

CHAPTER 2

PROBLEM GAMBLING TREATMENT IN NEW ZEALAND: A SYSTEMATIC RESPONSE

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Introduction

In 1997 the Problem Gambling Purchasing Agency (PGPA) was contracted by the Committee on Problem Gambling (later to be renamed the Problem Gambling Committee (PGC)) to develop a funding and purchasing system to provide treatment for problem gamblers in New Zealand. In 1996 the New Zealand Government had decided that the ‘treatment of problem gamblers’ was not a core service to be provided through the health system and that the payment for treatment of the ‘few’ problem gamblers should come ‘voluntarily’ from the gambling industry. This initiative was set up by a combination of treatment providers and the industry to provide assured treatment for problem gamblers.

The gambling industry was prepared to provide \$2 million for the 1996/1997 fiscal year through the Committee on Problem Gambling, a charitable trust with an independent chair, five trustees from the gambling industry sector and five trustees from the problem gambling provider sector. Because of the many conflicts of interest involved, this trust contracted PGPA as the ‘independent purchaser’ charged with recommending the funding required each year to provide treatment for problem gamblers and to develop and administer contracts for these services. PGPA has provided these services from 1997 through to 2004. As a result of the Gambling Act 2003 the Ministry of Health will take over the role of managing problem gambling services from July 2004.

This chapter gives an overview of the range of services developed over the seven years from 1997-2003. It has been an interesting and invigorating

time, with these service developments occurring totally outside the public sector and with the services being delivered by non-governmental organisations.

Counselling for problem gambling issues

The provision of professional ‘help/interventions/counselling’ for gambling problems is still at a relatively early stage. It is important not to close off the range of approaches that might best help people with serious gambling problems. In the early days of treatment there was a temptation for many providers and clinicians to simply fall back on what they knew from ‘other’ addictions, in particular the treatment of alcohol and drug problems. Different approaches are currently being trialled around the world. Very few are rigorously reviewed – the few control studies that have occurred are not particularly useful in setting a direction.

Dominic Lim and Doug Sellman report in this book on a pharmacological treatment currently being trialled with funding from the Problem Gambling Committee. This is an adjunct treatment that might prove to be useful for selected clients. The client ‘progress’ process is discussed later in this chapter and, for my money, this should be the key monitoring tool for checking on what IS working for the client – and one that should be used to adjust treatment to achieve effectiveness.

Considerations as to whether serious gambling problems are another form of addiction, a mental health disorder of an obsessive compulsive nature (DSM-IV), or mainly a modern lifestyle problem, need to be energetically discussed (for example see Lim & Sellman, 2002). What is known for sure is that the rise of gambling problems (and people seeking help for gambling problems) has followed closely on from the increased access to gambling opportunities; in particular to casinos and non-casino gaming machines. Figure 1.1 shows that in the six years from 1997/1998 to 2002/2003:

- the number of gaming machines increased by 96%; from 12,897 to 25,221;
- expenditure (the amount lost) on gambling increased by 79% from \$1,045 million to \$1,871 million; and
- new problem gambling clients to community counselling increased by over 140% from 1,190 to 2,898 new clients in 2003.

The aetiology of gambling problems does not just sit in an individual. It arises from the various contexts in which people live, and in particular in

the community settings in which gambling opportunities are provided and extolled. What is it that draws people to gambling and keeps some there, no matter how destructive it is to them and their families? The dream of winning may not be what keeps problem gamblers gambling, but the dream does attract people to gambling in the first place. Part of the 'entertainment' of gambling is the dream of winning. In order to learn more about the 'context' and effects of gambling some major research initiatives have been commissioned.

Massey University's Shore Centre is developing and trialling a methodology to analyse the short and long-term socio-economic impacts of gambling on communities. The Centre for Gambling Studies of Auckland University is developing and trialling a methodology to explain why people gamble and why some progress from moderate to problematic levels of gambling. In addition, the Department of Preventive and Social Medicine at the University of Otago is adding problem gambling questions to the Dunedin Multidisciplinary Study to gain an understanding of how gambling issues fit into people's lives. The study involves participants, now in their early 30s, from a major longitudinal study which has followed this group since they were born. These studies will give some leads into the association of issues that co-occur with problem gambling and will also hopefully give a lead on 'protective factors' which may prevent gambling problems from occurring in individuals in the first place.

In purchasing counselling and other services, we have been clear that all services need to be set within an overall public health approach to gambling issues. The context of counselling takes place, for agencies and clients, within the wider gambling dynamics that occur in New Zealand. The majority of people with gambling problems do not require intensive ongoing and specialised intervention. Gambling problems are successfully resolved in a number of ways, including 'natural recovery'; people get better with the help of family and friends. It is those with more serious gambling problems, and in particular those who also have a mental health problem such as depression or alcohol problems, who are likely to need help from a specialised problem gambling service. The Problem Gambling Purchasing Agency estimated that in 2002 up to 19% of 'pathological' problem gamblers presented to problem gambling services, but fewer than 5% of less serious 'problem' gamblers did. This is appropriate. Specialised problem gambling services need to be targeted at the most serious cases, with less serious problem gamblers receiving information and help from primary and community

agencies. In 1999 PGPA suggested a potential ceiling on the number of new clients that might require specialised problem gambling services each year – this was estimated to be 3,500 in any year. The concept of an upper limit for specialised treatment, rather than an rising target, helps to shift the emphasis of services to early intervention and prevention efforts.

From the beginning of service development the family members of problem gamblers were viewed as potentially needing and benefiting from counselling assistance. Family members bear the brunt of the ‘disasters’ visited on them by the problem gambler and they understandably feel confused and helpless – and often experience health problems as a result of their family situation. In 2003 it was pleasing to note that 32% of those who phoned the helpline for assistance, and 28% of those who attended personal counselling, were family members. In following up on the progress of family members, it is reassuring to note that the problem gambler was gambling less (or not at all) and that the family member was coping much better following counselling.

Funding of problem gambling services

Each fiscal year (1 July to 30 June) PGPA has recommended annual funding levels to the Problem Gambling Committee. While all trustees of the Problem Gambling Committee debate the funding recommendation, only the gambling industry trustees decide the amount of funding to be contributed each year. The major segment of funding has been based on the costs of reaching a target of new clients, together with the reasonable operational funding of the helpline. Added to funding for these core treatment services, funding has been recommended (and agreed) for services targeted at Māori, Pacific, Asian and youth, as well as for educational training, resource development, and research and development. While trustee debates on funding levels have been vociferous, agreement has always been reached on the recommended levels of funding for treatment services. Agreement on funding levels for the provision of health promotion and other public health services has been difficult to reach, as this has been seen, in particular by the industry, as an area best left to government.

The funded target for new clients for the 2003/2004 year is 3,500 new clients. Total funding provided by the gambling industry for 2003/2004 is \$10 million (up from \$2 million in 1996/1997). Of this funding, \$5.8 million is for the helpline and face-to-face counselling services.

Problem gambling counselling service structure and service delivery (1997-2004)

From 1992-1997 services for problem gamblers were provided by a small number of treatment providers on an 'ad hoc' basis dependent, in the main, on funding grants from the Lotteries Commission. The number of clients provided with a service was relatively small. The establishment of the Committee on Problem Gambling, with an agreement to fund problem gambling services for an initial five-year period from 1996/1997 to 2000/2001, allowed the development of a strategic approach to the national delivery of problem gambling services. The purchasing approach placed an emphasis on creating national access to counselling (phone and face-to-face) and a focus on monitoring the progress of clients to ensure that gambling problems were reduced.

In 1997 three service providers, the Helpline (a new agency – The Problem Gambling Helpline), the Compulsive Gambling Society (now the Problem Gambling Foundation – PGF) and the Salvation Army (Oasis Service) were contracted as the core national service providers. In 2000, Te Rangihaeata Oranga was added as a provider offering counselling services in Hawkes Bay and, in particular, with the ability to deliver this from a Māori kaupapa. These services provided for some client choice, and allowed the agencies to develop a critical mass of staffing and infrastructure. Contracting and payment was based on a target of new clients, not on the number of clinicians employed: for example, a provider agency might be contracted for \$1 million for 12 months for providing services to 1,000 new clients, plus all ongoing and returning clients (likely to be 1,400 clients in total). This system was, and is, different from the Ministry of Health approach, in which funding is based on the number of full-time staff employed. This approach requires accurate collection of data to monitor the agreed achievement of targets.

Access to service and client progress/outcome

As noted above, the emphasis in the provision of counselling services has been on creating access for an increasing number of new clients to professional assistance, and on achieving good results for those clients in terms of reducing their problems. The 'good results' are measured through follow-up assessments. Clients are generally driven to counselling by a crisis, frequently a financial one. The challenge for counsellors is to engage the client to address the gambling issues once the immediate crisis is

resolved and to work for a sustained long-term solution to the gambling problems.

Without accurate information, effective services cannot be delivered at either the individual level to a client or at the strategic level to all clients. To know how clients have fared from counselling it is critical to have basic demographic and clinical information. The information that has been collected through the PGPA data collection system is no more than good clinical practice should require, and is a core part of contract agreements. The data collected (client confidentiality is preserved) have provided an excellent picture, both of service provision and of trends in problem gambling. In the seven calendar years from 1997 to 2003, almost 35,000 individuals have been provided with counselling for problem gambling, and trends tracked over these years.

Three pieces of assessment information are collected as part of the data collection system. These assessments are (ideally) repeated at six-monthly intervals as clients are followed up to check on their progress, until their recovery from the gambling problems is reasonably assured. An integrated care system has been established in which the helpline keeps in phone contact with referred counselling clients at 1, 3, 6, 12 and 18 months from entry into the system (more frequently if required), with reassessments at six-monthly periods. In February 2004 the helpline was following up 1,063 clients on behalf of face-to-face counselling agencies. Ten percent of these clients have been followed up for 18 months. Results indicate that 86%+ are markedly improved in reducing their gambling problems.

The three assessment criteria used for initial and follow-up assessment are:

- the modified SOGS (South Oaks Gambling Screen). This is called the SOGS 3M (for three months), as the client is asked questions relating to behaviour over the previous three months. Accordingly, when the questions are asked again six months later the client has the potential to have made changes that will be measured by their answers;
- the amount of dollars lost in gambling by the client in the previous four weeks; and
- the client's subjective statement on whether they are 'completely in control,' 'mostly in control,' 'mostly out of control,' or 'completely out of control' of their gambling.

These three assessments incorporate both quantitative and qualitative information. In accordance with clinical practice, the assessments are always reported back to the client. It is expected that clinicians summarise for the client what the assessment means, any progress that has been made in reducing problems and, in particular, suggestions on actions the client and counsellor might take to reduce the problems and minimise the harms. In research undertaken on the establishment of the data collection system clients indicated that they were keen to hear back the results of their personal clinical progress.

The assessment data collected on new face-to-face counselling clients in 2003 is informative:

- Almost 2,000 SOGS 3M scores were collected in 2003, with a median SOGS score of ten, which could be viewed as indicating a serious gambling problem (this has been a stable median score of ten for the past five years).
- The median dollars lost in the four weeks prior to assessment was \$800 (stable at \$800 for the past five years) and on average clients lost \$1,834 in the four weeks before assessment.
- 73% of clients said that their problem was ‘mostly’ or ‘completely’ out of control.

The majority of clients improve their situation after counselling treatment:

- 72% report reduction in their SOGS score;
- 74% report losing less money (loss on average \$996 less than at assessment); and
- 62% report an improvement in their sense of control over gambling. This is lower than the other assessment improvements and possibly represents the ongoing vulnerability problem gamblers feel over their gambling. The personal sense of control over gambling is an issue that can constructively be discussed in relapse prevention support. The results regarding ‘sense of control’ confirm the value in following up the progress of clients for some time after their last counselling session to ensure that their long-term ability to control gambling is assured.

Tracking of client results indicates that not all clients are benefiting from the counselling provided. It makes sense to know who these clients are and how the assistance provided could be improved. Unfortunately this good clinical practice does not happen auto-

matically, as clinicians can be more inclined to focus on individuals than groupings of clients.

PGPA has commissioned two projects, one with Oasis and one with PGF, to investigate how to improve counselling for the clients who were not benefiting – that is, those clients whose repeat scores (SOGS 3M, \$ lost, and self-rated control) indicated deterioration or no change. The agencies were able to follow up approximately half of these clients and offer an enhanced treatment offer. Preliminary results indicate that these clients improved significantly, reducing the \$ lost (in most cases to zero), the SOGS scores dropped dramatically and the sense of control improved. The hope is that this approach will be built into future delivery of client services.

A similar project has been undertaken with long-term clients. These are clients who have been receiving counselling for longer than 12 consecutive months. The data and review indicated that the only variables separating these clients from shorter term clients were age and ethnicity – the clients were generally older and mainly European. It was recommended that a clearer structure to therapy and client progress be provided.

These examples of reviewing the ‘clients not benefiting’ and ‘long-term clients’ would suggest that counselling services move to develop as the norm more structured programmes (such as a solution based therapy programme) and to incorporate data results into programme development and monitoring.

Help for the general population – public health services and screening

It has been noted earlier that the approach to providing interventions for gambling problems has occurred within the setting of a public health perspective. From 2002, PGC has agreed to support this broader approach to gambling problems. This approach incorporates the:

- promotion of increased knowledge, responsible choices and community participation in relation to gambling issues and the minimisation of gambling problems by individuals, tangata whenua, communities and industry;
- protection of all groups from gambling-related harm, including a refinement of approaches for population groups, through responsible gambling policies, community support programmes and public safety approaches; and

- prevention of gambling-related problems in individuals and groups through public awareness, early identification of problems and the provision of information, counselling and other interventions.

Below are examples of this wider approach to minimising gambling related harms.

Working with territorial authorities

The Gambling Act 2003 provides a critical role for territorial authorities in the regulation of gambling in their communities. PGC has contracted the Problem Gambling Foundation to provide information and advice to all territorial authorities to prepare for this role. PGF has policy analysts based in Auckland, Wellington and Christchurch, to provide education and information to the 75 territorial authorities throughout New Zealand. Working alongside territorial authorities at the community level is a productive public health approach, and creates relationships at the important level of community policy. Through this relationship providers are able to keep local communities informed on problem gambling trends and to suggest community actions to reduce gambling harms.

Community development projects

Over the past two years two providers have been contracted to work at the community development level to reduce gambling problems. This requires working alongside community groups to help them understand the impact of gambling in their areas. The providers also work to support the communities to make their own responses to gambling issues, and to work out their own strategies for reducing gambling harms in their own areas. These projects are based in Manukau City and in Waikato.

Health promotion

Eight health promotion workers have been contracted to work in three agencies. These workers provide information on gambling issues to communities and groups and base their work on *Te Ngira: Gambling and Public Health – A Workplan* (Raeburn & Herd, 2003). The Problem Gambling Foundation and Hapai Te Hauora Tapui, in association with Pacific and Asian agencies, developed this workplan (see Chapter 1).

Screening

In order to reach wider population groups and to provide assistance at earlier stages of gambling problems a number of screening trials are being piloted. These include screening for gambling problems in a number of

general practitioner practices. It is anticipated that up to 3,000 patients will be screened. Early results indicate that 7% of GP patients have current gambling problems and up to 16% of people are experiencing gambling problems in their families. The gambling problems are also likely to be affecting the health of those patients.

A further screening project is underway with selected social service agencies in Auckland and almost 1,000 clients of these agencies have been screened for gambling problems. Results note that 11% in these client groups currently have gambling problems and, strikingly, up to 40% of these social service clients are experiencing gambling problems in their families. Social workers are now being employed to provide a structured response to the presentation of gambling problems in these agencies. Strategies will be developed to reduce the gambling harms being experienced by these groups. It is not anticipated that many of these clients will require specialised problem gambling counselling, but rather responses in other 'social' areas that take account of the gambling issues. (Watch this space.) Screening projects are also underway with Māori populations in city and rural areas in Waikato and in Taranaki.

Population groups

One size does not fit all in most areas of life and the same is true in the problem gambling area. Different segments of the population have different experiences and contexts for their gambling and may require different understandings and approaches to provide the best results. For example, the Department of Internal Affairs (2003) has indicated that while Māori and Pacific peoples are less than 20% of the general population, they make up 40% of problem gamblers, and also spend more money on gambling than other ethnic groups. In addition, clinical experience and community comment indicated that Asian peoples, especially new migrants, also experience significant gambling problems (see Chapter 17). Paton-Simpson et al, (in press) show rates for new problem gambler client presentations (the first figure is the helpline – the second is face-to-face counselling):

- 28% or 31% Māori (the percentage of Māori clients in face-to-face counselling has moved from 17% in 1997 to 31% in 2003);
- 9% or 7% Pacific people (grown from 5% in 1997);
- 6.5% or 4% Asian (Asian referrals have been relatively stable over the past seven years).

Given this information it makes sense to consider responses that best address the needs of these populations. Note that there are special helpline options for Māori, Pacific, Asian and youth populations.

Māori

The purchasing response to gambling problems among Māori has been to work with local iwi providers at the community level. The task has been for these providers to gain an understanding of the impact of gambling as a relatively new phenomenon in their community and then to formulate an approach to reduce these gambling problems. This approach does not always include the provision of counselling services. There are currently 14 Māori organisations providing coverage for most areas of the country. The co-ordinating mechanism for this Māori approach is through Te Herenga Waka o Te Ora Whanau, which is the national Māori co-ordinating committee charged with fostering a Māori response to problem gambling issues.

Pacific

The development of an effective Pacific response to problem gambling issues was initially difficult to establish. A ‘request for proposal’ process in 2003 resulted in Niu Development establishing and managing the National Pacific Project, which delivers a co-ordinated ethnic-specific approach through the employment of Samoan, Cook Islands, Tongan and Niue workers, each supported by their own ethnic community, but co-ordinated under the one umbrella. In 2004 the National Pacific Project will include projects in Wellington and Christchurch. Pacificare delivers the Pacific component of the Manukau community action project and also provides counselling services for Pacific people; there are two other small Pacific projects currently underway in Auckland and Hamilton.

Asian

The Problem Gambling Foundation has been contracted to provide an Asian response to gambling problems and has a long-established Asian team providing services in Auckland, Hamilton and Christchurch. Services are delivered in Mandarin, Cantonese and Korean. A national development strategy for addressing Asian gambling problems is currently being developed. The Asian team has concentrated on a community and family focus and has been very successful in making inroads into the different Asian communities, including international Asian students.

Young People

Any approach to minimising gambling harm needs to consider ways of reaching the younger populations. A strategic plan for addressing youth gambling issues, *Supporting the Wellbeing of Young People in Relation to Gambling in New Zealand*, (Problem Gambling Foundation of New Zealand, 2003), has been developed, and a review of public health literature undertaken (Rossen, 2002). These projects focus on considerations of a 'strengths-based approach' to considering gambling issues among young people and form the basis for the ongoing development of youth services.

Over the past three years a youth resource on problem gambling, *When is it not a game* (Problem Gambling Foundation of New Zealand & Top Shelf Productions, 2003), has been developed by educationalists for inclusion in the health and physical education curriculum in secondary schools. The purpose of this resource is to assist students in developing a critical discernment of the influences of gambling on individuals and the wider society. Teachers are being trained in the delivery of the resource. The resource and approaches are also being used with young people in non-school settings, in particular, the Problem Gambling Foundation in Auckland, Wellington and Christchurch and Te Rangihaeata Oranga in Hawkes Bay, has developed a series of health promotion initiatives with young people using this resource. The interventions currently provided for young people include a youth helpline option delivered by young people and provided by the Problem Gambling Helpline (0800-654-655).

Women

Problem gambling is an 'equal opportunity' problem. Women are now as much at risk of gambling problems as are men. Currently almost half of new clients seeking help are female. Since 1997 the percentage of female problem gamblers seeking help has risen from 38% to 49% for the Helpline and from 29% to 45% for face-to-face counselling clients. Gambling machines outside casinos are the main gambling problem for 84% of all female clients and gambling machines inside casinos are the main problem for 11% of all women. Altogether gaming machines account for 95% of female problem gamblers seeking treatment.

In 2003 more Māori women (65%) than Māori men sought help for gambling problems. Women on average lost \$1,453 in the four weeks pre-assessment, compared to men who lost \$2,154. Currently there are two projects underway that are seeking specifically to learn more about

female gamblers and problem gamblers, and the best method of providing help. This research is due for completion in June 2004.

Corrections

Research on sentenced male and female prisoners undertaken in the New Zealand Gaming Survey (Abbott and McKenna, 2000; Abbott, McKenna, & Giles, 2000) and other surveys, shows a high rate of gambling problems among inmates and others sentenced in the justice system. Forty-five percent of women prisoners were classified as having experienced significant gambling problem at some stage in their lives and 34% had gambling problems at the time of imprisonment. Seventy-five percent of the lifetime problem gamblers in this study were Māori.

Similarly, with male prisoners 31% had experienced significant gambling problems at some stage in their lives and 23% had serious gambling problems at the time of their current imprisonment. Fifty-four percent of the problem gamblers were Māori. There are currently two projects underway trialling interventions that are able to screen for and help problem gamblers sentenced in the justice system to overcome their gambling problem – in particular on their return to the community. One project is targeted particularly at Māori and both projects have a community and family emphasis. These projects are due for completion in July 2004.

The future

This chapter has given a brief overview of the range of approaches that have been used over the past seven years to address problem gambling. In the main these services have focused on providing counselling services for problem gamblers, but they have increasingly started to address gambling issues at the community level.

The Gambling Act 2003 focuses on preventing and reducing harm that can result from gambling. This Act will lead to a range of regulations and standards that will focus on problem gambling issues at a broader level than counselling. The Ministry of Health has stated its intention to develop a wide-ranging public health approach to problem gambling issues. Together these initiatives should make inroads into the harms caused by problem gambling, while creating a safer environment for gambling.

At the ‘intervention’ level of service provision there is a need for development in two areas. The first is an increased commitment to

focusing on long-term client progress in treatment, using data to refine and structure services for different groups in the counselling population. The second development is to expand the screening programme, providing information and help to those affected by problem gambling at the earliest possible time.

Figure 1.1

Key Data - Gambling/Problem Gambling Trends June 1997 - June 2003

	2002/ 2003	2001/ 2002	2000/ 2001	1999/ 2000	1998/ 1999	1997/ 1998
Expenditure* on gambling (after wins distributed)	\$1871 million	\$1666 million	\$1459 million	\$1297 million	\$1167 million	\$1045 million
Number of non-casino gaming machines at 30 June	25,221	21,743	20,097	16,396	13,812	12,897
Non-casino gaming machines as primary presenting problem	76.2%**	73.8%	71.1%	62.8%	60.8%	51.8%
Casino gaming machines as primary presenting problem	11.3%**	11.2%	12.3%	13.6%	15.2%	18%
Funding for problem gambling services	\$8.6 million	\$5.8 million	\$4 million	\$3.26 million	\$2.75 million	\$2.2 million
New clients — community	2,898	2,237	2,071	1,731	1,539	1,190
— Helpline	4,866	4,223	3,827	3,561	—	—

* This refers to the amount of money 'lost' on gaming machines after wins have been distributed. It could also be called the gross profit of the gambling industry. A larger amount is wagered by individual gamblers – this is called the 'turnover,' a major percentage of which is circulated to 'winners' and some of which is also expended back on gambling. Turnover for the 2003 year would be around 13 billion.

** In 2002/2003 a total of 87.5% of new clients presented gambling machines (either inside or outside casinos) as their primary gambling problem. For the 2003 calendar year the helpline reports that 92% of all new clients presented gaming machines as their primary problem. Gaming machines are the main gambling problem in New Zealand.