The University of Sydney

Problem Gamblers Receiving Counselling or Treatment in New South Wales

Seventh Survey
December 2003

A Report for
The Casino Community Benefit Fund Trustees

Prepared by:

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

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

EXECUTIVE SUMMARY

The seventh annual survey of counsellors providing services for problem gamblers was conducted in November, 2003. An attempt was made to contact all agencies and counsellors who provide face-to-face counselling for problem gamblers and their families. Altogether 181 counsellors were interviewed from a full list of 188. The counsellors were asked demographic details of their clients who have problems associated with gambling. These details were obtained for clients counselled in a seven day period prior to the date of interview and for clients with appointments in the next seven days following the interview. The counsellors were also asked about the maximum number of clients that could be counselled in a one week period, assessment of clients' problems, approaches to treatment, and evaluation of effectiveness of treatment. The results showed that:

(1) the number of individuals receiving treatment/counselling in a one week period (n=843) was similar to the number in the same period in 2002 (n=834). This result may indicate that the numbers of individuals seeking help in relation to gambling problems is reaching a plateau. Previously, numbers had steadily increased from year to year.

(2) 87% of the individuals receiving face-to-face counselling were problem gamblers. The remainder were significant others, primarily family.

(3) 82% of the counselling sessions involved the counsellor and one client only;

(4) Of the problem gamblers, 59% were male, 54% resided in Sydney, 64% were Anglo-Australian, and the average age was 40 years;

(5) The primary cause of problems was gambling on electronic gaming machines (86%); betting on races (horse and dogs) accounted for 7% and casino gambling (excluding poker machines) accounted for 1%.

(6) Most counselling focused on helping the individual to cut back and/or stop gambling, (81%).

(7) The G-line telephone referral service was responsible for 27% of all referrals, which is consistent with previous surveys.

(8) Usage of counselling services (numbers counselled compared to the maximum) across the State was 55% compared with 63% in 2002. When 'no shows' are taken into account, the availability of places for prospective clients was 34%.

(9) The most commonly used assessment of problem gambling was the South Oaks Gambling Screen which was used by 51% of CCBF funded counsellors.

(10) A majority of CCBF funded counsellors work with either abstinence or control as the goal of treatment (76%), and negotiate which will be the goal of treatment with the client (70%). The clients of a majority of CCBF funded counsellors (67%) are evaluated between one month and two years following the completion of treatment.

BACKGROUND

Surveys of problem gamblers receiving treatment in New South Wales began in 1997. At that time agencies offering specialist services to problem gamblers and their families were relatively few in number. In 1995, a two percent levy on casino profits was introduced under the title of the Casino Community Benefit Fund (CCBF). A primary role of the CCBF is to fund services for problem gamblers. Since 1997, a majority of the agencies providing these services have been supported by the CCBF. Among the services introduced was the G-line telephone counselling and referral service. The first two surveys, conducted in 1997 and 1998, had as their primary aim the evaluation of the effectiveness of the G-line initiative. Since its introduction, approximately 25% of problem gamblers seeking help have been referred by G-line.

One of the important results of the annual survey has been the documentation of the increasing numbers of individuals seeking help with problems associated with excessive gambling. Since 1997, there has been a uniformly increasing usage of services by problem gamblers from 154 per week to 834 per week in 2002. To what extent this increased usage of services is associated with increased availability and advertising is not known. However, there can be little doubt that the knowledge of the extent to which the existing network of services is used has provided feedback on the extent to which the planning and provision of services has been successful.

Although the primary aim of the surveys has been to provide demographic information concerning the population of problem gamblers seeking help, a secondary aim has been to document the services offered and to indicate levels of usage. The annual surveys have reported on methods of assessment, approaches to treatment, and the extent to which the success of treatment is evaluated. Additionally, the 2002 survey reported on the availability of counselling and the usage of services in relation to capacity. The seventh annual survey in 2003 is thus able to provide information on changes in availability, usage and capacity of the network of existing services.

AIMS OF THE SEVENTH SURVEY

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

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

METHOD

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

Locating Relevant Agencies and Individuals

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

The full list of agencies and individuals providing services for problem gamblers was constructed based on reference to a number of different sources. The starting list was set at the agencies and individuals contacted in the sixth survey conducted in 2002. This list was extended by adding agencies and individuals for whom information was available from:

- a complete list of agencies funded by the CCBF and supplied by the CCBF Branch of the Department of Gaming and Racing;
- information acquired from counsellors during their interviews for the 2003 survey in answer to a question concerning any other services for problem gamblers in their neighbourhood, suburb or township.

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

Success in completing interviews

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

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

Counsellor Interview Status	N All
Full list of all counsellors providing services for problem gamblers	188
Counsellors who were interviewed	181
Counsellors who were not interviewed	7
• Could not be contacted in the survey period - status unknown	2
• On holidays during the survey period	2
• No suitable time could be arranged for the interview	2
• Declined to be interviewed	1

Note: 153 of the 181 counsellors interviewed were CCBF funded counsellors

Altogether, 181 counsellors of a complete list of 188 were interviewed. The proportion of counsellors not interviewed (4%) is relatively small for a survey of this size. The major difference between this survey and that of the previous year was the number of counsellors on recreation leave. This number dropped from 11 in 2002 to 2 in 2003. Counsellors who are on leave can be assumed to have made arrangements for the care of their clients during their absence. For example, other counsellors at the agency may have taken on a temporary increased load. Only one counsellor declined to participate, two could not be contacted and one counsellor did not make a time at which they would be available for interview. The absence of this number of counsellors from the survey is relatively small and the absence of their data is likely to have little impact on the demographic profile of problem gamblers receiving help.

Conduct of Survey and Interviews

The interviews were conducted by seven interviewers. All were experienced interviewers who were supervised by the senior interviewer from the fourth, fifth and sixth surveys. The interviewers were trained in conducting the structured interview in order to minimise variations in actual interviewing procedures.

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

Counsellors were contacted by telephone to arrange a suitable time for an interview. It was the intention of the research team that all interviews would be conducted face-to-face. Altogether, 181 counsellors were interviewed. Of these, 178 interviews were conducted face-to-face and three were conducted by telephone. In all three interviews conducted by telephone, the small number of clients seen in the previous week and the large distances of travel involved, precluded the use of the face-to-face technique.

Interview Questions

The interview questions fall into six parts. Part A contains questions concerning the demographic details of all clients counselled, in relation to problem gambling, in the seven days prior to the day of the interview. 'Counselling a client' included face-to-face contact with the client alone or within a family or group context, telephone counselling, and counselling via the internet. However, nearly all analyses in the report are based on face-to-face contact only. Part B contains questions concerning the demographic details of clients for whom there are appointments in the next seven days following the day of the interview. Age is sometimes estimated by counsellors as falling in a range (for example, 50-55 years). In these cases, the mid-point of the range is entered as the datum. Ethnicity is based only on self identification by the client. Type of gambling sometimes includes a range of gambling activities. Interviewers probed for the type of gambling that appeared to be the main cause of gambling problems. Where no main cause of problems could be established, the type of gambling was categorised as multiple. Poker machine gambling in the casino was counted as ' poker machine' gambling rather than 'casino gambling'. Part C includes questions concerning the current caseload of the counsellor and the capacity of the counsellor to provide a service to clients. Capacity is conceptualised as the maximum number of clients that can be offered a service that meets the counselling standards of the counsellor. Part D concerns the extent to which the gambling and associated problems are assessed prior to treatment. Counsellors were asked to nominate the screening devices used. Part E includes questions concerning the process whereby the counsellor determines whether the help given to the client has been successful in achieving its goals. Finally, in part F a set of questions was included which related to the goals, expectations and nature of the treatment provided to the gambler. The full interview schedule is shown in Appendix B. The questions in parts A, B and C were also asked in all previous surveys and form the basis for measuring change over time. Questions in parts D and E were included in 2001 and 2002. The questions in part F were from the sixth survey in 2002 but with minor changes in wording.

Rationale for the treatment section of the interview

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

The implication of these problems is that the straightforward approach of asking the counsellor to give a label to the treatment method used should be avoided as the sole means of classifying the treatment approach. A method by which a treatment approach is

classified according to a set of explicit criteria would be preferred over self-reported labels. In the report on the sixth survey conducted in 2002, treatment approach was classified by the responses to two questions concerning (a) the nature of excessive gambling, and (b) the main processes by which a gambler can be helped to cut back or stop gambling. The category of treatment determined by this approach was then validated against the procedure used in counselling the last client seen and the self-reported label supplied by the counsellor or therapist for the treatment. It is proposed to use the same approach in the analysis of treatment related responses obtained in the current survey.

Three broad treatment categories were defined on theoretical grounds:

- methods aimed at reducing addiction to gambling ("addiction");
- methods aimed at changing cognitions about gambling ("cognition");
- methods aimed at decreasing outside pressures to gamble ("escape").

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

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

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

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

RESULTS

Consistent with previous reports in this series, the primary results are those obtained by interviewing counsellors throughout New South Wales. The main funding for problem gambling counselling comes from the Casino Community Benefit Fund, accounting for (85%) of the counsellors interviewed. In the tables that follow, the focus of the demographic information is that group of individuals receiving face-to-face counselling for gambling problems in New South Wales (Tables 2-7). Parallel tables summarising the data provided by CCBF funded counsellors appear in appendix C. Information relating to assessment, treatment and evaluation is presented for CCBF-funded counsellors only (Tables 8-17).

Numbers of Problem Gamblers in Treatment

Prior to 1997, there were very few counselling services specifically oriented to the needs of problem gamblers. Services were available in some of the larger public hospitals, but there was no attempt to provide services accessible to individuals across the State. In 1995, a community levy was placed on the revenues of the Darling Harbour Casino and this levy has continued with the Star City Casino. The levy contributes approximately ten million dollars, of which approximately seven million dollars are allocated to support sixty specialist services throughout New South Wales. Of the 181 counsellors interviewed in this study, 153 are funded through the CCBF. Table 2 shows the modes of counselling undertaken.

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

Counselling modality	CCBF funded		Other funded		Total	
	N	%	N	%	N	%
Number of Counsellors	153	84.5	28	15.5	181	100
Number of Clients (1 week)	767	87.3	112	12.7	879	100
Problem Gamblers (1 week)	657	86.6	102	13.4	759	100
Face-to-face counselling	734	87.1	109	12.9	843	100
• Individual	601		96		697	
• Group	133		13		146	
Counselling at a distance	33	91.7	3	8.3	36	100
• Telephone	33		3		36	
• Internet	0		0		0	

The results in table 2 should be interpreted in the context of the survey which is oriented to face-to-face counselling. An attempt was made to include all agencies that provided face-to-face counseling for problem gambling. Agencies which provided only telephone counselling (such as G-line) or internet counselling were not included.

Altogether, in a one week period in November 2003, 181 counsellors provided face-to-face counselling services for 843 clients. Figure 1 shows the numbers of clients seen in a one week period at a similar time of year across the years 1997-2003. With the results for 2003 included, the increasing numbers of clients year-by-year can now be best interpreted as

beginning to level off. Nevertheless, whether the numbers of problem gamblers seeking help in New South Wales is reaching a plateau depends heavily on the data that will be obtained in 2004.

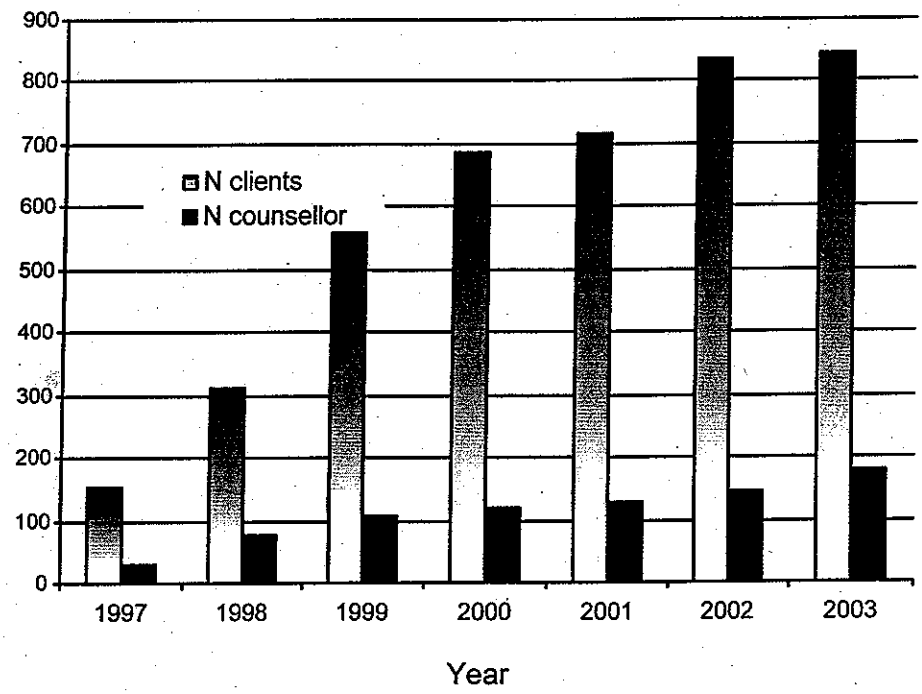

Figure 1: The numbers of individuals receiving face-to-face counselling in relation to problem gambling in NSW (tall columns) and the numbers of counsellors providing those services (short columns).

The Different Types of Service Provided

A range of counselling services are available in New South Wales for problem gamblers and their families. Most of the counselling is directed to helping the problem gambler cut back or stop their gambling behaviour. Counselling is also supportive with respect to the problems associated with the excessive gambling. In table 3, all of these counselling services are grouped together under the label of "addiction". Other services include financial counselling, legal counselling, and court assessments. In terms of the help provided, a distinction is made between one-on-one face-to-face counselling and group counselling. In table 3, group counselling is regarded as any counselling where two or more people are receiving the counselling at the same time. Thus, counselling a husband and wife in relation to the gambling problems of one of the partners is counted as group counselling. Counselling a person who does not have a gambling problem is listed as "relationship" counselling. Thus, group counselling typically includes both addiction counselling (for the problem gamblers) and relationship counselling (for others who are not problem gamblers).

Table 3 shows that, although the total numbers of problem gamblers and their families receiving counselling has increased dramatically across years, the percentages receiving different types of counselling have remained relatively constant. Across the years 1999 to 2002, 15% of counselling occurred in a group context compared with 18% in 2003. In

2003, 87% of the clients counselled were problem gamblers themselves and 13% were significant others (primarily family). This proportion of problem gamblers to significant others is similar to those in previous years (88% in 2002; 86% in 2001).

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

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

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

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

Counsellors were asked to provide, for each client counselled in the last seven days, the gender, estimated age, ethnic background, main type of gambling currently causing problems, and the postcode or name of the suburb or town in which the client lived. Counsellors were also asked to provide a category label for each gambler (problem, pathological, compulsive, etc). Where age was estimated as falling within a range, the mid-point of the range was used in calculations. Table 4 shows the proportions of gamblers according to gender, location (rural or Sydney), and ethnic background of problem gamblers counselled face-to-face in a one-week period prior to the day of interview. The data for previous years is provided for comparison.

The demographic trends across years are shown in figure 2. Across years the trends in the percentages of problem gamblers falling in different demographic categories is relatively stable. The trends can be summarised as follows.

Gender: From 1999 to 2003, the proportion of male problem gamblers seeking help has been approximately 60% across years. However, the proportions of male and female problem gamblers seeking help vary depending on the type of gambling. For machine gambling the proportions in 2003 were 54% (male) and 46% (female) whereas for betting on horses the equivalent proportions were 96% and 4%.

Location: Approximately 63% of the population of New South Wales lives in metropolitan Sydney (ABS, 2000). On a simple population basis, a similar proportion of problem gamblers would be expected. However, since 1999, the proportion of Sydney-based problem gamblers has been consistently lower than 63% (varying across years between 54% and 62%). Part of the explanation for this difference may involve the distribution of poker machines between Sydney and the rest of New South Wales. According to Shepherd and Manning (2003) the proportion of poker machines in NSW that are located in Sydney is approximately 50%. Thus, if availability is associated with problem gambling, the percentages of problem gamblers for Sydney would be expected to be relatively lower than for areas outside Sydney.

Table 4:
Percentage of problem gamblers (seen individually in face-to-face sessions in the last seven days) in various demographic categories

	Year	1997	1998	1999	2000	2001	2002	2003
	N=	154	310	558	686	558	672	634
Variable	**Demographic Category**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Gender	Male	80	65	61	62	63	59	59
	Female	20	35	39	38	37	41	41
Location	Sydney	79	73	54	55	62	58	54
	Rural	21	27	46	45	38	42	46
Average age	Full sample (yrs)	37	38	39	38	39	39	40
Ethnicity	Anglo-Aust.	71	71	76	68	57	66	64[1]
	Other English	9	4	4	4	10	6	8
	NESB non-Asian	15	17	11	21	21	16	17
	Asian	3	5	6	5	9	8	7
	Islander	1	2	2	1	<1	1	2
	Aboriginal-Aust.	0	1	1	1	3	3	2
	Other	1	0	0	0	0	0	0
Type of gambling	Machines	74	79	83	88	85	87	86[1]
	Racing	17	12	11	8	6	5	7
	Casino	6	6	5	2	6	3	1
	Numbers	0	2	1	1	<1	<1	<1
	Sports betting	-	-	-	<1	<1	<1	<1
	Stock market	0	0	0	<1	<1	0	<1
	Multiple	3	1	0	0	2	4	4
	Other	0	0	0	0	<1	<1	1

Notes: (1) Percentages are calculated excluding the category 'unknown' (ethnicity n=1; gambling type n=3)
(2) Prior to 2001, percentages were based on all clients rather than problem gamblers only.

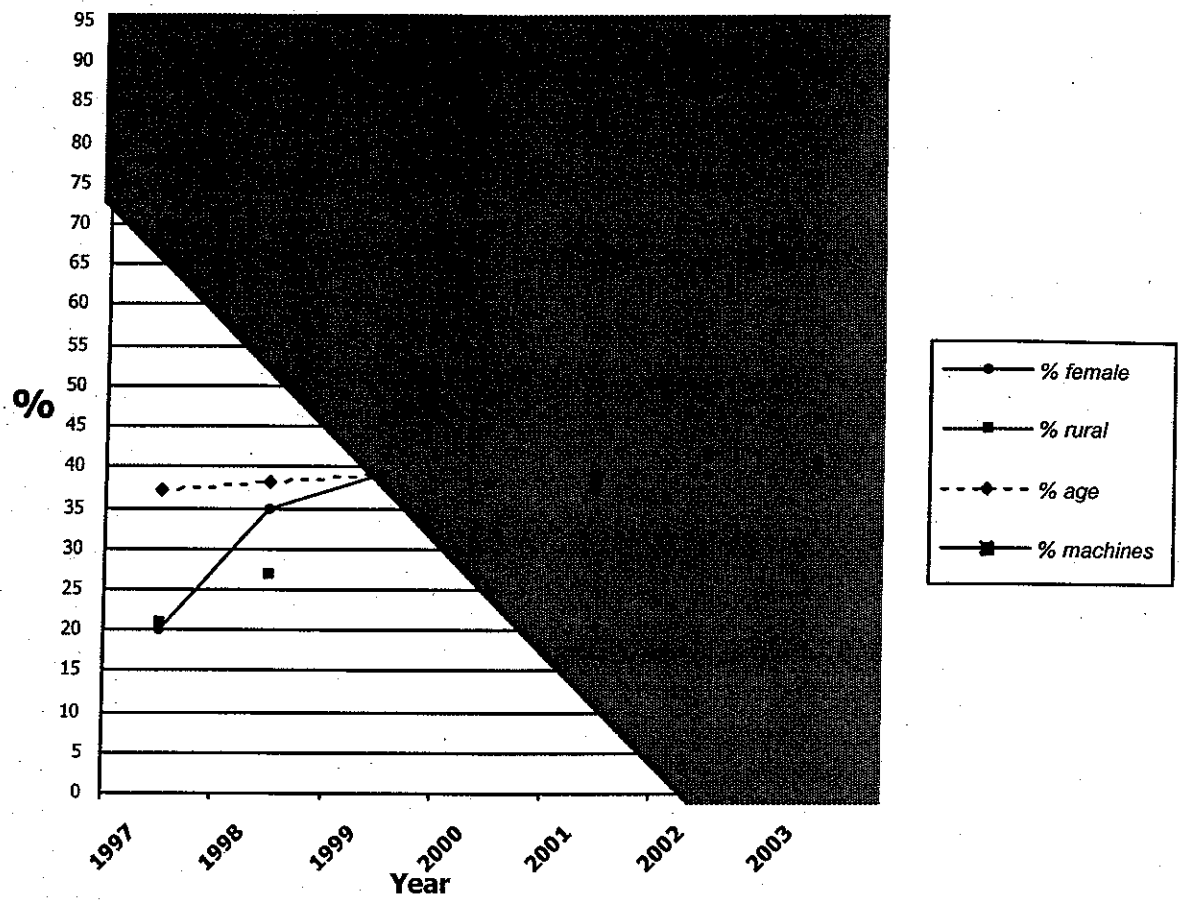

Figure 2: Demographic trends of problem gambling

Average age: The mean age of problem gamblers seeking treatment has been remarkably constant across years with an average age of 39 from 1999 to 2003. However, it is important to note that the mean conceals wide variability.

Ethnicity: Approximately two thirds of problem gamblers seeking treatment are classified as Anglo-Australian. From the perspective of planning services, the large proportion of people from non-English-speaking backgrounds (at least 17% in 2003) is an important result.

Gambling type: It can be seen that 86% of individuals seeking help in relation to gambling have electronic gaming machines as the primary cause of their problems. Individuals with electronic gaming machines in the casino as their primary problem are categorised under 'machine' rather than 'casino'. Casino games accounted for only 1% of problem gamblers seeking treatment. For the first time, the 'Other' category accounted for 1% of problem gamblers. The main problem in the 'Other' category was internet gambling.

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

A similar analysis may be made of clients with appointments in the next seven days. Since many of the clients with appointments in the coming week will be clients counselled in the previous week, it can be anticipated that the same demographic trends shown in table 4 will be repeated in table 5. Many appointments for sessions in the next seven days are for new clients, about whom little is known. Data for new clients is included only if it is known that the new client is a problem gambler. On this basis, the information for 64 new clients was excluded.

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

	Year	1997	1998	1999	2000	2001	2002	2003
	Number of clients	116	249	456	246	445	481	531
Variable	**Demographic Category**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Gender	Male	75	66	57	61	64	57	63
	Female	25	34	43	39	36	43	37
Location	Sydney	91	72	58	54	59	61	63
	Rural	9	28	42	46	41	39	37
Average age	Full sample (yrs)	38	39	39	38	40	39	40[(1)]
Ethnicity	Anglo-Australian	67	67	77	72	63	65	68[(1)]
	Other English	10	5	3	7	7	5	8
	NESB non-Asian	15	17	12	15	22	18	16
	Asian	3	7	6	3	6	8	5
	Islander	2	1	1	1	<1	1	1
	Aboriginal	0	1	1	2	2	3	2
	Other	3	2	0	0	0	0	0
Type of gambling	Machines	67	83	85	90	86	87	84[(1)]
	Racing	24	10	10	9	6	5	8
	Casino	9	6	5	1	4	3	4
	Numbers	0	1	0	0	1	<1	0
	Stock market	-	-	-	0	<1	0	<1
	Multiple	-	-	-	0	2	4	3
	Sports Betting	-	-	-	-	<1	<1	<1
	Other	-	-	-	-	<1	<1	<1

Notes: (1) Percentages are calculated excluding the category 'unknown' (age n=11; ethnicity n=17; gambling type n=1)
(2) Prior to 2001, percentages were based on all clients rather than problem gamblers only.
(3) Entries where it was not known whether the client was a problem gambler were excluded (n=64 in 2003).

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

Problem gamblers find help through a number of sources. A person seeking help with gambling problems can find that help through advertisements in local newspapers, signage in clubs and hotels, entries in telephone books, and through word of mouth. However, in order to provide a centralised referral service specialising in appropriate referrals, the CCBF funded the G-line telephone referral service.

Table 6:
Source of referral for all clients treated in a seven-day period in 2003

Source of Referral	Last seven days			Next seven days		
	all %	N	%	all %	N	%
Telephone Referral	**28.4**			**28.7**		
• G-line [1]		231	27		209	28
• Lifeline		8	1		8	1
Advertising	**13.2**			**9.1**		
• Advertising [2]		83	10		47	6
• Telephone books		23	3		17	2
• Internet		5	1		5	1
Individuals	**16.0**			**14.4**		
• Self		24	3		28	4
• Family or friends		94	11		63	8
• Another client of the agency		17	2		18	2
Gambling Related Agencies	**14.8**			**12.3**		
• Another gambling agency		60	7		54	7
• Other counsellor within agency		17	2		10	1
• Gambling industry		48	6		29	4
Non-Gambling Agencies	**22.7**			**20.9**		
• Medical		32	4		26	3
• Parole service		21	2		20	3
• Police		2	<1		0	0
• Legal agent		9	1		5	1
• Employer		3	<1		3	<1
• Church		5	<1		6	1
• Other non-gambling agency		119	14		98	13
Other	**0.2**	2	<1	**0.3**	2	<1
Not known	**4.7**	40	5	**14.3**	108	14
Number of clients	**100**	843		**100**	756	

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

This service is advertised in clubs and hotels and was the subject of televised advertisements in November 2002. Table 6 shows a break down of the various ways in which clients acquire the information that leads them to seek help from a particular agency.

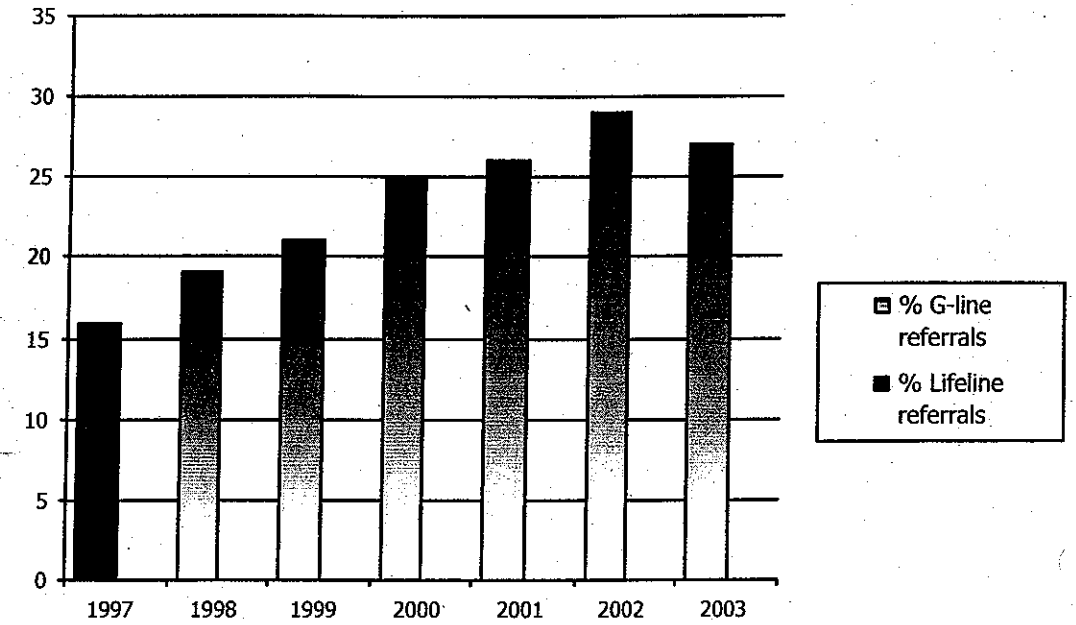

Figure 3: G-line referrals expressed as a percentage of referrals
Note: The G-line referral service was not implemented until after the 1997 survey. Prior to 1998 the main telephone referral service was Lifeline.

In 2003, G-line referrals accounted for 27% of all clients receiving face-to-face counselling in relation to problem gambling. This is consistent with the proportion of referrals in previous years (figure 3). The small decrease from 2002 to 2003 is probably attributable to the G-line advertising campaign which was active in November, 2002, but had not yet begun in November, 2003. Although the G-line referral service is the major single source of referrals, it is clear that other referral agents also play important roles. In particular, a range of agencies which are not directly related to gambling (medical, legal, employers etc) are able to make referrals directly to specialist problem gambling services.

Capacity and usage of services

Ideally, problem gambling services are available when individuals require them. If a particular service is not available, then the individual seeking help may be placed on a waiting list. Waiting lists are defined as individuals seeking help who cannot receive an appointment within seven days because all available appointment times are full. If there are multiple agencies providing the same or similar service in the area, then it is expected that appropriate referrals are made. Waiting lists are most likely to arise in rural districts where there is only one agency providing services for a large geographical area, or where the service required is highly specialised, as is the case with in-patient treatment facilities.

Table 7 shows the actual numbers of individuals on waiting lists for services across years. It can be seen that the numbers of potential clients waiting for services in 2003 is comparable with previous years. Furthermore, of the twenty individuals waiting for places, eight were waiting for admittance to an in-patient service. A further four individuals were waiting for the opportunity to see a counsellor from an agency which is not funded by the CCBF. The relatively small numbers of individuals waiting for services suggests that there is adequate availability of help for those who seek it.

Table 7:
The presence of waiting lists for problem gambling clients

	1997	1998	1999	2000	2001	2002	2003
Number of Counsellors	31	78	105	120	130	147	181
Counsellors with waiting lists	7	3	4	3	6	7	8
Number of clients waiting	22	24	9	5	21	15	20

Counsellors were asked to nominate the maximum number of clients that they could counsel while maintaining their counselling standards. Summed across counsellors throughout the State, this figure defines the capacity of the network of agencies to provide a quality service for individuals with gambling problems. The actual number of individuals who received counselling defines the usage of services. In figure 4, usage is expressed as a percentage of capacity. Figure 4 shows the percentage usage across years. The data labelled 'rural' refers to all agencies which operate outside of the Sydney region.

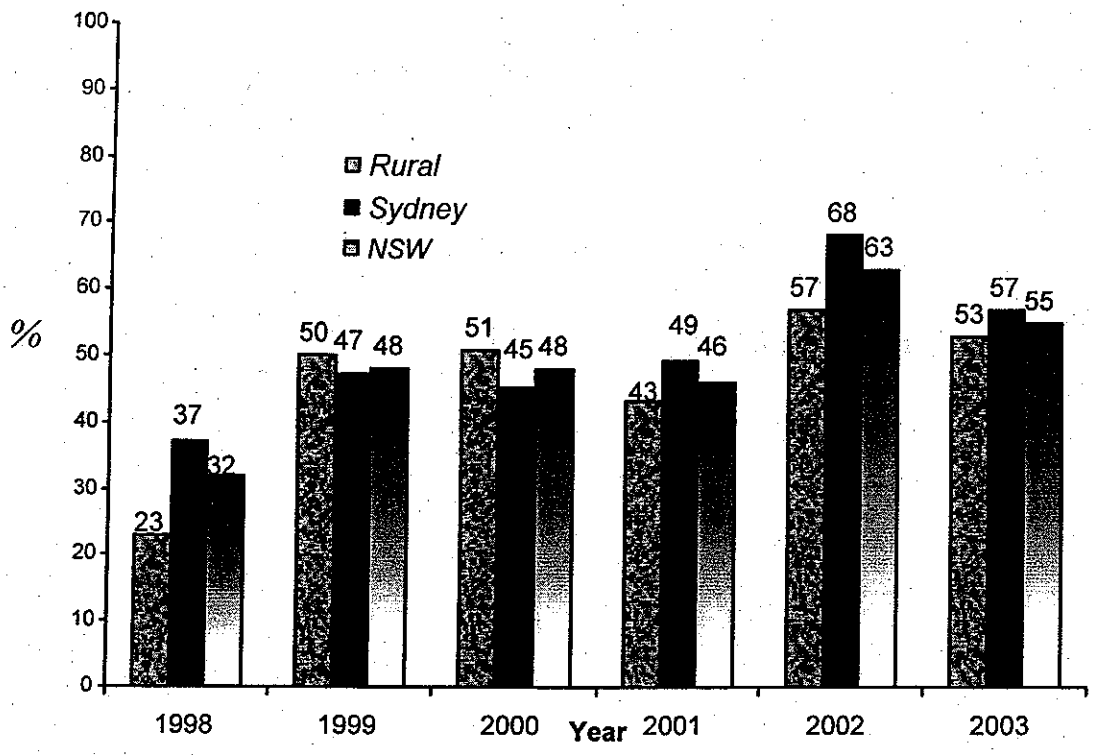

Figure 4: Usage of services as a percentage of capacity.

Percentage usage in 2003 was 55%. Although this is a decrease from the 63% recorded in 2002, it should be noted that usage in 2002 and 2003 is higher than in previous years.

Usage figures do not fully reflect the availability of services. An individual counsellor, with a capacity to provide face-to-face counselling for ten clients in a week, for example, may have eight appointments but see only five clients. Three clients may not arrive for their appointments. Thus, although this counsellor has 50% usage, the availability for further appointments is only two out of ten (20%). Availability refers to available appointment times calculated as a percentage of capacity. From the perspective of both counsellors and their prospective clients, percentage availability is a better indicator than usage of the ease with which an appointment can be made. For New South Wales, availability was 34% in 2003 compared to 37% in 2002. Availability in locations outside Sydney was 42% whereas availability within Sydney was 29%.

Assessment of Problem Gambling by CCBF Funded Counsellors

Assessment refers to the means by which the counsellor obtains information which guides or determines treatment and/or referral. A full assessment of each client would involve both assessment of the problem gambling and assessment of co-morbidities in relation to the problem gambling.

Assessment of the severity of problem gambling makes possible evaluation of treatment effectiveness and may be used to guide treatment. Assessment of co-morbidity allows the counsellor to plan the management of the problem, which may involve further referrals. From the perspective of treatment effectiveness, pre-treatment measures of the severity of problem gambling are prerequisite. A range of tests are available of which the two most well-known are the South Oaks Gambling Screen (SOGS) and the criteria for pathological gambling in the Diagnostic and Statistical Manual of the American Psychiatry Association, fourth edition (DSM-IV). The SCIP is a structured clinical interview which provides a measure of the DSM-IV criteria. Table 8 shows that a wide range of problem gambling assessment methods are used by CCBF funded counsellors. Of the 153 counsellors interviewed, only 19 (12%) used no form of assessment. The most commonly used tests were the South Oaks Gambling Screen (51%) and the DSM-IV criteria (38%). Since some counsellors use more than one test, the percentages for usage of each test will sum to more than 100%.

Table 8:
Tests used to measure problem gambling
(based on 153 CCBF-funded counsellors)

Assessment	%	N
South Oaks Gambling Screen	**51**	
Lifetime		6
Revised		54
Modified		17
Chinese		1
DSM Criteria	**38**	
DSM Criteria-Questionnaire		41
SCIP –Structured Interview		17
Other Questionnaires	**38**	
G-map		19
Gamblers Anonymous 20 Questions		11
Agency questionnaire		13
Intake questionnaire only		1
Victorian Gambling Screen		2
NODS		2
Gambling Symptoms Assessment Screen		1
Gambling Severity Index		2
Other Questionnaire		2
Wesley Questionnaire		5
Other Interview	**21**	
Unstructured interview		26
Structured interview		6
No Assessment	**12**	19

Note: Percentages do not sum to 100 since some counsellors use multiple tests.

Assessment of suicidality

One of the most important tasks for the counsellor is the assessment of the likelihood of self-harm and suicidal ideation. Assessment may proceed by recognised test or by structured or unstructured interview techniques. Table 9 shows the distribution of approaches used by the 153 counsellors funded by the CCBF.

Table 9:
Method of assessing suicidal tendency
(based on 153 CCBF-funded counsellors)

Assessment	N
Determined by interview	
• Structured interview	26
• Unstructured interview	89
• DSM-IV	2
• SCIP interview	3
Inferred from Gambling Questionnaire	
• Beck Depression Inventory	5
• Depression, Anxiety & Stress Scale	2
• Agency questionnaire	1
• Intake questionnaire	10
• Other questionnaire	7
• G-Map	2
No assessment	6
Total	**153**

From table 9, it is clear that the most common approach to assessing suicidal tendency involves interviewing the client (78%).

Assessment of co-morbid conditions

Structured tests are available for a wide range of clinical problems. In most cases counsellors are not trained to treat most clinical conditions or, if trained, are not employed to provide the necessary treatment. Thus, the major reason for assessing the clinical profile of the problem gambler is to determine suitable referral for problems beyond the scope of the problem gambling counsellor. Table 10 shows the methods currently employed to assess different conditions.

Table 10:
Assessment of Co-morbid Conditions
(based on 153 CCBF-funded counsellors)

Assessment	N
Formal Assessment	
DSM criteria	8
Depression Anxiety and Stress Scale	29
Beck Depression Inventory	10
Beck's Hopelessness Scale	4
DAST-20 (Drug Abuse Substance Test)	4
AUDIT (alcohol screen)	13
Short form 12 well-being scale (SF-12)	2
Substance Abuse Subtle Screening Inventory	5
Other Questionnaires	7
Agency Questionnaire	8
Intake questionnaire	6
Structured Interview	12
No Formal Assessment	
Unstructured interview	60
No assessment	15

Assessment of co-morbid conditions can be expected to occur only when warranted by indications during history taking, problem description, or treatment. Although many different tests are used, no formal assessment is made of co-morbid conditions by 49% of CCBF funded counsellors.

Treatment Approaches Used by CCBF Funded Counsellors

Excluding counsellors who provide only financial or legal counselling, there were 140 CCBF funded counsellors who provided information concerning their approaches to helping individuals cut back and/or stop gambling. Four aspects of treatment were investigated:

(a) counselling goal - is the aim of treatment, control of gambling or abstinence?
(b) setting treatment goals - does the counsellor or the client set the treatment goal?
(c) manualised treatment - does the counsellor follow a manual in providing treatment?
(d) theoretical orientation to treatment - is the gambling problem treated as a problem of behaviour control, a problem of erroneous thinking, or a means of escaping other unpleasant aspects in the individuals life?

Counselling goal

According to the disease concept of compulsive gambling, the impulse to gamble is present for life in the psyche of the afflicted individual. The only effective treatment goal is abstinence (Custer & Milt, 1985). At the other extreme, problem gambling is sometimes regarded as nothing more than the consequence of a poor gambling strategy. Controlled gambling is not only possible, but ideal (Sartin, 1988). It is likely that most CCBF funded counsellors have counselling goals that fall between these extremes. Table 11 shows the counselling goals nominated by counsellors.

Table 11:
The type of counselling goal

Q "What is the goal for counselling?"	N
Abstinence	25
Control	7
Either depending on the client	106
No set goal	0
No response	2
Total	**140**

Table 11 shows that a large majority of counsellors (76%) are comfortable in working towards either abstinence or control depending on the client.

Setting treatment goals

'Treatment goals' is a broader concept than the distinction between abstinence and control. For example, when treating problem gambling by imaginal desensitisation the aim of the therapist is to disrupt the association between gambling and excitement. Similarly, the goal of the cognitive therapist is to replace erroneous beliefs about gambling by factual beliefs. In both cases, the treatment goals are set by the therapist. Whether the consequence of treatment is abstinence or control is a secondary matter. To a large extent, whether or not the counsellor sets goals for therapy will depend on the theoretical orientation of the counsellor. Table 12 shows counsellor response concerning the setting of goals for the treatment.

Table 12:
The setting of treatment goals

Q "How do you set the treatment goal?"		N
YES	Counsellor lets the client set the goal	27
NO	Counsellor sets the goal	13
OTHER	Counsellor and client negotiate goals	98
No response		2
	Total	**140**

Taken together, tables 11 and 12 suggest that a large majority of counsellors discuss with the client whether the desired end result of counselling will be abstinence or controlled gambling.

Manualised treatment

For a variety of reasons, a manual describing therapy is often regarded as beneficial. A manual may provide a compendium of solutions to frequently occurring problems, facilitates the training of new counsellors, and ensures a certain amount of homogeneity of treatments across counsellors in an agency. Table 13 shows the extent to which manualised treatment approaches are being used by CCBF funded counsellors.

Table 13:
Use of a manual to guide treatment

Q "Do you use and follow a written manual?"		N
YES		29
NO		65
OTHER:	sometimes	7
	more or less use manual as a guide but don't follow it	28
	set procedure which is not written down (but could be)	10
No response		1
	Total	**140**

The use of manuals is relatively widespread with approximately half of the counsellors interviewed reporting using a manual at least some of the time or as a guide.

Theoretical orientation to treatment

When asked whether they had a predominant theoretical orientation towards treatment, 75% responded that they did have such an orientation. In order to investigate the counsellor's orientation to treatment, each counsellor was asked to nominate the primary process in the client by which gambling involvement is reduced. Depending on which primary process was nominated, the orientation to treatment could be categorised as cognition, addiction or escape. A cognitive orientation implies that the change in gambling behaviour is caused by a change in beliefs about gambling. An addiction orientation implies that change in gambling behaviour is caused by an increased ability to control the urge to gamble. An escape orientation implies that changes in other aspects of the client's life cause the need to gamble to decrease. Table 14 shows the categorisation of treatment approaches according to the primary process of change during treatment.

Table 14:
Treatment categories determined by the primary process of change

Treatment Category (based on primary process of change)	N
Escape	53
Addiction	43
Cognition	37
not specified	3
no response	4
Total	**140**

Consistent with the results obtained in 2002, the primary process of change, for a large number of counsellors, is one of enabling the clients to cope better with problems

elsewhere in their lives. Nevertheless, all three categories of theoretical orientation are well represented among CCBF funded counsellors.

Evaluation of Treatment Effectiveness

One of the most important facets of any treatment program is an evaluation of the effectiveness of the therapies provided. Evaluation of treatment success may be used in planning changes in the approach to treatment or fine-tuning the methods used. Table 15 shows the frequency with which the clients of counsellors are evaluated post-treatment and the elapsed period to the last such follow-up where multiple follow-ups are used.

Table 15:
The length of time following completion of treatment
at which follow-up evaluation is conducted

Time interval to follow up	N
One to three months	6
Three months	21
Three to six months	11
Six months	31
Nine months	1
Twelve months	10
Two years	4
Follow-up at variable time	12
No follow-up	44
Total	**140**

The clients of a majority of CCBF funded counsellors (69%) are evaluated between one month and two years following the completion of treatment. However, for only 15% of counsellors that conduct follow-ups is treatment effectiveness evaluated one year or longer after treatment. Reviews of treatment success suggest that a high percentage of clients treated for problem gambling relapse into problem patterns of behaviour over the two years following the completion of treatment. For this reason, long-term follow-ups play an important role in the evaluation of treatment effectiveness.

When a large number of problem gamblers are counselled in an agency, it may be impractical to follow-up all clients. One solution to the cost of follow-up evaluations is to conduct evaluations on a random sample of clients rather than on all clients. Table 16 shows that, for 50% of counsellors, the post-treatment evaluation is conducted on all clients. The option of random sampling is not commonly adopted. For the clients of 31% of counsellors, no follow-up evaluations are conducted. This figure is consistent with 2002 (30%).

Table 16:
Numbers and percentage of counsellors using different approaches to sampling clients for treatment effectiveness.

Assessment	N	%
Conduct follow-up on all clients	70	50
Follow-up clients who give permission	7	5
Follow-up clients that complete treatment	1	1
Follow-up at clients request	10	7
Follow-up sample of clients	8	6
• Random sample	(3)	(2)
• Counsellor chosen sample	(5)	(4)
Don't conduct follow-ups	44	31
Other	0	0
Total	**140**	**100**

Ideally, post-treatment evaluation is conducted in the same format as pre-treatment assessment. By maintaining similar conditions unwanted sources of variation in scores are minimised. Table 17 shows the percentages of counsellors whose clients are evaluated by various means. Since clients treated by the same counsellor may be evaluated in different ways, table 17 shows the prescribed or preferred method of conducting follow-ups. Where this was not known, the entry is the most frequently used method. Where no other information was available and multiple methods were used, the preferred method was entered.

Table 17:
Preferred or most frequent method of conducting post-treatment follow-up assessments

Follow-up Methods	N
Letter	12
Telephone	66
Questionnaire	5
Face-To-Face Interview	7
Variable	3
Support Group	3
No follow-up	44
Total	**140**

Note: 'Support Group' refers to the situation where the client continues to be seen in a support group context for a period following completion of treatment.

Table 17 shows that, where post-treatment evaluation is carried out, most is conducted by telephone (69%). Relatively few clients (7%) are interviewed face to face.

References

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

Australian Bureau of Census and Statistics (2003). Population by Age and Sex, Australia. Catalogue Number 3201.0.

Custer, R.L., and Milt, H. (1985). When Luck Runs Out. New York : Warner Books.

Malik, M.L., Beutler, L.E., Alimohamed, S., Gallagher-Thompson, D., and Thompson, L. (2003). Are all cognitive therapies alike? A comparison of cognitive and noncognitive therapy process and implications for the application of empirically supported treatments. Journal of Consulting and Clinical Psychology, 71, 150-158.

Sartin, H.G. Win therapy: An alternative diagnostic and treatment procedure for problem gambling. In Eadington, W.R. (Ed.), Gambling Research: Proceedings of the Seventh International Conference on Gambling and Risk Taking, Vol 5 (pp. 365-391), Reno: University of Nevada-Reno, 1988.

Shepherd, C. and Manning, I. (2003). The Economic Impact of Gambling. NIEIR report for the Casino Community Benefit Fund, New South Wales, Department of Gaming and Racing.

Appendix A: Full list of Agencies Surveyed in 2003

ORGANISATION	SUBURB	NUMBER OF COUNSELLORS
Allcock, Dr. Clive	Burwood	1
Anglican Counselling Services	Inverell	1
Anglican Counselling Services	Moree	2
Anglican Counselling Services	Tamworth	6
Auburn Asian Welfare	Auburn	1
Australian Arabic Communities Council	Bankstown	1
Australian Chinese Community Association (Surry Hills & Granville)	Surry Hills	1
Australian Hotels Association (AHA)	Haymarket	1
Baptist Inner City Ministries (Inner City Gambling Counselling Service)	Darlinghurst	2
Best Bet Counselling Service (Wagga Wagga Family Support Service)	Wagga Riverina	2
Betsafe (Paul Symond Consultancy)	Eastwood	3
Bridge House (Salvation Army)	Wickham	3
Bourke Family Support Services	Bourke	1
Bulli Community Health Service	Warrawong	1
Carlingford Counselling Services	Carlingford	1
Centacare Catholic Family Services (Blacktown & Parramatta)	Blacktown	4
Central Coast Problem Gambling Service (Penninsular Community Centre)	Woy Woy	3
Central West Gambling Counselling Service, Bathurst (Lifeline Central West)	Bathurst	3
Central West Gambling Counselling Service, Dubbo (Lifeline Central West)	Dubbo	1
Cessnock Family Support Service	Cessnock	1
Chinese Australian Services Society Co-operative Ltd	Campsie	4
Chinese Youth League of Australia	Haymarket	1
Christian Community Aid Service Inc	West Ryde	2

Community Health Service	Nowra	1
Creditline Financial Counselling Services- Manly Warringah Pittwater	Balgowlah	1
Creditline Macarthur	Narellan	2
Creditline Westlake Macquarie (Woodrising Neighbourhood Centre)	Woodrising	2
Exodus Foundation	Ashfield	1
Freeman House Armidale (St. Vincent De Paul)	Armidale	3
Gamblers Help	Wodonga	3
Gamblers Helpline Incorporated	Berkeley	1
Gambling Treatment Clinic- The University of Sydney	Camperdown	3
Greek Welfare Centre	Newtown	2
Greek Orthodox Community of NSW	Lakemba	1
George St Health Centre	Liverpool	2
Harbour City Counselling Services	Coffs Harbour	1
Lao Gambling Intervention Service	Cabramatta	1
Life Activities	Newcastle	8
Lifeline Face to Face Counselling	Canberra ACT	4
Lifeline Face to Face Counselling	Coffs Harbour	2
Lifeline Broken Hill	Broken Hill	1
LifeLine Manly Warringah Pittwater	Balgowlah	2
Lifeline Northern Rivers	Lismore	1
Lifeline Western Sydney (Parramatta Mission Uniting Church)	Parramatta	2
Mackensie & Associates	Coffs Harbour	1
Maryfields Day Recovery Centre	Campbelltown	3
Migrant Resource Centre	Hamilton	1
Mission Australia - Nowra	Nowra	2
Mission Australia - Riverina Region	Wagga Wagga	2
Mission Australia - Wollongong (Same as Wollongong City Mission)	Wollongong	3
Moree Area Health Service	Moree	1
Multicultural Problem Gambling Service	North Parramatta	14

Newcastle City Mission (The Mission)	Newcastle	3
Northern Rivers Gambling Service (Buttery Inc)	Bangalow	3
Northern Syd Area Health G C S (Hornsby Ku-ring-gai Hospital)	Hornsby	3
Northside Private Clinic	Wentworthville	1
NSW Indo-China Chinese Association Inc	Canley Vale	3
Odyssey House McGrath Foundation	Minto	2
Odyssey House McGrath Foundation	Sydney	2
Port Macquarie Neighbourhood Centre Inc	Port Macquarie	1
Regenesis	Moss Vale	1
Salvation Army William Booth Institute	Surry Hills	8
St David's Care (The Uniting Church in Australia Property Trust)	Albury	1
St Saviour's Neighbourhood Centre (Beat the Odds Program)	Goulburn	4
St Vincent de Paul Society - GAME	East Sydney	3
St Vincent's Hospital	Darlinghurst	3
Streetside Oasis	Coffs Harbour	1
Unifam	Gosford	1
Vietnamese Community in Australia (NSW Chapter)	Cabramatta	1
Waverley Action for Youth Services (WAYS)	Bondi	3
Wesley Gambling Counselling Services - Surry Hills (Include. Korean Project)	Surry Hills	7
Welsey Legal Gambling Counselling Services	Surry Hills	3
Wesley Gambling Counselling Services - St George/Sutherland	Sutherland	1
Wesley Gambling Counselling Services- Penrith	Penrith	5
Wesley Mission Central Coast	Tuggerah	2
Wesley Mission Sadlier	Sadlier	1
Westmead Hospital	Westmead	1
		181

Appendix B

Counsellor Interview Schedule 2003

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

Date of interview: _____ Interviewer: _____

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

Gamblers Currently Receiving Treatment

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

___/___/___ to ___/___/___

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

Gender	Age	Ethnicity	Source of	Counselling Service	Type of gambling	Category of gambler	Other	Town/

Referral

Suburb
Or P/C

5.

6.

7.

8.

9.

10.

11.

12.

13.

14.

15.

16.

17.

Gamblers Currently Receiving Treatment
(Next 7 days; have appointment)

___/___/___ to ___/___/___

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

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

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

Gamblers Currently on Waiting List

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

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

N= _____

Assessment

Do you assess the level of gambling involvement of each client? Y/N
If Y, how? (List names of tests or screens)

_____

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

_____

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

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

Evaluation

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

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

(d) assessed in other ways (List ways)

Treatment Interview

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

1. What is the goal for counselling?

___ Abstinence
___ Control
___ Either depending on the client
___ No set goals (skip to question 3)

2. How do you set the treatment goal?

___ Counsellor lets the client set the goal
___ Counsellor sets the goal
___ Counsellor and client negotiate goals

3. Do you use and follow a written manual?

___ Yes-Details _____
_____
[Obtain copy if possible]
___ No
___ Sometimes [Details above]
___ More or less- use manual as a guide but don't follow it closely [Details above]
___ Set procedure which is not written down (but could be)

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

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

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

___ Yes
___ No

6. Do you have predominant theoretical orientation towards treatment?

___ Yes- Name of approach _____
___ No

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

(a) ___ extinguishing the gambling response by conditioning processes
(b) ___ reducing the excitement or arousal associated with gambling
(c) ___ reducing problems elsewhere in the gambler's life
(d) ___ increasing the gambler's problem-solving skills in general
(e) ___ increasing the gambler's social skills in general
(f) ___ changing the gambler's constructs about him/her self as a gambler
(g) ___ directing the gambler to attend to opportunities to pursue alternatives
(h) ___ educating the gambler about gambling probabilities and risks
(i) ___ convincing the gambler that they can't win at gambling

(j) ___ making salient the harm the gambler is causing family and friends

(k) ___ working through the grief and guilt that is driving the gambling

(l) ___ giving the gambler the skills to deal with the urge to gamble

(m) ___ showing the gambler gambling strategies that are less dangerous

(n) ___ showing the gambler how gambling is being used as avoidance

8. Now, think about a client with whom you recently completed counselling. Could you please describe the course of treatment or the steps through which counselling proceded? If you can, take me through the stages and through the sessions.

Appendix C
CCBF Funded Agencies

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

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

Table 2:

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

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

Note: Percentages are calculated excluding the category 'unknown'; type of gambling n=3)

Table 4:

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

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

Note: New Clients (where it was unknown whether the client was a problem gambler) were excluded from the analysis (2003 assessments n=53). (1) Percentages are calculated excluding the category 'unknown' (ethnicity n=16, type of gambling n=1)

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

Source of Referral	Last Seven Days all %	N	%	Next Seven Days all %	N	%
Telephone Referral						
• G-line	**31.2**	222	30	**30.9**	203	30
• Lifeline		7	1		5	1
Gambling Related Agencies						
• Another gambling agency	**12.4**	59	8	**11.1**	50	7
• Other counsellor within agency		17	2		9	1
• Gambling industry		15	2		16	2
Non-Gambling Agencies						
• Medical	**23.1**	20	3	**20.6**	16	2
• Parole service		20	3		20	3
• Police		1	<1		0	0
• Legal agent		9	1		5	1
• Employer		2	<1		2	<1
• Church		5	1		6	1
• Another non-gambling agency		113	15		90	13
Advertising						
• Advertising	**12.3**	71	10	**8.5**	39	6
• Telephone books		14	2		13	2
• Internet		5	1		5	1
Individuals						
• Self	**15.8**	16	2	**14.3**	18	3
• Family or friends		86	12		60	9
• Another client of the agency		14	2		18	3
Other	**5.2**	2	<1	**14.6**	2	<1
Not known		36	5		96	14
Number of clients	**100**	734	100	**100**	673	100

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

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