Alberta Gambling Research Institute   Alberta Gambling Research Institute

2005-06-06

Improved Client Outcome Services Project: An Intervention with Non-Benefiting Clients of Problem Gambling Treatment

Mintoft, Bridget; Bellringer, Maria E.; Orme, Cynthia

eCOMMUNITY: International Journal of Mental Health & Addiction

Improved Client Outcome Services Project:
An Intervention with Non-Benefiting Clients
of Problem Gambling Treatment

Bridget Mintoft
Dept. of Health Psychology,
Faculty of Medicine and Health Sciences,
University of Auckland, New Zealand

Maria E. Bellringer
Gambling Research Centre,
National Institute for Public Health and Mental Health Research,
Division of Public Health and Psychosocial Studies,
Faculty of Health, Auckland University of Technology, New Zealand

Cynthia Orme
Problem Gambling Foundation of New Zealand, Auckland, New Zealand

A recent review of psychological and pharmacological treatments for pathological gambling revealed a paucity of evidence for their effectiveness (Oakley-Browne, Adams, & Mobberley, 2000). Data from a national client database in New Zealand suggest that up to a quarter of clients (depending on the measure used) have not benefited from treatment (Paton-Simpson, Gruys, & Hannifin, 2003). Clearly, there is a need for a treatment program to address the particular requirements of this group. This paper documents the development and piloting of a multimodal program for clients who have not previously benefited from program-gambling treatments. The program employed a composite approach of education and Solution-Focused Brief Therapy. To the authors' knowledge, there is no published evaluative research on the use of this approach with problem gamblers. The intervention was trialled in three treatment centres within New Zealand. Results indicate that the intervention positively affected several measures of gambling behaviour and self-reported well-being.

Keywords: Problem gambling; Multimodal treatment; Solution-focused brief therapy; South Oaks Gambling Screen (SOGS); Well-being; New Zealand.

Introduction

The expansion in the modes and availability of gambling in New Zealand over the past 10 to 15 years has led to increasing numbers of clients (gamblers and their relatives) seeking assistance for problem gambling. For example, in 2002, 6,410 new clients received problem gambling counselling, which was an increase of 21% from the previous year (Paton-Simpson, Gruys, & Hannifin, 2003). During the past six years, over 27,000 people have sought and received help (Paton-Simpson et al., 2003).

Various agencies exist to provide counselling services to those with problematic gambling behaviours, or those worried about their, or someone else's, gambling. Anecdotal evidence suggests that the counselling pro-

Correspondence concerning this article should be addressed to Bridget Mintoft, Department of Health Psychology, Faculty of Medicine and Health Sciences, University of Auckland, Private Bag 92019, Auckland 1, New Zealand. Phone: (09) 3737599 x83753. E-mail: br.mintoft@auckland.ac.nz.

vided by these agencies varies, depending on the organization, the individual counsellors' preferred therapeutic modalities, and the presenting characteristics of the clients. This seems to be the general scenario, with no consensus treatment approach currently existing to treat problem gamblers (Raylu & Oei, 2002).

A recent Cochrane systematic review and meta-analysis of randomized-controlled trials (RCTs) of psychological and pharmacological treatments for pathological gambling revealed a paucity of evidence for effective treatments (Oakley-Browne, Adams, & Mobberley, 2000). It should be noted that such studies exemplify the difficulties in working with, and researching, this client population. Issues, such as a lack of rigorous control, high attrition rates, and failure to attend follow-ups, are common (Stinchfield & Winters, 2001). Randomized-controlled studies often require a degree of resourcing and scientific rigor that is seldom found in treatment agencies, whose natural priority is the client's immediate well-being.

The Cochrane review (Oakley-Browne et al., 2000) was limited by the number of RCTs available for analysis (four), poor methodologies in the trials, and an exclusive focus on either behavioural or cognitive-behavioural therapy. Nevertheless, Oakley-Browne et al. (2000) also observed that these experimental interventions were more efficacious than controls in the short term. An earlier review of treatment approaches for pathological gamblers indicated that cognitive-behavioural therapies for pathological gambling can be effective (López Viets & Miller, 1997).

A follow-up of New Zealand clients one year after they had received counselling indicated that 58 to 76 percent of clients (depending on the measure used) showed an improvement in terms of reduced gambling problems (Paton-Simpson et al., 2003). (The measures typically used include the three-month version of the *South Oaks Gambling Screen* (SOGS-3M), a *Dollars Lost* assessment (over the past 28 days), and a subjective *Control Over Gambling* rating scale; the latter two are in-house developed measures that have not undergone reliability and validity assessments.) Thus, it would appear that, while current treatments for problem gamblers are successful to some extent, there is a proportion of gamblers that does not "benefit" from counselling or therapy. Admissions information from the Problem Gambling Foundation (PGF) of New Zealand—the largest service provider in the country—reveals that re-admissions are relatively stable at 5 to 7%, and "brought-forward" clients (those who span one data collection year to the next) are at 16 to 20%; thus, with the number of clients increasing every year, non-benefiting problem gamblers represent a significant commitment of resources.

There likely are a multitude of reasons why some clients do not reduce or stop their gambling despite treatment. These reasons could include, but are not confined to: (a) the client not being in the right motivational stage to change his or her behaviour (e.g., does not want to change; attending counselling due to court order); (b) a mismatch between client and counsellor (e.g., in terms of culture, gender, and other factors); or (c) conditions are not conducive for counselling (e.g., transport difficulties, clinic location, or clinic opening hours).

Rationale for the Project

As indicated previously, there is a proportion of people in New Zealand who seek help for problematic gambling, but who subsequently do not "benefit" from the counselling received. In 2002, this proportion varied between 5 and 32%, as ascertained from various measures assessing improvement in, or cessation of, gambling behaviour. (Paton-Simpson et al., 2003). Thus, there was a need both to examine the particular requirements of this population of clients and to develop a program that could meet their needs.

Humanitarian and ethical concerns aside, difficulties associated with unresolved gambling problems result in significant costs to the individual and to society in general. Blaszczynsky, McConachy, and Frankova (1989) noted that up to 13% of gamblers serve prison sentences for gambling-related crimes. Pathological gamblers often give up or jeopardize work, social, and family responsibilities to gamble (Petry, 2002). The risk of anxiety, depression, and suicide is significantly greater in problem gamblers than in the normal population (Frank, Lester, & Wexler, 1991); other health problems, such as substance-use disorders and their physical consequences, are also associated with problem gambling (Potenza, Fiellin, Heninger, Rounsaville, & Mazure, 2002). Thus, there are significant potential benefits associated with the development of a program guiding the delivery of effective and efficient treatments to these clients.

Given the promising nature of brief advice, motivational interviewing, and self-help manuals (Petry & Armentano, 1999), the present study aims to examine these methods of treating gambling problems. *Solution-Focused Brief Therapy* (SFBT; Berg & Briggs, 2002), in particular, merited attention. This approach recognizes the individuality of each client, and that each person comes with their own repertoire of successful or effective behaviours. The focus of SFBT is on the needs and strengths of the clients, and on solutions rather than problems. In brief, SFBT begins with eliciting the client's views of what would be a better life, and treatment goals are negotiated. Then, the client's frame of reference (e.g., Is the world hostile or friendly? Do they see the problem as soluble or insoluble?) is explored. Third, clients are asked to find instances of exceptions

to problems, which in turn form the building blocks of customized solutions to the client's needs.

There were several appealing reasons for using SFBT. This mode of therapy had previously been used successfully with a variety of client groups (Macdonald, 2000). SFBT has been used with varying success in couples therapy (Zimmerman, Prest, & Wetzel, 1997) teaching parenting skills (Zimmerman, Jacobsen, MacIntyre, & Watson, 1996), and dealing with anti-social behaviour in adolescents (Triantafillou, 1997). The comparative brevity of the treatment has economic benefits. Time and budget constraints also factored into the decision to try this approach, as the time-consuming exercise of retraining staff was not a viable option. In the current study, SFBT was coupled with a "toolkit" of resources and information given to each client.

López Viets and Miller (1997) describe some promising multimodal approaches in the treatment of problem gambling that include self-monitoring, contracting, imaginal desensitization, cognitive restructuring, group therapy, and education. Rhodes (1997) studied six different modalities of therapy (family systems, 12-step, group, cognitive-behavioural, loss and grief, and cognitive), and noted that no single treatment program or modality was more effective than the others. Furthermore, the decision to use a composite intervention was a response to clients in the focus group and in questionnaire feedback expressing a need for additional information. It was also acknowledged that each client can and will exercise control independent of the clinician's input. This resource is often undervalued, and many therapies that are less respectful of client competence may fail to appreciate its potential. Therefore, given these issues, a composite approach appeared to be more promising than a single mode of intervention.

Thus, this project aimed to use practicable, simple, and easily transferable techniques that leveraged the assets of the client in their own treatment. The core objective was to provide a prototype for working with the increasing numbers of non-benefiting clients, and trialling this method with a group of such clients. The program that was designed and trialled in this project was designated the *Client-Centred Solution-Focused*, or CCSF, program, the specifics of which are described below.

Method

It should be noted that the present study was a very simple pilot project that had not been rigorously designed, evaluated, or implemented. The research was conducted to determine what might be effective in reducing the number of clients who do not benefit from treatment; this study should thus be considered

exploratory. A quasi-experimental design was used with interrupted time-series analyses.

Settings

The project was carried out between February and November in 2003 at three PGF treatment facilities, located in the major cities of Auckland, Wellington and Christchurch.

Participants

For the purposes of this study, clients who were "not benefiting" were defined as returning clients who scored worse on the SOGS-3M, Dollars Lost, or Control Over Gambling measures at the second assessment.

The treatment outcomes of three groups were studied in this pilot project. The PGF provided a list of clients ($n = 62$) from the national database who had not benefited from treatment (the "PGF Sample"). It was presumed that these clients would form the basis of the Trial Group, but that was not the case. Only two of the 62 people from the PGF Sample expressed a wish to participate in the new program. This situation necessitated a rethinking of the trial admission procedure. Thus, clients who were more recent re-admissions to PGF and who met the original criteria for inclusion were informed about the program and invited to join. The number of people who were asked and declined (if any) was not recorded. In total, 23 people agreed to participate. This group was designated the "Trial Group." Auckland was significantly under-represented, with only two clients in this sample coming from Auckland. Wellington provided seven clients, and Christchurch provided 14.

There was no control group (for practical reasons), but comparison groups were used instead. Trial Group results were compared with the PGF Sample's treatment records, and also with treatment statistics of clients presenting at problem-gambling treatment agencies in the previous year (2001)—information that was supplied from the national database. This latter group was designated the "National Sample."

Selection of Clinicians

Clinicians were selected and trained to deliver the program by the PGF National Client Services and Programs Manager. The selection was based on clinicians' mode of therapy, with clinicians who had expressed a preference for an eclectic or person-centred therapeutic mode being chosen. Thus, it is acknowledged that clinician bias in the outcomes of this project is a possibility.

The training of clinicians took up to one day, spread over several occasions. The format consisted of the ex-

planation and demonstration of standardized CCSF Program instructions. These are outlined later (in the Program Design section). Consistency across settings was improved by adherence to specific protocols from the European Brief Therapy Association (EBTA).

Materials

The toolkit. The toolkit was comprised of several items designed to stimulate self-reflection and non-gambling behaviours in clients. These items were designed to bring to conscious awareness both the pros and cons of stopping or reducing gambling, and to identify resources that could be used to avoid gambling behaviours. The toolkit included:

- *My Gambling Diary.* A diary in which the client could record information about instances of their controlled gambling.
- *Knowing the Odds/Building Up to Gambling.* An informational leaflet, published by PGF, on increasing the client's awareness of probabilities in various modes of gambling, and factors likely to precipitate a gambling episode.
- *CCSF Program: "Your Personal Booklet."* A small, easily accessible, A5-sized booklet that encouraged clients' self-reflection using paper-and-pencil exercises. This booklet assisted clients in remaining aware of their goals and motivations for change, and the factors that would enhance that motivation. Clients recorded their thoughts and emotions concerning a number of issues under the following titles: (a) benefits and costs of gambling; (b) reasons to reduce or stop gambling; (c) support; (d) things that can help; (e) alternatives to gambling; (f) triggers and safeguards; and (g) goals.

Measures for client progress. Several measures were used to assess client progress in the CCSF Program trial. Gambling behaviour was assessed using the *South Oaks Gambling Screen-3M* (SOGS-3M), the *Control Over Gambling* (COG) Scale, and the Dollars Lost in Prior Four Weeks (*Dollars Lost*) measure. The COG scale is a four-item scale that asks the client to rate their degree of control over their gambling in the prior three months, from *completely in control* to *completely out of control*. Dollars Lost is a simple record of the amount lost on all gambling activities for each of the previous four weeks. A *Well-Being Questionnaire* was also developed for the program; it assessed clients' perception of their well-being with six items using a non-standardized Likert-type scoring system. The Well-Being Questionnaire and the COG were in-house, non-piloted, unvalidated measures designed and used by clinicians for the provision of collaborative outcome information.

Procedures

Development of program. In order to help clients who had not previously benefited by the service, client feedback was taken into account when designing the new program. A variety of simple methods of inquiry were used in the development of the CCSF Program to gain an understanding of issues affecting non-benefiting clients. These methods included phone interviews, a focus group, and questionnaires to returning clients and their clinicians. Apart from the 33.9% response rate to phone and focus group questionnaires, responses to other measures were poor and added little further information. The process was iterative, with different methods tried successively to increase the information gathered.

Demographics of the 62 person list (the PGF Sample) were briefly analyzed to ascertain if there were any patterns or anomalies with respect to the national client database.

Attempts were made via mail and telephone to contact the 62 people from the PGF Sample. Twenty-one people (33.9%) responded. These individuals were invited to contribute to the development of the service to problem gamblers by providing feedback via questionnaires on what they thought had helped them and what could be improved upon. At that time, clients were also told about the new program and were invited to participate. In addition, in Auckland, a focus group was held in order to elicit more detailed and specific opinions from the clients.

Twenty-one sets of client feedback yielded the following main points of interest: (a) individual sessions were seen as very important; (b) clients wanted a greater focus on alternatives to gambling; and (c) clients wanted information about modes of gambling and information on how to stop gambling

Clinicians' therapeutic modality was reviewed to ascertain the most favoured methods in use; it was important in terms of time and funding that the new approach did not diverge too much from the current skill base. Motivational interviewing techniques and cognitive-behavioural therapy (CBT) were generally utilized. The clinicians were also asked the "mirror image" questions of those asked of the clients. This feedback, in conjunction with clients' feedback, was crucial in constructing the program. Clients and clinicians generally concurred in their responses.

Program Design

Initial sessions. Explanations were provided regarding the new CCSF program, and the reasons for evaluations in the first-, second-, and last- or fourth- month sessions were given. Clients were informed that they did not have to attend for the full 16 weeks. There were interactive discussions between counsellors and clients

on a variety of gambling-related topics (e.g., the odds of winning; how electronic gambling machines [EGMs] work) using motivational interviewing and CBT techniques. Clients were also counselled on how to gamble safely and how to seek help. This allowed the client to think about how they could make their gambling safer, while providing alternative ideas for further reflection. Clients were given the "Personal Booklet," and content was discussed with them. Clients were also given an information sheet regarding the program, and the next session was scheduled for one or two weeks later. There was also discussion as to whether telephone contact in between sessions was required.

During the second session, the counsellor discussed with the client why the client gambles and what the triggers were for gambling; the Personal Booklet was used. The counsellor discussed with the client the course of gambling, and prepared the client for slips or relapses into gambling. The control of gambling was discussed, and how the client knew when gambling was getting out of control for them. Control over Gambling was assessed using the COG questionnaire. The *Miracle Question* (Berg & Briggs, 2002) was also asked. This pivotal question helped orient the client to the future, where the problem would no longer exist. This empowered clients to envision their future without gambling and to set new goals for themselves. The counsellor followed EBTA minimal requirements, which stipulated necessary behaviours and their frequency, in order to ensure the consistency of the intervention.

As part of these requirements, the client was asked a Progress Scale Question (a part of the SFBT). This question was asked toward the end of each session to regularly monitor the client's perception of progress throughout the trial.

Subsequent Sessions. Subsequent sessions with the client were not structured, but continued to use the Personal Booklet, exception questions (to build on the client's strengths), the Control Over Gambling scale, and the Progress Scale Question. EBTA minimal requirements were followed.

Evaluation. Evaluations were performed in session one, after two months (session 8, if held weekly), and at the end (session 16, if held weekly) of the trial period. For the evaluations, clients were asked to complete the SOGS-3M, the Dollars Lost measure, the COG, and the six-item Well-Being Questionnaire.

If the client stopped coming, they were asked to complete the forms either at their last session (if known), or were informed that the forms would be sent to them by post for completion (with a postage-paid envelope).

Results

Each client in the Trial Group ($n = 23$) had at least one session. Eleven clients completed the program, while twelve did not complete it. Of these latter twelve, only one continued to the second month of treatment. Although feedback was requested from clients who dropped out of the program, they declined or were unavailable to provide such feedback. Therefore, we were unable to ascertain why they did not wish to continue.

It is to be reiterated that this was a simple pilot study on a limited budget to examine non-benefiting clients, and to try to create an effective, simple, and time-limited counselling strategy that would help this particular client group. There was no control group within the study; therefore, all results are descriptive. Moreover, due to the small sample sizes involved, the current findings can only provide a general inference in terms of the success of the piloted intervention.

Table 1

Gender and Ethnicity Percentage Breakdown for the Three Locations and Samples

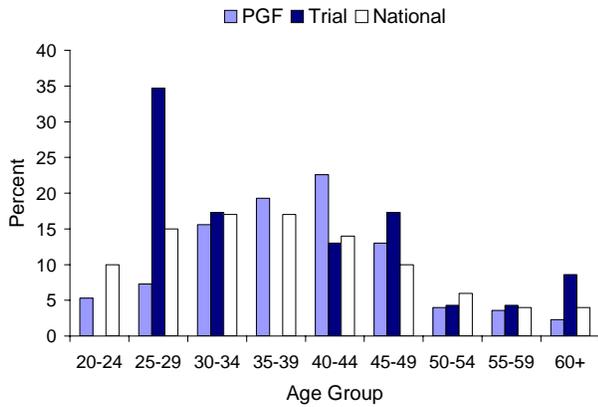|	Location			Sample		
	Auckland	Wellington	Christchurch	Total PGF Sample	Trial Group	National Sample
Gender						
Male	59%	83%	57%	66%	57%	59%
Female	36%	17%	36%	30%	43%	41%
Unspecified	5%	—	6%	4%	—	—
Ethnicity						
European	59.1%	83.3%	80.0%	74.1%	69.6%	58.0%
Maori	18.2%	17.7%	10.0%	15.3%	13.0%	26.0%
Pacific	13.6%	—	—	4.50%	4.30%	6.00%
Asian	—	—	—	—	4.30%	4.00%
Multi/Other	—	—	3.00%	1.00%	4.30%	6.00%
Unspecified	9.10%	—	7.00%	—	4.30%	—

Figure 1. Age distribution by age group and sample source.

Demographics of Non-Benefiting Samples

Age. The samples were generally similar with respect to age, with some exceptions (see Figure 1). The 20-24 age group was not represented in the Trial Group, nor was the 35-39 group. In contrast, the 25-29 bracket formed the largest proportion (35%) of the Trial Group. Consequently, samples were not well-matched in all age groups, and this must be taken into account when reviewing the results.

Gender. All figures for gender (see Table 1) were similar to the National Sample, except the Wellington sample, which had, as stated previously, a comparatively small sample size. This would have skewed the figures for the total PGF Sample.

Ethnicity. Table 1 also shows the breakdown of ethnic groups. New Zealand Europeans were over-represented, while Maori and Pacific peoples were under-represented in both the non-benefiting samples.

Number of sessions. Auckland and Christchurch had a majority of the PGF Sample clients who had 20 or fewer sessions; most of these clients had more than simply individual sessions (i.e., they also had group or couples counselling sessions). In Wellington, the majority of clients had 11 to 30 sessions, and most had more than merely individual sessions. All cities had a few long-term clients. Multiple types of sessions (e.g., individual, group and couples therapy) did not appear to be related to whether clients benefited from treatment or not. These data were not directly comparable to the National Sample, as the latter were reported in terms of the duration (number of hours) of treatment in incompatible time series.

Gambling-Related Data

SOGS-3M at first assessment. Clients in all three groups—the Trial Group and the two comparison groups (i.e., the PGF Sample, being the other non-

benefiting sample, and the National Sample, being representative of the outcomes using orthodox problem-gambling treatments, such as motivational interviewing techniques and cognitive-behavioural therapy) were assessed on the SOGS-3M. The distribution of SOGS-3M scores at the first assessment was similar across all three groups, although there was a larger proportion than expected with a score of 11 in the Trial Group (26.2% vs. 10.7% and 9.20% in the National and PGF Samples, respectively). Both non-benefiting samples had fewer scores at the lower end of the range than the National Sample.

Mean SOGS-3M scores were similar across the three groups. The mean SOGS-3M scores were 10.7 (*SD* = 10.3, range = 2-20) for the PGF group, 9.98 (*SD* = 11.3, range = 1-20) for the National Sample, and 10.9 (*SD* = 9.8, range = 4-17) for the Trial Group. However, the percentage of SOGS-3M scores of ten or more was higher for both non-benefiting groups (PGF, 66.1%; Trial, 69.%) than for the National Sample (54.1%).

Distribution of dollars lost in the four weeks prior to the first assessment. None of the clients in the Trial Group lost less than $100 in the four weeks prior to the first assessment (see Figure 2). The most frequent dollar loss for all groups was in the $500-$999 category, with the Trial Group being higher than the others. The
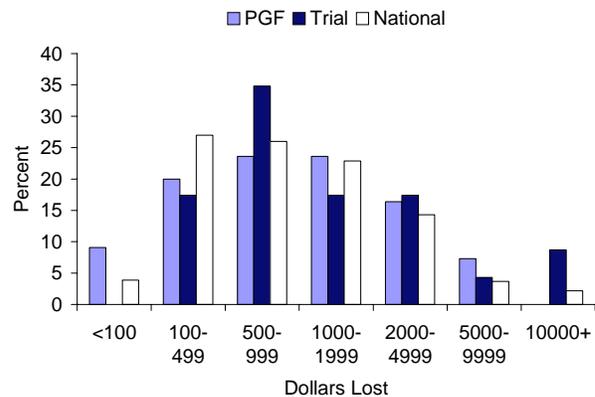

Figure 2. Distribution of dollars lost according to sample source.

Trial sample also had the largest representation in the highest dollars lost category.

Distribution of COG for the first assessment. On the COG, there was almost a 20% discrepancy between PGF and Trial Sample figures for "Mostly" and "Completely out of Control" (see Figure 3). The PGF Sample had the highest percentage of responses in the latter category, while the Trial Group dominated the
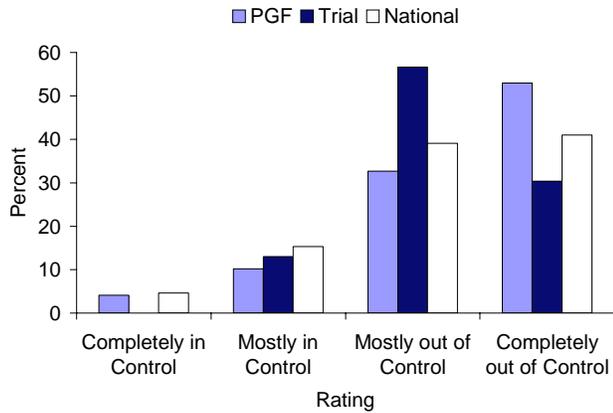
Figure 3. Distribution of gambling control ratings at first assessment.

former. However, the majority of clients described their gambling as being mostly or completely out of control (PGF, 87.4%; Trial, 85.7%; and National, 80.1%).

Evaluation of the Program

All eleven clients who completed the CCSF Program benefited from it in terms of revealing lowered SOGS-3M scores, lowered COG scores, and lowered Dollars Lost scores by the final assessment. However, due to the limitations of the current study (discussed later), and particularly the small size of the sample, all statistics are purely descriptive.

Reduction in SOGS-3M. The mean and median reduction in SOGS-3M scores in the Trial Group (M = 9.7, median = 9.0) were both more than twice as large as the reduction in the National Sample (M = 3.9, median = 4.0; see Table 2). The proportion of the
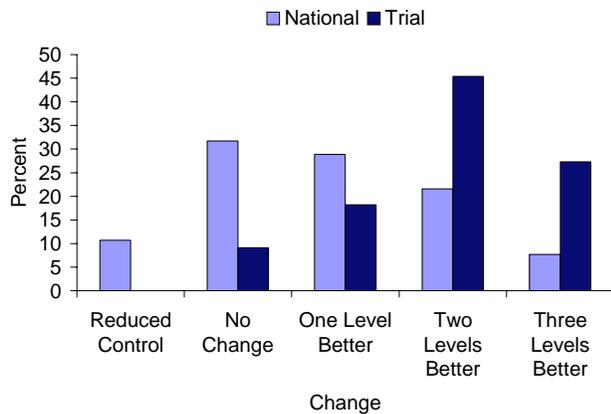
National Sample and Trial Group for whom SOGS-3M was reduced was 69.0% and 100.0%, respectively.

No outcome data were available on partial completers of treatment for the Trial Group.

For the National Sample, the SOGS-3M scores of 16.0% of clients who completed orthodox treatments were worse at a one-year follow-up than they were at their first assessment. For the Trial Group, none of those who completed treatment had worse SOGS-3M scores following treatment completion. If the Trial group data were appended to data for the whole sample, this figure fell to 47.8%. However, similar data-collection problems would apply to the National Sample. Again, the caveats concerning small samples apply.

Reduction in COG. The Trial Group achieved a greater degree of change than the National Sample in terms of Control Over Gambling (see Figure 4). In the National Sample, most of the change occurred at the "one level better" and "two level better" categories.
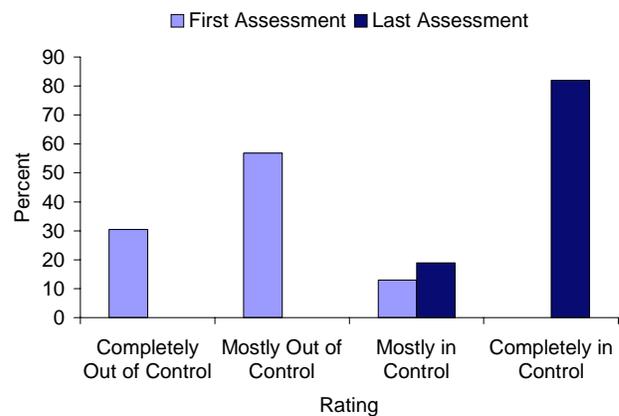

Figure 5. Change in COG scores over the trial.

More than three times the number of Trial Group members improved by three levels, as compared to the National Sample. In the Trial Group no clients experienced reduced Control Over Gambling.

Improvement in COG during the trial. Within the Trial Group, ratings of control changed over the course of treatment from mostly or completely out of control (87.2%) to mostly or completely in control (100%; see Figure 5).

Reduction in total dollars lost. All clients in the Trial Group experienced a reduction in Dollars Lost (see Figure 6). None of these clients experienced an increase, and none remained the same, in terms of the amount of Dollars Lost. The National figures were collected at a one-year follow-up, while the Trial Group

Figure 4. Change in COG scores following the trial.

Table 2

Range of Reduction in SOGS-3M Scores (%) for the National Sample and Trial Group

	1-5	6-10	11-15	16-20
National Sample[a] (*n* = 538)	45.0	37.8	13.9	2.00
Trial Group (*n* = 23)	18.2	45.5	27.3	9.10

[a] This figure was derived as a percentage of only the total number of clients whose SOGS-3M score reduced, so it was comparable to the Trial Group.

was assessed at four months, or when treatment finished, whichever occurred first.

Reduction in dollars lost as a percentage of original loss. Examining the reduction in dollars lost as a percentage of original loss (see Figure 7) permits the comparison of improvement between bettors of larger and smaller amounts, as the effect of overall dollar loss may vary between wealthy and impoverished clients.

Most clients in the Trial sample (81.8%) had an 80 to 100% reduction in their losses. The majority (63.6%) had a 100% improvement. This improvement is nearly twice that of the National Sample. Almost one-third (29.4%) of the National Sample either continued to lose the same amount, or lost more at follow-up.

Changes in Well-Being Questionnaire scores. Participants' subjective well-being was assessed by an in-house six-item Likert-scale questionnaire. Items inquired about their feelings of well-being generally, as well as how effectively they felt they were dealing with gambling-related issues. Scores are out of a possible 30. The Well-Being Questionnaire was administered during the first session (*M* = 15.9), second month (*M* = 25.2) and the fourth month or last assessment (*M* = 26.4). A large increase in reported well-being usually occurred in the second month and subsequently remained stable.

Discussion

The aim of this project was to gather information about non-benefiting clients and to use that information to design, develop, and trial a treatment intervention for them. The desired outcomes were: (a) the engagement of clients in the Client-Centred Solution-Focused Program; (b) the improvement of clients' scores on the SOGS-3M, COG, and Dollars Lost gambling measures; and (c) the improvement of clients' scores on the Well-Being Questionnaire. The engagement of clients in the program was similar to standard rates of engagement in treatments for problem gambling.

Changes in clients' scores occurred on each of the SOGS-3M, COG, and Dollars Lost gambling measures. These changes appeared to compare favourably with those in problem-gambling treatment nationally. Additionally, there was a general improvement in reported well-being, as reflected by scores on the Well-Being Questionnaire.

This encouraging result must be considered in light of a 52.2% dropout rate. It is possible that those clients for whom the program was not working simply absented themselves. However, the same rationale applies to the National Sample (e.g., of the original 1551 SOGS-3M ratings in 2001, only 50.3% were available a year later). In addition, this trial could be considered to have had a 47.8% success rate in treating the 20% of clients who do not otherwise respond to treatment the first time.

Limitations

The difficulty in recruiting clients was a major influence on the design and execution of this study. Many clients who do not benefit from treatment may be reluctant to re-engage with the service for a number of reasons, such as embarrassment or a sense of "having let the counsellor down." Thus, the information received may have been limited, and the clients in the trial may possibly have not been representative of the larger group. For this reason, and also because of budget constraints, there was no control group.

The representativeness of the Trial Group should be considered with caution. This group was smaller in number than other groups, and Auckland (the largest city in the country) was under-represented. Contact with the PGF Sample was generally difficult, while nearly all clients in the Trial Group were, out of necessity, recent re-admissions to treatment. These recently re-admitted clients may have had motivations and
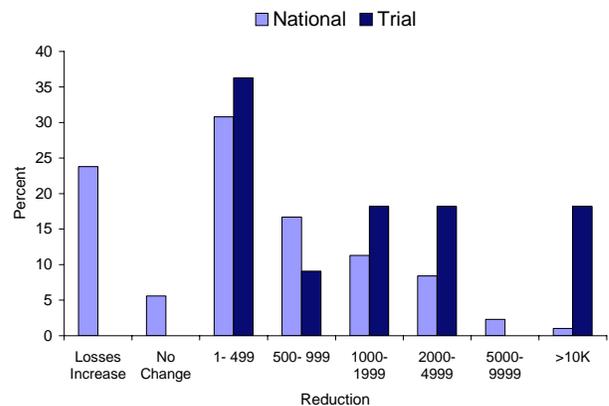

Figure 6. Reduction in dollars lost following the trial.

views of treatment that differed from those of clients in the PGF Sample. Clients in the Trial Group were invited by their clinicians to participate in the program, so the sample was not randomly chosen. In comparisons across groups, it should be noted that the PGF Sample and the Trial Group differed in that the Trial Group sample wished to try the treatment again, whereas the PGF Sample expressly did not. This higher readiness for change may have been a significant factor in the findings obtained. Additionally, the PGF Sample was assessed at 12 months after the first assessment, whereas the Trial Group was assessed after four months or less following the first assessment. Greater validity of results could have been assured if the Trial Group were also followed up at 12 months.

Nonetheless, the improvement in gambling measures in this trial compare very favourably to improvements in the treatment of "normal" problem gamblers, ostensibly a group that is more receptive to treatment.

Methodological issues also presented some challenges. Since the pilot assessments occurred in a two-month frame, the SOGS-3M test overlapped with the pre-treatment phase for one month, potentially influencing the results in the prior direction. Similarly, with the COG, if a client was not yet fully committed to treatment, they may have stated that they had more control over gambling than they actually objectively had. As clients spent more time in counselling, they may have become more honest and realistic about their problems, and their COG score may have risen or seemingly deteriorated.

Client feedback assumes insight and accuracy, a coherent and useful schematic of one's psychological processes, and some understanding of the processes of counselling, as well as the ability to express that. Some answers were less than useful in assessing what had changed for readmission to occur. "My attitude" was not an infrequent response to that question. While a reasonable response in the vernacular, it was not especially useful for the purposes of the study. This highlights the difficulty in constructing instruments for the collection of qualitative information about internal dynamics from a naive sample.

The difficulty in collecting information from clinicians is an ongoing problem for researchers. This results in missing or incomplete data, which, in turn, means that conclusions must be stated with more caution. Collection difficulties may include the issues of time, the complexity of administration, or differing priorities. As the sophistication of assessment and treatment approaches increases, there will be a commensurate onus on clinicians and managers to ensure that sufficient valid information is recorded. The procedures for this data recording need to be integrated in clinical guidelines and policies.
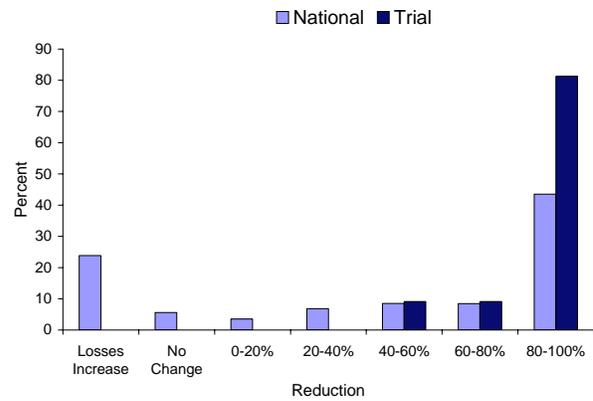

Figure 7. Reduction in dollars lost (following the trial) as a percentage of original loss.

Implications

The quality of the therapeutic relationship has long been found to be a strong predictor of successful treatment outcomes (Howgego, Yellowlees, Owen, Meldrum, & Dark, 2003; Lambert & Barley, 2002). SFBT prescribes positive regard and praise from the clinician, an active focus on the client, and an emphasis on examples of the client's success and efficacy, rather than his or her failures or inadequacies. Such a focus is very likely to strengthen the therapeutic relationship. This may well be a factor in the success of the SFBT approach.

Maori and Pacific peoples were under-represented in the non-benefiting PGF sample. There could be a variety of reasons for this. Maori and Pacific people may do very well in first-time treatments, or fewer may be prepared to respond to follow-ups. This may be influenced by the scarcity of Maori or Pacific clinicians, especially within PGF, which is staffed predominantly by New Zealand Europeans. Matching client and therapist cannot always be regarded as the mainstay of treatment, yet when that matching serves as a potent force for cultural-identity strengthening, it can be a significant factor in developing a repertoire of healthy alternative behaviours and self-concepts that are integral to recovery.

There are various ways to improve the effectiveness of the treatment. These methods are generally centred on devising more potent therapeutic interventions and on improving clients' engagement in treatment. Screening for factors that predict partial completion of treatment, and devising interventions that take those into account, is also valuable.

It is important to draw the distinction between treatment completion and outcome, although these variables are associated. Partial completers of treatment are often considered as dropouts—the assumption is

that treatment is not working for them. Yet, a number of clients in the PGF Sample said they stopped treatment because they thought that they had their problem under control. Nevertheless, national database statistics (Paton-Simpson et al., 2003) show a better treatment outcome for those who do complete treatment.

The trial CCSF program appeared to improve outcomes, but not necessarily rates of completion. It would be beneficial, therefore, to further explore compliance-enhancing interventions. Milton, Crino, Hunt, and Prosser (2002) demonstrated a reduction of dropout rates in the treatment for problem gambling from 65% to 35% with their compliance-improving interventions. Obviously, this approach merits further attention.

Screening for substance abuse is a routine procedure, given that comorbid problem drinking is a predictor of partial completion (Milton et al., 2002). Impulsiveness is also associated with dropping out of treatment (Leblond, Ladouceur, & Blaszczynsky, 2002, as cited in Daughters, Lejeuz, Lesieur, Strong, & Zvolensky, 2003). Thus, screening for impulsiveness may be valuable. Dialectical Behaviour Therapy interventions for impulsiveness and distress tolerance may also be useful.

As with smoking, a certain percentage of problem gamblers would probably cycle through treatment a number of times before achieving the long-term maintenance of treatment gains (Prochaska & Velicer, 1997); it could also be argued that repeated exposure to the same treatment may have a similar effect. However, this does not mesh with the fact that the PGF is treating an increasing proportion of longer-term clients. According to clinicians, these individuals are more likely to be dual-diagnosis clients with a greater need for support (Paton-Simpson et al., 2003)

Of note is that half of the (albeit small) sample of clinicians providing feedback in this study mentioned the complexity of clients' situations due to the ongoing effects of pre-existing events or conditions, such as PTSD, sexual abuse, alcohol abuse and serious illness, as well as anxiety and depression related to gambling. This also implies that gambling could be a "secondary" problem or a means of emotional "affect management" for other problems, in a similar manner as alcohol abuse (Milton et al., 2002). This raises the question of adequate training and the issues of treatment priorities and referral.

Despite the limitations of this study, the results are encouraging, although the findings should be interpreted with appropriate care. Further investigation is needed to determine the efficacy of this methodology. A larger sample is needed, although this need not be limited to non-benefiting clients. The trial Client-Centred Solution-Focused intervention may well prove to be a valuable and cost-effective method of treating problem gamblers, including those who do not benefit from standard treatments.

References

Berg, I. K., & Briggs J. (2002). Treating the person with a gambling problem. Electronic Journal of Gambling Issues, 6. Retrieved March 3, 2004, from http://www.camh.net/egambling/issue6/feature/index.html.

Blaszczynsky, A., McConachy, N., & Frankova, A. (1989). Crime, antisocial personality and gambling. Journal of Gambling Studies, 5(2), 137-152.

Daughters, S., Lejeuz, C., Lesieur, H., Strong, D., & Zvolensky, M. (2003). Towards a better understanding of gambling treatment failure: Implications of translational research. Clinical Psychology Review, 23(4), 573-568.

Frank, M. L., Lester, D., & Wexler, A. (1991). Suicidal behaviour among members of Gamblers Anonymous. Journal of Gambling Studies, 7, 249-254.

Freidenburg, B., Blanchard, E., Wulfert, E., & Malta, L. (2002). Changes in physiological arousal to gambling cues in motivationally enhanced cognitive-behaviour therapy for pathological gambling. Applied Psychophysiology and Biofeedback, 27(4), 251-260.

Hodgins, D., & El-Guebaly, N. (2000). Natural and treatment assisted recovery from gambling problems: A comparison of resolved and active gamblers. Addiction, 95(5), 777-789.

Howgego, I., Yellowlees, P., Owen, C., Meldrum, L., & Dark, F. (2003). The therapeutic alliance: The key to effective outcome? Australian and New Zealand Journal of Psychiatry, 37(2), 169-183.

Lambert, M., & Barley, D. (2002). Research summary on the therapeutic relationship and psychotherapy outcome. In J. Norcross (Ed.), Psychotherapy relationships that work: Therapist contribution and responsiveness to patients (pp. 17-32). London: Oxford University Press.

López Viets, V. C., & Miller, W. R. (1997). Treatment approaches for pathological gamblers. Clinical Psychology Review, 17(7), 689-702.

Macdonald, A. J. (2000). Solution-focused brief therapy evaluation studies. The European Brief Therapy Association. Retrieved February 9, 2002, from http://www.enabling.org/ia/sft/evs.htm.

Martin, G., & Pear, J. (1992). Behaviour modification: What it is and how to do it. New Jersey: Prentice Hall.

Milton, S., Crino, R., Hunt, C., & Prosser, E. (2002). The effect of compliance-improving interventions on the cognitive-behavioural treatment of pathological gambling. Journal of Gambling Studies, 18(2), 207-229.

Oakley-Browne, M. A., Adams, P., & Mobberley, P. M. (2000). Interventions for pathological gambling. Cochrane Database of Systematic Reviews, 2, CD001521.

Paton-Simpson, G. R., Gruys, M. A., & Hannifin, J. B. (2003). Problem gambling counselling in New Zealand: 2002 national statistics. Palmerston North, New Zealand: The Problem Gambling Committee.

Petry, N. M. (2002). How treatments for pathological gambling can be informed by treatments for substance use disorders. Experimental and Clinical Psychopharmacology, 10(3), 184-192.

Petry, N. M., & Armentano, C. (1999). Prevalence, assessment, and treatment of pathological gambling: A review. *Psychiatric Services, 50*(8), 1021-1027.

Potenza, M. N., Fiellin, D. A., Heninger, G. R., Rounsaville, B. J., & Mazure, C. M. (2002). Gambling: An addictive behaviour with health and primary care implications. *Journal of Internal General Medicine, 17*(9), 721-732.

Prochaska, J. O., & Velicer, W. (1997). The transtheoretical model of health behaviour change. *American Journal of Health Promotion, 12*(1), 38-48.

Raylu, N., & Oei, T. P. S. (2002). Pathological gambling: A comprehensive review. *Clinical Psychology Review, 22*(7), 1009-1061.

Rhodes, W. (1997). *Evaluation of the Minnesota state-funded compulsive gambling treatment programs: Final report.* Cambridge, MA: Abt Associates.

Stinchfield, R., & Winters, K. C. (2001) Outcome of Minnesota's gambling treatment programs. *Journal of Gambling Studies, 17*(3), 217-245.

Triantafillou, N. (1997). A solution-focused approach to mental health supervision. *Journal of Systemic Therapies, 16,* 305-328.

Zimmerman, T. S., Jacobsen, R. B., MacIntyre, M., & Watson, C. (1996). Solution-focused parenting groups: An empirical study. *Journal of Systemic Therapies, 15,* 12-25.

Zimmerman, T. S., Prest, L., & Wetzel, B. E. (1997). Solution-focused couples therapy groups: An empirical study. *Journal of Family Therapy, 19,* 125-144.