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Outcome of treatment seeking rural gamblers attending a nurse-led cognitive-behaviour therapy service: A pilot study

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ABSTRACT

Objectives: Little is known about the differences between urban and rural gamblers in Australia, in terms of comorbidity and treatment outcome. Health disparities exist between urban and rural areas in terms of accessibility, availability, and acceptability of treatment programs for problem gamblers. However, evidence supporting cognitive-behaviour therapy as the main treatment for problem gamblers is strong. This pilot study aimed to assess the outcome of a Cognitive-Behavioural Therapy (CBT) treatment program offered to urban and rural treatment-seeking gamblers.

Methods: People who presented for treatment at a nurse-led Cognitive-Behavioural Therapy (CBT) gambling treatment service were invited to take part in this study. A standardised clinical assessment and treatment service was provided to all participants. A series of validated questionnaires were given to all participants at (a) assessment, (b) discharge, (c) at a one-month, and (d) at a 3-month follow-up visit.

Results: Differences emerged between urban and rural treatment-seeking gamblers. While overall treatment outcomes were much the same at three months after treatment, rural gamblers appeared to respond more rapidly and to have sustained improvements over time.

Conclusion: This study suggests that rural problem gamblers experience different levels of co-morbid anxiety and depression from their urban counterparts, but once in treatment appear to respond quicker. ACBT approach was found to be effective in treating rural gamblers and outcomes were maintained. Ensuring better availability and access to such treatment in rural areas is important. Nurses are in a position as the majority health professional in rural areas to provide such help.

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1. Introduction

There are inequities in health and a health divide between urban and rural areas, reflecting the social determinants of health. There are also less health services available and outcomes after treatment are lower in rural than urban areas [1]. This is also true for people experiencing problems with gambling in rural areas where gambling is often linked to sociodemographic variables such as poverty, poor housing, and unemployment [2]. With recent improvement in mobile and internet technologies in rural settings in Australia, there are more opportunities for people to access gambling services [3]. However, little has been reported on the success of such treatment [4]. Increased access to technology also introduces more gambling in the form of online casinos, bingo and lotteries which is rated by participants as more addictive than offline gambling and may lead to more gambling problems in rural areas [5].

Problem gambling affects approximately 2% of Australians with an estimated international prevalence between 0.5 and 9.0% [6–9]. While a great deal of research has taken place to attempt to understand the impact of gambling on the individual, their families and the wider community, far less research has been conducted into the specific issue of rural gamblers. Given the increase in opportunities for rural residents to gamble using smart technologies and mobile gaming, more research is needed.

A wide range of treatments are available to help combat gambling problems. However, despite a growing history of such treatments, there is little clear empirical evidence to support any particular approach. Cognitive-Behavioural Therapy (CBT) and psycho-pharmacological therapies are two treatment options that have shown some significant results in terms of reducing problem gambling behaviour [10–12]. Two approaches to CBT have been shown to be effective: exposure therapy with response prevention [13]; and cognitive restructuring to gambling specific erroneous beliefs [14].

In many gambling studies, therapists from various disciplines offer treatment to problem gamblers. For example, in two studies of exposure therapy the therapists were mental health social workers, mental health nurses, clinical psychologists and counsellors [15,16]. While little has been reported on nurses treating problem gamblers, there are a number of examples as to how they may be able to help with other conditions including mental health [17] and addictions [18] in rural settings. It was noted, rural mental health nurses were required to occupy broader and more complex roles often treating patients outside of their scope of practice such as gambling [19]. In addition a number of studies have noted a severe lack of mental health nurses in rural areas despite a demand for their services [20,21].

This study was designed to evaluate the routine clinical outcomes from a nurse-led and nursing delivered CBT treatment program for problem gamblers in South Australia [22]. There have been few studies examining specific differences between rural and urban treatment outcomes of gamblers. This study provides a clear indication of the potential problems facing rural gamblers and how such issues can be addressed. The inclusion of nurses in such treatment especially in rural areas may be one way to address this as they typically represent the largest rural health professional group.

2. Materials and methods

2.1. Participants

A convenience sampling method was used to recruit participants from an out-patient gambling treatment service attached to a large teaching hospital in Adelaide, South Australia [22]. As a result, all participants were seeking treatment for problem gambling. In order to be included in the study, participants needed to give consent for the assessment and treatment outcome data to be collected and used for research purposes. As this was a naturalistic clinic population there were no exclusion criteria.

2.2. Procedures

Ethics approval for the study was granted by Flinders Medical Centre and Flinders University joint ethics committee. All participants were initially assessed and demographic data was recorded. They were invited to complete several measures, as described in Section 2.4. Having been determined as suitable for the treatment program, participants were offered between 6 and 12 sessions with a Masters prepared CB therapist using a guided treatment manual [23].

2.3. Interventions

Therapists were all nurses with Masters level qualifications who had been trained as CBT therapists [24]. A standardised treatment was used, that has been described in detail elsewhere [22,23,25,26]. In essence, all clients completed four steps: 1) stimulus control methods to bring about immediate control of gambling; 2) imaginal and live exposure with response prevention to gambling specific triggers; 3) cognitive restructuring and behavioural experiments to further support the urge reduction obtained through exposure; and 4) standard client focussed relapse prevention.

2.4. Measurements

Participants were asked to complete a series of measures at the initial assessment, at discharge, at a 1 month follow-up session (1MFU) and at a 3 month follow-up session (3MFU). Data was also collected at a 6-month and 12-month follow-up session, but has not been included in this report due to the low number of rural participants attending the follow-up sessions.

The measures used included an anxiety inventory, a depression inventory, a work and social adjustment questionnaire, a simple gambling severity tool and an assessment of their suitability for CBT therapy. This assessment included an overview of their main gambling problem, psychiatric assessment, mental state examination and a risk assessment.

The *Beck Anxiety Inventory (BAI)* is a 20-item measure of state anxiety that has been shown to be valid and reliable