

**State Experiences in Addressing Problem Gambling:
A Follow-up Meeting**

Developed for the

Center for Substance Abuse Treatment

August 2005

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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Center for Substance Abuse Treatment
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TABLE OF CONTENTS

	Page
I. INTRODUCTION	1
A. Background	1
B. Meeting Attendees	1
C. Welcome and Introductions	2
II. MEETING SUMMARY	8
A. Credentialing/Clinical Workforce Development and Supervision	8
B. Data and Outcomes	11
C. Elements of Good Treatment/Clinical Issues	13
D. Challenges in Treating Problem and Pathological Gambling	15
E. Next Steps	15

I. INTRODUCTION

A. Background

On June 25, 2004, The Center for Substance Abuse Treatment (CSAT) held a meeting with representatives from eight States to develop a white paper addressing how best to include gambling addiction under the auspices of the Single State Authorities (SSA). This white paper was distributed in September 2004.

This follow-up meeting assembled a larger group of representatives from States responsible for providing services for problem and pathological gambling. The meeting was held to (1) ask these representatives to share their progress in effectively including these services under the auspices of SSAs, and (2) provide them the opportunity to discuss the availability of existing technical assistance resources and ask for further assistance from CSAT.

B. Meeting Attendees

Federal Representatives:

Frank Canizales
Capt. Carol Coley
Anne M. Herron
Gayle J. Saunders

State Representatives:

Christopher Armentano (Connecticut)
Tim Christensen (Arizona)
Michael Couty (Missouri)
Tom Dumas (Louisiana)
Deborah J. Hollis (Michigan)
Kimberly Johnson (Maine)
Alan Kott (New York)
Kim Lucas (Delaware)
Rebecca Martell (New York)
Jamie McCarville (Wisconsin)
Fran Miceli (New Jersey)
Reece Middleton (Louisiana)
Mark Stovall (Mississippi)
John Viernes (Indiana)
Layne Wilhelm (Nevada)
Janet Zwick (Iowa)

JBS Staff:

Megan Martin
Cheri Peterson
Emily Schiffrin

C. Welcome and Introductions

Ms. Herron welcomed participants to the meeting. She noted that until recently, SSAs were not responsible for gambling treatment, nor had any Federal agency been responsible. She explained that inasmuch as problem/pathological gambling is a co-occurring disorder and the responsibility of the SSAs, CSAT has a stake in the issue. CSAT is exploring the possible development of a technical assistance protocol (TAP) on problem/pathological gambling and a compendium of resources for SSAs and providers.

Ms. Herron told the group that 25 States are now organizationally responsible for addressing problem/pathological gambling: 23 have dedicated funding, and 21 get money from gaming revenues. She said that because the amount of money for federally funded technical assistance is shrinking, it will be important to address the issues common to most States. Ms. Herron said that there is not a lot of research on good outcomes, best practices, or level of care determination.

Ms. Herron listed the topics that she wanted the participants to discuss, which included:

- What resources exist for providers?
- How is credentialing done in their States?
- What are the standards for program development in their States?
- What are the standards for counselor supervision, advanced education, and training in their States?
- What barriers and gaps in resources and knowledge are they encountering?
- What can the States represented at the meeting share with other States who are just beginning to struggle with these issues?
- How can CSAT help States?

Ms. Herron asked the participants to introduce themselves and give a brief description of the status of gambling prevention and treatment programs in their States. Their introductions are as follows:

Jamie McCarville

Prevention and Disabilities Program Coordinator

Wisconsin Department of Health and Family Services

Division of Disability and Elder Services

Bureau of Mental Health and Substance Abuse Services

Revenues from the gaming industry and tribal gaming support the Wisconsin Council on Problem Gambling. The council runs a 24-hour helpline and does conferences and training. It does a lot of advertising and develops brochures that target specific populations, such as elders and women. Ms. McCarville said that the council is a small group and does a fantastic job but is overwhelmed by the demand for services.

Deborah J. Hollis, M.P.A.
Administrator
Division of Substance Abuse and Gambling Services
Michigan Department of Community Health
Office of Drug Control Policy

The Michigan Department of Community Health has addressed problem and pathological gambling for about 5 years. Its first step was hiring a contractor through a competitive bidding process. The department receives approximately \$3 million a year in funding from casino licensing fees. The following activities are funded: 24-hour helpline, media, and prevention including video library, speaker's bureau, brochures, and a middle and high school gambling curriculum. Last year approximately 400 clients received outpatient treatment services. Ms. Hollis expressed concern about the small amount of advertising the department can afford compared to the amount of advertising the casinos place. She also indicated that the average number of treatment session clients attend is 8, about half of what was anticipated. She said that is hard to measure success, and more stakeholders are asking for accountability.

Alan Kott, M.A.

Director for Evaluation

New York State Office of Alcoholism and Substance Abuse Services (OASAS)

OASAS recently took over responsibility for gambling from the State Office of Mental Health. Mr. Kott said that New York gets general State funding but is one of the few States that does not receive funding for gambling treatment from the gaming industry. OASAS has six freestanding outpatient treatment programs and one prevention program. It is hoping for funding for another 6 outpatient programs and 10 prevention programs. Mr. Kott said that New York is establishing a Treatment Episode Data Set (TEDS)-like data collection system and a performance measurement system to look at retention rates, completion, and abstinence. He introduced Rebecca Martell, who was recently hired to oversee OASAS's gambling programs. He noted that she was incorporating best practices, to the extent possible, into the outpatient treatment system.

Rebecca Martell, B.A., M.S.W.

Addictions Program Specialist 2 (Gambling)

New York State OASAS

Ms. Martell added that the State is reevaluating its certification process. The New York Council on Problem Gambling has been doing counselor certification for 3 years, but OASAS is now creating a State credentialing process. The only gambling court in the country is operating in New York State, and OASAS is looking at the impact on treatment access and retention.

Fran Miceli, M.Ed., CSW, CAS, CPS

Director

New Jersey Department of Human Services

Division of Addiction Services

Ms. Miceli noted that compared with some other States, New Jersey has a small budget for gambling treatment: It was just raised to \$900,000 (\$200,000 of which comes from off-track betting). Her division has worked with the gambling council to develop a prevention curriculum for use in schools. The State has nine treatment facilities, one with outpatient capacity. There is

an alcohol/drug resource center in every county and someone at each of these centers is trained to do gambling assessments. The State screens drug court clients for problem/pathological gambling and has also added gambling questions to screenings done in drug and alcohol treatment programs. The State currently accepts national certification. New Jersey staffs a helpline. The State has focused on co-occurring disorders. For example, it has appended gambling questions to the assessment instrument used for intoxicated drivers (many of whom are arrested on the parkway near Atlantic City). The State is working with attorneys who handle trust accounts for clients who are problem gamblers. The State has done a video on Texas Holdem, which has become a major issue even in the middle schools. Ms. Miceli said that the State is having problems meeting cultural competency needs: Although over 30 percent of the population is Hispanic, only one counselor speaks Spanish. The State is also concerned about meeting the needs of older people since 16 percent of helpline calls are from seniors.

Mark Stovall, B.A.

Project Director

Mississippi Region I Community Mental Health Center

Mr. Stovall runs an adolescent treatment facility, where he is starting to see more problems with gambling. He said that he had just recently started in this position, and was attending the meeting to learn about other State's efforts.

Janet Zwick

Deputy Director

Iowa Department of Public Health

Division of Behavioral Health and Professional Licensure

Iowa has a fairly extensive gambling data system that is modeled on its substance abuse system and has been collecting data for over 10 years. The department receives funding (capped at \$6 million with \$4.3 million going to gambling services) as a set-aside from the gaming industry. The State contracts out for the following services; education, prevention, outpatient treatment services, marketing services, a 1-800-BetsoffHelpline, and recently opened transitional housing. Gambling counselors are certified through the State's substance abuse counselor certification process and are required to complete additional training specific to gambling. The State also accepts national certification. Iowa has recently begun an outcome study on its gambling treatment program in collaboration with the University of Northern Iowa.

Kimberly Johnson, M.Ed.

Director

Maine Department of Health and Human Services

Office of Substance Abuse

Ms. Johnson said that she does not have responsibility for gambling treatment yet because Maine has not had any State-provided treatment, but she is about to receive that responsibility. There are two Gamblers Anonymous (GA) meetings in Maine and a one-person gambling council. The State has not had any gaming except for its lottery, but the legislature passed a law last year allowing for racinos. The racinos will direct funds to her department for treatment.

John Viernes, M.Ed.

Deputy Director

Family and Social Services Administration

Indiana Division of Mental Health and Addiction

Indiana has 13 gaming boats. The State receives money from an admission tax to provide treatment, and this was the first year that location experienced a waiting list. Last year, 325 people were admitted for treatment. The State certifies all gambling treatment providers and requires 60 hours of training. About 300 counselors have been trained. The State contracts for the training, which is provided throughout the year. Trainers also do a follow-up once a quarter with each person who has been trained. Counselors themselves are screened for problem gambling. Mr. Viernes's agency has a good relationship with the State's council on problem gambling, which helps administer its "self-exclusion policy." The policy calls for problem gamblers to pledge not to go on the gaming boats and forfeit any winnings if they do. The State conducts a household survey by telephone to look at the prevalence of gambling among adults and adolescents.

Reece Middleton, M.A., BCSAC, BCCGC

Executive Director

Louisiana Association on Compulsive Gambling

Mr. Middleton's association is an affiliate of the National Council on Problem Gambling (NCPG). It contracts with the State's office for mental disorders to provide services for compulsive gamblers. Louisiana has two residential programs—one in the northern part of the State and one in the south. Treatment is provided free to Louisiana residents and is also available to residents of other States at a very reasonable cost. The association staffs a 24-hour helpline. The helpline number appears on the back of every lottery ticket, as well as on billboards throughout the State and on signs in casinos. The association is working with the attorney general's office to establish a diversion program that would allow treatment instead of prison for nonviolent offenders whose crimes are directly related to their gambling problem. Mr. Middleton said that the ultimate goal would be to establish gambling courts. The State's certification process for gambling counselors has been connected to board certification for substance abuse counselors, but the process is now changing.

Tom Dumas, LCSW

Program Manager

Louisiana Department of Health and Hospitals

Office for Addictive Disorders

Mr. Dumas said that his office works closely with Mr. Middleton's association. The department receives \$2 million per year from gaming taxes and provides outpatient treatment programs. The department screens all alcohol and substance abuse clients for problem/pathological gambling using the Lie-Bet tool. One positive answer on this instrument gets clients a referral to a certified gambling counselor for a full assessment. The department has 10 regional districts that provide outpatient services and tries to ensure that each office has at least one board-certified gambling counselor. The department has residential and intensive outpatient program (IOP) facilities, in various parts of the State. If OAD receives additional funding, it would likely establish IOP programs in other parts of the State. The department is also considering how to strengthen the range of services provided to recovering gamblers, including transitional housing.

Kim Lucas, M.S., CADC
Coordinator of Treatment and Prevention Programs
Delaware Health and Social Services
Division of Substance Abuse and Mental Health

Ms. Lucas's agency is responsible for gambling treatment in Delaware. The State has three gaming facilities, one in each of its counties. One percent of the profits from slot machines, which is about \$1 million per year, is allocated to problem gambling services. The agency funds the State's gambling council, which is responsible for media outreach, education and awareness, and counselor training. The council subcontracts for outpatient gambling treatment services and currently contracts with 11 counselors. The State has a 24-hour helpline, and its number is printed in bold on every lottery ticket. Delaware conducts a school survey to which it has added some gambling questions. Mr. Lucas said, "The extent of gambling among young people is eye-opening." The council has worked with the department of education to add some prevention material to the school health curriculum, but the State does not offer gambling treatment for adolescents. All outpatient substance abuse treatment providers screen clients for co-occurring problem gambling.

Layne Wilhelm, B.S., LADC, LASW
Treatment Supervisor
Nevada State Health Division
Bureau of Alcohol and Drug Abuse

In 1999, the bureau assigned certification of counselors to a board of examiners, which oversees training, supervision, and regulation. The State does not separate funding for gambling treatment from funding for treatment of co-occurring disorders. Mr. Wilhelm reported a high degree of alcohol and methamphetamine abuse in conjunction with problem gambling. Many clients enter treatment through the legal system. The State government gave \$2.5 million this year to the department of human resources (of which the bureau is a part) for gambling treatment programs. The department will ask a nine-person advisory board to allocate these funds to various agencies. According to a study that was done 2 years ago, Nevada has 53,000 adults and 10,000 adolescents who are pathological gamblers. The State will collect \$1 for each slot machine this year and \$2 starting next year to help fund treatment.

Michael Couty
Director
Missouri Department of Mental Health
Division of Alcohol and Drug Abuse

Missouri's department of mental health, lottery, and gaming commission formed the Alliance on Problem Gambling. Every piece of gambling material in Missouri has a 24-hour helpline number, and the number is also on billboards and on the radio. The gaming commission pays \$2 for every client admitted for treatment: \$1 goes to the county or city in which the program is located, and \$1 goes to the State. The State gets \$2.5 million annually to address problem/pathological gambling. Missouri does its own certification of counselors: Anyone treating gambling must be a certified substance abuse provider or have a license to provide treatment. The person must also have received an additional 60 hours of gambling-specific training. The State has credentialed over 300 people at no charge. Every year, the State does an educational media program on compulsive gambling. The State will provide up to 10 hours of outreach to an identified family member.

Christopher Armentano, LCSW

Director of Problem Gambling Services

Connecticut Department of Mental Health and Addiction Services

Connecticut's Problem Gambling Services was established in 1982. Connecticut has the oldest State-funded gambling program currently in existence. It also has the two largest and most profitable casinos in the world. The program has a \$1.7 million annual budget. The majority of funding comes from the gaming industry, and a small amount comes from client fees. The department provides services in one region and funds two provider agencies in the other two regions of the State. The State spends \$300,000 annually on prevention, which Mr. Armentano said he believes is insufficient. About 750 clients are treated each year, and clients must attend three assessment sessions to be admitted to treatment. The program does a lot of phone work, particularly with families, and employs some family specialists, including a family peer counselor. Twenty-five percent of clients are family members, 75 percent are gamblers, and 30 percent to 40 percent of the gamblers are women. Mr. Armentano said that the only counselors who get certification in treating gambling are those who are employed by or contract with the State. Most counselors who do get certified receive their certification from the National Gambling Counselor Certification Board. The State offers a competency certificate program for people who are already licensed mental health or substance abuse treatment providers, but only a couple of providers have applied for this.

Tim Christensen, M.P.A., LADC

Treatment Administrator

Arizona Office of Problem Gambling.

Mr. Christensen worked on gambling in Nebraska until recently, so he discussed his experience in both Nebraska and Arizona. Although there are no casinos in Nebraska, the State annually allocates \$750,000 and receives \$500,000 more from the tobacco industry for gambling treatment. In 2003, the State included six gambling questions in its youth risk and protective factors survey and plans to do that again this fall. Mr. Christensen spoke very positively of a Midwest conference on gambling that included Nebraska, Iowa, Missouri, and Kansas. It was supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) with a Knowledge Dissemination Grant and conducted in partnership with two Addiction Technology Transfer Centers (ATTC). Nebraska had a standalone system for credentialing counselors.

The Arizona Office of Problem Gambling provides education, prevention, and treatment services. It does not contract out for these services. Because it is not a human services agency, it has its own data system that is not tied to the State's mental health or substance abuse data system. Mr. Christensen is very interested in States establishing a uniform minimum dataset. He reported that researchers at the University of Chicago are developing new screening tools that will be more specific than existing instruments. Arizona has not done a lot of workforce training and development, but has just logged the first 30 hours of counselor training. Mr. Christensen would like to do strategic planning across State agencies and is particularly interested in the establishment of gambling courts. He mentioned that the Association of Problem Gambling Service Administrators is an excellent resource for States. He noted that while the NCPG is very helpful to its State affiliate councils, it doesn't address many State issues.

II. MEETING SUMMARY

After the introductions, Ms. Herron listed four questions that she asked the group to address during the remainder of the meeting:

- What method of credentialing has your State chosen and why?
- How are you collecting and using data and outcomes?
- How are you handling clinical workforce development and supervision?
- What are the elements of good treatment?

A. Credentialing/Clinical Workforce Development and Supervision

Ms. Herron noted that she had heard three basic ways that States credential counselors:

- Deeming or accepting national credentialing,
- Adding a gambling-specific component to State Alcohol and Other Drug (AOD) credentialing, or
- Requiring ongoing training and acknowledging completion of training, but not requiring a specific credential.

She asked each participant to explain how his/her State does credentialing. Their processes are summarized below.

Arizona: Arizona is transitioning its AOD credentialing from certification to licensure. Providers participate in a monthly 1-hour conference call, and clinical reviews are conducted.

Connecticut: Treatment providers must be licensed therapists, social workers, or substance abuse treatment counselors (i.e., qualified health professionals or QHPs). Counselors must participate in ongoing biweekly supervision provided by the State at one of four locations. The State's treatment staff, who works for the "Bettor Choice Program," meets quarterly to build camaraderie and a sense of purpose. The State holds ongoing clinical trainings.

Delaware: The State recognizes national certification but does not have a State certification program. Counselors who contract with the State's council must receive individual supervision. **Indiana:** The State requires 60 hours of gambling-specific training and an additional 200 hours of gambling-specific treatment experience. It offers supervision via regular conference calls and track each counselor's supervision hours. Any counselor providing gambling treatment services in Indiana must meet the State's requirements, and receive a treatment provider endorsement added to their addiction provider certification.

Iowa: Providers must be certified substance abuse counselors or licensed mental health professionals with a certain number of hours of gambling-specific treatment experience. The State also accepts national certification. The State does limited clinical oversight of providers,

but there are no formal supervision requirements. Iowa currently does not license programs, but recent legislation requires licensure. When the State begins to license programs, it will institute clinical supervision requirements.

Louisiana: Generally, if a counselor is already certified in substance abuse, he or she is required to complete an additional 30 hours of gambling-specific training. All other mental health care providers must complete 60 hours of AOD training, 30 of which must be gambling-specific. The State does not require this certification of all gambling treatment providers, but will only contract with State-certified providers. There currently is no statewide supervision requirement for compulsive gambling counselors, although counselors employed by the Louisiana Association on Compulsive Gambling are required to have supervision. Louisiana is currently undergoing changes to its AOD licensing and certification. One change is that those counselors with a specialty certification (e.g. CCGC) are eligible for premium pay.

Maine: Counselors who want to supervise other gambling treatment counselors must have a supervision credential.

Michigan: Michigan does not require supervision; however a certified addictions counselor oversees the State's panel of over 50 gambling treatment providers. This counselor periodically monitors client files for quality assurance and compliance track to counselors' progress. Michigan recognizes national certification and requires ongoing continuing education units (CEU).

Missouri: The State used the national council to certify its first 100 counselors and now uses a "train the trainer" process. Providers must be certified counselors or social workers. They must complete 60 hours of gambling-specific training, which the State pays for, and have a certain number of years of experience treating gambling. (The number of years depends on their degree.) Missouri does not require supervision but does require CEUs for certification renewal. Twenty hours of the State's training program is devoted to training in supervision.

Nevada: The State's board of examiners certifies alcohol, drug, and gambling counselors. Counselor must complete 60 hours of gambling-specific training and have 2,000 hours of experience for certification. The board may grant waivers as it deems appropriate, and there is an extended internship to allow counselors to transition into gambling treatment. It is difficult finding enough qualified supervisors to oversee these counselors. The State agency does not have oversight, but checks providers' credentials when it certifies programs.

New Jersey: Currently, New Jersey requires only 6 hours of training for drug and alcohol certification. The State requires national certification for gambling counselors, but the State certification board is looking into establishing State certification. The State contracts with a certified supervisor to oversee counselors.

New York: Up until June 10, 2005, the New York Council on Problem Gambling was issuing a gambling certification. There was no State statutory authority to do this under the Office of Mental Health. As of July 1, 2005, OASAS has been given authority to issue a State gambling credential. OASAS is looking at a stand-alone gambling credential, a CASAC gambling

specialty, and a gambling prevention specialty. A 60-hour core gambling curriculum will be required as well as direct clinical hours and supervision.

Wisconsin: he State has no credentialing requirements yet. Most counselors get national certification. Some county employees are not permitted to leave their counties and get only \$100 per year for training, so the State is looking into training via video conferencing.

Issues Raised by Participants

- Requiring 1,000 hours of experience would be ideal but is unrealistic in areas with sparse populations.
- Although there are similarities between working with clients with gambling problems and working with clients with substance abuse problems, there are also many differences. These differences need to be better understood.
- It might be possible to use clinical supervision best practices from the substance abuse arena as well as the National Outcomes Measurement System to develop guidelines for clinical supervision of gambling treatment providers.
- There are two exams for gambling counselors—one through Castle Worldwide and one through Professional Testing Corporation in New York. What role should testing play?
- Some people don't think that AOD counselors are qualified to treat gamblers, so certification is important.
- The ATTCs have developed online and video training materials.
- Some States recognize Indian Health Services certification while others do not.
- One participant asked if the group could develop common contracting requirements.
- Should the focus be on training gambling treatment experts or on training all AOD treatment providers on gambling treatment issues?

Requests of CSAT

- A summary of all available resources and what other States are doing.
- An issues paper focusing on clinical supervision issues specific to gambling and co-occurring disorders.
- A summary of States' contracting requirements.

B. Data and Outcomes

Indiana collects data from all providers but has not yet analyzed it. In examining referral data, the State realized that 75 percent of people who call the helpline never access treatment, although appointments are scheduled within 48 hours of the call. The State has a gambling research agency and partnerships with NCAA universities to study gambling in the student population.

Helpline counselors in Connecticut asked callers if they wanted a call back from a peer counselor, which increased engagement rates. When peer counselors became too busy to do this, the counselors to whom callers were referred made the call. This has increased engagement rates even more.

Nebraska saw helpline calls decrease as the treatment infrastructure developed. Referrals are now mostly through word of mouth. (Other States had not observed this.)

New Jersey has collected data on referral sources. There are 247 people in treatment, which represents fewer than 10 percent of callers. Nineteen percent of referrals came from the helpline, about 17 percent came from family or friends, 16 percent came from courts, and 16 percent of clients were self-referred. Ms. Miceli distributed copies of “Compulsive Gambling and its Effects on New Jersey Citizens.”

Iowa analyzes the impact of advertising on admissions and has noted a direct relationship. Ms. Zwick said that the State needs to do an analysis of referral sources. Iowa did a youth survey in the schools in 2002 and plans another for the fall. They expect to see a large increase in the number of young people with gambling problems. Iowa has also added gambling questions to the Behavioral Risk Factor Surveillance System.

Arizona did a telephone survey. Ninety percent of respondents said that gambling could become a problem or addiction. Although 86 percent said they would know where to go for help, in a follow-up question, 95 percent could not say where they would go if they needed treatment. Mr. Christensen concluded that awareness among the general population, as opposed to just among the treatment population is important.

New York OASAS is developing a Web-based reporting system as an offshoot of its chemical dependency data system. The system will contain demographic information and TEDS items, as well as gambling data. Information on the type of gambling, money spent on gambling, and time spent on gambling is collected at admission and discharge. The system will contain information on units of service, length of treatment, retention rates, completion rates, and abstinence rates. Mr. Kott offered to share these data with other States. Indiana is also using a Web-based system for both problem and pathological gamblers.

Delaware found that the majority of people who call the helpline say they got the number from the yellow pages, so it has been hard to track the impact of its media campaigns.

Michigan has developed and implemented a gambling curriculum for middle and high schools and will do pre- and post-testing.

In Louisiana, 50 percent of problem gamblers are women, which surprised treatment professionals. Slot machines and video poker games seem to appeal to women.

When asked by Ms. Herron what they had learned about prevalence from school and other surveys, participants reported that there has been a significant increase in the number of children and adolescents engaging in gambling. The popularity of Texas Holdem has contributed to this increase. Mr. Stovall noted the high co-occurrence of methamphetamine abuse and compulsive gambling. Ms. Lucas reported that school surveys showed that youngsters in Delaware are betting on video games rather than on poker. Mr. Christensen said that a survey of 6th, 8th, 10th, and 12th graders showed that while males were three times more likely than females to have problems with gambling, the rate of problem gambling was the same across grades. This finding, he said, made him question the instrument's validity.

Mr. Wilhelm said that it is difficult to know the prevalence of co-occurring gambling problems, because if a counselor's checklist is full of alcohol and substance abuse problems, he or she will not even note the gambling problem. Nevada would like to develop a standardized assessment instrument.

Participants said that they were concerned about accountability and spoke of the importance of being able to link outcomes to treatment. The following were mentioned as possible outcome measures:

- Retention in treatment
- Abstinence
- Reduction in gambling activity
- Financial status
- Employment status
- Hospitalization
- Loss of home or business
- Bankruptcy
- Family relationships and problems

One participant noted that family relationships often deteriorate during treatment as family members realize the severity of the gambler's problem and its impact on them. Thus, improvement in family relationships might not necessarily be a good outcome measure. Another noted that "successful completion of treatment" may have no relationship to future gambling behavior.

A participant noted that any analysis of helplines' utility would have to consider geography; callers who live closer to treatment providers are more likely to follow up.

One participant mentioned the potential value of developing a minimum gambling-specific dataset to use across States. He suggested that TEDS could be the model for this dataset and said that development should begin before States start to develop their own datasets. Another participant noted the lack of a funding source for this project.

Participants mentioned that Oregon probably has the largest and most intricate gambling dataset.

Ms. Herron said that CSAT is working on a description of different data systems being used by all States, which may help States see different possibilities.

Ms. Herron asked participants if their programs had abstinence as a goal. Most participants said that it was a goal but not a requirement.

C. Elements of Good Treatment/Clinical Issues

Ms. Herron observed that when a State is addressing gambling, screening becomes a standard, across-the-board process, but treatment still seems to be done by specialists with advanced degrees, training, or certification.

Mr. Kott noted that by the time most gamblers in New York access treatment, they are full-blown pathological gamblers. With more prevention and education, the State hopes to reach and treat more problem and at-risk gamblers.

Mr. Middleton said that being able to offer different levels of treatment in the same location enables providers to better accommodate clients' needs. He noted that Louisiana tries to "meet people where they are" and that clients do not have to fail at outpatient treatment before being admitted to a residential program.

Ms. Zwick said that motivational interviewing, a best practice for substance abuse treatment, also seemed to work for gambling. She said that The National Institute on Drug Abuse and the ATTCs are developing a toolbox that should be useful across both fields. A participant suggested that ATTCs offer training on best practices.

Participants discussed the movement toward diversion. Diversion offers treatment as an alternative to prison for people who have committed nonviolent crimes as a direct result of their gambling problems. Mr. Middleton said that people referred by the courts will generally require residential treatment, probably for about 3 years. Clients in Louisiana sign a paper agreeing to remain in treatment for as long as the district attorney recommends. Mr. Middleton said that a placement criteria instrument that will stand up in court would facilitate the creation of gambling courts. Mr. Kott agreed, noting that only one town court in New York currently makes referrals to gambling treatment programs.

Mr. Christensen said that in some parts of Arizona, drug courts "hijacked" substance abuse treatment programs, and the programs had no room to treat non-offenders. He said that with the limited resources supporting gambling treatment, diversion programs for gamblers could result in the same problem.

Ms. Herron noted that the level of care available varied greatly among the States attending the meeting—from residential treatment that is used often, to brief residential treatment, to no residential treatment. Participants discussed the levels of care available in their States:

- In New York, OASAS wants to move toward residential treatment and halfway houses, but it will be difficult justifying the need to the State since we have been operating successfully with only outpatient programs for over 10 years.
- Ms. McCarville said that Wisconsin, an “antitax State,” has no money for residential treatment.
- New Jersey has about 12 inpatient admissions for gambling treatment a year and uses beds in an alcohol treatment facility for these patients.
- Delaware, Maine, Indiana, and Arizona offer only outpatient treatment.
- Missouri pays only for outpatient services, but if a client is getting residential treatment for substance abuse, he or she can get concurrent outpatient treatment for gambling.
- Nevada does not have standalone treatment for gambling; treatment must be in conjunction with a co-occurring substance abuse problem.
- Louisiana, which offers residential treatment, would like to have transitional housing for clients after they complete treatment.
- Indiana offers a continuum of care that includes inpatient care to clients who are suicidal.
- Iowa does not have residential treatment but can provide transitional housing for clients during their treatment.

A participant noted that there are only three to five residential treatment facilities for gamblers in the country. Mr. Viernes suggested that States partner to create regional residential treatment facilities and mentioned that Indiana is exploring this idea with Ohio and Illinois, through Tri-Meridian.

In terms of length of treatment, participants reported the following:

- In New York, outpatient and IOP treatment averages 6 months. Clients with access to Gamblers Anonymous meetings may be discharged sooner.
- In Arizona and Iowa, outpatient treatment averages 9–10 sessions.
- In Louisiana, there is not a set number of sessions; counselors try to keep clients engaged in outpatient treatment for 8 months to 1 year. Two years of weekly aftercare is recommended after clients achieve abstinence.

- In Connecticut, Mr. Armentano said that it is difficult to tell when treatment is over because clients and clinicians are supposed to mutually determine criteria for completion but typically do not.

D. Challenges in Treating Problem and Pathological Gambling

Over the course of the meeting, participants identified the following challenges:

- There are several significant differences between gambling and substance abuse: financial issues are involved in gambling, and AOD counselors are not trained in addressing these; there are relatively few GA groups; and families are usually blindsided by the existence or extent of the problem.
- Gambling is not yet accepted as a true addiction by society.
- In most cases, insurance will not pay for gambling treatment. When it does, copays may still be prohibitive.
- Most casinos offer free drinks, and the effect of free alcohol on problem gambling is not well understood.
- Screening is progressing faster than treatment capacity—clinicians often do not know what to do about a positive screen. (One participant did point out that by identifying unmet need, agencies can get more attention and funding for gambling treatment. Another suggested that telephone sessions may be useful until more face-to-face treatment is available.)
- The need for culturally competent services is a major issue.
- Legislators will not do anything until they are forced to by an advocacy group of people who have been hurt by gambling.

E. Next Steps

Ms. Herron identified issues that require follow-up:

- 1) Outcomes. She would like to create a small workgroup (4–6 people) to make recommendations on how to measure success in treatment, determine what systems are already available to do so, and suggest a set of standardized data elements.
- 2) Supervision. She would like to create a small workgroup to prepare a guidance document or an issues paper laying out criteria for good supervision and identifying the elements unique to supervising gambling treatment counselors.

- 3) Patient placement criteria and level of care determination. She would like to create a small workgroup to prepare an outline (for a future Treatment Improvement Protocol or Technical Assistance Publication) discussing the science and evidence behind this. The outline would also address continuing care, aftercare, and discharge criteria.
- 4) Areas that States can collaborate on and share materials that already exist, (e.g., cultural competency). CSAT will follow up with participants to see if they have anything to contribute to a resource guide.
- 5) CSAT's ensuring that everyone knows what professional development curricula are available for States and providers through the Knowledge Application Program and ATTCs.
- 6) Sharing marketing information, PR information, and examples of certification standards, protocols, and program design. Ms. Herron asked that participants send to her things that they are willing to share, including the names of good resources that are not publicly available.

A participant suggested involving Canadian representatives in these efforts, as Canada has done a lot of work on gambling

The following State representatives volunteered for the workgroups:

- Outcomes: Indiana, Connecticut, Missouri, New York, Delaware, Iowa, Michigan
- Supervision: New York, Indiana, Connecticut, Iowa, Arizona
- Patient placement: New York, Nevada, Louisiana, Indiana, Iowa

Capt. Coley asked the attendees to participate in SAMHSA's dual diagnosis listserv (dualdx@treatment.org) to share their expertise and solicit information from others. She said that gambling has never been discussed on the listserv and that this might be an excellent international forum from which to learn.

Ms. Herron said that The State Associations of Addictive Services and National Association of State Alcohol and Drug Abuse Directors have committed to ongoing assistance.