Statewide Gambling

Therapy Service

Client experiences of gambling treatment pathways in South Australia: a qualitative analysis

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Client experiences of gambling treatment pathways in South Australia: a qualitative analysis

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for

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Executive Summary

Client experiences of gambling treatment pathways in South Australia: a qualitative analysis

Clients (n = 26) of a range of gambling help services in South Australia took part in interviews and focus groups designed to explore their experiences of attending gambling help services, how they came to be involved in the help service programme and how they progressed in the treatment of their condition over time. Sampling continued until saturation; that is until no new themes or concepts emerged in discussions with the participants. The study was approved by the Flinders Clinical Research Ethics Committee as part of an ongoing longitudinal research programme at Flinders University.

Semi-structured focus groups and interviews were used to collect and document client experiences of gambling help services and to illuminate their perceptions of these treatment or intervention processes. Data was compiled and analysed by two key researchers and condensed into main themes through a collaborative discussion, clarification and coding process.

These emerging themes suggest that there is much to be learnt from the qualitative follow-up of participants of gambling help services that can not necessarily be deduced or gleaned from the routine quantitative data collected during treatment and follow-up processes in the gambling help cycle. Treatment accessibility and the importance of the gambling helpline in the process of linking clients to the services they needed were seen as important issues. Many clients contacted support services as a result of major gambling related crises during which time suicidal thoughts and actions were commonly reported. Clients accessed a range of services and treatment types and identified the importance of being able to connect with support staff and explore a range of co-related factors, through the treatment process, that linked to their gambling problem. The relationship between the client and support worker is crucial to engagement, retention in treatment and the success of treatment programme.

An exploratory model of treatment pathways for people with gambling problems was constructed around the findings for this study. Clients suggested that they need flexible options for accessing help when they the need arises and that service providers need to be able to respond to the uniquely individual circumstances and situations of prospective clients. More pro-active screening of people accessing the wider health care system is recommended as a way of identifying potential problem gamblers before they reach crisis point with their gambling and to enable early intervention strategies to be implemented to reduce the likelihood of adverse events occurring due to clients' gambling problems.

Peter Harvey & David Smith
SGTS 2010

Client experiences of gambling treatment pathways in South Australia: a qualitative analysis.

1. Introduction

Problem or pathological gambling from a mental health perspective is defined by the American Psychiatric Association DSM-IV as "…persistent and recurrent maladaptive gambling behaviour that disrupts personal, family and vocational pursuits" [1]. Estimates of the prevalence of problem gamblers in the Australian adult population average around 2% across the States and Territories [2]. Similar rates in the United States and Canada estimated 1-2% of the adult population met the diagnostic criteria for pathological gambling [3]. Prevalence estimates are expected to rise further with increasing accessibility to gambling activities and legalization of new forms of gambling [4].

The availability of different gambling treatment modalities has also increased in recent years [5]. Psychological treatments for problem gambling include peer-support approaches such as Gamblers Anonymous (GA) modeled after Alcoholics Anonymous; self-guided approaches such as self-help workbooks based on a cognitive behavioural model; and cognitive behavioural therapies (CBT) including a focus on cognitive distortions such as the illusion of control over gambling, and behavioural therapy. There has also been a parallel development of pharmacological treatments of problem gambling [6]. Also eclectic treatment approaches involving a mixture of client centered, cognitive behaviour orientated, solution focused counselling approaches have been well established [7].

Corresponding to a rise in gambling treatment availability has been an increase in gambling treatment outcome studies reported in scientific journals [8, 9]. However, there are inconsistencies in results between these studies and limited empirical support for specific types of treatment [10, 11]. Although controlled studies are often considered the 'gold standard' in terms of rigor, they tend not to account for heterogeneous groups, which are often the reality in community-based gambling help services. Development of an evidence base for problem gambling treatments needs to include complementary methodologies that seek to understand better the treatment experiences of individual problem gamblers.

Considering that problem gamblers often have co-occurring conditions such as psychosocial stressors and that they may be engaged in concurrent treatments at any given time presents difficulties in reliably identifying causal relationships between treatment and outcomes. At a system level, the ability to evaluate a gambling help service is also somewhat limited due to the diversity of client presentations and treatment pathways. These situations present significant challenges for quantitative approaches in attempting to evaluate treatment efficacies, treatment effectiveness, and service outcome data.

This report presents findings from interviews conducted with clients of gambling help services in South Australia. Whilst not for inferential purposes, this study will enable insights into individual experiences of various forms of interventions for problem gambling. Research grounded in the experiences of problem gamblers will inform further research and quality improvement processes.

2. Method

Participants

Recruitment of participants for this study occurred through a general invitation to managers of gambling help services in metropolitan and rural regions of South Australia. Twenty-six clients of gambling help services participated in the study: nine (9) clients from the Statewide Gambling Therapy Service (SGTS) who had completed psychological treatment or dropped out before completion; eleven (11) members and one (1) support person from Pokies Anonymous (PA); four (4) clients from Relationships Australia Gambling Help Service and one (1) client from UnitingCare Wesley Gambling Help Services. Nine of the participants were male and seventeen female; thirteen were aged between 27 and 52 years; and thirteen were aged 53 and over. Participants were provided with an information sheet describing the present study and written consent was obtained from each participant. The study was approved by the Flinders Clinical Research Ethics Committee. A summary of each gambling help service follows.

Statewide Gambling Therapy Service (SGTS).

The Statewide Gambling Therapy Service provides services in the metropolitan area in Salisbury, Port Adelaide and the Southern Area of Adelaide, as well as in the following rural areas: Mount Gambier, Riverland, Berri, Murray Bridge, Port Pirie, Port Augusta, Port Lincoln, Whyalla and Ceduna. The treatment program offers both one-on-one therapy, and group therapy and employs cognitive behavioural approaches with an emphasis on eliminating the urge to gamble which is often out of control in problem gamblers. An inpatient program at Flinders Medical Centre is also available.

Relationships Australia (RA).

The Gambling Help Service team members at Relationships Australia (SA) are health care professionals with qualifications in counselling and social work and experience in helping people with gambling problems and relationship difficulties. Services include: working out if a person has a gambling problem, assessing family relationships, help with the impact of gambling on family relationships, financial counselling, and education by community seminars/ workshops, training for service providers, client support and information groups.

UnitingCare Wesley.

UnitingCare Wesley provides gambling and financial counseling in metropolitan and rural regions of South Australia.

Pokies Anonymous (PA).

Pokies Anonymous is a self-help peer support organisation based on similar principles to Alcoholics Anonymous, although, as the name suggests, PA is about helping people abstain from poker machine gambling only. PA has regular meetings in Adelaide that are anonymous and incorporate the 12 Step recovery goals.

Procedure

In order to explore a diversity of experiences and perceptions from problem gamblers, purposeful sampling was utilised to provide a reasonable representation of treatment modalities and geographical locations in South Australia. Using an iterative process between data collection and preliminary analyses a number of participants within each treatment modality were invited to participate in one-on-one interviews based on developing themes. Some participants were also selected using convenience sampling due to practical considerations within gambling help agencies. Sampling continued until theoretical saturation had been achieved were no new or relevant data seemed to emerge for each of the categories of information established from preliminary analyses [12].

In-depth semi-structured interviews were conducted using one-on-one interviews and a focus group to enable perspectives at both the individual and group level. Semi-structured interviews allow the researcher to explore perceptions of individuals and how they give meaning to, or interpret their experiences. They are also flexible, allowing the researcher to follow the lead of the interviewee into how they construct particular phenomena, pursue emergent themes and thus gain new insights [13]. With a paucity of qualitative research into the experiences of problem gamblers the semi-structured format provided the opportunity to explore new domains and subsequently inform theory development while retaining focus on the central research topic.

One-on-one interviews lasted between 33 and 64 minutes and were conducted in person with participants from SGTS, Relationships Australia, and UnitingWesley. Each interview commenced with a ‘grand tour’ question “tell me about your experiences with gambling”? Five open ended questions were designed to guide interviews including “what are some of your experiences with gambling help services in South Australia?” “what made it easy or difficult with support/treatment services?” and “how can treatment/support services improve for problem gamblers?” Data analyses from earlier interviews also informed the design of further open ended questions in later interviews. Interviews were scheduled in advance at a designated time and location. The sessions were recorded using a digital voice recorder and transcribed verbatim.

A semi-structured focus group was also conducted with members of Pokies Anonymous to enhance participation from individuals who would normally talk about their experiences in a familiar group structure. This allowed the researcher access to the kind of discussions that might happen at one of their regular meetings and minimise artificial opinions that may be more readily offered in one-to-one interviews [14]. The focus group was scheduled in advance at a time the group would have their regular meeting and in their usual location. Two researchers facilitated the group. The backgrounds of each facilitator were presented and no participants reported difficulties engaging in a research discussion with any researcher. The session was recorded using a digital voice recorder and transcribed verbatim.

Analysis and validation

To preserve the inductive strength of qualitative research, we focused more on explaining the dynamics of problem gambling and treatment interventions that emerged from the words of the participants and less on descriptive analyses or frequencies of words [15]. Also, as there were no preconceived theories relating to processes in clients experiences with problem gambling help services prior to commencement of this research a grounded theory approach was employed. A systematic analysis of interview data using grounded theory enabled the researchers to gain a better understanding and synthesise the experiences of participants [16, 17]. Each transcript was independently read by the two primary researchers (DS and PH) and using open coding initial major categories of information were created. Each primary researcher also read all memos of the other researcher to maintain a common conceptual framework. Both researchers also participated in decision making regarding theoretical saturation with initial categories.

Further data analysis was conducted by a primary researcher (DS) in close consultation with other researchers using axial coding to develop categories around the open code categories. Types of categories were causal conditions, strategies, intervening conditions, and consequences. The final step comprised selective coding where a conceptual model was developed that related categories to one another and surrounded core phenomenon (initial open codes). QSR-Nvivo software for the analysis of qualitative data was used to manage the coding of transcripts.

3. Results

Participant characteristics

Socio-demographics and gambling characteristics of participants are presented in Table 1. To assess for any associations between participant characteristics and gambling help service type based on primary treatment modality, Wilcoxon rank-sum tests were used for continuous variables and chi-square tests for categorical variables. With four of the demographic variables (marital status, highest education level, employment, and living arrangement) and duration of problem gambling there were low or zero cell counts when cross-classified with service type. To increase cell counts for comparative purposes, categories were combined within each variable. There were no statistically significant differences between SGTS and non-SGTS participants on all characteristics.

Table 1. Characteristics of SGTS and non-SGTS participants [a]

Characteristics	SGTS (n =9)	non-SGTS (n =17)
Age, median, (75th - 25th percentile)[b], y	52 (61 - 47)	54 (64 - 49)
Male sex	5 (56)	4 (24)
Marital status		
Married/defacto	4 (44)	6 (35)
Single	2 (22)	4 (24)
Separated/divorced	3 (33)	6 (35)
Widowed	0	1 (6)
Highest education level		
Primary school	0	1 (6)
High school	5 (56)	11 (64)
TAFE/Trade qualification	4 (44)	2 (12)
University degree	0	3 (18)
Employment		
Full-time	3 (33)	3 (18)
Part-time	2 (22)	5 (29)
Unable to work	2 (22)	2 (12)
Retired	2 (22)	5 (29)
Student	0	2 (12)
Living arrangement		
Alone	2 (22)	7 (41)
Couple with dependent children	3 (33)	3 (18)
Couple without dependent children	2 (22)	3 (18)
Single parent	0	2 (12)
Living with parents	1 (11)	0
Sharing	1 (11)	2 (11)
Primary form of gambling		
Gaming machines	8 (89)	17 (100)
Horse racing	1 (11)	0
Duration of gambling problem		
< 2 y	1 (11)	2 (12)
2 - 5 y	4 (44)	2 (12)
> 5 y	4 (44)	13 (76)

[a]Data are expressed as No. (%) unless otherwise indicated. Wilcoxon rank-sum tests were used for continuous variables and χ^2 tests for categorical variables.

[b]Inter-quartile range (IQR) comprises 50% of ages between the 25th and 75th percentile.

Clients' experiences of gambling treatment pathways

Category: Treatment accessibility

To explore participants' experiences and perceptions of the effectiveness of gambling help services, interviews commenced with an open or 'grand tour' question. Participants began by talking about their experiences leading up to their contact with a gambling help service. Emergent themes included participants experiencing a crisis situation and associated suicidal ideation and behaviours as proximal events to seeking help from a gambling help service. Seven of the 26 participants (27%) from four independent gambling help agencies, including a self-help support group and counseling service, stated the following:

> …but I reached where I honestly think some people would just about have committed suicide you know it's so bad. So serious…for people like me. But you have to be able to get to people before they get to that stage, there has to be a better understanding that gambling is no different to drug addiction or chronic drinking.(S1)[1]
>
> …it was October last year that I actually ended up in hospital suicidal through gambling…(S6)
>
> Oh, I ended up in hospital a couple of times because I did something silly…(W1)
>
> I got really close to suicide many, many times…and I thought I've got to do something…(P4)
>
> Um, at the end of July I attempted suicide. I was taken by ambulance to the (name of hospital) hospital and stayed there in intensive care for 2 days, then I was detained and sent to (name of inpatient mental health unit) where I spent 8 days. I first heard of the (SGTS) program there through a social worker and psychiatrist. (S7)
>
> Yeah finding money and paying my debts off that I incurred through gambling. We had money in the bank, savings, but I didn't want to cause my family any more pain…until I got to the stage where I just couldn't take anymore and I was feeling suicidal…(R4)
>
> I knew my family would know where I was, I was out somewhere gambling, and I, standing at the traffic lights, I had been for a walk to some other venues just finding myself looking at people in the venues and just looking at the surroundings and feeling really disappointed with myself and I was quite sad and standing at the traffic lights the buses and trucks were zooming past and I thought I could just walk out in front of one of those and all this unhappiness would be over..(S9)

[1] Participants coded by service type followed by interview number: S= SGTS; W= UnitingCare Wesley; P= Pokies Anonymous; R= Relationships Australia

Often in crisis, most participants' initial contact with a gambling help service involved Gambling Help Line (GHL). Following counseling from GHL was referral to a diversity of services:

> My daughter kept saying to ring the Gambling Helpline, yeah mum here's the number… . (W1)

> Gambling Helpline put me on to SGTS. The lady she actually spent quite a bit of time talking to me…she must have assessed that I was at a critical stage okay and that I was genuinely looking for help, not just ringing in because I'd gone in that day and spent too much whatever it was, you know. (S1)

> About half way a long, I realised I was in trouble, that it was out of control, and I rang the gambling helpline and I was referred to the Anglicare program… . (P4)

> It was just through one of those gambling hotlines (Gambling Helpline), I just rang them and they put me onto that person (Relationships Australia, South Australia). (S3)

> I actually rang the helpline, the gambling helpline and they gave me one mob (WesleyUniting Church) down at the Port. I tried ringing them and apparently they've closed down. Well they are still at the Port but they weren't doing the gambling side of it anymore and so they put me on to Statewide Gambling. (S2)

Following a description of events preceding contact with a gambling help service, participants then talked about their experiences and perceptions of help services. These experiences were discussed in terms of geographical location, service operating hours, continuity and rapport with counsellors and therapists. One participant living in the country discussed her experiences in accessing gambling help services in terms of resources including limited trained professionals:

> Yeah I mean like if you look at the gambling thing, I mean we've had pokies for a long time now, and now people like SGTS are only just getting here, you know like and they have been around for a while. Why does it take so long for these services to get to the country?...But yeah I think people down here, like the centers who work with people like me, and especially us with mental illness, yeah we should really be connected with people who specialise with gambling addiction itself, not a band-aid approach. (S6)

Another key area in terms of service accessibility was operating hours of some gambling help services:

> And it is really upsetting me actually… this (gambling help service) is business and this is the times you work and this is the times you don't work and it doesn't work like that for gamblers. You know it is better to be on call and be there for someone, especially when they are feeling really vulnerable… (P10)

> …it's really hard because it was only open 9-5 where I was having troubles getting there, and I went there twice probably to see them and that, it was just, I

just couldn’t get the time off of work in the end…I just tried to do it myself for a while, just slowly trying to work it out, yeah but it’s a little bit hard.(S3)

And I went there for a while (gambling help service) and I gave up gambling for months or more, no 100 days, I gave up gambling for 100 days… And then I stopped going there, because I started working and I couldn’t get to the appointments… So it just sort of fizzled out a bit… (R1)

On accessing services the following participant emphasized the importance of receiving professional help at the time of self-initiated contact:

…because really if you make contact with the counseling service, you want immediate treatment, because if you go even a few hours afterwards, to cope with the, whatever drove you to actually contact them in the first place, you deal with that by going back to gambling. (S8)

Similarly, the need for ongoing accessibility following treatment to prevent relapse:

Yeah because I suppose if it, well it would be a help if somebody is feeling vulnerable and they really don’t want to have a relapse but they want to talk to somebody. But they can’t always get into their therapist, and that is another thing too I think, that the door should always be open for people to come back. (S9)

Other factors associated with treatment accessibility included a client’s sense of rapport with their counselor or therapist. The quality of an established rapport was expressed in terms of commitment to their treatment provider:

…she is there to support me and I can call her if I get tempted, and the feeling of being guilty if I do go. Like I did, I went and I felt awful telling her that I went…it’s the worst feeling in the world when you hit the pokies and you’ve lost all your money or most of the money and you feel so small…(W1)

Sometimes people like to please their counselor…I’ve embellished some things I’ve said to a therapist. (R2)

It made it more, a bit of a challenge where you’re trying to prove to someone yeah I can do it. You go there and they say how did you go and your like yeah no worries, I haven’t been since last week and it sort of gave me a bit more motivation to actually try to just to beat it sort of thing yeah. (S3)

Yep I reckon I am totally committed to it. I am putting all my energies and thoughts into other things like wife, children, work. I look forward to coming here and seeing (counsellor). It has been two weeks and I think I was ready to come and see (counsellor) again because I have had a bit of guilt lately as I said. (R4)

Continuity with the same therapist/counselor was also a key factor for most participants to effective rapport building:

> I was going along quite well with the chap (counselor) and I turned up one day for an appointment and I was told he was no longer with the service. I was given another counselor, she got down to all that was wrong with me was that my inner child was hurting and after three weeks I thought I've had enough of that and stopped going. (PA4)

> …I know I've got someone that I can go and talk to rather than make a phone call. I feel familiar with him, I feel comfortable with him rather than just speaking to a stranger on the phone, and them more or less trying to just talk me out of going to gamble (S7)

Most participants felt that accessibility to problem gambling help services could be improved by advertising and engagement with other health service providers:

> I think pamphlets should be made available to doctors so that doctors can actually give them to their patients…I think some stuff should be available in the venues, I think there should often be the odd poster around…coz a pokie person doesn't see a little card, they don't. I think there should be some yeah, some section given that's actually visible to you (S6)

One participant felt that problem gambling was not publicly acknowledged as a serious health problem like other conditions such as drug and alcohol addiction:

> You see because gambling is so accepted as part of entertainment you have a real big problem you see. Because that is how I took it as entertainment, something where I went out took $25 with me, spent an evening having fun, laughing, winning a bit, I can afford $25 see. It is not a stigmatised thing as drug addiction is now or drinking now has become. Gambling has to become the same because it destroys families, it has got to have a different label on it to what it has now okay. It is not, it is a respected thing...it is a very soul-destroying destructive thing the same as, it destroys families, it destroys children, it destroys husbands and wives, it destroys whatever. It puts people in financial situations that sometimes they can never repay. I know one guy who lost his unit okay, then the next step was, this was years and years ago, and I couldn't understand at that stage why, how could he keep on doing what he did. That's because people accept gambling as something that is okay and it isn't. (S1)

Another participant felt problem gambling was already stigmatized:

> So there is a lot of stigma around it and it is hidden, very much hidden, but I got the same feeling from talking to those people as I do in the small country towns. In the small country towns it is hidden as well and I think that would be one of the, the most important things would be what we have started to do in the metropolitan area, removing the stigma, bringing it out in the open more, acknowledging that it is a problem but its not necessarily a shameful thing to do. And yeah just bringing it out into the open more, but how you go about doing that I'm not too sure. (S8)

Category: Treatment modality

All participants discussed benefits and shortcomings of attending gambling help services. Problem gambling interventions offered by the various services were primarily based on psychological therapy and the provision of specialized counseling services. Participants' experiences from engaging in some form of help for their problem gambling are discussed in terms of treatment modality. This provided an opportunity to conceptualize how individuals may have benefited, or otherwise, from specific modes of intervention. Some participants who had been treated as outpatients with a form of cognitive behavior therapy called exposure therapy spoke about treatment benefits in terms of their urge to gamble:

> …like probably a couple of years ago I used to just get the urge and you'd just jump in the car, grab the wallet and get in the car and go. Now you sort of think about it, maybe I should just not, just hang off for a bit… just sit there and go ah it will be alright, and then I think I will just sit here for a while…you just forget about it…(S3)
>
> Rather than avoid, which I have tried to do at home, rather than avoid going and playing the pokies, facing the feelings that I want to play and knowing now that if I stay there long enough, the urge to play will drop, like a panic attack. I know, I have panic attacks and I know when I get them that it will go away. (S7)
>
> I had no real desire to gamble, it was great because I had put a fair amount of energy into doing the task down in Adelaide, and it actually got me to a point where I could sit in a club with a cup of money and I didn't spend it. (S6)

An inpatient gambling treatment program also using exposure therapy provided the opportunity for one participant to focus on her treatment and not be distracted by other stressors that were current in her life:

> Well the …program that I went through, the inpatient program and I found being able to go into hospital allowed me to totally concentrate on me and my problem and devote my whole time to it and, where as if I had, the one on one is quite good. It, not everybody wants to go into hospital and I can understand that especially when it says mental health ward, but for me doing it one on one, other things would have got in the way… (S9)

Some participants experienced less favourable outcomes following an attempt at cognitive behavior therapy:

> … I didn't get to acquire an understanding of CBT…I had relapses…(found it) beneficial in the short term but wasn't ready to take it seriously. Didn't end up a permanent thing for me… it's a whole lot of thought processes required to overcome problem gambling. (R2)
>
> I actually did cognitive therapy as well probably about 18 months ago and it was the same for me. Like I don't know if I was ready to stop gambling then…I don't think I was like strong enough in myself to be able to do that and so I maybe lasted 5 weeks and then off…back gambling. So for me it didn't work.(PA9)

One participant who received counselling talked about a need to address other psychosocial stressors in parallel to gambling related problems:

> …now I am sort of trying to make a whole lot of little changes in other areas as well, so it's not just one this time…the depression and all the other stuff never really got dealt with properly…(R1)

Individual motivation or commitment to treatment was perceived as essential for successful recovery. Commitment to a treatment may initially arise from firstly admitting to one-self of a gambling problem:

> Once a person has admitted that they have a problem they will find help and that will ease their mind. If the person does not admit they have a problem, it doesn't matter what you do, you won't help them… Once they have done that, they can access help and it would help them.(S4)

In most interviews participants discussed the role of support groups in dealing with problem gambling:

> So I think this group is the foundation and then use other adjuncts if you need to. (PA4)
>
> …to know you're not alone…all participants get something out of it. (R3)
> I think it is important the people that are members of this group we don't need to convince everyone, everyone knows where everyone has been. We all know what it feels like…(PA4)
>
> …it (support group) helped me, because it was easier, a bit easier, because I had the problem relating to some people one on one. With a group it's sort of not quite so intimidating, so that was helpful for me.(R1)

On completion of treatment some discussed the need for follow-up support particularly at times of vulnerability to a lapse or relapse:

> And when I stop seeing (therapist), if I don't feel quite ready to stop seeing him, I am going to try and get help from somewhere, so I can actually go and speak to somebody face to face, just to have a chat, otherwise if things get worse at home, or anything happens and I feel stressed or something, just so I know I have someone to fall back on as a crutch, that I can go and speak to, rather than take money from somewhere and go play the pokies, because if I started again I wouldn't stop. (S7)

4. Emergent theory of problem gambling treatment pathways

Figure 1 provides a visual representation of the links between gambling treatment accessibility, treatment modalities, and community awareness of gambling issues. Problem gambling (A) is proposed to involve both the consequences of gambling behaviour and social conditions. The contrasting effects of social isolation due to

limited community awareness and stigmatization, and psychosocial stress operate as positive feedback systems resulting in a decreasing potential for self-referral to a treatment service over time. With minimal supports and increasing emotional disturbances, the problem gambler may reach a critical threshold where a crisis situation eventuates.

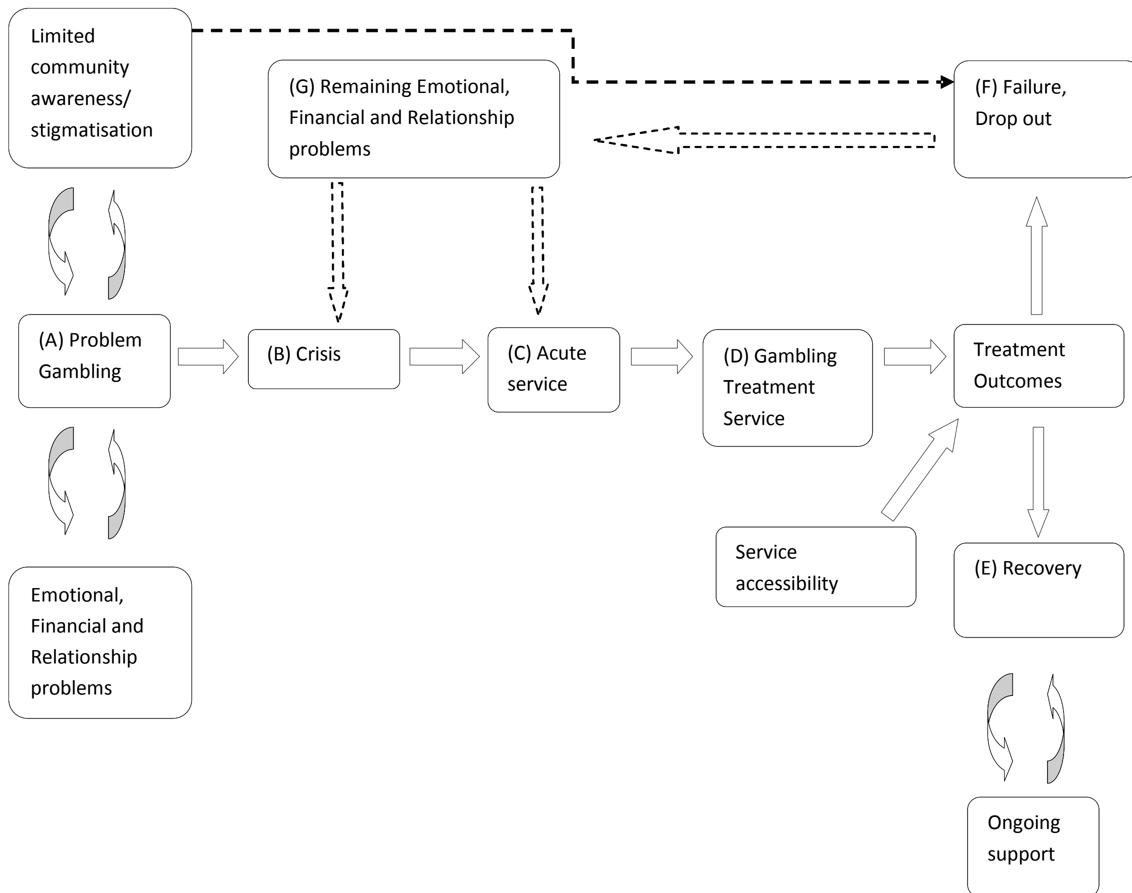

FIGURE 1 A theory of gambling treatment pathways

Crisis situations (B) for the individual problem gambler are often characterised by intense periods of emotional disturbance which may include suicidal ideation and behaviours. During these periods the person will either directly seek assistance from a readily available service such as a helpline or receive intervention from an acute health service (C) such as an inpatient mental health facility as a result of suicidal tendencies. In response to the crisis situation the client is then referred to a gambling treatment modality (D) without any formal assessment of underlying psychological disturbances relating to the gambling behaviours. This process of referral may impact on treatment outcomes resulting in treatment success (E) or treatment failure and treatment drop out (F).

Treatment success or recovery is not an endpoint in itself as other dynamic systems emerge in this realm of the individual's experiences. Often problem gamblers in recovery tend to engage in social networks that act as support systems in maintaining their achieved goals with gambling behaviours. The strong social connections that

develop at this stage are a contrast to the experiences of isolation often encountered in the preliminary stages of Figure 1 or pre-gambling treatment engagement. These connections provide individuals with a sense of belonging in a non-judgemental environment and an outlet for sharing their experiences.

Treatment outcomes are, at least partly, dependent on the degree of suitability of the treatment modality for the individual's needs. Also, as the symptoms of the crisis episode begin to subside following acute service intervention the person begins to reinstate their pre-crisis routines such as vocational and family pursuits. This may conflict with their gambling help treatment in terms of accessibility, for example an inability to attend appointments during business hours. Further, as a result of stigmatization associated with problem gambling, accessibility is further diminished due to factors relating to service operating hours. The following extract provides insight into one client's experiences in terms of accessibility and perceived stigmatization:

> Yeah I think if it was easier to get access to appointments and that, I probably would have gone probably more sort of thing, but it's just, it's even like I was taking the times that I worked sort of those hours and I was trying to get time off work, but I was trying to find an excuse every week why I could take time off work and I didn't really want to say that I have a gambling problem to the boss coz we deal with a lot of cash and that when we are away. I didn't want him to start thinking oh you're a gambler and you have all this money in your hands all the time, so that was a bit of a worry that one and I didn't really want to tell anyone I've got a bit of a gambling problem, so when I go away I look after all the money from what we do. And yeah so I think wanting to really know that, so it was getting harder to make excuses, like a doctor's appointment, a dentist appointment, I found hard as well. It would have been easier if I could have gone at night probably, like go there at seven o'clock or so, knock off work and go out there after work. (S3)

Often following treatment failure or treatment drop out the problem gambler continues to experience emotional disturbances and financial and relationship problems which may precipitate a further crisis and/or contact with an acute service or helpline. This cyclical pattern comprising of the elements 'crisis', 'acute service contact', 'gambling treatment', and 'treatment outcomes' in terms of failure or drop out is analogous to the revolving door syndrome often encountered with individuals suffering a chronic mental illness.

5. Discussion

The initial research questions for this study were framed to provide flexibility to explore phenomenon related to problem gambling treatment and based on the assumption that they had not previously been asked of problem gamblers in South Australia. Semi-structured interviews and a focus group were conducted with treatment seeking problem gamblers in South Australia and were analysed using qualitative methods. Major categories that broadly characterized effective interventions were gambling help service accessibility and treatment modality. Within each category a number of themes emerged including the importance of continuity and rapport with a therapist/counsellor, social support and community awareness. An emergent theory of gambling treatment pathways was developed which demonstrated the complex and fluid interrelationships between categories and themes.

Implications of the findings from this investigation and previous research include the need for routine screening of patients suspected of having a gambling problem or as part of a suicide risk assessment. On diagnosis of a gambling problem clinicians could then motivate the patient to contact a gambling help service. Findings from this study support previous empirical studies that have identified a significant association between problem gambling and suicidal ideation and behaviours [18-20]. Routine screening for problem gambling in community health settings such as medical centers could also incorporate an initial assessment to identify appropriate treatment modalities for individuals.

In summary, findings from this investigation suggest that treatment outcomes are, at least partly, dependent on the degree of suitability of the treatment modality for the individual's needs and contingent upon a wide range of factors that may or may not pre-dispose individuals to compliance to treatment. Interviews highlight the fact that the archetypal progression of clients through problem recognition, help seeking, participation in treatment and ongoing relapse prevention is more likely to be the exception rather than the rule. In short, our current understanding of a client's journey to, through and beyond treatment that may be constructed from extensive quantitative and longitudinal data does not provide a truly accurate picture of the diverse factors, stimuli and motivations that actually drive client help seeking behaviour.

Qualitative analysis provides a more detailed view of the treatment process grounded in the experiences of problem gamblers. Also, the qualitative inquiry illuminates our understanding of client behaviour and the need to match treatment modalities to the specific needs of clients.

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