Gambling Support Program

Research Report

Evaluation of Therapeutic Counselling; Break Even Gambling Support Services in Tasmania

Department of Health and Human Services

Tasmania
Explore the possibilities

Acknowledgements and authorship

Research Report: Evaluation of Therapeutic Counselling; Break Even Gambling Support Services in Tasmania.

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Preamble:

This research was conducted as part of Tasmania's Integrated Gambling Framework which brings together government, stakeholders from the gambling industry and the community with the aim to maximise the benefits from legal gambling while minimising the impacts of any negative social consequences.

This project was conducted by the Gambling Support Program (GSP), a business unit within Disability, Housing and Community Services (DHCS), Tasmanian Department of Health and Human Services (DHHS).

The GSP is responsible for gambling-related community education, social and harm minimisation policy and research, and administration of the Tasmanian Health and Wellbeing Fund and The Charitable Organisations Grants Program.

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- Break Even clients and counsellors who participated in the research.

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Executive Summary

The aim of this report is to provide insight into Break Even Gambling Support Services (BE Services). This includes a program evaluation of the BE therapeutic counselling, and review of suggestions for improvement of these services.
BE Services are operated by contracted service providers under the administration of the Gambling Support Program, Department of Health and Human Services and provide:

- therapeutic counselling for individuals, couples and families;
- financial counselling;
- facilitated group support;
- an online counselling and self-help service; and
- a 24 hour helpline.

The research involved surveying BE clients and BE counsellors who presented to the service with gambling problems. Clients were invited to provide information relating to their gambling, including gambling frequency and expenditure prior to the commencement of counselling and following the cessation of counselling. Clients were also invited to provide:

- demographic information;
- information relating to known correlates of problem gambling, such as mental health concerns, drug and alcohol use, perceived quality of life; and
- feedback relating to client satisfaction with the counselling service.

Counsellors were invited to provide information pertaining to four domains:

- the theoretical orientation of counselling;
- methods used in diagnosis and case formulation;
- case management and related issues; and
- counselling outcomes.

The report begins with a review of therapy approaches (p.4-17) outlining established and accepted therapy approaches to problem gambling intervention that are found

within the research literature. Where available, research on therapy approach efficacy for problem gambling is cited.

Following this, within the method section (p.20-24), particular attention is paid to the process of recruitment for the client sample, and the consequences of this process are also examined. Briefly, it was estimated that the sample of clients (N=41) was not representative of the population of BE clients as a whole, rather it appeared to represent more particular sub-groups of the BE client population. After discussing the methodology employed for both counsellor and BE client surveys, the method section concludes by outlining some characteristics of the chosen sample of BE clients.

The report then presents the results and conclusions of:

i. the BE client survey; and
ii. the counsellor survey.

i. The vast majority of clients within the BE client sample reported a positive response to counselling as indicated by significant decreases from pre- to post-counselling (3.6 → .2 sessions/week), the amount of money lost gambling per week ($2,102 → $152 /week), and in mean South Oaks Gambling Screen scores. From this sample, the client experience and outcomes related to BE services are considered to be highly positive. However the results should be treated with caution with regards to generalising beyond the BE client survey sample. This is because the survey pertains specifically to BE clients who were: agreeable to post-counselling contact by BE services; judged to not be at risk due to contact; contactable; and agreeable, in principle, to being involved in research related to problem gambling counselling. Furthermore as 95% of the client sample reported electronic gaming machines (EGMs) as their primary gambling activity, the results of the study are generally applicable to BE clients whose primary gambling activity is playing EGMs.

ii. From the counsellor survey, the Tasmanian counselling interventions can be considered to be sound, responsive and in line with best practice Australian service

delivery. The counsellor survey responses indicated that counsellors are basing their counselling on established and accepted theoretical approaches to intervention for problem gambling, including cognitive-behavioural therapy, motivational interviewing, stages-of-change or trans-theoretical model, person-centred therapy, and solution-focused therapy. Furthermore counsellors reported that, consistent with research, their understanding of the problem gambling client population is that it is heterogeneous in profile and thus counsellors' case formulation tends to be 'individually-tailored', based on the needs of the client. In this sense the counselling approach reported by the counsellor sample as a whole could be described as 'eclectic' or 'integrative', in that counsellors draw on different theoretical approaches and techniques from different theoretical approaches to match the needs of the clients.

In considering the client survey and the counsellor survey results together, the BE services are considered to be effective. However the limitation of the client sample, in terms of selection and size, also limits the conclusions that can be reached. The report responds to this by discussing options for obtaining a fully representative sample of clients at a later stage.

Review of therapy approaches

There are many and varied definitions of problem gambling. The *Productivity Commission, Gambling, Draft Report* contains the following definition:

> *"Problem gambling is characterised by difficulties in limiting money and/or time spent on gambling which leads to adverse consequences for the gambler, other, or for the community (Neal, et al. 2005, p. i)."* (2009: 3:10).

Problem gambling has frequently been defined as a mental illness, as is the case with the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV).* In the United States in particular, the medical model of problem gambling has been widely adopted. However in Australia, researchers and help professionals have rarely characterised problem gambling as strictly a medical problem, instead problem gambling is predominantly understood to be a public health issue with psychological and sociological dimensions.

Therapy modality and problem gambling

The Australian Psychological Society (APS), in its position statement review paper, *Psychological Aspects of Gambling Behaviour* states, "there is no single intervention modality that is the 'gold standard' or 'best practice' in the management of problem gambling" (1997: 21). Furthermore the *Productivity Commission, Gambling, Draft Report* (2009) states that "while cognitive behavioural therapy has the most empirical support, no one style of intervention is necessarily best practice" (5.1). There is wide consensus that the knowledge base of what constitutes effective treatment of problem gambling lags behind other fields. Indeed Orford (2003) has estimated the knowledge of treating problem gambling to be approximately 20-30 years behind that of substance abuse treatment. Numerous meta-analysis reviews have concluded that there exists no treatment that meets the current standard of evidence for treatment efficacy (Westphal, 2008; Walker, 1992; Blaszczynski & Silove,1995; Lopez Viets & Miller, 1997; Oakley-Brown, Adams & Mobberley, 2004; Toneatto & Ladouceur,

2003; Abbott, Vollberg, Bellringer & Reith, 2004; Toneatto & Millar, 2004; Gooding & Tarrier, 2009). This reflects, in part, the complex nature of the problem and the difficulty in measuring what works.

The research body on problem gambling treatment effectiveness has been plagued by methodological limitations including: small sample size; no control group; multiple concurrent interventions; poorly defined outcome criteria (Blaszczynski & Silove, 1995); non-randomised control groups; and the lack of independently conducted replication studies (Toneatto & Ladouceur, 2003), which prevents any one treatment approach as being described as 'efficacious'. However, there exists much research which can be described as meeting methodological criteria, allowing the use of the description: 'possibly efficacious' (Toneatto & Ladouceur).

The APS states that problem gambling is a treatable condition and that successful treatment should address ecological, psychophysiological, developmental, cognitive and behavioural components which are thought to interact in a complex dynamic in the processes which lead to problem gambling.

The APS suggests the following as minimal requirements for intervention in problem gambling:

- "Counselling or psychological intervention must be competently delivered by appropriately trained clinicians.
- Only an intervention whose effectiveness is supported by empirical research should be used.
- The most appropriate minimal and non-intrusive approach should be applied in the first instance.
- Comorbid primary conditions must be diagnosed and treated accordingly.
- Relapse prevention strategies should be included to help avoid recurrence of problems."

Within the literature on treatment for problem gambling, the majority of treatment approaches described fall within a broad spectrum of cognitive-behavioural therapies, however other approaches described are: psychodynamic, psychoanalytic, Gamblers

Anonymous, self-help, multimodal and eclectic treatments (Ledgerwood & Petry, 2005; Pallesem, Mitsem. Kvale, Johnsen & Molde, 2005; Toneatto & Ladouceur, 2003; in Gooding & Tarrier, 2009).

Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) has been applied with success to a broad range of psychological/psychiatric disorders (Tarrier, 2006), including disorders of addiction and repetitive impulse driven behaviours (APS, 1997). Much of the therapy approaches used to treat problem gambling at present, as well as for other mental disorders, are cognitive-behavioural in nature (Petry, 2005). Walker (2005) states that CBT is the most common and promising approach for treating problem gambling, and that CBT as a treatment approach in general lends itself well to evaluation.

A main component of CBT for problem gambling is the identification and modification of gambling related thoughts and emotions, including cognitive distortion that increase a person's vulnerability to gambling. Cognitive distortions are considered to fall into three broad categories: misperceptions about randomness of gambling events, illusions of control, and superstitions (Ladouceur, 2004). An example of a misperception about gambling event randomness is the 'gambler's fallacy'. The gambler's fallacy is "the expectation of a reversal following a run of one outcome" (Roney & Trick, 2009: 197). Tversky and Kahneman's (1971; in Roney & Trick) 'law of small number' has been used to explain the gambler's fallacy. That is, when people make judgements about the probability of uncertain events, they erroneously believe that the balance of random outcomes that occurs in very large samples will also occur in small samples. For example, if a coin is tossed 1,000 times, 50% of those times the outcome will be heads, however within a sample of 10 coin tosses, the outcome may not follow this pattern. Instead the outcome may be seven tails and three heads. The gambler's fallacy occurs when people make the erroneous belief that the probability of tossing a head is more likely following say, a sequence of six tails (Roney & Trick). An illusion of control may manifest in the belief that a win, which in actuality is due to chance, is instead the result of skill, strategy or specific

actions (e.g. playing a favourite EGM or playing with the same lottery numbers each time) by the gambler. Gambling related superstitions may involve taking a 'lucky' item to the gambling venue or deciding to gamble due to feeling lucky, possibly following seeing a 'lucky sign' in the environment (Miller & Currie, 2008).

In addition, CBT approaches may involve teaching and developing strategies and skills aimed at building gambling refusal and relapse prevention. These include assertiveness, problem solving and coping skills training. Furthermore CBT for gambling may involve the reinforcement of non-gambling related activities and interests (Morasco, Ledgerwood, Weinstock & Petry, 2009).

Gooding and Tarrier (2009) conducted the most recent meta-analysis, involving 25 studies, evaluating the effectiveness of cognitive-behavioural therapies. Studies were included if they: were published in a refereed journal; contained a control group; contained a treatment group consisting of a form of cognitive, behavioural or cognitive-behavioural therapy or consisted of cognitive, behavioural or cognitive-behavioural methods as a substantial component of treatment; and contained outcome measures of gambling behaviour or gambling severity indicators. Some studies that contained no control group were included if they contained both pre- and post-counselling measures. The majority of studies, 19 of the 25, involved predominantly male samples. Five studies contained more females than males and one study focused on females only. No study compared males to females in terms of efficacy or effectiveness of treatment. Nineteen studies reported the primary gambling activity of study participants. The primary gambling activities reported were: EGMs in 10 studies, poker in three studies, lottery in four studies, and dog and horse racing in two studies. Gooding and Tarrier identified three variants of CBT across the 25 studies: generic CBT, motivational interviewing[1] with or without CBT, and imaginal desensitisation. All three variants of CBT demonstrated large and significant effects in reducing gambling behaviour and/or problems associated with problem gambling assessed at three months following treatment cessation. As well significant effects were found at six, 12 and 24 month follow-up periods in the studies which

[1] The developers of *motivational interviewing,* William R. Miller and Stephen Rollnick, state that *motivational interviewing* is not a form of *cognitive-behaviour therapy (*Miller & Rollnick, 2009).

reported following-up at these time duration periods. Gooding and Tarrier warn however that the small study numbers at 12 and 24 months limit the robustness of the results from these time periods.

The majority of studies assessed involved the administration of treatment on a one-to-one basis, however six studies used group therapy and in two, self-help workbooks were used. All therapy modes showed significant treatment effect sizes at three month follow-up, however only group therapy was associated with a significant effect size at six months. Gooding and Tarrier concluded that the results of their meta-analysis indicate that CBT provides a treatment approach for problem gambling displaying efficacy. Further they state that this does not mean that other forms of therapy will be ineffectual, rather they speculate that CBT may provide an 'added effectiveness value' (2009: 605). This position is supported by the *Productivity Commission, Gambling, Draft Report* (2009: 5.24) which states: "the best evidence and support, however, is for cognitive-behavioural treatment approaches". The Productivity Commission also highlights research by Toneatto and Ladouceur (2003), which involved CBT delivered via manuals and involving only minimal therapist contact, as being part of this evidence and support.

Pharmacotherapies

Application of effective pharmacotherapy of pathological or problem gambling is complex and is limited by a lack of research demonstrating clear findings. There are a number of factors that complicate the issue. Firstly pathological or problem gambling is a behavioural construct containing great heterogeneity in behavioural manifestation and conceptualised psychopathology. Impulsivity arising from heightened arousal, compulsivity as a means to reduce anxiety, and addiction through withdrawal symptoms are all potential targets for intervention (Hollander, Kaplan & Pallanti, 2004). Neurobiological investigations have implicated multiple neurotransmitter systems (serotonergic, noradrenergic, and dopaminergic) as involved in the etiology of problem or pathological gambling (Shah, Potenza & Eisen, 2004). Decreased serotonin function within the ventromedial prefrontal cortex resulting in behavioural disinhibition and impulsive behaviour has been suggested as a contributing factor in

problem gambling. In addition, the uncertainty and anticipation associated with gambling behaviour is posited to stimulate dopaminergic neurons in the ventral tegmental area, resulting in increased release of dopamine in the nucleus accumbens (Fiorillo, Tobler & Schultz, 2005). This cascade of neurotransmission is similar to that observed in illicit drug addiction and hypothesised to underlie feelings of pleasure or raised excitement.

Further pharmacotherapy strategies involve the use of mu-opioid receptor antagonists to inhibit dopamine release in the nucleus accumbens and ventral pallidum by means of disinhibition of the inhibitory effects of gamma-aminobutric acid on dopamine neurons in the ventral tegmental area. This complex interaction was thought to modulate the excitement and craving related to gambling. However, there remains limited understanding as to the specific mechanisms involved (Grant, Kim & Potenza, 2008). Grant, Kim and Potenza (2008) conducted the most recent review of research on pharmacotherapy for problem gambling. Their findings are summarised below:

Antidepressants

Selective serotonin reuptake inhibitors (SSRIs)

The SSRIs investigated were: *Clomipramine* (in a single case double-blind, placebo controlled design study reporting 90% improvement in gambling urges, thoughts, and behaviour), *Fluvoxamine* (in a single-blind, a double-blind and a double-blind placebo controlled study collectively providing mixed results with respect to efficacy), *Paroxetine* (in two double-blind, placebo controlled studies collectively providing mixed results in regards to efficacy), *Citalopram* (in one study not placebo controlled), and *Escitalopram* (in an initial open label with double-blind placebo controlled discontinuation follow-up study showing improvement in gambling symptoms and anxiety in problem gamblers with co-morbid anxiety).

Atypical antidepressants

Two open label studies examining *bupropion* and *nefazodone* respectively reported improvements in gambling symptoms. However, both were limited in methodological rigour by the lack of placebo controls.

Mood stabilisers

The mood stabilisers investigated were: *Lithium carbonate* (in a double-blind, placebo controlled study of problem gamblers with bi-polar disorder reporting reductions in gambling behaviour), *Valproate* (in a single-blind trial comparing lithium carbonate to *valproate* reporting reductions in gambling symptoms for both with no difference between groups. The main effect was reduced gambling related euphoria), *Carbamazepine* (in a single-blind, placebo controlled case study reporting reduction in gambling behaviour), and *Topiramate* (in a single-blind, comparison study comparing *topiramate* to *fluvoxamine* reported 75% of both treatment groups showing full remission with the remaining showing partial remission of gambling behaviour).

Opioid receptor antagonists

The opioid receptor antagonists investigated were: *Naltrexone* (in a double-blind, placebo-controlled study reporting a reduction in gambling behaviour and intensity and frequency of gambling urges) and *Naltrexone* (in a double-blind, placebo-controlled study reporting improvements in gambling urges, thoughts and behaviours).

Grant, Kim and Potenza (2008) conclude that the results from the studies on SSRIs are mixed, as no placebo-controlled study has been reproduced to demonstrate successful use of an antidepressant to treat problem gambling symptoms. The researchers state that mood stabilisers appear to be effective in controlling gambling symptoms in individuals with co-occurring bipolar spectrum disorders. In relation to opioid receptor antagonists they state that as opioid antagonists operate to block receptors that process pleasure, and that they have been shown extensively to be

effective in treating alcohol dependence, they may be effective in treating problem gamblers with strong urges to gamble, and in problem gamblers with co-occuring alcohol dependence or a history of alcohol dependence in their family history.

Person-centred therapy (client-centred therapy)

Person-centred therapy, known also as client-centred therapy or Rogerian therapy is a form of psychotherapy developed by Carl Rogers. Person-centred therapy is a non-directive approach to therapy that was developed from the concept of the 'humanistic' approach which 'views people as capable and autonomous, with the ability to resolve their own difficulties, realise their potential, and change their life in positive ways' (Seligman, 2006). The focus of person-centred therapy is on the client being able to develop a greater understanding of themselves in order to resolve their problems without direct intervention by the therapist. The aim of therapy, for Rogers, was not to solve problems but to assist clients in their growth processes so that they are better equipped to deal with current and future problems (Corey, 2008).

The key techniques used by the therapist in person-centred therapy are as follows (summarised from the Australian Institute of Professional Counsellors' (2007) *Five Therapies eBook)*:

Congruence

Congruence reflects the degree to which the therapist is genuine and authentic within the therapeutic relationship with the client. It is important that the therapist is conscious of their body language, what they are communicating as well as remaining 'in the present moment' so that the client is assured that the relationship is built on trust and openness.

Unconditional positive regard

Unconditional positive regard refers to the therapist's acceptance, respect, and care for the client which is fundamental to allowing the client to express themselves freely without concern of being judged. The role of the therapist is to convey the message to the client that they are valued and cared for, independent of what the client expresses.

Accurate empathic understanding

The therapist aims to understand the client's experiences and feeling in a sensitive and accurate fashion as they occur within the moment-to-moment therapy process. The therapist aims to sense the client's feelings and experience as if it were their own without becoming lost in those feelings. This deep and meaningful empathy must be displayed by the therapist so that the client can feel that their therapist has the best possible understanding of their situation and response to it.

Nondirectiveness

As indicated above, person-centred therapy involves a nondirective approach. That is, the therapist does not direct the client or provide solutions for the client. Nor does the therapist provide strategies or activities for the client to follow. Rather the therapist helps provide the environment within which the client can feel empowered to grow.

Gamblers Anonymous

Gamblers Anonymous (GA) is a self-help fellowship modelled after Alcoholics Anonymous (AA). GA proposes that pathological gambling is a disease that can never be cured but only arrested by complete abstinence from gambling. As in AA, 12 principles or steps are followed and members 'work the steps'. These steps include accepting their problem and powerlessness over gambling and surrendering to a 'higher power'. Little literature exists on its efficacy and most conclude that most

members fail to become actively involved in the fellowship (Preston & Smith 1985; Rosecrance, 1988; Taber & Chaplin, 1988; Turner & Saunders 1990). The most detailed study was by Stewart and Brown (1988) who reviewed attendance records from three meetings, over a 16 year period in Scotland. Of the 232 attendees, 52 (22.4%) attended only one meeting, 36 (15.5%) attended only 2 meetings, and of the full sample, 161 (69.4%) attended 10 or fewer meetings, and only 7.5% earned a 1-year abstinence pin. Brown (1986, 1987a, 1987b) reported that gamblers who attend GA appear to differ from gamblers who do not attend GA, with GA attendees being older and more likely to be married. The 10% of gamblers who attend regular meetings with GA tend to have more severe gambling problems. In terms of efficacy, GA seems to be associated with improved outcomes but controlled studies are needed to confirm this. In terms of advice to therapists, referring gamblers who present for professional treatment to GA may assist them to prevent relapse/maintain abstinence, but only a minority of gamblers and only those whose goal is to stop gambling are likely to become involved in the 12-step program (Petry, 2005).

Motivational interviewing

Motivational interviewing is defined as being "a collaborative, person-centred form of guiding to elicit and strengthen motivation to change" (Miller & Rollick, 2009: 137). Motivational interviewing combines a supportive, empathic counselling style derived from Rogerian counselling with a consciously directive method for resolving ambivalence for change (Hettema, Steele & Miller, 2005). There are adaptations of motivational interviewing, the most common of which is Motivational Enhancement Therapy (MET) which combines motivational interviewing with feedback of a person's assessment results.

Motivational interviewing is focused on increasing motivation for change as well as consolidating commitment to change (Miller & Rollnick, 2002). Motivational interviewing does not aim to instil within clients something that may be lacking, as is the case in other therapies, rather it aims to elicit or evoke the client's own motivation for change. This is done through the counsellor evoking and reflecting the

client's own expressions regarding their desire, ability, reason, and need for change. In reflecting and periodically summarising the client's own 'change talk', the counsellor provides the environment for the client to hear their own motivations for change. This method encompasses Bem's self-perception theory (see Bem, 1972) which posits that people commit more so to what they hear themselves defend (Hettema, Steele & Miller).

There is little research on the efficacy of applying motivational interviewing for problem gambling. Diskin and Hodgins (2009) conducted a randomised clinical trial on people who expressed concern about their own gambling and reported moderate to severe gambling behaviour. Results showed that gamblers who participated in one face-to-face session of motivational interviewing reported at 12 months follow-up significantly less spending per month gambling, significantly less days per month spent gambling, and significantly less distress compared to gamblers who participated in a control interview. The control interview involved counsellors providing empathy to participants' reports about gambling yet refraining from utilising any motivational interviewing skills or recommendations for behaviour change. The control group also reported a reduction in gambling problem severity.

Hodgins, Currie and el-Guebaly (2001) conducted research into the efficacy of telephone delivered motivational interviewing with provision of a self-help workbook in comparison to the provision of a work-book alone. They reported that the motivational interviewing was more effective in reducing gambling than the self-help book alone at one, three, and six months post-intervention. While at 12 months post-intervention the groups no longer differed, Hodgins, Currie, el-Guebaly and Peden (2004), in a continuation of the research reported that at 24 month post-intervention those who received motivational interviewing spent less time and money on gambling than those who had received the work-book alone.

Transtheoretical model

The transtheoretical model, and its best-known component, the stages of change, is a conceptualisation of people's readiness to change. The transtheoretical model

proposes that readiness to change addictive behaviours can be conceptualised on a continuum (DiClemente & Prochaska, 1985; Miller & Hester, 1986; Prochaska & DiClemente, 1992). In this sense it attempts to characterise both the initiation processes of addictive behaviour, as well as the recovery processes (modification or recovery).

There are three components to the model, these are: the stage of change; the process of change; and the levels of change, or problem areas complicating change. There are five stages of change representing the motivational, temporal and developmental nature of change, these are: *pre-contemplation*, representing no intention or desire to change; *contemplation*, representing serious considerations of change; *preparation*, representing commitment and preparation to change; *action*, representing the actual change behaviours and; *maintenance*, representing the behaviour change over time. The processes of change are dynamic principles and activities (identifiable sets of cognitive/experimental and behavioural techniques from various theories of therapy) used to move through stages. The levels of change, or problem areas complicating change represent the factors in the individual's areas of functioning (symptom/situational, cognitive, interpersonal, family and systems, and intrapersonal) which can facilitate or restrain movement though stages (DiClemente, Story & Murray, 2000). There has been no known research conducted of the effectiveness of applying the transtheoretical model with problem gamblers.

Solution-focused therapy

Solution-focused therapy provides a framework for counsellors to explore and utilise the existing resources of clients - their strengths, social networks, ideas, and theories. This is built on the premise that having a clear vision of a preferred future can generate solutions to any problem. Within this context the therapist aims to redirect the client's thinking from being focused on the problem to being focused on the solution.

The basic assumptions of solution-focused therapy are:

- Focusing on the positive and on solutions for the future provides advantages within therapy.
- People in therapy have the capacity to provide the solutions they need in life, however this capacity is temporarily blocked.
- There exist exceptions to every problem.
- Clients have a tendency to focus on and present only one side of a problem. Solution-focused therapy involves inviting the client to consider other sides of the problem.
- Little change leads to bigger change.
- Clients have the desire and capacity to change and are doing their best to change.
- Every individual is unique and every solution is unique.

At present there exists no research evaluating the effectiveness of solution-focused therapy for problem gambling. A recent review by Corcoran and Pillai (2009) showed that solution-focused therapy was beneficial over an alternate therapy or no therapy for orthopaedic rehabilitation; care givers of individuals with schizophrenia; criminal offenders; callers at a telephone help line; Hispanic children of incarcerated parents; and parents who experience adolescent-parent conflict.

Eclectic or integrative approaches

Within much of the early literature the terms *eclectic therapy* and *integrative therapy* were frequently used in an interchangeable fashion (Hollanders & McLeod, 1999). However, more recently, distinctions between the two have been applied. The defining distinction is that eclectic therapy refers to the integration of techniques from different theoretical approaches whereas integrative therapy refers to the integration of different theoretical orientations. In practice, this distinction in definitions is somewhat redundant, with many counsellors applying either label to indicate that their approach to counselling is not rigidly confined to one theoretical therapeutic approach (Hollanders, 2007).

Recent research has indicated that eclectic/integrative therapy approaches have widespread appeal for both psychologists and counsellors in Australia, Britain and the United States. Surveys data has indicated that 32.6 % of Australian and 27% of North American psychologists reported using an eclectic/integrative theoretical approach (Kazantzis & Deane, 1998).

Aim and rationale

The Social and Economic Impact Study into Gambling in Tasmania (2008) reported that the vast majority (>90%) of Tasmanian adults are recreational gamblers or non-gamblers. Of the regular gamblers, who represent approximately 6.5% of the adult population, the vast majority are recreational gamblers. Just under 1% of the adult population are deemed 'low risk' gamblers, .86% are deemed 'moderate risk', and .54% are deemed 'problem gamblers'. While 'at risk' and 'problem gamblers' represent a small proportion of Tasmanian adults who gamble, gambling can cause considerable harm to these individuals and their significant others, causing personal and health problems, financial problems, legal problems, interpersonal problems, work and study problems and increasing demands on community services.

Break Even Gambling Support Services provide therapeutic counselling for individuals, couples and families; financial counselling; facilitated group support; and a 24 hour helpline. Break Even Services are managed by the Gambling Support Program (GSP), Department of Health and Human Services. Funding for the services comes from the Community Service Levy, a tax on the profits of gaming machines located in hotels and clubs.

The aim of this project was to conduct a program evaluation of the therapeutic counselling service that is provided as part of Break Even Gambling Support Services to help Tasmanians deal with problem gambling in themselves or others. This study consisted of two components. One component involved recruiting and surveying a sample of Break Even clients with problem gambling. The other component involved recruiting and surveying a sample of counsellors from Anglicare Tasmania (Anglicare) and Relationships Australia Tasmania (Relationships Australia) who provide counselling services to clients with gambling problems as part of Break Even Services. The specific aim of the Break Even client component was to collect quantitative data in relation to gambling behaviour prior to and following counselling; and gambling correlates. The specific aim of the counsellor component was to collect qualitative data in regards to counsellor perceptions and practices over four aspects of

counselling. These were the theoretical orientation of counselling; diagnosis and case formulation; case management; and outcomes. A secondary aim was to make suggestions for improvements to the service where appropriate.

Method

The optimal study design to evaluate a health service is a randomised, controlled trial. This is an experimental study design in which subjects are randomly allocated to groups which either receive or do not receive a therapeutic or treatment intervention. The groups are then compared in terms of their outcome. However, for this Break Even study an initial limited time frame (less than six months) required the study design to consist of a combination of quantitative methods to identify outcomes from the therapeutic counselling for problem gamblers. In effect this design is a 'pilot' for the feasibility of conducting more comprehensive evaluations of therapeutic counselling services provided by the Break Even Gambling Support programs in the future.

Participants and their recruitment

Problem gambler clients

The study gained ethical approval through the Human Research Ethics Committee (Tasmania). It consisted of a sample of 41 clients who had received personal counselling from Break Even Gambling Support Services for problem gambling more than six months prior. People with gambling problems were selected using de-identified data from the GSP's Fourth Dimension Break Even Client Information System. While the GSP is the custodian of the database, the two contracted therapeutic counselling service providers, Anglicare and Relationships Australia, use the database to record and manage client information. Anglicare and Relationships Australia are required to provide the GSP with client data each quarter as a condition of the service agreement with the Department. The data provided is de-identified in that it does not contain client names and contact details.

A stratified sampling technique was used to identify 300 clients from Anglicare and 300 clients from Relationships Australia who were eligible to participate. Criteria for eligibility was that clients must have had attended therapeutic counselling with

Anglicare or Relationships Australia for problem gambling or problems caused by their gambling behaviour. Clients' last counselling session had to be at least six months ago or longer for the follow-up measures to be valid. In addition, the clients must have completed the South Oaks Gambling Screen (SOGS) at the time of their first counselling session. Approximately 70-80% of all clients had completed the SOGS at their first counselling service.

Due to the de-identified nature of client data managed by the GSP, counsellors at Anglicare and Relationships Australia were employed to assist in the recruitment of participants. The recruitment process was as follows: eligible clients' service identification codes were matched with de-identified clients' information on the database by GSP researchers, then lists of potential participants containing service identification codes of clients were provided to employed counsellors within Anglicare and Relationships Australia. Client names and contact details were then matched using client codes. Counsellors attempted to contact all the clients on the lists. If contact was attained within three attempts, counsellors explained the nature of that contact and asked if clients would agree to signing a consent to contact form, which would allow a GSP researcher to contact them directly. When the GSP received signed 'consent to contact' forms, direct contact was attempted and if successful the research was explained and clients were formally invited to participate in the study. As an incentive to increase the response rate, clients who completed the questionnaire were provided with a supermarket voucher to the value of $25.

Table 1 displays the numbers of clients, of those identified by the GSP, who were able to be contacted by Break Even (BE) Services. It can be seen that less than one third of clients identified by the GSP were contacted by BE for the purpose of this study. For Relationships Australia the main reason given for this was that a large number of clients' files had indications that post counselling contact would be unwelcome. For Anglicare the main reason was that for a large number of clients contact information was not available. Table 2 shows the numbers of clients, of the 192 for who contact by BE was permitted, who were contacted by BE and subsequently participated in the study.

Table 1. Recruitment details and numbers of Break Even clients identified by the Gambling Support Program (N=600) for whom post-counselling contact was not permitted.

	Relationships Australia	Anglicare	Total
Number of clients identified by the GSP	**300**	**300**	**600**
Clients whose file indicated no contact post counselling	142	48	190
Decision made by BE not to contact	30	8	38
Unable to locate contact details	0	132	132
Unable to locate record	7	0	7
Duplicate record	38	2	40
Contact by BE permitted	**82**	**110**	**192**

Table 2. Recruitment details and numbers of Break Even clients for whom post counselling contact by Break Even services was permitted.

	Relationships Australia	Anglicare	Total
Contact by BE permitted	**82**	**110**	**192**
• Refused	13	27	40
• Unable to contact, no answer/number not connected	40	22	62
• Consent to receive study info pack gained and info pack sent	29	61	90
Total 'consent to contact' received by the GSP			50
Participated in the study			41

Break Even counsellors

Counsellors employed by Break Even Support Services as dedicated therapeutic counsellors for people with gambling problems and counsellors who until recently were employed by the two organisations as dedicated therapeutic counsellors were invited to participate in the study.

Study procedure

Of the 50 clients who returned the 'consent to contact' form to the GSP, 45 were contacted. Five people were unable to be contacted following numerous attempts at different times of the day and evening, over a period of months. Three people chose not to be involved in the research following a preamble given prior to the questionnaire administration, and one person chose to discontinue the study mid-

interview and thus their incomplete data set was not included. Participating BE clients were telephoned and informed again of the purpose of the study, that they would not be identified in any way within the results and that the study operated under strict confidentiality protocols. They were also informed that the study had Human Research Ethics Committee (Tasmania) approval and that they may withdraw from the study at any time without consequence. Participants were then asked to complete a questionnaire (Appendix 1) by telephone. Participants were also offered the opportunity to complete the questionnaire in a face-to-face meeting with the researcher. One participant chose this option. Following the administration of the questionnaire participants were thanked and the $25 supermarket voucher was sent to their address with their approval.

Participating counsellors received the 'counsellor questionnaire' (Appendix 2) in hard copy or electronic form following the return of the consent form. On completion of the questionnaire, counsellors returned their completed questionnaires to the researcher.

Results

Problem gambling client results

Demographics of problem gambling client sample (N=41)

Just over 90% of the client sample was born in Australia with the remaining four clients reporting being born in the Philippines, England, The Netherlands, and the (former) Soviet Union, respectively. The sample consisted of 15 males and 26 females. Figure 1 shows that the age range distribution of the sample is consistent with the estimated age range distribution of *problem gamblers in counselling* (N=2220) within the general population reported by the Productivity Commission (1999: table 6.16). The proportion of BE clients who reported their age being within the 40-55 years age range was approximately 50%. This is similar to the Productivity Commission estimation within the general Australian population. However the BE sample contained a higher proportion within the 55-65 age range (approx. 28%) in comparison to the Productivity Commission estimation within the general population (approx. 10%). Furthermore the BE sample contained a lower proportion within the 30-40 age range (approx. 14%) in comparison to the Productivity Commission estimation within the general population (approx. 24%).

There were no clients under 30 years of age within the BE sample in contrast to the Productivity Commission estimation within the general population (approx. 15%). The differences in age range frequencies may be a result of sample size discrepancy. The Productivity Commission sample (N=2220) was much greater than the BE sample (N=41). Furthermore the Productivity Commission reported that problem gamblers who entered counselling tended to be older than those who have not sought help. This tendency may appear to be greater in the BE sample due to sampling error dynamics. The sampling error will be greater for smaller samples.

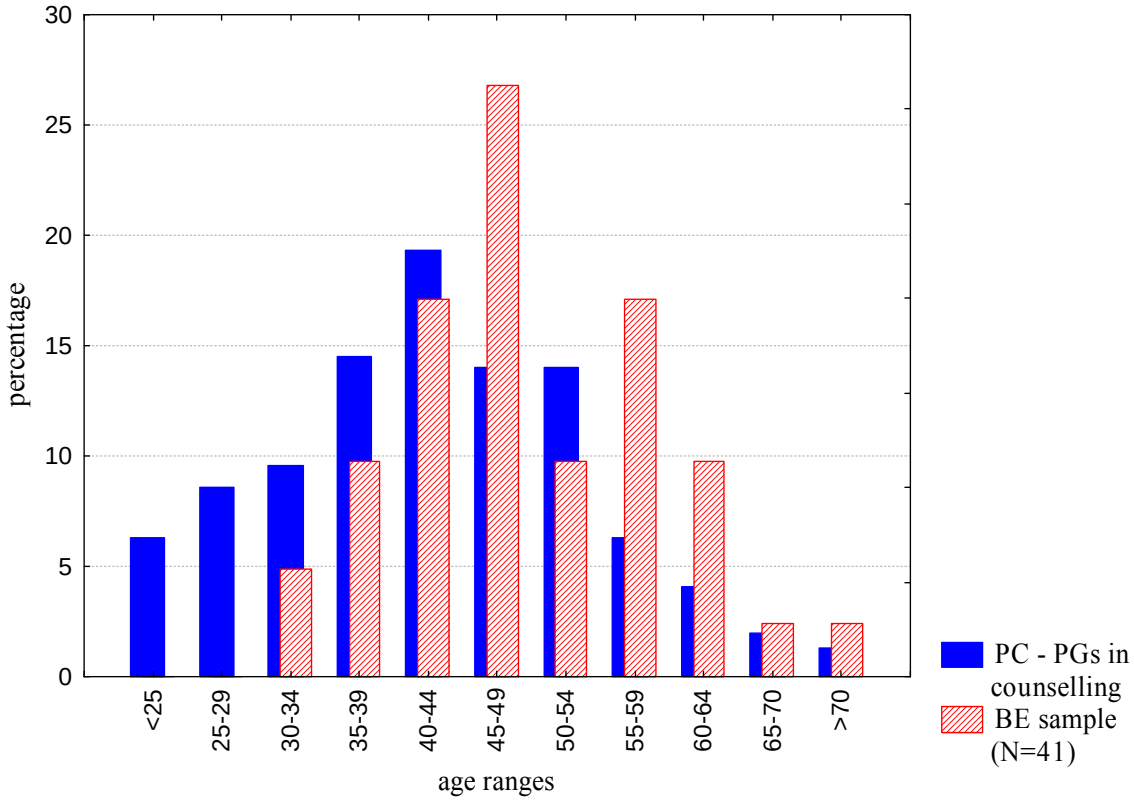

Figure 1. Age range distribution percentages for the Break Even client sample (BE sample) and for the Productivity Commission's sample of problem gamblers in counselling (PC-PGs in counselling).

Table 3 displays demographic information on: education level, marital status, major income source, and work status for the BE client sample in comparison to the Productivity Commission estimates of proportions within the general population. The BE sample contained a higher proportion of clients with lower levels of education, such as primary school or 4th year high school as the highest level achieved, and smaller proportions of clients with higher levels of education, such as TAFE/technical education and university degrees. Differences in marital status data appear to show that the BE client sample has a lower proportion of clients married or living with a partner and a higher proportion of clients reporting being separated or divorced.

The most striking difference between BE client data and the Productivity Commission estimates of the general population within 'major income source' data is that the BE client sample has a higher proportion of clients on disability pensions and

a smaller proportion of clients reporting a salary or wage as their major income source. Furthermore within 'work status' data the BE client sample displays higher proportions of clients working part-time and clients unemployed and lower proportions of clients working full-time, when compared with than the Productivity Commission estimates of *problem gamblers in counselling* within the general population.

Table 3: Demographic information on: education level, marital status, major income source, and work status for the BE client sample in comparison to the Productivity Commission estimates of proportions within the general population.

	Productivity Commission (1999) *Problem gamblers in counselling (%)*	*Break Even client sample (%)*
Education [1]		
Up to 4th year high school	38.4	
Finished high school	26.7	
TAFE/technical education	12.7	
CAE/university	21.1	
Completed primary school as highest level		26.2
Completed 4th year high school as highest level		50
Completed matriculation as highest level		7.1
Completed TAFE qualification as highest level		9.5
Undergraduate university degree as highest level		4.8
Post-graduate university degree as highest level		2.4
Marital status		
Married or living with a partner	47.3	29.3
Separated or divorced	25.1	41.5
Widowed	3.3	2.4
Single	24.3	26.8

Major income source		
Wages/salary	55.3	23.7
Own business	11.2	4.8
Other private income	.8	2.4
Unemployment benefits	8.4	11.9
Retirement benefits	2.0	n/a
Sickness benefits	2.3	n/a
Supporting parent benefits	3.8	n/a
Aged/invalid pension	13.5	(Aged pension – 4.8) (Disability pension – 50) [2]
other	2.3	2.4
Work status		
Working full-time	42.6	11.9
Working part-time	15.3	33.3
Home duties	8.9	9.5
Student	2.8	0
Retired (self supporting)	2.0	0
Pensioner	13.0	4.8
Unemployed (or looking for work)	12.0	40.5
Other	3.3	0

[1] Proportions for Productivity Commission estimates of the general population and the BE client sample are listed separately due to slightly different education level categories being used.

[2] Productivity Commission estimates of the general population for aged/invalid pension are provided combined. However, within the BE client data 'aged pension' and 'disability pension' (formerly known as 'invalid pension') proportions are separate.

The majority of clients within the sample described their income level as low (71.4%) with 23.8% reporting their income as medium. Only two clients reported their income as high. Figure 2 displays the response frequency percentages for 'main source of household income' for the BE sample as well as for *problem gamblers in*

counselling reported by the Productivity Commission[2]. The vast majority of clients in the BE sample report an annual household income of less than $30,000 (73.8%), with the most frequent response being the annual household income bracket of $20,000 - $29,999 (54.8%). As a whole the BE sample consists of clients on lower household incomes when comparing BE sample data to that reported by the Productivity Commission. In comparison to the 32.8% of *problem gamblers in counselling* from the Productivity Commission report, 63.4% of the BE sample reported an annual household income of under $20,000.

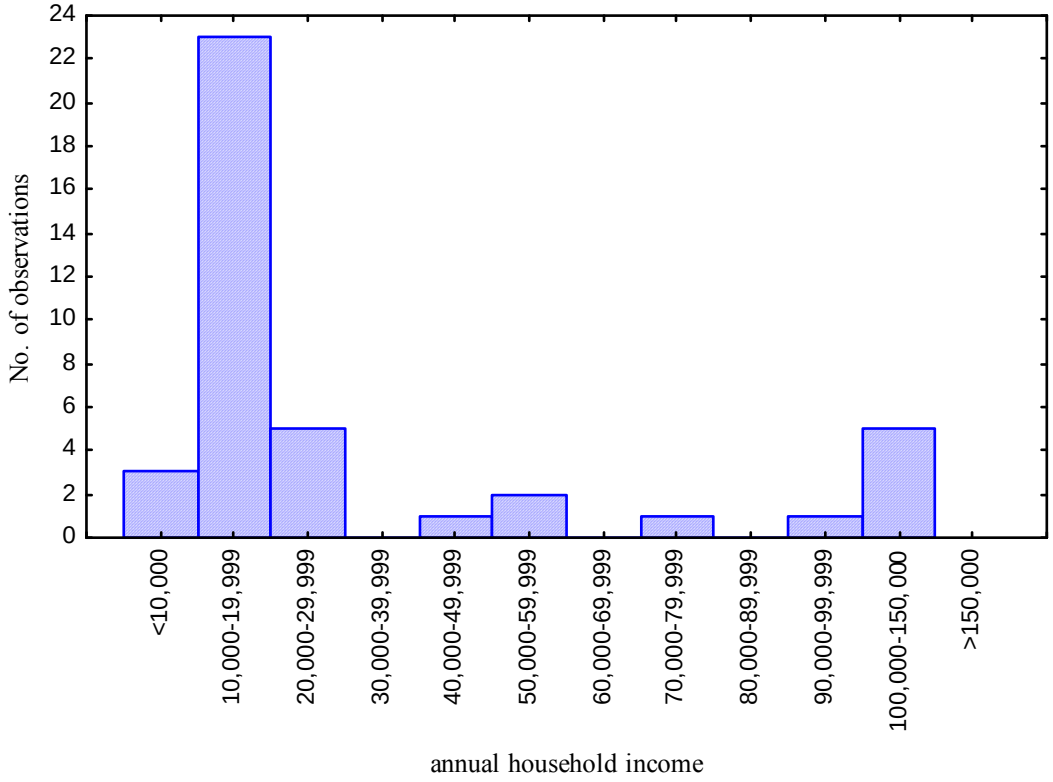

Figure 2. Response frequencies across ranges of annual household income brackets.

Figure 3 displays the data for the reported main source of household income for the BE sample. Approximately half of the client sample reported 'disability pension(s)' and approximately a quarter of the sample reported 'salary' as the main source of income. Viewing 'disability pension', 'aged pension', and 'social security' together, the

[2] Estimated annual household income range frequency percentages of *problem gamblers in counselling* reported by the Productivity Commission is data sourced from Jackson, Thomas et al., (1999)

results show that 64.3% of the sample report a government benefit as the main source of income.

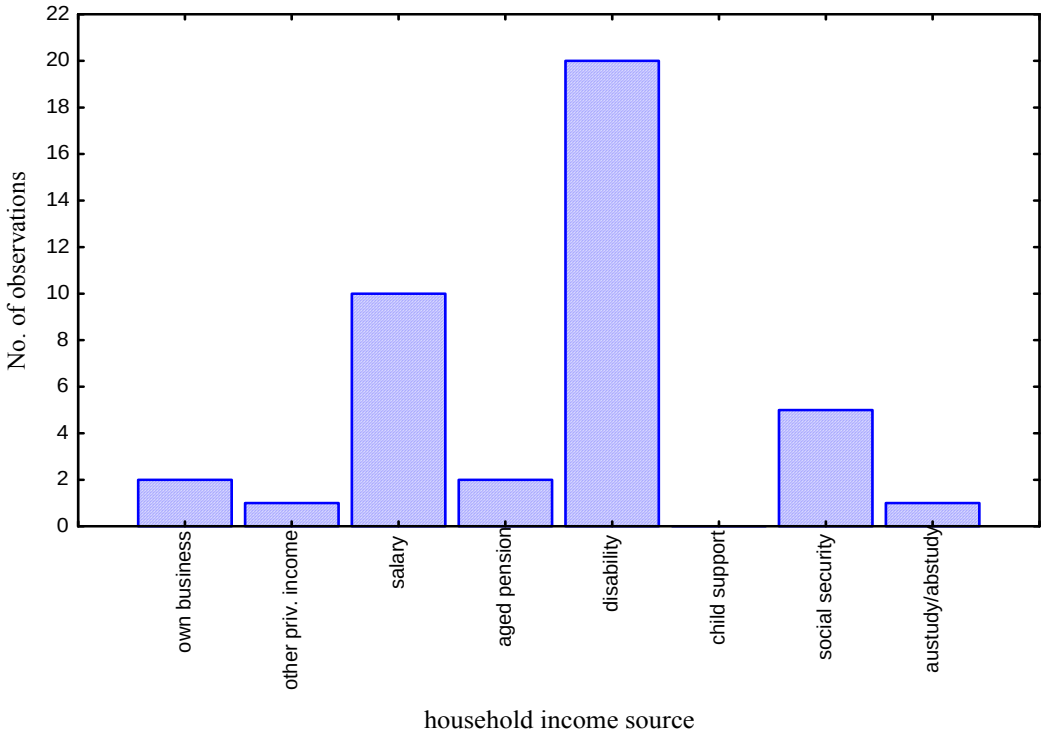

Figure 3. Response frequencies for 'main source of household income'.

Drug and alcohol use

In relation to the six month period immediately prior to the administration of the questionnaire, half of the client sample reported consuming tobacco on a daily basis while half reported not being consumers of tobacco. For alcohol use within this six month period, 19% reported no alcohol consumption, 35.7% reported consuming alcohol less than once a month, 23.8% reported consuming alcohol 1-3 days a month, 11.9% reported consuming alcohol 1-2 days a week, and 7.1% reported consuming alcohol 3-6 days a week. For marijuana or hash, 95.2% of the sample reported no consumption within this six month period. One client reported smoking marijuana or hash 1-3 days a month and one client reported daily consumption of marijuana or hash.

Clinical history

Questions were asked about clients' clinical history in relation to the time period of the six months directly prior to their first session with BE Services; the time period when they were attending BE counselling; and the time period of the six months directly prior to their first session with BE Services. Figure 4 displays the response frequencies for the question *"What was the main reason you came to Break Even counselling at that time?"* The most frequent single reasons reported were: 'my own decision', 'financial difficulties', and 'depression, suicidal thoughts or attempts' which collectively accounted for 83.3% of responses. Figure 5 displays the response frequencies to a question assessing the degree to which clients had intended, planned or acted towards reducing or stopping their gambling behaviour, immediately prior to their first session with BE Services. It can be seen that approximately two thirds of the sample had either intentions or plans to begin reducing or stopping their gambling and approximately one quarter of the sample had already begun to reduce or stop their gambling prior to commencing counselling.

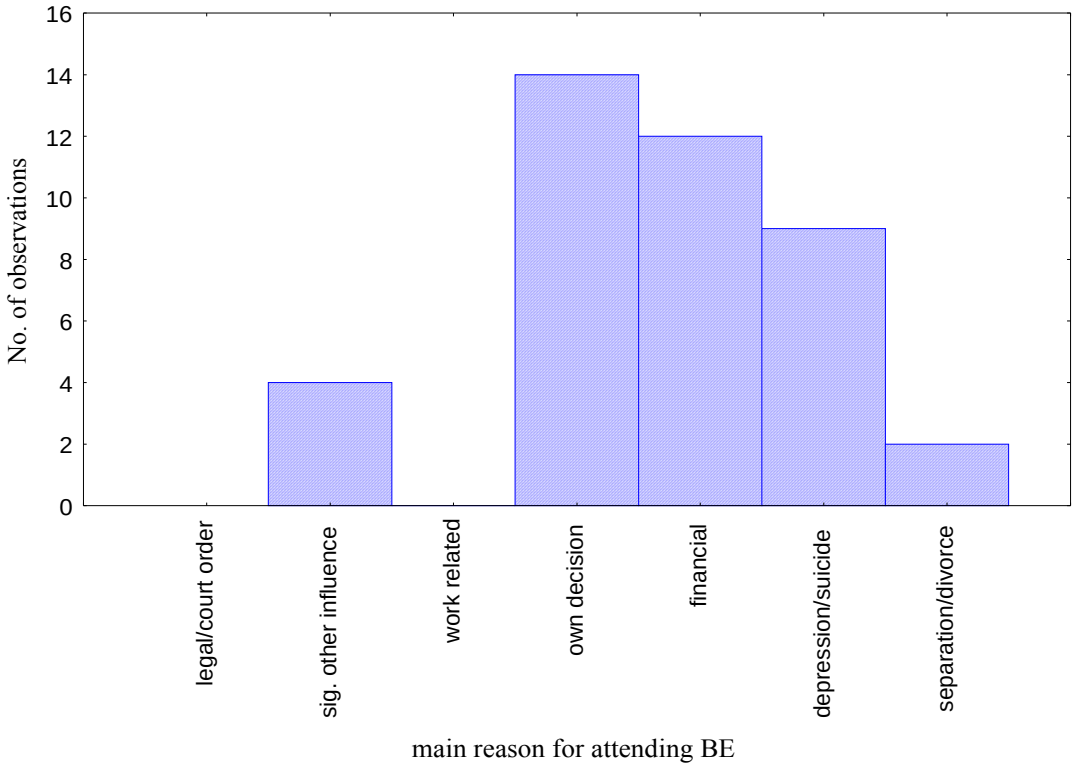

Figure 4. Response frequencies across dominant reasons why clients chose to attend Break Even counselling.

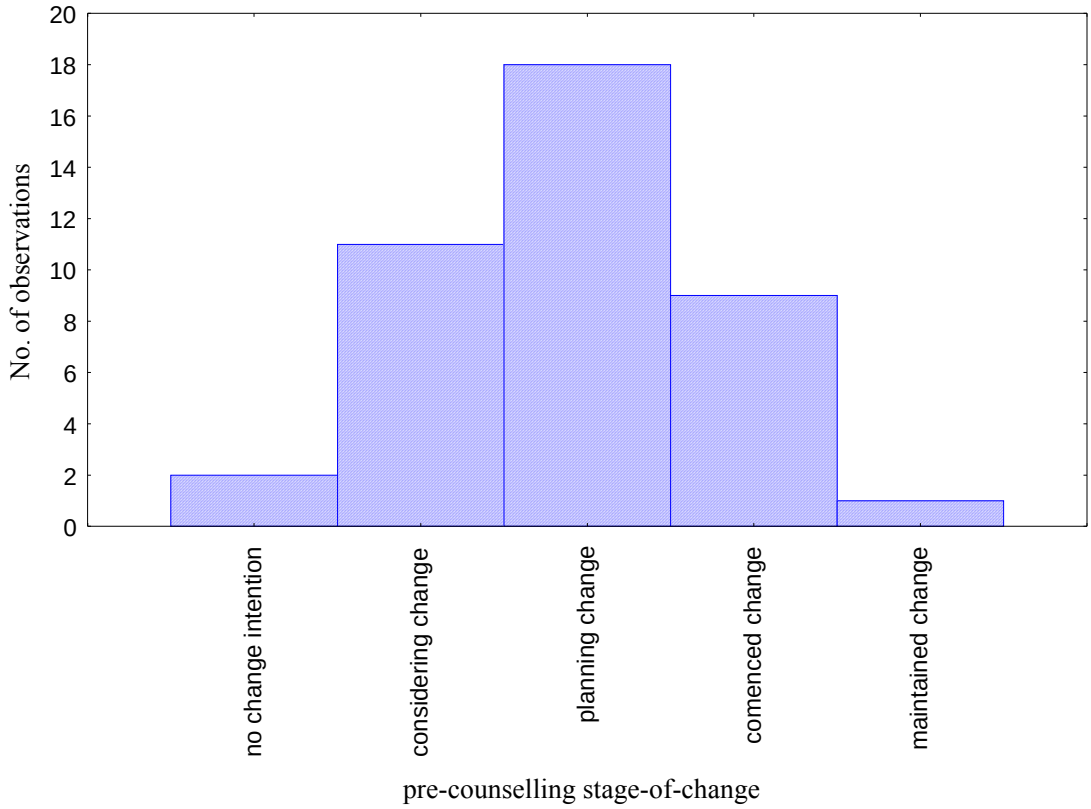

Figure 5. Response frequencies regarding clients' intentions, plan, and actions in reducing or stopping their gambling

All but two clients reported EGMs as their 'preferred game or type of gambling'. These two clients reported 'keno' and 'speculative investing in stocks, futures or commodities' respectively as their preferred type of gambling. Of the clients reporting EGMs as their preferred game, 82% reported that they mainly played in clubs while the remaining clients reporting EGMs as their preferred game reported mainly playing in casinos.

In relation to the time period of the six months immediately prior to the questionnaire administration, 50% of the sample reported not gambling at all. The remainder of the sample reported differing degrees of post-counselling engagement in gambling. Within this six month period, 26.2% of clients reported returning to their previous gambling behaviour on one or two occasions (otherwise not having gambled or significantly reduced their gambling), 7.1% reported gradually cutting back on their gambling, 7.1% reported gambling regularly but less than they used to, and

7.1% reported gambling at the same or at an increased degree. All clients who gambled during this time reported the same preferred 'game or type of gambling' as they reported for the six month period prior to commencement of counselling. Furthermore, clients who reported gambling in some degree within the six month period immediately prior to the questionnaire administration date were subsequently asked to indicate the reason they believe led them to return to gambling. Table 4 displays the endorsement frequencies for the return to gambling reason options provided on the questionnaire (multiple responses were allowed).

Table 4: Endorsement frequencies as percentages for the return to gambling reason options provided on the questionnaire.

Perceived reasons for return to gambling	**Proportion of 'return to gambling' clients (n=21) endorsing reason**
I bet for the feeling of excitement I get	30%
I bet to get money I need	25%
I bet because others around me were betting	10%
I bet because I have a good time	30%
I bet because I feel lonely	40%
I bet because it is challenging	10%
I bet because it's an important part of my social life	15%
I bet because I felt sad or depressed	55%
I bet for other reasons	25%
Note: Percentages do not equal 100% as multiple responses were allowed.	

Pre-counselling to post-counselling comparison

A number of analyses were conducted on pre-counselling referenced data in comparison to post-counselling referenced data. With regard to estimated average gambling sessions per week and estimated average monthly expenditure on gambling, the sample was divided into two groups according to whether clients had not gambled (n=20) or whether clients had gambled (n=21) in the post-counselling period of the six months immediately prior to the questionnaire administration. Obviously clients who reported not gambling in this post-counselling period also reported no gambling sessions and nil net gambling expenditure, therefore analysing the sample as two groups allows for a more accurate assessment of gambling activity and expenditure following counselling by controlling for those clients who reported gambling following counselling. Repeated-measures ANOVA for 'estimated average gambling sessions per week' demonstrated that there was a significant decrease in the number of gambling sessions per week for all clients $F(1, 39) = 81.39$, $MSE = 2.97$, $p < .001$, and that this did not significantly differ between groups $F(1, 39) = .05$, $MSE = 2.97$, $p = .82$. These results are displayed in figure 6.

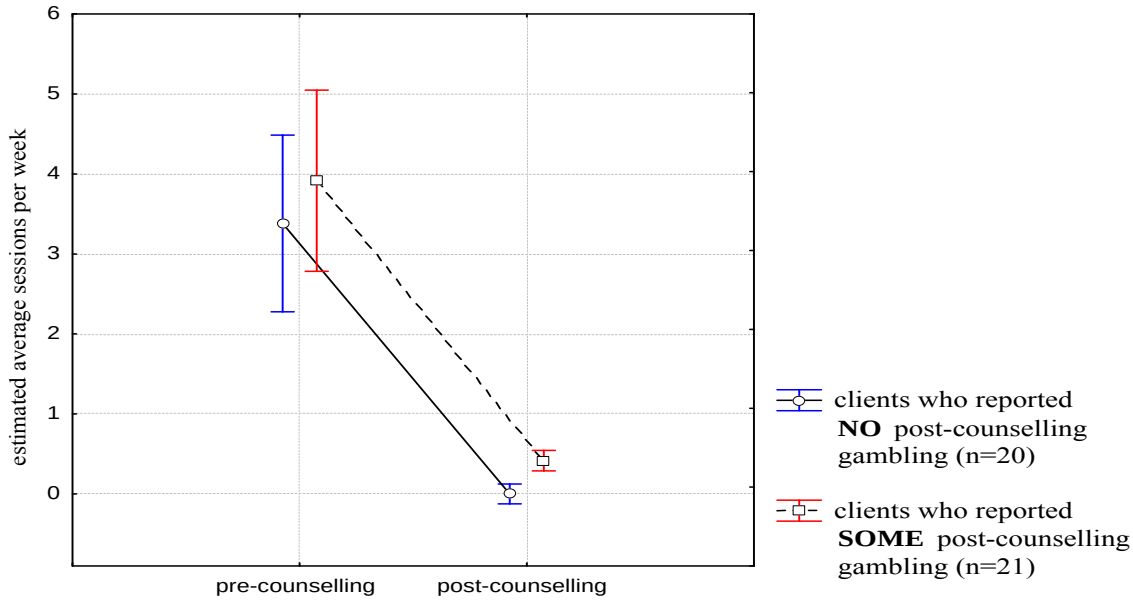

Figure 6. Estimated average gambling sessions per week for pre- and post-counselling time periods for clients who reported no post-counselling gambling and clients who reported some post-counselling gambling (error bars represent 95% confidence intervals).

For 'estimated average net gambling expenditure per month', displayed in figure 7, a repeated-measures ANOVA likewise demonstrated that there was a significant decrease in the average net monthly gambling expenditure for all clients $F(1,39) = 56.28$, $MSE = 1384354.45$, $p < .001$, and that this did not significantly differ between groups $F(1,39) = .61$, $MSE = 1384354.45$, $p = .43$.

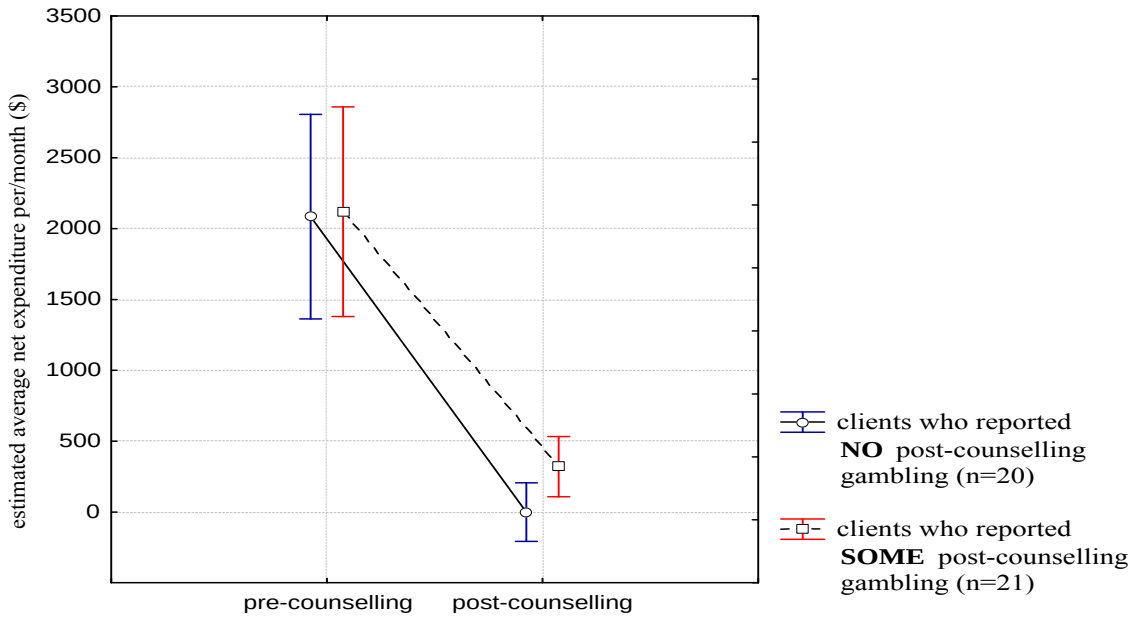

Figure 7. Estimated average net gambling expenditure per month for pre- and post-counselling time periods for clients who reported no post-counselling gambling and clients who reported some post-counselling gambling (error bars represent 95% confidence intervals).

Collectively these results demonstrate that clients who did engage in gambling during the post-counselling six month period immediately prior to the survey administration displayed a significant decrease in weekly session numbers and monthly net gambling expenditure comparable to that displayed by clients who did not gamble during this time period. As a whole the sample displayed a significant decrease in average gambling sessions per week, from 3.6 to 0.19 sessions per week, and average net gambling expenditure per month, from $2,102.67 to $152.53.

Further pre-post counselling analyses involved assessing differences in South Oaks Gambling Screen (SOGS) scores. Wilcoxon matched pairs test demonstrated that SOGS scores were on average significantly lower post-counselling than pre-

counselling W(36) = 33.5, z = 4.2, p < .001. When the sample was split into those who had gambled post-counselling and those who had not gambled post-counselling, both groups displayed significant decreases in SOGS score from pre- to post-counselling. However the average decrease in SOGS scores for clients who had not gambled post-counselling was greater than for clients who had gambled post-counselling, as shown in figure 8.

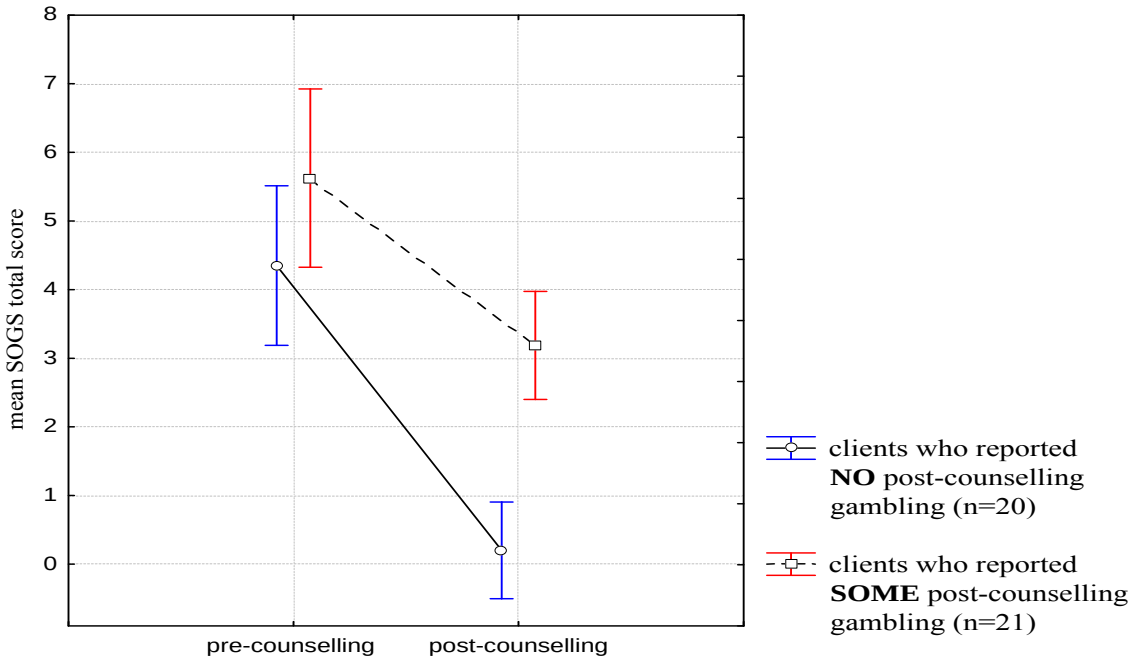

Figure 8. Mean SOGS total scores at pre- and post-counselling times for clients who reported some post-counselling gambling and clients who reported no post-counselling gambling.

Conclusion and limitations

Problem gambling clients

The results of this study are based on a sample of 41 clients who attended BE counselling and completed their last therapy session more than six months prior to the questionnaire administration. Before the summary findings of the study are presented, a number of cautionary statements are made about the recruitment process and sample of the study.

- There is a high likelihood that the sample is not representative of the BE client population. This undermines the aim of the study to evaluate the counselling service provided by BE Services to clients with gambling problems. The reasons for this conclusion are as follows:
    - Of the 600 BE clients selected through using a stratified sampling technique to be a representative sample of BE clients and potential study participants, only 42 were recruited and one later withdrew.
    - Of the above mentioned 600 BE clients:
        - 190 clients had 'no post-counselling contact' indicated on their file.
        - 38 clients were removed from the list due to decisions made by counsellors after viewing client files. This was done because of counsellor concerns for the wellbeing of the client (e.g. the reported presence of domestic violence or concerns that household members, other than the client, may not be aware of the client's relationship with BE Services).
        - 132 clients were not available for recruitment due to the service staff being unable to locate their contact details within the required time. These 132 clients were all from Anglicare and contact details were not available due to their files either

being archived in a system not amenable to easy access, or not containing the necessary contact information.

- Of the remaining 192 BE clients whose files permitted contact, 40 clients refused to receive study information, and a further 62 were not contactable following three phone call attempts.

- This summary of the processes of recruitment highlights that clients who completed the questionnaire were: agreeable to post-counselling contact by BE Services; judged to not be at risk due to contact; contactable; and agreeable, in principle, to being involved in research related to problem gambling counselling.

- Research has highlighted the chaotic and erratic lifestyles that are led by some problem gamblers (e.g. Darbyshire, Oster & Carrig, 2001; Griffiths, Bellringer, Farrell-Roberts & Freestone, 2001). Furthermore Shaffer, Freed and Healea (2002) have reported finding a higher prevalence of disordered gambling in a sample of homeless people than in the general population. Lepage, Ladouceur and Jacques (2000) have reported finding elevated rates of probable pathological gambling amongst a sample of people who were partially dependent on welfare for food, material assistance and lodging. Therefore it is reasonable to speculate that the BE sample may not be representative of those clients whose lifestyle could be described as chaotic and erratic or who do not have a stable place of residence and thus are not easily contactable.

Other characteristics of the sample

- All but two clients in the study identified EGMs as their primary gambling activity. These two clients reported 'keno' and 'speculative investing in stocks, futures or commodities' as their primary gambling activity. Therefore the results of this study are generally applicable to problem gambling clients who identify EGMs as their primary gambling form. This characteristic of the BE sample shows consistency with data from the Break Even Services

Network Client Information Report, (1 July 2000- 30 June 2007) where 76.1% of the sample (N= 2789) reported EGMs at hotels and clubs, 40.9% reported EGMs at casinos, and 7.6% reported keno as '*forms of gambling that are causing problems'* (multiple responses were permitted).

- There were many characteristics of the BE sample that differentiated it from the sample of *problem gamblers in counselling* from the Productivity Commission report. These were:
    - a higher proportion of older and lower proportion of younger clients.
    - a higher proportion of divorced or separated clients.
    - a higher proportion of lower income earners.
    - a higher proportion of unemployed or part-time employees.
    - a higher proportion on disability pensions and lower proportion earning a salary.

Findings

- The dominant reasons given for commencing counselling were:
    - the client's own decision.
    - depression or suicide attempts or thoughts.
    - financial difficulties.
- The vast majority of clients reported that they were either considering, planning to, or had commenced reducing or stopping their gambling behaviour prior to entering BE counselling. Only two clients reported having no intention of changing their gambling behaviour when they commenced therapy. This limits the application of results beyond clients who commence counselling with intentions of changing their behaviour.

- Outcome indicators for BE counselling services revealed that:
    - 50% of the sample had not gambled since their last therapy session.
    - 45% of the sample reported having reduced their gambling since their last therapy session.
        - The dominant reasons given for post-counselling gambling were:
            - feeling sad and depressed.
            - feeling lonely.
            - to have a good time.
            - to get money needed
    - 5 % of the sample reported that their gambling has remained the same or got worse.
- The sample as a whole demonstrated significant decreases from pre- to post-counselling in:
    - Average number of weekly gambling sessions (3.6 → .2 sessions/week).
    - Average amount of money lost gambling ($2,102 → $152 /week).
    - Average SOGS total scores.
- There was a significant difference in post-counselling SOGS scores dependent on whether clients had abstained from gambling post-counselling or not.

This study provides information on client characteristics for those who largely have had a positive outcome from BE counselling. The recruitment process highlights possible areas for improved record keeping as well as indicating that a more valid evaluation of the BE counselling would require an approach which avoids the

obstacles to recruiting a representative sample. In response, BE Services have implemented protocols to address some of the limitations associated with sample size and sampling bias contained within the current study. On entering the service BE clients are now invited, in an appropriate fashion, to consent to potential contact in the future from the GSP for purposes of partaking in research. This process is aimed at limiting the difficulties apparent in the GSP establishing post-counselling contact with BE clients through a third party (BE Services). While it does not adequately address all the recruitment limitations identified within the current study, it is expected to make recruitment of larger samples less complicated for future research.

In addition to this protocol, BE Services are implementing more detailed counselling outcome measures for BE clients, which have been developed by the GSP with guidance from BE Service coordinators and counsellors. An aspect of the outcome measures and protocols is specifically aimed at providing information regarding clients' response to BE Services from BE clients who attend one or a few counselling sessions only. Assessment of counselling outcomes for clients with problem gambling is somewhat problematic as only a small percentage of people experiencing problems with gambling seek formal help. The *Productivity Commission, Gambling, Draft Report* (2009: 5.3) estimates that only 8 to 15% of people experiencing gambling problems seek formal help and this is consistent with estimates internationally and observations of the BE Services client flows.

In conclusion, the results show that for the vast majority of clients who participated in this study, the counselling service provided a positive outcome in terms of either a reduction or cessation of gambling sessions, gambling expenditure, and correlates of gambling as measured by SOGS scores.

Counsellor questionnaire results

Theoretical orientation

The theoretical orientation that counselling practice at BE Services is based upon is best described as *eclectic* or *integrative*. All counsellors in the sample reported using CBT to some degree as part of their practice. CBT was used by some counsellors with the aim of modifying irrational or unhelpful beliefs and thought processes

related to gambling. Some counsellors additionally reported applying rational emotive behavioural therapy (REBT), a version of CBT developed by Albert Ellis. There is virtually no research examining the effectiveness of REBT for problem gambling. However, with a major component of REBT aimed at examining and disputing irrational or unhelpful beliefs, many authors have posited it as well-suited for the treatment of problem gambling (Lorenz, 1993; Angelillo, 2001). The treatment approach known as Rogerian psychotherapy, client-centred counselling, or person-centred therapy was reported by four of the seven counsellors as being an important part of their counselling approach. Five of the seven counsellors reported using the stages of change model and/or motivational interviewing as part of their approach.

The stages of change model and motivational interviewing are separate yet complementary. The transtheoretical model of change, which comprises the stages of change, is a conceptualisation of how and why change occurs, whereas motivational interviewing is a specific clinical approach used to elicit change within clients (Miller & Rollnick, 2009). Solution focused therapy was reported by three counsellors. Other approaches reported by individual counsellors but not described in this documents review of therapy approaches include: strengths based, feminist/structural analysis, narrative therapy, philosophical counselling, mindfulness, gestalt therapy, dialectic behavioural therapy, systems theory, pathways model, and reality therapy.

There was a degree of consistency in counsellors' understanding of what 'problem gambling' is and what causes it. Most counsellors identified 'problem gambling' to involve maladaptive or dysfunctional behaviour that results in negative outcomes for the client, or for the client and the client's significant others. Many of the counsellors identified problem gambling as a form of coping with, escaping from, or avoiding negative aspects of life, such as stress; past trauma; abuse; grief; lack of personal relationships, interests, or social skills; negative mood; low level of mood or arousal; or loneliness. Some counsellor responses highlighted the role that addiction or habitual behaviour, compulsion, and impulsivity play in manifestations of problem gambling. Problem gambling behaviour as the result of learned behaviour, through familial modelling or via an early big win, was identified by a small number of the

counsellors. A common thread through the counsellors' responses was that there are many varied and complex manifestations of problem gambling and that 'no one cause' can be identified.

Diagnosis and formulation

The criteria applied when assessing the counselling needs of the client varied somewhat across counsellors. However some common criteria were present across some of the counsellors.

- Five of the counsellors identified factors relating to the immediacy of a specific action. These factors include assessments of the immediate risk or safety of clients and the affected others from, for example, violence, suicide, financial ruin, homelessness, severity of impacts, and level of distress.
- A number of counsellors responded that they assess clients' ability to deal with the situation through criteria such as coping abilities; cognitive abilities; and the degree of social supports clients have.
- Most counsellors responded that they collect a full history from clients or assess for the presence of known gambling correlates such as relationship or social problems, and psychological or mental health issues.
- Some counsellors identified an assessment criteria of whether problem gambling manifests as a symptom of deeper, underlying problems that may exist due to, for example, past trauma or abuse.
- Other assessment criteria utilised by individual counsellors include stage of change assessment, and client identified needs and goals.

Where counsellors used goal setting processes for interventions with clients, a number of themes were present. Most counsellors endorsed allowing clients to set their own goals whilst providing direction or assistance to those clients. Direction and assistance to clients differed somewhat across these counsellors' reports. However, collectively this assistance and direction to clients in goal setting aimed to help make the clients' goals: realistic, achievable, appropriate, prioritised, and connected with any identified underlying issue (such as the function gambling may play in a client's life).Most counsellors answered a question on when and where they would refer clients to another service, indicating that they would refer the client

when the counselling requirement exceeded their expertise or mandate, or when the special needs of the clients required a referral.

Case management and related issues

All counsellors rated the extent to which they consider the counsellor-client relationship important in counselling practice as "a great deal", the highest rating of importance. The therapeutic relationship was reported by the counsellors as a means to provide a sense of trust, respect, understanding and acceptance in order to facilitate therapy processes such as providing an environment for challenging the client and working with the client towards change.

A number of themes were apparent in the reports of techniques they use in bringing their counselling to a close with clients. Counsellors identified that many clients do not formally end therapy, rather they just stop coming to sessions. One counsellor reported that in this case they contact the client by phone to check on how they are doing and to invite them back if there is a need. All counsellors reported that when clients formally end therapy, they engage the client in a review or summary of goals and achievement and a number of the counsellors described this as involving future planning (such as discussing group support options or reiterating learned strategies) for the post-therapy period. Many counsellors reported conducting regular reviews of goals, tasks, achievements and progress through the duration of the therapy, irrespective of cessation plans. Most counsellors indicated that preceding therapy cessation, clients are invited to re-connect or re-refer to the service in the future if they feel the need for support with gambling issues. Further, around half of the counsellors reported reducing the frequency of sessions towards the end of therapy.

Many BE clients present a second or numerous times for therapy. Counsellors reported that therapy may differ for these 're-presenters' in comparison to therapy for clients who present for the first time. Many counsellors reported that they spend time reviewing the client's history in the context of the reason for the re-presentation. Rather than looking at it as a 're-lapse', it is considered as a 'glitch' or a

'normal aspect of the process' as a whole. This may involve consideration of the 'stages-of-change' model.

Counselling outcomes

There was diversity in the counsellors' reports as to what constitutes a successful outcome. One common general theme related to a positive change in the client with regard to gambling. Counsellors differed in how this was expressed specifically. Some counsellors required that a successful outcome needs to be client-specific, that is, that clients set individual goals and success involves reaching those goals. Goals may be ceasing or abstaining from gambling behaviour; learning strategies to use post-counselling; increasing motivation; confidence; or a sense of power to change or make decisions for themselves; or gaining insight into the cause of the gambling problem. One counsellor stated that a successful outcome involves clients gaining an understanding that their response to therapy is better understood as part of a larger journey that they are on. Instead of framing their response to therapy as being successful or not, it is more helpful to view it as being the right thing to do at this time in their life.

All counsellors identified the therapeutic relationship as a factor that contributes to achieving or hindering success. Aspects that were identified as conducive for a successful outcome were being non-judgemental; accepting; genuine; supportive and providing an environment for open communication. Most counsellors identified the client's level of motivation, readiness to change or degree of commitment to therapy as factors that can either hinder or facilitate success from therapy. Most counsellors also identified existing complex issues in the clients' life, such as co-morbid mental or physical health conditions, stressors, or substance use or abuse as factors that can hinder the achievement of goals. Factors identified by some counsellors as hindrances included personality attributes, such as rigid beliefs in control over chance, or a desire of the client to be 'fixed' quickly. Other factors identified by counsellors as being conducive to achieving successful outcomes were quick access to counselling; no counselling fees; and a consent from the client for the counsellor to follow-up post-counselling.

Most counsellors indicated that therapy for their clients is 'individually tailored'. Additional observations offered by counsellors included:

- that men tend to want a quick fix, such as self-exclusion.
- that men are equally vulnerable as women to the development of problem gambling, but may be slower to access support.
- that if a client had spent time in jail or had gambling related matters before the court or in the media, these factors might may influence the intervention method applied by counsellors.

Reported ways to keep up-to-date with new developments in the field included reading journal articles and research; consultation with colleagues; peer discussions and supervision; and workshops, conferences and training.

Some additional information other than that collected via the questionnaire on client numbers (who have accessed the service for 10 sessions or multiples of 10 sessions) comes from the Anglicare Break Even Quarterly Report Oct-Dec 2008. For the full four quarters of 2008, 30 clients have accessed between 10 and 19 sessions of problem gambling related counselling, six have accessed between 20 and 29 sessions, and one has accessed more than 30 sessions. Case management/review outlines have been implemented and all clients with complex or high needs are being reviewed after three, six and 10 sessions and this pattern is ongoing. Clients accessing more than 10 sessions of BE counselling often experience complex issues requiring additional support for lapse/relapse prevention and management of their responses to distressing situations, particularly where traumatic events are identified as predisposing factors. Some clients return to renew self-exclusions, with some accessing counselling support every couple of months. Some clients require additional support for mental health, legal issues, and relationship breakdowns. Referrals are provided for these, but while these factors are present, a monthly or bi-monthly session facilitates relapse prevention. A final group of longer-term clients include pre-release and post-release prison inmates requiring additional support to facilitate their successful rehabilitation.

In summary, the number of clients accessing more than 10 sessions represents a very small proportion (less than 5%) of the clients accessing BE Services throughout the year. Furthermore the case management/review protocols implemented facilitate an increase in levels of expertise directed towards clients who are likely to require the most resources.

In conclusion, the theoretical therapy approach practised by the Break Even counsellors who completed the questionnaire is best described as 'eclectic' or 'integrative'. Counsellors most frequently reported using techniques from cognitive-behavioural therapy, motivational interviewing, stages-of-change or trans-theoretical model, person-centred therapy, and solution-focused therapy. This indicates that as a whole the counsellor sample bases its counselling on established and accepted theoretical approaches to intervention for problem gambling. Most counsellors reported that there is a focus on 'individually tailoring' the therapy approach based on the needs and/or requests of the client. This position is consistent with the considerable body of literature on problem gambling which demonstrates that the population of people with problematic gambling is heterogeneous in profile (e.g. Vachon & Bagby, 2009; Westphal, 2007; Blaszczynski & Nower, 2002; Legderwood & Petry, 2006; Steel & Blaszczynski, 1998). Furthermore there was general consensus amongst counsellors that there was no 'best practice' for different groups of problem gamblers. This position is extended to the sub-group of problem gamblers who re-present at a later stage. Again this is consistent with the literature and with the APS, whose position statement review paper, *Psychological Aspects of Gambling Behaviour*, states, "there is no single intervention modality that is the 'gold standard' or 'best practice' in the management of problem gambling" (1997: 21). This position is further supported by the *Productivity Commission, Gambling, Draft Report* (2009) which states that "while cognitive-behavioural therapy has the most empirical support, no one style of intervention is necessarily best practice" (5.1).

There was however, some indication in counsellors' responses that there was a tendency for males to seek a quick fix, such as self-exclusion. There was consensus amongst counsellors that problem gambling manifests in varied and complex ways. However, most counsellors identified problem gambling as maladaptive or

dysfunctional behaviour with negative consequences. Some counsellors highlighted that problem gambling is often used as a means to attempt to cope with or avoid something negative in life, such as past trauma, abuse, social isolation, low arousal or negative mood.

In diagnosis and formulation, most counsellors highlighted the immediacy of specific action being dependent upon any risk to the safety or well-being of clients and affected others. Other factors identified include the clients' ability to deal with the situation by means of their coping abilities, cognitive abilities, and the degree of social support they have. There were themes within counsellors' responses that case formulation is client-specific as the heterogeneity of the problem gambling client population requires this, and that clients are involved in the setting of goals and therapy direction. Some emphasis is placed on directing client goals towards being realistic, achievable, appropriate, prioritised, and connected with any identified underlying issue where relevant.

There was some consensus amongst counsellors that a 'successful outcome' from therapy was a positive change in gambling related activity. However, many counsellors indicated that this was 'client specific' and that it was often related to goals set by the client and counsellor together. The therapeutic relationship was indicated by the counsellor sample as a whole to be the most important factor in supporting therapy effectiveness. Factors identified by counsellors that may hinder therapy were existing complex issues in the clients' life, such as co-morbid mental or physical health conditions; stressors; or substance use or abuse. As well, personality attributes, such as rigid beliefs in control over chance or a desire of the client to be 'fixed' quickly were identified by some counsellors as factors that can hinder therapy.

The commitment and motivation of the client was indicated as being very important to therapy effectiveness. A number of themes were present in counsellors' responses to questions about therapy cessation processes. All counsellors reported conducting a review or summary of goals and achievement at the last therapy session. Most counsellors indicated that, in situations when therapy is formally ended, they invite the client to re-present if the client feels the need for support

around gambling issues. This position is consistent with the APS minimal requirement for treating problem gambling that: 'relapse prevention strategies should be included to help avoid recurrence of problems'. Most counsellors identified that many clients do not formally end therapy, rather they just stop coming. This final point highlights a challenge in seeking to assess outcomes for all clients from the therapeutic counselling of the Break Even Gambling Support Services.

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Appendix 1

Break Even Gambling Support Services

Therapeutic Counselling Follow-Up Questionnaire

ID#_____

Today's date ___/___/___

Good morning / afternoon / evening.

May I please speak with [name of participant].

This is Jason Little from the Gambling Support Program at the Department of Health and Human Services in Tasmania.

I am calling you to conduct the telephone questionnaire with you today as we had arranged. Is this still a suitable time for us to do this?

If NO, arrange an alternative time to phone back to conduct the interview:
Date ___/___/_____ Time ___:_____ am /pm

Just to remind you, this study aims to find out how effective the counselling service is at helping people with problem gambling or with problems associated with gambling.

The questionnaire asks about you and your experiences in the past six months.

It will take between 30 and 45 minutes to complete and you may withdraw from the interview or choose not to answer any questions at any time.

Your participation is voluntary and your answers will be kept confidential, so please respond openly and honestly.

If respondent asks about the confidentiality of their information?
Any information you give to me today will be coded; this means that your name or any other information that might identify you will not be written on the questionnaire. This coded information will be stored on a database and used for analysis purposes only. The questionnaire and database will be kept in a locked area in the Department of Health and Human Services and will only be accessible by the researchers. No identifying (named) information will be kept by the investigators or the Department of Health and Human Services, only by the counselling services. Any reports produced as a result of this study will not contain any information that could identify you.

Introduction

Many of the questions I am going to ask require you to reflect on two periods of time: the 6 months before you started counselling and the past 6 months of your life. It may be helpful to have a calendar or diary in front of you. Do you need a few minutes to get this?

There are no right or wrong answers, just give the answers that best describe you. Please feel free to ask me to repeat any question that you need to hear again.

Demographics

For demographic purposes the first set of questions are about yourself, such as your age, postcode etc. This will help us to understand the life patterns of people in the survey).

1. What is your age? _____ years

2. What is your postcode

3. What is your sex?

1. Male
2. Female
3. Other _____
4. Refused

4. What is your current marital status?

1. Unknown
2. Married
3. Single / never married
4. Separated
5. Divorced
6. Refused
7. Defacto

5. Do you have children?

1. no
2. yes
3. Refused

6. In what country were you born? _____

7. What has been your work situation for most of the past year?

1. In paid employment full time
2. In paid employment part time
3. Involved in household duties
4. Student
5. Retired
6. Unemployed
7. Looking for work
8. Other _____
9. Can't say

10. Refused

8. What is your occupation? *(If retired, what was your occupation?)*

1. Unknown
2. Not in paid employment
3. Professional
4. Tradesperson
5. Production / Transport
6. Manager / Administrator
7. Technical / Associate Professional
8. Clerical / Sales / Service
9. Labour and related
10. Student
11. Home duties
12. Refused

9. What is the highest level of education that you have achieved?

1. Primary school
2. High school
3. Matriculation
4. Tafe qualification
5. Undergraduate university degree
6. Post-graduate university degree
7. Other _____
8. Refused

10. How would you describe your income level?

1. Unknown
2. Low
3. Medium
4. High
5. Refused

11. What is your annual <u>household</u> income?

1. Less than $10,000
2. $10,000 - $19,999
3. $20,000 - $29,999
4. $30,000 - $39,999
5. $40,000 - $49,999
6. $50,000 - $59,999
7. $60,000 - $69,999
8. $70,000 - $79,999
9. $80,000 - $89,999
10. $90,000 - $99,999
11. $100,000 - $149,999
12. $150,000 or more
13. Can't say
14. Refused

12. What is the main source of income in your <u>household</u>?

1. Own business
2. Other private income (incl. superannuation)

3. Salary
4. Aged pension
5. Disability
6. Child support
7. Social Security
8. Austudy or Abstudy
9. Other _____
10. Can't say
11. Refused

Clinical history

The following questions ask about your reasons for attending the Break Even counselling service and about any other help you may have received for problem gambling or associated problems.

Thinking about the time when you were attending counselling for gambling problems with the Break Even Services…..

13. What was the main reason that you came to Break Even counselling at that time?

1. Legal difficulties or court-ordered treatment
2. Encouraged / pressured into treatment by spouse, family or friends,
3. Work difficulties or treatment suggested by employer
4. My own decision
5. Financial difficulties
6. Depression, suicidal thoughts or attempts
7. Separation or divorce
8. Other _____

14. When you began counselling which of the following statements best applied to you?

1. I had no intentions of changing my gambling.
2. I was seriously considering reducing or stopping my gambling in the next six months.
3. I planned to reduce or quit my gambling in the next month.
4. I had already began to reduce or quit my gambling in the previous six months.
5. I had reduced or quit my gambling over 6 months ago and had been able to maintain these changes during that period of time.

15. How many times in your life, before attending Break Even counselling with Anglicare or Relationships Australia, had you ever had 'help' for gambling problems?

	Type of help	**No. of times** *(1=Never, 2=One time, 3= Twice, 4=Three times, 5= Four times, 6= Five or more times)*
1.	Counsellor, psychologist or psychiatrist in a one-to-one setting	
2.	Telephone counselling	
3.	Financial counselling	
4.	Family counselling	
5.	Support group	
6.	Self-exclusion	
7.	Medication	
8.	Other, please describe_____	

16. During the time that you were attending personal counselling for problem gambling with Anglicare or Relationships Australia, did you receive any other treatment for problem gambling, such as?

	Type of help	**No. of times** *(1=Never, 2=One time, 3= Twice, 4=Three times, 5= Four times, 6= Five or more times)*
1.	Other counsellor, psychologist or psychiatrist in a one-to-one setting	
2.	Telephone counselling	
3.	Financial counselling	
4.	Family counselling	
5.	Support group	
6.	Self-exclusion	
7.	Medication	
8.	Other, please describe_____	

Gambling behaviour

The following questions ask about your gambling behaviour.

17. Of the games listed below, which ONE was your preferred game or type of gambling before you started counselling at Break Even?

1. Gaming machines – Casino
2. Gaming machines – Hotel/Club
3. Casino gaming tables
4. Raffles / Bingo
5. Lotteries / XLotto / Powerball
6. Keno
7. TAB / Races
8. Card games
9. Other _____
10. Can't say
11. Refused

18. Which of the following statements comes closest to describing your gambling behaviour in the past 6 months? (From today looking backwards in time over the past 6 months)

1. I have not gambled at all
2. On one or two occasions I returned to my previous gambling behaviour, but otherwise I have not gambled or have significantly reduced my gambling.
3. I have gradually cut back on my gambling
4. I gamble regularly, but less than I used to.
5. My gambling has remained the same or increased.
6. Refused

19. If you <u>have</u> gambled in the past 6 months, please indicate the reasons you believe led to your return to gambling:

1. I bet for the feeling of excitement I get
2. I bet to get money I need
3. I bet because others around me were betting
4. I bet because I have a good time
5. I bet because I feel lonely
6. I bet because it is challenging
7. I bet because it's an important part of my social life
8. I bet because I felt sad or depressed
9. I bet for other reasons_____

20. If you have gambled in the past 6 months, of the games listed below, which ONE <u>was</u> your preferred game or type of gambling?

1. Gaming machines – Casino
2. Gaming machines – Hotel/Club
3. Casino gaming tables
4. Raffles / Bingo
5. Lotteries / XLotto / Powerball
6. Keno
7. TAB / Races
8. Card games
9. Other _____
10. Can't say
11. Refused

21. South Oaks Gambling Screen (SOGS) 1992 French version

1. **Please indicate which of the following types of gambling you have done in the past <u>6 months</u>.**

(For each type, mark one answer: 'not at all', 'less than once a week', or 'once a week or more').

	Type	**Not at all** <u>(1)</u>	**Less than once a week** <u>(2)</u>	**Once a week or more** <u>(3)</u>
a.	Scratch tickets (Scratch 'n win tickets)			
b.	Lotteries (649 Lottery tickets)			

c.	Break open tickets			
d.	Sports betting (Sports Select)			
e.	Poker / Electronic Gaming machines (Video lottery / poker machines)			
f.	Bingo			
g.	Casino			
h.	Card games for money			
i.	Dice games for money			
j.	Raffles or fundraising tickets			
k.	Skill games like pool, darts, or golf for money			
l.	Sports pools (e.g. footy tipping)			
m.	Horse races			
n.	Speculative investing in stocks, futures, commodities			

2. What is the largest amount of money you have ever gambled with on any one day (past 6 months)?

Never have gambled	
$1 or less	
More than $1 up to $10	
More than $10 up to $100	
More than $100 up to $1000	
More than $1000 up to $10,000	

3. Do (did) your parents (or others close to you) have a gambling problem? (past 6 months)

Father	
Mother	
A brother or sister	
A grandparent	
My spouse or partner	
My child(ren)	
A friend or someone else important in my life	

4. When you gamble, how often do you go back another day to win back money you lost? (past 6 months)

Never	
Some of the time (less than half the time) I lost	
Most of the time I lost	
Every time I lost	

5. Have you ever claimed to be winning money gambling but weren't really? In fact you lost? (past 6 months)

Never (or never gamble)	
Yes, less than half the time I lost	
Yes, most of the time	

6. Do you feel you have a problem with betting and gambling? (past 6 months)

No	
Yes, in the past but not now	
Yes, most of the time	

7. Did you ever gamble more than you intended to? (past 6 months)

No	
Yes	

8. Have people criticised your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true? (past 6 months)

No	
Yes	

9. Have you ever felt guilty about the way you gamble or what happens when you gamble? (past 6 months)

No	
Yes	

10. Have you ever felt like you would like to stop gambling but didn't think you could? (past 6 months)

No	
Yes	

11. Have you ever hidden betting slips, lottery tickets, gambling money, IOUs or other signs of betting or gambling from your spouse/partner, children or other important people in your life? (past 6 months)

No	
Yes	

12. Have you ever had an argument with people you live with over how you handle money? (past 6 months)

No	
Yes	

13. (If you answered 'yes' to question 12): Have money arguments ever centred on your gambling? (past 6 months)

No	
Yes	

14. Have you ever borrowed from someone and not paid them back as a result of your gambling? (past 6 months)

No	
Yes	

15. Have you ever lost time from work (or school) due to gambling? (past 6 months)

No	
Yes	

16. If you borrowed money to gamble or to pay gambling debts, who or where did you borrow from? (past 6 months) ***(Check 'yes' or 'no' for each)***

		Yes (2)	**No (1)**
a.	From household money		
b.	From your spouse or partner		
c.	From other relatives or in-laws		
d.	From banks, loan companies, or credit unions		
e.	From credit cards		
f.	From loan sharks		
g.	You cashed in stocks, bonds or other securities		
h.	You sold personal or family property		
i.	You borrowed on your chequing account (passed bad cheques)		
j.	You have (had) a credit line with a bookie		
k.	You have (had) a credit line with a casino		

Gambling involvement

The following questions ask about your gambling behaviour in the 6 months before you attended counselling and then in the past 6 months (from today looking backwards in time over the past 6 months).

Thinking about the <u>6 months</u> <u>before</u> you <u>started</u> counselling, can you please tell me?

22. In a typical week, how many times did you gamble? (average number of gambling sessions)_____
23. In a typical week how many days <u>per week</u> did you gamble? _____

24. In a typical week, on average how much money did you take to the venue? $_____
25. In a typical week, on average how much additional money did you add to your gambling by:
    a) Withdrawing money from the ATM while at the venue? $_____, or
    b) borrowing money from other sources while at the venue? $_____
26. In a typical week, on average how much money did you take away from the venue? $_____
27. In a typical week, how many hours a day did you spend thinking about gambling? _____

Now, just thinking about the time during the <u>past</u> 6 months, can you please tell me?

(From today looking backwards in time over the past 6 months)

28. In a typical week, how many times did you gamble? (average number of gambling sessions)_____
29. In a typical week how many days <u>per week</u> did you gamble? _____
30. In a typical week, on average how much money did you take to the venue? $_____
31. In a typical week, on average how much additional money did you add to your gambling by:
    a) Withdrawing money from the ATM while at the venue? $_____, or
    b) borrowing money from other sources while at the venue? $_____
32. In a typical week, on average how much money did you take away from venue? $_____
33. In a typical week, how many hours a day did you spend thinking about gambling? _____

34. Quality of Life Inventory

I am now going to ask you some questions about how satisfied you are with parts of your life, such as your work, your health and how you have been in the <u>past 6 months</u>. I am also going to ask you how important these things are to your happiness. It is important that you answer every question even if it does not seem to apply to you. It is your feelings and opinions that are important, so there are no right or wrong answers. Just give the answers that best describe you in the <u>past 6 months.</u>

Drugs and alcohol use

The following questions ask about your use of tobacco, alcohol and drugs in the past 6 months.

35. During the past 6 months how frequently have you used?

	Not in the past 6 months	Less than once a month	1-3 days a month	1-2 days a week	3-6 days a week	Daily
Tobacco (cigarettes, chew)						
Alcohol (beer, wine, liquor)						
Marijuana or hash						
Other drugs (not for medical purposes) please specify:						

Mental health

The following questions ask about your mental health now and in the past.

36. Have you ever had a significant period (that was not a direct result of drug / alcohol use), in which you have:

		No	**Yes**
	Experienced serious depression in your life? Past 30 days?	1 1	2 2
	Experienced serious anxiety or tension in your life? Past 30 days?	1 1	2 2
	Experienced hallucinations in your life? Past 30 days?	1 1	2 2
	Experienced trouble understanding, concentrating or remembering in your life? Past 30 days?	1 1	2 2
	Experienced compulsive behaviour (other than gambling) such as binge-eating, fasting or sexual activity in your life? Past 30 days	1 1	2 2
	Experienced trouble controlling violent behaviour in your life? Past 30 days?	1 1	2 2
	Experienced serious thoughts of suicide in your life? Past 30 days?	1 1	2 2
	Attempted suicide in your life? Past 30 days?	1 1	2 2
	Been prescribed medication for any psychological or emotional problems in your life? Past 30 days?	1 1	2 2

Client satisfaction

The final questions ask about your experiences with the counselling service.

37. How helpful was the individual counselling you received?

1. Much help
2. Some help
3. Little help
4. No help

38. How satisfied were you with:

i) Your counsellor?

1. Very satisfied
2. Mostly satisfied
3. Mildly satisfied
4. Quite dissatisfied

ii) The skills / strategies you learned?

5. Very satisfied
6. Mostly satisfied
7. Mildly satisfied
8. Quite dissatisfied

iii) The overall services you received?

9. Very satisfied
10. Mostly satisfied
11. Mildly satisfied
12. Quite dissatisfied

39. If you were dissatisfied, please explain?

_____
_____
_____
_____

40. What was most helpful about this service?

_____
_____
_____
_____

41. What would you change about this service?

_____
_____
_____
_____

42. Do you have any further comments or suggestions?

_____
_____
_____

Appendix 2

Gambling Support Program

Break Even Gambling Support Services

Clinical Practice Evaluation of Break Even Services – Counsellor Questionnaire

The following set of questions is aimed at providing an in-depth look at the personal counselling work being undertaken at Break Even Services in helping people with gambling problems. The questions are open-ended and require answers in written format. This format has been selected to provide counsellors with the opportunity to have time to consider their counselling practice and then articulate it. It is important that you answer these questions carefully and in your answers reflect both the range of your practice and the most typical features of your counselling practice at Break Even.

The questions cover the following sections with a description of the purpose of the section provided at the beginning of each section.

Section 1: The relationship between theoretical frameworks and applied techniques in counselling practice.

Section 2: Diagnosis and its formulation. The diagnostic decision-making process of counsellors.

Section 3: Case management and related issues. An overview of the way counselling practice occurs within Break Even Services.

Section 4: Counsellor views on counselling outcomes.

If you require additional space please use the back of the sheets, noting clearly the question to which the answer belongs. If you would like to prepare your response on the computer and have email access, please contact Jason Little and he will forward you a copy: Jason.Little@dhhs.tas.gov.au or email: gambling@dhhs.tas.gov.au.
Your responses to this questionnaire will be kept strictly confidential and stored within a secure area in the Health Department. The published report will not identify you in any way.

If you have any questions or queries please contact Jason Little (Researcher) on 6233 – 2790.

Today's date ___/___/___

Counsellor ID number: _____

Agency: [ ] Anglicare

[ ] Relationships Australia

Section One: Theoretical Orientation

This section considers the relationship between theoretical frameworks and applied techniques in counselling practice.

1. Describe the theoretical orientation your counselling practice at Break Even is based on. (Please provide a descriptive overview of your theoretical framework, including the names of any influential individuals or books. Details of the actual techniques and strategies you use are covered in question 8.)

2. Describe what you understand 'problem gambling' to be.

3. Describe what you understand to be the cause(s) of 'problem gambling'

Section Two: Diagnosis and its Formulation

In this section we would like to understand the diagnostic decision-making process of counsellors. We are interested in what counsellors' therapeutic decisions are based on and how these relate to the issues clients present with.

4. What criteria do you apply when assessing the counselling needs of your client?

5. Describe the process you use for setting goals for your interventions with clients.

6. How do you decide which techniques and strategies you will use with clients?

7. How do you decide when and where to refer clients for additional support?

Section Three: Case management and related issues

This section will provide an overview of the way counselling practice occurs within Break Even Services. We are interested in exploring the 'minutiae' of a counsellor's daily practice and the techniques and strategies they employ in that practice.

8. Please provide specific examples of the techniques and strategies you use when counselling clients. (Examples: Reflective listening, imaginal desensitisation, free association, role playing).

9. Describe the techniques you understand to constitute Cognitive Behavioural Therapy.

10. To what extent do you consider the counsellor-client relationship important in your counselling practice? (Please circle your answer.)

A great deal A fair amount Somewhat Very little Not at all

11. Describe how you use the counsellor-client relationship in your counselling practice.

12. Describe the techniques you use in ending counselling with a client.

13. Describe how you go about reviewing the progress of your counselling with clients.

14. In what ways does the work you do with re-presenters differ from that with new clients to the service?

Section Four: Counselling Outcomes

This section aims at developing a picture of counsellors' views regarding counselling outcomes; what they are and how they are achieved.

15. What do you consider to be a successful outcome in your counselling practice?

16. What factors do you consider to contribute to achieving successful outcomes in counselling?

17. What factors do you think hinder the achievement of successful outcomes?

18. Do the 'best' methods of intervention for people with gambling problems differ for different groups (e.g. men/women, people from different cultural backgrounds, type of gambling preferred, severity of gambling-related problem, length of time the person has experienced the problem, other problems a person may have in their life).

19. What do you do to keep up-to-date with new developments in your field?

This Counsellor questionnaire is taken from:
Jackson, A.C., Thomas, S.A., Thomason, N., Borrell, J., Crisp, B.R., Ho, W., Holt, T.A. and Smith, S. (2000) *Longitudinal Evaluation of the Effectiveness of Problem Gambling Counselling Services*, Community Education Strategies and Information Products – Volume 2: Counselling Interventions, Melbourne: Victorian Department of Human Services, Appendix D: Clinical Practice Evaluation of Break Even Services – Counsellor Questionnaire, pages 139 – 141.

Additional question (no. 18) taken from:
Jackson, A., Thomas, S., Blaszczynski, A. (2003), *Best Practice in Problem Gambling Services*, Prepared for the Gambling Research Panel by Melbourne Enterprise International, Gambling Research Panel Report No. 3, page 57.

Thank you for your participation in this study. Please return your completed questionnaire to the researcher in the reply-paid envelope provided.

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GAMBLING SUPPORT PROGRAM

Disability and Community Services

Department of Human Services

GPO Box 125, Hobart 7001

Ph: 6233 3204

Email: gambling@dhhs.tas.gov.au

Visit: www.dhhs.tas.gov.au/gambling