# 2007 STRATEGIC PLAN FOR PROBLEM GAMBLING

### Georgia State University

### Gambling Project

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# ACKNOWLEDGEMENTS

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# BACKGROUND

This report is the culmination of several years of supported research by the Department of Human Resources and the collaboration of agencies, individuals, and institutions in Georgia to document the needs of problems gamblers and those affected by problem gambling.  The strategic planning process started in July 2006 when HODAC, Inc contracted with consultants Tim Christensen and Jeff Marotta to facilitate a three-day training and think tank on the development of a strategic plan for the implementation of problem gambling services in Georgia.  One of the recommendations from that report was that the state should seek additional input from diverse stakeholders throughout the state of Georgia.  The Georgia Department of Human Resources contracted with Georgia State University to gather this input; this report documents both the process used to gather feedback from stakeholders, as well as the feedback received from stakeholders in the process.

# METHODOLOGY

### Strategic Planning Meeting 2007:  Stage One Stakeholders

The preferred method of gathering stakeholder input for the strategic plan was a meeting of stakeholders in which stakeholders could brainstorm together various ways to prevent and treat problem gambling.  Therefore, telephone calls were made to 59 stakeholders throughout the state of Georgia.  Fifteen of the people contacted agreed to volunteer their time to provide their opinions and expertise to the state for the development of a strategic plan for problem gambling services.  The fifteen volunteers were then invited to a one day meeting at Georgia State University to begin the process of developing this plan.  Five volunteers were able to attend that meeting.

At this meeting stakeholders were first given a brief summary of services provided by other states with a state lottery (Emshoff, Valentine et al. 2004).  They were then asked to brainstorm and list all services they felt should be included in the final strategic plan.  After prioritizing this list, stakeholders used a brainstorming process to discuss how best to implement each service within the state of Georgia.  The format of the brainstorming sessions roughly followed the format of the work sessions facilitated by Christensen and Marotta (2006).  At the end of the meeting stakeholders were given the opportunity to identify which specific items they felt should take priority when making final funding decisions.

### The First Annual Georgia School of Addiction Studies Calloway Gardens, GA in August 2007:  Stage Two Participants

The second stage of data collection was initiated after data were collected and analyzed from the Strategic Planning Meeting.  These data were gathered to supplement preexisting data and to pinpoint areas where data were limited.  A Strategic Plan Response Form was generated using the themes found in the previously collected data.  This form was distributed to 62 practitioners and students who attended the First Annual Georgia School of Addiction Studies in August 2007.  These responses have been merged with data collected from the first stage.

### Strategic Plan Telephone Interviews for Stage One Stakeholders

A second meeting was planned, but researchers were unable to gather enough stakeholders together at one time.  Therefore, the next best option, telephone interviews with stakeholders, was implemented.  Interviews were attempted with 37 stakeholders and 14 interviews were completed.  Researchers used a semi-structured guide for the interviews; all stakeholders were asked to respond to a list of 36 open-ended questions.  Using open-ended questions allowed stakeholders to provide information they felt most relevant to each topic.

The information gathered from the strategic planning meeting and individual interviews were then analyzed and combined into this report, which is organized by the services selected during the initial meeting.  The results of all discussions are included in each section and organized similar to the report produced by Christensen and Marotta (2006).

**Strategic Plan Response Forms for Stage Two Participants**

Attendees of the Gambling Prevalence Forum were asked to assist with the Strategic Action Plan by completing a 12 item form.   These qualitative data were transcribed and entered into a Microsoft ACCESS database to identify themes and chart frequencies of themes.  A copy of the blank form can be found in Appendix A.

# DATA THEMES

**Services Included**

During the brainstorming meeting, stakeholders listed fourteen services or topics they felt should be addressed in this strategic plan.  At the end of the meeting they "voted" on which services should receive funding priority.  Table 1 lists each of the services and their rankings.  This report is organized such that the services stakeholders identified to include in the plan are used as headings for report sections and covered in priority order.

**Table 1**

*Services for Problem Gambling and Their Importance to Stakeholders*

| Service/Topic | Rank* | Comments |
|---|---|---|
| Council/Advocacy/Policy | 8 | Council = 4; Advocacy = 2; Policy = 2 |
| Treatment | 5 | |
| Prevention | 4 | |
| Public Awareness/Education | 3 | Public Awareness = 2; Education = 1 |
| Reducing stigma | 2 | |
| Research/evaluation | 2 | |
| Workforce development | 1 | |
| Access | 1 | |
| Assessment tools | Not ranked | This item was not ranked because it is addressed in another section |
| Family | Not ranked | Similar to "assessment tools" this item is addressed in other sections |
| Culture | Not ranked | Stakeholders felt that culture should be addressed in all sections of the strategic plan, which is why it was not ranked |

*Larger numbers indicate higher priority

## Mission Statement

The mission statement was developed at the 2006 HODAC meeting.  All contributors to the first level of the Strategic Plan development approved the statement below.

*Reduce the social and economic impacts of problem gambling in Georgia.*

## Vision Statement

The Strategic Plan Participants created a similar vision statement to the statement created at the 2006 HODAC meeting ("Support **healthy** individuals, families, and communities by providing an effective, sustainable system of services addressing problem gambling in Georgia").  The new vision statement is as follows:

*Support individuals, families, and communities by providing an effective, sustainable system of services addressing problem gambling in Georgia.*

Several stakeholders expressed concern about using the word "healthy" in the vision statement, so it was removed.

## Advocacy

*Stage One Stakeholders*

A topic that was discussed at length during the 2007 meeting was the need for a group that could advocate for problem gamblers and those affected by problem gambling. Stakeholders would like to see a council or similar body formed that could advocate for increased funding for prevention, treatment, public awareness and professional training specifically for problem gambling.  All stakeholders agreed that the lack of an advocacy group limits the opportunities for these services in Georgia.

Stakeholders had several suggestions about how to begin such a group.  They suggested that it be registered as a non-profit organization and that whoever decides to lead the formation of the group seek help from the National Council on Problem Gambling (NCPG), which is based in DC.  In fact, Keith Whyte, the current Executive Director of the NCPG has offered his organization's assistance to several people involved in the development of this strategic plan.

Stakeholders also suggested that funding from the state in the form of seed money or grants to provide services would help support its start up and continued viability.  In fact, local affiliates of the NCPG are frequently involved in at least some portion of service delivery in many other states (Emshoff, Valentine et al. 2004).  Stakeholders also discussed the possibility of lottery funding for a council in the form of in kind services and/or direct funding of the organization.

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Stakeholders suggested that the organizers of a council consider joining with or seeking assistance from the Georgia Council on Substance Abuse (GCSA) and/or the Georgia Addiction Counselors Association (GACA). Some stakeholders indicated that both of these organizations may benefit from the organization of an advocacy group for problem gambling and may therefore have a vested interest in assisting with its development. Stakeholders suggested that members of the recovery community, including individual Gamblers Anonymous or Gam-Anon members, may be willing to volunteer for such an organization.

Stakeholders also felt that a coalition or council consisting of various stakeholders, including Gamblers Anonymous members, should oversee or work in an advisory position with an agency that administers problem gambling services supported by the state.

### *Advocacy Messages*

Stakeholders' top two advocacy priorities for the state are:

1) Invest in internet controls at public institutions such as public schools and military facilities, and

2) Set a maximum payout (dollar amount) that the Georgia Lottery may offer as winnings for scratch-off tickets.

Stakeholders indicated that games with immediate payoffs, such as scratch-offs, are more addictive than games with longer-term payoffs, such as the weekly lottery. Reducing the maximum payoff on scratch-offs may decrease the number of people who initially become interested in the game, and may reduce the positive consequences of playing by reducing the total payout available at any one time.

Other issues that stakeholders would like to advocate for are:

1) Anti-legalization measures. Stakeholders indicated that there has been some talk of opening a casino in Georgia; they would like a council to advocate against any additional gambling opportunities in the state.

2) Tighter enforcement of existing laws, such as the legal gambling age (18) and cash prizes from gambling/poker machines.

3) Improve the publics' and the legislature's understanding of problem gambling in general as well as the benefits of treatment in order to improve funding opportunities.

*Stage Two Participants*

Types of advocacy efforts were further explored when Stage Two Participants were asked to recommend different types of advocacy efforts. The respondents overwhelmingly emphasized the need to increase public education and awareness by targeting policymakers, general community, schools, and families. The methods recommended to bolster advocacy include the development and support of advocacy networks, using media (PSA's, radio, newspapers), and interventions. Other recommendations for initiating advocacy were research, treatment, and training for professionals.

**Treatment**

*Stage One Stakeholders*

### Levels of Care

Overall, stakeholders felt the state's first priority should be to develop outpatient treatment capacity.  Additional suggestions for treatment included:

1) Intensive outpatient treatment with support groups, scaling down to less intensive outpatient services.

2) Multiple levels of care based on the needs of individual gamblers. One stakeholder suggested using ASAM as a model for levels of care with explicit criteria to determine which level of care an individual should receive.

3) Development of a continuum of care after treatment, including various forms of recovery support (e.g. Gamblers Anonymous meetings, family support, and continued access to treatment).

4) Inpatient services available to gamblers who are at risk of harming self or others, or who refuse to participate in outpatient services.

Stakeholders also discussed outpatient treatment modalities, and agreed that a mix of treatment modes should be available, including individual, group, and family therapy. Stakeholders repeatedly stressed the importance of family in the treatment of problem gambling.  They indicated that it is often family members who are able to convince problem gamblers to seek treatment, and families often need their own support and counseling.

### Assessment

In addition to treatment, stakeholders discussed the need for improved assessment of gambling problems.  A previous report (Emshoff, Valentine et al. 2003) indicated that most mental health and addiction counselors in the state of Georgia do not assess for problem gambling.  This report also found that most practitioners see little need for problem gambling treatment, primarily because they have not had clients present with gambling problems at their practice or agency.  However, research (Emshoff, Valentine et al. 2003) has also demonstrated that it is easier for individuals to hide or mask gambling problems.  For this reason, stakeholders expressed a desire for the state to adopt one or more empirically validated instruments to assess individuals entering treatment for other disorders.

Stakeholders also indicated that because problem gamblers appear to have a higher rate of suicide attempts and completions than the general population (Ledgerwood, Steinberg et al. 2005), the state should provide training to suicide helpline counselors on how to assess for problem gambling in order to provide the most effective follow-up to suicide crisis calls.

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*Treatment Settings*

When asked in what settings treatment should be provided and who should provide treatment, stakeholders responded:

1) Qualified mental health service providers (CAC II or higher)

2) Addiction counselors with experience in obsessive compulsive behaviors

3) Mental health service providers with certificates and/or experience treating problem gambling

4) Community-based clinics

5) Private practitioners (however, most participants indicated that a solid reimbursement program would be needed to make treatment of gamblers feasible for most private practitioners)

6) State-run facilities.

*Target Treatment Populations*

1) Anyone seeking services for problem gambling, which may include sub-clinical gamblers and their family members
2) Individuals who are incarcerated, on parole or probation for crimes related to gambling.

*Measuring Success*

1) Improvement in specific outcomes, such as reduction or elimination of gambling behaviors, stability in financial and family status.
2) Evaluations could be conducted using follow-up interviews, post-treatment assessments, and repeated prevalence studies.
3) DHR should be responsible for monitoring, but evaluations should be conducted by an outside party.

*Licensure/Certification*

1) The state should adopt certification guidelines for treating pathological gambling.
2) CAC II or higher.

*Additional Recommendations*

1) Regular updates to, publication and dissemination of a resource directory for problem gambling treatment, including information on Gamblers Anonymous meetings.

2) Provide a residential program that would offer housing to gamblers in treatment. A residential program is different from an inpatient treatment program. Stakeholders indicated that most problem gamblers would not seek treatment until their financial difficulties reached crisis levels and they may need assistance with housing while in treatment.

3) Develop a website specifically for gambling prevention and treatment referrals.

4) Investigate treatment options in the correctional system, as problem gamblers often engage in illegal behavior and may need treatment before leaving the correctional system.

5) Individual and family motivational sessions (e.g. CRAFT, which is a motivational program for family members of problem gamblers).

6) Psychoeducational services.

*Stage Two Participants*

The Stage Two Participants were able to consider treatment options by responding to five questions. These questions include the following:

a) What *barriers* do you see for the implementation of pathological gambling treatment in Georgia?

b) How can *stigma* be reduced around seeking treatment for PG?

c) How can *access to treatment* be increased for those suffering from PG?

d) How should *problem gambling symptomology* be assessed?

e) What methods should be used to integrate the *family system* into treatment models

A summary of common responses to these questions can be found below:

### Barriers

Stage One Stakeholders provided detailed treatment strategies for problem gambling. Their recommendations were advanced by determining what barriers could prevent individuals from seeking treatment in the Stage Two data collection. Awareness was again central to the responses on barriers to treatment. Many participants indicated that *lack* of awareness was a barrier to implementation of pathological gambling. Other popular barriers included a) lack of resources, b) lack of competent professionals, c) lack of support for treatment, and d) economic benefits of gambling.

### Stigma

Stigma is a consistent challenge for all addiction and mental health issues in general. Since stigma may influence an individual's decision to seek treatment or even discuss problem gambling, solutions for reducing stigma were requested. Using education/awareness to reduce the stigma around seeking treatment for problem gambling was the most popular response for this question (See Appendix X). Other strategies for reducing stigma were: a) research, b) meeting with other stakeholders (law enforcement, staff at public treatment facilities, c) and present it as an illness that can be successfully treated. Two related quotes regarding reducing stigma can be found below:

*" I had a cousin who was a compulsive gambler and he would steal monies from the family business. This changed the stigma my family had about seeking treatment but yes, there is a stigma. Public awareness should help change this"*

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*"I think we would encourage people to be open to publicity and forget anonymity. I believe the best way to reduce the stigma is to forget about trying to hide it and pretend that it doesn't exist. It does exist and the public should view it as a very treatable and highly desirable outcome—recovery. Should not be an embarrassment."*

Access to Treatment

This question is similar to the barriers question in that it asks for the respondent to provide answers instead of identifying challenges to implementation of treatment. Increased awareness (public education campaigns, billboards, word of mouth) and increased treatment availability (more qualified professionals, affordable treatment, hotlines, and group and family support) were the most popular solutions for increasing access to treatment (See Appendix X). Other options suggested were increased funding and integrating with other systems (public health, mental health, and substance abuse)

Problem Gambling Symptomology

Most respondents favored a more comprehensive assessment style for identifying problem gambling symptomology by advocating the combined use of different measures (e.g., [1]a standardized questionnaire, self report, and collateral reports). Other suggestions included broadening the DSM IV gradients, using the same strategy as substance abuse, legal referrals, questionnaires, phone surveys, and self reports (See Appendix X).

Family System

The impact of family systems as buffers and social support is well established in behavioral science literature. The difficulty remain in determining how best to utilize this resource when addressing problem gambling. Respondents reported the following strategies for integrating family systems in problem gambling treatment:

a. Family Education Groups

b. Family Support Groups

c. Address underlying problem

d. Best practices

e. Families involved throughout the process

f. Family counseling

g. Public awareness

h. Present education at popular attractions for families

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[1] This question provided respondents with examples of measures (standardized questionnaire, self report, collateral reports) which explains why many responses simply stated "All of the above."

**Prevention**

*Stage One Stakeholders*

*Targeted Groups*

Most stakeholders would like a comprehensive prevention program that targets all members of the general population.  When asked to prioritize target populations, stakeholders did so as follows:

1) Youth, starting in elementary school

2) College/university students

3) Adults and children with a personal or family history of addictions

4) People with low socioeconomic status

5) People in treatment for disorders that are frequently co-morbid with pathological gambling

6) Family members of those at risk for problem gambling (see above).

Several stakeholders indicated that family members are the ones most likely to convince problem gamblers to seek treatment, so any prevention message that targets potential family members would be welcome. An example would be to target PTAs so that parents know what symptoms to look for in their children.

*Prevention Approaches*

1) Integrate prevention messages about gambling into existing prevention programs for other addictions

2) Strengths-based

3) Use a variety of media, particularly television and in-store advertising, as this is where most youth receive media messages about gambling.  A few stakeholders suggested warning labels on gambling "products" such as gambling machines, lottery terminals, etc.

4) After school and mentorship programs as well as Parent Teacher Associations (PTAs)

5) Control access to gambling by underage gamblers by enforcing existing laws regulating the use of poker machines and the legal age for participation in the state lottery.

Stakeholders indicated that they have seen poker machines offering cash prizes in convenience stores in various parts of the state and that they believe these machines are now illegal and/or that offering cash prizes at these machines is illegal.  Stakeholders also

indicated that they rarely see retailers ask for ID; the current legal age to gamble in Georgia is 18 *(*Rose 2001*)*.

### *Prevention Messages*

1) Information about problem gambling, including prevalence and the signs and symptoms of problem gambling.

2) Contact information for available services, such as certified therapists and hotlines.

3) The odds of winning the lottery and other popular forms of gambling to counteract the primarily positive information currently portrayed in the media.

4) Negative consequences associated with excessive gambling.

### *Who should be responsible*

Stakeholders stressed that prevention efforts should involve diverse community stakeholders, including the organizations mentioned below as well as policy makers, law enforcement officials, Department of Education, prevention (e.g. Prevention Research Institute) and treatment specialists, media, Gamblers Anonymous, and mental health agencies such as HODAC.  Stakeholders would also like to see prevention efforts conducted in various settings, e.g. schools, churches, gambling places, shops where lottery tickets are sold etc. for maximum impact.

1) Include in existing prevention programs for ATOD.

2) Government agencies tasked with mental health and addictions prevention and treatment, such as DHR.

3) Community-based organizations tasked with mental health and addictions prevention and treatment.  Examples included schools, churches, chambers of commerce, businesses, Family Connections, CIS, community service boards, PTA groups, ICRC, NADAC, and other treatment associations.

### *Measuring Success*

1) Increased awareness of gambling as a problem among the general population, with a subsequent change in attitudes towards gambling,

2) Reduction in gambling behaviors.

3) Reductions in the social and economic consequences of gambling.

4) Increased capacity to recognize early warning signs of problem gambling as well as where to access services.

5) Reduction in the number of calls to gambling help lines.

6) Reduction in gambling related crimes.

Additional criteria suggested included fewer suicides due to gambling, decreases in lottery sales, and increased Gamblers Anonymous membership.

*Additional Recommendations*

Stakeholders also discussed the need to change the culture around gambling.  For example, they cited poker tournaments held in bars and on college campuses as examples of promotions of a potentially addictive behavior that one would not normally see with other addictive behaviors or substances (e.g. one would not see a university sponsored drinking tournament). Another example they discussed was the prevalence and acceptance of gambling at sports events.  Stakeholders would like to see more responsible gambling and "no gambling" messages at sports venues.

*Stage Two Participants*

Problem gambling prevention questions were not posed to the meeting attendees. Yet, prevention was a common strategy included in many of the participants' responses.

**Public Awareness and Education**

*Stage One Stakeholders*

*Targeted Groups*

Although it was not their top ranked intervention, initiation of a public awareness campaign was viewed by stakeholders as a very important part of any strategic plan. Stakeholders viewed the public awareness campaign as a way to prevent problem gambling, raise awareness of the symptoms of problem gambling, reduce the stigma associated with problem gambling, and make both problem gamblers and others aware of services available.

Therefore, stakeholders indicated they would like to see any public awareness campaign target all audiences from middle school-age children to senior citizens.  However, when asked to rank specific populations, they ranked the following:

1) Middle and high school students

2) College students

3) Parents of young children

4) Low socioeconomic status groups and immigrant populations.

When thinking about developing a public awareness campaign designed to let gamblers and those affected by problem gambling know about treatment services available, stakeholders indicated that targeted groups for this effort should be "people with leverage," i.e. family members, employers, and/or spouses of problem gamblers. Stakeholders indicated that it frequently takes an ultimatum from someone important in the gambler's life to convince him/her to seek treatment, and, therefore, these efforts would be most effective if targeted at these groups.

Stakeholders suggested that public awareness campaigns target both employers and employee assistance programs (EAPs), because employees are often more willing to

disclose personal information such as a gambling problem with EAPs. Stakeholders suggested that information about problem gambling should be offered at professional conferences along with direct outreach to various employers throughout Georgia.

Stakeholders discussed, but did not rank, targeting awareness campaigns to senior citizens. They suggested visiting senior centers and residences as a way to efficiently target this age group. They also discussed partnering with AARP to distribute information to their members about the signs and symptoms of problem gambling, and eventually where to get help.

Stakeholders also discussed ways to target the general population to both raise awareness of the signs and symptoms of problem gambling but also to begin changing the culture around gambling. They suggested that major sporting events may be a good place to start with this type of message, as people often bet on sporting events and some of these sporting events receive advertising money from gambling related companies. They also discussed raising awareness with faith based organizations, as these organizations often use some form of gambling to raise money for their organizations.

Finally, they felt that a general advertising campaign, following the stepped approach suggested in the Christensen and Marotta report (2006), would make sense to inform the general public about problem gambling and any services as they become available.

### *Public Awareness Messages*

Stakeholders prioritized public awareness messages as follows:

1) Potential negative consequences of gambling

2) Signs and symptoms of problem gambling

3) Stigma reduction; helping others understand that problem gambling is an addiction, addictions are illnesses, and recovery is possible. Stigma reduction may also increase others' willingness to consider funding for treatment.

4) Information about how and where to get help for problem gambling.

### *Implementation*

Stakeholders suggested using a variety of media, especially television, radio, and billboards. Additional media suggested included:

1) Public service announcements

2) Local and state newspapers

3) Information provided by the gambling help-lines

4) Mental health certification offices, in order to raise awareness among practitioners

5) Addiction recovery centers

6) Flyers and pamphlets in public service offices

7) Flyers and pamphlets at lottery retailers

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8) Advertising at sports events.

Many stakeholders proposed including help-line and service information on gambling products, such as lottery tickets, as well as on prime time TV, during the evening news, and before and after Lottery advertisements.

### *Measuring Success*

Stakeholders would like to see any public awareness campaign result in greater awareness about problem gambling and its recognition as an addiction. Stakeholders would use the following benchmarks to measure the efficacy of the public awareness campaign:

1) Moderation of lottery sales, particularly to vulnerable populations, such as minors and seniors

2) Increased Gamblers Anonymous membership, perhaps with an increase in the number of Gamblers Anonymous meetings available throughout the state

3) Increased calls to the gambling hotline and subsequent referrals to service.

Should the state decide to implement a website devoted to problem gambling, then hits on that website could also be used to measure the effectiveness of the public awareness campaign. A public awareness campaign may also increase a Council's activity level and/or their level of success advocating for services and/or funding.

### *Management of Awareness Campaign(s)*

Stakeholders would like any future Council or other community-based, multi-stakeholder group to be charged with implementing a public awareness campaign, perhaps in coordination with DHR. The majority of stakeholders indicated that the public awareness campaign should be coordinated at the state level, in the words of one stakeholder, to "avoid local politics." However, a few stakeholders felt that local communities would be better able to design and implement public awareness campaigns targeted to the needs of that community.

Stakeholders indicated that public awareness message(s) will be more effective if coordinated with state agencies through their crisis and/or access lines and existing prevention specialists, particularly in public health. Finally, stakeholders would like to see the Georgia Lottery provide assistance by including messages in their advertisements and by contributing money to help fund public awareness campaigns.

*Stage Two Participants*

Attendees at the Georgia School of Addiction Conference also chose many of the same group as the earlier stakeholders with youth as the most popular response. These respondents also mentioned policy makers/legislature, health care workers (MD, mental health and addiction practitioners, men under 30, senior citizens, as other populations that should be targeted for public awareness and education.

Respondents were asked how should the groups they identified for problem gambling awareness and education be educated.  The use of various media was the most common answer.  A list of other strategies can be found below:

1) Literature

2) Continuing Education Unit Activities or Training

3) Include information on consequences of gambling

4) Community Focus Groups

5) Seminars/Conferences

6) Prevention Curriculum (e.g. DARE)

7) Posters

8) Positive alternative activities

9) "Braining" sessions in schools or colleges

10) Financial education and intervention

11) Group Therapy

12) Multilingual messages

13) PSA's

14) Broad approach to addiction education

Measuring success and management of awareness campaigns were not posed to Stage Two Participants.


## Research/Evaluation

Stakeholders indicated that they would like to see two types of research programs implemented over the next five years:

1) A basic research program that provides more information about gamblers, problems gamblers, and other information related to problem gambling and

2) Evaluation of the implementation and outcomes of any services related to this strategic plan.

Almost all stakeholders indicated a need for ongoing monitoring and evaluation research on the implementation of any programs that result from this strategic plan in order to insure that they follow the guidelines suggested by the plan and are implemented efficiently.  They would also like research to evaluate outcomes to determine if these services are effective in preventing and treating problem gambling.

### *Research Topics*

Specific research topics for basic research included:

1) Understanding more about where lottery tickets are sold in order to gain a better understanding of who participates in the Georgia Lottery and what parts of the state

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are more likely to pay into this system. Related to this topic, several stakeholders indicated a desire for community-focused needs assessments.

2) Demographic information on problem gamblers, such as age, gender, educational background, ethnic background, and marital status. All of these questions, with the exception of marital status, will be answered with the prevalence study that is currently being conducted.

3) Risk and protective factors for problem and pathological gambling.

4) Number of gambling-related suicides, with ongoing tracking of gambling-related suicides.

5) Gambling in immigrant communities and the effects of culture on gambling behavior.

6) The efficacy of specific treatment approaches, including possible drug treatments, and different types of therapy.

7) Neurobiology of gambling behavior, and particularly problem and pathological gambling.

Stakeholders suggested that the state should gather information from existing research on the consequences of excessive gambling, the demographics of those most likely to gamble, and the physiology of problem gambling. They would also like more information on participation in internet gambling and whether or not internet gambling has a more deleterious effect on gamblers than other forms of gambling.

### *Implementation*

Stakeholders indicated that service providers and program implementers should conduct ongoing monitoring and evaluation of their programs and outside independent organizations, such as universities or consulting and research firms with culturally diverse research teams, should conduct evaluation and research in order to eliminate bias.

Overall, stakeholders agreed that research could be an important piece of any implementation plan, because it can help guide the implementation of future services and act as a tool for advocates when they ask for additional funding.

*Stage Two Participants*

The responses centered more on the cause, risk, and predisposition to problem gambling. Other popular research topics were the consequences of gambling (individual and system), treatment modalities, media influence, brain research and hereditary, and specific populations (youth, elderly, low socioeconomic status).

**Workforce Development**

*Stage One Stakeholders*

Although professional training was prioritized last by stakeholders, they did agree that any implementation of treatment and/or prevention services would hinge on the development of practitioners who are familiar with the state of the art in problem gambling prevention and treatment services.

### *Targeted Groups*

Stakeholders agreed that addiction counselors (LPC, LCSW, MFT) may be the most likely treatment professionals to target for training on the treatment of problem gambling. However, most stakeholders agreed that any mental health professional trained to treat addictions should be the first priority for training. Stakeholders agreed that problem gambling is an addiction, and felt that treatment of problem gambling could be best handled by professionals already trained to treat other addictions.

Stakeholders would also like to see crisis line counselors trained to assess for problem gambling. Stakeholders indicated that appropriate referrals can only be made if those answering the telephone are trained to recognize problem gambling. In addition, they indicated that because problem gamblers have high rates of suicide attempts and completions, they would like to see counselors on any suicide hotlines in the state receive training in how to assess for problem gambling.

Stakeholders would also like to see awareness of problem gambling and its signs and symptoms raised among all mental health professionals, regardless of training or specialization. If more professionals are familiar with the symptoms of problem gambling, gamblers are more likely to be referred to appropriate treatment resources.

Stakeholders also suggested that the state consider providing information and training on the assessment of problem gambling to the following groups: employees of Employer Assistance Programs, health care workers, public health clinics, teachers, and coaches. Each of these professions is in a unique position to spot problem gambling early and may be instrumental in encouraging those with gambling problems to seek treatment.

*Required Education or Training*

Stakeholders were adamant that professionals receive at least 30 hours of continuing education credit in order to treat problem gambling. Although problem gambling is similar in many ways to other addictions, they indicated that there are enough differences that merit specialized training.  In fact, stakeholders would eventually like to see the state require certification in order to treat problem gambling.

1) Follow the national certification model to provide specialized knowledge on gambling

2) Education on co-morbid disorders and how to assess and treat problem gambling

3) Education on prevention and how to integrate gambling messages into general practice

4) 30 - 60 hours of training on gambling, renewed every 2 years

5) Supervision and interactive training on evidence based therapies

Greater detail in course recommendations for health care workers may be related to the addiction backgrounds of meeting participants.

*Implementation*

Stakeholders offered the following as potential training providers:

1) Ph.D. level professionals with experience in addictions, assessment and differential diagnosis and/or other qualified trainers

2) DHR

3) Agencies who hire professionals to treat problem gambling have responsibility for training

4) The Council or other stakeholder group

5) The market will provide training if funds are available for treatment.


Stakeholders recommended that whoever is charged with delivering professional training seek consultation from Gamblers Anonymous (GA) members on what issues are important to problem gamblers; some members of GA may be willing to assist with training.

Stakeholders suggested that the Georgia Addiction Counselors Association (GACA) could be a good partner for developing trainings for problem gambling.  They also suggested that the state encourage organizations, such as Georgia State University and the Georgia Psychological Association to include a presentation on problem gambling among their CEU training opportunities.

Stakeholders suggested that regional trainings might receive better attendance because it would require less travel time and time away from work for stakeholders.  They also suggested that the trainings should be ongoing, rather than one time events.  Other states have successfully implemented video conferencing to make it easier for professionals

in rural areas to receive training (Emshoff, Valentine et al. 2004).  In-services have also been found to be more successful, because professionals can receive training at their workplace (Emshoff, Valentine et al. 2004).

*Stage Two Participants*

For this subject, the participants were asked, "what strategies should be used to prepare the health care workforce."  The response form did not separate the questions into categories however; respondents' answers most often would be among the three categories used in this section:  targeted groups, required education or training, and implementation methods

Few respondents indicated population groups but those who did identified professionally trained counselors, health care workforce, treatment specialists in the addiction field, psychiatrists, and other clinicians.  The type of training recommended was also very similar to the Stage One Stakeholders as can be seen in the text below.

a)  Specific training for counselors and therapists

b)  Teach treatment methods that have been proven effective

c)  Train on psychological effects

d)  Provide information on access to resources

e)  Screening and assessment

f)  Multimodal

g)  Cognitive Behavioral

h)  Treatment unique to addiction

i)  Information on depressive states caused by lack of financial security

Strategy implementation recommendations included seminars, competency based training, certifications and licensure, course modules or CEU's, workshops presented by the state, referral process, and a treatment website.

**Structure and Funding**

*Stage One Stakeholders*

<u>*Administration of prevention, public awareness, and treatment services*</u>

1)  DHR (MHDDAD)/Community Service Boards

2)  Independent organization, such as a Council or other multi-stakeholder organization. Stakeholders who preferred this option indicated that having a state agency such as DHR implement programs designed to reduce negative consequences caused by another state agency, such as the lottery, may be counterproductive.

3)  Department or agency on addictions directly accountable to the Governor with regional offices

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4) Regional administration/direction with local/private organizations implementing programs

5) Collaboration between community mental health centers, treatment centers, and groups that specialize in gambling treatment.

*Priorities*

Most stakeholders were uncomfortable setting priorities for implementation of services, and indicated that a successful program must include public awareness, prevention, treatment and training. However, most participants were able to select their top three priorities; when summed across stakeholders, services were prioritized as follows:

1) Treatment

2) Prevention

3) Public Awareness

*How does this structure avoid the obstacles or barriers experienced in the past in advancing Georgia's problem gambling services?*

1) In the past no one was responsible for problem gambling, so a designated agency is an improvement.

2) The designation of a responsible agency increases commitment to long-term efforts towards prevention, treatment and training.

3) More and diverse stakeholders and points of entry would reduce the stigma attached to gambling.

*Potential Funding Sources*

1) SAMSHA funding for mental health and addictions

2) Georgia Lottery

3) Grants from organizations such as the Robert Wood Johnson Foundation, Annie Casey Foundation

4) Tax on casinos

5) Private donations from individuals and corporations.

*What portion of treatment should gambling clients pay?*

Most stakeholders believe that clients should pay for at least some portion of treatment in order to increase commitment to treatment and improve sustainability of services. However, some stakeholders argued that requiring clients to pay may place undue hardship on problem gamblers, as they may have greater financial problems than other addiction clients, which may be a barrier to treatment.

1) Same as any other mental health service; sliding scale

2) 50%

3) Insurance should cover with co-pay.

**Policy**

*Stage Two Participants*

Stage Two Participants had an additional question on policy. Respondents were asked "what types of policy recommendations do you think should be made." Their answers generally were related to four categories: restriction, regulations, funding, and awareness. Examples of the type of recommendations made can be found below:

Restriction
- *Controls on advertising that will reduce exposure (problem gambling) to younger children*
- *Limit advertising by legislature act and mandate advertising the dangers involved with gambling—someone loses! 100 lose 1 win?*
- *Make it (gambling) illegal or sin tax like alcohol or tobacco*

Regulations
- *Checking ID's*
- *Policy to accept this as an addictive disease, treatment criteria*
- *Screening assessment info should be gathered on consumers community in the system*

Funding
- *Funding for treatment and research to come out of lottery (etc) moneys*
- *Tax it, especially the games and winners*
- *Funding treatment is imperative*

Awareness
- *Have policy makers take seminars on effects of gambling*
- *Raise awareness of warning signs*
- *Raise awareness of treatment options*

Stage One Participants also made policy recommendations but these answers are embedded within other sections.

**Culture**

The influence of culture was specifically raised for Stage Two Participants since Stage One Stakeholders felt that culture should be addressed in all sections of the strategic plan. The respondents were asked if culture plays a role in gambling. The most frequent response was yes. The responses were mixed regarding how each participant interpreted culture (behavior norm of a distinct population group or the behavior norm of mainstream American culture) and its relevance to gambling. The lack of a definition of culture may have confused some respondents. More research is needed on this topic. Examples of pro and con response on culture can be found below.

# CONCLUSION

These data were collected as part of DHR ongoing commitment to refine prevention, treatment, and policy strategies in the reduction and elimination of problem gambling behavior.  These recommendations were made by practitioners, researchers, public health workers, and other community stakeholders.  Many of the recommendations made are consistent with gambling treatment literature and indicate a broadening a trend of interest on a disorder that for many is "invisible."

# References

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Appendix A.    Strategic Plan Response Form
Appendix B.    Recommended Summary of Services and Topics for Problem Gambling

Georgia State University

## Appendix A.    Strategic Plan Response Form

*We are in the process of finalizing the State of Georgia 2006-2007 Strategic Action Plan.  In your group, work with team members in answering the following questions:*

1.  After attending Dr. Emshoff's lecture, how urgent is implementing treatment for pathological gambling to you?
    _____
    _____
    _____

2.  What barriers do you see for the implementation of pathological gambling treatment in Georgia?
    _____
    _____
    _____

3.  What types of advocacy efforts would you recommend?
    _____
    _____
    _____

4.  What types of policy recommendations do you think should be made?
    _____
    _____
    _____

5.  Who should be targeted for public awareness and education?
    _____
    _____
    _____

    a.  How should the groups you identified be educated on this topic?
    _____
    _____
    _____

6. How can stigma be reduced around seeking treatment for problem gambling?
    _____
    _____
    _____

7.  What topics do you think should be researched?
    _____
    _____
    _____

8.  What strategies should be used to prepare the health care workforce that will be serving those seeking treatment for problem gambling?

    _____
    _____
    _____

9.  How can access to treatment be increased for those suffering from PG?

    _____
    _____
    _____

10. How should PG symptomology be assessed?   Standardized Questionnaire, self report, collateral reports (data from files, family members, friends, or people familiar with client or their disorder).

    _____
    _____
    _____

11. What methods should be used to integrate the family system into treatment models?

    _____
    _____
    _____

12. Does culture play a role in problem gambling?  If so, how should it role be addressed in reducing problem gambling?

    _____
    _____
    _____

*\*\*\*Please turn in all feedback forms to Dr. Emshoff.  Thank you for your participation!\*\*\**

Appendix B.    Recommended Summary of Services and Topics for Problem Gambling

| Service/Topic | Rank* | Comments |
|---|---|---|
| Council/Advocacy/Policy | 8 | Council = 4; Advocacy = 2; Policy = 2 |
| Treatment | 5 | |
| Prevention | 4 | |
| Public Awareness/Education | 3 | Public Awareness = 2; Education = 1 |
| Reducing stigma | 2 | |
| Research/evaluation | 2 | |
| Workforce development | 1 | |
| Access | 1 | |
| Assessment tools | Not ranked | This item was not ranked because it is addressed in another section |
| Family | Not ranked | Similar to "assessment tools" this item is addressed in other sections |
| Culture | Not ranked | Stakeholders felt that culture should be addressed in all sections of the strategic plan, which is why it was not ranked |