treatment?"	**N**
YES	99
NO	31
No response	1
Total	**131**

Note: Financial and legal counsellors were excluded from the analysis, as they did not complete the treatment interview (financial counsellors n=12, legal counsellors n=3)

Table 15:
Treatment categories determined by the primary process of change at CCBF agencies

Treatment Category (based on primary process of change)	N
Escape	57
Addiction	43
Cognition	27
not specified	1
no response	3
Total	**131**

Note: Financial and legal counsellors were excluded from the analysis, as they did not complete the treatment interview (financial counsellors n=12, legal counsellors n=3)

Table 16:
The frequency with which counsellors fall into different treatment categories based on the three main processes of change at CCBF agencies

Treatment categories based on the three main processes of change	N
Pure treatment processes	
escape	22
addiction	3
cognition	2
Modal treatment processes	
escape	42
addiction	27
cognition	10
Mixed treatment processes	22
Not specified	0
No response	3
Total	**131**

Note: Financial and legal counsellors were excluded from the analysis, as they did not complete the treatment interview (financial counsellors n=12, legal counsellors n=3)

Table 17:
Treatment approach as a function of problem formulation at CCBF agencies

	N
Singular cause	
escape treated as escape	61
addiction treated as addiction	6
cognition treated as cognition	6
Multiple causes	
multi-cause treated as escape	4
multi-cause treated as addiction	3
multi-cause treated as cognition	0
Multi-cause treated as multimodal	42
Not specified	6
No response	3
Total	**131**

Note: Financial and legal counsellors were excluded from the analysis, as they did not complete the treatment interview (financial counsellors n=12, legal counsellors n=3)

Table 18:
The length of time following completion of treatment
at which follow-up evaluation is conducted at CCBF agencies

Time interval to follow up	N
Less than 1 month	16
1 month	7
1 – 3 months	13
Three months	19
3 – 6 months	2
Six months	22
Twelve months	11
Two years	3
Follow-up at variable time	3
No follow-up	35
Total	**131**

Note: Financial and legal counsellors were excluded from the analysis, as they did not complete the treatment interview (financial counsellors n=12, legal counsellors n=3)

Table 19:
Numbers and percentage of counsellors using different approaches to the evaluation of treatment effectiveness at CCBF agencies

Assessment	N	%
Conduct follow-up on all clients	72	55
Follow-up clients who give permission	9	7
Follow-up clients that complete treatment	3	2
Follow-up upon clients request	0	0
Follow-up sample of clients	12	9
• Random sample	2	1
• Counsellor chosen sample	10	8
Don't conduct follow-ups	35	27
Total	**131**	**100**

Note: Financial and legal counsellors were excluded from the analysis, as they did not complete the treatment interview (financial counsellors n=12, legal counsellors n=3)