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Evaluation and Clinical Audit of Problem Gambling Intervention and Public Health Services

Provider Number: 467589

Contract Numbers: 348109/00 and 01

FINAL REPORT

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LIST OF ABBREVIATIONS AND ACRONYMS

ABACUS	ABACUS Counselling, Training & Supervision Ltd
AOD	Alcohol and Other Drugs
AUTEC	AUT Ethics Committee
Class 4	Non-casino electronic gaming machine gambling venue (i.e. pub or club)
CLIC database	Client Information Collection database
DIA	Department of Internal Affairs (New Zealand)
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
EGM	Electronic Gaming Machines
GPs	General Practitioners (non-specialist physicians)
HPA	Health Promotion Agency (Crown entity established on 1 July 2012)
HSC	Health Sponsorship Council[1]
MOH	Ministry of Health
MVE	Multi Venue Exclusion
MVSE	Multi Venue Self Exclusion
PGCS	Problem Gambling Counselling Services
PGPH Services	Problem Gambling Public Health Services
SOGS	South Oaks Gambling Screen
TAB	Totalisator Agency Board
TLA	Territorial Local Authority
WINZ	Work and Income New Zealand

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[1] The Health Sponsorship Council (HSC) is the previous Crown entity in New Zealand responsible for health promotion. The Health Promotion Agency (HPA) took over HSC's function as of 1 July 2012. The present report uses both terms (HPA and HSC) as used in the original sources of documents cited or examined.

EXECUTIVE SUMMARY

Background

The Ministry of Health (The Ministry) funds a range of problem gambling intervention services in recognition of the diverse situations, and points of readiness to change, people with gambling problems are at in their lives. While gambling treatment services that focus on addressing the symptoms of problem gambling have long been established within health sectors internationally, the conception of problem gambling as a public health issue is relatively new, with New Zealand being a pioneer of this approach. Additional to problem gambling intervention services, The Ministry funds a range of public health services focused on preventing, reducing or minimising gambling harm. These intervention and public health services are contracted to organisations that are typically referred to as 'providers' by the Ministry.

Aims

The objective of this evaluation and clinical audit was to assess the effectiveness of four Ministry-funded problem gambling intervention services (*Brief Intervention*, *Full Intervention*, *Facilitation Services*, *Follow-up Services*) and five public health services (*Policy Development and Implementation*, *Safe Gambling Environments*, *Supportive Communities*, *Aware Communities*, *Effective Screening Environments*). In brief, the evaluation and clinical audit aimed to assess whether providers were achieving what they were contracted to achieve for these services (also referred to as purchase units). The focus of the project included elements of cultural practice, service delivery and quality; data management; and staff, allied organisations and service-user perspectives.

Evaluation Methods and Audit Process

Employing a mixed-methods evaluation, both quantitative and qualitative data were collected and analysed:

- Literature review - national and international literature (published between 2002 and 2014) reviewed to identify international best practice examples and appropriate evaluation methods.

- Document analysis - sets of six-monthly progress reports submitted to the Ministry by 20 problem gambling public health service providers between July 2010 and June 2013, analysed for content, trends and best practice examples.

- Surveys (semi-structured questionnaires) - staff (n=64), clients (n=148) and allied agencies (n=42) of a non-probability sample of eight Ministry-selected providers were surveyed to gain perspectives on activities, outputs and outcomes of services delivered.

- Focus group interviews - three focus group interviews (comprising eight to nine individuals) were carried out with staff and managers involved in delivering public health and intervention services from the eight selected organisations to gain further understanding of key aspects and issues identified from the document analysis and surveys.

- Client Information Collection (CLIC) database analysis - client data submitted by 19 intervention service providers (between July 2010 and June 2013) were analysed to determine key trends in service delivery. Collectively, services were delivered to an average of 1,840 clients per month[2].

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[2] This average is based on the total number of clients who accessed a service at least once in each respective month thus cannot be used to estimate number of clients in a year (see section 2.3.5 of the report for further details).

The evaluation focused on a set of evaluation criteria and was guided by a logical framework that considered the following aspects, relative to the Ministry's objectives, and international best practice:

- Operational processes - the effectiveness of processes in place.

- Service inputs - how inputs affected, or translated to, outputs.

- Service outputs - how effectively, or to what extent, were Ministry-recommended activities carried out.

- Service outcomes/impacts - the extent to which activities resulted in intended changes, improvements or impacts.

- Possible external factors that could influence service outcomes.

- Optimal approaches, successful strategies (best practice examples) and areas for improvement.

All providers are required to consider the Ministry's objectives for the various intervention and public health services and reporting requirements. These are described in a number of Ministry documents that guided the evaluation process:

- *A guide to developing public health programmes: A generic programme logic model* (Ministry of Health, 2006) - provides recommendations on the use of logic models for developing measurable and effective public health programmes.
- *Intervention service practice requirements handbook* - clarifies "aspects of problem gambling intervention service delivery" and "details the screening and intervention practice requirements for service providers" (Ministry of Health, 2008b, p.1). This guide includes advice on scoring screens and client assessments.
- *Problem gambling service: Data collection and submission manual* - describes the minimum requirements for collecting and submitting client data into the Client Information Collection (CLIC) database as well as submission timeframes (Ministry of Health, 2008c).
- *Service specification: Preventing and minimising gambling harm - Problem gambling services* - this document has two parts. The first part "sets out general information about the Government's approach to problem gambling services" and the second "sets out the detail of the services to be provided, activities to be delivered, and reporting requirements" (Ministry of Health, 2010, p.1).

In the **clinical audit**, each of the eight providers' level of compliance was determined against their contract with the Ministry of Health, Health and Disability Service Standards, and other best practice guidelines. The auditors visited each provider, interviewed its staff and clients, and reviewed documentation to assess if providers had fully complied, partially complied, or did not comply with aspects relating to: *Service Delivery and Quality*, *Clients Rights* and *Cultural Perspectives*. This includes a written "plan of care" which all providers are required to maintain for each client.

Key Findings, Strengths and Areas for Improvement

In the analysis and reporting process, a triangulation process was used to compare and contrast findings from the various evaluation data sources and clinical audit observations. Key findings in relation to the evaluation criteria are summarised in the tables below.

In brief, the evaluation noted both strengths and areas for improvement. In delivering Intervention Services, providers effectively ensured clients' access to information, met clients' expectations in terms of service quality and cultural appropriateness, reached out to targeted at-risk populations, and facilitated clients' access to other support services. However, some providers did not meet the minimum number of client sessions agreed with the Ministry and a greater level of clinician involvement in delivering *Follow-up* services appeared to be required. Although providers are not mandated to record scores for all recommended screens in the CLIC database, changes to provider practice in reporting pre- and post- screen scores could enable reliable measurement of client outcomes.

In delivering public health services, providers reported a range of outcomes including policy outcomes, impacts on host responsibility practices, and enhanced public awareness. Providers were effective in ensuring appropriate public health resources for community members and in delivering public health activities using culturally appropriate approaches. Overcoming challenges, all providers successfully collaborated with a broad range of stakeholder groups suggesting strength in terms of commitment and perseverance. Community engagement was another strength as this led to community partnerships in public health programmes as well as community ownership over initiatives suggesting output sustainability (i.e. ongoing outputs independent of service funding). However, the evaluation also noted a lesser level of overall output for some Ministry-recommended activities reported by a lesser number of providers. Areas for improvement included staff knowledge development and clarity in public health work plans, progress reports and description of aspects regarded to be innovative.

Operational Processes and General Areas of Input

Evaluation Criteria	Key Findings, Strengths, and Areas for Improvement
Utilisation of allocated FTE	• Staff believed their organisations were effective in utilising allocated full time equivalent (FTE) staff for delivering services.
	• Specification on minimum delivery of public health services expected of one FTE staff was irrelevant to the reality of how services were delivered; this particular area of service specification may require alteration.
	• Staff views suggested that time sufficiency was as an input area that requires consideration for both intervention and public health services.
	• Although staff views suggested the value of holding dual-roles (public health and intervention), the knowledge and competency of staff taking on dual roles and time pressure implications require consideration within providers' planning.
	• Time estimates for potentially lengthy public health activities need to be a key component in providers' annual planning.
Workforce development	• Staff were generally satisfied with their level of knowledge and training; however, additional training on advanced approaches to therapy, and additional opportunities to share best practice between public health service providers were suggested.
	• The clinical audit identified workforce development as an area of partial compliance. Workforce development processes could be enhanced by implementing viable career development plans for all staff.
Knowledge: Clarity around population of interest, service objectives and reporting requirements	• The majority of staff were aware of their service objectives and reporting requirements; this awareness was supported by managers and team leaders.
	• Over half of staff survey respondents were aware of the details of annual public health work plans their organisation had in place.
	• Public health staff views suggested the need for a clearer understanding of some purchase unit descriptions.
Utilisation of purchase unit funding	• Staff reported that their organisations were effective in utilising purchase unit funding for delivering services.
	• A few suggested the need for additional funding to support specific areas or service delivery (e.g. *Follow-up Services*). Implications of funding limitations would require discussions between respective providers and the Ministry.
Access to resources	• Staff reported that their organisations were effective in sourcing and developing required resources.
	• The document analysis noted providers' proactive seeking of resources and efforts to adapt existing resources to fit public health activity needs as areas of strength.

	• The clinical audit noted that informational resources were readily available to clients.
	• However, a need for more language and culture-specific resources was suggested.
External factors	• Staff views suggested two categories of external factors that can affect service delivery: factors beyond their control, and external parties and stakeholder groups they worked with.
	• Both categories of external factors require consideration in logic model development, in the planning of activities, and when making evaluative judgements about service effectiveness.
Service functioning (sustainability)	• Although staff believed their organisations had processes in place to ensure longer-term capacity to continue providing services, insufficient funding input in some areas and uncertainties around contract extensions were seen as external factors that affect service delivery.
	• The audit found "Quality management" as an area of partial compliance. Intervention services need to review and enhance the implementation of quality management plans and improve on the collection, analysis and use of quality improvement data.
	• As public health programme sustainability requires processes in place at programme planning stages, the effectiveness of the five Ministry-funded public health services could be enhanced with clearer articulation of sustainability as an intended outcome.

Other Key Findings

Collaborations and joint initiatives	• Staff believed there was effective teamwork between intervention and public health staff when delivering services.
	• Public health staff collaborated with other organisations in planning and carrying out joint activities; these collaborations offered a number of advantages for public health service delivery.

Problem Gambling Intervention Services

Evaluation Criteria	Key Findings, Strengths, and Areas for Improvement
Overall contract compliance	• Staff reported that their organisations complied with most of the four intervention services' specifications. However, delivery of services in accordance with service specifications varied across providers.
	• Within the *Service Delivery and Quality* clinical audit criteria, three areas of partial compliance (i.e. Quality management, Plan of Care, Planning discharge from and/or transfer between services) and one area of non-compliance (i.e. minimum delivery of services) require attention.
	• Areas of full compliance in meeting contractual requirements included meeting clients' expectations in terms of service quality and cultural needs and in ensuring client rights; these were regarded as strengths.
	• Staff suggestions included an updated *Intervention Service Practice Handbook*, and reconsideration of time allocations specified for the different intervention services to accommodate Māori communication approaches, which may require a longer engagement time.

Compliance with the Ministry's reporting requirements	• Staff reported that their organisations were effectively meeting the Ministry's requirements for CLIC data submissions. However, analysis of the CLIC database found several areas of inconsistent reporting. • Staff suggested the need for improvement in the technical aspects of the CLIC database. However, issues experienced at a staff level may have resulted from CLIC data entry practices and possible confusion resulting from additional databases used by providers. Staff also suggested a need for further clarity around CLIC data collection and submission.
Achievement of contract targets	• Within the *Service Delivery and Quality* clinical audit criteria, minimum delivery of services (referred to as "Implementing the care plan") was identified as an area of non-compliance, as a majority of providers were not consistently delivering the minimum number of sessions agreed with the Ministry for the four purchase units. • New *Brief Intervention* monthly client numbers increased across the three-year period[3]. This was due to increases in the monthly number of significant other clients[3]. Most providers delivered an average of one *Brief Intervention* session per client, which lasted 20 minutes on average. • New *Full Intervention* monthly client numbers remained consistent across the three-year period[3] suggesting an ongoing demand for intervention services. Most providers delivered approximately seven to eight sessions per gambler client and fewer than six sessions per significant other client. Sessions were 60 minutes each on average. • *Facilitation Services* were delivered more frequently for gambler clients than for significant others. Providers delivered an average of 2.5 sessions per client. Average session duration varied across providers ranging from less than one hour to over one hour. • *Follow-up Services* were also delivered more frequently for gamblers than for significant others. Providers did not exceed four follow-up sessions per client. With the exception of five providers, no others exceeded 30 minutes per follow-up session.
Population serviced: Ensuring outreach to targeted communities	• Providers were successfully reaching out to targeted at-risk populations in terms of ethnicity and age group. • Overall, two thirds of clients were gambler clients[3]. • Over time, there was an increasing number of significant other clients in *Full Interventions* whose initial contact was in a *Brief Intervention* session.
Ensuring service access	• Providers enabled clients' access to a range of services through referrals to other services and through *Facilitation Services*.
Cultural responsiveness in delivering intervention services	• The *Cultural Perspectives* clinical audit criteria received full compliance rating. • Staff reported that their services met clients' cultural and spiritual needs. Most Māori, Pacific and Asian clients expressed satisfaction with culture-related service provision. However, services' cultural responsiveness was irrelevant to the needs of some European clients. • Some staff expressed a need for screening tools in appropriate languages. In view of their potential to ensure a greater level of receptiveness among some

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[3] These trends are based on the total number of clients who accessed a service at least once in each respective month thus cannot be used to estimate number of clients in a year (see section 2.3.5 of the report for further details).

ethnic groups, the feasibility of establishing such screening tools would require consideration.

Clients' entry pathways into services	• Most clients were self-referred.
	• Among referred clients, most were from other problem gambling services, followed by the Justice sector.
	• Staff reported that referrals from other agencies were not fully within their control. To address this limitation, providers could ensure service area integrations in their planning. Better integration with *Facilitation Services* and with relevant public health services could offer relationship development opportunities with other community support services for two-way referrals.
Client support and engagement in the four intervention services	• A majority of staff reported that activities were effectively carried out for the four interventions. Most clients surveyed reported having experienced these activities during their sessions.
	• Operational processes in place (treatment approaches, counsellors' skill, staff friendliness and service location) met client needs. Some clients found services' mobility (an aspect specific to Māori-dedicated services) to be useful as it enabled out-of-office sessions.
	• Staff observations suggested justice-referred clients were less committed and had less motivation for change. The approaches used by some clinicians to accommodate the needs of justice-referred clients could be considered in the future development of treatment provision for this unique client group.
	• *Brief Intervention* services were delivered primarily in public settings, often in collaboration with public health activities.
	• *Full Intervention* services:
	o Clients were supported primarily through face-to-face sessions followed by telephone. The inclusion of evolving approaches that require little direct interactions with clients (e.g. online intervention) could be considered, as international observations have found these to be effective.
	• *Facilitation Services:*
	o Enabling a seamless referral process was a strength. To further improve this service aspect, the feasibility and effectiveness of arranging for allied organisation representatives to be present at the premises of problem gambling treatment services could be explored.
	o Areas for improvement include the need for up-to-date allied organisation contact lists, greater contact regularity and follow-up and clearer joint client management protocols.
	o A broader definition of allies, which includes two-way referrals of clients and four distinct categories of allies (i.e. in-house services, external services, gambling venues and supportive individuals), might be of value.
	o Integrated working processes that combine the objectives of *Facilitations* for self-exclusions and the objectives of the *Safe Gambling Environments* and *Effective Screening Environments* public health services could lead to screening and referral practices among gambling venues.
	o Facilitations to in-house services offered the advantage of greater staff-level collaboration and communication, and easier accessibility for clients resulting in higher levels of client attendance. These advantages and resultant client outcomes could be explored further to inform changes to models of service delivery.
	• *Follow-up Services:*
	o The difficulties of supporting clients through *Follow-up Services* were similar to difficulties mentioned in the previous evaluation (i.e. clinician's time constraints and difficulties in re-contacting clients). Staff suggested

additional funding was required. At the least, the difficult nature of this activity should be taken into account in service planning.

- o *Follow-up* contacts were made either by clinicians themselves or by support staff. While the use of support staff may be suitable when the key aim is to obtain client progress data, clinicians should play a greater role in *Follow-up* sessions if the aims are to ensure relapse prevention and maintenance of clients' treatment outcomes.

Outcomes for service users

- Staff views and clients' self-reported impacts indicated positive client outcomes for the respective intervention services.

- However, the CLIC database showed that relatively few clients had screen scores recorded and less had them recorded twice. At present, providers are not mandated to record scores for all recommended screens in the CLIC database. Scores for the Brief Gambler Screen and the Brief Family/Affected Other Screen were recorded at least once for the majority of clients. However, scores for other screens were not consistently recorded within *Full Interventions* and *Follow-up* sessions. Outcome screen scores were rarely recorded twice with clients. This meant sufficient data were not available for a robust assessment of client outcomes in the present evaluation.

- For the very small number of gambler clients with screen scores recorded twice during the course of their intervention, some positive outcomes were noted but these cannot be considered representative of clients as a whole.

- Changes to provider practice in reporting screen scores (pre- and post-treatment) would enable an independent evaluation of client outcomes and treatment effectiveness using the CLIC database.

- Although the four intervention services are separately funded, the services offered to clients are inter-related. The value and feasibility of future evaluations that determine the effectiveness of the four intervention services distinctively or evaluations that determine treatment outcomes summatively could be considered.

- While *Brief Interventions* may lead to further treatment (and seems to be for significant other clients), there is presently a lack of evidence of *Brief Intervention* sessions resulting in recovery without formal counselling support. Providers could have additional processes in place to obtain outcomes data from at-risk individuals who decline treatment support.

Other Key Findings and recommendations

Understanding and use of success indicators within a logical framework of intervention service delivery

- Staff beliefs about the main indicators of successful delivery of intervention services fit within three broad categories: activities, outputs and outcomes, with almost all providing a single indicator category. This suggested that what was perceived to be the most important aspect of service delivery varied across individual staff members.

- The application of logic models and a deeper level of understanding and use of success indicators within a logical framework of service delivery could:
  - o Ensure consistency in key areas of focus within organisations as well as within the sector.
  - o Enable planning to increase inputs and resource efficiency by considering overlaps between different intervention services offered to clients (e.g. activities that ensure flow from *Full Intervention* to *Follow-up* services) and with public health services.
  - o Offer an inbuilt process for self-monitoring and evaluation.

- Outcome indicators for *Brief Interventions* require additional attention considering possible lack of its clarity among staff.

Problem Gambling Public Health Services

Evaluation Criteria	Key Findings, Strengths, and Areas for Improvement
Overall contract compliance	• The majority of staff reported the effective delivery of activities for all five public health services. • Indicative findings from a document analysis of providers' progress reports showed that while some activities were delivered consistently across all providers (contracted for the respective PGPH purchase units), others were delivered by fewer providers[4]. It was beyond the scope of the present evaluation to determine if this was due to some activities being implicit in work carried out and not clearly reported on, or activities not being carried out due to difficulties and challenges.

Compliance with the Ministry's reporting requirements	• *Planning processes and use of the public health work plan template*
	   o There was minimal distinction between one purchase unit and another when planning public health projects. Planning focused on wider projects that contributed to outcomes that met contract requirements of several purchase units.
	   o Although a majority of staff reported that their organisation was effective in submitting public health work plans, some commented on the work plan's limitations.
	   o Submission of work plans was variable in terms of timing, and completion of different sections varied across providers.
	   o The work plan template was often used for reporting, rather than for planning.
	   o A separate planning template could be developed providing clearer terms to guide activity or project planning. This planning template could also require additional clarity, when a particular project relates to more than one public health service.
	
	• *Six-monthly progress reports*
	   o Staff reported that their organisations were effective in meeting the Ministry's progress reporting requirements. However, progress reports on public health services varied in terms of breadth, format (in using the Ministry's templates) and clarity (in connecting activities and outputs with purchase unit descriptions and outcomes).
	   o The current work plan template could be adapted into a reporting template, as it appeared to guide providers in thinking about their projects using a logical framework. Such reporting could lead to a greater level of clarity, particularly the connections between activities, outputs and outcomes.
	   o Improvements to reporting templates use among providers could be achieved by supplying reporting examples. A *Public Health Service Practice Requirements Handbook*, similar to that presently available for intervention services, could be developed where such reporting examples could be included, alongside descriptions of services, logic models and success indicators.

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[4] This and other verbal quantifications (i.e. implied numbers such as "some" or "most") throughout this report should be interpreted with caution because of the limitations in the primary data (i.e. providers' six-monthly progress reports) used for the PGPH services component of this evaluation (see section 2.3.2 for details).

Innovativeness	• Staff reported that their organisations were effective in developing innovative approaches for delivering public health services. However, their descriptions of innovative activities overlapped with those required in their service specification. • Nevertheless, a few examples of proactive approaches noted in providers' reports contained elements of innovation. • Descriptions of aspects regarded to be innovative could be made more explicit in providers' reports.
Community engagement	• Providers reported community engagement in the delivery of all five public health services. • Community engagement was a strength as such engagement was often associated with successful outcomes such as community involvement in public health activities and joint-organisation of events. • In some cases, community members subsequently took over leading roles and ongoing project work suggesting long-term sustainability of the outcome of community involvement. The inclusion of a sustainability element as an objective in other Problem Gambling Public Health (PGPH) services could lead to planned outputs that lead to increases in voluntary involvement of community in gambling harm minimisation.
Use of strategic communication for stakeholder engagement	• Despite challenges, all providers successfully collaborated with a broad range of stakeholder groups, which suggested a strength in terms of their commitment and perseverance. • Some provider reports indicated specific communication approaches and strategies used or learned from stakeholder engagement processes. • The sector could benefit from a formal documentation of challenges in engaging stakeholders, and mitigating strategies and approaches. Such documentation could enable a greater level of information sharing on established approaches.
Cultural responsiveness in delivering public health services	• Staff views and culture-appropriate approaches documented in providers' reports suggested that providers were effective in delivering services in ways that were culturally appropriate. • Most Māori and Pacific providers reported explicit examples of cultural approaches in delivering public health services. • There was a lack of explicit examples of public health cultural approaches designed to suit Asian clients. A greater depth in reporting would be required to gain further clarity on health promotion approaches that meet the unique needs of Asian clients.
Materials developed/ used in delivery of activities	• For some purchase units, there was the need to develop new resources, adapt existing materials or reproduce materials in appropriate languages to enable service delivery. • The efficiency of this input area could be enhanced by eliminating the need for providers to "reinvent the wheel". Presently available language and culture-specific resources (i.e. those that have been developed or translated) could be built upon and made available nationally through a formal system of resource sharing and exchange.
Providers reporting of successes in delivering activities	• Providers reported successes and challenges in delivering the five purchase units. • However, the majority did not explicitly report against the indicators listed in the *Purchase Unit Descriptions*. The reasons behind this may be worth exploring.

	• Future development of logic models could consider some of the success indicators identified by staff, which may lead to the development of measurable indicators.
Delivery of public health activities	• Key areas of input mentioned in providers' reports included staff knowledge development, time insufficiency, and the need to develop new resources.

• Key areas of input mentioned in providers' reports included staff knowledge development, time insufficiency, and the need to develop new resources.

• All providers' included aspects of relationship development with stakeholders and other PGPH service providers in their reports.

• Education and awareness raising was a service aspect reported for all five purchase units. Assessments carried out by some providers showed impact on knowledge and increased stakeholder willingness towards participation in the advocated activity or project.

• Providers' reporting indicated that some public health activities have the capacity to result in outputs for several purchase units.

• *Policy Development and Implementation*
   o To encourage the development and implementation of *workplace and organisational gambling policies*, some providers used a number of different strategies. However, reports contained little explicit evidence of awareness-raising focused on *gambling-policy relevance to the core business of targeted sectors*.
   o Very few providers reported examples of successful development of *policies on non-gambling fundraising*.
   o *Public policy* support included the Gambling (Gambling Harm Reduction) Amendment Bill and the Gambling (Class 4 Net Proceeds) Regulations 2004.
   o The larger area of policy focus was in relation to *Class 4 venue policy* and the associated "sinking lid" approach to pokie machine numbers.
   o The majority of reports did not contain explicit evidence of participation in, or contribution towards, *gambling harm social impact assessments*.

• *Safe Gambling Environments*
   o While all providers supported the development of gambling venues' *host responsibility measures*, and a few reported on improvements to multi venue exclusion processes, there was limited evidence of *monitoring and following up on venues' practices* and support for venues' *harm minimisation policies*.
   o Reports also contained limited evidence of activities *enabling collaboration between gambling venues and other organisations*. Less than half of staff members indicated the effective delivery of this activity.

• *Supportive Communities*
   o Providers' *identification of community strengths and protective factors* were not always evident in reports.
   o Some providers used specific approaches to purposefully encourage *public discussion and debate on gambling harms* and on the *ethical perspectives of gambling funds*.
   o Providers used a number of approaches to support *culturally appropriate resiliency building* through community partnerships.
   o Some providers reported community involvement in related activities and increased knowledge about gambling harms.
   o Providers appeared more successful in developing community initiatives than media initiatives for *promoting family and community connectedness* and *positive leisure and entertainment opportunities*.

- o *Key groups' access to evidence-based community action approaches for reducing gambling harm* was ensured through a range of channels and approaches.
- o Providers appeared less successful in ensuring *key groups' access to evidence based-approaches to monitoring and controlling licensing of gaming venues*.
- o There was limited evidence of success in providing a *point of public contact for raising issues on public health approaches* and *improving public awareness of avenues for complaint regarding public health approaches*. This purchase unit description requires further clarity.

- • *Aware Communities*
  - o Preliminary steps included delivering *awareness-raising* presentations and training on brief screening.
  - o While it was not possible to determine from providers' reports if they *maintained an awareness of other social marketing campaigns*, a few providers reported attempts to support inclusion of problem gambling as an issue in such campaigns led by community groups.
  - o A number of providers supported community and youth-led *culturally relevant awareness-raising initiatives*.
  - o The media and other awareness-raising initiatives were used to *raise public awareness* and *encourage public discussion and debate* on the harms of gambling.
  - o There was limited evidence of *monitoring and responding to public media discussions on gambling or problem gambling* in providers' reports.
  - o While providers' *educational initiatives* were likely to have included the *health and social risks of gambling,* there was less evidence of content that included *knowledge about gambling odds*, *risk-taking* or *dealing with risky gambling situations*.
  - o Providers believed their awareness-raising efforts led to increased public understanding of gambling harms.

- • *Effective Screening Environments*
  - o While most providers discussed their own collaborations with stakeholder groups, very few gave evidence of facilitating *cooperation or coordination between key stakeholder organisations*.
  - o *Raising awareness of the relevance of screening and referral practices to the core business of target sectors* was not strongly featured in reporting, but may have been implicit in the work carried out with stakeholder organisations.
  - o A few providers enabled *screening and referral practices* among targeted stakeholder groups, with some reporting *monitoring and follow-up* initiatives.
  - o Some providers reported initiatives to increase stakeholder organisations' awareness of the *availability of their problem gambling intervention services*.

Delivery of Brief Interventions at

- • Providers often reported having carried out brief screening at public health events and during health promotion activities.
- • CLIC data trends showed peaks in *Brief Intervention* client numbers in March[5], which could be associated with Pasifika Festivals; in September, with

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[5] These trends are based on the total number of clients who accessed a service at least once in each respective month, thus cannot be used to estimate number of clients in a year (see section 2.3.5 of the report for further details).

public health activities	annual *Gamblefree Day;* in August, with Matariki festival; and in November, with White Ribbon Day.
	• An accurate assessment of *Brief Interventions* would require clear documentation of the number of brief screens, and the extent to which subsequent *Brief Intervention* activities were delivered in the different settings of public health activities.
Impact of public health promotion activities on help-seeking behaviour	• Some staff reported minor increases in help-seeking behaviour following major public health campaigns and public health activities at local events and festivals.
	• The data collected from the client survey was insufficient to determine the extent to which providers' interactions with community members at public events or festivals triggered help-seeking behaviour.
	• A detailed analysis of impacts would require the collection of more specific data.

Other Key Findings and recommendations

Problem gambling terminology	• Some providers' refrained from using the term "problem gambling" in public health messages and when interacting with individuals at risk. Other providers reported the difficulty of getting stakeholders to understand gambling harms and recognise "problem gambling" as a public health issue; with some attributing this difficulty to the hidden harms of gambling.
	• The use and implications of alternative terms in public health messages requires careful consideration. An elimination of (or adjustment to) the term "problem gambling" would require deliberation between the Ministry, providers, and the HPA and would need to take account the views of the public. Implications for wider communication will also need to be considered as removal of the term "problem gambling" also means a diversion from a long established, and internationally used terminology.
Political neutrality expectations	• Further clarity (and examples) on activity aspects where providers are required to adhere to the principles of political neutrality and approaches for handling risky situations, could enhance public health service delivery. This is considering some providers' difficulties in carrying out some activities that they believed would be perceived as not being politically neutral.
Overlaps in PGPH Purchase Units Descriptions	• Activities and expected outputs in the Purchase Units Descriptions of some PGPH services were somewhat similar.
	• Such overlaps had repercussions on the reporting of activities and consequently on the present evaluation concerning activity outputs. The analysis found that often a single activity was reported for more than one purchase unit. Future evaluations of public health services would need to take account of such overlaps, particularly if individual evaluations of the five PGPH services are required.
	• Overlaps also suggested a need for a greater level of planning which builds in processes that ensure a greater level of efficiency in time and resource use when delivering activities. While providers may have been doing this as a matter of course, a proactive planning of activities that considers overlaps can increase efficiency.
Collaboration between PGPH service providers	• Measurement of public health outcomes could incorporate "shared success" as an indicator. Such shared success was observed in the present evaluation as providers often collaborated with other PGPH service providers when delivering public health activities.
	• Such collaboration offered the advantage of publicly exhibiting a common goal in the push for a problem gambling public health focus, and enabled wider

geographical reach, joint organisation of events and sharing of knowledge and resources.

- To enable a greater level of cost effectiveness, purchase units could be restructured to shift the focus to wider public health projects. Multiple providers could then jointly purchase the project contracts to deliver services in a collaborative manner. This would be particularly useful for national and regional type projects such as national awareness campaigns and regional policy advocacy.

Understanding and use of success indicators within a logical framework of public health service delivery

- In describing success indicators for the five PGPH services, staff tended to focus on one indicator category (activity, output or outcome), suggesting varying perceptions about the most important measures of service delivery.

- To move towards a logic model framework for delivering services, providers first need to have a clearer and consistent definition of success for public health services that is shared across the sector.

- Providers could benefit from detailed logic models that identify the linear process of inputs, outputs, outcomes and impacts for specific activities while identifying areas of overlap with other public health activities and intervention services[6].

Measurement of outcomes (evaluations of public health services)

- Some providers' proactive efforts in carrying out activity evaluations and use of informal methods to make evaluative judgements was a strength that could be further built upon. Evaluation instruments established by providers' could be compiled and collectively developed prior to being made available as evaluation templates that all providers could use.

- At present, there is a lack of rigorous collection of public health outcomes data. In their current state, the public health six-monthly progress reports are insufficient for evaluating long-term outcomes. This, in combination with a dearth of formal evaluations in the literature, means a lack of research-informed decision-making in the implementation of public health services. There is a need for efficient methods for monitoring and evaluating Ministry-funded PGPH services in a way that could enable accumulation of evidence, linking service outputs with health and wellbeing outcomes. The following could be considered:

  o Establishment of sets of input, output, outcome and long-term impact indicators through the development of detailed logic models. These indicators could serve as measures of change.

  o Ongoing monitoring of outputs and documentation of short-term outcomes could be conducted to gather evidence on changes or improvements that take place immediately following public health activities. Such evidence, in turn, may serve as a baseline for gauging resultant longer-term impacts.

  o A more standardised format of progress reporting. Following a similar concept to the CLIC database, a database for collecting public health services data could be developed. Alternatively, comments from providers could be collected using common online data collection software such as *SurveyMonkey*. The collection of providers' progress in a more structured format would provide more reliable and readily analysable data. The collection of information using a standardised tool (as opposed to individual provider reports in variable formats) would ease the Ministry's monitoring process, and lessen the time required for collation of key trends and progress across providers. Such a system would also provide more useful data for longer-term evaluations.

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[6] Draft logic models for each public health activity are provided in the respective sections in Chapter 5 of this report.

1   Introduction

As part of its strategy to prevent and minimise gambling harm, the Ministry of Health (the Ministry) funds problem gambling public health (primary prevention) and intervention services (secondary and tertiary prevention) in New Zealand. The Ministry contracts providers who deliver either intervention services or public health services as well as providers who deliver both. Funding is essentially through purchase of services (termed 'purchase units') from the Ministry, for delivery to clients and communities (Ministry of Health, 2010).

The Ministry funds five types of intervention services: (1) *Helpline and Information Services*, (2) *Brief Intervention Services*, (3) *Full Intervention Services*, (4) *Facilitation Services*, and (5) *Follow-up Services*, recognising the diverse situations and points of readiness to change people with gambling problems are at in their lives. Five types of public health services provide additional support for communities: (1) *Policy Development and Implementation*, (2) *Safe Gambling Environments*, (3) *Supportive Communities*, (4) *Aware Communities*, and (5) *Effective Screening Environments*. Public health services take a preventative approach to reducing or minimising gambling harm through awareness raising, policy development and implementation, and through health promotion.

As shown in Figure 1, in addition to direct funding support from the Ministry, a *National Coordination Service* provides coordination support and *National Workforce Development Services* provide training and capacity building for these intervention and public health services (Ministry of Health, 2008b). Details of these services are available in the Ministry of Health's (2008b) *Intervention Service Practice Requirements Handbook* and the Ministry of Health's (2010) *Service Specification* document.
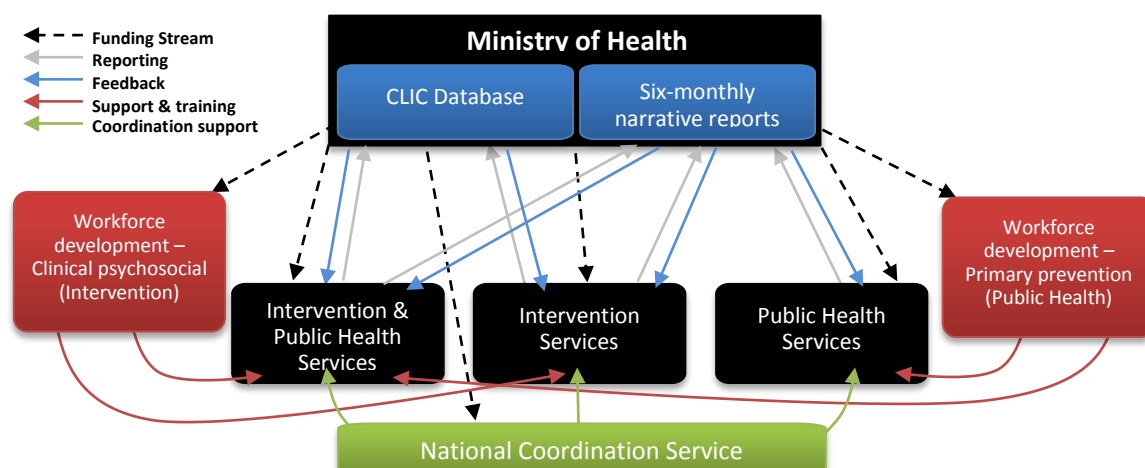
Figure 1: Problem gambling intervention and primary prevention public health services in New Zealand

The overarching objective of the present evaluation and clinical audit was to identify the effectiveness of the above Ministry-funded problem gambling intervention and public health services (i.e. if providers were achieving what they were contracted to achieve). The focus of the project included elements of cultural practice, service delivery and quality, data management, and service-user perspectives. The three individual aims of the project were to:

1. Conduct a process, impact and outcome evaluation of problem gambling intervention services
2. Conduct a process, impact and outcome evaluation of problem gambling public health services
3. Conduct a clinical audit of problem gambling intervention services

The Ministry of Health contracted the Gambling and Addictions Research Centre, AUT University to conduct the project. The first two aims of the project involved secondary analysis of Ministry of Health data over a three-year period for all funded intervention and public health service providers as well as a more detailed evaluation of eight selected providers. This part of the project was conducted by the Gambling and Addictions Research Centre. The third aim was achieved through the audit of eight selected intervention providers (the same providers that underwent the detailed evaluation); this part of

the project was conducted by KPMG who was commissioned to undertake this work by the Gambling and Addictions Research Centre.

Due to the quantity of data obtained for this project, there are two supplementary reports to this report that detail more fully what is described more briefly in this report.

- *Supplementary Report No. 1 - Evaluations of Problem Gambling Intervention and Public Health Services: A Review of Literature.* This supplementary report contains an overview of problem gambling intervention and primary prevention public health services in New Zealand. It is followed by a review of literature that focuses on previous evaluations of different types of public health services that have been reported nationally and internationally. The final section of the review provides a discussion on the methodological aspects and other relevant findings that are of interest to the present evaluation.
- *Supplementary Report No. 2 - Evaluation of Problem Gambling Public Health Services: An analysis of service providers' progress reports*. This supplementary report provides a summary of findings from a document analysis of existing public health activity data (sets of six-monthly narrative reports submitted by 20 problem gambling public health service providers to the Ministry of Health) between the period July 2010 and June 2013.

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2 Evaluation Methodology and Audit Process

This chapter details the processes undertaken to ensure ethical processes were followed in the collection of data from eight Ministry-selected Problem Gambling Service Providers[7] (hereinafter, eight selected providers). This is followed by details on steps taken to ensure a culturally sensitive evaluation approach; the methodologies used for the evaluation; and finally, the approaches used for the clinical audit.

2.1 Ethical considerations

The researchers submitted applications for ethical approval to the AUT Ethics Committee (AUTEC) prior to conducting the clinical audit, staff and client surveys, and staff focus group interviews with the eight selected providers. AUTEC is a human ethics committee accredited by the Health Research Council.

The applications to AUTEC included all participant materials (i.e. information sheet and consent form) and data collection materials (e.g. questionnaires, interview protocols). AUTEC applied the following principles in its decision making to ensure a high level of research ethics:

Key principles:

- Informed and voluntary consent
- Respect for rights of privacy and confidentiality
- Minimisation of risk
- Truthfulness, including limitation of deception
- Social and cultural sensitivity including commitment to the principles of the Treaty of Waitangi/Te Tiriti O Waitangi
- Research adequacy
- Avoidance of conflict of interest.

Other relevant principles:

- Respect for vulnerability of some participants
- Respect for property (including University property and intellectual property rights).

Appendix 1 contains AUTEC approvals for the clinical audit, surveys and focus group interviews.

To ensure compliance with the above research ethics principles, the researchers and auditors took the following measures to protect the identity of all individual participants and problem gambling service providers:

- The surveys did not request respondent names; the audit did not make records of information that could identify clients

- Codes allocated to providers in presentation of findings from the CLIC database protected their identities

- All qualitative survey data, focus group interview notes, and extracts from providers' progress reports underwent a de-identification process where individual names, background details, organisation names, and location (which may have indirectly identified service providers) were removed. The de-identification process also included the removal of some ethnic specific terms that may have inadvertently identified problem gambling service providers. Rewording of responses and data merging (presenting collective sets of responses provided by more than one respondent) was also used as a method in the de-identification process.

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[7] A joint letter from AUT and KPMG was sent to the eight providers on 11 April 2014 informing them that their organisation was selected to participate in the evaluation and audit.

KPMG clinical auditors informed client participants about their right to decline answering questions or withdrawing from interviews. AUT researchers informed all participants that partaking in the evaluation was voluntary and that they could withdraw at any time, prior to the completion of data collection. Additionally, consultation meetings between the researchers and the eight participating providers included discussions on measures to ensure staff and client confidentiality and conformance to ethical requirements.

A concern expressed during the consultation meetings, about being individually evaluated as a service, was addressed. Providers were reassured that data would be presented collectively, and that all data would undergo a de-identification process. The researchers clarified that the aim of the evaluation was not to compare or evaluate the performance of individual service providers, but rather to provide evidence on the effectiveness and/or impact of problem gambling services in general.

2.2   Cultural sensitivity

Cultural safety, integrity and appropriateness were key considerations throughout the evaluation process. As noted above, among others, AUTEC's expectations are that all AUT researchers ensure high levels of social and cultural sensitivity in the design and implementation of research and evaluation work. The need for culturally sensitive approaches becomes especially important when research or evaluation is conducted within communities of diverse cultures (Butler and Molidor, 1995; Tillman, 2008). As the present evaluation concerned a diverse range of community sectors including European, Māori, Pacific and Asian people, the researchers undertook several measures to ensure a culturally respectful evaluation process.

First, the project established a Cultural Advisory Group comprising expert Māori, Pacific and Asian representatives. The first consultation took place at the preliminary stages of the evaluation project on 3 December 2013. The Advisory Group made recommendations and provided advice on approaching and working with Māori, Pacific and Asian service providers and clients when carrying out audits. They also provided advice on the design of evaluation tools to ensure that the tools were culturally sensitive and items were meaningful and appropriate for all potential participants.

The researchers presented the Cultural Advisory Group with drafts of the client and staff questionnaires prior to the second meeting on 11 April 2014. Discussion focused on questionnaire wording and appropriateness of particular terms; for instance, that the term "counsellor" may not be familiar to all clients. In some cultures, counselling received could be seen as simply receiving help or support; the need for a broader definition was identified. The Advisory Group also recommended the simplification of other technical and clinical terms used in the client questionnaire. Another point concerned cultural differences in the concept of time. For some clients, a 'brief' intervention may not necessarily be similar to the definition within the Ministry's service specifications. As a result, *Brief Interventions* were referred to as "the very first conversations" with someone from a gambling support service and details concerning time frames were removed from the client questionnaire.

The final meeting with the Cultural Advisory Group on 5 December 2014 was to obtain comments on key findings of the evaluation, particularly those concerning cultural aspects. Their discussion included possible reasons behind some observations, key points to consider in interpreting the data, and recommendations in response to some culture-related findings.

As a second step, to establish whanaungatanga (a reciprocal relationship) with providers, the researchers ensured a consultative research process, recognising that in addition to developing a shared evaluation purpose, tohu (advice, recommendation and guidance) offered by providers enables researchers to gain a clearer understanding of providers' perspectives and the context of their service and clients. This is instrumental for evaluation design and implementation. The researchers invited five service providers (selected by the Ministry) to comment on drafts of the staff and client surveys. One client representative was also included in this consultation process (an initiative undertaken by one of the providers). Comments sought from providers included the cultural appropriateness of the instruments within the context of their staff and client base. Providers identified the need for simpler language, the removal of technical terms, changes to rating scales, and shortening the client questionnaire. Considering that

"counselling" was not an appropriate term for some cultures and not used in some ethnic-specific services, service providers were simply referred to as *gambling support services* in the client questionnaire. Providers' feedback also led to the removal of the term "problem gambling" from the client questionnaire amongst other changes. The researchers sent revised drafts back to the providers for final comment prior to finalising the questionnaires.

Mindful of the value of kanohi ki te kanohi (face-to-face) contact, as a third step, prior to conducting the surveys, the eight selected providers were offered face-to-face consultation meetings to discuss their participation and role in the evaluation[8] ensuring open, supportive and constructive conversations between the researchers and providers. For two providers, who declined face-to-face meetings, consultation was carried out through telephone and email conversations. Discussions included logistics around how to conduct the evaluation to maximise participation of staff as well as culturally respectful methods for client recruitment and participation. The response from some providers about the cultural appropriateness of face-to-face interviews rather than surveys and the need for evaluation instruments in multiple languages was acknowledged. The researchers acknowledged that the exclusion of some clients because of language limitations would mean that the survey would be based on a non-representative sample of English-speaking clients.

As a fourth step, the evaluation process also drew on tikanga Māori values for welcoming and hosting participants. The focus group interviews started and ended with a karakia (prayer) undertaken by Māori and Pacific participants. All participants were offered hospitality, through appropriate mihi (greetings) and the sharing of kai (food). Participants were also offered a koha (in the form of a petrol voucher) in appreciation of their time and sharing of information. Manaakitanga (wellbeing) was ensured by the research team through these processes.

In general, the evaluation benefitted from ongoing engagement with the Ministry of Health, the Cultural Advisory Group and the eight selected providers to establish a clear, shared understanding of the goals, objectives, activities and outcomes of the intervention and public health services. Additionally, the consultative process with these stakeholder groups has ensured a clear understanding of their interests and expectations.

2.3 Mixed-method evaluation approach guided by a logical framework

The overarching objective of the project was to identify the effectiveness of Ministry-funded problem gambling intervention and public health services (i.e. if providers were delivering expected services and achieving intended objectives). To meet this objective, the evaluation used a structured and systematic approach to gather, analyse and report data to support effective decision-making, and to inform service development and improvement.

When considering methodologies for problem gambling treatment outcomes, Blaszczynski (2005) argued that well-designed randomised controlled trials using validated outcome measures are required to assess long-term outcomes. However, an initial literature review for this project found that not all evaluations in related fields employed controlled experimental designs. This is understandable considering the practicability of this method in real world settings. Even so, many of the evaluations reviewed used pre-treatment and post-treatment data to measure impacts and outcomes of a programme, often using a broad range of instruments to measure multiple outcomes.

Compared to evaluations of specific interventions (detailed in Chapter 4), there is a paucity in evaluation literature on national or state level multimodal gambling treatment programmes and services. There are even fewer published evaluations on problem gambling public health programmes and services. Nevertheless, a number of state level evaluations from the United States (Bernhard, Abarbanel, Crossman, Kalina & St. John, 2009; Shaffer, LaBrie, LaPlante, Kidman, & Donato, 2005; Stinchfield & Winters, 2001; Stinchfield, Winters, & Dittel, 2008) and a few national and state-level evaluations

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[8] Prior to this, the research team had presented a summary of the evaluation objectives and responded to providers in a Q&A session at a Provider Briefing (28th March 2014) that was open to all problem gambling service providers.

from Australia were noted (Australian Government Productivity Commission, 2010; Evolving Ways, 2005; Thomas & Jackson, 2001; Victorian Responsible Gambling Foundation, 2012). These broad scope evaluations of state/government funded treatment programmes and services tended to use a range of evaluation approaches including experimental methods (using gambling screens and client satisfaction scales) and longitudinal evaluations. They were often informed by reviews of relevant literature and used a range of data collection methods and data sources such as: client, significant other, and treatment staff questionnaires; analysis of client databases; analysis of counselling services data on problem gambling severity (DSM-IV); computer-assisted telephone interviews to gain quantitative and qualitative data on clients' experiences of services; clients' self-evaluation of their own improvements and recidivism; retrospective client surveys; prospective client surveys; one-on-one interviews with clinicians; small group-based discussions with personnel; interviews with service users; and, inclusion of open-ended questions for collection of important details that cannot be captured with quantitative data alone.

Considering the above, the present evaluation employed a mixed-methods approach. The use of a mixed-methods approach is appropriate in this context as its purpose is to provide support for the improvement of programmes as they develop, and assess their effectiveness at appropriate times (Stufflebeam, 1999). Mixed-method approaches employ both quantitative and qualitative methods to gain "dependable feedback on a wide range of questions" and "depth of understanding of particular programs" (Stufflebeam, 1999, p. 28). Evaluators use quantitative methods for larger data sets to ensure standardised and replicable findings. Qualitative methods are used to gain clarity on, among others, a "program's cultural context", its underlying forces, emerging "patterns and themes, deviant cases" and the diverse affects on individuals and groups (p. 28). "By using both quantitative and qualitative methods, the evaluator secures cross-checks on different subsets of findings and thereby instils greater stakeholder confidence in the overall findings" (p. 28); an approach also referred to as *methodological triangulation* (Jack & Raturi, 2006; Mathison, 1988) in the literature.

In the analysis and reporting process, triangulation is used to compare and contrast findings from the various data sources obtained using the multiple methodologies. A greater level of confidence in the findings is offered when a particular observation is evidenced through more than one data source. However, different data sources that show conflicting findings may mean differing perceptions, lack of consistency or lack of clarity, which in turn may highlight areas that require improvement.

While it was acknowledged that the effectiveness of individual gambling treatment services and interventions are best ascertained through rigorously conducted effectiveness studies (randomised controlled trials) (Westphal & Abbott, 2006), an evaluation that includes processes, outcomes, and impacts of services offers indications of optimal approaches and identifies successful strategies and areas for improvement (Bellringer *et al.*, 2009, p. 5). Furthermore, the inclusion of public health services in the present evaluation necessitated the inclusion of non-experimental evaluation methods.

This evaluation was based on a logical framework of service delivery. Part of the rationale for evaluating services is to ensure that they are doing what they intend to, as services do things to realise a goal, use a plan and apply techniques as part of a process in a chain of activities - a 'causal chain' (White, 2009), or what is sometimes called a 'logic model' or interchangeably as 'programme theory' (Curnan, LaCava, Sharpsteen, Lelle, & Reece, 2004). The logic model is the theory behind how an intervention will work, i.e. the logic used to explain the model from the start of an organisation's goals and activities, to its end, which is the intervention's impact on clients. The use of a programme theory-based evaluation clarifies the questions, indicators and assumed linkages between, and among, the elements of a programme that should be central to the evaluation (Stufflebeam, 1999).

The evaluation also considered external factors that affected service delivery. Delivery of services within the public arena may be subject to external factors and contexts that are not within the control of service providers. "The real time and context between activities and outcomes means many external issues… have the potential to influence the outcomes" (Knowlton & Phillips, 2013, p. 58). Therefore, an important aspect of service evaluation includes:

> …the identification and description of key contextual factors external to the program and not under its control that could influence its success either positively or negatively. It is important to examine

the external conditions under which a program is implemented and how those conditions affect outcomes. This explanation helps clarify the program "niche" and the assumptions on which performance expectations are set (McLaughlin & Jordan, 1999, p. 66).

Acknowledgement of external factors suggests a service model that is open to modifications and responsive to the dynamics and changeability of environmental contexts. Identification of external influences may also inform areas for improvement in service delivery. Documenting external influences such as "the social, physical, political, and institutional environments that can influence outcomes helps to improve the program planning process" as this provides evidence on useful partners and collaborators, evaluation measures that can accurately reflect outcomes, and other areas of input needed to address the issues at hand (McCawley, 2002, p. 4). Additionally, identification of external factors in the present evaluation may also inform the development of future evaluations that include a plausibility assessment, which provides a higher level of assurance that observed changes are in fact a result of the services delivered, by ruling out external factors that may have caused the observed changes (Habicht, Victora & Vaughan, 1999).

In brief, the present evaluation employed a mixed-method approach and was largely guided by a logical framework which captured the key inputs and processes, outputs, and outcomes or impacts. Service inputs were evaluated in terms of how they affected, or translated to, outputs. Service outputs were evaluated in terms of how effectively and/or the extent to which Ministry-recommended activities were carried out. Service outcomes were based on the extent to which these activities resulted in the intended changes, improvements or impacts. The evaluation examined service delivery relative to the Ministry's objectives and expectations and compared services to international best practice. The evaluation also documented possible external factors that can influence service outcomes, ways to improve services by identifying areas that are working well and areas where improvement may be beneficial.

The evaluation process comprised: (1) a review of literature to inform the development of evaluation methods and to identify best practice for each intervention and public health service; (2) a document analysis of providers' progress reports; (3) surveys of staff, clients and allied agencies of eight Ministry-selected providers; (4) a focus group discussion with staff of the eight selected providers; and (5) an analysis of the Ministry's Client Information Collection (CLIC) database. The following sub-sections detail the methods used for each of these evaluation components.

2.3.1 Literature review

The objective of the literature review was to provide a summary of relevant information that can inform the current work by drawing from nationally and internationally reported evaluations of gambling harm minimisation services. More specifically the literature review intended to inform decision making around the methodology used for the present evaluation and to inform development of best practice for each intervention and public health service of interest to the Ministry. Additionally, the intent was to enable a comparison of New Zealand services to international best practice, thus providing an extra layer to the overall evaluation.

To achieve this objective, the researchers reviewed available national and international literature including peer-reviewed journal articles and reviews (from both subscription-based and open-access journals), book chapters and government research reports. Literature was compiled using several electronic databases (EBSCO Megafile, ProQuest Central and Web of Science), the AUT University library catalogue, and the search engine, Google, using multiple combinations of key words and search terms as shown in Figure 2 below. The search was conducted between 1 August and 11 November 2013.

Figure 2: Keywords, phrases and subject categories used in the search process

The second step was a focused search on evaluations reported in the following primary journals related to gambling: *International Gambling Studies, Journal of Gambling Issues, Journal of Gambling Studies, Asian Journal of Gambling Issues and Public Health* and *International Journal of Mental Health and Addiction.* While the focus was on sources that directly related to problem gambling, selected articles on equivalent areas such as alcohol, drug and tobacco use were also included. Additional to evaluation literature, this review also includes highlights selected non-empirical papers that were highly relevant to the discussions around the respective intervention or public health service and that were regarded to be useful for the current evaluation.

To ensure that the literature review was relevant to contemporary society and captured the most recent developments, articles published between 2002 and 2014 were prioritised. However, an exception was made for highly informative literature that directly related to evaluation of problem gambling interventions and literature on methodology.

The most relevant findings from the literature are summarised under the respective sections that relate to the different intervention and public health services in Chapters 4 and 5. A synthesis of the literature on methodology has been included in the preamble to this section. Fuller details are available in a supplementary report (*Supplementary Report No. 1 - Evaluations of Problem Gambling Interventions and Public Health Services: A Review of Literature*).

2.3.2   Document analysis (six-monthly public health progress reports)

"Document analysis" - an organised process of reviewing and evaluating sets of relevant documents, was used in combination with other methods in this evaluation, offering a means of triangulation of data sources (Bowen, 2009). The documents selected for this evaluation were sets of six-monthly narrative reports (i.e. progress reports) submitted to the Ministry by 20 problem gambling public health (PGPH) service providers between July 2010 and June 2013. These amounted to over 100 reports ranging between 12 and 100 pages in length. Despite some limitations discussed below, these progress reports were a rich source of data that formed a key component of this evaluation. The reports offered:

1. Background information, historical insights and the context within which providers operated

2. Historical data that informed the development of essential evaluation questions to be included in the survey and focus group interview

3. Supplementary data which provided "valuable additions to a knowledge base" particularly in the form of best practice examples and a record of areas for improvement

4. A way for "tracking change and development" over time through an analysis of progress reported on specific projects and activities

5. "A way to verify findings or corroborate evidence from other sources" (Bowen, 2009, p. 29-30).

Although an evaluative approach based on providers' work plans was proposed, a preliminary review of the reports found that providers did not have a clear or consistent way of submitting annual work plans together with their progress reports (see Section 3.10 for details). The lack of a logical time order in work plan submission meant that an evaluative approach based on the work plans was neither reliable nor feasible. Instead, the evaluative approach used here was based on the extent to which providers delivered activities and followed processes as detailed in each Purchase Unit Description offering a preliminary indication of the degree of providers' compliance and their successes in achieving intended outcomes.

Bowen's (2009) recommended method for document analysis (an integration of thematic analysis and content analysis) was used. The thematic analysis component used here was similar to the process used for analysing other types of qualitative data; the documents were read and re-read by the researchers to identify relevant themes. Themes were identified based on their relevance to objectives, activities and processes detailed by the Ministry in each specific Purchase Unit Description. The coding and category construction process was carried out largely using a deductive approach (also referred to as theoretical thematic analysis) as the evaluation was concerned with fitting the data with specific evaluation aspects.

The analysis process involved reading selected sections of the reports (the overall narrative report sections, the Purchase Unit specific sections and relevant activities reported in the work plan template) and identifying input, output and outcome aspects that matched the Purchase Unit Descriptions. The analysis also focused on identifying the range of activities carried out, the range of stakeholders engaged, procedures used, successes reported in the form of outcomes or indicators, as well as barriers and challenges.

Although the quantitative content analysis method used to identify frequency of themes across the data set (i.e. total number of providers contracted to deliver a particular PGPH service) may indicate theme prevalence and thus (presumably) importance, this is not the intention of the use of counts in the present report given the limitations of this data set as detailed in Section 2.3.6. In the present analysis "the 'keyness' of a theme is not necessarily dependent on" a theme's frequency "but rather on whether it captures something important in relation to the overall" (Braun & Clarke, 2006, p. 82) evaluation question.

In the present report, key findings from the document analysis that were of relevance to general areas of inputs and operational processes were integrated with other data sources in Chapter 3, those directly related to the five Public Health Services are presented in the respective sub-sections in Chapter 5. The full range of findings from the analysis of providers' progress reports, which includes appropriate extracts from service providers' reports, is submitted as a supplementary report (*Supplementary Report No. 2 - Evaluation of Problem Gambling Public Health Services: An analysis of service providers' progress reports*). The supplementary report also provides further details regarding the limitations of this component of the evaluation.

2.3.3   Surveys (Staff, Clients and Allied Agencies)

This component of the evaluation involved eight Ministry-selected Problem Gambling Service Providers. The eight providers represented varying geographical areas (urban and rural areas) and included both general service providers (national providers) and ethnic-specific service providers focusing on Māori, Pacific and Asian client groups.

Questionnaire development

Considering the value of providing a more distinctive evaluation for the four types of intervention services, *Brief Interventions*, *Full Interventions*, *Facilitation Services* and *Follow-up Services*, and to enable comparison of findings between different informant groups, the staff, client, and allied services questionnaires used in the earlier 2009 and 2010 evaluations were reconstructed; retaining or adapting some general items. These changes did not remove the advantage of information continuity or the ability to make relevant comparisons across time, as the key aspects from the previous evaluation were retained.

In the **Staff Questionnaire**, questions relating to intervention services were based primarily on the Purchase Unit Descriptions and findings from the previous evaluations. An additional section on the five public health services was included in the revised staff questionnaire. Questions relating to public health services were based on the respective Purchase Unit Descriptions and findings from a document analysis of providers' reports (described in subsection 2.3.2).

The **Client Questionnaire** was reconstructed, with separate sections to enable an assessment of their experience of the four types of intervention services, additional to other aspects such as general background information, primary gambling mode and satisfaction with services.

The allied services questionnaire (termed "**Support Services Questionnaire**") was redesigned to contain separate sections on working relationships, *Facilitation Services* activities and processes, outcomes for clients, and outcomes for the allied services. Provider-supplied lists of allied services comprised three categories of organisation types: (1) in-house community support services which were part of the same wider organisation as the problem gambling service provider, (2) external community support services such as community law centres and budgeting services, and (3) casinos, hotels, restaurants and bars (i.e. businesses that provide gambling services which may have necessitated *Facilitation Services* that supported self-exclusions). Considering the three distinct categories of allied services, a category identifier question was included in the "Support Services Questionnaire". The more generic term "allied organisations" is used in this report to describe the sample in the present evaluation when it includes both gambling venues and allied health and social community support services.

All three questionnaires were semi-structured containing both closed and open-ended questions enabling the collection of quantitative and qualitative data. In most instances, an "Other (please specify)" option was included in lists of categories following closed questions acknowledging that the identified categories were not exhaustive, and providing space to capture any new or alternative perspectives that respondents may have had.

As detailed in Section 2.2, the questionnaire development included consultation with a Cultural Advisory Group and five Ministry-selected providers.

The questionnaires were available online (via Survey Monkey) and in hard copy (Appendix 2). While clients were provided the option of completing the survey online, on paper or via telephone, staff respondents were encouraged to use the online format. Staff of allied organisations were invited to complete the survey online with hard copies were posted out on request.

Participant recruitment (non-probability sampling)

The staff survey was based on a non-probability sample of eight providers selected by the Ministry of Health. Client and allied service samples were obtained through convenience sampling; managers and staff of the eight providers assisted in the recruitment of clients; six providers assisted in the recruitment of allied services. Considering the small sample of eight providers, all survey results in this report are indicative and should be interpreted with caution.

The researchers consulted with the eight providers prior to participant recruitment (See Section 2.2 for details). Face-to-face consultation was carried out with six of the providers (16-26 May 2014); with the other two, this was done via telephone and email. Following the consultation meetings, providers were sent a brief summary of the discussions in the form of a checklist containing details of the assistance needed by the researchers in recruiting staff, clients and allied service participants. All providers were supplied with prepaid self-addressed envelopes to be given to participating clients. The researchers also emailed the survey web links to the services' managers to be forwarded to all staff members and clients who might prefer this option. Providers were asked to encourage the participation of all staff members and recruit a selection of clients that best represented their client base in terms of gender and ethnicity.

Six of the eight service providers who offered *Facilitation Services* were contacted again in early June 2014; they were asked to send through lists of allied services they had worked with including names and email addresses of individual staff who had dealt with their *Facilitation Services* clients. The

researcher also requested that providers let the individual know that they would be forwarding his/her contact details to AUT researchers for the purpose of an evaluation.

As mentioned in the sub-section above, providers supplied the researchers with lists of allied services consisting of three categories of organisation types. The initial lists suggested providers' difficulties in maintaining a clear record of individuals they had contacted for *Facilitation Services*. Changes in staffing within a provider's team and within the allied services meant further difficulties in maintaining up-to-date contact details. In some cases, researchers carried out online searches and made multiple telephone calls to obtain missing details such as appropriate individual names and contact details. Researchers were unable to contact some services on the lists because of inaccurate contact information. The researchers contacted as many individuals as possible from the list, to inform them about the evaluation and encourage participation. This process of communication with individuals in the original list of allied services found that in some cases the referral was the other way around, where an allied service had referred their clients to a problem gambling treatment provider. These individuals were removed from the list. In other cases, although a provider cited individual names, the allied organisation contact person did not recollect the provider or "facilitated" clients. Such individuals were also removed from the list. Invitations to participate in the evaluation were sent to individuals in a final list of 77 allied organisations. A few declined participation and a small number contacted the researchers explaining why they were unable to answer the questions as they had not experienced or did not recall a *Facilitation Service*.

Respondents

Of 64 **staff survey respondents**[9], a majority (82%) completed the survey online; 11 (17%) completed the survey on paper. The 64 staff respondents represented the four service types[10] as described by the Ministry: *Dedicated Māori Service*, *Dedicated Pacific Service*, *Dedicated Asian Service* and *General Service* (Ministry of Health, 2008b). Staff respondents included managers, service staff and support staff (Table 1); almost half held multiple roles. Other roles mentioned included "volunteer", "telephone follow-up support", "matua", "facilitator/assessor" and "media work".

Table 1: Breakdown of staff survey respondents according to role

	Number of respondents (*n*)
Counsellor / Clinician	45
Public Health promoter	26
Manager / Director / CEO	11
Administrator	14
Helpline/Hotline operator	10
Support staff (e.g. IT, Finance)	6
Student placement	6
Other	14

The staff sample (*n*=64) represented diverse ethnicities with 19% identifying as Māori, 30% as Pacific, 22% as Asian and 30% as European. Female employees (64%) exceeded males (34%)[11] in number.

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[9] It was not possible to calculate a response rate for this informant group. The researchers obtained a rough estimate of the number of employees within each of the eight organisations, which totalled up to 59. The number of responses received was higher than this expected number.

[10] Four respondents selected two categories for this question. This question may have been subject to staff perceptions about their organisation's service type and may not necessarily fit in with the Ministry's designated definitions of service types. Comments at the consultation phase suggested that some ethnic-dedicated services also viewed themselves as a general service because of their openness to all clients regardless of ethnicity.

[11] The percentage calculations here include one respondent (2%, n=64) who declined to answer.

The client survey generated 148 responses[12]. A majority of **client respondents** (85%) completed the survey on paper; 18 (12%) completed it online, and four (3%) opted to provide answers by telephone. Clients were of diverse ethnicities[13] with 47% identifying as Māori, 24% European, 16% Asian and 14% Pacific. There was a slightly higher percentage of female clients (59%) than males (41%). Seventy-two percent reported that they were New Zealand born. Among those born in New Zealand, 29 specified the number of years lived in New Zealand, which ranged between 2 and 72 years (with a median of 20 years). Clients represented a diverse age range: 18-30 years (20%), 31-50 years (43%), 51+ years (35%). Client respondents were at different stages of their treatment, with some still undergoing treatment[14] and others responding as former clients, post-treatment[15].

This client sample specified a range of gambling types that had led them to seek help. Similar to the 2009 evaluation, the most frequently indicated gambling type among clients in the present evaluation was electronic gaming machines (Figure 3).
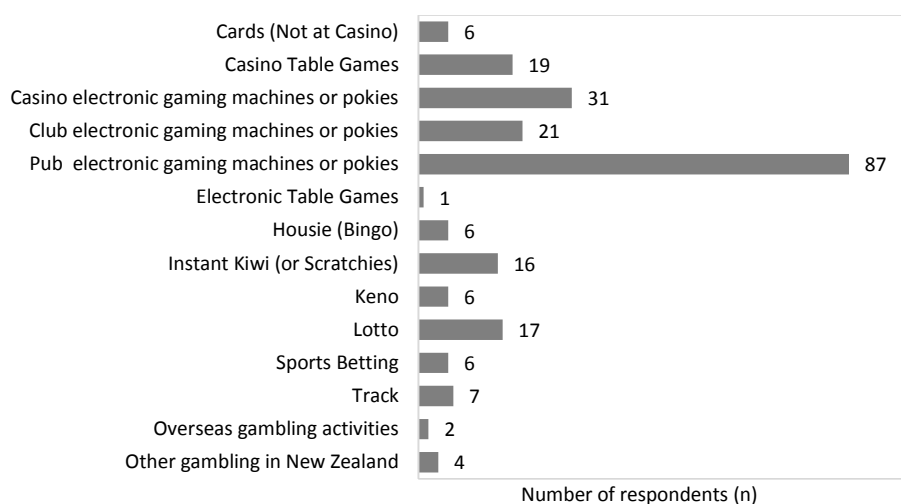
Figure 3: Main gambling types that had led participating clients to seek help[16]

Just over half (55%) of the allied organisations invited to participate responded[17]. Of 42 **allied organisation respondents**, 14 (33%) were from within the same wider organisation as the problem gambling service provider (in-house community support service). Respondents from this group included case workers and social workers as well as directors and managers. Seventeen (41%) were from external community support services. Among roles mentioned by respondents from this group were counsellor, clinician, case manager, community nurse, budget advisor, social worker, facilitator, and manager. Eleven (26%) were from private businesses (casinos, hotels, restaurants and bars); designations mentioned included host responsibility executive, duty manager, club manager and owner. Over half (55%) of allied organisation respondents had worked in their organisations for over five years, 17% between three and four years, 17% between one and two years, and 12% for less than a year. Their organisations offered a range of services as listed in Table 2.

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[12] Although the initial recruitment generated 158 responses, ten respondents (non-gamblers and those below the age of 18) were excluded. It was not possible to calculate a response rate for clients as recruitment was carried out solely by providers.

[13] 144 clients responded to the question on ethnicity. They selected a diverse range of ethnicities listed in the questionnaire, with 17 indicating multi-ethnicity. For the purpose of analysis, their responses were re-coded into the four key ethnic groups. Fourteen who had selected both European and Māori were included in the Māori category.

[14] Less than one month (12%); more than one month but less than three months (19%); more than three months (30%).

[15] Recently stopped contacting the service and agreed to follow-up contact (16%); recently stopped contacting the service and did not agree to follow-up contact (3%); previous client with no further contact with the service (21%).

[16] Percentages are not provided considering the variations in how clients responded to this question. Although the majority of clients (n=106) selected only one type of gambling as instructed in the questionnaire, over a quarter (n=42) selected more than one type of gambling (ranging from 2 to 12 different types of gambling).

[17] Invitations were sent out to 77 individuals; 42 responded.

Table 2: Services offered by participating Allied Organisations

Types of Services Provided	In-house Community Support Service (n)	External Community Support Service (n)	Businesses (casinos, pubs, hotels, bars) (n)
Assistance with addictions other than gambling (e.g. drugs, alcohol, smoking)	8	5	2
Budgeting advice / Financial Advice and Support	10	8	1
Employment assistance	4	3	1
Gambling venue exclusions (e.g. exclusion / self-exclusion orders)	3	0	9
Housing assistance / Housing and accommodation	9	3	1
Legal assistance / Legal advice	0	2	0
Life skills programme	10	3	1
Mental health support	4	8	1
Physical health support	3	2	1
Police and victim support	3	2	1
Relationship counselling	6	4	0
Self-help / support group	4	3	0
WINZ assistance	6	4	1

Other types of services specified by in-house support service respondents included parenting programmes, immigration advocacy, spiritual activation, special supports for Māori and welfare supports such as food banks. External support service respondents mentioned family violence counselling, child safety support, welfare support and whānau support as other areas of services.

Data analysis

All online data, combined with paper-based data (manually entered), were exported into Excel and SPSS (*IBM SPSS Statistics 22*) for analysis. Relevant responses were categorised more specifically for comparative purposes to determine possible cultural or service provider differences (i.e. based on service type).

Qualitative survey responses were analysed using a thematic analysis where themes were identified largely in a deductive manner. Additionally, the counting of coded themes (by number of individuals) enabled an account of the prevalence of points that respondents made. The purpose of counts here was to generate clearer meaning by identifying patterns in the data.

> Pattern recognition implies seeing something over and over again in one case or across a selection of cases. Finding that a *few*, *some*, or *many* participants showed a certain pattern, or that a pattern was *common*, *thematic*, or *unusual* in a group of participants, implies something about the frequency, typicality, or even intensity of an event (Sandelowski, 2001, p. 231)

While counting is often an unconscious process in a purely qualitative analysis, the method employed here offers a greater degree of assurance, as it reduces the validity risks often associated with qualitative analysis such as over or underweighting of data as a result of researchers' preconceptions, biases, or beliefs (Sandelowski, 2001). Mindful of the limitations of quantifying qualitative data (Hannah & Lautsch, 2011) and the drawbacks of over-counting (Sandelowski, 2001), in the present report exact numbers are detailed where appropriate, whilst in other instances, verbal counts (i.e. implied numbers such as "a few" or "many") were used to ensure that the focus remained on providing a well-rounded interpretation of the data.

An overall comparative analysis was also employed to compare and contrast responses between different individuals, between groups and with other data sources.

2.3.4   Focus Group Interviews

Development of focus group interview guides

Two focus group interview guides were developed for intervention and public health services. The topics focused on drawing further insights from the eight selected providers on key areas that were

highlighted in the staff, client and allied organisation surveys, the 2009 and 2010 evaluations, findings from a preliminary analysis of the CLIC database, and the document analysis of providers' six-monthly reports. Additional to seeking details and clarification, and suggestions for change or improvement from participants, the researchers also invited participants to raise any unaddressed issues. The interview guides used are provided in Appendix 3.

Participant recruitment

During the consultation meetings with the eight providers (16-26 May 2014) the researchers informed managers and other staff present about the upcoming focus group component of the evaluation. On 17 July 2014, managers of the eight provider organisations were sent an invitation to participate in the focus group. The researchers requested that the invitation be made open to all staff. Researchers also asked that managers inform staff that they could contact the researchers directly for further details about the focus group interview or to discuss their participation. Two focus groups were held for intervention service staff and one group for public health staff.

Considering often-cited recommendations on group size in focus group methodology literature, the number of participants was limited to about eight individuals per group. A mix of both managers and staff participants was encouraged. Six out of the eight organisations participating in the focus groups were represented by both managers and staff; two were represented by managers and team leaders alone. The final numbers of participants are provided in Table 3.

Table 3: Focus group interview dates and number of participants

	Number of participants (n)
Intervention Focus Group 1 (14 August 2014)	8
Public Health Focus Group (14 August 2014)	8
Intervention Focus Group 2 (21 August 2014)	9

Group moderation

A senior researcher moderated the focus groups ensuring a relatively informal and friendly environment conducive to discussion. All participants seemed at ease in discussing their thoughts and opinions despite some initial worries about risks associated with such open sharing of information.

The groups were facilitated with the assistance of a second researcher who added probe questions where appropriate and handled the audio recording, the time keeping and administrative aspects.

The senior researcher ensured maximum participation by asking others to provide views and opinions following prolonged individual responses to questions. While the researchers aimed to keep the discussion focused, some divergence was unavoidable. The moderator managed this as far as possible, and in the analysis, only items of relevance to the present evaluation were retained and presented in appropriate sections of the report.

Data analysis

All focus groups were audio recorded. A researcher transcribed the majority of the recordings verbatim. However, where appropriate, prolonged responses were summarised, retaining only key points of relevance to the evaluation. Responses provided by second-language speakers were sometimes rephrased to capture their meaning more clearly. A second researcher listened to the recordings and checked the transcripts and summaries for accuracy. The transcripts were then emailed to all participants for review, where they were given the opportunity to withdraw their comments or correct any inaccuracies.

Two participants withdrew specific statements they had made, while a few others made minor corrections to their comments. The finalised transcripts and response summaries were then analysed using a deductive thematic analysis approach similar to the analysis of qualitative data from surveys (described in sub-section 2.3.3).

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2.3.5 CLIC Database Analysis

Access to relevant portions of the national database (CLIC) was provided by the Ministry to the research team for all clients (existing and new) between 1 July 2010 and 30 June 2013.

The key information obtained from the database analyses included:

- Identification of baseline information including typical provider and client patterns and presentations
- Identification of referral (or *Facilitation*) pathways, both into and out of problem gambling services
- Documenting screening administration and other data; data recording or other issues of accuracy or completeness evident in the data
- Examination of services based on client characteristics, outcome characteristics or any patterns evident in the data (e.g. patterns of presentation, length of episodes).

Summary statistics were developed for:

- Total number of clients accessing a service (at least one Brief, Full, Facilitation or Follow-up session) each month (for all providers)[18]
- Total number of clients accessing a service each year (for each service provider)[19]
- Total number of new clients by month[20]
- Clients' demographic trends and patterns (age, gender, major ethnic groups and geographical location using local territorial authority of residence) both nationally and by service provider
- Number of sessions, types of sessions and treatment outcome within the timeframe 1 July 2010 to 30 June 2013, noting the Ministry's preferred treatment pathways.
  - o B - up to three brief sessions
  - o F - up to eight full or facilitation sessions
  - o BF - combination of B and F above
  - o BFU - BF as above and up to four follow-up sessions
  - o FU - F as above and up to four follow-up sessions
- Pathway into the service provider
- Referral pathway from the service provider
- Assessment scores and any changes in scores over treatment process where repeated measures were available.

Where possible, these data were examined (overall and by provider - noting that the low number of recorded screen scores[21] meant samples were often small and presumably unrepresentative) across the three years to assess any changes in presentations, outcomes, data collection and reporting. These were considered in the context of information from other aspects of the evaluation (narrative reports documenting public health activities, staff and client surveys, and staff focus groups). Some aspects of these data were discussed further in staff focus groups and with the Cultural Advisory Group.

2.3.6 Limitations

Findings and evaluative judgments throughout this report should be treated as indicative rather than definitive as a number of factors including the nature and quality of the data, recruitment methods,

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[18] These are the total number of clients for those respective months only, i.e. a client who accessed a service more than once in a particular month is counted as just one client for that month; the same client accessing the service in a subsequent month is re-accounted for in the totals for that month. Therefore, these data cannot be used to estimate number of clients in a year.

[19] Total number of clients who accessed a service from the respective service providers at least once within the 12 month period.

[20] Counts are based on unique CLIC identity numbers that clients are given upon their initial entry into a service. These estimates are based on the assumption that a "previous client" status has been recorded for all existing clients re-entering the service and that clients have not been given more than one CLIC identity number.

[21] Limitations in the recording of screen responses and scores are discussed in Section 2.3.6

nature of the evaluation questions, number of participants and context of the evaluation (as explained below) limited the generalisability of the findings.

Six-monthly public health progress reports

Although the reports of all providers contracted to deliver public health services were included in the analysis, the counts (number of providers) specified for key thematic areas are only indicative of theme prevalence and are not exact quantifications due to four key limitations identified in this data set:

- Although a majority of providers based their reports on Ministry recommended templates, the variability in report formats meant an inconsistent data set (i.e. different from data obtained from a standardised tool);
- Providers may have differed in what they considered to be important or relevant for their reporting;
- The activities reported often related to more than one purchase unit; and,
- The lack of clarity and depth in some cases added to the limitations of counts provided in this report.

Reporting that appeared to be a provider's observations of external situations and cases where it was unclear if an outcome was a result of a provider's initiatives were not included in the analysis. In brief, while the report contents were coded in relation to the respective Purchase Unit Descriptions of the five public health services, it was not feasible to provide an exact count of themes relevant to the details of each Purchase Unit.

Client and staff surveys and staff focus groups

The client and staff surveys were valuable for data triangulation; however, several factors limited the generalisability of reported findings.

- Client survey respondents (n=148), staff survey respondents (n=64) and staff focus group participants were recruited from a non-probability sample of eight Ministry-selected providers and were, therefore, not necessarily representative of the sector in general.

- Although the inclusion of a small number of non-English speaking clients was possible through interpreter assistance within the research team, client survey respondents were a non-representative sample of mainly English-speaking clients. The availability of the evaluation instrument in English only precluded the inclusion of some non-English speaking clients.

- The client survey also lacked neutrality in terms of participant recruitment, as providers recruited respondents. Therefore, the clients included in this component of the evaluation are likely to have had ongoing and regular positive contact with the services.

- The results provided for *Brief Interventions* in this report do not fully represent the targeted clients due to difficulty in identifying clients who had undergone *Brief Interventions* from those who had not. As *Brief Interventions* usually occur at public events, this aspect was included in an initial identifier question to selectively direct clients to appropriate sections of the questionnaire. However, many client respondents proceeded to complete the section on *Brief Interventions* regardless of the instructions provided (including some clients from a service provider not contracted for *Brief Interventions*). This limitation suggests the need for a different approach for evaluating the outcomes of *Brief Interventions* – either through a more controlled evaluation method or the use of a purposefully selected group of clients.

- Combining outputs and outcomes for *Full Intervention* and *Workshop-based Interventions* limited the results reported for these services. While key descriptions of these two services were largely similar, the differences in the contexts of their delivery (the former being personalised, and the latter being delivered in group settings) reduces the specificity of reported findings.

- Staff focus group participants representing two of the eight providers were managers and team leaders only; this limited the inclusion of staff views in the discussions.

- Although all staff respondents were assured of confidentiality, the evaluative nature of the staff questionnaire and focus group interview questions may have led to *evaluation apprehension* and, therefore, response biases. In programme evaluations, *evaluation apprehension* occurs because of the anxiety respondents experience; anxiety may result from a reaction towards performance evaluation and/or fear of receiving a poor appraisal, which in turn may have an influence on responses (Geva-May & Thorngate, 2003).

- Additionally, although providers were assured that the evaluation would not influence the Ministry's decision on service contracts, the timing of the evaluation coincided with a period where providers were experiencing changes to their contracts and funding uncertainty may have exacerbated *evaluation apprehension.*

CLIC database

Whilst the CLIC database has the potential to provide sound information on intervention outcomes, limits to available data prevented definitive conclusions in the present evaluation. The *Data Collection and Submission Manual* and the *Intervention Service Practice Requirements Handbook* both provide general advice on client data recording; however, there are a number of reasons that may prevent data entry. For instance, limitations to administration hours following clinical hours could mean limited time for clinicians to complete data entry for each client. While clinicians are likely to have assessed clients using Ministry-recommended screens, in the event that a client opts out of the treatment pathway, final screens cannot be administered and are, therefore, not available in the CLIC database.

Although the Ministry's guidelines and service specification documents directed the present evaluation's processes, these documents are 'guides' rather than binding documents, and thus there are varying interpretations. For instance, specifications on data requirements in the *Data Management Manual* (Ministry of Health, 2008a, p.14) indicate that "relevant… screens and scores must be recorded" for the various intervention services, which suggests that providers are not required to record all recommended screens. This appeared to be the practical interpretation given the variation with which screen data were recorded within CLIC. The Ministry also describes the *Intervention Service Practice Requirements Handbook* as "indicative of the Ministry of Health's intentions for problem gambling intervention services and a guide for typical client pathways and practices" and that practices should be based on clinicians' judgements when dealing with exceptional client situations (Ministry of Health, 2008b, p.1). Therefore, clinical judgement, and/or unusual intervention circumstances or client situations, may have also affected CLIC data entries.

Combined treatment of Full Interventions and Workshop-based Interventions

The combined treatment of inputs, outputs and outcomes of *Full Interventions* and *Workshop-based Interventions* in the present evaluation is an additional limitation. While the objectives and key purchase unit descriptions of these two intervention services were for the most part similar, the differences in the contexts of their delivery (the former being personalised, and the latter being delivered in group settings) reduces the specificity of reported findings. It is recommended that future evaluations consider other more appropriate methods for the evaluation of *Workshop-based Interventions*. One method that could be considered is the *Success Case Method*[22], a quasi-evaluation approach that is narrower in scope (Stufflebeam & Coryn, 2014). This method uses success cases to rapidly (and relatively inexpensively) produce evidence on the effectiveness of an intervention in a manner that enables stakeholders to understand "what worked, what did not, what worthwhile results have been achieved" and "what can be done to get better results from future efforts" (Brinkerhoff, 2005, p. 90).

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[22] Although the Success Case Method emerged from the field of human resource development, it has been used to evaluate other programmes and services, for example, a tobacco cessation educational intervention (Olson, Shershneva & Brownstein, 2011). The method emphasises a data collection approach that is based on the notion of confirmation and encourages the collection of confirmatory evidence from multiple sources (Brinkerhoff, 1983).

Aspects that have not worked well are explored to identify limitations in a manner that can produce information for those able to address the problems.

2.4   Audit process and methods

The objective of the clinical audits undertaken by KPMG was to assess whether each provider implemented national guidelines, industry standards and best practice for the:

- Delivery of high quality clinical services to treat those affected by gambling harm.

- Provision of services that are culturally appropriate and meet the needs of clients.

KPMG assessed each provider's level of compliance against its contract with the Ministry of Health, Health and Disability Service Standards and other best practice guidelines.

A pilot clinical audit was carried out in June 2014, followed by a post-pilot briefing on 25 June 2014, prior to fieldwork delivered between July and September 2014.

The clinical audit process consisted of the completion of three audit tools by the audit team. These tools covered areas relating to:

- Service delivery and quality

- Clients' rights

- Cultural perspectives.

Each criterion referenced in the audit tools was taken directly from one of the following documents:

- The contract held between the Ministry and the provider

- The Health and Disability Service Standards

- The Addiction Practitioners Association Aotearoa New Zealand (DAPAANZ) Addiction Intervention Competency Framework 2011.

Each of the audit tools required the auditor to assess whether the provider had fully complied, partially complied or had not complied with each contract/standard criterion outlined in the tools. These have been defined as follows:

- **Full compliance** - all of the requirements of the contract with the Ministry and/or the Health and Disability Service Standards have been achieved by the provider

- **Partial compliance** - some of the requirements of the contract with the Ministry and/or the Health and Disability Service Standards have been achieved by the provider

- **Non-compliance** - the requirements of the contract with the Ministry and/or the Health and Disability Service Standards have not been achieved by the provider.

In order to complete each clinical audit, KPMG representatives visited the providers' locations, interviewed staff members (including volunteers) and clients, and reviewed documentation such as policies, procedures and clients files. Overall KPMG representatives:

- Visited 13 locations relating to eight providers

- Interviewed 59 staff members (including volunteers)

- Interviewed 78 clients individually (after receiving their written and informed consent) either face-to-face or via telephone call.

The results of the individual clinical audits were collated in a final report (Appendix 5). This report also includes complete details of the audit process.

3   Operational Processes and General Areas of Input

This chapter summarises key findings in relation to operational processes and general input areas that have implications for the delivery of problem gambling intervention and public health services. The findings are derived from the results of the staff survey and subsequent focus group discussions, findings from the document analysis of providers' six-monthly reports and key findings from the clinical audit. Inputs are typically materials, resources and processes that an organisation requires to achieve the objectives of a programme or a service. These may include finances, facilities, staffing, time, knowledgebase, information, necessary partnerships, operational systems and processes (Curnan *et al.*, 2004; McCawley, 2002; McLaughlin and Jordan, 1999). When using a logical framework in evaluating public programmes or policies, inputs may also include external stakeholders and the surrounding contexts of a programme (Curnan *et al.*, 2004).

3.1   Service operational processes

Figure 4 shows that the majority of staff survey respondents believed that their organisations were effective (darker blue) or somewhat effective (lighter blue) in operational processes such as allocation of staff and funding, ensuring resource availability, management of staff, encouraging teamwork, ensuring processes for improvement, promotion of service availability and delivery of intervention services that meet clients' needs.
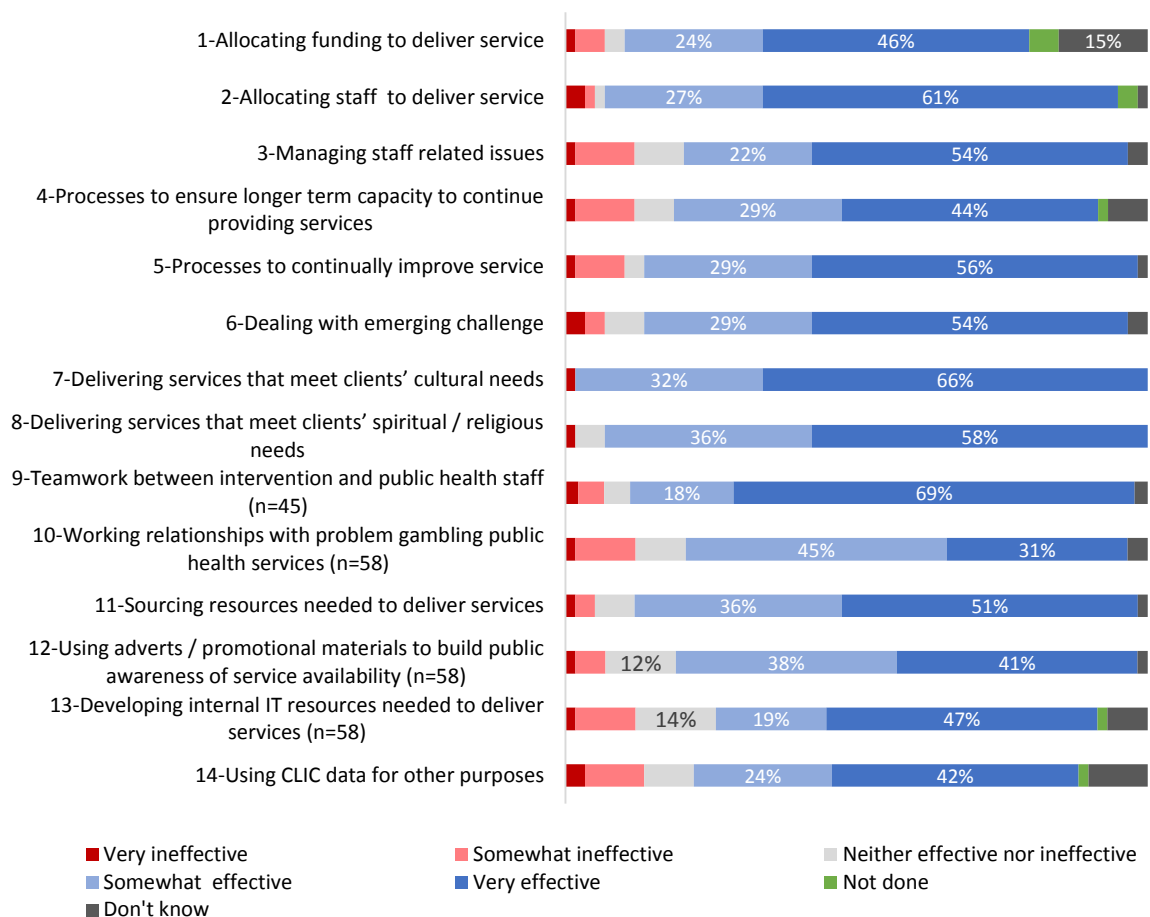
Figure 4: Overall effectiveness of organisational processes and delivery of activities for Problem Gambling Intervention Services as rated by staff (n=59)

Similarly, most of the staff survey respondents believed that their organisations were effective or somewhat effective in all operational processes related to delivery of public health services (Figure 5). Additionally, a majority of respondents also believed that their organisations were effective in

developing working relationships with appropriate stakeholders and in ensuring other required processes such as enabling community participation, developing innovative approaches for service delivery, planning public health activities and carrying out activities as planned.

Although uncertainties in relation to their funding situation[23] had impacts on organisational functioning in various ways (further detailed in Sections 4.11 and 5.6), as shown in the fourth rows in Figure 4 and Figure 5, most staff survey respondents believed that their organisations were effective in ensuring longer term capacity to continue functioning (i.e. organisational sustainability).
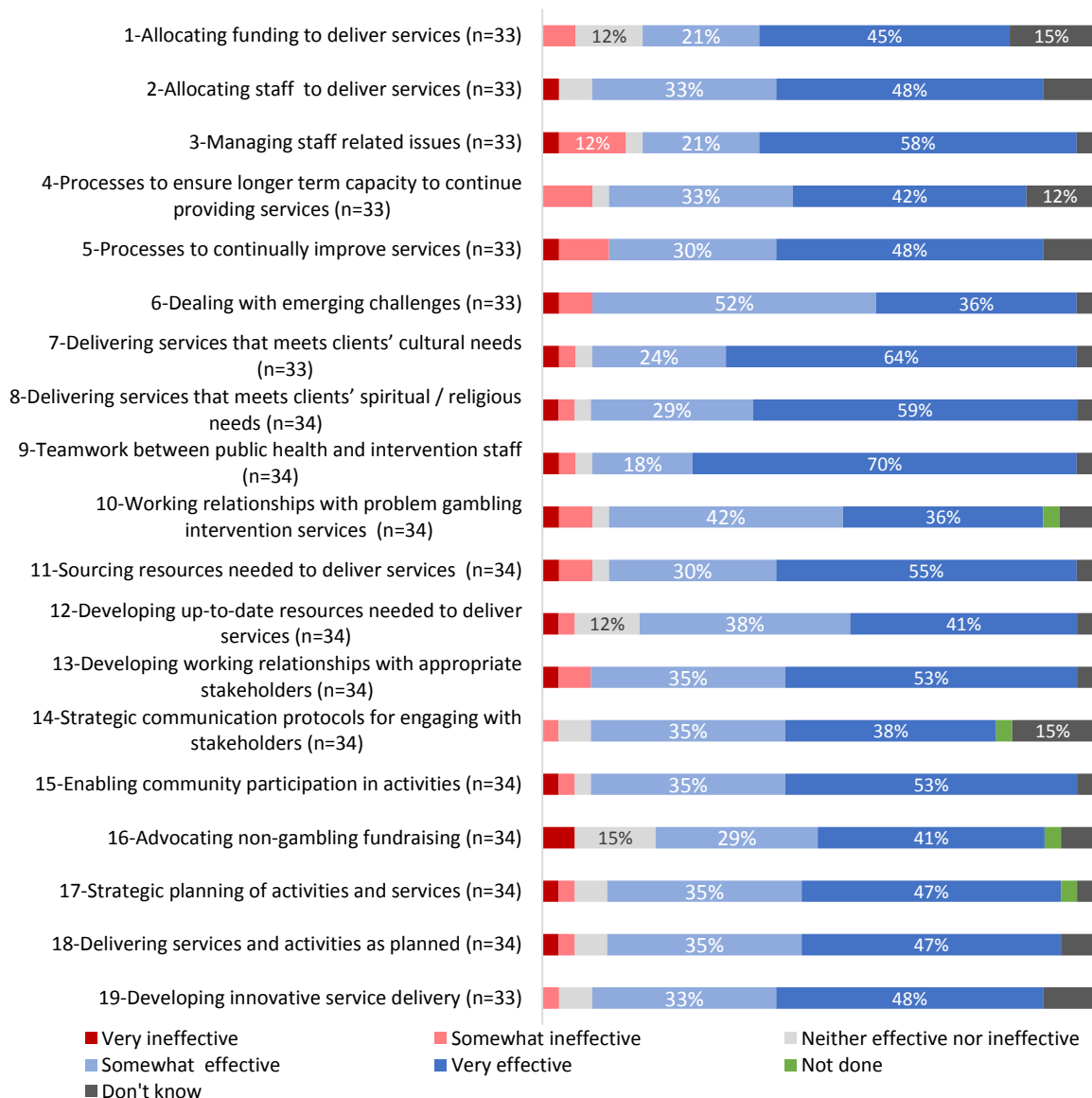
Figure 5: Overall effectiveness of organisational processes and delivery of activities for Problem Gambling Public Health (PGPH) Services as rated by staff

As shown in rows 7 and 8 of Figure 5, a majority of respondents believed that their organisations were effective in delivering public health services using approaches that met the cultural, spiritual and religious needs of their clients. The document analysis found examples of approaches providers had

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[23] At the time of this evaluation, the Ministry of Health was in the process of re-contracting problem gambling intervention and public health services. This was a protracted process, which meant that none of the providers undergoing the evaluation could be certain of long-term funding at that time.

used to achieve this aim. One provider described *Talatalaga a Aiga* as a Pacific cultural approach that enabled collaboration between stakeholder groups.

> *Talatalaga a Aiga* describes [our] approach to working with families and developing and engaging with Pacific communities. *Talatalaga a Aiga* is both cultural and spiritual, and opens up spaces to engage in meaningful collaboration with families and community, and members of the health and gaming sector. Decision-making within families leading to participation, empowerment and celebration speaks to [the Ministry of Health's] Harm Minimisation Strategy's aims and objectives.

Another provider reported conducting training to build their staff's cultural competencies.

> [Our organisation] has previously provided Māori language awareness training for all staff, supported staff in additional te reo learning and examined appropriate approaches for Māori clients (who constitute a significant part of our client load). We oversee the development of cultural competency through… [an established ethnic and cultural committee]. [In addition our] Cultural Advisor has been working with… staff to improve teamwork and has been using these sessions to give more exposure to cultural approaches to work and service delivery.

Cultural approaches were also incorporated into delivery of activities such as awareness raising presentations. One provider described the delivery of presentations during a *Gamblefree Day* event as follows:

> Presentations are made to the Māori and general public who attend. The event is captured within a tikanga process pōwhiri, mihi whakatau etc.). It concludes with a shared hangi[24].

This provider believed that the contract specifications (for PGPH 03) did not capture Māori cultural aspects for delivering services.

> Having a relationship with Māori community involves working with agendas, which are relevant to them. Such work, which will strengthen whānau resilience and transformation, often does not look like activities associated with problem gambling. Where the goal is to strengthen immunity to all addictions and support whānau to be the 'change agents' themselves, is investment into reducing gambling harm in the future. The contract specifications do not capture the work done by the service to address problem gambling. Inherent within the contract, is that it quantifies activities directly related to problem gambling. There is disconnect with how the Māori community perceives their health and wellbeing.

Another culture-related issue encountered in the delivery of services concerned the term "problem gambling". One provider reported:

> [We have] identified that we have an issue with our strap line which depicts the word 'problem' and is a deficit message… Feedback has recommended that our strap line also needs to identify to non-Māori or non te reo speakers what the mahi of the organisation is…

Likewise, in delivering problem gambling public health services another provider suggested that use of "a tikanga approach, provides a point of difference, with a wellness approach, as opposed to a deficit one". They referred to "Gamblefree whānau first" as an…

> …axiom [which] captures the importance of whānau for Māori. It was a development to the once 'Problem Gambling' slogan, which had the effect of promoting a malaise around nationally driven Māori initiatives, meant to be promoting wellbeing.

Although a majority of staff believed that their organisations were effective in developing innovative ways for service delivery (row 19 of Figure 5), an analysis of examples they provided indicated that most were activities expected in the Purchase Unit Description of the various public health services.

> Multi venue exclusion programme with pubs, societies and casinos and developing effective working relationships. Working with food banks re screening environments.

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[24] Māori, Pacific, slang and other non-standard words are described in the Glossary later in this report.

[Organising] family orientated events, power point presentations to community health and social services, attending community based networking meetings i.e. hui, AOD meetings, migrant networking meeting, WINZ etc., [and] liaising with other Public Health workers

3.2   Collaborations and joint initiatives

Collaboration and information exchange between public health and intervention teams, and collaboration between providers were regarded as organisational processes that can lead to increased overall work efficiency and outputs as required by the Ministry. The Ministry has identified a number of areas where Problem Gambling Public Health Services related to, complemented or supported Problem Gambling Intervention Services and vice versa. For example, clinical practitioners may provide useful information on client trends that can inform public health initiatives. If clinical practitioners notice "clients are having trouble with self-exclusion at a certain venue" this could be raised with a public health team delivering the *Safe Gambling Environments* public health service (Ministry of Health, 2008b, p. 104). In delivering *Effective Screening Environments*, while public health staff are responsible for awareness raising and supporting the development of screening and referral practices, "the intervention service needs to be involved in discussions about developing a local relationship" (Ministry of Health, 2008b, p. 105).

Furthermore, the Ministry's expectations included that all providers worked "together collaboratively to co-ordinate services within their region and ensure access for the populations they serve" regardless of the types of services offered by individual providers (Ministry of Health, 2008b, p.3). Providers not contracted for specific purchase units were required to "show evidence of working with other providers to ensure that the full range of problem gambling services" were "provided locally and regionally in an effective and complementary manner" (Ministry of Health, 2008b, p.10).

3.2.1   Collaboration between public health and intervention teams

Most staff survey respondents believed that their organisations were effective in building teamwork between intervention and public health staff in their own organisations (see row 9 in Figure 4 and Figure 5) and in developing working relationships with other problem gambling services in their area (see row 10 in Figure 4 and Figure 5).

Although intervention focus group participants described different staffing situations (some with designated roles as full-time clinicians and others with dual-roles), all confirmed that there was a good degree of collaboration between the public health and intervention teams within their organisations. Some mentioned collaborations with other community support services within their own wider organisation and with other problem gambling services in their region. Collaboration was mainly in the planning and carrying out of joint activities. Participants identified the promotion of intervention service availability to members of the public as a beneficial output of such collaborative work.

I'll start off with the brief screening. We always do that in collaboration with our public health workers. Because we always have expos and community activities that occur regularly where we attract quite a few people in the community… We are part of the planning. We are part of the organising… We have to keep our finger on the pulse to know about what is happening, to be inclusive. So they know who we are. That is primarily why we do it….

It does work well… with us working together with our public health and our intervention and/or our drug and alcohol service, and/or our mental health service to make sure that we get all of them together… when [people] come in, they find it really helpful that there are face-to-face that they can engage.

We definitely network… with other problem gambling services within our region. We have a close relationship with them… They always call us and we call them to be inclusive of anything in their part of [the city].

One of the benefits is that, for those who are doing health promotion, when they are partnered up with the clinicians, the public can be informed straight away, where our offices are, so it is about enabling accessibility. The public health staff are able to inform members of the public of the help that is available via the clinical team.

Full-time clinicians at the focus group also mentioned that they were often involved in public health-type work even when it was not within their job descriptions.

> I don't have any public health components to my job description but I am doing it - quite a bit… I also go out and give talks to people; as my previous role has been in public health. So I can do that as necessary.

One intervention focus group respondent noted the added advantage of dual-role staff, which enabled service provision based on demand.

> Dual role offers flexibility. Whatever area where there is in demand they focus on that area first. For example during Gamblefree Day we are more focused on public health activities. Therefore, we are more flexible.

Comments by another intervention focus group participant also suggested that a dual role was useful for accessing potential clients.

> We are employed to do a dual role… I do both health promotion and clinical but I am asked to do more health promotion than clinical. For us, you have to do the health promotion to get the clinical. …In doing the dual role health promotion, getting out that, that is where most of our client base comes from… We are out there, doing the flea market.

The comments of public health focus group participants on the collaboration between public health and intervention teams provided supporting data. However, the public health role was perceived as separate to the role of clinicians who were seen to have a focus on supporting individual clients.

> [Public health and clinical staff]… are split up slightly differently with primary and secondary roles… The teams meet together all the time… [They] know each other and what is going on and they can plan ahead on how we do joint programmes… Although they are two separate arms, they do need to link.

> We have got a clinical team of about 5 or 6. Every six weeks they do presentations to our AOD services, and they come to our Gamblefree Day event every year. They are willing to support if we want to do a joint public health-clinical presentation to another service or something. But generally the work that I do is separated from theirs. They are focused on their clients and working face to face with them and they get stuck in their routine of sessions.

Nevertheless, the discussions clarified the intrinsic links between public health and clinical work. In addition to collaborating with clinical staff within their own organisations, public health staff also collaborated extensively with other organisations.

> … Anything that I do [for public health], the other two [clinical staff] come along. We are an iwi based organisation. We … have access to a lot of different services. And whenever we go anywhere, it is not just our services going and promote ourselves but other health services will come along. I am quite lucky in that sense, I plan it all but they will come and help support …. I [also] do things by myself in problem gambling [public health work]. And it helps with Facilitation Services. If they come to me I can refer them to someone else. That way the clinical side fills in. So it helps.

Public health focus group respondents stressed the value of involving the clinical team in policy lobbying work as clinicians can strengthen their arguments with examples of real life situations they have dealt with while supporting clients.

> I think one good example of a success story is the strength of using real life stories. I have seen a counsellor in two different instances over a period of time… in a Class 4 venue review …Because of her direct experience in dealing with clients who have real gambling issues, the counsellor was able to give a very realistic view about the situation to policy makers… from a clinical perspective, and was able to make a strong impression by raising voice. Counsellors like that can work effectively together with public health workers.

3.2.2 Collaboration between public health service providers

Analyses of the providers' six-monthly reports suggested that collaboration with other public health service providers was a key feature in the delivery of many activities, particularly those that involved

organising public events such as exhibitions and activities such as workshops and encouraging public involvement. Collaboration was also a feature in training and knowledge exchange between providers; this included sharing of strategies with one another. Some providers reported the value of such collaboration (over competition) and some noted a desire for more collaborative work in their reports.

Comments by public health focus group participants as detailed in the preceding sub-section (3.2.1) suggested that in some cases they tended to work more frequently with other public health service providers than they did with the intervention staff of their own organisation. As noted in Section 3.11, focus group participants also remarked that collaborative work with other service providers contributed to time and resource efficiency. Working with other service providers meant that they were able to cover wider areas while preventing overlaps in work.

The comments by one public health focus group participant, suggested that another advantage of collaborating with other service providers was that it enabled consistency in public health messages delivered by different service providers.

> …we are all speaking the same words, however we are working in different areas… Because that is the consistency we are trying to create and keep going. Or else we will be [saying different things] and that creates confusion. So that is when we sit down [together] with the [other teams] in [the region], and decide on the message that we want to talk about, and we all talk [about] that in our own areas.

In discussing the main points and best practice concerning collaboration between service providers, additional comments suggested that maintaining consistency in messages could also help strengthen the outcome potential of policy-lobbying work.

> …The sinking lid policy - all public health [service providers] got together to do that. And it is still going today… We also worked with the policy change with the new council. We have all gone around presenting the same words, as I said, we are saying the same thing to each new council; areas to push for – gambling policy within the [region's] council areas.

As another participant remarked, in addition to a wider geographical reach, that collaboration also enabled planning of public health work that suited the different organisations' time availability and the sharing of responsibilities.

> The timing. What everybody has on their plate. What they can or can't do… Sometimes, a couple of services [would say] yes we will take this on board, but others will be busy, and they will say is it okay if some other service puts it together; and on behalf of… and it has a sign off from everybody else. So that is one thing that we have [done] more efficiently… we put together submissions that… came from… as a working group, and it says that these are the members and so we put together different submissions and we allocated the team to different local boards, so we had put in lots of different information for the different areas. And we also made oral submissions. We split it up. We had two people go to each different oral submission.

Focus group participants explained that they clearly reported work done collaboratively with other service providers.

> In our reports we are always straight up, there is a part in the monthly narrative report, it asks about your tasks and other services' tasks. So we state which service provider carried out which activity. And being really clear in the report about who did what and how we all work together.

In a small number of instances, the document analysis found that providers had reported on lack of collaboration and elements of competitiveness between providers. One provider reported on their concerns over another provider dominating working relationships with a key stakeholder organisation.

> [We] have been told our services are no longer required at [two] prisons and were told that [another service provider] are the problem gambling service that is now utilised. We have also found that [this service provider] has a national contract with the Department of Corrections and are concerned that this service will operate in Corrections with an exclusive contract stopping current work we are undertaking and this will impact on future service delivery

Another provider reported on tension among staff because of differing ways of working; they noted the need for providers to be respectful of one another's differences in approach.

...Individual members of [our] team have come under pressure from individuals from other services to participate in activities which [were] inconsistent with [our] policy, approach and iwi mandate (e.g. protest marches against the installation of pokie machines…). As a service we respect the rights of other providers to engage in activities which they feel comfortable with - and [we] expect to have the same level of respect returned. As a result of those experiences we have become somewhat cautious about the activities we engage in and the partnerships we form. Further, [we] are clear that while collaboration is to be encouraged - we maintain the right to engage in strategies which service our communities best. We also stand by our belief that public health initiatives should not be promised on a "one size fits all" basis. In our view, partnerships and collaboration should not mean that as an organisation we should have to cede our unique approach.

A third provider suggested the value of considering joint working contracts that can enable providers to work collaboratively in an official manner.

Consideration for some 'collaborative contracts' – i.e. joint working contracts for Providers on specific projects… (whereby more than one Provider would be the applicant.) As a personal observation there appears very little working collaboration amongst providers and despite trying to encourage this - for various reason barriers seem to exist…

3.3   Funding utilisation

Staff survey responses (as shown in the first row of Figure 4 and Figure 5) suggested that the eight selected providers were effective in utilising purchase unit funding for delivery of services. However, the comments of a few staff survey respondents suggested that they viewed insufficient funding as an external factor that had negative impacts on service delivery in various ways (see details in Sections 4.11 and 5.6). One respondent suggested the need for additional funding to develop appropriate resources. Another suggested the need for additional funding to compensate the contribution of volunteers and community groups who supported the delivery of public health services.

A few intervention staff focus group respondents suggested the need for additional funding to deliver *Follow-up Services* considering how time consuming they could be (see section 4.10 for details). Focus group participants also suggested the value of additional budgets for advertising service availability.

It would be so useful for the Ministry to allocate part of the funding to each provider to advertise to their own targeted niche. Everybody knows what their niche gamblers targets are and to have an advertising budget to target those niches in a way that is going to reach those niches will be so useful for providers.

The majority (overall 68%) of staff survey respondents indicated that their organisations delivered services that were not funded by the Ministry of Health. Figure 6 shows the percentage of respondents reporting each type of service.
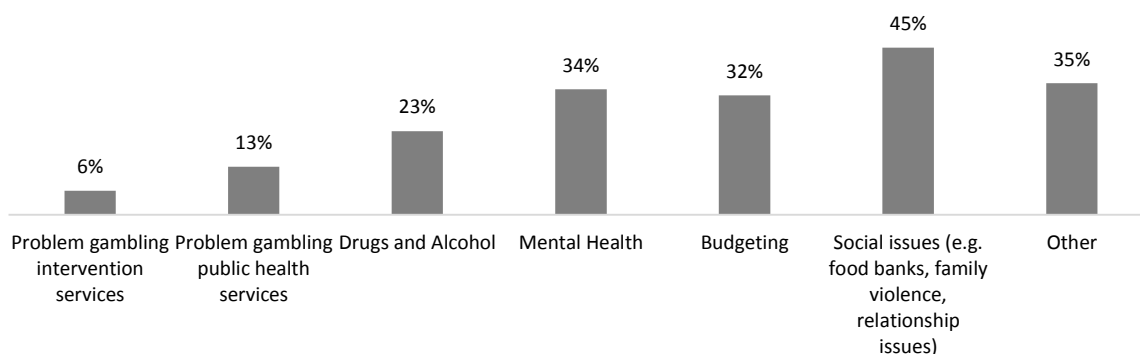
Figure 6: Non-funded services delivered as indicated by staff survey respondents (n=62)

A few staff survey respondents reported that their organisation delivered public-health type activities they were not contracted to deliver (e.g. harm minimisation training and policy development for gambling venues, and awareness raising through radio advertising). Other types of services such as driver licence application assistance, prisoner reintegration services, church services, spiritual support for recovery from addiction, parenting programmes and family fun days organised for clients were also

specified as additional services that were not Ministry-funded. Four survey respondents mentioned the incorporation of cultural aspects in service delivery as components that were not Ministry-funded.

> We deliver Māori and Pacific cultural tikanga, aspects, and perspectives to our communities. We incorporate Māori and Pacific Models of Health that address the root cause of the addiction. These are not funded for.

3.4   Resource sufficiency

The staff survey results suggested that staff from the eight selected providers believed they had sufficient access to the resources needed for service delivery. As shown in Figure 4, the majority of staff indicated that their organisations were effective in sourcing resources needed (e.g. screening tools, referral forms) and in developing required internal IT resources (e.g. databases) to deliver intervention services. Likewise, among staff responding to the public health section of the staff questionnaire, most believed that their organisations were effective in sourcing required resources (e.g. screening tools, promotional materials) as well as in developing up-to-date resources needed to deliver services (Figure 5).

However, as detailed Section 5.6, a few staff survey respondents reported inadequacies in resources to support public health work as an external factor that negatively affected service delivery; comments included the lack of language and culture-appropriate resources. Similarly, one focus group participant mentioned that Health Promotion Agency (HPA) resources were often not suited to some ethnic groups, and additional efforts were required to adapt resources to fit the needs of targeted communities.

> HPA is a little bit inadequate [in terms of] resources. Coming from a cultural perspective that is what is lacking for Māori and Pacific… And perhaps it is the same for the Asian community. So again we have to adapt a lot of those mainstream stuff to fit those cultures. It will be great if they can improve on that. And again, that collaboration with HPA is sometimes not there in terms of their opening to conversations, it is not there. So that is another thing that could help.

Other resource needs of relevance to public health services are detailed in the respective sections in Chapter 5.

3.5   Staffing allocation and time sufficiency

Staffing allocation was a key input area necessary for all problem gambling services. In the Purchase Unit Description (Ministry of Health, 2010) for intervention services the minimum delivery specified was one full time equivalent staff (FTE) for a minimum monthly delivery of:

- 120 *Brief Intervention* sessions of an average of 15 to 30 minutes each

- 60 *Full Intervention* sessions of an average of 60 minutes each

- 60 *Facilitation* sessions of an average of 60 minutes each

- 120 *Follow-up* sessions of an average 15 to 30 minutes each.

Services contracted to deliver workshop-based interventions (PGCS-06) were required to deliver a minimum of five workshop sessions in a year with each session averaging five hours and delivered in a single day.

For the Policy Development and Implementation, Safe Gambling Environments, and Effective Screening Environments public health services, the minimum delivery was one FTE working with either eight medium-sized or four large organisations per year. Additionally for Safe Gambling Environments, one FTE would also establish and provide "co-ordination and leadership to one harm minimisation network that meets at least four times a year" (Ministry of Health, 2010, p. 32). For Supportive Communities, "1 FTE would deliver 4 medium sized mental health promotion projects per annum (or 2 large projects)" (p. 33) and for Aware Communities "1 FTE would deliver 8 medium sized social marketing projects per annum (or 4 large projects)" (p. 34).

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However, in their discussions on how Purchase Unit Descriptions were used to enable public health staff and health promoters to achieve outcomes, public health focus group participants detailed how these FTE specifications were irrelevant when considering the reality of how work was delivered within their organisations. In most instances, this was through teamwork within the organisation.

> In terms of the minimum delivery, where it says one FTE should work with… two medium sized organisations or one large; to be honest I don't pay attention to that… It is not something that we have to… sit and think about and worry about. Our FTE, we spread out delivery between all the teams. …we are delivering something all the time. Doing something [here] that is more on policy stuff and next year someone in [another city] might do it, and [here] we don't do any policy stuff for one year, but we deliver the requirement anyway.

Out of 64 respondents in the staff survey, 70% held full time roles and 30% worked part time. The initial consultation with the eight providers found that service providers had varying numbers of public health and intervention staff. While some organisations had designated public health and intervention staff, others had staff members who took on dual roles working across both intervention and public health services. As detailed in Figure 7, the staff survey found that over half were within the dual role category.
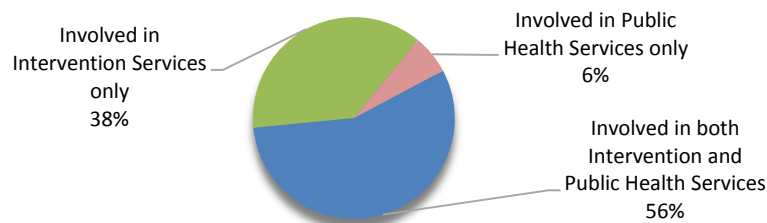
Figure 7: Allocation of staff to deliver services: Intervention-only, public health-only and dual-role (n=64)

Focus group participants clarified that while some dual-role staff had an even split between public health and intervention work, the focus of work was sometimes dependent on priorities and demands determined by the current situation. For other staff, although they had a designated full time role as a clinician, which was the primary role, they also had a secondary role in public health.

> We are almost 50-50 for my department. So all staff work on both public health and intervention. Our minds are mixed with both. But they are not involved in both all of the time.

> We have one FTE on public health and another FTE in clinical. So it is not really split. However, there is a primary core business, if they are intervention, that is their primary core business, and as a secondary they assist the public health. And public health works the same way.

Staff survey findings indicated that the eight selected providers were effectively utilising their allocated FTE staff in delivering services. As shown in the second rows of Figure 4 and Figure 5, a majority of staff believed that their organisations were effective in allocating staff to deliver services. Additionally, as shown in the first row of Figure 8, most respondents were satisfied with the time they were allocated to complete tasks or deliver services (combining blue bars). However, there was a substantial minority (22%) who indicated that they were 'very' or 'somewhat' dissatisfied with the time they had to complete tasks or deliver services.
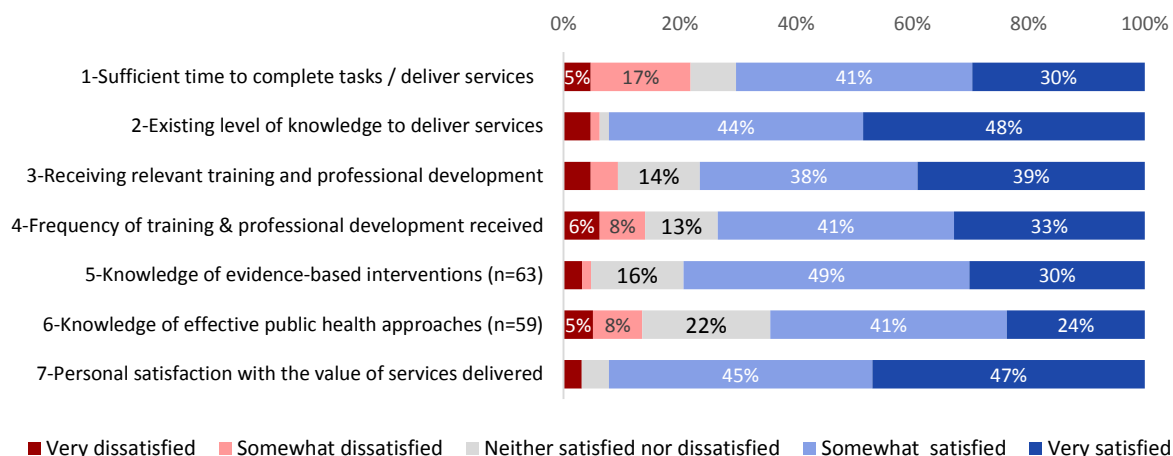
Figure 8: Satisfaction with capacity to deliver services in terms of time and knowledge as rated by staff (n=64)

Public health focus group participants discussed factors that can contribute to the effectiveness of their services and suggested that flexibility in managing time and multiple responsibilities was an important factor for meeting community needs.

> One of the important things in public health as well as intervention is flexibility – being able to jump in many different ways, at different times, in one second. We are not always fixed as "this is it". We have to do this, that, and the other, at the drop of a hat. We have to because the community is all different.

> And that is what it is all about - mobility. It comes down to mobility. It is about keeping the whānau, hapū and iwi happy and safe.

Figure 8 also shows that almost all respondents (92%) indicated that they had personal satisfaction with the value of services they were involved in delivering.

3.6   Workforce development

Workforce development was one of nine aspects within the "Service Delivery and Quality" audit criteria. Providers are required to ensure that there are processes in place to support professional career pathway development, continuing education and training for staff. These include:

- Preparing and implementing workforce development plans that cover all problem gambling staff

- Implementing management practices which support and encourage staff training and development

- Developing and maintaining performance management systems for all employees and reviewing practices and processes used in service delivery.

However, workforce development was identified as an area of "partial compliance" in the audit process. The auditors noted that five out of eight provider's processes were limited in supporting workforce development in their organisations.

- Staff at one provider had not prepared workforce development plans and had not had performance appraisals or a review of staff professional practices used in service delivery in at least the previous three years.

- Two of the providers had workforce development plans but they had not been updated nor progress against the plans regularly reviewed. For example, where staff had identified a training need in their workforce development plan, and had attended that training, this was not documented against the workforce development plan as being achieved.

- Formal performance appraisals had not been carried out regularly (at least annually) at two of the providers.

3.7 Knowledge sufficiency

Knowledge, skills and expertise are key inputs required to ensure high quality service delivery. For instance, selecting the most appropriate intervention approach requires consideration of the existing body of knowledge and best practice. Likewise, public health services require specific knowledge in relation to the service's focus area. For instance, knowledge "of the legal framework is particularly important when the programme is closely related to a regulatory function" (Ministry of Health, 2006, p. 5). Additional to field knowledge, it was assumed that staff would also need to have a good understanding of the Ministry's service specifications for effective delivery of services.

3.7.1 Knowledge of contract requirements and service specifications

Understanding of the Ministry's contract requirements and services was considered an input area that may have implications both for intervention and public health service delivery.

Of the 64 staff survey respondents, a majority (80%) indicated that they were aware of the details of the Ministry of Health contract requirements and service specifications; for instance, the required activities, recommended processes and expected outcomes (Table 4). A high percentage (83%) of staff survey respondents were also aware of details concerning the demographics of the priority client groups (e.g. at-risk groups, ethnicity, age and gender).

Table 4: Staff awareness of Ministry of Health Contracts and Reporting Requirements

	Not aware		Aware, but not of details		Aware of details	
	n	(%)	n	(%)	n	(%)
Awareness of the details of Ministry of Health contract requirements / service specifications (n=64)	0	-	13	(20)	51	(80)
Awareness of the demographics of priority client groups for the problem gambling services you deliver (e.g. at-risk groups, ethnicity, age, gender) (n=64)	4	(6)	7	(11)	53	(83)
Awareness of the annual work plans in place for delivering public health activities (n= 46)	8	(17)	15	(33)	23	(50)
Awareness of processes in place for clinicians to collect and submit service utilisation data in the CLIC database (n=60)	1	(2)	5	(8)	54	(90)

3.7.2 Work experience and field knowledge

Work experience and knowledge is an input area necessary for intervention and public health services. The Purchase Unit Descriptions specified that all intervention services (including workshop-based interventions) would be delivered "by a team or person with appropriate qualifications, competencies, skills and experience in working with people with gambling problems and/or other behavioural addiction problems, as outlined in the revised practitioners manual" (Ministry of Health, 2010, p. 24-27). All problem gambling public health (PGPH) services "will be provided by a team or person with appropriate qualifications, competencies, skills and experience in community action, community development, social and community change, and project management, as outlined in the revised practitioners manual" (Ministry of Health, 2010, p. 30-35).

The staff survey results showed variation in the duration of staff employment within problem gambling services (including their current and previous experience), but that almost all respondents (97%) had over a year of experience. Thirty-one percent had between one and three years of experience, 22% had between three and five years, and 44% had five years or more.

Rows two to six in Figure 8 show that a majority of staff were satisfied with their existing level of knowledge and professional development received in relation to their capacity to deliver services. Over half (56%) indicated that they did not need any additional training; the majority (79%) were satisfied with their knowledge of evidence based intervention approaches, and two-thirds (65%) were satisfied with their knowledge of effective public health approaches.

Nonetheless, just under half (44%) indicated a need for some additional training, and some (14%) were dissatisfied with the frequency of training. Four respondents reported training needs in general skill areas such as communication, reporting and use of office software; others indicated requiring training of relevance to intervention and public health services.

Knowledge and training needs for delivering Intervention Services

Among those who indicated a need for additional training, twelve staff members specified training areas of relevance to intervention services. Training mentioned included advanced training in areas of therapy such as Dialectical Behaviour Therapy, Interpersonal Psychotherapy and Cognitive Behavioural Therapy, and on co-existing disorders and co-existing issues.

Three staff survey respondents reported a need for training in cultural competency and culture-appropriate intervention approaches. This need was also discussed in the intervention staff focus group, where one participant suggested the incorporation of cultural approaches in training provided by ABACUS.

> With ABACUS training, they will benefit from having a cultural [approach], like having a kaumatua. They are rather clinical. They rely on us to do it [i.e. to deliver in culturally appropriate ways, but it would be good to have that in the training as well] - they could deliver more.

Another three staff survey respondents noted a need for training in budgeting and money management. Likewise, in one intervention focus group, participants noted the importance of budgeting advice for their client base.

> If my colleague was here, he would say, just about budgeting, understanding around money and things like that. Because we are constantly dealing with it. Just a basic understanding of finances would be [useful].

Other areas of training mentioned by intervention focus group participants included training in neurobiological assessments and in mental health. One also suggested that funding to carry out culture- and language-appropriate research could add to their knowledge.

Intervention focus group participants also suggested that provider meetings and conferences could be used as a venue to discuss training needs and conduct training reviews.

> I think better use of the national providers' hui, or the regional providers' hui. Because ABACUS has that clinical training thing, and we have talked about CLIC… the basic things, that you keep going over them…

> Problems as they emerge should be part of the conference setting. We are on a panel. We have got all of you here. What are the issues you are having with follow-up? How can you improve on the follow up? What do you need from us? That sort of thing, would be very useful on a practical level. That is not just the follow-up, you can take all the spec[ification]s.

In another intervention focus group, one participant mentioned regular organisation of in-house training with external trainers, while comments from another participant suggested the need to share best practice, particularly models that were working well.

> There is more to be done from a Ministry level. There are many models, Asian model - it works, Pacific model - it works. There is the Māori model, and general, that works. [However, in] the use of the Ministry's language, there is nothing in there… that meets our Māori world and the cultural component… They need to acknowledge that there are fabulous models that are working for the different iwis… But I think, why don't they allow us to use what we are good at, and what we know works for our whānau no matter what ethnic group that you come from. Regardless of what world you come from there are little words that you use, that make the lights switch [on]…

Discussions among intervention focus group participants also suggested the need for more standardised training for clinical practitioners, better communication, and information exchange about training availability.

> There is no standardised training for a gambling practitioner. I would like to see that. It is not prescriptive but it opens up to introduce other stuff. We have all got to train our staff as they come through, and the way we do it, is that what the Ministry wants? There is no best practice around that... it is a bit little fluid ...Perhaps there should [also] be a coordination service that disseminates information about training. If one provider is organising a training, others could be informed about it.

Knowledge and training needs for delivering Public Health services

Training areas of relevance to public health services mentioned by six staff survey respondents were: (1) policy development, (2) preparations for submissions and presentations, and (3) the need for tertiary public health qualifications.

One public health focus group participant emphasised the broad knowledge of the public health worker which included knowledge on the broad range of gambling harms and cultural and language competencies as key factors that can impact on the effective delivery of public health services.

> A key factor that contributes to successful outcomes in public health I think is that the public health worker needs to understand the full picture of problem gambling. Gambling itself is a core business, but once the problem happens, what kind of areas in their life will be affected. Somewhat they need to have the whole picture of that. So the public health worker needs to know what the core issue is, what the secondary issue is, what needs to work together and understanding these clearly. The person needs to know about research findings as well. I think the cultural identity and language proficiency of the public health worker is very important, they need to know about general society, different type of cultures... as that can be translated into their work.

Discussions among focus group participants suggested that communication skills, adaptableness, personality and an understanding of the local community were more important than qualifications for delivering public health services. This was because public health work often required skills in engagement with the community; something that is acquired through experience.

> Well you can only go so far with training. From my experience, the community that you work with, the whānau, that you cannot get trained in. You just have to throw yourself in there... it is getting in there and getting involved...

> I have not been trained in public health... I don't think I need to be trained. On paper work stuff, yes, but that can be taught [informally]. I think I bring other skills to [the]... mix, my delivery of public health is unique to where I live. Because I am local, I know pretty much everyone in the area. And if I don't know them, I will get to know them. Because that is pretty much who I am. And I think if you get all these people who are qualified but don't necessarily know their community, it will be harder to break the barriers.

The participants clearly favoured experience over qualifications and contrasted this, to an extent, with clinical staff.

> ... I know our clinical team has to be qualified. But [when recruiting for] our public health team when I was looking at CVs of applicants, [we gave preference to candidates with some qualifications, not necessarily a bachelor's degree] but just a certificate with some study in public health; but then at the same time actual work experience was a massive factor.

Although one participant mentioned the availability of tertiary level qualifications such as the Bachelor of Health Science in Health Promotion, focus group participants noted the lack of easily accessible training for public health staff, particularly when compared to training that was available for clinical staff.

> ...I know that Te Kakano are planning now for a new roll out of training which sounds really good. But I know the clinical team uses ABACUS and they can just call them and ask for specific training. But if we needed some training on report writing or planning in the public health side of things, I don't think we can just call Te Kakano and ask if they can do a workshop like this for us; which

would be great if we were able to, for new staff. When we have new staff [to] do like a short induction; these are the specs, that sort of… training would be useful.

Discussions also suggested the need for public health training to be relevant and based on identified needs to ensure efficient use of the public health worker's time.

…We have done the level 4 training, [but it was] all on the Treaty. We live it, eat it, sleep it; why would [we] want to do that? But [still] it was great because it was for across the board nationalities….

I think there is no harm in training and upskilling your staff, but training has to be useful and actually relevant.

In discussing factors that contribute to the effectiveness of public health activities, participants mentioned the difficulty in measuring outcomes for some public health work, suggesting a knowledge input area that may require further development.

…It is really difficult when you are doing [activities for *Supportive Communities* to measure, for example social connectedness], we can't ask them to fill out an evaluation asking them how connected they feel. It is really… [For public events we have used] evaluation cards. We got about 190 evaluation cards back in last year, but there was probably like a thousand people present. So it is really difficult when you are putting on a big event to get feedback from everyone and that is something that we are taking into account for this year that we are going to measure it in a slightly different way.

In addition to the knowledge areas identified above, the document analysis of providers' six-monthly reports found other knowledge input areas that providers had reported on. The respective sections in Chapter 5 provide related details.

3.8 Six-monthly progress reporting processes

Delivery of problem gambling services includes reporting requirements specified by the Ministry where providers are required to report "progress against the specific reporting details for the contracted purchase units" (Ministry of Health, 2010, p. 11). All providers were required to submit six-monthly narrative reports using the Ministry's reporting templates.

These reports varied in length, breadth, format and clarity. They ranged from highly comprehensive reports of over a hundred pages to shorter, simpler reports with bullet point statements. In some cases, report sections were identical to preceding reports; this copying and pasting could be an indication that the activities reported were ongoing or that the same activities were being repeated.

Providers also differed in their reporting format in terms of how much and what was reported using the Ministry's *Overall Narrative Report* template, the *Purchase Unit Narrative Report* templates, and the two sub-sections in the annual planning template: (1) *Overall description of the projects* and (2) *Key project features that can be linked into the six monthly reporting to the Ministry*.

Some providers' reports showed a logical flow of actions undertaken, the processes they followed, and the observed or expected outcomes and impacts. However, others were not explicit in linking outcomes with the activities delivered. Additionally, providers were often not explicit in reporting the relevance of their activities to the respective *Purchase Unit Descriptions*. In some cases, where activities and progress were reported in a general way, it was not possible to ascertain to which purchase unit the activities related. In other cases, the lack of depth in reporting meant that it was not possible to ascertain if some activity aims were achieved. For example, in cases where providers reported on having delivered awareness-raising presentations without detailing the content, it was not possible to determine the knowledge development areas (i.e. intended outcomes).

In some instances it was also unclear whether the activities and outcomes described were what providers had observed or what they had initiated. For example, while the extract below points to the benefits of a meeting between stakeholders, it does not clearly define the provider's role in the organisation of this meeting:

> In … [a] casino liaison meeting (re-engaged after 18 months) had a good turn-out including the casino Director, HR and security staff, DIA national initiatives rep and local DIA staff and service providers. Discussion included casino re-entry, referrals, use of the correct MVE documentation by casino, and regular three monthly liaison meetings to be held again.

Likewise, the reporting of another provider on media coverage of a *Gamblefree Day* event did not specify if this was a result of their initiative in informing the media:

> Māori Television, Radio Waatea and Te Karere covered the event contributing to the spreading of *Gamblefree Day* messages to a wider Māori audience.

However, as shown in the first two columns in Figure 9 most staff survey respondents (who were involved in reporting), believed their organisations were effective in meeting the Ministry's reporting requirements and in using the reporting templates.
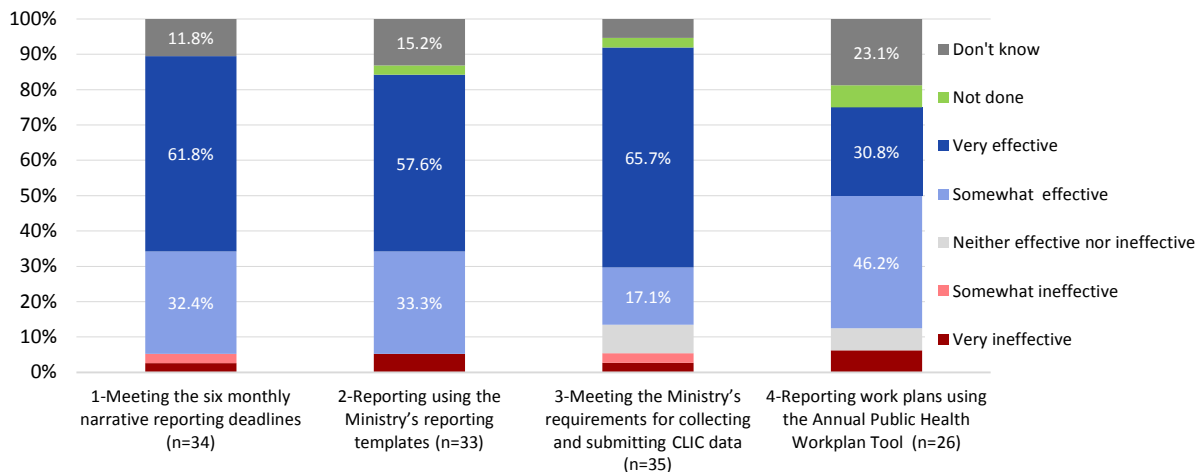
Figure 9: Organisational effectiveness in meeting the Ministry's reporting requirements as rated by staff[25]

The first three columns in Figure 10 show that most staff survey respondents also believed that their organisations were effective in enabling staff understanding of reporting requirements, in consulting staff prior to reporting and in keeping staff informed about the Ministry's comments on written reports. These findings suggested a good level of information sharing with staff.

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[25] The third statement (which applied to intervention services) was rated by four public health only staff. The fourth statement (which applied to public health services) was rated by seven intervention-only staff members. The percentages provided for the first three columns include one staff member who indicated they were NOT involved in reporting, but provided ratings nevertheless. In response to a question about their involvement in reporting for their organisations, twenty one (33%, N=64) indicated that they were fully involved, sixteen (25%) sometimes involved and twenty five (39%) not involved. Two respondents (3%) indicated that they did not know anything about it. In the online questionnaire, staff who confirmed involvement in reporting were directed to a set of statements which asked them to rate their organisations' effectiveness in meeting the Ministry's reporting requirements. While the majority of staff who completed the questionnaire online were automatically directed to this section of the questionnaire, staff who completed the survey on paper were not subject to such automatic direction to applicable questionnaire sections.
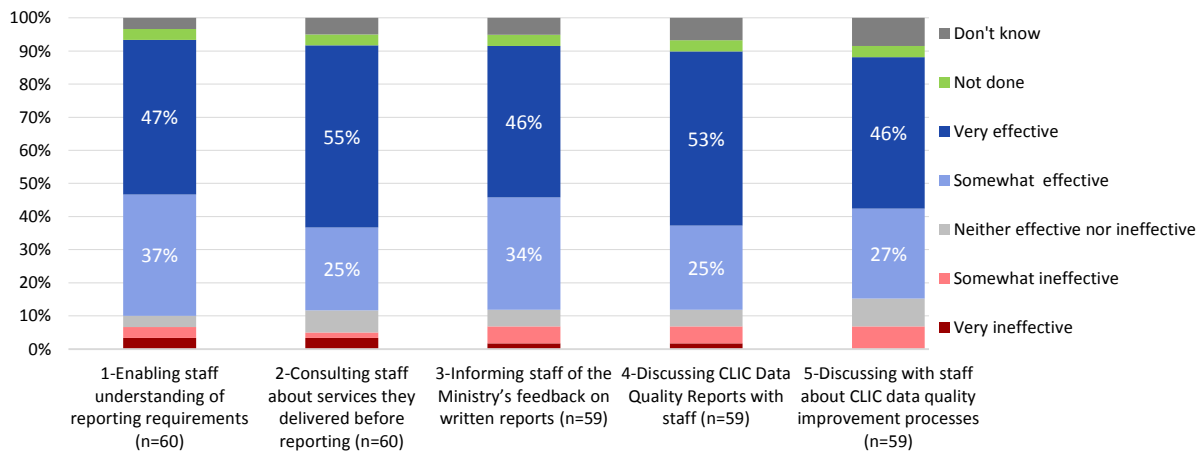
Figure 10: Effectiveness of organisational reporting processes as rated by staff

Three staff survey respondents further affirmed that teams worked collaboratively and received support from managers in the reporting process.

> Public Health and Treatment teams work very closely together when writing six monthly reports

However, one survey respondent reported the possibility that time consuming reporting processes may have an impact on service delivery.

> Reporting sometimes blocks my practice because it takes away a lot of time and energy. Sometimes I think I better not… have new clients due to the demanding of a lot of recording.

Two staff survey respondents reported the need for a clearer alignment between the Ministry's reporting requirements and kaupapa Māori practices, and further clarity on the purpose of reporting on numbers.

> The reporting does not make sense to me when we are a kaupapa Māori practice and do these things differently. I never seem to be able to get a tick in the box for the financial side so I reverted to giving the minimum. I am told that there are things like purchasing vehicles that is not allowed but this is not in the contract (that I can see) and we are a mobile service. The reporting needs to be focused on whanau outcomes and whanau ora framework rather than only numbers.

Likewise, one provider suggested a view that the Ministry's reporting templates needed further re-alignment to capture Māori approaches to service delivery.

> ...one issue we encountered was in completing the public health outcomes framework. In particular, we were challenged by the lack of recognition for service delivery at an iwi level. Certainly, the public health outcome template recognises community, regional and national level initiatives. However, the template does not provide scope for recognition of iwi boundaries or understandings. Given that the public health initiatives have a requirement to provide Māori communities it would be helpful to have capacity to document Māori boundaries.

3.9   CLIC data collection and submission processes

Intervention service providers are required to "collect and submit service utilisation data into the Client Information Collection "CLIC" database" (Ministry of Health, 2008c, p. 4).

Providers submit CLIC data from the preceding month within the first week of each month. Prior to 2011, after data validation and collation and the generation of data quality reports (sent to each provider) by an externally contracted consultancy, the Ministry produced reports at the end of each month (Ministry of Health, 2008c). Since 2011, providers validate the data themselves prior to sending it directly to the Ministry. All providers are expected to adhere to the same timeframe; however, processes may vary depending on the provider's data collection method, which may be hardcopy CLIC forms (completed following client sessions) or a local CLIC database (Ministry of Health, 2008c).

A high percentage of staff survey respondents (90%)[26] indicated that they were aware of processes in place for clinicians to collect and submit service utilisation data in the CLIC database (see Table 4 in Section 3.7.1). As detailed in the third column of Figure 9 above, staff involved in reporting believed that their organisations were effectively meeting the Ministry's requirements for CLIC data submissions. As columns four and five of Figure 10 show, most staff survey respondents also believed that their organisations effectively discussed CLIC Data Quality Reports and related improvement processes with staff.

However, analysis of the CLIC data identified some areas where improvement might be required. An analysis of trends in CLIC data over the three-year period (July 2010 - July 2013) indicated an increase in the percentage of clients that did not fit with the Ministry's preferred pattern of intervention sessions, and that the percentage of clients for whom the end of treatment was recorded was low. Additionally, it was not possible to determine the end of one treatment episode and the start of another based on CLIC data entries. Some clients had very large numbers of sessions, and it was not clear whether these were a result of multiple relapses, or perhaps indicated the use of "dummy" identifiers in order to manage the matching up of provider activities to Ministry criteria. For some clients, when end of treatment indicators were used they were often used multiple (and often sequential) times towards the end of a treatment, while for many others there were no records of achieving treatment end; this made it difficult to determine if clients had opted out of treatment or if treatment was in fact closed. This demonstrates the need for better/more accurate identification and or/documentation of end of treatment or relapse and start of another treatment cycle.

Analysis of the CLIC database identified a range of issues and practices that were unclear. It was apparent that initial assessments were not necessarily conducted at the start of first sessions. This could be due to general rapport building, clinical judgment or a range of other practical considerations. For clients outside the standard treatment pathway it was often not possible to determine in which treatment phase assessments were conducted, and varying numbers of assessments were reported. These factors, in conjunction with the lack of clarity in the start and end of treatments, and variations in the reporting of screens, meant that it was not possible to conclusively assess treatment outcomes from the CLIC data.

Given those ambiguities, focus group respondents were asked how they managed the entering of CLIC data to indicate the ending of one treatment programme and the starting of a second. Participants explained that situations that necessitated client re-entry were based on client needs.

> Some clients need to be re-admitted. We have to do the whole process again, but using the same name and number. We have to redo the screening and everything. And it could be that another clinician works with the client.

> …[Some client populations] don't get all the information in a first attempt in a one day workshop. Because we are talking about understanding how gaming machines are designed, understanding percentage returns, understanding probability theory. If they don't get all the information from the first workshop, and when they can come back and get a second workshop… they get far better information processing when they are hearing that information a second time…

Some clarified that the re-entry pathway leads the client back into a *Full Intervention* and that such re-entry does not necessarily occur after follow-ups.

> We have been told that you go back to Full Intervention, you don't go back to Brief [intervention]s. But you are limited in terms of what you can give in terms of the Ministry. If the client re-enters I am pretty sure they can go back to Full.

> [Re-entry is] not necessarily [after follow-up]. We do screening again. After we close the case, we follow up with them. But by then if there is anything they can come back.

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[26] This comprised 19 intervention-only staff, 34 dual-role staff and one public health-only staff.

Comments by a few other participants suggested staff also faced the issue of working around the requirements of CLIC data submissions while trying to meet clients' needs, which in reality may be different from the recommended number of sessions and timeframes.

> …One of the difficulties we have is that our client is coming to eight group sessions. After a month, it is four sessions. When they finish eight sessions that is when we [should] begin a follow up, but it is already passed. It is a dilemma. We have a duty to give to our client, but the Ministry's requirement is that we give them one month alone. But our duty is to give them eight sessions… But I will be creative. I am trying to follow a system that would show when the sessions end. So even though he is still here, I will call it a one month follow up. That is where I see, there is an issue.

> We have a similar issue. I have never seen clients in a place where they are finished. Unless they say they want the support to stop. So we continue to support them. So when we go into CLIC and it comes up with the information that you have gone over with the session, we just ignore it. Ignore and carry on.

> We find that the eight session thing is driven by client needs. It is what we agree in the intervention plan, it could be six, 12. They either come to a natural end to that and then we do a follow up, if that is what they agreed and we will follow up in a month. Or they may fall out of the system. Or we can't contact them. So it is client driven.

The focus group discussions also revealed that approaches used to identify when one round of treatment was insufficient included client's self-evaluations, lack of changes to clients' gambling behaviours, and counsellors' clinical judgements.

> Recently we have had more clients coming to us for re-entry into casino. For those kinds of individuals, you can definitely know… we argue that they have relapsed and they [need to] come back…

> I think this is just recognising that even when you are leaving clients at the end of a group therapy which ones need more intensive one on one that needs to be ongoing. Not just on gambling, but often it is across a whole range of areas, food, budgeting…

> …Not just over a period of time, but even over a period of one day or two to three days, or within a week, you would see them more than eight times depending on the complexity of the issue. So that can amount to quite a few hours worked with the client, and it is not just half hour of one hour precisely, but usually two to three hours depending on their social situations at the time. And yes, you can hit eight sessions in one week, and by then you will definitely know how long you could be working with the client [in terms of sessions needed – group or individual].

There was some evidence of ongoing difficulties with the CLIC system. Some survey responses indicted issues around accessibility and frequent changes.

> CLIC data entry is problematic as the database can't be accessed remotely.

> The CLIC system gets too overwhelming at times and then it changes a lot of times[27]. Very unsettling!

Intervention focus group participants were asked about these difficulties and if there was anything done differently to increase reporting efficiency to benefit their organisation whilst fulfilling the Ministry's requirements. It was clear that whilst some providers used only the CLIC database, others used additional databases for recording client intervention sessions. The need to manage two databases sometimes led to other challenges.

> …Our biggest challenge is that we have got two databases, we have an [name removed] system and we have got CLIC. The systems don't talk to each other; and the money involved in trying to link them up; it is frustrating for the staff. We are constantly trying to juggle the two systems and this has been a challenge we have had for years since we started for CLIC as well as for [name removed].

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[27] The CLIC system has not been revised since 2011.

We have two databases, and CLIC is one of them. We are entering in screens twice, so that is not efficient in terms of time. Both are from the Ministry, and that is a national database. The two systems are quite different. They are not compatible with each other. Data entered in one system is not recognised by the other system. So this means data has to be entered twice.

However, other focus group participants discussed the additional databases they used as a necessity as these databases compensated for the limitations of CLIC. They argued that other databases provided a greater depth of client information and enabled the capturing of additional data such as new types of gambling (e.g. online gambling). Additionally, these comments perhaps provide some insight into the difficulties in analysing CLIC data given the data seem to be often retrospectively entered.

We have our own database, which is then transferred on to CLIC. With our database we can get more information which enables us to know a lot more about our clients…

…[name removed] can be adjusted to meet our needs and it is interchangeable. The problem we have now is that some clients have internet gaming problems, this kind of data can be recorded in [name removed] but may not be accepted by the Ministry. So some of these kinds of trends in change in mode of gambling cannot be reflected in the data reports. Maybe in the narrative report, but not in the data report.

Other perceived limitations mentioned in focus groups included the lack of some particularly useful measurement features for issues such as depression and anxiety, the lack of capacity to capture Māori communication approaches and models and the possibility of entry errors.

…when we first started with CLIC we were able to enter [scores for several depression and anxiety screens but these were later removed]. They were very useful information to have from a clinical perspective because … it gave you mild, moderate and severe depression; we could not understand why those entry options were taken away.

We only use the one CLIC system. But what CLIC is not capturing is the mahi with our whānau and the kōrero around that. And the models that we use…

When we do enter our clientele the first time there can be some difficulty recapturing that person because someone else may have entered the person twice into CLIC. A spelling mistake could have deviated everything and it is counted as two individuals and sometimes up to three as well.

There was no consensus on whether a single CLIC database that met everyone's needs would be feasible. According to one focus group participant, separate databases were essential as they contained valuable historical client data.

…Everyone has their own market niches. Different data systems need to be used based on what is relevant and culturally appropriate for the clients that we are serving. We can't say that one system is better than the other; you can just say what the best fit is for the clients that you are working with.

However, comments by another focus group participant suggested that providers may welcome changes to the CLIC database to meet their needs.

…This also has something to do with the CLIC system that requires to be reconsidered and updated or upgraded, so it is like the system that we have and what we record. The way we record things, we have more substantial information.

The need for ongoing training to better utilise CLIC was also discussed in one of the focus groups.

There is so much to CLIC that we still don't know about… Like how to collect information, different methods in CLIC, and how to compare data from last year to now. There is so much on CLIC that we haven't really investigated or looked at yet… [Knowing] how to work best with CLIC data and how more efficient we could be, so more or better training [would be good]

3.10   Annual public health work plan submissions

Providers delivering public health services were required to submit yearly work plans as described by the Ministry.

Prior to the commencement of service delivery by [providers] an annual problem gambling public health work plan will be agreed with [the Ministry] using the template provided… [This] annual

problem gambling public health work plan will be updated and agreed with [the Ministry] prior to the commencement of each new twelve month period (Ministry of Health, 2010, p. 5)

The analysis of narrative reports found that providers had often used the work plan template as a reporting tool, rather than a planning tool. Furthermore, the work plan templates in the narrative reports were not presented in a consistent manner nor were they necessarily in a logical order. While some providers referred to a particular project name in a work plan, listing its connections to three or four purchase units, others had completed work plans that were specific to a single purchase unit. Differences of this nature were also noted across reports submitted by individual providers. For instance, submitting several unit specific work plans in the first report and later submitting a general work plan in a subsequent report. Variability was also evident in how providers completed the section in the work plan that requested the project's linkages "to specific objectives/outcome measures in the MOH Strategy/Objectives/Outcome Monitoring Framework" (Ministry of Health, 2010, p. 47). Providers were also inconsistent in the completeness of the work plan; some providers only addressed some questions in the template while others completed only one of the two parts of the template.

Considering that the template was for a yearly work plan, it was expected that a plan would be submitted in alternate reports, for example in the first, third and fifth reports (as reports were six-monthly). However, this was not the case, and no pattern of submitting annual work plans was discernible.

Table 4 (Section 3.7.1) shows that half (50%, n=46) of staff survey respondents indicated that they were aware of the details of annual work plans in place for delivering public health activities. Of the remaining respondents, fifteen[28] (33%) indicated that while they knew there were plans they were not aware of the details and eight[29] (17%) indicated that they were not aware of such annual work plans.

As shown in the fourth column in Figure 9, the majority of staff involved in reporting believed their organisations were effective in submitting public health work plans; however, approximately one-quarter (23%) indicated that they did not know about the effectiveness of this process.

Comments by some survey respondents suggested the need to consider the viability of the Ministry's *Annual Public Health Work Plan* template and that at the least, additional training or support would be beneficial.

> We report using the Ministry's 'Annual Public Health Workplan Tool' very well. The reason why I answered 'neither effective nor ineffective' is because when we have difficulties, it is due to the tool itself, rather than us not doing the work. In terms of a PH Workplan tool, it's not easy to use, it doesn't flow and it doesn't cover things that are important… to consider when implementing a PH project. I only use it because it's the required reporting template - otherwise I use a more comprehensive template and cut and paste the info into the Ministry's doc. I'd like to see it reviewed and a new, more user friendly one developed.

Discussions among public health focus group participants confirmed that the work plan template was intentionally used as a guide for reporting purposes, rather than as a tool for planning.

> I don't use this tool to plan. It seems like it is good for reporting and saying what we have been doing using the Ministry's language so they can see it and understand it better. But in terms of planning it's… For us, we have a different planning template that I use… I don't use this as a tool [for planning]

Discussions elaborated on the limitations of the work plan template including its lack of clarity, its generic nature and its lack of space for reporting other aspects such as budgets.

> I don't like the layout of them. I have talked to my manager about them. Especially the order of things here. I don't think it is very clear on what information it is exactly they want…

> I think they are trying to use a generic tool to fit everything in, but it doesn't. I like that we beg to differ on how we are going to utilise the tool. You can have a tool; if you haven't had the training, all education on how to use to tool… [it may] backfire. We have yet to have a report come back

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[28] One public health only staff, four intervention only staff, and ten dual-role staff (involved in both intervention and public health services).
[29] Four intervention only staff and four dual-role staff.

saying we haven't met targets, but we don't stick to this format. It is quite sterile, you know. You have to have room for movement. So it is a good tool to have for a guide, but I think it is really important that each service roll it out to how it is going to suit them…

We have got another couple of pages that we add on [to the template]. Like whenever I do a project I will have the costing in. So there are a few more sheets that we attached, and this is just the front. When I give to my manager it has the whole thing in it, the whole plan… [The template] is just at the top, as a cover sheet…

When used as a planning tool, participants suggested they had used the template variably and adapted it to fit their needs; for one, the lack of negative comments from the Ministry suggested that they were on the right track.

…With this type of format, that we use, it is about planning, how many projects we want to do throughout the year. So it is all pre-set. Of course depending on the time frame as time goes on, it changes. We will pull out projects or not do them and move them to the next year. We don't use everything on [the template]… However, even though we have not used every heading in here, we have not had any negative feedback from the Ministry. As long as it met what our requirements were.

One participant suggested that the planning template resembled a logic model and provided a similar kind of guideline.

In terms of using this kind of guideline, is that we follow the logic model. It is quite similar with this one. We don't follow exactly what it says, but actually it is kind of what the long term outcome is and what is the input… How much we can expect from it… We use that one, instead of this one. But actually when I compare it, it is quite similar.

Focus group participants expressed mixed views about the need to modify the work plan template to enable the meeting of everyone's planning needs. While some suggested reconsidering the clarity and feasibility of this planning tool, another outlined that meeting service specifications was more important than planning aspects.

Well this is a generic [tool]. As long as we meet the outcomes that they require… I have no problems leaving it the way it is. As long as it… answers all the questions they want to know and we have all the outcomes and proof behind it. As I said we have not had any problems with that.

3.11   Utilisation of Purchase Unit Descriptions

As detailed in Section 3.7, the majority of staff survey respondents reported that they were aware of Ministry of Health contract requirements and service specifications as well as the demographics of the priority client groups. Both intervention and public health focus group participants were asked how Ministry of Health *Purchase Unit Descriptions* were used to help staff achieve outputs.

3.11.1   Utilisation of intervention Purchase Unit Descriptions

Managers and staff present at both intervention focus groups discussed how they ensured that staff were reminded about targeted activities and outputs detailed in the *Purchase Unit Descriptions* for problem gambling intervention services.

[I] …encourage the clinicians to remember what those specs are. It is not in the forefront of their minds. They are busy with clients and they are they are not thinking about the contract or service specs on a day to day basis. So it is me driving it - this is the way we need to do it because it is described in our contract.

For me as a clinician, when the team leaders reminds of me of that, it kind of just bursts my bubble. It is not what I think about when working with clients - it is the least of my worries. The Manager drives it.

Other remarks suggested that the target outcomes detailed in the contract motivated staff, and details provided in the service specifications were useful for staff to stay focused on outcomes.

…what drives us, is our target outcomes, we have to be seen to be performing to those. Yes, we are driven by those target outcomes, and we know what those goals are each week, we break it to weekly in fact. At times it will push us to always maintain achieving so many per week Briefs, Facilitations, Fulls and Follows-ups.

I think with Full Intervention… because you are doing the full assessment, it is the most important part… [It] helps guide you because you have the assessment, e.g. where they are with their gambling, it kind of guides; those assessments are really good because it keeps you focused on what's most important.

One intervention focus group respondent, however, suggested the need to reconsider time allocations specified for the different intervention services as this conflicted with the realities of Māori communication approaches.

They have to take the times off that is what they have got to do. 15 minute Brief, 15 minute Follow -up and half hour for clinical counselling, and maybe maximum two hours for a Facilitation. They are actually limiting the Kaimahi and [not] allowing them [to] work fully… because you are governed by time. Those are times according to the CLIC bible; that is what I read. You can't tell me that I can have a hui with Māori for an hour and half and then say "cut, hold that for the next session". Takes two and half (hours). That is the stuff that is going on.

Another participant suggested the need for an updated *Intervention Service Practice Handbook*.

One thing I would really like to see, is that if the Ministry wants us to work from the intervention handbook, it would be good if they could… get one to us that is current. The draft is from 2011. It might be what they want us to work from but it was never published, and never ever disseminated… so if that is what they want us to work from they have done a poor job in letting us all know.

One participant suggested that an area that required consideration was the scores for the *Gambler Harm Screen* specified by the Ministry because of a belief that it limited client admission into a *Full Intervention*. Another participant, however, clarified that the "updated" version of the handbook provides further clarity on the Ministry's requirements.

When they score on one of those questions, "Do you have any problem gambling?" …When it comes to Full [Interventions] the Ministry will cut that, you have to have [a score of] three or four. That is where the problem is… We run, what we call, awareness programmes. And here we have clients who ticked that they have a little problem, but based on the scoring… it appears that they don't have a problem, even though they have indicated that they have a problem.

From the administration side, if I go back to the handbook, if you are working from the 2008 copy, which you possibly are, the latest draft one has explanations of what the Ministry really wants to see but that they accept other stuff. So that is where the scoring things fall under, the Ministry expects scores in this a particular range, but they can understand instance where the score could be lower, if people are still in services.

3.11.2 Utilisation of Public Health Purchase Unit Descriptions

While one public health focus group participant indicated that the planning and implementation of activities for public health services were generally guided by contract specifications, discussion in the group suggested that there was minimal distinction between one purchase unit and another when planning on projects. Participants suggested that planning was focused on wider projects that contribute towards outcomes that meet contract requirements of several purchase units, considering that a single activity can be used to achieve objectives within several purchase units.

A lot of those purchase units can be used in one project in itself pretty much. Like the awareness… it can show up in sharing information on what is going on in the community around gambling. That is an automatic conversation within any project that we have. [And another example is] policy development; again that can be put into same conversation. So all of that can be linked into one way or another. None of it stands out on this own… Most of our projects have a minimum of three and up out of those purchase units. And we can identify how they are linked in terms of outcomes. When we do projects we normally have one that leads it first. If it is about safe environments, then that is obviously the first intent that leads that project, and how we can align the rest of them to that.

And if it is about awareness, if the first priority is awareness, we link the rest of it to that if we can, depending on the community we are working with at that time.

…As a person working in this area, we talk about gambling issues. So on the one hand it is counted as supporting communities, but at the same time it is awareness raising… So one project can meet two types of targets. We don't have a clear guideline where it says for this type of activity only count for this one; it is a kind of blur.

Considering that some purchase units had similar expected outputs, public health focus group participants were asked if the five public health services were planned and implemented to increase time or resource efficiency. Participants' responses suggested that planning and delivery of public health services was not necessarily a straightforward process, but was rather dependent on community needs and contexts within the regions they worked in. Several referred to a degree of flexibility and responsiveness being key.

At the end of the year we have an annual planning. But when there is some kind of a request from a community organisation, in the middle of the year, [not within] our planning, we can't say no when it is a good opportunity for us to go there and talk about gambling issues. Sometimes it is that kind of request that makes us go [out of] our target.

In other words, our planning is not set in stone. It can be changed at any time. So it is always a living document.

We have a hui once a year where [staff from the different regions] meet and do a plan… and we do go over our specs, in terms of what the minimum delivery is. We have gone over few times and we deliver well over what is supposed to be anyway. So now we kind of let everyone go with the flow in terms of how they work… We all have slightly different working groups… So we all have slightly different ways of working but still manage to deliver.

Participants highlighted that collaborative work with other services was a factor that contributed to time and resource efficiency as it enabled a wider geographical reach and reduced overlaps. Such collaboration was facilitated by provider collectives and joint agency meetings.

In terms of planning for efficiency. When I first started I was on three days and was told that [the entire region] was the space that I was supposed to work on. I thought that was impossible. I was lucky when I was introduced to the Te Ngira Public Health working group; we collaborate heaps on the projects that we do. Because if each service just tried to do individual things, the spread of what we would achieve is so much less.

I think having Te Ngira increases the efficiency as well. Without communication between agencies, if we approach the community there may be overlaps in work we are delivering. If we communicate with each other about what we are going to do, what can be done and who can do it, in advance, that increases efficiency and outcome as well.

3.12   Summary of Findings

Service operational processes

- Staff believed that their organisations were effective in **utilising allocated full time equivalent (FTE) staff** for delivering services.

- For public health work, Ministry specifications on minimum delivery of services expected of one FTE staff were considered largely irrelevant when considering the reality of providers' delivery of services. Public health work was often delivered through teamwork and staff tended to hold dual roles where they were involved in both intervention and public health work.

- Although staff perceptions were that their organisations were effective in **utilising purchase unit funding** for delivering services, a few suggested the need for additional funding to support some areas.

- Staff perceptions about their existing **knowledge, and training and professional development**, suggested an effective workforce development although some training needs remained.

- In contrast, the audit process identified **workforce development** as an area of partial compliance - workforce development plans were not always prepared for each staff member and progress against the plans were not regularly reviewed.

- Staff views and **culturally appropriate approaches** documented in providers' reports suggested that providers were effective in delivering culturally appropriate services. However, a few culture-related issues suggested the need for service specifications that capture cultural aspects of service delivery.

- Staff believed that their organisations were effective in **sourcing and developing the resources** needed to deliver services. However, some inadequacies remained in resources to support public health work.

General areas of input required for service delivery

- Although most staff indicated satisfaction with **time allocation** for task completion or service delivery, almost one-quarter indicated that they were dissatisfied. Time insufficiency in some cases combined with staffing issues made it challenging to meet the outcomes of some public health services.

- Most staff members had several **years of work experience** within problem gambling services.

- Staff views were that for public health roles, **skills** in communication, adaptableness, personality and an understanding of the local community were more important than qualifications.

Six-monthly progress reporting processes

- Providers' six-monthly public health progress reports varied in terms of breadth, format (in using the Ministry's templates) and clarity (in connecting activities and outputs with purchase unit descriptions and outcomes).

- Staff believed that their organisations were effective in meeting the Ministry's reporting requirements.

- Staff believed that their organisations were successful in enabling staff understanding of reporting requirements, in consulting staff prior to reporting and in keeping staff informed about Ministry's comment on written reports. This suggested a good level of information sharing with staff.

- Time consuming reporting processes may have an impact on service delivery.

- Some staff suggested the need for a clearer alignment between the Ministry's reporting requirements and kaupapa Māori practices, and further clarity on the purpose of reporting on numbers.

CLIC data collection and submission processes

- Clinicians were aware of CLIC data collection and submission processes in place.

- Staff believed that their organisations were effectively meeting the Ministry's requirements for CLIC data submissions.

- The analysis of the CLIC database identified several ambiguities in recording (e.g. recording of treatment start and end, relapses and clients outside the standard treatment pathway).

- Some providers maintained additional client databases because of contractual requirements or for their own purpose (these databases contained other details regarded important for clients).

- For some participants, the need to manage two databases meant additional time was required and challenges were faced when transferring data into CLIC.

- Other participants noted the additional databases as compensating for perceived limitations in CLIC, which included:

- The frequent changes to its features
- Lack of client information depth
- Inability to capture newly emerging gambling modes (e.g. online gambling)
- Lack of useful measurement features for issues such as depression and anxiety
- Lack of capacity to capture Māori communication approaches and models
- Inaccessibility to staff working in satellite clinics
- The possibility of data entry errors.

- Some staff suggested that they worked around the requirements of CLIC data submissions while trying to meet clients' needs, which in reality may be different to the recommended number of sessions and timeframes.

- It was unclear whether a single CLIC database version that meets everyone's needs would be feasible.

- Some staff mentioned a lack of understanding of CLIC's functions and the need for further training.

Annual public health work plans

- A majority of staff involved in reporting believed their organisations were effective in submitting public health work plans.

- Over half of staff survey respondents were aware of the details of annual work plans in place for delivering public health activities. A few were not aware of annual work plans and some were not aware of the details.

- Annual work plans did not seem to be submitted at expected times.

- Variability was noted in how providers completed the different sections in the work plan (within and between providers).

- Providers often used the work plan template as a reporting tool, rather than a planning tool.

- When used as a planning tool, staff comments were that the template was used variably and adapted to fit needs. A lack of negative comments from the Ministry was interpreted as suggesting they were on the right track.

- Some staff commented on the limitations of the work plan which included its:
  - Difficulty of use
  - Lack of clarity in terms of what information was required
  - Generic nature
  - Lack of space for recording important aspects of service delivery
  - Lack of space for additional aspects such as budgets.

- Staff suggested that planning and delivery of public health services was not necessarily a straightforward process but was rather dependent on community needs and contexts within the regions that providers worked in.

- Although it was posited that careful planning of the five public health services could increase time and resource efficiency, staff responses were that collaborative work with other services was a key factor contributing to time and resource efficiency.

Utilisation of Purchase Unit Descriptions

- A majority of staff confirmed they were aware of Ministry of Health contract requirements and service specifications (i.e. respective *Purchase Unit Descriptions*) as well as the demographics of priority client groups.

- For intervention services, managers and team leaders ensured that staff were reminded about targeted activities and outputs detailed in the respective *Purchase Unit Descriptions*.

- Staff suggestions included the need for an updated *Intervention Service Practice Handbook*, and the need to reconsider the time allocations specified for the different intervention services as this conflicted with the realities of Māori communication approaches, which may require a longer engagement time.

- For public health services, there was minimal distinction between one purchase unit and another when planning projects. Planning focused on wider projects that contribute towards outcomes that meet contract requirements of several purchase units; considering that a single activity could be used to achieve the objectives within several purchase units.

Collaborations and joint initiatives

- Staff believed that their organisations were effective in building teamwork between intervention and public health staff.

- Focus group respondents confirmed that there was a good degree of collaboration between the public health and intervention teams when delivering services.

- Although staff were aware of the intrinsic links between public health and clinical work and the value of working together, the public health role was perceived as separate to the role of clinicians.

- Additional to collaborating with clinical staff within their own organisations, public health staff also collaborated extensively with other organisations. Such collaboration was mainly in the planning and carrying out of joint activities.

- Collaborative work with other PGPH providers:
  - Contributed to time and resource efficiency
  - Enabled training and knowledge exchange
  - Enabled a wider geographical reach
  - Enabled planning of public health work to suit the different organisations' time availability
  - Enabled sharing of responsibilities
  - Prevented overlaps in work
  - Enabled consistency in public health messages delivered by different service providers.

- In a small number of instances, providers reported on lack of collaboration, which included elements of competitiveness between providers and tensions resulting from different ways of working.

4 Problem Gambling Intervention Services

In New Zealand, secondary and tertiary gambling harm intervention services are "based on a multimodal approach and acknowledges the widespread impact of problem gambling on the individual and their family and affected others" (Ministry of Health, 2010, p. 20). These intervention services target at-risk and high need groups. Gambling treatment services are delivered through five types of intervention services: (1) *Helpline and Information Services*, (2) *Brief Intervention Services*, (3*) Full Intervention Services*, (4) *Facilitation Services*, and (5) *Follow-up Services*.

At the time of the present evaluation, intervention services were delivered by three national treatment providers and several regional treatment providers including dedicated Māori and Pacific services. Asian specific services were provided as a division of one of the national face-to-face treatment providers.

The Gambling and Addictions Research Centre's (GARC) earlier evaluation of Ministry of Health funded problem gambling intervention services suggested that even though clients were generally satisfied with the services they received (Bellringer *et al.* 2009; Bellringer, Coombes, Pulford, Garrett, & Abbott, 2010b) some staff responses suggested mixed views "as to whether current models of brief and full intervention were good approaches to assess or assist someone with a gambling-related problem and it was frequently suggested the contractual targets for delivering each form of intervention could be improved" (Bellringer *et al.* 2009, p. 9). That study also found that whilst there were "some differences between the individual gambling treatment services funded by the Ministry of Health in terms of client population group attracted and specific interventions provided, there [were] no major findings which would indicate that one type of service or intervention provision [was] significantly superior to another in relation to client outcomes" (Bellringer *et al.* 2009, p. 13). However, the evaluation was of a general nature and did not include in-depth individual evaluation of each type of intervention service; therefore, findings need to be viewed with caution.

The present chapter provides key findings from seven relevant data sources (available literature, staff survey, intervention staff focus group discussions, client survey, allied organisation survey, CLIC database and the clinical audit) in relation to four of the above-mentioned problem gambling intervention types (*Brief Interventions*, *Full Interventions*, *Facilitation Services* and *Follow-up Services*). Extracts from evaluation literature of relevance to these four intervention services types are provided in the respective sub-sections. The *Helpline and Information Service* has been previously evaluated (Abbott *et al.*, 2012, 2013) and is thus not included in the current evaluation. Nevertheless, some relevant CLIC data findings on helpline services are presented in respective chapters and a supplementary literature review report provides a more detailed account of other related literature of relevance this service.

4.1 Clients' initial entry pathways into services

The "typical pathways that clients use to access problem gambling intervention services" may result from the identification of their gambling problems by community support agencies or gambling venues or by chance during a public health activity carried out by the provider" (Ministry of Health, 2008b, p. 14). Clients may have been referred by other gambling services (e.g. Gambling Helpline) or they may have self-referred in a crisis stage (Ministry of Health, 2008b).

4.1.1 Initial entry pathways

Throughout the period from July 2010 to June 2013, a minority of clients were referred. Figure 11 shows the percentage of new clients (gambler or significant other clients) that were noted as referred to a gambling service provider. A much higher percentage of gambler clients (M=22.1%, SD=4.2%) were referred to gambling service providers than significant other clients (M=5.6%, SD=3.1%). No clear patterns were evident, but there were noticeable increases in referred clients of both types in January, October and December 2011 and a general trough early in 2012. Additionally, there was a large increase in the percentage of gambler clients referred in July 2011. Overall, however, these changes were largely due to variations in the numbers of non-referred clients.
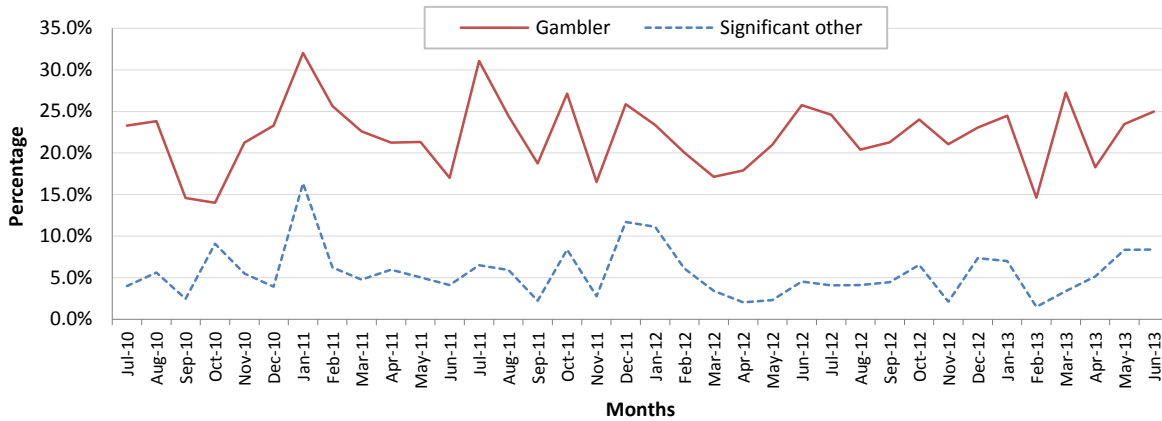
Figure 11: Percentages of new clients who were referred

The average monthly numbers of referrals (for gambler and significant other clients) to all providers are shown in Figure 12. Most referrals to problem gambling service providers came from other problem gambling services, regardless of whether the clients were gamblers (33 per month) or significant others (11). Referrals from the Justice sector were the next most common with an average of 26 gambler clients per month (on average one significant other client). All other sectors referred on average fewer than 10 new clients per month; Health Services referred an average of nine gamblers and four significant others per month. Just six new gambler clients per month were attributed to gambling industry referrals.
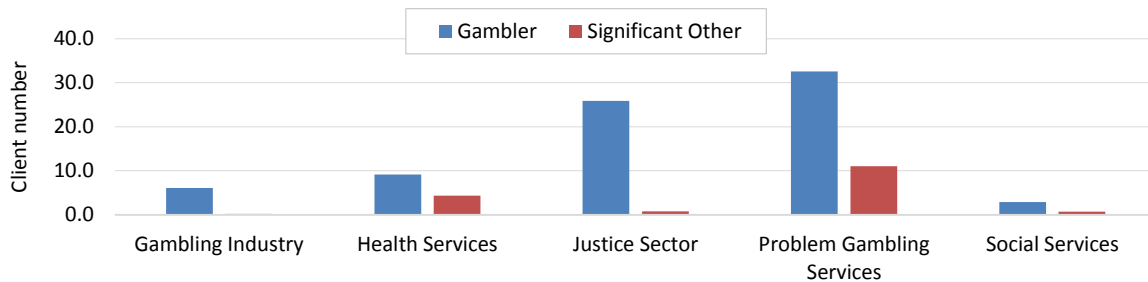
Figure 12: Average monthly referrals from different sectors as recorded in CLIC

The fewest referrals were from social services, with an average of three gamblers per month. These findings differed somewhat from staff perspectives. As Figure 13 below shows, the majority of staff survey respondents reported that client entry to a service was occasionally or frequently via referrals from allied agencies (i.e. social support services). Based on staff observations, clients' entry pathway into services were least frequently enabled by referrals from gambling venues compared to entry enabled by other means. On the contrary, findings based on records in the CLIC database (Figure 12) show that referrals of gamblers from gambling venues were twice the average of referrals from social services, and that both were relatively infrequent compared to other gambling services, the Justice sector and Health Services.
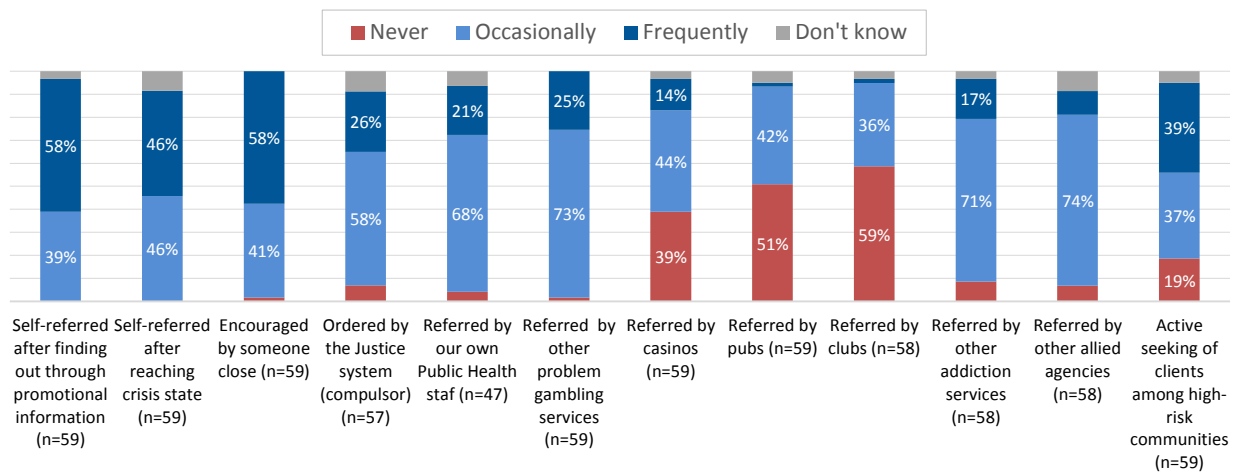
Figure 13: Frequency of clients' mode of entry into service as rated by staff

Overall, the CLIC data and staff responses suggest self-referrals were the most common mode of entry. Focus group participants were asked about activities that facilitated client self-referrals. Additional to media publicity and advertising which staff perceived as contributing to self-referrals, two intervention focus group respondents explained that another method used to enable clients' initial entry was through programmes unrelated to gambling. This was particularly important for communities that experience a stigma associated with admittance of gambling problems.

> Sometimes we run something that is totally unrelated to gambling. For example, a parenting programme. From the workshop, they ask for help because they know we are providing services in this area from paper and electronic media exposure. They come to our workshops knowing we work [with a problem gambling treatment provider]. They turn up.

> Among Māori, Pacific and Asian communities there is a strong stigmatisation associated with problem gambling. No one wants to seek help or be seen as a problem gambler. So that is why we use an indirect approach, we use parenting programme to run it; so afterward a lot of people come to seek help. Although initially all claimed that they had not gambling problems, but during the programme we found half of them indicated that they had been affected by problem gambling.

4.1.2 Impact of entry pathway on intervention outcomes

When asked if the mode of clients' entry into their service had an impact on intervention outcomes, the majority of staff survey respondents (74%) affirmed that it did. In detailing the differences they noticed, 18 staff respondents indicated that compared to self-referred clients, clients who were directed to undergo counselling by either the court system or exclusion programmes were less committed and had less motivation for change.

> If the client is self-referred, they have more motivation to control or stop their gambling. However, if they are coming due to other reasons, mandated, asked to do so by concerned others or to get back into casino (six sessions), they seem to be less motivated.

> Self-referred clients usually have better attendance and engagement in the counselling process which causes better outcomes in terms of awareness and behavioural change.

Two staff respondents reported the need to tailor intervention services to clients from different modes of entry as they were at different stages of readiness to change.

> In relation to what they come from, their readiness to change would be different so that in responding to their readiness, our treatment approach would be flexible to meet it.

> Justice-referrals require short term intervention; six to eight sessions. Self-barred, self-referred clients require six sessions. Mental Health referrals require more long term intervention.

4.1.3   Clients with a compulsory mode of entry

Analysis of the CLIC database indicated that there was an increase in referrals from the justice system (corrections and parole) particularly in 2012/13. Over half of staff survey respondents indicated that this mode of client entry occurred occasionally, while over a quarter indicated that this occurred frequently (see column four in Figure 13 above). Qualitative feedback from a few staff survey respondents suggested that clients referred through the justice system were less motivated to attend sessions and exhibited less commitment to making changes.

Considering this unique category of clients with a compulsory mode of entry into intervention services, focus group participants were asked if there were any measures in place to enhance the treatment outcomes for these clients. One explained that justice-referred clients were treated in a similar manner to other clients.

> …In terms of working with clients, we are mindful that they have come out from a corrective facility that wants to correct their behaviour. We are not set up to do that… So in some ways we don't work with them any differently than we do with other clients, because even though they have been mandated to come and get treatment we can't make them change. It is not what we are there to do. We can do as much as they want, they will engage when they want. Same as anybody else who comes to us, who has been coerced by a family member or whatever… probably we don't work with them too differently. Probably work with their motivation and that kind of thing.

However, another participant noted the unique situation of those clients that may necessitate additional support.

> The main thing with prison clients and justice referrals is that you may be the only person that they now have. Everyone else is gone, employers, whānau, partners, family, are gone. So, you are it. That is the difference.

Other participants explained the changes made, and approaches used, to accommodate the needs of those clients. These included increasing their treatment length, encouraging a more holistic life perspective, education on risk-taking behaviour and relapse prevention, making efforts to establish a trusting relationship, and providing additional assistance, which went beyond the scope of problem gambling counselling.

> We get a lot of justice referral because of drug and alcohol and often gambling is a secondary issue. In terms of catering for them we have moved from four to eight weeks. [An]…evaluation on groups showed that eight week groups were more therapeutically beneficial for consumers.

> We use the resistance – roll with it to look at resistance to change in other areas; give them the benefits to go holistic and look at the intangible benefits of their life. We work with motivational interviewing and we find that they are really open; once they see a brown face and they really work with us.

> …When we do get referrals from probation; I suppose with breaking the resistance; we tell them that we are not obligated to communicate or give any kind of written report to the probation officers without the client knowing first. So usually that breaks a lot of the barriers for them to be able talk to us

> The difference is that their criminal offending has put them on the margins. So you have got issues do to with their family rejecting them… Plus it can get into things like repossession by the person they have stolen from [and] issues like insolvency and… It can become extremely tense; so you need to educate your client about all of that very often. The issue with the family… [can at] times… be difficult; the person is about to be sentenced and the family does not know anything about the crime… You also need to prepare them for the court experience… I have done role plays with them about how you behave in court; and also [the importance of appearance and looking tidy].

4.1.4   Impact of national social marketing campaigns on help-seeking behaviour

When asked why they sought help from a gambling support service, only nine client survey respondents (6%) indicated having been encouraged by a service provider they met at an "information stall at a public event or festival." Four other clients reported other forms of national awareness raising campaigns that may have led to their help seeking behaviour:

I heard the advert on the radio and phoned up for information.

[At a] TAB [outlet]. Information by way of pens, Choice Not Chance.

Television.

Poster advert on the door of the ladies toilet [at a] bar.

Overall, staff respondents were evenly split in their views of the impact of social marketing campaigns with 51% reporting that they noticed increases in help-seeking behaviour following major national public health activities such as on National *Gamblefree Day* or following *Choice Not Chance* campaigns. However, three commented that the increases were not substantial. Forty-nine percent reported that they did not notice such impacts.

Two respondents suggested that seeking client feedback was one way for estimating the effectiveness of public health communication efforts.

Clients are asked how they came to our service and when there has been a publicity campaign may give this as the reason.

People refer to the TV ads quite often.

Four participants reported that the increased levels of awareness about gambling harms and about the availability of support services resulted in increased help-seeking behaviour.

Around *Gamblefree Day*, people understand more about gambling harm and more people know where to get help.

Two participants reported increased numbers of *Brief Interventions* as an indicator; six others noted increases in calls, enquiries and referrals following national public health activities.

I have noticed at our *Gamblefree Day* event the many referrals that came through as opposed to normal weekly/fortnightly events that take place in the communities. The event encouraged those affected to admit and make a stand.

Often see a slight increase in referrals following advertising campaigns.

4.1.5   Impact of local public health promotion activities on help-seeking behaviour

Twenty-three (16%) client survey respondents reported that being encouraged by a service provider they met "at a public meeting, workshop or public health presentation" was a reason for their initial help-seeking behaviour while nine (6%) indicated a service provider they met at an "information stall close to a supermarket or shopping mall" was their reason.

Just over half (58%) of staff survey respondents indicated that they noticed increases in help-seeking behaviour following awareness-raising activities during local events and festivals organised by PGPH service providers in their area.

Two staff respondents reported that their clients had suggested the effectiveness of local public health promotion activities.

When client come, they told us that they found out about our service through a public health promotion…

Three staff respondents associated help-seeking behaviour with enhanced awareness about gambling harms and availability of support services.

We have draw cards at our stall and this is our opportunity to explain our service and how they could be affected. Eighty percent of those we speak to are most likely affected. This increases help-seeking behaviour because it's like a domino effect when they share to family and friends.

Two staff respondents reported the value of using language- and culturally-appropriate approaches at such events as this enables more effective awareness-raising among specific ethnic groups. Four staff reported increased numbers of brief screenings and interventions during these events.

Yes, clients are aware of their gambling issues and shared their struggles in these events; numbers increase in filling up of gambling screens.

4.2   Primary mode of harmful gambling

The primary mode of problem/harmful gambling is recorded within the CLIC database. As shown in Figure 14 and Figure 15, among both gambler and significant other clients, pub-based EGMs are the most commonly cited primary mode of problem gambling. For gambler clients this is around 50% of clients, and for significant others it is around 60%. For both client groups, casino EGMs are the second most commonly cited form of problem gambling (in 2012/13, 16% and 12% respectively). When all EGMs are combined (pub, casino and club) they are cited as the main form by approximately 70% of gambler and significant other clients. Across both client groups as a whole, there is some evidence for an increase in the percentage of clients citing casino based gambling, and small decreases in those citing club EGMs and track betting across the three years. Among gambler clients, there was a decrease in those citing Lotto, and a parallel increase in significant other clients.
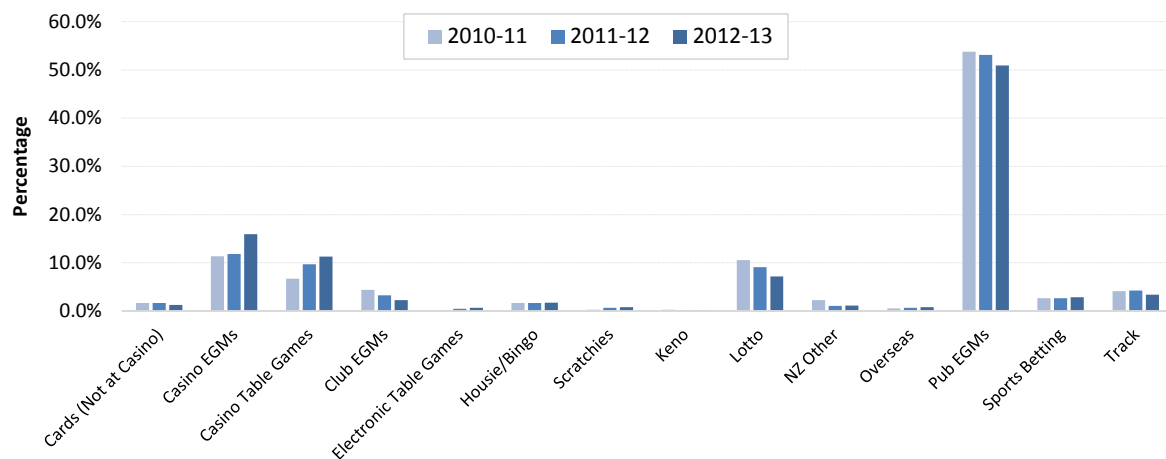
Figure 14: Primary mode of harmful gambling among gamblers

Figure 15: Primary mode of harmful gambling experienced by significant others

When considered by provider type, some differences emerged among clients of Māori and Pacific providers (Table 5 in Appendix 4) whilst the data from general and Alcohol and Drug services approximated the overall figures. Among gambler clients of Māori providers, two-thirds reported pub EGMs as their primary mode; the comparatively lower figures for casino gambling likely reflected the rural populations often serviced by these providers. Nonetheless, casino EGMs were the second most commonly cited form (increased to 9% in 2012/13) and EGMs generally were cited by 80% of Māori provider gambler clients. Lotto was also cited by a noticeably higher percentage of clients of Māori providers (7.5% in 2010/11 and 2012/13 and 10.3% in 2011/12).

Lotto was the most frequently cited form of problem gambling among gambling clients of Pacific providers (approximately one-third of clients). Casino and pub EGMs were next, and both increased annually; together all EGMS were the primary mode of problem gambling for 41% of gambler clients of Pacific providers in 2012/13 (cf. 33% citing Lotto). Housie/bingo and "NZ other" gambling were also more common among this client group.

As the percentages in Table 5 show, the significant other client data were similar to the gambler client data, with the exception of significant other clients of Pacific providers. Among these clients, Lotto was not the most commonly cited form of problem gambling (12% vs. 33% of gambler clients), rather pub EGMs (38%) and casino EGMs (25%) were more common, and two-thirds of these clients cited EGMs overall. This finding seems to suggest that Pacific gamblers experiencing problems with EGM gambling might not be seeking help or may not be comfortable admitting issues with EGMs.

4.3   Population serviced

Intervention service providers were required to target at-risk and high-need populations within their areas (Ministry of Health, 2008). Māori and Pacific communities "have continued to be more at risk of gambling problems since 1991" (Ministry of Health, 2009, p. 89). Additionally, "people aged 35-44 years", "people with lower educational attainment" and people living in more deprived areas are at greater risk for experiencing gambling harms (Ministry of Health, 2009, p. 56).

Based on an analysis of the CLIC database (covering a three-year period from July 2010 to June 2013), the following sections details general trends[30] in the number of clients accessing a service at least once each month across all gambling treatment services (i.e. number of clients who accessed at least one Brief, Full, Facilitation or Follow-up session). Trends (based on these montly numbers) are presented for selected demographic variables, i.e. client type (gambler and family /affected other; hereinafter referred to as significant other), gender, ethnicity, and age.

Provider-level differences are based on the total numbers of clients who accessed a service at least once in the 12 month period. These data are presented in tables in Appendix 4. The geographic locations of clients are detailed using yearly client number data for the July 2012 - June 2013 reporting period only.

Client types (gamblers and significant others)

Overall, an average of 1,840 clients[31] accessed a service at least once within each month (SD=230). As shown in Figure 16 noticeably lower numbers were evident in December and January each year (Dec: M=1,490, SD=36; Jan: M=1,386, SD=102). Average values for other months ranged between a low in April of 1,735 (SD=79) to a high of 2,072 in March (SD=68).

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[30] Trends and estimates reported in this section are based on the total number of clients in each respective month. A client who accessed a service more than once in a particular month is counted as one client for that month; the same client accessing the service in a subsequent month is re-accounted for in the totals for that month. Therefore, these data cannot be used to estimate total number of clients in a year.

[31] This average is based on the total number of clients who accessed a service at least once in each respective month thus cannot be used to estimate total number of clients in a year.
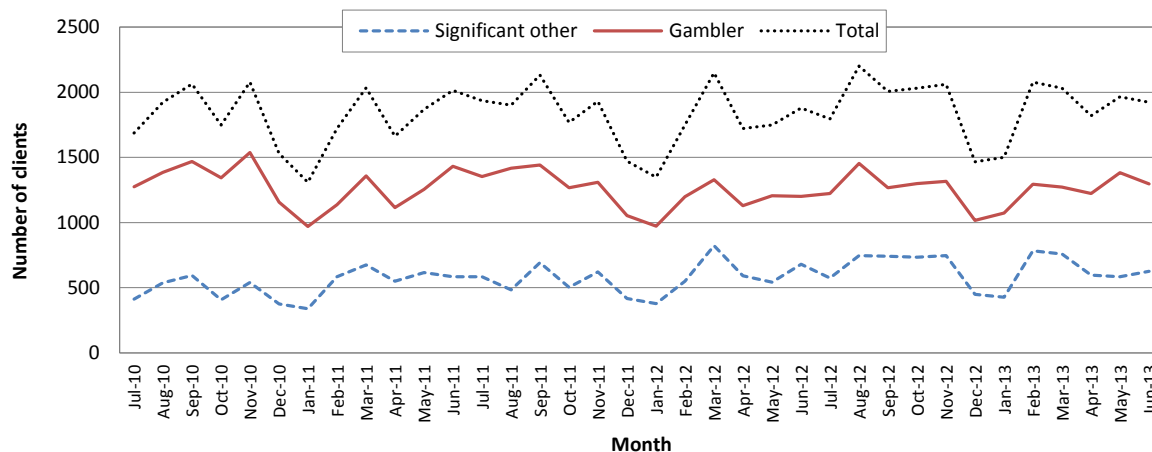
Figure 16: Total number of clients who accessed a service in each month

Over two thirds (M=69%, SD=4%) of clients were gamblers. On average 1,262 gambler clients accessed a service each month (SD=141). In contrast, the montly numbers of significant other clients were more variable (M=579, SD=127). That variability was due to proportionally large decreases in significant other clients having sessions throughout the December-January periods when numbers were 35% lower than the rest of the year; whilst for gamblers they were 20% lower across this period.

As the yearly client numbers detailed in Table 6 (in Appendix 4) show, there was some variation across providers. Among the general providers, two (A01 and A11) were consistent with the overall trends shown in the monthly client numbers. One (A02) had approximately half of its clients in each category and another (A15) had almost exclusively gambler clients. Similar variation was evident among Māori, Pacific and Alcohol and Drug services. Among Māori providers, five (B05, B07, B10, B12 and B7) had consistently fewer, or had shifted towards having fewer, gambler clients. One Pacific provider (C19) was similar. Others had either two-thirds or more of gambler clients or in some cases (B18, D03, D16) almost all their clients were gamblers.

Gender ratios

Figure 17 shows the percentage of clients (total, gambler and significant other) who were female. Overall, trends in monthly client numbers indicated that half of all clients were female, this was consistent across the entire three-year period (M=51%, SD=2%). However, there were gender differences between the two client types (gambler and significant other). There were consistently fewer female gambler clients (M=45%, SD=2%) and females did not reach 50% of total gambler clients in any single month throughout the three-year period. In contrast, nearly two thirds of significant other clients were female (M=64%, SD=3%) throughout the three year-period.
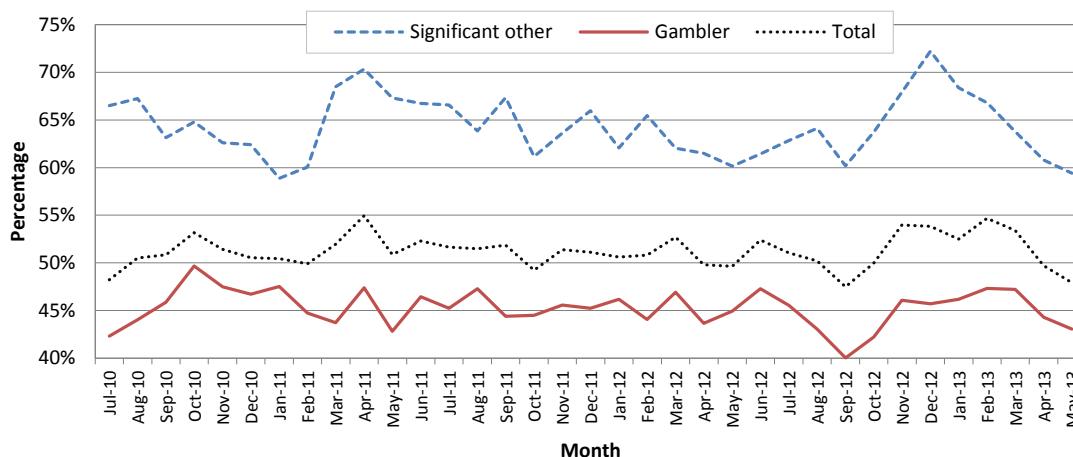
Figure 17: Percentage of female clients who accessed a service in each month

As the yearly client numbers detailed in Table 7 (in Appendix 4) show, at a provider level these data were consistent. Females were consistently the larger proportion of significant other clients, with the only consistent variation from this being two Pacific (C04 and C19) and one Māori provider (B14). Similarly, in 31 of 48 instances, males were 50% or more of gambler clients. However, there was a more even split among the Māori providers (13 of 30 instances had more male clients) and Pacific (4 of 9), although it should be noted that the largest Pacific provider (C04) consistently had three quarters of its gambler clients being male.

Client ethnicity

Clients were grouped into four key ethnicity categories: Māori, Pacific, Asian and European/Other. The percentages of gambler clients by these ethnic groups, who accessed a service at least once within each month, from July 2010 to June 2013 are shown in Figure 18. Decreases in gambler client numbers were generally evident annually in December and January, with the possible exception of Asian clients. The European/Other group was consistently the largest (M=622, SD=72) accounting for about half of all gambler clients (M=49%, SD=2%). There was some evidence of a decline in the percentage of gambler clients in the European/ Other group, with July 2012 being the last month in which more than 50% of clients were European/Other. It is not clear whether this very slight decrease is due to a reduction in the percentage of European clients or a more accurate recording of ethnicity in other categories. This possible change aside, the ethnic composition of the gambler client group was very stable, with only the percentage of Pacific clients varying to any degree.
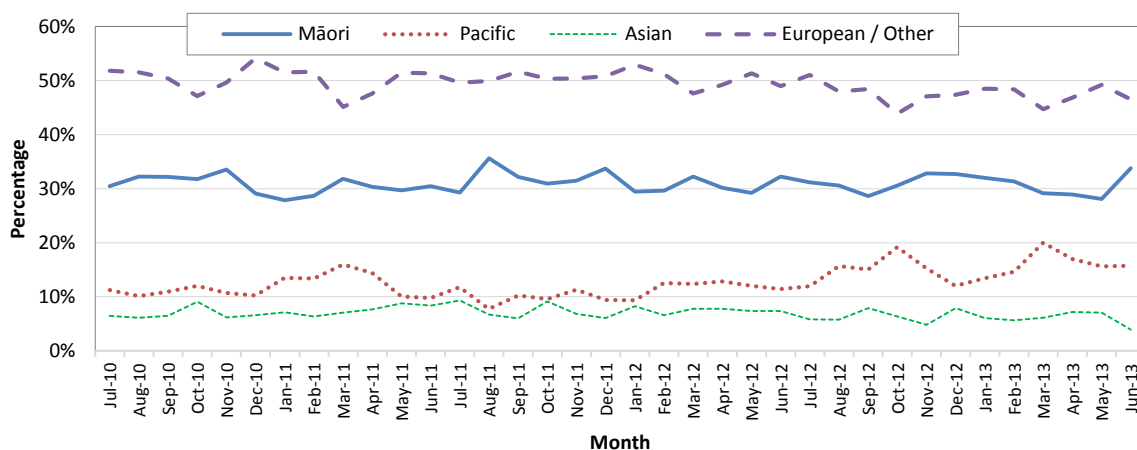
Figure 18: Percentage of gambler clients who accessed a service in each month by ethnicity for the 3-year period

Yearly client numbers (Table 8 in Appendix 4) show that among the general providers, the European/ Other group was the largest for gamblers. At one (A11) the percentage declined over time from 73% to 55%, at another (A02) it remained constant at around two-thirds, and at the other two (A01, A15) approximately half of gambler clients were European/Other. Twenty percent to 30% of gambler clients at each of these providers were Māori, and seven percent to 10% were Pacific. Asian clients were approximately 10% of all gambler clients at service A01. Among the Māori service providers, Māori gambler clients tended to be the largest group, but some Māori providers also had large percentages of gambler clients in the European/ Other group (notably B05, B09, B12, B13 and B18). Among Pacific providers, the majority of gambler clients were Pacific people. The two Alcohol and Drug providers had mainly European/Other (53%-84%) and Māori (16%-41%) gambler clients.

The percentages of significant other clients, accessing a service in each month, by ethnicity are shown in Figure 19. These data are more variable than the gambler client data (c.f. Figure 18). The largest two groups are European/Other (M=224, SD=56) and Māori (M=203, SD=58). These two groups generally accounted for 30% to 40% of significant other clients (European/Other: M=39%, SD=7%; Māori: M =35%, SD=5%). The numbers and percentages of Pacific significant other clients were more variable than the other ethnicities (M=132, SD=46; M=23%, SD=6%) but there was some evidence of a general increase in numbers accentuated by annual peaks in March and most recently November. The

numbers (M=19, SD=6) and percentage (M=3%, SD=1%) of Asian clients remained low and consistent throughout the three-years examined.
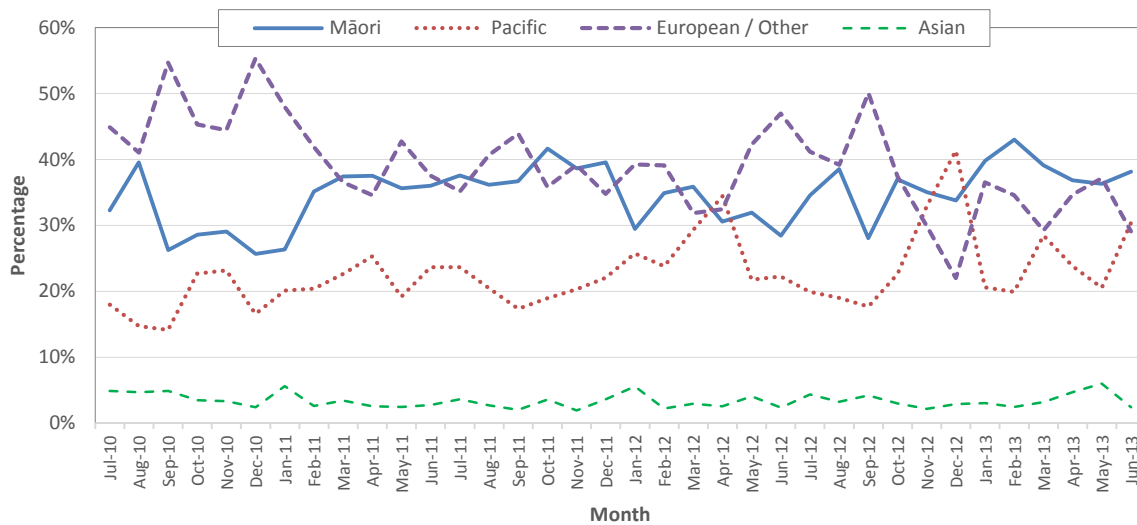
Figure 19: Percentage of significant other clients who accessed a service in each month by ethnicity

Again, yearly client numbers indicated that among general providers, the European/Other group was the largest significant other group, although in one (A02) the Māori significant other client group was a similar size (Table 9 in Appendix 4). Pacific significant other clients were a large group (18%-29%) for two providers (A01, A02); for AO1 this was second to European/Other, and approximately twice as large as their Māori significant other client group. Moreover, approximately 10% of A01's significant other clients were Asian. Amongst the Māori providers, the majority of significant other clients were Māori; some Māori providers (B05, B09, B10, B12, B13 and B14 had substantial proportions of significant other clients of European/Other ethnicity. As expected, the majority of Pacific providers' significant other clients were Pacific people, with one provider (C08) having a substantial proportion of Māori clients. One Alcohol and Drug provider (D16) had a large number of significant other clients who were almost exclusively European/Other.

According to the 2013 Census results, 74% identified as European, 15% as Māori, 12% as Asian and seven percent as Pacific (Statistics New Zealand, 2014). Recording of ethnicity differs across sources so caution must be used; nonetheless, this would seem to imply that Māori and Pacific people were over-represented among both gambler and significant other clients. However, as these groups have substantially greater risk of developing problem gambling than European/Other (Abbott, Bellringer, Garrett, & Mundy-McPherson, 2014) it is expected that they would seek help from appropriate services at a higher-than-expected level proportional to overall population.

Client age range

The ages for about six percent of clients were not recorded. As Figure 20 shows, among clients who had an age group reported, there was some evidence that significant other clients were more likely to report their age as being less than 30 years. Gambler clients tended to be within the 30-39 years and 40-49 years age ranges[32].

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[32] These are indicative data only. Percentages for the age categories were based on the total number of clients assessing a service at least once each month over the entire 3-year period. This equated to 45,422 gambler clients and 20,834 significant other clients accessing the services over the 3 years. Although the monthly numbers, when aggregated in this manner, are larger than actual annual client numbers because they includes multiple counts of the same clients accessing the service throughout the 3-year preriod, it provides a rough estimate of the typical age categories of clients accessing services each month.
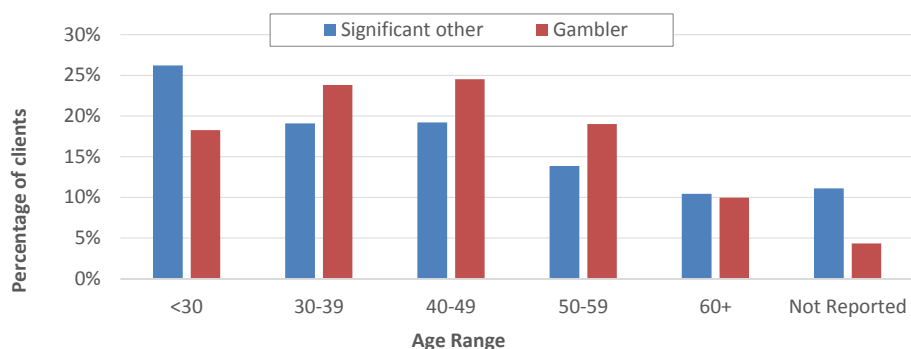
Figure 20: Average age range figures for gambler and significant other client groups

Geographic spread

The geographic spread of clients[33] was considered by provider type (General, Māori, Pacific, Alcohol and Drug) for the 2012/13 period. For gambler clients of **General Service** providers, the larger numbers of clients were generally resident in more densely populated urban areas (notably several in the Auckland region). In the 2012/13 period, 11 Territorial Local Authority (TLA) boundaries were each home to more than 100 clients. In order from largest number to smallest number of gambler clients for this reporting period, these were:

- Auckland (Howick, Maungakiekie-Tamaki, Orakei, Watemata and Gulf, Whau) (728 clients)
- Christchurch (Christchurch City Council, Banks Peninsula] (664 clients)
- Auckland (Manukau) (383 clients)
- Dunedin (222 clients)
- Auckland (North Shore, Albany) (179 clients)
- Auckland (Mount Albert-Eden-Roskill) (170 clients)
- Auckland (Waitakere) (157 clients)
- Hamilton (155 clients)
- Wellington (155 clients)
- Clutha District (113 clients)
- Tauranga District (109 clients)

The significant other client numbers tended to be similar in their geographic distribution. Just five TLA boundaries had more than 100 significant other clients with General Service providers. Again, these tended to be in urban areas (and again, several in the Auckland region):

- Auckland (Manukau) (768 clients)
- Auckland (Howick, Maungakiekie-Tamaki, Orakei, Watemata and Gulf, Whau] (386 clients)
- Christchurch (Christchurch City Council, Banks Peninsula] (333 clients)
- Auckland (Manurewa-Papakura) (243 clients)
- Auckland (North Shore, Albany) (216 clients)

There were some differences compared to the gambler client numbers, with some regions having more significant other clients and other areas having fewer.

Amongst **Māori providers,** there were some differences with more rural and smaller urban TLA boundaries being prominent. In the 2012/13 period, 12 TLA boundaries were each home to 50 or more gambler clients of Māori services, in order from largest to smallest number of clients, these were:

- Hastings District (209 clients)*

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[33] Derived from total number of clients who accessed a service in a 12 month period.

- Whangarei District (162 clients)*
- Napier (147 clients)*
- Rotorua District (125 clients)*
- Auckland (Manukau) (111 clients)
- Hamilton (108 clients)
- Invercargill (102 clients)*
- Far North District (95 clients)*
- Auckland (Manurewa-Papakura) (81 clients)
- Porirua District (75 clients)*
- Nelson (60 clients)*
- Gisborne District (52 clients)

Those marked with an asterisk, and the Waikato, Whakatane, Wairoa, Central Hawkes Bay, Palmerston North, Horowhenua and Tasman District TLA boundaries all had more Māori clients than general services in 2012/13.

Among Māori providers, 13 TLA boundaries also had 50 or more significant other clients:

- Hastings District (307 clients)*
- Whangarei District (92 clients)*
- Napier City (206 clients)*
- Rotorua District (195 clients)*
- Auckland (Manukau) (129 clients)
- Hamilton (298 clients)*
- Invercargill (53 clients)*
- Far North District (64 clients)*
- Auckland (Manurewa-Papakura) (54 clients)
- Porirua District (250 clients)*
- Waikato District (87 clients)*
- Gisborne District (100 clients)*
- Wairoa District (58 clients)*

Again, those marked with an asterisk, and the Taupo, Western Bay of Plenty, Whakatane, Kawerau, Central Hawkes Bay, Wanganui, Palmerston North, Tasman and Nelson District Councils all had more Māori clients than general services in 2012/13 (Note: some numbers were very small).

Pacific provider gambler clients were concentrated in four Auckland TLA boundaries: Manukau (369 clients); Waitakere (155 clients); Howick, Maungakiekie-Tamaki, Orakei, Watemata and Gulf, Whau (126 clients); and Manurewa-Papakura (61 clients). Ten percent of clients from Porirua District Council were clients of Pacific services. As with gambler clients, Pacific significant other clients were concentrated in four Auckland TLA boundaries: Manukau (257 clients); Waitakere (94 clients); Howick, Maungakiekie-Tamaki, Orakei, Watemata and Gulf, Whau (84 clients), Manurewa-Papakura (39 clients). There were also 109 Pacific significant other clients in the Porirua District.

Alcohol and Drug service gambler clients were largely from the Auckland regions, although the majority of clients from the Masterton and Carterton District Councils attended Alcohol and Drug services. In 2012/13, very few significant other clients accessed help through Alcohol and Drug Services; however, in the preceding two years there were on average 35 clients per year in the Masterton District (just three clients in 2012/13).

4.4 Delivering to client needs

4.4.1 Providers' compliance with the "Client Rights" audit criteria

Areas covered during the clinical audit to gauge providers' compliance with client rights included:

- Rights to an advocate
- Opportunities to provide feedback
- Managing complaints
- Informed consent
- Confidentiality
- Access to appropriate information

The auditors did not identify any significant areas of partial or non-compliance with the Client Rights criteria. The audit reported the following findings:

- All providers had information available for potential and current clients to access about the providers' services. This information was usually in the form of a brochure; although some providers had information available online.

- All providers had policies and procedures for ensuring that clients gave their informed consent prior to receiving services. All clients interviewed recalled receiving information about the services and auditors were able to sight evidence that clients had provided informed consent.

- All clients interviewed confirmed they were informed of their right to have an advocate.

- All providers had policies and procedures to ensure that information about the client is disclosed to a third party only with the client's informed consent, and only to assist in effective service provision and for achieving positive outcomes for the client.

- All providers had written and implemented procedures for managing complaints from clients and their whānau/family. Clients were aware of where to find information about the complaints procedure should they wish to make a complaint. All providers had information available at their premises.

- Clients were given opportunities to give feedback on the services they received either formally through client feedback forms and surveys or informally during the counselling process. However, as noted in audit findings in relation to the "quality management" criteria, while auditors sighted evidence that feedback was received, seven out of eight of the providers had not collated and analysed the feedback in order for client input to be reflected in the maintenance and improvement of the quality of service.

4.4.2 Providers' compliance with the "Service Delivery and Quality" audit criteria

The "Service Delivery and Quality" audit criteria included the following aspects:

- Quality management
- Access and entry
- When services are declined
- Plan of care
- Minimum delivery of services (referred to as "Implementing the care plan")
- Planning discharge from and/or transfer between services
- Managing client information
- Workforce development
- Participating in research and evaluation

The audit found that all eight of the providers had areas of non-compliance or partial compliance with

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the "Service Delivery and Quality" audit criteria. Audit findings on the "Workforce development" aspect of this criterion are detailed in Section 3.6 in the preceding chapter.

Quality management

Each provider is required to develop, document, implement and evaluate a transparent system for managing and improving the quality of services to achieve the best outcomes for clients. As part of this system, the provider is required to prepare a Quality Plan that is designed and implemented to improve outcomes for clients, and is reviewed at least annually. The plan should outline a clear quality strategy and the organisational arrangements to implement it. The plan should also be of a size and scope appropriate to the size of the provider's service. In addition to the Quality Plan, quality improvement data should be collected, analysed and evaluated. If necessary, corrective action plans should be developed to address areas requiring improvement.

The audit found "Quality management" as an area of partial compliance. The auditors noted the following findings:

- Four out of the eight providers had quality management plans in place. However, only two had reviewed their plans annually to ensure that the quality strategy and the risks associated with the provision of services were still relevant.

- The remaining four providers did not have a documented quality management plan; however, elements of quality management, such as collecting quality improvement data, were still evident across all eight providers.

- All of the providers collected at least some quality improvement data (including feedback from their clients). However, four out of eight providers did not have processes in place to collate and analyse the collected information.

- As there were few instances where quality improvement data had been analysed, very few providers had developed corrective action plans to address the issues identified by clients or the provider themselves.

Plan of care

Providers' contracts with the Ministry state that they must develop a written plan of care and record of treatment for each client which:

- Is based on an assessment of the client's individual needs (including cultural needs)

- Includes consultation with the client

- Includes consultation with the client's family and/or caregivers where appropriate, and with the consent of the client

- Contains detail appropriate to the impact of the service on the client

- Facilitates the achievement of appropriate outcomes as defined with the client

- Includes plans for discharge or transfer

- Provides for referral to, and co-ordination with, other medical services and links with community, iwi, Māori and other services, as necessary.

Additionally, the Health and Disability Service Standards state that the needs, outcomes and/or goals of clients should be identified and documented via the assessment process, and serve as the basis for service delivery planning. The assessment and intervention outcomes are to be communicated to the client, referrers and relevant service providers.

"Plan of care" was identified as an area of partial compliance in the audit process. The auditors noted the following findings:

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- Care plans were not consistently completed at six out of eight providers. In most instances, the care plans were incomplete, as they did not provide sufficient detail on the assessment of need, support and interventions required to achieve the client's desired outcomes.

- At one of the above six providers, only the goals of clients were documented and not the assessment of need nor the interventions required for clients to achieve those goals.

- At four out of eight providers, assessments of need had either not been completed or not been documented for every client. Where the assessment of need had been completed, there was insufficient information documented to support the assessment process.

The Health and Disability Service Standards also state that reviews of progress against the client's plan of care should be documented, service user-focused, indicate the degree of achievement or response to the support and/or intervention, and the progress towards meeting the desired outcome. Additionally, the reviews should be carried out regularly in order to monitor progress, and if progress is not as expected, the plan altered in response.

The clinical audit noted the following findings:

- At six out of eight providers, reviews of progress were not being carried out consistently. The auditors found instances where:
  - The client's file did not record the progress made towards achieving their goals.
  - When progress was being monitored, care plans were not altered when it was identified that progress was not as expected.

Planning discharge from and/or transfer between services

The contract requires that providers develop policies and procedures for planning discharge or transfer of clients from their services. This includes the requirement for providers to identify, document and minimise the risks associated with each client's transition, exit, discharge or transfer.

The audit found this aspect to be an area of partial compliance. The auditors reported the following findings:

- All providers had policies in place; however, these policies could be improved to ensure coverage of all areas set out in the contract with the Ministry. For example, ensuring that discharge planning is incorporated into the client's plan of care, where appropriate, from or before admission.

- At four out of eight providers, the documentation to support the planning for discharge or transfer was insufficient. The auditors found that the planning on the client files did not identify the risks of relapse associated with the client's discharge or did not indicate that the discharge or transfer had been planned in collaboration with the client.

Minimum delivery of services

Each contract between the Ministry and the provider sets out the types of intervention service, and the minimum number of sessions, that are agreed to be delivered by the provider. The volume of sessions varies for each provider based on the number of full time equivalent employees that will be providing the service. The audit process identified the minimum number of sessions for each service type in each provider's contract and compared this to the actual number of sessions delivered by the provider.

The audit found this aspect (referred to as "Implementing the care plan") to be an area of non-compliance. The auditors found that for:

- *Brief Intervention Services* - three of the seven providers contracted by the Ministry to deliver this service did not deliver the minimum number of sessions required under their contracts.

- *Full Intervention Services* - five out of the eight providers did not deliver the minimum number of sessions required under their contracts with the Ministry.

- *Facilitation Services* - five out of seven providers contracted by the Ministry did not deliver the minimum number of facilitation sessions required under their contracts.

- *Follow-up Services* seven out of the eight providers did not deliver the minimum number of sessions required under their contracts with the Ministry.

- *Workshop-based Intervention Services* - the provider contracted to deliver this service met the minimum requirements of its contract with the Ministry.

- *Helpline and Information Services* - the provider contracted to deliver this service met the minimum requirements of its contract with the Ministry.

Providers discussed with the auditors the challenges in delivering the minimum number of contracted services. The most common challenges related to staffing, such as high staff turnover, difficulties in recruiting new staff, and long periods of staff absence due to serious illness.

Providers also mentioned difficulties in specifically providing *Follow-up Services* as often clients could not, or did not want to be contacted after the conclusion of their *Brief* or *Full Interventions* and services received through *Facilitation Services*.

4.4.3   Meeting client general needs

Generally, staff and client survey findings suggested that operational processes ensured provision of services that met the general needs of clients as service users. Nearly all clients were satisfied with the services provided by their respective treatment providers (with 73% indicating they were very satisfied and 22% satisfied). A high percentage of clients (98%) also confirmed that they found all aspects of the service to be helpful. Only three clients (2%) indicated the contrary; for one, location of the service was a deterrent and for the other, information on behavioural change strategies was lacking.

Service aspects selected by a higher percentage of clients as being particularly helpful were treatment approaches, counsellors' skill and staff friendliness (Figure 21). Location of services was important to over half of client respondents. Among the 66 individuals who indicated availability of a gender specific counsellor as a helpful aspect of the service, there were more females (n=43) than males (n=20).

In explaining other aspects of the service that were helpful, nine clients re-emphasised counsellors' skills and personality. Eight clients reported particular components of their treatment programme such as group discussions and relationship counselling. Other useful aspects related to approaches (including cultural approaches) that made clients feel safe and supported leading them to feel valued and empowered (reported by eight clients). Four clients reported services' mobility to be useful as it enabled out-of-office sessions; this was an aspect specific to dedicated Māori services.
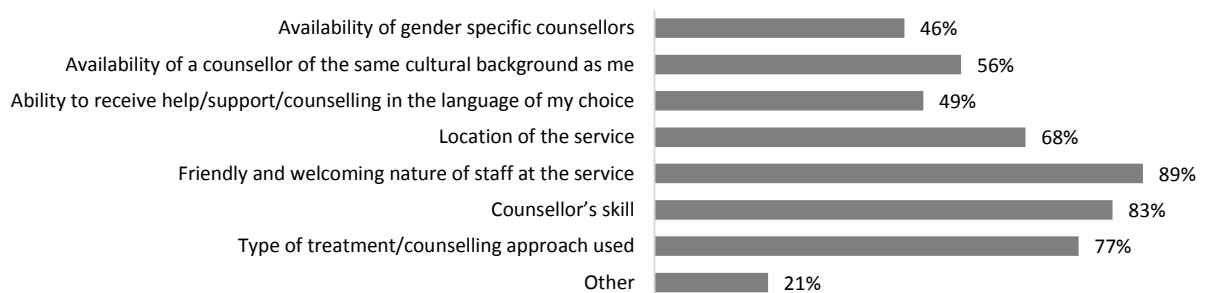
Figure 21: Services aspects that clients found particularly helpful (n=145)

4.4.4   Personalised service delivery

Communication via email and text messages are not regarded as "valid modes for a face-to-face brief or full intervention or facilitation or follow-up services" (Ministry of Health, 2008b, p. 42). This is based on evidence showing the value of "client-practitioner relationship" for successful client outcomes. The "Ministry of Health believes practitioners should encourage clients to attend face-to-

face sessions and offer phone support when the client cannot attend a face-to-face session" (Ministry of Health, 2008b, p. 42). However, as described in the literature review in the sections that follow, online intervention methods and other types of intervention that require little direct interaction with clients suggest that these "impersonal" methods can be effective for achieving client outcomes such as changes to gambling behaviours.

Drawing from entries in the CLIC database, Table 10 (in Appendix 4) shows the manner of service delivery (face-to-face or telephone) and number of sessions across the three years for each provider and for gamblers and significant other clients. Considering gamblers first, all services except two conducted the majority of their sessions face-to-face. One exception was the national helpline through which almost all sessions were by telephone; the other was general service A11 where the percentage of face-to-face sessions rose annually (29.1%, 31.3% and 39.7% for 2010/11, 2011/12, 2012/13 respectively). On average, the percentage of face-to-face sessions for other providers was approximately 80% (85%, 84%, 81% annually). One provider, Māori service B17, conducted almost all sessions (100%, 99%, 99% annually) face-to-face, while a Pacific provider (C04) had the lowest percentage of face-to-face sessions (aside from the two services using telephone sessions more often) with two-thirds to three quarters of sessions being face-to-face (65%, 69%, 74%). Overall, there was little difference between general (removing the two providers who specialise more in telephone sessions), Māori, Pacific and Alcohol and Drug services, which all conducted about 80% of their sessions face-to-face.

The types of intervention approaches that client survey respondents indicated having experienced are shown in Figure 22. Eighty-two respondents reported that they were they were supported in various ways, by selecting more than one option.
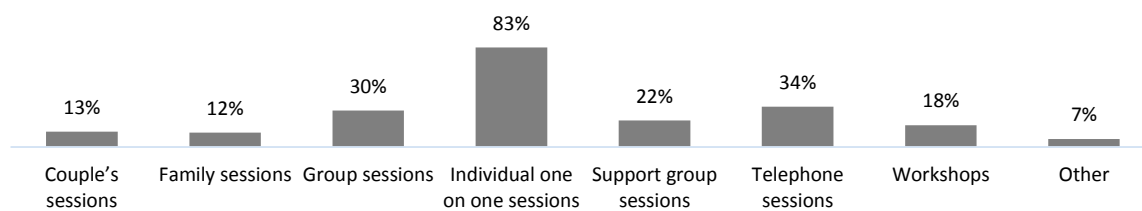
Figure 22: Clients' experiences of intervention services (n=148)

Based on CLIC database entries, Tables 11 and 12 in Appendix 4 detail four intervention approaches (individual, group, family and couples) that providers used with their clients and the number of sessions across the three years for each provider for gambler and significant other clients respectively. For gambler clients, the majority of sessions were individual sessions, with one exception being Alcohol and Drug service D03 which largely ran group sessions. In general, there seemed to be two approaches. Several providers (notably general providers A01, A02, A11 and Pacific provider C04) undertook the majority (60-80%) of their sessions with gambler clients individually. These were supplemented by 10% to 35% of group sessions and relatively rarely with family sessions (Pacific provider C04 used these most often, with about four percent of their sessions being with family) or couples sessions (general provider A01 used these most often, with about 4.5% of their sessions being with couples). Other providers almost exclusively conducted individual sessions with gamblers; notably (with the exception of B06) this included all other Māori providers. Providers B06 and C08 appeared to have shifted towards a greater (50%) use of group sessions with gamblers.

The intervention approaches used for significant other clients were very similar to those with gamblers; in the majority of cases, individual intervention approaches were used. The only difference worth noting is one general provider (A11) which made more use of group sessions with significant other clients (as compared to gamblers), and in 2012/13 more than half of its sessions for significant other clients were group sessions.

4.4.5 Meeting cultural and spiritual needs

Since ethnic-specific services "focus on a specific population group" they should be "based on a non-mainstream cultural paradigm", deliver services "in a manner that utilises culturally derived beliefs,

values and practices" and "employ staff who are of the same ethnic descent as the population being worked with wherever reasonably possible" (Ministry of Health, 2008b, p. 8). General services were also expected to be "responsive to the particular cultural needs of service users by delivering services that are culturally safe and that may include programmes based in culturally specific paradigms" (Ministry of Health, 2008b, p.10).

The eight providers selected for the evaluation and clinical audit comprised two *General Service* providers, three *Dedicated Māori Service* providers, two *Dedicated Pacific Service* providers and one *Dedicated Asian Service* provider.

Intervention services in line with cultural and spiritual needs

The Cultural Advisory Group recommended that the staff survey include items addressing clients' spiritual and religious needs. In the Ministry's *Co-existing issues screen*, a question on family/whānau concerns about gamblers' health and wellbeing included concerns about "spiritual health". However, that clients might vary in their response towards spiritual and religious approaches was acknowledged. For instance, some clients may "find the spiritual approach of Gamblers Anonymous of calling on a 'higher power' too religious" (Ministry of Health, 2008b, p. 76).

From staff survey responses, it was noted that the ethnic-specific service providers (among the eight selected providers) tended to employ staff who were of similar ethnic backgrounds as their clients. Although general services had largely European staff, a small number were of other ethnicities.

Most of the staff survey respondents reported that their organisations were effective in delivering intervention services in a manner that met clients' cultural needs as well as their spiritual and religious needs (see rows seven and eight in Figure 4 in the preceding chapter). However, a comparison of percentages across client groups based on their ethnicity[34] shown in Figure 23 and Figure 24 indicated there were some differences in how clients' responded to these aspects. While most Māori, Pacific and Asian clients indicated satisfaction with service provision that met their cultural and spiritual/ religious needs, a higher percentage of European clients indicated that these were not of relevance to their needs.
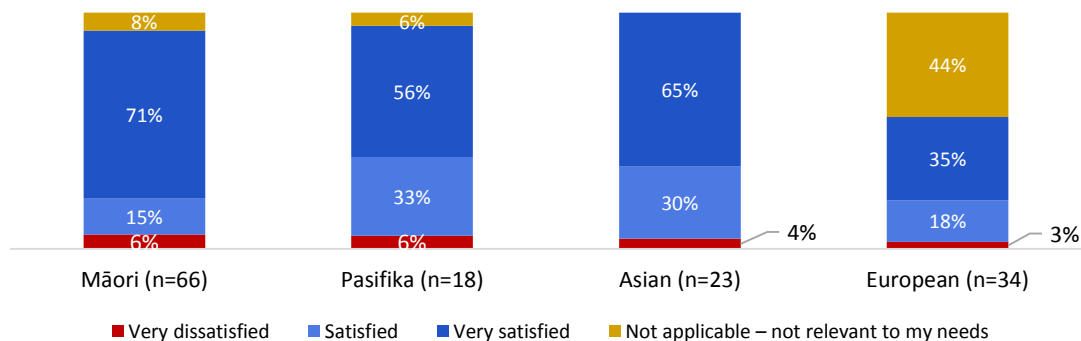
Figure 23: Clients' satisfaction with the provision of services that met their cultural needs

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[34] The percentages shown for the "Very dissatisfied" categories are likely to be a result of response error. Clients may have selected the wrong end of the scale while ticking their answers as an inspection of their responses to other questions suggested that these clients were generally satisfied with their service providers.
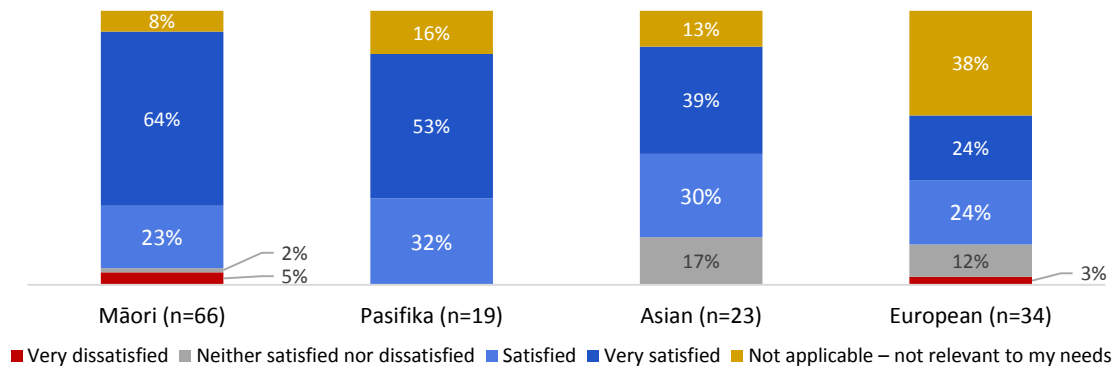
Figure 24: Clients' satisfaction with provision of services that met their spiritual or religious needs

A comparison of percentages across client ethnic groups (Figure 25) also indicated that only a small portion of European clients found the provision of service in a language of their choice and counsellors of similar culture to them as service aspects that were particularly helpful. A service provided in a language of the client's choice was noticeably more important to Asian clients; although it should be noted that language barriers were an issue in accessing Pacific participants for the survey.
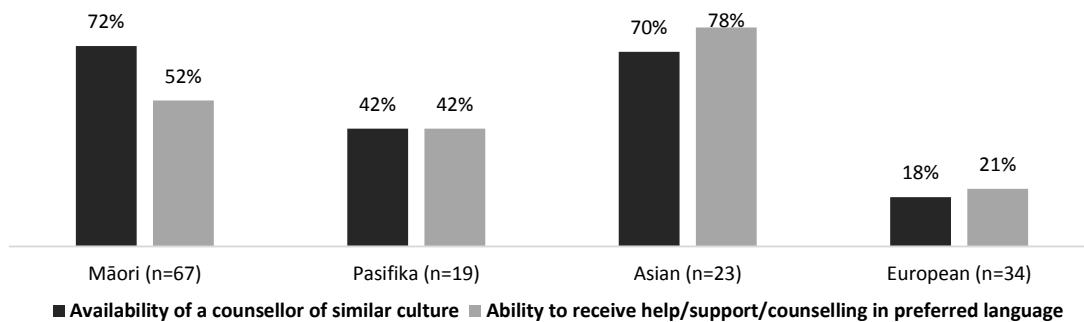
Figure 25: Culture-related service aspects that clients found particularly helpful

Comments from a Māori client of a general service provider suggested that quality of service and respectfulness may outweigh cultural appropriateness in some cases.

> The service as a whole in relation to cultural appropriateness was awesome. I am a European/Māori female and my two counsellors were Asian and the respect shown to me in the beginning in regard to offering to find me a Māori counsellor if that was what I wanted is greatly appreciated; however, my response at that time was no because I believed as long as I received the help I was seeking then and to me the counsellor's ethnicity was not an issue. I must add that my two counsellors are really awesome ladies.

Likewise, a comment by a Pacific client of a general service provider suggested an acceptance of counsellors of dissimilar ethnic background.

> I was not sure that counselling support in different languages [was available]. In any case, my main language is English. I did not know that counsellors that were of the same cultural background as me were available. My counsellor is Asian, I am fine with this.

However, most Asian clients indicated that services in their language were helpful to them and for many among both Asian and Māori client groups, availability of counsellors of similar cultural background was helpful. There was a self-selection bias here as most Asian and Pacific client respondents were clients of ethnic-specific services; thus there is the implicit suggestion (evidenced in the quotes above) that clients will actively seek the sort of service they require.

Providers' compliance with the "Cultural Perspectives" audit criteria

The purpose of the ethnic-specific services is to minimise gambling-related harm particularly to, and for, Māori, Pacific and Asian people.

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The clinical audit did not identify any significant areas of partial or non-compliance with the Cultural Perspectives criteria. The auditors reported the following findings:

- All clients interviewed reported a high level of satisfaction with the cultural elements of the services they had received.

- Services delivered by General Service providers were accessible to all groups regardless of gender, ethnicity, age or health status. Clients had access to cultural support and expertise as required to ensure the services were culturally safe and appropriate to a diverse population.

- Services delivered by Dedicated Māori, Pacific and Asian services were based in each of their own cultural paradigms. The services utilised their beliefs, values and practices specific to its clients' cultures.

- Where reasonably possible the staff at the Dedicated Māori, Pacific and Asian services were of the same descent as their clients.

- Staff interviewed could not recall any instances where clients who were not of Māori, Pacific or Asian descent were excluded from any of the dedicated services.

- All of the providers' staff and clients had access to appropriate cultural advice and support from a kaumātua. This assisted providers in ensuring they offered an environment that was culturally safe for Māori clients, their whānau/family, and significant others, as well as for those delivering the services.

4.4.6   Enabling access to a range of services

The Ministry's aim is to ensure that clients have access to "a comprehensive range and mix of services" at a regional level (Ministry of Health 2008, p. 4). The Ministry expects that "regardless of the range of services an individual provider delivers, all providers… work collaboratively to co-ordinate services within their region and ensure the populations they serve have access to those services" (Ministry of Health 2008, p. 4).

The present evaluation does not include an analysis of providers' progress reports on intervention services to determine if providers purposefully collaborated with other services in their region to broaden client access to a range of services. Nevertheless, collaboration with other services as a general organisational process has been addressed in sub-section 3.2 in the preceding chapter. Collaboration, as a purposeful process to enable client access to other support services, is discussed in Section 4.9 (*Facilitation Services*).

Eighty-four percent of staff survey respondents reported that their organisation offered other support services in addition to problem gambling services; the types of services they indicated are detailed in Figure 26.
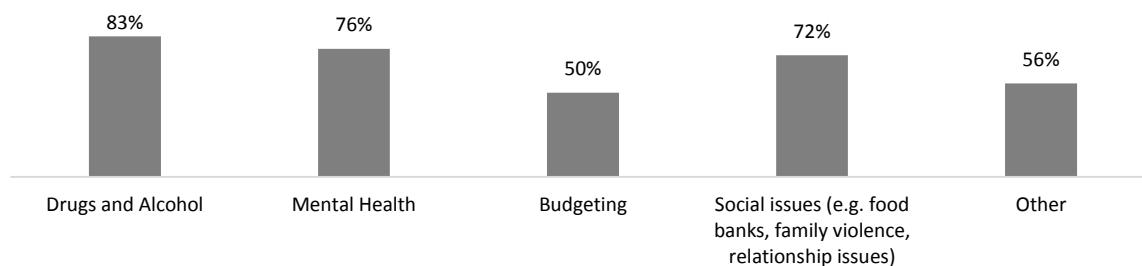
Figure 26: Other services offered in addition to problem gambling services as indicated by staff survey respondents (n=54)

Additional services mentioned included supportive accommodation, elder services, positive lifestyle and live skills programmes, stress and anger management, parenting programmes, youth mentoring programmes, welfare services, smoking cessation programmes, and support to access other services, as needed. In delivering intervention services for a client presenting with multiple issues, 30% of staff survey respondents reported that the common practice in their organisation was one dedicated staff

member delivering all services for that client. Seventy percent reported that clients were referred to other staff members in their organisation who would then provide services in other areas for that client. A few mentioned that clients were also referred to other organisations, when needed.

4.5 Pathways of Intervention Services

4.5.1 Pathways

The Ministry has considered evidence that supports "the effectiveness of brief intervention of 15-30 minutes over 1-2 sessions, and a number of 60-minute full psychosocial intervention and facilitation sessions followed by follow-up" (Ministry of Health, 2010, p. 20). The Ministry's preferred practice of intervention sessions delivery is outlined in the figure below.
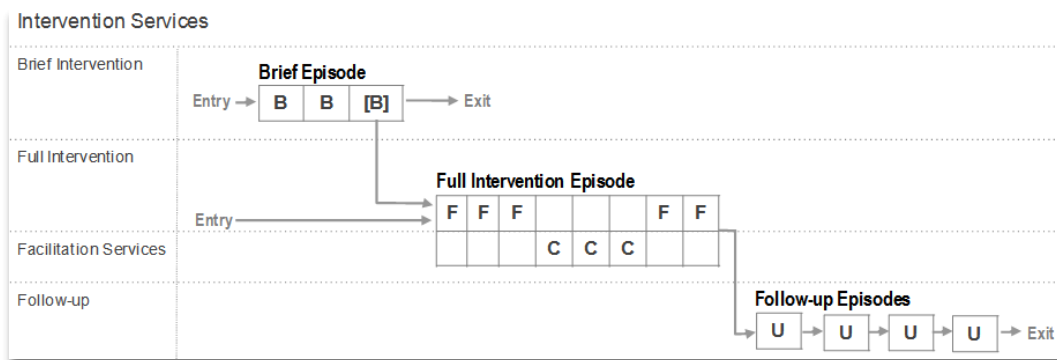
Figure 27: Preferred pathways for intervention services (Ministry of Health, 2010, p. 20)

A *Brief Episode* should contain one or two (B) brief intervention sessions followed by a brief follow-up contact. A *Full Intervention Episode* contains a "maximum of eight sessions comprising of a mix of (F) Full Intervention sessions and (C) Facilitation sessions" (Ministry of Health, 2010, p. 21). A *Follow-up Episode* consists of a schedule of follow-up sessions "at 1, 3, 6 and 12 months after the last Full Intervention Episode session" (Ministry of Health, 2010, p. 21). However, the Ministry recommends that practitioners "use their clinical judgement when dealing with exceptions, particularly when clients are presenting in crisis or issues of safety are involved" (Ministry of Health, 2008b, p. 1).

For the present analyses, clients (excluding pre-existing clients at 1 July 2010) were collated by pathway groups. The preferred pathways were denoted as follows:

- B - up to three Brief Invention sessions

- F - up to eight Full Intervention or Facilitation sessions

- BF - combination of Brief Invention and Full Intervention

- BFU - combination of Brief Invention and Full Intervention and up to four Follow-up sessions

- FU Full Intervention and up to four follow-up sessions

The non-preferred, or other pathways were denoted BF+, FF+U, BM, F+, F+U, FM, U and UM. The F+ indicates *more than* eight Full and/or Facilitation sessions, and the M denotes *a mixture* of Full, Facilitation and Follow-up sessions where *at least* one Follow-up session was interspersed between various combinations of Full or Facilitation sessions.

Overall, the majority of gambler clients followed Ministry preferred pathways; however, this percentage has decreased in successive years from 96% in 2010/11 to 77% in 2011/12. As shown in Figure 28 there was a decrease in the number (2,012 to 1,718) and percentage (62% to 32%) of gambler clients on the B pathway. Across the same period, increases were evident in both the numbers and percentages

of clients on the other four preferred pathways and several (BF+, BF+U, BM, F+, F+U, FM) non-preferred pathways. Overall, more clients were in various pathways with full sessions but these did not necessarily follow brief sessions.
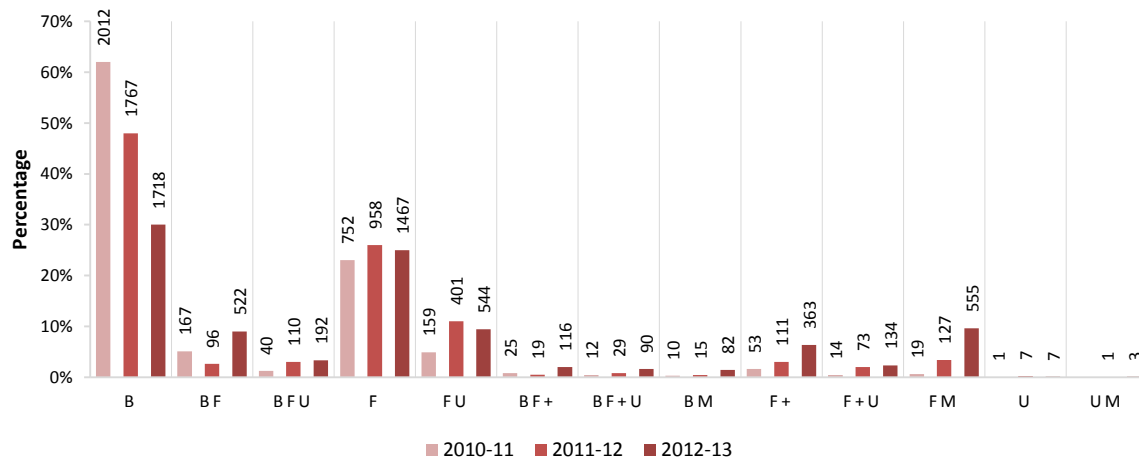
Figure 28: Percentage and number of gambler clients on treatment episode pathways

These patterns were reasonably representative of a provider-by-provider consideration. In 2010/11 (across providers) between 64% (D03) and 100% (A15, B09, B12, B13 and C19) of gambler clients were tracked on preferred pathways. Moreover, this figure was below 90% for only two providers (D03 and B06; 70%). The most common non-preferred pathway was F+ (more than eight Full or Facilitation sessions) but that included only 53 clients overall (1.3%). Just six providers had more than five percent of gambler clients who were on non-preferred pathways, and only three of those included 10 or more clients (B06: 30%, 17 clients; B10: 5.4%, 13 clients; C04: 10%, 19 clients).

By 2012/13 these figures had shifted to where only one provider (A15: 92%) had more than 90% of gambler clients on a preferred pathway. As seen in Figure 28 above, there was a substantial decline in gambler clients on the B pathway, paralleled by an increase in BF and BFU pathway clients. Two providers had half or more of their gambler clients on non-preferred pathways (B18: 50% and D03: 83%) and a further eleven (A01: 24%; A02: 23%; A11: 36%; B06: 34%; B07: 20%; B13: 21%; B14: 35%; B17: 30%; C19: 36%; and D16 21%) had more than 20% on these pathways. As is evident in Figure 28, the most common were F+ (more than eight Full or Facilitation session and FM (up to eight Full or Facilitation sessions with *Follow-up* sessions interspersed)).

Figure 29 shows the same data for significant other clients and indicates that although the percentage of significant other clients on the B pathway decreased over the three-year period; the actual numbers of significant other clients on this pathway increased (2,640 in 2010/11 to 3,310 in 2012/13). This trend was paralleled by increases in the percentage and numbers of significant other clients on other preferred pathways (BF: 55 [1.8%] to 511 [9.7%]; BFU: 9 [0.3%] to 105 [2%]; F: 311 [10%] to 747 [14%]; and FU: 42 [1.4%] to 206 [3.9%]). In 2012/13, there were still over 90% of significant other clients on preferred pathways, and as in Figure 28 very substantial increases in the numbers of significant other clients having full intervention sessions following brief sessions. The most non-preferred pathway in 2012/13 was F+ with a total of 180 clients (1.8% of significant other clients).
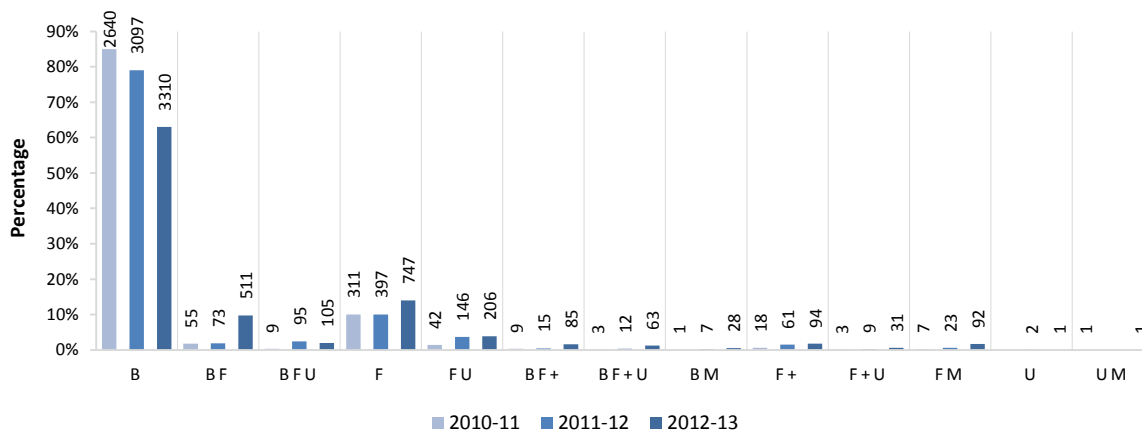
Figure 29: Percentage and number of significant other clients on treatment episode pathways

A provider-by-provider consideration is similar. In 2010/11, just two providers had less than 90% of significant other clients on preferred pathways (B06, 82% of 76 clients and D03 with a single significant other client). In 2012/13, this increased to six providers (A01 89% of 1,160 clients; A11 83% of 104; B07 87% of 347; B13 81% of 53; B14 80% of 40; C04 86% of 249; and C08 78% of 217).

4.5.2 Relapse

Table 13 (Appendix 4) shows the recorded relapses (determined by a gap of least three months between sessions) by provider for each year. For gambler clients there was an increase over time, with relapses reported for just 1.5% of gambler clients in 2010/11. For all providers except A15 (29%, 5 of 17 clients) less than 10% of clients had relapses recorded. However, in 2012/13 this increased to 11% of gambler clients overall. Closer inspection of the data shows that this was, to an extent, a result of a substantial increase in relapses among clients of provider A01 (1.7%, 26 clients to 16%, 336 clients). Two newer providers (B06 and C08) also had substantial proportions of clients relapse (31%, 63 clients and 33% 74 clients respectively). It is not clear from these data what might underlie the increase in relapses or gaps of three months or more between sessions for clients of provider A01. This pattern is mirrored almost exactly among significant other clients. Less than one percent of significant other clients relapsed in 2010/11; this increased to 6.4% in 2012/13. Again, underlying this was a substantial increase for provider A01 (1.3%, 11 clients in 2010/11 to 14% 160 clients in 2012/13, and providers B06 (29%, 52 clients) and C08 (18%, 40 clients).

4.6 Treatment completion

The Ministry recommends that providers "aim for a full intervention episode to end with a 'treatment completion' discharge code… when the treatment ends with the client's successful completion of agreed" interventions (Ministry of Health, 2008b, p. 101). A clear ending of a full intervention episode enables the commencement of a follow-up episode a month later. However, the Ministry recognises that discharges are not always clear "and often service providers are attempting to connect with clients, by phone or mail, who have not attended previously scheduled appointments" (Ministry of Health, 2008b, p. 101). In such cases, the Ministry expects that multiple attempts are made to reconnect with clients and the following four possible scenarios and methods for opening and closing episodes are noted (Ministry of Health, 2008b, p. 102):

(1) An "administrative discharge" should be made for clients following unsuccessful attempts to re-contact them within a 90-day countdown period.

(2) Successful re-contacts with clients who agree to recommence intervention should be recorded as a *Full Intervention* session.

(3) A "treatment partially complete discharge" should be made for a re-contacted client who "does not agree to recommence intervention, but does agree to engage in follow-up" and "a follow-up episode is started" for such a client.

(4) A "treatment partially complete discharge" should be made for re-contacted clients who decline both intervention recommence and follow-up; in this case "a follow-up episode is started, and the contact is recorded as a one-month follow-up. The follow-up episode is ended, and the provider notes that no further follow-up is required.

For the purpose of examining treatment completion, data on clients' "last visit" have been used. Clients were classified as "ongoing" or "complete" for each year. Ongoing means there were sessions in the following year; and, completed means that the last session was recorded in the period in question. For 2012/13, clients were classified as complete if no session was recorded in the three months leading to April 1 2013, and ongoing if at least one session was recorded in that period.

Many clients did not have a last visit recorded and variation was evident in how the last visit flag in CLIC was used. In some cases, the last visit flag was used for all of the last *Full Intervention* sessions, the last *Facilitation* session, and the last *Follow-up* session. The reasons for last sessions (summarised in Figure 30) were variable, suggesting multiple last visits were not necessarily indicators of a relapse and further treatment. Findings from the present analyses suggest that different providers and perhaps even different counsellors apply different rules in specifying last sessions.
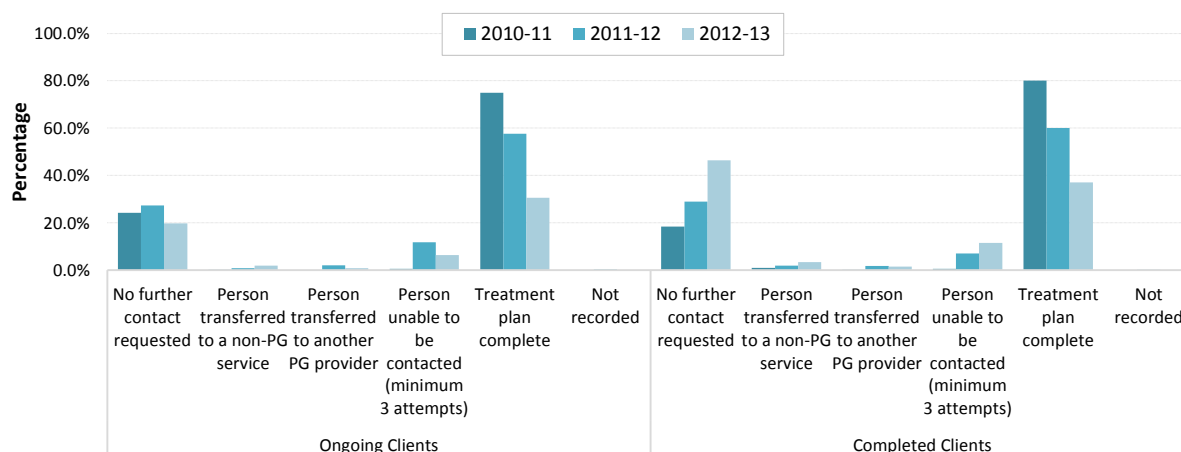
Figure 30: Reasons for last session

Figure 31 plots the number of last sessions recorded for ongoing clients who naturally should not have "last sessions" (as noted above, the 2012/13 data are determined differently). There is some evidence suggesting that the occurrence and number of last sessions for ongoing clients is declining.
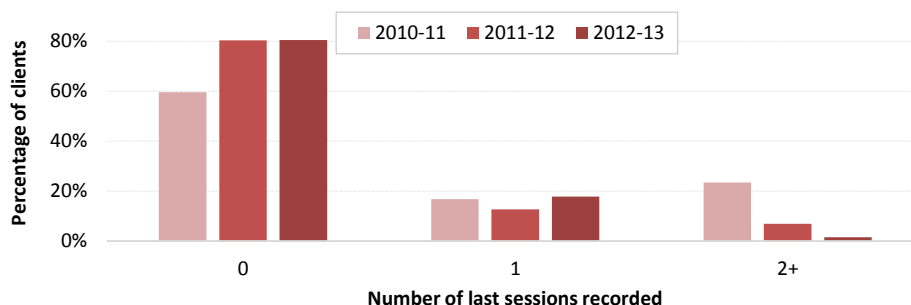
Figure 31: Number of "last" sessions recorded for ongoing gambler clients

However, Figure 32 shows that the number of last sessions recorded for completed clients also declined. Therefore, the suggestion seems to be that there is a tendency to not record last sessions, as opposed to an improvement in practice/record keeping.

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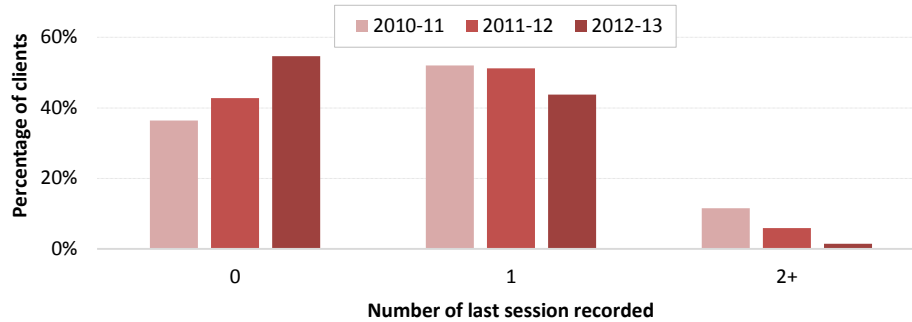
Figure 32: Number of "last" sessions recorded for completed gambler clients

This is further supported when data from individual providers are considered (Table 14 in Appendix 4). General providers A01 and A02 provide an illustration. In both 2010/11 and 2011/12, provider A01 had no last visits recorded for all of their ongoing clients; this decreased slightly in 2012/13 but could be due to the different way those data were collated. In contrast, provider A02 had a substantial proportion of ongoing clients (42%, 76% and 34% in successive years) with last visits recorded. The immediate implication is that provider A01 is recording this information more accurately. However, when completed clients are considered, provider A01 also recorded most of them with no last visits (76%, 83%, and 78% in successive years), indicating a general tendency to not record last sessions. In contrast, provider A02 was more variable with the majority of completed clients (95%) having a single last visit recorded in 2010/11, one-third (32%) in 2011/12 and just 16% in 2012/13. Other providers tended to be more similar to provider A02, with a high proportion of completed clients having a last visit recorded in 2010/11 and a decline since, and variable percentages of ongoing clients having last sessions recorded.

4.7   Brief Intervention (PGCS-02)

Brief Intervention services offer one client entry pathway, funded by the Ministry to support providers to actively seek at-risk individuals and enable their entry into treatment services. The objective of PGCS-02 is to provide services "specifically for people early in the course of developing gambling problems. The service aims to encourage individuals experiencing harm from gambling to recognise and acknowledge the consequences of their gambling and either make changes to their gambling behaviour or seek specialist support where necessary" (Ministry of Health, 2010, p. 24). *Brief Interventions* are also described as "opportunistic" encounters with individuals who are yet to realise that they are experiencing gambling harms. Usually, such individuals are not ready to accept responsibility for their gambling; they "may not realise the impact of their gambling on their life or on the lives of those around them, or may not realise that they have been affected by someone else's gambling and can seek help for themselves" (Ministry of Health, 2008b, p. 22). Brief interventions thus target "people who are at risk of gambling harm and who may be experiencing some of the effects of such harm, but who do not yet associate their gambling with the problems in their lives" (Ministry of Health, 2008b, p. 11). While PGCS-02 is a service area itself, it is one that also functions as an "input" for the delivery of the subsequent *Full Intervention* services.

Aspects from the Purchase Unit Description and the *Intervention Service Practice Requirements Handbook*, the likely outputs, and expected outcomes are summarised in a preliminary logic model (Figure 33). Activities within this intervention could include screening, problem gambling assessment, delivery of brief interventions, provision of education and information, and referrals to more intensive problem gambling services or other services.

PGCS-02   Brief Intervention

Inputs	Activities	Outputs	Outcomes

Inputs
- Purchase Unit Funding
- Staffing
- Qualification, competencies, skills and experience

Activities
- Seek out environments and community settings in which to engage with at risk populations
- Establish partnerships with community agencies that are in contact with high-risk groups (e.g. Community Corrections, WINZ, budgeting services, foodbanks, and Child, Youth & Family)
- Carry out screening for suicidality / homicidality potential
- Carry out gambling problems assessments using Ministry-approved tools
- Carry out brief interventions (as outlined in the current Ministry Intervention Service Practice Requirements)
- Facilitate culturally appropriate interventions or referrals
- Provide at risk groups with accurate education and information on gambling harms and available interventions
- Offer all brief intervention clients the option of an additional contact within two weeks of the previous intervention

Outputs
- People, previously unaware, alerted to the possibility that they have an addiction to gambling and related harms
- Early detection of symptoms among people at the early stages developing gambling problems enable the prevention of gambling harms progression
- Identified individuals referred to intensive problem gambling intervention services (including Facilitation) where appropriate
- Identified individuals referred to other services where appropriate
- Individuals initiate contact with a gambling intervention service because of increased concerns about gambling harms
- Increased awareness of gambling harms among family/whānau and significant others
- People rethink how gambling is affecting their life and consider changes at their own initiative as a result increased awareness

Outcomes
- People identified as problem gamblers or being at risk of gambling related harm receive evidence based brief motivational support and intervention that encourages reductions in gambling related harm to them and their family
- People experiencing gambling harms recover from their addictions without formal problem gambling support

Figure 33: Preliminary Logic Model: Brief Intervention

This chapter consists of findings from the literature that were of relevance to Brief Intervention services, the staff and client surveys, two focus group interviews with staff delivering intervention services and analysis of the CLIC database. The survey and focus group findings represent the seven providers (of the eight selected) contracted to deliver *Brief Intervention* services.

4.7.1   Literature review

In the literature, *Brief Interventions* are also referred to as *early interventions* and include various types of brief intervention programmes as detailed below.

Brief cognitive/behavioural treatment programme to influence gambling decisions

Robson, Edwards, Smith and Colman (2002) employed a pre-test/post-test design to evaluate the efficacy of *Gambling Decisions*, an early intervention programme in Canada. The programme used an eclectic approach in designing a brief cognitive/behavioural treatment programme for individuals in the early stages of developing gambling problems that offered a choice of control-related goals and abstinence-related goals. The programme's aims were to reduce gambling frequency, time spent and money lost, as well as reduce the number of problems clients would face in their home, social and work lives. The findings, based on 60 individuals who participated in the programme and completed four questionnaires (prior to the programme, immediately after, and upon completion of six months and 12 months), showed money lost in gambling was reduced from an average of $680 per month to $116 at the sixth week of the programme and to $73 at 12 months. The average monthly hours spent on

gambling were significantly reduced from 23.5 hours at the pre-test to 6.5 hours at the 12 month post-test. Gambling frequency was also significantly reduced and participants reported substantial reductions in gambling-related life problems after completing the programme.

Self-help interventions

In another Canadian-based study, Cunningham, Hodgins, Toneatto, Rai and Cordingley (2009) described a self-help intervention that used personalised feedback as a brief intervention approach. This enabled gamblers to self-evaluate their behaviours by providing them with summary information that compared their gambling behaviours with those of the general population. In a pilot evaluation of this intervention, 61 participants were randomly assigned to receive the personalised feedback summary or to a wait-list control group. At a three-month follow-up (N=49), the authors found that compared to the control group, participants who received personalised feedback showed some evidence that they were spending less money on gambling.

The above intervention was subsequently made available online at www.CheckYourGambling.net, and referred to as the Check Your Gambling screener (CYG). Cunningham, Hodgins and Toneatto's (2011) pilot evaluation of this online, personalised feedback screener for problem gamblers suggested the potential of this tool for encouraging short-term decreases in gambling behaviour. The authors noted the need for further research to determine if the CYG screener is capable of encouraging reductions in gambling behaviour or motivating treatment-seeking action among problem gamblers. Nevertheless, they argued that the advantages of tools such as the CYG are that they offer a gateway that is simple to access and unthreatening, to motivate gamblers to seek further assistance either online or through face-to-face services.

Venue self-exclusion programmes

Within the context of the Ministry's service specifications, venue-self exclusions are more commonly delivered through *Facilitation Services* (PGCS-04) and also relate to activities delivered for the *Safe Gambling Environment* (PGPH-02) public health service when working with venues.

However, as identified in the literature, self-exclusion from gambling venues has the potential to serve as an effective early intervention as it can positively influence treatment outcomes and support the recovery of individuals in the starting phases of developing gambling problems as well as those with established gambling problems (Bellringer, Coombes, Pulford, & Abbott, 2010a). The evidence surrounding existing self-exclusion strategies have led to arguments about its importance in public health intervention for problem gambling and its inclusion in public health strategies (Gainsbury, 2014).

A formative investigation into the effectiveness of gambling venue exclusion processes in New Zealand by Bellringer *et al*. (2010a) which included focus group interviews with problem gambling service providers and gambling venue staff, a survey of 123 gamblers (both self-initiated and venue-initiated excluders) suggested some benefits of this intervention approach. Findings showed "that current exclusion processes have a positive impact and are effective to varying degrees in reducing or stopping gambling activities and in encouraging help-seeking behaviours" (Bellringer *et al*. 2010a, p. 8). The study also documented several areas of improvement identified both by stakeholders and excluded gamblers which "focused around general practice, improving multi-venue exclusion contracts, training issues, increased awareness-raising regarding exclusion processes, length of exclusion contracts, enforcement of exclusions, and treatment provider and venue links" (Bellringer *et al*. 2010a, p. 9).

A small-scale study of a single community problem gambling self-exclusion treatment service in New Zealand (Townshend, 2007) based on a survey of 35 self-excluders, found that this intervention approach led to reduction in problem gambling severity and money lost, and increases in level of control over gambling and abstinence from gambling. The study was, however, limited by the small non-representative sample, the lack of a control group and an inability to distinguish the effects of the self-exclusion agreement from overall treatment effects.

Ladouceur, Sylvain and Gosselin's (2007) longitudinal evaluation of a self-exclusion programme in Quebec, Canada which involved 161 participants who were followed at six, 12, 18 and 24-months after

they had signed self-exclusion agreements, found that the programme resulted in many positive outcomes. Follow-up evaluation findings included reductions in the urge to gamble, significant increases in the perception of control and significant decreases in the intensity of negative consequences of gambling in their day-to-day undertakings, frame of mind, social life and work environment.

Tremblay, Boutin and Ladouceur (2008, p. 507) described an "improved" self-exclusion service offered by the Montreal casino, Canada which included counselling support from a psychologist, monthly 15 minute telephone support, and referrals to additional supports. An evaluation of this improved self-exclusion programme (which drew findings by comparing data collected from 39 self-excluders during meetings at an initial and an end of agreement period) found a higher percentage of gamblers chose the improved self-exclusion programme over the regular self-exclusion contract. A majority of participants indicated satisfaction with the service and regarded it to be useful. Comparison of findings from the initial and final evaluations found major improvements in time and money spent, gambling consequences, DSM-IV scores, and psychological distress.

Helpline services

In New Zealand, *Brief Interventions* are also offered through the Helpline and Information Service (PGCS-01). In a randomised controlled trial, Abbott *et al.* (2012) evaluated the effectiveness of four types of brief telephone interventions provided by the New Zealand national gambling helpline: (1) helpline standard care (treatment as usual), (2) single motivational interview, (3) single motivational interview plus cognitive-behavioural self-help workbook, and (4) single motivational interview plus workbook and four follow-up motivational telephone interviews. Follow-up assessment calls to 451 randomly assigned helpline callers were made at three, six and 12 months post-intervention. Results showed statistically and clinically significant treatment outcomes for all four interventions, which were maintained at the 12-month follow-up. Additional to three primary measures of days gambled, money lost and achievement of treatment goals, considerable improvements were "also found for problem gambling severity… control over gambling, gambling impacts on work, social life, family and home and health, psychological distress, major and minor depression and quality of life" (Abbott *et al.* 2012, p. 11).

In a subsequent uncontrolled outcome study of 150 participants who received the helpline standard care, (Abbott *et al.*, 2013) found substantial improvements in outcome measures from baseline to three months and that these improvements were maintained at six and 12 months. Participants also "reported substantial reductions in the adverse impacts of gambling on work, social life, family/home and physical health" (Abbott *et al.*, 2013, p. 8). One notable finding of this study was "that clients improved substantially, both in statistical and clinical terms, with respect to problem gambling and some associated mental health problems" with improvements in many instances occurring in the first three months which were sustained at the 12-month assessment (Abbott *et al.* 2013, p. 8). These changes "were achieved even though most callers received only one Helpline call and did not access other, more intensive, gambling counselling or therapy" (Abbott *et al.* 2013, p. 8). Another key finding of this study was that additional treatment for problem gambling was not associated with improved treatment outcome.

4.7.2   Effectiveness of PGCS-02 activities (staff and client views)

Figure 34 shows staff responses to survey questions on the effectiveness of *Brief Intervention* services. The majority of staff respondents reported that all activities carried out were very or somewhat effective in achieving positive outcomes for clients.
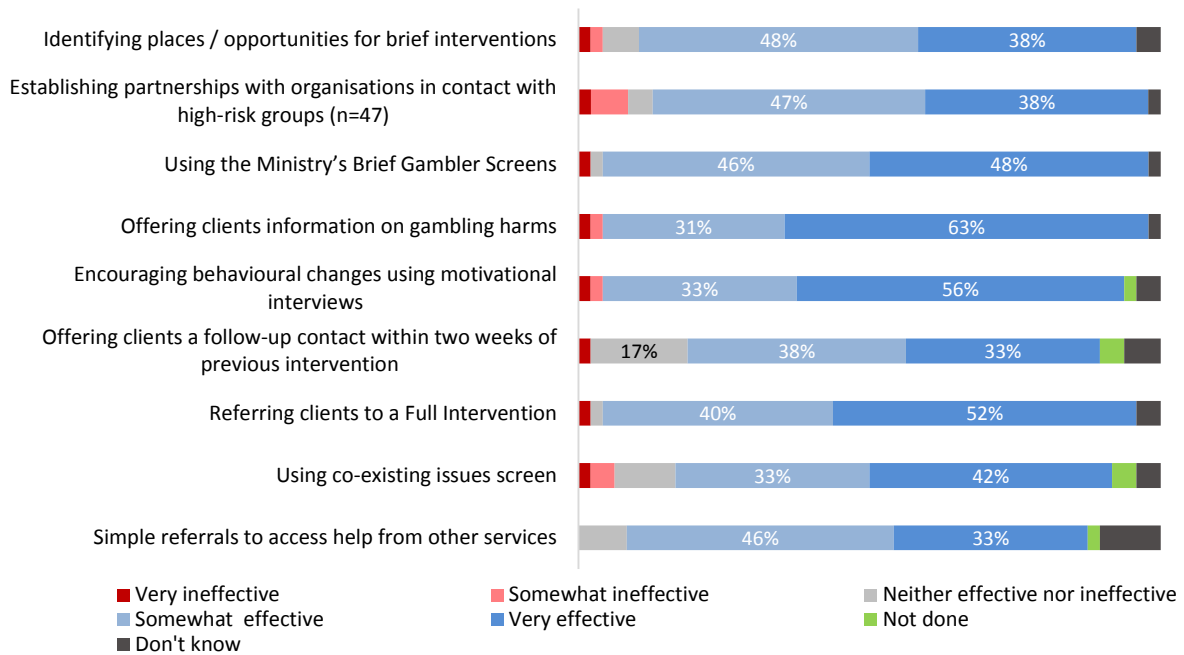
Figure 34: Effectiveness of Brief Intervention activities as rated by staff (n=48)

Figure 35 shows a summary of clients' recollections of experiences during brief intervention sessions. Their responses indicated that most recalled the activities delivered by staff during brief intervention sessions; to some extent, this suggests evidence of service outputs. However, as detailed in Section 2.3.6, this finding should be interpreted with caution, as the client sample responding to this section of the questionnaire is not necessarily representative of those who experienced *Brief Intervention* sessions.

Of the 83 clients who responded to the *Brief Intervention* section of the questionnaire, 88% indicated that staff from the provider contacted them again after the initial conversation, which may mean they had further brief sessions. A few also reported other experiences including invitations to participate in support groups, and advice to seek help from other supports such as the church, budgeting services and legal help.
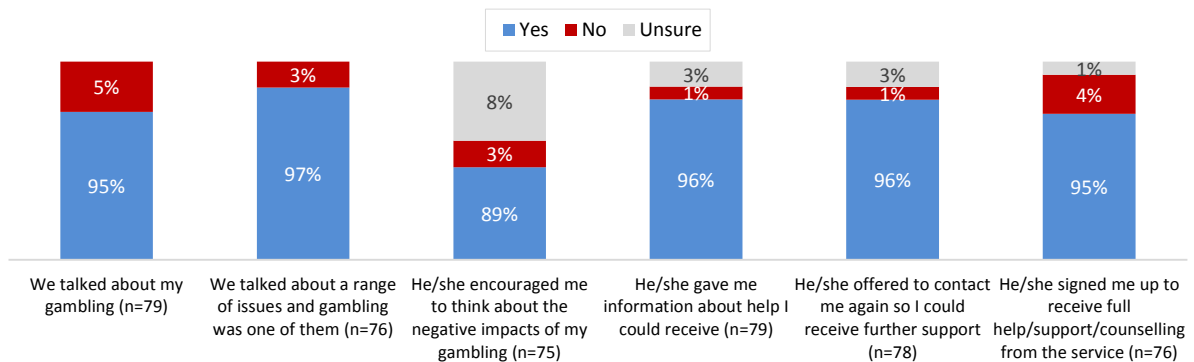
Figure 35: Clients' experiences of Brief Intervention activities (n=83)

4.7.3   Brief Intervention sessions - volume and delivery processes

As shown in Figure 36, the total number of *Brief Intervention* sessions reported by all providers shows delivery to significant other clients was more frequent than to gambler clients; this pattern remained consistent across the three-year reporting period.
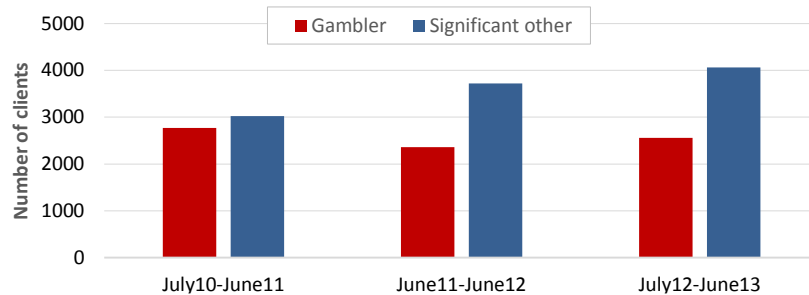
Figure 36: Total number of recorded Brief Intervention sessions for gamblers and significant others

As specified by the Ministry, *Brief Interventions* consist "of no more than three sessions" for each client and are "usually 15-30 minutes each in duration" (Ministry of Health, 2008b, p. 24). Overall, there was little variation in the number of *Brief Intervention* sessions per client; most providers delivered an average of one session per client and the highest recorded was three sessions per client (Table 15 in Appendix 4). Only two providers (B06 and C08) provided an average of more than two sessions per client. Average session durations are shown in Figure 37, regardless of client type or year; average session length was approximately 20 minutes.
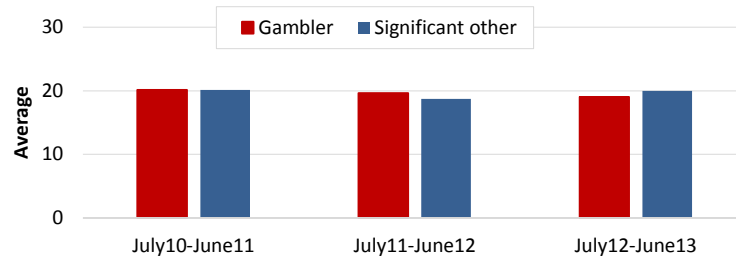
Figure 37: Average Brief Intervention session duration (minutes) across the 3-year period

There was some variation by provider but with the exception of one provider (D16 reporting an average of 36 minutes per session for the 2010/11 reporting period), all other providers reported an average of 30 minutes or less per session (see details in Table 16, Appendix 4).

4.7.4   Brief Intervention clients - trends and features

Number of clients

Figure 38 shows the number of new *Brief Intervention* clients (significant other clients, gambler clients and the total number of new *Brief Intervention* clients) across the three-year period (July 2010 to June 2013). The data show peaks in numbers of new *Brief Interventions* occurring annually, most notably in March, but also in September and a smaller secondary peak in November. As expected, fewer new clients were recorded between December and January each year.
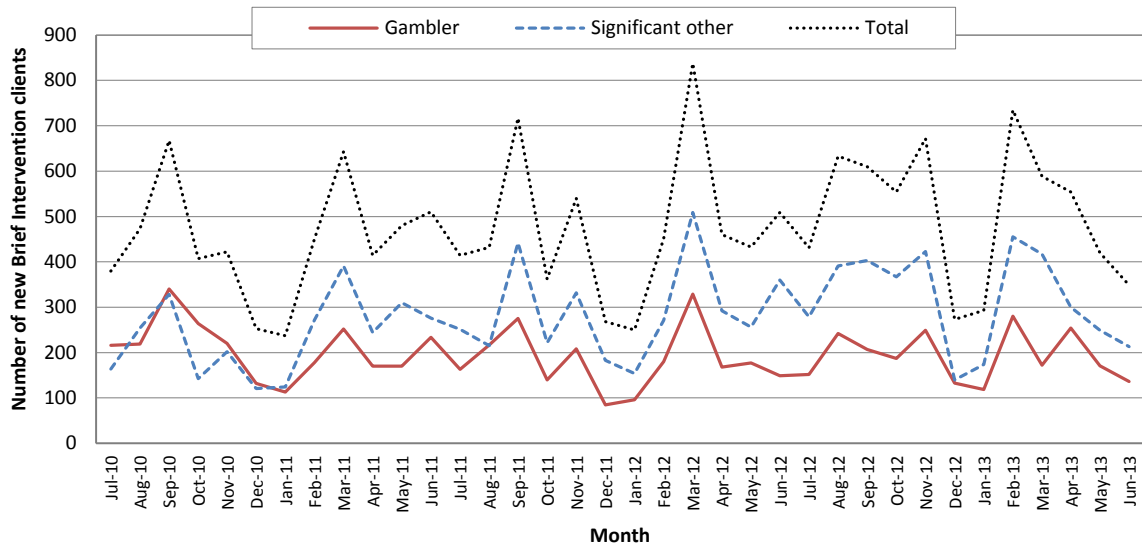
Figure 38: New Brief Intervention client (significant other and gambler) numbers for the period July 2010 to June 2013

Further considering the annual patterns, Figure 39 presents the same data as monthly averages across the three-year period. While there was variation, the annual patterns appear clearer. There are major peaks in March, September and November. The March peaks are most likely associated with coordinated public health initiatives at the Pasifika Festivals. Similarly, the September peaks are likely to be related to similar coordinated approaches to the annual *Gamblefree Day*, and November with activities around White Ribbon day.
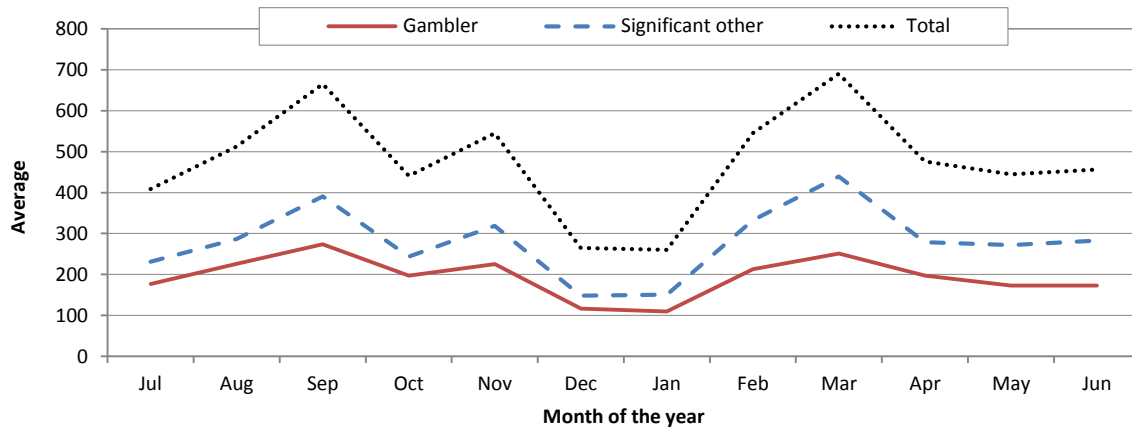
Figure 39: Average number of new Brief Intervention clients based on the month of the year

A relatively steady growth in the number of new *Brief Intervention* clients was evident across the three-year period. Given the period spans July 2010 to June 2013, this is best seen by considering the six-month averages of the numbers of new *Brief Intervention* clients (Figure 40). Overall (black dotted line), this increased from a monthly average of 434 new *Brief Intervention* clients in July to December 2010 (M=434, SD=136) to 490 in January to June 2013 (M=490, SD=166). The peak was a monthly average of 529 new *Brief Intervention* clients in July to December 2012 (M=529, SD= 151).

Figure 40 shows that the overall growth was driven by a steady increase in the numbers of new significant other *Brief Intervention* clients (blue line). These increased from an average of 202 (M=202, SD=78) in July to December 2010 to 301 (M=301, SD=113) in January to June 2013, peaking at 334 (M=334, SD=107) in July to December 2012. As a percentage, across the three-year period, 59% of new *Brief Intervention* clients were significant other clients (M=58%, SD=8%), which increased from 46% in July to December 2010 (M=46%, SD=6%) to approximately 60% in the all the other six month periods. In contrast, the numbers of new gambler *Brief Intervention* clients (red line) have remained

steady (six-monthly averages ranging between 181 and 195) after a decrease from the initial high of 232 in July to December 2010 (M=232, SD=68).
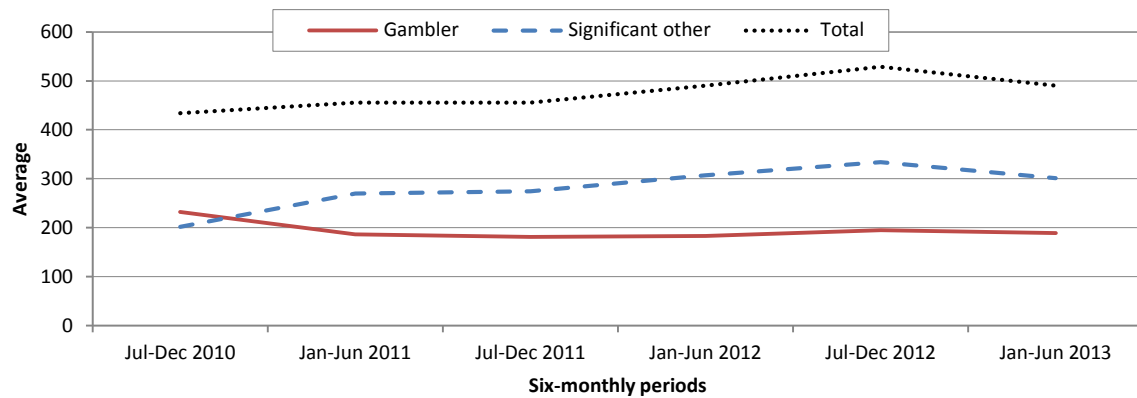
Figure 40: Six-monthly averages for new Brief Intervention client numbers for the period July 2010 to June 2013

When considered in the context of overall new client numbers, new *Brief Intervention* clients were consistently two thirds of all new clients (M=67%, SD=6%). Similar consistency was evident when the two client types were considered. The majority were new significant other clients (M=81%, SD=5%); this was much lower among gambler clients with about half (M=54%, SD=7%) being new *Brief Intervention* clients (Figure 41).
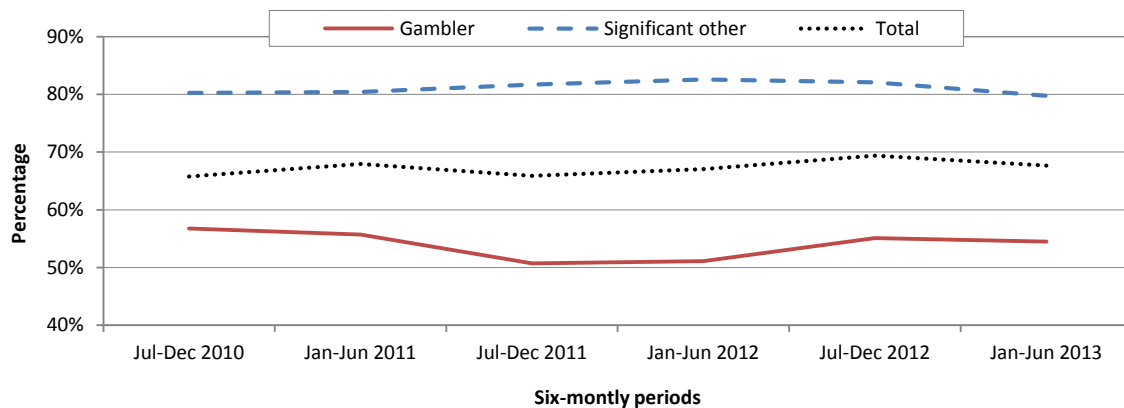
Figure 41: New Brief Intervention clients in proportion to all new clients

Gender

Just over half of all new *Brief Intervention* clients across the July 2010 to June 2013 period were female (M=57%, SD=5%). Figure 42 shows the gender data for all new *Brief Intervention* clients, new significant other and new gambler *Brief Intervention* clients separately for the six-month periods as per previous analyses. The main feature evident in these data is that the overall gender difference is driven by the majority of new significant other *Brief Intervention* clients being female (M=61%, SD=6%). In contrast, new gambler *Brief Intervention* clients were equally split between males and females.

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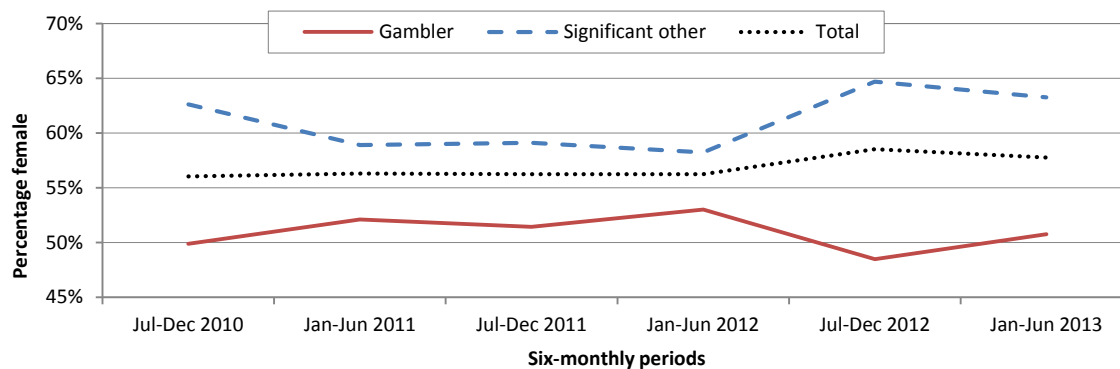
Figure 42: The percentage of new Brief Intervention clients that were female

Ethnicity

An average of 68 new Māori gambler *Brief Intervention* clients were reported each month (M=68, SD=31), representing 34% of this client group (M=34%, SD=10%). The same number of European/ Other new gambler clients were reported (M=67, SD=28), again being approximately one-third of these clients (M=34%, SD=8%). An average of 26 new Pacific clients were reported each month (*M*=34, *SD*=17); just less than one fifth of these clients (M=17%, SD=7). An average of 26 (M=26, SD=17) new Asian gambler clients per month were reported, meaning 14% of clients in this category were Asian (M=14%, SD=10%),

Figure 43 shows monthly average numbers for new gambler *Brief Intervention* clients for the four ethnic groups across the three-year period. Clear peaks were evident in September (European/Other), August (Māori), March (Māori, Pacific and Asian) and November (Māori and European/Other). A decline in new gambler client numbers was evident over the December-January period, with the exception of Asian clients, whose numbers were generally steady month-by-month.
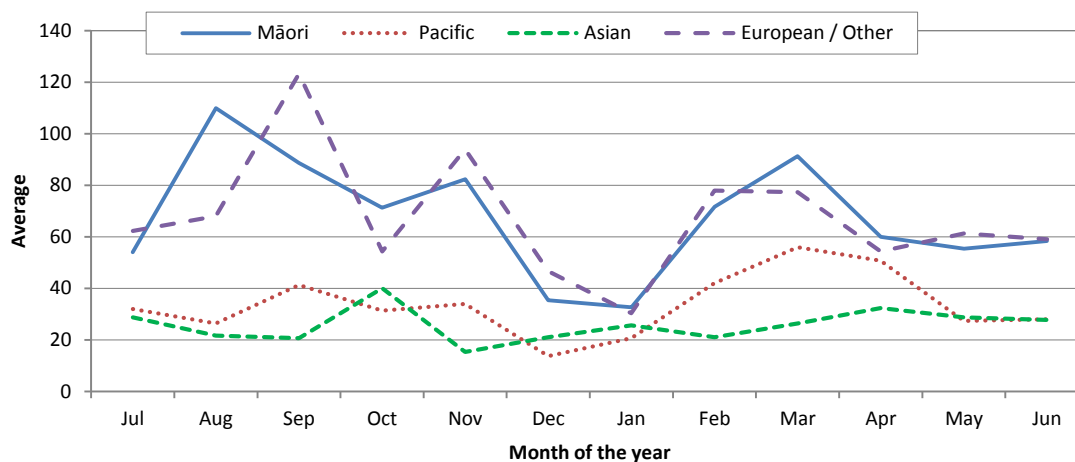
Figure 43: Average numbers (by month) for new gambler Brief Intervention clients by ethnicity

The October peak for Asian clients was due to an increase in October 2010 (66 new gambler clients) which subsequently decreased (34 new clients in October 2011 and 20 new clients in October 2012). The 2012 figure is relatively consistent with the three-year average and, overall, there is general evidence of a decline in new Asian gambler *Brief Intervention* clients (new Asian clients were the only ethnic category where a decrease in numbers was evident across 2011 to 2013, with the two lowest averages in 2012 and 2013).

Figure 44 shows monthly percentages of all new gambler *Brief Intervention* clients by ethnicity. There was a peak in the percentage of new Māori clients in August (as there was with the numbers shown in Figure 43); this was most evident in 2010 (106 clients, 48%) and 2011 (134 clients, 62%), with a slight decrease in 2012 (90 clients, 38%). Otherwise the data are generally consistent with those presented

previously, the percentage of new European/Other *Brief Intervention* gambler clients increased in September, and the percentage of new Pacific *Brief Intervention* gambler clients increased in March and April.
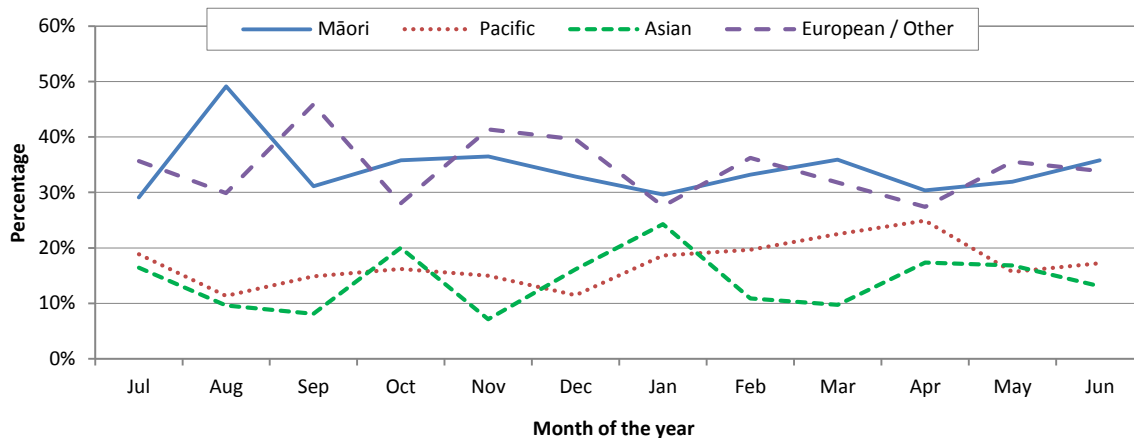
Figure 44: Percentages (by month) for new gambler Brief Intervention clients by ethnicity

Figure 45 shows monthly average numbers for new significant other *Brief Intervention* clients for the four ethnic groups across the three-year period. The peak months identified among new gambler clients (March, September and November) were also evident for significant others. Of interest is that the March peak was associated with elevated significant other (and gambler) client numbers among Māori, Pacific and European/Other new clients. Given the main public health events around March are associated with Pacific cultural events, this is somewhat surprising. In part, this peak might represent an increase in general activity of agencies following the summer break, or the broad appeal of Pacific events. The November peak was also associated with increases for these three ethnicities. However, the September increase seemed specifically associated with European/Other. Given this peak was likely to be associated with activities surrounding the annual *Gamblefree Day*, this perhaps suggests uptake by, or outreach to, Māori and Pacific groups is not strong around this event. A more specific investigation would be required to delineate this finding; however, it is somewhat surprising that the timing of a Pacific event and associated public health activities is associated with an elevation in Brief Interventions for all ethnic groups, whereas a general event (*Gamblefree Day*) is specifically associated with an increase in European/Other. Discussions with the Cultural Advisory Group suggested that events such as the Pasifika Festival are community-based and thus might have a broader appeal, as opposed to *Gamblefree Day* which is more issue focused. The number of new Asian significant other clients per month was very low and did not appear to be affected by any of the public health events.
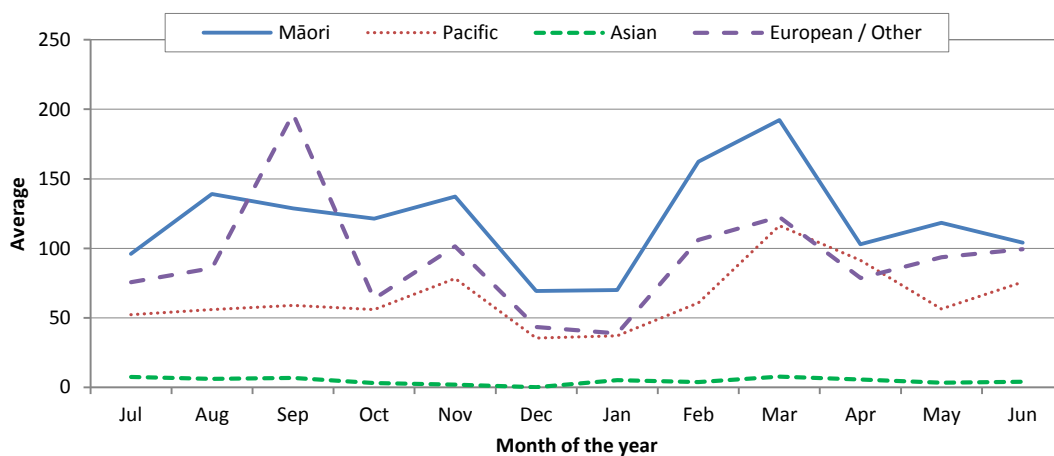
Figure 45: Average numbers (by month) for new significant other Brief Intervention clients by ethnicity

The same data are shown as monthly percentages of all new significant other *Brief Intervention* clients (Figure 46). This Figure (along with Figure 44 for gambler clients) confirms that the peak evident in

September was due to an increase in both the number and percentage of new European/Other significant other clients. This supports the notion that the activities surrounding *Gamblefree Day* resulted in more new European/Other *Brief Intervention* clients (gambler and significant other). Figure 44 and Figure 46 also provide clarification of the changes around March and April; while the overall numbers for Māori, European/Other and Pacific clients all increased (Figure 43 and Figure 46), in percentage terms there was an increase in new Pacific clients throughout March and April. This is possibly attributable to activities surrounding the large festivals of interest to Pacific communities (e.g. Pasifika Festival and Polyfest) running at that time. Whether the general increase in client numbers was associated with the Pasifika Festivals is unclear, but even in the context of the general increase in client numbers there was a larger proportional increase in Pacific clients. The percentage data also showed an increase in the percentage of Māori clients in August; this could perhaps be related to activities surrounding the Matariki festival which occurs annually in July.
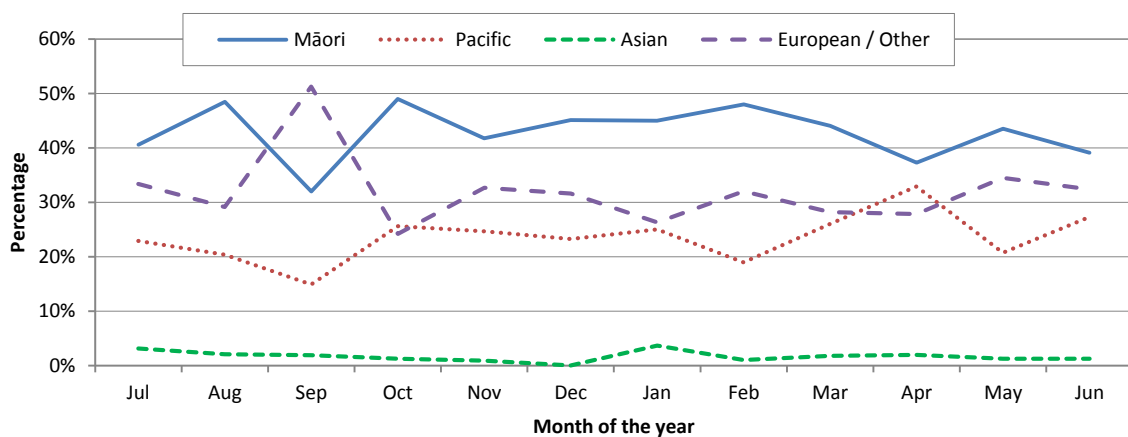
Figure 46: Percentages (by month) for new significant other Brief Interventions by ethnicity

4.7.5 Brief Intervention Screens

"As a form of secondary prevention (i.e. preventing the progression of the gambling harm), brief intervention screening can detect the early stages of a potential problem" (Ministry of Health, 2008b, p.23). The Ministry has endorsed two screens for use in *Brief Interventions:* the Brief Gambler Screen and the Brief Family/Affected Other Screen. Screens in face-to-face *Brief Interventions* are either self-administered by the individual concerned (a form is filled) or are practitioner-guided; in "a telephone brief intervention… the questions are read to the client" (Ministry of Health, 2008b, p. 24). Individuals are recorded as clients only after they have received a minimum of 15 minutes of "individualised time that involves a discussion of their screen results, disclosure and a discussion of clinically relevant information" (Ministry of Health, 2008b, p.31). Appropriate screen scores are recorded in CLIC.

Brief Gambler Screen

For gamblers, the Brief Gambler Screen (Figure 47) is intended "to be the gateway screen for brief intervention services and to inform the need for ongoing engagement with the presenting individual" (Ministry of Health, 2008b, p. 33).

Table 17 in Appendix 4 shows the number of times Brief Gambler Screen scores were recorded for gambler clients as part of *Brief Intervention* sessions in each successive year for each provider; it also shows the overall average of these numbers. For the majority of gambler clients, scores for this screen were recorded once (95% in 2010/11, 99% in 2011/12 and 99% in 2012/13). This was reasonable considering that the aim of the Brief Gambler Screen was early risk detection and judgement on further intervention needs. However, several providers (A01, A02, B05, B07, C04, C08, D16) recorded screen scores twice for a small proportion of their gambler clients. One Māori provider (B06) differed; in 2010/11, Brief Gambler Screen scores were recorded twice for the majority (76%) of their gambler

clients in *Brief Intervention* sessions. However, this changed across the years and in 2012/13 screen scores were recorded twice for just one client.

> **Brief gambler screen** *(record the number of positive responses to questions 1 to 4. If there are no positive responses, then record a zero "0")*
>
> 1   Do you feel you have ever had a problem with gambling? (Only ask if not obvious)
>
> 2   **If the answer to Q1 is yes, ask:** And do you feel you currently have a problem with gambling?
>
> 3   Have you ever felt the need to bet more and more money?
>
> 4   Have you ever had to lie to people about how much you gambled?
>
> 5   If you answered yes to any of the above, what would help?
> ☐ I would like some information
> ☐ I would like to talk about it in confidence with someone
> ☐ I would like some support or help
> ☐ Nothing at this stage

Figure 47: The Brief Gambler Screen (Ministry of Health, 2008b, p. 32)

Table 18 in Appendix 4 shows the number of times Brief Gambler Screen scores were recorded for significant other clients in *Brief Intervention* sessions. Screen scores were recorded for a small and decreasing percentage of clients (16% in 2010/11, 7% in 2011/12, and 2% in 2012/13). The exception was provider C04 who recorded screen scores for a majority (75%) of their significant other clients in 2010/11 and 2011/12; however, in 2012-13 this decreased to 19%.

Further analyses of the CLIC data showed that the Brief Gambler Screen was rarely recorded as being used within other intervention sessions (i.e. *Full Interventions*, *Facilitation Services* and *Follow-up Services*). Nonetheless, in *Full Intervention* services, scores for Brief Gambler Screens were recorded at least once for nine percent of gambler clients in 2010/11, seven percent in 2011/12 and eight percent in 2012/13.

Individuals with positive responses to the Brief Gambler Screen (score between 1 and 4) are regarded as meeting the Ministry's conditions for further intervention funding. Initial Brief Gambler Screen scores recorded for all gambler clients (including instances where this screen was used in sessions other than Brief Interventions) are provided in Table 19 (Appendix 4). Clients of some providers had noticeably higher positive scores (A02, B05, B07, B14 and B18) indicating higher risk levels. All except one of these were Māori providers. Conversely, clients of some providers had consistently lower scores (B06, C04, C08 and C19). Other providers exhibited increases (B09 and B12) or decreases (B10) over the years. These fluctuations are likely to be a result of the varying approaches to recruitment and varying populations accessed.

When total scores were considered the majority of clients scored one or more (Figure 48). More than one-third of gambler clients scored one. Scores between two and four were noted in approximately 20% of clients each.
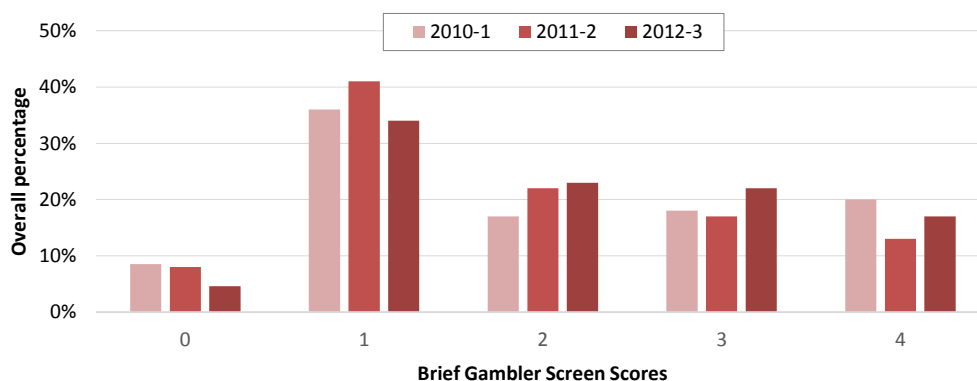
Figure 48: Initial Brief Gambler Screen scores recorded for gambler clients

Brief Family/Affected Other Screen

The Brief Family/Affected Other Screen consists of two questions (Figure 49). The first question determines if the individual is aware of the effect someone else's gambling is having on them. The aim of the second question "is to direct the client's attention to their own needs, often for the first time"; answering the questions helps "raise the client's awareness about the effects of the gambling on themselves" (Ministry of Health, 2008b, p. 35).

1   **Awareness of the effect of the gambler's gambling** *(record the number of the response i.e., 0–3)*
   Do you think you have ever been affected by someone else's gambling?
   (0) ☐   No, never **(you need not continue further)**
   (1) ☐   I don't know for sure if their gambling affected me
   (2) ☐   Yes, in the past
   (3) ☐   Yes, that's happening to me now

2   **Effect of gambler's gambling** *(record the total number of positive responses (ticks) between question 1 and 5. Record 0 or 6 if no other responses are ticked)*.

   How would you describe the effect of that person's gambling on you now? (Tick one or more if they apply to you.)

   (0) ☐   It doesn't affect me any more
   (1-5) ☐   I worry about it sometimes
   ☐   It is affecting my health
   ☐   It is hard to talk with anyone about it
   ☐   I am concerned about my or my family's safety
   ☐   I'm still paying for it financially
   (6) ☐   It affects me but not in any of these ways

Figure 49: Brief Family/Affected Other Screen (Ministry of Health 2008b, p. 34)

The number of times scores for the Brief Family/Affected Other Screen were recorded for significant other clients as part of Brief Intervention sessions in each successive year for each provider, and the average of these numbers are detailed in Table 20 (Appendix 4). The data showed that in all instances clients were asked both questions. The Brief Family/Affected Other Screen was seldom reported as being used in *Full Intervention*[35], *Facilitation* or *Follow-up* sessions.

Overall, for the majority of significant other clients (96% to 99%), Brief Family/Affected Other Screen results were recorded once. However, two providers recorded screen results and scores twice for large proportions of their clients in 2010/11 (B12: 42% of their clients, C08: 94%). This changed across subsequent years and their current practice is single recordings. Table 21 (Appendix 4) shows that Family/Affected Other Screen results were sometimes recorded for gambler clients. While for four providers (A01, B07, B10 and B13) this was an infrequent practice, for three other providers (A02, B12 and C04) this was done frequently.

Figure 50 summarises all clients' responses to Question 1 on this screen. Approximately one-third of significant other clients indicated that they were currently affected by someone else's gambling, and a further third indicated that they had been affected in the past. About a quarter indicated uncertainty about such effects. Generally, these trends were consistent across providers, with some year-to-year variation (Table 22, Appendix 4). In 2012/13, providers B07 and B10 had noticeably higher percentages of clients indicating they were currently affected, while some providers (B06, B09, B12, B17 and C19) had noticeably lower percentages of clients who were currently affected.

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[35] The "Full Family/Affected Other Screen" used with significant others in Full Intervention is similar to the "Brief Family/Affected Other Screen"; findings are reported in the following section on Full Interventions.
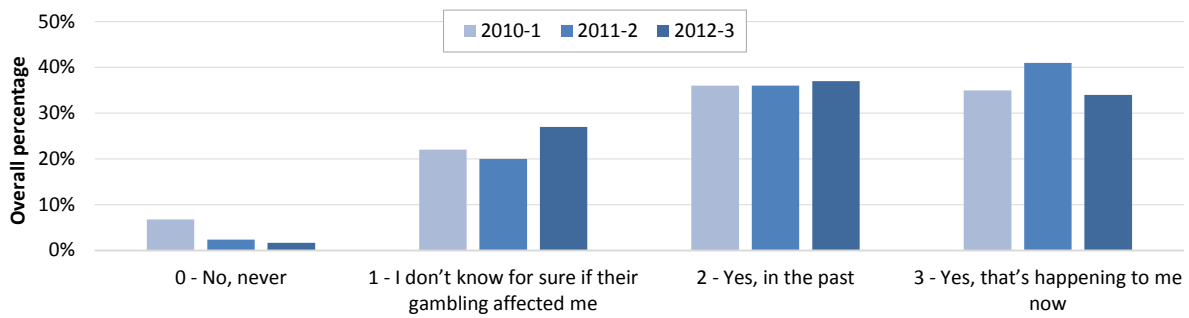
Figure 50: Significant other client responses to Question 1 in an initial Brief Family/Affected Other Screen

The frequency and percentage of clients' responses to Question 2 for each provider are detailed in Table 23 (Appendix 4) and overall percentages shown in Figure 51. While most providers encountered clients who experienced between one and three effect types, one Māori provider (B06) and one Pacific provider (C08) encountered more clients experiencing 4 or 5 effect types (i.e. a larger range of gambling harms) in some reporting periods. Figure 51 shows that overall, approximately one-third of clients experienced one effect type and 20% to 25% were no longer affected. Progressively smaller percentages of clients experienced two, three, four and five effect types.
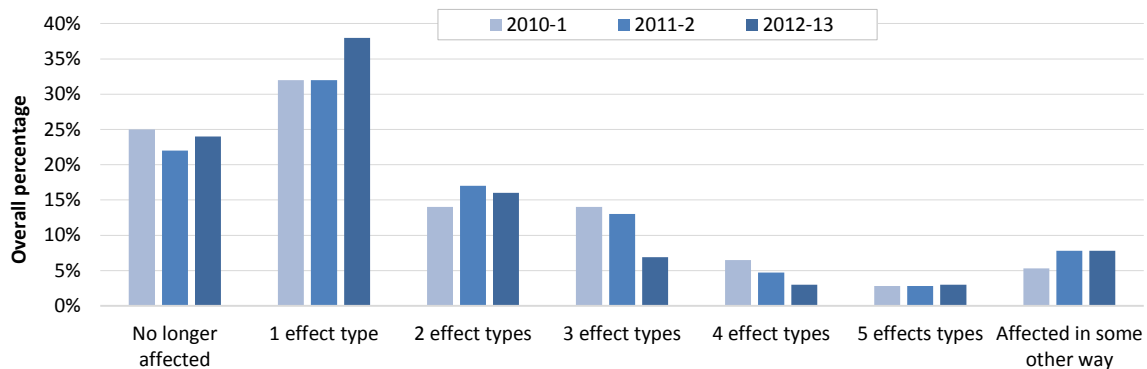
Figure 51: Significant other client responses to Question 2 in an initial Brief Family/Affected Other Screen

4.7.6   Brief Intervention outcomes for clients

Figure 52 shows the *Brief Intervention* impacts that most client survey respondents experienced related to their thinking about gambling harms and their realisation that they needed help. The only impact that was reported by less than half of the client respondents was "I thought about how gambling affected my work/job" (40%).
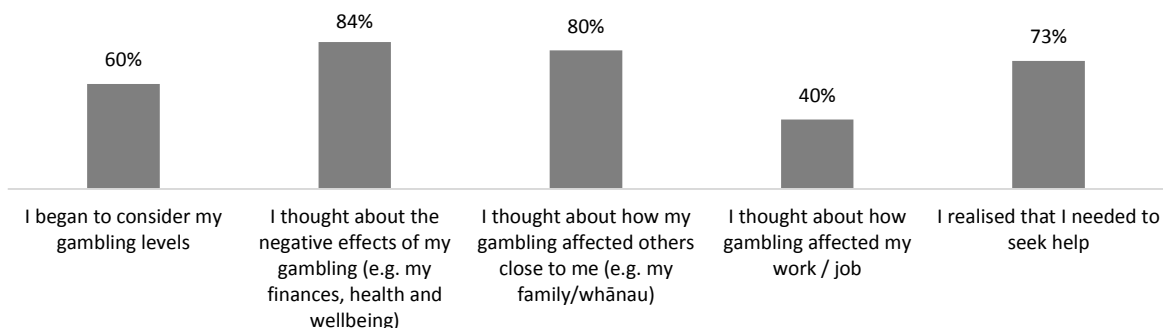
Figure 52: Impact of Brief Interventions as indicated by clients (n=83)

Commenting on other experiences, three clients reported that they accessed an intervention session to address their gambling. One described how it affected motivation to change behaviour.

I needed to start a plan of attack [e.g.] change of routine, change my thought pattern especially when I have money. Do stuff that is totally the opposite of my usual habit [i.e.] staying away from bars and/or pokie machine outlets.

4.7.7 Success Indicators: Brief Intervention

Staff survey respondents' beliefs about the main indicators of successful *Brief Interventions* fit within three broad categories: activity-related indicators, output-related indicators and outcome-related indicators. Almost all survey respondents provided one indicator category. Similarly, explanations provided by focus group participants were also activity, output or outcome focused.

Twenty-five survey respondents reported various **activity indicators**, focusing on what needed to be done during *Brief Interventions*. This included seeking intervention opportunities within community settings, ensuring the appropriateness of the intervention environment, carrying out assessments, providing information and ensuring appropriate communication approaches when engaging with potential clients.

> Being at the right time at the right place. Therefore it is important to attend as many as possible community events and other services. Building a brief relationship with the impending client to create an atmosphere where they feel safe to address their gambling issues.

> Engagement in ongoing conversation about gambling and its consequences [and] proceeding to a more focused assessment interview.

Similarly, one focus group respondent explained that while there were no exact measures of outcomes, the activity of using brief screens in engaging with people was a success in its own right.

> I think if there are no measuring tools, I can't tell you that they are effective. I think what is effective is having the brief screens that you can do with a person and actually start a conversation with them. Because it is brief, we have some quick indicators. It is a good starting point. But there are no measurements of outcomes that we have used...

Descriptions provided by nine survey respondents suggested **output indicators** such as increased awareness of gambling harms and of the availability of gambling intervention services.

> Be able to identify problems associated with gambling behaviour. Become aware of various gambling modes. Awareness on the available support for the problem gambling behaviour.

One focus group participant mentioned clients' interest in further communication with clinicians as an indicator of *Brief Intervention* effectiveness.

> There is a tick box asking if they want to hui with someone (a kaimahi or kaumātua). There is also a box for - What are you gambling, and what is happening. And then they leave a contact number. When they tick those two boxes, you know they want to engage in a hui.

During discussions, a few focus group participants identified the lack of explicit outcome indicators for *Brief Interventions*.

> I don't think there has ever been an outcome measure for Briefs. I have never seen an outcome measure for Briefs. So I am not quite sure what the question is. As part of our contract, we have to do it. That is probably the driver. A lot of public health stuff is not measurable. You put it out there and it takes a life of its own.

> In a workshop, one explanation about Brief Intervention was that it is just like planting a seed into people's minds. We don't know when they will grow. We know that we plant seeds.

Nevertheless, seven survey respondents provided descriptions that suggested a key **short-term outcome indicator**, that is, help-seeking behaviour among *Brief Intervention* clients and increased referrals to treatment services.

> Encourages the person to take the next step and engage in the service for treatment intervention. They will be able to seek help and support from other providers around the consequences of their gambling. Take steps on their own to change their gambling behaviour.

One focus group participant suggested a lack of direct conversions from *Brief Intervention* to *Full Intervention* indicated some ineffectiveness of *Brief Interventions*.

> …I am mainly [conducting] Full Interventions and I am not in the position of doing [Brief Interventions]. But what I am noticing is, all of the Brief Interventions that are done [in my area] they are not coming through to me. So that sort of defeats the purpose in a sense. I was expecting that if you are doing Brief Interventions that it would result in some change or some action. But for me it is not actually there at this stage. But it could be logistics; I don't know. May be they come up later… That is where I see it as being ineffective I suppose. Where is the [outcome]? What is actually happening as a result of it…

However, others noted that while *Brief Interventions* might not result in *Full Interventions,* they remain a good way of engaging with the community and the results might not be immediate.

> We would say it is effective. Because we are out there in the community; we are talking face to face with people that we would normally never see. And in their communicating with us it builds our awareness as a service, of what people understand as harmful gambling, problem gambling; their interpretation of what gambling is… So we get them to think about it, instead of us thinking about it… The common saying out there is "No I am not a gambler, I don't gamble". We know how to engage with people like that. We ask them, "Tell me, if you don't gamble, then what is gambling? What is your definition of gambler or gambling." Next minute, there is a discussion: "I know so and so" and the story starts.

Although most survey participants provided a single success indicator category, the explanation by one focus group participant suggested a more fluid approach and a succession of indicators from *activity* (engaging in conversations) to *outputs* (increased awareness) and *outcomes* (help-seeking behaviour).

> From a clinician's point of view, based on the body language of a client you can tell that something hit them on the brain; they realise something they haven't been told before …In my practice I don't use those screens. If I use those screens directly, there is no response …We use the dollars lost approach to get their attention and show how much has been lost over weeks. And we can see their eyebrows rising when they come to a realisation. These are the measurements of how we know that the Briefs are working. The key for Brief for me, is about how you present the work that you do, and also invite them to see, to talk and talanoa. There are various outcomes, when they attend the group session that is a good one, or they come back seeking to get more awareness - that is a good indicator.

Likewise, comments from another focus group member suggested the increased awareness that occurs among clients as a valuable *output* that can result from the *activity* of carrying out brief screening and this in turn may mean early identification and the *outcome* of timely support.

> We get our clients who come in for meth[amphetamine] possession or selling and we ask them about their gambling and they say: "Yes it is a problem, no one has ever asked me that before". And suddenly they feel that there is an area in their life where they can get some help. If the question wasn't asked in the brief assessment, there wouldn't be that option for them to get that support. That is the only positive I see in the brief gambling screens… With youth education events we do the screens, and it gives an opportunity; some may get into Full [Intervention], and some won't. But you are still educating them; you are still getting the awareness out there.

4.8   Full Intervention (PGCS-03) / Workshop-based intervention (PGCS-06)

Full Intervention services, as described by the Ministry of Health (2010), are community-based assessment and intervention services that include a range of psychosocial interventions provided to an individual problem gambler or someone affected by another's problem gambling with the aim of minimising harm for an individual and their whānau/family. The service provide "an opportunity to work clinically with people" experiencing gambling-related harms resulting from their own or someone else's gambling behaviour (Ministry of Health, 2008b, p. 39). "A full intervention consists of a set of clinical intervention sessions (an episode) that are usually completed within eight sessions and within three months of the first session" (Ministry of Health, 2008b, p. 41). Each session lasts between 15 and 60 minutes.

Entry into *Full Intervention* may result from a clients' own initiative in seeking help, through referrals from other services or via brief intervention screening carried out in the community. A re-entry into *Full Intervention* may occur because of discussions with clients during follow-up calls or if the client wants further support after a relapse (Ministry of Health, 2008b).

Although Workshop-based interventions (PGCS-06) target people in the early stages of developing gambling problems and are offered within non-clinical settings, the expected activities in the PGCS-06 Purchase Unit Description are similar to PGCS-03. Activities within these services may include screening, problem gambling assessment, education on gambling harm, comprehensive assessments, provision of education and psychological therapy, relapse prevention and referrals to other appropriate services, as required. PGCS-03 has an additional activity of developing intervention and relapse prevention plans with clients. These activities and others detailed in the *Intervention Service Practice Requirements Handbook* and the likely outputs and outcomes are summarised in a preliminary logic model (Figure 53).

This chapter details findings from literature of relevance to Full Intervention services, the staff and client surveys, two focus group interviews with clinicians, and analysis of the CLIC database. The survey and focus group findings represent the eight selected providers contracted to either *Full Intervention* or Workshop-based Intervention services.

PGCS-04 Full Intervention / PGCS-06 Workshop-based Intervention

Inputs	Activities	Outputs	Outcomes

Inputs

- Purchase Unit Funding
- Staffing
- Qualifications, competencies, skills, and experience

Activities

- Establish relationship with the client, discuss expectations, clarify needs, and address concerns about confidentiality
- Use Ministry-approved Screens in the various phases of a client's treatment as recommended
- Educate clients about gambling harm and its management
- Carry out comprehensive assessments to identify co-existing issues
- Assist clients to develop treatment and relapse prevention plans
- Provide interventions including psychosocial therapy, support and case management (for individuals and groups)
- Determine if clients need simple referrals or Facilitation Services
- Carry out simple referrals or provide Facilitation Services within the Full Intervention episode based on clients' identified needs
- Educate clients about early intervention, maintenance of health, relapse prevention, problem prevention, and promotion of health
- Review treatment plans with clients
- Use the Ministry's *Review and Assessment Tools* with clients before discharge
- Seek clients' feedback about treatment effectiveness before discharge

Outputs

- Individuals experiencing gambling harms are accurately identified and admitted into Full Intervention Services
- Increased understanding among clients about gambling harms, its effects, and its management through the use of appropriate strategies
- Increased understanding among clients about gambling triggers, relapse prevention and of coping behaviours
- Increased motivation among clients to make changes to their gambling behaviours
- Clients with co-existing issues identified and referred or facilitated to other services where appropriate
- Screens effectively used to gain understanding of levels of gambling harms among clients
- Screens effectively used to provide feedback to clients, build understanding of gambling harms, and develop incentive for change
- Screens effectively used to monitor client progress and gauge treatment outcomes

Outcomes

- All people identified as experiencing gambling related harm (from their own gambling or from the gambling of a significant other) receive evidence-based interventions that reduce the gambling related harm occurring to them and their family
- Increased ability among clients to monitor and control their gambling
- Increased ability among clients to stop gambling
- Improvements to clients' health and wellbeing

Figure 53: Preliminary Logic Model: *Full Intervention and Workshop-based Intervention*

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4.8.1 Literature review

GARC's previous evaluation of *Full Intervention* services in New Zealand found in a survey of staff, that 79% indicated this intervention approach:

> …to be a good approach for assisting someone with problems related to their or someone else's gambling. The most commonly reported positive features of the Full Intervention were its comprehensive nature, the opportunity it provides for problem gamblers to engage in a counselling/ change process and that it supports preferred or flexible counselling approaches. However, some participants noted (amongst other things) that the intervention length needs to be longer for some/ most clients and that the screening measures are lengthy, poorly worded (in places), or restrictive" (Bellringer, *et al*. 2010b, p. 12).

In focus group discussions, responses suggested that "the Full intervention was seen as a broad intervention that was not necessarily suited to different clients' needs" and one of the concerns raised related to the "Ministry of Health's apparent restriction to eight sessions per client for a Full Intervention" (Bellringer, *et al*. 2010b, p. 14).

A review of the international literature found that the components included within intervention programmes for problem gamblers were diverse in range and include self-help materials, online interventions, community-based treatment programmes, motivational treatment, cognitive behavioural treatments, and incorporation of additional aspects such as physical activity within treatment programmes. In three cases (reported in the immediate sub-sections that follow), evaluators referred to their treatments as either *Brief Interventions* or *Brief Treatments,* although the target audiences were at-risk and "pathological" gamblers. This highlights an inconsistency in the definition of *Brief Interventions* and clarity around differences between *Full* and *Brief Interventions*.

Self-help materials

In Canada, considering that some problem gamblers recover by themselves without formal help, Hodgins (2005, p. 16) compiled recovery and relapse prevention techniques into a self-help workbook containing specific sections on "self-assessment, goal setting, strategies, maintenance, and other available resources". Hodgins referred to the evaluation of this workbook self-help approach as a "brief intervention trial" for problem gamblers. It was observed that participants with evidence of significant gambling problems were very keen on this self-help approach, suggesting a need to provide a variety of intervention options for problem gamblers to consider, as proposed in the *stepped care model*. This is an intervention system of providing different levels and types of interventions for gamblers in different stages of readiness for change. Hodgins also reported that over half of those participating in the trial were women; although the exact reasons behind the approach's appeal to women was unclear, it was suggested that confidentiality, the option to undergo treatment despite busy schedules and the emphasis on self-management were possible reasons. The study also noted that the initial positive changes were maintained at a 12- and 24-month follow-up in terms of reduction of money lost and improvements in abstinence from gambling.

Hodgins suggested that an ideal design would require "a credible placebo treatment or comparison of one active treatment to another" (Hodgins, 2005, p. 18). He also highlighted the importance of establishing consensus around the measurement of essential outcome indicators. Consistent outcome variables would also enable comparisons between different evaluations.

Outpatient community-based treatment programmes

In a quasi-experimental evaluation, Toneatto and Dragonetti (2008) compared the efficacy of two Canadian-based *brief outpatient treatments* for problem gambling. They compared 65 individuals who underwent eight sessions of Cognitive-Behavioural Therapy (CBT) to 61 individuals who underwent eight sessions of a twelve-step treatment approach, which was based on a Gamblers Anonymous' five steps approach. They found little difference between the two types of treatment in terms of outcome. In the follow-up, the study found that both treatments led to significant reductions in gambling frequency and amount of money staked. The authors commented that this "suggests that a common set of process variables may mediate change, regardless of the form of the treatment intervention"

(Toneatto & Dragonetti, 2008, p.303). However, a quarter of the participants continued to show signs of pathological gambling at the one-year follow-up, which may be result of poor engagement and incomplete interventions. Other inconsistencies in their findings led the authors to conclude that "balanced evaluation of gambling treatment-related outcomes may need to separately measure gambling behavior, life satisfaction, and gambling severity" (Toneatto & Dragonetti, 2008, p. 302). Reductions in gambling behaviour and expenditure alone were regarded as insufficient for measuring clinical efficacy.

Motivational treatments and cognitive-behavioural therapy

Petry, Weinstock, Ledgerwood and Morasco (2008) evaluated different combinations of what they termed "brief interventions" for problem and pathological gamblers recruited from substance abuse treatment services, medical clinics for the underprivileged, and via advertisements. Inclusion criteria included being at least 18 years of age, and spending at least $100 on gambling and gambling at least four times in the past two months. Problem/pathological gambler status was assessed via the South Oaks Gambling Screen (Petry *et al.*, 2008, p. 319). Petry et al. randomly assigned 180 problem gamblers to four groups: an *assessment only control*; ten-minute *brief advice*; one *motivational enhancement therapy (MET)* session; or one *MET session together with three cognitive-behavioural therapy* sessions. They found that participants in their *assessment only control* decreased their gambling. They reasoned that the very act of participating in the baseline evaluation might have increased understanding of gambling intensities, in turn increasing aspirations to reduce gambling regardless of the type of intervention received. The study suggested the benefits of the *brief advice* condition; as relative to the control group the *brief advice* condition showed significant reductions in gambling from baseline to week six and was associated with clinically significant decreases in gambling at the ninth month. Compared to the control, the group receiving *MET plus cognitive-behavioural therapy* showed significant decreases in gambling on one index between week six and the ninth month. Overall, the authors argued that their results point to "the efficacy of a very brief intervention for reduction of gambling among problem and pathological gamblers" who are not "actively seeking gambling treatment" (Petry *et al.*, 2008, p. 318).

Wulfert, Blanchard, Freidenberg and Martell (2006, p. 317) highlighted the value of motivational interviewing as a complementary component to cognitive interventions, as empathising with clients and providing objective, nonjudgmental feedback on the impacts that result from their addiction may lead clients to "evaluate their situation more realistically and less defensively". In their exploratory study, nine "severe pathological gamblers" receiving a "hybrid intervention" treatment (a combination of motivational enhancement and CBT) were compared with a control group consisting of 12 other pathological gamblers who underwent treatment as usual (Wulfert *et al.*, 2006, p. 315). At post treatment, they had lower scores for SOGS and DSM-IV criteria relative to the control group. Preliminary results indicated that although not everyone receiving the hybrid treatment showed equal treatment outcomes, all nine were retained at a 12-month follow-up period; a retention rate significantly greater than in the control group. The study noted the value of combining a motivational intervention with CBT, particularly its role in preventing attrition (Wulfert *et al.*, 2006).

An evaluation of the *BreakEven Problem Gambling Counselling Services* (which included face-to-face individual and group counselling and behavioural cognitive psychotherapy techniques) in Australia used a multi-methods design, which included a literature review, client data (n=3,149)[36], a retrospective client survey (n=150), a prospective client survey (n=43), counsellors' survey and counsellor interviews (Jackson, *et al.* 2000). The evaluation used pre- and post- client data (based on DSM-IV criteria for assessing gambling severity) to evaluate intervention outcomes. "Pre- and post-counselling measures of maladaptive behaviours" suggested that "counselling had a positive effect of between 21-29 per cent

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[36] This is referred to as the "BreakEven Minimum Data Set" a "definitive data set" which "is an ongoing census of all services provided to all clients in the BreakEven agencies" (Jackson *et al.* 2000, p. 33).

improvement on clients in eight of the ten behaviours listed" and "the number of 'problem gamblers' reduced from 76 per cent to 37 per cent" (Jackson, *et al.* 2000, p. 102).

Online interventions

Online interventions, particularly online therapy, are relatively new in the field of problem gambling treatment. While some therapists and academic critiques remain sceptical about the effectiveness of this intervention method, others have argued for the need to take advantage of opportunities offered by "the new technology and to carry out research into this potentially innovative form of therapy" (Wood & Griffiths, 2007, p. 374). A recent review of literature on self-guided online problem gambling interventions noted empirical evidence indicating this form of intervention to be effective and an important adjunct treatment for problem gamblers (Gainsbury & Blaszczynski, 2011). Advantages offered by online interventions include its convenience and geographical reach, flexibility in fitting with clients' preferred pace and sequence, relevance to the youth population, offer of privacy and anonymity, cost-effectiveness, compatibility with shared and stepped-care treatment models, and ease of data collection for evaluation.

An evaluation of online forums in the United Kingdom, designed to support people with gambling issues and their affected others, used content analysis of 60 forum posts, online semi-structured interviews ($n = 19$) and an online survey ($n = 121$). The evaluation found that the:

> …forums helped members to better understand and cope with their own gambling problems or with those of others. A lack of other alternative support, ease of access and availability, need for additional support, insight gained through posting and hearing other's stories, help in resisting urges to gamble, and perceived anonymity were all given as benefits of the forums. The forums were most popular with online gamblers, and had a higher ratio of females to males (with gambling problems) than any other comparable service. Significantly more females than males suggested that the forums helped them to cope better with their gambling problem" (Wood & Wood, 2009).

Another form of online intervention in the United Kingdom, referred to as GamAid, consisted of an advisory, guidance and signposting service that provided clients with the option of simply browsing through web links and information, communicating with an online advisor or requesting further information (Wood & Griffiths, 2007). A mixed methods design (which included the researchers posing as problem gamblers to gain direct experience of the service) was used to evaluate this pilot service; the variety in data collection methods was noted by the evaluators to be a key strength of the study. An online 15-item evaluation questionnaire was completed by 80 service users (33 of whom provided qualitative feedback about the services) and secondary data were obtained from 413 distinct users who contacted an online advisor. The evaluators found that the majority of service users were online gamblers and that women tended to prefer the service more than other similar services. Despite noting some technical difficulties, the majority of users positively reported their experience of the GamAid service. The majority of survey respondents:

> …agreed that GamAid helped them to consider their options, made them more confident in seeking help, helped them to decide what to do next, made them feel more positive about the future, provided useful information for local help which they intended to follow up through the links provided (Wood & Griffiths, 2007, p. 383).

Respondents who compared GamAid to other services they had used found the service beneficial because they felt more comfortable communicating online than they did communicating by telephone or in person. The study was, however, limited by its short time frame of nine weeks, which did not enable evaluators to gauge if the GamAid service had the capacity to reduce problem gambling behaviour among its clients. The authors recommended that a longer term study that follow-up with clients over an extended period was necessary.

Incorporation of physical activity in problem gambling treatment

Angelo, Tavares and Zilberman (2013) evaluated the outcomes of the inclusion of a physical activity component in a problem gambling treatment programme. They used a controlled experimental design (n=33 treatment, and n=30 control) and found that although both groups showed decreases in anxiety

levels, depression and gambling behaviour, the group receiving physical activity as part of their treatment had a more consistent and noticeable improvement. Their study was, however, limited by a non-equivalent control group, the small sample size and the lack of random assignment. The authors had recruited from physically fit patients seeking treatment for pathological gambling at a university outpatient clinic. Of the 137 individuals who were invited to participate, 33 were assigned to the physical activity group and 30 who had refused to undergo physical activity were assigned to the non-physical activity control group; the latter group was considered to be less motivated to engage in physical activity. Nevertheless, the authors argued that their findings suggested the value of including physical activity as part of problem gambling treatment programmes.

4.8.2 Effectiveness of PGCS-03 / PGCS-6 activities (staff and client views)

Figure 54 shows that staff survey respondents reported that *Full Intervention* activities were effective in achieving positive outcomes for clients. "Using the Ministry's Review and Assessment Tools before discharge" was viewed less favourably, with eight individuals (15%) indicating that this activity was neither effective nor ineffective (nonetheless, a majority still rated it as effective).
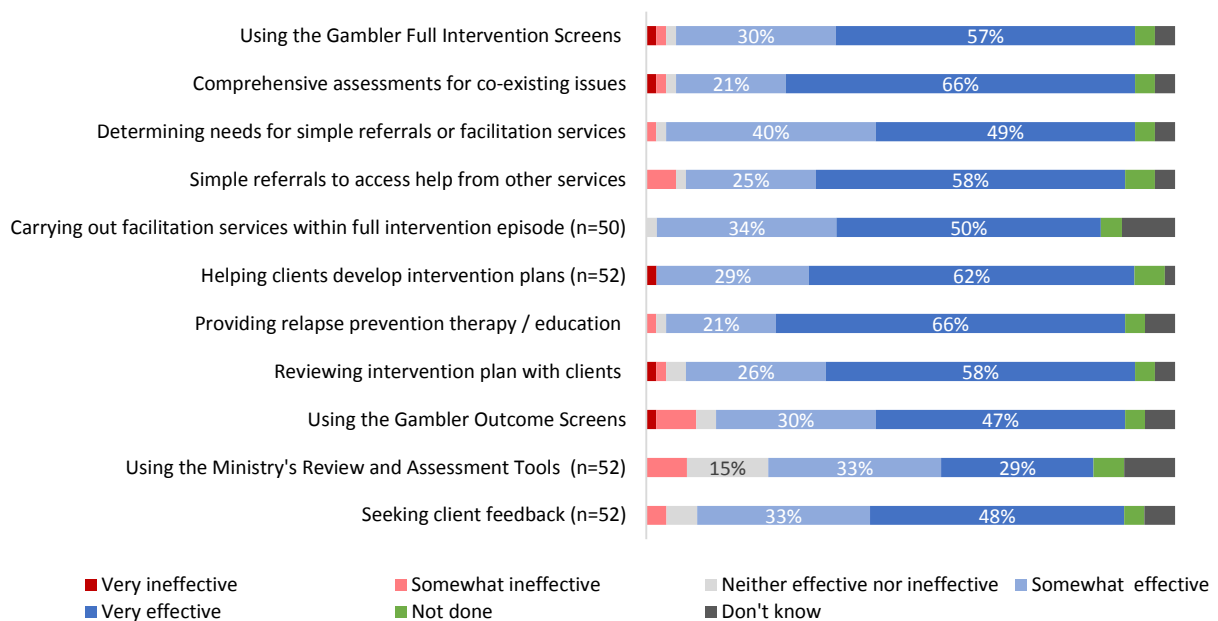
Figure 54: Effectiveness of *Full Intervention* activities as rated by staff (n=53)

Figure 55 shows client survey responses and indicates that almost all recalled experiencing the activities delivered by staff during Full and Workshop-based interventions. The lowest percentage (72%) was for support to gain access to other services. Overall, the evidence supports outputs in the form of services delivered to clients.

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Figure 55: Client experiences of Full / Workshop-based Intervention activities

4.8.3   PGCS-03 / PGCS-06 activities and processes

A few staff survey respondents reported additional activities that were carried out for this intervention. Four noted that they often involved family members in treatment. Two reported communication with clients and counselling via letters. Seven staff survey respondents reported the provision of additional support such as peer support groups and parenting groups, help with developing social and communication skills and anger management, and supportive client-clinician relationships.

> Providing parenting skills, communication skills and anger management. Making connections between clients and communities. Encouraging and supporting client for volunteering activities.

> Ongoing support group can provide effective peer support for problem gamblers and their family members.

> The main tool for the Full Intervention is the relationship with the counsellor. In addition, the environment in which the intervention is carried out. The issues of cultural respect (for difference), a client-centred approach and trust that their privacy will be maintained.

One focus group participant suggested that inclusion of additional financial knowledge components in counselling sessions might be beneficial for some clients.

> …It then links in to financial literacy, financial management issues, and how they manage themselves in their connection with money …I use it often in a short sharp way with young men where I perceive they won't be coming back for another appointment. This occurs often when they have been bought to counselling by a parent.

Several staff survey respondents reported the use of additional measures and data to monitor treatment outcomes. These often included scales and other instruments that their organisations had developed.

> Statistical analyses are detailed frequently for all clients as part of [our] service provision and these results inform us as to how successful our programmes have been in reducing the harm for our gamblers and their wider communities and families.

4.8.4   Full Intervention sessions - volume and delivery processes

The Ministry specifies that *Full Intervention* episodes consist of a "maximum of eight sessions comprising a mix of full intervention" and *Facilitation* sessions (Ministry of Health, 2008b, p. 14). The minimum, maximum and average numbers of Full Intervention sessions per client are provided in Table

24 (Appendix 4). While one session was a frequently reported minimum number, the maximum number of sessions reported was high for most providers, ranging from nine to 191[37].

Overall, for gambler clients the average number of recorded sessions was eight in 2010/11, seven in 2011/2 and 7.9 in 2012/13. One provider (D03) had large averages in comparison to others (successive annual averages of 46.2, 31.9 and 53.0). However, this is a residential provider and, as such, has a different client group and treatment delivery mechanism. When this provider was excluded, the average number of sessions decreased to 5.8, 5.6 and 5.4 across successive years. These figures reflected very closely the figures of individual providers; there were just two Māori providers that noticeably diverged (B07 and B09) with their annual averages being approximately twelve sessions per client.

For significant other clients, the average number of recorded sessions was 5.9, 5.0 and 4.3 across the successive years from 2010/11. For one smaller provider (B18), there was one year (2010/11) in which the average number of sessions was unusually high, reaching 10.3. The aforementioned residential service (D03) also recorded a high average of 13.5 in 2011/12. Three Māori providers (B07, B09 and B13) and one Pacific provider (C19) tended to have a higher number of sessions per significant other client.

The Ministry estimates that a *Full Intervention* session usually lasts for 60 minutes (Ministry of Health, 2008b). Average *Full Intervention* session durations for each provider are shown in Table 16 (Appendix 4). Several providers consistently reported *Full Intervention* session averages (with both gambler and significant other clients) of less than 60 minutes in duration; these tended to be Māori (B12, B13, B14, B18) and Pacific (C04, C19) providers but included one general provider (A15).
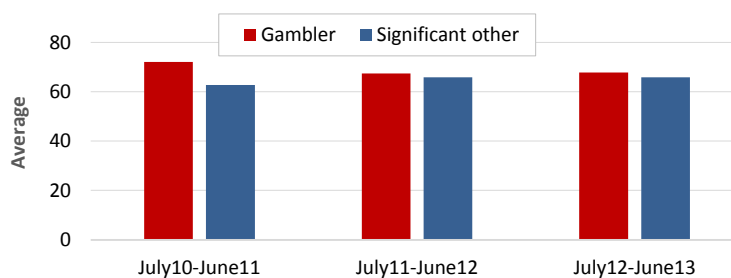
Figure 56: Average Full Intervention session duration (minutes) across the 3-year period

Overall, annual average *Full Intervention* session duration, regardless of client type, was approximately one hour in duration (Figure 56). When averages were considered by provider type (Figure 57), with both gambler and significant other clients, Pacific providers tended to have shorter *Full Intervention* sessions than overall (Figure 56 above) and both general and Māori providers (which approximated the overall figures). This was contrary to comments from focus group participants that Ministry recommended session duration was not sufficient to meet client needs. The Cultural Advisory Group suggested the possibility that Māori and Pacific providers might under-report session length to conform to Ministry requirements. Figure 57 shows that session durations have increased for Pacific providers (and, to a lesser extent, for Māori providers) across the three-year reporting period. Whether this reflects a changing practice or more accurate reporting is unclear.

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[37] It was not possible to ascertain if the higher number of sessions was due to clients who were readmitted into a Full Intervention episode following relapse. CLIC data entry does not specify when one treatment episode ends and another begins.
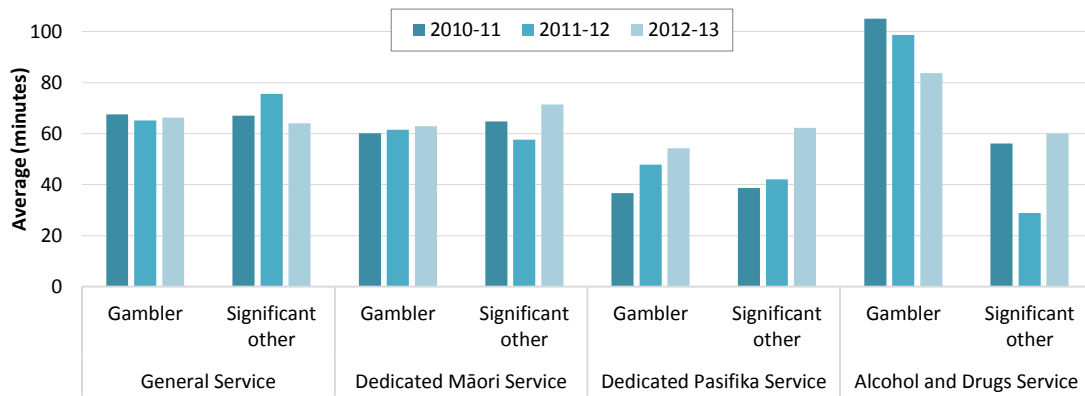
Figure 57: Average Full Intervention session duration (minutes) by provider type across the 3-year period

4.8.5 Full Intervention clients - trends and features

Number of clients

Figure 58 shows the number of new *Full Intervention* clients each month from July 2010 to June 2013, with significant other and gambler clients shown separately[38]. Overall, the numbers of new gambler *Full Intervention* clients were substantially larger than new significant other clients. Substantial month-to-month variation is evident, and patterns are difficult to discern.
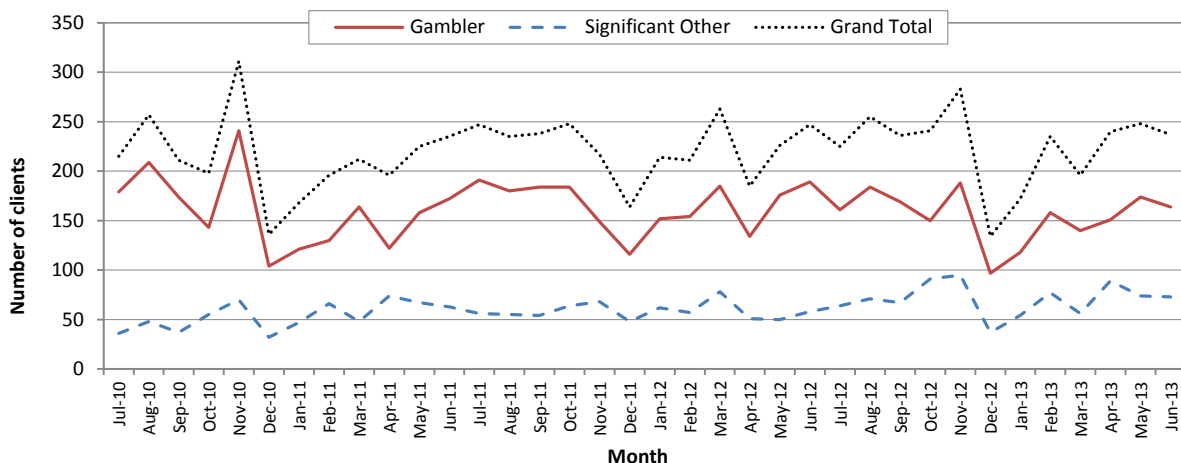
Figure 58: Total number of new Full Intervention clients each month (gambler and significant other) for the three-year period

Figure 59 presents the same data as monthly averages across the three-year period in an attempt to assess any month-to-month patterns. The most obvious effect seems to be a monthly increment throughout the calendar year (with the exception of December, which consistently had the smallest numbers of new clients). The most obvious peak in both new gambler and significant other *Full Intervention* clients is in November, and smaller peaks are apparent in August and March.

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[38] The analyses of the CLIC database showed a small number of clients for whom only Follow-up sessions were recorded. However, for the purpose of the present analysis, all new non-Brief Intervention clients have been considered clients that started with a Full intervention.
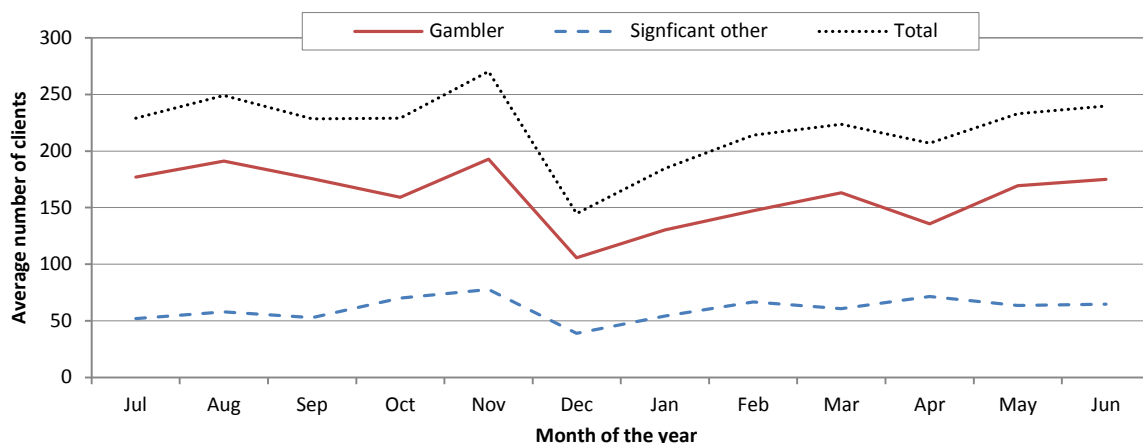
Figure 59: Averages for new Full Interventions based on the month of the year (for the period July 2010 to June 2013)

To examine growth in new *Full Intervention* client numbers, six-monthly averages for the three-year period are shown in Figure 60. This suggests that overall there has been no growth in the numbers of new *Full Intervention* clients. The average number of new clients in these periods varied between a low of 205 (M=205, SD=24, January to June 2011) and a high of 229 (M=229, SD=51, July to December 2012). However, underlying this there is some evidence for a gradual decline in new gambler *Full Intervention* clients compensated for by a gradual increase in new significant other *Full Intervention* clients. For gambler clients, if the low in January to June 2011 is ignored (M=145, SD=23) the other six-month periods incrementally decrease from the high in June to December 2010 (M=175, SD=48) to the low in January to June 2013 (M=151, SD=20). In contrast, the new significant other clients seem to gradually increase across the same period from July to December 2010 (M=46, SD=14), to an average of 71 new significant other clients across both July to December 2012 (M=71, SD=21) and January to July 2013 (M=71, SD=13).
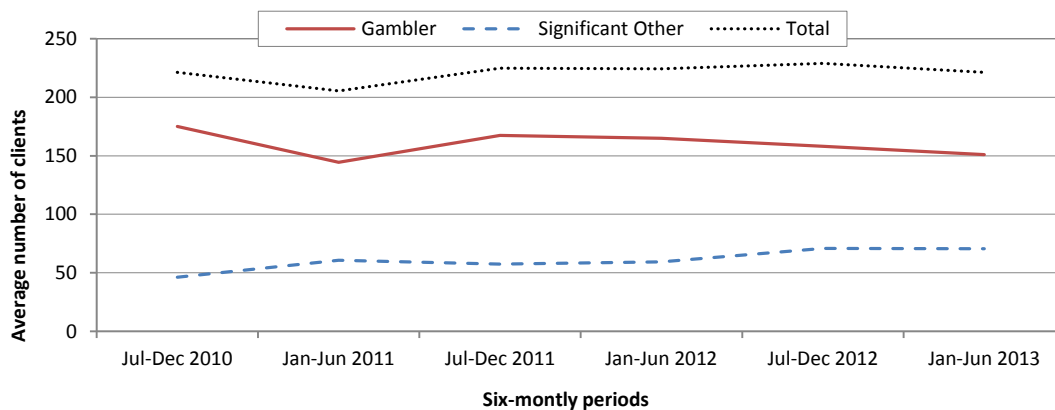
Figure 60: Six-monthly averages for new Full Interventions for the period July 2010 to June 2013

Gender

Approximately half of new *Full Intervention* clients were female (M=49%, SD=4%). Figure 61 shows the percentages of new significant other, gambler and all *Full Intervention* clients who were female, for six-month periods from June 2010. While the overall gender split was relatively even throughout the months between July 2010 and June 2013, when just significant other clients were considered, consistently two-thirds (approximately 66%) of these clients were female (M=66%, SD=6%). In contrast, approximately 40% (M=42%, SD=5%) of gambler clients were female apart from in November 2010 when 53% of new gambler clients were female.
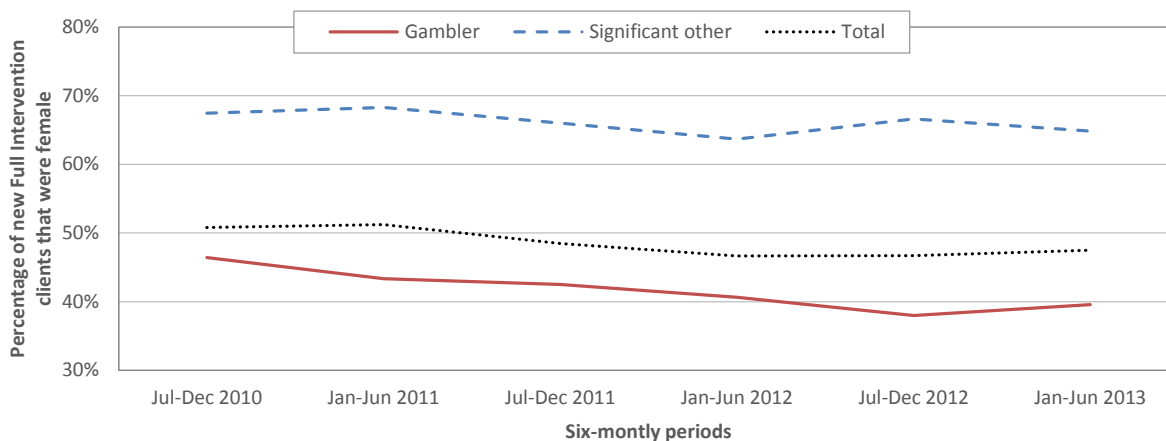
Figure 61: Percentage of new Full Intervention clients that were female

There is an indication that the percentage of new female *Full Intervention* clients has decreased over time (Figure 61). Thus, the actual numbers of new clients are worth considering. Overall, there was an average of 93 (M=93, SD=18) new male gambler clients (ranging from 55 in December 2010 to 119 in November 2012 and May 2013), and 67 (M=67, SD=17) new female gambler clients (ranging from 36 in December 2012 to 127 in November 2010). There were 100 or more new male gambler clients in 15 of the 36 months. In contrast, there was just one month in which there were more than 100 new female gambler clients. Figure 62 shows the six-monthly averages for new male and female gamblers and, while not equivocal, there is some evidence of a small decline in new female gambler clients (notably since the second half of 2011) while new male gambler client numbers have remained relatively constant.
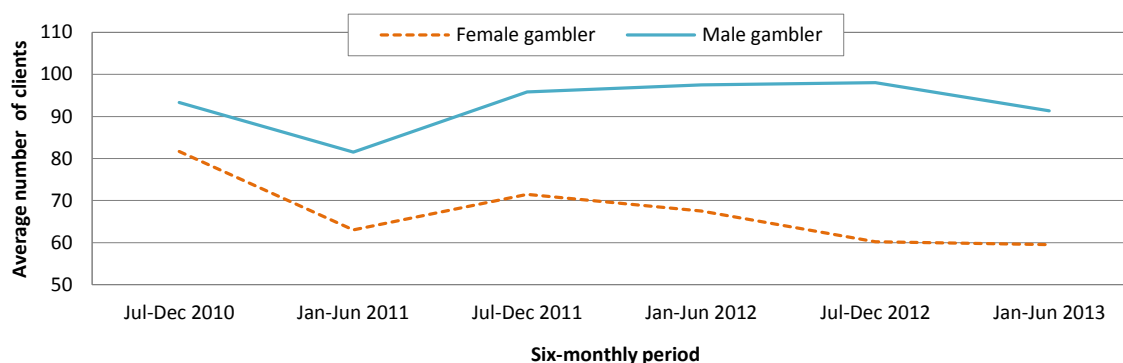
Figure 62: Six-monthly averages for new Full Intervention female and male gamblers for the period July 2010 to June 2013

Ethnicity

The numbers of new gambler clients were substantially larger than the numbers of new significant other clients. Figure 63 shows the monthly average number of new gambler clients by ethnicity and Figure 64 shows the monthly percentages. European/Other was consistently the largest group (M=75, SD=18) and overall represented just under half (M=47%, SD=6%) of all new *Full Intervention* gambler clients. Māori were the second largest group (M=54, SD=14) at approximately one-third of clients were Māori (M=34%, SD=5%). Across months, the percentages were relatively constant (Figure 64). However, in terms of the absolute number of clients, there were variations and these two groups generally paralleled each other; the most notable pattern was the decrease in December and January followed by an increase in numbers throughout the calendar year peaking in August, September and November. Pacific and Asian new *Full Intervention* clients remained relatively stable, with Pacific numbers a little more variable (M=17, SD=9) than Asian (M=14, SD=4). Overall, these clients were each approximately 10% of all new gambler clients (Pacific M=11%, SD=5.5%; Asian M=9%, SD=3%).

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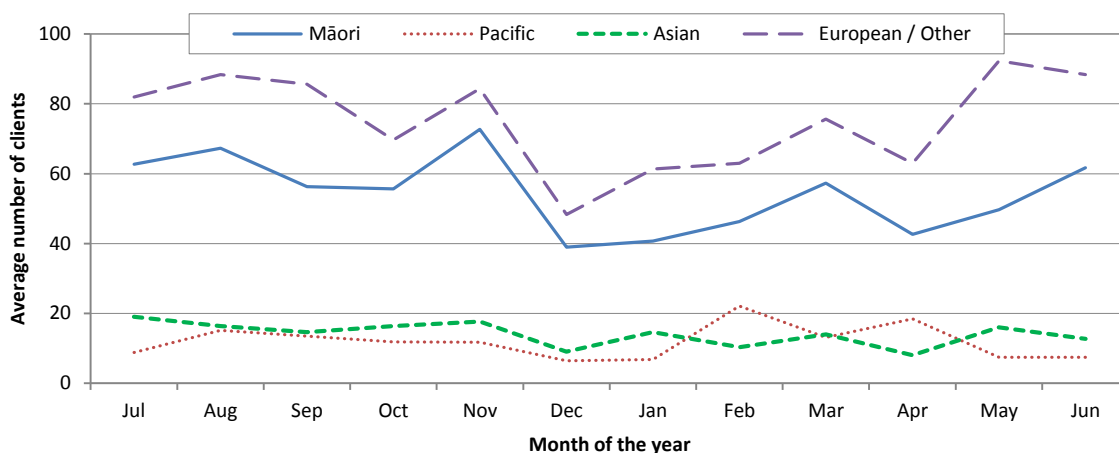
Figure 63: Monthly average number of new Full Intervention gambler clients by ethnicity
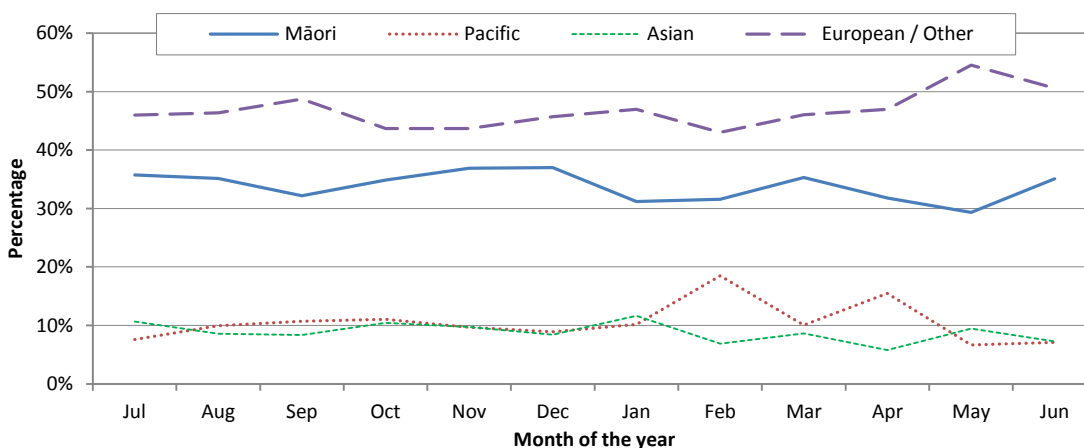
Figure 64: Monthly percentage of new gambler Full Intervention clients by ethnicity

As reported in sub-section 4.7.4, among new *Brief Intervention* significant other clients, Māori were the largest group (Figure 45). Figure 65 shows that in contrast, the largest significant other group of *Full Intervention* clients was European/Other (M=31, SD=8). However, this client group was relatively small, meaning that small one-off variations in client numbers substantially affected the data. Māori client numbers were relatively constant (M=15, SD=6) with slight peaks in April, June and October. The number of Pacific clients, however, was quite variable (M=10, SD=11). Generally, the numbers were small with three notable months; there were 29 new Pacific significant other clients in April 2011, 57 in November 2012 and 33 in February 2012. The next largest month for Pacific had just 16 new clients and when those months are excluded the data are much less variable (M=7, SD=5). The large November average is exacerbated by the high November 2012 figure of 57 clients (with only nine clients in November 2010 and 16 in November 2011). The numbers of new Asian significant other clients were consistently small (M=5, SD=3) and varied between none (in February 2013) and 13 (in March 2011), with just three months containing 10 or more new clients (March 2011, June 2011 and September 2012).
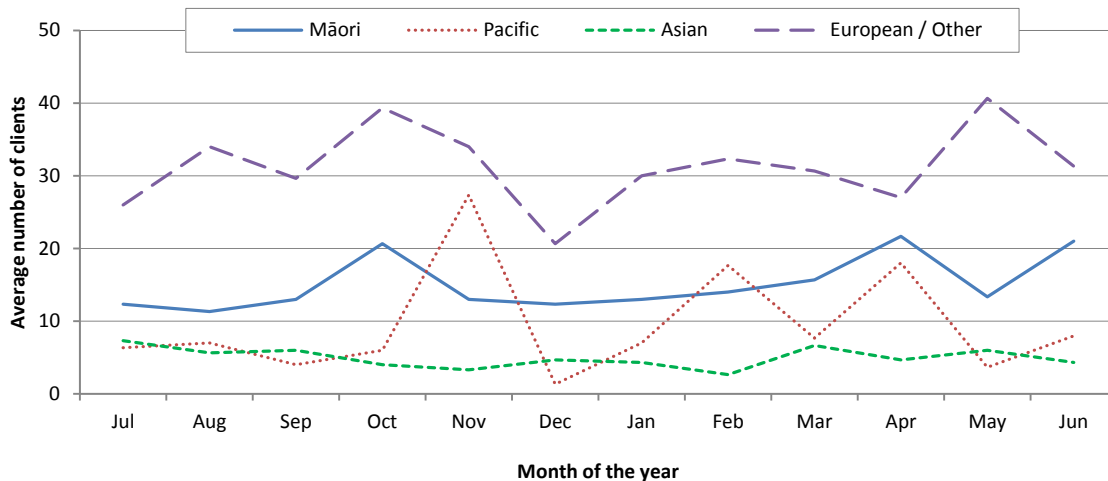
Figure 65: Monthly average number of new Full Intervention significant other clients by ethnicity

The monthly percentages shown in Figure 66 confirmed that just over half of new significant other *Full Intervention* clients were European/Other (M=53%, SD=12%). Similarly, approximately one in four new significant other clients were Māori (M=25%, SD=9%). Variations in the percentages of new clients in those two groups were largely a result of the months in which much larger numbers of new Pacific clients were reported (November, February and April). Pacific clients were 14% of these new clients (M=14%, SD=12%), though variability was substantial, ranging between none (December 2012) and 60% (November 2012). The percentages of Asian clients were also affected by the variation in Pacific clients, but were generally low (M=9%, SD=6%).
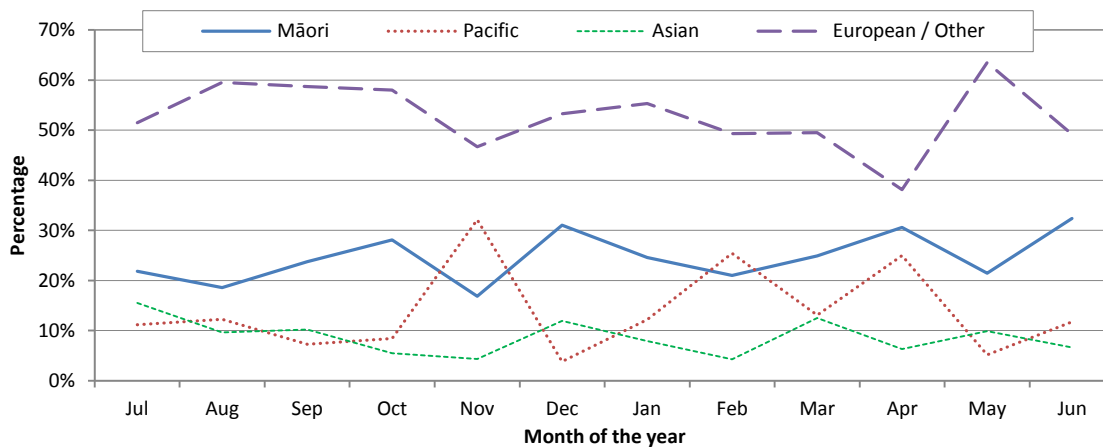
Figure 66: Percentages (by month) for new significant other Full Intervention clients by ethnicity

4.8.6 Full Intervention Gambler Screens

The minimum screens recommended by the Ministry for use within a Full Intervention episode are "the gambling harm screen (gambler or family/affected other)", "outcomes screens to assess change for the client (gambler or family/affected other) and service" and "co-existing issues screens to assess other issues for the client (gambler or family/affected other)" (Ministry of Health 2008b, p. 51). Clinicians are advised to discuss and explain the screens being used and how they can benefit each client. The Ministry believes that discussing the screens with clients will encourage them to reflect on "the effects of gambling on their life in new ways" (Ministry of Health 2008b, p. 51). Once administered, screen scores are entered into the CLIC database.

The Gambler Harm Screen[39] is used for assessing gambling harm and to determine if a client meets the Ministry's requirement for *Full Intervention* funding.

Three Gambler Outcomes Screens are recommended within a *Full Intervention* as part a comprehensive assessment for gambler clients. These screens have questions about "their control over their gambling", "the amount of money they have lost ('dollars lost')" and "their annual household income" (Ministry of Health, 2008b, p. 53). The first two screens are included in this report as they provide some level of pre- and post- data that can determine client outcomes. Used in combination with the Dollars Lost Screen, the annual household income question is used by clinicians to raise clients' "awareness about their gambling" by comparing "their gambling losses against their disposable income" (Ministry of Health, 2008b, p. 55).

Figure 67 shows the frequency with which these screens were recorded for gambler clients. Overall, they were generally recorded once or more often for about half of clients and in 2012-13 this was close to 60% of clients.
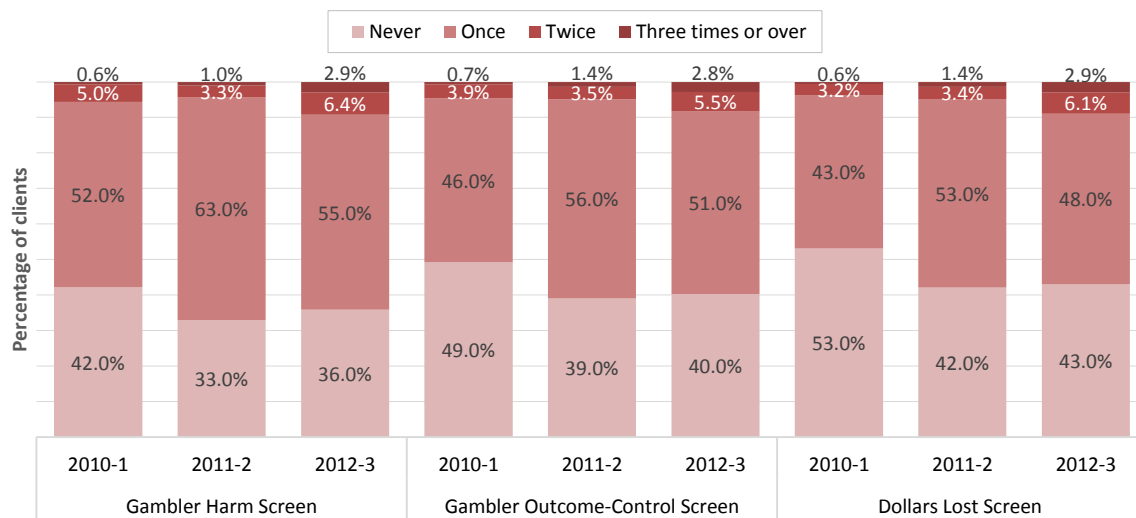
Figure 67: Number of times screen results were recorded for gambler clients during Full Intervention

Gambler Harm Screen

The Ministry regards the Gambler Harm Screen as "the gateway screen for full intervention services" (Ministry of Health 2008b, p. 53). As shown in Figure 68, this screen contains nine items (about gambling behaviours and experiences) each rated on a frequency scale of 0 (never) to 3 (almost always), which are then added to determine a total score. When a client has a score of three or more, they meet the Ministry's criteria for Full Intervention funding. "A positive screen of 3 - 7 indicates moderate risk and 8 - 27 indicates problem gambling" (Ministry of Health, 2008b, p. 53).

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[39] This is the Problem Gambling Severity Index (PGSI).

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Gambler harm screen

Gambler Harm *(record the total score)*
The Gambler Harm Full Screen is scored by the client's response to each
question (never = 0, sometimes = 1, most of the time = 2, almost always = 3)

- Thinking about the past 12 months, how often have you bet more than you could really afford to lose?
- Thinking about the past 12 months, how often have you needed to gamble with larger amounts of money to get the same feeling of excitement?
- Thinking about the past 12 months, how often have you gone back another day to try to win back the money you lost?
- Thinking about the past 12 months, how often have you borrowed money or sold anything to get money to gamble?
- Thinking about the past 12 months, how often have you felt that you might have a problem with gambling?
- Thinking about the past 12 months, how often have people criticised your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?
- Thinking about the past 12 months, how often have you felt guilty about the way you gamble, or what happens when you gamble?
- Thinking about the past 12 months, how often has your gambling caused you any health problems, including stress or anxiety?
- Thinking about the past 12 months, how often has your gambling caused any financial problems for you or your household?

Figure 68: The Gambler Harm Screen (Ministry of Health, 2008b, p. 116)

The number of times the Gambler Harm Screen scores were recorded for gambler clients in *Full Intervention* sessions is shown in Table 25 (Appendix 4). The CLIC database shows that on rare occasions Gambler Harm Screen scores were also recorded for significant other clients and with both gambler and significant other clients during *Brief Interventions*.

At a provider level there was variation, with some (A02, A11, A15, B14, C04, D16) consistently recording screen scores at least once; presumably these providers integrate (where clinically possible) the assessment into their initial session. One provider (B06) initially recorded screen scores for the majority of gambler clients (84% and 73% in 2010/11 and 2011/12, respectively) but in 2013 this decreased to 11%. Other providers were generally consistent with the overall figure.

As shown in Figure 67 above, scores for this screen were recorded once for over half of gambler clients. However, in all three reporting periods, scores for this screen were not recorded for over 30% of gambler clients. As this screen is intended to gauge clients' gambling harm severity and to determine intervention needs, the lack of recorded scores is a concern as this limits to usefulness of the CLIC database in evaluating client progress through the intervention process.

The average initial scores for clients of each provider, and the overall averages are shown in Table 26 (Appendix 4). The average score was constant across the years at between 11 and 12. While most providers exhibited fluctuations in average scores over the years, several providers had average scores noticeably higher (A02, A15, B07, B09, B13, D16) whilst other providers had noticeably lower average scores (B12, B17, C04, D03) across the three years.

In some instances, providers recorded screen scores twice for gambler clients. The average change in score between the initial and second administration of the screen is shown in Table 27 (Appendix 4); negative values indicate an improvement. The data are included in the year in which the second assessment was undertaken. The very small sample size in 2010/11 makes interpretation problematic; therefore, 2011/12 and 2012/13 were the focus. On average, scores improved by 6.23 points on this screen when the second assessment was undertaken in 2011/12 and by 6.83 points in 2012/13. Overall, the sample size for individual providers were relatively small, but the larger sample sizes indicated (as expected) improvements similar in magnitude to the overall figure.

Gambler Outcome-Control

Using the single question Gambler Outcome-Control Screen, clients are asked about the level of control they have over their gambling, using a rating scale of 1 (complete control over gambling) to 4 (no control over gambling). Clients' responses on their "perceived control over their gambling provides a starting point or baseline. The question can be asked again after the full intervention treatment, and the answer may provide evidence of a positive outcome from the treatment" (Ministry of Health, 2008b, p. 54). Clients' responses also offer information that could determine the therapeutic approach.

The number of times scores for the Gambler Outcome-Control Screen were recorded for gambler clients in *Full Intervention* sessions by all providers is shown in Table 28 (Appendix 4). The overall data are also shown in Figure 67 above. CLIC analyses show that the Gambler Outcomes Screens scores were seldom recorded for significant other clients or with gambler clients in Brief or Facilitation sessions.

Most recently (2012/13), Gambler Outcome-Control Screen scores were recorded for 51% of gambler clients in *Full Intervention* sessions, and for 8.3% scores were recorded twice or more, leaving a substantial group (40% of gambler clients) with no recorded scores in CLIC. Nevertheless, Table 28 (Appendix 4) shows several providers recorded screen results for the majority of their clients at least once in 2012/13 and, in several cases, this was for 75% or more of gambler clients (providers A02, A11, A15, B12, C19); other providers were generally consistent with the overall figures. There was little evidence in any systematic increment in the recording of screen results across time, but there was provider-by-provider and year-by-year variability.

Table 29 in Appendix 4 shows the average initial rating for the Gambler Outcome-Control Screen for each provider, and overall. These ratings were relatively constant across years (averages of 2.46, 2.41 and 2.35 respectively) and across providers. Although, as was generally the case with other measures, provider C04 had lower ratings.

Among clients for whom scores were recorded twice, Table 30 (Appendix 4) shows the average change in ratings between the first and second assessments. As with other repeat measures, this analysis was hampered by the low frequency with which the scores were recorded twice. Nonetheless, clear average improvements were evident across most providers and overall (average annual improvements of -0.39, -0.63 and -0.55 respectively across the three years). At a provider-by-provider level, the sample sizes were often very small (given the infrequency of recorded scores) and as such, few definitive conclusions can be made.

Dollars Lost Screen

The Dollars Lost Screen consists of a single question that asks gambler clients to estimate the amount of money they spent on gambling in the previous month; they are asked to include additional money accessed while gambling but to exclude any money won (Ministry of Health, 2008b). The amount of money lost can serve as a baseline prior to the client's participation in a *Full Intervention* treatment. "When this question is asked again after treatment, the response, if lower, may indicate a positive outcome that could be due to the treatment" (Ministry of Health, 2008b, p. 55).

The number of times results for the Dollars Lost Screen were recorded for gambler clients in *Full Intervention* sessions by providers and overall is detailed in Table 31 (Appendix 4). Screen results were not recorded for a substantial proportion of clients (over 40%, see Figure 67) and was recorded only once for a similar proportion of clients. As with the other screens, results were rarely recorded more than once.

The annual averages recorded in the Dollars Lost Screen for gambler clients varied between providers ranging from a few dollars to several thousands of dollars (Table 32 in Appendix 4). In 2012/13, many providers had annual average monthly figures of several hundred dollars (B06, B07, B12, B14, B17, B18, C04, C19, D16). Some provider averages were variable year-to-year (e.g. B06, B14) while others were relatively constant. The general providers (A01, A02, A11, A15) and some Māori providers (B05, B10) tended to report higher amounts on this measure, which is more appropriately contextualised with respect to the socio-economic status of the clients.

Although screen results were rarely recorded twice, for clients for whom it was, positive improvements were estimated (Table 33 in Appendix 4). While there were variations at a provider level, the overall data showed that the overall percentage of clients showing improvement increased over successive reporting periods (47% in 2010/11, 65% in 2011/12 and 75% in 2012/13. However, these results should be interpreted cautiously given the small sample sizes, and the finding that a substantial proportion of clients' estimates were worse on the second assessment.

4.8.7 Full Intervention Family/Affected Other Screens

Three screens comprise the assessments recommended for use in *Full Intervention* sessions with significant other clients; the Full Family/Affected Other Screen and two outcome screens, Gambler's Gambling Frequency Screen and Coping with the Gambler's Gambling Screen. As shown in Figure 69, providers did not record results for these screens for 50% or more of their significant other clients throughout the three years.
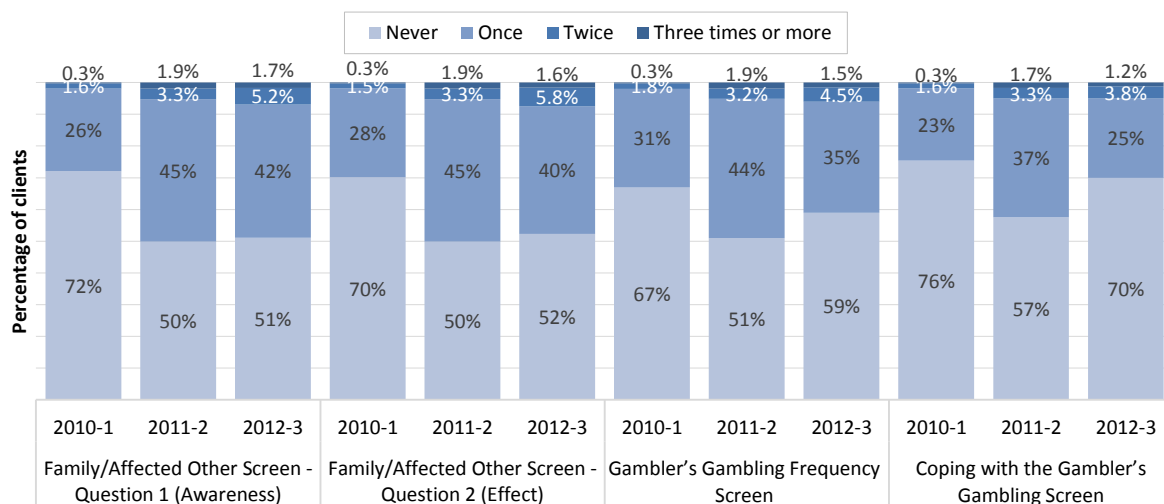
Figure 69: Number of times screen results were recorded for significant other clients during Full Intervention

Nevertheless, screen results were recorded at least once with a higher percentage of clients in the 2011/12 and 2012/13 periods compared to the 2010/11 period.

Full Family/Affected Other Screen

The Full Family/Affected Other Screen is used to screen "people for the impact of another person's gambling problem on them" (Ministry of Health, 2008b, p. 56). The two questions in this screen (Question 1: Awareness of the Effect of the Gambler's Gambling, and Question 2: Effect of gambler's gambling) are similar to those in the Brief Family/Affected Other Screen but are recorded separately in the CLIC database under *Full Intervention*. For clients who have recently completed this screen in a *Brief Intervention*, clinicians are advised to "discuss the client's previous responses and current views. This provides a further opportunity for the client to consider the current effects of the gambling on them, and these may vary with further consideration between the two" (Ministry of Health, 2008b, p. 57).

As the overall results for Question 1 of this screen (summarised in Figure 70) showed, in all three reporting periods, over a third of significant other clients indicated that they were currently affected by someone else's gambling while about a quarter indicated that they had been affected in the past. In the 2011/12 and 2012/13 reporting periods, about a third of clients indicated uncertainty about such effects (there was a corresponding decrease in those reporting they were currently affected).
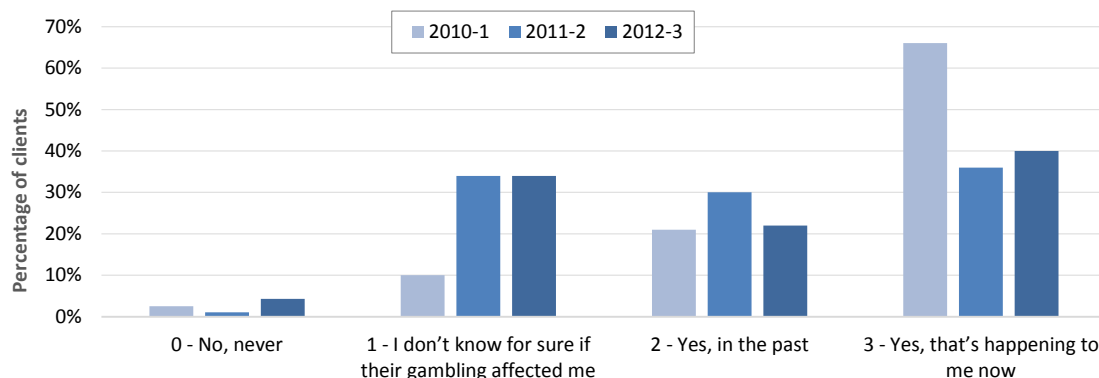
Figure 70: Significant other client responses to Question 1 in an initial Full Family/Affected Other Screen

The overall percentage of clients' responses to the second question of this screen (Figure 71) showed that over a quarter indicated one effect type. Smaller percentages of clients experienced two, three, four and five effect types. Increases were evident in two categories in 2012/13; those no longer affected, and those affected in a way not listed in the screen.
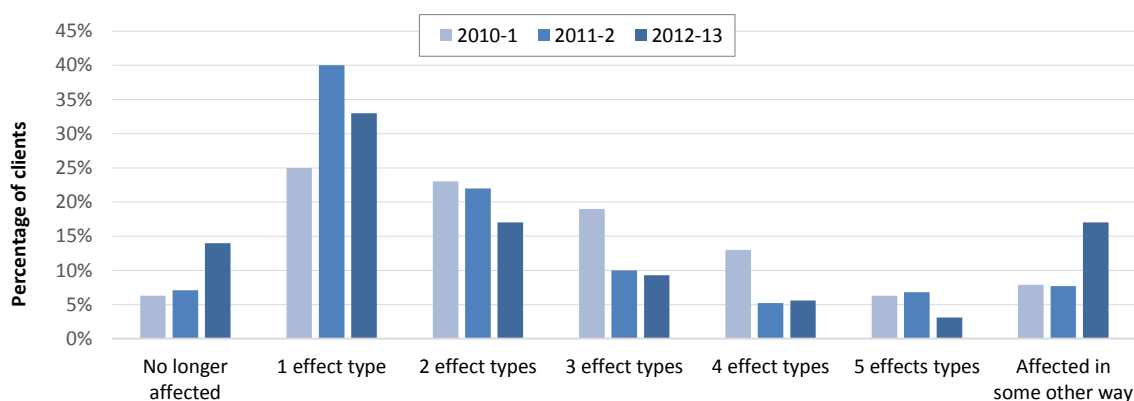
Figure 71: Significant other client responses to Question 2 in an initial Full Family/Affected Other Screen

Gambler's Gambling Frequency Screen

The Gambler's Gambling Frequency Screen asks significant other clients to rate the gambling frequency of the gamblers in their lives over the past three months (Ministry of Health, 2008b). This screen has four responses: 0 (not been gambling), 1 (gambling less), 2 (gambling about the same as usual) and 3 (gambling more than usual). This screen is intended to provide "a context for the coping with the gambler's gambling" (Ministry of Health, 2008b, p. 58). For instance, screen results may help clinicians in their discussion with clients about affects or other underlying issues that may remain despite decreases in the gambler's gambling frequency.

The initial recording of client responses to this screen (Figure 72) showed that most indicated that the gambling behaviours remained the same as usual or increased.
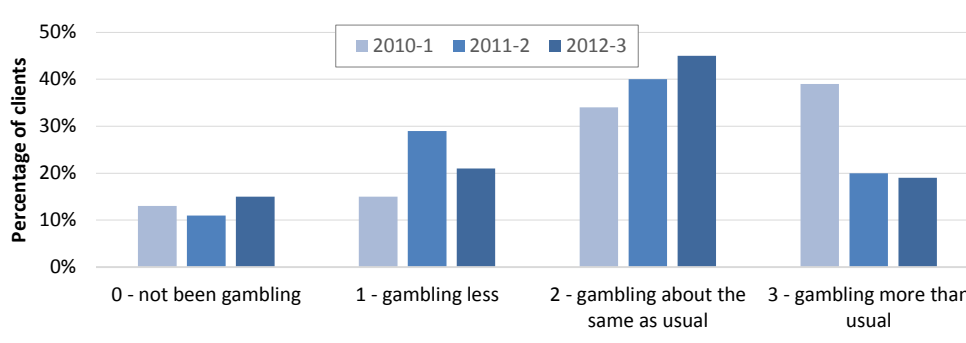
Figure 72: Significant other client responses to an initial Gambler's Gambling Frequency Screen

For the very small sample of clients with screen results recorded twice, it is more appropriate to consider the movement within the scale, 0 being no change to non-gambling behaviour, to +3 or − 3 meaning shifts towards the gambler gambling more (+) or less (-). Changes are shown in Figure 73. Over half of these significant other clients reported increases in the gambler's gambling frequency; a trend that remain constant throughout the reporting period. This small group of clients had multiple assessments in multiple sessions, likely to be a result of the worsening issues.
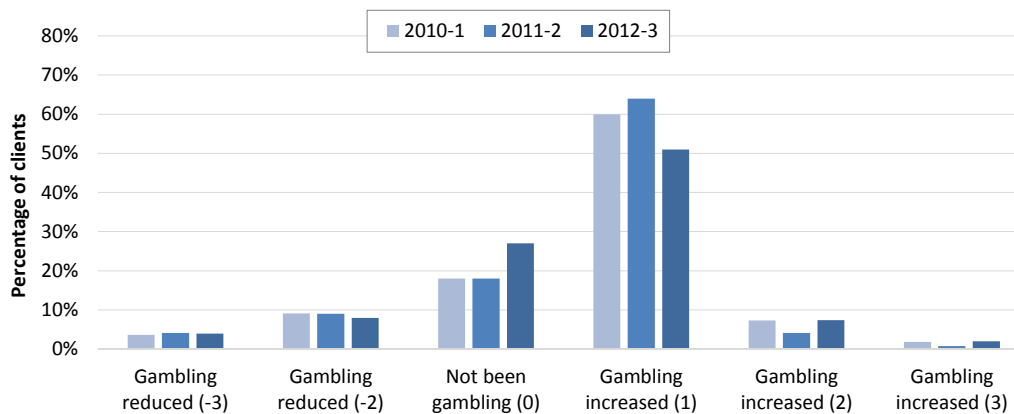
Figure 73: Changes to Gambler's Gambling Frequency Screen results (percentage and number)

Coping with the Gambler's Gambling Screen

The Coping with the Gambler's Gambling Screen asks clients "how they are coping with the gamblers gambling" (Ministry of Health, 2008b, p. 57). Clinicians are required to interpret client responses to this screen alongside the Gambler's Gambling Frequency Screen, thus providing "an opportunity for the client to realise" and for the clinician to acknowledge "that the client's wellbeing is not contingent on the gambler reducing their gambling and to focus on their own recovery. It is also an opportunity to discuss any non-improvement in coping and consider further therapy" (Ministry of Health, 2008b, p. 58). It is important for clinicians to consider that significant other clients may have improved in their coping abilities even when the gambler's behaviour remains unchanged.

This screen has three responses with 1 indicating that the significant other is coping better than in the past, 2 indicates coping the same, and 3 indicates the coping is worse. The overall percentages of client responses to an initial administration of this screen are shown in Figure 74. The majority of significant other clients reported that they were coping better than before or were coping about the same.
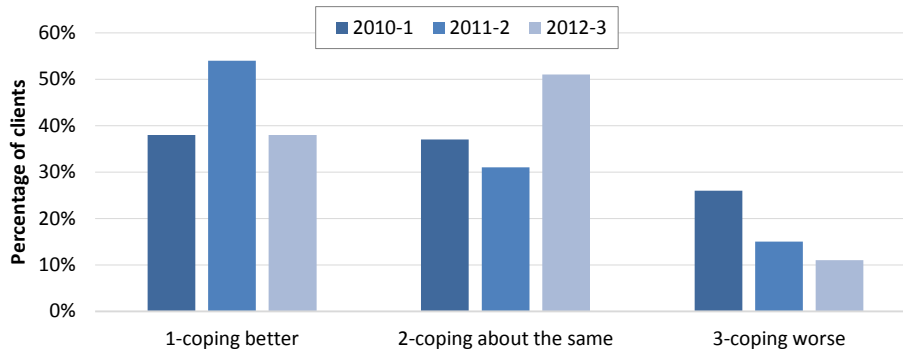
Figure 74: Significant other client responses to an initial Coping with the Gambler's Gambling Screen

For a small number of clients with screen results recorded twice, changes between the initial and second assessment were considered as shifts from the client's initial score: (0) meaning no change, (-) indicating improved coping and (+) indicating poorer coping. The overall results in Figure 75 show that over 50% reported no changes in their coping abilities, while about one-quarter reported improved coping. Only a small number of clients indicated worsening of their coping abilities. These trends were fairly constant across the three years.
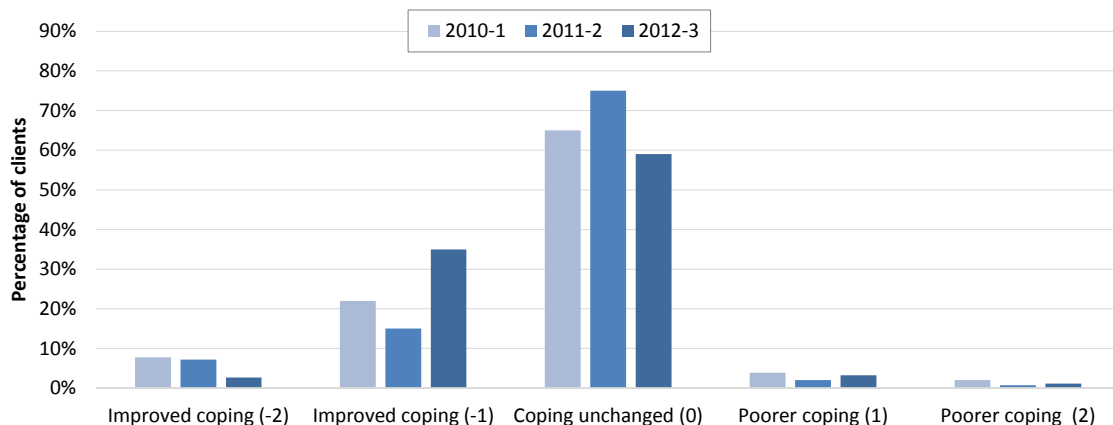
Figure 75: Change to Coping with the Gambler's Gambling Screen results (percentage and number)

Due to the small sample size, no conclusions can be made. Many clients had only one session, generally screen results were recorded relatively infrequently, and this screen referred to "how they coped in the past" making interpretation of changes difficult. One interpretation is that clients who continued to have problems continued to seek help, and as such, multiple measures are sometimes obtained and show little change in outcome scores. This was confused by the fact that there was also provider level variation in collection of this information. Overall, little can be concluded other than ways of ensuring screen results are recorded for clients more consistently to allow outcomes to be examined. This particular screen might also be re-worded to provide a more concrete reference point for client coping.

4.8.8   Co-existing Issues Screens

Several Co-existing Issues Screens are used "as part of a comprehensive assessment for all clients (gamblers and family/affected others) who are in a full intervention episode" (Ministry of Health, 2008b, p. 59). Co-existing Issues Screen implemented during a *Full Intervention* episode, helps clinicians determine if clients need referrals to other support services including their requirement for *Facilitation Services*. Even when clients screen negatively for problem gambling, clinicians should see this as an "opportunity to work with the individual by assessing them for co-existing issues and doing referral planning to support the client to access appropriate community, health or social services" (Ministry of Health, 2008b, p. 85).

While there were variations among providers in screen results recording frequency, the overall percentages (Figure 76) show that results for these screens were recorded at least once for approximately half of gambler clients.
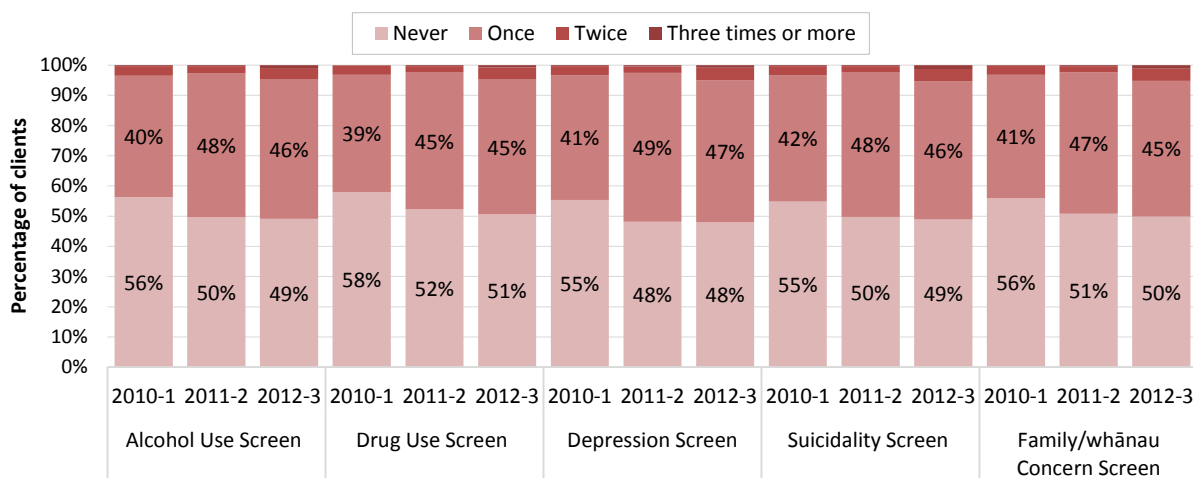
Figure 76: Number of times Co-existing Issues Screen results were recorded for gambler clients during Full Intervention

However, as shown in Figure 77, screen results were not recorded for approximately two-thirds of significant other clients in each of the three reporting periods.
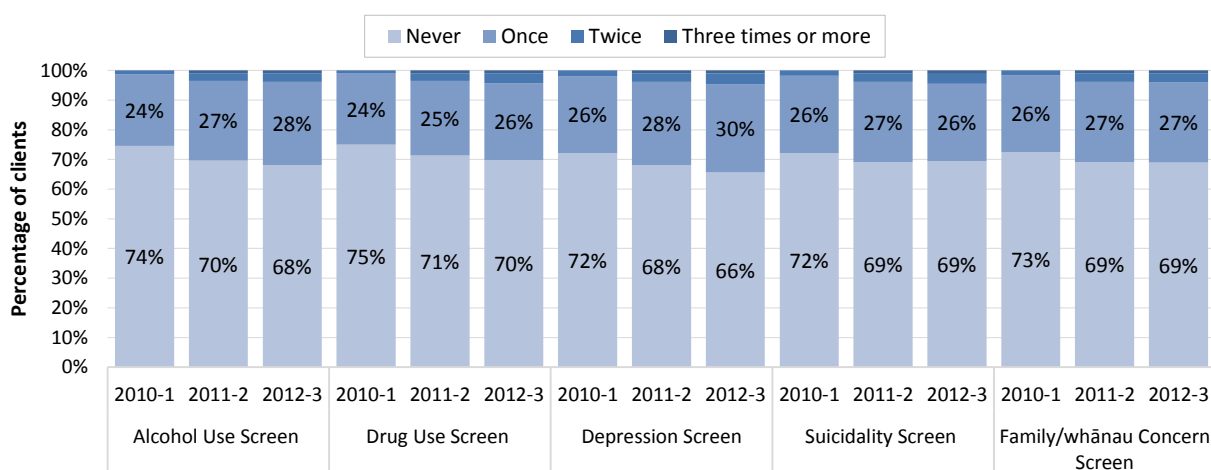
Figure 77: Number of times Co-existing Issues Screen results were recorded for significant other clients during Full Intervention

The data also showed that results for all five screens were infrequently recorded for both gambler and significant other clients during *Brief Intervention*, *Facilitation* and *Follow-up* sessions, often involving less than one percent of clients and never exceeding 10% of clients.

Screen results were recorded more than once only for a small percentage of clients. For such cases the percentage change from initial to second assessment are provided to show improvements or worsening of clients' situations. However, these estimates are based on screen implementation at points other than in a *Full Intervention*, and are thus not specific to *Full Interventions* but rather to treatment in general.

Alcohol Use Screen

Using the 3-question Alcohol Use Screen, clients are requested to rate their alcohol consumption using a 0 to 4 frequency scale for each question. Responses are added to form a total score ranging from 0 indicating either no or very low-level alcohol consumption to 12 indicating high-level alcohol use. During clinical intervention, scores of five or more for males and four or more for females show that their "use of alcohol is at a risky level and warrants an enquiry" (Ministry of Health, 2008b, p. 59).

"Tracking how the client's alcohol abuse fits within the client's gambling behaviour may be insightful for the client" (Ministry of Health, 2008b, p.60).

The average scores for this screen are detailed in Table 34 for gamblers and Table 35 for significant other clients (in Appendix 4). Generally, the data show that most significant other clients had lower levels of alcohol consumption than gamblers. This pattern was consistent across providers and the total averages showed a score of less than three in each reporting period.

By comparison, gambler clients had higher total average scores, almost reaching four in each reporting period. The annual average scores for gambler clients of some Māori providers (B06, B07, B10, B14), Pacific providers (C04, C08, C19) and one AOD service provider (D16) were higher, ranging from five to eight. Although the small sample sizes of these providers need to be considered, these trends suggest a higher level of alcohol use issues among clients of some Māori and Pacific services, in some cases reflective of from where clients are referred or recruited (e.g., AOD services).

The average change from initial to second assessment for Alcohol Use Screen scores in Table 36 (Appendix 4) shows that while improvements were a common feature, some providers recorded average deteriorations in some reporting periods. Once again, however, repeat assessments were relatively rare.

Drug Use Screen

The Drug Use Screen is a single yes or no question asking clients if they felt the need to use prescription or other drugs in the past year (Ministry of Health, 2008b). A positive response is a positive result warranting further enquiry during clinical intervention. Clinicians could undertake to address "drug use and gambling at the same time" or refer "the client to a specialist alcohol and other drug service provider" (Ministry of Health, 2008b, p. 60). Additionally, "tracking how the drug use interrelates with the gambling may be insightful for the client" (Ministry of Health, 2008b, p. 60).
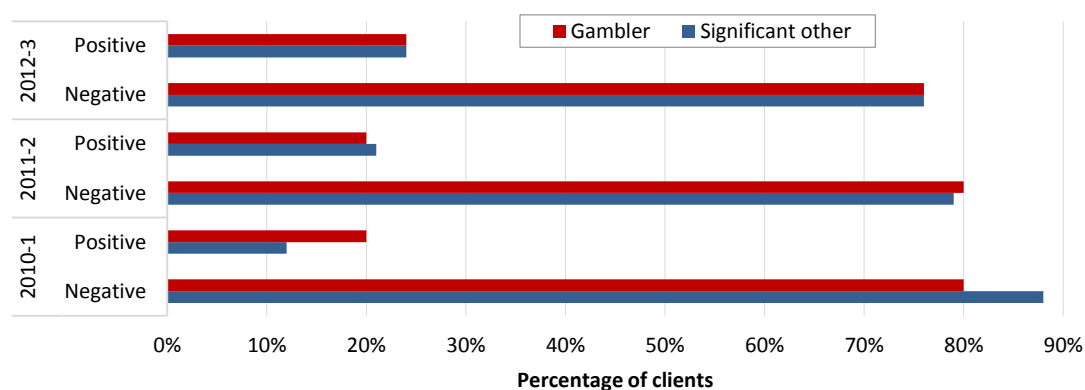
Figure 78: Client responses an initial Drug Use Screen

In general, the initial Drug Use Screen results recorded for both gambler and significant other clients (Figure 78) show that less than quarter in both groups presented with self-identified drug-use as a co-existing issue. This pattern was consistent across providers with the exception of three Māori providers (B06, B12 and B14) which had a higher percentage of clients presenting with drug-use issues in some reporting periods.

Again, results for this screen were seldom recorded twice. Changes from the first to second assessment were examined and showed that in the great majority of cases, for both client groups no change was reported.

Depression Screen

The two-question Depression Screen asks clients if they have experienced feelings of depression and demotivation. Positive responses are added and recorded as follows: 0=no to both questions, 1=yes to one question and 2=yes to both questions. "A 'yes' response to either depression screen question is a positive result, so further enquiry is appropriate" (Ministry of Health, 2008b, p. 61). While clinicians

could suggest strategies to address depression, clients with severe levels of depression should also be referred to "to a general practitioner for consideration of anti-depressants" (Ministry of Health, 2008b, p. 61).
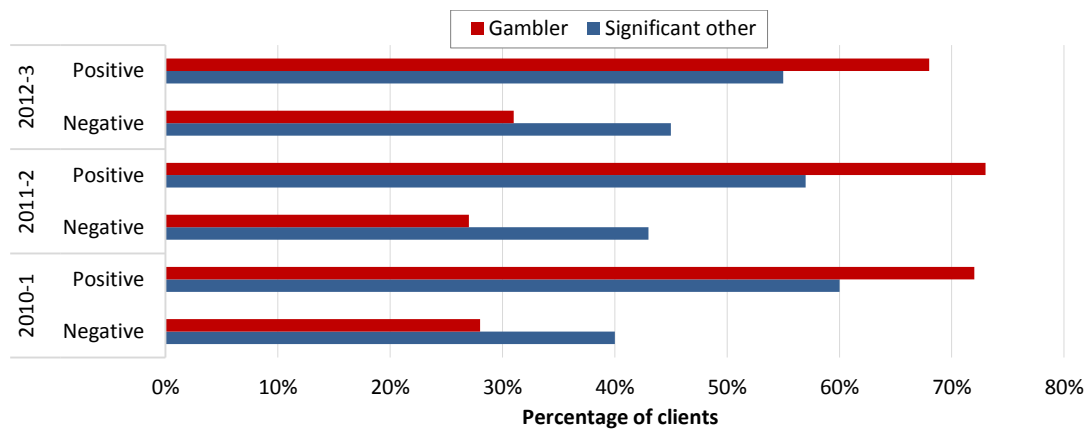
Figure 79: Client responses to an initial Depression Screen

In general, the initial Depression Screen results show that depression was potentially an issue for about two-thirds of gambler clients (Figure 79). Although percentages were lower for significant other clients, the percentage who screened positively for depression was higher than those who screened negatively. On the few occasions where screen results were recorded twice, the majority of clients were unchanged (and a small percentage either improved or worsened); the extent to which clients were referred to other mental health professionals was unclear.

Suicidality Screen

The single question Suicidality Screen asks clients if they have had suicidal ideation in the past year. Clients' responses are recorded as 0=for no thoughts, 1=just thoughts, 2=thoughts and plan, 3= attempted self-harm in the past 12 months. When a risk is identified, even if it was 'just thoughts' clinicians would need to "continue this enquiry at subsequent sessions and when clients are distressed in subsequent sessions, even if they respond 'no' in an assessment screening session" (Ministry of Health, 2008b, p. 62).

The overall results summarised in Figure 80 show that suicidality was not an issue for the majority of gambler and significant other clients. However, in all three reporting periods, approximately 21% of gambler clients had thought about suicide, three percent had planned a suicide, and almost three percent had attempted suicide. These figures were slightly lesser for significant other clients.

On the few occasions where the screen results were recorded twice, there was no change from the initial score for the majority of clients.
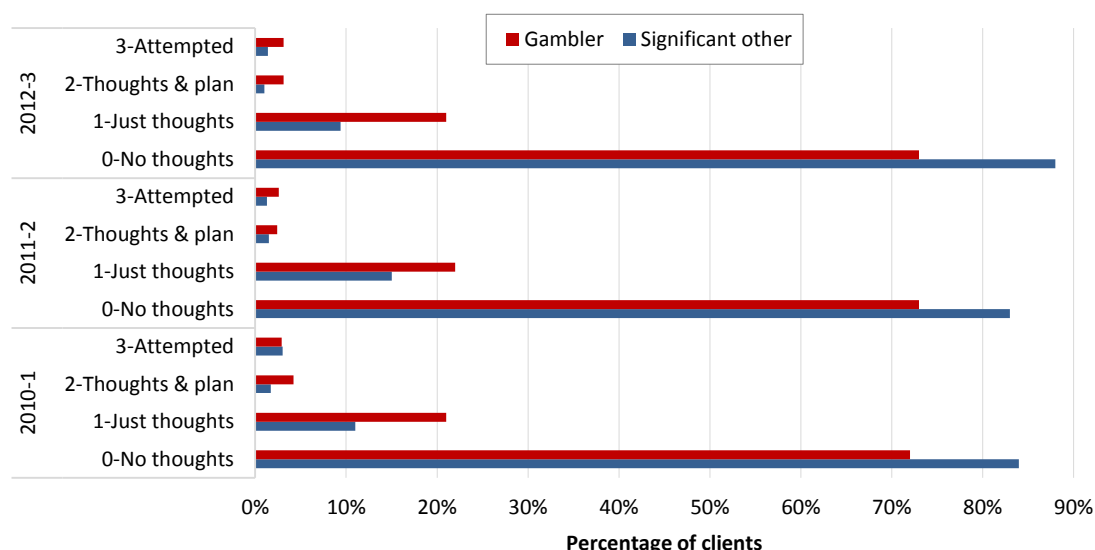
Figure 80: Client responses to an initial Suicidality Screen

Family/whānau Concern Screen

The Family/whānau Concern Screen asks the client if someone in their family or whānau had expressed concerns over their health or wellbeing in the past year, and records a 'yes' or 'no' response. A positive response to this screen enables clinicians to discuss health issues that clients may not yet be ready to acknowledge. This could help clients identify other issues that they may want to address or realise the connections between their gambling and health issues (Ministry of Health, 2008b).
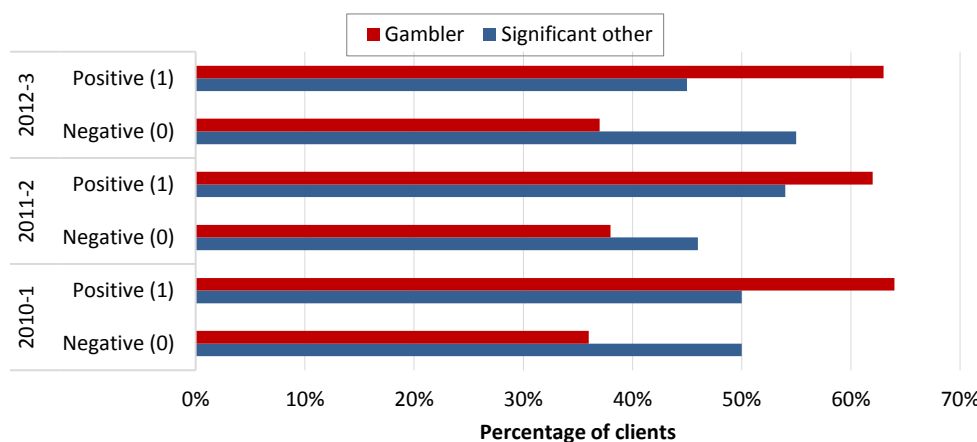
Figure 81: Client responses to an initial Family/whānau Concern Screen

As shown in Figure 81, across all three reporting periods, over 60% of gambler clients and approximately half of all significant other clients indicated positive responses to this screen, suggesting that they were experiencing health-related issues evident to others around them. On the few occasions when the screen was recorded a second time, no changes were evident for the majority of clients.

4.8.9 Full and Workshop-based Intervention outcomes for clients

Clients' self-rated changes with respect to a range of possible impacts of Full and Workshop-based Interventions are shown in Figure 82. The majority indicated positive outcomes in terms of improvement in understanding gambling harms and gambling triggers, greater control over gambling behaviours, greater ability to stop gambling, and improvements to health, wellbeing and financial situations.

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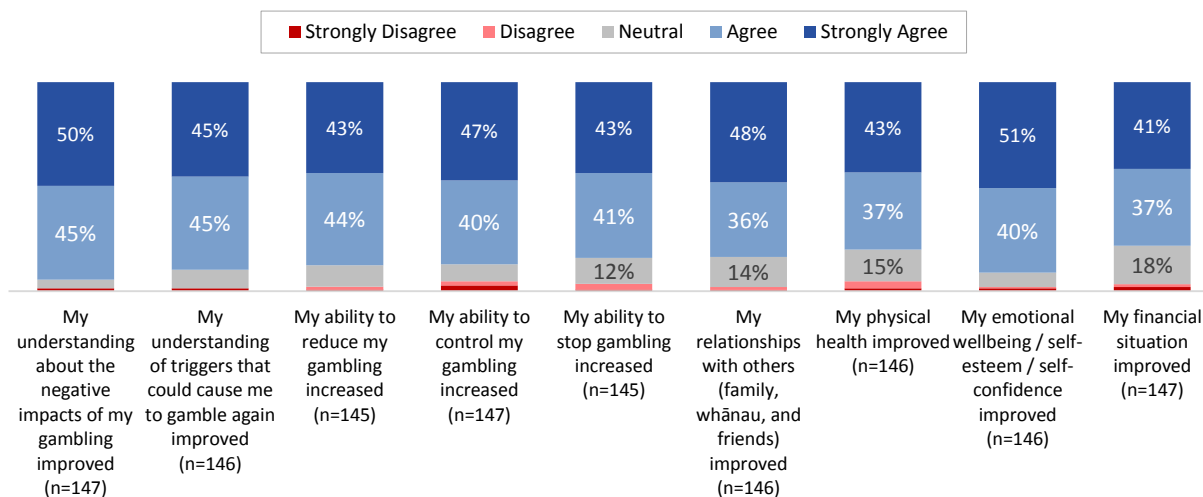
Figure 82: Impact of Full and Workshop-based Interventions as indicated by clients

Among the 89 clients who responded to an open-ended question on other positive or negative impacts, most elaborated on those detailed in Figure 82. Twenty-nine commended their service providers for their educative information, flexibility, support, and for the qualities of their caseworkers/counsellors.

> I was out of control and was educated at the workshop re[garding] the complexities of the machine.

> My counsellors were non-judgemental and supportive, thereby making it so much easier for me to discuss my issues and try and look for some kind of resolution.

For eight clients, the sessions helped increase their understanding of factors related to their gambling behaviours.

> It taught me to recognise the triggers to my gambling and how to deal with it.

> I understand myself more; I can stand back and assess my gambling better and the underlying issues to my addiction/s.

For another three clients, the sessions helped them acknowledge and address their gambling problem.

> I learned not to chase up the loss, but to use appropriate ways to work for money.

> Learning to take responsibility for my problems and letting other people handle their own.

Four clients expressed a sense of self-control over their gambling.

> Able to bar myself from the places I was visiting… Being confident to walk past previous gambling venues and not having any urge to gamble.

Seven clients reported that they had stopped gambling because of their intervention sessions. Five clients referred to the action plan, noting a feeling of ownership.

> Feel I am being listened to; the plan is mine, something I can do because I did it.

Twenty-two clients commented on improvements to their quality of life in a range of ways.

> Learned to balance my mental state, calm my mood down.

> I have gained positive respect and understanding from family and look forward to a bright journey.

> Made new friends because I didn't isolate myself on the machines…

Ten clients commented on improvements to their financial situation, with a few explaining how this benefitted them, for instance, being able to pay bills and spend money on family members and recreational activities.

However, a small number (five) suggested that they found the sessions insufficient in terms of time and change strategies offered.

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More information regarding how to change negative behaviour and thoughts to gamble. Would like success stories from people who have stopped gambling behaviour.

…the only thing not so good is I needed more time to make sure the plan works, things do not happen overnight.

The session was short; needed to have more time than an hour and a half.

4.8.10   Success Indicators: Full and Workshop-based Intervention

Staff comments on what they believed to be key indicators of successful Full or Workshop-based Interventions corresponded with four types of indicator: input indicators, activity indicators, output indicators and outcome indicators. Although seven staff survey respondents reported a combination of two types of indicators, most focused their description on one type of indicator.

Two staff reported input indicators concerning staff clinical knowledge and communication skills.

Skill of counsellors to establish rapport and facilitate the change process.

Twenty staff provided descriptions of activity indicators consistent with various activities as detailed in the Purchase Unit Description.

Care and treatment plan developed with the client and meeting goals that the client has set for themselves. Preparing and planning for the client and ensuring proper supports are in place and relapse prevention is discussed openly. Complete a follow up plan.

Cultural, language, spiritual, empathy, compassion, open discussion and transparency.

Helping the client and whānau gain an understanding of how the pokie machines work and setting goals which are followed up in and around the person's gambling and continually evaluating clients' progress towards goals.

Nine staff provided descriptions that were output focused.

Change in client including their awareness for change, willingness for change and support for change.

Clients understand the addictive feature of gambling and know how to manage their gambling behaviour. Clients learned more about themselves and are willing to seek help when they need.

Thirteen staff described descriptions that were outcome focused indicators.

Improved client and significant other wellbeing. Return to healthy balanced engagement with daily life. Positive lifestyle choices re[garding] gambling, substance use and beyond. Some sense of positive future. Increased sense of client self-efficacy. Increased sense of self-worth. Improved relationships.

Through the indication of ORS and SRS[40] scores. Through client's feedback at the end of the sessions. Through the follow-up calls, knowing clients were able to maintain their job, keeping the family relationship well, have a happier family relationship, spending more time with their family at home, spend less money, time at casino …Send us thanks letter, cards, and tell us about their progress and achievement…

4.9   Facilitation Services (PGCS-04)

Facilitation Services are carried out within a *Full Intervention* episode and aim to minimise gambling-related harms to individuals and their families and significant others by enabling access to support from other health and social services (Ministry of Health, 2010). The service specification was developed by the Ministry in recognition of "the importance of actively supporting clients to access other services they need for recovery" (Ministry of Health, 2008b, p. 81). While practitioners may be able to assist

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[40] Outcome Rating Scale and Session Rating Scale.

clients with gambling-related issues, some client problems may require assistance from other specialist services.

Through *Facilitation Services,* clients may be supported to access a range of community support services including "access to specialist mental health, alcohol and other drug, or social services" (Ministry of Health, 2008b, p. 79). "Some clients may need a facilitated referral to more intensive problem gambling interventions or the inclusion of additional social supports, such as the Gambling Helpline, Gamblers Anonymous or budgeting services" (Ministry of Health, 2008b, p. 81). The Ministry also recognises "supporting clients to attend venues to self-exclude themselves from further gambling" as a valid facilitation session (Ministry of Health, 2008b, p. 87).

Activities from the Purchase Unit Description and details from the *Intervention Service Practice Requirements Handbook*, the likely outputs, and expected outcomes are summarised in a preliminary logic model (Figure 83), which shows the flow of inputs, activities, outputs and outcomes in the delivery of *Facilitation Services*.

This chapter consists of findings from the literature of relevance to *Facilitation Services*, the staff and client surveys, allied organisation surveys, two focus group interviews with clinicians, and analysis of the CLIC database. The survey and focus group findings represent the seven providers (of the eight selected) who were contracted to deliver *Facilitation Services*.

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PGCS-04   Facilitation Services

Inputs

Purchase Unit Funding

Staffing

Qualifications, competencies, skills, and experience

Activities

Establish working relationships with key staff of community support agencies

Establish formal referral and relationship protocols with services being utilised (including accountability for access, case management, exit processes, follow-up, and information sharing)

Develop referral plans that identify appropriate facilitations services based on clients' needs identified during assessments in the Full Intervention episode

Actively encourage clients to seek assistance from other agencies (e.g. explain benefits, help clients overcome feelings of reluctance)

Actively enable a seamless referral process for clients (e.g. make appointments on client's behalf, assist clients with a formal referral process, ensure other services understand client's situation, arrange for other services to be available at the premises of the problem gambling intervention service)

Accompany clients to initial meetings with other community support agencies or to venues to complete self-exclusions

Support clients' access to a more intensive problem gambling intervention service, the Gambling Helpline, or Gamblers Anonymous

Review referral plans with clients to gauge progress in addressing other issues and provide motivational support

Outputs

Clients feel encouraged to seek help to address other co-existing issues

Clients experience an easier entry into other support services they need

Clients receive timely support to address other co-existing issues

Clients receive timely support to address consequential issues resulting from their gambling problems

Clients benefit from a more intensive problem gambling intervention or from other additional supports such as the Gambling Helpline or Gamblers Anonymous

Increased motivation among clients to make changes to their gambling behaviours or necessary behavioural changes in other areas

Outcomes

All people identified as experiencing gambling related harm (from their own gambling or from the gambling of a significant other) are able to access relevant services that assist them to reduce the gambling related and associated harms occurring to them and their family

Clients resolve their other issues or experience improvements to their situation

Improvements to clients' gambling-related problems

Figure 83: Preliminary Logic Model: *Facilitation Services*

4.9.1   Literature review

Although the existence of comorbid issues alongside gambling problems is acknowledged in the literature (Abbott *et al*., 2014; Holdsworth, Nuske, & Breen, 2013, Ibanez *et al*., 2001) the search did not find any international evaluation literature focusing specifically on *Facilitation Services* for problem gamblers. However, the shortcomings relating to this component of treatment provision have been noted in a previous evaluation by Stinchfield, Winters and Dittel (2008). Their evaluation of eleven state-supported pathological gambling treatment programmes/providers in Minnesota, USA found that family members who had completed a *Significant Other Discharge Questionnaire* (n = 47) which included an open-ended question about their experiences with support received or not received,

indicated that they were "left to deal with the financial problems" and that they needed "assistance with these issues and/or referral to other services in the community" (Stinchfield *et al.*, 2008, p. 16). Considering the possibly high number of pathological gamblers who may not be seeking treatment, the authors suggested that key areas for service improvement were the identification of these individuals and their referral to treatment services.

GARC's previous evaluation which included *Facilitation Services* found "a gradual, but steady increase in the number of Facilitation sessions provided per month between the period July 2007 to June 2008" (Bellringer *et al.*, 2010b, p. 93). However, the findings of this evaluation also indicated:

> …that many (probably most) clients of gambling treatment services do not receive a Facilitation session during the course of a treatment episode and that gambling treatment staff do not strictly adhere to Facilitation guidelines; rather, the decision to Facilitate a client to another service or not is seemingly made on a case by case basis… (Bellringer *et al.*, 2010b, p. 95).

GARC's evaluation also found a frequently expressed concern about facilitation and perceptions of it being a "threat to holistic or comprehensive treatment provision". The evaluation also suggested that:

> …the current level of support for Facilitation sessions is based on the counsellor/treatment provider maintaining a reasonably high degree of discretion as to if and when (and where to) Facilitation occurs. …It [was] also unknown, given the limitations of the available data, whether Facilitation significantly improves client outcome. Further examination of the benefits of Facilitation, ideally via independent and prospective research activity, on client outcome may therefore be beneficial before changes to Facilitation practice were sought (if changes were being considered). Future research could also examine why Māori service providers facilitate clients at a higher frequency relative to other service providers. The findings from such an investigation could potentially inform greater uptake of Facilitation in other services (Bellringer *et al.*, 2010b, p. 95).

4.9.2 Effectiveness of PGCS-03 activities (staff and allied organisation views)

Figure 84 shows that activities within this intervention were generally rated by staff survey respondents' as effective.
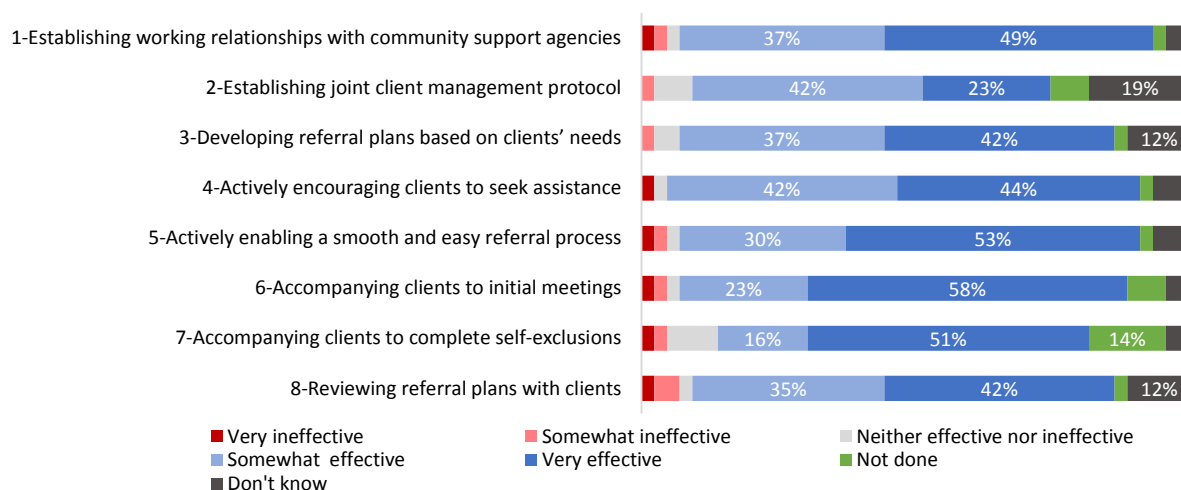
Figure 84: Effectiveness of *Facilitation Services* as rated by staff (n=43)

As shown in Figure 85, in most instances, staff of allied organisations indicated that they had observed (either occasionally or frequently) the range of support provided to clients by problem gambling intervention service providers evidencing outputs in the form of activity delivery. However, nearly a third (31%) indicated that the problem gambling treatment service had never explained clients' spiritual or religious needs in the *Facilitation Services* process (see column 8 in Figure 85). In addition, 21% indicated that the problem gambling treatment service had never arranged for allied organisation representatives to be at their premises (see column 11). Such arrangements may be beneficial considering that support service proximity was important for some clients.
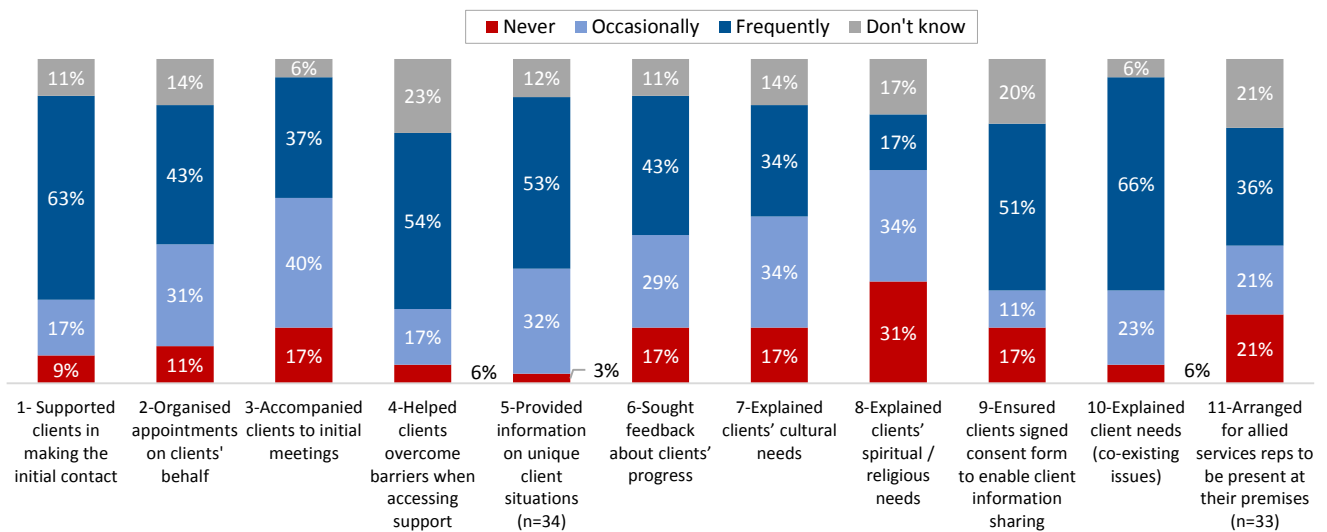
Figure 85: *Facilitation Services* provided to clients as reported by staff of Allied Organisations (n=35)

Joint client management protocols

Providers were required to "develop memoranda of understanding or relationship agreements with other services that outline how they will engage, share information and develop joint client management protocols" (Ministry of Health, 2008b, p. 20). The Purchase Unit Description required providers to establish "formal referral and relationship protocols with those services being utilised (including accountability for access, case management, exit processes, follow-up and information sharing)" (Ministry of Health, 2010, p. 26).

As shown in the second row of Figure 84, 19% of staff respondents did not know if "establishing joint client management protocol" was effective, indicating a possible lack of clarity among these staff members or a lack of evidence on the value of this activity. Three staff survey respondents (7%) indicated that this activity was not done. Likewise, a participant in one intervention staff focus group commented that this required progress in their organisation.

> I think for facilitation we don't actually; it is about the working protocols and the kind of memorandum - this is what we will do, this is what you will do; that is something that we have to sharpen up on. That is something highlighted, in our service, who is going to do what [so that] everybody is clear.

Of the 42 allied organisation respondents, only 12 (29%) indicated that establishing a joint client management protocol/Memorandum of Understanding was one of the actions taken by the problem gambling treatment service. Four allied organisation respondents reported that processes around client information sharing was an area that required improvement.

> Joint commitment to sharing of vital information to assist client to be well managed and understand any issues or concerns to enable positive results for the client and services.

Clearer joint client management protocols are of value as they may lead to better outcomes for clients. An allied organisation respondent reported on the value of concerted support for some clients.

> Generally good follow-up but there were times when we felt that clients would have benefitted from further three-way support meetings. These could take some [time] to arrange and by then the crisis was over.

Additionally, the following comment from another allied organisation respondent suggested the need for greater clarity in roles and responsibilities of both parties during *Facilitation Services*.

> There is a potential risk of delaying referrals to mental health services, especially when there are concerns about client safety, whether it is current or in the past. The service focuses more on gambling and related social problems. Their referral criteria may need to be reviewed to highlight

and clarify the purpose of their service. They may also need to be able to differentiate between which parts of the co-existing problems that they have more expertise in – gambling or mental health.

Enabling a seamless referral process

One of the features that distinguish *Facilitation Services* from a conventional referral process is the active role played by the service provider in making the referral as seamless as possible for clients. The activities carried out to support clients during *Facilitation Services* as indicated by staff and allied organisation respondents (shown in Figure 84 and Figure 85) and client comments suggest this objective was largely met.

In describing positive impacts for clients, one allied organisation survey respondent noted the value of "mediation" in *Facilitation Services*.

> The mediation is always seen as very helpful in lowering the anxiety and helping establish the first contact.

Among the subgroup of clients (n=55)[41] who responded to this section of the questionnaire, many (75%) indicated that the counsellor had enabled easy access to other support services (Figure 86).
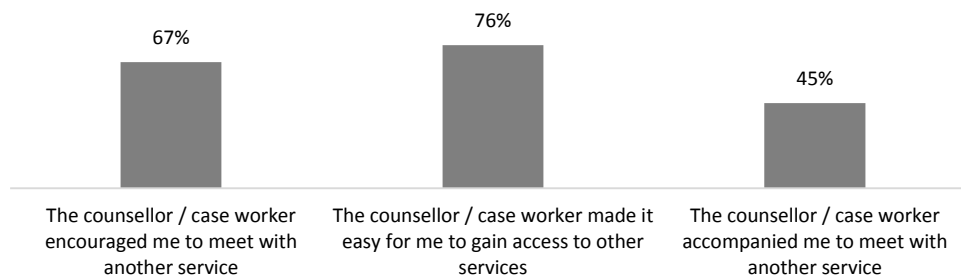
Figure 86: Client experiences of support received through *Facilitation Services* (n=55)

Telephone was a frequently used communication channel, and in one intervention staff focus group, a participant suggested that using the phone was a time efficient way for delivering *Facilitation Services* for clients.

> Staff tell me how they have spent so long in trying to find out information from clients outside of the session. That is a bit back to front. I suggest that they use the session to do that with the client, empower them. And use the phone and do a facilitation then. So using the session a bit smarter, it is not just about coming in and having just an hour of face-to-face. That if they need facilitating or you recognise that in the session, then use the session, and getting on the phone. You don't actually need to know the agency, you can look it up to get them. You may not know the person you are ringing but you can introduce the person to them over the phone and then they can take the call over. So it is working a bit smarter.

However, another participant noted that the telephone was not always the best approach.

> Facilitation requires you to use the phone or take them to another place. But most of my clients - they don't want to talk on the phone. So the construct itself of Facilitation and the way it is set up in such a specific way, is quite limiting. Māori and Pacific don't want to talk on the phone on the whole, and/or other individuals who are in distress. They don't want to call them up; they don't want to talk on the phone with the other agency. It is negative to the client.

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[41] The results provided in this section do not fully represent the targeted clients. It was noted that this section was completed by some clients from a service provider which is not contracted for Facilitation Services. This may be due to the lack of clarification in distinguishing Facilitation Services from conventional referrals. Future evaluation of Facilitation Services will benefit from a purposefully selected sample of clients known to have experienced facilitations. Although preceding category identifier questions aimed to direct only clients who have undergone Facilitation Services to complete this section of the questionnaire, seven respondents who indicated in the negative (i.e. did not go through with seeking help from other services) responded to subsequent questions about their experiences of having received support and resultant impacts. Percentage calculations included these seven respondents.

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A seamless Facilitation process may be easier when clinicians refer clients to in-house community support services. When focus group participants were asked if there were differences between in-house and external community support services in terms of achieving beneficial results for clients, participants from both groups discussed the benefits of internal services. They suggested this may mean less travel time for clients, and that clients may benefit from the comfort of familiarity and ease of communication offered within one organisation.

> I have clients who won't go to… the next suburb, they say it is too far. We have got onsite, it is easier, and the same organisation. Otherwise they see it as being pushed off to another organisation and they don't like it.

> And they don't have to repeat their story over and over again.

There was also a belief among staff that clients preferred such in-house services.

> This is consumer feedback; they want a one stop shop.

> For us, we get good feedback from our whānau that we work with, once they knew that was what we could offer - [They say] Why didn't I know this before? Then they withdraw from other services they have been in and then just come to the wrap-around service that we can offer. So it is client driven.

Another participant suggested that the service specifications were too prescriptive.

> The way the service spec[ification] is set up is limiting. If we go with facilitating clients to external parties, the clients miss the support people that are readily available around them to support their wellbeing. A service like ours, we have all kinds of support services here under one roof, we have our doctors, matua, and psychiatrists involved in the life of the client. The service specs restrict how we support the wellbeing of a client ourselves, because we are required to facilitate.

4.9.3 PGCS-04 activities and processes

Categories of allied organisations

As explained in Section 2.3.3, providers worked with three categories of allied organisation types: (1) in-house community support services, (2) external community support services, and (3) businesses providing gambling services (casinos, hotels, restaurants and bars).

Facilitation "involves working with an agency or service other than the specialist problem gambling intervention service" (Ministry of Health 2008b, p. 79). Focus group participants were asked how in-house community support services counted as allied services within the context of descriptions provided in the *Intervention Service Practice Handbook*. Participants in both focus groups confirmed that from their perspective in-house services were viewed as operating separately.

> Yes, they are not us; they are someone over there that actually provides a different set of skills and support. For us it is a referral to our AOD service, a facilitated referral to our mental health service, because they are going there for their anxiety, for their depression, and AOD issues. So we just happen to have it under the one umbrella, instead of having to go out…

There was a broad interpretation of *Facilitation Services* including facilitations of clients to receive support from individuals such as a kaumātua. This suggested a need for a fourth category of "allied services" which might be termed "supportive individuals" that providers may work with in delivering *Facilitation Services*.

> And that is another definition that I find interesting that you would think that it is a referral to another service. That kind of definition. Because for us, as long as there is another organisation or person that they work with; whether on the phone or face-to-face or driving them somewhere, then that is a Facilitation, whether you refer them or not to another service… See we can't refer them to our kaumātua, we just take them along to them. [But the outcome for the client] is similar as when you support them to go to a budgeting service or a legal service.

Two-way referral of clients between problem gambling service providers and allied organisations

While *Facilitation Services* require a "facilitated" referral of a client from a problem gambling intervention service to an allied organisation, comments from staff focus group participants suggested they viewed allied organisations as those that also refer clients to their service, for instance by implementing problem gambling screening and referral. This observation could explain the original allied organisation list sent to the researchers which included organisations that had referred clients to the problem gambling treatment service (see sub-section 2.3.3 for details). Two staff focus group participants also mentioned their efforts to develop their connections with reciprocal arrangements in mind.

> But in the last couple of months we have intentionally gone out into the community and introduced ourselves face-to-face …We have had a good feedback on that. We have had these people come back and ask what programmes are happening and if they can refer people to our organisation. So that has been good… And out of that we have created a database spreadsheet, and we put in the networks that we have started to build a rapport with (of contact names and numbers) so that when we walk away from it, anyone can just come in access it.

> Recently we started another approach - what we call an inter-sectoral approach where we work with a few organisations related to various related issues. The police, the probation office, mental health, alcohol and drug, and us, and we form a group to work together, so we can refer to each other.

Just over half (51%) of allied organisation respondents reported that their organisation had formal processes for problem gambling screening and referral. Of those without formal screening and referral processes, 30% indicated there was a need and eight percent that there was not. Comments suggested that such screening and referral practices were underdeveloped or under development in their organisations.

These findings indicate that client outcomes could be further enhanced through collaborative work between teams delivering *Facilitation Services* and the *Effective Screening Environments* public health service.

Communication and contact with Allied Organisations

Allied organisation respondents reported that telephone was a frequently used communication channel (76%) when carrying out *Facilitation Services,* followed by face-to-face meetings (65%), email (50%), and posted letters (15%). Figure 87 shows variation in the frequency of contact; the three allied organisation groups with more frequent contact occurred with in-house services. A few (n=4) allied organisation respondents reported that communication frequency depended on a client's needs.
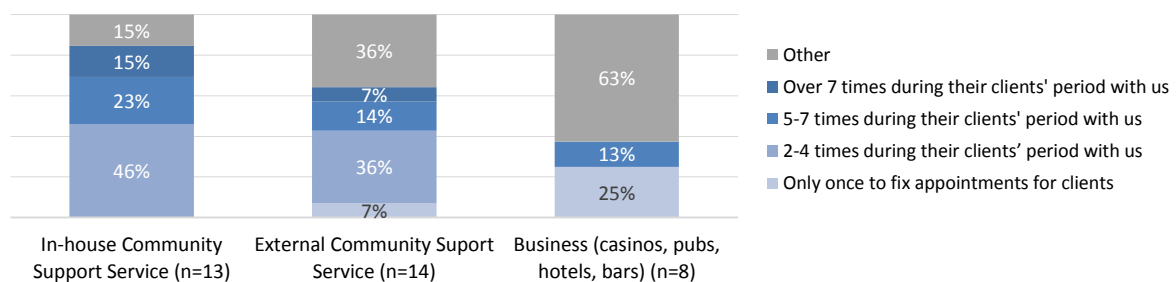
Figure 87: Frequency of communication reported by Allied Organisations

The extent to which clients attended sessions at allied organisations may affect outcomes. As the findings from the three allied organisation groups (Figure 88) suggest, there may be some differences in client attendance, that is, a higher level of attendance when facilitated to in-house services than when facilitated to external community services. The lower levels of attendance at gambling venues were likely to be result of these being one-off incidents for the purpose of self-exclusion.
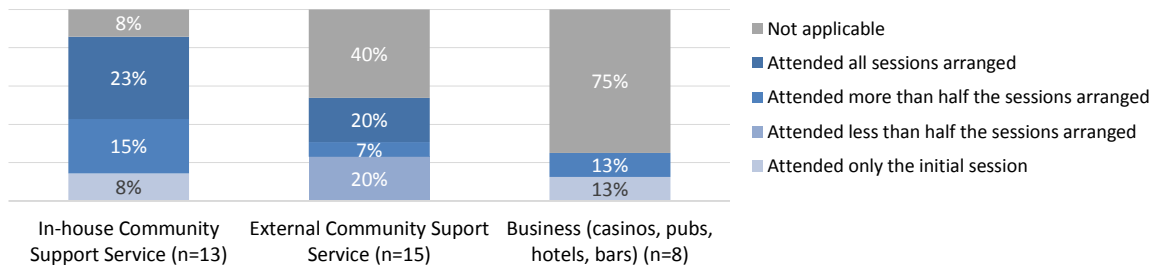
Figure 88: Frequency of client attendance as observed by Allied Organisations

Working relationships with allied organisations

Establishing working relationships with a variety of community support services or allied organisations is particularly important for enabling a seamless referral process for clients (Ministry of Health, 2008b).

> Service providers should become familiar with key staff in community agencies who can be contacted directly if a referral is needed. In doing so, clients are more likely to buy in to the referral, especially those who are reluctant to consider support outside the problem gambling service. Clients are more likely to consider other agencies as part of their interventions if their service provider's recommendation is based on familiarity with the external agency (Ministry of Health, 2008b, p. 86-87).

Staff survey respondents reported the effectiveness of their efforts in developing working relationships with key staff of community support services in their area (see row one of Figure 84 above). Similarly, the majority of allied organisation respondents reported that the problem gambling treatment service had made efforts to establish working relationships with them (67%) and had explained to them about "*Facilitation Services*" (59%). Additionally, most allied organisation survey respondents also rated the working relationship between their organisation and the problem gambling treatment service as either good or very good (Figure 89).
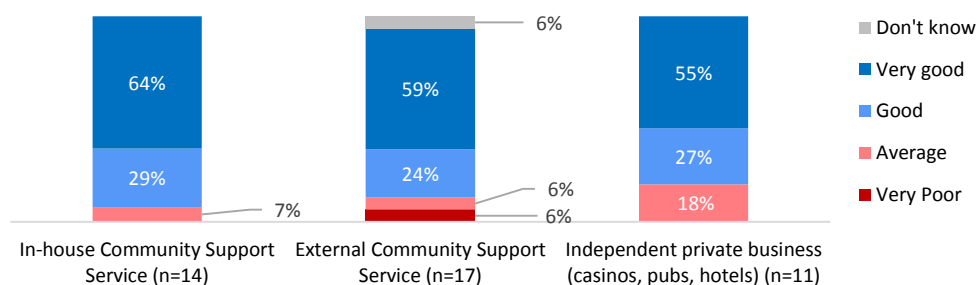
Figure 89: Quality of working relationships as rated by staff of allied organisations

Eleven allied organisation respondents commented on the effectiveness of established working relationships.

> The working relationship is very good. There are many "shared" clients. The gambling service works hard at getting gambling issues included in the addictions work done by the organisation.

> With our Total Money Management service and education we provide the assistance to manage the budget effectively and the problem gambling service manages the emotional support and other assistance as required. It is an effective working relationship.

Four allied organisation respondents from the in-house community support service group reported that within-organisation facilitations benefit from greater staff-level collaboration and communication.

> We screen people for possible gambling issues. We have a person from [problem gambling treatment service] who does initial assessments. [Their staff] educate our staff and volunteers. They attend our staff meetings. They use our rooms for counselling.

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… we are regularly talking with the problem gambling team to seek to enhance the way we work together for the client's benefit…

Intervention staff commented that they benefitted from the existing relationships with in-house community support services.

> Yes, we already know the clinicians really, really well. We communicate often. We don't have to develop a relationship, often it is already done. We can do reviews with them or check things out. It is not a distance thing; we see each other regularly. So we find it works better, or best.

They also preferred to facilitate clients to a service within their broader organisation.

> We all know each other's extensions and within our service, we almost meet once a month. So accessibility to other clinicians. And we can grouch a little better. "Hey what happened with the referral I gave you last week?" With an external agency you have to be quite polite about it. And it makes it easier for us to visit with other clinicians together. But not with external agencies as there are boundaries and different timetables.

Consistent with this, comments from seven allied organisation respondents suggested that some improvement was needed in communication and follow-up.

> We [would] appreciate better communication with the [problem gambling treatment] Service. The current practice is that most of the communications were initiated by our service… We are not aware that they are operating a "Facilitation Services" model.

> Can always be improved. Regular participation in a more social context and possible clinical team meetings could be useful. We are a very busy wrap-around service… it is important that… [the problem gambling treatment] staff regularly remind other staff of their intentions and wishes regarding working together and remaining vigilant as to each other's needs.

Intervention staff noted the regularity of contact with allied organisations as important to the strength of the relationship; in cases where referrals were infrequent or when staff turnover occurred at the allied organisation, this meant difficulties in maintaining ongoing relationships.

> Time is a factor. If we have a client that needs to be facilitated to mental health, and it is outside of our DHB. You facilitate them, you get them locked in. The ongoing relationship with that agency because it is not happening regularly, you really have to make an effort to build the relationship if you are not facilitating clients there all the time. I think the relationship with them is not regular, you have got to work on it. The ones you do all the time, it's good. But that feedback may have come back because they don't see us enough… Another part of that is the turnover in those agencies. If one staff, you have met and facilitated to, and then they have a turnover [the new staff that take over are not going to know you].

A range of approaches for establishing working relationships was discussed by intervention staff.

> When I don't know the agency, I make an effort to get their website and find out what they offer, who their people are, and know what I am dealing with… For Pacific and Māori organisations I have to really go out and meet them. And that is what I am endeavoring to do at the moment, is networking.

> Usually at the beginning we have to develop a database for ourselves, what organisations there are, what they are doing and what language they speak, because there are plenty of organisations but they don't [speak our clients'] language, so what is the point? Later on, we will connect with those [appropriate] organisations. Then we [offer] them training and [invite them] to introduce their service to us. So that all their staff know what we do. In this way we build up the relationship, develop trust towards one another.

Comments by two respondents from the private business group indicated that gambling treatment providers might benefit from improved relationships with gambling venues.

> Many clients are told "gambling/casino is bad". Although clients recall their counselling well, they have the view it was a "tick box" counselling - all they require is to obtain a letter confirming six sessions. A minority don't understand/realise their gambling was causing harm, and the counsellor has "approved them to return" by not stating they have gambling issues on their confirmation of counselling letter. Some clients felt "coerced" into making a gambling plan they did not want.

> … we often want more involvement with the counsellors concerning their clients who want to return to gamble after an exclusion period. This process could be expanded beyond what it is. There is a concern that if a client is aware that the counsellors talk to… [us, the gambling business] that they wouldn't present to treatment.

Focus group participants were asked if there were any specific approaches used when working with gambling venues. Participants in both staff focus groups suggested the relationship with venues was somewhat different, that it was more a business-like working relationship. There were variations in the relationships they had with the different types of venues.

> …For casino we have regular meetings with them and we have a working relationship with them. Whenever we have an issue we can call to find out. For Class 4 venues, very often clients want to go there to exclude themselves, we will accompany them to do that.

Their comments also suggested that they were aware of the value of taking a collaborative rather than an adversarial approach when working with venues.

> We have mostly success stories, [our multi-venue exclusion coordinator] has worked hard at building relationships …It is about building relationships. They can work with our clients as well. We want them to offer the best service to our clients. And to know when things are not going well and for them to come to us. And they do that as well. Venues will come to us about concerns. So it is a positive relationship.

However, one participant commented on differences in views among providers because of the differing interests of venues and service providers.

> One of the issues that has come up in our networking meeting - there is a conflict. There is an allegation that [a casino] uses the information to build their arguments around how they work with the gamblers. There was mixed feedback… within the network. Some felt that we need to work with them because at the end of the day our people are coming to us because of what is happening. And the other side were saying: "Why are we working with these people, when they are the ones causing the issue?"

4.9.4 Facilitation sessions - volume and delivery processes

The total number of *Facilitation* sessions reported by all providers is shown in Figure 90. This service was delivered more frequently for gamblers than for significant others.
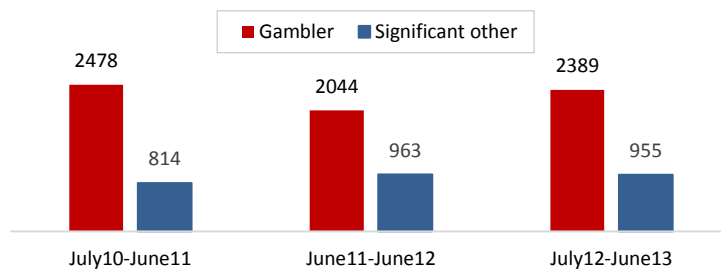
Figure 90: Total number of recorded Facilitation sessions for gamblers and significant others

The minimum, maximum and average numbers of facilitation sessions per client reported by providers are shown in Table 37 in Appendix 4. The number of facilitation sessions for gambler clients was generally low, for most providers the average was around 2.5 sessions per client. However, occasional clients received a very large number of facilitation sessions. The highest maximum recorded was 128 sessions for a gambler client of a Māori provider (B05) in 2012/13. Table 37 (Appendix 4) also shows several other unusually large numbers but it is clear from the average values that most gambler clients just had one or two facilitation sessions.

To count as a "facilitation activity, a service provider needs to have had at least a 15 minute or more phone call or face-to-face contact with the client and another provider or external agency" and sessions were estimated to take about 60 minutes (Ministry of Health, 2008b, p.81). The average *Facilitation* session durations for each provider detailed in Table 16 (Appendix 4) show variation across providers. Some providers usually reported short facilitation sessions of less than one hour (notably A15, B09,

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B13, B18 and C04) whilst others reported comparatively long sessions, often exceeding an hour (B10, B17, C08 and D03). Sometimes (e.g. D03) these were from a very small number of facilitation sessions; nonetheless the variation likely reflects the variation in types of facilitation sessions undertaken.

Figure 91 shows that session duration for *Facilitation Services* has increased across the three-year reporting period for dedicated Māori and Pacific providers, and Alcohol and Drug services, exceeding session duration reported by general providers.
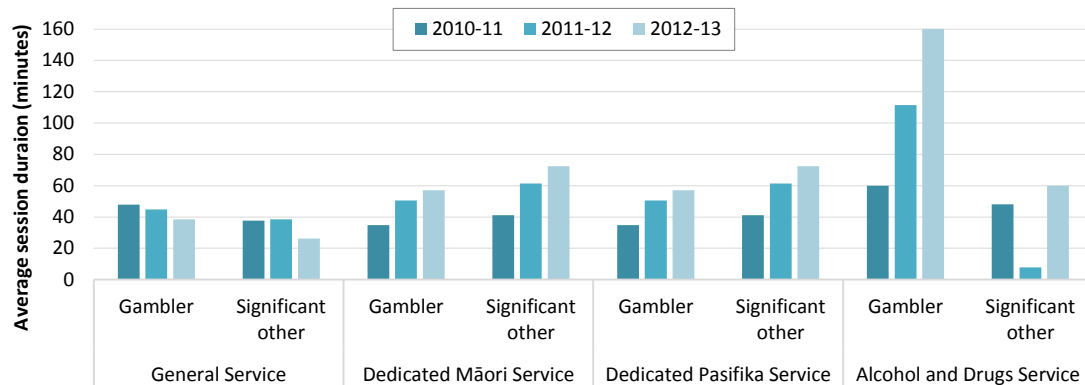
Figure 91: Average Facilitation session duration (minutes) by provider type across the three-year period

4.9.5 Types of facilitated referrals

Figure 92 shows the percentages for the various types of referrals for gambler clients over the three-year period reported for *Facilitation Services*. The most common facilitation types for gamblers were to "Other" services, to "Addictions-Gambling" services and to "Financial Advice and Support" services. Generally, the percentages for the various types of facilitations remained consistent over time, but three facilitation types seemed to change systematically. The percentage (and number) of 'Other' facilitations decreased from being a third (32%) of all facilitations in 2010/11, to a quarter (25%) in 2011/12, to less than one fifth (17%) in 2012/13. Venue exclusion facilitations increased systematically (2% to 6% to 10%), as did housing and accommodation facilitations to a lesser degree (3% to 4% to 5%). The others all showed mixed patterns, however the percentages (and numbers) of 'Other', "Addictions - AOD and Smoking", "Mental Health", "Physical Health", "Police and Victim Support", and "Relationship and Life Skills" were all lower in 2012/13 than in 2010/11.
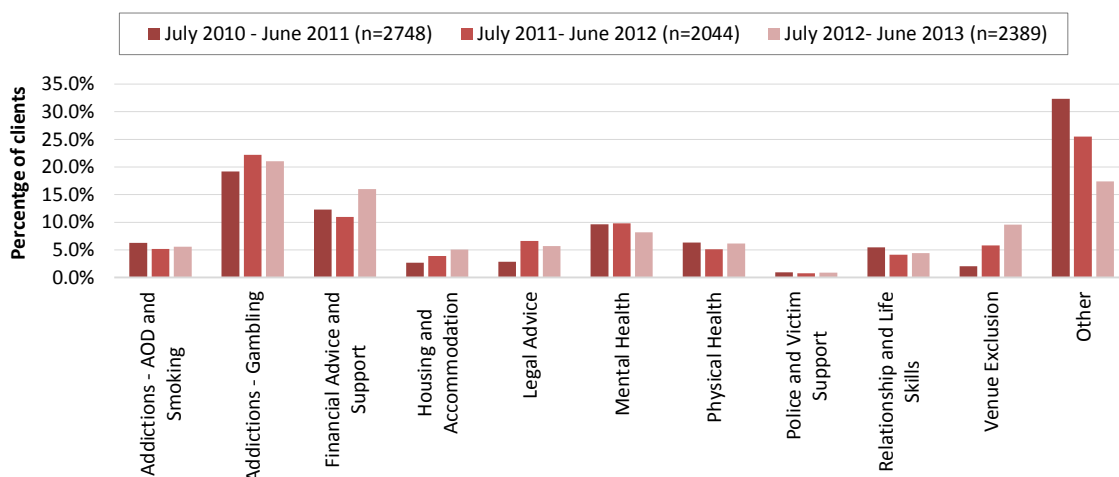
Figure 92: Types of Facilitations Services carried out for gambler clients

Figure 93 shows the percentages of facilitation sessions delivered for significant other clients. These were far less common (814 in 2010/11, 963 in 2011/12 and 955 in 2012/13) than for gambler clients (2,748, 2,044 and 2,389 respectively). In 2012/13, the most common facilitations for significant other

clients were for financial advice and support, physical health, mental health and 'Other'. As with gambler facilitation sessions, the number and percentage of 'Other' facilitations decreased markedly over time, and were paralleled by increases in the various other facilitation types. From 2010/11 to 2012/13 all categories of facilitation increased with three exceptions ('Other' 46% to 15%; Relationship and Life skills, 9% to 8%; and Venue Exclusions, 0.5% to 0.3%). The most notable increases were in financial advice and support (8% to 22%), housing and accommodation (2% to 8%), mental health (8% to 13%), and physical health (12% to 18%).
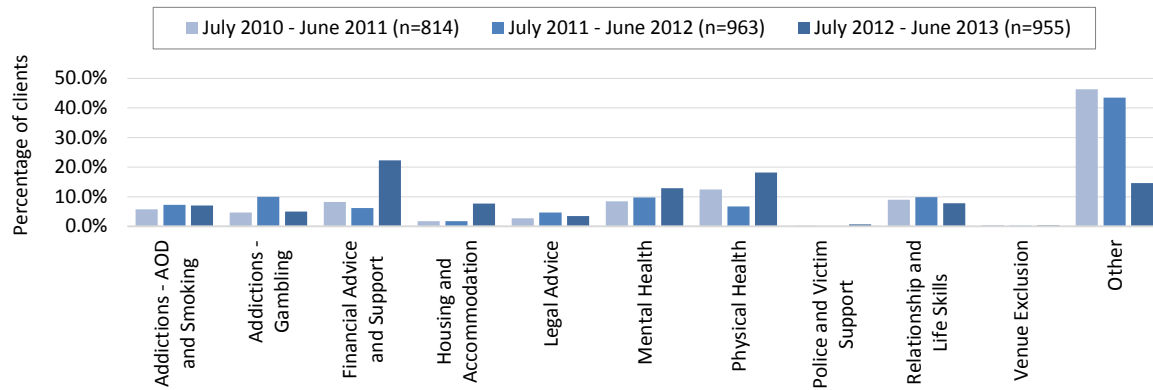
Figure 93: Types of Facilitations Services carried out for significant other clients

For both client types, there was a substantial decline in the number of "Other" facilitations and increases in several other categories. It is not clear from these data whether there has been improved accuracy in recording or a greater specificity/recognition of the types of beneficial facilitation sessions. Given that overall referral numbers were quite steady, the former might be hypothesised. With respect to the latter, there are some clear differences between the types of facilitation sessions for the client types. For significant other clients there were substantial increases in facilitations for mental and physical health, which were not apparent among gambler clients. For gambler clients, facilitation for venue exclusion was an area of growth not evident in significant other clients. Both groups had increases in financial and housing/accommodation advice and support.

Focus group participants were asked about these changes. One participant noted that they are unlikely to be a result of previous recording in the "Other" category, as providers are required to specify any additional categories.

> I always use the categories that are already in there. I haven't clicked "other" that often. Just from my work with CLIC… In short, to answer your question, for other, if they haven't identified what it is, then they should do. We would always identify who we worked with under "other".

While some participants confirmed that they had experienced an increase in these two types of facilitations because of arising client needs, others suggested increasing client needs for budgeting and financial advice among gamblers, the ease of facilitation to budgeting services, increases in request for self-exclusions, and the venue multi-exclusion implementation.

4.9.6 Facilitation Services outcomes for clients

Some client survey respondents reported that they were able to resolve their other issues (78%) by accessing help from other community services, and that this positively influenced their gambling behaviours (71%).

Sixty-three percent of allied organisation respondents reported that they noticed impacts for clients "facilitated" from problem gambling treatment services, and two-thirds of allied organisation respondents believed that *Facilitation Services* was effective for achieving positive client outcomes (see Figure 94 for response distribution).
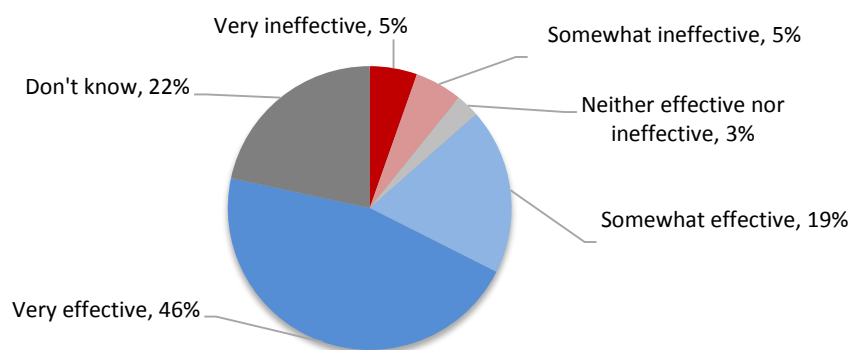
Figure 94: Effectiveness of "*Facilitation Services*" in achieving positive outcomes for problem gambling clients as rated by allied organisation staff (n=37)

Two allied organisation respondents reported clients' enhanced understanding and acknowledgement of their problem gambling as a resulting impact; two others commented on positive outcomes of changed client gambling behaviours.

> Our client has given up his [casino] loyalty card, he has been banned from [the casino] for an initial period of nine months, he hasn't been betting at the TAB and hasn't bought a Lotto [ticket].

Four respondents reported changes and impacts in other areas related to the support services they provided.

> They can see the positive result of coming to us, particularly when they are on our Total Money Management programme where their money comes to us and we pay the bills. They then stop getting the demanding letters and can see money building up in their account.

> Some clients quit smoking and either want ongoing support or not. Others who continue to smoke have cut right down to what they would usually smoke. They show signs of content[ment] and even look happier.

Among a few allied organisation respondents who had observed negative client impacts, three reported undesirable emotions that clients may experience such as uncertainty, emptiness or hopelessness.

> Some clients feel useless and hopeless because they can't quit smoking, which can make them feel depressed or just not good. We don't ever see it as a failure and ensure them to take one day at a time. We never give up on them.

4.9.7   Facilitation Services outcomes for allied organisations

Facilitation Services also resulted in outcomes for allied organisations. Thirty-eight percent of allied organisation respondents reported that their organisation's general awareness of problem gambling had greatly increased because of *Facilitation Services* and a further 43% reported a slight increase. Among 30 who responded to a subsequent question, 20% noted that this improved awareness had greatly increased their ability to identify problem gambling symptoms among their other clients, and a further 73% indicated a slight increase. Seven allied organisation respondents suggested further education could improve their organisation's awareness of problem gambling issues.

> More information on what to do when faced with a person who comes for budget advice and maybe this person has not realised he/she has gambling problem.

> Workshops on what to look for. Further education on how to detect it as I find of all the addictions, this one is the hardest to detect. It is kept very quiet and the last one to be admitted to.

Two respondents from the community support services group reported an increased ability to assist their own clients who may present with gambling-related problems (e.g. by referring to problem gambling treatment services). Comments of another four respondents indicated that another outcome was their increased ability in, and commitment to, problem gambling screening. Likewise, one respondent from the private business group reported that the process of *Facilitation Services* could lead to informal screening and referral practices among gambling venues.

We were able to refer our clients to the service, in order to help many of our clients with various issues. We house over 140 people and at least 30% have addictions of one form or another… if we see certain things or patterns occurring, we tend to look for support quicker.

4.9.8 Success Indicators: Facilitation Services

Staff comments on indicators of successful *Facilitation Services* fit within three indicator types: activity-related indicators, output indicators and outcome indicators. Most focused their description on one type of indicator.

Ten staff survey respondents described indicators that showed successful delivery of services, that is, activity indicators which included establishing working relationships with other community agencies, identifying clients' needs, encouraging clients to seek assistance from other agencies, and ensuring a smooth and timely Facilitation process.

Output indicators reported by eight staff survey respondents were focused on changes to clients' understanding of available support and their motivation to access it.

Client has better understanding of the available services in terms of what they could be helped with and in which way.

Client being able to access other community services as part of their change process… Making a commitment to get help and support.

Outcome indicators reported by nine staff respondents included changes to gambling behaviour, the meeting of other needs or changes to behaviours in relation to other issues.

The main indicator would be whether the client starts improving their behaviour or not in the area that they sought for help.

4.10 Follow-up Services (PGCS-05)

Follow-up Services provide a scheduled series of one-on-one contact with clients at the first, third, sixth and twelfth month following completion of a *Full Intervention* session, as a way of maintaining contact and providing motivational support. Follow-up sessions, either face-to-face or by telephone, last between 15 and 30 minutes and are intended to provide supplementary motivational support to clients after they are discharged (Ministry of Health, 2010, p. 27). The services are flexible in terms of location and hours to accommodate user needs. Activities within this service include reassessments, review of relapse prevention plans, advice, motivational support and referral to other appropriate services, if needed.

The Ministry identified several challenges in delivering *Follow-up Services* resulting from clients' mobility (changes to contact details), change of mind, lack of clarity of follow-up rationale, concerns over privacy and reluctance. In addition, the Ministry also acknowledged the increased workload for practitioners in delivering *Follow-up Services*. However, the value of *Follow-up Services* for clients, clinicians and treatment service providers outweigh the disadvantages. "As well as supporting clients to manage their recovery and contributing to outcome data, the knowledge gained through follow-up" informs the improvement of "supports and services available to clients" (Ministry of Health, 2008b, p. 89).

Activities from the *Purchase Unit Description* and details from the Intervention Service Practice Requirements Handbook, and the expected outputs and outcomes are summarised in a preliminary logic model shown in Figure 95.

PGCS-05   Follow-up Services

Inputs	Activities	Outputs	Outcomes
Purchase Unit Funding	Encourage clients' agreement to a Follow-up plan during Full Intervention	Clients experience a sense of ongoing support when transitioning from the support of Full Intervention services to independence from gambling harm	All people identified as experiencing gambling-related harm (from their own gambling or from the gambling of a significant other) continue to receive support to minimise any gambling related harm occurring to them and their family
Staffing	Ensure clients understand follow-up time frames -1, 3, 6 and 12 months following a Full Intervention episode	Clients benefit from a reinforcement of their ability to achieve and maintain long-lasting change	Clients who have successfully addressed their gambling behaviours remain motivated to sustain changes
Qualifications, competencies, skills, and experience	Use the Ministry's *Follow-up Gambler Screens* to re-assess clients at 3, 6 & 12 months to gauge progress in addressing problem gambling	Clients referred to other services where appropriate	Clients who are still in the process of recovery feel supported and motivated to keep on trying to overcome their gambling problems
	Provide motivational support (e.g. ensure clients' motivation remain clear and unchanged)	Clients gain the opportunity to reconnect with the service at an earlier stage	
	Review relapse prevention plan with client	Practitioners gain knowledge about client outcomes following treatment	
	Re-assess clients to gauge co-existing issues	Practitioners gain knowledge about clinical practices and engagement approaches that work best	
	Provide clients with additional support to access other support services when necessary	Client feedback enables practitioners to reflect on their training needs and processes to improve the support and services available to clients	
	When deemed necessary, refer clients to undergo another episode of intervention	Practitioners benefit by knowing their clients have improved	

Figure 95: Preliminary Logic Model: *Follow-up Services*

This section details findings from the literature of relevance to *Follow-up Services*, the staff and client surveys, two focus group interviews with clinicians, and analysis of the CLIC database. The survey and focus group findings represent all eight selected providers contracted to deliver *Follow-up Services*.

4.10.1   Literature review

The literature search conducted for this evaluation did not find any evaluations of the effectiveness of *Follow-up Services* per se. Nevertheless, evaluations that have focused on *relapse prevention* provide elements of best practice that may be of relevance to *Follow-up Services*. A study by Echeburúa, Fernández-Montalvo and Báez (2000) in Basque Country, Northern Spain, which used a one-group repeated measures design (pre- and post-treatment) and a multi-group repeated measures experimental design (pre- and post-treatment and follow-ups) found that those who underwent a relapse prevention programme exhibited a higher rate of success with relapse compared to the control group. The goal of the relapse prevention programme was to train gamblers to recognise risky situations such as social pressure; adverse emotional states such as anxiety, depression, and rage; and interpersonal conflicts, where relapse is likely to occur. The programme also educated gamblers about external factors that can

contribute to relapse such as alcohol overuse, irrational beliefs about gambling, poor financial planning, and the lack of alternative pastime activities. Second, the programme aimed to provide gamblers with suitable coping strategies when dealing with challenging circumstances. Considering the promising findings of their study, the evaluators emphasised the importance of incorporating relapse prevention components within treatment for pathological gamblers.

Additionally, other literature on relapse prevention and relapse prevention treatment effectiveness for other addictive problems such as drugs and alcohol (Larimer, Palmer, & Marlatt, 1999; Witkiewitz & Marlatt, 2004) could be drawn upon for informing best practice in relapse prevention (RP) strategies for this intervention type. In their review, Witkiewitz & Marlatt (2004) referred to previous studies that had noted the success of relapse prevention interventions for other addictions such as substance use. They indicated the need to reconceptualise relapse as a multidimensional and complex system and proposed a model that focused on the "interrelationships between dispositions, contexts, and past and current experiences" and "situational dynamics" (Witkiewitz & Marlatt, 2004, p. 229). They argued:

> Incorporating the cognitive-behavioral model of relapse and RP techniques, either within the brief intervention or as a booster session, will provide additional help for individuals who are attempting to abstain or moderate their use following treatment (Witkiewitz & Marlatt, 2004, p. 232).

They recommended the empirical testing of their proposed model and the need for research to improve measurement devices and data analysis strategies for effectively evaluating behavioural outcomes.

4.10.2 Effectiveness of PGCS-5 activities (staff and client views)

The activities delivered for this service were rated as effective for achieving positive client outcomes by a high percentage of staff survey respondents (Figure 96).
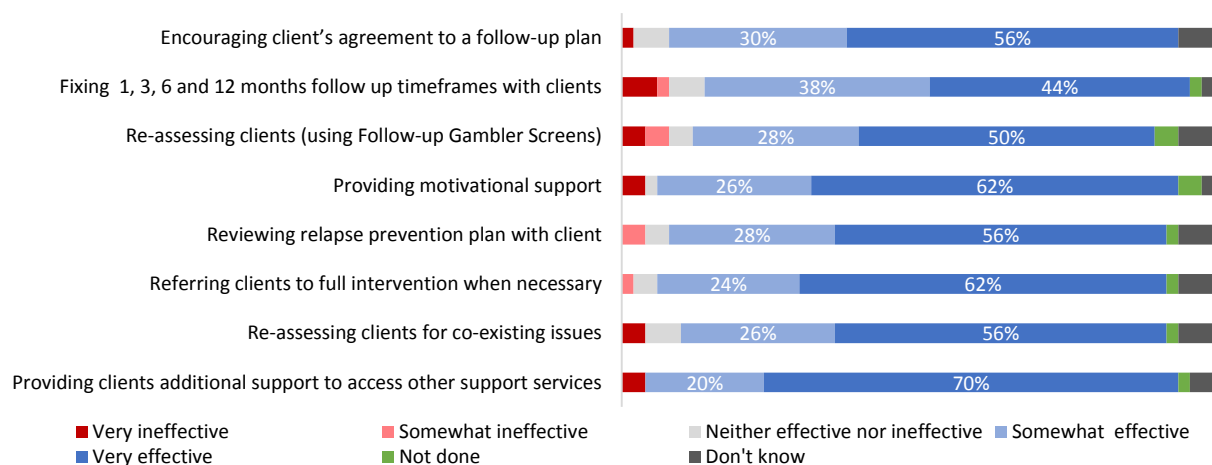
Figure 96: Effectiveness of *Follow-up Services* as rated by staff (n=50)

Among clients who responded to this questionnaire section[42], three-quarters (76%) indicated that they agreed to a follow-up plan while they were undergoing treatment. Ten client respondents also reported that their counsellors had discussed their progress in addressing their gambling behaviours during the *Follow-up* sessions.

> Asked how I was doing, any chances of falling back into gambling.

> Able to reflect how I have been going and what I've achieved.

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[42] Percentages for this section of the questionnaire were based on the number of respondents for each question. Similar to other sections of the questionnaire, although a preceding category identifier question aimed to direct only clients who were likely to have experienced Follow-up Services to complete this section, a few who indicated in the negative proceeded to complete subsequent questions. As the sample of clients in this survey may have included those who have re-entered services, they may have experienced Follow-up contacts between one full intervention episode and another.

Further evidence of outputs was noted in terms of informing clients of follow-up procedures. Almost all clients (90%) reported that their counsellor let them know that they would be contacted for follow-up sessions at one, three, six and 12 months following their treatment end. Clients also reported that the set timeframes were suitable (92%), and a majority of staff survey respondents also reported that fixing follow-up timeframes was effective. This was a notable change from the previous evaluation where feedback from staff focus group participants was that the Ministry's follow-up specifications were too prescriptive and that the "set timeframes for follow-up sessions were not conducive to helping clients" (Bellringer *et al.*, 2009, p. 83). In one of the present staff focus groups, participants commented that this change in staff views was a result of improvements to, and standardisation of their processes.

> Everybody is getting used to it. And standardising your systems. It is just a developmental thing.

> It is clearer now, in the past our assessment form was a separate form. When they come in there was a consent form and a separate form for follow-up. We have combined that together into one form, and when the client comes we inform them that as part of our services, when you sign a consent form it is agreed that we will call you… Now it …has become a standard process.

One participant expressed ongoing concerns about how this information was entered into the CLIC database.

> I don't think you can be coerced into working in such a sterile manner that it is A, B, C, D. It is about how we are going to do it, and capture that… It was a three month follow-up, you missed the first month, but you caught them on the third month. But when you go and put that information on to CLIC, you have to put that as the first month… because it won't allow you to go directly to a three month…We have to be creative, but the system tells you, why did you put in as three, what happened to the first one.

4.10.3 PGCS-05 activities and processes

Staff delivering Follow-up Services

Qualitative comments in the staff survey indicated that *Follow-up Services* were delivered either by clinicians themselves or by support staff. In the previous evaluation, participants suggested that some clients tended not to "open up to a different counsellor conducting the Follow-up sessions" (Bellringer *et al.*, 2010b, p. 14). In the current focus groups, most staff said clinicians should ideally deliver the follow-up as this provides a sense of ongoing relationship with clients, is respectful of client confidentiality and ensures ongoing clinical support.

> For me it is about the relationship; following on with the relationship you had with them in their counselling and that you are still there for them and are interested in how they are doing...

> [Some clients may not] want their information to be passed on to someone else. We have had an instance where a counsellor left and someone else called the client, and the client questioned [how their details were accessed]. [It is also] about continued therapeutic relationship, motivating them… we need someone experienced, a counsellor or social worker to do that. It is not just someone else. It is not something that anyone can do…

However, some participants suggested there might be an advantage when follow-up calls are conducted by support staff.

> There are two ways of seeing it. When it is not the counsellor doing the follow-up, sometimes the client may feel that they can speak more freely if not speaking with the counsellor. If they relapse they won't feel shame. But if they see their counsellor they will feel shame.

Sharing follow-up responsibilities also enabled others to take on the task when the respective clinician was unavailable.

> It is not either or, it is not one or the other. In our service we have had quite [a lot of] staff change. People aren't there, they can't do the follow-up; someone else has to do it. So it is who has got the capacity at the time. Someone is on leave for a month and there is a bunch of follow-ups, we are not going to let them get piled up until they get back.

One focus group participant noted that there were two components to follow-up contacts: obtaining data on client progress and providing ongoing clinical support.

> There are two parts to the follow-up, one is getting that data, how well are they doing? What do we know about them from the last data entry points? You can do that in a number of different ways; that is very different with going on with some clinical intervention work. And depending on what you are asking for, you approach it in different ways, depending on what comes up. So, follow-up, according to contracting, is get that information back that we want to know; we want to know those data points, the Ministry wants to know those data points; which is separate. There are two parts to it.

Challenges in delivering Follow-up Services

Six staff survey respondents reported challenges in carrying out Follow-up sessions. Practitioners' time constraints, clients' lack of understanding about the purpose of follow-up contacts, clients not wanting to be reminded of their previous gambling habits, difficulty in contacting clients due to changes in contact details, and clients' unavailability at the time of contact were all mentioned.

> I admit, I should do more follow-ups but the reality is I'm so busy with existing clients and the public health work including admin[istrative work] and answering hotline calls …In addition, I am busy with bookings for counselling, rooms and parking spaces for every session, marking out on calendar, all the above is just too much.

> I find this part of my job the most difficult to carry out. They have changed phone numbers, shifted, or don't want to be reminded of their gambling. A very small minority respond.

The logistical difficulties of contacting clients were discussed in focus groups.

> Whenever you do follow-up, it is very time consuming. When you call that person, they may not be there. And you have to keep calling. And sometimes, some clients move. Sometimes they go back to their home countries for a visit. So we cannot follow their schedule. Some of the staff are very busy - the clinical staff, with new clients. And they don't have time to do follow-up at that time. So their minds very often will be distracted by the face-to-face client and not the follow-up.

It was suggested that the funding allocated to these services might not be adequate given the efforts involved.

> I do think the Ministry needs to have another look at the amount of funding they are allocating for follow-ups because it is very difficult to get. You have people moving addresses, you have people not being able to get credits on their phones; you can spend seven or eight attempts before you can get a one month or three month follow up… It would be very useful for the Ministry to increase the FTE for follow up - it is underfunded.

4.10.4 Follow-up sessions – volume and delivery processes

In general, as shown in Figure 97, Follow-up sessions were delivered more frequently for gamblers than for significant others.
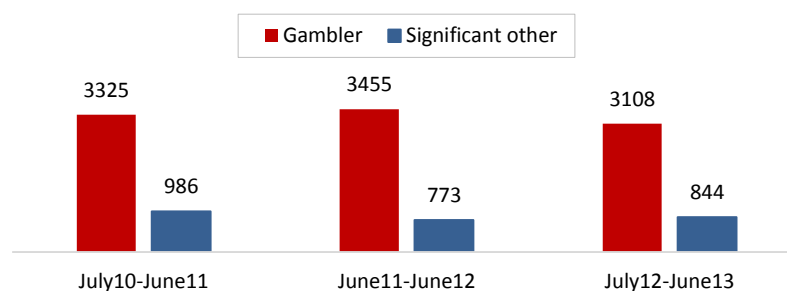
Figure 97: Total number of recorded follow-up sessions for gamblers and significant others

The minimum, maximum and average numbers of follow-up sessions for gamblers and significant others reported by providers are detailed in Table 38 in Appendix 4. While the average figures show

no provider exceeded four sessions per client, one provider (A01) had exceptionally high maximum number of sessions per client ranging from nine to 34 sessions.

The average time spent per session is detailed in Table 16 in Appendix 4. Average sessions were 30 minutes or less for most providers, with five having longer average sessions (B10, B13, C08, D03 and D16). As shown in Figure 98, when overall session duration was considered, the average duration was slightly greater than 20 minutes for gamblers and 19 minutes for significant others. These remained consistent over the three-year period.
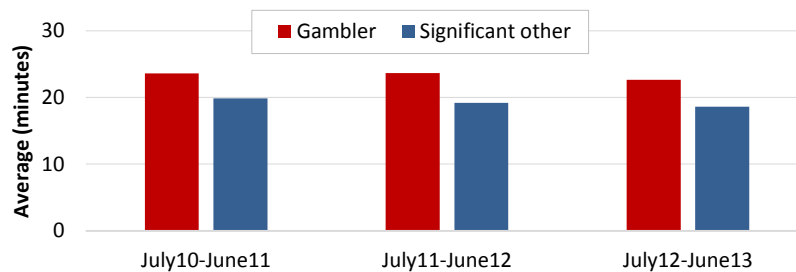
Figure 98: Average Follow-up session duration (minutes) across the three-year period

4.10.5   Gambler screens for Follow-up

Within *Follow-up Services*, clinicians are expected to administer similar screens as used in *Full Intervention* with gambler clients at the three, six and 12 month *Follow-up* sessions. When the Gambler Harm Screen is used during *Follow-up*, the questions are asked slightly differently. Clients are asked to think about the last time he or she talked with the clinician rather than the past 12 month time frame when answering the questions (Ministry of Health, 2008b). Clients are also administered the Gambler Outcome-Control Screen, the Dollars Lost Screen and the Annual Household Income Screen during *Follow-up* sessions. Figure 99 shows the overall number of times results for these screens were recorded for gambler clients during *Follow-up* sessions.

The data show that while **Gambler Harm Screen** scores were not recorded for the majority of clients in Follow-up sessions, overall, the reporting of scores from this screen (once or more) has increased annually (in 2010/11 93% did not have screen scores recorded, this figure decreased to 71% in 2011/12 and 51% in 2012/13). Despite this overall increase, as detailed in Table 39 (Appendix 4), many providers (A02, A11, B05, B06, B10, B17, C04, C19, D03) did not record screen results for the majority of clients in *Follow-up* sessions.
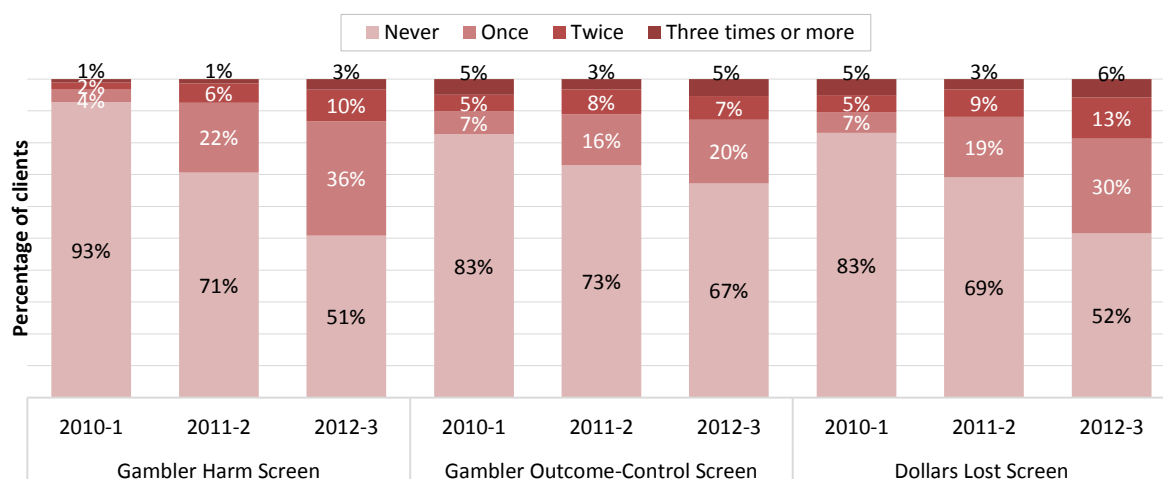
Figure 99: Number of times Gambler Screen scores were recorded for gambler clients during Follow-up sessions

Figure 99 also shows that there was a yearly increment in the percentage of gambler clients for whom **Gambler Outcome-Control Screen** scores were recorded in *Follow-up* sessions. However, in 2012/13 only a third of gambler clients had scores recorded. As detailed in Table 40 (Appendix 4), in 2012/13

some providers recorded results for this screen for the majority of gambler clients in *Follow up* sessions (A11, A15, B07, B09, B12, B13, B14, B18, D16) while others very rarely recorded screen results in *Follow-up* sessions (A01, B06, B10, C04, C08, C19, D03).

Similarly, although Figure 99 shows that responses for the **Dollars Lost Screen** were recorded more often over time, screen results tended not to be reported for a majority of gambler clients at *Follow-up* sessions. Recording of this screen was variable among providers, as shown in Table 41 in Appendix 4. One general provider (A01) and the majority of Māori and Pacific providers either never or rarely recorded results for this screen at *Follow-up* sessions in the 2010/11 reporting period. The general provider (A01) increased the screen's result recording frequency in subsequent years, and the Māori providers showed small successive increases. However, only one Pacific provider (C04) showed an increase in 2012/13, and another (C19) which showed low levels of recording in 2010/11, ceased its recording in subsequent years.

4.10.6   Family/affected other screens for Follow-up

For significant other clients, clinicians are expected to administer screens at the three, six and 12 month *Follow-up* sessions. The screens are the Family/Affected Other Harm Screen, the Gambler's Gambling Frequency Screen and the Coping with the Gambler's gambling. One value of multiple screen use at *Follow-up* as described by the Ministry was that clients could be offered the opportunity to reconnect with the service for additional support.

The overall number of scores recorded, summarised in Figure 100 shows that in general providers did not record results for these screens to significant other clients during *Follow-up* sessions in all three reporting periods. Nevertheless, small increases in recording were noted for the 2011/12 and 2012/13 reporting periods.
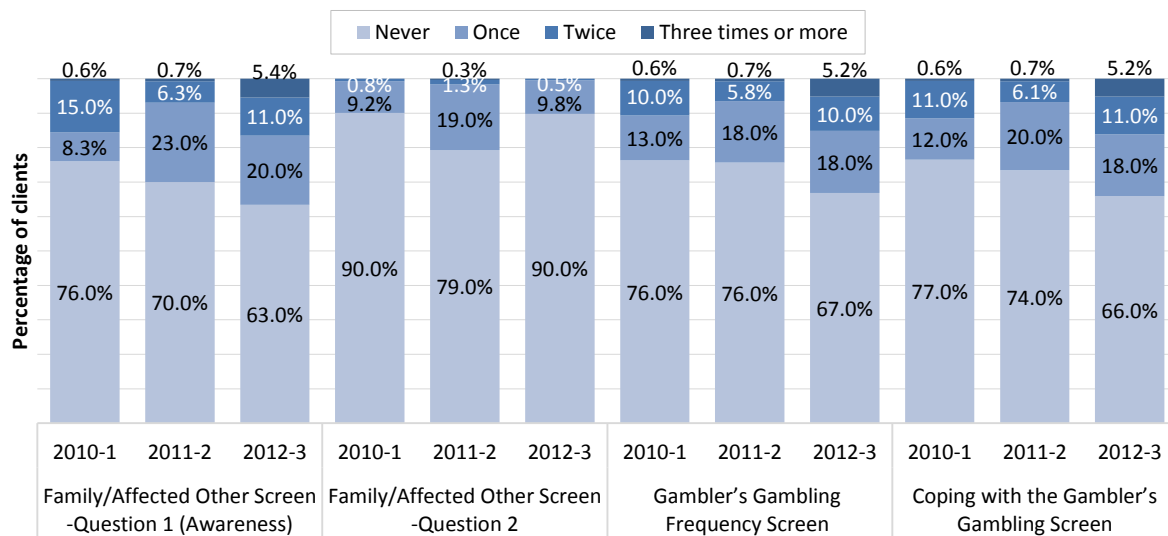
Figure 100: Number of times Family/Affected Other Screen results were recorded for significant other clients during Follow-up sessions

4.10.7   Follow-up Service outcomes for clients

Sixty-one clients (79%) who reported receiving follow-up contact from their service provider were asked to explain what happened as a result of the contact. Some respondents simply described the conversations that took place. Responses from twenty clients indicated reassurance and encouragement gained from a sense of ongoing support and care; a few clients reported being grateful for such support.

> I felt thankful to know that there is someone who cares about me, and I feel secure because I have a place to go if I have gambling problems again.

Seventeen clients commented on positive changes to their gambling behaviour and the good state they were in; for some clients this provided reassurance and a sense of achievement.

> Just being able to contact and talk and tell them how well things are going now and that gambling doesn't rule my life any more.

Only one participant indicated a lack of positive outcomes.

> Nothing. My gambling increased again soon after finishing the course. I think I could have benefited from ongoing attendance at group sessions and would have gone if they had been available.

4.10.8 Follow-up Service outcomes for clinical practitioners

Outcomes from *Follow-up Services* may also benefit clinical practitioners. The rationale for *Follow-up Services* includes three areas of benefit to practitioners identified by the Ministry of Health (2008b, p. 88):

(1) It "enables clients to give feedback to practitioners" which contributes towards affirming "their clinical and engagement skills".

(2) It contributes "knowledge about client outcomes following treatment" and "about what works with clients" thus providing "opportunities for [practitioners] to reflect on training needs and processes".

(3) It "enables counsellors, teams and agencies to benefit by knowing their clients have improved".

Knowledge about clients' improvements may contribute to practitioners' work satisfaction, and so it might be expected that clinicians would view *Follow-up Services* as contributing to their clinical knowledge, self-evaluation capacity and overall work satisfaction.

When asked to describe what they gained from the follow-up sessions, eight staff survey respondents suggested that the sessions had contributed to the development of their knowledge about clients' experiences, the effectiveness of intervention services, aspects that were working well and areas for improvement.

> This can provide a way of understanding how our counselling strategies work well or not, what point we need to improve and which way works well. Also a way to know how clients move on.

> Unless you have accurate follow-up data you cannot assess how effective the intervention programme has been. The follow-up data drives programme development for the clinicians…

Three staff reported that they gained satisfaction knowing that they had successfully supported their clients. Seventeen other staff survey respondents commented on the importance of Follow-up sessions for assessing clients' progress and providing further support if necessary.

> I get to know how my client is doing after finishing his/her face-to-face session and if needed, encourage them to re-engage with the service.

4.10.9 Success Indicators: Follow-up Services

Similar to the success indicators for the preceding three intervention services, most descriptions by staff survey respondents fitted within a single category (activity, output or outcome) of indicator type.

The outcome (as specified in the Purchase Unit Description) that people experiencing gambling harm "continue to receive support" to minimise gambling harms suggests that the activity of providing ongoing support was an outcome in itself for this intervention service. Fifteen staff survey respondents described activity indicators focused on ensuring support was ongoing. These included being persistent in attempts to contact clients, being flexible to suit clients' availability, carrying out assessments and providing necessary additional support, and engaging with clients in a supportive manner.

> There are always good numbers of clients who had relapse but can't seek help due to shame issues.
> So, we need to proactively contact them make it easy for them to come back to another treatment.

Read through the clients' case notes about the clients' situation, e.g. not ask a mental illness client if you are gambling now. Welcome clients to call us when they need help. Be patient to hear what the clients say to us and find out if the clients have any new issues.

The main indicators of successful follow-up are engaging with the client and the client's whānau to achieve motivational goals across a number of areas including gambling, for the clients to be comfortable in being honest with their follow-up and for …staff to provide the necessary support, expertise and therapeutic empathy to enable clients to stay focused.

As *Follow-up Services* are a continuation from *Full Interventions* there were some overlaps in activities and outputs. Four staff members commented that they had viewed client willingness to receive follow-up contacts itself as a success indicator. In the *Intervention Service Practice Handbook*, clinicians are encouraged to gain "client's agreement to a follow-up plan early, for example, when agreeing the intervention plan" (Ministry of Health, 2008, p. 88). For one staff survey respondent, ensuring client commitment to follow-up at the onset was an indicator of successful delivery of activity.

Letting client know at the beginning that these follow-ups are part of the services which are offered in the Full Intervention and getting their agreement.

Four staff survey respondents described clients' commitment to their treatment plans as indicator of success.

Successful Follow-up Services are when the client is motivated to achieve change, has a self-belief that he/she can achieve that change and has a good support team and whānau that can assist with the change process

Ten staff survey respondents described outcome-type indicators that identified impacts on clients such as full recovery, changes to gambling behaviour, maintenance of behavioural changes and reduced gambling harms.

Client has transitioned well from the support of the Full Intervention to independence from gambling harm. Positive changes are happening in the life of the client. Client is achieving long lasting changes.

Successful Follow-up Services measure reductions in gambling harm for Ministry of Health Dollars Lost, Control over Gambling and the Gambling Harm Screen as well as …other measures which are …analysed to determine our effectiveness as a successful provider of follow-up for our clients and their whānau.

4.11   External factors impacting on intervention services delivery

Sixty-six percent of staff survey respondents completing the section on intervention services reported that there were external factors that affected delivery of intervention services. These are detailed in Figure 101. Staff suggested some external factors, both positive and negative, could affect service delivery by affecting employees or the organisation, particularly when it concerned key areas of input such as funding and staff capacity. Other external factors could affect clients either by influencing service uptake or treatment outcomes. Overall, they included a range of factors beyond the control of their organisation, external parties and stakeholders.

Positive	Negative
Allegiance of the gambling industry	Christchurch Earthquakes
Support for clients from community agencies	Insufficient funding
Staff access to training and information on effective treatment approaches	Termination of and changes to provider contracts
Community involvement	Stigma associated with problem gambling
Active promotion of service availability	Inadequacies in referrals from other parties
Media / public discussions on gambling-related issues	Lack of cooperation among external organisations in addressing problem gambling

Figure 101: Positive and negative external factors affecting delivery of Intervention Services as identified by staff

Two respondents suggested that the allegiance of the gambling industry was an external feature that can positively affect the delivery of intervention services.

> The gambling industry's ongoing commitment to the development of their sector for the benefit of all gamblers. The gambling industry support for effective treatment intervention services…

> Improved working relationships with gambling industries enables effective referrals to services and better understanding of each other's work and support.

Two others noted the value of community service agencies, which they saw as external parties that can influence outcomes for clients.

> Some organisations like CAB, budgeting services, etc. are really helpful for us and our clients.

Three regarded staff access to training and information (a key input area as noted above) on effective treatment approaches as a positive external element.

> Constant training on gambling from Abacus Training Services which trained us around the whole system of recording as well as the terminology of diagnosis etc.

> New information regarding successful treatments that have been used in overseas countries. I got very good resources from [other countries].

Five respondents identified various types of community involvement as positive external features; these included community voluntary support, involvement in awareness raising activities, and access to at-risk communities.

> Networking and building strong community relationships gives the possibility to advertise the [our] Services to the wider community. The positive effects are seen in referrals and raising awareness around gambling issues.

Four staff noted the media and open public discussions on gambling-related issues as another area of external influence as these might lead to increased awareness of gambling harms.

> Public interest and attention on problem gambling behaviour impacts, which follows some hot topics like high profile crime which was associated with problem gambling behaviour…

In identifying negative external factors that affected the delivery of intervention services, six respondents detailed the Christchurch earthquake, which disrupted day-to-day operation of offices. Seven regarded insufficient funding (an area of key input as identified above) as an external factor that had an impact on service delivery as it affected staff motivation, training provision and delivery of services.

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Funding schema changes, it could impact on the staff's devotion to the work and terminate some events which are just in the initial establishment stages…

Insufficient funding to support my professional wellbeing in what can be an isolated and sometimes stressful environment (through reducing provision of external supervision). Problems funding the provision of an adequate rural support service…

Eight respondents commented on the recent changes to provider contracts as a negative factor; contractual uncertainties resulted in stress and planning difficulties and the termination of some providers' contracts meant an increased workload for existing providers.

Delay in contract roll out, making it difficult to plan and start new activities. Lack of clinical staff at other general problem gambling services, leading to high demand for our services with limited FTE…

Not finding out about the outcome of contracts until very late which put a lot of stress on our organisation; however, we as an organisation were still able to deliver our target effectively.

Potential loss of a collaboration partner, coverage of a wide area with limited staff.

Removal by the Ministry of major problem gambling service provider who cover other areas that our service is not doing or not strong in – leaving one option for clients to access was unhelpful and unwise in my view.

Several respondents reported issues that create ongoing challenges. Four commented that stigma associated with problem gambling among some cultures was an external aspect that prevented help-seeking behaviour.

Strong stigma associated with gambling in our communities. People tend to be secret about their problem gambling and this hampers help-seeking behaviour.

Four respondents reported inadequacies in referrals from other parties.

Referral systems. I always wonder that [our] team has not had many cases referred by casinos, pubs and other gambling [help]line.

Help line, 0800 very low referrals.

Another two respondents detailed the lack of cooperation among external organisations in addressing problem gambling.

…External agencies do not see problem gambling as a significant issue for their clients and/or do not have time to work with this with their clients

4.12   Summary of findings

Clients' initial entry pathways into services

- Throughout the three-year reporting period, most clients were not referred by external agencies (i.e. they self-referred).

- Gambler clients were more likely to be referred by an external agency than significant other clients.

- Most referrals were from other problem gambling services, followed by the Justice sector. Referrals from other sectors were less common.

- Although CLIC data showed that referrals of gamblers from gambling venues were twice the average of referrals from social services, staff survey respondents expressed contrasting views.

- Staff views were that media publicity and advertising enabled clients' self-referrals.

- CLIC data showed annual peaks in the number of *Brief Interventions* in March, September, August and November, each likely associated with activities surrounding the Pasifika Festivals, *Gamblefree Day,* Matariki festival and White Ribbon day, respectively.

- Some staff reported minor increases in help-seeking behaviour following major national public health campaigns and public health activities at local events and festivals. However, few client respondents indicated their help-seeking behaviour was enabled by activities at a public event, or because of national awareness raising campaigns.

- Staff suggested the mode of clients' entry might have an impact on intervention outcomes; they indicated that compared to self-referred clients, those with compulsory modes of entry were less committed and less motivated to change.

Primary mode of harmful gambling

- Among both gambler and significant other clients, EGMs were the most commonly cited primary mode of harmful gambling that led them to seek help.

- Higher percentages of gambler clients of Māori providers cited EGMs as their primary harmful gambling mode, while gambler clients of Pacific providers cited often Lotto.

Population serviced

- Collectively, providers delivered services to an average of 1,840 clients per month[43], with noticeably lower numbers in December and January each year.

- Overall two-thirds of clients were gamblers and one-third were significant others[43]

- Client demographics (based on trends in total number of clients accessing a service each month[43]):

  - **Gender:** Although there was an approximate 50:50 gender ratio overall, there were fewer female gambler clients and more female significant other clients.

  - **Ethnicity:** Among the four client ethnicity groups (Māori, Pacific, European/Other and Asian), European/Other (half of gambler clients and one-third of significant other clients) and Māori (one-third of each group) were the two largest groups.

  - **Age:** Among those with reported age, almost half of gambler clients were aged 30 to 49 years; while over a quarter of significant other clients were aged less than 30 years.

  - **Geographic spread:** Both gambler and significant other clients of General Service providers tended to be from more densely populated urban areas. Clients of Māori providers tended to be from more rural and smaller urban TLA boundaries. Clients of Pacific providers were concentrated in four Auckland TLA boundaries. Alcohol and Drug service gambler clients were largely from the Auckland regions.

Delivering to client needs

- The clinical audit found that all providers complied with the "**Client Rights" audit criteria**.

- Within the "**Service Delivery and Quality" audit criteria**, "Quality management", "Plan of care", and "Planning discharge from and/or transfer between services" were identified as areas of partial compliance. Minimum delivery of services (referred to as "Implementing the care plan") was identified as an area of non-compliance, which meant that the majority of providers audited were not consistently delivering the volume of services agreed with the Ministry.

- Staff and client views suggested that operational processes ensured provision of services that met **clients' general needs** as consumers of services.

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[43] Estimates are based on the total number of clients who accessed a service at least once in each respective month, thus cannot be used to estimate number of clients in a year.

- A few clients reported services' mobility, an aspect specific to Dedicated Māori services, to be useful as it enabled out-of-office sessions.

- The majority of providers ensured **personalised services** through primarily face-to-face sessions followed by telephone. Although clients were supported with a variety of intervention approaches, individual one-one-one sessions were the most common approach used.

- Clients' cultural and spiritual needs:
    - Staff reported that providers were effective in delivering intervention services in a manner that met **clients' cultural and spiritual/religious needs**.
    - The clinical audit found that all providers complied with the "**Cultural Perspectives" audit criteria**.
    - All clients interviewed in the audit expressed high levels of satisfaction with the cultural aspects of the services they received. However, the client survey found that these service aspects tended to be viewed as helpful by Māori, Pacific and Asian clients. A lesser portion of European/Other clients viewed these as particularly helpful service aspects.
    - Findings from both the clinical audit and staff survey showed that providers tended to employ staff who were of similar ethnic backgrounds as their clients.

- **Enabling clients' access to a range of services** appeared easier for providers with access to other services within their own wider organisations.

Pathways of Intervention Services

- The majority of gambler clients were recorded as following preferred pathways; however, this has decreased in successive years from 96% in 2010/11 to 77% in 2011/12.
    - This decrease was largely due to a reduction in numbers of brief intervention-only gambler clients.

- For significant other clients over time, there was a substantial increase in the number of clients on preferred pathways including a full intervention.

Treatment completion

- There was variation in how the last visit flag was used in CLIC; many clients had no last visit or several last visits recorded.
    - In some cases, the last visit flag was used for the last *Full Intervention* session, the last *Facilitation session* and the last *Follow-up session*. The reasons for the multiple last sessions were also variable, meaning multiple last visits were not necessarily indicators of a relapse and further treatment.

- There was evidence in the CLIC data that both the occurrence and number of last sessions for ongoing clients declined over time.

Brief Intervention Services

- Effectiveness of PGCS-02 activities:
    - Staff reported that all PGCS-02 activities were effective in achieving positive outcomes for clients.
    - Most clients reported having experienced the activities delivered by staff during *Brief Intervention* sessions, suggesting evidence of service outputs.

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- Session volume and delivery processes:

  o The clinical audit found that three out of seven providers contracted to deliver PGCS-02 did not deliver the minimum number of sessions required under their contract with the Ministry.

  o Total number of *Brief Intervention* sessions recorded showed that this service was delivered more frequently for significant other clients (4,061 sessions in 2012/13) than for gambler clients (2,565 sessions in 2012/13). This pattern that remained consistent across the three-year reporting period.

  o Most providers delivered an average of one session per client.

  o The overall average duration of each session was approximately 20 minutes both for gambler and significant other clients.

- Client trends and features:

  o Overall CLIC data trends showed a relatively steady growth in the **number of new *Brief Intervention*** clients across the three-year period. This growth was due to increases in the number of significant other clients.

  o New *Brief Intervention* clients comprised two-thirds of all new clients across the three years.

  o Trends across the three years showed an overall 50:50 **gender split** among new *Brief Intervention* clients, with a greater proportion of significant others being female.

  o The **ethnic breakdown** for new *Brief Intervention* clients showed that Māori and European/Other were the largest groups among gamblers; while Māori comprised the largest group among significant others. There was a disproportionately small number of Asian significant other clients.

- Brief Gambler Screen use:

  o For the majority of gambler clients (95%-99%) screen results were recorded once.

  o While there was some provider level variance, with clients of some providers exhibiting noticeably higher positive scores, in general about a third of gambler clients exhibited a score of one for this screen. Scores between two and four were reported in less than a quarter of clients.

- Brief Family/Affected Other Screen use:

  o For the majority of significant other clients (96%-99%) screen results were recorded once.

  o Each year approximately one-third of significant other clients indicated that they were currently affected by someone else's gambling, and a further third indicated that they had been affected in the past.

  o Approximately a third of clients experienced one effect type, followed by two, three, four and five effect types.

- Client outcomes:

  o Self-reported **impacts** for most of the client survey respondents related to their thinking about gambling harms and their realisation that they needed help.

Full and Workshop-based Intervention Services

- Effectiveness of PGCS-03/PGCS-06 activities:

  o The majority of staff reported that activities carried out for these interventions were effective in achieving positive outcomes for clients. A lower percentage of staff reported the effectiveness of "using the Ministry's Review and Assessment Tools before discharge".

- o Almost all client respondents reported experiencing the activities delivered by staff during Full and Workshop-based Interventions, providing evidence of outputs in the form of services delivered.
  - o However, a few clients reported the sessions to be insufficient in terms of time and change strategies.
- PGCS-03/PGCS-06 activities and process:
  - o Additional activities reported by staff included:
    - Involvement of family members in the process of treatment
    - Communication and counselling via letters
    - Provision of additional support via support groups (e.g. peer support groups, parenting groups)
    - Additional help with developing social and communication skills and with anger management
    - Provision of supportive client-clinician relationships
    - The use of additional instruments to measure and monitor treatment outcomes.
  - o Staff suggested that inclusion of additional financial knowledge components in counselling sessions might be beneficial for some clients.

- Session volume and delivery processes
  - o The clinical audit reported that five out of the eight providers contracted to deliver PGCS-03 did not deliver the minimum number of sessions required in their contracts. The provider contracted to deliver PGCS-06 met the minimum requirements of their contract.
  - o Total number of sessions recorded in the CLIC data showed that this service was delivered more frequently for gambler clients (24,569 sessions in 2012/13) than for significant other clients (6,470 sessions in 2012/13). This pattern that remained consistent across the three years.
  - o Based on overall average figures, most providers delivered an approximate seven to eight sessions per gambler client and less than six sessions per significant other client. However, a few providers (AOD service, Maori and Pacific services) recorded higher average number of sessions.
  - o Generally, the average *Full Intervention* session duration was approximately 60 minutes. However, several Māori and Pacific providers and one general provider consistently reported sessions of less than 60 minutes duration.

- Client trends and features:
  - o Overall CLIC data trends did not show growth in the **numbers of new *Full Intervention* clients** across the three-year period.
  - o The numbers of new gambler *Full Intervention* clients were substantially larger than the numbers of new significant other clients throughout the three-year period.

- Gambler Harm Screen use
  - o In general, screen scores were recorded once for over half of gambler clients and not recorded at all for approximately a third. Instances where screen scores were recorded more than twice were infrequent.
  - o Although there were some provider level differences, generally, the average initial score for this screen was consistent across the years at between 11 and 12. This indicated problem gambling.

- For the small number of gambler clients with screen scores recorded twice, on average, scores improved by 6.23 points in 2011/12 and 6.83 points in 2012/13. However, the small numbers mean this cannot be used to comment on treatment outcomes generally.

- Gambler Outcome-Control Screen use
  - While this screen's results were recorded once for about half of gambler clients, it was not recorded for about 40% of clients.
  - Across all three reporting periods, results for this screen were rarely recorded twice for clients. This meant a lack of clarity on how this screen was used to measure client outcomes during the course of their *Full Intervention*.
  - The initial average rating for this screen remained relatively constant across the three years (averages of 2.46, 2.41 and 2.35 respectively) and across providers.
  - For the small sample of clients who had screen results recorded twice, improvements were evident across most providers and overall (average annual improvements of -0.39, -0.63 and -0.55 respectively across the three years).

- Dollars Lost Screen
  - While responses were recorded for over 40% of clients, they were not recorded for a further 40% of clients in all three reporting periods.
  - Screen results were rarely recorded twice, meaning these scores cannot be used to assess client outcomes.
  - The annual average for dollars loss for gambler clients was variable between providers ranging from a few dollars to several thousands of dollars.
  - For the small sample of clients with two responses recorded, the overall percentage of clients showing improvement increased over the successive reporting periods (47% in 2010/11, 65% in 2011/12 and 75% in 2012/13).

- Use of Full Intervention Family/Affected Other Screens
  - Providers did not record results for the three Ministry-recommended screens for significant other clients for 50% or more of clients throughout the three years. Nevertheless, these screens' results were recorded at least once for a higher percentage of clients in the 2011/12 and 2012/13 reporting periods when compared to the 2010/11 period.
  - For the Full Family/Affected Other Screen in all three reporting periods, over a third of significant other clients indicated that they were currently affected by someone else's gambling while about a quarter indicated that they had been affected in the past. While over a quarter indicated one effect type, smaller percentages of clients experienced two, three, four and five effect types.

- Use of Co-existing Issues Screens
  - Overall, the recording of results in CLIC were low for these screens.
  - While there were variations among providers, the overall percentages show that scores for the five Ministry recommended co-existing issues screens were recorded at least once for approximately half of gambler clients but not for a remaining 50% of clients.
  - The five co-existing issues screens' scores were not recorded for a majority of significant other clients.
  - The **Alcohol Use Screen** results showed that in general most significant other clients had low levels of alcohol consumption. The gambler clients, however, had high total average scores on this screen.

- o The **Drug Use Screen** results showed that less than a quarter of those assessed in each client group presented with drug-use as a co-existing issue. This pattern was consistent across providers with the exception of three Māori providers that had higher percentages in some reporting periods.

- o The **Depression Screen** results showed that depression was an issue for about two-thirds of gambler clients assessed. This was also the case for just over half of significant other clients.

- o The **Suicidality Screen** results showed that suicidality was not an issue for the majority of clients assessed. However, in all three reporting periods, approximately 21% of gambler clients had thought about suicide, three percent had planned a suicide, and almost three percent had attempted suicide.

- o Across all three reporting periods, over 60% of gambler clients assessed, and approximately half of all significant other clients, indicated positive responses to the **Family/whānau Concern Screen** indicating they were experiencing health-related issues noticed by others.

- Client outcomes:

- o Clients' self-rated changes on the impacts of Full and Workshop-based Interventions suggested improvements in understanding gambling harms and gambling triggers, greater ability to stop or control gambling, and improvements to health, wellbeing and financial situations.

- o In the small percentage of cases where scores were recorded twice, improvements were evident in the respective areas addressed in the screen.

Facilitation Services

- Effectiveness of PGCS-04 activities

- o Staff rated PGCS-04 activities as effective in achieving positive outcomes for clients.

- o Staff of allied organisations observed the range of support provided to clients by problem gambling intervention service providers evidencing **outputs in the form of activity delivery**.

- o Activities carried out to support clients and client feedback indicated that the objective of **enabling a seamless referral process** was largely met.

- o Enabling a seamless *Facilitation* process may be easier when clinicians refer clients to in-house community support services than to external community services; a range of access and relationship advantages was cited.

- o Staff may lack clarity on the value of establishing **joint client management protocols**; this is sometimes an area not actively pursued among providers.

- o Areas for improvement included processes around client information sharing and clarity in roles and responsibilities of both parties during the Facilitation process.

- PGCS-04 activities and processes

- o Facilitations included working with **four categories**: (1) in-house community support services, (2) external community support services, (3) businesses providing gambling services, and (4) supportive individuals.

  - ▪ There was some lack of clarity among staff about agencies comprising "allied services".

- o Providers regarded an allied organisation as one to, or from, which clients can be referred. However, almost half of allied organisations in the present study did not have formal process for screening and referral.

- o More training could improve allied organisations' awareness of problem gambling issues and in identifying symptoms.

- o Telephone was the most frequently used method of *Facilitation Services* followed by face-to-face meetings, email and posted letters.

- o Contact with gambling operators for *Facilitation Services* was infrequent. Client attendance at gambling venues was likely to be one-off for the purpose of self-exclusion.

- o Although **working relationships between providers and allied organisations** were good, improvements were still needed particularly in the areas of communication, contact and follow-up. The strength of relationships depends on the frequency of contact, which in many cases is variable/infrequent.

- o Providers had mixed views about collaborative work with gambling venues because of differing interests, but many acknowledged the advantages of these collaborations.

- Session volume and delivery processes

  - o The clinical audit noted that five out of seven providers contracted to deliver PGCS-04 did not deliver the minimum number of sessions as required in their contracts.

  - o Overall, more *Facilitation* sessions were delivered to gambler clients (2,389 sessions in 2012/13) than to significant other clients (955 sessions in 2012/13), consistent with the client population.

  - o Generally, providers delivered an average of 2.5 sessions per client. There were some clients with very large numbers of facilitations.

  - o Average session duration varied across providers with some reporting short facilitation sessions (less than one hour) whilst others reported comparatively long sessions (exceeding one hour). Session duration has increased across the three-year reporting period for dedicated Māori and Pacific providers.

- Types of facilitated referrals

  - o *Facilitation Services* provided to gambler clients were frequently recorded as "Other" in the CLIC database. Other common facilitation types for gamblers were to "Addictions-Gambling" services and to "Financial Advice and Support" services.

  - o For gambler clients, there were increases in venue exclusion facilitation sessions across years.

  - o For significant other clients, there were substantial increases in facilitations for mental and physical health over the three-year period, which were not apparent among gambler clients.

- Client outcomes:

  - o Accessing help from other community services may result in positive **client outcomes** such as resolving other issues, which in turn can positively influence gambling behaviours.

    - ▪ Other positive outcomes noted included enhanced fiscal management abilities, financial situation, and understanding and acknowledgement of gambling problems.

- Outcomes for allied organisations included:

  - o Increased general awareness of problem gambling

  - o Ability to identify problem gambling symptoms among their other clients

  - o Ability to assist their own clients who may present with gambling-related problems

  - o Ability in, and commitment to, problem gambling screening.

Follow-up Services

- Effectiveness of PGCS-05 activities:
  - PGCS-05 activities were rated as effective for achieving positive client outcomes by a high percentage of staff survey respondents.
 - Client responses provided evidence of outputs that are likely to have resulted from follow-up procedures.
  - Both clients and staff indicated that fixing follow-up sessions at one, three, six and 12 months following treatment end was effective.

- PGCS-05 activities and processes:
  - The **delivery of** *Follow-up Services* was either by clinicians or by support staff. There were mixed views regarding the merits of these two approaches.
  - Most staff believed that a clinician should ideally follow-up with clients as this provides a sense of an ongoing relationship with the client.
  - Substantial logistical challenges were noted in carrying out Follow-up services.
  - Further consideration of whether funding for Follow-up services was adequate was suggested.

- Sessions volume and delivery processes:
  - The clinical audit noted that seven out of eight providers did not deliver the minimum number of sessions required under their contracts.
  - Overall, more Follow-up sessions were delivered to gambler clients (3,108 sessions in 2012/13) than to significant other clients (844 sessions in 2012/13), consistent with the client population.
  - Overall average figures show providers did not exceed four follow-up sessions per client. One provider had a very high maximum number of sessions per client ranging from nine to 34 sessions.
  - Most providers reported an average session length of 30 minutes or less.

- Follow-up Screens use:
  - Although there were differences between providers, generally, scores for Ministry-recommended screens for Follow-up were not recorded for the majority of clients at follow-up sessions.
    - Some increase in screen score recording was noted for the 2011/12 and 2012/13 reporting periods.

- Client outcomes:
  - Outcomes for clients resulting from follow-up included reassurance and encouragement gained from a sense of ongoing support and care.
  - For those who were more successful in addressing their gambling behaviours, being able to share their successes and their sense of achievement may be an experienced outcome.

- Outcomes for clinicians: *Follow-up sessions* contributed towards outcomes for practitioners in terms of enhancing their knowledge of clients' experiences, the effectiveness of aspects of interventions and areas of potential improvement.

Intervention "Success Indicators"

- Staff beliefs about the main success indicators for the four intervention types tended to fit within one of four categories: input-related indicators, activity-related indicators (often focusing on what needed to be done and carrying out activities in the Purchase Unit Descriptions), output-related indicators and outcome-related indicators. These are summarised in Figure 102.

    - Only a few staff reported a combination of indicators that showed a succession from activities carried out to outputs and outcomes achieved.
    - Staff suggested that *Brief Intervention* services lacked explicit outcome indicators.

External factors affecting intervention services delivery

- Staff reported that some external positive and negative factors could affect service delivery by affecting employees or organisations, particularly when they concerned key areas of input such as funding and staff capacity.

- Recent contractual uncertainties resulted in stress and planning difficulties.

- Positive external factors included:

    - Allegiance of the gambling industry
    - Support for clients from community agencies
    - Staff access to training and information on effective treatment approaches
    - Community involvement
    - Active promotion of service availability
    - Media/public discussions on gambling-related issues.

- Negative external factors included:

    - Christchurch Earthquakes
    - Insufficient funding
    - Stigma associated with problem gambling
    - Inadequate referrals and referral processes from other parties
    - Lack of cooperation among external organisations in addressing problem gambling.

Input Indicators	Activity indicators	Output indicators	Outcome indicators

Brief Interventions

	Seeking intervention opportunities within community settings	Clients' increased awareness of gambling harms	Help-seeking behaviour among clients
	Ensuring the appropriateness of the intervention environment	Clients' increased awareness of the availability of gambling intervention services	Increased referrals to treatment services
	Carrying out assessments / Using brief screens	Early identification of those at risk	Timely support for those at risk
	Providing information	Clinician's increased understanding of clients' interest in receiving support	Conversion from Brief to Full Intervention
	Ensuring appropriate communication approaches when engaging with potential clients		Unintended outcome: Increases in clinicians' knowledge about community perceptions of gambling harms

Full and Workshop-based Intervention

Clinical knowledge	Delivering activities as detailed in the Purchase Unit Description	Increases in clients' understanding about problem gambling	Changes to clients' gambling behaviours
Communication skills	Ensuring culturally appropriate supportive approaches when engaging with clients and evaluating for outcomes	Increases in clients' willingness to address gambling behaviours	Increases in clients' coping skills
			Improvements to clients' financial situations
			Improvements to clients' life quality and wellbeing

Facilitation services

	Establishing working relationships with community support agencies	Increases in clients' awareness about help availability	Changes to clients' gambling behaviour
	Identifying clients' needs	Increases in clients' motivation towards seeking help and wanting change	The meeting of other needs among clients
	Encouraging clients to seek assistance from other agencies		Changes to clients' behaviours in relation to other issues
	Ensuring a smooth and timely Facilitation process		

Follow-up Services

	Being persistent in attempts to contact clients	Clients' willingness to receive follow-up contacts	Clients' full recovery
	Being flexible to suit clients' availability	Clients' commitment to treatment plans	Changes to clients' gambling behaviour
	Carrying out assessments		Maintenance of clients' behavioural changes
	Providing necessary additional support		Reduced gambling harms among clients (e.g. financial losses)
	Engaging with clients in a supportive manner		

Figure 102: Key success indicators for intervention services as identified by staff

Generally, providers were achieving what they were contracted to achieve albeit at varying levels and in different areas. While evidence of cultural practices was clear from staff and client feedback in the evaluation and the clinical audit, clearer documentation of these practices could enable sharing of best practice across the sector.

5 Problem Gambling Public Health Services

While gambling treatment services that focus on addressing the symptoms of problem gambling have long been established within health sectors internationally, the notion of problem gambling as a public health issue is relatively new, with New Zealand being one of the pioneering countries to take this approach.

> To date, national responses to harm from gambling have concentrated by and large on establishing treatment services. Few nations have looked seriously at investing in public health responses to gambling expansion, and those that have commit only a small fraction of what they devote to treatment. Despite this indifference, efforts have already been made to articulate a public health approach to gambling… This is specially the case in New Zealand, where not only have efforts been made to formulate a comprehensive public health approach to gambling, but progress has been made in putting some aspects of this into action. These opportunities were only possible because in their 2003 Gambling Act, the New Zealand Government recognized gambling formally as a public health issue (Adams, Raeburn, & De Silva, 2009, p. 689).

New Zealand's public health approach for addressing gambling issues is focused on three central activity areas: minimisation of gambling-related harm, health promotion and political determinants (Adams *et al.*, 2009). Harm minimisation initiatives, an area that has received the most international focus, concerns the use of evidence-based strategies to modify the gambling environment, product or facility and influence public knowledge about gambling-related harm with the aim of reducing harmful gambling behaviours. The second area, health promotion, focuses on health inequalities and community action, and involves building community capability, knowledge and resilience in addressing gambling harms; this is based on the premise that an empowered public will be better able to instil responsible gambling practices. The third area, political determinants, is likely to be the most challenging intervention area considering its focus on changing the conflicting connections between the government's social outcome objectives and the contribution of gambling profits towards its economic objectives. The Ministry of Health in New Zealand aims towards these focus areas through the delivery of five types of public health services: (1) *Policy Development and Implementation*, (2) *Safe Gambling Environments*, (3) *Supportive Communities*, (4) *Aware Communities*, and (5) *Effective Screening Environments*.

This chapter provides key findings from four data sources (literature, providers' progress reports, staff survey, and public health staff focus group discussions) in relation to these five public health services. Verbal quantifications (i.e. implied numbers such as "some" or "most") throughout this chapter should be interpreted with caution because of the limitations in the primary data (i.e. providers' six-monthly progress reports) used in this component of the evaluation. As noted in in Section 2.3.2, the progress reports were not in a consistent format and often there was a lack of explicit connections between reported activities and outputs and the outcomes described in the Ministry's service specifications. Therefore, the quantitative content analysis method used to provide frequency of specific activities and outputs across the data set provide indicative findings only.

5.1 Policy Development & Implementation (PGPH-01)

The *Policy Development and Implementation* public health service focuses on activities that foster various organisations' implementation and development of practice that can reduce gambling-related harms. The objective of this public health service is:

> …to increase adoption of organisational policies that support the reduction of gambling related harm for employees and organisation's client groups (i.e. employee assistance policies, organisational positions on accepting gambling funding, relationships with gambling venues, permitting gambling promotions in internal/external media) (Ministry of Health, 2010, p. 30).

Activities and key processes identified by the Ministry in the PGPH-01 Purchase Unit Description are summarised in a preliminary logic model (Figure 103).

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PGPH-01 Policy Development and Implementation

Inputs	Activities	Outputs	Outcomes	Impact
Purchase Unit Funding	Identify relevant priority organisations from a range of sectors	Organisations advised on the significance of gambling harms	Increase in the adoption of organisational policies that support the reduction of gambling related harm for employees (i.e. employee assistance policies, organisational positions on accepting gambling funding, relationships with gambling venues, permitting gambling promotions in internal/external media)	Government agencies, social organisations, private industry and businesses actively work to reduce the harm occurring from gambling in their own places of business and re-orientate their services to actively support reductions in gambling related harm where possible
Staffing	Build relationships	Healthy public policies and planning that contributes to gambling harm reductions in place		
Qualifications, competencies, skills and experience	Facilitate community action	Effective work carried out with territorial local authorities and other stakeholders which address Class 4 gaming machine venue policies		
	Collaborate with a range of sectors			
	Identify and educate on policy relevance to identified organisations	Community concerns regarding density and locality of gaming venues effectively addressed in work leading up to Class 4 gaming machine venue policies		
	Provide policy development and implementation support	District level social impact assessment of gambling harm supported		
	Monitor and follow up	Policies that promote fundraising methods that do not involve gambling established		
		Organisation policies that support the reduction of gambling harm for employees and client groups established		

Figure 103: Preliminary Logic Model: Policy Development and Implementation

Activities within this service include "advising organisations on the significance of gambling-related harm"; facilitating "the development of healthy public policy and planning that will contribute to the reduction of gambling-related harms"; working with "local authorities and other stakeholders to address Class 4 gaming machine venue policies" and encouraging non-gambling fund-raising (Ministry of Health, 2010, p. 30).

This chapter contains a review of literature of relevance to this purchase unit, a summary of key findings drawn from a document analysis of 17 providers' reports contracted for PGPH-01 service as well as findings from the staff survey and public health staff focus group discussions. The survey represents the six providers (of the eight selected for this evaluation) contracted to deliver PGPH-01.

5.1.1   Literature review

Although a number of articles discussing the need for workplace gambling policies and gambling policy development processes were noted (Alberta Health Services, 2010; Griffiths, 2009; Laker 2006; Makarovič, Macur & Rončević, 2011) no evaluation articles directly related to public health services focusing on policy development and implementation were found. In considering internet gambling policies, Gainsbury and Wood (2011, p. 309) highlighted that the present uncertainty "and questionable effectiveness of policies in place makes it difficult for gambling operators, treatment providers, players and other stakeholders to formulate appropriate responses to online gambling".

An inquiry report by the Australian Government Productivity Commission (2010) noted the lack of evaluation of gambling polices as well as the lack of research-informed policy decision making by governments.

> As in other areas of social research, there are many difficulties in assessing the effectiveness and impacts of gambling policies. As noted in previous chapters, in making policy decisions about gambling, governments have to weigh this uncertainty against the potential costs of inaction. However, an ongoing program of high quality, policy-focused research and evaluation will supplement policymakers' use of judgment and expert opinion, and enrich the existing evidence base. Better information may lead to new directions in policy and will allow policymakers to adapt, revoke or introduce regulations with greater certainty about their impacts (Australian Government Productivity Commission, 2010, p. 18.2).

The inquiry report provided a range of observations and recommendations for improving research and evaluation in this area including possible models for national gambling research and recommendations for improving policy evaluation and review.

Nevertheless, Williams, Simpson and West (2007) drew attention to a range of policies that restrict or limit gambling availability, number of gambling venues, harmful types of gambling, gambling opportunities (outside dedicated gambling venues), location of gambling venues, venue operating hours, as well as policies that place restrictions on who can gamble and how gambling services are provided. They also provided grades of "estimated effectiveness potential" for the different types of policy initiatives. However, they commented that the effectiveness of many of the individual initiatives remains largely unknown.

Recently, Gainsbury, Blanders, Wilkinson, Schelleman-Offermans and Cousin (2014) examined best practice examples of substance use public health policies to provide recommendations for the development of gambling-related policies. They provided a list of gambling-related public policy areas that may be considered and their potential effectiveness. They concluded that while their list is not exhaustive, it provides a starting point for commencing "dialogue that may eventuate in international consistency in standards of [gambling] harm-minimisation" (Gainsbury *et al*., 2014, p. 783).

Considering the limited availability of research and evaluation on problem gambling policies, the PGPH-01 service could draw insights from evaluations of policy-related interventions for other addiction areas. For instance, in Washington State, USA, Wickizer, Kopjar, Franklin and Joesch (2004) used an experimental evaluation design (a treatment group consisting of 261 companies and a non-equivalent comparison group of 20,500 companies) to test the impacts of a publicly funded drug-free workplace programme in preventing occupational injuries, which was a notable public health problem. The model drug-free workplace programme included:

> (1) a written policy describing the employer's expectations about drug use and consequences of policy violations; (2) an employee assistance program (EAP) to provide confidential problem assessment, counseling, referral to treatment, and follow-up support after treatment; (3) supervisor training to orient supervisors to the employer's drug abuse policy, to define the supervisor's responsibility to refer employees when job performance deficits are noted, and to recognize and respond to employees with problems; (4) employee education to describe the signs and symptoms of drug abuse and its effects on performance and to explain the program; and (5) drug testing on a controlled and carefully monitored basis (Wickizer *et al*., 2004, p. 93).

Their evaluation found that the programme was statistically associated with a significant reduction in occupational injury rates for companies within three industry categories, and significant reductions in serious injuries that result in loss of over four working days.

Edwards *et al*. (2008) conducted an evaluation to gauge the impacts of the 2003 New Zealand Smoke-free Environments Amendment Act (SEAA), which extended smoking restrictions to include bars, casinos, clubs and restaurants. They used a range of data sources including literature searches, consultations with project team members and other relevant informants, and analysis of data obtained

from surveys by the Health Sponsorship Council and the national Quitline[44]. They also explored key stakeholders' attitudes towards, and experiences of, the SEAA and included testing of indoor air quality in venues offering hospitality services and an analysis of respiratory and cardiovascular-related hospitalisation rates. Edwards *et al*. found that an increasing majority were supportive of the SEAA and that there was a high rate of compliance among bars and pubs. Their data also showed significant decreases in exposure to second-hand smoke from 20% in 2003 to eight percent in 2006. Although they did not observe definite evidence in terms of health impacts and smoking frequency, they noted that there was an increase in the number of calls received by Quitline despite reduced advertising.

Fichtenberg and Glantz's (2002) systematic review with a random-effects meta-analysis[45] of 26 published studies that evaluated the effects of smoke-free workplace policies found that smoke-free workplaces were associated with decreases in smoking frequency as well as decreases in number of cigarettes smoked in a day among smokers. The authors argued that smoke-free policies in the workplace serve not only in terms of protection from passive smoking for non-smokers but also serve as means for positively influencing smoking behaviours among smokers.

5.1.2 Providers' knowledge development and time

Providers' reporting suggested implications for two areas of input in relation to the *Policy Development and Implementation* Purchase Unit: knowledge and time sufficiency. One provider highlighted the need for training on the policy submission process. Others indicated limitations in staff knowledge capacity, expertise, and lack of establishment within a public health role as barriers to progress in delivering services within this purchase unit. Some providers reported that their time and resource limits, including staffing issues, also made it challenging to meet the outcomes of this purchase unit. For one provider, time also became a barrier when faced with the need to provide explanations in various languages.

5.1.3 Effectiveness of PGPH-01 activities (staff views)

Figure 104 shows the staff-rated effectiveness of various activities in achieving the respective objectives. The first row shows the majority of staff respondents (79%) rated the activity of *raising awareness of the relevance of gambling-related policies to the core business of targeted sectors* as effective for achieving outcomes for the PGPH-01 service. *Working with territorial local authorities to address Class 4 gaming machine venue policies* was rated as effective by two-thirds (67%). All other activities were rated as effective by over half of respondents.

Additional findings in relation to these activities are detailed in the following sections, based on the document analysis of 17 providers' reports, and focus groups discussions.

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[44] Quitline, New Zealand is a free service funded by the Ministry of Health offered to smokers seeking help with their smoking addiction (see http://www.quit.org.nz/)

[45] As defined by Borenstein, Hedges, Higgins, & Rothstein (2010, p. 97) by contrast to the fixed-effect model for meta-analysis which is based on the assumption that all studies included in the analysis share a common effect size, the random-effects model allows "the true effect sizes to differ" enabling the inclusion of studies with different effect sizes. "In a random-effects meta-analysis model, the effect sizes in the studies that actually were performed are assumed to represent a random sample from a particular distribution of these effect sizes (hence the term random effects). " (Borenstein et al., 2010, pl. 97).
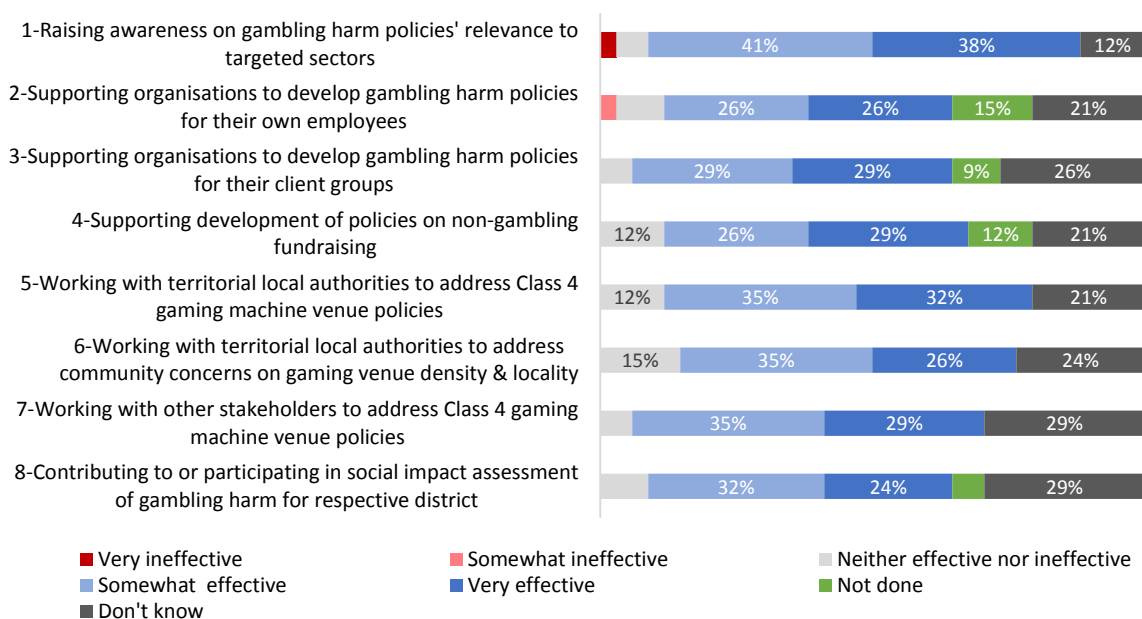
Figure 104: Effectiveness of Policy Development and Implementation activities as rated by staff (n=34)

5.1.4 Identification of relevant organisations and relationship building

In the PGPH-01 Purchase Unit Description, it was specified that key processes should "include identification of relevant organisations" and relationship building (Ministry of Health, 2010, p. 30). Delivery of services should include "government agencies, social organisations, private industry and business" and "community organisations (i.e. councils, agencies, schools and tertiary education providers, sports clubs, marae, churches, not for profit community organisations)" (Ministry of Health, 2010, p. 30).

The document analysis found that all providers indicated having contacted and engaged with several stakeholder groups in delivering this purchase unit with some engaging with more groups than others. Stakeholders mentioned were categorised within ten broad stakeholder groups, shown in Figure 105.
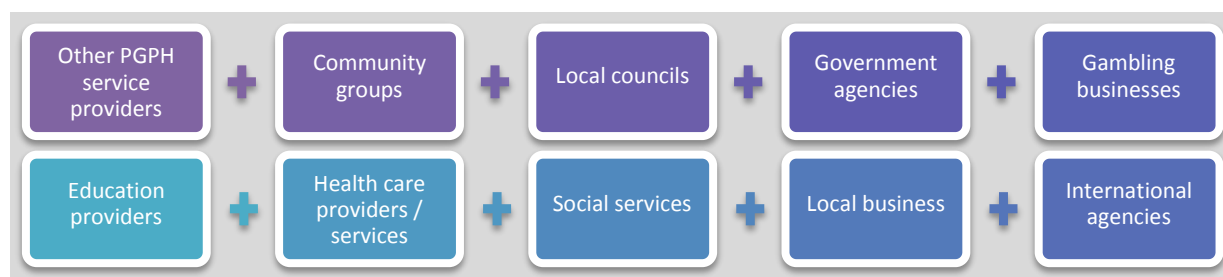
Figure 105: Stakeholder groups engaged with for delivering PGPH-01

All providers included aspects of relationship development in their reports, suggesting the importance of relationship development for the success of their work. The relationship development process enabled identification of allies and ways for collaborative work. Relationship development may start with an introductory awareness-raising phase, transitioning into a subsequent phase of looking into mutually beneficial working relationships, and followed by a *relationship maintenance* phase.

Many providers indicated having collaborated with other Ministry-contracted problem gambling public health (PGPH) service providers when carrying out some policy-related initiatives. This was described in one provider's report as displaying a "united front with the collective of other problem gambling services" highlighting the value of a commonly shared goal among different providers in their push for policies that address problem gambling. Working in a collaborative way with other service providers

helped with the challenge of covering larger geographical areas. Some barriers and challenges to working with stakeholder groups were reported:

- Incompatibility of approaches when working with other PGPH service providers

- Lack of willingness of stakeholder groups' to engage in collaborative approaches

- Difficulty in finding time and energy for problem gambling among the myriad of other pressing public health and social issues

- Bureaucratic processes and procedures inhibiting progress towards collaborative work

- Lack of understanding and acknowledgement of problem gambling as a health-related problem among some health service providers

- Unique challenges of working with individuals in the justice system in collaboration with the Department of Corrections.

5.1.5 Education and awareness raising

In the PGPH-01 *Purchase Unit Descriptions* expected activities included "advising organisations on the significance of gambling related harm" and processes included "…educating and identification of the relevance of this work to identified organisations" (Ministry of Health, 2010, p. 30).

As noted above, 79% of staff survey respondents rated awareness-raising activities as effective (Figure 104). Analysis of providers' reports suggested that they had delivered this activity through several approaches as summarised in Figure 106.

Figure 106: Education and Awareness Raising approaches reported by providers

While advising on the significance of gambling harm may have been implicit within policy advocacy initiatives, thirteen providers reported having carried out purposeful education and awareness-raising activities. These included information **workshops, presentations and education sessions** delivered to various groups such as community organisations, tertiary students, businesses and the city council. Their assessments showed impacts in the form of increased stakeholder willingness towards policy participation.

Materials developed and used for awareness-raising and educational sessions included the use of "local literature" and the "Choice Not Chance brand" in the design of documents, and the use of recent gambling information and statistics that was relevant to a particular area. Other resources included publicity newsletters; posters; informational cards for gambling venues; a venue brochure with gambling support information for venue patrons (in collaboration with the HPA); kaupapa Māori resources for Māori specific sites; information pamphlets and merchandise; and training packages on public health approaches, report writing and policy development.

A few providers reported on specific **cultural approaches** in their awareness-raising efforts to meet the needs of Māori and Pacific communities. For example, the development of "kaupapa Māori resources", the inclusion of Maori health models; the approach of providing "Tikanga Best Practice Training" alongside problem gambling; and emphasis on the need for gambling policies that were guided by Māori health frameworks. A few providers reported on the **organisation of special events** as part of their awareness-raising activities. These included an annual kapa haka event, mayoral debate, and community meetings with mayoral candidates.

A small number of providers reported having made **special submissions** to the Gambling Commission, the Department of Internal Affairs and other relevant parties highlighting the need to maintain awareness of connections between problem gambling and other social issues.

The providers also reported a few challenges. A few reported the lack of awareness of the significance and scope of gambling harms among stakeholder groups (particularly the community). They linked this with the difficulty of recognising the "hidden" harm in problem gambling, thus highlighting a need for clearer messages about problem gambling. One provider reported the need to understand the community context to overcome challenges such as perceptions held by lower socio-economic communities that gambling is a "social activity" or an "entertainment option" that is proximally available to them, and associated misconceptions about the real costs of gambling. Another provider observed that culturally held perceptions about the term 'problem gambling' among some communities posed challenges; they suggested the need for more positively framed messages to facilitate policy support.

5.1.6 Organisational/workplace gambling harm minimisation policies

As detailed in the introduction to this chapter, the objective of this public health service was "to increase adoption of organisational policies that support the reduction of gambling related harm for employees and organisation's client groups" (Ministry of Health, 2010, p. 30).

Over half of the staff survey respondents believed related activities were effectively delivered by their organisations (see rows two and three of Figure 104). Nine providers reported on various approaches (summarised in Figure 107) to encourage the development and implementation of workplace and organisational gambling policies. Target sectors for this area of work included community services, businesses, sports teams, correction facilities, and community groups.

Figure 107: Approaches used to encourage development of organisational/workplace gambling policies

A few providers detailed the need to first **develop their own workplace gambling policies** to progress work in this area. In one case, a provider believed there was an "integrity debate" when it came to advocating for workplace gambling policies, based on a "you can't preach what you don't practice" philosophy. The provider believed that developing their own policy would equip them with the experience and integrity to be able to provide *Policy Development and Implementation* support to others.

To support their work in this area a few providers developed **tools**. For instance, an online workplace survey "to gather information about the attitudes and values about problem gambling" was reported by one provider, and a "self-audit tool that employers/organisations could use to identify areas of potential risk and improvement" was reported by another (see details in the example below).

Best Practice Example 1: Development of an organisational self-audit tool

The process used by a provider for developing an organisational self-audit tool is summarised in the figure below. The tool aimed to support: identification of gambling activities that staff may engage in at work, identification of resource needs, development of "strategies… to reduce financial risk to [the]

workplace/organisation", provision of "specialist assistance" for those needing help, and policy development.
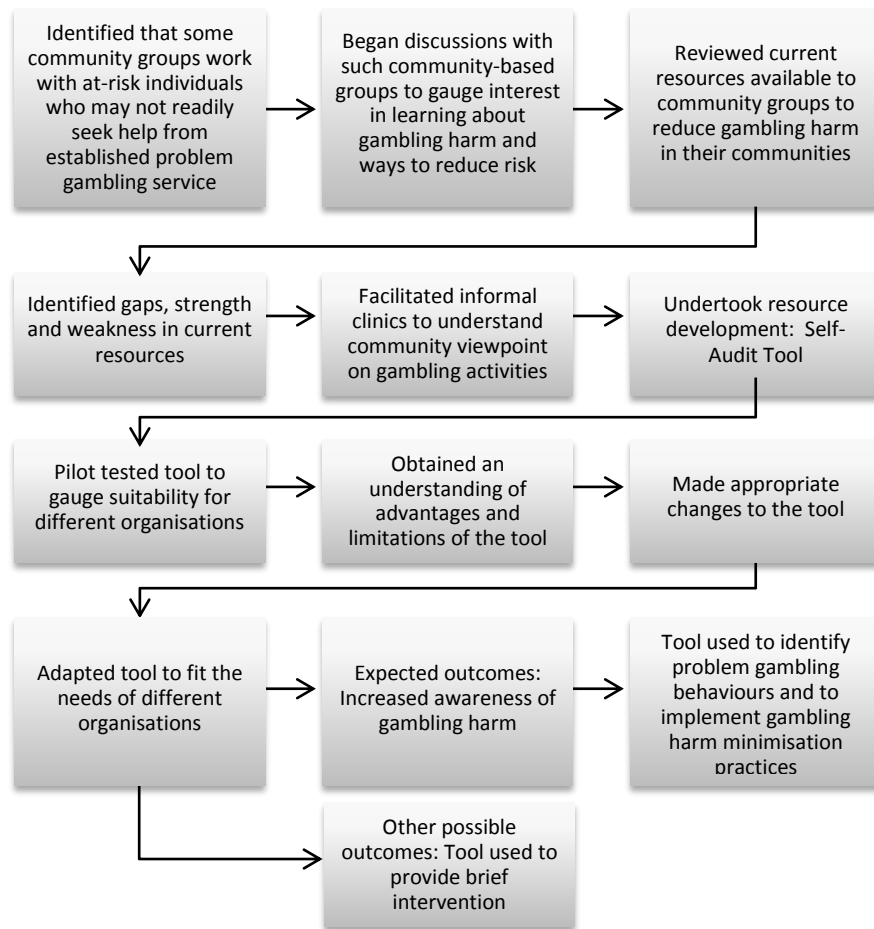
Figure 108: Development of an organisational self-audit tool

The provider expected that the audit tool had the potential to "increase awareness of gambling harm [and] assist workplaces to identify the target behaviours and practices required to minimise the impact of gambling harm." An additional feature in the form of a simple checklist enabled the self-audit tool to also serve as a *Brief Intervention* screening tool.

Some providers attempted to encourage community services such as Work and Income centres to adopt workplace gambling polices, others targeted private businesses and organisations in their area, providing them with **incentives to encourage development of workplace gambling policies**. One provider used the concept of a "business award" to acknowledge local businesses that developed and implemented a harm minimisation policy within their workplace. In their description of progress, this provider noted positive outcomes in terms of some organisations including problem gambling in their harm minimisation policies, while other organisations were slower in making a commitment due to other priorities. Similarly, another provider reported on their work on a "Gambling Harm Education Audit and Awards" programme, to encourage organisations to implement gambling harm minimisation policies.

Prisons were also target stakeholders for some providers. One provider's efforts focused on **awareness raising as an initial step** to encouraging the development of gambling-related policies. A second provider focused on the **possible changes to the existing operational policies** in the Prison Service Operations Manual to address problem gambling behaviours among prisoners.

Sports groups were also approached with one provider reporting success in developing a Team Problem Gambling Policy for a rugby league team and another in developing a Problem Gambling policy for a Touch Committee.

Some providers reported on their ongoing work and successes in working with various types of community groups and community organisations in adopting organisational gambling policies. For instance, one achieved success by using an approach of **extending existing strategic plans** among marae to become "drug and alcohol free by 2020" to include gambling-related policies. Another provider's description of the process used in developing a workplace gambling policy with a Māori development organisation suggested that they had supported the organisation by **actively providing help in drafting and finalising a policy** based on consultation with staff of the organisation.

Policy development support was also offered by **endorsing existing gambling policies**. In one case, a provider reported endorsing existing gambling-related policies among church groups. They noted that some churches they engaged with "already had their own policy regarding gambling". Another approach reported by some providers was an effort to **include problem gaming within broader health-related policies**. For instance, the inclusion of problem gambling within 'whānau ora' policies.

However, the majority of provider reports provided little evidence of awareness-raising material content or other activities designed to raise awareness on the **relevance of gambling-related policies to the core business of targeted sectors**. Considering that a majority of staff survey respondents rated this as effectively delivered, it is likely they perceive these activities as implicit in many services they deliver.

Providers also reported a number of barriers to the adoption of workplace gambling policies among organisations. Some providers identified that getting stakeholders to recognise and acknowledge that gambling was an issue relevant to them and worthy of attention was often the first hurdle. They cited a need for information provision and more awareness-raising.

Other barriers included:

- Underlying perceptions that gambling was a personal rather a "public safety" issue and resistance from social gamblers

- Perceptions that problem gambling policies were not their responsibility

- Non-recognition of gambling harm as a workplace issue

- Perceptions about the adequacy of policies already in place

- Other work area priorities or other pressing organisational issues such as redundancies and structural changes

- Time and resource limitations

- The fact that there is no legal requirement to engage.

In overcoming challenges, two providers believed that they needed first to understand the context of these organisations before attempting to influence their policy uptake. Then to present policies as being beneficial to their organisation, negating the perception that policy uptake increased workload. Two other providers reported on the value of having policy exemplars to support their work.

Some providers detailed instances where *stakeholders' lack of interest or conditional interest* had acted as a barrier. For three providers, conditional interest was encountered among stakeholders, notably sports teams and schools, who were supportive of gambling policies provided that they did not result in financial or administrative costs. To engage such organisations in policy development, additional to information provision there was a need to offer screening tools and to propose practice that were not perceived as "intrusive," and to ensure they were clear about the availability of support from problem gambling clinical services.

5.1.7   Policies on non-gambling fundraising

Another activity described in the PGPH-01 Purchase Unit Description was "encouraging the development and adoption of policies that encourage and promote methods of fund-raising that do not involve gambling" (Ministry of Health, 2010, p. 30).

One provider reported on their work with a women's group, which they believed might have led to the successful development of a policy on non-gambling fundraising. Their awareness-raising efforts led to the group's recognition of gambling harms and subsequent formulation of a policy to guide group members in funding applications. The policy mandated that members do not apply for funds generated from gambling proceeds.

However, very few providers reported examples of successful development of policies on non-gambling fundraising. Providers have found this to be a particularly challenging policy activity. Two providers reported that it was often difficult to secure alternative funding sources for groups that were currently dependent on gambling funds. Nonetheless, some reported their efforts to encourage and support non-gambling fundraising practice and encourage alternative fundraising methods such as through the sale of food and other items.

Just over half of staff survey respondents (55%) rated the activity of supporting development of policies on non-gambling fundraising as one that their organisations had effectively carried out (fourth row of Figure 104). A few indicated that this activity was not performed (12%) while others indicated they did not know (21%).

Focus group participants' comments on what they had done to enhance the effectiveness of this activity suggested that the focus remained largely on encouraging alternative fundraising practices.

> We have promoted cultural activities, such as kapa haka, [and]…looking at old traditional flax [weaving], so they can sell the product and promote the cultural awareness as well. Those are some ways that we have worked with…

> We do lots of work with sports groups and we help to fundraise by doing food related things, hāngī things, and will help them with the prep[aration]. We teach them how to make fried bread and adding different elements. In that way we are teaching them skills as well as helping them, with the [sales aspects]… And we find this very effective…

> [A local Girl Guides group who] used to accept [gambling] funding, [was encouraged to go] back to doing door knocking selling things in the community… Their membership had gone down but after they started interacting more with their community their club grew, because they were reconnecting. So that is one the things that we are encouraging people…

Participants' discussions also suggested that they found the expected outcome of non-acceptance of gambling funds in relation to this activity to be debatable. They argued that groups benefitting from such funds were often from other higher socio-economic communities and not from the communities experiencing gambling harms.

> …It is our whānau that is spending the money, why should we let someone else take that money? [We suggest that they] apply for the money because it is our whānau money that has been spent. When it comes to targeted sports or rescue services, not one of their parents' gamble, so why should they apply for the money. There should be a big fight at the council's chambers because they want the funding. [I question how many of their parents engage in gambling] which gives them the right to apply for the money. Because I know the whānau that do [spend money gambling] and it is not one of their family… Yet it is not seen as appropriate that a gambling service would encourage whānau to apply for the funding that is rightfully theirs because it is not professional. We have been smacked on the hands. But I think I am not going to let some other [group] take the funding when our tamariki, [are in need of the funding and lacking the very basics].

> It is a fine line that needs balancing. Like you were saying, in some areas where the money is getting spent, why shouldn't those groups be benefiting from it?

The notion of providers themselves being funded by gambling proceeds was also noted.

> The gambling is paying our wages. That is the other thing that you have got to look at.

> Yes, exactly. I had an interesting conversation with [our] youth worker… [In our organisation] there is a policy that [staff] cannot apply for those grants. So he is struggling to get money [to fund his youth project] and he was unable to apply for those grants. When he found out that we get paid from gambling money, [he questioned the fairness of it]. And I understand that.

One focus group participant commented that they were supportive of Councils rather than Trusts being responsible for distributing gambling funds.

5.1.8 Public policy development and implementation

Activities described in the PGPH-01 Purchase Unit Description included "advocating, encouraging, assisting, or providing advice for the development of healthy public policy and planning that will contribute to the reduction of gambling related harms (both internally and externally to participating organisations)" (Ministry of Health, 2010, p. 30). Key expected processes included providing "policy development and support, policy implementation and support, monitoring and follow-up" (Ministry of Health, 2010, p. 30). Service providers were requested to report on activities they had "delivered to encourage agencies to develop problem gambling and problem gambling harm minimisation policies" (Ministry of Health, 2010, p. 30).

Several providers reported on their efforts to support the Gambling (Gambling Harm Reduction) Amendment Bill. The purpose of this Amendment Bill was to empower local communities to decide on the locality of gaming machines and distribution of profits. To support this Bill, providers made a range of efforts to increase community engagement in the process including organising community meetings, making submissions and gathering signatures for a submission to Parliament. A challenge noted by one provider was a combination of a lack of resources, the need to remain politically neutral as a publicly funded service provider, and the counteractive lobbying by the gambling industry.

One provider reported on their efforts to make a submission in relation to regulation 16 (g) of the *Gambling (Class 4 Net Proceeds) Regulations 2004* which concerns the distribution of profits by gaming machine societies. Their efforts to undertake a research project on the distribution of grants was, however, a challenge due to the lack of readily available information.

5.1.9 Class 4 (gaming machine) venue policies

Providers contracted to deliver PGPH-01 were also required to work "with territorial local authorities and other stakeholders to address Class 4 gaming machine venue policies and other planning issues in relation to community concerns regarding density and locality of gaming venues" (Ministry of Health, 2010, p. 30).

Approximately two-thirds of staff survey respondents reported that their organisations were effective in addressing Class 4 venue policies by working with territorial local authorities (67%), incorporating community concerns regarding gaming venue density and locality (61%) and working with other stakeholders (64%) (See rows 5 through to 7 in Figure 104). Councils' Class 4 venue policy[46] and the associated "sinking lid" approach to electronic gaming machine numbers[47] (which aims to reduce the number of gaming machine venues in a district through restrictions on new consents) was often mentioned in providers' reports. All providers described activities that were relevant in some way to these expected outputs and processes in their six-monthly reports (summarised in Figure 109).

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[46] Councils are required under the Gambling Act 2003 to have a Class 4 venue policy taking into account the social impacts of gambling in the respective territory (The New Zealand Government, 2013). Class 4 venue policies need to be reviewed every three years.

[47] This approach is often colloquially referred to as "sinking lid policy". The adoption of a "sinking lid" approach to electronic gaming machine numbers means that when an existing Class 4 venue closes, the Council does not provide consent for its relocation, ownership transfer or for the establishment of a new venue in its place, leading to a declining number of gaming machines. In other words, this means that consent for new gaming machine venues is not granted.

Figure 109: Policy development activities reported by providers

Policy advocacy often involved **conversations and discussions with key stakeholders** including attending meetings, hui and fora (Figure 110). Discussions were mainly with city councillors and members of the public. The discussions included providing an overview of current gambling policies, descriptions of how a multi-venue exclusion policy might work in the region, on-going promotion of council gambling policy review processes including the benefits and consequences, and the connections between problem gambling and issues such as domestic violence and other crime.
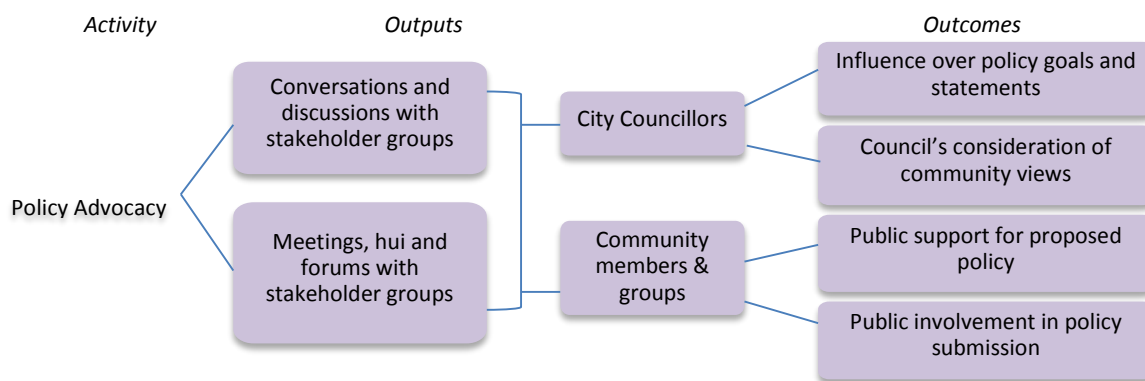
Figure 110: Policy advocacy through meetings and conversations

Providers **enabled community and stakeholder involvement in their council's policy review process**. Eleven providers reported a range of efforts to encourage community involvement in policy-related processes including the formation of special groups to support their policy advocacy work, providing groups with a venue to discuss problem gambling as an issue in their community, and gathering signatures at public events and festivals. A value of encouraging community involvement was that it generated public pressure (either directly or indirectly through the media), which then influenced policy decision making. As shown in Figure 110, these activity outputs led to outcomes such as policy influence, community involvement and public support for policies. Other reported outcomes included enhanced public knowledge of gambling-harm and increased public awareness of their right to be involved in their council's policy review process.

Providers also detailed **resources developed to support community involvement in the policy process**. These included promotional materials, submission-related information, postcards highlighting the council's review process, petition forms, submission forms and submission templates. As explained in one provider's report, these materials were developed "to make it easier for the community to have their say".

Several providers reported on efforts to influence council decision-making through their own research, **submissions, and written statements**, often supplying appropriate facts that highlight gambling harms to support evidence-based policy development. They made submissions to local boards, at council public forums, in relation to regional plans and the period preceding councils' Class 4 gambling and policy review processes. Some providers indicated making submissions to several city councils. Written submissions were more common but oral submissions were also reported.

Seven providers reported **policy advocacy through the media** (including radio, print and television) to reach a broader audience. Media engagement included efforts to raise awareness and to influence policy outcomes. Examples included media releases, letters to the editor, advertisements and some media interviews.

Best Practice Example 2: Engagement with multiple ethnic media channels

One provider engaged with several ethnic specific media channels to reach Tongan and Samoan communities. Their systematic media engagement process is described in Figure 111.
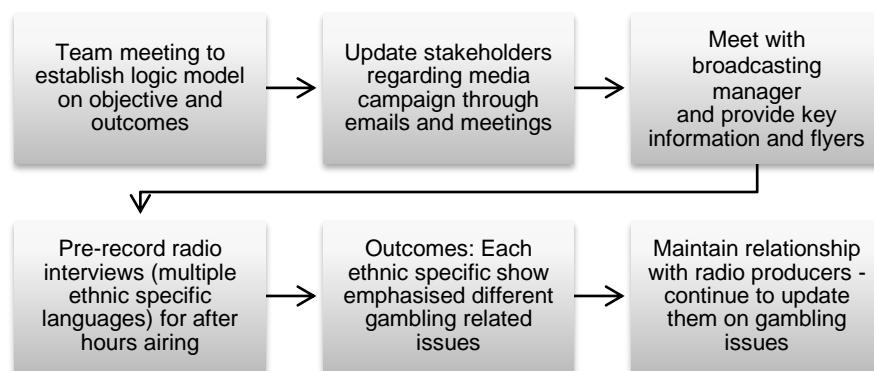
Figure 111: Media engagement to raise awareness

The provider reported delivering several "radio presentations and talks which included the importance of policy development." They also contributed to live telephone interviews in the Samoan language on topics focused on "raising awareness of gambling harm and … policy submission". They reported that outcomes included increases in "broadcasting of information on health and social risks associated with gambling in the Samoan language", "public discussion and debates on gambling harm and related issues" and "opportunities for [the] Samoan community to send policy submission to Parliament". Subsequently, the provider received numerous "calls from the community wanting more information" and requesting policy submission forms.

Some providers mentioned challenges and barriers in efforts towards achieving policy outcomes. These included the lack of clarity in council policy review timing, uncertainties around council decision-making processes, limitations in council policy review procedures, a perceived stake by some city councillors in the gambling business and resistance from gambling venue operators. A few providers also mentioned that the *perceptions about the economic benefits from gambling revenue* were a challenge to policy advocacy efforts in general.

Nevertheless, a few providers reported that their efforts were successful in influencing councils' decisions in relation to the Class 4 gaming machine venue policy. Additionally, one provider described receiving positive comments and being sought for information, as indicators of the success of their work. Another reported that their policy advocacy work had resulted in other unexpected outcomes such as increased awareness and help-seeking behaviour.

5.1.10   Other policy outcomes

While the focus of providers' six-monthly reports was largely on Class 4 gaming machine venue policies, four providers also mentioned the inclusion of Racing Board (TAB) Venue Policy in their policy advocacy work. Two providers reported on work in support of alcohol-related policies and legislation due to the associations with gambling harm.

5.1.11   Social impact assessments of gambling harm

The PGPH-01 Purchase Unit Description expected providers to "contribute to and participate in any social impact assessment of gambling harm for" their respective districts (Ministry of Health, 2010, p. 30).

The majority of providers' reports did not contain clear or explicit evidence of their participation in, or contribution towards, social impact assessments. Only three providers reported providing related support to district health boards and councils. Their support included responding to a council's request

for assistance in preparing social impact assessments, drafting policies and completing a social impact assessment questionnaire. However, 56% of staff survey respondents reported that their organisations had effectively delivered this activity (see row seven of Figure 104).

Two providers mentioned plans by their city council to undertake a social impact assessment with no subsequent details. Other providers simply referred to the various social impacts of gambling with some noting currently available evidence in their reports while others mentioned the need for, concerns over, efforts to address, or intent to address the social impacts of gambling in their reports. In discussing the implementation and outcomes of this activity, public health focus groups participants suggested its feasibility was dependent on local council interest.

> …That is in relation to the Gambling Act. It says that each territorial authority has to do a policy review every three years and part of the review can include a social impact assessment. So, the problem with this is that, we can contribute and participate to it, if the local territorial authority is willing to do it in the first place. They don't have to do it. It is really in their court as to whether or not one happens in your area when they are doing a review of their policy. And yes, of course, in terms of being involved in the social impact assessment, all of our services probably would want to be involved and contribute to it. But this is generally a social impact assessment in terms of policy it is run by the local council. [They choose not to]… because it is expensive, if you are going to do a proper social impact assessment it is expensive. And the councils, they don't want to spend that money to see if gambling is that much of an issue in their area. I know [one] council did. But we were really lucky, we had a policy change that were really on to it and really supportive of us.

Focus group participants also commented that decisions around social impact assessments would be different for different councils and dependent on council members and policy staff.

> It also depends on the council members but also on their policy staff. Because there is an option as well. There are two options; they can both review their policy and do a social impact assessment. Or they can just roll over their current policies.

5.1.12 Success indicators: Policy Development and Implementation

"The number of organisations (community, private sector etc.) that have adopted gambling harm reduction policies in the target community" and "the number of organisations (community, private sector etc.) that are actively addressing or working to reduce gambling related harm in the target community as part of their core service" were noted as indicators in the PGPH-01 Purchase Unit Description.

The providers' narrative reports showed that although providers did not report outcome-related indicators in the form of exact numbers of organisations that had adopted or implemented policies, they reported a range of policy outcomes. As shown in Figure 112, additional to successfully influencing council decisions in relation to Class 4 gaming machine venues, a few providers also reported on other policy outcomes such as Racing Board (TAB) Venue Policy and the Gambling (Gambling Harm Reduction) Amendment Bill, and inclusion of problem gambling in wider health-related policies. Providers also supported a range of different organisations in developing workplace gambling policies.

The reports also suggested a number of other output-related indicators. Success was reported in the development of effective working relationships with stakeholder groups, and for various education and awareness raising activities that they organised. A number of providers also noted the inclusion of community and stakeholder groups in policy development processes as a successful output.

Figure 112: Successful areas of policy outcomes

Staff survey respondents' beliefs about key indicators of successful *Policy Development and Implementation* fitted within three broad categories: activity-related indicators, output indicators and outcome indicators, with two providing more than one indicator type.

Ten respondents described implementation of awareness-raising, relationship development and community engagement activities that was needed for this purchase unit.

> Inform the community of the current gambling situation, so that they can have an informed choice and encourage them to give feedback to the government.

> Raising council and local community awareness around gambling harm.

> Robust relationship with gambling industry and local government in asking the hard questions in a respectful but critical manner.

Three respondents provided output indicators: enhanced awareness, increased community participation and organisational action.

> Community members having input into the policy (submissions)… The number of organisations that are actively addressing or working to reduce gambling- related harm in their organisation and local community.

Likewise, one public health focus group respondent suggested that output in the form of enhanced community willingness to participate in change was an indicator of effective delivery of public health activities.

> …Once we run public health workshop or training, we find that more people are willing to do something. For example when we are doing submissions, a good number of people who have gone through training with us, want to take action; they actually collect some kind of support or submission from their own personal professional network …In the submissions they collected, I was surprised to see so many different names… because of our public health approach they know what the problem is and how to take action. I see that clearly that they are more willing to participate in creating change.

Comments by five staff survey respondents suggested outcome indicators including policy adoption and resultant impacts such as reduced gambling opportunities.

> …Healthy policies (sinking lid) adopted that reduce gambling opportunities especially in areas where there are high numbers of EGM venues… Over time, a reduction in the number of EGM venues… Number of TLAs and/or organisations that adopt policies that reduce gambling opportunities and

gambling related harm, e.g. sinking lid or cap, not accepting direct gambling funding, workplace gambling policy…

5.1.13 Adapted Logic Model: Delivery of Policy Development and Implementation

Based on the findings from the analysis of the six-monthly narrative reports, an adapted logic model is shown in Figure 113. Additional to the three key areas of inputs identified by the Ministry, providers' reports suggested that development of appropriate resources was another area of input required for service delivery. Resource development included consideration of culture appropriate resources for ethnic-specific community groups, and the use of recent gambling information and statistics.

PGPH-01 Policy Development and Implementation
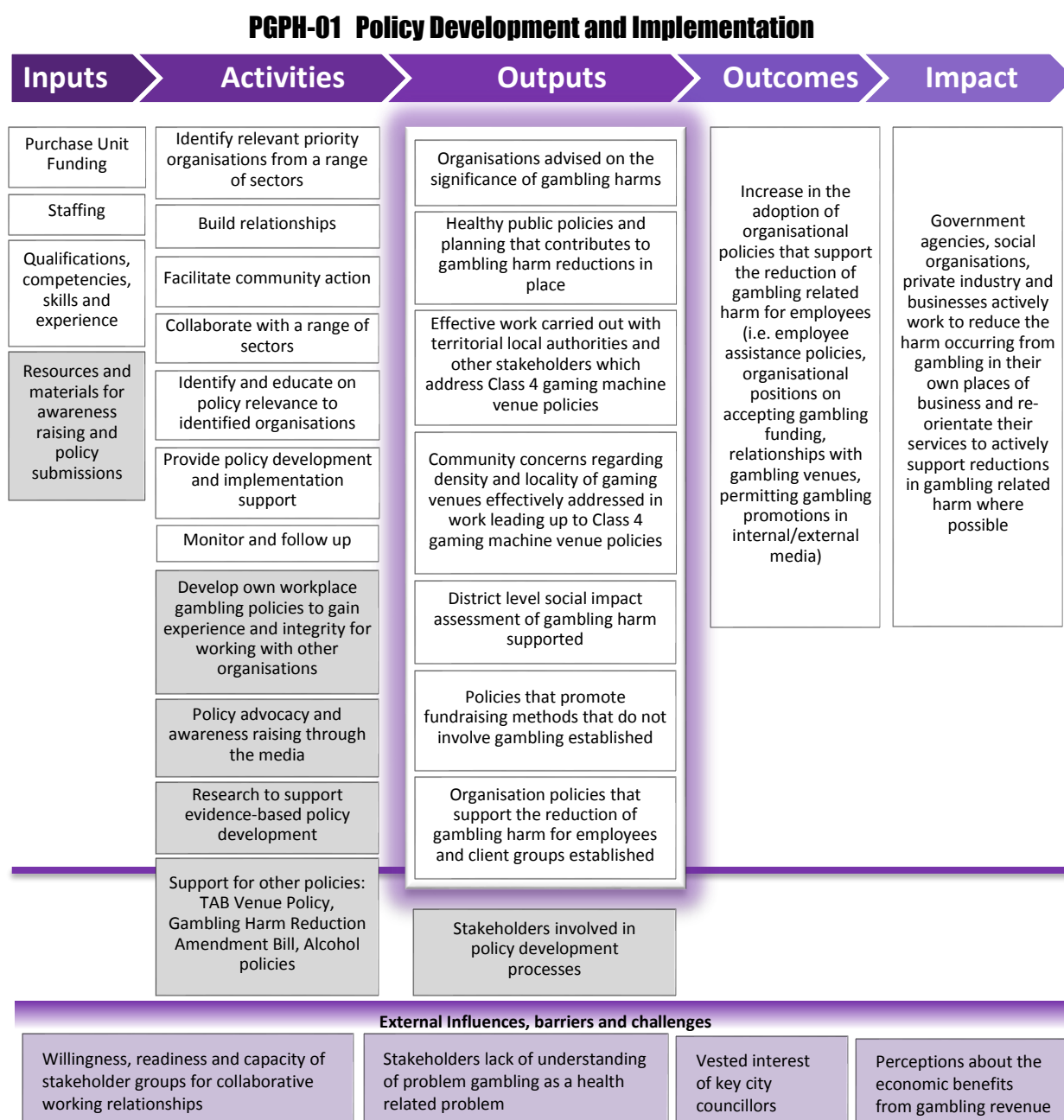
Figure 113: Adapted Logic Model: Policy Development and Implementation

As detailed in the sections above, providers faced several challenges when delivering this public health service, some of which appeared to be beyond their capacity to address. For instance, other competing issues may mean lower priority given to problem gambling among some stakeholder groups. Class 4 policy outcomes were often determined by a range of factors and while much effort could be put into

encouraging community involvement and strengthening support for the desired policy outcomes, policy decisions were also influenced by views held by a local council about the severity of gambling harm or of its economic benefits. These observations and the range of barriers and challenges identified in the section above suggest the need to consider the range of possible external influences that can have an impact on the delivery of this public health service.

5.2   Safe Gambling Environments (PGPH-02)

The Safe Gambling Environments Public Health Service aims "to ensure that gambling environments are safe and provide effective and appropriate harm minimisation activities" (Ministry of Health, 2010, p. 32). The activities and key processes identified by the Ministry of Health in the PGPH-02 Purchase Unit Description are summarised in a preliminary logic model (Figure 114).
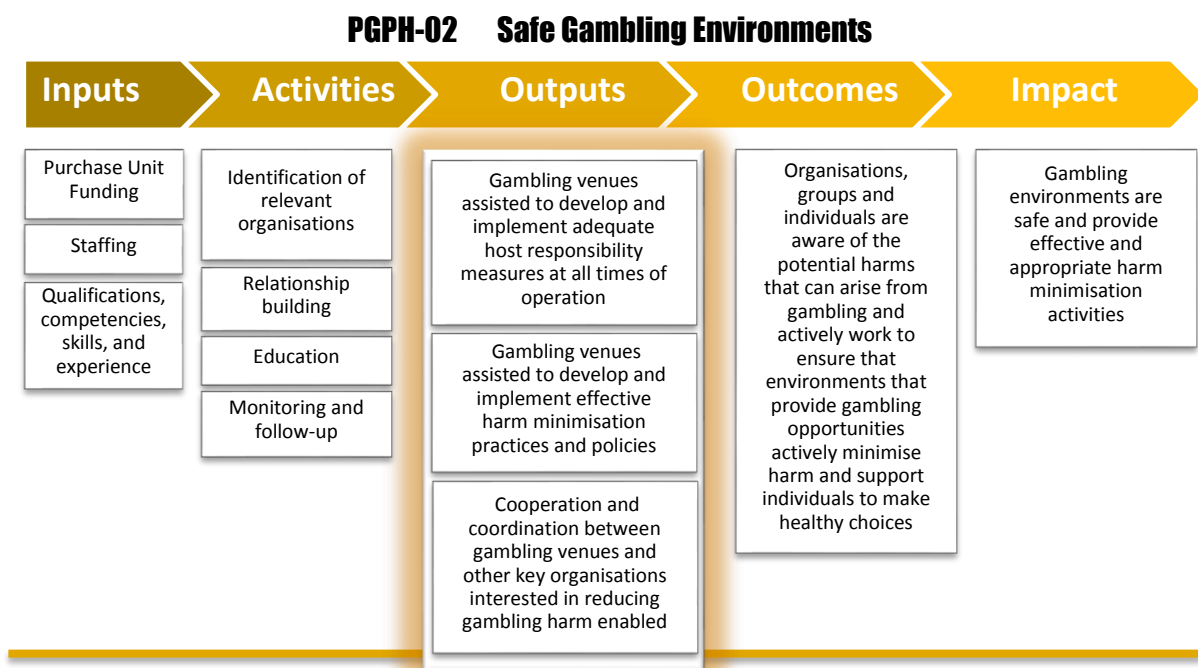
Figure 114: Preliminary Logic Model: Safe Gambling Environments

The findings from the analysis of narrative reports presented in this chapter are based on the reporting of 15 providers. Although the PGPH-02 purchase unit was contracted to 14 providers, one additional provider reported on work for this purchase unit in the second half of their reporting period. Their reporting was included in the document analysis. Four of the eight providers selected to participate in the staff survey and focus groups for this evaluation were contracted to deliver the PGPH-02 purchase units.

5.2.1   Literature review

The literature suggested that this primary prevention public health service is likely to be particularly challenging considering the possibility of partial responses from gambling venue operators. In New South Wales, Australia, a survey to gauge how managers of registered clubs (gambling operators) prioritised economic, legal, ethical and discretionary principles found that these club managers tended

to favour practice that focused on minimising secondary harm[48] followed by reactive primary interventions[49] (Hing, 2001). They were less in favour of a proactive approach to primary intervention[50] and discretionary practice[51]. Such principles and practices were contrary to those urged by key stakeholder groups, that is, the need for a more balanced and holistic set of principles and management practices for ensuring responsible gambling (Hing, 2001). These findings are also of concern considering that in another Australian study, the perspectives of problem gamblers indicated both reactive and proactive measures to be effective harm minimisation measures. A 2009 counselling services client survey (219 respondents unequally distributed in seven jurisdictions) by the Australian Productivity Commission found problem gamblers believed the removal of ATM machines from gambling venues, technologies that enabled limit setting, and technologies that enabled self-exclusion as measures that were most likely to work (Australian Government Productivity Commission, 2010). The problem gamblers regarded signage in venues (suggesting that repeated gambling leads to increases in money loss) to be the least effective.

Training for staff of gambling venues

One approach mentioned in the literature for ensuring safe gambling environments is through the provision of training programmes for staff of gambling venues. In Quebec (Canada), Giroux, Boutin, Ladouceur, Lachance and Dufour (2008) reported results of an evaluation of a training workshop for casino employees that focused on the issue of problem gambling, ways of helping gamblers who may be experiencing crisis as well as introducing them to helpful resources that were available for gamblers and for employees. Their evaluation, which relied on self-administered questionnaires (n=789) before and after the training, found improved understanding about problem gambling and notions of chance and randomness. Participants became more reassured about their role in spotting gamblers facing crisis and exhibited improved understanding about the procedures for helping gamblers. A telephone follow-up after six months revealed that understanding of the notions of randomness was maintained. The casino employees also maintained belief that it was important that they received information about the availability of help and resources. For instance, one of the resources available for problem gamblers at the casino was a self-exclusion programme; employees need to be well informed about such resources that can be used to assist problem gamblers. However, some of their perceptions about problem gambling and procedures for helping gamblers in crisis were not well sustained at six months. Considering this lack, the evaluators recommended the provision of additional information after training, such as refresher sessions and print and audio-visual information, to keep staff informed.

Also in Quebec, Canada, another evaluation to gauge the effectiveness of a training programme among video lottery retailers found that trained staff exhibited improved understanding of problem gambling and ability to identify the right moment to assist a gambler (Ladouceur *et al.*, 2004). Compared to those who were untrained, staff who had received training tended to approach problem gamblers more frequently.

Similarly, an evaluation of a multimedia responsible gambling programme for casino employees (n=217) in the United States of America, found that from baseline to follow-up the programme increased staff understanding of responsible gambling concepts (LaPlante, Gray, LaBrie, Kleschinsky, & Shaffer, 2012). However, while the programme was effective in developing new knowledge, it was

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[48] Strategies to minimise secondary harm include informative materials on the signs or indicators of problem gambling and contact information of tertiary intervention providers. The aim is to enable people to recognise their own or others' problem gambling and become aware of what they can do to address the problem (Hing, 2001).

[49] Reactive primary interventions include measures such as self-exclusion programmes that restrict a gambler's access to gambling venues. The aim is to take away completely or reduce opportunities to engage in harm causing gambling (Hing, 2001).

[50] Proactive primary interventions include strategies that make it difficult for gamblers to obtain additional cash by, for example, enforcing a cool-off period after big wins, restricting ATM and EFTPOS withdrawals and the cashing of cheques. The objective is to restrict gamblers from gambling beyond their means and help them make rational decisions (Hing, 2001).

[51] Discretionary strategies for responsible gambling include financial and in-kind support for initiatives and measures that address problem gambling. For instance, in-kind support could be provided to develop relationships between the gambling industry and the public health sector to facilitate problem gambling awareness raising activities, referral processes, and data collection activities that enable the development of informed responsible gambling strategies at gambling venues. Financial support could be in the form of donations provided to problem gambling counselling services and to supported related research (Hing, 2001).

not as effective in rectifying pre-existing erroneous beliefs. The evaluators suggested that the development:

> …of responsible gambling programs should take note of this finding and devote more resources to correcting false pre-existing beliefs during employee training. To do so, training programs must have an understanding of common pre-existing misconceptions about gambling and the public among casino employees (LaPlante *et al.*, 2012, p. 183).

Dufour, Ladouceur and Giroux (2010) carried out a controlled experimental evaluation (N=456) of a training session provided for employees of a video lottery terminal (VLT) venue in Quebec, Canada on ways to help to help problem gamblers. They found that the training improved staff attitudes towards problem gamblers, developed their understanding of how they could help and resulted in behavioural changes (as evidenced in their reactions towards pseudo help-seeking patrons). However, considering that behavioural changes among employees after the training were not fully sustained at an eight-month follow-up phase, the evaluators suggested that such training programmes should incorporate strategies to maintain long-term positive effects.

Responsible gambling codes of practice

Another approach for providing safe gambling environments is through responsible gambling codes of practice. In Australia, Breen and Hing (2008) reported an evaluation of Queensland's voluntary industry code of practice using qualitative methodologies (interviews with staff and managers of 14 gambling venues). They found that of the six practice areas within the Code, respondents believed that the one relating to physical environments (which included setting up of practices within the gambling premises that encourage responsible gambling) was the most effective. Providing information (which included the provision of information such as the odds of winning, help availability and gambling policy) was viewed as the least effective (Breen & Hing, 2008). Breen and Hing also found that training and education of staff and managers were regarded as an important factor for encouraging the adoption and implementation of such a code of practice.

Responsible gambling tools and warning messages

Responsible gambling and warning messages were also noted as tools that can be used to promote safe gambling environments; a number of evaluations on the effectiveness of this approach note its potential. A study examining the effects of responsible gambling tools in video lottery terminal screens showed that interrupting the gambling session through the use of pauses or pop-up messages (with information about randomness in gambling) reduced the severity of erroneous beliefs and persistence to play (Cloutier, Ladouceur, & Sévigny, 2006). This suggested that the insertion of messages and pauses into games could be used as an approach for encouraging responsible gambling by helping gamblers stay informed while they gamble.

Other evaluations have highlighted the potential of warning messages and provided findings for enhancing the effectiveness of such messages. A study exploring the potential effectiveness of threatening warning messages for addressing compulsive gambling by Munoz, Chebat and Suissa (2010) showed that warnings with higher threats and the medical source of warnings enhanced the depth of information processing, which in turn positively affected changes in attitude change and compliance intentions. Monaghan and Blaszczynski's (2010a) comparison of two types of electronic gaming machine warning messages suggested a focus on providing gamblers with self-appraisal and self-regulation skills, rather than simplistic provision of information on winning odds, to maximise the effectiveness of these messages as a public health tool. Monaghan and Blaszczynski's (2010b) studies on warning signs in gambling venues and on electronic gaming machines suggested the effectiveness of pop-up messages compared to static messages; the former was recalled more effectively and resulted in a significantly greater impact on gamblers' thoughts and behaviours within-session. An evaluation to determine optimal placement for pop-up messages by Gainsbury, Aro, Ball, Tobar and Russell (2015) involving a survey of regular gamblers (n=667) found that dynamic warning messages placed in the middle of the EGM screen were better recollected by gamblers.

In the United States, an experiment involving a heterogeneous group of college-age gamblers (N=101) was used to gauge if warning[52] and warning plus Brief Intervention messages[53] were effective in increasing knowledge about the odds of winning, altering levels of irrational beliefs, and influencing behaviours when playing a computerised roulette game (Steenbergh, Whelan, Meyers, May, & Floyd, 2004). The evaluation used previously designed instruments (*Gamblers' Beliefs Questionnaire* and *Gambling Self-efficacy Questionnaire*) as well as specifically designed tools (*Gambling History Questionnaire*, *Gambling Knowledge*, *Limit Setting Questionnaire* and a recording form for the roulette) to evaluate the outcomes of the intervention. Although the messages did not significantly have an impact on gambling behaviour, in comparison to the control group, participants who were exposed to the messages showed a higher level of knowledge about gambling risk and reduced gambling-related irrational beliefs. The study suggested the informational value of the warning messages and potential of limit-setting strategies in producing cognitive change among gamblers.

A more recent study in New Zealand investigating the effects of pop-up messages on gambling and problem gambling behaviour reported that, for one-quarter of the gamblers who were aware of the existence of these messages, they assisted gamblers to control their time and money spent gambling. The study also noted that pop-up messages could be used to help support gamblers to make an informed choice about whether to continue gambling (Palmer du Preez *et al*., 2014).

5.2.2 Effectiveness of PGPH-02 activities (staff views)

Figure 115 shows staff ratings of the effectiveness of activities related to safe gambling environments. As shown in the first four rows, over half of staff survey respondents reported that their organisations were effective in *developing working relationships with gambling venues*, contributing to their *knowledge development* and *supporting the development and implementation of host responsibility measures*.
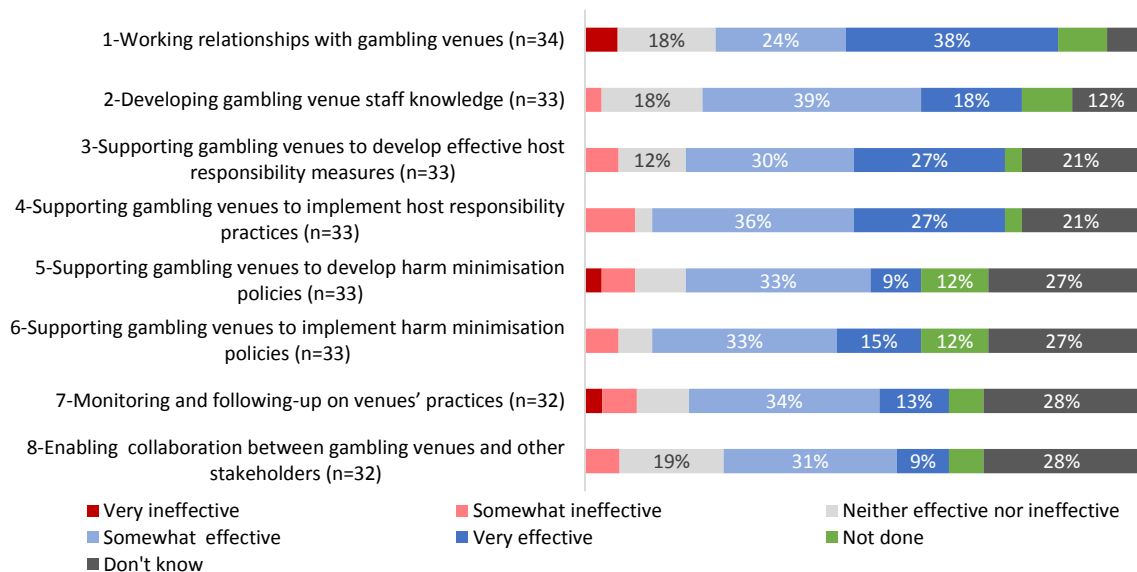
Figure 115: Effectiveness of Safe Gambling Environments activities as rated by staff

Supporting the development and implementation of venue harm minimisation policies, *monitoring and follow-up*, and *enabling venue collaboration with other stakeholders* were rated by less than half of staff survey respondents as activities that were effectively carried out (see rows 5 through to 8 in Figure

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[52] "Those in the Warning condition received a 22-second computer delivered audio-visual message that explained the odds of winning at roulette and warned viewers of the risks associated with gambling" (Steenbergh et al., 2004, p.7).

[53] Those in the "Warning Plus Brief Intervention" treatment "condition received the warning message …as well as limit-setting and belief-modification components designed to produce incremental effects on gamblers' beliefs and wagering behaviour" (Steenbergh et al., 2004, p. 8)

115). Over a quarter indicated that they were unsure about the effectiveness of these activities. Supporting this finding, there are few examples of success in relation to these activities in the providers' narrative reports.

5.2.3 Providers' knowledge development

Two providers reported on activities carried out for the purpose of their own knowledge development, suggesting an area of input needed for the delivery of this purchase unit. The first provider indicated making an effort to keep updated with recent related data; the second reported having attended a seminar on host responsibility organised by another organisation. Other providers noted that meetings with various stakeholders and visits to venues had indirectly contributed to their knowledge, for example about gamblers' trends and about related processes such as implementation of Multi-venue Exclusions.

5.2.4 Identification of relevant organisations and relationship building

Key processes in the PGPH-02 Purchase Unit Description included "identification of relevant organisations" and "relationship building" (Ministry of Health, 2008b, p. 32).

The document analysis showed that all providers detailed the various organisations and groups they had worked with in delivering this purchase unit. These fell within four broad categories shown in Figure 116. Providers made efforts to develop working relationships with Class 4 gambling venues, gambling trusts and casinos through visits and provision of resources and support for implementing host responsibility measures. All providers reported that they visited gambling venues with some indicating they made regular visits. Visits to gambling venues (Class 4 venues and casinos) were with the aim of building and maintaining relationships. Providers also took advantage of these visits to gain information from venue staff about gamblers to support other associated areas of work.

Class 4 Gambling Venues	+	Gaming Machine Societies / Gambling Trusts	+	Casinos	+	Stakeholders: Community groups, DIA, other PGPH Service providers
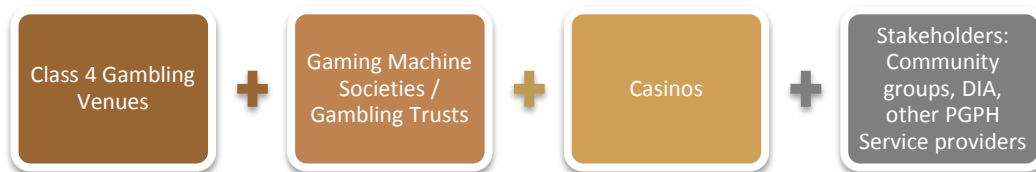
Figure 116: Groups and organisations identified for PGPH-02

For some providers, part of the work in delivering this purchase unit included discussions and collaboration with appropriate stakeholders such as community groups, other PGPH providers, the Department of Internal Affairs (DIA) and relevant government agencies. Discussions around Multi Venue Exclusion (MVE[54]) implementation and encouraging stakeholder involvement in enabling safer gambling environments. Some providers reported on their own development in gaining an understanding of the MVE process (including recent changes to the process) and its connections to their service contracts, through these discussions with stakeholders.

Best Practice Example 1: Establishing a "symbiotic" relationship with venues

One provider reported on their relationship development efforts, which included encouraging MVE and host responsibility policy development at gaming machine venues. Their approach was to establish a "symbiotic" relationship with the Trust licensed to operate the gaming machines. Such a relationship was reported to result in value for both parties; this was based on the premise that the provider would be able to assist the Trust in "meeting their regulatory requirements," "offer support towards sector innovation," and "reduce reputation risk". In turn, "a good strategic relationship" with the Trust would open doors for "problem gambling harm minimisation" initiatives that would "have both public health

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[54] Multi-venue exclusion (MVE) is a process that enables gamblers to exclude themselves from multiple venues without needing to visit each venue.

and clinical intervention aspects". The relationship development process envisaged and partly implemented by this provider is described in Figure 117.
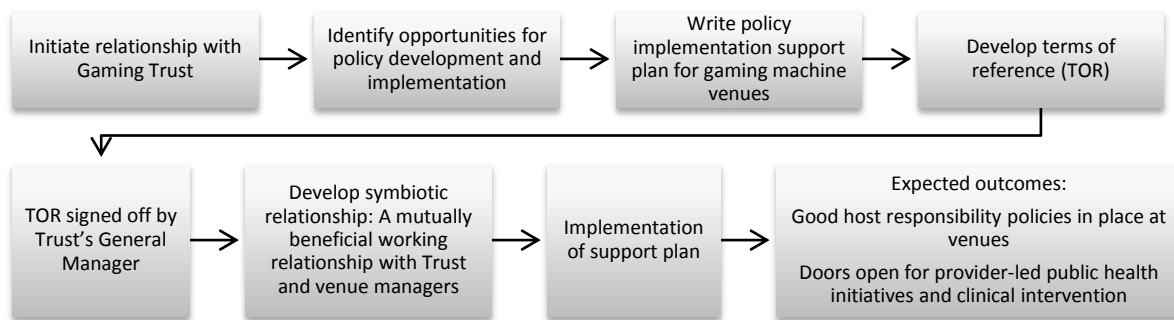
Figure 117: Establishing a "symbiotic" relationship with venues

Although visits to venues proved to be valuable for a range of reasons (detailed in the subsequent sections), relationship development with venues was often a time consuming process and could entail additional administrative work whenever there was a change in venue ownership. Three providers suggested that developing relationships with venues often required diplomacy, especially if venues felt that they were being monitored or if they were undergoing DIA investigations. One provider experienced unexplainable changes in attitudes among venue operators' with regard to working relationships. They reported on how they overcame this challenge by employing a different communication approach of requesting comments from venues on the resources they supplied. Although 62% of staff survey respondents indicated that their organisations were effective in developing working relationships with venues (Figure 115), discussions among public health focus group participants confirmed that this was difficult to achieve.

> I engage with them once a month and I [have established a close relationship with them]. But it has taken years to get there; they have different managers at different times of the day, and I make it my business to go and meet those managers once a month, so they know who I am. And I ask "When are you having the next harm minimisation training?" And I invite myself. [They take my name down but it often doesn't happen] but it is about building those relationships.

> There are different staff as well [at different times]. When I go in, there will be a manager or owner with one perspective, and when you go another time, and talk to staff, they are completely aware of it.

> It is a bit paradoxical but it is true that complaining actually works. What I meant by complaining is, when we talk to staff about what they do; actually they don't want to lose their licence…

5.2.5 Venue host responsibility measures and harm minimisation policies

The PGPH-02 Purchase Unit Description outlines that services would include activities that "assist gaming venues to develop, promote, support and implement adequate host responsibility measures at all times the venue is operating" (Ministry of Health 2010, p. 32). Key processes would include "harm minimisation policy development and support, policy implementation and support" and "monitoring and follow-up" (Ministry of Health 2010, p. 32). Providers were also required to report on activities they "delivered to support gambling venues to develop, improve and implement effective harm minimisation practices and policies" (Ministry of Health 2010, p. 32).

Generally, the document analysis showed that while providers had supported gambling venues' development and implementation of host responsibility practices, by comparison there was very little evidence in providers' reports showing they had supported the development and implementation of venue harm minimisation policies. Staff survey results indicated that over half believed their organisations were effective in supporting gambling venues to develop (57%) and implement (63%) host responsibility measures (see rows 3 and 4 of Figure 115). However, less than half of staff survey respondents reported that their organisations were effective in developing (42%) and implementing

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(48%) harm minimisation policies (rows five and six of Figure 115). A small percentage of staff survey respondents reported that these policy-related activities were not conducted (12%) while over a quarter (27%) reported that they did not know.

The document analysis showed that all providers had contributed towards outcomes that supported the development and implementation of host responsibility practices by delivering a range of activities (Figure 118). The majority of reported activities were in relation to Multi-Venue Exclusions with some providers also reporting on other aspects related to the concept of "host responsibility."
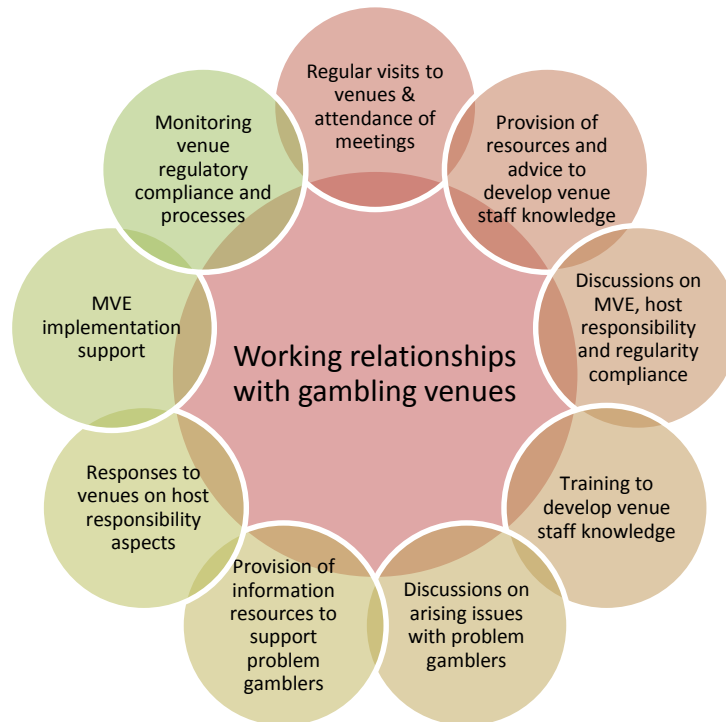
Figure 118: Activities to support gambling venues' host responsibility and harm minimisation practices

As shown in Figure 115 (second row), 57% of staff survey respondents rated the activity of *developing venue staff knowledge on harm reduction measures* as one that their organisations had effectively delivered. The document analysis found that providers developed venue staff knowledge through **provision of information and advice**. During visits, providers met with venue staff to **discuss MVE and host responsibility processes**. Regular **attendance at casino liaison meetings** were also noted by a few providers to be valuable as it resulted in useful discussions on gambling harm, regulatory compliance, self-exclusions and support for problem gamblers. However, not all providers were successful in engaging venues in productive discussions. One provider reported that their meeting with a casino, which included questions around gambling harm preventative measures, received resistance on the grounds of its "commercial sensitivity". Some providers also reported on discussions with gaming machine societies to investigate possible collaborations and to offer their services such as harm minimisation training.

A few providers reported on **building venue staff knowledge through training**. Such training support was offered to venues with the aim of enhancing knowledge of gambling harm and building awareness of the need for harm minimisation through regulatory compliance and harm reduction measures. However, gambling venues' perceptions about the adequacy of training they were already receiving from their Trusts sometimes prevented uptake. Some providers believed additional training was required, and one emphasised the need to go beyond awareness-raising to identifying the merits of MVE policies, tailoring training to suit varying gambling environments, and involving venues in the planning and implementation of training programmes.

One public health focus group participant suggested that more effort could be put into provision of standardised training to develop the knowledge of venue staff, considering the limitations of training offered through gambling societies and Trusts.

> There is still so much discrepancy between the different Trusts. There is no standard training that they give their staff; they can just do whatever they want. They are supposed to have somebody who has done host responsibility training and they have to have a policy for identifying problem gamblers. Those are the two minimum things that they have to have; but there is no standard training on what they have to know; what they have to be able to do. That is why we have such different perspectives as well.

Established relationships led to collaborative work between providers and venue operators and enabled **discussions on arising issues with problem gamblers**; for instance, cases where self-excluders continued to access gambling venues, those requesting an annulment of their self-exclusions and other related issues such as gambling impacts on children. Visits to venues also led to the identification and addressing of misconceptions among patrons (e.g. the cost of counselling services, which was clarified in MVE-related promotion).

Another area of support for gambling venues reported by the majority of providers was provision of **information resources that venues could use to support problem gamblers**. These resources included those designed by providers as well as materials obtained from the HPA. The content of these resources included details on the true costs of gambling and support services including those offered by providers. However, one provider noted several challenges in relation to HPA brochures, including the time consuming process of its development, its lack of Māori and Pacific perspectives, and some of the content that had caused resistance from some gaming societies.

Although most providers reported positively on venues' receptiveness towards awareness-raising materials and resources to support problem gamblers, one provider encountered difficulty with some operators who were resistant to making these resources available at their venue. Another provider reported venue perceptions about the unimportance of awareness-raising information as a challenge.

Best Practice Example 2: Collaborating with gaming machine societies in resource development

One provider reported the need for provider-venue collaboration in developing resources as this ensures mutual agreement to its content and thus its usefulness to venues. The value of this approach was evidenced in the report of another provider. Their development of an information card to facilitate host responsibility measures in casinos (detailed in Figure 119), in collaboration with another PGPH service provider, was preceded by consultation with gaming machine societies all of which had expressed interest in the pilot card. The societies were also keen on a study that could determine when clients were "most receptive to receiving staff intervention and information" which prompted the development of an evaluation process. This was followed by a teleconference with the HPA to discuss the card's content and to acquire baseline information for evaluation purposes.

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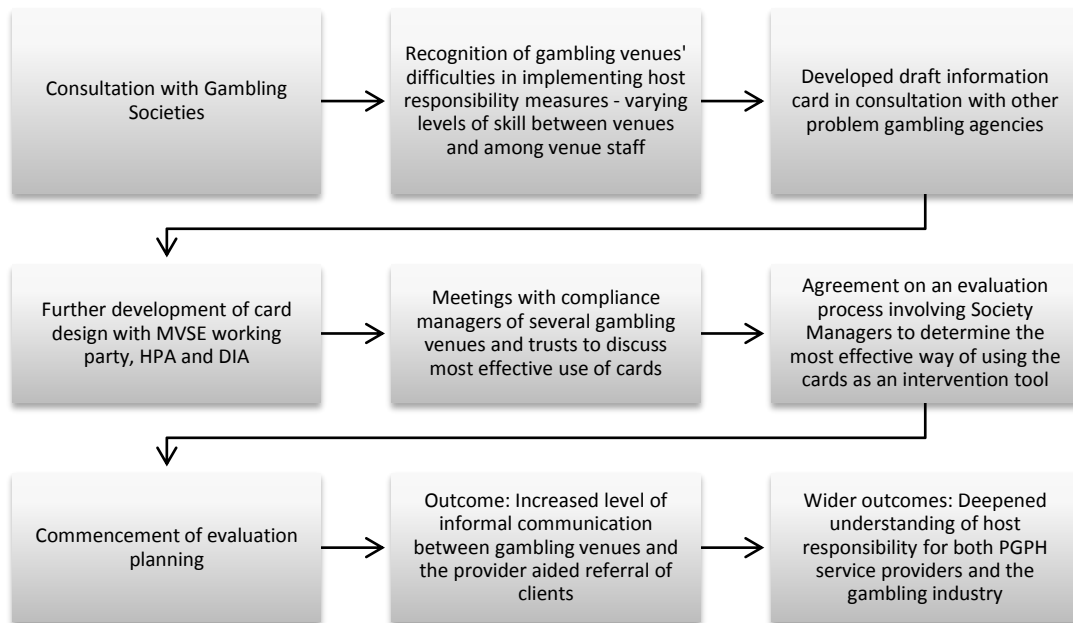
Figure 119: Development of an information card in collaboration with gaming machine societies

The provider later reported on the wider outcome that resulted from their process. Additional to the development of a tool for use in venues, the process also resulted in greater clarity on host responsibility and enhanced provider-venue collaboration.

Four providers reported they had **responded to venues on host responsibility aspects**. These responses included providing comments on venues' host responsibility promotional displays and patron photograph storage systems for MVE implementation. One provider reported commenting on a venue's host responsibility strategy, which included suggestions for improvement such as the need for "measureable milestones and objectives," a clearer indication of the types of training required for implementing culturally appropriate responses, and the need for objectivity in the venue's outcomes evaluation. Another provider advised venue operators on correct host responsibility practice such as ensuring the visibility of problem gambling support materials and best practice around checking patrons' identification to ensure their legal age for gambling. Comments made by a few providers concerning venue practice and venue staff perceptions suggested possible barriers to enabling safer gambling environments. Perceptions about the need to honour individual rights may be a barrier, according to one provider, as this may mean no action taken. Another provider noted inconsistencies among venue policies on patron access to cash as an issue.

A key area of support offered to gambling venue operators was in the **implementation of Multi-Venue Exclusions**. Under the Gambling Act 2003 (New Zealand Government, 2013) gambling venues are required to develop policies to identify problem gamblers (Section 308), offer advice or information including information on self-exclusion procedures, and where appropriate issue exclusion orders (Section 309) to identified individuals. Additionally, venues are also required to issue exclusion orders for self-identified problem gamblers (Section 310).

Providers reported assisting venue operators with various MVE-related processes with the aim of ensuring successful outcomes for excluders. They reported collaborations with the gambling industry, other PGPH providers and the DIA. These relationships were valuable and led to multi-faceted relationships and the development of a national multi-venue exclusion system. Four providers who were part of the MVE working group reported on how the group developed effective and user-friendly processes, standardised documentation, clarified roles and addressed arising issues. The aim of the working group was to enable venues to implement MVEs effectively and with ease. Other areas of MVE-related support offered to venues included processing exclusion orders, supporting patrons with the exclusion process, clarifying re-entry protocols and developing appropriate resources.

One provider reported on their initiative in developing a multi-venue self-exclusion form which had taken into account comments from venues leading to improvements to the form. The form's ease of use may have led to increased use among venues and thus an increase in MVE requests. The provider reported that discussions between stakeholders led to the identification of issues related to MVE implementation and their resolution (Figure 120).
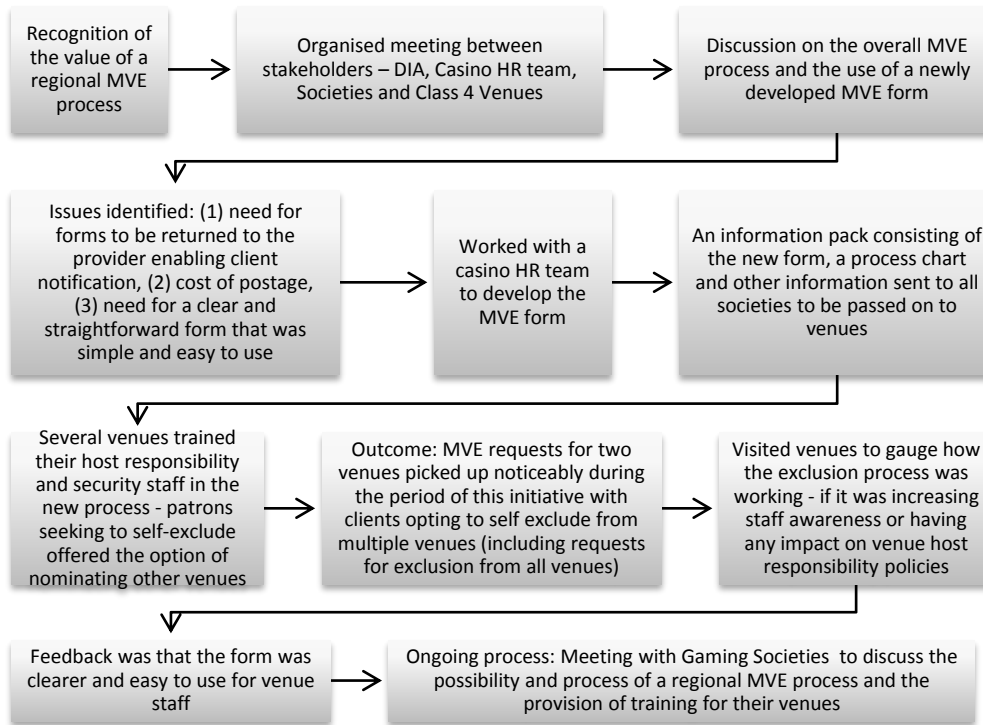
Figure 120: Developing a multi-venue self-exclusion form in collaboration with stakeholders

A few providers noted their introduction to, and consideration of appropriate technologies that could assist MVE implementation; for instance, facial recognition technology and scanners that may enable identification of excluded gamblers, database systems with the potential to ease MVE administrative processes and systems that enable online processing of exclusions. However, one provider identified limitations and challenges in relation to the implementation of these technologies, including cost and the possible loss of personalised human interactions.

Nevertheless, one provider's pilot project which used digital photograph frames for "effective recognition of patrons that have self-excluded" to assist venues in implementing their MVE process was one example of effective use of technology which was noted to have led to a more effective implementation of MVEs among venue operators. The provider's aim was to establish a more effective exclusion process and to "build effective working relationships with venue operators so they will contact [the provider] for local support and information". As detailed in Figure 121, they described this as a pilot project that was preceded by a development phase that had taken "into account feedback from venue operators on what patrons and venues find discreet and acceptable."
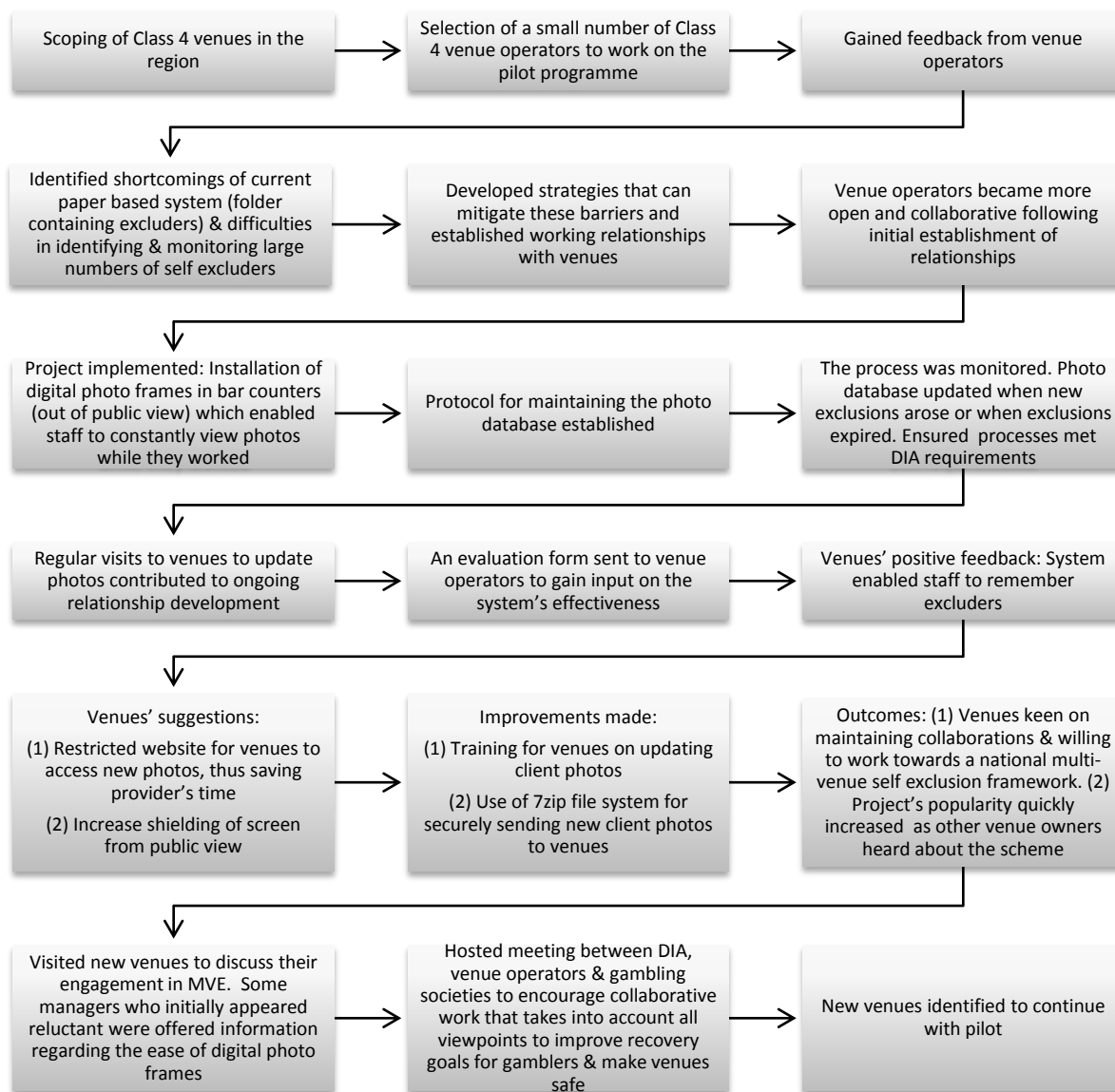
Figure 121: Development of a digital photograph frame for MVE implementation

The provider reported on the success of this pilot project as it led to ease of patron recognition and other positive outcomes, including more active monitoring of patrons and increased referrals.

Barriers and challenges to MVE implementation

A few providers reported that implementing MVE was particularly challenging in several ways (summarised in Figure 122). Two providers reported that the lack of priority given to MVEs and the "It's not my job attitude" held by some venues towards harm minimisation and provision of safe gambling environments was a barrier to progress in **uptake of MVE-related practice among venues**.

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Venue MVE uptake	MVE processes	Venue MVE implementation	Client MVE uptake
Lack of MVE prioritisation among venues	Complex and time-consuming process for providers	Venues' understaffing	Lower uptake among Pasifika
"It's Not My Job Attitude"	Lack of clarity in stakeholder roles	Venues' lack of understanding of MVE procedures	
	Lack of clarity in MVE administrative and coordination processes	Negative perceptions about manageability of increasing MVE numbers	

Figure 122: Barriers and challenges to MVE implementation as reported by providers

For some providers, the complex and time-consuming process needed in implementing MVE programmes was a challenge. One provider noted that the need to engage with multiple stakeholders, address arising concerns, develop relationships and cater for a large geographical area were factors that had made their MVE initiatives highly time consuming. A few providers also noted the need for better clarity in the roles of the various stakeholders involved in implementing MVE programmes including those of the venue, and those of problem gambling service providers. Another provider reported the need for clarifying the administration and coordination of the MVE process in order to develop an effective system for all parties. To some extent, this challenge may have been addressed, as "role clarification" was included as part of the MVE process to ensure a more effective implementation of MVE across the country.

Another challenge was around **venues follow-through on implementing MVEs**. One provider noted that understaffing in one venue was a barrier to effective MVE implementation. Another noted how many venues remained confused about MVE procedures and described the challenges they faced in ensuring that all venues understood the MVE process and related responsibilities. This provider took a 'MVE Coordination Service' role for the MVE project in their region; a role that required "processing exclusions and visiting venues to ensure [that] the exclusions [were] being actioned and monitored properly". A key challenge was the number of venues that did not return exclusion order forms to the provider. The number of venues in the region made the task of resolving this issue by visiting venues difficult.

While the efforts made by providers led to increases in MVE implementation and uptake, providers reported on concerns venue operators had around the manageability of increasing numbers of MVEs. One provider noted that venue fears over the resources required for accommodating increases in MVEs led to unwillingness to undertake MVEs. Another provider reported that venues were doubtful of their capacity to manage exclusions and comply with the regulations if there should be an excessive increase in MVEs. Extensive conversations were needed with some venues to gain their confidence in the feasibility of the process.

A final challenge concerned **clients' uptake of MVE**. One provider reported difficulty in implementing the MVE programme among Pacific clients who had lower uptake of MVEs. The suggestion was made that research was required around the effectiveness of MVE for Māori and Pacific, and the development of strategies to increase MVE uptake by both these communities.

Monitoring and following up on venues' practices

The PGPH-02 Purchase Unit Description noted "monitoring and follow-up" as a key process that flows from policy development and implementation support (Ministry of Health 2010, p. 32).

The document analysis found that a few providers reported visiting venues with the aim **of monitoring venues' regulation compliance** and implementation of exclusions. One provider described a project that they referred to as "Venue Audit and Exclusion Update" which involved visiting venues to conduct audits to gauge implementation of MVE and regulation compliance and reporting results back to the

venues. Providers also reported identifying and taking action on problems encountered during visits to venues. These included addressing patron privacy in relation to the visibility of excluders' photographs in venues. Other compliance and process issues addressed in relation to MVE were the visibility of gaming machines from outside a venue, the display of expired gambling licenses, incomplete staff training, incomplete records of excluders and breaches of the Gambling Act. The present staff survey found that only 47% reported that monitoring and following up on venues' practices was an activity that their organisations had effectively delivered. While a small percentage (9%) reported that their organisations were ineffective, over a quarter (28%) indicated that they did not know (See row seven of Figure 115).

Collaboration between gambling venues and other organisations

The PGPH-02 Purchase Unit Description also expected providers to "promote, support, participate in, and where necessary lead, stakeholder groups to enhance cooperation and coordination between gambling venues and other key organisations interested in the reduction of gambling related harm" (Ministry of Health 2010, p. 32).

As detailed in the section above, for many providers, activities in relation to MVE included collaborating with other PGPH providers, and discussions with the Department of Internal Affairs and with gambling venues. Collaborative work often involved meetings with these stakeholder groups to discuss processes, exchange ideas and information, and gain responses. By comparison, there were fewer explicit examples of providers' efforts to encourage collaboration between gambling venues and other organisations. The staff survey found that only 40% had rated the activity of *enabling collaboration between gambling venues and other stakeholders interested in reducing gambling harm* as one that their organisations had effectively delivered (See row eight of Figure 115).

In one example (Best Practice Example 3: Development of a user friendly self-exclusion form) the provider organised a meeting which involved the DIA and gambling venues. Two other providers reported examples of work that suggested purposeful organisation of activities that enhanced collaboration between gambling venues and community groups and the family and friends of gamblers. The first provider reported on plans for a project that would enable collaborative work between gambling venues and the whanau/friends of problem gamblers who take note of excessive gambling behaviours and approach the gambler. The process used by the second provider to develop a harm minimisation resource to support problem gamblers involved collaboration with several parties including the gambling sector, problem gambling counsellors, MVE participants, and whānau impacted by gambling harms. They referred to the resource as a tool for engaging stakeholders in contribution towards, and strengthening of, community action.

5.2.6   Other activities to enable safer gambling environments

In their reporting for this purchase unit, additional to the activities aimed at encouraging venue host responsibility and harm minimisation practices detailed above, providers reported on other activities to enable safer gambling environments.

One provider reported on a project that **delivered *Brief Interventions* at pubs and clubs** in collaboration with venue operators. Three providers reported having extended their MVE and host responsibility work to other types of gambling venues such as Lotto outlets, TAB outlets, internet gambling providers and housie/bingo operators suggesting an **extension of *Safe Gambling Environments* to other gambling facilities**. Another provider reported how they had supported a community group in making a submission regarding an application made by a venue operator for longer operating hours. The need to minimise venue operating hours, in this case, may have been viewed as extending the concept of "safe gambling environments" to include the **accessibility of gambling opportunities** at a community level.

Ten providers reported **awareness-raising activities for stakeholders** including community groups, schools and health service providers, with the aim of enhancing knowledge about problem gambling, gambling harm, the prevalence of gaming machine venues within their community, available gambling

help services (including services that their own organisations offer) as well awareness of MVE and its purpose.

5.2.7 Success Indicators: Safe Gambling Environments

"The number of organisations that provide opportunities to gamble that are identified by DIA as having effective and appropriate harm minimisation activities in place" was specified as an indicator in the PGPH-02 Purchase Unit Description (Ministry of Health, 2010, p. 32).

Providers' reports did not provide exact numbers of organisations with effective harm minimisation practices in place. However, some providers reported the identification of other outcome indicators. Success was noted when gaming venues expressed interest in MVE, exhibited a willingness to collaborate and undertook harm minimisation activities. One provider viewed the closing of some venues in support of *Gamblefree Day* as a sign of success in gaining the commitment of venues. Development of good working relationships with venues was also reported as a success indicator. Other providers reported increased referrals to their services and the number of completed exclusions as signs of success. Unintended outcomes included development of providers' general awareness of the gambling industry and knowledge about venues' promotional strategies, and building their profile as service providers.

In their descriptions of key success indicators for the PGPH-02 purchase unit, staff survey respondents provided activity indicators, output indicators and outcome indicators, with four providing more than one indicator type.

Fourteen staff survey respondents provided indicators that described activities such as building and maintaining relationships with gambling venues and societies, raising the awareness of venues, policy submissions and encouraging community involvement.

> Yes we work with venues, but we also work with their societies as they are the ones that provide the venues with the host responsibility training and policies. We also attend liaison meetings with the casino, and submit to the gambling commission when they're reviewing the casino's host responsibility programme. This is what is in our plan as being signalled as success indicators: Participation at casino liaison meetings, organisation of MVE meetings with EGM Industry and minutes of meetings.

> Encourage the community to provide feedback to the local and central government so that they tighten the monitoring of the gambling industry and set up better Gambling Acts.

Four staff members described increases in venue uptake of host responsibility and harm minimisation practices.

> The number of organisations that provide opportunities to gamble that are identified by DIA as having effective and appropriate harm minimisation activities in place

Six staff survey respondents described output indicators in the form of multi-venue exclusion order implementation, increased referrals of clients from gambling venues to problem gambling treatment services and the number of problem gamblers identified and excluded.

5.2.8 Adapted logic model: Safe Gambling Environments

The preliminary logic model detailed in the introduction to this chapter was expanded based on the findings from the analysis of the six-monthly narrative reports for this purchase unit (Figure 123). Additional areas of input needed for service delivery included development of staff knowledge, clarification of processes and roles in relation to MVE and the development of appropriate resources to support service delivery.

Figure 123 shows providers delivered several additional activities. Additional to outcomes in the form of MVE practice in venues, providers observed increased numbers of exclusions and referrals. The document analysis summarised a range of barriers and challenges in delivering PGPH-02. These included limitations to available resources, challenges in the relationship development process with venues, and perceptions held by venues that acted as barriers to enabling safer gambling environments.

Providers also faced a number of challenges in relation to MVE implementation. Some of these challenges, particularly those that were not within the control of the service provider, may be seen as external influences that can have an impact on outputs and outcomes.

PGPH-02   Safe Gambling Environments

Inputs	Activities	Outputs	Outcomes	Impact
Purchase Unit Funding	Identification of relevant organisations	Gambling venues assisted to develop and implement adequate host responsibility measures at all times of operation	Organisations, groups and individuals are aware of the potential harms that can arise from gambling and actively work to ensure that environments that provide gambling opportunities actively minimise harm and support individuals to make healthy choices	Gambling environments are safe and provide effective and appropriate harm minimisation activities
Staffing	Relationship building	Gambling venues assisted to develop and implement effective harm minimisation practices and policies		
Qualifications, competencies, skills, and experience	Education	Cooperation and coordination between gambling venues and other key organisations interested in reducing gambling harm enabled	Signs of MVE practices in venues	
MVE Working Group – clarifying processes and roles	Monitoring and follow-up		Increased number of exclusions	
Staff knowledge development	Consideration and use appropriate technologies to assist MVE implementation	Increased venue willingness towards collaborative work with providers	Increased number referrals to problem gambling intervention services	
Development of appropriate resources	Inclusion of other gambling facilities (Lotto outlets, TAB outlets, internet gambling providers and housie halls)	Improved MVE processes and a greater level of venue implementation		
	Influencing accessibility of gambling opportunities			
	Awareness raising activities for stakeholder groups			

Possible External Influences

Change of ownership in venues	Venue perceptions about individual rights	Venue policies concerning limits to patrons' access to cash	Venues' follow-through on implementing MVEs	Venue perceptions about manageability of increasing numbers of MVEs

Figure 123: Adapted Logic Model: Safe Gambling Environments

5.3   Supportive Communities (PGPH-03)

The objective of the Supportive Communities public health service was "to ensure that communities have access to services that provide strong protective factors and build community, family and individual resiliency" (Ministry of Health, 2010, p. 33). Activities within this service include working with health service providers and community groups in the delivery of health promotion programmes to develop community resilience, promoting public debate on gambling-related issues and promoting positive leisure activities. Activities and key processes identified by the Ministry in the PGPH-03 Purchase Unit Description are summarised in a draft logic model (Figure 124).

## PGPH-03   Supportive Communities

Inputs	Activities	Outputs	Outcomes	Impact
Purchase Unit Funding	Identification of community strengths and protective factors	Health promotion programmes that build community resiliency and enhance social protective factors delivered in collaboration with mental health promotion providers and allied organisations	Communities have access to services that provide strong protective factors and build community, family and individual resiliency	People living in communities that provide strong protective factors and support individual and family resiliency
Staffing	Identification of partner organisations and relationship building	Public discussion and debate on gambling harm and related issues (including the ethics of gambling funding) enabled		
Qualifications, competencies, skills and experience	Build resilience and enhance social protective factors through health promotion programmes	Communities supported to develop culturally appropriate resiliency building activities		
	Promote public discussion and debate on gambling harms	Key groups' access to evidence based community action approaches for reducing gambling harm and evidence based approaches for monitoring and controlling gambling opportunities and licensing of gaming venues opportunities ensured		
	Enable culturally appropriate resiliency building through community partnerships	A clear point of public contact for raising concerns on harm minimisation public health approaches provided		
	Provide access to evidence based community action approaches	Improved public awareness of avenues for complaint regarding public health approaches to reducing gambling harm		
	Provide point of public contact for raising issues on harm minimisation approaches	Positive local media and community initiatives developed to promote family/community connectedness and positive leisure / entertainment opportunities		
	Develop media and community initiates promoting social connectedness and positive leisure			

Figure 124: Preliminary Logic Model: Supportive Communities

Nineteen providers delivered PGPH-03. This chapter summarises key findings from an analysis of their reports, the staff survey and focus group discussions (represented by six out of the eight selected providers in this evaluation).

5.3.1   Literature review

While community based initiatives for analogous areas such as alcohol addiction (Fagan, Hawkins, & Catalano, 2011; Saltz, 1988) have long been established, similar initiatives focusing on gambling harm prevention are relatively new. Only one study that fitted our search criteria was found at the time of the search. Brown, Johnson and Wyn (2001) described a community-focused programme led by Women's Health West for minimising gambling harm among an Eastern African community in Melbourne, Australia. The project used a two-year action research method which trained and employed women from this community as co-researchers and cultural consultants. The women carried out focus groups, were involved in the data analysis and later drew from the findings to design and implement strategies to reduce the negative impacts of gambling in their community. The women were later provided with training and contracted to work as peer educators. Based on their involvement in the project, the authors concluded that this community group:

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…established many networks and links, which have facilitated better access to a range of health and community services. The development of trust between Women's Health West as a government funded agency and the community led to the formation of connections with other types of support services. Community awareness of gambling and its potential harm has started to increase although the women acknowledge that this is the first step (Brown *et al.*, 2001, p. 127).

5.3.2 Effectiveness of PGPH-03 activities (staff views)

Figure 125 shows PGPH-03 staff ratings of the effectiveness of activities in achieving the respective objectives, targets and outcomes. Most staff reported that these activities were carried out effectively by their organisations. However, ensuring key groups' access to evidence-based approaches to monitoring and controlling licensing of gaming venues, and improving public awareness of avenues for complaint regarding public health approaches were rated by a lower percentage of staff survey respondents, with just over half rating these to be effective. There was also less evidence of these activities in providers' reports.
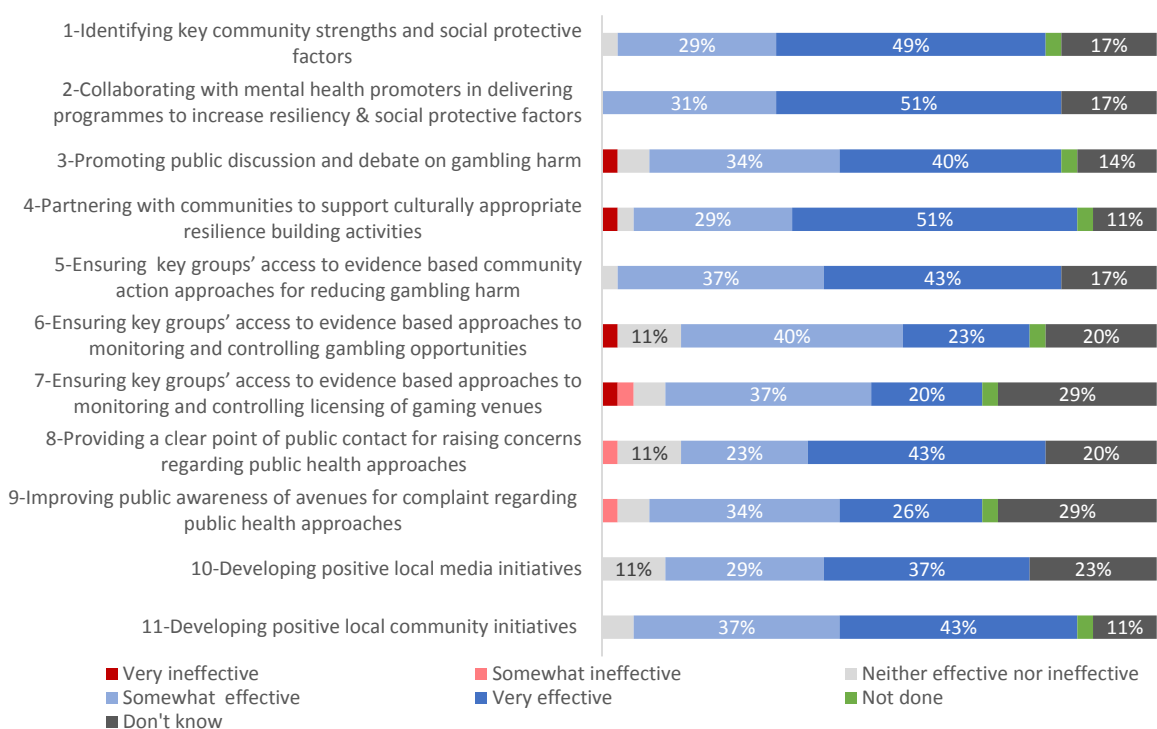
Figure 125: Effectiveness of Supportive Communities activities as rated by staff (n=35)

5.3.3 Provider's knowledge development

Two providers reported that there was a need for providers' knowledge development in some areas, which required some preliminary work. One provider suggested developing an understanding of community views on gambling funding. They reported on efforts to understand, through surveys, the views of community and social service organisations regarding their reliance on gambling funding. This provider also took the opportunity to have discussions with stallholders during public events, to gain further understanding of alternative fundraising options.

Among the activities reported by another provider was an initiative to develop a methodology to identify problem gambling-related inequalities that would provide a basis for developing harm minimisation action in their region.

5.3.4 Identification of partner organisations and relationship building

The PGPH-03 Purchase Unit Description indicated that key processes for delivering services should include "identification of partner organisations, relationship building, mental health promotion, and community development" (Ministry of Health, 2010, p. 33). The PGPH-03 reporting template also required providers to report on "the target groups, communities at risk and populations identified as priorities" (Ministry of Health, 2010, p. 33).

The document analysis showed that all providers identified the organisations and stakeholder groups they had either approached or worked with. As summarised in Figure 126, these included the **health sector** such as public health organisations, mental health organisations and disability and elder care, the **social services sector** such as Work and Income and Budget Services, **non-health stakeholder groups** such as tertiary institutions, church groups, the Department of Corrections, Māori organisations, and **targeted groups** representing high-risk communities and the public.

Figure 126: Stakeholder sectors identified for PGPH-03

Several providers indicated having attended appropriate meetings such as the Joint Agency Public Health Working Group (Te Ngira) and other network meetings, local board meetings and community network meetings.

Although one provider suggested the need for clarification of the meaning of "communities at risk" and the implied "labelling" of communities, other providers had targeted specific communities. One reported that they targeted low socio-economic communities for the delivery of this public health service because of the high-risk groups within these communities. Three providers reported the value of engaging with Māori and Pacific organisations and groups. This engagement led to the inclusion of these organisations in public health promotion activities and also enabled providers access to the at-risk target communities connected to these organisations.

The relationship development process with targeted community groups was instrumental for gathering information to develop communication strategies and enabling provider involvement in the organisation of yearly events, thus increasing the frequency of opportunities for community connectedness.

5.3.5 Identification of community strengths and protective factors

The Purchase Unit Description indicated that key process for delivering services should include "identification of community strengths and protective factors" and that indicators include "community measures of social connectedness, resiliency, cultural identity, and belonging" (Ministry of Health, 2010, p. 33).

The document analysis suggested that although some providers mentioned enhancement of community resiliency and social protective factors as an objective of their activity, few providers explicitly identified "community strengths" or "protective factors." However, as shown in the first row of Figure 125, a majority of staff (78%) reported that their organisation was effective in identifying key community strengths and social protective factors. It may be that "community strengths" and "protective factors" were implied in providers' reports. For instance, the use of a "community voices" concept, which includes community stories of overcoming problem gambling, described by one provider, could be seen as a "community strength" in addressing problem gambling issues. In another case, a youth education programme designed by a provider indicated that youth education was a "protective factor" which can contribute towards prevention of problem gambling within their community. Another provider's comments on a community's awareness of their potentially influential role in health promotion indicated a form of "community strength". These examples are detailed in the sections that follow.

Nevertheless, two providers, (detailed in Best Practice Examples 2 and 3 in the following section) explicitly reported how they had identified and built on social protective factors in a way that contributed towards protection from gambling harms.

5.3.6   Health promotion programmes enhancing community resilience

Whilst the PGPH-03 Purchase Unit Description acknowledged "that mental health promotion requires partnerships across a wide range of allied public health services, sectors and disciplines", it also noted that activities for this purchase unit should include working with "mental health promotion providers and allied organisations to deliver health promotion programmes that increase community resiliency and promote and enhance social protective factors (i.e. social connectedness, cultural identity, knowledge and understanding, access to health services)" (Ministry of Health, 2010, p. 33).

Staff survey results showed that a majority (82%) reported their organisations to be effective in collaborating with mental health promotion providers in delivering health promotion programmes that increased resiliency and social protective factors (See second row of Figure 125). The document analysis indicated that providers had engaged with both health-sector and non-health sector groups and organisations; their approaches in engaging these groups in health promotion activities are summarised in Figure 127.
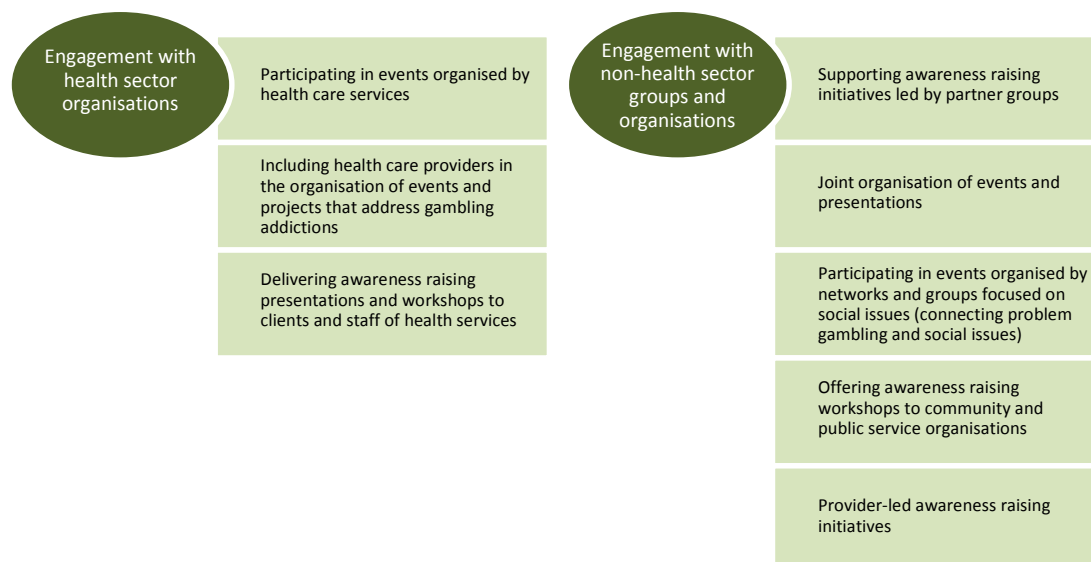
Figure 127: Approaches used in engaging groups in health promotion activities

Nine providers reported specific engagement with **organisations within the health sector** in educational and awareness-raising activities. One approach used by some providers involved *participating in events organised by health care services*, which led to increased awareness of gambling support services among staff of the health care services and enabled help-seeking behaviour among health care clients. A second approach was the *inclusion of health care providers in the organisation of events and projects* that address gambling issues while promoting healthier behaviours, community connectedness, and opportunities to address health-related issues. A third approach was the *delivery of awareness-raising presentations and workshops* to clients and staff of mental health services and health promoters.

Best Practice Example 1: Enabling longer-term inclusion of gambling harms within health education

One provider reported delivering presentations to health professionals and "emerging health professionals" (i.e. tertiary students within the health field). They noted that by "providing gambling harm awareness training to emerging health professionals" they were able to "have an ongoing influence" to ensure "that the issue of gambling harm remains visible". They reported on positive outcomes in terms of developing student understanding.

…The students were able to see that whānau experiencing gambling harm may present in a similar way to whānau experiencing symptoms consistent with a major depressive disorder. They were also able to identify that undertaking a comprehensive assessment which included the possibility of gambling harm being an issue would be important in order to appropriately assess and treat the whānau.

This provider reported on plans to develop relationship with the education provide to enable a more visible inclusion of problem gambling in health education.

Nine providers worked with **non-health stakeholder groups** in educational and awareness-raising activities. Some providers noted that celebrations of relevance to Māori and events that were attractive to Māori were effective settings for engaging communities in activities that can develop awareness. A few providers reported having *supported awareness-raising initiatives by partner groups* they had helped establish, thereby providing avenues for future collaboration in gambling-related health promotion activities. For instance, one provider established a setting for future awareness-raising activities through active support for the development of an Association of Social Workers sub-branch.

Best Practice Example 2: Enhancing support for youth as a social protective factor

Another provider identified the existing support provided to youth in their region to be a "protective factor". They sought for "opportunities to engage and support youth initiatives" and later reported on the formation of a youth steering group "who were then tasked to develop and implement an event that would strengthen protective factors and support individual and whānau resiliency". Their reported activities and outcomes are described in Figure 128.
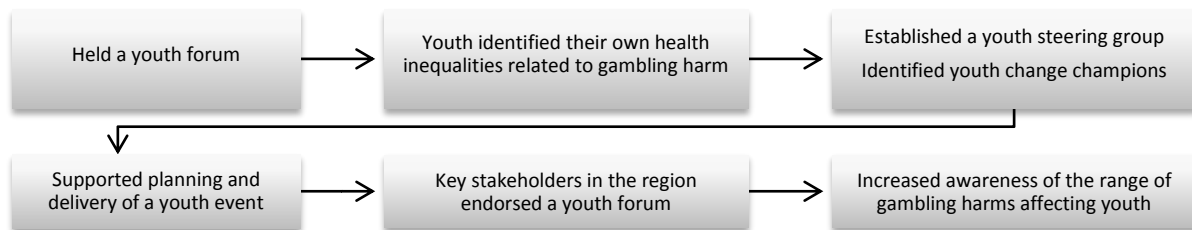
Figure 128: Supporting youth initiatives to enhance youth support as a protective factor

The youth group later delivered presentations to communities and students at a youth event in their district and at schools. Based on the results of pre- and post- evaluations, the provider reported on the success of the organised youth forums and presentations. They reported that the sessions had led to increased understanding of cultural identity, social connectedness, resiliency and belongingness.

Providers also reported the outcome of their discussions and collaborative working arrangements with Pacific and Māori community groups. These provided opportunities for developing awareness through *joint organisation of events and presentations*.

One provider identified Māori art and culture as protective factors with the capacity to enhance cultural connectedness. As detailed in Figure 129, the provider reported on a pilot art and culture activity where they engaged with several Māori community groups including gamblers and affected others. The provider noted this as "an opportunity to bring whānau together in the community they live in".

Figure 129: Pilot Māori art and culture activity to raise awareness of gambling harm

Through the activity, the provider was able to "sustain and maintain trust and rapport with whānau" and to promote the availability of their gambling support services. They reported on their success based on the learning outcomes they observed, comments received from participants and their responses to what they learned about Māori culture.

Another approach was *participating in events organised by networks and groups that were focused on social issues* with the aim of including problem gambling on their agenda and linking problem gambling with other social issues.

Providers *offering awareness-raising workshops to community and public service organisations* appeared to be another approach. For instance, one provider indicated having approached Māori Wardens, which led to the organisation of a workshop for this stakeholder group. Another reported a relationship with the Community Law Centre in their area, and the delivery of monthly awareness-raising workshops for the centres' clients. A different provider reported on their working relationships with the Department of Corrections in developing pathways for prisoners to receive counselling services and the potential for inclusion of gambling harm into prison education.

Provider-led awareness-raising initiatives, for instance, awareness raising at an annual school *kapa haka* event, as reported by one provider, was another approach.

One provider reported that a challenge was the difficulty in obtaining HPA sponsorship to enable grassroots community groups to deliver gambling-harm related messages in their own events. They reported that the HPA "found no reason to support this action and did not supply sponsorship or resources". They recommended that the Ministry of Health

> …work alongside the HPA… to ensure equitable outcomes for community groups trying to access sponsorship and/or resources. Especially, those groups with high proportions of Māori, Pacific and rangatahi.

5.3.7   Public discussion and debate on gambling harm and related issues

The Purchase Unit Description also required that activities delivered for PGPH-03 included the promotion of "public discussion and debate on gambling harm and related issues (i.e. the ethics equity of accepting (or not accepting) gambling funding" (Ministry of Health, 2010, p. 33).

Staff survey results showed that most (74%) reported that their organisations had effectively promoted public discussion and debate on gambling harm (see third row of Figure 125). However, the document analysis noted that some providers' reports were clear that the aim of their activity was to *encourage public discussion and debate*; for instance, providing the space for such discussions to occur. In other cases, it was not explicitly stated that a particular activity was for the purpose of encouraging public discussion and debate. Encouraging public discussion may have been implicit in the various awareness-

raising activities, such as the delivery of presentations to stakeholders and the provision of information stalls in public places. As the objective of these activities was to raise awareness about gambling harms and the availability of help, it can be assumed that such activities are likely to have led to, or involved, some form of public discussion and debate. Key themes in relation to this activity, identified from the document analysis are detailed in Figure 130.

Figure 130: Approaches used for encouraging public discussion and debate on gambling harm and related issues

Four providers reported that purposeful **provision of space and avenues for conversations to occur** was one way that *public discussions about gambling harms* could be encouraged. One provider noted the need to develop a "Community Voices Group" for discussions to occur and they believed that the Choice Not Chance campaigns provided the arena for productive conversations to occur. Other providers reported organising workshops and meetings with the objective of providing the "space" for conversations about gambling harms to occur.

As detailed in the section above, the delivery of health promotion programmes often included presentations and workshops. Providers' inclusion of **discussions with workshop participants** may be viewed as a second approach for encouraging public discussion and debate. For instance, one provider included breakout discussion groups as part of a workshop, which facilitated community discussions about problem gambling.

Twelve providers reported raising awareness during local public events such as mental health awareness week, health days, *Gamblefree Day*, White Ribbon Day, special school-based events and cultural festivals such as Matariki. Promotional activities included providing information stalls, organising fun activities, distributing resources, delivering presentations and, in some cases, carrying out brief screenings. These events sometimes **involved discussions with visiting members of the public;** this may be viewed as a third approach for encouraging public discussion and debate about gambling harms. While participating in an annual speech competition event at a local school, one provider organised the inclusion of problem gambling as a speech topic, thereby contributing to discussions among students. However, as reported by another provider, reluctance among the public to approach information stalls at some events was a challenge. While awareness-raising activities in public spaces often involved the distribution of resources, one provider reported that provision of information alone was insufficient in achieving the outcomes for this purchase unit.

Nine providers reported various efforts in relation to the output of *public discussions on the ethical perspectives of gambling funds*. Enabling **opportunities for discussions about the ethics of gambling funds** appeared to be one approach used by four providers. One provider reported the establishment of an Ethical Funding Forum in collaboration with another PGPH service provider. They noted that the Forum provided a "community awareness space" where effects of gambling harms on the community could be brought to the attention of the community. The partner PGPH service provider reported that "the Ethical Funding Forum created a safe and respectful space for discussion and debate around funding issues", and reported on the various discussions and debate that took place among community members, city councillors and Members of Parliament. Another provider also took the opportunity to steer thinking around the issue of accepting gambling funds in a health-related conference, which led to the development of a project on the issue that targeted the recipients of financial contributions from

gaming trusts. Their report suggested a consideration of social marketing approaches by eliminating the "guilt appeal," focusing instead on raising understanding on the concept of minimising and reducing harm.

Other reported approaches may have indirectly aimed for the outcome of public discussions on the ethical perspectives of gambling funds. A second approach identified in the document analysis was **encouraging and supporting the uptake of alternative funding sources**. One provider reported several projects with different groups. Among others, they reported having worked with a Māori interest group in sourcing alternatives to gambling funding, providing assistance with funding proposals and thus supporting the group towards becoming an exemplar within their community. Another provider reported a "Gambling Harm Minimisation Programme for Communities" to encourage alternative fundraising among community groups that were engaging in gambling-based fundraising activities. However, they reported that work progressed slowly because of difficulties in "re-conceptualising ways to assist communities with fundraising". In working with community groups, the provider noted that although the groups were keen on learning about gambling harm and harm minimisation measures they were less ready to consider alternative fundraising methods.

A third approach was to **support groups that already have a stance of not accepting gambling funds** while also promoting awareness of alternative funding. In a jointly organised cultural festival with another PGPH service provider and community groups, one provider supported a stance of non-acceptance of gambling funds held by the event organisers. They also reported having supported the awareness-raising work carried out by a community group alongside their stance of non-acceptance of gambling funds, and expressed solidarity with a sports organisation that held an event free of gambling funding by providing funding support to promote this ethical stance.

As youth are an at-risk population group, two providers reported **introducing the idea of alternatives to gambling funds among youth groups** and supporting youth in efforts to secure such funds. While one provider supported tertiary students in alternative fundraising while building on their awareness of gambling harms, another provided support to a youth group in seeking and securing alternative funding; this led to increased knowledge about alternative sources of funding as well as gambling harm in relation to youth.

5.3.8 Culturally appropriate resiliency building through community partnerships

Another expected activity within the PGPH-03 Purchase Unit Description was for providers to "partner with communities to support the development of resiliency building activities that are culturally appropriate. This may include gambling free forms of fundraising, entertainment or skills and strategies to limit gambling related harm" (Ministry of Health, 2010, p. 33).

Eighty percent of staff survey respondents reported that their organisations were effective in collaborating with communities to support development of culturally appropriate resilience building activities (See row four of Figure 125). The document analysis identified a range of approaches (listed in Figure 131) that thirteen providers had used.

Some providers indicated **using kaupapa Māori approaches**, thus ensuring the cultural appropriateness of resiliency building activities. For example, one provider reported developing a school holiday programme for children based on Māori guiding principles such as "manaakitanga, kaitiakitanga, rangatiratanga" and "kotahitanga" which they believed "provided direction around the outcome of developing the resilience, capacity and capability of the tamariki" they worked with. Another reported a programme for students based on Māori culture that encouraged healthier alternative behaviours. Inclusion of teachers in the programme enabled a degree of sustainability as the teachers expressed confidence in being able to take over the delivery of the programme.

Other providers reported having **established client or consumer groups** that they worked with in planning and delivery of various awareness raising activities. One provider reported having organised a client focus group to discuss appropriate approaches for building resiliency.

Figure 131: Approaches used to develop partnerships with communities to support resiliency-building activities

Best Practice Example 4: Collaborative establishment of a consumer voices action group

In collaboration with other PGPH service providers, one provider reported establishing a *consumer voices action group* with individuals who had overcome problem gambling, who expressed stories of the impact of gambling on their lives, the lives of those close to them and their community. The provider reported how the idea for the formation of such a group was derived from the works of a former gambler who had publicly shared her experiences as a result of "her desire to help prevent friends and whānau from going down [the same] problem gambling path" which eventually led to the issue becoming a priority among iwi. The provider reported how their staff initially "formulated the theory that gambling harm for iwi, hapū, whānau, and community would decrease further if consumers were fully engaged, and provided with the resources to develop their own organised voice to create change" (Figure 132).
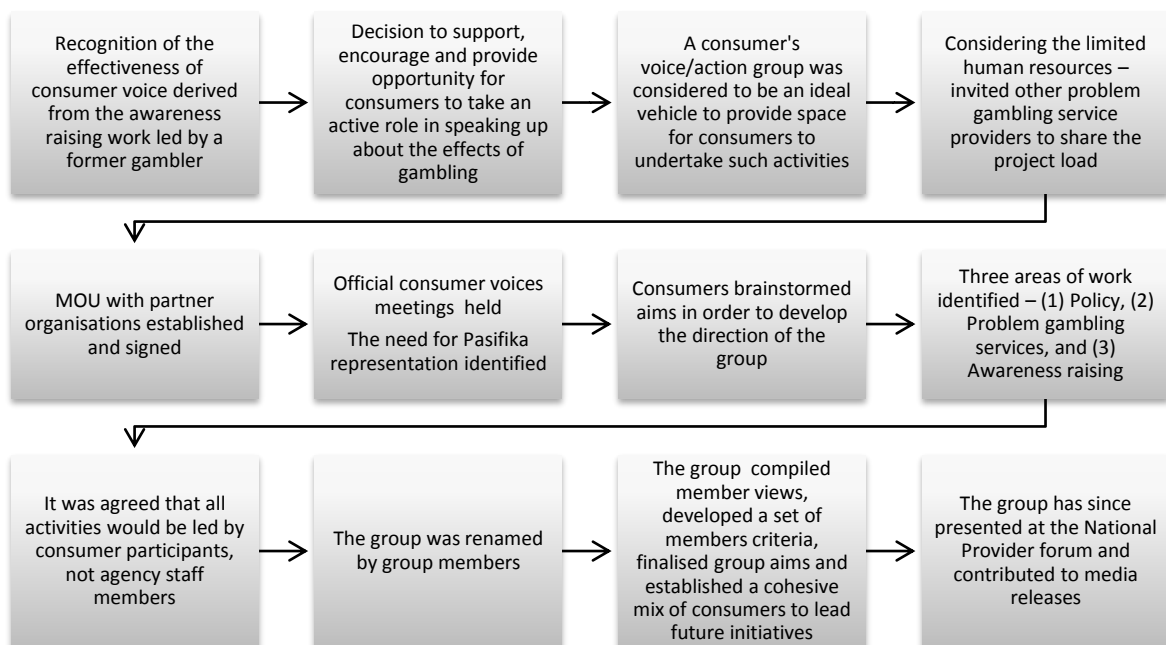
Figure 132: Establishment of a consumer voices action group

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The provider explained that they based the establishment of the group on "the premise, if raising community awareness and strengthening community action was to be truly effective, those who struggle with gambling addiction from all other backgrounds must be part of the equation".

The consumer group noted several challenges such as inconsistent attendance, "strong" personalities of some consumer members, fear of discrimination (in relation to future employment) that may result from participation, and cultural difference among consumer members with regard to meeting processes. Nevertheless, the group has since achieved several positive outcomes, which included a presentation at a national providers' forum that emphasised the need for service providers to effectively consider and act upon consumer voices. The consumer group had also written letters to the editor and contributed to press releases relating to issues such as internet and television gambling advertisements targeting youth, and the "revenue that is being taken out of low socio-economic areas [through]… the pokies". The group's media engagement later expanded to a regular activity and group members become more active in other related advocacy activities.

To maintain the group, the provider highlighted the importance of ongoing engagement with group members, providing coordination support and providing the required resources.

One provider **supported community groups working against gambling harms** by assisting in the establishment of several action groups. The provider worked with the groups to develop their capacity to build resilience within their communities. They also reported supporting the efforts of other action groups to protect their communities from gambling harms. Likewise, another provider's collaborative work with a "Kaumātua/kuia reference group" led to awareness-raising activities being taken on by these groups and their active involvement in policy development to support community resiliency in a culturally appropriate manner.

Some providers reported that they had **supported community-led projects** that had the potential to build social connectedness and community resilience. One provider supported a community development project in their area by developing surveys "supporting the planning and implementation of events, gathering information regarding strengths and helping to connect whānau with other whānau that can support and meet [each other's] needs". Based on a finding identified in a community survey, another provider delivered a Driver Licence programme that enhanced their relationship with the community. The provider suggested this was "an innovative way to engage with an at-risk community to prevent and minimise gambling harm". By incorporating gambling-related education in the programme, they were able to achieve broader outcomes facilitating community resilience. The programme led to several outcomes including increased awareness about the range of gambling harms and about their problem gambling service. Securing driver licences led to "increased self-confidence and self-esteem" and "increased job prospects and placement that may lead to increased income [which is] a determinant of health".

Supporting programmes for children and youth was another approach. One provider reported an after-school programme for children affected by gambling harms that had a resiliency-building aim. The programme familiarised children with pro-social activities within a supportive environment. This provider also supported the delivery of holiday programmes for children based on Māori guiding principles, in which problem gambling themes were incorporated. Other providers reported on a youth mentoring programme and support for a school in developing a health profile survey that included gambling behaviour.

Providers also reported on **support they provided to health-focused community programmes**. One provider reported the development of a project that provided an opportunity to engage the community in walking and running. They later received positive feedback on the supportive nature of the project. Likewise, another provider supported several community groups by incorporating a problem gambling theme into other health-related programmes.

Some providers encountered challenges in establishing collaborative work with communities. These included the time needed to develop relationships and ongoing related pressures when trying to meet community needs. Rural communities' tendency to be resistant to external influences was another

challenge. There was an identified need to reach rural communities but there were concerns over the availability of intervention services in some of these areas.

5.3.9   Access to evidence-based information and education

The PGPH-03 Purchase Unit Description specifies that providers were expected to "ensure access to high quality, evidence based information and education to agencies, community groups and the public about: reducing gambling related harm through community action approaches [and] processes for monitoring and enforcing controls over gambling opportunities and licensing of gaming venues" (Ministry of Health, 2010, p. 33).

The majority of provider reports did not provide explicit examples of this in their reporting. As gaming venue licensing had connections to the PGPH-01 purchase unit, this particular activity might have been delivered and reported concurrently with PGPH-01, particularly when encouraging community involvement in the policy process. Nevertheless, nine providers reported several approaches to ensure the delivery of *evidence-based information and education on gambling harms*.

Despite this, a majority (80%) of staff survey respondents indicated that their organisations were effective in ensuring key groups' access to evidence-based community action approaches for reducing gambling harm. Smaller percentages reported effectiveness in ensuring key groups' access to evidence-based approaches on monitoring and controlling gambling opportunities (63%) and on monitoring and controlling licensing of gaming venues (57%) (See rows five through to seven in Figure 125).

Some providers reported **specially designed educational programmes and awareness-raising events on gambling harms**. One provider described the value of educating parents about children's excessive video game playing and highlighting parental restrictions might prevent the development of addictive habits. Another provider detailed the development and implementation of a youth education programme (Figure 133) which aimed to equip youth with the ability to have "informed conversations" about gambling harm. The long-term outcome expected was that "whānau and communities will continue to benefit from the knowledge imparted to and gained by these youth".
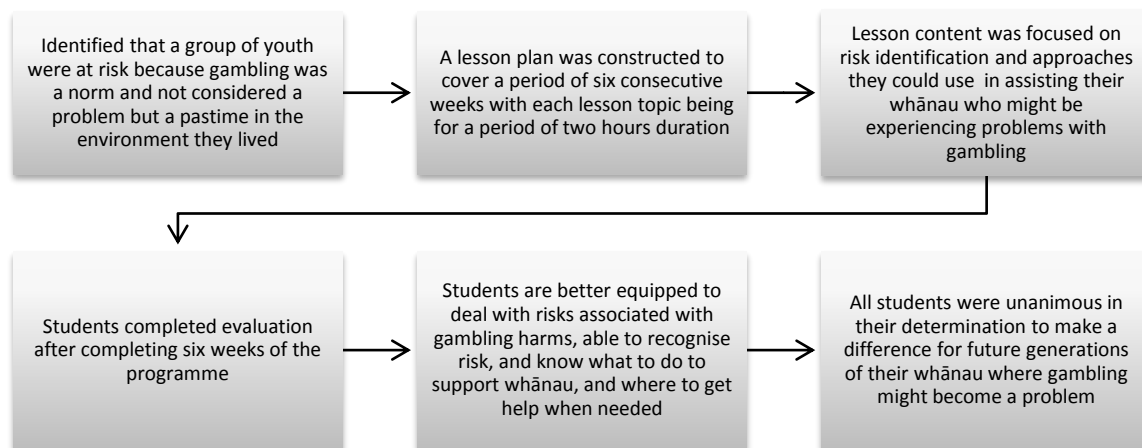
Figure 133: Youth education programme to enable informed discussions on gambling harm

Providers also ensured access to evidence-based information on gambling harms by presenting and discussing evidence around gambling harms with various community groups. Creative approaches were required to influence pre-existing community attitudes towards gambling. One provider reported how their initial review of the literature identified several key factors on which to base their project. Their activities and processes, detailed in Figure 134, indicated consultation with a number of stakeholder groups in the development and use of exhibition materials. Ratings on evaluation forms handed out during one of the exhibitions showed that a majority of attendees reported increased knowledge of gambling harm. A majority also reported that the exhibition "identified protective and resiliency factors for Māori dealing with problem gambling" and that they would "look for ways to minimise gambling for others now and in the future."

| Identified the need for health promotion messages that focused on preventing gambling addiction | → | Conducted literature review to inform project needs and rationale | → | Explored likely participants – narrowed to a selected few who had previously gambled – each with a unique skill set for creative and lateral thinking and of unique backgrounds and characteristics | → | Candidates supported to become champions for change in their own families and communities |

| Explored and established necessary supports for individuals in the duration of the programme | → | Introduced project and plan to all stakeholders, participants, and support services. Discussed methods of image collection and timeframes | → | Project introduced to participants as a public health measure of harm minimisation | → | Stakeholders introduced to gambling as a health issue and to the concept of protective and resiliency factors |

| Discussion on ideas for preventative methods and the range of different populations that are affected by gambling either directly or indirectly | → | Stakeholders became more aware of these factors and more prepared to support, engage and encourage positive behaviour change throughout the duration of the project | → | Implemented image collection plan – Met with individual project participants to commence images and stories collection | → | Images processed for selection by panel and prepared for print. Story board created to accompany images |

| Investigated similar projects in the region – How other campaigns are delivered using photographic exhibitions | → | Invited feedback from service users, agencies and social services | → | Engaged in dialogue with medical students designing a population health intervention – Gained valuable insight into the perceptions and attitudes of health professionals which enabled identification of protective factors and resiliency for problem gambling | → | Discussion with individual project participants suggested that they understood the project objectives and were mindful of the value of their experiences. Addressed concerns with regard to anonymity and emotional safety |

| Completed exhibition materials – photos and stories of individual experiences compiled into booklets | → | Inspected and assessed suitable exhibition sites that incurred minimal cost | → | Reviewed project plan with all stakeholders, participants and support services and discussed methods of dissemination, exhibition dates and venues | → | Media networks contacted to promote event |

| Regional exhibitions held (with external speakers and photo voice participants) | → | Evaluations conducted to determine exhibition's impacts |

Figure 134: Development of evidence-based exhibition materials on problem gambling prevention

5.3.10 Point of public contact for raising issues on harm minimisation public health approaches

The PGPH-03 Purchase Unit Description specified that service providers are expected to deliver activities that "provide an accessible and recognisable point of public contact for concerns and issues regarding public health approaches to reducing gambling related harm and improving public awareness of avenues for complaint" (Ministry of Health, 2010, p. 33).

Provider reports generally did not contain explicit examples of enabling a point of contact for the public to raise concerns or improving public awareness of avenues for complaint. One provider reported that they had acted as a contact point for receiving complaints "from consumers and others about venues" in relation to "breaches of the Gambling Act" and self-exclusion. However, as shown in Figure 125 (row eight) the staff survey results indicated that 66% reported that their organisations were effective in providing a clear point of public contact for raising concerns regarding public health approaches to

reduce gambling harm, and 60% indicated their organisations' effectiveness in improving public awareness (row nine).

Public health focus group participants suggested a lack of clarity around this activity. For instance, in response to a question seeking clarity on how this activity was implemented, one respondent questioned the meaning and objectives of the activity.

> Does that mean we have to let the community know, how to, if they have any issues with the work that we are doing, what they can do about it? Is that what that means? …Well that is my understanding of it. When I read that sentence.

Participants' discussions also suggested they contributed to the objectives of this activity by providing opportunities for comment, particularly when public events were organised.

> Again it comes back to the feedback. Survey forms. There are lots of forms that do ask for [feedback], have you any concerns, or any feedback, or anything we could do better. That's the way we have [understood] that.

> Depending on what the joint programmes are that we do, we have also the client rights that also allows them to know that they can complain if they want to and they know who they can go to see to complain to. It is all stated in those joint events.

The suggestion was made that the community would voice concerns directly.

> Yes, when we meet people we tell them the person they can complain to, you can put it in writing, or it can be verbally. But to be honest, I work in the community, if they are angry they will let everyone know. You don't have to tell them that. You'll know [when] you have done something bad.

While focus group participants agreed that this particular activity was unclear, discussions suggested a belief that vagueness enabled varied interpretations and thus flexibility in implementation.

> I think it is worded the way it is so that it has many different [meanings]… and hopefully if anyone is asked to define it or clarify it, it is very similar to "what do you think?" …And to clarify? I think if it is not broken don't fix it.

> Yeah. I quite like how vague it is actually. Because that means you can put that into lots of different things. I would read that question, and could run a whakapapa evening. And that for me it is building a strong protective factor for people that you work with. It allows you to, I guess, say what you want. It allows you to tailor your activities around, you know.

5.3.11 Media and community initiates promoting social connectedness and positive leisure

Finally, the PGPH-03 Purchase Unit Description also required that service providers "develop local media and community initiatives that promote connectedness to family and community, positive leisure/ entertainment opportunities, and support key stakeholders to reduce gambling related harm within their communities of influence" (Ministry of Health, 2010, p. 33).

The document analysis found that while provider reports did not offer precise examples of *media initiatives* that specifically promoted family and community connectedness or positive leisure and entertainment opportunities, nine providers reported on *community initiatives* towards these aims. The staff survey found that while 80% reported that their organisations were effective in developing community initiatives, less (66%) indicated the same for developing *media initiatives* (see rows ten and eleven in Figure 125).

A few providers reported on **community initiatives promoting family and community connectedness**. A *Gamblefree Day* quiz night organised by one provider "provided an opportunity for the community to draw on each other's strengths in working together as teams and/or family and to enjoy each other's company". Two other providers reported that community connectedness could be achieved by focusing on other community-related activities that have a "common good" element, even when these do not have a direct relevance to gambling. Other providers reported on **community events that promoted positive leisure and entertainment opportunities**. One provider facilitated public discussions about alternative sources of entertainment and leisure at a community event. Other

activities reported by providers included promoting or supporting culturally-based recreational activities, sporting events such as "waka ama", music and art, outdoor activities, "whānau fun day" and free family movies as healthier alternatives to gambling. A few providers secured additional sponsorship from fitness centres and other organisations providing alternatives to gambling activities to support these community events.

5.3.12 Barriers and challenges

A few challenges specific to particular activities have been noted in the preceding sections. One provider reported the time it takes for change to take effect and the lack of reliable measurement tools as a key challenge. The provider reported the difficulty of measuring change within a community and suggested a pre- and post-evaluation approach as a possible solution.

5.3.13 Other activities

Additional to activities that were directly related to the activities specified in the PGPH-03 *Purchase Unit Descriptions*, a few providers reported other activities under this purchase unit. One reported being on the organising committee for an international gambling conference as part of their activities for this purchase unit. They reported that their successful contributions included "securing additional funding", "weaving more Māori themes, speakers and presenters into the conference", and "expanding inter-sectorial collaborations and input towards the conference". Three providers reported on their action to enhance awareness of their intervention services availability, which included promotion through distribution of brochures at Corrections facilities and gambling venues, and through media advertising.

5.3.14 Success indicators: Supportive Communities

"Community measures of social connectedness, resiliency, cultural identity and belonging" and "number of communities participating in the development of culturally relevant campaigns/ communications that provide information to individuals on the health and social risks of gambling" were noted as indicators in the PGPH-03 Purchase Unit Description (Ministry of Health, 2010, p. 33).

Providers' reports did not state numbers of communities that were participating in culturally relevant awareness campaigns. Nevertheless, some providers reported on how the aims of their activities were to build community resiliency and social protective factors. Many providers partnered with community groups to support culturally appropriate resiliency building activities. Examples of the various ways through which providers had encouraged public discussion and debate on gambling harm and related issues suggested successful outputs. Providers also often reported successes based on the learning outcomes resulting from their awareness-raising and education activities.

Staff survey respondents' descriptions of success indicators for PGPH-03, fit within three indicator types: activity indicators, output indicators and outcome indicators, with two providers providing more than one indicator type. Thirteen staff survey respondents described the activities they had carried out including education and awareness-raising, organising public events, setting up community groups, encouraging community involvement, and developing relationships with community support services and the media; these suggested activity-related indicators.

> A youth steering group has been developed and is the main focus for this purchase unit... Based on their personal knowledge and experience they consult with their communities, schools and peers to gauge their understanding, wants and desires for their regions. From this, information is gathered, developed into work plan and then delivered back to their communities and schools. Key activities are then highlighted and planned into inter-active events annually and promoted widely. A great success was... *Gamblefree Day* held last year. A key outcome was the number of services and people who attended. The event attracted around 500 people on the day, a big step up from the 150 who attended the year before...

One public health focus group participant suggested that being flexible in meeting community interests while keeping problem gambling on the agenda was a factor that contributed to the effectiveness of activities carried out in partnership with communities.

> One of the things I have noticed in the last two years is identifying a key stakeholder to get 'buy-in'… that you can partner with in the community. When you are developing something. Finding that champion and supporting them and helping them to do, not necessarily what you want to do. And also being flexible on our approach. We obviously want to focus on gambling but if they are working in a different field but is also someone that can be a really good support, then we have to be flexible in our approach. I'll bring gambling to the table and you bring the issue that you want to focus on.

Five staff survey respondents described output indicators that included enhancements in public discussion, increases in community awareness, increases in community participation and willingness of community organisations towards establishing on-going relationships with a service provider.

> Raising the level of debate in community forums. Raising public awareness about the unseen features of gambling in communities.

> It is about whether the community organisation wants on-going relationship with our agency or not for bilateral benefits in protecting their people or clients.

While one staff survey respondent reported "reducing inequalities" as an indicator, another made reference to "community feedback on social connectedness, resiliency, cultural identity and belonging" and the "number of referrals to services", which suggested outcome-related indicators of success.

Public health focus group participants discussed that *communities taking ownership of projects* and *community willingness to stay engaged in community activities* were good indicators of effective delivery of public health services. This was associated with services providers stepping aside and taking a secondary supportive role after initiating a project or programme.

> The sustainability [of a project in collaboration with a] marae [is a good example]; they have had a *Gamblefree Day* for [about 3 consecutive] years. That has been going on for a while. And they have had a whole lot of different providers, that are sitting around the table that came up with the initiation and supported them through it. And then we gave the ownership to community. So it is actually them that is running it now and we just support them by bringing resources.

> …one of the key indicators for… is the fact that this year it is… a community church and [a] marae who are organising the [*Gamblefree Day*] event. And we are just helping them have the relationship with the HPA to get the money to put the event on. So that is a massive indicator for us that it is working really well. And they are keen to do it.

> We help support a community garden… The community has taken over, we just help with the planning of activities and running of workshops. We have got so many different people sponsoring it and supporting it, it is really good thing. Because the garden needs constant up keep, people have to constantly come together. We have just finished a massive tree planting project where we planted fruit trees all over the area… and in 15 years' time, it will provide kai. People enjoy doing things like that and they all come together quite happily in the early morning.

However, one focus group participant suggested that the Ministry lacked understanding of the indirect outcomes of providing alternative activities.

> What we are doing is that, we are giving them another activity to participate in, in a time framework where they would normally be feeding the machine… [For example] we do a waka ama… where men participate, competing out on the water with each other… and then they go back to shore and cook a sausage. [And they have their partners taking care of the kids] whilst [they] are out on the water, so they learn to be parents again. Although we detail it as "Supportive Communities", they [the Ministry] don't want to see the details, and they don't comprehend what we see, and what we are saving.

5.3.15 Adapted Logic Model: Delivery of Supportive Communities

The preliminary logic model previously depicted was expanded based on the findings from the present analysis of the six-monthly narrative reports for this purchase unit (Figure 135). Additional input areas

concerned providers' knowledge development and clarity of terminology in the Purchase Unit Description. In delivering activities for the purchase unit, providers developed evidence-based resources and materials that included background research work and community consultations. Increased community knowledge, their ownership towards projects, their engagement in healthier activities and signs of social connectedness were noted as outcomes resulting from providers' community-focused initiatives.

A few providers identified challenges, such as community resistance, the need to fit in with communities timing, and the lack of measurement tools to gauge longer-term impacts which may affect service outputs and accurate measurement of outcomes.

PGPH-03   Supportive Communities

Inputs	Activities	Outputs	Outcomes	Impact
Purchase Unit Funding	Identification of community strengths and protective factors	Health promotion programmes that build community resiliency and enhance social protective factors delivered in collaboration with mental health promotion providers and allied organisations	Communities have access to services that provide strong protective factors and build community, family and individual resiliency	People living in communities that provide strong protective factors and support individual and family resiliency
Staffing	Identification of partner organisations and relationship building	Public discussion and debate on gambling harm and related issues (including the ethics of gambling funding) enabled	Increases in community knowledge about gambling harm	
Qualifications, competencies, skills and experience	Build resilience and enhance social protective factors through health promotion programmes	Communities supported to develop culturally appropriate resiliency building activities	Programme sustainability – projects taken over by community groups	
Staff knowledge development	Promote public discussion and debate on gambling harms	Key groups' access to evidence based community action approaches for reducing gambling harm and evidence based approaches for monitoring and controlling gambling opportunities and licensing of gaming venues opportunities ensured	Communities engage in healthier sporting and cultural activities	
	Enable culturally appropriate resiliency building through community partnerships	A clear point of public contact for raising concerns on harm minimisation public health approaches provided	Communities engage with each other during organised events	
	Provide access to evidence based community action approaches	Improved public awareness of avenues for complaint regarding public health approaches to reducing gambling harm		
	Provide point of public contact for raising issues on harm minimisation approaches	Positive local media and community initiatives developed to promote family/community connectedness and positive leisure / entertainment opportunities		
	Develop media and community initiates promoting social connectedness and positive leisure			
	Raise awareness on intervention service availability	Evidence-based resources and materials developed through review of literature and research materials and community consultation		

Possible External Influences

Challenges in working with rural communities – resistant to external parties	Timing pressures to fit with communities' preferences and needs	Difficulty measuring long-term changes and lack of measurement tools

Figure 135: Adapted Logic Model: Supportive Communities

5.4   Aware Communities (PGPH-04)

The focus of the Aware Communities Public Health Service was on activities and information that could increase the visibility of harms generated by excessive gambling, with the aim of ensuring consumers became more cognisant of these negative effects. As described in the service specifications, the aims of PHGH-04 were to deliver social marketing campaigns "consistently at national, regional and community levels to improve community awareness and understanding of the range of harms that can arise from gambling" (Ministry of Health, 2010, p. 34). Activities within this service could include initiatives such as encouraging public debate, responding to public discussions or carrying out social marketing campaigns that complement and support the themes and messages in the national social marketing campaign. Activities and key processes identified by the Ministry in the PGPH-04 Purchase Unit Description are summarised in a draft logic model (Figure 136).
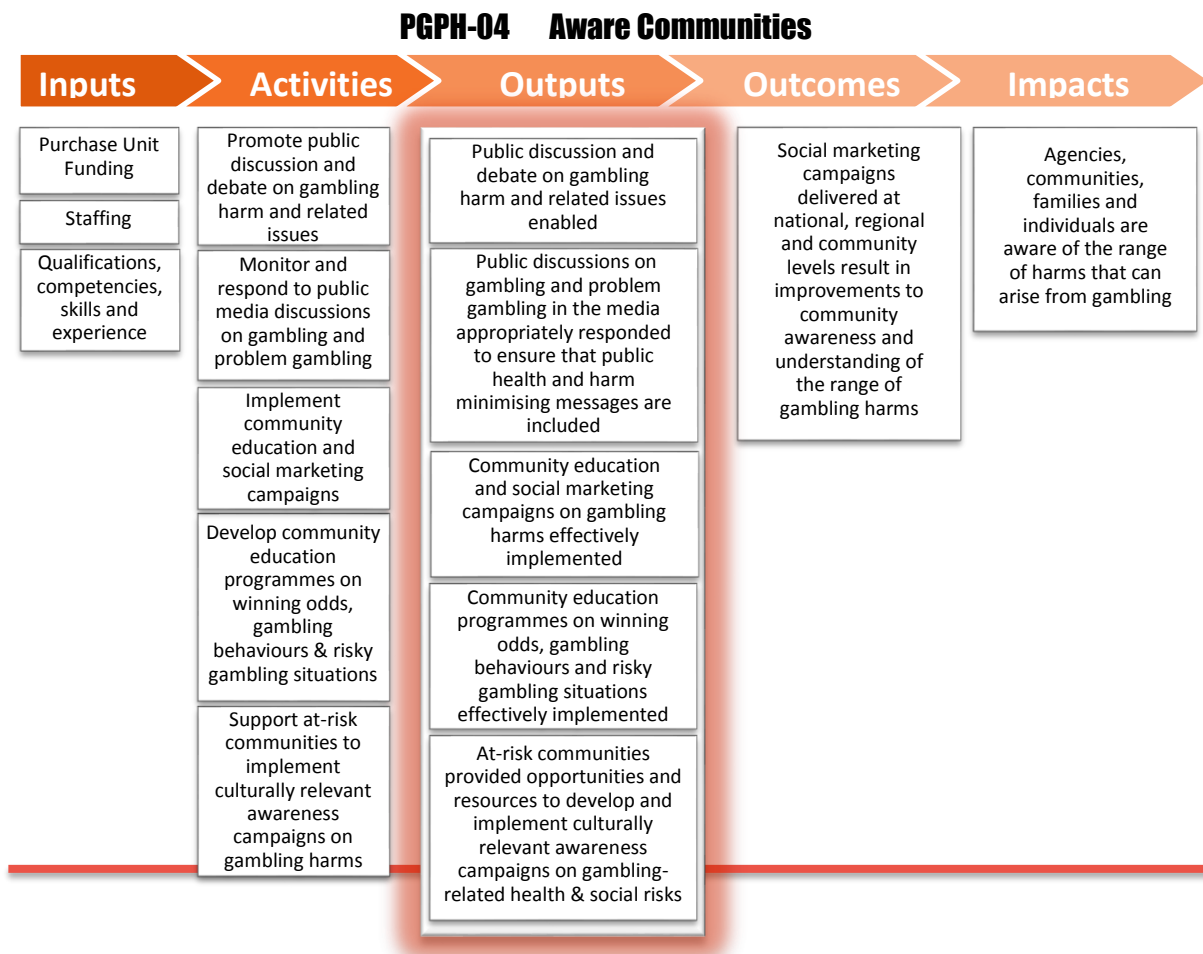
Figure 136: Preliminary Logic Model: Aware Communities

Eighteen providers had contracts to deliver PGPH-04.   Additionally, one non-contracted provider reported some activities related to this purchase unit. Following a review of literature, this chapter provides a summary of key findings from an analysis of provider reports. Of the eight providers selected for this evaluation, seven were contracted to deliver PGPH-04. Staff survey responses presented in this chapter are representative of these seven providers.

5.4.1　Literature review

Social marketing and advertisement campaigns

In New Zealand, an earlier report on the effectiveness of the *Kiwi Lives* advertising campaign (a national social marketing programme to minimise gambling harm) noted that although prompting help-seeking was not a primary aim of the campaign, the programme resulted in an increased number of calls to the national helpline and more people seeking help from problem gambling service providers (Hall & Dickinson, 2009). An evaluation of the *Kiwi Lives* III campaign used a national telephone survey (using Random Digit Dialling) to gauge campaign reach and understanding, and response to the campaign (Research New Zealand, 2013). The study was based on 350 respondents who had either experienced or been exposed to harms from gambling (group 1) and 500 respondents who had not (group 2). Over 80% from both groups reported having seen or heard advertising about gambling harm with most reporting having seen the advertisements on television. However, those in the first group (i.e. those with experience of or exposure to gambling harm and the campaign's key target audience) had a higher level of awareness of the *Kiwi Lives* advertisements than the second group.

A sub-sample of respondents from the first group who were aware of the campaign (n=300) were asked to rate a set of statements about the advertisements to gauge if they found the advertisements relatable and personally relevant. Most found the *Kiwi Lives* advertisements relevant in some way with 90% agreeing that the advertisements showed the importance of seeking help early; 87% agreed that the advertisements appeared believable and 82% agreed that they were thought provoking. A lesser percentage related to the advertisements at a personal level; 65% indicated that it made them think about how to help others and 39% agreed that the messages spoke to them directly. Among this sub-sample of respondents, 38% indicated having done something because of the advertisements; for instance a few indicated having either reduced or stopped their gambling while others indicated having made the initiative to talk to someone else about their gambling.

Kiwi Lives has received some international recognition; it was referred to as a programme that "offers an example of how social marketing can be used to target problem gambling" in an article by Gordon and Moodie (2009, p. 246) in the *International Journal of Nonprofit and Voluntary Sector Marketing*. The authors discussed how the campaign design was based on formative research findings on social marketing principles. The preliminary evaluation findings were noted as providing evidence for the effectiveness of using a social marketing approach for problem gambling awareness raising. They suggested the potential for using a similar social marketing approach for addressing problem gambling in the United Kingdom (UK) and in other nations with high prevalence of gambling problems. The authors also recommended an audit of gambling marketing communications and further research on behavioural effects resulting from gambling marketing. Evidence from such research "could contribute to upstream social marketing activities such as media advocacy and policy development". For example,

> …regulation of gambling marketing and the gambling industry (e.g. limiting the amount of TV ads, regulating the content of marketing executions and developing social responsibility codes for the gambling industry), efforts to improve corporate social responsibility and social policy around problem gambling (Gordon & Moodie, 2009, p. 248).

The authors suggested the value of embedding social norms in marketing campaigns[55], considering the emerging evidence in the literature showing how social marketing is able to successfully challenge norms. They noted that "social norms" were not used in the Kiwi Lives campaign. The authors also suggested the need for "targeted interventions, using social marketing benchmark criteria" and outlined how such "benchmark criteria could be employed to tackle problem gambling in low-income groups" (Gordon & Moodie, 2009, p. 248).

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[55] "Social norms marketing campaigns typically involve correcting erroneous perceptions regarding the prevalence of behaviour, for example, emphasising that the majority of children do not smoke or take illicit substances" and in the case of gambling, "a social norms campaign aimed at correcting misperceptions regarding gambling expenditure and frequency, highlighting that the vast majority of adolescents and adults only gamble infrequently, and expenditure is minimal, has potential value" (Gordon & Moodie, 2009, p. 248).

As social marketing has not been widely explored for problem gambling prevention programmes targeting youth, Messerlian and Derevensky (2007) used focus groups to explore adolescents' preferences for message content and communication strategy based on their exposure to messages of alcohol and tobacco use prevention campaigns. Findings from their study offer a foundation for developing a gambling prevention social marketing campaign focused on youth. They noted that their respondents indicated a preference for advertisements that:

> … depict real-life stories, use an emotional appeal and portray the negative consequences associated with gambling problems. They further recommend illustrating the basic facts of gambling using simple messages that raise awareness without making a judgment. Participants caution against the "don't do it" approach, suggesting it does not reflect the current youth gambling culture (Messerlian & Derevensky, 2007, p. 101).

Although youth were critical of the barrage of television advertisements in general, the majority believed television was the best medium for reaching youth; however, exposure would need vigilant monitoring, as youth tend to be susceptible to habituation and overexposure.

While television may remain an influential medium, social marketing campaigns would need to consider evolving online media channels for reaching youth. Jordan (2012) argued that with low-cost/ large-reach features of social media such as Facebook, public health practitioners need to acquaint themselves with best practice in this field to maximise the exposure, reach and impacts of their messages. In an evaluation of eight different tobacco prevention social media strategies implemented on Facebook (used in two tobacco counter-marketing campaigns targeting youth by the Southern Nevada Health District and the Virginia Foundation for Healthy Youth in the USA), the author used *Facebook Insights* (an analytic tool freely available to all Facebook users) to test the effectiveness of each strategy.

> "Likes" and "Unique Visitors" were compared, as well as the average measure of weekly "People Talking About This" between the end of the first and second weeks of the trial. "Likes" were calculated by subtracting "unlikes" from "likes" to account for any strategies that may have a negative impact. Each of the 3 variables were weighted equally to form an "effectiveness" score for each of the tested strategies" (Jordan, 2012).

The strategies that were found to be effective included "mixing lifestyle with health education" and "using contests that prompt users to post their own text about the program". Strategies that were found to be ineffective included "creative content creation contests (i.e. t-shirt or video contests) and posts that were purely health-based.

Additional to the above, best practice for developing media campaigns targeting youth could also be identified from findings and recommendations provided by Byrne, Dickson, Derevensky, Gupta and Lussier (2005) which were based on an examination of 25 health communication media campaigns related to drug, alcohol and tobacco use. The authors identified the key effectiveness features in these campaigns and assessed these in terms of their applicability for youth problem gambling, providing design and implementation recommendations. One of their recommendations concerned the use of "negative health effects messages"; although gambling health effects are not as clearly evident as effects resulting from "alcohol, drug, or tobacco use, gambling prevention messages should nonetheless highlight the risks associated with gambling" (Byrne *et al*., 2005, p. 694). Likewise, "denormalization messages" could be used to alter the social norms of gambling. When considering the potential impacts of "industry manipulation messages", gambling harm prevention could, for example, include messages that "underline the fact that in order to make profits the industry must produce games designed to make individuals repeatedly lose money" (Byrne *et al*., 2005, p. 694). The authors also stressed the need to evaluate the effectiveness of anti-gambling media messages by establishing baseline measures before programme implementation, and extensive evaluations following the campaign to gauge impacts on attitudes, knowledge and behaviour, as well as campaign reach and exposure (Byrne *et al*., 2005).

In the United States, Najavits, Grymala and George (2003) used a pre- to post- statewide telephone survey of 800 Indiana adult residents (400 respondents randomly sampled prior to the campaign and another 400 after the campaign) to gauge the impact of a state-funded advertisement campaign that aimed to increase public awareness about the signs of problem gambling and available resources for

help. Advertisement messages were designed for a variety of media types including radio, billboards, brochures and newspapers and for items such as t-shirts and pens, which included the campaign slogan "Play smart. Don't bet more than you can lose". The study found that the campaign had a low rate of exposure (8%) and resulted in little impact. However, the few individuals who saw or heard the advertisement reported that their knowledge of problem gambling increased as a result. The authors "suggest that advertising does hold promise in educating the public about problem gambling but that more effective means of reaching people" were needed (Najavits *et al.* 2003, p. 326). Slogans were noted to be particularly effective, as many in their sample understood and related to the campaign slogan. The authors also recommended that future advertising campaigns on problem gambling "may benefit from a more focused approach (e.g. targeting individuals at risk for gambling problems rather than the population at large), as well as adding other, perhaps more powerful, media (e.g. television)" (Najavits *et al.* 2003, p. 327).

Part of the longitudinal evaluation of problem gambling services (1996 - 2000) undertaken for the Victorian Government Department of Human Services (Melbourne, Australia) included an evaluation of a national awareness campaign, education strategies and information products (Thomas & Jackson, 2001). The evaluation used a mixed set of methodologies:

- A telephone survey (n=502) to gauge public knowledge about problem gambling and their recall of a recently implemented national campaign

- Analyses of the number and nature of calls received by Victoria's telephone counselling services (G-Line) and the number of new client registrations during and after a national television campaign

- A structured questionnaire sent to community education and gambling liaison officers to obtain information about their work and views about problem gambling and an analysis of their diary records of undertaken tasks

- Questionnaire sent to staff and managers of gambling venues to gauge their knowledge and use of BreakEven problem gambling counselling services

- Face-to-face general public and venue patrons questionnaire to gauge the reach of, and people's recollection and understanding of, the problem gambling information products that were designed and distributed during the campaign

- An analysis of samples of the above problem gambling information products.

Among other things, the findings of this study indicated a high level of residual recall of the campaign (i.e. recall of advertisements six months after its cease), increased awareness about gambling as a problem and increased awareness about available support services. The study also found "a dramatic and immediate increase in the number of telephone calls received by G-Line during Phase II and Phase III[56] of the state wide campaign" and an increase in the number of registrations for the BreakEven problem gambling counselling service (Thomas & Jackson, 2001, p. 18).

Problem gambling prevention programmes targeting youth

Although legislation generally prohibits youth gambling, in reality, indulgence in both legal and illegal forms of gambling has become a popular recreational activity among adolescents (Messerlian, Derevensky & Gupta, 2005). This may have become exacerbated as children now have greater access to games (Todirita & Lupu, 2013) both online and through other means.

A school-based prevention programme for adolescents who were gambling at non-problematic levels in Alberta, Canada, consisted of information about the nature of problem gambling; exercises to reduce

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[56] "The state wide campaign was a phased campaign with Phase I comprising radio and print advertisements, which ran for five weeks commencing …Phase II of the campaign ran for approximately 14 weeks… and consisted of two television advertisements. Phase III used the same two television advertisements as Phase II plus radio ads" (Thomas & Jackson, 2001, p. 17).

students' susceptibility to cognitive errors (common misconceptions about gambling); information about, and exercises in, calculating odds in gambling activities; and teaching and practice on decision-making, social problem-solving and adaptive coping skills (Williams, 2002). A controlled evaluation of this programme (experimental n=371, control n=226) showed significantly increased knowledge and negative attitudes towards gambling and a significantly decreased level of cognitive errors, frequency of gambling and amounts of money spent gambling. The evaluation noted that the observed changes in gambling behaviour were unanticipated as the programme had not advocated abstinence and was focused on responsible gambling. While findings suggested the potential for such programmes to prevent students from becoming problem gamblers, the need for a longer-term follow-up study was recommended for a true evaluation of this hypothesis. The authors noted that the limitations of their study included the reliance on self-reports and the risk of bias caused by *demand characteristics*[57] and the use of a custom-designed questionnaire that was not previously tested for reliability and validity.

Turner, Macdonald, Bartoshuk and Zangeneh (2008) delivered a prevention programme at schools in Ontario, Canada which included a one-hour live presentation by the authors and brief student performed skits. The programme focused on the nature of gambling, randomness, and how the winning/losing emotional states and erroneous beliefs can develop into problem gambling behaviours. A controlled experimental evaluation[58] (experimental n=212, control n=162) found that the prevention programme resulted in a small but significant increase in students' understanding of "random chance". However, the programme did not change students' gambling behaviour, their attitudes towards gambling or their coping strategies.

A recent study in Cluj-Napoca, Romania using a controlled experimental design evaluated the influence of a specific primary prevention tool (interactive software referred to as *Amazing Chateau*) on children's knowledge about gambling (Todirita & Lupu, 2013). The study randomly assigned 81 children into three groups (control, exposed to *Amazing Chateau*, and exposed to rational emotive education) and tested them for change using a 38-item questionnaire before and after the intervention. Findings suggested that the software resulted in significant improvements to gambling-related knowledge and corrected children's understanding about how games work. The evaluators argued that the results were affirming that the use of specific primary prevention tools for correcting misconceptions about games was more effective than using rational emotive education only.

Another controlled experimental evaluation (experimental n=145, control n=36) of a school-based intervention programme in Italy found similar results (Donati, Primi & Chiesi, 2014). The intervention aimed to develop accurate knowledge about gambling and reduce related fallacies, unrealistic optimism about gambling profitability and superstitious beliefs. Students in the experimental group showed improvements in knowledge and reductions in misconceptions, optimistic views about gambling profitability and superstitious thinking. The study was, however, noted to be limited as result of unequal experimental and control group sample sizes.

5.4.2 Effectiveness of PGPH-04 activities (staff views)

Figure 137 shows staff survey responses on the level of effectiveness of the various PGPH-04 activities in achieving their respective objectives. The results suggest that most respondents rated the majority of the Aware Communities activities as effectively delivered by their organisations. The lowest percentage of staff rating an activity as effective was *ensuring consistency of all activities with national social marketing campaign*, but this was still two thirds of respondents.

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[57] In experimental research, the term *demand characteristics* generally refers to how participants sometimes alter their behaviour in order to fit with what they believe the researcher is expecting of them or to fit with what they believe to be the experiment's purpose. Such an act on the part of the participant can have an impact on research results because participants are changing their behaviour to conform with conceived expectations and not necessarily because of an intervention.

[58] The evaluators included a range of measures in their pre-test and post-test questionnaire that adapted items from previous tools which included a "random event knowledge test", "the SOGS-RA", "the luck and skill questionnaire", as well as "an open-ended questionnaire asking the students how they would cope with various stressful situations" (Turner et al., 2008, p. 239).

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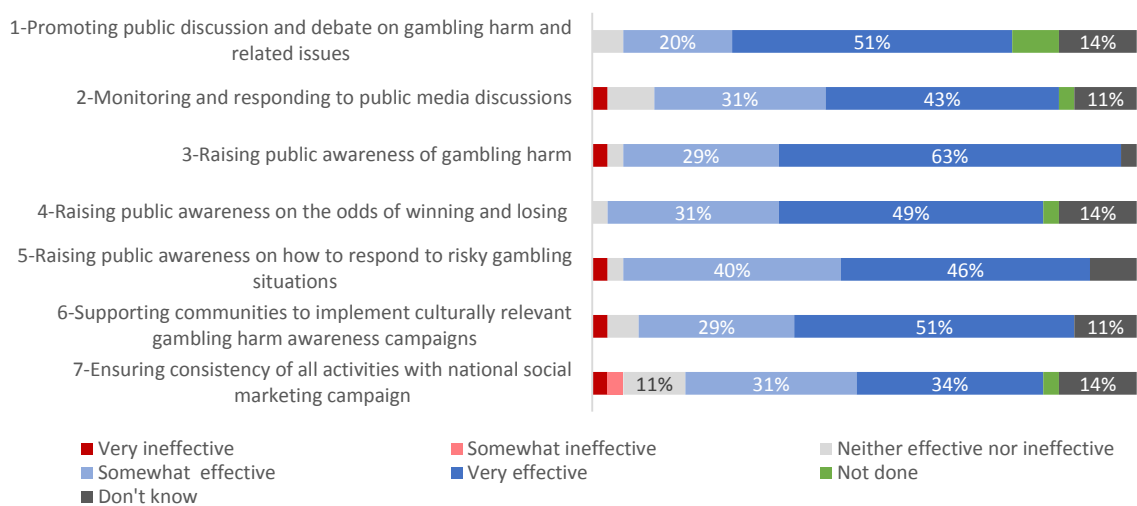
Figure 137: Effectiveness of Aware Communities activities as rated by staff (n=35)

5.4.3 Providers' knowledge development

Analysis of narrative reports suggested a few providers had developed their own knowledge and capacity to deliver services for this purchase unit. One provider reported involvement in a gambling-related national research project, which built their knowledge of communication approaches that were effective for Māori. Likewise, another provider reported their efforts to develop staff knowledge and capacity by using research-based information resources obtained from another PGPH service provider, and through meetings with the HPA on social marketing approaches.

5.4.4 Stakeholder engagement and relationship building

Similar to other public health purchase units, developing relationships with stakeholders and building networks were included as activities in the reports of a number of providers. Providers reported engaging in discussions with stakeholders about gambling in their area, attending meetings, delivering introductory presentations, and introducing the problem gambling services that were available. Providers may have engaged in these activities to pave a path towards future opportunities for public discussion and debate.

Considering "problem gambling information" was not a factor that can bring together "communities, families or individuals" one provider suggested that awareness-raising needed to be "tagged on to [other] community initiatives". They documented that Māori and Pacific communities tended to naturally congregate in high numbers in places such as marae, churches and at sports events, and attendance at these venues/events built their profile within these communities. Likewise, another provider indicated attending local community meetings as these offered opportunities for raising the issue of problem gambling as well as for networking.

5.4.5 Public discussion and debate on gambling harm and related issues

Similar to PGPH-03, promoting "public discussion and debate on gambling harm and related issues" was one of the activities described in the PGPH-04 Purchase Unit Description (Ministry of Health, 2010, p. 34). The reporting template also required providers to report on "any social marketing and media activities delivered over the preceding six months" and noted that "copies of media releases and activities [are] to be provided to the Ministry on request" (Ministry of Health, 2010, p. 34).

Staff survey results, as shown in Figure 137, found that 71% rated the activity of *promoting public discussion and debate on gambling harm and related issues* as one that their organisations had effectively delivered. The document analysis found that providers had enabled *public discussion and*

debate through public fora, reported by one provider, and a variety of media-related initiatives, as reported by 16 providers (summarised in Figure 138).

Figure 138: Methods and channels used to enable public discussion and debate

One provider reported that their objective was to "utilise the media to promote public discussion and debate on gambling harm and raise awareness in communities". Although the majority of providers did not explicitly report such objectives, they reported engaging with a range of media including radio, mainstream newspapers, community newspapers, television, the internet and social media.

Additional to raising awareness of gambling harm, providers noted the importance of raising awareness of their service availability through media messages. Some reported using the media to raise awareness of events, campaigns or the projects they were working on. For instance, one reported having contacted several "media networks… via a series of teleconference and face-to-face meetings to promote" one of their projects, while a few others referred to their efforts to promote national events such as *Gamblefree Day*, the national *Choice Not Chance* social marketing campaign and the associated *Scribe With Us* event.

Thirteen providers reported on their engagement with **radio channels and programmes** including ethnic radio stations and community access radio. Encouraging public discussion and debate was particularly feasible through radio programmes that invited live comment from members of the public. Radio programme content focused on gambling harms, the prevalence of problem gambling, healthier alternatives, and the help available from intervention services. Some providers also noted the value of delivering such programmes in different languages as it enabled a greater understanding of, and response towards, the media messages.

One provider reported implementing a successful media campaign which resulted in help-seeking behaviour among listeners. Their inclusion of a poetry competition attracted listeners and a fortnightly presence of a staff member on the show led to *Brief Interventions*.

Another provider reported on a youth awareness-raising radio programme implemented via an ethnic radio station, which they believed increased the "support for Tongan youth to have a voice on the radio". Their process led to increased awareness about problem gambling and other social issues among the Tongan community, in addition to other outcomes such as reduced language barriers, and strengthened relationships with the radio station and the Tongan youth community (Figure 139). They also reported positive emails that the radio station received from listeners.
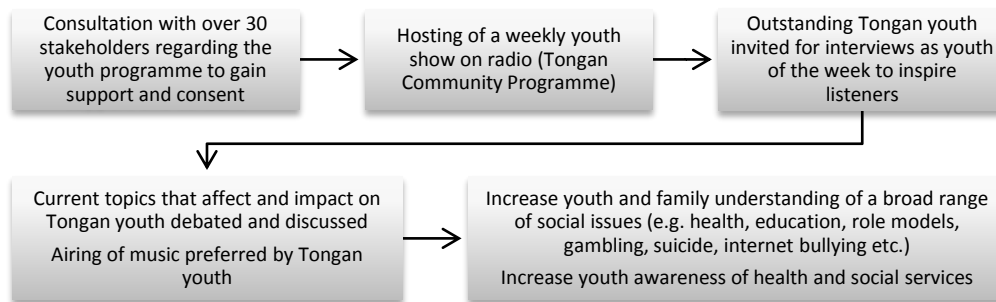
Figure 139: Youth awareness raising radio programme

Ten providers referred to **print and online news media** including national and community newspapers, as an approach for raising awareness as well as informing the public about the availability of intervention services. They reported contributing to newspaper articles on various issues related to problem gambling; topics included health and social impacts resulting from problem gambling, gambling policy reviews, political issues surrounding the acceptance of gambling funds, and participation in *Gamblefree Day*. One provider also reported on their engagement with an ethnic online news medium that had a broader outreach including communities outside New Zealand.

Four providers reported on their experience in engaging with **television media** for awareness-raising purposes; approaches included the use of press releases, contributing to documentary production, participating in media interviews and promotional shows. Highlighted issues included the prevalence of problem gambling among Māori, gambling harms related to electronic gaming machines, funding issues, difficulties in establishing healthy gambling policies, and effective communication approaches when addressing individuals faced with gambling harms.

Five providers reported on their use of **social media** such as Facebook, Twitter and blog posts for awareness-raising purposes. This media approach required regular monitoring and updating of content as well as responding to messages. For one provider, social media was useful for gaining public support in the form of submissions in favour of a sinking-lid policy. In the process of using social media for various promotional purposes, this provider developed a better understanding of what works best for the different social media types; this understanding in turn lead to a more selective use of media content.

Social media is likely to be an increasingly important channel to consider for reaching out to online gamblers. One provider noted its effectiveness as it led to engagement with problem gamblers (who were also users of such media). In their attempts to explore social media as an awareness-raising channel, another provider noted "the volume of gambling-related activities that were available or being promoted via Facebook" and how incentives and networks were used to engage others. This led to concerns over harms from online gambling activities.

One provider reported a very systematic approach for developing a Facebook page for their organisation with the aim of ensuring its ongoing manageability. Their process started with a review of existing public health social media pages. They found very limited information about gambling harm available

on Facebook. As shown in Figure 140, the provider's process also included a focus group discussion to first identify user information needs, prior to designing the content.
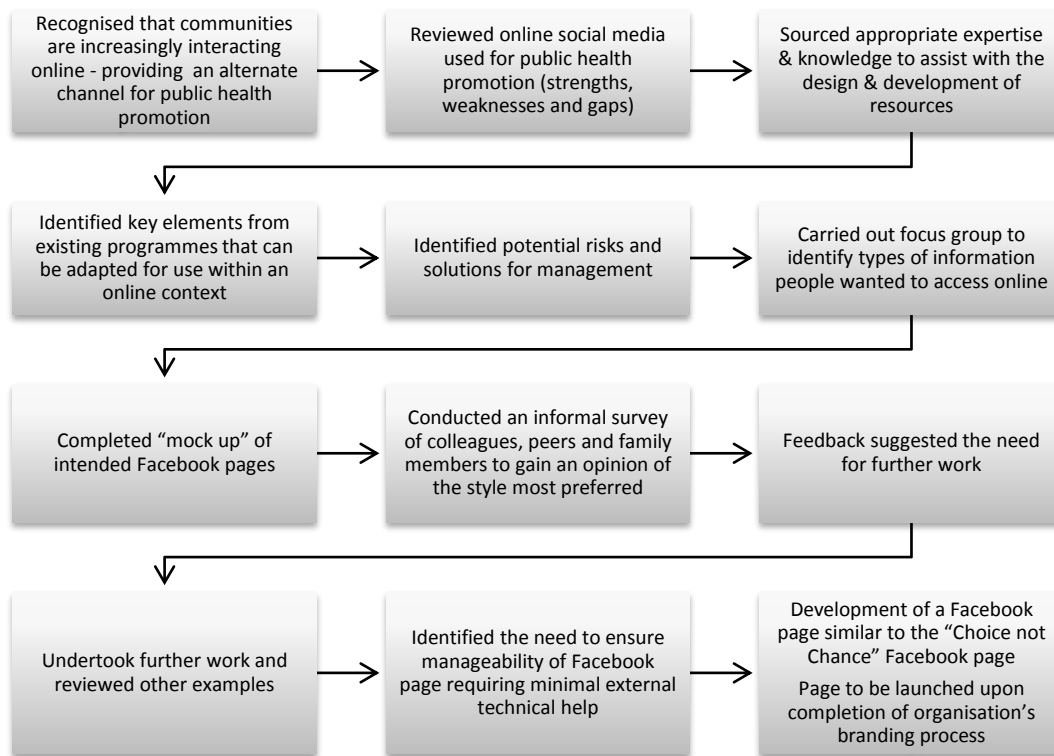
Figure 140: Systematic approach to developing an organisational Facebook page

As a second step, the provider undertook an informal survey to gain advice on the layout. This resulted in an additional review of other examples to inform their Facebook page development. Based on the gathered evidence, the provider decided to base their Facebook page on the Choice not Chance Facebook page while ensuring the development of a page that was within their capacity to manage with minimal need for external technical assistance.

While most providers have established websites, one mentioned additional efforts in **organisational website development**. They aimed to "…develop new concepts, designs and marketing material that appeals to both Māori and non-Māori audiences to promote gambling minimisation services". To improve their website they met with a website design company; despite some successful outcomes, they noted a lack of cultural understanding on the part of the website developer as a limitation.

Additional to direct involvement with the media, a few providers **encouraged community and client involvement in media coverage**. One supported the community groups they had established to contribute to media discussions on problem gambling, by working collaboratively with the groups in developing media articles and press releases. Another provider's approach of including the media in an awareness-raising bus tour also led to community involvement in media coverage and public discussion in a talk-back radio show. Caller comments suggested that while there was a problem among the Tongan community, there was also a lack of awareness of gambling as a form of addiction. A small number of providers reported involving their clients in media coverage. One provider reported that their "clinician worked with a client who told their story in the… newspaper". Another provider noted the value of encouraging client involvement in media coverage, which includes therapeutic benefits to the client; however, this process required caution and careful consideration of the client's situation.

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5.4.6 Monitoring and responding to public media discussions

The Purchase Unit Description for PGPH-04 notes an expected activity for providers to "monitor public media discussions of gambling and problem gambling and respond to ensure that public health harm minimising messages are included in public discussion and promotion of gambling" (Ministry of Health, 2010, p. 34). As shown in Figure 137 (second row), 74% of staff survey respondents rated this activity as being effectively delivered by their organisations.

However, the document analysis found that only five providers reported that they had kept track of gambling-related media articles with some indicating how they had responded to these media articles, when appropriate. One provider reported that when news articles referred to "local or regional individuals or communities" they responded "with a brief letter to the editor or a statement". Another provider noted that their media-related work also included responding to media enquiries, which in turn provided the opportunity to raise awareness of gambling harms.

One provider highlighted the need to expand media monitoring to include monitoring of gambling advertising. They reported that advertising of gambling includes television promotion of sports betting, "promotion of gambling successes" such as on individuals' significant wins, "promotion of online gambling via unsolicited" emails, and "multiple newspaper articles promoting 'Big Wednesday', Bulls Eye, Instant Kiwi and Lotto". They "anticipated that with the advent of the Rugby World Cup, there will be increased promotion of sports betting and sports themed gambling activities (e.g. Instant Kiwi)". They noted that online forms of gambling are likely to have a particular impact on youth and they suggested that gambling advertising should be accompanied by Government health risk messages.

Two providers reported challenges when responding to the media. The lack of organisational media policy for one provider acted as a barrier to their responding to media discussion. Another provider reported on the difficulty of being timely in preparing media responses, as issues raised in the media become "old news" very quickly.

5.4.7 Community education and social marketing campaigns on gambling harm

Delivery of activities, as described in the Purchase Unit Description for PGPH-04, includes "implementing community education and social marketing campaigns to raise public awareness of gambling related harm"   (Ministry of Health, 2010, p. 34). Figure 137 (third row) shows the staff survey results and found that a high majority (91%) of staff indicated that their organisations were effective in *raising public awareness of gambling harm*.

As noted in the section above, the document analysis found that providers engaged with the media in a manner that resulted in coverage that contributed to community awareness on gambling-related harms. Additional to these, providers also engaged in other types of education and awareness raising activities (summarised in Figure 141).

Figure 141: Community education activities reported by providers

Fifteen providers reported educational activities, often in the form of **presentations and workshops organised for selected stakeholder groups** such as community groups (e.g. ethnic-based groups, women's groups and church groups), health and social services (e.g. general practitioners), community services council, local boards, tertiary students, elders and senior citizens. One provider indicated having carried out research to support the development of their health promotion presentations.

The objectives of these presentations differed depending on the target audience. For instance, some presentations aimed to raise-awareness of gambling harms, encourage screening practices and promote the availability of intervention services. Other presentations, such as those targeting local board

decision-makers, focused on gaining support for related policies and healthier alternative activities. Some providers reported distributing relevant resources during their presentations. When screening was included as an activity within the presentation or workshop session, this often led to identification of individuals with gambling problems and referral to intervention services.

Some providers reported the outcomes of their awareness-raising initiatives based on attendees' responses. These included requests for additional presentations, increased awareness of the seriousness of problem gambling and, in the case of social service employees, its relevance to their respective areas of work. One provider reported including evaluations at the end of presentations, to gauge presenters' effectiveness and their need for further training.

Four providers reported organising **specially tailored education programmes for youth groups and schools**. One described how their educational programme for Māori youth led to positive outcomes such as enhanced understanding of problem gambling among Māori, ways to make healthier choices and ways to support affected whānau. Another reported an educational programme for a boys' group in their area and the positive outcomes resulting from the programme, which included an awareness of potential triggers of problem gambling behaviours and protective factors.

Other providers reported programmes designed for schools, which included informative sessions on gambling harm, quizzes, career mentoring and distribution of youth-appropriate HPA resources. Follow-up with the schools and received comments suggested positive outcomes in terms of student learning. As one school reported, "the resources generated a lot of constructive discussion and provided a possible explanation for some issues [that] whānau within the school presented with". Students became more capable of questioning teachers and other students around problem gambling issues and gained an understanding of the importance of budgeting and financial management. One provider noted that gaining access to schools was challenging.

Nineteen providers reported being present at and/or setting up **information stalls during public events**, and in public places to deliver messages and resources to ensure that community members were well informed about gambling harms. Local public health expositions (e.g. Community and Social Service Expo, Whānau Ora Day) as well as at national festivals and cultural events such as the Kapa Haka Festival, Matariki Festival, Polyfest and Chinese New Year and Korean Day were all noted. Presence at cultural events were seen as advantageous for attracting large crowds and populations that included Māori and Pacific ethnic groups and for targeting other ethnic groups such as Asians.

A few providers reported collaborating with other PGPH service providers in their region in the organisation of events. Some noted that interactions with public members enabled them to gain an understanding of public perceptions and needs in relation to problem gambling and problem gambling services. These events often involved the distribution of awareness-raising resources (many referred to the *Choice Not Chance* materials) as well as information about the providers' services. Two providers reported on specific approaches they used at their public information stalls to engage public discussion about problem gambling. One used laptops and iPads to upload public comments onto their Facebook page, which enabled community members to engage in discussions about problem gambling. A second provider encouraged public discussion by inviting community members to participate in games and quizzes at their stall.

Some providers used their involvement in public information stalls to achieve outcomes other than raising awareness. Many providers reported conducting *Brief Interventions* at such events, some used surveys to assess public opinion, while others used the opportunity to seek public support for policy implementation. Another outcome that appears to have resulted from such events is media coverage, which led to subsequent outcomes in the form of political interest in gambling-related issues. Media coverage of such events may have occurred as a matter of course or because of providers' initiatives.

Nine providers reported providing coordination support for the organisation of *Scribe with Us* events in their regions. Their support included ensuring cultural aspects of the event, developing promotional materials, promoting the event locally and through the media, providing security support and assisting with venue set up.

One provider reported organising a local event on ending harmful gambling, in line with the national *Scribe With Us* rap campaign. They reported their intention of making this an annual event with the theme for 2012 being 'Choice not Chance'. In addition to awareness-raising, their process shown in Figure 142 indicated success in involving health and social service organisations in their event.
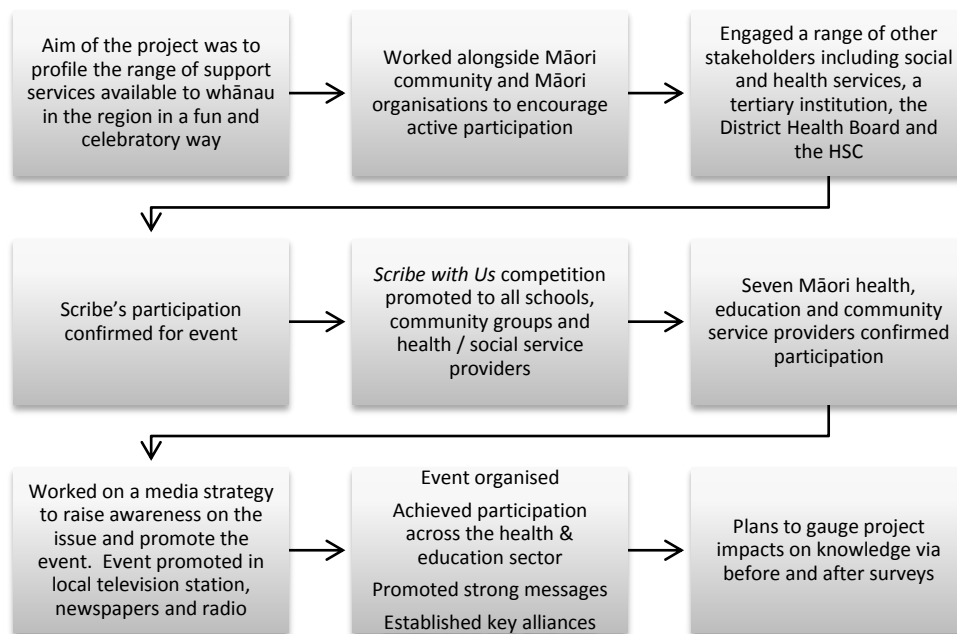
Figure 142: Provider-organised local event in line with the national *Scribe With Us* rap competition

Fourteen providers mentioned their presence at and activities during *Gamblefree Day* events in their respective areas. Although one provider reported on their successful involvement in a joint agency planning and execution of *Gamblefree Day*, they noted several areas of concern. They provided a list of key issues, some of which they believed were not yet resolved.

> 1. [A lack of a] local plan or [clearly defined] objectives… [meant that] that… [possibilities for] evaluation was limited. 2. A focus on clinical (e.g. numbers of interventions) rather than public health (such as raising-awareness) approaches. 3. Lack of Pacific and Māori involvement in the planning process. 4. The planning processes were not inclusive so… cultural and public health expertise were side-lined. 5. Lack of recognition of [our organisation] both in the planning, implementation and evaluation of the event. 6. [Uncertainty if] the branding and approach [were] the best way forward for public health providers in the future. These have been raised with the planning group and particularly item 6 with Health Sponsorship Council but not resolved at this time.

Organising and **participating in community meetings** was another approach used by a few providers to raise awareness of gambling harms. For example, one provider reported the value of attending a meeting with the Family Violence Strategic Group organised by the whānau centre in their community. They were able to develop awareness of gambling harms as well as develop their networks with other community services. A few providers had collaborated in organising **community awareness bus tours** as a method for raising awareness of gambling harms and attracting media coverage. Their evaluation suggested positive impacts on knowledge about problem gambling, and the participants gained first-hand knowledge from seeing the number of patrons at venues, and from clients' personal stories about gambling harms.

Distribution of **awareness-raising materials and information dissemination** was another method used to build awareness of gambling harms. As noted earlier, both HPA and the providers' own resources were used at a range of events and direct to stakeholders. Other providers also disseminated

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information through newsletters and emails. Mobile communication technologies such as text messages and the use of iPhone applications were other communication methods considered by providers.

One provider reported challenges to awareness-raising because of the social normalisation of gambling behaviours, gambling advertising, and the difficulties in encouraging and sustaining behavioural changes through awareness-raising alone. They also noted the "ease of accessibility of gambling within the community" as a challenge to their work.

5.4.8 Awareness of gambling odds, risky gambling, and health and social risks

The PGPH-04 Purchase Unit Description requires providers to "develop and implement programmes that provide communities with information on the odds of winning and losing, gambling behaviour and how to respond to risky gambling situations, and the health and social risks associated with gambling" (Ministry of Health, 2010, p. 34).

The majority of staff survey respondents (80%) reported that their organisations were effective in raising public awareness on the odds of winning and losing (see row four in Figure 137). The majority (86%) also reported their organisations effectiveness in raising public awareness on how to respond to risky gambling situations (row five). The document analysis showed many of the community education and awareness-raising activities reported by providers (detailed in the preceding section) had focused on gambling harms; for instance, impacts on financial situations and impacts on family members. Some providers also highlighted the prevalence of problem gambling behaviours among lower socio-economic decile communities.

Although the *Choice Not Chance* information about the odds of winning handed to members of the public may have contributed to knowledge development in this area, generally, providers' reports showed very little evidence of material that included knowledge about gambling odds, risk-taking behaviours while gambling, or approaches for dealing with risky gambling situations. However, the analysis did not include attachments in providers' reports so findings in relation to this particular activity were inconclusive.

Five providers provided some details that had relevance to this activity. One reported the delivery of educational programmes and "workshops on problem gambling, risk taking and addictions". Another provider reported developing an awareness-raising programme that included information about responding to problem gambling symptoms and seeking help for an affected gambler. A different provider reported the positive outcomes resulting from a weekly gambling support group they had organised, which included strategies to avoid risky gambling behaviours. They also noted the false beliefs held by the public about gambling and the odds of winning. They later reported on "plans to produce 'pictorial story boards' as a resource to promote positive mental health and debunk problem gambling myths". Likewise, comments by two other providers about the views held by public members suggested the need to identify and address existing perceptions about gambling as a positive activity, and the role advertising plays in instilling optimistic views about the odds of winning.

5.4.9 Community-led culturally relevant awareness campaigns

The Purchase Unit Description for PGPH-04 requires services to "provide opportunities and resources for at-risk communities to develop and implement culturally relevant campaigns that raise awareness and provide information on the health and social risks associated with gambling" (Ministry of Health, 2010, p. 34).

The sixth row of Figure 137 shows the staff survey results. Most (80%) staff reported that their organisations were effective in *supporting communities to implement culturally relevant gambling harm awareness campaigns*. The document analysis noted nine providers who reported various examples where they had supported community and youth-led awareness-raising initiatives. A few providers supported initiatives led by Māori and Pacific groups. One provider reported on a marae-based health promotion project through which they aimed to work "collaboratively with marae, kaumatua, whānau, hapū and iwi to address gambling harm and reduction with whānau". Their project plan is summarised in Figure 143.

| Establish a kaupapa Māori environment at the marae to promote and minimise gambling harm for whānau | → | Identify key Māori concepts of health, wellbeing and whānau ora as a framework for health promotion and gambling harm | → | Promote gambling awareness by working collaboratively with kaumatua groups | → | Establish our organisation's Māori intervention programme at the marae to assist Māori wahine | → | Develop a rangatahi strategy to identify youth gambling issues and potential risk |

Figure 143: Marae-based health promotion

Among the expected outcomes for their project were provision of "opportunities for initial engagement and education about gambling harm on a marae setting", promotion of gambling harm prevention by "key kaumatua and iwi leaders", development of "tikanga/protocols for the delivery of a kaupapa Māori intervention programme", and establishment of "a presence and point of contact for gambling support on" the marae. The provider reported that they had achieved several awareness-raising outcomes and were "satisfied with the results" they "achieved around gambling harm minimisation and working with whānau at" the marae.

Another provider reported supporting several Pacific community-led events where health and social risks of gambling were included. The events included guest speakers who presented "research about gambling harm in the Tongan Community and how to minimise… harm", "alternative funding options instead of gambling means", "mental health issues affecting… Pacific people and how it's connected to gambling harm", and gambling harm and impacts on life and family based on experiences shared by an individual. The events incorporated culturally relevant activities, such as skits and dances, which contained awareness-raising content.

A different provider highlighted the value of encouraging existing community-focused youth groups to take the lead with awareness-raising activities, as this would create a sense of ownership while also contributing towards the prevention of gambling in later life. Another provider also reported a project involving youth, detailing their efforts to develop a cultural performance for raising-awareness of gambling harms, which they later taught at an after-school programme. Their process included consultation with an expert to ensure cultural appropriateness (Figure 144). They reported that following training, the after-school programme participants will "use the haka to perform at community events where appropriate…" They believed their efforts were a success as they had "provided a resource for the iwi, and increased the cultural capacity of participants."

| Met with a Te Reo me ona Tikanga expert | → | Provided expert with project idea and he formulated the conceptual framework and words for the haka | → | Several meetings between with the expert to complete the haka | → | The haka ngeri proposed discussion around the downside of gambling and how to stay gamble free | → | Haka training provided to after-school programme tamariki |
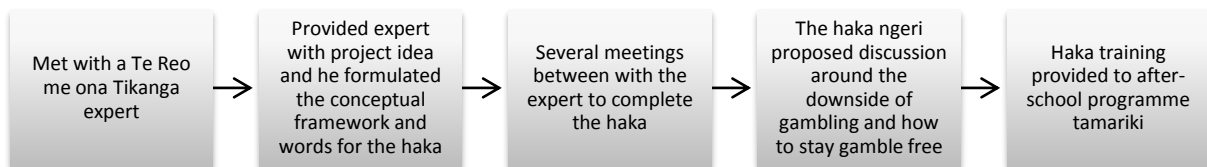
Figure 144: Designing an awareness raising cultural performance

5.4.10 Alignment of activities with national social marketing campaign

The Purchase Unit Description also states "all activities should complement and support the national social marketing campaign themes and messages" (Ministry of Health, 2010, p. 34). It indicates that key process will "include maintaining an awareness of other social marketing activities occurring and providing a problem gambling focus to these programmes where possible and delivering activities that compliment or link to national social marketing campaigns" (Ministry of Health, 2010, p. 34).

While it was not possible to determine from the analysis of providers' reports whether they maintained an awareness of other social marketing campaigns, a few providers (detailed in the preceding section) reported on their attempts to support campaigns led by community groups and their attempts to encourage the inclusion of problem gambling as an issue in such campaigns. However, these campaigns may not necessarily have been "social marketing campaigns" as defined within the field of marketing, that is, campaigns that draw from commercial marketing strategies and methods to influence voluntary social behaviour changes (Andreasen, 1994; Lefebvre and Flora, 1988).

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Sixty-six percent of staff survey respondents reported that their organisations were effective in *ensuring that all activities delivered were consistent with the national social marketing campaign* (see row seven in Figure 137). The document analysis found that all providers, at varying levels, indicated activities that either complemented or supported national social marketing campaign themes. Providers often referred to **use and distribution of national social marketing campaign materials.** Most mentioned *Choice Not Chance* promotional materials, while some reported their involvement in, and promotion of, *Scribe*-related awareness raising events. One provider's description of an awareness-raising activity on *Gamblefree Day* noted the use of materials from *Kiwi Lives*; another national social marketing campaign.

One provider reported how they had **aligned their awareness-raising resources to reflect national campaign materials** by refreshing existing materials and developing new tools. Five reported **consultations with the HSC**. Meetings held with staff of HSC helped ensure that their activities aligned with the national social marketing campaign. While providers noted the value of HSC input for their work, one provider noted an area for improvement was the need for clarity and timeliness of information from HSC. Two providers reported providing commentary to the HSC on the design of promotional materials and social marketing strategies.

5.4.11 Success indicators: Aware Communities

The Purchase Unit Description specified indicators for this purchase unit as follows:

> Community awareness and understanding of gambling harms as measured by the HSC behaviour change survey.
>
> The number of public media articles that promote debate and discussion of gambling related harm.
>
> The number of public media articles that promote life skills and resilience to gambling.
>
> The number of communities that participate in the development of culturally relevant campaigns/ communications that provide information to individuals on the health and social risks of gambling (Ministry of Health, 2010, p. 34).

The providers' reports, as noted in the prior sections, suggested a number of success and outcome indicators. Success of activities reported by a few providers included number of media articles released or the number of hits for a particular website. Although providers often mentioned working with several community groups, most did not report on the number of communities that were participating in culturally relevant information campaigns. However, reports by some providers included outcome indicators such as public responses, participant comments and referrals to intervention services.

Several providers reported efforts to evaluate impacts of the public health communication approaches they used. One indicated conducting an evaluation to determine the effectiveness of information stalls at an event in which they had participated. This provider also reported the value of conducting surveys during public events as it led to an understanding of public views about problem gambling. Contact with members of the public and posing questions also enabled identification of possible trends in public responses. For example, one provider noted that children were more receptive to questions and messages about problem gambling than adults. Other providers noted the need for more objective approaches to measuring the outcomes of this public health service. For example, one highlighted the need for "research into the effects of gambling-related material (including public health information)".

Comments by staff survey respondents on success indicators for the Aware Communities purchase unit corresponded with three types of indicators: activity, outputs and outcomes. Thirteen survey respondents described various awareness-raising initiatives including delivering presentations and ensuring cultural appropriateness of awareness-raising materials; this suggests activity-related indicators.

> The success is based on culturally and linguistically appropriate ways to communicate with the [ethnic-specific] community. That means English messages will not be passed to the [ethnic-specific] community.

A public health focus group participant suggested that organised events needed to be enjoyable.

Can I also add that it has to be fun? It is a really serious issue… gambling is an escape for people, they want to have fun. So if you want people to come to your event you need to make it interesting and fun, you need to think outside of the box, if you want them to spend time with you as opposed to where they want to be, at the pokie. Also add kai, it breaks barriers. You have to give them something, if you want them to give to you.

Six staff survey respondents detailed output-related indicators: increased public discussions and understanding of gambling harms and the number of related media articles.

Increased community awareness and understanding of gambling harms as measured by local evaluation and national surveys e.g. HSC behaviour change survey. The number of public media articles that promote debate and discussion of gambling and gambling related harm.

One public health focus group participant suggested that increases in self-referrals was an outcome of increased media messages on gambling harms.

We have got more and more clients seek help from us through self-referrals. We do a lot of media. We have two newspapers where we send articles to and place advertisements in. So the more they notice us, they know what we are doing, and how we can help, so they self-refer in coming to seek help.

Another focus group respondent suggested that the occurrence of *Brief Interventions* during public health events and subsequent referrals to the clinical team was another outcome indicator.

…When the public health team are doing a programme, especially when they are on their own, and if the intervention team is also there at the same time, they will pull them aside to talk to them… That is where successes [lie] around that…. The penny drops for people…at [such] events… That is another way through which we get self-referrals… So we get them to fill in some information and they can call. Some people want help then and there. We cannot just tell them we will get back to them later.

Focus group participants also commented on the use of evaluations to measure the effectiveness of awareness-raising activities, often seeking comments on outcomes in the form of impacts on knowledge increase and perceptions about help-seeking.

We do evaluation forms. If I do for example, Guy Fawkes celebration, with a Māori name. We put out flyers and I give them evaluation forms, asking if they had a good time and if they learned anything. I asked them if they knew who we were; I asked if [they] would consider referring to our service if they knew anyone with a gambling problem… We thought that it was a different way of putting ourselves out there and making ourselves known and we got good feedback from it. For something like that, I usually do an evaluation form so I can validate what I have done.

We usually find out if they have received some useful information from us. Did the workshop increase your knowledge about gambling? If you or your friends are involved in gambling do you know where to seek help? And some other questions.

5.4.12 Adapted logic model: Aware Communities

The preliminary logic model provided in the introduction to this chapter was expanded based on these findings (Figure 145). In addition to the activities listed in the Purchase Unit Description, other activities for this purchase unit included relationship development with stakeholders such as health and social groups, health service providers, politicians and community groups. This entailed a range of awareness-raising activities to ensure that problem gambling was included in the stakeholders' agendas. Some providers also reported on their efforts to develop staff knowledge on communication and social marketing approaches through meetings with the HPA, research participation and the use of research-based information resources. Other inputs included the development of additional health promotion materials for distribution and use in educational activities. Some providers noted the importance of a clear understanding of existing perceptions about gambling, and the role advertising plays in instilling such optimistic views about gambling. Additional to raising awareness, some providers used their activities to achieve other outcomes such as Brief Interventions and surveying public opinion.

PGPH-04   Aware Communities

Inputs	Activities	Outputs	Outcomes	Impacts
Purchase Unit Funding	Promote public discussion and debate on gambling harm and related issues	Public discussion and debate on gambling harm and related issues enabled	Social marketing campaigns delivered at national, regional and community levels result in improvements to community awareness and understanding of the range of gambling harms	Agencies, communities, families and individuals are aware of the range of harms that can arise from gambling
Staffing	Monitor and respond to public media discussions on gambling and problem gambling	Public discussions on gambling and problem gambling in the media appropriately responded to ensure that public health and harm minimising messages are included		
Qualifications, competencies, skills, and experience	Implement community education and social marketing campaigns	Community education and social marketing campaigns on gambling harms effectively implemented		
Staff knowledge development: effective communication and social marketing approaches	Develop community education programmes on winning odds, gambling behaviours & risky gambling situations	Community education programmes on winning odds, gambling behaviours and risky gambling situations effectively implemented		
Development of health promotion resources and materials	Support at-risk communities to implement culturally relevant awareness campaigns on gambling harms	At-risk communities provided opportunities and resources to develop and implement culturally relevant awareness campaigns on gambling-related health & social risks		
Clear understanding of existing public perceptions about gambling				

	Relationship development and networking	Referrals to problem gambling intervention services / brief interventions		
	Introductory presentations	Public opinions used in presentations to Council		
	Monitoring and updating of social media content	Signed petitions used to support "sinking lid" policy approach to pokie numbers		
	Monitoring gambling advertising			
	Screening during activities			
	Public opinion surveys			
	Seeking public support for gambling policy			

Possible External Influences

Ease of accessibility of gambling within the community	Social normalisation of gambling behaviours	Gambling advertisements that instil optimistic views about winning

Figure 145: Adapted Logic Model: Aware Communities

5.5   Effective Screening Environments (PGPH-05)

The Effective Screening Environments Public Health Service intends to ensure that pertinent "organisations, groups and sectors are made aware of the potential harms that can arise from gambling and actively screen and refer individuals to appropriate gambling intervention services" (Ministry of Health, 2010, p. 35). Hence, this service focuses on activities that promote awareness about, and tools that can identify, problem gamblers. Activities and key processes identified by the Ministry in the PGPH-05 Purchase Unit Description are summarised in a draft logic model (Figure 146).
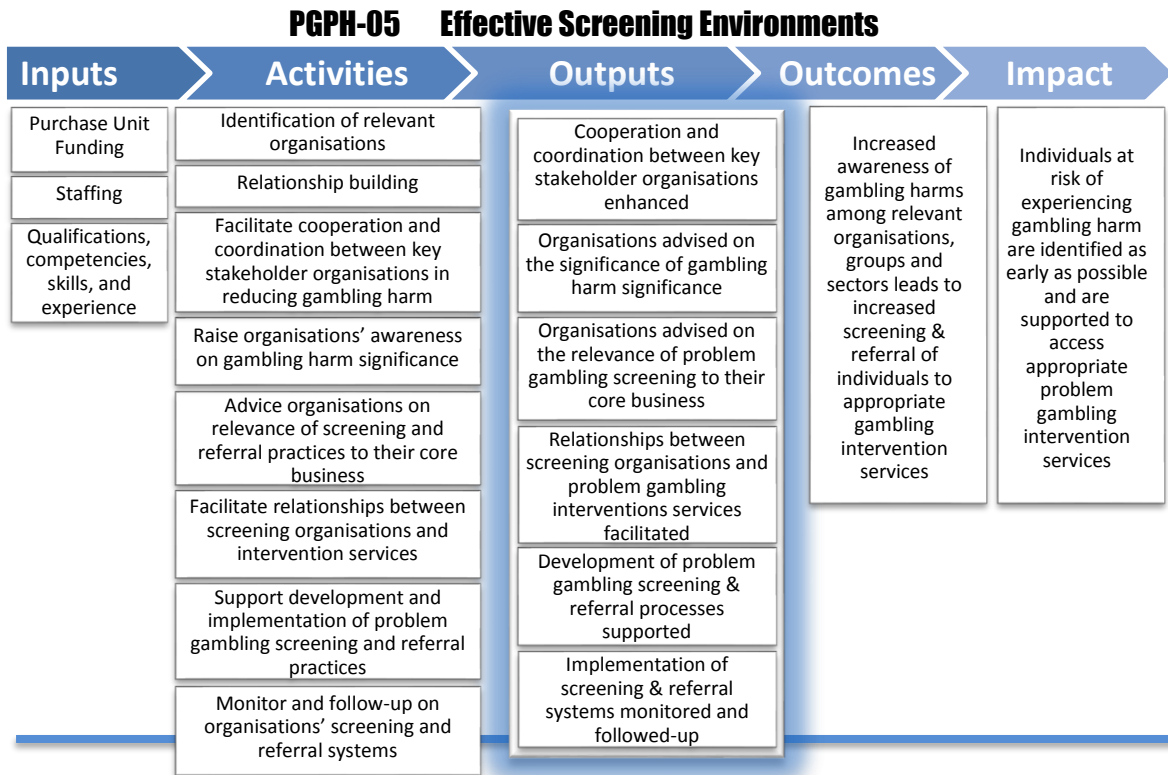
Figure 146: Preliminary Logic Model: Effective Screening Environments

This chapter contains a review of literature of relevance to PGPH-05, key findings from an analysis of 18 provider reports and survey findings representing seven[59] of the eight selected providers contracted to deliver PGPH-05.

5.5.1   Literature review

Effective Screening Environments as a public health service was another area that has not been empirically well explored in the literature. Very few studies that fit within the search criteria were found and those that were found were mainly on screening practices, which were interlinked with the provision of brief interventions. In Australia, a pilot project by an Adelaide-based gambling treatment service explored the role of general practitioners (GPs) in screening patients for potential gambling problems (Tolchard, Thomas & Battersby, 2007). Sixty GPs were informed of the prevalence of problem gambling within their community and were provided with information on how to identify and help problem gamblers and a list of relevant referral services. Forty percent of the GPs responded to a questionnaire designed to evaluate the usefulness of the resources, impacts on their knowledge, and outcomes for patients. Findings suggested that this approach was insufficient for changing practice.

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[59] One provider had subcontracted out this purchase unit.

> Despite targeting GP's with previous referral experience there was still a distinct lack of knowledge of the extent of problem gambling in the community (61%), although 96% knew of the link between emotional, psychological or physical symptoms and problem gambling. Forty-four percent of the respondents found most of the information on the sheet [to be] new and a further 22% [found] some of the information new (Tolchard *et al.*, 2007, p. 501).

Nevertheless, all respondents in the above study agreed that assisting individuals with gambling problems was part of their role. Therefore, while GPs may be a relevant stakeholder group for providing early identification and intervention they may lack resources and knowledge. Considering that their pilot study suggested the ineffectiveness of simply providing GPs with resource materials, the evaluators stressed the importance of also providing them with adequate training in the recognition and treatment of problem gamblers in order to build their capacity to identify and assist problem gamblers.

In New Zealand, Sullivan, McCormick, Lamont, and Penfold (2006) reported on the experiences of nine GPs who had received training on problem gambling intervention. Their training on brief interventions involved the reading and application of strategies described in the problem gambling treatment manual. Problem gamblers and their affected others were identified among their patients using the *Eight Gambling Screen* (Sullivan, 1999; 2007) and the *Concerned Others Gambling Screen* (Sullivan, McCormick, Lamont, & Penfold, 2007) respectively. The GPs then provided brief interventions to these patients discussing their screening results, addressing related issues that had implications for their gambling behaviour and providing referrals to specialist treatment services. In focus group interviews, the GPs reported that their skills and confidence developed over time. They also reported that most patients were receptive when questioned about their gambling behaviours. Most GPs believed that it was within their role to provide help, and patients viewed them as suitable help providers. Most also believed they were able to help their patients in addressing their problem gambling issues with their intervention. However, all of them were of the view that this was a time consuming process that often required additional appointments; suggesting that insufficient time could pose as a barrier to the GPs' role in screening and providing problem gambling interventions. Nevertheless, the authors argued that appropriate training for GPs could develop their capacity to provide intervention services, which in turn contributes towards the Ministry of Health's objectives to develop primary health care settings as venues for problem gambling screening and secondary interventions.

A subsequent study by the above authors (Sullivan *et al.*, 2007) aimed to gauge patients' perceptions of GPs as problem gambling help providers. In a survey of 1,580 patients (of which 7.5% tested as problem gamblers) they found that 13% had indicated they believed their doctor could help with gambling problems, while 36% indicated uncertainty and 39% did not believe that their doctor could help. Their study also found that problem gamblers were more likely than others to regard their GP as an appropriate help provider; however, affected others did not exhibit a similar view. The authors suggested that recognition of a GPs' role as a help provider for problem gambling could be developed through more information. They also recommended the need to train GPs in the use of specialist problem gambling screens.

Also in New Zealand, Sullivan, Brown and Skinner (2008) described the testing of the *Eight Screen* (originally developed for use by general practitioners) and SOGS with 100 inmates in a medium security prison. Twenty-nine of the inmates scored four or over in the *Eight Screen* or five or over in SOGS. The authors suggested that the *Eight Screen* was a suitable screening method for use in prisons considering its capacity to identify both early stage and established problem gambling behaviour while requiring little resources in terms of time and training for administrators. The *Eight Screen* has since been adopted by the New Zealand Department of Corrections as an assessment tool.

Within the broader primary health care sector, screening and brief intervention (SBI) have been noted to be effective prevention strategies for alcohol problems. Amaral, Rozani and Souza-Formigoni's (2010) review found that:

> SBI techniques have been used in primary health care (PHC) services in many countries and are considered good prevention strategies for detecting alcohol related problems at early stages and delivering counselling to help reduce excessive alcohol consumption and its adverse consequences (Amaral *et al.*, 2010, p. 162).

In their own study, the authors evaluated the implementation process of an SBI programme for alcohol risk in two primary health care settings in Juiz de Flora, Brazil employing a qualitative action research methodology. They found that aspects that facilitated implementation included positive project-related expectations, the SBI technique's ease of use, the collaborative way used in planning the project and data confidentiality. However, barriers to implementation included time constraints, unease among health professionals in dealing with alcohol issues, competing priorities, inconsistencies in terms of institutional support, and the culture of the organisation when it came to their own alcohol consumption (e.g. work-related celebrations). These findings could inform the implementation of screening and brief interventions for problem gambling.

The development of tools for the *Effective Screening Environments* public health service could be based on existing problem gambling screening instruments and assessment tools (Alberta Health Services, 2004; Bellringer, Abbott, Volberg, Garrett, & Coombes, 2008a; Bellringer, Abbott, Coombes, Garrett, & Volberg, 2008b; Fager, 2006; Problem Gambling Research and Treatment Centre, 2011) as well as methods described in studies on early detection. For instance, a number of authors have provided methods of early detection in physical gambling venues (Allcock, 2002; Häfeli & Schneider, 2005; Thomas, Delfabbro & Amstrong, 2014). Haefeli, Lischer and Schwarz (2011) identified communication-based indicators for online gambling-related problems based on semi-structured interviews with customer service employees of three online gambling operators and from customer correspondence. Their testing of the effectiveness of these indicators suggested the value of customer correspondence for predicting problem gambling; for instance, email tonality (neutral, complaint or threat), urgency (repeated emails) and content relating to payments. The authors suggested that incorporation of "these new indicators for future gambling-related problems to existing policies could increase the hit-rate for early detection as well as the time interval in which emerging problems are identified in advance" (Haefeli *et al.* 2011, p. 284).

5.5.2   Effectiveness of PGPH-05 activities (staff views)

Figure 147 shows that staff survey respondents generally reported that their organisations had effectively delivered the activities required for the PGPH-05 purchase unit.
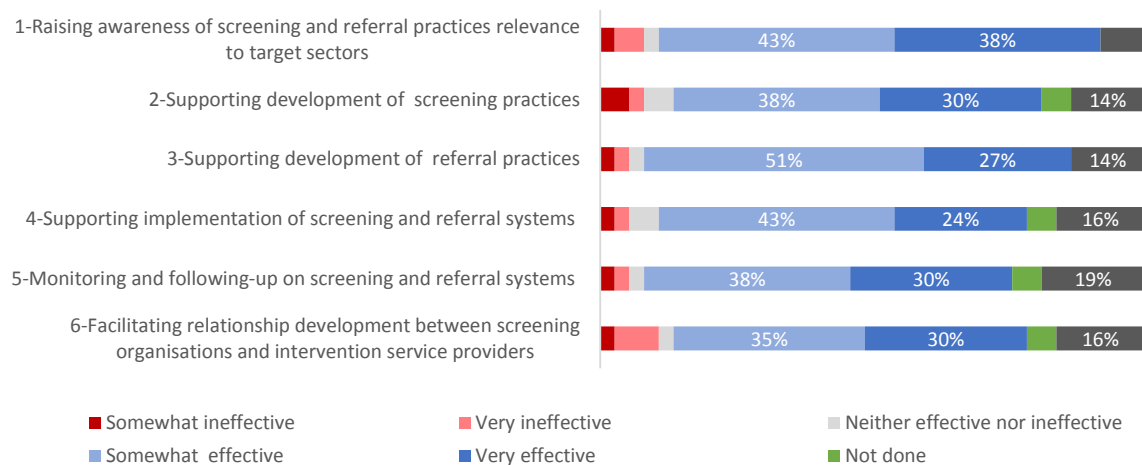
Figure 147: Effectiveness of Effective Screening Environments activities as rated by staff (n=37)

5.5.3 Providers' knowledge development

The analysis of providers' reports suggested that they engaged in a number of preliminary activities, including building their own capacity to carry out screening by attending training themselves. Three reported having attended, or having plans to attend, training on Brief Interventions and screening provided by ABACUS.

Providers also needed to acquire additional knowledge about stakeholders, which included gauging existing levels of knowledge and perceptions about problem gambling, gauging existing screening tools used by stakeholder organisations and identifying barriers to screening practices. The preliminary activities of three providers included assessing existing screening practices and tools used by organisations such as WINZ, prisons, probation services, and mental health and addictions services. Their reporting focused on the effectiveness of existing screening tools, if these screening tools incorporated problem gambling, and the contexts within which they were used. This enabled providers to consider how problem gambling screens might be incorporated into existing processes.

5.5.4 Identification of relevant organisations and relationship building

The PGPH-05 Purchase Unit Description specifies that key processes should "include identification of relevant organisations" and "relationship building" (Ministry of Health, 2010, p. 35). The Purchase Unit Description also specifies that delivery of services should "include facilitation of community action and collaboration with a range of sectors that results in development of appropriate screening practices in appropriate organisations (i.e. social service agencies, financial institutions, debt agencies, utility services, gambling venues, volunteer services, primary care sector, primary health organisations, mental health services and corrections)" (Ministry of Health, 2010, p. 35).

Providers' reporting referred to four broad sectors (Figure 148) they had worked with in the delivery of this purchase unit. These sectors included gambling venues, the New Zealand Police, prisons, probation services, health care services, and community and social service organisations such as relationship services, WINZ, food banks, budgeting services, child and family services, and drug and addictions counselling services as well as schools and marae. A few providers also referred to working with groups within the primary health care sector.

Figure 148: Stakeholder sectors identified for PGPH-05

One provider identified that working with organisations was a challenge. Other providers reported that the process enabled providers to gauge stakeholders' levels of knowledge and interest (as noted in the section above), and the preliminary discussions also enabled providers to offer training on problem gambling screening and promote the availability of their service for problem gambling-related referrals.

The activities listed in the PGPH-05 Purchase Unit Description require providers to "promote, support and participate in stakeholder groups as a tool to enhance cooperation and coordination of key organisations in the reduction of gambling related harm" (Ministry of Health, 2010, p. 35). The document analysis suggested that while most providers discussed their own collaborations with stakeholder groups, few reported how they had facilitated cooperation or coordination between key stakeholder organisations in reducing gambling harm. Nonetheless, one provider reported a collaborative approach with another PGPH service provider and the Department of Internal Affairs whom they invited to participate as guest speakers in a training they had organised on brief screening.

5.5.5 Development of screening and referral practices in appropriate organisations

The PGPH-05 Purchase Unit Description specifies that key processes should include "educating and identification of the relevance of this work to identified organisations, screening process and referral system development and support, process implementation and support, monitoring and follow-up" (Ministry of Health, 2010, p. 35). Activities included "advising organisations on the significance of gambling related harm and the relevancy of problem gambling screening and intervention to their core business" and "advocating, encouraging, and assisting organisations to develop appropriate problem gambling screening and referral processes (i.e. screening for gambling problems, accurate information giving regarding the range of intervention services available and accurate information giving regarding problem gambling and related harms)" (Ministry of Health, 2010, p. 35).

Findings from the document analysis suggested that another preliminary activity needed for delivering this public health service was the development of appropriate promotional approaches. One provider reported work in progress in collaboration with another PGPH service provider to develop a local promotional activity for screening and referral. The majority of staff survey respondents (81%) rated the activity of *raising awareness of the relevance of screening and referral practices to the core business of target sectors* as one that was effectively delivered by their organisations (see row one of Figure 147). This activity may have been implicit when providers worked with stakeholder organisations as the document analysis found very little direct evidence in providers' reports on how this activity was implemented. Nevertheless, several providers reported the need to influence stakeholder groups' perceptions of the significance of gambling harm and its connection to other issues.

Staff survey responses (Figure 147 rows two through to five) showed that most reported that their organisations were effective in supporting the development of screening (68%) and referral practices (78%), the implementation of screening and referral systems (68%), and monitoring and following-up on screening and referral systems (68%) within targeted sectors. Provider reports suggested that following preliminary work, their activities included delivering awareness-raising presentations and training on brief screening.

Thirteen providers reported various awareness-raising presentations and training on brief screening for a number of different stakeholder groups. Additional to delivering training and presentations to external organisations, two providers reported delivering training for staff of other (non-gambling) services within their own wider organisation. Some included **public sector groups** such as teachers, the police, and probation officers in their targeted stakeholder groups. One provider reported the value of establishing screening in schools by building teachers' capacity to identify gambling harm among students. Another reported efforts to develop screening approaches with probation officers who were likely to encounter problem gamblers. For similar reasons, another provider noted the police as an important stakeholder with which to engage. Their activities, which led to the development of appropriate public health materials, are detailed in Figure 149.
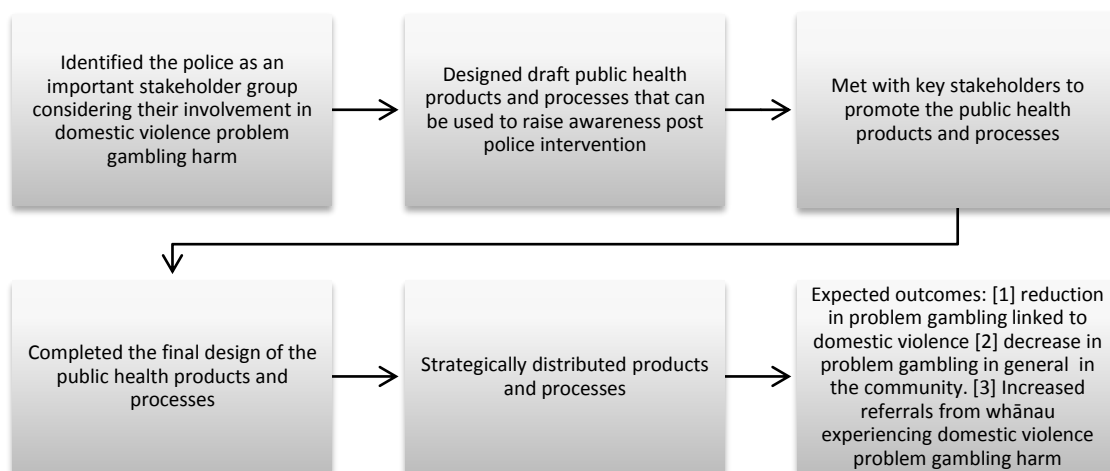
Figure 149: Development of public health materials on problem gambling-related domestic violence for the police

Some providers targeted the **primary health care sector**, for awareness-raising and developing screening approaches. One provider reported promoting screening approaches at primary health care centres. However, they reported that screening for problem gambling remained infrequent, as medical staff did not view screening for problem gambling as a priority. Despite ongoing difficulties, they maintained working relationships and efforts to progress screening in this sector. Another provider cited research indicating barriers to screening by GPs due to their lack of confidence in raising the issue of problem gambling with their patients. Their plan, which included identifying and approaching a medical centre in their region to implement a pilot programme, is shown in Figure 150.

Identified GP practices to engage in a trial to use gambling screens with their patients	→	Identified key staff from the GP practices and offered training on problem gambling screening	→	Promoted thinking amongst health professionals to incorporate gambling screens into health care packages	→	Identified pathways to capture at risk referrals from GP practices

Figure 150: Approaching medical centres to screen for problem gambling

However, they later identified nurses as a more appropriate target group. Discussions with nurses at the medical centre led to the delivery of a presentation that aimed to encourage the inclusion of problem gambling screening while at the same time meeting the nurses' requests for "information around mental health issues associated with gambling". The process was unfortunately disrupted by restructuring and redundancies. Nevertheless, the provider maintained a relationship with the medical centre by providing "cubes to the nurses to use as a prompt and reminder to screen …patients". They also expanded their training initiative to other medical centres in their district, often resourcing the centres with "brochures, cubes and pens" prior to training. They noted that although their project on screening for gambling had "fallen behind… with the milestones and expected outcomes" and they did not receive increased referrals, the relationship they had developed with one medical centre was particularly successful.

Best Practice Example 1: Problem gambling harm minimisation programme for health professionals

Another provider reported on a specially designed *Problem Gambling Harm Minimisation Programme for Professionals* - a pilot programme targeted specifically at health professionals. Their process, shown in Figure 151, began with identification of barriers to screening practices. They noted that their discussions with others in the health and social services sector led to awareness of limitations and challenges such as lack of knowledge about gambling harms, perceptions about problem gambling as a non-life-threatening problem, and lack of awareness about accesses to problem gambling services, which in combination, acted as barriers to screening.

From the knowledge gained from these discussions, the provider considered strategies that they could use to increase health practitioners' knowledge and awareness of gambling harm and influence their perceptions about the need for related screening practice. They developed an eight-week training programme.

Discussions with health and social services sector suggested that perceptions about problem gambling can act as barriers to effective screening	→	Identified strategies to develop practitioners' awareness and knowledge about problem gambling, alter perceptions about screening needs and increase screening practices	→	Gained support of senior management and board for a professional development package for health professionals

| Programme elements were based on the feedback received through discussions and relevant literature – both from the sector and adult education | → | Engaged with an NZQA-registered private training establishment that offered programme development support | → | Pilot programme offered to a Māori mental health service provider as part of their workforce development |

| Programme delivered to a range of practitioners at the mental health service including nurse assessors, social workers, service co-ordinators and doctors | → | Undertook evaluation and review of the pilot | → | Positive feedback received – Practitioners reported increased knowledge about gambling harms, increased confidence to conduct screening, and increased screening practices |

| Programme was subsequently delivered to a number of other services | → | Ongoing contact with services maintained / Regular training updates provided on request | → | Six-monthly reviews of programme conducted / Materials and resources updated as required |

Figure 151: Development of a problem gambling harm minimisation programme for professionals

Following delivery of the pilot training programme to an organisation, the provider reported positive comments received from trainees indicated increased knowledge and awareness about "gambling activities, problem gambling and gambling harm", the "potential 'life-quality threatening' and 'life threatening' effects [of] gambling harm" and referral pathways. The majority of trainees also reported that they regularly included gambling harm assessments in their general assessment because of the training programme. The provider believed that success was a result of "increased practitioner knowledge about gambling intervention services and how to access them" and "practitioners having increased confidence in their ability to screen for gambling harm" in addition to other factors such as their collaborative working relationships with these services.

The provider also expanded the programme by including a section focused on gambling harm and children after receiving comments from professionals who underwent the programme. Considering its success and importance, the provider reported that the programme had become a regular component of their service delivery.

Most providers reported delivering presentations and training on brief screening for **health and social service** organisations and groups. These included drug and alcohol counselling services, budgeting services, food banks, mental health services, Lifeline Aotearoa, WINZ, mental health and disability support services, Women's Refuge, violence prevention programmes and tertiary students in public health-related fields. Presentations and training aimed to encourage problem gambling screening and referrals. The development of collaborative relationships with the target organisations was a priority, and in some cases extended to collaboration with other PGPH service providers. To encourage various organisations' development and use of appropriate screening, one approach used by two providers was to increase awareness of the importance and merits of the screening tools by providing evidence that highlighted gambling-related harms and the prevalence of problem gambling. Another provider noted

the importance of ensuring that the introduced screening fitted within the existing practices of the organisation, avoiding the perception of additional work.

Best Practice Example 2: Tailoring screening tools to meet stakeholder organisation needs

One provider described their process in developing screening approaches for several health and social service organisations including food banks and services associated with family violence and financial issues. They noted a requirement for simple tools tailored to the needs of the respective organisations that require minimum time for implementation. They stressed the importance of using simple referral processes, which would help ensure that screening is carried out and referrals are made. This required an understanding of the context and pressures within which these organisations operated.

The provider later reported that they monitored the programme based on the number of referrals they received. They then followed up with the organisation to assess how the implementation of the screening and referral system was progressing. This led to further refinement of the screening and referral process to facilitate timely screening and easier referrals.

> Over this reporting period we… met with the regional probation service during this period in order to evaluate and review the screening programme we had set up with them. It appears that a change in report writing requirements of probation officers has resulted in less screening occurring early on when engaging with their clients …Our way forward was to run presentations to the regional services seeking their feedback on the referral pathway. From this we altered the screening process slightly and developed a new referral form to ensure their service users could be easily referred to a clinical service if required.

A different provider reported efforts to increase Pacific community groups' and organisations' understanding of the importance of problem gambling screening and referrals to problem gambling intervention services. They noted language to be a key challenge and that substantial effort was needed around relationship and trust building.

Best Practice Example 3: Development of a culturally appropriate screening and referral toolkit

Considering the need for increased awareness of screening and referral practices, particularly within non-health sectors, one provider reported efforts to develop a "screening and referral toolkit". Their activities and processes, detailed in Figure 152, showed that the development of the toolkit was based on needs identified through a consultative process that took into account Māori cultural aspects.

The provider noted that it was important to monitor the use of the toolkit to ensure its ongoing use and increase the prospect of Brief Interventions. Their finalised screening and referral toolkit contained "brief gambler screen, affected other whānau screen, [provider's] referral form, gambling information pamphlet, [provider's] rack card containing contact details and criteria, Māori Health Sponsorship Council (HSC) problem gambling pamphlet [and] English HSC problem gambling pamphlet".

Although their initial delivery of workshops on the toolkit to immigration services, a community law centre and a health and disability advocacy service resulted in very few referrals to their service, they later reported successful increases in referrals from budgeting service providers. This suggested the possibility of a time lag between introductory activities and resultant output. The provider also increased the number of workshops delivered to a broader range of stakeholder groups including budgeting services, community mental health and addiction services, settlement support services, probations, charitable trusts and community groups. Despite their success, they noted remaining challenges included agencies that tended not to prioritise gambling referrals and that overlook the significance of problem gambling, and the complex needs of clients where problem gambling is not their main issue.

Observed minimum referrals from other services. Almost all clients either self referred or found access through the national gambling helpline	Key agencies were contacted and asked to complete a survey which was designed to gauge levels of understanding of gambling harm	Surveys revealed a lack of knowledge regarding the link between gambling harm and their core business	Identified the need for better awareness of screening and referral practices within the non-health sectors
Rationale for a toolkit that can be used by frontline staff and those whose work brings them in contact with the community	The need for toolkits to be tailored to meet the individual needs of services and agencies	Introduced the concept of gambling screening and referrals to stakeholders within the health and social sectors	Input from individuals, whānau and community sought to determine design of toolkit
Time devoted to assessing the cultural appropriateness and relevance of a safe gambling checklist	Guidance and advice sought (previously developed safe gambling checklist)	Draft checklist developed	People were canvassed for their opinions on the checklist component of the screening and referral toolkit
The checklist accompanying the manufacture and print of the toolkits ensured minimal additions to planned budget	Referral /screening toolkit peer reviewed and finalised	Delivered a series of Screening and Referral Toolkit workshops to service providers	Ongoing relationship development with other organisations to promote toolkit Toolkit promoted at public events to increase uptake

Figure 152: The development of a screening and referral toolkit

Finally, a few providers also reported the value of developing relationships with other health and social services within their own wider organisation, which resulted in increased referrals. One provider noted problem gambling as an issue to be identified in the referral forms of other community services offered within their own organisation, therefore encouraging screening.

Providers reported several challenges in relation to this purchase unit. One of the barriers to successful implementation of training on screening for problem gambling was **the lack of response and initial uptake**. One provider reported that they encountered a number of challenges including lack of registrations, which meant delays to training delivery, and the need to seek alternative channels to promote the training. They also reported that selecting suitable dates to maximise attendance was also a challenge.

Lack of interest among stakeholder organisations despite promotional efforts was another challenge. One provider reported on the lack of interest among some stakeholder organisations such as Corrections, WINZ and gambling venues to take on screening and referral roles. They suggested the need to normalise the screening process and the need to define environments that were likely to be most responsive to screening. Even when there was interest, encouraging uptake of screening practices appeared to be a particularly time consuming process when screen was considered to be a time-consuming additional burden.

One provider reported difficulties in encouraging stakeholder groups to take up **"holistic" screening practices**, which included co-existing issues as well as impacts on others. They noted the need for a different approach, which combines this PGPH-05 outcome with the activities under the PGPH-01 purchase unit that aims to encourage workplace gambling policies.

A few providers experienced **culture-related challenges**, and one cited language issues. Two other providers reported culture-related challenges in the development of screening approaches. Identifying that someone has a problem through screening was noted to be in conflict with the Māori cultural norm of refraining from causing shame or embarrassment to another. The need to consider cultural

differences in the screening process, which would take into account Māori perceptions about addictions as well as sensitivities around being exposed as a problem gambler was reported.

5.5.6   Facilitating relationships between screening organisations and intervention services

As part of their activities, providers were also expected to facilitate "relationships between potential screening organisations and problem gambling intervention service providers" (Ministry of Health, 2010, p. 35). Sixty-five percent of staff survey respondents rated their organisations as being effective in facilitating relationship development between screening organisations and intervention service providers (see row six of Figure 147).

Based on findings from the document analysis, it seemed the objectives of this activity were largely met through the development of connections between screening organisations and the providers' own problem gambling intervention services. Considering that 15 of the 18 organisations delivering this public health service were also contracted to deliver problem gambling treatment services, it is likely that providers would have seen this as the most viable step.

5.5.7   Other Activities: Brief screening at public events and premises of community support services

Additional to developing stakeholder groups' screening practices, providers reported that they had carried out brief screening themselves. Twelve providers reported delivering screening assessments at public events, with a few indicating that they conducted brief screens in the premises of community support services. Delivery of this activity included preparatory work such as developing appropriate materials for screening. One provider reported developing appropriate resource materials such as flyers, screening cards, banners and evaluation forms. Another provider reported that they "developed a small poster with EIGHT screen" which was displayed and later "prompted a referral" to their service.

Some providers noted the value of carrying out brief screening at public events as it served as an awareness-raising activity, reached out to target groups in high need communities and lead to increases in *Brief Interventions*. One provider reported attending a number of events where they delivered presentations and carried out brief screening. However, a challenge was that these brief screens did not result in help-seeking behaviour. They noted the value of involving clinicians in public health promotion events as a way of increasing help-seeking behaviour. Three of the 12 providers also reported conducting screening at the premises of support services (allied agencies) such as WINZ, and alcohol and drug treatment services and how this resulted in referrals as well as instilled an interest in problem gambling screening.

5.5.8   Success Indicators: Effective Screening Environments

"The number of organisations that actively screen for problem gambling harm and refer to appropriate problem gambling services" was specified as an indicator for PGPH-05 service delivery (Ministry of Health, 2010, p. 35). As detailed in the preceding sections, while some providers reported how they had successfully supported the implementation of screening and referral processes in some organisations, none reported the exact number of organisations with which they achieved success.

Three providers reported on other measures of success. Success indicators included positive responses from participants on training programmes, implementation of screening, increase in referrals and sometimes, early-stage interventions. One of these providers identified a need for better data collection on their part, for self-evaluation purposes.

Similar to responses concerning other public health service areas, staff survey respondents' descriptions of success indicators for the PPGPH-05 purchase unit fit within three indicator types: activity, output and outcome.

Nine providers mentioned activities carried out to raise awareness, develop relationships and support the development of screening practices as indicators of success.

Face-to-face with organisations, good relationships with problem gambling services knowing kaimahi who will be working with the whānau that they refer to the gambling services.

Output indicators, described by four providers, largely related to the uptake of screening and referral practices among organisations approached.

Problem gambling screening practice is carried out by many sectors. Problem gambling screening is more accessible and available for public.

A key outcomes indicator mentioned by four staff members was increased referrals to problem gambling treatment providers.

We have specific gambling referrals coming into the services and are being allocated to clinicians for follow-up.

5.5.9   Adapted Logic model

The preliminary logic model provided in Section 5.1 was adapted based on the findings detailed above. As shown in Figure 153, additional to inputs in the form of staff time, the delivery of this purchase unit also required other inputs, which were providers' development of knowledge and skills in brief screening, and the capacity to identify appropriate stakeholders to work with. To carry out these activities successfully, other input areas included providers' understanding of the contexts of stakeholder groups including the pressures within which they operated, their existing levels of knowledge about gambling harms, their training needs and level of interest in training. Providers also needed to know about existing screening processes and tools and have the knowledge of appropriate approaches for introducing problem gambling screens.

Building relationships was a time consuming task, which often required multiple contact with stakeholder groups, to gain their trust, to encourage their interest in screening, and to alter pre-existing perceptions they may have held about the irrelevance or insignificance of screening for gambling harms. It was also necessary to maintain ongoing contact with these organisations to ensure that problem gambling remained on their agenda.

Additional to the delivery of activities that resulted in the targeted outputs, providers also needed to carry out other activities such as the development of evidence-based resources including screening tools that were culturally appropriate, easy to use and tailored to individual organisations. Encouraging uptake required promotional activities and the promotion of training availability. Following training delivery, evaluation and feedback were used to update and modify training resources, as required. Increased awareness of the availability of problem gambling intervention services was another short-term outcome that could be targeted in awareness-raising activities.

PGPH-05   Effective Screening Environments

Inputs	Activities	Outputs	Outcomes	Impact
Purchase Unit Funding	Identification of relevant organisations	Cooperation and coordination between key stakeholder organisations enhanced	Increased awareness of gambling harms among relevant organisations, groups and sectors leads to increased screening & referral of individuals to appropriate gambling intervention services	Individuals at risk of experiencing gambling harm are identified as early as possible and are supported to access appropriate problem gambling intervention services
Staffing	Relationship building	Organisations advised on the significance of gambling harm significance		
Qualifications, competencies, skills, and experience	Facilitate cooperation and coordination between key stakeholder organisations in reducing gambling harm	Organisations advised on the relevance of problem gambling screening to their core business		
Staff knowledge and capacity in brief screening	Raise organisations' awareness on gambling harm significance	Relationships between screening organisations and problem gambling interventions services facilitated		
Capacity to identify appropriate organisations	Advice organisations on relevance of screening and referral practices to their core business	Development of problem gambling screening & referral processes supported		
Understanding of contexts and pressures within which other sectors operate	Facilitate relationships between screening organisations and intervention services	Implementation of screening & referral systems monitored and followed-up		
Understanding of organisations' existing knowledge, training needs, and training interest	Support development and implementation of problem gambling screening and referral practices			
Understanding of existing screening tools and knowledge of appropriate approaches for introducing problem gambling screens	Monitor and follow-up on organisations' screening and referral systems			
	Multiple contacts to gain interest, alter pre-existing perceptions about screening, develop relationship and gain trust			
	Maintain ongoing contact to ensure problem gambling remains on the agenda			
	Develop simple screening tools that are culturally appropriate, require minimal implementation time and are tailored to the needs of respective organisations			
	Prepare evidence based resources & training materials that highlight the importance and merits of screening			
	Prepare screening promotion activity and promote training			
	Deliver presentations and training			
	Conduct evaluation / Seek participant feedback			
	Update, modify training resources as required			
	Carry out brief screens carried out at public events and premises of other support services			

Possible External Influences

Pre-existing perceptions about gambling harms as non-life- threatening / not public health related	Lack of response to training offer	Stakeholder organisations' time pressure, and other commitments
Culture-related challenges: Screening perceived as causing whakamā and language barriers	Lack of interest among other organisations in taking on screening and referral roles despite promotional efforts	Staffing changes in other organisations – require additional training provision

Figure 153: Adapted Logic Model: Effective Screening Environments

5.6 External factors impacting Public Health Services delivery

Among staff survey respondents who completed the questionnaire section on public health services, 87% reported that there were external factors which had affected the delivery of public health services. They suggested factors that were not within their control as well as some aspects of activity delivery and challenges in delivering services, as these had both positive and negative impacts on their capacity to deliver services. A summary of external positive and negative factors identified by staff survey respondents is in Figure 154.

Positive	Negative
Supportive social and political direction on gambling harm prevention	Excessive political sensitivities
Active and regular involvement in community activities	Government's vested interest in gambling profits
Stakeholders' willingness towards collaboration and interest in involvement	Lack of clarity on the meaning of "political neutrality"
Using the media to encourage public discussion	Other service providers' negative relationships with gambling industry
Public discussions on gambling-related issues	Contract and funding uncertainties
	Stakeholders' lack of support and willingness towards collaboration
	Resource insufficiencies
	High staff workloads and time pressures
	Insufficient investment in media public health messages
	Community group acceptance of gambling funds
	Technical difficulties with communication technologies
	Stigma associated with problem gambling and lacks in stakeholder screening practices

Figure 154: Positive and negative external factors affecting delivery of Public Health Services as identified by staff survey respondents

One staff survey respondent regarded "the supportive social and political direction on the prevention of problem gambling" as a positive external influence. Another three detailed the value of stakeholders' willingness to collaborate, including support shown by gambling venues, volunteers and community groups.

> Support from volunteers, churches, and community leaders is very effective but no funding for this part. We always ask them for support but not much rewards for them. I felt sorry for them and I use my own finance to show my thanks.

Two staff reported the value of using the media to encourage public discussion and building effective media relations.

> As we have good relationships with [the relevant ethnic] media, they understand what we are doing and doing well. So they provide support to pass out our messages to the community and we also

provide articles that their readers and viewers love to see, that would be a win-win-win situation (we, media and community).

Public discussions on gambling-related issues was viewed by another two staff members as a positive external factors as this may enable public health problem gambling service providers to build on raised issues.

> The debate over the International Convention Centre in Auckland and Auckland Council Class 4 Policy review. These gave us the opportunity to explain about the harm of problem gambling and effective prevention strategies to stay healthy from gambling harm.

In explaining negative external factors, two staff survey respondents referred to excessive political sensitivities, whilst comments by another two suggested that they viewed the government's stake in profits from the gambling industry to be a negative external influencer.

The Intervention Service Practice Handbook indicates that providers need to "perform the agreed services in a manner that is consistent with and maintains the Ministry's actual and perceived political neutrality". (Ministry of Health 2008b, p. 6). This is not intended to restrict providers' implementation of other activities; however, providers need to make clear that such activities are "independent of the services contracted with the Ministry" (Ministry of Health 2008b, p. 6). However, comments by one staff survey respondent suggested that the lack of clarity on the meaning of "political neutrality" as described in their contract, had negatively had an impact on service delivery.

> [The Ministry of Health] stating that we have to be 'politically neutral' but not giving us a clear indication of what that really is. What we can and can't do. It has meant that we didn't partake in something that was important for our sector; only to later be told that we [could have].

Another staff survey respondent commented on how expectations of political neutrality had acted as a deterrent to open public discussions in the delivery of the Supportive Communities and Aware Communities public health services[60].

> [For a more effective delivery of the Supportive Communities purchase unit, there needs to be] reduced constraint from Ministry of Health in deciding what conversations can happen in the community about pokie gambling. Discussions about political neutrality are hampering success in this area.

Likewise, discussion among public health focus group participants also suggested that some found the political neutrality expectation to be a challenge when delivering public health services.

> I suppose another challenging thing can be the political neutrality part. We are out there, our intention is not to be pulled into the political arena but we do end up there sometimes. So that can be difficult. In our service, we constantly remind staff - remember whatever you say, be careful what you say, especially out in the public arena. Because you stand then, not as yourself, but as the organisation that you are part of.

For one staff survey respondent, a negative external factor was a result of the actions of other service providers which affected the working relationship with a key stakeholder group; the gambling industry.

> Other gambling service providers having negative relationships with industry [which] blocks working relationships at times.

Uncertainties over their own contracts and funding-related worries among potential collaborating agencies were also viewed as negative external influences by three staff respondents.

> Difficulty in working collaboratively when other agencies are worried about funding.

Lack of support and willingness towards collaboration from stakeholders' was mentioned by four staff survey respondents as a negative external influencer.

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[60] This explanation was provided in relation to success indicators for the Aware Communities and Supportive Communities public health services.

> Our three priority stakeholders are not engaging with us even though one of their chairpersons is on our Board. These three are the big services in our region. They say they are not funded for problem gambling even though the offer is only to make a presentation to them. We serve a population of approximately 46,000 and we get no co-operation from these providers who have community assets in rural areas.

Five staff mentioned insufficiencies in resources, including the lack of language and culture appropriate promotional public health messages.

> The Health Promotion Agency's media campaigns and promotional material are all in English, all messages and information are not understood by [some ethnic] communities. They should be aware and provide culturally and linguistically appropriate services to the [ethnic] communities. That will affect our public health services.

Three staff survey respondents mentioned limitations in staff numbers, high workload and time pressures as negative influencers.

> We know [that family-oriented activities are]… really helpful to change clients, but we have limited [staff] and finance, we cannot deliver as much as we want for the successful change of gamblers.

Other external barriers mentioned by staff respondents included community groups' acceptance of gambling funds, technical difficulties with communication technologies, stigma associated with problem gambling, and the lack of screening practices in some services such as the police, GPs and hospitals.

5.7   Summary of Findings

Some aspects of service delivery were similar across the five public health purchase units. These common areas are summarised in the immediate subsections that follow.

Key areas of input

- An area of input frequently mentioned in providers' reports related to **providers' knowledge**. This could mean challenges and needs such as:
  - o   Limitations in staff knowledge and expertise
  - o   Lack of establishment within a public health role
  - o   Additional training required (e.g. on the policy submission process for PGPH-01).

- In other cases, positive aspects were recorded relating to **providers' knowledge**, for example:
  - o   keeping updated with recent data
  - o   Attending relevant programmes and training
  - o   Understanding community perspectives through surveys
  - o   Engagement with various stakeholders, other PGPH providers and the HPA (e.g. to increase knowledge about gamblers' trends, MVE processes and alternative fundraising options).

- A few providers reported that **time** and resource limits, including staffing issues, made it challenging to meet the outcomes of public health services.

- For some purchase units, there was the need to **develop new resources**, adapt existing materials or reproduce materials in appropriate languages to enable service delivery.

Stakeholder engagement and relationship development

- All providers' included aspects of relationship development with stakeholders and other PGPH service providers in their reports.

- Providers sought and identified suitable allies, raised awareness, elicited support for their agendas, and engaged in, or enabled, collaborative public health activities.

- Stakeholder engagement was a gradual and often a time-consuming process. Engaging with the gambling sector required both caution and tact to ensure cooperation.

- Engagement was often through face-to-face meetings using a consultative approach. Such engagement and communication with stakeholder groups led to:

  o Increased awareness among stakeholders about gambling harms and community-related processes that can address gambling harms (i.e. stakeholder participation and action)
  o Strengthened provider-stakeholder relationships
  o Better-informed decisions
  o Community input into decision-making and a stronger community voice in the prevention of gambling harm
  o Development of providers' understanding of stakeholder perceptions, situational contexts, and existing practices, which in turn provided insight for developing appropriate public health strategies and approaches.

Education and awareness raising

- Purposeful education and awareness-raising activities that providers reported upon included:

  o Delivery of workshops, presentations, and education sessions
  o Development and distribution of awareness-raising materials (e.g. newsletters, posters, informational cards and brochures)
  o Use of culture appropriate resources and educational approaches
  o Organisation of special events (e.g. debates, cultural events, community meetings).

- Assessments carried out by some providers showed impact on knowledge and increased stakeholder willingness to participate.

Policy Development and Implementation

- To encourage the development and implementation of **workplace and organisation gambling harm minimisation polices** providers used several strategies:

  o Developing their own problem gambling policies
  o Developing support tools (e.g. gambling behaviour surveys and self-audit tools)
  o Raising awareness and understanding of gambling harms that staff may be exposed to
  o Providing incentives (such as special awards) to encourage development of workplace gambling policies
  o Providing active help in drafting and finalising policies
  o Adapting or adding to existing operational polices or plans
  o Endorsing existing gambling policies
  o Adding problem gambling to wider health-related policies.

- The majority of provider reports gave little evidence of activities that had aimed to raise awareness on the **relevance of gambling-related policies to the core business of targeted sectors**. The majority of staff survey respondents rated this activity as effectively delivered, perhaps suggesting they viewed it as implicit in their activities.

- Key factors that impaired uptake of policy development among organisations centred on perceptions that gambling was not an issue of relevance to them.

- Few providers reported on examples of successful development of **policies on non-gambling fundraising**, instead they focused on encouraging alternative fundraising practices.

- **Public policies** supported by providers' included the *Gambling (Gambling Harm Reduction) Amendment Bill* and submission efforts in relation to regulation 16(g) of the *Gambling (Class 4 Net Proceeds) Regulations 2004*.

- The larger area of policy focus was in relation to **Class 4 venue policy** and the associated "sinking lid" approach to pokie machine numbers. Several steps and approaches to influence policy decisions were used:
  - o Education and awareness raising
  - o Discussions with members of the public and meetings with key stakeholders particularly city councillors
  - o Encouraging and enabling community involvement in the policy decision-making process
  - o Carrying out research and providing councils with relevant statistical information to support an evidence-based policy development process
  - o Lobbying and advocacy through the media
  - o Putting forward submissions and written statements.

- Despite some successes in achieving policy outcomes, challenges were noted around pre-existing views and interests of councils.

- Although providers were expected to contribute to, and participate in, **gambling harm social impact assessments** in their respective districts, the majority of providers' reports did not contain clear or explicit evidence of this activity.

Safe Gambling Environments

- Over half of staff survey respondents reported that their organisations were effective in developing working relationships with gambling venues.

- Providers had mostly supported the **implementation of host responsibility practices** in venues by delivering a range of interconnected activities incorporated within a process of developing working relationships.

- Some providers achieved success by:
  - o Establishing a symbiotic relationship with venues
  - o Collaborating with, or consulting, venues when developing resources
  - o Developing resources that enabled greater uptake and implementation of MVEs.

- There was little evidence in providers' reports of success in supporting **venue harm minimisation policies**, **monitoring and following up on venues' practices** and **enabling collaboration between gambling venues and other organisations**. Less than half of staff members rated these activities as effectively carried out.

- A range of challenges was noted, centred on pre-existing views of gambling operators/venues.

Supportive Communities

- Most of the staff survey respondents reported that PGPH-03 activities were effectively carried out.

- Providers engaged with both health-sector and non-health sector groups and organisations and used a range of approaches to engage these groups in health promotion activities.

- Providers' **identification of community strengths and protective factors** may have been implicit in the delivered activities as these were not always evident in providers' reports.

- Encouraging public discussion on gambling harms and related issues may have also been implicit in the various awareness-raising activities, such as the delivery of presentations to stakeholders and the setting up of information stalls in public places.

- To encourage **public discussion and debate on gambling harms,** providers used a range of approaches, often providing venues and presentations or workshops.

- To encourage **public discussion on the ethical perspectives of gambling funds** providers facilitated fora, and explicitly supported alternative funding sources and organisations using them.

- Providers used several approaches to support culturally appropriate resiliency building through community partnerships, including:
  - Use of kaupapa Māori approaches when working with communities and when delivering activities
  - Establishing and supporting client groups and client-led awareness raising initiatives
  - Supporting community groups working against gambling harms in their own communities
  - Supporting community-led projects and initiatives that had the potential to build social connectedness and community resilience
  - Supporting programmes for children and youth

- Providers appeared more successful in developing community initiatives than media initiatives for **promoting family and community connectedness and positive leisure and entertainment opportunities**. Reported activities included organising recreational activities, family-based events, sporting events, music and art-based events and outdoor activities.

- Providers ensured **key groups' access to evidence-based community action approaches for reducing gambling harm** through specially designed evidence-based educational programmes and awareness-raising events on gambling harms, provision of informational materials and development of exhibition materials.

- Providers may have been less successful in **ensuring key groups' access to evidence-based approaches to monitoring and controlling licensing of gaming venues**. However, gaming venue licensing had connections to the PGPH-01 purchase unit.

- Providers also appeared unsuccessful in providing a **point of public contact for raising issues on public health approaches and improving public awareness of avenues for complaint regarding public health approaches**. These opportunities may have been provided as services were delivered.

- Challenges in delivering this purchase unit centred on time and resource demands, and the community's lack of responsiveness.

Aware Communities

- While it was not possible to determine if providers had **maintained awareness of other social marketing campaigns** (other than the national campaigns), a few providers reported their attempts to support campaigns led by community groups and their attempts to encourage the **inclusion of problem gambling as an issue in such campaigns**.

- Most providers mentioned *Choice Not Chance* promotional materials and *Gamblefree Day* activities, while some reported involvement in *Scribe*-related awareness-raising events.

- In delivering PGPH-04, providers may have viewed the media as a venue for **raising public awareness** as well as for **encouraging public discussion and debate** on the harms of gambling. Most providers engaged with a range of media including radio, mainstream newspapers, community newspapers, television, the internet and social media.

- Although staff survey respondents rated the activity of **monitoring and responding to public media discussions on gambling or problem gambling** as being effectively delivered by their organisations, the document analysis found limited evidence of this.

- A number of providers had supported **community and youth-led culturally relevant awareness-raising** initiates such as marae-based health promotion programmes, Pacific community-led events and youth-led events that incorporated gambling harm-related themes. Providers also engaged in a range of other types of **education and awareness-raising activities**.

- Outcomes resulting from these awareness-raising initiatives (based on informal comments and provider evaluations) included:
  - Requests for additional presentations

- o Increased awareness of the seriousness of problem gambling
- o Enhanced understanding of problem gambling among Māori, ways to make healthier choices and ways to support affected whānau
- o Increased awareness of potential triggers of problem gambling behaviours and protective factors.

- While providers' awareness-raising initiatives are likely to have included the **health and social risks of gambling,** there was less evidence of educational or awareness-raising material that included **knowledge about gambling odds, risk-taking behaviours**, or **approaches for dealing with risky gambling situations** that can lead to excessive gambling or loss of control over gambling.

- Challenges were:
  - o Issues in relation to joint agency planning and execution of *Gamblefree Day* events
  - o Social normalisation of gambling behaviours and ease of communities' access to gambling venues
  - o Various methods and persuasive techniques used in gambling advertising which instils optimistic views about the odds of winning
  - o Difficulties in encouraging and sustaining behavioural changes through awareness raising alone.

Effective Screening Environments

- Most of the staff survey respondents reported that their organisations had effectively delivered the required activities.

- Providers worked with four broad sectors in the delivery of this purchase unit: gambling venues, the Police and Corrections facilities, health care services and social services, including other health and social services within their own wider organisation.

- While most providers discussed their own collaborations with stakeholder groups, few reported how they had facilitated **cooperation or coordination between key stakeholder organisations** in reducing gambling harm.

- A few providers enabled screening and referral practices among targeted stakeholder groups (such as the Police and health professionals) with some reporting on monitoring and follow-up initiatives.

- Although a majority of the staff surveyed rated the activity of **raising awareness of the relevance of screening and referral practices to the core business of target sectors** as delivered effectively, this activity may have been implicit when providers worked with stakeholder organisations as analysis of provider reports found very little direct evidence in providers' reports on how this activity was implemented.

- Challenges were noted around resourcing and organisations not viewing screening as a high priority. Some language and cultural issues around screening were also noted.

- In facilitating **relationships between potential screening organisations and problem gambling intervention services**, providers focused on developing connections between screening organisations and intervention services within their own organisations.

- To increase stakeholder organisations' awareness of the **availability of their problem gambling intervention services** some providers distributed promotional materials and signage to identify services/locations.

Activities that relate to several purchase units

- Providers' reporting indicated that some public activities have the capacity to result in the achievement of multiple outputs. As illustrated below, organising a stall at a public event can result in outputs that meet the objective of several purchase units (both public health and intervention).
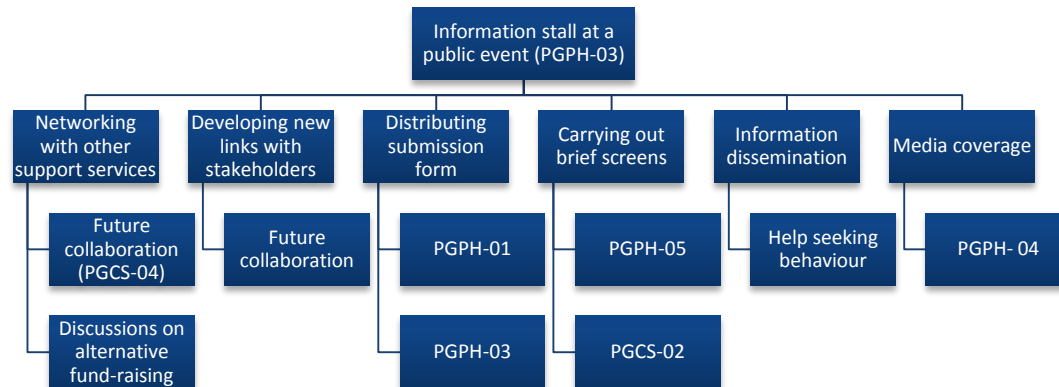
- As public health events were often organised in **collaboration with other health and social services,** this enabled stallholders to network and develop understanding of one another's services. Meeting a broad range of visitors to stalls also enabled the development of **new links and relationships with other stakeholder organisations** (PGCS-04). Holding culturally appropriate events in targeted communities enabled outreach to high-risk communities and addressing health inequalities. Some providers distributed submission forms at these events (PGPH-01 and PGPH-03). Providers also reported having **conducted brief screening** (PGPH-05 and PGCS-02). In some cases, dissemination of information led to help-seeking behaviour. Such events also attracted media coverage (PGPH-04). Focus group findings suggested that providers were aware of such overlaps, and tended to conceptualise the different purchase units as contributing to a broader public health project with multiple aims and outcomes.

Public Health services "Success Indicators"

- Staff belief about the main success indicators for the five public health services tended to fit within one of three categories: activity-related, output-related and outcome-related. These are summarised in Figure 155.

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Activity indicators	Output indicators	Outcome indicators
Policy Development and Implementation		
Implementation of awareness raising activities	Enhanced awareness among communities	Adoption of harm minimisation and prevention policies
Relationship development	Increased community participation	Adoption of a "sinking lid" policy approach to pokie machine numbers (including number of adoptions)
Implementation of community engagement activities	Enhanced community willingness to participate in change creation	Reduced gambling opportunities
	Increased number of organisations taking action	Adoption of workplace gambling polices
		Non-acceptance of gambling funds
Safe Gambling Environments		
Building and maintaining relationship with gambling venues and societies	Increases in venue uptake of host responsibility and harm minimisation practices	
Carrying out awareness raising activities	Implementation of multi-venue exclusion orders	
Encouraging community involvement	Increased referrals of clients from gambling venues to problem gambling treatment services	
Making policy submissions	The number of problem gamblers identified or excluded	
Supportive Communities		
Delivering education and awareness raising activities	Increases in community awareness	Reduced inequalities
Organising public events	Enhancements in public discussion	Number of referrals
Setting up community groups		Signs of social connectedness, resiliency, cultural identity and belonging among communities
Encouraging community involvement in public health activities	Increases in community participation	Communities taking ownership of projects
Developing relationships with community support services and the media	Willingness of community organisations towards establishing on-going relationship with service provider	Community willingness to stay engaged in community activities
Aware Communities		
Delivering presentations	Increased public discussions and understanding of gambling harms	
Ensuring cultural appropriateness of awareness raising materials	The number of media articles on gambling harms	Increases in self-referrals resulting media messages on gambling harms
Engaging with the community		
Organising events that are enjoyable and inviting		
Carrying out Brief Interventions at public events		Subsequent referrals to the clinical team
Effective Screening Environments		
Raising awareness		
Developing relationships		
Supporting the development of screening practices	Uptake of screening and referral practices among organisations approached	Increases in referrals to problem gambling treatment providers

Figure 155: Main success indicators for public health services as identified by staff

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External factors affecting public health services delivery

- To explain external factors that were perceived to affect the delivery of public health services, staff survey respondents detailed issues that were not within their control as well as some aspects of activity delivery and challenges when delivering services. These had both positive and negative impacts on their capacity to deliver services.

   o Positive factors included the supportive social and political climate, and the general willingness of communities and stakeholders to engage.

   o Negative factors included political sensitivities, some providers' poor relationships with the gambling industry, communities' dependence on gambling funds and contract uncertainties.

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6 Discussion: Strengths and Areas for Improvement

This chapter contains key findings in relation to the evaluation criteria agreed with the Ministry in relation to this project. It also highlights strengths that can be expanded, and provides suggested areas for improvement.

6.1 Operational Processes and General Areas of Input

Staffing - utilisation of allocated FTE staff

The eight selected providers are likely to be effectively utilising their allocated full time equivalent (FTE) staff in delivering services, considering staff perceptions about effectiveness in this area.

Reconsideration of specifications on the minimum delivery of services expected of one FTE staff for public health services may be warranted due to their apparent irrelevance to the reality of how services are delivered.

While a small number of staff were in full time public health roles, there was a tendency among providers to have staff performing dual roles, as both clinicians and public health workers. Providers believed that such dual-roles offered several advantages such as flexibility in meeting community needs, service focus based on demands of the moment, and ease of connecting public health and intervention services. However, as clinicians do not necessarily have training in public health approaches, providers may need to ensure that staff who take on dual roles are well equiped with appropriate knowledge, skills and competencies. Time-pressure implications are another important consideration to ensure ongoing efficiency of such dual-roles in delivering services.

Time sufficiency

Time sufficiency is an area that requires some consideration. Although most staff expressed satisfaction with the time they were allocated for task completion or service delivery, almost one-quarter indicated dissatisfaction.

For clinicians (intervention staff), time-consuming aspects of *Follow-up Services* were an issue as were maintaining multiple client information databases, and accommodating additional time needed for clients with complex issues and for some ethnic-specific client groups (Talanoa and Māori communication approaches).

Time insufficiency was a challenge for delivering some public health activities due to the lengthy and varied nature of these activities (e.g. development and implementation of MVE processes). The length of time needed for such public health activities and for relationship development and maintenance in particular, require acknowledgement. Time frame estimates for time-consuming public health activities would be a crucial component in providers' annual planning. Providers could also specify timeframes for relationship development more clearly in the planning of new public health activities, distinguishing between stakeholders with whom pre-established relationships exist and new stakeholder groups that would require a greater level of time investment. This might alleviate staff concerns, and allow transparent discussions among the key parties.

Overall, these issues are worth further investigation; it is not clear from the present data whether the issues are related to insufficient funding, institutional planning or time management at an individual level. It is inherently difficult to plan time for activities that by their very nature are unpredictable, and some level of concern around the time allocated to such activities is unavoidable. Nonetheless, relationship development in public health activities and follow-ups in clinical services are core components, and the providers have significant experience in these areas.

Workforce development and knowledge sufficiency

Most staff were satisfied with their existing knowledge (including required information to deliver services, target populations, and contract and reporting requirements), and the training and professional development received. Most also reported substantial experience within problem gambling services; nonetheless, some areas for improvement remained.

The clinical audit identified workforce development as an area of partial compliance. Providers could improve their processes for workforce development by ensuring implementation of viable career development plans for all staff. Plans could be more proactively used to support staff with their career development and capacity to work to their potential. This could be achieved by considering their longer-term ambitions, their training requirements, and time needs for upgrading skills and knowledge to enable coping with the varying and often changing demands of their work environment. When effectively carried out through regular reviews with staff and collaborative implementation of agreed goals, career development plans can enhance staff motivation and contribute to the overall quality of their work lives.

Understanding contractual requirements was regarded as a key input area. The evaluation found that staff reported one PGPH-03 purchase unit description to be difficult to understand - providing "an accessible and recognisable point of public contact for concerns and issues regarding public health approaches to reducing gambling related harm and improving public awareness of avenues for complaint" (Ministry of Health, 2010, p. 33). The document analysis noted a few other instances, where providers may have found purchase unit descriptions difficult to understand. Very few providers explicitly identified "community strengths" or "protective factors" in their reports for PGPH-03 and very few reported on the PGPH-05 activity which required providers to "promote, support and participate in stakeholder groups as a tool to enhance cooperation and coordination of key organisations in the reduction of gambling related harm" (Ministry of Health, 2010, p. 35). Future revisions of purchase unit descriptions, could consider areas where lack of understanding may have influenced providers' reporting or contributed to non-delivery of activities. Additional clarity of specific terms and clearer descriptions could enable more comprehensive reporting and result in enhanced delivery of activities.

To enable better delivery of intervention services, the areas of additional training identified by staff warrant some consideration. While generally satisfied, clinical staff suggested that training in new, or more advanced, approaches to therapy would be useful. They also suggested additional training around co-existing issues and budgeting/money management, which were common needs among their clients. Neuropsychological assessments were also suggested, as was further training around the CLIC database and its functions.

Some staff suggested there were gaps in training with respect to culturally appropriate and culturally specific approaches to intervention. They noted that this was not ABACUS' area of expertise and that, to an extent, they were expected to develop these approaches themselves. The Cultural Advisory Group discussed the possibility of a reciprocal learning approach embracing the Māori principle of ako, where ABACUS trainers learn from providers' experiences and vice versa – enabling the creation of new knowledge. However, the issue of intellectual property (with ABACUS being a commercial entity) and the need for such training to be delivered by trainers of multiple cultures could prevent the feasibility of such an approach.

Staff reported that their experiences and best practice were shared at hui and conferences but that more opportunities or an improved mechanism was desirable. One participant indicated that culture-based models were applicable to everyone, regardless of ethnicity. While formal training does not seem appropriate, or feasible, staff capacity in culturally appropriate interventions could be developed further through provision of additional opportunities for knowledge exchange between providers, perhaps with the aim of documenting and creating a user manual on these approaches. Although some ethnicity and culture-based psychotherapy for other health issues such as personality disorders and depression were noted in the literature (Hwang, 2006; Kohn *et al.*, 2002; Matos, Torres, Santiago, Jurado, & Rodriguez, 2006; Miranda *et al.*, 2005) there appears a lack in culturally-based examples specific to problem gambling interventions. To varying degrees, culturally-based practices have been developed by

providers throughout New Zealand, and there seems a need for better documentation and evaluation of these models to enable broader application supported by evidence.

Participants noted the value of tertiary qualifications; however, they were clear that experience and relationship development skills were fundamental for public health work. The time needed for new staff coming into such roles to gain appropriate experience, develop communication skills, acquire a flexible attitude towards working approaches and develop connections with, and understanding of, the local community is a key consideration, along with mechanisms to facilitate the development of these skills and attributes. Additional to such on-the-job development and mentoring, public health workers would likely benefit from additional training based on identified knowledge needs. Staff noted a need for additional education around policy development, preparing formal submissions, the broad range of gambling harms, and methods for measuring public health outcomes. Some of these would be included in currently available degree programmes but for those in the workforce, full-time shorter more focused courses would be more suitable.

Funding utilisation

Staff perceptions suggested providers were effective in utilising purchase unit funding for delivering services. Nonetheless, *Follow-up Services* were perceived by some staff as an area where additional funding might be considered. This was largely on the basis that *Follow-up Services* could be time consuming and difficult to deliver. Again, variability is inherent in this service, so some caution is needed. Certainly, this area is worth some consideration, as the present data (including those available in CLIC) were not definitive; more precise detailing of the time and effort devoted to *Follow-up Services* would be helpful in this regard.

Resourcing

Generally, providers appeared to have had access to required resources for delivering services. Staff were of the view that their organisations were effective in sourcing and developing resources for delivering both intervention and public health services. The clinical audit found that resources such as informational brochures were readily available to clients. Provider reporting suggested that they often proactively sought resources and adapted existing resources to fit their public health activity needs, suggesting areas of strength.

Some providers expressed concern around the absence of culturally-specific and also Māori language specific resources. HPA resources were sometimes regarded as unsuitable for some ethnic groups, and required adaptation to fit the needs of these targeted communities. Some staff also expressed the need to develop culturally-appropriate resources. For the smaller client groups (Pacific and Asian) these concerns were intertwined with language issues. Language specific resources might improve accessibility; however, it is not clear whether this is feasible given the number of languages and variations required. Māori-specific resources and screens are worth further attention in New Zealand given their status as tangata whenua, their level of risk for gambling harm, and the large number of clients.

Various providers have developed resources in specific languages. Enhanced availability of existing resources (i.e. those that they have developed or translated) could be facilitated if a formal system of resource sharing and exchange were to be established. This could ensure input efficiency as it would eliminate repeated work by individual providers in developing resources from scratch. A formal mechanism for sharing educational and promotional materials could result in a nationally available set of comprehensive resources, which in turn could make the effectiveness of content and public health outcomes easier to measure.

Reporting compliance

Reporting on client-related data (CLIC database) and progress reports on delivered services are important for the Ministry for gauging the effectiveness of activities as they provide a method for collecting evidence of activities, outputs and outcomes resulting from the Ministry's input into services

(i.e. funding). Staff views were that their organisations were effective in meeting the Ministry's reporting requirements. However, the evaluation found several areas that require consideration.

CLIC database reporting

Some staff participants expressed concerns about the flexibility and usability of CLIC and some indicated that they required additional training to use it more effectively.

Analysis of the CLIC database found some areas where improvement is required if the database is to be useful for future evaluations. It was difficult to clearly establish some aspects of treatment, notably treatment end; reporting of this was variable across and within providers. Many clients did not have treatment end recorded, and many others had several treatment ends recorded. Relapses were also difficult to discern, with post-hoc criteria applied based on the data. The lack of consistent recording of screen scores was also problematic for evaluative purposes; while results were generally recorded for the correct client groups, they were not recorded for many clients, and seldom recorded twice[61]. There were improvements on some measures for clients who were assessed twice and had their results reported, but this group was very small and certainly non-representative; therefore, definitive conclusions were not possible. Changes to reporting practices could enable more accurate outcome measurements in future.

A few providers maintained separate databases (which included additional client information regarded to be important). The logistics of transferring data between databases sometimes required additional time and effort. Although some staff expressed doubt over the feasibility of a single database that could cater to everyone's needs, providers would need to consider the implications of maintaining two client databases, particularly in terms of resources and time. This is considering staff comments, which included that time consuming reporting processes can have an impact on service delivery. Additional efforts to ensure that data are collected and entered into CLIC in a more systematic and robust manner may reduce the need for multiple databases.

Some staff comments indicated that there was a lack of alignment between the Ministry's reporting requirements and kaupapa Māori practices and a lack of clarity on the purpose of reporting numbers. However, there were no obvious differences in reporting in CLIC between Māori and mainstream providers to support this. This suggests that the Māori providers may have adapted to reporting requirements in the same way as others. While expressed concerns are worth further investigation, it is possible that clarification on the functionality of the quantitative data collected in CLIC combined with some additional consideration of the cultural aspects in the present purchase unit descriptions could suffice.

Although Māori and Pacific providers often commented that Ministry recommended session lengths were insufficient to meet client needs, CLIC data did not support this. In fact, those data indicated that the length of *Full Intervention* sessions delivered by Māori and Pacific providers were slightly shorter, on average. A possibility is that providers did not accurately record additional time spent in delivering services. Again, additional training and clarity on the CLIC system could address this, if it is actually the case. The Cultural Advisory Group suggested that within a collectivist culture in which family is regarded more important than the individual, one-on-one counselling may have been viewed as somewhat self-indulgent and thus a hesitance to spend too much time talking about oneself; this too could lead to slightly shorter sessions. It is also possible that providers may have reported only the therapy session, leaving out other aspects such as travel time when conducting sessions in rural areas, and time spent in getting to know each other (e.g. whakapapa) and establishing historical linkages; these may have been viewed as separate events. Some of these aspects could explain the difference between staff perceptions and what was recorded in the CLIC database. The CLIC data recording system could

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[61] In the Ministry's Data Management Manual, description of screen scores entry into the CLIC database indicates that it is not compulsory for providers to record scores for the recommended screens. However, this meant that the existing data in CLIC were inadequate for determining treatment outcomes at a national level.

provide for the entering of additional data that takes into account time spent for travel, relationship building, talanoa, reflection on sessions and data entry, in addition to direct contact time with clients.

Six-monthly progress reports

The inconsistencies in providers' progress reports (e.g. differing breadth, format) and the lack of reporting clarity (i.e connections between activities and outputs with purchase unit descriptions and outcomes) in some cases, meant that these reports, in their present format, were not a fully reliable data source for determining the long-term effectiveness of public health services. A more standardised format of reporting would be necessary for more systematic monitoring of outputs and outcomes.

External factors

The evaluation found that, to some extent, delivery of services was subject to external factors and situations that were not always within the control of providers. While the present evaluation did not aim to assess the extent to which these external factors influenced outcomes, they would nevertheless be important to consider when making evaluative judgements about service effectiveness.

Staff views suggested two categories of external factors. The first were external factors that were truly beyond their control. For instance, earthquakes in some areas temporarily disrupted services and are likely to have had an impact on the volume of service delivery during those periods. Contractual uncertainties was another example; this led to impacts on workload, staff motivation and recruitment. Uncertain working environments make retaining and motivating staff difficult, along with attracting new employees, which may have contributed to difficulties in hiring new staff.

A second category of external factor was related to external parties and stakeholder groups that providers were required to work with (e.g. gambling industry, community agencies). The degree of stakeholders' willingness and commitment towards the work proposed by providers resulted in either positive or negative effects. While providers would have had the opportunity to have an influence over such "external factors," in some cases, such influences are likely to require a longer time to take effect or may not take effect despite efforts. Such willingness and commitment may be subject to other factors that are not directly within the providers' control. For instance, the time constraints of allied agencies may mean a lesser priority given to gambling harm minimisation activities. The stake of other groups in the gambling industry may mean limited or partial commitment to problem gambling solutions. However, these issues are intrinsic to public health work, especially in an area such as gambling where diverse views are held, gambling remains legal, and when taken part in responsibly is a socially acceptable behaviour.

Nonetheless, both categories warrant consideration in logic model development and in the planning of activities.

Service functioning (sustainability)

The majority of staff were of the opinion that their organisations had processes in place to ensure longer-term capacity to continue providing services. However, as noted in the section above, uncertainties around contract extensions were of concern to staff. No longitudinal data were available, so the impact of these uncertainties on staff views could not be assessed. At this point, while concerns were held around contractual issues, staff still believed in the sustainability of their organisations.

While sustainability of an organisation is reliant on funding, public health services hold potential for sustainability even after funding ceases. Thus, there is a requirement for a clearer definition of the broader meaning of service sustainability, beyond its direct link with service funding. Possible dependent variables to measure public health programme sustainability include sustained programme outcomes (e.g. ongoing impacts of enhanced awareness of an issue), continued community-led projects, programme replication and diffusion to other sites, maintenance of newly developed organisational practices (Scheirer & Dearing, 2011) and continued use of developed reusable resources. While some elements of sustainability potential were noted in this evaluation, more detailed research that includes

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data on output continuation and longer-term outcomes would be necessary to determine the sustainability potential of public health services.

As sustainable outcomes require processes to be implemented at the planning stage of public health programmes, the effectiveness of the five Ministry-funded public health services could be enhanced with a clearer articulation of sustainability as an intended outcome. This may encourage planning and implementation of projects with sustainable outcomes as a key aim, as well as methods to measure and document those outcomes.

Evaluation synthesis - Inputs and operational processes

Inputs - time, knowledge, resources and funding

- Providers appeared to be effectively managing allocated staff for delivering services, though issues included lack of staff time sufficiency. Clearer time frame estimates would be useful, particularly within public health activity work plans.
- Time-pressure implications for staff holding dual-roles and their knowledge and competency needs require consideration to ensure ongoing efficiency of service delivery.
- Workforce development improvements could be achieved by ensuring implementation of viable career development plans for all staff; this could include supporting staff with their career development and capacity to work to their potential.
- Knowledge improvement areas identified by staff include clearer understanding of purchase unit descriptions, and additional training needs.
- Staff capacity in culturally-based intervention practices could be enabled through provision of additional opportunities for knowledge exchange between providers and through documenting and creating a user manual on these approaches.
- Generally, providers had access to required resources and were effective in sourcing and developing necessary resources (including adapting existing resources to fit specific activity needs). Areas for improvement include culturally-specific and Māori language specific resources. Availability of existing resources (i.e. those developed or translated by individual providers) could be broadened through a formal system of resource sharing and exchange, in turn ensuring a sector-wide input efficiency.
- Funding limitations identified by some staff regarding supporting specific areas of service delivery, will require discussions between respective providers and the Ministry.

Processes - reporting and collaborating

- Staff perceptions were that their organisations were effective in meeting the Ministry's reporting requirements. While this may be the case, the evaluation identified an important area for improvement. Although providers are not mandated to report all recommended screen scores in CLIC, changes to reporting practice could enable more accurate outcome measurements.
- Providers that currently maintain two client databases need to consider implications in terms of resources and additional staff time required. The use of CLIC in a more systematic and robust manner may reduce the need for multiple databases.
- The CLIC data recording system could be improved by provision for entering additional data such as time spent for travel, relationship building, talanoa, reflection on sessions and data entry, in addition to direct contact time with clients.
- The inconsistencies in providers' public health progress reports (e.g. differing breadth and format) and the lack of reporting clarity, meant that these reports were not a fully reliable data source for determining the long-term effectiveness of public health services. There is a need for public health data collection using standardised tools for systematic monitoring of outputs and outcomes.
- Public health staff collaborated with other organisations in planning and carrying out joint activities; these collaborations offered a number of advantages for public health service delivery.

External factors

- External factors that may have had an impact on outputs include those that were beyond providers' control such as earthquakes and contractual uncertainties as well as external parties

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and stakeholder groups that providers were required to work with. Both categories warrant consideration in logic model development, in the planning of activities and when making evaluative judgements about service effectiveness.

6.2   Problem Gambling Intervention Services

Overall contract compliance

Generally, staff perceptions were that their organisations successfully complied with the service specifications of the four purchase units. Areas of strength included meeting clients' expectations in terms of service quality and cultural needs, and in ensuring client rights. However, the evaluation and clinical audit found that providers varied in their individual contract compliance as well as in delivering services in accordance with Purchase Unit Descriptions. Within the "Service Delivery and Quality" audit criteria, "Quality management," "Plan of care" and "Planning discharge from and/or transfer between services" were identified as areas of partial compliance. Minimum delivery of services (referred to as "Implementing the care plan" in the audit) was identified as an area of non-compliance which meant that the majority of providers audited were not consistently delivering the volume of services agreed with the Ministry.

The evaluation identified several strength and improvement areas within the delivery of specific intervention service activities; these are discussed in respective sub-sections below.

Population serviced

In New Zealand, Māori and Pacific communities and those living in more deprived areas remain more susceptible to the risks of harmful gambling (Abbott *et al*., 2014; Ministry of Health, 2009). The CLIC database showed that providers were reaching out to these targeted at-risk populations. European/Other was the largest group accounting for about half of all gambler clients[62]. The second largest group was Māori who were approximately one third of clients, followed by Pacific. Asian clients were the smallest client group.

Of the two major client types, two-thirds were gamblers and a third were significant others[62]. A higher proportion of gambler clients was male, while a higher proportion of significant other clients was female[62]. Being male is a risk factor in itself, so these patterns were expected. However, facilitating more help-seeking behaviour by all those gambling harmfully, and affected by someone else's harmful gambling is important. As with other health areas, enabling more and earlier help-seeking by Māori, and Pacific should be an ongoing priority.

Other aspects of the populations serviced (e.g. geographic distribution, age) were as expected. Where age was reported, gamblers were more often in the at-risk age groups[63]. Clients of general and Pacific providers tended to be from urban areas in which the services are based, and with respect to Pacific clients, in Auckland where the population tends to reside[64]. Clients of Māori providers tended to be more from rural areas, consistent with the location of those providers. The different challenges of service delivery in urban and rural areas, and to clients from different cultural and ethnic groups is something that has been explicitly recognised, and is something that should continue to be a focus.

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[62] These trends are based on the total number of clients who accessed a service at least once in each respective month, thus cannot be used to estimate number of clients in a year.

[63] These are indicative trends only. Percentages for the age categories were based on the total number of clients assessing a service at least once each month over the entire 3-year period. This equated to 45,422 gambler clients and 20,834 significant other clients accessing the services over the 3 years. Although the monthly numbers, when aggregated in this manner, are larger than actual annual client numbers because they includes multiple counts of the same clients accessing the service throughout the 3-year preriod, it provides a rough estimate of the typical age categories of clients accessing services each month.

[64] These estimates are based on total number of clients who accessed a service at least once within the June 2012 - July 2013 reporting period.

Service accessibility

The Ministry expected that regardless of the services they offered, providers collaborated with one another to ensure that clients within their region had access to a complete range of services (Ministry of Health 2008). Providers are likely to have ensured clients' access to a range of services through referrals to other services in their own organisation and to external organisations. Providers are also likely to have enabled such access through *Facilitation Services*. As the present analysis did not include an analysis of providers' narrative reports on intervention services, it was not possible to provide an evaluative judgement on work that clinicians may have purposefully undertaken to collaborate with other services within their region to ensure that the shared populations they served had access to a range of services.

Cultural responsiveness in delivering services

Staff reported that the services they delivered met clients' cultural and spiritual needs. The clinical audit rated the Cultural Perspectives criteria as an area of full compliance. Most Māori, Pacific and Asian clients expressed satisfaction with culture-related service provision. However, for a higher percentage of European/Other clients, these aspects were not relevant to their needs and only a small proportion reported language and counsellors of similar culture to be particularly helpful service aspects. It remains important for clinicians to keep in mind that clients may vary in terms of their responses towards cultural/spiritual/religious approaches, although there is no evidence in the present evaluation to suggest that this is not being done well. Providers should continue to ensure clients' informed choice by clarifying the intervention approaches available to them at the onset.

As noted in Section 6.1 (**Resourcing**) some staff expressed the need for screening tools in appropriate languages. It was the view of the Cultural Advisory Group, that the availability of tools in appropriate languages was important for achieving better outputs. For instance, the availability of culture appropriate tools such as Māori screening tools could ensure a greater level of receptiveness from the Māori population. This is something that might be worthy of further investigation. The development of a new, Māori gambling screen is one possibility; however, whether this is viable is unclear, and assuming it was psychometrically valid it would need to be comparable to existing screens. The other component, and one perhaps more readily addressed, are issues around the process of screening and integrating these in a more culturally appropriate manner. Ensuring a culture of mutual respect could very well overcome any cultural differences between clients and clinicians.

Enabling clients' initial entry into intervention services

To be able to provide services to individuals at-risk, providers need to have in place effective methods for capturing individuals from targeted populations and encouraging their uptake of intervention services.

For both gambler and significant other client groups there was, over time, a decline in the number of clients on the *Brief Intervention* only pathway. For gambler clients, this did not translate to more clients on *Brief* followed by *Full Intervention* pathways, though this was the case for significant other clients. Thus, brief approaches seem particularly useful in facilitating those affected by someone else's gambling into accessing support, but most gambler clients remain self-referred. As noted elsewhere, Pacific clients of Pacific providers often had lower gambler harm scores, and these providers seemed to be effective at enabling access to support for clients who had issues with gambling but present at services for other reasons. However, given the higher risk of gambling harm among Pacific people, there remains some concern that those more severely affected are not seeking help to the desired extent.

While *Brief Intervention* services offer one client entry pathway, other client entry modes, such as referrals from other agencies and self-referrals are subject to external influences and appear not to be fully within providers' control. A greater level of planning of service area integration with public health services (that enable screening and referrals) and with other intervention services (e.g. *Facilitation Services*) which offer relationship development opportunities with other community support services for two-way referrals of clients, could result in a more coordinated effort in enabling client's initial entry into intervention services.

Clients with a compulsory mode of entry

Staff observations suggested that clients referred through the justice system were less motivated to attend sessions and exhibited less commitment to making changes. However, staff expressed mixed views with regard to the treatment of justice-referred clients. While in some cases such clients are treated in a similar manner to other clients, others noted the unique situation of these clients that may necessitate additional support. Changes made, and approaches used, to accommodate the needs of these clients included increasing treatment length, encouraging a more holistic life perspective, education on risk-taking behaviour and relapse prevention, making efforts to establish a trusting relationship, and providing additional assistance which went beyond the scope of problem gambling counselling. These aspects could be considered in the future development to treatment provision for this unique client group.

Delivery of Brief Intervention Services

The literature generally refers to *Brief Interventions* as *early interventions* and includes various types of programmes. Evaluations of these brief intervention programmes evidenced their effectiveness as it led to a number of positive outcomes. A brief cognitive/behavioural treatment programme in Canada to influence gambling decisions had led to decreases in gambling frequency and gambling-related life problems (Robson, *et al.*, 2002). Another Canadian-based brief intervention programme, which used a self-help intervention approach (giving gamblers personalised feedback to enable them to self-evaluate their behaviours against those of the general population), led to decreases in money spent on gambling (Cunningham, *et al.*, 2009).

Several evaluations of venue self-exclusion programmes (another type of initiative regarded as brief intervention) in New Zealand (Bellringer *et al.*, 2010a; Townshend, 2007) and Canada (Ladouceur, Sylvain, & Gosselin, 2007; Tremblay *et al.*, 2008), suggested that this method can lead to positive outcomes. For instance, increases in level of control over gambling or abstinence from gambling and reductions in gambling urges, problem-gambling symptoms, money lost, and the intensity of negative gambling-related consequences on frame of mind, social life and work environment.

Within the context of the Ministry's service specifications, however, venue-self exclusions are more commonly delivered through *Facilitation Services* (PGCS-04) and also relate to activities delivered for the *Safe Gambling Environment* (PGPH-02) public health service when working with venues. *Brief Interventions* (PGCS-02) are focused instead on encouraging behavioural changes using motivational interviews and referring clients onto a *Full Intervention* when deemed necessary.

CLIC data trends showed increases in new *Brief Intervention* clients driven by increases in the number of significant other clients. The total number of *Brief Intervention* sessions recorded also showed that this service was delivered more frequently for significant other clients. Among new *Brief Intervention* clients, Māori were equal with European/Other as the largest groups. These trends may indicate that providers are doing a good job in enabling help-seeking behaviours among those in the earlier stages, or at-risk, of developing gambling harm.

However, present CLIC data recordings do not enable a measurement of client outcomes resulting from *Brief Interventions* as pre- to post- data is presently not captured. Nevertheless, staff views and clients' self-reported impacts indicated positive client outcomes. As noted above, there has been a substantial increase in significant other clients who follow *Brief Intervention* followed by *Full Intervention* pathways. Thus, as a general awareness-raising exercise, particularly in terms of explicitly enabling significant others affected by gambling to access support, they seem effective.

The *Intervention Service Practice Handbook* refers to evidence which "suggests that, when combined with an appropriately targeted motivational discussion, recognition and awareness-raising is sufficient to encourage many people experiencing harm from gambling to recover, even if they never seek formal problem gambling support" (Ministry of Health, 2008b, p. 22). This is as an important outcome of *Brief Interventions* that has yet to be examined, and none of the present data were helpful in this regard. Comments received from staff in the present evaluation offered no evidence to this end. This is understandable considering that such an outcome may result from one-off interactions between

individuals and clinicians with little way for clinicians to assess the effects they may have caused. The very nature of *Brief Interventions* means that this would be very difficult to examine, and following up on *Brief Intervention* clients to assess this would likely confound the issue. Providers could be encouraged to try various approaches to gain additional data, but additional to the likely confounds, low response rates would be expected given the nature of the intervention itself.

Delivery of Full and Workshop-based Interventions

Measurements of client outcomes

National level evaluations (Jackson *et al*., 2000) and individual evaluations of problem gambling treatment outcomes reported in the literature (Petry *et al*., 2008; Toneatto & Dragonetti, 2008; Wulfert *et al*., 2006) are based on robust methods, often relying on pre- and post- measurement data. In some cases, random assignment and control groups were used to show treatment impacts on measures such as money lost, gambling behaviours, and SOGS and DSM-IV scores. Similarly rigorous, independently conducted outcome evaluations in New Zealand would be required for an accurate assessment of the effectiveness of Ministry-funded intervention services. Such evaluations would enable comparisons with previously conducted assessments, such as the effectiveness of brief telephone interventions study (Abbott *et al*., 2012, 2013) and would inform future service design and purchase unit planning.

Qualitative comments from providers in the present evaluation indicated that additional to CLIC, several maintained their own databases (containing other client details believed to be important), and that some were carrying out their own outcome evaluations. However, a national level outcome evaluation is prevented by limitations in client data reported in CLIC. Although the Ministry's Data Management Manual recommends the recording of relevant screens and scores, providers are not mandated to record the scores. The current practice (as evident through CLIC data) indicated that providers tended not to record screen scores for a substantial percentage of clients. While CLIC data provides details such as client numbers, session numbers and the duration of intervention sessions, it does not provide sufficient pre- and post- measurements of client conditions to enable an effective evaluation of client outcomes. Full Intervention Gambler Screens scores were not recorded for between 33% and 53% of gambler clients throughout the three years. Full Intervention Family/Affected Other Screens scores were not recorded for 50% or more of significant other clients throughout the three years. No screens, including those specified as outcome screens, were reliably recorded twice for clients, which meant first, a lack of clarity in how these screens were used to monitor clients' progress as recommended by the Ministry and second, limitations to the usability of CLIC data for monitoring client outcomes during the course of their *Full Intervention*. Where screen results were recorded twice or more it was difficult to ascertain whether this was associated with end of treatment or due to clinical judgement. In brief, the current evaluation found that there were too few records of formal client assessments, and even fewer formal records of re-assessment for an evidence-based evaluation of client outcomes.

Evaluation findings also indicated that providers might be resorting to fitting what they do with the Ministry's criteria although these may not necessarily reflect the reality of approaches used to treat clients. This is understandable considering that CLIC is an operational database that collects information to meet the Ministry's requirements. The CLIC database in its current state appears to be at a middle ground where it is complex enough to capture useful data but simple enough that providers are able to enter client information within the required structure; this may be viewed as a strength. The Ministry has made adaptations to requirements in relation to end of treatment entries (in an earlier version of CLIC) to enable greater flexibility; however, the lack of clarity in treatment start and end coupled with the aforementioned lack of reported repeat assessments deters measurements of treatment outcomes. While CLIC needs to maintain its simplicity, considering the difficulty that some providers were still facing, CLIC programming features could be enhanced to capture unusual client situations (i.e. those that do not fit within the treatment provision criteria and the Ministry's preferred pathways).

Whether changes are required to the CLIC database, provider practices, or both, is not entirely clear. Certainly for outcomes to be commented on, results from key screens need to be recorded reliably in the CLIC database. They must be practical for providers to record, the importance of recording scores

must be evident to providers and the CLIC database must be able to link the assessments to key milestones in treatment. To ensure screen scores are reliably recorded it may be necessary to re-evaluate specifications regarding reporting of screening data while taking into account providers' perceptions about their importance, possible issues they may face in assessing clients and recording results, and associated training needs. Providers suggested that additional training was required for them to use CLIC more effectively and this, in combination with assessing the functionality of CLIC, might support more clear delineation of treatment milestones and the intervention phases within which screens are administered.

Providers also need to understand the value of CLIC as a database for monitoring not only individual client progress but also for monitoring intervention outcomes at a national level. Overall findings on client outcomes (change measured using screen results at the start and end of treatment) can inform the sector about which interventions are working well. Provider level data may also be compared to determine which types of clinical practice or intervention models are working well. For instance, with comprehensive recording of screen results, ethnic-specific models might be compared with conventional models, or client outcomes might be compared by ethnicity or gender. Such analysis and resultant findings could inform clinical practice at a deeper level and enable informed changes to practice in a way that meets the needs of different client groups and populations. Understanding the value of a national database could be a step forward in encouraging providers' improvements to the recording of screen scores as well as other client data.

Where screens scores were recorded more than once, there was some evidence of client improvement. However, the limitations above preclude any meaningful conclusions. For the small proportion of clients for whom screen results were recorded twice, there were generally improvements between the initial and second assessments. Additionally, staff perceptions were that the four intervention services were effective for achieving client outcomes and correspondingly client comments confirmed outputs in the form of service delivery and positive outcomes such as changes to clients' gambling behaviour and overall improvements to life quality. Naturally, staff feedback must be interpreted cautiously, and the client sample was also non-representative. Unfortunately, the limitations in the CLIC data mean that while there are data suggestive of positive outcomes for clients, there is no definitive supporting evidence available.

Co-existing Issues Screens

The recording of results for Co-existing Issues Screens (as evidenced through CLIC data) for gambler and significant other clients was also poor. Although the service specifications do not explicitly describe the Co-existing Issues Screens as outcome measures, the specifications describe the value of monitoring clients' co-existing issues; in particular its relation with gambling behaviours. However, findings show that these screens' results were rarely recorded more than once. As noted previously, providers are not mandated to record scores for the recommended screens.

Among the small number of clients for whom screens results were recorded twice, while a small percentage showed improvements, a small percentage also showed worsening of situation. While this suggests the value of repeated use of screens to monitor clients' situations, it also highlights the risk of assuming that clients testing negative in an initial assessment would remain the same throughout the course of their treatment. Depression for instance, may occur even if clients exhibit improvements to their gambling behaviour. "For these clients, stopping and reducing gambling may result in the emergence of an ongoing, unrelieved depression" (Ministry of Health, 2008b, p. 61). However, it remains unclear how clinicians might have used these screens for monitoring their clients' situations throughout the course of interventions.

Increases in the formal recording of co-existing screens results could provide valuable data for improving clinical practice in general. In addition to a readily available database for monitoring individual client outcomes, overall national data could inform the sector on the level or intensity of co-existing issues, which in turn could inform the need for other services such as *Facilitation Services* (PGCS-04) and *Effective Screening Environments* (PGPH-05).

Delivery of Facilitation Services

Although the existence of comorbid issues alongside gambling problems is acknowledged in the literature (Abbott *et al*., 2014; Holdsworth *et al*., 2013, Ibanez *et al*., 2001) there was no international evaluation literature focusing specifically on *Facilitation Services* for problem gamblers. Nevertheless, the shortcomings relating to this component of treatment provision was reported in one US-based evaluation where affected others identified the need for referrals to other services to address financial problems they were faced with (Stinchfield *et al*., 2008).

In GARC's previous evaluation, although there was a gradual increase in the number of *Facilitations* between July 2007 and June 2008, most clients did not appear to receive a *Facilitation session* during the course of their treatment episode (Bellringer *et al*., 2010b). Whether or not a client received a *Facilitated session* was largely at the discretion of the counsellor or treatment provider (Bellringer *et al*., 2010b)

In the present evaluation, the overall numbers of *Facilitation* sessions reported across the three years showed that this service was delivered more frequently for gamblers. Both staff and allied organisations noted the value of this service in achieving positive outcomes for clients, and ensuring that they received support for the range of issues they faced.

Enabling a seamless referral process

Enabling a seamless referral process was a strength within *Facilitation Services*. The activities carried out to support clients, and client comments, suggested that the objective of enabling a seamless referral process was largely met. This may have, to some extent, been possible through facilitations to in-house community support services.

To gain further clarity on other service aspects that can enable seamless *Facilitation* processes, the feasibility and effectiveness of arranging for allied health and social service representatives to be present at the premises of problem gambling treatment services should be examined. Almost a quarter of allied organisation respondents indicated that this was not done. Such arrangements may be beneficial considering that support service proximity was important for some clients.

Working relationships with allied organisations

Although providers generally had good working relationships with allied organisations, some improvements are needed in relationship development and communication, including contact regularity and follow-up. As detailed in sub-section 2.3.3, the lack of up-to-date contact lists of allied organisation staff and the fact that some allied staff indicated that they were not aware of the problem gambling intervention service suggests a need for a more systematic relationship-building process where providers maintain a clear record of allied organisation staff for the purpose of *Facilitation Services*. Providers may also benefit from moving towards a database of allied organisations that is shared across the sector.

Facilitation Services includes four categories of allied services (in-house community support services, external community support services, gambling venues, and supportive individuals); providers considered an allied organisation to be one where a client can be referred to, and from. This suggests that a broader definition of allied services might be of value. Allied service collaboration is often needed in other areas of problem gambling services, particularly *Brief Intervention* services and the public health service *Effective Screening Environments*. The delivery of *Brief Intervention* services requires service providers to establish relationships with agencies and organisations that tend to be in contact with high-risk groups such as "Community Corrections, Work and Income New Zealand, budgeting services, food banks, and Child, Youth and Family" which would also support the Ministry's aims to increase these organisations' awareness of problem gambling and the benefits of *Brief Interventions* (Ministry of Health, 2008b, p. 22). The *Effective Screening Environments* public health service also has similar objectives where providers are required to support the development of screening and referral practices among such organisations. As these organisations deal with financial, social and health issues (i.e. likely co-existing issues for problem gambling clients) they also serve as effective

allies when delivering *Facilitation Services*. Therefore, the relationship development process with these organisations could be tailored to meet the objectives of all three purchase units.

Facilitation of clients to in-house community support services was a strength within *Facilitation Services*. Due to pre-existing relationships and established trust, within-organisation facilitations offer the advantage of greater staff-level collaboration and communication, easier accessibility for clients and appear to result in higher levels of client attendance. Considering these findings and the benefits to clients in terms of a seamless referral process, future evaluations could consider whether *Facilitation Services* carried out in collaboration with in-house community services would offer greater advantages over external community services in terms of client outcomes. This in turn could shift the focus of *Facilitation Services* or result in changes to models of service delivery where multiple services are provided alongside problem gambling intervention services.

Relationships with gambling venues require a different approach considering the differing interests of venues and service providers. Greater collaborative working relationships with gambling venues could lead to better understanding of client outcomes following self-exclusions. Integrated working processes that combine the objectives of *Facilitations* for client self-exclusions and the objectives of the *Safe Gambling Environments* and *Effective Screening Environments* public health services could lead to a greater level of screening and referral practices among gambling venues.

Joint client management protocols

Establishing joint client management protocols is an area that requires improvement. Additional to the need for more formally established protocols, areas that seem to need consideration include clarity in roles and responsibilities of both organisations during the *Facilitation* process and procedures around client information sharing. One specific concerns was the sharing of information about clients' spiritual and religious needs. Such information was not always shared with allied organisations. This may be important for clients of some ethnic groups for whom these service aspects were important.

Delivery of Follow-up Services

The literature search did not find any evaluations on the effectiveness of *Follow-up Services* per se. Nevertheless, an evaluation in Northern Spain (Echeburúa *et al.*, 2000) suggested the value of *relapse prevention* programmes for problem gamblers. *Follow-up Services* could draw on best practice in relapse prevention strategies for other addictive problems such as drugs and alcohol (Larimer *et al.*, 1999; Witkiewitz & Marlatt, 2004) to inform discussions with clients during *Follow-up* contacts.

The present evaluation found that *Follow-up* sessions were delivered more frequently for gambler clients than for significant other clients. Generally, scores for Ministry-recommended screens for *Follow-up* were not recorded for the majority of clients at *Follow-up* sessions, and screen scores were rarely recorded more than once. As previously noted, providers are not mandated to record scores for the recommended screens; this meant that CLIC data were insufficient for estimating client outcomes at the *Follow-up* stage.

Nonetheless, both staff and client views were that *Follow-up* sessions result in positive client outcomes. A notable change from the previous evaluation was that both clients and staff indicated that fixing *Follow-up* sessions at one, three, six and 12 months following their treatment end was effective. However, in some cases, providers may have resorted to adjusting CLIC database entries to meet the Ministry's data needs; therefore, CLIC records may not necessarily reflect the reality of how *Follow-up* sessions were carried out.

Providers were still facing similar challenges as they had previously in delivering *Follow-up Services*; these included practitioners' time constraints and difficulties in contacting clients. Some staff expressed concern that such difficulties and the time and effort required for follow-ups were not appropriately recognised. Some consideration of this is warranted, though self-reported data have inherent limitations.

Follow-up Services were delivered either by clinicians themselves or by support staff. Staff perceptions were that there were two components to *Follow-up* contacts: obtaining data on client progress and

providing ongoing clinical support for clients, thus the position of the individual delivering *Follow-up Services* needs careful consideration. Support staff may be suited to delivering *Follow-up Services* when the key aim is to obtain client progress data. However, clinicians should take on *Follow-up* responsibilities if the aims are to ensure relapse prevention and the maintenance of clients' treatment outcomes.

Understanding and use of success indicators within a logical framework of intervention service delivery

Staff belief about the main indicators of successful delivery of intervention services fit within three broad categories: activity-related indicators, output-related indicators and outcome-related indicators with almost all providing a single indicator category. This suggested that what was perceived to be the most important aspect of service delivery varied across individual staff members.

The development of logic models for intervention services could ensure consistency in key areas of focus within organisations as well as within the sector. Additional to building on the indicators identified by staff in the present evaluation, national and international literature on problem gambling intervention services that offer a range of process, output and outcome indicators could also be considered. For instance, among the process indicators that have been reported in the literature include the gambler-counsellor therapeutic relationship, client-focused strategies used, and inclusive goal setting approaches in gambling treatment interventions. Output indicators include increases in the number of individuals seeking help and client satisfaction with the services received. Outcome indicators include improvements to knowledge about gambling risks and reductions in gambling-related irrational beliefs, gambling frequency, money spent on gambling, amount of money lost, and number of financial problems. These indicators may also be used to gauge the potential effectiveness of treatment. Consistent usage of such indicators may serve as a basis for evaluating intervention effectiveness by comparison with previously reported successes and best practices in other equivalent interventions.

Development of logic models for intervention services would need to consider overlaps between the different interventions presently offered to clients. For instance, client willingness or receptiveness towards *Follow-up* contacts would be dependent on if the relevant activity of encouraging clients' agreement to a *Follow-up* plan was carried out during the course of the *Full Intervention* process. Overlaps with public health services should also be considered. For instance, the reliance on public health activities in seeking opportunities to deliver *Brief Interventions*. A higher level of understanding and use of success indicators within a logical framework of service delivery could result in better planning to increase inputs and resource efficiency. It also offers an inbuilt process for self-monitoring and evaluation.

Outcome indicators for *Brief Interventions* would require additional attention considering its possible lack of clarity. While some staff identified help-seeking behaviour and increased referrals to intervention services as indicators, others were of the view that there were no explicit outcome indicators for *Brief Interventions*. The lack of visible outcomes in the form of a direct conversion from *Brief Intervention* to *Full Intervention* was also perceived as *Brief Intervention* ineffectiveness. These observations suggest a need for further clarity on measurable success indicators.

Evaluation synthesis – Problem gambling intervention services

Processes and outputs

- In general, providers were achieving what they were contracted to achieve, albeit at varying levels and in different areas within the four intervention services. Some providers did not meet the minimum number of client sessions agreed with the Ministry.
- Services were delivered to targeted at-risk populations, and were accessible to both gambler and significant other clients.
- Self-referrals, referrals from other services and sectors, and *Brief Intervention* activities all contribute towards enabling clients' initial entry pathways into treatment services.
- Providers effectively ensured clients' access to information.
- Evidence of cultural practices and perceptions (of staff and clients) about quality of services were positive both in the evaluation and in the clinical audit. A clearer documentation of cultural practices used within intervention services could enable sharing of best practice across the sector.

Intervention services outcomes

- The Intervention Service Practice Handbook suggests that *Brief Interventions* delivered with good motivational discussions can result in positive outcomes for individuals even if they do not undergo formal counselling. This, however, is an important outcome of *Brief Interventions* that remains unknown and needs to be addressed in future evaluations.
- A small sample of CLIC data (cases with two records of screen scores), and staff and client views suggest that *Full* and *Workshop-based Intervention* services were effective in resulting outcomes for clients.
- Providers ensured clients' access to other support services through referrals and through implementation of *Facilitation Services*. Providers within wider organisations that offer multiple support services under one roof appeared to have an advantage in terms of ease of service accessibility for their clients. Areas of improvement for *Facilitation Services* include communication, contact and follow-up with allied services, and establishment of joint client management protocols.
- Both staff and client views were that *Follow-up* sessions result in positive client outcomes. *Follow-up Services* were delivered either by clinicians or by support staff. While it may be recommended that clinicians should take on *Follow-up* responsibilities to ensure relapse prevention, clinicians' time constraints will need to be considered.
- At present, providers are not mandated to record scores for the recommended screens in the CLIC database. While providers may be carrying out appropriate assessments, and some providers are maintaining additional databases (with other client details regarded as important), data are not always available in CLIC for monitoring client progress or for a national level evaluation of client outcomes. To ensure availability of these data, it may be necessary to re-evaluate specifications for reporting required screen scores (in service purchase unit descriptions) and to consider providers' perceptions about the importance of assessment data recording practices and possible issues they may face when assessing clients and recording results. Understanding the value of CLIC as a national database could encourage improved reporting. An example is the value of the CLIC database for informing the sector about the types of clinical practice or intervention models, including ethnic-specific models that are working well. Accurate records of co-existing issues among gambler and significant other clients can inform other services such as *Facilitation Services* (PGCS-04) and *Effective Screening Environments* (PGPH-05). Accurate data and comprehensive records would allow more robust analysis of data to improve clinical practice and inform changes to practice and service provision in a way that meets the needs of different clients groups and populations.

6.3 Problem Gambling Public Health Services

Overall compliance with service specifications

The majority of staff survey respondents indicated the effective delivery of activities for all five services. However, the document analysis of providers' reports found that while some activities were delivered consistently across all providers (those contracted for the respective PGPH purchase units), a smaller number of providers delivered other activities[65]. It is possible that some activities might have been implicit within work carried out and not clearly reported, or not carried out due to difficulties and challenges. It was beyond the scope of the present evaluation to determine which the case was.

The sections that follow discuss key areas of strength and improvement.

Innovativeness

Most staff respondents believed that their organisations were effective in developing innovative approaches for delivering public health services. However, with the exception of a few examples of proactive approaches noted in providers' reports which contained elements of innovation, staff descriptions of innovation were insufficient to determine the extent to which providers incorporated innovative ways in delivering public health services (i.e. beyond Purchase Unit Descriptions). Most staff description of innovative activities appeared to be what was required in their service specification. This could simply be a result of differing perceptions regarding the term innovativeness.

Descriptions of aspects regarded to be innovative could be made more explicit in providers' reports; for instance, by including clarifications on the level of novelty. While some approaches may be regarded novel at a sector level, others may be new to the problem gambling public health field.

Delivery of Brief Interventions during public health activities

The findings suggested that providers delivered activities in relation to *Brief Interventions* during public health activities. Providers often reported having carried out brief screenings at public health events and during health promotion activities for PGPH-03 and PGPH-04. These included formal use of screens as well as informal discussions with visitors to their information stalls. In some cases, they reported that such efforts led to identification of at-risk individuals and subsequent referrals. Some providers also reported having carried out brief screens at the events and premises of other support services and gambling venues when delivering PGPH-02 and PGPH-05 activities.

Focus group respondents' comments on how some public health activities were delivered in collaboration with clinical staff suggested the possibility that the delivery of brief motivational interviews following brief screens would have been likely. An analysis of recordings of new *Brief Interventions* in the CLIC database suggested major peaks in particular months, which coincided with months where public health activities were delivered, i.e. in March coinciding with Pasifika Festivals, in September with *Gamblefree Day* and in November with White Ribbon day. However, the extent to which the full range of *Brief Intervention* activities (as detailed in PGCS-02 service specifications) were delivered during public health activities was unclear in providers' public health progress reports. While it is acknowledged that these may have been detailed in the intervention-related sections of providers' progress reports (not included in the present evaluation), it is suggested that an accurate assessment of such activities would require clear documentation of the number of brief screens, and the number of subsequent *Brief Intervention* activities that were delivered in the different settings of public health activities.

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[65] As noted in Chapter 5, because of the limitations in the primary data (i.e. providers' six-monthly progress reports) used for the PGPH services component of this evaluation, this estimate and other verbal quantifications on specific activities and outputs are indicative findings only.

Impact of local public health promotion activities on help-seeking behaviour

The data available for the present evaluation were insufficient to determine precisely the impact of local public health promotion activities on help-seeking behaviour or the extent to which clients benefited from elements of public health services they may have experienced. Overall, staff respondents were divided in their views of the impact of national social marketing campaigns and awareness-raising activities carried out at local events and festivals on help-seeking behaviour, with about half indicating they noticed increases in help-seeking and half indicating that they did not. Only a very small percentage of client survey respondents indicated having been encouraged by a service provider they met at such an event as a reason for their help-seeking behaviour. Analysis of client pathways suggests this was much more likely to be the case for significant other clients than for gambler clients.

As noted in the section above, CLIC database findings suggested increases in the number of *Brief Intervention* on particular months of the year coinciding with national public health events. However, it was not possible to determine impacts based on the various geographical locations where these activities were carried out because of the diverse and dispersed nature of these activities, as described in providers' reports, and the need to consider other influencing variables. Participation in events such as White Ribbon Day, and organisation of *Gamblefree Day* were at various locations. Providers also participated in a range of other local festivals and events, which were smaller in scale and specific to a particular town or area. It was of interest that the Pacific events seem to be associated with a specific increase in new Pacific clients along with increases in other ethnicities. In contrast, *Gamblefree Day* was more specifically associated with new European/Other clients. As discussed elsewhere, it could be that cultural differences underlie this, with European/Other being more open to approach that are issues specific (*Gamblefree Day*) and family/community activities, and Māori and Pacific ethnicities more responsive through family or community-oriented events.

A detailed analysis of trends in relation to location of public health activities would require the collection of more specific data within the CLIC database or in a similar public health activity database compatible with CLIC. Alternatively, providers' record keeping of clients' reasons for initial help-seeking behaviour, if collected in a systematic manner across all providers, could result in useful data for determining the effectiveness of public health promotional approaches used by providers as well as for determining public-health outcomes (i.e. if public health activities result in self-referrals or help-seeking behaviour). Although some providers' comments suggested that such information was used to gauge the effectiveness of their promotional activities, impacts at a national level remain unclear due to lack of robust data at the required level.

Cultural responsiveness in delivering services

Most Māori and Pacific providers reported explicit examples of cultural approaches used when delivering public health services. These approaches were noted to be effective as they enabled an outreach to the targeted at-risk population groups and facilitated their engagement in the respective activities. Often these activities included reference to gambling, as opposed to being centred on gambling. Reconnecting with cultural practices and emphasising cultural values were a major part of cultural approaches, as was the use of appropriate language. The availability of health promotion resources in the languages suited to the target populations was identified as an area of need.

Additional to activities delivered during national and local cultural events, activities were also often carried out in collaboration with ethnic-based community groups and in appropriate places such as churches and marae. Post-hoc discussions with the Cultural Advisory Group noted providers' consideration of locations to suit the needs of specific groups as a strength, as certain places and spaces were regarded important to some ethnic groups. However, the Advisory Group also suggested that marae-based public health promotion might not be readily practicable, considering the high cost of hiring such spaces as venues. Nevertheless, providers' relationships with marae groups and the organisation of collaborative activities as evidenced in their reports are likely to have overcome the challenge of such additional costs.

While the need for language-appropriate services was frequently emphasised as being important for Asian clients, there was a lack of explicit examples of public health cultural approaches designed to suit

Asian clients in provider reports. A greater depth of reporting would be required to gain further clarity on health promotion approaches that meet the unique needs of Asian clients.

Community and stakeholder engagement

Building relationships with community and other appropriate stakeholders was a common theme across the five public health services.

Providers reported community engagement in the delivery of many public health activities. Engagement was with prominent individuals, community organisations, ethnic-based community groups and with members of the general public. Community engagement was a strength, as such engagement was often associated with successful outcomes. Providers encouraged community involvement in public health activities by inviting their participation in joint-organisation of events, building on activities that the communities were already interested in and facilitating opportunities for meetings and deliberation (for instance, between community members and council staff). Providers' contributed to community understanding of gambling harms by encouraging discussions in the news media and delivering awareness-raising programmes and workshops.

An important aspect within community engagement was elements of sustainability in community involvement. In some cases, while providers played an active role at the start of a project, community members subsequently took over leading roles and ongoing project work, suggesting a long-term sustainability of the outcome of community involvement. While this was an important feature of PGPH-03, the inclusion of a sustainability element as an objective in other PGPH services could lead to planned outputs that lead to increases in proactive voluntary involvement of community members in addressing gambling-related harms. This would be similar to community involvement in other public health issues such as smoking and alcohol and drug-use. This in turn, could mean a greater recognition of problem gambling as a commonly shared public health responsibility.

Some provider reports indicated specific communication approaches and strategies they used or learned through their process of engaging with stakeholders. For instance, when engaging with gambling businesses, it was important for providers to act as allies, highlighting benefits to the business, as opposed to a more confrontational approach.

However, providers faced a range of challenges in engaging stakeholders. Encouraging stakeholders to recognise and acknowledge the existence, prevalence and significance of gambling harms (a likely result of the difficulty of recognising the "hidden" harms of problem gambling) may be an initial hurdle that first needs to be overcome. While collaboration with community groups was a key requirement for some PGPH services, providers needed to consider the time availability and interests of community members, which were not always directly related to problem gambling. Providers also needed to alter pre-existing perceptions of gambling as a "social activity" or "entertainment option" held within lower socio-economic communities, and misconceptions about the real costs of gambling.

Collaborating with other community and health services was also often a challenge, considering the wide range of other competing social issues and competing demands on this stakeholder group's time and resources. The experience of some providers in addressing these challenges offer effective practice that could be shared across the sector. To overcome barriers related to stakeholder engagement, providers would first need to understand the context of these organisations and present their agendas (e.g. policy development, awareness programmes) as something beneficial, negating the association of uptake to workload increases. Offering sample materials (e.g. sample policies and screening tools or best practice examples) that will not be perceived as additional work or invasive may also encourage uptake. Organisations would also need to be clear about the ready availability of support from problem gambling clinical services to encourage their participation.

Collaborations with gambling venues had unique challenges in that venues tended to have a different set of priorities. Challenges some providers faced included venues' resistance towards the content of some awareness-raising materials, perceptions of its importance and lack of willingness to making these resources available at their venue. Lack of priority given to, and follow-through with, MVE implementation and their negative perceptions about the manageability of increasing numbers of MVEs

were among other challenges. Providers' experiences corresponded with observations in the literature on partial responses from gambling venue operators. An Australian-based survey of gambling venue operators found that while they were in favour of minimising secondary harm and reactive primary interventions, they were less in favour of proactive approaches to primary intervention and discretionary practices (Hing, 2001).

Despite such challenges, providers successfully collaborated with a broad range of stakeholder groups, which suggested a strength in terms of providers' commitment and perseverance. While they documented challenges to, and successful approaches for, engagement with stakeholders in their individual progress reports, and have shared strategies with one another at providers' meetings, the sector could benefit from a formal documentation of these challenges, and mitigating strategies and approaches. Such documentation can ensure a greater level of information sharing on established approaches.

Providers may also benefit from reviewing non-empirical guides (Coulter, 2009; Griffiths, Maggs & George, 2008; Mallery *et al*., 2012; Morgan & Lifshay, 2006; Public Health Association of New Zealand, 2010; Queensland Government Department of Communities, 2011) and online resources (Community Tool Box, 2014) on stakeholder engagement in other health-related fields. These guides and resources provide methods and approaches for stakeholder engagement such as establishing engagement plans, carrying out community consultations, establishing shared understanding and consensus, enhancing involvement, information-sharing techniques and communication strategies, among others. While these guiding documents do not relate directly to problem gambling as a public health issue, the processes involved are transferable.

Problem gambling and related terminologies

Terms like "problem gambling" and "at-risk communities" are used in official descriptions of service provision (e.g. problem gambling public health services), in policy documents, and in both local and international literature. These terms offer a common language that all stakeholders are familiar with and are thus terms that can ensure consistency in understanding of meaning when discussing related issues and for linking related best practice and strategies.

However, one provider suggested the term "at-risk communities" could be seen as a form of labelling communities. A few providers' perspectives suggested a need to review the usage of the term "problem gambling" in public health messages and when interacting with individuals at risk. Stigma associated with "problem gambling" among some Asian cultures prevented help-seeking behaviour. Identifying that someone has a gambling problem through screening was seen as conflicting with the Māori cultural norm of refraining from causing shame or embarrassment to another. Some providers also reported that rather than a deficit view concerning "problem gambling" among Māori, a more effective approach would be to focus and build on existing community strengths; this may mean a focus on activities that may not have direct connections with gambling harm minimisation. On the contrary, as noted in the preceding section, some providers reported the difficulty of getting stakeholders to recognise problem gambling as a public health issue. Others mentioned the challenge of overcoming community perceptions of gambling as a harmless social activity, attributing this to the hidden harms of gambling.

These conflicting perspectives raise the question of whether culturally appropriate public health messages can be developed without trivialising the seriousness of problem gambling and resultant gambling-related harms. On the one hand, a culturally responsive approach may require removal of the term "problem gambling" from public health messages. On the other hand, such removal could mean an on-going non-recognition of the existence of problem gambling or maintenance of a view that it is less serious than other issues such as drug and alcohol addictions, both of which are widely accepted as serious problems with health and social effects.

The view of the Cultural Advisory Group was that the term "problem gambling" might lead to reluctance among some groups to admit that they have a problem; thus use of an equivalent alternative term may better attract people to address the issue and seek help. "Gambling misuse", "harmful gambling" or "minimising gambling harms" as described by the Ministry were suggested as possible alternatives. Whether or not a 'culturally appropriate' terminology is possible is debatable. However,

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the public health activities (focused on community and family, as opposed to gambling harm) of some providers show they are aware of, and addressing, this issue. The possible links between new client presentations around the times of gambling specific (*Gamblefree Day*) and community/family (Pasifika Festivals) events further supports this general issue of how best to frame gambling issues, and make discussing and engaging with them accessible for all cultural groups.

The use and implications of alternative terms in public health messages would require careful consideration. A complete elimination of the term "problem gambling" would require deliberation between the Ministry, providers, and the HPA and would need to take into account the views of the public. Implications for wider communication will also need to be considered as removal of the term "problem gambling" also means a diversion from a long established common language.

Policies on non-gambling fundraising

Providers reported that encouraging policies on non-gambling fundraising was particularly challenging. Instead of actual development of policies, providers focused on encouraging alternative fundraising practices. As noted in Section 5.1.1, the review of literature found limited research and evaluation on problem gambling policies in general. Policies on non-gambling fundraising and non-acceptance of gambling funds remain largely unexplored in the literature. Further development of public health work in this area may require providers to familiarise themselves with locally available codes of practice and guidelines, such as the *FINZ Standard of Charitable Gambling Fundraising Practice* (Fundraising Institute of New Zealand, 2011) which includes a risk assessment plan. The sector in general may also benefit from consideration of regulatory approaches used by other government bodies. For example in the United States of America, the State of California requires eligible non-profit organisations to submit an application to the Bureau of Gambling Control prior to carrying out a gambling fundraiser event (State of California Department of Justice, 2015). Regulations surrounding such events include restrictions on the number of gambling fundraiser events to only one per year (State of California Department of Justice, 2015).

Development of this public health area should also consider the ethical debates on charitable gambling funds and the growing dependence of community groups and the non-profit sector on these funds (Adams & Rossen, 2012; Azmier & Roach, 2000), the latter being a likely reason for the challenges experienced by providers in this evaluation. In New Zealand, references to gambling profits' benefits for communities in the Gambling Act 2003 have been regarded as an obstacle to successful implementation of a public health approach to gambling (Adams & Rossen, 2012). Therefore, it appears that the development of policies should clearly distinguish two key aspects, non-acceptance of gambling funds and non-gambling fundraising, and coincide with providing community groups with alternative funding sources and fundraising ideas.

Political neutrality expectations

The Ministry's expectations of political neutrality in the delivery of services was not intended to inhibit providers' delivery of independent activities. However, expectations for political neutrality acted as a barrier to successful implementation of some public health services as this restricted open public discussion and debate. Further clarity (including examples) on activity aspects where providers are required to adhere to the principles of political neutrality and approaches for handling risky situations could enhance public health service delivery. The implications of political neutrality expectation on other policy related work that providers are expected to deliver under PGPH-01 (e.g. encouraging policy development and encouraging policy-related public debates) seem to require some clarification or further discussion with providers. A clear understanding of the Ministry's expectations could prevent perceptions about political neutrality acting as barriers to the delivery of future public health activities.

Overlaps in PGPH Purchase Units Descriptions

Activities and expected outputs in the Purchase Units Descriptions of some PGPH services were somewhat similar. For instance, both PGPH-03 and PGPH-04 required the delivery of activities that encourage public discussion and debate on gambling-related harms necessitating an awareness-raising

activity for both purchase units. Activities relating to multi-venue exclusion policies were reported by some providers under PGPH-01, while others reported it under PGPH-02. This is likely to be a result of underlying policy focus overlap. Overlaps in purchase unit activities and outputs also meant that providers could achieve outputs for multiple purchase units through a single project or even a single activity. For example, *Gamblefree Day* activities were seen to be relevant for achieving outputs for up to three purchase units (PGPH-02, -03 and -04).

Such overlaps, however, had repercussions on the reporting of activities and consequently on the present evaluation concerning activity outputs. The analysis found that often a single activity was reported for more than one purchase unit. Therefore, in such instances, a broad range of reported activities does not necessarily mean that a larger number of activities were carried out. This observation emphasises the need to take such overlaps into account in future evaluations of public health services, particularly if individual evaluations of the five PGPH services are required.

As mentioned earlier, purchase unit overlaps also suggested a need for a greater level of planning that builds in processes that ensure a greater level of efficiency in time and resource use when delivering activities. While providers may have been doing this as a matter of course, proactive planning of activities that considers overlaps can increase efficiency.

Collaboration between PGPH service providers

Although it steers away from the idea of precise measurements of individual provider success, collaboration between PGPH service providers is a key factor for public health promotion. Measurement of public health outcomes could incorporate "shared success" as an indicator. Such shared success was observed in the present evaluation as providers often collaborated with other PGPH service providers when delivering public health activities. Although some areas for improvement remain; for instance, competitiveness between providers and differences in working approach, which deterred collaboration, providers were generally aware and appreciative of the value of collaboration. Such collaboration offered the advantage of publicly exhibiting a commonly shared goal in the push for a public health focus to address problem gambling, and enabled a wider geographical reach, joint organisation of events and the sharing of knowledge and resources.

To enable a greater level of cost effectiveness, contracts could be restructured in a way that shifts the focus to wider public health projects, rather than individual provider outputs. Multiple providers could then jointly purchase the contracts to deliver services in a collaborative manner. This would be particularly useful for national and regional type projects such as national awareness campaigns and regional policy advocacy.

Understanding and use of success indicators within a logical framework of public health service delivery

The Ministry of Health (2006) recommends the use of logic models to develop health programmes. Providers were thus expected to design and implement public health programmes that are "comprehensive, effective and measurable, that will deliver improved public health outcomes" (Ministry of Health, 2010, p. 30). The Ministry also provided outcome-related indicators for each Purchase Unit Description. Within a logical framework, the Ministry distinguishes:

> …short-term objectives… from activities (which are the actions needed to achieve the objectives). Long-term objectives specify the outcomes or changes needed to achieve programme goals, such as the reduction in the incidence of a health problem or improvements in health status resulting from the implementation of a healthy public policy or environmental supports (Ministry of Health, 2006, p. 24)

While providers reported varied successes, the majority did not report against the indicators listed in the Purchase Unit Descriptions. The description of success indicators by staff suggested the tendency to focus on one indicator category, either activity-related, output-related or outcome-related. This tendency suggested varying perceptions among staff about what they believed was most important within the logical framework of activities, outputs and outcomes. While for some providers, success was in delivering activities, for other providers success was in the achievement of outcomes.

To move towards a logic model framework for delivering services, providers would first need to have a clearer and consistent definition of success that is shared across the sector. This shared definition would in turn determine the key areas of focus for public health services. The preliminary and adapted logic models provided in this report are general. Providers are likely to benefit from developing more detailed logic models that identify the linear process of inputs, outputs, outcomes and impacts for specific activities while identifying areas of overlap with other public health activities as well as overlaps with intervention services.

Annual planning template and reporting templates

Some staff survey respondents indicated that while they knew about the annual work plans they were not aware of the details. A small percentage indicated that they were not aware of annual work plans. This is highlighted as an area for improvement considering that staff clarity on work plans are a logical prerequisite for effective implementation of planned activities.

Some staff noted the work plan template's lack of clarity as a planning tool. Some providers found the planning template more suited for reporting than for planning and had thus used the template for reporting work done rather than work planned. The logical direction provided in the template may have served as a guide for providers to think about service delivery within a logical framework. The section in the template, which requested description of the project in terms of *why it was done*, may have served as a guide for providers to think about purchase unit objectives. The sections on *what was done* and *who they engaged with* may have steered providers' focus to outputs (i.e. activities delivered) prior to the reporting of outcomes. In cases where providers used this template for reporting, a logical flow of actions taken, processes used and outcomes achieved were clear. Some of these are presented as "best practice examples" in Chapter 5.

The current planning template could be adapted into a reporting template, as it appeared to guide providers in thinking about their projects using a logical framework. Such reporting would address some of the limitations identified in the present document analysis, as it would elicit a greater level of clarity in reporting, particularly the connections between activities, outputs and outcomes. Providers' use of reporting templates could be further improved by supplying examples of what the reporting should ideally look like. A "Public Health Service Practice Requirements Handbook" similar to that presently available for intervention services could be developed where such reporting examples may be included, alongside descriptions of services, success indicators and logic models.

A separate planning template could be developed, providing clearer terms to guide activity or project planning, for instance: (1) objectives, (2) required inputs (e.g. resources, staffing and background information), (3) anticipated external influences, barriers or challenges (based on previous experiences) and suggested precautionary measures, (4) targeted audience, (5) targeted partner groups for collaborative work and their distinctive roles in delivering activities, (6) expected outputs and timeframes, (7) expected immediate outcomes, and (8) expected longer-term outcomes. The planning template could also require additional clarity, when a particular project relates to more than one public health service.

Planning and reporting that is based on such a logical framework would also aid the process of outcomes monitoring and evaluation of progressions made over time.

Measurement of outcomes (evaluations of public health services)

The present review of literature found very limited evaluation literature that considered the outcomes of public health approaches for problem gambling. Among the few examples found, most used experimental-type methods to determine outcomes or impacts. Evaluations also tended to focus on individual programmes and initiatives, rather than broad inter-related areas of public health services. This general lack of related formal research and evaluation is suggestive of the novelty of these types of public health services in both New Zealand and elsewhere.

Considering the lack of formal research evidence in the form of health outcomes that may be associated with public health initiatives, the Ministry suggests that the effectiveness of a programme may be

gauged by considering informal evaluations by programme implementers, or by carrying out "focus group discussions and interviews with key informants" (Ministry of Health, 2006, p. 17).

Although some staff mentioned difficulties in measuring impacts of public health activities, the document analysis of provider reports found that in some cases providers had conducted their own evaluation of activities, by for instance, using evaluation and feedback forms. In other cases, informal discussions with participants or observations of participant's reactions, may have contributed to providers' evaluative judgements about the effectiveness of their initiatives. It was presumed that such informal evaluation practices were implemented by providers on their own accord due to the lack of explicit requirements for evaluations in the Purchase Unit Descriptions. Providers' initiatives in carrying out evaluations (albeit informally) was noted as a strength that could be further built upon.

The evaluation instruments established by providers' could be compiled and collectively developed prior to being made available as evaluation templates that all providers could use in various public health activities. While some tools would require collection of data from members of the public, other templates could be designed for capturing data based on staff observations.

While the delivery of intervention services requires service providers to "maintain an information system that efficiently and accurately monitors utilisation of service and outcomes for service users" (Ministry of Health, 2010, p. 21) by comparison, public health services lack a similar rigour in collecting or maintaining public health outcomes data. Although the public health progress reports required by the Ministry provided a method for recording public health outcomes that may have resulted from the delivered activities, as noted earlier, in their current form, these reports are insufficient for evaluating long-term outcomes. This lack, in combination with limited formal evaluations in the literature, could restrict research-informed decision-making in the implementation of public health services.

The above limitations suggest a need for more efficient methods for monitoring and evaluating Ministry-funded public health services in a way that could enable accumulation of evidence linking the outputs of public health services with health and wellbeing outcomes. Although it is acknowledged that some public health impacts take a long time, sometimes several years, to occur, ongoing monitoring of outputs and the documentation of short-term outcomes gathers evidence on changes or improvements that take places immediately following public health activities. Such evidence may serve as a baseline for gauging resultant longer-term impacts.

A first step could be the development of more detailed logic models based on the indicators identified in the present evaluation. Establishing sets of possible indicators and methods to monitor progress over time may lead to the establishment of a more systematic measurement of PGPH service outcomes.

As reported earlier, provider's progress reports, in their present format, were not a fully reliable data source for determining the long-term effectiveness of public health services. Therefore, as a second step, a more standardised format of reporting could be established to enable a more systematic monitoring of outputs and outcomes. Following a similar concept to the CLIC database, a database for collecting public health services data could be developed. Alternatively, provider comments could be collected using common online data collection software such as *SurveyMonkey*. The collection of providers' progress in a more structured format, which includes structured tick-in-the-box type responses as well as narrative comments, would provide more reliable and readily analysable data.

This would be an important consideration, particularly if the progress reports are to be used for future evaluation and monitoring purposes. The collection of data using such systems (as opposed to individual provider reports) could ease the Ministry's monitoring process, as lesser time would be required for collation of key trends and progress across providers. Such a system would also provide valuable data for longer-term evaluations as it would offer data that is collected and stored via a standardised tool.

Considering the complexity of some public health services, evaluation of outcomes may need to take a more compartmentalised approach, drawing from longitudinal evaluation methodologies. For instance, in evaluating PGPH-01, four separate evaluations are likely to be necessary to determine the four key areas of policy outcomes: workplace/organisational policies, policies on non-gambling fundraising,

public policies in general, and Class 4 gambling venue policies in specific. A longer-term evaluation could consider co-relations between implementation of these policies and observed changes or impacts.

Drawing from international best practice

Considering the scarcity of formal evaluations, the development of PGPH services in New Zealand should consider publications and evidence from other closely related public health areas (e.g. drugs, tobacco use) and specific areas within each public health service (e.g. educational components, social marketing concepts).

The PGPH-01 service could draw insights from evaluations of policy-related initiatives for other addictive areas. Some research evidence in other addictive areas indicate that public health policies, particularly those that require changes to practice, can result in public health outcomes. An evaluation of a drug-free workplace programme in the United States, which included relevant workplace policies, found that the programme was effective in reducing occupational injuries and thus loss of workdays (Wickizer *et al*., 2004). An evaluation of smoking-related legislation extension to include bars, casinos, clubs and restaurants in New Zealand noted how this contributed to public health because of reduced exposure to second-hand smoke (Edwards *et al*., 2008). Further development of PHPH-01 may also consider estimates of gambling policy effectiveness and policy recommendations (Gainsbury *et al*., 2014; Williams *et al*., 2007) that have been put forward.

The approaches used by providers in delivering PGPH-02, particularly in venue staff training and MVE implementation support, appeared to be consistent with those recommended in the literature. Encouraging venue uptake of MVE exclusion processes is likely to be an effective activity within PGPH-02 considering the value of self-exclusion programmes in achieving positive outcomes for those experiencing gambling harms (these are detailed in Section 4.7.1 under the chapter on Brief Interventions). Evidence from several evaluations in Canada and the United States suggested the value of training for employees of gambling venues. Training increased staff understanding about problem gambling, responsible gambling concepts and procedures for helping gamblers; improved staff attitudes towards problem gamblers; and enhanced staff confidence about their role in spotting and approaching gamblers in crisis (Dufour, *et al.*, 2010; Giroux, *et al*., 2008; Ladouceur *et al*., 2004; LaPlante *et al*., 2012). However, these findings also identified a need for more effective training programme content and implementation. For instance, by including training strategies that ensure venue employees' previously held erroneous beliefs about problem gambling are corrected and ensuring trained employees continue to apply what they have learned through the provision of additional information and refresher training. Further development of PGPH-02 activities could also consider findings from other evaluations on approaches for providing safer gambling environments including findings on the effectiveness of particular features of voluntary industry code of practice (Breen & Hing, 2008), responsible gambling tools, and warning messages (Cloutier *et al*., 2006; Monaghan and Blaszczynski, 2010a; Munoz *et al*., 2010; Steenbergh *et al*., 2004).

Public health services in relation to PGPH-03 have hardly been addressed in the literature. The value of community-focused programmes was nevertheless highlighted in one report as it can lead to enhanced community awareness of gambling harms (Brown *et al*., 2001). To gain a better understanding of community-related public health activities, outputs and outcomes, future evaluations could broaden the literature search criteria to include other social issue areas where community involvement outcomes are likely to have been documented.

Providers' organisation of, or support for, awareness-raising campaigns in the delivery of PGPH-04 could be further enhanced by considering best practice examples in the literature. A number of evaluation and research articles on problem gambling social marketing and advertisement campaigns suggested that impacts include enhanced understanding of gambling harms, help-seeking behaviour, and changes to gambling behaviour (Byrne *et al*. 2005, Gordon & Moodie, 2009; Jordan, 2012; Messerlian & Derevensky, 2007; Najavits *et al*., 2003; Thomas & Jackson, 2001). These articles provided suggestions on suitable media channels, strategies and effectiveness features (e.g. use of slogans, social norms, denormalisation messages, industry manipulation messages) when implementing problem gambling social marketing and advertisement campaigns. They offer important perspectives

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that can inform further development of the PGPH-04 service in New Zealand as well as national public health campaigns implemented by the HPA.

Providers' observations of outcomes resulting from education programmes were, to some extent, similar to observations noted in the literature, particularly evaluations of prevention programmes targeting youth (Donati, *et al*., 2014; Todirita & Lupu, 2013; Turner, *et al*., 2008; Williams, 2002). These education-focused programmes were effective in correcting misconceptions, increasing gambling-related knowledge including understanding of "random chance", and developing negative attitudes towards gambling, while reducing gambling frequency and money spent. However, the content of education programmes described in the literature appeared more comprehensive. While content of providers' awareness-raising initiatives is likely to have included the health and social risks of gambling, there was less evidence of educational or awareness-raising material content that included knowledge about gambling odds, risk-taking behaviours or approaches for dealing with risky gambling situations that can lead to excessive gambling or loss of control over gambling.

Public health activities in relation to PGPH-05 have not been empirically well explored in the literature. Very few studies that fit within our search criteria were found; articles were mainly on screening practices that were interlinked with the provision of brief interventions. Nevertheless, providers' practices and observations corresponded with evaluations on the effects of providing GPs and staff of primary health care services with training and resources to carrying out screening (Amaral *et al*., 2010; Tolchard *et al*., 2007; Sullivan *et al*., 2006, 2007, 2008). Findings from these studies include:

- Provision of information alone was insufficient for changing practices
- Adequate training in the recognition and treatment of problem gamblers and in the use of specialist problem gambling screens was necessary
- Screening and brief intervention techniques need to be easy to use
- Assurances around data confidentiality was necessary
- Collaborative project planning can increase chances of implementation.

However, time constraints and competing priorities can act as barriers to screening practices (Amaral *et al*., 2010; Sullivan *et al*., 2006). Although the provision of brief interventions following screening would be largely applicable to the health services stakeholder sector, these findings could be used as a base to further improve providers' areas of strength in delivering training on screening and referral practices to other stakeholder organisations.

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Evaluation synthesis – Problem gambling public health services

Processes and outputs

- Six-monthly progress reports on public health services varied in terms of breadth, format (in using the Ministry's templates) and clarity (in connecting activities and outputs with purchase unit descriptions and outcomes). As this meant a limited data set, verbal quantifications (i.e. implied numbers such as "some" or "most") throughout this report only provide an indication of extent.

- Indicative findings from the quantitative content analysis of providers' progress reports show that some activities were delivered consistently across all providers (those contracted for the respective PGPH purchase units) whilst other activities were delivered by a smaller number of providers. It was not clear whether some activities were implicit in work carried out and not clearly reported, or not carried out due to challenges. It was beyond the scope of the present evaluation to determine which the case was.

- The majority did not explicitly report against the indicators listed in the *Purchase Unit Descriptions*. The reasons behind this may be worth exploring.

- To enable a systematic measurement of PGPH service outcomes, detailed logic models and measurable indicators could be developed. A standardised format of reporting could be established, where both quantitative and qualitative data on inputs, activities, outputs and outcomes are collected using a standardised tool. This will enable easier data collation for shorter-term progress monitoring, and a more robust evaluation of longer-term outcomes.

- Providers' use of the public health work plan template was identified as an area for improvement. Submission of work plans was variable in terms of timing and completion of the different sections. Improvements to the planning template could include providing clearer terms to guide activity or project planning and the planning of projects that relate to more than one public health service.

- The current work plan template could be adapted into a reporting template, as providers tended to use it for reporting and it appeared to guide providers in thinking about their projects using a logical framework.

- Improvements to reporting and planning template use among providers could be achieved by supplying clear examples. A Public Health Service Practice Requirements Handbook, similar to that presently available for intervention services, could be developed where reporting examples could be included, alongside descriptions of services, logic models and success indicators.

- Community engagement was a strength as such engagement was often associated with successful outcomes such as community involvement in public health activities and joint-organisation of events. In some cases, community members subsequently took over leading roles and ongoing project work suggesting long-term sustainability. The inclusion of a sustainability element as an objective in other Problem Gambling Public Health services could lead to planned outputs that lead to increased voluntary involvement of community members in gambling harm minimisation.

- Despite challenges, all providers successfully collaborated with a broad range of stakeholder groups, suggesting a strength in terms of their commitment and perseverance. Some provider reports indicated specific communication approaches and strategies used or learned from stakeholder engagement processes. The sector could benefit from a formal documentation of challenges in engaging stakeholders, and mitigating strategies and approaches.

- Most Māori and Pacific providers reported explicit examples of cultural approaches in delivering public health services. These approaches were noted to be effective as they reached the targeted at-risk population groups and facilitated their engagement in the respective activities. There was a lack of explicit examples of public health cultural approaches designed to suit Asian clients. More detailed reporting is required to clarify health promotion approaches that meet the unique needs of Asian clients.

Public health service outcomes

- *Policy Development and Implementation* PGPH service outputs and outcomes in provider reports included:
  - Development and implementation of workplace and organisational gambling policies,
  - Influences on Class 4 venue policy and the associated "sinking lid" approach to pokie machine numbers, and

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- o Some public policy support.

  However, reports contained little explicit evidence of:
  - o Awareness-raising focused on gambling-policy relevance to the core business of the targeted sector,
  - o Development of policies on non-gambling fundraising, and
  - o Contributions to gambling harm social impact assessments.
- *Safe Gambling Environments* PGPH service outputs and outcomes reported included:
  - o Improvements to multi venue exclusion processes, and
  - o Development of gambling venues' host responsibility measures.

  However, reports contained little explicit evidence of:
  - o Monitoring and following up on venues' practices,
  - o Supporting venues' harm minimisation policy development, and
  - o Activities enabling collaboration between gambling venues and other organisations.
- *Supportive Communities* PGPH service outputs and outcomes included:
  - o Supporting culturally appropriate resiliency building through community partnerships,
  - o Developing community initiatives for promoting family and community connectedness and positive leisure and entertainment opportunities,
  - o Encouraging public discussion and debate on gambling harms and the ethical perspectives of gambling funds,
  - o Ensuring key groups' access to evidence-based community action approaches for reducing gambling harm, and
  - o Community involvement in related activities and increased knowledge about gambling harms.

  There was limited evidence of:
  - o Providers' identification of community strengths and protective factors,
  - o Success in ensuring key groups' access to evidence based-approaches to monitoring and controlling licensing of gambling venues,
  - o Media initiatives for promoting family and community positive leisure and entertainment opportunities.
  - o Success in providing a point of public contact for raising issues on public health approaches, and
  - o Improvements to public awareness of avenues for complaint regarding public health approaches.
- *Aware Communities* PGPH service outputs and outcomes in provider reports included:
  - o Delivering awareness-raising presentations and training on brief screening,
  - o Supporting community and youth-led culturally relevant awareness-raising initiatives,
  - o Using media and other awareness-raising initiatives to raise public awareness and encourage public discussion and debate on the harms of gambling, and
  - o Increased public understanding of gambling harms.

  There was limited evidence of:
  - o Monitoring and responding to public media discussions on gambling or problem gambling, and,
  - o Content that included knowledge about gambling odds, risk-taking or dealing with risky gambling situations in providers educational initiatives.
- *Effective Screening Environments* PGPH service outputs and outcomes in provider reports included:
  - o Screening and referral practices among some targeted stakeholder groups, and
  - o Increasing stakeholder organisations' awareness of the availability of their problem gambling intervention services.

  There was limited evidence of:
  - o Providers facilitating cooperation or coordination between key stakeholder organisations, and
  - o Raising awareness of the relevance of screening and referral practices to the core business of target sectors.
- Providers delivered activities in relation to Brief Interventions during public health activities. However, an accurate assessment of such activities requires clear documentation of the number of

- brief screens, and the number of subsequent Brief Intervention activities that were delivered in the different public health settings.
- The data available for the present evaluation were insufficient to determine precisely the impact of local public health promotion activities on help-seeking behaviour or the extent to which clients benefited from elements of public health services they may have experienced.
- A detailed analysis of trends in relation to location of public health activities requires the collection of more specific data within the CLIC database or in a similar public health activity database compatible with CLIC. Alternatively, providers' record keeping of clients' reasons for initial help-seeking behaviour, if collected in a systematic manner across all providers, could result in useful data for determining the effectiveness of public health promotional approaches as well as for determining public-health outcomes (i.e. if public health activities result in self-referrals or help-seeking behaviour). Although some providers' comments suggested that such information was used to gauge the effectiveness of their promotional activities, impacts at a national level remain unclear.

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GLOSSARY

Aotearoa	Māori name for New Zealand
Guy Fawkes	A traditional English event celebrated on 5th of November with fireworks and family get-togethers in the evening.
hāngī	An earth oven which uses heated stones for cooking (Moorfield, 2011).
hapū,	"Kinship group, clan, tribe, subtribe - section of a large kinship group and the primary political unit in traditional Māori society…" (Moorfield, 2011).
hui	(verb) to gather or to meet; (noun) meeting, conference (Moorfield, 2011).
iwi	"Extended kinship group, tribe, nation, people, nationality, race - often refers to a large group of people descended from a common ancestor" (Moorfield, 2011).
kai	food, meal
kaikaranga	"Caller - the woman (or women) who has the role of making the ceremonial call to visitors onto a marae, or equivalent venue, at the start of a pōwhiri. The term is also used for the caller(s) from the visiting group who responds to the tangata whenua ceremonial call…." (Moorfield, 2011).
kaimahi	Employee, staff (Moorfield, 2011).
kaitiakitanga	Guardianship, stewardship (Moorfield, 2011).
kanohi ki te kanohi	Face-to-face, in person (Moorfield, 2011).
kapa haka / kappa haka	A Māori performing group.
karakia	Prayer (Moorfield, 2011).
kaumātua	An elder, "a person of status within the whānau" (Moorfield, 2011).
kuia	"Elderly woman, grandmother, female elder" (Moorfield, 2011).
Kaupapa Māori	"Māori approach, Māori topic, Māori customary practice, Māori institution, Māori agenda, Māori principles, Māori ideology" (Moorfield, 2011).
koha	"Gift, present, offering, donation, contribution - especially one maintaining social relationships and has connotations of reciprocity" (Moorfield, 2011).
kōrero	(noun) discussion or narrative (Moorfield, 2011).
kotahitanga	(noun) unity, togetherness or solidarity (Moorfield, 2011).
mahi	(verb) "to work, do, perform, make, accomplish, practise"; (noun) "work, job, employment, trade (work), practice, occupation, activity, exercise, operation" (Moorfield, 2011).
manaaki	(verb) to "give hospitality to" or to "show respect"; (noun) support, hospitality (Moorfield, 2011).

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manaakitanga	"Hospitality, kindness, generosity – the process of showing respect, generosity and care for others" (Moorfield, 2011).
marae	"Courtyard - the open area in front of the wharenui, where formal greetings and discussions take place. Often also used to include the complex of buildings around the marae" (Moorfield, 2011).
Matariki festival	Māori new year celebration.
matua	"Father, parent, uncle" (Moorfield, 2011).
mihi	"Speech of greeting, acknowledgement, tribute" (Moorfield, 2011).
mihi whakatau	"Speech of greeting, official welcome speech - speech acknowledging those present at a gathering" (Moorfield, 2011).
Pasifika Festival	An Auckland-based festival held yearly in March which offers visitors a variety of Pacific Islands-themed cultural experiences such as traditional foods and performances.
pokie	Term used for an electronic gaming machine.
Polyfest	A large Pasifika dance/cultural festival held in Auckland every year in March (www.asbpolyfest.co.nz).
pōwhiri	"Rituals of encounter, welcome ceremony on a marae" (Moorfield, 2011).
rangatahi	"Younger generation, youth" (Moorfield, 2011).
rangatiratanga	"Sovereignty, principality, self-determination, self-management" (Moorfield, 2011).
talanoa	Pasifika ways of conversing or discussing issues of shared concern. It is a "form of dialogue that brings people together to share opposing views without any predetermined expectations for agreement" where "participants set the parameters for their discussions" (Robinson & Robinson, 2005, p. 2).
Talatalaga a Aiga	A Pasifika model for family therapy and counselling based on a process developed for engaging with Pasifika families. It entails engaging families in informal and open conversations, which includes a process of "talatala" which may be described as first untangling an old mat that requires repair, salvaging parts that can be reused while discarding parts that require replacement, and an on-going relationship development (Southwick, Kenealy, & Ryan, 2012).
tamariki	Children (Moorfield, 2011).
Te Kakano	Public Health Gambling Harm Minimisation workforce (http://www.tekakano.ac.nz/).
Te Ngira	The Auckland Problem Gambling Health Promoters' Collective.
Te Reo	The Māori Language.
Te Reo me ona Tikanga	The Māori Language and its Customs.

Te Toi o Matariki	Also known as the "Awakanening" model, Te Toi o Matariki is based on Maori philosophies and cultural values which emphasises that to recognise the need for change, individuals would first need to understand who they are as individuals and as Maori; personal growth and development is integral to the intervention process (Iwikau, 2007).
tikanga	"Correct procedure, custom, habit, lore, method, manner, rule, way, code, meaning, plan, practice, convention" (Moorfield, 2011).
tohu	Advice, recommendation, and guidance (Moorfield, 2011).
tohu mātauranga	"University degree, academic qualification" (Moorfield, 2011).
waka ama	"Outrigger canoe" (Moorfield, 2011).
Whānau ora	"Whānau ora has been used widely within the public sector in New Zealand to describe an overarching goal in the development of Māori specific programmes, strategies and policies" (Kara *et al*., 2011, p.102). Within the health sector the implementation of the whānau ora framework "acknowledges that health and wellbeing are influenced and affected by the "collective" as well as the individual, and the importance of working with people in their social contexts, not just with their physical symptoms" (Kara *et al*., 2011, p.102).
whānau	"Extended family, family group, a familiar term of address to a number of people - the primary economic unit of traditional Māori society. In the modern context the term is sometimes used to include friends who may not have any kinship ties to other members" (Moorfield, 2011).
whanaungatanga	"Relationship, kinship, sense of family connection - a relationship through shared experiences and working together which provides people with a sense of belonging. It develops as a result of kinship rights and obligations, which also serve to strengthen each member of the kin group. It also extends to others to whom one develops a close familial, friendship or reciprocal relationship" (Moorfield, 2011).
White Ribbon Day	White Ribbon Day is celebrated in November, with campaigns that focus on the issue of violence against women. See http://whiteribbon.org.nz/ for details.

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APPENDIX 1: Ethics Approval

ETHICS APPROVAL: CLINICAL AUDIT UNDERTAKEN BY KPMG

A U T E C
S E C R E T A R I A T

16 December 2013

Maria Bellringer
Jason Landon
Faculty of Health and Environmental Sciences

Dear Maria and Jason

Re Ethics Application: **13/335 Evaluation and clinical audit of problem gambling intervention and public health services.**

Thank you for providing evidence as requested, which satisfies the points raised by the AUT University Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 16 December 2016.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 16 December 2016;

- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 16 December 2016 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

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A U T E C
S E C R E T A R I A T

16 April 2014

Maria Bellringer
Faculty of Health and Environmental Sciences

Dear Maria

Re: **14/80 Evaluation and clinical audit of problem gambling intervention and public health services.**

Thank you for submitting your application for ethical review. I am pleased to confirm that the Auckland University of Technology Ethics Committee (AUTEC) has approved your ethics application for three years until 14 April 2017.

AUTEC recommends that you amend the invitation of the Information Sheets so as to identify the researchers involved and invite the participants in a friendlier manner.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 14 April 2017;

- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 14 April 2017 or on completion of the project;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Jason Landon; Komathi Kolandai-Matchett

ETHICS APPROVAL: STAFF FOCUS GROUP EVALUATION COMPONENTS

A U T E C
S E C R E T A R I A T

17 June 2014

Maria Bellringer and Jason Landon
Faculty of Health and Environmental Sciences

Dear Maria

Re Ethics Application: **14/148 Evaluation and clinical audit of problem gambling intervention and public health services.**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 17 June 2017.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 17 June 2017;

- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 17 June 2017 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

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APPENDIX 2: Questionnaires

SERVICE PROVIDER QUESTIONNAIRE

Section 1: Some general questions about your organisation

1. Which best describes your organisation's service type?
   - ☐ Dedicated Māori service - based on a Māori cultural paradigm
   - ☐ Dedicated Pacific service - based on a Pacific cultural paradigm
   - ☐ Dedicated Asian service - based on as Asian cultural paradigm
   - ☐ General service - delivered in a manner that is accessible to all groups regardless of gender, ethnicity, age, or health status

2. Which of the following Problem Gambling Intervention services does your organisation offer? *(Select all that apply)*
   - ☐ Brief Intervention services (PGCS-02)
   - ☐ Full Intervention services (PGCS-03)
   - ☐ Facilitation services (PGCS-04)
   - ☐ Follow-up services (PGCS-05)
   - ☐ Workshop based interventions (PGCS-06)

3. Which of the following Problem Gambling Public Health services does your organisation offer? *(Select all that apply)*
   - ☐ Policy Development & Implementation (PGPH-01)
   - ☐ Safe Gambling Environments (PGPH-02)
   - ☐ Supportive Communities (PGPH-03)
   - ☐ Aware Communities (PGPH-04)
   - ☐ Effective Screening Environments (PGPH-05)

4. In addition to problem gambling services does your organisation offer other services such as drugs, and alcohol intervention, budgeting, or other social services?
   - ☐ NO – *Skip to Q.7*
   - ☐ YES – *Please specify these services in the next question*

5. What other services does your organisation provide? *(Select all that apply)*
   - ☐ Drugs and Alcohol
   - ☐ Mental Health
   - ☐ Budgeting
   - ☐ Social issues (e.g. food banks, family violence, relationship issues)
   - ☐ Other (please specify) _____

6. How are intervention services usually delivered for clients presenting with multiple issues? *[Note: This question only applies to organisations that offer other services such as alcohol and drugs interventions in addition to Problem Gambling Intervention Services]*
   - ☐ One dedicated staff member delivers all services for a client
   - ☐ Clients are referred to other staff members in our organisation who would then provide services in other areas
   - ☐ Other (*please explain*)_____

7. Does your organisation deliver any services that are not funded by the Ministry of Health?
   - ☐ NO – *Skip to Section 2 – Q.9*
   - ☐ YES – *Please specify these services in the next question*

8. What types of non-funded services does your organisation deliver?
   ☐ Problem gambling intervention services
   ☐ Problem gambling public health services
   ☐ Drugs and Alcohol
   ☐ Mental Health
   ☐ Budgeting
   ☐ Social issues (e.g. food banks, family violence, relationship issues)
   ☐ Other (please specify) _____

Section 2: Some general questions about yourself

While we have asked you about other services your organisation offers, this evaluation concerns problem gambling services only. Therefore, please respond to the questions in relation to your role in problem gambling services.

9. What is your role in the problem gambling service? (*Tick all that apply if you are in more than one role*).
   ☐ Counsellor / Clinician
   ☐ Public Health promoter
   ☐ Manager / Director / CEO
   ☐ Administrator
   ☐ Helpline/Hotline operator
   ☐ Support staff (e.g. IT, Finance)
   ☐ Student placement
   ☐ Other (please specify) _____

10. What is your form of employment at the problem gambling service?
    ☐ Full time
    ☐ Part time (please specify number of days per week: _____)

11. Which of the following Problem Gambling Intervention services do you help provide in your organisation?
    (Select all that apply)
    ☐ NONE OF THE FOLLOWING
    ☐ Brief Intervention services (PGCS-02)
    ☐ Full Intervention services (PGCS-03)
    ☐ Facilitation services (PGCS-04)
    ☐ Follow-up services (PGCS-05)
    ☐ Workshop-based interventions (PGCS-06)

12. Which of the following Problem Gambling Public Health services do you help provide in your organisation?
    (Select all that apply)
    ☐ NONE OF THE FOLLOWING
    ☐ Policy Development & Implementation (PGPH-01)
    ☐ Safe Gambling Environments (PGPH-02)
    ☐ Supportive Communities (PGPH-03)
    ☐ Aware Communities (PGPH-04)
    ☐ Effective Screening Environments (PGPH-05)

13. If yours is a broader role, what other services do you help provide in your organisation?
    ☐ NONE OF THE FOLLOWING
    ☐ Drugs and Alcohol
    ☐ Mental Health
    ☐ Budgeting
    ☐ Social issues (e.g. food banks, family violence, relationship issues)
    ☐ Other (please specify) _____

14. How long have you worked in problem gambling services (including the current and other previous roles in problem gambling services)?
    ☐ Less than 1 year
    ☐ 1 - less than 3 years
    ☐ 3 - less than 5 years
    ☐ 5 years or over

15. For the following statements, rate your level of satisfaction in relation to the problem gambling services you are responsible for. *In the rating scale, (-2) is a negative rating, meaning "Very dissatisfied" and (+2) is a positive rating, meaning "Very satisfied".*

Your satisfaction with your capacity to deliver services	-2 Very dissatisfied	-1 Somewhat dissatisfied	0 Neither satisfied nor dissatisfied	+1 Somewhat satisfied	+2 Very satisfied
a. Sufficient time to complete tasks / deliver services	(-2)	(-1)	(0)	(+1)	(+2)
b. My existing level of knowledge to deliver the services	(-2)	(-1)	(0)	(+1)	(+2)
c. Receiving training and professional development that is relevant to my work	(-2)	(-1)	(0)	(+1)	(+2)
d. The frequency of training and professional development I receive	(-2)	(-1)	(0)	(+1)	(+2)
e. My knowledge of evidence-based intervention approaches	(-2)	(-1)	(0)	(+1)	(+2)
f. My knowledge of effective public health approaches	(-2)	(-1)	(0)	(+1)	(+2)
g. Personal satisfaction with the value of services delivered	(-2)	(-1)	(0)	(+1)	(+2)

16. Is there any training / professional development that you believe you need that is not currently provided?
    ☐ No
    ☐ Yes (Please specify) _____

17. What is your gender?
    ☐ Male
    ☐ Female
    ☐ Decline to answer

18. What is your ethnicity? (Select all that apply)
    ☐ NZ European   ☐ Other Pacific (please specify) _____
    ☐ Māori   ☐ Chinese
    ☐ Samoan   ☐ Indian
    ☐ Cook Island Maori   ☐ Other Asian (please specify) _____
    ☐ Tongan   ☐ Other (please specify) _____
    ☐ Niuean   ☐ Refused

Section 3: Ministry of Health Contracts and Reporting Requirements

The following questions apply only to problem gambling intervention and public health services. It excludes other services your organisation may provide such as drugs and alcohol addictions interventions.

19. Are you aware of the details of Ministry of Health contract requirements / service specifications (e.g. required activities, recommended processes, expected outcomes) for the problem gambling services you deliver?
    - ☐ No, I am not aware of the details
    - ☐ I know there are contracts but I am not aware of the details
    - ☐ Yes, I am aware of the details

20. Are you aware of the demographics of the priority client groups for the problem gambling services you deliver (e.g. at-risk groups, ethnicity, age, gender)?
    - ☐ No, I am not aware of the details
    - ☐ I know there are priority groups but I am not aware of the details
    - ☐ Yes, I am aware of the details

21. If you are involved in **Public Health Services**, are you aware of the annual work plans in place for delivering activities?
    - ☐ No, I am not aware of the details
    - ☐ I know there are plans but I am not aware of the details
    - ☐ Yes, I am aware of the details
    - ☐ NOT INVOLVED IN PUBLIC HEALTH SERVICES

22. If you are involved in **Intervention Services**, are you aware of processes in place for clinicians to collect and submit service utilisation data in the CLIC (Client Information Collection) database?
    - ☐ No, I am not aware of the details
    - ☐ I know there are processes but I am not aware of the details
    - ☐ Yes, I am aware of the details
    - ☐ NOT INVOLVED IN INTERVENTION SERVICES

23. Delivery of Services (Purchase Units) come with reporting requirements specified by the Ministry of Health. Are you directly involved in the reporting for your organisation?
    - ☐ Yes fully involved
    - ☐ Sometimes involved
    - ☐ NOT involved – Skip to Q. 26
    - ☐ DON'T KNOW anything about it – Skip to Section 4 – Q. 28

24. *Based on what you may have observed or experienced please rate your organisation's effectiveness in meeting the Ministry of Health's (the Ministry's) reporting requirements. In the rating scale, (-2) is a negative rating, meaning "very ineffective" and (+2) is a positive rating, meaning "very effective". Only rate activities that were carried out. If otherwise, please select "NOT DONE". If you are unsure, please select "DON'T KNOW".*

		-2 Very ineffective	-1 Somewhat ineffective	0 Neither effective nor ineffective	+1 Somewhat effective	+2 Very effective	NOT DONE	DON'T KNOW
a.	Meeting the six monthly narrative reporting deadlines	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
b.	Reporting using the Ministry's reporting templates	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
c.	Reporting work plans using the *Annual Public Health Workplan Tool* (for **Public Health Services** only)	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
d.	Meeting the Ministry's requirements for collecting and submitting CLIC data (for **Intervention Services** only)	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )

25. Please detail any comments or suggestions you may have on reporting requirements.

_____

26. *Based on what you may have observed or experienced please rate the effectiveness of your organisation's reporting processes. In the rating scale, (-2) is a negative rating, meaning "very ineffective" and (+2) is a positive rating, meaning "very effective". Only rate activities that were carried out. If otherwise, please select "NOT DONE". If you are unsure, please select "DON'T KNOW".*

		-2 Very ineffective	-1 Somewhat ineffective	0 Neither effective nor ineffective	+1 Somewhat effective	+2 Very effective	NOT DONE	DON'T KNOW
a.	Enabling staff understanding of reporting requirements	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
b.	Consulting staff about services they delivered before reporting	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
c.	Informing staff of the Ministry's feedback on written reports	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
d.	Discussing CLIC *Data Quality Reports* with staff (for **Intervention Services** only)	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
e.	Discussing with staff about CLIC data quality improvement processes (for **Intervention Services** only)	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )

27. Please detail any comments or suggestions you may have on reporting processes. _____

28. The completion of the rest of this questionnaire is based on the types of services you deliver.

- ☐ Involved in both Intervention and Public Health Services – *Go to Section 4, Q. 29*
- ☐ Involved in Intervention Services only – *Go to Section 4, Q. 29*
- ☐ Involved in Public Health Services only – *Skip to Section 5 – Q. 47*

Section 4: Problem Gambling Intervention Services (PGCS)

29. How do clients seeking treatment generally come to your service? Rate the frequency of each type of entry.

		1 Never	2 Occasionally	3 Frequently	DON'T KNOW
a.	Self-referred – after finding out about us from promotional materials or at public events	①	②	③	○
b.	Self-referred – after reaching crisis state	①	②	③	○
c.	Encouraged by someone close (e.g. family, whānau, friend)	①	②	③	○
d.	Ordered by the Justice system (compulsory)	①	②	③	○
e.	Referred to us by our own Public Health staff *(This applies only to organisations that offer both Intervention and Public Health Services – Skip if not applicable)*	①	②	③	○
f.	Referred to us by other problem gambling services (e.g. Gambling Helpline, Other problem Gambling Public Health Service)	①	②	③	○
g.	Referred to us by casinos	①	②	③	○
h.	Referred to us by pubs	①	②	③	○
i.	Referred to us by clubs	①	②	③	○
j.	Referred to us by other addiction services (e.g. alcohol and drugs)	①	②	③	○
k.	Referred to us by other allied agencies (e.g. WINZ, Budgeting Services, Child Youth & Family)	①	②	③	○
l.	We actively seek clients among high-risk communities (e.g. prisons)	①	②	③	○

30. From what you have observed or experienced, does the way clients come into your service have an impact on intervention outcomes?
- ☐ No
- ☐ Yes (*please explain*) _____

31. Have you noticed any increases in help-seeking behaviour following major national public health activities (e.g. National *Gamblefree Day* – 1st September, Choice Not Chance Campaigns / Advertisements)
- ☐ No
- ☐ Yes (*please explain*) _____

32. Have you noticed any increases in help-seeking behaviour following awareness raising activities organised by Problem Gambling Public Health Service providers in your area; for example, at local events and festivals (e.g. Matariki Festival, local health expos, White Ribbon Day, Pasifika Festival)
- ☐ No
- ☐ Yes (*please explain*) _____

33. Based on what you may have observed or experienced please rate the overall effectiveness of **your organisation's** processes and delivery of activities for Intervention Services. *In the rating scale, (-2) is a negative rating, meaning "Very ineffective" and (+2) is a positive rating, meaning "Very effective". Only rate activities that were carried out. If otherwise, please select "NOT DONE". If you are unsure, please select "DON'T KNOW".*

		-2 Very ineffective	-1 Somewhat ineffective	0 Neither effective nor ineffective	+1 Somewhat effective	+2 Very effective	NOT DONE	DON'T KNOW
a.	Allocating funding to deliver services	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
b.	Allocating staff to deliver services	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
c.	Managing staff related issues	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
d.	Processes in place to ensure longer term capacity to continue providing services	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
e.	Processes in place to continually improve services	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
f.	Dealing with emerging challenges	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
g.	Delivering services in a manner that meets clients' cultural needs	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
h.	Delivering services in a manner that meets clients' spiritual / religious needs	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
i.	Teamwork between intervention and public health staff within your organisation *(This applies only to organisations that offer both Intervention and Public Health Services – Skip if not applicable)*	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
j.	Working relationships with other problem gambling public health services in your area	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
k.	Sourcing resources needed to deliver services (e.g. screening tools, referral forms)	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
l.	Using adverts / promotional materials to build public awareness of service availability	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
m.	Developing internal IT resources needed to deliver services (e.g. databases)	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
n.	Using CLIC data for other purposes (e.g. monitoring client progress, self-evaluation)	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )

34. Were there any external factors (i.e. factors beyond your organisation's control) that had positive or negative effects on intervention service delivery?
    ☐ NO – *Skip to Section 4.1 – Q.37*
    ☐ YES – *Proceed to the next question*

35. Please list any POSITIVE external factors and explain how these affected the delivery of intervention services. (If related to a specific purchase unit, please specify the exact area of work that was affected)
    _____

36. Please list any NEGATIVE external factors and explain how these affected the delivery of intervention services. (If related to a specific purchase unit, please specify the exact area of work that was affected)

_____

Section 4.1:   Brief intervention (PGCS-02)

37. Based on your observations or experience rate the effectiveness of the following activities in achieving positive outcomes for clients in Brief Interventions.

In the rating scale, (-2) is a negative rating, meaning "Very ineffective" and (+2) is a positive rating, meaning "Very effective". Only rate activities that were carried out. If otherwise, please select "NOT DONE". If you are unsure, please select "DON'T KNOW".

		-2 Very ineffective	-1 Somewhat ineffective	0 Neither effective nor ineffective	+1 Somewhat effective	+2 Very effective	NOT DONE	DON'T KNOW
a.	Identifying places / opportunities to carry out brief interventions for high-risk groups	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
b.	Establishing partnerships with organisations in contact with high-risk groups (e.g. Community Corrections, WINZ, budgeting services, Foodbank)	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
c.	Using the Ministry's *Brief Gambler Screens* to assess potential gambling problems	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
d.	Offering clients information on gambling harms	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
e.	Encouraging behavioural changes using motivational interviews	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
f.	Offering clients a follow-up contact within two weeks of previous intervention	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
g.	Referring clients to a Full Intervention	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
h.	Using co-existing issues screen (e.g. Alcohol use screen, Drug use screen, Suicidality screen, Depression screen)	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
i.	Simple referrals to access help from other services	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )

38. What do you believe are the main indicators of successful brief interventions? _____

_____

Section 4.2:   Full Intervention (PGCS-03) / Workshop-based Intervention (PGCS-06)

39. Based on your observations or experience rate the effectiveness of the following activities in achieving positive outcomes for clients in Full Interventions / Workshop-based Interventions. *In the rating scale, (-2) is a negative rating, meaning "Very ineffective" and (+2) is a positive rating, meaning "Very effective". Only rate activities that were carried out. If otherwise, please select "NOT DONE". If you are unsure, please select "DON'T KNOW".*

	-2 Very ineffective	-1 Somewhat ineffective	0 Neither effective nor ineffective	+1 Somewhat effective	+2 Very effective	NOT DONE	DON'T KNOW
a. Using the Ministry's *Gambler Full Intervention Screens* to assess gambling problems	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
b. Comprehensive assessments to identify co-existing issues (e.g. alcohol and other drug use, mental health, financial and cultural variables)	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
c. Determining if clients need simple referrals or facilitation services	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
d. Simple referrals to access help from other services	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
e. Carrying out facilitation services within the full intervention episode for clients who need it	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
f. Helping clients develop an intervention plan (i.e. goals they want to achieve from treatment)	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
g. Providing relapse prevention therapy / education	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
h. Reviewing intervention plan with clients	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
i. Using the *Gambler Outcome Screens* to monitor clients progress and gauge treatment outcomes	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
j. Using the Ministry's *Review and Assessment Tools* before discharge	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
k. Seeking client feedback about treatment effectiveness before discharge	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )

40. Pleased detail any other activities (including its effectiveness) that were carried out that are not in the list above. _____

41. What do you believe are the main indicators of successful Full Interventions / Workshop-based Interventions? _____

Section 4.3: Facilitation Services (PGCS-04)

42. Based on your observations or experience rate the effectiveness of the following activities in achieving positive outcomes for clients receiving Facilitation Services. *In the rating scale, (-2) is a negative rating, meaning "Very ineffective" and (+2) is a positive rating, meaning "Very effective". Only rate activities that were carried out. If otherwise, please select "NOT DONE". If you are unsure, please select "DON'T KNOW".*

	-2 Very ineffective	-1 Somewhat ineffective	0 Neither effective nor ineffective	+1 Somewhat effective	+2 Very effective	NOT DONE	DON'T KNOW
a. Establishing working relationships with key staff of community support agencies in your area	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
b. Establishing joint client management protocol / MOU with key community support agencies (which provides details such as accountability for access, case management, exit processes, follow-up and information sharing)	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
c. Developing referral plans based on clients' needs identified during assessments	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
d. Actively encouraging clients to seek assistance from other agencies (e.g. explaining benefits, helping clients overcome feelings of reluctance)	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
e. Actively enabling a smooth and easy referral process for clients (e.g. making appointments for clients, ensuring other services understand your client's situation)	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
f. Accompanying clients to initial meetings with other community support agencies	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
g. Accompanying clients to complete self-exclusions at gambling venues	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
h. Reviewing referral plans with clients to gauge progress with addressing other issues	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )

43. What do you believe are the main indicators of successful Facilitation Services? _____

_____

Section 4.4: Follow-up (PGCS-05)

44. Based on your observations or experience rate the effectiveness of the following activities in achieving positive outcomes for clients receiving Follow-up. *In the rating scale, (-2) is a negative rating, meaning "Very ineffective" and (+2) is a positive rating, meaning "Very effective". Only rate activities that were carried out. If otherwise, please select "NOT DONE". If you are unsure, please select "DON'T KNOW".*

		-2 Very ineffective	-1 Somewhat ineffective	0 Neither effective nor ineffective	+1 Somewhat effective	+2 Very effective	NOT DONE	DON'T KNOW
a.	Encouraging client's agreement to a follow-up plan during Full Intervention / Workshop-based Intervention (including using the Ministry's *Follow-up agreement form*)	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
b.	Fixing follow up timeframes with clients – 1, 3, 6 and 12 months after completion of full intervention	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
c.	Re-assessing clients to gauge progress in addressing problem gambling (using the Ministry's *Follow-up Gambler Screens*)	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
d.	Providing motivational support (e.g. ensuring their motivation remained clear and unchanged)	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
e.	Reviewing relapse prevention plan with client	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
f.	Referring clients to undergo full intervention again when deemed necessary	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
g.	Re-assessing clients to gauge co-existing issues	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
h.	Providing clients with additional support to access other support services when necessary	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )

45. What do you believe are the main indicators of successful Follow-up Services? _____

_____

46. As a clinical practitioner what did you gain from carrying out follow-up sessions with clients? _____

_____

Section 5: Problem Gambling Public Health (PGPH) Services

THE FOLLOWING QUESTIONS APPLY ONLY TO PROBLEM GAMBLING PUBLIC HEALTH SERVICES. IF YOU ARE NOT INVOLVED IN SUCH SERVICES, SKIP ALL QUESTIONS UNDER SECTION 5.

47. Based on your observations or experience rate **your organisation's** effectiveness in delivering Public Health Services in general. *In the rating scale, (-2) is a negative rating, meaning "Very ineffective" and (+2) is a positive rating, meaning "Very effective". Only rate activities that were carried out. If otherwise, please select "NOT DONE". If you are unsure, please select "DON'T KNOW."*

		-2 Very ineffective	-1 Somewhat ineffective	0 Neither effective nor ineffective	+1 Somewhat effective	+2 Very effective	NOT DONE	DON'T KNOW
a.	Allocating funding to deliver services	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
b.	Allocating staff to deliver services	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
c.	Managing staff related issues	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
d.	Processes in place to ensure longer term capacity to continue providing services	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
e.	Processes in place to continually improve services	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
f.	Dealing with emerging challenges	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
g.	Delivering services in a manner that meets clients' cultural needs	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
h.	Delivering services in a manner that meets clients' spiritual / religious needs	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
i.	Teamwork between public health and intervention staff within your organisation	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
j.	Working relationships with other problem gambling intervention services in your area	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
k.	Sourcing resources needed to deliver services (e.g. screening tools, promotional materials)	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
l.	Developing up-to-date resources needed to deliver services	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
m.	Developing working relationships with appropriate stakeholders	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
n.	Strategic communication protocols in place for engaging with stakeholders	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
o.	Enabling community participation in activities	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
p.	Advocating non-gambling fundraising	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
q.	Strategic planning of activities and services	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
r.	Delivering services and activities as planned	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )

		-2 Very ineffective	-1 Somewhat ineffective	0 Neither effective nor ineffective	+1 Somewhat effective	+2 Very effective	NOT DONE	DON'T KNOW
s.	Developing innovative service delivery	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )

48. Please provide examples of any innovative ways your organisation used to deliver public health services

_____

_____

49. Were there any external factors (i.e. factors beyond your organisation's control) that had positive or negative effects on Public Health Service delivery?
☐ NO – *Skip to Section 5.1 – Q.52*
☐ YES – *Proceed to the next question*

50. Please list any POSITIVE external factors and explain how these affected the delivery of Public Health Services. (*If related to a specific purchase unit, please specify the exact area of work that was affected*)

_____

_____

51. Please list any NEGATIVE external factors and explain how these affected the delivery of public health services. (*If related to a specific purchase unit, please specify the exact area of work that was affected*)

_____

_____

Section 5.1: Policy Development & Implementation (PGPH – 01)

53. Based on your observations or experience rate the effectiveness of the following activities in achieving objectives, targets or outcomes for the Policy Development & Implementation purchase unit. *In the rating scale, (-2) is a negative rating, meaning "Very ineffective" and (+2) is a positive rating, meaning "Very effective". Only rate activities that were carried out. If otherwise, please select "NOT DONE". If you are unsure, please select "DON'T KNOW".*

	-2 Very ineffective	-1 Somewhat ineffective	0 Neither effective nor ineffective	+1 Somewhat effective	+2 Very effective	NOT DONE	DON'T KNOW
a. Raising awareness of the relevance of gambling-related policies to the core business of targeted sectors (i.e. government agencies, councils, social organisations, private industry and businesses, education providers, sports clubs, marae, churches, non-profit community organisations)	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
b. Supporting organisations to develop policies that support gambling harm reduction for their own **employees**	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
c. Supporting organisations to develop policies that support gambling harm reduction for their **client groups**	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
d. Supporting the development of policies on non-gambling fundraising	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
e. Working with territorial local authorities to address Class 4 gaming machine venue policies	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
f. Working with territorial local authorities to address community concerns regarding density and locality of gaming venues	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
g. Working with other stakeholders to address Class 4 gaming machine venue policies	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
h. Contributing to or participating in social impact assessment of gambling harm for your district	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )

54. What do you believe are the main success indicators for the Policy Development and Implementation purchase unit? _____

_____

Section 5.2: Safe Gambling Environments (PGPH-02)

55. Based on your observations or experience rate the effectiveness of the following activities in achieving objectives, targets or outcomes for the Safe Gambling Environments purchase unit.

In the rating scale, (-2) is a negative rating, meaning "Very ineffective" and (+2) is a positive rating, meaning "Very effective". Only rate activities that were carried out. If otherwise, please select "NOT DONE". If you are unsure, please select "DON'T KNOW".

		-2 Very ineffective	-1 Somewhat ineffective	0 Neither effective nor ineffective	+1 Somewhat effective	+2 Very effective	NOT DONE	DON'T KNOW
a.	Working relationships with gambling venue staff	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
b.	Developing gambling venue staff knowledge on harm reduction measures	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
c.	Supporting gambling venues to develop effective host responsibility measures	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
d.	Supporting gambling venues to implement host responsibility practices	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
e.	Supporting gambling venues to develop harm minimisation policies	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
f.	Supporting gambling venues to implement harm minimisation policies	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
g.	Monitoring and following-up on venues' practices	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
h.	Enabling collaboration between gambling venues and other stakeholders interested in reducing gambling harm	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )

56. What do you believe are the main success indicators for the Safe Gambling Environments purchase unit?

_____

_____

Section 5.3: Supportive Communities (PGPH-03)

57. Based on your observations or experience rate the effectiveness of the following activities in achieving objectives, targets or outcomes for the Supportive Communities purchase unit. *In the rating scale, (-2) is a negative rating, meaning "Very ineffective" and (+2) is a positive rating, meaning "Very effective". Only rate activities that were carried out. If otherwise, please select "NOT DONE". If you are unsure, please select "DON'T KNOW".*

		-2 Very ineffective	-1 Somewhat ineffective	0 Neither effective nor ineffective	+1 Somewhat effective	+2 Very effective	NOT DONE	DON'T KNOW
a.	Identifying key community strengths and social protective factors	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
b.	Collaborating with mental health promotion providers in delivering health promotion programmes that increase resiliency and social protective factors	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
c.	Promoting public discussion and debate on gambling harm	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
d.	Partnering with communities to support development of culturally appropriate resilience building activities	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
e.	Ensuring key groups' access to evidence based community action approaches for reducing gambling harm	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
f.	Ensuring key groups' access to evidence based approaches to monitoring and controlling gambling opportunities	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
g.	Ensuring key groups' access to evidence based approaches to monitoring and controlling licensing of gaming venues	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
h.	Providing a clear point of public contact for raising concerns regarding public health approaches to reducing gambling harm	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
i.	Improving public awareness of avenues for complaint regarding public health approaches to reducing gambling harm	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
j.	Developing positive local media initiatives (e.g. promoting family/community connectedness; positive leisure / entertainment opportunities)	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
k.	Developing positive local community initiatives (e.g. promoting family/community connectedness; positive leisure / entertainment opportunities)	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )

58. What do you believe are the main success indicators for the Supportive Communities purchase unit?

   _____

   _____

Section 5.4: Aware Communities (PGPH-04)

59. Based on your observations or experience rate the effectiveness of the following activities in achieving objectives, targets or outcomes for the Aware Communities purchase unit.

In the rating scale, (-2) is a negative rating, meaning "Very ineffective" and (+2) is a positive rating, meaning "Very effective". Only rate activities that were carried out. If otherwise, please select "NOT DONE". If you are unsure, please select "DON'T KNOW".

		-2 Very ineffective	-1 Somewhat ineffective	0 Neither effective nor ineffective	+1 Somewhat effective	+2 Very effective	NOT DONE	DON'T KNOW
a.	Promoting public discussion and debate on gambling harm and related issues	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
b.	Monitoring and responding to public media discussions on gambling and / or problem gambling	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
c.	Raising public awareness of gambling harm	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
d.	Raising public awareness on the odds of winning and losing	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
e.	Raising public awareness on how to respond to risky gambling situations	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
f.	Supporting communities to implement culturally relevant awareness campaigns on gambling harms	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
g.	Ensuring that all activities are consistent with the national social marketing campaign	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )

60. What do you believe are the main success indicators for the Aware Communities purchase unit?

_____

_____

Section 5.5: Effective Screening Environments (PGPH - 05)

61. Based on your observations or experience rate the effectiveness of the following activities in achieving objectives, targets or outcomes for the Effective Screening Environments purchase unit.

In the rating scale, (-2) is a negative rating, meaning "Very ineffective" and (+2) is a positive rating, meaning "Very effective". Only rate activities that were carried out. If otherwise, please select "NOT DONE". If you are unsure, please select "DON'T KNOW".

		-2 Very ineffective	-1 Somewhat ineffective	0 Neither effective nor ineffective	+1 Somewhat effective	+2 Very effective	NOT DONE	DON'T KNOW
a.	Raising awareness of the relevance of screening and referral practices to the core business of target sectors (i.e. social service agencies, financial institutions, debt agencies, utility services, gambling venues, volunteer services, primary care sector, primary health organisations, mental health services and corrections)	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
b.	Supporting the development of problem gambling **screening practices** within target sectors	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
c.	Supporting the development of problem gambling **referral practices** within target sectors	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
d.	Supporting the implementation of screening and referral systems within target sectors	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
e.	Monitoring and following-up on screening and referral systems within target sectors	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )
f.	Facilitating relationship development between screening organisations and intervention service providers	(-2)	(-1)	(0)	(+1)	(+2)	( )	( )

62. What do you believe are the main success indicators for the Effective Screening Environments purchase unit?

_____

_____

❧Thank you for your time in completing this questionnaire. All responses will be anonymous and kept confidential❦

CLIENT QUESTIONNAIRE

Section A. How you first accessed a Gambling Support Service

We would like to find out how you first accessed a Gambling Support Service.

1. Why did you seek help from a Gambling Support Service? *[Tick ONE answer only]*
   - ☐ I was encouraged by someone from a Gambling Support Service I had met (e.g. at an event, meeting, workshop or information stall) – *Go to Q.2*
   - ☐ For some other reason (e.g. I made my own decision to go; I was referred by some other service) – *Skip to Section B – Q.7*

2. If you were encouraged to go by someone from a Gambling Support Service, where did you first meet them? *[Tick ONE answer only]*

   - ☐ Information stall at a public event or festival
   - ☐ Information stall close to a supermarket or shopping mall
   - ☐ At a community service (e.g. WINZ, Foodbank, Budgeting Service)
   - ☐ At a public meeting, workshop or presentation (e.g. community hui, public health presentation)
   - ☐ Other (please specify) _____

3. Do you remember the name of that Gambling Support Service?
   - ☐ No
   - ☐ Yes *[Please write down the name of the service here: _____]*

4. What do you recall happening during the very first conversation with someone from that Gambling Support Service? *[Tick all that apply]*

a.	We talked about my gambling	○Yes ○No ○Unsure
b.	We talked about a range of issues and gambling was one of them	○Yes ○No ○Unsure
c.	He/she encouraged me to think about the negative impacts of my gambling	○Yes ○No ○Unsure
d.	He/she gave me information about help I could receive	○Yes ○No ○Unsure
e.	He/she offered to contact me again so I could receive further support	○Yes ○No ○Unsure
f.	He/she signed me up to receive full help/support/counselling from the service	○Yes ○No ○Unsure
g.	Other (please specify)	○Yes ○No ○Unsure

5. Did the staff of the Gambling Support Service contact you again after the first conversation?
   - ☐ Yes
   - ☐ No
   - ☐ I did not give them my contact details

6. How did these conversations with someone from the above Gambling Support Service make you feel or think? *[Tick all that apply]*
   - ☐ I began to consider my gambling levels
   - ☐ I thought about the negative effects of my gambling (e.g. my finances, health and wellbeing)
   - ☐ I thought about how my gambling affected others close to me (e.g. my family/whānau)
   - ☐ I thought about how gambling affected my work / job
   - ☐ I realised that I needed to seek help
   - ☐ Other (please specify) _____

Section B. Your main Gambling Support Service

You may have talked to or visited more than one Gambling Support Service. This section is about the help you received from the Gambling Support Service that you have been in contact with MOST FREQUENTLY.

7. Which Gambling Support Service have you been in contact with most frequently? *[Please tick ONE service only and write down the location of your service if required].*

- ☐ Asian Family Services (PGF), Location: _____
- ☐ BestCare (Whakapai Hauora), Palmerston North
- ☐ Hauora Waikato, Hamilton
- ☐ Lifeline (Gambling Helpline), Auckland
- ☐ Mental Health Solutions (Pathways / Care NZ), Location: _____
- ☐ Nga Kete Maturanga Pounamu, Location:_____
- ☐ Nga Manga Puriri Trust, Whangarei
- ☐ Odyssey House, Auckland
- ☐ Pasifika Ola Lelei Services, Manukau
- ☐ Problem Gambling Foundation (PGF), Location: _____
- ☐ Raukura Hauora o Tainui Trust, Te Piringa Tupono Services
- ☐ Raukura Hauora o Tainui Trust, Pasifika Ola Lelei Services
- ☐ Taeaomanino Trust, Porirua City, Wellington
- ☐ Te Ara Tika, Gisborne
- ☐ Te Kahui Hauora Trust, Rotorua
- ☐ Te Kahui Hauroa O Ngati Koata Trust, Nelson
- ☐ Te Rangihaeata Oranga Trust, Location:_____
- ☐ Te Runanga O Toa Rangatira, Porirua, Wellington
- ☐ The Salvation Army Problem Gambling Services (Oasis), Location: _____
- ☐ Waitemata DHB (TUPU), Location: _____
- ☐ Woodlands Charitable Trust, Location: _____

8. If your main Gambling Support Service is not on the list above, what is the name and location of your service?

   Service Name:_____
   Location:_____

9. Which of the following most applies? [*Tick ONE answer only*]
- ☐ It has been less than 1 month since I started contacting the service
- ☐ It has been more than 1 month but less than 3 months since I started contacting the service
- ☐ It has been more than 3 months since I started contacting the service
- ☐ I have recently stopped contacting the service and have agreed to follow-up contact
- ☐ I have recently stopped contacting the service and have NOT agreed to follow up contact
- ☐ I am a previous client with no further contact with the service
- ☐ Other (please explain) _____

10. Select the main type of gambling that led you to seek help from your Gambling Support Service *[Tick ONE only]*

- ☐ Cards (Not at Casino)
- ☐ Casino Table Games
- ☐ Casino electronic gaming machines or pokies
- ☐ Club electronic gaming machines or pokies
- ☐ Pub electronic gaming machines or pokies
- ☐ Electronic Table Games
- ☐ Housie (Bingo)

- ☐ Instant Kiwi (or Scratchies)
- ☐ Keno
- ☐ Lotto
- ☐ Sports Betting
- ☐ Track
- ☐ Overseas (with an overseas betting organisation / gambling activities overseas)
- ☐ Other gambling in New Zealand (please specify) _____

11. Which of the following types of support did you experience at your Gambling Support Service? This includes any help, advice, educational information, or counselling you may have received. *[Tick all that apply]*

☐ Couple's sessions
☐ Family sessions
☐ Group sessions
☐ Individual one on one sessions
☐ Support group sessions
☐ Telephone sessions
☐ Workshops
☐ Other (please specify) _____

12. What do you recall happening at your support sessions?

a.	Discussions about confidentiality	◯Yes ◯No ◯Unsure
b.	Discussions about my gambling behaviour and related issues	◯Yes ◯No ◯Unsure
c.	I was supported to develop an action plan for goals I wanted to achieve	◯Yes ◯No ◯Unsure
d.	I received advice on how to manage my gambling behaviour	◯Yes ◯No ◯Unsure
e.	I felt supported	◯Yes ◯No ◯Unsure
f.	Discussions about activities to build health and wellbeing	◯Yes ◯No ◯Unsure
g.	Discussions about factors that could trigger gambling again	◯Yes ◯No ◯Unsure
h.	Discussions about ways to prevent me from gambling too much	◯Yes ◯No ◯Unsure
i.	I was supported to review my original action plan to see how I was achieving my goals	◯Yes ◯No ◯Unsure
j.	I was encouraged to agree to a follow-up plan where I would be contacted again after completion of sessions	◯Yes ◯No ◯Unsure
k.	Discussions about my other needs / issues (e.g. depression, suicidal thoughts, financial issues or drugs and alcohol)	◯Yes ◯No ◯Unsure
l.	I was supported to get help from other services to address other issues (e.g. budgeting, housing, food)	◯Yes ◯No ◯Unsure

13. Please rate any changes or impacts you experienced because of the above sessions.

a.	My understanding about the negative impacts of my gambling improved	☐ Strongly Disagree	☐ Disagree	☐ Neutral	☐ Agree	☐ Strongly Agree
b.	My understanding of triggers that could cause me to gamble again improved	☐ Strongly Disagree	☐ Disagree	☐ Neutral	☐ Agree	☐ Strongly Agree
c.	My ability to reduce my gambling increased	☐ Strongly Disagree	☐ Disagree	☐ Neutral	☐ Agree	☐ Strongly Agree
d.	My ability to control my gambling increased	☐ Strongly Disagree	☐ Disagree	☐ Neutral	☐ Agree	☐ Strongly Agree
e.	My ability to stop gambling increased	☐ Strongly Disagree	☐ Disagree	☐ Neutral	☐ Agree	☐ Strongly Agree
f.	My relationships with others (family, whānau and friends) improved	☐ Strongly Disagree	☐ Disagree	☐ Neutral	☐ Agree	☐ Strongly Agree
g.	My physical health improved	☐ Strongly Disagree	☐ Disagree	☐ Neutral	☐ Agree	☐ Strongly Agree

h.	My emotional wellbeing / self-esteem / self-confidence improved	□ Strongly Disagree	□ Disagree	□ Neutral	□ Agree	□ Strongly Agree
i.	My financial situation improved	□ Strongly Disagree	□ Disagree	□ Neutral	□ Agree	□ Strongly Agree

14. Please explain any other positive or negative impacts you may have experienced because of the above sessions. _____

Section C. Getting help from other services

15. The services you received may have included your counsellor or case worker supporting you to access other community services to get help for other matters such as budgeting, housing or food. Were you offered support to access other community services by your counsellor or case worker?
    - ☐ Yes – Go to Q.16
    - ☐ No – Skip to Section D - Q.19

16. Did you go through with seeking help from other community services?
    - ☐ Yes – Go to Q.17
    - ☐ No – I didn't need it – Skip to Section D - Q.19
    - ☐ No – I didn't want to be referred to other services – Skip to Section D-Q.19

17. Which of the following did you experience in the support you received when accessing other community services? *[Tick all that apply]*
    - ☐ The counsellor / case worker encouraged me to meet with another service
    - ☐ The counsellor / case worker made it easy for me to gain access to other services
    - ☐ The counsellor / case worker accompanied me to meet with another service
    - ☐ Other (please specify) _____

18. What did you experience as a result of accessing help from other community services? *[Tick all that apply]*
    - ☐ I was able to resolve / improve some of my other issues
    - ☐ Solving other issues had a positive impact on my gambling behaviour
    - ☐ Other (please specify) _____

Section D. Follow-up Sessions

This section is for clients who have finished going to a Gambling Support Service.

19. Are you still undergoing sessions at your Gambling Support Service?
    - ☐ Yes – Skip to Section E - Q.25
    - ☐ No – Go to Q. 20

20. Did you agree to a follow-up plan while you were receiving support from your main Gambling Support Service?
    - ☐ Can't remember
    - ☐ Yes
    - ☐ No (Why Not? Please explain)_____

21. Did your counsellor let you know that you would be contacted for follow-up sessions at 1, 3, 6 and 12 months after regular sessions end?
    - ☐ Can't remember
    - ☐ Yes
    - ☐ No

22. Were the times set (after 1, 3, 6 and 12 months) for the follow-up sessions suitable for you?
    - ☐ Yes
    - ☐ No (Why Not? Please explain) _____

23. Have you received a follow-up contact from your main Gambling Support Service since you stopped going?
- ☐ Yes – Go to Q. 24
- ☐ No – Skip to Section E - Q.25

24. What happened as a result of these follow-up contacts? _____

Section E. Overall Assessment

25. Overall, how satisfied have you been with the services provided by your main Gambling Support Service provider? [*Tick ONE answer only*]
- ☐ Very dissatisfied
- ☐ Dissatisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Satisfied
- ☐ Very satisfied

26. Are there specific things about your main Gambling Support Service that have been particularly helpful to you? [*Tick all that apply*]
- ☐ None of the following. There was nothing specific
- ☐ The availability of gender specific counsellors
- ☐ The availability of a counsellor of the same cultural background as me
- ☐ The ability to receive help/support/counselling in the language of my choice
- ☐ The location of the service
- ☐ The friendly and welcoming nature of staff at the service
- ☐ The counsellor's skill
- ☐ The type of treatment / counselling approach used
- ☐ Other (please specify) _____

27. How satisfied are you with your main Gambling Support Service in providing services that meet your cultural needs? [*Tick ONE answer only*]
- ☐ Very dissatisfied
- ☐ Dissatisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Satisfied
- ☐ Very satisfied
- ☐ NOT APPLICABLE – this is not relevant to my needs

28. How satisfied are you with your main Gambling Support Service in providing services that meet your spiritual or religious needs? [*Tick ONE answer only*]
- ☐ Very dissatisfied
- ☐ Dissatisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Satisfied
- ☐ Very satisfied
- ☐ NOT APPLICABLE – this is not relevant to my needs

29. Was there anything about the service or the counselling that was NOT helpful to you?
- ☐ All aspects of the service were helpful
- ☐ Yes (please explain)

D. Background information

30. What is your gender?
   - ☐ Male
   - ☐ Female
   - ☐ Decline to answer

31. What is your ethnicity? [*Tick all that apply*]

   - ☐ NZ European
   - ☐ Māori
   - ☐ Samoan
   - ☐ Cook Island Maori
   - ☐ Tongan
   - ☐ Niuean
   - ☐ Other Pacific _____
   - ☐ Chinese
   - ☐ Indian
   - ☐ Other Asian _____
   - ☐ Other:_____
   - ☐ Refused

32. Were you born in New Zealand?
   - ☐ Yes
   - ☐ No - Please specify how long you have lived in New Zealand? _____

33. Please select your age range
   - ☐ 18-30 years
   - ☐ 31-50 years
   - ☐ 51+ years

❧Thank you for your time in completing this questionnaire. All responses will be anonymous and kept confidential❧

SUPPORT SERVICES QUESTIONNAIRE

Evaluation of "Facilitation Services" provided by Problem Gambling Intervention Services

"Facilitation Services" is different from a conventional referral process. While a conventional referral process may simply consist of providing clients with completed referral forms, "Facilitation Services" is a more active referral process for clients who need additional support. Such support may include, their counsellor making appointments on their behalf or accompanying them to initial meetings.

If you are not familiar with problem gambling clients referred through "Facilitation Services," please pass this questionnaire on to someone else in your organisation who is involved in dealing with such clients.

Section 1: Some questions about yourself and your organisation

1. What type of service does your organisation provide? (*Select all that apply*)

   ☐ Assistance with addictions other than gambling (e.g. drugs, alcohol, smoking)
   ☐ Budgeting advice / Financial Advice and Support
   ☐ Employment assistance
   ☐ Gambling venue exclusions (e.g. exclusion / self-exclusion orders)
   ☐ Housing assistance / Housing and accommodation
   ☐ Legal assistance / Legal advice
   ☐ Life skills programme
   ☐ Mental health support
   ☐ Physical health support
   ☐ Police and victim support
   ☐ Relationship counselling
   ☐ Self-help / support group
   ☐ WINZ assistance
   ☐ Other (Please specify) _____

2. What is your job title? _____

3. What is your role within your organisation? _____

4. How long have you worked for your organisation?

   ☐ Less than 1 year
   ☐ 1-2 years
   ☐ 3-4 years
   ☐ Over 5 years

Section 2: Working Relationships with Problem Gambling Treatment Services

The following sections concern the Problem Gambling Treatment Service that invited your participation in this evaluation.

5. How would you define the connections between your organisation and the Problem Gambling Treatment Service?

   ☐ We are part of the same larger organisation
   ☐ We are an external community support service (independent from the Problem Gambling Treatment Service)
   ☐ We are an independent private business

6. How would you rate the working relationship between your organisation and the Problem Gambling Treatment Service? (*Select ONE answer only*)

☐ Very poor
☐ Poor
☐ Average
☐ Good
☐ Very good
☐ DON'T KNOW

7. Which of the following actions taken by the Problem Gambling Treatment Service are you aware of? (*Select all that apply*)

☐ The Service made efforts to establish working relationships with our staff members
☐ The Service explained to us about the "Facilitation Services" that they provide to clients who need additional support
☐ The Service established a joint client management protocol / MOU with our organisation which provides details such as accountability for access, case management, exit processes, follow-up and information sharing
☐ None of the above
☐ Other (*Please specify*) _____

8. Please detail any comments or suggestions you may have on the working relationship between your organisation and the Problem Gambling Treatment Service. _____

Section 3: "Facilitation" of clients from Problem Gambling Treatment Services

9. Which of the following have you observed being provided to clients by the Problem Gambling Treatment Service? (*Rate the frequency of each type of action you have observed*)

		1 Never	2 Occasionally	3 Frequently	DON'T KNOW
a.	The Service supported clients in making the initial contact with us	①	②	③	○
b.	The Service organised appointments with us on behalf of clients	①	②	③	○
c.	Counsellors from the Service accompanied their clients to initial meetings with us	①	②	③	○
d.	The Service helped clients overcome barriers when accessing support from us	①	②	③	○
e.	The Service provided us information on unique client situations to enable our effective support	①	②	③	○
f.	The Service contacted us to gain feedback about their clients' progress	①	②	③	○
g.	The Service explained to us about their clients' cultural needs	①	②	③	○
h.	The Service explained to us about their clients' spiritual / religious needs	①	②	③	○
i.	Following appointments the Service ensured that clients signed our service consent form to enable sharing of client information	①	②	③	○
j.	The Service explained to us about the needs of their clients when accessing our services (i.e. co-existing issues within the context of problem gambling)	①	②	③	○
k.	The Service made arrangements for our representatives to be present at their premises	①	②	③	○
l.	Other (*Please detail in the space below*)	①	②	③	○

Other (Please provide details) _____

_____

10. How does the Problem Gambling Treatment Service usually communicate with your organisation regarding their client? (*Select all that apply*)
   ☐ By telephone
   ☐ Face-to-face
   ☐ In writing (posted letter)
   ☐ Online (email)
   ☐ Other method (*please specify*)_____

11. How often does the Problem Gambling Treatment Service communicate with you? (*Select ONE answer only*)
   ☐ Only once to fix appointments for clients
   ☐ 2-4 times during their clients' period with us
   ☐ 5-7 times during their clients' period with us
   ☐ Over 7 times during their clients' period with us
   ☐ Other (please specify)_____

12. How often do "facilitated" problem gambler clients tend to attend sessions at your organisation? (*Select ONE answer only*)

   ☐ They attend only the initial session
   ☐ They attend less than half the sessions arranged
   ☐ They attend more than half the sessions arranged
   ☐ They attend all sessions arranged
   ☐ NOT APPLICABLE
   ☐ Other observations about attendance (*please specify*) _____

13. Have you noticed any impacts on clients "facilitated" from Problem Gambling Treatment Services? This may include impacts on their gambling problems and/or other issues they face.

   ☐ NO – *I have not noticed any impacts – Skip to Q. 15*
   ☐ YES – *Proceed to the next question*

14. Please list and explain any POSITIVE impacts you may have noticed among clients "facilitated" from Problem Gambling Treatment Services. _____

15. Please list and explain any NEGATIVE impacts you may have noticed among clients "facilitated" from Problem Gambling Treatment Services. _____

16. In general, how would you rate the effectiveness of "Facilitation Services" in resulting positive outcomes for problem gambling clients? (*Select ONE answer only*)

   ☐ Very ineffective
   ☐ Somewhat ineffective
   ☐ Neither effective nor ineffective
   ☐ Somewhat effective
   ☐ Very effective
   ☐ DON'T KNOW

17. Please provide any suggestions you have on how the "Facilitation" service process could be further improved

   _____

Section 4: Outcomes for your organisation

18. Has your organisation's general awareness of problem gambling increased as a result of "Facilitation Services"?

    ☐ NO – Stayed the same (Skip to Q. 21)
    ☐ YES – Slightly increased (Proceed to Q. 18)
    ☐ YES – Greatly increased (Proceed to Q. 18)

19. Has increased awareness of problem gambling resulted in an ability to identify problem gambling symptoms among your organisation's other clients?

    ☐ NO (Skip to Q. 20)
    ☐ YES – To some extent (Proceed to Q. 19)
    ☐ YES – Greatly (Proceed to Q. 19)

20. Has the ability to identify problem gambling symptoms resulted in any referrals of your organisation's other clients to Problem Gambling Treatment Services?

    ☐ NO
    ☐ YES – a small number of referrals
    ☐ YES – a substantial number of referrals
    ☐ NOT APPLICABLE

21. Are there any other changes or developments as a result of this increased awareness? _____

    _____

22. Please provide suggestions on how your organisation's awareness of problem gambling issues might be improved? _____

23. Does your organisation have a formal process for problem gambling screening and referral?

    ☐ NO – I don't see a need for this
    ☐ NO – But I do see a need for this
    ☐ YES
    ☐ Other (please specify) _____

❧Thank you for your time in completing this questionnaire. All responses will be anonymous and kept confidential❧

APPENDIX 3: Focus Group Interview Guide

FOCUS GROUP INTERVIEW: INTERVENTION SERVICE PROVIDERS

Inputs-related questions

1. Having sufficient knowledge is regarded necessary for effective delivery of interventions. What additional training is necessary for better delivery of interventions?

Process-related questions

2. The contract with the Ministry of Health (service specifications) includes a number of reporting requirements such as the 6-monthly narrative reports and recording cases in the CLIC database. In the survey a few staff mentioned difficulties faced with CLIC. What has been done or is there anything that can be done differently to increase reporting efficiency in a way that could benefit your organisation while fulfilling the Ministry's requirements?

3. Trends in CLIC data over a three year period (July 2010 – July 2013) suggest that approximately 10% of clients appear to not fit with the Ministry's preferred pattern of intervention sessions. (*Relevant sections of the service spec document is available if needed*)

   a. Based on CLIC data we are unable to tell when one treatment program ends and the second one starts. For such clients, how do you manage the entering of CLIC data to indicate the end of one treatment program and the start of a second?

Probe question: Do you wait until follow-up calls are complete before starting another round of treatment, or do additional full interventions follow-on from the previous full intervention sessions?

   b. When do you identify when one round of treatment is not enough?

4. For facilitation services, trends in CLIC data suggest an increase for two categories in 2012/13: "financial advice and support" and "venue exclusions". These increases coincide with a decrease in the "Other" category for facilitations during the same period.

   a. What are some of the reasons for these changes?

   b. Probe question: Could these trends be a result of more accurate classification? In other words, were these two categories recorded as "Other" in the earlier 2010 records?

5. Each intervention type (e.g. Brief's, Full Intervention) comes with a specific Ministry of Health *Purchase Unit Description* that details the required activities and processes as well as key goals. *(Copies of PUDs are available if needed).* How are these *Purchase Unit Descriptions* used to help counsellors to achieve the goals?

6. Some intervention activities have connections to public health activities. For example, identification of places to carry out brief interventions has connections with public health activities such as organising awareness raising events and development of screening practices within community support services.
   a. Do counsellors plan intervention activities in collaboration with public health staff in your organisation or other problem gambling public health service providers?

   b. How is this done?

   c. What are the benefits of this approach?

Outputs and Outcomes-related questions

7. Trends in CLIC data and staff survey responses indicate that there is an increase in referrals from the Justice system. Are there any measures in place to enhance treatment outcomes for this unique category of clients who have a compulsory mode of entry?

8. All activities under Brief Interventions were rated as either very or somewhat effective for achieving positive impacts on clients by majority of staff.

d. How do you know if brief interventions have been effective?

e. What else can be done to measure the effectiveness of brief interventions on a wider scale?

Probe question: Some impacts may remain unknown, for example briefs conducted at a public event. Are there any approaches used to measure impacts?

9. Establishing working relationships with community support agencies (allied agencies) is a key activity under Facilitation Services.

a. What are the main lessons learned or best practices concerning the relationship building process that could be shared across the sector?

b. Our survey of allied agencies suggested that some areas for improvement still remain. What can be done to further improve relationship development with allied agencies for Facilitation Services?

10. In the list of allied agencies that your organisations sent us for an evaluation of facilitation services, we noted three categories of agencies – (1) external community support services; (2) in-house community support services; and, (3) venues providing gambling facilities such as casinos, hotels and bars. In the *Intervention Service Practice Handbook* allied services are referred to as "allied health and social services", "other community services", or "another provider or external agency".

a. For some providers, in-house community support services are from the same wider organisation. How do these in-house services count as allied services within the context of what is described in the Intervention Service Practice Handbook? We have extracted a few descriptions from the Service Practice Handbook if you would like to read them.

Probing question: Are in-house services considered as allied services even when they are funded by the Ministry of Health?

b. Are there any differences between in-house and external community support services in terms of ease or working relationships or for achieving beneficial results for clients?

c. Are there any specific approaches used for working with gambling venues considering that they are not community support services but rather a partner in enabling facilitation services for self-exclusion purposes?

11. In Follow-up services, follow up timeframes are fixed at 1, 3, 6 and 12 months. The majority of staff (41 out of 50) indicated that fixing follow up timeframes was effective for clients. Likewise, majority of clients indicated that these set time frames were suitable for them (*73 out of 79*). an you give examples of why you believe this is effective for clients?

12. Our survey findings suggest that follow-up services are either carried out by clinicians themselves or by support staff. What are the pros and cons about these two approaches that can inform further development of follow-up services?

General

13. Is there anything else that is critical for improving the effectiveness of intervention services that you would like to add?

FOCUS GROUP INTERVIEW: PUBLIC HEALTH SERVICE PROVIDERS

Inputs-related questions

1. Having sufficient knowledge is regarded necessary for effective delivery of public health services.
   a. What additional training is necessary for better delivery of public health services?

Process-related questions

2. The contract with the Ministry of Health (Service specifications) includes a number of reporting and planning requirements such as the 6-monthly narrative reports and submitting an annual public health work plan. *(Copies of the Appendix A template is available).*

   a. What has worked well with the process of preparing annual public health work plans?

   b. A few respondents mentioned difficulties faced with the Annual Workplan. What has been done or is there anything that can be done differently to increase the efficiency of annual planning in a way that could benefit your organisation while fulfilling the Ministry's requirements?

3. Each public health service comes with a specific Ministry of Health *Purchase Unit Description* which details the required activities and processes as well as the key goals to be attained. *(Copies of PUDs are available if needed).*

   a. How are these *Purchase Unit Descriptions* used to enable public health workers and health promoters to achieve the goals?

   b. Some purchase units have similar goals. For instance, both Supportive Communities and Aware Communities, require the delivery of activities that encourage public discussion and debate on gambling harm. On the other hand, activities such as meetings with stakeholders or holding an information stall at a public event can be used to achieve multiple goals for several purchase units. Are public health activities across the five public health services planned and implemented to increase time or resource efficiency? How is this done?

4. Some public health activities have connections to intervention activities. For example, identification of places to carry out brief interventions for high risk groups under Brief Intervention has connections with public health activities such as organising awareness raising events and development of screening practices within community support services.

   a. Do you plan public health activities in collaboration with intervention staff in your organisation or other problem gambling intervention services?

   b. How is this done?

   c. What are the benefits of this approach?

5. Some activities were carried out in collaboration with other public health service providers.

   a. What are the main lessons learned or best practices concerning collaboration between service providers that could be shared across the sector?

   b. How are collaborative successes reported or shared?

Outputs and Outcomes-related questions

6. The majority of staff survey respondents believed that their organisations were either somewhat or very effective in the delivery of all activities for all five public health services.

   a. How do you know if public health activities have been effective?

Probe question: What evidences of impact are used to determine if these activities are effective.

   b. What are the key reasons or factors that have contributed to the effectiveness of these activities?

7. *"Providing a clear point of public contact for raising concerns regarding public health approaches to reducing gambling harm"* was one of the activities under the Supportive Communities purchase unit.

   a. How was this activity implemented?

   b. What public health goals were achieved from this activity?

8. *"Contributing to or participating in social impact assessment of gambling harm"* was an activity under Policy Development and Implementation.

   a. How was this activity implemented?

   b. What public health goals were achieved from this activity?

9. Our analysis of the 6-monthly narrative reports found that some activities were particularly challenging. One such example is supporting the development of *"policies that encourage and promote methods of fund-raising that do not involve gambling"* under Policy Development and Implementation.

   a. What been done to enhance the effectiveness of this activity?

   b. Are there any other activities that were particularly challenging or difficult to carry out? How did you deal with these challenges?

10. Relationship development with key stakeholders (e.g. community groups, community and social service agencies, and gambling venues) were crucial for the delivery of all five public health services.   What are the main lessons learned or best practices concerning the relationship building process that could be shared across the sector?

General

11. Is there anything else that is critical for improving the effectiveness of public health services that you would like to add?

APPENDIX 4: CLIC Database analysis

Table 5: Primary mode of harmful gambling (percentage of clients by provider type)

	Gambler clients (%)												Significant other client (%)											
	General Service			Māori Service			Pacific Service			AOD Service			General Service			Māori Service			Pacific Service			AOD Service		
Gambling type	2010-11	2011-12	2012-13	2010-11	2011-12	2012-13	2010-11	2011-12	2012-13	2010-11	2011-12	2012-13	2010-11	2011-12	2012-13	2010-11	2011-12	2012-13	2010-11	2011-12	2012-13	2010-11	2011-12	2012-13
Cards (not at casino)	0.9	0.7	0.7	2.7	2.8	1.5	4.1	7.3	3.0	1.2	1.0	3.4	0.6	0.5	0.4	1.8	1.8	1.7	2.0	1.0	1.5	2.0	0.0	0.3
Casino EGMs	14.1	13.7	18.3	3.7	5.4	9.1	5.7	12.4	16.5	29.9	24.1	17.4	12.4	13.7	13.1	1.8	7.8	7.9	14.6	15.0	24.7	4.2	12.6	24.9
Casino table games	9.7	13.9	16.5	1.0	1.4	1.6	1.1	2.1	2.2	5.2	4.9	12.0	8.2	11.2	13.8	0.3	1.2	1.0	0.6	1.7	4.1	2.0	0.0	0.8
Club EGMs	3.5	2.1	1.8	4.7	4.2	2.8	7.9	7.7	3.1	10.1	9.4	3.4	5.7	3.8	1.8	3.9	4.2	2.6	9.0	7.0	4.1	4.1	4.2	0.8
Electronic table games	0.0	0.5	0.6	0.0	0.2	0.2	0.0	0.2	1.9	0.0	0.0	0.0	0.0	0.4	0.5	0.0	0.1	0.1	0.0	0.2	0.7	0.0	0.0	0.1
Housie/bingo	1.7	1.6	1.5	1.3	1.9	1.0	3.1	1.4	4.9	0.4	0.0	0.0	6.6	6.4	4.2	1.6	2.0	1.7	9.9	6.3	3.9	0.2	4.2	0.8
Scratchies (scratchcards)	0.3	0.2	0.3	0.1	1.1	1.0	0.0	4.5	2.8	0.0	0.5	0.7	0.0	0.4	0.4	0.0	0.3	0.7	0.0	0.0	0.3	0.0	0.0	0.1
Keno	0.1	0.1	0.1	0.5	0.1	0.1	0.4	0.9	0.3	0.8	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.1	0.0	0.5	0.0	0.0	0.0	0.0
Lotto	9.3	6.5	2.5	7.6	10.3	7.5	39.1	33.6	33.3	2.6	3.6	2.2	4.0	5.1	3.3	1.2	2.3	5.5	18.0	11.1	12.2	2.3	0.2	2.4
NZ Other	1.6	0.9	0.6	1.0	0.4	0.2	13.1	5.2	6.1	2.1	1.5	0.7	3.4	1.4	0.9	0.6	0.3	0.0	3.7	1.0	1.0	4.0	0.0	0.2
Overseas	0.9	0.8	1.0	0.0	0.5	0.4	0.0	0.0	0.9	0.0	0.0	0.0	1.6	1.2	1.6	0.0	0.0	0.3	0.0	0.2	0.3	0.0	0.0	0.1
Pub EGMs	50.6	52.0	49.7	72.6	65.1	67.8	15.7	17.6	21.1	42.4	50.1	56.1	48.9	48.1	53.2	83.1	74.7	72.0	29.9	45.8	38.0	67.3	68.3	47.6
Sports betting	2.9	2.7	3.0	2.2	3.0	3.4	2.6	0.9	0.9	1.2	2.0	1.3	2.2	2.3	2.7	1.2	1.3	2.9	1.7	1.2	3.6	2.0	0.0	0.7
Track betting	4.4	4.3	3.4	2.7	3.6	3.4	7.2	6.1	3.0	4.5	3.5	3.4	6.3	5.6	4.0	4.7	3.9	3.5	10.7	9.0	5.7	13.9	12.4	41.1

Service		Gambler						Significant Other					
		2010-1		2011-2		2012-3		2010-1		2011-2		2012-3	
		No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
General	A01	2875	(70.3)	2565	(65.1)	2424	(66.7)	1212	(29.7)	1376	(34.9)	1211	(33.3)
	A02	1124	(53.4)	1206	(47.8)	1318	(48.7)	982	(46.6)	1316	(52.2)	1390	(51.3)
	A11	247	(71.8)	240	(71.6)	219	(66.4)	97	(28.2)	95	(28.4)	111	(33.6)
	A15	48	(96.0)	234	(93.2)	195	(96.5)	2	(4)	17	(6.8)	7	(3.5)
Māori	B05	264	(40.2)	275	(47.7)	396	(40)	393	(59.8)	301	(52.3)	594	(60)
	B06	223	(74.1)	125	(71.8)	210	(52.9)	78	(25.9)	49	(28.2)	187	(47.1)
	B07	108	(20.1)	87	(23.0)	104	(22.9)	430	(79.9)	291	(77)	351	(77.1)
	B09	247	(87.9)	304	(92.4)	268	(61.5)	34	(12.1)	25	(7.6)	168	(38.5)
	B10	315	(55.8)	130	(24.1)	154	(34.1)	250	(44.2)	410	(75.9)	297	(65.9)
	B12	354	(62.2)	362	(62.2)	143	(27.7)	215	(37.8)	220	(37.8)	374	(72.3)
	B13	153	(69.9)	119	(64.7)	102	(65.8)	66	(30.1)	65	(35.3)	53	(34.2)
	B14	77	(58.8)	81	(58.7)	74	(62.7)	54	(41.2)	57	(41.3)	44	(37.3)
	B17	1	(100.0)	78	(41.3)	50	(35.7)	.	.	111	(58.7)	90	(64.3)
	B18	28	(82.4)	70	(92.1)	46	(95.8)	6	(17.6)	6	(7.9)	2	(4.2)
Pacific	C04	383	(66.3)	303	(65.9)	505	(66.1)	195	(33.7)	157	(34.1)	259	(33.9)
	C08	19	(46.3)	81	(45.0)	223	(50.1)	22	(53.7)	99	(55)	222	(49.9)
	C19	26	(19.1)	14	(9.7)	14	(11.3)	110	(80.9)	131	(90.3)	110	(88.7)
AOD	D03	95	(95.0)	90	(96.8)	118	(99.2)	5	(5)	3	(3.2)	1	(0.8)
	D16	83	(65.4)	85	(65.4)	28	(87.5)	44	(34.6)	45	(34.6)	4	(12.5)

Table 7: Gender of gambler and significant other clients

		Gambler						Significant other					
		Female			Male			Female			Male		
Service		2010-1	2011-2	2012-3	2010-1	2011-2	2012-3	2010-1	2011-2	2012-3	2010-1	2011-2	2012-3
		No. (%)	No. %	No. %	No. %	No. %	No. %	No. %	No. %	No. %	No. %	No. %	No. %
General	A01	1282 (44.6)	1077 (42)	964 (39.8)	1593 (55.4)	1488 (58)	1460 (60.2)	801 (66.1)	902 (65.6)	776 (64.1)	411 (33.9)	474 (34.4)	435 (35.9)
	A02	518 (46.1)	535 (44.4)	564 (42.8)	606 (53.9)	671 (55.6)	754 (57.2)	636 (64.8)	853 (64.8)	893 (64.2)	346 (35.2)	463 (35.2)	497 (35.8)
	A11	137 (55.5)	123 (51.3)	118 (53.9)	110 (44.5)	117 (48.8)	101 (46.1)	51 (52.6)	56 (58.9)	79 (71.2)	46 (47.4)	39 (41.1)	32 (28.8)
	A15	33 (68.8)	117 (50)	81 (41.5)	15 (31.3)	117 (50)	114 (58.5)	2 (100)	17 (100)	5 (71.4)	.	.	2 (28.6)
Māori	B05	159 (60.2)	174 (63.3)	230 (58.1)	105 (39.8)	101 (36.7)	166 (41.9)	310 (78.9)	223 (74.1)	426 (71.7)	83 (21.1)	78 (25.9)	168 (28.3)
	B06	78 (35)	49 (39.2)	100 (47.6)	145 (65)	76 (60.8)	110 (52.4)	40 (51.3)	21 (42.9)	118 (63.1)	38 (48.7)	28 (57.1)	69 (36.9)
	B07	67 (62)	48 (55.2)	63 (60.6)	41 (38)	39 (44.8)	41 (39.4)	298 (69.3)	192 (66)	227 (64.7)	132 (30.7)	99 (34)	124 (35.3)
	B09	168 (68)	216 (71.1)	159 (59.3)	79 (32)	88 (28.9)	109 (40.7)	29 (85.3)	19 (76)	117 (69.6)	5 (14.7)	6 (24)	51 (30.4)
	B10	181 (57.5)	72 (55.4)	99 (64.3)	134 (42.5)	58 (44.6)	55 (35.7)	166 (66.4)	214 (52.2)	180 (60.6)	84 (33.6)	196 (47.8)	117 (39.4)
	B12	219 (61.9)	222 (61.3)	90 (62.9)	135 (38.1)	140 (38.7)	53 (37.1)	116 (54)	108 (49.1)	261 (69.8)	99 (46)	112 (50.9)	113 (30.2)
	B13	74 (48.4)	36 (30.3)	27 (26.5)	79 (51.6)	83 (69.7)	75 (73.5)	36 (54.5)	28 (43.1)	30 (56.6)	30 (45.5)	37 (56.9)	23 (43.4)
	B14	30 (39)	30 (37)	25 (33.8)	47 (61)	51 (63)	49 (66.2)	30 (55.6)	24 (42.1)	21 (47.7)	24 (44.4)	33 (57.9)	23 (52.3)
	B17	1 (100)	41 (52.6)	32 (64)	. (.)	37 (47.4)	18 (36)	.	63 (56.8)	65 (72.2)	.	48 (43.2)	25 (27.8)
	B18	9 (32.1)	32 (45.7)	22 (47.8)	19 (67.9)	38 (54.3)	24 (52.2)	5 (83.3)	6 (100)	2 (100)	1 (16.7)	.	.
Pacific	C04	59 (15.4)	68 (22.4)	153 (30.3)	324 (84.6)	235 (77.6)	352 (69.7)	61 (31.3)	49 (31.2)	115 (44.4)	134 (68.7)	108 (68.8)	144 (55.6)
	C08	18 (94.7)	66 (81.5)	159 (71.3)	1 (5.3)	15 (18.5)	64 (28.7)	18 (81.8)	71 (71.7)	164 (73.9)	4 (18.2)	28 (28.3)	58 (26.1)
	C19	7 (26.9)	3 (21.4)	9 (64.3)	19 (73.1)	11 (78.6)	5 (35.7)	28 (25.5)	51 (38.9)	51 (46.4)	82 (74.5)	80 (61.1)	59 (53.6)
AOD	D03	30 (31.6)	30 (33.3)	39 (33.1)	65 (68.4)	60 (66.7)	79 (66.9)	1 (20)	.	.	4 (80)	3 (100)	1 (100)
	D16	31 (37.3)	40 (47.1)	14 (50)	52 (62.7)	45 (52.9)	14 (50)	23 (52.3)	25 (55.6)	4 (100)	21 (47.7)	20 (44.4)	.

Table 8: Ethnicity of gambler clients

Service		Māori 2010-1 No.	(%)	Māori 2011-2 No.	(%)	Māori 2012-3 No.	(%)	Pacific 2010-1 No.	(%)	Pacific 2011-2 No.	(%)	Pacific 2012-3 No.	(%)	Asian 2010-1 No.	(%)	Asian 2011-2 No.	(%)	Asian 2012-3 No.	(%)	European / Other 2010-1 No.	(%)	European / Other 2011-2 No.	(%)	European / Other 2012-3 No.	(%)
General	A01	548	(19.1)	529	(20.6)	506	(20.9)	293	(10.2)	236	(9.2)	264	(10.9)	686	(23.9)	607	(23.7)	458	(18.9)	1348	(46.9)	1193	(46.5)	1196	(49.3)
	A02	302	(26.9)	322	(26.7)	335	(25.4)	83	(7.4)	90	(7.5)	85	(6.4)	12	(1.1)	17	(1.4)	35	(2.7)	726	(64.6)	776	(64.3)	861	(65.3)
	A11	46	(18.6)	59	(24.6)	75	(34.2)	17	(6.9)	19	(7.9)	19	(8.7)	5	(2)	6	(2.5)	5	(2.3)	179	(72.5)	156	(65)	120	(54.8)
	A15	14	(29.2)	93	(39.7)	57	(29.2)	7	(14.6)	18	(7.7)	22	(11.3)	1	(2.1)	12	(5.1)	13	(6.7)	26	(54.2)	111	(47.4)	103	(52.8)
Māori	B05	134	(50.8)	169	(61.5)	231	(58.3)	8	(3)	10	(3.6)	12	(3)	1	(0.4)	1	(0.4)	2	(0.5)	121	(45.8)	95	(34.5)	151	(38.1)
	B06	162	(72.6)	90	(72)	116	(55.2)	28	(12.6)	11	(8.8)	74	(35.2)	.	.	.	.	.	.	33	(14.8)	24	(19.2)	20	(9.5)
	B07	78	(72.2)	70	(80.5)	76	(73.1)	17	(15.7)	15	(17.2)	12	(11.5)	.	.	.	.	1	(1)	13	(12)	2	(2.3)	15	(14.4)
	B09	199	(80.6)	203	(66.8)	189	(70.5)	6	(2.4)	8	(2.6)	6	(2.2)	.	.	1	(0.3)	.	.	42	(17)	92	(30.3)	73	(27.2)
	B10	249	(79)	115	(88.5)	116	(75.3)	7	(2.2)	1	(0.8)	4	(2.6)	.	.	.	.	.	.	59	(18.7)	14	(10.8)	34	(22.1)
	B12	219	(61.9)	226	(62.4)	105	(73.4)	11	(3.1)	9	(2.5)	5	(3.5)	1	(0.3)	2	(0.6)	.	.	123	(34.7)	125	(34.5)	33	(23.1)
	B13	46	(30.1)	37	(31.1)	25	(24.5)	5	(3.3)	5	(4.2)	1	(1)	1	(0.7)	.	.	.	.	101	(66)	77	(64.7)	76	(74.5)
	B14	29	(37.7)	27	(33.3)	23	(31.1)	3	(3.9)	3	(3.7)	.	.	1	(1.3)	.	.	.	.	44	(57.1)	51	(63)	51	(68.9)
	B17	.	.	67	(85.9)	42	(84)	.	.	2	(2.6)	2	(4)	.	.	.	.	.	.	1	(100)	9	(11.5)	6	(12)
	B18	17	(60.7)	43	(61.4)	28	(60.9)	.	.	1	(1.4)	2	(4.3)	.	.	.	.	.	.	11	(39.3)	26	(37.1)	16	(34.8)
Pacific	C04	20	(5.2)	22	(7.3)	57	(11.3)	328	(85.6)	252	(83.2)	404	(80)	.	.	.	.	4	(0.8)	35	(9.1)	29	(9.6)	40	(7.9)
	C08	7	(36.8)	19	(23.5)	54	(24.2)	9	(47.4)	55	(67.9)	160	(71.7)	.	.	.	.	.	.	3	(15.8)	7	(8.6)	9	(4)
	C19	1	(3.8)	2	(14.3)	2	(14.3)	23	(88.5)	12	(85.7)	12	(85.7)	.	.	.	.	.	.	2	(7.7)	.	.	.	.
AOD	D03	26	(27.4)	28	(31.1)	48	(40.7)	4	(4.2)	4	(4.4)	8	(6.8)	.	.	.	.	.	.	65	(68.4)	58	(64.4)	62	(52.5)
	D16	13	(15.7)	14	(16.5)	6	(21.4)	.	.	6	(7.1)	.	.	.	.	.	.	.	.	70	(84.3)	65	(76.5)	22	(78.6)

Table 9: Ethnicity of Significant Other clients

Service		Māori 2010-1		Māori 2011-2		Māori 2012-3		Pacific 2010-1		Pacific 2011-2		Pacific 2012-3		Asian 2010-1		Asian 2011-2		Asian 2012-3		European / Other 2010-1		European / Other 2011-2		European / Other 2012-3	
		No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
General	A01	135	(11.1)	192	(14)	134	(11.1)	297	(24.5)	392	(28.5)	240	(19.8)	135	(11.1)	116	(8.4)	125	(10.3)	645	(53.2)	676	(49.1)	712	(58.8)
	A02	333	(33.9)	494	(37.5)	605	(43.5)	179	(18.2)	289	(22)	273	(19.6)	3	(0.3)	5	(0.4)	14	(1)	467	(47.6)	528	(40.1)	498	(35.8)
	A11	16	(16.5)	25	(26.3)	56	(50.5)	7	(7.2)	5	(5.3)	3	(2.7)	1	(1)	1	(1.1)	1	(0.9)	72	(74.2)	64	(67.4)	51	(45.9)
	A15	.	.	5	(29.4)	.	.	1	(50)	3	(17.6)	1	(14.3)	.	.	.	.	.	.	1	(50)	9	(52.9)	6	(85.7)
Māori	B05	213	(54.2)	211	(70.1)	378	(63.6)	12	(3.1)	17	(5.6)	24	(4)	.	.	1	(0.3)	4	(0.7)	168	(42.7)	72	(23.9)	188	(31.6)
	B06	41	(52.6)	37	(75.5)	67	(35.8)	31	(39.7)	7	(14.3)	102	(54.5)	.	.	.	.	.	.	6	(7.7)	5	(10.2)	18	(9.6)
	B07	312	(72.6)	203	(69.8)	245	(69.8)	69	(16)	62	(21.3)	61	(17.4)	1	(0.2)	1	(0.3)	2	(0.6)	48	(11.2)	25	(8.6)	43	(12.3)
	B09	20	(58.8)	20	(80)	135	(80.4)	.	.	1	(4)	.	.	.	.	.	.	.	.	14	(41.2)	4	(16)	33	(19.6)
	B10	207	(82.8)	299	(72.9)	203	(68.4)	7	(2.8)	6	(1.5)	2	(0.7)	.	.	.	.	.	.	36	(14.4)	105	(25.6)	92	(31)
	B12	151	(70.2)	107	(48.6)	193	(51.6)	2	(0.9)	2	(0.9)	14	(3.7)	1	(0.5)	.	.	4	(1.1)	61	(28.4)	111	(50.5)	163	(43.6)
	B13	29	(43.9)	29	(44.6)	20	(37.7)	.	.	1	(1.5)	.	.	.	.	.	.	.	.	37	(56.1)	35	(53.8)	33	(62.3)
	B14	10	(18.5)	17	(29.8)	13	(29.5)	1	(1.9)	2	(3.5)	3	(6.8)	.	.	.	.	.	.	43	(79.6)	38	(66.7)	28	(63.6)
	B17	.	.	103	(92.8)	78	(86.7)	.	.	.	.	.	.	.	.	.	.	1	(1.1)	.	.	8	(7.2)	11	(12.2)
	B18	3	(50)	4	(66.7)	2	(100)	.	.	.	.	.	.	.	.	.	.	.	.	3	(50)	2	(33.3)	.	.
Pacific	C04	25	(12.8)	13	(8.3)	38	(14.7)	159	(81.5)	137	(87.3)	201	(77.6)	2	(1)	.	.	2	(0.8)	9	(4.6)	7	(4.5)	18	(6.9)
	C08	11	(50)	40	(40.4)	40	(18)	9	(40.9)	50	(50.5)	164	(73.9)	.	.	1	(1)	1	(0.5)	2	(9.1)	8	(8.1)	17	(7.7)
	C19	6	(5.5)	15	(11.5)	19	(17.3)	93	(84.5)	107	(81.7)	80	(72.7)	1	(0.9)	.	.	.	.	10	(9.1)	9	(6.9)	11	(10)
AOD	D03	2	(40)	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	3	(60)	3	(100)	1	(100)
	D16	3	(6.8)	5	(11.1)	.	.	1	(2.3)	1	(2.2)	.	.	.	.	.	.	.	.	40	(90.9)	39	(86.7)	4	(100)

Table 10: Manner of service delivery (Face-to-face and telephone)

Service		Face-to-Face												Telephone											
		Gambler						Significant other						Gambler						Significant other					
		2010-1		2011-2		2012-3		2010-1		2011-2		2012-3		2010-1		2011-2		2012-3		2010-1		2011-2		2012-3	
		No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
General	A01	7977	(72.9)	7671	(73.7)	7620	(75.9)	2568	(76.6)	3059	(82.8)	2293	(76.1)	2972	(27.1)	2735	(26.3)	2419	(24.1)	784	(23.4)	635	(17.2)	720	(23.9)
	A02	5245	(84.8)	5300	(84.6)	5718	(83.7)	1511	(90.4)	2048	(93.5)	2169	(87)	940	(15.2)	963	(15.4)	1114	(16.3)	161	(9.6)	142	(6.5)	325	(13)
	A11	291	(29.1)	270	(31.3)	294	(39.7)	109	(40.8)	104	(45.4)	146	(55.1)	710	(70.9)	592	(68.7)	446	(60.3)	158	(59.2)	125	(54.6)	119	(44.9)
	A15	4	(2)	4	(0.6)	7	(1.8)	.	.	.	.	.	.	194	(98)	633	(99.4)	372	(98.2)	12	(100)	23	(100)	7	(100)
Māori	B05	1375	(89.7)	1116	(80.6)	1618	(82)	628	(92.9)	404	(81.8)	871	(93.2)	158	(10.3)	268	(19.4)	354	(18)	48	(7.1)	90	(18.2)	64	(6.8)
	B06	1132	(81.7)	637	(75.8)	888	(81.9)	479	(93.9)	303	(81.9)	811	(88.8)	253	(18.3)	203	(24.2)	196	(18.1)	31	(6.1)	67	(18.1)	102	(11.2)
	B07	381	(91.6)	377	(89.1)	267	(88.1)	1023	(95)	858	(96.9)	938	(90.5)	35	(8.4)	46	(10.9)	36	(11.9)	54	(5)	27	(3.1)	99	(9.5)
	B09	786	(81.2)	966	(84)	954	(70.9)	77	(93.9)	75	(86.2)	206	(93.2)	182	(18.8)	184	(16)	392	(29.1)	5	(6.1)	12	(13.8)	15	(6.8)
	B10	690	(91.5)	532	(93.3)	455	(75.8)	433	(97.7)	623	(96.9)	411	(88.2)	64	(8.5)	38	(6.7)	145	(24.2)	10	(2.3)	20	(3.1)	55	(11.8)
	B12	628	(80.1)	457	(76.4)	198	(57.2)	270	(80.4)	289	(83.8)	452	(86.6)	156	(19.9)	141	(23.6)	148	(42.8)	66	(19.6)	56	(16.2)	70	(13.4)
	B13	564	(83.9)	431	(88.5)	408	(79.4)	234	(90.3)	202	(89.8)	134	(79.8)	108	(16.1)	56	(11.5)	106	(20.6)	25	(9.7)	23	(10.2)	34	(20.2)
	B14	273	(74.6)	292	(74.3)	273	(71.7)	103	(62.8)	123	(67.2)	65	(66.3)	93	(25.4)	101	(25.7)	108	(28.3)	61	(37.2)	60	(32.8)	33	(33.7)
	B17	1	(100)	261	(99.2)	178	(99.4)	.	.	337	(98.8)	194	(99)	.	.	2	(0.8)	1	(0.6)	.	.	4	(1.2)	2	(1)
	B18	150	(72.1)	235	(77)	241	(76)	39	(81.3)	7	(46.7)	3	(75)	58	(27.9)	70	(23)	76	(24)	9	(18.8)	8	(53.3)	1	(25)
Pacific	C04	1134	(64.7)	894	(69)	1362	(74.4)	510	(66.1)	425	(72.9)	647	(75)	618	(35.3)	401	(31)	468	(25.6)	262	(33.9)	158	(27.1)	216	(25)
	C08	191	(96.5)	497	(98.8)	941	(89.8)	252	(99.2)	995	(100)	872	(93.1)	7	(3.5)	6	(1.2)	107	(10.2)	2	(0.8)	.	.	65	(6.9)
	C19	37	(92.5)	33	(94.3)	114	(82)	110	(100)	155	(99.4)	156	(85.7)	3	(7.5)	2	(5.7)	25	(18)	.	.	1	(0.6)	26	(14.3)
AOD	D03	4199	(91.7)	2183	(85.5)	4387	(97.4)	4	(44.4)	19	(35.2)	.	.	380	(8.3)	369	(14.5)	118	(2.6)	5	(55.6)	35	(64.8)	2	(100)
	D16	545	(92.4)	259	(84.6)	62	(83.8)	109	(85.8)	58	(85.3)	7	(100)	45	(7.6)	47	(15.4)	12	(16.2)	18	(14.2)	10	(14.7)	.	.

Table 11: Intervention approaches used for Gambler clients

Service		Couple 2010-1 No.	(%)	Couple 2011-2 No.	(%)	Couple 2012-3 No.	(%)	Family 2010-1 No.	(%)	Family 2011-2 No.	(%)	Family 2012-3 No.	(%)	Group 2010-1 No.	(%)	Group 2011-2 No.	(%)	Group 2012-3 No.	(%)	Individual 2010-1 No.	(%)	Individual 2011-2 No.	(%)	Individual 2012-3 No.	(%)
General	A01	529	(4.8)	465	(4.5)	446	(4.4)	128	(1.2)	216	(2.1)	272	(2.7)	986	(9)	1422	(13.7)	1247	(12.4)	9306	(85)	8303	(79.8)	8074	(80.4)
	A02	135	(2.2)	98	(1.6)	148	(2.2)	16	(0.3)	19	(0.3)	7	(0.1)	699	(11.3)	630	(10.1)	934	(13.7)	5335	(86.3)	5516	(88.1)	5743	(84.1)
	A11	.	.	.	.	.	.	.	.	.	.	.	.	286	(28.6)	252	(29.2)	275	(37.2)	715	(71.4)	610	(70.8)	465	(62.8)
	A15	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	198	(100)	637	(100)	379	(100)
Māori	B05	12	(0.8)	41	(3)	47	(2.4)	.	.	8	(0.6)	24	(1.2)	29	(1.9)	38	(2.7)	45	(2.3)	1492	(97.3)	1297	(93.7)	1856	(94.1)
	B06	.	.	.	.	2	(0.2)	.	.	1	(0.1)	1	(0.1)	404	(29.2)	70	(8.3)	554	(51.1)	981	(70.8)	769	(91.5)	527	(48.6)
	B07	.	.	.	.	.	.	15	(3.6)	8	(1.9)	1	(0.3)	.	.	43	(10.2)	8	(2.6)	401	(96.4)	372	(87.9)	294	(97)
	B09	.	.	.	.	.	.	1	(0.1)	3	(0.3)	1	(0.1)	.	.	.	.	.	.	967	(99.9)	1147	(99.7)	1345	(99.9)
	B10	12	(1.6)	17	(3)	2	(0.3)	52	(6.9)	82	(14.4)	2	(0.3)	.	.	.	.	.	.	690	(91.5)	471	(82.6)	596	(99.3)
	B12	.	.	.	.	.	.	2	(0.3)	3	(0.5)	.	.	.	.	.	.	.	.	782	(99.7)	595	(99.5)	346	(100)
	B13	5	(0.7)	.	.	9	(1.8)	2	(0.3)	1	(0.2)	.	.	.	.	.	.	40	(7.8)	665	(99)	486	(99.8)	465	(90.5)
	B14	17	(4.6)	12	(3.1)	6	(1.6)	3	(0.8)	7	(1.8)	1	(0.3)	.	.	3	(0.8)	.	.	346	(94.5)	371	(94.4)	374	(98.2)
	B17	.	.	.	.	.	.	.	.	1	(0.4)	.	.	.	.	.	.	.	.	1	(100)	262	(99.6)	179	(100)
	B18	2	(1)	.	.	.	.	.	.	.	.	2	(0.7)	.	.	.	.	.	.	206	(99)	303	(99.3)	317	(100)
Pacific	C04	24	(1.4)	15	(1.2)	19	(1)	40	(2.3)	69	(5.3)	72	(3.9)	266	(15.2)	163	(12.6)	394	(21.5)	1422	(81.2)	1048	(80.9)	1345	(73.5)
	C08	7	(3.5)	4	(0.8)	.	.	7	(3.5)	12	(2.4)	1	(0.1)	.	.	121	(24.1)	511	(48.8)	184	(92.9)	366	(72.8)	536	(51.1)
	C19	.	.	3	(8.6)	.	.	.	.	.	.	.	.	.	.	.	.	.	.	40	(100)	32	(91.4)	139	(100)
AOD	D03	1	(0)	.	.	1	(0)	3	(0.1)	.	.	1	(0)	3876	(84.6)	1857	(72.8)	3865	(85.8)	699	(15.3)	695	(27.2)	638	(14.2)
	D16	9	(1.5)	9	(2.9)	1	(1.4)	.	.	.	.	1	(1.4)	274	(46.4)	49	(16)	.	.	307	(52)	248	(81)	72	(97.3)

Table 12: Intervention approaches used for significant other clients

Service		Couple 2010-1 No.	(%)	Couple 2011-2 No.	(%)	Couple 2012-3 No.	(%)	Family 2010-1 No.	(%)	Family 2011-2 No.	(%)	Family 2012-3 No.	(%)	Group 2010-1 No.	(%)	Group 2011-2 No.	(%)	Group 2012-3 No.	(%)	Individual 2010-1 No.	(%)	Individual 2011-2 No.	(%)	Individual 2012-3 No.	(%)
General	A01	439	(13.1)	330	(8.9)	358	(11.9)	145	(4.3)	274	(7.4)	320	(10.6)	820	(24.5)	1179	(31.9)	432	(14.3)	1948	(58.1)	1911	(51.7)	1903	(63.2)
	A02	114	(6.8)	92	(4.2)	129	(5.2)	13	(0.8)	19	(0.9)	10	(0.4)	15	(0.9)	77	(3.5)	163	(6.5)	1530	(91.5)	2002	(91.4)	2192	(87.9)
	A11	.	.	.	.	.	.	.	.	.	.	.	.	104	(39)	94	(41)	144	(54.3)	163	(61)	135	(59)	121	(45.7)
	A15	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	12	(100)	23	(100)	7	(100)
Māori	B05	6	(0.9)	19	(3.8)	27	(2.9)	.	.	.	.	18	(1.9)	4	(0.6)	.	.	2	(0.2)	666	(98.5)	475	(96.2)	888	(95)
	B06	11	(2.2)	.	.	2	(0.2)	1	(0.2)	1	(0.3)	2	(0.2)	94	(18.4)	168	(45.4)	525	(57.5)	404	(79.2)	201	(54.3)	384	(42.1)
	B07	.	.	2	(0.2)	.	.	7	(0.6)	11	(1.2)	4	(0.4)	.	.	.	.	.	.	1070	(99.4)	872	(98.5)	1033	(99.6)
	B09	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	82	(100)	87	(100)	221	(100)
	B10	16	(3.6)	17	(2.6)	.	.	146	(33)	202	(31.4)	.	.	.	.	.	.	.	.	281	(63.4)	424	(65.9)	466	(100)
	B12	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	336	(100)	345	(100)	522	(100)
	B13	7	(2.7)	.	.	13	(7.7)	2	(0.8)	.	.	.	.	.	.	.	.	1	(0.6)	250	(96.5)	225	(100)	154	(91.7)
	B14	21	(12.8)	14	(7.7)	5	(5.1)	6	(3.7)	9	(4.9)	3	(3.1)	.	.	4	(2.2)	.	.	137	(83.5)	156	(85.2)	90	(91.8)
	B17	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	341	(100)	196	(100)
	B18	2	(4.2)	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	46	(95.8)	15	(100)	4	(100)
Pacific	C04	18	(2.3)	3	(0.5)	6	(0.7)	35	(4.5)	30	(5.1)	62	(7.2)	70	(9.1)	76	(13)	138	(16)	649	(84.1)	474	(81.3)	657	(76.1)
	C08	12	(4.7)	16	(1.6)	.	.	30	(11.8)	30	(3)	3	(0.3)	.	.	122	(12.3)	563	(60.1)	212	(83.5)	827	(83.1)	371	(39.6)
	C19	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	110	(100)	156	(100)	182	(100)
AOD	D03	.	.	.	.	.	.	.	.	.	.	.	.	.	.	11	(20.4)	.	.	9	(100)	43	(79.6)	2	(100)
	D16	5	(3.9)	8	(11.8)	1	(14.3)	.	.	3	(4.4)	1	(14.3)	.	.	.	.	.	.	122	(96.1)	57	(83.8)	5	(71.4)

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Table 13: Relapse (gap of at least three months between sessions)

		Gambler												Significant Other											
		2010 - 11				2011 - 12				2012 - 13				2010 - 11				2011 - 12				2012 - 13			
		None		Relapse		None		Relapse		None		Relapse		None		Relapse		None		Relapse		None		Relapse	
Service		No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
General	A01	1498	(98)	26	(1.7)	1332	(94)	82	(5.8)	1730	(84)	336	(16)	868	(99)	11	(1.3)	1029	(96)	42	(3.9)	1000	(86)	160	(14)
	A02	393	(100)	.	.	587	(97)	20	(3.3)	1022	(94)	65	(6)	857	(100)	2	(0.2)	1207	(100)	4	(0.3)	1340	(98)	23	(1.7)
	A11	11	(100)	.	.	68	(100)	.	.	181	(93)	13	(6.7)	5	(100)	.	.	29	(85)	5	(15)	100	(96)	4	(3.8)
	A15	12	(71)	5	(29)	190	(98)	3	(1.6)	190	(98)	3	(1.6)	.	.	.	.	16	(94)	1	(5.9)	7	(100)	.	.
Māori	B05	98	(99)	1	(1)	142	(98)	3	(2.1)	317	(95)	15	(4.5)	321	(99)	2	(0.6)	248	(99)	3	(1.2)	494	(96)	20	(3.9)
	B06	53	(95)	3	(5.4)	22	(69)	10	(31)	140	(69)	63	(31)	27	(96)	1	(3.6)	3	(75)	1	(25)	130	(71)	52	(29)
	B07	85	(100)	.	.	64	(100)	.	.	98	(96)	4	(3.9)	252	(100)	.	.	249	(100)	.	.	334	(96)	13	(3.7)
	B09	197	(100)	.	.	257	(100)	.	.	255	(100)	1	(0.4)	29	(100)	.	.	15	(100)	.	.	161	(99)	1	(0.6)
	B10	233	(96)	9	(3.7)	109	(98)	2	(1.8)	149	(97)	5	(3.2)	216	(100)	.	.	400	(100)	1	(0.2)	294	(99)	3	(1)
	B12	220	(100)	.	.	314	(100)	1	(0.3)	137	(98)	3	(2.1)	153	(100)	.	.	197	(99)	1	(0.5)	370	(99)	4	(1.1)
	B13	101	(100)	.	.	77	(92)	7	(8.3)	93	(99)	1	(1.1)	48	(100)	.	.	49	(98)	1	(2)	50	(94)	3	(5.7)
	B14	38	(97)	1	(2.6)	29	(91)	3	(9.4)	43	(84)	8	(16)	32	(97)	1	(3)	35	(97)	1	(2.8)	38	(95)	2	(5)
	B17	.	.	.	.	64	(100)	.	.	48	(96)	2	(4)	.	.	.	.	100	(100)	.	.	88	(99)	1	(1.1)
	B18	16	(94)	1	(5.9)	49	(100)	.	.	44	(96)	2	(4.3)	4	(100)	.	.	5	(100)	.	.	2	(100)	.	.
Pacific	C04	185	(98)	3	(1.6)	176	(99)	2	(1.1)	442	(95)	21	(4.5)	130	(99)	1	(0.8)	109	(99)	1	(0.9)	243	(98)	6	(2.4)
	C08	.	.	.	.	5	(100)	.	.	147	(67)	74	(33)	.	.	.	.	13	(81)	3	(19)	177	(82)	40	(18)
	C19	25	(100)	.	.	13	(100)	.	.	14	(100)	.	.	109	(100)	.	.	127	(99)	1	(0.8)	106	(96)	4	(3.6)
AOD	D03	14	(100)	.	.	20	(100)	.	.	98	(95)	5	(4.9)	1	(100)	.	.	.	.	.	.	.	.	.	.
	D16	36	(100)	.	.	61	(97)	2	(3.2)	23	(96)	1	(4.2)	29	(100)	.	.	38	(93)	3	(7.3)	4	(100)	.	.

Table 14: Percentage of 'Last' sessions recorded for gambler clients

| Service | | 2010-11 | | | | | | 2011-12 | | | | | | 2013-13 | | | | | |
| | | % Ongoing | | | % Complete | | | % Ongoing | | | % Complete | | | % Ongoing | | | % Complete | | |
		0	1	2+	0	1	2+	0	1	2+	0	1	2+	0	1	2+	0	1	2+
General	A01	100	.	.	72	28	.	100	.	.	63	37	.	84	16	.	58	42	.
	A02	37	29	34	14	70	17	68	25	7	36	55	10	77	21	3	66	32	1
	A11	20	5	75	5	56	39	83	12	5	34	64	2	100	.	.	98	2	.
	A15	41	18	41	7	74	19	90	3	8	1	95	4	98	2	.	43	57	.
Māori	B05	24	23	54	3	71	26	36	32	32	10	74	16	67	28	4	13	84	3
	B06	13	70	17	7	70	23	73	24	3	4	80	16	67	32	1	63	38	.
	B07	11	33	56	1	97	2	72	17	11	7	87	6	68	26	5	48	52	.
	B09	38	35	26	2	94	4	90	8	3	63	35	2	99	1	.	100	.	.
	B10	48	24	28	14	64	21	63	32	5	93	7	.	90	5	6	88	9	3
	B12	14	30	57	5	69	27	84	12	5	4	90	7	36	61	4	16	81	4
	B13	30	38	32	3	90	8	65	23	12	54	34	12	70	26	5	81	19	.
	B14	30	33	37	30	42	28	72	21	7	32	58	11	53	40	7	30	68	2
	B17	100	.	.	.	.	.	92	.	8	82	18	.	100	.	.	100	.	.
	B18	36	64	.	35	41	24	76	19	5	33	55	12	41	53	6	28	62	10
Pacific	C04	17	59	23	14	62	24	19	40	42	5	63	32	46	46	8	21	71	8
	C08	42	47	11	.	.	.	93	7	.	71	29	.	95	5	.	96	4	.
	C19	.	.	100	.	92	8	100	.	.	38	54	8	100	.	.	100	.	.
AOD	D03	37	8	55	.	18	82	75	5	20	.	65	35	98	2	.	41	57	3
	D16	30	19	52	13	61	27	58	33	8	11	70	19	100	.	.	59	41	.

Service		Gambler										Significant other								
		2010-1			2011-2			2012-3			2010-1			2011-2			2012-3		
		Min	Ave	Max	Min	Ave	Max	Min	Ave	Max	Min	Ave	Max	Min	Ave	Max	Min	Ave	Max
General	A01	1	1.0	2	1	1.0	1	1	1.0	2	1	1.0	1	1	1.0	1	1	1.0	1
	A02	1	1.0	3	1	1.0	2	1	1.0	2	1	1.0	2	1	1.0	2	1	1.0	3
	A11	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	A15	.	.	.	.	.	.	.	1.0	.	.	.	.	.	.	.	.	.	.
Māori	B05	1	1.0	3	1	1.0	2	1	1.0	2	1	1.0	3	1	1.1	3	1	1.0	2
	B06	1	2.5	3	1	2.5	3	1	1.9	3	2	2.7	3	1	2.7	3	1	1.8	3
	B07	1	1.0	2	1	1.0	1	1	1.0	2	1	1.0	2	1	1.0	2	1	1.1	2
	B09	1	1.0	1	1	1.0	2	1	1.0	1	1	1.0	1	1	1.0	1	1	1.0	1
	B10	1	1.0	2	1	1.0	1	1	1.0	1	1	1.0	1	1	1.0	1	1	1.0	1
	B12	1	1.2	2	1	1.0	2	1	1.0	1	1	1.4	2	1	1.0	1	1	1.0	2
	B13	1	1.0	1	1	1.0	1	1	1.0	1	1	1.0	1	1	1.0	1	1	1.0	1
	B14	1	1.1	2	1	1.1	2	1	1.2	2	1	1.1	2	1	1.1	2	1	1.0	1
	B17	.	.	.	1	1.0	2	1	1.0	1	.	.	.	1	1.0	2	1	1.0	1
	B18	1	1.2	3	1	1.0	1	1	1.0	1	1	1.0	1	1	1.0	1	1	1.0	1
Pacific	C04	1	1.1	3	1	1.1	3	1	1.0	3	1	1.0	2	1	1.0	3	1	1.0	1
	C08	1	2.5	3	1	1.5	3	1	1.8	3	2	2.8	3	1	2.4	3	1	1.4	3
	C19	1	1.0	2	1	1.0	1	1	1.1	2	1	1.0	1	1	1.0	2	1	1.1	3
AOD	D03	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	D16	1	1.0	2	1	1.1	3	1	1.1	2	1	1.0	2	1	1.0	1	.	.	.

Table 16: Average time spent (hour) per session for Brief Interventions, Full Interventions, Facilitation Services and Follow-up Services

Service		Brief Intervention						Full Intervention						Facilitation Services						Follow-up Services					
		Gambler			Significant Other			Gambler			Significant Other			Gambler			Significant Other			Gambler			Significant Other		
		2010-1	2011-2	2012-3	2010-1	2011-2	2012-3	2010-1	2011-2	2012-3	2010-1	2011-2	2012-3	2010-1	2011-2	2012-3	2010-1	2011-2	2012-3	2010-1	2011-2	2012-3	2010-1	2011-2	2012-3
General	A01	0.3	0.3	0.3	0.3	0.3	0.3	1.1	1.1	1.1	1.2	1.4	1.1	0.8	0.7	0.7	0.6	0.6	0.7	0.5	0.5	0.5	0.5	0.5	0.5
	A02	0.3	0.3	0.3	0.3	0.3	0.3	1	1	1	1.1	1.1	1.2	0.8	0.8	0.6	0.8	0.9	0.3	0.3	0.3	0.3	0.3	0.3	0.3
	A11	.	.	.	.	.	.	2.8	2.3	3.1	3.6	3.1	4	.	.	.	.	.	.	0.3	0.3	0.3	0.3	0.3	0.3
	A15	.	.	.	.	.	.	0.4	0.4	0.4	0.4	0.5	0.5	0.3	.	0.3	.	.	.	0.4	0.3	0.3	0.3	0.4	.
Māori	B05	0.4	0.5	0.4	0.4	0.5	0.5	1.1	1.1	0.8	1	1	0.9	0.7	1.5	1.1	0.8	0.9	1.1	0.4	0.4	0.4	0.4	0.4	0.4
	B06	0.4	0.4	0.3	0.4	0.3	0.3	1.4	0.8	1.6	1.1	1.2	1.6	0.9	1.4	0.9	0.9	1	0.3	0.5	0.4	0.3	0.5	0.4	0.3
	B07	0.3	0.3	0.3	0.3	0.3	0.4	1.1	1.8	1.2	1.3	1.1	1.1	0.9	1.4	0.6	1	0.6	0.8	0.3	0.3	0.3	0.3	0.3	0.3
	B09	0.3	0.3	0.3	0.3	0.3	0.3	0.9	1	1	0.9	1	1	0.5	0.5	0.8	0.5	0.3	1.1	0.4	0.3	0.3	0.3	0.3	0.3
	B10	0.4	0.4	0.3	0.3	0.3	0.3	0.7	1.3	1.1	1.2	1.2	1.2	0.7	1.6	2	1.2	1.7	1.8	0.4	0.5	0.4	0.9	0.4	0.3
	B12	0.4	0.3	0.3	0.5	0.3	0.3	0.8	0.9	0.8	1	0.9	0.9	1	0.8	0.7	0.9	0.7	0.9	0.3	0.3	0.3	0.3	0.3	0.3
	B13	0.4	0.4	0.3	0.4	0.4	0.3	0.8	0.9	0.9	0.9	0.9	0.9	0.3	0.3	0.3	0.4	0.3	0.3	0.5	0.5	0.3	0.7	0.3	0.3
	B14	0.5	0.3	0.3	0.4	0.4	0.3	0.9	0.8	0.7	0.9	0.8	0.9	0.9	0.7	0.8	0.6	0.7	0.8	0.4	0.4	0.4	0.3	0.4	0.4
	B17	.	0.3	0.3	.	0.3	0.3	1	0.9	1.2	.	0.8	1.2	.	1.9	1.4	.	1.8	1.4	.	0.4	0.4	.	0.4	0.4
	B18	0.3	0.3	0.3	0.4	0.3	0.3	0.5	0.7	0.7	0.6	0.5	0.6	0.7	0.7	0.3	0.3	.	.	0.4	0.3	0.3	.	0.3	.
Pacific	C04	0.3	0.3	0.3	0.3	0.3	0.3	0.6	0.7	0.6	0.6	0.7	0.6	0.4	0.5	0.3	0.4	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.3
	C08	0.5	0.4	0.4	0.5	0.4	0.4	0.7	1.1	1.4	0.8	0.7	1.4	1	1.1	1.5	1	1.1	1.8	1	0.5	0.4	.	0.6	0.3
	C19	0.3	0.3	0.3	0.3	0.3	0.3	1	0.8	0.8	.	0.8	0.6	0.5	0.6	1.3	.	0.9	1.1	0.5	0.5	0.4	.	0.5	0.5
AOD	D03	.	.	.	.	.	.	1.8	1.7	1.4	0.7	1.1	.	1	2	2.8	.	0.3	.	0.4	0.3	0.3	0.4	1.1	0.3
	D16	0.5	0.4	0.4	0.6	0.3	.	1.3	1	0.9	1	1	1	1	0.9	1.1	0.8	1.2	1	0.6	0.4	0.3	0.5	0.3	0.5

Table 17: Number of Brief Gambler Screen score records for gambler clients within Brief Intervention sessions

Service		2010-1 0 No.	(%)	1 No.	(%)	2 No.	(%)	3+ No.	(%)	2011-2 0 No.	(%)	1 No.	(%)	2 No.	(%)	3+ No.	(%)	2012-3 0 No.	(%)	1 No.	(%)	2 No.	(%)	3+ No.	(%)
General	A01	.	.	1008	(100)	.	.	.	.	.	.	619	(100)	.	.	.	.	.	.	448	(100)	1	(0.22)	.	.
	A02	.	.	324	(100)	.	.	.	.	.	.	352	(99)	2	(0.56)	.	.	.	.	566	(99)	6	(1)	.	.
	A11	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	A15	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Māori	B05	.	.	106	(98)	2	(1.9)	.	.	.	.	100	(96)	4	(3.8)	.	.	.	.	229	(99)	2	(0.87)	.	.
	B06	1	(1.1)	20	(22)	70	(76)	1	(1.1)	1	(2)	33	(65)	16	(31)	1	(2)	.	.	64	(98)	1	(1.5)	.	.
	B07	.	.	84	(100)	.	.	.	.	.	.	72	(100)	.	.	.	.	.	.	82	(96)	3	(3.5)	.	.
	B09	.	.	207	(100)	.	.	.	.	.	.	252	(100)	.	.	.	.	.	.	190	(100)	.	.	.	.
	B10	.	.	141	(99)	1	(0.7)	.	.	.	.	81	(100)	.	.	.	.	.	.	91	(100)	.	.	.	.
	B12	.	.	101	(81)	23	(19)	.	.	.	.	146	(100)	.	.	.	.	.	.	57	(100)	.	.	.	.
	B13	.	.	117	(100)	.	.	.	.	.	.	81	(100)	.	.	.	.	.	.	73	(100)	.	.	.	.
	B14	.	.	29	(100)	.	.	.	.	.	.	16	(100)	.	.	.	.	.	.	16	(100)	.	.	.	.
	B17	.	.	.	.	.	.	.	.	.	.	72	(100)	.	.	.	.	.	.	24	(100)	.	.	.	.
	B18	.	.	12	(92)	1	(7.7)	.	.	.	.	35	(100)	.	.	.	.	.	.	19	(100)	.	.	.	.
Pacific	C04	1	(0.53)	180	(95)	8	(4.2)	.	.	1	(0.48)	208	(99)	1	(0.48)	.	.	2	(0.57)	341	(98)	3	(0.86)	2	(0.57)
	C08	.	.	6	(40)	8	(53)	1	(6.7)	.	.	56	(97)	2	(3.4)	.	.	.	.	100	(95)	5	(4.8)	.	.
	C19	.	.	23	(100)	.	.	.	.	.	.	11	(100)	.	.	.	.	.	.	10	(100)	.	.	.	.
AOD	D03	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	D16	.	.	36	(100)	.	.	.	.	.	.	33	(97)	1	(2.9)	.	.	.	.	6	(86)	1	(14)	.	.
Total		2	(0.08)	2394	(95)	113	(4.5)	2	(0.08)	2	(0.09)	2167	(99)	26	(1.2)	1	(0.05)	2	(0.09)	2316	(99)	22	(0.94)	2	(0.09)

Table 18: Number of Brief Gambler Screen score records for significant other clients within Brief Intervention sessions

| | | 2010-1 | | | | | | 2011-2 | | | | | | 2012-3 | | | |
| | | 0 | | 1 | | 2 | | 0 | | 1 | | 2 | | 0 | | 1 | |
Service		No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
General	A01	650	(100)	.	.	.	.	790	(100)	.	.	.	.	531	(100)	1	(0.19)
	A02	624	(76)	200	(24)	2	(0.24)	1048	(91)	107	(9.3)	.	.	1232	(98)	23	(1.8)
	A11	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	A15	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Māori	B05	337	(100)	1	(0.3)	.	.	246	(100)	1	(0.4)	.	.	533	(100)	1	(0.19)
	B06	31	(100)	.	.	.	.	35	(100)	.	.	.	.	90	(85)	16	(15)
	B07	255	(100)	.	.	.	.	266	(100)	1	(0.37)	.	.	314	(100)	.	.
	B09	30	(100)	.	.	.	.	16	(94)	1	(5.9)	.	.	161	(100)	.	.
	B10	210	(100)	.	.	.	.	364	(100)	1	(0.27)	.	.	249	(97)	9	(3.5)
	B12	1	(0.7)	81	(57)	60	(42)	78	(89)	10	(11)	.	.	226	(100)	.	.
	B13	55	(98)	1	(1.8)	.	.	46	(100)	.	.	.	.	39	(98)	1	(2.5)
	B14	11	(100)	.	.	.	.	7	(100)	.	.	.	.	11	(100)	.	.
	B17	.	.	.	.	.	.	101	(96)	4	(3.8)	.	.	64	(96)	3	(4.5)
	B18	3	(100)	.	.	.	.	4	(100)	.	.	.	.	2	(100)	.	.
Pacific	C04	29	(22)	101	(75)	4	(3)	3	(2.3)	128	(97)	1	(0.76)	165	(81)	38	(19)
	C08	16	(100)	.	.	.	.	76	(99)	1	(1.3)	.	.	74	(99)	1	(1.3)
	C19	110	(100)	.	.	.	.	130	(100)	.	.	.	.	109	(100)	.	.
AOD	D03	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	D16	24	(100)	.	.	.	.	33	(97)	1	(2.9)	.	.	.	.	.	.
Total		2386	(84)	384	(14)	66	(2.3)	3243	(93)	255	(7.3)	1	(0.03)	3800	(98)	93	(2.4)

Table 19: Initial Brief Gambler Screen scores reported for gamblers within Brief Intervention sessions

		2010-1								2011-2								2012-3							
		0		1		2		4		0		1		2		4		0		1		2		4	
Service		No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
General	A01	22	(1.8)	524	(44)	210	(18)	157	(13)	277	(23)	9	(1.2)	368	(49)	150	(20)	10	(1.8)	240	(43)	147	(26)	100	(18)
	A02	18	(5.5)	70	(21)	60	(18)	91	(28)	87	(27)	7	(2)	97	(27)	62	(18)	28	(4.9)	136	(24)	90	(16)	154	(27)
	A11	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	A15	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	16	(20)	8	(9.9)	13	(16)	24	(30)
Māori	B05	15	(13)	19	(17)	16	(14)	26	(23)	38	(33)	2	(1.9)	19	(18)	25	(23)	1	(0.4)	51	(22)	26	(11)	78	(34)
	B06	.	.	91	(100)	.	.	.	.	.	.	.	.	50	(98)	1	(2)	2	(2.9)	63	(93)	1	(1.5)	2	(2.9)
	B07	.	.	7	(8.3)	8	(9.5)	32	(38)	37	(44)	1	(1.3)	20	(26)	27	(36)	3	(3.5)	5	(5.9)	38	(45)	18	(21)
	B09	42	(20)	70	(33)	54	(26)	27	(13)	16	(7.7)	105	(42)	67	(26)	58	(23)	1	(0.5)	41	(21)	61	(32)	66	(35)
	B10	2	(1.4)	6	(4.1)	26	(18)	66	(45)	47	(32)	24	(28)	10	(12)	21	(25)	35	(32)	22	(20)	18	(16)	14	(13)
	B12	85	(66)	22	(17)	7	(5.5)	13	(10)	1	(0.8)	12	(7.7)	137	(88)	6	(3.9)	.	.	10	(18)	30	(53)	15	(26)
	B13	15	(13)	33	(28)	38	(32)	30	(26)	1	(0.9)	5	(6)	16	(19)	32	(39)	10	(14)	14	(19)	13	(18)	36	(49)
	B14	.	.	2	(6.7)	.	.	13	(43)	15	(50)	.	.	.	.	2	(12)	.	.	.	.	8	(50)	4	(25)
	B17	.	.	.	.	.	.	.	.	.	.	6	(8.2)	8	(11)	46	(63)	.	.	12	(38)	16	(50)	3	(9.4)
	B18	.	.	4	(31)	1	(7.7)	7	(54)	1	(7.7)	.	.	7	(18)	5	(13)	.	.	.	.	2	(11)	9	(47)
Pacific	C04	27	(13)	113	(53)	44	(21)	16	(7.5)	13	(6.1)	10	(4.6)	102	(47)	70	(32)	2	(0.6)	159	(44)	118	(33)	52	(14)
	C08	.	.	15	(100)	.	.	.	.	.	.	.	.	58	(100)	.	.	.	.	105	(100)	.	.	.	.
	C19	4	(16)	7	(28)	7	(28)	6	(24)	1	(4)	5	(42)	3	(25)	3	(25)	.	.	8	(80)	1	(10)	.	.
AOD	D03	.	.	.	.	1	(100)	.	.	.	.	2	(25)	2	(25)	.	.	11	(69)	1	(6.3)	.	.	.	.
	D16	3	(8.3)	7	(19)	5	(14)	12	(33)	9	(25)	2	(5.9)	5	(15)	8	(24)	.	.	1	(14)	4	(57)	2	(29)
Total		233	(8.5)	990	(36)	477	(17)	496	(18)	543	(20)	190	(8)	969	(41)	516	(22)	119	(4.6)	876	(34)	586	(23)	577	(22)

Table 20: Number of Brief Family/Affected Other Screen score records for significant other clients within Brief Intervention sessions

Service		Q1 0 N	(%)	Q1 1 N	(%)	Q1 2 N	(%)	Q1 3+ N	(%)	Q2 0 N	(%)	Q2 1 N	(%)	Q2 2 N	(%)	Q2 3+ N	(%)
							Question 1 - Awareness of effect						Question 2 - Effect of gambler's gambling				
2010-1																	
General	A01	.	.	650	(100)	.	.	.	.	.	.	650	(100)	.	.	.	
	A02	.	.	824	(100)	2	(0.24)	.	.	.	.	824	(100)	2	(0.24)	.	
	A11	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	
	A15	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	
Māori	B05	.	.	334	(99)	3	(0.89)	1	(0.3)	.	.	334	(99)	3	(0.89)	1	(0.3)
	B06	.	.	5	(16)	26	(84)	.	.	.	.	5	(16)	26	(84)	.	.
	B07	.	.	251	(98)	4	(1.6)	.	.	.	.	251	(98)	4	(1.6)	.	.
	B09	.	.	30	(100)	.	.	.	.	.	.	30	(100)	.	.	.	.
	B10	.	.	210	(100)	.	.	.	.	.	.	210	(100)	.	.	.	.
	B12	.	.	82	(58)	60	(42)	.	.	.	.	82	(58)	60	(42)	.	.
	B13	.	.	56	(100)	.	.	.	.	.	.	56	(100)	.	.	.	.
	B14	.	.	11	(100)	.	.	.	.	.	.	11	(100)	.	.	.	.
	B17	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	B18	.	.	3	(100)	.	.	.	.	.	.	3	(100)	.	.	.	.
Pacific	C04	.	.	130	(97)	4	(3)	.	.	.	.	130	(97)	4	(3)	.	.
	C08	.	.	1	(6.3)	15	(94)	.	.	.	.	1	(6.3)	15	(94)	.	.
	C19	.	.	110	(100)	.	.	.	.	.	.	110	(100)	.	.	.	.
AOD	D03	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	D16	.	.	23	(96)	1	(4.2)	.	.	.	.	23	(96)	1	(4.2)	.	.
Total		.	.	2720	(96)	115	(4.1)	1	(0.04)	.	.	2720	(96)	115	(4.1)	1	(0.04)
2011-2																	
General	A01	.	.	790	(100)	.	.	.	.	.	.	790	(100)	.	.	.	.
	A02	.	.	1154	(100)	1	(0.09)	.	.	.	.	1154	(100)	1	(0.09)	.	.
	A11	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	A15	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Māori	B05	.	.	235	(95)	11	(4.5)	1	(0.4)	.	.	235	(95)	11	(4.5)	1	(0.4)
	B06	.	.	20	(57)	15	(43)	.	.	.	.	20	(57)	15	(43)	.	.
	B07	.	.	259	(97)	8	(3)	.	.	.	.	259	(97)	8	(3)	.	.
	B09	.	.	17	(100)	.	.	.	.	.	.	17	(100)	.	.	.	.
	B10	.	.	365	(100)	.	.	.	.	.	.	365	(100)	.	.	.	.
	B12	.	.	88	(100)	.	.	.	.	.	.	88	(100)	.	.	.	.
	B13	.	.	46	(100)	.	.	.	.	.	.	46	(100)	.	.	.	.
	B14	.	.	7	(100)	.	.	.	.	.	.	7	(100)	.	.	.	.
	B17	.	.	103	(98)	2	(1.9)	.	.	.	.	103	(98)	2	(1.9)	.	.
	B18	.	.	4	(100)	.	.	.	.	.	.	4	(100)	.	.	.	.
Pacific	C04	.	.	131	(99)	1	(0.76)	.	.	.	.	131	(99)	1	(0.76)	.	.
	C08	.	.	60	(78)	17	(22)	.	.	.	.	60	(78)	17	(22)	.	.
	C19	.	.	128	(98)	2	(1.5)	.	.	.	.	128	(98)	2	(1.5)	.	.
AOD	D03	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	D16	.	.	34	(100)	.	.	.	.	.	.	34	(100)	.	.	.	.
Total		.	.	3441	(98)	57	(1.6)	1	(0.03)	.	.	3441	(98)	57	(1.6)	1	(0.03)
2012-3																	
General	A01	.	.	532	(100)	.	.	.	.	.	.	532	(100)	.	.	.	.
	A02	.	.	1250	(100)	5	(0.4)	.	.	.	.	1250	(100)	5	(0.4)	.	.
	A11	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	A15	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Māori	B05	.	.	528	(99)	6	(1.1)	.	.	.	.	528	(99)	6	(1.1)	.	.
	B06	.	.	105	(99)	1	(0.94)	.	.	.	.	105	(99)	1	(0.94)	.	.
	B07	1	(0.32)	298	(95)	15	(4.8)	.	.	1	(0.32)	298	(95)	15	(4.8)	.	.
	B09	.	.	161	(100)	.	.	.	.	.	.	161	(100)	.	.	.	.
	B10	.	.	258	(100)	.	.	.	.	.	.	258	(100)	.	.	.	.
	B12	.	.	225	(100)	1	(0.44)	.	.	.	.	225	(100)	1	(0.44)	.	.
	B13	.	.	40	(100)	.	.	.	.	.	.	40	(100)	.	.	.	.
	B14	.	.	11	(100)	.	.	.	.	.	.	11	(100)	.	.	.	.
	B17	.	.	67	(100)	.	.	.	.	.	.	67	(100)	.	.	.	.
	B18	.	.	2	(100)	.	.	.	.	.	.	2	(100)	.	.	.	.
Pacific	C04	.	.	203	(100)	.	.	.	.	.	.	203	(100)	.	.	.	.
	C08	.	.	74	(99)	1	(1.3)	.	.	.	.	74	(99)	1	(1.3)	.	.
	C19	.	.	102	(94)	6	(5.5)	1	(0.92)	.	.	102	(94)	6	(5.5)	1	(0.92)
AOD	D03	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	D16	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Total		1	(0.03)	3856	(99)	35	(0.9)	1	(0.03)	1	(0.03)	3856	(99)	35	(0.9)	1	(0.03)

Table 21: Number of Brief Family/Affected Other Screen score records for gambler clients within Brief Intervention sessions

		Question 1 - Awareness of effect						Question 2 - Effect of gambler's gambling					
		0		**1**		**2**		**0**		**1**		**2**	
		N	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**
Service													
2010-1													
General	A01	1007	(100)	1	(0.1)	.	.	1007	(100)	1	(0.1)	.	.
	A02	150	(46)	174	(54)	.	.	167	(52)	157	(48)	.	.
	A11	.	.	.	.	.	.	.	.	.	.	.	.
	A15	.	.	.	.	.	.	.	.	.	.	.	.
Māori	B05	108	(100)	.	.	.	.	108	(100)	.	.	.	.
	B06	92	(100)	.	.	.	.	92	(100)	.	.	.	.
	B07	84	(100)	.	.	.	.	82	(98)	2	(2.4)	.	.
	B09	207	(100)	.	.	.	.	207	(100)	.	.	.	.
	B10	140	(99)	2	(1.4)	.	.	140	(99)	2	(1.4)	.	.
	B12	6	(4.8)	101	(81)	17	(14)	9	(7.3)	100	(81)	15	(12)
	B13	116	(99)	1	(0.85)	.	.	116	(99)	1	(0.85)	.	.
	B14	29	(100)	.	.	.	.	29	(100)	.	.	.	.
	B17	.	.	.	.	.	.	.	.	.	.	.	.
	B18	13	(100)	.	.	.	.	13	(100)	.	.	.	.
Pacific	C04	46	(24)	138	(73)	5	(2.6)	45	(24)	139	(74)	5	(2.6)
	C08	15	(100)	.	.	.	.	15	(100)	.	.	.	.
	C19	23	(100)	.	.	.	.	23	(100)	.	.	.	.
AOD	D03	.	.	.	.	.	.	.	.	.	.	.	.
	D16	36	(100)	.	.	.	.	36	(100)	.	.	.	.
Total		2072	(83)	417	(17)	22	(0.88)	2089	(83)	402	(16)	20	(0.8)
2011-2													
General	A01	619	(100)	.	.	.	.	618	(100)	1	(0.16)	.	.
	A02	258	(73)	95	(27)	1	(0.28)	259	(73)	94	(27)	1	(0.28)
	A11	.	.	.	.	.	.	.	.	.	.	.	.
	A15	.	.	.	.	.	.	.	.	.	.	.	.
Māori	B05	103	(99)	1	(0.96)	.	.	103	(99)	1	(0.96)	.	.
	B06	51	(100)	.	.	.	.	51	(100)	.	.	.	.
	B07	72	(100)	.	.	.	.	72	(100)	.	.	.	.
	B09	252	(100)	.	.	.	.	252	(100)	.	.	.	.
	B10	80	(99)	1	(1.2)	.	.	80	(99)	1	(1.2)	.	.
	B12	8	(5.5)	138	(95)	.	.	8	(5.5)	138	(95)	.	.
	B13	81	(100)	.	.	.	.	81	(100)	.	.	.	.
	B14	16	(100)	.	.	.	.	16	(100)	.	.	.	.
	B17	71	(99)	1	(1.4)	.	.	72	(100)	.	.	.	.
	B18	34	(97)	1	(2.9)	.	.	35	(100)	.	.	.	.
Pacific	C04	31	(15)	178	(85)	1	(0.48)	27	(13)	182	(87)	1	(0.48)
	C08	57	(98)	.	.	1	(1.7)	57	(98)	.	.	1	(1.7)
	C19	10	(91)	1	(9.1)	.	.	11	(100)	.	.	.	.
AOD	D03	.	.	.	.	.	.	.	.	.	.	.	.
	D16	33	(97)	1	(2.9)	.	.	34	(100)	.	.	.	.
Total		1776	(81)	417	(19)	3	(0.14)	1776	(81)	417	(19)	3	(0.14)
2012-3													
General	A01	449	(100)	.	.	.	.	449	(100)	.	.	.	.
	A02	454	(79)	115	(20)	3	(0.52)	456	(80)	113	(20)	3	(0.52)
	A11	.	.	.	.	.	.	.	.	.	.	.	.
	A15	.	.	.	.	.	.	.	.	.	.	.	.
Māori	B05	228	(99)	3	(1.3)	.	.	228	(99)	3	(1.3)	.	.
	B06	63	(97)	2	(3.1)	.	.	63	(97)	2	(3.1)	.	.
	B07	85	(100)	.	.	.	.	85	(100)	.	.	.	.
	B09	190	(100)	.	.	.	.	190	(100)	.	.	.	.
	B10	91	(100)	.	.	.	.	91	(100)	.	.	.	.
	B12	57	(100)	.	.	.	.	57	(100)	.	.	.	.
	B13	72	(99)	1	(1.4)	.	.	72	(99)	1	(1.4)	.	.
	B14	16	(100)	.	.	.	.	16	(100)	.	.	.	.
	B17	24	(100)	.	.	.	.	24	(100)	.	.	.	.
	B18	19	(100)	.	.	.	.	19	(100)	.	.	.	.
Pacific	C04	300	(86)	47	(14)	1	(0.29)	301	(86)	46	(13)	1	(0.29)
	C08	104	(99)	1	(0.95)	.	.	104	(99)	1	(0.95)	.	.
	C19	10	(100)	.	.	.	.	10	(100)	.	.	.	.
AOD	D03	.	.	.	.	.	.	.	.	.	.	.	.
	D16	7	(100)	.	.	.	.	7	(100)	.	.	.	.
Total		2169	(93)	169	(7.2)	4	(0.17)	2172	(93)	166	(7.1)	4	(0.17)

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Table 22: Initial Brief Family/Affected Other Screen scores (Question 1 - Awareness of the effect of the gambler's gambling) reported for significant other clients within Brief Interventions

Service		2010-1 0 N	(%)	1 N	(%)	2 N	(%)	3 N	(%)	2011-2 0 N	(%)	1 N	(%)	2 N	(%)	3 N	(%)	2012-3 0 N	(%)	1 N	(%)	2 N	(%)	3 N	(%)
General	A01	23	(3.2)	213	(30)	164	(23)	315	(44)	26	(3.1)	302	(36)	238	(29)	267	(32)	21	(3.4)	285	(47)	148	(24)	158	(26)
	A02	57	(6.9)	85	(10)	388	(47)	297	(36)	11	(1)	58	(5)	539	(47)	547	(47)	10	(0.8)	82	(6.5)	607	(48)	555	(44)
	A11	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	A15	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Māori	B05	33	(9.7)	52	(15)	150	(44)	105	(31)	.	.	73	(29)	95	(38)	81	(33)	9	(1.7)	92	(17)	319	(60)	110	(21)
	B06	.	.	5	(16)	8	(26)	18	(58)	.	.	13	(37)	6	(17)	16	(46)	1	(0.9)	44	(42)	47	(44)	14	(13)
	B07	.	.	91	(36)	108	(42)	56	(22)	.	.	30	(11)	113	(42)	125	(47)	.	.	.	.	84	(27)	229	(73)
	B09	.	.	7	(23)	11	(37)	12	(40)	.	.	15	(88)	2	(12)	.	.	7	(4.3)	111	(69)	26	(16)	17	(11)
	B10	1	(0.5)	4	(1.9)	78	(37)	130	(61)	21	(5.7)	13	(3.6)	101	(28)	231	(63)	5	(1.9)	31	(12)	97	(37)	126	(49)
	B12	38	(27)	105	(73)	.	.	.	.	6	(6.6)	61	(67)	24	(26)	.	.	11	(4.9)	130	(58)	50	(22)	35	(15)
	B13	1	(1.8)	11	(20)	28	(50)	16	(29)	1	(2.1)	11	(23)	14	(29)	22	(46)	2	(4.8)	13	(31)	9	(21)	18	(43)
	B14	.	.	.	.	4	(33)	8	(67)	.	.	.	.	6	(67)	3	(33)	.	.	.	.	8	(73)	3	(27)
	B17	.	.	.	.	.	.	.	.	3	(2.8)	68	(64)	34	(32)	1	(0.9)	.	.	47	(69)	17	(25)	4	(5.9)
	B18	.	.	.	.	.	.	3	(100)	.	.	.	.	1	(25)	3	(75)	.	.	.	.	.	.	2	(100)
Pacific	C04	43	(31)	38	(27)	34	(24)	25	(18)	19	(14)	42	(31)	36	(26)	39	(29)	2	(1)	116	(57)	16	(7.8)	70	(34)
	C08	.	.	.	.	.	.	16	(100)	.	.	6	(7.7)	19	(24)	53	(68)	.	.	26	(35)	28	(37)	21	(28)
	C19	1	(0.9)	30	(27)	67	(61)	12	(11)	.	.	30	(23)	36	(28)	64	(49)	.	.	105	(98)	1	(0.9)	1	(0.9)
AOD	D03	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	D16	.	.	2	(8.3)	14	(58)	8	(33)	.	.	4	(12)	15	(44)	15	(44)	.	.	.	.	.	.	.	.
Total		197	(6.8)	643	(22)	1054	(36)	1021	(35)	87	(2.4)	726	(20)	1279	(36)	1467	(41)	68	(1.7)	1082	(27)	1457	(37)	1363	(34)

Table 23: Initial Brief Family/Affected Other Screen scores (Question 2 - Effect of gambler's gambling) reported for significant other clients within Brief Interventions

Service		0 N	(%)	1 N	(%)	2 N	(%)	3 N	(%)	4 N	(%)	5 N	(%)	6 N	(%)
2010-1															
General	A01	115	(16)	165	(23)	97	(14)	173	(24)	92	(13)	28	(4)	38	(5.4)
	A02	282	(34)	242	(29)	144	(17)	92	(11)	41	(4.9)	17	(2)	12	(1.4)
	A11														
	A15														
Māori	B05	112	(33)	148	(44)	38	(11)	13	(3.8)	9	(2.6)	3	(0.9)	17	(5)
	B06	.	.	9	(29)	.	.	.	.	7	(23)	7	(23)	8	(26)
	B07	50	(20)	97	(38)	10	(3.9)	17	(6.7)	8	(3.1)	13	(5.1)	60	(24)
	B09	.	.	15	(50)	11	(37)	3	(10)	.	.	1	(3.3)	.	.
	B10	15	(7)	52	(24)	68	(32)	46	(22)	18	(8.5)	5	(2.3)	9	(4.2)
	B12	99	(69)	44	(31)	.	.	.	.	.	.	.	.	.	.
	B13	6	(11)	30	(54)	16	(29)	.	.	3	(5.4)	1	(1.8)	.	.
	B14	.	.	2	(17)	3	(25)	5	(42)	1	(8.3)	1	(8.3)	.	.
	B17	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	B18	.	.	1	(33)	.	.	1	(33)	1	(33)	.	.	.	.
Pacific	C04	27	(19)	86	(61)	17	(12)	5	(3.5)	3	(2.1)	.	.	4	(2.8)
	C08	.	.	2	(13)	.	.	6	(38)	2	(13)	6	(38)	.	.
	C19	27	(25)	36	(33)	5	(4.5)	35	(32)	4	(3.6)	.	.	3	(2.7)
AOD	D03														
	D16	4	(17)	5	(21)	10	(42)	1	(4.2)	1	(4.2)	.	.	3	(13)
Total		737	(25)	934	(32)	419	(14)	397	(14)	190	(6.5)	82	(2.8)	154	(5.3)
2011-2															
General	A01	211	(25)	189	(22)	158	(18)	165	(19)	36	(4.2)	8	(0.9)	93	(11)
	A02	346	(30)	350	(30)	267	(23)	131	(11)	31	(2.7)	13	(1.1)	18	(1.6)
	A11														
	A15														
Māori	B05	33	(13)	129	(52)	32	(13)	16	(6.4)	7	(2.8)	7	(2.8)	25	(10)
	B06	1	(2.9)	5	(14)	.	.	5	(14)	.	.	8	(23)	16	(46)
	B07	84	(31)	118	(44)	11	(4.1)	6	(2.2)	4	(1.5)	.	.	45	(17)
	B09	.	.	13	(76)	4	(24)	.	.	.	.	.	.	.	.
	B10	47	(13)	38	(10)	62	(17)	96	(26)	67	(18)	31	(8.5)	25	(6.8)
	B12	2	(2.2)	81	(89)	8	(8.8)	.	.	.	.	.	.	.	.
	B13	7	(15)	30	(63)	7	(15)	.	.	3	(6.3)	1	(2.1)	.	.
	B14	.	.	1	(11)	4	(44)	3	(33)	1	(11)	.	.	.	.
	B17	2	(1.9)	63	(59)	40	(38)	1	(0.9)	.	.	.	.	.	.
	B18	.	.	1	(25)	.	.	.	.	1	(25)	1	(25)	1	(25)
Pacific	C04	37	(27)	79	(58)	13	(9.6)	4	(2.9)	2	(1.5)	.	.	1	(0.7)
	C08	2	(2.6)	13	(17)	2	(2.6)	4	(5.1)	14	(18)	32	(41)	11	(14)
	C19	21	(16)	37	(28)	8	(6.2)	24	(18)	.	.	.	.	40	(31)
AOD	D03														
	D16	6	(18)	9	(26)	8	(24)	4	(12)	2	(5.9)	1	(2.9)	4	(12)
Total		799	(22)	1156	(32)	624	(17)	459	(13)	168	(4.7)	102	(2.8)	279	(7.8)
2012-13															
General	A01	160	(26)	204	(33)	89	(14)	43	(7)	14	(2.3)	4	(0.6)	103	(17)
	A02	368	(29)	392	(31)	339	(27)	103	(8.2)	31	(2.5)	12	(1)	10	(0.8)
	A11														
	A15														
Māori	B05	283	(53)	96	(18)	16	(3)	17	(3.2)	24	(4.5)	56	(11)	38	(7.2)
	B06	2	(1.9)	67	(63)	4	(3.8)	.	.	2	(1.9)	3	(2.8)	28	(26)
	B07	42	(13)	187	(60)	24	(7.7)	16	(5.1)	.	.	11	(3.5)	33	(11)
	B09	.	.	71	(44)	55	(34)	27	(17)	6	(3.7)	.	.	2	(1.2)
	B10	13	(4.9)	50	(19)	41	(16)	52	(20)	37	(14)	16	(6.1)	54	(21)
	B12	57	(25)	127	(56)	41	(18)	1	(0.4)	.	.	.	.	.	.
	B13	15	(36)	10	(24)	4	(9.5)	4	(9.5)	5	(12)	4	(9.5)	.	.
	B14	.	.	2	(18)	7	(64)	2	(18)	.	.	.	.	.	.
	B17	.	.	47	(69)	17	(25)	4	(5.9)	.	.	.	.	.	.
	B18	.	.	.	.	.	.	.	.	1	(50)	.	.	1	(50)
Pacific	C04	30	(14)	146	(70)	13	(6.3)	6	(2.9)	1	(0.5)	1	(0.5)	11	(5.3)
	C08	1	(1.3)	26	(35)	3	(4)	.	.	.	.	14	(19)	31	(41)
	C19	.	.	104	(97)	3	(2.8)	.	.	.	.	.	.	.	.
AOD	D03														
	D16	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Total		971	(24)	1529	(38)	656	(16)	275	(6.9)	121	(3)	121	(3)	311	(7.8)

Table 24: Minimum, average, and maximum number of Full Intervention sessions per client

		Gambler									Significant other								
		2010-1			2011-2			2012-3			2010-1			2011-2			2012-3		
Service		Min	Ave	Max	Min	Ave	Max	Min	Ave	Max	Min	Ave	Max	Min	Ave	Max	Min	Ave	Max
General	A01	1	5.3	66	1	4.9	61	1	4.8	42	1	4.8	44	1	4.9	112	1	3.6	56
	A02	1	7.5	92	1	7.1	100	1	7.6	85	1	5.6	40	1	6.7	98	1	7.8	115
	A11	1	4.7	21	1	4.2	29	1	3.6	16	1	3.2	12	1	3.0	25	1	2.3	16
	A15	1	4.1	11	1	2.5	10	1	1.9	10	3	5.5	8	1	1.3	4	1	1.0	1
Māori	B05	1	6.0	51	1	7.2	49	1	8.8	55	1	4.5	20	1	4.5	15	1	5.8	24
	B06	1	5.9	24	1	6.4	37	1	5.3	23	1	4.6	10	1	5.6	17	1	4.5	20
	B07	1	11.8	27	1	11.7	47	1	5.2	16	1	10.0	39	1	8.6	40	1	6.0	14
	B09	1	12.9	31	1	12.8	37	1	11.2	49	1	11.3	22	2	6.3	12	1	11.8	28
	B10	1	2.2	10	1	8.0	33	1	7.3	23	1	5.2	13	1	4.7	12	1	4.4	19
	B12	1	1.7	30	1	1.6	14	1	2.5	26	1	1.1	3	1	1.0	2	1	1.0	2
	B13	1	6.5	37	1	6.5	30	1	5.6	32	1	8.9	32	1	8.3	28	1	4.5	20
	B14	1	3.6	35	1	3.2	23	1	4.0	18	1	2.2	20	1	2.2	10	1	2.2	8
	B17	1	1.0	1	1	2.1	8	1	2.4	6	.	.	.	1	1.5	7	1	1.7	5
	B18	1	7.0	31	1	3.9	14	1	4.9	17	2	10.3	19	1	1.8	4	1	1.0	1
Pacific	C04	1	5.5	39	1	5.0	23	1	4.5	23	1	5.8	20	1	5.6	18	1	4.6	20
	C08	1	6.8	18	1	4.6	10	1	3.9	19	1	8.7	14	1	5.3	13	1	4.1	14
	C19	1	3.7	9	2	4.8	8	2	9.8	33	.	.	.	3	7.0	11	6	9.4	13
AOD	D03	1	46.2	191	1	31.9	176	1	53.0	182	5	5.0	5	5	13.5	22	.	.	.
	D16	1	8.9	48	1	4.9	19	1	3.3	11	1	3.4	12	1	2.5	6	1	2.5	4

Table 25: Number of Gambler Harm Screen score records for gambler clients within Full Intervention

		2010-1 0		1		2		3+		2011-2 0		1		2		3+		2012-3 0		1		2		3+	
Service		**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**
General	A01	306	(31)	655	(66)	25	(2.5)	3	(0.3)	518	(40)	742	(58)	20	(1.6)	1	(0.08)	525	(36)	814	(56)	85	(5.8)	30	(2.1)
	A02	45	(14)	236	(75)	30	(9.6)	2	(0.64)	123	(27)	308	(67)	25	(5.4)	5	(1.1)	106	(21)	346	(69)	39	(7.8)	10	(2)
	A11	11	(11)	88	(86)	3	(2.9)	.	.	20	(16)	96	(79)	6	(4.9)	.	.	27	(25)	78	(73)	2	(1.9)	.	.
	A15	.	.	30	(97)	1	(3.2)	.	.	13	(5.8)	212	(94)	1	(0.44)	.	.	10	(5.8)	153	(88)	9	(5.2)	1	(0.58)
Māori	B05	37	(56)	19	(29)	8	(12)	2	(3)	18	(22)	56	(67)	8	(9.6)	1	(1.2)	36	(38)	49	(52)	8	(8.5)	1	(1.1)
	B06	78	(81)	10	(10)	7	(7.3)	1	(1)	41	(50)	31	(38)	7	(8.5)	3	(3.7)	127	(80)	24	(15)	7	(4.4)	1	(0.63)
	B07	2	(50)	1	(25)	1	(25)	.	.	3	(19)	9	(56)	3	(19)	1	(6.3)	10	(50)	5	(25)	4	(20)	1	(5)
	B09	3	(14)	18	(82)	1	(4.5)	.	.	10	(26)	25	(66)	3	(7.9)	.	.	33	(52)	30	(48)	.	.	.	.
	B10	153	(84)	26	(14)	3	(1.6)	.	.	33	(73)	8	(18)	4	(8.9)	.	.	6	(11)	29	(52)	15	(27)	6	(11)
	B12	149	(81)	8	(4.4)	26	(14)	.	.	30	(23)	93	(72)	2	(1.5)	5	(3.8)	4	(6.1)	47	(71)	4	(6.1)	11	(17)
	B13	2	(8.7)	18	(78)	2	(8.7)	1	(4.3)	14	(44)	16	(50)	2	(6.3)	.	.	12	(32)	16	(42)	7	(18)	3	(7.9)
	B14	4	(12)	27	(82)	1	(3)	1	(3)	7	(16)	36	(80)	2	(4.4)	.	.	11	(32)	21	(62)	2	(5.9)	.	.
	B17	.	.	1	(100)	.	.	.	.	.	.	44	(77)	2	(3.5)	11	(19)	2	(5.4)	18	(49)	5	(14)	12	(32)
	B18	12	(60)	2	(10)	1	(5)	5	(25)	36	(60)	22	(37)	1	(1.7)	1	(1.7)	13	(33)	6	(15)	5	(13)	15	(38)
Pacific	C04	114	(69)	49	(30)	3	(1.8)	.	.	43	(27)	109	(69)	7	(4.4)	.	.	74	(31)	149	(62)	12	(5)	5	(2.1)
	C08	12	(80)	3	(20)	.	.	.	.	22	(34)	42	(66)	.	.	.	.	170	(88)	18	(9.3)	5	(2.6)	.	.
	C19	1	(33)	1	(33)	1	(33)	.	.	1	(25)	3	(75)	.	.	.	.	.	.	8	(80)	2	(20)	.	.
AOD	D03	53	(96)	2	(3.6)	.	.	.	.	41	(73)	12	(21)	3	(5.4)	.	.	51	(67)	23	(30)	1	(1.3)	1	(1.3)
	D16	.	.	28	(88)	4	(13)	.	.	6	(18)	22	(67)	3	(9.1)	2	(6.1)	3	(25)	6	(50)	3	(25)	.	.
Total		982	(42)	1222	(52)	117	(5)	15	(0.64)	979	(33)	1886	(63)	99	(3.3)	30	(1)	1220	(36)	1840	(55)	215	(6.4)	97	(2.9)

Table 26: Average Gambler Harm Screen initial scores reported for gamblers within Full Intervention sessions

Service		2010-11		2011-2		2012-3	
		N	**Ave Score**	**N**	**Ave Score**	**N**	**Ave Score**
General	A01	686	11.86	740	11.36	844	11.75
	A02	272	14.90	325	13.36	340	14.14
	A11	91	14.09	101	12.12	75	11.03
	A15	31	15.42	214	14.34	155	13.39
Māori	B05	43	9.67	68	14.25	55	13.78
	B06	18	17.00	41	15.27	29	7.79
	B07	2	27.00	16	17.56	7	15.57
	B09	21	17.95	21	14.24	29	16.24
	B10	30	11.53	12	11.92	44	9.27
	B12	34	3.91	111	6.74	57	3.61
	B13	21	16.29	19	15.79	20	16.20
	B14	29	10.48	37	10.43	18	13.56
	B17	1	1.00	57	2.56	31	2.90
	B18	9	6.22	27	9.52	21	13.10
Pacific	C04	61	3.64	133	4.36	174	3.64
	C08	3	11.33	43	13.12	18	10.50
	C19	5	2.60	3	21.67	9	7.00
AOD	D03	2	5.50	19	6.16	32	7.09
	D16	32	14.31	25	14.88	8	15.75
Total		1391	12.24	2012	11.38	1966	11.18

Table 27: Average change (from initial to second score) in the Gambler Harm Screen for gamblers within Full Intervention sessions

Service		2010-11		2011-2		2012-3	
		N	**Ave Change**	**N**	**Ave Change**	**N**	**Ave Change**
General	A01	29	0.38	140	-8.09	353	-8.17
	A02	49	-2.33	81	-6.25	140	-6.96
	A11	3	2.67	63	-7.51	88	-7.18
	A15	4	-7.25	19	-5.74	23	-3.17
Māori	B05	19	-0.53	31	-2.97	23	-11.17
	B06	9	-1.00	17	0.59	7	-1.86
	B07	2	0.00	8	-8.88	9	-11.78
	B09	2	-11.50	18	-10.00	14	-13.07
	B10	10	3.10	6	-0.50	26	-2.19
	B12	26	0.00	45	-4.38	38	-1.05
	B13	5	0.00	7	-14.57	21	-10.90
	B14	4	-1.75	18	-6.67	13	-11.38
	B17	.	.	15	-1.20	15	-0.07
	B18	7	0.57	2	-0.50	21	-3.43
Pacific	C04	7	0.00	21	0.00	41	-0.93
	C08	1	0.00	1	0.00	8	-6.13
	C19	2	0.00	.	.	2	-2.50
AOD	D03	.	.	5	-4.40	10	-2.90
	D16	16	-6.88	19	-10.47	5	-12.20
Total		195	-1.27	516	-6.23	857	-6.83

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Table 28: Number of Gambler Outcome-Control Screen result records for gambler clients within Full Intervention sessions

Service		2010-1 0 N	(%)	1 N	(%)	2 N	(%)	3+ N	(%)	2011-2 0 N	(%)	1 N	(%)	2 N	(%)	3+ N	(%)	2012-3 0 N	(%)	1 N	(%)	2 N	(%)	3+ N	(%)
General	A01	398	(40)	563	(57)	26	(2.6)	2	(0.2)	624	(49)	638	(50)	18	(1.4)	1	(0.08)	624	(43)	756	(52)	54	(3.7)	20	(1.4)
	A02	48	(15)	233	(74)	30	(9.6)	2	(0.64)	127	(28)	300	(65)	28	(6.1)	6	(1.3)	104	(21)	348	(69)	39	(7.8)	10	(2)
	A11	11	(11)	87	(85)	3	(2.9)	1	(0.98)	16	(13)	99	(81)	7	(5.7)	.	.	18	(17)	83	(78)	6	(5.6)	.	.
	A15	.	.	30	(97)	1	(3.2)	.	.	12	(5.3)	213	(94)	1	(0.44)	.	.	10	(5.8)	153	(88)	9	(5.2)	1	(0.58)
Māori	B05	36	(55)	20	(30)	8	(12)	2	(3)	20	(24)	54	(65)	8	(9.6)	1	(1.2)	36	(38)	49	(52)	8	(8.5)	1	(1.1)
	B06	80	(83)	9	(9.4)	6	(6.3)	1	(1)	41	(50)	30	(37)	8	(9.8)	3	(3.7)	130	(82)	21	(13)	7	(4.4)	1	(0.63)
	B07	2	(50)	1	(25)	1	(25)	.	.	3	(19)	10	(63)	2	(13)	1	(6.3)	9	(45)	6	(30)	4	(20)	1	(5)
	B09	4	(18)	17	(77)	1	(4.5)	.	.	10	(26)	25	(66)	3	(7.9)	.	.	34	(54)	29	(46)	.	.	.	.
	B10	163	(90)	19	(10)	.	.	.	.	34	(76)	8	(18)	3	(6.7)	.	.	8	(14)	28	(50)	14	(25)	6	(11)
	B12	173	(95)	7	(3.8)	3	(1.6)	.	.	37	(28)	85	(65)	3	(2.3)	5	(3.8)	4	(6.1)	45	(68)	5	(7.6)	12	(18)
	B13	2	(8.7)	18	(78)	2	(8.7)	1	(4.3)	14	(44)	16	(50)	2	(6.3)	.	.	12	(32)	16	(42)	7	(18)	3	(7.9)
	B14	4	(12)	27	(82)	1	(3)	1	(3)	7	(16)	36	(80)	2	(4.4)	.	.	11	(32)	21	(62)	2	(5.9)	.	.
	B17	.	.	1	(100)	.	.	.	.	.	.	44	(77)	2	(3.5)	11	(19)	2	(5.4)	18	(49)	5	(14)	12	(32)
	B18	10	(50)	.	.	4	(20)	6	(30)	15	(25)	23	(38)	11	(18)	11	(18)	3	(7.7)	10	(26)	6	(15)	20	(51)
Pacific	C04	151	(91)	15	(9)	.	.	.	.	128	(81)	30	(19)	1	(0.63)	.	.	108	(45)	118	(49)	9	(3.8)	5	(2.1)
	C08	12	(80)	3	(20)	.	.	.	.	22	(34)	42	(66)	.	.	.	.	172	(89)	16	(8.3)	5	(2.6)	.	.
	C19	1	(33)	1	(33)	1	(33)	.	.	1	(25)	3	(75)	.	.	.	.	.	.	8	(80)	2	(20)	.	.
AOD	D03	55	(100)	.	.	.	.	.	.	50	(89)	3	(5.4)	3	(5.4)	.	.	70	(92)	4	(5.3)	1	(1.3)	1	(1.3)
	D16	.	.	28	(88)	4	(13)	.	.	6	(18)	22	(67)	3	(9.1)	2	(6.1)	3	(25)	6	(50)	3	(25)	.	.
Total		1150	(49)	1079	(46)	91	(3.9)	16	(0.68)	1167	(39)	1681	(56)	105	(3.5)	41	(1.4)	1358	(40)	1735	(51)	186	(5.5)	93	(2.8)

Table 29: Average Gambler Outcome-Control Screen initial rating reported for gamblers within Full Intervention sessions

Service		2010-11		2011-2		2012-3	
		N	Ave Rating	N	Ave Rating	N	Ave Rating
General	A01	594	2.41	631	2.34	754	2.42
	A02	268	2.65	322	2.44	344	2.43
	A11	93	2.57	102	2.33	76	2.21
	A15	31	2.61	214	2.77	155	2.75
Māori	B05	44	2.23	67	2.63	55	2.87
	B06	17	2.06	42	2.48	26	1.96
	B07	2	4.00	16	2.88	7	2.86
	B09	20	2.55	21	2.57	28	2.75
	B10	20	2.70	12	2.75	43	2.09
	B12	10	1.70	98	2.19	58	2.22
	B13	21	2.62	19	2.53	20	2.50
	B14	29	2.38	37	2.51	18	2.50
	B17	1	1.00	57	2.07	31	2.10
	B18	12	2.50	44	2.16	22	2.36
Pacific	C04	18	1.56	29	1.69	141	1.47
	C08	3	2.00	43	2.16	16	2.00
	C19	5	1.20	3	3.33	9	1.11
AOD	D03	.	.	6	2.33	4	1.75
	D16	32	2.38	25	2.40	8	2.38
Total		1220	2.46	1788	2.41	1815	2.35

Table 30: Average change (from initial to second score) in Gambler Outcome-Control Screen administered to gambler clients within Full Intervention sessions

Service		2010-11		2011-2		2012-3	
		N	Ave Change	N	Ave Change	N	Ave Change
General	A01	29	-0.14	55	-0.65	125	-0.23
	A02	51	-0.39	95	-0.78	136	-0.76
	A11	66	-0.71	68	-0.62	88	-0.48
	A15	4	-0.75	20	-0.60	22	-0.18
Māori	B05	19	-0.11	31	-0.55	23	-1.35
	B06	8	0.00	18	-0.11	7	-0.43
	B07	2	0.00	7	-1.29	10	-1.20
	B09	1	0.00	19	-1.16	14	-1.36
	B10	3	0.00	5	0.40	25	-0.28
	B12	3	0.00	38	-0.66	38	-0.53
	B13	5	0.00	7	-1.57	21	-0.81
	B14	4	0.00	18	-0.50	13	-0.77
	B17	.	.	15	-0.47	15	-0.07
	B18	10	-0.30	23	-0.17	19	-0.16
Pacific	C04	3	0.00	6	0.00	22	-0.41
	C08	1	0.00	1	0.00	8	-0.88
	C19	2	0.00	.	.	2	-1.50
AOD	D03	.	.	3	-0.67	2	0.00
	D16	16	-0.63	19	-0.68	5	-1.00
Total		227	-0.39	448	-0.63	595	-0.55

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Table 31: Number of Dollars Lost Screen result records gambler clients within Full Intervention

		2010-1								2011-2								2012-3							
		0		1		2		3+		0		1		2		3+		0		1		2		3+	
Service		N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)
General	A01	398	(40)	563	(57)	26	(2.6)	2	(0.2)	624	(49)	638	(50)	18	(1.4)	1	(0.08)	624	(43)	756	(52)	54	(3.7)	20	(1.4)
	A02	48	(15)	233	(74)	30	(9.6)	2	(0.64)	127	(28)	300	(65)	28	(6.1)	6	(1.3)	104	(21)	348	(69)	39	(7.8)	10	(2)
	A11	11	(11)	87	(85)	3	(2.9)	1	(0.98)	16	(13)	99	(81)	7	(5.7)	.	.	18	(17)	83	(78)	6	(5.6)	.	.
	A15	.	.	30	(97)	1	(3.2)	.	.	12	(5.3)	213	(94)	1	(0.44)	.	.	10	(5.8)	153	(88)	9	(5.2)	1	(0.58)
Māori	B05	36	(55)	20	(30)	8	(12)	2	(3)	20	(24)	54	(65)	8	(9.6)	1	(1.2)	36	(38)	49	(52)	8	(8.5)	1	(1.1)
	B06	80	(83)	9	(9.4)	6	(6.3)	1	(1)	41	(50)	30	(37)	8	(9.8)	3	(3.7)	130	(82)	21	(13)	7	(4.4)	1	(0.63)
	B07	2	(50)	1	(25)	1	(25)	.	.	3	(19)	10	(63)	2	(13)	1	(6.3)	9	(45)	6	(30)	4	(20)	1	(5)
	B09	4	(18)	17	(77)	1	(4.5)	.	.	10	(26)	25	(66)	3	(7.9)	.	.	34	(54)	29	(46)	.	.	.	.
	B10	163	(90)	19	(10)	.	.	.	.	34	(76)	8	(18)	3	(6.7)	.	.	8	(14)	28	(50)	14	(25)	6	(11)
	B12	173	(95)	7	(3.8)	3	(1.6)	.	.	37	(28)	85	(65)	3	(2.3)	5	(3.8)	4	(6.1)	45	(68)	5	(7.6)	12	(18)
	B13	2	(8.7)	18	(78)	2	(8.7)	1	(4.3)	14	(44)	16	(50)	2	(6.3)	.	.	12	(32)	16	(42)	7	(18)	3	(7.9)
	B14	4	(12)	27	(82)	1	(3)	1	(3)	7	(16)	36	(80)	2	(4.4)	.	.	11	(32)	21	(62)	2	(5.9)	.	.
	B17	.	.	1	(100)	.	.	.	.	.	.	44	(77)	2	(3.5)	11	(19)	2	(5.4)	18	(49)	5	(14)	12	(32)
	B18	10	(50)	.	.	4	(20)	6	(30)	15	(25)	23	(38)	11	(18)	11	(18)	3	(7.7)	10	(26)	6	(15)	20	(51)
Pacific	C04	151	(91)	15	(9)	.	.	.	.	128	(81)	30	(19)	1	(0.63)	.	.	108	(45)	118	(49)	9	(3.8)	5	(2.1)
	C08	12	(80)	3	(20)	.	.	.	.	22	(34)	42	(66)	.	.	.	.	172	(89)	16	(8.3)	5	(2.6)	.	.
	C19	1	(33)	1	(33)	1	(33)	.	.	1	(25)	3	(75)	.	.	.	.	.	.	8	(80)	2	(20)	.	.
AOD	D03	55	(100)	.	.	.	.	.	.	50	(89)	3	(5.4)	3	(5.4)	.	.	70	(92)	4	(5.3)	1	(1.3)	1	(1.3)
	D16	.	.	28	(88)	4	(13)	.	.	6	(18)	22	(67)	3	(9.1)	2	(6.1)	3	(25)	6	(50)	3	(25)	.	.
Total		1150	(49)	1079	(46)	91	(3.9)	16	(0.68)	1167	(39)	1681	(56)	105	(3.5)	41	(1.4)	1358	(40)	1735	(51)	186	(5.5)	93	(2.8)

Table 32: Annual averages on dollars spent as recorded in the Dollars Lost Screen administered to gambler clients within Full Intervention sessions

Service		2010-11		2011-2		2012-3	
		N	Ave ($)	N	Ave ($)	N	Ave ($)
General	A01	511	5750.76	599	8922.10	745	4815.66
	A02	268	2331.64	321	1585.92	340	2550.90
	A11	94	1295.53	102	738.82	76	1529.08
	A15	31	1641.29	214	2217.31	156	2819.29
Māori	B05	44	617.73	67	1520.45	55	1049.27
	B06	17	4837.76	42	1155.88	25	275.68
	B07	2	7500.00	16	211.25	7	248.57
	B09	20	2933.00	21	561.90	28	1313.57
	B10	14	862.86	10	1050.00	44	13873.36
	B12	4	595.00	56	516.20	25	491.20
	B13	21	620.95	19	1135.79	20	1147.10
	B14	29	514.14	37	1005.95	18	478.89
	B17	1	40.00	55	267.82	31	149.35
	B18	13	357.08	44	176.68	23	162.17
Pacific	C04	18	205.67	26	192.08	131	153.63
	C08	3	416.67	42	1374.52	16	244.13
	C19	4	10000.00	3	300.00	9	110.00
AOD	D03	.	.	6	2.33	4	1.75
	D16	32	1224.50	25	4708.40	8	675.00
Total		1126	3597.24	1705	4029.88	1761	3297.66

Table 33: Percentage of clients exhibiting improvement (from initial to second assessment) in the Dollars Lost Screen administered to gambler clients within Full Intervention sessions

Service		2010-11		2011-2		2012-3	
		No. Clients	(% Improved)	No. Clients	(% Improved)	No. Clients	(% Improved)
General	A01	15	(60)	122	(81.1)	319	(75.2)
	A02	51	(23.5)	91	(57.1)	136	(77.9)
	A11	64	(87.5)	69	(71)	88	(78.4)
	A15	4	(50)	20	(75)	21	(52.4)
Māori	B05	18	(11.1)	32	(37.5)	23	(87)
	B06	8	(0)	18	(66.7)	7	(28.6)
	B07	2	(50)	8	(50)	9	(100)
	B09	1	(0)	19	(73.7)	14	(92.9)
	B10	3	(0)	4	(25)	23	(52.2)
	B12	.	.	8	(62.5)	19	(73.7)
	B13	5	(0)	7	(85.7)	21	(76.2)
	B14	4	(75)	18	(66.7)	13	(100)
	B17	.	.	15	(60)	15	(26.7)
	B18	11	(27.3)	27	(44.4)	18	(72.2)
Pacific	C04	2	(0)	6	(0)	19	(68.4)
	C08	1	(0)	1	(0)	8	(75)
	C19	2	(0)	.	.	2	(100)
AOD	D03	.	.	3	(33.3)	2	(0)
	D16	16	(62.5)	19	(68.4)	5	(100)
Total		207	(47.3)	487	(64.9)	762	(74.5)

Table 34: Average initial scores reported in Alcohol Use Screens administered to gambler clients

Service		2010-11		2011-2		2012-3	
		N	Ave Score	N	Ave Score	N	Ave Score
General	A01	562	3.94	598	4.01	723	4.03
	A02	187	3.78	224	4.31	312	4.31
	A11	81	3.28	99	4.47	71	4.28
	A15	31	2.71	213	3.82	153	3.56
Māori	B05	30	4.17	70	4.73	56	4.27
	B06	15	6.47	30	3.73	25	4.48
	B07	2	7.00	16	2.69	7	1.86
	B09	20	1.05	21	0.86	26	1.54
	B10	17	5.12	12	2.58	42	1.55
	B12	3	0.00	49	1.06	54	1.15
	B13	21	3.10	18	3.89	19	3.37
	B14	30	6.07	37	5.00	17	4.65
	B17	.	.	1	0.00	6	0.17
	B18	8	3.50	17	2.65	6	3.83
Pacific	C04	8	8.00	5	3.80	59	3.34
	C08	3	0.00	44	1.91	15	5.80
	C19	1	0.00	3	7.33	9	1.56
AOD	D03	.	.	5	1.80	4	1.00
	D16	28	5.14	25	4.12	8	4.38
Total		1047	3.91	1487	3.86	1612	3.81

Table 35: Average initial scores reported in Alcohol Use Screens administered to significant other clients

Service		2010-11		2011-2		2012-3	
		N	Ave Score	N	Ave Score	N	Ave Score
General	A01	87	2.79	69	2.33	101	1.27
	A02	30	2.17	36	3.36	55	2.82
	A11	35	3.34	39	3.46	57	3.74
	A15	2	1.00	14	3.07	7	2.00
Māori	B05	5	2.00	27	2.67	22	3.73
	B06	1	2.00	27	1.52	29	0.76
	B07	4	0.00	35	1.00	36	1.06
	B09	.	.	2	0.50	1	0.00
	B10	6	4.67	8	1.50	32	0.81
	B12	1	0.00	49	0.94	72	1.11
	B13	8	2.63	5	3.20	12	0.25
	B14	14	4.71	22	4.27	14	4.07
	B17	.	.	.	.	5	0.20
	B18	2	0.50	.	.	.	.
Pacific	C04	4	6.00	2	2.00	14	5.00
	C08	2	1.50	42	2.43	31	0.71
	C19	.	.	1	7.00	2	0.50
AOD	D03	7	2.43	4	0.00	1	0.00
	D16	208	2.88	382	2.33	491	1.86
Total		87	2.79	69	2.33	101	1.27

Table 36: Average change from initial to second assessment for scores reported in Alcohol Use Screens administered to gambler clients

Service		2010-11		2011-2		2012-3	
		N	Ave Change	N	Ave Change	N	Ave Change
General	A01	24	-0.25	39	-0.54	97	0.19
	A02	33	-0.03	27	-0.78	71	-0.76
	A11	3	0.00	8	0.63	11	0.82
	A15	1	1.00	1	1.00	11	-0.55
Māori	B05	13	0.00	28	0.14	25	-1.16
	B06	7	0.00	18	-0.28	8	0.88
	B07	2	-2.00	8	-0.75	9	-0.44
	B09	1	0.00	19	-0.05	14	0.57
	B10	.	.	9	-1.22	20	-0.40
	B12	.	.	9	-1.00	27	-0.11
	B13	5	0.00	7	0.00	21	0.33
	B14	10	-0.20	13	-0.62	16	-0.81
	B17	.	.	.	.	1	0.00
	B18	6	0.00	3	0.00	2	-0.50
Pacific	C04	4	0.00	2	0.00	10	-0.10
	C08	1	0.00	1	0.00	9	-0.11
	C19	.	.	.	.	2	1.00
AOD	D03	.	.	.	.	2	-1.00
	D16	8	-1.88	20	-1.30	7	0.00
Total		118	-0.23	212	-0.46	363	-0.20

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Table 37: Minimum, average and maximum number of Facilitation sessions per client

| | | Gambler | | | | | | | | | Significant other | | | | | | | | |
| | | 2010-1 | | | 2011-2 | | | 2012-3 | | | 2010-1 | | | 2011-2 | | | 2012-3 | | |
Service		Min	Ave	Max	Min	Ave	Max	Min	Ave	Max	Min	Ave	Max	Min	Ave	Max	Min	Ave	Max
General	A01	1	1.7	12	1	1.8	8	1	2.0	21	1	2.2	7	1	1.9	16	1	2.5	12
	A02	1	2.3	17	1	2.3	16	1	2.3	29	1	1.1	2	1	1.6	4	1	1.7	5
	A11	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	A15	1	1.0	1	.	.	.	1	1.0	1	.	.	.	.	.	.	.	.	.
Māori	B05	1	6.0	44	1	3.6	30	1	7.4	128	1	2.5	5	1	2.4	5	1	4.1	16
	B06	1	6.5	12	1	4.3	17	1	2.8	7	2	4.6	10	1	1.0	1	1	1.0	1
	B07	1	15.1	54	1	7.5	47	1	3.5	14	1	12.8	61	1	5.7	16	1	5.4	27
	B09	1	6.6	23	1	9.2	33	1	7.4	24	2	2.5	3	1	4.3	10	1	1.5	2
	B10	1	1.6	5	1	4.3	16	1	2.4	8	1	2.0	5	1	3.7	8	1	1.4	2
	B12	1	1.9	19	1	1.2	4	1	1.1	3	1	1.0	1	1	1.0	1	1	1.0	1
	B13	1	7.4	73	1	4.3	26	1	5.9	27	1	6.1	18	1	2.9	8	1	3.4	8
	B14	1	3.1	16	1	2.1	7	1	2.4	8	1	2.8	15	1	2.0	9	1	1.4	3
	B17	.	.	.	1	1.7	3	1	1.1	3	.	.	.	1	1.8	3	1	1.0	2
	B18	1	4.8	12	1	1.5	4	1	2.7	10	4	4.0	4	.	.	.	.	.	.
Pacific	C04	1	1.4	7	1	1.2	7	1	1.3	8	1	1.6	10	1	1.1	5	1	1.1	3
	C08	1	3.8	9	1	4.7	12	1	2.3	6	2	5.9	14	1	5.3	16	1	2.3	7
	C19	1	1.0	1	1	2.0	3	1	2.6	6	.	.	.	7	7.0	7	2	2.7	4
AOD	D03	1	4.9	65	1	4.5	14	1	3.7	11	.	.	.	2	12.5	23	.	.	.
	D16	1	1.8	5	1	1.4	3	1	2.7	6	1	1.6	2	3	3.0	3	1	1.0	1

Table 38: Minimum, average and maximum number of Follow-up sessions per client

| | | Gambler | | | | | | | | | Significant other | | | | | | | | |
| | | 2010-1 | | | 2011-2 | | | 2012-3 | | | 2010-1 | | | 2011-2 | | | 2012-3 | | |
Service		Min	Ave	Max	Min	Ave	Max	Min	Ave	Max	Min	Ave	Max	Min	Ave	Max	Min	Ave	Max
General	A01	1	1.6	26	1	1.8	34	1	1.6	13	1	1.4	4	1	1.6	9	1	1.3	4
	A02	1	1.5	4	1	1.5	5	1	1.6	5	1	1.6	5	1	1.5	3	1	1.6	4
	A11	1	2.1	4	1	1.7	4	1	1.9	4	1	1.5	3	1	1.2	2	1	1.7	3
	A15	1	1.7	3	1	2.0	4	1	1.5	4	1	1.0	1	2	2.0	2	.	.	.
Māori	B05	1	1.9	4	1	1.9	4	1	1.4	3	1	1.7	4	1	1.9	3	1	1.3	3
	B06	1	1.7	5	1	1.5	4	1	1.3	3	1	1.7	3	1	1.4	3	1	1.2	2
	B07	1	1.2	3	1	1.1	2	1	2.1	4	1	1.4	4	1	1.0	1	1	2.3	4
	B09	1	1.8	4	1	2.5	4	1	2.4	4	1	1.0	1	1	2.8	4	1	2.3	3
	B10	1	1.1	2	1	1.4	5	1	2.1	7	1	1.3	2	1	1.2	2	1	1.4	3
	B12	1	1.5	4	1	1.2	5	1	1.5	4	1	1.5	3	1	1.1	2	1	1.6	3
	B13	1	1.8	4	1	1.7	5	1	2.1	5	1	1.6	2	1	1.8	3	1	1.9	4
	B14	1	1.3	3	1	1.7	3	1	1.5	4	1	1.4	3	1	1.7	3	1	1.3	2
	B17	.	.	.	1	1.0	3	1	1.4	5	.	.	.	1	1.0	2	1	1.3	3
	B18	1	2.5	4	1	1.4	2	1	1.4	4	.	.	.	1	1.0	1	.	.	.
Pacific	C04	1	1.1	3	1	1.1	2	1	1.3	4	1	1.1	2	1	1.1	3	1	1.2	2
	C08	1	1.0	1	1	1.4	3	1	1.2	2	.	.	.	1	2.3	4	1	1.1	2
	C19	1	2.0	3	1	1.0	1	2	4.0	6	.	.	.	1	1.0	1	1	3.3	5
AOD	D03	1	2.4	5	1	2.2	10	1	2.1	4	1	1.0	1	1	1.0	1	2	2.0	2
	D16	1	1.9	5	1	1.8	4	1	1.3	2	1	1.9	3	1	1.2	2	1	1.0	1

| Service		**2010-1** 0		1		2		3+		**2011-2** 0		1		2		3+		**2012-3** 0		1		2		3+	
		N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)
General	A01	153	(99)	2	(1.3)	.	.	.	.	301	(74)	90	(22)	16	(3.9)	.	.	177	(37)	198	(42)	80	(17)	19	(4)
	A02	123	(96)	5	(3.9)	.	.	.	.	224	(79)	41	(15)	14	(5)	3	(1.1)	175	(61)	91	(32)	21	(7.3)	1	(0.35)
	A11	65	(100)	.	.	.	.	.	.	72	(55)	59	(45)	.	.	.	.	64	(41)	91	(58)	1	(0.64)	.	.
	A15	6	(67)	1	(11)	2	(22)	.	.	17	(46)	12	(32)	6	(16)	2	(5.4)	10	(28)	18	(50)	7	(19)	1	(2.8)
Māori	B05	10	(40)	7	(28)	4	(16)	4	(16)	18	(33)	21	(39)	11	(20)	4	(7.4)	38	(66)	15	(26)	5	(8.6)	.	.
	B06	11	(100)	.	.	.	.	.	.	44	(92)	4	(8.3)	.	.	.	.	53	(100)	.	.	.	.	.	.
	B07	.	.	.	.	.	.	.	.	6	(86)	1	(14)	.	.	.	.	6	(35)	5	(29)	2	(12)	4	(24)
	B09	2	(67)	1	(33)	.	.	.	.	6	(32)	5	(26)	3	(16)	5	(26)	9	(26)	8	(24)	9	(26)	8	(24)
	B10	23	(88)	3	(12)	.	.	.	.	13	(93)	1	(7.1)	.	.	.	.	19	(68)	6	(21)	3	(11)	.	.
	B12	111	(100)	.	.	.	.	.	.	98	(71)	28	(20)	12	(8.6)	1	(0.72)	4	(7.7)	36	(69)	4	(7.7)	8	(15)
	B13	3	(75)	1	(25)	.	.	.	.	15	(68)	3	(14)	4	(18)	.	.	14	(45)	5	(16)	7	(23)	5	(16)
	B14	8	(89)	1	(11)	.	.	.	.	11	(42)	10	(38)	4	(15)	1	(3.8)	10	(32)	18	(58)	3	(9.7)	.	.
	B17	.	.	.	.	.	.	.	.	48	(98)	1	(2)	.	.	.	.	20	(65)	11	(35)	.	.	.	.
	B18	4	(100)	.	.	.	.	.	.	4	(44)	4	(44)	1	(11)	.	.	8	(50)	5	(31)	2	(13)	1	(6.3)
Pacific	C04	41	(100)	.	.	.	.	.	.	45	(100)	.	.	.	.	.	.	113	(84)	20	(15)	1	(0.75)	.	.
	C08	1	(100)	.	.	.	.	.	.	9	(100)	.	.	.	.	.	.	26	(100)	.	.	.	.	.	.
	C19	.	.	1	(50)	1	(50)	.	.	1	(100)	.	.	.	.	.	.	3	(100)	.	.	.	.	.	.
AOD	D03	28	(100)	.	.	.	.	.	.	43	(86)	7	(14)	.	.	.	.	27	(64)	8	(19)	4	(9.5)	3	(7.1)
	D16	1	(6.7)	5	(33)	6	(40)	3	(20)	.	.	10	(38)	13	(50)	3	(12)	1	(10)	6	(60)	3	(30)	.	.
Total		590	(93)	27	(4.2)	13	(2)	7	(1.1)	975	(71)	297	(22)	84	(6.1)	19	(1.4)	777	(51)	541	(36)	152	(10)	50	(3.3)

Table 40: Number of Gambler Outcome-Control Screen score records for gambler clients within Follow-up sessions

Service		2010-1								2011-2								2012-3							
		0		**1**		**2**		**3+**		**0**		**1**		**2**		**3+**		**0**		**1**		**2**		**3+**	
		N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)
General	A01	153	(99)	2	(1.3)	.	.	.	.	394	(97)	13	(3.2)	.	.	.	.	468	(99)	6	(1.3)	.	.	.	.
	A02	120	(94)	8	(6.3)	.	.	.	.	213	(76)	49	(17)	17	(6)	3	(1.1)	174	(60)	89	(31)	23	(8)	2	(0.69)
	A11	1	(1.5)	19	(29)	20	(31)	25	(38)	3	(2.3)	56	(43)	47	(36)	25	(19)	.	.	60	(38)	44	(28)	52	(33)
	A15	6	(67)	1	(11)	2	(22)	.	.	17	(46)	12	(32)	6	(16)	2	(5.4)	11	(31)	17	(47)	7	(19)	1	(2.8)
Māori	B05	9	(36)	8	(32)	4	(16)	4	(16)	18	(33)	21	(39)	11	(20)	4	(7.4)	38	(66)	15	(26)	5	(8.6)	.	.
	B06	11	(100)	.	.	.	.	.	.	44	(92)	4	(8.3)	.	.	.	.	53	(100)	.	.	.	.	.	.
	B07	.	.	.	.	.	.	.	.	6	(86)	1	(14)	.	.	.	.	6	(35)	5	(29)	2	(12)	4	(24)
	B09	3	(100)	.	.	.	.	.	.	6	(32)	5	(26)	3	(16)	5	(26)	9	(26)	8	(24)	9	(26)	8	(24)
	B10	26	(100)	.	.	.	.	.	.	13	(93)	1	(7.1)	.	.	.	.	20	(71)	5	(18)	3	(11)	.	.
	B12	111	(100)	.	.	.	.	.	.	111	(80)	26	(19)	1	(0.72)	1	(0.72)	3	(5.8)	37	(71)	4	(7.7)	8	(15)
	B13	3	(75)	1	(25)	.	.	.	.	15	(68)	3	(14)	4	(18)	.	.	14	(45)	5	(16)	8	(26)	4	(13)
	B14	8	(89)	1	(11)	.	.	.	.	11	(42)	10	(38)	4	(15)	1	(3.8)	10	(32)	18	(58)	3	(9.7)	.	.
	B17	.	.	.	.	.	.	.	.	48	(98)	1	(2)	.	.	.	.	20	(65)	11	(35)	.	.	.	.
	B18	4	(100)	.	.	.	.	.	.	4	(44)	3	(33)	2	(22)	.	.	6	(38)	8	(50)	1	(6.3)	1	(6.3)
Pacific	C04	41	(100)	.	.	.	.	.	.	45	(100)	.	.	.	.	.	.	120	(90)	13	(9.7)	1	(0.75)	.	.
	C08	1	(100)	.	.	.	.	.	.	9	(100)	.	.	.	.	.	.	26	(100)	.	.	.	.	.	.
	C19	.	.	1	(50)	1	(50)	.	.	1	(100)	.	.	.	.	.	.	3	(100)	.	.	.	.	.	.
AOD	D03	28	(100)	.	.	.	.	.	.	50	(100)	.	.	.	.	.	.	42	(100)	.	.	.	.	.	.
	D16	1	(6.7)	5	(33)	6	(40)	3	(20)	.	.	10	(38)	13	(50)	3	(12)	1	(10)	6	(60)	3	(30)	.	.
Total		526	(83)	46	(7.2)	33	(5.2)	32	(5)	1008	(73)	215	(16)	108	(7.9)	44	(3.2)	1024	(67)	303	(20)	113	(7.4)	80	(5.3)

Service		2010-1 0 N	(%)	1 N	(%)	2 N	(%)	3+ N	(%)	2011-2 0 N	(%)	1 N	(%)	2 N	(%)	3+ N	(%)	2012-3 0 N	(%)	1 N	(%)	2 N	(%)	3+ N	(%)
General	A01	154	(99)	1	(0.65)	.	.	.	.	305	(75)	90	(22)	12	(2.9)	.	.	190	(40)	190	(40)	80	(17)	14	(3)
	A02	120	(94)	7	(5.5)	1	(0.78)	.	.	214	(76)	50	(18)	16	(5.7)	2	(0.71)	176	(61)	86	(30)	24	(8.3)	2	(0.69)
	A11	2	(3.1)	18	(28)	20	(31)	25	(38)	3	(2.3)	55	(42)	48	(37)	25	(19)	.	.	60	(38)	44	(28)	52	(33)
	A15	6	(67)	1	(11)	2	(22)	.	.	17	(46)	12	(32)	6	(16)	2	(5.4)	11	(31)	17	(47)	7	(19)	1	(2.8)
Māori	B05	10	(40)	7	(28)	4	(16)	4	(16)	18	(33)	21	(39)	11	(20)	4	(7.4)	38	(66)	15	(26)	5	(8.6)	.	.
	B06	11	(100)	.	.	.	.	.	.	44	(92)	4	(8.3)	.	.	.	.	53	(100)	.	.	.	.	.	.
	B07	.	.	.	.	.	.	.	.	6	(86)	1	(14)	.	.	.	.	6	(35)	5	(29)	2	(12)	4	(24)
	B09	3	(100)	.	.	.	.	.	.	6	(32)	5	(26)	2	(11)	6	(32)	9	(26)	8	(24)	9	(26)	8	(24)
	B10	26	(100)	.	.	.	.	.	.	13	(93)	1	(7.1)	.	.	.	.	21	(75)	5	(18)	2	(7.1)	.	.
	B12	111	(100)	.	.	.	.	.	.	136	(98)	2	(1.4)	.	.	1	(0.72)	35	(67)	12	(23)	3	(5.8)	2	(3.8)
	B13	3	(75)	1	(25)	.	.	.	.	15	(68)	3	(14)	4	(18)	.	.	14	(45)	5	(16)	8	(26)	4	(13)
	B14	8	(89)	1	(11)	.	.	.	.	11	(42)	10	(38)	4	(15)	1	(3.8)	10	(32)	18	(58)	3	(9.7)	.	.
	B17	.	.	.	.	.	.	.	.	48	(98)	1	(2)	.	.	.	.	20	(65)	11	(35)	.	.	.	.
	B18	4	(100)	.	.	.	.	.	.	4	(44)	3	(33)	2	(22)	.	.	6	(38)	8	(50)	1	(6.3)	1	(6.3)
Pacific	C04	41	(100)	.	.	.	.	.	.	45	(100)	.	.	.	.	.	.	125	(93)	9	(6.7)	.	.	.	.
	C08	1	(100)	.	.	.	.	.	.	9	(100)	.	.	.	.	.	.	26	(100)	.	.	.	.	.	.
	C19	.	.	1	(50)	1	(50)	.	.	1	(100)	.	.	.	.	.	.	3	(100)	.	.	.	.	.	.
AOD	D03	28	(100)	.	.	.	.	.	.	50	(100)	.	.	.	.	.	.	42	(100)	.	.	.	.	.	.
	D16	1	(6.7)	5	(33)	6	(40)	3	(20)	.	.	10	(38)	13	(50)	3	(12)	1	(10)	6	(60)	3	(30)	.	.
Total		529	(83)	42	(6.6)	34	(5.3)	32	(5)	945	(69)	268	(19)	118	(8.6)	44	(3.2)	786	(52)	455	(30)	191	(13)	88	(5.8)

APPENDIX 5: Clinical audits of problem gambling intervention service providers

KPMG
cutting through complexity

Report on the clinical audits of problem gambling intervention service providers
February 2015
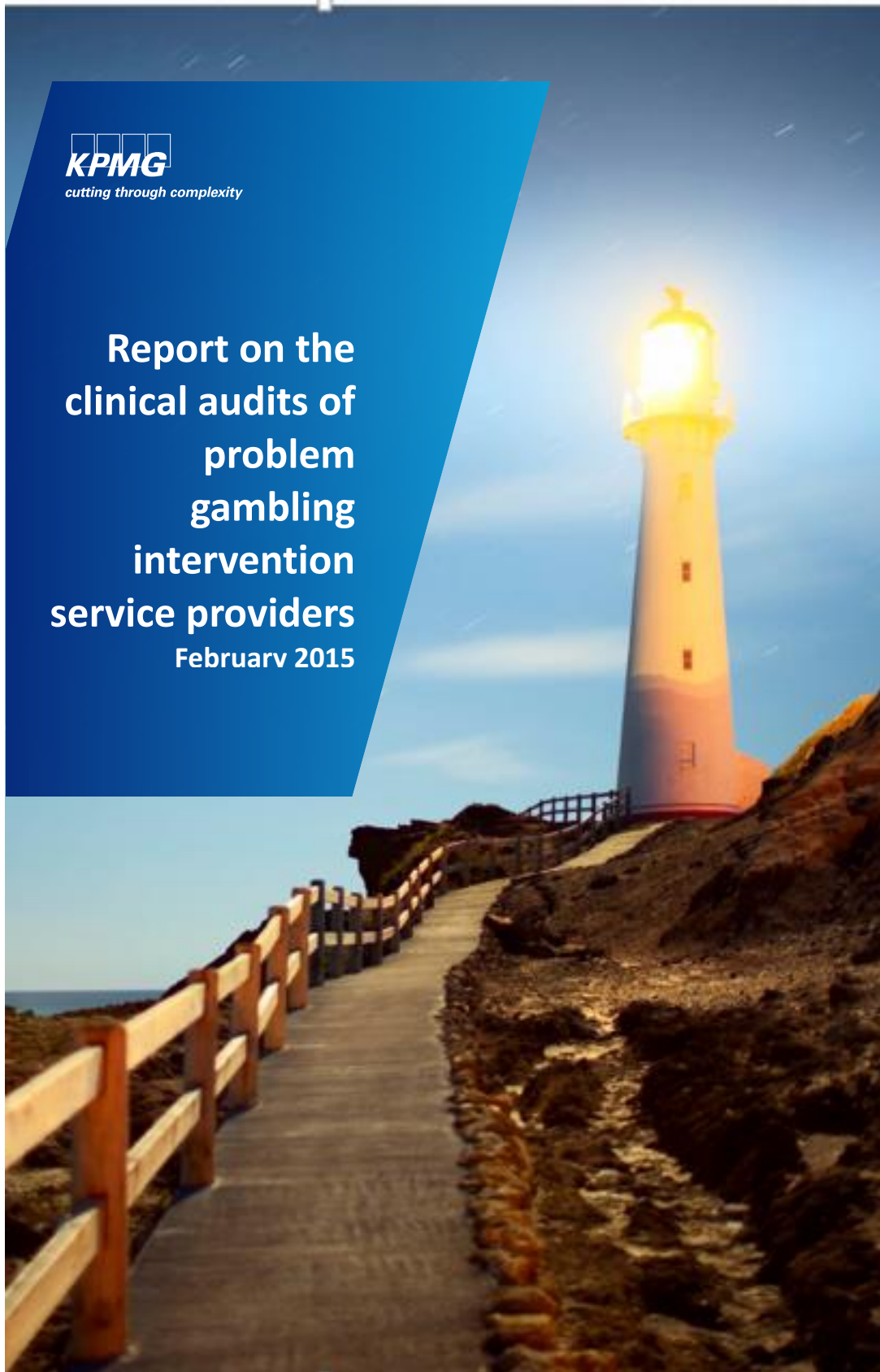
Disclaimers

Inherent Limitations

This report has been prepared in accordance with our contract dated 4 September 2013. The services provided under our engagement letter ('Services') have not been undertaken in accordance with any auditing, review or assurance standards. The term "Audit/Review" used in this report does not relate to an Audit/Review as defined under professional assurance standards.

The information presented in this report is based on that made available to us in the course of our work provided by the Ministry of Health and the providers selected to take part in the clinical audits. We have indicated within this report the sources of the information provided. Unless otherwise stated in this report, we have relied upon the truth, accuracy and completeness of any information provided or made available to KPMG by the Ministry of Health or providers in connection with the Services without independently verifying it.

No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by, the providers consulted as part of the process.

Third Party Reliance

Other than our responsibility to the Auckland University of Technology, neither KPMG nor any member or employee of KPMG undertakes responsibility arising in any way from reliance placed by a third party on this report. Any reliance placed is that party's sole responsibility.

Our report was prepared solely in accordance with the specific terms of reference set out in the contract dated 4 September 2013 between ourselves and the Auckland University of Technology and for no other purpose.

KPMG expressly disclaims any and all liability for any loss or damage of whatever kind to any person acting on information contained in this report, other than the Auckland University of Technology. Additionally, we reserve the right but not the obligation to update our report or to revise the information contained therein because of events and transactions occurring subsequent to the date of this report.

The Ministry of Health acknowledges that it is not a party to the contract dated 4 September 2013 whereby KPMG has been engaged by the Auckland University of Technology to undertake clinical audits of problem gambling providers and to report its findings to the Auckland University of Technology and the Ministry of Health. Our engagement was neither planned nor conducted in contemplation of the purposes for which a third party may have requested the report on the clinical audits of problem gambling intervention service providers.

Accordingly, third parties acknowledge that they may not place reliance on the results and findings contained in the report on the clinical audits of problem gambling intervention service providers.

KPMG shall not be liable for any losses, claims, expenses, actions, demands, damages, liabilities or any other proceedings arising out of any reliance by third parties on the report on the clinical audits of problem gambling intervention service providers. KPMG are not liable to Auckland University of Technology for any such liabilities as a result of reliance by the Auckland University of Technology on the report on the clinical audits of problem gambling intervention service providers.

Evaluation and Clinical Audit of Problem Gambling Intervention and Public Health Services: Final Report | 25 September 2015 | Provider No: 467589, Contract Nos.: 348109/00 & 01| Auckland University of Technology, Gambling & Addictions Research Centre |

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Contents

1 Executive Summary

1.1 Objectives

The Ministry of Health (the Ministry) contracted the Auckland University of Technology (AUT) to undertake an evaluation and clinical audit of Problem Gambling Intervention and Public Health Services.

Subsequently, AUT contracted KPMG to undertake clinical audits of intervention services for preventing and minimising problem gambling harm, as set out in the contract dated 4 September 2013. The audit programme covered eight providers reflecting geographic, national and regional service delivery, and providers that specialise in delivering services to Māori, Pacific or Asian populations.

The objectives of the clinical audits were to assess whether each provider implemented national guidelines, industry standards and best practice for the:

- Delivery of high quality clinical services to treat those affected by gambling harm.

- Provision of services that are culturally appropriate and meet the needs of its clients.

The objective of this report is to outline the key themes from the collated findings of the audits of the providers.

1.2 Scope

We assessed each provider's level of compliance against its contract with the Ministry of Health (the Ministry), Health and Disability Service Standards, and other best practice guidelines.

During the audit, we visited each provider, interviewed its staff and clients, and reviewed documentation to assess whether each provider had fully complied, partially complied, or did not comply with aspects relating to:

- Service delivery and quality

- Client rights

- Cultural perspectives.

1.3 Approach

Briefing → Pilot Clinical Audit → Post-pilot Briefing → Fieldwork → Reporting

1.3.1 Consultation and planning

Briefing

On 28 March 2014 all 19 problem gambling intervention providers from across New Zealand, and funded by the Ministry, were invited to attend a briefing. The purpose of the briefing was to inform the providers of the:
- objectives of the clinical audits
- timeframes for planning, audit fieldwork and reporting the results to the providers involved in the audits
- proposed audit approach
- areas to be covered during the clinical audits
- processes to ensure the providers', and their clients', confidentiality was maintained.

The briefing was held in Auckland, with video conferencing for providers located in Wellington and Christchurch.

Pilot clinical audit

In June 2014, KPMG conducted a clinical audit of one provider to pilot the planned audit approach. This was to provide learnings to the clinical audit team in order to streamline the site visits for future audits.

KPMG then sought feedback on the clinical audit process from the provider that was selected to take part in the pilot clinical audit. We made minor amendments to our audit approach based on that feedback.

Post-pilot briefing

KPMG hosted a post-pilot briefing on 25 June 2014 to advise the providers on the process undertaken for the pilot clinical audit and the amendments that had been made to the audit approach based on the feedback we had received.

This briefing was attended by the provider selected by the Ministry for the pilot and the remaining seven providers that were yet to be audited at that time.

1.3.2 Fieldwork

The audit of each provider was conducted in accordance with the scope set out in the Agreement with the Ministry and the letters to each provider dated 11 April 2014.

Timing

Each clinical audit was conducted over 3 to 5 days between July and September 2014.

Audit teams

Each team used in conducting the audit was comprised of a KPMG lead auditor, a clinical auditor and a cultural auditor.

Selection of providers

The Ministry contracts 19 providers to deliver problem gambling intervention services. The Ministry selected eight providers to take part in the clinical audits – these providers represent a combination of:
- National and regional providers.
- Providers that specialise in service delivery for Māori, Pacific or Asian populations.
- A geographic spread of providers and clients across New Zealand.

The requirement to participate in the clinical audits is set out in the contracts between the Ministry and the providers.

Audit methodology

The clinical audit process consisted of the completion of audit tools by the audit team. These tools covered areas relating to:

- Service delivery and quality
  - Quality management
  - Access and entry
  - When services are declined
  - Plan of care
  - Implementing the care plan
  - Review of progress
  - Planning discharge from and/or transfer between services
  - Managing client information
  - Workforce development
  - Participating in research and evaluation

- Client Rights
  - Access to appropriate information
  - Informed consent
  - Rights to an advocate
  - Confidentiality
  - Managing complaints
  - Opportunities to provide feedback

- Cultural Perspectives
  - Providers of General services
  - Providers of Māori, Pacific and Asian dedicated services
  - Kaumātua Consultation and Liaison

Each of the audit tools required the auditor to assess whether the provider had fully complied, partially complied or had not complied with each contract/standard criterion outlined in the tool. Each criterion referenced in our audit tools was taken directly from one of the following documents:

- The contract held between the Ministry and the provider.
- The Health and Disability Service Standards.
- The Addiction Practitioners' Association Aotearoa New Zealand (DAPAANZ) Addiction Intervention Competency Framework 2011. The DAPAANZ Framework is not designed under contract to the Ministry but provides best practice guidelines.

The audit tools were reviewed by cultural and clinical subject matter professionals for completeness and relevance to the group of providers.

In order to complete each clinical audit we visited the providers' locations, interviewed staff members (including volunteers) and clients, and reviewed documentation such as policies, procedures and clients' files. Overall we:

- Visited 13 locations relating to eight providers
- Interviewed 59 staff members individually (including volunteers)
- Interviewed 78 clients individually, after receiving their written and informed consent, either face-to-face or via phone call.

1.3.3 Reporting

We prepared a report for each provider at the conclusion of its clinical audit. This summarised the findings of the KPMG auditors, clinical auditors and cultural auditors.

Access to the individual provider reports was restricted to the relevant provider and the Ministry. No information that would allow an individual client to be identified was included within these reports.

The results of the individual clinical audits were then collated in this report for the Auckland University of Technology Gambling and Addictions Research Centre. This report does not identify any of the providers that took part in the clinical audits, or their results. It only outlines the key findings from the collated results.

1.4 Summary of Findings

We did not identify any significant areas of partial or non-compliance with the following Service Delivery and Quality criteria:

- Access and entry
- When services are declined
- Managing client information
- Participating in research and evaluation

Therefore, we have deemed these areas as being fully compliant.

We identified areas of partial and non-compliance with the Service Delivery and Quality criteria. These findings related to quality management, plan of care, planning discharge from and/or transfer between services, the delivery of minimum volumes of service agreed with the Ministry, and workforce development.

We did not identify any significant areas of partial or non-compliance with the Client Rights or Cultural Perspectives criteria across the eight providers. Therefore, we have deemed these areas as being fully compliant.

1.4.1 Service Delivery and Quality

The key areas of non-compliance related to:

- Implementing the plan of care – the majority of the providers we audited were not consistently delivering the volume of services agreed with the Ministry. We found:

    - Seven out of the eight providers deliver Brief Intervention Services. Three of those providers did not deliver the minimum target agreed with the Ministry.

    - All of the providers deliver Full Intervention Services. Five out of eight providers did not deliver the minimum target agreed with the Ministry.

    - Seven out of eight providers deliver Facilitation Services. Five of those providers did not deliver the minimum target agreed with the Ministry.

    - Eight providers deliver Follow Up Services. Seven of those providers did not deliver the minimum target agreed with the Ministry.

    - Two providers deliver Workshop Based Services, and Helpline and Information Services. They delivered the minimum services agreed with the Ministry.

The key areas of partial compliance related to:

- Quality Management – the majority of the providers did not meet all of the requirements of their contract with the Ministry for managing and improving the quality of services to achieve the best outcomes for their users.

Four out of eight providers had documented quality plans as specified in their contracts. Of those four providers, only two reviewed their plans regularly to ensure the risks related to quality service delivery remain relevant.

We found that the remaining four providers did not have documented quality plans.

- Plan of Care – we found that the documentation of the Ministry's requirements (including the Health and Disability Service Standards) for planning were not consistently carried out within the providers' organisations.

    We found that at six out of eight providers the processes to support the client's assessment of need, planning (including discharge and/or transfer to another provider) and review of progress (against the intervention plan) were not either fully documented on the client's file or not documented at all (suggesting the process had not taken place).

- Workforce Development – we found that processes (such as preparation of workforce development plans, performance evaluations, and training) that are required to support workforce development have not been consistently implemented across all the providers' organisations.

    We found instances in five out of eight providers where workforce development plans were not always prepared for each staff member and progress against the plans was not regularly reviewed.

1.4.2 Client Rights

All of the clients we interviewed reported high levels of satisfaction with the services they received from their provider.

Clients have had access to appropriate information about the provider's service and their rights in order to provide their informed consent. They also received information about their rights to an advocate, the ways their confidentiality will be maintained and the complaints process. We also found that providers ensured their clients were given the opportunity to provide feedback on the service they had received.

We did not identify any significant areas of partial or non-compliance with the Client Rights criteria.

1.4.3 Cultural Perspectives

All of the clients we interviewed reported high levels of satisfaction with the cultural aspects of the services they received from their provider.

All the providers we audited (regardless of whether they were a General or dedicated Māori, Pacific or Asian service provider) had appropriate processes in place to ensure their clients received services specific to their cultural needs.

All eight providers had access to appropriate cultural advice and support from Kaumātua to ensure that staff, clients and their whānau/families were offered a culturally safe environment.

We did not identify any significant areas of partial or non-compliance with the Cultural Perspectives criteria.

2 Detailed Findings

2.1 Audit Methodology

For each clinical audit we visited the providers' locations, interviewed staff members (including volunteers) and clients, and reviewed documentation such as policies, procedures and clients' files. This was in order to complete the audit tools that allowed the auditor to assess whether the provider had fully complied, partially complied or had not complied with each contract/standard criterion outlined in the tool.

2.1.1 Selection of providers

The Ministry contracts 19 providers to deliver problem gambling intervention services. The Ministry selected eight providers to take part in the clinical audits – these providers were selected to represent a combination of:

- National and regional providers.
- Providers that specialise in service delivery for Māori, Pacific or Asian populations.
- A geographic spread of providers and clients across New Zealand.

The requirement to participate in the clinical audits is set out in the contracts between the Ministry and the providers. All providers were notified of the Evaluation and Clinical Audit of Problem Gambling Intervention and Public Health Services in December 2013. The eight providers selected to take part in the clinical audits were notified in April 2014.

In order to complete the audit fieldwork, we visited the providers' offices. We visited a total of 13 offices relating to 8 providers. In instances where the provider delivered services out of more than one location, we determined which locations we would visit depending on:

- The number of offices the provider had.
- The location of client files and other documentation required for the audit.
- Where it would be most convenient for clients and staff to meet the auditors for interviews.

2.1.2 Audit tools

We developed three audit tools in order to assess the providers' level of compliance with the following:

- Service delivery and quality

  - Quality management
  - Access and entry
  - When services are declined
  - Plan of care
  - Implementing the plan of care

  - Planning discharge from and/or transfer between services
  - Managing client information
  - Workforce development
  - Participating in research and evaluation

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- Client Rights
  - Access to appropriate information
  - Confidentiality
  - Informed consent
  - Managing complaints
  - Rights to an advocate
  - Opportunities to provide feedback

- Cultural Perspectives

  - Providers of General services
  - Kaumātua Consultation and Liaison.
  - Providers of Māori, Pacific and Asian dedicated services

Each criterion referenced in our audit tools was taken directly from one of the following documents:

- The contract held between the Ministry and the provider.

- The Health and Disability Service Standards.

- The Addiction Practitioners' Association Aotearoa New Zealand (DAPAANZ) Addiction Intervention Competency Framework 2011. The DAPAANZ Framework is not designed under contract to the Ministry but provides best practice guidelines.

The audit tools were then reviewed by cultural and clinical subject matter professionals, AUT and the Ministry, for completeness and relevance to the group of providers. All providers were invited to attend a briefing in March 2014 where they were advised of the areas that would be audited. The development of the audit tools was completed before the providers were selected to take part in the clinical audits.

A clinical audit was carried out with one provider in June 2014 for the auditors to pilot the audit methodology. This was to determine whether the audit methodology was appropriate or if amendments were required.

In order to complete the audit tools for the pilot, the auditors held staff and client interviews, reviewed client information, and reviewed any other information relevant to the audit. They then assessed each criterion in each of the three tools to determine whether there was full compliance, partial compliance or non-compliance.

These have been defined as follows:

- Full compliance – all of the requirements of the contract with the Ministry and/or the Health and Disability Service Standards have been achieved by the provider.

- Partial compliance – some of the requirements of the contract with the Ministry and/or the Health and Disability Service Standards have been achieved by the provider.

- Non-compliance – the requirements of the contract with the Ministry and/or the Health and Disability Service Standards have not been achieved by the provider.

No amendments were made to the audit tools as a result of this process and the remaining seven clinical audits were carried out between July and September 2014 using the same audit methodology. The audit fieldwork was completed over a three to five day period (depending on the size of the provider) and the initial results discussed with the provider on the final day.

A summary of the audit methodology, client information sheet, and client consent form were approved by the Auckland University of Technology Ethics Committee (AUTEC) on 16 December 2013.

2.1.3 Staff interviews

We interviewed 59 staff members (including volunteers) across the eight providers. Before the audits began, we advised the providers of the areas we would be auditing (service delivery and quality, client rights and cultural perspectives), and the topics we would like to discuss within each of those areas.

We requested the provider organise the relevant staff to meet with the auditors to discuss the areas. Methods for Interviews varied from provider to provider in that they were carried out individually and in groups. We did not interview every staff member at the provider's organisation.

The meetings with staff were summarised and documented in minutes. The information provided by the staff was then corroborated against policies and procedures, client information and/or any other relevant documentation or evidence.

2.1.4 Client interviews

We interviewed 78 clients individually and after receiving their written and informed consent. We interviewed a minimum of five clients at each provider. The sample size was increased based on the professional judgement of the auditor. The maximum number of clients interviewed at a provider was nineteen.

Prior to the audits, we requested the provider identify a sample of clients that would be willing to participate in interviews with the auditors. In collaboration with AUT, we prepared an information sheet for the provider to give to the clients which set out:

• The purpose of the clinical audits
• How they were identified and invited to participate in the clinical audit
• What their role would be in the clinical audit
• What the risks and benefits to them would be of participating in the clinical audit
• That the client could choose not to answer any question or withdraw from the interview at any time
• How their privacy would be protected.

Those who were willing to participate were then requested to complete and sign a consent form.

We were notified by one provider that seven of its clients would require interpreters. In that instance, we arranged for an interpreting service to provide trained interpreters to assist in our interviews.

Interviews were conducted face-to-face (at the provider's office) or via phone conference. Each interview took no longer than one hour and the information obtained from the client was summarised and documented in minutes. No information was recorded about the client that would be able to identify them.

The information provided by the clients was then corroborated against discussions with staff, or by reviewing policies and procedures, client information and/or any other relevant documentation or evidence.

2.1.5 Review of client files

The purpose of reviewing the client files was to corroborate the information obtained through interviews with the providers' staff and their clients and to assess the providers' level of compliance with the criteria in the audit tools.

We reviewed a total of 104 client files across all 8 providers. At a minimum, we reviewed 10 client files for each provider.

The sample size was increased based on the professional judgement of the auditor. For example, if one issue in the sample was identified, the sample was increased to determine whether it was a 'one off' or indicated a more common issue.

The client files were randomly selected by the auditors from the files available at the time of the audit. No information was taken or copied from the client files and no information was recorded in our audit tools that would identify any individual clients.

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2.1.6 Review of documentation

We reviewed a range of documentation to corroborate the information obtained through interviews with the providers' staff and their clients and to assess the providers' level of compliance with the criteria in the audit tools.

The types of documentation we reviewed included:

- Policies and procedures.

- Six monthly reporting to the Ministry.

- Quality management information such as quality plans and quality improvement data.

- Employment information such as training records, workforce development plans and performance appraisals.

2.1.7 Reporting results

After the audit fieldwork was completed at each of the providers' locations, quality assurance over the results was carried out by KPMG.

A draft report was prepared and sent to the providers to confirm that they agreed with the assessment of the level of compliance against the audit criteria. Once agreement had been reached, the final report was provided to the Ministry and the provider.

A summary of the audit methodology, client information sheet, and client consent form were approved by the Auckland University of Technology Ethics Committee (AUTEC) on 16 December 2013.

2.2 Service Delivery and Quality

The Service Delivery and Quality audit criteria were taken directly from the contract held between the Ministry and the provider, the Health and Disability Service Standards, and the Addiction Practitioners' Association Aotearoa New Zealand (DAPAANZ) Addiction Intervention Competency Framework 2011.

The audit of Service Delivery and Quality covered:

- **Quality management**
  Has the provider developed, documented, implemented and evaluated a transparent system for managing and improving the quality of services?

- **Access and entry**
  Do all eligible people have fair, reasonable and timely access to effective services?

- **When services are declined**
  Are there appropriate policies and procedures to manage the immediate safety of the client for whom entry to the service is declined and, where necessary, the safety of their immediate family/whānau and the wider community?

- **Plan of Care**
  Are care plans developed for all clients where the needs, outcomes and goals of the client are identified and documented to serve as the basis for service delivery planning? Are the care plans up to date and do they provide a record of treatment? Is the client's progress against the care plan reviewed and documented?

- **Implementing the plan of care**
  Does the provider deliver the range and volume of services (or purchase units) agreed with the Ministry? If the provider does not deliver all purchase units, do they collaborate with other providers in order for their clients to have access to the full range of services? Has the provider established linkages between problem gambling providers and other service providers?

- **Planning discharge from and/or transfer between services**
  Does the provider have written, implemented and reviewed policies and procedures for planning clients' discharge, exit or transfer of its services?

- **Managing client information**
  Does the provider maintain an information system that efficiently and accurately monitors utilisation and outcomes for service users? Are there processes to regularly monitor and improve the quality of data recorded in hardcopy and/or information systems? Are there appropriate processes for ensuring the confidentiality of client information?

- **Workforce Development**
  Are staff supported to access appropriate training and workforce development to deliver effective, high quality, sustainable intervention activities for their clients?

- **Participating in research and evaluation**
  Do staff participate in national, regional and local research, monitoring and evaluation processes as required in order to support intervention service practices and theories that are informed by an up to date and sound evidence base?

  ▪

We did not identify any significant areas of partial or non-compliance across the eight providers for the following Service Delivery and Quality audit criteria:

- Access and entry
- When services are declined
- Managing client information
- Participating in research and evaluation.

Therefore, we have deemed these areas as being fully compliant.

We found that all eight of the providers had consistent areas of non-compliance or partial compliance with the following Service Delivery and Quality audit criteria:

- **Implementing the care plan**

   In order to prevent and minimise gambling harm, each provider agrees with the Ministry to provide a range of services (or purchase units) comprised of:

   – Brief Intervention Services delivered by seven out of eight providers participating in the audit.

   – Full Intervention Services delivered by all eight of the providers participating in the audit.

   – Facilitation Services delivered by seven out of eight of the providers participating in the audit.

   – Follow Up Services delivered by all eight of the providers participating in the audit.

   – Workshop Based Services delivered by one provider participating in the audit.

   – Helpline and Information Services delivered by one provider participating in the audit.

   Each contract between the Ministry and the provider sets out the types of intervention service, and the minimum number of sessions per month. The volume of sessions varies for each provider based on the number of full time equivalent employees that will be providing the service.

   We identified the minimum number of sessions for each service type in each contract between the provider and the Ministry and compared this to the actual number of sessions delivered by the providers.

   We found:

   – Brief Intervention Services – three out of the seven providers contracted by the Ministry to deliver brief intervention services did not deliver the minimum number of sessions required under their contract with the Ministry.

   – Full Intervention Services – five out of the eight providers audited did not deliver the minimum number of sessions required under their contract with the Ministry.

   – Facilitation Services – five out of seven providers contracted by the Ministry to deliver facilitation sessions, did not deliver the minimum number of sessions required under their contracts.

   – Follow Up Services – seven out of eight providers audited did not deliver the minimum number of sessions required to be delivered under their contract with the Ministry.

   – Workshop Based Services – the provider contracted to deliver workshop based services met the minimum requirements of its contract with the Ministry.

   – Helpline and Information Services – the provider contracted to deliver helpline and information services met the minimum requirements of its contract with the Ministry.

   Providers discussed with the auditors the challenges in delivering the minimum contracted services. The most common challenges related to staffing such as difficulties in recruiting new staff, high staff turnover and long periods of staff absence due to serious illness.

   Providers also discussed with the auditors the difficulties in specifically providing follow up services as often clients could not, or did not want to be contacted after the conclusion of their brief, full or facilitation Services.

The consistent areas of partial compliance we identified during the audits were:

- **Quality management**

  Each provider is required to develop, document, implement and evaluate a transparent system for managing and improving the quality of services to achieve the best outcomes for clients.

  As part of this system, the provider is required to prepare a Quality Plan that is designed and implemented to improve outcomes for clients, and is reviewed at least annually. The plan should outline a clear quality strategy and the organisational arrangements to implement it. The plan should also be of a size and scope appropriate to the size of the provider's service.

  In addition to the Quality Plan, quality improvement data should be collected, analysed and evaluated. If necessary, corrective action plans should be developed to address areas requiring improvement.

  We found:

  - Four out of eight providers have quality management plans in place. However, only two of those providers had reviewed their quality management plans annually to ensure that the quality strategy and the risks associated with the provision of services were still relevant.

  - The remaining four providers did not have a documented quality management plan however, elements of quality management, such as collecting quality improvement data, were still evident across all eight providers.

  - All of the providers collected at least some quality improvement data (including feedback from their clients). However, four out of eight providers did not have processes in place to collate and analyse that information.

  - As there were few instances where quality improvement data had been analysed, only three providers had developed corrective action plans in order to address the issues that had been identified by clients or the provider themselves.

- **Plan of care**

  The providers' contract with the Ministry states that they must develop for each client, a written plan of care and record of treatment which:

  - is based on an assessment of the client's individual needs (including cultural needs)

  - includes consultation with the client

  - where appropriate, and with the consent of the client, includes consultion with the client's family and/or caregivers

  - contains detail appropriate to the impact of the service on the client

  - facilitates the achievement of appropriate outcomes as defined with the client

  - includes plans for discharge or transfer

  - provides for referral to, and co-ordination with, other medical services and links with community, iwi, Māori and other services as necessary.

In addition, the Health and Disability Service Standards state that the needs, outcomes and/or goals of the clients should be identified and documented via the assessment process, and serve as the basis for service delivery planning. The assessment and intervention outcomes are to be communicated to the client, referrers and relevant service providers.

We found care plans were not consistently completed at six out of eight providers. In most instances, the care plans were incomplete as they did not provide sufficient detail on the assessment of need, support and the interventions required to achieve the client's desired outcomes.

At one of those providers we found that only the goals of the client were documented – not the assessment of need nor the interventions required for the client to achieve those goals.

At four out of eight providers, we found that the assessments of need had either not been completed or they had not been documented for every client. Where the assessment of need had been completed, there was insufficient information documented to support the assessment process.

The Health and Disability Service Standards also state that reviews of progress against the client's plan of care should be documented, service user-focused, indicate the degree of achievement or response to the support and/or intervention, and the progress towards meeting the desired outcome.

In addition, the reviews should be carried out regularly in order to monitor progress, and if progress is not as expected, the plan altered in response.

At six out of eight providers, reviews of progress were not being carried out consistently. We found instances where:

- The client's file did not record the progress made towards achieving their goals.
- Where progress was being monitored, we found instances where care plans were not altered when it was identified that progress was not as expected.

- **Planning discharge from and/ or transfer between services**

The contract requires that the provider develop policies and procedures for planning discharge or transfer of clients from its services. This includes the requirement for providers to identify, document, and minimise the risks associated with each client's transition, exit, discharge or transfer.

We found that all providers had policies in place. However, the policies could be improved to ensure coverage over all areas that are set out in the contract with the Ministry. For example, ensuring that discharge planning is incorporated into the client's plan of care, where appropriate from or before admission.

At four out of eight providers, the documentation to support the planning for discharge or transfer was insufficient. We found that the planning on the client files did not identify the risks of relapse associated with the client's discharge or did not indicate that the discharge or transfer had been planned in collaboration with the client.

- **Workforce Development**

Providers are required to ensure that there are processes in place to support professional career pathway development, continuing education and training for its staff. This includes:

- Preparing and implementing workforce development plans that cover all problem gambling staff
- Implementing management practices which support and encourage staff training and development
- Developing and maintaining performance management systems for all employees and reviewing practices and processes used in service delivery.

Five out of eight providers' processes were limited in supporting workforce development in their organisations.

- Staff at one provider had not prepared workforce development plans and had not had performance appraisals or a review of staff professional practices used in service delivery in at least the previous three years.

- Two of the providers had workforce development plans but they had not been updated nor progress against the plans regularly reviewed. For example, where staff had identified a training need in their workforce development plan, and had attended that training, this was not documented against the workforce development plan as being achieved.

- Formal performance appraisals had not been carried out regularly (at least annually) at two of the providers.

2.3 Client Rights

The Client Rights audit criteria were taken directly from the contract held between the Ministry and the provider, the Health and Disability Service Standards, and the Addiction Practitioners' Association Aotearoa New Zealand (DAPAANZ) Addiction Intervention Competency Framework 2011.

The audit of Client Rights covered:

- **Right to an advocate**
  Are staff and clients aware of the client's right to an advocate, including support in the resolution of any complaint? Is the provider able to facilitate access to a Māori advocate for consumers who require this service?

- **Opportunities to provide feedback**
  Do the providers regularly offer clients, their families/whānau and referrers the opportunity to provide feedback? Is the feedback reflected in the maintenance and improvement of the quality of service?

- **Managing complaints**
  Are clients, families/whānau and other people enabled to make complaints through a written and implemented procedure for the identification and management of complaints? Does this meet the Code of Health and Disability Services Consumers' Rights?

- **Informed consent**
  Does the provider have appropriate policies and procedures in place to ensure the client is aware of what they are consenting to?

- **Confidentiality**
  Are there appropriate policies and procedures in place to ensure the client's information is maintained confidentially (unless the client gives their informed consent to disclose information to a third party)?

- **Access to appropriate information**
  Do potential and current clients and referrers have access to appropriately presented information in order for eligible people to access the providers' services?

We did not identify any significant areas of partial or non-compliance with the Client Rights audit criteria across the eight providers. Therefore, we have deemed these areas as being fully compliant. We found that:

- All providers have information available for potential and current clients to access about the providers' services. This information is usually in the form of a brochure. However, some providers had information available on the internet via website and social media.

- All providers have policies and procedures for ensuring that the clients give their informed consent prior to receiving services. All clients we interviewed recalled receiving information about the services and we were able to sight evidence that informed consent had been provided by the clients.

- All clients we interviewed confirmed they had been informed of their right to have an advocate.

- All providers had policies and procedures to ensure that information about the client is disclosed to a third party only with the client's informed consent and only to assist in effective service provision and achieving positive outcomes for the consumer.

- All providers had written and implemented procedures for managing complaints from clients and their whānau/family. The clients were aware of where to find information about the complaints procedure should they wish to make a complaint. All of the providers we audited had information available at their premises.

- Clients reported that they had been provided opportunities to give feedback on the services they had received. This feedback was provided formally by client feedback forms and surveys, or informally during the counselling process. We noted in section 2.1 Quality Management, that while we sighted evidence that feedback is received, seven out of eight of the providers had not collated and analysed the feedback in order for the clients' input to be reflected in the maintenance and improvement of the quality of service.

2.4 Cultural Perspectives

The Cultural Perspectives audit criteria were taken directly from the contract held between the Ministry and the provider, the Health and Disability Service Standards, and the Addiction Practitioners' Association Aotearoa New Zealand (DAPAANZ) Addiction Intervention Competency Framework 2011.

The audit of Cultural Perspectives covered:

- **Providers of General services**
  Do providers of General services aim to minimise gambling-related harm for all members of the community, and include consideration for delivering to Māori, Pacific, Asian and other priority subgroups?

- **Providers of dedicated Māori services**
  Does the provider demonstrate the services are based in a Māori cultural paradigm? Does the provider utilise Māori derived beliefs, values and practices? Where possible, are staff of Māori descent? Is there an emphasis on whānaungatanga?

- **Providers of dedicated Pacific services**
  Does the provider demonstrate the services are based in a Pacific cultural paradigm? Does the provider utilise Pacific derived beliefs, values and practices? Where possible, are staff of Pacific descent? Is the service mandated by the local Pacific communities?

- **Providers of dedicated Asian services**
  Does the provider demonstrate the services are based in an Asian cultural paradigm? Does the provider utilise Asian derived beliefs, values and practices? Where possible, are staff of Asian descent? Is the service mandated by local Asian communities?

- **Kaumātua Consultation and Liaison**
  Do providers have the capacity, skills and relationships to work effectively and appropriately with and for Māori? Do providers offer an environment that is culturally safe for Māori service users, their whānau and significant others, as well as for those delivering the services?

The provider must deliver its services as either a General, Dedicated Māori, Dedicated Pacific or Dedicated Asian service (as agreed with the Ministry). Our sample of providers included two General, three Māori, two Pacific and one Asian Dedicated service provider. The purpose of the dedicated cultural services is to minimise problem gambling related harm particularly to, and for, Māori, Pacific and Asian Peoples.

We did not identify any significant areas of partial or non-compliance with the Cultural Perspectives audit criteria across the eight providers. Therefore, we have deemed these areas as being fully compliant. We found that:

- The clients we interviewed reported a high level of satisfaction with the cultural elements of the services they had received.

- Services delivered by General Service providers are accessible to all groups regardless of gender, ethnicity, age or health status. They have access to cultural support and expertise as required to ensure the services are culturally safe and appropriate to a diverse population.

- The services delivered by dedicated Māori, Pacific and Asian providers are based in each of their own cultural paradigms. The services utilise the beliefs, values and practices specific to their clients' cultures. We also found that where reasonably possible, the staff at the dedicated Māori, Pacific or Asian providers were of the same descent as their clients.

- The staff we interviewed could not recall any instances where clients that were not of Māori, Pacific, or Asian descent were excluded from any of the dedicated service providers.

- All of the providers' staff and clients we interviewed had access to appropriate cultural advice and support from a Kaumātua. This assisted providers in ensuring they offered an environment that is culturally safe for Māori clients, their whānau/family, and significant others, as well as for those delivering the services.

3 Conclusion

Overall, we have assessed the level of compliance with the providers' contract with the Ministry and the Health and Disability Service Standards relating to Service Delivery and Quality as partially compliant.

Service Delivery and Quality			🟧
Quality management	🟧	Planning discharge from and/or transfer between services	🟧
Access and entry	🟩	Managing client information	🟩
When services are declined	🟩	Workforce development	🟧
Plan of care	🟧	Participating in research and evaluation	🟩
Implementing the plan of care	🟥		

Overall, we have assessed the level of compliance with the providers' contract with the Ministry and the Health and Disability Service Standards relating to Client Rights as fully compliant.

Client rights			🟩
Access to appropriate information	🟩	Confidentiality	🟩
Informed consent	🟩	Managing complaints	🟩
Rights to an advocate	🟩	Opportunities to provide feedback	🟩

Overall, we have assessed the level of compliance with the providers' contract with the Ministry and the Health and Disability Service Standards relating to Cultural Perspectives as fully compliant.

Cultural Perspectives			🟩
Providers of general services	🟩	Providers of Asian dedicated services	🟩
Providers of Māori dedicated services	🟩	Kaumātua consultation an liaison	🟩
Providers of Pacific dedicated services	🟩		

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■	**Fully compliant** No significant areas of partial or non-compliance with the Ministry and/or the Health and Disability Service Standards were identified. That is, we found the majority of requirements have been achieved based on the testing we carried out of the eight providers and the sample of client files, policies and procedures and other relevant documentation we audited.
■	**Partially compliant** Some of the requirements of the contract with the Ministry and/or the Health and Disability Service Standards have not been achieved by the providers. That is, we found some of the requirements have been achieved based on the testing we carried out of the eight providers and the sample of client files, policies and procedures and other relevant documentation we audited.
■	**Non-compliant** The requirements of the contract with the Ministry and/or the Health and Disability Service Standards have not been achieved by the provider. That is, we found the majority of requirements have not been achieved based on the testing we carried out of the eight providers and the sample of client files, policies and procedures and other relevant documentation we audited.

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