

**Providing Services to Problem and Pathological Gamblers
Through the Single State Authorities (SSAs)**

White Paper on Issues for States

Developed for the

Center for Substance Abuse Treatment

September 2004

Prepared under the

**Center for Substance Abuse Treatment
State Systems Technical Assistance Project**

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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FOREWORD

Within the past 10 years, most States have instituted some form of authorized gaming. Because an estimated 1 to 3 percent of adults and three times as many adolescents who gamble develop compulsive or addictive gambling problems, this national rise in gaming has brought with it an increase in the number of people who need help and treatment. A number of States have asked their Single State Authorities (SSA) to take compulsive gambling under their purview, and these SSAs have been responding with such strategies as public education, prevention, telephone helplines, and treatment.

The Center for Substance Abuse Treatment (CSAT) began to be involved 3 years ago, when CSAT was approached by several States for help with the pathological gambling issue. After sponsoring several conferences, CSAT invited representatives from eight States to meet and share their experiences, concerns, and strategies. This white paper reflects the thinking of this group. We expect it to be an important cornerstone for our shared work with States in addressing the serious negative consequences of at-risk, problem, and pathological gambling.

Combined with substance-related or other mental disorders, pathological gambling is a co-occurring psychiatric diagnosis, recognized in the DSM-IV as an impulse control disorder. Problem gambling has an extraordinarily strong relation to substance abuse, and it is also related to Axis I affective disorders, such as bipolar disease and mood disorders, particularly depression. Pathological gambling is therefore an issue of great concern to the Substance Abuse and Mental Health Services Administration (SAMHSA), which defines co-occurring disorders as one of its major program priorities. To deal effectively with this addictive disorder, those of us in the substance abuse and mental health service delivery system face two central issues:

- 1. Jurisdiction and funding.** Which State system is the most reasonable, and potentially most effective, choice to take responsibility for pathological gambling, and how can programs be funded? SAMHSA's mental health and substance abuse block grants offer only limited resources. Since pathological gambling does not meet the definition of "serious and persistent mental illness" (SPMI) required for public treatment in most jurisdictions, the mental health block grant cannot be used. Funds from the substance abuse block grant could be used in a limited way for co-occurring substance abuse and gambling problems. However, these block grant funds are already inadequate to treat all those with substance abuse problems. Other substantive funds must be found. For instance, States could direct a portion of gambling revenues toward addressing problem gambling, and research arms of the Federal Government could look at addressing problem gambling in grants.
- 2. Effective evidence-based practices.** What are the most effective ways to deal with the addiction and with the profound negative consequences of pathological gambling, which include depression, suicide, child neglect and abuse, loss of jobs, home foreclosures, and domestic violence? In this white paper, the State representatives share their knowledge and recommendations concerning promising strategies and needed research, including ideas about phasing in strategies, credentialing counselors, designing programs, and training

counselors. This white paper takes an important step toward formulating a core of evidence-based practices to help those with compulsive gambling problems.

Legalized gambling has become part of the national American scene, and gambling revenues now play a major role in generating funds for many State governments. While these funds can mean financial rescue for States, they come at a social price. Many States have already recognized their moral obligation to provide services for those unable to walk away from their gambling. We at SAMHSA/CSAT are committed to working with, and raising the consciousness of, State governments about the need for greater resources to deal with this serious issue. We see this white paper as an initial tool that will help SAMHSA direct our efforts with State Governors and counties, define needed research on proven and best practices, and develop strategies for assisting those who suffer the severe consequences of a compulsive gambling disorder.

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I. INTRODUCTION

This white paper responds to concerns expressed by many Single State Authorities (SSA). Increasingly, SSAs are being tasked with the responsibility for addressing gambling addiction within their existing alcohol and drug systems of care. Some States have modified their authorizing legislation to allow for this expansion, and some States are receiving earmarked money to support the treatment. Many SSAs are concerned that their program staffs are not appropriately trained to treat gambling addictions and that their systems are already overwhelmed by the demand for addiction treatment. States are also concerned that providing gambling addiction treatment may displace those with substance use disorders, and that the reimbursement streams for gambling addiction treatment are not well established.

In response to these concerns, the Center for Substance Abuse Treatment (CSAT) invited representatives from seven States to help the Center develop a white paper addressing how best to include gambling addiction under the auspices of the SSAs. The invited States reflect a range of experience with gambling addiction issues—several have well-established gambling service systems, while others are still in the planning stage. Representatives from Indiana, Louisiana, Maine, Michigan, Nebraska, Nevada, New York, and Wisconsin met with CSAT to consider this important issue on June 25, 2004, in Rockville, Maryland. The executive director of the National Association of State Alcohol and Drug Abuse Directors (NASADAD) brought NASADAD's support on this issue. Both the State Association of Addiction Services (SAAS) and the Association of Problem Gambling Service Administrators (APGSA) were also represented at the meeting.

This white paper summarizes the thinking and recommendations of the State representatives on these questions posed by CSAT at the meeting:

- Should problem/pathological gambling treatment be provided in the existing SSA-authorized system of care?
- Is problem/pathological gambling sufficient as an admission diagnosis, or should it be addressed as one treatment component for a substance use disorder diagnosis?
- Are there sufficient reimbursement streams to support the provision of care? The Substance Abuse Prevention and Treatment Block Grant cannot be used for services unrelated to substance-related disorders.
- Does an SSA need statutory language to authorize the provision of treatment for problem/pathological gambling?
- What resources exist to provide clinical consultation and supervision, skill development, and dissemination of best practices in the treatment of problem/pathological gambling?

- What constitutes “good treatment” (assessment, evaluation, treatment planning, discharge, etc.), and what are reasonable outcomes?

CSAT’s Division of State and Community Assistance would like to thank the following State and organization representatives, whose thinking, experience, and recommendations form the content of this white paper:

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II. THE CONTEXT FOR STATE ACTION

What is the Current Climate for Action on Pathological Gambling Issues, and How Might States Most Effectively Approach This Issue?

Participants in the CSAT meeting expressed optimism and enthusiasm about this opportunity to share their experiences and plan how to help other States address problem gambling. Authorized gaming is relatively new for most States, and there is a growing awareness that problem gambling has become a national issue. By 2003, 48 States had legalized gambling and 30 States had already recognized the problem and were allotting funds to prevent and treat pathological gambling among their residents.

State experience with this issue has been growing since the early 1990s, and a few States now have relatively complete systems of care for those with gambling problems. A considerable body of practical information is therefore available. Participants were eager to share their knowledge and bring a halt to the current situation in which States tend to be working independently and “reinventing the wheel” as they start up their programs. Clearly, there is a dearth of well-designed, scientifically based research on best practices for the treatment of pathological gambling. But the States have come a long way in learning about this issue over the last 10 years, and participants agreed on core principles of best practices for this field.

Recommendations

As State agencies work to address this issue, some for the first time, meeting participants made a number of recommendations concerning the most effective ways to approach the issue.

- 1. Assume a neutral stance.** Gaming, like alcohol use by adults, is a legal activity. This initiative is not antigaming; it is about helping those who encounter addictive problems and negative consequences from their legal gaming activities. It is important that the initiative not be seen as aligned with either pro-gambling or antigambling political interests within the State. Also, providing help for compulsive gambling is a public health issue, not a moral issue. The substance abuse field has long fought the moral stigma that society attaches to those who abuse alcohol. The participants hope that gambling problems can be understood and dealt with at all levels as a compulsive disorder, not as a moral failing.
- 2. Recognize the State’s moral responsibility.** Gaming offers States a rich source of revenue. In States benefiting from these funds, it is only just that some portion of these funds be used to assist people victimized by this policy—those whose gambling has become addictive. Many States already acknowledge this responsibility, but the funds being provided are often too little to meet the full scale of the need. It is important for State agencies to present legislatures with the prevalence rate for gambling problems in their States, as well as with the cost of pathological gambling in terms of the social consequences across systems, including the criminal justice and child welfare systems. The aim is for State legislatures to provide sufficient funds to treat all those who need services, as well as to carry out public awareness and prevention campaigns.

- 3. Work with the gaming industry.** States report that the gaming industry is an important ally in the effort to help pathological gamblers. Obviously, the gaming industry generates the funds that will support services for problem gamblers. But in addition, the States' experience is that the gaming industry has been cooperative and supportive in treatment efforts. In one State, the industry is a collaborative partner in assisting treatment providers. The industry also wants help with its substance-abusing employees who, because they lack job skills, keep cycling back to work in the gaming environment where alcohol is constantly present.
- 4. Learn from other States.** In starting or expanding an initiative, reach out to find out what other States already know or have developed. A platform of knowledge already exists, and the State participants at this meeting are eager to share information. SAMHSA is supporting several conferences for States on gambling issues. National organizations and Web sites are available to help States make contact and explore resources. (See the Resource section of this white paper.)
- 5. Be flexible in planning.** Be aware that the provision of services for problem gambling is a new, evolving field where much is being learned. Keep the systems and program planning flexible so that any aspect of the service plan can be refined or revised as new findings emerge.

III. PLACING GAMBLING SERVICES WITHIN A STATE SYSTEM

Which State Jurisdiction Will Be the Most Effective Choice for Managing the State's Compulsive Gambling Services?

Participants reported that clients present with varying diagnoses: (1) compulsive gambling only, (2) compulsive gambling co-occurring with either mental disorders or substance abuse, and (3) compulsive gambling co-occurring with a combination of both mental disorders and substance abuse problems. As a co-occurring disorder, compulsive gambling could reasonably be managed through either a State's authority for mental health or substance abuse.

Among States represented at the meeting, nearly all had gambling services located in their alcohol and other drug (AOD) treatment systems. In five States, the responsibility for gambling services had originally rested with either a mental health or revenue division before being moved to substance abuse. The State representatives reported that their substance abuse divisions had either volunteered or welcomed the responsibility for handling gambling addiction. Participants felt that the substance abuse system was the most appropriate choice to manage gambling services for the following reasons:

- \$ Substance abuse providers are experienced and skilled in treating addictive disorders and are comfortable with this challenging population, whereas mental health providers often are not.
- \$ The origin and vernacular for substance addiction and pathological gambling are conceptually similar and therefore familiar to substance abuse providers, since both disorders involve progression, chronicity, and increasing tolerance.
- \$ Treatment for substance abuse and compulsive gambling involves the same modalities, such as group and individual counseling, spirituality, and 12-Step principles, whereas mental health practitioners more typically deal with medication management and individual counseling.
- \$ The substance abuse treatment community seems willing and often eager to work with clients who have compulsive gambling problems. Mental health providers are often less willing and are hampered by the fact that compulsive gamblers have no money to pay for services, yet are unlikely to qualify for public treatment in the mental health system.

Should Gambling Services be Structured as a Separate System or as a Component of a Larger System?

Too little is currently known about alternative service systems to reach a conclusion about what arrangement would be most desirable. Participants strongly differed on this issue. There was, however, some concern that gambling services might be swallowed up within a larger State system.

View 1: Gambling services require a separate system. At least two States had established separate systems for their gambling services (Louisiana and Indiana). Louisiana operates a separate statewide system that provides a full continuum of gambling services, including two residential treatment centers, intensive outpatient treatment, four other levels of outpatient care, and continuing care. The Louisiana representatives reported that, in their experience, gambling clients treated in separate facilities had considerably better retention and outcomes than when treatment occurred in a substance abuse setting. They were skeptical about the feasibility of holding gambling treatment sessions in a substance abuse treatment facility and doubted whether a gambling track located within a substance abuse treatment setting could be successful.

View 2: Gambling services can be successfully offered in substance abuse treatment settings. Other States at the meeting do not have the funds to set up separate gambling treatment facilities, particularly for residential treatment. In Nebraska's experience, gambling clients can be successfully treated in outpatient programs co-located in substance abuse treatment facilities. Several States expressed an interest in trying out pilot tests in which gambling tracks could be set up within substance abuse treatment programs. Because of practical funding issues, several States clearly want to set up gambling programs within the facility infrastructure that already exists. Participants who felt that gambling services could be successfully integrated with the substance abuse treatment system strongly expressed the following cautions:

§ ***The administration of the State's gambling program should be separate from the substance abuse and mental health systems.*** In Nebraska, the gambling services system is located in the substance abuse and mental health division, but it is separately administered. The fund for gambling services is also kept separate. This separation allows the State to maintain separate eligibility criteria for public treatment of people with gambling problems, which is a critical factor. In addition, the gambling program has its own set of operating, facility, and credentialing standards distinct from those for the substance abuse system.

§ ***Programs treating gambling addiction must be seen as distinctly different from those for substance abuse.*** A gambling program absolutely cannot be added onto an existing substance abuse treatment program without substantial change. Programs, and counselors, need to clearly understand the key differences between the clinical treatment of gambling and substance abuse addiction. Section 10 in this white paper, titled "Effective Practice Principles and Outcomes," spells out some of the major differences.

Eligibility for services. The eligibility criteria for publicly funded gambling treatment must be separately defined for the problem gambling population; criteria must not be the same as for publicly funded mental health or substance abuse treatment. Pathological gamblers present for help in the public treatment system because they have huge debt loads and no discretionary income, even though many are working two jobs. SSAs report that the problem gambling population tends to be in the 30- to 50-year age range; many are working at middle- to upper-income jobs. These are people who will not qualify for help if the usual eligibility criteria for substance abuse services are applied—that is, having an income of less than 200 percent of the poverty level. This population also does not qualify as having a serious and persistent mental illness. Separate eligibility criteria must be established so that pathological gamblers can be

treated in the public treatment system. Further, it is important that significant others and family members be eligible for services whether the identified gambler presents for treatment or not.

Should Gambling Services Be Exclusive to Any Single System

Participants agreed that services for compulsive gamblers should not be limited to any single system. One State (Indiana) has located programs in both community mental health centers and in substance abuse treatment facilities. Another State (Nebraska) trains public-sector substance abuse counselors and mental health clinicians, as well as private practitioners—and finds that all can be highly skilled in working with compulsive gambling clients. Participants stressed the following:

§ ***Uniform need for training.*** All clinicians who will be treating people with compulsive gambling addictions should be trained and credentialed before working with this population; one State (Illinois) pays for treatment only when provided by credentialed counselors.

§ ***Development of a specific infrastructure.*** All counselors who receive training also need an extensive period of followup encouragement, support, and supervision. This is because of the extensive learning curve before trained counselors begin to retain the ir troubled gambling clients. This need for longterm followup requires that the State create an infrastructure to support the credentialing, training, and ongoing support of treatment providers.

The meeting participants encouraged States, in setting up services for problem gamblers, to include as many relevant stakeholders as possible. For example, enlisting the help of employers through employee assistance programs would be a positive strategy.

Recommendations

- 1. Locate compulsive gambling services within the State's substance abuse agency as the most logical administrative choice.** Participants felt that the substance abuse system is best equipped and most willing to provide efficient services to the population with addictive gambling problems.
- 2. Plan on the basis of what is best for the client, not convenience for the system.** States will tend to locate gambling services within their State systems in accord with convenience and available funds. As more is learned about the most effective way to organize gambling service systems, it is hoped that States will be able to make their structuring decisions on the basis of what produces the best outcomes for clients and consumers.
- 3. Keep the gambling treatment system administratively separate within the substance abuse system.** Separate administrative standards and a separate funding stream are both essential for the gambling program. Otherwise, certain requirements in the substance abuse system may be barriers to treatment for those needing help with their compulsive

gambling.

4. **Make sure to establish separate eligibility criteria for public gambling services.** Few pathological gamblers will qualify to receive services if they must meet the eligibility criteria established for substance abuse and mental health clients.
5. **Mandate skills standards and training for counselors in all systems that provide services for pathological gambling.** The States' experience is that counselors require a particular set of skills to work successfully with gambling clients. Even after training, counselors undergo a long period of hands-on experience before they can begin to achieve successful outcomes with these challenging clients.
6. **Explore creative cross-agency methods that can integrate services in the many State systems involved with addictive gambling.** SAMHSA is sponsoring a number of initiatives, such as the State Incentive Grants (SIG), that are designed to integrate the efforts of multiple State agencies and are often coordinated through the Governors' offices or State legislatures. Participants hoped that similar efforts may be possible on gambling treatment issues, using innovative strategies to create a coordinated State infrastructure across such areas as mental health, substance abuse, criminal justice, the education system, and family services.

IV. PRESENTING THE CASE FOR GAMBLING SERVICES

What Are the Steps That SSAs Can Take to Initiate or Expand Gambling Treatment Services in Their States?

An SSA needs to work through its State legislature to gain the authorization and adequate funds to address problem gambling issues. In most States, gaming revenues offer a rich resource that should be tapped to meet the true negative costs of problem gambling. It is suggested that SSAs approach this issue in a hardheaded, proactive way. Put together the facts about the extent and costs of problem gambling in the State and present these facts to the legislature. The facts about the need for services should drive the level of funds made available from State gaming revenues.

Prevalence of problem gambling. By far, the most effective strategy is to show legislators the prevalence of lifetime at-risk, problem, and pathological gamblers within the State, particularly if it can be done on a regional basis. Louisiana has done three prevalence studies, using respected local university researchers, and then has been able to meet with legislative committee members to review the findings—convincing them of the need for services district by district. States that cannot afford a prevalence study can use the national prevalence rates on problem gambling. A meta-analysis has been done of all prevalence studies in North America (Shaffer et al. 1997). Regional prevalence rates for problem gambling are likely to fall within the statistical probability rates established in this national meta-analysis. The estimate, based on this meta-analysis, is that 1.6 percent of adults in the United States and Canada have experienced pathological gambling at some point in their lives, while 1.1 percent have experienced it in the last 12 months. An additional 3.85 percent of adults have experienced mild to moderate problems with gambling at some point in their lives but have not progressed to the pathological level.

Need for services. Many SSAs may be able to demonstrate levels of need based on their existing services. Although gambling programs across the country are in their infancy, a look at these existing services suggests a high level of unmet need. Many States have gambling helplines, and as these lines become known, the level of calls escalates. For example, calls to Wisconsin's 24-hour helpline increased by 55 percent in 2 years; Louisiana received more than 50,000 in-State calls on its helpline in 2003. Also, when mental health or substance abuse providers add a problem gambling screen to their assessments, a high level of problem gambling emerges. For example, out of 100 admissions to substance abuse treatment in Nebraska, 30 percent of clients screened positive for co-occurring pathological gambling problems.

Cost benefits of gambling services. SSAs can also point out the cost-effectiveness of treating compulsive gamblers. Providing services for pathological gamblers can save the State money across other systems, reducing the costs that problem gambling exacts in terms of the criminal justice system, child neglect and abuse, domestic violence, and other social systems. In a 1-year pre- and post-treatment study of 500 clients in its gambling assistance program, Nebraska found that gambling treatment reduced the clients' use of both public mental health and substance abuse services.

Needs of special populations. States feel that the extent of gambling problems is like the "elephant in the room"—enormous and unrecognized. There was particular concern that the

needs of special populations are not being identified and addressed. The vulnerable groups that States feel need special attention include:

- \$ **Older adults.** A prevalence study of Florida residents found that almost 2 percent of older adults could be classified as lifetime pathological or problem gamblers, and an additional 8 percent were lifetime at-risk gamblers. More than 1 percent had exhibited pathological or problem gambling in the past year, with almost 4 percent showing at-risk gambling behavior during the year (Volberg 2003).
- \$ **College students.** A great deal of nonlegalized gambling takes place on college campuses, and this can be a major problem for some students. In prevalence studies, community college students consistently demonstrate higher rates of gambling problems than adults (Shaffer and Hall 2001).
- \$ **Public school students.** School systems are beginning to express concern about student gambling, and Michigan is funding a school curriculum to help address this issue among students.

Outcome results. For SSAs that already conduct gambling programs, reports on positive client outcomes are a significant way to ensure continuing legislative support. Outcomes reporting to the legislature needs to be built into the SSA's planning. For startup programs, there is an important caveat. *Startup programs should not be expected to show immediate positive outcomes within the first year.* State legislatures need to understand that gambling programs require significant startup time. The SSA will need months to build the infrastructure and to train providers, who will then need 6 to 9 months of learning before they will be effective with clients. As an example, one State received 3,800 calls in the first year on its gambling helpline and referred 1,200 of those callers to gambling treatment, but only 154 of them actually engaged in treatment. Subsequently, the State has revised its eligibility criteria and is training clinicians to provide a faster response.

Recommendations

The State participants suggested that SSAs undertake the following steps to strengthen their case when approaching State legislatures:

1. **Develop a business plan.** The SSA needs to present a concrete plan for a gambling services program, including level of State need, types of services to be provided, costs, and number of clients to be served. The funds provided would determine the total number of clients who can receive services.
2. **Present the State legislature with prevalence data.** It is recommended that SSAs do a specific study of prevalence within the State, at a district level if possible. Using national prevalence data is an option, if a State study is not feasible. Prevalence data should also be compiled concerning any special populations that the SSA hopes to address. Some prevalence studies on special populations may be available from other States.

- 3. Compile and present existing data on the State costs and consequences of compulsive gambling.** The SSA should look at potential data that can demonstrate and reinforce the social costs that pathological gambling is causing. For example, a high percentage of problem gambling clients are involved with the criminal justice system; it may be possible to compile regional or State data on this. The State rate of suicide among problem gamblers may be a compelling figure. As more pathological gamblers enter treatment services, it will be easier to collect data on related consequences and costs. One State recommended Federal assistance to look at cost benefits from a National perspective.

V. GUIDANCE ON FUNDING ISSUES

What Are the Funding Issues and Opportunities for State Compulsive Gambling Programs?

Finding adequate funding to support problem gambling services is a serious issue. Although at least 30 States now provide funds for gambling services, the overall levels of support for gambling programs are quite low. Among States that provided funding between 2000 and 2003, the per capita allocation ranged from \$0.003 to \$1.04 for gambling services, an average of \$0.31 per capita as compared to \$9 per capita for substance abuse and mental health (Christensen 2003). However, once a State gambling services program has been set up, the SSAs report that the State funds allotted for the program increase over time, sometimes quite dramatically.

Because State systems serving compulsive gamblers are so new, the participants believe that existing programs reach only a tip of the iceberg—a tiny percentage of those who need help with gambling problems. A representative from Louisiana, which has one of the most well-established and well-funded State systems, believes that the programs are serving only 1 percent of the problem gamblers in the State who need help, as compared to serving 8 percent of those with substance abuse problems. At this early stage, States do not know either the total extent of the population that may request gambling services or the total funds necessary to meet that need. Participants did not want to lock their gambling programs into arrangements that could hinder future growth or integrate them into funding streams that might siphon off potential gambling program resources. Participants expressed concern about the following issues:

- \$ **A possible unfunded Federal mandate.** Representatives were concerned that SAMHSA might require treatment for gambling disorders under the block grant without any commensurate increase in funds. CSAT reassured the participants that SAMHSA would not mandate gambling treatment.
- \$ **State fund formulas that could limit future use of gaming funds.** In several States, funds from gaming revenues are being used to support both substance abuse and gambling addiction services. When such funds are allotted on a percentage basis, such as 75 percent for substance abuse and 25 percent for gaming addiction programs, participants feared that such percentages could not be revised even if the need for gambling services escalated. That is because the maintenance of effort (MOE) requirement of the block grant would tie substance abuse funding to the same continued funding level.
- \$ **Combined funding streams that could be cumbersome and swamp the needs of the gambling program.** Participants felt that a funding stream shared with some other system, such as substance abuse, carried built-in disadvantages. The group agreed that a separate funding stream is preferable for a State compulsive gambling program.
- \$ **State funding that is divorced from levels of need.** Some State policymakers may be satisfied that dedicating some money for gambling services is sufficient. It was hoped that SSAs would be able to shape the dialogue. The money made available from State

gambling funds should not be an arbitrary figure; the funding needs to be rationally designed to meet the actual needs of problem gamblers within the State for help and services.

Are There Special Funding Issues That Affect Compulsive Gambling Programs and Individual Consumers?

Gaming addiction programs are unusual because of the long learning curve before trained counselors begin to retain their compulsive gambling clients. For many months, new programs will struggle and will generally retain their clients for only four or five sessions. SSAs need to think about what funding mechanisms will be most encouraging, and cost-effective, under these conditions. As an example of the problem, the HMO system in one State pays a flat per capita per patient annual rate for clients, which produces a reimbursement rate of several hundred dollars per visit for compulsive gambling clients seen just a few times. Some helpful options to consider would be initially paying a new program on a grant basis and then moving to a fee-for-services system as the program becomes established. One State pays programs for their outreach efforts to generate clients and for their outreach to probation officers.

Client attitudes about paying for services is a second unusual issue that may affect treatment outcomes. Louisiana now provides free treatment services for all its compulsive gambling clients. The State found that retention in treatment was directly related to free service. Clients remained in treatment when services were free, dropped out when payment began to be expected, and then retention rates rose again when free treatment was reinstated. It was suggested that this behavior may reflect the compulsive gambler's strange and unique relationship to money. Although this behavior was seen in Louisiana, this phenomenon has not been seen in other States where co-pays are assessed without impacting retention.

Recommendations

- 1. A separate, dedicated funding stream is suggested as the most desirable way to set up funding for a new SSA compulsive gaming program.** A dedicated fund will offer some protection and security for the program's funding levels, although even dedicated funds can be subject to manipulation at times of budget cutbacks. State representatives felt that a dedicated fund offered less complexity and more assurance from the competition of other State needs. The SSA should collect data on outcomes of services provided by its separate gaming fund; this data can then be used to justify the request for additional funds for services on a broader scale.
- 2. SSAs should explore ways to leverage their funds in terms of partnerships with mental health and substance abuse services.** Participants pointed out that there may be many opportunities to save money through partnering with other agencies, such as through shared administrative structures, accounting systems, and training resources.
- 3. In setting up a gambling services system, SSAs need to explore the most effective way of funding startup local programs.** Funding mechanisms can be an important way of

supporting programs during the initial months, when they will be struggling to attract and retain clients.

VI. CHANGES IN STATUTORY LEGISLATION

What Statutory Changes May Be Necessary to Establish State Gambling Services within the SSA?

Typically, SSAs have the authority to address only substance use disorders. None of the participating States reported any difficulties in gaining the statutory authority to handle gambling problems. The type of new legislation or statutory change needed will differ, depending on how an SSA is placed within the State infrastructure, the nature of existing State legislation, and how the authority for gambling services will be structured. The SSA's authority for managing gambling services can be established through the following types of legislation:

- \$ New or changed legislation authorizing the SSA to address problem gambling
- \$ A statute authorizing a gaming fund to be managed by the State agency
- \$ Statutory legislation that combines the authorization for the SSA to address problem gambling with the authority to manage a gaming fund
- \$ Memorandums of understanding (MOU) that transfer the existing legislative authority for addressing gambling problems from one State agency to another
- \$ Legislation to establish the authority for licensing, certifying, or accreditation of programs and credentialing of counselors. This responsibility might be placed with the SSA under the authorizing legislation, as in Nebraska, or can be added to the purview of an existing State licensing/certification/accreditation board for substance abuse programs, as in Nevada.

Recommendations

1. **The authorizing legislation needs to provide for program administration.** Often, an SSA is authorized to conduct gambling services without any provision for added staff to manage the program. What SSA staff, already committed to other projects, then do is award sole-source contracts to carry out the State's gambling services. The authorizing legislation needs to allow for full-time SSA staff members, so that the State gambling services program can be appropriately administered.
2. **The legislation needs to allow for flexible program planning.** Participants felt strongly that, in a developing field where so much practical knowledge is emerging, the legislation should not hinder the SSA's clinical and service delivery choices. It is important that the legislation not be strictly tied to existing mental health centers, substance abuse programs, or particular ways of distributing funds. Louisiana suggested that its legislation works well. The legislation specifies that the gambling program "shall" provide a helpline and "may" conduct treatment. The SSA has interpreted this to mean that it may institute whatever levels and types of treatment are most promising and needed for its population.

- 3. The legislation should establish the authority for development and monitoring of standards for gambling programs.** As with any program that receives State funds, the legislation should authorize the SSA to establish and monitor the operating regulations for programs. In two States with established gambling treatment systems (Nebraska and Louisiana), operating standards are less extensive than for substance abuse. The SSA piggybacks off the substance abuse facility licenses but has developed program manuals and regulations specific to gambling programs regarding such issues as minimum operating standards for health and safety, staff requirements, case records, services to be provided, and admission/discharge data.
- 4. SSAs need regulatory flexibility with programs in this emerging field.** States beginning new gambling service programs need to be cautious about their regulatory controls. New York State, planning a pilot program, pointed out that its agency has many regulatory mechanisms to ensure the compliance of substance abuse programs. However, the State plans to be careful and flexible about regulations regarding gambling programs until more is known about the science regarding pathological gambling and about the differences between a gambling and substance addiction.
- 5. The reporting of outcomes data is critically important for a State gambling program.** To do this, it is necessary to implement a client data system. None of the States represented at the meeting has authorizing legislation that requires the reporting of outcomes data. However, one State is required to submit an annual report, one State reports to the legislature on how it spent the State funds, and, in a third State, a separate advisory group appointed by the Governor provides oversight to the gambling program. Although their legislation does not require outcomes data, most States reported that they are already tracking outcomes data or are making plans to do so. Participants stressed that they see the tracking and reporting of outcomes data as absolutely essential to their future. The participants further suggested that SAMHSA's seven National Outcomes Measures could also be used to effectively capture the necessary outcome data. Solid outcomes data, reported back to the State legislature, is the vehicle for maintaining and expanding program funds.

VII. LICENSURE, CERTIFICATION, AND/OR ACCREDITATION OF PROGRAMS AND COUNSELORS

What Resources Are Available to Assist SSAs in Preparing to License/Certify/Accredit and Monitor Programs and Counselors Involved in Gambling Treatment?

All the representatives at CSAT's meeting expect to set up a process for licensing/certifying/accrediting their State gambling programs and credentialing counselors, just as is done for substance abuse treatment. Several States attending the meeting have already established a system of State licensure/certification/accreditation specific to gambling addiction; the other States are at different stages in the planning and development of their systems. This diversity is typical of the situation across States. From 10 to 12 States have fully developed licensing/certification/accrediting systems for gambling addiction treatment. Other States are at some stage in the planning process. A good deal of this work represents duplicative efforts. There is currently no systematic method for SSAs to find out about the processes developed by other States or to share their regulations, protocols, or training materials.

Licensure/certification/accreditation and monitoring of programs. SSAs will need to establish standards that are specific to gambling services. The substance abuse program standards and regulations will not cover certain aspects important to the treatment of compulsive gambling. For example, the counselor's ability to address financing issues, so critical in treating compulsive gamblers, will not be included in the existing standards and regulations for a State's substance abuse programs. Several States, including Nebraska and Louisiana, have already established such specific standards.

The SSAs demonstrate wide variation in their levels of oversight and monitoring of gambling treatment programs. This lack of standardized monitoring procedures can be seen in the range of practices described by States at the CSAT meeting:

- \$ Michigan has a uniform system in which all providers use the same clinical charts and report data from these charts to the SSA on a monthly basis.
- \$ Louisiana's SSA monitors and surveys all State-supported gambling treatment programs on a quarterly basis.
- \$ Indiana's programs are accredited by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF); these programs are relicensed each year but usually receive a site visit that focuses on quality of care only once every 3 years.

Credentialing of counselors. Most States involved at CSAT's meeting have some arrangement for credentialing gambling counselors. There is total agreement that gambling counselors must have a separate credentialing process distinct from that for substance abuse. Some programs, such as Louisiana's residential programs for compulsive gambling, utilize counselors who have multiple credentials in such areas as substance abuse, mental illness, and family therapy, as well as gambling. State credentialing is key to preparing counselors for dealing with gambling

addiction. One State at the CSAT meeting is in an exploratory stage, with no known credentialed counselors in the State. Louisiana, on the other hand, now has more than 150 certified compulsive gambling counselors.

National gambling credentialing boards are a significant resource for SSAs. Certification is available through the National Gambling Counselor Certification Board and the American Compulsive Gambling Certification Board.

Some States provide training for counselors, while expecting them to obtain a national certification on their own. Other States grandfather in counselors who are nationally certified, but then develop their own State certification process. These credentialing programs—both the national certification and those developed by States—are using similar standards. Certification elements include the following:

\$ For counselors: For non-competency-based credentialing systems, counselors are required to have a minimum of a master's degree in a social science, 30 hours of specific training in gambling addiction, and additional continuing education hours every 2 years. Gambling addiction is considered to be a field where clinicians need continuing education.

\$ For helpline operators: Michigan's helpline operators are trained to screen and assess callers and help them get into immediate treatment for gambling problems. The helpline operators must have at least a bachelor's degree (most have master's degrees), are required to obtain 30 hours of gambling-specific training, and must also complete 30 hours of continuing education.

Training of supervisors. Several States require that supervisors receive training in clinical supervision of substance abuse counselors, and they are expanding the system to include supervisors in gambling programs. Nevada also requires that supervisors take continuing education units to maintain their certification. The participants felt that gambling counselors need two types of specialized help from clinical supervision: (1) assistance with the reality that counselors cannot resolve some issues, such as the permanent loss of a client's retirement income, and (2) support for helpline operators after they have dealt with crisis situations involving suicidal callers.

Curricula and training in colleges and universities. The SSAs feel that workforce development is badly needed in the addictions field. New York, Wisconsin, and Nevada all work through their State community college and university systems to incorporate addiction training curricula into the schooling of professional counselors and therapists. These programs are being expanded to bring in a compulsive gambling component.

Recommendations

- 1. A reciprocal certification process for gambling counselors should be set up across States.** Since States that have set up certification processes are using similar regulations and requirements, it would be advantageous and convenient for them to offer reciprocity

across States.

2. **A mechanism is needed to set up national standards for certification at the counselor level.** It would be highly desirable to have such national standards and for States to collaborate in setting these standards.
3. **The national credentialing programs are a significant resource for SSAs as they set up new gambling treatment programs.** SSAs interested in developing their own State guidelines should also explore the credentialing standards already developed by other States.
4. **States should look for opportunities to build the addiction treatment workforce through curricula and courses in professional schools.** SSAs should be able to work with technical schools and universities in their home States to set up training for students at the 2-year community college level through master's degree programs.

VIII. NECESSARY CLINICAL SKILLS FOR COUNSELORS

What Are the Unique Skills Needed for Working with the Compulsive Gambling Population?

The State participants stressed that gambling addiction is not the same as substance abuse addiction and that it requires a unique set of clinical skills. Much of this difference revolves around the crisis life situations of pathological gamblers and their families, the depression and suicide danger found in many clients, the financial issues that require immediate and skillful handling, and the difficulty of engaging and retaining these clients in treatment.

As with substance abuse, intangible personal factors play a significant role in successful counseling. In the State representatives' experience, the counselors who become skilled in working with compulsive gamblers share the following characteristics:

- \$ **An ability to establish a relationship with the client.** Counselors with the best retention rates have been able to make a connection, to establish a relationship with their clients. These counselors are described as people who really care about their clients, are enthusiastic about treating the population of problem gamblers, and have the "fire in the belly" to reach out and find and bring these people into treatment.

- \$ **An ability to be persistent through the initial learning phase.** The State representatives felt that clinicians who are interested in treating this population will do well. But the States report that no provider just puts out a shingle and attracts clients. Even very motivated counselors need a minimum of 6 months to figure out how to build rapport with these clients; the first year is painful. For a typical new counselor, the first 8 to 12 clients will not stay beyond about four sessions. After 9 to 12 months of effort, counselors will have made connections with attorneys and probation officers and learned how to attract and retain these clients. At this point, they become successful with their gambling clients and love their work. But counselors must learn and persist despite discouragement through a relatively long learning curve.

Recommendations

To work with clients with problem/pathological gambling disorders, the counselors will need professional competency and certification in multiple areas, as well as skills specific to gambling addiction. The State representatives compiled the following list of competencies and skills needed by counselors who work with compulsive gambling clients.

1. **Crisis intervention.** Counselors need the ability to deal effectively with unremitting crisis situations. With these clients, the initial crises do not let up and are likely to get worse.

2. **Financial issues.** Clients present in a state of financial chaos, often in the process of losing their homes and with 10 or more credit cards at their maximum limit. The counselor needs to be able to deal with these financial issues in a therapeutic way. For

example, it is not advisable to send these clients immediately to credit card advisors or bankruptcy court, which would prematurely restore their access to funds.

- 3. Suicidal ideation.** Counselors need to be sensitive to, and prepared to deal with, suicide issues. The suicide attempt rate for this population is 100 times the norm. The completed suicide rate is also very high among pathological gamblers because these individuals are often both deeply depressed and have a high-energy focus of attention. Faced with financial ruin, compulsive gamblers may commit suicide so that their families can receive their life insurance proceeds.
- 4. Support issues.** Counselors need to be able to work successfully with families and others in setting up a support structure for compulsive gamblers during treatment. Usually, their families are willing to provide this support for male compulsive gamblers. For women gamblers, on the other hand, it is almost impossible to arrange family support, and other sources of support must be found. Setting up a support system can be both challenging and imperative for older people, for whom the loss of their retirement funds is permanent and irretrievable.
- 5. Treatment approaches.** Counselors need to be trained and skilled in using a cognitive behavioral approach to treatment, which the State participants felt was by far the most promising approach for dealing with addictive gambling. Michigan is now successfully using a stages-of-change model and motivational interviewing techniques with compulsive gambling clients; and strongly recommends that counselors be trained to use these techniques. This approach, which is used to motivate and retain substance abuse clients in treatment, directly addresses the major barrier to helping problem gamblers—the difficulty of engaging them in treatment.
- 6. Family issues.** Counselors need to be trained and skilled at helping families in crisis. Unlike alcohol or drug addiction, the families of compulsive gamblers are often unaware of the gambler's problem until suddenly faced with financial disaster. Usually, the family's lifestyle has been abruptly destroyed. Counselors need the skills not only to help the compulsive gambling client, but also to assist the client's family with this acute trauma irrespective of the gamblers' involvement in counseling. For instance, counselors who work with gamblers need to be particularly skilled in helping families of gamblers protect themselves legally and financially should the gamblers refuse treatment.

IX. PUBLIC AWARENESS AND SCREENING

What Services Do States Provide to Raise Public Awareness about Pathological Gambling and about How to Obtain Help with Problems?

The Association of Problem Gambling Service Administrators (APGSA) surveyed its members and found that 15 of the 16 States conduct media and public awareness efforts, as well as provide a telephone helpline. These efforts consume an appreciable share of available program funds. On average, 19 percent of program funds go to the helplines and 10 percent go to media and public awareness campaigns, as compared to 44 percent for treatment (see Exhibit 1).

Public awareness and media campaigns. As one example of State efforts, Wisconsin conducts an annual State conference to promote public awareness, advertises on billboards and bus signs, and lists the helpline telephone number in 125 telephone books throughout the State. The States tend to develop these awareness activities in isolation. Methods for States to share what they are doing could potentially be of help in surfacing creative messages and ideas for reaching the public, as well as saving States from having to develop each awareness activity from scratch.

Prevention. Prevention efforts receive only 8 percent of State gambling program budgets (Exhibit 1). At the Midwest Conference on Problem Gambling and Substance Abuse, the CSAT director reported two gambling prevention programs met criteria as “promising” according to SAMHSA’s National Registry of Effective Prevention Program (NREPP) standards. This is an area in which a great deal more could productively be done, and that effort is beginning. The Michigan program, for example, is working with the public schools to develop a school curriculum. School administrators are concerned about students who are shooting dice and betting, often over the Internet. New York State plans to integrate problem gambling initiatives into its prevention activities even more than into treatment. The State is structurally elevating its substance abuse prevention division to the same level as treatment and expects to extensively utilize its statewide community-based prevention networks, such as schools, using a risk and protective factors framework. New York intends to integrate problem gambling into these prevention plans. Developing prevention initiatives now will save States money in the long term, since prevention can reduce the number of people who will in the future require services resulting from their pathological gambling.

Helplines. The State helplines are a major resource for identifying and getting help to people with compulsive gambling problems. States with an established helpline can make thousands of referrals to gambling treatment in a single year. The experienced helplines employ trained staff who screen callers, do an evaluation, and refer those with gambling problems to an appropriate clinician on the same day, in a single call.

Screening. States have found that screening clients who are being admitted for substance abuse treatment is a second major way to identify those with gambling problems. The Louisiana program decided to embed the small, two-question LIE-BET screen into its Web-based assessment process for all people admitted to public substance abuse treatment, a process which worked well. All people who screen positive on the LIE-BET screen (roughly 13,000 out of 29,000 substance abuse clients to date) prompt a trigger to receive a followup assessment.

Louisiana uses the Southoaks tool for this followup assessment.

The State participants would like to see gambling screens become a standard part of primary medical care. Unfortunately, there is no mandate from any source to require that questions on gambling be included in health screens. Many patients, including older people, are more likely to access care through their doctor than through any other source. The participants would like to build gambling questions into screens used in all kinds of health and social service settings. Several of the States (e.g., New York, Michigan, Wisconsin, and Louisiana) are involved in addictions training in medical schools for interns, residents, and physician assistants; gambling addiction issues are being included in some of the States' training. A flyer for primary care physicians that may be useful to States was developed as part of the 2004 Problem Gambling Awareness Week. This flyer can be downloaded at www.npgaw.org and could be handed out to physicians and professional associations.

Screening instruments. The current screening and assessment instruments for problem gambling were developed for small samples and specific populations; so how well they transfer to the general population is not clear. Research is currently underway to validate five specific indicator questions from screens now in use. It is expected that instruments to assess gambling problems will improve as more research is done. However, in the meantime, several screening and assessment tools are available and in use. These include:

- \$ **The LIE-BET tool.** This is considered to be a good and quick two-question screen that can be readily embedded in another instrument, such as in a substance abuse assessment. The two questions are: "Did you ever find it necessary to lie about your gambling?" and "Did you ever bet more than you intended to?"
- \$ **NORC DSM-IV Screen for Gambling Problems (NODS).** The NODS, developed by the National Gambling Impact Study Commission, is a 17-question screen that correlates to the DSM-IV. The Michigan helpline staff use the NODS to assess callers' needs for services and to make an appropriate referral. The NODS questions can be asked in a conversational way.
- \$ **South Oaks Gambling Screen (SOGS).** (Lesieur and Blume 1987). Like the NODS, the SOGS tool can be used in a conversational manner. This widely used screen was based on the original DSM-III criteria published in 1980. The SOGS appears to be a valid, reliable instrument for the rapid screening of AOD-dependent clients for pathological gambling. The SOGS has also been adapted to measure the severity of gambling problems in adolescents (Winters et al. 1993).
- \$ **Gamblers Anonymous (GA) 20 Questions Screen.** Some States follow up a quick screen with the GA list of 20 questions, which helps clients determine that they might have a gambling problem.

Post-screening referral process. What action should a substance abuse or mental health counselor take if a client tests positive on a gambling problems screen? The States report that often no action is taken; the positive result simply stays unnoticed on the client's record.

Obviously, it is fruitless to screen if nothing is done for people with positive results. To combat this, an SSA needs to set up an infrastructure that will accomplish two things: (1) train counselors on how to handle and refer a person with a positive gambling screen, and (2) require that a followup assessment be made for every client who has a positive screen.

Recommendations

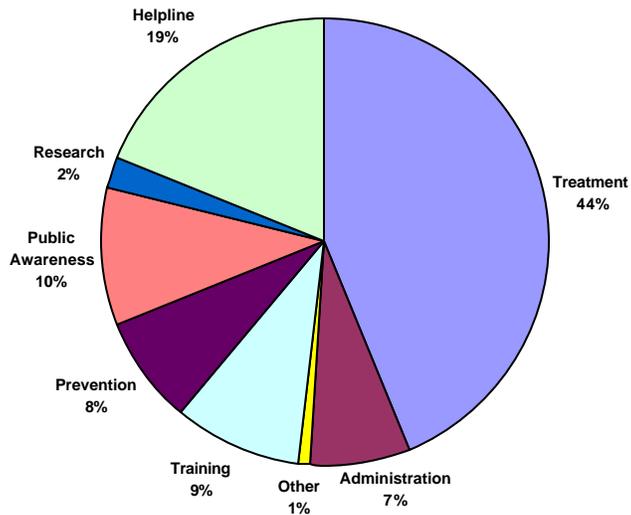
The participants recommended that best practices for a State compulsive gambling program should include the following public awareness and screening components:

1. Marketing and public information campaigns about the services available
2. A prevention component
3. A helpline system of screening and referral on a same-day, single-call basis
4. A process to screen for problem gambling as part of client assessment in substance abuse and mental health services, and ideally in primary care and other social service settings as well
5. A required followup assessment with potential referral for all clients identified as problem or pathological gamblers on screens conducted during the admission and assessment of substance abuse and mental health clients
6. State collaboration on inclusion of universal questions addressing gambling issues in risk and protective factor student surveys through school-based substance abuse prevention efforts

Exhibit 1. Allocation of Gambling Services and Funds in States Belonging to the Association of Problem Gambling Service Administrators (APGSA)

Gambling Services Provided by Selected States							
	Helpline	Prevention	Media/P. Awareness	Treatment	Training	Research	Other
Arizona	✓		✓	✓			
Connecticut	✓	✓	✓	✓	✓		
Illinois	✓	✓	✓	✓	✓	✓	
Indiana	✓	✓	✓	✓	✓		
Iowa	✓	✓	✓	✓	✓		
Kansas	✓		✓		✓		
Louisiana	✓	✓	✓	✓	✓	✓	✓
Maryland	✓		✓		✓		
Massachusetts	✓	✓	✓	✓	✓	✓	
Minnesota	✓	✓	✓	✓	✓		✓
Missouri	✓		✓	✓	✓		
Nebraska	✓		✓	✓	✓		
New York	✓	✓	✓	✓	✓		
Oregon	✓	✓	✓	✓	✓	✓	
Washington				✓	✓		
West Virginia	✓		✓		✓		✓

Pathological Gambling Allocation by Services



Data compiled by the Association of Problem Gambling Service Administrators in a 2000 survey with later updates.

X. EFFECTIVE PRACTICE PRINCIPLES AND OUTCOMES

What Evidence-based Best Practices Should Be Used for Providing Services to the At-risk, Problem, or Pathological Gambling Client?

Best practices have yet to be established for gambling treatment programs. Defining best practices will be inhibited by two factors:

- \$ **Lack of research.** Little research on therapeutic gambling practices and models has been done; there is no scientific evidence base of controlled or demonstration studies. State programs are insufficiently financed to conduct much research; on average, States expend only 2 percent of their gambling program funds on research (see Exhibit 1).
- \$ **Lack of a standardized theoretical base.** Since States started developing gambling services in the early 1990s, they have learned a great deal about successful practices with this population. But States have been fending for themselves, developing many different types of interventions based on different premises. There is no body of agreed-on standards or outcome measures as yet. Until there is collaboration to set such standards, States will continue to collect various kinds of data that cannot be compared across programs. This scenario will make it very difficult to evaluate best practices.

Theoretical approaches. Participants felt that, ultimately, many approaches will prove successful for treating gambling addiction. The key factors for success will be the level of care the person needs, what works best for the individual client, and the training and skills of the clinician. Several States reported seeing successful outcomes for clients across different service systems. For example, substance abuse providers tend to develop programs based on the 12-Step model approach, emphasizing group sessions, and this method can be successful with gambling clients. Mental health clinicians in community mental health centers tend to use individual counseling, and this approach can also produce successful outcomes.

Client outcomes. What are the goals of successful treatment? Should abstinence from gambling be the only measure of treatment success? Participants felt that treatment outcomes should be measured broadly and should consider the many areas of life affected by a person's gambling addiction. The domains to be evaluated with gambling clients are quite consistent with the seven domains for measuring performance outcomes with substance abuse clients. Significant outcome indicators for gambling clients include the following:

- \$ Abstinence from gambling. (Note: It is not now known whether a reduction in the level of gambling could be an appropriate goal for some clients.)
- \$ Improvement in quality of life issues
- \$ Improvement in family relationships
- \$ Improvement in job performance and issues relating to the workplace

- \$ Improvement in financial status
- \$ Reduction in contacts with the criminal justice system
- \$ Reduction in demand for publicly funded services, particularly substance abuse and mental health services

Treatment goals need to be individualized for each client. In one State, a number of clients have been middle-aged women with long and problem-free employment at the same company, who suddenly embezzle funds to cover their gambling debts. For these women, successful outcomes mean returning the money, providing restitution, and never embezzling again.

Recommendations

At this time, the field does not have established, evidence-based best practices or models. However, based on their professional experience in treating problem gamblers, the State participants agreed that it is possible to state the core principles for effective practice. These principles for effective gambling treatment are consistent with the recognized best practice principles for treating substance abuse. Participants recommended that gambling treatment programs be based on the following principles.

1. **Place clients in the level of care most appropriate for that individual.** As with the American Society for Addiction Medicine criteria for placement of substance abuse clients, pathological gambling clients should be placed in the levels of care most appropriate for each individual. Because so many gambling clients have complicated co-occurring mental health or substance abuse disorders, the assessment and sequence of services must be skillfully managed. At present, most States do not have the systems in place to provide a seamless continuum of care for gambling clients.
2. **Use cognitive behavioral therapy as the preferred therapeutic approach.** The participants recommended cognitive behavioral approaches as the most promising for treating pathological gambling.
3. **Include motivational interviewing techniques.** In one State, the average length of stay for problem gambling clients was only seven sessions. When asked what they wanted to accomplish in treatment, most clients said: "I need to get my gambling under control." When motivational interviewing techniques and readiness to change began to be addressed, the average client stay increased to 45 days.
4. **Develop treatment designs that are specific to the clinical needs of problem gambling clients.** Key components of this design must include the following:
 - \$ The duration of treatment should be extended, compared to substance abuse treatment. The recovery from a gambling addiction is less rapid than for substance abuse.

- \$ Financing issues must be handled immediately, rather than at the later stages of recovery as is typical in the 12-Step model. For problem gamblers, financial issues represent a crisis situation and require a nuanced response.
- \$ Problem gamblers are an energetic population. Residential treatment programs, particularly, need schedules that accommodate this energy level so that clients are awakened early and kept busy throughout the day with sessions, homework, and structured recreation. (For a sample schedule, see Appendix A).
- \$ Relapse is likely to occur. One intent of treatment is to build the client's ability to work through relapses. Relapse should not be a cause for discharge from the program.
- \$ Continuing care must be provided by the treatment program for clients at all levels of care. To fit clients' work schedules, it is desirable to offer both day and evening sessions. A typical continuing care schedule would be a 1½-hour session once a week conducted by a certified gambling counselor. Continuing care is considered to be treatment and should involve a gradual decrease in services over time. The longer the treatment episode continues in place, the better the client outcomes.
- \$ Clients should be encouraged to attend Gamblers Anonymous (GA). It is desirable to have GA meetings located in gambling treatment facilities.

5. Include a family program component. The family program should provide a type of support similar to that given in programs for post-traumatic stress disorder (PTSD). One potential strategy is the 1-day intensive workshop for problem gamblers and their families developed by Michigan. It is intended to help attract those clients who do not stay in treatment.

XI. MOVING FORWARD: RECOMMENDATIONS TO SAMHSA

How Can SAMHSA Assist the States in Moving Forward to Increase Funding and Provide More Comprehensive Services for People with Gambling Problems?

Legalized gaming is now a national pastime. Providing help for those Americans who have serious gambling problems is also a national issue. Yet treatment for those with gambling addictions is wildly inconsistent across the country. A few States have fairly comprehensive systems to respond with help and treatment for compulsive gamblers. Many States offer no public services at all.

This is a national issue that requires leadership at the Federal level. The State participants applauded CSAT's offer to help elevate this dialogue—and the recognition of this problem—at the national level. This national health problem requires a national initiative, which SAMHSA can provide. The group asked for SAMHSA's help and leadership in two critical areas: (1) in stimulating a high-level political commitment to gambling services, and (2) in establishing the research base, standards, protocols, and outcome measures that will form the foundation for developing evidence-based programs and models to prevent and treat gambling problems.

Recommendations

To move the gambling services initiative forward, the States felt that CSAT's leadership and help would be crucial. States recommended that CSAT consider undertaking the following activities:

- 1. Raise awareness about the scope of this problem and the importance of adequate funds for gambling services at the highest levels of State government.** The participants welcomed CSAT's offer to work with States at the Governor's level through such organizations as the National Governors Association, the State Council of Governments, and the National Council of State Legislatures. They felt this would help leverage and support the SSAs in gaining funds for gaming services. Participants also hoped CSAT would encourage governors and State legislatures to explore setting up multiagency coordinated planning around problem gaming issues.
- 2. Engage other Federal agencies on this issue.** Participants felt that, because of the large-scale gaming industry on Indian reservations, it was important to include the Indian Health Service in this initiative. The criminal justice system might also play a significant role. Several gambling courts, based on the drug court model, have now been developed. Since States report that about half of their gambling clients are involved with the criminal justice system, the States felt that gambling courts were a promising concept that should be explored and evaluated.
- 3. Assist States in cooperating and finding out what others are doing.** Some 10 to 12 States have well-developed gambling service systems, with counselor credentialing standards, training curricula, operations manuals, and other materials. CSAT is sponsoring several multistate gambling conferences and might consider sponsoring

additional communication vehicles that would allow the States to share materials they have developed, the results of studies, and other information.

- 4. Develop products to standardize and codify best practices for the gambling treatment field.** A number of States have acquired considerable practical experience and knowledge about how best to treat those with gambling problems. This knowledge has never been compiled or systematically analyzed. The participants felt that CSAT could dramatically increase the state of knowledge in the field by developing a Treatment Improvement Protocol (TIP) or a Technical Assistance Publication (TAP). A TIP would compile whatever evidence-based research is now available on gambling services, and would also be a cutting-edge opportunity to bring together the most experienced experts in this field to develop treatment protocols. A TAP on the certification skills and competencies needed by gambling counselors would be of great help to States.

- 5. Encourage research opportunities.** Little research is being done on gambling services, and SAMHSA needs to work with other institutes to promote research on this topic. States hope that there may be opportunities to do pilot tests or demonstration projects on such topics as service systems, administrative issues, and on the service package needed to provide comprehensive State gambling programs.

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Books and Articles

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Web sites

www.apgsa.org. The Association of Problem Gambling Service Administrators (APGSA) is made up of the administrators of publicly funded problem gambling services. The Web site provides presentations on the issues of concern to public treatment systems and links to other sites.

[www.castlearning.com/castests/webdesign/gambling/GamblerCandidate Guide.pdf](http://www.castlearning.com/castests/webdesign/gambling/GamblerCandidate%20Guide.pdf). Provides a candidate guide on the Professional Examination for Counselors of Problem Gamblers, which is a collaboration among the American Compulsive Gambler Certification Board, the International Certification and Reciprocity Consortium, and the National Council on Problem Gambling.

www.npgaw.org. This Web site for the Problem Gambling Awareness Week offers public education materials that can be downloaded.

www.naspl.org. This Web site of the North American Association of State and Provincial Lotteries provides a variety of information, including a bibliography of problem gambling materials, as well as a list of many gambling studies that can be downloaded.

www.ncpgambling.org. This is the Web site of the National Council on Problem Gambling (NCPG) and its 33 State affiliates. Resources are available through this Web site, and the NCPG also operates a 24-hour, toll-free helpline at 800-522-4700. Contains information about national certification conducted by the National Gambling Counseling Certification Board, a search feature for locating nationally certified counselors, and a list of scheduled CEU courses and resources.

www.ncrg.org. The National Center for Responsible Gaming (NCRG) was founded in 1996 to fund independent, peer-reviewed scientific research on pathological and youth gambling. The NCRG awards grants to academic institutions for research in (1) neuroscience and (2) social and behavioral science. The Web site provides information on gambling research and on grant opportunities.

www.ptcny.com/pdf/NGCCB2004_5.pdf. This site contains information and application forms for the national certification examination for gambling counselors conducted by the National Gambling Counselor Certification Board.

www.responsiblegambling.org. This Web site of the Responsible Gambling Organization of Canada offers research information and abstracts on current articles about problem gambling in the United States, Canada, and abroad.

www.thewager.org. The Wager is a Weekly Addiction Gambling Education Report produced by Harvard Medical School and the Massachusetts Council on Compulsive Gambling. It is funded in part by the National Center for Responsible Gaming and the Massachusetts Department of Public Health.