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EVALUATION OF PROBLEM GAMBLING INTERVENTION SERVICES

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STAGES ONE AND TWO FINAL REPORT

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EXECUTIVE SUMMARY

Background

The Ministry of Health is responsible for the funding and coordination of problem gambling services and activities in New Zealand. This includes the funding of a national telephone helpline, two national face-to-face counselling services and several regional treatment providers which include Maori and Pacific specific services (Asian specific services are provided as a division of one of the national face-to-face treatment providers) (Ministry of Health, 2008a).

From 2008, Ministry funded face-to-face problem gambling treatment providers have received specific training around Ministry expectations for service practice requirements (e.g. the types of intervention that will be funded and the processes expected within those interventions as well as for referrals for co-existing issues), and expectations around data collection, management and information submission to the Ministry. The Ministry has also identified specific sets of screening instruments to be used with clients, which vary depending on whether the client is receiving a brief or full-length intervention, or is a problem gambler or family/whanau member ('significant other') of a gambler. These screening instruments came into use in 2008, with different sets of instruments having been used previously.

At the present time, the effectiveness of the current problem gambling treatment services is largely unknown, as is the optimal intervention process for different types of client. Whilst this sort of information can ultimately only be ascertained through rigorously conducted effectiveness studies (randomised controlled trials) (Westphal & Abbott, 2006), an evaluation (process, impact and outcome) of services could provide indications as to optimal treatment pathways and approaches for problem gamblers and affected others, as well as identifying successful strategies currently in existence and areas for improvement in current service provision.

In September 2008, the Gambling and Addictions Research Centre at Auckland University of Technology was commissioned by the Ministry of Health to conduct the research project *Problem gambling: Evaluation of problem gambling intervention services.*

This project focused on four priority areas:

- Review and analysis of national service statistics and client data to inform workforce development, evaluation of Ministry systems and processes, and other related aspects
- Process and outcome evaluation of the effect of different pathways to problem gambling services on client outcomes and delivery
- Process and outcome evaluation of distinct intervention services
- Process and outcome evaluation of the roll-out and implementation of Facilitation Services

Methodology

The priorities as detailed above were achieved through a three-stage process:

1. Stage One: Involved a desktop analysis of two national gambling treatment service datasets for the 2007/08 financial year (1 July 2007 to 30 June 2008) (face-to-face counselling [CLIC] and helpline data) plus the Asian hotline database
2. Stage Two: Involved key stakeholder input and further analysis of data from gambling treatment services and other sources on relevant delivery from 1 January to 30 June 2008
3. Stage Three: Will involve a review and comparative analysis of 2008/09 service delivery and national data trends against initial findings

Stage One

The three databases were analysed for sample population, profile of clients, data completeness and accuracy, and trends. Statistical comparisons were performed for key areas of interest, and where numbers were large enough to allow comparisons. Preliminary information from Stage One was used to inform the design of the survey questionnaires for Stage Two.

Stage Two

Fourteen gambling treatment services were involved in Stage Two; they included the national helpline, two national face-to-face services, seven regional Maori services, two regional Pacific services, one national Asian service and one regional Mainstream service[1]. Their involvement included staff participation in one of four semi-structured focus groups, and surveys of all staff available during the time frame of the survey (N=60) and of 61 clients recruited by convenience sampling. Eighteen staff from allied agencies to which clients (from the 14 gambling treatment services) have a facilitated referral for co-existing issues (Facilitation Services) also took part in a survey. Stage Two also included a group interview with the provider of training and workforce development to gambling treatment services.

The focus groups and survey questionnaires covered topics relating to clients' pathways into and out of treatment, distinct (specific) interventions provided by some services, Facilitation Services, satisfaction with the processes, and training and workforce development issues in relation to the processes. The group interview covered similar topics from a training and workforce development point of view.

Stage Three

This will be a repeat of Stages One and Two and conducted in 2009, with comparison of findings against those from Stages One and Two.

Results

Stage One

Client demographics

- *Gambler versus significant other:* Generally the majority of services recorded two-thirds or more gambler clients with the remaining third or less being significant others. Four Maori services had a higher proportion of significant other clients than

[1] These treatment services represented about half of the services funded by the Ministry of Health and were selected by the researchers to include a mix of national and regional services, and Mainstream and Ethnic-specific services.

the Mainstream services. The residential Alcohol and Drug service had a much higher proportion of gambler clients to significant others.

- *Gender:* Generally the majority of services recorded a similar ratio or slightly more male gambler clients than female. Seven Maori services had a higher proportion of female gambler clients than male, and the Asian hotline recorded substantially more male than female gambler clients. A different profile was noted for significant other clients whereby generally two-thirds were recorded as female.
- *Ethnicity:* Almost all services provided interventions for more than one ethnic group. However, as expected, Maori services generally had higher proportions of Maori clients than other services with a few only having Maori gambler or significant other clients. Similarly, one of the Pacific services had a higher proportion of Pacific clients, although the other Pacific service had more clients of other ethnicities than Pacific clients. The Mainstream service which also provides Asian services had a higher proportion of Asian clients than all other services, apart from the Asian hotline which had almost exclusively Asian clients.
- *Age:* Whilst the majority of services had gambler clients across the age ranges, one Mainstream service had more clients (gambler and significant other) in the older age groups (50+ years) than the other Mainstream services. This service provides a workshop approach as one of its main problem gambling interventions. Additionally, a few Maori services had more clients in the younger age groups (39 years or less) than other services.
- *Geographic location:* Mainstream and Maori services generally recorded clients in almost all Territorial Local Authorities. Pacific services recorded clients in the area within which the services were located.

Treatment programmes, sessions and type

- *Episodes[2] and sessions:* On average, clients were in 1.3 to 1.5 (significant other, gambler) episodes over the 12-month period. However, there was some variability in the average number of counselling sessions per episode varying from between one and ten (average 2.9 gambler/2.0 significant other) at different services. The residential Alcohol and Drug service was substantially different from the others with an average of 26 sessions per gambler client per episode.
- *Episode type:* The distribution of episode type was similar across services. However, several services other than Mainstream did not record brief, full or follow-up episodes with gambler or significant other clients. One Mainstream service did not record any brief interventions with gamblers or significant others. The latter service provides a unique workshop approach to problem gambling interventions which would not be compatible with a brief intervention approach.
- *Length of time per episode type:* Overall, the average length of time (gambler/significant other) for a brief intervention was 0.76/0.59 hour, for a full intervention was 1.17/1.23 hours and for a follow-up session was 0.36/0.67 hours. The average length of session times was generally similar across services although some recorded episodes substantially longer than the average. The average length of time for a full intervention at one Mainstream service was four hours; this is due to the workshop approach offered by this service.
- *Intervention outcome (treatment completion):* Treatment programme completion data for clients was fairly consistent across services; however, there were three Maori services with high levels of administrative discharges or partially complete treatments

[2] An episode is a distinct series of counselling sessions providing an intervention for a client. An episode can be brief, full or follow-up. A brief episode contains only brief sessions. A full episode contains only full or facilitation sessions. A follow-up episode contains only follow-up sessions. Each client is expected to have two to three episodes, i.e. full and follow-up or brief, full and follow-up..

for gambler and/or significant other clients. An average completed treatment episode was 51 days for gambler clients and 41 days for significant other clients, though there was considerable variability amongst services with some recording longer or shorter episode durations.

- *Primary gambling mode:* In general, the primary gambling mode recorded per episode of treatment was electronic gaming machines, particularly those outside a casino.
- *Counselling type:* All services provided individual counselling in the 12-month period, with some services also providing group, couple and family/whanau counselling for gamblers.
- *Counselling sessions:* The majority of sessions recorded by all services were counselling sessions. Although there was wide variability, on average 15%/20% (gamblers/significant others) of sessions were recorded as assessments, and 3%/6% were recorded as follow-up sessions.

Contact dates, referral pathways and treatment pathways

- *Initial contact date:* Overall an average of one-third of gambler clients pre-existed the time frame of analysis with a further third of new clients in each of the first and second half of the year of analysis. For significant other clients, an average of one-fifth pre-existed the time frame of analysis. Some services recorded an increase in clients during the second half of the year of analysis whilst others recorded a decrease.
- *Referral pathway into and out of services:* Overall, 26% of gambler clients and 48% of significant other clients self-referred themselves to a service, 17% of gambler clients were referred by a helpline, and 12% of significant other clients were referred by family/relatives. Overall, less than 10% of clients entered a service by each of the other recorded pathways. There were some service differences with one Mainstream service recording approximately one-third of clients finding out about the service via the media (this service focuses on advertising to access participants), and a few Maori services recording a substantial proportion of gambler clients self-referring into the services. The residential Alcohol and Drug service recorded a fifth of gambler clients entering the service from other Alcohol and Drug services. The 'Kiwi Lives' social marketing campaign may have had some slight positive impact on gambler clients entering gambling treatment services. Formal Facilitation Services were not in place during the time frame of analysis so referral pathways out of services were not routinely recorded.
- *Treatment episode pathway:* Overall, a majority of gambler (54%) and significant other (65%) clients at each service followed a pathway of up to three brief, or up to eight full counselling sessions (with up to three facilitation sessions). A proportion (16% gambler, 6% significant other) of clients followed the pathway of up to three brief followed by up to eight full counselling sessions (including up to three facilitation sessions) (gamblers and significant others) followed by up to four follow-up sessions (gamblers only). A mixed number of brief, full counselling, facilitation and/or follow-up sessions was recorded for other clients.

Assessments

For all assessments, there was either variability amongst services in scores at initial assessment or the service did not record scores at initial assessments. Numbers of follow-up assessments were generally too small to allow meaningful conclusions to be drawn regarding client improvement over time, though overall an improvement was noted for all assessment scores. Perhaps of note is that in general, all services recorded a similar average initial SOGS-3M score for gambler clients, though three Maori services recorded lower initial scores than the average.

Analysis of trends

Overall, for gambler and significant other clients, there appeared to be a reduction in numbers during December 2007.

- *Services:* One Mainstream service recorded a slight reduction in the number of gambler new clients in the first half of the analysis period; this was matched by a reduction in number of counselling sessions. Another Mainstream service recorded a slight increase in the number of gambler counselling sessions in the first half of the analysis period; however, this was not matched by an increase in new clients. Maori services recorded an overall increase in numbers of significant other new clients in the first half of 2008, matched by an increase in number of counselling sessions.
- *Age:* There was an increase in the number of significant other new clients aged 30 years or younger during the first half of 2008; however, an increase in number of significant other counselling sessions was noted for those in the 30 to 39 year age range.
- *Ethnicity:* There was an overall slight increase in number of Maori significant other clients during the first half of 2008; during the same time period there was a substantial increase in number of counselling sessions. During this same period, there was an overall slight increase in the number of Pacific gambler and significant other new clients with no corresponding change in average number of counselling sessions, and an overall slight decrease in the number of Mainstream gambler counselling sessions with no corresponding overall reduction in gambler new client numbers (through the trend appeared similar).
- *Gender:* A substantial increase in the number of counselling sessions for male and female significant other clients was recorded during the first half of 2008, though a corresponding increase in number of new clients was not apparent.

Stage Two

Survey: Staff

- *Demographics*: 60 participants completed the staff survey. The majority were female (68%), of New Zealand European ethnicity (53%), and were employed full time (70%) in a mainstream service (85%). Nevertheless, a high percentage of Maori and Asian staff members were successfully recruited (22% and 20%, respectively) as were a smaller percentage of Pacific Island staff (8%).
- *Pathways into services*: The five most frequently reported pathways into gambling treatment services were: formal referral from other gambling treatment services, self-referral, informal referral from family or friends, in response to media advertising, and a formal referral from the corrections/justice sector. Opinion was mixed as to whether there was a relationship between a client's pathway into a service and their presenting problems, the treatment approach employed or subsequent outcome.
- *Distinct intervention services*: Participants from mainstream and ethnic-specific services reported that they provided a similar range of services, with the exception of Marae Noho, workshop and group treatment approaches which were more often provided by ethnic-specific services. Opinion was mixed 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.
- *Facilitation Services*: Participants generally agreed that allied agencies respond positively to client facilitation, and that facilitation had a positive impact on their relationship with a client and resulted in (of those who answered the question) improved client outcomes. However, many participants stated they spent a lot of time

implementing the new Facilitation Services, one-third (33%) thought they could be better implemented, and over half (55%) felt the outcomes of the new facilitation approach were comparable to previous methods employed.

- *Training and workforce development*: When asked to rate, via a series of structured questions, their experience of the Ministry of Health data collection, reporting and data entry systems a minority of participants (typically ranging between 20% to 27%) provided a "very good" or "good" response. A slightly larger percentage of participants (typically ranging between 16% to 32%) provided a "poor" or "very poor" response. Similarly, there was mixed opinion as to whether the collected data were clinically useful and improvements in the training process were suggested.

Survey: Clients

- *Demographics*: 61 participants completed the client survey. Just over half were male (56%), aged between 30 to 39 years (31%) or 40 to 49 years (27%) and of New Zealand European ethnicity (59%). A relatively high percentage of Maori and Asian clients were recruited (28% and 12%, respectively). Eighty-seven percent were seeking treatment for their own gambling-related problem and 13% were significant others. The median number of treatment appointments attended at the time of the interview was eight (range 1 to 200).
- *Pathways into services*: The most frequently reported pathways into gambling treatment services were advertisement, referral by family or friends, and referral from the helpline. Fifty-six percent of participants knew of more than one treatment service prior to seeking help. The most frequently reported influences on their decision to choose one service over another were the type of treatment/help provided, service recommendation or the service location.
- *Distinct intervention services*: Irrespective of which type of service the participating clients had attended, the vast majority reported positive treatment outcomes and high levels of satisfaction with the treatment experience. Factors considered most helpful/ satisfying were the clinician skills or personal attributes, the knowledge or insight gained during the treatment process or the progress made, and the supportive environment. A number (ranging between 17% to 24%) of participants suggested there was room for improvement in the treatment or counselling approach, the information provided about the services, or the locations of services.
- *Facilitation Services*[3]: Thirty-four percent of participants stated that they had been facilitated to another agency for co-existing issues. The most commonly reported method of facilitation was "in person". The counsellors' assistance in the facilitation process was widely considered "helpful", as was the assistance received from the new agency (to which they had been facilitated).

Survey: Allied agencies

Although gambling treatment services conduct facilitated referrals of clients to a range of allied agencies, many of these agencies are unaware that the process is taking place. Of those who are aware, the majority appear to be health/counselling/social support services.

Eighteen completed survey forms were received. A majority of respondents reported that the facilitated referral occurs over the telephone and that the clients attend their service more than half or all of the time after the facilitated referral has been made. Two-thirds of respondents also reported that they refer clients to gambling treatment services as well as the other way round.

[3] Facilitation Services is the Ministry of Health term for active support of clients (by their problem gambling counsellor) to access allied social or health services for co-existing issues.

Half of the participants reported benefits to clients of the facilitated referral process including that entry to the allied agency is made easier and that clients may receive a more effective service. However, negative aspects were also reported relating to possible coercion effects, client frustration with the allied agency or unsuitability to that agency, or embarrassment at having been referred.

Two-thirds of participants reported that the facilitated referral process benefitted their agency though information sharing/networking, increase in number of clients, opportunity for assisting people, or building good relationships with clients. Only four negative responses were received, each reported by one person only, reflecting individual bias. Similarly, a variety of individual responses were received relating to how facilitated referral of clients could be improved.

A majority of participants reported that they thought clients have more positive outcomes if they are receiving interventions for their gambling issues as well as other co-existing issues.

Over two-thirds of respondents rated the relationship between their agency and gambling treatment services as very good or good, though a number suggested that the relationship could be improved through greater contact and/or more attention to relationship building activities.

Focus groups

Various themes were identified that fit into the broad categories of: pathways into services; the provision of interventions including any specific or distinct interventions; Facilitation Services; training and workforce development; data collection, entry and monitoring for the CLIC database; and other relevant issues.

- *Pathways into services*
    - Types of pathways: There is a range of common pathways for clients to access/find out about services including: social marketing campaign, self-referrals, telephone books, advertising, mental health services, courts, probation, local knowledge, schools, gambling venues, food banks, alcohol and drug treatment services, notices at gambling venues and on machines, online requests and assistance, text messaging and General Practitioners. However, pathways for clients accessing different services differed by service.
    - Awareness raising: Raising awareness of what counselling entails (for gamblers and general community) was considered important.
    - Specific pathways: Helpline referral, justice system referral and being in crisis were three pathways that were considered to be particularly major routes for client entry to services and were discussed in depth.
    - Major barrier: The fact that counsellors are not always available when clients want them to be was considered to be a major barrier to service entry, especially for ethnic-specific clients.
- *Distinct intervention services, organisational and client characteristics*
    - Service characteristics: There was a variety of organisational frameworks operated by different services.
    - Holistic approach: A holistic approach to treating problem gambling was considered of great importance, though the degree of the holistic approach provided by individual services varied.
    - Cultural aspects: Being able to speak a client's language was considered important, as was an understanding of a client's culture. Ethnic-specific services and some mainstream services offer counselling in the languages of the clients commonly accessing their services.

- *Facilitation Services*
    - Implementation: Different services were at different stages of implementation of formal Facilitation Services.
    - Interpretation of requirements: Some of the major issues raised were due to how the requirements were interpreted and the fact that services were still working through the process of understanding the new requirements.
    - Cultural aspects: Ethnic-specific services in particular, felt that Facilitation Services did not necessarily fit with the holistic relationship they build with their clients.
    - Positive aspects: There are many ways in which clients can be helped using Facilitation Services.
    - Negative aspects: Facilitation Services can take up a lot of time and some allied agencies do not take the facilitation seriously.
    - Linkages and relationship building: Sometimes it was not possible to build a relationship with an allied agency because the agency could not be informed that the client was a problem gambler. Maori participants, in particular, felt the need for reciprocal arrangements, with referrals from allied agencies to gambling treatment services, and Asian participants discussed a general negative attitude towards Asian clients.
- *Training and workforce development*
    - Interventions Service Practice Requirements Handbook: Concerns focused around interpretation of the handbook, that it was too prescriptive and that the process was too contract/database led rather than being client led.
    - Training: The training provided was generally viewed as positive but lacking in length and detail, as well as focusing on meeting targets and contractual obligations rather than the best provision of interventions for clients. The training appeared to lack cultural relevance and as requirements kept changing, it became confusing.
    - Workforce issues: Workforce development was considered to be an important issue due to the workforce being small. Training was considered to help with workforce development but some participants also felt the Ministry of Health could be trained in relation to clinical processes, which they felt would assist the development of more appropriate intervention requirements.
- *Data collection, entry and monitoring*
    - Numerous issues were raised in relation to data entry for the CLIC national gambling counselling database. Some of these related to processes (paper based versus online entry), the requirements and time taken to meet them, duplication of effort for multiple databases, the ability to input incorrect data or forget to enter data, and interpretation of the requirements. Feedback on CLIC data from the Ministry did not always filter back to those entering the data.
- *Other issues*
    - Targets: Concern was raised around services being target rather than client driven. The necessity for targets was understood but not how they were arrived at.
    - Follow-up sessions: The requirements for follow-up sessions were viewed as being too prescriptive and also that they were not possible with all client types.

Group interview

A set number of eight regional training days is scheduled annually with a further 12 ad hoc training days allowed as required. Initial training was around use of the CLIC data manual and is now focusing on the Interventions Service Practice Requirements Handbook. Formal

onsite follow-up training sessions (not part of the set 12 ad hoc days) would be beneficial to services to aid in implementation of processes learnt at the formal training days and to assess whether staff who did not attend formal training have received training via their service.

The manuals in use were felt to be daunting due to their size and layout, and thus service staff were more likely to want to approach the training provider with queries than to try and find the relevant information in the manuals. This was deemed to be more important for smaller regional services which do not have the infrastructure of the larger services. Various suggestions were made regarding potential improvements to the manuals.

The training to date has focused around understanding CLIC requirements rather than clinical practice, which will be a focus of the next stage of training.

Stage Three
Results will be detailed in the Stage Three final report.

Discussion and conclusion

The project findings indicate that whilst there are 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 are no major findings which would indicate that one type of service or intervention provision is significantly superior to another in relation to client outcomes. However, this conclusion must be viewed with caution given that this project has evaluated the services in a broad way and has not been an in-depth evaluation of each service individually. Additionally, some services are substantially different from others in terms of organisational size, regional location, type of intervention provided and length of operation under Ministry funding. This has meant that not all results are directly comparable and again raises the need for caution when reviewing the findings. Furthermore, analyses have been conducted whilst services are in different stages of implementing Ministry intervention and data collection/management requirements which again has meant that results are not directly comparable. This latter anomaly should be removed during the Stage Three analyses in 2009, when all services should be fully operational and au fait with Ministry requirements.

Other major project limitations included researcher reliance on the quality and availability of database information for the Stage One analyses, some non-completion of surveys due to the tight time frame for Phase Two, and convenience sampling of participants for the client survey meaning that responses are not necessarily representative of all clients accessing services.

Pathways to gambling treatment services
Different services attract different client populations based generally on the ethnic specificity of the service (where appropriate), the geographic location of the service, or the type of intervention approach provided. Of note is that some Maori services particularly seem to attract clients in younger age groups (39 years or less) or more significant others, than other services. Whilst there are many pathways into services, self-referral, helpline referral and informal referral via family or friends appear to be the most common routes. There was insufficient information to definitely identify whether there was a relationship between a client's pathway into a treatment service and subsequent outcome; and, in general, numbers of responses from the staff survey were too small for any major conclusions to be made.

Distinct interventions

From the database analyses, Maori and Mainstream services appear to differ in terms of the most common type of treatment provided (brief versus full interventions, respectively), though all offer the full range of interventions. Services were generally consistent in their view of a need for a holistic approach to treatment provision (i.e. being able to deal with all a client's presenting issues by one service), and that the current requirements for brief, full, and follow-up sessions and Facilitation Services is not conducive to this approach. There was relatively little inter-service variation in terms of how treatment episodes end, client experience of those episodes, and client improvement at the end of treatment.

Facilitation Services

Clients of gambling treatment services have facilitated referrals to a large range of allied agencies, not only for co-existing mental health or substance use issues but also relating to financial matters and alternative activities (to gambling). Since formal Facilitation Services are only just being implemented by services, there appeared to be significant confusion around the process (this should be alleviated by the time of the Stage Three analyses). Several barriers to the process were identified ranging from clients not wishing to be facilitated to another agency, to counsellors not wanting to facilitate clients away from their service, through to the attitude of the allied agencies. However, clients' perception of facilitated referrals was good in relation to positive outcomes for the co-existing issues. Positive relationships between gambling treatment services and allied agencies appeared to exist though there were suggestions for improvement from both types of oganisation.

Data collection, training and workforce development

There appeared to be confusion around the required processes, possibly as they are relatively new and there were some major concerns around the prescriptive nature of the requirements and the cumbersome nature of the manuals and handbook making interpretation and comprehension less easy. The training programme as it stands appears not to fully meet the needs of service staff or the training provider due to its structured format and approach, though more than half the service staff participants reported the training to be beneficial.

1. BACKGROUND

The Ministry of Health is responsible for the funding and coordination of problem gambling services and activities in New Zealand. This includes the funding of a national telephone helpline, two national face-to-face counselling services and several regional treatment providers which include Maori and Pacific specific services (Asian specific services are provided as a division of one of the national face-to-face treatment providers) (Ministry of Health, 2008a). However, at the present time, the effectiveness of the current problem gambling treatment services is unknown, as is the optimal treatment process for different types of client. It is anticipated that the results from this project may be informative for improving the effectiveness of current intervention processes, in particular in relation to Ministry requirements for intervention provision and data collection, management and processing, as well as improving access to particular service types by specific client population groups.

From 2008, Ministry funded face-to-face problem gambling treatment providers have received specific training around Ministry expectations for service practice requirements (e.g. the types of intervention with clients that will be funded and the processes expected within those interventions as well as for referrals for co-existing issues), and expectations around data collection, management and information submission to the Ministry. The Ministry has also identified specific sets of screening instruments to be used with clients, which vary depending on whether the client is receiving a brief or full-length intervention, or is a problem gambler or family/whanau member ('significant other') of a gambler. These screening instruments came into use in 2008, with different sets of instruments having been used previously.

In September 2008, the Gambling and Addictions Research Centre at Auckland University of Technology was commissioned by the Ministry of Health to conduct the research project *Problem gambling: Evaluation of problem gambling intervention services.*

This project is an evaluation (process, impact and outcome) of gambling treatment services, to provide indications regarding optimal treatment pathways and approaches for problem gamblers and affected others, as well as identifying successful strategies currently in existence and areas for improvement in current service provision.

- *Process evaluation* measures the activities of the services in question, in the current case treatment services for gamblers and affected others, as well as measuring services' quality and the population groups reached by the services (Davidson, 2005; Hawe, Degeling & Hall, 1990; Lunt, Davidson & McKegg, 2003; Patton, 1997; Waa, Holibar & Spinola, 1998).
- *Impact evaluation* assesses the immediate effects of the services' objectives as well as measuring the services' objectives which have been achieved by the strategies put into place to meet the objectives (Davidson, 2005; Hawe, Degeling & Hall, 1990; Lunt, Davidson & McKegg, 2003; Patton, 1997; Waa, Holibar & Spinola, 1998).
- *Outcome evaluation* usually measures the longer-term effects of the services' objectives, though is also concerned with whether goals have been achieved and the effects on clients and stakeholders (Davidson, 2005; Hawe, Degeling & Hall, 1990; Lunt, Davidson & McKegg, 2003; Patton, 1997; Waa, Holibar & Spinola, 1998).
- In addition, evaluation involving Maori services will be based on *Kaupapa Maori evaluation*, based on Maori values, perspectives and research methods.

Throughout this report a number of technical/specific terms have been used (e.g. brief intervention, full intervention, follow-up, episode, session, administrative discharge). These

terms are routinely used by the Ministry of Health in terms of intervention delivery, data collection and management. Detailed definitions for these terms are documented in the Intervention Service Practice Requirements Handbook (Ministry of Health, 2008b).

1.1 Research design

1.1.1 Objectives

This project is focusing on four priority areas:

- Review and analysis of national service statistics and client data to inform workforce development, evaluation of Ministry systems and processes, and other related aspects
- Process and outcome evaluation of the effect of different pathways to problem gambling services on client outcomes and delivery
- Process and outcome evaluation of distinct intervention services
- Process and outcome evaluation of the roll-out and implementation of Facilitation Services

The research is being conducted in three Stages.

Stage One

- Desktop analysis of data within the national face-to-face (CLIC), helpline and Asian hotline databases from the period 1 July 2007 to 30 June 2008

Stage Two

- Structured surveys with:
    - Counsellors, managers and administrative staff from the participating gambling treatment services
    - Current or recent past clients from the participating gambling treatment services
    - Major agencies/organisations (allied agencies) to which gambling clients have a facilitated referral
- Focus groups with counsellors, managers and administrative staff from the participating gambling treatment services
- Group interview with the provider of training and workforce development to gambling treatment services.

Stage Three

- A repeat of Stages One and Two (in 2009) for an impact and outcomes evaluation

1.1.2 Stage One

The three databases were analysed for any client recorded in the CLIC, helpline or Asian hotline databases, who accessed gambling treatment services in the time period 1 July 2007 to 30 June 2008. This included new clients, on-going clients and repeat clients. Statistical comparisons were performed for key areas of interest, where numbers were large enough to allow comparisons.

Preliminary information from Stage One was used to inform the design of the survey questionnaires for Stage Two.

1.1.3 Stage Two

The focus groups and survey questionnaires covered topics relating to clients' pathways into and out of treatment, distinct (specific) interventions provided by some services, Facilitation Services, satisfaction with the processes, and training and workforce development issues in relation to the processes. The group interview covered similar topics from a training and workforce development point of view.

Surveys
All surveys were structured and completed on paper. Staff of gambling treatment services and allied agencies self-completed the surveys. Clients of gambling treatment services completed the survey via a face-to-face or telephone interview with a researcher.

- Staff from gambling treatment services: All (problem gambling) counselling, managers and (problem gambling) administrative staff from each of the participating gambling treatment services were requested to completed the survey[4]. Managers in each organisation took responsibility for requesting staff participation.
- Staff from allied agencies: Where provided by gambling treatment services, the main contact at the agency/organisation was requested (initially by telephone, then by Email or post and followed up again by telephone, where possible) to complete the survey. Where specific contact details were not provided to the researchers by the participating gambling treatment services (e.g. if clients were referred to the local District Health Board or the local Work and Income New Zealand branch to whoever is on duty at the time), the researchers attempted to contacted the manager of the agency/organisation to deliver the survey to an appropriate person for completion.
- Clients of face-to-face gambling treatment services: Clients were selected via convenience sampling and were asked by their counsellor/service if they would like to participate in the research.

Focus groups
Four semi-structured focus groups were conducted with gambling treatment service staff. A focus group was held for each of: mainstream, Maori, Pacific and Asian gambling treatment providers/staff.

Group interview
One semi-structured group interview was conducted with staff of the provider of training and workforce development to gambling treatment services.

1.1.4 Stage Three

Stage Three will involve, on the whole, a methodological repeat of Stages One and Two and will focus on evaluating progress made in implementing the interventions services together with their data management, and their effectiveness for clients and services, one year later. Actual methodology may vary based on findings and experience from Stages One and Two.

[4] Only one helpline staff member completed the survey since the service had not formally commenced provision of interventions in the Ministry required manner and contributed to CLIC data collection, management and recording at the time of the survey.

2. RESEARCH METHODOLOGY

2.1 Ethics approval

An application for ethical approval was submitted to the AUT Ethics Committee (AUTEC) prior to conducting Stage Two. A further application will be made prior to Stage Three. Stage One did not require ethical approval since it involved a desktop analysis of data from existing databases. AUTEC is a Health Research Council accredited human ethics committee. Participant materials (i.e. information sheet and consent form) and other relevant documents were submitted to AUTEC, which considers the ethical implications of proposals for research projects with human participants. AUT is committed to ensuring a high level of ethical research and AUTEC uses the following principles in its decision-making in order to enable this to happen:

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)

Ethics approval for Stage Two was received on 24 October 2008 (Appendix One).

Ethics approval for Stage Three will be detailed in the Stage Three final report.

During the research the following measures were taken to protect the identity of the participants:

- All participants and participating gambling treatment services were allocated a code by the research team to protect their identities
- No personal identifying information has been reported

In addition:

- Participants in focus groups, group interview and surveys were informed that participation in the research is voluntary and that they could withdraw at any time, prior to data reporting

2.2 Cultural awareness

Cultural safety, integrity and appropriateness of the research process were key considerations throughout, particularly in relation to Maori research processes. In this regard, Papa Nahi (Ngapuhi) (Research Officer within the Gambling and Addictions Research Centre) took

responsibility for the research with the Maori organisations utilising tikanga Maori processes, where possible. Ms Nahi also took responsibility for all aspects of the research involving Maori including data analysis and interpretation.

Significant consultation meetings were held with each gambling treatment service regarding their participation in the research. The discussions included logistics around how to conduct the research to maximise participation of staff as well as the optimal methods for client recruitment and participation, and how to conduct the research (within ethical and methodological constraints) within the appropriate organisational and/or cultural framework.

In addition, client surveys were conducted in Te Reo or Mandarin, where required, utilising researchers within the Gambling and Addictions Research Centre/National Institute for Public Health and Mental Health Research who are native speakers of those languages. This enabled ethnic-matching between researchers and client survey participants, where necessary.

2.3 Stage One

Access to relevant portions of the national face-to-face counselling (CLIC), helpline, and Asian hotline databases was granted to the researchers by the respective organisations owning the databases.

The key information obtained from the database analyses included:

- Identification of baseline information including typical provider and client patterns and presentations
- Evaluation of referral (or facilitation) pathways, both into and out of problem gambling services
- Evaluation of screening and other data, data recording or client management issues apparent from the data, including accuracy and completeness
- Identification of unique or distinct services based on client characteristics, outcome characteristics or trends or features of service process (e.g. patterns of presentation, length of episodes)

This was achieved as follows:

Sample population

Any client (new, on-going and repeat) recorded in either the CLIC or the helpline databases accessing gambling treatment services in the period 1 July 2007 to 30 June 2008.

Profile of clients

Summary statistics were conducted for:

- Demographics of clients (i.e. age, sex, 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 intervention outcome within the time frame 1 July 2007 to 30 June 2008

- Previous intervention history, where identified. The amount of intervention taking place before 1 July 2007, identifying repeat and on-going clients (and including co-existing issues)
- Pathway into gambling treatment services (and trends for specific population groups, where identified)
- Referral pathway from gambling treatment services, where data were available
- Assessment scores and any changes in scores over treatment process

Separate summary statistics were also conducted for distinct interventions, namely workshop and Marae Noho participants (identified by the Ministry of Health for evaluation).

Data completeness and accuracy

For the summary statistics specified above, completeness of data was assessed by the identification of missing information, for example unspecified age, sex, gender, or geographical location. The presence or absence of follow-up assessment measures and treatment episodes/sessions that are still 'open', i.e. no reason for completion given, were also reviewed.

Accuracy of data was only reviewed for screening/assessment data, by the identification of any values that were outside the valid bounds for a specific screening/assessment tool.

Trend analysis

Trends were reviewed to identify any effects due to the impact of the:

- New service specification (introduction of facilitation, revised brief intervention, required follow-up), and introduction of the Data Management Manual and Data Submission Manual in January 2008
- Social marketing work within the media, primarily July to September 2007, December 2007 and May 2008

Trends were reviewed:

- At the national level
- For the service providers identified as part of this evaluation
- By major ethnic groups
- By pathways into services

Trends were evaluated using weekly or monthly data (adjusted for the number of working days) depending on the size of the relevant cohort of interest.

2.4 Stage Two

The three topic areas evaluated as part of Stage Two were:

1. The effect of different pathways to problem gambling services on client outcomes and service delivery
2. Identifying characteristics and evaluating distinct intervention services
3. Evaluation of the roll-out and implementation of Facilitation Services

1. *Evaluating the effect of different pathways to problem gambling services on client outcomes and service delivery*

People experiencing gambling harm typically only present to specialist problem gambling services once they have reached a crisis point. In its revision of problem gambling service specifications, the Ministry of Health increased the emphasis on screening for problem gambling in non-specialist settings, and developing and enhancing referral pathways into problem gambling services. The focus for this topic was to evaluate the processes being used to support access and referrals to problem gambling services, implications for service delivery and for other services (referring agencies) and the impact on gambling outcomes.

Key areas for the evaluation were:

- The advantages and/or disadvantages of different pathways for clients
- The effect of different pathways on problem gambling outcome measures (i.e. whether different pathways into problem gambling services result in better outcomes related to gambling harm measures)
- The impact of different pathways on issues relevant to referral agencies (i.e. positive or negative outcomes for co-existing issues)
- Implications for service delivery dependent on different pathways, i.e.
    - Advantages/disadvantages for counsellors
    - Impact on contract compliance
    - Implications for workforce development
    - Implications for inter-agency relationships
- Implications for different agencies and settings related to different pathways

2. *Review of distinct interventions*

While many problem gambling intervention services deliver services and practice in a relatively similar manner, the Ministry of Health has identified several services that engage with their clients and provide services in a manner that demonstrates very different theoretical, philosophical and practical underpinnings. Two services were identified by the Ministry for involvement in this aspect of the evaluation (a workshop approach and a Marae Noho approach).

Key areas for the evaluation were:

- The distinguishing characteristics of each service identified for this stage of the evaluation (partially informed by Stage One) including:
    - Features in common with mainstream services and points of difference
    - Commonalities in clients, (i.e. if a service sees a particular group of clients, whether the group is similar to or different from mainstream services)
- Whether distinct interventions have different outcomes and measures of effectiveness, or address different barriers or enhancers for clients
- Whether gambling outcomes, addressed barriers or enhancers differ for key client characteristics (e.g. gender, ethnicity, socio-economic status, mode of gambling, level of presenting harm, or pathways for each service).

3. *Review of the implementation of Facilitation Services*

When people experiencing gambling harm present to specialist problem gambling services they often have a range of other concerns they need addressed. In its revision of problem gambling service specifications, the Ministry of Health created a process for problem gambling intervention services to actively support clients to access allied social or health services (e.g. alcohol or drug, mental health, budget or financial advice, and housing services). The Ministry refers to this process as Facilitation Services for co-existing issues.

The focus for this topic was to evaluate the processes being used to support access and referrals to community social service and health agencies from problem gambling services,

evaluation of any implications for service delivery and for other services (Facilitation agencies) and the impact on gambling outcomes and co-existing issues.

Key areas for the evaluation were:

- The different processes and mechanisms being used to provide Facilitation Services to problem gambling clients
- The differences and commonalities between providers' facilitation processes (with particular emphasis on comparing findings for differences between local and national, and dedicated and general providers)
- The effectiveness of Facilitation Services for improving client access to non-problem gambling related mental health, alcohol and other drugs, and other related social services
- The impact Facilitation Services is having on the range of agencies to which problem gambling clients are facilitated
- The views and experiences of allied agencies
- The implications or effect Facilitation Services are having on relationships with clients, and other agencies, on client outcomes
- The kinds of linkages and relationships that enhance facilitation
- Some of the common barriers and issues experienced by problem gambling treatment services and allied agencies

Stage Two was conducted via structured surveys, in-depth semi-structured focus groups, and a semi-structured group interview.

Surveys:

a) With counsellors, managers and administrative staff from the participating gambling treatment services
b) With current or recent past clients from the participating face-to-face gambling treatment services
c) With major agencies/organisations (allied agencies) to which gambling clients have a facilitated referral

Focus groups

a) With counsellors, managers and administrative staff from the participating gambling treatment services

Group interview

a) With the provider of training and workforce development to gambling treatment services.

The focus groups and survey questionnaires covered topics relating to clients' pathways into and out of treatment, distinct (specific) interventions provided by some services, Facilitation Services, satisfaction with the processes, and training and workforce development issues in relation to the processes. The group interview covered similar topics from a training and workforce development point of view. Survey questions, and focus group and group interview themes were developed based on the key topics for evaluation detailed previously and were also informed by the results of the Stage One databases analyses.

2.4.1 Planning and scoping the evaluation

The Stage Two evaluation required the partnership, participation and cooperation of various national and regional problem gambling treatment services in order to achieve the aims of the project.

The following problem gambling treatment services[5] located within the North and/or South Island were involved in the evaluation:

- National helpline
- Two national face-to-face services
- Seven regional Maori services
- Two regional Pacific services
- One national Asian service
- One regional Mainstream service

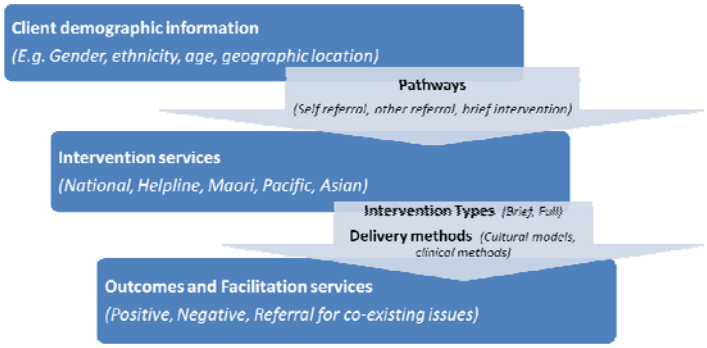
Consultation

During Stage One, the research team held substantial face-to-face or teleconference consultation meetings with each treatment service regarding participation in the research. The main focus of the meetings was around logistics and planning to ensure full cooperation and participation of counsellors as well as the optimal methods for researcher access to clients. The meetings were generally with managers of the organisations and senior counselling staff. In the case of smaller regional services, usually all counsellors involved in the provision of interventions for gambling-related issues, were involved in the meetings too. In addition, there was substantial Email and telephone discussion between the research team and service providers regarding project participation.

All approached treatment services showed a keenness to participate in the evaluation and to ensure good outcomes from the project. There were individual service requirements and differences which have been accommodated into the design of the project. These included such things as travel costs being funded through the project for counsellors to attend a focus group, or clients being gathered together into a group to encourage participation in the survey.

Logic framework

The first task in any service evaluation is the preparation of a logic framework that captures the key *inputs*, *outputs* and *outcomes* to be evaluated. As the current research has a client as well as a service focus, the following simple diagram has been created to depict the flow of logic for the evaluation.



[5] These treatment services represented about half of the services funded by the Ministry of Health and were selected by the researchers to include a mix of national and regional services, and Mainstream and Ethnic-specific services.

In this framework, the *inputs* include:

- Client demographics
- The pathway of referral into a problem gambling treatment service

The *outputs* include:

- Activities
  - Client (e.g. other support)
  - Service (e.g. coordination with other services, facilitation services)
- Participants
  - Client (problem gamblers and significant others)
  - Service (those identified to be part of this project)
- Process
  - Client (e.g. referral process, engagement of client, interventions strategies, case management of client)
  - Service (e.g. access, referral process, partnerships, training, workforce development, reporting requirements, type of intervention delivery, cultural models, clinical methods)

Evaluation of the inputs and outputs comprises a *process evaluation* (Stage Two of the research).

Evaluation of the *outcomes* relates to:

- Short-term effects
  - Client (positive outcome, e.g. controlled gambling or abstinence, successful facilitated referral for co-existing issues; negative outcome, e.g. continued problem gambling, premature termination of treatment; unsuccessful facilitated referral for co-existing issues)
  - Service (service functioning)
- Medium-term and long-term effects
  - Client (e.g. sustained positive outcome, resilience and self-reliance, relapse)
  - Service (improved capacity to deliver effective services, workforce development, effective training and processes)

Evaluation of short-term effects is an *impact evaluation* (Stage Two of the research) whilst evaluation of medium and long-term effects comprises *outcomes evaluation* (Stage Three of the research).

2.4.1 Surveys

All surveys were structured and were completed on paper (maximum 10-15 minutes to complete). Staff of gambling treatment services and allied agencies self-completed the surveys. Clients of gambling treatment services completed the survey via a face-to-face or telephone interview with a researcher.

- Staff from gambling treatment services: All (problem gambling) counselling, managers and (problem gambling) administrative staff from each of the participating gambling treatment services[6] were requested to complete the survey (Survey

[6] Only one helpline staff member completed the survey since the service had not formally commenced provision of interventions in the Ministry required manner and contributed to CLIC data collection, management and recording at the time of the survey.

presented in Appendix 2). Managers of each organisation took responsibility for requesting staff participation.

- Clients of face-to-face gambling treatment services: Using convenience sampling, a total of 77 clients was asked by their counsellor if they would like to participate in the research (Survey presented in Appendix 3). This included up to five from each regional service[7] and 15 from each national service (five clients from each of their Auckland, Wellington and Christchurch offices).
- Staff from allied agencies: Where provided by gambling treatment services, the main contact at the agency/organisation was requested (initially by telephone, then by Email or post and followed up by telephone, where possible) to complete the survey (Survey presented in Appendix 4). Where specific contact details were not provided to the researchers by the participating gambling treatment services (e.g. if clients are referred to the local District Health Board or Work and Income New Zealand branch to whoever is on duty at the time), the researchers attempted to contact the manager of the agency/organisation to deliver the survey to an appropriate person for completion.

Recruitment

Participant recruitment occurred during October 2008, with survey completion taking place from 3 to 14 November 2008.

- Staff from face-to-face gambling treatment services: The manager/s of each organisation were either Emailed or given hard copies of the survey questionnaire together with an information sheet detailing the project and requested to circulate the documents to all relevant staff for completion. Completed questionnaires were returned to the researchers by Email or post.
- Clients of face-to-face gambling treatment services: Counsellors at each of the participating gambling treatment services recruited potential clients for the survey[8]. Current clients (predominantly gamblers but not precluding significant others) were recruited where possible, and recent past clients were recruited, where necessary. To maximise client participation, project researchers conducted the surveys with the clients face-to-face, travelling to the relevant service provider location. However, where that was not feasible or practical (e.g. in rural locations) or where the client preferred, the survey was conducted over the telephone. Clients deemed by their counsellor to be at risk of harm to themselves or others, were not recruited for the survey.
- Staff from allied agencies: Contact details for the major allied agencies used as part of the Facilitation Services were obtained from the participating gambling treatment services. The research team or the gambling treatment service working with the allied agency attempted to contact the relevant person at the allied service, by telephone, to inform them about the project and encourage participation in the survey. The specified contact, where available, or the manager (where specified contact details were not available) of each organisation was then Emailed or posted (with a reply paid return envelope) the survey questionnaire together with an information sheet detailing the project, and requested to circulate the documents to the relevant staff for completion. Completed questionnaires were returned to the researchers by Email or post. A third contact was made by telephone or Email, as required, to encourage participation.

Process

[7] Ethnic-specific services do not necessarily have clients only of that ethnicity.

[8] Thus client participants were recruited by convenience sampling.

All surveys were completed on paper, either by the participants (staff and allied agency surveys) or with responses recorded by a researcher (client survey). Ethnically matched researchers (who can speak Te Reo or Mandarin) were available, where required, for the client surveys. Paper copies of completed surveys were returned to the researchers either by Email, fax or by post.

Participation

Survey of staff from gambling treatment services

Sixty participants were recruited from 10 of the 14 gambling treatment services participating in this stage of the evaluation. Participants represented Mainstream, Maori, Pacific and Asian services. No completed survey forms were received from three Maori and one Pacific service. For two of the Maori services, this was because their staff delivered the interventions but were not involved in Ministry of Health required data collection, entry, management, or monitoring. Participation from the remaining Maori and Pacific service had been expected; however, completed forms were not received by the research team. Notwithstanding, a good participation rate was achieved; services not represented in the survey are small with few staff members. In particular, participation was achieved for services representing Mainstream, Maori, Pacific and Asian as well as the Ministry identified distinct interventions of workshops and Marae Noho.

Survey of clients

Sixty-one participants were recruited from the 77 contact details given to the research team (79% response rate). The 16 clients not included in the survey did not answer telephone calls or reply to messages left by the research team, declined to participate, or had provided an incorrect contact number. Participants represented clients from nine of the 14 participating face-to-face gambling treatment services, which included Mainstream, Maori[9], Pacific and Asian services. Participants did not represent five Maori services and one Pacific service. One of the five Maori services did not have problem gambling clients (but participated in the staff survey because they deal with the data collection, entry, management and monitoring aspects of data collected from four other services). The other four Maori services did not provide clients for the survey due to issues relating to relationship and trust in their communities (however, one service did participate in the staff survey and all participated in the Maori focus group). One Pacific service did not provide any clients for participation in the survey. However, a 79% response rate is considered reasonable given the short time frame available for survey conduct and included representation of clients who attended services providing the Ministry identified distinct interventions of workshops and Marae Noho.

Survey of allied services

Participating gambling treatment services identified a total of 100 agencies to which they provided facilitated referral of clients. Of these 100 allied agencies, 37 agreed to participate in the current study. Of the remaining 63 allied agencies, the research team: a) was unable to establish contact with 40[10], b) was provided with incorrect contact details in 12 cases[11], and c) in 11 cases the agencies declined to participate in the research (often stating that they did not have any knowledge of gamblers being referred to their service). Of the 37 allied agencies which did agree to participate, the survey was successfully completed in 49%

[9] This included the Maori service which did not participate in the staff survey due to lost survey forms.

[10] This was mainly because information given to the researchers about the allied agency was very general and not specific, e.g. local District Health Board, local Work and Income New Zealand department, local polytechnic. Thus, it was extremely difficult to contact any person within the agency who was aware of problem gambler facilitation to the service.

[11] Often the details were out of date due to facilitation having occurred many months earlier.

(18/37) of cases[12] (this included follow-up Emails and telephone calls by the researchers to encourage survey completion).

Data analysis

Survey data were entered into the SPSS (version 14.0) statistical package prior to analyses. Due to the small sample sizes, only broad findings (mainly descriptive statistics and cross-tabular results) have been reported. Where possible, responses were ordered into more specific categories for comparative purposes to determine possible cultural, population group or service provider differences. Open-ended questions were categorised and analysed quantitatively.

2.4.2 Focus groups

Process and participation

Four semi-structured focus groups were conducted on 3 and 4 November 2008 with gambling treatment service staff. One focus group was held for each of: Mainstream, Maori, Pacific and Asian gambling treatment services/staff[13]. The focus groups were facilitated by research team members experienced in facilitation.

Focus group	Focus group location	No. of attendees
Mainstream	Auckland	8
Maori	Rotorua	13
Pacific	Auckland	6
Asian	Auckland	5

Participants in the focus groups comprised counsellors, managers and administrative staff from the participating gambling treatment services. At least one representative from each participating service participated in a relevant focus group[14]. Participants were selected following identification by the research team subsequent to discussions with the managers and other staff of each participating gambling treatment service.

Focus groups were semi-structured to elicit detailed discussion around:

- Pathways into and out of treatment:
    - Advantages and disadvantages of different pathways for clients accessing services
    - The effect of different pathways on problem gambling outcome measures
    - The impact different pathways have on issues relevant to referral agencies
    - Implications for service delivery dependent on different pathways
    - Implications for different agencies and settings related to different pathways

[12] Having agreed to participate, a number of services then contacted the researchers and stated that they would not participate because on reflection, they did not feel that their service had any gamblers facilitated to them by gambling treatment services.

[13] This format did not preclude ethnic-specific staff from mainstream services from attending the mainstream focus group, or Pakeha staff from ethnic-specific services attending the relevant ethnic-specific focus group. Similarly, staff of different ethnicities participated in the corresponding ethnic-specific focus group irrespective of the type of service they represented.

[14] Staff from one Maori service were unable to attend the relevant focus group, instead providing comments on the focus group topics to the facilitator via telephone.

- Distinct interventions:
    - The distinguishing characteristics of each service
    - Whether distinct interventions have different outcomes and measures of effectiveness, or address different barriers or enhancers for clients
    - Whether gambling outcomes, addressed barriers or enhancers differ for key client characteristics (including demographics, mode of gambling, level of presenting problem, and pathways into service)
- Facilitation Services:
    - The different processes and mechanisms being used to provide Facilitation Services to problem gambling clients
    - The costs and effort required to implement Facilitation Services
    - The differences and commonalities between services' facilitation processes
    - The effectiveness of Facilitation Services for improving client access to non-problem gambling related associated services
    - The impact of facilitation on the range of agencies to which problem gambling clients are facilitated
- Satisfaction, training and workforce development:
    - Adequateness of service reach
    - Perceived client and service provider satisfaction
    - Measures of success that relate to services' views and basis of practice
    - Implementation of processes including intervention development, monitoring and reporting as well as staff training, workforce development and in-service mentoring
    - Performance/quality of services and materials used

Data analysis

Focus group discussions were digitally recorded for subsequent transcription and analysis. A systematic qualitative analysis of similarities and differences in participants' perceptions was conducted to interpret the data from the transcribed recordings in relation to the original research questions. Emerging trends and patterns were grouped according to themes. Responses were ordered into more specific categories for comparative purposes to determine possible service provider, cultural or population group differences. Analyses were undertaken using NVivo (Version 2) software.

2.4.3 Group interview

Process and participation

One semi-structured group interview was conducted on 12 November 2008 with three staff from the provider of training and workforce development to gambling treatment services. The interview was facilitated by a research team member experienced in facilitation.

The interview was semi-structured to elicit detailed discussion around:

- Training and workforce development:
    - Implementation of processes including intervention development, monitoring and reporting as well as staff training, workforce development and in-service mentoring
    - Performance/quality of services and materials used
    - Benefits and drawbacks of current mandated intervention approach with different service providers particularly those with distinct intervention approaches
    - Implications of the above in terms of service provision, delivery and outcomes for clients

    - Adequateness of service reach
    - Perceived client and service provider satisfaction
- Pathways into and out of treatment:
    - Advantages and disadvantages of different pathways for clients accessing services
    - Implications for service delivery, training and workforce development dependent on different pathways
- Facilitation services:
    - Implications for service delivery, training and workforce development dependent on services' facilitation processes

Data analysis

The group interview discussion was digitally recorded for subsequent transcription and analysis. Findings were compared and contrasted with those from the focus groups. Analyses were undertaken using NVivo (Version 2) software.

2.5 Stage Three

Stage Three will involve, on the whole, a methodological repeat of Stages One and Two and will focus on evaluating progress made implementing the interventions services together with their data management, and their effectiveness for clients and services one year later. Actual methodology may vary based on findings and experience from Stages One and Two, and thus will be detailed in the final report for Stage Three.

3. RESULTS

3.1 Stage One

Analyses of the face-to-face counselling national database (CLIC), the helpline national database and the Asian hotline database were conducted for the period 1 July 2007 to 30 June 2008. Data were analysed for:

- Identification of baseline information including typical provider and client patterns and presentations
- Evaluation of referral (or facilitation) pathways, both into and out of problem gambling services
- Evaluation of screening and other data, data recording or client management issues apparent from the data, including accuracy and completeness
- Identification of unique or distinct services based on client characteristics, outcome characteristics or trends or features of service process (e.g. patterns of presentation, length of episodes)

Summary statistics are presented from analysis of each database; data from each database are presented in a single table for each category. Service A3 represents national helpline data and service E1 represents Asian hotline data; all other data represent face-to-face counselling services. Summary statistics have been conducted for each gambling treatment service separately and for all services overall, and have been categorised by client demographics and received treatment.

For confidentiality purposes, gambling treatment services funded by the Ministry of Health in the specified time frame have been classified into one of five groups: Mainstream services, Maori services, Pacific services, Asian hotline, and Alcohol and Drug services; and coded according to involvement in Stage Two of this project.

Code	Type of service	Participation in Stage Two
A1 to A4	Mainstream	Yes
A5	Mainstream	No
B01 to B04, B06 to B08	Maori	Yes
B05, C01 to C10	Maori	No
D1 to D2	Pacific	Yes
E1	Asian hotline[15]	Yes
F1	Alcohol and Drug[16]	No

The distinct interventions identified by the Ministry of Health to be part of this evaluation are represented in the following data as A4 (workshop approach), and B02 and B03 (Marae Noho approach). Other services with differences of note identified as part of the analyses have generally participated in Stage Two.

It is important to note that in some of the tables clients may fit in more than one category. For example, three clients received counselling both from services A1 and A2 in the 12 months

[15] Asian face-to-face services are not identified as a separate service in the CLIC database.
[16] This is a residential Alcohol and Drug service that is also funded by the Ministry of Health to provide problem gambling interventions.

from 1 July 2007 to 30 June 2008 and are, therefore, included in the data for both services. Additionally, there are many clients who access services both as a significant other and as a gambler.

All Stage One summary statistics tables are presented in APPENDIX 5 due to their size and number.

3.1.1 Client demographics

This section details the distribution of clients across gambling treatment services by selected demographic variables, namely whether the client was a gambler or a significant other, and by gender, ethnicity, age and geographic location.

Gambler versus significant other

Table 1 presents the distribution of clients across gambling treatment services over the 12 month period from 1 July 2007 to 30 June 2008, by client type.

Overall, two-thirds of clients were gamblers and one-third were significant others. Mainstream, Pacific, the Asian hotline and the majority of Maori services generally had two-thirds or more gambler clients with the remaining third or less being significant others. Four Maori services (B02, B07, C01 and C04) had a higher proportion of significant other clients (two-thirds or more) than the Mainstream services.

The Alcohol and Drug service (F1) only had gambler clients. However, this was to be expected as the service is residential. Two Maori services (C09 and C10) also had no significant other clients; however, their numbers of gambler clients were low.

Gender

Gambler

Table 2 presents the distribution of gambler clients by gender. Overall, there was an approximately even split of male to female clients. Individual Mainstream, Pacific, Alcohol and Drug, and the majority of Maori services generally had a similar ratio or slightly more male gambler clients than female. The Asian hotline (E1) had substantially more male (71%) than female (29%) clients. Seven Maori services (B02, B03, B04, B05, B07, C04 and C06) had a higher proportion of female gambler clients than male (approximately two-thirds to one-third, respectively).

Significant other

Table 3 presents the distribution of significant other clients by gender. Overall, two-thirds of significant other clients were female with the remaining third being male. The total number of significant other clients recorded in the databases was about half of that for gambler clients in the same time frame. Most services had at least two-thirds female significant other clients apart from one Pacific service (D1) which had only one-fifth (21%) female clients. One mainstream service (A5) and one Maori service (B04) only had female significant other clients and one Maori service (C05) only had male clients; however, the sample size for each of these services was extremely small (five or less) so these findings should be treated with appropriate caution.

Ethnicity

To ensure some consistency between the national helpline data which contains single ethnicity data and face-to-face treatment service data which contain multiple ethnicity data, ethnicity has been classified based on a hierarchical definition[17,18]. It is also important to note that Mainstream services, in particular A1 and A3, have a large number of clients where ethnicity was not reported.

Gambler

Table 4 presents the distribution of gambler clients by ethnicity. Almost all services provided interventions for more than one ethnic group. However, as would be expected, Maori services generally had higher proportions of Maori gambler clients than other services, with two only having Maori clients (B05 and C10).

Similarly, one of the Pacific services (D1) had a higher proportion of Pacific gambler clients, although the other Pacific service (D2) had slightly more Maori than Pacific clients. The Mainstream service which also provides Asian face-to-face services (A1), not unexpectedly, had a higher proportion of Asian clients than other services with the exception of the Asian hotline (E1) which had 99% Asian clients.

Significant other

Table 6 presents the distribution of significant other clients by ethnicity. The majority of services provided interventions for more than one ethnic group. However, as would be expected, Maori services generally had higher proportions of Maori significant other clients than other services, with two only having Maori clients (B04 and B05). Two other Maori services (C03 and C07) had a lower percentage of Maori significant other clients than other ethnicities.

Similarly, one of the Pacific services (D1) had a higher proportion of Pacific significant other clients, although the other Pacific service (D2) had an equal percentage of Maori, Pacific and European clients. The Mainstream service which also provides Asian services (A1), not unexpectedly, had a higher proportion of Asian clients than all other services, with the exception of the Asian hotline (E1) which had 91% Asian clients.

Age

Service A3 had a large proportion of clients where age was not reported, therefore, its age distribution needs to be interpreted with care. Additionally, age was not recorded in the Asian hotline (E1) database.

Gambler

Table 6 presents the distribution of gambler clients by age group. Whilst the majority of services had gambler clients across the age ranges, it is of note that service A4 had more clients in the 50 to 59 and 60+ year age groups (i.e. an older population group), than the other Mainstream services. Service A4 provides workshop and structured group approaches as its main problem gambling interventions. Additionally, some Maori services (B07, C01, C02 and C04) generally had more gamblers clients in the <30 and 30 to 39 year age groups (i.e. a younger population group) than other services.

[17] Clients identifying with multiple ethnicities have been classified in the following order: Maori, Pacific, Asian, Other, European (e.g. someone identifying as Maori and European has been classified as Maori).

[18] Clients documented as 'Kiwi' have been classified as European.

Significant other
Table 7 presents the distribution of significant other clients by age group. The distribution profile of clients was similar to that seen for gambler clients. In addition, Maori service C08 also had a higher proportion of significant other clients in the younger population groups, though numbers were very small and thus the findings should be treated with caution.

Geographic location
Data are presented by Territorial Local Authority (TLA) for face-to-face gambling treatment services only, since location data were captured via a different system in the national helpline database and not captured as part of the Asian hotline database. Face-to-face Asian services are not presented separately in the database thus there is no column for Asian. In the tables the 'n' is the number of clients (of any ethnicity) recorded by the service type in the TLA.

Gambler
Table 8 presents the number of gambler clients receiving interventions at each service type, by TLA. Mainstream services had clients in almost all TLAs with the greatest number of clients being in the Auckland, Manukau and Christchurch city/Banks Peninsula areas. Mainstream services did not have any gambler clients in eight of the 73 TLAs during the time frame of analysis. Maori services had clients in a majority of the TLAs. Of note is that Maori services had all the clients originating in the Hastings/Napier/Central Hawkes Bay districts. Pacific services had clients in the areas within which they are located, namely the greater Auckland and Hamilton/Waikato areas.

Significant other
Table 9 presents the number of significant other clients receiving interventions at each service type, by TLA. Significant other client distribution was similar to that for gambler clients.

3.1.2 Treatment programmes, sessions and type

This section details the distribution of clients across gambling treatment services by selected treatment variables. These were: average number of episodes[19] per client and the average number of counselling sessions per episode; the type of treatment received (i.e. brief intervention, full intervention and follow-up); whether the treatment was completed; and whether the treatment was individual, delivered in a couple approach or family/whanau approach, or whether it was group treatment; and primary gambling mode per intervention.

Episodes and sessions
A summary of the number of gambler clients, the number of episodes (completed and partially completed), and the number of counselling sessions has been presented in the tables.

Gambler
On average, gambler clients were in 1.5 episodes over the 12-month period; this was fairly consistent across different services although Mainstream service A1 and Maori service B01 had a higher average with over two episodes per client. As detailed in footnote 16, two to three episodes per client is the expected norm. There was, however, some variability in the

[19] An episode is a distinct series of counselling sessions providing an intervention for a client. An episode can be brief, full or follow-up. A brief episode contains only brief sessions. A full episode contains only full or facilitation sessions. A follow-up episode contains only follow-up sessions. Each client is expected to have two to three episodes, i.e. full and follow-up or brief, full and follow-up.

average number of counselling sessions per episode varying from between one and ten at different services, with an overall of 2.9 sessions (Table 10).

The Alcohol and Drug service (F1) was substantially different from the others with an average of 26 sessions per gambler client per episode. However, this was a residential service and thus provided treatment in a different manner than the other outpatient services (Table 10).

Significant other
On average, significant ooher clients were in 1.3 episodes over the 12-month period; this was fairly consistent across different services. Similar to the profile for gambler clients, Maori service B01 had a higher average with two episodes per client. As with gambler clients, there was some variability in the average number of counselling sessions per episode varying from between one and eight at different services, with an overall of two sessions (Table 11).

Episode type
The type of episode relates to whether the intervention was classified as being 'brief', 'full' or 'follow-up'. Episodes in the databases for Mainstream service A3 and the Asian hotline (E1) were not classified as brief, full or follow up and thus have not been reported in the following tables.

Gambler
Table 12 presents the episode type for gambler clients. The majority of services recorded all three episode types. Two Maori services did not undertake any full interventions with gambler clients in the 12-month period (B07 and C10), and one Mainstream service (A4) did not record any brief interventions with gambler clients. The latter service provides a unique workshop approach to problem gambling interventions which would not be compatible with a brief intervention approach. The residential Alcohol and Drug service (F1) and three Maori services (B05, C05 and C10) did not record any follow-up episodes.

Significant Other
Table 13 presents the episode type for significant other clients. For those services with significant other clients, the majority recorded all three episode types. One Maori service (B04) and one Pacific service (D2) did not record any full interventions with significant other clients in the 12-month period; and two Maori services (C05 and C08) and one Mainstream service (A4) did not record any brief interventions with significant other clients (as with gambler clients, detailed above). Approximately half (7/15) Maori services with significant other clients did not record any follow-up episodes.

Length of time per episodes type
Episodes in the databases for Mainstream service A3 and the Asian hotline (E1) were not classified as brief, full or follow up and thus have not been reported in the following tables.

Gambler
Table 14 presents the average length of time per gambler client per treatment session. Overall, the average length of time for a brief intervention was three-quarters of an hour (0.76 hour), for a full intervention was just over an hour (1.17 hours) and for a follow-up session was about 20 minutes (0.36 hours).

In the main, the average length of session times was generally similar across services. Notable exceptions included four Maori services (B02, C05, C07 and C09) and the Alcohol

and Drug service (F1) whose average brief interventions per client lasted over an hour. The Alcohol and Drug service (F1) being a residential service is likely to provide brief interventions in a different manner than other services and this could account for the longer average duration of a brief intervention session.

Mainstream service A4 did not record any brief interventions as detailed previously. Additionally, the average length of time for a full intervention was four hours; again this is due to the workshop approach offered by this service. One Maori service (B02) also recorded full intervention sessions 2.5 times longer than average duration (almost 3 hours as opposed to 1.17 hours).

One Mainstream service (A1) and three Maori Services (C07, C08 and C09) recorded follow-up sessions of longer than average duration (one hour or more).

Significant other

Table 15 presents the average length of time per significant other client per treatment session. Overall, the average length of time for a brief intervention was 0.59 hour, for a full intervention was an hour and a quarter (1.23 hours) and for a follow-up session was about 40 minutes (0.67 hours).

In the main, the average length of session times was generally similar across services. Notable exceptions included one Maori service (C02) whose average brief interventions per client lasted over an hour and a half. As for gambler clients, Mainstream service A4 recorded an average length of time for a full intervention as four hours; again this is due to the workshop approach offered by this service. One Maori service (B02) also recorded full intervention sessions of longer than average duration (2.5 hours).

Seven of the 15 Maori Services with significant other clients did not record any follow-up sessions.

Intervention outcome (episode completion)

Episode completion in the databases for Mainstream service A3 and the Asian hotline (E1) were not detailed and thus have not been reported in the following tables.

Gambler

Table 16 presents the intervention outcome (episode completion) data for gambler clients. Overall this is fairly consistent across services; however, there were three Maori services (C02, C05 and C07) with high levels of administrative discharges or partially complete treatments; no demographic or population group differences for this was readily apparent from the information within the database.

Table 18 presents the average length (days) of each episode type for gambler clients. Overall, an average completed treatment episode took 51 days. Whilst there was considerable variability amongst the different services, those of note included shorter episode duration (nine to 12 days) noted for Mainstream service A4 (which provided structured workshop and group approaches), and for three Maori services (B01, B05 and C01). Conversely, longer treatment episodes (over 160 days) were noted for two Maori services (B02 and C04) and the residential Alcohol and Drug service (F1); the longer duration for the latter service is to be expected given the residential nature of treatment. Other differences in completed treatment episode duration from the overall value, are likely due to the very small sample sizes and thus no importance is assigned to them. Table 18 also details the average duration of episodes that were partially completed, closed through administrative discharge or where the client was

transferred to another problem gambling service; there was wide variability amongst these incomplete treatment episodes amongst services.

Significant other

Table 17 presents the intervention outcome (episode completion) data for significant other clients. As with the gambler client data, overall this is fairly consistent across services; however, there were two Maori services (C02 and C05) with a high level of administrative discharge or partially complete treatments, as was seen for those services with gambler clients. However, for significant other data, the numbers are small and the results should be viewed with caution.

Table 19 presents the average length (days) of each episode type for significant other clients. Overall, an average completed treatment episode took 41 days, slightly less than for gambler clients. Again there was considerable variability amongst the different services; those of note included very short episode duration (less than one to seven days) for five Maori services (B01, B03, B06, C01 and C07). Conversely, a longer treatment episode (123 days) was noted for Maori service C04 following the trend noted for gambler clients at that service. Other differences in completed treatment episode duration from the overall value, are likely due to the very small sample sizes and thus no importance is assigned to them. Table 19 also details the average duration of episodes that were partially completed, closed through administrative discharge or where the client was transferred to another problem gambling service; there was wide variability amongst these incomplete treatment episodes amongst services and generally numbers were small.

Primary gambling mode

The primary gambling mode that is causing the problem is recorded within the databases. However, it should be noted that within the time frame of analysis, clients could report multiple primary modes (thus percentages do not always total 100), and for each treatment episode a different primary mode could be recorded. As primary mode has been reported against episode, and as episode completion in the databases for Mainstream service A3 and the Asian hotline (E1) were not detailed, primary mode has thus have not been reported in the following tables for these services.

Gamblers

Table 20 presents the percentage each gambling mode was recorded as the primary mode per episode of treatment, for gamblers. Electronic gaming machines, particularly those not in a casino, were recorded more frequently than any other mode for all but two services. Maori service B05 recorded Keno/Lotto as the primary mode more frequently than electronic gaming machines, and also recorded a higher percentage of track/sports betting than other services. Maori service C10 also reported Keno/Lotto more frequently; however, the number of episodes reported for this service was very small and thus this result should be treated with extreme caution. Maori service C02 reported a higher than average proportion of 'other' gambling as the primary mode.

Significant others

Table 21 presents the percentage each gambling mode was recorded as the primary mode per episode of treatment, by significant others. As to be expected, the spread of primary mode of problem gambling recorded by significant others tended to match that recorded for gamblers at the services.

Counselling type

Counselling type was not detailed in the databases for Mainstream service A3 and the Asian hotline (E1) and thus have not been reported in the following tables.

Gambler
Table 22 presents the type of counselling provided for gambler clients. All services provided individual counselling in the 12-month period, with some services also providing group, couple and family/whanau counselling. The majority of services mostly provided individual counselling, with four exceptions: A4, B02, C07 and F1. Mainstream service A4 mostly provides a workshop and group approach to treatment so not unexpectedly, 46% of its gambler counselling was classified as group. The residential Alcohol and Drug service (F1) recorded 68% of gambler counselling to be group therapy, similarly for one Maori service (C07) at 51%, whilst the other Maori service (B01) recorded 36% of it's sessions as group. Services providing couples or family/whanau counselling recorded 10% or less of their gambler clients fitting into these categories, apart from Maori service C04 where 16% of sessions were recorded as family/whanau.

Mainstream service A4's group counselling sessions included four workshops attended by 68 gamblers. In addition, based on separate information provided to the researchers a further workshop was held (which is not recorded in the database) at which 18 gamblers attended. Maori service B02's group counselling sessions included 48 sessions identified as Marae Noho. Maori service B03 also ran two Marae Noho during the time frame of analysis; however, the data were not recorded as such within the database.

Significant other
Table 23 presents the type of counselling provided for significant other clients. As with gambler clients, all services which recorded significant other clients provided individual counselling in the 12-month period, with some services also providing group, couple and family/whanau counselling. The majority of services mostly provided individual counselling, with four exceptions: A4, A5, B03 and C07 which provided mostly group or couples sessions.

Counselling sessions

Counselling type was not detailed in the databases for Mainstream service A3 and the Asian hotline (E1) and thus have not been reported in the following tables.

Gambler
Table 24 presents the type of counselling session for gambler clients. As would be expected, the majority of sessions provided by all services were counselling sessions. Overall, on average, 15% of sessions were recorded as assessments though there was wide variability between the services ranging from zero to 61%. On the whole, facilitation sessions (where recorded) were a low percentage of sessions (three percent overall), which is to be expected as this requirement was formally instigated following the time frame of analysis; however, Maori service C04 recorded 26% facilitation sessions.

Significant other
Table 25 presents the type of counselling session for significant other clients. As with gambler clients, the majority of sessions provided by all services were counselling sessions. Overall, on average, one-fifth of sessions were assessments though there was wide variability between the services ranging from three percent to 68 percent. On the whole, facilitation

sessions (where recorded) were a low percentage of sessions (six percent overall); however, Maori service B01 recorded 29% facilitation sessions.

3.1.3 Contact dates, referral pathways and treatment pathways

This section details the distribution of clients in terms of their initial contact date with services, their referral pathways into and out of services, and their treatment episode pathway within a service. This information was not readily available in the databases for Mainstream service A3 and the Asian hotline (E1) and thus have not been reported in the following tables.

Initial contact date

Gambler
Table 26 presents the initial contact date of gambler clients analysed within the time frame of analysis (1 July 2007 to 30 June 2008). Overall, an average of one-third of the clients pre-existed the time frame of analysis with a further third each of new clients recorded in the first and second half of the year of analysis. Several services showed an increase in percentage of clients during the second half of the year (Mainstream service A4, Maori services B04, B07 and C08, Pacific services D1 and D2, and the Alcohol and Drug service F1). Conversely, some services showed a decrease in percentage of clients during this time frame (Mainstream service A5, and Maori services C01, C05, C06 and C07), with two Maori services (C09 and C10 having no clients receiving a session in this period).

Significant other
Table 27 presents the initial contact date of significant other clients analysed within the time frame of analysis. Overall, an average of one-fifth of the clients pre-existed the time frame of analysis with the remainder being new clients within the year of analysis. As with gambler clients, of those services which recorded significant other clients, several showed an increase in percentage of clients during the second half of the year (Mainstream services A4 and A5, Maori services B01, B04, B07, C01, C04, C07 and C08, and Pacific services D2). Conversely, some services showed a decrease in percentage of clients during this time frame (Maori services B05, B06, C02, C03, C05 and C06), with two Maori services (C09 and C10 having no clients receiving a session in this period). Due to the small numbers for some services, these findings should be treated with caution.

Referral pathway into and out of services
The tables in this section detail the method that clients found out about the service that they attended, i.e. their referral or pathway into the service, during the time frame of analysis. Additionally, the tables show a monthly breakdown of media referrals to enable some assessment of the impact of the social marketing campaign 'Kiwi Lives' on client entry into services.

Due to extremely small numbers of referrals out of services, no tables are presented of these data. However, findings are detailed below.

Gambler

Table 28 presents percentage of gambler clients accessing gambling treatment services by the method of referral/pathway. Overall, a quarter of clients (26%) self referred themselves to the service and another 17% were referred by a helpline. Overall, less than 10% of clients entered a service via each of the other reported referral pathways.

Different referral pathway trends were noted for some services. Mainstream service A4 had 31% of gambler clients finding out about the service through the media, which reflects the advertising approach taken by this service, and only one percent referred through a helpline. Several Maori services had a significant proportion of clients self-referring into the services at 80% or greater (B04, B05, B07 and C04). The residential Alcohol and Drug service had a fifth of clients (21%) referred via (other) Alcohol and Drug services and none via helplines. For other services exhibiting a different trend from the overall, numbers were very small making interpretation of observations difficult.

The 'Kiwi Lives' social marketing campaign may have had some impact on clients entering into services with slightly higher numbers of clients generally accessing gambling treatment services during the times the campaign was aired (television and/or radio) (Table 30). However, as overall numbers were small and as it was not possible to separate out pathways in to services due solely to the social marketing campaign but to a 'media' category in general, this finding should be viewed with caution.

In terms of referrals out of services to other agencies, Maori service B03 recorded two referrals to gambling self-help, and Mainstream service A2 recorded 48 referrals, mainly to the Salvation Army. The formal Facilitation Services were not in place during the time frame of analysis, which may account for the low number of recorded outward referrals.

Significant other

Table 29 presents percentage of significant other clients accessing gambling treatment services by the referral or pathway method. Overall, almost half the clients (48%) self referred themselves to the service and 12% were referred by family/relatives. Overall, less than 10% of clients entered a service via each of the other reported referral pathways.

Different referral pathway trends were noted for some services. Mainstream service A1 had between 11 to 16% of entry into the service via friend, media or phone book, Mainstream service A4 had 32% of significant other clients finding out about the service through the media (as with gambler clients at this service). For other services exhibiting a different trend from the overall, numbers were very small making interpretation of observations difficult.

It was not clear whether the 'Kiwi Lives' social marketing campaign had any impact on significant other clients entering into services, due to very low overall numbers (Table 31).

In terms of referrals out of services to other agencies, Mainstream service A2 recorded 13 referrals, mainly to the Salvation Army.

Treatment episode pathway

The tables in this section detail the episode pathway summary for clients within services. Due to the large number of different pathways, data have been collapsed into 11 categories relating to the Ministry of Health's current preferred pathway (three brief sessions followed by eight full counselling sessions which may include three facilitation sessions, followed by four follow-up sessions) and major variations to this.

Gambler
Table 32 presents treatment pathways for gambler clients. A majority of clients at each service followed a pathway of up to three brief (overall, 23%), or up to eight full counselling sessions (overall, 31%) (with up to three facilitation sessions). Sixteen percent of clients followed the pathway of up to three brief followed by up to eight full counselling sessions (including up to three facilitation sessions), or up to eight full counselling sessions (including the facilitation sessions) followed by up to four follow-up sessions. The remaining 29% of clients appeared to have a mixed number of brief, full counselling, facilitation and/or follow-up sessions. No individual service appeared to be particularly different from the others in this respect.

Significant other
Table 33 presents treatment pathways for significant other clients. The majority of clients at each service followed a pathway of up to three brief (overall, 42%), or up to eight full counselling sessions (overall, 23%) (with up to three facilitation sessions). Six percent of clients followed the pathway of up to three brief followed by up to eight full counselling sessions (including up to three facilitation sessions). The remaining 28% of clients appeared to have a mixed number of brief, full counselling, facilitation and/or follow-up sessions. No individual service appeared to be particularly different from the others in this respect.

3.1.4 Assessments

This section details the distribution of clients across gambling treatment services by initial and follow-up assessment score using 'Total Dollars Lost', Control over Gambling' and the South Oaks Gambling Screen, three-month time frame (SOGS-3M) for gamblers, and 'Family Checklist', 'Family Coping' and 'Family Gambling Frequency' for significant others. In addition, other measures are also detailed, though these were less often used than those just mentioned. This information was not readily available in the databases for Mainstream service A3 and the Asian hotline (E1) and thus has not been reported in the following tables.

Total Dollars Lost
Data are presented only for gamblers (Table 34). The overall median Total Dollars Lost was $620. However, there was substantial variability amongst services with a median range of zero to $1,000. Some Maori services (B06, B07 and C10) did not record Total Dollars Lost assessments with clients in the time frame of analysis. Overall, the median difference in Total Dollars Lost from first to last assessment was an improvement of $250. However, apart from Mainstream services A1, A2 and A4, and Maori service B01, the numbers of follow-up assessments were too small to allow meaningful conclusions to be drawn.

Control over Gambling
Data are presented only for gamblers (Table 35). The overall average Control over Gambling score was 2.78. Seven of the 17 Maori services did not record Control over Gambling assessments with clients in the time frame of analysis. Overall, the average difference in Control over Gambling score from first to last assessment was an improvement of 0.73. However, apart from Mainstream services A1, A2 and A4, and Maori service B01, the numbers of follow-up assessments were too small to allow meaningful conclusions to be drawn.

SOGS-3M

Table 36 presents the average SOGS-3M scores for gambler clients at initial assessment and the average difference in SOGS-3M score at follow-up assessment from the initial assessment score.

Overall, the average initial SOGS-3M score was 8.6 with an improvement by 3.2 points at follow-up assessment. In general, all services had a similar average initial SOGS-3M score for clients. Three Maori services (B05, B06 and C04) recorded a lower initial average client SOGS-3M score (between 3.7 and 5.9) than other services. Three Maori services (B02, B07 and C10) did not record SOGS-3M scores for clients at initial assessment; services B02 and B07 routinely used the EIGHT screen for problem gambling rather than the SOGS-3M during the time frame of analysis. Service C10 only had eight clients in the time frame of analysis, all having a brief episode only, thus the lack of SOGS-3M assessments is to be expected for this service.

There was more variability amongst services in terms of average SOGS-3M scores at follow-up assessment; however, as the majority of services other than Mainstream had very small numbers of follow-up assessments the results need to be interpreted with extreme caution. This applies in particular to the two Maori services (B05 and C05) which showed an apparent increase in average SOGS-3M scores at follow-up assessment (i.e. a worsening in problem gambling severity) since the data are based on only two clients at each service that were followed up in the time frame of analysis.

The average initial SOGS-3M score for new gambler clients was cross-tabulated against referral pathway into gambling treatment service to ascertain whether some referral pathways were likely to be associated with more or less severe gambling problems at initial client presentation at the service (Table 40). As previously mentioned, the overall average initial SOGS-3M score was 8.6. When examined by referral pathway, the average initial SOGS-3M score ranged from 5.2 (gambling venue referral pathway) to 10.2 (phone book, and alcohol and drug referral pathway). The majority of the other referral pathways fell within one SOGS-3M score point of the overall average initial score.

Family Checklist

Data are presented only for significant others (Table 37). The overall median Family Checklist score was 8.88. Six of the 15 Maori services with significant other clients did not record Family Checklist assessments with clients in the time frame of analysis. Overall, the median difference in Family Checklist score from first to last assessment was an improvement of 3.42. However, apart from Mainstream service A1, the numbers of follow-up assessments were too small to allow meaningful conclusions to be drawn.

Family Coping

Data are presented only for significant others (Table 38). The overall median Family Coping score was 1.96. A majority of services with significant other clients did not record Family Coping assessments with clients in the time frame of analysis. Overall, the median difference in Family Coping score from first to last assessment was an improvement of 0.36. However, the numbers of follow-up assessments were too small to allow meaningful conclusions to be drawn.

Family Gambling Frequency

Data are presented only for significant others (Table 39). The overall median Family Gambling Frequency score was 2.83. A majority of services with significant other clients did not record Family Gambling Frequency assessments with clients in the time frame of analysis. Overall, the median difference in Family Gambling Frequency score from first to

last assessment was an improvement of 0.5. However, the numbers of follow-up assessments were too small to allow meaningful conclusions to be drawn.

Other assessments

Other assessment measures were only utilised by services, within the time frame of analysis, if there was cause to conduct the particular assessment, i.e. these were not routinely conducted. Other than those detailed below, various other measures were also used with gambler and Significant Other clients; however, the numbers were all too small for analysis.

Gambler

The AUDIT-C for alcohol misuse was primarily used by Mainstream service A2, with 140 initial assessments (average score of 9.5). There were only 21 follow-up assessments showing an average increase of 1.5 in AUDIT-C scores. This could be an artefact of the small number of follow-up measures. Only six other clients were assessed using AUDIT-C from Mainstream service A1, and Maori services B01 and C01.

A clinical diagnosis of problem gambling using the DSM-IV gambling criteria was primarily used by Mainstream service A2, with 359 initial assessments (mean score 6.33). There were 76 follow-up scores showing an average reduction of -0.71. Only 12 other clients from Mainstream services A1, A4 and A5, and Maori service B01 had DSM-IV measures taken during an initial assessment.

Cannabis use was measured primarily by Mainstream service A2 (mean score of 3.64). There was only one follow-up assessment showing an increase of 2.00. Only six other clients from Mainstream services A1 and A4, and Maori services B01 and C02 were assessed using this measure.

The CES for depression was primarily used by Mainstream service A2 and Maori service B01. For service A2 there were 172 initial assessments (average score of 28.8), and 40 follow-up assessments showing an average decrease of 2.5 in the scores. Service B01 recorded 15 initial assessments (average score of 21.8) but only one follow-up assessment showing an increase of 14. One other client from mainstream service A1 was assessed with the CES for depression.

3.1.5 Analysis of trends

This section details trends for new clients and for counselling sessions. Trends for new clients provides information on changes in attracting new clients to services, whereas trends in counselling sessions provides information on changes in clients continuing treatment or returning for further treatment as required. Overall for gambler and significant other new clients, there appeared to be a reduction in numbers during December 2007, which was apparent in each of the analyses.

New client trends

Services

On the whole, apart from Mainstream services A1 and A2, numbers were too small for individual services to be detailed. Services are thus presented in the figures as A01, A02, A (other Mainstream services other than A1 and A2), B and C (Maori services), D (Pacific services), and F (Alcohol and Drug service). Numbers were too small for the Asian hotline (service E1) to be presented in the figures.

Figure 1 and Figure 2 present number of gambler and significant other clients respectively, attending gambling treatment services during the 12-month time frame of analysis. The major trends of note included an overall slight reduction in number of gambler new clients for Mainstream service A1 during the first half of the analysis period, though subsequently numbers increased although not to original levels. Maori services showed an overall increase in numbers of significant other new clients during the first half of 2008. Numbers of new clients at other services fluctuated over the year without any definitive trends.

Figure 1 - Gambler new clients by service

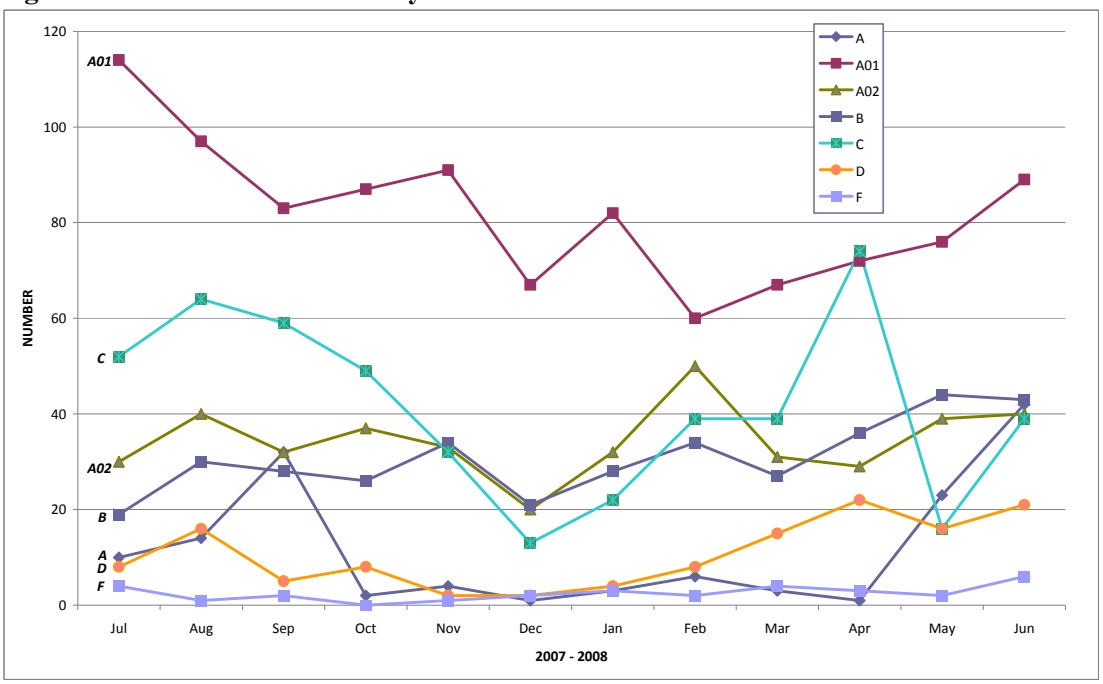
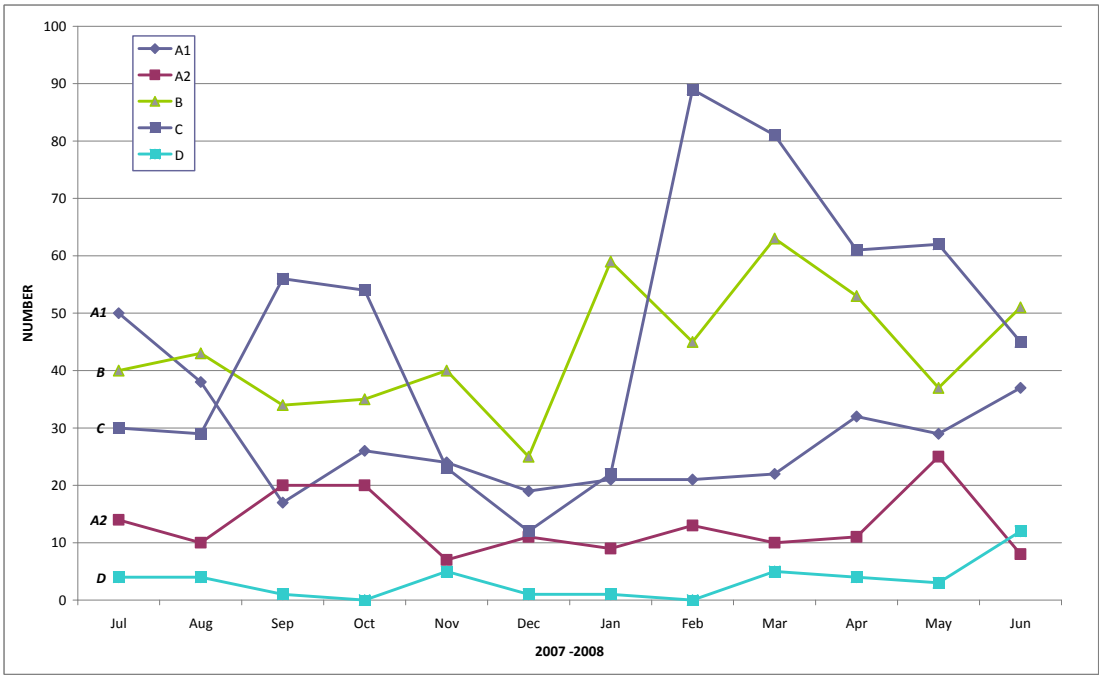


Figure 2 - Significant other new clients by service



Age

Figure 3 and Figure 4 present number of gambler and significant other clients respectively, by age group during the 12-month time frame of analysis. There was much fluctuation in numbers of new clients and the only major trend of note was an overall increase in the number of significant other new clients aged 30 years or younger during the first half of 2008.

Figure 3 - Gambler new clients by age

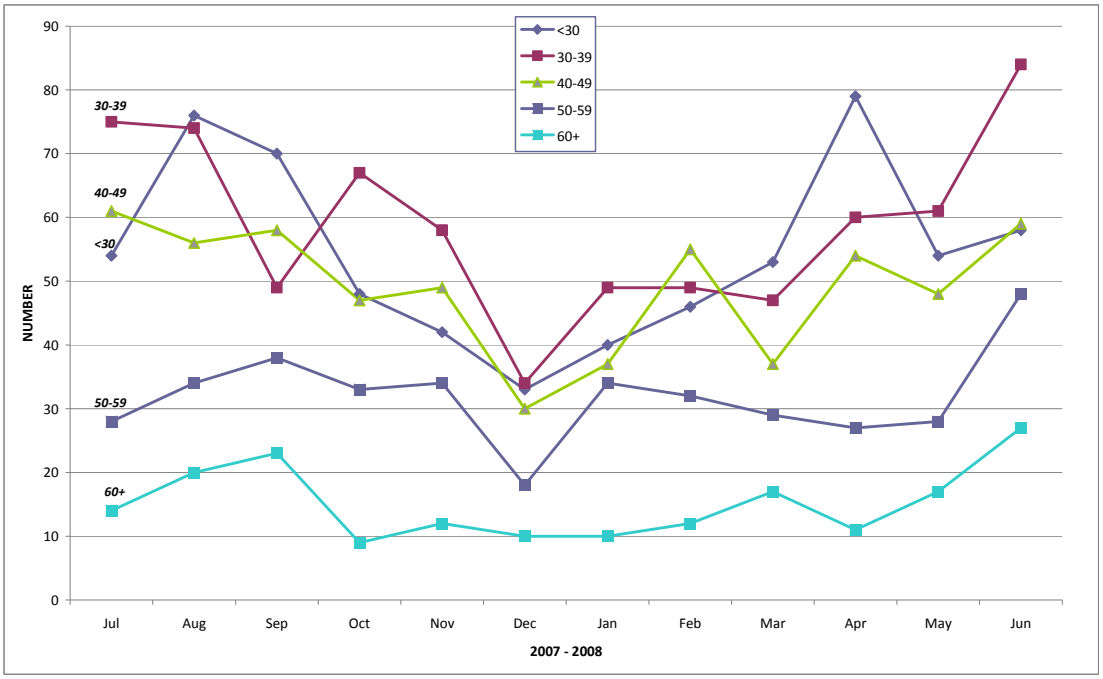
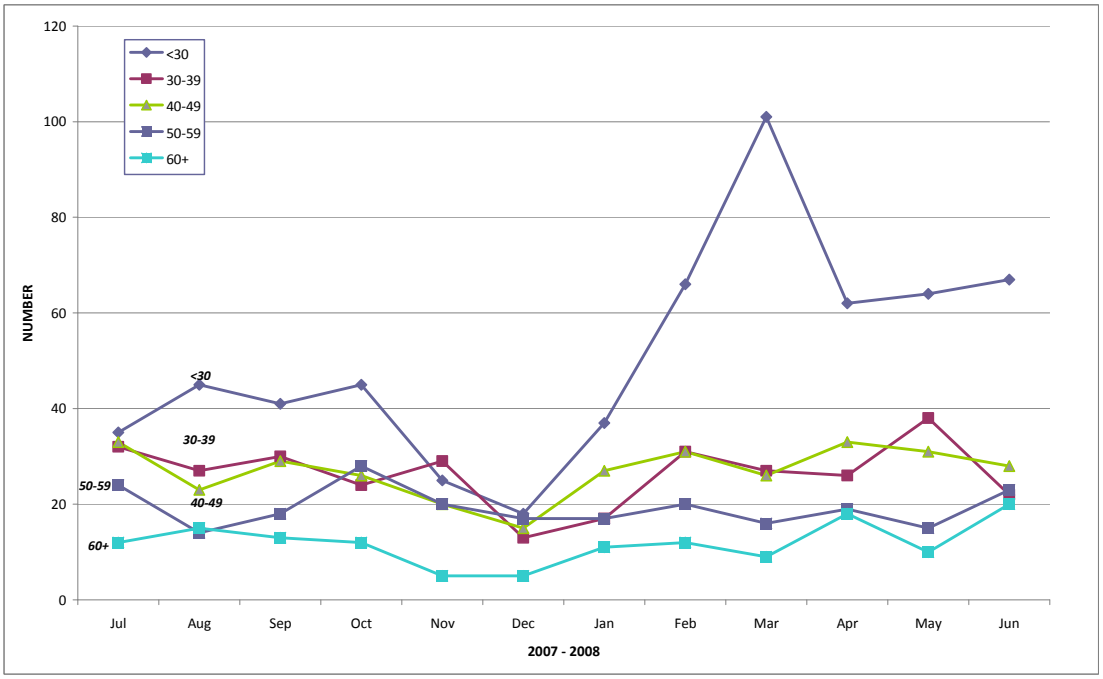


Figure 4 - Significant other new clients by age



Ethnicity

Figure 5 and Figure 6 present number of gambler and significant other clients respectively, by ethnicity during the 12-month time frame of analysis. The only major trends of note were an overall slight increase in the number of Pacific gambler and significant other new clients, and an overall slight increase in the number of Maori significant other new clients during the first half of 2008.

Figure 5 - Gambler new clients by ethnicity

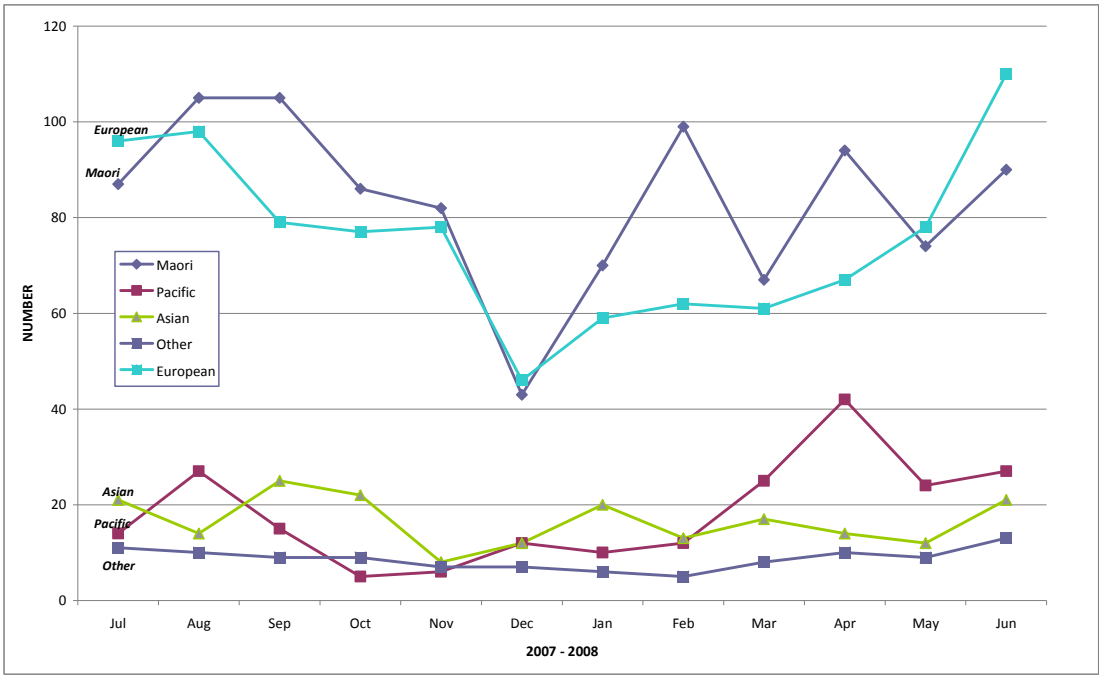
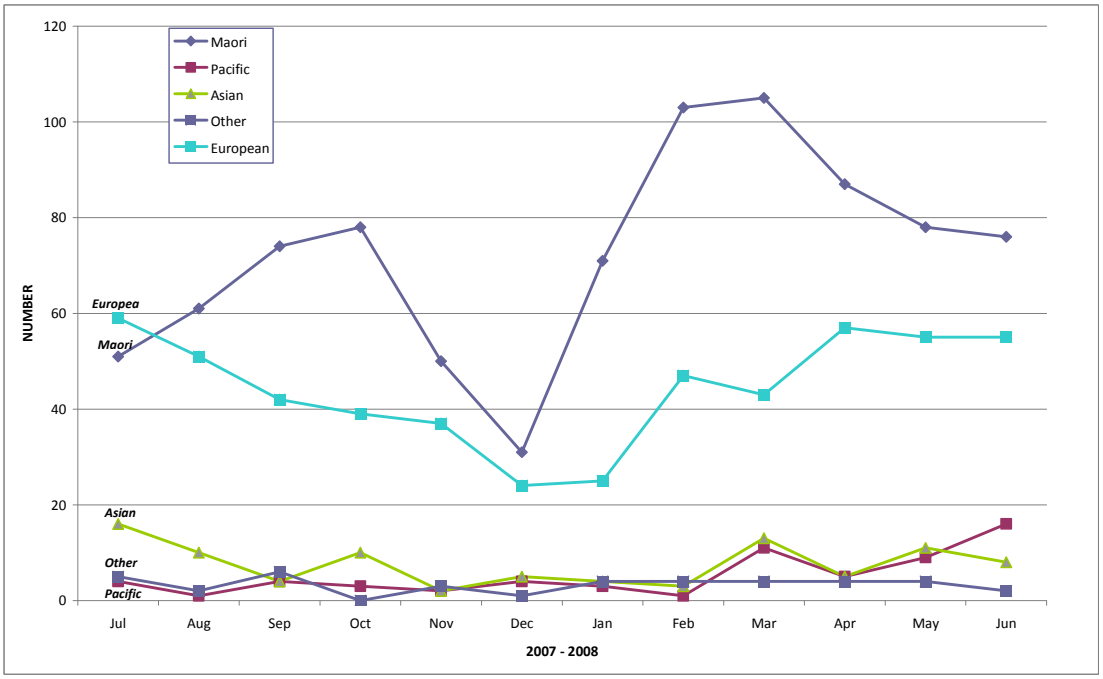


Figure 6 - Significant other new clients by ethnicity



Gender

Figure 7 and Figure 8 present number of gambler and significant other clients respectively, by gender during the 12-month time frame of analysis. There was much fluctuation in numbers of new clients and no major trends were noted.

Figure 7 - Gambler new clients by gender

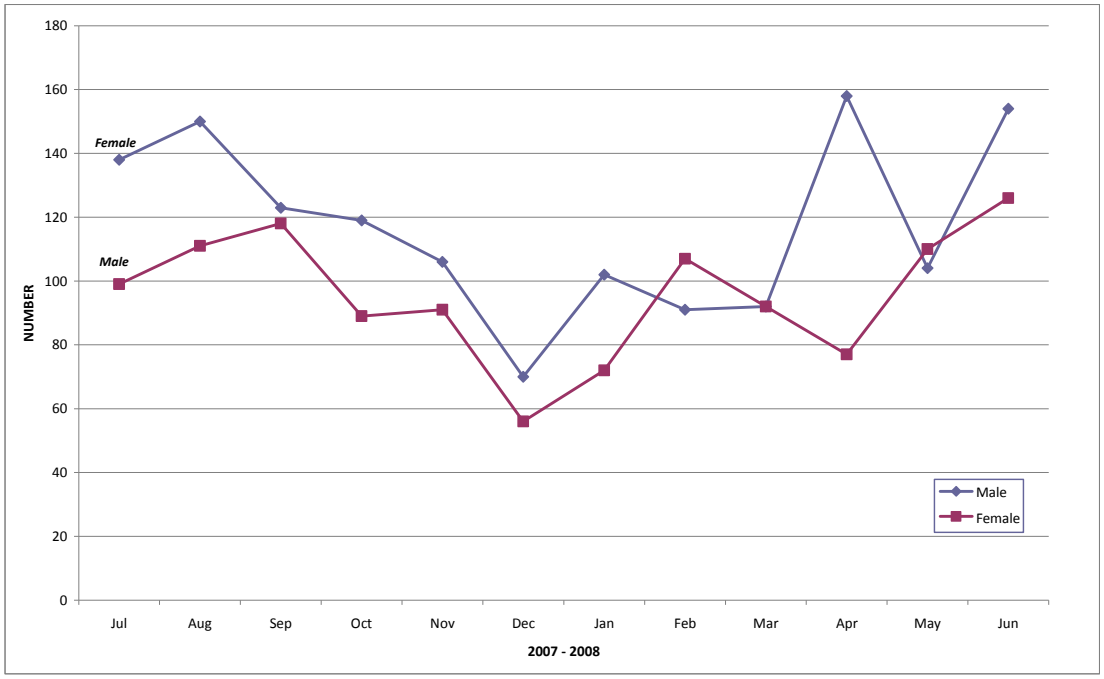
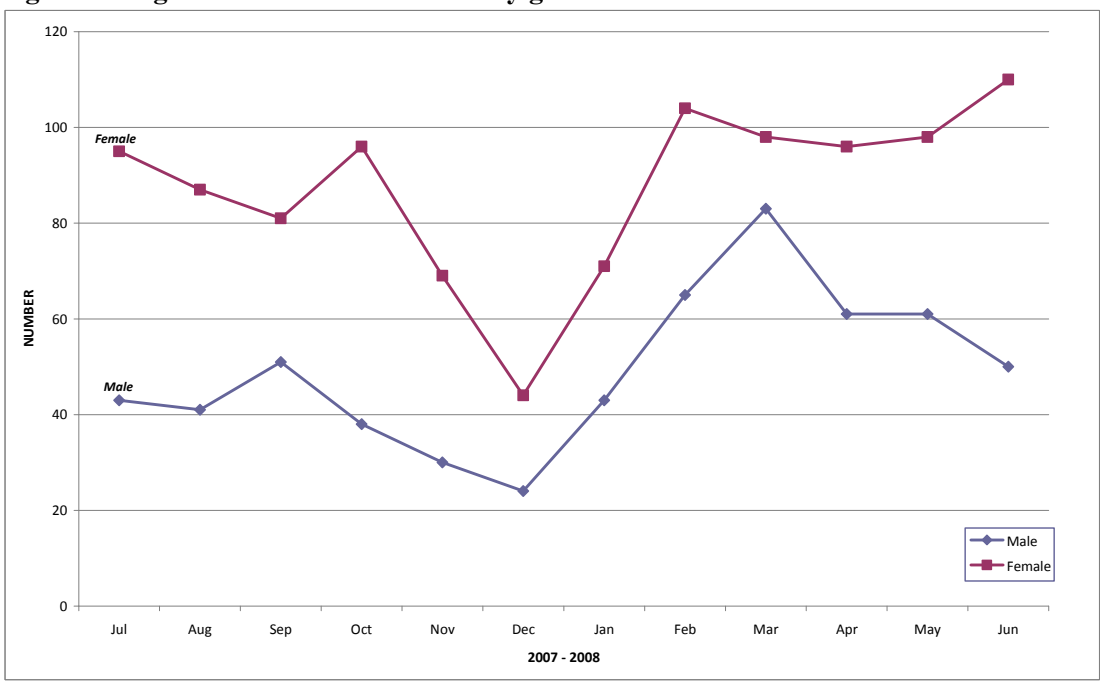


Figure 8 - Significant other new clients by gender



Session trends

Services
On the whole, apart from Mainstream services A1 and A2, numbers were too small for individual services to be detailed. Services are thus presented in the figures as A01, A02, A (other Mainstream services other than A1 and A2), B and C (Maori services), D (Pacific services), and F (Alcohol and Drug service). Numbers were too small for the Asian hotline (service E1) to be presented in the figures.

Figure 9 and Figure 10 present number of gambler and significant other counselling sessions respectively, by gambling treatment services during the 12-month time frame of analysis. The major trends of note included an overall slight reduction in number of gambler counselling sessions for Mainstream service A1, and an overall slight increase in number of gambler sessions for Mainstream service A2. Maori services showed an overall increase in numbers of significant other counselling sessions during the first half of 2008, which reflected the number of clients presenting for treatment in that time period. Numbers of new clients at other services fluctuated over the year without any definitive trends.

Figure 9 - Gambler counselling sessions by service

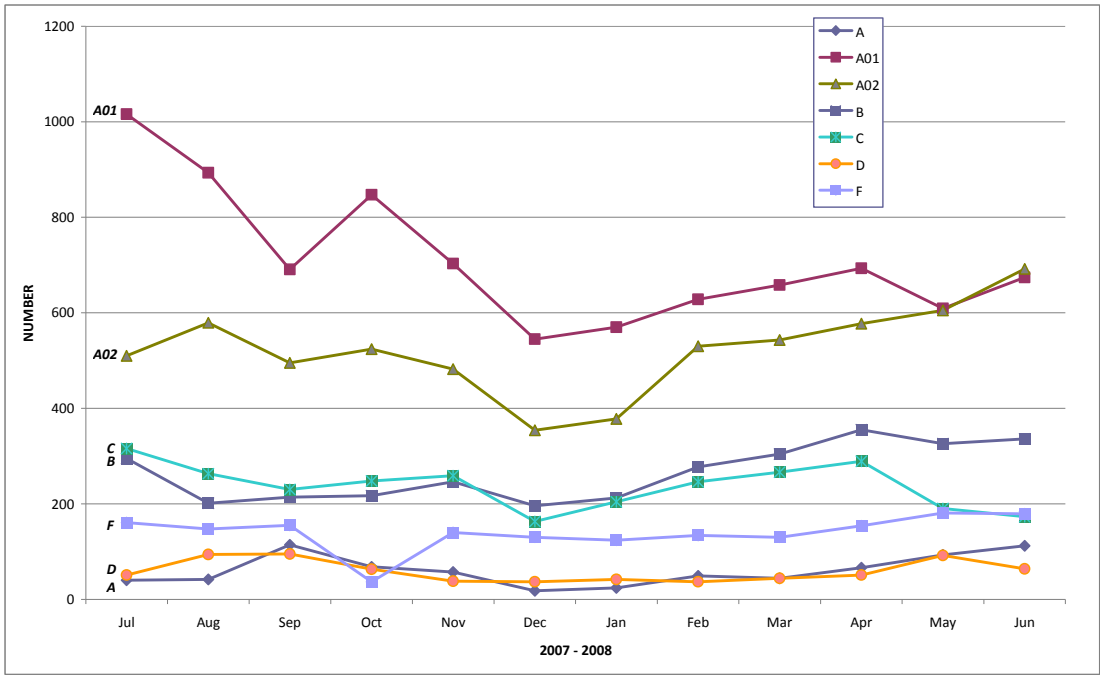
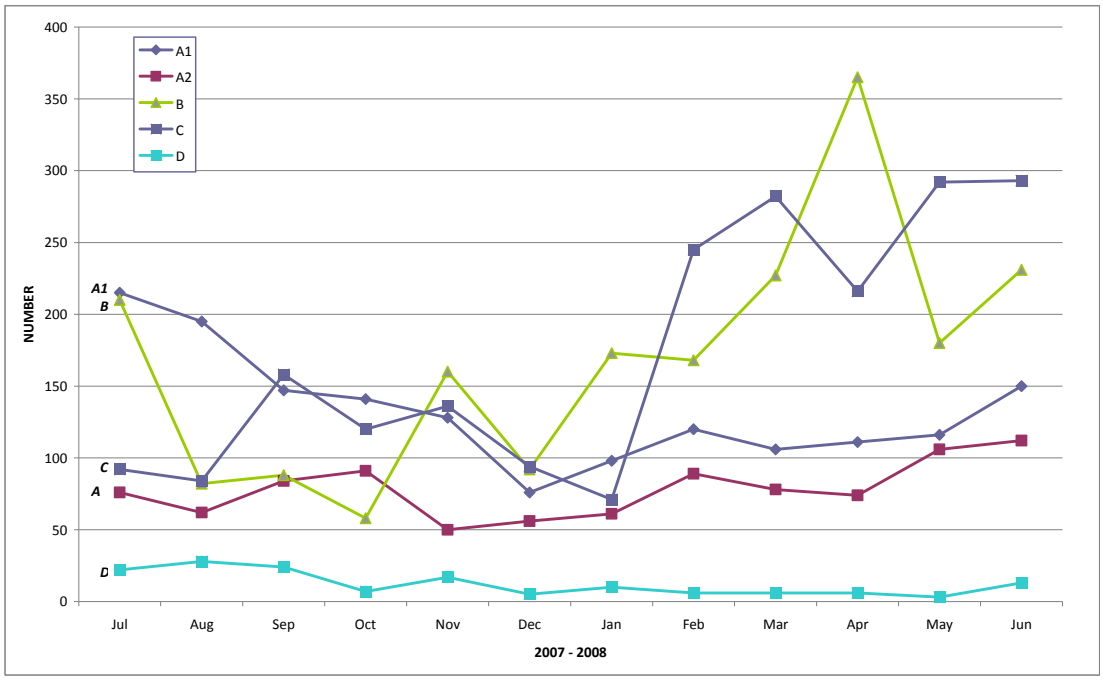


Figure 10 - Significant other counselling sessions by service



Age

Figure 11 and Figure 12 present number of gambler and significant other counselling sessions respectively, by age group during the 12-month time frame of analysis. There was much fluctuation in numbers of counselling sessions and the only major trend of note was an overall increase in the number of significant other counselling session for clients aged in the 30 to 39 year age group during the first half of 2008.

Figure 11 - Gambler counselling sessions by age

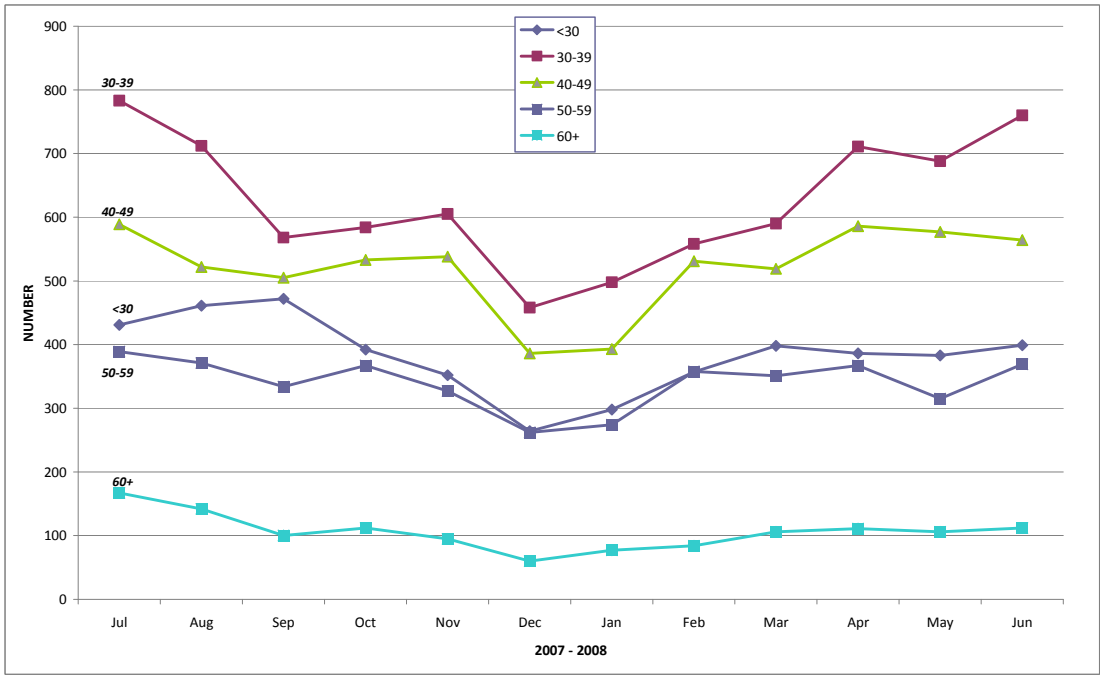
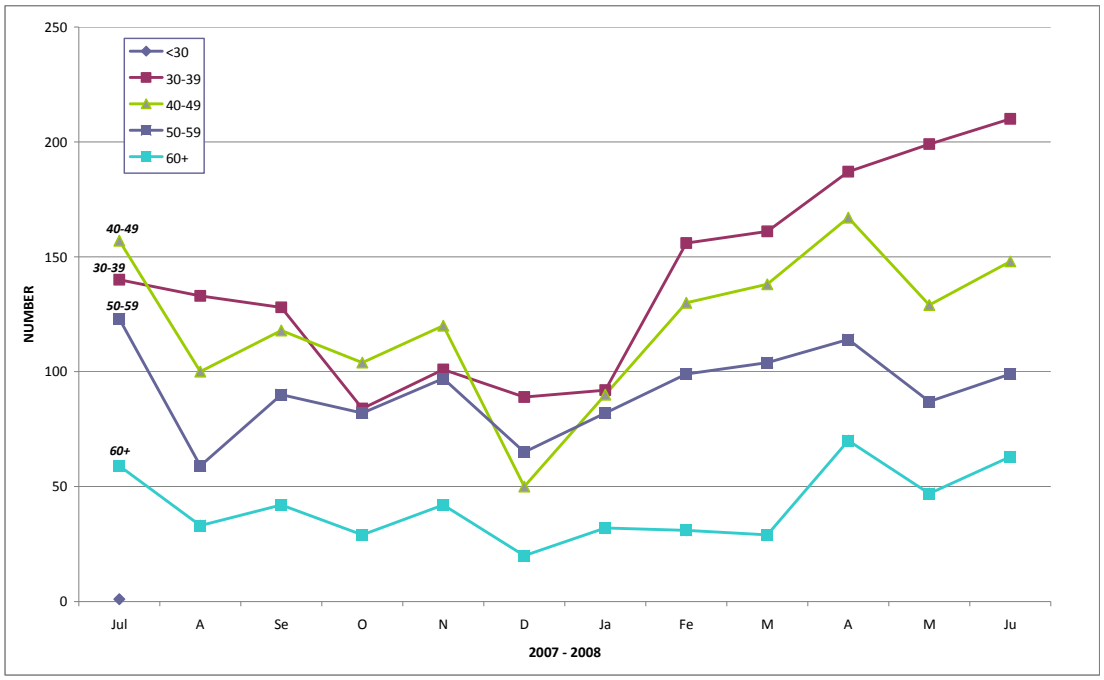


Figure 12 - Significant other counselling sessions by age



Ethnicity

Figure 13 and Figure 14 present number of gambler and significant other counselling sessions respectively, by ethnicity during the 12-month time frame of analysis. The only major trends of note were an overall slight decrease in the number of Euoropean gambler counselling sessions, and an overall substantial increase in the number of Maori significant other counselling sessions during the first half of 2008; this latter finding reflected the increase in new Maori significant other clients during this time frame.

Figure 13 - Gambler counselling sessions by ethnicity

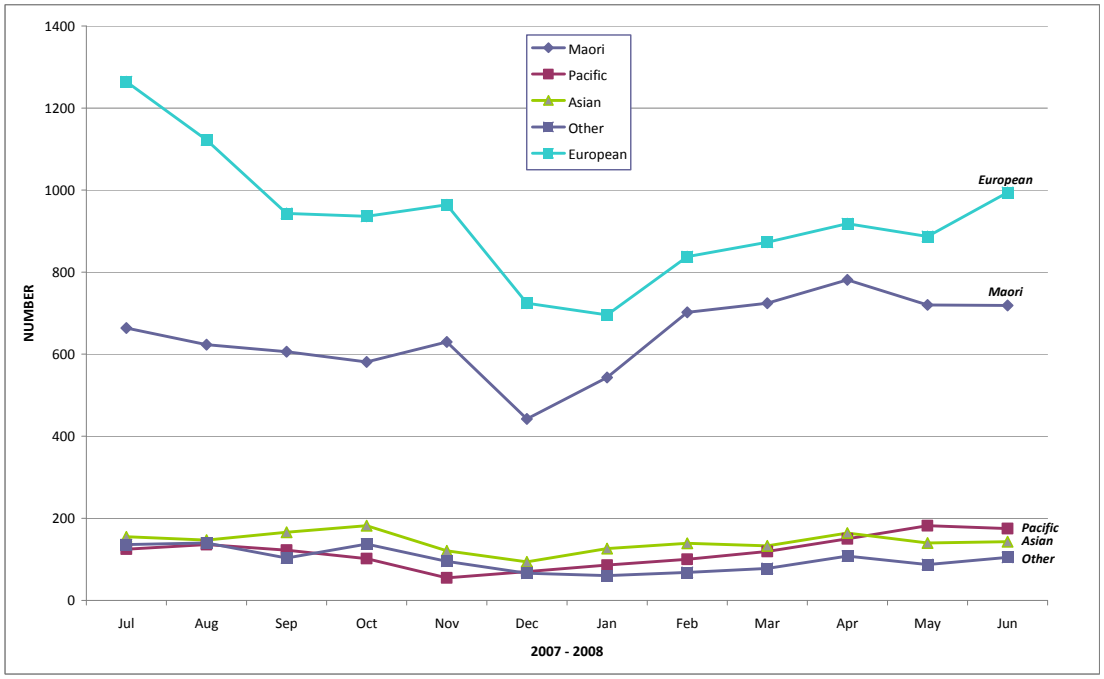
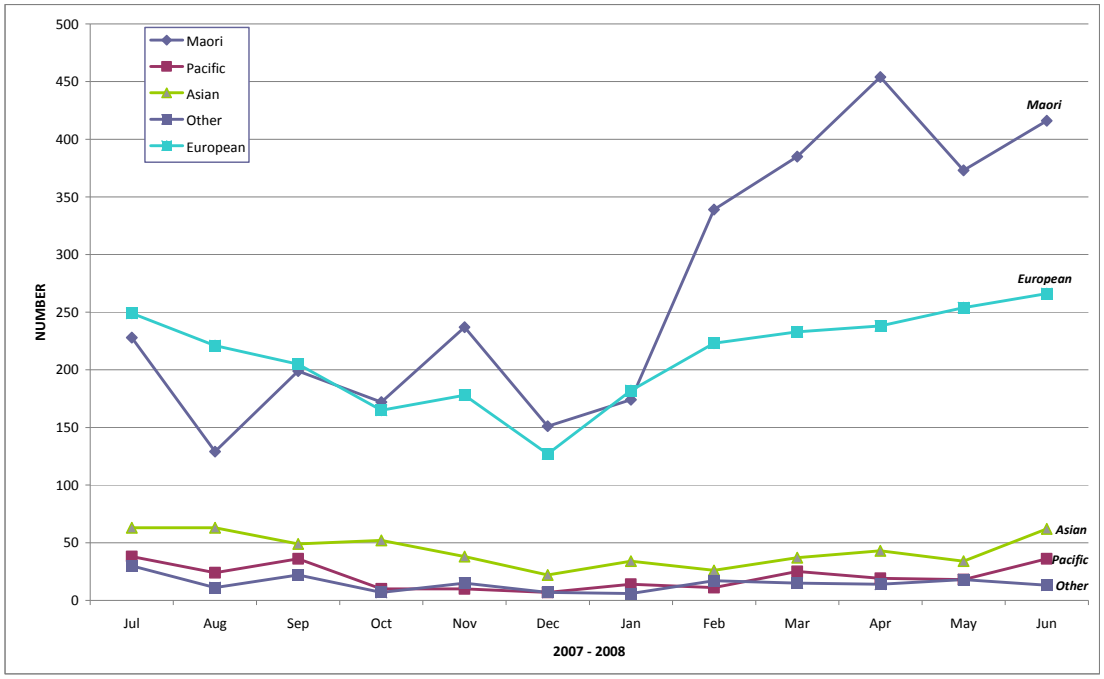


Figure 14 - Significant other counselling sessions by ethnicity



Gender

Figure 15 and Figure 16 present number of gambler and significant other counselling sessions respectively, by gender during the 12-month time frame of analysis. The only major trend noted was a substantial increase in the number of counselling sessions for male and female significant other clients, during the first half of 2008.

Figure 15 - Gambler counselling sessions by gender

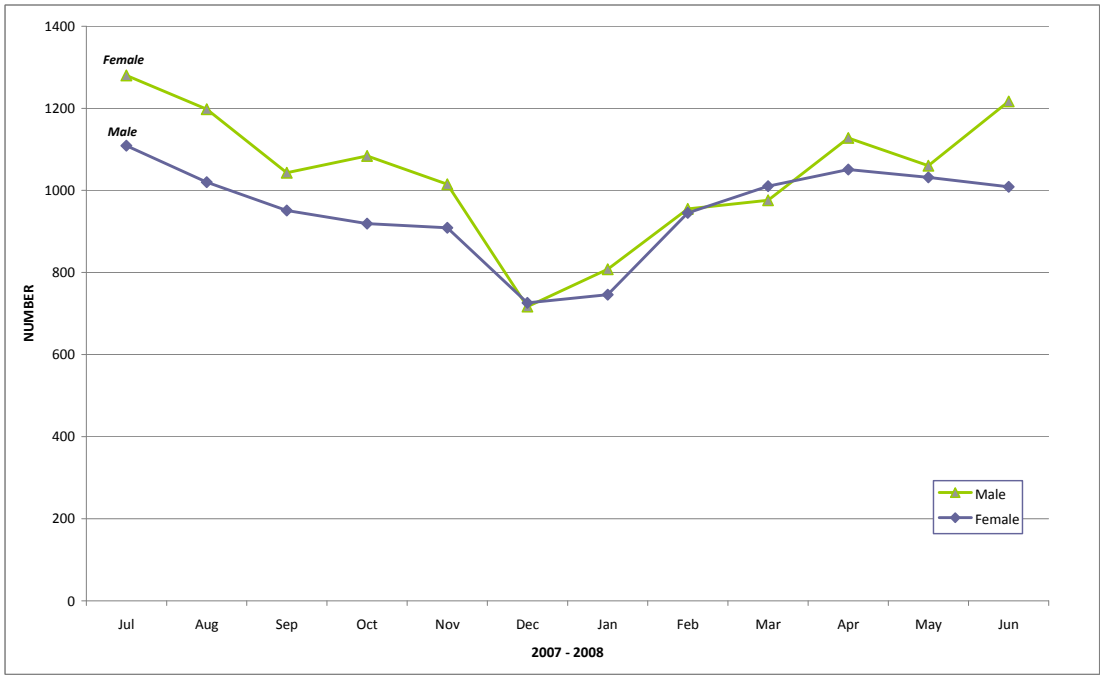
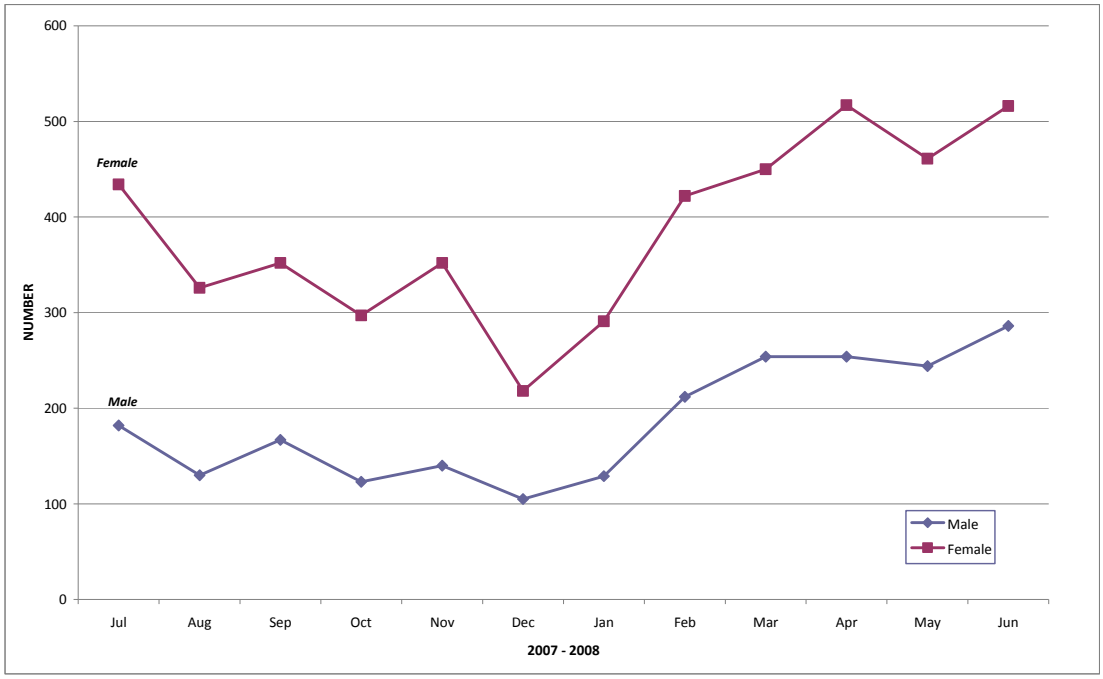


Figure 16 - Significant other counselling sessions by gender



3.2 Stage Two: Surveys

The key areas of interest in Stage Two of the evaluation were:

1. The effect of different pathways to problem gambling services on client outcomes and service delivery
2. Identifying characteristics and evaluating distinct intervention services
3. Evaluation of the roll-out and implementation of Facilitation Services

This was achieved via a mixed-mode methodology which included surveys, focus groups and a group interview[20]. In addition, some services provided the researchers with additional documentation regarding their specific methods for providing interventions. These materials were reviewed but have not been utilised within this report since they were not available for all services and did not add specific information that would enhance the data gathered as part of the project.

Three types of survey were conducted, with staff of gambling treatment services, current or recent past clients of gambling treatment services, and staff of allied agencies (for co-existing issues). Data from these surveys are presented in sections 3.2.1, 3.2.2 and 3.2.3, respectively. Only descriptive analyses are presented due to the small sample sizes, particularly when looking at services by ethnicity.

3.2.1 Survey: Gambling treatment services

This section presents findings from the 60 employees of gambling treatment services who completed the 'staff survey' described in section 2.4.2. A number of responses were missing for individual questions, dependent on the question. This was considered to be due, in part, to individual participants not being involved with, and thus not having knowledge of, certain topic areas within the survey, for example in relation to Facilitation Services, or CLIC data entry and management.

Demographics

Table A presents the demographic and employment characteristics of participating gambling treatment service staff. As can be seen, the majority were female (68%), of New Zealand European ethnicity (53%), and were employed full time (70%) in a Mainstream service (85%). Nevertheless, a high percentage of Maori and Asian staff members were successfully recruited (22% and 20%, respectively) as were employees of ethnic-specific or telephone-based services (45% and 32%, respectively)[21]. Participants spanned a range of professional roles.

[20] Gambling treatment services were included in the Stage Two analyses; the residential alcohol and drug treatment service was not included since gambling interventions are a secondary focus of the service. Although differences were noted between this service and the others in the Stage One analyses, they were due to the residential nature of service provision rather than any other aspect.

[21] Several participants endorsed multiple 'service type' options, suggesting that they provided a mix of mainstream, ethnic-specific or telephone-based services.

Table A - Demographic and employment characteristics

Variable		N	(%)
Gender	Male	19	(32)
	Female	40	(68)
Ethnicity	NZ European	32	(53)
	Maori	13	(22)
	Pacific Island	5	(8)
	Asian	12	(20)
	Other	4	(7)
Service type	Mainstream	51	(85)
	Ethnic specific	27	(45)
	Telephone	19	(32)
Role	Counsellor	46	(45)
	Health promoter	29	(28)
	Manager	9	(9)
	Administrator	18	(18)
Employment	Full-time	38	(70)
	Part-time	15	(28)
	Volunteer	1	(2)

Apart from gender and employment options, participants could select multiple responses

Pathways into services

Participants were asked to identify the pathways by which clients "generally come to your service". The eight most common response types are presented in Table B. Other responses included: health promotion, service promotion or educational events (x6), internet (x4), church (x2), internal agency referrals (x1), and the Kaimahi screening process (x1). Whilst these responses should only be considered indicative of referral pathways (as it is unlikely that participants provided a detailed list of all referral pathways), they do suggest that many clients enter specific gambling treatment services via referral from other parties in the gambling treatment sector (in particular, the national telephone helpline), informal referral or through their own initiative.

Table B - Common pathways into gambling treatment services

Pathway	N	(%)
Formal referral - gambling treatment sector	36	(60)
Self referral	31	(52)
Informal referral - family, friends or word of mouth	29	(48)
Formal advertising	28	(47)
Formal referral - corrections/justice sector	14	(23)
Formal referral - social support sector	12	(20)
Formal referral - health sector	9	(15)
Formal referral - gambling provider	9	(15)

Participants could select multiple responses

In response to the question, "do you think different pathways deliver people to your gambling treatment service at different stages along the gambling continuum?", 45% (27/60) of participants answered "yes", 20% (12/60) "no", 20% (12/60) were unsure, and 15% (9/60) did

not answer the question. A small number of the "yes" participants elaborated on their response, stating: media advertisement facilitating contact from less problematic clients or from significant others (x3); unpredictable motivation of coerced clients, including correction/justice referrals and/or family-driven referrals (x3); clients with greatest gambling problems being referred from casino (x1), legal services or government departments (x1), or "other agencies" (x1); website referrals from younger and/or "shy" clients concerned about confidentiality and who have not disclosed their gambling problem (x1); and "phone book referrals tend to occur when a discussion has been held with significant others".

Participants were asked whether different pathways into "your service impact on clients' outcomes". Thirty-three percent (20/60) of participants answered "yes" to this question, 25% (15/60) "no", 25% (15/60) were unsure, and 17% (10/60) did not answer the question. A small number of "yes" participants elaborated on their answers, stating: that the outcome depended more on the clients' level of motivation rather than their referral pathway (x5); that outcomes would be more positive if a client entered treatment before their gambling problem became too severe (x2); that location and parking issues can put off clients (x1); that when the pathway to treatment entry is poor that it may suggest to the client that the quality of care will be poor (x1); and that clients may be more likely to attend treatment if they contact services directly rather than have another service refer them on their behalf (x1).

Participants were also asked whether the type of intervention they provide to their clients differed "based on the pathway into your service". Forty-five percent (27/60) of participants responded "no" to this question, 18% (11/60) "yes", 18% (11/60) were unsure, and 18% (11/60) did not answer the question. Again, a small number of "yes" participants elaborated on their answer, stating: each intervention is tailored for each client (x2); if referred from another service then a collaborative treatment approach may be required (x1); deliver brief interventions in the community and full interventions in the clinic (x1); clients referred from corrections and/or who have mental health co-morbidities may require specific help (x1); and the treatment provided will depend on whether they have been referred solely for a gambling problem or for a gambling and alcohol or other drug problem (x1).

Distinct intervention services

Participants were asked to identify the types of services, or treatment approaches, provided at their place of employment. Responses are presented in Table C and indicate a large range of service/treatment provision amongst staff at Mainstream and Ethnic-specific services. As can be seen, a majority of participants reported that their service provided full (97%) or brief (95%) interventions for a gambling problem, health promotion (87%) or group treatment (54%). The provision of specialist Marae Noho and workshop interventions for problem gambling were reported by relatively few participants (10% and 14%, respectively). However, a large proportion of participants (28% to 48%) provided assistance with alcohol, drug, mental health, budgeting, or social issues, in addition to problem gambling interventions. Table C also provides a comparison of services as reported by participants from mainstream (n = 47) and ethnic-specific (n = 13) services. These data should be interpreted with considerable caution, as many respondents were employed at the same service (i.e. many participants were describing the same service). This was particularly true of the 47 participants from Mainstream services who were recruited from only four services (six ethnic-specific services were represented by 13 participants).

Table C - Services provided by survey participants

Offered Services	Service Type				Overall	
	Mainstream (n = 47)		Ethnic-specific (n = 13)		(n = 60)	
	N	(%)	N	(%)	N	(%)
Brief intervention	45	(96)	12	(92)	57	(95)
Full intervention	46	(98)	12	(92)	58	(97)
Marae Noho	2	(5)	3	(27)	5	(10)
Workshop	4	(10)	3	(27)	7	(14)
Group work	20	(49)	8	(73)	28	(54)
Health promotion	41	(87)	11	(85)	52	(87)
Alcohol	19	(40)	6	(46)	25	(42)
Drugs	19	(40)	6	(46)	25	(42)
Mental health	12	(26)	5	(39)	17	(28)
Budgeting	19	(40)	3	(23)	22	(37)
Social issues	23	(49)	6	(46)	29	(48)
Other	10	(21)	4	(31)	14	(23)

Participants were asked a number of structured questions that sought to examine their experiences of gambling treatment service provision in the current context. The questions and resulting responses are presented below. In addition to overall response trends (presented below), statistically significant differences between the response of those participants who worked for a Mainstream service and those who did not were examined via a series of Mann Whitney U tests. No statistically significant differences were identified.

Q. "Overall, how do you find the Ministry of Health standard requirements for providing intervention services?"
A. No participants answered "very good", 32% (19/60) answered "good", 42% (25/60) answered "average", 23% (14/60) answered "poor", 2% (1/60) answered "very poor", and 2% (1/60) did not answer the question.

Q. "Overall, is the brief intervention, as required by the Ministry of Health, a good approach for assessing whether someone has a problem related to gambling and may be in need of further assistance?"
A. 47% (28/60) of participants answered "yes", 30% (18/60) "no", 20% (12/60) were unsure, and 3% (2/60) did not answer the question.

Q. "Overall, is the full intervention, as required by the Ministry of Health, a good approach for assisting someone with problems related to their or someone else's gambling?'
A. 52% (31/60) of participants answered "yes", 20% (12/60) "no", 20% (12/60) were unsure, and 8% (5/60) did not answer the question.

Q. "Do brief interventions naturally progress to full interventions?"
A. 30% (18/60) participants answered "yes", 35% (21/60) answered "no", 17% (10/60) were unsure, and 18% (11/60) did not answer the question.

Q. How easy is it for you to meet Ministry of Health contractual requirements in relation to numbers of brief and full interventions each month?"
A. 5% (3/60) answered "very easy", 3% (2/60) "easy", 33% (20/60) "average", 25% (15/60) "hard", 12% (7/60) "very hard", and 22% (13/60) did not answer the question.

Q. "Could the contractual targets be improved?"
A. 53% (32/60) of participants answered "yes", 3% (2/60) "no", 27% (16/60) were unsure, and 17% (10/60) did not answer the question.

Participants were invited to comment on how the brief intervention process could be improved. Twenty-four participants chose to do so. The most common response was criticism of the brief intervention model (x10), including: brief interventions were better suited to other settings (x4), documentation and reporting requirements inhibit, rather than assist, the intervention process (x4), and public health/health promotion workers do not have the necessary clinical skills to conduct brief interventions (x2). Other comments included the need to reduce the reporting requirements of the brief intervention (x5), simplify the wording of questionnaires (x4), translate questionnaires into Pacific languages (x1), integrate reporting requirements into existing data collection systems (where they exist) rather than introduce another data reporting system (x1), and that the process is poorly suited to a client group who is often in denial (x1).

Similarly, participants were invited to comment on how the full intervention process could be improved. Eighteen participants chose to do so. The most common response was the need for an increase in, or flexible requirements regarding, the length of a full intervention (x7). Other comments included: reduced reporting requirements (x5), greater variety of full interventions required (x1), less emphasis on quantity of interventions and more on quality (x1), concerns regarding the capacity of the problem gambling workforce to deliver effective full interventions (x1), greater emphasis on a holistic treatment approach rather than facilitation to a range of specialists (x1), and the Ministry of Health requires a greater understanding of long term systemic intervention (x1), and less Ministry of Health policy "telling me how to do my job" (x1).

Finally, the 32 participants who believed that the contractual targets could be improved were invited to provide suggestions as to how this could be done. Twenty six participants chose to do so. The most common response type was a suggested decrease in the brief intervention target (x5), a decrease in targets overall (x3), a revised target formulation taking into account clinical and regional characteristics (x7), or removal of the target system altogether (x6). Other comments included: greater flexibility in reporting so that a greater range of clinical activities are documented (x3), limit brief interventions to public health/health promotion services (x2), and additional funding to meet targets (x1).

Facilitation Services

Findings relevant to this section are divided into those pertaining to the experience of facilitating clients to other services (service experience) and the perceived impact Facilitation Services have on the client (client experience).

Service experience
Participants were asked a number of structured questions that sought to examine their experience of Facilitation Services. The questions and resulting responses are presented below:

Q. "How much time and effort have you had to put into implementing the new Facilitation Services in terms of building new relationships with other agencies?"
A. 33% (20/60) of participants answered "a lot", 22% (13/60) "a little", 13% (8/60) "not much", and 32% (19/60) did not answer the question.

Q. "Overall, how have you found implementing the Facilitation Services?"
A. 2% (1/60) of participants answered "very easy", 20% (12/60) "easy", 45% (27/60) "average", 7% (4/60) "difficult", 2% (1/60) "very difficult", and 25% (15/60) did not answer the question.

Q. "How do you normally facilitate a client to another service?"
A. 67% (40/60) of participants selected the "telephone" option, 57% (34/60) the "in person" option, and 27% (16/60) the "other" option (participants could select more than one option). The most common "other" options included: Email (x5), mail (x2), providing client with details (x2).

Q. "In your opinion, how have the other services responded to your facilitation of a client to them?"
A. 8% (5/60) of participants answered "very positively", 47% (28/60) "positively", 12% (7/60) "average", 0% "negatively", 3% (2/60) "very negatively", and 30% (18/60) did not answer the question.

Q. "Why are some clients not facilitated to other services?"
A. 53% (32/60) of participants selected the option "client doesn't have other issues", 63% (38/60) selected the option "client has co-existing issues, but doesn't want facilitation", 37% (22/60) selected the option "gave the client information and referral rather than a full facilitation", and 18% (11/60) selected the "other" option (participants could select more than one option). Stated "other" options included: a number of agencies require clients to self-refer (x1), and clients already engaged in required services (x2).

Q. "Do you think the Facilitation Service could be better implemented?"
A. 23% (14/60) of participants answered "yes", 33% (20/60) "no" and 43% (26/60) did not answer the question.

Participants were provided an open-ended opportunity to identify how they thought Facilitation Services could be better implemented. The most commonly suggested improvements included: educating other services about problem gambling issues (x4); reducing the paperwork and/or increasing the flexibility of current process (x6); clarifying the facilitation process between services (x3); having the provision to provide referral details to clients and letting them self-refer (x2); allowing intra-agency facilitation (x1); and changing data collection to a "narrative approach" to better capture "quality relationships and doing agency work". Two participants were critical of the facilitation process suggesting referral/ facilitation was a normal part of the therapeutic process and mandating it was neither necessary nor helpful.

Participants were also asked "what other kinds of linkages and relationships do you feel would enhance facilitation?" Fifteen participants provided a response, many of which were generic comments on the need for greater networking initiatives or information on the types of services available, how they operate and what they offer. A number of specific services were identified that warranted closer links, including: community drug, alcohol and mental health services, Work and Income New Zealand, Housing New Zealand, banks, lending institutions, lawyers, employment agencies, alternative therapies, and sports/crafts/arts co-ordinators. It was also suggested that the Ministry of Health could develop an educational resource for counsellors that detailed the advantages of case management across agencies and fund a coordinating service to assist agencies "come together" over a joint client. Finally, two participants highlighted the negative impact a poor facilitation can have on client wellbeing, as evidenced by the following quotes:

Facilitations are most successful when you have an established relationship with that organisation, so that you are clear on what they are offering to a client…otherwise there can be a sense of 'abandonment' by the client, being passed on.

Gambling problems often push the boundaries too far and clients are devastated when they are judged and treated badly by service centre staff.

Client experience

Participants were asked a number of structured questions that sought to examine the perceived impact of the Facilitation Service on their clients. The questions and resulting responses are presented below:

Q. "In your opinion, how have clients generally found the Facilitation Services?"
A. 5% (3/60) of participants answered "very good", 37% (22/60) "good", 17% (10/60) "average", 3% (2/60) "poor", 2% (1/60) "very poor", and 35% (21/60) did not answer the question.

Q. "In your opinion, have the Facilitation Services increased client access/utilisation of these other services?"
A. 23% (14/60) of participants answered "yes", 23% (14/60) "no", 25% (15/60) were unsure, and 28% (17/60) did not answer the question.

Q. "In general how does facilitation impact on your relationship with your clients?"
A. 7% (4/60) of participants answered "very positively, 45% (27/60) "positively", 17% (10/60) "average", 0% "negatively", 0% "very negatively", and 32% (19/60) did not answer the question.

Q. "What are the outcomes for clients who have had facilitated referral to other services compared to the methods your organisation previously used?"
A. 2% (2/60) of participants answered "much better", 13% (8/60) "better", 55% (33/60) "the same", 3% (2/60) "worse", and 27% (16/60) did not answer the question.

Q. "In your opinion, do you feel Facilitation Services improve your client's outcomes in terms of their gambling issues?"
A. 48% (29/60) of participants answered "yes", 5% (3/60) "no", 17% (10/60) were unsure, and 32% (19/60) did not answer the question.

Participants were also provided an open-ended opportunity to identify why they felt Facilitation Services improved client outcomes. The most common response was that the facilitation resulted in additional support for the client in identified areas of need (x19). Four participants noted that facilitation made it easier for the client to enter another service and/or improved the therapeutic relationship and one participant noted that facilitation can have a "retrograde effect if the agency/organisation either fails to deliver or doesn't respond well".

<u>Training and workforce development</u>

Participants were asked a number of structured questions that sought to examine their experience of Ministry of Health data collection and reporting requirements. The questions and resulting responses are presented below:

Q. "Overall, how do you find the Ministry of Health data collection and reporting requirements?"
A. 5% (3/60) of participants answered "very good", 17% (10/60) "good", 32% (19/60) "average", 25% (15/60) "poor", 5% (3/60) "very poor", and 17% (10/60) did not answer the question.

Q. Overall, how have you found the CLIC data reporting system?"
A. 5% (3/60) of participants answered "very good", 20% (12/60) "good", 23% (14/60) "average", 13% (8/60) "poor", 3% (2/60) "very poor", and 35% (21/60) did not answer the question.

Q. Overall, how has the use of the CLIC data entry system been?"
A. No participants answered "very easy", 20% (12/60) "easy", 20% (12/60) "OK", 22% (13/60) "complicated", 2% (1/60) "very complicated", and 37% (22/60) did not answer the question.

Q. "Overall, how did you find the training for the intervention services, data collection and reporting systems?"
A. 5% (3/60) of participants answered "very good", 22% (13/60) "good", 23% (14/60) "average", 22% (13/60) "poor", 10% (6/60) "very poor", and 18% (11/60) did not answer the question.

Q. "Overall, do you think the training is beneficial, for example in terms of workforce development and your understanding of Ministry of Health processes and requirements?"
A. 55% (33/60) of participants answered "yes", 17% (10/60) "no", 15% (9/60) were unsure, and 13% (8/60) did not answer the question.

Q. "Do you collect the data purely for Ministry of Health (contractual requirements)?"
A. 25% (21/60) of participants answered "yes", 47% (28/60) "no", and 18% (11/60) did not answer the question. Participants responding either "yes" or "no" were spread across organisational types.

Q. "Does the collection of data have a positive or negative influence on the relationship building process with your clients?"
A. 8% (5/60) of participants answered "positive", 22% (13/60) "negative", 37% (22/60) both", 17% (10/60) were unsure, and 17% (10/60) did not answer the question.

Q. "Overall, how supportive is your organisation in providing training/education, mentoring and monitoring of the CLIC data management system?"
A. 15% (9/60) of participants answered "very supportive, 37% (22/60) "supportive", 15% (9/60) "average", 5% (3/60) "not supportive", 8% (5/60) "completely not supportive", and 20% (12/60) did not answer the question.

Participants were invited to recommend possible improvements to the CLIC data reporting system. Twenty one participants chose to do so. Four participants suggested a "simpler" process without describing how this might be achieved and two participants suggested removing the data reporting system altogether. Five participants suggested a greater range of, and/or more flexible, reporting options, two suggested a data entry system was required that prompts inaccurate data entry and two recommended the use of a single national database to simplify the process. Other comments included: monitoring internal training (x1), follow-up reports that provide all relevant client information (x1), "client recent data at end of session should be at beginning" (x1), "database is full of clients that do not access services" (x1),

independent analysis with clinical input rather than Ministry of Health analysis (x1), reduction in the amount of data collected (x1), remove episodes (x1), and "stop changing the requirements every week" (x1).

Participants were also invited to suggest how training for the intervention services, data collection and reporting systems could be improved. Twenty-four participants provided a response, the most common of which related to a need for more and/or more timely training (x11), or the need for more clinical (x6) or cultural (x3) input in the training/data reporting process. Other comments included: training occurring before service specifications had been finalised (x2), less change in the reporting requirements (x2), clear purpose and learning outcomes for participants (x1), implementation of brief interventions needs to consider the non-confidential environment of community/public health work and the level of skill of public health workers to manage conflict situations (x1), more time needed when implementing new data measures (x1), and more written material in training and opportunity to practice in the training environment (x1).

3.2.2 Survey: Clients

This section presents findings from the 61 clients of gambling treatment services who completed the 'client survey' described in section 2.4.2.

Demographics

Demographic characteristics of the 61 participants who completed the client surveys are presented in Table D. As can be seen, just over half were male (56%), aged between 30 to 39 years (31%) or 40 to 49 years (27%), and of New Zealand European ethnicity (59%). The majority of participants had no tertiary or trade qualification and a gross annual household income of lower than $60,000. A relatively high percentage of Maori and Asian clients were recruited (28% and 12%, respectively).

Table D - Demographics

Variable		N	(%)
Gender	Male	34	(56)
	Female	27	(44)
Age	20-29	6	(10)
	30-39	19	(31)
	40-49	17	(27)
	50-59	12	(19)
	60+	7	(13)
Ethnicity[#]	NZ European	36	(59)
	Maori	17	(28)
	Pacific Island	2	(3)
	Asian	7	(12)
	Other	3	(5)
Location	Auckland/Northland	18	(30)
	Other North Island	24	(40)
	South Island	18	(30)
Highest Qualification	None	13	(21)
	Secondary school	22	(36)
	Technical/trade	9	(15)
	University	13	(21)
	Other tertiary	4	(7)
Household Income	<$20,001	16	(27)
	$20,001 - $40,000	11	(18)
	$40,001 - $60,000	16	(27)
	$60,001 - $80,000	9	(15)
	$80,001 - $100,000	4	(7)
	>$100,000	4	(7)

[#]Participants could select multiple responses

Eighty-seven percent (53/61) of participants were seeking treatment for their own gambling-related problem and 13% (9/61) were significant others. The primary gambling activity of those participants seeking help for their own gambling-related problem, along with participants' self-rating of their gambling problem severity, at the time of treatment entry, are presented in Table E. Nearly two-thirds of participants (62%) reported electronic gambling machines in pubs as their primary gambling activity, with 70% (37/53) of participants self-rating their problem severity as being a 'big problem'.

Sixty-nine percent (42/61) of participants stated they were still currently attending a gambling treatment service. Of the 31% who were no longer attending treatment, all had exited within three months before completing the survey. The median number of treatment appointments attended at the time of the interview (inclusive of current and former clients) was eight (range 1 to 200).

Table E - Primary gambling activity and self-rated problem severity of participants seeking help for their own gambling problem

Variable		N	(%)
Primary gambling activity[#]	Horse/dog racing	10	(19)
	Sports betting	2	(4)
	Table games - casino	5	(9)
	Gaming machines - casino	5	(9)
	Gaming machines - club	2	(4)
	Gaming machines - pub	33	(62)
	Internet-based	1	(2)
	Other	1	(2)
Problem severity (self-rated)	Big problem	37	(70)
	Moderate problem	10	(19)
	Slight problem	2	(4)
	Not a problem	4	(8)

N=53
[#] Participants could select multiple options

Pathways into services

Information sources
Participants were asked to identify how they found out about the gambling treatment service they were currently attending (or most recently attended). The five most frequently identified information sources are presented in Table F (participants could identify more than one information source). The identified forms of advertisement included television (x5), newspapers (x4), radio (x4), internet (x2), pamphlet (x 1), and a street promotion (x1). Other responses included: budgeting service (x2), General Practitioner (x2), gambling venue referral (x2), work-related contact with the gambling treatment service (x2), referral from a health service (x2), and citizens advice bureau (x1).

Table F - Top five sources of gambling treatment service information

Information Source	N	(%)
Advertisement	17	(25)
Referred by family/friends	13	(21)
Referred by helpline	14	(21)
Telephone book/Yellow Pages	9	(15)
Referred by justice system	4	(7)

Decision making
When asked "when you chose the service to attend, did you know about other gambling treatment services too?", 56% (34/61) of participants answered "yes". Thus, the majority of participants were aware of other options when choosing which gambling treatment service to attend. To obtain some sense of the factors that may have influenced their decision-making process, all participants were asked to identify any characteristics about the service they were currently attending (or most recently attended) that "helped you choose to go there". The five most frequently reported responses are presented in Table G (again, participants could identify more than one characteristic). As can be seen, 'the treatment/help given' was the most frequently cited response, although this included both the type of treatment on offer and/or the characteristics of the counsellor providing the treatment. It was also sometimes

uncertain as to whether participants were providing this response based on knowledge they had of a service prior to treatment entry or the experiences after having entered the service. The next most frequently cited response was a 'service recommendation', which also included specific encouragement from family or friends to attend a specific service. Other responses (not listed) included: had previously tried another service that didn't provide what I needed (x7), service reputation (x3), I was sent by the justice system (x2), the availability of gender specific counsellors (x1), free (x1), no waiting list (x1), something new (x1), didn't want to attend other service as they knew people who worked there (x1), wanted to attend this service as knew someone who worked there (x1).

Table G - Top five reasons for selecting a gambling treatment service

Choice factor	N	(%)
The treatment/help given	18	(30)
Service recommendation	16	(26)
Service location	10	(16)
Only known option	9	(15)
Availability of ethnic specific counsellors	8	(13)

Participants were also asked to identify whether they entered their current/most recent gambling treatment service to attend a specific programme. Thirty-nine percent (24/61) of participants answered "yes" to this question. When asked to identify the specific programme they had sought to attend, the responses included: a treatment group (x13), one-on-one counselling (x5), a workshop (x4), and Marae Noho (x3).

When asked "would you have gone to a different gambling treatment service if there were other options available?" 28% (17/61) of participants answered "yes". When asked to explain their answer, eight of the 17 'yes' respondents indicated no dissatisfaction with their current service but suggested they would have been willing to explore other options - possibly in addition to their current service. Two respondents indicated some dissatisfaction with their current service (not "connecting with counsellors" and "no waiting list and easier location") and seven provided no comment.

Distinct intervention services

This section presents findings pertaining to client outcome, sources of support, treatment experiences/satisfaction, and recommended improvements for future service provision. It was originally anticipated that between-group differences would be presented (e.g. clients of Maori services versus clients of Mainstream services); however, the consistency of the reported findings rendered such comparison redundant.

Outcome: gambling problems

Ninety-five percent (58/61) of participants reported that their gambling treatment service had helped them with their gambling issues, two percent (1/61) were "not sure" and three percent (2/61) did not answer the question. Participants who had sought assistance for their own gambling-related problems were also asked whether their level of gambling activity, control over gambling, and control over money had decreased, stayed the same, or increased since beginning treatment. Results are presented in Table H and indicate that the majority of respondents reported that their level of gambling activity had decreased since starting treatment (100%), that their control over gambling had increased (86%), and that their control over money had increased (77%).

Table H - Self-reported change in specified outcome measures since treatment entry

Outcome measure	Increased		Same		Decreased	
	n	(%)	n	(%)	n	(%)
Level of gambling activity	0	-	0	-	51	(100)
Control over gambling	44	(86%)	1	(2%)	0	-
Control over money	39	(77%)	3	(6%)	0	-

Percentages do not always total 100% due to missing values

Outcome: other problems

Seventy-five percent (46/61) of participants reported that attending their gambling treatment service had helped them deal with other, non-gambling related, issues. Table I presents the reported 'other issue' types. Given the sensitive nature of some of these issues (e.g. sexual abuse, mental health, and alcohol or drug addiction) the reported figures are most likely to be an underestimate of 'other' issues addressed in a gambling treatment context.

Table I - Identified 'other' issues addressed in a problem gambling treatment context

Identified issue	N	(%)[#]
Personal development	20	(33)
Relationship issues	16	(26)
Mental health	6	(10)
Other addiction	5	(8)
Financial management	3	(5)
Grief	2	(3)
Physical health	2	(3)
Sexual abuse	1	(2)

[#] Calculated as percentage of overall sample (n = 61)

Sources of support

In addition to the treatment service they were attending (or recently attended), 49% (30/61) of participants reported that they were receiving support from somewhere/someone else in regard to their gambling issues. Family or friends were the most commonly reported source of additional support (24/30), followed by other gambling treatment services (3/30), other addiction services (3/30), other health professionals (3/30), church (1/30), support worker (1/30), and sports (1/30).

Treatment experience/satisfaction

In order to obtain some indication of participants' first impressions of their gambling treatment service, as well as any subsequent change in their first impressions, they were asked to respond to a number of structured questions on this subject. These questions and the participant response are presented in Table J. As can be seen, 90% or more of all participants responded to each of the questions with a "good" or "very good" response with the exception of "client rating of the premises". Seventeen percent of participants rated their first impression of their gambling treatment service premises as "average" or "poor" and this did not improve over time.

Table J - Participant ratings of selected gambling treatment service features

Client rating of	Impression	Very Poor		Poor		Average		Good		Very Good	
		n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
The information provided at the service	First	0	-	2	(3)	5	(8)	13	(21)	41	(67)
	Current	0	-	1	(2)	0	-	10	(17)	47	(81)
The premises	First	0	-	2	(3)	8	(14)	20	(33)	28	(48)
	Current	0	-	1	(2)	9	(16)	17	(30)	29	(52)
The reception/first contact with service	First	0	-	0	-	5	(8)	13	(22)	42	(70)
	Current	0	-	0	-	4	(7)	9	(16)	45	(78)
The counsellors	First	0	-	1	(2)	4	(7)	6	(10)	50	(82)
	Current	0	-	0	-	0	-	4	(7)	56	(93)
The treatment/help received	First	0	-	0	-	1	(2)	11	(18)	49	(80)
	Current	0	-	0	-	0	-	7	(12)	52	(88)

Percentages do not always total 100% due to rounding

When asked, 84% (51/61) of participants reported being "very satisfied" with their current/most recent gambling treatment service, 15% (9/61) were "satisfied" and two percent (1/61) did not answer the question. No participant reported being "dissatisfied" or "very dissatisfied". All participants were provided an open-ended opportunity to identify what they found most satisfying or helpful about their treatment experience; the most frequently reported comments are presented in Table K, with the top three being: clinicians' skills and attributes, the knowledge/insight gained by the client or their progress, and the supportive environment provided by the service. Other comments included: video examples (x1), positive feeling post-treatment attendance (x1), effective coordination between services (x1), the one-on-one treatment approach (x1), and courtesy calls if the clinician has to cancel an appointment (x1).

Table K - Most helpful/satisfying characteristics of treatment

Characteristic	N	(%)
Clinician skill/attributes	40	(66)
Knowledge/insight gained or progress made	22	(36)
Supportive environment	10	(16)
Service accessibility	5	(8)
Camaraderie with other clients	5	(8)
Holistic treatment approach	3	(5)

Recommended improvements

Possible areas for service improvement were examined via a series of structured questions. The questions and participant responses are presented in Table L. The majority of respondents reported that there was no need for improvement (76% to 93%), with less than one-quarter reporting a need for improvement in each of the identified areas.

Table L - Response to structured 'service improvement' questions

Is there room for improvement in…	Yes		No		Don't Know	
	n	(%)	n	(%)	n	(%)
The treatment/counselling approach	12	(20)	46	(78)	1	(2)
The information provided about the service	14	(24)	45	(76)	0	(0)
The information provided at the service	3	(5)	54	(93)	1	(2)
The location of the service	10	(17)	48	(81)	1	(2)
The reception/first contact with the service	4	(7)	53	(91)	1	(2)

In addition, all participants were provided an open-ended opportunity to identify what they found unhelpful about their treatment experience. Ten participants provided a response, including: difficulties contacting counsellor or scheduling appointments (x3), the treatment ceasing (x2), found the questions relating to personal finances a little intrusive (x1), found it difficult to voice opinion in a group context (x1), poor match with counsellor (x1), brevity of treatment (x1), and need for greater gambling-specific information/help (x1).

Facilitation services

Sixty-two percent (38/61) of participants reported that their "gambling treatment service counsellor" had not helped them to "access any other agency/organisation to deal with other issues", 34% (21/61) of participants reported that they had been helped to access another agency/organisation and three percent (2/61) did not answer the question.

The 38 "no" respondents were asked why this was the case, responses included: no other issues to deal with (x11), current counsellor was dealing with other, non-gambling specific, issues (x6), no other assistance wanted (x4), already had someone else helping out (x2), had yet to explore other issues in counselling (x1). The remaining "no" participants did not answer the question.

Fifteen of the 21 participants who stated that their gambling treatment service had helped them access another agency/organisation provided further detail about this process. In terms of how the assistance took place, seven participants stated their counsellor visited another agency/organisation with them, in three cases the counsellor set up a telephone conversation between the client and the new organisation, and in two cases the counsellor provided the client with a pamphlet. Fourteen of the 15 participants stated that their counsellor's assistance in accessing other agencies/organisations was helpful, and one reported that it was not. When asked whether the assistance process could have been improved, no constructive suggestions were provided. Finally, 13 of the 15 participants stated that the assistance received from the new agency helped them with their 'other' issues. The remaining two stated that it helped with their gambling issues only (i.e. still helpful).

3.2.3 Survey: Allied agencies

Eighteen allied agencies completed the survey, representing 49% of those contacted (18/37). Due to the small sample size, only descriptive analyses have been presented below.

Although the apparent response rate for this survey was low, there were a number of reasons for this as follows:

- Forty percent (40/100) of the allied agencies for which contact information was provided by gambling treatment services were not able to be contacted by the

researchers in relation to completion of the survey. This was mainly because the information provided was very general, for example a local District Health Board, Work and Income New Zealand branch, or polytechnic. Upon speaking to the gambling treatment services providing this information, researchers were informed that clients had a facilitated referral to whoever was on duty at the allied agency at the time. As some of these organisations are large, it was not possible for the researchers to identify individuals who knew about facilitated referrals of problem gamblers to their service and who would thus be able to complete the survey.

- Twelve percent (12/100) of provided contact information was incorrect. This was generally because the contact details were out of date caused by the facilitated referral being isolated events that occurred quite some time previously.
- Eleven percent (11/100) of contacts reportedly had no knowledge of facilitated referral of problem gambling clients to their service and thus declined to take part in the survey. In some cases, this may have been because the gambling treatment service did not divulge that the client for which they were facilitating the referral, was a problem gambler. This was particularly the case for referrals to services such as education classes that were an alternative past-time for the gambler instead of gambling.
- Of the 37% (37/100) of allied services which initially expressed interest in participating in the survey, subsequent only 18 took part. Many of the services contacted the researchers on receipt of the survey form and indicated they had changed their mind because they felt that they did not have problem gamblers referred to their organisation after all and thus would not be able to complete the survey.

Thus, in terms of contactable allied agencies (from the list supplied to the researchers) who knew that they had been involved in facilitated referral of problem gamblers, the majority completed the survey.

The majority of the survey questionnaires (13/18) were completed by a health/counselling/ social support service. The remaining five surveys were completed by: a budgeting service (x2), a taxation assistance service (x1), a careers information and guidance service (x1) and a legal advice and representation service (x1).

Sixteen of the 18 participants stated that they were aware that gambling treatment service clients are referred to their organisation for co-existing issues through a facilitated referral process. The remaining two reported that they were unaware of this facilitated referral process. Due to the low sample size, all 18 participants have been included in the descriptive analyses reported below.

A majority of participants reported that the gambling treatment service usually liaises with their organisation (regarding the referred client) by telephone (16/18). Other methods included: face-to-face contact (7/18), fax (5/18), mail (2/18), and Email (2/18). One participant provided a 'don't know' response.

A majority of the respondents reported that facilitated referral clients attended the allied agency 'all of the time' (2/13) or 'more than half the time' (8/13). A further three of the 15 respondents reported that clients attended 'less than half the time' but no respondents reported that clients attended 'less than quarter of the time'.

Two-thirds (12/17) of respondents reported that they had referred clients to gambling treatment services, whilst just over one-third (5/17) reported that they had not done so. Eleven participants described their method(s) of referral. These included: telephone (6/11),

face-to-face (6/11), Email (1/11), in writing (1/11), and by giving the client contact details of the agency (1/11).

Participants were asked about the benefits of the facilitated referral approach to clients and to their agency/organisation. With regard to the benefits for clients, half of the participants (9/18) provided a specific response: that it makes entry into the new service an easier process (8/18) and that the client may receive a more effective service having been introduced by a "familiar facilitator" (1/18). A further six respondents described the service that they provide in response to this question (i.e. the service the client would receive once the referral had been completed), two were uncertain and one simply stated that it "helps him/her address their problems in a positive way".

With regard to the benefits for the allied agency/organisation, two-thirds of participants (12/18) provided a specific response: benefits of information sharing and networking (7/18), increase in the number of clients (2/18), opportunity to assist people in need (2/18), and helps builds good relationships with clients (1/18). A further five respondents described the service that they provide in response to this question (i.e. the service the client would receive once the referral had been completed) and one was uncertain.

Participants were also asked about the negative aspects of the facilitated referral approach to clients and to their agency/organisation. There was a substantial number of blank responses in relation to this question, which may possibly indicate that respondents could not think of negative aspects. With regard to negative aspects for clients, half the participants (9/18) provided a response: the possibility of a coerced or poorly informed referral (4/18), the possibility that the client may be frustrated with some aspect of the service they have just been referred to (2/18), the possibility that the client may not be suited to the service they have just been referred to (2/18), and referral from a gambling treatment service may cause embarrassment to the client (1/18).

Only four responses were received in regard to negative responses for the allied agency/ organisation: not keeping to terms of agreement (1/18), potential cost of a referred client not attending in person (1/18), an expectation by the client that they will be automatically accepted into the service because they were referred, even when they reside outside the catchment area (1/18), and the potential for a referral to create "a lot of work for little return" (1/18).

A variety of individual responses were received in relation to what would improve the facilitated referral process of clients to the allied agency: more face-to-face facilitation rather than Email, phone or fax (x1), informing the client that the allied agency is not mandatory (x1), providing more information about the allied agency in the community (x1), gambling treatment services inviting the allied agency to talk about what they provide and to refer more clients to the allied agency for help (x1), allowing the client to make the initial contact (x1), closer collaboration with the gambling treatment service (x1), three-way conference call with client, allied agency and gambling treatment service (x1), and "a phone call first to set up a time" (x1). Another participant noted that they need to restructure their service so they can provide more information to their clients and network better with other agencies.

A majority of participants (13/18) reported that they thought clients have more positive outcomes if they are receiving interventions for their gambling issues as well as their other co-existing issues, one participant felt this was not the case, and four participants did not know. Eleven of the 13 participants who provided a positive response emphasised the importance of a "holistic" treatment approach for dealing with the range of client issues. The other two respondents providing a positive response emphasised the ability of gambling

treatment services to establish a relationship with the client (1/13) or to normalise addiction (1/13). The single negative respondent suggested that "the co-existing issues have been the main issue…if the co-existing problems are addressed first, the gambling issues may not be as problematic as first thought". One respondent who provided a 'don't know' response noted "I don't know the answer to this, but my experience with drug and alcohol clients suggests that careers interventions are a positive experience that definitely help clients re-integrate into society with a degree of success".

Over two-thirds of respondents (11/15) rated the relationship between the allied agency and gambling treatment services as very good (8/15), or good (3/15). Two respondents reported the relationship to be 'average, and three reported the relationship to be 'very poor'. Nine respondents suggested that the relationship could be improved through greater contact and/or more attention to relationship building activities. Another respondent suggested the possible use of teleconference facilities. Other responses included: that it was hard to comment as "we have a good working relationship" (x1), that "we need to clean ourselves up and restructure so we can provide a framework for agencies to tap into" (x1), and that their relationship with local gambling treatment services had lapsed since the loss of their own gambling treatment contract (x1).

3.3 Stage Two: Focus groups

Focus groups were conducted with counselling, managerial and administrative staff of gambling treatment services, i.e. with staff who provide interventions or who are involved in the data collection and management processes for the CLIC database. There were between five and 13 participants per focus group[22], and each group represented more than one service which allowed for cross-organisational discussions. The focus groups represented Mainstream, Maori, Pacific and Asian gambling treatment services though the participants were not necessarily of the same ethnicity as the service they represented.

Focus groups were semi-structured to allow scope for participants to elaborate within the areas of interest, to enable more detailed responses than could be captured by the more structured surveys. This section of the report provides a summary of the themes identified from the focus groups. Through the process of examining the dialogue from the focus groups a number of themes presented. As there was wide discussion within the groups, the reported themes are those pertinent to issues of pathways into services; the provision of interventions including any specific or distinct interventions; Facilitation Services; training and workforce development; data collection, entry and monitoring for the CLIC database; and other relevant issues. The themes are outlined based on type of focus group since that is where commonalities and differences appeared to lie; however, during the analysis special attention was paid to different service perspectives (since service differences were apparent from the Stage One database analyses) and if there were differences, these have been detailed below.

3.3.1 Pathways into services

Many different pathways into gambling treatment services (ways that clients access or find out about the services) were discussed in each of the four focus groups. These discussions included current pathways into services and possible alternative pathways/improvements to current pathways to increase numbers of clients accessing services. The discussion also revolved around barriers to clients accessing services and how each specific organisation attempts to improve pathway access to their service.

Types of pathways

Participants noted a range of common pathways for client access to services. These included: social marketing campaign (there was some discussion within ethnic focus groups about lack of consultation/input into the campaign, and one Mainstream focus group participant comment about the campaign stigmatising gambling), self-referrals, telephone books, advertising (paper, billboards, at events), mental health services, courts, probation, local knowledge of families and what is going on, schools, gambling venues, food banks, alcohol and drug treatment services, notices on electronic gaming machines and at gambling venues, online requests for help and assistance, text messaging, and General Practitioners. However, it was apparent from the discussions that pathways for clients accessing services differed slightly for different services. Examples included Mainstream service A4 which provides structured workshops and advertises for clients, and services which provide treatment for other health related issues as well as gambling.

> *Pathways, it actually creates quite a complex intertwining of what's going on.* (Mainstream focus group)

[22] One Maori organisation was unable to send representatives to the focus group but supplied their comments on the focus group themes via telephone.

> *We deal with domestic violence, alcohol management. We capture our clients because they come in for those other services.* (Maori focus group)
>
> *Mental health professionals more and more, those pathways with community mental health so we're getting referrals.* (Mainstream focus group)

Awareness raising in relation to counselling

Participants in each of the Maori, Pacific and Asian focus groups discussed the need for raising awareness of what counselling for problem gambling entails, including its confidentiality, to enable clients to make an informed choice about whether or not to seek help. Community events were often used to achieve this purpose.

Asian group participants discussed the issue of counselling being a foreign (unknown) word for older generation Asians in New Zealand:

> *In most of the Asian community, the term of counselling is a foreign term - they do not understand the concept for this.* (Asian focus group)

Participants in all three ethnic focus groups discussed how they work with families to help encourage a problem gambler into counselling. Thus, sometimes the pathway of access is by word of mouth and pressure through the family environment.

> *There was a big health day at the Marae and we got a lot of screens through them which was excellent…mainly Maori but that was fine as we said we welcome any ethnicity.* (Pacific focus group)

Some of the participants found barriers with community leaders, until the leaders could be encouraged to see a reason for the education about counselling and/or gambling.

> *So - at the beginning, we approach the community leaders and we coming to talk with your members - No, with your schools - No, we don't have gambler here. But the hurdle is from the community leaders at the beginning because they don't know us so until there is something wrong happen and then we approach them again*. (Asian focus group)

There was also discussion around community awareness raising and actually engendering interest.

> *We can go out there and do lots of road shows and all that, but if we don't get them there, it's easy to talk, but it's the engagement.* (Maori focus group)

Helpline referral

One of the common pathways included referral from the national telephone helpline although some issues were raised in regard to the process:

> *We get referrals too from the helpline and I'm thinking, hang on, where are all the Maori going? And a lot of them are going to the other… and I know we're meant to have a relationship with them but how can they work with our people?* (Maori focus group)

However, helpline participants commented on their unbiased method for facilitating or referring clients to other Ministry of Health funded gambling treatment services.

Wherever possible we have been sending them face-to-face, face-to-face agencies we give them a choice, we don't pick one over another as you guys know so we allow the client to take that choice and over on with it and we offer them a call back and support around that choice. (Mainstream focus group, helpline)

Justice system referral

Participants from all groups discussed the large number of clients that pathway into their services via the justice system.

I would have to say 30% if not higher and court referrals. (Mainstream focus group)

However, there appeared to be a number of problems associated with this process and barriers preventing it from happening successfully.

Probation is meant to be doing that screening and they don't do it so realistically they should be doing the screening then passing it on to us. So that's a barrier other government departments not buying into it. (Maori focus group)

It's domestic violence and being ordered there by the courts is the first issue... (Maori focus group)

Another issue raised regarding clients who pathway into services via the justice system was where the clients fit along the continuum of willingness to take action and make changes. Participants discussed the different issues that occur when a client is voluntarily attending the service versus involuntarily attending, as probation clients generally are. Whilst positive outcomes can be achieved with the involuntary clients, those were different from the outcomes for voluntary clients. Participants felt this related to the clients being in either a pre-contemplative stage for change (involuntary clients) or a contemplative stage (voluntary clients). Success with the involuntary clients included such things as understanding how gambling can be a problem, where to get help and when it might be needed, and an understanding about the counselling process and how it can help. Often working well with involuntary clients was as simple as first dealing with other more important issues for the client, such as meeting all court mandated counselling sessions to prevent a gaol term.

Crisis

Some participants felt that clients contacted their service because they had reached crisis point, whereas other participants specifically targeted a different client base. In particular this was noticeable for Mainstream service A4, which provides structured workshops for gambling issues.

I have found people have phoned us because they want to phone us because they're in crisis at the time and most of the time they want to do something about it, they want to change, or they want to make themselves feel better so they call us. (Mainstream focus group)

And we are a little bit different because we are not a crisis, we have never said and we don't have any expertise in it, what we can do is offer a very specific programme for gamblers to see where they are at and hopefully we can grab them a little bit before they end up if you like in a crisis situation, so 90% of our referrals are self-referral. (Mainstream focus group, service A4)

Major barrier

A major barrier to client entry into services discussed by participants was the fact that counsellors are not always available 24 hours a day, seven days a week and the need for this, particularly for ethnic-specific clients.

> *You've got to be at the other end of that first phone call because a majority of our Maori people only give you one opportunity and if you're not right there for them you're lose them.* (Maori focus group)

> *When people ring them, English people answer - they hang up.* (Asian focus group)

3.3.2 Distinct intervention services, organisational and client characteristics

Service characteristics

The different services appear to have different organisational frameworks. In some services, the problem gambling counsellors were also alcohol and other drug counsellors, health promotion workers, food bank assistants or budgeting advisers. In many of the ethnic-specific services, particularly Maori services, the organisations also have social service roles within the community in which they work. In other services, a problem gambling counsellor is specialised as such. Maori services offering a Marae Noho approach for problem gambling did not appear to differ from other Maori services.

Holistic approach

Participants from all focus groups voiced the need for a holistic approach to treating problem gambling and discussed, to varying degrees, how this is achieved in their service. Great importance was placed on a holistic approach to understanding the whole person, as the basis to enable a positive outcome for clients.

> *So very often most of the clients have multiple problems and we have to sort out the most problem that affect the client at that moment so usually, the serious one dealt with and the minor things they can manage but if the serious ones - they still have a order in them so even the minor thing they cannot deal with it.* (Asian focus group)

> *Powhiri is a good process, te whare tapa wha all of that because they're looking at both things, we're looking at the person, we're not looking at things in isolation. If that's what [service] does, purely focused on the gambler but we're looking at the person and that's the difference I think.* (Maori focus group)

> *It is never really just about the gambling is it, you know the gambling might be the presenting issue but if I have to kind of quantify how much time is actually spent talking about the gambling as opposed to everything else that we talk about umm its probably no more than 15-20% you know, the other 80% is looking at the family relationships, the other stresses on that person at the moment. It could be unresolved grief, it could be… abuse… I would have to say that a lot of my Maori and Pacific clients have histories of abuse… and so… you go in as a gambling counsellor but you have to be prepared that you have to deal with whatever is coming up. You've got to be able to hold that and be able to hold that person because they will get a sense if you are faking it or if you are not really there for them and you want see them again.* (Pacific focus group)

Only Mainstream service A4, which provides a structured workshop for gambling issues was different.

> *We don't look at a holistic approach, we are there for the gambling, we are going to get the gambling out of their lives*. (Mainstream focus group, service A4)

However, there was variation in the degree with which individual services provide a holistic approach. Participants in each of the Maori, Pacific and Asian focus groups, and ethnic participants within the Mainstream focus group discussed the need for a hands-on approach which could include: home visits; family/whanau meetings; facilitating/assisting with other areas of life by assisting with language comprehension; and in-house assistance with alcohol and other drug issues, food banks, budget or other issues where the service was multi-faceted.

Cultural aspects

The ethnic-specific services and some of the mainstream services offer counselling in the languages of the clients commonly accessing their services. However, participants noted that when they are unable to meet language needs, the client is often 'lost' as they unable to communicate even with the receptionist.

> *Even though sometimes we have an ID display, we cannot use it, because it is confidential… later on, if we ring these people and we from [service] with the interpreter - "how do you know my number, I did not give any number to you". We know it but cannot use it.* (Asian focus group)

The ability to use a client's own language was seen as very important by participants in the Maori, Pacific and Asian focus groups since language is just the first step in understanding cultural differences and methods of communication.

An example of the importance of cultural understanding was discussed at length in the Pacific focus group. The discussion was based around the use of Matua (elders) as a way to gain respect and have the opportunity to be heard within the community. The involvement of elders as a positive and unique aspect of ethnic-specific services was also discussed in the Maori and Asian focus groups.

Another interesting point raised in the Asian focus group, related to Asian clients specifically going to Mainstream services to avoid the shame of being recognised with a problem within their own community. Once within the service and when the counselling process was understood, clients were often transferred to an Asian counsellor. The reason for transferring the client to an Asian counsellor was to allow cultural aspects to be discussed. In contrast, it was also noted there were non-Asian clients who specifically wanted to see an Asian counsellor. Interestingly, these cases were often where the problem gambler had an Asian partner and wanted an Asian perceptive or understanding of how their issues were affecting the partner.

3.3.3 Facilitation Services

Participants in the focus groups were in varying stages of implementing the Ministry of Health required Facilitation Services, which came into effect from 1 July 2008. Discussions on this topic included past methods of referral, and how these have been adapted to fit within the new requirements, along with how they fit and where they do not fit. For participants who had not started formal Facilitation Services or who do not have Facilitation Services as part of their contract, discussion was around their process for referrals to other services for co-

existing issues. The discussion varied within focus groups and between participants, as different services and individuals viewed facilitation in heterogeneous ways. Overall, participants felt that there were beneficial aspects to the required Facilitation Services and that it was a way in which to capture what they were doing anyway, but that it was too prescriptive to be able to count all the many different ways in which clients are helped with co-existing issues.

Interpretation of requirements

Some of the major issues around Facilitation Services raised in the focus groups were around how the requirements were interpreted[23], though it was noted by a number of participants that they are still working through the process of understanding the new requirements and that they hope to have a clearer view to discuss in the next stage (Stage Three) of this project.

> *I guess give us three months and we can tell you a lot more around that.* (Mainstream focus group)

> *The majority of the time it's quite challenging to make those facilitation requirements and the way we are working with it through our referral points such as the use of facilitation when we are actually case managing that client.* (Mainstream focus group)

> *It's open to a bit of interpretation and my advice is to push those boundaries. And you've got to. If you know inside and out what those specs are and how far to push them, you can become quite innovative in how [to] capture your stats, your targets.* (Maori focus group)

Some contrasting views within the Maori focus group were based on participant differences in understanding and interpretation of the requirements

> *It's sad, when the original specs came out they were excellent, they were beautiful, broad, whanau support, it was easy and we were very comfortable with them but then over the years, they've nearly actually become clinical. Now have to be almost clinically trained and competent and that change has really been quite sad because many of us as organisations won't actually, didn't come into this on the basis that it is now, but the good thing is that there has been a good lead in period so you're slowly adjusted to the new specs.* (Maori focus group)

> *I think it's much better now. It's much wider now because you can be innovative like [participant name] said, before we couldn't because it was either one or the other. I was really peed off when whanau support was taken out because I think whanau is a really big part of it but now we can get them back in because once again it's using this.* (Maori focus group)

Cultural aspects

A negative aspect of Facilitation Services, raised in particular by participants in the ethnic focus groups, was around the feeling of needing to pass clients to another organisation and in doing so lose the bond with, and respect of, clients when their service's holistic and personal touch would allow a better outcome for clients. Other negative aspects, again arising from participants in ethnic-specific focus groups, related to clients not wanting to be facilitated to other services, or not facilitating clients until they were ready to go to the other agencies.

[23] It was apparent to the focus group facilitators that often the focus group appeared to be a learning environment for some participants about how other services conducted activities within the Ministry of Health's Facilitation Services description.

Pacific focus group participants discussed trying to deal with clients' issues in a more holistic manner rather than facilitating clients to other agencies for non-gambling-related issues.

> *One is because I feel that in facilitation, in that availing of facilitation services with Asian clients, I physically have to hand over or bring them over to the agency itself and do a whole lot more introducing the service or giving information and knowledge about the service to the client simply because they, most of them are not familiar with the services as such.* (Asian focus group)

> *How are we expected to get our numbers when some of our people don't even want to go to the facilitation service?* (Maori focus group)

> *We have no qualms about referring to other services if we believe that that's appropriate in relation to that particular client is comfortable with it. But it doesn't really happen all that often.* (Maori focus group)

> *When you facilitate a client or whatever you may call it a referral or whatever, you don't dump them yeah, no you follow through, you walk alongside so if you look at the MoH facilitation of letting them go to get that need sometimes we don't let them go to a very long time until they are ready to be let go.* (Pacific focus group)

> *I'd rather take the whole file so that you may have one clinician with alcohol and another clinician with the gambling so that what we try and do is take the whole thing together rather than divide the whole thing.* (Pacific focus group)

<u>Positive aspects</u>

A variety of positive aspects to provision of Facilitation Services, in terms of the type of help that could be provided to clients, was discussed by participants.

> *We have to encourage the client to do the exclusion and then if they willing to do that, we can - we got the form and then we can help them to fill in the form and then we can send it out to the [name of casino] - but this is the kind of involvement - helping them to fill in the form - not directly talk to the industry.* (Asian focus group)

> *I think you have got a range of facilitations from that immediate help of the homeless or they haven't got food and they need a food-bank or those practical things.* (Mainstream focus group)

> *It is far easier to facilitate in-house than to other organisations, for example if a client walks in the door you do the screen, you do the full intervention and you identify problems like violence or budgeting issues or whatever, if you've got those services in-house it's easier to say well in ten minutes you could go out that door and go and see this person and knock all that stuff on the head in the one visit.* (Maori focus group)

> *…client who came through, husband was beating her up because of her gambling so what I did was crisis services, she went straight into women's refuge so I followed her through women's refuge and connected her with gambling helpline.* (Pacific focus group)

> *A lot of our philosophies are around empowerment and choice so we don't walk them hand in hand. Before we cannot count them as facilitation but for all other intent and purposes that is we are motivating them to seek help, the help they are requiring themselves and to empower themselves by doing that.* (Mainstream focus group)

We have a focus on working out where the individual is whether not standing in their way, we see our job is to say here is a programme, grab hold of that and move it, its always up to the individual to do it, but that doesn't stop us doing home visits, hospital visits, two weeks ago I had a suicide patient at night at his home and take the knife out of his hand… none of that gets recorded… by way of facilitation but its very important part of putting a programme in place. (Mainstream focus group)

Negative aspects

Some negative aspects were also discussed. These particularly revolved around the time taken to provide Facilitation Services in a way that would meet the Ministry of Health requirements.

The real clash about testing clients' empowerment …and you think they need a service you have to get their consent from them and they have to drive it and that sometimes can take what level, what facilitation, then you can get probation referrals or the probation manage cases are, it would be quite long, drawn out… then other times were that you got to attend appointments with a client because of their difficult mental health problems. (Mainstream focus group)

Almost a day trip, two hours, hour and a half there, hour and a half back for facilitation. We have other services in [name of town] but because some of our clients who are problem gamblers who've been through some of those services, they've lost faith in those services so we have to try and marry them back to those services because we can't go up the coast, it's a long drive just to take one client. (Maori focus group)

Our facilitation is that we can go on behalf of the client and advocate for them. Their facilitation is, we've got to take the client to the service, to whoever, and then that counts as a facilitation. Our way of doing it doesn't count. (Maori focus group)

There appeared to be some issues with how seriously calls from problem gambling services are treated by different organisations.

I tried to get hold of [name of allied agency] but the nurse didn't get back to me and I rang about five times. (Pacific focus group)

One of the challenges that I have is around services - either being ill-equipped to deal with other cultures or some services have been very, very prejudiced attitude towards Asians - maybe not intentionally but the nuances that how they behave Asians… they have misinterpreted them and marginalised Asians and we have to work very hard in advocating for our clients, particularly with [name of allied agency]… and I'm finding that some agencies - or a lot of agencies out there - do not, simply do not have the culturally appropriate services. (Asian focus group)

Linkages and relationship building

Participants reported mixed views in relation to the quality of relationships with allied agencies. Sometimes, it was not possible to build up a relationship with the allied agency because, for various reasons, the allied agency could not be informed that the client they were about to see was a problem gambler or coming from a gambling treatment service.

… it depends on who you are dealing with, we deal with [name of supermarket chain] and you know vouchers and you use vouchers and they don't need to know, you know, [name of benefit service] it depends on who you get on the phone, so no they don't

necessarily know that its gamblers, and its sometimes depending on the relationship or the type of relationship if you refer someone on to a psychologist or psychiatrist then there might be the need to know the information, pass the information on, because you have the confidentiality and privacy issues and things and it really, it's the whole full spectrum really I think. (Mainstream focus group)

Some Maori focus group participants discussed the need for a reciprocal arrangement so that they also receive referrals back to their service, thus increasing general understanding of problem gambling within the community. Without a reciprocal arrangement it was felt that their time was wasted in explaining the need for assistance for gamblers and they were unable to account for this time when completing forms for the Ministry of Health. Participants in the Asian focus group discussed issues around the general feeling towards Asians in New Zealand and how this lack of understanding creates a barrier to successful facilitation and treatment in other agencies. For this reason they felt it was beneficial for them to extend the facilitation process for as long as necessary to ensure the client had the best possible outcome. It was also hoped that this would help the allied agency to perhaps understand the Asian culture a little better.

Facilitation has to be reciprocal, that's the thing, if it's not reciprocal it's not worth it. (Maori focus group)

… don't understand the culture and also, they do not have to deal with... that is why they become frustrated. They become frustrated - I am trying to help you (but they don't know how) so they become frustrated - sometimes when they have other work to do, they will not spend too much time on this one… (Asian focus group)

We have been working with crisis team, but crisis team sometimes is very difficult to engage with them. (Asian focus group)

My client went there to the manager of the gambling venues - their answer was that no person would take care of that exclusion process then you need to come back later. That kind of attitude and then when I walk up to them and present my name card they immediately take obligation form. (Asian focus group)

3.3.4 Training and workforce development

Participants discussed a number of different issues regarding training and workforce development.

Interventions Service Practice Requirements Handbook

One major area of discussion was that of the Interventions Service Practice Requirements Handbook (referred to as a manual by some participants) and how this was or was not used when training staff. Participants discussed concerns around the handbook and how it was being interpreted by counsellors as well as improvements for the handbook such as the inclusion of quick references, and one page summaries for each intervention followed by examples which could include more detail. Concern was raised that the handbook is too prescriptive and is contract/database led rather than being led by client needs for positive outcomes.

But not enough clarity on what is but it's too prescriptive on how to do it. (Mainstream focus group)

They will just put in underneath their drawer. How can they have time to read all this? Asian focus group)

I have had some real concerns here around the quality of data that is being collected and the different ways people might be doing it, their interpretation of the manual. (Mainstream focus group)

… still working on getting consistency across centres and counsellors on what everything means even after training in a manual, in fact the manual came out, the contract with new specs came out in January for us and the manual came out in July, ok so there was six months where nobody knew what was going on overall and we were trying to interpret it ourselves. (Mainstream focus group)

… the whole other end of the spectrum where it becomes too prescriptive, it becomes too complicated and too hard and you end up not being able to do it, so the idea was right at the very first place, I think the intentions behind the different contract specs are good, but when they try to iron it down, especially when you get up to the CLIC database and try to put it in to something like that then it becomes a whole lot more complicated, complex too and then it makes them unrealistic and that's where you feel like its not being client led, its being contract led. (Mainstream focus group)

… be more flexible, because what we are doing is very flexible, the Ministry of Health trying to tick box. (Asian focus group)

It's very hard and it's not necessarily anybody's fault so I am not trying to say it's the Ministry's fault but translating something from theory or from a manual or from contract specs into practice, it takes so long to iron out and find out all the things. (Mainstream focus group)

... if you go over fifteen minutes, it becomes a full intervention, hello this is just a brief at the moment, but wait you've only got fifteen minutes, get out. Now you just can't do that. You put it in as a brief intervention and you say for this brief intervention I'm after an hour, they come back and say to you, well that's a full intervention. Yet you try and explain to them that no it's not because being Maori, we can't very well tell the person to - hey, enough is enough you've had your fifteen minutes…and you just can't do that to them. So it is hard to get that across to them that it doesn't take fifteen minutes to hear a person's life story. (Maori focus group)

Training

In regard to the training that has been provided, participants viewed this as positive but lacking in length and detail. The training appeared to also focus more on meeting targets and contractual obligations rather than the best provision of interventions for clients. Some participants also felt the training lacked cultural relevance and that as the requirements kept changing, it was just too confusing.

When you talk about training there has only been one day so don't think there has been enough, but here you have come up with another thing, when you start offering more training, our counsellors are saying na, we don't want to hear anything more about the contracts, targets, specs, we have had enough, its not driven, we are going to do, we want to do what is best for our clients and that so we don't want any training we don't want to talk about those targets anymore. (Mainstream focus group)

… one is business side through the organisation to deal with the... business, about money and therefore the councillor is about care for the community, care for the individual so they don't care about the money. (Asian focus group)

… only reason we got training because we got off our backsides and did it ourselves. (Maori focus group)

And so what's compounded this situation is we only have one training to date since the new specs have come in that we actually had here with [name of training organisation] which was really good. Apart from that, us as the lead provider, I've had to school myself up and read that book cover to cover, and then go out to our organisations and do one-on-one trainings and go through the forms… (Maori service provider)

Once you come to familiarise yourself with the actual episode each spec, it actually does become easier and you can use that book to your advantage. And all we've done is gone and highlighted the bits that are relevant, that you use regularly… and once you get over that we've found that it's already showing in our stats. Our stats are coming up pretty nicely now. (Maori focus group)

…[name of training organisation] may be good, I don't feel they bring in a cultural aspect and they've been told and we've been up and down to Auckland to get this sorted but found it didn't incorporate tikanga because the people who have a say don't take any consideration around Maori things at all and they have the last say around this. So it's having a strong voice to articulate a culture, same for Pacific as well, for some reason Asians… Asians get heard more around training needs. (Maori focus group)

… they always changing and we are... so for the time being, I don't want to bore the staff, I just won't tell them anything. So, once I sort it out, then I will tell them, otherwise I'm so confusing already by saying - they are more confused. (Asian focus group)

Workforce issues

Participants generally felt that workforce development was an important issue and some participants felt that the training could help with this. However, some participants also felt that the Ministry of Health also needed some training in a clinical context to assist with developing more appropriate intervention requirements.

Being such a small workforce in the problem gambling, given that we are problem gambling specific, the meat in our sandwich if you like, we can't take leave. We feel like if we leave, who's going to look after things because there isn't anyone else out there. (Maori focus group)

Ministry wanted this whole process of changing everything and training to me has become an afterthought but now that they've realised how important it is, because when people leave the services, like I say there's no off the shelf person you can grab. (Maori focus group)

The field of practice in itself might warrant a training programme - maybe a certificate degree in cross cultural counselling. (Asian focus group)

Train the Ministry of Health. They need to be trained and have a person who have clinical background to do the clinical contract. People who have mental, who have public health background to design the public health contract. (Asian focus group)

3.3.5 Data collection, entry and monitoring

Whilst participants generally understood the need for the CLIC database it was felt there were a number of areas for improvement. This included that the requirements should not continually be changing. There were also concerns about how a 'one size fits all' approach could work with different services which might have different specifications, as well as issues with different individual interpretations of the requirements. These issues were felt to impact on the quality of the data being collected. The fact that not everything could be entered into the database was also a concern to a few participants. Some participants discussed the time taken to meet the CLIC data entry requirements. Other participants detailed that in their service there was only one, or a limited number of people, who were responsible for data entry into CLIC. In this way, those organisations limited communication from the Ministry of Health to their counsellors and hoped this would reduce some of the confusion as well as improving the quality of the data they were providing.

Although the duplication of information for CLIC and other internal databases, whether paper-based or computerised were discussed by the Maori, Pacific and Mainstream focus groups, it was only participants in the Pacific and Maori focus groups who discussed how computerisation of CLIC data would improve things for some of the services, and issues were raised around the paper-based system they were still using. These participants also suggested that the CLIC database should not accept incorrect data and should alert users when data are missing, so that services can deal with this immediately.

> *I think the Ministry has grabbed hold of this, working their best to move things forward and that's a process we all need to be involved with to make sure it's easy… I am comfortable with this sort of info with trying to capture and trying to get a lot of validity and ability factoring into it, making it easier… but I would think that they few organisations here, except for the helpline, could probably interpret things a little differently depending on our contract specifications, and that's a matter of time before that we can get a consensus, I am happy with the process.* (Mainstream focus group)

> *There is a lot of stuff that is left out, we try to put it into a narrative report because that is what you are supposed to do if you can't put it in to the CLIC database… we do that but it is just every time its more work, more work, more work, more work, instead of making things easier which I thought was supposed to be the case, its getting more and more and more harder, more and more paper work, more and more time.* (Mainstream focus group)

> *CLIC forms they don't even have letters as part of the section, that's about 20 minutes just to write a letter to the client... they only have phone and face-to-face so where do you put that in, where do you put if you take a Matua with you, an elder, with you they don't even have a section for that and that is a big important part of our work.* (Pacific focus group)

> *My concern as a counsellor is that we are focusing so much on getting the boxes ticked that the Ministry of Health want that we actually lose sight of supporting the person that is calling up and doing what they actually want to do.* (Mainstream focus group)

> *We have someone dedicated to follow up, we do all our own data entry and we are finding its taking a lot of time.* (Mainstream focus group)

Client report form filling is horrible. We're spending more time in that form of accountability than in providing quality service and the Ministry must work out a system as soon as possible to computerise that system whereby you can tick a box and it won't move on until that box is ticked. (Maori focus group)

We want a system where, if you've done something wrong it's going to chuck you out. (Maori focus group)

Put it online on a database. The biggest fault from my perspective, as I process all the stats for our collective every month. The biggest hassle is it's a paper based system. (Maori focus group)

We struggle and we've got electronic CLIC and we've got a dedicated... a dedicated database person and that is all they do, they answer our phones they take our messages and they do the database and we struggle... so how on earth are my colleagues here going to cope? (Pacific focus group)

More training would be good but also having that CLIC software because... in [name of service] we have two systems running, the CLIC physical paper... filling in that... then we have an electronic [XX] system so we have to input our [XX] input AOD then input our physical paper filling out for gambling and then now we are trying to put in the electronic [XX] and adding gambling on there so that we can capture the gambling to show that we are seeing AOD and gambling clients that come through… so its usually how many versions guys three duplications of one stat and its too much. (Pacific focus group)

Some participants also felt it was important that staff should receive feedback about CLIC database issues, but that this did not always occur, sometimes because the process was felt to be too confusing.

We will draw those data and then put in the CLIC system and then afterwards the report will not come back to the staff, so it is only the managers who calculate whether we are OK or not. (Asian focus group)

We have feedback loop from because we have CLIC that gets reported every month and then gets sent back to us. In the past, we have involved staff in that immediately, the reports are generated from CLIC and then that becomes part of our staff meetings - our regular staff meeting. But of late, probably in the last - what's today, October - maybe in the last 10 months - since they have introduced this new system or these new contracts, the goal posts seem to be changing every month and it's very ill-defined and we come back to the Ministry and then they go - Oh, OK, we missed that and that, let's change it a bit and there's always changing so at first we would send that feedback back to the clinicians but what it only achieved was not to make their work better but to get them more confused so at some stage we had to make an executive decision - let's leave the clinicians out of it until such time that the Ministry have got their act together - then and only then can we open up those communication lines. (Mainstream focus group)

3.3.6 Other issues

Targets

Participants in the Mainstream, Maori and Pacific focus groups discussed the issue of targets. There were differing opinions on how they found meeting targets and various aspects related to this. Concern was raised about services becoming target driven rather than client driven. Facilitation was discussed as a concern for meeting targets due, in some instances, to a lack of understanding of the time involved. The participants understood why there were targets in place but questioned how these were set.

> *I have heard so many times from our counsellors that the fact they feel like this target driven, number driven and not at all about client driven so the tension between the contract and the target.* (Mainstream focus group)

> *Their reporting requirement is measuring their dollar and we're trying to work it in terms of quality of service for their dollar.* (Maori focus group)

> *… look at a year's worth of data from specific organisations because I'm pretty sure how they arrived at the targets we've got now is that they've gone for an average for New Zealand and they've gone and applied that across the whole board. What I'm saying is that could be a wee bit unfair, particularly for the rural based regions and particularly regions like ours, a huge geographical area but not much people per square metre. Is that we're competing with the urban, you know the Christchurch, the Auckland, the Wellington areas, which is a high density population and going to refer someone in a service, a facilitation might be you know from this road to that building there. Whereas in reality, in the other areas, that might be an hour's drive.* (Maori focus group)

> *I struggle to meet them, follow-ups and facilitation, mainly briefs and fulls, are pretty well, yeah, I just think they're unrealistic to be perfectly honest.* (Pacific focus group)

Follow-up sessions

Participants in the Mainstream, Pacific and Asian focus groups discussed issues around follow-up sessions as defined in the new specifications. The main issues again related to the prescriptive nature of the specifications. The participants discussed how follow-up of clients had previously occurred and how the new set timeframes for follow-up sessions were not conducive to helping clients since clients request different time periods or do not give permission to be contacted at all. Participants also observed that follow-up sessions could only occur with specific types of clients and were not possible with other clients such as those in the justice system or who were transient.

> *Having a very prescribed one month, three month, six month, and 12 month follow-up with screens, the same screens basically on all of the three, six and twelve months is not making the counsellors happy and not making the clients happier. I would have to say on the whole yeah, you know sometimes ringing up, the clients don't want to be talked about again, sometimes they don't want to have follow-ups sometimes they do, but they don't want it one month, three months, six months, 12 months, sometimes they want a phone call every month, to see how you are going, so there is a vast array of what its just having it prescribed I think, it doesn't really help.* (Mainstream focus group)

…very prescriptive on how it should be, you're doing the follow-up you're doing it probably more regularly but it doesn't necessarily fit into this neat little thing… you're not getting counted for some of those things that you're automatically doing because of the way they are saying that it needs to fit into this little slot. (Pacific focus group)

Whenever we take a client on board we let them know, this is required, its almost like an apology, we will be required to follow up on Ministry of Health follow-ups. (Mainstream focus group)

The newly introduced requirement around follow-up is something that we still struggle with. Primarily, because we do not simply do not know how to frame it in terms to the clients in such a way that you get a buy in or cooperation. (Asian focus group)

And it's not that easy to get to, it's five phone calls in the evening… That's right, you have to do your follow-ups outside of office hours. (Mainstream focus group)

… it takes a lot out of your budget to get the follow-up. The Ministry of Health are saying, this work here is not priced out properly in the contract specifications, it does require a lot of effort and I've got someone that phones up and does nothing about follow-up. We did two parts for it, one part is part of the Ministry of Heath screens and the other is to provide that feedback to the counsellors and its all evening work, all evening work. (Mainstream focus group)

… with follow-up you miss out a whole group of people, so you miss on the itinerant people, your homeless people that don't have phones, follow-up is people who are willing to be followed up and its people who have conventional means of contact. (Mainstream focus group)

… twenty to 30% of people we see you get all their contact details, and because of the type of population that we are working with have moved on, are in prison, don't have any phones and things like that because they are in debt and they don't have a telephone line and all of these, its actually a difficult, the most difficult populations to follow up on. (Mainstream focus group)

… the client have to give consent for us - after we have finished, we will do follow-up - so, without consent, we cannot ring them. (Asian focus group)

3.4 Stage Two: Group interview

A face-to-face group interview was conducted with three staff members of the provider of training and workforce development to gambling treatment services (training provider). The group interview was semi-structured to allow scope for participants to provide detailed responses within the topic areas of pathways into and out of treatment, training and workforce development, and Facilitation Services. This section of the report provides a summary of the discussions from the group interview.

3.4.1 Training and workforce development

The training provider is contracted by the Ministry of Health to provide eight regional training days per year for staff of gambling treatment services; this includes ethnic specific training days. Twelve ad hoc training days or sessions are also provided as and when gambling treatment services require additional training.

The contract for the training provider stated that the first eight sessions should include the new practice requirements and the practitioner's manual (Interventions Service Practice Requirements Handbook). The handbook is not distributed by the training provider though a copy is held by them; this is generally not used during training sessions. The training provider has found the handbook difficult to use since it has no easy reference guide for finding items/examples; their preference, therefore, is to use scenarios for training, rather than the handbook text.

The number of annual training days is mandated by the Ministry of Health along with where they will be and which services will attend. Thus, when a new staff member is appointed to a service there may not be a training day scheduled in their area; this has proven to be a problem for small or regional services.

Initial training sessions were around use of the CLIC manual and now have moved onto the handbook. The ad hoc training sessions are now used to deal with enquires around the CLIC database by different services. As this process uses up the small number of ad hoc training sessions, the training provider has discussed with the Ministry of Health an idea around an orientation module for new staff to learn about the on-going processes. This could then be offered as part of the regional training days or on an individual service basis and selected by just those who need it. This could also involve an orientation to the problem gambling field to help transition people into this specialised workforce.

The training provider staff commented that the day-long mixed methods training sessions seem to work for people who attend. They suggested that once the training is implemented by participants, that follow-up would be useful. This is an area where they often do ad hoc training to clarify issues where a service struggles to implement/incorporate required changes.

Training days involve staff in a variety of roles including administrators, counsellors and managers. The training provider staff felt that the first round of training days worked for all staff roles as there was a requirement for everyone to understand the broad issues. It was noted that in the future it would be an advantage to have training focused for each of these roles around the issues that arise for them.

Some of the issues raised by services to the training provider staff have included the difficulty of getting everyone from a service to attend training on one day (thus taking everyone

simultaneously out of the office) and the need for managers to be happy about using and understanding the manual (since any disquiet filters down to the counsellors). The lack of follow-up days has left the training provider unsure if the training of some practitioners has filtered back to the other staff in those services. Some attempts to rectify this have led to the training provider attending the services to provide onsite training; this then counts as part of the 12 ad hoc training days.

The 12 ad hoc days are often used as sessions for situations where there is a need to assist with a new member of staff. In the past, this onsite training or mentoring was done more on an 'as needed' basis, but now it has to fit within the formal training schedule. The training provider sees the set training days as good but there is a need for more flexible training and mentoring between the set days in order to be able to assist services with their issues as they arise.

The training provider staff commented that training around the CLIC manual is methodical. On one level it is logical, but on another it is extremely complicated for services to comprehend. The issue arises of what someone will do in the clinical process to get data that will fit the requirements, rather than the other way round. The training provider feels the intervention process works well and is easy to explain and to train people in when approached in a scenario based way, but all possible scenarios cannot be covered. People sometimes go to the manual to find the answer, but often they are not inclined to do so as it can be very daunting ("it is not something with a quick reference"). The number of manuals is also daunting (interventions manual, data management manual etc). The training provider felt that whilst individual people are fine with manuals, others are not and the ability to be able to pick up the telephone and ask someone rather than flicking through the manuals was the preference for many people. The training provider felt that after a training session, during implementation of what was learned at the training, people were more likely to ring the training provider with queries and if they were not able to contact the training provider would often put things on hold if they could not easily find an answer in the manuals.

When planning training, the training provider suggests a number of ideas which the Ministry of Health will comment on and approve, this includes Maori and Pacific specific training days (all of which count as part of the set annual number of training days). Similarly for specific services, the training provider will use the same method of training but write scenarios specifically for each service and their method of intervention provision. This allows for the training to be relevant to each service and to be tailored to their requirements. Again, this is only possible in the 12 ad hoc sessions.

The training provider felt that the Ministry of Health processes were beginning to be understood by the services, despite the complexity of the processes. The training provider staff commented that the complexity would not be helped by further documentation. In particular, for Maori and Pacific groups, a personal touch was especially needed, with the ability to have more frequent communication and onsite training, where possible. The smaller regional services especially require an ongoing relationship with the training provider to assist when issues arise. The larger organisations have their own infrastructure to help practitioners, so an ongoing relationship with the training provider is not seen to be as important.

The size of the CLIC data entry and management manuals was considered to discourage people from reading them. They mainly detail the data entry process, what is acceptable and what is not acceptable, and how to record the data. The training so far has only been on this first step, and not on how to use the results within the clinical process or on how to integrate them into clinical practice. A suggestion for improvements to the manuals was to include a Frequently Asked Questions (FAQ) section. The intentions of the manuals are seen to be

good, but could be improved with the addition of a quick reference section with examples in a separate document for additional reference, if required. The issue of putting the concepts into the clinical process is still missed. Similarly, service specification details required by managers but not other staff could be separated out of the main manual. The feedback received by the training provider on the CLIC forms has been positive, with the form apparently being easy to follow.

Both the training provider and the people attending the training sessions have to date been largely focused on understanding CLIC requirements (critical to meeting targets and receiving funding). However, the training provider views this as only the first phase of the training with a second phase being about clinical practice. The training provider staff view their role as "making sense of what the requirements are to clinical practice like how you do things in a positive way rather than going through the motions for the data collection". Currently they are starting to try to increase understanding around opportunities for services to conduct brief interventions and how these could be opportunities to connect with people. The training provider staff hope the next phase of training will allow them to show how clients do not fit into boxes, and training on how to be flexible to accommodate real life situations, to allow clinicians to meet their client's needs whilst also meeting the Ministry of Health's requirements.

3.4.2 Pathways to services

The training provider has anecdotally heard that guilt and shame issues are one of the biggest barriers to people seeking specialist help for gambling problems and that this prevents many of the pathways into any specialist help.

3.4.3 Facilitation Services

The training provider is developing and training a range of services to refer their clients to allied agencies for co-existing issues and this seems to have a positive outcome for clients. They train in the area of facilitation to allied agencies but at this stage feel motivation is needed. The training provider believes organisations have been struggling with Facilitation Services; they see the good intentions of the process but feel it is difficult to fit practice with the data requirements, though this understanding should come with time.

4. DISCUSSION

The primary objectives of this project were two-fold. First, to review and analyse national service statistics and client data, and second a process and outcomes evaluation of the effect of different pathways to gambling treatment services on client outcomes and delivery, of distinct intervention services, and of the roll-out and implementation of Facilitation Services.

These objectives were achieved via:

- Analysis of three databases (national face-to-face treatment service data - CLIC, national telephone helpline data, and Asian service hotline data) from 1 July 2007 to 30 June 2008 (Stage One). This was the calendar year prior to introduction of Ministry of Health required intervention processes including Facilitation Services to other agencies (for client co-existing issues). The follow-up to this evaluation will be conducted in Stage Three, which will be a repeat of the methodological processes described in this report, analysing database information from 1 July 2008 to 30 June 2009, i.e. the calendar year immediately following introduction of Ministry of Health required processes.
- Surveys of staff and clients from gambling treatment services and of staff from allied agencies, focus groups with staff of gambling treatment services, and a group interview with the provider of training and workforce development for the gambling treatment services (Stage Two). These took place in early November 2008, at a point in time when the gambling treatment services were starting to implement the Ministry of Health required intervention processes. The follow-up to this evaluation will be conducted in Stage Three in June/July 2009, i.e. approximately one-year after introduction of, and seven to eight months after full implementation of, the Ministry required intervention processes.

It is important to re-iterate that the Stage One database analyses were from the time point immediately *prior to* introduction of Ministry of Health required intervention processes, whilst the Stage Two surveys, focus groups and group interview were conducted in a transition period where services were starting to implement the processes. Thus, results are from a period of flux and include a mixture of old and new practices.

Findings from Stages One and Two have been presented, independently, in Section 3 of this report. This Section draws together key findings from Stages One and Two, and discusses their significance in terms of this evaluation research.

This discussion is presented under the broad headings of: Pathways to gambling treatment services, Distinct interventions, Facilitation Services, and Data collection, training and workforce development.

4.1 Pathways to gambling treatment services

Client demographics

The most reliable demographic data (in terms of overall representativeness of service users) were obtained from the Stage One database analyses. Analyses were performed for client type, gender, ethnicity, age and geographical location looking at overall values and individual service findings. Whilst there were inevitable differences between the different services,

probably due the different sizes and locations of the organisations, certain findings were of particular note.

Not unexpectedly, all services generally attracted a greater proportion of clients of the same ethnicity as the organisation, although some Maori and Pacific services attracted a greater percentage of clients of ethnicities other than the organisation's ethnic orientation. This may be related to the geographical location of those services and the availability, or lack thereof, of other ethnic services in those areas.

All services catered for gamblers and the majority catered for significant others. Two Maori services did not have any significant other clients, possibly because their total number of clients in the time frame of analysis was extremely low. Additionally, the residential Alcohol and Drug service, being an in-patient facility, did not cater for significant others. Four Maori services had a higher than average proportion of significant other clients to gambler clients.

In general from the database analyses, the gender split for gambler clients was fairly similar or biased towards slightly more males than females. Of particular note is that seven of the 18 Maori services had a substantially higher proportion of female clients than male and the Asian hotline had substantially more male (71%) than female gambler clients. This latter finding may reflect cultural traditions whereby gambling is less acceptable amongst females than males. Slightly more male clients (54%) than female clients participated in the survey which reflects the general gender split just detailed. However, it should be remembered that participants were recruited by convenience sampling and not randomly recruited.

Significant others were more likely to be female than male (two-thirds to one third). There were some individual service exceptions, though in all cases numbers were low and thus the validity of these exceptions should be viewed with caution.

Although the majority of services had clients across the age range, there were some notable differences. Mainstream service A4 appeared to attract an older population (50 years and above) than other Mainstream services. This service provides specific structured workshop and group approaches to gambling interventions (detailed more in Section 4.2 Distinct interventions) which may appeal to an older population. Conversely, five of the 18 Maori services appeared to attract clients in the younger age groups (39 years or less). Two of these services also had a higher proportion of female gambler clients as well as a higher proportion of significant other clients, as previously detailed.

Clients of Mainstream and Maori services originated from the majority of Territorial Local Authorities, dependent on location of services, whilst Pacific services, not unexpectedly, only had clients from the two areas in which the services are located.

Pathways into services

Overall, the database analyses identified self-referral (48% of significant others, 26% of gamblers), helpline referral (17% of gamblers) and an informal referral by family or friends (12% of significant others) as the primary pathways into gambling treatment services. These were also the referral pathways most commonly reported by participants in the staff survey (reported by 52%, 60% and 48% of participants, respectively). Similarly, helpline referral and an informal referral by family or friends were two of the three most commonly reported means by which participants in the client survey found out about the treatment service they were attending (both reported by 21% of participants). The most commonly reported means by which participating clients found out about their respective gambling treatment service

was advertising (reported by 25% of participants), most commonly via television, newsprint or radio. Arguably, attending a treatment service in response to an advert may also be considered a form of self-referral. Focus group participants identified a wide range of pathways into their respective services, although helpline referrals and referrals from the justice and corrections sectors were perhaps considered most influential.

The largely consistent findings across independent data sources strongly suggests self-referral, helpline referral and informal referral via family or friends are the primary pathways into gambling treatment services; however, the database and focus group analyses indicated some inter-service variation as to the importance of each and, across all data sources, a wider range of referral pathways was identified. For example, rates of self-referral reported in the database analyses were particularly high for Maori services, helpline referrals were generally higher for mainstream services and in some services, media, alcohol and drug services, or 'other' agencies accounted for 31% to 52% of referrals. On the basis of these results, it is probably reasonable to conclude that: there is some intra-service variability in pathways of treatment entry; despite this variability, entry pathways based on one or more of self-referral (including self-referral in response to media advertisement), referral from a friend or family member, and referral from the gambling helpline are of central importance to many services; and that there are multiple pathways to treatment entry to most services, most of which are utilised by relatively low numbers of service users (some of which are used by relatively high numbers in specific service contexts).

On a slightly different note, findings from the client survey indicated most participants (56%) were aware of more than one gambling treatment service when seeking help for a gambling problem. Thus, not only are there multiple pathways into any one treatment service, it would also seem that the same pathways may lead to multiple services and it is the client who often determines the end-point. Responses to a subsequent question provided further insight into participating clients' treatment selection process. When asked to identify the characteristics of the service that they were currently (most recently) attending that helped them "choose to go there", the three most frequently reported responses were: the treatment/help given (30% of participants), service recommendation (26%) and service location (16%). These results suggest that clients may be choosing one service over another based on a unique or preferred treatment approach, a favourable recommendation or convenience.

Advantages and disadvantages of different pathways

Almost half (45%) of the participants in the staff survey believed there was some association between the severity of a client's gambling problem and their pathway into the treatment service. Thus, there was a common (although not majority) view that the needs of clients may vary according to their manner of service entry. It was difficult to determine what these pathway-related differences might have been as few of the participating staff elaborated on the perceived association. Those that did typically suggested media advertisement increased the number of less problematic clients and/or significant others and that coerced clients may be less motivated to resolve their gambling-related issues. However, examination of CLIC database information for initial average SOGS-3M score against referral pathway into a gambling treatment service revealed very little difference in average severity of gambling problem between the media pathway (SOGS-3M score 8.83) and the justice system pathway (SOGS-3M score 8.35); both of these average scores were similar to the overall average score of 8.6. Thus, staff perceptions did not match the evidence in terms of severity of initial problem in relation to the referral pathway into service. Additionally, staff perceptions that coerced clients may be less motivated to resolve their gambling-related issues may not hold merit either as additional CLIC database analysis revealed that 21% of episodes for clients

referred by the justice system were administrative discharges with 60% of episodes completed and two percent partially completed, versus 18% administrative discharge, 63% completed and 11% partially completed for the media pathway into services (the remaining proportion of episodes were ongoing). However, it was not possible, based on available data, to examine treatment outcomes (such as problem gambling severity at completion of treatment) against pathway into a service.

Focus group participants elaborated on their comments regarding coerced clients, suggesting that positive outcomes could be achieved but that the type of outcome was different (relatively modest) as they were generally pre-contemplative about changing their gambling behaviour. These findings should not be generalised at this stage, given the small number of responses upon which they are based. Whilst it is logical to assume that coerced clients may be less inclined to change their behaviour relative to those who enter treatment of their own will and it is equally logical that advertising may increase the number of less problematic gamblers seeking help by promoting awareness of the potential for greater harm if change does not occur, by promoting the availability of treatment services, or by normalising the treatment seeking process, the database information does not seem to support these assumptions.

Effect of pathways on client outcome

It was originally envisaged that the relationship between various treatment entry pathways and client outcome could be examined via the Stage One database analyses; however, the number of treatment services, the wide range of treatment entry pathways and treatment approaches, and the variable sample sizes for each service rendered the required analyses unfeasible. Having said this, it is anticipated that in Stage Three of the research process (to be completed in 2009) analysis of the database information may be feasible given the more standardised approach to treatment provision. Furthermore, findings from the staff and client surveys provide some insight into the relationship between a client's pathway into a treatment service and subsequent outcome. One third (33%) of participants in the staff survey believed a client's treatment outcome was in some way influenced by their pathway into the service, though additional database analyses investigating the relationship between media and justice system pathways into a service against treatment episode completion did not reveal any major differences. However, examination of entry pathway against outcomes such as problem gambling severity at completion of treatment was not possible, as detailed above. Only a small number of staff elaborated on the perceived relationship, and half of those who did (n=5) noted that it was not so much the pathway that was influential as the level of client motivation. Thus, it is difficult to determine based on the staff survey data what the relationship might be, or even if a relationship exists independent of other factors such as client motivation. It was perhaps of note that only 18% of participants in the staff survey reported that the type of intervention they provide to their clients differed based on their pathway into the service. This, too, would suggest that it may be client characteristics, rather than the pathway itself, that determines the treatment approach and (by extension) the likely outcome.

Findings from the client survey also suggest the pathway into a treatment service may have minimal influence, or be a secondary influence on, client outcome. Ninety-five percent of the client survey respondents reported that their gambling treatment service had helped them with their gambling issues. Similarly, all of the 51 participating clients who had sought help for their own gambling problem reported a decrease in their level of gambling activity, with the vast majority also reporting an increase in their level of control over their gambling (86%) and their money (77%). Thus, irrespective of pathway (which varied between participants),

client outcomes were uniformly positive. This finding needs to be interpreted with considerable caution, as the client sample may not have been representative of gambling treatment clients in general, there was a strong possibility of selection bias in the recruitment methodology, and some participant outcomes may have been more positive than others. So whilst the staff and client survey findings provide some insight into the relationship between a client's pathway into a treatment service and subsequent outcome, further research with a substantially larger and more representative participant base is required before firm conclusions can be drawn.

Implications for service delivery

The implications of findings already discussed in this section on gambling treatment service delivery are readily apparent. Firstly, the primacy of self-referral or informal referral pathways indicates services with a greater advertising budget, more prominent location, less competition, or larger client bases are more likely to attract a greater number of clients (due to their greater visibility). The prominence of the helpline as a referral source would also suggest that services favoured by the helpline, or at least known to the helpline, may be more likely to attract a greater number of clients. At least one participant in the Maori focus group raised the possibility of helpline referral bias, although an employee of the helpline who participated in the Mainstream focus group emphasised the neutrality of their referral process. Thus, conflicting opinion was evident on this point. Nevertheless, the factors identified above may variously influence the number of clients that enter distinct services.

Since the data presented in this report, as discussed on the previous page, indicate that only one-third of staff survey participants believed that a client's treatment outcome was influenced by their pathway into the service, and since 95% of client survey respondents reported that their gambling treatment service had helped them (this was irrespective of pathway of entry), it appears that the pathway into treatment may be relatively unimportant in terms of subsequent service provision and the resulting outcome. The characteristics and needs of the presenting client may be more likely (as one would expect) to influence clinical decision-making as compared to the pathway by which they entered the service. Treatment outcome, in many cases, is also likely to be independent of the treatment pathway. Admittedly, there is limited data on which to base these conclusions and it is quite possible that the needs of clients and the degree of subsequent change may have some relationship with treatment entry pathways. However, many participants in both the staff surveys and focus groups were seemingly reluctant to express or endorse this view and it would be extremely difficult to gather convincing evidence in the current environment (due to the range of pathways into the gambling treatment sector, the eclectic and non-standardised nature of most treatment provision and limitations in current data reporting).

The primacy of self-referral or informal referral pathways may also be taken to suggest that the potential of formal referral pathways has yet to be developed sufficiently. Twelve out of the 24 services included in the Stage One database analyses received 50% or more of their clients via self-referral or referrals from friends or family members. Arguably, these services have yet to develop effective partnerships with potential referral agencies such as the national helpline, corrections/probation, social services, and health services. Thus, investing more resource in developing inter-agency relationships could result in a significant boost in referrals, thereby making it easier to meet (or exceed) contracted output targets.

4.2 Distinct interventions

Distinguishing characteristics of services

The Stage One database analyses indicated some variation between Mainstream and ethnic-specific services in treatment practice. In all four of the Mainstream services the majority of treatment episodes provided to gamblers were either full interventions or follow-up. In 13 out of the 19 ethnic-specific services, however, the most common type of treatment episode for gamblers was a brief intervention. In only four ethnic-specific services were the majority of treatment episodes full interventions. Similar trends were evident in terms of treatment provision to significant others. The database and staff survey data indicate that most Mainstream and Maori services offer a similar range of services. Thus, Maori and Mainstream services appear to differ in terms of the most common type of treatment provided, not in the range of services on offer. The Stage One database analyses also suggest that, despite the variation in which each type of treatment episode is provided, the average length of time spent conducting each type is relatively consistent between Mainstream and Maori services.

Whilst services may provide a similar range of interventions, the survey findings suggest that many gambling treatment staff members are not overly supportive of the mandated brief and full intervention process. Only half (or thereabouts) of staff survey participants felt the brief and/or full interventions as currently specified were good for assessing or assisting a person with a gambling-related problem. Similarly, only eight percent of staff surveyed believed it was "easy" or "very easy" to meet the contractual requirements for brief and/or full interventions and the majority (53%) felt the contractual targets could be improved. These views were consistent across staff employed in Mainstream and ethnic-specific services. On a (possibly) related note, focus group participants from Mainstream and ethnic-specific services consistently voiced the need for a holistic approach to treating problem gambling. Thus, there was a widespread belief that gambling treatment services should focus on more than just gambling-specific issues. This belief likely contributed to some of the frustration with current service specifications, including Facilitation Services (discussed below). Furthermore, the client survey results suggested a holistic treatment approach was often required. Participants identified a range of 'other' issues that had been addressed in a problem gambling treatment context, the most common of which were personal development issues (33% of participants), relationship issues (26% of participants) and mental health issues (10% of participants). When asked what they had found most satisfying/helpful about their experience, three participants specifically stated the holistic treatment approach.

As with the range of interventions on offer, there were few differences between services in regard to counselling type. The majority of treatment sessions provided to gamblers were one-on-one (individual) in 22 out of the 24 services included in the Stage One analyses. Similarly, in no service was the gambler's partner (couple) present in any more than seven percent of the treatment sessions provided and in only one service was a family/whanau member present in more than 10% of the sessions provided. Nevertheless, a quarter or more of treatment sessions were provided in a group context by five services, one of which was Mainstream, three of which were Maori and one of which was primarily a residential Alcohol and Drug service. Thus, a small number of the reviewed services were unique in this respect. One may also conclude from these findings that, with respect to treating problem gamblers, there is significant room to increase the involvement of partners and family/whanau members in the treatment process across all services.

Slightly more inter-service variation in counselling type was evident with respect to significant others. Whilst the majority of treatment sessions were provided in a one-on-one

context in 18 out of the 21 services analysed, five services included the client's partner in nearly a quarter or more of the sessions provided, four included a family/whanau member(s) in 10% or more of sessions provided, and in three services a quarter or more of treatment sessions were provided in a group context. Maori services were more likely to include a significant other's partner or family/whanau member in counselling, or provide counselling in a group context, when compared with Mainstream services. Again, this finding should not be overly generalised as there were more Maori services included in the analysis, and in most services (including most of the Maori services) there is considerable scope for increasing the involvement of partners or family/whanau members in the treatment of significant others.

The Stage One database analyses provided a range of information pertaining to service utilisation trends. Across all services, the mean number of treatment episodes over a 12-month period per client was 1.54 for gamblers and 1.26 for significant others. The mean number of sessions attended per episode was 2.85 and 2.05, respectively. There was considerable inter-service variation in both the mean number of episodes per year (range = 1.00 to 2.31 for gamblers and 1.00 to 2.00 for significant others) and the mean number of sessions attended per episode (range = 1.00 to 9.65 for gamblers and 1.00 to 7.50 for significant others); however, similar levels of variation were evident both in Mainstream and Maori services (i.e. neither Mainstream nor Maori services seemed to have consistently higher or lower means on either measure). This would suggest that, overall, service utilisation trends do not vary markedly between the Maori and Mainstream treatment sector. It was of note that only two of the 13 services that had a mean session attendance of greater than 3.00 per treatment episode, served more than 100 clients during the 12-month review period (Mainstream service A2 and Maori service B01). This would suggest that smaller services may be better placed to provide longer-term treatment and/or may be better able to retain clients in treatment. Alternatively, it may be that smaller services cater to distinct (niche) client groups who, for whatever reason, may be more interested in longer-term treatment attendance. The fact that 10 of the 13 services were ethnic-specific suggests this may be the case, although this should be interpreted with some caution as there were considerably more ethnic-specific services included in the analysis in comparison with Mainstream providers (and, as mentioned, there was considerable variation in the mean number of sessions attended between Maori services).

Treatment outcomes and experiences

In 13 of the 24 services included in the Stage One database analyses, the majority of interventions provided to gamblers concluded as a result of treatment completion. In seven additional services, treatment completion was either the most common outcome or the majority of treatment episodes included in the review period were still on-going. Three of the remaining services (all Maori service providers) had a disproportionately high number of treatment episodes end in either an administrative discharge or partial completion. In the remaining service, a large percentage of treatment episodes reviewed were ongoing (37%), but of those that had been terminated, treatment completion was the most commonly reported outcome (31%). With respect to interventions provided to significant others, the majority of interventions concluded as a result of treatment completion in 17 of the 21 services included in the analysis. In three of the remaining services a high percentage of interventions were ongoing and in one, a Maori service, 50% of treatment episodes were ongoing and 50% were recorded as partial completion. Taken together, then, these results suggest that the majority of interventions that ended during the course of the review did so as the result of treatment completion and this was true irrespective of service type. Nevertheless, there appear to be a small number of Maori-specific services in which outcomes other than treatment completion are the norm.

The client survey data suggest few inter-service differences in treatment satisfaction. Eighty-four percent of clients surveyed reported being "very satisfied" with their current (most recent) treatment service and a further 15% were "satisfied". When asked to rate both their initial and current impressions of a range of service factors, 80% or more of all participants rated each of the specified factors as being "good" or "very good" at both time points. The high levels of satisfaction were mirrored in terms of reported outcomes. As previously discussed, all 51 survey participants who had sought help for their own gambling problem reported problem improvement. Furthermore, 75% of all survey participants reported that their gambling treatment service had helped them deal with other, non-gambling related, issues. When asked to specify what had been most satisfying or particularly helpful about their treatment experience, 66% of participants commented on the personal attributes of their counsellor (e.g. nonjudgmental) or their clinical skill. It would appear, therefore, that for most participants in the client survey the quality of the therapeutic encounter was of central importance. Caution should be taken not to over-generalise these findings as the client sample may not have been representative of the range of gambling treatment clients and was likely prone to selection bias (in that most participants were identified by the service). Nevertheless, based on the findings presented in this report it would seem that there is relatively little inter-service variation in terms of how treatment episodes end and the client experience of those episodes.

Despite their typically positive treatment experiences, between 17% to 24% of participants in the client survey did suggest there was room for improvement in the treatment/counselling approach, the information provided about, and the location of, their respective services (20%, 24% and 17%, respectively). Given the low sample size, it was not meaningful to examine potential inter-service variations on these suggested improvements. Nevertheless, they highlight areas of potential concern for some clients. In thinking about service improvement, it is worth reflecting on the three treatment characteristics that were most highly rated by participants. These included clinician skill or attributes (as discussed), the knowledge or insight gained during treatment or the progress made during treatment and the sense of a supportive environment. Enhancing or building upon these characteristics, which are largely grounded in positive inter-personal relationships and expert knowledge, is likely to improve the treatment outcome for clients, irrespective of service type. Focus group participants also identified a number of areas that may enhance service provision, including: greater service availability (especially for ethnic-specific services), greater provision to employ "hands on" treatment approaches (e.g. home visits), the provision of holistic multi-faceted treatment approaches (as discussed), and greater capacity to provide services in a range of non-English languages.

Assessments

The Stage One database analyses identified considerable inter-service variation in terms of baseline 'Total Dollars Lost' among their respective gambling clients (median $620; range zero to $1,000). However, there was less marked variation in baseline 'Control Over Gambling' scores (median 2.78; range 1.56 to 3.50) and baseline SOGS-3M scores (median 8.57; range 3.72 to 11.43), suggesting the level of problem severity was similar across clients of different services even if clients of some services were losing greater sums of money on average when compared to others. The follow-up scores on the same three measures typically indicated improvement, although there continued to be considerable inter-service variation with respect to Total Dollars Lost (with an increase in Total Dollars Lost indicated in four services). Having said this, the numbers of follow-up assessments were too small in most cases to allow meaningful comparisons to be drawn. Thus, based on the current data it is

difficult to state with any confidence whether clients of one service type typically experience greater improvement when compared to clients of another service type. Nevertheless, the database findings coupled with the outcome data reported by participants in the client survey (discussed in the previous section) suggest improvement is the norm across all services.

Drawing firm conclusions from the Stage One data pertaining to significant others is even more difficult. Few services obtained 'family coping' or 'family gambling frequency' scores at either baseline or follow-up and the data that were obtained typically pertained to a small number of clients. Baseline 'family checklist' scores were available for a greater number of services, but follow-up assessments in sufficient quantity were rare. Thus, although those data that were available were suggestive of relatively minimal inter-service variation and improvement over time, more data is needed from a greater number of services at both baseline and follow-up before firm conclusions can be drawn.

4.3 Facilitation Services

The database analyses provided limited information regarding client pathways out of gambling treatment services, since formal Facilitation Services had not been implemented at that stage. Those analyses also indicated a large range of treatment pathways within services. Furthermore, Facilitation Services were only in the initial stages of being implemented by many gambling treatment services at the time of the Stage Two surveys. These issues have meant that it is not possible, at this stage, to discuss specific pathways in relation to Facilitation Services. In addition, participant numbers from surveys were too small to allow discussion of differences between services or by gender or ethnicity; however, no major differences were apparent from the analyses.

In the staff survey, there was a substantial number of missing responses to questions on Facilitation Services. Again this was due to Facilitation Services being newly implemented and thus it was likely that many participants were unable to answer the questions on this topic because they had no knowledge in the area. Additionally, participants from one Mainstream service did not complete the questions relating to Facilitation Services because they have not been contracted to provide Facilitation Services due to the nature of the interventions they provide (workshop and structured group approach).

Allied agencies

The range of allied agencies reported by gambling treatment service staff was larger than the range of allied agencies completing the survey. A major reason was that staff from allied agencies did not realise that they had problem gamblers referred to their service (detailed later in this section).

Gambling treatment service staff reported facilitated referral of clients to: community drug, alcohol and mental health services, Work and Income New Zealand, Housing New Zealand, banks, lending institutions, lawyers, employment agencies, alternative therapies, and sports/arts/crafts coordinators. Survey responses were received from staff of allied agencies representing: health/counselling/social support services, budgeting services, taxation assistance services, careers information and guidance services, and legal advice and representation services.

Processes

Two thirds (67%) of staff survey respondents reported conducting facilitated referrals by telephone, just over one half (57%) by face-to-face contact and just over one quarter (27%) by other means (e.g. Email, mail, giving client the details). Multiple options were reported by participants implying that different methods of facilitated referral are utilised for different clients or allied agencies. These findings were broadly corroborated by responses to client and allied agency surveys.

Common barriers to Facilitation Services

Several barriers were identified to effective Facilitation Services. A current and pervasive barrier which was discussed in the focus groups related to issues with understanding and interpretation of the requirements to undertake Facilitation Services, and confusion with the required processes as a whole. There was also discussion around what was currently considered by the participants as being facilitation, but which is not considered as such under the new requirements. These particular issues should be alleviated as implementation of Facilitation Services becomes more routine and service staff become used to the requirements and processes. If this is the case, it should be evident from the Stage Three analyses to be conducted in 2009.

Sixty-three percent of staff survey respondents reported that although clients may have co-existing issues they may not want to be facilitated to another service for those issues. This same barrier was discussed within the focus groups and was also corroborated, to some extent, in the client survey where seven of 38 respondents reported either not wanting assistance, already being helped by someone else, or were yet to explore their issues in counselling. Six (of 38) client survey respondents also reported that the current (gambling) counsellor was dealing with their other issues. In the latter case, it would appear that in services providing a holistic approach, Facilitation Services would not be necessary since co-existing issues would be dealt with by the same counsellor.

Focus group participants discussed not wanting to "pass clients on" to other services for a variety of reasons including that the other service is not receptive, or that they do not want to let a client go to another agency because they feel the client is unreceptive to going to that agency or because it does not fit with their holistic approach. For services that try to provide a holistic approach (mainly ethnic-specific services) participants discussed that they would rather provide all aspects of treatment within their service, i.e. by passing clients to another organisation they felt they would lose their bond with, and respect of, their clients. These participants also discussed the time required to take clients to an allied agency, particularly in rural areas and that they may not feel inclined to facilitate clients to another agency unless there is a reciprocal arrangement with the allied agency for referrals back to the gambling treatment service. In some cases this already occurs, 12/17 allied agency survey respondents reported referring clients <u>to</u> gambling treatment services.

Focus group participants also discussed how they are not always able to tell an allied agency that the client is a problem gambler or that they are from a gambling treatment service. This is potentially a barrier to effective provision of Facilitation Services and outcomes for clients. This issue certainly had a major impact on allied agency survey participation with a significant number of agencies declining to take part because they did not consider that they had gambler clients referred to them by gambling treatment services.

Implications of Facilitation Services on services

One third (33%) of staff survey respondents reported that they had to put 'a lot' of time and effort into implementing Facilitation Services with regard to building new relationships with other agencies. Only about one-fifth of respondents found implementation easy (20%) or very easy (2%), although only nine percent reported the process to be difficult/very difficult.

Six of the 60 staff survey respondents reported that Facilitation Services could be improved if the amount of paperwork was reduced or the required processes could be more flexible. A few staff survey respondents reported that Facilitation Services would be improved if allied agencies could be educated about gambling issues, or the process of Facilitation Services could be clarified between the gambling treatment service and the allied agencies. Closer links with a range of allied agencies were also suggested by a number of staff in order to enhance Facilitation Services.

Impact of Facilitation Services on outcomes for co-existing issues

Fifty-five percent of staff survey respondents reported that Facilitation Services provided no different outcomes for clients than their previously used referral methods, with 15% reporting better/much better outcomes and three percent reporting worse outcomes. However, in relation to gambling issues, 48% reported that Facilitation Services improved client outcomes in terms of gambling issues. The most common reason suggested for the improved outcomes was the additional support provided for clients in their identified areas of need.

Clients' perceptions of the impact of Facilitation Services, however, was slightly more positive than the service staff perceptions with 14/15 clients reporting that their counsellor's assistance in helping them to access other agencies was helpful, and 75% reported that attending gambling treatment services had helped them to deal with other non-gambling related issues. Additionally, 13/18 allied agency survey respondents reported that clients have better outcomes when addressing gambling as well as coexisting issues.

Client access to allied agencies

Forty-two percent of staff survey respondents reported that clients probably perceived Facilitation Services as good (37%) or very good (5%) with only five percent reporting poor/very poor. Just under a quarter (23%) of respondents reported that Facilitation Services would likely have increased client access to allied agencies, and the same percentage reported that it would not have increased client access to the agencies.

Responses from 10 of the 18 allied agency staff indicated that clients generally attended the agency all, or more than half of the time, after being facilitated. However, comment cannot be made as to whether this is an improvement over previous referral methods since there are no baseline data by which to judge this.

Impacts of Facilitation Services

Just over half of the staff survey respondents reported that allied agencies had responded positively (47%) or very positively (8%) to them, whilst only three percent reported a negative experience. Similarly, 11 of 15 allied agency survey respondents rated the relationship between gambling treatment services and themselves as good/very good although

suggestions for improvement in the relationship were made such as increasing contact and/or giving more attention to relationship building activities.

Just over half of the staff survey respondents reported that Facilitation Services had a positive impact on their relationship with their clients (45% positive, 7% very positive), and no negative impacts were reported.

Half (9/18) of the allied agency survey participants reported that Facilitation Services benefitted clients by making the process easier for them, or by making it more effective. However, there were also some negative aspects reported by nine participants, including coerced or poorly informed referral, and clients who may be frustrated, embarrassed or otherwise not suited to the referral. Twelve of the 18 participants reported benefits to their agency including information sharing and networking, increased number of clients, opportunity for assisting people, and building good relationships with clients. Only four individual negative impacts relating to the agencies were reported. There were a few suggestions for improvement of Facilitation Services, which varied according to each participant.

4.4 Data collection, training and workforce development

In the survey of staff of gambling treatment services there were a substantial number of missing responses to questions around data collection, training and workforce development, likely due to some participants not having relevant knowledge in the question topic areas. There will be a number of reasons for this including the way individual services have approached the task of data collection and reporting (e.g. employment of specific people tasked to perform duties relating to CLIC data collection and reporting), and the current general confusion and lack of understanding around the required processes, which was discussed in depth at the focus groups. Focus group participants also raised particular concern about interpretation of the Interventions Service Practice Requirements Handbook and its apparent prescriptive requirements that were incongruous with client needs to achieve positive outcomes. Meeting targets and issues around the requirements for follow-up sessions were two other areas of significant concern raised in the focus group discussions. The concern was around services having to be more target than client-needs driven and that set timeframes for follow-up sessions were not always conducive to clients needs, again detrimentally affecting positive outcomes for clients.

Data collection and reporting

One-fifth (22%) of staff survey participants reported the Ministry of Health data collection and reporting requirements to be good/very good; however, a greater proportion (30%) reported the requirements to be poor/very poor. One quarter (25%) of the participants reported collecting the data purely for the Ministry (i.e. they do not build the gathered information into the therapeutic relationship with their clients); however, almost double the number of participants (47%) reported the opposite (i.e. they do use the gathered information in the therapeutic process); the spread of responses was across organisations. Only eight percent of staff survey participants reported that data collection solely has a positive influence on their relationship building with clients, with 22% reporting a negative influence and 37% reporting both a positive and negative influence.

CLIC system

One-quarter (25%) of staff survey participants reported that the CLIC data reporting system was good/very good, with 16% reporting poor/very poor. One-fifth (20%) of participants found the CLIC data entry system easy to use but another fifth (22%) found it complicated/ very complicated. A range of suggestions for improvements to the CLIC system were provided by participants; however, these were individual in nature and reflected idiosyncratic preferences.

Focus group participants discussed concern about the "continually changing" requirements and the "one size fits all" approach that does not necessarily suit individual services which have different methods for providing interventions. Additional concern was voiced around the way the requirements were open to different interpretations which impacted on the quality of the collected data. Focus group participants without computerised CLIC data collection systems discussed the usefulness of computerised systems that would incorporate checks to minimise data entry errors. From the focus group discussions it seemed apparent that feedback on CLIC performance was not always being fed back by managers to staff, in one case because this was deemed to be too confusing due to the changing requirements.

Training

In regard to training for interventions services, data collection and reporting systems, 27% of staff survey participants reported that overall the training was good/very good, whilst a slightly greater proportion (32%) reported poor/very poor. However, 55% of participants reported that the training was beneficial in terms of workforce development and their understanding of processes and requirements; 17% reported that the training was not beneficial. Given that the training to date has focused on use of the CLIC manual (and not on how to integrate results into clinical practice) and is only now moving to the Interventions Service Practice Requirements Handbook, the perceived benefits or otherwise of the training may reflect the stage of training and the needs and requirements of the individuals attending the sessions; for example some counsellors may not be involved in CLIC data entry and management and thus may not see that part of the training sessions as being of relevance. The lack of provision of follow-up training was a concern voiced by the training provider and this may reflect in the overall experience of service staff with regard to the training package received.

Half (52%) of staff survey participants reported that their service was supportive/very supportive in providing training, mentoring and monitoring for the CLIC data management system whilst 13% reported that their service was unsupportive in this regard. Focus group discussions broadly reflected the survey results with the provided training viewed positively although lacking in length and detail. This may not be through any fault of the training provider but may relate to the structured nature of the training sessions including the fixed number and location of sessions allowed within a calendar year. Focus group participants also discussed the importance of training for workforce development and to keep people within the sector.

A range of suggestions for improvements to the provided training were made by staff survey participants. The most common of these related to a need for more and/or more timely training and the need for more clinical or cultural input in the training/data reporting process. These concerns have also been noted by the training provider staff who feel constrained by the imposed training structure and requirements. These suggestions were reflected in the focus group discussions. Other suggestions reflected individual preferences.

4.5 Conclusion

The project findings indicate that whilst there are 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 are no major findings which would indicate that one type of service or intervention provision is significantly superior to another in relation to client outcomes. However, this conclusion must be viewed with caution given that this project has evaluated the services in a broad way and has not been an in-depth evaluation of each service individually. Additionally, some services are substantially different from others in terms of organisational size, regional location, type of intervention provided and length of operation under Ministry funding. This has meant that not all results are directly comparable and again raises the need for caution when reviewing the findings. Furthermore, analyses have been conducted whilst services are in different stages of implementing Ministry intervention and data collection/management requirements which again has meant that results are not directly comparable. This latter anomaly should be removed during the Stage Three analyses in 2009, when all services should be fully operational and au fait with Ministry requirements.

Pathways to gambling treatment services

Different services attracted different client populations based generally on the ethnic specificity of the service (where appropriate), the geographic location of the service, or the type of intervention approach provided. Of note is that some Maori services particularly seemed to attract clients in younger age groups (39 years or less) or more significant others, than other services. Whilst there are many pathways into services, self-referral, helpline referral and informal referral via family or friends appeared to be the most common routes. There was insufficient information to definitely identify whether there was a relationship between a client's pathway into a treatment service and subsequent outcome; and, in general, numbers of responses from the staff survey were too small for any major conclusions to be made.

Distinct interventions

From the database analyses, Maori and Mainstream services appear to differ in terms of the most common type of treatment provided (brief versus full interventions, respectively), though all offer the full range of interventions. Services were generally consistent in their view of a need for a holistic approach to treatment provision (i.e. being able to deal with all a client's presenting issues by one service), and that the current requirements for brief, full, and follow-up sessions and Facilitation Services is not conducive to this approach. There was relatively little inter-service variation in terms of how treatment episodes end, client experience of those episodes, and client improvement at the end of treatment.

Facilitation Services

Clients of gambling treatment services have had facilitated referrals to a large range of allied agencies, not only for co-existing mental health or substance use issues but also relating to financial matters and alternative activities (to gambling). Since formal Facilitation Services are only just being implemented by services, there appeared to be significant confusion around the process (this should be alleviated by the time of the Stage Three analyses). Several barriers to the process were identified ranging from clients not wishing to be facilitated o another agency, to counsellors not wanting to facilitate clients away from their service, through to the attitude of the allied agencies. However, clients' perception of facilitated referrals was good in relation to positive outcomes for the co-existing issues.

Positive relationships between gambling treatment services and allied agencies appeared to exist though there were suggestions for improvement from both types of service.

Data collection, training and workforce development

There appeared to be confusion around the required processes, possibly as they are relatively new and there were some major concerns around the prescriptive nature of the requirements and the cumbersome nature of the manuals and handbook making interpretation and comprehension less easy. The training programme as it stands appears not to fully meet the needs of service staff or the training provider due to its structured format and approach, though more than half the service staff participants reported the training to be beneficial.

5. LIMITATIONS OF THIS STUDY

Stage One

Database analyses were constrained by the availability (including sample size) and quality of the data. Low sample size was a particular issue in terms of analyses by ethnicity for Pacific and Asian clients of services and precluded further ethnic sub-analyses within those population groups. However, this did not prevent broad level differences from being identified.

Results of analyses are dependent on the accuracy of the coding and data entry into the databases, which cannot be verified by the researchers. Thus, data have been taken at face value; however, major and obvious inconsistencies were investigated.

In the main it has not been possible to track clients who attended more than one service since unique client identifiers are generally not transferred with a client from one service to another (there are a few exceptions to this). It also appeared that client assessments were not directly liked to treatment episodes/programmes within the CLIC database which precluded the linking of changes in assessment scores to a specific treatment episode/programme. Within the time frame of the 2007/2008 year where the new recommended guidelines (from 1 July 2008) were not yet in place, and also recognising that treatment programmes need to be tailored to the individual, there was a lot of variability in the treatment pathway, which made it difficult to identify whether clients were following a 'continuous' treatment programme or were sporadically receiving partial treatments, as needed.

Age, sex and ethnicity were not reported by some services for many of their clients; however, as would be expected, the majority of this occurred for telephone-based services where it is often not easy to collect demographic information from clients.

In terms of the distinct interventions identified as part of this evaluation, Marae Noho for one organisation, and some of the workshops for another were not specifically identified within the CLIC database. Although this information was obtained directly from the relevant services for this current project, this is a limitation within the database itself. Similarly, face-to-face counselling data from the Asian services division of one of the national Mainstream services is indistinguishable within the CLIC database from other data for the parent organisation. This precluded specific analysis of characteristics of clients attending the Asian service, and again is a major database limitation. Finally, telephone hotline data for the Asian service was captured in a further separate database.

Stage Two

Approximately half of the gambling treatment providers funded by the Ministry of Heath participated in Stage Two of this evaluation (selected by the research team). Whilst those that participated represented Mainstream, Maori, Pacific and Asian services as well as national and regional, and urban and rurally based services, there may be some services which provide specific intervention approaches that have not been addressed as part of this evaluation. However, since the Stage One analyses reviewed data from all funded services during a 12-month period, and as variations from general trends were identified from those analyses, it is considered that any intervention approaches not covered in Stage Two of the evaluation will not be too dissimilar from those of services that have participated.

Although the recruitment methodology was designed to minimise survey non-completion, and whilst every attempt was made to include all relevant staff from gambling treatment services and a representative from each major allied agency in the surveys, given the short time constraint of this project, some surveys were not completed. This was due to staff absences or workloads at the time of the surveys, and some services did not participate in all parts of Stage Two, though each service participated in at least one part (survey, focus group, or client recruitment). Gambling treatment services were involved in substantial consultation meetings prior to study commencement, where time frames were detailed and agreed, and allied agency staff were contacted prior to survey mail out (where possible) to pre-warn them of the survey and to establish their willingness to participate. These measures ensured that survey responses are likely to provide representative views. For Stage Three, where the time constraints will be less tight, it is envisaged that staff participation will be greater (capturing part-time staff, and those who may be away from the office or with high workloads, during shorter periods of data collection such as during Stage Two).

Recruitment of participants for client surveys was by convenience sampling from each participating gambling treatment service, where possible. A maximum of five clients was recruited per service, where possible (15 for national services; five from clinics in each of three major cities), thus the survey results will not necessarily be representative of all clients accessing each of those services. However, they are likely to give a broad indication of overall issues of interest. In isolation this would have limited the ability to draw firm conclusions in relation to any one particular treatment service. To offset this limitation, the multi-pronged approach to obtaining information about the different gambling treatment services (staff and client surveys, focus groups, and database analyses) has enabled some identification of service-specific findings. Again, in Stage Three, it is envisaged that there will be greater client recruitment than in Stage Two due to the longer time frame that will be available for researchers to contact clients (in Stage Two, some clients were 'lost' since they were not contactable within the time frame of the data collection period of the project).

Focus group data, group interview data and open-ended responses from the surveys were coded prior to analysis. This involved subjective judgement by the researchers. However, the judgement bias was minimised as at least two members of the research team were involved in the coding process including a Maori researcher (as half of the participating gambling treatment services were Maori).

6. REFERENCES

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APPENDIX 1
Stage Two ethics approval

M E M O R A N D U M
Auckland University of Technology Ethics Committee (AUTEC)

To:	Maria Bellringer
From:	**Madeline Banda** Executive Secretary, AUTEC
Date:	24 October 2008
Subject:	Ethics Application Number 08/223 **Evaluation of problem gambling intervention services.**

Dear Maria

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 13 October 2008 and that I have approved your ethics application in stages. This delegated approval is made in accordance with section 5.3.2.3 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 10 November 2008.

Your ethics application is approved for a period of three years until 24 October 2011.

This approval is only for the focus groups, interviews, and surveys associated with the first stage of the research. Full information about the later stages needs to be submitted to AUTEC and approved before those stages may commence.

I advise that 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/about/ethics*. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 24 October 2011;
- A brief report on the status of the project using form EA3, which is available online through *http://www.aut.ac.nz/about/ethics*. This report is to be submitted either when the approval expires on 24 October 2011 or on completion of the project, whichever comes sooner;

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 reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at charles.grinter@aut.ac.nz or by telephone on 921 9999 at extension 8860.

On behalf of the AUTEC and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Madeline Banda
Executive Secretary
Auckland University of Technology Ethics Committee

APPENDIX 2
Gambling treatment service survey

Evaluation of problem gambling intervention services

I have read the Participant Information Sheet dated 22 October 2008 that accompanies this survey.		
I consent to taking part in this research project	**Yes I do**	□
	No I do not	□

First, some general questions about yourself and your organisation

1. Gender: □ Male □ Female

2. Ethnicity *(tick all that apply):*

   □ European New Zealand
   □ Maori
   □ Pacific Island (please further specify) _____
   □ Asian (please further specify) _____
   □ Other (please specify) _____

3. Your organisation type *(tick all boxes that apply):*

   □ Mainstream
   □ Ethnic specific
      □ Maori
      □ Pacific Island
      □ Asian
   □ Telephone

4. Does your organisation use any special approach/s other than those the Ministry of Health requires?

   □ Yes □ No □ Don't know

   a. If yes, please indicate *(tick all boxes that apply)*

      □ Marae Noho
      Please give brief detail_____

      □ Workshop
      Please give brief detail_____

      □ Group work
      Please give brief detail_____

      □ Other
      Please specify _____

   b. If your organisation uses a special approach, how do you assess a positive outcome in your clients from participation in the special approach/ programme?

      _____

5. Your role in the organisation *(tick all boxes that apply):*

   □ Counsellor

   - % of time? _____

□ Health promoter

- % of time? _____

□ Manager

- % of time? _____

□ Administrator

- % of time? _____

□ Other, please state _____

-% of time? _____

6. Do you work in the organisation

□ Full time

□ Part time

□ Specific number of days per week (state number of days) _____

□ Other, please specify_____

7. Are there any key characteristics that make your organisation stand out from others.

□ Yes □ No □ Don't know

What are these? *(Tick all boxes that apply*)

□ Ethnic specific counsellors

□ Specific modes of counselling (specify) _____

□ Treatment approach framework

i. Please explain _____

□ Location of service

□ Other

i. Please specify _____

8. What services does your organisation provide? *(Tick all boxes that apply)*

□ Problem gambling treatment

□ Brief intervention

□ Full intervention

□ Health promotion/prevention

□ Treatment for other issues

□ Alcohol

□ Drugs

□ Mental health

□ Budgeting

□ Social issues (e.g. food banks, family violence, relationship issues)

□ Other

Please specify _____

□ Other

Please specify _____

Now, some questions about the clients your organisation sees.

9. Does your organisation try to attract the following particular categories of clients? *(Tick all boxes that apply)*

   □ Gender

   (please specify) _____

   □ Ethnicity

   (please specify) _____

   □ Socio-economic level

   (please specify) _____

   □ Geographic location (town/city)

   (please specify) _____

   □ Rural

   □ Urban

   □ Mode of gambling

   (please specify) _____

10. Are the types of clients you detailed above actually the clients that come to your gambling treatment service?

    □ Yes □ No □ Don't know

    Please explain _____

11. How do clients generally come to your service (pathway)? *(e.g. referred by Helpline, through word of mouth, through advertisements etc)* _____

12. Do you think different pathways deliver people to your gambling treatment service at different stages along the gambling continuum?

    □ Yes □ No □ Don't know

    If yes, please explain _____

13. Do you think different pathways into your service impact on clients' outcomes for their problem gambling?

    □ Yes □ No □ Don't know

    a. If yes, please explain _____

14. Is the type of intervention you provide to clients different based on their pathway into your service?

    □ Yes □ No □ Don't know

    a. If yes, please explain how _____

15. Are there any types of gambling-related clients that your service is unable to provide interventions for?

    □ Yes □ No □ Don't know

    a. If yes, please explain _____

The next section contains questions about the Ministry of Health requirements for provision of intervention services and data collection, management and monitoring.

16. Overall, how do you find the Ministry of Health standard requirements for providing intervention services?

    □ Very good □ Good □ Average □ Poor □ Very poor

17. Overall, is the brief intervention, as required by the Ministry of Health, a good approach for assessing whether someone has a problem related to gambling and may be in need of further assistance?

    □ Yes □ No □ Don't know

    a. Are there any aspects that could be improved? _____

18. Overall, is the full intervention, as required by the Ministry of Health, a good approach for assisting someone with problems related to their or someone else's gambling?

    □ Yes □ No □ Don't know

    a. Are there any aspects that could be improved? _____

19. Do brief interventions naturally progress to full interventions?

    □ Yes □ No □ Don't know

    a. If yes, please explain how _____

20. How easy is it for you to meet Ministry of Health contractual requirements in relation to numbers of brief and full interventions each month?

    □ Very easy □ Easy □ Average □ Hard □ Very hard

21. Could the contractual targets be improved?

    □ Yes □ No □ Don't know

    a. If yes, please explain how _____

22. Overall, how do you find the Ministry of Health data collection and reporting requirements?

    □ Very good □ Good □ Average □ Poor □ Very poor

23. Overall, how have you found the CLIC data reporting system?

    □ Very good □ Good □ Average □ Poor □ Very poor

24. Overall, how has the use of the CLIC data entry system been?

    □ Very complicated □ Complicated □ Ok □ Easy □ Very Easy

25. Could any improvements be made to the system? *(please detail)* _____

26. Overall, how did you find the training for the intervention services, data collection and reporting systems?

    □ Very good □ Good □ Average □ Poor □ Very poor

    a. How could the training be improved? _____

27. Overall, do you think the training is beneficial, for example in terms of workforce development and your understanding of Ministry of Health processes and requirements?

    □ Yes □ No □ Don't know

28. Do you collect the data purely for Ministry of Health (contractual requirements)?

    □ Yes □ No □ Don't know

29. Does the collection of data have a positive or negative influence on the relationship building process with your clients?

    □ Positive
    □ Negative
    □ Both
    □ Don't know
    If positive, how does it influence the relationship _____
    If negative, please explain why _____

30. How does having the data assist in the provision of an effective therapeutic relationship with clients? _____

31. Overall, how supportive is your organisation in providing training/education, mentoring and monitoring of the CLIC data management system?

    □ Very supportive □ Supportive □ Average □ Not supportive □ Completely not supportive

Finally, some questions around the Ministry of Health's "Facilitation Services" where you provide assisted (facilitated) referral of clients to other services for co-existing issues.

32. What methods were in place prior to the new roll out of Facilitation Services, to enable detection and assistance with co-existing problems? (i.e. before 1 July 2008, Facilitation Services as per Chapter 7 Intervention Service Practice Requirements Handbook)

33. What types of services/agencies do you currently facilitate clients to? _____

34. Before the Ministry of Health brought in their requirements for Facilitation Services, did you facilitate clients to other organisations for co-existing issues?

    □ Yes □ No □ Don't know

    a. If yes, please explain how _____

    b. If yes, was this facilitation similar to the current requirements for facilitation services or was it a referral only?

        □ Facilitation □ Referral □ Both □ Don't know

35. How much time and effort have you had to put into implementing the new Facilitation Services in terms of building relationships with other agencies?

□ Not much □ A little □ A lot

36. How much time and effort have you had to put into implementing the new Facilitation Services in terms of developing an understanding between your organisation and the other agencies?

□ Not much □ A little □ A lot

37. What are the outcomes for clients who have had facilitated referral to other services compared to the methods your organisation previously used (before the introduction of Facilitation Services)?

□ Much better □ Better □ The same □ Worse □ Much worse

38. Why are some clients not facilitated to other services? *(tick all boxes that apply)*

□ Client doesn't have other issues
□ Client has co-existing issues but doesn't want facilitation
□ Gave the client information and referral rather than a full facilitation
□ Other
please state _____

39. Overall, how have you found implementing the Facilitation Services?

□ Very easy □ Easy □ Average □ Difficult □. Very difficult

40. How do you normally facilitate a client to another service? (*Tick all boxes that apply)*

□ By telephone
□ In person
□ Other
Please explain _____

41. Do you think the Facilitation Services could be better implemented?

□ Yes □ No

a. if yes, please explain _____

42. What improvements could be made to the Facilitation Services process?

_____

43. In your opinion, how have clients generally found the Facilitation Services?

□ Very good □ Good □ Average □ Poor □ Very poor

44. In your opinion, have the Facilitation Services increased client access/utilisation of these other services?

□ Yes □ No □ Don't know

45. In your opinion, how have the other services responded to your facilitation of a client to them?

□ Very positively □ Positively □ Average □ Negatively □ Very Negatively

46. Do other services usually know that you are facilitating a client to them?

□ Yes □ No □ Don't know

If no, please explain why they do not know *(eg. Facilitated client to dance lessons as an alternative to gambling)*_____

47. In general, how does facilitation impact on your relationships with your clients?

□ Very positively □ Positively □ Average □ Negatively □ Very Negatively

48. In your opinion do you feel Facilitation Services improve your client's outcomes in terms of their gambling issues?

□ Yes □ No □ Don't know

a. If yes, how does it improve their outcomes? _____

b. If no, why do you think this? _____

49. What other kinds of linkages and relationships do you feel would enhance facilitation?

Please state _____

Thank-you for your time in completing this questionnaire.
All responses will be anonymous and treated confidentially.

APPENDIX 3
Client survey

Evaluation of problem gambling intervention services

If a telephone survey: ***Read the Participant Information Sheet dated 22 October 2008 relating to this survey (offer to send to them, will require a postal address to be given).***

I consent to taking part in this research project **Yes I do** □
No I do not □

Firstly, we would like to ask you some questions about yourself.

1. Gender: □ Male □ Female

2. Age: □ <20 □ 20-24 □ 25-29 □ 30-34 □ 35-39 □ 40-44
□ 45-49 □ 50-54 □ 55-59 □ 60-64 □ 65+

3. Ethnicity (*tick all boxes that apply*):
□ New Zealand European
□ Maori
□ Pacific Island (please further specify) _____
□ Asian (please further specify) _____
□ Other
Please specify _____

4. Which of these groups best describes your total annual household income from all income earners and all other sources before tax?
□ Up to $10,0000
□ Between $10,001 and $20,000
□ Between $20,001 and $30,000
□ Between $30,001 and $40,000
□ Between $40,001 and $50,000
□ Between $50,001 and $60,000
□ Between $60,001 and $70,000
□ Between $70,001 and $80,000
□ Between $80,001 and $100,000
□ Over $100,000

5. Geographic location

   What town or city do you live in or close to? _____

   Do you live in an…

   □ Urban area

   □ Rural area

6. Which of these groups describes the last level you completed in formal education? *(Tick all boxes that apply)*

   □ No qualification
   □ School Certificate
   □ U.E./Matric/6th Form/Bursary
   □ Technical or Trade Qualification
   □ University Graduate
   □ Other Tertiary Qualification

We would now like to ask you questions about gambling treatment services.

7. Which gambling treatment service are you now or have you recently been going to:

   □ Nga Manga Puriri
   □ Ngati Porou Hauora
   □ Te Rangihaeata Oranga
   □ Te Kahui Hauora Trust
   □ Mana Social Services trust
   □ Te Hunga Manaaki O Te Puke
   □ Tuwharetoa ki Kawerau
   □ Tuwharetoa Social Services
   □ Tupu Alcohol and Drug/Gambling Pacific Services
   □ Pacific Peoples Addictions Service Inc. (PPASI)
   □ Asian Service at Problem Gambling Foundation
   □ Gambling Helpline
   □ Problem Gambling Foundation of New Zealand
   □ Salvation Army Oasis Centres
   □ Woodlands Charitable Trust Inc.
   □ Other (*Please specify which one*) _____

   a. In what location did you access this service (town/city/suburb)?

      _____

8. How did you find out about the gambling treatment service you are currently/ recently attending? *(Tick all boxes that apply)*

   □ Telephone book
   □ Yellow pages
   □ Advertisements
      What and where? _____
   □ Referred by the Helpline
   □ Referred by another agency
      Please specify which agency_____
   □ Referred by friends/family
   □ Referred by gambling venue
   □ Referred/sent by justice system
   □ Other
      Please specify _____

9. When you chose the service to attend, did you know about other gambling treatment services too?

□ Yes □ No □ Not sure

10. Are there any characteristics about the service you are attending/recently attended that helped you choose to go there? *(Tick all boxes that apply)*

□ The treatment/help given
□ The availability of gender specific counsellors
□ The availability of ethnic specific counsellors
    □ Maori counsellors
    □ Pacific Island counsellors
    □ Asian counsellors
    □ Other
□ It was the only one I knew about
□ It is the only one in my location
□ The location of the service
□ The service was recommended to me
□ Friends/family encouraged me to go to this service
□ I tried another service that didn't provide what I wanted
□ I was sent/recommended by the justice system (i.e. family court, probation, court order etc) to this service
□ There was nothing specific
□ Other reason
    Please specify _____

11. Would you have gone to a different gambling treatment service if there were other options available?

□ Yes □ No □ Not sure

a. Please explain the reasons why _____

12. Have you recently attended any other gambling treatment services?

□ Yes □ No □ Not sure

If yes please state which one _____

13. Are you currently going to a gambling treatment service for gambling issues?

□ Yes □ No

a. If no, when did you last attend the service for gambling issues?

_____

b. Are you currently/did you recently attend the service for a specific programme?

□ Yes □ No □ Don't know

If yes, was it for
    □ Marae Noho
    □ Workshop
    □ Group
    □ Other (please specify) _____

14. In your current/most recent visits to the gambling treatment service, how many times have you seen a counsellor/s?

1 2 3 4 5 6 7 8
Other_____

If only once, for how long did you see the counsellor (time)?
_____

15. Are you still seeing a counsellor at the service for gambling issues?

□ Yes □ No

a. If no, how did the sessions end

□ I ended it/stopped going
□ Joint choice between myself and the counsellor to end them
□ I was referred to a different gambling treatment service
□ Other
Please specify _____

16. What were your <u>first impressions</u> of the gambling treatment service you are currently/recently attended?

a. On the information provided at the service:
□ Very poor □ Poor □ Average □ Good □ Very Good
b. On the premises:
□ Very poor □ Poor □ Average □ Good □ Very Good
c. On the reception/first contact with service:
□ Very poor □ Poor □ Average □ Good □ Very Good
d. On the counsellors:
□ Very poor □ Poor □ Average □ Good □ Very Good
e. On the treatment/help received:
□ Very poor □ Poor □ Average □ Good □ Very Good

17. What are your impressions about the gambling treatment service <u>now</u>?

a. On the information about the service:
□ Very poor □ Poor □ Average □ Good □ Very Good
b. On the premises:
□ Very poor □ Poor □ Average □ Good □ Very Good
c. On the reception/first contact with service:
□ Very poor □ Poor □ Average □ Good □ Very Good
d. On the counsellors:
□ Very poor □ Poor □ Average □ Good □ Very Good
e. On the treatment/help received:
□ Very poor □ Poor □ Average □ Good □ Very Good

18. If your impressions of the gambling treatment service changed from first impressions to now, please state how

a. On the information at the service: _____
b. On the premises: _____
c. On the reception/first contact with service: _____
d. On the counsellors: _____
e. On the treatment/help received: _____

19. What is/was your main type of gambling? *(Tick one option only)*

 Lotto (including Strike, Powerball and Big Wednesday)
 Keno (not in a casino)
 Instant Kiwi or other scratch ticket Housie (bingo) for money
 Other lotteries and raffles
 Horse or dog racing (excluding office sweepstakes)
 Sports betting at the TAB or with an overseas betting organisation
 Gaming machines or pokies at a casino
 Table games or any other games at a casino
 Gaming machines or pokies in a pub (not in a casino)
 Gaming machines or pokies in a club (not in a casino)
 Internet-based gambling
 Other gambling activity. *Please specify:* _____

20. When you first started attending the gambling treatment service do you think your gambling is/was…

 A big problem Moderate problem Slight problem Not a problem
Or,
 The problem was with someone else close to me (i.e, not my problem)

21. Has attending the gambling treatment service helped you with your gambling issues?

 Yes No Not sure

a. If yes or no, was it because (*please tick all that apply*):

 I had stopped gambling before attending the service

 I have now stopped gambling

 My gambling has reduced

 My gambling is the same

 My gambling has increased

 I'm more in control of my gambling

 I'm less in control of my gambling

 My control over my gambling has stayed the same

 I'm more in control of my money

 I'm less in control of my money

 My control over my money is the same as before

 Other, please specify _____

22. Are you receiving support or treatment with regard to your gambling from anywhere else as well as this gambling treatment service?

 Yes No

If Yes, please specify

 Other gambling treatment services

Please state which one/s _____

 Family or friends

 Other

Please specify _____

23. What issues are/were you receiving assistance with at the gambling treatment service?

    □ Harm reduction with regard to gambling

    □ Dealing with gambling problems/issues

    □ Facilitation or referral to other agencies for assistance

    □ Other issues

    Please specify _____

24. Has attending the gambling treatment service helped you deal with other non-gambling issues/problems you may also have?

    □ Yes □ No □ Not sure

    a. If yes, what are these issues?

    _____

25. Has/did your gambling treatment service counsellor helped you to access any other agency/organisation to deal with other issues?

    □ Yes □ No □ Not sure

    If no, was this because you…

    □ Didn't have any other issue/s

    □ Didn't want assistance with any other issue/s

    □ The same counsellor/service dealt with all your issues

    □ Other

    Please specify _____

    a. Is there any other assistance that the gambling treatment service could have provided to help you?

    □ Yes □ No

    If yes, please specify _____

    b. If you have/had other issues, as well as gambling, please specify what these are/were

    _____

    c. If the gambling treatment services helped you to access another agency, how did the assistance take place?

    □ Counsellor set up telephone conversation between me and other agency/organisation
    □ Counsellor visited other agency/organisation with me
    □ Other

    Please specify _____

    d. Was the counsellor's assistance in accessing the other agency/organisation helpful to you?

    □ Yes □ No □ Not sure

    1. If yes, how was it helpful? _____

    e. How could the assistance been improved? _____

f. Did you know that these other agencies/organisations were available for these issues **before** your counsellor assisted you?

□ Yes □ No □ Don't know

g. How has assistance to other agencies/organisations by your gambling counsellor affected your relationship with your counsellor?

□ Improved the relationship □ The relationship stayed the same
□ Made the relationship worse

h. Overall, how has assistance to other agencies/organisations helped you to deal with your gambling and other issues? *(Tick one box only)*

□ Helped only with gambling issues
□ Helped only with other issues
□ Helped with gambling and some other issues
□ Helped with everything
□ Other
Please specify _____

26. Is there any other assistance you feel would have helped you to deal with your gambling and other issues?

□ Yes □ No □ Don't know

a. If yes, please specify what would have helped _____

27. Overall, how satisfied are you with your experience with the gambling treatment service you are attending/recently attended?

□ Very satisfied □ Satisfied □ Unsatisfied □ Very unsatisfied

a. Please describe what is particularly satisfactory or unsatisfactory
_____

28. What did the gambling treatment service do that is/was especially helpful to you?

Please state _____

29. What was not helpful to you?

Please state _____

30. In relation to the gambling treatment service, do you feel there are any areas for improvement?

a. In the treatment/counselling approach
□ Yes □ No □ Don't know
Please explain _____

b. In the information provided about the service
□ Yes □ No □ Don't know
Please explain _____

c. In the information provided at the service
□ Yes □ No □ Don't know
Please explain _____

d. In the location of the service
□ Yes □ No □ Don't know
Please explain _____

e. In the reception/first contact with service
□ Yes □ No □ Don't know
Please explain _____

f. Anything else
□ Yes □ No please explain _____

Thank-you for your time in completing this questionnaire.
All responses will be anonymous

APPENDIX 4
Allied agency survey

Evaluation of problem gambling intervention services

You have been contacted because problem gamblers have been referred to your organisation by a problem gambling treatment service using a process called facilitation. The gamblers have co-existing issues and their counsellor will have personally contacted your organisation to discuss referral of the client.

If you are aware of this, you have read the Participant Information Sheet dated 22 October 2008 that accompanies this survey and you consent to take part in this research (please tick)

I agree to take part in this research ☐

If you are not aware of this, can you please pass this survey to someone who is aware of it.

We would like to start by asking you a few questions about your agency/organisation

1. Are you aware that gambling treatment service clients are referred to your organisation for co-existing issues through a facilitated referral process?

   ☐ Yes ☐ No

2. What type of service does your agency/organisation provide?

   _____

3. What is your role within the agency/organisation?

   _____

4. How does the gambling treatment service usually liaise with your organisation regarding the referred client?

   ☐ By telephone

   ☐ Face to face

   ☐ Other method

   Please specify _____

5. What are the benefits of this facilitated referral approach of gambling clients to your agency/organisation?

   a. For the clients? _____

   b. For your agency/organisation? _____

6. What are the negative aspects of this facilitated referral approach of gambling clients to your agency/organisation?

   a. For the clients? _____

   b. For your agency/organisation? _____

We would now like to ask some questions about the clients

7. After the gambling treatment service has facilitated referral of a client to your service, do clients actually attend your service?

   □ All the time □ More than half of the time □ Less than half of the time
   □ Less than quarter of the time

8. In what ways could the facilitation referral process of clients to your agency/ organisation be improved?_____

9. Have you facilitated referral of clients to gambling treatment services?

   □ Yes □ No □ Don't know

10. If yes to Q10, how do you do this?

    □ By telephone
    □ Face-to-face
    □ In writing
    □ Other method
    Please specify _____

11. Do you think clients have more positive outcomes if they are receiving interventions for their gambling issues as well as their other co-existing issues?

    □ Yes □ No □ Don't know
    Why do you think this is? _____

12. What sort of a relationship exists between your organisation and gambling treatment agencies who facilitate referral of gamblers to your organisation?

    □ Very good □ Good □ Average □ Poor □ Very poor

    How could this relationship be improved?
    _____

Thank-you for you time to complete this questionnaire.
All responses will be anonymous and kept confidential.

APPENDIX 5
Stage One database analysis tables

Table 1 - Number and type of clients

Service		No. clients	Client type			
			Gambler		Significant other	
		N	n	(%)	n	(%)
Mainstream	A1	1946	1494	(77)	452	(23)
	A2	944	740	(78)	206	(22)
	A3	2330	1589	(68)	741	(32)
	A4	254	216	(85)	38	(15)
	A5	47	42	(89)	5	(11)
Maori	B01	355	239	(67)	119	(34)
	B02	403	72	(18)	344	(85)
	B03	61	35	(57)	26	(43)
	B04	72	70	(97)	2	(3)
	B05	64	59	(92)	7	(11)
	B06	87	58	(67)	37	(43)
	B07	125	18	(14)	107	(86)
	C01	577	195	(34)	383	(66)
	C02	206	176	(85)	31	(15)
	C03	98	67	(68)	31	(32)
	C04	306	95	(31)	214	(70)
	C05	28	26	(93)	2	(7)
	C06	44	27	(61)	17	(39)
	C07	65	61	(94)	4	(6)
	C08	32	20	(63)	12	(38)
	C09	12	12	(100)	-	
	C10	8	8	(100)	-	
Pacific	D1	120	98	(82)	24	(20)
	D2	92	63	(68)	30	(33)
Asian	E1	846	653	(77)	193	(23)
A and D	F1	58	58	(100)	-	
Total		*9177*	*6188*	*(67)*	*3025*	*(33)*

Table 2 - Gambler clients by gender

Service		No. clients	Gender				
			Not reported	Male		Female	
		N	n	n	(%)	n	(%)
Mainstream	A1	1494	9	894	(60)	591	(40)
	A2	740	-	402	(54)	338	(46)
	A3	1589	25	813	(52)	750	(48)
	A4	216	-	93	(43)	123	(57)
	A5	42	-	21	(50)	21	(50)
Maori	B01	239	-	110	(46)	129	(54)
	B02	72	-	24	(33)	48	(67)
	B03	35	-	12	(34)	23	(66)
	B04	70	-	24	(34)	46	(66)
	B05	59	-	16	(27)	43	(73)
	B06	58	-	29	(50)	29	(50)
	B07	18	-	6	(33)	12	(67)
	C01	195	-	93	(48)	102	(52)
	C02	176	-	76	(43)	100	(57)
	C03	67	-	39	(58)	28	(42)
	C04	95	-	34	(36)	61	(64)
	C05	26	-	13	(50)	13	(50)
	C06	27	-	9	(33)	18	(67)
	C07	61	-	40	(66)	21	(34)
	C08	20	-	11	(55)	9	(45)
	C09	12	-	5	(42)	7	(58)
	C10	8	-	5	(63)	3	(38)
Pacific	D1	98	-	67	(68)	31	(32)
	D2	63	-	37	(59)	26	(41)
Asian	E1	653	-	461	(71)	192	(29)
A and D	F1	58	-	39	(67)	19	(33)
Total		*6188*	*34*	*3371*	*(55)*	*2782*	*(45)*

Table 3 - Significant other clients by gender

Service		No. clients	Gender				
			Not reported	Male		Female	
		N	n	n	(%	n	(%)
Mainstream	A1	452	11	121	(27)	320	(73)
	A2	206	-	57	(28)	149	(72)
	A3	741	5	203	(28)	533	(72)
	A4	38	-	10	(26)	28	(74)
	A5	5	-	-		5	(100)
Maori	B01	119	-	32	(27)	87	(73)
	B02	344	-	113	(33)	231	(67)
	B03	26	-	2	(8)	24	(92)
	B04	2	-	-		2	(100)
	B05	7	-	1	(14)	6	(86)
	B06	37	-	13	(35)	24	(65)
	B07	107	-	50	(47)	57	(53)
	C01	383	-	194	(51)	189	(49)
	C02	31	-	9	(29)	22	(71)
	C03	31	-	11	(35)	20	(65)
	C04	214	-	72	(34)	142	(66)
	C05	2	-	2	(100)	-	
	C06	17	-	4	(24)	13	(76)
	C07	4	-	1	(25)	3	(75)
	C08	12	-	1	(8)	11	(92)
	C09	-					
	C10	-					
Pacific	D1	24	-	19	(79)	5	(21)
	D2	30	-	9	(30)	21	(70)
Asian	E1	193		41	(21)	152	(79)
A and D	F1	-					
Total		*3025*	*16*	*965*	*(32)*	*2044*	*(68)*

Table 4 - Gambler clients by ethnicity

Service	No. clients	Not reported	Ethnicity									
			Maori		Pacific		Asian		Other		European	
	N	n	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Mainstream												
A1	1494	131	303	(22)	68	(5)	243	(18)	59	(4)	690	(51)
A2	740	11	186	(26)	55	(8)	30	(4)	56	(8)	402	(55)
A3	1589	535	307	(29)	134	(13)	79	(7)	43	(4)	491	(47)
A4	216	6	27	(13)	8	(4)	12	(6)	10	(5)	153	(73)
A5	42	-	14	(33)	3	(7)	-		5	(12)	20	(48)
Maori												
B01	239	-	138	(58)	3	(1)	-		-		98	(41)
B02	72	3	57	(83)	-		-		2	(3)	10	(14)
B03	35	1	29	(85)	1	(3)	1	(3)	-		3	(9)
B04	70	-	55	(79)	4	(6)	-		2	(3)	9	(13)
B05	59	-	59	(100)	-		-		-		-	
B06	58	-	51	(88)	-		-		5	(9)	2	(3)
B07	18	-	13	(72)	1	(6)	-		-		4	(22)
C01	195	2	142	(74)	5	(3)	3	(2)	3	(2)	40	(21)
C02	176	3	113	(65)	39	(23)	-		6	(3)	15	(9)
C03	67	-	20	(30)	2	(3)	-		5	(7)	40	(60)
C04	95	-	90	(95)	2	(2)	-		-		3	(3)
C05	26	-	12	(46)	-		1	(4)	1	(4)	12	(46)
C06	27	3	14	(58)	1	(4)	-		-		9	(38)
C07	61	-	42	(69)	6	(10)	-		1	(2)	12	(20)
C08	20	-	4	(20)	-		-		-		16	(80)
C09	12	-	6	(50)	-		-		-		6	(50)
C10	8	-	8	(100)	-		-		-		-	
Pacific												
D1	98	-	9	(9)	75	(77)	2	(2)	5	(5)	7	(7)
D2	63	-	25	(40)	22	(35)	-		3	(5)	13	(21)
Asian												
E1	653	-	-		1	(0)	644	(99)	6	(1)	2	(0)
Alcohol and drug												
F1	58	-	16	(28)	3	(5)	-		1	(2)	38	(66)
Total	*6188*	*695*	*1739*	*(32)*	*433*	*(8)*	*1015*	*(18)*	*213*	*(4)*	*2093*	*(38)*

Table 5 - Significant other clients by ethnicity

Service	No. clients	Not reported	Ethnicity									
			Maori		Pacific		Asian		Other		European	
	N	n	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Mainstream												
A1	452	23	57	(13)	14	(3)	97	(23)	7	(2)	254	(59)
A2	206	9	29	(15)	8	(4)	11	(6)	14	(7)	135	(69)
A3	741	167	75	(13)	22	(4)	46	(8)	17	(3)	414	(72)
A4	38	1	3	(8)	1	(3)	1	(3)	2	(5)	30	(81)
A5	5	-	-		-		-		-		5	(100)
Maori												
B01	119	-	62	(52)	3	(3)	2	(2)	3	(3)	49	(41)
B02	344	-	179	(52)	3	(1)	-		-		62	(18)
B03	26	1	17	(68)	1	(4)	1	(4)	2	(8)	4	(16)
B04	2	-	2	(100)	-		-		-		-	
B05	7	-	7	(100)	-		-		-		-	
B06	37	-	35	(95)	-		-		-		2	(5)
B07	107	-	78	(73)	4	(4)	-		2	(2)	23	(21)
C01	383	26	263	(74)	9	(3)	7	(2)	5	(1)	73	(20)
C02	31	-	24	(77)	1	(3)	1	(3)	3	(10)	2	(6)
C03	31	-	6	(19)	-		-		4	(13)	21	(68)
C04	214	-	174	(81)	14	(7)	1	(0)	5	(2)	20	(9)
C05	2	-	1	(50)	-		-		-		1	(50)
C06	17	3	7	(50)	-		-		-		7	(50)
C07	4	-	1	(25)	1	(25)	-		-		2	(50)
C08	12	-	6	(50)	1	(8)	-		1	(8)	4	(33)
C09	-											
C10	-											
Pacific												
D1	24	-	1	(4)	17	(71)	1	(4)	4	17)	1	4)
D2	30	-	10	(33)	10	(33)	-		-		10	(33)
Asian												
E1	193	-	-		3	(0)	175	(91)	7	(4)	8	(4)
Alcohol and drug												
F1	-											
Total	*2832*	*230*	*1037*	*(37)*	*112*	*(4)*	*343*	*(12)*	*76*	*(3)*	*1127*	*(40)*

Table 6 - Gambler clients by age group

Service	No. clients	Age group									
		Not reported	<30 years		30-39 years		40-49 years		50-59 years		60+ years	
	N	n	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Mainstream												
A1	1494	38	303	(21)	447	(31)	351	(24)	250	(17)	105	(7)
A2	740	4	141	(19)	210	(29)	207	(28)	130	(18)	48	(7)
A3	1589	606	293	(29)	248	(25)	226	(22)	151	(15)	65	(6)
A4	216	-	13	(6)	21	(10)	57	(26)	54	(25)	71	(33)
A5	42	-	10	(24)	16	(38)	11	(26)	1	(2)	4	(10)
Maori												
B01	239	-	39	(16)	78	(33)	77	(32)	30	(13)	15	(6)
B02	72	2	13	(19)	21	(30)	19	(27)	14	(20)	3	(4)
B03	35	1	4	(12)	9	(26)	13	(38)	3	(9)	5	(15)
B04	70	-	24	(34)	14	(20)	15	(21)	10	(14)	7	(10)
B05	59	1	12	(21)	12	(21)	10	(17)	13	(22)	11	(19)
B06	58	-	14	(24)	16	(28)	11	(19)	14	(24)	3	(5)
B07	18	-	9	(50)	5	(28)	3	(17)	-		1	(6)
C01	195	-	80	(41)	50	(26)	34	(17)	21	(11)	10	(5)
C02	176	21	68	(44)	51	(33)	20	(13)	15	(10)	1	(1)
C03	67	-	20	(30)	10	(15)	19	(28)	13	(19)	5	(7)
C04	95	-	44	(46)	21	(22)	21	(22)	2	(2)	7	(7)
C05	26	1	3	(12)	9	(36)	6	(24)	6	(24)	1	(4)
C06	27	-	4	(15)	7	(26)	8	(30)	7	(26)	1	(4)
C07	61	-	22	(36)	21	(34)	15	(25)	1	(2)	2	(3)
C08	20	-	2	(10)	8	(40)	2	(10)	4	(20)	4	(20)
C09	12	-	4	(33)	6	(50)	2	(17)	-		-	
C10	8	-	1	(13)	2	(25)	4	(50)	1	(13)	-	
Pacific												
D1	98	-	17	(17)	40	(41)	23	(23)	13	(13)	5	(5)
D2	63	-	17	(27)	17	(27)	17	(27)	9	(14)	3	(5)
Asian												
E1	653	653	-		-		-		-		-	
Alcohol and Drug												
F1	58	-	22	(38)	19	(33)	13	(22)	4	(7	-	
Total	*6188*	*1327*	*1179*	*(24)*	*1356*	*(28)*	*1183*	*(24)*	*766*	*(16)*	*377*	*(8)*

Table 7 - Significant other clients by age group

Service	No. clients	Age group										
		Not reported	<30 years		30-39 years		40-49 years		50-59 years		60+ years	
	N	n	n	(%)	N	(%)	n	(%)	n	(%)	n	(%)
Mainstream												
A1	452	14	85	(19)	104	(24)	105	(24)	94	(21)	50	(11)
A2	206	1	35	(17)	52	(25)	52	(25)	42	(20)	24	(12)
A3	741	229	96	(19)	149	(29)	121	(24)	97	(19)	49	(10)
A4	38		7	(18)	2	(5)	5	(13)	12	(32)	12	(32)
A5	5		2	(40)	-		2	(40)	-		1	(20)
Maori												
B01	119	1	20	(17)	27	(23)	30	(25)	24	(20)	17	(14)
B02	344	1	93	(27)	67	(20)	81	(24)	59	(17)	43	(13)
B03	26		9	(35)	3	(12)	5	(19)	7	(27)	2	(8)
B04	2		-		-		1	(50)	1	(50)	-	
B05	7		-		3	(43)	1	(14)	2	(29)	1	(14)
B06	37		16	(43)	7	(19)	8	(22)	4	(11)	2	(5)
B07	107		65	(61)	20	(19)	11	(10)	7	(7)	4	(4)
C01	383		254	(66)	47	(12)	41	(11)	19	(5)	5	(1)
C02	31		9	(29)	8	(26)	5	(16)	3	(10)	3	(10)
C03	31		7	(23)	8	(26)	10	(32)	5	(16)	1	(3)
C04	214		90	(42)	35	(16)	47	(22)	23	(11)	19	(9)
C05	2		-		1	(50)	-		1	(50)	-	
C06	17		2	(12)	5	(29)	2	(12)	7	(41)	1	(6)
C07	4		-		2	(50)	2	(50)	-		-	
C08	12		7	(58)	4	(33)	1	(8)	-		-	
C09	-											
C10	-											
Pacific												
D1	24		7	(29)	9	(38)	4	(17)	2	(8)	2	(8)
D2	30		3	(10)	8	(27)	9	(30)	7	(23)	3	(10)
Asian												
E1	193	193	-		-		-		-		-	
Alcohol and Drug												
F1	-	-	-		-		-		-		-	
Total	*3025*	*439*	*807*	*(31)*	*561*	*(22)*	*543*	*(21)*	*416*	*(16)*	*239*	*(9)*

Table 8 - Gambler clients by Territorial Local Authority

	Territorial Local Authority	Service type		
		Mainstream*	Maori	Pacific
		n	n	n
1	Far North District Council	77	16	-
2	Whangarei District Council	43	14	-
3	Kaipara District Council	8	3	-
4	Rodney District Council	6	-	-
5	North Shore City Council	111	1	9
6	Waitakere City Council	112	24	22
7	Auckland City Council	429	18	34
8	Manukau City Council	179	117	31
9	Papakura District Council	17	34	2
10	Franklin District Council	15	26	-
11	Thames - Coromandel District Council	4	-	-
12	Hauraki District Council	3	-	-
13	Waikato District Council	13	14	-
14	Matamata - Piako District Council	4	-	-
15	Hamilton City Council	97	158	48
16	Waipa District Council	9	6	-
17	Otorohanga District	-	-	-
18	South Waikato District Council	22	2	1
19	Waitomo District Council	2	-	-
20	Taupo District Council	6	18	14
21	Western Bay of Plenty District Council	6	49	-
22	Tauranga District Council	74	6	-
23	Rotorua District Council	47	69	-
24	Whakatane District Council	13	2	-
25	Kawerau District Council	13	59	-
26	Opotiki District Council	2	-	-
27	Gisborne District Council	34	64	-
28	Wairoa District Council	1	11	-
29	Hastings District Council	-	119	-
30	Napier City Council	-	89	-
31	Central Hawkes Bay District Council	-	12	-
32	New Plymouth District Council	31	1	-
33	Stratford District Council	2	-	-
34	South Taranaki District Council	6	-	-
35	Ruapehu District	-	-	-
36	Wanganui District Council	35	-	-
37	Rangitikei District Council	2	1	-
38	Manawatu District Council	5	-	
39	Palmerston North District Council	33	22	
40	Tararua District Council	6	-	

* Excluding Service A3

Table 8 - Gambler clients by Territorial Local Authority continued

	Territorial Local Authority	Service type		
		Mainstream*	Maori	Pacific
		n	n	n
41	Horowhenua District Council	10	5	
42	Kapiti Coast District Council	4	2	-
43	Porirua District Council	19	85	-
44	Upper Hutt City Council	24	-	-
45	Hutt City Council	46	2	-
46	Wellington City Council	121	6	-
47	Masterton District Council	32	-	-
48	Carterton District Council	5	-	-
49	South Wairarapa District Council	5	-	-
50	Tasman District Council	4	9	-
51	Nelson City Council	29	55	-
52	Marlborough District Council	21	13	-
53	Kaikoura District Council	1	-	-
54	Buller District Council	2	-	-
55	Grey District Council	18	-	-
56	Westland District Council	2	-	-
57	Hurunui District	-	-	-
58	Waimakariri District Council	25	-	-
59	Christchurch City Council/ Banks Peninsula	472	64	-
60	Selwyn District Council	12	1	-
61	Ashburton District Council	14	-	-
62	Timaru District Council	22	1	-
63	MacKenzie District Council	1	-	-
64	Waimate District Council	1	-	-
65	Chatham Islands Territory	-	-	-
66	Waitaki District Council	8	-	-
67	Central Otago District Council	1	-	-
68	Queenstown - Lakes District Council	4	1	-
69	Dunedin City Council	108	-	-
70	Clutha District Council	5	-	-
71	Southland District Council	1	-	-
72	Gore District Council	-	1	-
73	Invercargill City Council	14	20	-
	Not Recorded	61	1	-

* Excluding Service A3

Table 9 - Significant other clients by Territorial Local Authority

	Territorial Local Authority	Service type		
		Mainstream*	Maori	Pacific
		n	n	n
1	Far North District Council	4	16	-
2	Whangarei District Council	11	7	-
3	Kaipara District Council	1	-	-
4	Rodney District Council	4	-	-
5	North Shore City Council	40	-	1
6	Waitakere City Council	27	2	4
7	Auckland City Council	125	6	7
8	Manukau City Council	41	24	12
9	Papakura District Council	-	7	-
10	Franklin District Council	7	6	-
11	Thames - Coromandel District Council	1	-	-
12	Hauraki District Council	-	-	-
13	Waikato District Council	6	42	1
14	Matamata - Piako District Council	2	-	-
15	Hamilton City Council	28	341	17
16	Waipa District Council	1	3	-
17	Otorohanga District	-	-	-
18	South Waikato District Council	2		2
19	Waitomo District Council	1		-
20	Taupo District Council	-	104	10
21	Western Bay of Plenty District Council	2	31	-
22	Tauranga District Council	22	3	
23	Rotorua District Council	15	5	
24	Whakatane District Council	1	1	
25	Kawerau District Council	5	8	
26	Opotiki District Council	-	-	-
27	Gisborne District Council	15	327	
28	Wairoa District Council	-	4	
29	Hastings District Council	-	67	
30	Napier City Council	-	42	
31	Central Hawkes Bay District Council	-	6	
32	New Plymouth District Council	7	-	-
33	Stratford District Council	-	-	-
34	South Taranaki District Council	-	-	-
35	Ruapehu District	-	-	-
36	Wanganui District Council	10	-	-
37	Rangitikei District Council	1	-	-
38	Manawatu District Council	2	11	-
39	Palmerston North District Council	10	17	-
40	Tararua District Council	3	-	-

* Excluding Service A3

Table 9 - Significant other clients by Territorial Local Authority continued

	Territorial Local Authority	Service type		
		Mainstream*	Maori	Pacific
		n	n	n
41	Horowhenua District Council	2	3	-
42	Kapiti Coast District Council	1	1	-
43	Porirua District Council	1	187	-
44	Upper Hutt City Council	5	-	-
45	Hutt City Council	15	4	-
46	Wellington City Council	29	9	-
47	Masterton District Council	4	-	-
48	Carterton District Council	1	-	-
49	South Wairarapa District Council	1	-	-
50	Tasman District Council	3	-	-
51	Nelson City Council	11	25	-
52	Marlborough District Council	4	-	-
53	Kaikoura District Council	1	-	-
54	Buller District Council	2	-	-
55	Grey District Council	4	-	-
56	Westland District Council	-	-	-
57	Hurunui District	-	-	-
58	Waimakariri District Council	6	-	-
59	Christchurch City Council/ Banks Peninsula	141	7	-
60	Selwyn District Council	8	-	-
61	Ashburton District Council	4	-	-
62	Timaru District Council	9	-	-
63	MacKenzie District Council		-	-
64	Waimate District Council	1	-	-
65	Chatham Islands Territory		-	-
66	Waitaki District Council	2	-	-
67	Central Otago District Council		-	-
68	Queenstown - Lakes District Council		-	-
69	Dunedin City Council	18	-	-
70	Clutha District Council		-	-
71	Southland District Council	1	-	-
72	Gore District Council		-	-
73	Invercargill City Council	8	12	-
	Not Recorded	25	-	-

* Excluding Service A3

Table 10 - Gambler client treatment summaries

Service		No. clients	Episodes		Sessions	
		N	No. episodes	Average episodes per client	No. sessions	Average sessions per episode
Mainstream	A1	1494	3297	2.21	8527	2.59
	A2	740	1093	1.48	6269	5.74
	A3	1589	1589*	1.00	1626	1.02
	A4	216	307	1.42	409	1.33
	A5	42	49	1.17	318	6.49
Maori	B01	239	553	2.31	1716	3.10
	B02	72	84	1.17	811	9.65
	B03	35	50	1.43	203	4.06
	B04	70	90	1.29	166	1.84
	B05	59	78	1.32	146	1.87
	B06	58	90	1.55	119	1.32
	B07	18	18	1.00	18	1.00
	C01	195	331	1.70	687	2.08
	C02	176	222	1.26	638	2.87
	C03	67	93	1.39	412	4.43
	C04	95	119	1.25	336	2.82
	C05	26	26	1.00	217	8.35
	C06	27	44	1.63	169	3.84
	C07	61	68	1.11	210	3.09
	C08	20	20	1.00	108	5.40
	C09	12	14	1.17	62	4.43
	C10	8	8	1.00	8	1.00
Pacific	D1	98	143	1.46	510	3.57
	D2	63	72	1.14	198	2.75
Asian	E1	653**	653*	1.00	653	1.00
A and D	F1	58	61	1.05	1572	25.77
Total		*6188*	*9172*	*1.54*	*26108*	2.85

* Assume one episode per client in absence of other evidence

** Assume one session per client in absence of other evidence

Table 11 - Significant other client treatment summaries

Service		No. clients	Episodes		Sessions	
		N	No. episodes	Average episodes per client	No. sessions	Average sessions per episode
Mainstream	A1	452	719	1.59	1603	2.23
	A2	206	303	1.47	939	3.10
	A3	741	741*	1.00	760	1.03
	A4	38	45	1.18	64	1.42
	A5	5	5	1.00	15	3.00
Maori	B01	119	238	2.00	763	3.21
	B02	344	389	1.13	1032	2.65
	B03	26	32	1.23	43	1.34
	B04	2	2	1.00	2	1.00
	B05	7	9	1.29	22	2.44
	B06	37	49	1.32	64	1.31
	B07	107	108	1.01	108	1.00
	C01	383	517	1.35	838	1.62
	C02	31	40	1.29	103	2.58
	C03	31	46	1.48	102	2.22
	C04	214	270	1.26	864	3.20
	C05	2	2	1.00	15	7.50
	C06	17	31	1.82	92	2.97
	C07	4	4	1.00	12	3.00
	C08	12	12	1.00	57	4.75
	C09	-				
	C10	-				
Pacific	D1	24	28	1.17	82	2.93
	D2	30	33	1.10	65	1.97
Asian	E1	193**	193*	1.00	193	1.00
A and D	F1	-				
Total		*3025*	*3816*	1.26	*7838*	2.05

* Assume one episode per client in absence of other evidence

** Assume one session per client in absence of other evidence

Table 12 - Gambler client episode type

Service		No. episodes	Brief		Full		Follow-up	
		N	n	(%)	n	(%)	n	(%)
Mainstream	A1	3297	180	(5)	1998	(61)	1119	(34)
	A2	1093[#]	148	(14)	758	(69)	182	(17)
	A4	307	-		118	(38)	189	(62)
	A5	49	20	(41)	27	(55)	2	(4)
Maori	B01	553	238	(43)	195	(35)	120	(22)
	B02	84	26	(31)	38	(45)	20	(24)
	B03	50	30	(60)	19	(38)	1	(2)
	B04	90	58	(64)	21	(23)	11	(12)
	B05	78	50	(64)	28	(36)	-	
	B06	90	46	(51)	40	(44)	4	(4)
	B07	18	16	(89)	-		2	(11)
	C01	331	151	(46)	104	(31)	76	(23)
	C02	222	91	(41)	91	(41)	40	(18)
	C03	93	26	(28)	48	(52)	19	(20)
	C04	119	51	(43)	29	(24)	39	(33)
	C05	26	7	(27)	19	(73)	-	
	C06	44	19	(43)	22	(50)	3	(7)
	C07	68	43	(63)	23	(34)	2	(3)
	C08	20	4	(20)	14	(70)	2	(10)
	C09	14	7	(50)	6	(43)	1	(7)
	C10	8	8	(100)	-		-	
Pacific	D1	143	69	(48)	65	(45)	9	(6)
	D2	72	52	(72)	11	(15)	9	(13)
A and D	F1	61	3	(5)	58	(95)	-	
Total		*6930[#]*	*1343*	*(19)*	*3732*	*(54)*	*1850*	*(27)*

[#] Includes five initial telephone contacts

Table 13 - Significant other client episode type

Service		No. episodes	Brief		Full		Follow-up	
		N	n	(%)	n	(%)	n	(%)
Mainstream	A1	719	38	(5)	481	(67)	200	(28)
	A2[#]	303	83	(27)	174	(57)	45	(15)
	A4	45	-		24	(53)	21	(47)
	A5	5	2	(40)	2	(40)	1	(20)
Maori	B01	238	121	(51)	71	(30)	46	(19)
	B02	389	316	(81)	25	(6)	48	(12)
	B03	32	24	(75)	6	(19)	2	(6)
	B04	2	2	(100)	-		-	
	B05	9	3	(33)	6	(67)	-	
	B06	49	36	(73)	13	(27)	-	
	B07	108	106	(98)	2	(2)	-	
	C01	517	327	(63)	124	(24)	66	(13)
	C02	40	16	(40)	19	(48)	5	(13)
	C03	46	17	(37)	19	(41)	10	(22)
	C04	270	131	(49)	77	(29)	62	(23)
	C05	2	-		2	(100)	-	
	C06	31	23	(74)	6	(19)	2	(6)
	C07	4	3	(75)	1	(25)	-	
	C08	12	-		12	(100)	-	
	C09	-						
	C10	-						
Pacific	D1	28	16	(57)	9	(32)	3	(11)
	D2	33	22	(67)	-		9	(27)
A and D	F1	-						
Total		*2882*	*1286*	*(45)*	*1073*	*(37)*	*520*	*(18)*

[#] Includes one initial telephone contact

Table 14 - Gambler client time per episode type

Service		No. episodes	Average time per session (hours)		
		N	Brief	Full	Follow-up
Mainstream	A1	3297	0.80	1.07	1.00
	A2	1093[#]	0.49	1.00	0.28
	A4	307	-	4.05	0.28
	A5	49	0.46	0.69	0.38
Maori	B01	553	0.73	1.31	0.36
	B02	84	1.30	2.93	0.46
	B03	50	0.69	1.07	0.88
	B04	90	0.46	0.54	0.38
	B05	78	0.44	0.83	-
	B06	90	0.45	0.57	0.38
	B07	18	0.25	-	0.25
	C01	331	0.78	0.94	0.43
	C02	222	0.94	1.29	0.34
	C03	93	0.91	1.18	0.44
	C04	119	0.43	0.73	0.40
	C05	26	1.05	1.08	-
	C06	44	0.74	0.76	0.56
	C07	68	1.21	1.22	1.13
	C08	20	0.81	0.86	1.00
	C09	14	1.04	0.88	1.25
	C10	8	0.38	-	-
Pacific	D1	143	0.55	0.55	0.30
	D2	72	0.85	1.09	0.46
A and D	F1	61	1.22	1.30	-
Total		*6930[#]*	*0.76*	*1.17*	*0.36*

[#] Includes five initial telephone contacts

Table 15 - Significant other client time per episode type

Service		No. episodes	Average time per session (hours)		
		N	Brief	Full	Follow-up
Mainstream	A1	719	0.75	1.09	0.97
	A2	303[#]	0.49	1.07	0.30
	A4	45	-	4.10	0.25
	A5	5	0.42	1.07	0.25
Maori	B01	238	0.44	1.55	0.28
	B02	389	0.64	2.54	0.48
	B03	32	0.79	1.57	0.83
	B04	2	0.25	-	-
	B05	9	0.33	0.87	-
	B06	49	0.35	0.52	-
	B07	108	0.26	0.25	-
	C01	517	0.66	1.08	0.48
	C02	40	1.69	1.20	0.54
	C03	46	0.83	1.36	0.69
	C04	270	0.36	0.85	0.34
	C05	2	-	1.10	-
	C06	31	0.65	0.85	0.88
	C07	4	0.93	1.25	-
	C08	12	-	0.96	-
	C09	-			
	C10	-			
Pacific	D1	28	0.72	0.50	0.31
	D2	33	0.73	0.98	0.25
A and D	F1	-			
Total		*2882*[#]	*0.59*	*1.23*	*0.67*

* Includes one initial phone contact

Table 16 - Gambler client intervention outcome

Service	No. treatment programmes	Treatment complete		Treatment partially complete		Admin-istrative discharge		Transferred to other prob. gamb. service		On-going	
	N	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Mainstream											
A1	3297	2121	(64)	149	(5)	630	(19)	13	(0)	384	(12)
A2	1093	513	(47)	95	(9)	248	(23)	5	(0)	232	(21)
A4	307	187	(61)	68	(22)	51	(17)	-		1	(0)
A5	49	15	(31)	8	(16)	6	(12)	2	(4)	18	(37)
Maori											
B01	553	404	(73)	46	(8)	21	(4)	2	(0)	80	(14)
B02	84	27	(32)	-		5	(6)	3	(4)	49	(58)
B03	50	30	(60)	3	(6)	2	(4)	-		15	(30)
B04	90	58	(64)	-		4	(4)	-		28	(31)
B05	78	62	(79)	2	(3)	1	(1)	-		13	(17)
B06	90	61	(68)	-		4	(4)	-		25	(28)
B07	18	16	(89)	2	(11)	-		-		-	
C01	331	268	(81)	19	(6)	6	(2)	1	(0)	37	(11)
C02	222	52	(23)	2	(1)	145	(65)	-		23	(10)
C03	93	43	(46)	7	(8)	3	(3)	1	(1)	39	(42)
C04	119	66	(55)	-		5	(4)	3	(3)	45	(38)
C05	26	-		17	(65)	-		-		9	(35)
C06	44	21	(48)	5	(11)	3	(7)	1	(2)	14	(32)
C07	68	22	(32)	6	(9)	31	(46)	-		9	(13)
C08	20	-		-		-		-		20	(100)
C09	14	1	(7)	1	(7)	2	(14)	-		10	(71)
C10	8	8	(100)	-		-		-			
Pacific											
D1	143	84	(59)	2	(1)	11	(8)	1	(1)	45	(31)
D2	72	41	(57)	15	(21)	-		-		16	(22)
Alcohol and Drug											
F1	61	11	(18)	10	(16)	-		2	(3)	38	(62)
Total	*6930*	*4111*	*(59)*	*457*	*(7)*	*1178*	*(17)*	*34*	*(0)*	*1150*	*(17)*

Table 17 - Significant other client intervention outcome

Service	No. episodes	Treatment complete		Treatment partially complete		Admin-istrative discharge		Transferred to other prob. gamb. service		On-going	
	N	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Mainstream											
A1	719	394	(55)	20	(3)	192	(27)	2	(0)	111	(15)
A2	303	193	(64)	27	(9)	43	(14)	2	(1)	38	(13)
A4	45	23	(51)	14	(31)	7	(16)	-		1	(2)
A5	5	1	(20)	1	(20)	1	(20)	-		2	(40)
Maori											
B01	238	186	(78)	13	(5)	3	(1)	-		36	(15)
B02	389	170	(44)	-		54	(14)	2	(1)	163	(42)
B03	32	28	(88)	-		-		-		4	(13)
B04	2	2	(100)	-		-		-		-	
B05	9	8	(89)	-		-		-		1	(11)
B06	49	39	(80)	-		2	(4)	-		8	(16)
B07	108	106	(98)	1	(1)	-		-		1	(1)
C01	517	438	(85)	3	(1)	-		-		76	(15)
C02	40	20	(50)	-		17	(43)	-		3	(8)
C03	46	24	(52)	-		4	(9)	-		18	(39)
C04	270	154	(57)	-		4	(1)	3	(1)	109	(40)
C05	2	-		1	(50)	-		-		1	(50)
C06	31	22	(71)	5	(16)	-		-		4	(13)
C07	4	2	(50)	-		-		-		2	(50)
C08	12	-		-		-		-		12	(100)
C09	-										
C10	-										
Pacific											
D1	28	16	(57)	1	(4)	6	(21)			5	(18)
D2	33	24	(73)	2	(6)	1	(3)			6	(18)
Alcohol and Drug											
F1	-										
Total	*2882*	*1850*	*(64)*	*88*	*(3)*	*334*	*(12)*	*9*	*(0)*	*601*	*(21)*

Table 18 - Gambler client average length of episode

Service	No. episodes	Treatment complete		Treatment partially complete		Administrative discharge		Transferred to other prob. gamb. service		On-going	
	N	n	Av. episode length (days)	n	Av. episode length (days)	n	Av. episode length (days)	n	Ave episode length (days)	n	Ave episode length (days)
Mainstream											
A1	3297	2121	57.8	149	115.3	630	49.7	13	90.9	384	-
A2	1093	513	73.3	95	202.8	248	160.6	5	110.2	232	-
A4	307	187	9.9	68	1.0	51	1.3	-		1	-
A5	49	15	34.5	8	184.1	6	86.0	2	229.5	18	-
Maori											
B01	553	404	12.1	46	105.0	21	185.2	2	196.5	80	-
B02	84	27	235.0	-		5	177.8	3	117.3	49	-
B03	50	30	19.9	3	20.3	2	179.0	-		15	-
B04	90	58	31.2	-		4	123.3	-		28	-
B05	78	62	9.6	2	13.5	1	17.0	-		13	-
B06	90	61	19.8	-		4	22.3	-		25	-
B07	18	16	0.0	2	0.0	-		-		-	-
											-
C01	331	268	9.1	19	53.4	6	39.0	1	16.0	37	-
C02	222	52	47.4	2	346.5	145	68.7	-		23	-
C03	93	43	75.8	7	58.1	3	14.0	1	56.0	39	-
C04	119	66	161.0	-		5	222.6	3	454.7	45	-
C05	26	-		17	217.5	-		-		9	-
C06	44	21	99.8	5	140.2	3	112.7	1	25.0	14	-
C07	68	22	70.6	6	44.3	31	1.9	-		9	-
C08	20	-		-		-		-		20	-
C09	14	1	0.0	1	67.0	2	7.0	-		10	-
C10	8	8	0.0	-		-		-		-	
											-
Pacific											
D1	143	84	41.2	2	18.0	11	14.4	1	0.0	45	-
D2	72	41	37.2	15	6.7	-		-		16	-
Alcohol and Drug											
F1	61	11	266.7	10	255.1	-		2	50.0	38	-
Total	*6930*	*4111*	*50.6*	*457*	*114.7*	*1178*	*75.8*	*34*	*132.3*	*1150*	-

Table 19 - Significant other client average length of episode

Service	No. episode	Treatment complete		Treatment partially complete		Administrative discharge		Transferred to other prob. gamb. service		On-going	
	N	n	Ave episode length (days)	n	Ave episode length (days)	n	Ave episode length (days)	n	Ave episode length (days)	n	Ave episode length (days)
Mainstream											
A1	719	394	*70.6*	20	*100.0*	192	*46.9*	2	*126.0*	111	-
A2	303	193	*43.8*	27	*130.7*	43	*73.8*	2	*44.0*	38	-
A4	45	23	*13.6*	14	*0.6*	7	*1.00*	-		1	-
A5	5	1	*0.0*	1	*3.0*	1	*88.0*	-		2	-
Maori											
B01	238	186	*2.8*	13	*62.9*	3	*137.7*	-		36	-
B02	389	170	*79.6*	-		54	*94.4*	2	*95.0*	163	-
B03	32	28	*6.8*	-		-		-		4	-
B04	2	2	*0.0*	-		-		-		-	-
B05	9	8	*17.1*	-		-		-		1	-
B06	49	39	*0.6*	-		2	*0.0*	-		8	-
B07	108	106	*0.0*	1	*0.0*	-		-		1	-
C01	517	438	*2.1*	3	*0.0*	-		-		76	-
C02	40	20	*39.8*	-		17	*97.6*	-		3	-
C03	46	24	*90.4*	-		4	*24.8*	-		18	-
C04	270	154	*122.8*	-		4	*136.5*	3	*138.0*	109	-
C05	2	-		1	*189.0*	-		-		1	-
C06	31	22	*45.9*	5	*0.0*	-		-		4	-
C07	4	2	*2.0*	-		-		-		2	-
C08	12	-		-		-		-		12	-
C09	-										
C10	-										
Pacific											
D1	28	16	*54.0*	1	*0.0*	6	*21.2*	-		5	-
D2	33	24	*33.8*	2	*4.0*	1	*0.0*	-		6	-
Alcohol and Drug											
F1	-										
Total	*2882*	*1850*	*41.3*	*88*	*74.5*	*334*	*60.5*	*9*	*104.9*	*601*	-

Table 20 - Gambler client primary gambling mode

Service	No. episode	Not reported	Casino tables	Electronic gaming machines				Housie	Keno/ Lotto	Track/ Sports betting	Other
				Casino	Non-casino	Pub	Club				
	N	n	%	%	%	%	%	%	%	%	%
Mainstream											
A1	3297	57	12	13	21	45	3	0	3	9	4
A2	1093	2	8	17	49	22	1	0	1	13	5
A4	307		3	37	36	28	20	0	6	7	2
A5	49	2	-	2	77	23	-	-	-	-	-
Maori											
B01	553		0	0	50	41	1	0	0	3	5
B02	84	2	-	15	38	22	1	6	-	6	7
B03	50		4	32	42	26	4	-	6	4	6
B04	90		1	10	44	36	9	-	3	1	-
B05	78	2	-	3	25	9	1	1	37	22	8
B06	90		-	11	47	31	2	-	-	-	9
B07	18		-	-	44	39	17	-	-	-	-
C01	331		0	8	66	18	1	-	1	3	8
C02	222		1	6	46	-	-	0	2	0	46
C03	93	2	2	-	66	20	-	-	-	7	5
C04	119	2	-	-	64	18	-	1	3	7	13
C05	26	3	4	17	91	-	-	-	-	-	-
C06	44	1	-	-	95	2	-	-	-	7	-
C07	68		3	6	66	12	1	6	9	7	1
C08	20		-	10	50	30	-	5	-	10	-
C09	14		-	-	93	-	-	-	-	7	-
C10	8		-	13	-	-	-	-	63	13	13
Pacific											
D1	143	2	-	21	50	17	-	2	9	11	1
D2	72		1	3	35	54	-	-	11	4	3
Alcohol and Drug											
F1	61	1	3	38	42	10	-	-	2	8	5
Total	*6930*	*76*	*7*	*13*	*37*	*34*	*3*	*0*	*3*	*8*	*8*

Table 21 - Significant other client primary gambling mode

Service	No. episode	Not reported	Casino tables	Electronic gaming machines				Housie	Keno/ Lotto	Track/ Sports betting	Other
				Casino	Non-casino	Pub	Club				
	N	n	%	%	%	%	%	%	%	%	%
Mainstream											
A1	719	54	16	7	25	42	2	0	1	9	4
A2	303	2	7	14	49	18	4	0	1	15	5
A4	45		4	38	40	22	38	-	7	13	4
A5	5		-	-	60	-	20	-	-	-	20
Maori											
B01	238		-	2	35	47	3	3	0	4	6
B02	389	3	-	11	38	15	1	3	7	5	25
B03	32	2	3	23	50	20	3	3	7	7	-
B04	2		-	-	-	50	-	50	-	-	-
B05	9	2	-	-	14	57	-	-	-	-	29
B06	49		-	2	59	29	-	-	-	-	10
B07	108	27	2	1	48	31	14	-	1	2	-
C01	517		-	3	55	24	3	1	2	5	12
C02	40		-	8	45	-	-	-	-	-	48
C03	46		11	4	61	15	-	-	-	4	4
C04	270	6	1	1	58	32	-	4	1	5	3
C05	2		-	50	50	-	-	-	-	-	50
C06	31		-	-	97	3	-	-	-	-	-
C07	4		-	-	-	50	25	-	-	-	25
C08	12	1	-	18	55	18	-	-	-	9	-
C09	-										
C10	-										
Pacific											
D1	28	5	-	22	61	9	-	-	-	-	13
D2	33		3	-	30	52	-	-	6	9	3
Alcohol and Drug											
F1	-										
Total	*2882*	*102*	*5*	*7*	*43*	*29*	*3*	*1*	*2*	*7*	*9*

Table 22 - Gambler client counselling type

Service		No. sessions	Individual		Couple		Family/whanau		Group	
		N	n	(%)	n	(%)	n	(%)	n	(%)
Mainstream	A1	8527	7327	(86)	502	(6)	107	(1)	591	(7)
	A2	6269	5515	(88)	152	(2)	18	(0)	584	(9)
	A4	409	219	(54)	-		-		190	(46)
	A5	318	276	(87)	16	(5)	26	(8)	-	
Maori	B01	1716	1462	(85)	7	(0)	3	(0)	244	(14)
	B02	811	418	(52)	25	(3)	77	(9)	291	(36)
	B03	203	187	(92)	12	(6)	1	(0)	3	(1)
	B04	166	161	(97)	2	(1)	2	(1)	1	(1)
	B05	146	144	(99)	-		2	(1)	-	
	B06	119	116	(97)	-		-		3	(3)
	B07	18	18	(100)	-		-		-	
	C01	687	648	(94)	-		-		39	(6)
	C02	638	432	(68)	1	(0)	21	(3)	184	(29)
	C03	412	374	(91)	27	(7)	6	(1)	5	(1)
	C04	336	280	(83)	-		53	(16)	3	(1)
	C05	217	213	(98)	-		4	(2)	-	
	C06	169	151	(89)	12	(7)	-		6	(4)
	C07	210	98	(47)	5	(2)	-		107	(51)
	C08	108	103	(95)	2	(2)	2	(2)	1	(1)
	C09	62	62	(100)	-		-			
	C10	8	8	(100)	-		-			
Pacific	D1	510	444	(87)	25	(5)	35	(7)	6	(1)
	D2	198	185	(93)	6	(3)	4	(2)	3	(2)
A and D	F1	1672	518	(31)	5	(0)	6	(0)	1143	(68)
Total		*23929*	*19359*	*(81)*	*799*	*(3)*	*367*	*(2)*	*3404*	*(14)*

Table 23 - Significant other client counselling type

Service		No. sessions	Individual		Couple		Family/whanau		Group	
		N	n	(%)	n	(%)	n	(%)	n	(%)
Mainstream	A1	1603	1052	(66)	378	(24)	159	(10)	14	(1)
	A2	939	758	(81)	111	(12)	60	(6)	10	(1)
	A4	64	24	(38)	-		-		40	(63)
	A5	15	5	(33)	10	(67)	-		-	
Maori	B01	763	458	(60)	11	(1)	104	(14)	190	(25)
	B02	1032	797	(77)	46	(4)	17	(2)	172	(17)
	B03	43	17	(40)	12	(28)	11	(26)	3	(7)
	B04	2	2	(100)	-		-		-	
	B05	22	22	(100)	-		-		-	
	B06	64	64	(100)	-		-		-	
	B07	108	108	(100)	-		-		-	
	C01	838	769	(92)	-		-		69	(8)
	C02	103	64	(62)	-		7	(7)	32	(31)
	C03	102	66	(65)	28	(27)	7	(7)	1	(1)
	C04	864	726	(84)	-		75	(9)	63	(7)
	C05	15	14	(93)	-		1	(7)	-	
	C06	92	82	(89)	2	(2)	5	(5)	3	(3)
	C07	12	6	(50)	5	(42)	1	(8)	-	
	C08	57	55	(96)	2	(4)	-		-	
	C09	-	-		-		-		-	
	C10	-	-		-		-		-	
Pacific	D1	82	78	(95)	3	(4)	1	(1)	-	
	D2	65	53	(82)	5	(8)	7	(11)	-	
A and D	F1	-	-		-		-		-	
Total		*6885*	*5220*	*(76)*	*613*	*(9)*	*455*	*(7)*	*597*	*(9)*

Table 24 - Gambler client type of session

Service		No. sessions	Assessment		Counselling		Facilitation	
		N	n	(%)	n	(%)	n	(%)
Mainstream	A1	8527	2121	(25)	6390	(75)	16	(0)
	A2	6269	612	(10)	5504	(88)	153	(2)
	A4	409	96	(23)	313	(77)		
	A5	318	9	(3)	266	(84)	43	(14)
Maori	B01	1716	266	(16)	1199	(70)	251	(15)
	B02	811	23	(3)	742	(91)	46	(6)
	B03	203	19	(9)	166	(82)	18	(9)
	B04	166	20	(12)	138	(83)	8	(5)
	B05	146	37	(25)	106	(73)	3	(2)
	B06	119	22	(18)	89	(75)	8	(7)
	B07	18	11	(61)	7	(39)	-	
	C01	687	182	(26)	471	(69)	34	(5)
	C02	638	20	(3)	618	(97)	-	
	C03	412	55	(13)	315	(76)	42	(10)
	C04	336	34	(10)	215	(64)	87	(26)
	C05	217	2	(1)	215	(99)	-	
	C06	169	13	(8)	155	(92)	1	(1)
	C07	210	21	(10)	188	(90)	1	(0)
	C08	108	8	(7)	100	(93)	-	
	C09	62	1	(2)	61	(98)	-	
	C10	8	-		8	(100)	-	
Pacific	D1	510	52	(10)	455	(89)	3	(1)
	D2	198	37	(19)	159	(80)	2	(1)
A and D	F1	1672	6	(0)	1647	(99)	19	(1)
Total		*23929*	*3667*	*(15)*	*19527*	*(82)*	*735*	*(3)*

Table 25 - Significant other client type of session

Service		No. sessions	Assessment		Counselling		Facilitation	
		N	n	(%)	n	(%)	n	(%)
Mainstream	A1	1603	419	(26)	1179	(74)	5	(0)
	A2	939	139	(15)	792	(84)	8	(1)
	A4	64	10	(16)	54	(84)	-	
	A5	15	-		15	(100)	-	
Maori	B01	763	129	(17)	414	(54)	220	(29)
	B02	1032	225	(22)	785	(76)	22	(2)
	B03	43	8	(19)	35	(81)	-	
	B04	2	-		2	(100)	-	
	B05	22	15	(68)	6	(27)	1	(5)
	B06	64	3	(5)	54	(84)	7	(11)
	B07	108	60	(56)	48	(44)	-	
	C01	838	389	(46)	428	(51)	21	(3)
	C02	103	6	(6)	97	(94)	-	
	C03	102	17	(17)	82	(80)	3	(3)
	C04	864	70	(8)	680	(79)	114	(13)
	C05	15	-		15	(100)	-	
	C06	92	3	(3)	88	(96)	1	(1)
	C07	12	4	(33)	8	(67)	-	
	C08	57	9	(16)	48	(84)	-	
	C09	-						
	C10	-						
Pacific	D1	82	7	(9)	75	(91)	-	
	D2	65	14	(22)	51	(78)	-	
A and D	F1	-						
Total		*6885*	*1527*	*(22)*	*4956*	*(72)*	*402*	*(6)*

Table 26 - Gambler clients initial contact date

Service		No. clients[#]	Existing clients (Pre Jul 2007)		New clients Jul-Dec 2007		New clients Jan-Jun 2008	
		N	n	(%)	n	(%)	n	(%)
Mainstream	A1	1494	509	(34)	539	(36)	446	(30)
	A2	740	328	(44)	192	(26)	221	(30)
	A4	216	110	(51)	40	(19)	66	(310
	A5	42	7	(17)	23	(55)	12	(29)
Maori	B01	239	113	(47)	52	(22)	74	(31)
	B02	72	41	(57)	16	(22)	15	(21)
	B03	35	6	(17)	14	(40)	15	(43)
	B04	70	11	(16)	18	(26)	41	(59)
	B05	59	-		27	(46)	32	(54)
	B06	58	10	(17)	25	(43)	23	(40)
	B07	18	-		6	(33)	12	(67)
	C01	195	30	(15)	103	(53)	62	(32)
	C02	176	66	(38)	44	(25)	66	(38)
	C03	67	19	(28)	26	(39)	22	(33)
	C04	95	34	(36)	19	(20)	42	(44)
	C05	26	11	(42)	11	(42)	4	(15)
	C06	27	12	(44)	10	(37)	5	(19)
	C07	61	8	(13)	36	(59)	17	(28)
	C08	20	7	(35)	2	(10)	11	(55)
	C09	12	2	(17)	10	(83)	-	
	C10	8	-		8	(100)	-	
Pacific	D1	98	27	(28)	28	(29)	43	(44)
	D2	63	7	(11)	13	(21)	43	(68)
A and D	F1	58	28	(48)	10	(17)	20	(34)
Total		*3946*	*1386*	*(35)*	*1272*	*(32)*	*1292*	*(33)*

Clients who received at least one session in the time frame of analysis (1 July 2007 to 30 June 2008)

Table 27 - Significant other client initial contact date

Service		No. clients[#]	Existing clients (Pre Jul 2007)		New clients Jul-Dec 2007		New clients Jan-Jun 2008	
		N	n	(%)	n	(%)	n	(%)
Mainstream	A1	452	116	(26)	174	(38)	162	(36)
	A2	206	48	(23)	82	(40)	76	(37)
	A4	38	15	(39)	7	(18)	16	(42)
	A5	5	1	(20)	1	(20)	3	(60)
Maori	B01	119	43	(36)	16	(13)	60	(50)
	B02	344	68	(20)	125	(36)	151	(44)
	B03	26	2	(8)	11	(42)	13	(50)
	B04	2	-		-		2	(100)
	B05	7	-		5	(71)	2	(29)
	B06	37	4	(11)	21	(57)	12	(32)
	B07	107	-		39	(36)	68	(64)
	C01	383	32	(8)	130	(34)	221	(58)
	C02	31	10	(32)	19	(61)	2	(6)
	C03	31	7	(23)	17	(55)	7	(23)
	C04	214	77	(36)	22	(10)	115	(54)
	C05	2	-		2	(100)	-	
	C06	17	4	(24)	11	(65)	2	(12)
	C07	4	-		1	(25)	3	(75)
	C08	12	-		2	(17)	10	(83)
	C09	-						
	C10	-						
Pacific	D1	24	10	(42)	6	(25)	8	(33)
	D2	30	4	(13)	9	(30)	17	(57)
A and D	F1	-						
Total		*2091*	*441*	*(21)*	*700*	*(33)*	*950*	*(45)*

Clients who received at least one session in the time frame of analysis (1 July 2007 to 30 June 2008)

Table 28 - Gambler client referral pathway into service

Service		No. clients	Not reported / unknown	Self	Family/ relative	Friend	Media	Phone book	Gambling venue	Helpline	Ex client	Alcohol & Drug	Justice system	Other agency	Other
		N	n	%	%	%	%	%	%	%	%	%	%	%	%
Mainstream	A1	1494	24	3	7	5	10	14	8	18	12	1	9	6	7
	A2	740	4	19	7	3	1	7	4	34	0	6	3	11	5
	A4	216	-	49	11	5	31	1	-	1	-	-	-	1	1
	A5	42	4	21	5	-	-	-	-	21	-	16	18	13	5
Maori	B01	239	-	52	8	2	-	1	-	10	2	3	12	8	3
	B02	72	4	56	15	-	-	-	-	4	7	-	1	10	6
	B03	35	-	26	9	3	-	-	-	29	-	-	-	17	17
	B04	70	2	90	-	-	-	-	-	7	-	-	-	3	-
	B05	59	-	100	-	-	-	-	-	-	-	-	-	-	-
	B06	58	-	79	7	-	-	-	-	-	12	-	-	-	2
	B07	18	-	100	-	-	-	-	-	-	-	-	-	-	-
	C01	195	-	42	2	5	-	-	-	10		1	3	11	27
	C02	176	1	29	2	-	-	-	-	2		32	11	19	5
	C03	67	2	38	8	-	-	-	-	9	2	5	3	29	6
	C04	95	4	80	2	-	-	-	-	4	1	-	-		12
	C05	26	4	59	-	-	-	-	-	14	-	-	-	18	9
	C06	27	1	58	-	-	-	-	-	19	-	-	-	23	-
	C07	61	1	20	3	-	-	-	-	13	-	8	-	12	43
	C08	20	3	65	-	-	-	-	-	24	-	-	-	6	6
	C09	12	-	25	8	-	-	-	-	-	-	8	8	50	-
	C10	8	-	25	63	-	-	-	-	-	-	-	-	13	-
Pacific	D1	98	9	12	1	-	-	-	-	30	2	44	2	6	2
	D2	63	-	41	3	-	-	-	-	2	-	14	2	19	19

Table 28 - Gambler client referral pathway into service continued

Service		No. clients	Not reported / unknown	Self	Family/ relative	Friend	Media	Phone book	Gambling venue	Helpline	Ex client	Alcohol & Drug	Justice system	Other agency	Other
		N	n	%	%	%	%	%	%	%	%	%	%	%	%
Alcohol & Drug	F1	58	6	42	-	-	-	-	-	-	6	21	13	10	8
Total		*3946*	*69*	*26*	*6*	*3*	*6*	*7*	*4*	*17*	*5*	*5*	*6*	*8*	*7*

Note

Family/relative includes: Family, relative, brother, sister, ex., wife, daughter, father, mother, partner, husband

Media includes: Media, radio, T.V. advert, website, internet, newspaper, news article

Gambling venue includes: Sky City, Sky casino, casino, G. host . ad, Class 4 venue, In house TSA

Justice system includes: Diversion, police, corrections, correctn/probtn, prison soc wkr, probation, court

Other includes: Other, stickers on GMs, brochure, Oasis advert, street sign, employer

Other agency includes: Other agency, Salvation Army, S.A. Bridge Akl, S.A. Henderson, S.A. Manukau, S.A. Waitakere, education, social worker, Te Whatuiapiti, Wai Health, budgeting, CAB, GA, Epsom Lodge, EA budget serv., church worker, CGS research, The Nest, Vincentian, Pleroma, needs assessmnt, GP, psych services, mental health, health promotn, hospital, counsellor

Helpline includes: Helpline, Asian Helpline

Table 29 - Significant other client referral pathway into service

Service		No. clients	Not reported / unknown	Self	Family / relative	Friend	Media	Phone book	Gambling venue	Helpline	Ex client	Alcohol & Drug	Justice system	Other agency	Other
		N	n	%	%	%	%	%	%	%	%	%	%	%	%
Mainstream	A1	452	17	3	25	13	11	16	5	9	5	0	2	6	5
	A2	206	-	31	21	5	1	6	1	21	-	2	-	7	2
	A4	38	-	55	5	8	32	-	-	-	-	-	-	-	-
	A5	5	1	50	-	-	-	-	-	25	-	-	-	-	25
Maori	B01	119	-	57	17	2	-	1	-	3	1	1	3	13	3
	B02	344	21	80	3	0	-	-	-	2	4		1	3	6
	B03	26	-	42	4	4	-	-	-	12	-	-	-	-	38
	B04	2	-	100		-	-	-	-	-	-	-	-	-	-
	B05	7	-	100		-	-	-	-	-	-	-	-	-	-
	B06	37	-	70	27	-	-	-	-	-	3	-	-	-	-
	B07	107	1	100		-	-	-	-	-	-	-	-	-	-
	C01	383	-	41	3	10	0	0	-	-	0			19	26
	C02	31	-	39	26	-	-	-	-	-	-	29	-	6	-
	C03	31	-	74	10	-	-	-	-	6	-	-	-	10	-
	C04	214	7	80	11	-	-	-	-	0	0	-	-	0	8
	C05	2	1		100	-	-	-	-	-	-	-	-		-
	C06	17	-	88	6	-	-	-	-	-	-	-	-	6	-
	C07	4	-	75	25	-	-	-	-	-	-	-	-	-	-
	C08	12	-	50	17	-	-	-	-	17	-	-	-	17	-
	C09	-													
	C10	-													
Pacific	D1	24	1	26	9	-	-	-	-	9	-	52	-	-	4
	D2	30	-	63	7	-	-	-	-	-	-	13	-	13	3

Table 29 - Significant other client referral pathway into service continued

Alcohol & Drug	F1	-													
Total		*2091*	*49*	*48*	*12*	*6*	*3*	*4*	*1*	*5*	*2*	*2*	*1*	*7*	*9*

Note

Family/relative includes: Family, relative, brother, sister, ex., wife, daughter, father, mother, partner, husband
Media includes: Media, radio, T.V. advert, website, internet, newspaper, news article
Gambling venue includes: Sky City, Sky casino, casino, G. host . ad, Class 4 venue, In house TSA
Justice system includes: Diversion, police, corrections, correctn/probtn, prison soc wkr, probation, court
Other includes: Other, stickers on GMs, brochure, Oasis advert, street sign, employer
Other agency includes: Other agency, Salvation Army, S.A. Bridge Akl, S.A. Henderson, S.A. Manukau, S.A. Waitakere, education, social worker, Te Whatuiapiti, Wai Health, budgeting, CAB, GA, Epsom Lodge, EA budget serv., church worker, CGS research, The Nest, Vincentian, Pleroma, needs assessmnt, GP, psych services, mental health, health promotn, hospital, counsellor
Helpline includes: Helpline, Asian Helpline

Table 30 - Gambler client media pathway

Date of initial contact	Number of new clients
2007	
July	14
August	18
September	16
October	7
November	8
December	7
2008	
January	7
February	9
March	12
April	9
May	21
June	22

Shading equates to peak times of social marketing campaign

Table 31 - Significant other client media pathway

Date of initial contact	Number of new clients
2007	
July	7
August	4
September	2
October	2
November	1
December	3
2008	
January	3
February	1
March	1
April	2
May	6
June	12

Shading equates to peak times of social marketing campaign

Table 32 - Gambler new completed clients episode pathway summary

Service		*No. Clients*	B	BF	BFU	B+	BM	*B Total*	F	FU	F+	FM	*F Total*	U+	UM	*U Total*	Not reported
		N	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n
Mainstream	A1	***730***	6	6	1	5	8	***26***	331	80	8	116	***535***	76	87	***163***	3
	A2	***264***	25	48	8	-	17	***98***	106	24	26	10	***166***	-	-	-	-
	A4	***105***	-	-	-	-	-	-	65	38	-	2	***105***	-	-	-	-
	A5	***21***	11	-	-	1	-	***12***	3	-	6	-	***9***				
														-	-	-	-
Maori	B01	***79***	29	18	5	-	25	***77***	-	-	-	1	***1***	1	-	***1***	-
	B02	***16***	4	-	-	-	1	***5***	-	-	4	-	***4***	7	-	***7***	-
	B03	***20***	15	-	-	-	2	***17***	-	-	1	2	***3***		-	-	-
	B04	***36***	18	5	-	1	5	***29***	2	1	2	-	***5***	2	-	***2***	-
	B05	***54***	25	10	-	1	2	***38***	10	-	6	-	***16***	-	-	-	-
	B06	***27***	19	7	1	-	-	***27***	-	-	-	-	-	-	-	-	-
	B07	***18***	16	-	-	-	-	***16***	-	-	-	-	-	2	-	***2***	-
	C01	***133***	81	9	7	2	25	***124***	9	-	-	-	***9***	-	-	-	-
	C02	***92***	41	23	-	9	5	***78***	13	1	-	-	***14***	-	-	-	-
	C03	***17***	4	-	2	1	-	***7***	5	5	-	-	***10***	-	-	-	-
	C04	***24***	13	2	-	-	1	***16***	-	-	-	-	-	8	-	***8***	-
	C05	***7***	-	-	-	1	-	***1***	6	-	-	-	***6***	-	-	-	-
	C06	***8***	6	1	-	-	1	***8***	-	-	-	-	-	-	-	-	-
	C07	***46***	32	3	-	1	1	***37***	9	-	-	-	***9***	-	-	-	-
	C08	-															
	C09	***2***	1	-	-	1	-	***2***	-	-	-	-	-	-	-	-	-
	C10	***8***	8	-	-			***8***	-	-	-	-	-	-	-	-	-
Pacific	D1	***38***	21	11	-	3	1	***36***	2	-	-	-	***2***	-	-	-	-
	D2	***43***	33	-	-	6	1	***40***	1	-	-	-	***1***	2	-	***2***	-

Table 32 - Gambler new completed clients episode pathways summary continued

Service	*No. Clients*	B	BF	BFU	B+	BM	*B Total*	F	FU	F+	FM	*F Total*	U+	UM	*U Total*	Not reported
	N	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n
Alcohol and Drug F1	***7***	1	-	-	1	-	***2***	2	-	3	-	***5***	-	-	-	-
Total	***1795***	*409*	*143*	*24*	*33*	*95*	***704***	*564*	*149*	*56*	*131*	***900***	*98*	*87*	***185***	*3*

Note
The following categories were used to collapse the numerous data for this table and utilise the new standard recommended pathway (as at 1 July 2008) of: up to three brief, then up to eight full counselling (including up to three facilitation), then up to four follow-up sessions. Facilitation sessions were not separated out from counselling sessions as numbers were too small.

B includes up to three brief sessions only
BF includes up to three brief plus up to eight counselling or facilitation sessions
BFU includes up to three brief plus up to eight counselling or facilitation plus up to four follow-up sessions
B+ includes only brief sessions but more than three of them
BM includes an initial brief session then a mixture of brief, counselling, facilitation and follow-up sessions
F includes only up to eight counselling or facilitation sessions (including a maximum of three facilitation sessions in the last three sessions)
FU includes up to eight counselling or facilitation sessions (including a maximum of three facilitation sessions in the last three sessions) plus up to four follow-up sessions
F+ includes only counselling or facilitation sessions but more than eight of them
FM includes an initial counselling or facilitation session then a mixture of brief, counselling, facilitation and follow-up sessions
U+ includes only follow-up sessions (likely to be transferred clients)
UM includes an initial follow-up session then a mixture of brief, counselling, facilitation or follow-up sessions (likely to be transferred clients)

Table 33 - Significant other new completed clients episode pathways summary

Service		*No. clients*	B	BF	BFU	B+	BM	*B Total*	F	FU	F+	FM	*F Total*	U+	UM	*U Total*	Not reported
		N	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n
Mainstream	A1	452	11	6	4	-	2	23	274	28	11	47	360	43	26	69	-
	A2	206	42	26	2	-	12	82	75	21	21	4	121	2	-	2	1
	A4	38	-	-	-	-	-	-	19	5	-	-	24	14	-	14	-
	A5	5	2	-	-	-	-	2	1	-	1	-	2	1	-	1	
																-	-
Maori	B01	119	32	20	1	-	23	76	3	1	3	4	11	30	2	32	-
	B02	346	239	1	-	31	44	315	12	2	9	2	25	6	-	6	-
	B03	27	19	3	1	-	1	24	2	-	-	1	3	-	-	-	-
	B04	3	2	-	-	-	-	2	-	-	-	1	1	-	-	-	-
	B05	7	1	2	-	-	-	3	4	-	-	-	4	-	-	-	-
	B06	38	24	5	-	-	4	33	4	-	-	1	5	-	-	-	-
	B07	107	105	-	-	-	-	105	2	-	-	-	2	-	-	-	-
	C01	381	234	52	-	1	33	320	31	3	3	-	37	21	3	24	-
	C02	31	8	6	1	-	1	16	9	-	2	-	11	4	-	4	-
	C03	30	10	1	2	-	4	17	9	3	1	-	13	-	-	-	-
	C04	213	103	9	2	2	15	131	24	13	25	-	62	19	1	20	-
	C05	2	-	-	-	-	-	-	1	-	1	-	2	-	-	-	-
	C06	16	10	2	1	1	-	14	1	-	1	-	2	-	-	-	-
	C07	4	3	-	-	-	-	3	1	-	-	-	1	-	-	-	-
	C08	12	-	-	-	-	-	-	9	-	3	-	12	-	-	-	-
	C09	-															
	C10	-															
Pacific	D1	24	12	2	-	1	1	16	3	-	2	1	6	2	-	2	-
	D2	30	19	-	-	2	1	22	-	1	1	-	2	6	-	6	-

Table 33 - Significant other new completed clients episode pathways summary continued

Service	*No. clients*	B	BF	BFU	B+	BM	*B Total*	F	FU	F+	FM	*F Total*	U+	UM	*U Total*	Not reported
	N	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n
Alcohol and Drug F1	-															
Total	*2091*	*876*	*135*	*14*	*38*	*141*	*1204*	*484*	*77*	*84*	*61*	*706*	*148*	*32*	*180*	*1*

Note
The following categories were used to collapse the numerous data for this table and utilise the new standard recommended pathway (as at 1 July 2008) of: up to three brief, then up to eight full counselling (including up to three facilitation), then up to four follow-up sessions. Facilitation sessions were not separated out from counselling sessions as numbers were too small.

B includes up to three brief sessions only
BF includes up to three brief plus up to eight counselling or facilitation sessions
BFU includes up to three brief plus up to eight counselling or facilitation plus up to four follow-up sessions
B+ includes only brief sessions but more than three of them
BM includes an initial brief session then a mixture of brief, counselling, facilitation and follow-up sessions
F includes only up to eight counselling or facilitation sessions (including a maximum of three facilitation sessions in the last three sessions)
FU includes up to eight counselling or facilitation sessions (including a maximum of three facilitation sessions in the last three sessions) plus up to four follow-up sessions
F+ includes only counselling or facilitation sessions but more than eight of them
FM includes an initial counselling or facilitation session then a mixture of brief, counselling, facilitation and follow-up sessions
U+ includes only follow-up sessions (likely to be transferred clients)
UM includes an initial follow-up session then a mixture of brief, counselling, facilitation or follow-up sessions (likely to be transferred clients)

Table 34 - Gambler client Total Dollars Lost

Service		No. clients	No. initial assessments	Median initial Total Dollars Lost[#]	No. follow-up assessments	Median difference in Total Dollars Lost [†]
		N	N	$	N	$
Mainstream	A1	1494	584	1000	191	-390
	A2	740	585	700	224	-308
	A4	216	216	420	170	-225
	A5	42	16	430	2	433
Maori	B01	239	173	500	82	-305
	B02	72	2	900	-	
	B03	35	8	435	-	
	B04	70	15	70	5	0
	B05	59	8	200	-	
	B06	58	-			
	B07	18	-			
	C01	195	8	450	4	308
	C02	176	38	287.5	11	0
	C03	67	10	400	-	
	C04	95	14	0	2	3
	C05	26	2	300	-	
	C06	27	17	93	11	-175
	C07	61	2	280	-	
	C08	20	13	600	1	0
	C09	12	1	320	-	
	C10	8	-			
Pacific	D1	98	37	500	3	-22
	D2	63	7	600	1	0
A and D	F1	58	9	400	2	20
Total		*5535*	*1785*	*620*	*709*	*-250*

[#] Initial Total Dollars Lost score was recorded for the first assessment for each client regardless of when the assessment occurred (e.g. the assessment could have been before the time frame of analysis and not necessarily in the first counselling session)

[†]Follow-up Total Dollars Lost score used in the analysis was the most recently recorded Total Dollars Lost score

Table 35 - Gambler client Control over Gambling

Service		No. clients	No. initial assessments	Average initial Control over Gambling score[#]	No. follow-up assessments	Average difference in Control over Gambling score[†]
		N	N		N	
Mainstream	A1	1494	1042	2.76	303	-0.49
	A2	740	595	2.96	225	-0.76
	A4	216	215	2.50	142	-0.94
	A5	42	15	3.07	3	-0.33
	B01	239	172	2.81	85	-1.34
Maori	B02	72	-			
	B03	35	8	3.25	-	
	B04	70	8	2.63	1	0.00
	B05	59	-			
	B06	58	-			
	B07	18	-			
	C01	195	6	3.50	2	0.00
	C02	176	29	2.48	3	-0.33
	C03	67	13	2.46	-	
	C04	95	16	1.56	4	-0.75
	C05	26	-			
	C06	27	15	2.67	7	-0.29
	C07	61	-			
	C08	20	12	3.08	1	0.00
	C09	12	1	3.00	-	
	C10	8	-			
	D1	98	31	3.00	1	0.00
Pacific	D2	63	-			
	F1	58	28	2.43	2	0.00
A and D						
Total		*5535*	*2206*	*2.78*	*779*	*-0.73*

[#] Initial Control over Gambling score was recorded for the first assessment for each client regardless of when the assessment occurred (e.g. the assessment could have been before the time frame of analysis and not necessarily in the first counselling session)

[†]Follow-up Control over Gambling score used in the analysis was the most recently recorded Control over Gambling score

Table 36 - Gambler client SOGS-3M scores

Service		No. clients	No. initial assessments	Average initial SOGS-3M score[#]	No. follow-up assessments	Average difference in SOGS-3M score[†]
		N	N		N	
Mainstream	A1	1494	1243	8.84	376	-1.88
	A2	740	581	9.04	212	-3.67
	A4	216	216	6.24	140	-4.20
	A5	42	16	8.81	2	-2.50
	B01	239	176	8.52	83	-5.89
Maori	B02	72	0	-	-	-
	B03	35	8	11.38	0	-
	B04	70	28	7.21	1	-4.00
	B05	59	28	5.93	2	6.00
	B06	58	29	3.72	6	-0.05
	B07	18	0	-	-	-
	C01	195	10	7.80	4	-4.00
	C02	176	24	11.04	5	-7.80
	C03	67	61	9.33	29	-4.66
	C04	95	36	5.50	6	-5.50
	C05	26	17	10.88	2	6.00
	C06	27	14	11.43	3	-8.33
	C07	61	2	8.00	0	-
	C08	20	13	9.46	0	-
	C09	12	1	11.00	0	-
	C10	8	0	-	-	-
	D1	98	33	10.79	3	0.67
Pacific	D2	63	11	6.18	0	-
A and D	F1	58	35	8.49	4	0.00
Total		*5535*	*2582*	*8.57*	*878*	*-3.19*

[#] Initial SOGS-3M score was recorded for the first assessment for each client regardless of when the assessment occurred (e.g. the assessment could have been before the time frame of analysis and not necessarily in the first counselling session)

[†]Follow-up SOGS-3M score used in the analysis was the most recently recorded SOGS-3M score

Table 37 - Significant other client Family Checklist scores

Service		No. clients	No. initial assessments	Median initial Family Checklist [#]	No. follow-up assessments	Median difference in Family Checklist [†]
		N	N		N	
Mainstream	A1	452	355	9.66	78	-2.60
	A2	206	128	10.39	13	-0.15
	A4	38	36	9.17	21	-5.81
	A5	5	2	4.50	-	
Maori	B01	119	80	6.71	22	-5.09
	B02	344	-			
	B03	26	-			
	B04	2	-			
	B05	7	2	5.50	-	
	B06	37	-			
	B07	107	7	0.29	-	
	C01	383	2	9.50	-	
	C02	31	9	11.11	-	
	C03	31	24	10.13	11	-6.27
	C04	214	85	5.51	3	2.67
	C05	2	-			
	C06	17	5	6.60	-	
	C07	4	-			
	C08	12	8	9.50	-	
	C09	-	-			
	C10	-	-			
Pacific	D1	24	7	10.43	1	-10.00
	D2	30	1	14.00	-	
A and D	F1	-	-			
Total		*2091*	*751*	*8.88*	*149*	*-3.42*

[#] Initial Family Checklist score was recorded for the first assessment for each client regardless of when the assessment occurred (e.g. the assessment could have been before the time frame of analysis and not necessarily in the first counselling session)

[†]Follow-up Family Checklist score used in the analysis was the most recently recorded Family Checklist score

Table 38 - Significant other client Family Coping scores

Service		No. clients	No. initial assessments	Median initial Family Coping [#]	No. follow-up assessments	Median difference in Family Coping [†]
		N	N		N	
Mainstream	A1	452	151	2.24	29	-0.55
	A2	206	73	2.07	8	-0.13
	A4	38	-			
	A5	5	-			
Maori	B01	119	31	1.19	9	0.11
	B02	344	-			
	B03	26	-			
	B04	2	-			
	B05	7	-			
	B06	37	-			
	B07	107	-			
	C01	383	-			
	C02	31	2	2.50	-	
	C03	31	-			
	C04	214	51	1.39	3	-0.33
	C05	2	-			
	C06	17	2	1.00	-	
	C07	4	-			
	C08	12	7	2.43	1	-1.00
	C09	-				
	C10	-				
Pacific	D1	24	-			
	D2	30	-			
A and D	F1	-				
Total		*2091*	*317*	*1.96*	*50*	*-0.36*

[#] Initial Family Coping score was recorded for the first assessment for each client regardless of when the assessment occurred (e.g. the assessment could have been before the time frame of analysis and not necessarily in the first counselling session)

[†]Follow-up Family Coping score used in the analysis was the most recently recorded Family Coping score

Table 39 - Significant other client Family Gambling Frequency scores

Service		No. clients	No. initial assessments	Median initial Family Gambling Frequency [#]	No. follow-up assessments	Median difference in Family Gambling Frequency [†]
		N	N		N	
Mainstream	A1	452	152	3.13	25	-1.12
	A2	206	67	2.79	8	0.00
	A4	38	-			
	A5	5	-			
Maori	B01	119	29	1.66	9	0.11
	B02	344	-			
	B03	26	-			
	B04	2	-			
	B05	7	-			
	B06	37	-			
	B07	107	-			
	C01	383	-			
	C02	31	-			
	C03	31	-			
	C04	214	45	2.73	3	1.00
	C05	2	-			
	C06	17	3	1.33	-	
	C07	4	-			
	C08	12	9	2.78	1	1.00
	C09	-				
	C10	-				
Pacific	D1	24	-			
	D2	30	-			
A and D	F1	-				
Total		*2091*	*305*	*2.83*	*46*	*-0.50*

[#] Initial Family Gambling Frequency score was recorded for the first assessment for each client regardless of when the assessment occurred (e.g. the assessment could have been before the time frame of analysis and not necessarily in the first counselling session)

[†]Follow-up Family Gambling Frequency score used in the analysis was the most recently recorded Family Gambling Frequency score

Table 40 - New gambler client average initial SOGS-3M scores by referral type

Referral type	Number	SOGS-3M score
Gambling venue	222	5.20
Self	744	7.62
Justice system	312	8.35
Friend	147	8.63
Other	197	8.72
Media	335	8.83
Family/relative	313	9.24
Other agency	273	9.62
Helpline	718	9.69
Unknown/Not reported	48	9.77
Ex-client	335	9.83
Phone book	504	10.22
Alcohol and Drug	75	10.28