

Preventing and Minimising Gambling Harm

Practitioner's Guide

2019

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1 Introduction

1.1 Purpose

The purpose of the *Preventing and Minimising Gambling Harm Practitioner's Guide* (Practitioner's Guide) is to:

- clarify aspects of service delivery of preventing and minimising gambling harm interventions
- detail the screening and clinical practice requirements for service providers.

The term 'provider' refers to organisations that have a preventing and minimising gambling harm (PMGH) intervention service contract with the Ministry of Health (see also the Glossary).

It is important to note that the Practitioner's Guide is intended as a guide only. The Practitioner's Guide indicates the Ministry of Health's intentions for PMGH intervention services and is a guide to typical client/tangata whai ora pathways and practices. Practitioners should use their clinical judgement when dealing with exceptions, particularly when clients/tāngata whai ora are presenting in crisis or issues of safety are involved.

1.2 Intended audience

This document is intended for the PMGH intervention service providers.

2 Intervention services

2.1 Introduction

This chapter gives an overview of the national and local gambling harm intervention services the Ministry of Health purchases.

2.2 Preventing and minimising gambling harm clinical services

PMGH intervention services include:

- helpline and information services (section 2.2.1)
- brief intervention services (section 2.2.2)
- full intervention services (section 2.2.3)
- facilitation services (section 2.2.4)
- follow-up services (section 2.2.5).

2.2.1 Gambling Helpline and information services

The focus of the Gambling Helpline (helpline) and information services is to provide an accessible information and intervention service to individuals experiencing gambling harm who are unable to access face-to-face intervention services.

The helpline services complement face-to-face services, because they are open longer hours and provide anonymity for people concerned about their privacy. In many cases, the helpline may represent a first point of access for a person who will later receive face-to-face support.

2.2.2 Brief intervention services

Brief intervention services are for people who are early in the course of developing gambling problems. The services aim to encourage individuals experiencing harm from gambling to recognise and acknowledge the consequences of their gambling and to change their gambling behaviour or seek specialist support where necessary.

The focus of these services is on people who are at risk of gambling harm and who may be experiencing some of the effects of such harm, but who do not yet associate their gambling with the problems in their lives.

Brief intervention services are typically delivered in settings where people are likely to be at risk of gambling harm.

If someone comes to your service seeking help for gambling, they are ready for a full intervention rather than a brief intervention.

2.2.3 Full intervention services

Full intervention services are community-based assessment and intervention services for people with gambling-related problems. They aim to minimise gambling-related harm to the client/tangata whai ora and their family, whānau and significant others by providing a range of psychosocial interventions.

Full intervention services make up the core clinical work that most face-to-face intervention staff engage in every day.

2.2.4 Facilitation services

Facilitation services involve minimising gambling-related harm to individuals and their families, whānau and significant others by facilitating people's access to health and social services.

Many people presenting at gambling services have more problems in their life than just gambling; sometimes those problems are connected to the gambling and sometimes they are separate from it.

Facilitation services recognise that merely referring someone to another service is not usually effective. Active effort and support are often required to help clients/tāngata whai ora to receive the support they need for other problems in their life.

2.2.5 Follow-up services

Follow-up services provide follow-up and motivational support to clients/tāngata whai ora for 12 months after their last full intervention session with a problem gambling intervention service (ie, from full intervention or facilitation services).

Many people recovering from addiction benefit from support even after they have received intervention services. The focus of follow-up is for the practitioner to maintain contact with clients/tāngata whai ora for a year after they have stopped coming to scheduled sessions and to continue to offer support and to motivate the client/tangata whai ora.

2.3 Background to the intervention service model

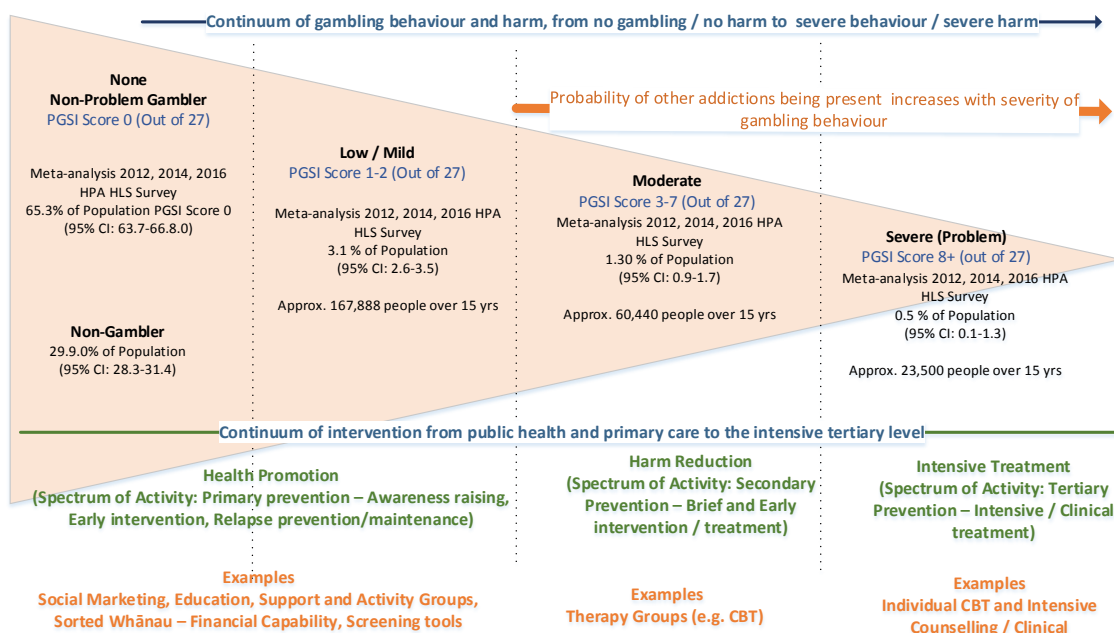
The system of intervention described in this Practitioner's Guide is based on the Korn and Shaffer (1999) spectrum of gambling harm model. The model:

... combines a mix of the medical model and public health ideas about gambling harm that runs through the following states: No gambling; Infrequent (light) gambling; Frequent (heavy) gambling; Problem Gambling; Pathological gambling (Korn and Shaffer 1999, cited in Rogers et al 2015, p 21).

This approach acknowledges the widespread impact of problem gambling on the gambling individual and their family, whānau and significant others.

Figure 2.1 adapts the original Korn and Shaffer (1999) spectrum of gambling behaviour. It populates the spectrum with 2012 estimates of the common categories of gambling behaviour described using the Problem Gambling Severity Index (PGSI) scoring, and overlays examples of public health intervention (Wren 2018).

Figure 2.1: Gambling behaviour and harm: the continuum of prevention and harm reduction



Note: CBT = cognitive behavioural therapy; CI = confidence interval; HLS Survey = Health and Lifestyles Survey; HPA = Health Promotion Agency; PGSI = Problem Gambling Severity Index.

All intervention service providers are responsible for promoting their services, with a primary focus on at-risk and high-need populations.

The intervention service model recognises that people affected by gambling harm can benefit from a range of services. The model aims not only to address the gambling behaviour, but also to reduce the impact of harm by facilitating the access of the client/tangata whai ora to other services, including:

- financial counselling
- relationship counselling
- other social service agencies
- mental health services
- alcohol and other drug services.

2.4 Client/tangata whai ora pathways and ideal patterns of care

Figure 2.2 sets out pathways and patterns of care for typical clients/tāngata whai ora. The Ministry of Health periodically reviews client/tangata whai ora presentation data and updates the typical pathway and pattern of care guidelines accordingly.

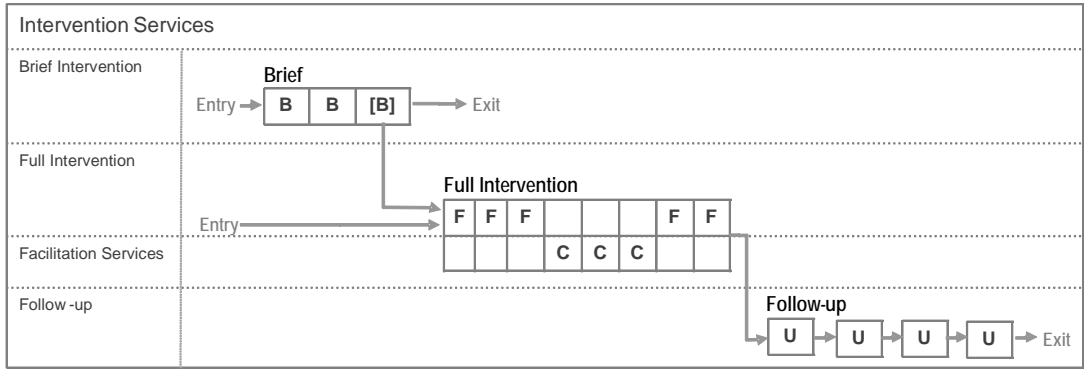
Clients/tāngata whai ora of some ethnicities have a choice of more than one PMGH service provider. They can choose a mainstream provider (most regions), dedicated Māori service (many regions), dedicated Pacific service (greater Wellington and Auckland regions) and, in Auckland, a dedicated Asian service. It is always best practice to support clients/tāngata whai ora to access services that best meet their needs, including ethnically and culturally. If you require any support in how to facilitate services for people of a culture other than you own or in facilitating services for clients/tāngata whai ora who are atypical, please discuss this with your practice supervisor. (Also refer to the Cross-cultural treatment guide in section 7.10.)

section 2.4.3 outlines the key forms and documents used to represent the journey of the client/tangata whai ora through the PMGH service.

2.4.1 Ideal pattern of care

Figure 2.2 outlines the preferred pattern of intervention sessions.

Figure 2.2: Preferred pathways for intervention sessions



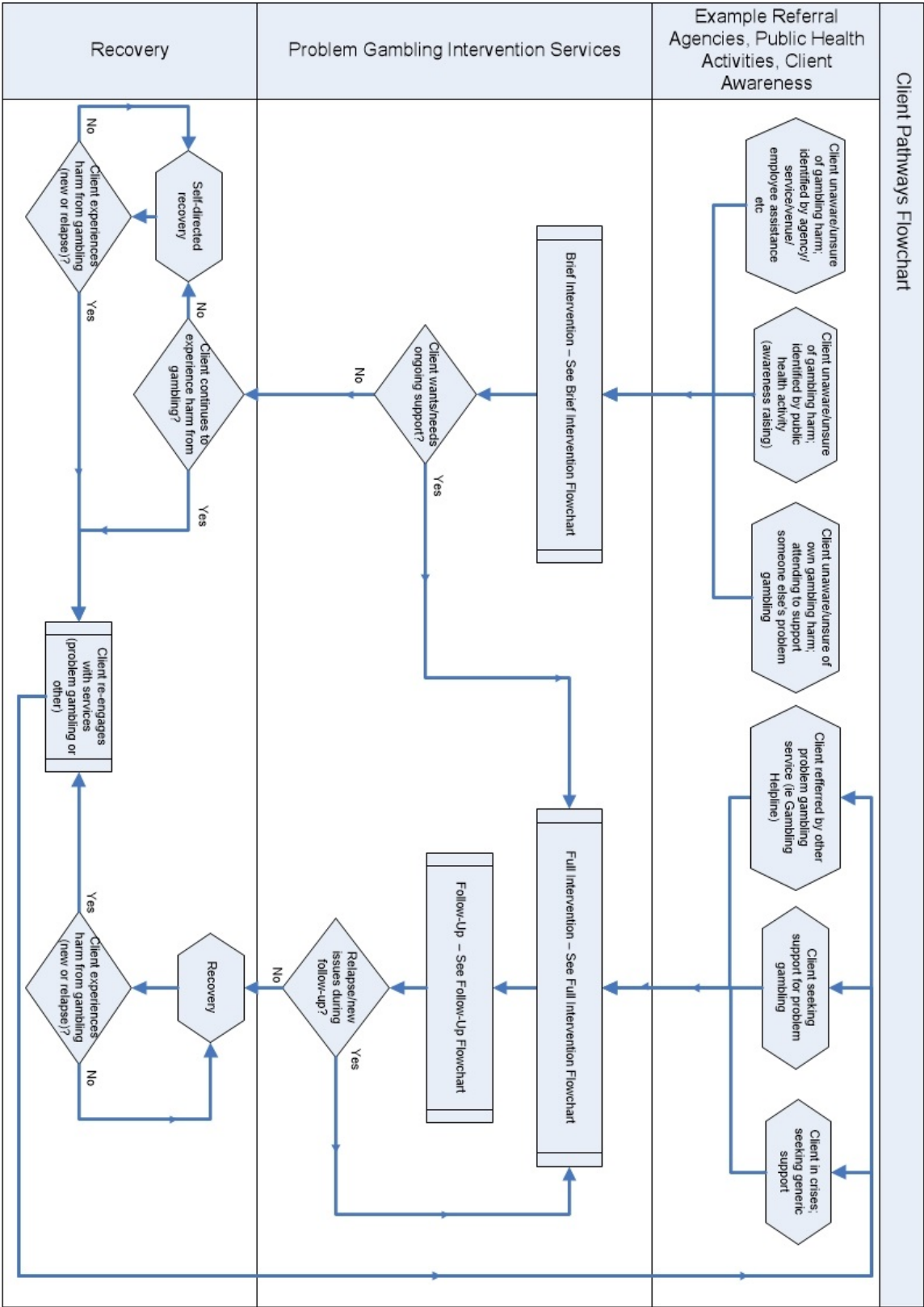
Notes:

- Brief: One or two brief sessions (B) followed by a third brief session if it is considered clinically appropriate. A brief session is 15–30 minutes long.
- Full Intervention: A maximum of eight sessions, involving a mix of full intervention sessions (F) and facilitation sessions (C). A full intervention or facilitation session is typically 60 minutes long.
- Follow-up: A scheduled follow-up session (U) undertaken at one month, three months, six months and 12 months after the last full intervention session. A follow-up session is 15–30 minutes long.

2.4.2 Typical client/tāngata whai ora pathways

Figure 2.3 represents a range of typical pathways that clients/tāngata whai ora use to access problem gambling intervention services. It also outlines the typical pathways clients/tāngata whai ora take between categories of problem gambling service and to and from recovery.

Figure 2.3: Typical client/tangata whai ora pathways into intervention services



Note: See Appendix 4 for a guide to the symbols in this figure.

2.5 Eligibility

As well as the characteristics of the service determined by the service type, that is, dedicated Māori, Pacific or Asian or general (see section 2.4), providers must ensure their services are provided to eligible people as set out below.

2.5.1 Eligible people

Eligible people are people:

- with any of a range of gambling problems
- with co-existing gambling problems and mental health (including substance use) problems
- at risk of developing pathological gambling problems
- who have been affected by the gambling of a family or whānau member or significant other.

2.5.2 Age of eligible people

Eligible people must be either:

- young people/taitamariki (14–17 years) or
- adults/pakeke (18 years or over).

Providers should establish and maintain relationships and key linkages with child, adolescent and young people's health and social services, and primary care, education, and other statutory agencies as appropriate to meet the needs of young clients/tāngata whai ora. Joint approaches to care and case management that combine the expertise of each service will involve negotiation about which service has primary responsibility for care.

Community PMGH intervention services accept referrals from other agencies for assessment and intervention.

2.6 PMGH gambling practitioner competencies

2.6.1 Practitioner competencies

The Ministry of Health recognises the Drug and Alcohol Practitioners Association of Aotearoa New Zealand (DAPAANZ) competency standards as the guiding standards for PMGH intervention practitioners. To access the practitioner competencies, go to: www.dapaanz.org.nz/vdb/document/22.

The Ministry of Health also recognises the importance of including specific cultural competencies to reflect the expertise of Māori, Pacific and Asian practitioners and the competencies necessary to work with different cultural groups safely and appropriately. Training workshops led by the PMGH National Coordination Service provide a forum for learning more about working with people who are from a culture other than your own.

2.6.2 Requirements for PMGH practitioners

The Ministry of Health states in the PMGH strategy:

The Ministry's expectation is that all gambling harm practitioners will be registered as health practitioners permitted to practice within a relevant scope of practice under the HPCAA (Health Practitioners Competence Assurance Act), or will be registered or endorsed by DAPAANZ, or will be equivalently registered with, or endorsed by other relevant professional organisations.

It is important to highlight that this is a long-term priority, and the strategy runs until 2023.

Practitioners must have good diagnostic skills and be able to refer to diagnostic screens and tools that assist with the assessment of clinical needs that are beyond problem gambling issues and make up a comprehensive assessment. They should also have competence in evidence-based interventions in a range in psychosocial and culturally based modalities. Finally, practitioners need to work competently in important areas such as early intervention, case management, relapse prevention and risk management.

2.6.3 Competencies for co-existing issues

The revised service model outlined in section 2.3 emphasises the importance of addressing co-existing issues. Often PMGH intervention practitioners have appropriate qualifications for addressing co-existing issues, such as alcohol and other drug or budgeting problems.

Having the appropriate training and qualifications is important. It enables the practitioner to provide support to a client/tangata whai ora for any issue directly relating to the gambling of the client/tangata whai ora through a full intervention session. When a practitioner does not have the necessary skills to address the additional needs or complex presentation of a client/tangata whai ora, the practitioner should facilitate their access to an appropriate service.

However, some clients/tāngata whai ora will present with co-existing issues that interact with but are not a result of their gambling. The Ministry of Health funds PMGH services so, in such cases, the practitioner should refer the client/tangata whai ora, or facilitate their access, to an appropriate service for support with these issues, even if the practitioner has the necessary skills.

3 Brief intervention

3.1 Introducing a brief intervention

A brief intervention:

- is a one-on-one intervention in a non-specialist setting
- is typically one or two short motivational interview sessions with a client/tangata whai ora
- involves people who may not yet acknowledge, recognise or accept, or may feel ambivalent about, the harms in their lives from their or another's gambling
- involves people who have not yet made a commitment to seek support to manage their gambling (either formally from a specialist gambling harm service or from another source) or to make the necessary changes in their lives.

Brief intervention is a specialised intervention that focuses on engaging with people at risk of gambling harm and encouraging them to recognise the potential impacts of their own or another's gambling behaviour on their life. Evidence suggests that, when combined with an appropriately targeted motivational discussion, recognition and awareness-raising can be enough to encourage many people experiencing harm from gambling to make changes, even if they never seek formal gambling harm treatment support. 'Brief' interventions are specialised and focused interventions to motivate change, as distinguished from other 'short' interventions that do not take much time.

Offering brief interventions is an opportunistic strategy for practitioners when they become aware of a person's gambling behaviour that has not yet been addressed. In contrast to interventions where clients/tāngata whai ora seek help themselves, brief interventions rely on the initiative of the service provider to be well positioned in community settings where they can easily and appropriately engage with people who are likely have a high risk of experiencing gambling harm. The person may not have realised that their gambling is causing harm to themselves and others and it may not have occurred to them to seek help for their gambling behaviour. In some cases, the person may become aware they have been affected by someone else's gambling behaviour and can seek help for this as a 'family or whānau affected other'.

Consequences that are often associated with gambling harm are financial, legal, social (including relationships) and health problems. To be appropriately positioned and to support client/tangata whai ora access, service providers should build strong relationships and partnerships with community agencies and organisations that deal with these types of issues. Agencies and organisations with clients/tāngata whai ora that may be at a higher risk for gambling harm include alcohol and drug treatment services, community probation services or corrections facilities, Work and Income, budgeting services, food banks, and Oranga Tamariki – Ministry for Children.

People who are experiencing gambling harm in their lives often have other issues that also impact on their lives and create a more complex situation. These are referred to as co-existing problems (CEP) and may include mental health problems and additional addictions, for example, alcohol and other drug problems, or internet addiction. People with CEP issues will usually require longer-term, more indepth interventions, which may also involve consultation, facilitation or referral to other services; however, a brief intervention may 'open the door' to more holistic interventions. See Chapter 4 for information on assessment screens both for those experiencing gambling harm and significant others, treatment planning, and outcome measure, as well as CEP and screening tools for these. Chapter 4 also refers to the Addiction Intervention Competency Framework (Addiction Practitioners Association Aotearoa New Zealand (DAPAANZ) 2011), as it applies to gambling harm practitioners (ABACUS Counselling, Training and Supervision Ltd). Other CEP resources are: the American Psychiatric Association's (2013) Diagnostic and Statistical Manual of Mental Disorders Version 5 (DSM-5); Te Ariari o te Oranga (Todd 2010); and Te Whare o Tiki (co-existing problems knowledge and skills framework) (Matua Raki and Te Pou 2013).

3.2 Settings for screening

Opportunities for brief interventions are generally at the initiative of the service provider, who seeks out environments in which to engage with populations who may be at high risk for gambling harm. For brief interventions to occur, service providers need to be available to these populations.

Typically, people experiencing gambling harm do not present to gambling harm services until they are in crisis or experiencing a high level of harm. As a form of secondary prevention (ie, preventing the progression of the gambling harm), brief intervention screening can detect the early stages of a potential problem. This may mean that less intrusive forms of intervention are necessary.

Brief interventions create an opportunity for people to think about how gambling is affecting their life and consider changes at their own initiative or with limited involvement from a specialist service. People with increasing concerns about their gambling behaviour may initiate contact with a specialist service, but most often their self-awareness will be heightened by timely opportunities that are offered when they least expect them.

You can provide brief interventions in a family or whānau setting, as long as all participants agree to discuss their screening results together. (This is different from group therapy, as group therapy clients/tāngata whai ora are likely to have already made a commitment to seeking help.) For example, several people may be present at a session with a client/tāngata whai ora (for support or interest), and you may believe it would be appropriate and useful to provide a brief intervention to some or all of the attendees (who are not already clients/tāngata whai ora). For each individual who has a brief session with you, you enter them as a client/tāngata whai ora and a unique brief session is created.

You are expected to manage and document agreement with the client/tangata whai ora (ie, have their informed consent) to having their screening results discussed with others present.

KEY MESSAGE

If the client/tangata whai ora is **seeking help**, then start a full intervention session immediately. Brief interventions are only for people who are **not** actively seeking help.

3.3 Family/whānau/affected other

For each person experiencing gambling harm, an estimated seven others, on average, are negatively affected by the person's gambling behaviour. These people are often unaware of the extent of the stress the gambling behaviour is causing them or that the effects can continue long past their association with the person directly experiencing gambling harm. Opportunistic screening of the family/whānau/affected other of the person who is experiencing gambling harm can help to identify such impacts, provide information to the family/whānau and motivate them to seek help for themselves.

3.4 Goals of brief intervention

People with moderate to significant levels of gambling harm may face barriers to initiating contact with specialist services. Compared with the development of other types of addiction, the development of gambling harm is more likely to go undetected for long periods, due to stigma and the gambler's belief that it may be possible to 'gamble their way out' of financial problems. This causes symptoms to become more entrenched before they are detected, which often leads to increased shame, embarrassment and concealment of gambling behaviour.

A timely brief intervention and good use of motivational interviewing skills can encourage a person to take the next step and engage with a specialist service for treatment intervention, to seek help and support from other help providers for other consequences of their gambling behaviour, or even to take steps on their own to change their gambling behaviour.

Brief interventions can be effective in engaging those who have experienced gambling harm and for building self-awareness in family/whānau who have also been harmed by gambling. The family and whānau of the person experiencing gambling harm may have focused on trying to control the gambling behaviour and overlooked their own deteriorating mental and physical health. They may also benefit from a brief intervention that helps them to focus on their own needs and address the impact another's gambling behaviour has had on them.

KEY MESSAGE

Brief intervention is **not** just about getting people to come for counselling for gambling harm. Brief intervention is a clinical intervention in its own right. For many people, the motivational interview part of a brief intervention will be enough to motivate them to change their gambling harm behaviours on their own.

3.5 Summary of brief intervention service specification

A brief intervention consists of no more than three sessions, with each usually 15–30 minutes long, although exact time can vary between people and settings. It usually takes place as part of a planned service initiative in the community, but it can take place at a service centre by way of a phone call or an unscheduled meeting. Most brief interventions involve only one session, where screens are completed and mandatory CLIC data is collected. Second and third sessions may only take place for people interested in some additional contact. Further screening for these is not needed unless results are likely to change through deeper engagement and increased openness. If the client/tangata whai ora wishes further intervention and support beyond brief sessions, open a full intervention.

A brief intervention can take place over the phone or face to face, but not in a group setting, because individualised engagement is necessary. (However, individuals from a group may approach a practitioner separately and have 15–30 minutes individualised time/screening.) With informed consent from all parties, brief intervention can also occur in a family or whānau setting.

At a brief intervention session, the client/tangata whai ora takes part in a self-administered or practitioner-guided screen. (However, if it is a telephone brief intervention, the practitioner reads the questions to the client/tangata whai ora or uses them conversationally.) The practitioner:

- discusses the responses of the client/tangata whai ora and results, to show the level of gambling harm that is resulting from their own or someone else's gambling behaviour
- discusses education and information resources
- suggests possible next steps for the client/tangata whai ora to address the issues raised.

3.5.1 Exceptions

It is important to note that not all clients/tāngata whai ora qualify for a brief intervention. If the Gambling Helpline has already screened a person and is now referring them to the service, that individual should go directly into a full intervention episode.

Clients/tāngata whai ora that have had a series of full or brief interventions that closed in the **past six months** are not eligible for another brief intervention. If these clients/tāngata whai ora seek further support from the gambling harm service, or you want to offer further support after a follow-up session, open a new full intervention session.

If a person initiates contact and is actively seeking help for concerns related to gambling harm, identify their contact as a full intervention session.

Brief screen score of zero

In some cases, a client/tangata whai ora may score zero in the brief screen.

- Do **not** use CLIC to record clients/tāngata whai ora who score zero on the Brief Gambler Screen or Brief Family/Whānau/Affected Other Screen, show no signs of other health or social issues, and do not acknowledge concerns about gambling harm.
- You can record a client/tangata whai ora with a brief screen score of zero as valid **if** harm from gambling is evident **and** a primary problem gambling mode (PPGM) can be identified. A score of zero from someone who, in conversation, admits to gambling harm, may be a result of their underplaying the effect of the gambling because of embarrassment, lack of awareness or misunderstanding of the screen questions. The discussion that comprises a brief intervention can provide clarification and permission to be more honest about gambling behaviours and their impact.

KEY MESSAGE

It is unusual to see brief interventions recorded (in CLIC) where they involve clients/tāngata whai ora with zero screen scores. Sometimes services are provided in these cases but such clients/tāngata whai ora will be the minority of clients/tāngata whai ora seeking help. You may be asked for clarification of such practices if they become a significant proportion of a service's client/tangata whai ora load.

As noted above, group therapy is not an accepted session type for a brief intervention.

Note: Practitioners **must provide a minimum amount of data for a brief intervention to be counted**. This data includes PPGM, gender, brief screen score and setting.

3.5.2 Ending a brief intervention

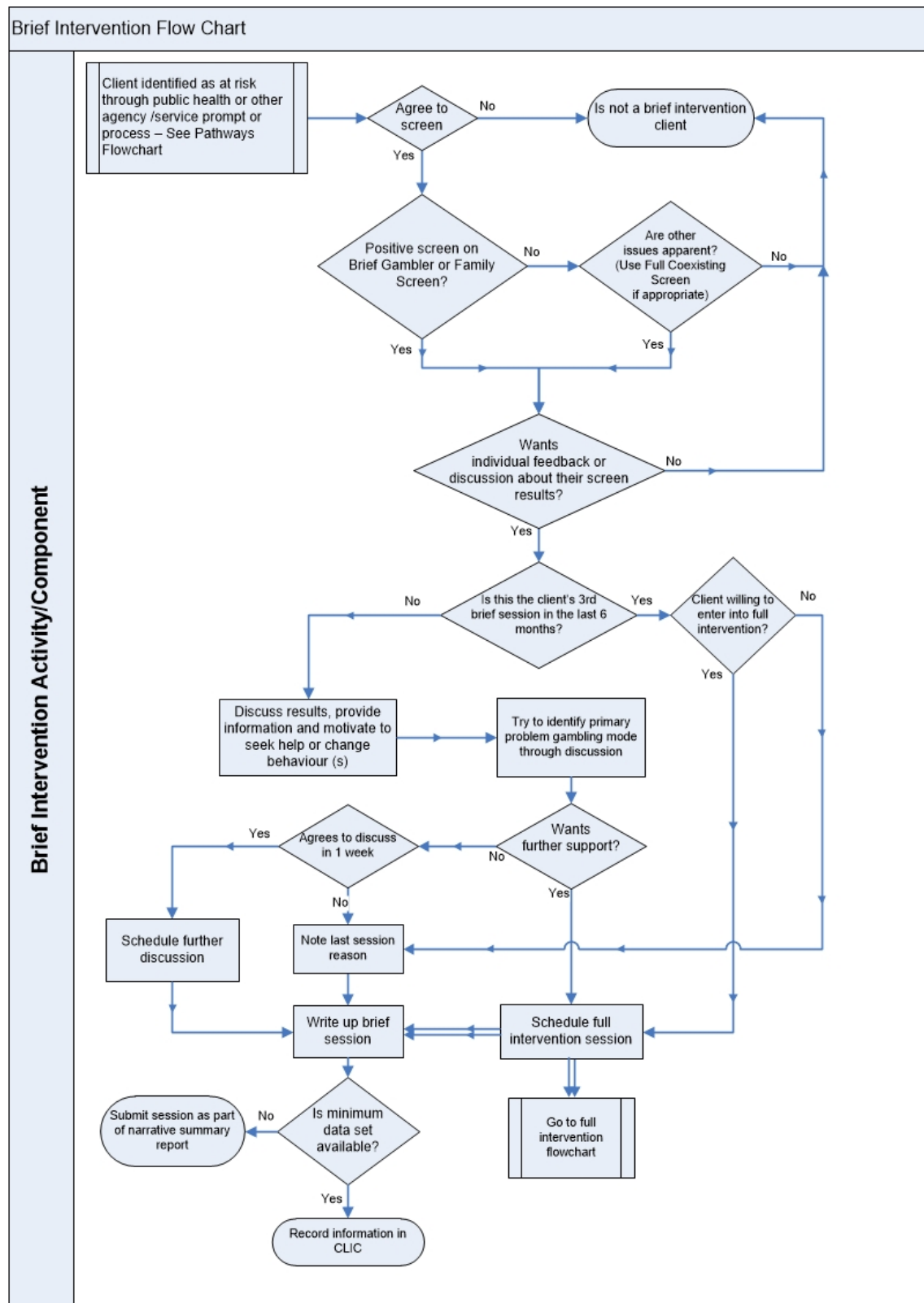
The purpose of a brief intervention is very specific: it focuses on motivating people to change, either on their own or with specialist support. Individuals who do not respond to one or two brief intervention sessions are unlikely to change without a period of reflection or a change in their personal circumstances. If a practitioner believes a client/tangata whai ora is showing genuine engagement and contemplation, a third brief intervention session may be useful, but this response is more likely to indicate a full intervention.

Once a client/tangata whai ora has received one or two (three maximum) brief intervention sessions, one or other of seven outcomes is likely. Table 3.1 lists these seven likely outcomes. Only enter a last session reason if you believe that the client/tangata whai ora in question will not be having any further sessions of any type with the service.

Table 3.1: Ending brief intervention

Client/tangata whai ora outcome	Clinical action	CLIC administration: last session reason
Client/tangata whai ora no longer wants to discuss their gambling behaviour with the practitioner.	No further action.	No further contact requested.
Client/tangata whai ora has received up to three brief intervention sessions and is not willing to receive specialist support (ie, to enter into a full intervention).	No further action.	No further contact requested.
Client/tangata whai ora has agreed to receive specialist support (ie, to enter into a full intervention).	Schedule full intervention session.	N/A. It is not the last session if the client/tangata whai ora has agreed to receive full intervention sessions.
Client/tangata whai ora has been referred to another non- gambling harm provider.	No further action.	Person transferred to another non-GH provider.
Client/tangata whai ora has been referred to another gambling harm provider.	No further action.	Person transferred to another GH provider.
Client/tangata whai ora received one brief intervention session and agreed to discuss their gambling behaviour further (a second brief intervention) but was unable to be contacted within 30 days .	No further action.	Person unable to be contacted (minimum three attempts).
Client/tangata whai ora has had a brief intervention open for longer than 30 days with no further contact recorded in CLIC.	No action taken.	N/A. No last session reason is required. The episode will be automatically closed and is considered an 'administrative discharge'.

Figure 3.1: Typical client/tangata whai ora pathways and practitioner decisions for brief interventions



Note: See Appendix 4 for a guide to the symbols used in this figure. See also Figure 2.3: Typical client pathways into intervention services (Chapter 2).

3.6 Examples of brief interventions

3.6.1 Case 1 – Community hui

You have arranged a community hui on gambling awareness and 12 people have responded, after having either communicated their interest to you or receiving notice of the hui from a variety of services (eg, a non-governmental organisation, district health board, Citizens Advice Bureau and budgeting service). The 12 attendees have never been assessed and are not clients/tāngata whai ora of any gambling harm service.

As part of the session, all attendees self-administer a brief screen. You offer to give feedback and discuss the results on an individual basis. Seven attendees each have a brief discussion (about 15 minutes) with you about their score, other aspects of their personal experiences with gambling behaviour and other resources available to them.

One of the seven asks for a later appointment with your service as a result of their score and discussion, which has heightened their awareness of the impact of their gambling behaviour on their family or whānau.

Three of the seven make no further commitments, even though their screen scores and discussion suggest gambling harm concerns and a primary problem gambling mode. They have no further direct contact with the agency in the short term.

Two of the seven in discussion indicate that, although they gamble, or have family or whānau members who gamble, they do not feel that it is causing them or their family or whānau members harm. These two attendees have zero screen scores and their conversation provides no indication of a gambling harm or a type of gambling associated with harm.

The remaining one of the seven is not interested in further face-to-face contact even though they have identified a primary problem gambling mode. However, they willingly give their phone number to you, so you can make second contact in a week's time.

Questions

After reading Case 1, answer the following questions.

- How would you account for the 12 people in your reports to CLIC and in your narrative monitoring reports?
- How would you account for the seven people who had additional time with the practitioner and any later contact?
- Would it matter if the attendees were concerned about their own gambling behaviour or about how someone else's gambling was affecting them?

Answers

- How would you account for the 12 people in your reports to CLIC and in your narrative monitoring reports?

You have completed an educational hui in the community for 12 people from various social services, so report this event in your six-monthly narrative report. It is the only way to account for the five people who did not have individual time with the practitioner.

How would you account for the seven people who had additional time with the practitioner, and any later contact?

Register each of the five people who had about 15 minutes each with the practitioner and who identified a primary problem gambling mode as a client/tangata whai ora, and record each as a brief intervention session. **The minimum data required is PPGM, gender, brief screen score and setting.**

For the person who requested an appointment time, you could record their next face-to-face contact as a new full intervention session. For the three people who did not want any further contact, record their brief intervention sessions as starting and ending on the same day, based on their one session contact.

Once the person who was willing for you to phone them has that second contact, you record a second brief intervention session. If no further contact is planned at this point, record the brief intervention as ended.

For the two people who had zero screen scores, who did not provide a primary problem gambling mode and who did not provide further indication of harm from gambling, you do not count the time or record it in CLIC.

Would it matter if the attendees were concerned about their own gambling behaviour or about how someone else's gambling was affecting them?

A brief intervention applies no matter whether the individual filled in a screen that was addressing their personal concern about their gambling behaviour or addressing the impact someone else's gambling behaviour was having on them. As long as some level of harm has been experienced due to gambling, a person can be registered as either a client/tangata whai ora who has experienced gambling harm, or a family/whānau/affected other by another's gambling after they have had an individualised session face to face or by phone and the practitioner has collected the minimum data. If the person could be identified as both experiencing gambling harm directly and affected by someone else's gambling harm, they can still only be registered as one person. Which one the service provider chooses is at their discretion, following a discussion with the client/tangata whai ora to determine which circumstance is currently contributing to the most harm. Both sets of brief screens can still be collected under these circumstances.

Guiding principles

People are not counted as clients/tāngata whai ora or given a file until they have received at least 15 minutes of individualised time that involves a discussion of their screen results, disclosure and discussion of clinically relevant information. This is the case even in a group setting where everyone is offered a screen.

If 15 minutes of individualised time has been offered to discuss a person's gambling harm screen results and other resources, create a client/tangata whai ora file and record this as a brief intervention session. It is likely this session will be the only brief session recorded. If a person wants another meeting after a brief intervention to examine their gambling behaviours in more detail, end the brief intervention session and record the new session as a full intervention when it occurs.

Although Case 1 involved a group of people, it was not group therapy. Group therapy is a specific mode of intervention and is different to a group of people being spoken to at the same time. See the Glossary for a definition and section 4.2.2 for a discussion of group therapy.

3.6.2 Case 2 – Health expo

Your organisation runs a health expo in the form of a public health awareness stall or health stall at a local community event. More than 1,000 people attend. As part of the event staff hand out 500 gambling harm education packs and brief screens to interested people. Three hundred people return their screens to your organisation's stall. One hundred return screens showed gambling harm (ie, they were positive screens).

On the screening form, you invite people to come and talk with the staff at the stall about gambling. The form also tells people that if they answer yes to any of the questions on the form, they are likely to be experiencing harm from their own or someone else's gambling, so they should come and talk privately to one of your practitioners. Practitioners are available in a caravan behind the stall, so that people can call in and leave discreetly.

Eighty people come and talk to the staff at your stall about gambling, of whom 40 ask for more information and take pamphlets and contact information. Twelve people come into the caravan, with the following outcomes.

- Eight talk privately with the practitioner for 15–30 minutes, of whom:
 - two make appointments to see the practitioner at a later date
 - one says they need to think about what the practitioner has talked about, but agree to see the practitioner in about a week's time
 - five ask for some clarification of the screen and some information about gambling harm but are not interested in discussing their scores further or receiving further support. Of these, three return positive screen scores and in conversation suggest a type of gambling causing harm for them or their family and whānau, and the other two gamble but have zero screen scores and do not identify a type of gambling causing harm.

- Three feel uncomfortable and leave the caravan quickly, although one says they might call the practitioner at the office.
- One says they do not gamble, but discusses feeling suicidal, so is given support and talks to the practitioner until a crisis team arrives (in an hour and a half).

KEY MESSAGE

Brief intervention is **not** just about getting people to fill out a screen that scores positive for gambling harm: it is a clinical session focused on helping the client/tangata whai ora recognise how their gambling is preventing them from reaching their goals for the future and motivating them to make positive changes, either on their own or with further support.

Questions

After reading Case 2, answer the following questions.

- How would you account for these people in your reports?
- How many people would you count as receiving brief interventions?

Answers

How would you account for these people in your reports?

You have completed a public health event, so your public health team reports on this event in its six-monthly monitoring report. The team reports its views of the event's success and may note how many people were interested in further information and how many people screened positive for gambling harm.

How many people would you count as receiving brief interventions?

The 12 people who went into the caravan should be recorded as follows.

- The eight people who spent more than 15 minutes with the practitioner are all counted as receiving brief interventions.
 - Record the session of the two people who made appointments to see the practitioner at another time as a brief intervention. When they come for their appointment, a full intervention session will be recorded.
 - Record a brief intervention session for the person who wanted to think about their results and the discussion. If a practitioner talks with the person again, the practitioner could record the new session as a second brief intervention or as a full intervention depending on their assessment of whether the person is at the point of seeking help or is still contemplating the impact of their gambling behaviour.
 - Of the five people who did not wish to have any further contact, record in CLIC the brief interventions with the three people with positive screen scores and a gambling type causing harm. For the two people with zero screen scores and no PPGM, do not record the sessions in CLIC.

- Do not count the three people who left quickly as receiving brief interventions. If the one person who left quickly but said they might call actually does ring back later to talk about their scores and ask questions about getting help, count them as receiving a brief intervention session for the period of the phone call. However, if they ring back saying they have thought about the information and then ask for help, record a full intervention session when they attend and do not score any brief intervention.
- **The one person who did not gamble but was provided with support for feeling suicidal is counted as receiving an hour and a half of counselling, which can be recorded on the provider's narrative report. This counselling is not recorded in CLIC.**

KEY MESSAGE

The difference between a brief intervention and a full intervention is whether or not the client/tangata whai ora is looking for support for their own, or someone else's, gambling. Anyone actively seeking help or support should receive a full intervention, **not** a brief intervention.

If your organisation has a public health service contract you can, as part of your public health activity narrative in your six-monthly monitoring report to the Ministry of Health, discuss: the 300 people who filled out screens, the 100 people who scored positive for gambling harm, the 80 people who talked to staff at the stall and the 40 people who asked for more information.

Of the 12 people who entered the caravan, record in CLIC the six people who had a primary problem gambling mode. You should note the activity with the two people who did not have a PPGM and the person who was provided support for being suicidal in your internal records for internal or external verification purposes, because it shows the practitioner's clinical workload and the ongoing pattern of care being provided.

KEY MESSAGE

No type of gambling associated with harm \Rightarrow no primary problem gambling mode.
No primary problem gambling mode \Rightarrow do not record in CLIC.

Guiding principles

People are not counted as clients/tangata whai ora or given a file until they have received at least 15 minutes of individualised time that involves a discussion of their screen results, disclosure, and a discussion of clinically relevant information.

If 15 minutes of individualised time has been offered to discuss a person's gambling screen results and other resources, create a client/tangata whai ora file and record this as a brief intervention session. It is likely this session will be the only brief session recorded.

If a person wants another meeting after a brief intervention to examine their gambling behaviours in more detail, end the brief intervention and start a full intervention session when they next meet with the practitioner.

If a person does not want to receive specialist support but agrees to be contacted to discuss their screen results again once they have had a chance to reflect on their answers, record the first brief intervention and schedule a second brief intervention session.

3.6.3 Case 3 – Brief intervention client/tangata whai ora (not experiencing gambling harm)

Hayley comes to a 'Gamble-free' hui at the local marae, along with her sister, who does not gamble but is interested in learning about gambling issues. You give Hayley a Brief Gambler Screen to complete, which returns a zero score. However, when she talks to you about the screen, she is very upset (from a relationship breakup and loss of her job) and reveals that she has been having thoughts of self-harm. You speak with Hayley for half an hour. You also ensure that her sister is aware of the situation, and she says she will monitor Hayley's safety in the meantime. Hayley asks you for help, as she is afraid that her anxiety and low mood might become worse. You make an appointment to see her tomorrow to discuss options for help and support. Next day, you ask Hayley to fill out a CHAT Screen and, after obtaining her consent, you speak to a doctor you have had previous contact with about Hayley's anxiety and depression 'positives' and negotiate an appointment time with Hayley in the room. Her sister, who also attends, has stated she is taking Hayley to Work and Income in the afternoon.

Question

- After reading this case, how would you account for the contact with Hayley and her sister in your data collection system?

Answer

Hayley's sister does not fill out a screen, does not have a PPGM and does not have any other issues that take up any time, so you do not record the contact in any data collection system. Hayley fills out a Brief Gambler Screen but has a zero score, so she has no PPGM and, therefore, does not qualify for further intervention as a client/tangata whai ora experiencing gambling harm. However, Hayley talks to you about her recent breakup, loss of job and thoughts of self-harm. As you have a duty of care to help with possible mental health issues (anxiety and depression) that could put her at risk of self-harm, you have followed through with an initial plan to put supports in place.

Do not count Hayley for a brief intervention or facilitation, because she does not have a PPGM. However, you can record the total time spent talking with her (one and a half hours) for internal and external verification purposes as it shows the pattern of care provided as part of your workload.

KEY MESSAGE

No type of gambling associated with harm ⇒ no primary problem gambling mode.
No primary problem gambling mode ⇒ do not record in CLIC.

3.6.4 Case 4 – Brief intervention phone call

You are a practitioner in an intervention service for gambling harm. You receive a request to take a phone enquiry from someone who is concerned about gambling. Robert tells you that he has started to play pokies in his local pub after a friend talked him into trying out the machines there. He says he has never considered himself a gambler but has found himself drifting away from his friends and playing on his own more and more. He realises, after seeing his bank statement yesterday, that he has spent a lot more money than he thought. He is also 'preoccupied' and has been distracted from work lately, thinking about winning.

You discuss these issues with Robert, and he asks you for your opinion on whether he may have a problem. You ask if he would like to respond to a screen over the phone to consider this, and he agrees. Robert is unsure about his answers to the first two questions, but answers 'yes' to Question 3 (Have you ever felt the need to bet more and more money?) and, in response to Question 5 about what would help, he says he would like to talk about it in confidence with someone. You ask if he would like to come to your service and see someone in person to discuss his situation further and he agrees to an appointment next week.

Questions

After reading Case 4, answer the following questions:

- How would you account for the time spent on the phone with Robert?
- How would you score the screen and how would you record this in the data collection system?
- How would you account for the face-to-face session with Robert when he attends?

Answers

You spend 20 minutes talking on the phone with Robert and he scores positive on the Brief Gambler Screen, so he has a primary problem gambling mode of Pub EGM and you have enough details to enter him in the data collection system as a brief intervention. Robert isn't sure yet if he has a 'gambling problem' but is concerned about wanting to bet more money, wants to speak further with someone face to face in confidence about his gambling behaviour and agrees to come in to the service for a counselling session. When Robert attends, you will record the session as a full intervention, engage with him and assess his needs further (counselling and screening), as time permits, and make ongoing arrangements as necessary.

If Robert had not wanted to come in for counselling face to face, but wanted time to think about the phone call, you could have arranged another phone call to discuss his thoughts and needs for further support later on and you would record this as another brief intervention session. A brief episode should not be open for more than 30 days if inactive. If he wanted no more contact, you would close the brief intervention and his file; if he wanted more intensive support, you could then enter into a full intervention (as above).

3.7 Screening for brief intervention

The Ministry of Health endorses two screens for brief intervention:

- Brief Gambler Screen
- Brief Family/Whānau/Affected Other Screen.

These screens are the minimum offered in brief interventions. Although only one screen may be offered in a particular setting, because both those directly affected by gambling harm and their family/whānau/affected other may access similar settings for help, it is often beneficial to offer both. In some cases, a person may be both experiencing gambling harm directly and affected by another's gambling (eg, a parent). The decision to offer a single screen or both screens is up to the practitioner.

KEY MESSAGE

You should screen and assess all clients/tāngata whai ora but asking the questions in a screen does not have to involve filling out a form. You can easily ask most of the required screening questions as part of a conversation with the client/tāngata whai ora.

This section describes both screens, as well as how to score and use them.

3.7.1 Brief Gambler Screen

For people screening for their own gambling behaviours, use the following screen for brief interventions. Text in *italics* gives instructions for the information to enter into CLIC for each screen; for example '*Record the number of positive responses to questions 1 to 4*'. For the full version of all screens, see Appendix 1.

Introduction/opening statement: Many people in New Zealand enjoy gambling, whether it's Lotto, track racing, the pokies or at the casino.

Sometimes, however, it can affect our health.

To help us to check your wellbeing, please answer the questions below as truthfully as you are able from your own experience. A 'no' answer can also mean that you don't gamble at all.

Brief Gambler Screen (*record the number of positive responses to questions 1 to 4. If there are no positive responses, then record a zero '0'.*)

- 1 Do you feel you have ever had a problem with gambling? (**Only ask if the answer is not obvious.**)
- 2 **If the answer to Q1 is yes, ask:** And do you feel you currently have a problem with gambling?
- 3 Have you ever felt the need to bet more and more money?

- 4 Have you ever had to lie to people about how much you gambled?

5 If you answered yes to any of the above, what would help? (*Do not record response in CLIC.*)

 - ☐ I would like some information.
 - ☐ I would like to talk about it in confidence with someone.
 - ☐ I would like some support or help.
 - ☐ Nothing at this stage.

How to use the Brief Gambler Screen

If the client/tangata whai ora answers yes to any of questions 1–4 in the Brief Gambler Screen (ie, a positive screen), the client/tangata whai ora meets the conditions for further intervention services. If the client/tangata whai ora answers no to questions 1, 3 and 4, use your judgement or further assess the client/tangata whai ora as necessary.

Responses to Question 5 identify the intervention the client/tangata whai ora would like. Although they may say that they require nothing at this stage, let them know that help is available if they change their mind. These responses can also be a topic for conversation in a later brief intervention session.

If the screen is positive, but the person does not want to do anything at this stage, offer to recontact the person in a week or two to see if they have reconsidered the help offered.

Note that ongoing support is unusual where individuals have not met the criteria for a positive screen. Sometimes services are provided in these cases but such clients/tāngata whai ora will be in the minority of those seeking help. The Ministry of Health will seek clarification of such practices if they become a significant proportion of a service's client/tangata whai ora load.

Why you use the Brief Gambler Screen

The Brief Gambler Screen (questions 1–4) is the gateway screen for brief intervention services and to inform the need for ongoing engagement with the presenting individual.

3.7.2 Brief Family/Whānau/Affected Other Screen

To screen people for the impact that another person's gambling harm is having on them, use the Brief Family/Whānau/Affected Other Screen for brief interventions.¹

Text in italics gives instructions for the information to enter into CLIC for each screen; for example '*(Record the number of the response)*'. For the full version of all screens, see Appendix 1.

Introduction/opening statement: Sometimes someone else's gambling can affect the health and wellbeing of others who may be concerned. The gambling behaviour is often hidden and unexpected, while its effects can be confusing, stressful and long-lasting. To help us identify if this is affecting your own wellbeing, please answer the questions below to the best of your ability.

1 Awareness of the effect of the gambler's gambling: *(Record the number of the response, ie, 0–3.)*

Do you think you have ever been affected by someone else's gambling?

(0) ☐ No, never. **(If chosen, you need not continue further.)**

(1) ☐ I don't know for sure if their gambling affected me.

(2) ☐ Yes, in the past.

(3) ☐ Yes, that's happening to me now.

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

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

(0) ☐ It doesn't affect me any more.

(1–5) { ☐ I worry about it sometimes.
☐ It is affecting my health.
☐ It is hard to talk with anyone about it.
☐ I am concerned about my safety or the safety of my family or whānau.
☐ I'm still paying for it financially.

(6) ☐ It affects me but not in any of these ways.

3 Support requested: *(Do not record response in CLIC.)*

What would you like to happen? (Tick one or more.)

☐ I would like some information.

☐ I would like to talk about it in confidence with someone.

☐ I would like some support or help.

☐ Nothing at this stage.

¹ The Brief Family and Whānau Whai Ora Screen uses the Concerned Others Gambling Screen, which was developed by Dr Sean Sullivan of ABACUS Counselling, Training and Supervision Ltd.

Guide to the questions in the Brief Family/Whānau/Affected Other Screen

The Brief Family/Whānau/Affected Other Screen comprises three questions.

Question 1 asks if the person has been affected by someone else's gambling. If they answer 'No, never', the screen result is negative and the client/tangata whai ora need not continue. If they answer, 'I don't know for sure if their gambling affected me', 'Yes, in the past' or 'Yes, that's happening to me now', the screen result is positive.

Research, although limited, indicates that people who 'don't know for sure' are often just as depressed as those disclosing past or present gambling harm effects, and that anyone who responds with a positive screen is significantly more likely to be depressed than those who respond 'No, never'.

Question 2 asks the client/tangata whai ora with a positive screen to focus on how the other person's gambling affects them. Many of those affected by another's gambling focus on trying to control the gambling behaviour and seldom focus on the effects of the gambling behaviour on themselves.

The intention of Question 2 is to direct the attention of the client/tangata whai ora to their own needs, often for the first time. The answers to Question 2 help to raise the awareness of the client/tangata whai ora about the effects of the gambling behaviour on themselves. They may have become numb to these effects or have accepted that they can do little about them, and so have not dwelled on them. These answers become topics to address in counselling.

If the client/tangata whai ora answers 'It doesn't affect me any more', it may be because they lack awareness, so focus on their answers to later questions (eg, health items) to verify their view. Research has also noted that those who choose the 'It doesn't affect me any more' option are likely to be more depressed than those never affected by gambling harm (Question 1), so this answer may indicate negative effects that they have not identified.

Question 3 asks the client/tangata whai ora what they would like to happen. The options it offers are information, talking in confidence (counselling), support or 'Nothing at this stage'. Clients/tāngata whai ora may choose more than one option.

Family and whānau members are much less likely to seek help for themselves than for those affected by their own gambling behaviour. It is possible that even if the client/tangata whai ora does not require help at this stage, the 'seed may be sown' for later help-seeking. The intention of this question is to confirm with the client/tangata whai ora that they are in control of the process (ie, it is client/tangata whai ora-centred) by giving them a range of options and indicating what options they might have.

The screen avoids the term 'counselling' because family and whānau members may not want to see themselves as needing counselling. They may feel it implies that they are in some way contributing to the gambling behaviour.

How to use the Brief Family/Whānau/Affected Other Screen

Offer the Brief Family/Whānau/Affected Other Screen carefully, because family and whānau members may perceive that services are focused on the person experiencing gambling harm or that their problems would be solved if that person stopped gambling (so help for themselves is irrelevant). They may also feel that if they are seen as needing help, they must have been in some way contributing to the gambling harm.

Use a motivational interviewing approach when offering the screen rather than assuming the client/tangata whai ora is aware that your service is available for them also (see section 7.9.2 for more on motivational interviewing). If you tell them why they could be affected but unaware of the effect, that you will offer feedback as soon as the screen is completed, and that members of other families and whānau use your service, you may reduce their resistance to undertaking the screen.

For people who remain focused on and concerned with the recovery of the person who has experienced gambling harm, offer them information that addresses their needs and supports them, and tell them how it might have a positive impact on that person's recovery. This may persuade the family or whānau member to participate.

Why you use the Brief Family/Whānau/Affected Other Screen

Brief Family/Whānau/Affected Other Screen is a gateway screen for brief intervention services and to inform the need for ongoing engagement with the presenting individual.

If a person has a positive screen but does not want to do anything at this stage, always offer to contact them again in a week or two to see if they have reconsidered the help offered.

Note:

- Ongoing support is unusual where individuals have not met the criteria for a positive screen. Sometimes services are provided in these cases but these clients/tāngata whai ora will be a minority of those seeking help.
- If the family/whānau/affected other does not know the primary problem gambling mode of the person who has experienced gambling harm, you should **not** record the session in CLIC. However, you should note the activity in your records for internal and external verification purposes because it shows your clinical workload and the ongoing pattern of care being provided.

KEY MESSAGE

No type of gambling associated with harm ⇒ no primary problem gambling mode.

No primary problem gambling mode ⇒ do not record in CLIC.

Family members may seek help for themselves by directly approaching your service with or without the person who has experienced gambling harm. If they do, your service should provide them with full intervention services. However, in many cases they may attend with the person directly experiencing gambling harm to the service, without expecting to participate in any way except perhaps in a support role. In these cases, the family member may not be aware that the gambling behaviour and its consequences have affected their health and wellbeing, and that they would also benefit from your services.

3.8 Frequently asked questions

3.8.1 Why should I conduct a brief intervention?

A brief intervention is an opportunity to:

- intervene before the consequences of a person's gambling behaviour are significantly damaging to the individual, their family and whānau and society
- intervene at an earlier stage of concern, making the intervention less intrusive than might otherwise be the case
- build awareness of gambling harm in communities and the importance of communities' involvement in the change process
- engage people in intervention processes and increase their awareness and recognition of the impact that gambling harm has on their life.

3.8.2 Who can conduct a brief intervention?

Even though brief interventions rely on community service involvement in screening the client/tangata whai ora base, they must be conducted by service providers who have assessment, screening and intervention skills in working with gambling harm. The practitioner who conducts an intervention must have motivational skills and a good knowledge of the appropriate resources to recommend to potential clients/tāngata whai ora. It is also important that the provider has a good understanding of the service delivery rules that guide the intervention processes.

KEY MESSAGE

A brief intervention is a clinical intervention and needs specific clinical training and skills. While there are benefits in having frontline and public health staff doing brief interventions – given they are often the public face of a service – staff should always be appropriately trained to deliver the intervention safely and effectively.

3.8.3 What do I do if a client/tangata whai ora screens positive in a public setting?

In some cases, you may screen a client/tangata whai ora in a public setting, such as in an education group as part of awareness raising and they return a positive score. If so, it is important to find an opportunity to take the client/tangata whai ora aside and ask them if you can give them feedback on the screen results.

Use motivational-style feedback to encourage the client/tangata whai ora to consider making an appointment where they can give and receive more information about their gambling behaviour and discuss its relationship with other aspects of their life. This is a brief intervention session. If the client/tangata whai ora agrees to seek further formal support from your service, record the next session they attend as a full intervention session.

If you cannot have a private conversation with the client/tangata whai ora at this time, or if they are unsure about making an appointment, you may be able to get them to agree to have another brief discussion in a week or so in a more private environment after they have had time to consider what has been discussed. You can record each of these sessions in CLIC as a brief intervention as long as the client/tangata whai ora has a primary problem gambling mode. Remember that many people can change their gambling behaviour on their own, so also offer the client/tangata whai ora brochures and other information to read and consider between sessions.

If the client/tangata whai ora makes an appointment for a full intervention session, open a file and ask them to complete the appropriate screens (if they have not already done so), as well as any other assessment or engagement procedures following the usual policy for your agency. Note that you can complete some of the administration and completion of forms after the session. See section 4.4 for a guide to key steps for welcoming clients/tāngata whai ora to a session.

3.8.4 What if my brief intervention client/tangata whai ora identifies as both experiencing

gambling harm directly and as family/whānau/affected other?

If the client/tangata whai ora is experiencing problems with their own gambling behaviour and is also affected by a family member's gambling behaviour, discuss with them their primary reasons for seeking help and use that category. However, if the client/tangata whai ora is experiencing significant harm from their own gambling behaviour, it is preferable to arrange a subsequent session for them as the person experiencing gambling harm, in a full intervention. If the client/tangata whai ora wants to be identified as a family/whānau/affected other, they must know the primary problem gambling mode of the person who has experienced gambling harm to be recorded in CLIC; if they don't (and they have also experienced gambling harm), then you could register them as the person experiencing gambling harm for the brief intervention. Once the client/tangata whai ora is in a full intervention, you can record them in either category, depending on the main focus of that session (see frequently asked questions on full intervention in section 4.7).

4 Full intervention

4.1 Introducing a full intervention

A full intervention:

- is one or more sessions in a specialist setting with people experiencing harm from their own or someone else's gambling
- involves working with people who have to some degree acknowledged the harms they are experiencing from gambling
- involves working with people who have made some commitment to seeking support from a specialist gambling harm service.

A full intervention is an opportunity to work clinically with people who have been identified as experiencing gambling-related harm. This harm can be the by-product of an individual's gambling behaviour or the negative impact of another person's gambling behaviour. The person could also be experiencing harm from their own **and** someone else's gambling behaviour, and the impact of this harm could be subject to current as well as past problem gambling experiences.

You have several clinical options within a full intervention. You may consider that:

- a full intervention need involve only the individual in assessment and counselling (full intervention sessions)
- the client/tangata whai ora needs support to access other services for co-existing issues they have concerns with (facilitation sessions)
- a group therapy session is appropriate as a full intervention sessions may also be provided through group therapy.

Full intervention is a complex service and represents the foundation of an intervention service. Full intervention loosely comprises five key parts:

- screening (section 4.1.1)
- developing an intervention or treatment plan (section 4.1.2)
- relapse prevention (section 4.1.3)
- planning for exit (section 4.1.4)
- working with family/whānau/affected other (section 4.1.5).

4.1.1 Screening

Important benefits of using a range of screens are that it:

- ensures that you formally ask about gambling harm and other associated issues
- enables you to give feedback
- raises the awareness of the client/tangata whai ora of the effects of the gambling
- provides information for treatment plans and a starting point from which you can measure progress.

Screens are used in both brief and full interventions to identify clients/tangata whai ora who have co-existing problems and will benefit from facilitation to another service, and in follow-up for measuring outcomes of the full intervention. They also provide an opportunity to identify further needs of the client/tangata whai ora.

KEY MESSAGE

Screens are not a diagnosis, but they can provide useful feedback for clients/tangata whai ora and practitioners. A screen score does not mean much on its own. The story it tells can only ever be fully understood by talking to the client/tangata whai ora about the results, and what those results mean to them in the context of what is happening to them now.

4.1.2 Intervention or treatment plan

The intervention or treatment plan is an action plan a client/tangata whai ora develops with your help. The plan comprises a series of goals the client/tangata whai ora wants to achieve during treatment. The plan should take into account information from the screens used, comprehensive assessment information, your feedback, the motivation of the client/tangata whai ora to change, their insight, and the priority that they place on the specific changes they want to achieve.

KEY MESSAGE

Each client/tangata whai ora should have a comprehensive assessment completed before they have a treatment plan. The treatment plan should map out the ideal treatment journey for the client/tangata whai ora according to best practice, reflecting their priorities and needs and what they want from participating in treatment.

The plan provides a structure for the goals of the full intervention. You can review it during therapy for evidence of the progress of the client/tangata whai ora or the need for change or further resources, or you can add to it as new insights are found. For a more detailed discussion of the plan, see section 4.6.

4.1.3 Relapse prevention

Addictions are characterised by addictive behaviours that can return to pre-treatment levels due to biological, psychological or social influences. In relapse prevention therapy, the aim is to help the client/tangata whai ora establish adaptive coping behaviours and ways of thinking that can counter risky behaviours, thoughts and beliefs. In addition, you can support the client/tangata whai ora to learn and engage in alternative behaviours that are inconsistent or incompatible with the addictive behaviour.

In addressing gambling harm, coping behaviours include avoiding gambling environments, such as through self-exclusion from their preferred venue of choice, or a multi-venue exclusion process, whereby the client/tangata whai ora excludes themselves from a number of venues in their area that they may have been likely to visit for gambling. This strategy helps to take away their choice to gamble and can provide for a break in their gambling behaviour, for up to two years (see section 7.3 for more on this process). In addition, addressing issues such as depression that may lead to relapses, managing their access to money, and developing social support networks can be useful strategies.

Although relapse prevention is addressed particularly at the end of a full intervention, it should be addressed throughout the process. Given that many clients/tāngata whai ora feel despondent and guilty if they relapse, it is useful to discuss relapse early on in an intervention, normalise the feelings and concerns the client/tangata whai ora may have and, if relapse does happen, reframe it as a 'learning experience'.

4.1.4 Planning for exit

Planning for exit is about focusing on empowering the client/tangata whai ora to be independent, while remaining supportive and ensuring their needs are met. Planning for exit should begin in the early stages of an intervention and be reflected through all the steps of the intervention process. It addresses other problems that might lead to gambling harm, establishes and maintains post-treatment goals, and ensures the client/tangata whai ora knows they can recontact the service if the need arises. Although you often agree on the number of sessions the client/tangata whai ora attends for a full intervention when you are developing the treatment plan, it is useful to discuss relapse with clients/tāngata whai ora and to acknowledge that, while you are both talking about an end-point for treatment, they can enter and exit services as often as they need to.

KEY MESSAGE

Planning for exit is not about telling the client/tangata whai ora that you are finished with them. It is about giving them hope for the future and reassuring them that, while they will have all the support they need for as long as they need it, there will come a day when they will be able to tell you that they do not need you any more.

4.1.5 Working with family/whānau/affected other

Family and whānau members and others affected by another's gambling often accompany clients/tāngata whai ora who are directly experiencing gambling harm to sessions or may present to a service on their own. Often family/whānau/affected other contact a service out of concern for someone else's gambling behaviour. Ensure that people who contact the service for someone else or attend to support someone else are aware that they could be experiencing harm from the other person's gambling behaviour and that they can receive support independent of the person experiencing gambling harm.

When the family/whānau/affected other is attending to support another person, they may focus on the other person's needs and may not be ready or able to acknowledge their own needs. In these cases, maintain an open offer of support. Screening and occasional motivational discussion can provide opportunities for the person to engage with the idea of seeking help for themselves.

In working with family/whānau/affected other, you need similar processes and skills to those needed for working with those experiencing gambling harm directly. Your main challenges are to maintain appropriate confidentiality between multiple clients/tāngata whai ora if they are all attending, and to help the person focus on their own needs rather than on those of the person experiencing gambling harm.

4.2 Summary of full intervention service

A full intervention consists of a set of clinical intervention sessions that are guided by the treatment and support needs of the client/tāngata whai ora. Some clients/tāngata whai ora may not need as much time or resources and may only need several sessions over a relatively brief period, for example, eight sessions over three months. Other clients/tāngata whai ora with complex needs and co-existing problems may need considerably longer; regular clinical reviews within the service can guide decisions about the exact time involved. Typically, sessions are booked for about 60 minutes, but they can be as short as 15 minutes, usually when contact with a client/tāngata whai ora is by phone. To comply with the intervention service contracts, **at least one full intervention must include a face-to-face session (which may be via technological means such as Skype).**

A full intervention can begin from several opportunities.

- The Gambling Helpline may refer an individual to the service, after conducting a screening of needs and providing some phone or text counselling. In this case, you can establish that harm has occurred so record a full intervention session with the referred individual. A brief intervention is not appropriate in this circumstance.

- You may have conducted brief interventions in the community, including screening, and a person has gained insights into the harm gambling has caused them and wants further to contact on a clinical basis. In this case, record your initial contact with this person as a brief intervention. Then record a full intervention session when you next see the client/tangata whai ora. Initial full intervention sessions are likely to include further screening and the start of a comprehensive assessment.
- If an individual makes direct contact with the service or has been referred to the service from a referral source, and has identified gambling-related harm, then record a full intervention. A brief intervention is not appropriate in this circumstance.
- If, through the follow-up process or the individual's own initiative, the client/tangata whai ora wants to re-engage with the service for further support (ie, after a relapse), record a new full intervention for the individual. A brief intervention is never appropriate in this circumstance, because once a full intervention has been activated for a client/tangata whai ora, a brief intervention is not applicable.

Figure 4.4 sets out a flowchart of typical client/tangata whai ora pathways and practitioner decisions for full interventions.

4.2.1 Exceptions

To receive ongoing support from a gambling harm intervention service, clients/tāngata whai ora should:

- have a primary problem gambling mode (PPGM) (see section 4.6 for examples)
- show signs of gambling harm (see section 4.5).

If clients/tāngata whai ora are identified as needing ongoing support for other health and social issues and are not experiencing harm from gambling, refer them, or facilitate their access, to an appropriate service within one to two sessions.

A client/tangata whai ora receiving support from face-to-face intervention services should have some face-to-face time with their practitioner. If you are to record a valid comprehensive assessment, a client/tangata whai ora must have had at least one session face to face (which may occur via technological means when there are no face-to-face options).²

Practitioners should encourage clients/tāngata whai ora to attend face-to-face sessions and should only offer phone support when the client/tangata whai ora cannot attend a face-to-face session. Email and text can be useful tools for maintaining contact with clients/tāngata whai ora – to quickly touch base or confirm a session or appointment – but they should not replace the in-depth contact of a face-to-face or, if necessary, phone contact. **Note that a comprehensive assessment requires at least one face-to-face session in order to be valid (which can be via technological means such as Skype if there are no face-to-face options).**

² Note that this requirement does not apply to full intervention services delivered by the Gambling Helpline.

Only in exceptional circumstances can you count a text message or email as a phone call. If client/tangata whai ora asks for it, and you consider all other options for contact are not feasible, text or email correspondence may be considered. In this case, you would have to see communication by text or email as a clinical intervention rather than a tool for maintaining contact. Any correspondence under these circumstances would have a written record of the correspondence that took place. After this event, there should be evidence that you have followed that correspondence through with a face-to-face session or phone call to the client/tangata whai ora, if at all possible.

KEY MESSAGE

With the exception of the Gambling Helpline, services should focus on face-to-face sessions with clients/tāngata whai ora. Sessions over the phone are acceptable when the client/tangata whai ora cannot easily access the service in any other way, but you need to have at least one face-to-face session (which can be via Skype, for example) to complete a comprehensive assessment.

4.2.2 Group therapy sessions

Group therapy can be provided within a full intervention episode and is a common form of treatment in the addiction field. Group therapy is an evidence-based approach that addresses drivers to gambling.

Group therapy is often implemented together with individual counselling sessions. The five category models or types of therapy groups are:

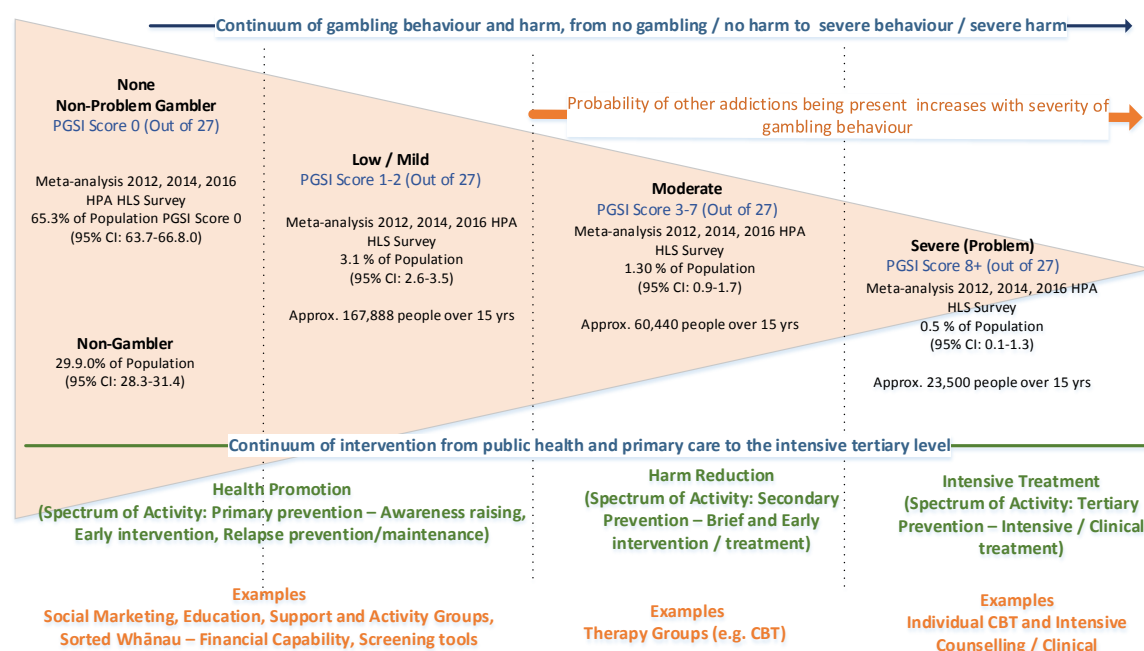
- psycho-education groups
- skills development groups
- cognitive behaviour groups
- support groups
- interpersonal process groups.

The most common features of all therapy-based groups are that they:

- are led by an experienced, qualified counsellor
- are very structured, goal oriented and explicit and use systematic procedures
- include behavioural change components
- usually have an optimum size of six to eight members
- are usually 60–90 minutes long for each session
- are usually over a set number of weeks.

In terms of gambling-related harm, therapy groups are for gamblers and family/whānau/affected other who have a moderate gambling problem, as Figure 4.1 shows.

Figure 4.1: Gambling behaviour and harm: the continuum of prevention and harm reduction



Note: CBT = cognitive behavioural therapy; CI = confidence interval; HLS Survey = Health and Lifestyles Survey; HPA = Health Promotion Agency; PGSI = Problem Gambling Severity Index.

Group therapy sessions/workshops are usually up to two hours long, begins once an individual comprehensive assessment has been completed, and is recorded as a group session and not a full intervention session. When a group therapy is longer than two hours, record the actual duration.

After assessment, counselling and, sometimes, brief group therapy, some clients/tāngata whai ora may prefer maintenance group therapy support over a longer period rather than go on to follow-up or be discharged. In this case, the above group guidelines also apply, and this process would still occur within full intervention, when it is a facilitated group. This would also allow clients/tāngata whai ora to be seen for counselling or facilitation, if required, during their period of group membership. On leaving the group, they would be eligible for follow-up at that point.

Recording group therapy sessions in CLIC

For all group therapy session participants, you must record the session in the CLIC. Record details of the type of group in the label of the session (Figure 4.2). You can edit the list of labels using the Settings option 'Session labels List' or by changing the Group Name after selecting 'Add Group Session'.

Figure 4.2: How to record group therapy sessions in CLIC

When: 03/04/19 Duration (hrs): 1.25 Extra Data

Who: Group How: Face-to-Face

Theme: Full - Counselling

Where: Office

Label: CBT Group Facilitation Ag

4.2.3 Comprehensive assessment

During a full intervention, the Ministry expects that providers will complete a comprehensive assessment of clients/tāngata whai ora experiencing gambling harm, as well as those presenting as family/whānau/affected other. The person to complete this comprehensive assessment should be an appropriately qualified clinical practitioner, who has skills and experience in working with people experiencing gambling harm.

Redo a comprehensive assessment at any point you consider it to be useful. As a guide you should consider redoing a comprehensive assessment for any client/tāngata whai ora who has not been seen by a practitioner for three months (in a full intervention session or follow-up session). If a client/tāngata whai ora is still engaging in treatment at three months, it is strongly recommended that a client/tāngata whai ora case review, where you rescreen using the mandatory gambling harm screens and use this information to provide the client/tāngata whai ora with evidence of progress and to update the comprehensive assessment.

Most of the screening questions needed to inform a comprehensive assessment are asked again at follow-ups three, six and 12 months later. Where a comprehensive assessment occurs because the client/tāngata whai ora returns to full intervention from follow-up, it can build on their response to these screens.

KEY MESSAGE

Although a comprehensive assessment involves some use of screens, it should also focus on identifying the wider social and cultural context and history of the client/tāngata whai ora, what has motivated them to seek help on this occasion, and what resources and strengths, including family, whānau and other close supports, are available to them.

Assessing gambling harm

You must complete several gambling harm screens and discuss them with the client/tāngata whai ora to comply with best practice and the requirements of the contract. Screens are effective for getting a basic understanding of how concerned a client/tāngata whai ora is about their level of gambling harm. You can also use them to provide feedback to the client/tāngata whai ora to increase their awareness and develop an incentive for change.

However, it is important to assess beyond the screens to get a complete diagnostic view of the level of gambling harm to the client/tāngata whai ora. You can do this by gathering information from the client/tāngata whai ora through conversation and other diagnostic tools and assessing how gambling has affected them and their family/whānau/affected other and other people in their life.

For example, obtain a history of the gambling behaviour development of the client/tāngata whai ora, (age gambling started, circumstances if relevant, types of gambling mode, frequency and patterns of play, and expenditure). Ask about any attempts the client/tāngata whai ora has made on their own to change, what the high-risk triggers to gambling are for them, and the extent to which gambling has affected

other aspects of their life, such as relationships, work, their physical and mental health (coexisting problems), and their financial and cultural/spiritual wellbeing.

Screens for co-existing problems

As part of the requirement for a comprehensive assessment, service providers also need to assess (by screening and using diagnostic skills and tools) other health and social areas of the life of the client/tangata whai ora that may have been affected by gambling behaviour. Along with their perception of these issues, it is also important to look at how concerned the family/whānau/affected other have been about the client/tangata whai ora.

When a person has a co-existing problem, it may make them more likely to have experienced gambling harm, and they may also have more difficulty trying to change their gambling behaviour. Because a co-existing problem makes a person more vulnerable, it is important to recognise co-existing problems in order to establish what extra resources will be required. This is where the facilitation service also becomes important.

A co-existing problem will have a significant impact on what relapse-prevention strategies need to be put in place to avoid a 'revolving door' situation. Although services should encourage clients/tāngata whai ora to re-engage with services when required, achieving a state of wellbeing is more likely when all associated problems are identified and addressed.

Recognition of co-existing problems for clients/tāngata whai ora who attend gambling harm services has become an increasing part of the work of gambling harm practitioners. The Ministry of Health's (2010) *Service Delivery for People with Co-existing Mental Health and Addiction Problems* highlights that mental health and addiction services are interrelated, and that both are the core business of mental health and addiction services.

Please refer to the 'Co-existing problems' guide (section 7.8), which covers assessment screens both for those experiencing gambling harm and significant others, treatment planning, and outcome measures, along with screening tools for co-existing problems. See Chapter 6 also for information about the Vulnerable Children Act 2014 (section 7.5) and *Supporting Parents, Healthy Children* (Ministry of Health 2015) (section 7.4).

RESOURCE

See also the separate 'Co-existing problems' guide (section 7.8) and other resources in Chapter 7.

4.3 Intervention planning

Intervention planning is a necessary component of a comprehensive assessment. Once you have gathered all the assessment material, negotiate an action plan with the client/tangata whai ora. This plan will guide your clinical work, such as appropriate

therapy initiatives, facilitations and community referrals. It also becomes the basis from which you can review and modify treatment plans and determine outcome measures.

4.3.1 Missed sessions

The level of enthusiasm, motivation and commitment of a client/tangata whai ora to address the issues in their life often changes over the course of an intervention, as do their personal circumstances. Clients/tāngata whai ora may miss sessions for a range of reasons, some of which are outside the control of both the client/tangata whai ora and the practitioner.

KEY MESSAGE

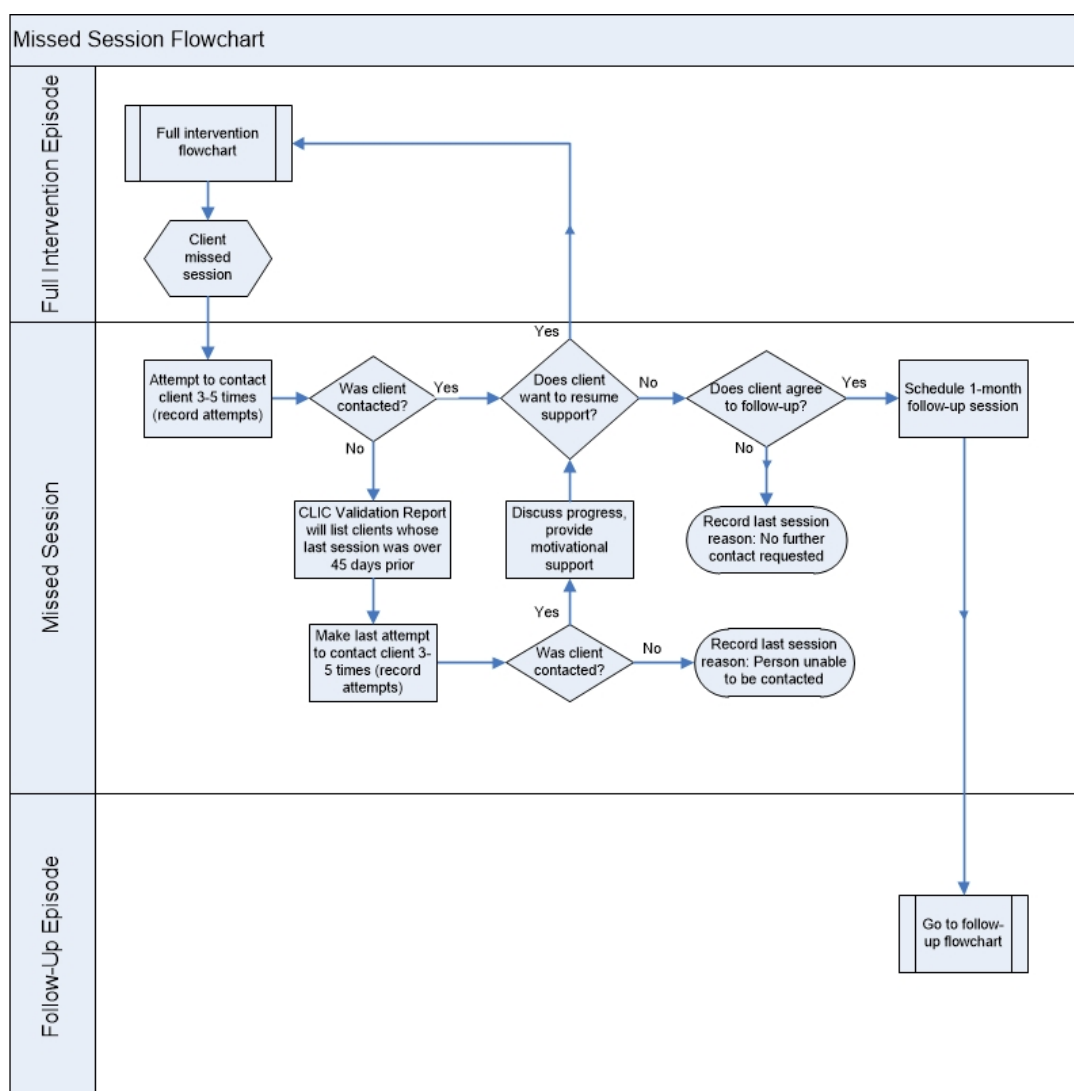
Contacting a client/tangata whai ora by phone or mail to discuss a missed appointment or to make a future appointment does not count as a session. Any session recorded in CLIC should involve significant discussion of the gambling harm status of the client/tangata whai ora as well as progress and satisfaction with their recovery.

Figure 4.3 clarifies the Ministry of Health's intentions for clients/tāngata whai ora who miss sessions and provides guidance on how to proceed when you cannot contact clients/tāngata whai ora.

KEY MESSAGE

Until a client/tangata whai ora with a primary problem gambling mode is no longer able to be contacted – or has asked a service to stop contacting them – you can always record the time you spent contacting or trying to contact them in CLIC as a failed contact.

Figure 4.3: Missed sessions and reconnecting with clients/tāngata whai ora



Note: See Appendix 4 for a guide to the symbols used in this figure.

4.3.2 Ending full intervention treatment

A full intervention is made up of an integrated set of full intervention sessions and represents the core of the intervention journey for most clients/tāngata whai ora. Ending full intervention treatment represents the progress of the client/tāngata whai ora, or a change in their needs or in their willingness to continue to engage with the service. Some clients/tāngata whai ora may return for support many times in the future, but it is important to record the end of this stage of treatment to provide an accurate representation of their experience.

KEY MESSAGE

Remember: clients/tāngata whai ora can always come back. Return visits and multiple full intervention episodes do not mean that either the client/tāngata whai ora or the practitioner has 'failed'. Relapse is a common part of recovery from addiction and can be reframed as a 'learning experience'.

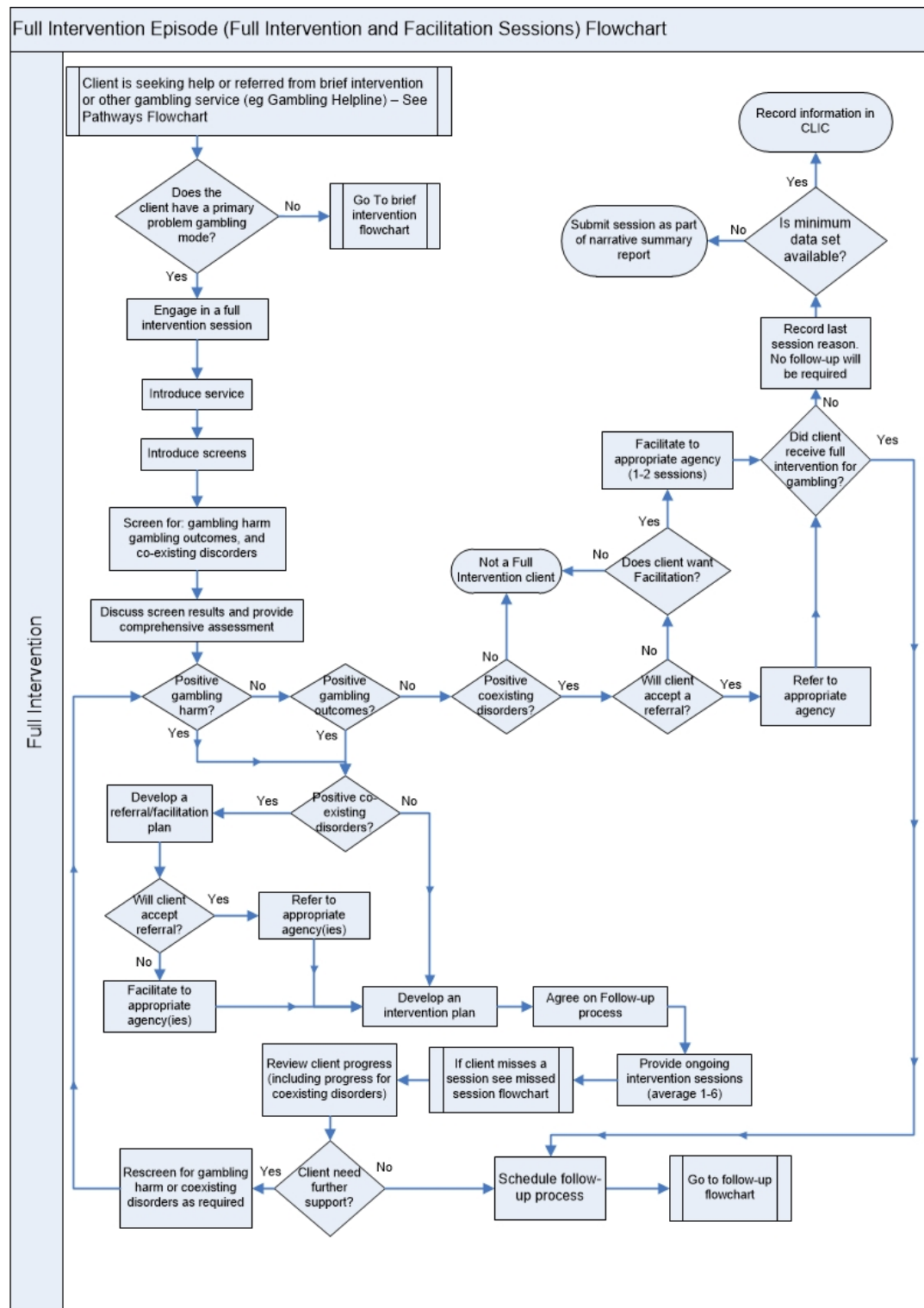
Table 4.1 summarises the most likely reasons for ending full intervention treatment. Note that you should enter a last session reason only if you believe that the client/tangata whai ora in question will not be having any further sessions of any type with your service.

Table 4.1: Ending full intervention treatment or episode

Client/tangata whai ora outcome	Clinical action	CLIC administration: last session reason
A client/tangata whai ora, who is not experiencing gambling harm and has no primary problem gambling mode but has other social or health issues, has been facilitated to access an appropriate service.	Do not schedule a follow-up session. Record the activity as a facilitation.	Person transferred to another non-gambling harm provider.
A client/tangata whai ora experiencing gambling harm has received full intervention and/or facilitation sessions and has agreed to be transferred to a different gambling harm service provider.	Do not schedule a follow-up session.	Person transferred to another gambling harm treatment provider.
A client/tangata whai ora experiencing gambling harm has received full intervention and/or facilitation sessions and has agreed they no longer need specialist support.	Schedule a follow-up session.	Not applicable. No last session reason is required as this is not the last session. The full intervention will be automatically counted as closed once the first follow-up session has been entered.
A client/tangata whai ora experiencing gambling harm has received some full intervention and/or facilitation sessions and has decided, against clinical judgement, that they no longer need specialist support.	Schedule a follow-up session.	Not applicable. No last session reason is required as this is not the last session. The full intervention will be automatically counted as closed once the first follow-up session has been entered.
A client/tangata whai ora experiencing gambling harm has received some full intervention and/or facilitation sessions and has explicitly stated that they no longer wish to be contacted (not even for a follow-up).	Do not schedule a follow-up session	No further contact requested.
A client/tangata whai ora experiencing gambling harm has received some full intervention and/or facilitation sessions, missed a scheduled appointment and was unable to be contacted further within 90 days (three months).	Do not schedule a follow-up session.	Person unable to be contacted.

<p>A client/tangata whai ora experiencing gambling harm has received some full intervention and/or facilitation sessions, but has had no session within the last 30 days (one month) and the practitioner has not entered any last session reason.</p>	<p>Schedule a follow-up session: this will be a final opportunity to formally recontact the client/tangata whai ora.</p>	<p>Not applicable. No last session reason is required at this stage as this may not be the last session. If you can recontact the client/tangata whai ora, the full intervention will be automatically counted as closed once the first follow-up session has been entered. The follow-up reminder report will generate a reminder for the follow-up attempt.</p>
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Figure 4.4: Typical client/tangata whai ora pathways and practitioner decisions for full intervention



Note: See Appendix 4 for a guide to the symbols used in this figure. See also Figure 2.3: Typical client pathways into intervention services (Chapter 2).

4.4 Key steps for first sessions

The first sessions with clients/tāngata whai ora are critical for establishing a relationship with them, discussing their expectations and clarifying their needs. The key steps below are intended as a guideline only; many organisations have their own protocols and processes for engaging with clients/tāngata whai ora.

Some clients/tāngata whai ora happily identify their needs in the first session, but others want to hear more about the service and the process before they discuss personal issues. For most people, these steps should be addressed early in the clinical journey of the client/tāngata whai ora.

The key steps to cover early are:

- welcoming the client/tāngata whai ora and establishing a relationship (section 4.4.1)
- identifying the needs of the client/tāngata whai ora and agreeing to an intervention plan (section 4.4.2).

4.4.1 Welcoming the client/tāngata whai ora and establishing a relationship

Early in establishing a relationship, discuss:

- confidentiality
- the expectations of the client/tāngata whai ora, including whether they know:
 - what counselling is
 - how you can help them
 - what a typical client/tāngata whai ora pathway might involve.

Concern about confidentiality is a key barrier for many new clients/tāngata whai ora experiencing gambling harm. Reassure the client/tāngata whai ora that their information will remain private and that they can ask to see or hold their own information at any time. This reassurance can help them to feel safe to discuss their gambling behaviour. You should also explain the exception to confidentiality: with confidentiality override, someone's safety might be at risk and that information may need to be discussed with others to ensure that person is safe.

Examples of confidentiality override are where the client/tāngata whai ora:

- is at risk from suicidal thoughts and has a plan they intend to carry out
- has thoughts or intentions of harming someone else or is neglecting or abusing a child or children.

If the issues cannot be resolved in the session or safety cannot be assured, discuss this with the client/tāngata whai ora and then take the steps needed to ensure safety. These steps could involve handing the issue over to a senior practitioner, manager, community assessment and treatment team, police or Oranga Tamariki (Vulnerable Children Act 2014). Practitioners must balance the concerns about maintaining engagement through confidentiality against high-risk safety concerns for tāngata whai ora, children and others.

Another key barrier to accessing intervention services, and to benefiting fully from the services, is that clients/tāngata whai ora do not understand what counselling is, how it can help them and what they should expect. Reassure clients/tāngata whai ora that they can reduce gambling harm. Also outline for them a range of typical client/tāngata whai ora journeys, which will help many clients/tāngata whai ora to understand how intervention services can help them and how much treatment can vary.

If the client/tāngata whai ora is also a family/whānau/affected other, they may need reassurance that therapy can be appropriate for them too. Even if they are attending with the person directly experiencing gambling harm to provide support, they may find it valuable to see the practitioner independently of the person experiencing gambling harm to discuss their own needs and concerns.

4.4.2 Identifying needs of the client/tāngata whai ora and agreeing to an intervention plan

As your relationship with the client/tāngata whai ora becomes established:

- screen for gambling harm, outcomes and other co-existing issues
- discuss relapse and how you will support the client/tāngata whai ora
- agree to an intervention plan
- discuss, ahead of time, how the full intervention treatment will end
- agree on a follow-up plan.

Although practitioners sometimes feel awkward introducing screens, those screens often help the client/tāngata whai ora to normalise their feelings, provide a context for the client/tāngata whai ora to see the impact of gambling on their life, provide points of comparison to show progress, and indicate other issues the practitioner should be considering. For more detail on screens, see section 4.5.

KEY MESSAGE

Ministry guidelines allow up to three sessions with a client/tāngata whai ora to complete the screening. Some clients/tāngata whai ora (including some cultures, eg, Asian peoples) may need more than three sessions. However, most of the time practitioners should be able to have the client/tāngata whai ora complete the screens in the first session as part of talking about what their gambling behaviour is like and why they are seeking help.

Discussing relapse, agreeing on an intervention plan and ending treatment are important for most clients/tāngata whai ora. Normalising the concept of relapse early in their journey makes it less likely that they will drop out of treatment or experience a sense of failure if they do relapse. By beginning to agree on an intervention plan, the client/tāngata whai ora gains a sense of a future without gambling harm and some feeling of control over their life, and this also clarifies how the practitioner will be supporting them.

Agreeing on a follow-up plan as part of the intervention plan helps to maintain contact and support the client/tāngata whai ora if they relapse, drop out of the service or become discouraged. It also helps to reassure the client/tāngata whai ora that, even though they are planning to become independent of their gambling and of treatment, you will still be in contact to support them as required.

4.5 Screening for full intervention

The minimum screens for a full intervention episode are:

- the gambling harm screens (gambler or family/whānau/affected other) (see sections 4.5.1 and 4.5.3)
- outcomes screens to assess change for the client/tāngata whai ora (the person experiencing gambling harm or family/whānau/affected other) and service (sections 4.4.2 and 4.5.4)
- co-existing problems screens to assess other issues for the client/tāngata whai ora (the person experiencing gambling harm or family/whānau/affected other) (section 4.5.5).

Comprehensive assessment involves asking the three groups of screening questions, discussing the responses and probing further as relevant. In addition, ask about the personal history of the client/tāngata whai ora (cultural, spiritual, family and whānau context), growing up (any significant or traumatic events), history of types of gambling behaviour and current gambling status. Also ask what has motivated them to seek help on this occasion, and what resources and strengths, including family, whānau and other close supports, are available to them.

The gambling harm and outcome screens are different for the person experiencing gambling harm and family/whānau/affected other. The co-existing problems questions are the same for both groups. The gambling harm screens are discussed in section 4.5.1 for the gambler and section 4.5.3 for family/whānau/affected other.

You should always start by determining whether the client/tāngata whai ora is attending for help with their own gambling harm or is affected by someone else's gambling behaviour (or both). Rather than asking direct questions, lead into an enquiry about their general life circumstances as well as gambling behaviour. Remember that clients/tāngata whai ora will be interested in the questions you are asking and what their responses mean.

Take the time to discuss the screens and explain how they can help the client/tangata whai ora. Talking about the screens with the client/tangata whai ora will often start them thinking about the effects of gambling on their life in new ways.

Check whether the client/tangata whai ora is seeking support for their gambling behaviour, or because of someone else's gambling.

If the client/tangata whai ora is gambling, go to the full Gambler Harm Screen (see section 4.5.1).

If it relates to someone else's gambling behaviour, go to the full Family/Whānau/Affected Other Harm Screen (see section 4.5.3).

4.5.1 Gambler Harm (PGSI) Screen

There is a screen for assessing gambling harm as part of a full intervention episode. This screen is called the Gambler Harm Screen; your contract refers to it as the Problem Gambling Severity Index (PGSI).

All services are required to undertake PGSI screens with **all** full intervention (as well as with follow-up) clients/tāngata whai ora at their first consultation and every three months thereafter if they are still in treatment. The PGSI screen is a key indicator of improved outcomes for clients/tāngata whai ora and is included as a 'is anyone better off' measure in service contracts.

There are three questions you should ask as outcome measures for clients/tāngata whai ora seeking help for their own gambling behaviour. These questions are the gambling outcome screens (see section 4.5.2).

Text in italics gives instructions for the information to enter into CLIC for each screen, for example '*Record the number of positive responses to questions 1 to 4*'. For the full version of all screens, see Appendix 1.

For people screening for their own gambling behaviours, the following screen is used for full interventions.³ The client/tangata whai ora may answer 'never' (0), 'sometimes' (1), 'most of the time' (2) or 'almost always' (3).

³ The Gambler Harm Screen uses the Problem Gambling Severity Index, a subset of the Canadian Problem Gambling Index.

Gambler Harm (PGSI) Screen *(record the total score)*

- 1 Thinking about the past 12 months, how often have you bet more than you could really afford to lose?
- 2 Thinking about the past 12 months, how often have you needed to gamble with larger amounts of money to get the same feeling of excitement?
- 3 Thinking about the past 12 months, how often have you gone back another day to try to win back the money you lost?
- 4 Thinking about the past 12 months, how often have you borrowed money or sold anything to get money to gamble?
- 5 Thinking about the past 12 months, how often have you felt that you might have a problem with gambling?
- 6 Thinking about the past 12 months, how often have people criticised your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?
- 7 Thinking about the past 12 months, how often have you felt guilty about the way you gamble, or what happens when you gamble?
- 8 Thinking about the past 12 months, how often has your gambling caused you any health problems, including stress or anxiety?
- 9 Thinking about the past 12 months, how often have you felt your gambling has caused financial problems for you or your household?

How to score the Gambler Harm (PGSI) Screen

Score the Gambler Harm (PGSI) Screen based on the response of the client/tangata whai ora to each question:

- Never = 0
- Sometimes = 1
- Most of the time = 2
- Almost always = 3.

If the total score is 3 or more, the client/tangata whai ora meets the conditions for full intervention services. A positive screen of 3–7 indicates moderate risk and 8–27 indicates problem gambling. If the client/tangata whai ora scores less than 3 (a negative screen), use your clinical judgement or assess them further.

4.5.2 Gambler outcome screens

As part of the comprehensive assessment, ask your clients/tāngata whai ora who are receiving support for their own gambling about:

- their control over their gambling behaviour (Gambler Outcome Screen – Control over Gambling)
- the amount of money they have lost ('dollars lost') (Gambler Outcome Screen – Dollars Lost)
- their annual household income (Gambler Outcome Screen – Annual Household Income).

This section sets out these three screens in turn.

Gambler Outcome Screen – Control over Gambling

The CLIC system calls this question 'Gam Outcome Control'.

Control over gambling (*record the number of the response, ie, 1, 2, 3 or 4*)

During the past month:

(1) I have had complete control over my gambling.

or

(2) I have had some control over my gambling.

or

(3) I have had little control over my gambling.

or

(4) I have had no control over my gambling.

Reason for using the control over gambler outcome measure

The response given to the question about the perceived control of the client/tāngata whai ora over their gambling provides a starting point or baseline. You can ask the question again after the full intervention treatment, and the answer may provide evidence of a positive outcome from the treatment.

The response may also indicate whether your therapeutic approach is inconsistent with other evidence. For example, if the client/tāngata whai ora selects 'no control' but describes control measures they have put in place but undervalued, you may highlight these to improve their confidence of success (given that a belief in success may be an important factor in trying to or maintaining change).

Alternatively, if the client/tangata whai ora is presenting under pressure, they may overestimate their control over their gambling. Your focus here may be to motivate change by making the client/tangata whai ora aware of the costs to themselves or others and reconsider the importance of changing. A belief in the importance of change is an important factor in even starting to change.

Gambler Outcome Screen – Dollars Lost

The CLIC system calls this question 'Gam Outcome Dollars'.

Dollars lost (*record the response, eg, \$5,000*)

In the last month when you were gambling, roughly what amount of money did you spend on gambling?

This is the total amount of money in dollars that you used on your gambling activity or activities (ie, money you took to gamble with plus any additional money you obtained and gambled with such as from cash machines and EFTPOS). Ignore any money you won during your gambling sessions.

Dollars spent on gambling: \$.....

Why use the dollars lost outcome measure?

The sum of money lost can provide a baseline for before the client/tangata whai ora participates in the full intervention treatment. When this question is asked again after treatment, the response, if lower, may indicate a positive outcome that could be due to the treatment. The question focuses on the amount spent, *not* the money won. If the client/tangata whai ora had won a jackpot in the past month, they may have offset many of their losses. If they took this win into account, the result might be a lower amount spent than in a usual month.

Gambler Outcome Screen – Annual Household Income

The CLIC system calls this question 'Gam Outcome Income'.

Annual household income (*record the number of the response, ie, 1–7.*)

- (1) ☐ < \$20,000
- (2) ☐ \$20,000–\$30,000
- (3) ☐ \$31,000–\$50,000
- (4) ☐ \$51,000–\$100,000
- (5) ☐ \$101,000–\$200,000
- (6) ☐ \$201,000–\$500,000
- (7) ☐ \$501,000+

Reason for using the annual household income outcome measure

The annual household income question helps you to estimate the financial impact of the gambling behaviour of the client/tangata whai ora. The amount of 'dollars lost' requires a context in which to assess the impact: a client/tangata whai ora spending \$100 a week with an annual household income less than \$20,000 is likely to be experiencing considerably more financial difficulty than a client/tangata whai ora spending the same amount with an annual income of more than \$200,000.

The answer to this question can help you to raise their awareness of their gambling behaviour if they have not previously compared their gambling losses against their disposable income. Many clients/tāngata whai ora will not have calculated the weekly costs for themselves and their family and whānau that must be paid before gambling. It may help them to take advice from a budgeter in the service, or to refer them to one, as part of their intervention plan.

4.5.3 Family/Whānau/Affected Other Harm Screen

When you are screening people for the impact of someone else's gambling behaviour on them in a full intervention, use:

- the Family/Whānau/Affected Other Harm Screen, which consists of two questions for assessing the gambling harm as part of a full intervention episode (discussed in this section)
- the Family/Whānau/Affected Other Harm outcome screens, which consist of two questions the Ministry has also selected as outcome measures for clients/tāngata whai ora seeking help related to someone else's gambling harm (see section 4.5.4).

Text in *italics* gives instructions for the information to enter into CLIC for each screen; for example '*Record the number of the response*'. For the full version of all screens, see Appendix 1.

To screen people for the impact of another person's gambling behaviour on them, use the Family/Whānau/Affected Other Harm Screen⁴ for full interventions. This screen is the same as the Brief Family/Whānau/Affected Other Harm Screen (see section 3.7.2).

The Family/Whānau/Affected Other Harm Screen is made up of two questions. You will see that the CLIC system calls these questions 'Family Awareness' and 'Family Effect'.

Introduction/opening statement: Sometimes someone else's gambling can affect the health and wellbeing of others who may be concerned. The gambling behaviour is often hidden and unexpected, while its effects can be confusing,

⁴ The Family and Whānau Whai Ora Harm Screen uses the Concerned Others Gambling Screen, which was developed by Dr Sean Sullivan of ABACUS Counselling Training and Supervision Ltd.

stressful and long-lasting. To help us identify if this is affecting your own wellbeing, please answer the questions below to the best of your ability.

1 Awareness of the effect of the gambler's gambling *(record the number of the response, ie, 0–3.)*

Do you think you have ever been affected by someone else's gambling?

- (0) ☐ No, never. **(If chosen, you need not continue further.)**
- (1) ☐ I don't know for sure if their gambling affected me.
- (2) ☐ Yes, in the past.
- (3) ☐ Yes, that's happening to me now.

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

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

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

3 Support requested *(Do not record response in CLIC)*

What would you like to happen? (Tick one or more.)

- ☐ I would like some information.
- ☐ I would like to talk about it in confidence with someone.
- ☐ I would like some support or help.
- ☐ Nothing at this stage.

How to use the Family/Whānau/Affected Other Harm Screen

For more information about using the Family/Whānau/Affected Other Harm Screen, see section 3.7.2.

Why you use the Family/Whānau/Affected Other Harm Screen

If a client/tangata whai ora has recently completed the Family/Whānau/Affected Other Harm Screen as part of a brief intervention, discuss their previous responses and current views. This provides a further opportunity for the client/tangata whai ora to consider the current effects of the gambling on them, and these may vary after further consideration between the two presentations.

If the client/tangata whai ora has not completed this screen, have them do so now to help them to focus on the impact of the gambling and choose their options for support.

4.5.4 Family/Whānau/Affected Other outcome screens

As part of the comprehensive assessment, ask your client/tangata whai ora seeking support for someone else's gambling behaviour about:

- the frequency of the gambling of the person experiencing gambling harm (Gambling of the person experiencing gambling harm Frequency Screen)
- how they are coping with the gambling of the person experiencing gambling harm (Coping with the Gambling of the person experiencing gambling harm Screen).

Either you or the client/tangata whai ora may fill in the outcome screens. This section details each of these screens.

Family/Whānau/Affected Other Outcome Screen – Gambler's Frequency

The CLIC system calls this question 'Fam Outcm Gam Freq'. The statements below are about the person who was gambling at the time the client/tangata whai ora sought help.

Gambler's gambling frequency

(record the number of the response, ie, 0, 1, 2 or 3)

Which of these four statements is true about the person's gambling over the past three months? (Tick one box only.)

- (0) ☐ The gambler in my life has not been gambling during the last three months.
- (1) ☐ The gambler in my life has been gambling less during the last three months.
- (2) ☐ The gambler in my life has been gambling about the same as usual during the last three months.
- (3) ☐ The gambler in my life has been gambling more than usual during the last three months.

Why you use the Family/Whānau/Affected Other Outcome Screen – Gambler's Frequency

The client/tangata whai ora affected by another's gambling behaviour may continue to be affected adversely by the behaviour of the person experiencing gambling harm if their gambling behaviour has continued at the same or a greater level. Alternatively, the gambling behaviour may be less, or not occurring at all, and improvement may be influenced more by this reduction than by the therapy.

This screen assesses the behaviour of the person experiencing gambling harm, which can be useful to discuss with the client/tangata whai ora. Changes in the gambling

levels of the person experiencing gambling harm that are not reflected in changes in other issues in the life of the client/tangata whai ora may suggest further areas requiring support. For example, if the person experiencing gambling harm has stopped gambling but the client/tangata whai ora is still having relationship or financial difficulties, the answer to this screen may suggest underlying issues are emerging that the gambling behaviour masked or aggravated to the point where they cannot be easily addressed.

How to use the Gambling of the Person Experiencing Gambling Harm Frequency Screen

The Gambling of the Person Experiencing Gambling Harm Frequency Screen is not a measure of the gambling behaviour of another client/tangata whai ora in (or previously in) therapy. The screen provides a context for the Coping with the Gambling of the Person Experiencing Gambling Harm Screen.

Family/Whānau/Affected Other Outcome Screen – Coping with the Gambler’s Gambling

The CLIC system calls this question ‘Fam Outcm Coping’. You can apply this screen during normal discussion with the client/tangata whai ora or over the phone, or the client/tangata whai ora can complete the screen on their own.

Coping with the gambler’s gambling

(Record the number of the response, ie, 1, 2 or 3)

Which of these three statements is true about your ability to cope with the person’s gambling over the last three months? (Tick one box only.)

- (1) ☐ I am coping better with the gambler’s gambling than I have in the past.
- (2) ☐ I am coping about the same with the gambler’s gambling as I have in the past.
- (3) ☐ I am not coping as well with the gambler’s gambling as I have in the past.

Why you use the Family/Whānau/Affected Other Outcome Screen – Coping with the Gambler’s Gambling

The Coping with the Gambling of the Person Experiencing Gambling Harm Screen provides an opportunity for the client/tangata whai ora to realise (and for you to acknowledge) that the wellbeing of the client/tangata whai ora does not depend on the person experiencing gambling harm reducing their gambling and to focus on their own recovery. It is also an opportunity to discuss any lack of improvement in coping and consider further therapy.

How to use the Family/Whānau/Affected Other Outcome Screen – Coping with the Gambler’s Gambling

Interpret the response of the client/tangata whai ora to the Family/Whānau/Affected Other Outcome Screen – Coping with the Gambler’s Gambling alongside their response to the Family/Whānau/Affected Other Outcome Screen – Gambler’s Gambling Frequency. Although the client/tangata whai ora may be improving because the person experiencing gambling harm has reduced or stopped their gambling behaviour, they may have improved even if the person experiencing gambling harm has not. This is an opportunity to emphasise this outcome and to demonstrate that the wellbeing of the client/tangata whai ora is independent of the person experiencing gambling harm.

The person experiencing gambling harm may reduce their gambling behaviour as a result of the change in response to the gambling behaviour of the family/whānau/affected other (eg, refusing to bail out the person experiencing gambling harm).

If you have applied the Family/Whānau/Affected Other Outcome Screen – Gambler’s Gambling Frequency as part of follow-up (see Chapter 6) and client/tangata whai ora has not improved, offer them the opportunity to reconnect with the service for further support, especially if the person experiencing gambling harm has reduced their gambling, as you would expect the client/tangata whai ora to be coping better.

4.5.5 Co-existing issue screens

Apply the co-existing issue screens as part of a comprehensive assessment for all clients/tāngata whai ora experiencing gambling harm and for family/whānau/affected other who are in a full intervention episode.

These questions are the minimum screening requirements to inform the basis of a comprehensive assessment. They represent a core set of questions that you should ask everyone presenting for help.

Ask other questions and use other screens you think are clinically useful. The American Psychiatric Association’s (2013) Diagnostic and Statistical Manual of Mental Disorders Version 5 (DSM 5) is another useful resource for coexisting disorders.

The Ministry’s core set of co-existing issue screens are:

- Alcohol Use Screen
- Drug Use Screen
- Depression Screen
- Brief Anxiety Screen
- Suicidality Screen
- Family and Whānau Concern Screen
- screening for homicidality

- screening for family violence.

This section describes each one and explains why it is important. Text in italics gives instructions for the information to enter into CLIC for each screen; for example '*(Record the number of positive responses to questions 1 to 4)*'. For the full version of all screens, see Appendix 1.

Alcohol Use Screen

Alcohol use (AUDIT-C) *(record the total score)*

One standard drink is 30 mL straight spirits (two nips/shots, one double), a 330 mL can of beer or a 100 mL glass of wine.

- 1 How often did you have a drink containing alcohol in the past year?
(never = 0; monthly or less = 1; two to four times a month = 2; two to three times per week = 3; four or more times a week = 4)
- 2 How many drinks did you have on a typical day when you were drinking in the past year?
(1 or 2 drinks = 0; 3 or 4 drinks = 1; 5 or 6 drinks = 2; 7 to 9 drinks = 3; 10 or more drinks = 4)
- 3 How often did you have six or more drinks on one occasion in the past year?
(never = 0; less than monthly = 1; monthly = 2; weekly = 3; daily or almost daily = 4)

How to use the Alcohol Use Screen

A score on the Alcohol Use Screen of 5 or more for males or 4 or more for females indicates that the person's use of alcohol is at a risky level and warrants further discussion with the client/tangata whai ora.

Why you use the Alcohol Use Screen

Risky alcohol use can interfere with the client/tangata whai ora ongoing treatment attendance and their ability to maintain reduced gambling harm once they achieve it, and can contribute to relapse. It can also be a health issue in its own right.

Both gambling harm and alcohol misuse are related to depression and reduced motivation. Raising motivation to change gambling behaviour may be offset by continuing depression due to problematic alcohol use. In addition, many premises selling alcohol also provide gambling, so intoxication can reduce a person's inhibition to restrain from gambling behaviour. Problematic alcohol use and gambling that causes harm may together result in more intensive problems (including higher suicide risk), demotivate help-seeking, and potentially introduce anger and violence issues that need to be addressed.

Because of their relationship, alcohol and gambling behaviour issues may be best addressed at the same time. Tracking how the problematic alcohol use of the

client/tangata whai ora fits within their gambling behaviour may be insightful for the client/tangata whai ora.

Drug Use Screen

Drug use *(record the code for the response: No = 0, Yes = 1)*

In the past 12 months, have you ever felt the need to cut down on your use of prescription or other drugs?

How to use the Drug Use Screen

A 'yes' response to the Drug Use Screen is a positive result, so further enquiry is appropriate.

Why you use the Drug Use Screen

Some drugs other than alcohol can become part of the gambling behaviour 'chain' that can lead to gambling harm. For example, the person experiencing gambling harm may use stimulants such as methamphetamines to stay awake or alert for longer gambling sessions. A perception of increased power and energy from many stimulants may result in controlled gambling behaviour becoming uncontrolled. Depressant drugs that also disinhibit may contribute to excessive gambling.

If continually done together, gambling and drug use may become linked behaviourally, with drug use often leading to excessive gambling. Addressing the drug use and gambling behaviour at the same time may be the best approach, either through your own service or by facilitating or referring the client/tangata whai ora to a specialist alcohol and other drug service provider. Tracking how the drug use interrelates with the gambling behaviour may be insightful for the client/tangata whai ora.

Depression Screen

Depression

(record the total number of positive responses, ie, 0 = no to both, 1 or 2)

- 1 In the past 12 months, have you often felt down, depressed or hopeless?
- 2 In the past 12 months, have you often had little interest or pleasure in doing things?

How to use the Depression Screen

A 'yes' response to either Depression Screen question is a positive result, so further enquiry is appropriate.

Why you use the Depression Screen

Depression is highly associated with gambling harm for both those directly experiencing gambling harm and others affected by the person experiencing gambling harm. Depression affects energy and motivation and, if it is not addressed, clients/tāngata whai ora may not believe they can change their behaviour. Even if they make progress, they may be easily discouraged if relapses occur.

Depression may have been present before the client/tāngata whai ora started gambling, or could result from the consequences of gambling harm, but it may not be addressed simply by the client/tāngata whai ora reducing their gambling behaviour (or if the client/tāngata whai ora is also a family/whānau/affected other and the person experiencing gambling harm has reduced their gambling). Family losses can be substantial, and the effects can be long lasting. Ongoing debt, guilt and loss of trust, employment or relationships may continue to impact on mood, with the person experiencing gambling harm no longer having gambling to provide either an escape or the hope of a debt-solving win. Gambling behaviour may have initially provided an effective escape from the depression but eventually is likely to have contributed to it. For these clients/tāngata whai ora, stopping or reducing gambling may result in the emergence of an ongoing, unrelieved depression. Therefore, we cannot assume that addressing the gambling harm will automatically reduce the depression.

Strategies to address depression include exercise, support, financial hope, new or regained social activities, an appropriate diet, sufficient sleep, and therapies using, for example, cognitively based strategies. Refer people with severe depression to a general practitioner or mental health professional, or facilitate their access to one, to consider antidepressants in addition to the approaches you are using.

Anxiety screens

Two anxiety screens you may use are the:

- Brief Anxiety Screen
- CHAT Screen.

Brief Anxiety Screen (ABACUS 2004)

During the past month, have you often worried excessively, sometimes even causing you to avoid places or situations?

☐ Yes ☐ No

During the past month, have you either felt yourself shaking, your heart racing, or had difficulty breathing, at the thought of something unpleasant?

☐ Yes ☐ No

How to score the Brief Anxiety Screen: A 'yes' response to either question suggests the possibility of an anxiety condition that may cause distress or affect the person's ability to enjoy life.

CHAT Screen

Another two-question screen for anxiety is part of the Case-Finding and Health Assessment Tool (CHAT) screen:

During the past month, have you been worrying a lot about everyday problems?

☐ No ☐ Yes

➔ If yes, do you want help with this?

☐ No ☐ Yes, but not today ☐ Yes

What aspects of your life are causing you significant stress at the moment?

<input type="checkbox"/> None	<input type="checkbox"/> Relationship	<input type="checkbox"/> Work
<input type="checkbox"/> Home life	<input type="checkbox"/> Money	<input type="checkbox"/> Health
<input type="checkbox"/> Study	<input type="checkbox"/> Other (specify) _____	

(For the full CHAT Screen, see section 7.6.)

Why you use an anxiety screen

Anxiety disorders are relatively common, affecting around 6 percent of the New Zealand population at some point in their lives, and anxiety and depression commonly co-exist. Although anxiety may have many causes, gambling and the effects of another's gambling can cause significant anxiety and distress, which can lead to poor health outcomes.

How to use an anxiety screen

You may use either of the above anxiety screens used to identify the presence of anxiety and provide an opportunity to discuss onset, causes and effects in relation to gambling. If it is causing significant distress, you may offer to refer the client/tangata whai ora or family/whānau/affected other or facilitate their access, to an appropriate service for additional support.

Suicidality Screen

Suicidality *(record the number of the response that best fits ie, 0, 1, 2, or 3)*

Within the last 12 months, have you had thoughts of self-harm or suicide?

- (0) No thoughts in the past 12 months.
- (1) Just thoughts.
- (2) Not only thoughts, I have also had a plan.
- (3) I have tried to harm myself in the past 12 months.

Why you use the Suicidality Screen

It is not uncommon for those who are experiencing gambling harm, to also experience a range of other wellbeing challenges, including additional mental illness or other

addictions, financial and relationship difficulties, housing or education inequity and, as such, they are at higher risk of suicidal behaviour. In New Zealand, Māori and Pacific populations are disproportionately represented in both suicide rates and gambling addiction rates. It is important to ensure the safety of those being supported by services or whānau and family. Where risks are high, you should carry out a Suicidality Screen and, if necessary, put further supports in place to manage safety risk.

How to use the Suicidality Screen

Suicidal thoughts are common among people experiencing gambling harm, so enquire about these thoughts in an appropriate way. If a client/tangata whai ora has only had thoughts about suicide without making a plan or attempting suicide, this is clearly a topic for further enquiry at the assessment session and in subsequent sessions. If you have any safety concerns, complete a 'risk assessment', using the screen as a basis and weighing up the balance of:

- risk factors (predisposing factors, eg, past trauma, abuse, poverty; precipitating factors, eg, just disclosed gambling behaviour, legal consequences, high debt; perpetuating factors, eg, ongoing alcohol/drug use, mental health disorders)
- protective factors (eg, intact relationship, employment, strong spiritual, cultural or community connections).

You can work through a safety plan with the client/tangata whai ora, including supports and protective actions, and refer them or facilitate their access to appropriate services.

If the client/tangata whai ora describes how they had thought they might carry out the suicide (ie, they have made a plan), the risk for a future attempt is heightened. Your enquiries should then cover how recent the thoughts about the plan were, accessibility to the means to attempt it, how regularly these thoughts occurred, and what supports the client/tangata whai ora has that could act as a protective factor.

If a client/tangata whai ora has attempted suicide in the past 12 months, discussion should include any attempts before the past 12 months. Previous suicide attempts (especially if recent) are a strong predictor of future attempts and of suicide completion. Ask if the client/tangata whai ora is receiving, or has received, support from a crisis assessment and treatment team as a result of a suicide attempt and seek their permission to liaise with the team (and the team with you) if necessary. This permission must be in writing.

It is important you are engaged with the client/tangata whai ora if they are to be open with you about any escalation in their risk. Discuss with them any further support they would like if this occurs. As a practitioner, you should contact the crisis assessment and treatment team with or without the support of your client/tangata whai ora if the risk of suicide is imminent (see rule 11[2][d] of the Health Information Privacy Code 1994). Discuss the situation with your manager/team leader and ensure a current 'risk assessment' or plan is easily accessible in the client/tangata whai ora file or record.

Family and Whānau Concern Screen

Family and whānau concern (record the code for the response: No = 0, Yes = 1)

In the past 12 months, has anyone in your family or whānau worried about your health or wellbeing (including spiritual health)?

How to use the Family and Whānau Concern Screen

A positive response to the Family and Whānau Concern Screen enables you to enquire further about any health issues (mental and physical) the client/tangata whai ora may be receiving help for. It can also raise the awareness of the client/tangata whai ora about the effects the gambling behaviour may be having, including on their spiritual health. You should use the response of the client/tangata whai ora to this question as a starting point for further discussion.

Why you use the Family and Whānau Concern Screen

The health issues that the family or whānau of your client/tangata whai ora worry about may reflect underlying or co-existing issues that your client/tangata whai ora is not yet ready to acknowledge. By asking this question, you have a chance to encourage the client/tangata whai ora to consider other issues they may want to address at a later date and how their health problems may be affecting their relationships. You may find the responses of your client/tangata whai ora to this question useful when you help them agree on goals (see section 4.6.2).

Screening for homicidality

Screening for 'homicidality' is screening for the intention of the client/tangata whai ora to kill someone else. This occurs only rarely, so no formal screen is provided. However, if a conversation with a client/tangata whai ora raises homicidality as a possibility, and you believe the threat is real and imminent, you should – with or without the support of your client/tangata whai ora – disclose this possibility to an appropriate person to prevent or lessen the threat (see rule 11[2][d] of the Health Information Privacy Code 1994).

Screening for family violence

More commonly, family violence may be an issue, involving the spouse or partner of the gambler, children, or partner and children. Violence and abuse can take many forms, including but not limited to: physical violence (eg, hitting, punching, assault with objects/weapons, pushing, shoving, hair pulling); intimidation (threats/standing over someone); emotional abuse (name calling, humiliating/shaming, constant personal criticism that lowers self-esteem); bullying, power and control (limiting freedom, controlling relationships with others, financial control); and sexual abuse. Children witnessing and hearing family violence and abuse of others is also considered as child abuse (Vulnerable Children Act 2014).

There is only limited research on the connections between gambling harm and violence, but findings that are available indicate that this area warrants attention from gambling harm treatment providers. For example, a recent (2013, early release) of a large-scale study of New Zealand, Australian and Hong Kong participants reported on its Australian arm, where those experiencing gambling harm and their families (n = 120) were attending services for gambling harm, drug and alcohol, or violence. One of the findings was:

the level of relationship between gambling harm and family violence (over 70%) was similar to and exceeded the finding in a previous study (Muelleman et al, 2002), with victimisation related to the anger of those experiencing gambling harm at their losses (financial stress and home crises), while perpetration against the person experiencing gambling harm was related to (underlying) anger and mistrust. (Dowling et al 2013)

The authors concluded, 'The findings of the current study can be used to inform the treatment of those experiencing gambling harm and should be used to encourage routine screening for family violence in gambling harm services'. In a recent interview, Professor Dowling noted that her research also identified 56 percent of those experiencing gambling harm report physical violence against their children.

CHAT Screen

The CHAT Screen is a nine-item screen covering a range of mental health, addiction and lifestyle issues. Two questions cover the issue of violence for victims:

Is there anyone in your life whom you are afraid of or who hurts you in any way?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Is there anyone in your life who controls you and prevents you from doing what you want?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes	
If yes to either or both of these questions, do you want help with this?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes, but not today	<input type="checkbox"/> Yes

One question covers someone that may be a perpetrator of violence:

Is controlling your anger sometimes a problem for you?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes	
If yes, do you want help with this?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes, but not today	<input type="checkbox"/> Yes

The value of using these screens is that the questions are relatively non-threatening and can give you an opportunity to open up a conversation about violence, which can then lead to interventions, facilitation or referral to appropriate services. (For the full CHAT Screen, see section 7.6.)

Hits Screen

The HITS Screen (Sherin 1998) was designed for victims of violence. Originally it contained four items, scoring 4–20, where a score of 10 or more indicated positive for violence.

This screen has been modified for use with gambling. New Zealand research at the Auckland University of Technology (AUT) has validated the new version (Bellringer et al 2016).

The new version of the screen is in two parts.

HITS scale and sexual abuse question

Victimisation

In the last 12 months before you started counselling on [date], has a current or ex-partner or a family /whānau member ...

- a. Physically hurt you?
- b. Insulted or talked down to you?
- c. Threatened you with harm?
- d. Screamed or cursed at you?
- e. Forced you to have sexual activities?

Scored: Yes/ No

Perpetration

In the last 12 months before you started counselling on [date], have you...

- a. Physically hurt a current or ex-partner or family/whānau member?
- b. Insulted or talked down to a current or ex-partner or family/whānau member?
- c. Threatened a current or ex-partner or family/whānau member with harm?
- d. Screamed or cursed at a current or ex-partner or family/whānau member?
- e. Forced a current or ex-partner or family/whānau member to have sexual activities?

Scored: Yes/ No

The screen is not scored and has a yes/no answer to all questions. It can now be used for both those who have experienced violence (including sexual violence), and those who have perpetrated violence (including sexual violence).

Findings of AUT problem gambling and family violence study

(Bellringer et al 2016)

Overall, half (50%) of the participants were victims of physical, psychological, emotional, verbal or sexual abuse in the past 12 months, and 44 percent committed the violence or abuse.

The most common abuse was verbal:

- 37 percent 'screamed or cursed at' another person and 41 percent were victims of this
- 34 percent 'insulted or talked down to' another person and 40 percent were victims of this.

Physical abuse was less common:

- 7 percent caused physical harm and 9 percent were victims of physical harm
- 9 percent threatened physical harm and 12 percent were threatened with physical harm
- no participants reported sexually abusing someone but 4 percent were sexually abused.

More affected others reported committing and being victims of violence and abuse (except for financial abuse) than gamblers:

- 57 percent of affected others committed violence or abuse compared with 41 percent of gamblers
- 66 percent of affected others were victims of violence or abuse compared with 47 percent of gamblers.

Gamblers were more likely to commit financial abuse; affected others were more likely to be victims.

For more information, go to: **www.health.govt.nz/publication/problem-gambling-and-family-violence-help-seeking-populations-co-occurrence-impact-and-coping**

Neither screen is compulsory or entered in CLIC. However, given that Bellringer et al (2016) and other studies highlight the prevalence of violence connected with gambling, it is good clinical practice to use the tool both educationally and as an opportunity to introduce discussion and to support the client/tangata whai ora or family/whānau/affected other in receiving help and support in treatment and referring them or facilitating their access to appropriate programmes. It is possible that perpetrators may be more reluctant to fill out the screen or may not be fully honest in completing it until after you have established a high level of trust and engagement in the relationship, so you will need to use your judgement in choosing the time to introduce the topic.

RESOURCE

See the resources in Chapter 7 for:

- CHAT Screen (section 7.6)
- Vulnerable Children Act 2014 (section 7.5)
- *Supporting Parents, Healthy Children: Supporting parents with mental illness and addiction and their children* (Ministry of Health 2015) (section 7.4).

4.6 Intervention planning

During a comprehensive assessment, clients/tāngata whai ora (experiencing gambling harm or family/whānau/affected other) may identify a range of issues they would like help with. Negotiate an intervention plan with the client/tāngata whai ora based on the needs that the comprehensive assessment has revealed. This plan forms the agreed basis on which a provider and client/tāngata whai ora will work together and the parameters that will be used to judge the success of treatment.

It is through intervention planning that a client/tāngata whai ora learns the importance of relapse prevention. The more that following through with a plan leads to positive outcomes, the more the client/tāngata whai ora will learn they can limit their risk of relapse. When you create an intervention plan early in the process of clinical engagement with a client/tāngata whai ora, the plan becomes the focal point where you can revisit the clinical needs of the client/tāngata whai ora and modify them as needed. Modification often happens when the client/tāngata whai ora meets goals or is addressing setbacks.

The following strategies are designed to help with:

- intervention and referral planning (section 4.7.1)
- committing to goals (section 4.7.2)
- reviewing progress and discharge planning (section 4.7.3).

Modify these strategies, as you need to.

4.6.1 Intervention and referral planning

Following its research on a group of 'non-improving clients/tāngata whai ora', ABACUS identified a number of specific additional interventions as being potentially helpful in treatment to both clients/tāngata whai ora experiencing gambling harm and family/whānau/affected other. From this project, ABACUS developed a 'wider model of treatment' for the Ministry of Health in 2006/07, including these additional interventions for clients/tāngata whai ora experiencing gambling harm and wanting help with it. The project included seeking support from practitioners and their organisations for these additional interventions.

For the seven 'general' items listed below, invite the client/tāngata whai ora to tick those items they would like to address.

This section suggests some approaches to dealing with the issues identified. However, approaches will vary depending on the:

- size of your organisation (eg, larger organisations may have specialist practitioners who can address particular items)
- existing skills of (or level of enthusiasm to upskill) its practitioners
- availability of these resources outside the provider organisation.

It would be helpful to ensure your organisation establishes and fosters a contact person in each organisation mentioned below to create effective pathways for your clients/tāngata whai ora in the future.

General items I would also like help with (*tick any items*)

- ☐ Budgeting or financial advice
- ☐ Legal matters
- ☐ Housing
- ☐ Employment matters
- ☐ Work and Income assistance
- ☐ Family, whānau or relationship matters
- ☐ General health matters

Also, I would like to (*tick as appropriate*)

- ☐ be given information about support groups (eg, Gamblers Anonymous or Gam-Anon)
- ☐ involve my family or support person in my counselling
- ☐ join a group as well as individual counselling

Budgeting or financial advice

Budgeting assistance can require comprehensive and time-consuming attention. Overall, a range of matters fall into this category, including:

- helping with budgeting in order to increase the awareness of the client/tāngata whai ora of the level of disposable income available for (controlled) gambling behaviour where gambling harm may be moderate
- budgeting to address accumulated debt, including help with negotiations with creditors (this is for more severe gambling harm and family/whānau/affected other)
- strategies to avoid 'blowing the budget' through gambling behaviour or other means
- addressing skewed thoughts around gambling harm risk or the resolution of financial problems through further gambling
- advice about insolvency or bankruptcy (see also 'Legal assistance' below)
- assistance with benefits and allowances (see also 'Work and Income assistance' below).

Some of these matters may be addressed by having budget advisors visit a provider's service on a structured basis. This is especially useful when 'full budgeting' appears to be needed; for example, when the service holds the benefit or wages in a trust account so the client/tāngata whai ora can experience respite from uncontrolled gambling behaviour and family and whānau members are protected from poverty.

It is possible that many of the issues listed above will arise in counselling, and you may need to have a wide knowledge to motivate clients/tāngata whai ora to refer to specialist budgeting services, even if the service is provided within your organisation or building.

Identify which approach is appropriate for your organisation, what arrangements are available for budgeting services to provide at least an onsite introduction to their services to maximise referral completion, or whether a practitioner with skills or interest in this area is willing to specialise in providing budgeting and financial advice for the organisation.

Financial literacy and capability programmes

Financial literacy or capability is the ability to make informed judgements and effective decisions about the use and management of money. It is about having financial knowledge, and the understanding, confidence and motivation to make and implement financial judgements and decisions, which will also impact on gambling behaviour.

Financial capability programmes (funded by Oranga Tamariki) are now delivered throughout New Zealand. Your service should find out what programmes are available in your local area, develop a relationship with the programme provider, and help those clients/tāngata whai ora wanting to learn about managing their finances to access that programme.

Another approach is to introduce a 'financial literacy' programme into the treatment schedule of gambling harm service providers. This approach has been piloted for Māori and Pacific tāngata whai ora. A gambling pre-programme helps clients/tāngata whai ora to understand their gambling harm behaviour and is needed to assess their readiness to talk about money and participate in the programme. The service then delivers the programme to clients/tāngata whai ora over 10 modules, after which gambling harm practitioners follow up the clients/tāngata whai ora to cement the learning, maintain the changes and to answer any further questions.

Legal assistance

Clients/tāngata whai ora experiencing gambling harm and their families and whānau are often affected by legal issues, which may be civil or, in the case of the person experiencing gambling harm, criminal. An estimated 60 percent of people experiencing gambling harm will be illegally obtaining money, and their help-seeking may largely be a result of escalating or crisis legal issues.

Legal issues are complex, and you are not expected to become a legal expert. However, some knowledge about how to access help with costs and debt recovery from the family and whānau of those experiencing gambling harm can help to reduce stress and harm, encourage continued attendance at counselling, and avoid relapse.

Some lawyers provide legal aid services. You can find them through your district law society, legal aid service (the District Court has their contact numbers) or Citizens Advice Bureau. Often, a local Citizens Advice Bureau will also have a lawyer available in the evenings for one-to-one advice and referral and will know the legal aid lawyers available. Legal aid committees also provide money for legal assessments that may reduce a sentence, ahead of a person's sentencing on serious criminal charges. However, many lawyers appear not to access this for their clients/tāngata whai ora, possibly because they are unaware of this option.

Clients/tāngata whai ora may be under pressure from civil claims such as for outstanding rent, and they may have to attend the District Court for an examination of their financial means. Clients/tāngata whai ora may not be aware that courts will not impose payment schedules where these are beyond the means of the client/tāngata whai ora, and so honesty and support from a practitioner or budgeter may substantially reduce the stress of the situation.

Clients/tāngata whai ora may be on the edge of insolvency or bankruptcy when they present to your service. Insolvency is when a person is unable to pay their debts as they fall due. Bankruptcy is a legal process that enables a client/tāngata whai ora to get relief from the burden of debt they cannot repay, despite their best efforts.

Bankruptcy is generally seen as a protective measure rather than a punishment, but the bankrupt person will face a number of restrictions and limitations on what they can and cannot do for three years after being declared bankrupt. You should always make sure a client/tāngata whai ora receives specialist financial and legal advice before considering bankruptcy.

Another option is a 'no asset procedure' (NAP), which is an alternative to bankruptcy and may be available to clients/tāngata whai ora who owe between \$1,000 and \$47,000 (excluding student loans, court fines and criminal reparations), in secured and unsecured debt and can show that they have no realisable assets (note that KiwiSaver is an asset), have no ability to repay any amount towards their debts and have never previously been in a NAP or been adjudicated bankrupt. The usual term for a NAP is one year, although this can be extended by up to 25 working days by the Official Assignee in certain circumstances. Entry into a no asset procedure will relieve the person of their provable debt, but their creditors will remain unpaid.

Housing assistance

Contact your Housing New Zealand regional office or council office about available housing. Social services such as the Salvation Army may also be able to help. In many cases, these enquiries will accompany a request to Work and Income for financial assistance (see 'Work and Income assistance' below). Work and Income may also be able to help with an accommodation supplement if the client/tāngata whai ora is aged over 16 years, depending on their income, assets, accommodation costs, family circumstances and where they live.

Employment assistance

Work and Income (see also 'Work and Income assistance' below) is a primary source for jobs, while Workwise is an agency (funded by Work and Income) that helps those with an experience of mental health and addiction to obtain employment.

Clients/tāngata whai ora may also be seeking advice about retraining or upskilling in order to reach a goal that has appeared unattainable in the past and contributed to their compensatory gambling behaviour. Advice about how to achieve a goal, but particularly motivation to reach it and to avoid self-limiting thoughts when they meet barriers, may be important in counselling.

Often, the issue of disclosing gambling harm to new prospective employers arises, with concerns that an employer may not wish to hire a person who has been labelled a 'problem gambler'. The client/tāngata whai ora could feel that non-disclosure would avoid this issue. However, if an employer later found out about previous problematic gambling behaviour, the result could be that the client/tāngata whai ora loses the job for not disclosing truthfully in the job application, which in turn could be a potential relapse trigger. Part of counselling could be a full discussion of both sides of the issue and reframing that a client/tāngata whai ora in recovery may be a much better prospect than a person who is still caught up in secrecy around their gambling behaviour.

Work and Income assistance

Many clients/tāngata whai ora do not wish to disclose their gambling behaviour to Work and Income because they fear their benefit will be cancelled. Work and Income is becoming aware that many people who have experienced gambling harm (or their families and whānau) are being affected by their inability to retain their money. Strategies include paying welfare benefits into safer accounts, replacing money lost in gambling (provided steps are taken to reduce the recurrence of this) and waiving stand-down periods when jobs end as a result of gambling harm.

Contact your local Work and Income office and identify a contact person who understands the situation and can help to avoid possible misunderstandings when the rest of the service is unaware that gambling behaviour is an issue for a person.

Help with family, whānau and relationship issues

If clients/tāngata whai ora experiencing gambling harm wish to have family or whānau support, poor relationships where they have been deceptive or are in high debt from gambling harm can be a barrier. You may be able to address family issues and provide counselling for couples and other family and whānau members, either in combined sessions or in individual sessions as clients/tāngata whai ora in their own right. In addition, if there are issues like family violence, you may need to facilitate their access to women's refuge or the Family Court, or with actions under the Vulnerable Children Act 2014.

General health matters

Health problems can contribute to gambling behaviour. Many health issues, especially if they are ongoing, can increase stress, from which the client/tāngata whai ora finds an escape through gambling behaviour. Unless your client/tāngata whai ora discloses health problems, you may be unaware of a barrier to their recovery.

Clients/tāngata whai ora can get help with many ongoing health problems by joining support organisations (eg, Diabetes New Zealand). If you know about these problems, you can design strategies that account for any limitations and minimise the risk of the client/tāngata whai ora becoming demotivated through failing to meet goals that have been set too high.

If a client/tāngata whai ora has general health issues and does not have a regular doctor, then facilitating their access a general practitioner (GP) can be another helpful strategy. If a patient enrolls with a GP, their costs are partially subsidised, and they can also apply for a community services card or 'high use health card' if they need financial help with regular medications. Some GPs offer 'low-cost health care' and children under 13 years can receive free health care.

Information about support groups

Support groups do not suit all clients/tāngata whai ora, but many people do find them useful for socialising and ongoing support. Gam-Anon is a '12-step' support group for family/whānau/affected other who have been affected by someone else's gambling.

For more information on Gam-Anon, go to www.gam-anon.org

Gamblers Anonymous is a support group for people who have experienced harm from their own gambling.

For more information on Gamblers Anonymous, go to www.12steps.nz/12-steps-programs/gamblers-anonymous/

You may find that the strong 'medical model' nature of the Gamblers Anonymous 12-step model does not suit all your clients/tāngata whai ora. Gamblers Anonymous sees 'compulsive' gambling as a disease for life and controlled gambling as an unacceptable activity, reflecting a person's denial of the risks and costs of their gambling. Some clients/tāngata whai ora also find the spiritual approach of Gamblers Anonymous, which involves calling on a 'higher power', too religious (although it is less emphasised than in Alcoholics Anonymous). Other clients/tāngata whai ora are uncomfortable with disclosing their thoughts and behaviours in a group setting.

However, Gamblers Anonymous does provide ongoing support and a way of socialising for (often isolated) people who have experienced gambling harm, and Gam-Anon can be a source of understanding for family members who often have felt they needed to be secretive about the gambling harm. Some who have experienced gambling harm do not follow the Gamblers Anonymous 12-step process, instead attending the meetings just for support. However, others appear able to work with the Gamblers Anonymous abstinence model, while also following the common practitioner–client/tangata whai ora approach of harm reduction.

To access a list of current Gamblers Anonymous and Gam-Anon meetings, contact the Gambling Helpline or download a list of meetings from their websites.

Involving family or a support person in counselling

Offer clients/tāngata whai ora the opportunity to involve their family and whānau or a support person in their counselling. This can occur in two ways: the family, whānau or support person can attend some or all sessions as the client/tangata whai ora decides, or they can be the person who is contacted in the follow-up sessions to independently confirm (or otherwise) the progress of the client/tangata whai ora (see also 'Nominating someone else to be involved' in section 4.6.2).

Joining a group as well as individual counselling

Although in the United States of America it is common for clients/tāngata whai ora to attend group therapy and then individual counselling, in New Zealand the order is often the reverse. Many clients/tāngata whai ora are reluctant to disclose their issues to strangers, and they behave in ways that isolate them from the group and show their discomfort when numbers exceed more than one or two.

Group therapy can help to socialise those who have experienced gambling harm and to support family and whānau members (separately) but may be more attractive to family and whānau members. Those who have experienced gambling harm directly may prefer to attend group therapy later in their treatment, especially if their practitioner is present as the group facilitator.

Group therapy can encourage honesty and allow the client/tangata whai ora to practise new behaviours, receive support they cannot gain elsewhere, and take on board the experiences of others to help them to learn and to avoid negative incidents and experiences of their own.

4.6.2 Committing to goals

Although clients/tāngata whai ora may use a range of methods to represent their commitment to recovery, the two steps that have been found to be particularly useful in other addiction settings are:

- having an agreed intervention plan
- nominating someone else to be involved.

Having an agreed intervention plan

Having formal goals is essentially the agreed intervention plan, which includes plans for attending treatment sessions and taking steps toward achieving the outcomes of problem resolution and enhancing wellbeing. Both the client/tāngata whai ora and the practitioner agree on the plan, so that the client/tāngata whai ora buys in and agrees to the process.

The process is client/tāngata whai ora-centred, with prompts provided about possible goals, but essentially it allows them to elect their own goals. Regular reviews of these goals are set in order to acknowledge progress or to renew the motivation of the client/tāngata whai ora when they have not achieved the goals.

RESOURCE

See section 7.74 for:

- **agreed action plan** – a sample intervention plan for clients/tāngata whai ora seeking support for their own gambling).

Nominating someone else to be involved

The option of nominating someone else to be involved is available as a more effective way of assessing the treatment outcome. It also introduces some 'accountability' into the process, as the nominated person will have not only an objective view of the progress of the client/tāngata whai ora, but also an investment in their success. This option is more applicable to those who have experienced gambling harm, although family and whānau members can also benefit.

The client/tāngata whai ora chooses the nominated person. Clients/tāngata whai ora are often uncertain about the effectiveness of change, especially when many problems persist following treatment: creditors may still be there, depression may be slow to overcome, and others may not be willing to trust the person who has experienced gambling harm. The opinion of someone who has some insight into the person's behaviour or condition before treatment as well as after treatment can be positive for the client/tāngata whai ora and the practitioner. The client/tāngata whai ora may agree to this nomination and sign their consent on the intervention plan.

4.6.3 Reviewing progress and planning to end the intervention

It is important to discuss not only progress during the full intervention, but also how and when to end the full intervention.

Review assessment

When you end a full intervention, you should give the client/tangata whai ora an opportunity to briefly assess their own progress and the quality of the help your service has provided to them. Use the feedback the client/tangata whai ora gives you to confirm that you are providing a quality service or to identify aspects for improvement. This feedback also provides, in part, evidence of treatment outcome. Services can establish processes to regularly review these findings for improvements and to confirm the effectiveness of their treatment goals. The service keeps records of these findings.

It is important, both for practitioners and for clients/tāngata whai ora, to get an overall view of the perspective of the client/tangata whai ora on achieving their goals and whether the treatment service is meeting their needs. Ask about possible improvements to service delivery. Remember to provide feedback too, as many clients/tāngata whai ora may minimise their achievements. Ask the nominated person about their view of the progress that the client/tangata whai ora has made.

Partners for Change Outcome Management System

One system of providing practitioners with feedback about client/tangata whai ora progress and their experience of the therapeutic alliance is the Partners for Change Outcome Management System (PCOMS), which is integrated into each treatment session. It consists of two brief scales that measure robust predictors of therapeutic success (developed by Duncan and Miller 2000).

- The Outcome Rating Scale (ORS) assesses the therapeutic progress of the client/tangata whai ora and their perceived benefit of treatment.
- The Session Rating Scale (SRS) assesses how the client/tangata whai ora perceives the client/tangata whai ora – therapist alliance.

Both scales consist of four items and each takes less than one minute to complete. Reflection on the feedback given by clients/tāngata whai ora also allows you to consider any changes you may wish to make in future sessions, to improve engagement and outcomes.

Outcome Rating Scale (ORS)

Name:

Age (years):

Male / Female:

Date:

Who is filling out this form? Self / Other

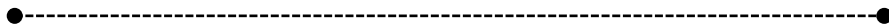
If 'Other', what is your relationship to this person?

Session number:

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. If you are filling out this form for another person, please fill out according to how you think he or she is doing.

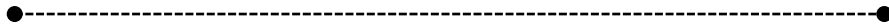
Individually

(Personal wellbeing)



Interpersonally

(Family, close relationships)



Socially

(Work, school, friendships)



Overall

(General sense of wellbeing)



Source: © Duncan and Miller (2000).

Session Rating Scale (SRS V.3.0)

Name:

Age (years):

Male / Female:

Date:

ID number:

Session number:

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

I did not feel heard, understood and respected.

Relationship

I felt heard, understood and respected.

We did not work on or talk about what I wanted to work on and talk about.

Goals and Topics

We worked on and talked about what I wanted to work on and talk about.

The therapist's approach is not a good fit for me.

Approach or Method

The therapist's approach is a good fit for me.

There was something missing in the session.

Overall

Overall, today's session was right for me.

Source: © Duncan and Miller (2000).

Work and Social Adjustment Scale

One measure of recovery is the Work and Social Adjustment Scale (WSAS), which has been tested for many issues, including gambling harm. This five-item measure of disability shows promise as a measure of improvement in clinical services.

WSAS asks questions about impairment caused by gambling harm in the following areas: ability to work; home management; social leisure activities; private leisure activities; and ability to form and maintain close relationships. The lower the score, the greater the improvement. You can administer the tool as a baseline assessment, and then again on discharge and at regular follow-up periods.

Work and Social Adjustment Scale (WSAS)

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problems, look at each section and determine on the scale provided how much your problem impairs your ability to carry out the activity.

If you're retired or choose not to have a job for reasons unrelated to your problem, tick here: ☐

Please circle the number you feel best answers the following questions:

1. Because of my gambling, my ability to work is impaired. '0' means 'not at all impaired' and '8' means very severely impaired to the point I can't work.

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly		Very severely

2. Because of my gambling, my home management (cleaning, tidying, shopping, cooking, looking after home or children, paying bills) is impaired.

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly		Very severely

3. Because of my gambling, my social leisure activities (with other people, eg, parties, bars, clubs, outings, visits, dating, home entertaining) are impaired.

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly		Very severely

4. Because of my gambling, my private leisure activities (done alone, such as reading, gardening, collecting, sewing, walking alone) are impaired.

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly		Very severely

5. Because of my gambling, my ability to form and maintain close relationships with others, including those I live with, is impaired.

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly		Very severely

SCORE:

Source: Mundt et al (2002).

Scoring note: The maximum score of the WSAS is 40 – lower scores are better. A WSAS score above 20 appears to suggest moderately severe or worse psychopathology. Scores between 10 and 20 are associated with significant functional impairment but less severe clinical symptomatology. Scores below 10 appear to be associated with subclinical population. Whether such a pattern will generalise to other disorders (apart from OCD [obsessive compulsive disorder] and depression) remains to be tested.

4.7 Frequently asked questions

4.7.1 When should I introduce the gambling harm assessment screens?

It is primarily a matter of your own working style and preference when you introduce the gambling harm assessment screens. If you introduce the screens at the beginning of the first session, you can interpret and discuss the answers from your client/tangata whai ora during that session. If you introduce the screens at the end of the session, you can first build your relationship with the client/tangata whai ora before asking for their involvement in filling out forms. This latter approach is also advantageous if you need to help the client/tangata whai ora with the forms if they have literacy problems, or if English is a second language.

If you leave the screens until a later session, you risk a failure to complete the forms if the client/tangata whai ora does not return for further sessions.

The screens and other instruments are necessary for generating the data the Ministry of Health requires. You are also required to complete a comprehensive assessment within the first three sessions of a full intervention.

The screens do not make up a comprehensive assessment on their own, but they do allow you to check for other problems and potential co-existing addictions and mental health problems. This is necessary in order for the treatment plan to address the impacts on the life and functioning of the client/tangata whai ora, not only from the gambling behaviour, but also from the interaction of the gambling with other factors.

Every client/tangata whai ora should have a comprehensive assessment completed during a full intervention; a warning is activated in CLIC if you have not completed a comprehensive assessment by the end of the third session of a full intervention with the client/tangata whai ora. You log a comprehensive assessment by ticking the 'Comprehensive assessment completed in this session' yes/no box. You must have at least one face-to-face session (which can be a Skype session if there are no alternative options for face-to-face contact) with a client/tangata whai ora to complete a comprehensive assessment.

4.7.2 How do I explain the purpose of these screens to clients/tāngata whai ora?

Emphasise to the client/tāngata whai ora that the screens are to help you work with them and to gain a greater understanding of their situation, and that you will provide them with feedback on the outcome of the screens.

It can be helpful to highlight to your client/tāngata whai ora that the information from the screens contributes (anonymously) to an annual data set, which raises the profile of gambling harm in New Zealand. This may contribute to further prevention and treatment resources, which help others affected by gambling harm. When clients/tāngata whai ora are receiving a free service, they may feel that offering something back is positive.

4.7.3 What happens if a client/tāngata whai ora has a zero score on the Gambler Harm Screen?

If a client/tāngata whai ora has a zero score on the Gambler Harm Screen, further assessment is required, particularly as the screen only focuses on the past 12 months. It may be that the client/tāngata whai ora has had control of their gambling behaviour for some time, but is now feeling at risk of gambling again, and that they are losing control and require an intervention. It may also be that the client/tāngata whai ora has not yet developed enough trust in the relationship to fully disclose their gambling and needs more time to engage. Alternatively, they may be more appropriately seen as family or whānau whai ora rather than as a client/tāngata whai ora experiencing gambling harm directly, so they would need to fill in the Family/Whānau/Affected Other Harm Screen.

If the client/tāngata whai ora is not experiencing harm from gambling, they do not qualify as a contracted client/tāngata whai ora for ongoing support. Refer this client/tāngata whai ora, or facilitate their access, to an appropriate service to meet any needs identified in the assessment. It is ethical and best practice to ensure that clients/tāngata whai ora seeking help are supported to receive the appropriate support.

KEY MESSAGE

A client/tāngata whai ora can have a zero score from a Gambling Harm or Family/Whānau/Affected Other Harm Screen and still be a contracted client/tāngata whai ora. This is a clinical decision that may take account of other information as well.

For more details about facilitation, see Chapter 5. For details about facilitating clients/tāngata whai ora with a zero problem gambling harm score, see section 5.7.3.

4.7.4 What do I do if a client/tangata whai ora or family or whānau whai ora will not provide details for the screens?

Clients/tāngata whai ora and family/whānau/affected other need to have an identity to be registered with a gambling harm minimisation service. Initially, the client/tangata whai ora and family or whānau whai ora may be concerned about their privacy and confidentiality. You need to explain the Privacy Act 1993 (and overrides) during the introduction and contracting phase, which may overcome their concerns and they may then be more willing to offer their details when you have good engagement and can establish trust. The National Health Index (NHI) number is a unique identifier that is assigned to every person who uses health and disability support services in New Zealand. Personal details will be required to provide services. If clients/tāngata whai ora and family/whānau/affected other still do not wish to disclose personal details yet want to discuss their situation, the confidential Gambling Helpline may be an option for them.

4.7.5 Can I ask just the screening questions I think are useful?

While it can sometimes seem that data collection is the main purpose behind collecting information at assessment, each individual question does have clinical significance. You can use this information in a counselling session to identify and prioritise particular areas to deal with. It is also useful for the client/tangata whai ora to understand the connection between the questions and what the plan following on from the initial assessment will be.

In addition, clients/tāngata whai ora often get therapeutic value from understanding where their experience sits on a screening tool that can be scored. Even though the score is often just used as a guide, it can help a client/tangata whai ora put into perspective their experience in relation to others who have been negatively affected by gambling harm. If you do not ask all the questions, the screen cannot determine the level of the problem.

4.7.6 Who is my client/tangata whai ora when a client/tangata whai ora brings family, whānau or other people?

Your client/tangata whai ora is always the person who has been negatively affected by gambling harm and has been individually assessed. In some cases, you may have more than one client/tangata whai ora at a session. For example, if a client/tangata whai ora experiencing gambling harm brings to a session their partner as someone affected by their gambling behaviour, and the partner fills in the appropriate screens, agrees to discuss their results with you and indicates harm arising from gambling, they too become a client/tangata whai ora who is registered and identified in CLIC (client/tangata whai ora type will be family/whānau/affected other).

However, if this same person experiencing gambling harm and the partner come to a family session with their eight-year-old son, the son is not registered as a client/tangata whai ora because the minimum age for a client/tangata whai ora is 14 years. The client/tangata whai ora experiencing gambling harm and their partner, as a family or whānau whai ora, are both recorded as attending the session together. Their son is identified only as a family session attendee and is not a family or whānau whai ora. However, if the son has been adversely affected by gambling (eg, trauma or neglect), you would consider this in relation to actions that may be required under the Vulnerable Children Act 2014.

4.7.7 How many sessions should my clients/tāngata whai ora need?

It is expected that your clients/tāngata whai ora will follow a wide range of pathways. The primary model of intervention (see section 2.4.1) suggests that there will ideally be a maximum of eight full intervention sessions within three months of the first session. This is used as a basis for measurement, and the Ministry expects that some clients/tāngata whai ora will only come for one or two sessions while others that will require more than eight sessions. Evaluate the need for extended sessions based on intervention planning, client need and outcome measure achievements. If co-existing issues are evident, the client/tangata whai ora may need more sessions and you can additionally refer the client/tangata whai ora, or facilitate their access, to other appropriate services.

4.7.8 What 'client/tangata whai ora type' in CLIC do I choose if my client/tangata whai ora identifies as someone both experiencing

gambling harm and also a family or whānau whai ora?

Many clients/tāngata whai ora will identify with experiencing gambling harm, as well as being affected by another's gambling (family/whānau/affected other). That is why it is good to have screening scores for both types when appropriate. In CLIC, you record these as 'gambler' and 'family/affected other'. **The 'client/tāngata whai ora type' in the CLIC database, however, can only record one client/tāngata whai ora type per session attended.**

It is possible to change the client/tāngata whai ora type for different sessions though, which you can decide on in each case. When a session with a client/tāngata whai ora is more focused on their own gambling harm, then the client/tāngata whai ora type would be 'gambler' in CLIC. When another session with the same client/tāngata whai ora is focused more on concerns related to the impact of someone else's gambling on them, then you would record the client/tāngata whai ora type in CLIC as 'family/whānau/affected other' for that session. You will vary the focus of sessions according to the needs of the client/tāngata whai ora and then enter only one main focus for each session in CLIC for it to be counted appropriately.

4.7.9 Do I need parental consent for seeing a client/tāngata whai ora under the age of 18 years?

In general, eligible people for gambling harm treatment are:

- young people/taitamariki (14–17 years) or
- adults/pakeke 18 years and over.

Parental consent is not needed provided that the young person being treated is competent to give informed consent for the service. Informed consent is determined by the ability to make a decision rather than by age. The young person must participate voluntarily, have received and understood full information, and understand the implications of agreeing to the service.

When working with young people, providers should establish and maintain relationships and key linkages with parents and also, where appropriate, with child, adolescent and young people's health and social services, and primary care, education and other statutory agencies as appropriate, to meet the needs of young clients/tāngata whai ora. Joint approaches to care and case management that combine the expertise of each service will involve negotiation about which service has primary responsibility for care. Referrals of young people from other agencies for assessment and intervention are also accepted by community gambling harm intervention services.

4.8 Safe transition of clients

When a contract to provide services for people affected by gambling comes to an end between the Ministry of Health and the gambling harm treatment agency ('the transitioning agency'), a priority is to safely transition existing clients/tāngata whai ora as well as past ones who may potentially recontact the service.

One way of safely transitioning these clients/tāngata whai ora from the transitioning agency may be to give them knowledge of other problem gambling treatment services. For some, it may involve facilitating their access to new gambling treatment services.

The process suggested in this section takes account of ethical issues, legal constraints (notably privacy requirements and standards that apply to health professionals)⁵ and best practice.⁶ It is also important that the transitioning agency has in place safe and appropriate strategies for staff⁷ who may be in direct contact with clients/tāngata whai ora, and whose skills and knowledge are critical for the delivery of this strategy.

4.8.1 Transition and privacy

Clients/tāngata whai ora may be notified that they need to transition to another provider in a number of ways. Because of the Privacy Act 1993 and its specific requirements for health agencies (Health Information Privacy Code 1994), their contact information is restricted and may only be used in certain circumstances (eg, when issue of safety – imminent and serious risk; if authorisation given; if the Privacy Commissioner grants permission under section 54 of the Privacy Act 1993). For this reason, the transitioning agency will be the agency that directly contacts current and past clients/tāngata whai ora, unless they give their consent for a gambling harm treatment service with an ongoing service contract to contact them with resource information.

When the contract for services by the transitioning agency expires, the transitioning agency sends a brief letter to the clients/tāngata whai ora who have not responded to requests to contact it. This letter, going to the last known address of each of these clients/tāngata whai ora, explains the change in service provision and lists potential providers they may access if they need to.

4.8.2 Clients to be notified

The clients/tāngata whai ora who the transitioning agency must notify of the transition process and potential providers are all current (undischarged) clients and clients who

⁵ Health Practitioners Competency Assurance Act 2003; Health and Disability Services (Core) Standards: Continuum of service delivery NZS 8134.1.3:2008.

⁶ Aotearoa New Zealand Physiotherapy Code of Ethics and Professional Conduct with Commentary (Physiotherapy Board of New Zealand 2011); Chartered Institute of Personnel and Development, London cipd.co.uk

⁷ Chartered Institute of Personnel and Development, London cipd.co.uk

have been discharged within the previous two years. (The Ministry acknowledges that problem gambling is a 'persistent and recurrent' behaviour⁸ and that the transitioning agency may be the first resource contacted by past clients when the need arises.)

4.8.3 List of gambling harm treatment providers for referrals

The Ministry of Health will give the transitioning agency a list of the contracted gambling harm services that it can refer clients/tāngata whai ora to. The transitioning agency can provide the information from the list that is most relevant to the region of the clients/tāngata whai ora and can facilitate them to access the contracted service, as a best practice approach on an individual basis.

4.8.4 New clients/tāngata whai ora

Where new clients/tāngata whai ora contact the transitioning agency, the transitioning agency conducts an initial assessment and, if appropriate, refers them or facilitates their access to a contracted service. This process applies for the time from when the transitioning agency receives advice of contracted services available in each region until the end of the contract, which is approximately a three-month period.

In following this process, the transitioning agency will ensure that, consistent with the Ministry's 'every door is the right door' policy, clients/tāngata whai ora are engaged and helped to access a contracted service, including by using the facilitation service if appropriate. It will also ensure that a safety enquiry process is provided for all new clients/tāngata whai ora and, when necessary, they receive appropriate support.

Where new clients/tāngata whai ora contact the transitioning agency after the contract ends, the transitioning agency immediately refers them to contracted services, following safety protocols that are established for that post-contractual period.

4.8.5 Transition process

The transitioning agency begins to notify clients/tāngata whai ora as soon as the three-month period starts (or as soon as possible after it has received advice from the Ministry of the list of contracted services) so as to minimise stress that may arise from concerns about re-engagement with another service. The process for the transition will ensure that consumers who can be contacted experience a planned and coordinated transition to another service, or discharge, and are facilitated to access their provider of choice in line with standards 3.9 and 3.10 of the Health and Disability (Core) Standards.⁹

The transitioning agency will:

⁸ DSM-5 introduction description of Gambling Disorder 312.31 in diagnostic criteria.

⁹ Health and Disability Services (Core) Standards: Continuum of service delivery NZS 8134.1.3:2008.

- contact or attempt to contact each client/tangata whai ora to begin the transition process in a timely manner
- advise the client/tangata whai ora about potential contracted services so as to give choices (if possible), cultural matching if appropriate, details of contacting and accessing such services, and whether the client/tangata whai ora gives consent for it to forward file information to such a provider
- where consent is given, cooperate with the contracted service to engage with the client/tangata whai ora, and will provide appropriate help and motivation for them to access the new service
- where current clients/tāngata whai ora prefer to discharge from the transitioning agency and choose not to access a contracted service, offer a list of the contracted services in the region and include the Gambling Helpline phone number, as well as providing assurance that counselling and support will continue to be available if the client/tangata whai ora or their family or whānau need it in the future
- establish a referral protocol with contracted services in the areas that it has provided services to ensure clients/tāngata whai ora who choose to engage with such contracted services for future counselling and support transition to them efficiently and effectively, and this shall include protocols for immediate referral after contract end (including safety issues)
- establish within the protocol a process for the client/tangata whai ora to keep their existing client CLIC number to avoid double counting and data set distortion
- where possible, offer the client/tangata whai ora a session to discuss the impact, options and safety issues that may arise either because of the process or because other issues may have impacted, such as to ensure safety remains a priority during the transition process. With current clients/tāngata whai ora who are attending the transitioning agency, the transition process will, unless not appropriate for their particular circumstances, begin at the earliest opportunity, with the possibility that several sessions may occur during the three-month process, including one or more facilitation sessions
- maintain their client/tangata whai ora files and store them in a safe and confidential process in line with the Privacy Act 1993, the Health Information Privacy Code 1994 and other relevant law and practice, and later dispose of them in line with the Health (Retention of Health Information) Regulations 1996¹⁰ and, if possible, in line with the wishes of the client/tangata whai ora
- identify clients/tāngata whai ora (current and discharged within the previous two years), document their contact details and attempt to contact them, document their choices about transition, and the transitioning agency's processes to facilitate the transition, minimising risk in accordance with the concerns of each client/tangata whai ora and the transitioning agency's professional opinion
- document the process and provide a monthly report of the transitioning progress of clients/tāngata whai ora to the Ministry
- establish appropriate processes with its clinical staff to ensure that sufficient staff are available to deliver the transitioning processes and that the process is prioritised and that such staff are supported in this process in a best-practice manner.

¹⁰ After storage for a minimum of 10 years, although a client may expressly ask to have the file after it no longer is required by the agency – storage must be in a safe and secure place (rule 5 of the Health Information Privacy Code 1994).

ABACUS Counselling Training & Supervision Ltd, under its contract with the Ministry as a clinical training provider, will be available on request to help with the transitioning process.

Table 4.2 summarises this transitioning process.

Table 4.2: Summary of transition process

Process	Description	Timeline
Client list established	The transitioning agency compiles details of current (undischarged) clients/tāngata whai ora and those who have been discharged in the past two years, including contact details.	At start of process
Process protocol established for contacting clients	Counsellors and management develop a protocol that includes privacy, effectiveness and safety strategies to provide a successful outcome.	At start of process
Process protocol established with contracted services in each region	After the Ministry provides a list of contracted services for each region, the transitioning agency contacts each contracted service and establishes protocols for transitioning clients/tāngata whai ora, developing relationships with a goal of seamless transition for each client/tāngata whai ora.	As soon as possible (about one week)
Information sheet	The transitioning agency develops an information sheet for clients/tāngata whai ora in each region, which gives details of available gambling harm treatment services, emergency services and Gambling Helpline, so as to emphasise services continue to be available.	As soon as possible (about one week)
Allocation of resources	The transitioning agency makes available enough staff to deliver the process at each stage and gives them suitable support.	Throughout the process
Provide transition reports	The transitioning agency makes monthly reports of complete lists of current and recently discharged client/tāngata whai ora (identified by their numbers only), progress with contact, and outcomes.	Monthly, to end

4.9 Examples of full interventions

4.9.1 Case 5 – Family or whānau whai ora attends with their partner experiencing gambling harm

Jim is a 52-year-old European man who arranged his first appointment with you for today through the Gambling Helpline. He has brought along Adele, his partner of one year, who is a 42-year-old woman of Pacific and European descent, and John, his 25-year-old son, who is staying with them while on holiday. John says little during the session, other than that he is there mainly to support his father.

During the interview, Jim is animated and at times upset as he talks about his worsening financial situation, the time spent at home waiting and wondering where Adele is, and, on one occasion, going to the casino and finding Adele in front of a pokie machine, where she refused to talk to him.

As you try to draw Adele into the conversation and ask her questions, she says she did not really want to come today, does not want to get involved in counselling and appears quite passive. She is, however, fully cooperative with filling out the Brief Gambler Screen at the beginning of the session and is anxious to hear the feedback on this.

Jim appears defensive and says to Adele that he just wanted her to listen to his concerns and what the practitioner says and maybe cut back a little on her spending. Jim would like to come back again, but Adele says she would rather not at this stage.

Questions

After reading Case 5, answer the following questions.

- How would you account statistically for each client/tangata whai ora?
- What feedback would you offer Adele?
- How would you approach ongoing case management for these clients/tāngata whai ora?

Answers

How would you account statistically for each client/tangata whai ora?

Jim is the presenting client/tangata whai ora so you open a file in his name and list him as a family or whānau whai ora in the session. Jim should fill out the Family/Whānau/Affected Other Harm Screen and the Family/Whānau/Affected Other outcome screens.

Adele is not seeking support in relation to gambling harm at this stage. If you do discuss Adele's screening results with her, you should record a brief intervention session for Adele (see Chapter 3). If Adele later agrees to attend full intervention sessions and seeks support in relation to her gambling harm (she is currently attending to support Jim), you should record the new session as a full intervention.

If Adele does not agree to seek help for her own gambling harm but does agree to continue to attend to support Jim, you should continue the brief intervention for another one or two sessions. You may find that Adele is more motivated to seek support in relation to her gambling harm after having had some time to reflect. If Jim and Adele each attend sessions on their own, each is an individual session.

Ensure Jim and Adele answer the co-existing issue screens as a part of their assessments and create treatment plans.

While Adele has an intervention open (brief intervention or full intervention) and attends again with Jim, it is a couples session (ie, both are a client/tangata whai ora of the service and attend the same session), so make notes in both files. If Adele does not want to become a client/tangata whai ora or has had three brief interventions (see section 3.5.2) but agrees to continue to attend to support Jim, you do not count her as an individual client/tangata whai ora.

You do not count John as an individual client/tangata whai ora unless he has individual concerns as a family and whānau member impacted by gambling harm and receives an assessment and feedback in his own right.

What feedback would you offer Adele?

Adele was anxious to hear feedback but did not want to commit herself, which indicates ambivalence and contemplation. This is an excellent opportunity for you to use motivational feedback styles to raise her motivation to consider change. Give Adele feedback on her Brief Gambler Screen score and discuss any concerns she has.

How would you approach ongoing case management for these clients/tāngata whai ora?

Adele may respond to an opportunity to attend an individual session because she may not want to reveal the extent of her gambling behaviour or relationship concerns with family and whānau members present. Offer her the choice of an individual session and the time for such a session. This session could be empowering and motivational for Adele.

Guiding principles

You must open a file for every individual who has a comprehensive assessment and treatment plan and so is a client/tangata whai ora in their own right. Ongoing notes on files must be individualised, even when the client/tangata whai ora attends a couples or family session (ie, each client/tangata whai ora must have their own file).

Not everyone who attends a session needs individualised treatment or assessment. Those who do not need such treatment or assessment do not have files and you do not account for them in any individual statistics.

4.9.2 Case 6 – Client/tangata whai ora experiencing gambling harm has potential risk features

Moana is a 32-year-old Māori woman who is separated, with two children aged six and eight years. She is on a social welfare benefit. Since both children have been at school, she has a lot more time on her hands than she did when they were preschoolers. Moana has been using this time to gamble at the local pub, and has found herself drinking during the day, when she has lost too much money and feels guilty about not having enough money to buy things for the children any more.

She has recently felt embarrassed after having to ask for a food parcel when she was broke and had no food in the house – something she thought she would never do. She says she does not know what she would do if she gambled her benefit away again.

Moana has attended two sessions but has just missed her third session. As you look through her notes, you see that the Gambling Helpline referral indicated that she had thought about suicide. You also recall that she was quite tearful at her first two sessions and has not completed all the assessment forms. You are required to consider any risks for her children with reference to the Vulnerable Children Act 2014.

Questions

After reading Case 6, answer the following questions.

- What actions would you take now?
- What feedback and support could you give Moana if she returns for further counselling?

Answers

What actions would you take now?

Phone Moana to ask her if she would like to reschedule her session. This also provides you with an opportunity to check on her safety. If Moana does not have a phone, then send her a brief personal note inviting her to contact you. If your service provides for home visits, you could schedule a visit and, if she is not home, you could leave a personal note at that time.

What feedback and support could you give Moana if she returns for further counselling?

If Moana returns for further counselling, make it a priority to ensure she completes all of the screens, including the co-existing issue screens, and check her safety, using the suicidality screen. You could also offer Moana the opportunity to use dedicated Māori services if she wishes. In counselling, discuss how she might develop an adequate support network to improve things for her in the long term.

Guiding principles

A high risk of suicide is associated with those experiencing gambling harm, so check the safety of your client/tangata whai ora as part of the comprehensive assessment. Do this as early as possible and appropriate in the engagement process.

In case important documentation is incomplete at the end of an appointment, make sure you have a system for identifying incomplete documentation so that you can follow it up, and make sure it is completed at the next session.

In case a client/tangata whai ora fails to attend an appointment, make sure their contact details are specific and accurate, so you can contact them. Ask your

client/tangata whai ora if it would be okay for you to contact them – or someone else in their family or whānau – to see how they are going, as a part of a relapse prevention process. Early on in your engagement, agree on their preferred method of contact, such as phone, text, email or home visit. Also, discuss what happens if you visit but they are not home, and you meet someone else there instead. Find out what would they like you to say about your reasons for calling (ie, how to identify yourself), with reference to their privacy.

4.9.3 Case 7 – Client/tangata whai ora experiencing gambling harm wants to remain anonymous

Gustav is a middle-aged man with a strong eastern European accent, who comes in off the street without an appointment, wanting to speak to someone about his gambling behaviour. You have just had an appointment cancelled so you make time to talk to him.

Gustav makes it plain from the outset that he does not want to commit himself to anything until he has had time to check if the service is going to be useful to him. Also, no one knows he is here and he is concerned about being on any kind of database because he believes that ‘anyone can get information from computers’. Gustav says he knows this because he spends hours daily on computers and ‘knows all the tricks’.

As you talk with Gustav, it becomes clear that he has experienced harm from his gambling on machines and the internet and owes a lot of money on a personal loan and two credit cards. His wife appears to know nothing about this, and he says that he wants to sort everything out before she finds out about the debt.

Questions

After reading Case 7, answer the following questions.

- What would you do about recording this session, and what feedback or information would you give Gustav?
- What documentation could you use if Gustav continues to not want his details recorded?

Answers

What would you do about recording this session, and what feedback or information would you give Gustav?

Explain the Privacy Act 1993 to Gustav as it applies to gambling harm treatment services, and that his information would be stored in password-protected electronic files or paper files locked away, accounted for by number, and with access only by those who have signed confidentiality forms. Tell him that no one receives information about him without his signed and informed consent. Explain that his information is anonymously added to statistics, which are then grouped together and do not identify individuals.

What documentation could you use if Gustav continues to not want his details recorded?

In order to receive treatment from health services, Gustav would need an NHI number with his name and details included and all his information would be held under terms and conditions of the Privacy Act 1993. All the usual screens and documentation would be kept private and confidential (apart from safety overrides). An alternative service such as the Gambling Helpline may offer him anonymity over the phone if he is still seeking advice for his gambling behaviours and he does not wish to register with a face-to-face service.

Guiding principles

All clients/tāngata whai ora who are seen individually and assessed must fill out the same relevant documentation, have an individual file and have a unique number for all treatment presentations.

For all clients/tāngata whai ora, you must adequately explain their rights under the Privacy Act 1993. Assure them that all staff, including the Gambling Helpline staff, are obliged to respect their rights and tell them what that involves. To count a client/tāngata whai ora against contract targets, you must record the minimum data requirements for a full intervention.

Note that if the client/tāngata whai ora does not identify a primary problem gambling mode, you should not record the session in CLIC. Instead, you should note the activity in your six-monthly narrative report to the Ministry of Health because it shows your clinical workload and the ongoing pattern of care being provided.

KEY MESSAGE

No type of gambling associated with harm \Rightarrow no primary problem gambling mode.
No primary problem gambling mode \Rightarrow do not record in CLIC.

4.9.4 Case 8 – Support group encounter

One night, a regular member of your women's support group brings along two of her friends: Jenny, a 22-year-old European woman; and Suzie, a 24-year-old New Zealand-born woman of Chinese descent. At the end of the group session, Jenny and Suzie say they got a lot out of it and would like to come on a regular basis.

Jenny has been wondering about her gambling behaviour and agrees to fill in the Brief Gambler Screen. She is not sure if she wants counselling yet but wants to engage with the service as a group member anyway.

Suzie fills out the Brief Gambler Screen and scores zero. You talk to Suzie about her screen score and she tells you that she plays Lotto every now and then. You discuss Suzie's gambling behaviour further and assess her gambling harm as low level with a low associated risk and note that you did not identify a primary problem gambling

mode. Suzie does acknowledge that she is always arguing about money with her family. Her concerns are financial problems and strained relationships because of her high spending and the lies she tells to keep her family from finding out her true financial situation. She says she feels that all her problems are the same as those of others in the group, and she wants counselling with you as well as group sessions because she feels desperate.

Questions

After reading Case 8, answer the following questions.

- What feedback would you give to Jenny?
- How would you account for Jenny statistically for the week?
- What forms are most appropriate for Jenny?
- How would you account for Suzie statistically?
- What feedback and information would you offer Suzie?

Answers

What feedback would you give to Jenny?

Give feedback to Jenny in a motivational style about the results of her screen score and motivate her to undertake further assessment and counselling.

How would you account for Jenny statistically for the week?

If Jenny had personalised feedback for approximately 15 minutes or more about her screen results, record this as a brief intervention session. If Jenny decides afterwards to have more help, record any future sessions as full interventions. At your first full intervention session with Jenny, you should begin a comprehensive assessment.

If Jenny does not agree to receive individual support, you cannot count her as a client/tāngata whai ora attending group therapy. You need to complete a comprehensive assessment with Jenny before she can start group therapy (see section 4.2.3). Note that not all groups are considered group therapy.

What forms are most appropriate for Jenny?

If Jenny:

- has personalised feedback of 15 minutes or more and completes a screen, record a brief session
- comes for more individualised (one-to-one) support, record these as full intervention sessions
- attends the group, enter her subsequent group attendances as group therapy sessions (which are full interventions). Add her as a group attendee along with all other attending clients/tāngata whai ora.

How would you account for Suzie statistically?

Suzie does not have a primary problem gambling mode. If the client/tangata whai ora does not identify a primary problem gambling mode, do not record the session in CLIC. Instead, you should note the activity in your six-monthly narrative report to the Ministry of Health because it shows your clinical workload and the ongoing pattern of care being provided.

KEY MESSAGE

No type of gambling associated with harm \Rightarrow no primary problem gambling mode.

No primary problem gambling mode \Rightarrow do not record in CLIC.

What feedback and information would you offer Suzie?

Tell Suzie that although she may have a problem with compulsive spending and needs help, she does not meet the criteria to be counselled under a gambling harm contract. The options for her include referral to budgeting services, alternative counselling services and other women's groups. It would also be prudent to check out safety issues by asking her to complete the co-existing issue screens.

When a client/tangata whai ora does not have a positive Gambler Harm Screen but does have a positive co-existing issue screen, it is expected that the gambling harm service facilitates their access to an appropriate service within one or two sessions. Because you cannot record time spent working with Suzie (facilitation) in CLIC, you should note the activity in your client notes as it shows your clinical workload and the ongoing pattern of care being provided.

Guiding principles

Group members are not clients/tāngata whai ora until they receive individualised assessment and treatment in their own right. Brief and full intervention screens provide criteria against which to measure whether prospective clients/tāngata whai ora are appropriate for the service. If a person does not meet these criteria, their needs may be better met elsewhere. You should give appropriate advice, make a referral or, if necessary, facilitate their access to an appropriate service within one or two sessions.

4.9.5 Case 9 – Full intervention by video conferencing (eg, Skype) for client/tangata whai ora experiencing gambling harm

Bill is a 46-year-old man who lives on a farm in a rural area in New Zealand. He has been in the army and served overseas for a brief period until he was wounded with shrapnel from a mine on the side of the road while on a mission with his military unit. Since then, he has had trouble working, leaving the house and carrying on with normal activities. He has been diagnosed with post-traumatic stress disorder and tells you he has been using alcohol to deal with his anxious feelings, so now his main social activity is going to the local hotel, drinking and also playing pokies. He has contacted your

service for help as he is having financial problems as a result of spending too much on the pokies. However, because of his illness and the distance, he feels unable to come to your service in person. He asks if he can have counselling support by Skype and perhaps also brief support by email or text at other times. You agree and schedule a Skype session with Bill for an initial assessment.

Questions

After reading Case 9, answer the following questions.

- How would you account for the time spent with Bill in your data collection system?
- How would you approach ongoing case management for Bill?
- What screens would you use and how would you manage the screening process?
- Could facilitation also be managed through Skype?

Answers

Bill's PPGM is Pub EGMs (pokies) and he is registered as a full intervention client/tangata whai ora. If possible, you could arrange a face-to-face initial session with Bill and then continue with Skype; otherwise you could use Skype for the initial session as well. Skype sessions can run at an appointed date and time negotiated with the client/tangata whai ora for the usual length of time (eg, approximately one hour). **They count as a face-to-face session.** At other times, you could use phone, text and email contact to keep in touch, offer brief support and arrange new times or quickly deal with crisis situations. **They count as a phone session.** It would be useful to get Bill's consent to contact his medical support providers also, to help in coordinating his care plans.

In addition to the gambling harm screens (Gambler Harm Screen, Gambler Outcome Screen – Control over Gambling, Gambler Outcome Screen – Dollars Lost and Gambler Outcome Screen – Annual Household Income), it would be useful for Bill to complete the Alcohol Use Screen to provide information about his level of use and any related harm, and also whether his alcohol use is potentially exacerbating gambling harm. You may also wish to use the CHAT Screen or other screens to monitor anxiety and check for depression. You can conduct the screens verbally, and discuss the feedback and results via Skype. If Bill requires additional interventions and supports, other practitioners or services could connect via Skype at the same time and you could register this session as a facilitation.

Guiding principles

A face-to-face intervention is always the preferred option. The Ministry accepts, however, that there are occasions when this will not be feasible for a range of reasons such as language barriers (eg, a client/tangata whai ora outside of Auckland could Skype with Asian family Services), other geographical reasons or exceptional clinical reasons. The primary consideration is always the needs of the client/tangata whai ora.

4.9.6 Case 10 – Client/tangata whai ora experiencing gambling harm is also a family or whānau whai ora

Liz is a 48-year-old woman of Māori and Pacific descent, who contacts you for help as a result of a family group conference. Liz had been playing pokies at the casino and had been excluded after an angry outburst one evening after losing all her money. She returned to the casino a few days later, when security staff asked her to leave and police had to be called. Her family had been concerned for some time that she may have been leaving her children at home alone after they went to bed and had gone out gambling. They were also concerned that through lack of money, the children's needs were being neglected and a neighbour had called Oranga Tamariki, who had called a family group conference. The result was that Liz was required to attend counselling and, in the meantime, no further action is to be taken.

During your first session with Liz, she tells you that her ex-husband used to gamble, and he was also physically and emotionally violent to her, but she has never had help for this. She says this has left her feeling anxious and insecure and with low self-esteem, and she feels more relaxed when playing pokies and having a few drinks. She works part-time and spends a lot on pokies but wins 'often' and doesn't feel she has a problem with them. Liz says that she only gambles at the casino as she feels safer there and there is safe parking at night. She says she does not leave her children alone when she plays, but does not want to risk losing her children, so has agreed to come and see you. She has been worrying about money lately too and had hoped that she would win enough to sort things out, but that has not happened. She does not want her family or whānau involved in her treatment at this stage, as she feels they do not understand her.

Questions

After reading Case 10, answer the following questions.

- How would you account for the time spent with Liz in your data collection system?
- How would you approach ongoing case management for Liz?
- What co-existing screens would you use?

Answers

Liz's PPGM is Casino EGMs (pokies) and she is registered as a full intervention client/tangata whai ora. In addition to completing the gambling screens (Gambler Harm Screen, Gambler Outcome Screen – Control over Gambling, Gambler Outcome Screen – Dollars Lost and Gambler Outcome Screen – Annual Household Income), Liz identified that her former husband gambled, so she should also complete the Family/Whānau/Affected Other Harm Screen. When Liz discusses her own gambling behaviour, you enter the session as a client/tangata whai ora experiencing gambling harm; when she discusses the effects of her former husband's gambling on her, you enter the session as a family or whānau whai ora. You should focus the sessions on those issues separately, as CLIC can only record one type of client intervention at a time.

In addition, Liz has talked about several co-existing issues and so she should also complete screens for all of these issues. It is important that she completes the Alcohol Use Screen (as she discussed having a few drinks when playing pokies, to relax) and the Suicidality Screen. She could also complete the CHAT Screen (which includes screening questions for depression and anxiety). Completing the Family and Whānau Concern Screen may enable a discussion around her perspective on involving her family or whānau as a support for her treatment and around general concerns about her wellbeing. Liz has also disclosed her former husband's violence to you so, in addition to the violence screening questions in the CHAT Screen, you could use the HITS Screen to open up further discussion about the effects of violence on her and the children. Facilitation to other services may be appropriate in regard to GP support, family violence supports, budgeting assistance and consultation with alcohol and other drug services, if warranted.

Guiding principles

Clients/tangata whai ora presenting for help for gambling harm may also be affected by another's gambling and although registered as a full intervention client/tangata whai ora experiencing gambling harm, they can also use sessions for focusing on the effects or another's gambling on them. For those sessions, they are entered in CLIC as a family/whanau/affected other. It is also important to explore and screen for co-existing issues in order to provide holistic treatment and support for these clients/tangata whai ora who may have additional harm from the effects of other's gambling behaviour.

5 Facilitation

5.1 Introducing facilitation

Facilitation:

- is one or more sessions alongside a full intervention that involve actively supporting people experiencing gambling harm to access specialist mental health, alcohol and other drug, or social services
- involves working with an agency or service other than the specialist gambling harm intervention service
- involves working one to one with people who have to some degree acknowledged the harms they are experiencing from their own or another's gambling
- involves working with people who have made some commitment to seeking support from a specialist gambling harm service
- is not a valid session type for group therapy.

5.2 Summary of facilitation

Facilitation is an opportunity to help clients/tāngata whai ora – both those experiencing gambling harm and affected others – to access other community services as part of their change process. A comprehensive assessment will most likely reveal other issues and needs that have to be addressed.

KEY MESSAGE

Facilitation is about 'any door being the right door'. At the same time, the core business of gambling harm intervention services is to support people experiencing harm from gambling.

Clients/tāngata whai ora experiencing harm from their own or other people's gambling often have other problems in their lives. The mental health, alcohol and other drug, or social service needs of clients/tāngata whai ora may exist separately from the gambling behaviour or could be caused or exacerbated by their gambling behaviour. Either way significant health outcomes can be achieved by ensuring people receive support for any issues a health professional identifies.

The key concept behind the facilitation service is that the gambling harm practitioner may not have the skills or capacity to provide ongoing support, or the complex skills required to address co-existing problems. However, they should have the skills to support people to access other services.

Clients/tāngata whai ora often slip through the cracks between services during referrals. The facilitation service is designed to actively support people to engage with other services – not just to advise them that another service is available. This service may include:

- supporting the client/tāngata whai ora to make first contact with another agency
- arranging for other services to be available within the gambling harm intervention service venue
- attending initial consultations and meetings with the allied service
- discussing the progress of the client/tāngata whai ora in addressing their other issues and providing motivational support, if required, as a normal part of full intervention.

The defining feature of a facilitation session is that it involves both the client/tāngata whai ora and another agency at the same time. Activities that do not involve both these parties are not valid facilitation sessions (eg, writing court or probation reports or general practitioner reports). The Ministry believes that the latter type of work should be part of the practitioner's non-clinical workload.

KEY MESSAGE

Facilitation is about time spent supporting clients/tāngata whai ora to access other services. When recording 'facilitation' in CLIC, record the time spent with the client/tāngata whai ora and the other agency. Where you spend time with the client/tāngata whai ora preparing them to access another service, but the other service is not involved, record that time as a normal full intervention session.

The Ministry also notes that some types of reports are paid for by other services or, in some instances, by clients/tāngata whai ora. Providers should ensure that work funded by other services is not delivered as part of Ministry-funded gambling harm services.

Where you have a facilitation with a single client/tāngata whai ora on one occasion, involving multiple different agencies, record it as a single session rather than multiple short sessions.

Note: **You do not classify multi-venue exclusions as facilitations** because the process does not normally involve a counsellor accompanying their client/tāngata whai ora to each venue. However, if the client/tāngata whai ora wishes to self-exclude individually from several venues, then the facilitation may be a much longer process and could involve more than one session. Record in CLIC the full time spent with the client/tāngata whai ora and the other agencies.

5.2.1 Court sessions

Supporting clients/tāngata whai ora to attend court sessions is a form of facilitation that can be particularly time-consuming. Attending a court session with a client/tāngata whai ora may use up a large portion of your day (eg, if the client/tāngata whai ora has a noon court session they need to be present for at 9 am).

It is accepted that working with clients/tangata whai ora can often involve a range of therapeutic work and support. It is appropriate and valid to record in facilitation support given to clients/tangata whai ora where you supported them for any court appearance related to gambling (eg, gambling-motivated or gambling-related theft, fraud or domestic violence). You should record the actual length of the session in CLIC. A facilitation session is up to four hours in any one day against contracted provider targets.

5.2.2 Relationships with other services

For facilitation to be effective for the client/tangata whai ora, it is important that both the facilitation service and the practitioner involved have established relationships with other services. At times, practitioners will need to form relationships with new services to address unique or unusual client/tangata whai ora needs. Ideally, you will make progress with establishing and defining these relationships separately to the time you spend providing clinical support to the client/tangata whai ora; time with the client/tangata whai ora should be focused on **their** needs.

There are several common issues that gambling harm services may need to negotiate with another service (the facilitation service) before facilitation with that service can become routine.

- The facilitation service should understand that the gambling harm practitioner has the consent of the client/tangata whai ora to attend with the client/tangata whai ora.
- The facilitation service, the gambling harm service and the client/tangata whai ora should have an agreement about how the services and practitioners involved will discuss the progress of the client/tangata whai ora with each other and with the client/tangata whai ora. This will often require discussion and negotiation between the facilitation service and the gambling harm service before meeting with the client/tangata whai ora as well.

The gambling harm service may need to develop memoranda of understanding or relationship agreements with other services, outlining how they will engage, share information and develop joint client/tangata whai ora management protocols. Completing consent forms with the client/tangata whai ora that reflect their individual privacy needs, while being specific about who can or cannot receive information as well as what information can be shared, will assist this process.

5.3 Rationale for facilitation

Many people put off seeking help in relation to their gambling harm until they can no longer cope with their problems on their own. By the time someone does seek help, they are often dealing with a range of other problems and issues. Section 4.5.5 discussed screening for a small range of co-existing issues. Section 4.6.1 discussed the following other needs that clients/tāngata whai ora may have related to their gambling:

- budgeting and financial advice
- help with legal matters
- help with housing
- help with employment matters
- help with Work and Income assistance
- help with family, whānau and relationship matters
- general health matters.

See section 4.6.1 for more detailed information on these issues.

Although practitioners can support clients/tāngata whai ora with many of the issues relating to their gambling harm, some problems will require specialist services or may be unrelated to the gambling harm of the client/tāngata whai ora. In many cases, you will refer a client/tāngata whai ora to an appropriate service and provide some motivation to attend, and the client/tāngata whai ora will successfully access the other service. However, the Ministry is aware that many clients/tāngata whai ora drop out of the health system when they are referred to another service. The Ministry developed the facilitation service specification to recognise the importance of actively supporting clients/tāngata whai ora to access the other services they need for recovery.

With the increasing diversity of cultures living in New Zealand, for many clients English will not be their first language and they may need an interpreter. The language differences may also make facilitation to other services more complicated, with the need for longer introduction processes and a longer time to develop trust. As a result, both the length and number of sessions required for helpful engagement may increase. In addition, some clients/tāngata whai ora may have immigration issues while engaged with a gambling harm minimisation service, which again may require additional time and consideration in facilitation to other services.

KEY MESSAGE

Facilitation is **not** about getting rid of clients/tāngata whai ora or fobbing them off. It is about building on the relationship the client/tāngata whai ora has with their gambling harm clinician to support them to get specialist support for other problems in their lives. Not every client/tāngata whai ora needs facilitation or wants facilitation. That is okay.

It is important to remember that facilitation may be required at any point during a full intervention. You will probably identify some issues early on, while others you may only identify towards the end of treatment, or even later, during follow-up.

Although it seems logical that changing gambling harm behaviour should bring positive influences into other aspects of a person's life, this is not always the result. Sometimes, addressing the initial presenting issues unexpectedly exacerbates or highlights the consequences of other problems. People often have few strategies to cope with these unexpected consequences.

When other problems are set off in this way, clients/tāngata whai ora become at risk of returning to their old ways of coping, which often means reverting to their gambling harm behaviours. Identifying these potential vulnerabilities during assessment and setting goals with the client/tāngata whai ora during intervention and relapse prevention planning helps to connect them with other resources that will help to minimise the risks. Some clients/tāngata whai ora may need a facilitated referral to more intensive gambling harm interventions, or additional social supports, such as the Gambling Helpline, Gamblers Anonymous or Gam-Anon groups.

5.4 Summary of the facilitation service

If a session is to count as a facilitation activity, a service provider needs to have had at least a 15-minute phone call or 15 minutes of face-to-face contact with the client/tāngata whai ora and another provider or external agency, as specified in the agreed facilitation plan. Facilitation and support access can be to relevant life-skills programmes, cultural activities and services, social and budgeting services, relationship counselling, and other gambling harm services, including the Gambling Helpline. In some cases, you may need to help with a formal referral process on behalf of the client/tāngata whai ora.

Gambling harm services providing facilitation should continue to review and support clients/tāngata whai ora who have experienced gambling-related harm for facilitated issues for 12 months following their last full intervention session, as part of follow-up services. If a client/tāngata whai ora does not have a positive score on a gambling screen but does have a positive score on a co-existing issue screen, it is expected that the gambling harm service would facilitate access to an appropriate service for the client/tāngata whai ora. You should not provide follow-up support to or take responsibility for care of a client/tāngata whai ora who does not have a positive score on a gambling screen once the facilitation is complete.

Because there is no primary problem gambling mode in such cases, you would **not** record this client/tāngata whai ora in CLIC. However, you should note the time spent on this activity in your own internal records. Your provider can highlight these records with the Ministry at a performance monitoring visit.

KEY MESSAGE

No type of gambling associated with harm ⇒ no primary problem gambling mode.
No primary problem gambling mode ⇒ do not record in CLIC.

5.5 Examples of facilitation

5.5.1 Case 11 – Facilitation with budgeting service and doctor for client/tangata whai ora experiencing gambling harm

Louise came to the service for support after her marriage broke up following financial problems and the loss of her job. She had been playing the pokies over a nine-month period and felt as though her gambling behaviour was getting increasingly out of control. Louise stopped gambling completely about two weeks before her first appointment.

As part of the comprehensive assessment, you consider Louise's financial debts and mental health status, especially because she has lost her job and her marriage has ended due to the gambling behaviour. Louise acknowledges that she is having financial problems and is feeling down about her circumstances even though she is feeling confident that she will not go back to gambling.

As part of intervention and referral planning, you speak to Louise about considering contact with a budgeting service that other clients/tāngata whai ora have had good outcomes with. You tell her you know one of the budgeters well and that this person has a good understanding of gambling harm issues. You also say you think it might be a good idea for her to see her doctor, with whom she says she has a good relationship, to discuss the levels of depression that you pick up from the screening.

Louise agrees to contact the budgeting service to make an appointment to see a budgeter. She also agrees to see her doctor. Louise meets with her doctor, who then asks if you could meet with him and Louise together. You attend a half-hour session with Louise and her doctor and discuss Louise's gambling behaviour and other issues. Louise agrees to your sharing her case notes with her doctor and for her doctor to discuss issues related to her depression with you. You spend time signing consent forms for this purpose.

At your next session with Louise, you ask her how the appointment with the budgeting service went. Louise tells you she made the appointment but felt silly telling someone she couldn't manage her money so she did not go. You discuss Louise's feelings and agree together that she will make another appointment with the budgeting service, but you say that this time you will attend with her for support.

You go to the budgeting service and spend an hour with the budgeter and Louise. Later, Louise's doctor calls you with an update on Louise's depression and the treatment he has recommended. You discuss Louise's case with the doctor for about 20 minutes.

Question

After reading Case 11, answer the following question.

- How would you account for the contact time with Louise statistically?

Answer

How would you account for the contact time with Louise statistically?

Louise is registered as a client/tangata whai ora with a PPGM of Pub EGM. The time you spend completing assessment and intervention requirements is designated as assessment. The time you spend talking to Louise about referral planning and making contact with external agents on her behalf is a full intervention session. Record this time in the same way as you would record any other counselling session.

You record a facilitation session when you spend time with the client/tangata whai ora and a third-party agency. Therefore, you should:

- record all of the time you spend with Louise on her own as full intervention sessions
- record the half hour you spent with Louise and her doctor and the one hour with Louise and the budgeting service as facilitation sessions
- not count the 20 minutes you spent talking with Louise's doctor as facilitation, because it does not meet the criteria without Louise present (part of the intervention session).

Guiding principles

Facilitation is a different activity to assessment. It requires generating a referral plan as a result of discussions with the client/tangata whai ora, signing consents and actively engaging in the referral with both the external agents and the client/tangata whai ora. You should monitor and review facilitation plans in the same way as for the intervention plan.

5.5.2 Case 12 – Suzie at the support group (from Case 8) revisited

Suzie was one of the women who showed up with a group member to sit in on a support group in Case 8 (see section 4.9.4). She filled out a Brief Gambler Screen and scored zero but pointed out that she was always arguing about money with her family.

Suzie's concerns were her financial problems, and strained relationships because of her high spending and the lies she told to keep her family from finding out her true financial situation. She said all her problems were the same as those of others in the group, and she wanted counselling with you as well as group sessions because she felt desperate. Suzie did not identify a primary problem gambling mode.

Questions

After reading Case 12, answer the following questions.

- How would you account for the contact with Suzie statistically?
- What could we do for Suzie in the way of interventions?

Answers

When Suzie completes the Brief Gambler Screen, you could not count her contact under a brief intervention because she does not have a PPGM. Because Suzie does not have a PPGM, she does not qualify for ongoing gambling harm intervention services. However, you identify that Suzie was experiencing high levels of stress and anxiety. As a result of Suzie's discussion with you, which focused on co-existing issues (in particular, her finances were causing her many problems), you felt that facilitation services should be provided.

Suzie says she is feeling desperate, so screening for depression and suicidality may also be appropriate.

Suzie says she is keen to see you individually and to be part of the group, so she would most likely be willing to come back for an appointment with you so that you could further assess the co-existing issues. The time in group sessions might not be appropriate to screen those concerns thoroughly. At your one-to-one appointment, you would assess co-existing issues and plan appropriate referrals, which might include referrals to a budgeting service and possibly a general practitioner or mental health service.

When Suzie is unsure about a service or unwilling to make contact on her own, you can offer to support her to make contact until she has established a relationship with the other agency. You should try to complete this within one or two sessions.

Because Suzie does not have a primary problem gambling mode, you would not record time spent with Suzie in CLIC. However, you should note the time spent on this activity in your internal client records because it shows your clinical workload and the ongoing pattern of care being provided.

KEY MESSAGE

No type of gambling associated with harm ⇒ no primary problem gambling mode.

No primary problem gambling mode ⇒ do not record in CLIC.

Guiding principles

A person scoring zero on a gambling harm screen still provides a service provider with an opportunity to work with the individual by assessing them for co-existing issues and providing facilitation planning to support them to access appropriate community, health or social services. The person is not experiencing gambling harm, so you should complete this facilitation within one or two sessions.

People you work with who do not have a primary problem gambling mode cannot be recorded in CLIC.

Not all people seeking help need facilitation to other services; sometimes you will only need to make a referral. Facilitation is designed for people who need additional support. People may not always select the right service when reaching out for help, but they should never be made to feel they have made a mistake by trying to get help.

It is the service provider's responsibility to ensure staff have the skills to appropriately screen, acknowledge the concerns presented and facilitate the individual to the right services for help.

5.5.3 Case 13 – Facilitation to address social isolation and financial literacy for client/tangata whai ora experiencing gambling harm

Penny has come to the service for help to stop gambling on pokies at the hotel close to her home. She has identified that she has few friends and social contacts now because most of her time has been spent playing pokies and avoiding social contact. She has also said that she is 'completely hopeless' with money, has a lot of debt and does not know where to start when it comes to living on a budget. Penny has done well in stopping her gambling, although she is worried that her boredom and lack of support could make her relapse. As part of the full intervention, you discuss with Penny some of the options she could take up to deal with these issues as part of her treatment and relapse prevention planning and produce an agreed facilitation plan.

You make arrangements with Penny to take her to her local pub and, while there, support her to fill out a self-exclusion and a multi-venue exclusion around her wider neighbourhood. Later that week, you take Penny to a local raranga group (weaving) and talk to the organiser, and Penny is introduced to a few group members. Penny joins the group and feels that, in picking up her old skills and meeting new friends, she will not feel bored and isolated, and will be less likely to relapse. You also tell Penny that your service is running a 'financial literacy' group the following week, and suggest that this would benefit her in learning to manage her money and transactions. You introduce her to the group facilitator, who takes her details and explains the purpose and expected outcomes of the group, and then adds her to the list of participants.

Question

After reading Case 13, answer the following question.

- How would you account for the time spent with Penny in these activities in your data collection system?

Answer

Penny's primary problem gambling mode is Pub EGM (pokies) and the time spent on assessment and on referral and relapse prevention planning is part of the full intervention counselling. You count the hour-and-a-half you spend picking Penny up and taking her to the pub for exclusions as a facilitation session. When you take Penny to the raranga group, talk to the organiser, meet a few group members and then leave Penny with the group, this takes one hour and you count this time as another facilitation session. Finally you take 15 minutes to introduce Penny to your colleague running the financial literacy group as a third facilitation session.

5.6 Recommendations for facilitation planning

Facilitation most commonly occurs after you have conducted a comprehensive assessment and identified additional areas of support. Sometimes it may while you are engaging in a brief screening that you become aware of safety or other risks for the client/tangata whai ora or their family or whānau. In these instances, you should directly support the client/tangata whai ora or their family to access the relevant services, regardless of their Brief Gambler Screen score.

Note that the Ministry sees ongoing support as unusual for individuals who have not met the criteria for a positive screen. The Ministry accepts that sometimes services are provided in these cases but believes such clients/tāngata whai ora will be the minority of those seeking help. The Ministry will seek clarification of such practices (ie, multiple facilitation sessions for clients/tāngata whai ora who have not had a positive brief or full intervention screen) if they become a significant proportion of a service's client/tangata whai ora workload.

Facilitation does not require any specific minimum screens. However, facilitation is a vital component of the full intervention process, just as screening, conducting a comprehensive assessment and intervention planning are.

Due to the potential benefits from offering facilitation services to a client/tangata whai ora, it is important that a service provider engage in a negotiated intervention planning process with a client/tangata whai ora as part of the assessment so that facilitation planning can be considered.

It is important for gambling harm service providers to be well acquainted with the variety of community services available in their area so that the facilitation process is as seamless as possible for the client/tangata whai ora. You should become familiar with key staff in community agencies who you can contact directly if a facilitation is needed. Through direct contacts like these, clients/tāngata whai ora are more likely to buy in to the facilitation, especially those who are reluctant to consider support outside the gambling harm service. Clients/tāngata whai ora are more likely to consider other agencies as part of their interventions if their service provider's recommendation is based on familiarity with the external agency.

When considering contact with external agencies on behalf of a client/tangata whai ora, first be sure that clients/tāngata whai ora sign service consents to clearly give their approval for you to give their name and circumstances to an external party as part of a formal referral.

5.7 Frequently asked questions

5.7.1 Can I count a facilitation activity before completing an assessment?

It is possible to count a facilitation activity before a comprehensive assessment is complete. Depending on the priority of the issues a client/tangata whai ora presents with, it may be important to act on a referral or a facilitation plan immediately, especially for mental health issues. Under normal circumstances, the Ministry still considers it is important to complete a comprehensive assessment within the first three sessions. If a client/tangata whai ora has not provided a primary problem gambling mode, then you cannot enter them into CLIC.

5.7.2 What if a client/tangata whai ora does not need any facilitation services?

A full intervention activity does not have to include facilitation to be counted against contract requirements. However, under normal circumstances, your file reporting client/tangata whai ora contact should show that assessment and intervention planning considered facilitation planning, but that the client/tangata whai ora did not require or agree to facilitation services.

5.7.3 Can I still count a facilitation activity if a person scores zero for gambling harm?

Facilitation activity is warranted even if the person has been screened as not having any specific concerns with gambling harm but has been assessed as having other social or health issues. For such clients/tāngata whai ora, you should complete facilitation within one or two sessions and should not provide follow-up support once the intervention has been closed. You should document the circumstances of this contact in the file of the client/tangata whai ora, as with any other client/tangata whai ora.

5.7.4 Does supporting clients/tāngata whai ora to attend venues to self-exclude count as facilitation?

Attending venues with clients/tāngata whai ora to self-exclude themselves from further gambling is a good example of a valid facilitation session. However, writing a self-exclusion letter with a client/tāngata whai ora does not count as facilitation. Instead, you should record the time taken for this process as part of a full intervention session, because it does not involve direct contact and interaction with the venue the client/tāngata whai ora is being excluded from.

5.7.5 Is it a facilitation when referring to another gambling harm service?

Referring clients/tāngata whai ora to another gambling harm service is not facilitation, even if three parties are involved, as this is a transfer of service. However, if you take a client/tāngata whai ora to meet a multi-venue exclusion coordinator, even if they are located in another gambling harm service (face-to-face or by phone), this will meet the criteria for a facilitation.

6 Follow-up

6.1 What is follow-up?

Follow-up:

- is a series of scheduled one-to-one sessions (or contacts) with a client/tāngata whai ora who has finished with full intervention treatment with a specialist gambling harm intervention service
- involves providing periodic support to people as they transition from the support of full intervention services to independence from gambling-related harm
- is not provided for clients/tāngata whai ora who are not experiencing harm from gambling and who a gambling harm intervention service has facilitated to other social or health services.

Follow-up is an opportunity to re-engage with clients/tāngata whai ora throughout the year after they have left full intervention and facilitation services. This service applies to clients/tāngata whai ora experiencing gambling-related harm and to family/whānau/affected other who have been previously registered as receiving full interventions.

You should seek the agreement of the client/tāngata whai ora to a follow-up plan early; for example, when agreeing the intervention plan (see section 4.6).

Ideally, clients/tāngata whai ora who have completed full intervention treatment should receive four follow-up sessions. These sessions should be at:

- one month from the last full intervention session
- three months from the last full intervention session (about 60 days from the last follow-up contact)
- six months from the last full intervention session (about 90 days from the last follow-up contact)
- 12 months from the last full intervention session (about 180 days from the last follow-up contact).

See section 4.3.2 for details on the pathways clients/tāngata whai ora take to follow-up services without fully completing a full intervention.

6.2 Rationale for follow-up

The rationale for follow-up includes that it:

- optimises the opportunity for clients/tāngata whai ora to reconnect with the service at an earlier stage than might otherwise have happened, if at all
- allows clients/tāngata whai ora to receive updates on their progress and reinforces their positive changes
- gives you a chance to provide motivational support
- offers support for the client/tāngata whai ora to review relapse prevention plans (including reassessment)
- enables you to advise the client/tāngata whai ora about, and refer them to, other social and health services as appropriate, and encourages ongoing liaison between the client/tāngata whai ora and referral services
- reinforces to the client/tāngata whai ora that they can achieve and maintain long-lasting change
- increases knowledge about client/tāngata whai ora outcomes following treatment
- increases knowledge about what works with clients/tāngata whai ora and provides opportunities to reflect on training needs and processes
- enables clients/tāngata whai ora to give feedback to practitioners (eg, to affirm their clinical and engagement skills)
- enables counsellors, teams and agencies to benefit by knowing their clients/tāngata whai ora have improved
- is best practice for health professionals.

6.3 Obstacles to client/tāngata whai ora follow-up

Follow-up may be difficult because:

- clients/tāngata whai ora may be mobile (eg, address and phone contacts change and clients/tāngata whai ora fail to advise of changes)
- the needs of clients/tāngata whai ora may change and they may not want to continue the process
- clients/tāngata whai ora may be uncertain about the rationale for follow-up and not understand what the follow-up process involves
- clients/tāngata whai ora may not want to be reminded of old behaviours after periods of remission
- clients/tāngata whai ora may be concerned about their privacy and be wary of future contact or messages left

- clients/tāngata whai ora may have relapsed and may not want to re-engage with the service at that time
- practitioners may feel overloaded and reluctant to take on additional work.

However, the advantages of follow-up outweigh the disadvantages for clients/tāngata whai ora, practitioners and treatment agencies. As well as supporting clients/tāngata whai ora to manage their recovery and contributing to outcome data, follow-up provides knowledge that helps everyone in the sector to improve the supports and services available to clients/tāngata whai ora. A signal of the importance of follow-up is that it is a significant part of contract funding and targets.

6.4 Summary of follow-up intervention service specification

Follow-up services will include the collection of results from standard screening tools that are detailed in this section. A follow-up is a scheduled review session by phone or face to face (but not in a group) with a client/tāngata whai ora who has recently completed full intervention treatment. The service provider usually initiates the contact with the client/tāngata whai ora at one month, three months, six months and 12 months after the full intervention services. The service provider should be flexible in its hours to accommodate the needs of clients/tāngata whai ora. Usually a scheduled follow-up will be completed in a single session.

At the three-month, six-month and 12-month follow-ups, you use reassessment screens with the person experiencing gambling harm and affected others. A follow-up session is usually about 15–30 minutes in length. If the follow-up session identifies that the client/tāngata whai ora needs further counselling, assessment or facilitation services, record any subsequent session as a new full intervention or facilitation session.

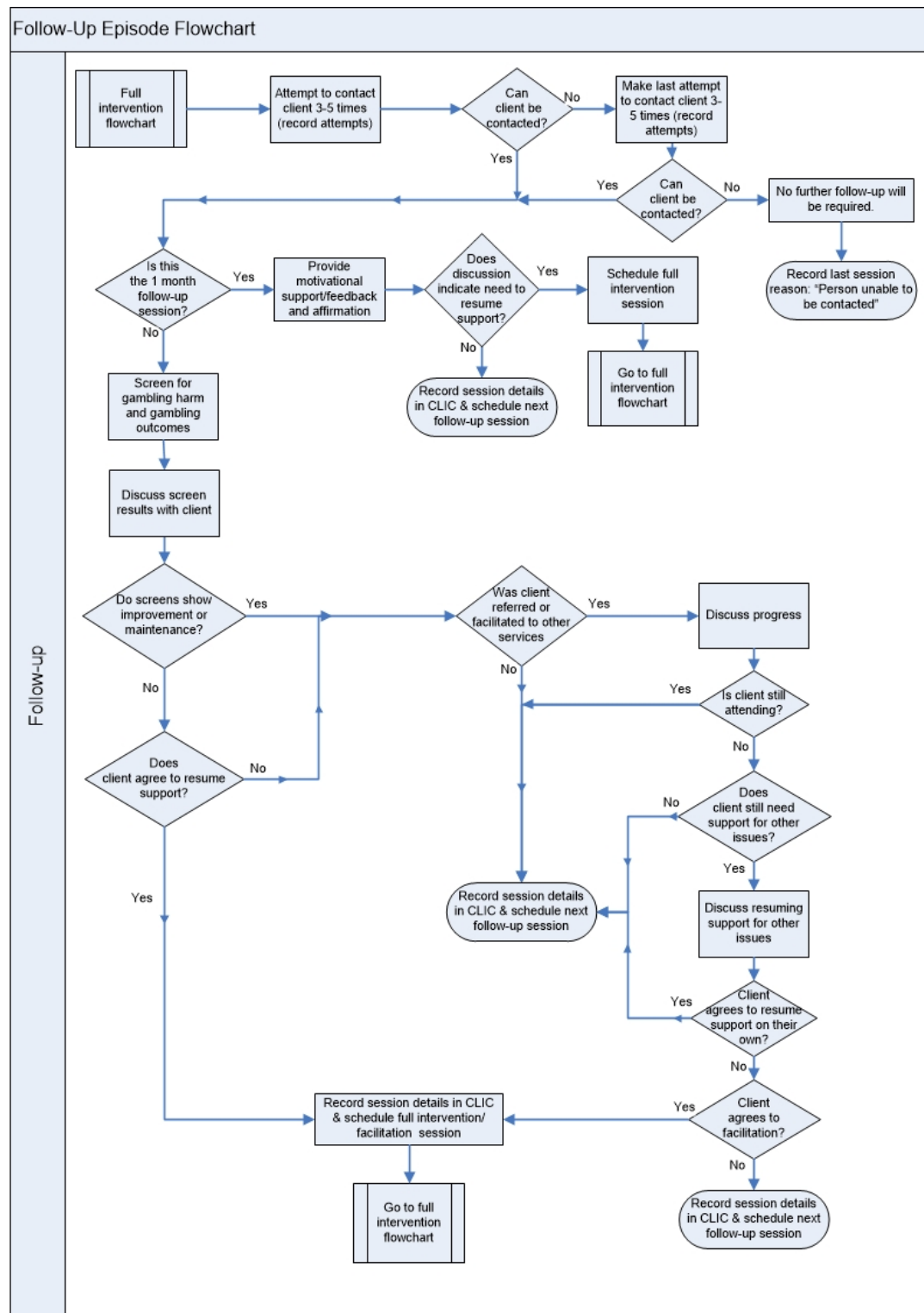
If the client/tāngata whai ora reconnects with the service provider because they are concerned about relapse and the call is not directly related to a scheduled follow-up, start a new full intervention session.

KEY MESSAGE

Follow-up is about supporting people towards recovery and independence. It does not mean people cannot come back for support whenever they or their clinician thinks it is useful. If you talk to a client/tāngata whai ora, as part of follow-up or because they come back to your service – or for any other reason really – and they agree that they would like to come back into treatment, restart full intervention sessions, including review of their primary problem gambling mode (PPGM) and a comprehensive assessment, as appropriate.

Figure 6.1 sets out a flowchart of typical client/tāngata whai ora pathways and practitioner decisions for follow-up.

Figure 6.1: Typical client/tangata whai ora pathways and practitioner decisions for follow-up



Note: See Appendix 4 for a guide to the symbols used in this figure. CLIC = Client Information Collection.

6.5 Follow-up procedure

As part of the comprehensive assessment process, you assure clients/tāngata whai ora of confidentiality under the Privacy Act 1993, and you can gain their consents to contact other services, including the Gambling Helpline, at that time. This is an ideal opportunity to explain the follow-up process and the benefits to the client/tāngata whai ora (ie, improved client/tāngata whai ora outcomes).

Unless the client/tāngata whai ora is too distressed or you have no opportunity to do so, it is preferable to offer this service to them at the first contact to ensure follow-through. Use a follow-up agreement to encourage the client/tāngata whai ora to commit to the follow-up process. It also offers certainty for the service provider about how to reconnect with clients/tāngata whai ora at the scheduled follow-up times. For an example of a follow-up agreement, see Appendix 2.

Be sure to include the name or CLIC ID of the client/tāngata whai ora on the follow-up agreement. Ask them what type of follow-up they would prefer (ie, telephone or face to face) to complete the follow-up screens. To respect the privacy of clients/tāngata whai ora, it is important to discuss their preferences for not only preferred means of contact for future follow-up, but also how you should respond if others answer the phone or door when you call, or whether to send mail or leave messages. This discussion will also help guide your actions when things do not go according to plan. Ensure the client/tāngata whai ora signs and dates the relevant section of the follow-up agreement.

6.6 Ending a follow-up

Follow-ups are an important part of empowering clients/tāngata whai ora and supporting their independent recovery. Follow-ups are different from every other intervention type as they almost always involve only one session. Note that occasionally a client/tāngata whai ora may not be able to complete a follow-up in one session. The Ministry believes that this situation will probably be rare, but in such an event you can agree to recontact the client/tāngata whai ora and complete the follow-up in a second separate session.

Table 6.1 lists the appropriate discharge code for each outcome.

Note that you should only enter a last session reason if you believe that the client/tāngata whai ora in question will not be having any further sessions of any type with the service.

Table 6.1: Ending follow-ups

Client/tangata whai ora outcome	Clinical action	CLIC administration: last session reason
Client/tangata whai ora could not be contacted over a period of one week. (There is an expectation that providers will make three or more contact attempts within seven days.)	Do not schedule further follow-up sessions.	Person unable to be contacted. Note: At least three contact attempts must be recorded before you can input this last session reason.
Client/tangata whai ora contacted, and discussion indicates a need (and willingness) to renew specialist support (full intervention).	Schedule full intervention session. Do not schedule further follow-up sessions.	N/A. Not last session. When you enter the new full session in CLIC, it will 'restart' the follow-up sequence when the client/tangata whai ora next ends full intervention treatment.
Client/tangata whai ora contacted, and discussion indicates they are maintaining or improving their progress to independent recovery.	Schedule next follow-up session.	N/A. Not last session. The follow-up reminder report will generate reminders for the next follow-up.
Client/tangata whai ora contacted, but they indicated they no longer agree to follow-up support.	Do not schedule further follow-up sessions.	No further contact requested.

6.7 Follow-up screens

6.7.1 Gambling screens for follow-up

For people who received support for their own gambling harm, use the following screens for follow-up services at three-, six- and 12-month follow-up sessions. (See section 4.5 for how to score and interpret these screens.) Note: If the client/tangata whai ora has completed no screening for a significant period before starting the follow-up process, you may use your clinical discretion to screen at the one-month follow-up as well.

Text in *italics* gives instructions for the information to enter into CLIC for each screen; for example '*Record the number of positive responses to questions 1 to 4*'. For the full version of all screens, see Appendix 1.

The Gambler Harm Screen

The Gambler Harm Screen is nearly identical to the Gambler Harm (PGSI) Screen used for full intervention. The difference is that, when you use the Gambler Harm Screen for follow-up, you ask the client/tangata whai ora to think about the time since you last talked.

Score the Gambler Harm Screen based on the response of the client/tangata whai ora to each question (never = 0, sometimes = 1, most of the time = 2, almost always = 3).

Gambler Harm Screen *(record the total score)*

1. Since we last talked, how often have you bet more than you could really afford to lose?
2. Since we last talked, how often have you needed to gamble with larger amounts of money to get the same feeling of excitement?
3. Since we last talked, how often have you gone back another day to try to win back the money you lost?
4. Since we last talked, how often have you borrowed money or sold anything to get money to gamble?
5. Since we last talked, how often have you felt that you might have a problem with gambling?
6. Since we last talked, how often have people criticised your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?
7. Since we last talked, how often have you felt guilty about the way you gamble, or what happens when you gamble?
8. Since we last talked, how often has your gambling caused you any health problems, including stress or anxiety?
9. Since we last talked, how often has your gambling caused any financial problems for you or your household?

6.7.2 Outcome screens

As part of the follow-up assessment, ask those of your clients/tāngata whai ora who receive support for their own gambling behaviour about:

- their control over their gambling behaviour ('Gambler Outcome Screen – Control over Gambling')
- the amount of money they have lost ('Dollars Lost Screen')
- their annual household income ('Annual Household Income Screen').

Gambler Outcome Screen – Control over Gambling

The CLIC system calls this question 'Gam Outcome Control'.

Control over gambling (record the number of the response, ie, 1, 2, 3 or 4)

During the past month:

(1) I have had complete control over my gambling.

or

(2) I have had some control over my gambling.

or

(3) I have had little control over my gambling.

or

(4) I have had no control over my gambling.

Dollars Lost Screen

The CLIC system calls this question 'Gam Outcome Dollars lost'.

Dollars lost (record the response, eg, \$5,000)

In the last month when you were gambling, roughly what amount of money did you spend on gambling?

This is the total amount of money in dollars that you used on your gambling activity or activities (ie, money you took to gamble with plus any additional money you obtained and gambled with such as from cash machines and EFTPOS). Ignore any money you won during your gambling sessions.

Dollars spent on gambling: \$.....

Annual Household Income Screen

The CLIC system calls this question 'Gam Outcome income'.

Annual household income (record the number of the response, ie, 1–7)

(1) ☐ < \$20,000

(2) ☐ \$20,000–\$30,000

(3) ☐ \$31,000–\$50,000

(4) ☐ \$51,000–\$100,000

(5) ☐ \$101,000–\$200,000

(6) ☐ \$201,000–\$500,000

(7) ☐ \$501,000+

6.8 Family/Whānau/Affected Other screens for follow-up

For rescreening people for the impact someone else's gambling behaviour has had on them, use the family/whānau/affected other screens at the three-month, six-month and 12-month follow-up sessions. (See section 4.5 for how to score and interpret these screens.)

Text in *italics* gives instructions for the information to enter into CLIC for each screen; for example '*(Record the number of positive responses to questions 1 to 4)*'. For the full version of all screens, see Appendix 1.

6.8.1 Family/Whānau/Affected Other Harm Screen

For follow-up assessments of the impact another person's gambling harm is having on their family or whānau whai ora after they have received a full intervention, use the variation of the full Family/whānau/affected other Harm Screen below.

The Family/whānau/affected other Harm Screen is made up of two questions. You will see that the CLIC system calls these questions:

- Family Awareness
- Family Effect.

Introduction/opening statement: When you were seeing our service regularly, you described your awareness of the effect of someone's gambling on you and identified a range of particular effects on you and your family or whānau. I would like to ask you some similar questions to see how your awareness and feelings about the other person's gambling have changed.

- 1 **Awareness of the effect of the gambler's gambling:** *(Record the number of the response, ie, 1, 2 or 3.)*

Do you think you are still being affected by someone else's gambling?

- (1) ☐ I don't know for sure if their gambling is still affecting me.
(2) ☐ It did affect me after we last talked, but not any more.
(3) ☐ Yes, that's happening to me now.

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

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

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

6.8.2 Family and whānau outcome screens

As part of the follow-up assessment, ask family/whānau/affected other seeking support for the effect of someone else's gambling behaviour about:

- the frequency of the gambling of the person experiencing gambling harm ('Gambling of the person experiencing gambling harm Frequency Screen')
- how they are coping with the gambling of the person experiencing gambling harm ('Coping with the Gambling of the person experiencing gambling harm Screen').

The family or whānau whai ora or you may fill in the outcome screens.

Gambling of the person experiencing gambling harm Frequency Screen

The CLIC system calls this question 'Family Outcm Gam Freq'.

The statements below are about the person who was gambling at the time you sought help and about you.

Gambler's gambling frequency

(record the number of the response, ie, 0, 1, 2 or 3.)

Which of these four statements is true about the person's gambling over the past three months? (Tick **one** box only.)

- (0) ☐ The gambler in my life has not been gambling during the last three months.
- (1) ☐ The gambler in my life has been gambling less during the last three months.
- (2) ☐ The gambler in my life has been gambling about the same as usual during the last three months.

- (3) ☐ The gambler in my life has been gambling more than usual during the last three months.

Coping with the Gambling of the person experiencing gambling harm Screen

The CLIC system calls this question 'Family Outcome Coping'.

You can administer this screen during normal discussion with the family or whānau whai ora or over the phone, or the family or whānau whai ora can complete the screen on their own.

Coping with the gambler's gambling

(record the number of the response, ie, 1, 2 or 3)

Which of these three statements is true about your ability to cope with the person's gambling over the last three months? (Tick one box only.)

- (1) ☐ I am coping better with the gambler's gambling than I have in the past.
- (2) ☐ I am coping about the same with the gambler's gambling as I have in the past.
- (3) ☐ I am not coping as well with the gambler's gambling as I have in the past.

6.9 Examples of follow-up

6.9.1 Case 14: Follow-up services for a couple

Roger came to the service four months ago with a gambling harm concern, relating to the pokies primarily and the track to a lesser extent. This gambling behaviour was significantly affecting his marriage, so he included his wife, Helen, in the treatment process.

Over a three-month period, you saw Roger almost weekly for full intervention sessions that included assessment and agreed interventions. Helen became so involved in the intervention process, mostly for couple work, that you registered her as a client/tangata whai ora as well and conducted an assessment over the course of contact.

At the end of a three-month intervention experience, Roger and Helen both felt they had made great progress and were ready to complete the full intervention services process. At an early point in the assessment process, you had explained follow-up

contact to Roger and Helen, and they both agreed to telephone contact past the point of full intervention for follow-up purposes.

Questions

After reading Case 14, answer the following questions.

- What would you have done statistically after the full intervention services were completed last month?
- What is your next step one month after seeing Roger and Helen for full intervention services?
- What will you do as part of the second follow-up contact?

Answers

What would you have done statistically after the full intervention services were completed last month?

Roger and Helen had each completed a series of full intervention sessions with your service. Because they both felt the service was complete, their next session theme will be one-month follow up.

What is your next step one month after seeing Roger and Helen for full intervention services?

The first follow-up is to occur one month after the last full intervention contact, and you plan to reconnect with Roger and Helen to see how the last month has been for each of them. You prepared them both during the assessment and received their agreement to phone contact as part of the follow-up process, so you now call them to see how they are each doing and to re-establish contact.

What will you do as part of the second follow-up contact?

When speaking individually with Roger and Helen, you receive feedback from both that they are still doing well. In CLIC, you now enter a one-month follow-up session. At the end of that call, you let them know that you plan to touch base again in two months' time. At the three-month contact you will ask Roger to answer the follow-up screens for a client/tangata whai ora who has experienced gambling harm and ask Helen the questions from the follow-up screen for an affected other. Document these screen scores for each in CLIC for their next session details as part of the follow-up session.

Guiding principles

It is always good practice to get agreement to follow-up as early in the full intervention process as possible, because it is difficult to predict how long the full intervention treatment will be. This applies especially if the end of treatment reason turns out to be 'administrative' or 'no further contact requested' (see section 6.6 for more detail).

Approximately one month following the last full intervention session, contact the client/tangata whai ora to confirm their engagement with the follow-up process. Use this follow-up to:

- check in with the client/tangata whai ora
- confirm means of ongoing contact
- check on their progress and wellbeing (with or without screening, at your discretion – see 6.7.1)
- remind them that you will be back in contact again three, six and 12 months after treatment ended.

Even if a client/tangata whai ora does not attend the last session scheduled in a full intervention, and efforts to reschedule have been unsuccessful, attempting a follow-up contact at the one-month mark may still be successful and may reflect the view of the client/tangata whai ora in regard to their progress and needs at this time.

KEY MESSAGE

At the one-month follow-up contact, you do not have to do the follow-up screens (but may at your discretion). Do the follow-up screens at the three-, six- and 12-month follow-up contacts.

6.9.2 Case 15 – Reopening a full intervention after a scheduled follow-up

Three months ago, you ended Fred’s full intervention episode after working with him for three months. Fred had made good progress clinically and you mutually agreed that no further sessions were required. At the one-month contact Fred seemed to have been consistently well since his last full intervention session.

It is now time for your second scheduled follow-up contact with Fred at the three-month mark. You contact Fred and discover during your conversation and by redoing the gambling harm screens that he has not been doing very well in the past six weeks. He has been struggling with his finances, which has put pressure on his relationship, and he has started betting on the horses again. You encourage Fred to come in for an appointment, which he agrees to do.

Questions

After reading Case 15, answer the following questions.

- How would you account for the types of contact you have had with Fred, using CLIC?
- What next steps might you take?

Answers

How would you account for the types of contact you have had with Fred, using CLIC?

Initially you saw Fred for a full intervention session, so you would have entered all his contacts during that time accordingly in the session details. When you re-engaged for his one-month follow-up contact, you would have recorded a follow-up session of about 30 minutes.

On re-engaging with Fred for the three-month follow-up, you enter the gambling harm screen scores as part of his reassessment in CLIC along with session details. At this point, you still record the current session as a follow-up session but, because of Fred's increased scores and risk of relapse, you schedule a new session, which you will record as a full intervention session when he comes in for his agreed appointment.

What next steps might you take?

At the agreed appointment you record a new full intervention session for Fred, and review relapse prevention and referral planning with Fred as part of the reassessment and intervention process. Fred may now see the need to engage with a budgeting service, which you could facilitate and identify as a facilitation session.

Guiding principles

When you do the screens again at the three-, six- and 12-month follow-ups, review them against previous scores with that client/tangata whai ora. This provides an opportunity to increase their motivation to maintain or reconnect with relapse prevention skills.

If the follow-up contact leads to full intervention support, use this opportunity to revisit assessment and intervention planning. Even though facilitation might not have been necessary at the original assessment, you might consider options and revisit co-existing issues as part of the reassessment.

6.9.3 Case 16 – Follow-up for client/tangata whai ora experiencing gambling harm and family/whānau/affected other

Felicity had been attending your service for five months for help to stop playing pokies at the casino. She had done very well and had achieved her treatment goals. Her new partner Bob attended the first session with her and then had some counselling sessions as a family or whānau whai ora, for his own support. They had both agreed to follow-up at their first session and had nominated phone contact for future approaches from your service.

One month after the completion of Bob's last full intervention session, you try to contact Bob for follow-up and are unable to contact him on the phone number given. You make two further attempts a few days later and finally find that the number is no longer his when someone else answers. When you contact Felicity for follow-up, she tells you that she relapsed and so Bob had broken up with her. She felt depressed after this and has continued to play pokies again. She agrees to come back to the service for further help.

Questions

After reading Case 16, answer the following questions.

- How would you account statistically for the time spent with recontacting Bob?
- How would you account statistically for your conversation with Felicity and what would happen next?

Answers

How would you account statistically for the time spent with recontacting Bob?

You record each of the three attempts to contact Bob as a 'failed contact' and record the last session reason as 'Person unable to be contacted'. His file will be closed and no further follow-ups will be attempted.

How would you account statistically for your conversation with Felicity and what would happen next?

Felicity has relapsed and has agreed to come back to the service for further intervention and support. It is important to emphasise to her that this is a 'learning experience' rather than a 'failure', in order to encourage her to re-engage in treatment. If you had a significant discussion with Felicity (eg, 15 minutes or more), then count that contact as a follow-up; however, the follow-up process will not continue any further. You will record the next session (face-to-face) as 'full intervention' and continue as long as needed, to support Felicity to achieve treatment goals.

As she has experienced a relationship break-up and stated she felt depressed, it is also important to use a co-existing issue screen for depression, as well as the gambling harm screens, as part of reassessment. If necessary, you could also use facilitation (eg, to a GP) to ensure she is supported to receive appropriate help for her mood and wellbeing. At the end of her full intervention treatment sessions, she would again be able to access follow-up processes to continue support, which you could discuss with her at an appropriate time, early on in her re-engagement.

6.10 Recommendations for follow-up

Follow-up services represent a significant component in the therapeutic process with clients/tāngata whai ora. Clients/tāngata whai ora who have experienced gambling harm can be at high risk of relapse, so a structured follow-up plan allows you to motivate the client/tāngata whai ora and encourage them to maintain their changes, and to address concerns before they appear insurmountable. This is a standard process all clients/tāngata whai ora are encouraged to be part of, so it normalises the experience and does not set clients/tāngata whai ora up to think they have little chance of succeeding in their recovery.

Introducing the concept of follow-up early in the full intervention reassures clients/tāngata whai ora of an extended connection with the service and allows them to complete the full intervention without feeling their support has been taken away. It is helpful for clients/tāngata whai ora to feel that support is available if they need it again.

It is important not to lose track of when clients/tāngata whai ora need to be contacted at one, three, six and 12 months, so service providers should develop a system within their service that reminds them to complete these follow-up contacts.

6.11 Frequently asked questions

6.11.1 What if I cannot contact my client/tāngata whai ora for follow-up?

Not all clients/tāngata whai ora will be available for follow-up, because it depends on what else is going on in their lives. However, service providers are expected to be able to make contact with most of their clients/tāngata whai ora. The first follow-up is about one month after last contact, which should ensure most clients/tāngata whai ora are still available.

The more invested clients/tāngata whai ora are in seeing the follow-up process as part of their treatment, the more agreeable they will be to receiving follow-up support and being proactive about updating their contact details with you. It is the service provider's responsibility to build up the awareness of the client/tāngata whai ora of the role of follow-up in their recovery. It is also the service provider's responsibility to be flexible in the hours they offer to accommodate the needs of clients/tāngata whai ora.

KEY MESSAGE

Until a client/tāngata whai ora with a PPGM is no longer able to be contacted – or has asked a service to stop contacting them – you can always record the time you spend contacting or trying to contact them in CLIC as a failed contact.

If a client/tangata whai ora does not attend or was not available for a scheduled follow-up contact, providers should make three or more contact attempts within seven days. If the client/tangata whai ora still cannot be contacted after at least three contact attempts, record attempts to contact the client/tangata whai ora in the section for failed contact details for the client/tangata whai ora. You should also record a last session reason of 'Person unable to be contacted'.

If you could not contact your client/tangata whai ora for follow-up, but they recontact the service within a short time, use your judgement to decide whether they are seeking to resume full intervention support or whether they could benefit from resuming follow-up. Record the clinical time spent engaging with the client/tangata whai ora and assessing their progress as the missed follow-up. If follow-up is resumed, the next session is the same as if the client/tangata whai ora had been contacted.

For example, James misses his three-month follow-up session. He recontacts the service two weeks later. He had been on holiday and forgot about his appointment. The practitioner spends half an hour with James discussing his progress. James gives the practitioner a new cellphone number for contacting him, and they agree on a date for the next follow-up session, which will be the six-month follow-up (90 days after the three-month session (the recontact) was held).

6.11.2 When does follow-up start? How do the reasons for ending full intervention treatment influence the follow-up process?

Ideally, service providers should aim for the last full intervention session for a client/tangata whai ora to end with 'treatment plan complete'. This is when the treatment ends with the successful completion of the agreed interventions for the client/tangata whai ora. With the full intervention treatment plan ended, a follow-up session can begin one month after the last session. You can do follow-ups as individual contacts or in whānau and group settings, as long as you have the opportunity to discuss the status of the client/tangata whai ora in regard to gambling harm (which may include screening), wellness and recovery progress.

Many reasons for ending treatment are not clear-cut, and often service providers are attempting to connect, by phone or mail, with clients/tāngata whai ora who have not attended previously scheduled appointments.

KEY MESSAGE

Contacting a client/tangata whai ora by phone or mail to discuss a missed appointment or to make a future appointment is not enough to count as a follow-up session. A follow-up should involve significant discussion of the gambling harm status of the client/tangata whai ora, their progress and their satisfaction with their recovery.

In the event that clients/tāngata whai ora do not attend a session, you will attempt to contact them to reschedule (you should make multiple attempts).

If clients/tāngata whai ora miss one or more full intervention sessions and are not able to be contacted (see section 4.3.1), the Follow-up Reminder Report will remind you to attempt to recontact the client/tangata whai ora in 30 days for a one-month follow-up.

The possible outcomes from these attempts to recontact the client/tangata whai ora are as follows:

- **No contact is made:** Record the contact attempts in the section for failed contact details for the client/tangata whai ora. You should also record a last session reason of 'Person unable to be contacted'. No further follow-ups will be scheduled (see section 6.6).
- **Contact is made:** If you have a significant discussion with the client/tangata whai ora about their progress, then record the contact as a one-month follow-up. The client/tangata whai ora is likely to have one of the three following responses.
 - The client/tangata whai ora agrees to re-start intervention, so you make a new appointment. If the client/tangata whai ora attends the agreed appointment, you record that next session as a full intervention.
 - The client/tangata whai ora does not agree to re-start intervention but does agree to continue to engage in follow-up. The full intervention treatment is considered ended. Note that you need not record an end-of-treatment reason because the client/tangata whai ora has agreed to continue treatment. The Follow-up Reminder Report will remind you of the next follow-up (depending on whether this session had sufficient contact and discussion to be counted as a one-month follow-up).
 - The client/tangata whai ora does not agree to re-start intervention or to engage in follow-up. The full intervention treatment is considered ended, and you should note that the end-of-treatment reason was 'No further contact requested'. The Follow-up Reminder Report will not produce any more reminders for the client/tangata whai ora and no further follow-up will be scheduled.

See section 4.3.1 and Figure 4.3 for further discussion about contacting and recontacting clients/tāngata whai ora during full intervention episodes.

7 Resources

7.1 Controlling gambling and coping with urges to gamble

The following are some ideas that you can discuss with clients/tāngata whai ora on the topic of resisting urges and temptations to gamble when they have decided to stop.

Even though it may seem difficult at first and clients/tāngata whai ora may even succumb to urges and have a lapse, which can be a learning experience. If they persevere, they will find out their own best strategies to overcome urges and become stronger.

When you try to stop an activity like gambling that you have been doing for a long time and you have enjoyed and that has been a habit or an addictive process, it feels normal and difficult to stop. It is natural to 'miss' gambling and feel an urge to gamble again or revisit places where you gambled. Urges may feel powerful and hard to resist but your brain cannot maintain an urge indefinitely so, if you wait long enough, the urge will go away without gambling. Each time you resist the urge, it reduces the power of the urge and it becomes easier to cope. Having access to money can make urges more difficult to resist, so when you are going out, it's best to leave non-essential money and cards at home, away from temptation.

These are some other strategies you can use.

- Keep money and cards out of easy reach.
- If you have arranged an exclusion, you know you 'can't' gamble so there's no point trying.
- Have a rubber band on your wrist and, when you feel an urge, pull and 'snap' it.
- Do something to distract yourself – it could involve a friend who doesn't gamble.
- Go for a walk or run (keeping away from venues).
- Do relaxation exercises or have a shower/bath to relax you.
- Try deep breathing, mindfulness or meditation to change your thoughts or focus.
- Phone a supportive friend, your counsellor or the Gambling Helpline to express your thoughts and get support and suggestions.
- Use self-talk, for example, 'I don't need to go now, I'll wait a while and see how I feel' and then do something else.
- Think of a holiday or something you would like that you need to keep your money for.
- Think of how good you'll feel after you have resisted the urge.

- Think of how proud your family, whānau and friends will be of you for resisting.
- Think of being able to pay all your bills and save money if you overcome the urges.
- Write down feelings and urges and how you overcame them – this is good reference for future urges.

7.2 E-counselling for gambling harm

In addition to face-to-face counselling and helpline options, increasingly more e-mental health options are being provided as health interventions for clients/tāngata whai ora. These may also be able to provide an appropriate, cost-effective option for the increasing proportion of people seeking help for those experiencing gambling harm. In a discussion paper, Rodda et al (2015) note that:

- only 8–17 percent of those experiencing gambling harm will seek professional help. The most commonly reported reasons people do not seek help are: the preference to self-manage recovery; feelings of shame and stigma; and a lack of ready access to services
- while there is evidence that face-to-face interventions for people experiencing gambling harm have been effective, their high cost and low uptake suggest they may be having a limited impact in reducing gambling harm across the population
- e-mental health may provide gamblers with an opportunity to self-manage their gambling in a setting that can be cost-effective, anonymous, private, convenient and immediate
- there is evidence of those experiencing gambling harm reporting a strong preference for e-mental health and showing a greater likelihood to seek help over the telephone or the internet than through face-to-face treatment.

E-mental health can be delivered through:

- email
- chat and instant messaging
- internet-based and video counselling
- online information
- online screening
- forums and message boards
- online self-directed programmes
- websites
- telephone counselling.

E-mental health can be delivered as part of integrated services, combined with other online options, or with in-person allied health or gambling help services. Recommendations for providers are as follows.

- Providers should proceed with e-mental health because it can be used to reach under-served populations and those who otherwise would not seek help.
- E-mental health should be embedded in responsible gambling programmes and offered in community and treatment settings, in venues and on gambling websites.
- E-mental health requires targeted promotion, especially to attract a new cohort of help-seekers.
- Future initiatives need to take advantage of existing services and deliver more integrated options across a range of modalities.
- E-mental health for gambling harm should be developed as part of an evidence-informed approach, with rigorous review and evaluation.

7.3 Gambling venue exclusions

The Gambling Act 2003 sets out the legislation for providing gambling in New Zealand. The 2005 regulations and 2015 amendments set out the conditions and requirements for gambling venues to follow when providing gambling. The Department of Internal Affairs administers the Act and enforces the regulations.

Under the regulations, gambling venues (both class 4 pokies venues and New Zealand Racing Board (NZRB) TAB outlets) are required to be trained in approaching patrons who may be experiencing gambling harm and offering them information or support to approach services. As part of this approach, venue operators and delegated staff can explain exclusion procedures to patrons. If a patron asks them to, they are required to fill out an exclusion form with patrons (self-exclusion, section 310) which notes their name, contact details, type of exclusion, venue details, conditions and length of time excluded (up to two years). A clear photo is also required so that staff can easily identify the patron if they return to the venue and try to gamble there (see section 7.3.2). Both parties sign the exclusion form and it is a legal document. The patron may be able to enjoy other activities at the venue (eg drinks, meals, social activities) but must not be in the gaming room.

It is the responsibility of the venue to ensure it does not allow a patron to gamble during the period of exclusion, as consequences for the patron can be very serious if they experience more gambling harm, and the venue operator can also receive a heavy fine. Excluded patrons can also be fined for attempting to gamble when excluded. If the venue approaches a patron who may be experiencing gambling harm over time, and the patron does not wish to voluntarily self-exclude even though their gambling is of high concern, then the venue can issue an exclusion for up to two years (section 309), which means that the patron cannot access the gaming room in that venue, whether or not the patron agrees with that action. The venue operator must have enough details to identify the patron and not allow them to gamble if they re-enter the venue, even if the patron refuses a photo.

Clients/tāngata whai ora who are excluded may come to gambling harm minimisation services for other interventions in addition to excluding themselves, or they may wish to have your help and support in approaching venues for an exclusion as part of the interventions. Please see Chapter 5 (Facilitation) on approaching this with your client if you wish to accompany them, or alternatively you can give them information on steps to take and refer them to their chosen venues (bearing in mind they may face risks in going alone).

7.3.1 Multi-venue exclusions

Generally, an exclusion form is generated by the venue where the client is experiencing harm and it relates to that venue only, although if the venue is part of a trust, exclusion usually covers all of the venues that are part of that trust. The concept of multi-venue exclusion (MVE) is that patrons may need to exclude from all venues in their geographical area and it would be time-consuming, difficult and perhaps risky for clients/tāngata whai ora to fill out a form in every venue. Therefore, they can fill out a request for MVE and the venue or their practitioner can assist them with the process. There are regional MVE coordinators in different parts of New Zealand. A national MVE administrator ensures the process is completed correctly; please contact them if you require any information or support.

Use the following guidelines in deciding whether to begin the MVE process and then in working through the process.

- Determine if MVE process is appropriate for the client/tangata whai ora.
- Explain the MVE process to the client/tangata whai ora. Cover what and how their information will be shared and with whom (ie, venues, societies, service provider, MVE administrator and coordinator and Department of Internal Affairs for managing the exclusion; Department of Internal Affairs and Ministry of Health for statistical purposes).
- Ensure the client/tangata whai ora understands the legal responsibilities and consequences of MVE.
- Complete the Request for Multi Venue Exclusion Form including:
 - client/tangata whai ora name and contact details, identification (recorded and signed)
 - length of exclusion – six months is optimal and the MVE can be renewed
 - signature of the client/tangata whai ora and date (indicating they have given informed consent).
- Complete the Venue Identification Form, considering the following.
 - On the form, include counsellor name, organisation and contact details for regional MVE coordinator or national MVE administrator to liaise with.
 - Discuss venues to be excluded from – identify venues near where they live or work initially and any other high-risk venues.

- Notify the client/tangata whai ora of any venue conditions, such as: venues with no designated gaming area so the client/tangata whai ora will be excluded from whole venue; NZRB exclusion criteria (ie, excluded from all TAB outlets and racecourses in their local area and prevented from opening an account with NZRB nationwide); venues that issue trespass notices; and any other exclusion policies known.
- Ask the client/tangata whai ora if they would like their venue exclusion orders to be sent to the address provided, or held by the National MVE Administration Service. Note their choice on the Venue Identification Form.
- Ask the client/tangata whai ora if they would like follow-up one month before the MVE expires. Check the box if required.
- Take a good-quality colour photo of the client/tangata whai ora (see section 7.3.2).
- Email the Request for MVE Form and the Venue Identification Form, along with the photograph of client/tangata whai ora, to your regional MVE coordinator within 24 hours after the MVE starts.
- If the MVE is a renewal, check the expiry of current exclusion, as the dates should not overlap. (Your regional MVE coordinator or the national MVE administrator can provide information.)
- Liaise with the regional MVE coordinator if any issues arise or the client has notified you that they have breached the exclusion so the appropriate venue can be informed.

7.3.2 Best-practice photo guidelines

A good-quality photo of the client/tangata whai ora:

- has the face covering at least 600 x 600 pixels
- has no harsh lighting (both sides of the face should have equivalent lighting)
- is taken on a plain background
- has no shadow visible behind the person
- is taken at a distance of 1–1.5 metres from the person
- shows the person with a neutral facial expression.

An image will be marked as low quality if the face covers less than 600 x 600 pixels. Photos smaller than 300 x 300 pixels will greatly reduce identification accuracy.

If an image is resized to increase face size, this will lower identification accuracy. Please provide original (or cropped) images only.

For further details, please refer to the guide to requirements for New Zealand Visa photos: www.mypassportphotos.com/country-blog/new-zealand-passport-visa-photo-requirements-and-size.

7.4 Supporting Parents, Healthy Children

A conservative estimate in 2009 was that over 32,400 children in New Zealand were living with a person who has experienced gambling harm and were potentially at risk of a variety of negative effects (Ministry of Health 2009). In 2011 the Royal College of Psychiatrists estimated that, around the world, 50–70 percent of people who are experiencing mental illness are parents. Twenty-three percent of Australian children live with a parent who has, or has had a mental illness and 60 percent of these are at greater risk of developing mental health issues than other children (Children of Parents with a Mental Illness Australia 2008, cited in NCETA 2010). The National Centre for Education and Training on Addiction in Adelaide found that 10–13 percent of children had parents with problematic substance use (NCETA 2010) and that percentage is likely to be similar for New Zealand.

While many children who have a parent with mental health and/or addiction issues do well, in general this group is potentially at greater risk of adverse health and social outcomes. These include developing mental health and addiction issues themselves, and experiencing higher rates of suicidal ideation and interpersonal and behavioural problems. In addition, parental substance misuse can affect children's emotional and psychological development and increase the risk of violence and abuse. Mental health issues and problematic substance use can result in financial and other stressors, which can impact on parenting ability and family functioning (Battams and Roche 2011). Many children of affected parents are required to take on caregiving responsibilities for one or both parents and for younger siblings, resulting in anxiety, socioeconomic disadvantage, isolation, poor health and wellbeing, impaired psychosocial development, and difficulties with friendships and intimate relationships. Such responsibilities can also affect their school attendance and achievement and how they transition to independence, and can mean they miss out on opportunities and choices.

Compelling evidence shows that interventions focused on families and whānau in which parents are facing mental health and/or addiction issues can help to prevent later mental health issues and reduce the prevalence and burden of mental illness and addiction for future generations (Beardslee et al 2011). Therefore, adult mental health and addiction services (eg, gambling harm treatment services) need to take a 'whole of family and whānau' approach with clients/tāngata whai ora in treatment. This involves having systems in place to identify parents of dependent children and use a 'strengths-based' whole family and whānau approach informed by the service-user, and involving well-integrated services, who can work proactively to intervene early, support strengths and address vulnerabilities. Conversations about parenting should be an essential part of practice in adult services, as should eliciting from the parents the realities of their lifestyle and abilities, and providing resources to cope. This will help to inform and enable services to support child development, rather than just focus on risk issues.

In taking a family and whānau approach with clients/tāngata whai ora, it is also important to acknowledge and support cultural and ethnic diversity. For Māori, whānau-centred best practice using holistic Māori models of health (eg, Te Whare Tapa Whā (Durie 1985); Te Wheke (Pere 1984)) is the most effective way of achieving whānau ora. A whānau ora perspective views the whānau as a whole, where the collective wellbeing of the whānau is affected by the wellbeing of every individual whānau member. For this reason, the needs of children should be considered in the context of whānau wellbeing, rather than independently or separately from the wellbeing of the parents (Te Rau Matatini 2014). For Pacific families, it is important to recognise and acknowledge that each Pacific culture is different and that views may be contemporary as well as traditional (Wille 2006). Pacific peoples have a holistic view of health, and it is important to involve families in supporting family members who are facing mental health and/or addiction issues.

The following are key points to keep in mind when taking a family and whānau approach.

- Ask about family and whānau and include them in ways that work.
- Acknowledge and respect strengths of clients/tāngata whai ora.
- Knowledge is power – provide clients/tāngata whai ora with good information.
- ‘It’s about so much more than protection’ (not just Oranga Tamariki referrals).
- ‘Forget about illness’ – deal with people.
- Do not assume abuse or neglect is happening; do not assume it is not.

7.5 Vulnerable Children Act 2014

7.5.1 Purpose of the Act

The purpose of the Vulnerable Children Act 2014 is to:

- improve the wellbeing of vulnerable children
- prevent abuse and neglect
- improve physical and mental health; and cultural and emotional wellbeing
- improve education and training; and recreation and cultural activities
- strengthen connections – family, whānau, hapū and iwi
- increase youth participation in decision-making about them
- improve their social and economic wellbeing.

The Vulnerable Children Act states that providers of health and social services must have a written policy and a process to ensure children who may be at risk of harm can be protected. The process will determine actions that will be taken if practitioners are concerned about children of clients/tāngata whai ora, and how Oranga Tamariki will be contacted in the event of serious concern about risk (where there is real concern that a child or children are at imminent risk of harm/neglect, or it is currently occurring). These issues would be initially addressed in counselling and whatever possible supports can be arranged, and facilitations or referrals can be completed, but if safety is still a concern, then the service would contact Oranga Tamariki. It would then be the role of Oranga Tamariki to investigate and follow up with any necessary interventions or actions from its perspective. This process follows on from 'Supporting Parents, Healthy Children' initiatives, when it is felt that more decisive actions need to be taken to ensure the safety and wellbeing of children and young people.

Children and young people in 'vulnerable families' face greater risk to their safety and wellbeing. Vulnerable families are those with:

- higher levels of socioeconomic deprivation and unemployment and/or housing issues
- parents who grew up in a violent or abusive environment
- current violence or abuse happening
- members with current problematic alcohol and drug use or experiencing gambling harm
- young mothers raising children on their own and with few supports (eg, unplanned pregnancy, low income, lack of parenting knowledge)
- social isolation (due to relationship breakups; no family or whānau support)
- bonding issues (due to depression or other mental health issues)
- carers with little understanding of normal child behaviour (so may use excessive punishment for things like soiling, bedwetting, acting out, etc).

7.5.2 What the Act means for working with clients/tāngata whai ora experiencing gambling harm

You may notice appearance or behaviour that could indicate violence, abuse or neglect, or you may hear details from your client/tāngata whai ora that raise your concerns about the safety, health or wellbeing of children at home. For example, clients/tāngata whai ora may:

- talk about current violence in the family, or disclose harm or neglect of their children through their own or their partner's gambling behaviour
- be 'absent', leaving children unattended or in care of older children while out, using alcohol or other drugs, or gambling

- have children and be in a new relationship with someone who has a history of violence or sexual assault or offences against children, and/or has excessive use of alcohol or other drugs
- have addictions or mental health issues, little money or support and inadequate housing, with the result that they are not coping with their children (not through choice) and neglecting their basic care and safety.

Some signs to watch for in children who attend

Signs that may suggest the need for further enquiry are when children:

- look dirty, unkempt or uncared for, 'underweight' or poorly dressed
- have cuts, bruises, burns or injuries
- have skin conditions or rashes, and look pale and unwell
- are emotionally withdrawn, afraid, isolated, attention- or affection-seeking; with parents withholding affection or attention
- have issues with anxiety, bedwetting, soiling or poor sleep.

Useful questions to ask

Use reflection and ask open questions about specific issues, such as:

- 'It sounds like things have been really stressful for you. How have you been able to manage with the children through all this?'
- 'Please tell me more about how this happened, and when you first noticed it and what you did to help. Has this happened before, and how often?'

The Case Finding and Help Assessment Tool (CHAT) Screen (section 7.6) is a validated instrument for general health issues that is easy to self-administer or to discuss with tāngata whai ora (taking two to three minutes). It asks about nine health issues: smoking, alcohol use, drug use, gambling, depression, anxiety and stress, violence, anger and exercise.

7.6 Case Finding Assessment Tool (CHAT) Screen

What we do and how we feel can sometimes affect our health. To help us assist you to reach and maintain a healthy and enjoyable lifestyle, please answer the following questions to the best of your ability.

How many cigarettes do you smoke on an average day?

- | | | |
|--------------------------------|--|-------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Less than 1 a day | <input type="checkbox"/> 1–10 |
| <input type="checkbox"/> 11–20 | <input type="checkbox"/> 21–30 | <input type="checkbox"/> 31 or more |

Do you ever feel the need to cut down or stop your smoking?

(Tick no if you don't smoke.)

- | | |
|-----------------------------|------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|-----------------------------|------------------------------|

➔ If yes, do you want help with this?

- | | | |
|-----------------------------|---|------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes, but not today | <input type="checkbox"/> Yes |
|-----------------------------|---|------------------------------|

Do you ever feel the need to cut down on your drinking alcohol?

(If you don't drink alcohol, just tick no.)

- | | |
|-----------------------------|------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|-----------------------------|------------------------------|

In the last year, have you ever drunk more alcohol than you meant to?

- | | |
|-----------------------------|------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|-----------------------------|------------------------------|

➔ If yes to either or both of these questions, do you want help with this?

- | | | |
|-----------------------------|---|------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes, but not today | <input type="checkbox"/> Yes |
|-----------------------------|---|------------------------------|

Do you ever feel the need to cut down on your non-prescription or recreational drug use? *(If you do not use other drugs, just tick no.)*

- | | |
|-----------------------------|------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|-----------------------------|------------------------------|

In the last year, have you ever used non-prescription or recreational drugs more than you meant to?

- | | |
|-----------------------------|------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|-----------------------------|------------------------------|

➔ If yes to either or both of these questions, do you want help with this?

- | | | |
|-----------------------------|---|------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes, but not today | <input type="checkbox"/> Yes |
|-----------------------------|---|------------------------------|

Do you ever feel unhappy or worried after a session of gambling?
(If you do not gamble, just tick no.)

☐ No ☐ Yes

Does gambling sometimes cause you problems?

☐ No ☐ Yes

➔ If yes to either or both of these questions, do you want help with this?

☐ No ☐ Yes, but not today ☐ Yes

During the past month have you often been bothered by feeling down, depressed or hopeless?

☐ No ☐ Yes

During the past month have you often been bothered by having little interest or pleasure in doing things?

☐ No ☐ Yes

➔ If yes to either or both of these questions, do you want help with this?

☐ No ☐ Yes, but not today ☐ Yes

During the past month have you been worrying a lot about everyday problems?

☐ No ☐ Yes

➔ If yes, do you want help with this?

☐ No ☐ Yes, but not today ☐ Yes

What aspects of your life are causing you significant stress at the moment?

<input type="checkbox"/> None	<input type="checkbox"/> Relationship	<input type="checkbox"/> Work
<input type="checkbox"/> Home life	<input type="checkbox"/> Money	<input type="checkbox"/> Health
<input type="checkbox"/> Study	<input type="checkbox"/> Other (specify) _____	

Is there anyone in your life whom you are afraid or who hurts you in any way?

☐ No ☐ Yes

Is there anyone in your life who controls you and prevents you doing what you want?

☐ No ☐ Yes

➔ If yes, do you want help with this?

☐ No ☐ Yes, but not today ☐ Yes

Is controlling your anger sometimes a problem for you?

☐ No ☐ Yes

➔ If yes, do you want help with this?

☐ No ☐ Yes, but not today ☐ Yes

As a rule, do you do more than 30 minutes of moderate or vigorous exercise (such as walking or a sport) on 5 days of the week?

☐ No

☐ Yes

➔ If no, do you want help with this?

☐ No

☐ Yes, but not today

☐ Yes

Source: © Department of General Practice & Primary Health Care The University of Auckland

For more information in the context of keeping children and young people safe, see: Child Youth and Family (now Oranga Tamariki). *Working Together to keep children and young people safe: An interagency guide*. URL:

www.education.govt.nz/assets/Documents/Early-Childhood/Licensing-criteria/Working-together-to-keep-CYP-safe.pdf.

7.7 Family and whānau violence

Family and whānau violence is relatively common in New Zealand, as it is in many countries, and has multiple causes across all levels of society. It covers a broad range of controlling behaviours, commonly of a physical, sexual and/or psychological nature, which typically involve fear, intimidation and emotional deprivation. It occurs within a variety of close interpersonal relationships, such as between partners, between parents and children, and between siblings, and in other relationships where significant others are not part of the physical household but are part of the family or whānau and/or are fulfilling the function of family or whānau (Ministry of Social Development 2002).

Common forms of violence in families and whānau include:

- spouse or partner abuse (violence among adult partners)
- child abuse or neglect (abuse or neglect of children by an adult)
- elder abuse or neglect (abuse or neglect of older people aged approximately 65 years and over, by a person with whom they have a relationship of trust)
- parental abuse (violence perpetrated by a child against their parent)
- sibling abuse (violence among siblings).

According to the Vulnerable Children Act 2014, children witnessing physical and emotional abuse in the home is also considered child abuse.

Family and whānau violence includes not only physical violence such as hitting, punching, kicking and sexual violence, but also power and control behaviours such as threats, intimidation, emotional abuse, isolation, financial control, and perpetrators minimising their actions and blaming victims. Those experiencing gambling harm may find that controlling household money or credit card spending and limiting spending on basic necessities help to provide them a means to gamble. At the same time, they hide losses and blame the spouse for overspending and then ‘punish’ them for their apparent inability to manage household money. Gambling wins can be ‘justification’ and support for money control, while the person who has experienced gambling harm may use anger and abuse to generate fear and enable them to leave home to gamble without any discussion. On the other hand, the spouse may be glad of the respite, but afraid to question the person who has experienced gambling harm about their losses or where they are going, so the family or whānau can become isolated.

For victims of violence, they may find gambling is a way of ‘losing time’ and switching off anxiety, depression, fear of abuse, and the guilt of staying in an abusive relationship and feeling powerless. Gambling losses and time out may cause guilt and feelings of deserving abuse or punishment, which can contribute to an abuse and gambling cycle. Sometimes, the illusion of control experienced while gambling may feel like the only available choice and the only time they have some power and control in an area of their lives.

7.7.1 Cycle of violence

The cycle of violence refers to a pattern of family and whānau violence often experienced in abusive relationships. It consists of three phases that repeat over and over, and the abuse escalates over time.

1. The first phase is **tension-building**, where the abuser may exhibit minor incidents of physical or emotional abuse and the victim ‘walks on eggshells’ trying to avoid or control the situation.
2. The next phase is the **explosion**, where the abuser acts out physically or emotionally with a major incident.
3. Then, in the **honeymoon phase**, the abuser apologises, promises it will never happen again and offers ‘hearts and flowers’ to make up.

As the abuse escalates, the ‘honeymoon phase’ may lessen and disappear. Denial and minimisation of the abuse keep the cycle going.

7.7.2 Help for clients/tāngata whai ora who are victims of violence

In an emergency, or when a violent incident has happened, it is the role of the police to intervene and to ensure that victims or potential victims are safe. The police can issue a Police Safety Order if domestic violence is suspected, and the perpetrator must leave the property for usually one to two days, but it can be for up to five days. During that time, the abuser cannot harm or threaten, follow or contact the victim(s) at their place of work or other frequently visited location. The order also protects any children living at the house.

If it is unsafe for the client/tāngata whai ora to continue living with the violent family or whānau member, they can contact (or be facilitated to) Women's Refuge. Women's Refuge can arrange to pick clients/tāngata whai ora up if they have no money or car; arrange emergency accommodation for them and their children if they need to get out of their home; and discuss the choices they have and the different kinds of legal, housing and financial assistance they can get. It can also inform clients/tāngata whai ora about how the system works, such as the role of the police, the Family Court and legal aid, and can quickly arrange an appointment with a lawyer and support clients/tāngata whai ora in applying for a Protection Order.

A Protection Order protects the applicant (and children) from the perpetrator and, if the perpetrator breaches the order, the police can pick them up and arrest them. A Protection Order states that the offender must not physically, psychologically or sexually abuse or threaten the applicant or their children; must not damage or threaten to damage the applicant's property; and must not encourage anyone else to physically, sexually or psychologically abuse or threaten the applicant or their children. In addition, clients/tāngata whai ora may be able to apply for an Occupation Order (allowing the person who arranged the Protection Order to live in the family home and not allowing the perpetrator to live there without agreement). An alternative is a Tenancy Order, which covers the same situation for renters of accommodation.

For perpetrators of violence, programmes are available through anger management or stopping violence groups. These groups provide education about areas such as 'male privilege', healthier male roles, self-awareness, taking responsibility for feelings and actions, early warning signs of anger and taking 'time out' in high-risk situations to avoid harming others, self-care and improving communication skills and support systems. Attendance at groups can be voluntary or may be required as a condition of court or community corrections. Where needed, individual counselling may be available as well.

The two questions from the CHAT Screen for victims of violence and the perpetrator question (see section 4.5.5) can help to open up a conversation about family violence:

1. Is there anyone in your life whom you are afraid of or who hurts you in any way?

☐ No ☐ Yes

2. Is there anyone in your life who controls you and prevents you from doing what you want?

☐ No ☐ Yes

If yes to either or both of these questions, do you want help with this?

☐ No ☐ Yes, but not today ☐ Yes

The following question is for someone that may be a perpetrator of violence:

Is controlling your anger sometimes a problem for you?

☐ No ☐ Yes

If yes, do you want help with this?

☐ No ☐ Yes, but not today ☐ Yes

7.8 Co-existing problems

7.8.1 Introduction

Co-existing substance use and mental health problems (CEP) are common in those presenting to both mental health and addiction services in New Zealand. The Ministry of Health has a general expectation that all mental health and addiction agencies will become 'co-existing problems capable'. This translates to an 'any door is the right door' approach, where people in need are welcomed and assisted to connect with services that can assist them, regardless of whether the service is a mental health or an addiction one. (Ministry of Health 2010)

The challenge for all services will be to do one of the following.

- Integrate treatment for co-existing problems independent of other services.
- Develop shared care or integrated approaches across services.
- Develop a small specialist co-existing problems resource.

The expectation for gambling harm treatment providers, therefore, is that they provide comprehensive assessment for all clients/tāngata whai ora and both recognise and follow up other addictions and mental health conditions. They may meet this expectation by using appropriate screens as well as DSM criteria in conjunction with clinical experience and expertise. In treatment planning and interventions, practitioners need a basic knowledge of CEP in order to decide whether some level of intervention can be provided in-house, or either referral or facilitation is required, to achieve the best outcomes for the client/tāngata whai ora.

For further information on:

- working with co-existing clients/tāngata whai ora, refer to *Te Ariari o te Oranga: The assessment and management of people with co-existing mental health and substance use problems* (Todd 2010)
- screens and screening, refer to *Screening, Assessment and Evaluation (alcohol and other drugs, smoking and gambling)* (Matua Raki 2011). This contains a variety of screens for use by treatment services, and includes information on uses, availability and scoring.

7.8.2 Co-existing Problems Knowledge and Skills Framework – Te Whare o Tiki

Te Whare o Tiki, the co-existing problems knowledge and skills framework (Matua Raki and Te Pou 2013), describes the knowledge and skills the mental health and addiction workforce requires to effectively respond to the needs of people, and their families and whānau, with co-existing problems. The framework aligns with the seven key principles of Te Ariari o te Oranga (cultural considerations, wellbeing, engagement, motivation, assessment, management and integrated care) and is underpinned by the values and attitudes outlined in *Let's Get Real* (Ministry of Health 2008c). Each key principle encompasses a set of knowledge and skills with performance indicators at three levels of practice: Foundation, Capable and Enhanced.

Te Whare o Tiki complements and adds to existing frameworks including:

- *Te Ariari o te Oranga: The assessment and management of people with co-existing mental health and substance use problems* (Todd 2010) – a clinical framework to assist health practitioners and clinicians working with co-existing problems
- *Let's Get Real* (Ministry of Health 2008c) – a framework describing the knowledge, skills and attitudes required to deliver effective mental health and addiction services
- Real Skills Plus CAMHS – a framework describing the knowledge, skills and attitudes needed to work with infants, children and young people
- Real Skills Plus Seitapu – a framework describing the essential and desirable knowledge, skills and attitudes to engage with Pacific peoples
- the professional competencies that mental health and addiction professionals are required to demonstrate for registration in nursing, social work, psychiatry, occupational therapy and psychology

- *Addiction Intervention Competency Framework* (Addiction Practitioners' Association Aotearoa-New Zealand 2011) – the values, attitudes, knowledge and skills to assist people with addiction problems and register as an addiction professional
- Takarangi Competency Framework – a cultural competency framework for engaging with Māori.

The levels of practice can be broadly defined as follows.

- **Foundation** represents the essential knowledge and skills that everyone working in mental health and addiction services requires to engage with and respond effectively to people with CEP.
- **Capable** represents the knowledge and skills that people working in mental health and addiction services require to support people with less complex CEP needs. People with less complex needs can include those who:
 - are motivated to get support and attend treatment
 - have one of the co-existing problems relatively stable, well managed through existing treatment or less severe
 - do not need extra medication or treatment
 - do not need hospital-based treatment
 - have problems that have straightforward interactions to formulate
 - gave good community, family and/or whānau supports.
- **Enhanced** represents the knowledge and skills people working in mental health and addiction services require to work effectively with people with more complex CEP needs. People with complex needs can include those who:
 - struggle to comply with treatment, including not taking medication as prescribed, and are currently affected by both mental health and substance use disorders
 - have no apparent community, family or whānau support
 - have current legal issues such as imprisonment
 - have physical health problems, including chronic pain or a history of brain injuries or have an intellectual disability
 - have multiple social stresses such as homelessness, relationship problems or children in care.

These levels have been structured to recognise the requirements of different workplaces and roles within the mental health and addiction sector from support worker to specialist CEP practitioner or clinician. The levels are stepped and, depending on the needs of the workplace and/or their role, a worker can move from Foundation to Capable to Enhanced, using the performance indicators to identify areas to be addressed through training and supervision.

Each level has a clear set of performance indicators for each area of knowledge and skills that outline what a worker needs to know or demonstrate to show that they have achieved that level of capability. Workers are able to self-rate their level of relevant knowledge and/or ability to demonstrate that particular area of knowledge and skill.

Using the framework, many workers will discover that they have a mixture of Foundation, Capable and Enhanced levels of knowledge and skills. Depending on the needs of their workplace and their specific roles, they may need to work towards developing more consistent levels of Foundation, Capable or Enhanced knowledge and skills.

The Ministry has no expectation that all mental health and addiction workers will move along the continuum to become experts in delivering mental health and addiction care. Rather it expects that everyone will become able to identify and respond to CEP at a Foundation level through screening, brief assessment and treatment planning, collaboration and shared integrated care with other services.

Depending on their service delivery requirements, workplaces can identify what proportion of their workforce will need to have or develop each level of CEP knowledge and skills. To better meet the needs of clients/tāngata whai ora, many services may expect all workers to have both Foundation and Capable levels of CEP knowledge and skills in some of the seven key principle areas. The Ministry suggests that all services will need to have, or have access to, workers that have Enhanced CEP knowledge and skills to support their colleagues as mentors and in an advisory capacity.

7.8.3 Alcohol use

Alcohol is often served in the same venues that provide gambling – for example, in pubs, clubs, bowling alleys, race tracks and casinos. For this reason, to heighten the motivation of clients/tāngata whai ora, you could explain the relevance of addressing alcohol issues alongside gambling behaviour.

Continuing an associated addiction (alcohol) while another addictive behaviour (even if treated) is available nearby raises the risk for relapse. In addition, alcohol reduces inhibitions and affects good judgement, which also increases the risk of gambling relapse. Further, alcohol use and gambling together may intensify other problems (eg, mood and anxiety), demotivate help-seeking and interfere with treatment attendance and treatment gains. Finally, gambling behaviour and alcohol use may be triggers for each other; for example, a person may use alcohol in commiseration for gambling losses or to celebrate wins. Many practitioners have existing skills in alcohol and other drug treatment, which will be a significant resource in addressing these co-existing issues.

You can give feedback on screen results and use motivational interviewing as a way to help prompt the response of the client/tāngata whai ora to the results. Along with using the Wheel of Change model (Prochaska and Diclemente 1986)(see section 7.9.1), you can target the appropriate strategies to the stage of change of the client/tāngata whai ora (eg, in pre-contemplation, eliciting own concerns; in contemplation, developing discrepancy through OARS – open questions, affirmation, reflection, summarising – skills and eliciting change or commitment talk). Clinical judgement and skill level will indicate whether you can address both issues (gambling harm and alcohol) simultaneously in-house, or if you need to facilitate or refer the client/tāngata whai ora to a specialist alcohol and other drug service.

Changes to criteria for alcohol problems under DSM-5

Previously, under DSM-4, alcohol use disorders were separated into two categories: alcohol abuse, and alcohol dependence for the more severe diagnosis. These two are now combined into 'alcohol use disorder', with a designation of 'mild' (meets two to three criteria), 'moderate' (four to five criteria) or 'severe' (six or more criteria). Diagnostic criteria are broken down into a total of 11 items leading to significant impairment or distress, occurring within a 12-month period. For diagnosis, at least two criteria must be met from the list, which includes either or both of two 'tolerance' items and two 'withdrawal' items.

Within the list of criteria, changes made are: 'Recurrent alcohol-related legal problems' has been removed and 'Craving, or a strong desire or urge to use alcohol' has been added (criterion 4). These changes in criteria have raised some concerns that some weekend 'binge drinkers' of higher socioeconomic status who drink and drive (formerly 'alcohol abuse') may be missed, while some underage students who binge-drink and may miss occasional classes would now be labelled with 'mild alcohol use disorder', which may cause problems for them in the future.

7.8.4 Drug use

Some people who use gambling also use various other drug or have associates who also use or supply drugs. Certain drugs, for example, amphetamines or methamphetamine, can be used to lower inhibitions and to increase excitement, leading people to undertake risk-taking behaviours, such as gambling, or to stay awake for long periods while gambling. Because drug dealing can also be associated with money laundering, it has a relationship with gambling, as a way of avoiding detection. Drugs like cannabis can also interact with the process of 'being in the zone' through playing electronic gambling machines (pokies), leading to further 'losing time', control, and poor judgement around excessive gambling.

As with alcohol use, you can give feedback on screen results and use motivational interviewing to help prompt the response of the client/tangata whai ora to the results. Along with using the Wheel of Change model (Prochaska and Diclemente 1986)(see section 7.9.1), you can target the appropriate strategies to the stage of change of the client/tangata whai ora. Similarly, clinical judgement and skill level will indicate whether you can address both issues (gambling harm and alcohol and other drug) can be addressed simultaneously 'in-house' or in the case of complex alcohol and other drug issues, you need to facilitate or refer the client/tangata whai ora to a specialist alcohol and other drug service.

7.8.5 Depression

Defining depression

Depression is common in the general population and can be categorised into several different clinical conditions. Essentially, they are:

- depressive disorders (major depressive disorder (depressed at least two weeks) and dysthymic disorder (depressed two years or more)). Up to one in four women and one in eight men experience major depressive disorder in their lives. Dysthymic disorder occurs at less than half the rate of major depressive disorder
- bipolar disorders (depressed and manic, or in some cases, only manic) – these are rarer than depression, probably less than one in 50 combined
- mood disorder due to a medical condition (eg, stroke, Parkinson's disease)
- substance-induced mood disorder (eg, alcohol, amphetamines).

The intervention approach will often be in conjunction with referral of the client/tangata whai ora to their doctor as many conditions (eg, bipolar disorders) are usually treated primarily with medication.

However, the relatively common major depressive disorder is often unrecognised by the general public and their health professionals, until it becomes severe.

- Mild major depressive disorder has just five or six of the symptoms specified with **either** mild disability or the capacity to function normally if the person makes substantial or unusual effort.
- If the symptoms are more severe, such as inability to function effectively, or the person has delusions or hallucinations, your primary goal is to refer them to their doctor or, if you have safety concerns, to the area community assessment and treatment team.

Depression is often associated with gambling harm – for both the person experiencing gambling harm and the family/whānau/affected other of someone experiencing gambling harm. Recent indications are that:

- family and whānau may be twice as likely as the general population to be experiencing depression, and those experiencing gambling harm directly may be three times as likely to be depressed
- three-quarters of those experiencing harm arising from their own gambling are likely to meet the criteria for major depressive disorder during their lives, and many experience recurrent episodes.

The stress of experiencing gambling harm, when occurring with behaviours, feelings and thoughts that surround the gambling, can often trigger depression. The problems can intensify as people start to use gambling as a way to temporarily relieve the depression (switch off the negative thoughts and feelings). Rather than being relieved, however, the depression can deepen as people gamble more over time to switch off the stress (this is often called developing a 'tolerance'). In other circumstances, some people with depression may find gambling behaviour relieves their depression temporarily (self-medicating) with the result that they begin to gamble problematically. If a client/tangata whai ora indicates that they are feeling worried, anxious, unmotivated, uncharacteristically tired, tearful, eating or sleeping poorly (too much or too little), they may be experiencing the effects of depression.

Depression Screen

(Record the total number of positive responses: no to both = 0; 1 or 2.)

1. In the past 12 months, have you often felt down, depressed or hopeless?
☐ No ☐ Yes
2. In the past 12 months, have you often had little interest or pleasure in doing things?
☐ No ☐ Yes

The two-question screen for depression (Whooley et al 1997) provides a brief assessment, with one 'yes' answer indicating the possibility of depression, which warrants further enquiry or facilitation or referral to a GP or other appropriate health professional. If a client/tangata whai ora answers yes to either or both screen questions, give them feedback that this suggests they may be affected by depression, a very common condition that is closely associated with gambling harm (either directly from their own gambling or because of gambling behaviour by someone who is important to them).

A subsequent assessment tool may be the Beck Depression Inventory II. However, this may be inaccessible to practitioners because of the need to pay for it and because the provider of the screens may require evidence of ability before sale. Some practitioners may be comfortable in assessing the client/tangata whai ora using DSM mood disorders criteria and can provide feedback to clients/tāngata whai ora on a range of symptoms and their connection with depressed mood.

Moderate to severe depression usually indicates that you may need to facilitate or refer the client/tangata whai ora to an appropriate health professional and that they may need medication. However, you may be able to address milder depressive symptoms with a number of strategies, such as those listed below.

Using exercise, diet and relaxation to address mild forms of depression

The following suggestions to address depression and stress issues are suggested as self-help options. You can discuss them with the client/tangata whai ora and/or copy or print them for the client/tangata whai ora to take away and implement themselves. You should also continue to monitor mood to check that it is improving and that symptoms are not progressing into more severe depression.

Additional or alternative strategies include counselling and/or prescribed antidepressant medication. The following suggestions are extracted from the resources below.

References for table above

- <http://www.depression.org.nz/content/waythrough/self+health/sleep>
- www.helpguide.org/home-pages/stress.htm
- <http://sleepdisorders.about.com/od/topwaystosleepbetter/a/getbettersleep.htm>
- <http://www.the-sleep-zone.com>
- <http://nhibi.nih.gov/health/public/sleep/healthysleepfs.pdf>
- <http://www.helpguide.org/articles/sleep/insomnia-causes-and-cures.htm>

Exercise as an antidepressant

The following exercise tips offer a powerful prescription for boosting mood:

- **Exercise now ... and again.** A 10-minute walk can improve your mood for two hours. The key to sustaining mood benefits is to exercise regularly.
- **Choose activities that are moderately intense.** Aerobic exercise undoubtedly has mental health benefits, but you don't need to sweat strenuously to see results.
- **Find exercises that are continuous and rhythmic (rather than intermittent).** Walking, swimming, dancing, stationary biking and yoga are good choices.
- **Add a mind-body element.** Activities such as yoga and tai chi rest your mind and pump up your energy. You can also add a meditative element to walking or swimming by repeating a mantra (a word or phrase) as you move.
- **Start slowly, and don't overdo it.** More isn't better. Athletes who over-train find their mood drops rather than lifts.

Eat a healthy, mood-boosting diet

What you eat has a direct impact on the way you feel. Aim for a balanced diet of protein, complex carbohydrates, fruits and vegetables.

- **Don't neglect breakfast.** A solid breakfast provides energy for the day.
- **Don't skip meals.** Going too long between meals can make you feel irritable and tired, so aim to eat something at least every three to four hours.
- **Minimise sugar and refined carbs.** You may crave sugary snacks, baked goods or comfort foods such as pasta or french-fries. However, these 'feel-good' foods quickly lead to a crash in mood and energy.
- **Focus on complex carbohydrates.** Foods such as baked potatoes, whole-wheat pasta, brown rice, oatmeal, whole-grain breads and bananas can boost serotonin levels without a crash.
- **Boost your B vitamins.** Deficiencies in B vitamins such as folic acid and B-12 can trigger depression. To get more, take a B-complex vitamin supplement or eat more citrus fruit, leafy greens, beans, chicken and eggs.
- **Consider taking a chromium supplement.** Some depression studies show that chromium picolinate reduces carbohydrate cravings, eases mood swings and boosts energy. Supplementing with chromium picolinate is especially effective for people who tend to overeat and oversleep when depressed. Aim for 600 mcg per day.
- **Practise mindful eating.** Slow down and pay attention to the full experience of eating. Enjoy the taste of your food.

Omega-3 fatty acids play an essential role in stabilising mood

- Foods rich in certain omega-3 fats called EPA and DHA can give your mood a big boost. The best sources are fatty fish such salmon, herring, mackerel, anchovies and sardines, and some cold-water fish-oil supplements. Canned albacore tuna and lake trout can also be good sources depending on how the fish were raised and processed.
- You may hear a lot about getting your omega-3s from foods rich in ALA fatty acids. The main sources are vegetable oils and nuts (especially walnuts), flax, soybeans and tofu. Be aware that our bodies generally convert very little ALA into EPA and DHA, so you may not receive as much of a benefit.
- Some people avoid seafood because they worry about mercury or other possible toxins. But most experts agree that the benefits of eating two servings a week of cold-water fatty fish outweigh the risks.

Progressive muscle relaxation for stress relief

Progressive muscle relaxation is another effective and widely used strategy for stress relief. It involves a two-step process in which you systematically tense and relax different muscle groups in the body.

With regular practice, progressive muscle relaxation gives you an intimate familiarity with what tension – as well as complete relaxation – feels like in different parts of the body. This awareness helps you spot and counteract the first signs of the muscular tension that accompanies stress. And as your body relaxes, so will your mind. You can combine deep breathing with progressive muscle relaxation for an additional level of relief from stress.

Most progressive muscle relaxation practitioners start at the feet and work their way up to the face, in this order:

- right foot
- left foot
- right calf
- left calf
- right thigh
- left thigh
- hips and buttocks
- stomach
- chest
- back
- right arm and hand
- left arm and hand
- neck and shoulders
- face.

Follow these steps for progressive muscle relaxation.

- Loosen your clothing, take off your shoes and get comfortable.
- Take a few minutes to relax, breathing in and out in slow, deep breaths.
- When you're relaxed and ready to start, shift your attention to your right foot. Take a moment to focus on the way it feels.
- Slowly tense the muscles in your right foot, squeezing as tightly as you can. Hold for a count of 10.
- Relax your right foot. Focus on the tension flowing away and the way your foot feels as it becomes limp and loose.
- Stay in this relaxed state for a moment, breathing deeply and slowly.
- When you're ready, shift your attention to your left foot. Follow the same sequence of muscle tension and release.
- Move slowly up through your body – legs, abdomen, back, neck, face (see above) – contracting and relaxing the muscle groups as you go.

Dealing with sleeping problems

- Do physical exercise every day (but avoid doing this in the four hours before bedtime).
- Allow yourself time to wind down before bed. Stop work or study at least half an hour before bedtime.
- Try to get up at the same time each day and get up when you wake up.
- If you have a late night, rather than sleeping in, have an early night the next night.
- Don't take naps during the daytime.
- Avoid or cut down on coffee, energy drinks, tobacco and alcohol, especially in the evening (four to six hours before bed) as it makes it harder for you to go to sleep at night.
- If you can't sleep because you are worrying about an unresolved issue, try setting aside time during the day for problem solving.
- Try activities that can help with relaxation, such as yoga, meditation or breathing exercises.
- Having to deal with bright lights or loud noises while in bed can make sleep more difficult. The best sleeping environment is a dark, quiet room.
- Too much stimulating activity before bed – whether it is vigorous exercise or violent images on TV – can make it difficult to sleep. It is best to avoid TV altogether.
- Worrying about life issues such as a new job, family conflicts, work deadlines or financial worries can keep you up at night. Relaxation or stress management techniques can help with this.
- Try keeping a sleep diary. By recording the following information daily, you may be able to pinpoint what is causing problems with your sleep:
 - physical exercise undertaken
 - types of food eaten and when you ate them
 - time you went to bed and time you woke up
 - total sleep hours, quality of sleep
 - times you woke during the night and what you did (stayed in bed with eyes closed, got up for a drink then went back to bed etc)
 - amount of caffeine and alcohol and when you drank it
 - feelings – happy, sad, anxious, stressed
 - drugs or medication taken, how much and when.
- Avoid sleeping on your back.
- Try raising up the head of your bed by a few centimetres.
- Avoid sedatives and narcotics as they slow down the activity of breathing muscles and may contribute to a worse sleep.
- Bedrooms are for sleeping and sex, not for watching television or doing work.
- Develop sleeping rituals that are quiet and relaxing, such as reading, 15 minutes before bed.
- Don't sacrifice sleep in order to do daytime activities (such as visiting friends, eating out, watching TV, surfing the internet).

- Try taking a hot bath before bed.
- Have the right sunlight exposure. Daylight is key to regulating our sleeping patterns, so try to get outside for at least 30 minutes per day.
- Avoid large meals and beverages late at night. Large meals may cause indigestion, and beverages may lead you to wake up during the night to urinate.

7.8.6 Anxiety

Introduction

Screening for anxiety is not mandatory as one of the Ministry of Health's co-existing screens. However, anxiety commonly co-exists with gambling harm. Identifying the presence of anxiety may help you to address an issue that contributes to the development of, or is a relapse risk for, gambling harm. A 'yes' answer to one or both of the two anxiety questions below can provide a basis for establishing whether anxiety is a relevant issue and disclosing a condition that is often hidden due to shame. Tools to address anxiety can help the client/tangata whai ora to maintain changes they make in working towards their gambling harm goals.

Anxiety screen

During the past month, have you been worrying a lot about everyday problems?

- ☐ No ☐ Yes

→ If yes, do you want help with this?

- ☐ No ☐ Yes, but not today ☐ Yes

What aspects of your life are causing you significant stress at the moment?

- | | | |
|------------------------------------|--|---------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Relationship | <input type="checkbox"/> Work |
| <input type="checkbox"/> Home life | <input type="checkbox"/> Money | <input type="checkbox"/> Health |
| <input type="checkbox"/> Study | <input type="checkbox"/> Other (specify) _____ | |

Scoring: A 'yes' response to either question suggests the possibility of an anxiety condition that may cause distress or affect our ability to enjoy life. Check below for any sign of anxiety conditions if there is a positive response to either question.

Note: This screen is part of the CHAT Screen (Goodyear-Smith et al 2008).

Defining anxiety

Anxiety is a common emotion. It is often an emotion that prepares us for action, such as the primitive 'fight or flight' effect that can accompany release of adrenalin into our bodies. However, if this elevated emotion is persistent and is not an appropriate response to a current threat (which may occur if the anxiety was 'learned' inappropriately or arose from a past crisis), the effect could be distressing and affect our wellbeing. Anxiety problems have a number of wide-ranging symptoms, many of which have been categorised together to describe an anxiety condition.

Anxiety can meet the level of a disorder

As described in DSM-5, the main categories of anxieties that meet the level of a mental health disorder are:

- separation anxiety disorder – recurrent excessive distress when anticipating or experiencing separation from home or major attachment figures
- selective mutism – consistent failure to speak in specific social situations in which there is an expectation for speaking
- specific phobia – unreasonable and persistent fear of objects (eg, spiders) or situations (eg, flying)
- social anxiety disorder – marked fear about a social situation in which the individual is exposed to possible scrutiny by others
- panic disorder – abrupt surge of intense fear
- agoraphobia – marked fear or anxiety about two or more of public transport, open spaces, enclosed places, crowds or being outside of the home alone
- generalised anxiety disorder – excessive anxiety occurring more days than not in six months about several events or activities
- substance/medication-induced anxiety disorder – panic attacks or anxiety soon after using a substance
- anxiety disorder due to another medical condition – panic attacks or anxiety as a direct consequence of another medical condition
- other specified anxiety disorder – does not meet the full criteria for other anxiety disorders.

In many cases, a person will have co-existing depression and agitation will be mixed with elements of low mood.

Anxiety and gambling harm

Gambling harm can be associated with anxiety generally in two ways.

- A **pre-existing anxiety condition** may be temporarily relieved through gambling behaviour. The gambling may distract a person sufficiently to forget the anxiety-raising thoughts, may focus their attention sufficiently to replace the negative emotion, and/or result in biological boosts in the pleasure-creating parts of the brain. In this way the person can escape the anxiety and feel better when gambling. Unfortunately as time goes on they can find they need more gambling to provide that effect as they adjust to the level of 'escape' that the gambling behaviour provides ('tolerance'). Also, the gambler finds they focus on escape as a way to cope, rather than using more functional ways to address stress. This can result in raising their anxiety as their main way to deal with it becomes less effective.
- A person can also **develop anxiety as a result of experiencing gambling harm**. Often after a 'win', they may increase gambling behaviour, believing can win more, or just wanting to have that winning feeling again. However, commercial gambling is weighted in favour of the gambling provider and over time the gambler will lose. Instead of seeing their gambling behaviour as an entertainment they expect to pay for, they can see it as a financial solution to many dreams. As they start to lose, they may start chasing their losses, especially they we lose money they can't afford to lose. Their anxiety rises, while once more the very gambling that causes the anxiety can provide temporary escape through hope as well as distraction from their growing problems.

Although this may suggest that the worry in the second category (resulting from gambling behaviour) may be restricted to financial worries, this can develop into one or more of the categories (eg, panic attacks, substance/medication-induced anxiety disorder). The experience of risks associated with loan sharks, onset of depression and illegal access of money, which often occurs with gambling harm, can raise the possibility of events that give rise to other anxiety conditions (eg, post-traumatic distress, acute stress, panic disorder).

Dealing with anxiety

The following information is provided to assist practitioners to discuss anxiety issues with the client/tangata whai ora and to identify whether these are affecting health and well-being. The client/tangata whai ora may wish to also be facilitated or referred to a General Practitioner to address some conditions with appropriate medication and other support, however, there are also some techniques that can be done as self-help therapy. You can then monitor progress and improvements in subsequent counselling sessions as part of ongoing treatment planning.

You can discuss the following suggestions for addressing anxiety that you can discuss with the client/tangata whai ora and/or copy or print for them to take away.

There are several approaches to deal with anxiety. When our anxiety rises, we are often immobilised and our ability to think of solutions can reduce as our mind becomes overwhelmed with fear. The following are options for treatment, some of which can work together.

Medication

Doctors can provide medication that can work quickly to reduce anxiety. Examples are benzodiazepines, beta-blockers, tricyclic antidepressants, monoamine oxidase inhibitors (MAOIs), mild tranquillisers and selective serotonin reuptake inhibitors (SSRIs). Many medications will target specific anxiety conditions. For example:

- beta-blockers such as propranolol are often used to target social phobia (fear of evaluation by and interaction with other people)
- SSRIs like Prozac and Aropax are often used to target panic, social phobia, obsessive-compulsive behaviour (compulsive rituals such as hand washing to prevent obsessive fear) and where depression exists alongside the anxiety
- tricyclic antidepressants like imipramine (Tofranil) can target generalised anxiety (always worried about something or other) as well as panic, especially when depression also is present
- benzodiazepines are often prescribed sparingly (for a short time), because people can become dependent on them, but in the past were seen as an important medication for anxiety.

Counselling therapy

Counselling therapy is often used alongside medication when anxiety is high, or on its own with lower levels of anxiety. Therapy will take longer to take effect than medication but can be a more lasting solution. Some with anxiety may prefer not to use medication at all. The following are two common types of therapy.

- **Behavioural therapy** may approach anxiety-reduction through gradually exposing the person to situations that may cause the anxiety in order to remove the anxiety-producing power of the situation. For example, when we have an overwhelming fear of public speaking that can stop our career progressing, a first step may be to write and repeatedly practise the speech, and then present it to one person that we trust. We can also use medication (eg, a beta-blocker) while presenting the speech this first time and then next time do it without the medication.
- **Cognitive-behavioural therapy** may focus on the feelings and teach us to separate realistic and appropriate thoughts from unrealistic and inappropriate thoughts that we may have learned over time. These unrealistic thoughts may automatically result in the anxiety because we filter out more appropriate interpretations. For example, when we become anxious, we may write down the apparent explanation behind the event that causes our anxiety and the level of anxiety we feel (eg, 9 out of 10). After that, we 'step back', consider alternative explanations for the event and then reassess our anxiety (eg, now 7 out of 10).

For example, our boss walks past with a frown without acknowledging 'Good morning'. Our generalised anxiety interprets this as meaning we are in trouble because we believe we don't perform as well as others in the job. We assess our anxiety at 9.5 out of 10. We then step back and consider possible alternatives to his failure to acknowledge our greeting: 1) He was preoccupied with something and didn't hear us; 2) He was preoccupied and thought we were greeting someone behind him; or 3) His ears are blocked from swimming at the gym, which he does every morning, and he has a sore tooth. Reassessing our anxiety level after these reasonable alternatives results in 6 out of 10.

Gradually, we do this on a regular basis when we identify we are anxious, and our level of general worrying decreases.

Relaxation therapy

Recognising when we are stressed allows us to monitor ourselves. We can learn to relax through doing stress-reducing actions when we notice our anxiety is high. Also, by incorporating relaxation techniques into our daily patterns, we can experience respite from regular anxiety while also valuing our own ability to control our environment (rather than be controlled by it).

- For 10 minutes or more and preferably twice a day (eg, before and after work), sit in a quiet place with hands in lap and either focus on a spot or close your eyes and breath slowly, noticing how you breathe in and out. Think beforehand of a word that is without tension (eg, 'relaxed', 'yes', 'ease' or even 'om'). At the end of each breath, say your word slowly. If you find you're thinking about something else, gently bring the focus back to your breathing. After five minutes, picture an idyllic scene from your memory or from a picture and continue to focus while slowly breathing.
- Another approach is to sit in a quiet place and, starting from the top of your head, contract and gradually release muscles, moving down your body (top of head to forehead to cheeks to jaw and down eventually to your feet). After doing this, sit quietly noticing your breathing, following where the air passes down your lungs, then back out. Again, bring back your focus gently from any intrusive thoughts.
- Brief steps to address an onset of anxiety may be practising deep-breathing. Slowly take two or three deep breaths and tell yourself the brief phrase you repeat or picture the relaxed environment you focus on when doing your 10-minute therapy in the morning and night.
- Tell yourself, 'I will think about (or worry about) my concern at 5 pm today. At the moment I am going to concentrate on (what I am doing).'
- Include **exercise** into your daily routine. Try not to over-stress your body and build up gradually the amount you do. Exercise can relax you, while giving you time out from work and other daily pressures to consider your environment (take time to 'smell the flowers'). Exercise can also produce endorphins in your body that both relaxes you and makes you feel good.
- Your library can provide books about relaxation self-help.

Diet

Regular meals and balanced diet are important. An irregular and poor diet can place our bodies under stress, making us less able to deal with stress, which can lead to anxiety. Certain vitamins (eg, vitamin B) and trace elements are important ingredients in managing stress. Beverages such as coffee can make anxiety symptoms worse in some people and they may find it helpful to either avoid or minimise their coffee consumption. Similarly, frequent and/or heavy alcohol use can interrupt sleeping patterns and can cause anxiety after the disinhibiting effect wears off, so being mindful about alcohol consumption can help reduce anxiety in the long term.

Definitions of common anxiety disorders and conditions that may co-exist with gambling harm

Generalised anxiety disorder

Generalised anxiety disorder is characterised by persistent, excessive and unrealistic worry about everyday things, with the person often expecting the worst even when there is no apparent reason for concern. They anticipate disaster and may be overly concerned about money, health, family, work or other issues. Generalised anxiety disorder is diagnosed when a person finds it difficult to control worry on more days than not for at least six months and has three or more symptoms. It is seldom severe but will persist and generally affect wellbeing. Symptoms are restlessness and/or agitation, tiredness, lack of concentration, irritable/moody, poor sleep and feeling tense.

Generalised anxiety disorder affects one in 20; the rate is likely to be higher among those affected by gambling harm.

Specific phobias

The perceived threat is usually a single thing or situation.

Panic arises suddenly when a person is either presented with the object of fear (eg, mice) or the situation of fear (eg, heights), experiencing extreme anxiety when in close proximity to it. It is diagnosed when the fear is sufficient to affect a person's wellbeing and exists for six months or more. The person is aware that the fear is excessive or unreasonable.

Selective mutism

Selective mutism usually occurs in childhood, where the child has a fear of speaking in social situations, which is not due to speech or language difficulties, and which lasts more than six months. It is often accompanied by social anxiety, excessive shyness, fear of social embarrassment, and social isolation and withdrawal. Ninety percent of people with selective mutism have social phobia, so the social anxiety or shyness can persist into adulthood.

Social anxiety disorder

Social anxiety disorder is diagnosed when a person has an excessive and unreasonable fear of social situations. Anxiety (intense nervousness) and self-consciousness arise from a fear of being closely watched, judged and criticised by others. A person with social anxiety disorder is afraid that they will make mistakes, look bad and be embarrassed or humiliated in front of others. The fear may be made worse by a lack of social skills or experience in social situations. The anxiety can build into a panic attack. As a result of the fear, the person endures certain social situations in extreme distress or may avoid them altogether. Performance-oriented social phobia is an anxiety that only arises when a person's performance is likely to be evaluated by others.

As with selective mutism, these conditions exist for six months or more and the effects on a person's life can range from moderate to severe.

Post-traumatic stress disorder (PTSD) – new criteria under DSM-5

For a diagnosis of PTSD, the following symptoms must last longer than one month; if they occur for a shorter period, it is acute stress disorder:

- exposure to death, threatened death, actual or threatened serious injury or sexual violence (which may occur in any one of the following ways: direct, witnessed, indirect (close friend, violent/accident) or repeated indirect exposure to aversive details of such events (but not through media)) – can include health, police or trauma workers or other first responders
- trauma re-experienced (which may include any one of the following: recurrent intrusive memories, nightmares, dissociative flashbacks, ongoing stress exposure after the trauma, physical reactions to trauma stimuli)
- avoidance – ongoing efforts to avoid either thoughts or feelings related to the trauma, external reminders (eg, people, places)
- negative changes in thoughts and mood that worsened after the trauma, which may involve any one of the following: inability to recall aspects of the event, negative beliefs about yourself or the world, blaming self or others for the trauma, negative feelings (eg, guilt, fear), reduced interest in activities, feeling alienation from others, no positive feelings
- changes in arousal and reactions, which may involve any two of the following: irritable or aggressive, reckless or destructive, over-vigilant, easily startled, hard to concentrate, or poor sleep.

In addition, PTSD:

- involves distress, or difficulty in functioning (but not due to drugs or illness)
- can be either of the subtypes of depersonalisation (feeling detached from self, dreamlike) or derealisation (feeling unreal, distorted)
- can be 'with delayed expression' if symptoms do not appear until at least six months after the trauma

- can occur in children aged under six years as ‘preschool subtype’, with symptoms coming out in play activities.
- DSM-5 has removed ‘response involving intense fear, helplessness or horror’ as a requirement for diagnosis.

7.8.7 Other common co-existing problems

Tobacco use

Tobacco use is common among clients/tāngata whai ora experiencing gambling harm and may be higher for their family and whānau members. The connection between the gambling and tobacco use is not well understood but is known (Sullivan and Beer 2003). It may well be that smoking triggers gambling, or that the stress that can arise from gambling behaviour triggers the urge to smoke, but as a life-threatening behaviour, smoking can cause health issues that may make it more difficult to reduce gambling behaviour, affect mental wellbeing, or reduce motivation to control gambling behaviour. On the other hand, successfully giving up smoking may provide evidence of success in behaviour change that could generalise to gambling behaviour. The person may also save in money and experience greater social acceptance as smoking becomes less acceptable.

A number of approaches for smoking cessation are available. Some examples are Smokefree Aotearoa NZ, phone support from the Smoking Quitline, self-help materials, internet-based support and face-to-face psychological strategies. Medical strategies include: nicotine replacement therapy (NRT) patches, gum or lozenges, Bupropion (Zyban), Varenicline (Champix) and Nortryptiline, or a mixture of these.

Another alternative is electronic cigarettes (e-cigarettes). These are electrical devices that mimic real cigarettes by producing a vapour by heating a solution (e-liquid), which the user inhales or ‘vapes’. E-liquid is available with or without nicotine, and usually contains propylene glycol and flavouring agents. Some resemble cigarettes and others are designer products. Some e-cigarettes do not use electronics but instead use an aerosol-delivering system. Evidence is emerging that switching completely to e-cigarettes is safer than smoking tobacco.

Describing to the client/tāngata whai ora the reasons for addressing smoking at the same time as gambling behaviour may be important to motivate them to address two problematic behaviours at the same time. You may need to overcome past perspectives that behaviours should be addressed one at a time to avoid overloading the client/tāngata whai ora, as when inter-connected behaviours are not addressed together, behaviour change is less likely to be successful.

Smoking and gambling harm – reasons for addressing smoking

- Although under 25 percent of the New Zealand population currently smoke, research shows 67 percent of those experiencing gambling harm are smokers, gamblers tend to be heavier smokers, and their rate of smoking increases substantially while gambling (Sullivan and Beer 2003).

- In one of the few published articles on problem gambling, Rodda et al (2004) conclude that there is a strong relationship between gambling behaviour and smoking, and that negative affect, especially anxiety, may be the cause of their co-existence. That is, higher levels of anxiety may cause both. The authors suggest:

The need to address these problems simultaneously by providing smoking cessation programs through already existing programs that provide services to those experiencing gambling harm. Although it is important to avoid taking on too much at one time, it is equally important to treat co-occurring problems simultaneously because each problem can exacerbate the other. (Rodda et al 2004)

- Other research (Petry and Oncken 2002) found daily smokers were more likely to have co-morbid psychiatric or substance abuse problems, had higher gambling harm screen scores, stronger gambling urges and spent more money and gambled more often, than non-daily smokers.
- These findings suggest that smoking may play a part in gambling harm. It may be a risk for gambling harm or a cue that can set off gambling urges, or it may maintain gambling behaviour that results in gambling harm.

Strategies for addressing both smoking and gambling harm

- Train gambling harm specialist providers to:
 - understand the possible connections between smoking and gambling behaviour in order to raise awareness of the co-existence
 - recognise the importance of the relationship between smoking and gambling behaviour, and therefore the importance of addressing this in treatment
 - motivate the counsellor to intervene
 - use strategies in therapy.
- Make written information resources available to clients/tāngata whai ora about the relationship between smoking and gambling behaviour.
- Make resources available to those clients/tāngata whai ora who decide to address smoking cessation or reduction as well as their gambling behaviour.
- Provide information around biological effects of nicotine.

Summary

- Evidence appears to be sufficient to support addressing smoking and gambling behaviour together.
- Upskilling counsellors can assist in providing help to a client/tāngata whai ora population that has difficulty in completing referrals.
- Smoking prevalence is high among those experiencing gambling harm, and the additional cost of cigarettes to a tight budget may cause additional stress and gambling (as self-medication).
- Health problems from smoking may affect mood, which in turn may result in gambling (self-medication of mood).

- Growing social ostracism of smokers may be a social cue (isolation) that can lead them to maintain the gambling behaviour or to relapse.
- Psychological cues to gamble may be influenced by the effects of nicotine (anxiety, withdrawal, mood fluctuations, and instant gratification).
- Biological effects may reinforce a person's gambling behaviour as well as their development of tolerance (dopaminergic effects in the central nervous system).
- The New Zealand Government and Ministry of Health have a goal for New Zealand to become smokefree by the year 2025.

Internet addiction

Internet use is extremely common, and access is virtually unlimited and available through many devices, including computers and laptops, smartphones, tablets and any device with a screen that can connect to the internet, including smart TVs and game consoles. Social networking sites, news sites, YouTube, Google, Wikipedia and many others ensure that people can spend many hours online, usually without problems. Internet gambling websites are prevalent and often advertise on or link with other websites and may offer free credits or incentives to draw people into play. Internet gambling is a gambling mode and is part of 'gambling disorder' (DSM-5) but experiencing harm from online gambling is distinct from internet gaming disorder (see below).

Internet gaming disorder (DSM-5)

Video games have become more complex, realistic and competitive and can introduce an alternative reality or a challenge to become more skilled to reach higher levels in the game. Research has shown that gamers' brains respond to stimuli and pictures of those games in a similar way to those with substance use disorders and gambling disorder. Gamers may spend increased time playing, to the detriment of other activities, eating, sleeping, socialising and relationships. They may become completely absorbed in games, losing track of time and a sense of responsibilities, including school or work.

Although some of the features and consequences of gaming disorder are similar to problem gambling, it is not a 'gambling mode'. Therefore, you would not enter it in CLIC as a brief or full intervention but may cover it under facilitation to another provider or enter it in the narrative report.

7.9 Useful clinical tools and resources

7.9.1 Transtheoretical model of change – Wheel of Change

One of the considerations in working with clients/tāngata whai ora experiencing gambling harm is: 'Why have they come to the service?' What are their goals – are they attending because they want to make changes to their gambling behaviour to reduce harm, or do they want to stop gambling completely (abstinence)? Is their motivation coming from within themselves, or are they attending to satisfy the demands of others, such as family, whānau and friends, the police or community corrections (following, eg, criminal charges because of theft or fraud), their doctor (due to stress, anxiety or other health reasons) or because they have been excluded from a casino or gambling venue because of their gambling behaviour? This raises the issue of 'motivation' in regard to change, which is an important factor in the successful implementation of care planning and achieving the goals of treatment.

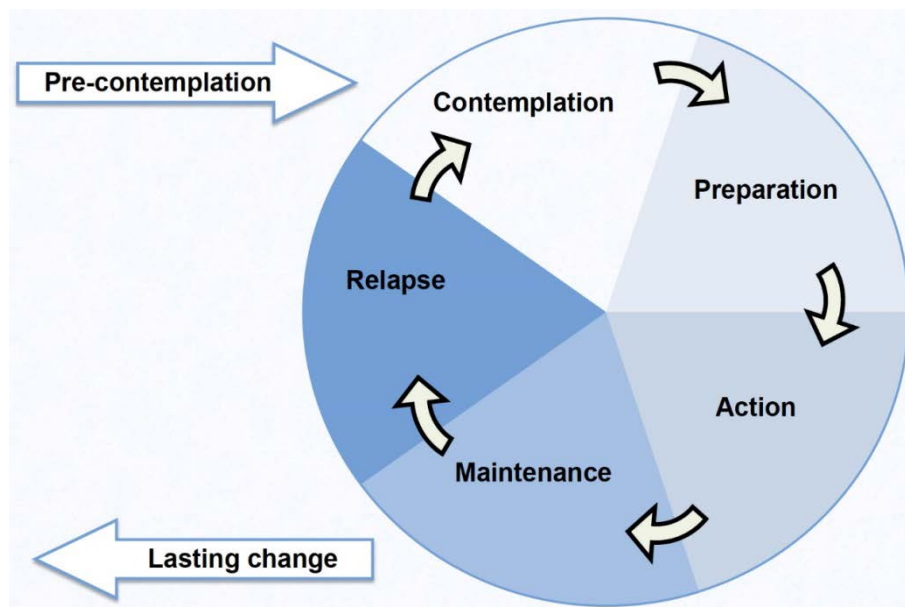
Motivation is a 'reason for acting or behaving in a particular way' (Oxford dictionary). We cannot take motivation to change for granted, and as motivation is a state of mind, it can come and go and can be changed, according to mood and circumstances.

As a model of change, the Wheel of Change (Figure 7.1) helps us to consider the stages that people usually go through in considering change and implementing strategies to make it happen and maintain the new behaviour.

1. **Precontemplation:** The person may not think the behaviour is a problem and has not even considered the need for change.
2. **Contemplation:** The person has now started to think that there may be a problem or concerns about their behaviour and, although they may enjoy it or benefit from parts of it, they may see negative aspects to it as well. This stage may also include ambivalence (alternating between wanting and not wanting to change).
3. **Preparation:** The person has started to decide that they should make changes and they start to investigate how they can go about it.
4. **Action:** Once they have found the means to change, the person enters this stage of implementing a plan for change and actually practising alternative behaviours.
5. **Maintenance:** Once the person makes changes, they need to keep up or maintain the new behaviours in order to benefit from lasting change. From this point, a person may continue to behave in new ways, achieving their goals and experiencing a greater sense of wellbeing. However, many addictions and habits can be hard to change and may take more than one attempt to fully overcome, involving the sixth stage.
6. **Relapse:** The person returns briefly or for longer periods to the old familiar patterns, or behaviours of the past.

A person may relapse for many reasons, including because they return to ambivalence or they experience circumstances they feel they cannot control and feel powerless against. Sometimes, people can quickly regain supports and resume recovery, while others may need more interventions to assist with this. You can recognise a person's stage of change by listening closely to what they say about their behaviour in relation to awareness and any thoughts or intentions to make changes, using empathy and seeking to understand their perspective. This information will help guide your interventions at each stage of change, in order to help the client/tangata whai ora explore their ambivalence and support them toward change. Motivational interviewing, which we discuss next, uses this process.

Figure 7.1: The stages of the Wheel of Change



Source: Adapted from Prochaska JO, DiClemente CC (1982).

7.9.2 Motivational interviewing

Motivational interviewing is a style of working with clients/tāngata whai ora that is both client/tangata whai ora-centred and strengths-based and is particularly concerned with assisting them to make positive changes toward a desired goal. Miller and Rollnick (2013) define motivational interviewing as:

a collaborative goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for, and commitment to, a specific goal by eliciting and exploring the person's own reasons for change, within an atmosphere of acceptance and compassion.

Motivational interviewing involves four processes:

1. **engaging** – connecting and establishing a trusting, effective working relationship
2. **focusing** on what issues the client/tangata whai ora came to deal with and establishing the agenda

3. **evoking** – drawing out from the client/tangata whai ora their own motivations for change, using motivational interviewing principles and micro-skills
4. **planning** – developing commitment to change and formulating a specific plan of action.

These processes fit well with traditional interventions in regard to engagement, assessment, counselling, treatment planning and implementation, along with evaluation of outcomes. Once integrated, motivational interviewing becomes a natural and effective style of working with clients/tāngata whai ora. Research has shown that retention and outcomes improve significantly in interventions involving motivational interviewing.

If we are drawing out their own motivations for change, then the client/tangata whai ora should be the one who voices their reasons for change rather than the practitioner. If the practitioner applies more pressure to change, this will often result in the client/tangata whai ora defending their autonomy and integrity and expressing reasons for not changing their present behaviour. When you hear this 'sustain talk' from the client/tangata whai ora, it is a signal to change what you are doing and to try a different strategy. Building trust in the relationship is achieved through the practitioner expressing 'accurate' empathy. It is about demonstrating to the client/tangata whai ora that you understand their situation and have 'unconditional positive regard' for them.

Another strategy is to develop discrepancy. Here, you draw out from the client/tangata whai ora their concerns and reasons for change, highlight the difference between 'where they are now and where they would like to be' and elicit what steps they might take to get there. You can support their self-efficacy by helping them to draw on and increase their existing skills and resources towards positive change.

The four communication micro-skills of motivational interviewing are:

- **open-ended questions** (eg, beginning with 'How', 'What', 'Tell me about') – used for information-gathering and eliciting the concerns of the client/tangata whai ora
- **affirmations** – genuine statements that acknowledge positive efforts and reinforce motivation for change, rather than 'praise', which could sound patronising
- **reflective listening style** – responding to the client/tangata whai ora with statements (selectively) that reflect the essence of comments made about positive change, and reinforcing these in the form of a statement, rather than using too many questions (interrogating the client/tangata whai ora)
- **summarising** – feeding back a summary of key points from client/tangata whai ora statements to gain further momentum, develop insight or change strategic direction during the counselling session.

Using these micro-skills (which requires some training, practice and experience) within the 'spirit' of motivational interviewing and using the four processes is an effective, client/tangata whai ora-centred approach that is used for changing all kinds of behaviours. It fits well with other counselling approaches and skills, such as cognitive behaviour therapy. You can also use the same skills when working with co-existing problems of the client/tangata whai ora to assist with change, as well as for facilitation and referrals.

Using 'change rulers/scales'

For a client/tangata whai ora to take steps toward changing a behaviour (which might be long-standing, ingrained, addictive and, therefore, difficult to change), the change must be important to them and they must have some confidence that they have both the resources and ability to change. In the gambling harm counselling context, you could introduce this idea as follows:

I would just like to ask you a couple of questions now about how you feel about changing your gambling behaviour.

Thinking about reducing or stopping your gambling behaviour, on a scale of 1 to 10, with 1 being of **no importance whatsoever** and 10 being **extremely important**, where would you place yourself (or what number would you give yourself)?

Thinking about how confident you feel about reducing or stopping your gambling behaviour, on a scale of 1 to 10, with 1 being **I have no confidence whatsoever** and 10 being **I am extremely confident**, where would you place yourself (or what number would you give yourself)?

A good strategy to increase motivation is to ask the client/tangata whai ora why they chose their number (eg, 5), then asking, 'Why was that a 5 and not a 2?' This gives them the opportunity to voice and reinforce their own reasons for expressing some importance in changing and/or having some confidence in their ability to change, which you can acknowledge and affirm. If they nominate a lower number (eg, 2), ask, 'What would help you to move up to a 5 or 6?'

If the client/tangata whai ora indicates they think it is very important to stop, but their confidence in changing is low, then it will be important they have a good support system and resources in place to boost self-esteem, self-awareness, strategies and coping skills. If the client/tangata whai ora indicates that the importance of changing gambling behaviour is low, regardless of confidence, then more work may be needed to raise awareness of their own concerns and possible consequences of not changing, to help them to move towards contemplation and commitment to change.

More information

For more detailed information on motivational interviewing, see Miller and Rollnick (2013).

7.9.3 Relapse prevention planning

It is helpful for the client/tangata whai ora to be able to discuss discharge plans early in treatment to help them prepare for when they will have to maintain goals and achievements after treatment and develop alternative ongoing support networks. Similarly, it is helpful for them to be aware of the potential for relapse, and for you to assist them to prevent it. An important part of relapse prevention is self-awareness and reflecting on personal triggers and high-risk situations.

Triggers are situations and emotions that can set a person up to gamble, such as being in a carpark and noticing a pub with a 'Gaming' sign or meeting someone who tells them they have just won a jackpot on a gambling machine. Other triggers may be: having money and 'free time', feeling bored or needing some excitement, wanting more money and having two-dollar coins in their pocket, being on their own in a strange city, being under the influence of alcohol or drugs and feeling disinhibited, or feeling frustrated and angry. Triggers are personal to the client/tangata whai ora and may have prompted gambling behaviour in the past. You can discuss these and/or record them in a 'template' (see Table 7.1), giving the client/tangata whai ora a printed copy to take away, which adds to and deepens self-awareness for future prevention of relapse. The client/tangata whai ora can then recognise certain situations or feelings as 'early warning signs' and, when they experience them, they have an opportunity to take 'evasive action' such as leaving the scene, phoning a support person or engaging in a safe alternative behaviour.

Table 7.1: Sample template of early warning signs

Trigger or situation	Thoughts before	Feelings before	What I did about it	Positive outcomes	Negative outcomes
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Exploring thoughts, feelings and outcomes helps the client/tangata whai ora to see and understand what is behind patterns of behaviour and gives you both an opportunity to explore alternative strategies to avoid relapse. You can record these reflections on the template too for the client/tangata whai ora to add to and use for reference when they identify feeling 'at risk' and need reminders, for further self-support.

In addition, by identifying high risk situations that are specific to the client/tangata whai ora, they will be able to plan ahead and avoid repeating past patterns of relapse. For example, a high-risk situation might be going into a pub with the intention of having a social drink (forgetting that is where they usually play pokies) and when they realise, it is too late and they end up playing. Another might be going 'out on the town' with the friend they usually go gambling with and then he says he wants to play; the high-risk situation here is being with someone who usually persuades them to gamble. These situations may seem similar to 'triggers' but are situations, rather than thoughts and feelings. Working with clients/tāngata whai ora to identify their personal triggers, early warning signs and high-risk situations prepares them for life after treatment when they do not have a practitioner or support person immediately available. Implementing rehearsed strategies to avoid risks and 'acting early' with alternatives when they experience early warning signs helps them to avoid relapse and maintain their goals. Table 7.2 is an example of a self-awareness template, which provides an opportunity to discuss strategies to minimise relapse risks.

Table 7.2: Template for self-awareness of high-risk situations

High-risk situations <i>My strategies</i>		
Situation	Strategy ideas	Supports, support people
Finding a carpark in town and then realising it is beside a pokies venue.	Move to another carpark. Phone a support person and tell them the situation to help remove temptation.	My partner. Gambling harm minimisation service/counsellor. A friend who doesn't gamble.

The four Ps

In spite of the best intentions of clients/tāngata whai ora and services and their efforts to maintain motivation and apply strategies, a number of other factors can have a profound influence on clients/tāngata whai ora. You need to consider these 'four Ps' in treatment planning.

Table 7.3 lists the four Ps and gives some examples of each of them.

Table 7.3: The four Ps influencing clients/tāngata whai ora

Factor	Examples
1. Predisposing factors Long-term demographics	Early childhood trauma Presence of mental illness Low socioeconomic status History of abuse, family violence, bullying Family or whānau history of gambling Alcohol and other substance use Disrupted family or whānau upbringing Cultural: identity, autonomy, acculturation
2. Precipitating factors Significant triggers	Recent bereavement Relationship break-up Issues with sexual identity Loss of employment Legal problems or trouble with the police Increased substance use (eg, methamphetamine) Major change in life circumstances Immigration or refugee status
3. Perpetuating factors Things that continue the risk	Ongoing major life stressors (increasing gambling, debt – 'chasing', isolation) Meaning of current events or issues to the individual (negative) Mental illness (depression, bi-polar, anxiety) Feelings of hopelessness Suicidal thoughts Ongoing alcohol use, using same venues

Factor	Examples
4. Protective factors	Others relying on them for ongoing care Sense of 'unfinished business'
Reward, meaning and sense of purpose to life, and connection	Having employment Having a framework for meaning in life (cultural or religious beliefs, need to care for family or whānau) Good self-esteem and self confidence Good community supports and close relationships Significant others aware of gambling and are supportive Engagement with a gambling harm minimisation service

Predisposing factors are a person's history and genetics. They cannot be changed, but can be understood, and interventions and management strategies can help reduce the long-term impacts. Precipitating factors may be expected or unexpected events that cause significant stress and/or distress and can trigger the compensatory behaviours (eg, gambling and other addictions). Addressing these issues in care planning can support and enable clients/tāngata whai ora to learn more functional alternatives to addictive behaviours and address the impacts of these. Perpetuating factors are behaviours and feelings that can complicate and worsen the presenting problems of the client/tāngata whai ora. They may be ongoing and can compound the effects of gambling and make change and recovery more difficult.

Treatment strategies to eliminate or defuse these complications may require facilitation and/or referral to other services for additional support, to reduce relapse risk and provide better and more long-lasting outcomes.

Balanced against the previous factors are the protective factors, which provide a foundation for change and recovery. As part of treatment, it may be necessary to both strengthen existing ones and create additional positive factors. Protective factors provide purpose for recovery and meaning to life, and include connections to family, whānau, friends and the community. The better a person's self-esteem, connection with others, sense of belonging and purpose in life, the better they can recover, with a greater ability to prevent relapse.

Generally, a client/tāngata whai ora with a high number of predisposing, precipitating and perpetuating factors and few protective factors may require more time for engagement and will likely require more time and supports throughout their treatment journey. A client/tāngata whai ora with fewer of the first three Ps and a greater number of protective factors may require less time and resources (although this can vary with individual resilience).

7.9.4 Agreed action plan

You usually negotiate an action plan with the client/tāngata whai ora following assessment findings. If appropriate, the action plan below may be a helpful format that

both the client/tangata whai ora and practitioner can sign. The client/tangata whai ora can then take it away to maintain motivation for change.

This suggested plan formalises the goals of treatment. It includes attending counselling sessions, budgeting and other facilitation options, increasing supports and planning against relapse. It also has an option of including a nominated support person who can offer an objective view of progress and offer feedback. In addition, both the client/tangata whai ora and practitioner sign, providing structure and accountability, which those experiencing gambling harm may have lost in the past. The process is strongly client/tangata whai ora-centred, with prompts provided as to goals, but essentially allowing the client/tangata whai ora to elect their own. Regular reviews of these goals are set, to acknowledge progress or to renew motivation where they have not been attained.

Agreed action plan

Name/ref

My goal/s

(Write down your initial goals or tick from the list below.)

1.
2.
3.

Possible goals

- ☐ I will attend our agreed sessions – initially this will be sessions.
- ☐ I will ask my partner/husband/wife to participate by
(*eg, authorising you to confirm I am attending sessions; inviting them to attend a session with me in the future*).
- ☐ Start a budgeting plan.
- ☐ Exclude myself from..... by
- Or:
- ☐ Reduce my gambling to.....
- ☐ Ready myself to get work.
- ☐ Start an exercise plan and carry it out.
- ☐ Improve my social life by (*eg, rejoining a club I used to belong to*).
- ☐ Reduce risk by
(*eg, telling my gambling friends I've stopped/having a break to see what it's like; staying away from gambling venues, even if just going out for a drink or meal*).
- ☐ Reduce risk by listing all the triggers that set me off gambling
(*and adding to the list on a regular basis, the times when they are most powerful, and people I may be around*).
- ☐ Avoid these situations that can trigger the gambling
(*and developing ways to ensure I act straight away to avoid them*).

- ☐ Contact a support group, eg, Gamblers Anonymous if available and attend.
- ☐ Use the Gambling Helpline as another support
(both during treatment and after it has been completed).
- ☐ Appoint a support person who could provide an independent opinion of my progress following treatment.

Name..... Phone/contact.....

Counsellor

I (or the treatment provider) agree to:

- provide help and counselling to assist you to achieve your goal/s
- endeavour to return your calls promptly
- provide you with follow-up information and advice about your progress after treatment.

Planned review dates of goals and progress

☐ Monthly ☐ Two-monthly ☐ Other

(Use new sheet for updating or renewing goals)

Agreed

Client/tangata whai ora Counsellor.....

Date

7.10 Cross-cultural treatment guide

7.10.1 Cross-cultural treatment considerations

‘Culture’ is defined by shared history, values, beliefs and practices of a group, not just ethnicity. It affects all aspects of living, including behaviour, family structure, child rearing, dress, body image, diet, food, caregiver’s roles and spiritual practices. In the context of health care, culture is integral to ideas of what constitutes illness and wellness and what acceptable and effective treatment is (Camplin-Welch et al 2007).

Many clients/tāngata whai ora access cultural services; however, many others may choose mainstream services for various reasons, including to remain anonymous from their cultural group, for convenience, through recommendation or referral, or based on a belief that the service offers particular expertise. For this reason, practitioners may have a client/tāngata whai ora caseload with a diverse cultural mix, and treatment responses will need to vary accordingly. In addition, for many clients/tāngata whai ora, English may not be their first language and they may need the support of family members, elders or interpreters and, for some cultures, from traditional cultural or spiritual healers. This brief resource offers some general guidelines or principles to help practitioners to work with clients/tāngata whai ora from some of the cultures in New Zealand.

7.10.2 Working with Māori

The Treaty of Waitangi requires the New Zealand Government to protect the health and wellbeing of Māori and to assist Māori to exercise authority in developing and delivering health improvement initiatives. Māori as a population have a higher prevalence and severity of addictions and mental health problems than non-Māori. The 2006/07 New Zealand Health Survey found Māori were four times more likely to be experiencing gambling harm than others in the community, so it is important to improve access and retention for Māori in gambling harm services and to develop a culturally competent and culturally safe workforce able to sustain engagement and generate trust within a therapeutic relationship.

Given Māori are tāngata whenua (indigenous people of Aotearoa New Zealand), the structures of whānau and communities (hapū and iwi) are unique to New Zealand. Māori health perspectives integrate mind, body and spirit within a context of social collectivity, so that an individual's wellbeing is in the context of their whānau and hapū and depends on the balance of a number of dimensions. Some contemporary models of Māori health, such as Te Wheke and Te Whare Tapa Whā (see below), emphasise the balance of personal (including family and whānau), environmental (including community), cultural and spiritual dimensions. Māori wellness includes a sense of identity and self-esteem as Māori, confidence and pride, spiritual awareness, personal responsibility, knowledge of te reo Māori (Māori language) and tikanga Māori (customs and codes of conduct) and whānau support.

For engagement, whakawhānaunga (connectedness) is important, linking the practitioner and client/tāngata whai ora to form a therapeutic alliance for recovery and wellness. For Māori, their sense of self may be shaped by who they are in connection with others, so rapport is established by taking time to establish links with 'who we are and where we are from'.

Two examples of Māori models of health

Te Whare Tapa Whā (Durie 1985, 1994, 1995) is represented by a four-sided house. The first side is taha wairua (spirituality); the second is taha hinengaro (mental health); the third is taha tinana (physical health); and the fourth is taha whānau (extended family), which also identifies with belonging, sense of purpose and support networks. The four sides ensure strength and balance.

Te Wheke (the octopus) (Pere 1984): The eight intertwining tentacles represent relationships between different dimensions of health and the body represents the family unit. The eight tentacles represent: wairuatanga (spirituality), hinengaro (mental health), tinana (physical), whānaungatanga (family), mana ake (uniqueness), mauri (vitality), hā a koro mā (cultural heritage) and whatumanawa (emotions).

The elements in the models are placed in the context of individual Māori beliefs, values and experiences. Exploring the beliefs, values and experiences of the client/tangata whai ora encourages more in-depth discussion of presenting concerns and, in turn, to reveal more about themselves and their whānau history.

Overcoming barriers

For many Māori, a stigma is linked to having mental health and/or addiction problems, which can be a barrier to seeking treatment. Other barriers include costs of seeking help, including travel costs, distance from services and restrictions of appointment and waiting times. As with all population groups, 'technical language' can lead to problems in communication and understanding. Additional influences on a decision about whether to seek help may be perceptions of cultural issues (eg, stereotypes, assumptions, lack of understanding of Māori values) and whether a service can include whānau in assessments and interventions. It is also important to recognise that Māori are not a homogenous group and may also have individual values and beliefs and ways of seeing the world. Generally, it is helpful to have a flexible approach to appointment times; 'home visits' may be appropriate for clients/tāngata whai ora with limited means.

It is important to check out and use correct pronunciation of names and Māori words, which will help demonstrate consideration and respect. Opening and closing sessions with a karakia (prayer) can also provide a safe space, and you can invite the client/tangata whai ora to do this if they are comfortable with that.

Key sources

- *Let's Get Real: Real skills for people working in mental health and addiction* (Ministry of Health 2008).
- *He Rongoā kei te Kōrero. Talking therapies for Māori: Wise practice guide for mental health and addiction services* (Te Pou o Te Whakaaro Nui 2010).

7.10.3 Working with Pacific peoples

Pacific communities in New Zealand are diverse and are primarily made up of people from Samoa, Tonga, Cook Islands, Fiji, Niue, Tokelau and Tuvalu; however, some also come from French Polynesia, Kiribati, Papua New Guinea and Solomon Islands. In addition, many people are of mixed descent and may be influenced by several cultures. Many people in the Pacific population in New Zealand were born in the islands and have more traditional views on their culture or cultures, while the majority of younger Pacific peoples were born in New Zealand and have adopted much of New Zealand culture. Approximately two-thirds of Pacific peoples live in the Auckland region. Health outcomes for Pacific peoples are generally worse in comparison with the general population, including incidence of mental health problems, although Pacific peoples tend to access treatment services at a much lower rate.

In Pacific societies, the family (and extended family) is the basic unit and there is less focus on the individual. Each person's role is defined by the family, and personal contribution to the family defines the individual. Therefore, the family is interconnected with a system of interrelated obligations, responsibilities and benefits. Good family relationships are important, and Pacific peoples also try to balance relationships between people and the surrounding environment. Good health is holistic, incorporating physical, mental and social wellbeing, and life and wellness are considered gifts. Being healthy is associated with being a productive member of family and community, while being unhealthy or unwell is associated with shame or embarrassment for not being able to contribute fully to one's family and community. Therefore, contribution is a key aspect of wellbeing, which creates a desire and duty to provide for and support the family and community financially, emotionally, practically and spiritually.

Relationships are characterised by integrity, the ability to give, generosity and mutual benefit, in order to meet one's obligations. There is also an expectation of the right way things should be done. For example, Fa'a Samoa (the Samoan way) refers to the obligations a Samoan owes to their family, community and church, and their sense of identity. Respect is also important, especially to those of higher social status, including older people, matai (chiefs), ministers, politicians, doctors and teachers. Spiritual faith is important throughout the Pacific and the church plays a central role in Pacific culture and life. Integrity and dignity are also important to the extent that some people may be more concerned about retaining dignity than about their health. For practitioners, this means that a key focus is to gain informed consent and ensure that Pacific clients/tāngata whai ora understand procedures in order to engage and retain them in the service.

There are often differences between New Zealand-born and migrant Pacific peoples but some Pacific peoples may see the terms 'Pacific born' and 'New Zealand born' as insulting. However, it is important to know their ethnicity, as this can help guide interventions and it is helpful to learn about their upbringing, life experiences, beliefs and values. The interconnectedness of Pacific culture may mean that Pacific clients/tāngata whai ora bring family and friends to treatment and wish to consult with them before accepting treatment recommendations. Sometimes others may speak on behalf of the client/tāngata whai ora and they can often add important information about the situation. If the family is not present with the client/tāngata whai ora, it is respectful to ask after the family at the start of the session as part of reconnecting and engaging, before moving on to clinical issues.

Communication style with Pacific peoples often includes use of metaphors to explain things and clients/tāngata whai ora may also need more time to express themselves. Many enjoy humour and respond well to animation, facial gestures, drama and long meaningful conversations. Some Pacific clients/tāngata whai ora may not fully understand complex health conditions and it is important to check their understanding of what you have discussed. Family members can assist with this as well as support and advocate for the client/tāngata whai ora and, if there is a difficult or embarrassing issue to discuss with them, it is appropriate to ask family members to wait outside during this discussion. Do not assume silence means consent; instead, try to draw out thoughts and opinions from the client/tāngata whai ora as they may not wish to show disagreement out of respect, or to be polite. It is helpful also to check out correct pronunciation of Pacific names and words with clients/tāngata whai ora, rather than mispronounce them, in order to show respect for the person and their heritage.

Finally, it is important to give explanations (in easy, non-technical language) for information related to the presenting problems and co-existing problems or other complications. This will help ensure they understand the issues and treatment plan, and any expected outcomes. Politeness, shyness and respect may make it difficult for Pacific clients/tāngata whai ora to question or challenge the treatment plan if they do not fully understand or agree with it. Checking out their understanding (and any accompanying family member's understanding) will make it easier for them to ask questions and to maintain trust and engagement. Also attend to body language and remember that prolonged eye contact may be uncomfortable for Pacific clients/tāngata whai ora and could make them feel scrutinised or challenged.

7.10.4 Working with Asian peoples

The Asian population group is New Zealand's third largest cultural group. It makes up 11.8 percent of the New Zealand population, with two-thirds of that population living in the Auckland area. The largest Asian group in New Zealand is Chinese, followed by Indian, Filipino, Korean, Japanese, Sri Lankan, Cambodian, Thai and Vietnamese (2013 New Zealand census). Asian culture is very diverse, and many people will also be of mixed ethnicity. The population includes new migrants, settled migrants (15 years plus) and New Zealand-born Asians, as well as refugees and asylum-seekers.

Generally, the family (including extended family) is the unit of Asian society and decisions are made by family and community to serve the collective interest. In most Asian cultures, religion plays a central role in life and provides a framework for aspects of living, including illness and health. In some cultures, beliefs and practices are a composite of a number of traditions and will have an effect on their approaches to health care. In terms of communication, gestures and greetings differ from Western ones and it is also best to avoid prolonged eye contact. For males, handshakes are acceptable. Customary greetings are appropriate for women or, if in doubt, a slight bow of the head and a smile are appreciated. For many, passivity and shyness may prevent them from asking health practitioner's questions or disagreeing with treatment findings or plans. Formality and respect, especially for older people, are important, and over-familiar touch is not appreciated. Health practitioners are seen as authorities and are highly respected. Informed consent is a family decision. Many Asian people may expect 'tangible treatments' (eg, medication) as part of care (often standard practice in

their countries of origin) and may believe 'just talking' is a waste of time. In these cases, you will need to explain interventions in order to maintain engagement and compliance with treatment.

In general, health care providers should be aware that traditional practices and beliefs of most Asian migrants and refugees are **dynamic** and that they **change** considerably after resettlement. Some people may have little or no reliance on traditional practices. For others, illness leads them to revert back to more traditional practices, especially as it becomes apparent that Western medicine does not have all the answers. Many second^{and} third generation Asians living in New Zealand may not hold any traditional health beliefs and practices. It is vital to make assessments on an individual basis. Some cultural therapies that may help are emotional freedom techniques and 'Ba duan jing' martial art movements, as well as other therapies.

When arriving in a new country to settle, people have many adjustments to make which can cause stress. Challenges may include the major change in the living environment, different expectations when applying for employment or study, language and communication difficulties, cultural differences and differing attitudes, to name a few. In this context, casinos and other gambling venues may be welcoming and migrants may see them as places where they can be with others socially without needing to communicate and can 'fit in' to the community. Some migrants may have good financial means or access to money from their homeland, can afford to gamble freely and may suffer gambling harm as a result. They may also be unaware of where they can seek help and what form this may take.

Before assessing an Asian client/tangata whai ora, consider the following.

- Do you know what culture they are from?
- Do you know what language and/or dialect they speak?
- Can you greet your client/tangata whai ora in their language?
- Will you need an interpreter?

The following are essentials for communicating clearly during the assessment.

- Explain your role to your client/tangata whai ora. (Someone who has come from a different health system does not always understand different professional roles.)
- Do not assume they are proficient at English.
- Speak clearly and slowly.
- Avoid jargon.
- Simplify the form of any sentences or questions (eg, use active not passive statements).
- Pause and take time to explore any issues that need clarifying to ensure the client/tangata whai ora understands you before continuing. (If you assume they understand everything, the result could be non-compliance.)
- Periodically summarise the discussion and encourage feedback to check understanding.

- Note differences in meanings of words. (For example, Anglo Europeans use 'Yes' as affirmative, while in some other cultures it can be a form of acknowledgement without indicating consent. Saying 'That is correct' or 'I understand' may be clearer – check what your client/tangata whai ora means.)
- Be aware of their level of understanding. (You need to find the correct midpoint so that you are neither patronising nor assuming they understand how the health system and treatments work.)
- Respect others' beliefs and attitudes. (Don't be afraid to ask how things are done, seen or understood in the culture of the client/tangata whai ora. People often open up if they feel the listener is genuinely interested.)
- Take note of non-verbal language. (People express emotions in different ways; a dissonance between verbal and non-verbal language may also indicate a lack of understanding.)
- Engage an interpreter where the client/tangata whai ora has low English proficiency and use the interpreter's role as a cultural advisor to assist the communication process.
- Address the client appropriately. (Not all cultures regard first names as acceptable in a formal setting.)
- Find out whether eye contact is acceptable or not.
- Find out what kind of physical touch is expected and acceptable.

7.10.5 Cross-cultural assessments

The following guidelines indicate important cultural background information to gather for culturally competent assessment.

1. Where was the client/tangata whai ora born?
2. How long have they been in New Zealand?
3. What is their ethnic affiliation?
4. Who are their major support people?
5. What are their primary and secondary languages; what is their reading and writing ability in these?
6. What is their religion; what is its importance in their daily life and current practices?
7. What are their food preferences and prohibitions?
8. How is their financial situation?
9. What are their beliefs and practices relating to health and illness?
10. What are their customs and beliefs around life events such as births, illness and death?

7.10.6 Working with interpreters

Working with interpreters is a further challenging factor in working with clients/tāngata whai ora from different cultures. The presence of a third party has a significant influence on rapport potential and, depending on the relationship between the client/tāngata whai ora and interpreter, can also affect outcome. It is essential to engage trained interpreters when necessary and to facilitate the process according to guidelines. You will also need to allow extra time for sessions to allow for the process of working through an interpreter. The primary roles of an interpreter are to act as a:

1. conduit – to process the spoken language, with meaning, so that they give an accurate equivalent in the target language, with no omissions, additions or editing (when language is perceived to be nonsensical, interpreting needs to be literal)
2. clarifier – to interpret underlying and metaphorical meanings within the cultural context
3. cultural clarifier – to provide a necessary framework for the message being interpreted. The interpreter would inform either party about relevant cultural practices and expectations, ethics and etiquette when there is either apparent or potential misunderstanding and assist in maintaining a good therapeutic relationship through mutual cultural respect and understanding. (Camplin-Welch et al 2007)

7.10.7 Refugees and asylum seekers

New Zealand has had an agreement with the United Nations High Commission to accept 750 refugees and asylum-seekers per year from various countries, which has increased to 1,000 per year from July 2018. New Zealand now has many new refugees settled in many parts of the country, especially in Auckland. Many have survived multiple losses, witnessed acts of war and lost family or whānau members and may have been subjected to violence, torture, rape and starvation. Trauma like this greatly increases risk for substance use (Kozarić-Kovacic et al 2000) and also for other co-existing and trauma-related disorders, including mental health disorders and gambling. We also know from the Centers for Disease Control and Prevention–Kaiser Adverse Childhood Experiences Study (Felitti et al 1998) that early trauma affects people throughout the lifespan and can result in depression, anxiety, post-traumatic stress disorder, and suicidal ideation and attempts. Therefore, this particular group of adults and children will likely be at high risk of developing problems. Also, in many of their countries of origin, gambling is not as freely available, accessible or socially acceptable as in New Zealand and could be seen as a means of acceptance and coping, so it is possible they could present to gambling harm minimisation services for help and may additionally need trauma assessment.

7.10.8 LGBT culture

A significant number of clients/tāngata whai ora of mental health and addictions services are likely to be from the LGBT community, although some may not initially be open about this. This term is used generally to encompass a diversity of sexuality and gender-based cultures, representing lesbian, gay, bisexual and transgender people. Sometimes the term is extended to LGBTQIA, which includes queer, intersex and asexual as well.

- The terms lesbian and gay refer to female and male same-sex relationships respectively, while bisexual refers to either sex relationships.
- Transgender describes a wide range of identities and experiences of people whose gender identity or expression differs from conventional expectations based on their assigned sex at birth.
- A transsexual person lives full time in a different gender from the one assigned at birth and sometimes people use hormones and/or have surgery to achieve this.
- The term 'queer' has in the past, been used as a slur against people who do not fit into sexual norms. However, for some, queer has been embraced as a radical, anti-assimilationist stance that captures multiple aspects of identities.
- Intersex refers to people who have primary or secondary sex characteristics that do not fit neatly into society's definitions of male or female. Although this is a relatively common condition, society's denial of these people's existence makes it hard to publicly discuss intersex issues.
- Asexual refers to an individual's sexual orientation, which is not characterised by feeling sexual attraction, or wanting 'partnered sexuality'. Being asexual is distinct from celibacy, which is deliberate abstention from sexual activity. Some asexual people do have sex, but there are many ways to be asexual.

It is of note that in the past it was illegal to have same-sex relationships in New Zealand and it remains illegal in some countries (eg, Malaysia, Myanmar, Brunei, Singapore and India). In New Zealand, the Civil Union Act was passed in 2004, and same-sex marriage became law in 2013. In a contrasting example, China decriminalised homosexuality in 1997, but it is only in the last few years that it has seen a rise in lesbian and gay communities with support groups, and bars and meeting places. In many parts of the country, homosexuality is still stigmatised because of the belief that children must marry and continue the family line. For Asian Muslim gay people, homosexuality is still not permissible even when people live in the Western world. Some people are either forced to never 'come out' or to have a 'marriage of convenience' to hide their true feelings.

It is difficult to know the exact size of the LGBT community, because so many are afraid to identify as such, and governments often measure only same-sex households. Some estimates are gay and lesbian 1.3–1.6 percent and bisexual from 0.7–1.1 percent of the population, but these are likely to be underestimates. Many people lie about their personal lives at work. The transgender population faces double the normal rate of unemployment, and many experience harassment or mistreatment on the job. The LGBT population also face health care risks that are often not addressed because of lack of knowledge of the patient's sexual orientation, ignorance of specific health care issues, or fear that the health care professional may be homophobic. Fear of

stigmatisation, often resulting from prior negative experience, prevents many from identifying themselves as LGBT.

Up to two-thirds of health care professionals never ask about sexual orientation and many assume their patients are heterosexual. Others may just wish to avoid the issue. The US Department of Health and Human Services Task Force on Youth Suicide (Feinleib 1989) estimated that gay youths accounted for 30 percent of completed suicides, 40 percent of lesbian, gay, bisexual or transgender youth have attempted or seriously contemplated suicide, gay men are six times more likely to attempt suicide than their heterosexual counterparts and lesbians are twice as likely to attempt suicide as heterosexual women. A number of other health issues are caused through the nature of the sexual activity, and shame and fear of stigmatisation may prevent this group from accessing help as early as they should. This includes sexually transmitted diseases and, for some lesbian women, breast and cervical cancer as well. Gay men have higher rates of dieting and binge eating than heterosexual men and also have a higher risk of sexually transmitted diseases, including HIV and AIDS. Generally, LGBT patients face unique health care risks.

LGBT community and addiction

It has been long observed that substance addictions disproportionately impact members of the LGBT community. Shame can make people feel bad or uncomfortable about who they are as a person. Drugs, alcohol and addictive behaviours such as gambling addiction, sex addiction or shopping addiction can all take people away from their bad feelings for a moment.

One of the very few existing studies on problem gambling in the LGBT community was conducted by Grant and Potenza (2006). The Yale University Medical School study was conducted with a sample of 105 men seeking treatment for pathological gambling. The researchers found a substantial overrepresentation of gay and bisexual men: 21 percent of this sample self-reported as being either gay or bisexual. The researchers also reported greater impairment and a higher incidence of impulse control and substance use disorder among these gay and bisexual men. The limitations of the study are its small sample size, and the fact that only men were included in its study sample. Much more research is needed to understand the scope of gambling harm among lesbians and transgender individuals. However, Grant and Potenza did highlight the need for additional research and for service providers to become more aware of the 'unique needs of LGBT problem and pathological gamblers'.

Other research shows that members of the LGBT community are more prone to suffer from a wide array of psychiatric disorders, including high rates of mood and anxiety disorders (Cochran et al 2003; Gilman et al 2001; Jorm et al 2002) and, as previously mentioned, substance abuse disorders. One key stressor comes from the stigma and discrimination of homophobia and heterosexism (prejudice against LGBT people), which remain a significant challenge for LGBT individuals. Aside from medical marginalisation, many LGBT individuals face extreme prejudice and often violence (Herek and Berrill 1992). Research has shown that gambling harm may disproportionately impact ethnic minorities and, in particular, immigrants. In a qualitative case study of four Chinese Canadian immigrants, immigration and acculturation stresses were cited as key factors in problematic gambling behaviours

(Lee et al 2007). For members of the LGBT community, the stresses and trauma associated with coming out may be very similar to those experienced by immigrants and may be a risk factor for gambling harm. Another similarity between the process of acculturation and the coming out process is the experience of loss and isolation (Lee et al 2007). Both immigrants and members of the LGBT community may experience loss of their social network – for the former through relocation and for the latter through dislocation. In either case, gambling establishments such as casinos may provide an inviting relief to social loss and isolation.

LGBT individuals may face a multitude of barriers to access professional care – both actual and perceived. LGBT individuals who experience gambling harm may see the barriers as even more insurmountable. Research shows that those experiencing gambling harm from marginalised communities, including ethnic minorities (Raylu and Oei 2004), older adults (Potenza et al 2006) and women (Volberg 1994), seek help at lower rates. Mistrust borne of the history of being pathologised does little to increase the community's trust of medical and mental health providers. This mistrust is likely to affect LGBT help-seeking behaviours, so an open, non-judgemental approach is even more important. Membership of an already stigmatised group may serve to make LGBT people wary of stepping forward to disclose issues such as gambling harm (also a 'hidden problem'), for fear of incurring additional stigma and discrimination. LGBT individuals may also be particularly resistant to additional labels, and 'normalising' and approaching the issue sensitively may assist to engage this under identified group.

Key sources

Birch (2015) *Examining Problematic Gambling and Mental Health in LGBTI community: A preliminary study*.

Lee (2000) Health care problems of lesbian, gay, bisexual, and transgender patients.

LGBTQIA Resource Centre Glossary, Internet 2017.

<https://igbtqia.ucdavis.edu/educated/glossary>

LGBT workplace issues, quicktake, Internet 2017.

<https://www.catalyst.org/.../lesbian-gay-bisexual-and-transgender-workplace-issues/>

Glossary

Terms used in this Practitioner's Guide have the following meanings. Where you need to use a term when entering data into CLIC, this is also noted.

Term	Definition
bankruptcy	A legal process through which the client/tangata whai ora gets relief from the burden of debt they cannot repay, despite their best efforts. See www.insolvency.govt.nz
Bingo	See Housie.
cards	<p>Card games played for money with other people at a private residence (ie, playing cards for money at home) or at a public venue outside of a casino (such as a poker night at a pub or club).</p> <p>The cards category is different from playing card games at a casino (see Casino Table Games). Record any form of card game played at a casino as Casino Table Games. If a client/tangata whai ora plays card games online, record this as Overseas Gambling (Remotely) – Cards.</p>
casino gambling	<p>Gambling in one of the countries six licensed casinos (Sky City Auckland, Christchurch Casino, Sky City Queenstown, Wharf Casino Queenstown, Sky City Hamilton and Dunedin Casino).</p> <p>The three categories of casino gambling that you can record in CLIC are:</p> <ul style="list-style-type: none"> • Casino EGM • Casino Electronic Table Games (a new category) • Casino Table Games. <p>In New Zealand, casino gambling can only occur in venues. Record any remote casino gambling under the appropriate category within Overseas Gambling (Remotely).</p> <p>Some casinos in New Zealand have TAB vending machines or outlets that allow patrons to place sports and track bets while in the casino. Record problem gambling associated with TAB vending machines or TAB outlets in casinos under the relevant NZ TAB PPGM category.</p>
Casino EGM	Playing electronic gaming machines or pokies at one of New Zealand's six licensed casinos. Record this gambling as Casino EGM.
Casino Electronic Table Games	A new mode of gambling introduced under the Casino category. This mode of gambling, while not common in New Zealand at present, includes gambling in a New Zealand casino on a table game (see Casino Table Games) that does not have an operator or croupier. This is different from gambling at a Casino EGM (Pokie).
Casino Table Games	Table games (such as those listed below) that are played in one of New Zealand's six licensed casinos. Note that many of these games may be played in other settings, such as cards in other settings or table games over the internet (see Overseas Gambling – Remotely). If the gambling has not occurred in one of New Zealand's six licensed casinos, do <i>not</i> record it under this category.

Term	Definition
Casino Table Games (continued)	<p>Common casino table games operated in New Zealand are:</p> <ul style="list-style-type: none"> • roulette • baccarat • blackjack • poker • tai sai • pontoon • casino war • Caribbean stud poker • tournament play • money wheel • craps • pai gow • Texas hold'em • three-card poker.
CLIC	The Ministry of Health's Client Information Collection database. This is the Ministry's preferred and default system for problem gambling intervention service providers to enter client details into.
Clinician	See practitioner .
Client/tangata whai ora	Health service user
Club EGM	<p>Venues where people have to be members, or signed in by members, in order to drink, eat or participate in activities. Venues that are commonly classed under the Club EGM category are:</p> <ul style="list-style-type: none"> • chartered clubs • sports clubs • Royal New Zealand Returned and Services Association (RSA) venues. <p>Some clubs have TAB vending machines allowing patrons to place sports and track bets in pubs and clubs. Where problem gambling is associated with TAB vending machines in clubs, record it under the relevant NZ TAB PPGM category.</p> <p>(See also pubs and clubs.)</p>
comprehensive assessment	A thorough assessment of a client for a range of health and social problems. The minimum screening tools the Ministry of Health requires for assessing clients/tāngata whai ora form the starting point for a comprehensive assessment. However, you should discuss screen results with clients/tāngata whai ora and obtain relevant clinical information when appropriate.
EGMs	<p>Commonly called pokies but referred to as Electronic Gaming Machines (EGMs) in the Gambling Act 2003. Gambling on EGMs in New Zealand can occur in pub or club venues, or in casinos. See Casino EGMs and pubs and clubs for more information.</p> <p>Gambling on internet EGMs or pokies is a subcategory of Overseas Gambling (Remotely).</p>

Term	Definition
family/whānau/ affected other	<p>The Ministry recognises that people can be negatively affected by someone else's gambling in many ways. The problem gambling sector uses 'family members', 'whānau', 'significant others' or 'affected others' to describe the broad range of relationships between a person affected by gambling and a gambler.</p> <p>The Ministry has used the term 'family/whānau/affected other' in this Practitioner's Guide to emphasise that people can be affected by the gambling of someone outside their immediate family. 'Family/other' is used as an abbreviation for 'family/whānau/affected other'.</p>
gambled on premises	<p>In New Zealand, most gambling can only occur within actual premises, such as a pub, a club or a casino. The two exceptions involve gambling with the New Zealand TAB and some New Zealand Lottery products (Lotto and Keno).</p> <p>If a client/tangata whai ora identifies that they have been gambling on EGMs or on casino table games but not in a New Zealand venue, record the gambling under the appropriate category within Overseas Gambling (Remotely).</p>
gambled remotely	<p>Placing bets or wagers without being in a physical gambling venue (such as a pub, club, TAB, lottery outlet or casino). The only remote gambling that can be legally operated from within New Zealand involves gambling on New Zealand TAB and some New Zealand Lottery products (Lotto and Keno).</p> <p>Record all remote lotteries gambling other than New Zealand Lottery products as Overseas Gambling (Remotely) – Lotteries.</p>
gambling	<p>'Gambling' has the meaning set out in the Gambling Act 2003:</p> <p style="padding-left: 40px;">paying or staking consideration, directly or indirectly, on the outcome of something seeking to win money when the outcome depends wholly or partly on chance.</p> <p>Gambling includes all forms of gambling and financial risk-taking, both present and future; for example, existing class 4 (pokies) and emerging internet modes linked to an increased incidence of harm.</p>
gambling harm	<p>'Gambling harm' has the meaning set out in the Gambling Act 2003. It means harm or distress of any kind arising from, or caused or exacerbated by, a person's gambling. It includes personal, social or economic harm suffered by the person, their spouse, partner, family, whānau and wider community, or in their workplace or society at large.</p>
group therapy	<p>A clinical counselling session where multiple clients (gamblers or their significant affected others) not previously known to each other meet to share their experience of gambling harm and to support each other.</p> <p>Clients should have had at least one full intervention session and have completed a comprehensive assessment before they start group therapy.</p>
Housie (also known as Bingo)	<p>Types of games where participants match tickets or cards containing numbered squares or symbols to numbers or symbols that are randomly selected and called by an announcer or displayed. Participants win when certain numbers or symbols match on their tickets or cards, and prizes are awarded accordingly.</p> <p>This category is only for Housie games run in New Zealand. Where problems are associated with playing Housie online or overseas, record them as Overseas Gambling (Remotely) – Housie (Bingo).</p>
insolvency	<p>When a person is unable to pay their debts as they fall due.</p>

Term	Definition
Instant Kiwi (also known as scratchies)	<p>The range of New Zealand Lottery instant game products. Instant Kiwi can only be purchased at New Zealand Lottery outlets. Record gambling on Lotto and Keno separately.</p> <p>(See also NZ Lotteries.)</p>
Keno	<p>The New Zealand Lottery Keno product. Keno can be purchased on premises and remotely through New Zealand Lotteries' MyLotto website. Record gambling on Lotto and Instant Kiwi separately.</p> <p>Record gambling on overseas Keno as Overseas Gambling (Remotely) – Keno. See the definition for Overseas Gambling (Remotely).</p> <p>(See also NZ Lotteries.)</p>
Lotto	<p>The New Zealand Lottery Lotto product, which includes Big Wednesday, Bullseye, Powerball and Strike. New Zealand Lotto tickets can be purchased on premises and remotely through New Zealand Lottery's MyLotto website. Record gambling on Keno and Instant Kiwi separately.</p> <p>Record overseas lotteries as Overseas Gambling (Remotely) – Lotteries. See the Overseas Gambling (Remotely) definition.</p> <p>(See also NZ Lotteries.)</p>
method of access	<p>A new category of additional information on PPGMs that helps inform the Ministry of Health, the Department of Internal Affairs and the gambling and problem gambling sectors on any emerging issues associated with new technologies that may be introduced into New Zealand.</p> <p>Some methods of access:</p> <ul style="list-style-type: none"> • are not permitted to New Zealand operators (ie, New Zealand casinos are not permitted to allow remote access to their table games) or • do not fit the criteria (ie, on premises gambling in the Overseas Gambling (Remotely) category does not make sense – see Overseas Gambling (On Premises) for an exception to this rule). <p>You can record both on-premises and remote gambling for a gambling mode that has both options. For example, a client/tangata whai ora tells you that they bet on sports with the NZ TAB over the phone and at the local TAB outlet. You record this as NZ TAB: Sports Betting 'on premises' and 'remotely'. This would only count as one mode for the purpose of PPGM limits (see Glossary entry for PPGM).</p> <p>Family and whānau (affected others) may not be certain of the main methods the gambler uses to place bets. When a client/tangata whai ora is not sure about the method of access for a gambler, then use 'on premises' as the default entry.</p>
NZ Lotteries	<p>Gambling harm associated with New Zealand Lotteries products. Gambling with New Zealand Lotteries products can involve Lotto tickets, Keno or Instant Kiwi (see each entry for more detail on these categories). Lotto and Keno gambling can be both on premises and remotely. Instant Kiwi gambling can only occur when tickets are purchased from a New Zealand Lotteries outlet.</p> <p>Record overseas lotteries recorded as Overseas Gambling (Remotely) – Lotteries.</p>

Term	Definition
NZ TAB	<p>Any form of bet placed with the New Zealand Racing Board. Gambling with the NZ TAB can involve either sports or track betting. (For more detail, see NZ TAB: Sports Betting and NZ TAB: Track.)</p> <p>NZ TAB betting can be placed both on premises and remotely in a number of ways. Record the forms of betting below under each category as follows.</p> <p>Gambling on premises</p> <p>NZ TAB gambling has several types of premises gamblers can attend to place bets or wagers. Record gambling at any of the following venues as NZ TAB Gambling on Premises:</p> <ul style="list-style-type: none"> • TAB agency (betting in an official stand-alone TAB location; ie, not part of a pub or club) • TAB outlet (betting at a TAB outlet located within another business, including hotels, pubs or clubs; ie, pub TAB or club TAB) • on-course (placing a bet at a race track). <p>Gambling remotely</p> <p>NZ TAB gambling has a number of remote options that clients may identify as using to place bets or wagers. Clients/tāngata whai ora may identify gambling on both premises and remotely. Record any of the following forms of placing bets as NZ TAB Remote Gambling:</p> <ul style="list-style-type: none"> • online (www.tab.co.nz) using a computer or internet-capable mobile device (www.m.tab.co.nz) to place a bet • Phonebet (speaking to an NZ TAB operator via a landline or mobile phone to place a bet) • Touch Tone (follow voice prompts using landline or mobile) • SKYbet (placing bets using a SKY digital decoder remote) • TXT betting (using text messages to place bets) • self-service TAB (a TAB vending machine located within another business (usually a hotel)). <p>Only record the primary problem gambling mode of a client/tāngata whai ora as NZ TAB if the TAB service they are using is within New Zealand. Record overseas TAB services such as TAB Australia (Tab.com.au) under the appropriate category within Overseas Gambling (Remotely) – Sports Betting; or Track.</p>
NZ TAB: Sports Betting	<p>Record all harmful gambling that involves betting at an NZ TAB (either on premises or remotely) as one of two categories: Sports Betting; or Track.</p> <p>The NZ TAB: Sports Betting category is for when a client identifies that the main form of gambling causing harm involves betting on sports with NZ TAB. Sports that are commonly bet on include:</p> <ul style="list-style-type: none"> • American football • Aussie rules • baseball • basketball • bowls • cricket • football • golf • ice hockey • motorsport

Term	Definition
NZ TAB: Sports Betting (continued)	<ul style="list-style-type: none"> • netball • rugby league • rugby union • tennis. <p>If a client/tangata whai ora identifies that they have been betting on sports events but not with NZ TAB, record the gambling as Overseas Gambling (Remotely) – Sports Betting.</p>
NZ TAB: Track	<p>Record all harmful gambling that involves betting at an NZ TAB (either on premises or remotely) as one of two categories: Sports Betting; or Track.</p> <p>The NZ TAB: Track category is for when a client/tangata whai ora identifies that the main form of gambling causing harm involves betting on track races with NZ TAB. Track events in New Zealand include:</p> <ul style="list-style-type: none"> • horses (gallops and harness) • dogs (greyhound). <p>If a client/tangata whai ora identifies that they have been betting on track events but not with NZ TAB, record the gambling as Overseas Gambling (Remotely) – Sports Betting.</p>
Other NZ Gambling	<p>The Ministry of Health has decided to retain the Other category, but notes that most forms of legal gambling in New Zealand are already covered and there are likely to be few occasions when the Other category is necessary. The Ministry believes that the Other category continues to have value for:</p> <ul style="list-style-type: none"> • recording and allowing the identification of new or emerging trends in types of gambling associated with harm • allowing the entry of unusual clinical presentations that do not easily match an existing category (eg, a client/tangata whai ora who cites the stock market as their primary difficulty). <p>Where possible, when recording a PPGM of Other, encourage the client/tangata whai ora to provide more detail and record the actual form of gambling in the free text field for the Other category.</p> <p>Common mistakes: Practitioners have sometimes used the free text field in the Other category to record additional information related to the client's help-seeking. As noted in primary problem gambling mode, the Ministry believes that this information would be better recorded in other fields.</p> <p>Common entries for the Other category that could be improved include entering 'other', 'affected' or 'family', or 'none' in the Other text field.</p> <ul style="list-style-type: none"> • 'Other' gives no further information. If a client cannot or will not elaborate on the type of gambling involved, then 'unspecified' should be entered. It is unnecessary to add 'other' in the Other text field. • 'Family / Affected Other' – enter the PPGM of the gambler in these cases. • 'None' – see section 2.1 and PPGM in Glossary of this 2.6 of this Practitioner's Guide. <p>Note that Other NZ Gambling is different from Overseas Gambling (Remotely) – Other.</p>

Term	Definition
Overseas Gambling (Remotely)	<p>This category is primarily intended to capture internet gambling. The Ministry has used the term 'remote' to allow the category to include bets placed with overseas organisations (such as TAB Australia) over the phone or over the internet. All modes recorded in this category should be for gambling with venues or organisations <i>outside</i> of New Zealand, and so the option of 'Gambling on Premises' is not applicable for this category.</p> <p>If the gambling involves either NZ Lotto or NZ TAB, then record the PPGM in one of these categories.</p> <p>If a client/tangata whai ora identifies their PPGM as overseas while travelling or on holiday, you should typically <i>not</i> record this as Overseas Gambling Remotely. See Overseas Gambling (On Premises) for detail of one exception.</p> <p>If a client/tangata whai ora says they have a problem with overseas gambling, providing no further description, encourage them to provide more detail. Subcategories for overseas gambling include:</p> <ul style="list-style-type: none"> • Casino Table Games – same as the definition for Casino Table Games but for internet casinos rather than physical casinos within New Zealand • EGM (Pokies) – virtual electronic gaming machines that can be played over the internet • Sports Betting – any betting on sports events that are placed through an agency other than NZ TAB • Track Betting – any betting on horse or dog racing that is placed through an agency other than NZ TAB • Lotteries – any lotteries entered that are <i>not</i> promoted by the New Zealand Lotteries Commission. • Housie (Bingo) – same as the definition for Housie but operated over the internet rather than at a physical venue within New Zealand • Cards – internet card games that are played against other players for money • Other (overseas) – like the definition of Other NZ Gambling, the Ministry believes that most modes of gambling fit into existing categories and that this category will seldom be required. An example where you might use this category is where a client/tangata whai ora identifies they have bet on an event the NZ TAB cannot offer (results of a governmental election, Oscar winners, etc).
Overseas Gambling (On Premises)	<p>The Ministry recognises that the proposed definitions do not include a specific mode for gamblers whose primary problem gambling mode <i>only</i> involves gambling at a venue (on premises) while overseas and does not include harmful gambling on New Zealand gambling products.</p> <p>The Ministry does not anticipate that this is a common mode for presentations in New Zealand. However, if a client/tangata whai ora meets this criterion, record the PPGM as Overseas Gambling (Remotely) – Other, specify the actual gambling type (eg, Casino Table Games) and note that it is on premises.</p> <p>For example, Jack travels overseas regularly as part of his work. When he is in New Zealand, he rarely gambles. When he is overseas, however, he finds he gets bored in the evenings and visits local bars and plays the pokies. Initially he would only play for an hour or two on one or two nights. Now he plays every night he's away and stays as long as the venue is open. In this case, record the PPGM as: Gambling (Remotely) – Other, and manually enter 'EGM on premises'.</p> <p>Note: Any New Zealand gambling entered in the Overseas Gambling (Remotely) – Other field will <i>not</i> be attributed to New Zealand gambling operators during levy calculations.</p>

Term	Definition
pokies	Refer EGM (electronic gaming machines)
practitioner	A person with the necessary skills and competencies to diagnose, screen, assess and provide psychosocial and culturally based interventions to people experiencing harm from gambling.
primary problem gambling mode (PPGM)	<p>The mode or modes of gambling most closely associated with the problems a client/tangata whai ora is experiencing. For people seeking support for someone else's gambling, PPGM refers to the mode or modes <i>of the gambler</i> that are causing the most harm or problems for the client/tangata whai ora. CLIC allows for the following gambling types to be recorded as a PPGM:</p> <ul style="list-style-type: none"> • Casino Table Games • Casino Electronic Table Games • Casino EGM (Pokies) • Pub EGM (Pokies) • Club EGM (Pokies) • NZ Tab Sports Betting • NZ Tab Track (Horse or Dog Racing) • Lotto (including Big Wednesday and Powerball) • Keno • Instant Kiwi (scratch cards) • Housie (Bingo) • Cards (not at casino) • Overseas Gambling Remotely (ie, internet or phone). <p>For more detail on each of the above gambling types, see its separate glossary entry.</p> <p>For the client/tangata whai ora to be a valid one in your intervention service, and for the client session to be recorded in CLIC, you must record at least one and no more than five PPGMs for a client/tangata whai ora. Only use the PPGM field to record the gambling modes the client/tangata whai ora associates with their presenting issues – noting that these may change as their relationship with and level of disclosure to you develop.</p> <p>Analysis of entries for 'other' in the PPGM field suggests that practitioners are recording motivations for help-seeking (eg, Why are you here?) as well as recording gambling modes associated with harm. While these entries do not affect the validity of the PPGMs recorded, the Ministry believes that there are more appropriate places for recording this type of information.</p> <p>Difference between PPGM and other gambling modes</p> <p>Evidence indicates that while most problem gamblers may participate in a variety of forms of gambling, often only one or two modes are associated with their presenting issues.</p> <p>Why only five PPGMs?</p> <p>As noted above, the PPGM field is only of value if clients and clinicians are distinguishing between modes of gambling the client associates with harm, and gambling modes the client may also participate in. The Ministry identified a maximum of five PPGMs as an appropriate balance between allowing clients/tangata whai ora to fully disclose their story and experiences and encouraging clients/tangata whai ora and practitioners to actively engage with the modes of gambling that are the most intimately associated with the presenting issues of the clients/tangata whai ora.</p>

Term	Definition
provider, service provider	A provider (or service provider) contracts with the Ministry of Health to provide services. Providers include individuals and organisations that act as a nominee, an agent or a subcontracted provider to a provider.
Pub EGM	<p>Venues that do <i>not</i> require membership to enter; essentially this category is all EGMs in venues other than the casino and club categories. Venues that are commonly classed under the Pub EGM category are:</p> <ul style="list-style-type: none"> • public bars and taverns • restaurant • entertainment venue (eg, bowling lanes) • playing pokies at New Zealand Racing Board venues (iTABs). <p>Some pubs have TAB vending machines allowing patrons to place sports and track bets. Where problem gambling is associated with TAB vending machines in pubs, record it under the relevant NZ TAB PPGM category.</p> <p>(See also pubs and clubs.)</p>
pubs and clubs	<p>Although relating to only one form of gambling (EGMs or pokies), gamblers from pubs and clubs appear to differ in their presentation patterns and rates in these venue types. Having separate pub and club categories allows the Ministry to identify or attribute the number of problem gambling presentations associated with each sector, and also to indirectly assess the effectiveness or impact of each sector's host responsibility programmes.</p> <p>In New Zealand, EGM gambling can only occur in venues. Record any remote EGM gambling as Overseas Gambling (Remotely) – EGM (Pokies).</p> <p>Some pubs and clubs have TAB vending machines allowing patrons to place sports and track bets in pubs and clubs. Where problem gambling is associated with TAB vending machines in pubs and clubs, record it under the relevant NZ TAB PPGM category.</p>
purchase unit	<p>A category of problem gambling services that the Ministry of Health funds. The four purchase units (and codes) addressed in detail in this Practitioner's Guide are:</p> <ul style="list-style-type: none"> • brief intervention (PGCS-02) • full intervention (PGCS-03) • facilitation (PGCS-04) • follow-up (PGCS-05).
scratchies	See Instant Kiwi .
screening	Asking a client/tāngata whai ora questions from a formal questionnaire. Many screens are developed so that clients/tāngata whai ora can read and answer them on their own. The screens required by the Ministry of Health have been chosen for simplicity, both to allow national and international comparisons and to provide clients/tāngata whai ora and practitioners with feedback on client/tāngata whai ora progress.
session	A single interaction with one or more clients/tāngata whai ora related to brief, full or follow-up treatment. Each purchase unit (brief, full, facilitation or follow-up) has specific rules for a valid session. For more information, see this Practitioner's Guide and the <i>Data Management Manual</i> (Ministry of Health 2008b). It is important for service providers to be familiar with the most up-to-date rules.
Family/whanau/affected other	Someone who is impacted by another person's harmful gambling.

References

- ABACUS. 2017. *Ministry of Health Strategy Think Piece: Domestic Violence as Coexisting Condition to Problem Gambling*.
- American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders* (5th edition) (DSM-5). Washington, DC: American Psychiatric Association.
- Battams S, Roche A. 2011. Child wellbeing and protection concerns and the response of the alcohol and other drugs sector in Australia. *Advances in Mental Health* 10(1): 62–71.
- Beardslee WR, Chien PL, Bell CC. 2011. Prevention of mental disorders, substance abuse, and problem behaviours: a developmental perspective. *Psychiatric Services* 62: 247–54.
- Bellringer M, Palmer du Preez K, Pearson J, et al. 2016. *Problem Gambling and Family Violence in Help-seeking Populations: Co-occurrence, impact and coping*. Auckland: Auckland University of Technology, Gambling and Addictions Research Centre and Centre for Interdisciplinary Trauma Research. URL: www.health.govt.nz/publication/problem-gambling-and-family-violence-help-seeking-populations-co-occurrence-impact-and-coping (accessed 4 April 2019).
- Birch P, et al. 2015. Examining problematic gambling and mental health in a LGBTI community: a preliminary study. *Medical Research Archives* (SI), 3:, June. ISSN 2375-1924. Available at: <https://journals.ke-i-org/index.php/mra/article/view/202>.
- Camplin-Welch V, Refugees As Survivors NZ Trust, Asian Health Support Services. 2007. *Cross-cultural Resource for Health Practitioners: Working with culturally and linguistically diverse (CALD) clients*.
- Cochran S, Mays V, Greer SJ. 2003. Prevalence of mental disorders, psychological distress, and mental services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology* 71: 53–61.
- Drug and Alcohol Addiction Practitioners' Association of Aotearoa-New Zealand. 2011. *Addiction Intervention Competency Framework: A competency framework for professionals specialising in problem gambling, alcohol and other drug and smoking cessation intervention*. Wellington: Drug and Alcohol Practitioners Association of Aotearoa New Zealand.
- Duncan BL, Reese RJ. 2015. The Partners for Change Outcome Management System (PCOMS): revisiting the client's frame of reference. *Psychotherapy* 52(4): 391–401.
- Durie M. 1985. A Māori perspective of health. *Social Sciences & Medicine* 20(5): 483–6.
- Durie M. 1994. *Whaiora Māori: Health development*. Auckland: Oxford University Press.
- Durie M. 1999. *Te Pae Mahutonga: A model for Māori health promotion*. Unpublished paper. Palmerston North: School of Māori Studies, Massey University.

- Feinleib MR (ed). 1989. *Report of the Secretary's Task Force on Youth Suicide. Volume 3: Prevention and Interventions in Youth Suicide*. Rockville, MD: Alcohol, Drug Abuse, and Mental Health Administration (DHHS/PHS).
- Felitti VJ, Anda RF, Nordenberg D, et al. 1998. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine* 14(4): 245–58.
- Gilman SE, Cochran SD, Mays VM, et al. 2001. Risk of psychiatric disorders among individuals reporting same-sex sexual partners in the National Comorbidity Survey. *American Journal of Public Health* 91(6): 933–9.
- Goodyear-Smith F, Coupe N, Arroll B, et al. 2008. CHAT (**C**ase Finding and **H**elp **A**ssessment **T**ool) case-finding of lifestyle and mental health problems in primary care: validation of the 'CHAT'. *British Journal of General Practice* 58(546): 26–31.
- Grant JE, Potenza MN. 2006. Sexual orientation of men with pathological gambling: prevalence and psychiatric comorbidity in a treatment seeking sample. *Comprehensive Psychiatry* 47(6): 515–8.
- Herek GM, Berrill KT. 1992. *Hate Crimes: Confronting violence against lesbians and gay men*. Newbury Park, CA: Sage Publications.
- Jorm AF, Korten AE, Rodgers B, et al. 2002. Sexual orientation and mental health: results from a community survey of young and middle-aged adults. *British Journal of Psychiatry* 180: 423–7.
- Kozarić-Kovacic D, Ljubin T, Grappe M. 2000. Comorbidity of posttraumatic stress disorder and alcohol dependence in displaced persons. *Croatian Medical Journal* 41(2):173–8.
- Lee. 2000. Healthcare problems and the lesbian, Gay, Bisexual and Transgender Community. *West J Med* June 172(6): 403–8.
- Lee B, Fong M, Solowoniuk J. 2007. Transplanted lives: immigration challenges and pathological gambling among four Canadian Chinese immigrants. In D Shek, TI Yiu, E Chan (eds) *Proceedings of Inaugural Asian Pacific Problem Gambling Conference 2005: Advances in Problem gambling: Theory, Service and Research in the Asia-Pacific Region*. Hong Kong: Tung Wah Group of Hospitals and The Chinese University of Hong Kong.
- Matua Raki. 2011. *Screening, Assessment and Evaluation (alcohol and other drugs, smoking and gambling)*. Wellington: Matua Raki.
- Matua Raki and Te Pou. 2013. *Te Whare o Tiki: Co-existing problems knowledge and skills framework (for the mental health and addiction workforce)*. Matua Raki and Te Pou.
- Miller WR, Rollnick S. 2013. *Motivational Interviewing: Helping people change* (3rd edition). New York: Guilford Press.
- Ministry of Health. 2008a. *Data Collection and Submission Manual*. Wellington: Ministry of Health. URL: www.health.govt.nz/our-work/preventative-health-wellness/problem-gambling (accessed 5 April 2019).

- Ministry of Health. 2008b. *Data Management Manual*. Wellington: Ministry of Health. URL: www.health.govt.nz/our-work/preventative-health-wellness/problem-gambling (accessed 5 April 2019).
- Ministry of Health. 2008c. *Let's Get Real: Real skills for people working in mental health and addiction*. Wellington: Ministry of Health.
- Ministry of Health. 2009. *A Focus on Problem Gambling: Results of the 2006/07 New Zealand Health Survey*. Wellington: Ministry of Health. In: Supporting Parents, Healthy Children: Bringing that green book to life in addiction and minimising gambling harm services. Matua Raki presentation, werryworkforce.org.
- Ministry of Health. 2010. *Service Delivery for People with Co-existing Mental Health and Addiction Problems*. Wellington: Ministry of Health.
- Ministry of Health. 2015. *Supporting Parents, Healthy Children: Supporting parents with mental illness and or addiction and their children: A guideline for mental health and addiction services*. Wellington: Ministry of Health.
- Ministry of Social Development: Te Manatū Whakahiato Ora. 2002. *Te Rito: New Zealand Family Violence Prevention Strategy*. Wellington: Ministry of Social Development.
- Mundt JC, Marks IM, Shear MK, et al. 2002. The Work and Social Adjustment Scale: a simple measure of impairment in functioning. *British Journal of Psychology* 180(5): 461–4.
- NCETA. 2010. *For Kids' Sake: A workforce development resource for family sensitive practice in the alcohol and other drugs treatment sector*. Adelaide: National Centre for Education and Training on Addiction.
- Paton-Simpson & Associates Ltd. 2005. *CLIC Database Manual* 14.
- Pere RR. 1984. Te Oranga o te Whānau: the health of the family. In K Whakahaere (ed), *Hui Whakaoranga: Māori health planning workshop*. Wellington: Department of Health.
- Petry NM, Oncken C. 2002. Cigarette smoking is associated with increased severity of gambling problems in treatment-seeking gamblers. *Addiction* 97(6): 745–53.
- Physiotherapy Board of New Zealand. 2011. *Aotearoa New Zealand Physiotherapy Code of Ethics and Professional Conduct with Commentary*. Wellington: Physiotherapy Board of New Zealand.
- Potenza MN, Steinberg MA, Wu R, et al. 2006. Characteristics of older adult problem gamblers calling a gambling helpline. *Journal of Gambling Studies* 22(2): 241–54.
- Prochaska JO, Diclemente CC. 1986. Toward a comprehensive model of change. In WR Miller, N Heather (eds) *Treating Addictive Behaviours: Applied clinical psychology* 13. Boston, MA: Springer.
- Raylu N, Oei TP. 2004. Role of culture in gambling and problem gambling. *Clinical Psychology Review* 23: 1087–114.
- Rodda S, Brown SL, Phillips JG. 2004. The relationship between anxiety, smoking, and gambling in electronic gaming machine players. *Journal of Gambling Studies* 20: 71–81.

Rodda S, Lubman D, Dowling N. 2015. Online counselling for problem gambling (AGRC fact sheet). Melbourne: Australian Gambling Research Centre.

Rogers B, Suomi A, Davidson T. 2015. *Preventive intervention for problem gambling: a public health perspective*. Final report: p 21.

Royal College of Psychiatrists. 2011 *Parents as Patients: Supporting the needs of patients who are parents and their children*. London: Royal College of Psychiatrists.

Sherin, KM, Sinaciore, JM, Li XQ, et al. 1998. HITS: a short domestic violence screening tool for use in a family practice setting. *Fam Med* July–August 30(7): 508–12.

Sullivan S, Beer H. 2003. Smoking and problem gambling in New Zealand: problem gamblers' rates of smoking increase when they gamble. *Health Promotion Journal of Australia* 14(3): 192–5.

Te Pou o Te Whakaaro Nui. 2010. *He rongoā kei te kōrero. Talking therapies for Māori: Wise practice guide for mental health and addiction services*. Auckland: National Centre of Mental Health Research, Information and Workforce Development.

Te Rau Matatini. 2014. *Whānau Ora and COPMIA: The interface. A literature review*. Wellington: Te Rau Matatini Māori Health Workforce Development.

Todd F. 2010. *Te Ariari o te Oranga: The assessment and management of people with co-existing mental health and substance use problems*. Wellington: Ministry of Health.

Volberg RA. 1994. The prevalence and demographics of pathological gamblers: implications for public health. *American Journal of Public Health* 84: 237–41.

Whooley MA, Avins AL, Miranda J, et al. 1997. Case-finding instruments for depression: two questions are as good as many. *Journal of General Internal Medicine* 12(7): 439–45.

Wille A. 2006. *Whakamarama te Huarahi: To light the pathways. A strategic framework for child and adolescent mental health workforce development 2006–2016*. Auckland: The Werry Centre for Child & Adolescent Mental Health.

Wren J. 2018. *Introduction to Key Gambling Harm Terms, Concepts, Theory and Issues in New Zealand*. Wellington: Ministry of Health.

Appendix 1:

Screens and tools

The Ministry of Health has identified the following screens for use in problem gambling services. Table A.1 lists each screen, along with the name for it used in CLIC and the section of the Practitioner's Guide that describes how to use and score it. This appendix then sets out all of these screens in full.

Table A.1: List of screens to use in problem gambling services

Screen category	Practitioner's Guide reference	Screen name	CLIC title
Brief intervention (section 3)			
Brief gambler	Section 3.7.1	Brief Gambler	Brief Gambler Harm
Brief family/whānau/affected other	Section 3.7.2	Awareness of the Effect of the Gambler's Gambling	Brief Fam Awareness
		Effect of Gambler's Gambling	Brief Fam Effect
Full intervention (section 4)			
Gambler harm	Section 4.5.1	Gambler Harm	Gambler Harm
Gambler outcome	Section 4.5.2	Control over Gambling	Gam Outcome Control
		Dollars Lost	Gam Outcm Dollars
		Annual Household Income	Gam Outcome Income
Family/whānau/affected other harm	Section 4.5.3	Awareness of the Effect of the Gambler's Gambling	Family Awareness
		Effect of Gambler's Gambling	Family Effect
Family/whānau/affected other outcome	Section 4.5.4	Gambler's Gambling Frequency	Fam Outcm Freq
		Coping with the Gambler's Gambling	Fam Outcm Coping
Co-existing issue (gambler or family/whānau/affected other)	Section 4.5.5	Alcohol Use (AUDIT-C)	Co-existing Alcohol
		Drug Use	Co-existing Drug
		Depression	Co-existing Depression
		Suicidality	Co-existing Suicide
		Family and Whānau Concern	Co-exist Fam Concern

Screen category	Practitioner's Guide reference	Screen name	CLIC title
Follow-up (section 6)			
Gambler harm	Section 6.7.1	Gambler Harm	Gambler Harm
Gambler outcome	Section 6.7.2	Control Over Gambling	Gam Outcome Control
		Dollars Lost	Gam Outcm Dollars
		Annual Household Income	Gam Outcome Income
Family/whānau/affected other harm	Section 6.8.1	Awareness of the Effect of the Gambler's Gambling	Family Awareness
		Effect of Gambler's Gambling	Family Effect
Family/whānau/affected other outcome	Section 6.8.2	Gambler's Gambling Frequency	Fam Outcm Freq
		Coping with the Gambler's Gambling	Fam Outcm Coping
Co-existing issue (gambler or family/whānau/affected other)	Section 4.4.5	Alcohol Use (AUDIT-C)	Co-existing Alcohol
		Drug Use	Co-existing Drug
		Depression	Co-existing Depression
		Suicidality	Co-existing Suicide
		Family and Whānau Concern	Co-exist Fam Concern

Brief Gambler Screen

For people screening for their own gambling behaviours, use the following screen for brief interventions (see section 3.7.1). The text in italics gives instructions for what information to enter into CLIC, eg '*Record the total score*'.

Introduction/opening statement: Most people in New Zealand enjoy gambling, whether it's Lotto, track racing, the pokies or at the casino.

Sometimes, however, it can affect our health.

To help us to check your wellbeing, please answer the questions below as truthfully as you are able from your own experience. A 'no' answer can also mean that 'I don't gamble at all'.

(Record the number of positive responses to questions 1 to 4. If there are no positive responses, then record a zero '0'.)

1. Do you feel you have ever had a problem with gambling? **(Only ask if the answer is not obvious.)**
2. **(If the answer to Q1 is yes, ask:)** And do you feel you currently have a problem with gambling?
3. Have you ever felt the need to bet more and more money?
4. Have you ever had to lie to people about how much you gambled?

If you answered yes to any of the above, what would help? (*Do not record response in CLIC.*)

- ☐ I would like some information.
- ☐ I would like to talk about it in confidence with someone.
- ☐ I would like some support or help.
- ☐ Nothing at this stage.

Brief Family/Whānau/Affected Other Screen

For screening people for the impact that another person's gambling problem has had on them, use the **Brief Family/Whānau/Affected Other Screen** (see section 3.7.2). Text in *italics* gives instructions for what information to enter into CLIC, eg '*Record the total score*'.

Introduction/opening statement: Sometimes someone else's gambling can affect the health and wellbeing of others who may be concerned. The gambling behaviour is often hidden and unexpected, while its effects can be confusing, stressful and long-lasting. To help us identify if this is affecting your own wellbeing, please answer the questions below to the best of your ability.

1 **Awareness of the effect of the gambler's gambling**

(Record the number of the response.)

Do you think you have ever been affected by someone else's gambling?

- (0) ☐ No, never. (If chosen, you need not continue further.)
- (1) ☐ I don't know for sure if their gambling affected me.
- (2) ☐ Yes, in the past.
- (3) ☐ Yes, that's happening to me now.

2 **Effect of gambler's gambling**

(Record the total number of positive responses (ticks) between questions 1 and 5.

Record 0 or 6 if no other responses are ticked.)

How would you describe the effect of that person's gambling on you now?

(Tick one or more if they apply to you.)

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

3 **Support requested**

(Do not record response in CLIC.)

What would you like to happen? (Tick one or more.)

- ☐ I would like some information.
- ☐ I would like to talk about it in confidence with someone.
- ☐ I would like some support or help.
- ☐ Nothing at this stage.

Gambler full intervention screens

The gambler full intervention screens comprise the:

- **Gambler Harm Screen**, referred to as the Problem Gambling Severity Index (PGSI) in your contract (see section 4.5.1)
- **Gambler outcome screens** (see section 4.5.2)
- **Co-existing issue screens** (these questions are the same for gamblers and family and whānau (affected others)) (see section 4.5.5).

Text in *italics* gives instructions for what information to enter into CLIC for each screen, eg, '*Record the total score*'.

Gambler Harm (PGSI) Screen

Score the Gambler Harm (PGSI) Screen based on the response of the client/tangata whai ora to each question: never = 0, sometimes = 1, most of the time = 2, almost always = 3. *(Record the total score.)*

- 1 Thinking about the past 12 months, how often have you bet more than you could really afford to lose?
- 2 Thinking about the past 12 months, how often have you needed to gamble with larger amounts of money to get the same feeling of excitement?
- 3 Thinking about the past 12 months, how often have you gone back another day to try to win back the money you lost?
- 4 Thinking about the past 12 months, how often have you borrowed money or sold anything to get money to gamble?
- 5 Thinking about the past 12 months, how often have you felt that you might have a problem with gambling?
- 6 Thinking about the past 12 months, how often have people criticised your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?
- 7 Thinking about the past 12 months, how often have you felt guilty about the way you gamble, or what happens when you gamble?

- 8 Thinking about the past 12 months, how often has your gambling caused you any health problems, including stress or anxiety?
- 9 Thinking about the past 12 months, how often has your gambling caused any financial problems for you or your household?

Gambler Outcome Screen – Control Over Gambling

(Record the number of the response.)

During the past month:

- (1) I have had complete control over my gambling.
Or
(2) I have had some control over my gambling.
Or
(3) I have had little control over my gambling.
Or
(4) I have had no control over my gambling.

Gambler Outcome Screen – Dollars Lost

(Record the response, eg, \$50,000.)

In the last month when you were gambling, roughly what amount of money did you spend on gambling?

This is the total amount of money in dollars that you used on your gambling activity or activities (ie, money you took to gamble with **plus** any additional money you obtained and gambled with such as from cash machines, EFTPOS etc). Ignore any money you won during your gambling sessions.

Dollars spent on gambling: \$.....

Gambler Outcome Screen – Annual Household Income

(Record the number of the response, ie, 1–7.)

- (1) ☐ <\$20,000
(2) ☐ \$20,000–\$30,000
(3) ☐ \$31,000–\$50,000
(4) ☐ \$51,000–\$100,000
(5) ☐ \$101,000–\$200,000
(6) ☐ \$201,000–\$500,000
(7) ☐ \$501,000+

Co-existing Issue Screen – Alcohol Use (AUDIT-C)

(Record the total score.)

One standard drink is 30 mL straight spirits (two nips/shots, one double), a 330 mL can of beer or a 100 mL glass of wine.

- 1 How often did you have a drink containing alcohol in the past year?
(never = 0; monthly or less = 1; two to four times a month = 2; two to three times per week = 3; four or more times a week = 4)
- 2 How many drinks did you have on a typical day when you were drinking in the past year?
(1 or 2 drinks = 0; 3 or 4 drinks = 1; 5 or 6 drinks = 2; 7 to 9 = 3; 10 or more drinks = 4)
- 3 How often did you have six or more drinks on one occasion in the past year?
(never = 0; less than monthly = 1; monthly = 2; weekly = 3; daily or almost daily = 4)

Co-existing Issue Screen – Drug Use

(Record the code for the response: No = 0, Yes = 1.)

In the past 12 months, have you ever felt the need to cut down on your use of prescription or other drugs?

Co-existing Issue Screen – Depression

(Record the total number of positive responses: 0 = no to both; 1 or 2.)

- 1 In the past 12 months, have you often felt down, depressed or hopeless?
- 2 In the past 12 months, have you often had little interest or pleasure in doing things?

Co-existing Issue Screen – Suicidality

(Record the number of the response that best fits.)

Within the last 12 months have you had thoughts of self-harm or suicide?

- (0) ☐ No thoughts in the last 12 months.
- (1) ☐ Just thoughts.
- (2) ☐ Not only thoughts, I have also had a plan.
- (3) ☐ I have tried to harm myself in the past 12 months.

Co-existing Issue Screen – Family and Whānau Concern

(Record the code for the response: No = 0, Yes = 1.)

In the past 12 months, has anyone in your family or whānau worried about your health or wellbeing (including spiritual health)?

Family/Whānau/Affected Other full intervention screens

The Family/Whānau/Affected Other full intervention screens are made up of the:

- Family/Whānau/Affected Other **Harm Screen** (see section 4.5.3) to screen people for the impact another person's gambling problem has had on them
- Family/Whānau/Affected Other **outcome screens** (see section 4.5.4), which the client/tangata whai ora can fill in independently or with the practitioner
- **co-existing issue screens**, which are the same for gamblers and affected others (see section 4.5.5).

Text in *italics* gives instructions for what information to enter into CLIC for each screen; eg, '*Record the total score*'.

Family/Whānau/Affected Other Harm Screen

Introduction/opening statement: Sometimes someone else's gambling can affect the health and wellbeing of others who may be concerned. The gambling behaviour is often hidden and unexpected, while its effects can be confusing, stressful and long-lasting. To help us identify if this is affecting your own wellbeing, please answer the questions below to the best of your ability.

1 Awareness of the effect of the gambler's gambling

(Record the number of the response.)

Do you think you have ever been affected by someone else's gambling?

- (0) ☐ No, never (you need not continue further)
- (1) ☐ I don't know for sure if their gambling affected me
- (2) ☐ Yes, in the past
- (3) ☐ Yes, that's happening to me now

2 Effect of gambler's gambling

(Record the total number of positive responses (ticks) between questions 1 and 5.

Record 0 or 6 if no other responses are ticked.)

How would you describe the effect of that person's gambling on you now?

(Tick one or more if they apply to you.)

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

3 **Support requested**

(Do not record response in CLIC.)

What would you like to happen? (Tick one or more.)

- ☐ I would like some information.
- ☐ I would like to talk about it in confidence with someone.
- ☐ I would like some support or help.
- ☐ Nothing at this stage.

Family and Whānau Ora Outcome Screen – Gambler's Gambling Frequency

(Record the number of the response.)

The statements below are about the person who was gambling at the time you sought help, and about you.

Which of these four statements is true about the person's gambling over the past three months? (Tick **one** box only.)

- (0) ☐ The gambler in my life has not been gambling during the last three months.
- (1) ☐ The gambler in my life has been gambling less during the last three months.
- (2) ☐ The gambler in my life has been gambling about the same as usual during the last three months.
- (3) ☐ The gambler in my life has been gambling more than usual during the last three months.

Family/Whānau/Affected Other Outcome Screen – Coping with the Gambler's Gambling

(Record the number of the response.)

The statements below are about the person who was gambling at the time you sought help, and about you.

Which of these three statements is true about your ability to cope with the person's gambling over the last three months? (Tick **one** box only.)

- (1) ☐ I am coping better with the gambler's gambling than I have in the past.
- (2) ☐ I am coping about the same with the gambler's gambling as I have in the past.
- (3) ☐ I am not coping as well with the gambler's gambling as I have in the past.

Co-existing Issue Screen – Alcohol Use (AUDIT-C)

(Record the total score.)

One standard drink is 30 mL straight spirits (two nips/shots, one double), a 330 mL can of beer or a 100 mL glass of wine.

- 1 How often did you have a drink containing alcohol in the past year?
(never = 0; monthly or less = 1; two to four times a month = 2; two to three times per week = 3; four or more times a week = 4)
- 2 How many drinks did you have on a typical day when you were drinking in the past year?
(1 or 2 drinks = 0; 3 or 4 drinks = 1; 5 or 6 drinks = 2; 7 to 9 = 3; 10 or more drinks = 4)
- 3 How often did you have six or more drinks on one occasion in the past year?
(never = 0; less than monthly = 1; monthly = 2; weekly = 3; daily or almost daily = 4)

Co-existing Issue Screen – Drug Use

(Record the code for the response No = 0, Yes = 1.)

In the past 12 months, have you ever felt the need to cut down on your use of prescription or other drugs?

Co-existing Issue Screen – Depression

(Record the total number of positive responses: 0 = no to both; 1 or 2.)

In the past 12 months, have you often felt down, depressed or hopeless?

In the past 12 months, have you often had little interest or pleasure in doing things?

Co-existing Issue Screen – Suicidality

(Record the number of the response that best fits.)

Within the last 12 months have you had thoughts of self-harm or suicide?

- (0) ☐ No thoughts in the last 12 months.
- (1) ☐ Just thoughts.
- (2) ☐ Not only thoughts, I have also had a plan.
- (3) ☐ I have tried to harm myself in the past 12 months.

Co-existing Issue Screen – Family and Whānau Concern

(Record the code for the response: No = 0, Yes = 1.)

In the past 12 months, has anyone in your family or whānau worried about your health or wellbeing (including spiritual health)?

Gambler follow-up screens

The gambler follow-up screens comprise the:

- **Gambler Harm Screen** (see section 6.7.1)
- **gambling outcomes screens** (see section 6.7.1)
- **co-existing issue screens** (these questions are the same for gamblers and affected others) (see section 4.5.5). Use your judgement about whether you need to use these screens. (You may consider it appropriate to reassess the client/tangata whai ora for co-existing issues during follow-up.)

Text in italics gives instructions for what information to enter into CLIC for each screen, eg, '*Record the total score*'.

Gambler Harm Screen

Score the Gambler Harm Full Screen by the client's response to each question:

never = 0, sometimes = 1, most of the time = 2, almost always = 3.

(Record the total score.)

1. Thinking about the past 12 months, how often have you bet more than you could really afford to lose?
2. Thinking about the past 12 months, how often have you needed to gamble with larger amounts of money to get the same feeling of excitement?
3. Thinking about the past 12 months, how often have you gone back another day to try to win back the money you lost?
4. Thinking about the past 12 months, how often have you borrowed money or sold anything to get money to gamble?
5. Thinking about the past 12 months, how often have you felt that you might have a problem with gambling?
6. Thinking about the past 12 months, how often have people criticised your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?
7. Thinking about the past 12 months, how often have you felt guilty about the way you gamble, or what happens when you gamble?
8. Thinking about the past 12 months, how often has your gambling caused you any health problems, including stress or anxiety?
9. Thinking about the past 12 months, how often has your gambling caused any financial problems for you or your household?

Gambler Outcome Screen – Control over Gambling

(Record the number of the response.)

During the past month:

(1) I have had complete control over my gambling.

Or

(2) I have had some control over my gambling.

Or

(3) I have had little control over my gambling.

Or

(4) I have had no control over my gambling.

Gambler Outcome Screen – Dollars Lost

(Record the response, eg, \$50,000.)

In the last month when you were gambling, roughly what amount of money did you spend on gambling?

This is the total amount of money in dollars that you used on your gambling activity or activities (ie, money you took to gamble with **plus** any additional money you obtained and gambled with such as from cash machines, EFTPOS etc). Ignore any money you won during your gambling sessions.

Dollars spent on gambling: \$......

Gambler Outcome Screen – Annual Household Income

(Record the number of the response. ie, 1–7.)

(1) ☐ <\$20,000

(2) ☐ \$20,000–\$30,000

(3) ☐ \$31,000–\$50,000

(4) ☐ \$51,000–\$100,000

(5) ☐ \$101,000–\$200,000

(6) ☐ \$201,000–\$500,000

(7) ☐ \$501,000+

Co-existing Issue Screen – Alcohol Use (AUDIT-C)

(Record the total score.)

One standard drink is 30 mL straight spirits (two nips/shots, one double), a 330 mL can of beer or a 100 mL glass of wine.

1. How often did you have a drink containing alcohol in the past year?
(never = 0; monthly or less = 1; two to four times a month = 2; two to three times per week = 3; four or more times a week = 4)
2. How many drinks did you have on a typical day when you were drinking in the past year?
(1 or 2 drinks = 0; 3 or 4 drinks = 1; 5 or 6 drinks = 2; 7 to 9 = 3; 10 or more drinks = 4)
3. How often did you have six or more drinks on one occasion in the past year?
(never = 0; less than monthly = 1; monthly = 2; weekly = 3; daily or almost daily = 4)

Co-existing Issue Screen – Drug Use

(Record the code for the response: No = 0, Yes = 1.)

In the past 12 months, have you ever felt the need to cut down on your use of prescription or other drugs?

Co-existing Issue Screen – Depression

(Record the total number of positive responses: 0 = no to both; 1 or 2.)

In the past 12 months, have you often felt down, depressed or hopeless?

In the past 12 months, have you often had little interest or pleasure in doing things?

Co-existing Issue Screen – Suicidality

(Record the number of the response that best fits.)

Within the last 12 months, have you had thoughts of self-harm or suicide?

- (0) ☐ No thoughts in the last 12 months.
- (1) ☐ Just thoughts.
- (2) ☐ Not only thoughts, I have also had a plan.
- (3) ☐ I have tried to harm myself in the past 12 months.

Co-existing Issue Screen – Family and Whānau Concern

(Record the code for the response: No = 0, Yes = 1.)

In the past 12 months, has anyone in your family or whānau worried about your health or wellbeing (including spiritual health)?

Follow-up Family/Whānau/Affected Other screens

The follow-up Family/Whānau/Affected Other full intervention screens comprise the:

- Family/Whānau/Affected Other Harm Screen (see section 6.8.1), a variation on the full Family/Whānau/Affected Other Harm Screen to use in assessing the impact another person's gambling problem is having on your client/tangata whai ora after they have received a full intervention
- Family/Whānau/Affected Other **outcome screens** (see section 6.8.2), which the client/tangata whai ora can fill in independently or with the practitioner
- **co-existing issue screens** (these questions are the same for gamblers and affected others) (see section 4.4.5). Use your discretion to determine whether it is appropriate to reassess the client for co-existing issues during follow-up.

Text in *italics* gives instructions for what information to enter into CLIC for each screen, eg, '*(Record the total score)*'.

Family/Whānau/Affected Other Harm Screen

Introduction/opening statement: When you were seeing our service regularly, you described your awareness of the effect of someone's gambling on you and identified a range of particular effects on you and your family or whānau. I would like to ask you some similar questions to see how your awareness and feelings about the other person's gambling have changed.

1 Awareness of the effect of the gambler's gambling

(Record the number of the response.)

Do you think you have ever been affected by someone else's gambling?

- (1) ☐ I don't know for sure if their gambling affected me.
(2) ☐ It did affect me after we last talked but not any more.
(3) ☐ Yes, that's happening to me now.

2 Effect of gambler's gambling

(Record the total number of positive responses (ticks) between questions 1 and 5. Record 0 or 6 if no other responses are ticked.)

How would you describe the effect of that person's gambling on you now?

(Tick one or more if they apply to you.)

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

Family/Whānau/Affected Other Outcome Screen – Gambler's Gambling Frequency

(Record the number of the response.)

Which of these four statements is true about the person's gambling over the past three months? (Tick **one** box only.)

- (0) ☐ The gambler in my life has not been gambling during the last three months.
- (1) ☐ The gambler in my life has been gambling less during the last three months.
- (2) ☐ The gambler in my life has been gambling about the same as usual during the last three months.
- (3) ☐ The gambler in my life has been gambling more than usual during the last three months.

Family/Whānau/Affected Other Outcome Screen – Coping with the Gambler's Gambling

(Record the number of the response.)

Which of these three statements is true about your ability to cope with the person's gambling over the last three months? (Tick **one** box only.)

- (1) ☐ I am coping better with the gambler's gambling than I have in the past.
- (2) ☐ I am coping about the same with the gambler's gambling as I have in the past.
- (3) ☐ I am not coping as well with the gambler's gambling as I have in the past.

Co-existing Issue Screen – Alcohol Use (AUDIT-C)

(Record the total score.)

One standard drink is 30 mL straight spirits (two nips/shots, one double), a 330 mL can of beer or a 100 mL glass of wine.

1. How often did you have a drink containing alcohol in the past year?
(never = 0; monthly or less = 1; two to four times a month = 2; two to three times per week = 3; four or more times a week = 4)
2. How many drinks did you have on a typical day when you were drinking in the past year?
(1 or 2 drinks = 0; 3 or 4 drinks = 1; 5 or 6 drinks = 2; 7 to 9 = 3; 10 or more drinks = 4)
3. How often did you have six or more drinks on one occasion in the past year?
(never = 0; less than monthly = 1; monthly = 2; weekly = 3; daily or almost daily = 4)

Co-existing Issue Screen – Drug Use

(Record the code for the response: No = 0, Yes = 1.)

In the past 12 months, have you ever felt the need to cut down on your use of prescription or other drugs?

Co-existing Issue Screen – Depression

(Record the total number of positive responses: 0 = no to both; 1 or 2)

In the past 12 months, have you often felt down, depressed or hopeless?

In the past 12 months, have you often had little interest or pleasure in doing things?

Co-existing Issue Screen – Suicidality

(Record the number of the response that best fits.)

Within the last 12 months, have you had thoughts of self-harm or suicide?

- (0) ☐ No thoughts in the last 12 months.
- (1) ☐ Just thoughts.
- (2) ☐ Not only thoughts, I have also had a plan.
- (3) ☐ I have tried to harm myself in the past 12 months.

Co-existing Issue Screen – Family and Whānau Concern

(Record the code for the response: No = 0, Yes = 1.)

In the past 12 months, has anyone in your family or whānau worried about your health or wellbeing (including spiritual health)?

Appendix 2:

Intervention planning tools

Intervention planning tools

Intervention planning tools comprise the:

- **agreed action plan (gambler)** – a possible intervention plan for a gambler
- **agreed action plan (family/whānau/affected other)** – a possible intervention plan for a family or whānau member
- **follow-up agreement** – a sample follow-up agreement.

Agreed action plan (gambler)

Name/ref:.....

My goal(s)

Write down your initial goals or tick from the list below.

1.
.....
2.
.....
3.
.....

Possible goals

- ☐ I will attend our agreed sessions – initially this will be sessions.
- ☐ I will ask my partner/husband/wife to participate by
(eg, authorising you to confirm I am attending sessions; inviting them to attend a session with me in the future)
- ☐ Start a budgeting plan
- ☐ Exclude myself from by
- OR
- ☐ Reduce my gambling to
- ☐ Ready myself to get work

- ☐ Start an exercise plan and carry it out
- ☐ Improve my social life by (eg, rejoining a club I used to belong to)
- ☐ Reduce risk by
(eg, telling my gambling friends I've stopped; having a break to see what stopping is like; staying away from gambling venues even if just going out for a drink)
- ☐ Reduce risk by listing all the triggers that set me off gambling (the times when they are most powerful, and people I may be around) and adding to the list on a regular basis.
- ☐ Avoid these situations that can trigger the gambling (and developing ways to ensure I act straight away to avoid them).
- ☐ Contact a support group if available and attend.
- ☐ Use the Gambling Helpline as another support (both during and after treatment has been completed).
- ☐ Appoint a support person who could provide an independent opinion of my progress following treatment.

Name Phone/contact

Practitioner

I (or the treatment provider) agree to:

- provide help and counselling to assist you to achieve your goal/s
- endeavour to return your calls promptly
- provide you with follow-up information and advice about your progress after treatment.

Planned review dates of goals and progress

☐ Monthly ☐ Two-monthly ☐ Other
(Use new sheet for updating or renewing goals.)

Agreed: (Client/tangata whai ora)

(Practitioner)

Date:

Agreed action plan – family/whānau/affected other

Name/ref:.....

My goal(s)

Write down your initial goals or tick from the list below.

1.
.....
2.
.....
3.
.....

Possible goals

- ☐ I will attend our agreed sessions – initially this will be sessions.
- ☐ I will ask my partner/husband/wife to participate by
(eg, authorising you to confirm I am attending sessions; inviting them to attend a session with me in the future).
- ☐ Start a budgeting plan.
- ☐ Ready myself to get work.
- ☐ Start an exercise plan and carry it out.
- ☐ Improve my social life by (eg, recontacting friends).
- ☐ Appoint a support person who could provide an independent opinion of my progress following treatment.

Name..... Phone/contact.....

Practitioner

I (or the treatment provider) agree to:

- provide help and counselling to assist you to achieve your goal/s
- endeavour to return your calls promptly
- provide you with follow-up information and advice about your progress after treatment.

Planned review dates of goals and progress

☐ Monthly ☐ Two-monthly ☐ Other.....

(Use new sheet for updating or renewing goals.)

Agreed: (Client/tangata whai ora).....
(Practitioner)

Date:

Follow-up agreement

CLIC ID:

We would like to reconnect with you one, three, six and 12 months after our contact finishes. We greatly appreciate you completing this follow-up as we like to know how you are. It also helps us to plan better services.

I agree to receive a telephone call to complete the follow-up screen questions and discuss my progress with a staff member.

☐ Yes

☐ No

(Circle one)

Name:

Signed:

Date:

The best telephone number to use to contact me is:

..... or

Instructions

.....
.....
.....

I would prefer an appointment to complete the questionnaire and discuss my progress with a staff member.

☐ Yes

☐ No

(Circle one)

Name:

Signed:

Date:

Please contact me by phone:

OR at this address:

.....

Please keep in touch and let us know if you change your address.

Thank you.

Appendix 3: Review and assessment tools

The following tools are examples of review and assessment forms you may use as part of your review with a client before closing a full intervention episode:

- the gambler – a sample review and assessment form for a problem gambling client
- family/whānau/affected other – a sample review and assessment form for a family or whānau member
- practitioner – your sample review and assessment form
- support person – a sample review and assessment form for a support person.

Review and assessment tools

Review and assessment form – the gambler

Name/ref:

Overall

1 Your progress

How well would you consider you have achieved your goal/s?

☐ Very well ☐ Quite well ☐ Average ☐ Not well

2 Our performance for you

How well did our service meet your needs when you attended?

☐ Very well ☐ Quite well ☐ Average ☐ Not well

How could we improve?

Thank you – please hand this form to your practitioner.

Review and assessment form – family/whānau/affected other

Name/ref:

Overall

1 Your progress

How well would you consider you have achieved your goal/s?

☐ Very well ☐ Quite well ☐ Average ☐ Not well

2 Our performance for you

How well did our service meet your needs when you attended?

☐ Very well ☐ Quite well ☐ Average ☐ Not well

How could we improve?

Thank you – please hand this form to your practitioner.

Review and assessment form – practitioner

Client's name:

Practitioner's name:

Practitioner's review assessments

How well do you think your client has progressed? (Complete periodic reviews.)

(a) Review

☐ Excellent progress ☐ Good progress ☐ Some progress ☐ Little progress

Comments (brief):.....
.....
.....
.....

(b) Review

☐ Excellent progress ☐ Good progress ☐ Some progress ☐ Little progress

Comments (brief):.....
.....
.....
.....

(c) Review

☐ Excellent progress ☐ Good progress ☐ Some progress ☐ Little progress

Comments (brief):.....
.....
.....
.....

(d) Final review on completion of therapy or exiting service

☐ Excellent progress ☐ Good progress ☐ Some progress ☐ Little progress

Comments (brief):.....
.....
.....
.....

Review and assessment form – support person

Support person’s response at final review (if nominated by the client)

How well do they think the client has progressed since.....
(date accessing service)?

☐ Excellent progress ☐ Good progress ☐ Some progress ☐ Little progress

Comments (brief):.....
.....
.....
.....

Appendix 4:

Flowchart symbols

Figure A.1 gives a guide to the symbols used in the flowcharts in this Practitioner's Guide.

Figure A.1: Guide to flowchart symbols

