Statewide Gambling Therapy Service

2014-2015 Annual Report

World leaders in gambling therapy

Government
of South Australia

SA Health

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Statewide Gambling
Therapy Service

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World leaders in gambling therapy

"Chase your dreams, not your losses"

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Department for Communities
and Social Inclusion

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Message from the Director

As I write this message, I look back on another constructive year for the Statewide Gambling Therapy Service of which the team has done an incredible job at improving the lives of people affected by problem gambling.

This year we saw the departure of our former manager, Professor Peter Harvey and we welcomed our new business manager Eleni Labadas. With this change, we sought the opportunity to review our strategic plan and look at the best ways in which we can raise community awareness about the impacts of problem gambling and access to our evidence-based service.

We continue to provide training and support to other Gambling Help and Mental Health Services across South Australia through our Stepped Care Training Program and we maintain our collaborative working relationship with our key partner, the Flinders University.

This year we saw the completion of the *"Problem gambling treatment pilot with prisoners"* project which has led to further work in prison settings. We also started the *"Significant others support group"* for family members or close friends affected by someone with a gambling problem.

We continue to strive for excellence in the treatment of problem gambling and we look forward to continuing to support and provide service to the people of South Australia.

Professor Malcolm Battersby

Professor and Head of Psychiatry
Faculty of Medicine, Nursing and Health Sciences
Flinders University

Director
Flinders Human Behaviour and Health Research Unit

Director
Statewide Gambling Therapy Service

1. Executive summary

1.1 Overview of problem gambling

Problem gambling is a significant public health issue in Australia costing up to $12 billion per year. It is estimated that around 3.1% of South Australians have either borderline or problem gambling. Problem gambling is associated with significant financial consequences, psychological and social impairment and poor health[8]. The term 'problem gambling' is used in the Australian context to describe harms associated with difficulties in limiting time and or money spent on gambling[9]. Electronic gaming machines have typically been the most common form of problematic gambling, however a new age of online wagering and sports betting raises growing concerns for future impacts on the community.

Problem gambling is associated with high levels of shame and stigma which results in many people choosing not to seek help. Problem gambling (or pathological gambling as it is otherwise referred to) is classified as a Gambling Disorder, an addiction in the DSM5 (Diagnostic and Statistical Manual for Mental Disorders)[8]. Therefore, like other addictions, a non-judgemental and empathetic approach when identifying people in need of help should be adopted.

There are a variety of treatment methods and cognitive and behavioural approaches that have been shown to reduce problem gambling in the short and long term[9]. Statewide Gambling Therapy Service (SGTS) uses an evidence-based Cognitive Behavioural Therapy (CBT) model which has been proven as highly effective in the treatment of problem gambling.

1.2 About SGTS

Our service

SGTS is a free community-based service funded by the Gambling Rehabilitation Fund which is administered by the Office for Problem Gambling. The purpose of the service is to assist people in overcoming gambling problems. SGTS's head office is located at the Flinders Medical Centre and the service is managed through the Southern Adelaide Local Health Network (SALHN). The service is headed by the Director of SGTS and the Flinders University Human Behaviour and Health Research Unit, Professor Malcolm Battersby. SGTS has three clinics in Adelaide located at the Flinders Medical Centre (Bedford Park), Port Adelaide and Salisbury.

SGTS has been helping South Australians beat problem gambling for more than fifteen years. Treatment is available for all kinds of gambling including electronic gaming machines (pokies), TAB, Keno, sports betting, card games and online gambling. The program is generally made up of four to twelve one-on-one therapy sessions with a highly qualified cognitive behavioural therapist. High therapy standards are ensured through a regular, structured supervision program managed by Professor Malcolm Battersby. The number of treatment sessions vary depending on the person's need and circumstances. In addition to one-on-one sessions, SGTS offers a hospital stay in-patient program as well as support groups for close friends and family members affected by problem gambling.

The therapy

Cognitive Behavioural Therapy (CBT) is a reserach-based therapy which focuses on identifying unhelpful thought patterns (cognitions) and reinforcing behaviours and retrains the person to respond in a different way. SGTS's CBT program is a unique model specifically for gambling addiction developed over fifteen years through research by Flinders University and SGTS. SGTS's CBT model has been evidenced as highly effective in the treatment of problem gambling[10]. The SGTS CBT program unlike other forms of CBT focuses on the urge to gamble. It aims to eliminate the urge or compulsion to gamble, and helps people to identify unhelpful thoughts and manage these through thought restructuring.

To maintain the quality assurance of the service and ensure the continued delivery of an evidence-based CBT model specific for problem gambling, SGTS works in a collaborative partnership with the Flinders University Gambling Research Centre and Masters of Cognitive Behavioural Therapy program. The therapy is constantly refined to improve its effectiveness and new practitioners are trained to apply the therapy adhering strictly to the CBT model. This collaboration and high standard of practice sets SGTS apart as a centre of excellence and world leader in evidence-based CBT for problem gambling.

SGTS service model

SGTS's treatment model is unique as it uses integrated CBT that unifies a cognitive and behavioural approach to treat problem gambling. The cognitive element addresses the common erroneous thoughts gamblers have around the odds of winning, randomness and the belief that skills can influence outcomes[11]. The behavioural element uses a graded exposure technique that reduces the individuals urge to gamble[11]. SGTS's treatment program includes a robust follow-up relapse prevention phase aimed at reducing relapse rates. Clients are followed up for up to thirty-six months which is an important phase of the program given that gambling is typically a relapsing condition[5].

Service outcomes are continuously improved by the established triad of research, clinical service and teaching. Each influences the other to deliver improved outcomes for clients. The key to achieving our remarkable research and clinical outcomes is that all clients enroll in an ethically approved outcome data collection system. Ethics approval is granted and governed by the Southern Adelaide Clinical Human Research Ethics Committee (SACHREC). This enables longitudinal data collection to measure change in outcome over time.

The model is supported by an active quality improvement process. It is continuously assessed by the Flinders Gambling Research Centre for its effectiveness and the model subjected to improvement. As a result, a number of peer review articles have been published supporting its validity and effectiveness in treating problem gambling. SGTS also invests in the education of cognitive behavioural therapists who deliver treatment to those with problem gambling. SGTS offers clinical placements to students from the Flinders University Masters in Cognitive Behavioural Therapy Program and provides specialised practical training in its unique CBT model. This approach to CBT makes SGTS a centre of excellence in the treatment of problem gambling.

Quality assurance
(academic review of model)

CBT treatment
(quality service delivery)

World leading
evidence-based CBT
model for problem
gambling

Community engagement
(raising awareness)

Industry Investment
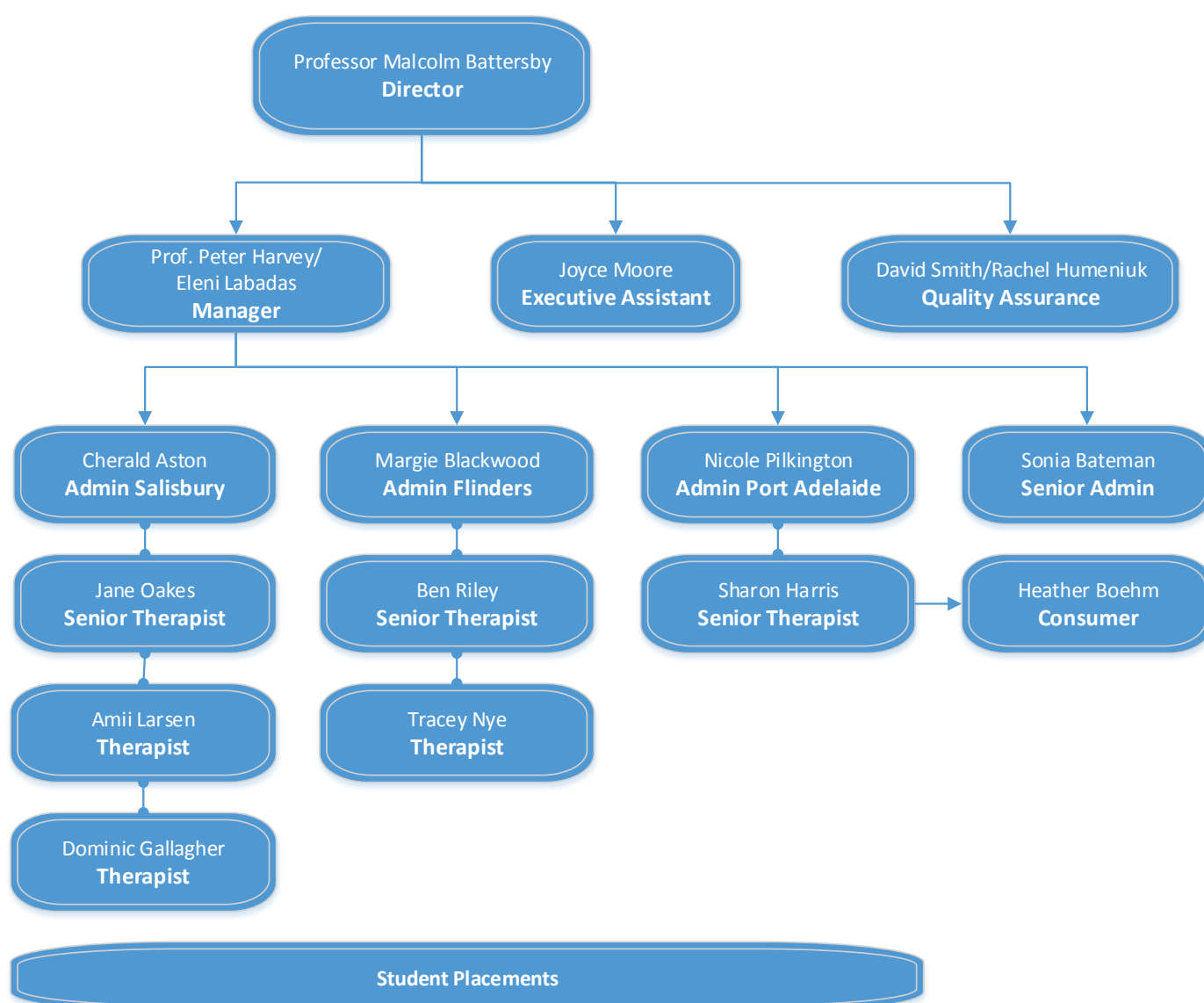(development of CBT experts &
industry education)

Our vision and goals

Vision: To be world leaders in gambling therapy

2013 to 2015 Strategic goals

> Provide access to evidence-based CBT for people with problem gambling.

> Deliver training and support to Gambling Help Service providers and Mental Health Services.

> Support research in the area of CBT for the treatment of problem gambling.

Our structure

Professor Malcolm Battersby
Director

Prof. Peter Harvey/
Eleni Labadas
Manager

Joyce Moore
Executive Assistant

David Smith/Rachel Humeniuk
Quality Assurance

Cherald Aston
Admin Salisbury

Margie Blackwood
Admin Flinders

Nicole Pilkington
Admin Port Adelaide

Sonia Bateman
Senior Admin

Jane Oakes
Senior Therapist

Ben Riley
Senior Therapist

Sharon Harris
Senior Therapist

Heather Boehm
Consumer

Amii Larsen
Therapist

Tracey Nye
Therapist

Dominic Gallagher
Therapist

Student Placements

1.3. Service and clinical outcomes

In the 2014-15 financial year SGTS provided services to 718 people across South Australia. Most of the clients who attended SGTS for gambling therapy self-referred. Clients were either drop in referrals who found out about the service via their own contact network or engaged with the service after a recommendation from the Gambling Helpline. Of the 718 people engaged, 276 (38.4%) were gamblers who were provided with epiosdes of care, 343 (47.8%) were in follow up treatment, and 39 (5.4%) were non-gamblers provided with face to face therapeutic support. Sixty people (8.4%) failed to attend their initial appointment. Of the 315 new clients (276 gamblers, 39 non-gamblers), 147 (46.7%) did so at the Flinders Medical Centre, 92 (29.2%) at the Salisbury clinic and 76 (24.1%) at the Port Adelaide clinic. Sixteen clients were treated in the in-patient program.

An analysis of patient outcomes showed significant reductions in psychological distress caused by gambling and marked improvements in functional capacity. A review of treatment goals set by clients showed that 92% (172) of clients who set treatment goals successfully achieved them. Recovery outcomes were measured using the Victorian Gambling Scale (VGS) and this found that 71% of 128 clients recovered from their problem gambling disorder moving from above to below the problem gambling cut off score.

In addition to service provision, SGTS continued to roll out the Stepped Care Training Program for Gambling Help Service providers and Mental Health Services. Educative sessions were provided to fifteen organisations across South Australia and a total of 208 attendees participated.

SGTS supported the Flinders Masters of Cognitive Behavioural Therapy program by providing placements for students completing their qualifications. SGTS provided supervision to three students, one of whom was offered a position with the organisation.

All SGTS clients are asked to consent to ongoing outcome data collection. All research is part of the SGTS quality improvement framework so that new interventions or models of care are tested before they are implemented into routine practice. This year in collaboration with the Flinders Gambling Research Centre, a number of scientific publications in peer review journals were produced. These internationally recognised publications provide evidence and support for SGTS's CBT program and its therapeutic benefits to problem gamblers. Four articles of relevance are highlighted as key achievements:

> Cognitive therapy versus exposure therapy for problem gambling, (2015) in *The Journal of Behaviour Research and Therapy*. D. Smith, M. Battersby, P. Harvey, R. Pols & R. Ladouceur.

> The role of homework in exposure-based CBT for problem gambling, (2015) *The International Gambling Studies Journal*. B. Riley.

> Problem gambling among a group of male prisoners, lifetime prevalence and association with incarceration, (2014) *The Australian and New Zealand Journal of Criminology*. B. Riley & J. Oakes.

> Problem gambling, family violence and alcohol misuse: exploring the triad for treatment-seekers, (2015) *The International Gambling Studies Journal*. Authors: T. Lavis, P. Harvey, M. Battersby & D. Smith.

Achieving our KPIs

Goal	Outcome
Provide access to evidence-based CBT for people with problem gambling	*Successfully achieved*
Deliver training and support to Gambling Help Service providers and Mental Health Services	*Successfully achieved*
Support research in the area of CBT for the treatment of problem gambling in collaboration with Flinders Gambling Research Centre	*Successfully achieved*

The facts – Did you know?

Interesting facts extracted from the Productivity Commission into gambling in 2010[9]:

Electronic Gaming Machines (EGMs) in pubs and hotels

> EGMs have remained the dominant segment of the gambling industry over the last decade in terms of expenditure and tax revenue.

> In 2009 Australia had 197,820 EGMs (13,294 more than in 1999).

> State-wide caps were part of broader regulatory changes designed to limit EGM numbers.

> South Australia has a policy to reduce EGM numbers by 3,000 over a phased approach.

Low numbers of problem-gamblers seek help

> Only a small proportion of people experiencing problems with their gambling seek professional help. In Australia, it is estimated that about 8% to 17% of people with problem gambling seek help.

> Most clients of help services have either 'hit rock bottom' or are coming close.

> Social stigma associated with having a problem, denial of a problem or believing they can handle it themselves, are the main reasons why gamblers do not seek professional help.

> Low rates of help-seeking by people experiencing problems with gambling are not unique to Australia.

2. Statistics

2.1 Demographics

Of the 315 clients (276 gamblers, 39 non-gamblers) who were provided with episodes of care, the proportion of males to females was 60% and 40% respectively (refer Figure 1).
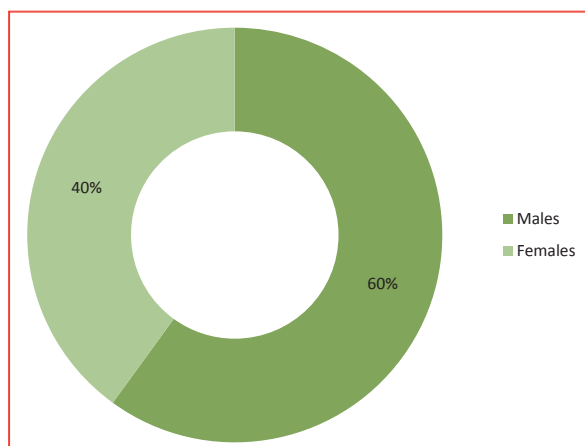

Figure 1: Gender

Approximately 39.6% of clients were married or living with a partner and 22.6% were either separated or divorced (refer Figure 2).
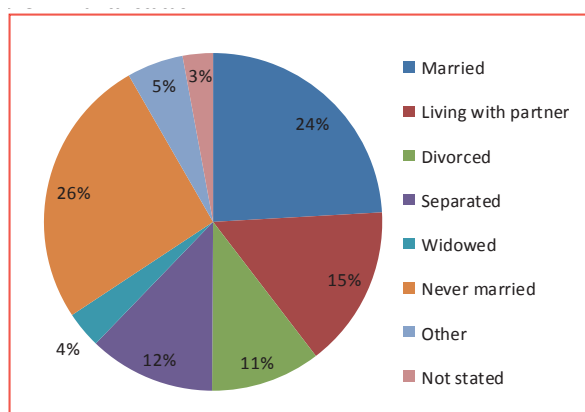

Figure 2: Marital Status

Approximately 48.9% of clients were in paid employment and 30.5% unemployed or on disability support (refer Figure 3).
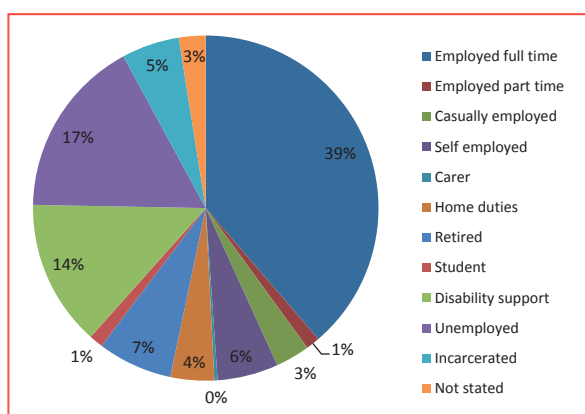

Figure 3: Work Status

2.2 Referral source

About 50% of clients were made aware of the service through either a friend or family member, their health professional or the Gambling Helpline (refer Figure 4). For those who self-referred (12%), approximately three quarters had found out about the service through the SGTS website.
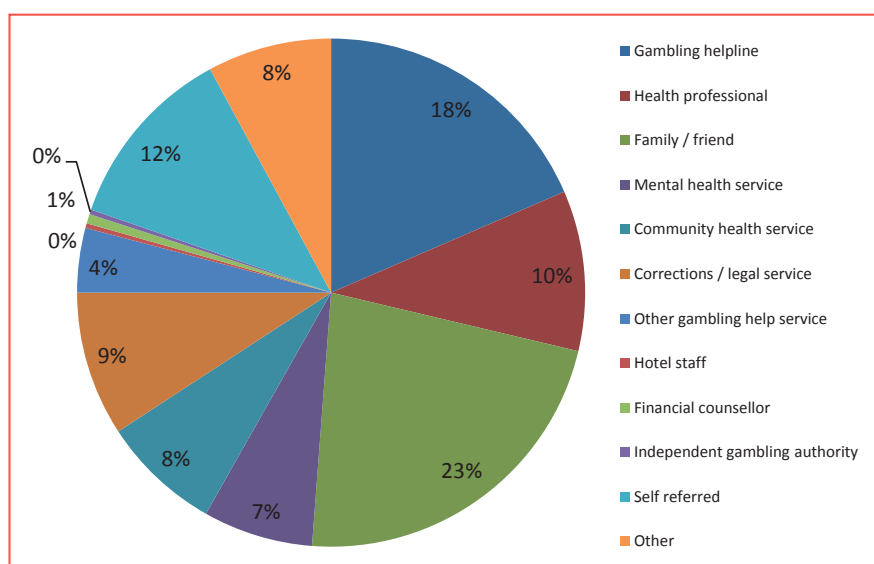

Figure 4: Referral Source

2.3 Main gambling type

Electronic gaming machines (pokies) continue to dominate the gambling activity type with three quarters of clients (75%) stating that pokies was their main gambling type. Horse and greyhound racing was the second largest gambling activity (13%). Other gambling activities such casino, sports betting, keno, card games or multiple forms made up the remaining gambling activity types (refer Figure 5).
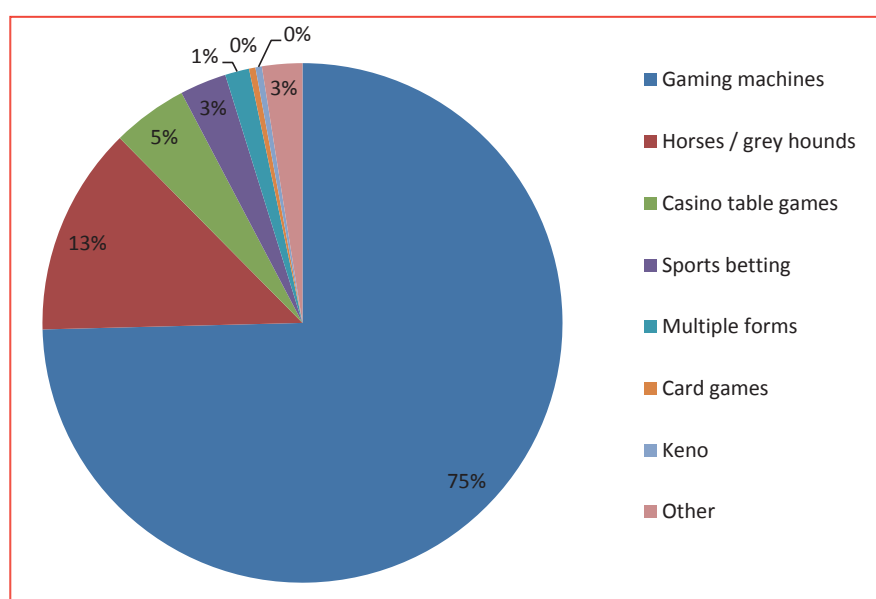

Figure 5: Main Gambling Type

2.4 Gambling severity

The Problem Gambling Severity Index (PGSI) is a nine-item scale aimed at assessing the severity of problem gambling[3]. The PGSI is a valid and reliable tool for discriminating recreational gamblers from problem gamblers[3]. Each of the nine items is rated on a four-point scale ranging from 0 (never) to 4 (almost always) with total scores ranging from 0 to 27. Total scores are used to assign gamblers to one of four gambler categories. The PGSI was administered to all clients at their initial screening to obtain an indication of gambling severity and the large majority of clients (90.5%) were classified as problem-gamblers (refer Table 1).

Table 1: PGSI Categories

PGSI Score	Gambler type	Percentage of Clients
0	Non-gambler	3.17%
1 – 2	Low-risk gambler	0.78%
3 – 7	Moderate-risk gambler	5.55%
>7	Problem-gambler	90.5%
		100%

The role of family and friends

Family and friends play a significant role

The Productivity Commission from 2010 states the following findings on the role of family and friends[10]:

> Client data on referrals to counselling services showed that family, friends and neighbours are an important referral source to gambling help services.

> Friends and family take an active role in helping participants stop or control their gambling.

> In a Victorian longitudinal study of problem gamblers, families, friends and service providers, the majority of problem gamblers stated that their families were aware of their gambling problems, although they were not aware of the extent of the problems.

3. Performance outcomes

All clients who commenced a treatment program through SGTS were provided with an initial assessment to allow understanding of the psychological and social factors and severity of their disorder. A number of well researched tools (brief questionnaires) were used at the initial assessment to obtain baseline measures. In addition, data relating to gambling behaviour such as time spent gambling, money spent and frequency of play was collected as these are some of the most reliable and valid measures. These measures were taken again at several points throughout treatment, at the completion of treatment and where possible at follow-up post treatment. This allows the service to assess the therapeutic benefit of treatment and the effectiveness of the treatment model. The areas covered in this report are:

> Level of psychological distress
> Level of functional capacity impairment
> Gambling severity
> Time spent thinking about gambling
> Confidence in gambling control
> Achievement of treatment goals.

Of the 276 gamblers who entered into CBT treatment, 222 (80%) completed their treatment. Forty (14.5%) were still in treatment and 14 (5.5%) chose to withdraw from the program. Data for this section relates only to the 222 clients who completed treatment.

Overall recovery rates

A high proportion of clients achieved their treatment goals and showed significant improvements in problem gambling related symptoms. As noted earlier, problem gambling is classified as an addiction in the DSM5 and therefore it is important to summarise recovery on a range of outcomes. For this purpose, SGTS used the VGS, WSAS and K10 given that they measure psychological aspects of problem gambling and are useful for assessing levels of change based on validated cut-off scores. Table 2 presents the proportion of recovery rates from pre-treatment to post-treatment.

Recovery Rate Summary*

Recovery rates (VGS): 71% of clients recovered from their problem gambling disorder
Recovery rates (WSAS): 79% of clients had full functional capacity post treatment.
Recovery rates (K10): 69.7% of clients showed low to moderate levels of distress.

Table 2: VGS, WSAS and K10 summary

VGS		
Category	Pre treatment	Post treatment
< 21 (non-problem gambler)	11.7%	71.1%
>21 (problem gambler)	88.3%	28.9%
Totals	100%	100%
WSAS		
Category	Pre treatment	Post treatment
< 10 (subclinical population)	40%	79%
>10 (significant to moderately severe functional impairment)	60%	11%
Totals	100%	100%
K10		
Category	Pre treatment	Post treatment
10 – 21 (low to moderate psych distress)	24.6%	69.7%
22 - 50 (high to very high psych distress)	75.4%	30.3%
Totals	100%	100%

* Based on sample sized 128 = number of clients who completed pre- and post- questionnaires

3.1 Level of psychological distress

The Kessler Psychological Distress Scale (K10) is a brief ten-item questionnaire measuring non-specific psychological distress in the anxiety-depression spectrum[4]. The K10 has been widely used for public health surveys in Australia and recommended as a simple measure of outcome following treatment[1]. This scoring range is widely used in primary health care for mental illness to assess symptom severity and treatment effectiveness[6] (refer Table 3). Eighty percent of people scoring above twenty-nine are likely to be diagnosed with a mental disorder such as depression or an anxiety disorder[4].

Table 3: K10 Scoring Categorisation

K10 Score	Level of psychological distress
10 – 15	Low level
16 – 21	Moderate level
22 – 29	High level
30 – 50	Very high level

At the commencement of treatment the client K10 mean score was 29.07 which is within the high level of psychological distress. Post treatment the client mean score dropped significantly to moderate levels of 18.39 (refer Table 4). This is a 37% reduction in psychological distress for clients who completed treatment.

Table 4: Level of psychological distress

Level of psychological distress		
Point of treatment	Average score	Range
Commencement	29.07 (n=268)	10 – 50
Completion	18.39 (n=123)	

3.2 Level of functional capacity impairment

The Work and Social Adjustment Scale (WSAS) is a reliable, validated and simple scale that measures self-reported functional impairment attributable to an identified problem[7]. It has been widely used to assess the level of disability, symptom severity and improvement with treatment for people with mental illnesses such as depression, anxiety and obsessive compulsive disorders[2].

The WSAS is a five-item scale that assesses the person's ability to perform everyday activities including work, home management, family and relationship interactions and social and private leisure activities[2]. Each of the five items is rated on a nine-point scale ranging from 0 (not at all a problem) to 8 (very severely impaired) with higher scores indicating a higher level of disability[2].

At initial assessment the client WSAS mean score was 15.58 and reduced to 5.47 post treatment (refer Figure 6). This shows a 65% improvement in overall functional capacity for clients who completed treatment.
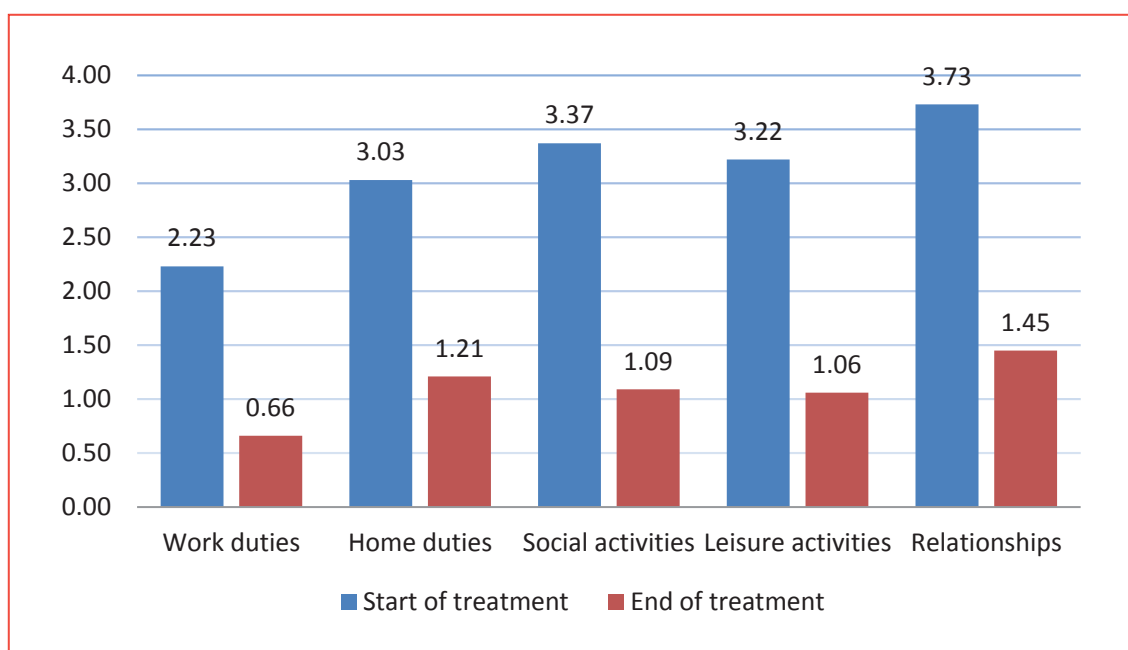

Figure 6: Functional capacity impairment

3.3 Gambling Severity

The Victorian Gambling Severity Scale (VGS) is a reliable outcome measure of problem gambling. This self-rated tool was developed and validated in Australia[10]. The VGS is a fifteen-item scale that assesses a person's experiences with gambling over the previous four week period. Each of the fifteen items is rated on a five-point scale ranging from 0 (never) to 4 (always). The lowest possible score is 0 and the highest possible score is 60. Scores over 21 identifies a person as a problem gambler[10].

At the commencement of treatment the VGS found that 88.3% of clients were identified as problem gamblers. This reduced to 28.9% at the end of treatment (these outcomes are based on a sample size of 128 being the total number of clients who completed a post treatment VGS questionnaire).

3.4 Time spent thinking about gambling

How much time a client spent thinking about gambling was measured using a self-rating scale in response to the question *"Over the last fortnight, how much time would you say you spent thinking about gambling?"* Responses were measured on a scale of 1 to 5 where '1' indicated none of the time and '5' indicated all of the time. At the commencement of treatment 70% of clients reported they had been thinking about gambling either some, most, or all of the time. Only 8.7% indicated that they had spent no time thinking about gambling. At the completion of treatment there was a significant drop in the time spent thinking about gambling with only 21.6% of clients reporting they had been thinking about gambling some, most, or all of the time. A total of 32.4% of clients reported that they spent no time thinking about gambling at all (refer Figure 7).
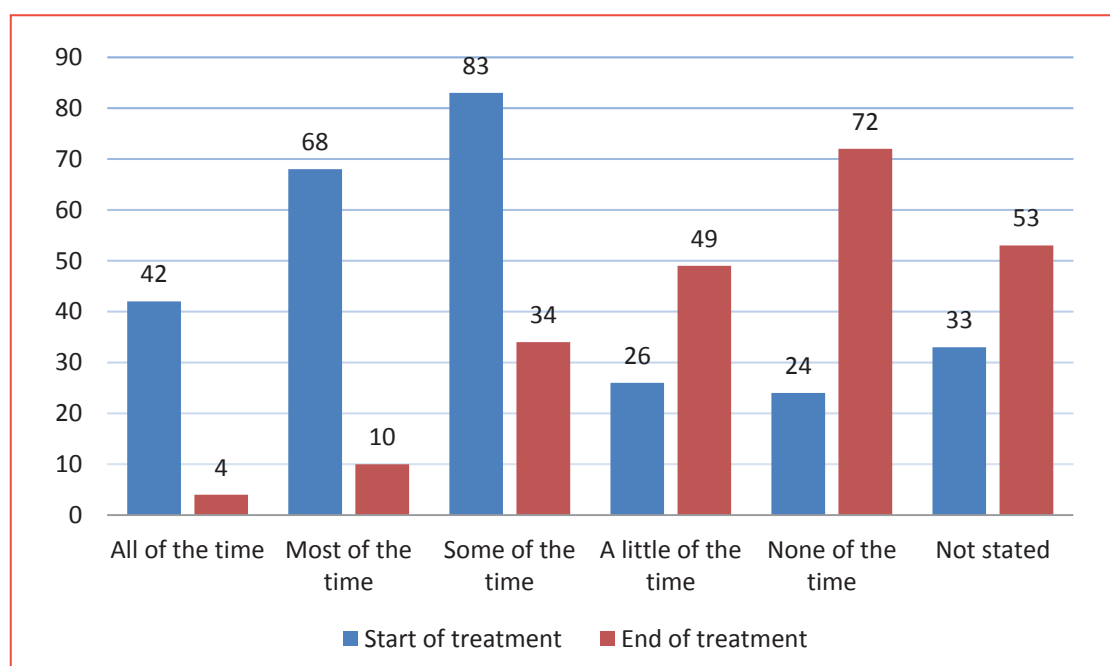

Figure 7: Time spent thinking about gambling

3.5 Confidence in gambling control

How confident a client feels about their level of gambling control was measured using a self-rating scale in response to the question *"How confident do you feel that you are currently in control of your gambling?"* Responses were measured on a scale of 1 to 10 where '1' indicated no confidence at all and '10' indicated extreme confidence. At the commencement of treatment the client mean score was 2.69. This increased significantly to 7.45 by the end of treatment showing a significant improvement in the client's perception of control over gambling behaviour (refer Table 5).

Table 5: Confidence in Gambling Control

Confidence in gambling control		
Point of treatment	Average score	Range
Commencement	2.69 (n=114)	1 – 10
Completion	7.45 (n=110)	1 (Low) – 10 (High)

3.6 Achievement of treatment goals

SGTS collects information on how successful a client has been in reaching their personal treatment goals. Goals are set early in the treatment program and re-evaluated at the client's final treatment session. Achievement of personal goals helps to assess whether or not the client has been successful in overcoming their urge to gamble. Of the clients who set treatment goals (n= 187) as part of their treatment plan 92% successfully partially or fully reached their goals (refer Figure 8).
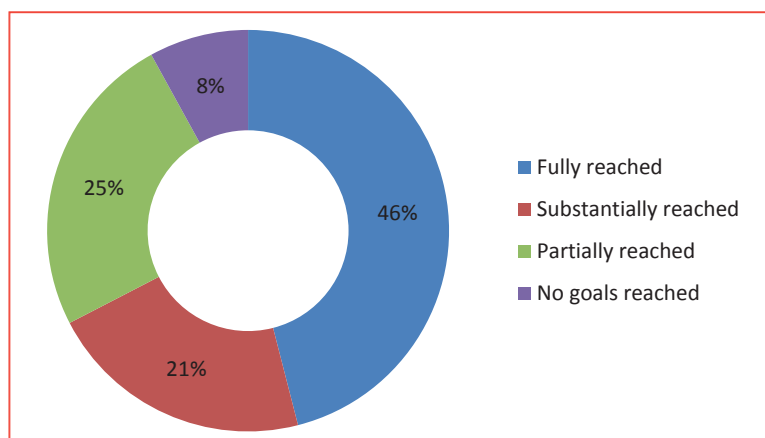

Figure 8: Treatment goals achieved

Special project on offenders in SA

Previous research has indicated that male prisons have the highest rate of problem gambling yet found in any population however there is a lack of research in the area of female prisoners and Aboriginal or Torres Strait Islander prisoners. In the 2015 financial year SGTS conducted a project targeted at male and female prisoners across South Australia. The project was funded by the Department for Correctional Services and supported by the Office for Problem Gambling. There were two aims of the project, to provide CBT to a range of prisoners in various prisons across South Australia and to investigate the lifetime prevalence of problem gambling among a group of prisoners.

Provision of CBT

A CBT program was delivered to 21 prisoners (18 males and 3 females) across Mobilong Prison, Adelaide Women's Prison, the Cadell Training Centre and the Adelaide Pre-release Centre. Results showed that the program was successful in reducing gambling urges, improving psychological well-being and increasing self-efficacy.

Prevalence study

A survey was conducted with 105 incarcerated male prisoners in South Australia. Data revealed lifetime gambling prevalence rates of 52% and 1 in 5 males reported that their current imprisonment was due to a gambling problem. This study will be expanded in 2015 to 369 male and female prisoners.

This project was led by Cognitive Behavioural Therapist Ben Riley and the results are in the process of being prepared for publication.

4. Plans for 2015 -16

As a result of a strategic planning session, the SGTS team identified two strategic goals for focus in the next financial year.

> Increase awareness of SGTS's evidence-based CBT program across the community.

> Continue to be a leader in the delivery of evidence-based CBT for problem gambling.

In order to achieve these goals, SGTS has committed to the following activities:

Strategic goal	Deliverables
Goal 1 *Increase awareness of SGTS's CBT program across the community*	1. Publish a suite of marketing materials 2. Revise the business brand 3. Complete website review and upgrade 4. Increase awareness through media channels 5. Increase awareness through information forums 6. Strategic response to spontaneous marketing opportunities
Goal 2 *Be a leader in the delivery of evidence-based CBT for problem gambling*	1. Continue best practice evidence-based service provision 2. Continue delivery of training program 3. Continue mentoring and support to MHS/GHS providers 4. Support the Masters of Mental Health Sciences program 5. Participate in outcome-based research and special projects

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For more information

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Government
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