



**FLINDERS UNIVERSITY**  
ADELAIDE • AUSTRALIA

FLINDERS MEDICAL CENTRE



## **Intensive Therapy Service for Problem Gamblers**

**Centre for Anxiety and Related Disorders**

**Independent Gaming Authority**

**Inquiry into the effectiveness of  
Gambling Rehabilitation Programs**

**March 2005**

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# Executive Summary

## 1. Introduction

This submission addresses the terms of reference of the enquiry into the effectiveness of gambling rehabilitation programs. The features of an effective treatment program will be discussed, looking at clinical approaches and treatment modalities to ensure the needs of the target groups are met. How the effectiveness of treatment can be measured to ensure treatment is evidence based and desired treatment outcomes are achieved and maintained will be described. Case examples and data will be used to support this submission. The importance of ongoing research in the areas of problem gambling and issues related to treatment will be discussed. Gaps in the current service provision will be addressed and possible solutions will be raised, which will include tertiary training and supervision of counselors working within gambling rehabilitation services.

## 2. An “effective” program for the rehabilitation of problem gamblers

An effective program for the rehabilitation of problem gamblers needs to provide a range of interventions and entry points. This include:

- Treatment programs based on evidence.
- Screening of clients and partners using a detailed psychosocial and psychiatric assessment interview, including a detailed gambling history.
- Assessment of co-morbid physical and mental health conditions.
- A comprehensive risk (suicide and harm to others) assessment and triage as appropriate.
- The option of an inpatient admission for clients who have complex co-morbidities to provide extra support to complete treatment and a comprehensive review by a multidisciplinary mental health team.
- Relapse prevention strategies should be put in place for all clients with an adequate follow up program after completing treatment.
- Use of validated outcome measures indicating that the treatment modalities are achieving desired outcomes for the client. This includes drop out rates and selection criteria for admission into the program.
- Common use of outcome measures across all agencies so that data can be aggregated to measure the success of the program over time as a whole and by agency.

- Evidence of continuous clinical improvements so that the program is modified according to international evidence and the feedback of the program's own outcomes.
- Training should be conducted providing the opportunity for rehabilitation workers to gain competencies, including academic education and training in the identification and treatment of problem gambling.
- Community education aimed at general practitioners and community agencies helping to reach clients who have a vulnerability to develop problem gambling.
- Harm minimisation approaches should be included in this early intervention and treatment model.
- Financial advisors should be easily accessible for clients and significant others in the client's life to help manage financial problems related to the client's gambling.
- Counseling should be available for significant others related to the client if needed.
- Specific interventions to identify and treat client groups such as elderly, couples, different cultural backgrounds and adolescents.
- Clinical trials looking at a variety of treatment interventions including psychotherapies and medications such as Naltrexone.
- A variety of treatment formats should be made available, i.e., individual face to face, group, inpatient (residential), telemedicine, manual, computerised / web based treatments. This would allow clients to receive treatment in both rural and remote areas of this state. Once identified clients may benefit from a residential program such as the Intensive Therapy Service offered at FMC.
- Interventions for underserved and disadvantaged client groups such as Aboriginal communities, taking into account cultural and historical aspects. Interventions should be based at socially defined levels as well as addressing the individual's problems. Intervention programs should be tailored to meet the unique demands of this cultural group.
- An open rehabilitation support group for clients who have completed treatment.
- The development of a web based assessment and treatment program for clients to have access to evidence based therapy, monitored by qualified staff.
- Teleconference facilities to provide ongoing supervision and training to mental health workers in the area of problem gambling and co-morbid mental health problems.
- Identification of problem gamblers within the emergency departments of general hospitals who may present after suicide attempts or in crisis and appropriate referral or management

### **3. Recommendations**

#### **3.1 Education and Training:**

- Training for workers in the rehabilitation programs for problem gamblers in evidence based (CBT) models.
- Scholarships for course fees for students enrolling in the Masters of Mental Health Sciences, Flinders University who undertake the gambling elective topic.
- Dedicated lecturing staff (3 FTE) to provide both clinical supervision and teaching in evidence based gambling treatments.
- Development of a gambling topic and provision on-line to support rural and remote students of the Masters of mental Health sciences.

#### **3.2 Service Delivery**

- Establish outreach services of the Intensive Therapy Service for Problem Gambling into other regions such as the Western and Northern Suburbs of South Australia. Funding should also be available to increase services into rural and remote areas of the state. New services specialising in Aboriginal health need to be established in areas such as Cooper Pedy where there are severe gambling impacts on local communities. This would mean funds to establish a similar inpatient program to the Intensive Therapy Service for Problem Gamblers (FMC) with out patient follow up using CBT principles. The training of staff in this specialised evidence based treatment with ongoing supervision and support will be essential.
- The establishment of a community based CARD clinic eg, at a major shopping center and/or general practice as an alternative to a hospital based program, which may discourage people seeking help.
- Provision of staff to provide screening and assessments for people presenting to emergency departments of public hospitals with suicide attempts.
- Development of innovative programs including the use of web based self-treatment programs, the use of telemedicine to assist clients and therapists in remote areas.

#### **3.3 Research**

- Research into the effectiveness of the clinical approaches / treatment modalities used within each agency. Agencies should be encouraged to take on going measures related to treatment outcomes.
- Funding for the South Australian component of the international clinical trials network to establish effective treatment modalities for problem gambling. Research and development

of appropriate treatment modalities into particular groups of the community who are vulnerable to developing problem gambling. These groups include adolescents, elderly, mentally handicapped, couples, culturally diverse communities and families of problem gamblers.

### **3.4 Community Education**

- Harm minimisation strategies, for example early intervention programs working with G.P.s and community agencies. Liaison with hotel staff in appropriate management of problem gamblers is also necessary.
- Focus on correcting the general public's misconceptions of winning in relation to gambling. Advertising campaigns should be aimed at teaching the community the true probabilities of winning money when gambling, so they can make informed decisions in relation to gambling.
- Education programs aimed at school children in the areas of gambling and problem gambling and alternative coping strategies.

### **3.5 Financial counseling**

- Funding for financial counselors who often are the point of entry for problem gamblers and their families. Financial counselors need to be skilled in appropriate management of gamblers experiencing mental distress in relation to their gambling consequences so appropriate referrals can be made. Representation

### **3.6 Representation**

- Adequate representation at the Gambling Rehabilitation Fund meetings by Break Even Staff.

# Intensive Therapy Program for Problem Gamblers

## 1. Intensive Therapy Program for Problem Gamblers

### 1.1 Overview of the service

The Intensive Therapy Service for Problem Gamblers is a South Australian State Wide Service. The Department of Human Services receives funding for this service from Gambling Rehabilitation Fund and the South Australian Government. As a member of the Executive Committee for the Break Even Network we have considerable knowledge of the gambling rehabilitation services available in South Australia. We work closely with many of these agencies to provide both education and appropriate referral of clients (e.g. for assistance with financial problems). Referrals are also received from other social agencies, community, general practice and mental health services for clients to be assessed for treatment by the unit.

This service provides assessment, evidence based treatment, ongoing support and follow up for problem gamblers. Client contact is predominantly face-to-face. For those clients who are unable to attend face-to-face interviews phone contact or the use of telemedicine is used to provide treatment and follow up support as required. Training in the cognitive and behavioral treatment of anxiety and related disorders, including problem gambling is conducted by the unit. Training is provided to the Break Even Network and health professionals or community agencies in both metropolitan and Rural areas. Close affiliation with Flinders University enables students in both the Graduate Diploma in Mental Health and the Masters of Mental Health Sciences to have an opportunity to study problem gambling and develop clinical competency. Research into treatment efficacy is also an important aspect of ongoing service delivery.

Clients with problem gambling (most of whom have a diagnosis of pathological gambling as per the DSM-IV), and are able to define their gambling problems in terms of a problem statement and work towards end of treatment goals, are suitable for admission into the treatment program. Clients can self refer or be referred from other Break Even agencies, social agencies, community, and general practice and mental health services.

Over the eight year period the service has been running we have had over 700 referrals to the unit. As the service has developed over this time client registrations have increased. The current waiting list for clients to be screened is approximately two weeks however the waiting time for treatment is up to eight weeks. There are severe constraints related to funding of this program which must be addressed. Much-needed additional resources are crucial to meeting the increasing demands placed on this service.

### 1.2 Staff

#### **Director: Dr Malcolm Battersby**

Senior Lecturer in Psychiatry, Flinders University  
Director, Centre for Anxiety & Related Disorders  
Flinders Medical Centre

Provides overview of clinical service and assessment of treatment of patients, particularly for the inpatient program. Provides supervision and clinical support to program staff. Provides community and professional education for Break Even, public and private health providers

**Team Leader: Jane Oakes**

Acting Team Leader, May 2004 -ongoing (0.9 FTE)

Consultant Nurse Psychotherapist

Associate Lecturer in Mental Health Sciences, Flinders University

Provides overall management of the service. Assessment, treatment and follow up for people with gambling problems and co-morbid mental health problems. Co-ordinates the community education, research and professional development within the health sector related to problem gambling. Co-ordinates the in-patient program at Flinders Medical Centre.

**Therapists**

Provide assessment, treatment and follow up for people with gambling problems and co-morbid mental health conditions. Provides community education, research and professional development in the area of gambling and anxiety disorders.

**Angus Forbes**

Senior Clinical Psychologist (FTE 0.2)

Senior Lecturer in Mental Health Nursing &  
Mental Health Sciences, Flinders University

**Zhila Javidi**

Consultant Nurse Psychotherapist (FTE 0.4)

Associate Lecturer in Mental Health Nursing &  
Mental Health Sciences, Flinders University

**Trainee positions**

**Sally Hampel**

Mental Health Nurse (FTE 0.2)

Trainee Cognitive Behavioural Psychotherapist  
(Masters in Mental Health Sciences, Flinders University)

**Michael Field**

Mental Health Nurse (FTE 0.2)

Trainee Cognitive Behavioral Psychotherapist  
(Masters in Mental Health Sciences, Flinders University)

**Administration officer**

**Margie Blackwood** (FTE 0.8)

Data entry/ clerical work

### 1.3 The Intensive Therapy Program

The treatment program is based on both cognitive and behavioral psychotherapy. Preliminary data from a 6-year follow up of clients completing treatment indicates positive treatment outcomes. Treatment incorporates the use of repeated measures to ensure positive outcomes are being achieved and that progress is reviewed appropriately. Relapse prevention strategies, problem solving skills and regular follow up is also incorporated in the treatment program. Behavioral techniques of graded exposure and response prevention are used to enable the client to achieve elimination or significant reduction of the urge to gamble in response to a range of gambling triggers. Cognitive therapy modifies various beliefs held by the individual regarding the likelihood of winning or achieving other desired outcomes through gambling. The client is also helped to identify and challenge negative automatic cognitions, which maintain a depressed mood, using a range of cognitive strategies. (See Appendix 1, 6, 7 and 8)

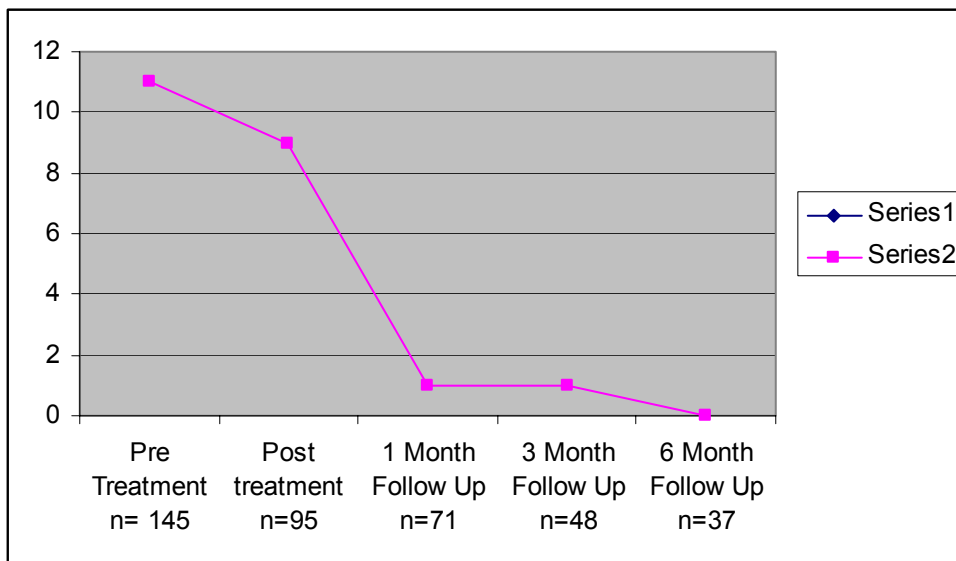
#### 1.3.1 Beck Depression Inventory Measures

Graph 1 represents data collected from clients from this service prior to commencement of treatment, at completion of treatment and at one month, 3 month and six month follow up. The Beck Depression Inventory scores ranges are:

No depression	0 -10
Borderline clinical depression	10-15
Mild depression	16-20
Moderate depression	21-30
Severe depression	31-63

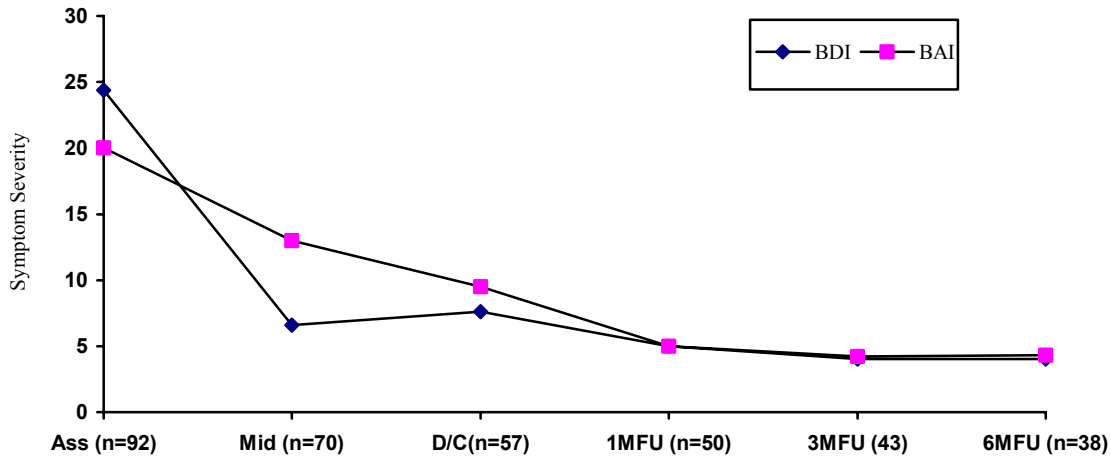
**Figure 1**

Degree of change in all completed gambling cases on the SOGS measure. By one-month follow-up on average all cases were in the non-clinical range on this measure.



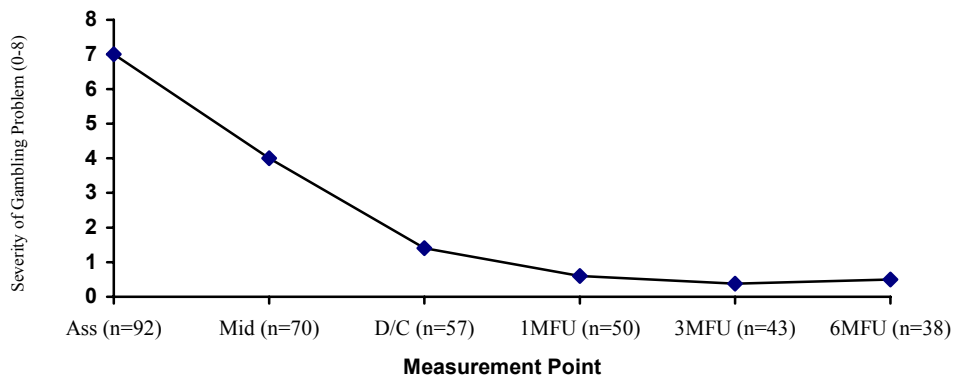
**Figure 2.**

Degree of change in all completed gambling cases on the 2 main co-morbidity measures of depression and anxiety. By one-month follow-up on average all cases were in the non-clinical range on both measures.



**Figure 3.**

Main problem ratings are a description of the persons main problem as decided by them and rated from 0 (no problem) to 8 (most severe problem they could experience).



### 1.3.2 South Oaks Gambling Screen

Graph 2 represents data collected from clients from this service prior to commencement of treatment, at completion of treatment and at one month, 3 month and six month follow up. The South Oaks Gambling Screen score ranges are:

- A score of 0 indicates no problem
  - A score of 1-4 indicates some problems
  - A score of 5 indicates a problem gambler
  - A score of 10 or above is a pathological gambler.
- (Lesieur & Blume 1987)

#### **1.4 Inpatient Intensive Therapy Program**

Clients who have a high level of psychiatric co-morbidity, do not live in close proximity to the service, or have limited support networks and difficulty engaging in treatment are assessed for their suitability for an Intensive Inpatient Treatment program. Once considered suitable for an inpatient program, the client is offered a bed on the acute psychiatric ward at Flinders Medical Centre, which is a 26 bed open ward treating a wide variety of mental illnesses. Current recourses mean that only 15-20 gambling patients are admitted each year.

Clients who are inpatients receive a multidisciplinary team approach, including a psychiatrist, cognitive behavioral therapist, pharmacist, nursing staff, social workers, occupational therapists, physiotherapist and any appropriate specialist departments such as the Pain Unit. If the client has a significant alcohol, benzodiazepine or illicit drug dependence they are withdrawn from this substance prior to commencing a treatment program for their pathological gambling. Co-morbid conditions are managed as appropriate. Throughout the admission clients are required to repeat a variety of behavioral tasks up to 4 times daily and work on cognitive worksheets throughout the day. The Cognitive Behavioral Therapist who works closely with the multidisciplinary team sees the clients approximately 5 times per week.

Once the client has shown a clear understanding of the treatment process, evidence of repeated habituation to their urge to gamble, and is developing appropriate relapse prevention strategies, a discharge date is set. When the client is discharged from the inpatient program they are placed into outpatient treatment sessions. The client will usually participate in a treatment group and recommence their home work tasks from the beginning to increase their confidence as an outpatient with a withdrawal of the intensive support received as an inpatient. The client's significant partner or relative is often included in a discharge plan, ensuring the client's finances continue to be controlled. The majority of clients are treated as outpatients and allocated into a treatment group.

## 2. Co-morbid mental health disorders

### 2.1 Overview of gambling and co-morbidity

It is well documented that clients with problem gambling have high rates of mental health co-morbidity.

**Table 1 Percentage of Gambling Co-morbidity compared with Battersby (1996): Gamblers and Non-gamblers.**

Condition	Pathological gamblers with condition	Non problem gamblers with condition	Pathological gamblers (Oakes, 2001)
Posttraumatic stress disorder	21.9	4.4	20
Social phobia	21.9	2.2	10
Agoraphobia/panic	18.8	2.2	85
Major depression	63.6	10.0	60
Dysthymia			40
Obsessive Compulsive disorder	6.3	4.4	10
Drug dependence	18.8		15
Alcohol dependence	25.0	2.2	20
Generalised anxiety disorder	9.4	2.2	75
Schizophrenia	0	0	5

Table 1 shows that pathological gamblers have higher rates of co-morbid diagnosis compared with non-problem gamblers. Co-morbidity is also common amongst people who have mental disorders other than pathological gambling (i.e. nearly one in three with an anxiety disorder have an affective disorder while one in five have substance use disorders). Those who have affective disorders are most likely to have a diagnosis from at least one of the other major diagnoses (61%), and in comparison 45% of those with anxiety disorders also had a mental disorder from one of the other major groupings (Australian Bureau of Statistics, 1998).

### 2.2 Suicidality

Suicide and attempted suicide are significantly more prevalent in pathological gamblers than the general public. A study in our service showed that 32% of clients had attempted suicide in the previous 12 months. These attempts were attributed to gambling and suicide behaviour, and were associated with the severity of gambling.

Professor Ross Kalucy, Head of Department of Psychiatry, Extended Emergency Care Unit, described significant findings from the Accident and Emergency Services at Flinders Medical Centre. Over the last 2-year period an increasing number of clients who present to the Emergency department after suicide attempts describe having significant gambling problems. Suicide attempts are often made after large financial losses, marital conflicts or homelessness secondary to gambling problems. The more the clients are asked about gambling related problems the more problem gamblers are being identified. He identified a need for a trained specialist in the field of problem gambling to be available to assess and triage these clients according to their needs. These needs include crisis interventions and then longer-term treatment interventions.

### **3. Management of co-morbid mental health problems**

The Intensive Therapy Program for problem gamblers assesses clients for both the diagnosis of problem gambling and co-morbid psychiatric conditions. Staff employed by the intensive therapy service for problem gambling are skilled in the diagnosis and treatment of anxiety, depression and other presenting psychiatric co-morbidity. The program offered within the unit is individualised to each client. When a client is referred to the unit they undergo a complete psychiatric assessment. This assessment consists of a structured psychiatric interview, which identifies the nature of the client's gambling problems and any other psychiatric co-morbidity. A suitable treatment plan is then developed, which includes the treatment of any other mental health conditions, including depression.

A risk assessment is routinely performed on all clients. If the client is considered at risk, appropriate interventions are put in place. This may mean that a liaison psychiatrist will be involved in the immediate management of the client or the ACIS team triages the client within the emergency department at Flinders Medical Centre. Clients often present with severe depression, as documented in Table 1. When a client is significantly depressed they are not suitable to commence a treatment program immediately, so are given the option of an inpatient program to address the depression. Clients are also admitted to review their medications or the use of substances such as illicit drugs and alcohol. If necessary a withdrawal program can be implemented. The client is withdrawn from these substances before commencing treatment. This is conducted in ward 4G at Flinders Medical Centre (S.A.). Once the client has been stabilised they commence the intensive treatment program for problem gambling initially as an inpatient.

## **Case Study of a client treated with gambling and other co-morbid mental health problems**

### **“Melissa”**

#### **Profile:**

40 year old separated woman living in rental accommodation and employed as a shift worker at a local hotel. She was referred to The Intensive Therapy Service for problem gamblers by the registrar on ward 4G (FMC) in 2001. Melissa had been admitted to the ward after an attempt to take her life after a recent gambling loss.

On clinical assessment she was diagnosed with pathological gambling. Her gambling history revealed that she gambled at least 5 times a week and at times up to twice daily. Her total financial loss to gambling was approximately \$70,000 which had been at least 70% of her total income.

She was also diagnosed with Panic and Agoraphobia which had significant impacts on her life. She was waking through-out the night with panic attacks fearing she was going to die from a heart attack. She would avoid leaving her house or answering her door to visitors. She was significantly depressed at the time of interview.

She was screened for her suitability for cognitive behavioural psychotherapy (CBT) to address her problem gambling, panic agoraphobia and depression. She was considered to be suitable for CBT. She was treated after discharge from hospital by one of the therapists at the unit.

Treatment was initially focused on her depression using cognitive therapy addressing her negative thought patterns maintaining her depressed mood. Once her mood had lifted she was given treatment for both her problem gambling and panic with agoraphobia.

She attended weekly treatment sessions for eight weeks in a group setting. Treatment involved graded exposure to her urges to gamble, cognitive therapy related to her erroneous beliefs about gambling and relapse prevention strategies.

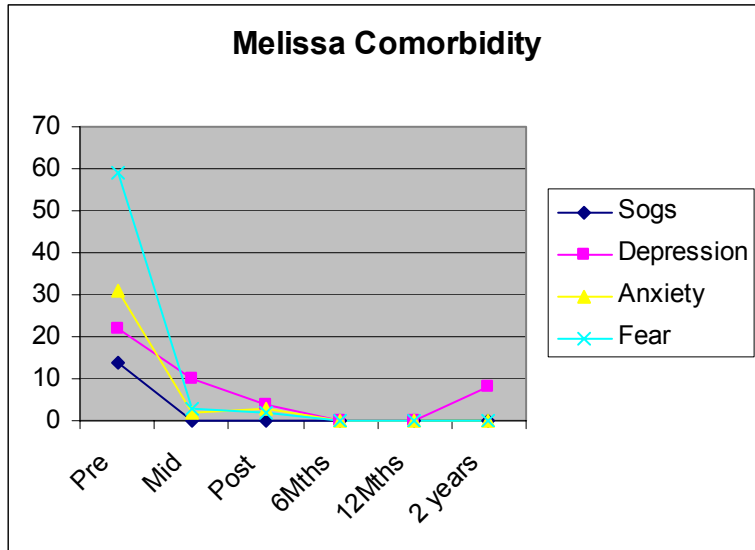
She also attended treatment sessions for eight weeks on a weekly basis for her panic and agoraphobia. Treatment involved CBT techniques to normalise body sensations, graded exposure to anxiety provoking situations and relapse prevention strategies.

She completed her individual treatment goals at the end of the eight week therapy course and was followed up over a two year period to ensure her treatment gains were maintained. She then moved to Barossa Valley where she bought a property with her new partner.

See Table 1 and Table 2

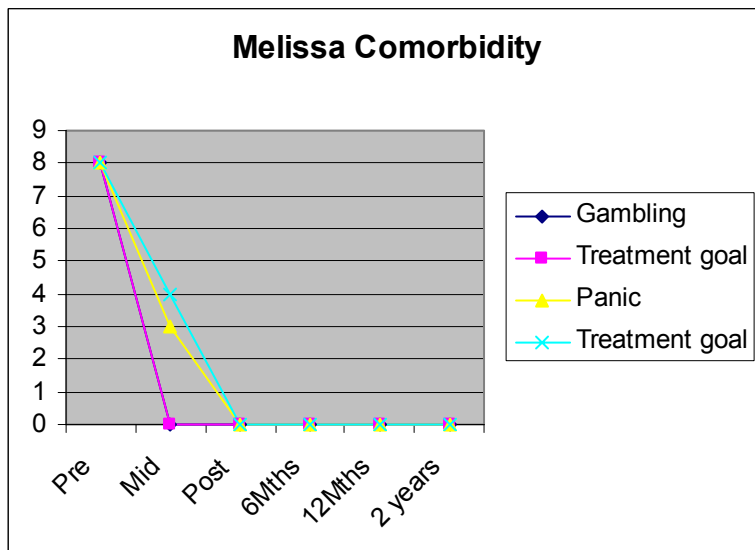
**Table 1**

Includes scores on the SOGS, Beck Depression, Inventory, Beck Anxiety Inventory and Fear questionnaire over a 2 year period. Her depression score increased after a health scare but the other scores remained stable



**Table 2**

This table represents Melissa's problem statements for both gambling and panic agoraphobia. Over a 2 year follow up it can be seen that treatment goals were maintained.



## **3.1 A Relapse Prevention Support Group**

### **3.1.1 Overview**

This is an open group for clients who have completed treatment at The Intensive Therapy Service for Problem Gamblers at FMC to have ongoing follow up and support. The group meets once every 6 weeks and clients who have completed treatment are invited to attend. Some clients choose to attend each session other attend when they can, e.g. around work and family commitments.

## **3.2 Objectives**

### **3.2.1 To maintain positive treatment gains**

Evidence of treatment gains has been maintained through the careful collection of standardised measures for each participant. These have included The South Oakes Gambling Screen, the Beck Depression and Anxiety Scales, Individualised Problem and Goal Statements and The Work and Social Adjustment Scale. All these questionnaires show that treatment gains have been maintained for clients participating in the support group.

### **3.2.2 To provide relapse prevention strategies**

A variety of activities have been used through out the support groups, which are outlined below. As well as these activities, clients have also enjoyed some more relaxed sessions where there is time for them to focus on their own areas of interest with other group members

An occupational therapist was invited to attend the initial group. She provided input with the therapists and clients attending the support group to help establish their identified needs prior to commencement of the support group. To meet these needs we invited a variety of guests to the group to present information on the topics identified by the group.

Some of the guest speakers included:

Mr Stephen Page from Regency TAFE, who provided a unique experience for clients by organising a gaming machine to be used for education at a group session. Clients found his input valuable, providing them with hands on experience of how gaming machines operate. This built on from their learning during treatment about random number generators and myths about improving winning odds. This opportunity allowed clients to see for themselves how randomness works, helping to dispute any lingering erroneous beliefs relating to winning.

- Recreation Link Up provided several sessions addressing the importance of recreation. Clients were then given the opportunity of individualised consultation with the staff at Recreation Link Up. Clients were given information about their identified recreational pursuits. The clients enjoyed these sessions and were able to identify a range of activities they felt positive about engaging in alone and with their partners. Activities ranged from ballroom dancing and swimming to car maintenance and pottery classes.
- The Occupational therapist from Flinders Medical Centre conducted relaxation classes and stress management activities. All the clients participated and were keen to continue to add relaxation into their weekly schedule.

- A nutrition specialist provided input into healthy lifestyles, which included education on healthy diets and the importance of good nutrition. Clients were also given a healthy lunch to complete an informative session
- Another guest speaker addressed goal setting and improving personal motivation. This included looking at how to balance a healthy lifestyle and incorporate exercise into a normal daily routine.
- The unit manager from The Intensive Service for Problem Gambling made a guest appearance giving some of his perspectives about issues surrounding gambling.
- An opportunity was given to a student from Flinders University studying her Masters of Mental Health Sciences to experience interact with clients who were in follow up and had achieved their identified goals from therapy. Clients proudly talked about their positive achievements since completing treatment.

### **3.2.3 Client co-morbidity identified and managed appropriately**

Regular contact with clients who have completed treatment for problem gambling gives the treating therapists the chance to keep in contact with these clients. An example of the importance of this service is a married couple that had recently completed treatment and were observed to be having difficulties. They recently had a gambling lapse, which was very distressing to them. They were able to share this experience within the group setting and the therapists were able to ensure these clients were given appropriate management. This was handled by providing them with the opportunity to have some booster sessions in a treatment group setting. They were relieved to have this opportunity for more intensive support.

Another client had a significant personal loss causing her to require specialist input to ensure her safety was maintained. This was handled quickly and appropriately, leading to a resolution of these problems.

Other clients who were attending the group were also able to have some ongoing input to the management of posttraumatic stress disorder, depression, substance use and Parkinson's disease.

Clients who were diagnosed with a co-morbid social phobia with their initial diagnosis of problem gambling were encouraged to attend the support group. These clients applied the skills taught for both problem gambling and social phobia in the group setting with positive gains.

### **3.2.4 Education re life skills and problem solving**

Clients have been given the opportunity to continue to receive feedback from therapists and other group members on the skills taught during treatment. These included thought diaries, used to identify negative thought processes and erroneous beliefs related to gambling. Problem solving activities were used to continue to teach clients how to manage situations, which would in the past usually have triggered an urge to gamble. As clients participated in these

support groups it was observed how their confidence levels increased, leading them to attempt new activities in place of gambling.

### **3.2.5 Peer support for mutual learning**

The support group has played an important role in providing a positive influence on clients who were in treatment groups and admitted into the intensive treatment program for problem gamblers. Clients who had completed treatment for their problem gambling shared their positive gains and treatment experiences with these clients. They reinforced the treatment rationale, giving clients in treatment the confidence to grasp the intricate details for successful habituation of their urges to gamble during treatment tasks. Clients who had just completed treatment could observe the longer-term gains from clients who had completed treatment months previously. Attendance and review of Support Group

Clients participating in the intensive treatment program for problem gambling are given the opportunity to attend this support group program. Most clients are enthusiastic about inclusion into this follow up program for ongoing support. Some clients received funding from their local Break Even service to travel to Adelaide from country areas to attend. Approximately 8 to 10 clients attend each session. During the 12 month period of this group several clients have moved on with their lifestyle goals, for example gaining full time employment, buying a property in the country, establishing new relationships, relocating to Tasmania to begin a “better life”, participating in volunteer work, returning to work and further study. These clients are unable to continue with the support group, but will continue to complete the standardised questionnaires to ensure treatment goals are maintained and can access the therapists for individual sessions or phone contact if required. They often request to be included in the invitation process for the group sessions with the chance of having the opportunity to attend sessions.

### **3.2.6 Future Directions**

This 12-month project of establishing a support group for problem gamblers has proven to be a positive exercise for the clients attending our service. It would be an advantage to the treatment program to have the ability to continue this support group to provide a complete treatment package for our clients. Currently there is no funding for this important maintenance program.

## **3.3 Non-English-Speaking-Background communities (NESB) and Gambling Problems**

### **3.3.1 NESB Clients**

The Intensive Therapy Services for Problem Gamblers at Flinders Medical Centre receives referrals from NESB clients themselves, their family members, GPs and the community services dealing with gambling problems. Initially it is difficult for NESB clients or their family members to ask for help or disclose their or their loved-ones’ gambling problems. As reported in the National Centre for Education and Training on Addiction, December 1998, clients from some NESB communities have difficulty accessing services because of the nature of their community and the particularly stigmatised view of gambling.

Our experience shows that NESB clients often report that their cultural and religious beliefs in relation to gambling have prohibited their behaviour, and that they carry strong negative emotions and distorted cognitions such as shameful, guilt, failure, weakness, self-hatred and a belief that their actions are unGodly.

A family member of an NESB client with gambling problems stated, "People who are playing these machines are stupid and others in the community will look down upon them." From our experience some NESB individuals with gambling problems prefer to stay in denial and refuse help, feeling shameful of disclosing their problem to anyone. NESB clients would not easily discuss these unacceptable behaviours (regardless of what form of gambling) to anyone, especially within their culture, in order to save face, as well as for confidentiality reasons. In some cases where an interpreter is needed due to the client's limited English language skills, the client becomes even more anxious and guilt-ridden due to their concern of word traveling throughout their small community.

"NESB clients perceived that confidentiality could not be assured, particularly in relation to those of a personal nature such as gambling or drug problems." (National Centre for Education and Training on Addiction, December 1998)

Our experiences show that gender also plays a large role in NESB communities and their view towards gambling problems. Traditionally men are seen as the superior sex, and as a result receive less severe punishment for gambling than women. There is much more of a stigma attached to women with gambling problems, and they lose their community's respect and are frowned-upon by others. Sadly, the majority of our clients are women from small NESB communities.

In Australia, men and women from non English speaking backgrounds feel completely trapped, firstly due to their problem with gambling and secondly their inability to be part of their cultural society if they disclose their problem or search for help outside their community. Seeking help is viewed as a weakness, as it is with depression. One gambling patient from Turkey stated that, "European people are very proud of themselves and when they have a gambling problem they feel like slaves of gambling, which can shatter their personality and force them to live in denial and self-hate." Also a Greek patient stated, "It is against my culture to be like this."

Clients from different cultures and religious backgrounds who have migrated to Australia with gambling problems have lost some or most of their identity. They lose their social skills within their culture, which is a large part of their life. In Australia people from different cultures can feel very lonely, especially those from older generations coming from very sociable cultures to a very individualised culture. It becomes very difficult for them to adjust themselves to their new country, and gambling can be seen as the easiest way to forget their concerns, and of course there is no language barrier. Gambling venues can be seen as the only place to socialise, however the end result is isolation.

### **3.3.2 Treatment program for NESB**

Our experiences show that the crucial part of any treatment for NESB clients is cultural awareness, which incorporates sensitivity, compassion and an understanding of a particular set of beliefs. The therapist needs to have the ability to understand the client's cultural and religious backgrounds in relation to their current problem. Examples include not matching a young therapist with an older patient from a different culture, and that older generations of men and women prefer the same gender therapist.

Having this awareness, knowledge and understanding of NESB communities will help to design a treatment program that would be more effective and efficient to both therapist and the client and with more satisfactory outcome measurements.

Our experiences show that the therapist needs to have a greater understanding of the concept of saving face within most NESB cultures, and discuss with their NESB clients how to provide confidentiality and build trust within the therapeutic relationship. Much of our work as therapists with NESB clients involves education and forming a trusting therapeutic relationship with the individual and the family. The role of family is very important to NESB clients; as usually a problem stays within the family and they try together to pay the debt, which impacts on the whole family.

(Research Consultancy-National Centre for Education and Training on Addiction December 1998, *Gambling and Self-Help*, Department of Human Services (Community Services Branch) published by Government of South Australia. pp. 43–44)

#### **4. Measurement of the effectiveness of the program**

The current measures we have in place are adequate to provide an evidence base for treatment and follow up outcomes. All clients are asked to complete initial and ongoing measures. Clients complete the measures listed below prior to commencement of treatment and at regular intervals during treatment and in the follow up phase of treatment. For some clients follow up measures have been completed for up to 5 years, and indicate treatment gains are ongoing.

##### **4.1 South Oaks Gambling Screen**

This tool is a 20-item questionnaire based on DSM-III criteria for Pathological Gamblers. It may be self administered or administered by a health professional or non-professional interviewer. Individuals scoring less than three are described as non-problem gamblers and those who score between 3 and 4 are potential problem gamblers. Those who score 5 or over are considered probable pathological gamblers (Lesieur & Blume, 1987). The South Oaks Gambling Screen (SOGS) is one of the most widely used questionnaires to determine if a client has a problem with gambling. This screen asks questions about a gamblers behaviours looking at whether they chase their gambling losses, have problems with the control of their gambling behaviours such as gambling more than planned, have guilt in relation to their gambling and if the client believes that they have a problem (Productivity Commission, 1999).

##### **4.2 Work and Social Adjustment (WASA)**

This generic measure of disability and handicap is a self-administered scale covering five areas of functioning on a scale of 0 - 40 (Marks, 1987). The Work and Social Adjustment Scale is a tool used to measure the disability and handicap as defined by the World Health Organisation in relation to work, home management, social leisure, private leisure, and family and relationships. It is an appropriate tool for those with both psychological and physical problems, because it describes the impact of problems on many aspects of an individual's life. This questionnaire measures the client's own perceptions of their problems and how this impacts on their daily lives. It can be used as an indirect measure of success. The main advantages of this tool are that it is quick to use, it is applicable to a full range of severity and has shown to be a sensitive measure over time (Battersby & Allen, 1998).

##### **4.3 Beck Depression Inventory**

The design of this 21-item test is to measure the degree of depression in adolescents and adults. Each item is designed to assess a specific symptom or attitude specific to depression. Each of these items relates to a specific category related to depressive symptoms or attitudes. This tool has no arbitrary cut off score, and the specific cut off depends on the individual characteristics of the clients and the purpose of which the inventory was given to the client. (<http://cps.nova.edu/~cpphelp/BDI.html>).

##### **4.4 Beck Anxiety Inventory**

The Beck Anxiety Inventory is used to assess severity of anxiety. Its specific design reduces the overlap between depression and anxiety scales. This is achieved by only measuring anxiety symptoms shared minimally with depression. It is a 21 item tool addressing both the psychological and cognitive components of anxiety, identifying subjective, somatic and panic

related symptoms. The total score ranges from 0 to 63. (<http://www.cps.nova.edu/~cpphelp/BAT.html> )

#### **4.5 Problems and Goals**

The aim of the problem and goal statement is for the client to describe as concisely as they are able what they perceive as their main problem and the specific goals they wish to achieve in relation to the problem (Battersby, 1998). The client regularly measures these statements on a scale of 0 to 8. The score of 8 means little achievement of goals or reduction of problem. As the client progresses through treatment it is expected that the scoring will reduce and a score towards 0 indicates improvement.

#### **4.6 The Victorian Gambling Screen**

Measures prevalence of problem gambling defined in terms of harmful consequences of gambling. Has strong psychometric characteristics and appears to be a valid measure of problem gambling with innovative features including enjoyment of gambling scale

## 5. Research

### 5.1 Background

To provide an effective rehabilitation program for problem gambling, research needs to be undertaken in order to measure the effectiveness and ongoing development of the service provided. This would ensure that best practice models are provided for rehabilitation with ongoing review and development of programs according to research findings.

#### 5.1.1 Best Practice in Problem Gambling Services

The Best Practice in Problem Gambling Services, GRP report N0.3 (2003) clearly states that there are no internationally established models of the best practice in the treatment of problem gambling. Several important issues related to the definition and measurement of treatment outcomes of rehabilitation programs compromised them as best practice guides. Research needs were clearly stated including the following:

- A need for a delineated selection process for inclusion of gamblers into treatment programs.
- Identification of all areas of improvement, including impacts on clients' social, work, family and leisure activities. Ongoing review of depression and anxiety disorders.
- Outcomes of different forms of gambling including TAB, Casino Games, gaming machines and sports betting.
- Looking at motivation to change and treatment outcomes.
- Use of ongoing outcome data being reported.
- Comparison of different interventions to determine those which have the best outcomes and acceptability to clients and therapists..
- Review of outcome measures to obtain optimal effectiveness of treatment.
- Clear definitions of lapse and relapse after treatment for gambling.
- Long term follow up measures of treatment programs.
- Identification of innovative effective and culturally sensitive models of service delivery.
- In collaboration with relevant researchers, the gambling industry and service providers to develop methods to identify potential problem gamblers and develop successful early intervention programs. (GRP Report No.3, 2003)

### **5.1.2 The Intensive Therapy Service for Problem Gambling has identified the following research needs:**

- Is Cognitive Behaviour Therapy (CBT) with urge reduction the best evidence based treatment for problem gambling?
- What is the prevalence, causes and strategies to intervene in relapse after treatment for problem gambling.
- What more can we do for psychiatric co-morbidity and problem gambling?
- How can treatment be tailored to meet the needs of non-English speaking clients and specific client groups such as the elderly, the young, and the disabled?
- How effective is treatment delivery via videoconference?
- How effective are support groups in preventing relapse after treatment completion?
- What is the effectiveness of group verses individual therapy?
- Examining the use of the Victorian Gambling Screen as an outcome measure in a clinical setting.
- Evaluation of the effectiveness of CBT training for trainees from a range of professional backgrounds.
- Can treatment of problem gambling using CBT be delivered on line?
- Development and ongoing management of a comprehensive data set, which would provide a wide selection of measures and evidence, related to the ongoing effectiveness of treatment.

### **5.2 Overview of the Intensive Therapy Service for Problem Gambling**

The table below shows a number of different interventions in the rehabilitation of problem gamblers. Psychodynamic formulations appeared early last century, with behaviourally based interventions emerging in the 1960s. By the 1980s multimodal programs were developed. In the 1990s cognitive-behavioural interventions, cognitive interventions and, in the 2000s, psychopharmacological regimes, with multimodal and cognitive or cognitive/behavioural interventions were introduced. (GRP Report 3, 2003)

It can be seen in this detailed summary of interventions that the studies are not consistent in their sample sizes, follow up periods and outcomes. Outcomes vary from controlled gambling to abstinence. There is a clear need to have some long term research into the development of rehabilitation programs for problem gamblers addressing lapse, abstinence and why treatment is not effective.

## Problem Gambling Treatment Outcome Studies

Author (bold denotes Australian study)	Technique	Cases	Outcome	Follow-up
Bergler, 1957	Psychoanalysis	60	80 patients 60 treated 45 successes	Not specified
Victor and Krug, 1967	Paradoxical intention	1	1 abstinent	Not specified
Barker and Miller, 1968	Aversive therapy	5	3 abstinent 2 abstinent with relapse episodes	< 2.5 years
Goomey, 1968	Aversive therapy	1	Abstinent	2 years
Seager, 1970	Aversive & supportive therapy	16	5 abstinent 6 relapsed	6 months – 3 years
Bolen & Boyd, 1970	Marital group	9	3 abstinent 5 near cessation	Nil
Kraft, 1970	Systematic desensitisation	1	Failure	1 year
Cotler, 1971	Aversive & covert sensitisation	1	Relapsed	
Peck & Ashcroft, 1972	Satiation	5	80 per cent improved at treatment termination	Nil
Koller, 1972	Aversive therapy	20	5 abstinent 1 virtually ceased	6 months – 2 years
Bannister, 1977	Rational emotive therapy & covert sensitisation	1	1 abstinent	2.5 years
Custer & Custer, 1978	Gamblers anonymous	150	42 per cent abstinent	Mean attendance 7 years 3 months
<b>Dickerson &amp; Weeks, 1979</b>	Behavioural counselling	1	Controlled	15 months
Moskowitz, 1980	Lithium	3	2 reduced 1 unclear	Not specified
Griffiths, 1982	Hypnosis	1	Improved at termination	Nil
Greenberg & Rankin, 1982	Stimulus control, exposure and covert sensitisation	26	5 controlled 7 controlled with periodic relapse	9 months – 5 years

Author (bold denotes Australian study)	Technique	Cases	Outcome	Follow-up
Stinchfield & Winters, 1996 Rhodes, Norman, Langenbahn, Harmon & Deal, 1997	Six-state funded multimodal programs	944 (368)	42 per cent abstinent 70 per cent improved No program differences	1 year
<b>Tolchard &amp; Battersby, 1996</b>	Desensitisation	75	81 per cent improved, but did not account for clients seen for fewer than 5 sessions	Nil
Henry, 1996	Emdr	22	?	Nil
Sylvain, Ladouceur, & Boisvert, 1997	Cognitive behavioural	29	71 per cent improved	6 months
Symes & Nicki, 1997	Cue-exposure	2	Both improved on treatment termination	Nil
Crockford & el Guebaly, 1998	Naltrexone	1	Improved on treatment termination	Nil
Ladouceur, Sylvain, Letarte, Giroux & Jaques, 1998	Cognitive	5	4 improved	6 months
Hollander, DeCaria, Finkell, Begaz, Wong & Cartwright, 2000	Fluvoxamine & placebo	10	Significant improvement in PG Clinical Global Impression Scale & on PG modification of Yale-Brown Obsessive Compulsive Scale	After 8 weeks of fluvoxamine and 8 weeks placebo
Kim, Grant, Adson & Shin 2001	Naltrexone & placebo	83	75 per cent of naltrexone treated patients statistically significantly improved of 24 per cent on placebo	After 11 week naltrexone or placebo treatment
Kim & Grant, 2001	Naltrexone	17	Reduction in gambling frequency, amount lost, and clinician-rated CGI	After 6 weeks of treatment in open-label study
Ladouceur, Sylvain, Boutin, Lachance, Doucet, Leblond & Jaques, 2001	Cognitive	35 & 29 controls	86 per cent no longer met DSMIV criteria at treatment end Change maintained at 6 & 12 months	6 and 12 months
Breen, Kruedelbach & Walker, 2001	Cognitive inpatient	66	Significant . change in gambling-specific attitudes & beliefs	After 28 days of residential treatment
Hodgins, Currie & el-Guebaly, 2001	Motivational interview & workbook	102	Combined brief treatments more effective than single. Effect maintained at 12 months for those with less severe problems	12 months
Bianco, Petkova, Ibanez & Saiz-Ruiz, 2002	Fluvoxamine & placebo	32	Fluvoxamine not superior to placebo in total sample, but significant. Superior for males and younger participants	After 6 months treatment
Zimmerman, Breen & Posternak, 2002	Citalopram	15	Significant improvement on gambling related measures. For 9 completing, gains held for 12 weeks of treatment	After 12 weeks treatment

### 5.3 Overview of research

Research at the Intensive Therapy Service for Problem Gambling is still in its infancy. The service at Flinders Medical Centre is closely affiliated with The Masters of Mental Health Sciences at Flinders University, South Australia. To ensure this service offers effective treatment ongoing research has been a priority. The service budget is minimal regarding research funding and this is often completed outside of work time by the treating team. The unit currently has 1 PhD student and one Masters student conducting research in the area of problem gambling.

Completed research studies have included a descriptive study of psychiatric co-morbidity amongst pathological gamblers presenting for treatment at this service, measuring suicidal behaviour in people attending the service and the development of the Victorian Gambling Screen for the detection of problem gambling in the community

An international student from Fiji is currently undertaking a survey of problem gambling amongst the Fijian population.

Dr Adrian Esterman Director of the Clinical Epidemiology Unit at FMC has assisted in the design and analysis of research projects.

Current research being conducted within the unit includes:

#### **5.3.1 The use of tobacco and alcohol, and evaluate health status amongst treatment-seeking problem gamblers and non-treatment seeking frequent and problem gamblers**

Authors Forbes, A., Oakes, J. and Battersby, Malcolm

The goal of this project is to examine the use of tobacco and alcohol, and evaluate health status amongst treatment-seeking problem gamblers and non-treatment seeking frequent and problem gamblers. Previous research has indicated that there is an increased incidence of tobacco and alcohol use within problem gamblers, and that this might contribute to an increased severity of the gambling problem. Survey results from Australian research studies have indicated the increased prevalence of alcohol and tobacco use within gambling populations, however it has not been demonstrated that treatment outcomes are affected by these risk factors. Confirmation of the relationship may offer the potential to improve the effectiveness of treatment services via tailoring of therapy and indeed pave the way for integrated approaches to treatment. This project will investigate these questions within a population of treatment-seeking gamblers attending the Flinders Medical Centre's Intensive Therapy Service for Problem Gamblers, and also a population of non-treatment seeking frequent and problem gamblers. Furthermore, this study has policy implications within the South Australian environment in terms of providing information of relevance to the contemporary debate surrounding proposed legislation that would ban cigarette smoking in gambling venues.

The proposed project has two major aims:

- To replicate a prevalence study by reported by Petry and Oncken (2002) that identified a higher than normal incidence of cigarette smoking amongst treatment-seeking problem gamblers, and that smoking status is associated with an increased severity of gambling problems.
- To extend this work by (1) examining alcohol use and health indicators; and (2) to broaden the investigation to also include a population of non-treatment seeking frequent and problem gamblers.

This project is significant in terms of offering the potential to:

- Identify extraneous factors such a cigarette smoking and other risk taking activities in gamblers that influence the nature of problem gambling.
- Determine if such factors play a significant role in the outcome of treatment.
- Determine differences in health outcomes of treatment and non-treatment seeking problem gamblers.
- Establish health promotion strategies to help reduce the risk of developing problem gambling and identify at risk problem gamblers in order to provide help earlier.
- Contribute to the development of legislature pertaining to restricting cigarette smoking in gambling venues.

### **5.3.2 Relapse and problem gambling**

Oakes, J., Pols, R. and Battersby, M.

The aim of this research is to: review the area of relapse for pathological gamblers treated with CBT, to define outcome measures and to examine the mechanisms where by relapse rates can be improved. This is part of a higher degree (Masters/PhD) study by Jane Oakes.

### **5.3.3 A randomised control trial using Naltrexone in the treatment of problem gamblers**

Battersby, M., Dolman, B., Herriot, P

The aim of this research is to review the effectiveness of Naltrexone as a treatment for problem gambling.

### **5.3.4 International Clinical Trials Network for the Flinders Medical Centre, Intensive Therapy Service for Problem Gamblers**

The Trials network proposal is a product of the International Think Tank on Problem Gambling (see attached). The purpose of the Think Tank is to provide a forum to address globally significant issues and developments in problem gambling policy, services and research in relation to presenting gambling populations and first contact services. Its ultimate aim is to contribute to the development of an international public health agenda on gambling. (See Appendix 3, 4 and 5)

The Think Tank brings together leading authorities and major stakeholders to consider information on presenting gambling populations and how best to assist them. Its aims are to foster cooperation between researchers, policy-makers and service providers and focus on the development of evidentially led policies and services to meet the needs of presenting and at-risk populations. The Think-Tank has three speciality areas each represented by a team of international specialists. These areas are Research, Treatment and Services, and Policy and Public Health.

To date the Break Even Intensive Treatment service at Flinders Medical Centre has a treatment model with 7 years clinical and research experience. This includes longitudinal collection of data related to the efficacy of the Flinders Model of Treatment using Cognitive Behavioral Therapy (CBT) for the treatment of problem gamblers. The outcome data from our service shows that clients who complete treatment have significant positive treatment outcomes (see attached). We have already trialed our treatment program at a variety of sites in this state. This treatment model is taught to both national and international students enrolled in the Masters of Mental Health Sciences at Flinders University.

The Flinders treatment model was presented at the International Think Tank Conference for Problem Gambling in Queensland in November 2004. It was well received and a keen interest was expressed both nationally and internationally to establish this model as apart of a Clinical Trials Network (CTN). We are currently in the final stage 3 of the National Institute of Drug Abuse checklist for a CTN.

NIDA check list completed:

- Theoretical Rationale
- Theory of Change
- Process for measures
- Procedures for supervising performance
- Procedures for training and certifying therapists
- Assignment of cases to treatment modalities.

NIDA Checklist underdevelopment

- Therapist manual
- Retention rate of treatment
- Effectiveness of training
- Study Inclusion
- Client recruitment at another site.

The proposal to trial the Flinders model has significant financial interest form the Victorian and Queensland Governments, and internationally from Canada, the United States, New Zealand and the United Kingdom. It appears at this stage the Flinders Model is the only model ready to start a CTN.

## 5.4 Publications

### 5.4.1 Journal Articles

- Battersby, M., Tolchard, B., Esterman, A. & Thomas, L. (2002). Review of the South Oaks Gambling Screen (SOGS): An Australian perspective. *Journal of Gambling Studies*, 18(2), 257-271.
- Oakes, J., Tolchard, B., Thomas, L. & Battersby, M. (2002). Behavioral psychotherapy training for nurses in Australia: One nurse's experience. *International Journal of Mental Health Nursing*,
- Tolchard, B. & Battersby, M. (2000). Nurse behavioral psychotherapy and pathological gambling: An Australian perspective. *Journal of Psychiatric and Mental Health Nursing*, 7, 335-342.
- Ben-Tovim, D., Esterman, A., Tolchard, B. & Battersby, M. (2001), *Victorian Gambling Screen*, Gambling Research Panel, Victorian State Government
- Currently in submission to the British Journal of Psychiatry  
*Suicidal ideation and behaviour in people with pathological gambling attending a treatment service*  
Authors Malcolm Battersby, Barry Tolchard, Mark Scurrah and Lyndall Thomas  
Corresponding Author Malcolm Battersby (See attachment)

### 5.4.2 Conference Proceedings

- Battersby, M, & Tolchard, B. (1996). The effect of Treatment of Pathological Gamblers referred to a Behavioral Psychotherapy Unit: 1-Changes in Psychiatric co-morbidity after Treatment. Seventh National Conference of the National Association for Gambling Studies, Adelaide, South Australia.
- B.Tolchard, & Battersby, M. (1996). The effect of Treatment of Pathological Gamblers referred to a Behavioral Psychotherapy Unit: 11 - Outcome of three kinds of Behavioral Intervention.
- Seventh National Conference of the National Association for Gambling Studies, Adelaide, South Australia.
- Battersby, M., Ben-Tovim, D., Esterman, A., Tolchard, B. & Dickerson, M. (2002). The VAGS: A new Australian instrument for the detection of problem gambling. 37<sup>th</sup> Congress of the Royal Australian and New Zealand College of Psychiatrists, Melbourne, Australia.

### 5.4.3 Conference Abstracts

- Battersby, M., Scurrah, M., & Tolchard, B. (2000). A systematic study of suicidal ideation and behavior in a cohort of patients with a diagnosis of pathological gambling presenting

to a hospital based gambling treatment service. *Australian and New Zealand Journal of Psychiatry*, 34 (suppl.).

- Tolchard, B., & Battersby, M. (2000). Evaluation of the intensive therapy service for problem gamblers and in-patient program. *Australian and New Zealand Journal of Psychiatry*, 34, (suppl.).
- Battersby, M., Tolchard, B., & Oakes, J. (1999). Outcome of a treatment program for pathological gamblers. *The Australian and New Zealand Journal of Psychiatry*, 33, (suppl.).

#### **5.4.4 In Submission**

- Tolchard, B. & Thomas. GPs and problem gambling: can they help with identification and early intervention?
- Oakes, J., & Forbes. A (2002). A descriptive study of psychiatric co-morbidity amongst pathological gamblers.
- Oakes, J Crommarty P, Battersby. M, Forbes. A & Pols.R“ Issues and benefits in relation of telemedicine to provide CBT and supervision in the management of problem gambling: A case study” (See Appendix 2)

#### **5.4.5 Conference Presentations**

- International Think Tank for Problem Gambling (Treatment and Services Working Group / Auckland University Gambling Research Centre) Queensland Conference November 2004 *Should a clinical trials network for gambling treatment be developed? The Flinders Model* J. Westphal & J. Oakes
- Oakes, J & Forbes A “Issues and benefits in relation of telemedicine to provide CBT and supervision in the management of problem gambling: A case study” AACBT National Conference, Perth, May 2004
- Oakes, J & Forbes, A “A descriptive study of psychiatric co-morbidity amongst pathological gamblers.” AACBT National Conference, Perth, May 2004
- Oakes. J & Forbes, A “High co-morbidity amongst pathological gamblers presenting for treatment: Implications for recognition and Management” National Conference of the National Association for Gambling Studies, Melbourne 2002.
- Forbes, A, & Oakes, J, “Group Treatment of Pathological Gamblers Using a Manual Based Behavioural Psychotherapy Intervention” 5th European Conference on Gambling Studies. Barcelona, October 2002
- Oakes, J & Forbes. A “Post Traumatic Stress Disorder a Case Presentation” Australian Association for Cognitive Behaviour Therapy Conference. Queensland 2002

- Oakes, J “Gambling and Co-morbidity” Evidence Based Mental Health Research Day. Flinders University August 2002
- Oakes, J & Tolchard, B “The Intensive Inpatient Program for Problem Gamblers: Centre for Anxiety and Related Disorders” National Conference of the National Association for Gambling Studies, Queensland 1999
- Oakes, J & Tolchard, B “The Intensive Inpatient Program for Problem Gamblers: Centre for Anxiety and Related Disorders” National Conference of the National Association for Gambling Studies, Adelaide 1998

## 6. Training (brief courses)

In response to the widespread use of gambling, the prevalence of problem gambling, and the co-morbidity of problem gambling and mental health disorders, the Centre for Anxiety and Related Disorders have conducted a number of brief training programs for Break Even agency staff, and the community including GPs, psychiatrists and social welfare agencies into problem gambling recognition and early intervention and referral.

Training and education has also included health professionals such as medical staff, nurses, occupational therapists, social workers, psychologists, student nurses and other allied health professionals. Teaching has been undertaken using a wide range of activities. These include:

- Formal education sessions which cover the recognition, immediate management and referral resources for problem gamblers,
- Training workshops where elements of assessment and treatment using cognitive and behavioral techniques and relapse prevention strategies are taught,
- Supervision where practitioners who have some skills in treatment for problem gamblers are assisted in cognitive and behavioral programs,
- Provision of advice and support to practitioners regarding cognitive and behavioral aspects of treatment and also mental health issues such as depression, anxiety and suicidal assessment and management,
- Academic presentations to conferences and teaching hospital academic programs,
- Identification of mental health co-morbidity,
- Evidence based practice.

End results:

- Increased identification of problem gamblers,
- Referral of suitable clients for cognitive behavioral management and the ability of these workers to provide ongoing support to clients during and post treatment within their program, and
- Increased awareness of gambling and related problems and management options.

### **6.1 Mental Health Awareness Workshop for Breakeven Workers in the areas of mental health, gambling (recreational gambling and problem gambling) and basic risk assessment skills.**

Topics included recognition and management of anxiety, depression and anxiety related disorders. Risk assessment was also taught.

Workshops conducted through out 2003 and 2004

Workshop targets a multidiscipline team of Breakeven Workers. The aim is to provide a basic understanding of a variety of mental illnesses and risk management skills

### **6.2 Gambling Helpline South Australia (DASC) 2004**

Workshops provided the helpline workers with education on

- Anxiety and related disorders
- Gambling history
- Recreational gambling
- Problem gambling and treatment
- Telephone counseling
- Risk assessment.

### **6.3 Full day Workshop: Problem gambling**

AACBT National Conference, Perth, May 2004

Cognitive Behavior Therapy and Problem Gambling

This workshop taught the identification, assessment and treatment of problem gamblers using didactic teaching, case studies, videos and role-plays in a practical and interactive workshop. Topics covered included history of problem gambling, onset and course of problem gambling; distinguishing those who gamble for fun and problem gambling, standardised measurement and structured assessment tools; co-morbidity: effectiveness of evidence treatments, relapse prevention and the CBT approach. Students were exposed to a wide variety of client profiles to aid their understanding and ability to recognise problem gamblers and those at risk of developing this problem.

### **6.4 Community Education**

A variety of presentations have been developed to meet the needs of community groups, including a Chinese version of a gambling, problem gambling and family impacts talk for a Chinese community. Topics include

- Overview about gambling in general including forms of gambling, prevalence and impacts to the individual and society,
- Education about problem gambling and co-morbid conditions,
- Assessment of problem gamblers and referral process.

## **6.5 Problem Gambling Treatment Group**

Involved in the development and evaluation of a treatment group for problem gamblers at Wesley Mission SA. This involved liaison with staff members at Wesley Mission to organise the fundamentals of a new group, education to these staff members re CBT principles and incorporating these principles in a treatment group setting, screening of clients suitability for a treatment group, evaluation of the group process. The aims of this teaching exercise were to run a treatment group in collaboration with The Wesley Mission and provide them with adequate skills to feel competent to run treatment groups independently. Ongoing clinical supervision is provided to Wesley Missions clinical staff.

## **7. Education and training for health professionals and counsellors undertaking the Postgraduate degrees in Mental Health Sciences at Flinders University.**

### **7.1 Background**

- Dr Battersby is Director of the Centre of Anxiety and Related Disorders, Department of Psychiatry, Flinders Medical Centre and Senior Lecturer in Psychiatry at Flinders University. He trained with Professor Isaac Marks, at the Maudsley Hospital & Institute of Psychiatry, London, in the behavioural treatment of anxiety disorders and severe neurotic conditions in both inpatient and outpatient settings. He has extensive experience in teaching, training and conducting anxiety disorder workshops for a range of disciplines in South Australia, interstate and internationally.
- Dr Battersby has recently returned from a 12 months Harkness Fellowship in the United States to research self-management for chronic conditions including mental health problems. His focus has been to make available evidence based treatment skills to a broad range of health professionals and counsellors by establishing the Master of Mental Health Sciences at Flinders University.
- The philosophy of this program is to equip health professionals with knowledge and skills in the theory, principles and practice of Mental Health Sciences with an emphasis on CBT (or Behavioural-Cognitive Therapy).
- Students learn to:
  - Assess, treat and evaluate clients presenting with a wide variety of clinical problems to a high standard of clinical competency consistent with evidence as recognised within the field of CBT and more widely in mental health sciences.
  - Act as the main therapist, liaising with other professionals.
  - Educate others (health professionals, clients and families) regarding mental health sciences and with particular reference to CBT.
  - Act as clinical supervisors to other health professionals on issues relating to mental health sciences and CBT.
  - Undertake research in the field of mental health sciences.
- The content of the program is characterised by the need to reflect both the science and art of clinical practice. Characteristically CBT is evidence-based practice. The philosophy of this program values the science of practice but the art of practice is equally as important. Therapists who are unable to establish therapeutic relationships are unlikely to be good practitioners, therefore a high degree of psychotherapeutic communication skills are valued as an integral part of the training. Likewise their role within the context of a multi-disciplinary setting requires an ability to respond to a large range of professional relationships including team member, clinical supervisor and referral receiver. Knowledge of both inter and intra relationship issues is therefore a crucial learning item in this program.
- Students enrolled in this course have a variety of disciplines including psychologists, social workers, teachers, nurses, occupational therapists and mental health nurses.
- The course was established in 2000. Since that time the course has gained momentum seen by the public and private sector as an immensely beneficial speciality. Many and varied

professionals from local, interstate and international areas including psychologists, social workers, nurses, counsellors, occupational therapists and teachers have been attracted to the course. Six students have graduated from the course and currently 40 students are enrolled, including 14 new enrolments for 2005.

- One of the perceived major strengths of the course is the strong clinical component. Students are required to complete 800 clinical hours to enable them to graduate in MMHS. This equates to treatment to completion of approximately 15 clients. The majority of students complete the clinical component of their course through placement at CARD, FMC.
- Current students and graduates of the course are gaining promotion and employment through their study. Many of these professionals are incorporating CBT into their workplaces.
- Currently 2 graduates and 1 current student work as CBT specialists within CARD, FMC.
- We have 3 international students currently completing their MMHS.
- One of our international students is Sitiveni Yanuyanutawa, National Co-ordinator, Mental Health, St Giles Hospital Fiji. He intends to introduce CBT throughout Fiji when he completes his MMHS this year.
- Students have been employed in mental health, general practice and Break Even gambling services.
- In 2006, The Ramsay group will be offering short-term on-going paid placement for current students of the course.
- The courses have an established Advisory Committee made up of a panel of industry experts from both the private and public sector. The direction of the course has evolved based on advice from this committee and other areas. The demand for CBT specialists in the Gambling area has become evident, and therefore the focus of the course has increasingly included the area of problem gambling.

## **7.2 Problem Gambling Education**

Currently, MMHS is in the process of increasing from an 18 month, 54-unit degree to a 2-year 72-unit master's program. With this increase, the focus on Gambling has been increased in the core topics to include:

- A problem gambling Problem Based learning module consisting of 4.5hours of direct lecturing and approximately 9 hours of student self directed learning
- A one day problem gambling workshop (available to other health professionals) covering the theory and practice of treatment in the area
- The study of several gambling related articles included in the Theoretical Foundation subjects
- Options of the research II and Research proposal being completed in the Problem Gambling area
- Treatment of a minimum of 2 Pathological Gamblers (approximately 50 hours of clinical treatment)
- A focus group of clinical treatment involving student screening of gambling patients and a program of 5 x 1.5hours of group supervision
- Participation in Group Gambling treatment program of 12 weeks and 24 clinical hours.

In 2006, students will be required to choose an elective topic within MMHS, which will constitute their speciality area. The areas students will be able to elect to undertake further studies in the problem gambling area are:

- The Problem gambling unit of FMC will be developing an elective topic to enable students taking this elective to have the title of MMHS (gambling).
- It is expected gambling specialist students will complete their 12 unit research topic in the gambling area
- Treatment of an additional 2 pathological gamblers.
- The students of the programs of Mental Health Sciences offered at Flinders University make a significant contribution to the treatment of problem gamblers through their studies and afterwards as highly competent therapists.

## **8. Recommendations to enhance the effectiveness of South Australian programs for the rehabilitation of problem gamblers**

### **8.1 Education and Training:**

- Training for workers in the rehabilitation programs for problem gamblers in evidence based (CBT) models.
- Scholarships for course fees for students enrolling in the Masters of Mental Health Sciences, Flinders University who undertake the gambling elective topic.
- Dedicated lecturing staff (3 FTE) to provide both clinical supervision and teaching in evidence based gambling treatments.
- Development of a gambling topic and provision on-line to support rural and remote students of the Masters of mental Health sciences.

### **8.2 Service Delivery**

- Establish outreach services of the Intensive Therapy Service for Problem Gambling into other regions such as the Western and Northern Suburbs of South Australia. Funding should also be available to increase services into rural and remote areas of the state. New services specialising in Aboriginal health need to be established in areas such as Cooper Pedy where there are severe gambling impacts on local communities. This would mean funds to establish a similar inpatient program to the Intensive Therapy Service for Problem Gamblers (FMC) with out patient follow up using CBT principles. The training of staff in this specialised evidence based treatment with ongoing supervision and support will be essential.
- The establishment of a community based CARD clinic eg, at a major shopping center and/or general practice as an alternative to a hospital based program, which may discourage people seeking help.
- Provision of staff to provide screening and assessments for people presenting to emergency departments of public hospitals with suicide attempts.
- Development of innovative programs including the use of web based self-treatment programs, the use of telemedicine to assist clients and therapists in remote areas.

### **8.3 Research**

- Research into the effectiveness of the clinical approaches / treatment modalities used within each agency. Agencies should be encouraged to take on going measures related to treatment outcomes.

- Funding for the South Australian component of the international clinical trials network to establish effective treatment modalities for problem gambling. Research and development of appropriate treatment modalities into particular groups of the community who are vulnerable to developing problem gambling. These groups include adolescents, elderly, mentally handicapped, couples, culturally diverse communities and families of problem gamblers.

#### **8.4 Community Education**

- Harm minimisation strategies, for example early intervention programs working with G.P.s and community agencies. Liaison with hotel staff in appropriate management of problem gamblers is also necessary.
- Focus on correcting the general public's misconceptions of winning in relation to gambling. Advertising campaigns should be aimed at teaching the community the true probabilities of winning money when gambling, so they can make informed decisions in relation to gambling.
- Education programs aimed at school children in the areas of gambling and problem gambling and alternative coping strategies.

#### **8.5 Financial counseling**

- Funding for financial counselors who often are the point of entry for problem gamblers and their families. Financial counselors need to be skilled in appropriate management of gamblers experiencing mental distress in relation to their gambling consequences so appropriate referrals can be made. Representation

#### **8.6 Representation**

- Adequate representation at the Gambling Rehabilitation Fund meetings by Break Even Staff.

## 9. **Affiliations**

- Executive Committee Breakeven Service S.A.
- Breakeven Network S.A.
- Education Working Committee Breakeven Network S.A.
- International Think Tank Treatment Team for Problem Gambling (Treatment, Research and Services Working Groups/Auckland University Gambling Research Centre)
- Member of AACBT (Australian Association for Cognitive and Behaviour Therapy)
- National Association for Gambling Studies Committee

## 10. References

- Australian Bureau of Statistics (1998). *Mental Health and Wellbeing: Profile of Adults*. Australia. Canberra
- Battersby, M. and Allen, K. (1998). *The Work and Social Adjustment Scale Individualised Problem and Goal Setting*. South Australia, Coordinated Care Training unit.
- Beck, A.T., Ward, C.H., Mendelson, M., Mock, J and Erbaugh, J. (1961). An Inventory for Measuring Depression. *Archives of General Psychiatry* 4, 561-571.
- Beck Depression Inventory  
<http://cps.nova.edu/~cpphelp/BDI.html>.
- Beck Anxiety Inventory  
(<http://www.cps.nova.edu/~cpphelp/BAT.html>)
- Blaszczynski, A. (1998) *Overcoming Compulsive Gambling*. Constable & Robinson: London.
- Gambling Research Panel Report NO. 3 (2003) Best Practice in Problem Gambling Services Prepared for the Gambling Research Panel by Melbourne Enterprise International.
- Lesieur, H. and Blume S (1987) The South Oakes Gambling Screen (SOGS): A new instrument for the identification of Pathological Gamblers. *American Journal of Psychiatry*, 144, 1184-88.
- Marks, I (1987). *Fears, Phobias and Rituals. Panic Anxiety and Their Disorders*. New York, Oxford University Press.
- Productivity Commission (1999). *Australia's Gambling Industries Draft Report No1*. Canberra.
- Research Consultancy-National Centre for Education and Training on Addiction December 1998, *Gambling and Self-Help*, Department of Human Services (Community Services Branch) published by Government of South Australia. pp 43-44.
- Tasmanian Gambling Commission (2001) Sourced from the Australian Institute of Gambling Research.
- The Daily Telegraph Mirror. 18 December 1995.

## 11. Appendix 1

### **Suicidal ideation and behaviour in people with pathological gambling attending a treatment service**

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#### **Abstract (186 words)**

**Objective:** This study aimed to describe the 12-month period prevalence and risk factors for suicidal ideation and behaviour in a cohort of patients with pathological gambling attending a treatment service.

**Method:** Seventy-nine people with a diagnosis of pathological gambling received a mail-out survey on postulated risk factors for suicidal ideation and behaviour, the modified Suicide Ideation Scale (SIS), the South Oaks Gambling Screen (SOGS), the Beck Depression Inventory (BDI) and the CAGE.

**Results:** 54.4% of the surveys were returned completed. 81.4% showed some suicidal ideation and 30.2% reported one or more suicide attempts in the preceding twelve months. Suicidal ideation and behaviours were positively correlated with the gambling severity, the presence of debt attributed to gambling, alcohol dependence and current depression.

**Conclusions:** People with pathological gambling attending a treatment service had significant levels of suicidal ideation and behaviour. Pathological gambling should be seen as a chronic condition with a similar risk for suicidality as other mental illnesses. Screening for gambling problems should be part of risk assessment for people with suicide attempts. Attempts to increase gambling availability in the United Kingdom have serious public health implications.

**Key words:** pathological gambling; suicide; depression; risk factors

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#### **Introduction**

Legislation has been proposed which will increase gambling availability in the United Kingdom. This has implications for the medical profession (Griffiths, 2004) and psychiatrists in particular. The increased availability of legalised gambling in developed countries including Australia, has led to an increase in gambling related disorders (Gerstein *et al.*, 1999, Shaffer *et al.*, 1999, Welte *et al.*, 2001,

Productivity Commission, 1999). Pathological gambling described in DSM IV (American Psychiatric Association, 1994) features loss of control over gambling, preoccupation with gambling, features of tolerance and withdrawal and legal, financial and relationship problems. Controversy over the classification of disordered gambling as a mental illness (Dickerson *et al.*, 1996, Battersby *et al.*, 2002) has led to the alternative term ‘problem gambling’ used either to describe all forms of disordered gambling or less severe forms than pathological gambling which nevertheless, cause distress or harm. Using the latter definition, a meta-analysis of prevalence studies in the community found 1.6% lifetime prevalence of pathological gambling and 3.8% lifetime problem gambling (Shaffer *et al.*, 2001).

Of the many adverse consequences of disordered gambling (Productivity Commission, 1999), suicidal behaviour is the most serious outcome of an activity which has received government support and is promoted as recreation. Research has focused on the potential links between pathological gambling and suicidal behaviour in three areas: population prevalence studies linking suicidal behaviour and gambling, studies of clinical samples assessing psychiatric co-morbidity with pathological gambling and risk factors for suicidal behaviour, and studies of completed suicides.

### **Suicide Epidemiology and Gambling**

In Australia, the number of reported suicides rose from 2,197 in 1988 to 2,723 in 1997, an increase of 24% over the ten year period, accounting for about 12.8% of all deaths and ranked as the sixth leading cause of all deaths (Australian Bureau of Statistics, 2002). The Productivity Commission estimated that 1.7% of suicides in 1997 were gambling related (Productivity Commission, 1999). The true rate of gambling related suicides is difficult to determine because coronial investigations do not necessarily determine motivation for suicide, however, Blaszczynski and Farrell (Blaszczynski *et al.*, 1998) reported forty-four gambling related suicides in a seven year period in Victoria with associated risk factors for suicide of depression, debts and relationship difficulties.

Mental illnesses, particularly depression, are major risk factors for completed suicide (Lonnqvist, 2000). Pathological gambling is inextricably linked to co-morbid mental illness both as a cause and an effect, and would be expected to raise the risk of suicide, whatever the direction of causality. Depression is a possible mechanism to explain the link between suicidal behaviour and pathological gambling, resulting from financial, relationship and legal crises and losses, and the effects of shame.

The Australian Productivity Commission survey of 3,498 randomly selected community members found that 9.2% of gamblers with a lifetime history of problem gambling had seriously considered suicide compared to 0% for non-problem regular gamblers and 0.3% for non-gamblers (Productivity Commission, 1999). This compares with 5.4% prevalence of suicidal ideation in a random Australian community sample found by Goldney *et al* (Goldney *et al.*, 2000). In Canada, a population study found that pathological gamblers were four times more likely to have attempted suicide than non-pathological gamblers (Newman *et al.*, 2003). In population surveys, rates of suicide attempts in pathological gamblers range from 13 – 27% (Ladouceur *et al.*, 1994, Frank *et al.*, 1991, Cunningham-Williams *et al.*, 1998).

Other researchers have compared suicide rates in gambling compared to non-gambling regions with Phillips *et al* (Phillips *et al.*, 1997) finding increased suicides in Las Vegas and Atlantic City compared to non-gambling regions. However, this finding was contradicted by studies using similar data (McLeary *et al.*, 2002, Marfels, 1998) and the St Louis epidemiological catchment area study

found no difference in suicidal ideation and behaviour between problem gamblers and non-problem gamblers (Cunningham-Williams *et al.*, 1998).

Clinical samples have shown high rates of suicidal ideation in pathological gamblers of between 17 – 80% (Frank *et al.*, 1991, Linden *et al.*, 1996, Lesieur *et al.*, 1990, Blaszczynski *et al.*, 1986, Horodecki, 1992, Specker *et al.*, 1996, MacCallum *et al.*, 2003, Petry *et al.*, 2002). A study of a New Zealand gambling crisis hotline found that 80% of callers described suicidal ideation (Sullivan, 1994).

Lifetime suicide attempts in clinical samples of pathological gamblers range from 13% in gamblers anonymous members (Frank *et al.*, 1991), 20% in a UK sample (Moran, 1969) and four in fifty Australian treatment attenders (MacCallum *et al.*, 1999). Of 342 US treatment attenders 17% had attempted suicide (Petry *et al.*, 2002), almost all following gambling problems.

### **Gambling Co-morbidity and Suicidality**

The two most common co-morbid disorders associated with pathological gambling are depression and substance abuse. Substance abuse co-morbidity ranges from 7.5%- 64%: (Ibanez *et al.*, 2001, Specker *et al.*, 1996, Battersby *et al.*, 1996, Black *et al.*, 1998, Ladd *et al.*, 2003, Feigelman *et al.*, 1998). Those with substance abuse and gambling co-morbidity had higher levels of psychiatric distress than substance abuse attenders without pathological gambling (Petry, 2000). Depression rates range from 16 –67% (Ibanez *et al.*, 2001, Specker *et al.*, 1996, Black *et al.*, 1998). Specker found that treatment-attending gamblers had higher rates of depression (70% lifetime) than non-psychiatric controls (23% lifetime) (Specker *et al.*, 1996). Few studies have examined the time sequence of depression and gambling however McCormick found that gambling preceded depression in 86% of cases (McCormick *et al.*, 1984).

Factors found to distinguish suicidal from non-suicidal pathological gamblers were earlier onset of gambling problems, more severe gambling problems and relationship difficulties in Gamblers Anonymous members (Frank *et al.*, 1991), and in 342 US clinic attenders (Petry *et al.*, 2002) more psychiatric symptoms, poor living conditions, conflict, gambling severity and craving. MacCallum *et al* (1999) found that depression, self-control and urge were related to the risk of suicidal ideation, and depression, marital difficulties and illegal activities but not gambling severity, for suicidal behaviour.

One of the limitations of previous studies has been the absence of a classification of suicidal ideation and behaviour to assess the level of risk and lethality, which may then reveal predictors of subsequent suicidal behaviour. To address this issue in gamblers, MacCallum *et al* (1999) used the four levels of suicidal risk developed by Rudd and Joiner (Rudd *et al.*, 1998). They found 38% of 50 treatment-seeking gamblers had suicidal ideation, 8% were in the extreme range of risk and 4% reported a past attempt. Similarly, the time frame in previous studies for recording suicidality has been either lifetime or current ideation or behaviour. Using a time frame of the previous twelve months would more likely capture a valid relationship between gambling related distress and suicidality than lifetime estimates, which are more likely to be subject to recall bias.

## Study Aims

This paper reports on a study of the prevalence of suicidality and risk factors for suicidal ideation and behaviour in a cohort of people with pathological gambling presenting to a specialist treatment service in South Australia. The study used a mail out method with a validated self-report measure of suicidal ideation and behaviour in the previous twelve months. Other questionnaires sought to determine a range of possible risk factors for suicidality such as demographic, alcohol dependence, gambling severity, debt, relationship problems, criminality, and depression.

## Methods

Consecutive attenders with pathological gambling to the Centre for Anxiety and Related Disorders (CARD) gambling treatment service at Flinders Medical Centre, Adelaide, received a mail out survey. The CARD treatment program is part of the Statewide Break Even network funded by the South Australian Government, provided as a free service to the public. Referrals to CARD come mainly from the other Break Even agencies and general practitioners. The survey included four psychometric instruments, a sociodemographic questionnaire and questions on postulated risk factors for suicidal ideation and behaviour.

The South Oaks Gambling Screen (SOGS) is the most widely used, reliable and validated instrument to detect pathological gambling (Lesieur *et al.*, 1987, Linden *et al.*, 1996). It is simple and quick to use (20 items), can be completed either as a self-report questionnaire or administered by professional or non-professional interviewers. Sixteen questions ask about gambling activity through the patient's lifetime (a six or twelve month period may also be used). Dimensions assessed include dysfunction at the emotional, family, social, occupational, educational and financial level. Items enquire about the need to borrow money for gambling, hiding evidence of or lying about gambling, taking time off work to gamble and feelings of guilt about gambling. It is based on DSM-III (American Psychiatric Association, 1980), and DSM-III-R (American Psychiatric Association, 1987) criteria for pathological gambling. The twenty items require a 'yes' or 'no' answer, and are equally weighted. The non-scoring items identify the type of gambling, the amount of money gambled daily and whether there is a family history of gambling. A score of 5 or more was chosen as the optimal cut-off point to indicate 'probable' pathological gambling and a score of 3-5 to indicate 'possible' pathological gambling.

In Australia, controversy surrounds the cut-off score of 5. Most patients presenting for help with gambling problems are scoring in excess of 10 on the SOGS (Tolchard *et al.*, 1996). Problems relating to the cut-off score of 5 in Australia may be reflective of the Australian gambling culture rather than the validity of the SOGS. Australian research (Dickerson *et al.*, 1996) found that a score of 10 or more on the SOGS would indicate pathological gambling, a score of 7-9 a significant gambling problem and scores of 5-6 would indicate a possible risk of developing gambling problems. In South Australia, research (Delfabro *et al.*, 1996) indicated approximately 3500 people would score ten or greater, 5600 people would score 7-9 and 4500 people score 5-6, a total of 13600 people (1.2% of the South Australian population). Although the construct validity and use of the SOGS in the Australian setting have been questioned (Battersby *et al.*, 2002), it was deemed the best available instrument.

Rudd's Suicide Ideation Scale (SIS) (Rudd, 1989) is a self-report inventory, which measures varying aspects of suicidal ideation and behaviour over a twelve month period. The method of scoring has been modified (Schweitzer *et al.*, 1995, Klayich, 1992) to provide a more precise description of

suicidal behaviour. Both the original and the revised scale have been shown to constitute reliable and valid instruments for the assessment of suicidal ideation and behaviour (Australian Institute for Gambling Research, 1997, Klayich, 1992, Rudd, 1989). This self-report instrument consists of ten questions that conceptualise suicidal ideation and behaviour into categories. These categories are shown in Table 1. Seven questions enquire about suicidal ideation and the remaining three questions enquire about suicide related behaviour. A Likert scale assesses each question. Eight questions use a 5-point Likert scale and 2 questions use a 3-point scale. Five exclusive hierarchical categories arise from this model. Respondents who endorse items within a category also generally endorse items within a lower category.

**Table 1: Categories of suicidal ideation and behaviour**

Category	Description	Condition
Category 0	No suicide ideation or behaviour	No positive responses on any items
Category 1	Minimal level of suicide ideation	Positive responses to either items 1 and/or 3 and negative responses to all other items.
Category 2	High level of suicide ideation.	Positive responses to item 5 and/or 7 and negative responses to items 2, 6 and 8.
Category 3	Suicide related behaviour.	Positive responses to items 6 and/or 8 and negative to item 10.
Category 4	Reported suicide attempt.	Positive response to item 10.

In addition, a score representing the sum tally of scores for each question can be calculated. The scores for the 5-point Likert scale consist of “never/none” scoring zero through to “always/great many times” scoring 4, whilst the 3-point Likert scale consists of “never” (0 point), “Yes, once” (2 points) and “Yes, two or more times” (4 points). The SIS has limitations. The SIS does not reveal information on the intent of the suicide attempt, the means of the suicide attempt or the consequences of the event. Additionally, to date, only one published study exists utilising the revised SIS in an Australian population (Schweitzer *et al.*, 1995) a cohort of Queensland University students.

The Beck Depression Inventory (BDI) (Beck *et al.*, 1961). Two measures of depression used were the twelve-month period prevalence of depression obtained from the survey and the one-week period prevalence of depression from the BDI. The BDI is a self-report scale consisting of twenty-one categories of attitudes and symptoms ranked 0 to 3. It has been found to have high levels of reliability and validity (Beck *et al.*, 1961). Scores of 0 to 13 are not significant for depression, 14 to 24 indicate mild to moderate depression and scores of 25 or greater indicate severe depression.

CAGE questionnaire. The CAGE is a brief alcoholism-screening test (Mayfield *et al.*, 1974). Although alcoholism has fallen out of favour as a diagnostic term, it is generally considered to equate to alcohol dependence (Kaplan *et al.*, 1989). The questionnaire consists of four yes/no questions directed at the problem of covert drinking during a subject’s lifetime. The scale has adequate sensitivity with two or more positive responses indicating alcohol dependence.

## **Subject Selection**

The subjects were drawn from the CARD patient registry.

## **Inclusion Criteria**

- Registered as patients within the last twelve months and met DSM-IV criteria for pathological gambling.
- Outpatients (not inpatients) when they completed the study.
- Had either completed (in the last twelve months) or were receiving a cognitive-behavioural treatment package for their pathological gambling.
- Aged 18 or older.

## **Exclusion Criteria**

- Consent to research not given.
- Patients who were known to have recently shifted address and failed to leave a forwarding address were not included in the study.

## **The Mail out Package**

The mail out package consisted of the patient information sheet, four questionnaires, a pencil and prepaid envelope. The Dillman repeat mail protocol (Dillman, 1978) was used to structure the correspondence and construct the research booklet. Dillman's protocol gave specific advice on the wording of each letter used in the mail out process. This was an attempt to overcome the low response rate (32.4%) of a previous mail out study on the suicidal ideation and behaviour of a cohort of people with pathological gambling (Frank *et al.*, 1991).

The four questionnaires consisted of the three psychometric instruments (SOGS, SIS and BDI) and the socio-demographic questionnaire (which included the CAGE questionnaire). Included in the socio-demographic section were questions covering hypothesised risk factors for suicidal ideation and behaviour. These included experiencing interpersonal difficulties, legal proceedings, significant alcohol problems and being in debt. The patient information sheet provided the participant with contact details of treatment agencies if the questionnaires identified suicidal ideation for which they wished to seek additional help. Ethical approval to conduct the study was obtained through the Flinders Medical Centre Clinical Investigations Committee.

## **Data Analysis**

The collated information was analysed using the Statistical Package for Social Sciences (SPSS) software (SPSS Inc, 1997). Descriptive statistics are reported and the relationship between suicidal ideation and behaviour and potential risk factors analysed using chi-square test of association, Fisher's exact test and the gamma statistic.

## **Results**

One hundred and one patients who had contact with the unit for the first time in the last calendar year were identified from the registry. Three of these patients were identified as "not consenting to research" and nineteen patients were known to have changed residential address without leaving a forwarding address. Seventy-nine patients were mailed the research package. Four mail outs resulted in a 55.5% response rate (43 respondents).

### Socio-demographic Data

Respondents were 30 (69.8%) males and 13 (30.2%) females. The mean age was 41.5 (SD 9.3) years ranging from 22 to 70. One patient was of Asian descent and the remainder were Caucasian. Two were from rural regions, the remainder from Adelaide. Ten (23.3%) lived alone, the remainder in some form of shared accommodation. Twenty-four (55.8%) were single at the time of the study with the remaining nineteen (44.2%) in some form of relationship.

Occupation status is described in Table 2. Only two (4.9%) indicated they were formally unemployed, a surprisingly low figure. This contrasted with the known 37% unemployment rate for the 186 patients (inclusive of this cohort) who had attended the CARD's Problem Gambling Service in the period 1996 to Sept 1998 (Petry, 2000). A possible reason for this difference related to the question "Main Occupation?" which conceivably resulted in unemployed subjects identifying their main occupation when they were employed. Additionally, home duties and disabled (not working) may have been included in the 37%.

**Table 2 Occupation**

Occupation	Frequency	Percent
-Managerial	5	11.6
-Professional	4	9.3
-Trades person	3	7.0
-Clerical	5	11.6
-Sales	2	4.7
-Driver/Operator	2	4.7
-Labourer	6	14.0
-Home duties	7	16.3
-Student	1	2.3
-Disabled/not working	4	9.3
-Retired	1	2.3
-Unemployed	2	4.7
-Missing result	1	2.3
Total	43	100.0

The income groups are revealed in Table 3. The mode of the group was \$10001 - \$14999. Twenty-one (48.8%) of the subjects indicated social security was the main source of income

**Table 3 Income**

Income/year (before tax) Dollars	Frequency	Percent
-0-10000	8	18.6
-10001-14999	15	34.9
-15000-19999	1	2.3
-20000-29999	7	16.3
-30000-39999	4	9.3
-40000-49999	2	4.7
-50000-59999	3	7.0
>59999	1	2.3
-not stated	2	4.7
Total	43	100.0

Twenty-nine of the forty-three respondents were in debt. The mode group debt was between \$1,001-\$5,000, with four respondents having debts greater than \$10,000. Only two of the forty-three respondents had been charged with a criminal act attributed to gambling in the last year and twenty-four (55.8%) had experienced adversity in a relationship attributed to gambling in the last year.

### **Pathological Gambling**

All forty-three respondents met DSM-IV criteria for pathological gambling in the preceding twelve months. Two (4.7%) scored 0-4 on the SOGS, ten (23.3%) scored 5-9 and thirty-one (72.1%) scored 10 or greater. The mean SOGS score was 11.7 (SD 3.8).

### **Prevalence of Suicidal Ideation and Behaviour**

The SIS quantified suicidal ideation and behaviour in two ways. A mean score was given and a category assigned. Thirty-five (81.4%) of the forty-three respondents indicated a positive response to the SIS. Thirteen (30.2%) had made one or more attempts on their lives. The mean SIS score for the sample was 10.1 (SD 9.7). Table 4 describes frequencies and examples in each categories of suicidality.

**Table 4 SIS category**

<b>Category 0:</b>	8 (18.6%) subjects indicated an absence of suicidal ideation or behaviour.
<b>Category 1:</b>	7 (16.3%) subjects indicated a minimal level of suicidal ideation. Thoughts of “I feel life isn’t worth living” and/or “Life is so bad I feel like giving up” were present
<b>Category 2:</b>	6 (14.0%) subjects indicated a high level of suicidal ideation. Thoughts of “I just wish my life would end” and/or “I have been thinking of ways to kill myself” were present.
<b>Category 3:</b>	9 (20.9%) subjects indicated suicide related behaviour. Subjects had told someone they were thinking of suicide and/or had “come close to taking their own life.”
<b>Category 4:</b>	13 (30.2%) subjects indicated at least one suicide attempt in the last year.

### **Psychiatric Co-morbidity**

Twenty-four (55.8%) subjects had received psychiatric treatment in the last year for problems other than gambling. Nineteen of the forty-three (44.2%) received treatment for depression. The questionnaire did not ask about the nature of the illness for the remaining four (9.3%). The BDI mean for the cohort was 16.3 (SD 12.7). Twenty-one (48.8%) of the forty-three respondents had BDI scores equal to or greater than 14. These scores were consistent with clinical depression. Thirteen (30.2%) scored 14-24 and eight (18.6%) scored 25 or greater. The CAGE questionnaire indicated that 25.6% of the subjects had alcohol dependence.

### **Risk Factors for Suicidality**

Chi-square was used to test for an association between the SIS categories and both demographic and specific variables. While the proportion of cells with an expected value of less than 5 was large, preliminary investigations showed no substantive difference between the results of Fisher’s exact test and the chi-square test of association. Thus the results of the chi-square tests were used in all cases.

Postulated risk factors for a positive SIS response included male gender, unemployment, rural accommodation, living alone and membership of an ethnic minority. The number of participants who declared themselves unemployed (two), rural (one), Asian (one) and charged with a criminal act attributed to gambling (two) were too small to form separate groups for statistical analysis.

The living arrangement classes were condensed to whether they lived alone or not. No association was noted ( $p=.916$ ) between SIS categories and these two classes of living arrangements, between SIS categories and gender ( $p=.652$ ), experiencing relationship discord ( $p = .188$ ) and being depressed/receiving treatment for depression in the last year ( $p=.130$ ).

A significant association was noted between SIS categories and being in debt due to gambling ( $p = .036$ ) with more debt being associated with more suicide attempts. A positive CAGE result was associated with more suicide attempts ( $p = .028$ ). Severity of gambling problems was associated with greater suicidal ( $p=.003$ ). Similarly, there was an association between Beck depression categories and suicidality ( $p= 0.001$ ).

## **Discussion**

This is the first study in Australia to have used mail out of a psychometric instrument to systematically describe and analyse the suicidal ideation and behaviour of a cohort of patients who had received a diagnosis of pathological gambling during the preceding year. The 54.4% response rate to the mail out survey surpassed the 32% response rate for a previous similar study (Frank *et al.*, 1991) of suicidal ideation and behaviour amongst a cohort who had pathological gambling. This is credited to the Dillman protocol (Dillman, 1978). Significantly, 72.1% scored 10 or greater on the SOGS, 81.4% of the cohort described suicidal ideation or behaviour, 30.2% had made one or more attempts on their lives in the last twelve months, 44.2% had treatment for clinical depression during the preceding twelve months, and 25.6% had scores consistent with alcohol dependence.

The results are consistent with previous Australian (MacCallum *et al.*, 1999) and overseas studies of high levels of suicide ideation in treatment seeking pathological gamblers (Petry *et al.*, 2002, Horodecki, 1992, Ibanez *et al.*, 2001). Levels of suicide related behaviour are greater than acknowledged in earlier studies (MacCallum *et al.*, 2003). This may have been related to the referral pattern associated with the CARD program being part of a mental health service in a general hospital.

Whilst the survey did not ask whether pathological gambling was the cause of suicidal ideation and behaviour, the authors' clinical experience with this group of patients suggests that pathological gambling was the major contributing factor. This is supported by MacCallum and Blaszczynski (2003) who found that 7% of their sample had made a suicide attempt related to gambling and 3% for non-gambling reasons. The combined effect of multiple financial, occupational and relationship losses, and the humiliation of criminal charges for some, lead to hopelessness, suicidal ideation and behaviour. Seventy-five percent of people with a depressive episode experience suicidal ideation and 50% of people diagnosed with schizophrenia will attempt suicide in their lifetime (Kaplan *et al.*, 1989). The suicidal ideation and behaviour of people with pathological gambling appears to be of the magnitude of depression and schizophrenia.

The SIS mean for this cohort was 10.1 (SD=9.7). A score of zero indicates an absence of suicidal ideation and behaviour. A study (Klayich, 1992) of Queensland University students revealed a mean SIS 5.6. Clearly, the pathological gambling cohort had greater suicidal ideation and behaviour than the acknowledged high-risk group of young people in a university environment.

This study's results confirmed previous research findings of high prevalence rates of depression in pathological gambling. Nineteen (44.2%) of the forty-three respondents had received treatment for depression during the preceding twelve months. Twenty-one (48.8%) of the forty-three respondents had BDI scores consistent with clinical depression during the week of the study. Comparison with other studies is limited by the differing methodologies used. An earlier CARD study (Battersby *et al.*, 2002, Sullivan, 1999, Battersby *et al.*, 1996) revealed a two week period prevalence for clinical depression of 67.5%. These results are comparable with two American studies of pathological gamblers showing a 35% two week period prevalence and 40% lifetime prevalence for major depression (MacCallum *et al.*, 2003, Specker *et al.*, 1996), and 50% current and 50% lifetime depression (Black *et al.*, 1998).

The absence of an association between the SIS results and the history/treatment of depression was surprising, however there was a positive association between the SIS results and the BDI scores. This apparent discrepancy may be explained by the subjects' mood state while completing the study, biasing their recall in favour of more suicidal ideation and behaviour than had been actually present in the preceding twelve months. Against this however is the evidence from previous studies where current depression has been associated with suicidality (Petry *et al.*, 2002, MacCallum *et al.*, 2003).

Consistent with previous studies (Ibanez *et al.*, 2001, Specker *et al.*, 1996, Battersby *et al.*, 2002), lifetime alcohol dependence was high (25.6%). This study did not aim to determine whether alcohol dependence preceded pathological gambling and/or depression and be the primary causal factor in the development of suicidality.

### **Risk factors for Suicide Ideation and Behaviour**

Multiple factors are involved in the development of suicidal ideation and behaviour in a person who has pathological gambling. Gambling severity (higher SOGS category) was predictive of a higher level of suicidal ideation and behaviour. This relationship was also found in a study of Gamblers Anonymous members (Frank *et al.*, 1991) and in 342 treatment attenders in Connecticut (Petry *et al.*, 2002) but not by MacCallum *et al.* (1999). This may be related to their sample where only 4% had made a past suicide attempt and associations were analysed according to current suicidal ideation, compared to the CARD sample where 30% had attempted suicide and categorisation was by twelve month suicidality.

Higher debt was also associated with a greater risk of suicidal ideation and behaviour in this sample but not by MacCallum *et al.* (1999) who found that marital difficulties and illegal behaviours did correlate with suicidal ideation. The incursion of debt may be a signal that gambling has extended from an enjoyable social activity to a state where the dire consequences of gambling contribute to a sense of hopelessness through the chasing of losses, one of the DSM-IV criteria for pathological gambling (American Psychiatric Association, 1994).

Alcohol disorders are well known risk factors for suicidal ideation (Kaplan *et al.*, 1989). In this study, the presence of alcohol dependence with pathological gambling represented an increase in

risk for suicidality. This finding supports previous studies where pathological gamblers with substance abuse had higher rates of psychiatric problems including suicidality than pathological gamblers without substance abuse (Ladd *et al.*, 2003, Kaplan *et al.*, 1997). Pathological gamblers and people with substance abuse may have similar and reinforcing pathways to suicidality including major depression, living alone, unemployment and serious coexisting medical conditions. Another pathway linking pathological gambling, alcohol dependence and suicidality may involve disinhibition and impulsivity. Pathological gamblers with co-morbid alcohol disorders have been found to have greater impulsivity and disinhibition (Sullivan, 1994). Impulsivity and disinhibition are likely to be risk factors for suicidal behaviour in the alcohol dependent person with pathological gambling.

### **Methodological Limitations**

Subjects in this study had accessed the CARD Problem Gambling Service. Difficulties are encountered in generalising these results to people with pathological gambling in other settings, as this cohort's problems are likely to be more severe. This cohort is a small subset of the estimated 3500 people in South Australia with pathological gambling who score 10 or more on the SOGS (Delfabro *et al.*, 1996), the majority not accessing services. Comparison of this cohort with non-gamblers matched for socio-demographic factors and a group with pathological gambling who were not in treatment would have enabled a comparison of the effect of pathological gambling alone and treatment seeking on SIS scores.

The 46% non-response rate was significant. Those who responded may have different rates of suicidal ideation and behaviour to the non-responders. Likely reasons for the non-response rate include patient reluctance to disclose information on sensitive subjects such as suicidal ideation and behaviour, gambling, debts and alcohol problems, the presence of depression, being in hospital or jail, being itinerant or homeless (22% of non-respondents' addresses indicated that they lived in shelters or hostel type accommodation) or deceased.

The cohort had been studied assuming they were homogeneous for gambling activities. The SOGS results indicated a wide range of activities were present. Most of this study's subjects were likely to have problems attributed to electronic gaming machines (EGMs) because 87% of CARD patients primarily use EGMs. Future research could compare suicidality for specific types of gambling (i.e., horse racing, EGMs and casino games).

### **Implications for Future Research**

Further research is needed to determine if these results can be generalised to people in the community with untreated pathological gambling and those attending Break Even gambling services. We need to understand the seriousness and meaning of the reported suicide attempts regarding intention to die, method used and the consequences of the attempt. The high prevalence of co-morbid anxiety disorders in treatment samples (Battersby *et al.*, 2002) should lead to an examination of the relationship between anxiety disorders and this cohort's suicidal ideation and behaviour. We need to determine what interventions are effective in treating the suicidal ideation and behaviour of this cohort and whether specific treatment of co-morbid substance abuse improves outcomes for pathological gambling and suicidality.

## **Clinical Implications**

There is convincing evidence from other countries that increasing the availability of gambling in the United Kingdom through legislation, will lead to an increased prevalence of pathological gambling and associated mental health problems. This study supports previous evidence that severity of pathological gambling is associated with an increased risk of suicidal ideation and behaviour. This implies that pathological gambling be seen not only as a risk factor for suicide but that it carries the attributes of a disabling and potentially chronic mental illness with lifetime suicide risk. Thirty percent of this sample had a previous suicide attempt and we know that the risk of suicide increases with previous attempts (Rudd *et al.*, 1998). People who have attempted suicide usually attend emergency departments. Admitting staff should seek information regarding previous suicide attempts and gambling problems as part of alcohol and drug screening questions in their risk assessment.

Psychiatrists and mental health workers will require skills in diagnosis and treatment of pathological and problem gambling and take a leadership role in supporting the education of general practitioners and primary care workers in early detection and management of these disorders. Community crisis services, financial counselors and mental health practitioners need to be informed about the significant levels of depression and suicidality in people who present with gambling related problems. It is known that most disordered gamblers seek help through their general practitioner's first, even before family members know there is a problem. A short screening tool, "The EIGHT", has been developed in New Zealand for use in primary care to encourage early detection (Sullivan, 1999).

## **Conclusions**

A moderate response rate to a mail-out survey showed high rates of suicidal ideation and suicide attempts in people with pathological gambling attending a specialist treatment service. There were high rates of co-morbid depression and significant levels of co-morbid alcohol dependence. Risk factors for suicidal ideation and attempts were gambling severity, debt, depression and alcohol dependence. Vigilance is necessary to avoid under-diagnosis and under-treatment of these patients. Pathological gambling should be considered as equal a risk factor for suicide as are other mental illness. Psychiatrists should take a leading role in shaping government policy in relation to gambling, emphasising the consequent mental health and social service resources which will be required to cope with the burden on individuals, their families and the community if gambling is expanded.

## **References**

**American Psychiatric Association (1980)** *Diagnostic and statistical manual of mental disorders (3rd Edition)*, American Psychiatric Association, Washington, DC.

**American Psychiatric Association (1987)** *Diagnostic and statistical manual of mental disorders (3rd Edition) Revised*, American Psychiatric Association, Washington, DC.

**American Psychiatric Association (1994)** *Diagnostic and statistical manual of mental disorders (4th Edition)*, American Psychiatric Association, Washington, DC.

**Australian Bureau of Statistics (2002)** *Year Book Australia 2002. Health Special Article - Suicide*, Australian Bureau of Statistics, Canberra.

**Australian Institute for Gambling Research (1997)** *Definition and Incidence of Problem Gambling, Including the Socio-Economic Distribution of Gamblers*, Victoria Casino and Gambling Authority Melbourne, Victoria.

**Battersby, M., Thomas, L., Tolchard, B., et al. (2002)** The South Oaks Gambling Screen: A review with reference to Australian Use, *Journal of Gambling Studies*, **18**, 257-271.

**Battersby, M. W. and Tolchard, B. (1996)** The effect of treatment on Pathological Gamblers referred to a Behavioural Psychotherapist Unit: I - Changes in Psychiatric Co-morbidity after Treatment in proceedings of the Seventh National Conference of the National Association for Gambling Studies, Flinders Press, Adelaide, South Australia,

**Beck, A., Ward, C., Mendelson, M., et al. (1961)** An Inventory for Measuring Depression, *Archives of General Psychiatry*, **4**, 561-571.

**Black, D. W. and Moyer, T. (1998)** Clinical Features and Psychiatric Co morbidity of Subjects With Pathological Gambling Behavior, *Psychiatric Services*, **49**, 1434-1439.

**Blaszczynski, A. and Farrell, E. (1998)** A Case Series of 44 Completed Gambling-Related Suicides, *Journal of Gambling Studies*, **14**, 93-109.

**Blaszczynski, A. and McConaghy, N. (1986)** Demographic and clinical data on compulsive gambling in *Faces of Gambling*, (Ed, Walker, M.) National Association for Gambling Studies, Sydney.

**Cunningham-Williams, R., Cottler, L., Compton, W., et al. (1998)** Taking Chances: Problem Gamblers and Mental Health Disorders-Results From the St. Louis Epidemiologic Catchment Area Study, *American Journal of Public Health*, **88**, 1093-1096.

**Delfabro, P. and Winefield, A. (1996)** *Community Gambling Patterns and the Prevalence of Gambling-Related Problems in South Australia. A Report Commissioned by the Department of Family and Community Services*, South Australian Government Adelaide.

**Dickerson, M., Baron, E., Hong, S., et al. (1996)** Estimating the extent and degree of gambling related problems in the Australian population: A National Survey, *Journal of Gambling Studies*, **12**, 161-178.

**Dillman, D. (1978)** *Mail and Telephone Surveys: The Total Design Method*, Wiley, New York.

**Feigelman, W., Wallisch, L. and Lesieur, H. (1998)** Problem Gamblers, problem substance users, and dual problem individuals: An epidemiological study, *American Journal of Public Health*, **88**, 467-470.

**Frank, M. L., Lester, D. and Wexler, A. (1991)** Suicidal Behavior Among Members of Gamblers Anonymous, *Journal of Gambling Studies*, **7**, 249-154.

**Gerstein, D., Hoffmann, J. and Larison, C. (1999)** Gambling Impact and Behavior Study, <http://www.norc.uchicago.edu/new/gamb-fin.htm>, accessed 27 March 1999,

**Goldney, R., Wilson, D., Dal Grande, E., et al. (2000)** Suicidal ideation in a random community sample: Attributable risk due to depression and psychosocial and traumatic events, *Australian and New Zealand Journal of Psychiatry*, **34**, 98-106.

**Griffiths, M. (2004)** Betting your life on it, *BMJ*, **329**, 1055-1056.

**Horodecki, I. (1992)** Treatment model of guidance center for gamblers and their relatives in Vienna, Austria, *Journal of Gambling Studies*, **8**, 115-129.

**Ibanez, A., Blanco, C., Donahue, E., et al. (2001)** Psychiatric Co morbidity in Pathological Gamblers Seeking Treatment, *The American Journal of Psychiatry*, **158**, 1733-1735.

**Kaplan, G. and Davis, B. (1997)** *Gambling, Alcohol, and Other Drugs: Prevalence and Implications of Dual Problem Clients*, The Addictions Foundation of Manitoba, Winnipeg, Manitoba.

**Kaplan, H. and Saddock, B. (1989)** *Comprehensive Textbook of Psychiatry*, Williams and Wilkins, Baltimore.

**Klayich, M. (1992)** An investigation into psychometric properties of the Suicidal Ideation Scale: A hierarchical-cumulative model of suicidal ideation (Unpublished Honours Thesis), University of Queensland.

**Ladd, G. T. and Petry, N. M. (2003)** A Comparison of Pathological Gamblers With and Without Substance Abuse Treatment Histories, *Experimental and Clinical Psychopharmacology*, **11**, 202-209.

**Ladouceur, R., Dube, D. and Bujold, A. (1994)** Prevalence of pathological gambling and related problems among college students in the Quebec metropolitan area, *Canadian Journal of Psychiatry*, **39**, 289-293.

**Lesieur, H. and Blume, S. (1990)** Characteristics of pathological gamblers identified among patients on a psychiatric admissions service, *Hospital and Community Psychiatry*, **41**, 1009-1012.

**Lesieur, H. R. and Blume, S. B. (1987)** The South Oaks Gambling Screen (SOGS): A New Instrument for the Identification of Pathological Gamblers, *The American Journal of Psychiatry*, **144**, 1184-1188.

**Linden, R., Pope, H. and Jonas, J. (1996)** Pathological gambling and major affective disorder: Preliminary findings, *Journal of Clinical Psychiatry*, **47**, 201-203.

**Lonnqvist, J. (2000)** Psychiatric aspects of suicidal behaviour: Depression in *The International Handbook of Suicide and Attempted Suicide*, (Eds, Hawton, K. and van Heeringen, K.) Wiley, New York, pp. 107-120.

**MacCallum, F. and Blaszczynski, A. (2003)** Pathological Gambling and Suicidality: An Analysis of Severity and Lethality, *Suicide and Life-Threatening Behaviour*, **33**, 88-98.

**MacCallum, F., Blaszczynski, A., Joukhador, J., et al. (1999)** Suicidality in gamblers: A systematic assessment of severity and lethality in Developing Strategic Alliances, Proceedings of the Ninth National Conference, National Association for Gambling Studies, Gold Coast,

**Marfels, C. (1998)** Visitor suicides and problem gambling in the Las Vegas market: A phenomenon in search of evidence, *Gambling Law Review*, **5**, 465-472.

**Mayfield, D., McLeod, G. and Hall, P. (1974)** The CAGE Questionnaire: Validation of a New Alcoholism Instrument, *American Journal of Psychiatry*, **131**, 1121-1123.

**McCormick, R., Russo, A., Ramirez, L., et al. (1984)** Affective disorders among pathological gamblers seeking treatment, *American Journal of Psychiatry*, **141**, 215-218.

**McLeary, R., Chew, K., Merrill, V., et al. (2002)** Does Legalized Gambling Elevate the Risk of Suicide? An Analysis of US Counties and Metropolitan Areas, *Suicide and Life-Threatening Behaviour*, **32**, 209-221.

**Moran, J. (1969)** Taking the final risk, *Mental Health*, **28**, 21-22.

**Newman, S. and Thompson, A. (2003)** A Population-Based Study of the Association Between Pathological Gambling and Attempted Suicide, *Suicide and Life-Threatening Behaviour*, **33**, 80-87.

**Petry, N. M. (2000)** Psychiatric Symptoms in Problem Gambling and Non-Problem Gambling Substance Abusers, *The American Journal of Addictions*, **9**, 163-171.

**Petry, N. M. and Kiluk, B. D. (2002)** Suicidal Ideation and Suicide Attempts in Treatment-Seeking Pathological Gamblers, *The Journal of Nervous and Mental Disease*, **190**, 462-469.

**Phillips, D. P., Welty, W. R. and Smith, M. M. (1997)** Elevated Suicide Levels Associated With Legalized Gambling, *Suicide and Life-Threatening Behaviour*, **27**, 373-378.

**Productivity Commission (1999)** *Australia's Gambling Industries*, Canberra, Australia.

**Rudd, M. (1989)** The prevalence of suicidal ideation among college students, *Suicide and Life-Threatening Behaviour*, **19**, 173-183.

**Rudd, M. and Joiner, T. (1998)** The assessment, management, and treatment of suicidality: toward clinically informed and balanced standards of care, *Clinical Psychology: Science and Practice*, **5**, 135-150.

**Schweitzer, R., Klayich, M. and McLean, J. (1995)** Suicidal ideation and behaviours among university students in Australia, *Australian and New Zealand Journal of Psychiatry*, **29**, 473-479.

**Shaffer, H. and Hall, M. (2001)** Updating and refining prevalence estimates of disordered gambling behavior in the United States and Canada, *Canadian Journal of Public Health*, **92**, 168-172.

**Shaffer, H., Hall, M. and Vander Bilt, J. (1999)** Estimating the Prevalence of Disordered Gambling Behavior in the United States and Canada: A Research Synthesis, *American Journal of Public Health*, **89**, 1369-1376.

**Specker, S. M., Carlson, G. A., Edmonson, K. M., et al. (1996)** Psychopathology in Pathological Gamblers Seeking Treatment, *Journal of Gambling Studies*, **12**, 67-81.

**SPSS Inc (1997)** *SPSS Base 7.5 for Windows Users Guide*, SPSS Inc, Chicago, IL.

**Sullivan, S. (1994)** Why Compulsive Gamblers Are a High Suicide Risk, *Community Mental Health In New Zealand*, **8**, 40-47.

**Sullivan, S. (1999)** Development of the "EIGHT" Problem Gambling Screen, Auckland Medical School.

**Tolchard, B. and Battersby, M. W. (1996)** The effect of treatment of pathological gamblers referred to in a behavioural psychotherapy unit: II - Outcome of three kinds of behavioural intervention in Seventh National Conference of the National Association for Gambling Studies, Flinders Press, Adelaide, South Australia,

**Welte, J., Barnes, G., Wiczorek, W., et al. (2001)** Alcohol and gambling pathology among US adults: prevalence, demographic patterns and co morbidity, *Journal of Studies on Alcohol*, **62**, 706-712.

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## 12. Appendix 2

### **The Treatment of Problem Gambling Using Telemedicine - A Case Report**

Example of a student from the Masters program who received training and supervision in a rural area and the client outcome measure over several years.

#### **Authors**

Jane Oakes, Paul Crommarty, Malcolm Battersby, Angus Forbes and Rene Pols

**Summary-** This paper describes the application of cognitive behaviour therapy (CBT) by telemedicine and the use of a clinical therapy assistant in the treatment of pathological gambling. A case report is used to demonstrate the effectiveness of this treatment with six sessions of therapy using CBT and four year follow up data. The use of telemedicine is discussed in relation to treatment effectiveness, ongoing follow up for the client and education and support for a local community health nurse, therapy assistant, in a rural setting in South Australia.

#### **Introduction**

It is estimated that 2.3% of the adult Australian population have significant adverse outcomes as a result of their gambling behaviour (Productivity Commission, 1999), its effects are devastating on individuals and families ((Crockford & Nady el-Guebaly, 1998). Access to effective treatment services for these people is strictly limited and this is even more so for those living in rural areas (Livingstone,1999 ). One approach to broach this gap for these clients has been the advent of Teleconferencing as a treatment for people with psychiatric illness ( Baigent, Loyd & Kavanagh, 1997) (Yellowlees & Kennedy 1997). However studies investigating the use of telemedicine are still very restricted (Ohinmaa & Hailey, 2002) and there are no studies reporting the use of this treatment vehicle for problem gambling.

In Australia there is a lack of psychiatrists and psychologists employed in rural and remote areas. It would make economic and practical sense that with appropriate training and on going supervision local mental health workers could be trained in behavioural psychotherapy to treat clients with problem gambling or other psychological disorders (Tolchard and Battersby 2000).

The case example in this paper describes the process of training a local community health nurse in the basic concepts of Cognitive Behavioural Therapy (CBT) as a “therapy assistant” and application to a patient with pathological gambling using telemedicine.

Cognitive Behavioural Therapy is clinically proven as an effective treatment for most of the major mental health disorders but many clients are disadvantaged by not having access to this treatment (Andrews & Hunt, 1998). These limitations are often due to the mode of delivery of treatment, the traditionally face-to-face contact, and appointments at out patient clinics. The delivery models of CBT need to be reviewed to make it more accessible and cost effective so as to provide a service to the many people who would benefit from this therapy (Lovell and Richards 2000).Providing treatment using telemedicine video conferencing is one approach to make effective treatment more available to people distant from treatment centres. Research shows that both arousals relating to the

urge associated with gambling and erroneous beliefs about gambling are related to cues for problem gamblers. A number of authors have developed protocols for the face to face CBT for problem gambling with good effect.( Echeburua, Baez, & Fernandez-Montalvo,1996 ), (Ladouceur, Sylvain, Boutin, Lachance, Doucet, Leblond, & Jacques, 2001),( Sharpe,1998). There are no other reports on the use of telemedicine to treat such patients.

### **Telemedicine**

Telemedicine is a means to provide a clinical service with the use of video conferencing equipment across 2 or more sites with a central bridge linking these sites. During a clinical session document cameras can be used to display written or visual materials and these sessions can be video taped for review at a later date (Livingstone 1999). This technology can help to improve some of the inequities in health services related to distance from services readily available in the city and the availability of both qualified and experienced staff (Hawker, Kavanagh, Yellowlees and Kalucy 1998) Telemedicine has now become an important part of the South Australian Rural and Remote Mental Health Service and has become one of only a few telepsychiatry services world wide that is a part of routine clinical practice.(Hawker et al 1998).

A study by Baigent et al 1997, compared interviews made by psychiatrists in both face to face interviews and those performed by teleconference and showed that diagnosis was reliable in both settings. These authors concluded that much of the “psychiatry in Telepsychiatry is not lost” (Baigent, Loyd, Kavanagh, Ben-Tovim, Yellowlees Kalucy and Bond, 1997 ).

Telemedicine can also be used to ensure clinical workers in rural and remote areas have adequate and ongoing supervision and support with the ability to demonstrate specific clinical skills. A supervisor has the ability to observe a client being interviewed by the student and if required the student can observe the supervisor interviewing clients. Joint interviews can also be conducted to ensure regular supervision sessions can be held to discuss cases and other clinical or professional matters. This offers a more accessible and cheaper medium than face-to-face supervision when the student lives in more remote locations. It is also possible to connect simultaneously to multiple sites for group supervision and support (Livingstone, 1999).

An evaluation of consumers, their families, psychiatrists and local service providers were reviewed in relation to the provision of telemedicine showed that positive outcomes were related to decreased travel, decreased waiting time, client’s influence on their individual needs and basic quality of life. These outcomes supported the benefits of telemedicine by cost savings related to avoidance of travel, and the clients overall satisfaction with confidentiality (Ohinmaa and Hailey 2002). Limitations to telemedicine were related to eye distortions and a minor delay between sending and receiving both audio and visual transmissions (Livingstone1999).

### **Case history**

This case study describes a 31-year old woman who lived with her husband and 2 young children in a rural town in South Australia. She worked part time in a local hotel as a barmaid and her husband was unemployed. She presented to the local health nurse with problems related to gambling on the electronic gaming machines. She was referred for assessment to the Centre for Anxiety and Related Disorders, Flinders Medical Centre Adelaide for her gambling problems and suitability for CBT. The initial assessment was conducted via telemedicine video conferencing. Her main problem at

assessment was an uncontrollable urge to gamble on the electronic gaming machines whenever she was alone with money available to her. The main cues for her to gamble were loneliness, depression and an escape from the stress in her life. The onset of her gambling problems began 18 months before presentation after her close girl friend left the local community. She described feeling alone and found gambling offered her time out from this loneliness. Her gambling behaviours soon escalated and became a significant problem affecting her relationships; self esteem and caused significant financial distress to her family. This client scored 7 on the South Oaks Gambling screen indicating at assessment she was a probable pathological gambler (Lesieur & Blume 1987). The client lived in a rural area and travel to the city for assessment and weekly appointments was not possible. Being the main income earner in her household she could not afford to have time from work or the expenses related to travel regularly into the city. An initial teleconference appointment was scheduled to conduct a behavioural assessment of her presenting problem. As her mental health nurse was involved in her care and would follow her up it was important he attended each session.

The telemedicine interview enabled the treating therapist to make a clear formulation and present the treatment rationale with the use of the document camera. Explaining this rationale for treatment would have been difficult without the use of clear diagrams, which were clearly visible for both the client and mental health nurse.

With a clear understanding of the treatment process the client agreed to undertake treatment in the company of her local mental health nurse. The treating therapist conducted each treatment session while the community mental health nurse sat beside the client in the interview room. The community mental health nurse was provided with an introduction and ongoing education regarding the application of CBT principles to pathological gambling. The community mental health nurse was able to support the client with weekly tasks within their rural community setting as necessary. There was always an opportunity for the mental health nurse to feedback any issues at the next teleconference meeting with the treating therapist.

Treatment was conducted by teleconference over a six week period for one hour appointments.  
Session 1 - assessment using CBT assessment and general psychiatry assessment.

Session 2- problems and goals identified and rated. Treatment and rationale explained to client and homework tasks agreed initially using a graded approach of imaginal cues, which triggered an urge for this client to want to gamble.

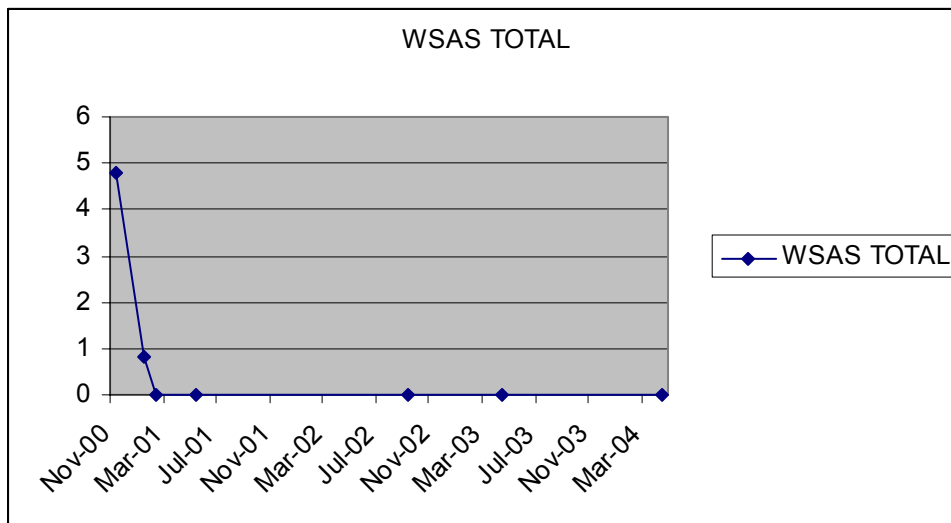
Sessions 3- 6 - Over 3-4 weeks Carefully graded imaginal tasks were regularly fine tuned to ensure all the principles of exposure were adhered to through out treatment sessions. The imaginal tasks were increased in difficulty as the client progressed through treatment to live graded exposure. Over the next 4 to 5 weeks the client habituated to her urge to gamble using a variety of live tasks e.g. until the treatment goals were achieved. The initial imaginal tasks were conducted in her own home at first then at gambling venues with an increasing range of cues, finally at her favourite machine with money. Eventually her gambling urge was eliminated and tested by repeated weekly tasks in the venue alone, using money and the gaming room environment to try and raise her urge to gamble. She was able to sit in front of a gaming machine with credits in it and collect the money without having an urge to gamble. As her urges to gamble reduced so did her erroneous beliefs about winning money by carrying out particular rituals. Her depression began to improve as the problems

related to her gambling behaviour began to be addressed and managed, as part of her relapse prevention strategies. The mental health nurse was able to gain a clear understanding of this specialised treatment providing a unique experience as supervision rarely involves direct supervision for each session with the supervisor. This client successfully completed treatment, which was reflected by the scores on all measures.

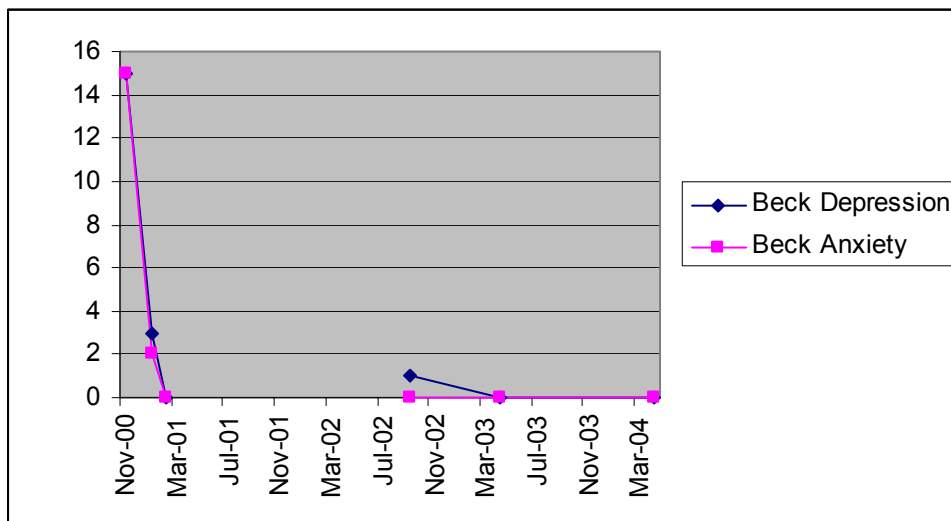
Follow up was conducted at one month, 3 months 6 months 12 months and yearly thereafter for 4 years. The therapist and community health nurse attended each follow up session with the therapist using teleconferencing to link up. These follow up sessions involved repeating measures and reviewing the client's ongoing gains. These included strategies for time out such as sporting activities part time work and time with her family.

### Client individual measures at assessment and follow up over a 5 year period

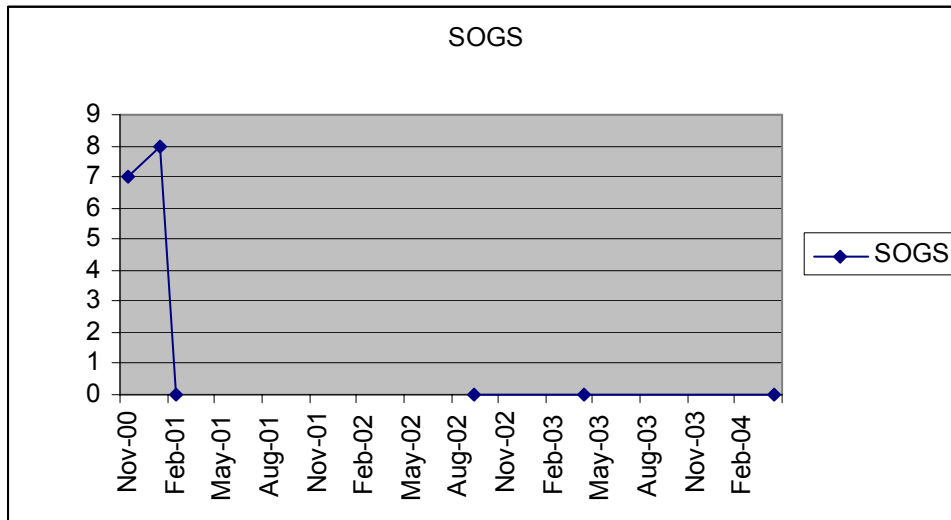
#### Work and Social Adjustment Scale



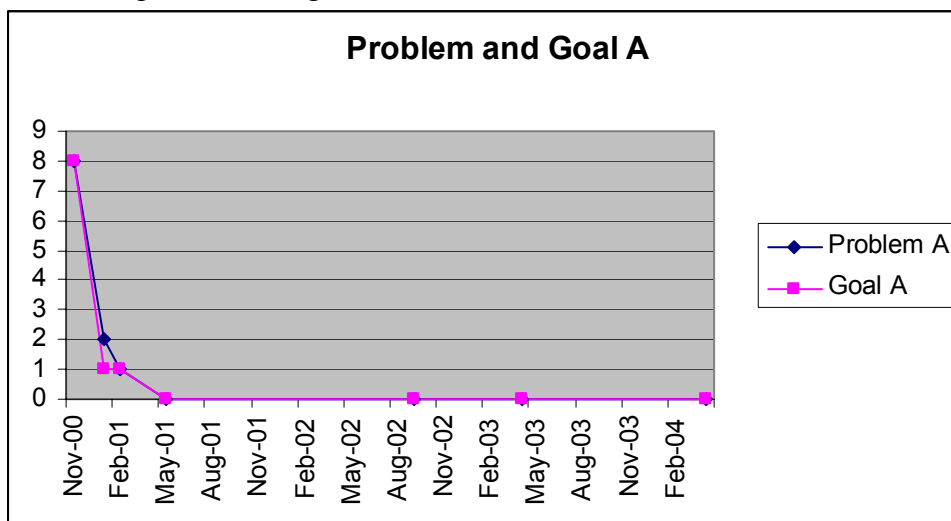
#### Beck Depression and Beck Anxiety Inventory



## South Oaks Gambling Screen



## Individual problem and goal statement



## Discussion

Telemedicine had the dual benefit of delivering an effective intervention for the client and providing education to a local health nurse.

The client found telemedicine of great benefit and did not find the process distressing or anxiety provoking. Rapport was easily established between the client, therapist and mental health nurse. In this case the appropriate management of emotion was not limited by the use of telemedicine. Throughout the treatment of this case telemedicine provided the opportunity for health professionals to learn different aspects of treatment by being part of the interview. The client responded well to the telemedicine, which gave her a chance to improve her own self-confidence as being apart of this experience.

After minimal apprehension regarding the use of the telemedicine equipment by the therapist and the community mental health nurse it became easy to use with only minimal assistance from the technician. The mental health nurse also found telemedicine an easy mode of treatment to use.

### **Conclusion**

Telemedicine enabled effective delivery of cognitive behavioural therapy to a client with pathological gambling in a remote setting over six sessions and four year follow up showed no evidence of gambling problems. Telemedicine also enabled a local mental health nurse to assist in therapy and simultaneously receive education, training and supervision from a specialised therapist. Telemedicine should be considered more often as an enabler to improve access and outcomes for evidence based therapy in both remote and city settings where access to specialised centres is also limited.

### **References**

- Andrews, G & Hunt, C. 1998, Treatments that work in anxiety disorders. *Medical Journal of Australia*, vol 168, 628-634`
- Baigent, M., Lloyd, C.J., and Kavanagh, S.J, Ben Tovim, D., Yellowlees, P., Kalucy, R. & Bond, M. (1997). Telepsychiatry: "Tele" yes, but what about the "psychiatry" ? *Journal of Telemedicine and Telecare* 3 (1), 3-5
- Crockford, D and N Nady el-Guebaly (1998). Psychiatric co morbidity in pathological gambling: a critical review. *Canadian Journal of Psychiatry* 43: 43-50
- Echeburua, E., Baez, C., & Fernandez-Montalvo, J. (1996). Comparative effectiveness of three therapeutic modalities in the psychological treatment of pathological gambling: Long-term outcome. *Behaviour and Cognitive Therapy*, 24(1), 51-72.
- Hawker, F., Kavanagh, S., Yellowlees, P., & Kalucy, R. (1998), Telepsychiatry in South Australia, *Journal of Telemedicine and Telecare* (4) 187-194
- Ladouceur, R., Sylvain, C., Boutin, C., Lachance, S., Doucet, C., Leblond, J., & Jacques, C. (2001). Cognitive Treatment of Pathological Gambling. *Journal of Nervous and Mental Disease*. 189(11), 774-780
- Lesieur, H and S Blume (1987). The South Oaks Gambling Screen (SOGS): A new instrument for the identification of pathological gamblers. *American Journal of Psychiatry* 144(9): 1184-1188.
- Livingstone, A., (1999). Professional Supervision and Support in Rural and Remote Psychology-Telemedicine and other approaches-Paper from Conference proceedings of The South Australian Conference September 1999.
- Ohinmaa, A & Hailey, D (2002). Telemedicine, Outcomes and Policy Decisions. *Disease Management Outcomes* 10 (5) 269-276
- Productivity Commission, (1999). *Australia's Gambling Industries Draft Report No1. Canberra*

Sharpe.L., (1998) Intenational handbook of cognitive and behavioural treatments for psychological disorders. 393-416

Richards.D. & Lovell. K. (2000) Multiple Access points and levels of entry (MAPLE): Ensuring choice, accessibility and equity for CBT services. *Behavioural and Cognitive Psychotherapy*, **28**, 379-391.

Tolchard.B. & Battersby.M (2000). Nurse Behavioural Psychotherapy and Pathological Gambling: an Australian Perspective. *Journal of Psychiatric and Mental Health Nursing*. 7 , 335-342.

Yellowlees. P & Kennedy.C (1997). Telemedicine: here to stay *Medical Journal of Australia*. A vol 166 262-266

**13. Appendix 3**  
**Think Tank Description**



***TŪTOHINGA TŪPONO NOA MŌ  
TE AO WHĀNUI***

***THE AUCKLAND INTERNATIONAL  
GAMBLING CHARTER***

*Second draft following work shopping at  
The Third International Conference on Gambling:  
'Gambling through a public health lens:  
Health promotion, harm minimisation and treatment'  
Auckland, New Zealand  
11th –13th September, 2003*



# *THE AUCKLAND INTERNATIONAL GAMBLING CHARTER*

## *REVISED DISCUSSION DRAFT*

**13 September 2003**

### **Principles**

#### ***Principle One: Enjoyment of gambling and freedom from harm***

All people have the right to enjoy responsible gambling, in the context of a family, community, and national life protected from the negative consequences of gambling.

All people have the right to be enabled to take self-determined action individually and collectively to ensure their own and their community's well-being with regard to gambling, and a right to be heard and to participate in a democratic fashion when it comes to the creation of policy by governments in the area of gambling.

All people have the right to have gambling issues communicated and dealt with in terms of their own culture and worldview. This includes people from indigenous groups, immigrants and refugees, those who are less well off, youth, older people, and other groups who are especially at risk or significant with regard to the impacts of gambling in a modern society.

#### ***Principle Two: Government duty of care and protection.***

Gambling should be recognised by governments as a public health issue.

Governments have a duty to provide regulatory frameworks and social policy responses on behalf of all their citizens to allow enjoyment and limit harm in the provision of all gambling, within a framework of independence from parties with a financial interest in the provision of gambling. They need to ensure that regulations are enforced. Supply of gambling products known to be harmful should be controlled.

Governments also have a duty to enable communities to take action with regard to gambling on their own behalf, and to have a decisive influence on relevant policy and legislation.

Governments need to ensure that appropriate consumer and product information is supplied with regard to gambling products and practices, and that the promotion of gambling is not unduly exploitative or manipulative.

#### ***Principle Three: Community empowerment***

All people have a right to effective participation in a democratic process of deciding the amount and type of gambling. Where possible, this process should be guided by research.

Where appropriate, extra consideration must be given to the rights of indigenous populations who have original occupant status in their own countries.

***Principle Four: Informed consent and education***

All people have the right to valid accurate, detailed information about gambling and education consonant with their language, culture and values, and about the consequences of gambling to health, family, community and society. This should start early in life. All people also have the right to information and resources, which enable them to take effective self-determined and responsible action in the area of gambling at the community, regional and national levels.

***Principle Five: Protection of populations from the negative effects of gambling***

All people have the right to an environment protected from the harmful effects of gambling, and where vulnerabilities are not exploited in the provision of gambling. This is particularly so for population groups such as young people, older people, women, minorities, immigrants, and indigenous peoples.

They also have the right to develop their own resilience and action with regard to the potentially damaging consequences of gambling. This includes the development of partnerships with experts, governments, and non-government organisations as is deemed appropriate by those people.

***Principle Six: Access to care and effective resources for those affected by problem gambling.***

All those adversely affected by gambling have the right to accessible professional treatment, care and support, which acknowledges their culture, gender and sexual preference. They also have the right to community support and information resources, which enable them to determine their own process of recovery and to improve their own quality of life. In the context of indigenous peoples, these processes involve recognition of those people's inherent right to self-determination.

***Principle Seven: Right to abstain or limit consumption***

All people who do not wish to gamble, or to gamble at only modest levels, have the right to be safeguarded from pressures to gamble, to be supported in their non-gambling lifestyle if that is their choice, and to have access to information and resources which facilitate choices and action related to such abstinence or low level participation in gambling.

*Governmental actions which flow from the above principles*

*In a context of awareness of cultural and equity considerations, governments can be expected to:*

1. Inform people about the consequences of gambling on health, well-being, family, community and society, about how to prevent or minimise harm, and about how to develop individual, family and community resilience with regard to gambling. This would include the use of broad educational programmes beginning in early childhood.
2. Through appropriate legislation and policy, restrict the sale and distribution of gambling products within communities to an extent that is agreed on by professionals and communities to constitute safe levels.
3. Strengthen the capacity of communities and indigenous populations to deal with their own gambling issues in a self-determined way, by ensuring that they are provided with the best information about gambling and its impacts, and are provided with expertise, resources and support personnel which enable them to take their own action, and make their own decisions, about gambling-related matters in their own localities.

4. Consult with such informed communities about levels of gambling that they feel are appropriate for their localities, ensuring that these communities are part of the decision-making process. This requires the development of suitable policy and legislation to support these processes, including the enabling of local governments to regulate in this area.
5. Ensure that gambling products known to have a potential for harm are clearly labelled about their risks and dangers at the point of sale.
6. Implement strict controls on direct and indirect advertising of gambling products, and ensure that no form of advertising is specifically addressed to young people, or to other recognised risk groups.
7. Ensure the accessibility to individuals, families and affected others of a range of early intervention, help-line, treatment and recovery services, using appropriately trained personnel, for people with risky, problematic or hazardous consumption of gambling.
8. Foster awareness of ethical, cultural and legal responsibility among those involved in the marketing or selling of gambling products, ensure strict control of product safety, including potential to form addictive behaviour patterns, ensure that that environments in which gambling take place are of high quality and do not foster abnormal or dissociative behaviour (e.g. by the absence of clocks and windows in gambling venues), and take measures against corrupt or illegal practices associated with gambling activities.
9. Enhance the capacity of society to deal with gambling through ensuring that there is appropriate training available for professionals in a variety of sectors, including health, social welfare, education and justice.
10. Support non-governmental and community organisations, and self-help/mutual aid groups and movements, the activities of which are aimed at strengthening resilience and health with regard to gambling.
11. Ensure that there is appropriate funding for research in all these areas, with the aim of providing knowledge for good information about gambling in communities and whole nations, monitoring the societal impact of gambling on an ongoing basis, and evaluating interventions and actions taken to benefit individuals, communities and society with regard to gambling.
12. Support from a gambling perspective other relevant national and international health and societal declarations, charters and treaties to do with health, quality of life and social well-being, including the Alma Ata Declaration for Primary Health Care, the Ottawa Charter for Health Promotion, the United Nations Declaration of Human Rights, the United Nations Convention for Children, the European Charter on Alcohol, and treaties defining the relationship of governments to their indigenous people.

## 14. Appendix 4

### Think Tank News letter 1

#### **International Think Tank on Presenting Gambling Populations and First Contact Services**

##### *Newsletter Number 1: August 2004*

Welcome to the first follow up newsletter from the Think Tank held in Auckland in May this year. Please accept our apologies for the delay in sending out this update. In this newsletter, we provide a reminder of what we set out to do and a summary of progress to date. We are also seeking input to the development of the concept before we reconvene next year.

#### **Purpose**

The purpose of the Think Tank was to provide a forum to address globally significant issues and developments in problem gambling policy, services and research in relation to presenting gambling populations and first contact services. Its ultimate aim is to contribute to the development of an international public health agenda on gambling.

The goal of the Think Tank was to bring together leading authorities and major stakeholders to consider information on presenting gambling populations and how best to assist them. It aimed to foster cooperation between researchers, policy-makers and service providers and focus on the development of evidentially led policies and services to meet the needs of presenting and at-risk populations.

#### **Participants**

Participation in the Think Tank was by invitation only and was intended to be limited to a maximum of 40 persons. However, a number of conference delegates heard about the Think Tank and asked if they could join. In the event, 65 people participated and represented Australia, Canada, Fiji, Hong Kong, New Zealand, South Africa, the United Kingdom and the United States of America. One third of the participants were from countries other than New Zealand. Participants included international leaders in the field and locals deemed well positioned to make a useful contribution. There was a mix of service providers, researchers/academics, policy makers, regulators, officials and industry executives. There was a range of nationalities and ethnicities, including indigenous and migrant participants.

The group as a whole agreed on the following:

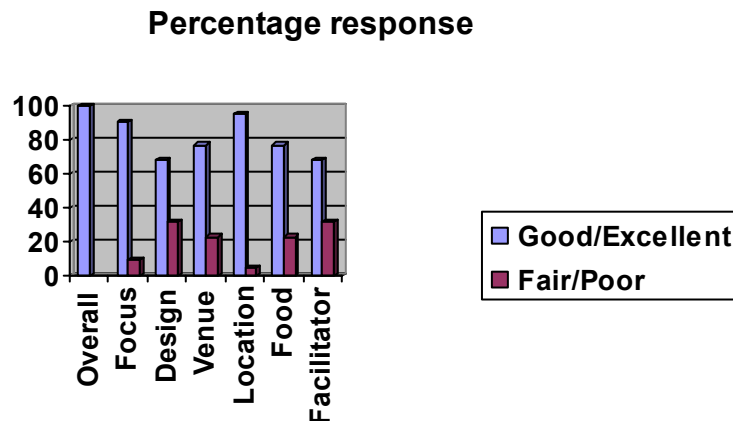
- Formation of ongoing international relationships that build a strategy towards an international NGO
- Create an “International Forum on Gambling and Public Health” with three domains
  - Research
  - Treatment and Services
  - Policy and Public Health
- Over the next twelve months identify key priorities and goals
- Develop representative committees for each domain
- Take an inclusive approach including research
- Support and coordinating leadership by AUT Gambling Research Centre and Gambling Helpline with further support from McGill University and Australia National University for the next 12 months
- Use conferences and Email contact as opportunities to develop the Forum, its priorities and objectives

- Encourage the development of a collaborative rather than competitive approach
- Invite wider international membership to the domain caucuses
- Develop an international ‘clearing house’ for information and research results
- Reconvene in 12 months to review actions achieved and progress made. *The current plan is for the Think Tank to reconvene in Auckland in May 2005.*

The original planning committee has held meetings to discuss how to disseminate the feedback from the Think Tank and how to establish and engage the working parties to continue the process. AUT and the Helpline will continue to coordinate the steering of Think Tank activities over the next 12 months with the ultimate aim of the Think Tank gaining a wide international ownership. Discussions have begun with other organisations willing to host (sub-) Think Tank meetings.

Arrangements have been made for proceedings from the Think Tank (i.e. selected background papers) to be published in a special edition of the journal *International Gambling Studies*. The papers will undergo a formal peer-review process so it is anticipated that the proceedings edition of the journal will be available in 2005. It is intended that abstracts and PowerPoint presentations from the Think Tank will be available in a special edition of the electronic journal *eCOMMUNITY: International Journal of Mental Health and Addiction*. These should be available later this year.

Feedback was sought from participants on their evaluation of the Think Tank. The overall response was:



In general, participants thought that the highlights of the Think Tank were the opportunity to network and to participate in/listen to the discussions and presentations of up-to-date information and research. They felt that the event could have been improved if the discussions were more focused and if there had been less repetitiveness amongst the presentations. Additional comments were mainly congratulations to the organisers and wondering what the next steps will be.

#### **Next steps**

Gary Clifford attended the National Council on Problem Gambling’s Conference in Phoenix and gave an update on the Think Tank to a helplines working group. There was general consensus that a Think Tank would be of benefit to helplines and that helplines should meet more often at international conferences. One outcome of the Phoenix meeting was agreement that an online forum for helplines should be established. Gary is in the process of setting this up.

Gary, together with Liz Stephenson from Manitoba, will also be giving a ‘North-South’ overview of the Think Tank at Insight Nova Scotia in October.

We now need to mobilise the working groups to which people signed up in Auckland. In case you cannot remember which list you added your name to, a list is attached (Appendix 1). We now seek volunteers to start the process of identifying and documenting key issues for each of the working groups, co-opting collaborators, deciding on research/project priorities, and putting together a plan of action. Please inform Dr Maria Bellringer (Email: maria.bellringer@aut.ac.nz) if you would like to take a lead role (otherwise we might tap you on the shoulder!).

**Some issues to be addressed**

- Licensed gambling has spread rapidly over recent decades. The policy and regulatory frameworks seem on the one hand to be permitting this growth while on the other failing to create any uniformity in the approach to standards, testing of products or monitoring the social and economic costs of gambling. To what extent should we be investing in public policy conventions or ‘treaties’ based on an evidentially led approach? What would such conventions look like?
- Research on presenting problem gambling populations has been somewhat piecemeal. What can we do in terms of international collaboration on systematic research? What sort of outcome or longitudinal research is required as a priority? What are the barriers and how do we overcome them?
- How do we promote and institutionalise collaboration or dialogue among researchers, service providers and regulators to advance the concepts of consumer protection and harm prevention?
- What are the most effective approaches to educating/informing consumers in a global harm minimisation strategy?
- What sorts of technologies do service providers need to keep up with the increasing demand for, and potential sophistication of, services? How will these be developed and provided?
- How can services be developed and delivered most effectively for the increasingly transient gambling population and for cyberspace gamblers?

***Treatment and Services sub-group meeting***

A half- to one-day meeting of the Treatment and Services Working Group is being planned for Wednesday 10 November 2004, immediately prior to the NAGS conference on the Gold Coast, Australia. This will be organised in conjunction with the Queensland Office of Gaming Regulation (Micheil Brodie) and with support from Australia National University (Prof. Jan McMillen). Please inform Maria Bellringer as soon as possible if you would like to attend/ participate in this meeting.

**APPENDIX 1**

**Think Tank Working Groups: Interested Participants**

<b>Research</b>		
Phillida Bunkle	Tony Carr	Vivian Cheung
Andrew Duncan	Debbie Edwards	Sitaleki Finau
Linda Hancock	Nerilee Hing	Nemu Lallu
John Lepper	Charles Livingstone	John Markland
Jan McMillen	Timothy Ore	Tracy Schrans
Sean Sullivan	Richard Tan	Rachel Volberg
Masood Zangeneh		

<b>Treatment/Services</b>		
Patrick Au	Andrea Brebner	Vincent Burke
Vivian Cheung	Andrew Duncan	Debbie Edwards
Krista Ferguson	Linda Hancock	John Hannifin
Lynette Hutson	Nemu Lallu	John Lepper
John Markland	Neil Mellor	Jane Oakes
Cynthia Orme	Campbell Roberts	Adrian Scarfe
Sean Sullivan	Richard Tan	Phil Townshend
Barbara van der Spuy	Jim Westphal	Masood Zangeneh

<b>Policy and Public Health</b>		
Phillida Bunkle	Vincent Burke	Vivian Cheung
Debbie Edwards	Krista Ferguson	Sitaleki Finau

Ralph Gerdelan	Linda Hancock	John Hannifin
Nerilee Hing	Carolyn Hobson	Nemu Lallu
Paul Lavulo	John Lepper	Dave Macpherson
John Markland	Jan McMillen	Graeme Minchin
Richard Northey	Timothy Ore	Roger Parton
John Raeburn	Campbell Roberts	Tracy Schrans
John Stansfield	Elizabeth Stevenson	Richard Tan
Rachel Volberg	John Wong	Nick Xenophon
Masood Zangeneh		

## 15. Appendix 5

### Think Tank News letter 2

#### International Think Tank on Presenting Gambling Populations and First Contact Services

*Newsletter Number 2: December 2004*



Welcome to the second Think Tank newsletter. This edition includes a brief update of the Treatment and Services subgroup meeting held on 10 November 2004, Surfers Paradise, Queensland, Australia. The meeting was held immediately prior to the 14<sup>th</sup> annual NAGS conference.

#### **Acknowledgement**

The venue for the Think Tank subgroup meeting and all conference facilities were kindly organised and funded by the Queensland Office of Gaming Regulation, Queensland Government Treasury.

#### **Participants**

Present at the meeting were representatives from New Zealand, Australia and the USA.

<b>New Zealand</b>	<b>Australia</b>	<b>USA</b>
Max Abbott	Leigh Barrett	James Westphal
Maria Bellringer	Andrea Brebner	
Gary Clifford	Angus Forbes	
Clare Docherty	Bill Horman	
Debbie Edwards	Jan McMillen	
Ralph Gerdelan	Leonie Middleton	
Sean Sullivan	Jane Oakes	
Philip Townshend	Eric Tyssen	
	Susan Munro	

#### **Content**

Following a welcome given by Max Abbott and Gary Clifford and a recap of the Auckland 2004 Think Tank meeting, the day progressed with presentations followed by discussions around the presentations and related issues.

The presentations were:

<b>Title</b>	<b>Presenter/s</b>
A treatment package using targeted information, in vivo desensitisation and biofeedback systems for gamblers	Philip Townshend
Should a clinical trials network for gambling treatments be developed?	James Westphal and Jane Oakes
Helpline assessment/integrated care/audiovisual support	Gary Clifford
The ClubCare NZ example	Gary Clifford and Ralph Gerdelan

The PowerPoint presentation given by James Westphal and Jane Oakes is available for those who are interested. Please Email Maria Bellringer ([maria.bellringer@aut.ac.nz](mailto:maria.bellringer@aut.ac.nz)) if you would like a copy.

### **Key points**

The key discussion points focused around:

- ❖ Treatments and the components of treatment
- ❖ What could be gained by the formation of a network with international collaborations A single site randomised controlled trial (clinical treatment programme) is scheduled to take place in Queensland (in collaboration with Turning Point) over a three year period
- ❖ Merits of setting up a multi-site clinical trials network
- ❖ Interface with industry is important

### **Key actions**

- 1) *Consider the different therapies that may be ready (or could soon be ready) to join a multi-site clinical trials network*

This process will need a discussion document to get things moving and which can be reported upon at the 2<sup>nd</sup> Think Tank meeting in May 2005. Specific proposals for a multi-site clinical trials network should be invited before May and the relevant governments who are likely to fund the work should be involved.

***Please advise if you would like to help with this initiative including development of the discussion document.***

- 2) *Data collection systems*

It is important to be able to make comparisons across jurisdictions regarding data collected from problem gamblers. Treatment providers (including helplines) often collect information for their own purposes. A decision needs to be made regarding what data should be collected to enable cross-jurisdictional comparisons. New Zealand has a data set, as does Victoria.

General population surveys do not have a large enough sample of problem gamblers to enable statistically valid mining for information. Should common screens and measures (e.g. across comorbidities) be used across jurisdictions? This would enable large enough samples for drilling down for further information.

*Please advise if you would like to help with this initiative.*

### 3) Use of helpline data

Helpline data could be used to look for patterns, and changes in patterns, in problem gambling behaviour. The problem is that different helplines collect different client data and the quality of data collected is varied.

The helpline network website will be live soon. Please contact Gary Clifford for more details [gary.clifford@gamblingproblem.co.nz](mailto:gary.clifford@gamblingproblem.co.nz)

*Please advise if you would like to help with this initiative.*

#### **REQUEST:**

*A budget will be required for the three action points detailed - this will need to be disseminated to the policy makers and governments so they can build the work into their funding strategies. Please advise if you would like to help with this initiative.*

#### **Think Tank subgroups**

- ❖ Treatment and Services Subgroup
  - Please inform Maria Bellringer if you would like to be involved in one or more of the three action areas detailed.
- ❖ Research Subgroup
  - Max Abbott and Masood Zangeneh are taking a lead with this subgroup. Further information will be disseminated as and when available.
- ❖ Policy and Public Health Subgroup
  - A leader/s is required for this subgroup.

If you would like to contribute to the leadership of a subgroup/action area please inform Maria Bellringer in the first instance.

An updated table of subgroup members is detailed in Appendix 1. Please inform Maria Bellringer if you would like to be added or removed from any of these lists. Also, please advise if there are other people who you believe could make a constructive contribution to the Think Tank and one or more of its subgroups.

#### **Las Vegas meeting**

At the beginning of December, Max Abbott and other Think Tank participants including Jeff Derevensky, Adrian Scarfe, James Westphal and Rachel Volberg (apologies if we have forgotten anyone) attended a meeting in Las Vegas. The main focus of the meeting was the issues surrounding definition and measurement of problem gambling; also visited was the design of a national UK prospective study of gambling and problem gambling.

## **Review of Research on Aspects of Problem Gambling**

For a majority of 2004, Max Abbott, Rachel Volberg and Maria Bellringer, together with Gerda Reith from the University of Glasgow were involved in conducting a review of research on aspects of problem gambling for the Responsibility in Gambling Trust, United Kingdom. The full report and a much shorter summary version are both available on the Responsibility in Gambling Trust's website at <http://www.rigt.org.uk/research.asp>

## **IMPORTANT NOTICE**

### **Think Tank meeting and Conference May 2005**

The second Think Tank meeting follows on from and builds upon the successful first *International Think Tank on Presenting Gambling Populations and First Contact Services* which was held in Auckland, New Zealand in May 2004. At the first Think Tank meeting, participants agreed that the second meeting would be held 12 months later (i.e. May 2005) in Auckland.

The purpose of this Think Tank is to address globally significant issues and developments in problem gambling policy, services and research in relation to presenting gambling populations and first contact services. The ultimate aim is to contribute to the development of an international public health agenda on gambling.

All three working domains agreed at the first Think Tank meeting will be featured. These are:

- ❖ Research
- ❖ Treatment and Services
- ❖ Policy and Public Health

A focus will be to further mobilise each of the three domains by identifying and documenting key issues, deciding on research and project priorities and coordinating an internationally collaborative plan of action.

The Think Tank will take place on 25 and 26 May 2005\* and will be followed by a one day international gambling conference on 27 May 2005\*. Post-conference workshops will be held on 28 May 2005\*.

For further information and/or if you would like to be involved in the May 2005 Think Tank meeting, please contact Maria Bellringer.

### **And Finally.....**

Max Abbott, Gary Clifford and Maria Bellringer wish you all the season's greetings and very best wishes for the New Year.....

.....and we look forward to seeing some of you again in May 2005.

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\* Provisional date

## APPENDIX 1

### Think Tank Working Groups: Interested Participants

<b>Research</b>		
<b>Leaders: Max Abbott and Masood Zangeneh</b>		
Phillida Bunkle	Tony Carr	Vivian Cheung
Andrew Duncan	Debbie Edwards	Sitaleki Finau
Linda Hancock	Nerilee Hing	Nemu Lallu
John Lepper	Charles Livingstone	John Markland
Jan McMillen	Tracy Schrans	Sean Sullivan
Richard Tan	Rachel Volberg	Masood Zangeneh

<b>Treatment/Services</b>		
Patrick Au	Leigh Barrett	Andrea Brebner
Vincent Burke	Vivian Cheung	Andrew Duncan
Debbie Edwards	Krista Ferguson	Angus Forbes
Linda Hancock	John Hannifin	Bill Horman
Lynette Hutson	Pefi Kingi	Nemu Lallu
John Lepper	John Markland	Jan McMillen
Leonie Middleton	Jane Oakes	Cynthia Orme
Campbell Roberts	Adrian Scarfe	Sean Sullivan
Richard Tan	Phil Townshend	Eric Tyssen
Barbara van der Spuy	Jim Westphal	

<b>Policy and Public Health</b>		
Phillida Bunkle	Vincent Burke	Vivian Cheung
Lorna Dyall	Debbie Edwards	Krista Ferguson
Sitaleki Finau	Ralph Gerdelan	Linda Hancock
John Hannifin	Nerilee Hing	Carolyn Hobson
Nemu Lallu	Paul Lavulo	John Lepper
Dave Macpherson	John Markland	Jan McMillen
Graeme Minchin	Richard Northey	Roger Parton
John Raeburn	Campbell Roberts	Tracy Schrans
John Stansfield	Elizabeth Stevenson	Richard Tan
Rachel Volberg	John Wong	Nick Xenophon

## 16. Appendix 6

### Transcript

**Jane Oakes, Cognitive Behaviour Therapist, Flinders University and Sue Pinkerton, client (891ABC 1315-13.35) Gambling Awareness Week/Gambling addiction**

(Whitelock: ... what was your life like? Did you really have a problem with pokies?)

**Pinkerton:** I certainly did. I was gambling about... five, six days a week, around about six hours per day as long as I had the money. All up I estimate ... I went through about \$60,000, which was everything I earned over the three and a half years, plus a little bit of my ex-husband's money.

(Whitelock: So what was the attraction? Why did it get you in?) ...

**Pinkerton:** initially my husband I were staying in a hotel while we waited for our furniture to transfer interstate. My husband and my children are all early-birds - they were asleep by 8 o'clock ... I'd stay up 'til midnight ... in a hotel room there's not much you can do with a whole heap of people sleeping around you ... the hotel had gaming machines in it ... I used to go up there and take my \$10 and sit down and while away the two or three hours until I was ready to go to bed ... before I came into contact with gaming machines I ... didn't have a gambling problem at all. I used to buy Lotto on the odd occasion, go to bingo, never overspent ...

(Whitelock: Did you have a few big wins upfront?)

**Pinkerton:** No comparatively big wins ... you're only spend \$10 and you win \$50 on the push of a button that seems like a huge win ... but ... in fact my biggest win in my whole poker machine career was \$3,000 ... that I couldn't tell anybody about because by then my ex-husband had known I had a problem ...

(Whitelock: Did that lead to the end of the marriage or was that going to happen anyway? ... )

**Pinkerton:** a really good question ... I don't know ... I went into ... counseling when I decided to quit ... subsequent to that my marriage broke up. At that point I certainly didn't realise the marriage was in that bad a state ... neither did my ex-husband ... I found that the counseling was particularly unhelpful ... which was why I found the Flinders program really excellent.

(Whitelock: ... [introduced Jane Oakes])

**Oakes:** our program, which is a State-wide program ... we help people deal with the urge ...

(Whitelock: ... it's a bit like when you give up smoking ... you know if you can resist the urge for that cigarette for a little while it will eventually wear off)

**Oakes:** that's correct ... that's how we start to help people who have gambling problems ... if they don't gamble ... their urge will slowly go away by itself ...

(Whitelock: It can be done either as an outpatient or an inpatient, can't it, so if you live miles and miles and miles away, do you tend to admit people to the centre?)

**Oakes:** We have a teleconference facility ... if they like they're welcome to come down to our hospital program ... they come in for about two weeks ...we give them some intensive therapy where

they start addressing their thoughts related to gambling ... also the urge ... then we'll discharge them ... and follow them up ...

**(Whitelock:** One of the things ... in this sort of resume that you sent me says that you give people addicted to pokies money to walk into a pokie room as part of a course which teaches them the probability of winning until they're urge goes away ... Sue, I would think that would have been a really tough thing to do? ... )

**Pinkerton:** Not by the time I actually did it, no ... you don't come into ... Flinders program and immediately go off to a venue ... by the time you get to the stage where you can do it, you're actually reasonably comfortable with it ... I can now walk into a venue, I can put \$25 in a machine, I can sit there for an hour ... at the end of an hour I just press the collect button, take my \$25 and go home

**(Whitelock:** Is it a hard journey?)

**Pinkerton:** Initially yes ... exceedingly hard, but going through the Flinders program was a whole heap easier. still found it very difficult to actually give up my access to money ...

**(Whitelock:** So they say no money in your hand for a while?)

**Oakes:** That's a very important part of the program ... we start of with very simple tasks where people learn that their urge will go away without gambling ... that's done in a very slow, controlled manner.

**(Whitelock:** ... what's step 1? If I came to you and said ... I've got this problem ... it's out of control, what would be the first thing you'd get me to do?)

**Oakes:** After I'd taken your history and found out exactly what was going on ... anything else that was important in your life ... if you're depressed we'd take that into consideration ... once we'd sat down and worked out the goals that you'd like to achieve ... from therapy ... we'll set up a program for you ...start off just showing you that your urge will go away, perhaps with some external stimuli from a pokie room. It might be a picture of a poker machine where you just sit and stay with the urge and see that after a period of time it goes away without gambling.

**(Whitelock:** So do you divert me away from that urge by getting me to do other things, or do I sit and concentrate on it?)

**Oakes:** No ... people do try to avoid ... people don't go into the venue, people ... do other things to try and escape from the urge, but that doesn't work, because once they stop avoiding, the urge comes back, so we ask them to face their urge and stay with it and see that they don't have to avoid it, that it will go away.

**(Whitelock:** So you front up to your fear? ... at what stage do you say ... you can't have any money? For how long?)

**Oakes:** That's an individual decision ... a twelve week course where people come once a week and see either myself as an individual therapist or within a group facility ... as they go through the program ... confidence comes back ... they start to see ... \$10 has value ... that's an important change that people have in their thinking ... once they get confident after a few months' people start thinking ... I can now carry small amounts of money and I don't have to avoid, I can actually go into the venue now with money.

**Whitelock:** ... you'd have to trust someone a lot, Sue to say ... I'm handing over my autonomy over certain things to you ... )

**Pinkerton:** ... very much so ... it's very, very difficult to do that ... in my case I knew within weeks of starting to gamble that I actually had a problem and spent basically two and a half, three years, trying to deal with that and to put blocks in place to stop myself from going, and would always end up back at the machines again ... I had learned that I was not trustworthy so to trust somebody else, while difficult, is also reasonably easy ...

**Whitelock:** you know what you're doing isn't working)

**Caller Tom:** ... I play the pokies a bit ...most of the people I know who play excessively are not people who make decisions on investments ... they're not people who look at the simple things like risk ... )

**Pinkerton:** I would actually disagree. I knew that I was not likely to win when I played the pokies ... I hoped that I would ... sometimes I did, which really taught me that it was possible, even though it was not likely ... I know ... gaming machines are in there to make money ... you can't make money as a customer from somebody who's trying to make money from you ... I always hoped that I would win ... occasionally I did ... that would reinforce ... the belief that I would.

**(Whitelock:** It's the same with casinos ... bookies ...they're all there because it's a way of making money ... nothing illegal or bad about that, that's what they do ... you cannot as a punter expect really to come out on top, can you?)

**Pinkerton:** And I would always go into a venue, even at what I'd call the height of my addiction ... I would go into a venue with the best of intentions. I was only ever going to stay for an hour and spend \$50 ... the last time I did that, I ended up staying for six hours and blew \$500.

**(Caller David:** ... if the South Australian expenditure on gambling is \$9 million a week, doesn't the government get most of that? ...)

**(Whitelock:** ... they get a tax on it ... ) ...

**(David:**... what's the State Government doing with \$4 million a week? ... )

**(Whitelock:** ... that's a very good question which you should address to the State Government, I think)

**(Whitelock:** ... you're gradually getting people to do simple tasks ... what's the next step? ... you get them looking at pictures of pokies. Do you get them listening to that ... it's that all-pervasive sound ... which I think it the most hideous ... noise in the world ... if it's a trigger for making people want to gamble, how to you deal with that?)

**Oakes:** It's a huge trigger, the music ... what people say is they hear that music all the time ... once they leave the venue it still goes on playing in their mind ... what we ask them to do is ... stay with that music, sit down and listen to a tape of pokie music until eventually it loses ... its interest.

**(Whielock:** ... does it drive you nuts after awhile, Sue?)

**Pinkerton:** Oh yes ... I got to the end of that particular task ... I literally hate the sound of it ... I ... can't remember how the sound goes any more ... it was constant at one stage but ... try as I might, I cannot bring up ... how it sounded ...

**Oakes:** ... how did you find the music when you went into the venue? How did you find listening to the music in the venue after having listened to it all the time on the tape recorder?

**Pinkerton:** Irritating ... in the extreme ... even so, having listened to it all the time and not gambled ... I now go and sit in a venue ... I walk out... it doesn't play over and over ...

**(Whitelock:** ... this takes you through... twelve weeks you said, Jane?)

**Oakes:** That's correct.

**(Whitelock:** ...at the end of twelve weeks it would be awfully easy to say ... I've done that, I'm all right now ... go out there on your own. Is there continuing... group support? How does it work?)

**Oakes:** ... we also address people's thinking about winning ... we've talked a little bit about that ... we do a work teaching people how to deal with the triggers ... also life skills ...how to deal with different triggers ... once they leave they've got a whole lot of skills to do with the urge ... the triggers ... depression ... so they're a lot more confident ... then we have support groups where people can come along ... talk to each other ... sometimes we have people talking about nutrition, different topics of interest ... a little bit of support if they need it along the way.

**(Whitelock:** ... once you've dealt with a problem like smoking ... if you are a reformed smoker ... lovely to talk to someone who's giving up smoking 'cause you know how they're feeling, you want to help them. I guess you feel like that now Sue? ... )

**Pinkerton:**I've been speaking publicly for some time now ... I've ... written an article that was published in The Advertiser ... eighteen months, two years ago ... I also run a problem gambling research consultancy ... I communicate with people all over the world, spoken at conferences in the US and New Zealand ... mostly it's dealing with how the gaming machines impact on human psyche and behaviour, how it changes that.

**(Whitelock:** ... we've sort of come fairly lately to having such saturation gaming machines, haven't we? What about ... America, New Zealand, Canada, and other places? Is there as much of a problem there, did you find?)

**Pinkerton:** Definitely ... New Zealand has got at least as great a problem as we've got. Canada has a big problem... same with the States in the US that have machines over there. They have slightly different machines in Canada and the United States than we have here. New Zealand have the same kind ... once again, they're computer-generated, they have certain things on the machine ... virtual wheel mapping ... random number generators and so on ... very quick ... it's impossible to predict what symbol follows what, whereas with the old machines ... you were limited by the actual size of the physical wheel ...

**(Whitelock:** ... you must feel very pleased ... your success rate is about what? Of the people who go right through, what's your success rate?)

**Oakes:** About 90% of clients reach the goals that they'd like to reach and go on maintaining that throughout many years of follow-up ...

**(Whitelock:** ...must give you a nice ... warm inner glow? ... )

**Oakes:** It's lovely, because people come with so many heartbreaking stories ... to see them get better and to have their life back and their families and trust can eventually come back. It's very rewarding ... it's evidence-based ... we know people get better ... we have lots of way to measure ...

**(Whitelock:** ... Which would help someone starting off ... if you can say to them look, if you stick with this it will work, we know it works ... it would be a very daunting task at the beginning, wouldn't it?)

**Oakes:** It is ... that's why we never ask anyone to do anything they can't do ... we spend a lot of time making sure clients understand what we want them to do and how we want them to do it.

**(Whitelock:** ... if people want to get in touch with your program, should they do it through their GP or can they 'phone Flinders direct? What happens?)

**Oakes:** People can call our service directly ... 8204 4779 ...

**(Whitelock:** ... it's really interesting to talk to you both ... an interesting glimpse of what can happen and what can be done about it).

**17. Appendix 7**  
**Client Testimonials**  
(See attached)

## 18. Appendix 8 Summary Data Sheet

Name MELISSA		Post code5	Age 15/3/61	Gender F	Therapist Jane Oakes			Referrer Dr simth		
Referral received	Assessment date 14/5/01	Attended Y/	Suitable Y/	Accepted treatment Y/		Assessed for in-patient N		In-patient N		
Diagnosis 1 (DSM-IV) Problem gambling			Diagnosis 2 (DSM-IV) Depression			Diagnosis 3 (DSM-IV) Agoraphobia				
Treatment 1 CBT LIVE / IMAGINAL			screening	ass	Mid	post	1 mth	3mth	6mth	12mth
Treatment 2 RELAPSE -PREVENTION			date→	14/5/01	3/4/01	5/8/01	4/1/02	7/3/02	21/10/2	11/7/03
Problem A <b>Gambling</b> When I have money and need time out from stress I gamble out of control on Pokies resulting in depression, relationship disharmony, financial and emotional problems			S	8	0	0	0	0	0	
Goal A1 <b>Gambling</b> To not gamble on the pokies again.			S	8	0	0	0	0	0	
Goal A2 <b>Gambling</b> -To sit alone in gambling venue alone for 2 hours with \$100 in my purse and not gamble or return to gamble. To repeat this task twice weekly.			S	8	0	0	0	0	0	
Problem 2 <b>Panic with Agoraphobia</b> When alone or have to leave the house I experience panic attacks with severe bodily sensations and fear that I will die from a heart attack. This results in me not leaving the safety of my own home, not answering the phone and waking through the night			S	8	3	0	0	0	0	
Goal 1- <b>Panic with Agoraphobia</b> I will go to Marion shopping alone twice a week at peak time( 12miday) and sit in a coffee shop with a coffee for 1 hour twice a week.			Self	8	4	0	0	0	0	
			Self							
Onset problem A (yrs)			SOGS	14		0	0	0	0	
Onset problem B (yrs)			FEAR Questionaire	59/34	3/0	2/0	0	0	0	
Total sessions:			General Health Questionaire	13	1	0	0	0	0	
Missed sessions:			WSAS Work	0	0	0	0	0	0	
Total therapist Hours:			WSAS Home Management	0	0	0	0	0	0	
Total assisted hours:			WSAS Social Leisure	0	0	0	0	0	0	
Outcome			WSAS Private Leisure	0	1	0	0	0	0	
1=Completed treatment			WSAS Relationships	1	0	0	0	0	0	
2=Dropout before ses. 2			Beck Depression Inventory	22	10	4	0	0	8	
3=Dropout between ses. 3-8			Beck Anxiety Inventory	31	2	3	0	0	0	
4=Other			MARKS PARKIN Depression/anxiety /suicide	15/14/2	2/3/0	0/0/0	0/0/0	0/0/0	0/0/0	
Other professional involved Y/N										