

Recognizing the Connection: Integrating Gambling Help into Alcohol & Drug Treatment

Presenters:

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- Shannon Campbell
- David Corse
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What we know about addictive disorders

- Per DSM5, those with gambling disorder have high rates of SUDs, depressive disorders, anxiety disorders, and personality disorders.
- Up to nearly 1/3 of individuals in SUD treatment identified as problem gamblers (Ledgerwood et al, 2002)
- The more severe the past year SUD, the higher the prevalence of gambling problems (Rush et al, 2008)
- Individuals with lifetime history of mental health disorder had 2-3 times rate of problem gambling (Rush et al, 2008)
- **Lorie Rugle study citation.**

Oregon legal gambling

- Oregon Lottery
 - >2,000 retailers with >12,000 VLTs
 - 3 lotteries
 - Scratch-its
 - Keno
 - Raffles
- 11 tribal casinos
- Card rooms
- Race tracks & sports betting & 8 OTBs

Multnomah County



Multnomah County Problem Gambling Treatment Services

- Comprised of five county service providers, four of whom provide other A&D/Behavioral Health services and one providing workforce development and training.
- Client-finding issues that were identified are:
 - Low penetration rate
 - All providers operated as separate entities with little or no collaboration, internally or externally
 - No peer mentors available in gambling treatment
 - Lack of financial resources to pay for mentors
 - Perceived liability issues by providers in hiring peer mentors
 - Outreach activities were redundant, counselors are not outreach workers, and follow-up falls off when caseloads rise

Collaboration works

- Decision to use an existing collaborative model approach to unify gambling treatment service providers, meet quarterly to provide opportunity to brainstorm, develop solutions
- Identify some measures that would provide solutions i.e. SBIRT/GBIRT, develop a new outreach strategy, and utilize peers
- Reach out to recovery community to collaborate – Voices of Problem Gambling Recovery (VPGR)

Implementation plan

- Conference call with Lorie Rugle and adaptation of **GBIRT** in one program's alcohol and drug treatment counterpart
- Discussion and decision to contract with VPGR for gambling **peer mentors** and **peer specialists**
- Contract for **outreach person** for the entire PGS treatment provider network

What happened?

- Mentor Program
- Gambling Brief Intervention & Referral to Treatment (GBIRT)
- Future planning

Why bother screening for gambling disorder?

- Evidence of high risk of gambling problems among individuals diagnosed with substance use and mental health disorders;
- Not addressing gambling issues decreases treatment effectiveness and adds to treatment costs;
- Early intervention and treatment work!

Limitations of brief screens

- Need to define what we mean by gambling – list types of gambling in community and personal involvement
- Developed to screen for most severe gambling problems
- Focus of counselor is on presenting problem and diagnosis

Screening questions & use

- Clinician factors that contribute to ineffective screening:
 - Workload
 - Length of intake assessments
 - Priorities
 - Comfort & knowledge discussing problem gambling
 - Personal beliefs and attitude about gambling

PG screening: what often happens

Counselor thinking: “I can save time on these (gambling questions)...That’s not why he/she is here anyway.”

Counselor out loud: “ You’ve never lied about gambling or wanted to spend more money on it, have you? ”

Client thinking: “Phew! Nobody cares about gambling here!”

Client out loud: “No, that’s not a problem”

Typical results of brief screens

- Client walks away without an increased understanding of problem gambling
- Clinician walks away without an increased understanding of how gambling might impact the client

GBIRT developed from SBIRT

- SBIRT

- Integrates alcohol & drug discussion into clinic workflow
- Education/prevention
- Graduated discussion
- Uses Motivational Interviewing approach
- Referral to treatment when indicated

- Strong research support

- e.g. Academic ED SBIRT Research Collaborative (2010);
Woodruff et al (2013)

- Motivational interviewing-based, non-judgmental approach to questions similar to SBIRT, only gambling-focused
- Specific information regarding perception of gambling
- Experience in home community – what's there, what types of gambling take place, etc.

Brief advice on reducing gambling

- Education that having an SUD puts client at higher risk for PG
- Feedback on personal gambling
- Define levels of gambling and gambling disorder
- Review risk factors for problem gambling/gambling disorder
- Four steps to reduce risk for gambling problems
 - Limit money
 - Limit time
 - Don't view gambling as a way to make money
 - Spend time on other recreational activities

Keep gambling fun & problem-free

- Set a limit on how much time and money you will spend and stick to it
- Learn how the games work and how much they cost to play
- Balance gambling with other leisure activities
- If you gamble and spend more time and money than you can afford, a good strategy is to take a break and look at your gambling. Consider seeking help if this is a concern.

High-risk gambling

- Situations where you are:

- Coping with grief, loneliness, anger or depression.
- Under financial pressure and stress.
- Recovering from mental health or substance use disorders.
- Using alcohol or other drugs.
- Under legal age to gamble.

Integrated assessment

- The key to this approach is to raise the issue of gambling and its role in your client's recovery in multiple contexts and repeatedly over time.
- It is also key to include the topic of gambling in a non-judgmental or labeling manner, in order to minimize defensiveness or resistance.

VOA study: methods

- Surveys about gambling given to alcohol/drug clients not in gambling treatment before and after GBIRT implementation, 5 months apart
- Sample of those there two months or less

Need for PG discussion in treatment

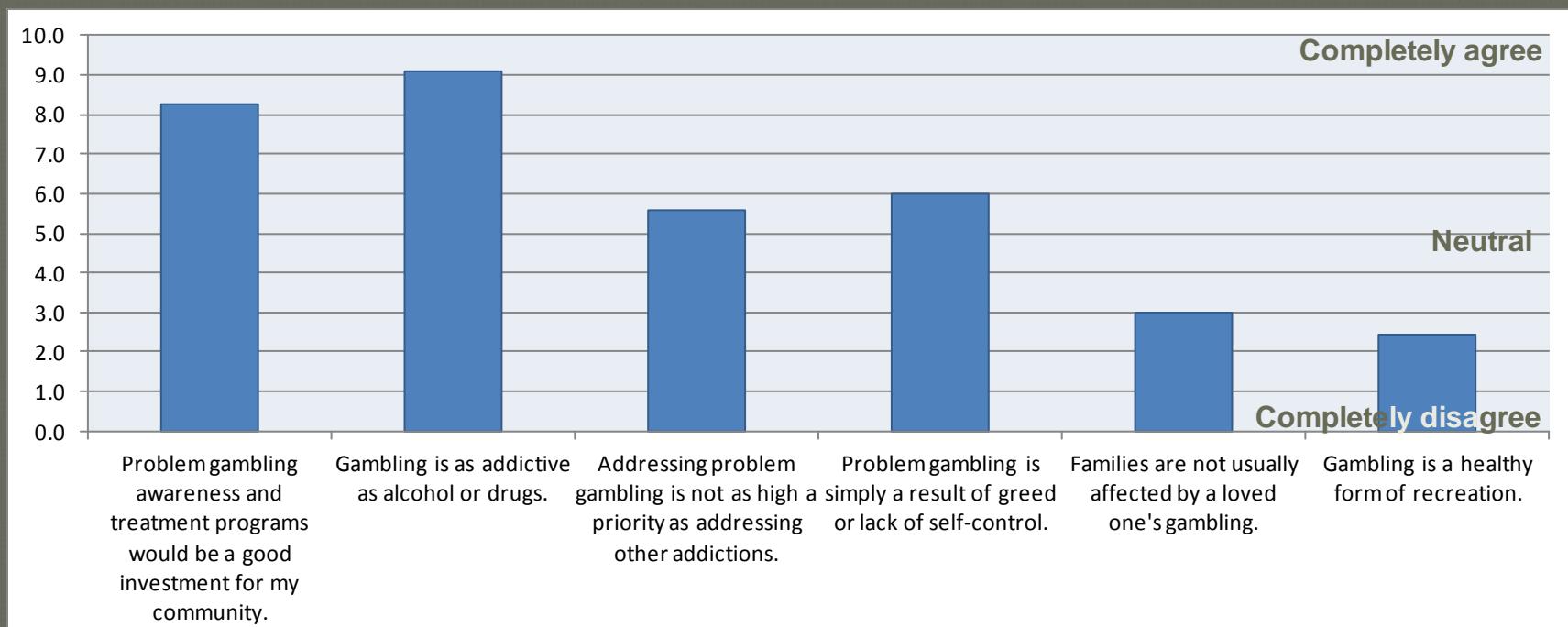
- 32.3% surveyed in December (pre-GBIRT) gambled at least monthly; 25.8% weekly or more
 - How aware are counselors? 2/3 of these clients indicated their counselor had spoken to them about it, as opposed to 1/3 of population overall
 - 12% said it would be helpful for their counselors to talk about how gambling may affect their A&D recovery
 - 53% of clients at that time had family/friends they identified as having gambling problems

The need

- Staff saw need, too: in December, staff were asked to rate their agreement/disagreement with several statements.
- Staff indicated agreement that their department needed to do more to address problem gambling (6.9 on 10-pt. scale), and strongly disagreed that PG wasn't a major issue for their A&D clients (2.1 on 10 pt. scale).

Understanding the population

- Client attitudes were measured on several gambling-related factors; no large or statistically significant change in these before/after GBIRT implementation



Client attitudes

- Clients both before and after intervention agreed that PG awareness and treatment would be a good investment for their community.
- Also agreed strongly that gambling is as addictive as alcohol/drugs and that gambling was not a healthy form of recreation. Recognized negative impact on families.

○ However:

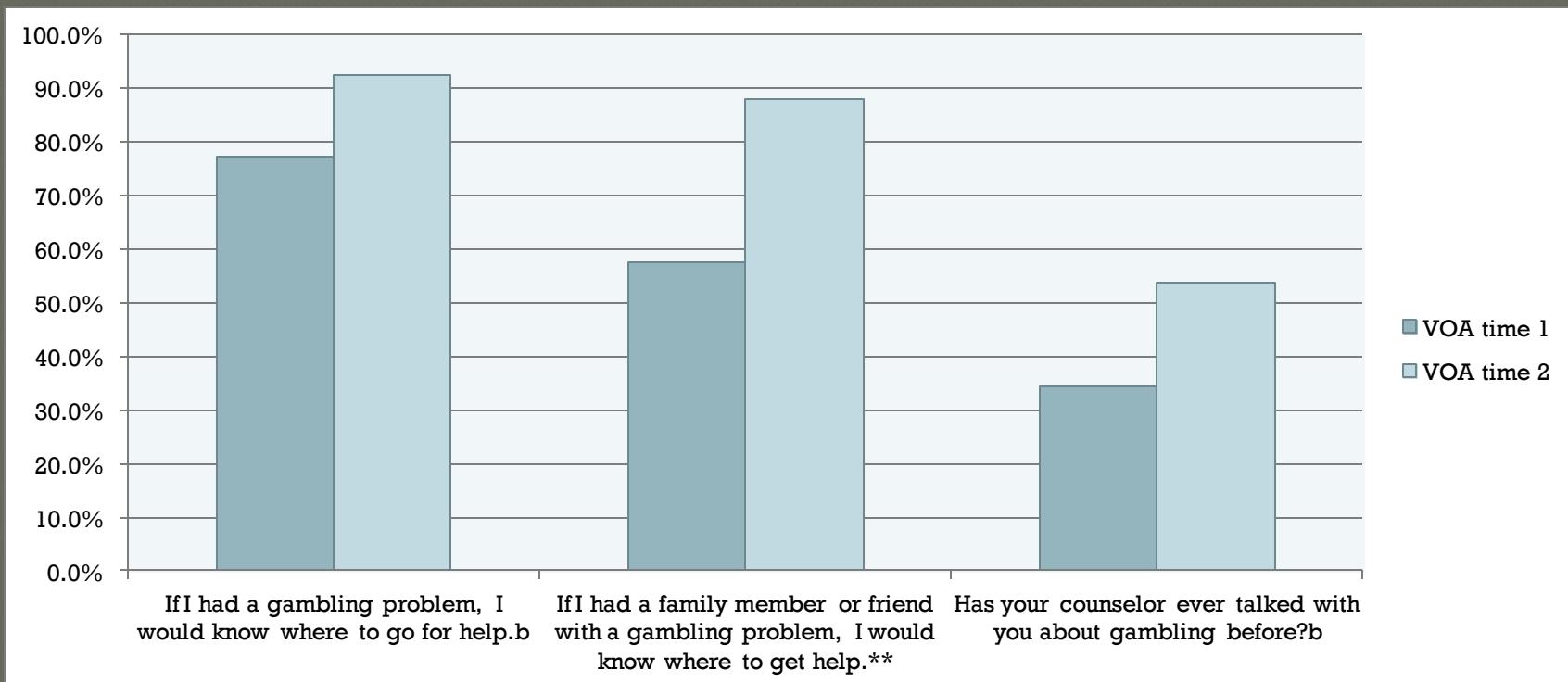
- Clients neutral on whether or not it was as high a priority to address as A&D addictions, and somewhat agreed that gambling was a mere symptom of greed or lack of self-control.
- Clients were generally not interested in learning more or having their program address it more directly.

Client attitudes

- Clients generally understand that gambling can be unhealthy and needs to be addressed, but remain less educated on some of the nuances and the importance of addressing it themselves in treatment.

Conversations starting to happen

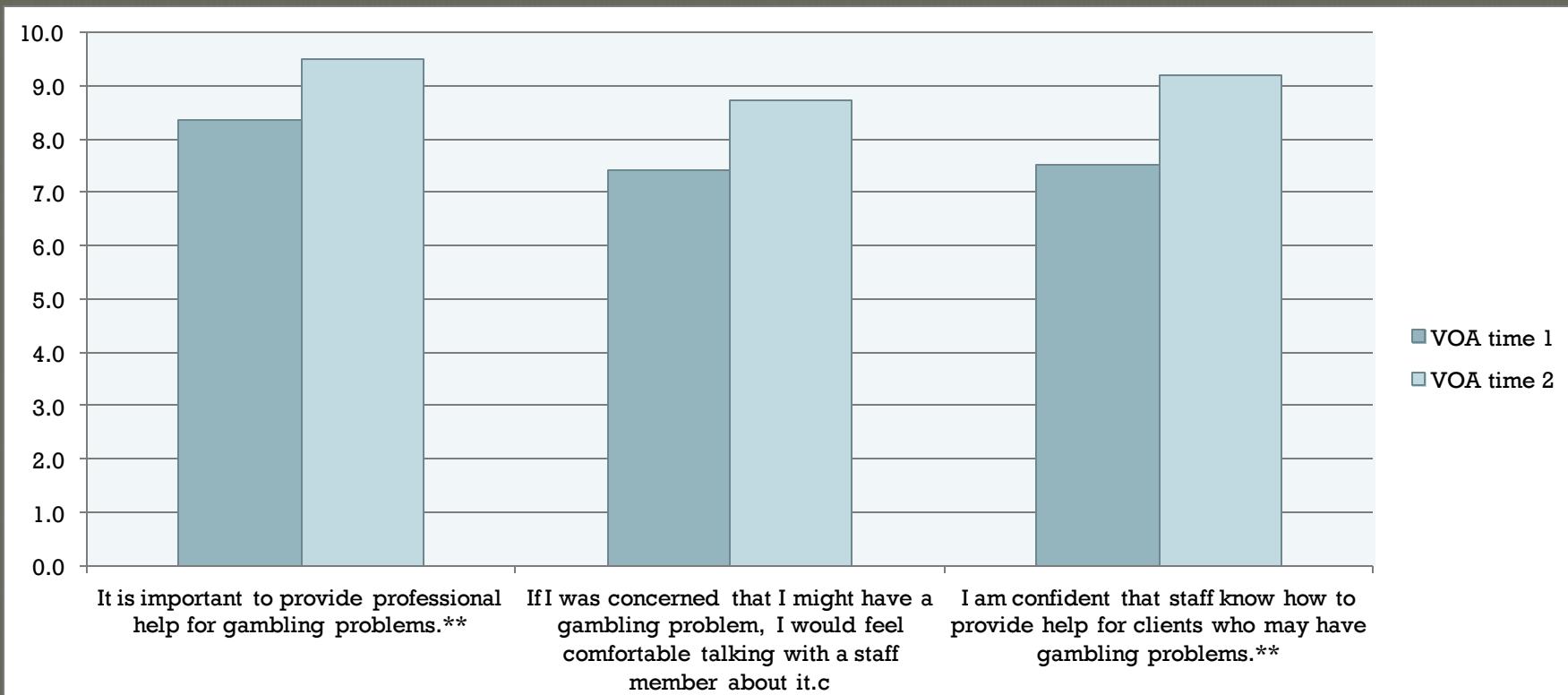
- Significant or near-significant positive changes found in multiple desired areas, from client perspective:



*** 99% ** 95% * 90% b. 85% c. 80%

Comfort level

- On a scale of 1 to 10, with 10 being complete agreement...

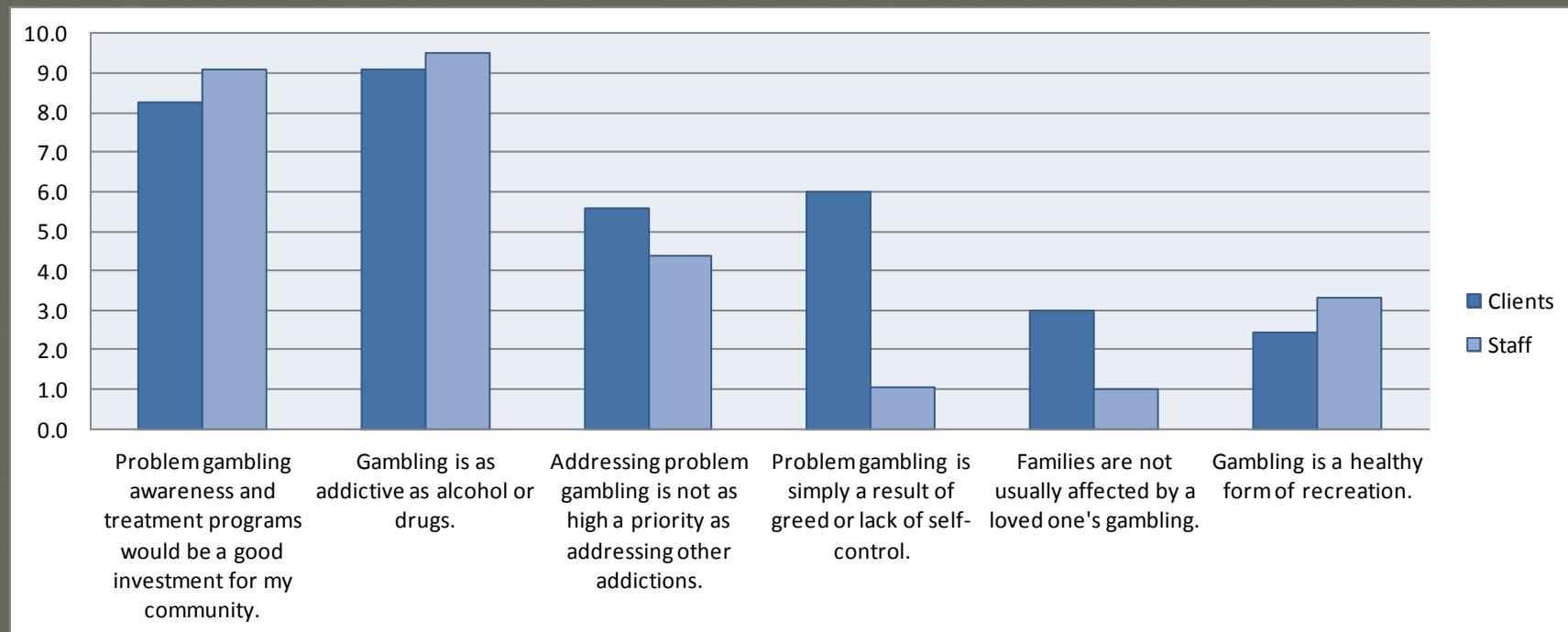


Staff knowledge and attitudes

- Similar surveys also given to A&D staff at same time periods
- Numbers presented represent clinical staff
- *Because of staff longevity (most staff, although not all, taking it both times) and the anonymous nature of the survey making matching impossible, we did not assess for statistically significant differences between time 1 and time 2; only averages are presented.*

Staff perspectives

- Compare clients to staff: on a scale of 1 to 10, with 10 being complete agreement...

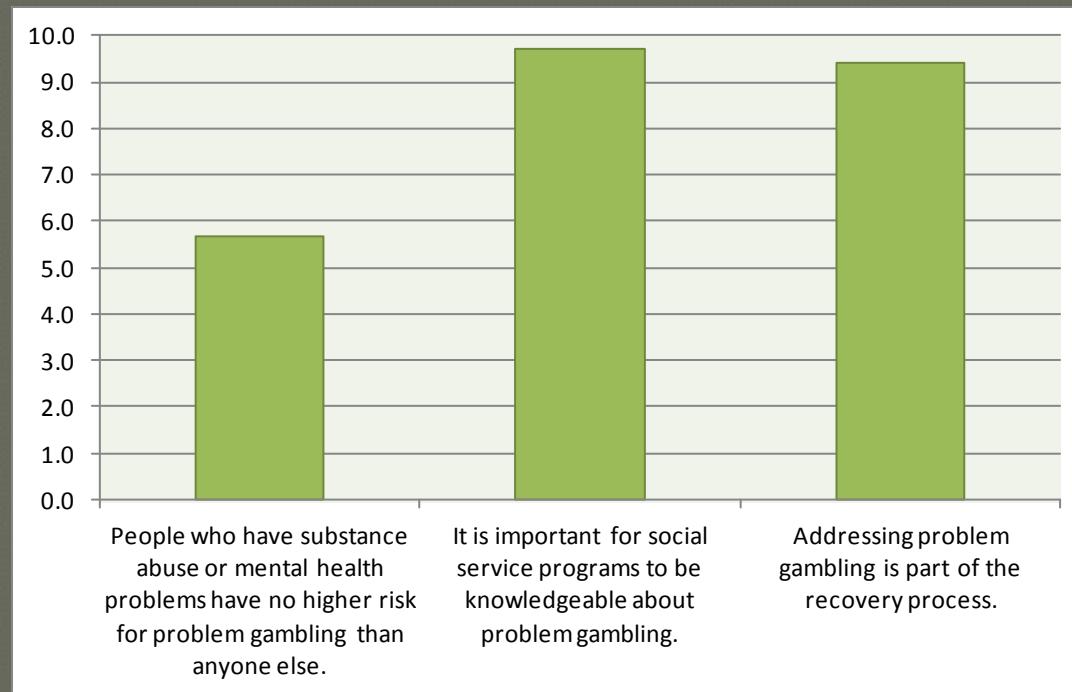


Staff perspectives

- Like clients, staff see gambling as addictive and treatment as a good investment.
- Staff better recognize impact of PG on families, that it is not just a greed or self-control issue, and disagreed that it is not as high a priority as A&D addictions.
- Interestingly, however, rank it slightly higher as a healthy form of recreation (although still in disagreement).

Staff perspectives

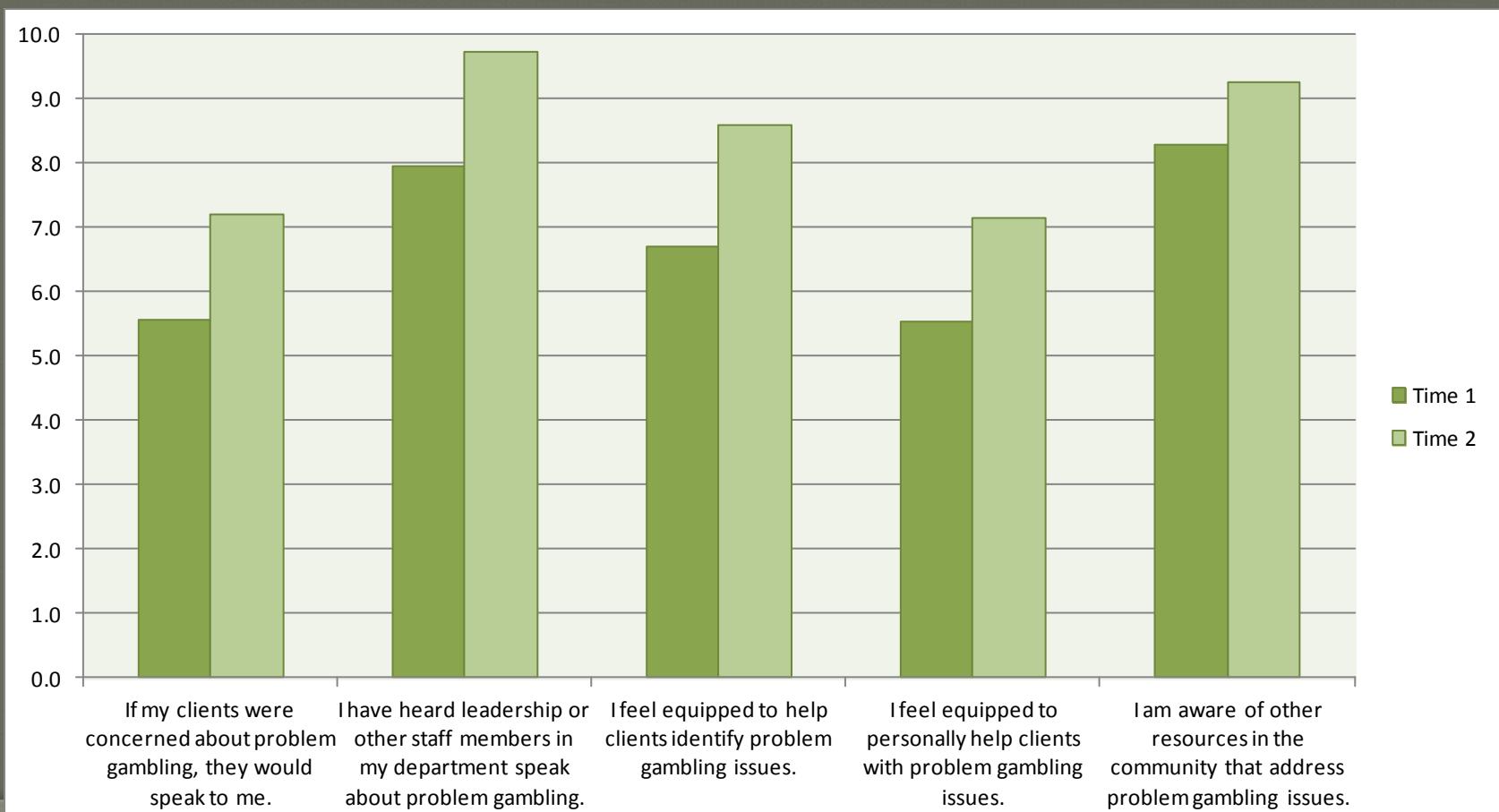
- A&D recovery and gambling: staff opinions in May



- Understand gambling affects recovery; room to grow on understanding the level of risk their clients have

Staff training

- Staff felt more personally-equipped, and recognized a larger gambling conversation presence in the agency



Staff conversations

- Reaching out to clients:

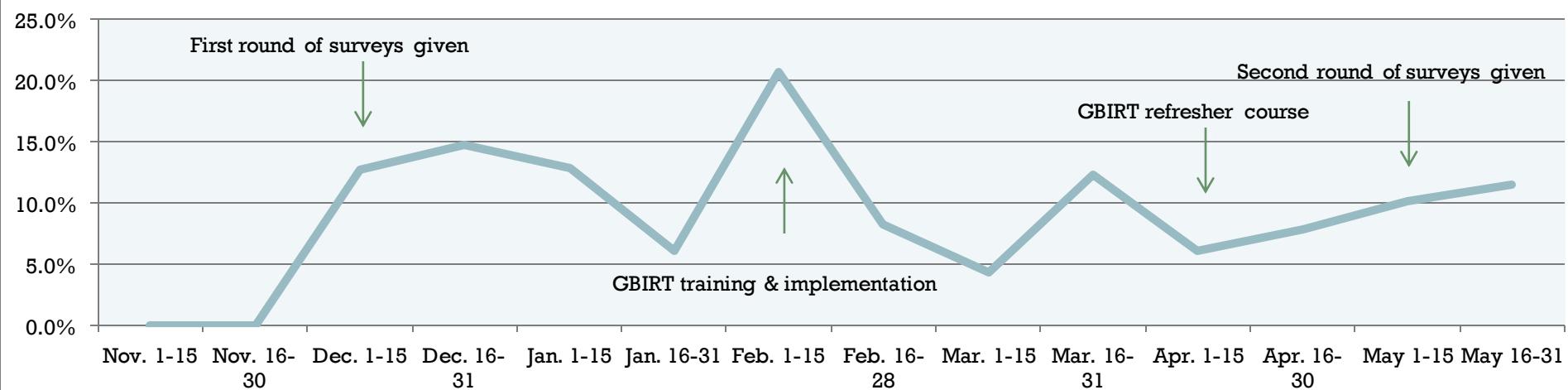


- Staff may tend to rank themselves highly initially (“oh, yes, we talk about this”) without full consideration (“oh, I thought I did this well before, but now I really see how much deeper I need to go!”) Also, this is talking to *any* client—could be just one; does not imply all.

Identification and referrals

- Act of collecting data itself promoted awareness
- Large spike with initial GBIRT implementation; leveled off, but then rose again with refresher, more surveys
- Next challenge: making this concrete in staff members' minds; further tackling general awareness and attitudes

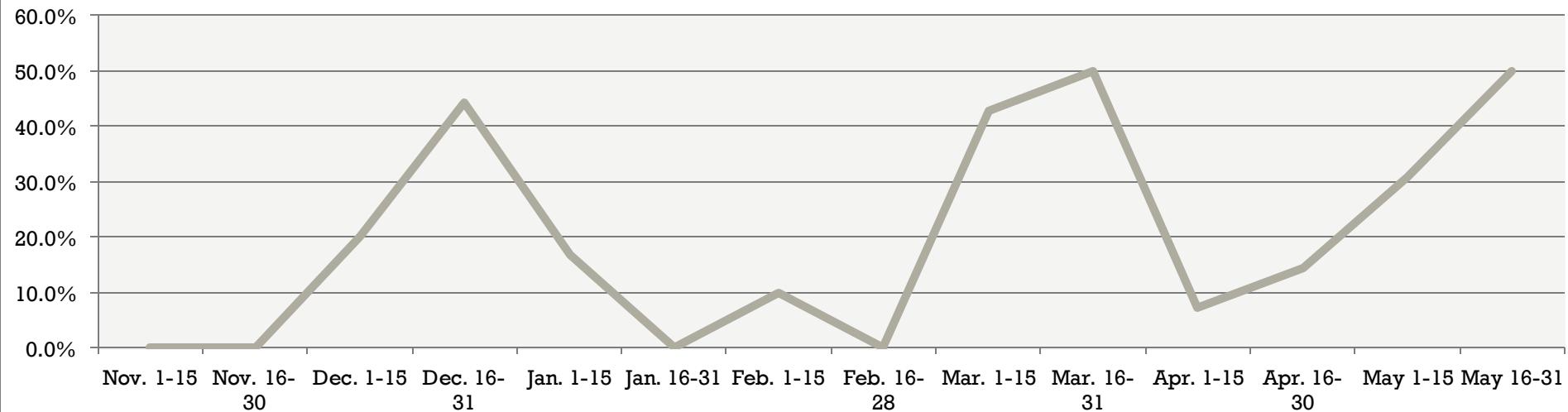
Positive screening rate



Identification and referrals

- Fluctuation on percent of incoming calls to gambling program that generate from A&D side of agency
 - Data collection may have helped increase internal referrals, reminding counselors about available resources (spikes in December, May), as well as problem gambling awareness month (March)

Internal referrals



VOA summary

- Need more nuanced gambling education, for both clients and staff
- Identification/referral patterns indicate a need to keep staff “on track”
- Develop passion in agencies for addressing PG
- Surveying alone seemed to have an impact for staff; possible this occurred for clients as well
 - Essentially echoing the point of the GBIRT—raising questions for consideration can be an intervention as well

Where do we go from here?

- Add GBIRT to Cascadia
- Begin education with other A&D providers
- Insert recovery mentors into treatment schedule of other A&D providers
- Move toward adding GBIRT into routine of more A&D providers