State-funded Gambling Treatment Programs

THINK TANK

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BOSTON, MASSACHUSETTS

Massachusetts Council
on Compulsive Gambling

Massachusetts Department
of Public Health

Harvard Medical School,
Division on Addictions

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The results of a national think tank on state-funded gambling treatment programs

A Massachusetts Initiative

Massachusetts Council
on Compulsive Gambling

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INTRODUCTION

As legalized gambling has become more common throughout the United States (National Gambling Impact Study Commission, 1999; National Research Council, 1999), treatment programs to address gambling related problems have emerged. Harvard Medical School's Norman E. Zinberg Center for Addiction Studies and the Massachusetts Council on Compulsive Gambling hosted the first national Think Tank on Pathological Gambling on June 3 & 4, 1988. During April 1995, the Minnesota Council on Compulsive Gambling joined Harvard Medical School's Division on the Addictions and the Massachusetts Council on Compulsive Gambling to host the first North American Think Tank on Youth Gambling.

On June 22 & 23, 2000, the Massachusetts Council on Compulsive Gambling, in cooperation with the Harvard Medical School Division on Addictions and the Massachusetts Department of Public Health, hosted a national Think Tank on State-Funded Gambling Treatment Programs. The project was supported primarily by special funding from the Massachusetts Department of Public Health, Dr. Howard Koh, Commissioner. Additional support was provided by The National Center for Responsible Gaming, The Center for Substance Abuse Treatment, Trimeridian/The Custer Center, and the Institute for Problem Gambling.

The first national think tank was designed to identify the nature of gambling, its potential adverse consequences and the extent of the problem; the second was intended to draw attention to the issue by focusing on youth.[1] The recent Think Tank on State-Funded Gambling Treatment Programs was the first national event dedicated to treatment, suggesting that the field is beginning to mature. Forty invited participants attended, representing each of the 13 states with state-funded gambling treatment programs. A complete list of participants and the planning committee is included as **Appendix I.**

The primary purpose of this Think Tank was twofold: (1) gather information about the structure and scope of existing state-funded treatment programs and (2) create a blueprint for the future development of such programs in jurisdictions where limited or no treatment programs presently exist. To help develop this blueprint, Think Tank participants shared their views about six distinct areas of gambling treatment program operation:

- ► Administrative Structure and Funding
- ► Treatment Delivery: Modalities and Settings
- ► Treatment Delivery: Client Recruitment and Retention
- ► Assessing Impact and Efficacy
- ► Patient Rights
- ► Best Practice Guidelines

1 The late Tom Cummings, a principal architect of the first two Think Tank events, would be very proud indeed at the development of this special treatment event. We owe him a great debt and dedicate this project to his enduring influence and memory.

PARTICIPANT AND PROGRAM CHARACTERISTICS: THE STATE OF STATE-FUNDED GAMBLING TREATMENT PROGRAMS

Seventy-three people were invited to participate in this think tank. Of these 48 accepted invitations, yielding a 65.8% acceptance rate. Of the 48 who accepted, 8 were unable to participate for one reason or the other, reducing the number of participants to 40 and the participation rate to 54.8%.

To stimulate thinking and provide a point of departure, participants were asked to complete a survey developed specifically to assess the status of gambling treatment programs in the United States. The Think Tank steering committee identified topics and items of importance that would be relevant to the activities of the Think Tank process and provide participants with an overview of gambling treatment program characteristics. A draft version of the survey was completed on March 15, 2000 and then reviewed by the steering committee. Several revisions were made to the original version and the final survey was completed and distributed on April 24, 2000.

Surveys were sent to all invitees who accepted the invitation to participate, as well as to some who were unable to participate but wished to submit a completed survey as a means of contributing to the think tank process. A total of 53 were sent out and 47 of them were returned. Thirty-eight of the forty participants completed surveys. In addition, nine surveys were received from non-participants, yielding an 88.7% survey completion rate.

Currently, there are 13 states with state-funded gambling treatment programs. These states are Connecticut, Delaware, Indiana, Iowa, Louisiana, Massachusetts, Minnesota, Missouri, Nebraska, New Jersey, New York, Oregon and South Dakota. To avoid misrepresenting larger states with more gambling treatment programs, the survey data was weighted by state. That is, whenever more than 1 person represented a state, the data was weighted proportional to the state's representation. For example, where two representatives responded from one state, the surveys were weighted .5 each; where four representatives responded from one state, each survey was weighted .25 and so on.

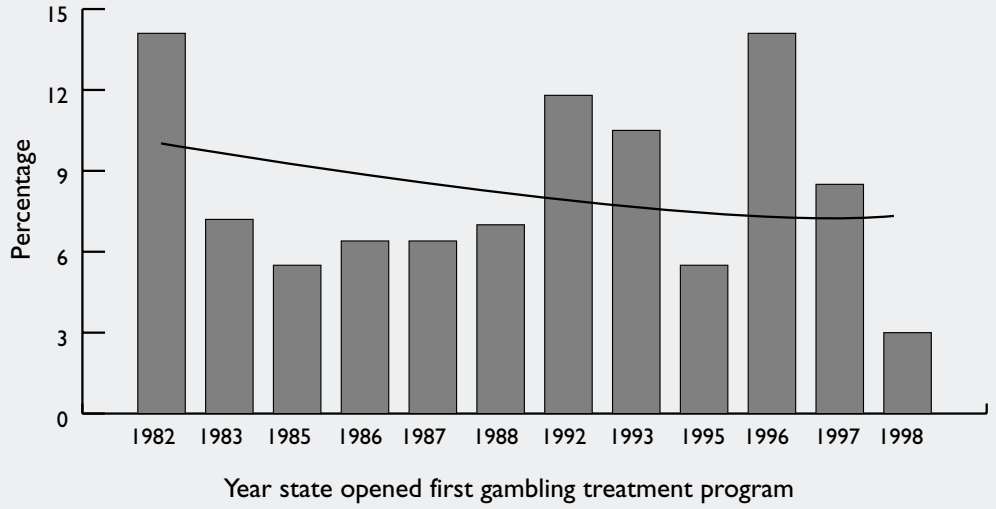
Participant Characteristics

Regarding their work responsibilities, 34% of the participants were treatment program administrators, 23% were government administrators, 19% were frontline clinical service providers and 24% classified themselves as "other." Similarly, 33% of the participants were treatment funders, 52% were fundees and 15% neither.

Program Characteristics

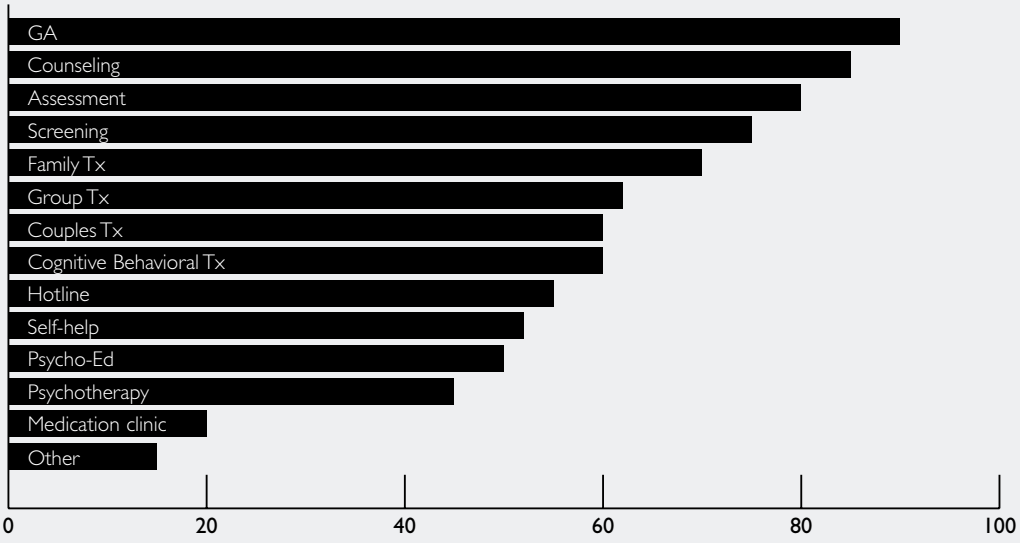
Figure 1 (opposite page) shows the participant affiliation pattern with state-funded gambling treatment program openings. The first state-funded gambling treatment program represented at the think tank opened during 1982 and the last during 1998. The figure reveals a steady pattern of treatment program openings during the last two decades of the twentieth century. These programs were sited in many different venues. For example, 51% of the participants reported that their treatment programs were located in mental health centers, 45% in gambling specific treatment centers, 32% in hospital outpatient settings, 32% in hospital inpatient settings, 24% in private practice, 23% in prisons, 17% in residential settings and 10% in other community settings.

Figure 1: Percentage of participants affiliated with first state funded gambling treatment program opening



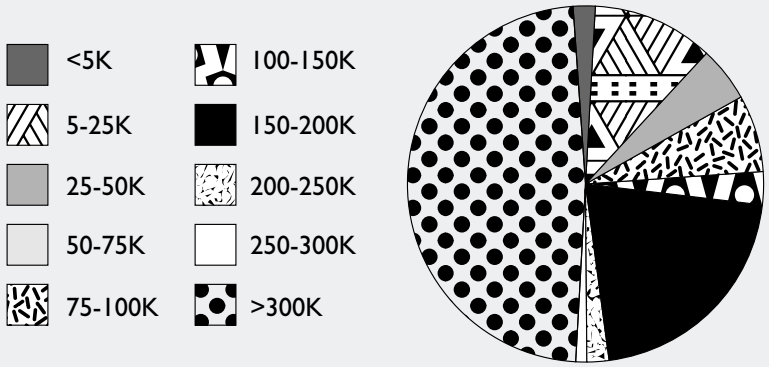
Within these settings, in addition to self-help, clinicians employed a wide array of treatment modalities, as described in ***Figure 2.*** Gamblers Anonymous was the most common form of assistance (89%) and medication was the least common (20%). The treatment modalities figure summarizes the variety and prevalence of clinical services among the treatment programs represented by the think tank participants.

Figure 2: Treatment Modalities



As ***Figure 3*** reveals, almost 50% of the participants represented programs that received more than $300,000 in annual funding; at the other end of the spectrum, 20% of the programs received $50,000 or less in annual funding. In addition, 86 percent of the participants reported receiving state funding; 61% also accepted fees for service; and 49% received private funding. In addition, participants reported that the funding for treatment services derived primarily from self-pay (33%), pro-bono (31%) and insurance (20%) sources. Of the patients seeking gambling services, 5% of the programs referred clients elsewhere, 5% denied treatment services, and 2% referred the treatment seeking patient back to their insurance company.

Figure 3: Total operating budget

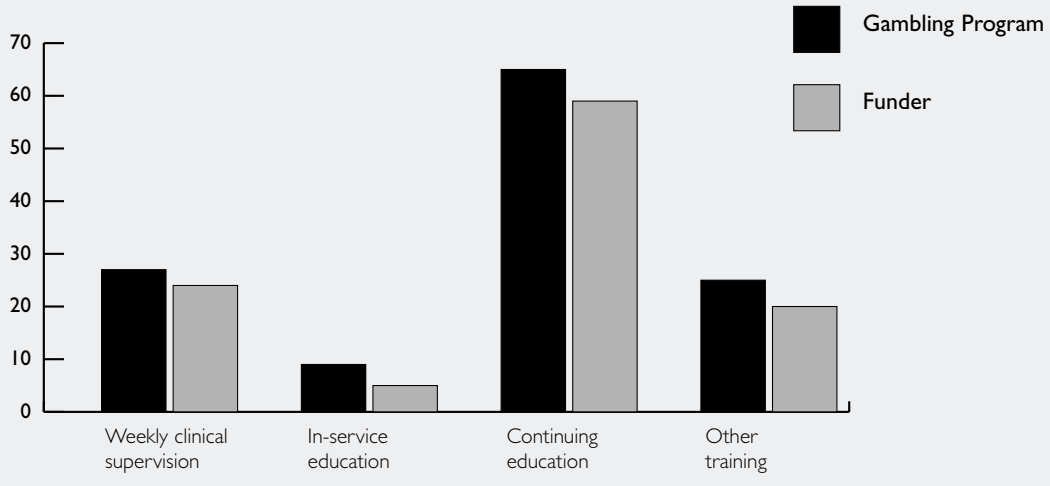


Participants reported that their treatment programs provided services for gamblers (94%), spouses of gamblers (84%), other family members (84%) and others (43%). For the period between July 1, 1999 and February 29, 2000, the median number of treatment seekers for all programs represented at the think tank was 249.74. Of these, the median number with insurance was 53.64, but only 9.52 paid with insurance.

Full time employees represented 58% of the staff of these programs; 52% were part-time employees and 14% were hired per diem. In addition, 21% of the programs reported using consultants.

With regard to training and supervision, there were limited resources and different perspectives offered by gambling program staff and funders. As ***Figure 4*** illustrates, program staff consistently reported receiving training more than funders thought the staff received training. Despite this difference of perspective, only 27% or fewer program participants reported that there was regular clinical supervision or other program–based training for gambling treatment programs.

Figure 4: Different perspectives on required training activities



THINK TANK PROCEDURES

The entire think tank was coordinated and guided by a facilitator.[2] Intersession plenary talks were provided to prime the participants' thinking by reviewing key concepts in relevant areas. These talks were limited to about 15 minutes each.

Participants were assigned to one of six breakout groups. They were directed to envision the "ideal" gambling treatment program, with specific attention to each of the general topic areas listed above. A list of the breakout group assignments is included as Appendix II. To assist in their deliberations, participants were provided with worksheets detailing each assignment and presented specific questions to be addressed under each of the general topic areas outlined. These worksheets are included as Appendix III. Upon completion of its work, each breakout group presented its findings to the entire assembly. The meeting facilitator recorded the presentations for inclusion in this summary report.

While most of the professionals attending the Think Tank held similar views on fundamental questions of program structure and funding, opinions varied, in some cases widely, on other issues addressed during the session. When no consensus was reached, the differing perspectives offered by Think Tank participants were noted and summarized. The following discussion summarizes the group's findings on each of the six treatment program areas described earlier.

2 Marsha Kelly of Kelly Media Counsel, 6 West 5th St., Suite 700, St. Paul MN 55102 facilitated and helped to organize the entire project. She contributed significantly to this final report. We owe her a great debt of gratitude and extend our special thanks.

FINDINGS: ADMINISTRATIVE STRUCTURE AND FUNDING

Designing an Effective Structural Model (Worksheet 1)

The first assignment for each group was to design a structural model for the ideal gambling treatment program. Participants addressed a series of questions to help them focus on key structural issues such as legislation, administrative structure, staffing, and accountability. They recommended a structural approach to developing gambling treatment programs that would rest upon legislation incorporating three key elements:

Clearly stated authority and accountability to senior administration officials

Participants felt that states should establish a separate department or office to handle problem gambling programs, independent from programs that address other addictive behaviors (e.g., alcohol, drug abuse) or other public health issues. The department should be clearly identified with the words "problem gambling services" in the title. The think tank participants thought that this separate identity would reinforce the notion that problem gambling is a unique problem requiring specialized solutions.[3]

According to participants, the ideal problem gambling program should be structured to report to high-level administration officials within state government, or even to the Office of the Governor. This high-level accountability was deemed consistent with the importance of gambling revenues to state budgets. It also was deemed useful in marking the program as a high priority for the state.

Continuity of management, even in the face of political changes, was an important issue for Think Tank participants. Although a political appointee might hold the top position in a problem gambling department, they felt that second-level program administrators should be qualified civil servants who would remain in place despite changes in administration.

Participants also recommended the establishment of an independent advisory board to include qualified problem gambling and mental health professionals, educators, academicians and others with special interest or expertise in the problem gambling field. The advisory board would assist the state agency responsible for problem gambling programs by developing qualifying standards for independent contractors seeking to provide services to the department; reviewing and evaluating proposed contracts; developing job descriptions for program administrators and clinical staff; interviewing and making recommendations on prospective hires; providing information on new trends in the field, and helping to identify public needs.

Dedicated funding mechanisms to ensure funding continuity

There was strong agreement among Think Tank participants that legislation establishing a problem gambling treatment program must include a mechanism for ongoing funding of the program in an amount sufficient to meet the cost of the mandated services. Participants felt that linking program funding directly to state gambling revenues was the most logical way to ensure funding continuity. As a practical matter, lottery or other state gambling revenues at least partly fund most existing problem gambling treatment programs. Earmarking a fixed percentage of state gambling revenues for problem gambling treatment was considered the best and most appropriate funding mechanism.

3 Readers should keep in mind that this and other suggestions represent the group's opinions. Empirical evidence is not always available to support these positions. For example, it has not yet been demonstrated that gambling is sufficiently unique from other mental disorders to require distinct treatment programs.

Specificity as to services to be provided and the qualifications/credentials of those who are to provide such services

Participants noted that legislation defining the services to be provided should clarify expectations, but also should leave room for flexibility, as new needs emerge and new program trends become apparent. Most important, they noted, was the need to avoid restrictive legislation that might limit the ability of a problem gambling treatment program to provide services appropriate to the client, either directly or under private contract.

Participants noted that states should require problem gambling service providers to be licensed and/or certified under state guidelines or national standards. This licensure or certification should require training specific to the field of problem gambling. Although training in other addictions might be helpful and perhaps even be required, there was strong agreement that problem gambling-specific training should be a condition of state licensure or certification. Similarly, where states might choose to contract for services with private vendors, participants agreed that gambling-specific licensure or certification of those responsible for delivery of services should be required as a condition of the contract.

Designing an Effective Funding Model (Worksheet 2)

Participants were asked to identify public and private funding for problem gambling treatment programs and to assess the advantages and disadvantages of each. In addition, the group examined self-payment and insurance strategies for delivering funding.

Public Funding

Potential sources of public funds include federal, state and local governments.

Participants identified several arguments in favor of seeking public funds:

Availability

In most states, public funds have been the primary source of support for newly established gambling treatment programs. Participants noted that public funds often become available in response to a perceived need, sometimes documented through needs assessments or incidence/prevalence studies. In addition, public funding can be tied directly to specific funding mechanisms such as lottery revenues, gambling taxes or event taxes.

Flexibility

Participants noted that public funds often are available for a broader range of purposes than private funds, which are seldom available for capital projects or administrative uses.

Accountability

Participants noted that public funding commitments often can be structured to include mandated quality control mechanisms for superior accountability.

Participants also identified several arguments against seeking public funds:

Risk of Politicization
Because gambling can be controversial, public funding for gambling treatment programs can sometimes fall victim to internal legislative or partisan politics. Funding also can be hampered by charges of conflict of interest when the legislators who raise gambling revenues are also asked to allocate funds for gambling treatment.

Cost and Timeliness
The slow and cumbersome nature of most state appropriation processes makes it difficult to obtain funding commitments quickly. Retaining lobbyists to assist in the process can become expensive.

Legislative Earmarking
While public funds are usually available for a broader variety of purposes than private funds, it is also true that most appropriations are earmarked for specific purposes and cannot be diverted to uses other than those intended, even if needs change.

Participants noted that most public funding to date has originated at the state level with little, if any, federal involvement in problem gambling programs. They suggested that federal funding for such programs is needed to balance funding inequities that currently exist from state to state, or within a state from disorder to disorder.

In most states, funding for problem gambling is allocated through the state's standard legislative appropriation process. Where independent advisory councils exist as an adjunct of state-funded programs, Think Tank participants recommended that the councils assist in the development of recommended budgets and state appropriation requests. They suggested a two-track approach, where funding would be directed to the responsible state agency, allowing for individual reimbursement options; or to private vendors under a system where treatment dollars follow the client to the provider of choice.

Private Funding

Participants identified two arguments in favor of private funding.
First, they noted, it often takes less time to obtain private grants than public funds. Second, private grants often allow for more creativity and innovation in programming. Private funding sources include:

Gaming and Gaming-Related Companies
Participants noted that gaming and gaming-related companies should be considered primary targets for gambling treatment fundraising efforts. Such companies face both ethical and practical imperatives to contribute to gambling treatment programs.

Non-Gaming Companies
Participants pointed to financial institutions, pharmaceutical companies and insurance companies as businesses that are likely to be negatively affected by problem gambling, and therefore represent prime targets for fundraising.

Charitable Organizations and Endowments
Community-based charities, regional or mission-specific foundations, estates and endowments are useful potential funding sources.

Participants identified several disadvantages of private funding:

Lack of Availability and Awareness
The pool of available private funds is far smaller than the pool of available public funds, and there may be less awareness of gambling problems in the private sector than in the public sector.

Difficulty and Cost of Fundraising
Raising funds from private sources can be expensive and time-consuming, and often requires special fundraising expertise.

Loss of Program Control
Private funders sometimes demand unwarranted control over programs, causing conflict and putting program quality at risk.

Self-payment
Participants discussed the concept of funding through self-pay programs, and acknowledged advantages and disadvantages of the self-pay approach.

The advantages of the self-pay approach include:

Perceived Value
According to participants, people tend to place a higher value on services they pay for themselves.

Therapeutic Message
Paying for treatment may help reinforce therapeutic messages of "no bailout."

Financial Impact
Patient payments can create a stable funding base for the treatment program.

The disadvantages of the self-pay approach:

Regulatory Conflicts
Requiring self-payment could violate state or HMO rules.

Disincentive Effect
Patients who need treatment might be discouraged by fees or might use cost as a reason to avoid treatment. In turn, families may be hurt if patients cannot or will not pay for treatment.

Fairness
Given the often considerable debt associated with gamblers who are entering treatment, it is frequently difficult to set fair fee structure. This group is often without gainful employment or faced with enormous financial obligations that complicate the fee for service relationship.

Insurance Coverage

The role of insurance coverage in paying for problem gambling services was the subject of considerable discussion. Participants identified several steps that might encourage insurance providers to cover the cost of problem gambling treatment at parity with other mental health disorders:

Recognition of Problem Gambling as Disease

Participants noted that insurance companies might be more inclined to cover treatment if they were aware that problem gambling has been recognized as a disorder in the same way that chemical dependency and other mental health disorders have been recognized for insurance purposes. Such recognition and subsequent response by insurance companies could vitiate the need for legislation.

Equal Access to Treatment

Participants said insurance companies are less inclined to cover treatment when there are geographic and/or other disparities that cause their customers to have unequal access to treatment services. Broader access to treatment would remove this barrier to coverage.

Improved Treatment Credibility

Participants felt insurance companies would look more favorably on the coverage of gambling treatment if there were more information available on the efficacy of various treatment programs, and if the credibility of clinical professionals could be enhanced through upgraded certification and licensure programs.

Legislation

Absent insurance industry action, state legislatures could be asked to require insurance providers to cover gambling treatment as they currently cover other mental health disorders including alcohol and/or drug addiction. Such legislation could be structured to make the state the payer of last resort and fund co-pay requirements or deductibles.

TREATMENT DELIVERY FINDINGS PART I: MODALITIES AND SETTINGS

Designing an Effective Treatment Model (Worksheet 3)

Treatment Modalities

Participants agreed that screening and assessment are critical elements in the continuum of care, irrespective of the treatment modalities in use. They noted the particular importance of appropriate and thorough assessment instruments that identify medical, psychiatric, personality and intelligence and neurocognitive concerns. Think Tank participants identified a range of treatment modalities, ancillary and support services that should be available in state-funded treatment programs. These services include individual counseling, group counseling, family counseling, peer counseling, spiritual counseling, psychological testing and aftercare or continuing care. In addition, the participants suggested that state-funded treatment programs provide opportunities to consider and integrate emerging or experimental treatments into the program (e.g., Eye Movement Desensitization Reprocessing (EMDR) and hypnotherapy). Participants also recognized the importance of evaluating experimental treatments to assure safety and efficacy.

Think Tank members also pointed to a series of support services that they believe are important adjuncts to treatment, including community outreach and education, reimbursed case management, occupational counseling, financial and bankruptcy counseling, psychoeducation[4], smoking cessation, and intervention.

Finally, participants stressed the desirability of providing prescription medication, transit to treatment, childcare services, and translation of materials for non-English speaking patients.

Treatment Settings

According to participants, gambling treatment services should be provided in a full range of settings. There was agreement that rural settings tend to have more limited resources, while urban settings usually offer more resource options. In addition, it was suggested that urban patients might be more receptive to treatment because treatment programs for alcohol and chemical dependency often are well publicized and visible in urban settings. Participants felt a mobile treatment unit would be highly desirable to service patients in rural communities.

Other settings viewed as optimum for providing gambling treatment services included residential facilities such as homes, halfway houses or housing developments; inpatient and outpatient hospital and clinic facilities; schools and universities; correctional facilities; community sites such as youth and senior centers, women's shelters and churches; workplace locations; internet chat rooms and gambling locations.

Licensure and Certification

Participants were asked to indicate what type of licensure or certification should be required of problem gambling program staff. They responded:

- Supervisors should be multi-credentialed (i.e., qualified in problem gambling counseling as well as other addiction and mental health fields).
- Entry-level staff should have problem gambling-specific training regardless of other credentials.
- National and/or state certification should be required, with an additional requirement of at least twenty hours of relevant gambling-specific continuing education every two years.

4 Education related to psychological and social skills and attitudes

TREATMENT DELIVERY FINDINGS PART II: ASSESSING IMPACT AND EFFICACY

Designing an Effective Client Recruitment & Retention Model (Worksheet 4)

To provide context for the discussion of treatment impact and efficacy, Dr. Howard Shaffer presented a definition of two essential terms, noting that treatment "efficacy" refers to the net positive effects and duration of treatment, while treatment "impact" is a function of efficacy and patient participation.

According to Shaffer, since gambling treatment programs currently attract only a small percentage of gamblers who might make use of such care, treatment protocols that attract larger numbers of people into treatment might ultimately result in higher impact than those that attract fewer numbers, even if the treatment efficacy rates are higher in the smaller group (e.g., Prochaska, 1996). As an example, he cited two scenarios:

Clinical Protocol A:	**100 patients x 50% efficacy rate**	**=**	**50 patients treated successfully**
Clinical Protocol B:	**1,000 patients x 25% efficacy rate**	**=**	**250 patients treated successfully**

Protocol B yields 5 times more treatment impact than protocol A in spite of having only half the efficacy. Shaffer suggested that current treatment approaches might be repelling potential patients, since some potential patients are "put off" by their perception of "excessive" treatment demands, such as having to change or never gambling again. He noted that, although it is likely, there is no evidence that higher levels of treatment efficacy, per se, encourage more participation in treatment. For this reason, he concluded, effective client recruitment and retention strategies are critical to maximizing treatment impact and helping more disordered gamblers.

Client Recruitment

Think Tank participants were asked to identify optimal methods of attracting clients into treatment programs. Specifically, they addressed ways of getting the message, that gambling problems can be treated and that treatment is available, out to the general public, the individual gambler, and family members of gamblers. They also identified the key messages to be delivered. In each case, participants noted that public information campaigns are pointless, and even counterproductive, if the systems and services necessary to meet the needs of those who will seek assistance are not in place. If a troubled gambler seeks help and is unable to get it due to a system failure, that individual may not seek help again unless or until a major crisis develops.

Key Principles for Public Messages

- ► Educate the public about the symptoms of disordered gambling and how to recognize problem gambling.
- ► Emphasize hope for recovery by noting the availability and accessibility of help.
- ► Avoid scare tactics.
- ► Promote hotline or referral numbers for quick access in crisis.

Public, Gambler and Family Outreach

Participants noted that systems must be in place to handle hotline inquiries and referrals generated by the approaches suggested here. It should be noted that many of the outreach methods suggested here would be useful in reaching all three groups—the general public, gamblers themselves, and the families of problem gamblers. The following grid presents each of the outreach vehicles mentioned, and the target audiences that might be reached by each.

RECOMMENDED OUTREACH VEHICLES BY TARGET GROUP

Vehicle Type	General Public	Gamblers	Gamblers' Families
News media/news coverage	♦	♦	♦
News media/paid or PSA	♦	♦	♦
Specialty media targeted by market segment	♦	♦	♦
Educational web site	♦	♦	♦
Internet Chat Room w/ access to Counselors		♦	♦
Educational curriculum for junior/senior high students	♦	♦	♦
School/university libraries	♦	♦	♦
Workplace HR/EAP offices, employee newsletters, pay envelope stuffers	♦	♦	♦
Casinos, lottery, pull tab sales outlets; message on lottery tickets, pull tab backs, parimutuel ticket backs		♦	♦
Casino employee education		♦	♦
Billboards, signs at sporting events	♦	♦	♦
Professional offices, organizations and conferences	♦	♦	♦
Information to medical providers, hospitals and clinics, addiction treatment centers and self-help/12-step groups		♦	♦
24-Hour walk-in crisis center at mental health or addiction treatment center		♦	♦
Community events, fairs, festivals	♦	♦	♦
Social service agencies and veterans service offices	♦	♦	♦
Law enforcement community (police, bankruptcy court, criminal court, judges, probation officers, attorneys)		♦	♦
Retail stores, service shops	♦	♦	♦
Banks, check cashing sites, pawn shops, consumer credit agencies		♦	♦
National Problem Gambling Screening Day: free screening at treatment centers, by phone, Internet or in person at other selected sites	♦	♦	♦

♦ = Target group

Client Retention

Think Tank participants emphasized that treatment must be matched to individual clients to maximize outcomes and enhance client retention. Every gambler is different and approaches that work for one may be ineffective or counterproductive for another. Given this caveat, participants identified an extensive list of factors that, where appropriate, might encourage clients to stay in treatment.

Comprehensive, Reliable Assessment

As previously noted, participants felt this is a key factor in client retention, since information gained in the assessment process drives the development of an individualized treatment plan. Group members felt that an effective and reliable assessment process requires quality staff as well as appropriate assessment instruments.

Immediate, Effective Crisis Response and Follow-Up

Immediate response by a live voice to callers in crisis, including Saturday/Sunday nights and late nights (24/7) as well as timely follow-up and callbacks by referring agents were recommended.

Helpful, Supportive Attitudes and Environment

Coordinating scheduling of appointments to promote attendance and optimize access to treatment activities; facilitating connections with appropriate therapeutic or community-based support groups; facilitating child care, transportation or other potential barriers to regular attendance; demonstrating helpful attitudes, experience and understanding among treatment staff; employing culturally sensitive communication and treatment methods; evaluating payment options and potential impacts on client's participation in treatment.

Appropriate Case Management

Participants recommended: developing individual client-appropriate treatment plans based on individual client strengths, and including realistic, flexible and individually appropriate treatment goals; engaging family in treatment program; coordinating with other systems and bureaucracies affecting client; offering/facilitating treatment of co-existing disorders and mental health issues; offering on-site Gamblers Anonymous meetings as well as alumni/mentor/peer counseling; providing financial counseling and crisis assistance; ensuring active follow-up by clinician after treatment; and knowing when to discharge clients from treatment.

Impacting High-Risk Populations

Think Tank participants agreed that special programs should be developed to reach high-risk populations and those from diverse cultures who may not be reached by traditional educational approaches. Examples of such programs are shown on the following grid:

RECOMMENDED STRATEGIES FOR HIGH-RISK POPULATIONS

	Signage	News/Ads	Hotline/On-site Evaluation and Treatment Capabilities	Education/Info	Other
Seniors	Senior centers, senior buses	Senior publications	Senior centers	Senior centers, agencies, clients and staff	
Youth	Schools and youth centers	School and youth publications	Schools and youth centers	Counselors, coaches, school drug/alcohol counselors	
Ethnic Minorities	Ethnic-based community centers	Culturally specific media, to targeted demographics	Culture-specific community centers with multi-linguistic counselors	Culturally specific community service providers	Research/input from targeted cultural groups
High-Risk Populations				Associations of professionals working with addiction disorders	
Homeless	Missions, food kitchens, shelters			Missions, food kitchens, shelters	

Measuring Effectiveness of Recruitment and Retention Efforts

Participants agreed that two primary criteria might be used to measure the effectiveness of client recruitment efforts:

Statistical Analysis including analysis of numbers of hotline inquiries compared to first appointment, compared to completion/discharge; analysis of client demographics to identify participants from high-risk or targeted populations; use of the formula to determine treatment impact (patient participation x efficacy).

Client Surveys including pre- and post-tests to determine quality and appropriateness of referrals and client satisfaction surveys.

Designing an effective assessment model for treatment programs (Worksheet 5)

Participants were asked to identify both objective and subjective criteria that could be used to measure treatment efficacy. These objective criteria included:

Changes in Gambler Behavior

Included a reduction of gambling, illegal behaviors, incidence of other addictive behaviors, debt, depression/anxiety, self-induced crises, manifestation of symptoms as described in diagnostic manuals. In addition, these criteria include improvement in fiscal management behaviors, coping skills, making restitution, active involvement in self-help activities as well as a stated satisfaction with treatment experience.

Observations of Others

These included observed increase in gambler's coping skills, based on periodic assessment of functioning level; periodic reports from client, family or others; compliance with treatment plan and accomplishment of agreed goals.

Subjective criteria for measuring treatment efficacy included:

Changes in Gambler Attitudes

Improvements in hopefulness, motivation for further change, ability to build intimacy, ability to withstand cravings, feeling of connection to family, friends, and appreciation of gambling related realities.

Observations of Others

More time spent on family and leisure activities, increased financial stability for client and family members, less secrecy/more open discussion of family finances, improved family resistance to bailouts, and improved trust among family members.

FINDINGS: A PATIENT BILL OF RIGHTS

Designing a model "Patient Bill of Rights" (Worksheet 6)

Think Tank participants noted that the concept of a "patient bill of rights" has gained momentum in recent years with the emergence of managed care and the perceived transfer of health care control from physicians and patients to insurance companies. They agreed that patients and family members should expect any problem gambling treatment program to provide certain elements of such a bill, including:

Patient Rights/Expectations

With respect to the treatment process, participants agreed that patients are entitled to expect an assurance of confidentiality and clarity about limits of confidentiality; the right to limit personal disclosure; a mechanism for receiving feedback, handling complaints and resolving conflicts; a clear statement of rules and regulations; open patient access to records and charts; respectful and courteous interaction with staff; flexible fee structures and assurance of treatment despite an inability to pay; and a mechanism for involving family members when appropriate.

With respect to the treatment program itself, participants felt patients should expect a clean, comfortable, safe and accessible treatment environment; competent, certified and/or licensed, properly trained staff; professional case management and reasonable continuity of care; patient participation in individualized treatment planning and goal-setting; state-of-the-art treatment based on cutting edge knowledge and research; a clear understanding of discharge criteria and follow-up alternatives; and the opportunity to change therapists if desired.

According to participants, family members of patients are entitled to an assurance of confidentiality, including any limits to confidentiality protection; to receive information to the extent authorized by the patient, and to express concerns and receive reasonable warnings if a threat to family safety is perceived; to receive education on problem gambling and related disorders, and referrals to other services where warranted; and to receive information on financial options and available finance-related services.

Patient Obligations/Responsibilities

There was substantial disagreement among Think Tank participants about the extent to which treatment programs should lay out patient duties and responsibilities. Some group members felt that a "Patient Bill of Rights" should not only tell patients what to expect, but also should tell patients what is expected of them. Those who supported a clear statement of "patient obligations" were inclined to include basic behaviors such as showing up for scheduled appointments, treating counselors and others with courtesy and respect, and making treatment a high priority. Other participants were in favor of limiting their expectations to a patient showing up and behaving in a safe manner. They felt that patients should not be dismissed from treatment for any of the same behaviors that qualified them for treatment in the first place; stated differently, some participants perceived many of the patient obligations to be the result of good treatment; therefore, such obligations should not be required to participate in treatment. These participants also felt that it was pointless to outline these expectations since patients come into the treatment process with widely varying levels of commitment and therefore could be discouraged from seeking or staying in treatment if they perceived the stated patient duties and obligations to be onerous. Those who opposed the statement of "patient obligations" noted that it might be more appropriate to include them as "hoped for" behaviors rather than "expected" behaviors because they could not reasonably be viewed as a requirement for receiving treatment.

FINDINGS: BEST PRACTICE GUIDELINES

Designing model "Best Practices" guidelines (Worksheet 7)

Think Tank participants identified services to be included in a model set of "best practices" guidelines for problem gambling treatment programs. These guidelines included:

Client Identification, Recruitment and Retention

- Community Outreach
- Collecting and Analyzing Data

Treatment Delivery

- Staff Training and Quality Assurance
- Patient and Family Education
- Treatment Modalities, Settings and Support Services
- Medical and Therapeutic Intervention
- Outcome Evaluation, Discharge and Relapse Prevention Planning
- Cultural Appropriateness and Accessibility

Fiscal Management and Planning

Confidentiality Guidelines

TOWARD THE FUTURE

Since the discussions were extensive and exceeded the available time, there were additional issues identified during the think tank process as central that require additional attention. The participants agreed that these issues warranted considerable further attention and deliberation. As these issues surfaced, they were moved to a virtual holding area designated as "the parking lot." These complex issues provide an important architecture for advancing gambling theory, treatment and research. These remaining issues provide a portal to the future of gambling treatment and research by identifying contemporary conceptual or practical areas that lack sufficient clinical and programmatic clarity. Eight major issues were identified for future consideration. A brief discussion of each area follows below.

Clarifying the nature of gambling disorders

Participants agreed that there is still no consensual and precise understanding of the nature of problem gambling as an addictive disorder, how it differs from other addictive disorders, or where it fits in the scheme of mental health issues. Participants noted that addiction and addictive disorders are not included in current diagnostic schemas. In addition, the participants noted that as pathological gambling is currently conceptualized, there is no diagnostic category equivalent to substance abuse. Important questions were raised about conceptualizing intemperate gambling as an impulse disorder, compulsive disorder, or addictive behavior.

Improving client assessment instruments and applications

Participants noted the need for better means of client assessment, and more research to help clarify appropriate application of these instruments in a variety of different clinical situations (e.g., crisis management).

Considering the relationships among treatment modalities and settings

Participants suggested that treatment modalities and settings should be the focus of extensive additional discussion among problem gambling professionals. More research is needed to evaluate the efficacy of various modalities and how clinical settings might influence treatment efficacy for individual clients across different venues.

Individualizing approaches to assessment, treatment and evaluation

Think Tank participants frequently felt the need to qualify their general recommendations with the phrase, "when appropriate." They noted often that various treatment modalities might be effective for one individual and not another. Patient attitudes toward treatment vary so dramatically that the "ideal" problem gambling program might have to offer the entire spectrum of modalities and settings—an approach that could be costly and difficult to justify to results-conscious legislators. More deliberative and evaluative work is needed, according to participants, to determine an optimal balance between the need for individualized approaches and the need to operate at maximum efficiency for minimum cost.

Resolving issues associated with self-payment for services

Participants recommended further examination of the implications of self-payment for services. Since gamblers often have considerable financial difficulties, this deliberation should include a consideration of whether self-payment increases or decreases the perceived value of treatment, whether it encourages or discourages continued treatment participation and follow through, or whether a self-payment requirement discourages participation and becomes an obstacle to treatment.

Focusing on the public health dimensions of problem gambling

It was agreed that public health officials at the state level generally have failed to address problem gambling as a public health issue. They have not attended to the social and economic consequences of widespread gambling. An effort should be made, according to Think Tank participants, to focus the attention of state public health officers on this issue in the future (e.g., Korn & Shaffer, 1999; Korn, 2000).

Developing in-patient treatment resources

Participants noted that only a handful of gambling states offer in-patient treatment services for problem gamblers. Gambling states should be made aware of the importance of in-patient services as one key component of a comprehensive state response to problem gambling. Representatives of state-funded programs might assemble again in the future to discuss developing a blueprint for establishing these programs and delivering this message to their own state legislatures.

Attracting financial support for problem gambling treatment programs from Indian tribes that operate casinos

Although some tribes and tribal organizations have supported local problem gambling treatment efforts, there has been no coordinated or organized effort to attract funding from tribes for problem gambling education and clinical care. Future efforts might produce suggested strategies for approaching tribal governments and making the case how they can best support these programs.

CONCLUSIONS

Think Tank participants learned that state-funded treatment programs vary widely in structure, funding, numbers of clients served, treatment modalities offered, and staffing. In addition, there were discrepant views of these services as a function of the participant's status as a funder or fundee, and government or program representative. More collaboration among these groups holds potential for advancing state funded gambling treatment programs.

Virtually all participants expressed a sense of frustration that so little is known about the nature of gambling disorders, or about the efficacy of various treatment approaches. The observations and recommendations recorded here reflect their personal, subjective and largely intuitive responses to the questions posed by the facilitator as a means of stimulating discussion. All agreed that much more scientific research needs to be done in this area.

There was a considerable amount of disappointment that time did not permit more extensive discussion of the issues relegated to the "parking lot." This circumstance suggests the importance of future efforts that convene representatives of state-funded gambling treatment programs. Some participants suggested a follow-up conference to address those issues and others that received limited attention during this meeting. The Massachusetts Council on Compulsive Gambling and Harvard Medical School's Division on Addictions have suggested that future Think Tank events might focus on the nature of problem gambling as an addiction or other disorder, client assessment, treatment efficacy, and gambling as a public health issue. In addition, the framers of this conference suggested that another event be convened for states without gambling treatment programs. This event would help these states to develop treatment programs based on the best clinical practices and experiences of existing programs.

Think Tank participants expressed the strong view that the field of gambling treatment would be well served if professionals were able to interact with one another more frequently in informal settings permitting wide-ranging discussion of the issues addressed here. This likely reflects the limited training and supervision opportunities that were reported by the participants.

There is much to do as we develop, implement and evaluate treatment programs for gambling and related disorders. More Americans are gambling than ever before. In addition, young people who have developed in a context of state-sponsored legalized gambling for their entire life are reaching adulthood. Consequently, it is possible that there will be increasing demand for gambling related clinical services. People suffering with gambling disorders deserve the best care that our treatment system has to offer. It is our responsibility to develop and deliver these services.

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APPENDIX III: THINK TANK WORKSHEETS

WORKSHEET 1

Program structure and funding: Designing an effective structural model

Groups 1, 2, 3 – STRUCTURE

Groups 1, 2 and 3 will meet separately but address the same questions on program structure.

Assignment: Design a structural model for the "ideal" gambling treatment program. Your model should address the following questions:

1. What legislation, if any, would be needed to establish the program? What structural issues should the legislation address?

2. Who would administer the program? To whom would management staff report?

3. Who would hire program staff? To whom would program staff report?

4. Who would set budgets and determine how resources are allocated?

5. Who would decide what treatment methods would be used?

6. What structural problems or issues, if any, is your approach designed to avoid?

Please be prepared to explain the key reasons or rationale behind each of your answers.

WORKSHEET 2

Program structure and funding: Designing an effective funding model

Groups 4, 5, 6 – FUNDING

Groups 4, 5 and 6 will meet separately but address the same questions on program funding.

Assignment: Design a funding model for the "ideal" gambling treatment program. Your model should address the following questions:

1. What sources of public funding are available? What are the advantages and disadvantages of public funding?

2. What methods are most effective in securing public funding?

3. What sources of private funding are available? What are the advantages and disad-vantages of private funding?

4. What methods are most effective in securing private funding?

5. What are the arguments for and against requiring clients to pay for gambling treat-ment?

6. What steps could be taken to secure coverage of gambling treatment by health care insur-ance providers?

7. What steps could be taken to ensure that patients are not denied treatment for lack of insurance coverage?

Please be prepared to explain the key reasons or rationale behind each of your answers.

WORKSHEET 3

Treatment deliver, part 1: Designing an effective treatment model

All groups

Each group will meet separately but address the same questions on treatment delivery.

Assignment: Design a treatment model for the "ideal" gambling treatment program. Your model should address the following questions:

1. What services would be provided as part of your treatment approach?

2. In what settings would your program deliver treatment?

3. Which treatment modalities would be optimal in which settings?

4. What licensure or certification, if any, would be required of your program staff?

5. What continuing education or training activities would be required?

Please be prepared to explain the key reasons or rationale behind each of your answers.

WORKSHEET 4

Treatment delivery part II: Assessing impact and efficacy by designing an effective client recruitment/retention model

All groups

Each group will meet separately but address the same questions on client recruitment and retention.

Assignment: Design a client recruitment/retention model for the "ideal" gambling treatment program. Your model should address the following questions:

1. How would the general public be informed about your program?

2. How would potential clients learn about your program?

3. How would family members of potential clients learn about your program?

4. How would potential clients or family members contact your program?

5. How would you ensure the continued participation (retention) of clients?

6. How would you reach out to clients in high-risk populations?

7. What criteria would you use to measure the impact of your client recruitment pro-gram?

8. What criteria would you use to measure the impact of your client retention effort?

9. What criteria would you use to measure the impact of your effort to reach out to high-risk populations?

Please be prepared to explain the key reasons or rationale behind each of your answers.

WORKSHEET 5

Treatment delivery, part II: Assessing impact and efficacy – Designing an effective assessment model for treament programs

All groups

Each group will meet separately but address the same questions on assessment of treatment effi-cacy.

Assignment: Design an effective assessment model for the "ideal" gambling treatment program. Your model should address the following questions:

1. What objective criteria would you use to measure the efficacy of your gambling treatment programs and services:

2. On clients

3. On client families

4. What subjective criteria would you use to measure these effects?

5. On clients

6. On client families

Please be prepared to explain the key reasons or rationale behind each of your answers.

WORKSHEET 6

Patient rights: Designing a model "Patient Bill of Rights"

All groups

Each group will meet separately but address the same questions on patient rights.

Assignment: Design a model "Patient Bill of Rights" for the "ideal" gambling treatment program. Your model should address the following questions:

1. What should a patient expect from your program?

2. What should a patient's family expect from your program?

3. What should be expected of the patient?

Please be prepared to explain the key reasons or rationale behind each of your answers.

WORKSHEET 7

"Best Practices" guidlines: Designing model "Best Practices" guidelines

All groups

Each group will meet separately but address the same questions on 'best practice' guidelines.

Assignment: Design a model set of 'Best Practice' Guidelines for the "ideal" gambling treatment program. Your model should address the following questions:

1. What general topics should such guidelines cover?

2. What specific issues should be addressed under each topic heading?

Please be prepared to explain the key reasons or rationale behind each of your answers.

(Helpful hint: visualize your final product as the Table of Contents in a textbook entitled "Guidelines for Best Practices in the Treatment of Problem Gambling.")