AUT UNIVERSITY GAMBLING RESEARCH CENTRE

PROBLEM GAMBLING - BARRIERS TO HELP SEEKING BEHAVIOURS

Provider Number: 467589

Agreement Numbers: 303177 / 00 & 01

FINAL REPORT

10 September 2008

Prepared for:
The Monitoring Team
HealthPAC
Ministry of Health
Private Bag 1942
DUNEDIN

Authors:
Dr Maria Bellringer
Justin Pulford
Professor Max Abbott
Ruth DeSouza
Dr Dave Clarke

ACKNOWLEDGEMENTS

This report has been prepared by the Gambling Research Centre, National Institute for Public Health and Mental Health Research, School of Public Health and Psychosocial Studies, Faculty of Health and Environmental Sciences, Auckland University of Technology, Private Bag 92006, Auckland 1142, New Zealand.

The authors are highly appreciative of, and thank, Gareth Edwards for coordinating and managing the first phase of the project. Gratefully acknowledged are Ruth Herd who provided advice to ensure that kaupapa Maori research was conducted, and to Laurie Morrison, Papa Nahi and Lana Perese who were facilitators of focus groups. Additionally, the authors express their appreciation of the service providers (with especial thanks to the Gambling Helpline) and other key stakeholders who generously gave of their time to participate in the focus groups and workshops and to assist in recruitment of participants for the survey phase of the project. Sincere thanks go to the recruitment and interviewing team: Jeremy Williams, TongJing (Lucy) Lu, Priscilla Clarke and Papa Nahi, and to Nick Garrett for biostatistical advice. Professor David Hodgins provided invaluable advice and peer review at key stages of the project; his input is highly appreciated. Finally, but not leastly, acknowledgement is made of all the participants who generously gave of their time and valuable knowledge to participate in telephone, face-to-face or internet surveys.

CONTENTS

LIST OF TABLES

LIST OF FIGURES

EXECUTIVE SUMMARY

Background

In New Zealand, as elsewhere, only a small proportion of problem gamblers seek formal help for their gambling problems. In particular, Pacific peoples appear to be significantly under-represented relative to general population prevalence estimates from the 1999 national survey (Abbott & Volberg, 2000). There also appears to be male under-representation, especially in the case of new Maori clients, and an over-representation of females and Pakeha/Europeans seeking help for someone else's gambling (Ministry of Health, 2006). Thus, increased understanding of the motivations and barriers for help-seeking behaviours is required.

In March 2006, the Gambling Research Centre at Auckland University of Technology was commissioned by the Ministry of Health to conduct the research project *Problem gambling - Barriers to help seeking behaviours.* The aim of the project was to describe and understand barriers and enablers to help-seeking, and the experiences when seeking help, of people experiencing gambling harm and of their families/whanau.

Methodology

An international and national literature review relating to health care access and utilisation (including alcohol and other substance use disorders) and of help-seeking by problem gamblers and their families (including barriers and enablers to, and relevance of, services) was conducted.

Four focus groups with a total of 30 key stakeholders knowledgeable in the areas of problem gambling and/or access to health care services were held. Focus groups were semi-structured to elicit detailed discussion around: factors influencing service access; relevance of services; specific barriers and enablers to treatment seeking; cultural aspects in relation to barriers and enablers to treatment-seeking, in particular Maori, Pacific and Asian; gender considerations in relation to barriers and enablers to treatment seeking; and optimal ways to investigate the topic of help-seeking.

The information obtained from the literature review and focus groups was used to design surveys for gamblers (including problem gamblers) and their families. These surveys and the methodology were then refined at two workshops (with key national and international stakeholders) prior to being used.

Structured surveys were conducted with gamblers currently seeking help (n=125), family/ whanau (of problem gamblers) currently seeking help for themselves or for a gambler (n=32), and general population gamblers (including problem gamblers) not currently seeking help (n=104). Semi-structured interviews were also conducted with five Maori problem gamblers, one Korean problem gambler and one Korean family member of a problem gambler.

All surveys examined enablers and barriers to help-seeking behaviours, knowledge of treatment services, and past treatment experiences. Participants in the help-seeking samples (gambler and family/whanau) were recruited via referral from a specialist helpline and completed either a telephone- or internet-based survey. The general population participants were recruited via advertisement, word-of-mouth or outside selected gambling venues and completed a survey by telephone, over the internet or in-person. All semi-structured surveys

were completed in-person with participants recruited via problem gambling treatment services.

Results

Literature review

There are intrinsic and extrinsic barriers to accessing health care. Intrinsic barriers include: procrastination, attitudes, stigma and shame, and self-efficacy. Extrinsic barriers include: gender, age, living in a rural area, acceptability and appropriateness of services, cultural issues, attitudes of practitioners and need factors.

Cultural factors influence problem gambling behaviour, perceptions of problems, help-seeking pathways and options. It is important to identify the pathways and trajectories of help-seeking so that family, friends and communities can provide support, and efforts at self-efficacy and self-recovery can be supported. Wider community campaigns and enlisting social networks and community leaders can also help to reduce denial, stigma and shame.

Focus groups

Various themes relating to help-seeking behaviours were identified. These included:

- Defining problem gambling: the threshold by which someone's gambling becomes a problem is blurred and the delay in recognising a problem can lead to delays in seeking help.
- Crisis: this can be instrumental in allowing recognition of a problem and motivating help-seeking.
- Stigma and shame: these two issues were both seen to be clearly linked to problem gambling and were seen as a central barrier to seeking help.
- Disclosure and confidentiality: these were particularly important barriers in 'small world' communities, especially for close knit communities such as Maori and Pacific and for small communities such as for Asian migrants.
- Help-seeking journey: the pathway that people take when deciding to seek help varies with the individual but with several commonalities such as the complexities of problem recognition, the individual response to the problem, and the fact that families and friends can either help or hinder help-seeking behaviours.
- Obstacles on the help-seeking path: often other problems co-exist with problem gambling - the problems may be prioritised by the gambler, the gambling may be perceived to have benefits that are more important than the problems and finally, problem gambling counselling services may be viewed in a negative light, for a variety of reasons.
- Awareness and accessibility of problem gambling services: a significant barrier appears to be a lack of awareness as to the problem gambling services that are available, followed by the accessibility of those services (such as opening hours).
- Culture, gender and age: there are some specific important issues that need to be considered in relation to different cultures (including age-related considerations) and genders, though many barriers and enablers to help-seeking are common to all.

Surveys

From a list of 15 possible enablers, the option 'financial problems' was most often identified as either a factor in (82%), or the primary reason for (35%), help-seeking by the helpline gambler sample. When presented with the same list, gamblers in the general population also identified 'financial problems' as the option most likely to influence (90%), or be the primary

reason for (50%), help-seeking behaviour. No other enabler received the same level of support across both samples, although options indicative of psychological distress, a desire for change or a relationship issue were identified as important secondary factors.

From a list of 22 possible barriers, the options 'believed didn't have a problem and didn't need help', 'wanted to resolve the problem on own or were too proud to seek help' and 'felt ashamed for self or family' were most often identified as either a factor in (42%, 78% and 73%, respectively) or the primary reason for (19%, 21% and 15%, respectively), *not* seeking help by the helpline gambler sample. Gamblers in the general population also identified these three options as a likely (87%, 84% and 84%, respectively) or primary (25%, 15% and 20%, respectively), barrier more than any other listed option.

Concerns about confidentiality when contacting a treatment service, and about the manner in which treatment services respond to help-seekers, were also evident in the helpline gambler sample. Over a third of participants (35%) identified both as a barrier in their help-seeking decision. Approximately two-thirds of the general population sample expressed corresponding beliefs.

Participant knowledge of specialist problem gambling services, other than the Gambling Helpline, was far from exhaustive. Over one third of participants in the helpline gambler sample had not heard of the Problem Gambling Foundation (38%) or Gamblers Anonymous (34%) and nearly one half had not heard of the Salvation Army Oasis Centres (47%). The knowledge rates were lower in the general population sample with 70% not having heard of the Salvation Army Oasis Centres, 58% not having heard of the Problem Gambling Foundation and 46% not having heard of Gamblers Anonymous. Knowledge of self-help strategies was low across both samples (23% and 21%, respectively). It was of note, however, that all of the helpline sample and 88% of the general population sample knew of at least one specialist problem gambling treatment service available to them. Thus, whilst knowledge of the range of specialist problem gambling services was relatively limited, the majority of participants knew of at least one service they could contact if considered necessary.

Just under half of the helpline gambler sample (46%) reported having sought formal or informal assistance for a gambling-related problem on at least one prior occasion, as did 24% of the general population sample. In both cases, the reported source of assistance most often involved counselling or some form of specialist treatment for a gambling problem. When asked to state how 'useful' the assistance received had been, 45% of the helpline gambler sample and 52% of the general population sample provided a response indicative of a negative service experience. Furthermore, when asked to say whether they had obtained the help they sought, 42% of the problem gambling sample and 60% of the general population sample reported that they had not.

The structured and semi-structured survey data revealed few gender- or ethnic-specific considerations with respect to enablers or barriers to help-seeking; however, this was possibly due to limitations in participant recruitment. Data pertaining to family/whanau members of problem gamblers was equally limited due to low sample sizes.

Discussion

The project findings indicate that help-seeking for a gambling problem primarily occurs following a crisis event, is accompanied by significant psychological distress and is most likely to involve some form of financial loss or hardship. Specialist help-seeking may also be motivated by a failure to achieve the required assistance elsewhere and may be one of the

final steps, rather than a first step, in the help-seeking journey. The primary barriers to help-seeking for a gambling problem appear to be intrinsic to the individual and consist of pride, shame and problem denial. However, knowledge of the range of specialist services available to problem gamblers and their family/whanau is not great, the treatment process is not well understood, and people who have previously sought specialist assistance often report quite a negative experience. All of these factors are likely to impede timely help-seeking in the problem gambling treatment sector.

Recommendations

Improving the rate of help-seeking amongst problem gamblers and the family/whanau of problem gamblers may best be achieved by attention to the following three areas:

1. Encourage earlier help-seeking behaviours

The overarching recommendation is to encourage problem gamblers to seek formal or informal assistance at an earlier stage, i.e. before a crisis point is reached. Key means of achieving this goal would include: raising problem awareness, normalising help-seeking activities and raising awareness of available supports (both specialist and non-specialist).

2. Increase the range and accessibility of specialist and non-specialist supports

The greater the range of specialist and non-specialist supports available, and the more accessible they are, the more likely it is that an individual with a gambling-related problem will find help. Key means of facilitating this outcome include: increasing the available range of non-specialist support, establishing clearer pathways from non-specialist to specialist support services, de-mystifying the specialist treatment process, and increasing the availability of specialist support.

3. Increase the effectiveness of specialist and non-specialist supports

There is little point increasing the range and accessibility of specialist and non-specialist supports if those provided are ineffective in reducing gambling-related harm. Accordingly, robust evaluation of specialist and non-specialist supports currently provided or planned for implementation is required. The importance of this recommendation is supported by the relatively high proportion of survey respondents who described previous help-seeking experiences in negative terms or who reported not receiving the help they sought.

Gains in these areas are most likely to be facilitated by the use of targeted social marketing strategies, opportunistic early intervention initiatives and the wider promotion of self-help resources and mechanisms. The effectiveness of specialist and non-specialist support services currently available to New Zealanders with a gambling-related problem, and services considered for future implementation, also need to be examined via independent evaluation. The ultimate aim would be to identify a gold standard range of evidence-based specialist and non-specialist interventions and to ensure their widespread availability across New Zealand.

Finally, due to limitations in participant recruitment, this study was unable to meaningfully examine enablers and barriers to help-seeking for the family/whanau of problem gamblers. The data pertaining to Pacific and Asian problem gamblers or family/whanau members of problem gamblers was equally limited for the same reasons. Accordingly, further investigation is warranted in these areas.

1. BACKGROUND

In New Zealand, as elsewhere, only a small proportion of problem gamblers seek formal help for their gambling problems. In particular, Pacific peoples appear to be significantly under-represented relative to general population prevalence estimates from the 1999 national survey (Abbott & Volberg, 2000). There also appears to be male under-representation, especially in the case of new Maori clients, and an over-representation of females and Pakeha/Europeans seeking help for someone else's gambling (Ministry of Health, 2006). Thus, increased understanding of the motivations and barriers for help-seeking behaviours is required.

In March 2006, the Gambling Research Centre at Auckland University of Technology was commissioned by the Ministry of Health to conduct the research project *Problem gambling - Barriers to help seeking behaviours.*

The aim of the project was to describe and understand barriers and enablers to help-seeking, and the experiences when seeking help, of people experiencing gambling harm and their families/whanau.

1.1 Research design

1.1.1 Objectives

The primary objectives of the project were to:

- Examine the experiences of gamblers and their family/whanau when seeking and obtaining help for gambling-related problems
- Identify barriers and enablers to help-seeking in relation to gender and ethnicity (obtaining information from problem gamblers that have not accessed treatment services is a critical feature)
- Identify factors that influence treatment services accessibility and relevance

The research was conducted in two phases.

Phase One

- Literature review
- Focus groups with key stakeholders including service providers, community and industry representatives

Phase Two

- Surveys carried out with gamblers, including problem gamblers, and their families and whanau to establish the barriers and enablers to help-seeking from their experience.

1.1.2 Phase One

The first phase of the project involved two core components.

Literature review

A review of relevant national and international literature pertaining to:

- Health care access and utilisation, including alcohol and other substance use disorders
- Help-seeking by problem gamblers and their families/whanau including barriers and enablers to, and relevance of, services

Information obtained from the literature review was used to help develop the survey instruments for use in Phase Two.

Focus groups

Focus groups were conducted with key stakeholders including treatment providers, researchers and others knowledgeable in the areas of problem gambling or access to health care services. The purpose of the focus groups was to elicit views on factors that influence service access, relevance and satisfaction and also to identify specific barriers to treatment seeking and the extent to which these apply to high risk groups such as Maori, Pacific and Asian peoples. Additionally, information was sought on the applicability of services to males and females within these high risk groups as well as to any other groups that currently under-utilise services.

Information obtained from the focus groups was also used to help develop the survey instruments and methodology for use in Phase Two.

In addition, two workshops were held with key stakeholders during this initial phase of the research project. The purpose of these workshops was to critique and ensure the appropriateness of the proposed Phase Two methodology and survey instruments. Participants included members of the research team, and national and international researchers, service providers and others knowledgeable in the areas of problem gambling or access to health care services.

1.1.3 Phase Two

The second phase of the project involved surveying gamblers (including problem gamblers) and family members/whanau of problem gamblers. Survey participants were recruited via the following:

- National telephone helpline callers and website visitors
- Maori, Pacific and Asian clients from mainstream and ethnic-specific face-to-face counselling services
- Gamblers, including problem gamblers, from the general population including gambling venue patrons

2. RESEARCH METHODOLOGY

2.1 Ethics approval

Phase One of the project proposal was submitted to the AUT Ethics Committee (AUTEC) which is a Health Research Council accredited human ethics committee. All participant materials (i.e. information sheet and consent form) and other relevant documents were submitted to AUTEC, which considers the ethical implications of proposals for research projects with human participants. AUT is committed to ensuring a high level of ethical research and AUTEC uses the following principles in its decision making in order to enable this to happen:

Key principles:

- Informed and voluntary consent
- Respect for rights of privacy and confidentiality
- Minimisation of risk
- Truthfulness, including limitation of deception
- Social and cultural sensitivity including commitment to the principles of the Treaty of Waitangi/Te Tiriti O Waitangi
- Research adequacy
- Avoidance of conflict of interest

Other relevant principles:

- Respect for vulnerability of some participants
- Respect for property (including University property and intellectual property rights)

The ethics approval for Phase One of this project was granted on 8 May 2006 (Appendix 1).

Phase Two of the project proposal was submitted to the Multi-Region Health and Disability Ethics Committee which is a Health Research Council accredited human ethics committee. All participant materials (i.e. survey questionnaires, information sheets and consent forms) and other relevant documents were submitted to the Committee, which considers the ethical implications of proposals for research projects with humans where participants are asked questions in relation to their health.

The ethics approval for Phase Two of this project was granted on 21 December 2006 (Appendix 2).

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

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

In addition:

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

2.2 Cultural awareness

Cultural safety, integrity and appropriateness of the research process were key considerations throughout, particularly in relation to kaupapa Maori research processes. In this regard, Ruth Herd (initially from Hapai te Hauora Tapui Ltd and currently with the University of Auckland) was consultant to this project in terms of research design and responsibility for kaupapa Maori research and participant recruitment. In addition, the researchers involved in the project also included Laurie Morrison and Papa Nahi (both Maori), Lana Perese (Samoan) and Ruth DeSouza (Goan). These researchers were able to provide additional guidance to the research process in terms of their respective cultural perspectives. They also facilitated the relevant focus groups (i.e. Laurie and Papa facilitated the Maori focus group, Lana facilitated the Pacific focus group and Ruth facilitated the Asian focus group).

2.3 Literature review

The literature review was conducted through the following means:

- Electronic bibliographic indexes accessed via on-line database searches
- Specialist libraries accessed via web-based searches and searches through personal collections
- Grey literature accessed via personal collections and through professional and informal networks
- Professional and informal networks contacted via personal communications

Electronic bibliographic indexes

A search of on-line databases accessible through the Auckland University of Technology and Massey University library systems was conducted to locate potentially relevant literature.

Each literature search on each database accessed varying numbers of articles. There were varying degrees of overlap between the databases. A full list of titles and/or abstracts was obtained from each search. For titles or abstracts that appeared to be relevant to this project, full text publications were accessed electronically and reviewed.

Specialist libraries

Various gambling-related organisations and government departments have websites which include searchable databases and/or libraries, or which detail gambling-related publications and reports. These websites were searched for literature relevant to the project. Any material that appeared to be relevant was downloaded and reviewed.

The research team also has access to substantial personal libraries on access to help/care services and other related subjects. These collections contain reports and articles that have not been published in mainstream literature plus publications that are difficult to obtain. They also include pre-publication reports and articles from a variety of sources. Where relevant, these materials were utilised for this project.

Grey literature

Grey literature, being unpublished works not widely available to the general public, was accessed by two means. Firstly, through the personal library collections detailed previously and secondly, via professional and informal networks, detailed below.

Professional and informal networks

The research team has a wide network of professional colleagues within the gambling and health care fields. This includes researchers, treatment/service providers, public health specialists and government officials. Specific people, where appropriate, were contacted who were considered possibly to have information that would be useful to the project.

2.4 Focus groups

Focus groups were conducted with treatment providers, members of the advisory groups for the Gambling Research Centre and the Centre for Asian and Migrant Health Research (both Auckland University of Technology research centres) and other key stakeholders with an interest/knowledge in the area of problem gambling and help-seeking behaviours. It was intended that Maori and Pacific treatment service users would participate in the focus groups. However, in the event, service users declined to take part. There was a specific focus on Maori, Pacific and Asian representation in the focus groups since these populations are most at risk for developing problem gambling behaviours. Four focus groups were held within the Auckland region.

Focus group	Participants	Total No.	No. problem gambling treatment providers	Gender
1	Members of Gambling Research Centre Advisory Group	5	2	3 male 2 female
2	Maori service providers	10	7	2 male 8 female
3	Members of the Centre for Asian and Migrant Health Research Advisory Group, Asian problem gambling service providers and Asian health care providers	6	2	5 male 1 female
4	Pacific service providers	9	3	5 male 4 female

The participants in the focus groups were selected by either their current involvement in the advisory groups or from their identification by the research team as problem gambling service providers and/or key stakeholders (i.e. providers of other services such as alcohol and drug treatment providers, budget advice services, community and health workers, gambling industry personnel and health promotion advisors). The focus groups were held between 23 May and 1 June 2006.

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

- Factors influencing service access
- Relevance of services
- Specific barriers and enablers to treatment seeking
- Cultural aspects in relation to barriers and enablers to treatment-seeking, in particular Maori, Pacific and Asian
- Gender considerations in relation to barriers and enablers to treatment seeking
- Optimal ways to investigate the topic of help-seeking

The focus groups were digitally recorded for subsequent data transcription and analysis. A systematic qualitative analysis of similarities and differences in participants' perceptions was

conducted to interpret the data from the transcribed recordings in relation to the original research questions. Emerging trends and patterns were grouped according to themes. Responses were ordered into more specific categories for comparative purposes to determine possible cultural differences. A 'picture' of the barriers and enablers to help-seeking for problem gamblers and their families/whanau emerged as the data analysis proceeded. Qualitative analyses were undertaken using NVivo (Version 2) software.

2.5 Surveys

2.5.1 Design

The second phase of the project involved surveys of gamblers (including problem gamblers) and their families/whanau to ascertain information in relation to barriers and enablers to help-seeking for gambling problems, knowledge of services and current and previous help-seeking attempts. Several different types of survey were conducted to assess a range of participants who were currently either seeking, or not seeking, help.

The surveys were developed during the first phase of the research and were designed to elicit responses in the key research question areas, i.e. enablers to accessing treatment, barriers to accessing treatment, knowledge of services, and current and previous help-seeking behaviours. The questions pertaining to barriers and enablers to treatment were designed to cover the key issues that had arisen from the literature review and the key stakeholder focus groups. For the gambler groups, the nine-item Problem Gambling Severity Index (PGSI) from the Canadian Problem Gambling Index was used to ascertain at-risk and problem gambler status. The PGSI was selected as it is brief, is being used internationally and nationally (e.g. in the recent New Zealand National Health Survey) and as it allows classification of non-problem gambler, low risk gambler, moderate risk gambler, and problem gambler[1]. It was thought that this classification would be useful if barriers and enablers to treatment seeking varied dependent on how problematic a person's gambling had become.

Recruitment of participants occurred over a six-month period. This included a three-month follow-up interview with telephone helpline participants in order to assess forms of help sought and obtained subsequent to the initial help-seeking telephone contact, motivations and barriers to accessing that treatment and exploration of the satisfaction with the quality and quantity of help received.

This part of the project had three main approaches (numbers presented were those expected to be achieved):

- Survey of problem gamblers currently seeking help
  - 100 participants recruited from national telephone helpline callers: to participate in an initial telephone interview (Appendix 3) and a three-month follow up telephone interview (Appendix 4).
  - 75 participants recruited from national telephone helpline website users: to participate in an internet survey (survey format similar to that detailed in Appendix 3).
  - 15 participants, of Maori, Pacific and Asian ethnicity (five of each), intended to be recruited from Salvation Army Oasis Centres, Problem Gambling Foundation mainstream and Asian Services, and Tupu (Pacific Island addictions treatment

[1] Score 0 = non-problem gambler, 1-2 = low risk gambler, 3-7 = at-risk gambler, 8-27 = problem gambler.

service): to participate in a face-to-face in-depth semi-structured interview (Appendix 5).

- Survey of family/whanau (of problem gamblers) currently seeking help for themselves or a gambler
  - 100 participants recruited from national telephone helpline callers: to participate in an initial telephone interview (Appendix 6) and a three-month follow-up telephone interview (Appendix 7).
  - 75 participants recruited from national telephone helpline website users: to participate in an internet survey (survey format similar to that detailed in Appendix 6).
  - 15 participants, of Maori, Pacific and Asian ethnicity (five of each), intended to be recruited from Salvation Army Oasis Centres, Problem Gambling Foundation mainstream and Asian Services, and Tupu (Pacific Island addictions treatment service): to participate in a face-to-face in-depth semi-structured interview (Appendix 8).
- Survey of general population gamblers (including problem gamblers) not currently seeking help
  - 100 participants recruited from the general population (recruitment outside gambling venues, via advertisements, flyers and word of mouth): to participate in a telephone or face-to-face interview[2] (Appendix 9) or in an internet survey (survey format similar to that detailed in Appendix 9).

The survey approach allowed for information to be obtained from current help-seekers (either for themselves or for someone else's gambling problems) and from gamblers who were not currently seeking help (but who may have been problem gamblers). The numbers were chosen to be sufficient to allow for analyses by gender and ethnicity. Additionally, the semi-structured interviews with Maori, Pacific and Asian clients were designed to provide an in-depth insight into the issues relating to help-seeking behaviours for these population groups which are known to be at high risk for developing problem gambling but which also tend to under-utilise formal sources of help.

2.5.2 Recruitment

Recruitment at service provider locations was performed by the counsellors at those organisations. All potentially suitable clients calling the national telephone helpline service in the recruitment time frame (22 January to 24 March 2007[3]) were asked by helpline staff to participate in the research, until the time frame expired. A contact name and telephone number for each client agreeing to participate in the research were provided to the researchers by the helpline. Interviewers on the research team subsequently telephoned the participants and again asked if they would like to take part in the survey. A minimum of three call backs were made if the participant was not available at the previous call. All interviewed participants were invited to participate in the three-month follow-up survey which commenced on 30 April 2007.

[2] A telephone interview was conducted with those responding to advertisements and word-of-mouth recruitment. A face-to-face interview was conducted with participants recruited outside gambling venues; this was originally intended to be a telephone interview, however, recruitment of participants for a subsequent telephone interview proved to be unsuccessful methodologically. Instead, participants preferred to take part in a face-to-face interview at the time they were approached by the recruiters.

[3] This was a slightly shorter recruitment period than planned (nine weeks instead of 13 weeks), due to the launch of a national problem gambling social marketing campaign on 25 March 2007 and the ensuing resources required by the helpline to deal with the effects from the campaign.

Recruitment for national telephone helpline website users was via information posted from 8 February to mid-May/mid-July[4] 2007 on the helpline's home and resources web pages and via a posting on their 'talking point forum' chat page. In addition, a media release was issued alerting people to the internet surveys.

Recruitment of participants for the in-depth interviews was by convenience sampling (due to the small numbers required) from face-to-face counselling agencies, which took place from 19 February to 27 July 2007. As with recruitment via the helpline, the counsellors asked potentially suitable clients if they would like to participate in the research. For those clients who agreed, a contact name and telephone number were passed to the researchers by the counsellors. Interviewers subsequently telephoned the participants to agree a time and location for the interview. Participants were offered a $20 petrol voucher as compensation for their time.

Recruitment of general population gamblers was undertaken by the following means:

- From 6 March until mid-May 2007, the research team recruited outside gambling venues (pubs with electronic gaming machines; participants were offered a $10 petrol voucher as compensation for their time). Venues were selected based on having the maximum of 18 machines and, if possible, if they were in an area that also contained other pubs with machines. In addition, the location of the venues selected varied around the Auckland region to ensure an ethnic mix in the recruited participants. The venue's permission was obtained before recruitment commenced outside the premises. Permission was sought from a total of 18 venues, all provided consent.
- Advertisements asking for participants for the survey were placed in local and national newspapers in two batches. The first round of advertisements was placed for a week, commencing 26 February 2007. The second round of advertisements was placed for a week from 11 April 2007 (this coincided with the national problem gambling social marketing campaign). Advertisements in Chinese media were translated into Mandarin. An example of the advertisements used is presented in Appendix 10. The newspapers featuring the advertisements in the first batch (and second batch, where indicated) included:
  - Auckland City Harbour News
  - Central Leader
  - Dominion Post (both batches)
  - Manukau Courier (both batches)
  - New Zealand Chinese Herald
  - New Zealand Herald (both batches) (together with a feature article on the first occasion)
  - North Shore Times (together with a media release)
  - Southland Times
  - The Aucklander
  - The Press
  - The Western Leader

Additionally, advertisements were placed in:

  - FM90.0 Chinese Radio
  - Triangle TV Community Notice Board
  - Woman's Weekly Magazine
  - World TV Magazine (Chinese and Korean)

- Placement of flyers in community venues. Flyers asking for participants in the project were placed in various locations across the Auckland region during March

[4] Mid-May for gamblers, mid-July for family/whanau.

and April 2007. As with the commercial advertisements, flyers detailed a contact telephone number (to take part in a telephone interview) and the Gambling Research Centre web address for the internet survey.

- On 20 February 2007, the researchers' contacts were asked to let their networks know about the survey (telephone and internet) and to encourage people to participate by a word-of-mouth 'snowball' technique.

The general population gambler internet survey was available on the Gambling Research Centre's website from 5 February to 22 May 2007.

2.5.3 Process

All survey interviews were carried out by the research team. Maori, Samoan and Chinese researchers were available to conduct ethnically matched face-to-face interviews. A professional Korean interpreter was also available to assist with face-to-face interviews, where appropriate. Telephone interviews were generally a maximum of 15 minutes duration. Face-to-face in-depth semi-structured interviews took no more than one hour. Internet surveys took no more than 10 minutes to complete.

On 25 January 2007, prior to the conduct of telephone surveys, the interviewers (n=5) participated in a 'client risk training' session to raise their awareness of the potential types of behaviour that might be exhibited by the participants during the telephone survey, and how to deal with potential crisis situations. The training was delivered by a senior counsellor from the national telephone helpline.

The exclusion criterion for all participants was those in crisis or otherwise emotionally or psychologically unable to take part in the research.

2.5.4 Participation

Survey of problem gamblers currently seeking help

One hundred and seventy-nine participants were recruited by the helpline counsellors during the nine-week recruitment period. From that group, a total of 97 interviews were successfully conducted, representing 54% (97/179) of the eligible number and 97% (97/100) of the target number of completed interviews. Forty-six percent (n=82) of the group requested not to take part in the survey when they were contacted by the interviewer, had provided an incorrect telephone number or did not answer the phone at the times the interviewer called.

Of the 97 participants who took part in the initial survey, 85 agreed to the three-month follow-up of which 45 were successfully contacted (46% of the initial sample). The remaining 40 participants who did not take part in the follow-up survey were not contactable within the scheduled time frame for the project or subsequently declined to participate when contacted.

Twenty-eight gamblers completed the internet survey. This represented 37% of the target sample of 75 participants.

Six in-depth semi-structured interviews were conducted with participants recruited via face-to-face counselling services (Problem Gambling Foundation mainstream and Asian services).

This included five Maori and one Korean participant. The target of 15 interviews was not met due to inadequate referrals from the counselling services[5].

Survey of family/whanau (of problem gamblers) currently seeking help

Thirty-two participants were recruited by the helpline counsellors during the nine-week recruitment period. From that group, a total of 14 interviews were conducted, representing 44% (14/32) of the eligible number and 14% (14/100) of the total number of target interviews. Fifty-six percent (n=18) of the group requested not to take part in the survey when they were contacted by the interviewer or did not answer the phone at the times the interviewer called.

Of the 14 participants who took part in the initial survey, 12 agreed to the three-month follow-up of which seven were successfully contacted (50% of the initial sample). The seven participants who did not take part in the follow-up survey were not contactable within the scheduled time frame for the project or subsequently declined to participate when contacted.

Eighteen family/whanau of problem gamblers completed the internet survey. This represented 24% of the target sample of 75 participants.

One in-depth semi-structured interview was conducted with a Korean participant recruited via a face-to-face counselling service (Problem Gambling Foundation Asian service). The target of 15 interviews was not met due to inadequate referrals from the counselling services[6].

Survey of general population gamblers

A total of 104 interviews was conducted with general population gamblers recruited outside gambling venues (n=54), through response to advertisements and word-of-mouth contacts (n=18), or via the internet survey (n=32).

2.5.5 Data analysis

Quantitative data

Responses to telephone interviews and general population face-to-face interviews were recorded by the interviewers on paper. Internet surveys were captured via the specialised online survey package, Survey Monkey. All quantitative data were entered into Survey Monkey and exported into the SPSS 14.0 statistical package.

For the help-seeking samples (problem gamblers and family/whanau of problem gamblers) the telephone and internet data were combined in order to increase the power of subsequent analyses. This resulted in a 'helpline' sample of 125 (97 telephone participants and 28 internet participants) and a 'family/whanau' sample of 32 (14 telephone participants and 18 internet participants). The 'general population' sample (n=104) already comprised participants recruited via the telephone, internet or from outside venues.

Analyses were primarily descriptive; however, a number of non-parametric (chi-square, Mann-Whitney U, Kruskal-Wallis) tests were employed to examine possible sub-sample differences based on age, gender and ethnicity. Logistic regression was also employed to

[5] A total of seven referrals was received, one of whom subsequently declined to participate in the interview process when contacted by a member of the research team.
[6] Only one referral for a family/whanau interview was received during the entire recruitment period.

examine potential differences between the 'helpline' and 'general population' samples. Open-ended response questions were analysed through thematic coding of the responses.

Qualitative data

In-depth semi-structured interviews were digitally recorded, transcribed and thematically analysed using NVivo7 software. This process involved coding of the data, with codes clustered according to similarity. Responses were ordered into specific categories for comparative purposes to determine possible cultural and gender differences. A 'picture' of the topic areas relating to barriers and enablers to help-seeking behaviours emerged as the data analysis proceeded.

3. RESULTS

3.1 Literature review

3.1.1 Introduction

Research shows that each problem gambler is likely to directly affect at least five other people (Productivity Commission, 1999; Sullivan, Arroll, Coster, Abbott, & Adams, 2000). These estimates are thought to be conservative (Rankine & Haigh, 2003); a study by Abbott and Volberg (1999) found that more than one-in-four adults knew someone among their family or friends whom they thought had a gambling problem. Understanding the barriers to help-seeking behaviour for problem gamblers and their families/whanau is an essential step towards ensuring that services are accessible and appropriate, and to improve the mental health of the community. Families are thought to be significant pathways to help-seeking (Rothi & Leavey, 2006). Recognising the need for help with gambling problems and making the decision to seek treatment are influenced by demographic factors (such as age, gender, ethnicity, level of education) and attitudinal factors (perception of the helpfulness of services, perceived stigma and shame, and health literacy).

This review of the national and international literature available on barriers to help-seeking behaviour for problem gamblers and their families/whanau includes general help-seeking, health care access and utilisation (including alcohol and other substance use disorders and mental health problems) and help-seeking by problem gamblers and their families/whanau including barriers to, and relevance of, services. Gender differences and cultural aspects are highlighted. Literature which offers generic models of help-seeking processes is included and is followed by an outline of the two models which are the most widely known to understand health care change and access (Callagahan & Herzog, 2006; Jerrell et al. 2002; Sutton, 2001): the Transtheoretical Model of Change (Prochaska, DiClemente, & Norcross, 1992) and the Social Behavioural Model (Aday & Andersen, 1974; Andersen, 1995). Specific intrinsic factors are presented within the Transtheoretical Model of Change. Extrinsic barriers consist of predisposing, enabling and need factors, according to the Social Behavioural Model. Because both models do not cover all aspects of the change process (Booth et al., 2000; Evans & Delfabbro, 2005; Hajema et al., 1999; Sutton, 2001; West, 2005), the Network-Episode Model which emphasises the importance of social networks and events (Pescosolido, 1992; Pescosolido, Gardner, & Kubell, 1998) is included to explain the dynamic interaction between intrinsic and extrinsic factors

Personal, socio-cultural and institutional reasons for delays in seeking help are presented. The significance of gender differences and cultural aspects is also discussed. Research questions regarding the implications for barriers to help-seeking for problem gamblers and their families are proposed. Finally, recommendations regarding addressing issues of under-utilisation and barriers to help-seeking are presented. In conclusion, changing barriers and social policies can encourage health care access and utilisation for people with various substance abuse and mental health problems including addictive behaviours such as problem gambling.

3.1.2 Health care utilisation and access

There is a substantial body of international and local research on health care utilisation and access. Ethnicity and gender have been considered extensively in this regard (Loue, 1999) and it is evident that both health care utilisation and health care access are multidimensional concepts. A variety of conceptual frameworks have been developed to guide utilisation and access research including demographic, social structural, social psychological, family resource, community resource and organisational models. None of these approaches is adequate, on its own, to explain variations in service use. Consequently, a number of investigators have combined individual models such as the Transtheoretical Model (Jackson et al., 2003) and the Social Behavioural Model with types of outpatient services (Jerrell et al., 2002) to examine access to health care, health services utilisation and consumer satisfaction. Others have focused on particular aspects including health care seeking processes and determinants of health care seeking behaviour. There are also numerous models of behaviour change that endeavour to explain why people participate in health programmes or utilise services and how participation can be increased. There are varying degrees of empirical support for these different models across a wide range of populations, health problems and services.

From the foregoing, it is evident that major elements of access include availability, accessibility, organisation of services, affordability and acceptability. Consumer satisfaction refers to attitudes toward the quantity and quality of care actually received. Satisfaction, as well as utilisation, can be regarded as outcome indicators of access. Access can be defined as the degree of fit between the health care consumer and the health care system (Penchansky & Thomas, 1981). In addition, there is growing emphasis being accorded not only to utilisation aspects of access and gaining entry into services but also broadening models of access to include processes and outcomes (Cormack, Ratima, Robson, Brown, & Purdie, 2005).

Removing barriers to health care access and utilisation for addiction interventions may have long-term economic and social benefits. For example, a review of economic studies in the United States (McCollister & French, 2003) showed that the greatest unique economic benefit of treatments for alcohol abuse and illicit drug use was avoided criminal activity. Reduced need for health care services was an additional economic benefit. Furthermore, from a study of the total population of African-American and white women using North Carolina (US) public mental health services in 1997 (Jerrell, Wieduwilt, & Macey, 2002), the costs of fitting patterns of care with consumers' needs may not be significantly greater than generic services which do not tailor programmes to their needs.

In New Zealand, culturally appropriate interventions for Maori with problems associated with alcohol and substance use are being encouraged, developed and supported by treatment services (Huriwai, 2002; Robertson et al., 2001). Extended family (whanau) and relationships are important key concepts in treatment (Huriwai, Robertson, Armstrong, Kingi, & Huata, 2001). In one study (Huriwai, Sellman, Sullivan, & Potiki, 1998), a large number of socially disadvantaged Maori in dedicated Maori alcohol and drug treatment services stayed in treatment longer and were more satisfied with treatment than a comparable group of Maori in non-dedicated services. The problem seems to be that many minority cultural group members who have problems are not getting the treatment available because of intrinsic and extrinsic barriers such as shame, stigma, wanting to handle problems on one's own and transportation to services.

3.1.3 Models of change for health care

Having examined issues of health access and utilisation, models of health care change and access, ways of conceptualising intrinsic and extrinsic factors in the models are now described. Intrinsic factors refer to personal emotions, cognitions and behaviour including shame, fears, motivation and treatment readiness (Cancer Prevention Research Centre, 2000a; Jessup, Humphreys, Brindis, & Lee, 2003). Extrinsic barriers are objectively defined and are usually socially located. In addition to diagnostic criteria and practical limitations such as accessibility, they include the attitudes and beliefs of social groups and of treatment providers (Jessup et al., 2003). Integration of findings from the literature, using the models as conceptual frameworks is also detailed.

Transtheoretical Model

Among researchers and practitioners in the health field, the most popular model related to intrinsic factors is the Transtheoretical Model of Change (TTM) (Prochaska et al., 1992). It focuses on the intentional decision-making behaviours of individuals and consists of five stages (Cancer Prevention Research Centre, 2000a, 2000b):

- *Precontemplation*: The stage at which there is no intention to change behaviour in the foreseeable future. People may be in this stage because they are uninformed or under-informed about the consequences of their behaviour or they may have tried to change a number of times and become demoralised about their ability to change. Both groups tend to avoid reading, talking or thinking about their high risk behaviours. They are often characterised in other theories as resistant or unmotivated, or as not ready for health promotion programmes which are often not designed for such individuals and are not matched to their needs.
- *Contemplation:* The stage in which people are intending to change in the next six months. They are more aware of the benefits of changing but also acutely aware of the costs. This balance between the costs and benefits of changing can produce profound ambivalence that can keep people stuck in this stage for long periods of time. This phenomenon is often categorised as chronic contemplation or behavioural procrastination. In addition, people in the contemplative stage are not ready for traditional action oriented programmes.
- *Preparation:* The stage in which people are intending to take action in the immediate future, usually measured as the next month. They have typically taken some significant action in the past year. These individuals have a plan of action such as joining a health education class, consulting a counsellor, talking to their physician, buying a self-help book or relying on a self-change approach. These are people that could be recruited for action-oriented programmes such as smoking cessation, weight loss or exercise programmes.
- *Action*: The stage in which individuals modify their behaviour, experiences or environment in order to overcome their problems. Action involves the most overt behavioural changes and requires considerable commitment of time and energy.
- *Maintenance*: The stage in which people work to prevent relapse and consolidate the gains attained during action. For addictive behaviours this stage extends from six months to an indeterminate period past the initial action.

Although conventional views assume that denial occurs at the precontemplation stage, research evidence supports early recognition of a drinking problem. For example, consistent with previous research, a large community sample of problem drinkers showed the following temporal sequence of events leading to help-seeking behaviour (Simpson & Tucker, 2002). Problem recognition occurred very early with pathological drinking patterns, usually many years before initial help-seeking. Relationship, employment, financial and legal problems developed somewhat later, followed by severity of physical and emotional symptoms. Once in the contemplation and preparation stages, women were quicker than men to seek help.

The TTM has been most frequently researched and applied to smoking cessation (Cancer Prevention Research Centre, 2000a). However, recently it has been criticised for lack of empirical support (Callaghan & Herzog, 2006; Sutton, 2001; West, 2006). For example, high correlations among the scales measuring the stages of change show that they are not yielding discrete stages; longitudinal and experimental studies of smokers fail to confirm predictions based on the model and evidence for the application of the model to substance abuse is "meagre and inconsistent" (Sutton, 2001, p.175). Prochaska (2006) has acknowledged the limitations but has argued that the model's concepts go beyond standard efficacy trials with samples of single-problem, motivated individuals with addictions, to entire populations with multiple problems in a wide range of formal and informal settings. Hence, its potential value as a conceptual framework seems quite appropriate for understanding change in public health research and intervention.

Social Behavioural Model

Andersen's Social Behavioural Model (Aday & Andersen, 1974; Andersen, 1995) is the most widely known model for understanding the use of health care services (Jerrell et al., 2002). It consists of three types of extrinsic factors:

- *Predisposing factors* include demographic variables such as gender, age, ethnicity and referral sources whether self, family member or others such as general practitioners.
- *Enabling or access factors* involve the actual and perceived means for individuals to use services. They include availability, accessibility, affordability and acceptability of services (Booth, Kirchner, Fortney, Ross, & Rost, 2000). Acceptability includes social stigma associated with seeking and utilising care, and communication difficulties between service providers and clients. From a recent review of New Zealand literature on services for Maori (Thomas, 2006), a fifth element related to acceptability could be added: appropriateness for specific ethnic and cultural groups.
- *Need factors* are determined by objective measures of the severity of a disorder. They include diagnoses, comorbidity with other disorders, previous treatment history and negative consequences such as work-related and financial difficulties (Booth et al., 2000).

To facilitate help-seeking behaviours, policy makers and health services researchers have emphasised alterations to access factors; however, help-seeking seems to be more influenced by immediate consequences such as family problems and arrests, at least for problematic alcohol use (Booth et al., 2000; Pescosolido, Gardner, & Kubell, 1998). Hence, more focus should be on needs factors for changing help-seeking behaviour. The model could also be expanded to include information about enabling factors during the maintenance stage of treatment (Jerrell et al., 2002).

Network-Episode Model

While there has been considerable support for the TTM framework, it does not provide sufficient attention to positive reasons for behaviour change, or external factors including social networks, that influence help-seeking and change (Barber, 2004). Both the TTM and the Social Behavioural Model seem to omit the dynamic interaction between intrinsic and extrinsic contextual factors associated with the access and utilisation of health care services. The Network-Episode Model (NEM) attempts to remedy this omission by highlighting the importance of social networks and events in an individual's decision to seek help, with a focus on coercion (Pescosolido, 1992; Pescosolido at al., 1998). Decisions to seek help and care are influenced by pressures from family members, friends, employers or the legal system. The model attempts to integrate rational individual decision-making models such as the TTM with predisposing, enabling and need factors proposed by the Social Behavioural Model. For example, in one study (Furstenberg & Davis, 1984) elderly people were asked about the influence of others on their decision to seek help for medical problems. They gave responses consistent with individual decision-making theories and the Social Behavioural Model, rather than pressure from others. However, when they were asked to tell open-ended stories about getting into care, suggestions, cajoling, nagging and coercion by many others came to the fore. While the model proposes a dynamic integration of the previous two models, it could be expanded to include another theme which Pescosolido and colleagues (1998) call "muddling through": "When people muddle, they 'bounce around' and 'off' circumstances and others as they attempt to deal with problems, engaging in successive, limited comparisons between alternatives … They neither resist nor do they seek treatment" (p. 275).

3.1.4 Intrinsic barriers to health care

Procrastination

Perhaps the greatest intrinsic barrier to seeking help during the contemplation stage of TTM is people's tendency to procrastinate for various reasons, even in acute medical or psychiatric situations of distress (DiMatteo, 1997; Wu & Bancroft, 2006). They may delay for many reasons, but often they misinterpret and minimise the importance of their symptoms, fear embarrassment if there is nothing really wrong or are reluctant to alter their plans and lifestyles (DiMatteo, 1997).

Attitudinal barriers

In a review of literature on intrinsic barriers to treatment, Cunningham and colleagues (1993) noted from population and clinical surveys that many people with alcohol and drug abuse problems have attitudinal barriers. Generally, they do not think that they have a problem or that it is not serious enough to warrant seeking treatment, they believe that they can handle the problem on their own or they like the intoxication feeling and do not want to relinquish it. Compared with drug abusers, the authors found that Canadian alcohol abusers in clinical and community samples were more likely to want to handle the problem on their own. For all health problems, the traditional masculine belief of self-reliance has resulted in delays in seeking help, especially among lower socio-economic status men (Galdas, Cheater, & Marshall, 2005; Jackson, Wernicke, & Haaga, 2003). From interviews with a large, representative sample of the United States population with an alcohol use disorder in the 1992 National Household Survey on Drug Abuse, attitudinal barriers were approximately twice as frequent as enabling factors such as accessibility and affordability (Grant, 1997). From the longitudinal Dunedin Multidisciplinary Health and Development Study (DMHDS) (New Zealand) which began in 1972, the main barriers to professional health care services for

18 year olds included embarrassment, particularly for females, and fears that a parent would be consulted (Dixon, Stanton, McGee, Langley, & Murdoch, 1995). At the age of 26 years, 59% of the 144 interviewees who reported self-harm behaviours within the past year had not sought help and 39% revealed attitudinal barriers to seeking help (Nada-Raja, Morrison, & Skegg, 2003). The barriers included feelings that they should be strong enough to handle the problem on their own, that the problem would get better by itself, that they did not think that anyone could help, or that they were too embarrassed to discuss it with anyone due to stigma or shame. Self-harm behaviours included suicide attempts, self-battery and intoxication to deal with emotional pain. Smaller percentages (<13%) indicated fear of what others might think, reluctance to answer personal questions or practical barriers such as lack of appropriate services, time or money.

Stigma and shame

Fears of stigma, shame and treatment are commonly found among people with alcohol and drug problems or depression, and are greater barriers to treatment than the extrinsic enabling factors of availability, affordability and accessibility (Barney, Griffiths, Jorm, & Christensen, 2006; Cowan et al., 2003; Cunningham, Sobell, Sobell, Agrawal, & Toneatto, 1993; Grant, 1997; Lane & Addis, 2005; Simpson & Tucker, 2002). In Australia, a large, random community sample was surveyed about seeking professional help for depression (Barney et al., 2006). Many respondents expressed that they would be embarrassed to seek such help and would expect others such as family and friends to have negative reactions to them if they did. The authors suggested that public health interventions should be aimed to lower the expectations of adverse reactions from others, which might be more imagined than real, especially for young people.

Shame in seeking professional help for alcohol and substance abuse may be prominent among young people (Dixon et al., 1995), particularly among minority groups such as Maori and Pacific groups in New Zealand in comparison to the general population (Alcohol Advisory Council of New Zealand, 1997; Barnes, McPherson, & Bhatta, 2003). From in-depth interviews with a small sample of young, immigrant Chinese males in drug treatment programmes in Vancouver, Canada, there was a strong sense of shame among participants before they entered treatment such that they avoided mainstream helping agencies and their own families (Kwok, 2000). However, much to the interviewees' surprise, once the abuse was discovered, their parents did all they could to help their children. Consistent with the Network-Episode Model, when they had exhausted all their resources, the parents were keen to get their offspring to mainstream agencies. Similarly, from a very large population sample of non-smokers calling the multi-lingual California Smokers' Helpline (US) for smokers whom they knew and who were ready to quit (contemplation stage), Asian speakers were much more likely to seek help for their smokers than English-speaking whites, Blacks, Native Americans or Hispanics (Zhu, Nguyen, Cummins, Wong, & Wightman, 2006). Across all ethnic groups, non-smoking callers were primarily women and living in the same household as the smokers.

For drug-dependent mothers (McMahon, Winkel, Suchman, & Luthar, 2002), women who are pregnant (Jessup et al., 2003) and for men with substance abuse or depression who define the male gender role in terms of success, power and competition (Lane & Addis, 2005; Mansfield, Addis, & Courtenay, 2005), these fears of shame and stigma present formidable intrinsic barriers to seeking help. The actual and perceived stigmas associated with substance-abusing mothers and weak or dependent males may discourage susceptible individuals at the precontemplation and contemplation stages from approaching services where their personal weaknesses would be exposed. In contrast, it has been found that while substance-abusing mothers who lived in a sexual relationship with substance-abusing men entered treatment infrequently, once both partners moved beyond the contemplation stage,

their commitment to treatment was strengthened, perhaps because of mutual support and caring for the children (McMahon et al., 2002).

Self efficacy

The TTM specifies self-efficacy as a subjectively defined construct which affects an individual's responses through the change process (Cancer Prevention Research Centre, 2000a). Self-efficacy involves confidence that one can deal with high-risk situations such as emotional upsets and social pressures without relapse into addictive behaviours. The TTM purports that self-efficacy should increase through treatment as the benefits begin to outweigh the disadvantages of changing. However, self-efficacy might predict behavioural change through the preparation and action stages but not help-seeking behaviour at the precontemplation and contemplation stages (Jackson et al., 2003; Lane & Addis, 2005). For example, compared to male and female substance abusers in United States federal prisons who chose to enter a voluntary substance abuse treatment programme, inmates with a history of substance abuse who did not enrol in the programme were more likely to have higher levels of self-efficacy, after controlling statistically for gender, age, ethnicity, education, comorbid diagnoses and drug-use history (Jackson et al., 2003). The authors suggested that because of their excessive self-reliance, the non-volunteers might have underestimated their need for professional treatment, and avoided stigma and shame that they might not be as self-reliant as they thought they were or appeared to be. Further, strong motivation to quit a substance problem might not be sufficient to carry men through all stages of the TTM process. For example, substance-abusing men who reported that their lives were out of control and wanted to quit were significantly more likely to drop out of a government sponsored substance abuse treatment programme than lesser motivated men (Green, Dickinson, Lynch, & Bennett, 2002).

3.1.5 Extrinsic barriers to health care

The enabling factors of availability, accessibility, affordability and acceptability of services depend upon differences among the predisposing factors of gender, age, ethnicity and socio-economic status. They also depend upon the need factors: type of problem, its severity and comorbidity with other disorders. Women are more likely than men to seek treatment for physical and mental health problems but men are more likely than women to seek help for substance abuse (Booth et al., 2000; Galdas et al., 2005; Green et al., 2002). For alcohol dependence, no significant differences between percentages of men and women seeking or even perceiving the need to seek treatment from alcohol treatment services were found in the 1999 United States National Household Survey on Drug Abuse (Wu & Ringwalt, 2004). Both percentages were remarkably low (<10%), indicating that the majority of alcohol dependent individuals do not seek treatment until family, employment, legal and health problems become substantial (Booth et al., 2000; Wu & Ringwalt, 2004). From a one-year prospective study of 579 at-risk drinkers in six southern states (Booth et al., 2000), these social consequences predicted the use of alcohol treatment services, whereas the enabling factors did not. After controlling for all extrinsic factors in the logistic regression model, only female gender, social consequences, social support, severity of the drinking problem, concurrent medical problems and prior treatment experience significantly and uniquely predicted use of treatment facilities. Consistent with the Network-Episode Model, the authors proposed that when social consequences become severe enough, social support is likely to be salient in helping abusers seek treatment. Social support involves helping abusers identify problems, providing information and encouragement to seek help, and reducing stress. Although severity of drinking problem was a stronger factor than social consequences in this study, social pressures and social problems were more influential than severity of symptoms

of alcohol abuse in getting Dutch male abusers into treatment (Hajema, Knibbe, & Drop, 1999).

Gender

Alcohol-dependent women in the 1992 and 1999 United States national surveys were significantly more likely than alcohol-dependent men to indicate that they did not know where to go for help, that they had difficulties getting child care, that they feared loss of custody of their children, and that they would fail to fulfil childcare responsibilities if they entered treatment (Grant, 1997; Wu & Ringwalt, 2004). These barriers and economic barriers such as cost of care and lack of insurance also apply to women with substance abuse problems (Cowan et al., 2003; Goldberg, 1995; Green et al., 2002; Jessup et al., 2003; Marsh, D'Aunno, & Smith, 2000) especially among minority groups such as African-American women (Allen, 1995; Jerrell et al., 2002; McMahon et al., 2002). Even when treatment facilities are available, women with children face greater problems than men for transportation, economic support and child care (Marsh et al., 2000). In New Zealand there are very few childcare facilities available for alcohol- and drug-dependent women (Cowan et al., 2003).

Rural versus urban

From the one-year prospective study of at-risk drinkers in six southern states (US) (Booth et al., 2000), the Australian National Survey of Mental Health and Wellbeing (Issakidis & Andrews, 2006) and New Zealand focus groups of clinicians, clients and their families involved in substance abuse or mental health services (Todd, Sellman, & Robertson, 2002), rural at-risk drinkers and persons with mental health problems are more likely than urban ones to have difficulties with accessibility, affordability and acceptability of some treatment services, especially among indigenous groups such as aboriginal Australians and native North Americans (Duran et al., 2005; Gruen, Bailie, Wang, Heard, & O'Rourke, 2006; Manson, 2000; Roberts, Warner, & Hammond, 2005). Primary health care services such as general practitioners and public health emergency services are usually the first contacts for people with substance abuse and mental health problems both in urban and rural communities (Booth et al., 2000; Issakidis & Andrews, 2006; Lester, Tritter, & Sorohan, 2005).

Age and other demographic variables

Findings regarding the relationships of other demographic variables including age, education, socioeconomic status and their interactions to seeking treatment for alcohol and substance abuse or psychiatric disorders are generally inconsistent (DeSouza & Garrett, 2005; DiMatteo, 1997; Green et al., 2002; Hajema et al., 1999; Jackson et al., 2003; Kessler, Olfson, & Berglund, 1998). As would be expected, from the 1992 United States National Household Survey on Drug Abuse, senior citizens were significantly more likely than younger age groups to endorse having problems getting to treatment for substance abuse and were significantly less likely to endorse time and fear of losing their jobs as barriers (Grant, 1997). In the 1999 survey, although younger women (18-25 years) were significantly more likely than older women to be alcohol-dependent, they were less likely to use treatment services or to perceive a need for treatment, especially among women from high income households or with more than one child (Wu & Ringwalt, 2004). Paid employment and younger age have been mitigating factors against seeking treatment among male alcohol abusers but not high socio-economic status and imbibing social networks as predicted by the Network-Episode Model (Hajema et al., 1999). It was expected that employed and high socio-economic status men would avoid getting help for fear of stigma, social disapproval or loss of employment.

In a north-western United States survey of a large, representative sample of male and female substance abusers who were eligible for outpatient treatment, young age, incomplete secondary school education and difficulties with employment and income were negatively associated with beginning and completing treatment (Green et al., 2002). From the United States National Comorbidity population survey (Kessler et al., 1998), people with substance-related disorders across all age cohorts had low rates of initial treatment contact. The authors suggested that intrinsic attitudinal barriers, public intolerance and lack of insurance for treating addictions contributed to the low rates. In contrast, contacts for major depression, general anxiety disorder and phobias progressively increased with the recency of birth of the cohorts, indicating that public attitudes and policies toward mental health problems other than addictions were encouraging younger people to seek treatment.

Acceptability and appropriateness

Knowledge about symptoms of substance abuse, the availability of treatment services and their effectiveness is important for abusers, caregivers, their families and social contacts (Cunningham et al., 1993; de Bonnaire, Fryer, Kalafatelis, & Whitfield, 2000; de Zwart, Sellman, & Robertson, 2002; Wu & Ringwalt, 2004). In New Zealand, from a population survey of 433 parents of youth aged 14 to 18 years (de Bonnaire et al., 2000), the authors found that less than five percent of participants were aware of support networks available to them for adolescent alcohol problems, such as Alcohol Helpline and the Alcohol Advisory Council of New Zealand's webpage. The most frequent sources mentioned were school, church, extended family, Alcoholics Anonymous and the police. When the Alcohol Advisory Council of New Zealand (ALAC) surveyed the major Pacific Island groups to ascertain drinking patterns, men and women in all the groups except the Niueans seemed totally unaware of the health effects of binge drinking.

Cultural issues

The 2006 New Zealand Census showed that there was growing diversity in New Zealand. Europeans/Pakeha made up 67.6% of the population, followed by New Zealand Maori (14.6%), Asians (9.2%) and people from the Pacific Islands (6.9%). Ethnicity and cultural issues play a significant part in access issues and health disparities. Maori at all educational, occupational and income levels have poorer health status than non-Maori. Pacific peoples are thought to have a health status between that of Maori and Pakeha (Ministry of Health, 2002b). It is thought that action to address inequalities in health must both tackle the social and economic inequalities that are the root causes of health inequality, and improve access to, and effectiveness of, health and disability services. This section reviews broad access issues with regard to Maori, Pacific and Asian populations.

Maori
Reducing inequalities in health status for Maori is a prominent goal in the New Zealand Health Strategy (Ministry of Health, 2000a) and ensuring accessible and appropriate services for Maori is seen as key objective. Research suggests that there are differences in access 'to' health care (referral processes) and 'through' health care (treatment processes) for Maori (Ellison-Loschmann & Pearce, 2006) which refers to the quality of the service being provided. In particular, there is mounting evidence that Maori and non-Maori differ in terms of access both to primary and secondary health care services. Ellison-Loschmann and Pearce refer to data that demonstrate that Maori are less likely to be referred for surgical care and specialist services, and that they receive lower than expected levels of quality hospital care than non-Maori. Another significant impediment to access is cost (Ellison-Loschmann & Pearce, 2006). He Korowai Oranga - Maori Health Strategy (Ministry of Health, 2002a) aspires to ensure accessible and appropriate services for Maori. The strategy suggests that access barriers existing for many Maori include: cost, availability of quality, lack of culturally

appropriate services, travel, referral patterns for major operations, the way outpatient services are organised, and the assumptions health professionals make about the behaviour of Maori. The strategy has recommendations both for the improvement of mainstream services and the development of Maori services. The strategy recommends that Maori providers play a pivotal part in improving access to, and the effectiveness and appropriateness of, health and disability services for whanau. Maori providers that practise Maori views of health and healing are essential in service development (Ministry of Health, 2002a). In addition, the strategy advocates for the reorientation of mainstream services, providers and systems so that Maori health needs are prioritised as most Maori continue to receive the majority of their health care from mainstream services. The strategy also emphasises the need for comprehensive and high quality Maori health research and information that can inform Government as well as whanau, hapu (sub-tribe) and iwi (tribe) to determine and provide health priorities (Ministry of Health, 2002a). Evaluation of service effectiveness is another important factor as well as use of that evidence for continuous quality improvement of services for whanau and the reduction of access barriers (Ministry of Health, 2002a).

Pacific peoples

Pacific peoples are a diverse group representing over 20 different cultures speaking even more languages. A youthful population concentrated in the Auckland region with smaller numbers scattered throughout the country (Ministry of Health, 2005), they make up six percent of the New Zealand population which is predicted to rise to 12 percent by the year 2051. The population is growing at a rate of 2.2% per year, compared to a growth rate of only 0.6% for the New Zealand population as a whole. The Pacific Health Chart Book found that compared to the total New Zealand population, Pacific peoples had poorer health status, were more exposed to risk factors for poor health and experienced barriers to accessing health services (Ministry of Health and Ministry of Pacific Island Affairs, 2004). The Pacific Health Chart Book claims that Pacific peoples in New Zealand have a life expectancy at birth of approximately 62.5 years, about four years less than the national average. In addition, the Pacific population experiences relatively high rates of avoidable mortality and ambulatory sensitive hospitalisation and has an avoidable mortality rate that is nearly double that of the total New Zealand population. These factors suggest public health strategies and primary care services do not fully meet the needs of Pacific peoples (Ministry of Health and Ministry of Pacific Island Affairs, 2004). In addition, Pacific peoples are the least likely of any ethnic group to access primary care and their rates of avoidable deaths and hospitalisations; ambulatory-sensitive hospitalisations are also higher than in non-Pacific populations (Ministry of Health 1999). There is a need to improve access for Pacific peoples to specialist services such as acute and elective services (Ministry of Health, 2000b). Thus, better access to more effective primary health care, and relevant disability services and specialist services, is an important intervention for Pacific families.

The mid-1970s economic downturn led to many Pacific people losing their jobs. Unemployment, low income, poor housing, the breakdown of extended family networks, cultural fragmentation, and rising alcohol and drug problems have had a significant impact on the mental health of Pacific peoples, with rates of mental illness being generally higher among Pacific males and Pacific older people than the rest of the population (Ministry of Health, 2005a). However, Pacific peoples are a little less likely to use mental health services than any other group in New Zealand (Ministry of Health, 2005)

Innovative health models have been developed to address Pacific health such as the 'Fonofale' created by Pulotu-Endemann (Crawley, Pulotu-Endemann, Stanley-Findlay, & New Zealand Ministry of Health, 1995) which promotes holism and continuity. The Fonofale model uses the metaphor of a Pacific Island house and incorporates the values and beliefs of various Pacific groups. In addition, two key mechanisms have been advanced to improve social and economic outcomes for Pacific peoples. These are to improve "the responsiveness

and accountability of public sector agencies to Pacific health needs and priorities, and to build the capacity of Pacific peoples, through provider, workforce and professional development, to deliver health and disability services and to develop their own solutions to health issues" (Mental Health Commission, 2001, p.15). In addition to increasing the responsiveness of mainstream services, for-Pacific-by-Pacific culturally specific services are advocated, that strengthen Pacific provider infrastructures, and increase capacity and capability. Such amendments will provide Pacific peoples both with incentive and opportunity to access high-quality and culturally competent health care and disability support services (Ministry of Health, 2000b).

Access is pivotal to the six key directions articulated in the Primary Health Care Strategy (Ministry of Health, 2001) and supported by the Pacific Health and Disability Action Plan (Ministry of Health, 2000b) which aims to:

- Work with local communities and enrolled populations
- Identify and remove health inequalities
- Offer access to comprehensive services to improve, maintain and restore people's health
- Coordinate care across service areas
- Continuously improve quality, using good information
- Integrate access to public health and primary health care services

Within the Pacific communities are specific populations with unique access issues such as children and women (Ministry of Health, 2000b). Pacific children have poorer access to preventive and screening services (Ministry of Health, 2000b). To improve health outcomes for Pacific women, access to prevention, screening and early detection and intervention services must be improved (Ministry of Health, 2000b).

Asian

The term Asian is problematic in New Zealand health research as the term has disguised and subsumed needs, and efforts are growing to disentangle the category while maintaining the strategic importance of such an umbrella term in advocating for health services (Workshop Organising Team, 2005). Within the category Asian, Chinese people are the largest ethnic group, making up 2.2% of the total New Zealand population followed by Indian people who are the second largest at 1.2% (Statistics New Zealand, 2002). Research on barriers to Chinese access to health and rehabilitation services identified barriers including communication difficulties and knowledge gaps (e.g. being unaware of what services were available, including the important role of primary healthy care as a first point of contact) (DeSouza & Garrett, 2005). Earlier research with Asian migrants identified language and a variety of cultural barriers to accessing health services (Abbott et al., 2003; Abbott, Wong, Williams, Au, & Young, 2000).

A survey examining health status in a large representative sample of Asian people in New Zealand found that Asians under-utilise health services (Scragg & Maitra, 2005). The survey identified particular ethnic groups at risk, but general findings across the Asian groups were that:

- Asians were less likely than other New Zealanders, Maori and Pacific peoples to have visited a health practitioner (or service) when they were first unwell
- Asians were less likely than Europeans to visit a health practitioner (general practitioner, specialist, nurse or complementary healer) about a chronic disease
- Asian women were less likely than other New Zealand women to have had a mammogram or cervical screening test in the last three years
- Asians were less likely than all New Zealanders to use any type of telephone helpline in the previous 12 months

- Asians only wanted to see their general practitioner for a short-term illness or a routine check up rather than visiting for an injury, poisoning, or for mental or emotional health reasons

This under-utilisation is further reflected in New Zealand mental health statistics. Of the 87,576 mental health clients seen by District Health Boards in 2002, only 1.9% were Asian despite making up over 6.5% of the population (New Zealand Health Information Service, 2005). This could be, in part, due to the bias of New Zealand's migration policy which selects young and healthy migrants but it is clear that Asians under-utilise mental health services and this does not necessarily mean that they are keeping well (Ho, Au, Bedford, & Cooper, 2002). A study among recent Chinese migrants using the General Health Questionnaire found that 19% reported psychiatric morbidity (Abbott, Wong, Williams, & Young, 1999). A study of older Chinese migrants aged over 55 years found that 26% showed depressive symptoms (Abbott et al., 2003). Lower emotional supports, greater number of visits to a doctor, difficulties in accessing health services and low New Zealand cultural orientation (i.e. poor adaptation to the Western lifestyle) increased the risk of developing depression. While participants with depressive symptoms consulted general practitioners more than their counterparts without such symptoms, they reported greater difficulty in accessing health services. Research with Asian migrants, refugees and student sojourners in New Zealand shows that social supports can assist newcomers to cope with the stresses of migration and reduce the risk of emotional disorder (Abbott et al., 1999). Conversely, research shows that language and cultural barriers can limit access to health services (Abbott, Wong, Williams, Au, & Young, 1999; DeSouza & Garrett, 2005; Ngai, Latimer, & Cheung, 2001).

For Asian immigrants in New Zealand, the main barriers to primary healthcare can include language difficulties, and lack of knowledge of services and entitlements, especially among those born in Mainland China (DeSouza & Garrett, 2005). There might be other reasons for not using conventional agencies. For example, Asian females have been less likely than females of other ethnic groups to have used primary health care services or a telephone helpline for help, but more likely to use alternative traditional remedies before approaching allopathic practitioners.

Attitudes of practitioners

Even when knowledge of the availability of health care services is present, the attitudes of social groups and clinicians, and communication barriers between clients and health care practitioners can mitigate against effective utilisation of services (Goodwin & Happell, 2006; Kennedy, Regehr, Rosenfield, Roberts, & Lingard, 2004; Kerkorian, McKay, & Bannon, 2006). For example, the stigma associated with substance abuse is much greater for women than for men, especially if they are pregnant or have young children (Cowan et al., 2003; Goldberg, 1995; Grant, 1997; Green et al., 2002; Jessup et al., 2003). Women who drink to excess are likely to be seen as immoral, whereas men who drink to excess are seen as manly. Possibly because of cultural stigmas and denial among the communities, female alcohol dependency among Maori and Pacific groups is a hidden problem (Alcohol Advisory Council of New Zealand, 1997; Barnes et al., 2003).

A recent survey of a random sample of 217 alcohol and drug treatment clinicians in New Zealand (97% response rate) by the National Addiction Centre, found that almost one-quarter of the sample did not support the view that women have different needs than men (Cowan et al., 2003). Among those who believed that women should receive different treatment than men, only 13% of the male clinicians and 36% of the female clinicians helped their female clients with parenting issues. In contrast and when working with Maori, more than 60% of the non-Maori individual clinicians took some form of culturally appropriate interventions

such as referring Maori clients to specialist Maori practitioners or making contacts with the extended family (Robertson et al., 2001). Cultural appropriateness refers to "the delivery of program and services so that they are consistent with the cultural identity, communication styles, meaning systems and social networks of clients, program participants, and other stakeholders" (Thomas, 2006, p.66). Impersonal, professional clinical styles can be unsettling for clients who identify with their respective ethnic groups, and can be interpreted as aloofness and lack of support.

Many of the barriers to access and utilisation of health care services for mental health problems in Western countries stem from the current system of managed care. Referrals to under-resourced specialist services from primary care physicians can take weeks or months, a limited number of treatment sessions are funded by governments and insurance plans, and clients are re-routed to less well-trained helpers (Zatzick, 1999). Further, both primary and secondary care professionals can overestimate a client's understanding of technical terms, what they have been told and what they need to do (DiMatteo, 1997).

Need factors

The third component of extrinsic barriers according to the Social Behavioural Model (Aday & Andersen, 1974; Andersen, 1995) involves need factors. For people with co-existing substance abuse and mental health disorders, a number of barriers have been identified through focus groups of clinicians, clients and their families involved in New Zealand substance abuse or mental health services (Todd et al., 2002). For example, Maori have expressed lack of trust of the intentions of government agencies and mainstream professionals (Todd et al., 2002). Consistent with research in other countries, systems barriers included fragmentation of services, poor communication between agencies, inconsistency of care, and time and resource constraints. Few clinicians had the knowledge and skills in assessment, treatment planning and interventions for comorbid disorders. Judgemental attitudes existed, particularly among mental health practitioners. Substance abuse problems were seen as a matter of choice and, therefore, were considered personal and moral deficits. Confrontation and insistence on abstinence without considering alternatives, rejection of medical interventions, and rivalry between professional groups and regions were found, even among some Maori helping agencies.

Substance dependence and mental health disorders present further challenges to helping agencies, especially if comorbidity between the two syndromes exist and particularly for major depression (Booth et al., 2000; Dixon et al., 1995; Green et al., 2002; Jackson et al., 2003; Jessup et al., 2003; Wagner, Heapy, Frantsve, Abbott, & Burg, 2006; Wu & Ringwalt, 2004). For example, from the previously mentioned Dunedin Multidisciplinary Health and Development Study, untreated schizophrenic or substance-dependent 21 year olds had higher rates of assaults and violent crimes than comparable control members of the cohort (Arseneault, Moffitt, Caspi, & Taylor, 2002). Comorbid cases were more likely than single-disordered cases to have a history of chronic mental and physical health problems, fewer social networks and greater frequency of use of treatments (Newman, Moffitt, Caspi, & Silva, 1998). Although women are less likely than men to seek treatment for substance abuse, when they do seek help, their substance-related and mental health problems are likely to be more severe, and they are less likely to begin treatment after initial assessment identifying that they are eligible for treatment programmes (Green et al., 2002). In addition to intrinsic and extrinsic barriers, treatments for alcohol and substance abuse tend to be oriented more toward men (Goldberg, 1995; Marsh et al., 2000).

3.1.6 Help-seeking by gamblers and their families/whanau

Having examined intrinsic and extrinsic factors, the focus of the literature review moves to the issue of help-seeking by people and their families.

The previous section of this review examined the literature about barriers to access and utilisation of health care for alcohol, substance abuse, physical and mental health problems and examined the research findings from international and New Zealand studies with a focus on gender differences and cultural aspects. The following section reviews issues around help-seeking and gambling problems.

Self-recognition of problem gambling

Many people who experience problems with gambling do not seek help (Duong-Ohtsuka & Ohtsuka, 2001). The Australian Productivity Commission found that about one tenth of people who experience problem gambling actually seek help for their problems (Productivity Commission, 1999). It is thought that at least five people, usually family members and significant others, are affected by one problem gambler (Productivity Commission, 1999).

In New Zealand, as elsewhere, only a small proportion of problem gamblers seek formal help for their gambling problems. Some aspects of help-seeking were examined in more detail in the second phases of both the 1991 (Abbott & Volberg, 1992; Abbott & Volberg, 1996) and 1999 (Abbott, 2001a) national gaming surveys. Phase one involved telephone interviews with a large, population-based sample to assess their gambling involvement and to estimate the prevalence of problem gambling in New Zealand. Phase two comprised face-to-face re-interviewing with smaller samples in greater depth. In both the 1991 and 1999 second phases, approximately half of the people identified as problem gamblers did not, themselves, believe that they had ever had a problem with gambling. This suggests that there has been no significant change over time with respect to self-recognition or awareness of problem gambling among people who have problems. In both surveys, people with more severe problems were much more likely than those with less serious problems to personally acknowledge having had problems currently or in the past. While there was no change in the proportion of self-assessed problem gamblers from 1991 to 1999, there was a very substantial increase in reported help-seeking in this group.

In 1991, only eight percent of 'self recognition' problem gamblers said they had ever sought help for themselves. Only friends, family members and mutual help groups were mentioned in this regard - none mentioned seeking professional or specialist services. All phase two participants (not just problem gamblers who considered that they currently or previously had a problem) were asked about seeking help for other people in their lives whom they thought had a gambling problem. Eleven percent of problem and non-problem regular gamblers said they had done so. Again, friends, family and mutual help groups (Gamblers Anonymous and GamAnon) were mentioned most often. A few participants mentioned doctors and mental health professionals.

Approximately two-thirds of the 1991 phase two participants mentioned in the previous paragraph were followed up in 1998 (Abbott et al., 1999). None of the people who had problems in 1991 or subsequently developed them said they had sought professional or specialist assistance during this period. However, eight percent said they had done so for family members and friends. Only mutual support groups (Gamblers Anonymous and GamAnon), general medical practitioners and mental health professionals were mentioned in this regard.

In contrast to the 1991 phase two study, its 1999 counterpart found that a third of 'self recognition' problem gamblers reported seeking help for themselves - a large increase since 1991. Approximately half of reported help-seeking instances involved family members, mutual help groups and other informal sources of assistance. Again in marked contrast to 1991, in 1999 half of the help-seeking instances involved specialist services and health professionals. Mental health professionals were most often mentioned, followed by the gambling helpline, alcohol and drug treatment centres and general medical practitioners. With respect to seeking help for other people, there was also an increase in the use of specialist services (gambling helpline and mental health professionals). However, family, friends and mutual help groups continued to be mentioned most often.

The 1999 phase two study also examined satisfaction with help sought. The 11 problem gamblers who answered the satisfaction questionnaire regarded most sources as very helpful or helpful. Only mental health professionals and general practitioners were considered to be unhelpful, possibly because of their attitudes towards addiction and lack of training in dealing with addictions, as noted previously in the attitudes and needs sections. It is, therefore, important that medical and psychiatric personnel be persuaded through marketing strategies to change their view that addictions are merely self-control problems and not medical or psychiatric ones (Todd et al., 2002). People seeking help for others also generally reported that sources were helpful, especially in the case of informal sources including family/friends.

Phase two problem gamblers in 1999 who acknowledged having problems were also asked if they had experienced periods of six months or more when they were free or mostly free of gambling problems. Nearly two-thirds reported one or more instances of this type. These people were asked what methods they had used to overcome their problems on these occasions. They could mention more than one method. While over half indicated using one or more types of informal or formal help, the great majority referred to doing it on their own. Three-quarters also reported that this (their 'own efforts') was the most effective method to overcome gambling problems. The only other 'most effective' method mentioned (by 10% of respondents) was alcohol or drug treatment centres.

Research on barriers to problem gambling treatment

From our reviews of the literature and professional networks, apart from the New Zealand studies mentioned, we are aware of only four problem gambling specific studies that have direct relevance to the present investigation (Productivity Commission, 1999; Evans & Delfabbro, 2005; Hodgins & el-Guebaly, 2000; Rockloff & Schofield, 2004). Recent reviews (Abbott et al., 2004; Evans & Delfabbro, 2005) indicate that there is a paucity of research on barriers to treatment for problem gambling. These reviews did not locate any published studies focusing specifically on family members of problem gamblers.

Some information on help-seeking for problem gambling (formal and informal) is presented and discussed in previous New Zealand studies (Abbott, 2001a, 2001b; Abbott, McKenna, & Giles, 2000; Abbott et al., 2004; Abbott & Volberg, 1992; Abbott et al., 1999). The first of these studies pre-dated the establishment of problem gambling specific information, referral and counselling services in New Zealand. A prospective extension of this study followed and assessed the same problem and regular non-problem gamblers over a seven-year period (Abbott et al., 1999), during which time problem gambling services were introduced.

Among various other things, previous New Zealand research (Abbott, 2001a, b; Abbott & Volberg, 1996, 2000), using nationally representative samples, has documented increased public awareness of, and concern about, problem gambling including growing support for the need for services to help people overcome gambling problems. It has also indicated significant change in the prevalence of problem gambling including marked variation in the

population sectors most at risk. Comparison of these findings with national gambling helpline and counselling service data has enabled the identification of groups that appear to be under-accessing services, such as Maori, Pacific Island people and Asians.

The Australian Productivity Commission (Productivity Commission, 1999) consulted widely with service providers and conducted national prevalence and problem gambling service surveys. Various factors that influenced help-seeking and service use were considered, including ethnic differences. As in the New Zealand national surveys, a substantial number of people identified as having gambling problems did not, themselves, consider that they had a problem. About a third of serious problem gamblers (South Oaks Gambling Screen-Revised (SOGS-R) score of five or more) said they had wanted help at some time and just under one half of this group indicated they had tried to get help. Of this latter group, two-thirds subsequently received counselling or support. This included about one-in-five people with particularly serious problems (SOGS-R scores of 10 or more) and one-in-fourteen with less serious problems (SOGS-R scores of five to nine). Again, as in New Zealand, problem gamblers most often first turned to spouses, families and friends for help, followed by other people outside their immediate personal network such as general practitioners, social workers or clergy. Those who subsequently received counselling or support mentioned a wide variety of services including Gamblers Anonymous.

Although not systematically examined, reasons suggested by service providers and clients for not seeking help included:

- Limited knowledge of service availability
- Poor location of services
- Inconvenient hours of operation
- Problems not considered serious enough
- Preference for other more informal assistance
- Culture and/or gender factors
- Stigma associated with gambling problems

Service providers commented that people rarely sought help until a crisis point was reached including major financial problems, family breakdown, job loss or criminal charges. Typically other sources of support were depleted and there was a high level of psychological distress, desperation and panic.

Recovery from problem gambling

Hodgins and el-Guebaly (2000) in Calgary, Canada, undertook a study to increase understanding of recovery from problem gambling. It involved 106 adults predominantly recruited from the general population by media advertisements and announcements. Participants included problem gamblers whose problems were resolved as well as those who continued to experience problems. Most mentioned that their goal to stop or control their gambling was a conscious decision. Reasons most often given for seeking to resolve gambling problems were negative emotions, financial concerns and seeing their gambling as something incompatible with their self image or goals. Particular life events, per se, did not appear to trigger change.

The majority of 'resolved' and 'active' problem gamblers reported that they had never sought treatment for gambling problems. People with more serious gambling problems were more likely to have entered formal treatment programmes. Comorbid alcohol or other drug problems did not, however, appear to increase help seeking. Examination of recovery processes included assessing barriers to treatment. This assessment used a checklist adapted from the substance misuse field (Sobell, Sobell, & Toneatto, 1992). Just over four out of five problem gamblers said they did not seek treatment because they wanted to handle the problem on their own. This was the most frequently mentioned reason for not seeking treatment both

by resolved and active problem gamblers. Approximately half of the respondents also mentioned one or more of embarrassment/pride, no problem/help needed, ignorance of treatment or availability, unable to share problems and stigma. Relatively few people mentioned negative attitudes towards treatment or cost as a reason for not seeking treatment. The present authors are unaware of any literature that discusses whether comorbidity can act in the opposite direction and decrease help-seeking behaviour.

The previous study provides a great deal of useful information about self- and treatment-assisted problem gambling recovery processes, as well as barriers to treatment. While having considerable merit, it involved a self-selected sample and relied on retrospective accounts of events that quite often had occurred some years prior to interview. Its authors described it as an exploratory investigation and pointed to the need for more representative studies including prospective research.

Drawing on the Hodgins and el-Guebaly study, Rockloff and Schofield (2004) developed and administered a questionnaire concerning barriers to treatment for problem gambling to 1,203 adults in Central Queensland, Australia who were chosen by random digit dialling of households. Selected items from the SOGS were incorporated. Factor analysis of the questionnaire responses identified five potential barriers to treatment, namely availability, stigma, cost, uncertainty and avoidance. Relative to people with few gambling problems, those with numerous problems more often reported treatment costs and the availability and effectiveness of treatment. Older people more often judged treatment-seekers negatively. Respondents with more formal education had more positive attitudes to problem gamblers and treatment-seeking. The study's authors indicated that further research is required to determine whether these factors do, in fact, influence treatment-seeking behaviour including 'readiness to change' (Prochaska et al., 1992). They also suggested cognitive distortions that are common among problem gamblers (such as superstitions, denial of odds of winning, feelings of omnipotence) may correlate with these factors in a 'common syndrome of resistance to change'.

The final study was undertaken in Adelaide, Australia (Evans & Delfabbro, 2005). Its purpose was to examine major motivations for, and impediments to, help-seeking. It involved interviews, predominantly via telephone, with 77 problem gamblers recruited through the mass media and from treatment agencies. Most had received professional help. A minority had used self-help strategies solely or predominantly. The primary theoretical framework used to structure the study was Prochaska and DiClemente's (Prochaska et al., 1992) Transtheoretical stages of change model which was referred to earlier in this review. With respect to motivations for change, people who had sought treatment or attended self-help groups most often sought help as a consequence of deteriorating psychological and physical health and/or serious financial hardship. Relationship problems, legal issues, employment and housing problems also played a role but were rated as being less important. Over half of the problem gamblers sought help for multiple reasons (Evans & Delfabbro, 2005).

Last resort

Evans and Delfabbro (2005) in their study of motivations for, and impediments to, help-seeking for problem gambling concluded that treatment agencies were not regarded as "points of intervention, but merely last resorts when all other possibilities had been exhausted" (p. 150). Rather than a lack of knowledge of services or dissatisfaction with them, they considered the main barriers to be psychological: "denial, embarrassment and shame" (p. 151), consistent with other studies' findings which they reviewed (e.g., Hodgins & el-Guebaly, 2000). They considered it likely that many current problem gamblers "remain trapped at the pre-contemplation phase", not acknowledging problems and largely hidden from people around them. For this reason they urged treatment services to be proactive and

argued that more emphasis needs to be given to community education to counter stigma and assist family members to recognise warning signs and give support and advice. They also pointed to successful efforts to promote screening and self-identification in primary health care settings (Sullivan et al., 2000). While this study is probably the most illuminating to date, it has deficiencies. Participants were self-selected and recognised that they had problems. Furthermore, the great majority had experienced at least some success in reducing or overcoming their gambling problems. They were all in the action or maintenance phases of change. As the authors indicate, the sample did not include problem gamblers who failed to recognise that they had problems and/or who did not seek either informal or formal help. This is the group that requires investigation to increase understanding of why problem gamblers move from the pre-contemplation stage to contemplation and preparation for change.

Changes in problem gambling status

In both the 1991 and 1999 New Zealand phase two surveys, problem and non-problem gamblers were asked about factors that led to past increases and decreases in gambling involvement. In 1991, problem gamblers reported that the arrival of children and leaving paid employment were life transitions that had the most impact in terms of gambling reduction. Reasons given for reduced gambling, in both 1991 and 1999, included less money available, loss of interest in gambling, not winning, other life priorities and changed circumstances.

Of particular relevance in the present context is the 1998 re-assessment of 1991 phase two respondents (Abbott et al., 2004; Abbott et al., 1999). Of those with serious gambling problems in 1991, approximately a quarter had problems of this severity seven years later. However, about a third still experienced problems of less severity and just under half were problem-free. Of those with less serious problems in 1991, only ten percent remained in this category in 1998. A slightly larger percentage developed more serious problems and over three-quarters were non-problematic.

When various factors, measured in 1991, that predicted future problem gambling status were considered together in multivariate analyses, it was found that initial problem gambling severity, comorbid hazardous or problematic alcohol use, and a preference for track betting were the strongest individual predictors of continued gambling problems. In one analysis there were indications that non-European ethnicity and male gender were additional risk factors for problem chronicity. The great majority of problem gamblers who preferred electronic gaming machines, as well as those who did not use alcohol excessively, were free of problems seven years later. It will be recalled that none of the participants in this study reported ever having received professional or specialist help for their own gambling problems, although some had sought such help for other people.

The findings referred to above, from the world's first prospective general population study of problem and non-problem gamblers, suggested that many, probably most, problem gamblers overcome their problems without professional or specialist assistance. While some of these people abstain from gambling, most continue to gamble without significant problems. The findings also indicate that some people have more persistent or relapsing problems and the study identifies some characteristics that differentiate these two groups. While limited by its small sample size, the complexity of the way in which the sample was derived, and attrition between assessments, this and other New Zealand studies (Abbott et al., 2004; Bellringer et al., 2005; Dyall & Hand, 2003; Sullivan et al., 2000) found that most people attribute problem gambling cessation to their own efforts and many also indicate that family members, friends and mutual help organisations assist. Some major life events such as the arrival of children, maturation, adverse experiences associated with excessive gambling and financial hardship

are among the factors that appear to play a part in what has been referred to as self recovery or spontaneous remission.

Many of the findings from the prospective study have more recently been replicated elsewhere (Abbott & Clarke, 2007; Abbott et al., 2004). They are also broadly in keeping with research on help-seeking and self-recovery for other addictive and mental health disorders. These findings are important in the present context because they remind us that, viewed from a whole population or public health perspective, help-seeking from formal health services is only one of a variety of resources that individuals, families and communities draw on to assist them with health problems. Reflecting on New Zealand research, Abbott (2001b, p.46) comments:

> "It is important to appreciate that many health problems improve without professional intervention and that recourse to this form of assistance is typically less often sought than other types of help including advice from friends and family, self medication, lifestyle changes and consultation with non-traditional or alternative health practitioners. Problem gambling is not unique in this regard. While these and other factors may often assist, in the case of problem gambling it is important to note that enormous damage often results during the period the problems persist - for the problem gambler, for others in their lives and for wider society. Appreciating the widespread occurrence of self-recovery and other agents of change in no way diminishes the importance of finding more effective ways of shortening the duration of gambling problems and reducing the probability of relapse. The widespread availability of services is important in this regard. However, it is critical that these services are, in fact, appropriate. This requires assessment. It cannot be assumed that current provisions are optimal."

3.1.7 Cultural issues and gambling help-seeking

Having reviewed the literature on help-seeking in general, the relationship between help-seeking related to gambling and ethnicity is now examined. Cultural factors influencing gambling such as indigeneity and acculturation are discussed, followed by how culture impacts on help-seeking.

Ethnicity is a key indicator of likely risk for problem gambling in New Zealand. Research suggests that there are high rates of gambling among some cultural groups (e.g. Chinese), ethnic minorities and indigenous groups (e.g. Maori) (Raylu & Oei, 2004). It has been suggested that gambling and social inequality are linked (Binde, 2005) and often migrants and indigenous communities are found in the lower social strata of communities. Another proposed explanation for these increased rates is the impact of acculturation in migrants (Raylu & Oei, 2004) and the impact of colonisation and, according to indigenous researchers, the erosion of cultural integrity (acculturation) in Maori communities (Durie, 1998; Dyall, 2004b) with Dyall arguing that gambling is the continuation of a colonising process for Maori. One study also found that particular groups were at risk, such as restaurant workers (McMillen, Marshall, Murphy, Lorenzen, & Waugh, 2004) while other research has identified international Asian students to be likely at risk as they have access to considerable amounts of cash and are frequently isolated.

In the early years, relative to general population prevalence, Maori and Pacific peoples were significantly under-represented at treatment services. Over time Maori utilisation has increased markedly; Pacific utilisation less so. Asian utilisation has also increased but probably remains low relative to prevalence (Ministry of Health, 2005b).

Cultural factors influence problem gambling in several ways (McMillen et al., 2004, p.15):

- Cultural values, beliefs and practices of the gambler's culture of origin
- The impact of acculturation to a society where gambling is acceptable
- The likelihood that members of a cultural group will (or will not) seek help for a gambling problem

McMillen and colleagues' work is supported by Raylu and Oei (2004) who found that cultural beliefs and values affect not only individuals' gambling behaviours but also help-seeking attitudes and utilisation of treatment and other health care services. However, this framework does not account for the impact of colonisation among indigenous groups or the needs of long-term settled communities (research shows that some problem gamblers are well established).

Duong-Ohtsuka and Ohtsuka (2001) suggest that help-seeking behaviour is unique to specific cultural groups. In their research of differences in attitudes towards psychological help-seeking between Vietnamese-born and non-Vietnamese Australian-born respondents, they found that recognition of need for help, stigma tolerance, confidence in helpers, and knowledge distinguished the two groups. Although Vietnamese expressed significantly higher confidence in helpers, they were less certain about where to get help as expected. Australian-born respondents showed both higher stigma tolerance and greater knowledge about what services were available (Duong-Ohtsuka & Ohtsuka, 2001).

Culture-specific beliefs and values

Culture-specific beliefs and values can reinforce the importance of gambling in people's lives, for example perceptions of luck, the desire to fit culturally into the dominant society, and the perceived status associated with some forms of gambling (e.g. for Chinese) (McMillen et al., 2004). McMillen and colleagues argue that beliefs and values can also be contradictory and ambivalent, for example Chinese in Canberra, Australia were found to have ambivalent attitudes to gambling. On the one hand it is accepted as part of Chinese culture and most people 'see the positive side and keep it under control'. On the other hand, problem gambling is highly stigmatised, especially if it impacts on achievements in business or study, or on family stability (McMillen et al., 2004). For other ethnocultural groups, gambling is viewed more negatively, contrasting with traditions and values, for example in Arabic speaking communities. The role of community-based gambling such as card games reinforces social obligations and assists in randomly redistributing money within the community (McMillen et al., 2004) but this can also cause harm (Perese & Faleafa, 2000). A study by Brown (2002) in Canada, with Arabic speaking participants, found that four key factors influenced help-seeking: the perception of the problem (addictive gambling located in a casino), magnitude of addictive gambling (led to divorce, abuse), lack of knowledge that institutional resources were available to people with a gambling problem, and lastly that the mosque was an option for help.

Paths to help-seeking

The first step in the pathway to seeking help is the recognition of symptoms of distress in oneself or in another. This is mediated by the culture and context in which it is experienced, so that what is recognised as a problem in some contexts may not be so in others. Studying the help-seeking pathways that people use is critical to understanding the link between the onset of symptoms of mental health distress and the use of mental health services (Fuller, Edwards, Procter, & Moss, 2000). Before seeking professional help, gamblers and family members utilise creative ways to help and support themselves, often with some success (McMillen et al., 2004). People primarily turn to families and friends, to group support or to other generic community agencies for help. Despite inflated problem gambling rates, some

ethnicities (Brown, 2002; McMillen et al., 2004) and age groups (adolescents) (McMillen et al., 2004) do not access mainstream gambling help agencies.

Maori

It is thought that indigenous peoples are at disproportionate risk of gambling-related harms. Indigenous problem gambling rates have been found to be higher than in non-indigenous populations in North America and among Australian Aboriginal groups (Robertson, Pitama, Huriwai, Ahuriri-Driscoll, Haitana, Larsen, et al., 2005). Robertson and colleagues argue that factors such as marginalisation and the denigration of cultural institutions that have been sustained with colonisation continue to contribute to health disparities. According to Abbott (2001b), Maori and Pacific populations in New Zealand have high rates of problem gambling and appear to be among the highest reported internationally; however, despite being over-represented in treatment statistics, Maori have traditionally under-utilised gambling treatment services in relation to need (as indicated by problem gambling prevalence surveys) (Paton-Simpson et al., 2002) though this appeared to be redressed somewhat by 2005 (Ministry of Health, 2006). Goodyear-Smith and colleagues, found in their review of literature (2006) that the main reasons for not seeking treatment were the desire to handle the problem without help, the negative attitudes related to stigmatisation of addiction problems and embarrassment and pride (Hodgins & el-Guebaly, 2000). A study by Goodyear-Smith and colleagues (2006) found that Maori were significantly more likely than New Zealand Europeans to be worried about their gambling behaviour and more likely to want immediate help. Results from studies in New Zealand have identified sub-groups at risk for problem gambling. They are Maori youth, Maori women, older Maori, Maori with mental illnesses, and Maori with comorbidity (Abbott & McKenna, 2000; Abbott et al., 2000, Abbott & Volberg, 2000).

In 2005, approximately 30% of people accessing gambling treatment or helpline services were Maori (Ministry of Health, 2006). Despite this, Dyall and Hand (2003) argue that Maori are under-utilising services due to barriers in accessing treatment services such as being in prison or feeling whakama (embarrassment) in having a problem. For Maori men and women presenting for help, electronic gaming machines are the primary form of gambling (Ministry of Health, 2006). Evidence is growing that reducing barriers to access for Maori can occur through the development of culturally appropriate and relevant services and programmes that are effective at engagement and retention (Huriwai et al., 2000). Effective treatment would include the integration of western practices within a framework of tino rangatiratanga (self-determination) and approaches which foreground the values, beliefs and practices of Maori (Robertson et al., 2005). In a review of literature, Robertson and colleagues suggest that the following are considered when developing effective interventions for Maori with gambling problems:

- Maori services need to cater for individuals who have a diversity of experience in terms of 'being Maori"
- Whanaungatanga and inclusion of whanau is central to successful interventions with Maori
- Maori practices and content contribute to improved access of services, as well as increased retention and satisfaction with treatment
- Health promotion material that makes use of Maori content in a meaningful way is more effective than non-Maori material
- Many Maori are willing to engage with non-Maori practitioners and treatment modalities, provided that they are responsive to Maori needs and aspirations

The literature is limited on Maori help-seeking, but typically Maori health models place individual wellbeing in the context of whanau (family) and hapu (sub-tribe) (Huriwai, Robertson, Armstrong, Kingi, & Huata, 2001). Contemporary Maori health models such as

Te Whare Tapa Wha (Durie, 1994) emphasise balance across a number of dimensions such as the personal (including family), environmental (including community), cultural and spiritual.

Migrants

While barriers to help-seeking can vary in relation to cultural background, the most common factors identified from research include:

- Suspicion of mainstream services
- Shame and loss of face
- Language barriers
- Concerns about trust and confidentiality
- Unfamiliarity with, or resistance to, the concept of counselling
- Lack of information
- Lack of culturally appropriate services

(McMillen et al., 2004, p.15)

Research by McMillen and colleagues (2004) found that Chinese gamblers will only seek help if there is no other way to solve the problem. They tend to rely on a trusted family member, then friends or employer. This is confirmed by a study by Cheung (1986) which found that the two most preferred coping strategies of the Chinese were initially a high reliance on self-help measures followed by help and support from one's primary social network. Raylu and Oei (2004) found that different cultural groups assume help for problem gamblers should come from different sources. Government or gambling providers were the choice of Arabic, Greek, Italian, Korean, Macedonian, Spanish and Vietnamese individuals and families for support, while Chinese and Croatians nominated themselves, their family or community as being responsible for managing gambling problems.

The link between acculturation, settlement and problem gambling

Acculturation has been defined as a process by which an individual's behaviour and a group's cultural knowledge, identity and behaviour styles change in the direction of those of the dominant group (LaFromboise, Coleman and Gerton, 1993 cited in Uba, 2002). Either success or difficulty with acculturation can lead to the development and maintenance of problem gambling and other health/mental health problems. For example, greater substance use related problems and poorer health status in a range of cultural groups has been associated with acculturation problems (Raylu & Oei, 2004). It is difficult to resist the dominant culture and, for example, the successful acculturation of Asians in New Zealand means that the longer they live in New Zealand the more likely they are to smoke and use cannabis (Scragg & Maitra, 2005). Similarly with the migration and adaptation processes of Pacific peoples in a Western country such as New Zealand, particularly in relation to gambling activity. However, due to the paucity of research with this population group, further research would be useful (Bellringer, Cowley-Malcolm, Abbott, & Williams, 2005).

Settlement

Migration is a major life transition and the extra stress on newcomers and refugees can increase their vulnerability leading to gambling as an escape to release feelings of loneliness and homesickness. The Niagara Multilingual Problem Gambling Program (undated) suggests that gambling often serves several functions for people who are adjusting to living in a new country. It can be a way of regaining status that might have been lost (in New Zealand, for example, migrants are twice as likely to be unemployed than the local population, despite being twice as likely to be tertiary qualified (Scragg & Maitra, 2005)). Gambling can also assist people to feel part of the new community and to feel a sense of belonging. The very early process of adjusting to living in a new country is termed settlement. Many researchers (cf. Raylu & Oei, 2004) argue that mainstream gambling support services are unable to meet the particular needs of ethnic community members, largely due to a range of cultural and

settlement issues which may influence the uptake of gambling. Thus settlement services need to be an integral aspect of help that is available. Settlement difficulties have been identified as major factors in the development of gambling problems (Raylu & Oei, 2004). Such settlement difficulties can increase pressure on some migrants, due to possible language difficulties, financial hardship and unemployment as well as the need to adapt to a new culture. These difficulties can in turn create issues such as boredom and isolation, which have been identified as key motivational factors for gambling (Tse, Wong, & Kim, 2003).

Long-term settled communities

The impact of migration can last for significant periods of time. Research by Scull and Woolcock (2005) found that the problem gamblers interviewed in their study had lived in Australia between 10 and 23 years, suggesting that settlement issues can continue for a number of years. Gambling was used as a coping mechanism for managing problems, unhappiness, boredom and isolation. The authors suggest that many popular social activities in Australia may not be enjoyed to the same extent by individuals from non-mainstream cultural backgrounds. Lack of English language skills might also prevent participation in other mainstream entertainment activities.

Denial, shame and stigma

Research by Scull and Woolcock (2005) into problem gambling among non-English speaking background communities in Queensland, Australia found that problem gambling was evident in the Chinese, Greek and Vietnamese communities studied, with a pervasive sense of denial attached to it. Scull and Woolcock also found that the lack of recognition of a gambling problem was one of the most widely reported and significant barriers to address in terms of accessing help, particularly within the Chinese and Vietnamese communities; this was related to issues of shame and stigma associated with problem gambling. Shame and stigma were identified by McMillen and colleagues (2004) as affecting both the problem gambler and their entire family, which meant that most problem gamblers tried to resolve the problem themselves or within the family rather than seeking professional help.

Social stigma attached to gambling among ethnocultural populations within their own communities may prevent problem gamblers from seeking professional help. It is assumed by cultural groups that family members will help deal with the problem and provide the necessary health, financial and legal care (Niagara Multilingual Problem Gambling Program, undated). Problem gambling is hidden due to shame, pride and loss of face, not only for the gambler but their whole family. In some communities, there may also be a reluctance to talk about problem gambling for fear the whole community may become stigmatised. The reluctance to seek help is related to the fact that in some cultures, the family unit is the source of help and support. Within Chinese and Vietnamese communities, for example, the extended family is the traditional source of support, and to seek help outside this is perceived as an admission of family failure. As a result, it is unlikely that non-English speaking background gamblers in various ethnic minority groups will seek help from gambling help services. Even if help is sought outside the family, it is more likely to be from church members or community leaders, rather than mainstream 'government services'. However, the shameful nature of gambling often makes problem gamblers reluctant to use even these informal channels of help, which can be compounded if the community is small, making people even more reluctant to admit to a gambling problem or to seek help (Scull & Woolcock, 2005).

Raylu and Oei (2004) suggest that shame can be interpreted in varying ways in different ethnic communities and is influenced by religious and cultural beliefs. They cite shame in Arab and Turkish individuals as being religious-based since gambling is prohibited in Islam, while shame in Chinese communities relates more to the loss of face and respect with restraint valued as a means of maintaining harmony, placing the needs of the collective above those of the individual (Raylu & Oei, 2004). Citing Cheung (1993) they suggest that the head of the

family would be the key to accessing appropriate help which would initially be traditional and herbal medicines and then escalated to other more mainstream forms of help if the traditional forms were not successful. Tse, Wong and Kim (2003) also suggest that shame is a critical factor preventing Asians in New Zealand from accessing help. Tse and coleagues suggest that help-seeking from professionals becomes a last resort strategy as the primary aim is to avert humiliating the family by keeping problems a secret, which in turn limits self-disclosure. In addition, there are groups who are particularly at risk; people working in the food industry, tourist operators, international Asian students, South East Asian refugees and members of 'astronaut' families (i.e., those in which the mothers stay behind in a foreign country to look after their children while the husband returns to the home country to work) (Tse et al., 2003).

Lack of accessible and appropriate services

Entry to the service

Across many ethnocultural communities, people can be unaware that specialist services are available to help problem gamblers and their families. Language and familiarity with health services play an important part in accessing information. If information is only available in English, this could make it difficult for those who do not read English to learn more about problem gambling and available support services (Scull & Woolcock, 2005) thereby exacerbating gambling problems (Niagara Multilingual Problem Gambling Program, undated). A perception that there might be poor levels of cultural understanding in a gambling help service can also prevent access (Scull & Woolcock, 2005). There are many reasons why people from ethnic communities do not seek help including limited knowledge of available services, lack of awareness regarding the severity of problems, cultural and/or gender factors and the stigma associated with gambling problems (Duong-Ohtsuka & Ohtsuka, 1999, 2001). This lack of knowledge of services is also compounded by the lack of availability of helpers from a similar cultural, ethnic and linguistic background (Delphin & Rollock, 1995 cited in Duong-Ohtsuka & Ohtsuka, 2001).

Several factors prompt people to seek help for gambling problems. Usually it is recognised as a serious problem when it impacts on finances or personal relationships (McMillen et al., 2004). This finding is supported by Duong-Ohtsuka and Ohtsuka (2001), who suggest that many people who seek help do so as a result of crises involving finances, relationships, occupational or criminal catalysts. However, Raylu and Oei (2004) found that Arabic, Chinese, Korean and Vietnamese were less likely to seek professional help than other cultural groups despite having higher amounts of unpaid debts, having problems clearing their gambling debts, spending more money than they could afford, or thinking their gambling was a problem. Reasons for not seeking help included: a limited knowledge of the availability of services, insufficient social and financial resources to support treatment entry and behaviour change, and language problems; these can often be related to settlement difficulties.

Mode of help

Scull and Woolcock (2005) argue that the mode of help can also be considered inappropriate; for example, counselling might be unfamiliar with a more 'indirect' service that does not require immediate disclosure of the gambling problem being perceived as more appropriate. Practical assistance such as financial counselling might also be useful rather than talking about a problem. Many people who need help might view their problem as being beyond help especially if they have financial problems.

Pacific peoples

Pacific peoples living in New Zealand have socio-demographic profiles that are associated with being at-risk of developing problem gambling such as low socio-economic status, being youthful, belonging to a particular minority ethnic group, residing in urban areas, and low

educational and low occupational status (Bellringer, Perese, Abbott, & Williams, 2006). National prevalence surveys conducted in New Zealand in 1991 and 1999 confirmed that adult Pacific peoples were the most at-risk ethnic population group for developing problem or pathological gambling behaviour (Abbott & Volberg, 1991; Abbott & Volberg, 1996; Abbott & Volberg, 2000). The prevalence estimate was more than six times greater than that of New Zealand Europeans, with 15% of the adult Pacific gambling population reported as problem gamblers and 16% as pathological gamblers in 1991. These estimates compared unfavourably with all other ethnicities (Abbott & Volberg, 1991). In 1999, approximately 11% of 110,707 Pacific peoples had experienced lifetime problem or pathological gambling behaviour, compared to approximately three percent of the general population. The data also indicated that 14% of current probable pathological and problem gamblers were of Pacific origin (Abbott & Volberg, 2000).

Data from the 1999 New Zealand prevalence survey also highlighted a 'bimodal' distribution for gambling among Pacific peoples (Abbott & Volberg, 2000). A bimodal distribution occurs where the population group contains proportionately large numbers of non- and infrequent- gamblers as well as frequent participation/high expenditure gamblers. Populations with a bimodal distribution of gambling may be more likely than others to develop gambling problems because a significant proportion are involved in continuous forms of gambling, lack prior experience with those forms of gambling, are exposed to stress associated with acculturation, and have high levels of unemployment or under-employment (Abbott, 1997; Abbott & Volberg, 2000). This bimodal pattern of gambling among Pacific people has been confirmed in an analysis of the gambling questions from the 2002/03 New Zealand Health Survey, which interviewed 12,529 people aged 15 years and over, and over-sampled Maori, Pacific, and Asian people (Mason, 2007).

In addition, when re-interviewed seven years after the first assessment, Pacific peoples were less likely than New Zealand Europeans to have overcome gambling problems, suggesting that Pacific peoples were more likely to have persisting gambling problems (Abbott, 2001b).

The number of Pacific people presenting at gambling treatment providers has gradually increased since 1999, despite the national adult population percentage of Pacific peoples remaining relatively static at around five percent (those aged 18 years and over) (Bellringer et al., 2006). However, this increasing presentation of Pacific peoples at gambling counselling services around the country from five percent (of total presentations) in 1999, to 7.4% in 2005 (Ministry of Health, 2006) disguises the fact that Pacific problem gamblers are actually under-represented at services. The 1999 national prevalence survey identified that 14% of current probable pathological and problem gamblers were of Pacific ethnicities (Abbott & Volberg, 2000). Thus if Pacific people were presenting for treatment at a level equivalent to the national prevalence, it would be expected that 14% rather than 7.5% of total presentations would be by Pacific people. This suggests there may be barriers to help-seeking amongst this population group.

3.1.8 Gender and gambling help-seeking

In New Zealand and many countries around the world, the number of women participating in gambling activities and seeking help for gambling-related problems is increasing (Davis & Avery, 2004; Delfabbro, 1998; Potenza et al., 2001). While the 1999 national prevalence survey found no significant difference in male and female prevalence rates for serious problem gambling in New Zealand, the presentation of males and females at counselling services was 64.5% and 35.5% respectively (Paton-Simpson, Hannifin & Gruys, 2001). The percentage of women presenting for treatment subsequently increased such that in 2004 the percentages were approximately equal; however in 2005, the percentage of new female

gambler clients accessing counselling services decreased with 45.3% being women compared with 54.7% men (Ministry of Health, 2006).

The Australian Productivity Commission (1999) noted that men of different ages, ethnicities and social backgrounds are, on average, consistently less likely than women to seek professional help for gambling problems. However, McMillen and colleagues' (2004) qualitative study found that men and women both preferred alternative forms of help to counselling such as mutual support groups, family and friends. In New Zealand, reference is also made to male under-representation, especially in the case of new Maori and Pacific clients, and an over-representation of females and Pakeha/Europeans seeking help for someone else's gambling (Abbott, 2001a).

In New Zealand, as in other countries, there are ethnic and gender differences with respect to the use of, and satisfaction with, a variety of health services. For example, in 2002/03 approximately 20% of New Zealand women used telephone helplines in the previous 12 months relative to approximately 10% of men (Ministry of Health, 2004). These gender differences are particularly marked in the case of European/Others and Maori. Relative to these latter groups, Pacific and Asian people generally are low users of telephone services. Within these two groups, gender differences are not significant. Ethnic and gender differences are also evident with respect to primary, secondary and complementary/ alternative health care utilisation.

While male and female service use now, overall, appears to reflect their respective prevalence rates, as noted previously there are substantial gender presentation differences within some ethnic groups. However, it is not clear whether this indicates utilisation differences relative to 'need', the reason being that there is insufficient statistical power in the national surveys to assess gender prevalence rates within Maori and Pacific populations. For this and other reasons there is also uncertainty about the extent of Asian under-utilisation. Several factors were frequently identified as triggering gambling-related problems with women and migrant groups, these include: social isolation, disconnectedness, sociocultural ambivalence and the need to participate in acceptable recreational activities (McMillen et al., 2004). The rise in the number of women participating in gambling activities and seeking help for gambling-related problems is replicated amongst Pacific women in New Zealand. In 2004, over 62% of the Pacific peoples (N=173) that accessed telephone gambling services were female (Gambling Helpline, 2005). However, there are differences within groups and a recent study found that Tongan mothers were more likely to gamble and Samoan mothers less likely (Bellringer et al., 2005).

Help-seeking was also considered in the New Zealand surveys of recently sentenced male and female prisoners (Abbott & McKenna, 2000; Abbott et al., 2000). Findings were similar to those reported for the general adult population. Twenty-two percent of men and 15% of women problem gamblers who considered that they had a problem reported having received help for gambling problems in the past, mainly from mutual help groups and family and friends but also from professional and specialist services, to a somewhat lesser extent. A significant minority wanted and sought help for gambling while they were in prison but very few said they obtained it.

A criticism of the evidence base of problem gambling is the focus on studies of male pathological gamblers while women have been overlooked, whereby assumptions have been made that what is true for men will also be applicable to women (Mark & Lesieur, 1992; Volberg, 2003). There is growing evidence that gender is linked with health-related behaviours such as treatment utilisation, substance use, and psychiatric symptoms and diagnoses (Westphal & Johnson, 2003). A review of the research literature by Crisp and colleagues (2000) demonstrates that women make up the majority of service users at most

health services and research shows that they are more than twice as likely as males to seek help from a counsellor at some point in their life (Collier, 1982 cited in Crisp et al., 2000). This difference is not necessarily an indication that women have a greater need for such services but is more likely to reflect gender differences in help-seeking behaviours (Crisp et al., 2000). However, when it comes to gambling, samples of problem gamblers in treatment are predominantly men in the United States and Australia, despite evidence that suggests men and women are equally likely to gamble. This under-representation of women could be a result of the increased likelihood that male problem gamblers are more likely to be in treatment than females (Volberg, 1994 cited in Crisp et al., 2000) or that women are less likely to be routinely assessed for gambling problems.

A review by Australia's Productivity Commission (Productivity Commission, 1999) identified the "feminisation" of problem gambling defined as the notion that more women are gambling, developing gambling problems and seeking help for such problems than in the past (Volberg, 2003). Growing numbers of women are seeking help for gambling problems which appears to be related to the increased availability of gaming machines (the preferred mode of gambling) (Volberg, 2003). Men are primarily engaged in 'strategic', skill-based and competitive forms of gambling while women remain predominantly engaged in 'non-strategic', luck-based forms of gambling (Volberg, 2003). Opportunities for women to participate in gambling in venues outside the home such as restaurants, hotels and bars that are considered safe has increased (Bunkle, 2003; Volberg, 2003), concomitant with the increase in numbers of women from ethnic communities and indigenous women gambling (Dyall, 2004b; Morrison, 2003). There also seems to be a shorter period of time between starting to gamble and problem onset among female gamblers than among male gamblers (Tavares, Zilberman, Beites, & Gentil, 2001). Additionally, women seeking treatment for problem gambling differ significantly from men, with increased reporting of childhood abuse, previous suicide attempts, having a mother who is a compulsive gambler, and being less likely to have been arrested.

Delfabbro and LeCouteur (2003) found that gender and age were the two strongest demographic predictors of gambling involvement among Australians. They found that younger males are more likely than women to gamble on racing activities, casino games, card games and sports; women are more likely to gamble on bingo; lotteries are generally less popular in younger age groups; gambling rates tend to be lower amongst older people; whilst electronic gaming machines tend to be equally popular across both genders and different age groups.

3.1.9 Lowering barriers to health care access and utilisation: Implications for problem gambling

The following recommendations and suggestions for lowering barriers to health care access and utilisation have been derived from research on substance abuse, medical and mental heath problems and problem gambling.

Utilising social networks

Across all ethnic groups, problem gamblers could be guided into treatment by encouraging and informing their social networks in ways to apply pressure for seeking help or treatment (Booth et al., 2000; Grant, 1997; Pescosolido et al., 1998; Wagner et al., 2006; Zhu et al., 2006). These ways include provision of information such as identification of symptoms and referral sources, and reducing stress in the problem gambler. Individual problem gamblers and their families can be empowered by learning to recognise symptoms, by writing questions and concerns in advance of formal assessment, by asking for clarification and by voicing

doubts about the suitability or feasibility of recommendations (de Bonnaire et al., 2000; DeSouza & Garrett, 2005; Kwok, 2000). Large social networks, closely tied communities and Employee Assistance Programmes can be conducive in assisting problem gamblers into treatment (Booth et al., 2000). Women whose male partners are problem gamblers could be especially targeted (Zhu et al., 2006). Female problem gamblers may be more likely than males to respond to encouragement from family, friends and advertisements (Booth et al., 2000).
The stigma of mental health disorders in Western societies seems to be diminishing, encouraging more young people to seek help (Kessler et al., 1998). It is possible that by changing social attitudes, the shame and fears of problem gamblers might be diminished (Cunningham et al., 1993; de Bonnaire et al., 2000; de Zwart et al., 2002; Goldberg, 1995; Kessler et al., 1998; Wu & Ringwalt, 2004). Attitudes may change due to increased awareness of the symptoms of problem gambling, availability of services and their effectiveness, and information about care-giving skills for relapse prevention (Cowan et al., 2003; Cunningham et al., 1993; DeSouza & Garrett, 2005; Grant, 1997). If social attitudes change, then the intrinsic barrier for problem gamblers of expectations of adverse reactions from society, friends, family and social networks could be lowered (Barney et al., 2006; Dixon et al., 1995).

Although the enabling factors of availability, affordability and acceptability are not as important as intrinsic factors, social attitudes, social consequences and severity of symptoms in access to treatment for substance abuse (Booth et al., 2000; Hajema et al., 1999), increasing the enabling factors for problem gambling may be more realistic to achieve in the short term than trying to change attitudes (Grant, 1997). Within the managed health care system, clinicians need to ensure that clients understand technical terms, what they need to do and match explanations with realistic outcomes (DiMatteo, 1997; Dixon et al., 1995; Todd et al., 2002). Furthermore, clinicians need to be aware of their professional attitudes and ways of changing them to provide appropriate services for different genders and ethnic groups (Marsh et al., 2000). These attitudes include judgements about impulse control disorders and the different needs of men and women. Although trust in treatment providers is important for people with mental health problems, individuals with impulse control disorders such as problem gambling may consider professional knowledge and training more salient (Lane & Addis, 2005). Problem gamblers from minority groups should be able to choose group interventions that are suitable for their respective backgrounds and with sufficient numbers of members that they do not feel alone (Kwok, 2000).

For comorbid problem gambling and substance abuse, integration of treatment services and coordinated strategies could be improved. Case managers could be assigned to coordinate multi-disciplinary teams, clinicians could be trained in assessment, treatment planning and interventions for comorbid disorders, motivational interviewing and cognitive behavioural strategies could be applied for treatment and relapse prevention (Todd et al., 2002).

Dissemination of material should be targeted both at community members and community-based workers, who need to be aware of available services for their clients. The most effective forms of information dissemination are local radio, community newspapers and newsletters (providing they are also delivered in relevant languages) (Scull & Woolcock, 2005). There is some evidence that media usage can overcome some of the intrinsic and extrinsic barriers associated with privacy (Hill, Weinert, & Cudney, 2006; Marks, 2005) and enable access to rural dwellers (Schopp, Demiris, & Glueckauf, 2006). For example, from interviews and a focus group with lower socio-economic status men, a television men's health documentary seemed useful in promoting awareness of physical health care and help-seeking (Hodgetts & Chamberlain, 2002). Men may be reluctant to seek help from their male friends for problems such as depression and substance abuse but anonymous Internet groups seem to be more acceptable (Humphreys & Klaw, 2001; Lane & Addis, 2005). In addition to

lowering the perceived stigma of having a problem and the privacy aspects, they learn that other men can have similar problems and that mutual help is available. Formal and informal treatment programmes for alcohol and substance abuse seem to be more suited to men (Goldberg, 1995; Marsh et al., 2000). However, women who are problem drinkers are more likely than men to visit Internet self-assessment and mutual help sites since with 24-hour access, women do not need to disclose personal thoughts and feelings in the presence of men (Cunningham, Humphreys, & Koski-Jannes, 2000; Humphreys & Klaw, 2001).

Utilising community leaders

Models that capitalise on the appropriate use of a broad range of helpers, such as ministers and ethno-religious organisations should be explored (Fuller et al., 2000). Community and religious leaders can also have a role in public awareness or treatment programmes (Brown, 2002); according to Brown, a change in attitude and access to community leaders could assist with this. Changing the perception that nothing will help is also important and strategies need to address this perception (Scull & Woolcock, 2005). To assist in the dissemination of information, there is also a need to build partnerships between communities and community workers. Working in partnership with ethnocultural communities is a key element for developing effective and alternative mental health practices to address the issue of problem gambling. By having strong relationships based on trust and understanding between gambling help services, communities and community workers, services can be promoted and information disseminated. Training and relevant information should also be provided to key community leaders, as they in turn can assist community members who approach them for help with a gambling problem. Such leaders could also provide legitimacy and support to the work of services (Scull & Woolcock, 2005). Seminars or workshops may also be helpful but need to be marketed as something less stigmatising than gambling, such as family life issues or money management workshops. More innovative ways to disseminate information should also be discussed with workers from specific non-English speaking background (NESB) communities to identify popular forms of entertainment (Scull & Woolcock, 2005).

Efforts to improve help-seeking for mental health problems have largely focused on improving mental health literacy of the community, and reducing the stigma associated with experiencing and seeking treatment for a mental illness (Judd et al., 2006). While these are important in some populations, these may not be sufficient areas for attention. In addition to community education around available services, a broader campaign needs to target the wider community to address the issue of stigma. While such attitudes remain, gambling problems will continue to be surrounded by secrecy and shame (Scull & Woolcock, 2005).

Community education plays a crucial role in increasing service access but this alone will be insufficient if available services remain inappropriate, or are perceived to be inappropriate. One way to overcome this is to use bilingual and bicultural counsellors who can talk with clients in their own language and who understand the cultural issues and pressures the clients face. In the absence of bilingual counsellors or multicultural workers, existing mainstream counsellors must also be trained to ensure they are aware of, and responsive to, the needs of non-English speaking background clients, and to ensure they have an increased understanding of cultural issues. It is also important in this situation to work with trained interpreters. Working with interpreters is recognised as more difficult and requires more time to build relationships and establish rapport and trust. One solution is to allow clients to nominate a preferred interpreter, if they have used one on other occasions, with whom they have already established a relationship (Scull & Woolcock, 2005).

Framing of problems

A key issue with regard to help-seeking is how people and/or their families perceive and frame the problems they face. A review by Featherstone and Broadhurst (2003) reveals divergence between lay and professional definitions of problems across a range of literature and research contexts in terms of the perception of the severity of the problems or symptoms and in terms of how such problems are labelled and viewed. Significantly, the more severely the problem is viewed the greater the likelihood that contact with formal services will occur (Featherstone & Broadhurst, 2003).

Accessible and appropriate services

Andersen (1995) suggests that community and personal enabling resources must be present for use of services to take place. First, health personnel and facilities must be available where people live and work. Then, people must have the means and know-how to get to those services and make use of them. Income, health insurance, a regular source of care, and travel and waiting times are some of the measures that can be important here. Scull and Woolcock (2005) make a number of suggestions about how gambling treatment services can be made more accessible; these include such elements as confidentiality (which is key to assisting all problem gamblers) and more flexible service delivery, moving away from a traditional office-based system to more informal, anonymous community settings. Service delivery modifications could address the barriers to obtaining help (shame and losing face) though practical assistance such as financial counselling may be preferable to talk therapies or telephone counselling. In terms of therapy, early counselling sessions could focus less on the gambler's perception or recognition of their gambling problem and more upon talking in general about their problems. Ethnicity data collection is another key strategy; collecting detailed sociodemographic information such as gender and cultural background should be included in gambling client records (McMillen et al., 2004) and a standardised minimum data protocol developed so that it can be cross-referenced with Census data to estimate which groups are under-utilising services. The effectiveness of these suggestions needs to be tested.

Culturally and gender specific services

Brady (1995) suggests that many indigenous people in Australia and North America have developed innovative interventions that incorporate traditional healing practices and cultural values into the addictions field. Increasingly, the reclamation of culture is an aspect of healing, and cultural wholeness is a prophylactic and curing agent in drug and alcohol abuse (Brady, 1995). This notion has been advanced over the last few decades with regard to Maori and mental health (Durie, 1998; Dyall, 2004a). Gender-specific initiatives, including non-traditional services, could be developed to address the particular problems and needs of men and women affected by problem gambling (McMillen et al., 2004). Alternatively, services having a coordinated network of culturally specific services could work in collaboration with multicultural and indigenous organisations (McMillen et al., 2004). There is also a need for assistance and resources for the families and friends of gamblers experiencing gambling problems (McMillen et al., 2004).

Provision of culturally appropriate community education and multilingual information

There is a need for education about problem gambling and the support services available for friends and families, including cultural communities (Niagara Multilingual Problem Gambling Program, undated). Scull and Woolcock (2005) recommended increasing access through such strategies as providing culturally appropriate community education and gambling help services; developing partnerships between NESB communities, gambling help services and community workers; and the development and implementation of preventative

strategies. This is similar to the strategies identified in DeSouza and Garrett's (2005) report into barriers to Chinese access to services in New Zealand.

The overall lack of awareness among community members about problem gambling needs to be urgently addressed using targeted multilingual information otherwise people unable to access basic information about problem gambling will remain unaware of available help. Multilingual information needs to provide a clear explanation about gambling and problem gambling, and about the available gambling help services and how they can assist. This may help to dispel the myth that counselling is a 'Westernised' form of treatment and should also help to ensure people do not approach gambling help services with unrealistic expectations about the help they will receive. The confidentiality of the service needs to be stressed, as does the availability of bilingual counsellors or a free interpreting service. It may also be advisable to use a term other than counselling, in preference of something more informal. Such information should help to address the perception held by many that no one can help with their problems (Scull & Woolcock, 2005).

Many responses to under-utilisation of services and barriers to access have been proposed by researchers and agencies. These include: improved outreach and service information, locating agencies in areas of minority concentration, provision of multi-lingual services, ethnic matching, multicultural training and cultural sensitivity, minority service units, inter-agency coordination, less formalised or bureaucratic service delivery, adoption and diffusion of equity policies, community consultation, action research to establish minority group needs, support for ethno-specific agencies, and coordination of ethno-specific and mainstream agencies. However, few have been evaluated (DeSouza & Garrett, 2005). In New Zealand, cultural competency and cultural safety have been advocated; however, these strategies have not been formally evaluated. The evaluation of impact needs to consider utilisation, and client and family wellbeing.

3.1.10 Conclusion

This review has outlined the barriers to help-seeking behaviour for problem gamblers and their families/whanau by reviewing literature about help-seeking, health care access and utilisation (including alcohol and other substance use disorders) and help-seeking by problem gamblers and their families/whanau including barriers to, and relevance of, services. Generic models of the help-seeking processes have also been reviewed together with models which assist in the understanding of health care change and access, with a particular focus on intrinsic and extrinsic factors. A number of recommendations have been proposed to make services more accessible and appropriate. The review shows that cultural factors influence problem gambling behaviour, perceptions of problems, help-seeking pathways and options. It is important to identify the pathways and trajectories of help-seeking so that family, friends and communities can provide support, and efforts at self-efficacy and self-recovery can be supported. The review demonstrates that wider community campaigns and enlisting social networks and community leaders can also help to reduce denial, stigma and shame. Suggestions are made about making services more accessible and appropriate including providing indirect, practical help and financial counselling. Clearly, the experiences of certain sub-groups need further exploration. Research and more effective ethnicity data collection are proposed to better understand the experience of men and women in different cultural groups to ensure that problem gambling interventions are both evidence-based and culturally appropriate.

3.2 Focus groups

Focus groups were conducted with treatment providers, members of the advisory groups for the Gambling Research Centre and the Centre for Asian and Migrant Health Research (both Auckland University of Technology research centres) and other key stakeholders with an interest/knowledge in the area of problem gambling and/or help-seeking behaviours. There were between five to ten participants per focus group. There was a specific focus on Maori, Pacific and Asian representation in the focus groups since these populations are most at risk for developing problem gambling behaviours.

The participants in the focus groups were selected by either their current involvement in the advisory groups or from their identification by the research team as problem gambling service providers and/or key stakeholders (providers of other services such as alcohol and drug treatment providers, budget advice services, community and health workers, gambling industry personnel and health promotion advisors).

Focus groups were semi-structured to allow scope for participants to elaborate within the areas under question, to enable more detailed responses. Focus groups were digitally recorded for subsequent data transcription and analysis. A systematic qualitative analysis of similarities and differences in participants' perceptions was conducted to interpret the data from the transcribed recordings in relation to the original research questions. Emerging trends and patterns were grouped according to themes. Responses were ordered into more specific categories for comparative purposes to determine possible cultural differences. A 'picture' of the barriers and enablers to help-seeking for problem gamblers and their families/ whanau emerged as the data analysis proceeded. Qualitative analyses were undertaken using NVivo (Version 2) software.

This section of the report provides a summary of the themes identified. Through the process of examining the dialogue from the focus groups a number of themes presented. As there was wide discussion within the groups, the themes that are reported are those pertinent to issues of help-seeking by people with gambling problems, and their family/whanau. The themes are outlined with special attention to different perspectives in relation to ethnicity and gender as these were identified as important considerations in the project design.

3.2.1 Defining problem gambling

Many of the participants felt that there were difficulties in defining 'problem gambling' and in particular the threshold at which 'gambling' became 'problem gambling'. This was seen as a barrier in regard to help-seeking as there is a delay in recognising that there is a problem that can be helped:

> *"... gambling's kind of continuum, social gambling or whatever, problem gambler and we find that yeah extreme is pathological gambler, but there is no clear some kind of indication that I have passed over the line and that may delay them to seek help"* (Asian, Male)

> *"I think quite often the, there's a lack of realisation that this is a problem that can be helped"* (Pakeha, Male)

> *"Can I just ask a question? What really, what is problem gambling? Like how far do you have to have gone ..."* (Pacific Island, Female)

The issue is also relevant for the families and whanau of people with gambling problems:

> *"That's a big one because lots of whanau don't see them having problems to do with gambling"* (Maori, Female)

Even within the professional field, the definitional difficulty is still prominent:

> *"You could have somebody who you know can afford to spend millions and yet that maybe doing them no harm, but there maybe someone who's spending their last five dollars and that is causing harm because it means the kids aren't getting fruit and veges for the week or whatever, so where do we draw the line, and if we don't know where to draw the line how do people with the problem even begin to know where to draw the line really"* (Pakeha, Female)

Despite the complexity of determining the conditions in which gambling can be seen as problematic, the majority of participants were clear that for many people problem recognition becomes most clear when problems become acute and severe.

3.2.2 Crisis

Most participants identified a personal crisis as instrumental both in recognising a gambling problem and in motivating help-seeking behaviours:

> *"I wrote down as an enabler that it's that crisis point, it's getting them at that crisis point, where something big is gonna happen, so avoidance is no longer an option, that's one of the reasons that gets people in"* (Maori, Female)

> *"What do you think are the specific enablers to seeking treatment for problem gambling?*
> *Hit rock bottom.*
> *Nowhere else to go.*
> *Running out of options.*
> *They reach that stage of kore [absolutely nothing, broke] and that's when it becomes dangerous for them"*
> (Maori, Females)

> *"Certainly an enabler is the crisis ... certainly we see that in alcohol and drug services where there's a strong relationship between symptom severity or stress and attendance, so once those symptoms of stress or distress are relieved or alleviated then attendance drops off markedly so, again that would support that crisis and just feeling of discomfort and not knowing what to do is a powerful enabler"* (Pakeha, Male)

The crisis can also extend beyond the person with gambling problems and impact on the family/whanau:

> *"... so if they don't come, the gambler, the significant other have to come first, actually to understand a situation, understand a background, why that person become like that ... if they understand it more and the anger can be put aside easier, otherwise if they lost their house already, lost the car, lost, no money, how can I not [be] angry"* (Asian, Male)

"... the alarm bells rang when she had no furniture, she sold her furniture, her house, and the excuse that she's given is that um, 'cause they're moving in to a new house, they want to buy new things, quite nice furniture, and so, but, it's her husband that's the gambler" (Pacific Island, Female)

A significant reason underpinning the delay of defining gambling as a problem until a crisis is reached is the shame and stigma of acknowledging a gambling problem to oneself, one's family/whanau and one's community.

3.2.3 Shame and stigma

The issues around the shame and stigma associated with problem gambling were recurring throughout participants' discussions and were seen as a central barrier to seeking help. In participants' minds, shame and stigma were both clearly linked to problem gambling:

"Well I think gambling it's relates to shame, that goes together I think" (Pacific Island, Female)

"It's too often I think stigmatised as an individual's weakness or whatever it might be and not addressed in a supported way by the rest of the society" (Pakeha, Male)

"There's a stigma around gambling, there's a stigma that's still around. The ones that we talk to shy away from going and getting help" (Maori, Female)

The shame and stigma are implicit in people's denial of a problem:

"There's a whakama [shame] around admitting that there's a problem."
"It's the fact that they don't want to admit it. Fifty five percent of them say 'no I don't have a problem' and yet eighty percent ... have a problem with gambling"
(Maori, Female)

"And the biggest barrier is a word that begins with 'D', called denial of course one little word, very powerful" (Pakeha, Male)

This individual level of experience of shame and stigma, of accepting that gambling has become a problem, are also inseparable from the shame and stigma that this will bring upon the family, whanau and community of the person with gambling problems:

"... you know guilt is the other thing, because um, I wouldn't look for, probably I punished myself for using the whole family assets on my gambling. And um, I will probably not seek help because it could be I punished myself for it" (Pacific Island, Female)

"Yeah, because among the Asian community most likely they are more a collective sum rather than individual sum, so it will bring down, it will put down the family's name and also if they respect their parent very much, let's say for the international students, they lost everything, they dare not to tell their families" (Asian, Male)

This is particularly relevant to help-seeking for problem gambling as it was felt that many people feared accessing treatment as they would have to tell the service that they had a gambling problem and this knowledge could get back to their family, whanau and community.

3.2.4 Disclosure and confidentiality

Beyond the difficulties in recognising and admitting to having a gambling problem, an additional barrier was seen in having to disclose this problem to a service that existed in a potentially 'small world' community, especially for close knit communities such as Maori and Pacific or for small communities such as for Asian migrants:

> *"... words like pride and shame and guilt and those sorts of things come into it as well, because, it's a key question we get asked about, which I think is a barrier, 'what say the person knows me?' 'Who is the person going to tell?'"* (Pakeha, Male)

> *"I have to run the risk of tell my secret to you, maybe if you can speak my language, the community is even smaller then you may disclose my information out so they [the gambler] don't, confidentiality"* (Asian, Male)

> *"There's also a lot of suspicion around that issue of disclosure and a suspicion of how much of this am I going to be revealing which I think acts as a hindrance"* (Maori, Female)

> *"Because if you go to a Pacific specific service, um a friend told me that 'I don't want to go there because it might be my uncle, it might be my aunty who's gonna be my counsellor' or whoever, and because we're all family orientated then it will probably leak out, that would be the assumption because you're related to the counsellor the person that um, it will leak out that way"* (Pacific Island, Female)

> *"Another major issue was around confidentiality, and Pacific people were very, very concerned that because it's a very small community or they tend to be very small, that people will talk"* (Pakeha, Female)

> *"We found both in Maori and Pacific groups that clients who would prefer to come to our mainstream service for that reason, confidentiality because if they went to a Pacific or a Maori service there'd be somebody there who'd know somebody in their family it would get back to them, so they just didn't want to do that"* (Pakeha, Female)

Thus, in relation to help-seeking behaviours, stigma, shame and issues around disclosure and confidentiality can be seen to delay problem recognition and acceptance and also impact on accessing professional services. Whilst an individual's experience of stigma and shame is entwined with how others (family, whanau, community) will respond to the knowledge of the gambling problem, this has a complicated impact on help-seeking. For example, there was an acknowledgement that it was precisely this stigma and shame that prevented many people's gambling from escalating into problems. Although embarrassed or fearful of how others will react, the journey that many help-seeking problem gamblers take will often start with family, whanau and communities.

3.2.5 Help-seeking journey

Whilst there is no prescriptive pathway that people with gambling problems take in seeking help, there were commonalities in how the participants described the ways in which help-seeking was carried out. Beyond the complexities of problem recognition (see 'Defining problem gambling' previously), the first stage appears to be an *individual response to the gambling problem*:

> *"... people come in thinking 'I can do this myself' or they continue with the problem thinking 'I can do this myself' ... when they're dealing with a machine ... its hard often for them to understand why they can't stop themselves when it's just a machine ... when people do finally present for treatment ... they're pretty far down the road as far as the extent of the problem, because they've been trying to stop and haven't been able to achieve that and so we kind of get to be the last stop"* (Pakeha, Female)

> *"... the problem is the problem gambler, mentally I believe they try every possible way to stop gambling but it doesn't work"* (Pacific Island, Male)

> *"We have to think about what kind of message we are giving to our children, usually we encourage them to stamp on their foot, which means independence, later on they have a problem with gambling, what problem it would be, do you think it's my problem I need to solve by myself, it's my problem, so they don't seek help from outside and they struggle with the problem on their own without professional or support from families and that makes them isolated from the good resource which you know can help them solve the problem"* (Asian, Male)

Along with attempting to stop gambling alone, many people often turn to *friends, family, whanau and communities* for help:

> *"I mean with this psychological problem if I may say that, then it doesn't have to go for treatment, clinical treatment, I will probably go to a Matua [elder] at church, and share what happened"* (Pacific Island, Female)

> *"... you know before they seek help they go a lot of different area to get solved to seek help, such as their family members or friend, but most time it's quite isolate from that kind of connection as their gambling become problem they isolate themselves"* (Asian, Male)

Other problems were noted in relation to the social isolation that people with gambling problems experience. Families and communities were seen as 'not equipped' to help. There was also caution signalled in accessing help at family, whanau or community levels as people may be seeking help from others with similar issues:

> *"Usually they seek help from their friends and their family, so usually those friends are the people, same as them, they are gamblers ... sometime say don't worry about everybody is the same. Some people say ok, I can control myself you better control yourself so sometime is peer pressure to make them go to gamble sometime those friends can help them, sometimes those friends cannot help them ... usually their family member cannot have a sign to see this person have gambling problem, so they don't have an early signal for other people to help [the problem] gambling"* (Asian, Male)

> *"What I've found is that the burden in barriers is the relationship they're in, they'll normally try and work it out with their partner, she'll be in a lifestyle, for Maori, for a lot of them anyway where 1) they can't be bothered, 2) they'll try and work it out themselves and before they know it the debt has tripled"* (Maori, Female)

The family can also be seen as a barrier both to addressing the problem gambling and professional help seeking:

> *"... there is huge pressure from the family members, the problem is that family members keep saying the same word, don't do it - don't do it - don't do it ... the*

message they give the problem gambler is all negative one, if you like to you can quit anytime, but it's not always like that, which means that problem gambler they try to, when they reach the problem stage, they try to stop it but it doesn't and so family member give them message that you fail it deliberately and you are failure, you don't have a strong will, which means they target on the person instead of problems" (Asian, Male)

"I wonder sometimes whether the family is also the barrier because they don't want the person with the problem to front up, they'd sooner keep it in the family" (Pakeha, Male)

"Advising and nagging are two different things" (Asian, Male)

Overall, the perception is that people with gambling problems will exhaust all other options, whether it is their own resilience or the support of others before they seek help from professional services.

It must be noted that this perspective is predominately representative of those who have worked with people who *do* access problem gambling services and there was recognition that problem gambling can and does get resolved at the individual or family/community level:

"... specialist treatment is not essential, people don't need it to recover or resolve their issues and there are plenty of ways they can do that, so almost perversely a barrier to accessing specialist treatment is probably not a need, they've got a nice mother they can talk to or a friend down the road or church group" (Pakeha, Male)

"I think we need to look at the basic system of fa'aSamoa (Samoan way of life) that um, I would probably advise them to go and talk to a matua (elder) to the matai (chief) ... the role is to look after the well-being of the family ... usually, back home, all the uncles and aunties, we sit together if something happens to the child, nephews and nieces, and have a discussion on what's the best thing to do ... it's part of the cultural healing as well in line with traditions as well to go back before the person becomes a heavy gambler to the path that he would usually lead in his daily life instead of going to the casino or pokie machine. I think that family is a strong element of our lives" (Pacific Island, Male)

However, for those who do seek professional help for gambling problems, it is usually only after the problem has been recognised and a range of individual and/or family, whanau or community solutions has been attempted. As the problems that people experience become increasingly severe and their options drastically reduced, there is a move towards accessing services. This scenario is far from a straightforward recipe for professional help-seeking as it is influenced by other factors (described below).

3.2.6 Obstacles on the help-seeking path

There was an acknowledgement that problems with gambling are often accompanied by *other problems* (often inter-related), and that help-seeking needs to be prioritised:

*"Often I find that the clients we see ... they're dealing w*ith multiple issues. So whatever's in front of them on that day, that takes precedence" (Maori, Female)

"Have we got like a scale of things, you know, you're a new migrant not financially stable, you would have other worries on your priority list and unless the problem

gambling issues becomes a really sort of a tangible in your face problem I don't think most people actually seek help" (Asian, Female)

"... people may not see it as a priority, like they'll go to work instead or look after your family" (Pacific Island, Female)

"... they need gambling assistance but they've come to our service, perhaps they see alcohol and drug issues as being more important" (Pakeha, Male)

There was also discussion of *the role gambling* (problematic or otherwise) plays in people's social and cultural lives (such as providing opportunities for socialisation) that were seen as potential barriers (i.e. whilst maladaptive, the problem gambling retains value). This was most noticeably seen in the experience of Asian migrants:

"... you can see that for international students you know I mean the peer pressure and all that could be coming from the fact that there's nothing else to do or, I mean it's the same with a lot of the migrants ... it all starts out in someone's home, they start playing cards, and if you say well don't gamble they say ok we'll stop if we can find a job or if we've something to do but there isn't anything else to do, it's the only way to escape" (Asian, Female)

"... usually among the Asian community most of them are new migrants ... most people seek help from one year to five years, so that means the longer people settle down, the less they will use gambling to escape from problem, they use that as a mechanism to cope with the frustration, loneliness or homesickness or unhappiness" (Asian, Male)

Along with being valued, problem gambling, like gambling itself, could also be seen as *inescapable*:

"In particular for Pacific people that very strong kind of fatalistic kind of attitude that, you know if you get sick or something happens to you, that's because you know you've offended a god and this is kind of your retribution, you know this is your pay back and so, there's very much a view that you know there's not much you can or even really should do about it ... well I've kept on losing, now I'm in this mess it's because I've done something and I'm being punished you know by, by the gods or god himself or, or whatever" (Pakeha, Female)

"The belief system is very, very powerful, if you're on a losing streak it's got to change, and if you suddenly get a winner, it is changing, and then you start beating up on yourself, punishing yourself, I deserve this, I'm worthless, I'm useless this is what I deserve, I am punished by some other god, whatever it may be that's why I'm being punished, that's why I'm losing" (Pakeha, Male)

Once gambling has become defined as a problem, usually through an experience of crisis, and a resolution sought on individual and social levels, and the problem is seen as a priority, the first major obstacle in seeking professional help is the *ways in which problem gambling counselling services are viewed*:

"... we all understand what counselling or treatment would involve, but that's not the case for most people ... most people have very distorted ideas about what counselling will involve, they don't understand it, they think that it's going to be somebody telling them how to live their lives, all those sorts of things, it's just a general attitudinal belief around, around what counselling would mean" (Pakeha, Female)

"... knowing what happens as well, when you actually engage with that counsellor or clinician ... clients don't seem to enter with a clear understanding of what will happen, they have sort of a vague idea of what might happen, and kind of vague ideas of the sorts of, types of treatment they might like, or the type of assistance they might like, but they're not well formed ..." (Pakeha, Male)

"... if people don't have much knowledge about counselling, that they may think, you know, you'll want them ... to be there for the rest of their lives" (Pakeha, Female)

"... especially with Maori, being the fact that they've got an issue with counselling, 'what help, I don't need it', it's so normalised to our people, counselling is like 'euw, I'm not weird or anything like that, I don't need it' it's so normalised in their life" (Maori, Female)

"... because they don't know what is counselling, I think most of the Asian country, counselling in the old day, there is nothing called counselling, so this is a foreign term so they don't believe it, so they don't know it so they don't know whether it can help them, so why [should] they use it ... what can you help me, can you borrow money to me, no that means you can't help me" (Asian, Male)

"... people want practical solutions and just to sort out their feelings ... and there's this perception that if you see the counsellor or if you go and talk to a psychologist or a therapist that it's only going to be, on one hand there's this expectation that this person's going to solve all my problems, find me a job, make me fluent in English and you know give me money so I can pay off my debts or whatever and then when they find out that oh you don't do that, what's the point of seeking help from you" (Asian, Female)

The ways in which counselling services are reported to be perceived by people with gambling problems are also seen to be influenced by *views and experiences of mainstream mental health services*:

"Especially because it does come up as a mental health issue and there's terror around the mental health system for Maori, we've traditionally been put away and drugged as a people, that's where the counsellor becomes the doorway to that mental health system" (Maori, Female)

"... people have mental health problem to see a counsellor, so they don't admit [to] themselves [that] they have psychological problems so they don't believe they have mental health problems so they don't want other people to look at him like a mental health patient" (Asian, Male)

"We have to explain to them in more detail about what will be happening in the counselling sessions so that they have more information they don't think that they treat me like a mental health [patient]" (Asian, Male)

The way counselling is constructed is also informed by other *traditional addiction services* and an assumed abstinence treatment model:

"... particularly with women this is a barrier that because they may not have a concept of what counselling's about and what to expect they may think that when they go in somebody's going to tell them 'well, you've just got to stop' and they may not be ready to stop they may want to slow down but not quite ready to stop and so if they

think that's the only option that they have they may not choose to come in for treatment" (Pakeha, Female)

"... they believe that if I seek help from professional, professional may talk to me 'stop doing it', that makes them delay the contact, and so but actually we are not talking about all of the above, you know how to reduce or cut off the gambling, we have other areas which can support the person stop gambling, but they don't expect that and that is the problem, they delay" (Asian, Male)

This is particularly relevant in the problem gambling area as there is a significant pull to continue gambling in some form in order to recoup financial losses - *'gotta be in it to win it'*:

"'Hey if I stop I'm not going to get out of this problem, I'm not going to win the money I need to get out of this problem', that can be a huge barrier for someone not travelling forward to actually take that next step" (Pakeha, Male)

"... I dare not to give up gambling, if I give up gambling that means all the money I have lost is definitely lost, if I got the chance to gamble I might have the chance to win it back so they have to think do I just cut it off like that or should I continue maybe luck will come" (Asian, Male)

"If I were a problem gambler seeking help exactly means that I have to give up my hope" (Asian, Male)

"... the incentive is actually to keep gambling because you kind of have this idea that if you have the big win, that will solve the problem, so the actual incentive is not to stop" (Pakeha, Male)

"... if they do stop, they've completely cut off any hope of recouping their losses, so there's that incentive to keep going ... because there's possibly the chance rather [than] saying no chance at all" (Pakeha, Female)

The perceptions of counselling reported in the discussions suggest the harm minimisation approach could be more accessible for people with gambling problems and that this approach needs to be more effectively communicated. The need for raising awareness was also strongly echoed in discussions around the knowledge of problem gambling services in general.

3.2.7 Problem gambling services: Awareness and accessibility

A significant barrier discussed in relation to help-seeking was a *lack of awareness* amongst people with gambling problems, their families, whanau and community of what problem gambling services are available:

"I think one of the barriers ... is education, the lack of awareness and education out there within the community of knowing and feeling safe. Feeling safe enough to be able pick up the phone to call, feeling safe enough about community places. So maybe it's a little bit about us getting out there a little bit more and walking amongst the people and letting them get to know us a lot better" (Maori, Female)

"... because people are not very well aware of this service ... I've been serving to the community for the last two or three years only but even we don't know ... how would expect that grass root level people would be knowing about this service ... they don't

know what problem gambling service is, and this is my major concern, is like people doesn't know, simple" (Asian, Male)

"When I was out in the gambling field, I never even knew the gambling line existed. Never ever. I was quite shocked when I saw it. I don't believe there are enough resources out" (Maori, Female)

"... thinking back to the Island when our people are sick, there's trees, they know the name of the trees to get, and what part of the tree to use for treatment, also they know who is the healer, the minister, it's very small but they know where to go, coming here to New Zealand, they can't do what they used to do because they don't know where to go" (Pacific Island, Male)

"It's about raising the awareness because I would really like to see more of the services who are here today promoted within our communities, on the radio all the time" (Pacific Island, Female)

"The 'A' word. Its awareness ... lack of awareness ... it's a problem" (Pakeha, Male)

The lack of awareness impacted on the accessibility of a service and was seen as an area for continuing improvement:

"Awareness I would see as the biggest issue, you can raise awareness and that can have a positive effect ... raising awareness will work to a certain extent ... we've invested in the last year or two in marketing and our numbers through the doors increased quite dramatically, so it's an easy way of getting more people through the door" (Pakeha, Male)

"It's all about, sometimes the advertisement can help a lot, you know, for example we have an advertisement in Tonga, Fiji, Cook Island, Niue, Samoa, and we also explain on the radio ... because this is the main tool, language, they use Pacific Island services because there's a Tongan clinician there, you know, there's a Samoan clinician, so that's why some of them are starting to look" (Pacific Island, Female)

"... so the question of why our people are not calling is for me just a lack of advertisement and more out there ... because their no longer in that networking where it goes back to what I'm talking about the fai kava where people start talking about their behaviour ... so, that's why I said it needs more of a media advertisement, because these people they can't go back to the community because of shame and all that" (Pacific Island, Female)

"So an enabler would be to put up notices?"
"Yes, get permission from management in shopping malls"
"And in the gambling casino rooms"
"Liquor outlets, all the gambling casinos, ask the mayor whether we can put one massive one up on the main street"
(Maori, Female and Male)

"... anywhere you look round the world whenever there's an advertising campaign then the number of contacts zoom up between two and ten times, so it would indicate that people just don't know services are there, or that they're appropriate" (Pakeha, Male)

"… advertising it and just raising that awareness, who they can approach, because a lot of the stuff I've seen to do with gambling counselling it's still got old information on the pamphlets, it's no use to the people out there, so just upgrading that stuff as well" (Pacific Island, Male)

The *type of awareness* that was reported was seen as complex in terms of identification (or not) with similar problems and help-seeking behaviours:

"It is similar to any other thing, like you take on drugs or you go on any other thing like that, it is the same problem, so the information required in all these things is the same that now and I know that this clinic is available or that help is available, I don't even tell anybody I just go and talk to them I have this problem" (Asian, Male)

"… quite often the service appears to be related to drugs and alcohol and cigarettes and that's not how the person sees it . . . there's a lot of comorbidity stuff but often the person who needs help doesn't want to be lumped in with all the druggies and alchies and so on" (Pakeha, Male)

"… one of the most common services used is the GP but no-one knows that you can actually see your GP for gambling services or mental health problems, they only think the doctor's only for your body sicknesses" (Pacific Island, Female)

"… there are so many places that the information could be made available that currently isn't being, venues are doing some but you know, I don't see anything in my library I don't see anything in my GPs I don't see it in all those places I might be sitting and I can just "that rings a bell" or I know a friend who might benefit from one of those" (Pakeha, Male)

"… health promotion is quite important, health promotion targets people [about] how to make themselves healthy [and] at the same time will deliver the message about our service availability as ok, we are there to help you . . . you are the person who fixes the problem but we will help you, so that kind of message needs to go together, health promotion, how they build themselves to be healthy in this foreign country, at the same time we need to give them the information on our service" (Asian, Male)

"I guess it's just a process of the education and the knowledge getting out there, it just takes time but the whole focus is about just getting that contact out there and that knowledge about what it can do, the effects of it" (Maori, Female)

A significant element of this lack of awareness, together with the recognition that people may be experiencing several problem areas (see above), was that those who are seeking help for their problems with gambling may do so in *other services*:

"The way they got there, it was never direct, it was very indirect, most of them had no idea of the Community Alcohol and Drug Service before eventually finding themselves there, so that was a real barrier to them, and almost without exception they all stated that if they'd known about CADS they'd would have walked in the door several months ago" (Pakeha, Male)

"And with gambling problems too there's so many other places where people with these problems can show up, for instance, WINZ [Work and Income New Zealand], budgeting services, places like that, so as well as you know GPs and general

counselling services, they're going there because they're depressed or they're anxious, those sort of things"
"Corrections, probation officers"
"Hospitals, suicide attempts"
(Pakeha, Female and Male)

"One of the big things I find is a one stop shop, people don't come in for problem gambling but we pick them up, 87% of people come for budgeting have gambling as the biggest issue ... I think if I didn't do budgeting the chance that I'd pick up on gambling problems is very little"
"We are picking up the bulk of our gambling via the food banks, via the budgeting services, people coming in for food parcels and if we screen them for gambling it's 'oh yeah okay I've got a gambling problem' but that's not what they're presenting with"
(Maori, Female and Male)

"... sometimes because we're drug and alcohol, they come because of other issues in their life as well ... just having the appropriate screens and that, so we can just share and just raise awareness, and then sometimes they'll admit that it's a problem they haven't identified themselves so um, well just with the gambling thing is that it can come through because of other issues and we find that they've taken up gambling because its another thing with drinking" (Pacific Island, Male)

The combination of problem recognition and awareness of services was seen as having the strongest potential for help-seeking and was best summed up in one participant's analogy:

"... now for instance I've got a leaking tap, that's a problem, and I try to fix [it]. I can't fix it, now where do I go to seek help, I ask my friend, but I'm maybe worried that my friend [will] laugh at me, it's just a simple thing any home handyman can fix it, and I'm worried I don't want to tell my friend I've got a problem. . . so it's a matter of being able to vocalise it, ok I can tell my friend, ok I'll refer you to somebody but of course that, the plumber needs to be someone I can communicate with and I can't talk, unless they speak the language, trouble understanding what I'm trying to say, so I think different steps you need to verbalise, to ask somebody to refer you to the appropriate service, and then you will be able to communicate with the person who provides the service" (Asian, Male)

Many participants stated that once appropriate help was identified, the *different experiences of contacting the services* were seen as critical to how accessible the service will be for people with gambling problems, particularly in crisis:

"... the old 24-hour syndrome is another great barrier as well ... everything will be all right the next day, you know, they're calling in crisis - 12 hours later everything seems different, when you are having a crisis in your life, when you wake up the next day, things seem a wee bit different, things don't seem quite as bad and so barriers all the way through, they can creep in" (Pakeha, Male)

"... he called the helpline number and there was no answer ... [then] the person who answered, he called twice, doesn't speak his language, again, I will say, language is the very strongest tool of connecting ... you need to have someone who's a bit more mature from the Pacific Island perspective because your first connection is the voice, if I can tell that's the voice of a young person and I'm trying, you know what we have to look at levels" (Pacific Island, Female)

"... we had a call last week from a casino where the person went to go and bar herself, and said the process was very comfortable but she had to wait an hour, she had to wait a whole hour, and she found that very, very off-putting because that's where she, even though it was away from the venue, she knew she was there so the mind set was very strong, but she said the people were marvellous, when she finally saw someone" (Pakeha, Male)

"*I think one of the things, that certainly we see overseas, not so much here ... a barrier tends to come up fairly early on, all the data that's been collected on it, when I've plucked up the courage to seek help instead of getting help it appears all I'm doing is filling in forms or giving information, and that can be a turn off"* (Pakeha, Male)

A number of *pragmatic issues* were also raised that could impact on help-seeking behaviours:

"... the barriers I work with most of the time, is time, also the accessibility of where they're going" (Pakeha, Female)

"I can't get there during work hours; transport's another issue, in Auckland 'hey where is it? That's miles from where I live, I haven't got transport'" (Pakeha, Male)

"Just a practical reason why people may not be seeking help is because they may not have a phone" (Pacific Island, Female)

"They can see it [Helpline] is free immediately"
"And you can call from anywhere"
(Pakeha, Male)

"Accessibility is an issue ... where is the place they've got to go to ... second is the opening hours ... can I go in times outside my normal working time, and the third is how quickly I can be seen" (Pakeha, Male)

"*What do you think are the specific barriers to seeking treatment in general?"*
"Transport"
"Family commitments, work commitments, timing of appointments"
(Maori, Female)

"Sometimes it's also the fact that they think they have to pay a lot of money, even though a lot of the Maori organisations are koha [gift] or a small fee but it goes with the whole terminology of a counsellor that they charge too much" (Maori, Female)

"[Helpline] not enough hours open, only a few days ... not enough hours for the Maori counsellor to work" (Maori, Female)

"Part of the problem is too that with face-to-face agencies and with the support groups, they function at certain times ... they close their front doors at 4:30, so there's a whole lot of clients that we can't access and that's why ... and I was thinking we need to run a group at night so that people can come"
"... when we did offer a night group as an option we got no takers because a lot of our ones are at home with kids at night and during the day when the kids are at school so we don't run the programme during school holidays 'cause they're at home with the kids. That seems to have worked"
(Maori, Female)

"A terrific enabler is … your agency does the home visit to the whanau because a lot comes out of that in terms of your assessment" (Maori, Female)

"… sometimes the treatment's not appropriate … whether its cultural appropriateness or age appropriateness or area … financial appropriateness … is it free? Is it cheap enough? So if it's a young person looking for gambling help, can that young person afford it or any person, even transport" (Pacific Island, Female)

Differences between the accessibility of telephone and face-to-face services were also seen as relevant in terms of help seeking:

"… a very clear barrier, people ring up 'can I speak to who I spoke to yesterday', no that person's not available, boom that could be the end of the contact we have with that person … that's why we have a call back system now, where the same counsellor offers a call back … 'I'd like to have spoken to the same person again because I spilt my life to that person I spilt my guts to that person then I've got this clown called Joe and he's asking me all the same questions again'" (Pakeha, Male)

"… one of the things that is an enabler about the telephone line is the anonymity, the fact that people can access it from wherever they are, those things by and large are the barriers to accessing face-to-face often because people can't get to appointments" (Maori, Female)

"… the Asian service agree that a lot of people have a shame issue with their problem gambling, they don't want to disclose their identification, so they prefer to go to telephone counselling first, and so that's quite important so let them" (Asian, Male)

"One of the potential barriers is that if I go and see a face-to-face counsellor they're going to look me in the eye and I've got to be honest, and so that's the other side of the anonymity that, someone might go through the helpline" (Pakeha, Male)

"… one of the questions I raise about their accessibility, where they are, do they feel that could be a stigma about someone coming in it [the problem gambling service] is right in the main street … huge banners … this could be off-putting for someone coming in"
"It's kind of like they come in a trench coat and dark glasses because they don't want anybody to see that they're coming into some place that does that sort of work" (Pakeha, Female and Male)

3.2.8 Culture, gender and age

There was an attempt in the focus group discussions to raise issues of culture, gender and age in help-seeking behaviours for problem gambling. As can be seen from the summary so far, most participants preferred to talk in general about the influences on help-seeking behaviours for people with gambling problems. There was some mention of different gambling experiences between cultures, and men and women:

"… they use the language, the fakalakalaka, this means they no longer have that ah, intimacy at home so they use that time after dropping off the children as an opportunity for them to come from there to the machine and do the fakalakalaka which is because they don't have that relationship with their partner or their husband" (Pacific Island, Male)

"I also think that when you go to most places, that men are more quiet but the women they're more open there's the hormone drives and all that stuff, but as a clinician it's developing different styles to get the men to open up" (Pacific Island, Male)

"I find with my Pacific men we laugh a lot, we share things a lot, the jokes and be able to cry and do those things without having any questions like 'is she understanding me?' you know, they know why we laugh, they know why tears, they relate well, there's a connection there it's so comfort[ing], I found that's more effective to work with men" (Pacific Island, Male)

"All depends on different ethnic groups ... and also we find out that now females are picking up quite a lot [at services], regionally we have gamblers, males more, now females are picking up so we cannot see, actually we do not know how many people have problem gambling but we can only see how many people seek help, the community out there you can see in the casino about 80% of them look like Asian, but seeking help, how many?" (Asian, Male)

"I find that in most men who bet horses, they will talk about their bet amongst men, you can hear them laugh about it and even though a lot of money was lost and some of them tell fibs you know, tell their own story, but the healing is there because [it's] no longer a hidden thing, it's part of their, we call Fai Kava, and they talk about it. So when they walk out from there, they feel good about it because they share that with their community" (Pacific Island, Male)

There was also identification of different service use for different cultures, and men and women:

"I don't think that there are any ... that there are too many women who go to Gamblers Anonymous here just because there seems to be more men in the group and I know I've had some women talk about feeling uncomfortable about being in a group with lots of men, but that may be a bit different"
"It's true; there is a barrier especially for gender around Gamblers Anonymous"
(Pakeha, Female and Male)

"The other model that we use is for women given that the women are the educators of the whanau and we use Whare Tangata as the other model that we use" (Maori, Female)

"Wahine Tupono fulfil a great brief because it's a women's group, a lot of the men's groups like the GA thing are very male orientated" (Maori, Female)

"I think it's a macho thing to simply talk about that, women they can do anything, with us it's 'oh yeah okay I'll do it' with men it takes time for them to decide whether I'm going, whether I really need help because they it's that sort of thing, so I think with women they care about their health as well, their wellbeing and they prefer to talk to somebody about it. With men as you said, they hold back, they're not really the type of human being they can openly, this is why women is using something to go to because if I have a problem and I talk to my husband, he doesn't listen" (Pacific Island, Female)

"It's an old school thing, if I feel sore, I'll carry that pain until it really gets worse and that's the time you go in and that's when it's too late ... So it's education, our

people need to have education. Remember, we are talking about those born here in New Zealand are more educated than the one like me who are born in the Island, we come, that's why I use the words old school, we are stubborn and we don't take medication because we came from a place where we don't take medication" (Pacific Island, Male)

"... just touching on the gender differences we do have about 80% men and 20% women in alcohol and drug counselling, but in gambling it's a little bit higher, like about 50/50. I mean it's a resource thing, it's all males and in regard to matching, gender, language, people have criticised us for not having others but another barrier to treatment is having services provided in the first place" (Pacific Island, Male)

Discussion around Pacific services use also touched upon issues relating to age:

"I'm looking at it from a younger person's perspective I guess, you know if they were getting into gambling and then they kind of don't really know that it's a problem but they're thinking I should really talk to someone, would they really go into the phone book and look up? Would a young person really do that? And the other side of things is that there's a lot of focus on treatment, but what about prevention?" (Pacific Island, Female)

"Another kind of important thing was around language barriers, particularly for older people who were very reliant for having younger members of the family available to take them along to services and to translate for them, that was, and again I'm not sure how relevant that would be for older Pacific people with gambling problems" (Pakeha, Female)

3.2.9 Other topics

This summary has focused on themes that relate to the help-seeking behaviours of people with gambling problems and their family and whanau, with the purpose of deriving topic areas and questions for the planned survey of people with gambling problems and their family and whanau. Other areas not covered in detail here but worthy of note are:

- Discussions around the role of gambling and risk-taking in different cultures
- The Ministry of Health contractual configuration of professional services, particularly for Maori services
- Natural resolution of gambling problems by individuals and with family, whanau and community support
- Suggestions on how to tackle the help-seeking problem such as through health promotion, screening in other services, early intervention, brief intervention and host responsibility
- Defining the help-seeking problem (e.g. the extent of the problem)
- Conceptualisations of problem gambling (e.g. is it a health issue at all, an addiction issue comparable to substance addiction, a mental health compulsive disorder)

3.3 Surveys : Problem gambler data

This section presents a range of survey data pertaining to people who seek help for a problem related to their *own* gambling behaviour. The data presented include: barriers and enablers to help-seeking for gambling problems, knowledge of gambling treatment services, previous treatment experience, and three-month follow-up findings. Survey data pertaining to people who seek help due to *someone else's* gambling behaviour are presented in the next section (**3.4. Surveys: Family/whanau data**).

The data presented in this section are drawn from two discrete groups: a group of helpline gamblers recruited via the national telephone helpline (n=125) and a group of gamblers (not necessarily problem gamblers) recruited from the general population (n=104). The recruitment details for both groups are described in the methodology chapter. The helpline sample was asked to respond to the barriers and enablers to help-seeking questions based on their own experiences seeking help for a gambling problem. The general population sample was asked to respond to the same questions based on their *beliefs* about what might serve as a barrier or enabler to help-seeking for someone with a gambling problem. Both samples were asked to respond to the knowledge of service and treatment experience questions based on their own knowledge/experience.

Data are presented in six categories (participant characteristics, enablers to help-seeking, barriers to help-seeking, knowledge of services, previous treatment experiences, and three-month follow-up findings) and according to a standard format: relevant data from the helpline sample are presented first, this is followed by the equivalent data from the general population sample, and then comparisons are made between the two samples (helpline versus general population). The only exception to this format is that the 'three-month follow-up' data only pertain to the helpline sample as comparative data were not sought from the general population sample.

3.3.1 Participant characteristics

Helpline sample

Demographics
Table 1 presents demographic data for the helpline sample (n=125) by recruitment methodology (telephone n=97, or internet n=28) and overall. The majority of participants were in the 30-39 year (28%) or 40-49 year (33%) age bracket, female (52%), of New Zealand European ethnicity (64%), New Zealand born (84%), single or separated/ divorced (53%), employed (63%), and residing in an urban locality (79%). A series of chi-square tests revealed a statistically significant difference between the telephone and internet sub-samples on the 'employment' variable (χ^2 = 6.23, df = 1, p = .01)[7]. No statistically significant between-group differences were identified for any other variable.

Available data also indicate the gender and ethnicity profile of the helpline sample is reasonably consistent with Gambling Helpline statistics. In 2006, 53% of callers to the Gambling Helpline were female, 47% were male, 48% were New Zealand European, 30% Maori, 11% Pacific, and 8% Asian (Ministry of Health, 2007). However, there were

[7] Demographic variables with multiple response options were re-coded into the following dichotomies for chi-square analysis due to low sample sizes in many of the response options: age = < 40 years vs. 40+ years; ethnicity = NZ European vs. other; origin = NZ born vs. other; marital status = married/defacto vs. single or separated/divorced; employment = employed vs. unemployed/other.

more helpline callers in the 20-29 year age bracket (25%) and less in the 40-49 year age bracket (22%) compared to the sample in the current research. This suggests that younger helpline callers may have been less inclined to participate in the study than their older counterparts.

Table 1 Participant demographics (helpline sample)

Variable		Sample by Recruitment Methodology		Overall Sample[1]
		Telephone (n = 97)	Internet (n = 28)	(n = 125)
Age	20-29 yrs	14 (15%)	8 (23%)	22 (16%)
	30-39 yrs	**25 (27%)**	**8 (36%)**	**33 (28%)**
	40-49 yrs	**32 (34%)**	**6 (27%)**	**38 (33%)**
	50- 59 yrs	16 (17%)	2 (9%)	18 (16%)
	60+ yrs	7 (7%)	1 (5%)	8 (7%)
Gender	Male	48 (51%)	8 (36%)	56 (48%)
	Female	**47 (50%)**	**14 (64%)**	**61 (52%)**
Ethnicity[2]	**NZ European**	**57 (62%)**	**16 (73%)**	**73 (64%)**
	Maori	26 (28%)	5 (23%)	31 (27%)
	Pacific Island	6 (7%)	0 (0%)	6 (5%)
	Asian	2 (2%)	0 (0%)	2 (2%)
	Other	7 (8%)	1 (5%)	8 (7%)
Origin	**NZ Born**	**76 (83%)**	**20 (91%)**	**96 (84%)**
	United Kingdom	7 (8%)	1 (5%)	8 (7%)
	Asia	3 (3%)	1 (5%)	4 (4%)
	Australia	2 (2%)	0 (0%)	2 (2%)
	Pacific Islands	2 (2%)	0 (0%)	2 (2%)
	Other	2 (2%)	0 (0%)	2 (2%)
Marital Status	**Single**	**30 (32%)**	**7 (33%)**	**37 (32%)**
	Married/Defacto	43 (46%)	11 (52%)	54 (47%)
	Separated/Divorced	**21 (22%)**	**3 (14%)**	**24 (21%)**
Employment	**Employed**	**52 (57%)**	**18 (86%)**	**70 (63%)***
	Unemployed	20 (22%)	3 (14%)	23 (21%)
	Other[3]	19 (21%)	0 (0%)	19 (17%)
Locality	**Urban**	**64 (79%)**	**17 (81%)**	**81 (79%)**
	Rural	17 (21%)	4 (19%)	21 (21%)

1 Sample size for each variable does not always meet 125
2 Participants who reported mixed ethnicity were counted once in each category provided
3 Includes students, retirees, sickness beneficiaries and stay-at-home parents.
* Between-group difference statistically significant at p <0.05 level

Gambling activity

Ninety-four percent (117/125) of the helpline sample reported at least one gambling activity in the 12-month period preceding survey completion. Table 2 presents data pertaining to the gambling activities reported by these 117 participants. Overall, the most frequently engaged in gambling activity was using a gaming machine at a pub or club (cited by 90% of the overall sample). The next most popular gambling activities included: Lotto (76%), instant kiwi or other scratch ticket (65%), and gaming machines at a casino (61%). These four gambling activities were the most popular in both the telephone and internet sub-samples.

Table 2 Gambling activities in past 12-months (helpline sample)

Gambling Activity	**Sample**		
	Telephone (n = 95)	Internet (n = 22)	Overall (n = 117)
Lotto	**71 (75%)**	**18 (82%)**	**89 (76%)**
Keno	13 (14%)	3 (14%)	16 (14%)
Instant Kiwi/Scratch Ticket	**62 (65%)**	**14 (64%)**	**76 (65%)**
Housie or Bingo	11 (12%)	2 (9%)	13 (11%)
Horse or Dog Racing	29 (31%)	5 (23%)	34 (29%)
Sports Betting	14 (15%)	3 (14%)	17 (15%)
Gaming machines at Casino	**58 (61%)**	**13 (59%)**	**71 (61%)**
Table games at Casino	21 (22%)	6 (27%)	27 (23%)
Gaming machines at pub/club	**83 (87%)**	**22 (100%)**	**105 (90%)**
Internet-based gambling	5 (5%)	6 (27%)	11 (9%)
Any other gambling activity	11 (12%)	0 (0%)	11 (9%)

Data pertaining to problem gambling severity are presented in Table 3. These data are specific to the 117 individuals who participated in one or more gambling activities in the 12 months preceding survey completion. Overall, 88% of this sample were rated 'problem gamblers' according to Problem Gambling Severity Index (PGSI) screening criteria. The internet sub-sample was more likely to meet problem gambling criteria in comparison with the telephone sub-sample (96% versus 86%), although this difference failed to reach a level of statistical significance. However, a Mann-Whitney U test identified a statistically significant between-group difference in mean score on the PGSI (17.41 vs. 13.91; $z = -2.47$, $p = .01$). This suggests that, whilst a similar percentage of participants from both the internet and telephone sub-samples met problem gambler criteria, the internet sample typically reported a greater range of problems and/or more severe problems (i.e. the distribution of their PGSI scores was weighted more towards the severe end of the scale as compared to the telephone sub-sample).

Table 3 Gambling severity by survey type & overall (PGSI ranking) (helpline sample)[1]

Classification	Sample		
	Telephone (n = 95)	Internet (n = 22)	Overall (n = 117)
Non-problem gambler	3 (3%)	0 (0%)	3 (3%)
Low risk gambler	4 (4%)	0 (0%)	4 (3%)
Moderate risk gambler	6 (6%)	1 (5%)	7 (6%)
Problem gambler	**82 (86%)**	**21 (96%)**	**103 (88%)**

1 PGSI screen only completed by the 117 survey respondents who had gambled in the past 12 months

Treatment status

Seventy-five percent (84/125) of the helpline sample stated that they were currently receiving formal assistance for a gambling-related problem at the time of the survey. Of these 84 participants, 43% (36/84) were receiving face-to-face assistance from a counselling service, 32% (27/84) were receiving assistance from the telephone helpline, 23% (19/84) were receiving assistance from both a face-to-face counselling service and the telephone helpline, two percent (2/84) were receiving internet-based assistance, and one percent (1/84) was receiving assistance from a General Practitioner.

Forty-five percent (56/125) of the helpline sample stated that they were currently receiving informal assistance for a gambling-related problem at the time of the survey. Of these 56 participants, 54% (30/56) were receiving support from their partner and/or a family member, 21% (12/56) were receiving support from a friend, 14% were receiving support from friends and family, four percent (2/56) were receiving support from an unspecified informal source, and 11% (6/56) were receiving support from an unspecified source (n=2), an online source (n=1), a drop-in service (n=1), their accountant (n=1) or their colleagues (n=1).

Thirty-three percent (41/125) of the sample reported receiving both formal and informal assistance for a gambling related problem and 14% (17/125) reported receiving neither form of assistance.

General population sample

Demographics

Table 4 presents demographic data for the baseline general population gambling sample (n=104) by recruitment methodology (telephone, internet or venue) and overall.

Table 4 Participant demographics (general population sample)

Variable		Recruitment Source			Overall[1]
		Telephone (n = 18)	Internet (n = 32)	Venue (n = 54)	(n=104)
Age	**20-29 yrs**	**3 (17%)**	**12 (39%)**	**11 (20%)**	**26 (25%)**
	30-39 yrs	**3 (17%)**	**4 (13%)**	**20 (37%)**	**27 (26%)**
	40-49 yrs	4 (22%)	5 (16%)	15 (28%)	24 (23%)
	50- 59 yrs	6 (33%)	3 (10%)	6 (11%)	15 (15%)
	60+ yrs	2 (11%)	7 (23%)	2 (4%)	11 (11%)
Gender	**Male**	**9 (50%)**	**14 (52%)**	**33 (61%)**	**56 (57%)**
	Female	9 (50%)	13 (48%)	21 (39%)	43 (43%)
Ethnicity[2]	**NZ European**	**13 (72%)**	**20 (74%)**	**22 (41%)**	**55 (56%)***
	Maori	5 (28%)	3 (11%)	14 (26%)	22 (22%)
	Pacific Island	3 (17%)	1 (4%)	10 (19%)	14 (14%)
	Asian	0 (0%)	1 (4%)	14 (26%)	15 (15%)
	Other	1 (6%)	4 (15%)	2 (4%)	7 (7%)
Origin	**NZ Born**	**16 (89%)**	**28 (88%)**	**30 (56%)**	**74 (71%)***
	United Kingdom	1 (6%)	4 (13%)	5 (9%)	10 (10%)
	Asia	0 (0%)	0 (0%)	14 (26%)	14 (14%)
	Pacific Islands	1 (6%)	0 (0%)	5 (9%)	6 (6%)
	Other	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Marital Status	Single	5 (28%)	13 (48%)	15 (28%)	33 (33%)
	Married/Defacto	**9 (50%)**	**11 (34%)**	**34 (63%)**	**54 (55%)**
	Separated/Divorced	4 (22%)	3 (11%)	5 (9%)	12 (12%)
Employment	**Employed**	**9 (56%)**	**18 (72%)**	**36 (74%)**	**63 (70%)**
	Unemployed	2 (13%)	2 (8%)	3 (6%)	7 (8%)
	Other[3]	5 (31%)	5 (20%)	10 (20%)	20 (22%)
Locality	**Urban**	**17 (94%)**	**22 (85%)**	**46 (85%)**	**85 (87%)**
	Rural	1 (6%)	4 (15%)	8 (15%)	13 (13%)

1 Sample size for each variable does not always meet 104.
2 Participants who reported mixed ethnicity were counted once in each category provided
3 Includes students, retirees, sickness beneficiaries and stay-at-home parents
* Between-group difference statistically significant at p <0.05 level

The majority of participants were in the 20-29 year (25%) or 30-39 year (26%) age bracket, male (57%), of New Zealand European ethnicity (56%), New Zealand born (71%), married or in a de-facto relationship (55%), employed (70%), and residing in an urban locality (87%). A series of chi-square tests, using the same collapsed categories as described in footnote 7

(page 64), revealed statistically significant differences between the telephone, internet and venue sub-samples on the 'ethnicity' (χ^2 = 10.58, df = 2, p = .01) and 'origin' variables (χ^2 = 9.80, df = 2, p = .01). Subsequent pair-wise analysis revealed that the venue sub-sample was significantly less likely to be of NZ European descent in comparison with the telephone (χ^2 = 5.36, df = 1, p = .02) and internet (χ^2 = 8.01, df = 1, p = .01) samples and was more likely to be born overseas (χ^2 = 6.50, df = 1, p = .01 & χ^2 = 5.26, df = 1, p = .02, respectively). No statistically significant between-group differences were identified for any other variable.

Gambling activity

Ninety-three percent (97/104) of the general population sample reported at least one gambling activity in the 12-month period preceding survey completion. Five percent (5/104) reported no gambling activity within the 12-month period preceding the survey and two percent (2/104) did not answer the question. Table 5 presents data pertaining to the gambling activities reported by the 97 participants who reported past 12-month gambling activity. Overall, the most frequently engaged in gambling activity was Lotto (cited by 84% of the overall sample). The next most popular gambling activities were: instant kiwi or other scratch ticket (64%), gaming machines at a pub/club (62%) and gaming machines at a casino (61%). These four gambling activities were most popular in the telephone, internet and venue sub-samples as well as the overall sample.

Table 5 Gambling activities in past 12-months (general population sample)

Gambling Activity	**Sample**			**Overall**
	Telephone (n =18)	Internet (n =27)	Venue (n =52)	(n = 97)
Lotto	**15 (83%)**	**22 (82%)**	**44 (85%)**	**81 (84%)**
Keno	4 (22%)	3 (11%)	10 (19%)	17 (18%)
Instant Kiwi/Scratch Ticket	**13 (72%)**	**17 (63%)**	**32 (62%)**	**62 (64%)**
Housie or Bingo	2 (11%)	1 (4%)	8 (15%)	11 (11%)
Horse or Dog Racing	8 (44%)	6 (22%)	17 (33%)	31 (32%)
Sports Betting	6 (33%)	4 (15%)	14 (27%)	24 (25%)
Gaming machines at Casino	**12 (68%)**	**13 (48%)**	**34 (65%)**	**59 (61%)**
Table games at Casino	6 (33%)	10 (37%)	19 (37%)	35 (36%)
Gaming machines at pub/club	**12 (67%)**	**13 (48%)**	**35 (67%)**	**60 (62%)**
Internet-based gambling	1 (6%)	2 (7%)	7 (14%)	10 (10%)
Any other gambling activity	6 (33%)	3 (11%)	5 (10%)	14 (14%)

Data pertaining to problem gambling severity are presented in Table 6. These data are specific to 94 of the general population gamblers who participated in one or more gambling activities in the 12-months preceding survey completion. Overall, 37% of this sample were rated 'problem gamblers' according to PGSI screening criteria. The telephone sub-sample were more likely to meet problem gambling criteria in comparison with the internet and venue sub-samples (80% versus 39% and 26%). A Kruskall-Wallis test revealed this difference between samples reached a level of statistical significance (χ^2 = 6.64, df = 2, p = .04).

Table 6 Gambling severity by survey type & overall (PGSI ranking) (general population sample)

Gambling Activity	Sample			Overall[1]
	Telephone (n =17)	Internet (n =26)	Venue (n =51)	(n = 94)
Non-problem gambler	3 (18%)	4 (15%)	13 (26%)	20 (21%)
Low risk gambler	1 (6%)	7 (27%)	12 (24%)	20 (21%)
Moderate risk gambler	1 (6%)	5 (19%)	13 (26%)	19 (20%)
Problem gambler	**12 (80%)**	**10 (39%)**	**13 (26%)**	**35 (37%)***

1. PGSI screen completed by 94 of the 97 survey respondents who had gambled in the past 12 months
* Between-group difference statistically significant at p <0.05 level

Treatment status
Thirteen percent (13/104) of the general population sample stated that they were currently receiving formal assistance for a gambling-related problem at the time of the survey. Of these 13 participants, six were receiving face-to-face assistance from a counselling service, one was receiving assistance from the telephone helpline, one was receiving assistance from both a face-to-face counselling service and the telephone helpline, one was receiving assistance from a budget advisor, one went on a 'course', and three did not specify from whom they were receiving assistance. Six of these 13 participants met PGSI 'problem gambler' criteria, one met 'low risk gambler' criteria, and one met criteria for 'non problem' gambling. PGSI data were not available for the remaining five participants.

Nineteen percent (20/104) of the general population sample stated that they were currently receiving informal assistance for a gambling-related problem at the time of the survey. Of these 20 participants, 11 were receiving support from their partner and/or a family member, three were receiving support from a friend, three were receiving support from friends and family, two were supporting themselves via self-help initiatives, and one was receiving support from family and their bishop.

Four percent (4/104) of participants reported receiving both formal and informal assistance for a gambling-related problem and 65% (68/104) reported receiving neither form of assistance.

Between-sample comparisons

A series of chi-square tests, using the same collapsed categories as described in footnote 7 (page 67), revealed that the helpline and general population samples only differed on one of the demographic variables reported in Tables 1 and 4: participants in the general population sample were less likely to be born in New Zealand ($\chi^2 = 5.85$, df = 1, p = .02) in comparison with participants in the helpline sample. Participants in the general population sample were also less likely to meet the PGSI problem gambler criteria (z = -7.49, p < .01) or to report currently receiving formal ($\chi^2 = 81.12$, df = 1, p < .01) or informal ($\chi^2 = 17.51$, df = 1, p < .01) assistance for a gambling problem in comparison with the helpline sample. These last three differences were an expected consequence of the differing recruitment methodologies.

3.3.2 Enablers to help-seeking

Helpline sample

Responses to specified enablers

Table 7 presents the number and percentage of participants in the helpline sample who endorsed each of 15 specified 'enablers' as a factor in their decision to seek specialist assistance for a gambling problem[8]. The ten most frequently endorsed options are presented graphically in Figure 1. Table 7 also identifies whether each item was endorsed with or without prompting and the number and percentage of participants who endorsed each item as their primary (number one) reason for seeking help. The most commonly endorsed of these enablers was 'financial problems' with 82% of the sample identifying this as a factor in their decision to seek help. Five more items were considered influential in the decision to seek help by more than 50% of participants. These included: other emotional factors (77%), wanting to prevent your gambling from becoming a major problem (75%), the costs of gambling outweighed the reasons for continuing gambling (70%), reaching a point where you felt like you could not go on (58%), and gambling was affecting your physical health (54%). The items considered least influential in the decision to seek help included: gambling venue intervention (15%), problems at work (18%), and legal problems (29%). Only one of these 15 items was regularly identified as a reason for seeking help without prompting. This was the financial problems enabler, which was identified without prompting by 46% of participants. The mean number of options endorsed per participant was 6.8 (SD 2.8).

The item most often endorsed as the primary reason for seeking help was financial problems (35% of the sample). The remaining items were seldom, and in some cases never, endorsed as the primary reason for seeking help. It is of note that five of the six most frequently endorsed 'enabler' options (as described above) were not widely selected as a primary reason for help-seeking. This would suggest that, financial problems aside, these items were generally considered important, but secondary influences on the help-seeking decision. It is perhaps also of note that whilst 'problems with your spouse or partner' was only considered influential in the help-seeking decision in 33% of cases, it was endorsed as the primary reason for seeking help 11% of the time (the second most frequently endorsed option). This would suggest that relationship difficulties, when they do occur, are a powerful influence on the help-seeking decision.

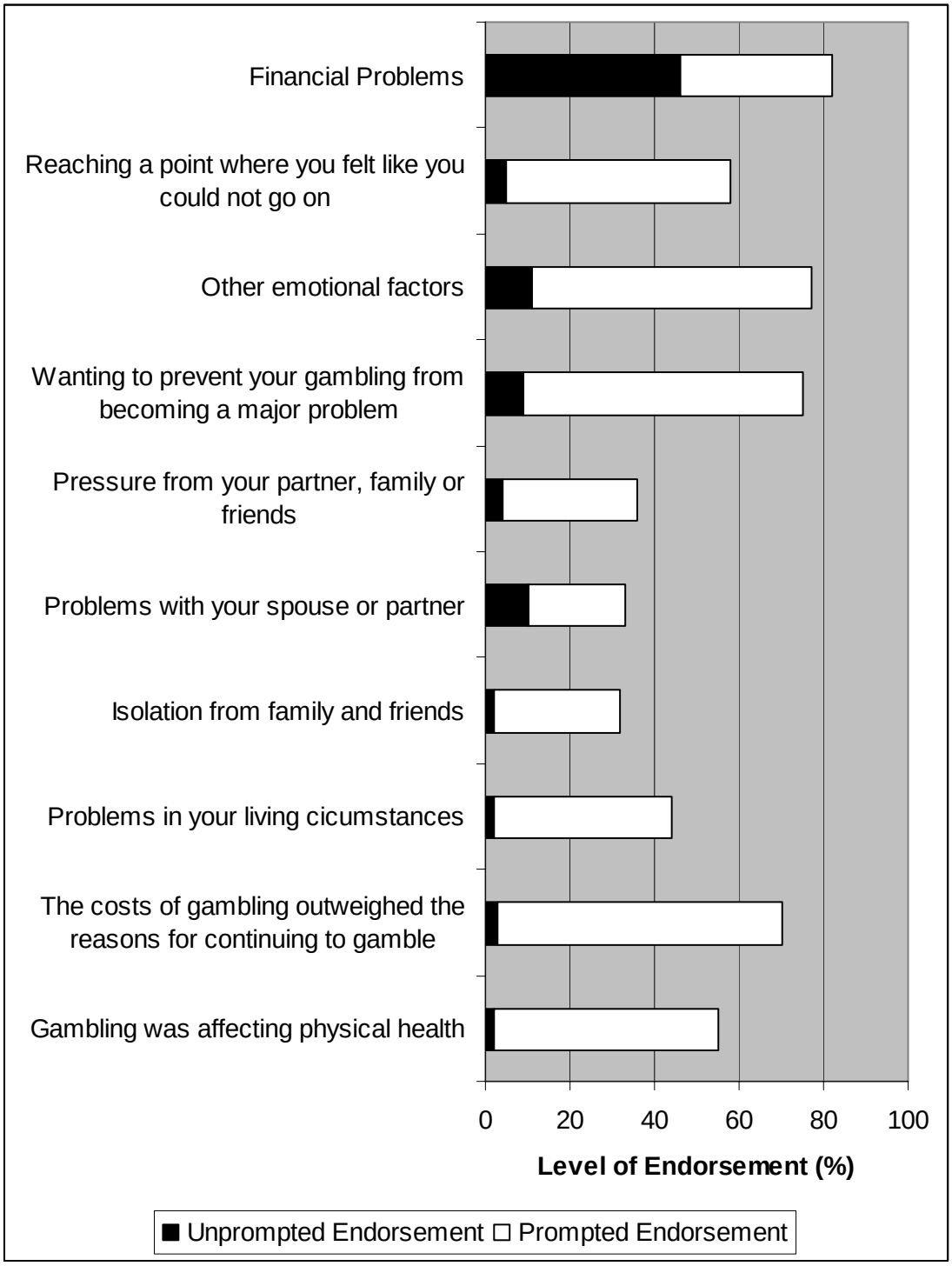
[8] The original wording of each enabler option has been abbreviated in this Table and all subsequent 'enabler' Tables to follow for ease of readership. Original wording may be seen in the relevant questionnaires included in the appendices.

Table 7 Enablers to help-seeking (helpline sample)

Response Option	Endorsed (n=125)			Endorsed as No. 1[1]
	Unprompted	Prompted	overall	
Financial problems	57 (46%)	45 (36%)	**102 (82%)**	**44 (35%)**
Reaching a point where you felt like you could not go on	6 (5%)	66 (53%)	**72 (58%)**	0 (0%)
Other emotional factors	14 (11%)	82 (66%)	**96 (77%)**	9 (7%)
Wanting to prevent your gambling from becoming a major problem	11 (9%)	83 (66%)	**94 (75%)**	10 (8%)
Pressure from your partner, family or friends	5 (4%)	40 (32%)	45 (36%)	4 (3%)
Problems with your spouse or partner	12 (10%)	29 (23%)	41 (33%)	14 (11%)
Problems with other family members	6 (5%)	26 (21%)	32 (36%)	0 (0%)
Concerns about the welfare of your children	5 (4%)	32 (26%)	37 (30%)	5 (4%)
Isolation from family and friends	2 (2%)	38 (30%)	40 (32%)	4 (3%)
Problems at work	3 (2%)	20 (16%)	23 (18%)	3 (2%)
Legal problems	4 (3%)	32 (26%)	36 (29%)	1 (1%)
Problems in your living circumstances	2 (2%)	53 (42%)	55 (44%)	1 (1%)
The costs of gambling outweighed the reasons for continuing to gamble	4 (3%)	84 (67%)	**88 (70%)**	8 (6%)
Gambling was affecting your physical health	2 (2%)	66 (53%)	**68 (54%)**	2 (2%)
The gambling venue intervened in your gambling	1 (1%)	18 (14%)	19 (15%)	0 (0%)

1 17 participants endorsed a factor not listed in this table as their number one reason for seeking help. Thus, total value does not equal 100%.

Figure 1 Ten most frequently endorsed 'enabler' options (helpline sample)



Other responses

Participants were provided an open-ended opportunity to identify other reasons for seeking help in addition to the 15 specified enablers. Twenty-six percent (33/125) of the sample subsequently provided a novel response. The most common of these pertained to a desire to improve one's financial situation (n=7). In these cases the participant was not experiencing any financial hardship, yet there was a realisation that if they stopped gambling their financial situation would be enhanced. Six participants reported seeking help because they felt their gambling was "out of control" and a further five identified feelings of "guilt" or "disappointment" in their gambling behaviour as a factor in their decision to seek help. Four participants sought help due to opportunistic encounters. These included: meeting a friend who had sought help, a community visit from a gambling counsellor, participation in a gambling study, and entering an alcohol and drug treatment service that also provided support for problem gamblers. Three participants stated they sought help because they "wanted to stop gambling" without specifying why they wanted to stop and two sought treatment due to a relapse in their gambling behaviour. Other reasons given for seeking help included: a desire to live a healthier lifestyle (n=2), to stop "embezzling money from my business" (n=1) or to stop "ripping off my mother" (n=1), because "my boyfriend at the time was committing crime to fund his gambling habit and I did not want to go down the same route" (n=1), and because "it was time to take responsibility for gambling away my money" (n=1).

Thirteen percent (16/125) of the sample identified a factor other than the 15 specified in Table 7 as their primary (number one) reason for seeking help. In five of these cases (four percent of overall responses to this question) the primary reason identified was the desire to improve one's financial situation. Feelings of "guilt", "disappointment" or "shame" were reported in four cases (3%) and a desire to "control" one's gambling behaviour were reported in a further three cases (2%). Other single responses (each representing less than one percent of the overall response) included: "it's [gambling] just a big problem"; "no single reason, rather multiple issues compounding"; "when you know you know"; and because they "wouldn't bar him from [gambling] venues".

Between-group differences

Between-group differences in the five options most commonly identified as an enabler to help-seeking were investigated. The groups examined included: males versus females, <40 years of age versus 40+ years of age, NZ Europeans versus Maori, single/separated/ divorced versus married/de-facto relationship, employed versus unemployed, urban residence versus rural residence, meeting PGSI 'problem gambler' criteria versus not meeting these criteria, and New Zealand born versus born elsewhere. Without exception, the options 'financial problems', 'other emotional factors', 'wanting to prevent your gambling from becoming a major problem', and 'the costs of gambling outweighed the reasons for continuing to gamble' were among the four most commonly endorsed reasons for seeking-help in each group examined (between-group rankings of all 15 enabler options presented in Table 21, Appendix 11). Some between-group differences were evident with respect to the fifth most common enabler identified; however, differences were limited to one of three options (i.e. one of the following was the fifth most frequently endorsed option in all groups examined): 'reaching a point where you felt like you could not go on', 'your gambling was affecting your physical health' and 'concerns about the welfare of your children'.

Between-group differences in the three options most commonly identified as the primary (number one) reason for seeking help were also investigated. The same groupings were examined as described above. The primary option in all cases was 'financial problems' (rankings presented in Table 22, Appendix 11), although the various comparison groups often differed in the frequency with which they endorsed this option. This difference, however, was only statistically significant in one instance (males, 45% versus females, 25%; $\chi^2 = 5.22$, df = 1, p = .02). The other two options most frequently endorsed included 'problems with

your spouse and partner' and 'other emotional factors'. The outcome of most note was the high percentage (45%) of male participants, in comparison with their female counterparts, who endorsed the 'financial problems' option as their primary reason for seeking help. This suggests that the influence of financial problems to motivate help-seeking behaviour may be gender-related.

General population sample

Responses to specified enablers

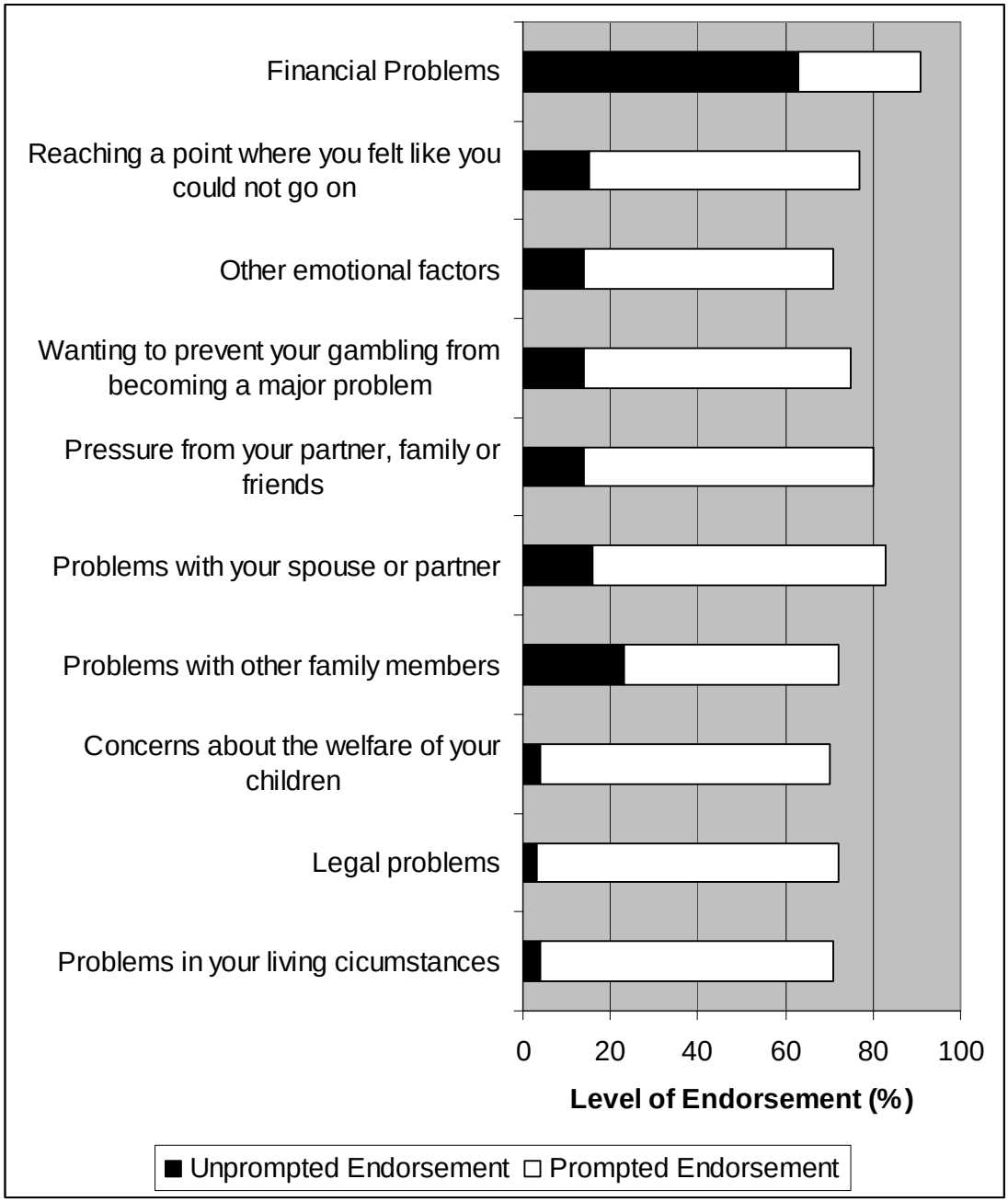
Table 8 presents the number and percentage of participants in the general population sample who endorsed each of 15 specified 'enablers' as a likely factor, in their opinion, as to why problem gamblers decide to seek specialist assistance. The ten most frequently endorsed options are presented graphically in Figure 2. Table 8 also identifies whether each item was endorsed with or without prompting and the number and percentage of participants who endorsed each item as their primary (number one) reason for seeking help. The most commonly endorsed enablers were 'financial problems', 'problems with spouse or partner' and 'pressure from partner, family or friends' (90%, 84% and 81% respectively), although 14 of the 15 enablers were endorsed by at least 60% or more of all participants. The only enabler to be endorsed by less than half the sample was 'the gambling venue intervened in the gambling' (44%). The items most often identified without prompting were 'financial problems' (63%) and 'problems with other family members' (23%). The remaining items were seldom, rarely or never identified without prompting. The mean number of options endorsed per participant was 10.6 (SD 3.9). The item most often endorsed as the primary reason for seeking help was 'financial problems' (50% of the sample). The remaining items were rarely, and in some cases never, endorsed as the primary reason for seeking help. Collectively, these data suggest that, financial problems aside, survey participants considered most of the listed items as important but secondary influences in the decision to seek help.

Table 8 Enablers to help-seeking (general population sample)

Response Option	Endorsed (n=104)			Endorsed as #1[1]
	Unprompted	Prompted	Overall	
Financial problems	65 (63%)	29 (28%)	**94 (90%)**	**47 (50%)**
Reaching a point where they felt like they could not go on	16 (15%)	64 (62%)	80 (77%)	11 (12%)
Other emotional factors	14 (14%)	59 (57%)	73 (70%)	3 (3%)
Wanting to prevent the gambling from becoming a major problem	14 (14%)	63 (61%)	77 (74%)	2 (2%)
Pressure from partner, family or friends	15 (14%)	69 (66%)	**84 (81%)**	8 (9%)
Problems with spouse or partner	17 (16%)	70 (67%)	**87 (84%)**	6 (6%)
Problems with other family members	24 (23%)	51 (49%)	75 (72%)	2 (2%)
Concerns about the welfare of their children	4 (4%)	69 (66%)	73 (70%)	1 (1%)
Isolation from family and friends	15 (14%)	51 (49%)	66 (64%)	2 (2%)
Problems at work	3 (3%)	66 (64%)	69 (66%)	1 (1%)
Legal problems	3 (3%)	72 (69%)	75 (72%)	3 (3%)
Problems in living circumstances	4 (4%)	70 (67%)	74 (71%)	0 (0%)
The costs of gambling outweighed the reasons for continuing to gamble	2 (2%)	70 (67%)	72 (69%)	1 (1%)
The gambling was affecting physical health	4 (4%)	58 (56%)	62 (60%)	1 (1%)
The gambling venue intervened in the gambling	0 (0%)	46 (44%)	46 (44%)	0 (0%)

1 Six participants identified some 'other' option as the number one reason for seeking help and 10 participants did not answer the question. Thus, total values do not equal 100%.

Figure 2 Ten most frequently endorsed 'enabler' options (general population sample)



Other responses

Participants were provided an open-ended opportunity to identify other reasons for seeking help in addition to the 15 specified enablers. Eight participants subsequently provided a novel response. These included: advised by health professionals, low self esteem, not being successful, own reasons, spending inheritance, the person comes to appreciate that they have an addiction, thoughts of suicide, and watching a mate lose all his money at a casino and feeling bad for him. Six participants identified a factor other than the 15 specified in Table 8 as their primary (number one) reason for seeking help. These included: not winning, it is ruining their lives, they are being ripped off, self-destruction, addiction, and not wanting to be a loser.

Between-group differences

Between-group differences in the five options most commonly identified as an enabler to help-seeking were investigated. The groups examined included: males versus females, <40 years of age versus 40+ years of age, NZ European versus Maori, single/separated/ divorced versus married/de-facto relationship, employed versus unemployed, urban residence versus rural residence, meeting PGSI 'problem gambler' criteria versus not meeting these criteria, and New Zealand born versus born elsewhere. The four options 'financial problems', 'reaching a point where they can't go on', 'pressure from partner, family or friends', and 'problems with spouse or partner' were among the top five most commonly endorsed reasons for seeking help in nearly every group examined (between-group rankings of all 15 enabler options presented in Table 23, Appendix 11). Between-group variation in the top five options endorsed was, therefore, rarely evident and typically limited to a single option when it was evident.

Between-group differences in the three options most commonly identified as the primary (number one) reason for seeking help were also investigated. The same groupings were examined as described above. The item most commonly identified as the primary reason for seeking help was 'financial problems' in every group examined (rankings presented in Table 24, Appendix 11). The item 'reaching a point where they can't go on' was the second or third most commonly endorsed number one reason for seeking help in every group examined. Variance in one out of the top three options was common between groupings, although the frequency with which all options other than 'financial problems' were endorsed suggests any difference in lower order ranking (below number one) is unlikely to be of real-world significance (and certainly not of statistical significance).

Between-sample comparisons

Statistical differences in the frequency with which participants in each sample endorsed each of 15 specified options as an enabler to help-seeking were examined via logistic regression. The potentially confounding effects of ethnicity (NZ European or other) and country of origin (NZ born or other) were controlled for in the analysis[9]. Results are presented in Table 9.

[9] The 'helpline and 'general population' samples were found to differ on country of origin, as reported on page 70.

Table 9 Percent of participants endorsing each of the 15 specified enablers

Response Option	% Endorsing		Statistic	
	Helpline	General Population	OR (95% CI)	p - value
Financial problems	82%	90%	0.396 (0.16, 0.97)	0.04*
Reaching a point where they felt like they could not go on	58%	77%	0.424 (0.23, 0.78)	0.01*
Other emotional factors	77%	70%	1.417 (0.76, 2.66)	0.276
Wanting to prevent the gambling from becoming a major problem	75%	74%	1.141 (0.60, 2.16)	0.687
Pressure from partner, family or friends	36%	81%	0.125 (0.07, 0.24)	<0.001**
Problems with spouse or partner	33%	84%	0.090 (0.05, 0.18)	<0.001**
Problems with other family members	36%	72%	0.155 (0.08, 0.29)	<0.001**
Concerns about the welfare of their children	30%	70%	0.181 (0.10, 0.33)	<0.001**
Isolation from family and friends	32%	64%	0.229 (0.13, 0.42)	<0.001**
Problems at work	18%	66%	0.113 (0.06, 0.21)	<0.001**
Legal problems	29%	72%	0.163 (0.09, 0.30)	<0.001**
Problems in living circumstances	44%	71%	0.309 (0.17, 0.56)	<0.001**
The costs of gambling outweighed the reasons for continuing to gamble	70%	69%	1.122 (0.61, 2.05)	0.709
The gambling was affecting physical health	54%	60%	0.848 (0.49, 1.48)	0.563
The gambling venue intervened in the gambling	15%	44%	0.266 (0.14, 0.51)	<0.001**

* p <0.05, ** p <0.01

Statistically significant differences were identified in 11 of the 15 possibilities (as reported in Table 9). In all 11 cases, general population participants were significantly more likely to endorse the respective option as an enabler to help-seeking in comparison with their helpline counterparts. Four options were endorsed at a similar frequency by both the helpline and general population samples. These included: other emotional factors (77% versus 70%), wanting to prevent the gambling from becoming a major problem (75% versus 74%), the costs of gambling outweighed the reasons for continuing to gamble (70% versus 69%), and the gambling was affecting physical health (54% versus 60%). It is also of note that the item most often endorsed by both samples was 'financial problems', although the general population sample endorsed this option at a significantly higher rate than their helpline counterparts (90% versus 82%).

Differences in the top three options endorsed as the primary (number one) enabler to help-seeking were also examined via descriptive statistical analyses. The three options most likely to be endorsed as the primary enabler to help-seeking, in rank order, for the helpline sample were: financial problems (35%), problems with spouse or partner (11%), and wanting to prevent your gambling from becoming a major problem (8%). The comparative options for the general population sample were: financial problems (50%), reaching a point where they felt like they could not go on (12%), and pressure from partner, family or friends (9%). This suggests that a large proportion of both samples considered financial problems to be the most influential factor in the help-seeking decision, although general population participants were more likely to report this than their helpline counterparts. These results also suggest that a number of participants in both samples considered the influence of personal relationships to be the most important factor in the help-seeking decision. The point of difference being that the helpline sample emphasised the influence of problems in intimate relationships whilst the general population sample emphasised the influence of peer- or family-pressure.

3.3.3 Barriers to help-seeking

Helpline sample

Responses to specified barriers

Table 10 presents the number and percentage of participants in the helpline sample endorsing each of 22 specified 'barriers' to seeking specialist assistance for a gambling problem[10]. The ten most frequently endorsed options are presented graphically in Figure 3. Table 10 also identifies whether each barrier was endorsed with or without prompting and the number and percentage of participants who endorsed each as the primary (number one) barrier to help-seeking. The most commonly identified barrier, endorsed by 78% of participants, was 'you wanted to resolve the problem on own or were too proud to seek help'. Two additional barriers were endorsed by 50% or more of the helpline sample. These included 'felt ashamed for self or family' (73% of participants), and 'too overwhelmed by problems to seek help' (51% of participants). The items least often endorsed as a barrier to help-seeking included: 'didn't think the service would understa nd your language' (6%), 'didn't want to use an online service' (8%), and 'didn't think the service would relate to culture or community' (10%)[11]. The 22 specified items were rarely identified as barriers to help-seeking without prompting. For example, the item most often identified without prompting, 'felt ashamed for self or family', was only identified in this manner by 11% of the sample. The mean number of options endorsed per participant was 6.7 (SD 3.6).

[10] The original wording of each barrier option has been abbreviated in this Table and all subsequent 'barrier' Tables for ease of readership. Original wording may be seen in the relevant questionnaires included in the appendices.

[11] The options "…understand your language" and "…relate to culture or community" were endorsed by 15% (7/47) and 21% (10/47) of the non-NZ European participants, respectively.

Three of the specified items were collectively identified as the primary barrier to help-seeking by 55% of the sample. These included: 'wanted to resolve the problem on own or were too proud to seek help' (21% of participants), 'believed didn't have a problem and didn't need help' (19%), and 'felt ashamed for self or family' (15%). The remaining 19 items were rarely endorsed as the primary barrier to help-seeking. It is of note that the item 'too overwhelmed by problems to seek help', whilst frequently endorsed as a barrier to help-seeking (51% of cases), was only rated the primary barrier to help-seeking by one participant. This would suggest that feeling overwhelmed may often impede help-seeking behaviour but may rarely be considered the primary reason for not seeking help. It is perhaps also of note that whilst the item 'believed didn't have a problem and didn't need help' was only considered a barrier to help-seeking in 42% of cases, it was endorsed as the primary barrier to seeking help 19% of the time. This would suggest that problem denial, when it does occur, is a powerful barrier to help-seeking.

Other responses

Participants were provided an open-ended opportunity to identify other barriers to help-seeking in addition to the 22 specified in Table 10. Fifteen percent (19/125) of the sample subsequently provided a novel response. The most common of these, reported in four cases, was the "temptation" to continue gambling. A further three participants cited boredom as a barrier to help-seeking in the sense that they were not sure how they would fill their time if they stopped gambling, and a further two referred to themselves ("me") as a barrier without further clarification. Other identified barriers included: "being looked at or considered a weak person who cannot handle his own issues", "I would seek help, but then I would be OK for a while" [thereby ceasing contact with the helping agency and subsequently resuming gambling activities], "my partner makes enough money so it's not financial and that was a big thing", "excuses", "fear of being caught", "getting the courage to take the first step and call PGF [Problem Gambling Foundation], [lack of] "motivation", and "trouble bonding with male counsellors due to a childhood experience".

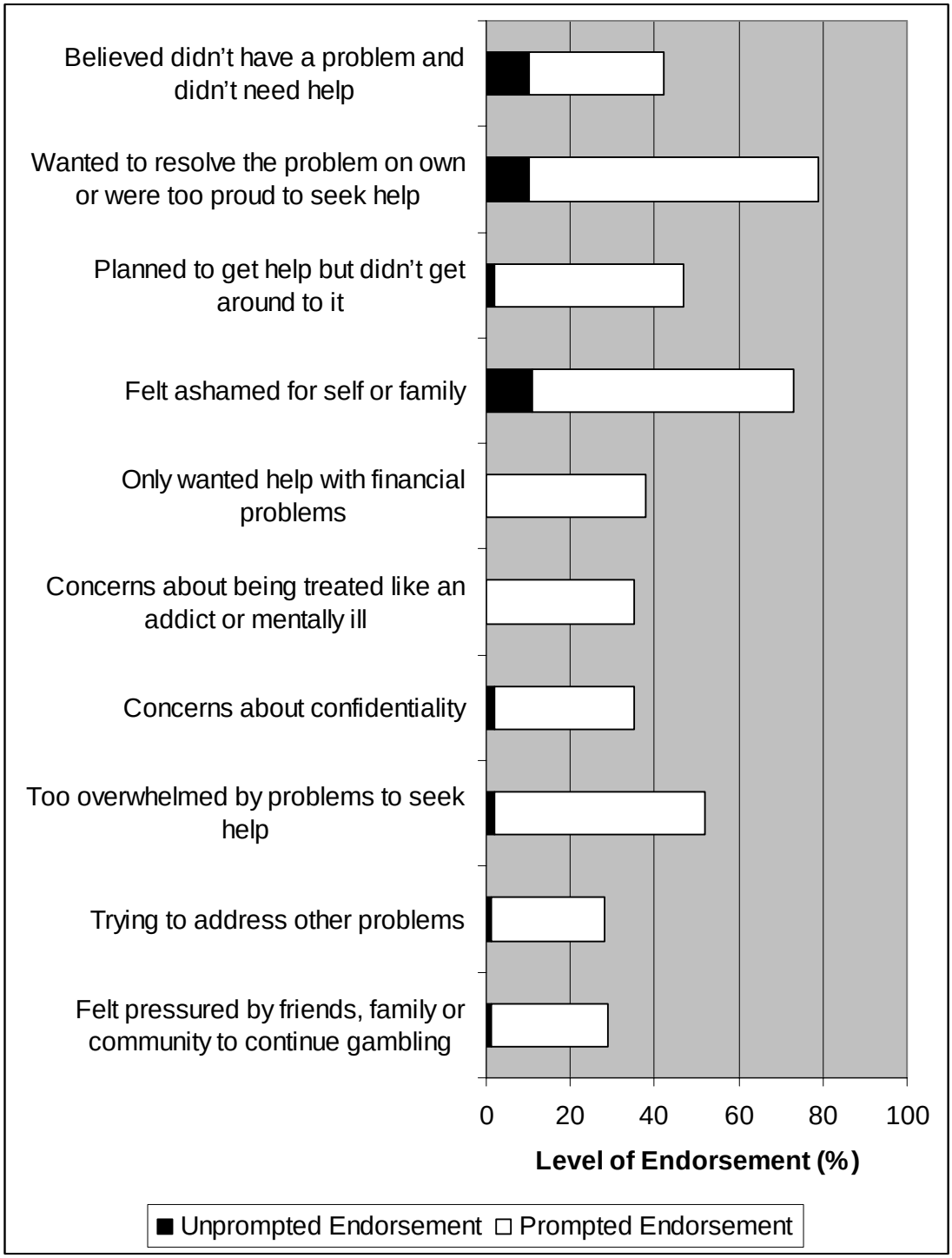
Thirteen percent (16/125) of the sample identified a factor other than the 22 specified in Table 10 as their primary barrier to seeking help. The most common of these, both reported by three participants, were a lack of motivation to seek help and an unwillingness to give up the euphoria associated with gambling. Other responses included: "a fear of failing", "fear of being embarrassed by the counsellor", "getting the courage to take the first step and call PGF", "transport [difficulties]", a sense that "no one would understand", and "no one factor stopped me, just a lot of little things". Four participants reported no barriers to help-seeking, stating that when they realised they needed help they sought it straight away. A further 10% (12/125) of the sample provided no response to this question.

Table 10 Barriers to help-seeking (helpline sample)

Response Option	Endorsed (n=125)			Endorsed as No.1[1]
	Unprompted	Prompted	overall	
Believed didn't have a problem and didn't need help	12 (10%)	40 (32%)	52 (42%)	**22 (19%)**
Wanted to resolve the problem on own or were too proud to seek help	12 (10%)	86 (69%)	**98 (78%)**	**24 (21%)**
Planned to get help but didn't get around to it	3 (2%)	56 (45%)	59 (47%)	1 (1%)
Felt ashamed for self or family	14 (11%)	77 (62%)	**91 (73%)**	**17 (15%)**
Only wanted help with financial problems	0 (0%)	48 (38%)	48 (38%)	2 (2%)
Not aware that treatment was available	1 (1%)	17 (14%)	18 (14%)	3 (3%)
Not aware that treatment was free	0 (0%)	28 (22%)	28 (22%)	0 (0%)
Couldn't get the service at the time or place wanted	5 (4%)	27 (22%)	32 (26%)	2 (2%)
Language concerns	0 (0%)	7 (6%)	7 (6%)	0 (0%)
Didn't think the service would relate to culture or community	0 (0%)	12 (10%)	12 (10%)	1 (1%)
Didn't want to use a telephone service	0 (0%)	25 (20%)	25 (20%)	0 (0%)
Didn't want to use a face to face service	2 (2%)	21 (17%)	23 (18%)	0 (0%)
Didn't want to use an online service	0 (0%)	10 (8%)	10 (8%)	0 (0%)
Concerns about being treated like an addict or mentally ill	0 (0%)	44 (35%)	44 (35%)	2 (2%)
Concerns about confidentiality	3 (2%)	41 (33%)	44 (35%)	8 (7%)
Too many commitments to seek help	0 (0%)	34 (27%)	34 (27%)	3 (3%)
Too overwhelmed by problems to seek help	2 (2%)	62 (50%)	**64 (51%)**	1 (1%)
Trying to address other problems	1 (1%)	34 (27%)	35 (28%)	3 (3%)
Not enough encouragement from friends, family, or community to seek help	0 (0%)	34 (27%)	34 (27%)	1 (1%)
Felt pressured by friends, family or community to continue gambling	1 (1%)	35 (28%)	36 (29%)	3 (3%)
Have had bad experiences of seeking help for gambling problems	2 (2%)	17 (14%)	19 (15%)	4 (4%)
Have had bad experiences of seeking help for other problems	0 (0%)	28 (22%)	28 (22%)	0 (0%)

1 17 participants endorsed a factor not listed in this table as their number one reason for seeking help and a further 12 provided no response. Thus, total values do not equal 100%.

Figure 3 Ten most frequently endorsed 'barrier' options (helpline sample)



Between-group differences

Between-group differences in the five options most commonly identified as a barrier to help-seeking were investigated. The groups examined included: males versus females, <40 years of age versus 40+ years of age, NZ European versus Maori, single/separated/divorced versus married/de-facto relationship, employed versus unemployed, urban residence versus rural residence, meeting PGSI 'problem gambler' criteria versus not meeting these criteria, and New Zealand born versus born elsewhere. With only two exceptions, the options 'wanted to resolve the problem on own or were too proud to seek help', 'planned to get help but didn't get around to it', 'felt ashamed for self or family', and 'too overwhelmed by problems to seek help' were among the five most commonly endorsed barriers to seeking help in the groups examined (between-group rankings of all 22 barrier options presented in Table 25, Appendix 12). Participants residing in a rural location and participants born outside of New Zealand were the sole exceptions in that the option 'planned to get help but didn't get around to it' was not among the top five barriers identified by these sub-samples. Overall, the various comparison groups only differed on one option at most and in all cases the difference was limited to one of the following three barriers: 'believed didn't have a problem and didn't need help', 'only wanted help with financial problems', and 'did not have enough encouragement from friends, family or community to seek help'.

Between-group differences in the three options most commonly identified as the primary (number one) barrier to seeking help were also investigated. The same groupings were examined as described above. The options 'believed didn't have a problem and didn't need help', 'wanted to resolve the problem on own or were too proud to seek help', and 'felt ashamed for self or family' were among the three options most commonly identified as the primary barriers to seeking help in all groups examined (rankings presented in Table 26, Appendix 12). It is of note, however, that male participants and participants 40 years of age or older endorsed the option 'felt ashamed for self or family' significantly less often than their female or younger counterparts ($\chi^2 = 6.30$, df = 1, p = .01 & $\chi^2 = 6.83$, df = 1, p = .01). This suggests there may be a gender and/or age relationship between feelings of shame and the decision to seek help for a gambling problem.

General population sample

Responses to specified barriers

Table 11 presents the number and percentage of participants in the general population sample endorsing each of 21 specified 'barriers' to seeking specialist assistance for a gambling problem[12]. The ten most frequently endorsed options are presented graphically in Figure 4. Table 11 also identifies whether each barrier was endorsed with or without prompting and the number and percentage of participants who endorsed each as the primary (number one) barrier to help-seeking. The most commonly identified barriers endorsed were 'believing there wasn't a problem and not needing help', 'wanting to resolve the problem on own or being too proud to seek help', and 'feeling ashamed for themselves or family' (87%, 84% and 84% respectively). Ten additional barriers were endorsed by 50% or more of the general population gambling sample[13]. The least endorsed item was 'not wanting to use an online service' (36% of sample). Three of the 21 items were regularly identified by participants without prompting. These included: 'wanting to resolve the problem on own or being too proud to seek help', 'believing there wasn't a problem and not needing help', and 'feeling ashamed for themselves or family' (35%, 34% and 32% respectively). The remaining items

[12] These were the same items presented to the problem gambler sample minus the option "not being aware that treatment services were free".

[13] The options "…understand their language" and "…relate to their culture" was endorsed by 55% (32/58) and 52% (30/58) of the non-NZ European participants, respectively.

were rarely, or never, endorsed without a prompt. The mean number of options endorsed per participant was 12.2 (SD 5.8).

Three of the specified items were collectively identified as the primary barrier to help-seeking by 60% of the sample. These included: believing there wasn't a problem and not needing help (25%), feeling ashamed for themselves or family (20%), wanting to resolve the problem on their own or being too proud to seek help (15%). The remaining 18 items were rarely endorsed as the primary barrier to help-seeking.

Other responses

Participants were provided an open-ended opportunity to identify other barriers to help-seeking in addition to the 21 specified in Table 11. Three participants subsequently provided a novel response. These included: inability to communicate, support of the casino to continue gambling, and that fact that the state is involved in the ownership of personal data on problem gamblers. Twelve participants identified a factor other than the 21 specified in Table 11 as the primary (number one) barrier to seeking help. These included: thinking that seeking help will not fix the problem (n=3), belief they can win again to recover debt (n=2), role of the state, inability to access help, government greed, guilt, mental attitude, hitting rock bottom, and the addiction itself.

Between-group differences

Between-group differences in the five options most commonly identified as a barrier to help-seeking were investigated. The groups examined included: males versus females, <40 years of age versus 40+ years of age, NZ European versus Maori, single/separated/divorced versus married/de-facto relationship, employed versus unemployed, urban residence versus rural residence, meeting PGSI 'problem gambler' criteria versus not meeting these criteria, and New Zealand born versus born elsewhere. The three options 'believing they didn't have a problem and didn't need help', 'wanting to resolve the problem on own or being too proud to seek help', and 'feeling ashamed for themselves or family' were among the five most commonly endorsed barriers to seeking help in the groups examined (between-group rankings of all 21 barrier options presented in Table 27, Appendix 12). The option 'planning to get help but not getting around to it' was also in the top five of all but three groups (unemployed, those not meeting problem gambler criteria, and those born outside of New Zealand). Between-group variation in the top five options endorsed was, therefore, rarely evident and typically limited to a single option when it was evident.

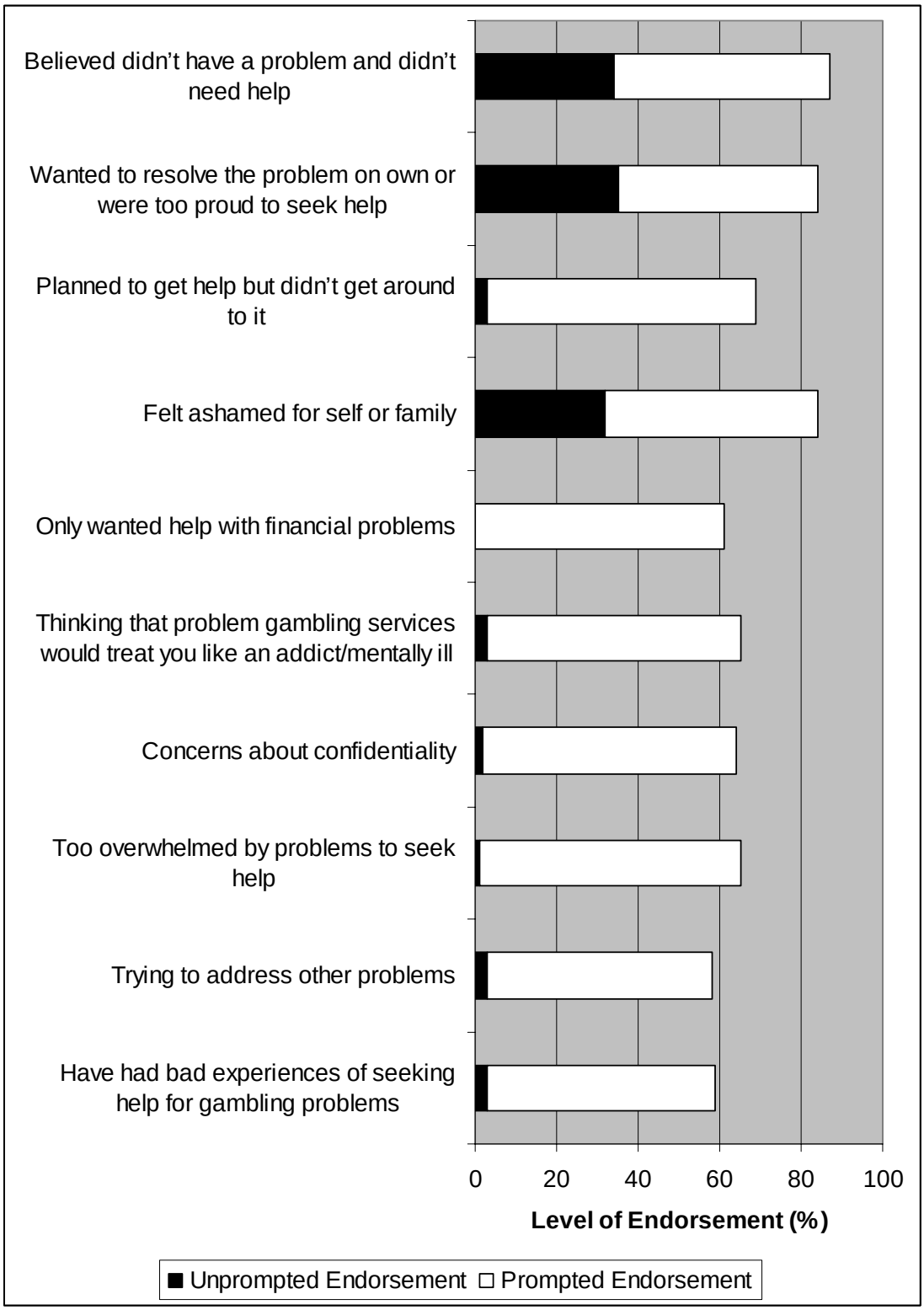
Between-group differences in the three options most commonly identified as the primary (number one) barrier to seeking help were also investigated. The same groupings were examined as described above. The top three items most often endorsed as the primary barrier to help-seeking were consistent, with only a single exception, across all groups examined. These included: 'believing they didn't have a problem and didn't need help', 'wanting to resolve the problem on own or being too proud to seek help', and 'feeling ashamed for themselves or family' (rankings presented in Table 28, Appendix 12). The sole exception was that for participants born outside of New Zealand the option most frequently perceived as being the primary barrier to help-seeking was: 'thinking the service would not understand their language'. This suggests that language concerns may be a significant barrier to help-seeking amongst migrant problem gamblers.

Table 11 Barriers to help-seeking (general population sample)

Response Option	Endorsed (n=104)			Endorsed as No. 1[1]
	Unprompted	Prompted	overall	
Believing there wasn't a problem and not needing help	35 (34%)	55 (53%)	**90 (87%)**	**23 (25%)**
Wanting to resolve problem alone or being too proud to seek help	36 (35%)	51 (49%)	**87 (84%)**	**14 (15%)**
Planning to get help but not getting around to it	3 (3%)	69 (66%)	72 (69%)	2 (2%)
Feeling ashamed for themselves or family	33 (32%)	54 (52%)	**87 (84%)**	**19 (20%)**
Only wanting help with financial problems	0 (0%)	63 (61%)	63 (61%)	0 (0%)
Not being aware that treatment was available	6 (6%)	45 (43%)	51 (49%)	3 (3%)
Not being able to get the service at the time or place wanted	7 (7%)	44 (42%)	51 (49%)	0 (0%)
Thinking the service would not understand their language	3 (3%)	41 (39%)	44 (42%)	6 (7%)
Thinking the service would not relate to their culture	2 (2%)	47 (45%)	49 (47%)	1 (1%)
Not wanting to use a telephone service	1 (1%)	42 (40%)	43 (41%)	0 (0%)
Not wanting to use a face to face service	0 (0%)	55 (53%)	55 (53%)	0 (0%)
Not wanting to use an online service	1 (1%)	36 (35%)	37 (36%)	0 (0%)
Thinking that problem gambling services would treat them like an addict/mentally ill	3 (3%)	64 (62%)	67 (64%)	1 (1%)
Concerns about their confidentiality	2 (2%)	64 (62%)	66 (63%)	5 (5%)
Having too many commitments to seek help	2 (2%)	46 (44%)	48 (46%)	0 (0%)
Being too overwhelmed by their problems to seek help	1 (1%)	67 (64%)	68 (65%)	1 (1%)
Trying to address other problems	3 (3%)	57 (55%)	60 (58%)	0 (0%)
Not having enough encouragement from friends, family, or community to seek help	1 (1%)	56 (54%)	57 (55%)	1 (1%)
Feeling pressured by friends, family or community to continue gambling	1 (1%)	48 (46%)	49 (47%)	1 (1%)
Having had bad experiences of seeking help for gambling problems	3 (3%)	58 (56%)	61 (59%)	2 (2%)
Having had bad experiences of seeking help for other problems	1 (1%)	59 (57%)	60 (58%)	1 (1%)

1 12 participants endorsed a factor not listed in this table as their number one reason for seeking help and a further 11 provided no response. Thus, total values do not equal 100%.

Figure 4 Ten most frequently endorsed 'barrier' options (general population sample)



Between-sample comparisons

Statistical differences in the frequency with which participants in each sample endorsed each of 21 specified options as a barrier to help-seeking were examined via logistic regression. The potentially confounding effects of ethnicity (NZ European or other) and country of origin (NZ born or other) were controlled for in the analysis[14]. Results are presented in Table 12. Statistically significant differences were identified in 19 of the 21 possibilities (as reported in Table 12). In all 19 cases, general population participants were significantly more likely to endorse the respective option as a barrier to help-seeking in comparison with their helpline counterparts. Two options were endorsed at a similar frequency by both the helpline and general population samples. These included: wanting to resolve the problem alone or being too proud to seek help (78% versus 84%) and being too overwhelmed by their problems to seek help (51% versus 65%). It is of note that the item most often endorsed by the helpline sample, wanting to resolve the problem alone or being too proud to seek help, was the second most endorsed option by the general population sample; however, the item most often endorsed by the general population sample, believing there wasn't a problem and not needing help, was only the fifth most commonly endorsed option among helpline participants. This would suggest that problem denial may be less of a barrier to gamblers who seek treatment as compared to those who do not, which would be consistent with expectation.

Differences in the top three options endorsed as the primary (number one) barrier to help-seeking were also examined via descriptive statistical analyses (based on data presented in Tables 10 and 11). The three options most often endorsed as the primary barrier to help-seeking were the same for both the helpline and general population samples but in a different rank order. These options, and their respective rankings, were: wanting to resolve problem alone or being too proud to seek help (1 and 3), believing there wasn't a problem and not needing help (2 and 1), and feeling ashamed for themselves and family (3 and 2).

[14] The 'helpline' and 'general population' samples were found to differ on country of origin, as reported on page 70.

Table 12 Percent of participants endorsing each of 21 specified barriers to help-seeking

Response Option	% Endorsing		Statistic	
	Helpline	General Population	OR (95% CI)	p-value
Believing there wasn't a problem and not needing help	42%	87%	0.088 (0.04, 0.19)	<0.001**
Wanting to resolve problem alone or being too proud to seek help	78%	84%	0.636 (0.30, 1.34)	0.233
Planning to get help but not getting around to it	47%	69%	0.337 (0.19, 0.61)	<0.001**
Feeling ashamed for themselves or family	73%	84%	0.449 (0.22, 0.93)	0.031*
Only wanting help with financial problems	38%	61%	0.416 (0.24, 0.73)	0.002**
Not being aware that treatment was available	14%	49%	0.196 (0.10, 0.38)	<0.001**
Not being able to get the service at the time or place wanted	26%	49%	0.396 (0.22, 0.71)	0.002**
Thinking the service would not understand their language	6%	42%	0.093 (0.04, 0.22)	<0.001**
Thinking the service would not relate to their culture	10%	47%	0.123 (0.06, 0.26)	<0.001**
Not wanting to use a telephone service	20%	41%	0.341 (0.18, 0.64)	0.001**
Not wanting to use a face to face service	18%	53%	0.184 (0.10, 0.35)	<0.001**
Not wanting to use an online service	8%	36%	0.155 (0.07, 0.35)	<0.001**
Thinking that problem gambling services would treat them like an addict/mentally ill	35%	64%	0.301 (0.17, 0.54)	<0.001**
Concerns about their confidentiality	35%	63%	0.290 (0.16, 0.52)	<0.001**
Having too many commitments to seek help	27%	46%	0.461 (0.26, 0.83)	0.010*
Being too overwhelmed by their problems to seek help	51%	65%	0.674 (0.38, 1.20)	0.179
Trying to address other problems	28%	58%	0.315 (0.18, 0.56)	<0.001**
Not having enough encouragement from friends, family, or community to seek help	27%	55%	0.296 (0.17, 0.53)	<0.001**
Feeling pressured by friends, family or community to continue gambling	29%	47%	0.430 (0.24, 0.77)	0.004**
Having had bad experiences of seeking help for gambling problems	15%	59%	0.105 (0.05, 0.21)	<0.001**
Having had bad experiences of seeking help for other problems	22%	58%	0.219 (0.12, 0.40)	<0.001**

* p <0.05, ** p <0.01

3.3.4 Knowledge of services

Helpline sample

All participants were asked 'what sources of help do you know of for gambling problems?' Unprompted and prompted replies to this question are listed in Table 13. As can be seen, participants had a greater knowledge of the specialist services such as Gamblers Anonymous (66%), Problem Gambling Foundation (62%) and Oasis (53%) in comparison with other forms of assistance. Online-based services were the least well known (18%). The unprompted 'other' responses included: one or more culturally-specific treatment services (n=7), an undefined counselling service (n=6), a mental health service (n=3), a church (n=2), friends (n=1), Lifeline (n=1), and a traumatic brain injury rehabilitation centre (n=1). The prompted 'other' responses included: a mental health service (n=5), Lifeline (n=4), general counselling service (n=3), a culturally-specific service (n=2), church (n=1), and an unknown response (n=1).

Table 13 Awareness of helping sources (helpline sample)

Source[1]	**Level of Awareness**		
	Unprompted	Prompted	Overall (n=125)
Online Services	10 (8%)	13 (10%)	23 (18%)
Problem Gambling Foundation	**29 (23%)**	**48 (38%)**	**77 (62%)**
Salvation Army Oasis Centre	**33 (26%)**	**33 (26%)**	**66 (53%)**
Gamblers Anonymous	**24 (19%)**	**58 (46%)**	**82 (66%)**
Other	16 (13%)	15 (12%)	31 (25%)
Self-Help	4 (3%)	25 (20%)	29 (23%)
General Practitioner	2 (2%)	25 (20%)	27 (22%)
Social & Welfare Service	6 (5%)	27 (22%)	33 (26%)
Alcohol & other drug service	7 (6%)	21 (17%)	28 (22%)

1 The Gambling Helpline was excluded from this table as it was the recruitment source for study participants

If a participant identified a source of help for a gambling problem, they were then asked 'how did you first become aware that this could be a source of help?' Participant responses for five different sources of specialist problem gambling assistance are listed in Table 14. Overall, a formal referral (from another service or health professional) was the most common source of specialist knowledge (30%). This was followed by media advertising (17%) and venue advertising or the phone book (both 12%). However, the source of specialist knowledge seemingly varied by service type. Participants were more likely to identify venue and media advertising as a source of knowledge for the Gambling Helpline, formal referral as a source of

knowledge for the Problem Gambling Foundation, Oasis and Gamblers Anonymous, and an internet search as a source of knowledge for an internet-based service.

Table 14 Source of specialist service knowledge (helpline sample)

Information Source	**Gambling Treatment Service**					**Total**
	Helpline	PGF[1]	Oasis	GA[2]	Internet	
	(n =119)	(n = 69)	(n = 53)	(n = 62)	(n = 20)	(n = 323)
Venue Advertising	24 (20%)	7 (10%)	1 (2%)	6 (10%)	1 (5%)	**39 (12%)**
Media Advertising	37 (31%)	9 (13%)	1 (2%)	7 (11%)	1 (5%)	**55 (17%)**
Formal Referral	12 (10%)	32 (46%)	27 (51%)	21 (34%)	4 (20%)	**96 (30%)**
Informal Referral	9 (8%)	6 (9%)	7 (13%)	10 (16%)	0 (0%)	32 (10%)
Phone Book	19 (16%)	11 (16%)	5 (9%)	3 (5%)	0 (0%)	**38 (12%)**
Internet Search	10 (8%)	2 (3%)	0 (0%)	0 (0%)	14 (70%)	26 (8%)
Existing Knowledge	8 (7%)	2 (3%)	12 (23%)	15 (24%)	0 (0%)	37 (11%)

1 Problem Gambling Foundation
2 Gamblers Anonymous

General population sample

General population participants were also asked 'what sources of help do you know of for gambling problems?' Unprompted and prompted replies to this question are listed in Table 15. The Gambling Helpline and Gamblers Anonymous were the two most well known services (77% and 54%, respectively). Online-based services were the least well known (14%). The unprompted 'other' responses included: an undefined counselling service (n=5), a culturally specific service (n=5), church (n=3), psychiatrist (n=2), friends (n=1), Employee Assistance Programme (n=1), a "course" (n=1), Yellow Pages (n=1), Lifeline (n=1), Ministry of Health (n=1), and a mental health service (n=1). The prompted 'other' responses included: a mental health service (n=3), Lifeline (n=1), marae (n=1), Lion Foundation (n=1), hospital (n=1), counsellor (n=1), embarrassing the gambler (n=1), and a self-help approach (n=1). Overall, 84% (87/104) of general population participants knew of a Ministry of Health funded problem gambling service (Gambling Helpline, Problem Gambling Foundation or Salvation Army Oasis Centre) whilst 88% (92/104) knew of a Ministry of Health funded service, Gamblers Anonymous or an online problem gambling support service.

Table 15 Awareness of helping sources (general population sample)

Source	Level of Awareness		
	Unprompted	Prompted	Overall (n=104)
Gambling Helpline	**47 (45%)**	**33 (32%)**	**80 (77%)**
Online Services	7 (7%)	8 (8%)	15 (14%)
Problem Gambling Foundation	9 (9%)	35 (34%)	44 (42%)
Salvation Army Oasis Centre	8 (8%)	23 (22%)	31 (30%)
Gamblers Anonymous	**22 (21%)**	**34 (33%)**	**56 (54%)**
Other	22 (21%)	11 (11%)	33 (32%)
Self-Help	0 (0%)	22 (21%)	22 (21%)
General Practitioner	5 (5%)	23 (22%)	28 (27%)
Social & Welfare Service	2 (2%)	28 (27%)	30 (29%)
Alcohol & other drug service	7 (7%)	22 (21%)	29 (28%)

If a general population participant identified a source of help for a gambling problem, they were also asked 'how did you first become aware that this could be a source of help?' Participant responses for five different sources of specialist problem gambling assistance are listed in Table 16. Overall, media advertising was the most common source of specialist knowledge (33%). This was followed by venue advertising (18%) and existing knowledge (18%). Some variance in response by service type was evident, but this may be a function of the low sample sizes.

Table 16 Source of specialist service knowledge (general population sample)

Information Source	Gambling Treatment Service					Total
	Helpline	PGF[1]	Oasis	GA[2]	Internet	
	(n = 31)	(n = 20)	(n = 10)	(n = 24)	(n = 5)	(n = 90)
Venue Advertising	7 (23%)	6 (30%)	1 (10%)	1 (4%)	1 (20%)	**16 (18%)**
Media Advertising	15 (48%)	9 (45%)	1 (10%)	4 (17%)	1 (20%)	**30 (33%)**
Formal Referral	1 (3%)	0 (0%)	1 (10%)	7 (29%)	0 (0%)	9 (10%)
Informal Referral	1 (3%)	2 (10%)	3 (30%)	1 (4%)	1 (20%)	8 (9%)
Phone Book	1 (3%)	1 (5%)	0 (0%)	2 (8%)	0 (0%)	4 (4%)
Internet Search	4 (13%)	0 (0%)	0 (0%)	2 (8%)	1 (20%)	7 (8%)
Existing Knowledge	2 (6%)	2 (10%)	4 (40%)	7 (29%)	1 (20%)	**16 (18%)**

1 Problem Gambling Foundation
2 Gamblers Anonymous

Between-sample comparisons

A series of chi-square tests were conducted in order to identify whether one or another sample was more or less aware of the various services available for problem gamblers in comparison with the other (i.e. comparing data presented in Table 13 with data presented in Table 15). Two statistically significant differences were found: the helpline sample was more likely to report awareness of the Problem Gambling Foundation (62% vs. 42%; $\chi^2 = 8.48$, df = 1, p = .01) or Oasis (53% vs. 30%; $\chi^2 = 12.29$, df = 1, p < .01) in comparison with the general population sample.

A series of chi-square tests were also conducted in order to identify whether the samples varied in their source of specialist service knowledge. These analyses were based on the data presented in the 'overall' columns of Tables 14 and 16 and tested whether one sample was more likely to identify each of the seven listed options as an 'information source' in comparison with the other sample. Three statistically significant results were identified. These included: the general population were more likely to cite the 'media' as a source of specialist service information in comparison with the helpline sample (33% vs. 17%; $\chi^2 = 11.45$, df = 1, p < .01); and the helpline sample was more likely to cite 'formal referral' (28% vs. 10%; $\chi^2 = 14.44$, df = 1, p < .01) or 'phone book' (12% vs. 4%; $\chi^2 = 4.13$, df = 1, p = .04) as a source of specialist service information in comparison with the general population sample.

3.3.5 Previous treatment experience

Helpline sample

Forty-six percent (57/125) of participants reported having sought formal or informal assistance for a gambling-related problem on at least one prior occasion. Of these 57 participants, 49% (28/57) reported having previously received face-to-face assistance from a counselling service, 14% (8/57) reported prior use of the telephone helpline, 23% (13/57) reported prior use of both a face-to-face counselling service and the telephone helpline, and a further 12% (7/57) reported prior use of: Alcoholics Anonymous (n=1), budget advisor (n=1), friends (n=1), telephone helpline plus the internet (n=1), hypnotherapy (n=1), General Practitioner (n=1), and the telephone helpline plus family, friends, a General Practitioner and a budget advisor (n=1). The remaining participant could not remember where he/she had previously sought assistance.

The 57 participants who had previously sought assistance for a gambling-related problem were asked to state how 'useful' the help received had been. Forty-seven percent (27/57) of the sample provided a response indicative of a positive experience, 33% (19/57) provided a response indicative of a negative experience, 12% provided both positive and negative feedback, and seven percent (4/57) did not answer the question. The positive feedback received was largely generic in nature with comments like "brilliant", "excellent" or "good" commonly provided. However, a number of quite specific negative responses were provided. These included: "[client] was not willing to disclose name or personal details at that time, felt he was being asked for these and was put off", "[counselling] was very confusing and often frustrating", "found the physical office space depressing", "felt group members were not being honest [she knew they were still gambling as she regularly saw them doing so] and felt put down when she was honest", "counsellor repeatedly got my name wrong and only seemed interested in me as an output", "the counsellor did not attend her first appointment. She was left to wait for half an hour in a very public place which made her feel angry and ashamed. She left the service to go and gamble". The 57 participants were also asked whether they obtained the help they sought. Fifty-six percent (32/57) provided an affirmative response, 35% (20/57) provided a negative response, seven percent provided a mixed yes and no response, and one participant (two percent of sample) did not respond.

General population sample

Twenty-four percent (25/104) of participants reported having sought formal or informal assistance for a gambling-related problem on at least one prior occasion. Of these 25 participants, 32% (8/25) reported having previously received face-to-face assistance from a counselling service, 20% (5/25) reported prior use of the telephone helpline, 16% (4/25) reported prior use of both a face-to-face counselling service and the telephone helpline, and 12% (3/25) reported prior support from family. The remaining 20% (5/25) had sought support from: a friend (n=1), their church (n=1), a self-help strategy (n=1), Gamblers Anonymous and a bishop (n=1), and telephone helpline plus a General Practitioner, psychologist and Landmark Education (n=1).

The 25 participants who had previously sought assistance for a gambling-related problem were asked to state how 'useful' the help received had been. Forty-eight percent (12/25) of these participants provided a response indicative of a negative experience, 40% (10/25) provided a response indicative of a positive experience, four percent (1/25) provided both positive and negative feedback, and eight percent (2/25) did not answer the question. The majority of the feedback received was very generic in nature with comments like "good", "useful" and "useless" commonly provided. However, a small number of quite specific responses were provided. These included: "[counsellor] was really understanding and non-

judgemental"; "[Gamblers Anonymous group] encouraging hearing other people's stories"; "[bishop] inspiring, encouraging and continuous". The 25 participants were also asked whether they obtained the help they sought. Fifty-two percent (13/25) provided a negative response, 32% (8/25) provided an affirmative response, eight percent (2/25) provided a mixed yes and no response, and a further eight percent (2/25) did not respond.

Between-sample comparisons

Chi-square analysis revealed that helpline participants were statistically significantly more likely to report having previously received formal or informal assistance for a gambling-related problem in comparison with their general population counterparts (46% vs. 24%; χ^2 = 11.48, df = 1, p < .01). Of the participants who reported having previously received assistance, the majority from both samples described having received some form of specialist–assistance (89% and 72%). However, a high proportion of both samples reported negative experiences (55% and 52%) and not obtaining the help they sought (35% and 52%)[15].

3.3.6 Three-month follow-up data

This section presents data from the 45 participants in the helpline sample who completed the three-month follow-up survey (as detailed in section 2.5.4). Only participants in the telephone sub-sample (n=97) were invited to complete this survey. Comparative data were not collected from participants in the general population sample. Demographic and problem gambling severity data for the follow-up sample are presented in Tables 29 and 30, Appendix 13.

The 45 participants in the follow-up sample were asked: 'since we last spoke with you about three months ago, have you used any services to get help for gambling problems?' In response to this question, 51% (23/45) of participants provided an affirmative answer and 49% (22/45) provided a negative response.

The 23 participants who answered in the affirmative were asked to identify the service(s) they had used and to rate each one, on a five-point scale (1 = very dissatisfied to 5 = very satisfied), according to the level of satisfaction with the service offered[16]. A total of six service types was identified with a median satisfaction rating of 4 (range = 1 to 5). Results, by service type, were as follows: Gambling Helpline (n = 12, median rating = 4, range = 3 to 5); Problem Gambling Foundation (n = 8, median rating = 5, range = 3 to 5); Oasis (n = 7, median rating = 4, range = 4 to 5); Gamblers Anonymous (n= 3, median rating = 4, range = 4 to 5); "general counselling" (n = 1, rating = 4); and a Maori-specific service (n = 1, rating = 1). Participants were asked to identify the positive aspects of each service reported and to recommend any possible improvements. Responses are presented in Appendix 14.

When asked 'has using services helped you achieve the outcome you wanted?' 19 of these 23 participants answered 'yes'. One responded 'no' (Maori-specific service), another was uncertain (Problem Gambling Foundation) and two reported that the service was helping, but they had yet to achieve their outcome. Participants were also asked to identify the outcome they wanted to achieve. The following responses were provided: to stop gambling/become bet free (n=18), to control the gambling behaviour (n=4), to understand the problem (n=4), "to sort out my problems" (n=2), "to get barred from venues" (n=2), "to become more safe to

[15] Chi-square analysis was not conducted on these latter measures due to low sample sizes
[16] A rating was sought for each service identified

myself" (n=1), "someone to listen to my concerns" (n=1), "stop damage from gambling" (n=1), "reality check" (n=1), "lose weight" (n=1), "stop smoking" (n=1), "set goals" (n=1), and "someone to talk to and check up on me" (n=1).

The 22 participants who stated that they had not used a service in the three-months following the original survey were asked why this was the case. The most common response, provided by 13 participants, was that they did not feel the need to attend treatment as their gambling problem was under control. A further four participants stated that they preferred to resolve their gambling problems on their own and two stated that they were reluctant to seek specialist help due to a negative service experience in the past. Other responses included having too many commitments to seek help (n=1) and not needing specialist help as her gambling problems were being dealt with as a result of addressing other issues (n=1). PGSI data, obtained at baseline assessment, was available for 21 of the participants who stated that they had not used a service in the three-months following the original survey and for 22 of the participants who had used a service. An independent samples *t* test revealed that the mean PGSI score of the 21 participants who had not used a service was lower, at a statistically significant level, than their counterparts who had used a service (10.57 versus 15.23; $t = -2.78$, $df = 41$, $p = .008$). This suggests that the decision to seek further help during the three month follow-up period may have been influenced by the level of problem gambling severity at baseline measurement.

3.4 Surveys : Family/whanau data

In this section a range of survey data pertaining to people who seek help due to *someone else's* gambling behaviour is presented. These data may be considered the 'family/whanau' equivalent to that presented in the previous section. Due to limitations in sample size, however, no inferential statistics are presented and nor are any between-group comparisons made.

3.4.1 Participant characteristics

Demographics

Table 17 presents demographic data for the family/whanau sample (n=32) by recruitment methodology (telephone or internet) and overall. Participants were spread across a number of different age-bands, were largely female (93%), of New Zealand European (56%) or Maori (26%) descent, New Zealand born (78%), married or in a de-facto relationship (79%), employed (70%), and residing in an urban locality (74%).

Treatment Status
Nineteen percent (6/32) of the 'family/whanau' sample stated that they were currently receiving formal assistance for someone else's gambling-related problem at the time of the baseline survey. Of these six participants, four were receiving assistance from the telephone helpline, one was receiving face-to-face assistance from a counselling service, and one was receiving assistance from both a face-to-face counselling service and the telephone helpline.

Twenty-eight percent (9/32) of the 'family/whanau' sample stated that they were currently receiving informal assistance for someone else's gambling-related problem at the time of the baseline survey. Of these nine participants, five were receiving support from their partner and/or a family member, two were receiving support from a friend, one was receiving support from family and their employer and one did not wish to identify the source of informal help.

Six percent (2/32) of the sample reported receiving both formal and informal assistance for a gambling related problem and 63% (20/32) reported receiving neither form of assistance.

Table 17 Participant demographics (family/whanau sample)

Variable		Sample by Recruitment Methodology		Overall Sample[1]
		Telephone (n=14)	Internet (n=18)	(n = 32)
Age	20-29 yrs	1 (7%)	7 (50%)	8 (29%)
	30-39 yrs	2 (14%)	3 (21%)	5 (18%)
	40-49 yrs	3 (21%)	3 (21%)	6 (21%)
	50- 59 yrs	4 (29%)	0 (0%)	4 (14%)
	60+ yrs	4 (29%)	1 (7%)	5 (18%)
Gender	Male	1 (7%)	1 (7%)	2 (7%)
	Female	**13 (93%)**	**13 (93%)**	**26 (93%)**
Ethnicity[2]	**NZ European**	**7 (50%)**	**8 (62%)**	**15 (56%)**
	Maori	**5 (36%)**	**2 (15%)**	**7 (26%)**
	Pacific Island	1 (7%)	0 (0%)	1 (4%)
	Asian	0 (0%)	0 (0%)	0 (0%)
	Other	1 (7%)	3 (23%)	4 (15%)
Origin	**NZ Born**	**12 (86%)**	**13 (72%)**	**25 (78%)**
	United Kingdom	0 (0%)	1 (6%)	1 (3%)
	Asia	0 (0%)	1 (6%)	1 (3%)
	Australia	0 (0%)	1 (6%)	1 (3%)
	Pacific Islands	1 (7%)	0 (0%)	1 (3%)
	Other	1 (7%)	1 (6%)	2 (6%)
Marital Status	Single	1 (7%)	1 (7%)	2 (7%)
	Married/Defacto	**9 (64%)**	**13 (93%)**	**22 (79%)**
	Separated/Divorced	4 (29%)	0 (0%)	4 (14%)
Employment	Employed	9 (64%)	10 (77%)	19 (70%)
	Unemployed	1 (7%)	0 (0%)	1 (3%)
	Other[3]	4 (29%)	3 (23%)	7 (26%)
Locality	**Urban**	**4 (29%)**	**8 (80%)**	**17 (74%)**
	Rural	9 (64%)	2 (20%)	6 (26%)

1 Sample size for each variable does not always meet 32
2 Participants who reported mixed ethnicity were counted once in each category provided
3 Includes students, retirees, sickness beneficiaries and stay-at-home parents

3.4.2 Enablers to help-seeking

Responses to specified enablers

Table 18 presents the number and percentage of participants in the family/whanau sample who endorsed each of 11 specified 'enablers' as a factor in their decision to seek specialist assistance[17]. Table 18 also identifies whether each item was endorsed with or without prompting and the number and percentage of participants who endorsed each item as their primary (number one) reason for seeking help.

Table 18 Enablers to help-seeking (family/whanau sample)

Response Option	**Endorsed** (n=32)			**Endorsed as No. 1**[1]
	Unprompted	Prompted	overall	
Financial problems	4 (13%)	20 (63%)	**24 (75%)**	**7 (22%)**
Reaching a point where you felt like you could not go on	1 (3%)	14 (44%)	15 (47%)	1 (3%)
Other emotional factors	1 (3%)	23 (72%)	**24 (75%)**	3 (9%)
Wanting to prevent the gambling from becoming a major problem	1 (3%)	21 (66%)	**22 (69%)**	1 (3%)
Problems with your spouse or partner	8 (25%)	9 (29%)	**17 (55%)**	**5 (16%)**
Problems with other family members	1 (3%)	15 (47%)	16 (50%)	**6 (19%)**
Concerns about the welfare of your children	4 (13%)	10 (32%)	14 (44%)	**4 (13%)**
Isolation from family and friends	0 (0%)	18 (56%)	**18 (56%)**	0 (0%)
Legal problems	0 (0%)	7 (22%)	7 (22%)	0 (0%)
Problems in your living circumstances	0 (0%)	9 (28%)	9 (28%)	0 (0%)
The gambling is affecting your physical health	1 (3%)	13 (41%)	14 (44%)	0 (0%)

1 Five participants endorsed a factor not listed in this table as their number one reason for seeking help

[17] The original wording of each 'enabler' option has been abbreviated in this Table and all subsequent 'enabler' Tables for ease of readership. Original wording may be seen in the relevant questionnaires included in the appendices.

The most commonly endorsed of these enablers was 'financial problems' and 'other emotional factors', with 75% of the sample identifying each as a factor in their decision to seek help. Three more items were considered influential in the decision to seek help by more than 50% of participants. These included: wanting to prevent the gambling from becoming a major problem (69%), isolation from family and friends (56%), and problems with your spouse or partner (55%). The items considered least influential in the decision to seek help included: legal problems (22%), and problems in your living circumstances (28%). The listed items were rarely identified as a reason for seeking help without prompting.

The items most often endorsed as the primary (number one) reason for seeking help were 'financial problems' (22%), 'problems with other family members' (19%), 'problems with your spouse or partner' (16%), and 'concerns about the welfare of your children' (13%). The remaining options were rarely, or never, endorsed as the primary reason for seeking help. These results would suggest that family/whanau primarily seek help due to financial pressures and/or problems with, or concerns about, their partner or some other family member.

Other responses
Participants were provided an open-ended opportunity to identify other reasons for seeking help in addition to the 11 specified enablers. No participant provided an answer in response to this opportunity. However, 16% (5/32) of the sample identified a factor other than the 11 specified in Table 18 as their primary (number one) reason for seeking help. These included: "because it's time to address this addiction", concern about welfare of grandchildren, curiosity, lack of trust in workplace, and to understand what a problem gambler was.

3.4.3 Barriers to help-seeking

Responses to specified barriers

Table 19 presents the number and percentage of participants in the family/whanau sample who endorsed each of 15 specified 'barriers' to seeking specialist assistance[18]. Table 19 also identifies whether each barrier was endorsed with or without prompting and the number and percentage of participants who endorsed each as the primary (number one) barrier to help-seeking. The most commonly endorsed barrier was 'planned to get help, but didn't get around to it' (53%). All of the remaining items were endorsed by less than 50% of the sample, and eight of the listed options were not endorsed at all. The listed items were rarely, and mostly never, identified as a barrier to help-seeking without prompting. None of the listed options was consistently endorsed as the primary barrier to seeking help. Nine of the listed items were only endorsed by one or two participants and the remaining six items were not endorsed at all.

[18] The original wording of each 'barrier' option has been abbreviated in this Table and all subsequent 'barrier' Tables for ease of readership. Original wording may be seen in the relevant questionnaires included in the appendices.

Table 19 Barriers to help-seeking (family/whanau sample)

Response Option	Endorsed (n=32)			Endorsed as No.1[1]
	Unprompted	Prompted	overall	
Not aware that treatment was available	1 (3%)	4 (13%)	5 (16%)	2 (7%)
Not aware that treatment was available for the family or friends of problem gamblers	0 (0%)	11 (36%)	11 (36%)	0 (0%)
Planned to get help but didn't get around to it	0 (0%)	16 (53%)	**16 (53%)**	2 (7%)
Were not aware that treatment was free	0 (0%)	7 (23%)	7 (23%)	1 (4%)
Couldn't get the service at the time or place wanted	3 (10%)	4 (13%)	7 (23%)	1 (4%)
Didn't think the service would understand your language	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Didn't think the service would relate to your culture or community	0 (0%)	0 (0%)	0 (0%)	1 (4%)
Didn't want to use a telephone service	0 (0%)	0 (0%)	0 (0%)	1 (4%)
Didn't want to use a face to face service	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Didn't want to use an online service	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Thought problem gambling services would treat your family member or friend like an addict / mentally ill	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Concerns about confidentiality	1 (3%)	2 (7%)	3 (10%)	2 (7%)
Too many commitments to seek help	0 (0%)	0 (0%)	0 (0%)	2 (7%)
Not enough support from friends, family, or community to seek help	0 (0%)	0 (0%)	0 (0%)	1 (4%)
Have had bad experiences of seeking help for other problems	1 (3%)	7 (25%)	8 (29%)	0 (0%)

1 15 participants endorsed a factor not listed in this table as their number one reason for seeking help and a further four provided no response

Other responses

Participants were provided an open-ended opportunity to identify other barriers to help-seeking in addition to the 15 specified in Table 19. No participant provided an answer in response to this opportunity. However, 47% (15/32) of the sample identified a factor other than the 15 specified in Table 19 as their primary (number one) barrier to seeking help. These included: the gambler not thinking their gambling was a problem (n=4), not being sure if there was a problem (n=2), shame (n=2), husband told her not to seek help (n=1), kept thinking things would get better (n=1), not convinced someone lese could help with the problem (n=1), lack of motivation (n=1), and not wanting to cause trouble (n=1). In addition, one of the these 15 participants stated that they experienced no barriers to help-seeking and one inferred that they had not sought treatment, so was unsure as to what the barriers might be.

3.4.4 Knowledge of services

All family/whanau participants were asked 'what sources of help do you know of for gambling problems?' Unprompted and prompted replies to this question are listed in Table 20. Gamblers Anonymous was the most well known service (39%), although no one service was known by 50% or more of participants. The unprompted 'other' responses included: a church (n=2), a culturally-specific treatment service (n=1), an undefined counselling service (n=1), a mental health service (n=1), friends (n=1), Youthline (n=1), and fact sheets (n=1). The prompted 'other' responses included Lifeline (n=1), and information obtained through a conference (n=1).

Information pertaining to the source of participant knowledge is not presented due to the low sample sizes.

Table 20 Awareness of helping sources (family/whanau sample)

Source[1]	**Level of Awareness**		
	Unprompted	Prompted	Overall (n=32)
Online Services	2 (6%)	3 (9%)	5 (16%)
Problem Gambling Foundation	3 (9%)	8 (25%)	11 (34%)
Salvation Army Oasis Centre	2 (6%)	5 (16%)	7 (22%)
Gamblers Anonymous	2 (6%)	11 (33%)	**13 (39%)**
Other	8 (25%)	2 (6%)	10 (31%)
Self-Help	0 (0%)	5 (16%)	5 (16%)
General Practitioner	2 (6%)	3 (9%)	5 (16%)
Social & Welfare Service	1 (3%)	5 (16%)	6 (19%)
Alcohol & other drug service	0 (0%)	8 (25%)	8 (25%)

1 The Gambling Helpline was excluded from this table as it was the recruitment source for study participants

3.4.5 Previous treatment experience

Twenty-two percent (9/32) of the family/whanau sample reported having sought formal or informal assistance on at least one prior occasion. Three of these nine participants reported having previously received help from the telephone helpline, two reported prior use of a face-to-face counselling service, two reported using both the telephone helpline and a face-to-face counselling service, one participant reported seeking help from a sister and another reported seeking help from a General Practitioner.

The nine participants who had previously sought assistance were asked to state how 'useful' the help received had been. Five of these participants provided a response indicative of a positive experience and four provided a response indicative of a negative experience. Most of the feedback received was very generic in nature with comments like "very good", "fine" and not useful". However, a small number of quite specific responses were provided. These included "[counsellor] was not useful as my son ran away"; "[helpline] was not very helpful, but it did give me an understanding of why people do it, but they did not tell me how to help them stop it"; "[sister] is a great listener but is unable to talk to my husband as he would go berserk if he knew I told people about his spending etc". The nine participants were also asked whether they obtained the help they sought. Four participants provided an affirmative response, four provided a negative response and one provided a mixed yes and no response.

3.4.6 Three-month follow-up data

This section presents data from the seven participants in the family/whanau sample who completed the three-month follow-up survey (as detailed in section 2.5.4). Only participants in the telephone sub-sample (n=14) were invited to complete this survey. Six of the seven participants were female, three were of NZ European descent, three were Maori and one was Pacific; they ranged in age from 30-65+ years, five were born in New Zealand, four were married, two were separated and one was single.

Only two of these seven participants reported having used a service to 'get help for gambling problems' since the time of the baseline questionnaire. The services used were the two national problem gambling treatment providers. When asked to rate the level of satisfaction with the service offered, on a five-point scale (1 = very dissatisfied to 5 = very satisfied), ratings of 2 and 5 were provided. The participant who gave a rating of 5 reported that the service had helped her achieve her desired outcome which was "peace of mind". The other participant stated that the service had not been helpful and that she did not return after the first visit.

Four of the five participants who had not attended a service reported that they had not done so as they no longer felt the need for assistance, although in one case this was because the participant had separated from her husband (who had been causing the gambling-related problems). The fifth participant did not provide a reason.

3.5 Surveys : Semi-structured interview data

This section presents semi-structured interview data obtained from five Maori problem gamblers (female n=3, male n=2), a Korean problem gambler (male) and a Korean family member (female) of a problem gambler.

3.5.1 Maori interview data

This section of the report gives an outline of the themes identified in the interviews with Maori participants.

Enablers to help-seeking

Primary enablers
The primary reason for seeking help varied amongst participants but centred mainly on a desire to regain control of their lives and the pressure they received from family to address their problem gambling. Often these issues coincided before help-seeking took place.

> *"The enabler was that personal willpower comes first. The desire, caused out of frustration and anger, and just the fact that it was wrecking my life and the life of people around me"* (Male)

> *"…every time I go I just wondered 'what for' because the wins don't help at all they just make me want to go out and win more money and I'd lose it back. I've just got sick of it basically I just got sick of gambling. It no longer became fun it became like some sort of bridal lebola, some dowry almost to the pokie machines. I was their servant like some blood thirsty god. So that's why I got sick of them and thought it's just time to end it because I'm just tired of it. I'm tired of being the laughing stock of people"* (Male)

> *"What are some of the reasons? Because I felt that my gambling was out of control. I just needed some tools to help me stop. My gambling had created a sense of being out of control"* (Female)

> *"Because I genuinely wanted to stop gambling. I wanted to become gamble-free. I wanted to stop having my life dictated to me by a mechanical television screen. I wanted to become a person again not 25 credits for $2"* (Male)

> *"Since my grandchild came along, she's my world... gambling at that time filled a void for me. Now it's just been replaced by baby, which is stronger than the pull of those machines"* (Female)

> *"Basically my family were on the condition that if I ever gambled again they'd disown me. And also I had friends that would go 'oh have you gambled your money away this week? Oh you need money because you gamble'. There was lots of pressure for me to stop it because I thought people didn't know but a lot of people knew. And people were starting to ignore me because they knew I was a slave to the gambling"* (Male)

If participants started the help-seeking process due to family or whanau pressure, genuine and committed help-seeking only occurred once the participants internalised the impact their gambling was having on their families' lives[19]:

> *"Generally to get my life back on track. That's true. I'm no good to my granddaughter the way I was"* (Female)

One participant found that straight talking from her partner provided her with the 'wake-up call' she needed to make a change in her life:

> *"The one thing that my husband said to me actually he said 'Are you proud of yourself? Look at yourself, look at what you've been doing, are you proud of yourself? Would your children be proud of you?' We're Maori and my dad's Maori I guess pride is something that is really critical to us and I hadn't really sat in front of the mirror and looked at myself and looked at my life and said you know 'what are you doing with your life?' I just needed somebody to say.. if [my husband] had said to me seven, eight, nine, ten years ago 'take a look in the mirror at yourself and see what you're doing and what you've done'. I needed someone to get honest… I needed someone to help me get honest with myself"* (Female)

Secondary enablers

A secondary enabler to help-seeking mentioned frequently by participants was the impact of gambling on their finances:

> *"The poverty, the fact that I was living on the bread line all the time. I was basically getting the essentials then leaving all the money left over for gambling and it was getting to the point that I was going to start sacrificing rent so I could go play the pokies"* (Male)

Family members frustrated with participants' lack of finance added to pressure to seek help:

> *"He was sick of me never having any money because I'd gamble all the time"* (Male)

For one participant, this represented the biggest factor in seeking-help:

> *"Come back to money, waste of. Waste of money"* (Male)

Being able to talk with a counsellor straight away was also something that participants viewed very favourably:

> *"When I rang she arranged to see me straight away which I liked, which made me think I'm getting help. Not weeks down the track"* (Male)

> *"Yeah I quite like that [speedy service] 'cause I'm quite like "I want it now", which is good and bad. I can't wait for things to come"* (Male)

Barriers to help-seeking

Primary barriers

For almost all the participants, the most significant barrier to help-seeking was not realising, or admitting, that they needed help. Despite the impact gambling had on the families of these

[19] For one participant this internalisation of the impact of gambling on her family was the difference between past failed attempts to seek help and her current more committed help-seeking attempt.

participants, they would perceive their gambling to not be that big an issue and, therefore, would delay doing anything about it until it escalated into an out of control level:

> *"I guess the main barrier for me in the past has been just really accepting the severity of my problem. Perhaps I just needed for my problem to escalate…"* (Female)

> *"I didn't really think I wanted to stop probably or think I needed to. It was something that I enjoyed doing in my life and I didn't really think it impacted enough on anything else in my life to warrant that I really wanted to stop"* (Female)

There were definite feelings of stubbornness from the participants who were, in general, aware of their heavy gambling:

> *"Generally it was my own feelings, I felt I had the democratic right to gamble, it was my pleasure and no one was going to tell me how to live my life"* (Male)

> *"[One barrier was] probably my own negative attitude. The fact that I thought I didn't need help, I didn't want help I didn't want people poking their nose into my business. There were sometimes I said I was getting help but I'd always go back and have one last flutter"* (Male)

> *"My own selfishness. Me being selfish, just to myself. I don't want to go"* (Female)

Whakama (embarrassment) was another frequently cited barrier to help-seeking, particularly when attending counselling:

> *"It's myself. Ultimately it's my pride. It's the shame that goes, it's the stigma, it's your thing attached see, I still have a problem walking in there [to the counselling servive], I try and find me another way of getting in there because it's not easy going in that door, but now I've come to accept that if just one person sees me walk in there 'hell if she can do it, maybe I can'. It takes a lot to walk in that door it's probably one of the reasons I've faulted on my appointments because I wasn't too keen, at that time of the day everybody's driving to work or home from work and I know people if they see me going in there….."* (Female)

Kanohi ki te kanohi (face-to-face service) was more appropriate for one participant who found the telephone service offered by the helpline a barrier to help-seeking:

> *"I've heard of the Helpline but I'm not a great talker on the phone so I can't relate" (Female)*

However, others found the anonymity of the telephone service helped overcome any embarrassment:

> *"I think making that 0800 number call is really easy because it's totally anonymous and you don't need to tell them your name, they can't see you. I think perhaps for the initial phone call there's no shame involved but potentially I guess for a face-to-face meeting with [the counselling service] or the group settings or some form of one-to-one counselling perhaps there could be some shame"* (Female)

For some participants, there was a process of starting the help-seeking process then discontinuing later due to a fear of disappointing the counsellor, themselves and their families if gambling relapse occurred. This fear of failure and the perception that they don't have the

confidence, ability or tools to quit ends in counselling appointments being cancelled altogether:

> *"…they've told me I need to bar myself from all the pubs that I go gambling at so I'll go do that but I'll find some more places to go so the next week when I'm due to go back I think to myself, 'hmm I really should go and see that counsellor but are they going to be disappointed with me?' I'm so embarrassed or ashamed I think you mentioned. Perhaps you're not ashamed to admit the initial contact but you're ashamed to go back and admit that you haven't been strong enough or that you perhaps just didn't do what they expected of you, you didn't do what you needed to for yourself so you don't go back or perhaps you do go back and you say 'yeah oh well I tried and this is what I did and blah blah blah but I failed' and you get that, you can see the disappointment. All the things you thought you might receive from them you get and you don't want to go back again because you've experienced it"* (Female)

Secondary barriers

Other barriers that participants mentioned were the importance of maintaining an image as a V.I.P gambler and having overwhelming problems.

One participant noted that as a V.I.P gambler at the casino, there was extra pressure to continue to maintain a 'wealthy' image. Consequently, help-seeking came with significant stigma attached:

> *"You start to build up this myth about yourself in the casino because you're a high roller so you've got to keep that image up, you can't fall"* (Female)

Overwhelming problems of lying to her family about returning to gambling and past failed help-seeking attempts have made one participant feel helpless about her gambling situation:

> *"I lied to them about everything. …my family have been aware of it for five or six years and for that whole time, from six years ago 'til now, all my family, all my friends thought that I have been getting help, it's all a big front really. Only because, whatever I'm going to say to them it's just going to be bullshit, like the boy that cried wolf. Nobody's going to believe what I say anyway…"* (Female)

Another just didn't get around to seeking help:

> *"Prioritising was like 'well I'm addicted to gambling but it can wait, when I find a better time, I'm just going there to relax, to have fun, rather than to make more money'. It dropped in its priority in my list"* (Female)

It is also worth noting that participants felt venues did not even pay lip-service to the issue of exclusion or self-bar orders, therefore, the lack of adherence to these by the venues was seen as a barrier:

> *"I never gambled at a venue responsible enough to bar me"* (Female)

> *"I did [self-bar]…. It's an illusion. All you have to do is go to security and sign your name back on again. You don't have to stay away for two years…. the guy who is head of security said 'oh don't be silly you don't have to bar yourself' that sort of coercion… next minute it's 'oh where have you been? Never mind anyway sign here and we'll give you a V.I.P park'. You're back into it. I wanted to self trespass myself*

and they didn't take me serious. [Security] just laughed me off. [The security guard said] 'Don't be silly come downstairs and I'll grab you a drink'" (Female)

Knowledge of services

National services
Participants were asked which services they knew of for problem gambling. Awareness of the Gambling Helpline was particularly high, with participants recalling stickers on casino gaming machines and pamphlets in venue toilets:

> *"I don't know whether it's in other gambling places but every single pokie machine [at the casino] the helpline number is right there and when you phone them they are very, very helpful"* (Female)

> *"I knew it was always out there. I rang them a couple of years ago and that's it. And they were very good when I rang them. I think it's just having that support of somebody listening because I know deep down I've got to do it"* (Male)

However, one participant did note a lack of promotion of the range of services available:

> *"There's virtually no advertisement of problem gambling services but Gambling Helpline"* (Male)

All participants knew of the Problem Gambling Foundation. This was to be expected since they were recruited via that organisation. The Gambling Helpline had been the main referral point for participants although general awareness and word-of-mouth also played a part. One participant accessed the services not via the helpline or any other referral but by walking in from the street. The Problem Gambling Foundation was felt to be a 'one stop shop' for most participants:

> *"I know of the Problem Gambling Foundation. Generally I haven't accessed any other services because I've felt like I don't need them"* (Male)

Participants were also aware of the Salvation Army Oasis Centres; however, despite the interviewer's attempt to explain the gambling services that they offer, there is a perception that they are for the 'down and outs' who need food grants:

> *"Yep. But I thought I'd never reduce myself to that level. I've got heaps of food in the house"* (Male)

> *"I know of the Salvation Army. Another thing is pride. I wouldn't even go in there for a food grant. It's all about that thing…it comes back to that I can't bite my pride to go in there"* (Female)

However, once the Salvation Army Oasis services are accessed, they are viewed favourably:

> *"I went to some good counselling through Salvation Army. Salvation Army run a group counselling course through the Salvation Army and it's based on the same principles as AA so you have a series of seven stages and the final stage is to accept God into your heart, the stage before that is perhaps share your knowledge consistently with others. I went to two or three"* (Female)

There was general awareness of Gamblers Anonymous but no utilisation of the service. Participants seemingly preferred to deal with their gambling in a one-to-one situation:

"I've heard of them….I thought of that but I'm not really quite ready to stand up in front of fifty people and say "hi my name's so and so, I've got a major gambling problem" (Male)

"I just felt that what I've got, it's helping. There probably are more. Like the group thing with people and talk about your problem, and to go along and listen to other people's woes, more one-on-one is me. I share enough with people I care about. I don't know if I could do it in a group" (Male)

Maori specific services

Although not personally accessed by most participants, there was a general awareness of Maori-specific services including the Maori Helpline, one-to-one counselling and spiritual healers. For one participant, after utilising the Maori Helpline, Maori specific counselling services were the avenue foremost for her; however, lack of finances prevented uptake of these services:

"It was the Maori outfit that said 'I think there's a place…' that's how I ended up with Tupu[20]. They were the only organisation that actually did home visits so I thought that was a bit funny, I didn't like the sound of that I mean I know a lot of Maoris who do gamble who have got a problem but their other problem as you can understand is finances and that is travel so to me I want to know how come the PI [Pacific Island] service do home visits and I know their clients aren't Maori or Pakeha as a rule. They even wondered how I got on to them I explained I had a medical condition. I was just so thankful, they saved me an expense that's why I didn't really look too far into that" (Female)

Having accessed services over seven years previously without receiving the help she needed, one participant contemplated the use of Maori-specific services:

"Well it hasn't been until five weeks ago [that I got the help I needed] so perhaps I should have gone down the other track. I just think that if you've got enough of a problem to call the Helpline, I just wish that when you rang the number, straight away you get what you need, get the tools that you need from them straight away' (Female)

One participant recalled the work of spiritual healers:

"Maori power can actually make a stand. And they now see gambling as a makutu [curse]" (Male)

Others were unconcerned about ethnic-specific services:

"Yeah I've been given that down in Newmarket there's a group down there [the counsellor] told me about it. I don't have a race-based thing about this thing. The machine doesn't see a colour. It only hears money" (Female)

Other services

Participants were aware that their General Practitioners offered information and help for gambling. Some had discussed their gambling with their General Practitioners:

[20] The Pacific counselling arm of the Waitemata District Health Board, alcohol and other drugs treatment service.

"I see mine every three months and I have mentioned to her in the past [about my gambling] and saw her recently and mentioned it and she said 'oh it's good that you're doing something about it" (Male)

There is modest awareness of the services for gambling available through social welfare organisations. For one participant there was a stigma in seeking help through such channels stemming from embarrassment about financial issues:

"I have been thrown that at me but I haven't used them yet. The most embarrassment for me is having no money. I've put into my mind just to get some assistance with the budget. But it's a bit of an embarrassment thing really" (Male)

Self awareness of one's own gambling problem was found to be valuable in helping to deal with the issue.

"I still need that reassurance that I can keep going, 'cause it's a strong pull. When you walk down town they're everywhere. Lights flashing, signs are going but I have a theory about my money these days that every twenty dollars I put in there is something my granddaughter is missing out on….I'm still trying to manage it" (Female)

"The biggest thing is diverting interest, I know that" (Male)

"I've had to sit back and reflect on everything that's got me to where I am now" (Female)

"Yeah, the help is also from me too I've got this trigger in my head saying 'don't gamble'. The message has been shining a lot more clear lately. I no longer feel I am at the stage where I can't walk down the street without being sucked into a pub or a pokie bar. I feel like I've moved on from that type of thing. I just think of the consequences if I do go back to it" (Male)

There was barely any awareness of information or help available through alcohol and drug services mainly because, for these participants, alcohol and drug issues were not considered to be a factor. There was no mention of community services by participants.

Current and previous help-seeking

The Problem Gambling Foundation was the main source of current formal help-seeking for most participants (who were recruited via this organisation). Apart from the pressure from family to seek help, female participants did not receive any informal help:

"No [I am not receiving any informal help] because I'm pretty reclusive. I'm like that gambler that doesn't like their space invaded. I've been like that since I was young. I don't ask people for help. I don't say things to my family I don't include them. Because I think at the end of the day it's my problem and they've got enough problems to deal with. I'm big enough, old enough to manage myself" (Female)

However, male participants sought help from friends and family alongside formal help:

"People ring me up and we usually talk about it. And they go 'have you been gambling this week?'" (Male)

Family pressure and realising that gambling was becoming a very regular activity provided the motivation for previous help-seeking:

> *"Because I knew it was getting out of hand back then too I thought I was losing too much. I had the inklings of a real problem then. It was starting to affect my studies at university too 'cause I was spending a lot of time in pokie palours instead of going to classes"* (Male)

The Gambling Helpline and Problem Gambling Foundation were the main two sources for previous help-seeking behaviours. One participant had utilised the Salvation Army Oasis Centres.

Participants did not perceive there to be a difference each time they sought help, rather, that each time they increased their knowledge and tools to cope with their problem gambling:

> *"Just somebody listening. Making me more aware of the reasons why I am doing it. When you come away and you've lost money it's just the worst feeling"* (Male)

They did find the help they received useful each time but what was lacking for them from previous help-seeking attempts was something that resonated for them personally to allow them to take ownership of the problem:

> *"I needed someone to get honest… I needed someone to help me get honest with myself"* (Female)

Participants found the immediacy of service availability helpful in their previous help-seeking attempts.

The number of times help was sought varied for participants from never to three times in a year.

3.5.2 Korean interview data

This section of the report gives an outline of the themes identified in the interviews with Korean participants.

Enablers to help-seeking

The problem gambler sought help after losing a large amount of money at the casino. He had thought of seeking help before this loss but had not done so as he was afraid of 'losing face' and felt that counselling was unlikely to help (discussed further under **Barriers to help-seeking** in this section). The problem gambler did not report any financial hardship as a result of his loss but it was enough to jolt him into action:

> *"…this time he lost the amount was huge and he just realised that he had to get some help" (problem gambler, male, as quoted by interpreter)*

At this stage, the problem gambler did not seek specialist assistance; rather, he sought an exclusion order from the casino. His entry into the counselling service was subsequently facilitated by the casino:

> *"…he went to the casino people and then told them please I want to sign for preventing me from coming to you for one year [exclusion order] and then they asked*

'do you want counselling as well' and he said 'yes' and that is why he is here" (problem gambler, male, as quoted by interpreter)

The family member also sought assistance as a result of financial loss [due to husband's gambling], but unlike the problem gambler described above, her living situation was desperate:

"Then one day my husband came to me and said 'I'm very sorry please help me'. I asked him what is going on and he said to me 'I lost all the money I don't have enough money and I went to the casino, I'm very sorry'. That's what he said to me so I made up my mind and asked him 'OK we are doing something from now on ok, first of all let's eat, there is some money in my jacket so buy some food and let's eat then think'. Then he cries 'there is no money' so I ask him why there is no money in my pocket and he said 'I used it' which means we don't have anything" (family member, female)

Prior to this point the family member had been aware of her husband's gambling problem and, believing it was something that only he could fix, had asked him *"not to go the casino anymore*". Believing that her husband had stopped his gambling, his admission that he had not and the realisation of their financial crisis came as a shock. The family member immediately sought advice from a trusted church mentor and resolved to try anything to improve the situation. It was this resolution that led her to contact a specialist treatment service after being given the contact details from a church contact. However, it took her a few days to overcome her sense of shame and it was her husband, under loving coercion, that made the first contact:

"...one of the Korean church members heard about my situation and she suggested to me to call [counsellor's name] and she gave me the Korean newspaper which had the number. I didn't think that I could call, I felt so ashamed and felt so shy you know. So I waited a couple of days and later on I didn't do anything and didn't know what to do, so I asked my husband to call. I asked my husband 'if you love me and want to live with me you do everything, right? What I mean is, if somebody says that if you go to church you can recover from a gambling problem then you go to church. If somebody says if you could get better and recover from a problem gambling, then call them, and if you love me you do everything what everybody says otherwise, I won't live with you anymore'. So he called [counsellor's name]" (family member, female)

The family member herself established contact with the treatment service shortly thereafter, on the advice of her husband's counsellor.

Barriers to help-seeking

Both interviewees had thought of seeking assistance (problem gambler) or had thought their loved one had a gambling problem (family member) for some time prior to actually contacting a specialist problem gambling treatment service. Some of the primary reasons for the help-seeking delay were the same in both cases: shame and a belief that counselling services would not be able to help with a gambling problem.

"Losing face you know what I mean, that was the biggest reason [for not seeking help]" (problem gambler, male, as quoted by interpreter)

"...for him counselling wasn't that easy to approach and also he had some kind of doubt how much it can help" (problem gambler, male, as quoted by interpreter)

"...I was so shamed to let myself be in front [of a counsellor], then I have got a problem, my husband or my family has got a problem. I didn't want to let everyone else know about it" (family member, female)

"It was not my problem and was not somebody else's problem. It was only my husband's personality, that's what I thought at the beginning" (family member, female)

The family member also identified two other primary barriers to help-seeking. These were her inability to recognise *"my husband was a problem gambler"* and her lack of awareness regarding sources of help:

"I didn't know there was some help out there. I didn't know about this [name of her counselling service] and I didn't know anybody who could help me" (family member, female)

The family member's inability to recognise her husband's problem gambling resulted in her shouldering a significant amount of responsibility for the difficult situation they found themselves in:

"If I knew that in advance that if I don't blame him, if I just treat him, or if I just let him know that I am here beside you, I don't blame you. If I let him know in advance he may not need to be a gambling problem. So, probably, I have a problem at the time as well" (family member, female)

Interestingly, this sense of shared responsibility motivated the interviewee to remain with her husband during the crisis period, to support him and to seek help together. Thus, the barrier or problem recognition ultimately served an enabling function.

Knowledge of services

The problem gambler reported having knowledge of Korean-specific problem gambling services for some time prior to treatment entry ("from Korean magazine") but was reluctant to contact them as he did not believe they would be useful (as previously discussed). He maintained this belief up until the point of treatment entry. The treatment experience subsequently changed his opinions about the utility of treatment and the benefit in having a Korean-specific service:

"Before he started counselling he didn't think it would matter [having a Korean counsellor] but as he is doing the counselling he realises that it could be an important factor so has realised that now" (problem gambler, male, as quoted by interpreter)

The family member was unaware that Korean-specific problem gambling services were available until a church contact referred her. She established contact soon after. Having a Korean-specific service available was essential due to the language barrier that would have resulted otherwise:

"My husband he couldn't speak English properly...and even for me...I don't feel comfortable with English speakers, I feel much more comfortable with Korean speakers" (family member, female)

The problem gambler was also aware of the Gambling Helpline, although he could not name any other mainstream service. The family member was only aware of the service she attended.

Current and previous help-seeking

Neither interviewee had previously sought formal treatment for a gambling-related problem. However, both reported seeking some form of informal assistance. The family member sought assistance from a church mentor (as previously detailed) and as a result subsequently contacted a specialist treatment service. The problem gambler reported seeking advice from the internet:

> *"He had tried to look through the internet because it was impersonal. He never talked about it or tried to get help or advice through other people, friends or family or whatever" (problem gambler, male, as quoted by interpreter)*

When asked why he had not sought help from friends or family, this interviewee replied:

> *"He felt shame to talk about this with those people and also he didn't think that they would be able to help him a lot anyway" (problem gambler, male, as quoted by interpreter)*

Thus, in the case of this individual, the barriers to both formal and informal sources of support were the same.

4. DISCUSSION

The primary objectives of this project were to: examine the experiences of gamblers and their family/whanau when seeking and obtaining help for gambling-related problems, identify barriers and enablers to help-seeking in relation to gender and ethnicity, and identify factors that influence treatment services accessibility and relevance. In order to achieve these objectives a comprehensive review of relevant literature was completed, focus groups were conducted with key problem gambling and related treatment stakeholders, and a series of surveys were completed with help-seeking and non-help-seeking gamblers, and the family/ whanau of problem gamblers. Findings from each area of investigation were presented, independently, in chapter three of this report. This section draws together key findings from each area of investigation, discusses their significance in terms of the research objectives and broadly outlines the resulting implications. Specific recommendations resulting from this project are presented in chapter 6 of this report.

The discussion is presented under the key headings of 'enablers to help-seeking', 'barriers to help-seeking', 'gender- and ethnic-specific considerations', and 'service-specific considerations'. It should also be noted that, of all the studies described in the literature review, only those that specifically pertained to problem gambling research are discussed in this section. However, the remaining literature has been drawn on to inform the resulting project recommendations (chapter 6).

4.1 Enablers to help-seeking

4.1.1 Focus group data: Stakeholder perspective

Two core themes emerged from the focus groups relevant to help-seeking in a problem gambling treatment context. Firstly, there was a widely held belief that help-seeking is motivated by a personal crisis of some sort. This was considered true both for problem gamblers and the family/whanau of problem gamblers. It was also of note that participants typically placed emphasis on the motivating influence of having reached a crisis point or hitting *rock bottom*; specific factors underlying the crisis were rarely mentioned. This would suggest that it may be the feeling of crisis, rather than the precipitating events, that motivate help-seeking. The second theme to emerge was the perception that people with gambling problems exhaust all other options, whether it is their own resilience or the support of others before they seek help from professional services. Thus, specialist help-seeking in the problem gambling treatment area may be motivated by a failure to achieve the required assistance elsewhere and may be one of the final steps, rather than a first step, in the help-seeking journey. Prior studies and reviews examining pathways to problem resolution in a problem gambling context support this contention (Abbott et al., 2004; Abbott et al., 1999; Cheung 1986; McMillan et al., 2004).

The literature review identified only one other report that discussed the perspective of problem gambling treatment providers with respect to reasons for help-seeking (Productivity Commission, 1999). Service providers in that report suggested clients rarely seek help until a crisis point, mediated by financial problems or specific events such as family breakdown, job loss or criminal charges, is reached, other sources of support are depleted and there is a high level of psychological distress, desperation or panic. These results are congruent with those reported in this study, although providers in the Productivity Commission report (1999) seemingly placed more emphasis on crisis *events* (i.e. a crisis that results from a specific event rather than a cumulative reaction to many distressing factors). Collectively, these results suggest that treatment access may be enhanced if problem gamblers can be encouraged to seek assistance prior to reaching a crisis point and if, when a crisis does occur, the subsequent

pathway into the problem gambling treatment sector is rapidly facilitated. Encouraging clients to seek treatment prior to a crisis point presents as a difficult task, but is perhaps best achieved via advertising and opportunistic brief intervention approaches. These approaches could seek to raise problem awareness and promote cognitive dissonance in a manner consistent with motivational interviewing strategies for 'precontemplative' individuals. The apparent reliance on self-help and informal support systems, at least in the first instance, could also be enhanced with a broader deployment of effective self-help resources (discussed more fully in section 4.2 below). Success in this area may reduce the need for specialist treatment assistance.

4.1.2 Survey data: Gambler perspective

When presented with a list of 15 possible reasons for seeking help ('enablers'), participants in the helpline survey and the general population survey endorsed the 'financial problems' option more than any other. This was also the only option in either sample to be regularly identified without prompting and was the option most often identified as the primary (number one) reason for seeking help. No other option came close to achieving the same level of endorsement across all three of these measurement types (percent support, percent support without prompting, and percent support as primary reason). This strongly suggests that, from the perspective both of problem and non-problematic gamblers, the primary influence on the help-seeking decision is financial loss or hardship. It is worth noting, however, that participants in the helpline sample endorsed seven of the 15 options, on average, as being influential in the help-seeking decision and participants in the general population sample endorsed an average of 11 options. This would suggest that, whilst financial problems were generally considered the primary motivator, help-seeking was widely seen as a decision influenced by multiple factors.

Secondary influences on help-seeking were evident. The helpline sample endorsed options indicative of psychological distress ('reaching a point where you felt like you could not go on' and 'other emotional factors') or a desire for change ('wanting to prevent your gambling from becoming a major problem' or 'the costs of gambling outweighed the reasons for continuing to gamble') at a high frequency, although these options were rarely identified as the primary reason for seeking help. Options pertaining to specific events (e.g. legal problems or employment issues) or relationship issues (e.g. problems with spouse, family or friends or concerns about children) were not widely endorsed. There was some evidence, however, that when problem gamblers did report problems with a spouse or partner as a reason for seeking help, it was often a primary (rather than secondary) motivator.

Secondary influences were less clear in the general population sample. All of the specified options, with the exception of gambling venue intervention, were frequently endorsed as a factor in the help-seeking decision and, on average, more options were endorsed than by the helpline sample (as discussed above). This suggests that gamblers in the general population may be less cognisant of the factors, other than financial hardship, that influence help-seeking; all the specified options were seemingly considered plausible and there was an apparent reluctance, or inability, to favour one factor over another. Nevertheless, options indicative of a relationship issue (pressure or isolation from, or problems with, spouse, family or friends) or psychological distress ('reaching a point where you felt like you could not go on' and 'other emotional factors') were, following financial problems, the next most likely to be identified without prompting or endorsed as the primary reason for help-seeking (although, as previously mentioned, the differences between these and other options were not as marked as in the helpline sample). The apparent emphasis on psychological distress factors is consistent with the helpline sample, although the emphasis on relationship issues is not. It is

possible, therefore, that general population gamblers consider relationship issues to be more influential in the help-seeking process than they actually are.

Two prior studies that had sought the perspective of problem gamblers with respect to reasons for stopping or changing their gambling behaviour were identified in the literature review (Evans & Delfabbro, 2005; Hodgins & el-Guebaly, 2000). The Hodgins and el-Guebaly study (2000) included 106 gamblers, most of whom had not sought specialist help. The reasons most often given by these participants for seeking to resolve their gambling problems were negative emotions, financial concerns and seeing their gambling as something incompatible with their self image or goals. The Evans and Delfabbro study (2005) included 77 problem gamblers, most of whom had sought specialist help. Irrespective of whether they had sought treatment, however, most sought to change their gambling behaviour due to deteriorating psychological and/or physical health and/or serious financial hardship. Particular life events, such as relationship problems, legal or employment issues, were found to be secondary or minimal influences on the help-seeking process. The findings presented in the current study are consistent with these previous reports, with financial concerns and psychological distress featuring prominently as key influences on help-seeking. Findings from the current study also concur with the Evans and Delfabbro (2005) conclusion that particular life events are a less important influence on the help-seeking decision. The similarity in reported findings across these studies suggests that problem gamblers in New Zealand seek help for the same reasons as their counterparts in other developed nations.

The emphasis on psychological distress, reported across all three of these 'gambler perspective' studies (inclusive of this one), is seemingly consistent with the provider view that problem gamblers seek help when a crisis point is reached; one symptom of a crisis, almost by definition, would be psychological distress. The finding that particular life events may be less important in the help-seeking decision further supports the view that it may be the crisis state itself, rather than the events that contribute to the crisis, that motivate treatment seeking. Financial hardship may be the exception to this, although any financial hardship is likely to be accompanied by psychological distress. This could possibly explain why, in the context of this study, focus group participants did not identify financial problems as an enabler to help-seeking with anything near the same degree of clarity as survey participants; gambling treatment providers may be picking up the distress associated with their clients' financial problems, rather than the financial problems themselves. The prominence of financial loss as an enabler to help-seeking suggests this aspect of problem gambling warrants particular emphasis in relevant advertising or marketing campaigns.

4.1.3 Survey data: Family/whanau perspective

This study was the first of its kind to examine reasons for help-seeking from a family/whanau perspective. Unfortunately, the resulting data were of limited value due to difficulties in participant recruitment (discussed more fully in **Limitations of this study** later in this report). The data that were obtained suggest that financial problems and problems with a partner or other family member were the primary motivators for help-seeking. The former is consistent with the view of problem gamblers, although it was reported at a much lower frequency in this sample. The latter is discrepant with the problem gambler perspective but is in no way surprising as, by definition, the family or whanau of problem gamblers are always going to be seeking assistance because of a problem with a family or whanau member. This study merely confirms the expected difference.

4.2 Barriers to help-seeking

4.2.1 Focus group data: Stakeholder perspective

Focus group participants identified a range of factors that may prevent or impede help-seeking for a gambling-related problem. Barriers internal to the individual, such as shame, stigma and problem denial, were perhaps most strongly emphasised. Barriers related to individual characteristics such as gender, age and ethnicity were also recognised, as were barriers related to an individual's social context. However, discussion was not solely centred on barriers intrinsic to the problem gambling population. Extrinsic barriers, including a range of potential service-related barriers were identified. These included the suggestions that specialist gambling treatment services may not be well known, that the treatment process, and the manner in which confidential information is managed, may be misunderstood and off-putting, and that logistical issues such as transport and childcare may prevent treatment attendance. Participants were, therefore, of the opinion that treatment services could do more to facilitate higher rates of help-seeking (discussed more fully in section 4.4).

Provider perceptions of the primary barriers to help-seeking have only been reported on one other occasion (Productivity Commission, 1999). As with this study, the reasons suggested for not seeking help included a mixture of factors intrinsic to the client (denial, stigma, culture and gender) and service-related factors (lack of awareness, location and hours of operation). Collectively, these findings suggest that providers of gambling treatment services recognise multiple barriers to help-seeking, understand that help-seeking can be an intensely difficult task for an individual to carry out, and acknowledge that limitations in service provision may contribute to the difficulty of the help-seeking task. Thus, from this point of view, a range of potential strategies to encourage treatment contact could be employed. These strategies could focus on resolving intrinsic barriers to help-seeking (e.g. marketing strategies designed to raise problem awareness, normalise help-seeking and demystify the treatment process could be developed) or on improving service accessibility (e.g. increasing hours of operation, providing transport assistance and reducing response time). However, employing any one strategy in isolation may only have a limited effect on rates of treatment entry if the barriers to help-seeking are as many and varied as these data indicate.

4.2.2 Survey data: Gambler perspective

Of a list of 22 possible barriers to seeking-help, only three options were endorsed by the majority of participants in the helpline sample. All three of these options, 'wanting to resolve the problem on your own or being too proud to seek help', 'felt ashamed for self or family' and 'being too overwhelmed by problems to seek help', represent barriers internal to the individual. A similar trend emerged when the helpline sample was asked to identify the primary (number one) barrier to help-seeking. The three most frequently identified options, collectively accounting for 55% of the response, were also barriers internal to the individual (the 'pride' and 'shame' options cited above plus the option indicative of problem denial - 'believed didn't have a problem and didn't need help'). Other than the item 'concerns about confidentiality' (endorsed by eight percent of participants), each of the other 22 listed options were only considered the biggest barrier to help-seeking by four percent or fewer of participants. These findings, therefore, suggest that the primary barriers to help-seeking amongst a sample of problem gamblers who eventually sought specialist assistance were all intrinsic to the individual and related to pride, shame, problem denial and, to a lesser extent, a feeling of being too overwhelmed to seek help.

The response of the general population sample was seemingly more diverse. Of a list of 21 possible options, 13 were considered a likely barrier to help-seeking by 50% or more of

participants. These 13 options spanned a range of factors, including those intrinsic (e.g. 'feeling ashamed for themselves or family') and extrinsic (e.g. 'having had bad experiences of seeking help for gambling problems') to the individual. However, the three options most frequently endorsed as a likely barrier to help-seeking 'believing there wasn't a problem and not needing help', 'wanting to resolve the problem alone or being too proud to seek help' and 'feeling ashamed for themselves or family', were all barriers internal to the individual. The same three options were also the items most frequently endorsed as the biggest potential barrier to help-seeking and were the three options most commonly identified without prompting. Thus, these findings would also suggest that the issues of pride, shame and problem denial present as the primary barriers to help-seeking for a gambling-related problem.

The predominance of intrinsic barriers to help-seeking is consistent with prior research. Evans and Delfabbro (2005) in their investigation into impediments to help-seeking amongst 77 problem gamblers concluded that the main barriers were psychological - "denial, embarrassment and shame". In the Hodgins and el-Guebaly (2000) study, in which barriers to help-seeking were investigated amongst a sample of 106 current or 'resolved' problem gamblers, just over four out of five participants reported that they did not seek treatment because they wanted to handle the problem on their own. Approximately half of these participants also mentioned one or more of embarrassment/pride, no problem/help needed, unable to share problems, and stigma. Relatively few people mentioned negative attitudes towards treatment or cost as reasons for not seeking treatment, although ignorance of treatment or availability was commonly reported. Service cost and availability emerged as two of the five most likely barriers to treatment in a factor analysis (based on household survey data) conducted by Rockfield and Schofield (2004). However, the remaining three barriers, stigma, uncertainty and avoidance, were all intrinsic to the individual. It is also of note that problem denial was evident in the 1991 and 1999 New Zealand national gaming surveys (Abbott & Volberg, 1992; Abbott & Volberg, 1996; Abbott, 2001a). Approximately half of the people identified as problem gamblers in these surveys did not, themselves, believe that they had ever had a problem with gambling.

The consistency of these results strongly suggests that intrinsic factors, especially those related to problem denial, shame, pride, and a sense of wanting to resolve ones problems on ones own, present as the primary barriers to help-seeking in the gambling treatment sector. This is somewhat divergent to the more multi-factorial picture that emerged from the stakeholder focus groups and suggests that strategies designed to raise problem awareness, de-stigmatise problem gambling and normalise treatment seeking behaviour should be prioritised if the aim is to increase rates of treatment entry amongst problem gamblers. These types of approaches, almost by definition, need to occur outside the treatment context and may best be achieved by various social marketing and public health initiatives. These results further suggest that greater effort could be made to enhance the effectiveness of self-help approaches to gambling-related problems. Self-help approaches can be effective and efforts should be made to enhance their potential. For example, self-help resources could be made available or advertised in gambling venues or self-help strategies could be promoted on the television or through other media. These resources/strategies could target the problem gambler or, alternatively, the aim could be to equip the family or friends of problem gamblers with the skills to stimulate and support the problem resolution process.

4.2.3 Survey data: Family/whanau perspective

This study was also the first of its kind to examine barriers to help-seeking from a family/ whanau perspective. Conclusive results failed to emerge. When presented with a list of 15 possible barriers to help-seeking for someone else's gambling problem, only one of the

options was endorsed by 50% or more of participants ('planned to get help, but didn't get around to it'). Similarly, none of the listed options was endorsed as the primary barrier to help-seeking by more than two participants. Few responses were provided without prompting and suggested alternatives were as sparse and diverse as participant response to the 15 specified barriers. Thus, other than procrastination and a possible lack of help-seeking knowledge (36% of participants endorsed the option 'not aware that treatment was available for the family or friends of problem gamblers', although no one identified this as the primary barrier to help-seeking), the survey data provide little insight into the primary barriers for help-seeking amongst the family/whanau of problem gamblers. The limited sample size (n=32) may be largely responsible for this outcome, although it is possible that the survey questions were not representative of the kinds of barriers family/whanau face when seeking help and those people who did participate were unable to effectively communicate more meaningful alternatives.

4.3 Gender- and ethnic-specific considerations

Focus group participants did not provide detailed comment regarding gender- or ethnic-specific enablers or barriers to problem gambling treatment; however, it was widely acknowledged throughout the general discussions that gender-, ethnic- and a range of other considerations (e.g. age, language or country of birth) do influence problem gambling and help-seeking behaviour and that treatment providers need to be aware of these influences and be adequately equipped to address them. In particular, women-focused treatment approaches were advocated as a counter-balance to male dominated approaches, as were the creation and maintenance of cultural- and language- appropriate treatment pathways. The importance of possessing an understanding of, and empathy with, the various gender- and ethnic- specific considerations seemed to underlie discussion in these areas: *"…there's terror around the mental health system for Maori, we've traditionally been put away and drugged as a people…", "I find with my Pacific men we laugh a lot, we share things a lot, the jokes and be able to cry and do those things without having any questions like 'is she understanding me?'"*. It was implicit in the focus group discussions that understanding and empathy come with a common gender or ethnic background.

Gender differences with respect to help-seeking enablers rarely emerged in the helpline or general population survey samples. Financial problems remained the primary reason for seeking help both for males and females, although statistical analysis suggested it was a more potent influence for males. Emotional factors were also seemingly important enablers both for males and females. The helpline data suggest males may be more motivated to seek help due to relationship problems whereas females may be more motivated by a desire to prevent their gambling from becoming a major problem. However, this trend was not evident in the general population sample and may be a product of low sample size. The gender profile of the family/whanau survey sample would also indicate that female partners of problem gamblers may be more motivated to seek assistance than their male counterparts (i.e. as compared to the male partners of female problem gamblers). The primary barriers to help-seeking were the same, irrespective of gender, in both the helpline and general population samples. These barriers (as discussed in section 4.2) related to problem denial, shame and pride. Specific gender differences with respect to enablers and barriers to help-seeking in the family/whanau sample were not conducted due to the low sample size (exacerbated by the fact that 93% of respondents were female).

Ethnic comparisons in the helpline and general population surveys were limited to New Zealand European versus Maori due to low participation by other ethnic groups. Few differences of note emerged. Financial problems were the primary enabler for NZ European and Maori participants in both samples. 'Problems with spouse or partner' also emerged as

an important enabler for NZ European and Maori participants in both the helpline and general population samples. The helpline data suggest NZ Europeans may be more motivated to seek help due to emotional problems whereas Maori may be more motivated by a desire to prevent their gambling from becoming a major problem. Again, this trend was not evident in the general population sample and may be a product of low sample size. The primary barriers to help-seeking were the same (problem denial, shame and pride) for NZ European and Maori participants in both the helpline and general population samples. Specific ethnic differences with respect to enablers and barriers to help-seeking in the family/whanau sample were not conducted due to the low sample size.

Two of the specified barriers in the helpline, general population and family/whanau surveys were designed to examine access issues related to language or culture. These were the options 'language concerns' and 'didn't think the service would relate to culture or community'. These barriers were rarely endorsed in the helpline (6% and 10%, respectively) and family/whanau samples (0% and 0%, respectively) suggesting that they were rarely a barrier to people who have accessed treatment. However, other than Maori, few non-NZ European participants were recruited in these samples and the frequency with which these options were endorsed more than doubled when the responses of NZ European participants were excluded in the helpline sample (15% and 21%, respectively). These options were also far more likely to be considered potential barriers to treatment by the general population sample which was more ethnically diverse (42% and 47% respectively, rising to 55% and 52% when NZ European participants were excluded from the analysis). This suggests that language and cultural concerns may be a major barrier to help-seeking, although the general population sample did endorse nearly every listed item at a far greater frequency than their helpline counterparts.

The original study design sought to obtain a range of ethnic-specific data via a series of semi-structured interviews with Maori, Pacific and Asian problem gamblers and family/whanau of problem gamblers. Unfortunately, only seven interviews were conducted: five with Maori problem gamblers and one each with a Korean problem gambler and a Korean family member of a problem gambler. Detailed analysis was, therefore, only able to be conducted with the five Maori interviewees. Findings from these interviews generally mirrored the survey results: the primary barriers to help-seeking related to problem denial and shame and financial difficulties were a key enabler. It was of note, however, that the Maori interviewees considered family pressure and the sheer frustration associated with their gambling as perhaps more potent enablers to help-seeking than the resulting financial problems. These three enabling influences are all likely to be related and these data suggest that, whilst financial loss may often be necessary for help-seeking to occur, it is perhaps only when financial losses cause conflict in other life areas that the required motivation to seek help is achieved. All five interviewees were in treatment at the time of the interview, although few reported current use of a Maori-specific service. Awareness of Maori-specific services was nevertheless high and a number of interviewees had used these services in the past or were contemplating future use. Maori-specific services were generally considered desirable.

Drawing specific recommendations from these data is difficult. Focus group participants, as discussed, clearly believed that problem gambling treatment clients can have disparate needs based on their gender and/or ethnicity. Beyond acknowledging the existence of these differences and the need to provide an appropriate response (seemingly implied to mean appropriate gender- or ethnic-matched service provision), suggestions that might inform constructive changes to service provision were not forthcoming. The survey and semi-structured interview data suggest that the primary enablers and barriers to help-seeking are consistent irrespective of gender or ethnicity. Thus, any attempt to improve access to problem gambling treatment services based on general recommendations arising from the survey findings is likely to be effective for males and females and across multiple ethnic

groups. Nevertheless, care must be taken not to draw too many gender- or ethnic-specific conclusions from the survey data. Ethnicities other than NZ European and Maori were not well represented and the level of analysis was limited due to sample size considerations and the type of data collected (discussed more fully in **Limitations of this study** later in this report). Similarly, semi-structured interview data were only obtained in quantity from Maori participants meaning the views and experiences of other ethnic groups were not examined in any detail.

4.4 Service-specific considerations

Focus group participants identified a range of potential service-related barriers to help-seeking. As previously mentioned, these included suggestions that specialist gambling treatment services may not be well known, that the treatment process, and the manner in which confidential information is managed, may be misunderstood and off-putting, and that logistical issues such as transport and childcare may prevent treatment attendance. The survey data did not reveal these issues to be primary barriers to help-seeking; however, there was evidence that some of these factors remain significant secondary impediments.

For example, whilst the option 'not aware that treatment was available' was only identified as a barrier to help-seeking by 14% of participants in the helpline sample, it was endorsed by nearly half (49%) of participants in the general population sample. Furthermore, additional survey data indicated that participant knowledge of specialist problem gambling services other than the Gambling Helpline, in both the helpline and general population samples, was far from exhaustive. Nearly one third of participants in the helpline sample had not heard of the Problem Gambling Foundation or Gamblers Anonymous and nearly one half had not heard of the Salvation Army Oasis Centres. The rates were lower in the general population sample with over 70% not having heard of the Salvation Army Oasis Centres, 60% not having heard of the Problem Gambling Foundation and slightly fewer than 50% not having heard of Gamblers Anonymous. It is worth noting, however, that 88% of general population participants knew of at least one specialist problem gambling treatment service. Thus, whilst knowledge of the range of specialist services available was relatively limited, most participants knew at least one service they could contact if considered necessary (Note: All of the helpline participants knew of at least one specialist service as they had been recruited via one).

Concerns about confidentiality when contacting a treatment service, or about being treated like an addict or a mentally ill person, were also evident in the helpline sample. Over a third of participants (35%) identified both as a barrier in their help-seeking decision. Approximately two-thirds of the general population sample expressed corresponding beliefs. It is also of note that just over a quarter of participants (26%) in the helpline sample identified the option 'couldn't get the service at the time or place wanted' as a barrier in their help-seeking effort. Thus, it would appear that service availability is a significant issue for many people seeking help.

Logistical issues related to treatment attendance, such as lack of transport or childcare, were not reported by survey participants in either the helpline or general population samples. It is, therefore, possible that contrary to stakeholder perception, these are not salient barriers to help-seeking. Having said this, response items representative of logistical issues related to treatment attendance were not included in the list of specified barriers to help-seeking. This omission may have biased participant response away from these types of issues.

A further service-related barrier, evident amongst many participants in the helpline sample, was the potential impact of prior help-seeking experiences. Forty-six percent (57/125) of the

helpline sample reported at least one prior treatment experience; nearly half of this group (26/57) described this experience in negative terms and just over a third (20/57) stated they had not received the help they sought. This presents as a high rate of treatment dissatisfaction and is unlikely to promote further help-seeking behaviour amongst those affected[21]. It is worth noting, however, that all of these participants did eventually seek further assistance from a specialist problem gambling treatment service and the majority of participants in the follow-up survey reported high levels of satisfaction with the most recent service received.

These service-related barriers suggest gambling treatment providers could do more to improve treatment access. Wider promotion of the range of problem gambling treatment options available may be warranted. Awareness of the Gambling Helpline seems high and this service undoubtedly acts as a gateway into the problem gambling treatment sector for many people but telephone contact may not suit everyone (indicated by 20% of the helpline sample and 40% of the general population sample). Knowledge of alternative sources of specialist assistance would be helpful in these cases. Survey data indicated participants in both the helpline and general population samples were made aware of problem gambling treatment services via a variety of advertising and referral mediums. Thus, a wide and diverse array of marketing strategies may be appropriate. Marketing strategies that demystify the treatment process and highlight the protection of privacy may also serve to ease concerns in these areas. The reportedly high levels of historic (although not recent) service dissatisfaction should be of concern to all gambling treatment providers. Survey participants rarely articulated the cause of their dissatisfaction, so it is difficult to recommend specific changes services may make to address this concern. However, focus group participants made a number of suggestions that may usefully inform optimal service provision, for instance problem gambling treatment services should seek to respond promptly and positively when contact is made, clients should be well informed of what to expect from the treatment process, flexible treatment approaches capable of meeting a range of client issues and treatment goals should be employed, and practical support to engage in the treatment process should be provided where necessary. Seeking constant improvement in all these areas is likely to positively enhance the treatment experience for most clients of problem gambling treatment services.

[21] The option 'having had bad experiences of seeking help for a gambling problem in the past' was only identified as a barrier to help-seeking by 15% (19/125) of the sample, although this represents a third of the participants who reported prior treatment-seeking experience.

5. LIMITATIONS OF THIS STUDY

The geographical location of the researchers was Auckland which led to participant inclusion in the key stakeholder focus groups being limited to the Auckland area. However, since the major problem gambling service provider organisations including several ethnic specific organisations are located or have their largest service in Auckland, and since the greatest single percentage of problem gambling service users originate from the Auckland area, this was considered not to have impacted on the representativeness of key stakeholder focus group participants.

Focus group data were coded prior to analysis. This involved subjective judgement by the researchers. However, the judgement bias was minimised since several members of the research team were involved in the coding process including representatives from different ethnicities (European, Maori, Pacific and Asian).

The number of survey participants recruited was constrained by time and budget, thus general population gamblers were recruited within the Auckland area and this sample, therefore, is not necessarily representative of the New Zealand general population as a whole. However, participants accessing the internet surveys and recruited via the national telephone helpline originated from throughout New Zealand and included rural as well as urban populations. The sample numbers were sufficient to allow sub-analyses of information to ascertain gender and some cultural differences, specifically European versus Maori. Pacific and Asian sample sizes were generally too small to allow ethnic-specific analyses for these populations. Partly to off-set the cultural limitation, in-depth semi-structured interviews were also conducted with Maori to enhance the interpretation and quality of the quantitative data obtained. Unfortunately, within the time frame of the project it was not possible to recruit Pacific participants for in-depth semi-structured interviews and only one Asian gambler participated in an in-depth interview. This has limited our ability to enhance and expand on any potential ethnic- and culturally-specific issues in relation to issues of accessing treatment services. Notwithstanding, some ethnic-specific findings were identified from the quantitative survey data, though these need to be treated with caution. Indications from the study are that any improvements in access to problem gambling treatment services are likely to be effective across different ethnic groups.

Family/whanau members (of problem gamblers) appeared reluctant to take part in the project and the numbers recruited were significantly lower than those expected. This appeared to be an issue around the family member not wanting to receive a phone call relating to gambling or to take part in an in-depth face-to-face interview (only one Asian in-depth interview was conducted with a family member). This has limited our ability to draw conclusions regarding the help-seeking behaviours of family/whanau of problem gamblers. Anecdotal evidence suggests other studies have experienced similar difficulties when attempting to recruit family members of problem gamblers for research participation. Thus, this may be a sub-population that cannot be effectively researched at this time. Nevertheless, if a range of recruitment methods were employed (e.g. peer referral, media advertising, household survey) and/or if recruitment extended over longer time-frames (e.g. 6-12 months), then meaningful sample sizes may be achievable.

Additionally, there was a high attrition in participants for the follow-up interviews (approximately 50%) with participants either not being contactable or withdrawing from the study. This limited our conclusions to the broad level and meant that sub-analyses could not be performed. Procedures for retention of participants for follow-up research should be considered for future studies with the problem gambling population.

The different recruitment methodologies used in this study were selected to maximise the sample size and demographics of the participants. Apart from family/whanau participants as detailed in the preceding paragraph, recruitment of gamblers via the telephone helpline and through the various methods for accessing general population gamblers, proved to be successful. Internet surveys accessed via links on the Helpline and University's web pages was less successful than expected and perhaps indicates reluctance on the part of gamblers to use this medium when divulging information about themselves for a research project; however, this did not impact on the results since the internet samples were designed to boost the gambler telephone and general population samples to increase the power of those analyses.

6. RECOMMENDATIONS

The project recommendations are presented under the headings 'focus areas' and 'strategies'. Each of the recommended strategies could potentially be employed across several of the focus areas. All of the recommendations are based on the findings from this study, inclusive of the literature review, focus groups and surveys. It is important to note, however, that in order for the recommendations to be most effective they need to be considered and acted upon concurrently. Each recommendation, in isolation, may be less effective since they will only target a limited aspect of the currently perceived barriers to accessing problem gambling services.

Recommended focus areas

1. Encourage earlier help-seeking behaviours

The overarching recommendation is to encourage problem gamblers to seek formal or informal assistance at an earlier stage, i.e. before a crisis point is reached. Key means of achieving this goal would include:

- *Raising problem awareness*

The project findings suggested problem denial was a major barrier to help-seeking. Raising awareness of what constitutes a gambling problem, ideally in ways that allow an individual to plot their or someone else's gambling behaviour on a continuum of problematic behaviour/outcome, therefore presents as one method of promoting earlier help-seeking activity. As financial problems were the primary enabler to help-seeking, awareness raising activities that focus on financial loss or hardship may be most effective.

- *Normalising help-seeking activities*

Shame and pride were also identified as major barriers to help-seeking. Accordingly, the act of seeking help for a gambling problem needs to be normalised in such a way that it minimises feelings of shame or embarrassment for the help-seeker. This would include the normalisation both of specialist and non-specialist help-seeking. Examples of the latter might include talking to a trusted friend, requesting self-help resources or utilising an employee assistance programme.

- *Raising awareness of available supports* (both specialist and non-specialist)

The project findings suggested many individuals with a gambling-related problem were largely unaware of the full range of specialist and non-specialist supports potentially available to them. Thus, in addition to normalising help-seeking activities, people need to be made aware of where they can seek help and the variety of ways in which help can be provided. The project findings suggest that a variety of marketing approaches will be needed in order to promote widespread awareness of available supports.

2. Increase the range and accessibility of specialist and non-specialist supports

The greater the range of specialist and non-specialist supports available, and the more accessible they are, the more likely it is that an individual with a gambling-related problem will find help. Key means of facilitating this outcome include:

- *Increasing the available range of non-specialist support*

The project findings strongly suggest that many individuals with a gambling-related problem will seek help via non-specialist supports in the first instance. Non-specialist support can be effective and, as a result, can reduce the demand on specialist services

making them more responsive to those who do seek their assistance. Parties with an interest in reducing gambling-related harm should, therefore, take advantage of this apparent preference for non-specialist support by maximising their availability in local communities. Examples might include the introduction of opportunistic early intervention programmes in non-specialist settings (e.g. General Practitioner clinic, budget advisors, family or other social services) or the provision of self-help resources or training to friends or family members of problem gamblers (discussed more fully under 'strategies').

- *Establishing clear pathways from non-specialist to specialist support services*

Non-specialist support may not always be adequate. Thus, clear referral pathways need to be established from non-specialist to specialist support services when the latter are required. In order to achieve this, primary providers of non-specialist support need to be aware of when specialist support is needed and the range of services available.

- *De-mystifying the specialist treatment process*

The survey data revealed concerns around the unknown entity of 'treatment' and what the process would entail as well as concerns around the management of confidential information. Easing concerns in these areas is likely to facilitate a greater uptake of specialist assistance.

- *Increasing the availability of specialist support*

Though a lesser barrier than those detailed above, the project findings did suggest that accessibility of specialist services in terms of hours of operation and location does play a part in terms of access and use of the services. Accordingly, these should be tailored to meet the needs of the problem gambling population.

3. **Increase effectiveness of specialist and non-specialist supports**

There is little point increasing the range and accessibility of specialist and non-specialist supports if those provided are ineffective in reducing gambling-related harm. Accordingly, robust evaluation of specialist and non-specialist supports currently provided or planned for implementation is required. The importance of this recommendation is supported by the relatively high proportion of survey respondents who described previous help-seeking experiences in negative terms or who reported not receiving the help they sought.

4. **Further investigation into help-seeking enablers and barriers**

Due to limitations in participant recruitment, this study was unable to meaningfully examine enablers and barriers to help-seeking for the family/whanau of problem gamblers. The data pertaining to Pacific and Asian problem gamblers or family/whanau members of problem gamblers was equally limited for the same reasons. Accordingly, further investigation is warranted in these areas.

Future studies may have more success securing participation from these population groups if data are sought as part of routine clinical contact in specialist treatment services (e.g. by a clinician administered survey) or following response to a family/whanau oriented or Pacific/Asian marketing campaign.

Recommended Strategies

The following strategies present as the most likely means by which desired change could be achieved in the aforementioned focus areas.

1. **Social marketing campaigns**

   Raising problem awareness, normalising help-seeking activities, raising awareness of available supports, and de-mystifying the specialist treatment process could all potentially be achieved via social marketing strategies. All of these focus areas could be addressed as part of a single social marketing campaign. For example, a series of television commercials could follow the lives of several New Zealanders as they identify they (or a loved one) have a gambling problem and then go about various help-seeking activities. Ideally, the television advertisements would be supported by other media, would canvas the lives of ethnically diverse New Zealanders, and would encompass and explain a range of help-seeking options. This process has already been initiated through the Health Sponsorship Council's 'Kiwi Lives' social marketing campaign, although evaluation of the effectiveness of the campaign has yet to be performed and the campaign may not be extensive enough to address all of these areas.

2. **Opportunistic early intervention schemes**

   Promoting earlier help-seeking, increasing the available range of non-specialist supports and ensuring clear pathways between the non-specialist and specialist treatment sectors could be achieved by the widespread implementation of early intervention initiatives. This could include further promotion of the current Ministry of Health funded 'early intervention' projects with general practitioners and other social service agencies. Since financial problems were the major reason for help-seeking, it would also seem prudent for budgeting and other financial institutions (e.g. banks and credit agencies) to be agencies where early intervention could be initiated. In addition, since relationship difficulties, when they occurred, were a primary influence on help-seeking behaviours, agencies working with families should also be considered for early interventions.

   In addition, attempts could be made to identify and train a range of community leaders (e.g. ministers, employers, coaches) to be help-seeking advocates. The aim in these cases would be to encourage the identified leaders to openly discuss the problem gambling issue in public fora and to promote a range of specialist and non-specialist help-seeking options. This approach will give credibility to the issue within specific communities (including cultural and ethnic communities) and will allow awareness-raising initiatives to be targeted to the needs of each community. The identification of suitable and willing community leaders and the development of a training resource would be the necessary first step in achieving this aim.

3. **Promotion of self-help resources and mechanisms**

   A further means of increasing the range of non-specialist support is via the widespread promotion of self-help resources. Self-help resources could be made available or advertised in gambling venues and self-help strategies could be promoted via television and other media. These resources/strategies could target the problem gambler and/or equip family or friends of problem gamblers with the skills to stimulate and support the problem resolution process. The identification of effective self-help strategies and their appropriate delivery mechanisms would be a necessary first step in achieving this aim.

4. **Independent evaluation**

   The effectiveness of specialist and non-specialist support services currently available to New Zealanders with a gambling-related problem, and services considered for future implementation, require independent evaluation. Evaluation should focus on the most utilised supports in the first instance and should encompass both outcome and satisfaction

domains. The ultimate aim would be to identify a gold standard range of evidence-based specialist and non-specialist interventions and to ensure their widespread availability across New Zealand.

7. REFERENCES

Abbott, M.W. (2001a). *Problem and non-problem gamblers in New Zealand: A report on Phase Two of the National Prevalence Study.* Wellington: Department of Internal Affairs.

Abbott, M.W. (2001b). *What do we know about gambling and problem gambling in New Zealand? Report Number Seven of the New Zealand Gaming Survey.* Wellington: Department of Internal Affairs.

Abbott, M.W., & Clarke, D. (2007). Conceptual and methodological issues in the study of the development of problem gambling. *International Gambling Studies, 7*(1), 123-144.

Abbott, M.W., & McKenna, B. (2000). *Gambling and problem gambling among recently sentenced women prisoners in New Zealand.* Wellington: Department of Internal Affairs.

Abbott, M.W., McKenna, B.G., & Giles, L.C. (2000). *Gambling and problem gambling among recently sentenced males in four New Zealand prisons.* Wellington: Department of Internal Affairs.

Abbott, M.W., Volberg, R., Bellringer, M., & Reith, G. (2004). *A review of research on aspects of problem gambling: Final report.* London: Responsibility in Gambling Trust.

Abbott, M.W., & Volberg, R.A. (1991). *Gambling and problem gambling in New Zealand. Research Series No. 12*. Wellington: Department of Internal Affairs.

Abbott, M.W., & Volberg, R.A. (1992). *Frequent and problem gambling in New Zealand.* Wellington: Department of Internal Affairs.

Abbott, M.W., & Volberg, R.A. (1996). The New Zealand National Survey of Problem and Pathological Gambling. *Journal of Gambling Studies, 12*(2), 143-160.

Abbott, M.W., & Volberg, R.A. (2000). *Taking the pulse on gambling and problem gambling in New Zealand: A report on Phase One of the 1999 National Prevalence Survey. Report Number Three of the New Zealand Gaming Survey.* Wellington: Department of Internal Affairs.

Abbott, M.W., Williams, M., & Volberg, R. A. (1999). *Seven years on: A follow-up study of frequent and problem gamblers living in the community.* Wellington: Department of Internal Affairs.

Abbott, M.W., Wong S., Giles L.C., Wong S., Young, W., & Au, M. (2003). Depression in older Chinese migrants to Auckland. *Australian and New Zealand Journal of Psychiatry, 37*(4), 445-451.

Abbott, M.W., Wong, S., Williams, M., Au, M.K., & Young, W. (1999). Chinese migrants' mental health and adjustment to life in New Zealand. *Australian and New Zealand Journal of Psychiatry, 33*(1), 13-21.

Abbott, M.W., Wong, S., Williams, M., Au, M.K., & Young, W. (2000). Recent Chinese migrants' health, adjustment to life in New Zealand and primary health care utilization. *Disability & Rehabilitation, 22*(1/2), 43-57.

Abbott, M. W., Wong, S., Williams, M., Au. M., & Young, W. (1999). Chinese migrants' mental health and adjustment to life in New Zealand. *Australian and New Zealand Journal of Psychiatry, 33*(1), 13-21.

Aday, L.A., & Andersen, R. (1974). A framework for the study of access to medical care. *Health Service Research, 9*, 208-220.

Alcohol Advisory Council of New Zealand. (1997). *The place of alcohol in the lives of people from Takelau, Fiji, Niue, Tonga, Cook Islands and Samoa living in New Zealand: An overview.* (No. ALAC Research Monograph Series: No 2). Wellington: Ministry of Health.

Allen, K. (1995). Barriers to treatment for addicted African-American women. *Journal of the National Medical Association, 87*(10), 751-756.

Andersen, R. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior, 36*(1), 1-10.

Arseneault, L., Moffitt, T.E., Caspi, A., & Taylor, A. (2002). The targets of violence committed by young offenders with alcohol dependence, marijuana dependence and schizophrenia-spectrum disorders: Findings from a birth cohort. *Criminal Behavior and Mental Health, 12*, 155-168.

Barber, J.G. (2004). *Social work with addictions* (2nd edition ed.). London: Macmillan.

Barnes, M.H., McPherson, M., & Bhatta, K. (2003). *Te Ao Waipiro. (2000) Maori national alcohol survey*. Auckland: Centre for Social Health Outcomes Research and Evaluation, Massey University.

Barney, L.J., Griffiths, K.M., Jorm, A.F., & Christensen, H. (2006). Stigma about depression and its impact on help-seeking intentions. *Australian & New Zealand Journal of Psychiatry, 40*(1), 51-54.

Bellringer, M.E., Cowley-Malcolm, E.T., Abbott, M.W., & Williams, M.M. (2005). Pacific Islands families: The first two years of life: Gambling amongst Pacific mothers. *eCommunity International Journal of Mental Health and Addiction, 3*(1), 53-60. Retrieved 26 March 2007 from http://www.ijma-journal.com/pdf/v3i1a06.pdf.

Bellringer, M.E., Perese, L.M., Abbott, M.W., & Williams, M.M. (2006). Gambling amongst Pacific mothers living in New Zealand. *International Gambling Studies, 6*(2), 217-235.

Binde, P. (2005). Gambling across cultures: Mapping worldwide occurrence and learning from ethnographic comparison. *International Gambling Studies, 5*(1), 1-27.

Booth, B.M., Kirchner, J., Fortney, J., Ross, R., & Rost, K. (2000). Rural at-risk drinkers: Correlates and one-year use of alcoholism treatment services. *Journal of Studies on Alcohol, 61*, 267-277.

Brady, M. (1995). Culture in treatment, culture as treatment. A critical appraisal of developments in addictions programs for indigenous North Americans and Australians. *Social Science & Medicine, 41*(11), 1487-1498.

Brown, K. (2002). Understanding problem gambling in ethnocultural communities: Taking the first steps. *Newslink: Responsible Gambling Issues and Information, Fall*, 1-5.

Bunkle, P. (2003). The changing participation of women in gambling in New Zealand. *eGambling: The Electronic Journal of Gambling Issues* (8). Retrieved 1 September 2006 from http://www.camh.net/egambling/issue8/opinion/index.html.

Callaghan, R.C., & Herzog, T.A. (2006). The relation between processes-of-change and stage-transition in smoking behavior: A two-year longitudinal test of the Transtheoretical Model. *Addictive Behaviors, 31*(8), 1331-1345.

Cancer Prevention Research Centre. (2000a). *Transtheoretical Model: Detailed overview of the Transtheoretical Model*. Retrieved 26 May 2006 from http://www.uri.edu/research/cprc/TTM/detailedoverview.htm.

Cancer Prevention Research Centre. (2000b). *Transtheoretical Model: Stages of Change*. Retrieved 26 May 2006 from http://www.uri.edu/research/cprc/TTM/StagesOfChange.htm.

Cheung, F.M. (1986). Psychopathology among Chinese people. In M.H. Bond (Ed.), *The Psychology of the Chinese people* (pp. 171–212.). Hong Kong ; New York: Oxford University Press.

Cormack, D., Ratima, M., Robson, B., Brown, R., & Purdie, G. (2005). *Access to cancer services for Maori: A report prepared for the Ministry of Health*. Wellington: Ministry of Health.

Cowan, L., Deering, D., Crowe, M., Sellman, D., Futterman-Collier, A., & Adamson, S. (2003). Alcohol and drug treatment for women: Clinicians' beliefs and practice. *International Journal of Mental Health Nursing, 12*(1), 48-55.

Crawley, L., Pulotu-Endemann, F.K., Stanley-Findlay, R.T.U., and New Zealand Ministry of Health. (1995). *Strategic directions for the mental health services for Pacific Islands people.* Wellington: Ministry of Health.

Crisp, B.R., Thomas, S.A., Jackson, A.C., Thomason, N., Smith, S., Borrell, J., et al. (2000). Sex differences in the treatment needs and outcomes of problem gamblers. *Research on Social Work Practice, 10*(2), 229-242.

Cunningham, J.A., Humphreys, K., & Koski-Jannes, A. (2000). Providing personalized assessment feedback for problem drinking on the Internet: A pilot project. *Journal of Studies on Alcohol, 61*, 794-798.

Cunningham, J.A., Sobell, L.C., Sobell, M.B., Agrawal, S., & Toneatto, T. (1993). Barriers to treatment: Why alcohol and drug abusers delay or never seek treatment. *Addictive Behaviors, 18*, 347-353.

Davis, D.R., & Avery, L. (2004). Women who have taken their lives back from compulsive gambling: Results from an online survey. *Journal of Social work Practice, 4*(1), 61 (Abstract only).

de Bonnaire, C., Fryer, K., Kalafatelis, E., & Whitfield, J. (2000). *Youth and alcohol: Benchmark survey of parental concern* (No. BRC #2012). Wellington: Alcohol Advisory Council of New Zealand.

de Zwart, K.M., Sellman, J.D., & Robertson, P.J. (2002). Public knowledge and attitudes regarding smoking and smoking cessation treatments. *New Zealand Medical Journal, 115*(1153), 219-222.

Delfabbro, P. (1998). *Gender differences in Australian gambling: A critical review of existing findings and methodological critique.* Paper presented at the National Association for Gambling Studies, Adelaide, Australia.

Delfabbro, P.H., & LeCouteur, A. (2003). *A decade of gambling research in Australia and New Zealand (1992-2002): Implications for policy, regulation and harm minimisation*. Adelaide: Independent Gambling Authority of South Australia.

DeSouza, R., & Garrett, N. (2005). *Access issues for Chinese people in New Zealand*. Auckland: Auckland University of Technology and Accident Compensation Corporation.

DiMatteo, M.R. (1997). Health behaviors and care decisions: An overview of professional-patient communication. In D.S. Gochman (Ed.), *Handbook of Health Behavior Research II: Provider Determinants*. New York: Plenum.

Dixon, G., Stanton, W.R., McGee, R.O., Langley, J.D., & Murdoch, J.C. (1995). Disability in late adolescence III: Utilization of health services. *Disability and Rehabilitation, 17*(5), 225-230.

Duong-Ohtsuka, T., & Ohtsuka, K. (2001). *Differences in attitudes towards psychological help among Vietnamese- and Australian-born respondents.* Paper presented at the Proceedings of the 11th National Conference of the National Association for Gambling Studies., Alphington, Victoria, Australia.

Duran, B., Oetzel, J., Lucero, J., Jiang, Y., Novins, D. K., Manson, S., et al. (2005). Obstacles for rural American Indians seeking alcohol, drug, or mental health treatment. *Journal of Consulting and Clinical Psychology, 73*(5), 819-829.

Durie, M.H. (1998). *Whaiora: Maori health development* (Second ed.). Auckland: Oxford University Press.

Dyall, L. (2004a). Gambling: A social hazard. *Social Policy Journal of New Zealand i*21, 22.

Dyall, L. (2004b). Why is wearing glasses useful in New Zealand? Paper presented at the International Conference: Gambling through a Public Health Lens. *Journal of Gambling issues* (12). Retrieved 1 September 2006 from http://www.camh.net/egambling/issue12/jgi_12_dyall.html.

Dyall, L., & Hand, J. (2003). Maori and gambling: Why a comprehensive Maori public health response is required in Aotearoa/New Zealand. *eCommunity International Journal of Mental Health and Addiction, 1*(1). Retrieved 1 September 2006 from http://www.ijma-journal.com/content/full/1/1/00005.

Ellison-Loschmann, L., & Pearce, N. (2006). Improving access to health care among New Zealand's Maori population. *American Journal of Public Health, 96*(4), 612-617.

Evans, L., & Delfabbro, P. H. (2005). Motivators for change and barriers to help-seeking in Australian problem gamblers. *Journal of Gambling Studies, 21*(2), 133-155.

Featherstone, B., & Broadhurst, K. (2003). Engaging parents and carers with family support services: What can be learned from research on help-seeking? *Child & Family Social Work, 8*(4), 341-350.

Fuller, J., Edwards, J., Procter, N., & Moss, J. (2000). How definition of mental health problems can influence help seeking in rural and remote communities. *Australian Journal of Rural Health, 8*(3), 148-153.

Furstenberg, A., & Davis, L. J. (1984). Lay consultation of older people. *Social Science and Medicine, 18*, 827-837.

Galdas, P.M., Cheater, F., & Marshall, P. (2005). Men and health help-seeking behaviour: Literature review. *Journal of Advanced Nursing, 49*(6), 616-623.

Gambling Helpline. (2005). Personal Communication. Auckland.

Goldberg, M.E. (1995). Substance-abusing women: False stereotypes and real needs. *Social Work, 40*(6), 789-798.

Goodwin, V., & Happell, B. (2006). Conflicting agendas between consumers and carers: The perspectives of carers and nurses.. *International Journal of Mental Health Nursing, 15*(2), 135-143.

Goodyear-Smith, F., Arroll, B., Kerse, N., Sullivan, S., Coupe, N., Tse, S., et al. (2006). Primary care patients reporting concerns about their gambling frequently have other co-occurring lifestyle and mental health issues. *BMC Family Practice, 7*(25). Retrieved 1 September 2006 from http://www.biomedcentral.com/content/pdf/1471-2296-7-25.pdf.

Grant, B. (1997). Barriers to alcoholism treatment: Reasons for not seeking treatment in a general population sample. *Journal of Studies on Alcohol, 58*, 365-371.

Green, C.A., Polen, M.R., Dickinson, D.M., Lynch, F.L., & Bennett, M.D. (2002). Gender differences in predictors of initiation, retention, and completion in an HMO-based substance abuse treatment program. *Journal of Substance Abuse Treatment, 23*, 285-295.

Gruen, R.L., Bailie, R.S., Wang, Z., Heard, S., & O'Rourke, I. C. (2006). Specialist outreach to isolated and disadvantaged communities: a population-based study. *Lancet, 368*(9530), 130-138.

Hajema, K.J., Knibbe, R.A., & Drop, M.J. (1999). Social resources and alcohol-related losses as predictors of help seeking among male problem drinkers. *Journal of Studies on Alcohol, 69*(1), 120-129.

Hill, W., Weinert, C., & Cudney, S. (2006). Influence of a computer intervention on the psychological status of chronically ill rural women: Preliminary results. *Nursing Research, 55*(1), 34-42.

Ho, E., Au, S., Bedford, C., & Cooper, J. (2002). *Mental health issues for Asians in New Zealand: A literature review* (Commissioned by the Mental Health Commission). Waikato: University of Waikato.

Hodgetts, D., & Chamberlain, K. (2002). "The problem with men": Working-class men making sense of men's health on television. *Journal of Health Psychology, 7*(3), 269-283.

Hodgins, D., & el-Guebaly, N. (2000). Recovery from gambling problems: A comparison of resolved and active gamblers. *Addiction, 95*, 777-789.

Humphreys, K., & Klaw, E. (2001). Can targeting nondependent problem drinkers and providing internet-based services expand access to assistance for alcohol problems? A study of the moderation management self-help/mutual aid organization. *Journal of Studies on Alcohol, 62*, 528-532.

Huriwai, T. (2002). Re-enculturation: Culturally congruent interventions for Mãori with alcohol-and drug-use-associated problems in New Zealand. *Substance Use & Misuse, 37*(8 - 10), 1259-1268.

Huriwai, T., Robertson, P.J., Armstrong, D., Kingi, T.P., & Huata, P. (2001). Whanaungatanga - a process in the treatment of Maori with alcohol- and drug-use related problems. *Substance Use & Misuse., 36*(8), 1033-1051.

Huriwai, T., Sellman, J. D., Sullivan, P., & Potiki, T. (1998). A clinical sample of Maori being treated for alcohol and drug problems in New Zealand. *New Zealand Medical Journal., 111*(1064), 145-147.

Issakidis, C., & Andrews, G. (2006). Who treats whom? An application of the Pathways to Care model in Australia. *Australian & New Zealand Journal of Psychiatry, 40*(1), 74-86.

Jackson, R., Wernicke, R., & Haaga, D. A. F. (2003). Hope as a predictor of entering substance abuse treatment. *Addictive Behaviors, 28*, 13-28.

Jerrell, J.M., Wieduwilt, K.M., & Macey, D.V. (2002). Use and costs of public-sector behavioral health services for African-American and white women. *Psychiatric Services, 53*(2), 195-200.

Jessup, M.A., Humphreys, J.C., Brindis, C.D., & Lee, K.A. (2003). Extrinsic barriers to substance abuse treatment among pregnant drug dependent women. *Journal of Drug Issues, 33*, 285-304.

Judd, F., Jackson, H., Komiti, A., Murray, G., Fraser, C., Grieve, A., et al. (2006). Help-seeking by rural residents for mental health problems: the importance of agrarian values. *Australian and New Zealand Journal of Psychiatry, 40*(9), 769-776.

Kennedy, T., Regehr, G., Rosenfield, J., Roberts, S., & Lingard, L. (2004). Exploring the gap between knowledge and behavior: A qualitative study of clinician action following an educational intervention. *Academic Medicine, 79*(5), 386-393.

Kerkorian, D., McKay, M., & Bannon, W.M. Jr. (2006). Seeking help a second time: Parents'/caregivers' characterizations of previous experiences with mental health services for their children and perceptions of barriers to future use. *American Journal of Orthopsychiatry, 76*(2), 161-166.

Kessler, R. C., Olfson, M., & Berglund, P. A. (1998). Patterns and predictors of treatment contact after first onset of psychiatry disorders. *American Journal of Psychiatry, 155*, 62-69.

Kwok, S. M. (2000). Exploring the experiences of Chinese in drugs treatment programs in Vancouver. *British Journal of Social Work, 30*, 633-672.

Lane, J.M., & Addis, M.E. (2005). Male gender role conflict and patterns of help seeking in Costa Rica and the United States. *Psychology of Men and Masculinity, 6*(3), 155-168.

Lester, H.E., Tritter, J.Q., & Sorohan, H. (2005). Patients' and health professionals' views on primary care for people with serious mental illness: Focus group study. *British Medical Journal, 330*(7500), 1112.

Loue, S. (1999). *Gender, ethnicity, and health research*. New York: Kluwer Academic/Plenum Publishers.

Mansfield, A.K., Addis, M.E., & Courtenay, W. (2005). Measurement of men's help seeking: development and evaluation of the Barriers to Help Seeking Scale. *Psychology of Men & Masculinity 6(2) Apr 2005, 95-108*.

Manson, S.M. (2000). Mental health services for American Indians and Alaska natives: Need, use, and barriers to effective care. *Canadian Journal of Psychiatry, 45*, 617-626.

Mark, M.E., & Lesieur, H.R. (1992). A feminist critique of problem gambling research. *British Journal of Addiction, 87*(4), 549-565.

Marks, I. (2005). The mental health professional and the new technologies: A handbook for practice today. *British Journal of Psychiatry, 186*(6), 545.

Marsh, J.C., D'Aunno, T.A., & Smith, B.D. (2000). Increasing access and providing social services to improve drug abuse treatment for women with children. *Addiction, 95*(8), 1237-1247.

Mason, K., & Arnold, R. (2007). Problem gambling risk factors and associated behaviours and health status: Results from the 2002/03 New Zealand Health Survey. *The New Zealand medical journal, 120*(1257). Retrieved 7 May 2008 from http://www.nzma.org.nz.ezproxy.aut.ac.nz/journal/120-1257/2604/content.pdf

McCollister, K.E., & French, M.T. (2003). The relative contribution of outcome domains in the total economic benefit of addiction interventions: A review of first findings. *Addiction, 98*(12), 1647-1659.

McMahon, T.J., Winkel, J.D., Suchman, N.E., & Luthar, S.S. (2002). Drug dependence, parenting responsibilities, and treatment history: Why doesn't mom go for help? *Drug and Alcohol Dependence, 65*, 105-114.

McMillen, J., Marshall, D., Murphy, L., Lorenzen, S., & Waugh, B. (2004). *Help-seeking by problem gamblers, friends and families: A focus on gender and cultural groups*. Acton, ACT, Australia: ACT Gambling and Racing Commission.

Mental Health Commission. (2001). *Pacific mental health services and workforce: Moving on the Blueprint*. Wellington: Author.

Ministry of Health. (2000a). *The New Zealand Health Strategy*. Wellington: Author.

Ministry of Health. (2000b). *The Pacific Health and Disability Action Plan*. Wellington: Author.

Ministry of Health. (2001). *The primary health care strategy*. Wellington: Author.

Ministry of Health. (2002a). *He Korowai Oranga - Maori Health Strategy*. Wellington: Author.

Ministry of Health. (2002b). *Reducing inequalities in health*. Wellington: Author.

Ministry of Health, & Ministry of Pacific Island Affairs. (2004). *Tou ola moui: The Pacific health chart book 2004*. Wellington, New Zealand: Ministry of Health.

Ministry of Health. (2005a). *Te Orau Ora - Pacific Mental Health Profile*. Wellington: Ministry of Health.

Ministry of Health. (2005b). *Problem gambling intervention services in New Zealand: 2004 national statistics*. Wellington: Ministry of Health.

Ministry of Health, (2006). *Problem gambling intervention services in New Zealand: 2005 Service-user statistics*. Wellington: Ministry of Health.

Ministry of Health. (2007). *Problem gambling intervention services in New Zealand: 2006 Service-user statistics*. Wellington: Ministry of Health.

Ministry of Health and Ministry of Pacific Island Affairs. (2004). *Tupu Ola Moui: The Pacific Health Chart Book 2004*. Wellington: Ministry of Health.

Morrison, L. (2003). Pokie gambling and Maori women: Friend or foe? Paper presented at the International Conference: Gambling through a Public Health Lens. *Journal of Gambling issues* (12). Retrieved 1 September 2006 from http://www.camh.net/egambling/issue12/jgi_12_morrison.html.

Nada-Raja, S., Morrison, D., & Skegg, K. (2003). A population-based study of help-seeking for self-harm in young adults. *Australian and New Zealand Journal of Psychiatry, 37*, 600-605.

New Zealand Health Information Service. (2005). *Mental health: Service use in New Zealand 2002*. Wellington: Ministry of Health.

Newman, D.L., Moffitt, T.E., Caspi, A., & Silva, P.A. (1998). Comorbid mental disorders: Implications for clinical treatment and sample selection. *Journal of Abnormal Psychology, 107*, 305-311.

Ngai, M.M.Y., Latimer, S., & Cheung, V.Y.M. (2001). *Healthcare needs of Asian people: Surveys of Asian people and health professionals in North and West Auckland*. Takapuna: Asian Health Support Service, Waitemata District Health Board.

Niagara Multilingual Problem Gambling Program. (undated). *Problem Gambling and Ethno-Cultural Groups*. Retrieved 7 July 2006 from http://www.gamb-ling.com/english/get_informed/ethnocultural_groups.pdf.

Paton-Simpson, G., Hannifin, J., & Gruys, M. (2001). *Problem gambling counselling in New Zealand: 2000 national statistics*. Wellington: Department of Internal Affairs.

Paton-Simpson, G., Hannifin, J., & Gruys, M. (2002). *Problem gambling counselling in New Zealand: 2001 national statistics.* Wellington: Department of Internal Affairs.

Paton-Simpson, G., Hannifin, J., & Gruys, M. (2003). *Problem gambling counselling in New Zealand: 2002 national statistics.* Wellington: Department of Internal Affairs.

Penchansky, R., & Thomas, J.W. (1981). The concept of access: Definition and relationship to consumer satisfaction. *Medical Care, 19*(2), 127–140.

Perese, L., & Faleafa, M. (2000). *The impact of gambling on some Samoan peoples lives in Auckland*. Auckland: Compulsive Gambling Society of New Zealand.

Pescosolido, B.A. (1992). Beyond rational choice: The social dynamics of how people seek help. *American Journal of Sociology, 97*, 1096-1138.

Pescosolido, B.A., Gardner, C.B., & Kubell, K.M. (1998). How people get into mental health services: Stories of choice, coercion and "muddling through" from "first-timers". *Social Science and Medicine, 46*(2), 275-286.

Potenza, M.N., Steinberg, M.A., McLaughlin, S.D., Wu, R., Rounsaville, B.J., & O'Malley, S.S. (2001). Gender-Related differences in the Characteristics of Problem Gamblers Using a Gambling Helpline. *The American Journal of Psychiatry, 158*, 1500-1505.

Prochaska, J.O. (2006). Moving beyond the transtheoretical model. *Addiction, 101*, 768-774.

Prochaska, J.O., DiClemente, C.G., & Norcross, J.C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*, 1102-1114.

Productivity Commission. (1999). *Australia's gambling industries, Report No. 10*. Canberra: AusInfo. Available at http://www.pc.gov.au/.

Rankine, J., & Haigh, D. (2003). *Social impacts of gambling in Manukau City*. Auckland: Manukau City Council.

Raylu, N., & Oei, T.P. (2004). Role of culture in gambling and problem gambling. *Clinical Psychology Review, 23*(8), 1087-1114.

Roberts, L.W., Warner, T.D., & Hammond, K.G. (2005). Ethical challenges of mental health clinicians in rural and frontier areas. *Psychiatric Services, 56*(3), 358-359.

Robertson, P., Futterman-Collier, A., Sellman, J., Adamson, S., Todd, F., Deering, D., et al. (2001). Clinician beliefs and practices related to increasing responsivity to the needs of Mäori with alcohol and drug problems. *Substance Use & Misuse, 36*(8), 1015-1032.

Robertson, P.J., Haitana, T.N., Pitama, S.G., & Huriwai, T.T. (2006). A review of work-force development literature for the Mori addiction treatment field in Aotearoa/New Zealand. *Drug and Alcohol Review, 25*(3), 233-239.

Robertson, P., Pitama, S., Huriwai, T., Ahuriri-Driscoll, A., Haitana, T., Larsen, J., et al. (2005). Developing services in te rohe o Ngai Tahu for Maori with gambling related problems. *New Zealand Journal of Psychology, 34*(1), 35-43.

Rockloff, M., & Schofield, G. (2004). Factor analysis of barriers to treatment for problem gambling. *Journal of Gambling Studies, 20*(2), 121-126.

Rothi, D.M., & Leavey, G. (2006). Mental health help-seeking and young people: A review. *Pastoral Care in Education, 24*(3), 4-13.

Schopp, L.H., Demiris, G., & Glueckauf, R.L. (2006). Rural backwaters or front-runners? Rural telehealth in the vanguard of psychology practice. *Professional Psychology: Research and Practice, 37*(2), 165-173.

Scragg, R., & Maitra, A. (2005). *Asian health in Aotearoa: An analysis of the 2002-2003 New Zealand Health Survey*. Auckland: The Asian Network Incorporated.

Scull, S., & Woolcock, G. (2005). Problem gambling in Non-English Speaking Background Communities in Queensland, Australia: A qualitative exploration. *International Gambling Studies, 5*(1), 29-44.

Simpson, C.A., & Tucker, J.A. (2002). Temporal sequencing of alcohol-related problems, problem recognition, and help-seeking episodes. *Addictive Behaviors, 27*, 659-674.

Sobell, L.C., Sobell, M.B., & Toneatto, T. (1992). Recovery from alcohol problems without treatment. In N. Healther, W.R. Miller & J. Greeley (Eds.), *Self-control and the Addictive Behaviours* (pp. 198-242). New York: Maxwell MacMillan.

Statistics New Zealand. (2002). *Census snapshot : cultural diversity*. Retrieved 25 January, 2005 from http://www.stats.govt.nz/products-and-services/Articles/census-snpsht-cult-diversity-Mar02.htm.

Sullivan, S., Arroll, B., Coster, G., Abbott, M., & Adams, P. (2000). Problem gamblers: Do GPs want to intervene? *New Zealand Medical Journal, 113*, 204-207.

Sutton, S. (2001). Back to the drawing board? A review of applications of the transtheoretical model to substance use. *Addiction, 96*, 175-186.

Tavares, H., Zilberman, M.L., Beites, F.J., & Gentil, V. (2001). Brief communications: Gender differences in gambling progression. *Journal of Gambling Studies, 17*, 151-159).

Thomas, D.R. (2006). Evaluating the cultural appropriateness of service delivery in multi-ethnic communities. In N. Kazantzis (Ed.), *Community of Applied Psychologists Paper Series 1* (pp. 65-74). Auckland, New Zealand: Centre for Psychology, Massey University.

Todd, F.C., Sellman, J.D., & Robertson, P.J. (2002). Barriers to optimal care for patients with coexisting substance use and mental health disorders. *Australian & New Zealand Journal of Psychiatry, 36*(6), 792-799.

Tse, S., Wong, J., & Kim, H. (2003). A public health approach for Asian people with problem gambling in foreign countries. *Journal of Gambling issues* (12). Retrieved 1 September 2006 from http://www.camh.net/egambling/issue12/jgi_12_tse.html.

Uba, L. (2002). *A postmodern psychology of Asian Americans: Creating knowledge of a racial minority*. New York: Albany State University of New York Press.

Volberg, R.A. (2003). Has there been a "feminization" of gambling and problem gambling in the United States? *eGambling: The electronic journal of Gambling issues* (8). Retreived 1 September 2006 from http://www.camh.net/egambling/issue8/feature/index.html.

Wagner, J., Heapy, A., Frantsve, L., Abbott, G., & Burg, M. M. (2006). Transtheoretical model constructs in smokers with and without medical illness: A second look at the medical effect. *Addictive Behaviors, 31*(7), 1283-1289.

West, R. (2006). The transtheoretical model of behaviour change and the scientific method. *Addiction, 101*, 774-778.

Westphal, J.R., & Johnson, L.J. (2003). Gender differences in psychiatric comorbidity and treatment-seeking among gamblers in treatment. *eGambling: The electronic journal of Gambling issues* (8). Retrieved 1 September 2006 from http://www.camh.net/egambling/issue8/research/westphal-johnson/index.html.

Workshop Organising Team. (2005). *Issues and options paper: The use of the term 'Asian' in New Zealand and implications for research, policy development and community engagement*. Retrieved 12 December 2005 from http://www.wairua.com/ruth/docs/UseOfTermAsian-WorkshopPaper.pdf.

Wu, L.T., & Bancroft, J. (2006). Filipino American women's perceptions and experiences with breast cancer screening. *Oncology Nursing Forum, 33*(4), E71-E78.

Wu, L.T., & Ringwalt, C.L. (2004). Alcohol dependence and use of treatment services among women in the community. *American Journal of Psychiatry, 161*, 1790-1797.

Zatzick, D.F. (1999). Managed care and psychiatry. In R.E. Hales, S C. Yudofsky & J.A. Talbott (Eds.), *American Psychiatric Press textbook of psychiatry*. Washington, D.C: American Psychiatric Press.

Zhu, S.-H., Nguyen, Q.B., Cummins, S., Wong, S., & Wightman, V. (2006). Non-smokers seeking help for smokers: A preliminary study. *Tobacco Control, 15*, 107-113.

APPENDIX 1
Ethical approval - Phase One

M E M O R A N D U M

To: Maria Bellringer
From: **Madeline Banda** Executive Secretary, AUTEC
Date: 8 May 2006
Subject: Ethics Application Number 06/57 **Problem gambling - Barriers to help seeking behaviours**

Dear Maria
Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 10 April 2006. Your ethics application is now approved for a period of three years until 8 May 2009.
I advise that as part of the ethics approval process, you are required to submit to AUTEC the following:

- A brief annual progress report indicating compliance with the ethical approval given using form EA2, which is available online through *http://www.aut.ac.nz/research/ethics*, including a request for extension of the approval if the project will not be completed by the above expiry date;
- A brief report on the status of the project using form EA3, which is available online through *http://www.aut.ac.nz/research/ethics*. This report is to be submitted either when the approval expires on 8 May 2009 or on completion of the project, whichever comes sooner;

You are reminded that, as applicant, you are responsible for ensuring that any research undertaken under this approval is carried out within the parameters approved for your application. Any change to the research outside the parameters of this approval must be submitted to AUTEC for approval before that change is implemented.
Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.
To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at charles.grinter@aut.ac.nz or by telephone on 921 9999 at extension 8860.
On behalf of the Committee and myself, I wish you success with your research and look forward to reading about it in your reports.
Yours sincerely

Madeline Banda
Executive Secretary
Auckland University of Technology Ethics Committee

APPENDIX 2
Ethical approval - Phase Two

Health and Disability Ethics Committees

- 8 JAN 2007

Multi-Region Ethics Committee
Ministry of Health
Level 2, 1–3 The Terrace
PO Box 5013
Wellington
Phone (04) 470 0655
(04) 470 0646
Fax (04) 496 2191

21 December 2006

Prof. Max Abbott
Auckland University of Technology
Faculty of Health & Environmental Sciences
Private Bag 92006
Auckland 1142

Dear Max

MEC/06/12/155 - An investigation of the barriers to help seeking behaviour for problem gamblers and their families and whanau.
Prof. Max Abbott, Dr. Maria Bellringer, Gareth Edwards, Krista Ferguson, Dr. John Stansfield, Mr Bruce Levi, Major Lynette Hutson

The above study has been given ethical approval by the **Multi-region** Ethics Committee.

Accreditation
The Committee involved in the approval of this study is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, April 2006.

Final Report
The study is approved until **July 2007** A final report is required at the end of the study and a form to assist with this is available from the Administrator. If the study will not be completed as advised, please forward a progress report and an application for extension of ethical approval one month before the above date. Report forms are available from the administrator.

Amendments
It is also a condition of approval that the Committee is advised of any adverse events, if the study does not commence, or the study is altered in any way, including all documentation eg advertisements, letters to prospective participants.

Please quote the above ethics committee reference number in all correspondence.

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

Yours sincerely

Sue Fish
Multi-Region Ethics Committee Administrator
Email: sue_fish@moh.govt.nz

Administered by the Ministry of Health | Approved by the Health Research Council | http://www.newhealth.govt.nz/ethicscommittees

APPENDIX 3
Survey questionnaire: Problem gambler (initial) - Helpline

Section A - Enablers

1) Why have you sought help now for your gambling problem?
    - If one factor is mentioned, prompt: Is there anything else?
2) As well as the things you've mentioned, were any of the following a concern for you in seeking help for gambling problems?

Unprompted Concern √	Prompted issue √	Prompted no issue √	Area
			a. Financial problems, for example, running out of money, increasing debt or being unable to pay bills
			b. Reaching a point where you felt like you could not go on
			c. Other emotional factors, for example having low mood or anxiety
			d. Wanting to prevent your gambling from becoming a major problem
			e. Pressure from your partner, family, whanau or friends
			f. Problems with your spouse or partner, for example they threatened to leave or did leave
			g. Problems with other family members, for example an argument about your gambling or conflict
			h. Concerns about the welfare of your children
			i. Isolation from family, whanau and friends
			j. Problems at work, for example difficulties with your employer or your colleagues, losing your job
			k. Legal problems, for example committing crimes, being arrested, facing prosecution
			l. You had problems in your living circumstances, for example housing problems
			m. The costs of gambling outweighed the reasons for continuing to gamble
			n. Your gambling was affecting your physical health
			o. The gambling venue intervened in your gambling, for example being barred or excluded

3) Is there anything else you would like to mention about what has motivated you to seek help for your gambling problem?
4) Of all the areas we've discussed, which is the single biggest factor that made you decide to get help?

Section B - Barriers

1) Did you find anything that got in the way or stopped you when you were seeking help? Yes/No
    - If yes, what was this? If one factor is mentioned, prompt: Is there anything else?
2) As well as the things you've mentioned, did any of the following get in the way of you seeking help for gambling problems?

Unprompted Barrier √	Prompted issue √	Prompted no issue √	Area
			a. You believed you didn't have a problem and didn't need help
			b. You wanted to resolve the problem on your own or were too proud to seek help
			c. You planned to get help but didn't get around to it
			d. You felt ashamed for yourself or family/whanau
			e. You only wanted help with your financial problems
			f. You were not aware that treatment was available
			g. You were not aware that problem gambling services were free
			h. You couldn't get the service at the time or place that you wanted it
			i. You didn't think the service would understand your language
			j. You didn't think the service would relate to your culture or community
			k. You didn't want to use a telephone service
			l. You didn't want to use a face-to-face service
			m. You didn't want to use an online service
			n. You thought problem gambling services would treat you like an addict or like you were mentally ill
			o. You thought that if you told someone at the service that your family, whanau and/or community would find out you had a gambling problem
			p. You had too many commitments to seek help, such as child care, work, community involvement
			q. You were too overwhelmed by your problems to seek help
			r. You were trying to address your other problems, such as mental health, alcohol/drug, social etc
			s. You did not have enough encouragement from friends, family, whanau or community to seek help
			t. You felt pressured by friends, family, whanau or community to continue gambling
			u. You have had bad experiences of seeking help for your gambling problems
			v. You have had bad experiences of seeking help for other problems (e.g. mental health, alcohol and drug, physical health, social)

3) Is there any thing else you would like to mention about what has got in the way or stopped you seeking help for your gambling problem?
4) Of the areas we've discussed, which is the single biggest factor that stopped you from seeking help?

Section C - Knowledge of Services

1) What sources of help do you know of for gambling problems?
2) How did you first become aware that this could be a source of help?
3) Which of the following services are you aware of (if not already mentioned)?
   a. Gambling Helpline Yes/No
   b. Online / Internet Based services Yes/No
   c. Problem Gambling Foundation Yes/No
   d. Salvation Army Oasis Centres Yes/No
   e. Gamblers Anonymous / GamAnon Yes/No

f. Self Help Yes/No
g. Other Specify

4) Are you aware that there are other services that are starting to offer information, help, and referral for gambling problems?
   a. General practitioners Yes/No
   b. Social and welfare services (e.g. budget advisors) Yes/No
   c. Alcohol and other drug services Yes/No
5) Are you aware that gambling venues can offer assistance, such as exclusion orders? Yes/No
6) Are you aware of alternative sources of help, for example a community or religious leader? Yes/No

---

Section D - Current and Previous Help Seeking

1) Are you currently getting formal help, such as helpline or face-to-face counselling, for gambling or related problems? Yes/No
   a. If yes, please specify what formal sources of help you are receiving
2) Are you currently getting informal help, such as from friends, family or in your community, for gambling or related problems? Yes/No
   a. If yes, please specify what informal sources of help you are receiving
3) How many times have you sought formal or informal help for gambling problems?
4) What was your motivation or reason to seek help previously?
5) Where have you sought help from in the past?
6) Did you obtain the help you sought?
7) How useful was the help you obtained?

Section E - Problem Gambling Severity Index

First of all I would like to ask you some questions about gambling and health. Most New Zealanders enjoy gambling but it can affect the health of some people.

1) Could you please tell me which gambling activities you have taken part in over the last 12 months? Prompt: Any others?
   a. Lotto (including Strike, Powerball and Big Wednesday)
   b. Keno (not in a casino)
   c. Instant Kiwi or other scratch ticket
   d. Housie (bingo) for money
   e. Horse or dog racing (excluding office sweepstakes)
   f. Sports betting at the TAB or with an overseas betting organisation
   g. Gaming machines or pokies at a casino
   h. Table games or any other games at a casino
   i. Gaming machines or pokies in a pub or club (not in a casino)
   j. Internet based gambling
   k. Other gambling activity. Specify……..
   l. None of the above

If none of the above: ask have you had problems because of someone else's gambling in the past 12 months? If No, thank participant for their time and close the interview

Some of the next questions may not apply to you but please try to be as accurate as possible.
Thinking about the past 12 months:
Answers: Never - Sometimes - Most of the Time - Almost Always

2) How often have you bet more than you could really afford to lose?

3) How often have you needed to gamble with larger amounts of money to get the same feeling of excitement?
4) How often have you gone back another day to try to win back the money you lost?
5) How often have you borrowed money or sold anything to get money to gamble?
6) How often have you felt that you might have a problem with gambling?
7) 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?
8) How often have you felt guilty about the way you gamble, or what happens when you gamble?
9) How often has your gambling caused you any health problems, including stress or anxiety?
10) How often has your gambling caused any financial problems for you or your household?

Section F - Demographics

1) Age group (years)
    a. <20
    b. 20-24
    c. 25-29
    d. 30-34
    e. 35-39
    f. 40-44
    g. 45-49
    h. 50-54
    i. 55-59
    j. 60-64
    k. 65 and over
2) Ethnicity (allow multiple responses)
    a. New Zealand European/Pakeha
    b. Maori
    c. Pacific
    d. Asian
    e. Other

    If Maori, Pacific Island or Asian ethnicity identify, ask: Were you aware that there are Maori / Pacific Island / Asian specific problem gambling services available?
3) Were you born in New Zealand? If no, ask for birth country and year of arrival
4) Which town or city do you live in?
5) Would you describe where you live as a rural or urban area?
6) Gender
7) Marital Status
    a. Single
    b. Married/de facto partner
    c. Separated/divorced
8) Occupation - please specify

APPENDIX 4
Survey questionnaire: Problem gambler (follow-up) - Helpline

1) Since we last spoke with you about 3 months ago, have you used any services to get help for gambling problems?

    a. If Yes:

        i. Which ones?

        For each service mentioned
        Overall, how satisfied were you with the service offered?
        1 (very dissatisfied) – 2 (somewhat dissatisfied) – 3 (neutral) – 4 (somewhat satisfied) – 5 (very satisfied)

        ii. What are/were the good aspects of using this service?
        iii. Is there anything that could have been done to make this service better for you?
        iv. Has using services helped you achieve the outcome you wanted?
        v. What was the outcome you wanted?

    b. If No:

        i. What are the any reasons why you didn't use services?
        ii. Is there anything that could have been done to have encouraged or helped you to use services?

2) Was there any service you would like to have used but weren't able to? If yes, why was this?

APPENDIX 5
Survey questionnaire: Problem gambler - Face-to-face services

Section A - Enablers

1) Firstly, could you talk about the reasons that you have sought help now for your gambling problem? (Prompts - are there any others?)
2) Some of the reasons that other people give for seeking help for gambling problems are around reaching a point where they can't go on, or feelings of depression or anxiety. Do these feel like part of your experience?
3) People also seek help when they're gambling because they want to prevent it becoming a bigger problem - was this the case for you?
4) Did you feel that your family/whanau pressured you into seeking help or that there were other family problems that made you want to seek help?
5) Were there any practical issues that led you to seek help, such as financial, employment or housing problems?
6) Were you ever barred from a gambling venue or faced legal problems such as being arrested or prosecuted?
7) Is there anything else you would like to mention about what has motivated you to seek help for your gambling problem?
8) From the things we've discussed about why you've sought help now for your gambling problems, which is the single biggest factor?

Section B - Barriers

1) While you were seeking help, did you find anything that got in the way or stopped you from getting help? (Prompts - are there any others?)
2) For some people they often believe that the problem doesn't exist or that they don't need help as they can resolve the problem on their own. Can you relate to this feeling?
3) People also tell us that they plan to get help, but for whatever reason don't get round to it - was this the case for you?
4) Financial problems can often be the first sign of a gambling problem, and initially people only want help with their finances - does this apply to your experience?
5) People often feel ashamed for themselves or their family about their gambling problems or about having to seek help - was this the case for you?
6) A big part of seeking help is knowing that there is help out there - what did you know about services that could help you with your gambling when you decided to seek help? (Prompts: availability, time and place, modality (telephone, face-to-face, online))
7) How important was it for you to go to a service that understood your language and could relate to your culture? Did the idea of going to service that couldn't speak your language or relate to your culture put you off seeking help?
8) Sometimes people don't know how services will treat them and people with gambling problems can feel that they will be treated as an addict or someone with a mental illness. Did you think this would happen to you?
9) Before you got to a service were you concerned that by telling the counsellor about your gambling problems your family/whanau and community would find out all about it?
10) For many people, gambling is only one area of concern and having several problems at one time can overwhelm a person seeking help - was this the case for you? Some people also address their problems one at a time - of the problems you've mentioned, did you attempt to resolve these before seeking help for gambling?
11) Families/whanau can be really helpful for those seeking help - did you feel supported enough to seek help? Did you ever feel pressured to continue gambling by someone in your family/whanau?

12) If this is not the first time you've sought help, have you had any bad experiences of seeking help for gambling or any other issue that got in the way of you seeking help this time?
13) Is there anything else you would like to mention about what has got in the way or stopped you seeking help for your gambling problem?
14) From the things we've discussed about things that got in the way when you were seeking help, which is the single biggest factor?

Section C - Knowledge of Services

1) Including the service you're with now, what sources of help do you know of for gambling problems?
2) How did you become aware that these could be a source of help?
3) Which of the following services are you aware of (if not already mentioned):
    a. Gambling Helpline
    b. Online / Internet Based services
    c. Problem Gambling Foundation
    d. Salvation Army Oasis Centres
    e. Gamblers Anonymous / GamAnon
    f. Self Help
    g. Other
4) Are you aware that there are other services that are starting to offer information, help, and referral for gambling problems?
    a. General practitioners
    b. Social and welfare services (e.g. budget advisors)
    c. Alcohol and other drug services
5) Are you aware that gambling venues can offer assistance, such as exclusion orders?
6) Are you aware of alternative sources of help, for example a community or religious leader?
7) Are you aware that there are Maori / Pacific Island / Asian specific problem gambling services available? How did this knowledge impact on your help-seeking?

Section D - Current and Previous Help-Seeking

1) Are you currently receiving any other kind of formal help for gambling problems?
2) Do you get any informal help for gambling problems, such as from friends, family or your community?
3) Looking back, how many times have you sought both formal and informal help?
4) What was your motivation or reason to seek help previously?
5) Where have you sought help from in the past?
6) Can you describe what is different for you each time you seek help?
7) Did you obtain the help you sought?
8) How useful was the help you obtained?

Section E - Problem Gambling Severity Index

First of all I would like to ask you some questions about gambling and health. Most New Zealanders enjoy gambling but it can affect the health of some people.

1) Could you please tell me which gambling activities you have taken part in over the last 12 months? Prompt: Any others?
    a. Lotto (including Strike, Powerball and Big Wednesday)
    b. Keno (not in a casino)
    c. Instant Kiwi or other scratch ticket
    d. Housie (bingo) for money

e. Horse or dog racing (excluding office sweepstakes)
f. Sports betting at the TAB or with an overseas betting organisation
g. Gaming machines or pokies at a casino
h. Table games or any other games at a casino
i. Gaming machines or pokies in a pub or club (not in a casino)
j. Internet based gambling
k. Other gambling activity. Specify……..
l. None of the above

Some of the next questions may not apply to you but please try to be as accurate as possible. Thinking about the past 12 months:
Answers: Never - Sometimes - Most of the Time - Almost Always

2) How often have you bet more than you could really afford to lose?
3) How often have you needed to gamble with larger amounts of money to get the same feeling of excitement?
4) How often have you gone back another day to try to win back the money you lost?
5) How often have you borrowed money or sold anything to get money to gamble?
6) How often have you felt that you might have a problem with gambling?
7) 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?
8) How often have you felt guilty about the way you gamble, or what happens when you gamble?
9) How often has your gambling caused you any health problems, including stress or anxiety?
10) How often has your gambling caused any financial problems for you or your household?

Section F - Demographics

1) Age group (years)
   a. <20
   b. 20-24
   c. 25-29
   d. 30-34
   e. 35-39
   f. 40-44
   g. 45-49
   h. 50-54
   i. 55-59
   j. 60-64
   k. 65 and over
2) Ethnicity (allow multiple responses)
   a. New Zealand European/Pakeha
   b. Maori
   c. Pacific
   d. Asian
   e. Other
3) Were you born in New Zealand? If no, ask for birth country and year of arrival
4) Which town or city do you live in? [Coding to be based on MoH Service User Statistics Report]
5) Would you describe where you live as a rural or urban area?
6) Gender
7) Marital Status
   a. Single

b. Married/de facto partner
c. Separated/divorced

8) Occupation – please specify

APPENDIX 6
Survey questionnaire: Family/whanau (initial) - Helpline

Section A - Enablers

1) When you rang the helpline were you looking for help for yourself, a family/whanau member or friend with gambling problems?
    a. Self, and/or
    b. Family/Whanau/Friend
2) Why have you sought help now for yourself and/or family/whanau member or friend who has gambling problems? (If one factor is mentioned, prompt: Is there anything else?)
3) As well as the things you've mentioned, which of the following is a concern for you in seeking help for yourself and/or family/whanau member or friend with gambling problems?

Unprompted Concern √	**Prompted issue** √	**Prompted no issue** √	**Area**
			Financial problems, for example, running out of money, increasing debt or being unable to pay bills
			Reaching a point where you felt like you could not go on
			Other emotional factors, for example having low mood or anxiety
			Wanting to prevent the gambling from becoming a major problem
			Problems with your spouse or partner, for example you have threatened to leave or did leave
			Problems with other family members, for example arguments about gambling or other conflicts
			Concerns about the welfare of your children
			Isolation from family, whanau and friends
			Legal problems, for example crimes committed, people being arrested, facing prosecution
			You had problems in your living circumstances, for example housing problems
			The gambling is affecting your physical health

4) Is there any thing else you would like to mention about what has motivated you to seek help for yourself/family member?
5) Of all the areas we've discussed, which is the single biggest factor that made you decide to get help?

Section B - Barriers

1) Did you find anything that got in the way or stopped you when you were seeking help? Yes/No
    a. If yes, what was this? (If one factor is mentioned, prompt: Is there anything else?)
2) As well as the things you've mentioned, which of the following got in the way of you seeking help for yourself and/or a family/whanau member or friend?

Unprompted Barrier √	Prompted issue √	Prompted no issue √	Area
			You were not aware that problem gambling services were available
			You were not aware that problem gambling services were available for the family and friends of problem gamblers
			You were not sure if your family member/friend had a gambling problem
			You planned to get help but didn't get around to it
			You were not aware that problem gambling services were free
			You couldn't get the service at the time or place that you wanted it
			You didn't think the service would understand your language
			You didn't think the service would relate to your culture or community
			You didn't want to use a telephone service
			You didn't want to use a face-to-face service
			You didn't want to use an online service
			You thought problem gambling services would treat your family/ whanau member or friend like an addict or like they were mentally ill
			You thought that if you told someone at the service that your family, whanau and/or community would find out your family/whanau member had a problem
			You had too many commitments to seek help, such as child care, work, community involvement
			You did not have enough support from friends, family, whanau or community to seek help
			You have had bad experiences of seeking help for other problems in the past

3) Is there any thing else you would like to mention about what has got in the way or stopped you seeking help for yourself/family member?
4) Of the areas we've discussed, which is the single biggest factor that stopped you from seeking help?

Section C - Knowledge of Services

1) What sources of help do you know of for gambling problems?
2) How did you first become aware that this could be a source of help?
3) Which of the following services are you aware of (if not already mentioned)?
    a. Gambling Helpline Yes/No
    b. Online / Internet Based services Yes/No
    c. Problem Gambling Foundation Yes/No
    d. Salvation Army Oasis Centres Yes/No
    e. Gamblers Anonymous / GamAnon Yes/No
    f. Self Help Yes/No
    g. Other Specify
4) Are you aware that they are other services that are starting to offer information, help, and referral for gambling problems?
    a. General practitioners Yes/No
    b. Social and welfare services (e.g. budget advisors) Yes/No
    c. Alcohol and other drug services Yes/No

5) Are you aware that gambling venues can offer assistance, such as exclusion orders? Yes/No
6) Are you aware of alternative sources of help, for example a community or religious leader? Yes/No

---

Section D - Current and Previous Help Seeking

1) Are you currently getting formal help, such as helpline or face-to-face counselling, for gambling or related problems? Yes/No
    a. If yes, please specify what formal sources of help you are receiving
2) Are you currently getting informal help, such as from friends, family or in your community, for gambling or related problems? Yes/No
    a. If yes, please specify what informal sources of help you are receiving
3) How many times have you sought formal or informal help for gambling problems?
4) What was your motivation or reason to seek help previously?
5) Where have you sought help from in the past?
6) Did you obtain the help you sought?
7) How useful was the help you obtained?

Section E - Demographics

1) Age group (Years)
    a. <20
    b. 20-24
    c. 25-29
    d. 30-34
    e. 35-39
    f. 40-44
    g. 45-49
    h. 50-54
    i. 55-59
    j. 60-64
    k. 65 and over
2) Ethnicity (allow multiple responses)
    a. New Zealand European/Pakeha
    b. Maori
    c. Pacific
    d. Asian
    e. Other
3) If Maori, Pacific Island or Asian ethnicity identify, ask: Were you aware that there are Maori / Pacific Island / Asian specific problem gambling services available?
4) Were you born in New Zealand? If no, ask for birth country and year of arrival
5) Which town or city do you live in?
6) Would you describe where you live as a rural or urban area?
7) Gender
8) Marital Status
    a. Single
    b. Married/de facto partner
    c. Separated/divorced
9) Occupation – please specify

APPENDIX 7
Survey questionnaire: Family/whanau (follow-up) - Helpline

1. Since we last spoke with you about 3 months ago, have you used any services to get help for yourself as a family/whanau member or friend of someone who has gambling problems?

    a. If Yes:

        i. Which ones?

For each service mentioned
Overall, how satisfied were you with the service offered?
1 (very dissatisfied) – 2 (somewhat dissatisfied) – 3 (neutral) – 4 (somewhat satisfied) – 5 (very satisfied)

        ii. What are/were the good aspects of using this service?
        iii. Is there anything that could have been done to make this service better for you?
        iv. Has using services helped you achieve the outcome you wanted?
        v. What was the outcome you wanted?

    b. If No:

        i. What are the any reasons why you didn't use services?
        ii. Is there anything that could have been done to have encouraged or helped you to use services?

2. Was there any service you would like to have used but weren't able to? If yes, why was this?
3. Have you used any of the help you got from services with the problem gambler in your family/whanau?
    a. If yes: What have you used and in what way?
    b. If no: Is there any reason for this?

APPENDIX 8
Survey questionnaire: Family/whanau - Face-to-face services

Section A - Enablers

1) Firstly, could you talk about the reasons you contacted the problem gambling service? (Prompts: For self or family/whanau member? Both? Any others?)
2) Some of the reasons that other people give for seeking help for someone else's gambling problems are around reaching a point where they can't go on or feelings of depression or anxiety. Do these feel like part of your experience?
3) People also seek help when to prevent the gambling from becoming a bigger problem - was this the case for you?
4) Were there any practical issues that led you to seek help, such as financial, legal, employment or housing problems?
5) What were some of the family/whanau issues around the other person's problem gambling that have led you to seek help? (Prompts: leaving spouse, arguments or conflict, children)
6) Is there any thing else you would like to mention about what has motivated you to seek help for your gambling problem?
7) Of the areas we've discussed, which is the single biggest factor that made you seek help now?

Section B - Barriers

1) While you were seeking help, did you find anything that got in the way or stopped you from getting help? (Prompts - are there any others?)
2) A big part of seeking help is knowing that there is help out there - what did you know about services that could help you with your gambling when you decided to seek help? (Prompts: availability, time and place, modality (telephone, face-to-face, online))
3) People also tell us that they plan to get help, but for whatever reason don't get round to it - was this the case for you?
4) How important was it for you to go to a service that understood your language and could relate to your culture or community? Did the idea of going to a service that couldn't speak your language or relate to your culture or community put you off seeking help?
5) Before you got to a service were you concerned that by telling the counsellor about your family member's gambling problems that your family/whanau and community would find out all about it?
6) If this is not the first time you've sought help, have you had any bad experiences of seeking help for gambling or any other issue that got in the way of you seeking help this time?
7) Is there any thing else you would like to mention about what has got in the way or stopped you seeking help for your gambling problem?
8) Of the areas we've discussed, which is the single biggest factor that stopped you from seeking help?

Section C - Knowledge of Services

1) Including the service you're with now, what sources of help do you know of for gambling problems?
2) How did you become aware that these could be a source of help?
3) Which of the following services are you aware of (if not already mentioned):
    a. Gambling Helpline
    b. Online / Internet Based services

c. Problem Gambling Foundation
d. Salvation Army Oasis Centres
e. Gamblers Anonymous / GamAnon
f. Self Help
g. Other

4) Are you aware that they are other services that are starting to offer information, help, and referral for gambling problems?
    a. General practitioners
    b. Social and welfare services (e.g. budget advisors)
    c. Alcohol and other drug services
5) Are you aware that gambling venues can offer assistance, such as exclusion orders?
6) Are you aware of alternative sources of help, for example a community or religious leader?
7) Are you aware that there are Maori / Pacific Island / Asian specific problem gambling services available? How did this knowledge impact on your help seeking?

Section D - Current and Previous Help-Seeking

1) Are you currently getting formal help, such as helpline or face-to-face counselling, for gambling or related problems? Yes/No
    a. If yes, please specify what formal sources of help you are receiving
2) Are you currently getting informal help, such as from friends, family or in your community, for gambling or related problems? Yes/No
    a. If yes, please specify what informal sources of help you are receiving
3) Looking back, how many times have you sought help because of someone else's gambling?
4) What was your motivation or reason to seek help previously?
5) Where have you sought help from in the past?
6) Can you describe what is different for you each time you seek help?
7) Have you ever sought help for your own gambling?
8) Did you obtain the help you sought?
9) How useful was the help you obtained?

Section E - Demographics

1) Age group (years)
    a. <20
    b. 20-24
    c. 25-29
    d. 30-34
    e. 35-39
    f. 40-44
    g. 45-49
    h. 50-54
    i. 55-59
    j. 60-64
    k. 65 and over
2) Ethnicity (allow multiple responses)
    a. New Zealand European/Pakeha
    b. Maori
    c. Pacific
    d. Asian
    e. Other
3) Were you born in New Zealand? If no, ask for birth country and year of arrival

4) Which town or city do you live in?
5) Would you describe where you live as a rural or urban area?
6) Gender
7) Marital Status
    a. Single
    b. Married/de facto partner
    c. Separated/divorced
8) Occupation - please specify

APPENDIX 9
Survey questionnaire: General population

Section A - Enablers

As we explained earlier, many people do not seek help for gambling problems they may experience. For those who do seek help, it is often sparked by a range of life events.

1) Why do you think people would seek help for gambling problems? Unprompted open answers and tick off from list

Unprompted √	Prompted issue √	Prompted no issue √	Area
			Financial problems, for example, running out of money, increasing debt or being unable to pay bills
			Reaching a point where the person felt like they couldn't go on
			Other emotional factors, for example having low mood or anxiety
			Wanting to prevent the gambling from becoming a major problem
			Pressure from partner, family, whanau or friends
			Problems with spouse or partner, for example threatening to leave or did leave
			Problems with other family members, for example an argument about gambling or conflict
			Concerns about the welfare of the children
			Isolation from family, whanau and friends
			Problems at work, for example difficulties with employer or colleagues, losing a job
			Legal problems, for example committing crimes, being arrested, facing prosecution
			Problems in living circumstances, for example housing problems
			The costs of gambling outweighed the reasons for continuing to gamble
			The gambling was affecting physical health
			The gambling venue intervened in the gambling, for example being barred or excluded
			Others: please specify

2) Which of the areas you have just mentioned do you think would be the single biggest factor to make someone decide to seek help for a gambling problem?

Section B - Barriers

1) Some people find difficulties in getting help - what do you think would get in the way when somebody is seeking help? Unprompted Open Answers and tick off from list

Unprompted √	Prompted issue √	Prompted no issue √	Area
			Believing there wasn't a problem and not needing help
			Wanting to resolve the problem alone or being too proud to seek help
			Planning to get help but not getting round to it
			Feeling ashamed for themselves or family/whanau
			Only wanting help with financial problems
			Not being aware that treatment was available
			Not being able to get the service at the time or place that they wanted it
			Not thinking the service would understand their language
			Not thinking the service would relate to their culture
			Not wanting to use a telephone service
			Not wanting to use a face-to-face service
			Not wanting to use an online service
			Thinking that problem gambling services would treat them like an addict or like they were mentally ill
			Thinking that if they told someone at the service that their family, whanau and/or community would find out they had a gambling problem
			Having too many commitments to seek help, such as child care, work, community involvement
			Being too overwhelmed by their problems to seek help
			Trying to address other problems, such as mental health, alcohol/drug, social etc
			Not having enough encouragement from friends, family, whanau or community to seek help
			Feeling pressured by friends, family, whanau or community to continue gambling
			Having had bad experiences of seeking help for their gambling problems
			Having had bad experiences of seeking help for other problems (e.g. mental health, alcohol and drug, physical health, social)
			Others: please specify

2) Which of the areas you have just mentioned do you think would be the single biggest factor that might stop someone from seeking help for their gambling problems?

Section C - Knowledge of Services

1) What sources of help do you know of for gambling problems?
2) How did you first become aware that this could be a source of help?
3) Which of the following services are you aware of (if not already mentioned)?
    a. Gambling Helpline Yes/No
    b. Online / Internet Based services Yes/No
    c. Problem Gambling Foundation Yes/No
    d. Salvation Army Oasis Centres Yes/No
    e. Gamblers Anonymous / GamAnon Yes/No
    f. Self Help Yes/No
    g. Other Specify
4) Are you aware that there are other services that are starting to offer information, help, and referral for gambling problems?
    a. General practitioners Yes/No

b. Social and welfare services (e.g. budget advisors) Yes/No
c. Alcohol and other drug services Yes/No

5) Are you aware that gambling venues can offer assistance, such as exclusion orders? Yes/No
6) Are you aware of alternative sources of help, for example a community or religious leader? Yes/No

---

Section D - Current and Previous Help Seeking

1) Are you currently getting formal help, such as helpline or face-to-face counselling, for gambling or related problems? Yes/No
    a. If yes, please specify what formal sources of help you are receiving
2) Are you currently getting informal help, such as from friends, family or in your community, for gambling or related problems? Yes/No
    a. If yes, please specify what informal sources of help you are receiving
3) Have you ever sought help for gambling problems?
    a. If yes:
        i. How many times have you sought help for gambling problems?
        ii. What was your motivation or reason to seek help previously?
        iii. Where have you sought help from in the past?
        iv. Did you obtain the help you sought?
        v. How useful was the help you obtained?

    b. If no:
        i. Have you ever thought about seeking help for gambling problems?
            1. If yes:
                a. What led you to start thinking about seeking help?
                b. What stopped you from seeking help?
            2. If no:
                a. Is there any reason why not?

Section E - Problem Gambling Severity Index

First of all I would like to ask you some questions about gambling and health. Most New Zealanders enjoy gambling but it can affect the health of some people.

1) Could you please tell me which gambling activities you have taken part in over the last 12 months? Prompt: Any others?
    a. Lotto (including Strike, Powerball and Big Wednesday)
    b. Keno (not in a casino)
    c. Instant Kiwi or other scratch ticket
    d. Housie (bingo) for money
    e. Horse or dog racing (excluding office sweepstakes)
    f. Sports betting at the TAB or with an overseas betting organisation
    g. Gaming machines or pokies at a casino
    h. Table games or any other games at a casino
    i. Gaming machines or pokies in a pub or club (not in a casino)
    j. Internet based gambling
    k. Other gambling activity. Specify……..
    l. None of the above

If none of the above: ask have you had problems because of someone else's gambling in the past 12 months?
If No, thank participant for their time and close the interview

Some of the next questions may not apply to you but please try to be as accurate as possible. Thinking about the past 12 months: [Never - Sometimes - Most of the Time - Almost Always]

2) How often have you bet more than you could really afford to lose?
3) How often have you needed to gamble with larger amounts of money to get the same feeling of excitement?
4) How often have you gone back another day to try to win back the money you lost?
5) How often have you borrowed money or sold anything to get money to gamble?
6) How often have you felt that you might have a problem with gambling?
7) 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?
8) How often have you felt guilty about the way you gamble, or what happens when you gamble?
9) How often has your gambling caused you any health problems, including stress or anxiety?
10) How often has your gambling caused any financial problems for you or your household?

Section F - Demographics

1) Age group (years)
    a. <20
    b. 20-24
    c. 25-29
    d. 30-34
    e. 35-39
    f. 40-44
    g. 45-49
    h. 50-54
    i. 55-59
    j. 60-64
    k. 65 and over
2) Ethnicity (allow multiple responses)
    a. New Zealand European/Pakeha
    b. Maori
    c. Pacific
    d. Asian
    e. Other
3) If Maori, Pacific Island or Asian ethnicity identify, ask: Were you aware that there are Maori / Pacific Island / Asian specific problem gambling services available?
4) Were you born in New Zealand? If no, ask for birth country and year of arrival
5) Which town or city do you live in?
6) Would you describe where you live as a rural or urban area?
7) Gender
8) Marital Status
    a. Single
    b. Married/de facto partner
    c. Separated/divorced
9) Occupation - please specify

APPENDIX 10
Example of advertisement

Gambling Research - Can U help?

The Gambling Research Centre at AUT University is currently carrying out research on people's experiences when they are, or are not, looking for help for gambling problems.

Why do people look for help for gambling problems? And what gets in the way of them looking for help?

If you are a gambler and would like to help us with this research project, we'd be pleased if you would complete a short telephone survey or a short on-line internet survey. The surveys should not take up more than 10 to 15 minutes of your time.

To access the internet survey, go to the Gambling Research Centre webpage at:
www.aut-grc.ac.nz

To take part in the telephone survey, please contact Jeremy Williams on:
09 917 9999 extn 7346

APPENDIX 11
Enablers to help-seeking: Between-group differences

Table 21 Rank/percent endorsing each specified enabler as factor in decision to seek help (helpline sample)

Response Option	Gender		Age (years)		Ethnicity		Employed	
	Male	Female	<40	40+	NZ Euro	Maori	Yes	No
	n=56	n=61	n=52	n=64	n=73	n=31	n=74	n=43
Financial problems	**1 82%**	**1 82%**	**1 85%**	**1 80%**	**1 82%**	**1 90%**	**1 84%**	**4 79%**
Reaching a point where you felt like you could not go on	6 64%	**5 53%**	**5 52%**	**5 64%**	**5 66%**	8 45%	**5= 53%**	**5 67%**
Other emotional factors	**2= 75%**	**2= 79%**	**3 77%**	**2= 77%**	**2 77%**	**3 81%**	**3 70%**	**1 88%**
Wanting to prevent your gambling from becoming a major problem	**2= 75%**	**2= 79%**	**2 79%**	**4 75%**	**3 74%**	**2 84%**	**2 72%**	**2 86%**
Pressure from your partner, family or friends	10= 32%	8 34%	8 39%	9 30%	9 32%	9= 32%	8= 32%	11 35%
Problems with your spouse or partner	8= 38%	9= 26%	9= 37%	10= 28%	10= 29%	9= 32%	8= 32%	12= 30%
Problems with other family members	12= 30%	13 23%	13 21%	8 31%	12 26%	13 23%	13= 18%	9 42%
Concerns about the welfare of your children	10= 32%	9= 26%	9= 37%	13 23%	13 23%	**5= 55%**	11 24%	10 37%
Isolation from family and friends	8= 38%	12 25%	11 35%	10= 28%	8 36%	9= 32%	13= 18%	8 54%
Problems at work	15 20%	14 16%	14 19%	15 17%	15 16%	14= 16%	12 19%	15 16%
Legal problems	12= 30%	9= 26%	12 29%	10= 28%	10= 29%	9= 32%	10 27%	12= 30%
Problems in your living circumstances	7 39%	6 49%	7 44%	7 44%	7 44%	7 48%	7 35%	7 61%
The costs of gambling outweighed the reasons for continuing to gamble	**2= 75%**	**4 69%**	**4 65%**	**2= 77%**	**4 67%**	**4 77%**	**4 66%**	**3 81%**
Gambling was affecting your physical health	**5 68%**	7 48%	6 50%	6 63%	6 58%	**5= 55%**	**5= 53%**	6 65%
The gambling venue intervened in your gambling	14 21%	15 10%	15 12%	14 19%	14 19%	14= 16%	15 11%	14 23%

Table 21 continued

Response Option	Current Partner		Locality		Problem Gambler		New Zealand Born	
	Yes n=54	No n=62	Rural n=21	Urban n=81	Yes n=103	No n=22	Yes n=96	No n=20
Financial problems	**1 76%**	**1 87%**	**3 81%**	**1 84%**	**1 85%**	**2 64%**	**1 84%**	**4 75%**
Reaching a point where you felt like you could not go on	6 52%	**5 63%**	8= 43%	**5 63%**	**5 61%**	**5= 41%**	**5 57%**	**5= 65%**
Other emotional factors	**2= 72%**	**2= 81%**	**1= 86%**	**3 75%**	**2= 78%**	**1 73%**	**2 76%**	**3 80%**
Wanting to prevent your gambling from becoming a major problem	**2= 72%**	**2= 81%**	**1= 86%**	**2 77%**	**2= 78%**	**2= 64%**	**3 74%**	**1 90%**
Pressure from your partner, family or friends	8 41%	12 27%	10= 33%	8 35%	8= 35%	5= 41%	8 32%	8= 40%
Problems with your spouse or partner	7 43%	13 23%	10= 33%	10 31%	8= 35%	10= 23%	12 27%	8= 40%
Problems with other family members	12 20%	9= 31%	8= 43%	13 22%	13 27%	14 18%	13 22%	7 50%
Concerns about the welfare of your children	11 26%	9= 31%	10= 33%	12 28%	11 31%	10= 23%	11 28%	9= 35%
Isolation from family and friends	10 30%	9= 31%	7 48%	11 30%	10 34%	10= 23%	9 31%	10= 30%
Problems at work	14 17%	14 19%	15 5%	14 19%	14 18%	10= 23%	14 15%	9= 35%
Legal problems	13 19%	8 36%	13= 19%	9 33%	12 29%	8= 27%	10 29%	11= 25%
Problems in your living circumstances	9 39%	7 48%	6 52%	7 44%	7 48%	8= 27%	7 43%	6 55%
The costs of gambling outweighed the reasons for continuing to gamble	**2= 72%**	**4 73%**	**4 76%**	**4 70%**	**4 73%**	**4 59%**	**4 68%**	**2 85%**
Gambling was affecting your physical health	**5 57%**	6 57%	**5 62%**	6 56%	6 58%	7 36%	6 55%	**5= 65%**
The gambling venue intervened in your gambling	15 15%	15 15%	13= 19%	15 17%	15 16%	15 14%	15 14%	11= 25%

Table 22 Rank/percent endorsing each specified enabler as primary reason to seek help (helpline sample)

Response Option	Gender		Age (years)		Ethnicity		Employed	
	Male	Female	<40	40+	NZ Euro	Maori	Yes	No
	n=56	n=61	n=52	n=64	n=73	n=31	n=74	n=43
Financial problems	**1 45%**	**1 25%**	**1 31%**	**1 38%**	**1 38%**	**1 32%**	**1 39%**	**1 26%**
Reaching a point where you felt like you could not go on	6= 4%	7= 3%	- 0%	**3= 6%**	5= 4%	- 0%	9= 1%	5= 7%
Other emotional factors	**3= 5%**	**3= 8%**	4= 8%	**3= 6%**	**3= 7%**	5= 6%	6= 3%	**2 14%**
Wanting to prevent your gambling from becoming a major problem	6= 4%	**2 13%**	**3 10%**	**3= 6%**	8= 3%	**2= 10%**	**3 10%**	5= 7%
Pressure from your partner, family or friends	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Problems with your spouse or partner	**2 16%**	5 7%	**2 12%**	**2 11%**	**2 11%**	**2= 10%**	**2 11%**	**3 12%**
Problems with other family members	9= 2%	7= 3%	- 0%	6= 5%	5= 4%	8= 3%	5 4%	- 0%
Concerns about the welfare of your children	**3= 5%**	7= 3%	7 6%	8= 3%	5= 4%	5= 6%	6= 3%	5= 7%
Isolation from family and friends	**3= 5%**	10= 2%	4= 8%	- 0%	8= 3%	8= 3%	- 0%	4 9%
Problems at work	- 0%	6 5%	9= 2%	8= 3%	- 0%	**2= 10%**	9= 1%	8 5%
Legal problems	- 0%	10= 2%	9= 2%	- 0%	- 0%	- 0%	9= 1%	- 0%
Problems in your living circumstances	9= 2%	- 0%	9= 2%	- 0%	11 1%	- 0%	- 0%	9= 2%
The costs of gambling outweighed the reasons for continuing to gamble	6= 4%	**3= 8%**	4= 8%	6= 5%	**3= 7%**	5= 6%	4 8%	9= 2%
Gambling was affecting your physical health	- 0%	7= 3%	8 4%	- 0%	8= 3%	- 0%	6= 3%	- 0%
The gambling venue intervened in your gambling	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%

Table 22 continued

Response Option	Current Partner		Locality		Problem Gambler		New Zealand Born	
	Yes n=54	No n=62	Rural n=21	Urban n=81	Yes n=103	No n=22	Yes n=96	No n=20
Financial problems	**1 29%**	**1 40%**	**1 43%**	**1 32%**	**1 36%**	**1 32%**	**1 33%**	**1 40%**
Reaching a point where you felt like you could not go on	8= 2%	6= 3%	- 0%	9 3%	7= 3%	6= 5%	6= 2%	**2= 10%**
Other emotional factors	5= 4%	**2 10%**	5= 5%	**3 9%**	**3= 8%**	6= 5%	4= 7%	3= 5%
Wanting to prevent your gambling from becoming a major problem	**3= 9%**	**3= 8%**	**2= 10%**	4 7%	**3= 8%**	**3= 9%**	**3 8%**	3= 5%
Pressure from your partner, family or friends	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	5= 3%	- 0%
Problems with your spouse or partner	**2 15%**	**3= 8%**	**2= 10%**	**2 13%**	**2 12%**	**3= 9%**	**2 13%**	3= 5%
Problems with other family members	5= 4%	11= 2%	- 0%	7= 4%	11= 1%	**2 14%**	- 0%	- 0%
Concerns about the welfare of your children	8= 2%	5 7%	- 0%	6 5%	7= 3%	**3= 9%**	5= 3%	**2= 10%**
Isolation from family and friends	5= 4%	6= 3%	5= 5%	7= 4%	6 4%	- 0%	5= 3%	3= 5%
Problems at work	8= 2%	6= 3%	5= 5%	10= 1%	7= 3%	- 0%	5= 3%	- 0%
Legal problems	8= 2%	- 0%	- 0%	10= 1%	11= 1%	- 0%	7= 1%	- 0%
Problems in your living circumstances	- 0%	11= 2%	- 0%	10= 1%	- 0%	6= 5%	7= 1%	- 0%
The costs of gambling outweighed the reasons for continuing to gamble	**3= 9%**	6= 3%	**2= 10%**	5 6%	5 7%	6= 5%	4= 7%	- 0%
Gambling was affecting your physical health	- 0%	6= 3%	5= 5%	10= 1%	10 2%	- 0%	6= 2%	- 0%
The gambling venue intervened in your gambling	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%

Table 23 Rank/percent endorsing each specified enabler as factor in decision to seek help (general population sample)

Response Option	Gender		Age (years)		Ethnicity		Employed	
	Male	Female	<40	40+	NZ Euro	Maori	Yes	No
	n=56	n=43	n=53	n=46	n= 55	n= 22	n=65	n=38
Financial problems	**1 86%**	**1 95%**	**1 87%**	**1 94%**	**1 96%**	**1 100%**	**1 94%**	**=1 84%**
Reaching a point where they felt like they could not go on	**5 75%**	**=3 79%**	**=5 77%**	**=3 76%**	**4 78%**	**2 95%**	**5 77%**	**=4 76%**
Other emotional factors	11 66%	=6 74%	11 72%	=7 67%	=8 73%	**=5 86%**	=6 75%	12 61%
Wanting to prevent the gambling from becoming a major problem	**4 79%**	=10 70%	=9 74%	**=3 76%**	11 71%	**=5 86%**	**4 80%**	=8 66%
Pressure from partner, family or friends	**3 82%**	**=3 79%**	**2 85%**	**=3 76%**	**3 85%**	=8 82%	**3 82%**	**3 79%**
Problems with spouse or partner	**2 84%**	**2 81%**	**4 81%**	**2 84%**	**2 91%**	**=3 91%**	**2 83%**	**=1 84%**
Problems with other family members	=8 68%	**5 77%**	**=5 77%**	=9 65%	=6 75%	**=5 86%**	11 71%	**=4 76%**
Concerns about the welfare of their children	=8 68%	=6 74%	=7 76%	=9 65%	=8 73%	13 77%	=9 72%	7 68%
Isolation from family and friends	13 63%	14 65%	13 66%	11 61%	=12 69%	=8 82%	=12 69%	14 55%
Problems at work	12 64%	=10 70%	=9 74%	=12 59%	=12 69%	=8 82%	=12 69%	=10 63%
Legal problems	6 73%	=10 70%	**3 83%**	=12 59%	=6 75%	=8 82%	=9 72%	6 71%
Problems in living circumstances	7 71%	=8 72%	=7 76%	=7 67%	**5 76%**	**=3 91%**	=6 75%	=8 66%
The costs of gambling outweighed the reasons for continuing to gamble	=8 68%	=8 72%	12 70%	6 70%	=8 73%	=8 82%	8 74%	=10 63%
The gambling was affecting physical health	14 52%	13 67%	14 59%	=12 59%	14 67%	14 68%	14 60%	13 58%
The gambling venue intervened in the gambling	15 39%	15 47%	15 49%	15 35%	15 38%	15 48%	15 46%	15 40%

Table 23 continued

Response Option	Current Partner		Locality		Problem Gambler		New Zealand Born	
	Yes n=54	No n=45	Rural n=13	Urban n=85	Yes n=35	No n=69	Yes n=68	No n=31
Financial problems	**1 89%**	=14 42%	**=2 92%**	**1 89%**	**1 83%**	**1 94%**	**1 100%**	**3= 68%**
Reaching a point where you felt like you could not go on	**=5 76%**	**3 78%**	**=2 92%**	**5 74%**	**=2 77%**	**=4 77%**	**4 79%**	**2= 71%**
Other emotional factors	=7 74%	=8 64%	7 80%	=7 69%	**4 74%**	=11 68%	7= 75%	6 58%
Wanting to prevent your gambling from becoming a major problem	**=3 80%**	7 69%	=8 77%	**4 75%**	**=5 71%**	=6 75%	**5 78%**	**3= 68%**
Pressure from your partner, family or friends	**=3 80%**	**1 82%**	**=2 92%**	**3 79%**	7 69%	**=2 87%**	**3 81%**	**1 81%**
Problems with your spouse or partner	**2 85%**	**2 80%**	**1 100 %**	**2 80%**	**=2 77%**	**=2 87%**	**2 88%**	**2= 71%**
Problems with other family members	=9 72%	**=5 71%**	=11 69%	6 73%	=10 63%	**=4 77%**	7= 75%	4= 65%
Concerns about the welfare of your children	**=5 76%**	=8 64%	=8 77%	=7 69%	=10 63%	8 74%	8= 74%	4= 65%
Isolation from family and friends	=11 70%	12 56%	14 54%	13 66%	13 57%	13 67%	8= 74%	8= 42%
Problems at work	=11 70%	11 62%	=11 69%	12 67%	=10 63%	=11 68%	8= 74%	7 52%
Legal problems	=11 70%	**4 73%**	**=2 92%**	11 68%	=8 66%	=6 75%	9= 72%	**2= 71%**
Problems in your living circumstances	=9 72%	**=5 71%**	6 85%	=7 69%	**=5 71%**	=9 71%	6 76%	5 61%
The costs of gambling outweighed the reasons for continuing to gamble	=7 74%	=8 64%	=8 77%	=7 69%	=8 66%	=9 71%	9= 72%	4= 65%
Gambling was affecting your physical health	14 63%	13 53%	=11 69%	14 58%	14 54%	14 62%	10 66%	8= 42%
The gambling venue intervened in your gambling	15 43%	=14 42%	15 46%	15 41%	15 28%	15 54%	11 44%	9 39%

Table 24 Rank/percent endorsing each specified enabler as primary reason to seek help (general population sample)

Response Option	Gender		Age (years)		Ethnicity		Employed	
	Male	Female	<40	40+	NZ Euro	Maori	Yes	No
	n=50	n=39	n=47	n=42	n= 50	n= 19	n=59	n=34
Financial problems	**1 40%**	**1 67%**	**1 51%**	**1 52%**	**1 52%**	**1 74%**	**1 48%**	**1 56%**
Reaching a point where they felt like they could not go on	**2 12%**	**=2 5%**	**=3 4%**	**2 14%**	**=2 10%**	**2 11%**	**2 14%**	**=3 3%**
Other emotional factors	=5 6%	0%	**=3 4%**	=5 2%	=5 4%	- 0%	=5 3%	**=3 3%**
Wanting to prevent the gambling from becoming a major problem	=7 2%	=4 3%	=7 2%	=5 2%	- 0%	- 0%	=8 2%	**=3 3%**
Pressure from your partner, family or friends	**=3 8%**	**=2 5%**	**2 11%**	=5 2%	**=2 10%**	**=3 5%**	4 5%	**2 9%**
Problems with spouse or partner	**=3 8%**	=4 3%	**=3 4%**	**3 7%**	=5 8%	**=3 5%**	**3 7%**	**=3 3%**
Problems with other family members	10 4%	- 0%	- 0%	4 5%	=8 2%	- 0%	=5 3%	- 0%
Concerns about the welfare of their children	- 0%	=4 3%	=7 2%	- 0%	=8 2%	- 0%	- 0%	**=3 3%**
Isolation from family and friends	=7 2%	=4 3%	=7 2%	=5 2%	=8 2%	- 0%	=5 3%	- 0%
Problems at work	- 0%	=4 3%	- 0%	=5 2%	=8 2%	- 0%	- 0%	**=3 3%**
Legal problems	=5 6%	- 0%	**=3 4%**	=5 2%	=5 4%	- 0%	=5 3%	**=3 3%**
Problems in living circumstances	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
The costs of gambling outweighed the reasons for continuing to gamble	=7 2%	- 0%	=7 2%	- 0%	=8 2%	**=3 5%**	=8 2%	- 0%
The gambling was affecting physical health	- 0%	=4 3%	- 0%	=5 2%	=8 2%	- 0%	- 0%	**=3 3%**
The gambling venue intervened in the gambling	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%

Table 24 continued

Response Option	Current Partner		Locality		Problem Gambler		New Zealand Born	
	Yes n=49	No n=40	Rural n=12	Urban n=76	Yes n=32	No n=62	Yes n=63	No n=26
Financial problems	**1 53%**	**1 50%**	**1 33%**	**1 55%**	**1 56%**	**1 47%**	**1 57%**	**1 39%**
Reaching a point where you felt like you could not go on	**2 8%**	**=2 10%**	**=3 8%**	**=2 8%**	**=2 9%**	**=2 11%**	**2= 8%**	**2= 15%**
Other emotional factors	=6 2%	=4 5%	- 0%	=4 4%	**=2 9%**	**=2 11%**	4 5%	- 0%
Wanting to prevent your gambling from becoming a major problem	=6 2%	=7 3%	**=3 8%**	=10 1%	=5 3%	=9 2%	- 0%	3= 8%
Pressure from your partner, family or friends	=4 4%	**=2 10%**	- 0%	**=2 8%**	4 6%	=4 7%	3 6%	**2= 15%**
Problems with your spouse or partner	**3 6%**	=4 5%	**2 17%**	=4 4%	=5 3%	=4 7%	**2= 8%**	- 0%
Problems with other family members	=4 4%	- 0%	- 0%	=8 3%	=4 3%	=9 2%	6= 2%	3= 8%
Concerns about the welfare of your children	- 0%	=7 3%	- 0%	=10 1%	=5 3%	- 0%	6= 2%	- 0%
Isolation from family and friends	=6 2%	=7 3%	- 0%	=8 3%	- 0%	=7 3%	6= 2%	4= 4%
Problems at work	=6 2%	- 0%	- 0%	=4 4%	- 0%	=7 3%	6= 2%	- 0%
Legal problems	=6 2%	=4 5%	- 0%	=4 4%	- 0%	6 5%	5 3%	4= 4%
Problems in your living circumstances	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
The costs of gambling outweighed the reasons for continuing to gamble	=6 2%	- 0%	**=3 8%**	- 0%	- 0%	=9 2%	6= 2%	- 0%
Gambling was affecting your physical health	=5 2%	- 0%	- 0%	=10 1%	- 0%	=9 2%	6= 2%	- 0%
The gambling venue intervened in your gambling	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%

APPENDIX 12
Barriers to help-seeking: Between-group differences

Table 25 Rank/percent endorsing each specified barrier as factor to seek help (helpline sample)

Response Option	Gender		Age (years)		Ethnicity		Employed	
	Male n=56	Female n=61	<40 n=52	40+ n=64	NZ Euro n=73	Maori n=31	Yes n=74	No n=43
Believed didn't have a problem and didn't need help	**5= 39%**	**5 46%**	7= 39%	**4 47%**	**5 36%**	**3 61%**	6= 39%	**5 49%**
Wanted to resolve the problem on own or were too proud to seek help	**1 79%**	**1 79%**	**1 85%**	**1 75%**	**1 82%**	**1 77%**	**1 80%**	**1 77%**
Planned to get help but didn't get around to it	**4 43%**	**4 53%**	**4 52%**	**5 45%**	**4 44%**	**5 55%**	**4 45%**	**4 54%**
Felt ashamed for self or family	**2 73%**	**2 75%**	**2 79%**	**2 70%**	**2 78%**	**2 65%**	**2 76%**	**2 72%**
Only wanted help with financial problems	**5= 39%**	7 39%	**5 46%**	6 34%	6 34%	8= 42%	**5 42%**	11 35%
Not aware that treatment was available	19= 11%	17 20%	18= 15%	18 16%	19 12%	15= 29%	17 16%	18= 14%
Not aware that treatment was free	16= 16%	12 28%	15 21%	13= 23%	18 16%	8= 42%	9 28%	20= 12%
Couldn't get the service at the time or place wanted	10= 27%	13 26%	12= 25%	10= 28%	10= 26%	14 32%	16 18%	6= 42%
Language concerns	22 5%	21 7%	22 6%	21= 6%	21= 4%	21= 10%	22 3%	20= 12%
Didn't think the service would relate to culture or community	19= 11%	20 10%	20 14%	21= 6%	21= 4%	19= 16%	21 7%	15= 16%
Didn't want to use a telephone service	15 18%	16 21%	14 23%	16= 17%	15 21%	17= 19%	12= 22%	15= 16%
Didn't want to use a face to face service	16= 16%	18 18%	18= 15%	16= 17%	16= 18%	17= 19%	14= 19%	18= 14%
Didn't want to use an online service	19= 11%	22 5%	21 8%	20 8%	20 7%	19= 16%	20 8%	22 7%
Concerns about being treated like an addict or mentally ill	10= 27%	6 43%	6 40%	9 31%	9 30%	8= 42%	6= 39%	13= 28%
Concerns about confidentiality	7 38%	8 33%	7= 39%	7= 33%	7= 32%	6= 45%	8 38%	12 30%
Too many commitments to seek help	14 22%	8= 33%	10 33%	13= 23%	13= 22%	6= 45%	10 27%	13= 28%
Too overwhelmed by problems to seek help	**3 48%**	**3 59%**	**3 56%**	**3 52%**	**3 53%**	**4 58%**	**3 51%**	**3 58%**
Trying to address other problems	8 34%	14 25%	12= 25%	7= 33%	10= 26%	11= 39%	12= 22%	6= 42%
Not enough encouragement from friends, family, or community to seek help	12 25%	10= 30%	9 35%	15 22%	12 25%	11= 39%	14= 19%	6= 42%
Felt pressured by friends, family or community to continue gambling	9 30%	10= 30%	11 31%	10= 28%	7= 32%	13 35%	11 23%	6= 42%
Have had bad experiences of seeking help for gambling problems	16= 16%	19 15%	15= 21%	19 9%	16= 18%	21= 10%	18= 15%	15= 16%
Have had bad experiences of seeking help for other problems	13 23%	15 23%	17 19%	12 25%	13= 22%	15= 29%	18= 15%	10 37%

Table 25 continued

Response Option	Current Partner		Locality		Problem Gambler		New Zealand Born	
	Yes	No	Rural	Yes	No	No	Yes	No
	n=54	n=62	n=21	n=96	n=20	n=22	n=96	n=20
Believed didn't have a problem and didn't need help	**5 41%**	**5 45%**	**3= 52%**	**5 43%**	**5 42%**	**4= 36%**	**5 39%**	**3 60%**
Wanted to resolve the problem on own or were too proud to seek help	**1 83%**	**1= 74%**	**1 86%**	**1 79%**	**1 82%**	**1 59%**	**1 79%**	**1= 75%**
Planned to get help but didn't get around to it	**3 50%**	**4 47%**	7= 43%	**4 47%**	**4 50%**	**4= 36%**	**4 48%**	5= 45%
Felt ashamed for self or family	**2 74%**	**1= 74%**	**2 71%**	**2 73%**	**2 78%**	**2 50%**	**2 74%**	**1= 75%**
Only wanted help with financial problems	6= 37%	6 40%	6 48%	7 33%	6 40%	7= 32%	6 36%	**4 55%**
Not aware that treatment was available	19 11%	17 19%	20= 10%	17 19%	19 13%	11= 23%	16 17%	12 10%
Not aware that treatment was free	13= 20%	15 24%	22 5%	9 30%	15= 19%	**4= 36%**	14 22%	9= 25%
Couldn't get the service at the time or place wanted	13= 20%	12= 31%	9= 38%	13= 24%	9= 31%	- 0%	12= 26%	8= 30%
Language concerns	22 4%	21 8%	14= 24%	22 3%	22 7%	- 0%	20 4%	11= 15%
Didn't think the service would relate to culture or community	21 7%	20 13%	14= 24%	21 5%	20 12%	- 0%	18 9%	11= 15%
Didn't want to use a telephone service	15= 19%	16 21%	11= 33%	16 20%	15= 19%	11= 23%	15 19%	9= 25%
Didn't want to use a face to face service	15= 19%	19 16%	14= 24%	19 15%	18 17%	9= 27%	17 15%	8= 30%
Didn't want to use an online service	20 9%	22 7%	20= 10%	20 7%	21 9%	18= 5%	19 8%	12= 5%
Concerns about being treated like an addict or mentally ill	8 35%	7 36%	9= 38%	6 36%	8 36%	7= 32%	8 33%	5= 45%
Concerns about confidentiality	6= 37%	8= 34%	7= 43%	10= 28%	7 38%	11= 23%	7 34%	6 40%
Too many commitments to seek help	9= 26%	14 29%	14= 24%	8 31%	13 27%	9= 27%	12= 26%	7= 35%
Too overwhelmed by problems to seek help	**4 46%**	**3 60%**	**3= 52%**	**3 56%**	**3 52%**	**3 46%**	**3 51%**	**2 70%**
Trying to address other problems	9= 26%	10= 32%	11= 33%	12 27%	11 30%	15= 18%	11 28%	7= 35%
Not enough encouragement from friends, family, or community to seek help	12 22%	10= 32%	**3= 52%**	15 22%	12 28%	11= 23%	10 29%	10= 20%
Felt pressured by friends, family or community to continue gambling	11 24%	8= 34%	11= 33%	10= 28%	9= 31%	15= 18%	9 32%	10= 20%
Have had bad experiences of seeking help for gambling problems	17= 13%	18 17%	19 14%	18 16%	17 18%	18= 5%	16 18%	12= 5%
Have had bad experiences of seeking help for other problems	17= 13%	12= 31%	18 19%	13= 24%	14 24%	17 14%	13 24%	10= 20%

Table 26 Rank/percent endorsing each specified barrier as primary reason to seek help (helpline sample)

Response Option	Gender		Age (years)		Ethnicity		Employed	
	Male n=52	Female n=56	<40 n=50	40+ n=57	NZ Euro n=69	Maori n=29	Yes n=68	No n=40
Believed didn't have a problem and didn't need help	**1= 17%**	**3 20%**	**3 14%**	**1 23%**	**1= 19%**	**2= 17%**	**2 18%**	**2 20%**
Wanted to resolve the problem on own or were too proud to seek help	**1= 17%**	**1= 23%**	**2 20%**	**2 19%**	**1= 19%**	**1 21%**	**1 19%**	**1 23%**
Planned to get help but didn't get around to it	9= 2%	- 0%	- 0%	9= 2%	- 0%	5= 3%	9= 2%	- 0%
Felt ashamed for self or family	**3= 6%**	**1= 23%**	**1 24%**	**3 7%**	**3 13%**	**2= 17%**	**3 15%**	**3 15%**
Only wanted help with financial problems	9= 2%	6= 2%	- 0%	5= 4%	9= 3%	- 0%	9= 2%	7= 3%
Not aware that treatment was available	9= 2%	5 4%	8= 2%	5= 4%	11= 1%	- 0%	6= 3%	7= 3%
Not aware that treatment was free	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Couldn't get the service at the time or place wanted	7= 4%	- 0%	8= 2%	9= 2%	11= 1%	- 0%	9= 2%	7= 3%
Language concerns	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Didn't think the service would relate to culture or community	- 0%	6= 2%	- 0%	9= 2%	- 0%	- 0%	9= 2%	- 0%
Didn't want to use a telephone service	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Didn't want to use a face to face service	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Didn't want to use an online service	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Concerns about being treated like an addict or mentally ill	9= 2%	6= 2%	- 0%	- 0%	9= 3%	- 0%	6= 3%	- 0%
Concerns about confidentiality	**3= 6%**	4 9%	4 10%	4 5%	4= 4%	4 10%	4 10%	7= 3%
Too many commitments to seek help	7= 4%	6= 2%	5= 4%	9= 2%	4= 4%	- 0%	5 4%	- 0%
Too overwhelmed by problems to seek help	9= 2%	- 0%	- 0%	9= 2%	- 0%	5= 3%	9= 2%	- 0%
Trying to address other problems	**3= 6%**	- 0%	5= 4%	9= 2%	4= 4%	- 0%	9= 2%	5= 5%
Not have enough encouragement from friends, family, or community to seek help	- 0%	6= 2%	- 0%	9= 2%	11= 1%	- 0%	- 0%	7= 3%
Felt pressured by friends, family or community to continue gambling	**3= 6%**	- 0%	8= 2%	5= 4%	4= 4%	- 0%	- 0%	4 8%
Have had bad experiences of seeking help for gambling problems	**3= 6%**	6= 2%	5= 4%	5= 4%	4= 4%	5= 3%	6= 3%	5= 5%
Have had bad experiences of seeking help for other problems	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%

Table 26 continued

Response Option	Current Partner		Locality		Problem Gambler		New Zealand Born	
	Yes	No	Rural	Yes	No	No	Yes	No
	n=48	n=59	n=20	n=89	n=18	n=17	n=89	n=18
Believed didn't have a problem and didn't need help	**1 21%**	**2 17%**	**2 20%**	**2 19%**	**2= 16%**	**1 35%**	**3 14%**	**1 44%**
Wanted to resolve the problem on own or were too proud to seek help	**2 19%**	**1 22%**	**3 10%**	**1 21%**	**1 21%**	**2 24%**	**1 23%**	**2= 11%**
Planned to get help but didn't get around to it	6= 2%	- 0%	- 0%	10= 1%	12= 1%	- 0%	7= 1%	- 0%
Felt ashamed for self or family	**3 17%**	**3 14%**	**1 25%**	**3 12%**	**2= 16%**	**3 12%**	**2 15%**	**2= 11%**
Only wanted help with financial problems	- 0%	8 3%	4= 5%	- 0%	12= 1%	4= 6%	6= 2%	- 0%
Not aware that treatment was available	- 0%	4= 5%	- 0%	7= 3%	6= 3%	- 0%	6= 2%	3= 6%
Not aware that treatment was free	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Couldn't get the service at the time or place wanted	6= 2%	9= 2%	- 0%	10= 1%	8= 2%	- 0%	6= 2%	- 0%
Language concerns	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Didn't think the service would relate to culture or community	- 0%	9= 2%	- 0%	10= 1%	12= 1%	- 0%	7= 1%	- 0%
Didn't want to use a telephone service	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Didn't want to use a face to face service	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Didn't want to use an online service	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Concerns about being treated like an addict or mentally ill	6= 2%	9= 2%	- 0%	7= 3%	8= 2%	- 0%	6= 2%	- 0%
Concerns about confidentiality	4 10%	4= 5%	4= 5%	4 8%	4 8%	- 0%	4 7%	**2= 11%**
Too many commitments to seek help	5= 4%	9= 2%	- 0%	5= 4%	6= 3%	- 0%	6= 2%	3= 6%
Too overwhelmed by problems to seek help	6= 2%	- 0%	4= 5%	- 0%	12= 1%	- 0%	7= 1%	- 0%
Trying to address other problems	- 0%	4= 5%	4= 5%	7= 3%	8= 2%	4= 6%	5= 3%	- 0%
Not have enough encouragement from friends, family, or community to seek help	- 0%	9= 2%	4= 5%	- 0%	12= 1%	- 0%	7= 1%	- 0%
Felt pressured by friends, family or community to continue gambling	- 0%	4= 5%	4= 5%	10= 1%	8= 2%	4= 6%	5= 3%	- 0%
Have had bad experiences of seeking help for gambling problems	5= 4%	9= 2%	4= 5%	5= 4%	5 4%	- 0%	5= 3%	3= 6%
Have had bad experiences of seeking help for other problems	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%

Table 27 Rank/percent endorsing each specified barrier as factor to seek help (general population sample)

Response Option	Gender		Age (years)		Ethnicity		Employed	
	Male	Female	<40	40+	NZ Euro	Maori	Yes	No
	n=56	n=43	n=53	n=46	n= 55	n= 22	n=65	n=38
Believing there wasn't a problem and not needing help	**=1 89%**	**1 91%**	**1 94%**	**=1 85%**	**1 93%**	**1 95%**	**1 91%**	**=1 82%**
Wanting to resolve the problem on own or being too proud to seek help	**3 86%**	**2 86%**	**=2 87%**	**=1 85%**	**2 91%**	**3 82%**	**=2 85%**	**=1 82%**
Planning to get help but not getting around to it	**4 73%**	**4 70%**	**5 68%**	**4 76%**	**4 75%**	**4 73%**	**4 77%**	=6 58%
Feeling ashamed for themselves or family	**=1 89%**	**3 81%**	**=2 87%**	**=1 85%**	**3 87%**	**2 86%**	**=2 85%**	**=1 82%**
Only wanting help with financial problems	7 70%	14 51%	=16 53%	**5 72%**	=9 60%	=17 50%	=9 62%	=6 58%
Not being aware that treatment was available	=12 54%	=18 44%	=8 62%	18 35%	=17 45%	19 45%	11 59%	=19 32%
Not being able to get the service at the time or place wanted	16 50%	=15 49%	=14 55%	=14 44%	=13 51%	=20 41%	=14 55%	=14 37%
Thinking the service would not understand their language	19 45%	20 42%	=14 55%	=19 30%	=17 45%	=9 59%	=17 52%	21 26%
Thinking the service would not relate to their culture or community	=14 52%	=18 44%	=12 57%	17 39%	=13 51%	=13 55%	=14 55%	=17 34%
Not wanting to use a telephone service	21 34%	=11 54%	=16 53%	=19 30%	20 36%	=13 55%	19 48%	=19 32%
Not wanting to use a face to face service	=14 52%	=9 56%	=12 57%	13 50%	=13 51%	=9 59%	=12 57%	13 45%
Not wanting to use an online service	20 39%	21 33%	21 42%	=19 30%	21 27%	=20 41%	21 37%	=17 34%
Thinking that problem gambling services would treat them like an addict / mentally ill	8 68%	**=5 63%**	**4 72%**	=9 59%	**5 71%**	=6 64%	**5 71%**	=9 53%
Concerns about their confidentiality	**=5 71%**	8 58%	7 64%	=6 67%	7 65%	=13 55%	6 67%	**5 61%**
Having too many commitments to seek help	=17 48%	17 47%	=19 51%	=14 44%	19 42%	=17 50%	=17 52%	=14 37%
Being too overwhelmed by their problems to seek help	**=5 71%**	7 61%	6 66%	=6 67%	=11 58%	=6 64%	7 65%	**4 66%**
Trying to address other problems	9 63%	=11 54%	=10 60%	=11 57%	8 62%	=6 64%	=12 57%	=6 58%
Not having enough encouragement from friends, family, or community to seek help	=12 57%	=11 54%	=19 51%	=8 61%	=11 58%	**5 68%**	=14 52%	=14 58%
Feeling pressured by friends, family or community to continue gambling	=17 48%	=15 49%	=16 53%	=14 44%	16 47%	=13 55%	20 46%	=11 50%
Having had bad experiences of seeking help for gambling problems	11 59%	**=5 63%**	=8 62%	=9 59%	6 67%	=9 59%	8 63%	=9 53%
Having had bad experiences of seeking help for other problems	10 61%	=9 56%	=10 60%	=11 57%	=9 60%	=9 59%	=9 62%	=11 50%

Table 27 continued

Response Option	Current Partner		Locality		Problem Gambler		New Zealand Born	
	Yes	No	Rural	Urban	Yes	No	Yes	No
	n=54	n=45	n=13	n=85	n=35	n=69	n=68	n=31
Believing there wasn't a problem and not needing help	**=1 93%**	**1 87%**	**1 93%**	**1 89%**	**4 83%**	**1 88%**	**1 93%**	**3 84%**
Wanting to resolve the problem on own or being too proud to seek help	**=1 93%**	**3 78%**	**2 92%**	**3 85%**	**1 89%**	**3 81%**	**3 84%**	**1 90%**
Planning to get help but not getting around to it	**4 76%**	**4 67%**	**=4 69%**	**4 73%**	**=2 86%**	7 61%	**4 74%**	6 68%
Feeling ashamed for themselves or family	**3 89%**	**2 82%**	**3 85%**	**2 87%**	**=2 86%**	**2 83%**	**2 85%**	**2 87%**
Only wanting help with financial problems	=8 65%	**=5 58%**	=20 39%	8 65%	6 63%	=8 59%	7 62%	=8 61%
Not being aware that treatment was available	14 54%	=17 44%	=15 54%	=15 48%	16 43%	=14 52%	=15 44%	=8 61%
Not being able to get the service at the time or place wanted	=15 52%	=15 47%	=20 39%	14 51%	=11 51%	17 48%	=13 47%	10 55%
Thinking the service would not understand their language	19 44%	=19 42%	**=4 69%**	20 40%	20 34%	18 46%	16 43%	=13 45%
Thinking the service would not relate to their culture or community	18 48%	=13 49%	=11 62%	18 46%	19 37%	=14 52%	=13 47%	=11 52%
Not wanting to use a telephone service	20 41%	=17 44%	=17 46%	19 42%	=17 40%	20 42%	=15 44%	=14 39%
Not wanting to use a face to face service	13 56%	12 51%	=11 62%	13 52%	=11 51%	13 54%	=11 56%	12 48%
Not wanting to use an online service	21 39%	21 33%	=17 46%	21 35%	21 26%	21 41%	17 35%	=14 39%
Thinking that problem gambling services would treat them like an addict / mentally ill	=6 72%	**=5 58%**	**=4 69%**	**=5 66%**	=7 60%	**4 67%**	**5 66%**	=7 65%
Concerns about their confidentiality	=6 72%	**=5 58%**	**=4 69%**	**=5 66%**	=7 60%	**5 65%**	6 63%	**5 71%**
Having too many commitments to seek help	=15 52%	=19 42%	=17 46%	=52 48%	=13 49%	19 45%	14 46%	=11 52%
Being too overwhelmed by their problems to seek help	**5 74%**	**=5 58%**	**=4 69%**	**=5 66%**	**5 77%**	=8 59%	8 60%	**4 81%**
Trying to address other problems	10 63%	11 53%	=11 62%	=10 58%	=13 49%	6 62%	=9 59%	9 58
Not having enough encouragement from friends, family, or community to seek help	=11 61%	=13 49%	**=4 69%**	12 54%	=13 49%	=11 58%	10 57%	=11 52%
Feeling pressured by friends, family or community to continue gambling	17 50%	=15 47%	=15 54%	=15 48%	=17 40%	16 51%	12 50%	=13 45%
Having had bad experiences of seeking help for gambling problems	=8 65%	=9 56%	**=4 69%**	9 59%	=7 60%	=11 58%	=9 59%	=7 65%
Having had bad experiences of seeking help for other problems	=11 61%	=9 56%	=11 62%	=10 58%	10 54%	=8 59%	=11 56%	=7 65%

Table 28 Rank/percent endorsing each specified barrier as primary reason to seek help (general population sample)

Response Option	Gender		Age (years)		Ethnicity		Employed	
	Male	Female	<40	40+	NZ Euro	Maori	Yes	No
	n=51	n=39	n=49	n=41	n= 43	n= 19	n=58	n=34
Believing there wasn't a problem and not needing help	**1 26%**	**1 26%**	**1 29%**	**1 22%**	**1 40%**	**1 37%**	**1 28%**	**1 21%**
Wanting to resolve the problem on own or being too proud to seek help	**=2 18%**	**3 13%**	**3 16%**	**=2 15%**	**3 21%**	**3 16%**	**3 16%**	**2 15%**
Planning to get help but not getting around to it	6 4%	- 0%	=6 2%	=6 2%	=5 2%	=4 5%	=7 2%	=6 3%
Feeling ashamed for themselves or family	**=2 18%**	**2 23%**	**2 25%**	**=2 15%**	**2 23%**	**2 26%**	**2 26%**	**3 12%**
Only wanting help with financial problems	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Not being aware that treatment was available	=7 2%	=6 3%	=6 2%	=6 2%	=5 2%	- 0%	6 3%	- 0%
Not being able to get the service at the time or place wanted	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Thinking the service would not understand their language	4 10%	=6 3%	=4 4%	4 10%	- 0%	- 0%	4 7%	=4 6%
Thinking the service would not relate to their culture or community	- 0%	=6 3%	=6 2%	- 0%	- 0%	- 0%	=7 2%	- 0%
Not wanting to use a telephone service	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Not wanting to use a face to face service	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Not wanting to use an online service	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Thinking that problem gambling services would treat them like an addict / mentally ill	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Concerns about their confidentiality	- 0%	=6 3%	=6 2%	- 0%	- 0%	=4 5%	- 0%	=6 3%
Having too many commitments to seek help	5 6%	=4 5%	=4 4%	5 7%	4 7%	- 0%	5 5%	=4 6%
Being too overwhelmed by their problems to seek help	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Trying to address other problems	- 0%	=6 3%	=6 2%	- 0%	- 0%	=4 5%	- 0%	=6 3%
Not having enough encouragement from friends, family, or community to seek help	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Feeling pressured by friends, family or community to continue gambling	=7 2%	=6 3%	=6 2%	=6 2%	- 0%	=4 5%	=7 2%	=6 3%
Having had bad experiences of seeking help for gambling problems	- 0%	=6 3%	- 0%	=6 2%	=5 2%	- 0%	- 0%	=6 3%
Having had bad experiences of seeking help for other problems	- 0%	=4 5%	=6 2%	=6 2%	=5 2%	- 0%	=7 2%	=6 3%

Table 28 continued

Response Option	Current Partner		Locality		Problem Gambler		New Zealand Born	
	Yes	No	Rural	Urban	Yes	No	Yes	No
	n=49	n=41	n=12	n=17	n=33	n=60	n=64	n=26
Believing there wasn't a problem and not needing help	**1 25%**	**1 27%**	**2 25%**	**1 26%**	**=2 18%**	**1 28%**	**1 33%**	**=3 8%**
Wanting to resolve the problem on own or being too proud to seek help	**3 10%**	**=2 22%**	**3 17%**	**3 16%**	**1 22%**	**3 12%**	**3 19%**	**=3 8%**
Planning to get help but not getting around to it	=6 4%	- 0%	=4 8%	=9 1%	=5 6%	- 0%	5 3%	- 0%
Feeling ashamed for themselves or family	**2 18%**	**=2 22%**	**1 33%**	**2 17%**	**=2 18%**	**2 22%**	**2 22%**	**2 15%**
Only wanting help with financial problems	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Not being aware that treatment was available	=8 2%	=5 2%	- 0%	=6 3%	- 0%	5 5%	=6 2%	=4 4%
Not being able to get the service at the time or place wanted	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Thinking the service would not understand their language	=4 8%	4 5%	- 0%	4 8%	4 12%	6 3%	16 0%	**1 23%**
Thinking the service would not relate to their culture or community	0%	=4 2%	=4 8%	- 0%	- 0%	=7 2%	- 0%	=4 4%
Not wanting to use a telephone service	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Not wanting to use a face to face service	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Not wanting to use an online service	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	=14 0%
Thinking that problem gambling services would treat them like an addict / mentally ill	- 0%	=5 2%	- 0%	=9 1%	=7 3%	- 0%	- 0%	=4 4%
Concerns about their confidentiality	=4 8%	=5 2%	- 0%	5 7%	=7 3%	4 7%	4 5%	**=3 8%**
Having too many commitments to seek help	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%
Being too overwhelmed by their problems to seek help	=8 2%	- 0%	- 0%	=9 1%	- 0%	=7 2%	=6 2%	- 0%
Trying to address other problems	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0
Not having enough encouragement from friends, family, or community to seek help	=8 2%	=5 2%	- 0%	=6 3%	=5 6%	- 0%	=6 2%	=4 4%
Feeling pressured by friends, family or community to continue gambling	=8 2%	- 0%	- 0%	=9 1%	- 0%	=7 2%	=6 2%	- 0%
Having had bad experiences of seeking help for gambling problems	=6 4%	- 0%	- 0%	=6 3%	- 0%	=7 2%	=6 2%	=4 4%
Having had bad experiences of seeking help for other problems	=8 2%	- 0%	- 0%	=9 1%	- 0%	=7 2%	- 0%	=4 4%

APPENDIX 13
Helpline follow-up sample: Demographic and PGSI data

Table 29 Demographic profile: helpline participants completing follow-up vs. those who did not (telephone sub-sample only)

Variable		Follow-Up Completed	
		Yes (n=45)	No (n=52)
Age	20-29 yrs	5 (11%)	9 (18%)
	30-39 yrs	7 (16%)	18 (36%)
	40-49 yrs	15 (34%)	17 (34%)
	50- 59 yrs	11 (25%)	5 (10%)
	60+ yrs	6 (14%)	1 (2%)
Gender	Male	23 (52%)	25 (49%)
	Female	21 (48%)	26 (51%)
Ethnicity**	NZ European	28 (64%)	23 (48%)
	Maori	7 (16%)	13 (27%)
	Pacific Island	1 (2%)	5 (10%)
	Asian	2 (5%)	0 (0%)
	Other	6 (13%)	7 (15%)
Origin	NZ Born	36 (80%)	45 (86%)
	United Kingdom	2 (4%)	4 (8%)
	Asia	3 (7%)	0 (0%)
	Australia	2 (4%)	0 (0%)
	Pacific Islands	0 (0%)	2 (4%)
	Other	0 (0%)	1 (2%)
Marital Status	Single	15 (34%)	15 (30%)
	Married/Defacto	18 (41%)	25 (50%)
	Separated/Divorced	11 (25%)	10 (20%)
Employment	Employed	21 (49%)	31 (65%)
	Unemployed	11 (26%)	9 (19%)
	Other***	11 (26%)	8 (17%)
Locality	Urban	28 (76%)	36 (82%)
	Rural	9 (24%)	8 (18%)

** Participants who reported mixed ethnicity were counted once in each category provided
*** Includes students, retirees, sickness beneficiaries and stay-at-home parents

Table 30 PGSI ranking: helpline participants completing follow-up vs. those who did not (telephone sub-sample only)

Gambling Activity	Follow-Up Completed*	
	Yes (n = 44)	No (n = 51)
Non-problem gambler	1 (2%)	2 (4%)
Low risk gambler	3 (7%)	1 (2%)
Moderate risk gambler	3 (7%)	3 (6%)
Problem gambler	37 (84%)	45 (88%)

*Data not available for two participants

APPENDIX 14
Participant comments for selected gambling treatment services
(based on feedback obtained from three-month follow-up survey)

For the twelve 'followed up' gamblers that used the Gambling Helpline service, the 'good aspects' mentioned were: "good listeners and easy to talk to" (n=6); "friendly" (n=3); "understanding" (n=3); "not judged" (n=3); "good advice and great help" (n=2); "accessible" (n=2); "supportive" (n=2); "put at ease" (n=2); "in-depth conversation" (n=1); "putting things into perspective" (n=1); "good at goal setting" (n=1) and "caring" (n=1). The 'improvements' mentioned for this service were: "relate to gambling problems more" (n=1); "remind people of the bad times" (n=1); "more advertisements" (n=1); some counsellors didn't understand the problem" (n=1); "increase the hours after 10pm" (n=1); "have interviews in a more private place" (n=1); "inconsistency among counsellors" (n=1)"; and "don't always feel welcomed" (n=1).

For the eight 'followed up' gamblers that used the Salvation Army Oasis service, the 'good aspects' mentioned were: "understanding" (n=3); "not judged" (n=3); "caring" (n=1); "friendly" (n=1); "put at ease"; "good listeners" (n=1); "counsellors are east to talk to" (n=1); "putting things into perspective (n=1); "honesty" (n=1); "good presentation" (n=1); "interested as a person not as a clinical output" (n=1); "covered all areas" (n=1) and "staff were well qualified and professional" (n=1). The 'improvements' mentioned for this service were: "relate to gambling more" (n=1); "counselling should not be cancelled from their end" (n=1); "help bar from venues" (n=1); and "increase volunteer opportunities to learn new skills" (n=1).

For the eight 'followed up' gamblers that used the Problem Gambling Foundation service, the 'good aspects' mentioned were: "easy to talk to" (n=3); "understanding" (n=2); "proactive counsellor" (n=1); "supportive" (n=1); "deals with a range of problems, not just gambling" (n=1); and "good listeners" (n=1). The 'improvements' mentioned for this service were: "group size is too small" (n=1) and "the group is quite repetitive for regular users as new clients disrupt the flow" (n=1).

For the three "followed up" gamblers that used the Gamblers Anonymous service, the 'good aspects' mentioned were: "compassionate people" (n=2); "the service was free" (n=1); "understanding" (n=1); "easy to talk to" (n=1); and "learning inside knowledge" (n=1). The 'improvements' mentioned for this service were: "personalities can dominate meetings" (n=1); "more publicity needed to promote Gamblers Anonymous" (n=1); and "less talk about golf games and more talk on personal experiences" (n=1).

For the "followed up" gambler that used a general counselling service, the 'good aspects' mentioned were: "support and understanding". No improvements were mentioned.

For the "followed up" gambler that used an "other" service, the 'good aspects' mentioned were: "friendly people". The 'improvement mentioned for this service was: "felt like they were not qualified to help someone with a gambling problem".