

**A Massachusetts Listening Session with Gambling
Treatment Practitioners:
Exploring a Continuum of Treatment Services
February 15, 2008**

Welcome

Michael Botticelli, Director of the Massachusetts Department of Public Health Bureau of Substance Abuse Services (BSAS) and *Kathleen Scanlan*, Executive Director of the Massachusetts Council on Compulsive Gambling (Massachusetts Council) welcomed the participants. *(Please see the Appendix for a list of participants and an agenda for the listening session)*. Michael reported that the casino proposal put forth by Massachusetts' Governor Deval Patrick has put the issue of problem gambling treatment on the forefront. The question of the need for a comprehensive problem gambling treatment system is separate from the discussion of gambling expansion in Massachusetts, Michael ascertained, but is essential for it to be explored given the ongoing gambling expansion debate in Massachusetts. Kathy offered that the primary purpose of today is to listen: a conversation with practitioners and BSAS, a look at what a continuum of care could look like for Massachusetts. The goal of today's meeting is to plant ideas, not to reach conclusions.

Listening to Their Stories: The Reality of Accessing Treatment Services in Massachusetts

Two former problem gamblers each told the story of how they began gambling, how they developed a problem, and how they found treatment and recovery. Some common themes arose from the two stories, one of a male problem gambler who served time in federal prison as a result of his gambling, and the other of a female gambler who was enrolled in a master's in counseling program when her gambling became a problem. Areas in which their stories were common are around accessing treatment for their gambling problem. Both found appropriate treatment difficult to find, reporting dark unwelcoming surroundings at all male GA meetings and a lack of understanding of gambling within the mental health field. One reported being hospitalized for a "severe mental illness," in relation to his gambling problem. He received no treatment for his addiction while hospitalized.

Listening Session I: Ambulatory Gambling Treatment Services

- **Outpatient treatment criteria and best practices**
 - Success oriented and have well paid, committed staff
 - The Connecticut program, which is state and grant funded, offers individual care, family care, peer counseling and legal assistance
 - Providers must be trained to address the families of gamblers, who may not interact with the mental health field in any other way
 - Helpline staff could be trained to recognize family members of problem gamblers as potential clients also.
 - Pharmacological options may be useful for family members
 - Involvement of family and significant others is important

Treatment Listening Session Report - Page 1

- Creativity, flexibility and a public health perspective are essential elements of family services
 - Individuals with gambling problems are often entering mental health system for other psychiatric disorders, not gambling
 - A need to increase awareness, use word of mouth referrals, determine payment methods
 - Limit restrictions on treatment options, using both traditional and non traditional
- **Outpatient Treatment Challenges and Rationale**
 - There is no infrastructure for problem gambling services in the United States
 - While there is a baseline rationale for treatment of addictions, there is no observed baseline for gambling treatment
 - A lack of knowledge and training is present within state service systems
 - Important to consider how problem gambling interacts with other state systems, such as corrections and mental health, and to look inside existing state systems for referrals
 - Not separate care, but integrated care into existing systems is needed
 - The importance of a person/people to champion the issue within Massachusetts and to promote integration and follow up on the results of the integration efforts was stressed
 - Greater leadership is needed at the “top,” a larger public health model
 - Concentrated legislative strategy is needed; national approach to legislative agenda
 - Advocacy for problem gamblers and families- who is the messenger? What is the message?
 - It is recommended that states take advantage of the freedom allowed since problem gambling services are not restricted by block grant or other federal funding
 - Critical to look at early interventions
 - Prevention is difficult to fund/move forward
 - Need to continue to push federal government to add dedicated funding for gambling data -a national survey
 - There may be a need to combine the data sets across state lines to increase the sample sizes
- **Problem Gambling Among Youth**
 - Research conducted over the last eighteen years in Canada has demonstrated a small but identifiable percentage of youth who get into trouble with gambling
 - Numerous barriers to getting youth into treatment for gambling and the consequences are not the same as for adults
 - Youth gamblers cannot measure “loss,” as they are still in school and live with their parents
 - Youth gamblers are not concerned with risks associated with gambling and often find gambling easily accessible, despite legal barriers

- The interest in gambling for youth may grow out of boredom and attempts at normalization, and may be fostered by parents
- A shift in Canada in recent years from kids going to casinos to kids playing on line either with friends or alone
- Once a kid accesses treatment for problem gambling, a whole host of other issues may arise
- It is found that gambling is often a solution to problems for kids
- Need to consider the individual when treating youth, and to use creativity when developing a youth program

Listening Session II: Residential Gambling Treatment Services

- **What are the criteria for residential treatment? Some scenarios:**
 - Motivated for treatment but cannot do it in outpatient setting
 - Sometimes accessed substance abuse treatment first
 - Needs crisis stabilization
 - Currently in outpatient treatment and referred
 - Attempted other ways to stop and asks for residential care
 - In need of structured setting
 - Comorbid issues
 - Suicidality

- **Residential treatment rationale**
 - Each state differs in how services are delivered and statutes of some states prohibit residential treatment
 - Very few states fund residential treatment for problem gambling
 - The need for “respite” services - 2-7 days has been heard
 - Some states purchase 1-2 beds form Halfway houses or other short term stay models
 - “Transitional Housing,” halfway house beds with outpatient counseling
 - Provide place for client to “land”
 - Questions for states around where gambling treatment should be (i.e. medical model, public health system)
 - Licensing and regulation issues exist

- **Patient placement criteria can be a “slippery slope”**
 - Cleveland criteria; ASAM criteria
 - Guliani & Scholl criteria for assessment for inpatient v. outpatient care
 - Clients met every criterion and were equally separated into outpatient/inpatient care- same success rates resulted.

- **Components and best practices of residential treatment**
 - No “gold standard” for treatment modality – always changing
 - Strong family component
 - Financial Counseling
 - Clients can be taken to outpatient appointments and GA meetings

- In Connecticut, the length of stay is 5-7 days and funded for state residents only. Calls are received from Massachusetts residents
 - In Louisiana, the program is 36 days at a cost of \$90 to state residents and \$6,000 to non residents; program has 21 beds
 - Reimbursement of about 20-50% from insurance companies of approximately 80% of program participants; daily per person cost of program is \$115 in Louisiana
 - New intensive outpatient program and working on an outcome measurement tool in Louisiana
 - Do not treat adolescents currently and ethnic/racial minorities are under represented in the Louisiana program
- **Residential Program Marketing and Promotion:**
 - Promote program through media events, newspapers
 - Helpline number on all casino ads
 - Louisiana diversion program works well
 - Word of mouth,
 - National council
 - Websites
 - Conduct trainings for casino employees and state police in Louisiana
 - Day long annual reunion for clients and families

Listening Session III: Crisis Interventions, Aftercare Services, Pharmacological Treatment, Regulations and Outcomes Measurement

- **Treatment Approaches**
 - Pharmacological treatment may be preferred by gamblers to other types and can be used to reduce urges
 - No indication that it inhibits ability to access psychosocial treatment
 - No data supporting that psychotherapy is a better treatment plan
 - Dialectical Behavioral Therapy and Cognitive Behavioral Therapy are used also
 - Treatment outcome studies demonstrate that Cognitive Behavioral Therapy is the most studied, not necessarily best modality
 - Nutritional Supplements are used; have less safety and efficacy data; some interest among those who would not “take a pill”
 - Co-occurring disorders such as sexual promiscuity and nicotine dependence; use individual and group counseling for both issues
 - Evidenced based practices are sought; however states do not want to fund outcome studies
 - Suggestion to make outcome measurement a sacred line item in the beginning
 - Cost of pharmacological treatment is concerning
 - Better use for certain populations to examine what is causing these problems
 - Resistance reduction approach regarding motivation, as many treatments tend to repel people

- All modalities delivered with compassion are probably equally effective
- **Helplines**
 - Important to ensure intervention and suicidal ideation management is in place for helplines
 - 1998 study showed that 87% of Iowans recognize the helpline #, following a media campaign in which close to 1 million was spent on advertising. Dramatic drops in both calls to the helpline and clients admitted to treatment in the years the media budget has dropped.
 - Most states will fund helplines; not many will provide for regulations or certification processes
- **Licensing, Regulations and Workforce Development**
 - Workforce training is key
 - All treatment agencies in Iowa have 24 hour cell phone coverage
 - Licensing and regulations are the great “gray area” – where does it go? Where within state agencies?
 - Difficult when it is a stand alone program; easier when tied to an agency that treats other issues
- **Problem Gambling Studies**
 - Useful to study cost of gambling on state services, a captive audience exists
 - The usefulness of prevalence studies is questioned
 - Risk and protective studies are recommended
 - Helpful to add a question or two to a current prevalence study

Listening Session IV: Moving Forward, Other Issues and Next Steps

Questions/Discussion points raised:

- Helpline caller in crisis -- What do you do?
 - Helpline calls go directly to a dedicated 211 information line in Connecticut
 - Clinicians in recovery carry cell phones - idea is to “give someone hope” and to let callers know “there are steps that you can follow,” “you called the right place”
 - Greyhound bus line and voucher system for taxi service are used to get people to the program
 - 2nd or 3rd shift people take calls are trained on screening, support, safety; staffed 24/7
 - Maybe problem gambling field has a “leg up” on other mental health issues with a dedicated number for gamblers in crisis
 - Belief that to handle a gambler in crisis is all about getting the gambler to “put on the brakes”
- What are some barriers and/or opportunities?
 - Integration of care is a concern/need
 - Where the client comes in – this is the opportunity to engage the individual

- Goes back to the revenue stream – whose client; insurance reimbursement
 - Current model is fee for service; additional “work” with clients is not reimbursable
 - Can often get secondary diagnosis covered
 - A California Medicare fraud investigation was noted. Clients were treated for problem gambling but Medicare was billed for the secondary diagnosis of depression, etc.
 - A dedicated person to negotiate with insurance companies is needed
 - Cautioned against building a system of care around insurance data, as these are not valid data sets
 - We do not pay attention to the largest percentage of the population who have gambling, tobacco, etc. problems and get “clean” on their own
 - Often these people could do this sooner/better with resources
 - Best to make changes early on in the “problem” – before addiction
 - DSM update could impact the problem gambling treatment field
- **What have we missed?**
 - Recidivism rates and related interventions
 - People who will never enter the treatment system
 - Consider natural recovery
 - Make changes before problems arise...prevention
 - Clinical work with academics/researchers – tap into these for outcome studies
 - McGill has salaried clinicians who conduct treatment studies with no limit on seeing clients. Treatment is viewed as a way to help clients and advance research
 - Need online, cost effective web based options for younger and other populations