



2019 PROBLEM GAMBLING STUDY



Washington State

GAMBLING
COMMISSION

Protect the public by ensuring that gambling is legal and honest.

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EXECUTIVE SUMMARY

The Gambling Commission's mission is to protect the public by ensuring gambling is legal and honest. Two significant ways to fulfill this mission are to promote effective responsible gaming policies in our gambling industry and advocate for effective problem gambling programs and services for people who wish to address their gambling disorder. The Gambling Commission has worked with the Legislature, Tribes, the gambling industry, Washington State Problem Gambling Program, Evergreen Council on Problem Gambling, and problem gambling behavioral health providers to educate ourselves on problem gambling topics and look for effective policies and programs that will benefit the regulated gambling industry and improve the lives of people suffering from gambling disorders.

In its 2018-19 supplemental operating budget, the Legislature included a provision – Engrossed Substitute Senate Bill 6032 –, directing the Washington State Gambling Commission to contract for a study to survey the scope of services available for pathological and problem gamblers and their families, and analyze current prevention, treatment and recovery programs and services in our state. The Legislature required the Gambling Commission to submit the results of the study and provide policy recommendations to improve problem gambling services and programs to the Legislature by February 15, 2019.

The Gambling Commission contracted with researchers from the University of Washington's Department of Psychiatry and Behavioral Sciences and the Washington State University's Carson College of Business to conduct the study. In developing the study, we determined that it would focus on two problem gambling topics—responsible gaming and behavioral health services. Therefore, this study reviews and analyzes current responsible gaming practices among Washington's gambling industry. It also reviews and analyzes prevention, treatment, and recovery services for pathological and problem gamblers in Washington. This comprehensive approach provides information and guidance for the gambling industry, including gambling regulators, and behavioral health providers while meeting the Legislature's objective for this study.

This problem gambling study is a significant positive step towards better addressing problem gambling in our state. It is important for the state to review current responsible gaming and problem gambling policies. We hope this study's results and recommendations will allow our state to move forward and update current responsible gaming practices, where needed, and strengthen the state's commitment to promoting and protecting the public health of those suffering from a gambling disorder.

There is a comprehensive set of responsible gaming and problem gambling results and recommendations. Additionally, there are many areas for improvement in responsible gaming practices and problem gambling public health services. However, not all results and findings lead to easy policy recommendations. Therefore, the Gambling Commission has identified several key results that we believe are most significant policy areas for consideration at this time.

Key Findings

1. Results suggest that a previous estimate of a 2.1 percent problem gambling prevalence rate underestimates the need in our state because this rate was based on prevalence estimates from the 1990s, prior to the growth of legalized and regulated gambling.
2. The most recent data in research literature suggests that the state's problem gambling prevalence rate is 2.7 percent of Washington adults could be classified as at-risk gamblers, 0.7 percent as problem gamblers, and 0.5 percent as probable pathological gamblers (i.e., those with diagnosable gambling disorder), for a rate of disordered gambling of 3.9 percent.
3. Using the current 2018 US Census data for adults residing in Washington State (5,862,960) the unofficial estimates of disordered gambling could be between 123,122 – 228,645 adult individuals in need of problem gambling services. However, the lack of recent prevalence studies of disordered gambling within Washington State make it difficult to determine the exact prevalence rate within the state at this time.
4. Healthcare providers agree that Washington should expand its services for problem gamblers, and strongly agree that the current funding for problem gambling prevention and treatment programs in our state is inadequate.
5. Healthcare providers reported receiving at least some clients through self-referral. The next most frequently reported source of referrals was the Problem Gambling Helpline.
6. There is capacity for problem gambling services statewide, but the greatest area of need is centered in Seattle and areas along the I-90 corridor.
7. There are gaps in availability of treatment providers outside the I-90 corridor, particularly in rural areas of central, eastern, and southwestern Washington. One potential solution to expand treatment services would be use of telehealth or internet-based therapy for problem gambling.
8. The pool of certified gambling counselors and supervisors needs to be expanded.
9. Respondent providers referred an estimated 36 patients to out-of-state inpatient programs in the past year.
10. Out of the 50 states, Washington ranks 26th in terms of per capita public funds invested in problem gambling services. The average per capita allocation of public funds for problem gambling services in the 40 states with publicly funded services was 37 cents; while only 10 cents per capita was expended in Washington State.
11. Tribal problem gambling services vary by tribe. Some programs are fully developed – providing mostly outpatient services – and some provide referrals to other tribal or non-tribal treatment programs. Several tribes cover the treatment costs for both outpatient and inpatient services.
12. Several tribes have provided considerable contributions to the ECPG to supporting its work on problem gambling. Tribal health and wellness programs have also contracted with ECPG to address problem gambling both within the tribal membership and in the surrounding community.
13. There are still significant barriers that cause the majority of individuals who need (and would benefit from) problem gambling treatment to never seek services. Increasing public exposure to problem gambling resources through media campaigns and more prominent displays at gambling operators would address key barriers and result in more people seeking treatment.
14. Results suggest there is little strategic consideration given to responsible gaming in Washington casinos. While a small majority (61%) report that they have corporate policies that provide guidance on related issues, only a minority regularly include responsible gaming as part of the strategic planning process (35%), have an accountable executive-level staff member (35%), or provide their staff with detailed training on the subject matter (46%).
15. The most common criticism of a single-venue self-exclusion program is that patrons can continue gambling elsewhere.

Based on these key findings, the Gambling Commission recommends two legislative priorities for the 2019-2020 legislative cycle— (1) creating a state-wide voluntary self-exclusion program; and (2) forming a joint legislative task force on problem gambling. These are attainable goals that will be significant next steps by the State to better address problem gambling and improve the lives of people suffering from gambling disorders.

Recommendation 1: Create a Centralized, Statewide Voluntary Self-exclusion Program

Currently, in Washington, all tribal casinos and most commercial card rooms and operate their own in-house self-exclusion program. However, a problem gambler must go to each individual casino and cardroom – over 60 statewide – and enroll in each of the self-exclusion programs. The study results indicate that this current system is not optimal because it is more effective for problem gamblers to voluntarily exclude themselves from multiple gambling locations using a single process and, if possible, register for a self-exclusion system without entering a casino property.

The study supports the Gambling Commission's current efforts to create a state-administered, centralized system that is more accessible to problem gamblers and allows them to exclude themselves from gambling facilities without entering one, which could trigger their addiction. House Bill 1302 and Senate Bill 5416 align with the results of this study and will improve the industry's current responsible gaming self-exclusion programs and will be more effective for those who suffer from a gambling disorder and wish to voluntarily exclude themselves from gambling establishments. The Gambling Commission has discussed a centralized, statewide self-exclusion program with the regulated commercial and Tribal gambling industries for nearly two years. The Commission is committed to creating a system that will work for all gambling operators while ensuring that persons with a gambling problem have an effective tool to help them with their harmful gambling behaviors. However, the next step is for the Legislature to authorize the Gambling Commission to create a statewide voluntary self-exclusion program.

Therefore, the Gambling Commission recommends the Legislature support and pass House Bill 1302 or Senate Bill 5416, including any amendments that will strength the policy considerations in these bills.

Recommendation 2: Create a Joint Legislative Task Force on Problem Gambling

Fourteen years ago, Governor Locke convened a work group that created Washington's original problem gambling policies and laws. The state has not committed to a comprehensive examination of its behavioral health programs and policies since the creation of the original problem gambling statutes in 2005. Since then, the Washington's gambling industry has grown significantly and has outpaced the policies currently in place.

Most of the recommendations identified in the accompanying report cannot be accomplished by the Gambling Commission alone. The Gambling Commission is a state law enforcement agency and is not situated to take the lead on social and behavioral health issues. However, the report recommends that the Gambling Commission advocate for the creation of a problem gambling task force. A joint legislative task force is the best way to bring all regulatory and behavioral and public health stakeholder groups together to comprehensively address this report's findings and recommendations. The task force would further study and develop outreach, prevention, and treatment services, as well as responsible gaming programs. It would also identify priorities, develop goals, and guide the improvements needed to help problem gamblers, their families and our communities.

The task force should be comprised of members from tribal and non-tribal organizations, including members of government, industry, public health, treatment, research and gamblers. These members will be well-positioned to take the results of this study and guide the state on how we can improve our outreach, prevention, and treatment services and responsible gaming programs.

Gambling is rapidly growing across the nation, and new activities being authorized in other states will eventually impact Washington. The state's problem gambling policies and laws need to be reviewed and a joint legislative task force is best suited to help the state take the next step in evaluating our current problem gambling structure and propose the most effective way forward in helping those suffering from a gambling disorder.

Currently, House Bill 1880 and Senate Bill 5818 are before the Legislature. These bills were filed prior to the issuance of this report but in anticipation of this recommendation. Due to the timing of this report and recommendation, these bills are not agency request legislation and are not in the Governor's 2019 budget. However, these bills are supported by the Gambling Commission and the agency will work with the Governor's Office and the state agencies mentioned in these bills to have an approved agency request problem gambling task force bill for the 2020 legislative session if House Bill 1880/Senate Bill 5818 are not passed in some form during 2019 legislative session.

Therefore, the Gambling Commission recommends the Legislature create a Joint Legislative Problem Gambling Task Force to comprehensively address this report's findings and recommendations during the 2019-2020 legislative cycle.

2019 Treatment, Prevention, and Responsible Gambling Programs in Washington State

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Introduction

The Washington State Legislature in its 2018-19 Supplemental Operating Budget, ESSB 6032 (section 717), directed the Washington State Gambling Commission to contract for a study to analyze the scope of services available for pathological or problem gamblers and their families in Washington State. The State Legislature directed the study to include, at a minimum, the following: (1) the availability of prevention programs and services offered within Washington State; (2) the availability of treatment programs and services offered for individuals with gambling-related problems and their families; (3) strengths and deficits in problem gambling programs and services. From this state mandate, researchers from the University of Washington, Department of Psychiatry & Behavioral Sciences (UW) and the Washington State University Carson College of Business (WSU) were approached by the Washington State Gambling Commission (WSGC) to conduct a review of the current state of prevention, treatment and recovery programs, responsible gambling programs, and other services for people with gambling-related problems offered within Washington State, and provide recommendations on improvement options.

This draft report provides the results of the work conducted by UW and WSU addressing the State Legislature's mandate. The report consists of two studies, the first addressing responsible gambling programs in Washington State, and the second addressing prevention, treatment, recovery services, and other services provided to assist people with gambling-related problems and their families and communities in Washington State. Within each study we provide information regarding purpose, methodology, findings, and conclusions/recommendations.

2019 Treatment, Prevention, and Responsible Gambling Programs in Washington State

Study 1: Responsible Gambling Programs

1 Study 1 Overview

In 2018, the University of Washington Department of Psychiatry & Behavioral Sciences (UW) and the Washington State University Carson College of Business (WSU) (collectively, “research team”) was approached by the Washington State Gambling Commission (WSGC) to conduct a review of the current state of prevention, treatment and recovery programs and services for people with gambling-related problems offered within Washington State, and provide recommendations on improvement options.

This section of the report summarizes the results of one major component of the project, the responsible gambling assessment. Industry-oriented programs designed to prevent or reduce the level of severity of problem gambling (PG) or gambling harms more generally are known as responsible gambling (RG) programs. These RG policies and practices often incorporate a diverse range of interventions designed to promote consumer protection, community/consumer awareness and education, and access to efficacious treatment. In conjunction with community-oriented prevention programs and gambling disorder treatment programs, RG programs are one third of user-oriented public health gambling services.

In the next section, an overview of the RG study methodology is provided that outlines the survey and literature review approaches. That section is then followed by a results section that integrates findings by RG focus area. Last, a conclusion is provided that summarizes study findings and recommendations.

2 Methodology

To assess the state of RG programs in Washington State, we first reviewed research literature to identify program components with evidence of effectiveness and/or evidence as an emerging best practice. This literature review then informed development of an operator survey tool, which was administered to all gaming operators in the state including Class III tribal-casino operators, cardroom-casino operators, Class II tribal bingo-casino operators, and operators of non-casino-based gaming regulated by the WSGC, including amusement games, pull-tabs, punchboards, raffles and fundraising events.

What follows in this report is a consolidated summary of the key insights from that literature, along with its direct implications for Washington State programs. The literature was weighed in connection with the research team’s knowledge of statewide RG programs and the survey data collected/analyzed from in-state operators, in order to develop a final set of recommendations of potential improvements.

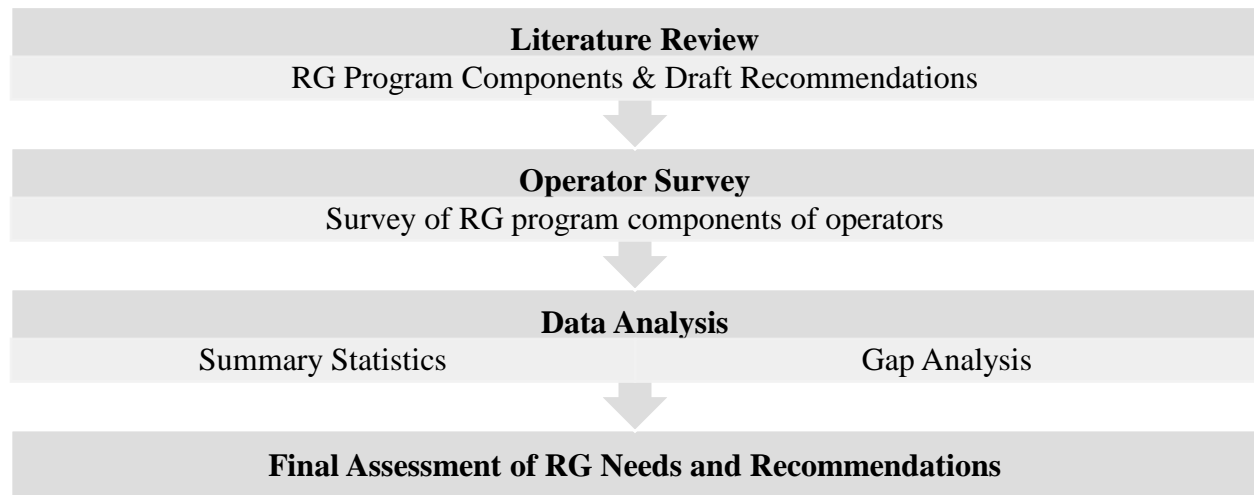


Figure 1 – Summary of overall RG study methodology: A literature review of RG-related studies informed development of an operator survey tool, which was administered to all gaming operators in the state, Survey data was analyzed and compared to literature, to develop a set of improvement recommendations

We note at the outset of this report that to integrate all the programs noted in the literature would be a significant undertaking. It is not our intention that stakeholders immediately address

all of the areas identified in this study, but it is reasonable for related stakeholders to identify a subset of higher impact interventions that can be prioritized and executed more expediently. For this reason, each section of the literature is followed by a recommended considerations subsection.

At this point in the study, we believe that there are several areas where Washington based programs can be improved. While many basic services are in place, there is an opportunity to improve coordination of efforts, and investment in services is low compared to the rate of growth of gambling in the state and compared to leading jurisdictions.

2.1 Literature Review

A major component of this study was an external literature review of RG-related best practices and evidence-based programs. Many of the practices introduced in leading jurisdictions have been the subject of limited study in empirical academic research. We weigh this evidence as part of our assessment, drawing significantly on two review studies for broad evidence of effectiveness from academic and grey-literature [1] and more scientifically rigorous peer-reviewed evidence [2]. We categorize the evidence into seven focus areas:

- (1) Strategy and evaluation
- (2) Venue design & other environmental features
- (3) Game design & machine structural characteristics
- (4) Advertising & marketing
- (5) Educating players
- (6) Assisting players in need
- (7) Self-exclusion programs

Last, we note that nearly all research-related content focuses on casino-style gaming operations. For non-casino-based gaming, including amusement games, pull-tabs, punchboards, raffles and fundraising events, our insights and recommendations are pragmatic to the nature of these operations, and we recognize that strategic/policy-based decision making must generally occur at the level of the regulator.

2.2 Survey

After the literature review was completed, an operator survey was developed to assess the state of existing services in Washington. A draft survey was developed by the research team, and the research team requested comments from the WSGC to ensure that local norms or practices were not ignored or missing. No modifications to the survey were suggested. The survey was found to be exempt from review by the Institutional Review Board of Washington State University and the Institutional Review Board of the University of Washington.

The survey was distributed through two different mechanisms: 1) to a distribution list of WSGC licensees that included commercial and non-profit operations; 2) to a distribution list of tribal casino operators provided by the Washington Indian Gaming Association (WIGA). The WSGC recruitment opened on November 2, 2018 and licensees received notification of the survey from WSGC roughly one week before that date. The tribal casino operator recruitment opened on November 16, 2018, after WIGA passed a resolution supporting this study. Both recruitment periods ended on January 6, 2019. Electronic informed consent was obtained from all respondents, and respondents had the opportunity to decline to respond to the survey. No compensation was provided to respondents. Study data is deidentified and stored in a secure password protected database on the UW server, only accessible to the research team.

Due to the complexity of the programs, their association with harms, and the scope of deliverables, we were primarily focused on results from tribal casinos and house-banked cardrooms. Based on organizations associated with each email and licensing information from the WSGC, house-banked cardroom operators were flagged in a category we refer to as cardroom casinos. In this report, we collectively refer to the group of cardroom casinos and tribal casinos as “casinos”, which subjectively captures the perspective of most Washington gamblers.

WSGC licensees received up to six reminder emails to complete the survey, while the contacts in the WIGA list received up to five reminders. Due to the importance of casinos in this study, we attempted to contact all of those operators by phone to encourage them to complete the survey. A summary of distribution statistics is provided in Table 1. We note that many email addresses appeared outdated, and there was not a one-to-one relationship between the contact information and active operations. For example, while 171 cardroom email addresses were invited to participate in the survey, based on a WSGC report dated December 11, 2018, there are 46 cardroom casinos operating in Washington [3]. Also, many operators oversee more than one casino.

Table 1: Distribution and response statistics

	Non-casinos	Cardroom Casinos	Tribal Casinos	Total Industry
Invited	1,758	171	25	1,954
Completed	107=6%	23=13%	3=12%	133=7%
Declines	63	6	0	69
Partials				226

Note: Among partial completes, 103 opened the survey but answered zero questions, 123 completed 5%-99%, and 20 completed over 50%.

To better measure the proportion of gambling operations that are captured in the survey, we asked a series of screening questions related to the types of gambling operations and the number of locations which our respondents oversee. This may overestimate representation from

cardroom casinos if multiple respondents of the same organization completed the survey, but still provides an upper bound on potential representation. Respondents that reported Class II casino operations, Class III casino operations, or house-banked cardroom operations were categorized as casinos. In total, 22 respondents reported one or more of those categories. Among those respondents 20 responded to the number of sites question, reporting management of 37 gambling properties, leading to a total estimate of 39 properties when the non-respondents to that question are counted. According to records from the Governor's Office of Indian Affairs and the WSGC, this is roughly 51% of casinos in the state. Many statistics are reported as percentages, and while this may appear to be a small sample, it is also a small population as a census would only be (roughly) twice as large.

3 Results

This section of the report describes findings from the literature review consolidated with the survey of available programs at Washington State operations. The section is divided into seven different content areas, chosen based on their closeness to past reviews and our perceived usefulness to in-state stakeholders:

- (1) Strategy and evaluation
- (2) Venue design & other environmental features
- (3) Game design & machine structural characteristics
- (4) Advertising & marketing
- (5) Educating players
- (6) Assisting players in need
- (7) Self-exclusion programs

For each section, our survey asked a series of related questions about whether the respondent's organization offered such a program. For example, in the *Advertising & Marketing* category, respondents were asked if their organization had processes in place where "Patrons identified with gambling problems, or who otherwise wish to opt out, are removed from the loyalty/rewards program", and are asked to agree or disagree. In this report, we provide and comment on responses from casinos. We provide responses from non-casinos without comment, as the RG programming questions are less material to non-casino operations, but some readers may be interested in the figures.

We note that all responses are self-reported, and like all such studies, may be subject to negligent reporting, personal biases, or purposeful misdirection. To increase the likelihood of survey takers responding truthfully, the study preamble clearly notes that responses will be held confidentially and only reported in aggregate statistics.

3.1 Strategy and Evaluation

RG-related strategies vary in scope, generally as a function of the operating jurisdiction and sophistication of the property(ies) in which they are implemented. Cultural, social, and political processes in regions often dictate the nature of gambling and the regulatory framework, and operational policies and strategies emerge from that foundation. The most well-known and useful framework underlying policy development in responsible gambling is the "Reno Model" [4–6], described as a science-based model that provides a strategic framework for responsible gambling initiatives. The model, which has been widely supported across many jurisdictions, asserts that responsibility to provide sufficient information on gambling-related processes and consequences lies with the industry and government regulators, while the decision of whether to gamble resides with consumers. It also recognizes a need for collaboration between stakeholders

that targets informing and evaluating public policy, identifying priorities, and using scientific research to guide the development of policies aiming to reduce the incidence of problem gambling and gambling-related harms.

Making effective strategic decisions about responsible gambling policies, programs, and guidelines also requires an understanding of how programs and their features contribute to specific outcomes and whether program performance meets established criteria. This is generally achieved through benchmarking against comparable institutions and past performance. One of the evaluation tools that is particularly notable in the field of responsible gambling is the Positive Play Scale – an instrument designed to measure responsible gambling behaviors [7]. It assesses players’ behaviors on such parameters as honesty and control, personal responsibility, and gambling literacy. This scale can complement measures of gambling disorder, which are informative of a much smaller user base [8].

3.1.1 Survey results

Results of the survey suggest that there is little strategic consideration given to RG in Washington casinos. While a small majority (61%) report that they have corporate policies that provide guidance on related issues, a minority regularly include RG as part of the strategic planning process (35%), have an accountable executive-level staff member (35%), or provide their staff with detailed training on the subject matter (46%).

Table 2: Responsible gambling strategy responses

	Non-Casino Responses	Share reported 'yes'	Casino Responses	Share reported 'yes'
My organization has corporate policies that establish guidance on problem gambling issues and responsible gambling programs	188	27.7%	18	61.1%

	Non-Casino		Casino	
My organization regularly (e.g., annually) updates its corporate strategy for responsible gambling, including goals and operational plans	186	26.9%	17	35.3%
There is an executive staff member (e.g., VP-level) who is accountable for responsible gambling programs	185	40.0%	17	35.3%
There is a responsible gambling strategy that includes regular (e.g., monthly) discussion of responsible gambling across business managers	185	17.8%	17	23.5%
There are regular (e.g., monthly) reminders to staff about responsible gambling policies and actions	185	23.8%	17	47.1%
My organization regularly (e.g., every three years) has an external and independent evaluation of our responsible gambling programs and policies	184	16.8%	17	23.5%
Corporate responsible gambling policies are identified in general employee training	109	34.9%	13	61.5%
Staff receive detailed training about problem gambling and its impact as well as key responsible gambling information	108	25.0%	13	46.2%

3.1.2 Recommended considerations

Several implications emerge for Washington State. First, all operators should (1) appoint a person accountable for RG strategy, and (2) should include responsible gambling as part of their regular strategic planning process. Second, at the regulatory level, regular review processes should be put in place to assess minimum standards and benchmark performance. Third, at the state-wide level, better coordination of planning and resourcing is needed. While many independent institutions are accountable for their own RG programs, all institutions interact at the consumer level, and those players would substantially benefit from a coordination of education and support programs. This association of firms should provide strategic direction for

informing and evaluating public policy, identifying priorities, and using scientific research to reduce the incidence of problem gambling and gambling-related harms.

3.2 Venue Design & Other Environmental Features

The local environment in which gambling activities are located are believed to be connected to risk and harms. Vulnerable players include those with greatest exposure to gambling opportunities (e.g. venue staff, people living in proximity of gambling venues), people afflicted by other psychological disorders, youth, and individuals with low socio-economic status [9–12]. Venues located closer to these populations may need different risk mitigation strategies, though it is important to note that exposure effects are not uniform across all settings and social environments [13, 14].

Operational factors also impact risk to players and the consumer experience. Easy cash access is believed to trigger impulsive decision making among persons with gambling disorders [15]. A recent study including three-quarters of U.S. casino automated teller machines (ATMs) found 12% of withdrawals are rejected due to insufficient funds and 42% are done with credit cards [16]. Similarly, the use of alcohol, which is often provided for free and can decrease decision making abilities and increase impulsive risk-taking, particularly people with gambling disorders [17, 18].

RG information centers located in casinos are increasingly becoming a part of venues. Centers are available to patrons seeking help or more general information about gambling. Research shows that the use of these resources is mostly motivated by their accessibility [19]. Consumers tend to view the centers positively, but there is limited evidence of their long-term effectiveness in reducing risky behavior, although some related research is underway [20].

3.2.1 Survey Results

Based on the response statistics, it appears that most casinos have core components of a responsible alcohol and gambling program. All report training is provided for employees (100%), and most report that alcohol is not complimentary (93%) nor are intoxicated players allowed to gamble (87%). Cash access is less well controlled. All allow patrons to withdraw cash using credit cards, and only 20% place ATMs off of the casino floor.

Table 3: Venue design & other environmental feature responses

	Non-Casino Responses	Share reported 'yes'	Casino Responses	Share reported 'yes'
ATMs are placed in a location that encourages a break in play (e.g., off casino floor)	129	31.8%	15	20.0%
Access to casino credit is prohibited or restricted	128	46.1%	15	93.3%
Patrons are not able to withdraw cash from credit cards at the property	128	43.8%	15	0.0%
Check cashing on-site is prohibited	129	46.5%	15	13.3%
Direct electronic access to casino credit, credit cards, or debit cards is prohibited at the games	128	47.7%	15	86.7%
Access to alcohol is well controlled, with training for employees that is specific to a gaming environment	131	58.8%	15	100%
Alcohol is never complimentary	133	68.4%	15	93.3%
Patrons under the influence are not permitted to gamble	132	48.5%	15	86.7%

3.2.2 Recommended considerations

From a design and environmental implication perspective, several recommendations emerge. Venues should independently and in coordination with other institutions, consider nearby resident risk-factors, and tailor RG best practices for their own community needs. Clear policies around the provision and location of alcohol distribution should be considered as part of

an industry wide code of conduct. Given the connections of alcohol and gambling in research literature, responsible alcohol service policies should not be developed as an independent amenity, but should instead be considered in conjunction with gambling-related risks.

ATM location policies should be contemplated in conjunction with both consideration of typical objectives of convenience, but also impulsive behavior by players. For example, locating ATMs near entrances of a resort but off of the casino floor would provide players with ease of access when entering the facility, but also an opportunity for players to ‘cool-off’ before withdrawing more cash. Venues should also consider whether credit card based withdrawals should be restricted, which we distinguish from casino credit, which typically includes a validation of the availability of funds.

Last, venues should assess the introduction of RG information centers or their integration into other onsite player services (e.g. loyalty desk). In either case, operators should continue to examine emerging evidence of information center’s effectiveness as it emerges.

3.3 Game Design & Machine Structural Characteristics

The overall structural characteristics and individual features of the games can affect gambling outcomes, and some features may increase the harms associated with gambling because of their relation to maladaptive thoughts that gamblers can develop about their likelihood of winning. Sounds, lights, pace of the game, and near misses artificially programmed into games may all contribute to these biases [21–26]. Games vary in their design and structure: speed, odds of winning, stakes, rule complexity, and the amount of social interaction required are different among different games, and certain game features (e.g. fast pace of play) can lead to more harmful outcomes than others [27–29].

Effective game design can also include better responsible gambling practices. There is some evidence that cash and time displays can encourage responsible play [30]. Pre-commitment tools, where an instrument is used to predetermine the amount of time or money the player intends to spend gambling, are also seen as responsible product features [31–33]. While there is limited evidence on optimal designs, some jurisdictions, including Massachusetts, are requiring these tools on all slot machines [34].

3.3.1 Survey Results

The results of the survey suggest that game features are generally not considered as part of the RG planning process. It is important to note that some of these responses may be biased as most casino responders are cardrooms without any gaming machines. However, the most applicable question to all respondents asks whether there is a formal RG screening process for games, and no casinos reported such a process.

Table 4: Game design responses

	Non-Casino		Casino	
	Responses	Share reported 'yes'	Responses	Share reported 'yes'
Machines are designed to display credits as cash value	116	19.8%	14	28.6%
Gaming machines have on-screen responsible gambling messaging displayed during play	113	13.3%	14	0.0%
Gaming machines do not have stop buttons	112	17.0%	13	7.7%
There is a formal screening process to evaluate new games for responsible gambling	113	16.8%	15	0.0%
Players can set personalized limits or reminders for time and/or money spent on gaming machines	113	11.5%	15	6.7%

3.3.2 Recommended considerations

Literature on game structural features is fairly clear in some areas (e.g. speed of play), but is only emerging in others (e.g. social interaction). To provide a more rigorous examination of potential risks from new and existing games and enable a more informed decision around these issues, Washington regulators and operators should consider adopting use of a game screening tool such as *Gamgard* [35]; *Tools for Responsible Games* [36]; or *AsTERiG* [37]. While evidence of the effectiveness of on-device pre-commitment tools is unclear, this should not preclude Washington from trialing the technology and/or continuing to closely monitor the value of adoption.

3.4 Educating Players

Informed decision making is a necessary condition for rational decision making. Gambling related cognitive distortions are a series of loosely-related sets of errors in human decision making, which are connected by their relationship to the gambling consumption experience and role in the development and maintenance of gambling disorders [38–42]. Much of the early research on gamblers’ cognitive distortions derived from ‘think-aloud’ methods, where gamblers expressed their thoughts while gambling or performing related tasks [43–46]. Analysis of transcripts from these studies revealed several categories of maladaptive thoughts, which conflicted with an objective assessment of reality. Correcting distorted thoughts became and continues to be, an important part of treatment protocols for gambling disorders [40, 47].

Research on “positive play” suggests that beliefs about gambling are a fundamental component of responsible gambling by players [7, 48]. Players often differ from each other in the intensity of their gambling involvement and their knowledge and attitudes about gambling, therefore educational information provided to players should be tailored to their unique

characteristics [49, 50]. Information on how to incorporate the notions of informed decision making and harm minimization in gambling regulations should be considered by regulators. While information on risks and probability of gambling might raise awareness, the evidence as to whether this raised awareness translates into behavioral change is still vague. Some authors suggest that personally-relevant information (e.g. behavioral feedback) may be more effective, along with information that outlines alternative actions the player should consider instead of gambling [51, 52].

Several studies show that presenting information in a way that interrupts gambling activities may be useful for drawing players' attention and disrupting the dissociative state that is frequently experienced during gambling sessions [53, 54]. Studies also suggest that the traditional ways of raising awareness about problem gambling (e.g. in-venue posters) are only mildly effective, when not paired with additional responsible gambling strategies [55–57]. Effective training programs should consider the appropriate ways to frame and deliver gambling-related information along with the importance of informed decision making.

3.4.1 Survey Results

In general, responses provided by casinos suggest that there is some information available for players that would like to learn more about responsible gambling. Four out of five casinos reported available information, and three out of five reported personalized information was available. Less obvious is efforts to directly educate players. Only 40% report that staff are directed to dispel myths and misconceptions about gambling, although 62% receive related training.

Table 5: Player education responses

	Non-Casino Responses	Share reported 'yes'	Casino Responses	Share reported 'yes'
There is a variety of information that is easily available to assist players to make informed decisions about their gambling	136	36.8%	15	80.0%
Staff are directed to dispel myths and misconceptions about gambling (e.g. "hot machines") when they speak with players	133	30.1%	15	40.0%
There is an on-site specialized information center whose purpose is to provide information about responsible and problem gambling	133	10.5%	15	26.7%
Players can easily access personal information about their gambling, such as play history	134	6.7%	15	60.0%
Staff are trained to avoid messaging that reinforces misleading or false beliefs	109	34.9%	13	61.5%

3.4.2 Recommended considerations

Player education is broadly considered a core area of responsible gambling programs but requires a comprehensive strategy that considers multiple channels and operational integration. While some jurisdictions have taken a compliance or task-oriented approach to this objective, a more productive approach may be to set measurable goals in related metrics such as awareness, game understanding, or positive play scale scores. This will allow operators to benchmark performance against one another and over time, and develop approaches that most closely suit their operations and player base.

3.5 Advertising & Marketing

Responsible gambling professionals often play a role in developing prevention-oriented ad campaigns and reviewing commercial advertisements for risks related to promotion of

distorted thinking around gambling. Communicating responsible gambling practices through marketing and advertising has been shown to be an important tool. Evaluations of responsible gambling campaigns often demonstrate that they are successful at raising awareness and educating the public about problem gambling risks and encouraging actions that reduce the risks of problem gambling [58–60].

The prohibition of misleading advertisements that overestimate the odds of winning or underestimate the gambling-associated harms is suggested as a policy option, as advertising plays a role in establishing social norms [61, 62]. Potential concerns with gambling advertisements also involve targeting people with gambling problems and underage gamblers. Research shows that these populations are particularly susceptible to the impacts of advertisement and marketing campaigns. Players with gambling problems are more likely to play longer and gamble more than others when offered the same incentives. Some codes of practices limit the offer of marketing incentives that might promote excessive gambling, but there is currently a lack of transparency regarding monitoring and enforcing these regulations [30, 58, 63–66].

3.5.1 Survey Results

Responses from operator survey suggest that a minority of casinos have basic programs in place to prevent deceptive advertising. Only one-third (33%) of casinos report having a policy that restricts misleading advertising or targeting vulnerable groups, while roughly one in four casinos (27%) has a screening process in place for advertisements. Most casinos (60%) do have a mechanism to enable patrons to opt out from the rewards program.

Table 6: Advertising and marketing responses

	Non-Casino Responses	Share reported 'yes'	Casino Responses	Share reported 'yes'
There is a clearly articulated advertising policy that states ads must not mislead, reinforce gambling myths, or target people with gambling problems or minors	144	29.9%	15	33.3%
A screening process is in place for all advertising to ensure adherence to responsible gambling policies	140	27.9%	15	26.7%
Patrons identified with gambling problems, or who otherwise wish to opt out, are removed from the loyalty/rewards program	137	13.9%	15	60.0%

3.5.2 Recommended considerations

Where feasible, operators should put in place programs to avoid excessive reinforcement of cognitive distortions through marketing materials. While some elements occur as part of the nature of gambling products, and indeed may be part of the excitement or arousal that make gambling an appealing leisure pastime, explicit actions or reinforcement of these thoughts should be limited. This includes advertisements or promotions that portray or encourage maladaptive thoughts, like ‘hot slots’, lucky features, or other deceptive portrayals that may exploit biases in human cognitions. In addition, programs to educate players and public of common gambling distortions should be put in place in facilities and public spaces to enable resistance to the development of erroneous thoughts. Prior research has provided evidence that even simple warning labels on lottery tickets may be effective in reducing play from distorted thought processes [67].

3.6 Assisting Players in Need

Helping players is a part of most responsible gambling programs. It is commonly achieved through identifying people with problem gambling behaviors or responding to people who self-identify and referring them to help resources. These resources may be educational literature, help-lines, local support programs, or more senior staff that can better manage a given situation.

Staff observations are most commonly used to identify players in need, but behavioral tracking of betting patterns can reliably identify people with gambling problems online [2, 68, 69], and there is reason to believe that this could be extended to loyalty card data in brick and mortar environments. Several studies monitored players’ gambling activity on online gambling sites and identified behavioral patterns that differentiate the players who trigger responsible gambling gaming alert systems from those who do not [70–73]. Intensity of gambling activities (number of bets, active betting days, gambling session duration, number of games played) and financial variables (total bet size and net losses) are used to identify people exhibiting signs of problem gambling.

3.6.1 Survey Results

In general, responses suggest that training (93%), knowledge (80%), and processes (80%) are in place at most Washington casinos to respond to players in need of assistance. These are core components of a responsible gambling program, and it is a useful foundation from which to build other strategies.

Table 7: Assisting players in need responses

	Non-Casino Responses	Share reported 'yes'	Casino Responses	Share reported 'yes'
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	Non-Casino		Casino	
All staff are knowledgeable about the helpline, self-exclusion, and local treatment resources and provide that information to patrons on request	135	28.9%	15	80.0%
Staff are trained in a process to respond appropriately to a distraught customer (e.g., crying, swearing)	136	38.2%	15	93.3%
Clear processes are in place to initiate escalating discussions with patrons suspected of having a gambling problem	135	20.0%	15	80.0%
Staff are taught skills and procedures required of them for assisting patrons who may have problems with gambling	108	24.1%	13	76.9%
Behavioral data from the player database is used to assess players' risk of gambling problems	137	7.3%	15	13.3%

3.6.2 Recommended considerations

All staff in the state that interact with players should receive basic training and instructions on how to respond to behavioral markers of distress (e.g. crying or yelling), when to escalate interactions to more knowledgeable staff, and where help resources are available. Developing interventions based on artificial intelligence tools also holds much promise, and stakeholders should continue to monitor this field for developments and/or invest in related research and Washington based trials.

3.7 Self-Exclusion Programs

Self-exclusion programs provide people with an option to ban themselves from gambling venues for a predetermined or indefinite duration of time. Self-exclusion is one of the most researched responsible gambling practices, with multiple studies in different jurisdictions indicating that the introduction of self-exclusion programs led to reductions in problem gambling accompanied by improvements in well-being, control over gambling, and social and familial functioning [74–80]. Providers offering self-exclusion programs face multiple obstacles for

responsible gambling knowledge workers to consider, including accessibility to players and preventing breaches at the venue [75, 81].

The most common criticism of single-venue self-exclusion is that patrons can continue gambling at other venues after self-excluding themselves from a particular website or casino, supporting coordination of multi-operator programs [82]. These programs have shown some value to consumers [83], but require sharing of data and resources among venues and therefore increased sophistication of knowledge workers.

3.7.1 Survey Results

The results of the self-exclusion survey questions suggest that a basic program is in place at most properties, but there may be substantial opportunity to improve the benefits that are received by players. Most notably, only a minority of respondents (38%) reported that their self-exclusion was well promoted across the property. Program awareness is the first requirement for reaching persons in need of assistance. Some emerging best practices such as active reinstatement processes (38%) and withholding prizes from excluded players (38%) also may warrant increased consideration in an overall self-exclusion strategy.

Table 8: Self-exclusion responses

	Non-Casino Responses	Share reported 'yes'	Casino Responses	Share reported 'yes'
A comprehensive and publicly available written self-exclusion policy is in place	150	16.7%	16	75.0%
The self-exclusion program is well promoted across the property (e.g., posters, brochures, TV screens, staff etc...)	149	14.8%	16	37.5%
Frontline staff are trained to talk about self-exclusion to players	147	14.3%	16	75.0%
Enrollment in self-exclusion is managed by specially trained personnel	145	9.0%	16	68.8%

	Non-Casino		Casino	
Self-exclusion ban length is variable and patrons have options in their length of ban.	145	17.2%	16	93.8%
Self-excluded players do not receive any promotional materials; direct marketing, etc.	143	9.1%	16	68.8%
Self-excluded persons receive information about local help resources as part of the enrollment process.	144	13.2%	16	75.0%
Self-excluded players receive clearly worded information that outlines the conditions of the ban and consequences of breaching.	142	8.5%	16	56.3%
Well designed, comprehensive information package provided to all self-excluders	142	5.6%	16	43.8%
A strong enforcement process is in place to identify and remove self-excluded patrons	142	9.2%	16	81.3%
Excluded players are not eligible to retain winnings, if found gambling	141	9.9%	16	37.5%
There is an active reinstatement process in place that excluded players must complete before returning to the venue	141	8.5%	16	37.5%
Enrollees are able to easily renew their exclusion before expiry, without entering the facility	141	8.5%	16	56.3%

3.7.2 Recommended considerations

Self-exclusion is a responsible gambling intervention that has received substantial evidence of effectiveness. The programs are also highly desirable from a business integration standpoint, as they have nearly no impact on players without issues. For these reasons, related stakeholders should invest meaningful resources to ensure that self-exclusion programs are successful. While programs appear to be in place at most operators, a more strategic approach would likely improve uptake of the program by those in need and improve outcomes of enrollees.

Areas of potential improvement include: 1) increasing awareness of the program among players; 2) ensuring that the programs adopt best practices in terms of ban length; 3) creating a shared (centralized) network among operators in the state that would allow users to ban themselves from all properties; 4) offer enrollment and re-enrollment processes that do not require entering a casino property.

4 Discussion

4.1 Engagement

The field of responsible gambling has advanced significantly since casinos first emerged and expanded in Washington State. While some programs like self-exclusion have received substantial focus by researchers to validate their effectiveness, other approaches remain the focus of ongoing study. To understand how industry norms have evolved, several questions related to organizational and state RG/PG programs were asked to operators. The results suggest that there is fairly low engagement.

Only 53% agreed or strongly agreed that their organizations devoted adequate resources to RG, while 23% disagreed or strongly disagreed. There is some RG-specific expertise in organizations. Among casino respondents, 38% reported ‘all’ or ‘most’ of their role related to RG, 43% reported ‘some’, and 19% reported ‘not much’. In addition, six respondents (29%) reported that they had employees whose role is entirely or mostly focused on RG. One-third of casinos (67%) reported that their EAP program included support for PG, and three respondents (14%) did not allow employees to gamble onsite.

While some respondents believe that both their firms and the State of Washington should invest more resources, there are several operators that are unsupportive of program expansion in Washington. Many respondents disagree or strongly disagree that Washington should have a

statewide self-exclusion program (30%), a policy on RG advertisement (16%), a statewide RG training program (31%), or more resources for treatment and prevention (23%).

Table 9: Casino operator perceptions of RG and PG needs

	Strongly Disagree	Disagree	Neither Disagree nor Agree	Agree	Strongly Agree
Responsible gambling is an important part of the organizational culture at my place of employment	0%	0%	38%	46%	15%
My organization devotes adequate resources to responsible gambling	8%	15%	23%	38%	15%
The employees in my organization are highly engaged in our responsible gambling program	0%	23%	31%	46%	0%
Washington should have a statewide self-exclusion program	15%	15%	31%	31%	8%
Washington should have a statewide policy on responsible gaming advertisement	8%	8%	54%	23%	8%
Washington should have a statewide training program for responsible gambling	8%	23%	46%	15%	8%
Washington should devote more resources to problem gambling treatment programs (e.g., counseling services)	15%	8%	38%	31%	8%
Washington should devote more resources to problem gambling prevention (e.g., awareness advertising)	15%	8%	46%	23%	8%
My organization would be interested in external responsible gambling training	8%	0%	54%	31%	8%
My organization would be interested in external responsible gambling reviews/audits	15%	23%	38%	23%	0%
My organization would be interested in funding responsible gambling research	31%	15%	46%	8%	0%

Note: Number of respondents = 13

4.2 Assessment

After comprehensively reviewing the state of responsible gambling research worldwide and providing an opportunity for operators to give feedback on their own programming, several implications emerge. First, it is clear that Washington State casinos are not among leading organizations worldwide in terms of RG services and programming. While many basic programs are in place like self-exclusion, there does not appear to be a process at most organizations to continually assess performance and improve program outcomes. In each subsection of this report, technical areas for improvement of programming and services are offered, but the biggest need in the state is a more strategic and integrated approach to RG at both an organizational and statewide level.

We view the goals of legal and regulated gambling in the state as threefold:

- i. Maximize economic impacts in terms of community investment and ongoing impacts on gross domestic product, employment, and income;
- ii. Generate sustainable revenue for tribal, local, and state governments; and
- iii. Reduce the impact of gambling related harms (e.g. problem gambling and crime) on communities.

Each of these goals are connected and require significant strategic coordination within and between participating organizations. Within the scope of this study, we make the following recommendations in support of item ‘iii’, while allowing for consideration of items ‘i’ and ‘ii’ in a public health strategy.

4.3 Recommendations

To improve coordination and leadership in RG, Washington stakeholders should establish a gaming neutral advisory group, with a mandate to develop a public health strategy for gamblers

and communities. The group should include membership from tribal and non-tribal organizations, including members of government, industry, public health, treatment, research and gamblers. The primary objective of the group should be to periodically develop a comprehensive responsible gambling strategy for the state to be approved by member organizations, and create alignment across the diverse organizations. Related sub-objectives may include:

- (1) Identification and leadership of priority initiatives, such as revised gambling industry advertising and marketing standards, modifications to self-exclusion programs, or gambling educational programs delivered to youth.
- (2) Establishment of a basic harm reduction framework for operators, which will enable smaller operations with fewer resources or in-house experts to introduce more sophisticated RG practices and provide a minimum level of RG service for all players.
- (3) Development of a research and evaluation strategy for responsible gambling programs, to ensure transparency and continuous program evaluation and improvement.

We recognize that integrated groups like the one recommended above require resourcing and must operate within pre-existing organizational dynamics and political structures. As the nature of those issues extends beyond the scope of this study and our expertise, we make no formal recommendation on that structure, but again reiterate the strong need that Washington gamblers and communities have a more invested approach to RG by all stakeholders.

5 Study 2 Overview

The University of Washington Department of Psychiatry & Behavioral Sciences (UW) and the Washington State University Carson College of Business (WSU) (collectively, “research team”) was approached by the Washington State Gambling Commission (WSGC) to conduct a review of the current state of prevention, treatment and recovery programs and services for people with gambling-related problems, specifically expressing a need to update the 2013 report entitled *Washington State Problem and Pathological Gambling Treatment Program: Levels of Care, Service Gaps, and Recommendation* [86]. We strongly recommend readers review the previous report as it provides an excellent overview of the history of gambling and problem gambling treatment in Washington State as well as reviews levels of treatment ranging from traditional outpatient to residential treatment and recovery-oriented aftercare programs. The previous report outlined important areas that needed improvement which continue to be apropos today, including: 1) *increased availability of resources for outpatient providers*; 2) *Coping with issues of comorbidity*; 3) *the need for residential gambling treatment in Washington State*; 4) *need for more aftercare options*; 5) *Need to incorporate Screening, Brief Intervention, and Referral to Treatment (SBIRT) strategies into levels of care, perhaps through integration into primary care and Helpline services*; and 6) *Need for Intensive Outpatient/Partial Hospital options for individuals with gambling problems (Appendix C, Levels of Care Original Report 2013)*.

In the next section, we provide an overview of the current Treatment Provider Study methodology that outlines the survey and literature review approaches. That section is then followed by a results section that presents our findings from the provider survey. We then supplement our findings with information provided by the Washington State Problem Gambling

Program (WAPGP) and the Evergreen Council on Problem Gambling (ECPG) to provide context for our survey findings and better characterize available services. Last, a conclusion is provided that summarizes study findings and updates and extends recommendations from the previous *Levels of Care* [86] report based on knowledge of strengths and limitations of problem gambling services currently available in Washington State.

6 Methodology

In order to evaluate the current state of treatment for problem gambling in Washington State, we reviewed the recent problem gambling treatment literature from 2013 to present. This literature review as well as previous research conducted by the research team on this subject matter informed the development of the survey instrument for the current Treatment Provider Survey. After survey questions were developed, an online survey was created using DatStat Illume, an online data collection program. To identify eligible treatment providers, we utilized a list of Certified Problem Gambling Counselors in Washington State provided by the ECPG and current publicly available websites to identify 24 treatment providers with current contact information. These 24 providers were sent an email invitation which described the study and provided a secure hyperlink which opened a web-page to the online survey. The research team sent out one invitational email (12/17/18) and three reminder emails (one email per week with the last email sent on 01/07/19). Prior to closing the survey on 01/10/19, providers were contacted once by telephone, if they had not completed the survey, to answer any questions they might have and confirm that they had received the survey link. Using these reminder methods, survey responses were obtained from 21 of 24 invited treatment providers, for a response rate of 87.5%.

In the invitation email, providers were informed that the survey would take approximately 10-20 minutes to complete and they would receive a \$25 Amazon e-gift card for completing the survey. The first page of the online survey included an information statement (the online equivalent of informed consent) which provided the purpose of the survey, example questions they would be asked, and informed participants of their rights as a participant, including the right not to answer any question they were not comfortable answering. The information statement also provided contact information for research staff who could answer any questions they might have before completing the survey. At the end of the survey, participants were asked to provide their preferred contact email address to receive the \$25 Amazon e-gift card as a token of appreciation for completing the survey. The University of Washington Institutional Review Board deemed the study minimal risk and qualified it for exempt status.

7 Results

7.1 Provider Demographics

Twenty-one respondents agreed to participate in this study. Not all respondents answered every question. Across respondents, 38% identified as male and 62% identified as female. Most respondents were white (80%), with two respondents identifying as multiracial (10%), two respondents identifying as American Indian/Alaskan Native (10%), and one respondent identified as Hispanic/Latino(a) (5%).

All respondents (100%) reported that they were certified gambling counselors.

Table 10: Level of certification of gambling counselors

Certification Level	Count	Share of total
Washington State Certified Gambling Counselor Level 1	8	38%
Washington State Certified Gambling Counselor Level 2	4	19%
Washington State Certified Gambling Counselor Supervisor	4	19%
International Certified Gambling Counselor Level 1 (ICGC-I)	1	5%
International Certified Gambling Counselor Level 2 (ICGC-II)	2	10%

Certification Level	Count	Share of total
Board Approved Clinical Consultant (BACC)	2	10%

Participants were also asked about other professional licenses. The majority reported they were certified as Chemical Dependency Professionals (81%) and/or Mental Health Counselors (38%). No providers reported doctoral or medical degrees.

Table 11: Professional licenses held

	Responses	Share reported 'yes'
Chemical Dependency Professional	21	81%
Marriage and Family Therapist	21	0%
Mental Health Counselor	21	38%
Licensed Social Worker	21	5%
Master’s degree – Licensed Therapist	21	14%
Doctoral degree – Licensed Psychologist	21	0%
Medical degree – Licensed Psychiatrist	21	0%
Other	21	29%

7.2 Insurance

At least one provider reported accepting each form of payment for treatment. Just over half of providers indicated at least some clients paid out-of-pocket for their treatment, with 43% of providers reporting they accepted private insurance. The next most common method of payment was through Washington State contract, which was reported by 38% of providers, and 19% of providers were supported by Evergreen Council on Problem Gambling (ECPG) contracts. Within the category of “other”, providers reporting offering services at no cost to the clients through support from tribal resources.

Table 12: Accepted payments for treatment

Insurance Program/Payments	Responses	Share reported 'yes'
Employer Insurance Program	21	24%
Medicaid/Apple Health	21	24%
Medicare	21	0%
Private Insurance Program	21	43%
Self-pay (pay out of pocket)	21	52%
Washington State Problem Gambling Contract	21	38%

Insurance Program/Payments	Responses	Share reported 'yes'
Evergreen Council on Problem Gambling Contract	21	19%
Other	21	33%

7.3 Treatment Strategies

Respondents were asked what clinical services/treatment strategies that they utilized with clients who are being treated for problem gambling, and were allowed to check all that applied. Providers reported a wide range of services incorporating different theoretical perspectives. With respect to treatment orientation, the most common approaches included Cognitive-Behavioral Therapy (95%), Gamblers Anonymous (81%), Relapse Prevention (81%) and Harm Reduction (71%). These approaches are largely consistent with recommendations from the literature [84]. With respect to treatment modality, providers indicated they primarily engaged in Individual Therapy (95%), Gambling Assessment (90%), Group Therapy (not GA based) (62%) and Financial Counseling/Debt Management (62%). The rate of providers offering Aftercare or Recovery Services (52%) is improved since the prior *Levels of Care* report [86], but nonetheless lags well behind assessment and primary treatment rates. Notably, only 5% of respondents indicated using a manualized treatment, again consistent with the prior *Levels of Care* report that indicated a need for more manualized therapy resources for gambling treatment providers.

Table 13: Strategies used to treat persons with gambling disorders

Strategy	Responses	Share reported 'yes'
Aftercare/Recovery Services	21	52%
Behavioral Therapies	21	52%
Cognitive-Behavioral Therapy (CBT)	21	95%
Couples/Marriage Counseling	21	48%
Evidence-Based Treatment (EBT)	21	67%
Family Therapy	21	57%
Financial Counseling or Debt Management	21	62%
Gamblers Anonymous	21	81%
Gam Amon	21	43%
Gambling Assessment	21	90%

Strategy	Responses	Share reported 'yes'
Group Therapy (NOT GA – psychotherapy-based)	21	62%
Harm Reduction	21	71%
Individual counseling/psychotherapy - Individual Therapy	21	95%
Manualized Therapy	21	5%
Mindfulness Meditation	21	52%
Person Centered Therapy	21	48%
Psychodynamic Psychotherapy	21	29%
Recovery Oriented Systems of Care	21	29%
Relapse Prevention	21	81%
Other Support Groups (AA, NA)	21	57%
Traditional Medicine	21	19%
Other	21	14%

7.4 Referral sources

All providers reported they received at least some clients through self-referral. The next most frequently reported source of referrals was the Problem Gambling Helpline, reported by 76% of providers. Fewer than half of providers (43%) received referrals to provide Court-mandated treatment. Notably, the Evergreen Council on Problem Gambling participated in a well-received pilot program offered from 2012-2016, embedded in Pierce County drug court, wherein individuals who were identified as having a gambling disorder could opt into a Therapeutic Justice court for problem gambling. However, this program was suspended due to loss of the gambling counselor affiliated with the program. This demonstrates a continued need to increase the pool of well-trained Certified Gambling Counselors throughout Washington State, to allow a sufficient workforce to serve in this capacity in Therapeutic Justice courts.

Table 14: Share of respondents who receive referrals from various sources

	Responses	Share reported 'yes'
Court-mandated Treatment	21	43%
Problem Gambling Helpline	21	76%
Patient assigned to provider by clinic or clinic manager	21	29%
Self-referral	21	100%
Other	21	24%

7.5 Co-morbid disorders

The vast majority of providers are treating patients with comorbid disorders in addition to gambling, including both mental health (95%) and alcohol (80%) and substance use disorders (83%). This is consistent with the literature demonstrating high levels of mental health and substance use comorbidity among individuals with Gambling Disorder [85] and continued need for programs and services addressing these comorbid conditions.

Table 15: Share of respondents that treat other disorders with gambling disorder patients

	Responses	Share reported 'yes'
Alcohol Abuse	20	80%
Mental Health	20	95%
Substance Abuse (Not-alcohol)	18	83%
Other	6	67%

7.6 Treatment counts

The modal response for number of clients served annually per provider was between 1-10 clients (37%), although the range of responses on this item was highly positively skewed with one provider serving between 201-300 clients annually. Providers were asked if they had capacity to serve more patients with gambling problems than they currently served, and if so how many. In total, 79% of respondents stated they had the capacity to serve more patients for problem gambling. Based on responses of those who are at maximum capacity and those who estimated potential capacity, an estimated 1,150 clients could be treated annually by the 16 respondents to this question, or roughly 72 per treatment provider. No respondents reported a wait list for new clients seeking treatment.

Of note, while this survey demonstrates capacity to serve additional clients with Gambling Disorder in Washington State, most of the capacity is centered in Seattle and closely surrounding areas along the I-90 corridor. Even within these areas, capacity is limited for after-

hours treatment access; clients with limited resources, poor access to transportation, and/or limited daytime availability face barriers to accessing care. Availability of care in rural communities in Central, Eastern, or Southwest Washington is notably limited, and limitations also exist in Northwest Washington.

Table 16: Number of clients with gambling problems treated annually

Estimated clients treated	Count	Share of total
0	1	5%
1-10	7	37%
11-20	4	21%
21-30	3	16%
41-50	2	11%
71-80	1	5%
201-300	1	5%
Total	19	100%

Length of treatment also varied substantially across providers. Responses regarding typical treatment length ranged from two months to two years, with the median between 10 months and one year and the modal response being one to two years; the second most frequent response was 2 years. Previous evaluations of state-funded treatment as described in the prior *Levels of Care* report [86] indicated absence of clear criteria for treatment completion and lack of aftercare/maintenance care resources both influenced length of treatment, suggesting additional provider training and operational definitions of treatment completion as well as increased resources for aftercare may be important considerations for optimizing treatment services.

Table 17: Reported typical treatment length

Length of treatment	Count	Share of total
2 months	1	6%
3 months	2	11%
6 months	3	1%
8 months	1	6%
9 months	1	6%
10 months	1	6%

Length of treatment	Count	Share of total
1 year	2	11%
More than 1 year but less than 2 years	4	22%
2 years	3	17%
Total	18	100%

The median number of treatment sessions per client is 16-20 sessions, with nearly half (45%) of providers indicating they provide 21 or more sessions on average.

Table 18: Reported typical number of sessions per client

Number of sessions	Count	Share of total
1-5 sessions	1	5%
6-10 sessions	3	15%
11-15 sessions	4	20%
16-20 sessions	3	15%
21 or more sessions	9	45%
Total	20	100%

7.7 Alternate treatment modalities

The majority (67%) of respondents reported providing weekly treatment sessions. This is somewhat at odds with the reported modal treatment duration (approximately one year) and number of sessions (16-20) overall reported previously, and suggests client compliance with weekly sessions may be relatively lower than provider recommendations. This suggests strategies to increase treatment attendance and/or provide alternatives to in-person attendance, such as telehealth, could improve efficiency and reduce length of treatment.

Table 19: Reported typical frequency of visit

Frequency	Count	Share of total
Daily	1	5%
Weekly	14	67%
Twice a week	1	5%
Every other week	4	19%
Other	1	5%
Total	21	100%

Providers report using a variety of technologies to enhance treatment engagement, though endorsement of any particular technology is low, ranging from 5% who utilize smart-phone apps to 29% who utilize email. Only 10% utilize telehealth strategies, a promising method with the potential to overcome barriers of distance, time, and transportation particularly in rural areas of the state. As the availability and utility of technology-based intervention and outreach strategies continues to expand, consideration of best practices for incorporating technology into existing services to increase reach and effectiveness of treatment services is warranted.

Table 20: Reported technology used in treating clients with gambling problems

	Responses	Share reported 'yes'
Email	21	29%
Smart Phone Apps	21	5%
Telehealth (delivering therapy over the Internet: Skype, FaceTime, Zoom)	21	10%
Text messages	21	24%

Of the 14 respondents to a question regarding the Evergreen Council on Problem Gambling Inpatient Reimbursement Services, 86% reported using the service at least once when referring a patient to inpatient services. A total of 36 patients are estimated to have been referred to out-of-state inpatient programs in the past year by respondents.

7.8 Policy Views

Given the reported number of referrals to out-of-state residential treatment programs, it is perhaps not surprising that treatment provider respondents in the current survey strongly supported the need for a residential or inpatient program in Washington State to support their clients. At the present time, one residential program is pending contract with Evergreen Council on Problem Gambling, and is expected to meet criteria for a contract within the next year.

There was also strong support for the effectiveness of the Problem Gambling State Contract Reimbursement Program and the Evergreen Council on Problem Gambling reimbursement contracts.

Providers view these as valuable resources to help pay for treatment to address the needs of a client population that is often without financial resources and coping with multiple barriers to treatment.

Providers were in agreement that Washington State should expand its services for problem gamblers, and disagreed strongly with the adequacy of current funding for problem gambling prevention and treatment programs in Washington State. Furthermore, treatment providers were given space to write in their own suggestions to four open-ended question about policy related issues including: “1) *For providers, what barriers exist in the access to treatment for problem gamblers that the Washington State Legislature should know about?* 2) *For patients, what barriers exist in the access to treatment for problem gamblers that the Washington State Legislature should know about?* 3) *You indicated that the state should expand its services for problem gamblers. Please provide the services you think the state should provide for problem gamblers;* and 4) *You indicated that the 0.13% tax on Class III games is not an adequate amount for funding problem gambling and prevention programs in Washington State. What do you think and adequate tax would be to fund problem gambling and prevention programs in Washington State?*” We have provided the each treatment providers’ response to these 4 questions as Appendix C.

According to Morotta and colleagues [87], Washington ranked 26th out of the 50 U.S. states in terms of per capita public funds invested in problem gambling services in their Survey of Problem Gambling Services in the United States Report. The average per capita allocation of public funds for problem gambling services in the 40 states with publicly funded services was 37 cents; while only 10 cents per capita public investment was expended in Washington State. This suggests that an increase in state investment to address problem gambling among Washington State citizens would be beneficial.

Table 21: Reported agreement with policy issues (0=strongly disagree; 6=strongly agree)

Statement	Responses	Average	Min	Max
Washington State should have an in-state residential or inpatient facility to treat problem gamblers.	20	5.6	3	6

Statement	Responses	Average	Min	Max
The Problem Gambling State Contract Reimbursement Program is an effective program that helps problem gamblers receive free treatment.	20	5.1	3	6
The Evergreen Council on Problem Gambling is an effective organization that helps problem gamblers and their families by supporting outpatient and inpatient problem gambling treatment.	20	5.25	2	6
Washington State should expand its services for problem gamblers.	20	5.6	3	6
Washington State currently funds problem gambling programs by taxing 0.13% on Class III games. This amount is adequate for funding problem gambling and prevention programs in Washington State.	20	0.95	0	3

8 Description of Problem Gambling Services in Washington State

In addition to information gained from literature review and the Treatment Provider Survey, the current report also integrates information provided by state and non-profit organizations serving individuals with gambling problems in the state. These included the state’s Problem Gambling Manager as well as the Evergreen Council on Problem Gambling.

8.1 Problem Gambling Manager

Washington State’s Problem Gambling Program (WAPGP) was created to address the prevention and treatment of problem and pathological gambling and training of professionals in the identification and treatment of problem gambling. In addition, the Program is responsible to track program participation and client outcomes. WAPGP was previously housed within the Division of Behavioral Health and Recovery (DBHR) and was recently moved to be under the Washington State Health Care Authority (HCA) in 2019.

Currently, WAPGP is tracking program client participation as part of the approval process for invoices submitted by contracted problem gambling outpatient treatment providers/organizations. The Program Manager also conducts site visits with contracted

providers to perform contract monitoring at least once every two years (during the contracted period). In addition, WAPGP also contracts with the Evergreen Council on Problem Gambling for problem gambling provider training and certification, as well as prevention and outreach activities.

8.2 Tribal Problem Gambling Services

There are 29 federally recognized tribes in Washington State and all 29 of those have Class III gaming compacts. Tribes are recognized by the Federal Government and State as self-governing nations. The Indian Gaming Regulatory Act (IGRA) establishes three separate classifications of Indian Gaming:

- Class I – is social gaming, such as traditional Indian games played as part of tribal ceremonies and celebrations. Tribes have exclusive authority to regulated Class I gaming.
- Class II – is bingo, pull tabs and other similar games, including non-house banked card games not prohibited by state law. Class II is regulated by the tribe and monitored by the NIGC
- Class III – all forms of gaming that are not included under Class I or Class II; Class III games are legal only if they are authorized by both the tribe and the state. The games must be conducted in accordance with a tribal- state compact.

Twenty-one tribes operate 28 Class III casinos under compact (21 tribes in Washington state operate at least one Class III gaming facility; three additional tribes operate only Class II facilities. In 2007, the tribes and the state negotiated that 0.13% of Class III net receipts be paid to government or non- profit/charitable organizations in Washington for education, awareness, and treatment. Each of the tribes is a sovereign nation and each tribe may have its own tribal health program, which may include treating problem gamblers. Some tribes provide services to only tribal members and other tribes offer health services to non-tribal community members. Currently, there are 7 Washington

State Certified and Nationally Certified Counselors working within tribal behavioral health programs to treat problem gambling.

Tribal problem gambling services vary by tribe. Some programs are fully developed, providing mostly outpatient services. Some tribal health programs without current capacity to directly treat problem gamblers will provide referrals to other tribal problem gambling programs or non-tribal community treatment programs. Several of the tribes will cover the costs of treatment for both outpatient and inpatient services.

Several tribes have provided considerable contributions and compact distributions for problem gambling services to the ECPG for supporting their work on the issue of problem gambling. Tribal Health and Wellness programs have also contracted with ECPG for specific programs specific to their tribes and have a long tradition of partnering with ECPG to address the issue of problem gambling both within the tribal membership and to serve the broader communities surrounding tribal lands.

8.3 The Evergreen Council on Problem Gambling (ECPG)

The Evergreen Council on Problem Gambling is a 501(c)(3) not-for-profit organization committed to providing services and programs for problem gamblers, their families, employers, students, treatment professionals, and the greater community through gambling addiction treatment support, information and education, advocacy, research, and prevention efforts. Founded in 1991, ECPG maintains a position of neutrality on gambling, recognizing that most people who gamble do so for recreation and suffer no serious problems. However, for some, gambling becomes a serious addiction, devastating to the individual and families. ECPG administers several of the state gambling services including but not limited to:

- ECPG provides Washington State's 1-800-547-6133 Helpline service, helping callers throughout the region connect with available gambling treatment programs.

- ECPG administers a regional training program for counselors interested in providing problem gamblers and their loved ones with outpatient treatment services.
- ECPG supports outpatient treatment and inpatient treatment for problem gamblers (Washington State residents) in extreme crisis.
- ECPG conducts public awareness presentations for a variety of groups, including businesses, social service organizations, senior citizens groups, financial organizations, colleges and universities, and many others.
- ECPG works with the gambling and casino industry to promote Responsible Gaming Programs and offers a Gaming Industry Responsible Gaming Certification program in Washington State.
- ECPG coordinates a Youth Program to improve gambling awareness among teenagers and young adults.
- ECPG works collaboratively with research groups to generate reliable data on compulsive gambling in our service area.
- ECPG functions as a central point of contact for current and emerging information on gambling addiction.
- ECPG is an affiliate of the National Council on Problem Gambling (NCPG). Its representatives have served on the NCPG Board of Directors, the Affiliates Committee, and many other NCPG bodies.

8.3.1 ECPG Prevention Programs

Universal Prevention. Universal prevention is aimed at increasing awareness of the issue of problem gambling and preventing the onset of Gambling Disorder in the general population. Within Washington State ECPG is the primary provider of universal prevention programs. In

conjunction with the National Council on Problem Gambling, ECPG spearheads Problem Gambling Awareness Month which takes place every March. In 2018, ECPG organized several events, provided media toolkits, organized problem gambling screening within health centers, aided in encouraging Governor Jay Inslee to issue a proclamation declaring March as Problem Gambling Awareness Month, and provided more than 16 presentations or attended events specifically on the issue of problem gambling awareness.

Selective Prevention. Selective prevention programs focus on providing prevention services to groups at potential increased risk for developing gambling problems, such as youth and young adults. ECPG supports an annual Peer to Peer program, which is a youth prevention program where high school students create a media campaign, from radio spots to videos, posters and slogans, social media and a logo, that is then promoted through area local media outlets via radio, online, and on billboards. The campaign focuses on problem gambling and gambling among youth. Over the years the Peer to Peer program has worked with both tribal and non-tribal high schools to address the issue of problem gambling among teens and adults.

8.3.2 Gambling Helpline (800.547.6133)

The State Gambling Program has a contract with the Evergreen Council on Problem Gambling to maintain the Gambling Problem Helpline. This hotline is maintained 24/7 and has the ability to respond to callers via phone calls, text, or online chat. The service functions as the main connection for problem gamblers or their loved one seeking services. The hotline number is advertised on commercial media during Problem Gambling Awareness Month and is provided on literature available at casinos, cardrooms, lottery venues, and the Washington Horse Racing Commission website.

Based on data provided by EPCG, there were 5778 calls to the helpline in 2017. However, many calls were not completed due to the caller hanging up (964), or the caller requesting information about gambling other than gambling treatment resources (3655). These latter category of calls suggests lack of understanding of the purpose of the hotline. A total of 75 contacts requested and received information about treatment resources via text or chat, and 408 telephone treatment intakes were completed via the helpline. Of callers completing a telephone intake, 24% were from King County, demonstrating the majority of those seeking services were from outside the geographic area with the highest access to certified gambling treatment providers. Most (74%) indicated they were experiencing financial problems related to their gambling, 20% indicated family problems, and 18% reported marital problems related to their gambling prompted them to call. Just over half of participants (51%) reported they were employed. The helpline was primarily accessed by adults and older adults, with no callers reporting they were under the age of 18 and only 3% of those completing an intake reporting age between 18-24 years. Taken together, the high number of calls for information other than treatment or prevention resources and the low utilization of the helpline by youth and young adults suggests a need for greater marketing of the helpline, especially to at-risk populations including youth, young adults, older adults, and individuals in gambling venues, as well as a need to increase public awareness of problem gambling as a disorder and the availability of prevention and free treatment resources within the state.

8.3.3 ECPG Support for Treatment Programs

Outpatient Treatment Services. All Washington residents and their family members are eligible for problem gambling treatment services. Citizens of Washington may access treatment by calling the Evergreen Council Problem Gambling Help Line, open 24/7, at 1-800-547-6133. If

they have funds or insurance that will cover treatment, help line staff will refer callers to a private, experienced counselor. If the individual does not have funds or insurance, they may qualify for Washington State-funded treatment, and hotline staff will refer to treatment providers who offer state funded treatment, as well as tribally-funded services when appropriate. Providers may also be contracted with ECPG, which is the payer of last resort for outpatient services not otherwise covered by private, State, or tribal resources.

Inpatient Treatment Services. Currently there is no Inpatient Gambling Treatment Program in Washington State (though one is in process of negotiating a contract with ECPG), nor does the Washington State Gambling Treatment Reimbursement Program cover the costs of Inpatient/Residential Treatment out of state. ECPG does offer financial assistance to those needing residential treatment from an out-of-state provider.

The procedure for referring a client to residential treatment is as follows:

- The client must be assessed by a state or nationally certified treatment provider.
- The client must be in outpatient treatment with the certified treatment provider for at least three months before being referred to residential treatment
- The treatment provider contacts ECPG for a referral and sends the filled out/signed forms to us (fax or email)
- ECPG collects information about the client for placement at the appropriate facility
- If the client meets financial eligibility requirements, ECPG contacts the residential facility for bed availability. A couple of things about the financial eligibility form: annual income for all members of the household must be included, and in the debt column, only include amounts for annual payments on debt, not the total amount owed.
- Residential facility will contact the client/treatment provider for intake information

8.3.4 ECPG Training Programs

Provider Training. Washington State Problem Gambling Program provides contract funding to ECPG for the required training to certify gambling treatment providers. The majority of problem gambling specific training is organized and delivered by the Evergreen Council on Problem Gambling via 2 major conferences annually (Focus on the Future and Four Directions), in addition to quarterly trainings, through various locations across the state, to enable providers to meet and maintain problem gambling certification training requirements.

Responsible Gambling Training for Industry. ECPG has initiated Responsible Gambling Training for Industry with a launch RG STAR an online employee training, focused on frontline employees and is currently developing a Supervisor/Manager Training program for casino managers and back of the house employees. The ECPG's RG STAR Training incorporates many of the recommendations made in the first chapter of this report and is designed to increase employee confidence in identifying and helping industry guest who may have a gambling problem.

8.4 Recovery Programs

Recovery Coaches. An emerging area within the recovery movement is the development of Recovery Coaches and Recovery Cafes. Recovery Coaches are individuals who receive specialty training to “coach” individuals as an aftercare program helping problem gamblers deal with issues related to family, job, and social responsibilities. Recovery coaching is designed to help people learn the skills and to do the work that helps them get free from gambling. ECPG has begun to offer Recovery Coach Certification Training designed to increase the recovery services available for people who have completed treatment but continue to need services to rebuild a healthy life.

Recovery Cafes. Recovery Cafes are programs not specifically focused on problem gambling per se, but designed to help individuals suffering from addictions maintain a life free from relapse to addiction. Recovery Cafes focus on services to stabilize the individual with a focus on mental health, relationships, housing and employment issues. There are a number of Recovery Cafes being implemented in Washington State. These cafes serve problem gamblers and provide education and services to problems gambling achieve and maintain recovery.

Community Self-Help. The most widely used recovery program is Gambler's Anonymous (GA). GA is a self-help recovery program founded in 1957. The most recent review of GA meetings in Washington State found there were 63 per week in various parts of the state. The meetings are free, and the only requirement to attend meetings is the desire to quit gambling [88]. Research has shown that GA can be an effective form of treatment from problem gambling for those who attend, however only about 1 out 3 attendees commit to regular meetings and one study found that only 8% achieved abstinence at one-year follow-up [89, 90]. Research also suggest that the combination of cognitive behavioral therapy + GA was found to be an effective form of treatment for problem gamblers [91]. The current Treatment Providers Study found GA was the 2nd most reported service offered to clients, with CBT being the most frequently provided service, consistent with this literature.

9 Discussion and Recommendations

In addition to the recommendations identified in the original *Levels of Care* report [96], the current study has indicated several recommendations which may enhance services for individuals affected by gambling problems in Washington State. These recommendations are reviewed below.

9.1 Outreach and Marketing of Helpline and Availability of Treatment

Findings from the current evaluation suggest it would be valuable to direct additional resources toward marketing, advertising, and promoting the Problem Gambling Helpline and the availability of free treatment for gambling problems. ECPG indicates annual advertising expenditures of between \$25,000 and \$50,000. Most of the advertising budget is expended during the month of March to promote Problem Gambling Awareness Month. Gambling Helpline data support a connection between advertising and calls for help during the month of March over the past several years, with similar increases associated with advertising expenditures prior to the winter holidays.

Based on a prevalence rate of 2.1% of adults with problem or pathological gambling, Williams and colleagues [92] estimated 118, 612 Washington State adults in 2016 could benefit from services for gambling. This is likely an underestimate of actual need, as it is based on prevalence estimates from the late 1990s, prior to the growth of legalized gambling over the past 2 decades. Given the lack of recent prevalence studies of disordered gambling, the exact prevalence rate within Washington State is difficult to determine. Previous adult prevalence studies in the mid 1990s suggested that rates of disordered gambling in Washington State were found to be similar to national levels, between 1-2% [93]. Based on the most recent data in the research literature, the 2003 Washington State Needs Assessment Household Survey (WANAHS; Washington State Department of Social and Health Services, 2005) estimated, based on the National Opinion Research Center DSM Screen for gambling problems [95], that 2.7% of Washington adults could be classified as at-risk gamblers, 0.7% as problem gamblers, and 0.5% as probable pathological gamblers (i.e., those with diagnosable gambling disorder), for a rate of disordered gambling of 3.9%, nearly double the rate estimated by Williams and colleagues

[92]. Rates of gambling problems among adolescents in Washington State were last assessed in the mid-1990s, at which time it was estimated that 10% experienced problems related to their gambling of whom approximately 9% were deemed to be at-risk gamblers and 1% considered to be probable pathological gamblers [96]. The WANAHS survey did not address the issue of prevalence of disordered gambling among adolescents. Washington State currently lacks any ongoing systematic program to assess or track the prevalence of problem gambling among any of its citizens, either adolescent or adult.

Importantly, research suggests the majority of individuals who need and would benefit from treatment for Disordered Gambling never seek services [97-103], in part due to lack of problem recognition and in part due to not knowing where to access treatment, inability to pay for services, and other barriers. Increasing marketing and outreach through media advertising as well as through increased prominence of gambling prevention and treatment materials onsite at gambling venues would increase awareness of Gambling Disorder symptoms, enhance the ability to reach individuals in need of but not yet seeking services, and address several barriers to treatment entry for this population. Given that self-referral and the ECPG hotline are major sources of referral for gambling treatment providers in the state, improving outreach and marketing is an important avenue for improving well-being of individuals with Gambling Disorder and their friends, family members, and others affected by the disorder.

9.2 Tele-health/Internet Therapy to Increase Access

The current report identified gaps in availability of treatment providers located outside the I-90 corridor, particularly in rural areas of Central, Eastern, and Southwestern Washington. One potential solution to expand treatment services would be use of telehealth or internet-based therapy for problem gambling [104-106]. A recent review of the existing literature found support

for internet-based therapy for problem gambling [107]. Implementation and evaluation of a pilot program to provide funds for training providers in telehealth and internet-based therapy, helping incentivize building tele-health infrastructure, advertising telehealth services, and facilitating reimbursement to providers billing for tele-health services is recommended.

9.3 Workforce Expansion

As identified in the report, in addition to considering alternative treatment implementation strategies such as Internet/Tele-Health, there continues to be a need to expand the pool of Certified Gambling Counselors as well as Supervisors, to expand the treatment workforce. This is particularly true in rural areas of Washington, but also relevant for more populous regions given the potential to expand services to Therapeutic Justice settings or other non-traditional therapeutic settings. Consideration of increases in reimbursement rates for problem gambling treatment and/or reductions in barriers to becoming certified, without reducing the rigorous training that produces highly skilled counselors in this area, is an important topic in order to address workforce shortages.

9.4 Creation of a Gambling Taskforce

The original creation of the Washington State Problem Gambling Program (WSPGP) is directly due to the advocacy of gambling treatment providers and gamblers in recovery, supported through an active and robust Problem Gambling Taskforce formed by the Washington State Legislature. The original Taskforce completed their work in 2005. Given the need to further enhance outreach, prevention, and treatment services as well as responsible gaming programs in Washington State, the establishment of a new legislative Problem Gambling Taskforce is recommended. We believe the Taskforce should be comprised of key stakeholders currently involved in providing problem gambling services including but not limited to: The Governor's

Office, The Gambling Commission, Washington State's Problem Gambling Program's Program Manager, The Evergreen Council on Problem Gambling, Washington Indian Gaming Association, The Recreational Gaming Association, representative from each of the state's gambling offices (horse racing, lottery, etc.), recovery services, problem gambling treatment providers (tribal and non-tribal), and other healthcare officials. The Taskforce could help identify problem gambling service priorities, develop goals, and guide the improvements need to lead to meaningful impact to help problem gamblers, their families, and communities. This recommendation is consistent with the recommendation reached in the previous section of this report regarding Responsible Gambling Programs, which presents similarly complex decision-making considerations.

9.5 Funding for sustained research initiatives

As noted elsewhere in this report, Washington State does not have any current or ongoing systems in place to track prevalence of problem gambling nor evaluate intervention outcomes, nor has it conducted any state-wide prevalence studies on the issue of problem gambling in almost two decades. The latest state-wide assessment of disordered gambling was completed in 2003, and the rates found were higher than the rates from the 1990s (approximately 4% compared to the 1-2% found in the 1990s). Accurate prevalence estimates could help determine the best use of allocated funds. However, prevalence studies are expensive and time-intensive, and the current data suggest improvements are needed now to better serve problem gamblers and their families. A task force, as recommended above, could help determine the best methods for estimating unmet need and reaching those in need while continuing to provide the best services possible to those seeking treatment.

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Appendix A: Survey Response Rates

Gaming Operator Survey

Launch date 11/7/2018

Tribal Launch Date 11/16/2018

	Total	Casinos	Non-casinos	Tribal
Invited	1954	171	1758	25
Completed	114=7.4%	11=6.4%	102=5.8%	1=4%
Declines	62	3	59	0
Partials	218			

Partials Breakdown

- i. 0% (opened survey but answered zero questions) = 101
- ii. 3%-99% = 117
- iii. 54%-99% = 20

Email reminders

- i. Casinos and Non-casinos
 - a. Reminder 1: 11/15/2018
 - b. Reminder 2: 11/27/2018
 - c. Reminder 3: 12/4/2018
 - 607 bounce backs
 - Re-Authentication required
- ii. Tribal Casinos
 - a. Reminder 1: 11/27/2018
 - b. Reminder 2: 12/4/2018

Appendix B: Treatment Providers' Open-Ended Responses

<p><u>For providers</u>, what barriers exist in the access to treatment for problem gamblers that the Washington State Legislature should know about?</p>	<p><u>For patients</u>, what barriers exist in the access to treatment for problem gamblers that the Washington State Legislature should know about?</p>
<p>More counselors are needed in order to better make the issue known and services available. In order to get more counselors, we need more available supervisors. In my opinion, a master's degree should not be needed to be an approved supervisor.</p>	<p>The need for services are often not identified by providers.</p>
<p>Biggest barrier is education. Clients do not KNOW that gambling is an actual disorder. Or once they realize they have a problem, they do not know where to go for help. Also, Medicare provides little coverage of services, such as medical, medical supplies, or dental care, that a patient may need to focus on meeting first, before they feel they are able to be present and benefit from treatment services.</p>	<p>Complicating factors such as medical conditions, mental health conditions, obtaining medical equipment. For example: I have a patient with Medicare who is diabetic and was doing well on an insulin pump. Then she could no longer get coverage for the pump. She switched to "the old fashion way", but could not get new supplies (such as test strips) from the supply company, because they thought she still had the insulin pump. Ability to afford transportation to treatment is an issue. All their money has gone to gambling.</p>

	<p>If they live outside of public transportation zones, they struggle to afford gas to get to treatment. In my tri-county service area, there are only two providers offering treatment services, we are both in the same city.</p>
<p>The system seems to work pretty well. I would like to be paid more to compensate for a large amount for paperwork time required. One paperwork requirement seems wrong: monthly treatment plan review is too frequent and actually interferes with the flow of counseling. Every three months would be more appropriate.</p>	<p>No response</p>
<p>The requirements for certification and to become a clinical supervisor are ludicrous. They need to match the requirements for CDPs in WA. We will never have enough providers until that is addressed.</p>	<p>Not enough treatment providers.</p>
<p>The supervision requirement to become certified is too difficult as there are very few supervisors and they are expensive- there is little incentive for providers to get this certification if they have to pay out of</p>	<p>There are not enough providers for the reasons listed above and so there are few places to seek treatment. There is no affordable inpatient and the evergreen reimbursement, though good, requires several</p>

<p>pocket because the services do not pay, often and gamblers often cannot afford it. For mental health counselors (myself) getting certified, especially at a level 2, should not require the amount of supervision. I would gladly sign up to be a supervisor (and I have the skills) but am not willing to travel or pay for another round of supervision as I have years and years in practice and it would not be worth my money or time.</p>	<p>months of outpatient beforehand, that can be a barrier for folks.</p>
<p>Too much red tape. It is difficult to reach people in rural areas. Need to be able to do off sight groups and 1x1 without needing to start a whole new agency.</p>	<p>Not enough advertisement. Most patients are surprised to find out that we exist.</p>
<p>Sometimes it is hard to get the checks in a timely manner.</p>	<p>Having enough Gambling counselors</p>
<p>Getting the word out that the help is available is the strongest gap that I have had to bridge. People just do not know that services are available beyond 12 step self-help programs.</p>	<p>The greatest barrier that I see in my practice is the patient's own pride. It is difficult to surrender and to admit that you have been defeated by gambling.</p>
<p>Screening with the SOGS by other behavioral health counselors isn't working.</p>	<p>Not knowing that free services exist.</p>

<p>Most counselors for SUD or mental health don't prioritize it.</p>	
<p>Few licensed and/or certified providers in rural areas</p>	<p>No response</p>
<p>None that are problematic over apply to everyone</p>	<p>No response</p>
<p>Need more support for traveling expenses, especially when provider is located in remote area. Need to pay for books, gas, hotel, ferry and food. Getting assigned credential supervisor was very difficult. I like to see more treatment training. Funding for Medicare patience. Not available for LMHC counselors.</p>	<p>Casinos don't have visible information around the casino. It is in small print. No Gamblers anonymous in the area. Funding for Medicare patients. Not available for LMHC counselors.</p>
<p>Limited reimbursement contracts and being an invisible program.</p>	<p>Transportation is a barrier, due to our location and limited transit access. Also just awareness of our program.</p>
<p>Low number of certified gambling counselors in this rural area, lack of time to work on problem gambling outreach strategies in order to engage more clients due to having an SUD caseload and productivity requirements. When I worked in Oregon they</p>	<p>Transportation in this rural area</p>

<p>reimbursed for time spent doing outreach which was very beneficial in building caseload numbers.</p>	
<p>There are no residential providers within Washington State. Our money goes to other states to treat our people who suffer with this issue. This is not for lack of providers being able to and having a desire to offer residential care for this.</p>	<p>Same as for providers, a full continuum of care needs to be available. People need to know that treatment is available, no matter how impacted they are from their gambling.</p>
<p>We are currently doing residential treatment for our client through insurance and private pay. We can also get funding help if they have substance use issues. We have not been able to contract with Evergreen Gambling Council and unfortunately have had to turn people away due to funding issues, even though we have done scholarships.</p>	<p>No response</p>
<p>It is hard to help a client with self banning. I'm telling the clients not to go to casinos but then it is the only way for clients to ban themselves.</p>	<p>There are limited individuals that provide treatment. I work 8:30 to 5:00 so if a client is in need of services in the evening time I am not able to provide the services.</p>

<p>Financial resources needed, funding for in-patient treatment, lack of education for loved ones.</p>	<p>Similar barriers for providers, including financial money management, how Casinos are contacting clients wishing no contact, easy access for self banning, etc.</p>
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<p>You indicated that the state should expand its services for problem gamblers. Please provide the services you think the state should provide for problem gamblers.</p>	<p>You indicated that the 0.13% tax on Class III games is not an adequate amount for funding problem gambling and prevention programs in Washington State. What do you think and adequate tax would be to fund problem gambling and prevention programs in Washington State?</p>
<p>IP treatment, more supervisors</p>	<p>No response</p>
<p>More counselors are needed and Evergreen needs employees in Eastern Washington to help coordinate more services throughout the state.</p>	<p>No response</p>
<p>Inpatient treatment. Funding to hire/train more certified Gambling counselors.</p>	<p>No response</p>

<p>There are virtually no problem gambling treatment providers west of Olympia in Grays Harbor and Pacific Counties.</p>	
<p>A full continuum of care.</p>	<p>0.25</p>
<p>Needs to be more incentive for providers. Gambling treatment is not covered by most insurance and typically when a gambler seeks treatment, they are in some kind of financial trouble and so they are not able to pay for counseling. I work for a tribe which is why we are able to offer it at no cost.</p>	<p>No response</p>
<p>Easier access, more advertisement</p>	<p>10</p>
<p>It would be nice to have in-patient treatment</p>	<p>No response</p>
<p>I feel that there should be a state wide self-exclusion system as well as a more effective help line number to call. Currently if you call the help line you are referred to GA rather than a qualified treatment provider that can be of more immediate support.</p>	
<p>Offer more money for awareness, prevention and navigating people into treatment. Western WA has evergreen but</p>	<p>0.2</p>

nothing is being done in Eastern Washington to help people get screened better and access care.	
Increase coverage in rural areas	0.2
State wide self-exclusion.	1.5
More funding for inpatient. Families and Individual counseling. Casino employees should also have more training and awareness to protect themselves from risk of being affected by GA.	0.25
Prevention and culturally responsive services.	No response
Add residential gambling treatment in Washington. Provide compensation for outreach into the community, education and increasing awareness of treatment services	
Residential care	0.3
In state residential treatment.	
There needs to be more outpatient agencies and we need to have an inpatient treatment center in Washington state. I have found it is a barrier for clients to get the inpatient they need because they have to pay	Don't know

<p>for airfare to get to inpatient treatment. We know that the states gives problem gamblers treatment because they have no money to pay for it.</p>	
<p>This needs discussion centered around financial support services and housing.</p>	<p>Don't know</p>

Appendix C: 2013 Levels of Care Report

WASHINGTON STATE PROBLEM AND PATHOLOGICAL GAMBLING TREATMENT PROGRAM:
LEVELS OF CARE, SERVICE GAPS AND RECOMMENDATIONS

Report to the

Evergreen Council on Problem Gambling

and the

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Division of Behavioral Health and Recovery

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Introduction

The purpose of this report is threefold. First, it reviews levels of care for gambling disorder and discusses criteria that may make an individual more or less appropriate for placement within a given level. Second, it presents a systematic review of current problem and pathological gambling prevention and treatment programs in Washington State. Third, it juxtaposes existing services within Washington State with the levels of care in order to recommend opportunities for growth and enhancement of gambling disorder services.

This report builds on an earlier report to the Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse (Larimer, Cronce, Neighbors, Miller & Hodge, 2009), which provided a narrative account of a preliminary program evaluation of the Washington State Gambling Treatment Program conducted in 2009. A total of 18 providers participated in that evaluation (Larimer et al., 2009), providing written and/or verbal interviews about their caseload, treatment approaches, assessment strategies, and strengths and weaknesses of the treatment program. Providers generally reported using clinical best-practices including cognitive-behavioral therapy and motivational interviewing. In contrast, relatively few providers were using specific treatment manuals to guide their interventions, and all reported considerable adaptation of interventions. Length and structure of treatment also varied considerably across agencies and clients, making it difficult to truly assess the content and process of treatment. Assessment of client progress was also a challenge, with little systematic tracking of client progress during or after treatment, and lack of clear information to guide treatment discharge decisions. Providers identified lack of outreach services to engage individuals earlier in the development of gambling problems, and the need for more guidance and structure regarding effective interventions and methods for tracking client progress as weaknesses of the program. Specific recommendations based on this evaluation included: (1) identifying and providing therapists with manuals and/or a core set of treatment components that should be addressed for effective gambling treatment, (2) implementing a systematic process for evaluating treatment outcomes and treatment satisfaction, and (3) increasing resources to support outreach to gamblers who have not yet identified as needing treatment.

While this prior evaluation captured the compass of outpatient options among providers contracted by the State, it did not include gambling treatment providers within the community who did *not* have a contract with the State. Moreover, this evaluation focused exclusively on delineating the nature of outpatient gambling treatment, with a minor focus on post-treatment referrals, without exploring what other services were needed. As part of the current evaluation, an exhaustive search was made for available gambling treatment options within Washington State. Some providers were identified through their contract with the Division of Behavioral Health and Recovery (DBHR); additional providers held contracts with the Evergreen Council on Problem Gambling (ECPG); the rest were identified via web searches for individual providers and treatment facilities who mentioned “gambling treatment” in any form as a service provided through their practice. This search yielded 34 unique providers/facilities (see Appendix A), all of which were contacted and asked to provide written and/or verbal interviews. Despite multiple phone and email contacts, and attempts to have providers attending the National Council on Problem Gambling’s 2013 national conference in Seattle, WA complete paper forms, feedback

from only 17 gambling treatment providers (50% response rate) was available at the time of this report. Provider feedback focused on the scope of existing services provided, general caseload and need (e.g., use of waitlists or referrals to other providers), use of evidence-based practices, use of aftercare programs (e.g., GA), planned expansion of services in the coming year, and perceived need for services within Washington State. Information regarding treatment services offered was taken from the websites of providers who could not be contacted (when such a website existed).

In order to understand the current state of gambling treatment within Washington State and formulate recommendations for future expansion of treatment services, it is important to first consider the historical and present context of gambling and problem gambling treatment within Washington State, the nature of gambling disorder, and the prevalence of the problem.

History of Gambling and Problem Gambling Treatment in Washington State

A history of gambling and problem gambling treatment in Washington State was prepared as part of the 2009 report to the Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse prepared by Larimer and colleagues. This history (from 1933 through 2008) is reprinted below and is updated to reflect more recent changes that have occurred within the past 5 years.

1933 - 2008

Although venues for gambling—ranging from bowling alleys selling pull tabs and corner markets selling lottery tickets to card rooms and tribal casinos—are now ubiquitous in Washington State, the history of legalized gambling in Washington is relatively nascent (see timeline developed by the Washington State Gambling Commission, 2009). Although gambling in the form of pari-mutuel betting on horse races was allowed under State law beginning in 1933, it wasn't until 1972 with the passage of Senate Joint Resolution No. 5 and Amendment 56 of the State Constitution that gambling in Washington State truly took hold. Amendment 56 to Section 24 of the State Constitution allowed for the existence of legalized lotteries provided that 60%-majority legislative approval on a proposed lottery was obtained. Legislation providing for social gambling activities (Chapter 218, Laws of 1973) came into effect less than a year later on July 16, 1973 (refer to Chapter 9.46 of the Revised Code of Washington [RCW] for more information; Washington State Legislature, 2009a). The first casino in Washington State was in operation from 1976 to 1978 on the Puyallup Reservation, at which point the federal government closed it. Legislation allowing for the State lottery was passed in 1982 (refer to Chapter 67.70 of the RCW for more information; Washington State Legislature, 2009b); however, it wasn't until 1984 that it came into operation as "Lotto." In the interim period (1983), the Tulalip, Puyallup and Muckleshoot tribes began operation of bingo gaming. Following passage of the Indian Gaming Regulatory Act by the U.S. Congress on October 17, 1988 (National Indian Gaming Commission, 2009), the Lummi Tribe opened the second casino in Washington in 1991. The Tulalip Tribe was the next to open a casino in 1992, followed by the Nooksack Tribe in 1993 and the Spokane, Colville, and Swinomish tribes in 1994. Six additional tribal casinos were opened in 1995, and gaming was expanded at existing facilities. In the five subsequent years, several more tribal casinos were opened and gaming opportunities as existing casinos were expanded

even further; although, these expansions, including slot and other electronic gambling machines, were often quickly shut down while law suits arguing their legitimacy were being adjudicated. In June 1998, an agreement was reached on a style of electronic gaming machine that would fit within State and federal laws. These Tribal Lottery System (TLS) machines (the specifications of which are detailed under *Appendix X* of the tribes' compact with the State of Washington) began appearing in tribal casinos soon after. Non-casino options were commensurately becoming more widely available; including off-track betting on horse races, pull tabs and punchboards, and additional State Lottery games, such as scratch tickets and *Mega Millions*. By 2006, tribes were nearing the maximum number of electronic gaming machines allowable under *Appendix X* of the original compact, prompting negotiation of a new compact agreement in 2007 (*Appendix X2*, also referred to as the *X2* compact) which included higher maximum limits both on number of machines and wagers (i.e., up to 15% of a tribe's TLS machines could accept \$20 wagers a 400% increase over the \$5 maximum stipulated in *Appendix X*).

Compared with the rapid and exponential expansion of gambling opportunities in Washington State over the last 30 years, local recognition of problems associated with gambling, inception of new agencies and retooling of existing agencies to monitor and address these problems, as well as creation and legislative support for funding of appropriate gambling treatment programs has lagged. The first meeting of Gambler's Anonymous (GA), the most widely available option for individuals seeking assistance to modify their gambling behavior, was convened in Los Angeles, California on September 13, 1957 (Gambler's Anonymous, 2009). It is unclear exactly when the first GA meeting was held in Washington State; however, the first meeting in Spokane took place as early as 1980 (Titone, 1989). In 1989, a total of eight Washington GA chapters were in existence (Titone, 1989). The Washington State Council on Problem Gambling (now known as the Evergreen State Council on Problem Gambling [ECPG]), a nonprofit organization whose mission is to promote public awareness of, research related to, and services for problem gambling, was established 2 years later in 1991. In 1992, the Washington State Lottery Commission tasked Dr. Rachel Volberg with conducting a statewide evaluation of gambling participation and problems among Washington adults; an additional study of Washington adolescents was conducted a year later in 1993. The results of these studies, as well as results from cross-sectional follow-up studies conducted 6 years later were published as separate reports in 1999. Results of both studies suggested relative stability of the rate of gambling problems despite decreased reporting of gambling participation and increased availability of gambling opportunities (Volberg & Moore, 1999a, 1999b). In 1998, the ECPG established a task force to assess and develop materials to increase gambling industry employee awareness of "compulsive" gambling; an awareness video produced by the taskforce in concert with industry representatives and State gambling regulatory agencies was released in March, 2000. This same year, in consultation with the ECPG, the Behavioral Health service of Deaconess Medical Center (DMC) in Spokane developed a problem gambling treatment program, which was partially funded by revenues from local gambling establishments. DMC's program was subsequently honored with the Distinguished Program Award from the National Council on Problem Gambling at its 15th annual conference in Seattle, WA.

Although DMC's program represented a leap forward in terms of the availability of formalized gambling treatment in Washington, it had limited impact due to its circumscribed catchment area. In 2002, the Division of Alcohol and Substance Abuse (DASA) under the Department of

Social Health Services (DSHS) enlisted the ECPG to develop a gambling treatment program targeting problem gamblers and their family members, provide the necessary training to 25 providers who would deliver the treatment, and pilot test the program (Evergreen Council on Problem Gambling, 2009). Although only 200 individuals were expected to enroll over the course of the 1-year program, 226 enrolled in the first 8 months and up to another 150 individuals were anticipated, far exceeding the pilot program's funding (Skolnik, 2004) and demonstrating a clear need for more gambling treatment resources to meet the needs of Washington residents. Despite the pilot program's limited scope, data collected post-treatment and 3 months following treatment indicated that receipt of the state-subsidized treatment was associated with sustained abstinence for more than 33% of those surveyed (Skolnik, 2004). Continuous funding, however, did not come until approximately 2 years later on July 1, 2005 when Engrossed Substitute House Bill 1031 (hereafter referred to as *Bill 1031*; Washington State Legislature, 2009c) was enacted into law, mandating allocation of funding generated from state gambling revenues (including the State Lottery and fees/taxes levied on gaming establishments) to establish and support a program administered by DASA [now DBHR] that could provide statewide education and treatment services for problem gambling, including a 24-hour helpline. Bill 1031 also mandated establishment of the Problem Gambling Advisory Committee, which comprises representatives from 14 agencies involved in the conduct of gambling activities or the provision of problem gambling related services, to guide prevention and intervention efforts supported by State funding. According to Bill 1031, all Washington residents are eligible for publicly-funded gambling treatment at minimal or no-cost provided that the following three criteria are met: (a) the person seeking services needs treatment for problem or pathological gambling or the person seeking services is a family member who is affected by problem or pathological gambling; (b) he or she is "unable to afford treatment;" and (c) he or she is "most amenable to treatment;" an individual's amenability to treatment is determined by representatives of the DSHS. From July 2005 through December of 2008, DASA-contracted providers supplied gambling treatment to 1079 clients.

Of note, a provision in the 2007 X2 tribal-state gaming compact was that each tribe agreeing to the compact would contribute 0.13% of their net win from Class III gaming to organizations that helped reduce problem gambling and an additional 0.13% of the net win from TLS machines would go to smoking cessation programs. The Spokane Tribe was the first to sign the new compact, and was soon followed by 26 additional tribes. Tribal governments retained discretion of where to direct their X2-stipulated prevention funds, and have supplemented their minimum contribution to varying degrees across fiscal years with generous voluntary donations to support gambling treatment services, frequently working in partnership with ECPG (as highlighted below).

2009 – Present

At the time of this report, 28 of the 29 federally-recognized Tribes in Washington State had a Class-III gaming compact with the State, with 21 of these Tribes operating 27 casinos; while each of these casinos were open prior to 2009, the Snoqualmie Tribe expanded their casino operations in 2010.

In terms of non-tribal gaming, in 2008, the Recreational Gaming Association (RGA) requested a number of changes to house-banked card rooms in Washington, most of which were enacted at the beginning of 2009. Specifically, card rooms saw expansion of hours of operation (from 20 hours/day 7 days/week, to 24 hours/day 5 days/week, with 2 days retaining existing hours), increased maximum number of players at gaming tables (from 7 to 9), increased maximum wagers (from \$200 to \$300 for certain games), and the addition of mini-baccarat. Texas Hold'em poker, which was popularized by the media, also saw significant changes during this time. Beginning in 2005, various petitions had been put forth attempting to increase the maximum wager limit from \$25 to \$100. One of these petitions was successful in increasing the wager to \$40 in 2007, and an 18-month pilot program was begun in October, 2010 to explore the impact of increasing the wager to the originally requested \$100 maximum. The outcome of this pilot, which ended May 2012, supported increasing the limit to \$100 per hand; this new maximum limit came into effect January 1, 2013. Legislative action also increased limits on raffle ticket prices. Engrossed House Bill 1053 was enacted into law in 2009, increasing the maximum price for which a raffle ticket could be sold from \$25 to \$100. Collectively, these increases are important to consider, insofar as they have the potential to simultaneously increase harm to individual gamblers, offering an avenue for higher betting for those with tolerance, and potentially facilitating faster losses (i.e., problem gamblers may exhaust available funds faster, which may lead them to seek other financial sources).

Other legislation passing since 2008 included Substitute Senate Bill 5040, which was enacted into law in 2009 and made gambling by minors (those under age 18) a civil infraction and empowered agents of the Gambling Commission to impose penalties, including fines and community restitution, on minors who were found gambling, except if these individuals were part of an establishment's in-house compliance program (i.e., to identify employees that were ineffective in preventing minors from gambling). The bill also stipulated that the winnings of minors who were found gambling would be forfeit. Engrossed Substitute Senate Bill 5921, enacted in 2011, mandated that gambling and gaming establishments must disable the ability of any ATM and point-of-sale machines on their premises to accept Electronic Benefit Transfer Cards (EBCs). Both of these bills, on their face, are forms of environmental prevention, limiting access to gambling by youth and placing a barrier to accessing funds for gambling that have been given to financially-disadvantaged individuals to purchase food and other necessities. The actual impact of these bills on prevention are yet undetermined. Also of note, an attempt was made through the legislature in 2009 and 2010 (via Senate Bill 6103, and companion bills Senate Bill 6152 and House Bill 2355) to change the definition of gambling outlined in RCW 9.46.0237. The hope of Senate Bill 6103 was to close potential loopholes in the definition of gambling that were made apparent by Seattle-based Betcha.com, a "social betting network" site, which allowed individuals to place online "honor-based" wagers, but did not enforce payment of losses (Jenkins, 2009). Each of these three bills failed to pass; however, the Washington State Supreme Court ultimately and unanimously found that Betcha.com engaged in professional gambling because it engaged in bookmaking, enforcing that the site be shut down.

Beyond the potentially beneficial legislative focus, the past 5 years has seen an expansion of gambling treatment services and prevention programs, most initiated and organized by the ECPG. In line with the recommendations from the Larimer et al. 2009 report, the ECPG instituted a number of outreach programs that have helped to identify individuals with problem

gambling in need of services. First and foremost, with the input of the Tulalip Tribal Council, the casino's CEO and employees, the ECPG developed a training and certification program in responsible gaming for casino employees. This program will help employees to identify problem gamblers and connect them with more information about available treatment services. The ECPG has also worked with major media outlets within the state to design public service announcements (PSAs) and awareness campaigns related to problem gambling, each of which include information about the treatment hotline. Themes from some recent PSAs have included underage and senior gambling awareness and sports betting. These PSAs have been developed in partnership individually or jointly with DBHR and the Washington State Gambling Commission (WSGC) and run on KOMO TV and Fisher Radio stations throughout Washington State, as well as on the web via YouTube.

In addition to prevention, the ECPG continues to support outpatient treatment services, funding providers for gambling treatment services who have exhausted funds available to them via contracts with DBHR. As this only serves to maintain existing providers, most of which are located within major metropolitan areas such as Seattle (see list of providers in Appendix A), the ECPG provides training in evidence-based treatment practices (with continuing education credit) and maintains a state-level problem-gambling treatment certification program to encourage expansion of outpatient treatment services. As no residential treatment facility specifically addressing problem gambling exists in Washington State, the ECPG also initiated financial support for out-of-state residential treatment services in 2009. Since its inception, 51 clients have been referred for residential treatment via the ECPG's program (approximately 15 per year). However, this process often removes clients from existing social support networks that could be used to aid their recovery; thus, this treatment gap represents a concern. Within the State, the ECPG, with support from the Puyallup Tribe and Department of Justice, in collaboration with the Lakewood Police Department, has also worked to implement a therapeutic justice (diversion) program for problem gamblers within the Pierce County Superior Court drug court. Currently in the pilot phase, this program has the potential to reduce burden on the criminal justice system, both by reducing the number of individuals who would otherwise be incarcerated and by treating a major underlying cause of financially-motivated crimes, thus hopefully reducing recidivism. If successful, the ECPG hopes to expand this program to other counties.

Definition of Gambling Disorder

Formerly referred to as Pathological Gambling (DSM-IV, APA, 2000), *Gambling Disorder* is defined in the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V, APA, 2013) as a disorder characterized by "persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress." The diagnosis of Gambling Disorder is given when an individual meets at least 4 of 9 (vs. 5 of 10, as in DSM-IV) diagnostic criteria, including preoccupation with gambling, needing to gamble with increasing amounts of money, repeated unsuccessful efforts to cut down or stop gambling, restlessness or irritability when stopping gambling, gambling as a way to escape problems, chasing losses, lying about gambling, jeopardizing a significant relationship, job, or career activity due to gambling, and relying on others to provide money to relieve financial stress caused by gambling. The criterion of "committing illegal acts to finance gambling" was dropped from the DSM-V.

In addition to DSM-V diagnosed gambling disorder, most clinicians and researchers also recognize the existence of sub-threshold gambling problems, typically referred to as "problem"

or “at-risk” gambling. These terms refer to individuals who experience some consequences or symptoms of gambling disorder but fail to meet full diagnostic criteria. Sub-threshold problem gambling and diagnosable gambling disorder are often combined under the general rubric of *disordered gambling* (Korn & Shaffer, 1999).

Prevalence of Disordered Gambling in Washington State

As reported previously (Larimer et al., 2009), disordered gambling affects 2-5% of the general adult U.S. population, depending on the method of assessment used to diagnose the disorder (Gerstein et al. 1999; Welte et al. 2001; Petry, Stinson, & Grant, 2005; Shaffer & Hall, 2001; Volberg, 2002). Nationally, rates of disordered gambling have been found to be higher among adolescents and young adults, seniors, men, and certain ethnic minority populations including Asian and Native American/Alaskan Native populations.

Rates of disordered gambling in Washington State have been found to be similar to national levels. The 2003 Washington State Needs Assessment Household Survey (WANAHS; Washington State Department of Social and Health Services, 2005) found over half (54%) of adults over age 18 in our state have gambled in the past year, and lost an estimated 1.5 billion dollars gambling in 2002. This survey estimated, based on the National Opinion Research Center DSM Screen for gambling problems (NODS; Gerstein et al. 1999), that 2.7% of Washington adults could be classified as at-risk gamblers, 0.7% as problem gamblers, and 0.5% as probable pathological gamblers (i.e., those with diagnosable gambling disorder), for a rate of disordered gambling of 3.9% among adults. Native American/American Indian, African American, and multiracial adults reported the highest rates of disordered gambling. In contrast with national epidemiological rates, Asians in this survey had lower risk of gambling problems, though Native Hawaiian and Other Pacific Islander populations were at higher risk if they had incomes less than 200% of the poverty level. Disordered gamblers in this survey reported higher rates of binge drinking, tobacco use, and use of illicit drugs other than marijuana, and greater need for substance treatment, than those without gambling problems.

Among adults, individuals ages 18-25 and 26-44 reported the highest rates of disordered gambling at 1.4% and 1.3%, respectively (Washington State DSHS, 2003). However, rates of disordered gambling among youth were found to be as high as 8% in Washington State in an earlier survey (Volberg & Moore, 1999b). Thus, based on both national and local prevalence information, disordered gambling represents a significant public health problem in Washington.

The 2003 WANAHS survey provides the most recent state-specific prevalence rates of disordered gambling; however, in a survey conducted for the Washington State Gambling Commission (Stern, Mann, & Furgeson, 2012), 28% of people reported knowing someone with a “gambling problem” and 72% were somewhat or very concerned about underage gambling. This suggests disordered gambling is a public health concern for Washington residents.

Description of Levels of Care

The appropriate prevention or intervention approach to apply to a given individual should be selected based on presence/severity of disorder in a *stepped* fashion, starting with the lowest

level of care that is clinically appropriate (which may be the highest level of care) and moving up one level of care at a time until an appropriate treatment response is achieved. Sometimes clinical crises warrant a dramatic jump from a low level of care to a high level of care. There are no clear criteria when this type of significant leap is required, and this determination must be made using the best clinical judgment of the provider in consultation with his or her client and sometimes the client's family. In theory, this stepped care approach ensures that finite resources (e.g., hospital or residential facility beds; treatment provider time) are reserved for those most in need of those services and stretches treatment-cost dollars. While stepped care models for disordered gambling exist (e.g., the California Problem Gambling Treatment Services Program, Oregon's Problem Gambling Services program), no studies could be identified in the literature that directly test the assumption of cost effectiveness when treating this population; thus, this remains an open question.

Universal Prevention: For behaviors that pose a risk to the public health, some level of universal prevention is warranted. Approaches within this category are applied to the whole population and may involve basic education and awareness campaigns or PSAa, but may also involve legislative and community action. For example, increased (and consistent) enforcement of the minimum legal gambling age (MLGA) at gaming venues or commercial venues that distribute lottery and scratch tickets should serve to decrease underage gambling, which may alter the long-term trajectory of a youth's gambling behavior. Decreases in drinking have been shown when underage drinking laws are more consistently enforced (Holder et al., 2000), and decreases in alcohol-related crashes have been found when check-points are frequent and advertised (Elder et al., 2002), suggesting consistent and visible attempts to enforce the MLGA would work as well. A similar environmental approach used to decrease drinking has been server training. While this has produced mixed findings in the literature (Toomey, Lenk & Wagenaar, 2007), it has been shown to work under certain conditions. A program to train casino employees and lottery distributors to identify disordered gamblers and refer them for help may produce greater treatment engagement even if it does not necessarily decrease an individual's gambling behavior in and of itself; moreover, such training may facilitate self-awareness and treatment engagement for employees/distributors who are struggling with their own gambling behavior.

Selective Prevention: Certain groups may be at greater risk for development of disordered gambling than others by virtue of their genetics, their environment, or the combination of the two. Many such groups have been identified as being at elevated risk in terms of their gambling, and more intensive prevention approaches can be applied. For example, casino employees are at greater risk for developing gambling problems (Shaffer, Vander Bilt, & Hall, 1999); elevated rates of gambling problems are also evident among individuals who started gambling at a younger age (see Hardoon & Derevensky, 2002) or who have a family member with a gambling problem (e.g., Hardoon, Gupta, & Derevensky, 2004; Slutske et al., 2000). College athletes may be at elevated risk for gambling problems (e.g., Huang, Jacobs, Derevensky, Gupta, & Paskus, 2007) as are college students in general (Shaffer, Hall & Vander Bilt, 1999). Selective intervention may be as simple as self-assessment of gambling behavior or as intensive as a one-on-one brief motivational session (see Indicated Prevention below).

Screening and Brief Intervention (Indicated Prevention): For some individuals who are experiencing disordered gambling, completing a self-assessment with or without receiving a

brief intervention facilitated by a trained professional may be sufficient to promote behavior change (see Epstein et al., 2005 regarding *assessment reactivity's* effect on alcohol use). The self-assessment may be completed online or in person within the context of a routine primary care visit or mental health check-up. Self-assessment, in particular, self-monitoring (see Kazdin, 1974), of behavior has been shown to decrease problematic behaviors alone. If self-assessment/self-monitoring is not sufficient, the addition of brief advice may make a difference. The brief intervention can be as little as 10 minutes, in the form of brief advice (Petry, Weinstock, Ledgerwood, & Morasco, 2008) wrapped into a planned primary care or mental health encounter, or can be as long as 90 minutes, utilizing a personalized feedback form to guide discussion of personal gambling behaviors, social normative perceptions of gambling, beliefs about gambling, and consequences experienced because of gambling.

Brief interventions are often delivered using a *Motivational Interviewing* style (MI; Miller & Rollnick, 2002), which does not require training medical and/or mental health staff. Motivational enhancement therapy using MI has been associated with decreases in gambling at longitudinal follow-up (e.g., Hodgins, Currie, el-Guebaly, 2001; Petry et al., 2006). If brief advice does not produce behavior change or if self-assessment detects more severe disordered gambling, the provider may use this encounter to facilitate referral for a higher level of treatment (i.e., the SBIRT model).

Self-Help: Research shows that about one-third of individuals with disordered gambling naturally recover (Slutske, 2006), perhaps engaging in self-help methods of recovery, but never receiving formal treatment. For self-help to be effective, the individual must be motivated to change their gambling behavior. Sometimes individuals reach this decision alone, but a brief motivational intervention (as described above) can tip the decisional balance for those who are ambivalent about change. Often, this ambivalence is not resolved in the room with the provider, but brief motivational interventions can encourage contemplation of behavior and its relation to personal values and goals (e.g., how gambling impacts family relations, work performance, financial goals) that continues long after an encounter with a provider is concluded.

Gamblers Anonymous (GA) is the most well-known and prevalent form of self-help for disordered gambling. While individuals who are *referred to* GA do show reduction in gambling and increased abstinence over time (Petry et al., 2006), it is not clear if this is the direct effect of GA or other confounding factors, as it is not consistent with the model of GA to use a randomized controlled design. However, in a study by Petry and colleagues (2006) the number of GA meetings attended was positively associated with abstinence (odds ratio 1.20, 95% CI: 1.07–1.33). While this may be promising for those who attend, past studies of GA attendance (Stewart & Brown, 1988) have found high dropout rates (with 69.4% of individuals attending 10 or fewer meetings). Moreover, in the study by Petry and colleagues, the median number of groups attended by patients referred to GA was *zero*. People who drop out report a range of reasons including feeling cured, changes in external circumstances that prevent attendance, personality conflicts with other group members, not fitting into the abstinence or disease model and/or religious/spirituality bent of the model, not being able to identify with the gambling severity of other group members, dislike of how “slips” are handled, and being dissatisfied with group politics (Brown 1986, 1987). Brown concluded that GA may be *less* effective for *gamblers with less severe gambling problems*, and not well suited for handling “slips” or “lapses” when/if they occur. While theoretically true, there is not a specific scientific foundation for this recommendation. As of the time of this report, there were 68 GA meetings scheduled each week

across the State of Washington (see Appendix B). Many of these meetings are *open meetings*, meaning that family and friends of the individual who is seeking help with their gambling are able to attend. GA (or GAM-ANON) may be helpful for these individuals from a psychoeducational and social support perspective.

Additional self-help programs for disordered gambling include self-help books and self-paced printable therapy workbooks (e.g., Blaszczynski, 1998; Fong & Rosenthal, 2008; Hodgins, 2002; Ladouceur & Lachance, 2006; Toneatto, Kosky, & Leo, 2003), online self-help tool-kits (e.g., www.gamblingselfchange.org/), peer-connect programs that facilitate social networking between Gambling HelpLine callers and members of the recovering community (such as the one operated by the Florida Council on Compulsive Gambling), and self-hypnosis. The efficacy of these different approaches has not been fully explored, and for those approaches that have undergone greater evaluation (e.g., GA) there is limited information about potential moderators of treatment effect that would suggest for whom these approaches are most appropriate. At least one study has found the *Your First Step to Change: Gambling* online self-help toolkit to be superior to assessment only (Labrie et al., 2012), and at least two studies combining self-help cognitive-behavioral therapy workbooks/online toolkits with brief therapist contact have shown efficacy (Carlbring & Smit, 2008; Hodgins Currie, & el-Guebaly, 2001).

Of note, *self-exclusion* or *self-banning* from gambling establishments is sometimes considered a form of self-help; however, it is essentially a protective behavioral strategy (stimulus control; i.e., limiting exposure to gambling cues) and could be used at any level of care. Thus, it is not discussed in this report.

Likewise, although not a self-help program per se, the ***Washington State Problem Gambling Helpline*** (1-800-547-6133) maintained by the ECPG is often a gateway to information about problem gambling and a means of accessing higher levels of care; thus, in this light, the Helpline can be seen as a form of self-help. In the past 3 years, the helpline has served close to 3,000 people seeking help related to gambling problems (see Appendix C). Given the volume of calls received by the helpline, this resource could be used to conduct a screening and brief intervention (as discussed above) or play a larger role in treatment engagement (see recommendations below).

Outpatient Treatment: Individuals who do not respond to a brief intervention, or who present with greater severity of gambling disorder symptoms, are likely candidates for outpatient treatment. Outpatient treatment involves meeting with a treatment provider individually or with a group of other clients who are struggling with gambling on a weekly basis for a course of treatment. Generally speaking, individuals engaged in outpatient treatment meet with their provider once per week for 45-50 minutes, but may meet more or less frequently based on practical limitations (e.g., distance, transportation) or clinical need. While a number of approaches have been applied to the treatment of disordered gambling, the one with the most scientific evidence of efficacy is *Cognitive Behavioral Therapy* (CBT) and manuals exist to guide the provider in delivery of this treatment (e.g., Ladouceur, Sylvain, Boutin & Doucet, 2002; Petry, 2005; Raylu & Oei, 2010; Whelan, Steenbergh, & Meyers, 2007). As a rule, a course of CBT can be completed within 16-20 sessions and should be *time limited*. A booster session may be offered one to several months following the last session as a means of monitoring progress and troubleshooting lapses. CBT focuses on identifying and changing thoughts, feelings and behaviors (*the cognitive triad*) that are interfering with an individual's functioning across different domains (e.g., home, work). Identification of problematic thoughts, feelings and

behaviors is accomplished through in-session analysis of specific gambling events, as well as homework assignments that require the individual to monitor their thoughts, feelings and behaviors outside of session. These self-monitoring exercises can also be used to challenge thoughts that often prompt gambling behaviors. Gambling behavior is further changed through teaching coping and problem-solving skills, including relapse prevention skills, and addressing barriers to skills use. In addition to self-monitoring, at a minimum, treatment providers should use standardized measures to assess quantity and frequency of gambling as well as associated symptom severity and consequences at treatment intake; these measures should be repeated regularly during treatment to monitor behavior change as well as at the conclusion of treatment and a period of time (weeks to months) *after* termination. When selecting measures for clinical practice, it is important to consider the known psychometrics (i.e., reliability, validity) of each measure, as well as consider the feasibility of implementation. A number of brief self-report measures are freely available that can be used to measure gambling behavior and cognitions, each of which could be completed independently by the client in the waiting room before or after a therapy session.

Intensive Outpatient Program (IOP): Individuals who do not respond to outpatient treatment may need a more intensive treatment environment, such as an IOP. The scope of services provided within an IOP range substantially; however, they generally involve multiple group therapy sessions per week with or without additional individual therapy sessions for a circumscribed number of weeks. For example, the Problem Gambling Center in Las Vegas, NV offers a 6-week program consisting exclusively of group sessions plus one year of aftercare. By comparison, the IOP component of the Center of Recovery (CORE) in Shreveport, LA involves participation in group therapy activities 4 days per week, 3 hours per day, for a period of 6 months. These programs often utilize the same techniques applied in outpatient therapy, namely CBT, but complete more of the therapeutic work in session versus as homework. In addition, IOPs typically incorporate family/couples therapy as part of the overall program, which is often delivered separately in a typical outpatient setting. IOPs also serve the purpose of providing a gambling-incompatible activity (often scheduled during hours when the individual likely would have been gambling).

Partial Hospitalization Program (PHP): Individuals who do not respond to an IOP and/or are in the midst of an acute crisis are likely a candidate for a PHP, which reflects the next step up in care and an alternative to inpatient. PHPs straddle the line between outpatient and inpatient, requiring the individual to be in the treatment setting 20-30 hours per week, generally spread across 5-6 days each week. For example, the Pederson-Krag Center West in Huntington, NY offers a 6-week (maximum) PHP that meets 5 days per week for 6 hours, combining psychoeducation groups with individual therapy, family therapy, case management, and comorbid substance use treatment.

Inpatient and Residential Treatment: Individuals with extremely severe disordered gambling who are actively suicidal may be a candidate for inpatient and/or residential treatment. Inpatient treatment can be thought of as distinct from residential treatment, as it focuses on acute stabilization of clients in crisis, usually lasting a few days to 1 week. Some residential treatment facilities accept acutely suicidal clients whereas other will not accept patients who are acutely suicidal, requiring inpatient stabilization prior to residential treatment entry. Given the high rates

of suicidal ideation and attempts among individuals with gambling disorder, this is a primary concern. Residential treatment involves all of the aspects of a PHP, but is usually more time-limited (generally around 30 days). Both inpatient and residential treatment are fulltime for the duration of treatment, requiring the client to be housed onsite at the medical facility. For clients with comorbid substance use problems, detoxification may be needed prior to inpatient or residential treatment. The primary advantage of inpatient or residential treatment over a PHP is the ability to place the individual in a safe, controlled environment, where staff is available to provide support 24/7. The primary disadvantage of inpatient and residential treatment is that, for some individuals, it provides a means of “escape” from financial and other pressures that reinforces avoidance of facing their problems. If a client has comorbid Borderline Personality Disorder, hospitalization may simultaneously serve to reinforce suicidal behavior, by providing increased attention in response to suicidal comments and gestures. If a client is pushing for inpatient or residential treatment, the provider should thoroughly assess if this level of care is needed for safety, stability and long-term treatment gains, or if the client would be better served by confronting family, work and legal problems in a less intensive yet supportive environment (e.g., PHP or IOP) or referral to a Dialectical Behavior Therapy program for concurrent treatment of chronic suicidality.

Pharmacotherapy: No medication is currently approved by the Federal Drug Administration for the treatment of pathological gambling. Nonetheless, a variety of psychopharmacological agents, including antidepressants (chiefly, selective serotonin reuptake inhibitors [SSRIs]), atypical antipsychotics, atypical stimulants, mood stabilizers, opioid antagonists and glutamatergic agents have been evaluated as treatments for DSM-IV defined pathological gambling. The most stringent evaluations of these drugs have been double-blind placebo-controlled trials, wherein neither the research clinician nor the patient knows if they are receiving an active or placebo agent, thus controlling for both patient and clinician expectancies on treatment effect. A review of extant double-blind studies in the published literature (Grant, Odlaug, & Schreiber, in press) found the greatest support for opioid antagonists (naltrexone and nalmefene) with 100% of studies (n = 4) showing reductions in the intensity of urges to gamble, gambling thoughts and gambling behavior in the treatment group that were superior to the placebo group. Additional research suggests treatment gains from naltrexone may extend beyond the point at which the medication is discontinued (Dannon, Lowengrub, Musin, Gonopolsky, & Kotler, 2007); however, more research is needed to establish the longevity of the effect. Only a single study was identified that examined the combined effect of CBT with naltrexone (Toneatto, Brands, & Selby, 2009). Results indicated that the naltrexone group did not significantly differ from the placebo group (both of whom received CBT), which could suggest that there is *not* an additive effect of medication; however, it may be that the dose of naltrexone used was too low (Grant et al., in press). Beneficial additive effects of medication plus CBT have been demonstrated with other disorders (e.g. Blanco et al., 2010; Cuijpers, van Straten, Hollon, & Andersson, 2010; Wadden et al., 2011), although this is not universally true (e.g., Anton et al., 2006), thus more research is needed.

As a stand-alone treatment, opioid antagonists may represent a treatment option for individuals experiencing *intense gambling urges* who are unwilling to engage in psychotherapy or who are unable to effectively utilize self-help. Opioid antagonists may also be most appropriate for clients with a *comorbid alcohol use disorder*, as this class of drug has been approved for use in treating alcohol dependence, but (as mentioned above) not yet for gambling

disorder. As with psychotherapy, compliance is a concern, one which may be somewhat mitigated through the use of long-acting injectable naltrexone; although, only one case study has been published on the effect of injectable naltrexone on gambling (Yoon & Kim, 2013), suggesting significantly more study is needed before this route of administration can be recommended as a best practice. Of course, medications must be prescribed by a psychiatrist, psychiatric nurse practitioner, or other prescribing medical professional who feels comfortable managing psychoactive medications, and who is willing to prescribe for “off-label” use. For providers in the community who are not medical professionals or do not work in a multi-disciplinary clinic with physicians on staff, this may require building relationships with local physicians in order to facilitate referral when pharmacotherapy is indicated.

Aftercare (Relapse Prevention) Program: Given high rates of relapse (up to 92%) following a quit attempt, including formal gambling treatment (Hodgins & el-Guebaly, 2004), a concrete plan for aftercare, with accountability to an identifiable provider (e.g., outpatient therapist, primary care physician, psychiatric nurse, aftercare program provider) is key. While GA remains the most commonly available aftercare (and primary treatment) option, the median number of sessions attended by those who do go to GA is *one* (Stewart & Brown, 1988). Most people who are referred to GA (up to 67%; Petry, 2003, 2006) *never* go to a meeting, and most outpatient providers do not have the capacity to follow-up with their clients following discharge to monitor GA attendance. While GA can be, and is, beneficial for many people who attend, it is not universally a good fit with clients. Other aftercare models exist, but their availability is extremely limited. For example, Oregon Problem Gambling Services offered a Mindfulness Based Relapse Prevention (MBRP) for Problem Gamblers program, which was supported by a grant from the National Center for Responsible Gaming. Clients ($n = 6$) who participated in the pilot of this program reported decreased gambling symptoms ($d = 0.41$), consequences ($d = 1.23$), gambling craving ($d = 0.74$), and depression ($d = 0.52$) from baseline to post-treatment. Analysis of other clients in the gambling treatment program during the same period, matched by gender, income, and severity, indicated MBRP participants had fewer post-treatment gambling dependence symptoms ($M = 1.29$, $SD = 0.52$) than case-matched controls ($M = 1.41$, $SD = 0.63$), supporting its potential usefulness when working with disordered gambling clients. More research is needed, but there is a clear science-base for mindfulness-based approaches and relapse prevention in treating addictive behaviors (Bowen et al., 2009). While these approaches have also been applied as primary (outpatient) treatments, they seem most appropriate to aftercare, as they can support skills acquired during primary treatment and offer an opportunity for ongoing skill practice and further skill acquisition.

Existing Treatment Program Options in Washington State

Of the 17 providers interviewed, nearly all offered long-term outpatient services with varying degrees aftercare planning (ranging from no referral to GA referral). One provider reported only providing services meant to transition clients who do not perceive they have a gambling problem into treatment (i.e., providing “interventions” wherein the individual is engaged by significant others who express their concern). Another provider indicated that they are attempting to develop a gambling treatment program within a hospital-based chemical dependency program which offers multiple levels of care, including IOP and residential treatment.

Individual providers generally fell into one of two categories: 1) State-certified Chemical Dependency treatment providers who have completed additional training in gambling treatment, or 2) Mental Health counselors (including masters' and doctoral-level providers in psychology, social work, or related disciplines) who have completed additional training in gambling treatment (many of whom also specialized in addiction counseling). Many of the providers were nationally certified and/or state certified to provide gambling treatment; however, others indicated they were "in the process of certification," having attended trainings, but not yet met minimum treatment hour and supervision requirements for certification.

Number and Description of Clients Served

In interview, providers responded to the prompts: "How many patients do you serve annually? How many could you serve? Do you have a wait-list and if so how long?" and "What are the demographic characteristics of your gambling patients (age, sex, ethnic background, etc)."

The number of annually enrolled clients reported per individual/agency ranged from 0 (St. Peter's Hospital) to 380 (Coastal Treatment Services). Two agencies represented statistical outliers in terms of individuals served, both reporting serving close to or over 300 clients per year. When these agencies (and the one agency reporting 0 clients) were not considered, the average annual case load per provider was approximately 19, with the modal case load being between somewhere between 10 and 15.

No providers indicated they had wait lists, although one provider did indicate that referrals to other gambling treatment providers were sometimes necessary to ensure prompt treatment entry. On a related note, it was often challenging to reach providers as part of this evaluation. Each provider was phoned several times, on multiple days at different times, as well as emailed (when an address was available). Messages were left each time, asking the provider to return the call, yet very few calls were returned. It may have been due to the time of year (summer) or the fact that callers indicated they were "from the University of Washington," thus potentially signaling that they were not clients seeking services. However, for individuals who are ambivalent about seeking treatment, not reaching a provider or receiving a prompt returned call from their *first* call may be a barrier to treatment entry.

Consistent with the prior report (Larimer et al., 2009), all providers reported that youth and young adult gamblers were absent or significantly underrepresented in treatment relative to the epidemiology of disordered gambling in the state (i.e., only three providers mentioned serving clients under age 30, even though rates of gambling among youth is triple or quadruple the general adult population) and it was not clear from the providers responses if these younger clients were presenting with disordered gambling). This suggests the continued need for further outreach and prevention/early intervention methods for this population, as they may be less likely to present for available treatment. The majority of providers reported their caseload contained some older adults (senior citizens), though the majority of patients were middle-aged (40-60). Most providers indicated that men and women were equally represented in their caseload; however, interestingly, a few providers noted that they see mostly men, while many others indicated that they see mostly women. Almost as many providers indicated their gambling clients were predominantly female as those who reported treating both sexes. This may speak to

relatively lower treatment seeking among men (Blanco, Hasin, Petry, Stinson & Grant, 2006; Slutske, Blaszczyński & Martin, 2009) and/or may be indicative of the telescoping effect observed among women, wherein they tend to develop problems with gambling later in life than men on average (Grant & Kim, 2002; Ladd & Petry, 2002). Overwhelmingly, providers reported their clients were predominantly Caucasian. Fewer providers noted a significant percentage of Asian clients. Only the three largest treatment agencies reported their clientele had more varied ethnic backgrounds, and even these noted Caucasians and Asians were still the most prominently served populations. As epidemiological studies suggest that disordered gambling may be experienced by disproportionately higher percentages of individuals from minority ethnic and racial backgrounds (see Grant & Potenza, 2004 for a review), the limited diversity reported by providers suggests that outreach efforts may need to specifically target other racial/ethnic groups affected by disordered gambling.

Existing Services Provided in Washington State

As part of the evaluation, providers responded to the prompt “Describe the structure of your program”, with follow up prompts requesting hours per day, days per week, and weeks per year to complete treatment, asking about group, individual, and family sessions, and aftercare services.

The vast majority of providers indicated that they offer individual outpatient psychotherapy and individual or group family therapy, with many indicating that they also offer group psychotherapy sessions for gambling clients. Of note, one provider interviewed *only* provided group psychotherapy sessions. As previously indicated, one provider (St. Peters) said they were in the process of developing an inpatient program, but could not provide details of what this program would ultimately include, nor a firm start date for the program.

Providers responded to the prompts “How would you describe your treatment approach?” and “What treatment strategies do you utilize, and do you use a manual?”, and were provided with a list of possible treatment approaches as well as the ability to respond in an open-ended fashion.

The vast majority of providers indicated they utilized individual treatment planning to help clients set goals and objectives for treatment. In the 2009 report (Larimer et al.), providers supported both total cessation and harm reduction treatment goals, though most expressed a preference for total cessation as the ultimate goal; of the providers interviewed in the current evaluation, most only mentioned total cessation (in relation to determination of readiness for *treatment completion*; see below). Providers reported they use a variety of approaches in working with disordered gamblers including CBT, MI, family-systems therapy, solution-focused therapy, Dialectical Behavior Therapy (DBT), 12-step facilitation, existential psychotherapy and the Medicine Wheel; every provider either reported adapting intervention components to meet individual client needs as identified through intake assessment, treatment goals, and progress in treatment or did not explicitly discuss how interventions were selected. Two providers indicated they use the Trimeridian treatment manual (Rugle & Taber, 2000), which was utilized in the original pilot project for the Washington State gambling treatment program (Stinchfield et al., 2003), though one of these two providers said they rarely use it. One provider indicated using the “No Dice” workbook and the DBT manual, with a second provider also mentioning “No Dice.” Another provider mentioned using The Change Companies “12-Step Guide for Compulsive Gamblers.” One provider mentioned using the “Overcoming your Pathological Gambling:

Workbook” in combination with other unnamed resources. Two providers indicated they were writing (or had written) their own manual to document the approaches they were using, and other providers reported using materials they had acquired over the year without specifying a particular manual or workbook. The provider from the developing inpatient program indicated that they would possibly be using DBT skills training, harm reduction and the Hazelden approach (the latter two of which are based on contradictory theoretical models), but they were unsure at this early date. In all cases, the impression was that providers were only using pieces of manuals as resources in developing an individualized treatment plan if a manual was used at all.

Most providers could not provide a description of a “standard course of treatment,” indicating that the specific number of individual versus group sessions necessary for treatment completion was highly individualized. When asked “How do you define treatment completion,” providers almost universally indicated that treatment ended via mutual decision when the client felt ready and/or evidenced a stable pattern of abstinence. Based on the 2009 report (Larimer et al.), this was sometime between 6-12 months, though some retained their patients much longer. One provider in the current evaluation indicated “the door never closes,” suggesting that treatment relationships may remain open indefinitely to accommodate lapse/relapse. At the time of the 2009 report, providers had come to consensus on a standard definition of treatment completion with Linda Graves, who then worked for DASA (which is now DBHR), that included sustained gambling cessation or improvement, improved financial and life stability, and connection with social support and relapse prevention resources. Based on provider reports, it is unclear the extent to which this definition is still in force, and is complicated by issues of comorbidity prevalent in this population. The one element of this definition that did seem to be more broadly applied was “gambling cessation” or abstinence. Use of this as a criterion for treatment completion is potentially problematic for two reasons: one, some clients may not choose abstinence as a goal (rather, sustained moderate gambling); and two, it places a burden on the system that may be unnecessary. There is no science to support that clients are less likely to relapse if they remain in treatment until abstinence is achieved. In fact, in CBT (the most well supported evidenced-based treatment for gambling) clients are specifically told that problematic behaviors for which they are seeking treatment may not be fully eliminated during the course of active treatment. Instead, the goal is reduction in symptoms, with the expectation that symptoms will continue to abate in the weeks following treatment. A booster session, several weeks following treatment termination is often offered as a “check-up” and opportunity to problem-solve barriers to cognitive-behavioral skill use (as part of an aftercare plan) versus keeping the client in therapy past 20 weeks. This model may present an alternative to increase availability of individual gambling treatment when needed.

Aftercare was generally regarded as a challenge by providers. Almost all providers indicated that they referred clients to GA or other gambling treatment groups (not in their practice). One provider noted that clients found it “hard to find a good fit” with a GA group, highlighting concerns about this being the only currently available aftercare option. Few providers indicated any kind of systematic post-treatment follow-up evaluation to determine if aftercare plans were followed. When follow-up evaluations were reported, they typically occurred by phone or mail. One provider made it explicit that follow-up was “attempted,” but it is not clear how much time and resources were being devoted to post-termination follow-up attempts by any provider.

Areas for Improvement

There were several areas for improvement to gambling treatment in Washington State identified by Larimer and colleagues (2009) that still hold true and bear repeating in this report. These areas were identified by providers who were interviewed as part of the earlier evaluation, and they resonate with the provider reports in the current evaluation as well as the systematic review conducted by the authors of this report. In particular, there is a clear need for:

1) *Increased availability of resources for outpatient providers.* Providers interviewed in 2009 expressed a desire for continued guidance regarding what treatments work for what types of gamblers, and some felt that a set of core treatment elements, perhaps as a set of guidelines, which could be flexibly implemented across all providers, would be helpful. This was not universally the case, however; some providers indicated they specifically did not want a manual that they were required to follow inasmuch as they preferred to adapt the treatment to the individual clients needs. In addition, the majority of providers indicated they would welcome additional advice regarding how to track patient outcomes without adding to patient or provider assessment burden. It was clear from the current evaluation (2013) that little has changed in the past 5 years. Although the desire for more guidance and availability of “toolkits” or manuals to guide gambling treatment was mixed, the heterogeneity of treatment approaches within the community, clear misinformation that evidence-based approaches are *not* available (voiced by one provider), and the lack of clear treatment completion guidelines suggests that providers may not be adhering to known best practices for outpatient treatment, namely CBT. Increased adherence likely requires more continuing education (a request of multiple providers that were interviewed) and provision of treatment manuals with demonstrated efficacy that can guide (even if only partially) available outpatient treatment. Moreover, making psychometrically valid assessments available to providers via a centralized source (e.g., website) may also increase use of such measures for gauging treatment effect and post-termination follow-up.

2) *Coping with Issues of Comorbidity.* In the 2009 evaluation, providers unanimously indicated that gambling treatment clients were presenting with high levels of substance use and mental health comorbidity. While commensurate reports could not be obtained from providers in the current evaluation, there is no reason to believe that this has changed as national epidemiological studies document high rates of substance use and other mental health disorders among those with gambling disorder. Many providers may have the requisite training to treat comorbidity issues with their gambling clients; however, there are often real limitations placed on the provider by their (1) scope of license and (2) administrative billing issues. Continued efforts to decrease barriers between behavioral and mental health at the State level are needed to effect long-term change in this area; however, more might be done in the short term to facilitate connections between mental health and chemical dependency counselors to encourage referrals for concurrent treatment of comorbid conditions as needed.

3) *Residential Gambling Treatment.* Two providers in the 2009 evaluation mentioned a need for inpatient (residential) gambling treatment in the state. This recommendation was almost universally echoed by providers in the current evaluation, and many of the providers had made at least one client referral for residential treatment. As detailed above, at present, the closest

residential facility contracted with ECPG (who pays for the treatment costs) is located in Oregon, 342 miles from Wenatchee (which is approximately at the center of Washington). The embryonic program at St. Peters Hospital may fill this void; however, too little was known about the ultimate structure of the program at this stage. Also of importance, there is a clear distinction between a chemical dependency program that also addresses comorbid gambling and a program specifically designed to treat gambling disorder as the primary focus. Either would be an improvement over the absence of any such services within the state; however, the latter is more desirable from a treatment perspective. The absence of a residential treatment program (and other more intensive levels of care) in the state presents a real barrier to continuity of care.

4) *Need for more aftercare options.* Several providers in the 2009 evaluation felt it would be beneficial to have additional aftercare support for gamblers who complete treatment, and this recommendation was echoed by some in the current evaluation. Although all providers referred to GA for ongoing support during and after treatment, providers' reports of patients' experiences with GA were mixed. Particularly in less-populated areas of the state, providers indicated access to GA was extremely limited and GA meetings were not serving a strong support function as they do in other parts of the state. Particularly in these areas, support for structured aftercare would be of value. However, as previously described, GA is not a good fit for everyone; especially clients who may not wish to abstain completely from gambling, but who do wish to moderate their gambling. Other programs consistent with this harm reduction model exist, but are not available within Washington State. Piloting such a program (i.e., Mindfulness Based Relapse Prevention) in a major metropolitan area would hopefully lend greater support for the efficacy of this approach for gambling. To the extent that such a program demonstrated efficacy, it could be broadened to other areas of the state. Finally, finding a way to assist and encourage individual providers to systematically contact their clients following termination, as part of an aftercare approach seems warranted.

In addition to the recommendations above, suggestions by providers in the current evaluation, and the systematic review conducted by the authors, highlight some additional areas where treatment gaps exist:

1) *Universal point of intake.* The Helpline represents an extremely important avenue to treatment entry. Individuals often reach out for help in a moment of crisis, but may shy away from treatment entry if their attempt to solicit help is not met in a timely fashion. When the authors of this report attempted to contact providers, almost none could be reached by phone on the first attempt. For several individuals, multiple messages had to be left, and not all phone calls were returned. Especially given the high rates of suicidal ideation, attempts and completion among individuals with gambling disorder, it is imperative that help-seeking be met with an immediate response from an individual who can facilitate treatment entry. In an ideal world, there would be a centralized system that Helpline operators could access to schedule clients for intake with a provider in (or close to) their area. In the absence of this, it might be advisable for all individual gambling treatment providers to include the gambling Helpline number in their voice mail message (i.e., To speak with someone who can provide immediate help, please call...).

2) *Brief intervention.* Only one provider indicated providing what might be considered a brief intervention; however, it was not motivational in nature. The treatment was described as

“assisting family and friends in conducting an intervention on their loved one,” which connotes a more hierarchical versus collaborative approach, the latter of which is the hallmark of a brief motivational intervention. To the extent that such brief interventions can be effective in reducing gambling (as detailed above), it would be helpful to explore how collaborations with primary care centers might be forged. Primary care centers (and to a lesser extent, emergency rooms) present a prime opportunity, as people with disordered gambling often present with increased somatic and medical complaints (Bergh & Kuhlhorn, 1994; Lesieur, 1998; Lorenz & Yaffee, 1986) even if they are not contemplating gambling treatment. Universal screening in this setting would increase identification of disordered gamblers, allow for brief intervention and referral to further treatment as needed. Developing this type of program would also provide an additional means of “outreach,” a recommendation included in the 2009 report.

3) *IOP / PHP*: At present, there is a large gap between outpatient services and the next available level of care: residential treatment. Not every client who is referred to residential treatment may actually need that level of care. It is possible that some (if not many) of these individuals could be adequately supported in an IOP or PHP setting. These levels of care address a potentially therapy-interfering issue related to residential treatment, namely, escape from problems and pressures. Removing an individual gambler from their everyday life may provide relief from acute crisis, but this relief serves to reinforce avoidance/escape, which are maladaptive in this context. IOP and PHP programs keep the gambler in their home and everyday environment while working with them in a more intensive fashion than is possible in regular outpatient treatment. This allows greater opportunity for therapeutic skill application and practice in the environment to which they will have to use these skills following treatment termination. It also keeps the individual in contact with their existing social support network.

Conclusions and Recommendations

Recommendations for improving gambling prevention and treatment within Washington State stem directly from service gaps and/or areas of relative weakness identified in this or the prior review.

First, consistent with findings from Larimer and colleagues (2009), it is recommended that appropriate treatment manuals, workbooks, and assessment materials are identified and made available to treatment providers free of charge via a centralized resource repository. To increase provider awareness of evidence-based practices, it is also recommended that a core set of elements for effective gambling treatment based on these materials is identified and presented in brief educational materials (e.g., brochures, newsletters). Furthermore, it is recommended that a list of practices that are *not* empirically-supported be compiled and publicized, to avoid situations where providers are engaging in practices known to be ineffectual or harmful. Continued training in evidence-based treatment practices, and continued availability of supervision or communities of practice following certification is also recommended as one method of maintaining high quality of intervention services offered.

Second, there exists a divide between services for chemical dependency and mental health in the State of Washington. Providers’ hands are often tied when trying to treat disordered gambling, given its high comorbidity with substance dependence and other mental health disorders (e.g.,

depression, anxiety). It is recommended that the ECPG in collaboration with the DBHR continue to try to bridge this divide through legislative advocacy, and to provide training to providers on how to manage this challenging issue. Guidelines for when to treat disorders concurrently or serially could be created, and networking mechanisms for providers could be created to facilitate referrals for simultaneous treatment when a particular issue is outside of an individual provider's scope of practice.

Third, there is an absence or dearth of certain levels of care within the current gambling treatment system in Washington State, and it is strongly recommended that filling these gaps be considered. The first gap relates to the lowest level of care: screening and brief intervention. Very few people who experience disordered gambling seek treatment, thus to reduce human and societal costs of disordered gambling, it is necessary to engage in outreach activities that include direct identification of those experiencing problems. Collaborations with primary care facilities to incorporate psychometrically sound screening measures into their standard battery of intake assessments and training of facility personnel in providing brief motivational advice to curtail or stop gambling would help fill this gap. The second gap relates to IOP and PHP care. No programs of this nature that specifically address disordered gambling could be identified within Washington State. These levels of care may be appropriate to individuals who require more support than standard outpatient treatment, but who do not require full inpatient/residential treatment or for whom this latter type of treatment may be detrimental. The need for an IOP program was specifically mentioned by more than one provider in the current evaluation. The third and final gap relates to residential treatment. There is a clear need for this level of care in Washington State, as 51 individuals have been referred out-of-state for residential treatment through the ECPG's program in the past 4 years (between 5-17 per year), and this only reflects the number of people who were seen by gambling treatment providers who contracted with ECPG to make this type of referral (Note: At the time of this report, only 12 gambling treatment providers held a contract with ECPG for residential treatment referral). Based on an evaluation of Minnesota's gambling treatment program (Stinchfield, Winters & Dittel, 2008), a single 20-bed residential facility serves approximately 138 people per year, suggesting there may be higher need within our State. As noted above, creating a residential program within the State was a priority expressed by the majority of gambling treatment providers interviewed in this evaluation.

Finally, in addition to gaps in the levels of care noted above, it is specifically recommended that resources be devoted to (1) centralizing treatment entry services via the Helpline if at all possible (at minimum, by encouraging/requiring providers to include the Helpline in their voice mail messages), (2) fostering more aftercare programs within the State, especially those that might offer an alternative to abstinence-only programs such as GA (e.g., MBRP), and (3) encouraging providers to engage in greater follow-up after termination to ensure continuity between outpatient (or another level of care) and aftercare.

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Appendix A: List of Gambling Providers and Facilities in Washington State.

Index of Terms and Symbols:

WSCGC – Washington State Certified Gambling Counselor

NCGC – National Certified Gambling Counselor

BACC – Board Approved Clinical Consultants

† Completed Interview as Part of the Current Evaluation

* State Contracted Provider

‡ ECPG Contracted Provider

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In the process of setting up gambling treatment:

† * **St. Peter Chemical Dependency Center**

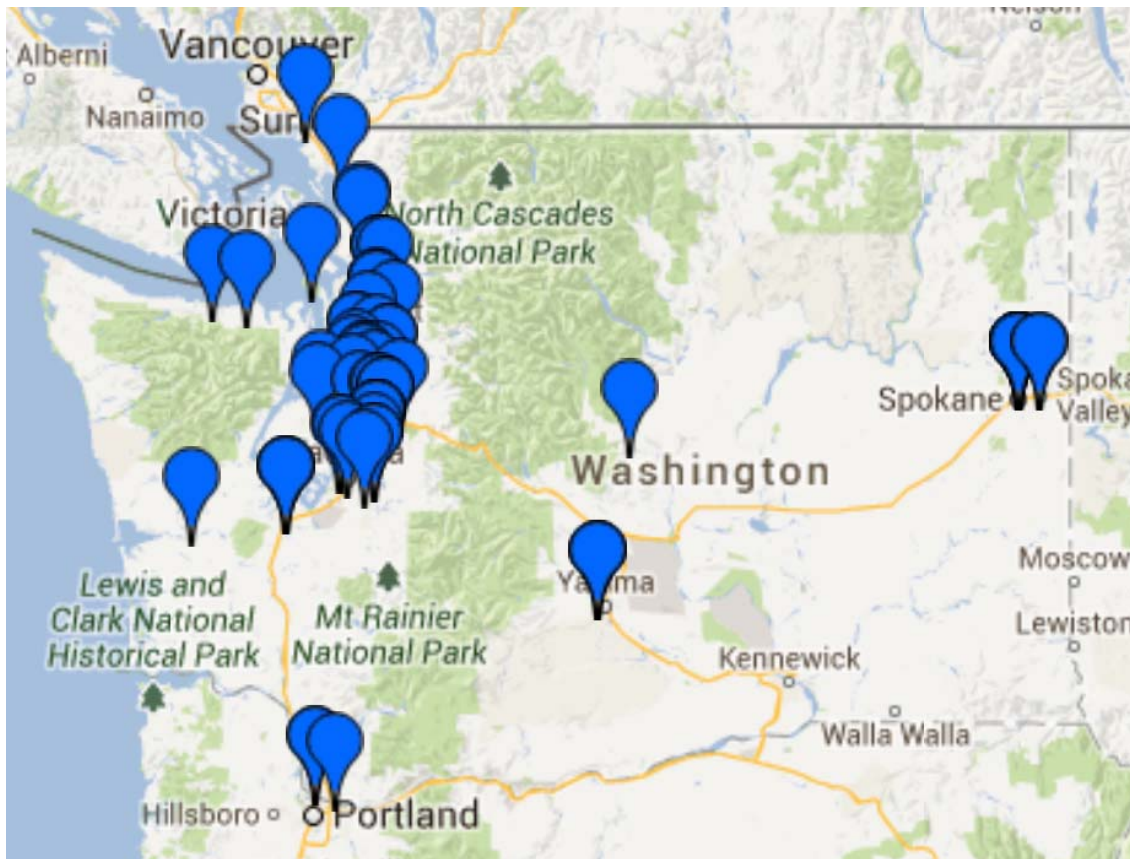
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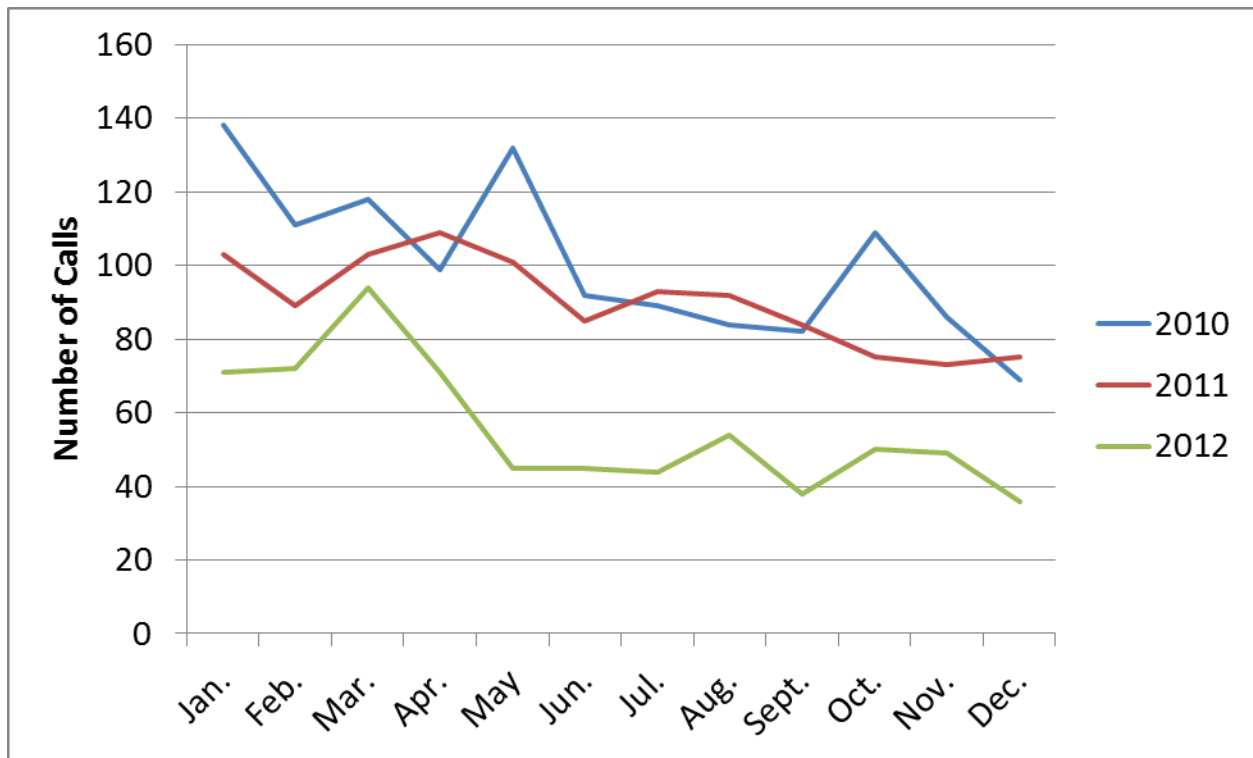
(360) 456-7575

<http://washington.providence.org/hospitals/st-peter/services/chemical-dependency-center/>

Appendix B: Location of Gamblers Anonymous (GA) Meetings in Washington State.



Appendix C: Number of Helpline calls by individuals who report having a gambling problem, who have relapsed or who know someone with a gambling problem by month and year (2010-2012).



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