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ENHANCING SUPPORT FOR FAMILY AND AFFECTED OTHERS IN NEW ZEALAND GAMBLING SERVICES: AN EXPLORATORY MIXED METHODS STUDY

Final report.

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EXECUTIVE SUMMARY

Background

New Zealand gambling harm prevention and reduction services are funded by the New Zealand Ministry of Health (MOH) to engage with family and affected others (FAOs) whether or not the person who is gambling chooses to engage. In the July 2017 to June 2018 year, FAOs comprised one quarter of clients receiving a structured intervention plan (1370 clients), and just under two thirds of motivational engagements with people in the community who were experiencing some gambling harm (3227 clients) (Ministry of Health, 2020a). The MOH does not prescribe any particular approach to working with families affected by gambling harm. However the MOH has variously challenged mental health and addictions service provision to empower (Ministry of Health, 1994), better respond to (Ministry of Health, 1997), address the needs of (Ministry of Health, 2006), and increase support for (Ministry of Health, 2012b) family/whānau[1]. Addictions services should ask about and seek to involve family and whānau 'in ways that work', and that partnership with families/whānau 'should be evident in service design' (Ministry of Health, 2015). Since 2009, a Whānau Ora approach has evolved in New Zealand to actively promote, support and fund whānau-centred and holistic support and services for health and well-being (Independent Whānau Ora Review Panel, 2018).

Despite these policy initiatives, the most recent New Zealand government inquiry into mental health and addiction services (He Ara Oranga) heard that families and whānau continue to feel disconnected, excluded and underserved by services (Patterson, Durie, Disley, Tiatia-Seath, & Tualamali'i, 2018). There is limited research exploring the role of FAOs in the treatment of problem gamblers (Kourgiantakis, Saint-Jacques, & Tremblay, 2018), and even fewer studies have focussed on the needs of FAOs or developed, documented and explored the efficacy of support designed especially for them (Rodda, Dowling, Thomas, Bagot, & Lubman, 2019). There has been no published research designed to support or inform gambling harm reduction services in their provision of support for FAOs in New Zealand. In 2019 the Ministry of Health commissioned the Gambling and Addictions Research Centre (GARC) to conduct an exploratory mixed methods study of how support provided for family members and affected others (FAOs) in New Zealand gambling services could be enhanced.

Aims

The aims of this study were to explore existing knowledge of quality and effective support for FAOs harmed by gambling; and suggest opportunities for enhancing the support that is provided for FAOs in New Zealand gambling services.

[1] Whānau is often translated as 'family', but its meaning is more complex. It includes physical, emotional and spiritual dimensions and is based on whakapapa (a genealogical sensibility). Whānau is based on a New Zealand Māori (Indigenous) and a tribal world view. It is through whānau that values, histories and traditions from the ancestors are adapted for the contemporary world. Whānau can be multi-layered, flexible and dynamic and encompass relationships with whāngai (foster children) and those who have passed on, as well as marae (gathering places) and hapū (tribal sections).

Approach

Given that published evidence for quality and effective service design and delivery for FAOs harmed by gambling is extremely limited, an exploratory approach, involving engagement with existing knowledge in the gambling and broader addictions fields was selected (Livingstone et al., 2019). The overarching research question was: How could support provided for family members and affected others (FAOs) in New Zealand gambling services be enhanced? The research design comprised the following four components:

Part one: Exploration of quality and effective FAO support practices

- A conceptual review of FAO addictions support and intervention literature,
- A structured engagement with expert opinion (n=40) on enhancing gambling harm reduction services for FAOs. Experts included service managers, researcher, policymakers, people with lived experience as FAOs and/or people who gamble, clinicians and workforce development professionals. This structured engagement was informed by the conceptual literature review.

Part two: Exploration of current FAO support practices

- A national and international scan and analysis of the types of gambling services advertised and/or provided for FAOs
- Descriptive analysis of New Zealand gambling service use data.

The overarching output of the project was the identification and discussion of opportunities to enhance support for FAOs in New Zealand gambling services.

Key results

Conceptual review of FAO addictions support and intervention literature

We found that addictions harm reduction approaches for families are informed by multiple understandings of addiction. These included addiction as a fundamentally psychological phenomenon, as shaped by fragmentation (and reintegration) of social relationships, and as shaped by macro-level social structures (e.g. socioeconomic inequalities, the provision and governance of harmful commodities). The emphasis in approaches to supporting families has been on universal thinking/approaches based on underlying psychological principles of human behaviour (i.e. largely cognitive behavioural therapy and motivational interviewing-based approaches). The most dominant approaches have focused on helping the FAO to support the gambling individual, with some specific approaches designed to improve FAO coping and reduce distress. These approaches are important and have been associated with some improvements in FAO wellbeing, however they do not reflect the full range of conceptualisation of addiction, harm and support available. Opportunities for creative reimagining of more FAO-centric services and offerings may be obscured.

Gambling recovery is also conceptualised as a social process, where options for practicing wellbeing are continually revised in response to changing relationships and social contexts. Comparatively few gambling harm reduction interventions have been developed to include FAOs in ways that centralise the social, economic and cultural determinants of harm and recovery. New Zealand Māori and other Indigenous perspectives have highlighted how a lack of engagement with the social, economic and cultural realities of gambling and harm has limited the development of relevant resources and interventions for families - particularly in vulnerable communities.

Engagement with FAOs has been framed by approaches largely driven by researchers and clinicians. Clinical expertise has been privileged over lived experience and the notion of partnership in recovery support. International research has suggested that addictions services tend to be guided by one approach to engaging and supporting FAOs at best, and little is known about how to achieve successful implementation and sustainability of family-focused practice within addictions treatment services. Given that there has been almost no engagement with the support preferences and expectations of FAOs in relation to gambling services, it is not possible to say with any clarity what a FAO-centric gambling service might involve or look like. Co-design and action research have demonstrated the value of in-depth and collaborative engagement between addictions service providers and FAOs in reshaping services to enhance the range and quality of support. This critical review suggests that such collaborative techniques and processes should be employed to conceptualise, design, plan and evaluate enhanced gambling harm reduction services for FAOs.

Structured engagement with expert opinion

An international panel of 40 participants with expertise in support for families affected by addiction (e.g. service managers, researcher, policymakers, people with consumer/lived-experience as people who gamble and as FAOs, clinicians and workforce development professionals) took part in an iterative two-round online survey focussed on issues, notions and practices relevant to enhancing support provided for FAOs in New Zealand gambling services.

Our analysis of the views of panel members suggested that enhancing support for FAOs in New Zealand gambling services should involve a combination of:

- Expanding the range and transparency of approaches to FAO support that exist in practice, and facilitating FAO choice among visibly diverse service offerings
- Tino rangatiratanga and mana motuhake: Ensuring Māori leadership, design and management of gambling harm reduction strategies and services.
- Developing and implementing social and cultural FAO recovery models to balance approaches that focus on the individual
- Exploring the role of FAO lived experience in service design and practice (e.g. peer support, consumer panels, community health models)
- Building and sustaining a culture of curiosity and learning in services (e.g. practitioner-inquirers, community engagement, creative and participatory evaluation)

- Bridging gaps between researchers/research and practitioners/practice.

In achieving the above, a role for government and policymakers was identified in funding and supporting practitioner-inquirers (i.e. clinicians and service managers who critically engage with a research/practice nexus e.g. in postgraduate study or in partnership with researchers). Requirements for collaborative and participatory service design, development and evaluation were advised. Additional policy suggestions included: actively ensuring the workforce is culturally diverse and aware enough to reflect New Zealand families, and broader workforce development around cultural and family responsiveness.

Review of FAO support service provision

During the structured engagement with expert opinion, panellists were invited to suggest a range of national and international gambling support services who they felt were engaged with families. An international review of (largely) publicly available information about these gambling harm reduction services for FAOs was conducted to explore how they appeared to be presented, orientated to, and engaging with the needs of FAOs. The purpose was to gain a sense of the support options available to FAOs affected by gambling harm at present. Data were collected from 16 organisations in New Zealand, Australia, the United Kingdom, Canada and the United States. The analysis aimed to answer three key questions: (1) How do gambling services appear to be oriented to FAOs at present? (2) What are the kinds of support that FAOs are offered in gambling services? And (3) How are gender, ethnicity and/or cultural issues/perspectives incorporated into service design and delivery?

We found that influential models of problem gambling development and intervention needs have shaped services in ways that focus largely on 'the problem gambler'. Few services were clear which approaches or options of support were available to FAOs independently of gamblers. Support for FAOs tended to be positioned as either a peripheral offering and/or an emerging area of practice. Services were ambiguous about what 'support' for FAOs might entail, few services were clear about specific offerings or approaches. We argue that this is problematic as clients might wish to know the kind of services/support that could be provided to encourage them to make contact. Greater transparency and a broader range of support options could support FAOs engagement with services.

There is still much to be done for services to become family/whānau inclusive and for FAOs seeking help to be without doubt that support services are available for them in their own right. Emerging recognition of FAOs' needs could be better supported by resources available within services, and public-facing information presented to individuals/families who might be investigating available support options. Some culturally and linguistically appropriate services in New Zealand and Australia appear to be inherently family/whānau inclusive and less constrained by the historical development of services for 'problem gamblers'. Their design and development have championed the voices of their communities and services users, bringing to light the community's desire to be involved and engaged with service development and

delivery. This provides a promising model to learn from going forward. However, it must be noted that most of these services have yet to be formally evaluated. Documentation and sharing of family focussed practice and service development appeared to be minimal, limiting knowledge transfer and learning opportunities at present.

New Zealand FAO engagement with intervention services

Descriptive analysis of a national MOH database was conducted to explore the demographic characteristics of FAOs engaging with New Zealand gambling services, and how these clients appear to be engaged. FAOs are receiving minimal support from services at present. Most FAOs were engaged for one, brief, one-on-one session of motivational support conducted outside of a clinical setting. Support for both FAOs and gamblers appears to be largely concentrated around the individual at present. There was little evidence of intervention practice involving couples or families for either FAO or gambler clients. Group support and/or therapy sessions comprised a quarter of session attended by gamblers, yet only around one in ten sessions attended by FAOs. Couple and family sessions accounted for just 4 percent of FAO and 2 per cent of gambler sessions. Further research should ascertain whether this reflects FAO preferences or is connected to low availability of appropriate support options for families. Our research suggests the latter is likely. Given that high engagement with FAOs is already occurring opportunistically in community contexts, finding ways to support community-based/community-led programmes and events may provide additional opportunities for more in-depth FAO engagement.

Some services appear to be engaging with a high proportion of FAO clients in comparison to other services. Examples include The Salvation Army, Te Rangihaeata Oranga Trust and Tu Te Ihi. Te Rangihaeata Oranga Trust, located in a small region on New Zealand's East Coast (Hawke's Bay, population 175,100), engaged with almost ten percent of FAO clients nationally, during the data extraction period. We argue that in depth mixed methods research with gambling services who are achieving high levels of engagement with FAOs will deliver learning and benefits for the harm minimisation and prevention sector.

Opportunities to enhance support for FAOs in New Zealand gambling services

We suggest three underlying principles that could be leveraged to create action towards systemic change in New Zealand: honouring Te Tiriti o Waitangi by embedding genuine and empowering partnerships with Māori at all levels of our gambling harm reduction system, an integrative approach to 'evidence-based practice', and transformative action-oriented inquiry.

Māori are disproportionately harmed by gambling. Te Tiriti o Waitangi (the Treaty of Waitangi) is the foundation for power sharing between tāngata whenua (the first peoples of Aotearoa New Zealand), and tāngata Tiriti (all others who have come here). Te Tiriti affords Māori sovereignty of hapū (Māori kinship groups). As Te Tiriti partners, whānau involvement at all levels of decision making in determining gambling policies, services and revenue

direction is vital. Our research suggests Māori approaches provide a useful model for family involvement in addiction harm reduction: whānau (family systems), wairua (spirit) and whānaungatanga ("relationships") are regarded as instrumental in the life journeys and support/treatment processes for families and communities. Inquiry continues to document important links between Indigenous healing practices, cultural concepts and recovery from addictions and wellbeing. These ideas link to the recent New Zealand government commissioned Health and Disability Systems Review (2020), and the Waitangi Tribunal recommendations on health services and outcomes (Waitangi Tribunal, 2019). The Waitangi Tribunal has proposed a Māori Health Authority be established to commission health services for Māori using an Indigenous driven model within the health system to achieve equity. This approach was also supported by some members of the Health and Disability Systems Review panel. This model could usefully be applied to gambling harm reduction service commissioning. Our expert panel identified the need to support Māori aspirations for tino rangatiratanga (self-governance) and mana motuhake (autonomy) as key to gambling harm reduction. These notions are also supported by the recent Waitangi Tribunal report on New Zealand Health Services and Outcomes (2019).

An integrative approach to enhancing practice requires the understanding of diverse approaches to addiction harm reduction: their conceptualisation, respective measurement techniques, and evaluation standards. This approach is in alignment with a 'human prerogative of care' which involves accepting that no single treatment system can address all addiction-related problems for families. Engaged commitment is needed that consists of an open, methodical, meaningful and ongoing search for the best responses for certain problems and families. While continually questioning our understandings of people affected, what they need and how best to reduce harm and support them is at times controversial and uncomfortable, we conclude that these conversations are vitally important to creating and sustaining person and family centred approaches, services and care. In depth engagement with how a range of FAOs view and experience gambling harm and recovery is vital if we are to balance professional expertise with experiential authority.

Outcome and evaluation data relevant to supporting families harmed by gambling is extremely limited. Transformative and action -oriented inquiry may assist in opening up this field in ways that directly inform practice. Often we can come to understand a process or system much more deeply when we work together with key stakeholders to try to improve it. We argue that service enhancement is a journey that begins with an iterative, collaborative and inclusive inquiry process. For example, in our research, experts endorsed the practice of critical reflexivity. Critical reflexivity happens when professionals working in a field are supported to actively consider how their practices interact with prevailing knowledge systems, generally through exposure to different ways of thinking about intervention, and particularly as grounded in client's experiences. The results of our expert consultation and analysis of addictions harm reduction literature could be used as a springboard for collaborative construction of principles of service design or re-design. Our exploration of current FAO support practice was limited

and therefore indicative only. We found that some services do appear to be engaging with a high proportion of FAO clients, and/or engaging with explicitly family focussed paradigms and/or approaches that are aligned with the recommendations of our panel and research. In depth engagement with these gambling services, e.g. exploration of service development, ethos, support practices and outcomes for families, could deliver important learning and benefits for the gambling harm minimisation and prevention sector.

Final recommendations

Taken together, our exploratory research suggests the following activities will enhance support for family and affected others (FAOs) in New Zealand gambling services:

- In depth engagement with how a range of FAOs view and experience gambling harm and recovery, and the development of models and approaches in accordance with this.
- Developing and expanding approaches that look beyond the individual to conceptualise harm and recovery as social and relational phenomena
- Mindfully engaging multiple harm and recovery paradigms (individual psychological and broader social, cultural and relational)
- Participatory research, service design and evaluation
- Creative workforce development.

Limitations of this inquiry

Our mixed methods inquiry has enabled the triangulation of multiple data sources to suggest some avenues for enhancing support for FAOs in New Zealand gambling services. Our engagement with experts was limited by participant availability during the COVID-19 pandemic and suffered from low consumer participation. We argue that limited engagement with FAOs who use services (and those who do not) in gambling studies is a barrier to quality and effective support practice which should be addressed in future studies. Our exploration of current FAO support practice was high-level, limited in scope, and therefore indicative of future avenues of inquiry only. We argue that in-depth exploration of current practice, with a view to service enhancement, is necessary to build an evidence base and improve support provided for FAOs.

Conclusion

This research was conducted to explore how gambling support services for family and affected others (FAOs) could be enhanced in New Zealand, in the context of long-standing disconnect between the expectations of families/whānau and mental health and addictions service delivery. Addiction related harm in families is a complex and multidimensional phenomenon. No single treatment system can address all addiction-related problems for families. Support should therefore engage with the multiple mechanisms through which addiction develops, is maintained and harm experienced. Addictions services tend to be guided by one approach to engaging and supporting FAOs at best, and to be dominated by the views of professionals. The service-user and person-centred movements within mental health care identify the role of services/interventions in helping FAOs to both conceptualise and articulate their multiple

understandings of harm and recovery needs. Honouring Te Tiriti o Waitangi by realising Māori aspirations for tino rangatiratanga (self-governance) and mana motuhake (autonomy) will improve support for New Zealand families by centralising whānau (family systems) and whānaungatanga (relationships) in gambling harm reduction. Transformative and action-oriented research has the potential to facilitate in-depth and collaborative engagement between addictions service providers and FAOs in reshaping services to enhance the range and quality of support provided for FAOs. Collaborative techniques and processes (e.g. co-design and consumer governance roles) could be usefully employed to conceptualise, design, plan and evaluate enhanced gambling harm reduction services for FAOs in New Zealand. These activities should be supported by government policy and funding for practitioner-inquirers, enhancing workforce diversity, family specific support and intervention training and remodelling of current service strategies and offerings with families and children in mind.

BACKGROUND

The need for gambling harm reduction services to address family and affected others (FAOs) is clear. Approximately 8% of the New Zealand population report experiencing harm related to the gambling of someone close to them (Abbott, Bellringer, Garrett, & Mundy-McPherson, 2014). Research has demonstrated that around six others are directly affected by someone classified as a high-risk gambler (Goodwin, Browne, Rockloff, & Rose, 2017). Partners and especially children, suffer both mental and physical health problems connected to living in a state of fear, anger, guilt, despair, loss and uncertainty as well as loss of safety and financial security (Kourgiantakis, Saint-Jacques, & Tremblay, 2013; Riley, Harvey, Crisp, Battersby, & Lawn, 2018). These issues can linger long after the harmful gambling has stopped, as encapsulated by the notion of 'legacy gambling harm' (Darbyshire, Oster, & Carrig, 2001; Langham et al., 2015). There are high relapse rates for people experiencing gambling problems (Ledgerwood & Petry, 2006), and chronic gambling disorders leave lifelong vulnerability to harm (Volberg 2002). There is limited research exploring the role of FAOs in the treatment of problem gamblers (Kourgiantakis et al., 2018), and even fewer studies have focussed on FAO needs or developed, documented and explored the efficacy of support designed especially for them (Rodda et al., 2019).

Family engagement with services has been associated with preventing and/or influencing the course of addictions, triggering people who are resistant to treatment to seek help, improving outcomes for the person with the addiction, helping to prevent relapse, as well as diminishing the negative effects of addiction on the family (Hampson, 2012). Indeed, it has long been argued that the only reason not to address FAOs in addictions service provision is if their involvement is refused by the FAOs themselves or by the person with the addiction (e.g. O'Farrell, 1993). Appropriate and timely provision of addiction related support and services for FAOs can reduce the severity and range of harms families experience (Adams, 2007a; Orford, Copello, Velleman, & Templeton, 2010; Orford, Cousins, Smith, & Bowden-Jones, 2017). However multiple international studies have shown that successful integration of family-focussed approaches into routine addictions service provision is both challenging and rare (e.g. Fals-Stewart & Logsdon, 2004; Lee, Christie, Copello & Kellett, 2012; Sawyer & Campbell, 2009). The most recent New Zealand government inquiry into mental health and addiction services (He Ara Oranga) heard that families and whānau continue to feel disconnected, excluded and underserved by services (Patterson et al., 2018).

New Zealand gambling harm prevention and reduction services are funded by the Ministry of Health (MOH) to engage with FAOs whether or not the person who is gambling chooses to engage. In the July 2017 to June 2018 year, FAOs comprised one quarter of all clients engaged in a structured intervention plan (1370 clients), and just under two thirds of shorter more opportunistic/motivational engagements with people in the community who were experiencing gambling harm (3227 clients) (Ministry of Health, 2020a). The MOH does not prescribe any particular approach to working with families affected by gambling. The MOH has variously

challenged mental health and addictions service provision generally to empower (Ministry of Health, 1994), better respond to (Ministry of Health, 1997), address the needs of (Ministry of Health, 2006), and increase support for (Ministry of Health, 2012b) family/whānau. 'Supporting Parents Healthy Children' addictions service guidelines recommend that services ask about and seek to involve family and whānau 'in ways that work', and that partnership with families/whānau 'should be evident in service design' (Ministry of Health, 2015). Since 2009, a Whānau Ora approach has evolved in New Zealand to actively promote, support and fund whānau-centred and holistic support and services for family health and well-being. This approach emphasises encouraging families to identify the aspirations they have to improve their lives and building whānau capacity to achieve their goals (Independent Whānau Ora Review Panel, 2018).

To date no research has explored how gambling services intervene with FAOs in New Zealand. There has been no published research designed to support or inform services in their provision of intervention for FAOs in New Zealand, or engagement with the views and experiences of FAOs as they relate to service delivery. Recent evaluation of MOH funded services did not explore engagement with FAOs in any depth, but suggested that FAO clients were less likely than gamblers to receive any facilitated referral to other allied services, or follow-up support and that limited screening may compromise monitoring of clients' progress and outcomes (Kolandai-Matchett et al., 2015). In 2019 the Ministry of Health commissioned the Gambling and Addictions Research Centre (GARC) to conduct an exploratory mixed methods study of how support provided for family members and affected others (FAOs) in New Zealand gambling services could be enhanced.

APPROACH

Published evidence for effective gambling service design and delivery for FAOs is extremely limited (Bowden-Jones & George, 2015; Calderwood & Rajesparam, 2014; Kourgiantakis et al., 2018; Orford, 1994, 2014). An exploratory approach, involving engagement with existing knowledge in the gambling and broader addictions fields was therefore selected (e.g. Livingstone et al., 2019). The overarching research question was: How could support provided for family members and affected others (FAOs) in New Zealand gambling services be enhanced?

A mixed methods approach was adopted to enable a multifaceted exploration of support for FAOs and how support could be enhanced in New Zealand gambling services. The project drew on the work of Greene (2007), and the notion of complementarity. Complementarity is brought into play when different methods are used to explore different features of the same phenomenon (Greene, Caracelli, & Graham, 1989). Mixed methods studies with a complementarity purpose are useful for studying dynamic and multi-layered issues. A component design was adopted, where methods remained largely discrete throughout the study, and the findings interpreted together in the final discussion (Greene, 2007).

Part one of the study comprised an exploration of quality and effective FAO support practices. Part two involved exploration of current FAO support practices. The specific details and rationale relating to the data selected and methods adopted in each component are discussed in the following sections of this report. The research design included the following four components:

Part one: Exploration of quality and effective FAO support practices

- A conceptual review of FAO addictions support and intervention literature,
- A structured engagement with an international expert opinion on enhancing gambling harm reduction services for FAOs. The expert panel included 40 participants with expertise in support for families affected by addiction (e.g. service managers, researcher, policymakers, people with consumer/lived-experience as people who gamble and as FAOs, clinicians and workforce development professionals). This structured engagement was informed by the conceptual literature review.

Part two: Exploration of current FAO support practices

- A national and international scan and analysis of the types of gambling services advertised and/or provided for FAOs
- Descriptive analysis of New Zealand gambling service use data.

The overarching output of the project was the identification of opportunities to enhance support for FAOs in New Zealand gambling services.

EXPLORATION OF QUALITY AND EFFECTIVE FAO SUPPORT

This section details the results of part one of the study, an exploration of quality and effective FAO support. Part one involved a conceptual review of addictions literature, which informed a structured engagement with expert opinion on enhancing support for FAOs.

Conceptual review of addictions literature

Conceptual reviews explore the underlying logic or assumptions about harm that are reflected in intervention practice (e.g. Delfabbro, 2000; Griffiths & Delfabbro, 2001; Harvey & Delfabbro, 2004; Orford, Velleman, Natera, Templeton, & Copello, 2013). The purpose of such reviews is to point out issues and areas of tension/contradiction in the knowledge base currently underpinning practice (e.g. Johnson, Riis, & Noble, 2016; Tuma, 1989). Support for FAOs is the subject of continuing debate and discussion as researchers, clinicians and policymakers develop and improve metrics and models of harm and recovery. Proposed interventions and strategies for reducing harm contain within them assumptions about gambling, harm and FAO needs. These assumptions should be identified and critically examined in the interests of informing harm reduction services (e.g. Casswell & Maxwell, 2005).

This conceptual review sought to consider and include multiple perspectives on 'evidence-based practice' in play across the addictions literature. For example, an empirical-analytical perspective focuses on experimental evidence, e.g. change in validated measures, as the basis for evidence-based practices (Erbes et al., 2015; Nayoski & Hodgins, 2016). A phenomenological-existential perspective views intervention success as based on reported experiences of well-being (e.g. R. Graham & Masters-Awatere, 2020). From a third, values-based perspective, intervention quality and effectiveness is based on a-priori principles such as inclusion, equity, self-determination, participation, and empowerment (Durie, 1997; Dyall, 2007).

Principles of intersectionality

Social models of addictions draw attention to cultural and environmental influences on biological, psychological and other factors, with implications for both the experience of and interventions to address harm in families and communities (Becker, McClellan, & Reed, 2016; Griffiths & Delfabbro, 2001; Sharpe, 2002). Intersectionality is a theoretical framework that posits that multiple individual social categories (e.g., ethnicity, gender, socioeconomic status) and systems of privilege and oppression at the social-structural level (e.g., racism, sexism, poverty) shape our lives and are therefore involved in producing health outcomes (Bowleg, 2012). An intersectional lens is useful when designing and assessing health promotion campaigns, social marketing, public health interventions, and in the delivery of primary health care to effectively engage with communities and avoid unintended negative effects (Bauer, 2014; Vardeman-Winter, Jiang, & Tindall, 2013). Principles of intersectionality were kept in mind to enable some commentary on the responsiveness of the FAO support literature to the

ways in which gender, ethnicity and culture-related issues, notions and practices influence addiction and related harm in communities.

Methods

Data selection/collection

Existing published and grey literature was reviewed to explore recommended support practice with FAOs in gambling services. This review considered FAO support literature from gambling studies as well as the related harmful commodity fields of alcohol and tobacco. To enhance the specificity of the review, literature from the broader mental health field was not included. Mental health literature did inform the discussion of results. Research inclusion criteria was as follows; studies/reports were required to meet all criteria for inclusion:

- Published anytime (enabling a historical perspective)
- Documents support practice designed to impact on harm experienced by FAOs in relation to gambling, alcohol, or tobacco, at any level (individual, couple, family, community) in a service setting (e.g. clinical, community, public health)
- Must include some evaluative/impact/outcome statements and/or some analysis in relation to effects on FAO health and/or wellbeing.

The purpose of data collection was not to be exhaustive, but to enable the articulation of key thinking/theory, intervention practice, and implications for service delivery for FAOs, as reflected in published literature (e.g. Ahl, 2007). The primary purpose of this review was to inform the structured engagement with expert opinion on the topic of enhancing support for FAOs in gambling services.

Data analysis

The literature analysis process was iterative. Alcohol, tobacco and gambling intervention literature meeting the above criteria, was first summarised and categorised in relation to how FAOs and their needs are primarily understood. Key theory underpinning intervention was noted, and examples of practice in the literature explored in relation to gender and ethnicity/culture related issues, and implications for service design and delivery.

Analytical questions included:

- How does the literature define/describe quality and effective support for FAOs?
- What thinking/theory/understandings of FAOs and their support needs can we discern from the literature?
- How are men, women, indigenous and culturally diverse peoples, made visible/excluded or absent in the FAO support literature?

After this first phase of analysis was completed and summarised into a lengthy report, it became clear that the literature related to alcohol harm reduction offered the clearest parallels/examples to inform gambling support practice. This was due to key similarities in the approach taken to

harm reduction related to alcohol and gambling (e.g. a clear harm reduction rather than elimination focus). For example, New Zealand has taken a clear policy stance on reducing the availability of and demand for tobacco, e.g. the Smokefree Aotearoa New Zealand 2025 goal (Ministry of Health, 2020c). Following the principles of conceptual review (e.g. Johnson et al., 2016; Tuma, 1989), key issues and tensions in the FAO addictions support literature were then explored, with illustrative reference to alcohol harm reduction practice. Gambling support literature was analysed for similarities and differences, as well as presence and absence of issues/tensions identified in the broader addictions literature. Some implications for enhancing gambling harm reduction practice with and services for FAOs are brought together in the concluding section.

Understandings of addictions, FAOs, the purpose of intervention and outcomes

We found that family-focussed addictions harm reduction are informed by multiple understandings of addiction as a fundamentally psychological phenomenon (with social effects), as shaped by fragmentation (and reintegration) of intimate relationships, and as shaped by macro-level social structures (e.g. socioeconomic inequalities, the provision and governance of harmful commodities) (Selbekk, Sagvaag, & Fauske, 2015).

Key bio-psychologically informed approaches to FAO support have included a focus on FAOs as 'intervention allies' capable of using psychological theory and tools to influence the person with the addiction to change and/or enter treatment (e.g. Kirby et al., 2017; Nayoski & Hodgins, 2016). Another approach in this vein has focussed on the need to support the psychological functioning of FAOs in their own right (without necessary reference to the needs of the person with the addiction) (Copello, Templeton, Orford, & Velleman, 2010). Examples of socially informed approaches to FAO support are more concerned with the contextual, social and relational determinants of addiction, and enhancing recovery capital, e.g. through family and social network therapies, and approaches informed by holistic, Indigenous and other culturally based models of wellbeing (Adams, 2007a).

Some broad approaches to addictions support for FAOs are outlined and explored below in relation to intersectional and conceptual challenges, as well as implications for service delivery.

<u>Assisting FAOs to assist the person with the addiction</u>

An estimated 6% of individuals with alcohol disorders, and 16% of drug users engage formal treatment (Stinson et al., 2005). Given the reluctance of many people struggling with addiction to seek help (e.g. Brogly, Link, & Newman, 2018; Perron et al., 2009; Saunders, Zygowicz, & D'Angelo, 2006), influencing and engaging users in treatment remains a dominant theme in addiction harm reduction for FAOs. Further, many FAOs reportedly reject help for themselves, and seek to focus on actively seeking help for their family member (Meyers, Smith, & Lash, 2005). Internationally, a large proportion of FAOs appear to prioritise seeking formal help services to change their relatives' drinking (see Howells & Orford, 2006). FAOs of people struggling with addiction have been positioned as a valuable resource to be engaged in

addiction rehabilitation and treatment efforts. This intervention approach positions FAOs as 'intervention allies' and as 'agents of change'. It holds that through learning productive communication tactics and/or behaviour change techniques, FAOs can contribute to improvements in the individual with the drinking or drug problem and experience benefits themselves e.g. a sense of power, purpose and direction and reduced helplessness. If the lived experiences and needs of FAOs are to shape service design and delivery, it appears inescapable that at least some part of an intervention for FAOs target the addiction itself.

Community Reinforcement and Family Training (CRAFT) as a key program

A key example of manualised intervention in this space is Community Reinforcement and Family Training (CRAFT) with partners/spouses of Alcohol and/or drug users (Meyers et al., 2005; Miller & Meyers, 2004; Sisson & Azrin, 1986). FAOs are trained in behavioural reinforcement techniques to provide positive consequences for abstinence, recognise and avoid conveying positive consequences for substance use, and identify when their loved one might be more receptive to considering entering treatment. FAOs participate using role-plays and other behavioural skills-training exercises during sessions, and homework assignments between sessions (Meyers et al., 2005). CRAFT-trained therapists conventionally provide eight to 12 individual sessions (Archer, Harwood, Stevelink, Rafferty, & Greenberg, 2019). Core components include: (1) enhancement of FAO motivation to influence the substance user; (2) functional analysis of the substance user's problem behaviour; (3) domestic violence precautions; (4) communication skills training; (5) judicious use of positive reinforcement; (6) use of negative consequences for substance using behaviour; (7) enrichment of FAO's own lives; and (8) substance user treatment invitation.

The wellbeing of FAOs is supported as a secondary goal by the CRAFT clinician working with the FAO to identify areas in their own life they would like to change and developing strategies to do so (Miller & Meyers, 2004; Miller, Meyers, & Tonigan, 1999). Since CRAFT is primarily positioned as a program for engaging treatment-refusing substance abusers into treatment, treatment entry is the most consistently investigated and best supported outcome of CRAFT (see review by Kirby et al., 2017). Treatment entry rates for substance use disorders have been consistently high; most studies achieve > 60%, with the earliest evaluation of CRAFT reporting a rate of 86% (see reviews by Archer et al., 2019; Roozen, De Waart, & Van Der Kroft, 2010). Enhancing FAOs' motivation to help and assertiveness to intervene have been suggested as the most important factors to target for maximising treatment entry (Archer et al., 2019; Roozen et al., 2010). Maximising treatment engagement has been explored across multiple CRAFT delivery modalities (e.g. online, brief, self-directed), with those offering the most comprehensive support to the FAO (e.g. multi-modal, including follow-up) associated with the highest levels of treatment engagement success (Meyers, Miller, Hill, & Tonigan, 1998; Meyers, Miller, Smith, & Tonigan, 2002; Sisson & Azrin, 1986; Waldron, Kern-Jones, Turner, Peterson, & Ozechowski, 2007).

Although treatment engagement has been the main focus of evaluative research, improvements in measures of FAO mental health, family cohesion, and relationship quality have been reported across CRAFT outcomes studies for a range of substance use, ethnicities of clients, and types of relationships (e.g. Dutcher et al., 2009; Kirby, Marlowe, Festinger, Garvey, & LaMonaca, 1999; Meyers et al., 1998; Meyers et al., 2002). Recent innovations in online CRAFT delivery for military families have taken more care to address FAO wellbeing as a coherent treatment component (Osilla et al., 2018), and web and community based adaptations of CRAFT seem to have had greater impact on measures of FAO wellbeing (e.g. psychological distress, quality of life) than noted in previous studies. Most evaluative research has been conducted from an empirical-analytic perspective, with almost no exploration of FAO experiences of engaging with services and their loved ones from this perspective/approach.

Centralising treatment engagement for the person with the addiction

Critique of CRAFT has centred on the notion that focussing on outcomes for the person with the addiction may at best obscure issues for FAO wellbeing, and at worst contribute to a sense that FAOs are responsible for causing and/or addressing addiction related harm in families (Orford, 1990, 1994). Similarly, although ostensibly focussed on the relationship, behavioural couples' therapy (BCT) in practice requires partners to support and coach their spouse with the addiction. BCT has two overarching components: assessing and improving behavioural interactions to reduce the likelihood of substance use, and improving communication skills (Copello et al., 2006). This approach posits if couples are happier and improve their communication, there will be a lower chance of relapse (O'Farrell & Clements, 2012). From this perspective, relationship functioning and substance dependence are seen as reciprocal (Powers, Vedel, & Emmelkamp, 2008). The partner can becomes a secondary therapist or coach for the addicted partner, helping them through the process of behavioural change (Walitzer & Dermen, 2004). The extent to which partners have the emotional capacity or willingness to engage in this way remains underexplored (O'Farrell & Clements, 2012).

Orford et al. (2010) describe a negative view of family members as subtle, pervasive, and by no means limited to the most obviously dated statements of some authors writing about 'wives of alcoholics' half a century ago. Werner and Malterud (2016) explored children's experiences of parental substance use and treatment, suggesting that fragmented and confined approaches from health and social services towards families with parental drinking problems were unhelpful:

> *"[Children] called for attention from a responsible service professional who would sit down with them and invite them to speak about the problems. Recognising the young person's situation implies, however, not only noticing that something is wrong, but also taking action, asking carefully for information and involving other professionals."* (Werner & Malterud, 2016, p. 669)

FAOs and advocates have sought to make visible the situations where addictions professionals seem reluctant to take action beyond the client with the addiction's acute problems. In doing so addictions clinicians and researchers have begun to position themselves as 'family-oriented' (Selbekk & Sagvaag, 2016) – this perspective is discussed further in the next section.

Gender issues related to the role of FAOs as treatment supporters

Harmful use of alcohol and illicit drugs has been generally higher in men; although recent epidemiological studies indicate a narrowing in this gender gap especially in adolescents (see Becker, McClellan, & Reed, 2017). The recruitment of women (partners and mothers) into the intervention process has therefore been seen as pivotal - wives were recognised early on by Yates (1988, p. 1309) as the 'natural influences' on drinking problems. In exploring and advocating for the role of FAOs as influencers, addictions intervention studies have mostly involved women (Archer et al., 2019; Roozen et al., 2010). Given women's traditional caring roles in families, the potential for this approach to ascribe to women a larger share of responsibility for addressing addiction-related harm in families than men has been suggested (Galvani, 2006; Lobsinger, 1997). For example, there is a dearth of research exploring how men specifically, can be involved in supporting loved ones to change their behaviour and/or access alcohol and drug treatment (Abbotts, 1994; Tuchman, 2010).

There is also potential for interventions positioning women as 'intervention allies' to inadvertently exacerbate addiction related harm. CRAFT interventions literature has promoted intensive engagement in monitoring and persuasive behaviour among women partners and carers, for example:

> *Each client was counselled on how to behave when her family member was drinking. She was to try to be present at the time of drinking, during which she would then encourage eating, drinking non-alcoholic beverages, suggest other activities besides drinking, make the drinker aware of how much he was drinking and remind him of how pleasant it was when he was not. (Sisson & Azrin, 1986, p. 17)*

Competing activities must be planned by FAOs to interfere and compete with drinking and potential drinking (Meyers et al., 2005; Miller et al., 1999). The notion of increasing 'positive consequences for not drinking' has recommended women engage in "making [his] favourite foods, talking about topics he enjoyed, providing preferred sexual activities, purchasing gifts and generally being pleasant" (Sisson & Azrin, 1986, p. 17).

If implemented in practice, the kind of engagement encouraged above is concerning given the association of alcohol and substance abuse with domestic abuse (Brem, Florimbio, Elmquist, Shorey, & Stuart, 2018; Galvani, 2006) and sexual violence (Florimbio et al., 2019) against women. Some proponents of CRAFT claim to make intimate partner violence (IPV) an integral part of the approach to intervention by exploring and discussing both the antecedents and consequences of IPV for the victim, and subsequently the avoidance and coping strategies of

FAOs/women (Roozen et al., 2010). For example, Meyers et al (2005) described how women could be supported to address IPV against them:

> *CRAFT sometimes employs a functional analysis to gather additional information about domestic violence, as it can be helpful for* ***identifying violence triggers, and for formulating new ways for the [FA]O to respond****. CRAFT devotes time to role-playing these new behaviors to minimize the likelihood of violent outbursts. CRAFT also aids [FA]Os in building a safety plan that can be used in the event that violence appears imminent. (Meyers et al., 2005, p. 93 emphasis added)*

The notion of 'handling dangerous situations' has involved teaching the FAO to identify signs of intoxication and physical violence, and how to respond in these instances such as leaving to stay with a pre-arranged relative, friend, or women's centre. In cases where the person who is drinking became violent, the FAO would be encouraged to call the police and file charges, "thereby making the drinker aware that violent behavior would not be tolerated" (Sisson & Azrin, 1986, p. 17). While constructing behavioural contingencies around the substance user may influence them to change or enter into treatment, the importance of services engaging with the intersectional nuance of women's experiences of addiction related harm in practice is reinforced. Seeking help is known to be an exceptionally difficult and complex process for victims, which can easily force women to remain in or return to a violent relationship (Wilson, McBride-Henry, & Huntington, 2005). We found no research engaging with the safety, support or intervention experiences of women engaging with CRAFT.

Questioning the notion of 'cross-cultural applicability'

Behaviourally based approaches to shaping and changing addictive behaviour, such as CRAFT, construct reinforcement as a fundamental process to learning that is independent of species, and culture. What is reinforcing and how contingencies are arranged should be assessed with each client as part of a functional assessment – so the specifics of the intervention can be worked through with the client in a way that is appropriate for them (Meyers et al., 2005). Careful re/co-design of CRAFT interventions and evaluation with groups of different cultural heritage is not generally carried out. For example, notable increases in the use of CRAFT over the past decade in countries such as the United Kingdom and Japan, have not been accompanied by rigorous research and evaluation with a wide variety of population groups (Archer et al., 2019).

Developing cultural competency in therapists applying CRAFT is suggested to ensure appropriate behavioural contingencies for the clients involved, and facilitating applicability and acceptability to particular families and communities (Calabria et al., 2019). Authentic and meaningful engagement between addictions services and Aboriginal community members has been found to promote access to drug and alcohol services (Allan & Campbell, 2011). Calabria and colleagues have advocated for in-depth consultation with Aboriginal Australian populations affected by addictions in developing culturally appropriate guidelines for CRAFT

use. Two studies have involved consultation surveys with Aboriginal communities (n=116, 51% female) and in depth focus groups and interviews with specialised Aboriginal health care and service providers (n=29) (Calabria, Clifford, Rose, & Shakeshaft, 2014; Calabria et al., 2013). CRAFT was viewed as highly acceptable to Aboriginal people, particularly by Aboriginal women wanting to assist individuals' post-alcohol withdrawal or those wanting to help a loved one initiate treatment. Participants indicated a preference for counsellors who were known, trusted and part of local communities. Alcohol-related harms were re-conceptualised in relation to local community knowledge (e.g. the notion that for young Aboriginal Australians, binge drinking is normalised as a way of creating social connectedness with peers and a sense of relief from a lack of hope for the future) (McCalman et al., 2013).

Approaches that seek to assist FAOs to change the behaviour of the person with the addiction may be useful as part of a multi-faceted approach –they have been widely evaluated and generally found to be effective in terms of what they were designed to achieve. There is a clear need to improve them with reference to more contemporary understandings and to complement them with other interventions. It is increasingly evident that addictions harm reduction efforts must go beyond raising awareness of services and support, and demonstrate relevance to affected populations (Miller, Sorensen, Selzer, & Brigham, 2006). Despite the demonstrated efficacy of community reinforcement for treatment engagement, it is argued that CRAFT is not widely advocated at a public policy level (e.g. Milford, Austin, & Smith, 2007). The cost-effectiveness of the intensive 12 session intervention focussing on more than treatment engagement has been questioned, especially given that benefits to FAO wellbeing are less clear (Kirby et al., 2017). CRAFT literature contains many assumptions about FAO experience – including the notion that treatment engagement and/or reduction in addictive behaviour will promote FAO wellbeing. More critically for service uptake, there is also a dearth of research exploring FAOs' own experiences of choosing and using CRAFT.

Enhancing FAO coping and social support

Family-oriented perspectives hold that although family involvement in addictions treatment can improve treatment engagement and outcomes for people experiencing addiction, it remains "an open question" whether these outcomes are compatible with enhancing FAO wellbeing (Orford, 1994, p. 420). FAOs can become the focus of help and support in their own right, without necessary reference to the person with the addiction's needs or issues. A stress-strain-coping-support (SSCS) model of addiction positions FAOs as 'normal people placed in an abnormal situation' by substance use that is largely beyond their control (e.g. Orford et al., 2010; Orford, Templeton, Velleman, & Copello, 2005; Templeton, Velleman, & Russell, 2010). The stress-coping model seeks to "incorporate the idea of being active in the face of adversity, of effective problem solving, of being an agent in one's own destiny, of not being powerless" (Orford et al., 2010, p. 37). Figure 1 illustrates the model, detailing the relationship between the family members and the experience of stress, strain, and coping.

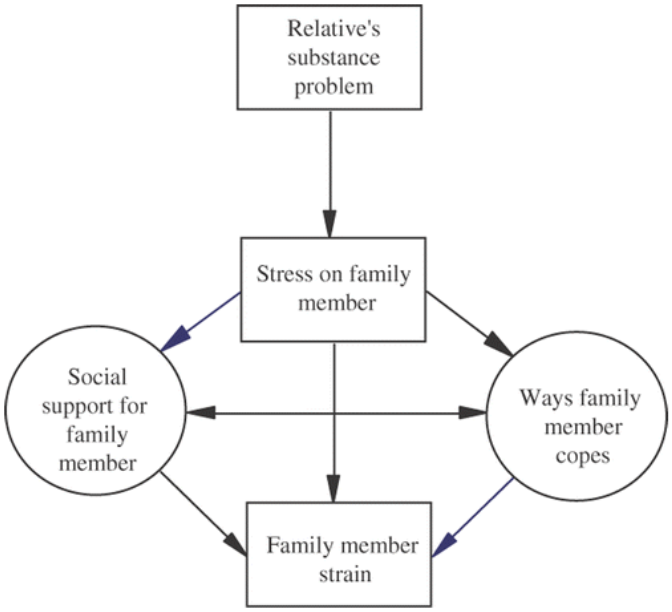


Figure 1. The stress-strain-coping-support (SSCS) model (Orford et al., 2010, p. 37)

Adaptive coping strategies for FAOs affected by substance abuse are held to include letting go of a feeling of total responsibility for the problem, setting firm boundaries, and clear communication (Gethin, Trimingham, Chang, Farrell, & Ross, 2016). Typical responses regarded as unhelpful to substance use and FAO wellbeing include hard-line threats, ultimatums, over-responsibility, obsessing, and rescuing behaviour (Gethin et al., 2016). Although addiction in a family can produce trauma and suffering, this perspective holds that FAOs can be supported to reduce their distress and cope more effectively. The role of professional support is to facilitate this process:

> *What primary health care workers can do…[is] Listen non-judgementally, provide useful information, counsel non-directively about ways of coping, help strengthen social support and joint problem-solving in the family. (Orford, 1994, p. 425)*

5-Step intervention as a key programme for enhancing FAO coping and social support

The 5-step method was developed incorporating components of the SSCS model into a step-wise method to be used when supporting individual FAOs to cope (Copello et al., 2010; Copello, Templeton, & Velleman, 2006). The five steps are detailed in Figure 2.

Step 1: Listen, reassure and explore concerns
- Allow family member to describe situation
- Identify relevant stresses
- Identify need for further information
- Communicate realistic optimism
- Identify need for future contacts

Step 2: Provide relevant, specific and targeted information
- Increase knowledge and understanding
- Reduce stress arising from lack of knowledge or misconceptions

Step 3: Explore coping responses
- Identify current coping responses
- Explore advantages and disadvantages of current coping responses
- Explore alternative coping responses
- Explore advantages and disadvantages of alternative ways of coping

Step 4: Discuss social support
- Draw a social network diagram
- Aim to improve communication within the family
- Aim for a unified and coherent approach
- Explore potential new sources of support

Step 5: Discuss and explore further needs
- Is there a need for further help?
- Discuss possible options with family member
- Facilitate contact between family member and other sources of specialist help

Figure 2. The five steps for supporting FAOs affected (Copello et al., 2010, p. 87).

Holding space for FAOs to articulate the nature of issues in their own terms is a central component of FAO support (Copello et al., 2010). FAOs engaged in this way have associated a sense of growing confidence and wellbeing with the belief that their needs matter just as much as their loved one's needs (Orford, Templeton, Patel, Copello, & Velleman, 2007). In keeping with the philosophy of SSCS, the main outcome measures are the Symptom Rating Test assessing anxiety, depression, somatic symptoms, and inadequacy symptoms (Kellner & Sheffield, 1973), and the Coping Questionnaire which comprises 30 statements that measure strategies FAOs use to cope with the substance abuse in the past three months (Krishnan & Orford, 2002). Analysis of a series of 6 single cohort 5-Step studies involving over 300 FAOs in the UK, has demonstrated clear reduction in addiction-related stress (Orford, Templeton, Patel, Copello, et al., 2007; Orford, Templeton, Patel, Velleman, & Copello, 2007). However FAOs also report that the intervention was not helpful to the extent that it had not affected their loved one's drinking / substance use (Orford, Templeton, Patel, Copello, et al., 2007; Orford, Templeton, Patel, Velleman, et al., 2007). In addition, impacts on coping are variable, and suggest that appropriate coping style may be very context specific (discussed further in relation to culture below). These tensions point to the need for addictions services to maintain a dual focus on options for FAOs who wish to focus on the addictive behaviour, their own wellbeing or a static or shifting combination of both. Again, the importance of services' in-depth engagement with and understanding of the social context through which their clients experience addiction related harm is indicated.

Engagement with intersectional influences on harm, coping and social support

As with approaches grounded in behavioural psychological theory (e.g. CRAFT), limited exploration of intervention with non-White, non-female populations has been carried out

(Copello et al., 2010). In-depth engagement with affected communities is important to support culturally safe practice that will be accepted by these communities (Rey, Mora-Ríos, Sainz, & Aguilar, 2010). The focus has been on identifying and adapting practice to be more cognisant of intersectional issues affecting these communities. For example, in Mexico Rey et al. (2010) reported:

> *Addictions are usually explained as a private problem that concerns the family alone, rather than as a social problem and a public health issue. Women are primarily held responsible for the problem, and they perceive themselves as such, either because they could not raise children properly or, in the case of a partner, because a woman has not known how to help him stop drinking. Culturally, the family is seen as an isolated entity, as if it were not the result of a structure, in which addictions appear primarily as a social problem.* (p.195)

Broader sociocultural context, e.g. 'suffering as self-sacrifice' based on deeply rooted religious beliefs, patriarchal structures, domestic violence, and the highly stigmatised nature of addictions impact on FAOs in Mexico, and their ability to engage with external support (Rey et al., 2010). Rey and Sainz (2007) noted that FAOs expressed a need for services to support them with the situation *as they defined and experienced it*. Taken together, the challenges for the 5-Step intervention to respond to, identified by the authors, are outlined below in Figure 3.

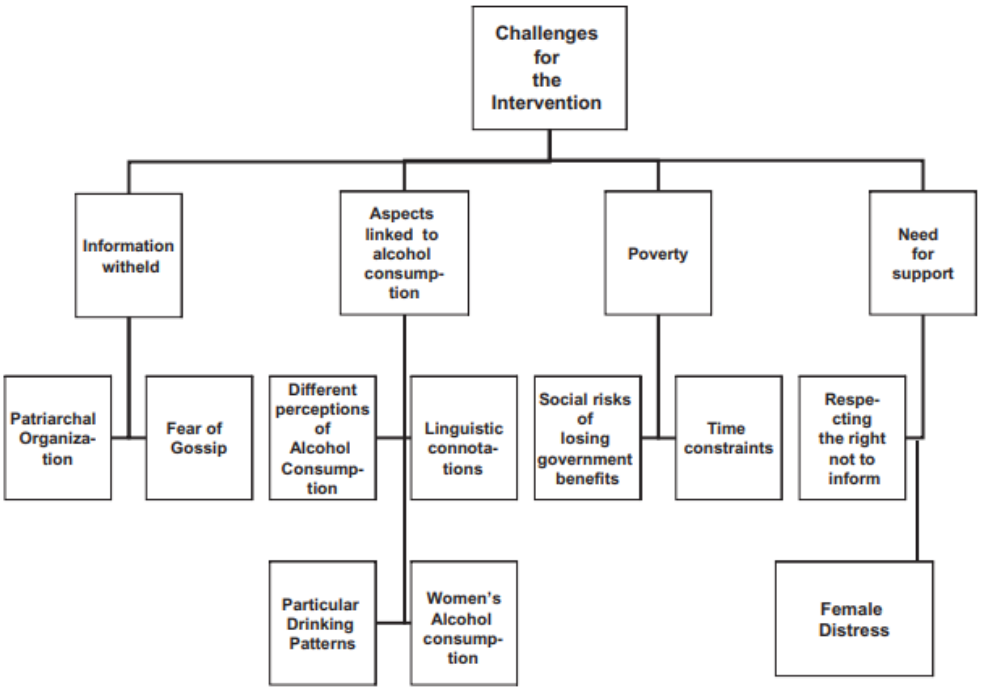


Figure 3. Challenges for and barriers to intervention (Rey & Sainz, 2007, p. 35)

5-Step could be conceptualised as a springboard for opening up discussion with FAOs about their needs, as potentially shaped by their particular context of poverty, marginalisation and

everyday survival, including the broader cultural notion that excessive alcohol consumption is a natural habit for men. Again, as a result of in-depth engagement with mothers affected by addiction in Malaysia, researchers have adapted a 5-Step approach including greater attention to environmental issues, collective family support (an open group to share experiences, information, and resources), and a family retreat (two-week intensive programme conducted twice a year involving the whole family). A family wellness approach to 5-Step includes addressing "an environment that challenges [FAOs] ability to maintain a healthy balance" in their lives (Baharudina & Sumarib, 2017, p. 113).

Any straightforward distinction between beneficial/harmful coping has been contested from socio-cultural perspectives. While the SSCS model suggests that coping may play the role of a moderator in the relationship between FAO stress and symptoms (strain), to date research has found limited support for a moderation effect (Orford, 2017; Orford et al., 2005b). Some evidence has also been produced that the way FAOs cope shows variation by social or cultural group: for example, Sikh wives in England reported more engaged and tolerant coping than white wives (Ahuja, Orford, & Copello, 2003). In-depth engagement with the lived experience of twenty-four British Sikh wives of men with alcohol problems, plus ten of their husbands and seven of their daughters highlighted that 'effective coping' involved a complex and shifting positioning between inactive resignation to the problem, active resignation and developing partial independence, and confrontation. All engagement with the alcohol issue occurred alongside commitment on the part of wives to continue to care for their husbands and a similar commitment on the part of daughters to support their mothers. These results suggest that approaches to FAO support must carefully engage with the socio-cultural realities shaping how 'coping' is and can be practiced.

Social support as an attribute of individual FAOs – the limits of 'particle thinking'
From the perspective of SSCS and the 5-Step intervention, social support tends to be described as an attribute of individual FAOs. Social support is brought into therapy through discussion of its nature and value e.g. – utilising 'social network mapping' and similar techniques to support network development. Adams (2016, p.90) identifies this approach as an example of bio-psychological thinking about the 'self' in relation to addiction:

> *"…social dimensions are not so easily reduced to 'variables', 'factors' and 'influences' attached to individual [FAOs]… Bio-psycho-social approaches do not embrace a truly social understanding of addiction. They tend to condense social dimensions into mere appendages attached to the primary particle. A person's social world—family and friends as well as occupational community involvements—are abstracted from their contexts and simply hung onto the particle as attachments. This enables treatment services to continue their work with particles while acknowledging the influence of social factors"*

Individual clients (as 'particles') report on their social and occupational involvements but these relationships and people tend to be excluded from actual service offerings and proceedings. Orford and colleagues acknowledge that the Stress-Strain-Coping-Support model does not appropriately address family members in their social and cultural context. They hold that SSCS offers the clearest alternative to individual psychological models which underserve (e.g. FAOs as 'treatment allies') or even pathologize FAOs (e.g. through the notion of co-dependency) (Orford et al., 2010).

Viewing addiction as a social or relational event can form the base for a variety of innovative approaches to service provision intervention (discussed in the following sections). This is not to suggest that relational approaches are inherently superior to more individual approaches, nor that one should replace the other. The two approaches engage different understandings of addiction, FAOs, and accordingly, recommend different ways for services to operate. Adams (2016) suggests that multiple approaches must be allowed to flourish in service environments and the evidence base be expanded and diversified, if clients are to be empowered to engage with the concepts and approaches that are the most relevant to them.

Supporting relational reconnection

Key to this approach is the notion of addictions recovery as a relational process (Adams, 2007a; Selbekk & Sagvaag, 2016; Selbekk et al., 2015). For example, Selbekk and Sagvaag (2016) explored encounters between families and addictions treatment services from the perspective of families, reporting that FAOs desired to have more than a peripheral role in the challenges associated with substance use. Selbekk et al. (2014) highlighted how the process of change in families where addiction is present is, by necessity, a slow process which focuses primarily on the relationships of friends and family. Rather than conceptualising support from the perspective of "recovery" (which implies a journey undertaken by an individual), "reintegration" has been promoted as a concept that centralises the social/relational determinants of addiction and recovery (Adams, 2016). Reintegration conceptualises addiction as a social event centred on the relationship between the individual and the substance. As this relationship intensifies, those other relationships around the individual deteriorate. Decreasing the strength of the addiction involves creating the conditions of possibility for reconnection with other relationships (FAOs), and such relationship building should therefore become a focus of intervention (Adams, 2016; Selbekk & Sagvaag, 2016).

Accordingly, interventions have been designed which focus on creating opportunities for quality relationships within a social system (Copello & Orford 2002; Simmons 2006). The characteristics and fostering of 'recovery communities' is receiving increasing attention (Best, McKitterick, Beswick, & Savic, 2015; Cano, Best, Edwards, & Lehman, 2017). For example, in-depth engagement with the experiences of members of an online addictions recovery community found that interactions enhanced the recovery process by helping participants to develop change-positive identities and social capital (Bliuc, Best, Iqbal, & Upton, 2017). Social

perspectives are also operationalised in peer social support practice (e.g. 12 step), family harm reduction/support groups, and some Indigenous and culturally based approaches (Adams, 2016; Huriwai, 2002). Treatment providers are well positioned to link individuals into recovery groups and supportive social networks (Best et al., 2015). Critical scholars of intervention practice have argued that a traditional focus on individual psychological approaches to mental health issues has limited the development of empirical, phenomenological and values-based evidence for social approaches to supporting FAOs (Adams, 2016; Selbekk & Sagvaag, 2016). Exclusively clinical definitions of 'addiction recovery as control over substance use' have opened up to incorporate global health and active participation in communities (Betty Ford Institute Consensus Panel, 2007; Commission, 2008). There is a recognised need to differentiate between observable empirical-analytical changes (substance use, offending, etc.) and experiential processes (such as changes in identity, quality of life and a sense of hope and belonging (Slade, 2010).

Within the addictions field, Best and Laudet (2010) have argued that the growth of recovery benefits families and serves to generate 'collective recovery capital' that provides support and hope for those in recovery and engages people in a range of activities in the local community. This process translates into active participation in community life and 'giving something back' by creating a collective commitment in recovery groups to community engagement and immersion. In other words, FAOs are an integral part of the 'recovery community', a positive force in the local community and a resource for that community that goes beyond managing addiction issues. At a systems level it is meaningful to conceptualise and measure recovery-oriented systems of care through the range and dynamism of recovery support groups, the local champions of recovery and the services that provide continued and ongoing care.

Indigenous and sociologically informed approaches to engaging with families.
Indigenous approaches to addressing substance abuse in families have been developed based on principles derived from specific social and cultural contexts. For example, drawing on traditional kin and tribal relationships and incorporating traditional practices associated with healing and strength building (Lavallee & Poole 2010). These approaches hold that addiction compromises connectedness to family, to one's village, to one's tribe, to the land and to a spiritual presence understood as critical to health and well-being (e.g. Durie 2001). Addiction is affected by and can also compromise the capacity of communities to respond to the impacts of colonization, poverty and cultural alienation on wellbeing (Huriwai, 2002, 2001). This approach to thinking about FAOs affected by addiction and intervention to support them, is supported by a broader international indigenous wellbeing movement exemplified in Healing Our Spirit Worldwide (HOSW). The first HOSW Gathering took place in 1992 in Edmonton, Canada and attracted 3,500 people from 17 countries intent on addressing the wide ranging impacts of chemical abuse and dependence among indigenous people around the world (Nikora, LaBoucane-Benson, Bublitz, & McClintock, 2016). Eight gatherings later, the movement celebrates the cultural and spiritual tenacity and resiliency of indigenous people

around the world and provides a forum for a broad spectrum of indigenous wellbeing knowledge, expertise and approaches to be discussed.

DeVerteuil and Wilson (DeVerteuil & Wilson, 2010) took up this perspective to explore the extent to which the substance abuse recovery system makes space for Aboriginal healing through the provision of culturally-appropriate services and programming in Winnipeg (Canada). Culturally appropriate services were held to incorporate a number of family and community factors including traditional healers, elders, traditional collective healing practices (e.g., sweat lodges or healing circles among some groups in Canada) and an understanding of the impact of colonialism on health. It has been argued that the creation of culturally-appropriate services, especially as they relate to indigenous health and well-being, is key to ensuring both the relevance and effectiveness of any service provided (Giger and Davidhizar, 2007, Poonwassie and Charter, 2001, Wilson, 2008). Mainstream services tend to normalise certain types of healing from substance abuse (i.e. individualised) and in doing so have excluded Aboriginal approaches to healing and alienated some Aboriginal families. Specifically, to the extent that services do not offer interested individuals the opportunity to seek treatment through both conventional and traditional approaches, the appropriateness of the addictions treatment system can be called into question (DeVerteuil & Wilson, 2010).

In New Zealand, Tipene-Leach and colleagues (1994) reviewed treatment services for Māori in the early 1990's and described many Māori presenting for alcohol- and drug-user treatment as "detribalised and deculturalised". Māori who are more connected with traditional Māori social organisation and structure were less likely to present for treatment at services. Sociological exploration of the experiences of Māori in treatment for alcohol- and drug-use problems suggested that a sense of belonging to an iwi ("tribe") could contribute to the recovery process. For many, regaining Māori identity became the crux of treatment and some appeared to make major steps once this had been reconfirmed. The links between addiction-identity-recovery have been a major focus in addictions recovery literature. For example, Warren (2014) suggested that

> *"Modern psychologies and therapies often contain an unspoken but clear salvational tone. If only you could learn to be more… or less… then your troubles would be over…I contest the idea of recovery as a destination and a return to 'full health', and argue for 'discovery' as a life journey."*

Concepts of whānau ("family") and whānaungatanga ("relationships") are regarded as instrumental in the life journeys and support/treatment processes for Māori families and communities (Huriwai, Robertson, Armstrong, Kingi, & Huata, 2001). The notion of re-enculturation has been suggested to focus services on supporting processes of collective and individual identity development - offering guidance, values, and principles with which to function as Māori, and in a Māori world (Huriwai, 2002).

Indigenous and sociologically informed approaches to alcohol harm reduction in families prioritise equity and inclusion. A recent systematic review examined two decades of published qualitative research detailing the experiences of Māori of Aotearoa New Zealand's public health system (R. Graham & Masters-Awatere, 2020). This review found that for many Māori, the existing public health system is experienced as hostile and alienating. Disengagement of whānau/family members can be an act of resistance to the individualized nature of Western treatment systems creating access barriers and poorer outcomes. Waldram et al. (2006, p. 251), in addressing the question of efficacy of traditional healing in general, note that medical anthropologists have successfully conceptualised 'illness' as socially- and culturally-constructed concept. Therefore what constitutes quality and effective treatment for an 'illness' can also be socially and culturally defined. In this vein, inquiry continues to document important links between indigenous healing practices, treatment that encompasses vital cultural concepts such as whānau (family systems) and wairua (spirit), sobriety and wellbeing (see for example Beals et al., 2006; R. Graham & Masters-Awatere, 2020; Patterson et al., 2018; Stone, Whitbeck, Chen, Johnson, & Olson, 2006).

Engaging FAOs in harm reduction

Harm reduction is a proactive approach to reducing the damage done by alcohol, drugs, and other addictive behaviours, as well as addressing broader health and social issues. Central tenets of harm reduction are conceptualising addiction as a public health and social justice issue, and enhancing the ability for individuals and families to make safer choices (Jackson, Dykeman, Gahagan, Karabanow, & Parker, 2011). Family involvement in addictions harm reduction has a long history. In the early 19th Century local temperance society meetings provided social support for the daughters, sisters, wives and mothers of alcoholics, and provided a vehicle through which personal pain could be transformed into political advocacy to reduce alcohol availability (White & Savage, 2005).

This approach emphasises that the relationships between FAOs and people experiencing addictions are complex, variable, and fluid, and that many addiction related issues are a product of wider structural forces. Services can encourage FAOs to frame addictions as a health and social justice issue (Jackson et al., 2011). Intervention involving family members can occur on the micro (individual) or (macro) level. Examples of micro level harm reduction include provision of safe spaces for substance use. Alternatively, macro level harm reduction involves identifying the drivers (e.g. product availability, socioeconomic inequality) behind the experiences of harm and working to influence those drivers e.g. through advocacy and contributing to policy and service development and change. This is connected to the notion that service users should be part of open, methodical, meaningful and ongoing searching for the best responses for certain problems and families (see Claes, van Loon, Vandevelde, & Schalock, 2015; Patterson et al., 2018).

Pat Denning incorporated addictions harm reduction principles within psychotherapy Family Group Support for addictions related harm (Denning, 2010; Denning & Little, 2011). Central tenets were the views that people know what they need to take care of themselves, people's behaviour makes sense and is always adaptive in some way. Using a series of case studies, Denning (2010) reported that harm reduction concepts allowed practitioners more freedom to develop approaches that aligned with an individual or family's core values and understanding of addiction. For example, 'not having hope' was developed into a useful position in a group support setting where members identified the cycle of hope and despair around their loved one's treatment outcomes as the main issue they were struggling with. FAOs valued an approach that was tailored to their particular situation and context, and supported only the activities they themselves felt able and willing to take on (Denning, 2010). Denning's approach also links to an emerging movement for patient (or person)-centred care (PCC) in addictions treatment (Marchand et al., 2018).

Multiple constraints on resourcing and capacity mean that it is not always feasible for service providers to independently design evidence-based programs or services or robust evaluation plans with the communities they serve. Australian Aboriginal scholars and organisations, and research institutions have advocated the involvement of research partnerships in developing, implementing and evaluating family-centred health improvement approaches (National Health Medical Research Council, 2003). McCalman and colleagues (2013) developed a model of community-owned responses, through collaborative action research conducted to reduce alcohol harm (Figure 4):

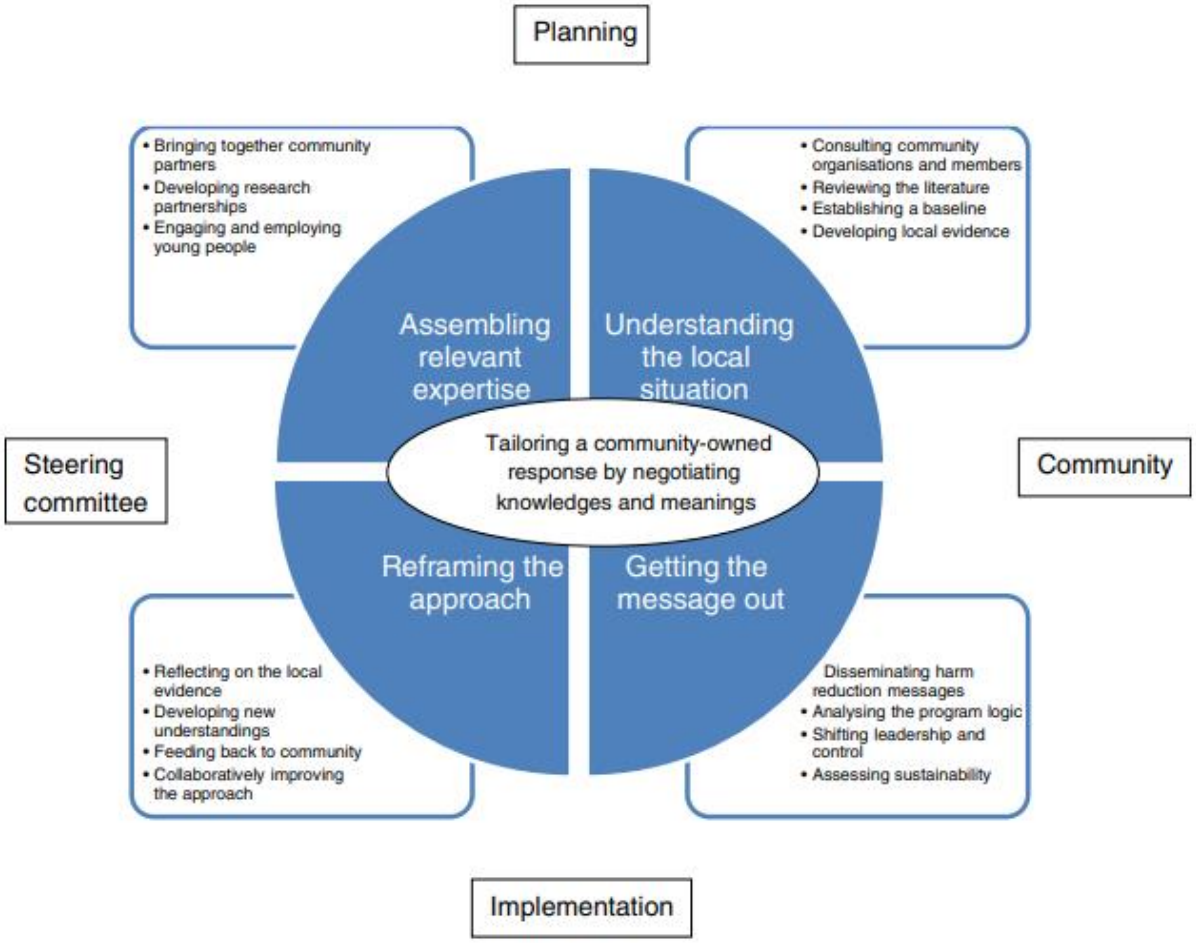


Figure 4. Tailoring a community response to alcohol harm (McCalman et al., 2013).

Negotiating local knowledges and meaning to tailor a community response to alcohol harm was achieved through 4 key stages of a research partnership with services: Assembling expertise, developing understanding of the local situation (community consultation), taking and evaluating action, and reflecting on/reframing service approaches in line with new understandings generated.

The social construction of intervention goals

Examination of the broader addictions literature has identified a wide variety of ways in which researchers have identified intervention goals for FAOs e.g. as about: treatment entry for the person with the problem, reduction in or absence of the problem behaviour, having a better relationship, improved coping skills and/or access to social support. The extent to which these goals are linked to models of recovery and support endorsed by FAOs is much less clear. The addictions field has been described as dominated by 'professional expertise', often operating with its own system-led logic, with limited connection to evidence base (Adams, 2007a). A perennial question in FAO support literature is whether the work conducted purportedly to improve the lives of FAOs is justified and benefits people in ways that are meaningful and valued by them (Marchand et al., 2018). This issue has been named as the 'elephant in the

room', particularly in relation to indigenous peoples and other communities most affected by health inequities (Bainbridge et al., 2015).

Informing gambling support services for FAOs

Taking our exploration of addictions literature as a starting point, we now explore implications for gambling support services for FAOs. To date, research on FAOs affected by gambling harm has been almost exclusively focused on identifying the nature and types of harms (Jeffrey et al. 2019; Kalischuk et al. 2006; Kourgiantakis and Ashcroft 2018). There is considerable congruence between the approaches that have been taken in the gambling and broader addictions fields (particularly AOD). FAOs affected by gambling have been similarly positioned as 'intervention allies', part of a disconnected relational system or dyad, and as under strain and in need of support in their own right. For example, involving FAOs has been associated with treatment gains for gamblers regarding relapse, adherence and attrition (Jiménez-Murcia et al., 2017). Focussing on FAO wellbeing by evaluating and improving coping resources and social support, has been championed as a tool to reduce FAO burden (reported gambling impacts, psychological distress and other health symptoms) (Orford et al., 2017). Gambling couples therapy techniques have been developed to address gambling symptoms, mental health distress, and relationship functioning simultaneously (Nilsson, Magnusson, Carlbring, Andersson, & Hellner, 2019).

Key themes in nascent gambling FAO support literature were considered in relation to the conceptual issues/tensions identified in the broader addictions literature above.

<u>Tailoring thinking from broader addictions to address gambling harm in families</u>

A key theme in the gambling field has been the extent to which approaches developed to address harm experienced by FAOs affected by other addictions can be 'tailored' to address gambling harm, whether these approaches achieve similar outcomes for FAOs, and/or make sense conceptually in relation to gambling and gambling harm. For example, gambling behaviour is described as more difficult to identify (i.e. more easily hidden) than substance abuse, and financial consequences for FAOs are more common (McComb, Lee, & Sprenkle, 2009). Supporting FAOs to reinforce sober behaviours is held to be more straightforward than it is for non-gambling behaviours (Nayoski & Hodgins, 2016). Accordingly, CRAFT as an intervention for gambling has involved extra support for identifying signs of gambling, as well as increased attention to financial issues, anger, trust and emotional abuse experienced by FAOs (Makarchuk et al., 2002). Possibly as a result, CRAFT wellbeing benefits appear to be more pronounced than treatment entry for gambling FAOs (Archer et al., 2019). It has also been suggested that CRAFT may constitute a dual focus intervention for gambling – capable of addressing both FAO needs and gambling outcomes for some FAOs (Archer et al., 2019; Rodda et al., 2019).

The stress-strain-coping-support (SSCS) model has been adopted into the gambling field, and the 5-step intervention associated with positive changes for family members (Orford et al., 2017). FAOs are held to have the same 'common core' experiences as FAOs affected by other addictions: high levels of stress, high levels of strain in the form of physical and psychological symptoms, a set of common coping dilemmas and difficulties in obtaining good quality social support (Orford et al., 2017). Orford and colleagues explored stress, strain, coping and social support for affected family members (N = 215, 82% women) attending the National Problem Gambling Clinic, and receiving the 5-Step intervention in London. The aims were to compare burden (reported impacts, engaged and tolerant coping, psychological distress and other health symptoms) experienced by these FAOs with FAOs affected by substance problems and to evaluate change following the 5-Step intervention. Baseline burden and related variables were comparable to those of family members affected by substance problems and were significantly reduced at follow-up 6 months later. The largest change was a perceived increase in social support. As has been found in the substance abuse literature, the importance of changes in specific coping mechanisms was less clear and there was no support for a moderation effect of coping on wellbeing.

Relational approaches to gambling harm are designed to "address the complex interpersonal dynamics and intense emotional experiences that often characterize couples and families whose lives have been impacted by problem gambling" (McComb et al., 2009). Because of the secrecy often associated with gambling, the disclosure of a gambling problem is held to be sudden, drastic, and devastating and more often described as a "traumatic experience" for the family that is the case with AOD (Lee & Awosoga, 2015; McComb et al., 2009). With reference to research detailing the links between gambling and violence against affected others (Dowling et al., 2018; Palmer du Preez et al., 2018), and the relationships between lifetime trauma and addiction (Petry & Steinberg, 2005), trauma-informed family therapy is suggested as an important way forward for extending relational work with gambling FAOs.

Emerging research suggests that gambling outcomes appear to be particularly important to FAO wellbeing. For example, in comparison to AOD studies, it is less clear if couple therapy is more effective for FAO wellbeing than individual therapy for gamblers (Nilsson et al., 2019; Tremblay et al., 2018; Tremblay et al., 2015). The wellbeing benefits of positioning FAOs as intervention allies have been contested by a recent study of the effects of internet CBT (gambler only) and behavioural couples therapy (involving both gambler and FAO) with 136 gambler and FAO couples in Sweden (Nilsson et al., 2019). Efficacy was measured in terms of gambling behaviour (days and dollars gambled), treatment engagement and various measures of health and wellbeing for both FAOs and gamblers. Few differences in outcomes were seen between the two groups, and FAOs did not appear to benefit additionally from taking part in the treatment, prompting these authors to question the involvement of FAOs in treatment of gamblers – at least in the online mode.

In the addictions field there are many references to 'recovery' with service providers and workers increasingly designated as 'recovery-focused', although in many areas there is confusion as to what this means in practice (Best & Laudet, 2010). Best and Laudet (2010) describe recovery is a process rather than an end state involving the lived experience of improved life quality, a sense of empowerment; hope, choice, freedom and aspiration that are experienced rather than diagnosed and occur in real life settings rather than in the "rarefied atmosphere of clinical settings". It is clear that tailoring thinking from broader addictions may import and reproduce narrower and less recovery focused approaches in gambling treatment services (Best et al., 2015; Bliuc et al., 2017; Cano et al., 2017). It is important that we also learn from social and FAO-led approaches to addictions support – as discussed further in the following sections.

What do FAOs affected by gambling want from services?

Experiential and values-based evidence appears underdeveloped and underutilised in service design and delivery to support recovery from mental health and addictions in New Zealand and internationally (Johnstone & Boyle, 2018; Patterson et al., 2018). Given that there has been almost no engagement with the support preferences and expectations of FAOs in relation to gambling services (Rodda et al., 2019; Rodda, Lubman, Dowling, & McCann, 2013), it is not possible to say with any clarity what a FAO-centric gambling service might involve or look like. Engagement with FAOs has been framed by approaches driven by researchers and clinicians. For example Tremblay and colleagues (Tremblay et al., 2018) documented the experiences of the therapy process for pathological gamblers and their intimate partners (n=21 couples), who were randomized for individual or couple treatment. Participants reported satisfaction with both treatment models, but their experience was more positive in couples treatment. Complementary benefits emerged from each form of treatment: Gamblers who were in individual treatment were more likely to mention that their partners' involvement was not necessary and appreciated the opportunity to focus on their own needs, couples in therapy together highlighted the benefits of mediated communication. The authors advocate for future treatments involving both types of engagement to enable a range of issues and needs to come to the fore and be met. In one online support space, around half of FAOs requested gambler-focussed support e.g. advice and support on getting the gambler to change, supporting behaviour change and facilitating treatment seeking (Rodda et al., 2019). Relational approaches to gambling harm were also commonly requested, and almost one quarter of help-seekers requested a dual focus on FAO and gambler wellbeing.

Expanding operationalisation of social and FAO-led approaches to harm reduction

The emphasis in gambling FAO interventions literature has been on universal thinking/approaches based on underlying psychological principles of human behaviour (i.e. largely cognitive behavioural therapy and motivational interviewing-based approaches). These approaches are important in responding to individual-level factors shaping gambling harm and should continue to be explored and improved (Adams, 2016). Comparatively few gambling harm reduction interventions have been developed to include FAOs in ways that centralise the

social, economic and cultural determinants of harm and recovery. Indeed, 'recovery' has been seen as too conceptually imprecise to be employed in gambling harm reduction (Nower & Blaszczynski, 2008). This would seem to ignore the transformative potential of the term. The growth of recovery capital is seen as idiosyncratic and personal, but its manifestation is inherently social and community-based and its impact can be measured in terms of those lived communities (Best & Laudet, 2010).

New Zealand Māori and other Indigenous perspectives have highlighted how a lack of engagement with the social, economic and cultural realities of gambling and harm has limited the development of appropriate and relevant resources and interventions - particularly in vulnerable populations (Dyall, 2007, 2012; Dyall, Hawke, Herd, & Nahi, 2012; Morrison & Boulton, 2013). Sociologically informed literature has also sought to bring the multiple pleasures and meanings of gambling for particular cultural and community groups and spaces to the fore in harm reduction efforts. In Australian Aboriginal communities bingo is variously a site that reinforces social connectedness for families, a source of fun and excitement and a strategy to find solace or respite in the face of personal pain and structural injustice (Maltzahn et al., 2019). These communities have argued for services to work with them to advocate for enhanced regulation of commercial bingo and not-for-profit bingo, and to deliver family focused intervention that includes finding ways for families to spend more time together outside of the opportunities created by gambling (Nagel, Hinton, Thompson, & Spencer, 2011).

Reith and Dobbie (2012, p. 515) argued that gambling recovery is a social process, where options for practicing wellbeing are continually revised in response to changing relationships and social contexts. Narratives of recovery involved a process of redirecting expenditure away from the uncontrolled and de-materialised consumption involved in gambling, and towards more material goods and activities with which to express the self and enrich social relationships. These authors noted how the conditions of possibility for recovery can be shaped by the extent to which people experiencing gambling harm are able to re-enter consumer life in socially acceptable ways, e.g. buying children's toys and clothes, Christmas presents, haircuts and gym membership, paying mortgages and bills. Fragmentation and dislocation can also be seen as a by-product of the globalized free-market society constructing 'acceptable consumer selves' at a macro-level (Alexander, 2008). For example gambling can be seen as a way that large numbers of people adapt to the breakdown of psychologically sustaining culture under the global influence of free-market society (Alexander, 2012).

The role of services in creating effective advocacy mechanisms for the lived experience of FAOs in decision making processes about how economic systems are structured and run and who is regarded as acceptable/valuable, have yet to be explored. For example, in New Zealand The Salvation Army run gambling support services and also a Social Policy & Parliamentary Unit which works toward the eradication of poverty by encouraging policies and practices that strengthen the social framework of New Zealand. Gambling with Lives was set up in the UK to support the families and friends of young people who have taken their own lives as a direct

result of gambling. This organisation aims to give a voice to families and friends bereaved by gambling and bring the health issues surrounding gambling to the attention of policymakers and bodies responsible for regulating the gambling industry. It has been instrumental in pointing out harm prevention and reduction shortcomings in the UK government supported regulator, the Gambling Commission (see Pidd, 2020). Exploration of how to support quality and effective family engagement in these processes could inform harm reduction practice.

Equity, whānaunatanga and inclusion of (and co-design with) whānau has been identified as central to successful gambling interventions with Māori families and communities (Robertson et al., 2005). Māori have argued from an indigenous rights perspective and as Treaty of Waitangi partners, for whānau involvement at all levels of decision making in determining gambling policies, services and revenue direction (Dyall et al., 2012). Adopting this lens has also been described as about shifting the burden of harm reduction engagement onto services and away from clients (Dyall et al., 2012). From this perspective a key role of services could be to support Māori whānau along with other stakeholder interest groups to determine the nature and scale of legalised gambling, negotiate and navigate the development of gambling free communities, neighbourhoods or spaces (Dyall, 2012).

There has been little published research on the operationalisation of support for FAOs in gambling services informed by the above. McGowan (2003) showed how in response to the hegemony of male-dominated groups and dominant ideologies, women seeking support for gambling recovery created both online and offline symbolic communities to enable them to express their experiences. Ngā Pou Wāhine outlined culturally embedded support for Māori women on a collective journey to develop and strengthen their potential, so that they are better positioned to address risky and problem gambling behaviours in families and communities (Morrison & Wilson, 2013). The *Tu Toa Tu Maia* intervention was developed specifically for use by Māori health promoters, in order to ensure that gambling services meet the needs of Māori gamblers, and their whānau (Morrison & Boulton, 2013). These interventions and studies drew on the notion of 'cultural congruency', to argue that for support for family and whānau to be effective, gambling harm concepts must be developed with and relevant to them. They argued that intervention strategies should involve in-depth exploration of the perceptions of gambling held by partner/whānau members, work with Māori women and their whānau, as well as with service providers, to identify possible intervention strategies which would help them to stop or at least reduce their engagement in casino and EGM gambling (Morrison, 2008).

Summary of further research needed

- In-depth exploration of FAO experiences, needs, service and support requirements.
- Exploration of the operationalisation and sustainability of support for FAOs in gambling services.
- Development of interventions that conceptualise and respond to the social, economic and cultural determinants of harm and recovery.

Conclusion

Addiction is conceptualised as a "complex and multidimensional phenomenon" (Larkin, Wood, & Griffiths, 2006, p.210). Addiction support should therefore engage with the multiple mechanisms through which addiction develops, is maintained and harm experienced (Adams, 2008; B. Alexander, 2010; Kazdin 2007). An integrative approach requires the understanding of diverse approaches to addiction harm reduction: their conceptualisation, respective measurement techniques, and evaluation standards. A 'human prerogative of care' involves accepting that no single treatment system can address all addiction-related problems for families (Broekaert, Autrique, Vanderplasschen, & Colpaert, 2010).

The range of gambling support options explored in New Zealand and international literature has for the most part reflected international trends in addictions: psychosocial modalities incorporating motivational, cognitive behavioural and group interventions in conjunction with financial advice and relationship counselling (Adams et al., 2003). These approaches are important and have been associated with improvements in FAO wellbeing, however they do not reflect the full range of conceptualisation of addiction, harm and support available. Opportunities for creative reimagining of more FAO-centric services and offerings may be obscured.

It remains unclear exactly what family members affected by gambling find most helpful relative to the full range of current intervention thinking and possibilities. This is a clear limiting factor in service design and delivery. In addition, exploration of how support functions to help FAOs cope with gambling harm and improve their health and well-being is only just beginning (Kourgiantakis & Ashcroft, 2018). It seems at this point that exposing FAOs to multiple service offerings (based around multiple ways of making sense of what is going on for them) is important to ensure their needs are met. There is also the recognition that recovery is something that is grounded in the community and that it is a transition that can occur without professional input. Where professional input is involved, the nature and extent of its role is far from clear (Best & Laudet, 2010). The notion of services as an iterative 'toolbox' of current thinking/approaches has been suggested as a way of enabling FAOs' to link to and access a wider range of approaches and interventions they may find helpful to support their wellbeing (Selbekk et al., 2015). Emerging models for 'shared' and 'supported' decision making in mental health recognises that respecting a person's choices about the services they do or do not use is a mark of quality support and a human rights issue. Providing information and assistance for people making decisions about mental health services is a complex process: a plethora of supportive practices are required to promote active involvement, which tend not to be prioritised in service delivery (Simmons & Gooding, 2017).

The service-user and person-centred movements within mental health care identify the role of services/interventions in helping FAOs to both conceptualise and articulate their needs. International research has suggested that addictions services tend to be guided by one approach

to engaging and supporting FAOs at best, and little is known about how to achieve successful implementation and sustainability of family-focused practice within addictions treatment services (Hampson, 2012; Orford et al., 2009). Co-design and action research has demonstrated the value of in-depth and collaborative engagement between addictions service providers and FAOs in reshaping services to enhance the range and quality of support provided for FAOs (Hampson, 2012; Orford et al., 2009). This review suggests that such collaborative techniques and processes could be usefully employed to conceptualise, design, plan and evaluate enhanced gambling harm reduction services for FAOs.

Structured engagement with expert opinion

The approach taken to our structured engagement with expert opinion was developed drawing on qualitative and dissensus Delphi study methodologies. Delphi is a structured iterative technique used to gather information and opinion from a group of people with expertise and experience relevant to a particular topic (Brady, 2015; Jorm, 2015; Linstone & Turoff, 1975). While the classic Delphi method focuses on the establishment of consensus and facts about a specific topic (often determining outcomes and/or decisions), policy and dissensus Delphi processes are used for idea generation and to explore policy and practice relevant issues and multiple arguments around how to achieve a goal (Linstone & Turoff, 1975; Manley, 2013; Turoff, 1975).

A dissensus approach was taken in alignment with a 'human prerogative of care' which involves accepting that no single treatment system can address all addiction-related problems for families (Broekaert et al., 2010). The aim was to maximise the range of opinions given by the experts, allow for a divergence of opinion whilst also seeking and highlighting consensus where possible. Ongoing discussion, discovery and exploration of relevant arguments were prioritised over achieving consensus (see Kuusi, 1999). Diversity of expertise, independent and autonomous thinking, and anonymous participation were emphasised (Surowiecki, 2004). Reliability and credibility was demonstrated through evidence of active and reflective participation from both the researchers and participants (Fink-Hafner, Dagen, Doušak, Novak, & Hafner-Fink, 2019). The overarching research question for the engagement with expert opinion was: How could support provided for family members and affected others (FAOs) in New Zealand gambling services be enhanced?

Defining the areas of inquiry

Development of a dissensus Delphi methodology requires extensive literature analysis to establish areas of inquiry (Fink-Hafner et al., 2019). Our study was informed by the conceptual literature review, which identified multiple understandings of addictions, FAOs, the purpose of intervention and outcomes in operation. Each understanding of FAO support carried implications for quality and effective gambling service design and practice. In the initial engagement with experts (Round 1) we invited participants to comment on the possibilities and constraints of each of these approaches for service design and delivery, alongside more general exploration of the purpose of providing support for FAOs (including key features and outcomes) and what constitutes quality and effective service design and practice for FAOs. Areas of inquiry for the second engagement (Round 2) were derived from content analysis of the first round in relation to the overarching research question: How could support provided for family members and affected others (FAOs) in New Zealand gambling services be enhanced? This content analysis is presented in Appendix One (Results of Round 1 engagement with expert opinion). The Delphi process and content of each of the two questionnaires are discussed further in the following sections.

Ethical approval

Full review of protocols and approval to conduct the study was provided by the Auckland University of Technology Ethics Committee (AUTEC), approval number 19/387.

Methods

Panel selection, recruitment and engagement

The development of criteria through which to establish appropriate expertise/experience of a topic is a delicate art in structured engagement with 'experts', and largely topic-dependent (Brady, 2015; Fletcher & Marchildon, 2014; Jorm, 2015). A panel of 20-40 participants has been identified as normative in Delphi health studies (Keeney, McKenna, & Hasson, 2010). In keeping with the dissensus Delphi methodology, we sought to encourage as much diversity of perspectives on support for FAOs as possible (e.g. service management, research, policy, consumer/lived-experience service advisors, clinician, workforce development). The following criteria and stratification were developed to guide recruitment (Table 1):

Table 1. Panel selection criteria

Perspective	Selection criteria	Max n
Researchers	Lead author on at least one publication focussed on addiction related FAO support issues in a peer-reviewed journal (e.g. Addington, McKenzie, Norman, Wang, & Bond, 2013).	10
Clinicians	Minimum of 5 years of experience in delivering support for FAOs harmed by addiction (e.g. Yap, Pilkington, Ryan, Kelly, & Jorm, 2014).	10
Consumer advisors	Lived experience of gambling harm as people who gamble and/or as FAOs. Engaged in consumer advisor role with an addictions support service or policy agency.	10
Service managers	Minimum of 5 years of addictions service planning and/or delivery for FAOs.	5
Policymakers	Minimum of 5 years of experience in addictions harm reduction policy role.	5

We sought to include those with expertise/experience in FAO support issues for women, indigenous peoples, and other minority groups. We also aimed to include experience of both the New Zealand, and international contexts in order to open up consideration of a range of possibilities for service enhancement (that may not yet have made it to New Zealand shores).

A list of potential panellists was assembled through the literature review component of this research, by accessing records of gambling and addictions conferences and sector events online, and in consultation with management of the following addictions harm reduction services: GamCare (UK), National Problem Gambling Clinic (UK), Turning Point (Australia), Victorian Responsible Gambling Foundation (Australia), Raukura Hauora o Tainui (NZ), The Problem Gambling Foundation (NZ), and The Salvation Army Oasis Problem Gambling Service (NZ). Snowball sampling was used to gain access to additional participants with

expertise/experience as a consumer of services or in relation to issues for women and minorities. Interested panel members were provided with a Participant Information Sheet (Appendix Two). We found that consumer advisors with experience as FAOs-only were rare in service settings and were therefore underrepresented in our consultation (just 1 participant out of 9 consumers). Experience as FAOs and as people who gamble was more common (3 out of 9 consumers).

A panel of 40 participants completed the Round 1 survey, and 29 participants (73%) also participated in Round 2. Panel recruitment structure and retention of perspectives across the study is presented below (Table 2). All of the panel members identified expertise/experience in support for FAOs affected by gambling, often in addition to expertise in the broader addictions field. This was particularly the case for participants based outside of New Zealand. Participants could fulfil the criteria for and therefore offer multiple perspectives. A similar balance of perspectives was included in each survey round (Table 2), with research and clinical views comprising approximately half the panel. While numbers dropped overall, proportional representation of policy, consumer and workforce development views remained in Round 2.

Table 2. Panel structure by sector group perspective

Perspective	**Round 1 n=40**	**Round 2 n=29**
	n (%)	n (%)
Research	20 (50)	14 (48)
Clinician/practitioner	18 (45)	13 (45)
Service management	14 (35)	11 (38)
Policy	9 (23)	8 (28)
Consumer	9 (23)	6 (21)
Workforce development	2 (5)	2 (7)

The panel identified additional expertise and/or experience working and/or conducting research with specific FAO population groups. The distribution of this expertise/experience across the two survey rounds is shown in Table 3. Around a fifth of experts had knowledge of issues for women, Māori and other indigenous populations. Five participants identified expertise in relation to Asian communities, and three participants held knowledge of issues for FAOs in communities of people with Pacific Island heritage.

Table 3. Panel identified expertise/experience with FAO population groups

FAO population groups	**Round 1 n=40**	**Round 2 n=29**
	n (%)	n (%)
Women	7 (18)	7 (24)
Men	1 (3)	1 (3)
Gender non-binary	1 (3)	1 (3)
Māori	6 (15)	4 (14)
Other indigenous populations	5 (13)	5 (17)

Asian peoples	5 (13)	5 (17)
Pacific peoples	3 (8)	2 (7)
Other ethnic minority groups	2 (5)	2 (7)

About two thirds of the panel was currently engaged around FAO support in the New Zealand context (26 participants, 65%). International research, service management, clinical practice, consumer, and policy perspectives were contributed by participants based in Australia, the United Kingdom, Canada and the United States of America.

Data generation procedure

The study procedure is presented below in Figure 5. Data collection was carried out using two rounds of online questionnaires.

The Round 1 questionnaire (see Appendix Three) was divided into four main parts: introduction and demographic questions, views on approaches to FAO support identified in the gambling and broader addictions literature, rating of agreement with statements about FAO support practice inspired by the literature, and participants' own views on quality and effective support and services for FAOs.

The Round 2 questionnaire (Appendix Four) focussed on our analysis of issues, notions and practices relevant to enhancing support provided for FAOs in Round 1: The inclusion of a social approach to gambling addiction and recovery, barriers and enablers of FAO centred design and practice, enhancing cultural awareness, building and sustaining a culture of curiosity and learning, the role of lived experience and bridging gaps between research and practice.

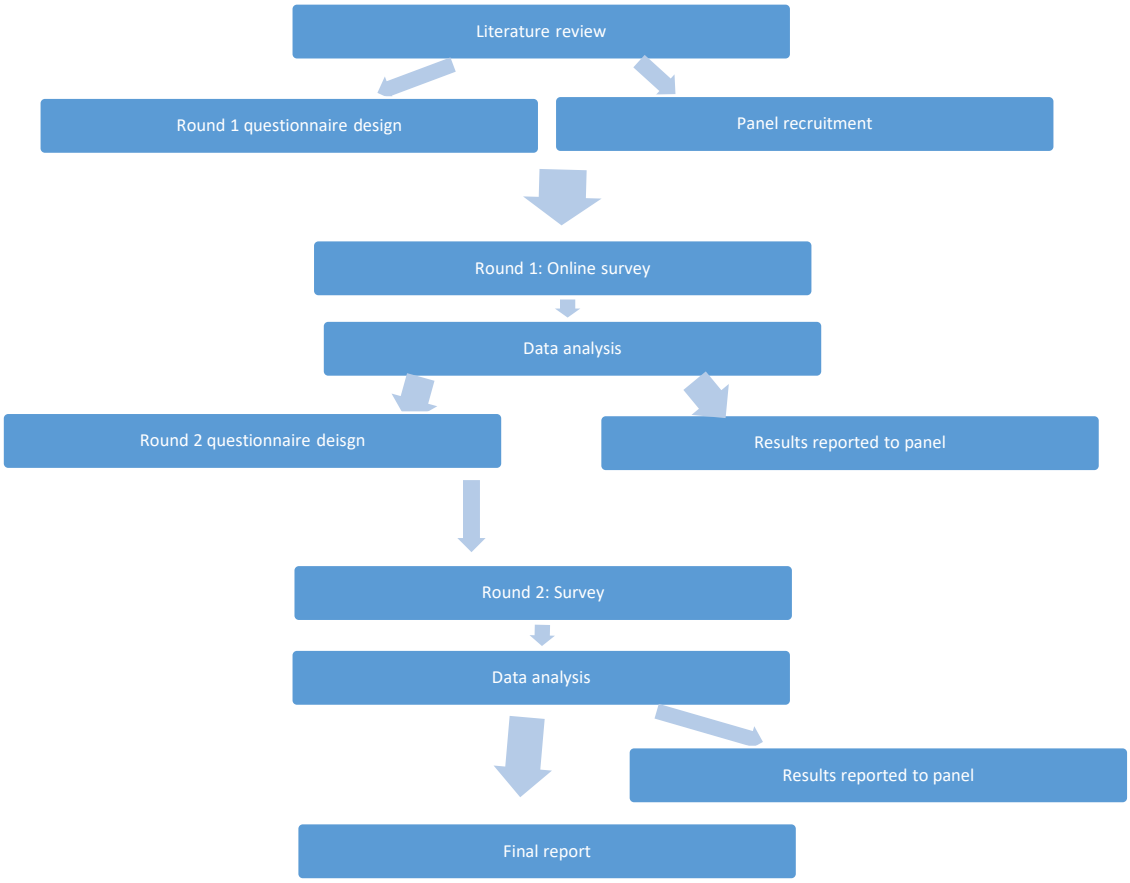


Figure 5. Structured engagement with expert opinion

Data analysis

Qualitative descriptive analysis was carried out to categorise and summarise the responses made by participants to the questions that were asked of them (Sandelowski, 2000). Data were coded independently by two researchers who met to discuss and refine the coding of data collected in relation to each question. Short quotes that best illustrated each code were assembled. Coding was then examined for examples of convergence (agreement), divergence (disagreement) and uncertainty within the panel, e.g. 'convergence' could be seen where a large proportion of the panel made a similar coded response to a question. Further exploration of convergence, divergence and uncertainty was carried out by participant perspective (e.g. research, clinician, policy) to look for any patterns in views on enhancing services for FAOs.

Quantitative data (e.g. rating and ranking of approaches and statements about FAO support found in the literature) were analysed and presented descriptively. Quantitative data were also examined for indication of convergence (agreement), divergence (disagreement) and uncertainty within the panel. For example, in analysis of key statement ratings during Round 1 (see Appendix One), convergence was suggested by over 80% agreement, divergence by less than 80% agreement and more disagreement than neutral responses. Uncertainty among the panel was suggested when neither the conditions for convergence nor divergence were met.

Views on enhancing support for FAOs in gambling services

Results of the Round 1 survey (presented in Appendix One) were provided to all participants and used to inform the development of Round Two. The results of Round 2 are presented in the following sections as the culmination of the iterative exploration with experts of how FAO inclusive and FAO centred service design and practice could be enhanced.

Endorsement of a wide range of approaches to FAO support

Participants rated the extent that FAO services should be designed around five approaches to conceptualising FAO support needs and delivering support in practice (Figure 6). Four were as identified and defined in the conceptual literature review conducted for this project, a fifth 'social approach' was as identified by participants in Round 1. Participants argued that a 'social approach' to supporting FAOs is needed to complement the more individual bio-psychological approaches that currently dominate the addictions field. The social approach holds that 'gambling harm', 'recovery' and 'wellbeing' are socially and culturally constructed and enacted phenomena. The meanings that are given to them, the way they are experienced, and what constitutes quality and effective support/intervention are shaped by particular family, community, cultural, gender and broader societal dynamics in play. This includes the practices of industries and governments, service organisational contexts and funding models. Participants who drew on this way of understanding harm/recovery described the integrity and wealth of relationships available to people as a defining feature of wellbeing and recovery capital:

> *Recovery involves 'family' (defined in the broadest sense, could be flatmates), and questioning where are the opportunities for strengthening relationships in this nexus? How safe is it to connect? From a service development perspective this suggests being set up to support incremental change in relationships over a long period of time, family inclusion to equip them, culturally based approaches and community engagement to strengthen social capital." (Researcher, clinician, NZ)*

This approach directs ongoing service attention to the social contexts in which harm/recovery is produced in the families/communities they serve, e.g. through community development and advocacy work. It also encourages the conceptualisation of additional social process and outcomes evaluation criteria:

> *Missing key outcomes are to support local and national political action to change the environments either causing or exacerbating harm" (Service manager, NZ).*

> *Engagement with families and communities would be my preferred starting point. The key outcome here is tino rangatiratanga." (Service manager, NZ)*

Five participants reported that the approaches models and frameworks identified in the addictions literature did not recognise and properly provide for tino rangatiratanga

(sovereignty) and mana motuhake (autonomy) of hauora Māori (indigenous Māori health). It was suggested that partnerships and processes are reviewed to ensure that Māori are able to participate in decision making about service delivery for whānau.

1. Supporting FAOs to enhance their own wellbeing;
2. A social approach to gambling harm reduction.
3. Improving the relationships between FAOs and the person who is gambling;
4. Engaging FAOs and communities to develop gambling harm reduction techniques.
5. Supporting FAOs to influence the person who is gambling;

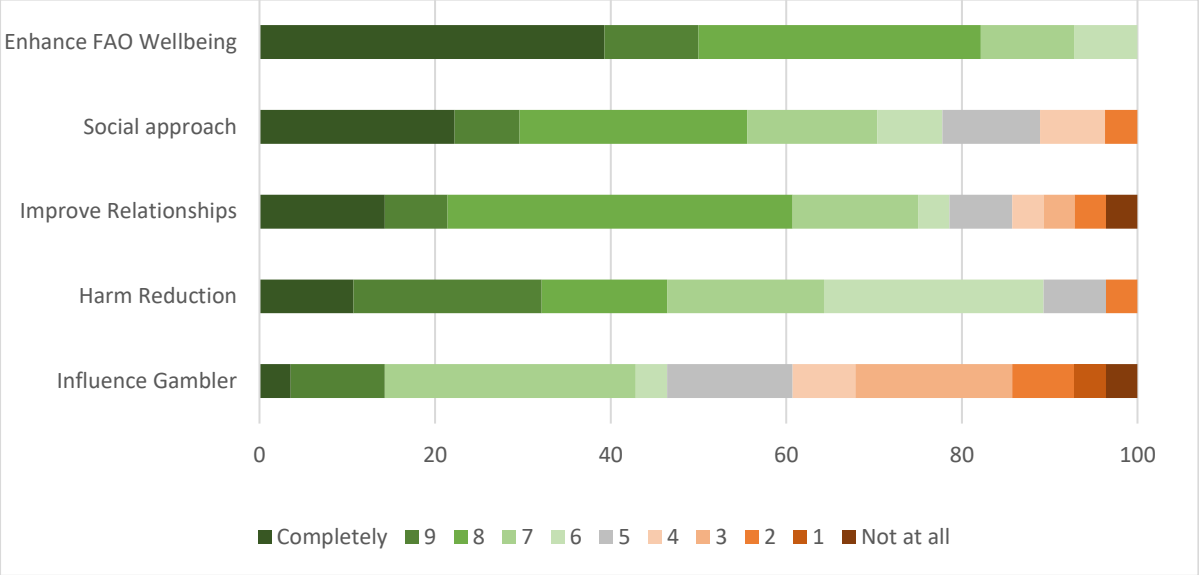


Figure 6. The extent that services should designed/orientated to five approaches

Figure 6 shows that in addition to 'enhancing FAO wellbeing', 'improving family relationships', 'engaging FAOs and communities in harm reduction activities', a social approach was valued highly by the panel. Approaches which focus on influencing the gambler were least favoured in influencing service design, though there was less uncertainty and more support for their incorporation as part of a suite of offerings in Round 2 compared to Round 1. Taken together, the panel supported the incorporation of a wide range of approaches to supporting FAOs in service design and delivery, and FAO focussed approaches.

<u>Prioritising FAO centric recovery models</u>

Reorientation of services away from the gambler/gambling problem to focus on families' issues and needs was supported by the panel,

> "*There is a need to shift from a gambler-centred model to (at minimum) a bi-foci model in addressing addiction problems i.e. FAOs and gamblers/addicts as independent and as interrelated units of analysis, planning and actions." (Clinician, UK)*

> *"Support is not just about individual gambler need. It is critical we shift our mindset to include families and whānau" (Policy, NZ)*

Participants reported that the primary purpose of providing support/intervention services for FAOs should be to support FAOs to identify and address their needs, provide family/whānau focused care, to educate and empower families and communities and to prevent gambling-related harm in families.

> *"Supporting FAO in their own right is a priority - feelings of lack of control along with all the harms means this should remain a priority. Many women may also have caring responsibilities and should receive support that avoids placing additional pressure on the need to care for another" (Service manager, UK)*

> *"In support FAOs, culturally safe services that align with the specific needs of the whaiora must be the foundation" (Clinician, NZ)*

Limits on FAOs' ability to create change in/for gamblers were discussed, as well as the potential for interventions emphasising gambler change to 'set FAOs up to fail' (basing support around the needs/behaviours of another, often treatment-resistant, person). FAO safety could be jeopardised given (1) gendered power differentials in family dynamics, and (2) the rate of domestic violence in the addictions field. A significant minority of panel members (n=7) endorsed a secondary purpose to reduce gambling behaviour in families – but tended to qualify this approach by stating that tools to influence/reduce gambling in families should only be provided if requested by FAOs (they should not be the default approach). Teaching FAOs to influence gamblers/gambling was identified as the most researched approach in supporting FAO wellbeing, however views on effectiveness varied:

> *My disagreement with CRAFT [anti-gambling behavioural reinforcement training for FAOs] is NOT that it does not work! It is that it uses the family members not to help themselves (although that can be a knock-on benefit) but to help the user. I am not against helping users, but my philosophy is that family-focused work should focus MAINLY on helping the FMs and not mainly on helping the users." (Researcher, UK)*

> *"There is relatively little evidence to support that pressure or influence from families works on the gambler. Evidence also does not reflect this as a reason for help-seeking by gamblers… However, FAOs who are only focussed upon the gambler may not connect with services unless they are able to think they can change the behaviour of the gambler (initially), or as one of several tools to improve their family's situation." (Researcher/clinician, NZ)*

Participants converged on the notion that expanded access and enhanced diversity (choice) in approaches for family support was necessary at every level of harm reduction practice: health promotion, harm reduction (e.g. community support) and treatment.

Barriers to FAO centred service design and practice

A key barrier identified by participants included policy and funding models that participants did not believe were supportive of service engagement with FAOs (Table 4). For example comments included: Funding models based on a narrow understanding of client and case (Researcher, NZ), no budget for service promotion and lack of clinician and FAO input into centralised advertising campaigns (clinician, NZ), and lack of budget for family specific intervention training and remodelling of current intervention strategies with families and children (service managers NZ and international). A researcher from the UK noted that national guidelines can lack coherent strategy around family support, connected to a limited evidence base and low service engagement in research. Two panel members from New Zealand commented that services' engagement with a designated FAO consumer advisor would ensure that services are oriented more fully towards FAOs:

> *"FAO whaiora voice in general is not a contract service delivery requirement in New Zealand and it should be" (Clinician, NZ)*

Table 4. Barriers to FAO centred service design and practice

Coded qualitative responses [#]	**N**	**%**[#]
Policy and funding models do not support engagement with FAOs	10	34
Practitioner/expert centric approaches and systems	10	34
Low practitioner confidence and competence	7	24
Family mistrust of services and social stigma	6	21
Lack of evidence-based family centred approaches and resources	5	17
Services designed for individual gamblers not families	5	17
Low cultural awareness and competency	3	14

[#] Note that participant responses could be coded at multiple categories.

In addition, expert/practitioner-based and individualized models were seen to dominate the field of mental health and addiction generally, limiting possibilities for FAO engagement. For example, a clinician from the UK stated that wider societal discourses and clinical conceptualisation of gambling harm as an 'individual problem' limits the ability of services to create space for families. A New Zealand based researcher mentioned as barriers:

> *"The mythologies of practitioner and service capacities to 'fix addictions', and the privileging of therapeutic relationships over the more important long-term relationships within a family and communities." (Researcher, NZ)*

Additional barriers included low practitioner confidence and competence working with families. Gambling support workers were described as eclectic in background, particularly in

New Zealand, with few trained in basic social/relational approaches to working with families, e.g.:

> *"Clinicians' can have biases about families (i.e. that they create conflict and are too intrusive, too dependent, too critical etc). Clinicians' express discomfort working with a family or family subsystems, worry about managing strong emotions. Lack of training in services and lack of family focus in most clinical education programs (i.e. social work, psychology). Even social work which is known for its systems approach and person-in-environment perspective, has few courses that teach students how to work with families and few that focus on addictions!" (Researcher and clinician, Canada).*

Family mistrust of services related to social stigma was identified as a powerful barrier to service engagement. Additionally, service design around individual gamblers, and low cultural awareness and competency (e.g. lack of appropriate space for large families to gather, lack of diversity in the workforce).

> *"The design of the service environment should be comforting to the eye and less clinical and individual. A homely feeling is important, something most people are used to and feel comfortable in. Diversity of the practitioners especially Māori and Pasifika would support this." (Clinician, NZ)*

FAO input into the physical/aesthetic environment in which services are offered would support engagement.

<u>Enablers of FAO centred service design and practice</u>

Developing and promoting an understanding of gambling harm as a social issue alongside holistic models of recovery were identified as key enablers of FAO centres services (Table 5), e.g.:

> *"Broader understanding in wider society that gambling problems are not just centred in an individual but in families and communities." (Clinician, UK)*

> *"The use of a working model that puts FAOs centre stage e.g. a 'triangle approach' that sees services for gambling problems as a collaboration between three parties - person with gambling problem, FAO(s), and professional(s)" (Researcher, UK)*

Family systems and social models of addiction/recovery, the notion of recovery as relational reintegration and a conceptualisation of 'the client' as the family, were seen as necessary to enhance family inclusive and family focussed practice in gambling services. These approaches would necessitate re-thinking service design from conceptualisation through to consideration of appropriate outcomes and evaluation. For example, evaluating the impact of support, and identifying key outcomes from a social perspective could involve:

"Using indicators of strength in the form of social cohesion, family mobilisation, collective action etc. But this is almost never the case." (Researcher, NZ)

Such social models of addiction/recovery were described as underdeveloped in the gambling field.

Table 5. Enablers of FAO centred service design and practice

Coded qualitative responses	N	%[#]
Gambling is conceptualised as a social issue/holistic models of recovery	11	38
Family inclusive policy and funding models	8	28
Partnership with families	8	28
Growing the evidence base	7	24
Staff competency	6	21
Targeted promotion and awareness raising for families	5	17

[#] Note that participant responses could be coded at multiple categories.

Family centred policies were identified as important, for example, changing mission statements from referring to 'client-centred' or 'family sensitive' services only. Rather, services could state that they offer client and family-centred services. Funding to support champions to lead initiatives for family-centred services was suggested as a model to kick-stark development of these practices. The need for enhanced and focussed evaluation practice in the FAO support space was noted with enthusiasm:

"We need to be funded to work and research with FAOs exclusively. Knowledge of the work and what's needed is broad and strong in the sector already, we need the evaluations and genuine shared learning to develop practice further." (Clinician and service manager, NZ)

Partnership with FAOs from the start of service and policy design was identified as helpful, in addition to clearly identifying family systems as the focus for support and change. For example, one researcher from New Zealand commented that family must not be seen as an adjunct but as an essential element in all service activities. From a Māori health perspective, partnership with whanau was held to be vital:

"The basics are an empowerment lens, tino rangatiratanga (self-determination) here are the tools we have to do it and let me share our resources with you" (Clinician, NZ)

Two consumer participants noted that partnerships with communities and families must be adequately resourced if they are to have meaningful impact on practice, e.g.:

"Resources enable client-centredness to happen, going out to where FAOs are and keeping them involved in the process e.g. not just going into a community to take stuff away. Resources include travel expenses, koha, kai etc." (Consumer, NZ)

Growing the evidence base for quality and effective practice necessitated developing (or defining) and testing out a range of specific FAO treatment offers, and targeted marketing and communications approaches, research carried out with the few specialist FAO counsellors who are currently practicing, and exploring how 'FAO champions' in services could enhance the range and quality of service delivery for families.

There was significant convergence on the notion that improving staff confidence in working with families could be achieved through general training, rather than specialist training in FAO intervention approaches (such as the 5-Step model) e.g.:

> *"Training for clinicians and leadership on the impact of PG on families, the role of families in recovery, and ways to involve families in services. Also, training on how to maintain confidentiality and client self-determination, while also providing families with psycho education and an opportunity to get involved." (Researcher, Canada)*

Targeted promotion and awareness raising around family harm and family support options, developed by services in partnership with FAOs was recommended.

Increasing client-centredness in gambling service design and practice

In alignment with the notion of 'practitioner-centric' systems and approaches, enhancing support was associated with increasing client-centredness. A key aspect involved co-designing approaches with families and engaging with more social and indigenous models and philosophies (Table 6). Taken together these practices and ideas could effectively support expanded choice of approach/delivery for FAOs. Client choice was positioned as paramount and referral to allied services and professionals encouraged. Collaborative practice among services with complementary strengths was seen to be severely constrained by competitive funding models. Supporting client choice could also mean questioning some traditional understandings of expert-patient dynamics, and the possibility of discomfort for some clinicians.

> *"Staff need to be encouraged and supported to work with those feelings of being challenged and feeling uncomfortable, not knowing, and follow this up to be able to develop our work around FAOs. Systems need to be embedded to be able to follow this up so we can review our work, understand gaps in services and staff knowledge." (Service manager, UK)*

Recommended practice to enhance client-centredness included: Consumer advice structures are in place and funded to support FAOs to participate in co-design of services (Clinician and service manager, NZ); People with gambling issues and affected others are actively involved in co-production, design, delivery and evaluation of services (Consumer, NZ); Support plans and goal setting is designed specifically for the FAO's circumstance with their input and family dynamic taken into consideration (Clinician, UK). Participants emphasised the unique needs and perspectives of each angle of the lived experience of FAOs - including that

children and partners and parents and siblings may all have different needs. Again, flexibility and multiplicity of service offerings were emphasised:

> *"[Enhancing client-centredness means] Welcoming the concern and involvement of FAOs; allowing FAOs to be involved in their preferred comfortable way, about themselves or about their gambling relatives or both, individually, with the relative, in a 'carers' group, by phone or other remote or face-to-face, etc. i.e. a flexible approach." (Researcher, UK).*

Table 6. Enhancing client-centredness in gambling service design and practice

Coded qualitative responses	N	%[#]
Co-design approaches with families	14	48
Social and indigenous models and philosophies	9	31
Wide range of choice for FAOs in approach and delivery	7	24
Prioritise evidence derived with FAOs	5	17
Family friendly environmental design	4	14
Enhanced practitioner diversity	1	3

[#] Note that participant responses could be coded at multiple categories.

Prioritising evidence derived with FAOs through careful review of ongoing practice was emphasised by five participants who described the need for a 'quality improvement' focus in services which could be grown and sustained by fostering a culture of curiosity and learning.

Exploring the role of lived experience in service design and delivery

The idea that FAOs should have some involvement in service conceptualisation, design and delivery was supported by over a third of panel members (e.g. co-design, FAO consumer advisers in senior management roles, FAO representation in lived experience advisory panels) (Table 7). Around a fifth of the panel endorsed FAO involvement in producing and selecting treatment models and approaches:

> *"Firstly, lived experience needs to be unpacked for family and affected others first and foremost, as most focus has been on the gambler. Then there's engaging the lived experience workforce e.g. gamblers and FAOs working in the reducing gambling harm sector e.g. clinician, public health workers, counsellor, manager, researcher. Each area of lived experience that I've outlined above needs to be involved in service design and delivery in partnership with other workers who do not have lived experience in reducing gambling harm." (Consumer, NZ)*

Table 7. The role of lived experience in service design and delivery

Coded qualitative responses	N	%[#]
FAO advisers should guide service design and delivery	11	38
Input into treatment models and approaches selected and delivered	6	21
Important resource for service promotion and delivery	6	21
Constrained and underfunded	4	14

Key part of evidence base for approaches and their ongoing development	3	10
Must be balanced with other perspectives	3	10
Practitioner-inquirers	2	7

[#] Note that participant responses could be coded at multiple categories.

FAOs were held to be an important resource for service promotion and delivery, e.g. through providing FAO narrative that could support and influence FAOs in dealing with their situation (Researcher, Australia), or ensuring information about harm and support needs resonates with people (Clinician, NZ). People with lived experience were seen to bring a deeper understanding by having been through harm themselves, enabling them to provide practical advice on strategies for recovery: FAOs could be mobilised in engagement and reaching out to those who historically do not access services (Clinician, UK). These kinds of activities and engagement with lived experience were seen to be constrained and underfunded at present by four participants (all based in New Zealand), e.g.:

> *"In an ideal world, funding would be provided for a consumer advisor - FAOs to provide their lens/feedback on all relevant policies, procedures, programmes, etc. However this has not happened and we have insufficient access to FAO input." (Service manager, clinician, NZ)*

Three participants commented on the role of FAO peer support in creating and delivering harm reduction work, as part of community mental health-care models:

> *"The Italian Club model focuses on removing therapy and engaging affected families to help other affected families. These meetings are facilitated by "servant teachers", respected members of a community who facilitate family contact without assuming therapeutic roles. I've seen it working well." (Researcher, NZ)*

The idea that lived experience should be balanced by other perspectives in service delivery, was encapsulated by the following comments from researchers based in the UK and NZ:

> *"As with the design of ANY service, for ANY problem, of course lived experience is fundamental. BUT lived experience is but one element. In some ways good research brings together LOTS of lived experiences, to enable generalisation to be made from that. The danger always is that one person's lived experience dominates, and that may be an unusual example - not to be ignored because it is unusual, but not to dominate either, if it is unusual. In my experience of developing and running services, individuals with lived experience make either the best counsellors, or the worst! (Researcher, clinician, UK)*

> *"It's important that consumers have a voice, but they often don't recognise they have an issue until very late, and their view on what services should look like is heavily influenced by the service they accessed and their perception of its success. Diversity of experience is important to capture and feed into service design, but this is much easier said than done" (Researcher, NZ)*

The need for practitioners to be flexible and to acknowledge their own experience as partial (not reflective of all experiences) was noted. Inquiry into lived experience of both harm and accessing/receiving support was advanced by two panel members as relevant to establishing a practitioner-inquirer model for workforce development, e.g.:

> *"The role of lived experience in service design is a big one. Materials, staff training etc etc need to be informed by what FAOs have said about their experience of harm and support. Use of qualitative inquiry with experts by experience (EBEs), quotations on hand, some staff recruited as EBEs, as supportive of quality practice-relevant research and evaluation" (Researcher, clinician, UK).*

Several participants cautioned against the potential exploitation of 'lived experience' in service design, promotion, mental health support work, and public health practice (awareness raising) given that significant shame and stigma remains in the community regarding gambling addiction. Families affected by gambling harm may be vulnerable and underserved in a range of areas of their lives. The need to protect client anonymity was described as vital to protecting clients from an additional 'second wave' of harm.

Enhancing cultural awareness in gambling service design and practice

The panel reported that services that are sensitive to clients' cultural beliefs and practices are more likely to include family as an important part of recovery (Table 8). For example:

> *"Cultural awareness involves practitioners having done their own self-work, understanding their cultural positioning and identity in relation to others, and knowing their blind spots. They must be careful not to judge FAOs for their plight, and take a broader historical, socio-cultural perspective of their clients and their clients' issues. That awareness might be conveyed to clients via correct pronunciation of names, asking about cultural practices the client might like to observe, being open to wider whānau attendance and support, but also acknowledging the collective orientation of many non-European groups, and what that means. Some awareness of culturally-specific details would be important too." (Policy, NZ)*

Table 8. Enhancing cultural awareness in gambling service design and practice

Coded qualitative responses	**N**	**%[#]**
Culturally competent staff	13	45
Developing a culturally nuanced evidence base	10	34
Cultural awareness in service design	7	24
Working for equity and social justice	5	17
Cultural diversity represented in governance design and practice	4	14

[#] Note that participant responses could be coded at multiple categories.

Developing a culturally nuanced evidence base, engaging cultural models, conceptualising and measuring culturally relevant outcomes were highlighted as priorities for enhancing work with

families by over a third of the panel. New Zealand participants particularly emphasised an equity and social justice focus for service development and delivery (Clinician, NZ), understanding that health equity means more resources to our ethnic minorities (service manager, NZ); awareness of the traumatic impacts of colonisation, racism, discrimination, and other oppressions (Policy, NZ); addressing systemic racism within organizations (Researcher, Canada) and the notion that clinicians need to be have heightened self-awareness and to be able to reflect on the impact of their intersecting identities on the client (Service manager, Australia).

Two participants noted that gambling harm is disproportionality a Māori health issue, as tangata whenua (Indigenous people) Māori involvement at all levels of practice is paramount: Tino rangatiratanga means ensuring Māori input into decision making from practitioners right through to upper management, board members and government. Others held that whilst designing a gambling service a variety of people from different cultural background should be involved so that services can be shaped appropriately for all those needing support, e.g. "[Enhancing cultural awareness means] practitioners from a wide variety of backgrounds are involved and there is translation of material both in verbal and written form so that any information, advice and therapy can be accessed in FAO's first language." (Clinician, UK).

<u>Building and sustaining a culture of curiosity and learning in services</u>

Embedding ongoing inquiry, learning and adaptation/growth within practice settings, e.g. described by one researcher/clinician as 'safe-space feedback loops', was held to be a singular challenge. For example, one researcher/clinician noted:

> *"In all services, most practitioners find change difficult and find developing and changing their practice in the light of emerging evidence very difficult! This is across the board, in ALL areas of practice. Getting practitioners to learn to wash their hands was one of the most difficult of all changes in medicine to introduce 100+ years ago!" (Researcher, clinician, service manager UK)*

> *"Unfortunately I don't believe that the distinction between approaches [in the literature] or awareness of other competing ways of addressing the issue is widely recognised within the service planning and delivery sector." (Researcher, Australia)*

The idea that practitioners could be better supported to undertake 'inquiry' and critical reflection on practice (critical reflexivity) was advanced (Table 9), e.g. career structures where learning and qualification are supported were critical:

> *"If learning becomes an extra burden, it is unlikely to foster engagement. We have qualifications for advanced learning in this area but few in the gambling field have engaged. It suggests ongoing learning is not encouraged." (Researcher, NZ).*

Clinicians held that being open to learning, acknowledging continual room for improvement, growth and development were all an important part of job satisfaction, including that "everyone

involved wants to be more opened minded about families, try new things and new ways and be supported, we're always asking ourselves how we can do things better." (Clinician, NZ). A culture of curiosity and learning involved using evidence appropriately, acknowledging the limits of existing evidence and working to create and share new knowledge.

A flourishing learning environment was seen to be inadequately supported by funding for frontline staff to have time to spend further developing their skills. Policy and service management participants noted the need for governance and management to value the insights of practitioners and support their pursuit of ongoing practice/continual improvement.

> *"Give front line staff flexibility and a clear role in service design AND improvement; use of rewards - what do we value? Use of measures - outcomes vs process; create culture that values people's experience and expertise and our desire to learn from it (rather assuming we know it all)." (Policy, NZ)*

Table 9. Building and sustaining a culture of curiosity and learning in services

Coded qualitative responses	N	%[#]
Practitioner-inquirers	12	41
Creative, collaborative and diverse evaluation	10	34
Funding and policy support	6	21
Improved stakeholder/sector communication	6	21
Enhanced cultural competency	2	7

[#] Note that participant responses could be coded at multiple categories.

Creative, collaborative and diverse evaluation approaches carried out with support from researchers were identified as a possible solution (to the extent that these processes were supported by adequate funding). Funding and policy support could involve embedded monitoring and evaluation practices, feedback loops, and emphasis on researcher, practitioner, and client-led innovation (while furthering knowledge at the same time):

> *"We need to encourage a systemic approach that supports learning and knowledge sharing from communities, service users, professionals, internal staff. At local, regional, national levels and from grass roots right up to central government. Collaborative problem structuring/diagnosis is needed to better understand the problem without focussing on a solution to what we think the problem may be...Ask the question 'what isn't working' and ask the right people. Use participatory approaches to gather learning via workshops, social media, interviews." (Service manager, NZ)*

<u>Bridging gaps between researchers/research and practitioners/practice</u>

> *"What is the purpose of research if it does not involve everybody? Unless research can be translated into practice then it's just a theoretical exercise, hence the importance of being inclusive. From my perspective people working at the coalface want to better engage with both the gambler and FAO, so everyone wins!" (Consumer, NZ)*

The need for enhanced knowledge translation and exchange between researchers and practitioners, supported by government policy and funding enabling quality engagement was discussed by over two fifths of the panel (Table 10).

> *"We need to foster more accessibility to research findings for practitioners, and have practitioners actively translate research into practice. Many practitioners do not have access to research articles, and often fail to read these when available on the mistaken assumption it is irrelevant to their practice." (Researcher, Australia)*

> *Putting researchers and practitioners together in settings with space and time to explain the practice gaps and jointly discover ways, through research, to fill these gaps. Personally, I have found being responsive to practitioners' quest for answers a most rewarding task. (Policy, UK)*

Again, participants across the spectrum (from researchers, to service managers and clinicians) emphasised that practitioners could and should be supported to develop research skills and carry out inquiries in collaboration with researchers and/or independently. Post graduate qualifications were noted as important (ideally), and a broader emphasis on supporting practitioners to be research active through building links between universities and services. In New Zealand, gambling practitioner engagement in further study and/or research was reported by three panel members to be low. The three panel members were speaking from research, clinical and service manager perspectives. One researcher noted that the AOD field has had a longer history in promoting practitioner-inquiry, and post graduate Masters and dissertation studies have been the most successful in attracting practitioners interested in enhancing service provision.

Table 10. Bridging gaps between researchers/research and practitioners/practice

Coded qualitative responses	N	%[#]
Knowledge translation and exchange	13	45
Policy and funding to support quality engagement	12	41
Collaborative research design	6	21
Practitioner-inquirers	4	14
Development of practice forms a coherent research stream	4	14

[#] Note that participant responses could be coded at multiple categories.

In relation to policy, the following were mentioned: funding to support meaningful collaboration within research projects, a designated research stream that is about reflecting on and improving practice, incorporation of collaborative evaluation strategy and planning into service contracts, and resourcing clinicians to undertake professional development which includes a research/inquiry component. Service managers and clinicians noted that policymakers and researchers regularly request data, at a level which can become overwhelming.

> *"Early involvement and co-design of the research and process are ideal. However, with the current situation, where services are just trying to meet the demand, it has become*

> *a big challenge for some services. Any further requests from research can be perceived as a burden due to under resources." (Clinician, NZ).*

The need for research and evaluation to have a clear practice improvement focus was described, particularly the idea of a series of pilots with evaluation of a range of services for FAOs that are currently active (e.g. culturally specific services) or emerging (e.g. the 5-Step intervention, couples and family therapeutic techniques for gambling harm) in New Zealand.

> *"There seems to be a constant need to verify the existence of your service with number crunching with little focus on quality and unique individual outcomes… more buy in from practitioners would be achieved if some training was provided. For example, if the process and effectiveness of approaches for working with couples or family members was evaluated. Practitioners really enjoy up skilling." (Service manager and clinician, NZ).*

Discussion of views on enhancing FAO support in New Zealand gambling services

Our analysis of the views of panel members has suggested that enhancing support for FAOs in New Zealand gambling services should involve a combination of:

- Expanding the range of approaches to FAO support that exist in practice, and facilitating FAO choice among diverse service offerings
- Tino rangatiratanga and mana motuhake: Ensuring Māori leadership, design and management of gambling harm reduction strategies and services.
- Implementing social and cultural FAO recovery models to balance approaches that focus on the individual
- Exploring the role of FAO lived experience in service design and practice (peer support, consumer panels, community health models)
- Building and sustaining a culture of curiosity and learning in services (practitioner-inquirers, community engagement, creative and participatory evaluation)
- Bridging gaps between researchers/research and practitioners/practice.

In achieving the above, a particular role for policy has been identified in funding and support activities for practitioner-inquirers (i.e. clinicians and service managers who critically engage with a research/practice nexus e.g. in postgraduate study or in partnership with researchers). Policy (and particularly funding) support for collaborative and participatory service design, development and evaluation was advised. Additional policy suggestions included: actively ensuring the workforce is culturally diverse and aware enough to reflect New Zealand families, and broader workforce development around cultural and family responsiveness.

<u>Engaging multiple paradigms</u>

In many countries, reliance on the objectivity of science to drive equity and rigor in healthcare has led to a situation of decreased explicit consideration of how socio-cultural dynamics contribute to what is considered good practice and appropriate systems (Mykhalovskiy & Weir,

2004). Expanding the range of approaches to FAO support that exist in practice involves a commitment to multiple ways of making sense of FAOs and their support needs. A key issue is opening up ways of thinking about support that conceptualise addiction and recovery beyond 'problematic individuals' in ways that work for families. The 'forgotten family' in addiction services (e.g. Cooke, 2007, 2018) has been linked to over-emphasis on addressing the 'problem behaviour' within individual psychological frameworks that prioritise medical and psychiatric expertise and devalue family experience and knowledge (Adams, 2007a; Johnstone & Boyle, 2018). Adams (2007a) described how dominant ways of conceptualising people affected by addictions (as individual 'particles' to which psychological, biological and social factors are attached) tend to crowd out sociocultural perspectives and approaches which focus on the reflexive nature of relationships between individuals in their family and community contexts.

Making visible a range of approaches is key to enhancing the ability of FAOs to choose the approach that is right for them, and enhancing person and family-centredness in mental health (Hummelvoll, Karlsson, & Borg, 2015). Sociocultural and individual approaches can wrap around each other in service provision, provided that those involved are committed and also clear on the theoretical underpinnings of practice (Adams, 2007a, 2016; Huriwai, 2002). Multiple ways of looking at things enable all parties involved to become aware of their assumptions, and to be challenged to reflect and justify their various positions (Adams, 2007a). Discussion of the influence of culture and values in support and recovery can be controversial and uncomfortable: however research has consistently demonstrated how societal culture and values structure what services are available, produce unconscious bias in healthcare provision and construct the intended goal/s of support and intervention (Cassell, 1998; FitzGerald & Hurst, 2017; Stephens, Porter, Nettleton, & Willis, 2006). For example, Māori in Aotearoa New Zealand have seen the individualized nature of Western treatment systems creating access barriers and poorer outcomes when compared to treatment that encompasses vital cultural concepts such as whānau (family systems) and wairua (spirit) (R. Graham & Masters-Awatere, 2020; Patterson et al., 2018). Pluralistic FAO support environments and systems require conscious effort and commitment to maintain and should be supported by appropriate policy and evaluation.

Participatory research, service design and evaluation

There is a dual need to explore current support practice more deeply, and to further understanding of quality and effective support for FAOs. In present services much of what is talked about, decided upon and done is based around the views, perspectives and culture of service systems and professionals (Borg & Karlsson, 2017; Hampson, 2012; Orford et al., 2009). The belief in and power of expertise is problematic if we are to make collaboration and dialogues with families a key component. Meeting the person as an autonomous individual in her/his social and cultural context involves developing collaborative partnerships. Harlene Anderson (2016) developed the concept of dialogue in mental health service provision to include the notions of mutual inquiry, relational and social competence, privileging the wisdom and expertise of the person and his/her network, and learning to live with uncertainty. To be

avoided are quick and premature decisions and letting procedures stand in the way of the person's recovery and life.

Community based and participatory research, service design and evaluation was strongly advocated by the panel, and is currently rare in the addictions field in comparison to broader mental health (Nieweglowski et al., 2018). Participatory research, service design and evaluation includes people with lived health conditions, family members and service providers, as active constituents in the process (Wallerstein et al., 2020). Teams of stakeholders work together to generate insight for practice that may be missed without such community involvement. The core principles of this active inquiry process are: participation of community members, cooperation and equal contribution between community members, researchers and service providers, co-learning, systems development and local community capacity building, empowerment, and a balance between inquiry and action (Wallerstein et al., 2020). Such approaches appear especially well suited to gambling services in New Zealand, where work with families is ostensibly being carried in diverse ways not currently captured by traditional evaluation techniques (Kolandai-Matchett et al., 2015). Existing MOH policy recommends that services ask about and seek to involve family and whānau 'in ways that work', and that partnership with families/whānau 'should be evident in service design' (Ministry of Health, 2015). No guidance is given around which inclusive practices 'work' and what minimal standards for 'partnership' might entail. Comments from the panel suggest that these policies be revitalised and reflected in service commissioning and funding structures supportive of participatory research, service design and evaluation.

Creative workforce development

Knowledge translation, or developing a close and productive relationship between research, knowledge creation and practice implementation, is a key priority and challenge in health care internationally (Straus, Tetroe, & Graham, 2013). Developing an evidence base together with those who are directly involved in shaping and delivering services, improves the likelihood that the knowledge generated will ultimately inform practice (Straus et al., 2013). For example, Orford's (2009) action research to increase the involvement of family members in two alcohol and drug treatment services, produced a nuanced account of the types of family work conducted, barriers to family involvement, and how to ensure changes in practice were sustainable in these particular organisations. The issues of knowledge translation are complicated in the context of gambling where appropriate levels of evidence for treatments are still in development.

Improving services can often require 'un-thinking' established modes of practice and delivery so that creativity can take place (Abercrombie, Harries, & Wharton, 2015), a practice that is also referred to as 'making the familiar strange' (Kumagai & Wear, 2014). Sustaining a culture of learning and improvement and bridging gaps between research and practice suggested using 'critical reflectivity' in enhancing support for families. Critical reflexivity happens when professionals working in a field are supported to actively consider how their practices interact

with prevailing knowledge systems, generally through exposure to different ways of thinking about intervention, and particularly as grounded in client's experiences (Gibson, 2016; Kinsella, Caty, Ng, & Jenkins, 2012; Kinsella & Whiteford, 2009). When facilitated in clinical settings, critical reflexivity generates new insight into intervention and engagement strategies, and understanding of desired endpoints or outcomes, that can contribute directly to service improvement (Gibson, 2016).

Enhancing addictions workforce diversity was suggested as a key strategy to enhance work with families. New Zealand's current Mental Health and Addiction Workforce Action Plan 2017–2021 already identifies creating 'a workforce that is the right size and skill mix' within the top four priorities for enabling people to thrive and experience wellbeing (Ministry of Health, 2018). Our findings suggest that targeted action around the following key outcomes would support the enhancement of support for FAOs in gambling services: "The workforce is culturally diverse to reflect the population, particularly Māori and Pacific peoples; The workforce reflects the diversity and experience of service users, and works in collaboration with the service user and their family and whānau" (Ministry of Health, 2018, p. 15).

Limitations of the structured engagement with expert opinion

This engagement with expert opinion has been necessarily limited by the availability of panel members during a year of many challenges and disruptions related to the COVID-19 pandemic and public health responses. Consumer representation was particularly low in this engagement with expertise/experience and should be addressed in future work with different methodologies designed to improve links with consumers (e.g. face-to-face engagement alongside the construction of consumer governance panels for mental health services). Additional convergence and validation of Round 2 analysis and recommendations with the panel would have further strengthened the conclusions made in this report. However, a third round of engagement was not possible within the lifecycle of the project.

Conclusion

This structured engagement with expert opinion on enhancing gambling and addictions service design and delivery for FAOs was carried out in the spirit of a 'human prerogative of care': accepting that no single treatment system can address all addiction-related problems for families. Our analysis of recommendations has shown that enhancing support for FAOs in New Zealand gambling services should involve expanding the range of approaches to FAO support that exist in practice, through commitment to engaging a range of individual psychological and broader social, cultural and relational paradigms. In present services much of what is talked about, decided upon and done is based around the views, perspectives and culture of service systems and professionals. The belief in and power of expertise must be challenged if we wish to base our practices on collaboration and dialogue with families. Active inquiry to support service design and practice should involve: participation of community members, cooperation and equal contribution between community members, researchers and service providers, co-learning, systems development and local community capacity building, empowerment, and a

balance between inquiry and action. The idea of ‘critical reflexivity’ could support a culture of learning and improvement in services where professionals are supported to actively consider how their practices interact with prevailing knowledge systems, generally through exposure to different ways of thinking about support/intervention, and particularly as grounded in client’s experiences. Promising avenues for enhancing support provided for FAOs through service commissioning include support and initiatives for: practitioner-inquirers, collaborative and participatory service design, development and evaluation, workforce diversity and broader workforce development around cultural and family responsiveness.

EXPLORATION OF CURRENT FAO SUPPORT PRACTICES

This section details the results of part two of the study, an exploration of current FAO support practices. Part two involved a review of FAO support service provision, and an exploration of FAO engagement with New Zealand gambling services.

Review of FAO support service provision

A review of FAO support service provision was conducted to explore how services were presented, orientated, and engaging with the needs of FAOs. During the structured engagement with expert opinion, panellists were invited to suggest a range of national and international gambling support services who they felt were engaged with families. This review examined information relating to these services. The purpose was to gain a sense of the support options available to FAOs affected by gambling harm at present.

Research questions:

- How do gambling services appear to be oriented to FAOs at present?
- What evidence is there of the kinds of support that FAOs are offered in gambling services?
- How are gender, ethnicity and/or cultural issues/perspectives incorporated into service design and delivery?

Approach to data collection and analysis

Data for analysis comprised:

(1) National and international gambling support service summaries and/or copies of programme documentation, practice resources and policies in use within the service that are relevant to support that is currently provided for FAOs, including any available evidence for the incorporation of gender, ethnicity and/or cultural issues/perspectives into service delivery.

(2) The websites and/or publicly available material associated with these services.

Data was collected from the organisations listed in Table 11 below.

Table 11. Organisations involved in review of service provision

Country	Service/Organisation
New Zealand	Asian Family Services
	Homecare Medical
	NZ Salvation Army Oasis Reducing Gambling Harm (Oasis)
	Mapu Maia
	PGF Services
	Raukura Hauora o Tainui
	South Seas
Australia	Gambling Help NSW
	Self Help Addiction Resource Centre (SHARC)
	The Victorian Responsible Gambling Foundation (VGRF)
	Turning Point/Gambling Help Online
	Warruwi Gambling Help

United Kingdom	GamCare UK National Problem Gambling Clinic
Canada	The Centre for Addiction and Mental Health (CAMH)
United States	GAM-ANON International

Data collection occurred in two stages:

(1) Discussions were held with service managers and programme coordinators to ascertain and understand the availability of support specific to FAOs within their service. The service managers and programmes coordinators were also asked to provide practice resources, programme documentation, and policies relevant to FAOs. Data collected from service managers/programme coordinators was not restricted to the previous 12-months.

(2) The researchers systematically reviewed websites, social media pages, and other publicly available information to collect data regarding support available for FAOs. Publicly available information was collected between February 2020 and April 2020 from the previous 12 months (January 2019 – January 2020). Screenshots were taken of relevant material and uploaded to NVivo 12 for analysis.

Data available and collected for analysis is summarised in Table 12 below.

Table 12. Summary of data sources for review of FAO service provision

Service/Organisation	Discussions with managers	Resources (from service manager or downloaded)	Annual reports / Policy	Service website screenshots	Social media screenshots
Homecare Medical					
Oasis					
PGF Group					
Raukura Hauora o Tainui					
South Seas					
Gambling Help NSW					
Warruwi Gambling Help					
SHARC					
VGRF					
Turning Point					
GamCare UK					
National Problem Gambling Clinic					
CAMH					
GAM-ANON International					

Note: Blank spaces indicate unavailable data.

In total, 139 units of data were collected for analysis, including notes of conversations and email correspondence with service managers, website and social media screenshots, annual reports, and resources supplied by service managers or downloaded from service websites.
All data was uploaded to NVivo 12, a programme used to organise data for qualitative research. Data were analysed using a qualitative descriptive thematic analysis (Braun & Clarke, 2006; Sandelowski, 2000, 2010). A qualitative descriptive approach provides a rich and comprehensive summary of data (Colorafi & Evans, 2016; Sandelowski, 2000, 2010). This approach was chosen because the outcome is an in-depth description and summary of the subject of interest, using the language of the participant/data pool. Finally, analysis also examined evidence for the incorporation of gender, ethnicity and/or cultural issues/perspectives into service delivery for FAOs.

How do gambling services appear to be oriented to FAOs?

A broad definition of FAOs establishes an inclusive orientation

The way FAOs were defined by a service suggested the focus of support and whether an inclusive approach has been taken. Generally, a broad definition of FAOs was used by services; the definitions included family/whānau as well as friends and other close support people (e.g. colleagues, teachers). For example, in the Family Support and Psychoeducational Group Manual for Problem Gambling available from the Centre for Addiction and Mental Health (CAMH) in Canada, it was stated that "Family is used as a broad term to describe anyone who has a significant relationship or role in the life of the gambling individual" (Kourgiantakis, Weyman, Teasell, & Pont, 2013a, p. 2). In New Zealand, the New Zealand Salvation Army Oasis (Oasis) utilised the following definition:

> *"[Definition of] Family & whānau:*
> *A client's family or an extended family/group of people who are important to the client. It is a set of relationships that is not limited to blood ties.*
> *Family & whānau may include:*
> - *Relatives – including a spouse or partner*
> - *A mixture of relatives, friends and others in a support network such as:*
>   - *Whānau, hapu and/or iwi*
>   - *Nuclear or extended family*
>   - *Families of a particular community (refugees, migrants, gender base, gay or lesbian, gang, deaf etc.)*
>   - *Families made up of people such as a client support group.*
>
> *Each of these family styles requires its own recognition and considerations."* (The Salvation Army, 2020)

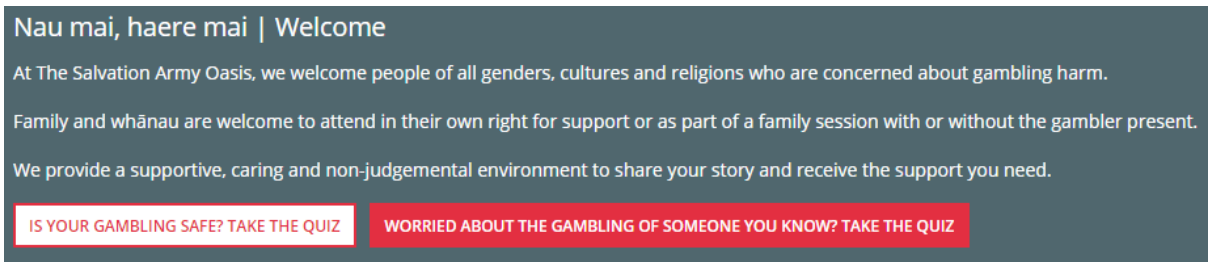
Most gambling services included an element of practice aimed at FAOs. The extent of inclusion ranged from a clear family-centred approach, as taken by culturally based approaches, with little to no distinction made between the individual gambling and the FAO, e.g.:

> *[Mission statement] Working with families and communities to be healthy and resilient; free from gambling harm.* (Mapu Maia, 2020a)

Other services specified that support was available for both the individual gambling and the FAO.

> *We know it can be hard to ask for help, but if gambling is impacting your life, or the life of someone you care about, we're here to help*. (PGF Services, n.d.-c)
> *Support is available for anyone affected by a gambling issue, not just the gambler themselves.* (Gambling Help Online, 2020a)

Most services highlighted in some way that 'support' was available for anyone affected by gambling. We found the majority of statements were ambiguous about what 'support' might entail, few services were clear about service offerings. This is likely to be problematic to the extent that clients might need to know the kind of services/support that could be provided to encourage them to make contact. Few services were clear which approaches or options of support were available to FAOs independently of gamblers. The homepage for Oasis is an example of (1) a clear inclusive orientation toward FAOs, and (2) detailing that support was available for FAOs in their own right:



(The Salvation Army Oasis, 2020b)

A service that appeared to be not generally aimed at FAOs was the UK National Problem Gambling Clinic (NPGC). The clinic is a National Health Service (NHS) provider "commissioned to deliver care and support to problem gamblers who have difficulties that might be described as complex" (Central and North West London NHS Foundation Trust, 2020b). Potential clients who do not meet the service criteria (e.g. lengthy period of problem gambling, with little or no abstinence, previous unsuccessful structured psychological support for problem gambling, mental health difficulties, homelessness or unstable housing etc.) are referred to the National Gambling Helpline. However, the clinic does state that "The team assesses the needs of problem gamblers as well as those of their partners and family members" (Central and North West London NHS Foundation Trust, 2020a). Conversation with service managers at NPGC revealed that in fact three broad options for families were in operation there: the 5-step programme informed by the work of Jim Orford (see Orford et al., 2017), monthly group psychoeducation courses, and family therapy conducted from a family systems perspective.

<u>Advertising can demonstrate service availability and orientation toward FAOs</u>

Searches of services' social media pages (Facebook, Twitter, Instagram) yielded promotional material aimed at both individuals who gamble and those affected by someone else's gambling (e.g. parents, partners/spouses, colleagues, teachers). The way in which a service advertised or promoted their services provided an indication of the orientation of the service toward FAOs. For example, although there was slight variation in the advertisement of the service number, most utilised a line similar to below:

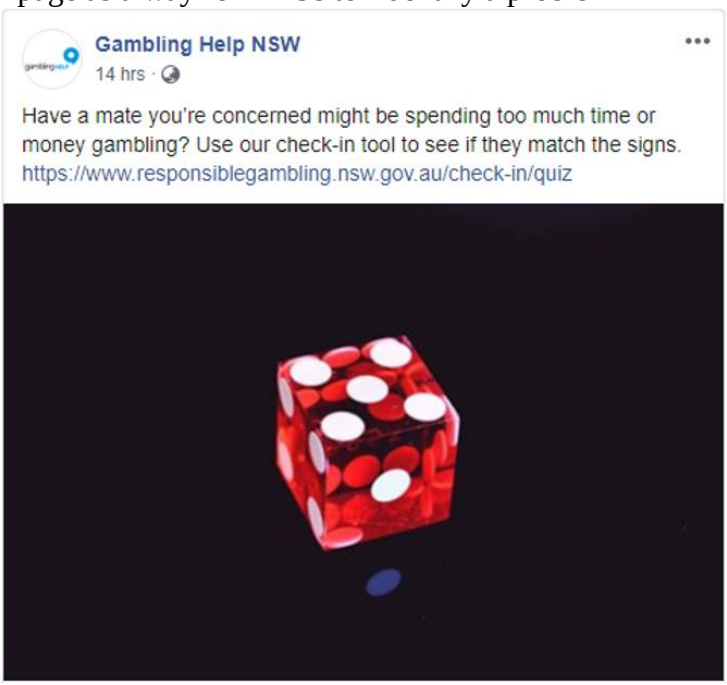
(Centre for Addiction and Mental Health [@CAMH_GGTU], 2019)

In general, social media promotional material indicated that support was available for individuals concerned about their own gambling as well as someone else's gambling. Alongside advertising for both the gambling individual and FAOs, there was promotional material which focussed solely on FAOs. This material could be placed in two categories: First, there were promotional materials which focussed on FAOs needs, aimed at informing FAOs that they could access support services in their own right. For example, the below Facebook post highlighted that FAOs can be negatively affected by gambling behaviour and also need support:

(Victorian Responsible Gambling Foundation, 2019a)

Second, it was most common for services to advertise that they were able to help the FAO to identify whether their loved one had a problem with gambling and how the FAO could assist and support the individual gambling. On social media pages, holiday seasons, going back to school or work, and other life changes were often used as opportunities to provide information to FAOs on how to identify and support someone who might have a gambling problem. For example, Gambling Help NSW provided a check-in quiz for individuals to identify if they or

someone they care about has a gambling problem; this check-in quiz was regularly advertised through their Facebook page as a way for FAOs to 'identify a problem':



(Gambling Help NSW, 2020)

What kinds of support do FAOs appear to be offered by gambling services?

Service documentation and discussions with service managers suggested that a range of support and intervention types were available to FAOs, including psychoeducation and general education, therapy and counselling, support groups, and different forms of lived experience representation (consumer advisors, peer support, articles/blogs exploring the experiences of FAOs). Additionally, support/information was available for specific groups such as family and friends, parents, teachers, and colleagues and employers.

The interventions and support available could be differentiated by type and focus. For example, the types of support included family therapy, support groups, counselling/intervention approaches (5-Step, Motivational Interviewing, Single Session Family Consultation etc), and public health and health promotion. The focus of interventions included stress reduction and mindfulness, shame reduction and healing, relationship dynamics and boundaries, enabling behaviour, communication tools, personal safety, and practical steps and financial skills. There were few geographical differences in the scope of what was offered. However, the NZ and Australian services appeared to include more public health/health promotion activities than the UK, U.S, and Canadian services (i.e. there was a greater clinical orientation in services outside of Australasia).

As an indication of the orientation of services for FAOs, the material on services' websites and social media was split between providing information on (1) FAO and gambler orientated information: how to support the gambling individual/enable access of services, enhancing FAO understanding of gambling and the gambler, and how to start a conversation about gambling with their loved one; and (2) FAO orientated information: how FAOs can support themselves (self-help) or access help in their own right. Commonly, on service websites there are tabs

labelled "Get Help", "Reducing Harm", "Treatment and Support", or "Helping Others". "Helping Others" commonly links to more information about the available services for FAOs. For example, below, selecting the tab "Helping others" on the Australian Gambling Help Online website led to further sections of information on "Signs of a problem", "Understanding the gambler", "Starting the conversation", "Helping yourself", "Accessing support", and the "Impact on others":

(Gambling Help Online, 2020b)

<u>There is a wealth of information provided for FAOs on how to support the gambling individual and improve the wellbeing and functioning of the family/whānau</u>

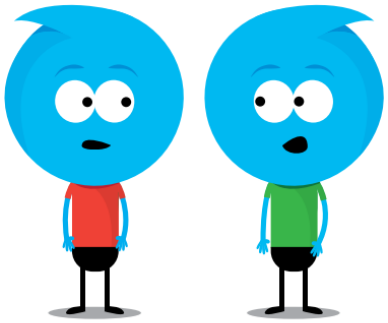
Publicly available information for FAOs provided a significant amount of information, advice and tips, and some lived experiences of FAOs supporting loved ones through problem gambling. This information generally covered three key areas: (1) how to identify if someone has a problem with gambling, (2) how to bring up and discuss gambling with the individual or family/whānau, and (3) how to support the individual or encourage treatment access. The information was presented in infographics, online information sheets, social media posts, lived experience articles, and blog posts.

Identifying if someone has a problem with gambling was a key part of information specific to FAOs. For example, a number of services included a questionnaire or checklist on their website: PGF Services used 20 questions from GAM-ANON to "help you determine if someone you live with is experiencing harm from gambling" (PGF Services, n.d.-a). Responsible gambling NSW regularly advertised their 6-item "check-in tool" (Responsible Gambling NSW, n.d.) which included questions on gambling location, the device(s) used to gamble, social or isolated gambling, and how they felt about their loved one's time and money spent on gambling. Following the questionnaire, tips for big and small changes the FAO could suggest were given – all tips were suggestions to give to the individual gambling and there did not appear to be any suggestions for the FAO to seek additional help/support. Suggestions for FAOs to give the individual gambling included:

> • *Do something different with the friends you normally gamble with*
> • *Set an alarm on your phone to limit the time you spend gambling*
> • *Avoid borrowing money or getting money on credit to gamble with*
> • *Try keeping a record of how much time you spend gambling each week (Responsible Gambling NSW, n.d.)*

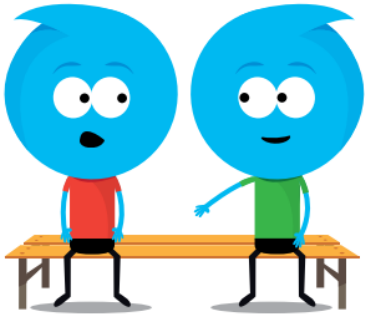
Suggested timing, wording and manner of approaching a discussion about a possible gambling problem with a family member was another key part of the information specific for FAOs. For example, Turning Point (Australia) provided detailed information on 'identifying the signs' of a problem and 'starting the conversation'. Advice for starting the conversation included using 'connecting statements', i.e. a truthful and positive statement about the relationship between

the FAO and the gambling individual that contributes to connectedness; e.g. “I really care about you and what happens to us and because of that I feel have to talk about what I've been noticing” (Gambling Help Online, 2020d). Advice for avoiding showing judgement, and ensuring the gambling individual felt safe was also given. Given the sensitive nature of bringing up a potential problem with gambling, caution around potential escalation and information about dealing with denial and anger was emphasised. Advice on dealing with anger provided by Gambling Help NSW included, validating the anger, acknowledging that anger is ok but aggression is not, informing the individual about how the anger is affecting them, and encouraging emotional expression in more productive ways. Further information on speaking to counsellors to help develop an action plan or to seek additional support was also provided. Two sections were provided on starting a conversation in a booklet provided by Gambling Help NSW; starting a conversation and developing the conversation:



STEP 6: STARTING A CONVERSATION WITH YOUR LOVED ONE

Getting your loved one talking about their gambling problem is very important. It is one step away from them actually doing something about their problem! This section will cover some useful strategies you can use to get them talking.



STEP 7: DEVELOPING THE CONVERSATION

Now that you've got the conversation started, here are some really useful things to keep in mind.

Expressing challenging emotions

It's important to learn how to express intense and distressing emotions like anger and hurt without pushing your loved one away. Here are some helpful Dos and Don'ts to keep in mind.

Do

- Express how you feel. "I/we are upset and angry about your gambling but I/we still want to help you as much as possible." Or "Yes, I am angry at what you have done but I do want to help you gain control and overcome your gambling urges."
- Acknowledge and validate the emotions that they express in words. "From what you're saying, it sounds like you've been feeling really down lately. Am I right in saying that?"

(Gambling Help NSW, n.d.-b, pp. 33-43)

The information on starting a conversation indicated a perception that FAOs might recognise a problem prior to the gambling individual and are a valuable resource for (1) getting gambling individuals to seek help and (2) taking control of the situation and enabling change within their family/whānau.

The third key area of information for FAOs focussed on advice for supporting their loved one to access support or manage their gambling (without external support). Information on referring a loved one to a service was given as well as advice on how to support them while they were in treatment (or not seeking treatment). For example, on PGF Service’s Facebook page (below), a link to a blog provided information and advice for FAOs during the Christmas holiday season on how to support their loved one. Advice included watching for signs their loved one was struggling with gambling (e.g. selling possessions, becoming secretive, isolating themselves), checking in and listening to their loved one, avoiding enabling behaviour (e.g. lending money, paying fines or debt, gambling with them), scheduling and encouraging alternative activities, encouraging the gambling individual to seek professional support, whilst not forgetting to focus on their own wellbeing.

(PGF Services, 2019b)

Parallel to advice on treatment referral was information regarding situations in which the gambling individual was unwilling to seek help. It was acknowledged that often the gambling individual might be reluctant or resistant to seeking external support. Thus, information aimed at FAOs presented that this was a normal situation and that there were options for both the FAO and gambler:

> *People experiencing mental health or addiction problems are not always willing to seek treatment. They may not believe there is a problem. Or they may feel that they can address the issue on their own, without treatment. The person may also have fears about the mental health system, or concerns about the stigma of a mental health or addiction diagnosis. This is a difficult situation for families. While your family member may not see the need for treatment, you are witnessing the situation and feel they need support*. (Centre for Addiction and Mental Health, 2020)

Advice given by CAMH (Canada) involved avoiding pleading or criticism, learning more about mental illness and addiction, and practicing self-care which could include seeking support independently of the gambling individual (Centre for Addiction and Mental Health, 2020). Some services clearly positioned FAO involvement as beneficial in the support of the gambling individual. For example, Gambler's Help (Australia) and CAMH (Canada) below:

> *If you suspect that someone you know has a problem with gambling, it's important for you to help them because there can be significant negative consequences. These can include relationship breakdown, financial problems, loss of employment, and mental health problems, including suicide.* (Gambler's Help, 2020b)

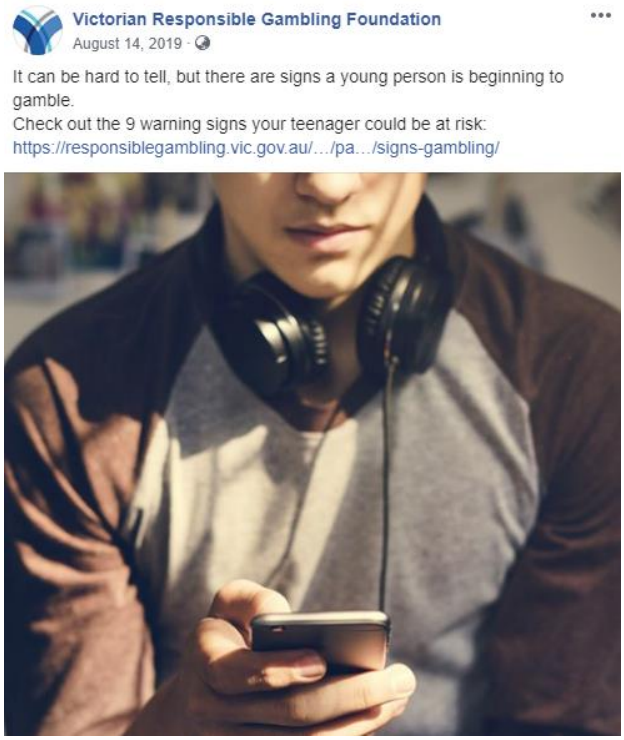
> *Why is family involvement important? Research supports the value of involving family members in treatment for problem gambling and substance use problems. Here are some salient findings: People remain in treatment longer when a family member is involved, and those who stay in treatment longer have better outcomes* (CAMH family support manual Kourgiantakis, Weyman, Teasell, & Pont, 2013b, p. 6)

Services provided information as to why FAO supporting the gambling individual would benefit themselves, their loved, and their family/whānau. For example, some services referenced research which indicated that family member involvement in support and treatment led to better outcomes for the gambling individual, as well as the family/whānau. The negative impact of the gambling behaviour was acknowledged alongside the notion that family involvement in therapy could assist the gambling individual and the FAOs, in turn, improving the wellbeing and functioning of the family. The below quote was from a pamphlet from SHARC, detailing the negative effects of problem gambling and how working together as a family can alleviate the negative effects.

> *When people are working on changing their problem gambling behaviour, the involvement of those close to them can really help. Having a gambler in the family can have negative effects on close relationships and can create financial difficulty, damage trust and increase stress. These effects don't go away overnight and the change process can take time. When families work together, gambling problems and negative effects can be dealt with more quickly. Research has shown that individuals do better when families are involved.* (Family Drug Help, 2017, p. 5)

Online information for parents focussed on online gambling and gaming

There was information available specifically for parents, which focussed on identifying the signs of a gambling problem in their teenage child and then how to approach them. This information was available from CAMH, VGRF, Gambling Help NSW, GAM-ANON, and Mapu Maia. Information available focussed on forms of gambling (online, sports betting etc.), the gambling industry and advertising, gambling and gaming convergence (e.g. loot boxes), and adolescent risk-taking behaviour. The information for parents was split between (1) preventing problem gambling through knowledge, awareness, and open discussion; and (2) identifying and responding to a gambling problem:



(Victorian Responsible Gambling Foundation, 2019b)

Information for colleagues and teachers: Recognising and responding to the signs

Information for colleagues, employers and teachers was provided by VGRF and Gambling Help NSW. The information and resources related to identifying the signs of problem gambling (e.g. students: anxiety and depression, abandoning study, alienation from friends; colleagues/employees: arriving late, gambling during work hours, borrowing money or requesting advance on salary), how to respond to someone exhibiting the signs of problem gambling (e.g. express facts, use "I" statements, show that you are listening), and the number to call for more information or to give to the student/employee. A brochure with frequently asked questions and classroom resources with common phrases (e.g. "one more punt") was also provided by Gambling Help NSW for teachers to print and display in their classroom (Gambling Help NSW, n.d.-a).

Acknowledgement of the wide-ranging benefits for engaging with the family/whānau

Service FAO policies identified engaging with the whole family as beneficial for broad improvements in family/whānau wellbeing and functioning. The Family Support and Psychoeducational Group Manual for Problem Gambling developed by CAMH detailed that involvement of family members improves treatment retention, reduces isolation, ameliorates the harm within relationships caused by gambling, and creates improvements for children even when not directly involved in therapy. Best practice for involving family members was also detailed:

- *Involve families in treatment as early as possible.*
- *Involve families in collaborative treatment planning as much as possible.*
- *Clarify your role as a therapist (e.g., who your client is, what information you can share with others).*

- *Clarify the limits of confidentiality and develop strategies for resolving problems related confidentiality.*
- *Even when clients do not consent to the release of information about their treatment, give families general information about problem gambling treatment and the help available for families.*
- *Discuss the impact of problem gambling on family relationships in individual sessions and group treatment for gambling clients.*
- *Provide services for families, such as individual sessions for family members and family psychoeducational support groups.*
- *Help families learn to cope and relate effectively.*
- *Treat family members with dignity and respect; avoid judging or blaming family members.*
- *Focus treatment on a family's strengths, expertise and contribution to treatment planning.*

(CAMH family support manual, Kourgiantakis, Weyman, et al., 2013b, p. 7)

Some services included family therapy or family groups as part of a range of programmes available. For example, PGF Services and Oasis use Single Session Family Consultation (SSFC) which is a model for engaging with families/whānau to identify and clarify (1) how they will be involved in the gambling individual's care or support and (2) identify and address the FAOs own needs. Family members are welcome and encouraged to attend services alongside the gambling individual.

Culturally diverse services (e.g. Raukura, AFS, Mapu Maia, and Warruwi Gambling Help) were developed with a family-inclusive approach as an inherent part of their framework. For example, in the PGF Group's annual report, it was detailed that the Pacific Advisory Board provides strategic advice and direction to the PGF Board and Mapu Maia which ensures that the voices of families and communities were reflected in the service:

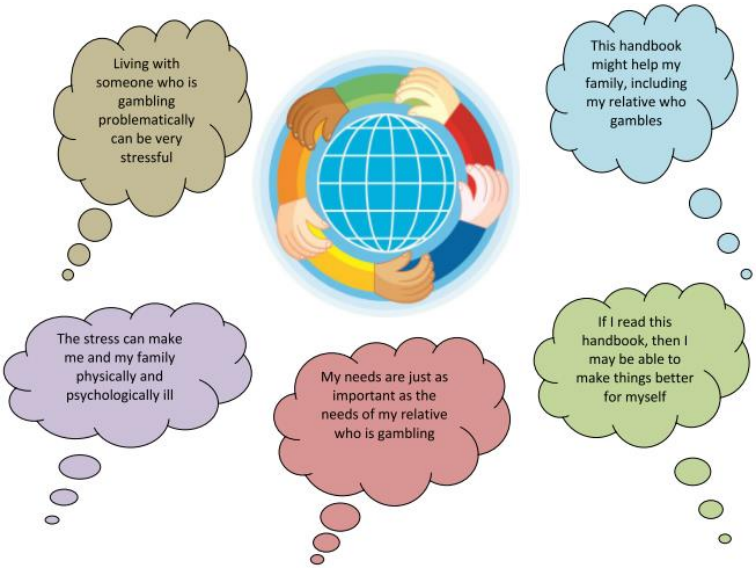
> *…This has led to the development of a Pacific Strategy involving a year-long talanoa process, reflecting the voices of our families and communities. This strategy highlights the interactions and conversations we shared, including their health and social needs. As the Pacific Advisory Board we place our Pacific peoples, families and communities at the heart of development, thinking and forward planning. Pacific communities expressed a strong desire to actively design and lead their own innovative solutions and as a Board we wish to create opportunities to share, understand and plan so that these objectives can be realised.* (PGF Group Annual report 2019, p. 22)

<u>Limited recognition of FAO support needs in their own right</u>

Few services were clear in their ability to offer support to FAOs in their own right. In particular, it was clear in the discussions with service managers that enhancing support for FAOs was a developing focus for services going forward as work was still needed. For example, it was discussed that barriers and constraints to providing a family-centred practice included limited resources specifically for FAOs, no clinical manual or model of care for working with family, and limited FAO specific policy. In general, it was reported that culturally and linguistically diverse services (e.g. Asian Family Services, Mapu Maia, Raukura, and Warruwi Gambling Help) were at the forefront of providing holistic family-centred services that catered to FAOs (discussed further below in the sections titled: "Acknowledgement of the wide ranging benefits

for engaging with the family/whānau" and "Culturally based services tend to conceptualise families/whānau as the client from the outset").

Most of the online/publicly available information appeared to lean more towards informing FAOs on how to support or approach the gambling individual. In contrast, SHARC's Family Gambling Help programme was established following the identification of gaps in meeting the needs of family members. Family Gambling Help includes the InFocus Education Program (support, information, coping strategies and community referral for anyone affected by problem gambling), an FAO support group in a remote community, and online resources for FAOs such as an interactive website, a radio show, and online support groups (SHARC, n.d.). Services that utilised the 5-step method (e.g. The Salvation Army Oasis) recognised that the needs of FAOs have been overlooked. For example, The Salvation Army Oasis policy document on the 5-Step Method stated that one of the key reasons to adopt the method was because "The needs of the family and whanau member in these situations are important in addition to the needs of the relative/friend with the addiction but are often overlooked." (The Salvation Army Oasis, n.d.-a). Indeed, the negative impact from gambling is presented on the front page of the 5-Step handbook:



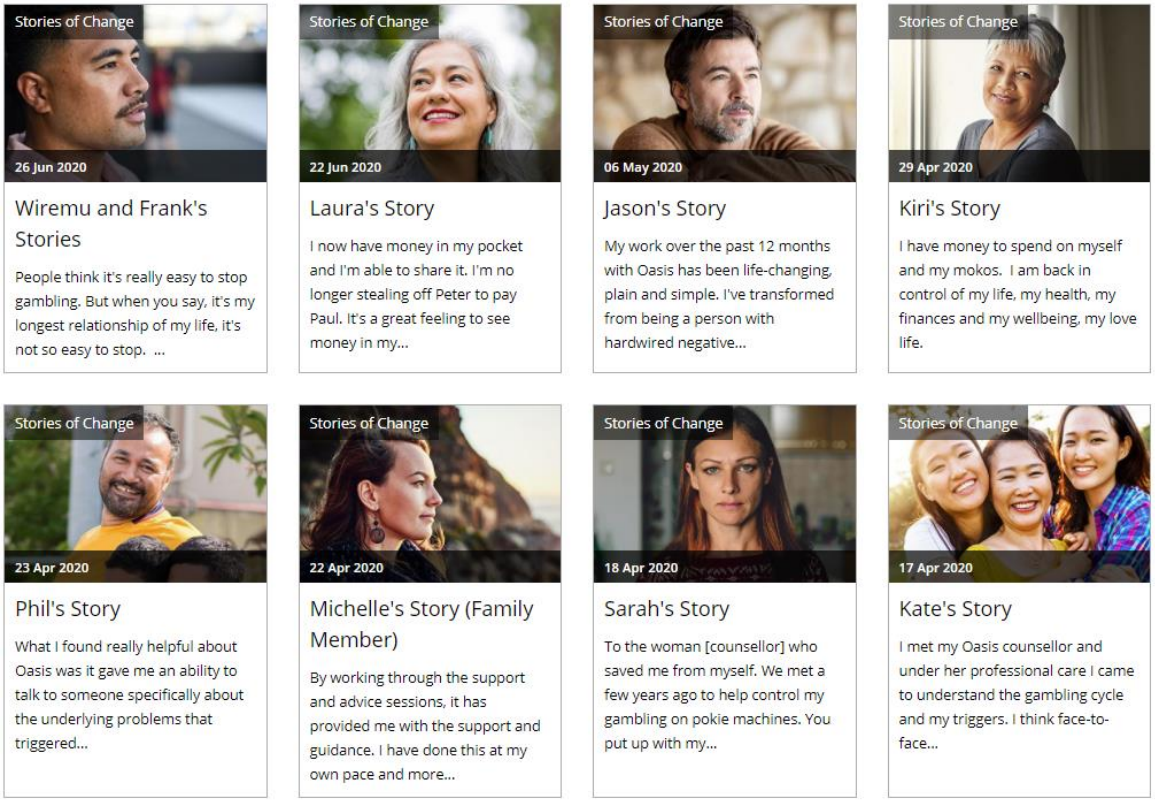
(Copello, Bowden-Jones, Cousins, Orford, & George, n.d., p. 0)

Recognition of the stress and negative impact of gambling on FAOs was evident in sections such the Impacts on Others on the Gambling Help Online website (Gambling Help Online, 2020c). Additionally, online information highlighted the importance of self-care, normalised the difficulty for FAOs seeking help, and presented support options for FAOs. Service managers emphasised that there is still significant work to be done to ensure that FAO needs are not lost amongst the wealth of information for or aimed at supporting the gambling individual.

Promotion of and engagement with lived experience

Lived experience articles and blog posts were available on some service websites and social media focussing on FAO perspectives, though this was less common in New Zealand. For example, within the Oasis website, there is a section called "Stories of Change" which provide personal stories from gamblers and FAOs about their involvement with gambling and Oasis

services. Of the eight stories of change currently available on the website, one is a story from an FAO:



(The Salvation Army Oasis, 2020c)

Most services posted articles on social media that included an FAO's perspective or story, for example: on Facebook, AFS shared a story of a newlywed discovering her husband's gambling problem and highlighted that there few support services available for FAOs (Asian Family Services, 2019); VGRF shared a story of a woman discovery her husband "had been leading a double life" while spending significant amounts of money on EGMs (Victorian Responsible Gambling Foundation, 2019c); and PGF Services shared a story about the likelihood of children experiencing abuse if they have parents with a gambling problem (PGF Services, 2019a). Further, VGRF and Gambling Help NSW included stories, tips, and awareness raising articles that included famous individuals (mostly sporting stars) in order to reach a wider audience and increase normalisation of seeking help or promote recognition of a gambling problem in a family member. However, stories that focussed on FAOs were far less common than other stories from a gambler's perspective, service advertisement, or encouraging gambling individuals to seek help.

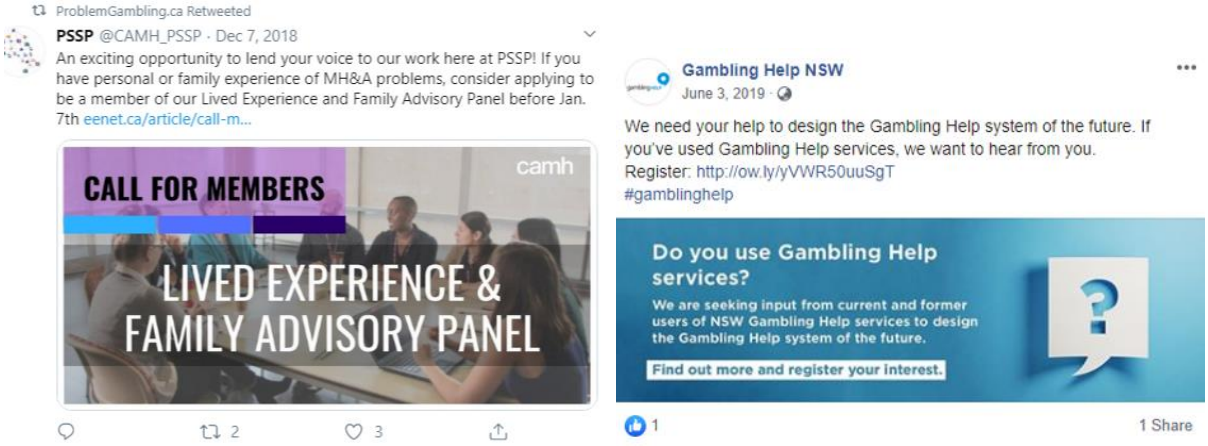
Engaging with lived experience and community members at a service level was evident in annual reports, discussion with service managers, and social media posts. For example, the PGF Group 2019 Annual Report stated that "One of our key areas of focus is communities, particularly those where the need is greatest, ensuring our public health work supports harm minimisation and promotes wellbeing." (PGF Group, 2019, p. 15). An example of community engagement included active encouragement of community members to make submissions on the SkyCity application to the Gambling Commission to substitute three Blackjack tables with

60 gaming machines. The Annual Report stated that "We encouraged people to have their say and supported a group of community champions with resources and information to inform their submissions" (PGF Group, 2019, p. 15).

Community and service users' (people who gamble and FAOs) feedback and engagement was also sought for service review and development in international services. This type of engagement was not clearly evident in New Zealand services. For example, the 2018-19 NSW Department of Industry Annual Report stated that:

> *In 2018–19, the Office of Responsible Gambling began redesigning the way Gambling Help services in NSW are delivered to better meet the needs of the community. This is about designing a flexible and dynamic service model that can respond to the changing needs of people in NSW who are negatively affected by gambling (…) In June 2019, the office started the second stage of the project, which includes co-designing a new service model with service users, current service providers, other support services, academics and industry representatives.* (NSW Department of Industry, 2019, p. 23 emphasis added)

Additionally, during the data collection period CAMH (below left) and Gambling Help NSW (below right) advertised on social media for current or previous service users and community members with lived experience to take part in service development and review processes:



(Gambling Help NSW, 2019; Provincial System Support Program [@CAMH_PSSP], 2018)

The CAMH call for members for the Lived Experience and Family Advisory Panel stated that panel members would:

> "*…work with other panel members to provide advice and feedback to PSSP* [Provincial System Support Program] *projects and initiatives, as well as to external partners and organizations doing system-level work in Ontario. You would also be able to participate in regular capacity-building opportunities offered to panel members to strengthen and support their work.*" (Provincial System Support Program, 2020)

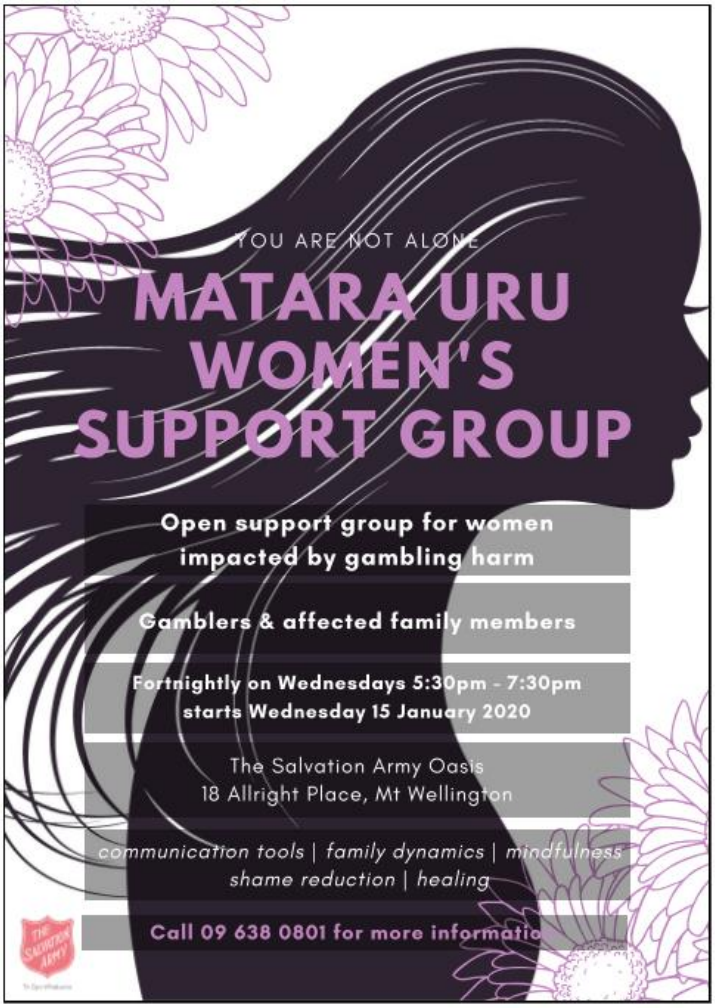
The engagement with lived experience and community members discussed above was targeted at 'service user' or those with lived experience, and thus, inclusive of but not restricted to FAOs. The proportion of actual engagement with FAOs versus gamblers was not ascertained.

Limited peer support

There was evidence of peer support groups inclusive of FAOs in both national and international services; however, within national services the peer support groups were mostly orientated towards to the gambling individual. For example, PGF Services stated:

> *The PGF Services "Gambling Support and Maintenance Groups" regularly meet in Auckland. Entry into the gambling support group meetings is by referral from a PGF Services counsellor. Please call 0800 664 262 and ask to book an assessment session with a counsellor from Auckland. These support groups are for people who would like to work towards and maintain being 'gamble free'. Significant others are also welcome. The meetings have a semi-structured group format. The facilitators lead the group in a learning activity and support the group to remain focussed and supportive of one another*. (PGF Services, n.d.-b emphasis added)

AFS also advertised group counselling and a peer support group for all service users. The peer support was advertised "To provide knowledge, experience, emotional, social or practical help to each other" (Asian Family Services, n.d.); not specifying that the group was for individuals gambling or FAOs, this aligned with their orientation of working with the whole family. Finally, Oasis advertised ongoing support groups in pamphlets, as well as a support group for women which appeared to be more inclusive of FAOs whereby all women impacted by gambling harm were welcomed. Indeed, gamblers and affected others were invited within a single sentence, rather than FAOs being a secondary sentence:



(The Salvation Army Oasis, n.d.-c)

Internationally, GAM-ANON is the largest peer support programme. The programme follows the 12-step approach and is solely focussed on FAO wellbeing. At the time of the current study, GAM-ANON was not available in New Zealand. GAM-ANON is a "12 Step self-help fellowship of men and women who have been affected by the gambling problem of another." The support group is set up solely for FAOs with four key purposes:

> *1. To welcome and give assistance and comfort to those affected by someone else's gambling problem.*
> *2. To communicate Gam-Anon's understanding of compulsive gambling and its impact on our lives.*
> *3. To share our experience, strength, and hope in coping with the gambling problem.*
> *4. To use the Steps and Tools of the Gam-Anon program which nurture our spiritual and emotional growth and recovery.* (GAM-ANON, n.d.)

Other international support groups included those run by SHARC (Australia; Family and Friends Gambling Group), Gamblers Help (Australia; Peer Connection / Online Forum), Turning Point (Australia; Peer Support Forum), and GamCare (UK; Peer Aid). These support groups or forums were aimed at providing a supportive, understanding and non-judgmental

environment for FAOs to share experiences, learn from each other, and receive support. For example, the Gamblers Help Peer Connection programme was available for individuals not experiencing a crisis. Peer Connection "matches your friend or family with a volunteer for regular phone contact. Volunteers have dealt with their own gambling addiction or worked through the impact of someone else's, so they know what your loved one is going through" (Gambler's Help, 2020a). In addition, the Gamblers Help Online Forum includes tailored areas/forums for FAOs to connect with people who share similar experiences and foster encouraging and useful discussions relevant to them.

Another example of peer support is the Peer Aid programme provided by GamCare; the new service provides one to one and group support by connecting individuals with Peer Supporters who have lived experience of gambling harms. The peer supporters are provided with training to achieve the NCFE (Northern Council for Further Education) Level 2 Award in Gambling Peer Support. The website details that Peer Aid is "a new peer support service for those affected by gambling harms across London and the South East", was designed and developed by individuals with lived experience of gambling harms, and will provide one-to-one and group support to complement treatment received from GamCare (GamCare, 2020). FAOs might fall under the umbrella of "those affected by gambling harms" but this is not made explicit on the website.

Limited publicly available information on managing safety risks to FAOs

Despite safety risk being a significant concern for FAOs (Dowling et al., 2018; Dowling, Smith, & Thomas, 2009; Palmer du Preez et al., 2018), there was limited information about where to seek help or manage the risk. These risks include domestic violence (physical, emotional / psychological, financial etc) as well as significant mental health risks for self-harm and suicide. In general, international services included a number or link to a domestic violence service on their service websites. Only Gambling Help NSW and Oasis websites included information about safety management and further support:

> *Keeping yourself safe: If you have ever felt threatened or unsafe, or if you are concerned about the welfare of children affected by a parent's gambling, it's important that you know that there is support available. Call the domestic violence line on 1800 65 64 63 or Gambling Help on 1800 858 858. There are many options available to you including counselling, temporary accommodation, and Apprehended Violence Orders (AVOs). See domesticviolence.nsw.gov.au for more information.*
> *Keeping them safe: Unfortunately, people with gambling problems are at a greater risk of self-harm and suicide than the general population. If you think your loved one is at imminent risk of hurting themselves, call emergency on 000, or your local community mental health crisis team.* (Gambling Help NSW, n.d.-b, p. 25)

> *Safety: If you are living with the gambler and they are emotionally volatile: quick to anger and yell or to put you down, then it is important that you reach out to Oasis to discuss next steps for safety and your emotional wellbeing and prevent family violence and abuse. This is an important step to create safety for your whole family/whānau, especially children. We can assist you to be in touch with family violence organisations if this is required and work on an immediate safety plan with you.* (The Salvation Army Oasis, 2020a)

In conversations with Oasis practice leaders, it was reported that patriarchal systems and relationship forms were covered by clinicians and were a focus of the support group for women. Finally, the 5-Step Self-Help Handbook supplied to the researchers by the National Problem Gambling Clinic (UK) included information and caution about domestic violence (Copello et al., n.d.). The handbook provided information for cases where the FAO is wary about the information being seen (e.g. keep the workbook at work or a friend's house), links to domestic violence websites, and advice about services that are not appropriate due to safety concerns for individuals experiencing domestic violence (marital or couples counselling and Family Therapy). There was also a section on dealing with violence and abuse (Copello et al., n.d.).

How do gender, ethnicity and/or cultural issues/perspectives appear to be incorporated into service design and delivery for FAOs?

In New Zealand it is imperative that gambling services cater for culturally diverse groups (Ministry of Health, 2018, 2019). Within the gambling sector, Māori, Pacific, and Asian communities are priority populations for services; with specific services designed around the priorities and needs of each group (e.g., Raukura - Māori, Mapu Maia - Pacific peoples, and AFS – Asian families). Mapu Maia and AFS were described in the 2019 PGF Group Annual Report as specialist teams who provide culturally and linguistically appropriate support to Asian and Pasifika communities living in New Zealand:

> *"Asian Family Services provide free, professional and confidential counselling, information and support in several languages and operate a nationwide helpline. Mapu Maia (Pasifika Services) provide a holistic, family-centred service which is free and confidential delivered by experienced and qualified staff who can support people in English, Samoan and Tongan."* (PGF Group, 2018, p. 4)

Culturally based services tend to conceptualise families/whānau as the client from the outset

Services for FAOs/family/whānau appeared to be inherent within Māori and Pacific worldview informed systems and services. The preferred way of working was held to be with the family/whānau, rather than the individual. For example, in conversations with practice leaders at Raukura, gambling harm reduction services, FAOs were incorporated within wrap-around Māori health and wellbeing services for whānau, provided at a community based hub offering medical, community health, mental health and other addictions services. Engagement with families affected by gambling harm could be through any of these pathways.

In Pacific services, Mapu Maia engage with families/whānau from the outset using culturally appropriate clinical intervention/Talatalanoa in Samoan, Tongan, or English. Talatalanoa is available through one to one, couples, family, group, and online/phone services. Talatalanoa is defined as a deep conversation involving the curation of space or 'va' between those involved, building trust, rapport and respect in culturally congruent ways (Mapu Maia, 2020b). Mapu Maia rarely see individuals alone, utilising holistic and collective approaches, "grounded in the notions of spirituality, connectedness and a complex set of inter-relationships between individuals, their families and their communities" (Langi, 2017). For example, in describing their approach, Mapu Maia state that a person is never seen as an individual alone: "As Figiel (1996) aptly states, 'I does not exist, I is always we, because I is always part of the aiga (family) part of the nu'u (village) part of Samoa'" (Mapu Maia, 2020bemphasis added). The values highlighted by Mapu Maia are respect, relationships, collectivity, and culture:

(Mapu Maia, 2020a)

Mapu Maia also take part in public health initiatives, delivering free education and presentations to community organisations, social services, government departments (etc), and taking part in community events. The concept of *va* underpins Mapu Maia's approach:

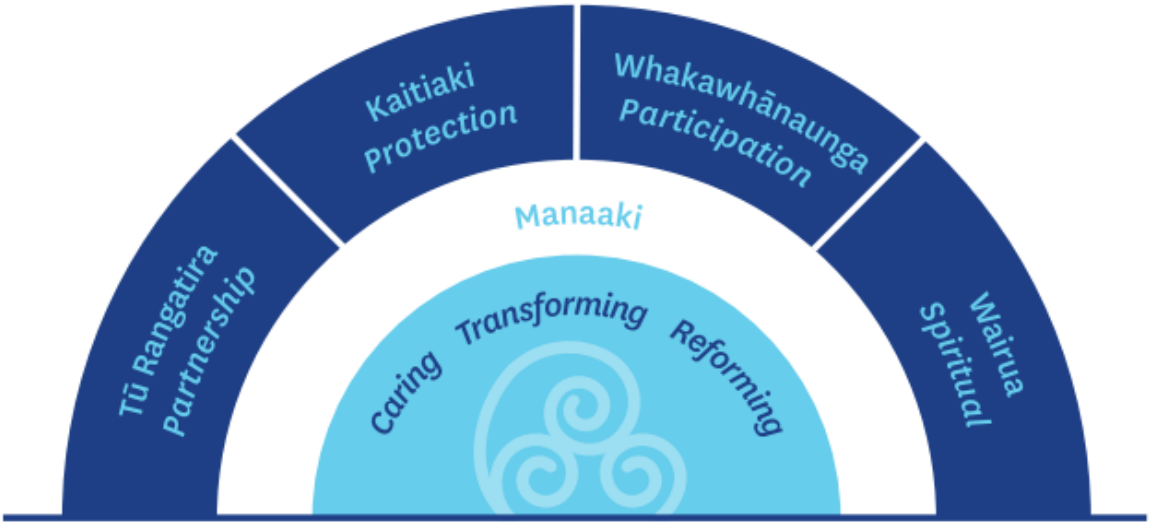
> *Literally va can mean 'space' va "can mean 'space' – not the space that divides, but the space or relationships that connects. Health to Pasifika people is not just about the absence of illness (being unwell) but whether or not they are happy with their relationships with each other, with their family, with God and to the land and environment. Maintaining respectful relationships is a very important cultural belief throughout Pasifika culture. An individual's health and well-being is dependent on a safe and balanced connection with others. (Langi, 2017)*

The explication of 'health to Pacific people' above is commensurate with the World Health Organisation's definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organisation, 1948, p. 100). Within a holistic framing, health and wellbeing can be seen as a product of societal and environmental issues such as income inequality and climate change.

<u>Understanding wellness from a Māori perspective</u>

According to the PGF Group 2019 Annual Report, "PGF Services provide free counselling, advice and support to gamblers and their families and works to ensure that support for our Māori clients fits a kaupapa Māori way of working" (PGF Group, 2019, p. 4); however, there is limited publicly available information with more detail on working with and for Māori at PGF. A pamphlet available from Oasis outlined a Māori approach and pathway to wellness that informed their service and concept of wellness (below). The approach appears more orientated towards individuals seeking help for their own gambling, however within the same pamphlet, it was made clear that Oasis services were available for FAOs as well.

Te Ara Whakaora: the Path to Wellness



Tū Rangatira
The practice of leadership, in partnership and in service to others. Tū Rangatira informs self determination and the ability to make good choices.

Kaitiaki
Enhances the sense of personal responsibility and care for the continued wellbeing of people, family, community, land and creation.

Whakawhānaunga
Building relationships based on reciprocity and participation. Understanding the rights and responsibilities in relationships.

Wairua
Affirming that mind and spirit are the fabric of individual and community wellbeing. Wairua enhances dignity, respect, identity, contentment and connection with others.

(The Salvation Army Oasis, n.d.-b, p. 2)

Raukura Hauora o Tainui is a kaupapa Māori service underpinned by tikanga (customary system of Māori values and practices that have developed over time and are embedded in social context) and whakawhanaungatanga (process of establishing relationships and relating well to others) as a holistic framework for serving communities affected by gambling harm. A number of kaupapa Māori ways of working are utilised at Raukura. An example of a kaupapa Māori model is Te Whare Tapa Whā (Durie, 1997) which encompasses the four cornerstones (pillars or sides) of Māori health: Taha Tinana (physical health), Taha Wairua (spiritual health), Taha Whānau (family/social health), and Taha Hinengaro (mental health). The Raukura website explains another model/pathway to wellness that underpins Raukura objectives:

> *TE PIRINGA TUPONO*
> *Te Piringa Tupono is a pathway to wellness, pursue the new pathway and you will find wellness. Our aim is "empowering positive change within whanau and community".* (Raukura Hauora O Tainui, 2020)

> *Te Toi O Matariki is the model used which is known as an "awakening" model. The model works on the concept that, in order to realise your need for change, one must understand who they are as individuals, then as Māori, then their cultural value base. Ownership of the way we behave is realigned with the traditional Māori philosophy of wellness.* (Raukura Hauora O Tainui, 2020)

Raukura's community gambling harm reduction programme charters an akonga (client's) journey from the darkness of the mind, Te Kore, (abyss) to Te Ao Marama (the world of light), drawing on culturally significant transformative concepts. There are many story telling elements to engage families, as well as a focus on educating and empowering whānau to become advocates in their communities for mauri ora (wellbeing). As explained by the indigenous research collective K.I.N (Knowledge in Indigenous Networks), mauri ora means being alive to the Māori world:

> *"It is what gives us our get up and go. A Māori person with a Māori life force is alive to things Māori. Potential is being realized and activated. When you have mauri ora you are getting involved in many different ways with Te Ao Māori. You might be seeking out tohunga [leaders] to help you with karakia [prayer], you may be organizing a whanau reunion, you may be becoming an active owner in Māori land rather than a passive owner, you may find ways to attend Māori gatherings, you may even go along to school Māori parent evenings for your tamariki [children] or mokopuna [grandchildren], you may go to Māori weaving classes and so on. To activate your mauri ora is to be getting up and going in the Māori world." (KIN & Arohaina Riwaka Thorpe, 2015)*

At Raukura gambling harm reduction services include one-to-one or couple/whānau counselling (usually eight sessions with follow-up support), community gambling harm reduction programmes, a financial literacy programme, and ongoing follow-up support. Importantly, gambling support is among a number of other services available to support family wellbeing within a kaupapa Māori context (e.g. primary health and social services). There is little distinction between the gambling individual and FAOs as the service aims to work with the family/whānau.

Making sense of migration and gambling harm

AFS were the only service reviewed in this study that was orientated towards Asian communities. Their services are available in a range of languages including Mandarin, Cantonese, Korean, Vietnamese, Japanese, Thai, Hindi, and English (an interpreter can be arranged for other languages if needed). Within their promotional material there is no specific mention of FAOs, instead, a holistic and whole family approach is taken. For example, in their general brochure, the heading reads: Working with Asian Families and Communities to be Healthy and Resilient (Asian Family Services, n.d.). Additionally, their list of services details that they offer "free counselling for anyone affected by gambling harm" (Asian Family Services, n.d.). Conversation with service managers indicated that the purpose of the framing as 'family services' is to counter significant stigma within the Asian community around mental health issues in general and addiction is particular, as well as the notion of seeking support.

An introduction to AFS on New Zealand's national addictions workforce development organisation webpage articulates the purpose of AFS as helping migrant families to "find a balance in an unbalanced world" (Raki, 2017). Gambling is seen as a response to the disconnect between dreams of having a better and enriched life in New Zealand, and the impact and struggle that immigration often brings to families. To assist with the impact of immigration on Asian communities, AFS has developed the 'Tree Model' to depict the challenges, struggles, grief and loss and growth of individuals and families:

> *"The 'Tree Model', illustrates how a firmly grounded tree can lose its roots during transplantation and how much it takes to adjust to the different climate of a new ground. It is likened to the experience that an Asian migrant goes through during the immigration process. The roots represent culture, values, beliefs, identity and family including extended family. The trunk represents status and self-esteem. The branches represent language ability and education. The leaves represent achievements, social network and friends. The fruit represent health." (Raki, 2017)*

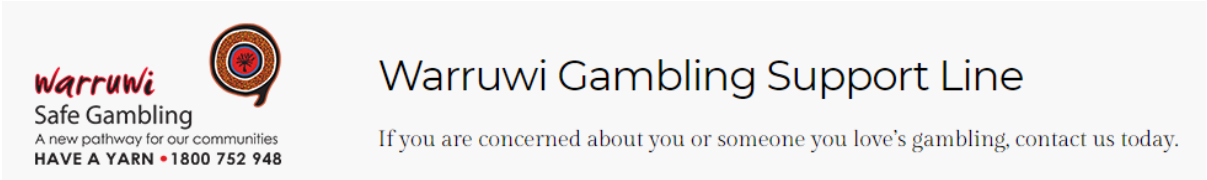
The AFS team uses the 'Tree Model' to help Asian communities understand their experiences, develop empathy for themselves and those who are going through a similar process and to encourage them to grow stronger connections with others to produce 'healthy fruit'.

Warruwi Gambling Help: An Aboriginal service designed and operated by Aboriginal communities

Warruwi Gambling Help is an Aboriginal owned and operated gambling help programme in Australia. The service takes a broad family and community perspective: "If gambling is creating problems for you, your family, your community and your culture, then the Warruwi Gambling Help Program can help you. The program works with communities to promote a healthy approach to gambling and seeking help" (Warruwi Gambling Help, n.d.-b). One of the key objectives of the Warruwi Gambling Help programme is "To provide opportunities for Aboriginal Community members & service providers to talk about gambling issues and impacts on their families" (Warruwi Gambling Help, n.d.-a). A related objective is to identify, support and foster Aboriginal Safe Gambling Ambassadors in each community to:

> *"Raise community awareness about Aboriginal gambling and its impacts on families and the community [and] provide ownership in the community of any gambling issues and the direction to address them – becoming the key contact in the community. (Warruwi Gambling Help, 2020)*

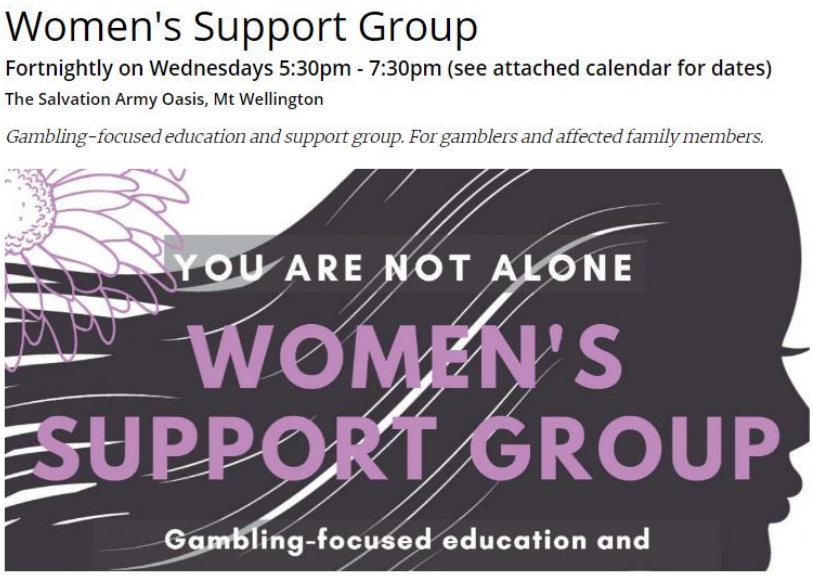
Co-design and delivery of services for FAOs is alluded to, but no further detail is given on service development mechanisms. Australian Aboriginal FAOs needing support are able to call or email an Aboriginal counsellor at any time. The service also runs educational workshops, raises awareness of gambling within Aboriginal communities and relevant services (promotional activities, advertising and social media), and takes part in community engagement (building meaningful relationships with people, key organisations, and relevant services). The service is closely linked with Gambling Help NSW, and thus, a number of the resources for FAOs provided on the website are the same. Finally, the service has a gambling support line for individuals and families worried about their own or someone else's gambling:



(Warruwi Gambling Help, n.d.-b)

Limited gender-responsive or gender-aware support

Few services included support groups or specific counselling for FAOs who were women, and none mentioned resources specifically to support FAOs who are men. FAOs seeking help are predominantly women, with significant gender-based issues intersectional with gambling harm (e.g. domestic violence, distribution of childcare and other family responsibilities, financial support). Conversations with Oasis service managers revealed that cultural and gender specific support and counselling was available for women which covered traditional marriages, patriarchal systems, and relationships forms. The Oasis women's support groups were held fortnightly and covered communication tools, family dynamics, mindfulness, shame reduction, and healing:



(The Salvation Army Oasis, n.d.-c)

Summary of Key Findings

The present analysis aimed to answer three key questions: (1) How do gambling services appear to be oriented to FAOs at present? (2) What are the kinds of support that FAOs are offered in gambling services? And (3) How are gender, ethnicity and/or cultural issues/perspectives incorporated into service design and delivery? Below is an integrated discussion of key findings.

Services signal inclusiveness of FAOs

A service's orientation and position towards FAOs was ascertained through examination of (1) the definition of FAOs utilised by the service and (2) the advertising and promotional material aimed at FAOs. Most services utilised an inclusive definition whereby FAOs generally included anyone close to or affected by the gambling behaviour – including immediate family, whānau, friends, colleagues and teachers.

FAOs seeking support might search online for services nearby or accessible information. Thus, it is important that the information is presented in a clear, inclusive, and straightforward manner. Most services included a broad and inclusive definition of family and affected others whereby anyone close to, or impacted by, the gambling was considered eligible for service

support. Indeed, websites detailed that services were available for 'families and communities', 'anyone affected by gambling', or 'for individual impacted by their own or someone else's gambling'. This definition was continued throughout advertising and promotional material aimed at FAOs on social media. Thus, at a glance, an FAO seeking out assistance would recognise through the language used by services that there were support options available. However, we found that the kind of support and approach to service delivery for FAOs was generally unclear in publicly available information.

There are support options available for FAOs, but much of it appears ad hoc

The evidence provided by services indicated that there was a range of support options available for FAOs: clinical intervention or counselling (in-person, online, via phone or text), psychoeducation and information on recognising a gambling problem and supporting the gambling individual, family/whānau inclusive therapies or group support, peer support groups, and engagement with lived experience in service review or development. Despite the range available, the support for FAOs was limited in comparison to support and intervention aimed at the gambling individual.

The evidence of the kinds of support available for FAOs in gambling services was diverse, however, it appeared relatively ad hoc. That is, there appeared to be gap between what service managers and practice leaders discussed as being available within their service for FAOs and information that was publicly available. Discussions with service managers and practice leaders highlighted a growing reflection and recognition of the support needs of FAOs in their own right. These professionals also suggested that FAOs remained a low proportion of clients seeking gambling support services; however, it was also reported in annual reports that there was a growing number of FAOs seeking help. As such, services in New Zealand were aiming to increase the inclusion of support available specifically for FAOs. Services for FAOs in the United Kingdom were informed by Copello's 5-Step method, but like New Zealand, most interventions were aimed at the gambling individual. In New Zealand, the creation and implementation of services for FAOs was reported as slow due to workload and intensive training involved in specialised interventions (e.g. 5-Step), the lack of policy support and/or clinical manuals for working with FAOs, no widely accepted model of care for FAOs, and limited resources for service development (funding). Taken together, this points towards the need for greater support for services to enable FAO specific intervention through collaborative inquiry and engagement with service users and communities.

Despite increasing recognition of FAO needs, much of the publicly available information appears targeted toward the gambling individual

Despite the growing recognition of FAO needs in research and practice, it remained that a significant amount of the online information was targeted at the gambling individual or for the FAO to support/assist the gambling individual into treatment. This information included identification of a gambling problem, tips on initiating a conversation, and advice on how to support a gambling individual into treatment / how to support them if they do not want to access treatment. As highlighted before, FAOs are highly likely to come across this material first if searching for available support options or information. When the majority of online information is gambler-focussed this could (1) overlook the impact and experiences of FAOs and potentially contribute to FAOs not recognising their own needs, and (2) place undue responsibility on the FAO to resolve or be accountable for the gambling behaviour. The latter

point is problematic given high rates of domestic violence or unhealthy relationship patterns, patriarchal relationship systems, and normalised gender roles.

The emphasis on FAO support of the gambler has the potential to place undue responsibility on the FAO. Although many FAOs might be willing to support their loved one and will opt for this approach, the responsibility of FAOs to identify and manage the problem gambling behaviour whilst they are experiencing the negative impact can present a significant challenge. For example, the FAO might not recognise their own need for support and, the harm they are experiencing, or there might power dynamics or safety issues within the relationship/family. Therefore, it is important that this perspective is not the main or sole focus of information presented to FAOs.

The engagement with FAO lived experience was limited, but regarded by some services as crucial to ensuring the service meet the needs of service users. Some services included blogs or articles focussing on an FAO's perspective and a couple of others actively recruited for lived experience to design and review service development. However, again, much of the lived experience engagement concentrated on the gambling individual. For a service to become truly family/whānau-inclusive, engagement with a diverse range of services users is imperative.

There are limited support options that incorporate gender-based issues

The Salvation Army Oasis (NZ) and GamCare (UK) offered support groups for women (both gamblers and FAOs). These groups offered an option for women to come together, share their experiences, foster meaningful support, and learn from each other. The support groups also included the exploration of gender-based dynamics such patriarchal systems, family dynamics, and the reinforcement of gender roles in care. There is little evidence of other support groups for women.

As a significant portion of the publicly available information focussed on supporting the gambling individual into treatment (or assisting them if they are unwilling to seek treatment), the reinforcement of women and female partners as 'carers' is prevalent. Further to this, the comparatively limited information on the impact of gambling harm and support for FAOs reinforces the 'self-sacrifice' and carer role experienced by women in many cultures (e.g., H. Graham, 1982; Holdsworth, Hing, & Breen, 2012; Kwan, Tse, & Jackson, 2020; Rey et al., 2010; Rey & Sainz, 2007). Facilitated support groups offer a safe and effective method of sharing experiences, exploring family dynamics, challenging attitudes and beliefs, and developing practical coping techniques. Further, a safe space to heal and connect with shared experiences is important in the FAO gambling field, particularly as domestic violence, control issues, and relationship dynamics are prevalent issues. It is important that these groups are continued, enhanced, and become a routine option for women.

Historically it has been recognised in research and practice that most FAOs are women (partners/spouses) whilst problematic gambling has been associated more with men. However, research has also indicated that an increasing number of women are gambling (e.g., Granero et al., 2018; Volberg, 2003); thus, it follows that greater numbers of FAOs are likely to be men. Further, it is likely that gender-based issues are important for FAOs who are men, including gender-roles, domestic violence and control over their gambling partner, and normalising help-seeking behaviour for men. We identified no evidence of support groups or resources

specifically for FAOs who are men. Enhancing the understanding of the needs of FAOs who are men through research and service user engagement is needed.

There are a range of culturally appropriate services which can model meaningful and responsive engagement with service users and communities

New Zealand appears to be at the forefront of holistic and culturally responsive engagement with families affected by gambling harm. Multiple services incorporated Māori models of health to appropriately work with and alongside Māori services users; for example, The Salvation Army Oasis and Raukura Hauora o Tainui detailed different pathways to health utilising Māori perspectives and understanding of wellness. Wrap-around health and wellbeing services for family/whānau made little distinction between the gambling individual and FAOs. Gambling services are not the only service provided by Raukura, as such, gambling harm and FAOs could be reached in several ways (e.g. identification of harm through another service pathway).

The ways in which some culturally and linguistically appropriate services in New Zealand operate can model a family/whānau inclusive approach, however exploration and evaluation of these approaches is largely absent. The services have been designed and are managed with the community served at the heart of service operations. For example, services such as AFS, Mapu Maia, and Raukura were family/whānau and community focussed, and thus, FAOs were likely to be included from the outset. This was also made clear on their websites where services were detailed as being available for 'families and communities' or 'family/whānau'. Mapu Maia is an example of way in which the design, review, and operation of a culturally appropriate service can be conducted in a manner which addresses cultural perspectives and issues. A year-long talanoa process was carried out by a Pacific Advisory Board which sought to engage with and reflect the voices of Pacific families and communities. The talanoa research model utilises ofa (love), mafana (warmth), malie (humour), and faka'apa'apa (respect) which builds relationships and contributes to rich and meaningful engagement and research outcomes (Vaioleti, 2006, 2013; Vaka, Brannelly, & Huntington, 2016). The talanoa process brought to light the desire of the Pacific communities to be actively engaged and lead the design of innovative solutions to harms experienced by community members. The Pacific Advisory Board advises service management and ensures that Pacific families and communities remain at the heart of service development, consideration, and future planning. This process could be replicated in other services to support quality and ongoing engagement with the community and service users, collaborative development of outcomes, consideration and implementation of key findings in meaningful ways, and ongoing evaluative work to ensure service users' voices are not lost.

Limitations of this review of service provision

This review was non-systematic, and organisations were included for selection based on the views of the expert panel only. Our findings should therefore be regarded as partial and indicative of current practices. Our review was limited to reported practice with and service offerings for FAOs. We did not carry out any investigation into the relationship between the funding structure of the organisations involved and the culture and style of services and treatment approaches.

Conclusion

This analysis of documented programmes, publicly available information, practice resources and policies, and discussions with service managers was conducted to explore how support provided for FAOs in New Zealand gambling services could be enhanced. It intended to improve understanding of the support options currently available to FAOs affected by gambling harm. Influential models of 'problem gambling' development and intervention needs have shaped services in ways that focus on 'the gambler'. Support for FAOs tends to be a peripheral offering. There is still much to be done for services to become family/whānau inclusive and for FAOs seeking help to be without doubt that support services are available for them in their own right. Reflecting more systemic understandings of addictions, there is a growing recognition of FAOs' needs in research and practice, but this appears yet to be supported by policy, resources available to services, and public-facing information presented to individuals/families who might be investigating available support options. Some culturally and linguistically appropriate services in New Zealand are inherently family/whānau inclusive and less constrained by the historical development of services for 'problem gamblers'. Their design and development have championed the voices of their communities and services users, bringing to light the community's desire to be involved and engaged with service development. This provides a promising model to learn from going forward. However, it must be noted that most of these services have yet to be formally evaluated and documentation and sharing of family focussed practice and service development is minimal, limiting learning opportunities at present.

New Zealand FAO engagement with intervention services

In this section we analyse a national New Zealand client database to describe the clients who accessed support and the support they appear to be receiving from gambling services.

Gambling harm for New Zealand FAOs

New Zealand National Gambling Study (n= 12,000, collected in 2012), provides the most representative estimates of the prevalence and nature of gambling harm for family and affected others (FAOs) in the New Zealand population (Abbott et al., 2014). This information suggests that gambling harm for FAOs is a significant public health issue with inequities related to gender, income and ethnicity. A third of adults said they know at least one person that they think currently has, or had, a problem with gambling. There was no gender difference in this regard and little or no differences in relation to age, other than adults aged 65 years and older being slightly more likely to indicate a relationship with someone who has experienced gambling problems. Half of Māori adults said they know one or more people who have or had a problem, compared to a third of European/Others and Pacific Islanders and around a quarter of Asian peoples.

Around eight percent of adults in New Zealand (equated to about 430,000 adults) reported that someone else's gambling affected them personally. Women more often mentioned being affected than men. Financial impacts (21%) were mentioned most often, followed by loss of relationships (9.5%), stress to family (8%), loss or lack of trust (7%), felt anger, frustration or resentment (6.5%). Other effects mentioned by smaller proportions included loss of time together, fights and family violence, and family break-ups or splits. Females more often than males mentioned adverse financial impacts, loss of relationships, stress to the family, loss or lack of trust, anger, frustration and resentment and family breakup or split.

Around one in ten New Zealanders (11.5%, equating to about 386,000 adults) said there had been an argument in their household about gambling, with just over a quarter of arguments occurring in the past 12 months. Most (88%) said the argument was mainly about someone else's gambling rather than their gambling (8%). All participants were asked if, in their wider family or household, they had to go without something they needed or bills weren't paid because too much was spent on gambling. About one in twelve adults (8%, about 430,000 adults) said this had happened at some time. A third of these people said it had happened in the past 12 months. Most (92%) said it was mainly about someone else's gambling rather than theirs (5%). Women more often reported arguments of this type and going without things and not paying bills than men. Māori and Pacific Island adults more often mentioned both experiences than European/ Other and Asians. New Zealand-born, unemployed people and people in large households also more often reported gambling-related arguments and financial deprivation.

Families are clearly involved in the help-seeking of and on behalf of people experiencing gambling problems. One in a hundred adults said they had tried to get help to stop or reduce

gambling at some time, just under half had done so in the last 12 months. Seeking help from friends was mentioned most often (25%) followed by family (18%), helpline/Gambling Helpline (17%), community support groups (14%), a counsellor or doctor (10%), Gamblers Anonymous (9.5%), a church or the Salvation Army (9%) and the Problem Gambling Foundation of New Zealand (2.5%). This pattern of help-seeking was similar across the non-problem, problem and at-risk groups. Around a fifth (21%) of people who tried to get help said their family, spouse or partner was involved in seeking help for them. Friends (11%), support groups or hotline (9%), and counsellors and doctors (7%) were mentioned less often.

New Zealand gambling support services

In New Zealand, preventing and minimising gambling harm services are funded by the Ministry of Health (MOH) to provide interventions for the individual who is gambling and their family and affected others (Ministry of Health, 2020b). The service model (Figure 7) is structured around a mix of bio-psychological and public health ideas about gambling harm, strongly linked to the person who is gambling at each risk level determined by the Problem Gambling Severity Index (PGSI, Ferris & Wynne, 2001):

Figure 7. Gambling behaviour and harm: the continuum of prevention and harm reduction

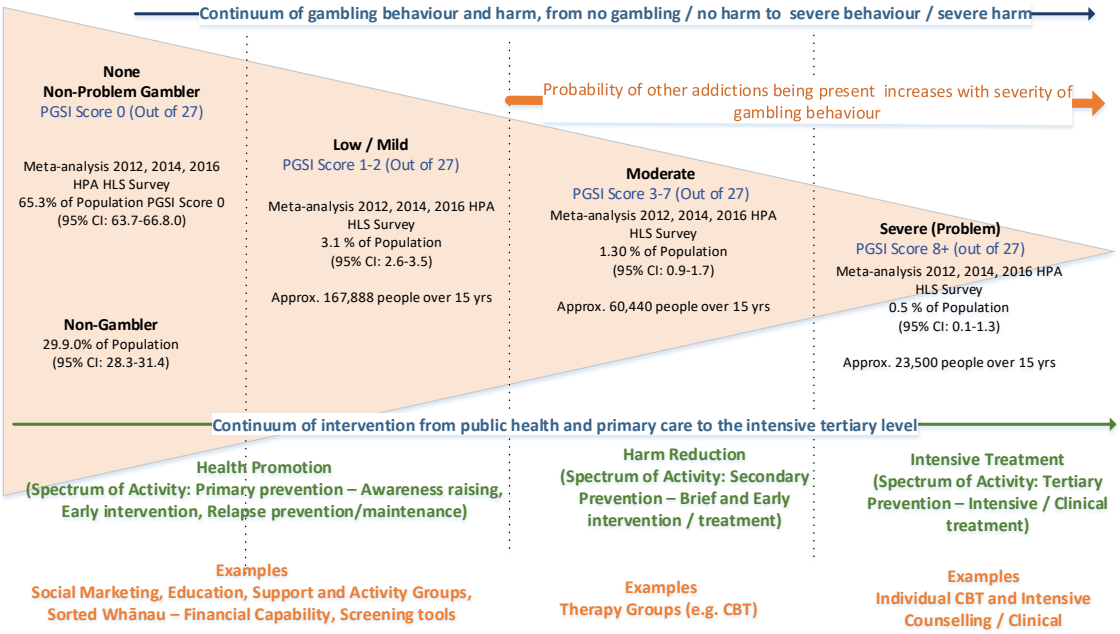


Figure reproduced from MOH Preventing and minimising gambling harm practitioner's guide (Ministry of Health, 2019, p. 4)

This model aims "to address the gambling behaviour, [and] reduce the impact of harm by facilitating the access of the client to other services, including: financial counselling, relationship counselling, other social service agencies, mental health services, and alcohol and other drug services." (Ministry of Health, 2019, pp. 4-5)

The main categories of intervention are 'brief intervention' and 'full intervention', with additional 'facilitation' to other health and wellbeing services as appropriate, and follow up telephone sessions to assess progress, reinforce learnings and reengage treatment if necessary. Brief interventions are short one-on-one motivational interview style sessions, delivered opportunistically in community settings. The purpose is to engage with people at risk of gambling harm and encourage them to recognise the potential impacts of their own or another's gambling behaviour on their life and make change. Full intervention involves working with people experiencing harm from their own or someone else's gambling, and who acknowledge the harms and "have made some commitment to seeking support from a specialist gambling harm service" (Ministry of Health, 2019, p. 33). Full intervention is positioned as a "complex service" and the "foundation of an intervention service", comprised of five key parts, including screening, developing an intervention or treatment plan, relapse prevention, planning for exit and "working with family/whānau/affected others" (Ministry of Health, 2019, p. 33). Framing of full intervention around addressing the needs of the individual who is gambling is evident.

The CLIC database

MOH funded intervention services collect and submit minimal client data to a MOH held and managed a Client Information Collection (CLIC) database (Ministry of Health, 2012a, 2019). CLIC is a service contract management tool. Data are collected about clients, and in relation to every brief and full intervention delivered. Only clients who screen positive for gambling harm using the screening tools outlined below are included in the database. CLIC variables relevant to clients include: gender, age, ethnicity and area of residence. Key CLIC variables describing sessions include: session type (brief or full), session focus (gambler or affected other), mode of gambling causing the harm, persons in attendance (e.g. individual, couple, family, group), medium (face to face, telephone), date and duration, and service setting. There is a total of sixteen screens included in the CLIC database, which are categorised according to the type of session in which they are delivered, and the focus of the session (either on the client as FAO or gambler). A brief description of these screens is as follows (see Ministry of Health, 2019, p. for detail):

Brief intervention screens:

- FAO Awareness – Identifies whether the FAO client is aware of their significant others gambling, and whether they have been affected by their gambling either presently, or in the past.
- FAO Effects – Identifies the effect that the FAO client significant other's gambling has on them, including effects on health, concerns around safety for themselves or their family, and financial concerns.
- Brief Gambler Screen – Identifies whether an individual has experienced problems with their own gambling, either presently or in the past.

Full intervention screens:

- FAO Effects - Identifies the effect that the FAO client significant other's gambling has on them, including effects on health, concerns around safety for themselves or their family, and financial concerns.
- FAO Awareness - Identifies whether the FAO client is aware of their significant others gambling, and whether they have been affected by their gambling either presently, or in the past.
- FAO Outcome – Coping – Identifies whether the FAO client is coping with their significant other's gambling or not.
- FAO Outcome – Frequency – Identifies the frequency at which the FAO client's significant other engages in gambling activity.
- Suicidality – Identifies whether or not clients are at risk of hurting themselves, according to whether they have had just thoughts, or if they have considered or executed a plan within the last 12 months.
- Depression – Identifies clients who may be experiencing symptoms of depression.
- Family/whanau concern – Identifies whether a member of the clients' family or whanau expressed concern about them in the last 12 months.
- Alcohol Use – Determines whether an individual is at risk of experiencing harm from drinking.
- Drug Use – Identifies whether or not clients have used prescription or other drugs in the past 12 months, though this does not specify if this use must be recreational or not.
- Gambler Harm – Assesses individuals based on the frequency that they experience gambling harm over the past 12 months. PGSI.
- Gambler Control – Measures how much control the individual perceives to have over their own gambling.
- Gambler Dollars Lost – Measures how much money a client has lost to gambling over the last month.

The Ministry of Health endorses screening practices for brief and full intervention to ensure that gambling harm and associated issues are asked about and to create space for feedback and discussion of gambling and related issues. Screens are used to identify clients who are experiencing more than one issue and who may benefit from facilitation to another service, and in follow-up for measuring outcomes (Ministry of Health, 2019). At present CLIC is not well designed to measure client outcomes through screening results (Kolandai-Matchett et al., 2015). For most FAO screens, results are not recorded in CLIC. For example, for the Family/Affected Other Effect Screen, clients are able to indicate one or more ways in which their significant other's gambling affects them, however the nature of the harms selected is not recorded in the CLIC database. The structure of the CLIC database means that clients may have sessions which focus on issues surrounding their own gambling recorded, sessions which focus on their needs as family or affected others, or both. CLIC data provides indicative information about how services work and engage with clients for funding accountability purposes (Kolandai-Matchett et al., 2015).

Approach and methods

A descriptive analysis of MOH CLIC data was conducted to provide an indication of how gambling support services work and engage with FAOs. The MOH provided an extract of cleaned and complete CLIC data on gambler and family/affected other clients and their associated sessions during the period from July 1st, 2014 to June 30th, 2019 (the five-year period prior to this study's commencement).

The research questions were:

- What can CLIC tell us about the demographic characteristics of FAOs accessing New Zealand gambling services?
- What support do FAOs appear to be receiving from gambling services?

To answer these questions, the characteristics of clients and sessions delivered in the 5 year timeframe were described. Intervention profiles were defined as follows:

- B: Client only has brief sessions registered against them in the 5-year period.
- F: Client only has full / facilitation sessions registered against them in the 5-year period.
- BF: Client has mix of brief and full / facilitation sessions registered against them in the 5-year period
- BFU: Client has mix of brief and full / facilitation sessions and follow up registered against them in the 5-year period.
- FU: Client has mix of full / facilitation sessions and follow up registered against them in the 5-year period.
- Other: Client has some other combination of sessions registered against them in the 5-year period.

Description of screening data focussed on indicative screening practices, e.g. number of screens completed for each client type during brief and full intervention engagement.

Description of clients

<u>Client type and key demographics</u>

During the extracted 5-year period, a total of 47,946 clients, and 236,938 sessions were recorded in the CLIC database. Recall that the structure of the CLIC database means that clients may have sessions which focus on issues surrounding their own gambling recorded (client as gambler), sessions which focus on their needs as family or affected others (client as FAO), or both (client as FAO/gambler). Table 13 outlines client type by key demographic details. Services engaged with roughly equivalent numbers of clients who had sessions focused on them as FAOs (n=23,261) and as gamblers (n= 23,896) exclusively. A small minority of clients were recorded as receiving sessions focussed on their own gambling and on the impacts of another's gambling on them (n= 429 FAO/gambler clients, 0.9% clients registered in the 5-year period). FAO and FAO/gambler clients were more likely to be female (65.13% and 59.9%

respectively), whereas gambler clients were more likely to be male (60.14%). FAO and gambler clients were of similar age. Approximately half of the clients in both of these groups fell between the age of 25 and 44 (46.9% of FAOs, 52.9% of gamblers). FAO/gamblers were more likely than FAOs and gamblers to be aged 55 or over (29.6%, c.f. 19.7 FAO, 17.8 gambler clients).

Table 13: Client type by gender age and ethnicity

	Type of client					
	FAO clients		Gambler clients		FAO/Gambler clients	
	N	%	N	%	N	%
Overall	23621	*49.3*	23896	*49.8*	429	*0.9*
Gender						
Female	15382	*65.1*	9518	*39.9*	257	*59.9*
Male	8235	*34.9*	14362	*60.1*	172	*40.1*
Age Group						
24 or less	3254	*14.6*	2299	*10.3*	59	*13.8*
25-34	5492	*24.6*	6545	*29.3*	93	*21.7*
35-44	5018	*22.4*	5280	*23.7*	71	*16.6*
45-54	4189	*18.7*	4226	*18.9*	78	*18.2*
55 or more	4412	*19.7*	3974	*17.8*	127	*29.7*
Ethnic Group						
Māori	9368	*39.7*	7725	*32.3*	170	*39.6*
Pacific	5268	*22.3*	3739	*15.7*	143	*33.3*
East Asian	1601	*6.8*	2768	*11.6*	4	*0.9*
Other[#]	7380	*31.3*	9664	*40.4*	112	*26.1*

[#]Other clients were predominantly of European ethnicity.

Engagement with Māori was high across FAO, gambler, and FAO/gambler client groups (39.7%, 32.3% and 39.6% respectively). Both Māori and Pacific engagement was slightly higher in FAO and FAO/gambler groups in comparison to gamblers. Across all groups, engagement with East Asian FAO clients was the lowest.

Given that the proportion of FAO/gambler clients was very small (less than 1% of total clients), only two categories of clients have been considered in the following descriptive analyses: 'FAO' and 'gambler' clients. Clients have been assigned a primary type, based on the focus of their first session. In the following sections FAO (n= 23, 814) and gambler (n= 24, 132) client demographics are explored overall, i.e. inclusive of all intervention types. Interventions received by clients are explored further in the following sections.

FAO clients by age gender and ethnicity

Table 14 examines FAO clients by gender, age and ethnicity. For the most part, there were few differences in age group proportions of men and women who were FAO clients presenting to

services. Among FAOs who were women, over two fifths identified as Māori (41.2%) and nearly one fifth as of Pacific Island heritage (19.4%). In comparison, a slightly higher proportion of men than women identified Pacific Island heritage (27.8%, c.f. 19.4% of female FAOs).

Table 14. FAO client demographics by gender

	Female		Male	
	N	%	N	%
Overall	15518		8311	
Age Group				
24 or less	2077	*13.4*	1380	*16.6*
25 - 34	3860	*24.9*	1986	*23.9*
35 - 44	3504	*22.6*	1828	*22*
45 - 54	2899	*18.7*	1571	*18.9*
55 or more	3178	*20.5*	1546	*18.6*
Ethnic Group				
Māori	6387	*41.2*	3050	*36.7*
Pacific	3008	*19.4*	2310	*27.8*
East Asian	1132	*7.3*	474	*5.7*
Other	4976	*32.1*	2477	*29.8*

Proportions of total FAO clients by gender and ethnicity are visualised in Figure 8 below. Māori women accounted for the single largest category of FAO client engagement (n= 6430, 27%), followed by women of other ethnicity (n=5001, 21%), Māori men (n=3096, 13%), and Pacific women (n=2858, 12%). Pacific men (n=2381, 10%), Other men (n=2380, 10%), East Asian women and men (n=1191, 5% and n=476, 2%) were in the minority of FAO clients engaged.

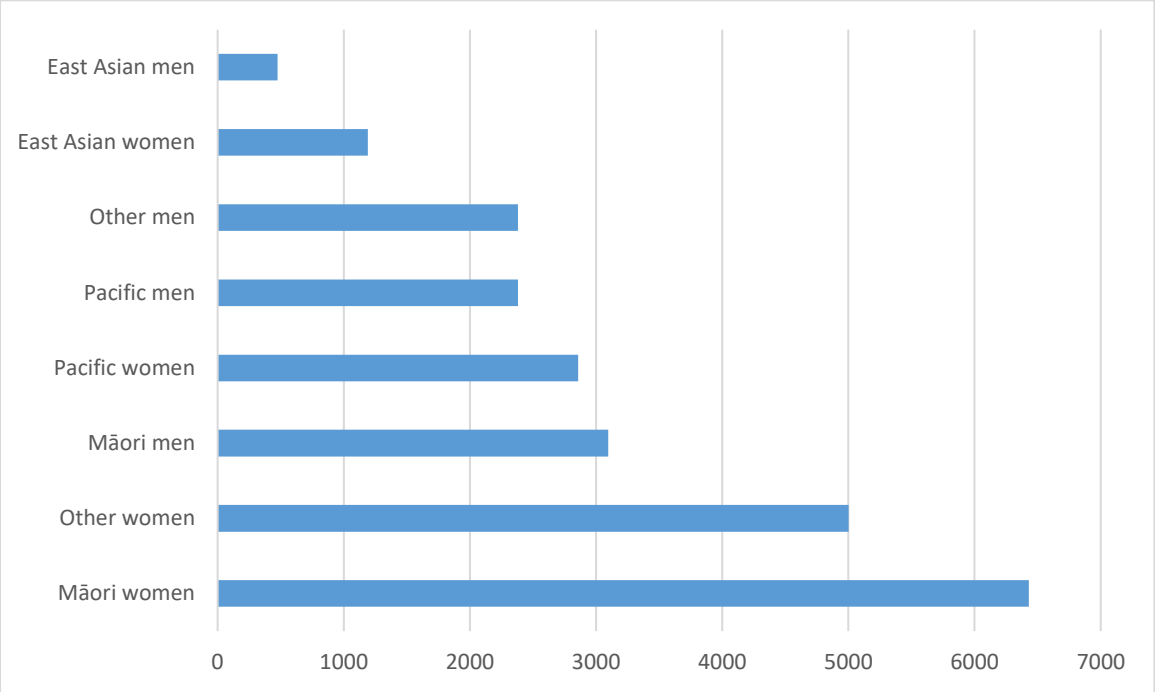


Figure 8. Distribution of (n) family and affected other clients by gender and ethnicity

Types of gambling identified as problematic

Most FAOs identified one (59.4%) or two (25.2%) primary gambling modes causing harm. Note that for FAO clients, this mode reported refers to the mode of gambling their significant other engages in (to their knowledge). Figure 9 below shows the percentage of gambling mode reported by FAO and gambler clients. Generally following patterns for gambler clients, pub EGMs were identified as problematic by the majority (62.8%) of FAO clients.

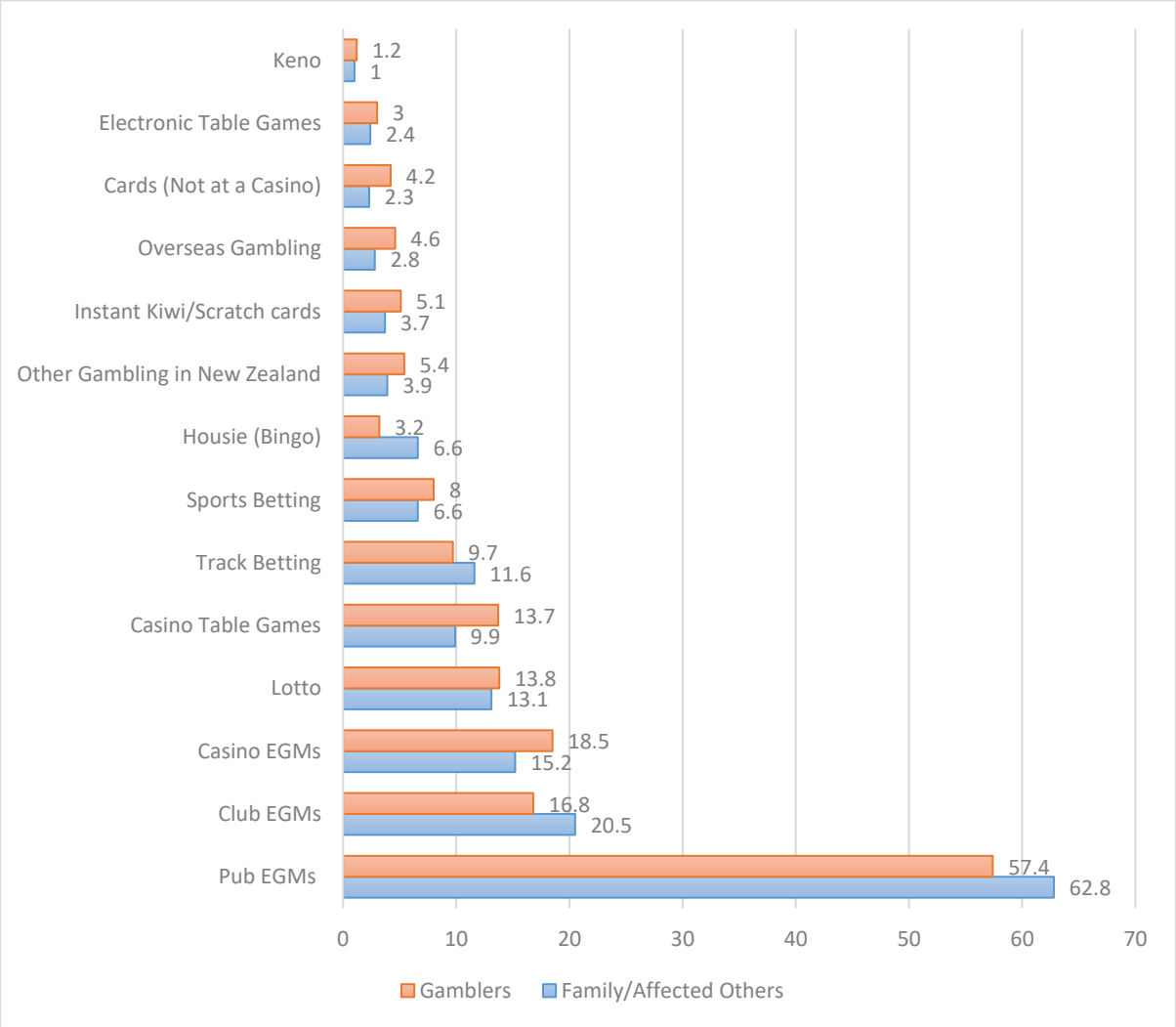


Figure 9. Percentage of all gambling modes recorded by clients

Description of sessions

Overview of FAO and gambler session engagement

While FAO clients represented 49% of the total client base during the period examined, they attended 28% of the sessions overall. The majority of FAO clients engaged in just one session (73.1%, c.f. 48.5% of gambler clients). Of clients who engaged in more than one session, a far greater proportion of FAO than gambler clients engaged in a maximum of two sessions (37% c.f. 17.2%) (Figure 10).

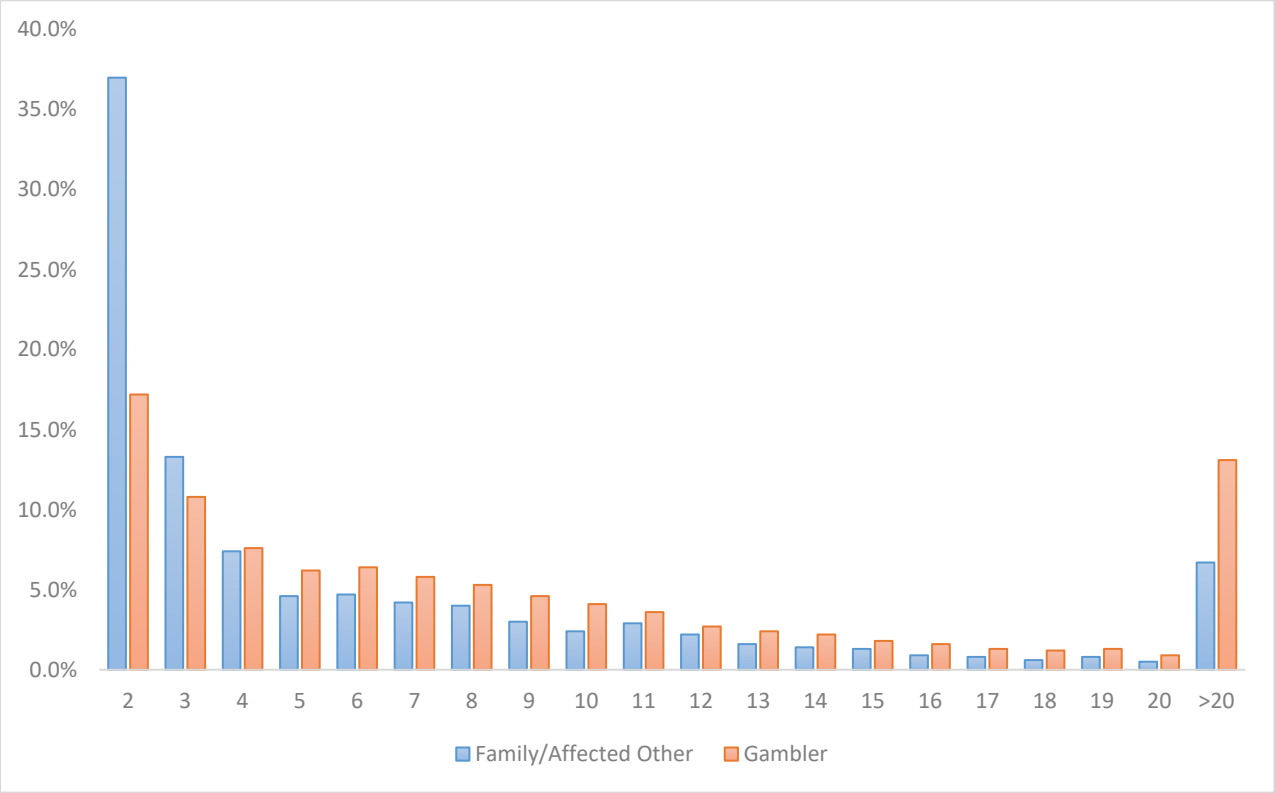


Figure 10. Percentage of FAO and gambler clients receiving 2 or more sessions

FAO clients were more often engaged in brief session types than gamblers (34.7% cf. 9.6%). Almost half of sessions attended by FAOs were full intervention sessions (c.f. 74.1% of gambler clients) (Figure 11). Similar proportions of FAO and gambler clients received facilitation and follow up sessions.

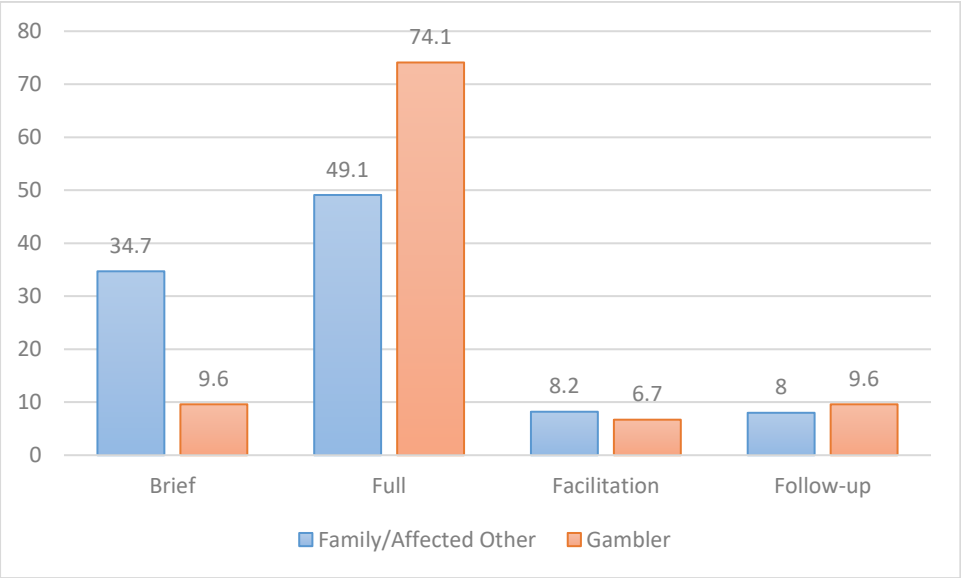


Figure 11. Distribution of session type by client

The vast majority of both FAO and gambler sessions were individual sessions, and this was particularly true for FAO sessions (82% c.f. 73% of gambler sessions) (Figure 12). Group session attendance was more commonly associated with gambler clients than FAOs (25% c.f. 13%). Couple and family sessions were rarely recorded for FAOs or for gambler clients, accounting for just 4 percent of FAO and 2 per cent of gambler sessions. Proportions of face-to-face and telephone sessions were roughly equivalent for FAO and gambler clients (78% c.f. 77% face to face, and 22% c.f. 23% telephone respectively).

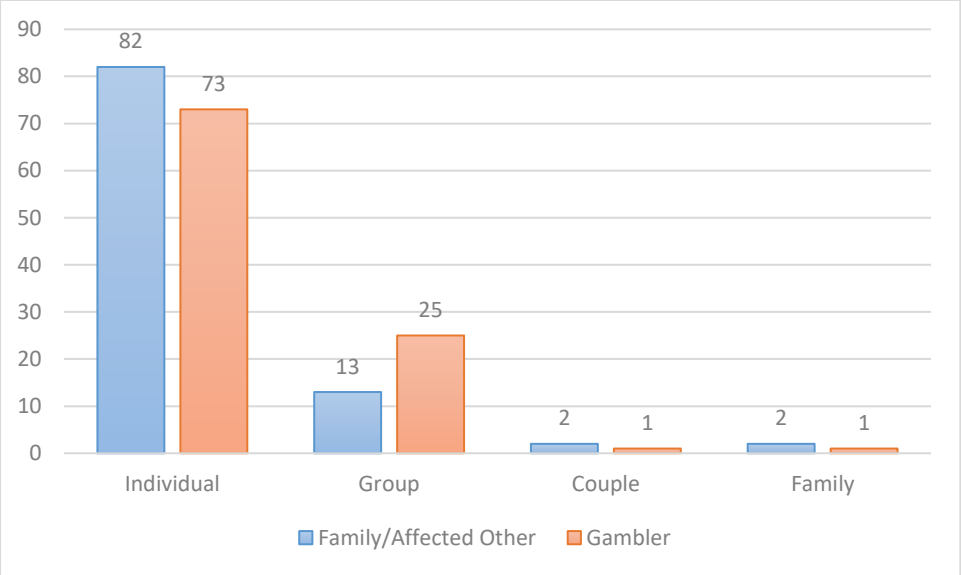


Figure 12. Distribution of session attendance types by client

Overall, the majority of FAO clients engaged with New Zealand's two largest service providers the Problem Gambling Foundation Group (32.5%), and The Salvation Army (26.1%) - see Figure 13 below. When the relative percentage of FAO and gambler clients was considered nationally, some services appear to engage with a high proportion of FAO clients including: The Salvation Army (engaged with 26.1% of FAO clients and 18.4% of gambler clients), Te Rangihaeata Oranga Trust (9.3% FAO c.f. 5.4% gambler clients), and Tu Te Ihi (5.8% FAO c.f. 2% gambler clients).

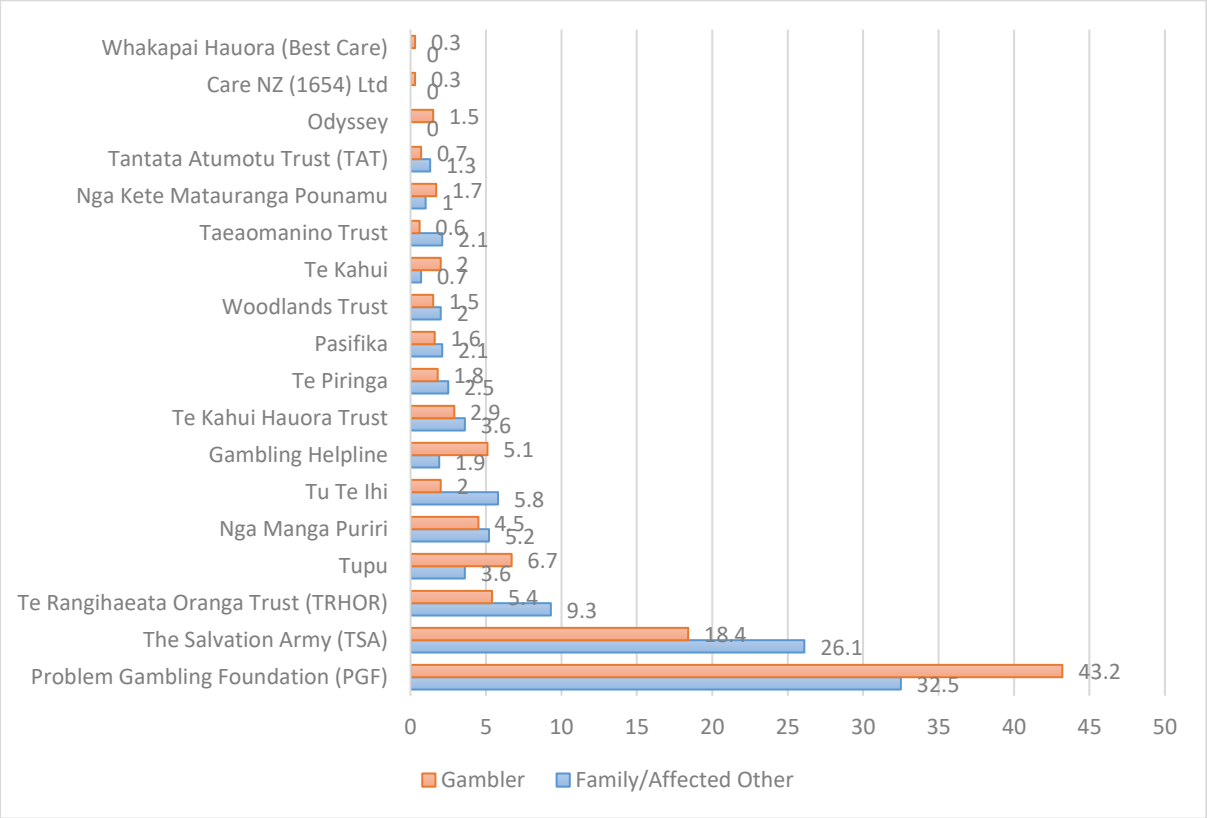


Figure 13. Distribution of agency engagement with FAO clients

<u>FAO session engagement by key demographics</u>

FAOs engaging in just one session (of any type) had a similar demographic profile in terms of gender and age, to those who attended multiple sessions (Table 15). A greater proportion of clients who engaged in multiple sessions were of Pacific heritage (29.3%) than those engaging in single sessions (19.8%). In comparison, a lower proportion of clients engaging in multiple sessions identified as East Asian (4.4%), than those engaging in just one session (7.6%).

Table 15. Demographic profile of FAO clients according to the number of sessions

	Number of sessions					
	One session		**Two sessions or more**		**Total**	
	N clients (17415)	*%*	N (6399)	*%*	N (23814)	*%*
Gender						
Female	11305	*64.9*	4194	*65.6*	15499	*65.1*
Male	6107	*35.1*	2204	*34.4*	8311	*34.9*
Age Group						
24 or less	2199	*13.6*	1077	*16.9*	3276	*13.8*
25-34	4014	*24.8*	1522	*23.8*	5536	*23.3*
35-44	3773	*23.3*	1279	*20*	5052	*21.2*
45-54	3101	*19.2*	1129	*17.7*	4230	*17.8*
55 or more	3079	*19.1*	1384	*21.7*	4463	*18.7*
Ethnic Group						
Māori	6923	*39.8*	2511	*39.3*	9434	*39.6*
Pacific	3451	*19.8*	1873	*29.3*	5324	*22.4*
East Asian	1323	*7.6*	281	*4.4*	1604	*6.7*
Other	5715	*32.8*	1733	*27.1*	7448	*31.3*

Table 16 below examines FAO session attendance type (individual, group, couple, family) by gender, age and ethnicity. FAO client family sessions were slightly more common for men (54.9%) than women (45.1%), while attendance at group sessions was more evenly split by gender (48.9% men, 51.1% women). Individual FAO sessions were more often attended by men (66.3%) than women (33.7%). Couple sessions were far more often initiated by FAOs who are women (73.9%) than men. FAO clients attending individual sessions were also more likely to be 25 or older, with little variation between the other age groups. Pacific FAO engagement in group (48.5%) and family sessions (42.2%) was particularly high, as was European/other engagement in couples sessions (66.5%).

Table 16: Sessions related to FAO clients by session type, gender, age, and ethnicity

	Session attendance type							
	Individual		**Group**		**Couple**		**Family**	
	N sessions	*%*	N sessions	*%*	N sessions	*%*	N sessions	*%*
Overall	53496		8782		1612		1399	
Gender								
Male	35454	*66.3*	4290	*48.9*	1191	*73.9*	768	*54.9*
Female	18035	*33.7*	4491	*51.1*	421	*26.1*	631	*45.1*
Age Group								
24 or less	7290	*14*	1589	*18.1*	89	*5.5*	244	*17.4*
25-34	11986	*23*	1626	*18.5*	412	*25.6*	378	*27*
35-44	11293	*21.6*	1100	*12.5*	385	*23.9*	186	*13.3*
45-54	10048	*19.2*	1470	*16.8*	332	*20.6*	215	*15.4*
55 or more	11613	*22.2*	2990	*34.1*	393	*24.4*	376	*26.9*
Ethnic Group								
Māori	19948	*37.3*	2173	*24.7*	175	*10.9*	169	*12.1*
Pacific	13214	*24.7*	4258	*48.5*	163	*10.1*	591	*42.2*
East Asian	3608	*6.8*	571	*6.5*	202	*12.5*	225	*16.1*
Other	16708	*31.2*	1780	*20.3*	1072	*66.5*	414	*29.6*

The demographic profile of gambler clients according to session attendance type (

Table 17) includes couple and family session types, which also involve FAOs. Couple sessions related to gambler clients tended to involve male gambler clients (75.8%), between the age of 25-54 (79.3%). In comparison to FAO couple sessions, a greater proportion involved Māori (20.26% cf. 10.9%) and Pacific clients (18.3% cf. 10.1%). Family sessions relating to gambler clients, were also particularly likely to involve Pacific clients (45.0%). For gambler clients, Māori engagement in family sessions (18.2%) was notably lower than Pacific (45%) and European/other (30.6) clients.

Table 17. Sessions related to gambler clients by session type, gender, age, and ethnicity

	Session attendance type							
	Individual		Group		Couple		Family	
	N	%	N	%	N	%	N	%
Overall	125275		43499		1747		1128	
Gender								
Female	49976	*39.9*	9976	*22.9*	423	*24.2*	455	*40.3*
Male	75278	*60.1*	33522	*77.1*	1323	*75.8*	673	*59.7*
Age Group								
24 or less	7766	*6.3*	5578	*12.8*	76	*4.4*	136	*12.1*
25-34	31157	*25.2*	14918	*34.3*	426	*24.4*	252	*22.3*
35-44	29084	*23.5*	11752	*27*	537	*30.8*	249	*22.1*
45-54	26173	*21.2*	5993	*13.8*	422	*24.2*	213	*18.9*
55 or more	29512	*23.9*	5256	*12.1*	285	*16.3*	278	*24.6*
Ethnic Group								
Māori	38659	*30.9*	14573	*33.5*	354	*20.3*	205	*18.2*
Pacific	17263	*13.8*	9403	*21.6*	320	*18.3*	508	*45*
East Asian	10075	*8*	4167	*9.6*	183	*10.5*	70	*6.2*
Other	59278	*47.3*	15356	*35.3*	890	*50.9*	345	*30.6*

Table 18 below outlines the demographic profile of FAO clients who engaged in brief, full intervention and follow up sessions. All session types were more likely to engage women than men, this was especially true for follow up sessions. Māori FAOs received a lower proportion of full intervention sessions (26.1%) than brief intervention sessions (42.9%) and received over half of full intervention sessions that also included facilitation (supported referral) to other health services (50.7%). Pacific FAO clients engaged in a higher proportion of full interventions (33.3%) than Brief sessions (22.8%) and full intervention with facilitation (20.6%).

Table 18. Types of FAO intervention sessions by gender, age, and ethnicity

	Session type													
	Brief		Full		Full + Facilitation		Follow-up 1 month		Follow-up 3 months		Follow-up 6 months		Follow-up 12 months	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Overall	22662	*34.7*	32072	*49.1*	5332	*8.2*	2784	*4.3*	1063	*1.6*	753	*1.2*	623	*1*
Gender														
Female	14735	*65*	19981	*62.3*	3480	*65.3*	1795	*64.5*	751	*70.6*	520	*69.1*	441	*70.8*
Male	7924	*35*	12089	*37.7*	1852	*34.7*	989	*35.5*	312	*29.4*	232	*30.8*	180	*28.9*
Age Group														
24 or less	3166	*14*	4508	*14.1*	817	*15.3*	387	*13.9*	141	*13.3*	100	*13.3*	93	*14.9*
25-34	5410	*23.9*	6921	*21.6*	1167	*21.9*	582	*20.9*	165	*15.5*	96	*12.7*	61	*9.8*
35-44	4919	*21.7*	5919	*18.5*	1149	*21.5*	544	*19.5*	196	*18.4*	129	*17.1*	108	*17.3*
45-54	4023	*17.8*	5898	*18.4*	1076	*20.2*	522	*18.8*	228	*21.4*	175	*23.2*	143	*23*
55 or more	3890	*17.2*	8811	*27.5*	1123	*21.1*	747	*26.8*	333	*31.3*	252	*33.5*	216	*34.7*
Ethnic Group														
Māori	9727	*42.9*	8358	*26.1*	2702	*50.7*	766	*27.5*	409	*38.5*	286	*38*	217	*34.8*
Pacific	5168	*22.8*	10669	*33.3*	1098	*20.6*	681	*24.5*	189	*17.8*	192	*25.5*	229	*36.8*
East Asian	1448	*6.4*	2407	*7.5*	409	*7.7*	169	*6.1*	78	*7.3*	61	*8.1*	34	*5.5*
Other	6316	*27.9*	10629	*33.1*	1117	*20.9*	1168	*42*	387	*36.4*	214	*28.4*	143	*23*

FAO intervention profiles by key demographics

Recall that brief interventions are short one-on-one motivational interview style sessions, delivered opportunistically in community settings. The purpose is to engage with people at risk of gambling harm and encourage them to recognise the potential impacts of their own or another's gambling behaviour on their life and make change. Full intervention involves working with people experiencing harm from their own or someone else's gambling, and who acknowledge the harms and "have made some commitment to seeking support from a specialist gambling harm service" (Ministry of Health, 2019, p. 33). Additional 'facilitation' to other health and wellbeing services is encouraged as appropriate, and follow up telephone sessions are conducted to assess progress, reinforce learnings and reengage treatment if necessary.

Client intervention profiles were defined as follows:

- B: Client only has brief sessions registered against them in the 5-year period
- BF: Client has mix of brief and full / facilitation sessions registered against them in the 5-year period
- BFU: Client has mix of brief and full / facilitation sessions and follow up registered against them in the 5-year period.
- F: Client only has full / facilitation sessions registered against them in the 5-year period.
- FU: Client has mix of full / facilitation sessions and follow up registered against them in the 5-year period.
- Other: Client has some other combination of sessions registered against them in the 5-year period.

The majority of FAOs engaged with services through brief intervention only (n= 17,170, 72.1%), see Table 19. A much smaller proportion engaged in brief as well as full intervention with or without facilitation (14.7%). A similar proportion received full intervention only (with or without facilitation) (12.1%). Of those who received a full intervention (n= 6380, 26.8%), just under one third (32%) received additional follow up support. Across intervention profiles for FAOs, men were much less engaged with services than women, who tended to engage in more sessions in each engagement profile. One exception was engagement through the most intensive pathway: brief, full intervention/facilitation and follow up (4.27% FAOs engaged with services in this way). In this case the ratio of men to women approached 50/50 (53.4% c.f. 46.6%). Age patterns were similar for clients engaging in each pathway, with the majority of clients aged between 25 and 54. One exception was those attending full interventions/facilitation sessions without having first attended a brief session in the 5 year period. These clients were notably older with nearly a third (31.1%) aged over 55.

Table 19: Demographic profile of FAO clients according to intervention profile

	Type of Intervention											
	B		BF		BFU		F		FU		Other*	
	N	%	N	%	N	%	N	%	N	%	N	%
Overall	17170	*72.1*	2487	*10.4*	1017	*4.3*	1850	*7.8*	1026	*4.3*	264	*1.1*
Gender												
Female	11170	*65.1*	1646	*66.2*	543	*53.4*	1270	*68.7*	716	*69.9*	154	*58.3*
Male	5997	*34.9*	841	*33.8*	474	*46.6*	580	*31.3*	309	*30.1*	110	*41.7*
Age Group												
24 or less	2156	*13.5*	476	*19.2*	222	*21.8*	242	*13.1*	139	*13.6*	41	*15.7*
25 - 34	4048	*25.4*	644	*25.9*	240	*23.6*	372	*20.1*	169	*16.5*	63	*24.1*
35 - 44	3785	*23.8*	505	*20.3*	194	*19.1*	338	*18.3*	192	*18.7*	38	*14.6*
45 - 54	3049	*19.2*	415	*16.7*	185	*18.2*	328	*17.8*	199	*19.4*	54	*20.7*
55 or more	2884	*18.1*	445	*17.9*	176	*17.3*	567	*30.7*	326	*31.8*	65	*24.9*
Ethnic Group												
Māori	7206	*42.0*	1067	*42.9*	297	*29.2*	462	*25*	326	*31.8*	76	*28.8*
Pacific	3383	*19.7*	839	*33.8*	411	*40.4*	386	*20.9*	212	*20.7*	93	*35.2*
East Asian	1277	*7.4*	104	*4.2*	49	*4.8*	98	*5.3*	55	*5.4*	21	*8*
Other	5302	*30.9*	476	*19.1*	260	*25.6*	903	*48.8*	433	*42.2*	74	*28*

*Other refers to combinations of session types that are likely to represent data entry errors, e.g. follow-up sessions are registered against client without any other intervention session type.

Brief interventions were more common for Māori clients (42%), as well as clients of European/Other ethnicity (30.9%). Pacific (19.7) and East Asian clients were least likely to receive a brief intervention (7.4%). Clients receiving a mix of brief and full interventions were more likely to be either Māori (42.9%) or Pacific (33.8%), than European/Other (19.1) or East Asian (4.2%). Clients who progressed through brief intervention to full intervention and follow up were more likely to identify with Pacific ethnicity (40.4%), followed by Māori (29.2%), European/other (25.6%), and East Asian (4.8%). Clients presenting for full intervention (without brief engagement) tended to be European/other (48.8%).

Description of FAO screening

Brief screening practice

Table 20 outlines brief intervention screening practice among FAO and gambler clients. It shows that clients were rarely offered both gambler and FAO screening. A small number of FAO clients were screened for harm from their own gambling (3.3%), a slightly higher proportion of gamblers were screened for impacts on them as FAOs (5.4%).

Full intervention screening practice

Full intervention screening for FAOs was very low, approximately half (between 49.3 and 51.9%) of FAO clients were not screened at all for effects or awareness of harm, or outcome measures (frequency, coping) (Table 21). In comparison to gamblers, screening for coexisting issues (suicidality, depression, alcohol and drug use) among FAOs was also low – almost two thirds of clients were not screened for each one of these issues, compared to two fifths of gamblers.

Table 20: Number of screening assessments for FAO and Gambler brief intervention clients

	Family/Affected Other						Gambler					
	0		1		2+		0		1		2+	
	N	%	N	%	N	%	N	%	N	%	N	%
Brief Screen												
FAO Awareness	159	*0.8*	19418	*93.9*	1097	*5.3*	14148	*94.5*	765	*5.1*	52	*0.3*
FAO Effects	194	*0.9*	19377	*93.7*	1103	*5.3*	14152	*94.6*	761	*5.1*	52	*0.3*
Brief Gambler Screen	19998	*96.7*	638	*3.1*	38	*0.2*	260	*1.7*	13737	*91.8*	968	*6.5*

Table 21: Number of screening assessments for FAO and Gambler full intervention clients

	FAO						Gambler					
	0		1		2+		0		1		2+	
	N	%	N	%	N	%	N	%	N	%	N	%
Full screen												
FAO Effects	3144	*49.3*	1807	*28.3*	1429	*22.4*	13269	*98.1*	182	*1.3*	75	*0.6*
FAO Awareness	3177	*49.8*	1802	*28.2*	1401	*22*	13267	*98.1*	186	*1.4*	73	*0.5*
FAO Outcome - Coping	3289	*51.6*	1726	*27.1*	1365	*21.4*	13289	*98.2*	164	*1.2*	73	*0.5*
FAO Outcome - Frequency	3309	*51.9*	1717	*26.9*	1354	*21.2*	13288	*98.2*	165	*1.2*	73	*0.5*
Suicidality	3902	*61.2*	1696	*26.6*	782	*12.3*	5450	*40.3*	5724	*42.3*	2352	*17.4*
Depression	3940	*61.8*	1676	*26.3*	764	*12*	5508	*40.7*	5794	*42.8*	2224	*16.4*
Family/whanau concern	3973	*62.3*	1647	*25.8*	760	*11.9*	5673	*41.9*	5689	*42.1*	2164	*16*
Alcohol Use	3978	*62.4*	1651	*25.9*	751	*11.8*	5492	*40.6*	5782	*42.7*	2252	*16.6*
Drug Use	3987	*62.5*	1642	*25.7*	751	*11.8*	5649	*41.8*	5656	*41.8*	2221	*16.4*
Gambler Harm	6225	*97.6*	108	*1.7*	47	*0.7*	3520	*26*	5723	*42.3*	4283	*31.7*
Gambler Control	6232	*97.7*	100	*1.6*	48	*0.8*	4092	*30.3*	5490	*40.6*	3944	*29.2*
Gambler dollars lost	6235	*97.7*	98	*1.5*	47	*0.7*	4382	*32.4*	5138	*38*	4006	*29.6*

Discussion

This descriptive analysis was conducted to explore the demographic characteristics of FAOs engaging with New Zealand gambling services, and how these clients appear to be engaged. When all intervention types were considered together, the largest proportion of FAOs engaging with services were Māori women (27%) and European/Other women (21%), followed by Māori men (13%) and Pacific women (12%). Lower engagement was noted for Pacific men (10%), European/Other men (10%), East Asian women (5%) and East Asian men (2%). All intervention service providers are responsible for promoting their services, with a primary focus on "at-risk and high-need populations" (Ministry of Health, 2019, p. 4). New Zealand population research shows a disproportionately higher rate of reporting by Māori of family members and other people considered likely to have gambling-related problems. This is also evident to a lesser degree for Pacific people (Abbott et al., 2014). Asian people are far less likely to report knowing someone experiencing gambling problems than all other ethnic groups (less than one quarter of Asian identified people), compared to around one-third of European/Other and Pacific people, and half of Māori (Abbott et al., 2014). New Zealand women are more likely to identify harm from someone else's gambling and more severe harms (Abbott et al., 2014). Taken together, these findings suggest that service engagement is broadly in alignment with priority populations, however engagement with Pacific peoples could be improved.

Support for both FAOs and gamblers appears to be largely concentrated around the individual at present. Most FAOs were engaged for one, brief, one-on-one session of motivational support conducted outside a clinical setting. There was little evidence of intervention practice involving couples or families for either FAO or gambler clients. Group support and/or therapy sessions comprised a quarter of session attended by gamblers, yet only around one in ten sessions attended by FAOs. Couple and family sessions accounted for just 4 percent of FAO and 2 per cent of gambler sessions. Further research could ascertain whether this reflects FAO preferences or the availability of support options. Given that high engagement with FAOs is already occurring opportunistically in community contexts, finding ways to support community-based/community-led programmes and events may provide additional opportunities for more in-depth FAO engagement.

Some services appear to be engaging with a high proportion of FAO clients in comparison to other services. Examples include The Salvation Army, Te Rangihaeata Oranga Trust and Tu Te Ihi. Te Rangihaeata Oranga Trust, located in a small region on New Zealand's East Coast (Hawke's Bay, population 175,100), engaged with almost ten percent of FAO clients nationally, during the data collection period. The latest New Zealand inquiry into mental health and addictions services found that while overall quality and effective engagement with families was poor, some services were doing markedly better, for example services undertaking a wrap-around Whānau Ora approach (Patterson et al., 2018). This approach, based in Māori understandings of wellness and community, emphasises encouraging families to identify the aspirations they have to improve their lives and building whānau capacity to achieve their goals

(Independent Whānau Ora Review Panel, 2018). In depth mixed methods research with gambling services who are achieving high levels of engagement with FAOs could deliver learning and benefits for the harm minimisation and prevention sector. In the addictions field there is limited understanding of how to increase, achieve and sustain family focussed practice in services (Orford et al., 2009).

Limitations

The CLIC database is a tool designed to support funding accountability and decision making. As such it is an imperfect research tool. CLIC data may be interpreted as indicative of currently practice, and suggestive of avenues for further investigation only. Data constitutes indicative information about how services work and engage with clients and is reliant on service compliance with data collection protocols.

Conclusion

Services are engaging appropriately with priority FAO populations, however engagement with Pacific men and women could be improved. Support for both FAOs and gamblers appears to be largely concentrated around the individual at present. Most FAOs were engaged for one, brief, one-on-one session of motivational support conducted outside of a clinical setting. It is unknown whether FAOs needs are met in this brief engagement. There was little evidence of intervention practice involving couples or families for either FAO or gambler clients. Some services appear to be engaging with a high proportion of FAO clients in comparison to other services. In depth exploration with gambling services who are achieving high levels of engagement with FAOs could deliver important learning and benefits for the gambling harm minimisation and prevention sector re: development and sustainability of quality and effective programmes.

OPPORTUNITIES TO ENHANCE SUPPORT FOR FAOs IN NEW ZEALAND GAMBLING SERVICES

In this discussion chapter, we explore opportunities to enhance support for FAOs in New Zealand gambling services, as suggested by our mixed methods study. Gambling harm reduction is a social practice with links to medical, psychological, economic, and political fields of knowledge, and technologies of 'truth production' such as academic research (Adams, 2007b; Reith, 2007). Focussed on reducing the negative impact of gambling on the wellbeing of people, communities and populations, it involves many diverse, strategies and programmes to achieve this aim, which have changed over time (Livingstone et al., 2019; Reith, 2007). Exploration and discussion of the influence of culture and values in gambling harm reduction and recovery promotion can be controversial. This is especially true in questioning our understandings of people affected, what they need and how best to support them and reduce harm (Adams, 2016; Gordon & Reith, 2019).

Addictions support systems have largely been designed to reduce addictive behaviours in individuals experiencing addiction. In present services much of what is talked about, decided upon and done is clearly based around the views, perspectives and culture of service systems and professionals. Our research suggests that many nodes of family focussed thinking and practice exist, particularly in relation to culturally specific services, but these have not yet been 'joined up' into a force powerful enough to create systemic change. It remains largely unclear what FAOs would like gambling harm reduction support to look like, and whether the support they are currently receiving (when they access it) is of sufficient quality and effectiveness from their perspective.

Promising avenues for enhancing support provided for FAOs through service commissioning include designated support and initiatives for: practitioner-inquirers (clinicians and service managers who critically engage with a research/practice nexus e.g. in postgraduate study or in partnership with researchers and training), collaborative and participatory service design and re-design, evaluation that includes FAO voices, and enhancing workforce diversity. A designated budget for family specific intervention training and remodelling of current intervention strategies with families and children in mind was suggested by service managers both in NZ and internationally. Funding for the phased development and evaluation of a new service based on the principles above could benefit New Zealand families.

These suggestions are not new in the mental health and addictions fields (see Abbotts, 1994; Adams, 2007a). Some services in New Zealand appear to have been developed in closer alignment with the above than others. For example, Mapu Maia's Pacific gambling harm reduction service design involved a year-long consultation process with families and communities and centralising Pacific models of relational wellbeing. Service strategy was designed to reflect these interactions and conversations leading to Pacific communities actively designing and leading their own innovative solutions.

Our research has also showcased the persistence of interest, energy and willing towards improving support for families across the gambling harm reduction sector. We suggest three underlying principles that could be leveraged to create action towards systemic change in New Zealand: honouring Te Tiriti o Waitangi (embedding genuine and empowering partnerships with Māori at all levels of our gambling harm reduction system), an integrative approach to 'evidence-based practice', and transformative action-oriented research.

Honouring Te Tiriti o Waitangi

Te Tiriti o Waitangi (the Treaty of Waitangi) is the foundation for power sharing between tāngata whenua (Māori as the first peoples of Aotearoa), and tāngata Tiriti (all others who have come here). Te Tiriti affirmed the sovereignty of hapū (kinship groups) and provided for the British to exercise governance. The intention of the Treaty was to establish an on-going relationship of mutual benefit, built on trust and good faith between tāngata whenua and all others. Through colonisation, the foundations of Māori society have been eroded and hapū rights to be self-determining have not been upheld. As a result, there is deep imbalance in our communities/society, and resulting Māori health inequities (Durie, 1997). Māori in Aotearoa New Zealand have seen the individualised nature of Western health systems creating access barriers and poorer outcomes when compared to support and intervention that encompasses vital cultural concepts such as whānau (family systems) and wairua (spirit) (R. Graham & Masters-Awatere, 2020).

Whānaungatanga ("relationships") are regarded as instrumental in the life journeys and support/treatment processes for Māori families and communities (Huriwai et al., 2001). Our research suggest that Māori approaches provide a useful model for family involvement in addiction harm reduction. Inquiry continues to document important links between indigenous healing practices, cultural concepts and recovery from addictions and wellbeing (see for example Beals et al., 2006; R. Graham & Masters-Awatere, 2020; Patterson et al., 2018; Stone et al., 2006). In New Zealand mental health and addictions services, quality and effective engagement with families has been associated with services undertaking a wrap-around Whānau Ora approach based in Māori understandings of wellness and community (Patterson et al., 2018). This approach emphasises encouraging families to identify the aspirations they have to improve their lives and building whānau capacity to achieve their goals (Independent Whānau Ora Review Panel, 2018).

Te Tiriti obligations are an appropriate foundation for achieving Māori health aspirations and equity for Māori, recognising the status of Māori as tāngata whenua (R. Graham & Masters-Awatere, 2020; Morrison, 2008). The Ministry of Health (2020d) identifies four goals, with their basis in Te Tiriti, expressed in terms of mana (lifeforce):

- Mana whakahaere: effective and appropriate stewardship or kaitiakitanga over the health and disability system. This goes beyond the management of assets or resources.

- Mana motuhake: Enabling the right for Māori to be Māori (Māori self-determination); to exercise their authority over their lives, and to live on Māori terms and according to Māori philosophies, values and practices including tikanga Māori.
- Mana tangata: Achieving equity in health and disability outcomes for Māori across the life course and contributing to Māori wellness.
- Mana Māori: Enabling Ritenga Māori (Māori customary rituals) which are framed by te ao Māori (the Māori world), enacted through tikanga Māori (Māori philosophy & customary practices) and encapsulated within mātauranga Māori (Māori knowledge).

Māori are disproportionately harmed by gambling, and have long argued as Te Tiriti partners, for whānau involvement at all levels of decision making in determining gambling policies, services and revenue direction (Dyall et al., 2012). These conversations link to the recent New Zealand government commissioned Health and Disability Systems Review (2020). The review panel highlighted how consultation cannot be the end point of equity partnerships for health system and service design and delivery, they must move to financial and decision-making empowerment. Most of the review panel, as well as the Māori advisory group recommended a Māori Health Authority be established to commission health services for Māori using an indigenous driven model within the health system to achieve equity. This model could usefully be applied to gambling harm reduction service commissioning. The recent Waitangi Tribunal report on Health Services and Outcomes (2019), particularly emphasises the need to support Māori aspirations for tino rangatiratanga (self-governance) and mana motuhake (autonomy): Concepts our expert panel identified as key to gambling harm reduction.

An integrative perspective on 'evidence-based practice'

Evidence for the effectiveness of gambling treatments remains extremely limited, which, in combination with processes of self-directed and natural recovery, may go some way to explaining low help-seeking by people who gamble and their FAOs (Abbott, 2019a, 2019b). Experiential and values-based evidence is particularly underdeveloped and underutilised in service design and delivery to support recovery from mental health and addictions in New Zealand and internationally (Johnstone & Boyle, 2018; Patterson et al., 2018). 'Evidence-based practice' (EBP) traditionally relies heavily on randomized controlled trials (RCTs), which test the efficacy of interventions for a defined population. The need for approaches to demonstrate efficacy in terms of generalisability of the intervention being tested across a population inherently marginalises systems where it is expected that an approach or intervention will interact with individual people in different ways, as is common in traditional medical systems (Fung & Linn, 2015). The dominance of empirical-analytical evidence[2] as a decision-making tool in healthcare provision often fails to produce equity because it ignores how socio-cultural dynamics contribute to what is considered good practice and appropriate systems (Mykhalovskiy & Weir, 2004). Significantly, this can exclude some Indigenous peoples

[2] Experimental evidence, e.g. change in validated measures, as the basis for evidence-based practices.

(Stephens et al., 2006), who already experience substantial health disparities relative to non-Indigenous counterparts worldwide (King, Smith, & Gracey, 2009).

An integrative approach to enhancing practice requires the understanding of diverse approaches to addiction harm reduction: their conceptualisation, respective measurement techniques, and evaluation standards (Claes et al., 2015). It is not a matter of rejecting traditional EBP, but of expanding our conceptualisation of quality and effective support, particularly from the perspectives of those most affected. If we engage a 'human prerogative' or 'person/family-centred care', we can accept that no single support system can address all addiction-related problems for families. Instead, engaged commitment is needed from all stakeholders that consists of an open, methodical, meaningful and ongoing search for the best responses to certain issues, needs and families (Broekaert et al., 2010; Hummelvoll et al., 2015). Ongoing inquiry into and questioning of our understandings of people affected, what they need and how best to reduce harm and support them is vitally important to person and family centred approaches, services and care (Borg & Karlsson, 2017). Energy and enthusiasm for such conversations was demonstrated in our inquiry by the willingness and generosity of the expert panel. Our panel emphasised the limited space and time available to have critical conversations about practice.

Transformative and action-oriented research

Outcome and evaluation data relevant to supporting families harmed by gambling is limited. Principles of transformative and action research hold that often we can come to understand a phenomena, process or system much more deeply when we work together with key stakeholders to try to enhance it (Argyris, 1993). In this case the purpose of inquiry is not just to describe, understand, recommend or explain, but to try to support and effect positive change (Reason & Torbert, 2001). Service improvement is seen as a journey, that begins with an iterative, collaborative and inclusive inquiry process (Abercrombie et al., 2015). For example, in our research, experts endorsed the practice of critical reflexivity. Critical reflexivity happens when professionals working in a field are supported to actively consider how their practices interact with prevailing knowledge systems, generally through exposure to different ways of thinking about intervention, and particularly as grounded in client's experiences (Gibson, 2016; Kinsella et al., 2012; Kinsella & Whiteford, 2009). When facilitated in clinical settings, critical reflexivity generates new insight into intervention and engagement strategies, and understanding of desired endpoints or outcomes, that can contribute directly to service improvement (Gibson, 2016).

At present little is known about how to achieve successful implementation and sustainability of family-focused practice within addictions treatment services (Hampson, 2012; Orford et al., 2009). This is a serious limiting factor for those seeking to enhance services for families. While our exploration of current FAO support practice was limited, and therefore indicative only, we found that some services do appear to be engaging with a high proportion of FAO clients, and/or engaging with explicitly family focussed paradigms and/or approaches that are aligned

with the recommendations of our panel and research. We found that these services are far less likely to be engaged in evaluation processes that result in accessible information for the harm reduction sector. In depth engagement with gambling services who are working in these ways could deliver learning and benefits for the gambling harm minimisation and prevention sector. The role of services in creating effective advocacy mechanisms for the lived experience of FAOs in decision making processes about how economic systems are structured and run and who is regarded as acceptable/valuable, have yet to be explored. For example, in New Zealand The Salvation Army run gambling support services and also a Social Policy & Parliamentary Unit which works toward the eradication of poverty by encouraging policies and practices that strengthen the social framework of New Zealand. These practices were highlighted as a key part of quality and effective service provision for families in our research. Exploration of how to achieve quality and effective family engagement in these processes could usefully inform and expand harm reduction practice.

Final recommendations

This research has suggested a range of opportunities to enhance support for family and affected others (FAOs) in New Zealand gambling services including:

- In depth engagement with how a range of FAOs view gambling harm and recovery, and the development of models and approaches in accordance with this.
- Developing and expanding approaches that look beyond the individual to conceptualise harm and recovery as social and relational phenomena
- Mindfully engaging multiple harm and recovery paradigms (individual psychological and broader social, cultural and relational)
- Participatory research, service design and evaluation
- Creative workforce development

Limitations of this inquiry

Our mixed methods inquiry has enabled the triangulation of multiple data sources to suggest some further avenues for enhancing support for FAOs in New Zealand gambling services. Our engagement with experts was limited by participant availability during the COVID-19 international pandemic and suffered from low consumer participation. Limited engagement with FAOs who use services (and those who do not) in gambling studies is a barrier to quality and effective support practice which should be addressed in future studies. Our exploration of current FAO support practice was high-level, limited in scope, and therefore indicative of future avenues of inquiry only. We argue that further in-depth exploration of gambling harm reduction practice with families, with a view to service enhancement, is necessary to build an evidence base and improve support provided for FAOs.

CONCLUSION

This research was conducted to explore how gambling support services for family and affected others (FAOs) could be enhanced in New Zealand, in the context of long-standing disconnect between the expectations of families/whānau and mental health and addictions service delivery. Addiction related harm in families is a complex and multidimensional phenomenon. No single treatment system can address all addiction-related problems for families. Support should therefore engage with the multiple mechanisms through which addiction develops, is maintained and harm experienced. Addictions services tend to be guided by one approach to engaging and supporting FAOs at best, and to be dominated by the views of professionals. The service-user and person-centred movements within mental health care identify the role of services/interventions in helping FAOs to both conceptualise and articulate their multiple understandings of harm and recovery needs. Honouring Te Tiriti o Waitangi by realising Māori aspirations for tino rangatiratanga (self-governance) and mana motuhake (autonomy) will improve support for New Zealand families by centralising whānau (family systems) and whānaungatanga (relationships) in gambling harm reduction. Transformative and action-oriented research has the potential to facilitate in-depth and collaborative engagement between addictions service providers and FAOs in reshaping services to enhance the range and quality of support provided for FAOs. Collaborative techniques and processes (e.g. co-design and consumer governance roles) could be usefully employed to conceptualise, design, plan and evaluate enhanced gambling harm reduction services for FAOs in New Zealand. These activities should be supported by appropriate government policy and funding for practitioner-inquirers, enhancing workforce diversity, family specific support and intervention training and remodelling of current service strategies and offerings with families and children in mind.

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APPENDIX ONE: Results of Round 1 engagement with expert opinion

Results of the Round 1 survey are presented in this section. These results were provided to participants and used to inform the development of Round Two.

The purpose of providing support/intervention services for FAOs affected by addiction

Participants converged on the notion that FAO services exist to support individual FAOs to address their own needs (Table), e.g.:

> *"So FAOs know they are not alone, can develop strategies for coping and boundaries; relationship and communication skill development; safety planning; grief and trauma support." (Clinician, NZ)*

Around a third endorsed a dual purpose including reducing gambling behaviours in the family (e.g. by supporting a gambler into treatment or creating conditions supportive of reduced gambling at home). The notion of addictions support as part of family/whānau focussed care involved an explorative and client-led approach (involving multi-disciplinary teams) that did not make assumptions about the needs of family in advance of working with them. Another key role was identified for services in preventing addiction related harm, including educating and empowering families and communities. Responding to an understanding of family and addiction systems was highlighted in this regard:

> *"It is part of understanding that someone with an addiction exists or lives within a whānau context - they are part of a system that has given rise to their addiction, and their addiction impacts on others within that system. A multi-pronged approach is needed to ensure success and recovery for the addicted person, wellbeing for family and others, and to ensure that family and others can support the addicted person's recovery." (Researcher, NZ)*

Table 10: The purpose of providing support/intervention services for FAOs affected by addiction

Purpose	*n* = 38	%
To support FAOs to identify and address their own needs	15	39
To support FAOs to identify and address their own needs and reduce addictive behaviours in families.	12	32
To provide family/whānau focussed care	8	21
To prevent addiction-related harm in families	5	13
To reduce addictive behaviours in families	4	11
To educate and empower families and communities	4	11
Other (e.g. 'unsure')	3	8

Important outcomes of an addictions service / intervention for FAOs

Views on key outcomes of an addictions service for FAOs were varied (Table). Important outcomes ranged from individual outcomes such as *FAO wellbeing* (Improvement in empirical measures of individual FAO wellbeing and quality of life, ability to support gambling individual), *FAO-centric outcomes* (holistic formulation of meaningful change and meaning for individual families), *relational outcomes* (Improved family relationships, improved relationship with gambling individual reduced isolation / increased support networks), *outcomes for the gambling individual* (Reduction in measures of gambling (e.g. time/expenditure), and *public health based outcomes* (Social/political change in communities served, enhanced education / understanding of gambling and services.)

Table11: Important outcomes of an addictions service / intervention for FAOs

Key Outcome (coded qualitative responses)	*n* = 38	%
Improvement in measures of individual FAO wellbeing and quality of life	25	66
Holistic formulation of wellbeing, change and meaning for individual families	21	55
Social/political change in communities served	15	39
Enhanced education / understanding of gambling and services	11	29
Improved family relationships	11	29
Reduced isolation / increased support networks	10	26
Reduction in measures of gambling (e.g. time/expenditure)	8	21
Improvement in measure of individual financial security	7	18
Improved relationship with gambling individual	7	18
Enhanced ability to support gambling individual	6	16
Appropriate referral (e.g. legal advice, access to foodbanks)	4	11
Other (e.g. ‘unsure’)	3	8

Measuring the quality and effectiveness of addictions services for FAOs

Quality and effectiveness were discussed as involving the use of empirical performance outcomes measurement and accountability frameworks measures such as Results-Based Accountability (RBA), Continuous Quality Improvement (CQI), and the collection of validated screening and data from clients over time (Table and Table). In relation to quality choice and multiple approaches was emphasised by over two fifths of the panel, e.g.:

> *“Some family members want to learn more about problem gambling, others need to connect with others so they feel less isolated, others need professional support regarding their own needs whilst others feel the impact most acutely within their relationship with their gambling relative and therefore may need family therapy. Having a wide number of options that can be accessed at different points or at the same time is vital.” (Clinician, UK)*

In commenting on quality and effectiveness, ten participants suggested that a ‘culture of curiosity and learning’ should be developed as a key strategy for ensuring that services conceptualise and measure outcomes that are relevant to the communities they purport to serve:

"Service quality is about mechanisms for listening carefully to clients' stories, being open and curious to picking up clues hidden within those stories, to make a commitment to assist in empathetic ways, to collect learning and feed it back into practice." (Researcher, Australia)

Table 12: Measures of quality services for FAOs affected by addiction

Key Measure (coded qualitative responses)	*n* = 38	%
Empirical measures, e.g. Treatment Outcome Profile, Results-based accountability (RBA), Continuous Quality Improvement (CQI)	27	71
A wide range of options to access	16	42
Community and client perspectives on service relevance, availability and engagement	15	39
Service staff commitment to a culture of learning	7	18
Cultural quality e.g. resourcing and accessibility of kaupapa Māori services	4	11
Other (e.g. 'unsure')	3	8

Participants also emphasised how both quality and effectiveness should be explored in a way that centralises FAO's perspectives on their wellbeing – including lived experience of harm and service use. From a third, values-based perspective, support and intervention quality and effectiveness was seen to be based on key principles such as inclusion, equity, self-determination, participation, and empowerment.

Table 13: Measures of effective services for FAOs affected by addiction

Key Measure:	*n* = 37	%
Evidence-based measures (pre- and post- service engagement) e.g. Recovery Index, Family Member Questionnaire (FMQ)	25	68
Meeting FAO identified need	21	57
Client retention / recommendation	12	32
Public health measures of an effective service e.g. diversity of families accessing services, community awareness of service	6	16
Service quality improvement initiatives	5	14

Views on approaches to supporting FAOs in the addictions literature

Participants' rated the extent that services should be designed/orientated around four approaches we identified in the conceptual literature review. The four approaches were:

1. Supporting FAOs to influence the person who is gambling;
2. Improving the relationships between FAOs and the person who is gambling;
3. Supporting FAOs to enhance their own wellbeing;
4. Engaging FAOs and communities to develop gambling harm reduction techniques.

Orientation towards enhancing FAO wellbeing, improving family relationships and engaging FAOs and communities in harm reduction activities were clearly preferred over supporting FAOs to influence the gambler.

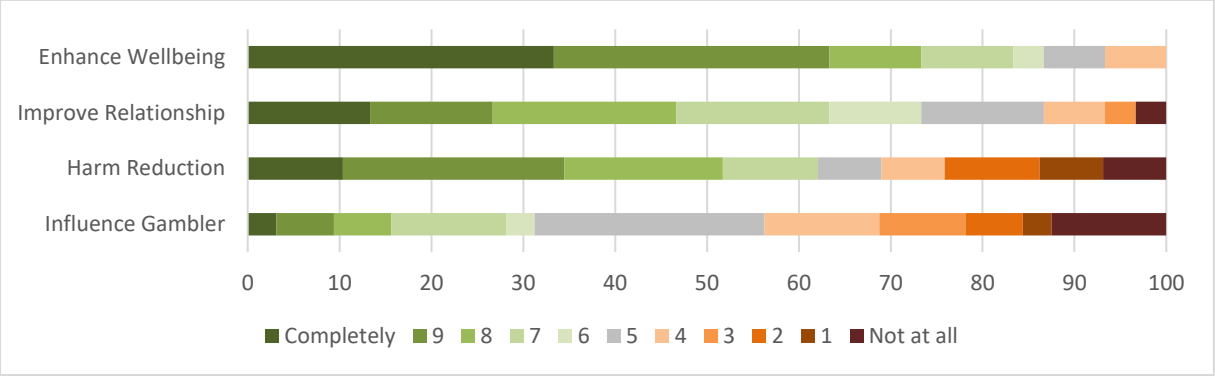

Figure 3. The extent that services should designed/orientated to the four approaches

In general, there was a large amount of uncertainty regarding effectiveness/appropriateness of each approach. What was clear, however, was that approaches that focus on supporting the FAO to influence the gambler were consistently rated the lowest on effectiveness and appropriateness (more "not at all" and "not effective/appropriate" responses). Moreover, approaches that focus on supporting FAOs to enhance their wellbeing were rated as "highly effective" and "effective" the most often. The reasons behind panel members' ratings were teased out in their responses to the open-ended questions. These are explored in more depth in the following sections which focus on participants views on each approach. Generally, supporting FAO wellbeing, as an end goal in itself, was seen as the most appropriate. Participants highlighted that FAOs are often in acute distress, and for many FAOs who could benefit from support their relative is currently not engaged in treatment or contemplating change. Further, from a family systems perspective, helping the FAO would likely benefit the relative too.

The four intervention approaches were seen to be somewhat reflected in current practice. A single or combined mix of 'Supporting FAOs to influence the person who is gambling' and 'Improving the relationships between FAOs and the person who is gambling' was identified as most common within current practice. 'Supporting FAOs to enhance their own wellbeing' and 'Engaging FAOs and communities to develop gambling harm reduction techniques' were not as well recognised or taken up as harm prevention/reduction approaches. Participants converged on the notion that each of the four approaches was necessary to engage and explore in far greater depth to address and prevent gambling harm for FAOs, e.g.:

> *"The whole range is needed to ensure learning impacts positively on the patient as well as the FAO." (Clinician, researcher, service manager, UK)*

"All of the approaches have validity, however I feel a range needs to be offered. The safety of FAO and the person who is gambling needs to be fully assessed." (Clinician, Australia)

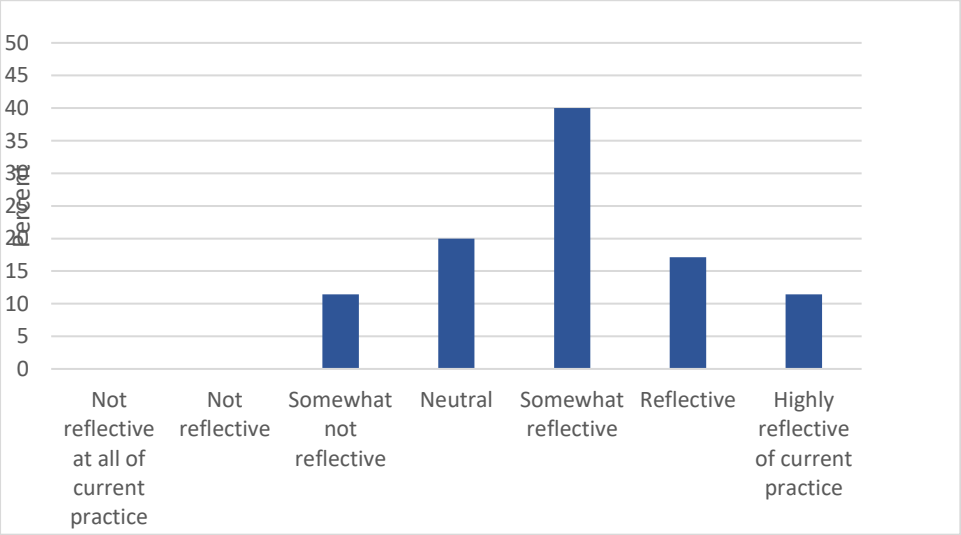

Figure 4. The extent that the four researcher-identified approaches are reflective of current practice with FAOs

A key challenge was identified in terms of services having access to and understanding of a range of approaches and being able to engage the approach/s best suited to affected families. Participants noted that generally it was the practitioner/s or the organisational structure and culture which determined the priority given to the approaches – rather than service users and/or the evidence base. This was seen as problematic.

"Really a good comprehensive service would not just be based on one or two of those approaches but, by engaging FAOs fully, would respond with whichever approach(es) were requested/considered most suitable." (Clinician, service manager, UK)

"I would want to provide all the interventions described [in the literature], according to client needs and desires, and integrated with treatment services for the person with the gambling problem. The flexibility of the approach is difficult to actualize as professionals develop ideas of what is required and orient services in that way." (Researcher, Canada)

Constraints and possibilities for service design and FAO wellbeing were inherent within each way of conceptualising support (discussed in the following sections). Complexity (e.g. multiple co-existing individual, social/cultural/contextual and relational considerations) was held to be the norm in work supporting families.

Developing a social approach to supporting FAOs

Panel member responses regarding additional approaches not reflected in the literature highlighted that service user and practice-based knowledge was not well represented.

Additional approaches not covered by the four identified approaches related to (1) culturally specific approaches; (2) harm prevention approaches; (3) family inclusive practice and impacts on children; and (4) social approaches using notions of social cohesion, social capital, family mobilisation, and collective action.

> *"None of the approaches mentioned engage with a social approach. They all look at outcomes in terms of individuals not families or communities." (Researcher, NZ)*

Taken together, participants' comments on missing approaches suggested a 'social approach' to supporting FAOs is needed to complement the more individual bio-psychological approaches that dominate the addictions field. The social approach holds that 'gambling harm', 'recovery' and 'wellbeing' are socially and culturally constructed and enacted phenomena. The meanings that are given to them, the way they are experienced, and what constitutes quality and effective support/intervention are shaped by particular family, community, cultural, gender and broader societal dynamics in play. This includes the practices of industries and governments, service organisational contexts and funding models. Participants who drew on this way of understanding harm/recovery described the integrity and wealth of relationships available to people as a defining feature of wellbeing and recovery capital:

> *"Recovery involves 'family' (defined in the broadest sense, could be flatmates), and questioning where are the opportunities for strengthening relationships in this nexus? How safe is it to connect? From a service development perspective this suggests being set up to support incremental change in relationships over a long period of time, family inclusion to equip them, culturally based approaches and community engagement to strengthen social capital." (Researcher, clinician, NZ)*

This approach directs ongoing service attention to the social contexts in which harm/recovery is produced in the families/communities they serve, e.g. through community development and advocacy work. It also encourages the conceptualisation of additional social process and outcomes evaluation criteria:

> *"Missing key outcomes are to support local and national political action to change the environments either causing or exacerbating harm" (Service manager, NZ).*

> *"Engagement with families and communities would be my preferred starting point. The key outcome here is tino rangatiratanga." (Service manager, NZ)*

Five participants reported that the approaches models and frameworks identified in the addictions literature did not recognise and properly provide for tino rangatiratanga (sovereignty) and mana motuhake (autonomy) of hauora Māori (indigenous Māori health). It was suggested that partnerships and processes are reviewed to ensure that Māori are able to participate in decision making about service delivery for whānau.

Supporting FAOs to enhance their own wellbeing;

Panel members were asked to consider the key elements of effectively supporting FAOs to enhance their own wellbeing. Providing assurance that the needs of family and affected others are at least as important as the person who is gambling, and responding in a client centred way were identified by more than half of the panel members. The importance of trauma informed care was also emphasised, alongside a focus on stress, strain, coping and social support.

Table 14: Key elements of effective interventions to support FAOs to enhance their own wellbeing

Key Elements (coded qualitative responses)	*n* = 20	%
Provide assurance that FAO needs are important	11	55
Key elements are unique to the FAO and family/whānau	9	44
Matching the service / counsellors' therapeutic approach to FAOs	7	35
Trauma informed care	7	35
Explore wider support networks for FAO	4	20
Address stress, strain, coping, and social support	4	20
Other (e.g. 'unsure')	4	20
Ensure safety for family members is considered	3	15
Cultural safety / incorporating culturally appropriate procedures	2	10
Provide psychoeducation to enhance understanding of gambling / addictions	2	10

The panel also identified a range of constraints and opportunities of this approach for service design and FAO wellbeing including:

Identifying unique and wide-ranging needs to inform family-centred approaches

Participants reported that FAO-centric service provision must allow enough time spent identifying FAO (and broader community) needs, so that family-centred approaches could be developed and implemented. In many communities, this groundwork has yet to be completed. The key outcomes of approaches that focus on FAO wellbeing could be wide ranging, e.g. improvements in FAO mental and physical health; FAOs leaving feeling heard, understood, and validated; and tino rangatiratanga (self-determination, family and community empowerment).

Addressing the problem gambling behaviour

The panel described approaches that focus on FAO wellbeing as particularly important because in many circumstances the individual with the gambling problem was not willing or able to change or access support. Two participants commented that the effectiveness of this approach will be limited if the gambling individual/behaviour is not explicitly addressed.

Incorporating understanding of cultural complexity and collective communities

A focus on individual FAO wellbeing was held to be less valuable for individuals living in a collective culture (e.g. some Asian families). However if FAO wellbeing support was developed and implemented appropriately, it had the possibility of empowering the individual in ways that would follow through to the wellbeing of the family. Whānau ora, wrap around support, family-inclusive practice, and culturally appropriate methods of addressing wellbeing were reported to ensure that both individual health and family/whānau health needs were

addressed. Examining intergenerational patterns in culture and worldviews was highlighted as important to provide holistic insight into ways to coordinate services and resources for families of diverse heritage.

Improving the relationships between FAOs and the person who is gambling

Panel members were asked to consider the key elements of approaches that effectively improve the relationship/s between FAOs and the person who is gambling. There was less consensus than divergence in views on what constitutes key elements of this approach, however enhancing communication skills was identified by half of the panel. Effective intervention was mainly conceptualised at the individual level (e.g. increasing FAOs understanding of family dynamics, and gamblers' understanding of the impact of their gambling on FAOs). Some participants constructed improving relationships at a broader societal level (e.g. understanding the context of gambling as wider society/cultural issues and increasing support networks in communities).

Table 15: Key elements of effective interventions to improve the relationship/s between FAOs and the person who is gambling

Key Elements (coded qualitative responses)	*n* = 22	%
Enhancing communication skills	11	50
Focus on building and strengthening relationships (gambling as a sub-focus)	8	36
Ensuring an understanding of family dynamics / family roles	7	32
Other (e.g. 'unsure but critical approach', 'ensure not offered in isolation')	7	32
Rebuilding trust in families	6	27
Enhancing gamblers' understanding of the consequences of their actions	4	18
Understanding the context of gambling (e.g. wider society/cultural issues)	3	14
Increasing support networks in communities	2	9
Determine safety of family/whānau (e.g. domestic violence, impact on children)	2	9
Multiple key elements that are unique to the family/whānau	2	9
Cultural safety / incorporating culturally appropriate procedures	1	5
Implementing strategies for relationship conflict	1	5

The panel also identified a range of constraints and opportunities of this approach for service design and FAO wellbeing including:

Viewing gambling harm as a relational (rather than an individual) issue

Participants reported that a focus on the family and relationships allowed exploration of and support for the relational context for gambling harm and recovery: couple, family, culture and community. However, the possibilities of this approach for conceptualising support beyond individuals was limited by an emphasis in research and service design on individual outcomes and 'couples therapies'. Three participants noted that family systems approaches have been shown to have a powerful effect on substance use and harm, yet were rarely enacted in the gambling services. These participants advocated for gambling workforce development in family systems work, alongside pilot projects and evaluation strategies.

Family relationships are built and maintained through social and cultural contexts

In general, this approach was considered appropriate for use with diverse communities, to the extent that social and cultural factors are taken into consideration. The design and delivery of the specific service utilising this approach would differ depending on the needs of the community served. For example, it was reported that Western models of family functioning can overemphasise 'independence' and 'individual behaviour and self-expression'. Awareness of how cultural norms and power dynamics play out within Māori, Pacific and Asian families and communities was held to be underdeveloped in some services. Responding to social and cultural dynamics required that a safe space and culturally responsive ways of working were available to families; for example, five participants mentioned that kaupapa Māori or Māori-focused approaches should be available and accessible to Māori whānau.

Engaging FAOs and communities to develop gambling harm reduction techniques.

Panel members were asked to consider the key elements of interventions that effectively engage FAOs and communities to develop gambling harm reduction techniques. These included resourcing families and communities to participate in community activism/action, policy and service development, and supported sharing of lived experiences to reduce stigma. A role for families within services as mental health support workers and consumer advisors was also mentioned.

Table 16: Key elements of effective interventions to support FAOs and communities to develop gambling harm reduction techniques

Key elements (coded qualitative responses)	*n* = 18	%
Providing families and communities with resources to get involved with community activism / policy	7	41
Respectful consultation and joint participation/collaboration with communities	7	41
Lived experience to enhance community awareness / reduce stigma	6	25
Support and training for FAO to ensure they have a voice and can safely share their experience (e.g. ensure safety, clarity about process, ability to withdraw)	5	29
Other (e.g. unsure)	3	18
Public health training (gambling and addictions) for staff in other sectors	2	12
Consumer advisors and peer support workers employed by service	2	12
Prior therapeutic work for FAOs to address acute harms	1	6
Having a long-term service plan/strategy around 'lived experience'	1	6

The panel also identified a range of constraints and opportunities of this approach for service design and FAO wellbeing including:

Lived experience of FAOs and communities to develop gambling harm reduction techniques

Engaging FAOs in harm reduction was held to effect larger (environmental) change and raise awareness of gambling as a public health issue. This approach was key to ensuring that the lived experience of FAOs was reflected in service and policy design, development, and evaluation – maintaining the relevance of services to affected communities. The collective

voice of FAOs' lived experiences could contribute to community wellbeing through peer support and advocacy/activism initiatives (e.g. media work, lobbying, and policy submissions).

'Activism' vs 'therapy', 'empowerment' vs 'exploitation'

Several participants advanced the notion that supporting FAO participation in community activism and change practices/processes may not be compatible with individual therapeutic goals. Other participants cautioned against the potential exploitation of 'lived experience' in service design, promotion, mental health support work, and public health practice (awareness raising) given that significant shame and stigma remains in the community regarding gambling addiction. Families affected by gambling harm may be vulnerable and underserved in a range of areas of their lives.

Further, one participant cautioned that this approach is not transformed into a mechanism for placing additional responsibility for addressing gambling harm producing environments on families. These comments point to tensions between therapy or support work, community development work and political engagement/advocacy, and complex ethical issues around professional practice.

Supporting FAOs to influence the person who is gambling

Although the least preferred approach overall, panel members reported a wide range of key elements of approaches that effectively support FAOs to influence the person who is gambling. Note that no key elements were endorsed by more than half of participants who answered this question. A key element, mentioned by nine participants (38%), was ensuring that FAO wellbeing is also supported.

Table 17: Key elements of effective interventions to support FAOs to influence the person who is gambling

Key Elements (coded qualitative responses)	*n* = 24	%
Ensuring FAO wellbeing is supported	9	38
Enhance communication skills	7	29
Repair family relationships	6	25
Enhance education on gambling (triggers, responses, enabling behaviours etc.)	6	25
Enhance ability to support gambler (to stop gambling, enter treatment etc)	6	25
Family dynamics and safety is considered	5	21
Multiple key elements that are unique to the FAO and family/whānau	4	17
Cooperation from gambling individual	2	8
Clear guidelines/procedures are followed (e.g. CRAFT)	2	8
Other (e.g. not enough knowledge about approach)	2	8
Ensure FAO financial security	1	4
Cultural safety / incorporating culturally appropriate procedures	1	4

The panel also identified a range of constraints and opportunities of this approach for service design and FAO wellbeing including:

Responding to FAO identified needs

The panel reported that many FAOs request support to help the gambler access treatment and/or change. In these cases, this approach was seen an important component of service provision that responds to FAO-identified needs. However, participants were generally uncertain about the effectiveness of this approach in encouraging treatment-seeking, reducing gambling behaviour or supporting FAO wellbeing. Some panel members described the need to design and build an evidence base for programs that provide families from diverse social and cultural backgrounds with strategies to motivate problem gamblers to acknowledge their problem and seek help.

Social and cultural complexity shapes FAOs ability to influence gambling in their families

Limits on FAOs' ability to create change in/for gamblers were discussed, as well as the potential for interventions emphasising gambler change to 'set FAOs up to fail' (basing support around the needs/behaviours of another, often treatment-resistant, person). FAO safety could be jeopardised given (1) gendered power differentials in family dynamics, and (2) the rate of domestic violence in the addictions field. Caution was advised regarding this approach to supporting FAOs who are women. Some participants reported that in the absence of a broader social change/effort to encourage/allow men to take on caring roles and seek support for these issues, this approach has the potential to reinforce gender roles of women being the 'carer' in families - increasing the pressure and responsibility on women. Additionally, participants described how in some cultures and families where there is a strong patriarchal family structure (e.g. some Asian and Pacific families), it is highly unlikely that a woman could effectively challenge, shape or influence the gambling behaviour of her male partner/spouse, particularly in the absence of broader whānau/family engagement and support.

Most panel members were clear that this approach was generally inappropriate and unethical for use with children. However, a panel member with expertise/experience in relation to Pacific populations reported that in some whānau contexts, young adults and children can be highly influential whilst in others the children would be at risk if they challenged the gambling behaviour of their parents or elders.

Endorsement of literature inspired statements

Endorsement of literature inspired statements (see Round 1 questionnaire, Appendix One), suggested strong support for social harm prevention and reduction and a focus on FAO wellbeing. There were diverging opinions around the relationship between supporting FAOs and reduction or improvement in the gambler/gambling behaviour. Over 75% of participants agreed with the notions that 'All gambling harm interventions should seek to involve wider family/whanau'. Over two thirds of the panel agreed that 'Much of what is discussed, decided on and done for FAOs in current services is ad-hoc and lacks strategy', however the remaining participants were neutral/unsure.

Strong support for social harm prevention and reduction and a focus on FAO wellbeing

Analysis of 26 statements indicating convergence (agreement by over 80% of the panel) revealed a preference for social harm reduction approaches and a focus on FAO wellbeing. Social approaches maintained a focus that was broader than the individual and included a clear

harm prevention focus e.g. ‘It is important to teach young people how media, industry, family and peers influence opportunities and decisions to gamble’. Strong support for engaging service user and community knowledge and experience to reduce harm was evident, e.g. ‘Active engagement of FAOs in gambling harm reduction policy and service design is vital for harm reduction’, ‘Gambling harm reduction interventions for FAOs should be defined by the communities most affected’, and ‘FAOs require a supportive collective environment so that they can share their experiences and gain support from one another’.

The importance of social and cultural context (including gender, cultural and socioeconomic background) for both the development of support and the evidence base was highlighted, e.g. ‘Social and cultural context must inform the design and implementation of support for FAOs’ and ‘Practice-based evidence must be taken seriously within service transformation, where the lived-experience of service users, family members, and practitioners are recognised.’

A focus on supporting FAO wellbeing independently of the gambler was clearly endorsed by the panel, e.g. ‘FAOs can be supported to reduce their distress and cope more effectively, even if the person with the gambling problem does not seek treatment’, ‘FAOs should be the focus of help and support in their own right, without necessary reference to the gambler's needs or issues’. The panel also converged on support for two key statements relevant to supporting FAOs to influence the person who is gambling: ‘FAOs can support behaviour change in the person who is gambling, even if the gambler never accesses formal treatment’ , ‘Including FAOs in the treatment of gamblers improves gambler treatment engagement, adherence, and overall outcome’.

Table 18. Statement ratings suggesting convergence

Statement	Strongly agree	Agree	Some-what agree	Neutral	Some-what disagree	Disagree	Strongly disagree
	%	%	%	%	%	%	%
Practitioners must integrate knowledge of the social and cultural context of people, families and whānau they are working with.	79.3	20.7	0.0	0.0	0.0	0.0	0.0
Practice-based evidence must be taken seriously within service transformation, where the lived-experience of service users, family members, and practitioners are recognised.	69.0	24.1	3.4	3.4	0.0	0.0	0.0
Social and cultural context must inform the design and implementation of support for FAOs.	62.1	37.9	0.0	0.0	0.0	0.0	0.0
The most important thing professionals can do is listen non-judgmentally to FAOs as they describe the problem in their own terms.	58.6	27.6	10.3	0.0	0.0	3.4	0.0
Interventions for families should include learning about problem gambling, coping skill development, and support from peers and professionals.	58.6	31.0	6.9	3.4	0.0	0.0	0.0
It is important to teach young people how media, industry, family, and peers influence opportunities and decisions to gamble.	55.2	34.5	10.3	0.0	0.0	0.0	0.0
FAOs can be supported to reduce their distress and cope more effectively, even if the person with the gambling problem does not seek treatment.	51.7	41.4	6.9	0.0	0.0	0.0	0.0
Many gambling harms are largely a product of wider structural and societal forces that shape gambling availability, practices, and impacts.	48.3	41.4	10.3	0.0	0.0	0.0	0.0
Active engagement of FAOs in gambling harm reduction policy and service design is vital for harm reduction.	44.8	24.1	24.1	3.4	3.4	0.0	0.0
Enabling access to community resources or facilities will contribute to reducing the negative impact of gambling on FAOs in the long-term.	44.8	34.5	10.3	6.9	0.0	3.4	0.0
Approaches to FAO support must engage with the cultural realities shaping how 'coping' is and can be practiced.	41.4	41.4	6.9	10.3	0.0	0.0	0.0
There are common experiences among FAOs which need to be addressed, including high stress, strain in the form of physical and psychological	41.4	34.5	20.7	3.4	0.0	0.0	0.0

symptoms, coping dilemmas, and difficulties in obtaining good quality social support.							
Gambling services should orient themselves to address the social and cultural constraints on receiving support (e.g. providing services in conjunction with childcare for FAOs who are women).	41.4	34.5	20.7	0.0	0.0	3.4	0.0
Addressing gambling harm in families with children involves creating space for children to have a voice.	37.9	34.5	20.7	6.9	0.0	0.0	0.0
Community / consumer activism can play a significant role in reducing gambling harms.	37.9	34.5	20.7	3.4	3.4	0.0	0.0
We need to acknowledge gambling harm as both personal and social.	37.9	51.7	6.9	3.4	0.0	0.0	0.0
There are many reasons why FAOs may need to end their relationships with people experiencing gambling problems.	34.5	31.0	17.2	13.8	3.4	0.0	0.0
Family focused intervention should create opportunities for families to spend time together outside of opportunities created by gambling.	34.5	37.9	17.2	10.3	0.0	0.0	0.0
FAOs can support behaviour change in the person who is gambling, even if the gambler never accesses formal treatment.	31.0	41.4	24.1	0.0	3.4	0.0	0.0
FAOs should be the focus of help and support in their own right, without necessary reference to the gambler's needs or issues.	31.0	37.9	17.2	13.8	0.0	0.0	0.0
FAOs require a supportive collective environment so that they can share their experiences and gain support from one another.	31.0	44.8	13.8	6.9	0.0	3.4	0.0
Working with families is not about restoring them to 'full health' but about helping them to enjoy the richness of life, with or without gambling.	31.0	24.1	31.0	13.8	0.0	0.0	0.0
Intervention with FAOs must respond to gender-related issues for gambling and harm.	27.6	44.8	17.2	6.9	0.0	3.4	0.0
Including FAOs in the treatment of gamblers improves gambler treatment engagement, adherence, and overall outcome.	17.2	41.4	31.0	6.9	0.0	0.0	3.4
Gambling harm reduction interventions for FAOs should be defined by the communities most affected.	13.8	31.0	41.4	6.9	6.9	0.0	0.0
FAOs should be required to identify themselves as 'dysfunctional' or ' not coping' in order to access support.	0	3.5	0	0	10.3	31.0	55.2

Divergence around the importance of reduction or improvement in the gambler/gambling behaviour

There were diverging opinions around the relationship between supporting FAOs and reduction or improvement in the gambler/gambling behaviour, i.e. mixed support for the notions that 'Effective interventions for FAOs must address the gambling behaviour', 'FAOs of problem gamblers may unintentionally contribute to the gambling problem' and 'Equipping the FAO to support the gambler into treatment will improve outcomes for the FAO.

Clear divergence was seen around the notion that problem gambling reflects an unbalanced family system, the idea that 'Men may not be as negatively affected as women by a problem gambler', and an aspect of some forms of empowerment practice, namely that 'FAO's decisions should be supported by clinicians, even if those decisions might lead to harm'.

Divergence was also evident around statements in alignment with 12-step approaches to supporting FAO wellbeing, e.g. that 'FAOs are not responsible for resolving the gambler's problem', 'If FAOs can be encouraged to understand and accept the gambling problem, they can then focus on rebuilding their own lives', and 'It is vital for FAOs to acknowledge their lack of control over the gambler'.

While there was a large amount of support for these statements (over 75% of participants endorsing them), some participants contested the idea that 'The voices of service users are still not listened to in service design and delivery' and 'Support for FAOs must address factors in the wider social environment such as pro-gambling work culture, government acceptance of gambling products, and those responsible for producing and promoting gambling machines and services'.

Table 19. Statement ratings suggesting divergence

Statement	Strongly agree	Agree	Some-what agree	Neutral	Some-what disagree	Dis-agree	Strongly disagree
	%	%	%	%	%	%	%
Problem gambling is the outcome of an unbalanced family system.	3.4	0.0	17.2	20.7	13.8	20.7	24.1
It is possible that men may not be as negatively affected as women by a problem gambler.	6.9	6.9	20.7	17.2	20.7	10.3	17.2
FAO's decisions should be supported by clinicians, even if those decisions might lead to harm.	0.0	6.9	20.7	31.0	20.7	17.2	3.4
Effective interventions for FAOs must address the gambling behaviour.	10.3	13.8	27.6	10.3	17.2	17.2	3.4
If FAOs can be encouraged to understand and accept the gambling problem, they can then focus on rebuilding their own lives.	10.3	10.3	27.6	24.1	17.2	0.0	10.3
It is vital for FAOs to acknowledge their lack of control over the gambler/gambling behaviour.	10.3	20.7	24.1	20.7	17.2	6.9	0.0
Equipping the FAO to support the gambler into treatment will improve outcomes for the FAO.	13.8	27.6	37.9	3.4	6.9	6.9	3.4
Support for FAOs must address factors in the wider social environment such as pro-gambling work culture, government acceptance of gambling products, and those responsible for producing and promoting gambling machines and services.	24.1	41.4	13.8	3.4	13.8	3.4	0.0
FAOs of problem gamblers may unintentionally contribute to the gambling problem (e.g. through enabling behaviours).	17.2	20.7	34.5	10.3	13.8	3.4	0.0
FAOs are not responsible for resolving the gambler's problem, encouraging them to engage and complete treatment, or managing their behaviour.	24.1	34.5	20.7	6.9	6.9	3.4	3.4
The voices of service users are still not listened to in service design and delivery.	17.2	24.1	37.9	6.9	6.9	3.4	3.4

Good support for involving family, but some uncertainty around couples' therapy for FAO harm reduction

There was good support for family involvement in gambling care, e.g. over 75% of participants agreed with the notions that 'All gambling harm interventions should seek to involve wider family/whanau', 'Couple therapy can improve communications style… so that gambling as a way of dealing with distress is no longer needed' and 'Stronger family relationships set the foundation for change in the gambler'. This support was tempered by neutrality/uncertainty and some disagreement. In particularly, there was less certainty around whether 'Couple therapy is more effective for FAO wellbeing than individual therapy for the gambler' (supported by 41.4% of the panel), and 'Rebuilding couple relationships is a critical part of recovery for both gamblers and FAOs' (supported by 51.7%).

While still supported by at least half of the panel, there was less certainty and more disagreement around the notions that 'Gambling and addictions services often overlook the complex interplay of addiction and intimate relationships' and 'FAOs know best how to address harms within their communities'. Over two thirds of the panel agreed that 'Much of what is discussed, decided on and done for FAOs in current services is ad-hoc and lacks strategy', however the remaining participants were neutral/unsure.

Table 20. Statement ratings suggesting uncertainty

Statement	Strongly agree	Agree	Some-what agree	Neutral	Some-what disagree	Disagree	Strongly disagree
	%	%	%	%	%	%	%
Couple therapy is more effective for FAO wellbeing than individual therapy for the gambler.	6.9	17.2	17.2	44.8	3.4	6.9	3.4
Much of what is discussed, decided on, and done for FAOs in current services is ad-hoc and lacks strategy.	17.2	31.0	20.7	31.0	0.0	0.0	0.0
Rebuilding couple relationships is a crucial part of recovery for gamblers and FAOs and should therefore become the focus of intervention.	0.0	13.8	37.9	27.6	10.3	6.9	3.4
Interventions designed to support FAOs to influence the person who is gambling have tended to involve women (e.g. partners and mothers).	10.3	44.8	17.2	27.6	0.0	0.0	0.0
There is a lack of understanding of how men can support the treatment and/or recovery of gamblers.	10.3	20.7	24.1	24.1	13.8	3.4	3.4
Gambling and addictions services often overlook the complex interplay of addiction and intimate relationships.	24.1	27.6	6.9	24.1	10.3	3.4	3.4
FAOs know best how to address harms within their communities.	20.7	13.8	27.6	20.7	13.8	0.0	3.4
Treating FAOs as contributing to the gambling problem can marginalise them and discourage their service use.	34.5	27.6	6.9	17.2	6.9	3.4	3.4
All gambling harm interventions should involve wider family/whānau	24.1	27.6	24.1	17.2	3.4	3.4	0.0
Improving family relationships will improve the outcomes for the FAO.	20.7	27.6	31.0	17.2	0.0	3.4	0.0
Given the reluctance of many gamblers to seek help, influencing and engaging gamblers in treatment through FAOs is vital for harm reduction.	17.2	10.3	48.3	13.8	0.0	6.9	3.4
Stronger family relationships set the foundation for change in the gambler.	13.8	27.6	34.5	13.8	6.9	0.0	3.4
Couple therapy can improve communication style, self-esteem, and self-awareness so that gambling as a way of dealing with stress and distress in the family is no longer needed.	3.4	31.0	44.8	13.8	6.9	0.0	0.0

Knowledge gaps: Informing FAO support

Participants identified three key gaps in knowledge needed to inform FAO support services and practices identified by the panel: (1) exploration of service-user and practice-based knowledge, (2) research with diverse groups, and (3) research utilising diverse approaches.

Exploration of experiential and practice-based knowledge

A significant gap identified was the lack of practice-based knowledge reflected in the literature. The current evidence base for FAO support was described as emerging and theoretically informed (e.g. drawing largely on cognitive behavioural and motivational understandings of behaviour change). Experiential and practice-based knowledge held by families from diverse backgrounds, and those involved in service design and provision was underexplored.

Research with diverse groups

Participants identified a lack of engagement with men and diverse cultural groups in the evidence base. Exploring needs of different families and communities and consultation and engagement were seen to be important prerequisites for service development. This was followed by appropriate outcome studies and a culture of service learning and evaluation. It was consistently identified by panel members that there remains a paucity in research with the above focus; thus, it was difficult to quantitatively respond to questions on effectiveness and appropriateness of FAO support and intervention approaches. It was reported that some minority groups who experience social disadvantage, marginalisation and discrimination often expect research findings and published evidence to confirm society's negative views. As a result, it can be difficult to engage with these communities in research aimed at improving responsiveness and outcomes. Thus, it was made that clear that any research conducted with diverse ethnic groups, needed to be conducted appropriately, with clear cultural engagement, and led by appropriate researchers/principle investigators.

Research with diverse approaches

Several different approaches were discussed as in use by panel members; however, these interventions were not present in the literature. For example, interventions that explored whakapapa (cultural genealogical approaches), whānau hui (gathering), approaches that engaged with sociocultural issues (e.g. Asian acculturative stress ‘Tree Model’), yoga meditation and mindfulness were described by panel members, yet do not yet have a presence in the evidence base. Consideration of a wider array of prevention and harm reduction techniques was suggested including peer support, and community activism and advocacy work.

Participants identified a lack of exploration of prevention/health promotion practices with families. Much of the literature is focussed on individuals in therapy, yet panel members reiterated the importance of diverse family-centric approaches. Indigenous and sociologically informed approaches to engaging with families could offer a method to shift away from an individual focus.

AUT GAMBLING & ADDICTIONS RESEARCH CENTRE

APPENDIX TWO: Participant Information Sheet

PARTICIPANT INFORMATION SHEET
Enhancing Support Provided for Family Members and Affected Others in New Zealand Gambling Services

Researchers: Dr Katie Palmer du Preez, Associate Professor Jason Landon, Dr Giulia Lowe and Laura Mauchline.

Research aims and description
Harm experienced by the family members and affected others (FAOs) of people experiencing problems with gambling (and other addictive products) can be severe. Partners and especially children, may suffer both mental and physical health problems connected to living in a state of fear, anger, guilt, despair, loss and uncertainty as well as loss of safety and financial security. Appropriate and timely support may reduce the severity and range of harms individuals and families experience. However there is no widely accepted best practice for supporting and intervening with FAOs, limited research available to support engagement, as well as limited understanding of the range of techniques and strategies currently used.

You are invited to participate in a study exploring how services and support provided for family members and affected others (FAOs) in NZ gambling services could be enhanced. The aim of the study is to identify available services for FAOs in NZ, enhance understanding of best practice, and to ascertain what else might be needed for effective service development and provision. It is hoped that findings from the study will demonstrate the need and value of support services for FAOs in New Zealand, as well as showcase the work currently being done.

How was I identified and why am I being invited to participate in this research?
We wish to draw on the expertise and experience of national and international researchers, clinicians, consumer advisors, service managers, and policymakers (including the New Zealand Ministry of Health) who have knowledge of FAO intervention/services in gambling and/or broader addictions.

What will participation involve?
If you agree to participate, you will be invited to take part in a Critical Delphi panel. The Critical Delphi method is a structured method for eliciting expert opinion and critical reflection, which relies on establishing a panel of experts. The researchers will develop a questionnaire and an interview schedule based on a critical review of evidence for effective FAO service design and delivery, including evidence from related fields, e.g. family interventions for alcohol and drug issues and relevant gender and cultural issues. Critical reviews go beyond summarising prior research to evaluate evidence on both a methodological and conceptual level.

The Critical Delphi method will involve two rounds of surveys with an optional interview, in which the second round is informed by the responses given in the first round. There will be the possibility of a third round. In the first round, you will be asked to complete a questionnaire and take part in an interview. You may choose to participate in the survey component only. The researchers will then analyse responses and send the results to participants to review. In

the second round you will invited to complete a questionnaire and, based on round one responses, a select number of participants will be invited to take part in a second interview to clarify and deepen thematic analysis.

The interviews and questionnaires will include rating scales and open ended questions about your understanding of best practice, quality and effective FAO support and service delivery, how you believe FAO service delivery could be enhanced, and factors that have contributed to, or impeded effective service delivery.

Diagram of Delphi process

If you are based in Auckland, the interview will take place at a time and location of convenience to you – for example, at an office at AUT or other private office space. If you are based outside of Auckland, the interview will take place over the telephone or via video-call (Zoom/Skype) at a time convenient to you. It is anticipated that each interview will last approximately 60 minutes. The interview would, with your consent, be audio recorded and transcribed by a professional transcription service.
The questionnaire will be made available online for completion at a time and place convenient to you.

To arrange an interview, please contact Dr Palmer du Preez (katie.palmerdupreez@aut.ac.nz) or Dr Lowe (giulia.lowe@aut.ac.nz) within the next two weeks.

Anonymity and confidentiality:
Due to a small number of potential participants in some expert groups, only limited confidentiality can be offered to those who choose to participate in this research. The extent of this confidentiality is outlined in the following text. Your decision to participate in this research

(or not) and all information collected from you will remain confidential to the researchers. The researchers will not solicit any information of a personal nature from participants about themselves, other staff members, or clients. Transcriptions of interviews will be stored using a code number and not your name. Responses returned to participants in round two (and potentially round three) will be provided in summary form with no identifying information. Your name will only appear on the consent form, which will be stored separately from transcriptions. All information collected during this research will be stored in a locked filing cabinet and in password-protected electronic files for six years following publication of research findings. It will only be accessible to the researchers. After six years, all data will be destroyed (paper records will be shredded and electronic files will be permanently deleted).

Research findings will be produced in a report and may be published in academic journals or presented at national and international conferences. Data collected as part of this study may be provided to students in the future for secondary analyses as part of their qualification (e.g. honours dissertation). Identifying information will be removed, and a pseudonym will be given to any of your data used in publications or student researcher. This means that your identity will never be made public.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. Once the findings have been produced (approx. date: July 2020), removal of your data will not be possible.

Risks and benefits

There are no anticipated risks to participating in this research. We hope that you find participation in this research encouraging and supportive of the important work that you do.

Costs of participating in this research: An interview is likely to last 45-60 minutes. A questionnaire will take approximate 30-45 minutes to complete. Overall, your time commitment to this study is likely to be between 1 and 3 hours over the course of approximately five months.

Research findings

You are welcome to a summary of the research findings (please indicate at the interview whether you would like to receive a copy). The summary of findings will be sent via email after the study has been completed. A copy of the final report will be made available on the Gambling and Addictions Research Centre website (https://niphmhr.aut.ac.nz/research-centres/gambling-and-addictions-research-centre).

Queries or concerns

If you agree to participate, we will ask you to sign a consent form indicating that you have understood the information in this letter. If you have any further questions about this project you can contact the research team at the addresses below.

Dr Katie Palmer du Preez (primary researcher) Gambling and Addictions Research Centre	Dr Giulia Lowe Gambling and Addictions Research Centre Auckland University of Technology

AUT GAMBLING & ADDICTIONS RESEARCH CENTRE

Auckland University of Technology
Ph. 09 921 9999 ext. 7640
katie.palmerdupreez@aut.ac.nz

Ph. 09 921 9999 ext. 8164
giulia.lowe@aut.ac.nz

Any queries regarding ethical or conduct concerns should be notified to Kate O'Connor, the Executive Secretary of Auckland University of Technology Ethics Committee: email: *ethics@aut.ac.nz*; Phone 921 9999 ext. 6038

This research was approved by the Auckland University of Technology Ethics Committee on 8 November, 2019, Reference number 19/387.

Please keep this Information Sheet and a copy of the Consent Form for your future reference.

Thank you for taking the time to consider this research.

AUT GAMBLING & ADDICTIONS RESEARCH CENTRE

APPENDIX THREE: Round One Questionnaire

PAGE 0 – CONSENT

QUESTIONNAIRE: INFORMATION & CONSENT

Enhancing Support Provided for Family Members and Affected Others in New Zealand Gambling Services

Researchers: Dr Katie Palmer du Preez, Dr Giulia Lowe, Associate Professor Landon, Laura Mauchline.

Thank you for participating in this Delphi study investigating quality and effective service design and delivery for family and others affected by gambling harm (FAOs). Below is a summary of information you would have received in your Participant Information Sheet in the email inviting you take part in this research. Please read thoroughly before continuing onto the next page.

Research aims and description: We wish to draw on your expertise and experience from working within the gambling and/or wider addictions sector to provide insight into appropriate and effective FAO support. It is hoped that findings from the study will reinforce the need and value of support services for FAOs, document current practice, as well as suggest opportunities for enhancement and/or development.

This questionnaire forms *the First Round* of the Critical Delphi Study and will take approximately 1 hour to complete. In this round, the questionnaire will include open-ended questions and ranking statements that have been developed as a result of a review of AOD, tobacco, and gambling FAO intervention studies. Support for FAOs is an emerging and growing area of research and practice. This Delphi study is an opportunity for gambling studies to consolidate existing knowledge and to learn from approaches taken with FAOs affected by other harmful commodities. Your experience and perspective will be used to enhance our understanding of how FAO services could be enhanced in the gambling field.

Following completion of this *round-one* questionnaire, the researchers will collate and analyse responses. You will be sent a summary of your own responses, and responses provided by the entire Delphi panel, along with a link to the next questionnaire (*round two*).

Anonymity and confidentiality: Due to a small number of potential participants, only limited confidentiality can be offered to those who choose to participate in this research. Only de-identified results will be reported or published. Your participation in this research is voluntary and whether you choose to participate will neither advantage nor disadvantage you. You can withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. Once the findings have been produced (approx. date: July 2020), removal of your data may not be possible.

Research findings: The findings from this research will be produced in a publicly available report for the Ministry of Health (research funder), published in academic journals, and presented at conferences. Data collected as part of this study may be provided to students in the future for secondary analyses as part of their qualification.

Risks and benefits: There are no anticipated risks to participating in this research. Findings from this study will have the potential to positively benefit policy and practice. Finally, we hope that you find participation in this research encouraging and supportive of the important work that you do.

Queries or concerns: Any queries regarding ethical or conduct concerns should be notified to Dr Carina Meares, the Executive Secretary of Auckland University of Technology Ethics Committee: email: *ethics@aut.ac.nz*; Phone 921 9999 ext. 6038

This research was approved by the Auckland University of Technology Ethics Committee on 8 November 2019; reference: 19/387

Thank you again for your participation in this research. To proceed, please click the "consent and proceed" button below, this indicates that you have read and understood the information on this screen and consent to taking part in this research. The survey will begin on the following screen.

AUT GAMBLING & ADDICTIONS RESEARCH CENTRE

☐ **Consent and proceed**

PAGE 1: Introduction

PART ONE: INTRODUCTION AND DEMOGRAPHIC QUESTIONS

This study is focussed on exploring evidence-based practice in gambling harm reduction services for family and affected others. We hold that it is very unlikely that any single treatment system can address all issues for all families. We wish to facilitate open and meaningful dialogue around a wide range of responses to gambling issues for families.

There are multiple perspectives on evidence-based practice. For example, the empirical-analytical perspective focuses on experimental evidence (e.g. interventions that seem to produce significant shifts in measures of stress or wellbeing). The phenomenological perspective views intervention success through people's experiences of well-being. Finally, from a values-based perspective, interventions are evaluated based on principles such as inclusion, equity, self-determination, participation, and empowerment.

The goal of this inquiry is to draw on your experience, along with a range of others with knowledge of FAO support practice in gambling, alcohol and other addictions. The panel involves people with experience in practice, policy, service design and research as well as people with lived experience (service users). Through engagement with you all, a set of integrated recommendations for evidence-based practice in gambling harm reduction services may emerge. This process allows for doubt and uncertainty - We seek to explore a broad spectrum of possible treatment approaches for FAOs that may not always align.

We are inviting participants to bring the perspective or perspectives on evidence-based practice that make sense to them, to answer a series of questions related to this main question: What is evidence-based practice in gambling harm reduction services for family and affected others (FAOs)?

PAGE 2: Background information / Demographic

To start, we are asking for your email so that we are able to provide feedback on round one responses and for you to indicate whether you would be able to take part in an interview in the second round.

Email address: (*Compulsory Question*)

In the next round of this Delphi study we would like to conduct some interviews with some of our panel members, so that we can get a more detailed understanding of their experiences. Is this something you might be interested in helping with? (*Compulsory Question*)

- ☐ Yes → email
- ☐ No thanks, I would like to complete the questionnaires only.

Now we move onto the main body of the questionnaire: These initial questions will provide us with some background information regarding your experience with services and interventions for FAOs affected by problematic use of gambling, tobacco, and/or AOD

<u>Is your experience in relation to (select all that apply):</u> (*Compulsory Question*)

- ☐ Family and others affected by gambling (gambling FAOs)
- ☐ Family and others affected by alcohol and/or other drugs (AOD FAOs)
- ☐ Family and others affected by tobacco (tobacco FAOs)
- ☐ Other. → Include text box for participant to elaborate

Which of the following best describes your area relating to support for FAOs? (*Compulsory Question*)

- ☐ Policy
- ☐ Service management
- ☐ Research
- ☐ FAO support practitioner
- ☐ Consumer/lived experience
- ☐ Other. → Include text box for participant to elaborate

How many years have you been working in the FAO support space? (*Compulsory Question*)

PAGE 3: Background information / Demographic – open-ended.

The following questions will ask you to tell us about the different groups you have worked, studied or have experience with. If any of the groups are not relevant to you, leave the question blank.

Please briefly describe your role, experience and/or expertise regarding support provided for family and others affected by gambling, alcohol and/or tobacco (FAOs) (*Compulsory Question*)

Please describe any role, experience and/or expertise in intervention with FAOs of different genders (men, women, non-binary)

Please describe any role, experience and/or expertise in intervening with FAOs of different cultural heritage or ethnicity

Please describe any role, experience and/or expertise in intervening with FAOs of different age groups

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PAGE 4: Introductory opinion questions

The following section is focussed on your perspective: The questions are aimed at understanding your experiences and opinion of FAO services including, their purpose, why they might be needed, and what more is needed.

This Delphi study is about exploring the array of ideas, opinions, and experiences – so feel free to get creative with your answers and consider the range of factors that impact or are impacted by addictions and services for FAOs. Please consider your role and experience when answering each question. Please write as much as little as you feel necessary to answer the question.

What sorts of services do FAOs request (tick all that apply)? (*Compulsory Question*)

- ☐ Information about addictions
- ☐ Self-help resources for FAOs

- ☐ Self-help resources for addictions
- ☐ Professional support for FAOs - in person
- ☐ Professional support for FAOs - online
- ☐ Support groups for FAOs
- ☐ Support groups for gamblers/users
- ☐ Professional support for the gamblers/user – in person
- ☐ Professional support for the gamblers/user - online
- ☐ Other (please specify)

What is the overarching purpose of providing support/intervention services for FAOs affected by addiction? (*Compulsory Question*)

What are the main reasons an FAO might engage with addiction support services? (*Compulsory Question*)

What do FAOs need from services? (*Compulsory Question*)

What are the key features of a quality and effective addictions service for FAOs? (*Compulsory Question*)

What are the important outcomes of an addictions service / intervention for FAOs?
(Consider the range of outcomes including immediate impacts (e.g. on service user) or broader affects (e.g. on the community) (*Compulsory Question*)

How would you measure the quality and effectiveness of an addictions service for FAOs?
(*Compulsory Question*)

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PART TWO: LITERATURE REVIEW INFORMED QUESTIONS

The researchers reviewed FAO intervention research in the AOD, gambling, and tobacco fields. From this literature review, the researchers identified four intervention approaches (ways of conceptualising FAOs and their intervention needs) which have produced and informed intervention practices. We would like you to consider both the possibilities and drawbacks of these approaches for gambling harm reduction drawing on *your area of expertise (AOD, tobacco etc), mode of work (individual treatment, public health etc), or lived experience.*

I. Supporting FAOs to influence the person who is gambling

FAOs have been positioned as a valuable resource in rehabilitation and treatment efforts. This approach positions FAOs as 'intervention allies' and as 'agents of change'. It holds that through learning productive engagement tactics or behaviour change techniques, FAOs can contribute to improvements in the individual with the gambling problem by encouraging them to seek and remain in treatment, and experience benefits themselves e.g. a sense of power, purpose and direction and reduced helplessness

- *Central to approach: Supporting FAOs to influence the individual with problematic gambling to change or engage in treatment will improve the outcomes for the FAO.*

II. Improving the relationship/s between FAOs and the person who is gambling:

FAOs can be seen as part of an affected family system with implications for their therapeutic journey. This approach holds that the family system has been harmed by the problem gambling and needs to be addressed relationally. Joint couples and/or family intervention or consultation is recommended. A key purpose of intervention is about mending the family system as a whole; this is done through communication, rebuilding trust, and acquiring understanding of each family member's perspective. General family or couple distress is addressed under the assumption that by improving family functioning and connectedness broadly, FAO wellbeing will improve.

- *Central to approach: Improving family relationships will improve the outcomes for the FAO.*

III. Supporting FAOs to enhance their own wellbeing:

This approach holds that the needs of FAO may not be compatible or aligned with the needs of the person who is gambling. Supporting FAO wellbeing is seen as an end-goal in itself (independently of any change in problem gambling behaviour or other outcomes for the person who is gambling). From this perspective, FAOs should become the focus of support in their own right, without necessary reference to the gambler's needs or issues. While addiction related issues in the family might produce stress, strain and/or trauma, FAOs can be supported to articulate and reduce their distress and cope more effectively, whether or not the gambling behaviour changes.

- *Central to approach: Focus of support is the FAO wellbeing regardless of whether or how the individual with the gambling problem changes or seeks help.*

IV. Engaging and empowering FAOs to develop gambling harm reduction strategies:

Harm reduction approaches recognise that as gambling is a legal and accessible practice, some people will gamble, and some will experience harm. As such, minimisation of the potential for harm is a key goal for intervention. These interventions for FAOs focus on enabling family to influence gambling practices and harm in their communities (e.g. through local policy). The narrative is shifted from individual harm to community or political level harm minimisation. Affected families and communities should be supported to be active and involved in determining harm reduction methods, considering contextual factors that contribute to harm (e.g. cultural, gender, socioeconomic factors), and creating interventions which promote equity and empowerment of communities.

- *Central to approach: Supporting families to name and influence the broader drivers of gambling practices and harm in their communities.*

	In your experience, to what extent do the approaches described above reflect the range of current practice in support available for FAOs?						
Unsure	1 Not at all	2 Not reflected	3 Somewhat not reflected	4 Neutral	5 Somewhat reflected	6 Reflected	7 Highly reflected

(*Compulsory Question*)

Please **(1)** discuss your thoughts on the intervention approaches summarised above and **(2)** list any additional approaches of FAO interventions that you can think of: (*Compulsory Question*)

(1) **(2)**

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PART THREE: FAO SERVICES

This section asks for more detailed responses on the four main intervention approaches the researchers identified through the literature review. You will be asked to identify if you have evidence for the intervention approach, the possible outcomes of the approach, and the effectiveness for different populations. You will also be asked to identify if evidence is lacking.

The questions are repeated for each approach, we realise this may become repetitive, but we hope you bear with us and respond to each subsection as an individual set of questions.

PAGE 7

I. Supporting FAOs to influence the person who is gambling

Central to approach: Supporting FAOs to influence the individual with problematic gambling to change or engage in treatment will improve the outcomes for the FAO.

Please consider your role and experience when answering each question. Please write as much as little as you feel necessary to answer the question. If a question is not relevant to you, select or write N/A. NOTE: The Likert questions require an answer, the open-ended question can be left blank if you do not wish to comment.

Please list examples of interventions you are familiar with that 'support FAOs to influence the person who is gambling'

Please comment:

What are the key outcomes <u>for FAOs</u>, of intervention approaches that 'support FAOs to influence the person who is gambling'?

Please comment:

(*Compulsory Question*)	Please rate how effective you think interventions are that focus on supporting FAOs to influence the person who is gambling						
N/A or unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective
	Please comment:						

What are the key elements of effective interventions to 'support FAOs to influence the person who is gambling'?

Please comment:

PAGE 8

Central to approach: Supporting FAOs to influence the individual with problematic gambling to change or engage in treatment will improve the outcomes for the FAO.

(*Likert questions compulsory*)

	How appropriate is this intervention approach for working with FAOs who are women?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with women FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

	How appropriate is this intervention approach for working with men FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with men FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

	How appropriate is this intervention approach for working with FAOs who are gender diverse?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with FAOs who are gender diverse?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

What are your thoughts on this approach when working with FAOs who are women, men, or gender diverse?

PAGE 9

Central to approach: Supporting FAOs to influence the individual with problematic gambling to change or engage in treatment will improve the outcomes for the FAO.

(*Likert questions compulsory*)

	How appropriate is this intervention approach for working with young FAOs? (e.g. children)						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with young FAOs? (e.g. children)						
Unsure	1	2	3	4 Neutral	5	6 Effective	7

	Not at all effective	Not effective	Somewhat ineffective		Somewhat effective		Highly effective
	How appropriate is this intervention approach for working with older adult FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with older adult FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

What are your thoughts on this approach when working with FAOs who are children? Or older adults?

PAGE 10

Central to approach: Supporting FAOs to influence the individual with problematic gambling to change or engage in treatment will improve the outcomes for the FAO.

(*Likert questions compulsory*)

	How appropriate is this intervention approach for working with New Zealand Māori FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with Māori FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly Effective

	How appropriate is this intervention approach for working with Pacific FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with Pacific FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

	How appropriate is this intervention approach for working with Asian FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with Asian FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

	How appropriate is this intervention approach for working with minority or other indigenous FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with other minority or other indigenous FAOs?						

Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

What are your thoughts on this approach when working with culturally diverse and/or minority communities?

PAGE 11

Central to approach: Supporting FAOs to influence the individual with problematic gambling to change or engage in treatment will improve the outcomes for the FAO.

(*Likert question compulsory*)

	To what extent should services be oriented/designed to support FAOs to influence the individual who is gambling? (*move the slider along the scale)*	
Unsure	1 Not at all designed / orientated in this way	7 Completely designed / orientated in this way
	Please comment:	

From your perspective, what evidence is lacking/needed to inform the design of services to support FAOs to influence the individual who is gambling?

Please comment:

PAGE 12

II. Improving the relationship/s between FAOs and the person who is gambling:

Central to approach: Improving family relationships will improve the outcomes for the FAO.

Please consider your role and experience when answering each question. Please write as much as little as you feel necessary to answer the question. If a question is not relevant to you, select or write N/A. NOTE: The Likert questions require an answer, the open-ended question can be left blank if you do not wish to comment.

Please list examples of interventions you are familiar with that 'improving the relationship/s between FAOs and the person who is gambling'

Please comment:

What are the key outcomes for FAOs, of intervention approaches that 'improving the relationship/s between FAOs and the person who is gambling'?

Please comment:

(*Compulsory Question*)	Please rate how effective you think interventions are that focus on improving the relationship/s between FAOs and the person who is gambling						
N/A or unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

	Please comment:

What are the key elements of effective interventions to 'support FAOs to influence the person who is gambling'?

Please comment:

PAGE 13

Central to approach: Improving family relationships will improve the outcomes for the FAO.

(*Likert questions compulsory*)

	How appropriate is this intervention approach for working with FAOs who are women?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with women FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

	How appropriate is this intervention approach for working with men FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with men FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

	How appropriate is this intervention approach for working with FAOs who are gender diverse?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with FAOs who are gender diverse?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

What are your thoughts on this approach when working with FAOs who are women, men, or gender diverse?

PAGE 14

Central to approach: Improving family relationships will improve the outcomes for the FAO.

(*Likert questions compulsory*)

	How appropriate is this intervention approach for working with young FAOs? (e.g. children)						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate

	How effective is this intervention approach for working with young FAOs? (e.g. children)						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective
	How appropriate is this intervention approach for working with older adult FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with older adult FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

What are your thoughts on this approach when working with FAOs who are children? Or older adults?

PAGE 15

Central to approach: Improving family relationships will improve the outcomes for the FAO.

(*Likert questions compulsory*)

	How appropriate is this intervention approach for working with Māori FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with Māori FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly Effective

	How appropriate is this intervention approach for working with Pacific FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with Pacific FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

	How appropriate is this intervention approach for working with Asian FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with Asian FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

	How appropriate is this intervention approach for working with minority or other indigenous FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate

	How effective is this intervention approach for working with other minority or other indigenous FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

What are your thoughts on this approach when working with minority communities?

PAGE 16

Central to approach: Improving family relationships will improve the outcomes for the FAO.

(*Likert question compulsory*)

	To what extent should services be oriented/designed to improve family relationships? (*move the slider along the scale)*	
Unsure	1 Not at all designed / orientated in this way	7 Completely designed / orientated in this way
	Please comment:	

From your perspective, what evidence is lacking/needed to inform the design of services to support FAOs to influence the individual who is gambling?

Please comment:

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III. Supporting FAOs to enhance their own wellbeing

Central to approach: Focus of support is the FAO wellbeing regardless of whether or how the individual with the gambling problem changes or seeks help.

Please consider your role and experience when answering each question. Please write as much as little as you feel necessary to answer the question. If a question is not relevant to you, select or write N/A. NOTE: The Likert questions require an answer, the open-ended question can be left blank if you do not wish to comment.

Please list examples of interventions you are familiar with that 'support FAOs to enhance their own wellbeing'

Please comment:

What are the key outcomes for FAOs, of intervention approaches that 'support FAOs to enhance their own wellbeing'?

Please comment:

(*Compulsory Question*)	Please rate how effective you think interventions are that focus on supporting FAOs to enhance their own wellbeing

N/A or unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective
	Please comment:						

What are the key elements of effective interventions to 'support FAOs to influence the person who is gambling'?

Please comment:

PAGE 18

Central to approach: Focus of support is FAO wellbeing regardless of whether or how the individual with the gambling problem changes or seeks help.

(*Likert questions compulsory*)

	How appropriate is this intervention approach for working with FAOs who are women?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with women FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

	How appropriate is this intervention approach for working with men FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with men FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

	How appropriate is this intervention approach for working with FAOs who are gender diverse?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with FAOs who are gender diverse?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

What are your thoughts on this approach when working with FAOs who are women, men, or gender diverse?

PAGE 19

Central to approach: Focus of support is the FAO wellbeing regardless of whether or how the individual with the gambling problem changes or seeks help.

(*Likert questions compulsory*)

	How appropriate is this intervention approach for working with young FAOs? (e.g. children)						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with young FAOs? (e.g. children)						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective
	How appropriate is this intervention approach for working with older adult FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with older adult FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

What are your thoughts on this approach when working with FAOs who are children? Or older adults?

PAGE 20

Central to approach: Focus of support is the FAO wellbeing regardless of whether or how the individual with the gambling problem changes or seeks help.

(*Likert questions compulsory*)

	How appropriate is this intervention approach for working with Māori FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with Māori FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly Effective

	How appropriate is this intervention approach for working with Pacific FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with Pacific FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

	How appropriate is this intervention approach for working with Asian FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with Asian FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

	How appropriate is this intervention approach for working with minority or other indigenous FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with other minority or other indigenous FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

What are your thoughts on this approach when working with minority communities?

PAGE 21

Central to approach: Focus of support is the FAO wellbeing regardless of whether or how the individual with the gambling problem changes or seeks help.

(*Likert question compulsory*)

	To what extent should services be oriented/designed to support FAO wellbeing regardless of whether or how the individual with the gambling problem changes or seeks help? (*move the slider along the scale)*
Unsure	1 Not at all designed / orientated in this way — 7 Completely designed / orientated in this way
	Please comment:

From your perspective, what evidence is lacking/needed to inform the design of services to support FAOs to influence the individual who is gambling?

Please comment:

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IV. Engaging FAOs and communities to develop gambling harm reduction techniques

Central to approach: Supporting families to name and influence the broader drivers of gambling practices and harm in their communities.

Please consider your role and experience when answering each question. Please write as much as little as you feel necessary to answer the question. If a question is not relevant to you, select or write N/A. NOTE: The Likert questions require an answer, the open-ended question can be left blank if you do not wish to comment.

Please list examples of interventions you are familiar with that are about 'engaging FAOs and communities to develop gambling harm reduction techniques'

Please comment:

What are the key outcomes for FAOs, of intervention approaches that 'engage FAOs and communities to develop gambling harm reduction techniques'?

Please comment:

(*Compulsory Question*)	Please rate how effective you think interventions are that focus on engaging FAOs and communities to develop gambling harm reduction techniques						
N/A or unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective
	Please comment:						

What are the key elements of effective interventions to 'engage FAOs and communities to develop gambling harm reduction techniques'?

Please comment:

PAGE 23

Central to approach: Supporting families to name and influence the broader drivers of gambling practices and harm in their communities.

(*Likert questions compulsory*)

	How appropriate is this intervention approach for working with FAOs who are women?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with women FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

	How appropriate is this intervention approach for working with men FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with men FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

	How appropriate is this intervention approach for working with FAOs who are gender diverse?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with FAOs who are gender diverse?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

What are your thoughts on this approach when working with FAOs who are women, men, or gender diverse?

PAGE 24

Central to approach: Supporting families to name and influence the broader drivers of gambling practices and harm in their communities.

(*Likert questions compulsory*)

	How appropriate is this intervention approach for working with young FAOs? (e.g. children)						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with young FAOs? (e.g. children)						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective
	How appropriate is this intervention approach for working with older adult FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with older adult FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

What are your thoughts on this approach when working with FAOs who are children? Or older adults?

PAGE 25

Central to approach: Supporting families to name and influence the broader drivers of gambling practices and harm in their communities.

(*Likert questions compulsory*)

	How appropriate is this intervention approach for working with Māori FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with Māori FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly Effective

	How appropriate is this intervention approach for working with Pacific FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with Pacific FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

	How appropriate is this intervention approach for working with Asian FAOs?						
Unsure	1	2	3	4	5	6	7

	Not at all appropriate	Not appropriate	Somewhat inappropriate	Neutral	Somewhat appropriate	Appropriate	Highly appropriate
	How effective is this intervention approach for working with Asian FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

	How appropriate is this intervention approach for working with minority or other indigenous FAOs?						
Unsure	1 Not at all appropriate	2 Not appropriate	3 Somewhat inappropriate	4 Neutral	5 Somewhat appropriate	6 Appropriate	7 Highly appropriate
	How effective is this intervention approach for working with other minority or other indigenous FAOs?						
Unsure	1 Not at all effective	2 Not effective	3 Somewhat ineffective	4 Neutral	5 Somewhat effective	6 Effective	7 Highly effective

What are your thoughts on this approach when working with minority communities?

PAGE 26

Central to approach: Supporting families to name and influence the broader drivers of gambling practices and harm in their communities.

(*Likert question compulsory*)

	To what extent should services be oriented/designed to support families to name and influence the broader drivers of gambling practices and harm in their communities? (*move the slider along the scale)*	
Unsure	1 Not at all designed / orientated in this way	7 Completely designed / orientated in this way
	Please comment:	

From your perspective, what evidence is lacking/needed to inform the design of services to support FAOs to influence the individual who is gambling?

Please comment:

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PART FOUR: AGREEMENT/DISAGREEMENT WITH STATEMENTS

In the following section we present a series of statements or claims that have been made in or inspired by the FAO support literature. Please indicate your agreement with the following statements in relation to support for family and others affected by gambling. Remember, we are interested in your views on the potential applicability to gambling harm reduction, whether or not you have specific experience in gambling support.

Page 28 - 32

I. Supporting FAOs to influence the person who is gambling

1. FAOs of problem gamblers may unintentionally contribute to the gambling problem (e.g. through enabling behaviours).
2. Equipping the FAO to support the gambler into treatment will improve outcomes for the FAO.
3. Including FAOs in the treatment of gamblers improves gambler treatment engagement, adherence, and overall outcome.
4. Given the reluctance of many gamblers to seek help, influencing and engaging gamblers in treatment through FAOs is vital for harm reduction.
5. FAOs can support behaviour change in the person who is gambling, even if the gambler never accesses formal treatment.
6. There is a lack of understanding of how men can support the treatment and/or recovery of gamblers.
7. Interventions designed to support FAOs to influence the person who is gambling have tended to involve women (e.g. partners and mothers).
8. Effective interventions for FAOs must address the gambling behaviour.

II. Improving the relationship/s between FAOs and the person who is gambling

9. Improving family relationships will improve the outcomes for the FAO.
10. Problem gambling is the outcome of an unbalanced family system.
11. Rebuilding couple relationships is a crucial part of recovery for gamblers and FAOs and should become the focus of intervention.
12. Addressing gambling harm in families with children involves creating space for children to have a voice.
13. Stronger family relationships set the foundation for change in the gambler.
14. .
15. Gambling and addiction services often overlook the complex interplay of addiction and intimate relationships
16. Couple therapy can create shifts in communication style, self-esteem, and self-awareness such that gambling as a way of dealing with stress and distress in the family is no longer needed.

Couple therapy is more effective for FAO wellbeing than individual therapy for gamblers

III. Supporting family and affected others to enhance their own wellbeing

17. Treating FAOs as contributing to the gambling problem can marginalise them and discourage their service use
18. FAOs should be the focus of help and support in their own right, without necessary reference to the gambler's needs or issues.
19. FAOs are not responsible for resolving the gambler's problem, encouraging them to engage and complete treatment, or managing their behaviour
20. The most important thing professionals can do is listen non-judgementally to FAOs as they describe the problem in their own terms
21. FAOs can be supported to reduce their distress and cope more effectively, even if the individual with the gambling problem does not seek treatment.
22. Approaches to FAO support must engage with the cultural realities shaping how 'coping' is and can be practiced FAOs require a supportive collective environment so that they can share their experiences, and gain support from one another
23. If FAOs can be encouraged to understand and accept the gambling problem, they can then focus on rebuilding their own lives.
24. It is vital for FAOs to acknowledge their lack of control over the gambler/gambling behaviour

25. There are many reasons why FAOs may need to end their relationships with people experiencing gambling problems.
26. Interventions for families should include learning about problem gambling, coping skill development, and support from peers and professionals.
27. There are common experiences amongst FAOs which need to be addressed, including high stress, strain in the form of physical and psychological symptoms, coping dilemmas, and difficulties in obtaining good quality social support.

IV. Engaging FAOs in gambling harm reduction activities

28. Practitioners must integrate knowledge of the social and cultural context of the people, families and whānau they are working with
29. Support for FAOs must address factors in the wider social environment such as a pro-gambling work culture, government acceptance of gambling products, and those responsible for producing and promoting gambling machines and services.
30. Gambling services should orient themselves to address the social and cultural constraints on receiving support (e.g. providing services in conjunction with childcare for women FAOs).
31. FAOs should not be required to identify themselves as 'dysfunctional' or 'not coping' in order to access support.
32. Active engagement of FAOs in gambling harm reduction policy and service design is vital for harm reduction.
33. It is important to teach young people how media, industry, family, and peers influence decisions to gamble and the ability to recognise high-risk situations.
34. Many gambling harms are largely a product of wider structural and societal forces that shape gambling availability, practices and impacts.
35. Community / consumer activism can play a significant role in reducing gambling harms.
36. Working with families is not about restoring them to 'full health' but about helping them to enjoy the richness of life, with or without gambling.
37. FAO's decisions should be supported by clinicians, even if those decisions might lead to harm.
38. FAOs know best how to address harms within their families and communities.
39. Enabling access to community resources or facilities will contribute to reducing the negative impact of gambling on FAOs in the long-term.
40. Family focused intervention should create opportunities for families to spend time together outside of the opportunities created by gambling.
41. Gambling harm reduction interventions for FAOs should be defined by the communities most affected.
42. We need to acknowledge gambling harm as both personal and social.
43. The voices of service users are still not listened to in service design and delivery

Other statements

44. Much of what is discussed, decided on and done for FAOs in current services is ad-hoc and lacks strategy.
45. Practice-based evidence must be taken seriously within service transformation, where the lived-experience of service users, family members, and practitioners are recognised.
46. All gambling harm interventions should involve wider family/whanau.
47. Social and cultural context must inform the design and implementation of support for FAOs.
48. Intervention with FAOs must respond to gender-related issues for gambling and harm.
49. It is possible that men may not be as negatively affected as women by a problem gambler

If you would like to add or comment on any of the statements, please do so here:

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PART FIVE: FINAL QUESTIONS

The final part of *round one* includes a question that draws on experience and creativity. Please feel free to write as much or as little as you feel necessary to answer the question.

Blue skies thinking without limitations (financial or otherwise): How would you design a service to reduce gambling harm for family and affected others?

Please provide any additional thoughts/comments/ideas/gaps:

Thank you for taking the time to complete *round one* questionnaire

AUT GAMBLING & ADDICTIONS RESEARCH CENTRE

APPENDIX FOUR: Round Two Questionnaire

ROUND TWO: Enhancing Support Provided for FAOs in New Zealand Gambling Services

Information and Consent (as per Round One questionnaire)

Q81 **INTRODUCTION** This study is focused on exploring evidence-based practice in gambling harm reduction services for family and affected others. We hold that it is very unlikely that any single treatment system can address all issues for all families. We wish to facilitate open and meaningful dialogue around a wide range of responses to gambling issues for families. Round one comprised an in-depth questionnaire; responses were wide-ranging and detailed, allowing the researchers to develop a comprehensive summary of findings. Round two will follow on from round one and will focus on the possibilities and constraints associated with service provision. The goal of this inquiry is to draw on your experience, along with a range of others with knowledge of FAO support practice in gambling, alcohol and other addictions. The panel involves people with experience in practice, policy, service design and research as well as people with lived experience (service users). Through engagement with you all, a set of integrated recommendations for evidence-based practice in gambling harm reduction services may emerge. This process allows for doubt and uncertainty - We seek to explore a broad spectrum of possible treatment approaches for FAOs that may not always align. *Round two* seeks to bring together the findings of *round one* by examining how we can incorporate different approaches into the design and evolution of services. We are inviting participants to bring the perspective or perspectives on evidence-based practice that make sense to them, to answer a series of questions related to this main question: What is evidence-based practice in gambling harm reduction services for family and affected others?

Q26 To start, please enter your email:

_____

Q233 What are your thoughts on the summary of *round one* responses developed by the researchers?

If needed, a copy of the round one summary is available here: FAO support summary for panel members

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Q520
APPROACHES IDENTIFIED IN THE LITERATURE

Q521 The researchers reviewed FAO intervention research in the AOD, gambling, and tobacco fields. From this literature review, the researchers identified four intervention approaches (ways of conceptualising FAOs and their intervention needs). A number of open-ended and closed questions were asked about each approach in the first round. Analysis of round one responses highlighted an additional approach that was not reflected: The social approach.

The social approach holds that 'gambling harm', 'recovery' and 'wellbeing' are socially and culturally constructed phenomena. The meanings that are given to them, the way they are experienced, and what constitutes quality and effective support/intervention are shaped by particular family, community, cultural, gender and broader societal dynamics in play. This also includes the practices of industries and governments, service organisational contexts, funding models etc. This approach directs services to pay ongoing attention to the ways in which harm/recovery is produced in the families/communities they serve, e.g. community development, advocacy work.

Given the summary of findings from *round one*, we would like you to re-rate the extent you think that services should include each approach in their design/orientation; including the social approach.

Q576 ***If needed, descriptions of the four approaches identified by the researchers are available here:*** Approaches identified in the literature

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Q561 To what extent should services be oriented/designed to support FAOs to influence the individual who is gambling? *0 = Not at all designed / orientated in this way - 10 = Completely designed / orientated in this way*

Unsure

0 1 2 3 4 5 6 7 8 9 10

Move the slider along the scale ()	

Q58 To what extent should services be oriented/designed to improve the relationship/s between FAOs and the person who is gambling? *0 = Not at all designed / orientated in this way - 10 = Completely designed / orientated in this way*

Unsure

0 1 2 3 4 5 6 7 8 9 10

Move the slider along the scale ()	

Q59 To what extent should services be oriented/designed to support FAOs to enhance their own wellbeing? *0 = Not at all designed / orientated in this way - 10 = Completely designed / orientated in this way*

Unsure

0 1 2 3 4 5 6 7 8 9 10

Move the slider along the scale ()	

Q60 To what extent should services be oriented/designed to engage with FAOs and communities to develop gambling harm reduction techniques? *0 = Not at all designed / orientated in this way - 10 = Completely designed / orientated in this way*

Unsure

0 1 2 3 4 5 6 7 8 9 10

Move the slider along the scale ()	

Q22 To what extent should services be oriented/designed to engage with the ways in which harm/recovery is produced in the families/communities they serve? *0 = Not at all designed / orientated in this way - 10 = Completely designed / orientated in this way*

Unsure

	0	1	2	3	4	5	6	7	8	9	10
Move the slider along the scale ()											

Q21

Client-centredness and cultural awareness The panel converged on the need for FAO support services and practices to be both client/family-centered and culturally aware.

Q22 What would a high level of client-centredness look like in gambling service design and practice for FAOs?

Q23 What would a high level of cultural awareness look like in gambling service design and practice for FAOs?

Q25 What is the role of 'lived experience' in FAO service design and delivery?

Q57

Barriers and Enablers The panel largely converged on a 'both/and' approach to FAO inclusive and FAO centred services and practices.

Q60 What are the enablers of FAO inclusive and FAO centred design and practices in gambling services?

Q59 What are the barriers to FAO inclusive and FAO centred design and practices in gambling services?

Page Break

Q23

Knowledge Creation Analysis of responses highlighted that there are significant gaps in knowledge needed to inform FAO services; in particular, the lack of practice-based knowledge (clinician/practitioner, service user knowledge) in the evidence base. Advanced by panel members was the need to foster a culture of openness, curiosity, and ongoing learning regarding FAO support among all stakeholders involved in FAO service design, delivery, and use.

Q24 How do we ensure practice-based knowledge and service-user knowledge is a part of the evidence base?

Q58 How can we build and sustain a culture of curiosity and learning into service design and provision for FAOs?

Q24 How can gaps between researchers/research and practitioners/practice be bridged?

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Q61

This is the final question:

Do you have any final thoughts on ensuring best practice for service design, development, and delivery for use with FAOs affected by gambling?

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