

**PROFESSIONAL COUNSELING
TREATMENT PROTOCOL
INTEGRATED TREATMENT OF CLIENTS DIAGNOSED AS PATHOLOGICAL GAMBLERS**

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PURPOSE

To provide guidelines for the effective identification, assessment, and treatment of pathological gambling, whether given as initial presenting problem or identified as secondary to another presenting problem. There is also a need to address the concept of dual addictions, and co-occurring disorders or problematic behaviors. It is reported in recent professional literature, that the majority of pathological gamblers have more than a single clinical problem; and these issues intertwine in complex patterns.

Increasing the effectiveness of treatment for pathological gamblers means that we need to treat the client for the entire range of problems they experience; but we need to do so in a planned and logical sequence and at a pace that is tolerable for the client.

Clients who are diagnosed as Pathological Gamblers are often dual-diagnosed or multi-problem who present for treatment with at least two concurrent clinical problems, each of which meet diagnostic criteria for a mental, emotional, or relational disorder; as well as other addictive problems such as alcohol abuse or substance abuse.

This protocol describes the process by which we organize our system to effectively identify and treat pathological gambling as dually diagnosed or multi-problem clients, and how we minimize barriers to effective treatment.

ESSENTIAL PRINCIPLES OF INTEGRATED TREATMENT

Dual (or more) diagnosis is the "usual", not the exception. It is common enough that it is important to screen and assess for co-morbid conditions when assessing for a pathological gambling diagnosis.

If a mental health problem or a substance disorder co-exist with a pathological gambling disorder, both diagnoses should be considered primary, and both should be treated simultaneously rather than serially.

A substance disorder or psychiatric disorder should be considered "secondary" only if it resolves when the pathological gambling disorder is at baseline

KEY FACTORS IN INTEGRATED TREATMENT

PRIMARY THERAPIST

The best predictor of progress for clients is a strong, effective, and enduring therapeutic relationship. When a client does receive treatment from more than one provider in the agency, one person is designated as the primary therapist. This will usually be the first person encountered by the client, or the one most likely to have a long term and/or in-depth involvement in the treatment process. This person will initiate case management or coordination efforts, and continue to monitor progress in all areas of treatment.

CASE MANAGEMENT

As treatment becomes more complex it becomes increasingly critical that someone help the client make sense of the overall process. Case Management responsibility is assigned to the primary therapist. Case management addresses questions of when and to whom to refer, client readiness to accept the referral, planning the sequence of treatment, coordinating the process of treatment with multiple providers, and following up as needed. With many of our clients we need to take an active role in regard to coordination and management

CLIENT ENGAGEMENT and READINESS TO CHANGE

We improve the chances that a client will accept our recommendation for a referral to a specialized service when they feel that their presenting problem is heard and understood. The therapeutic relationship and the joining process help build client motivation and readiness to change. Some clients may stay in a “pre-treatment” stage for a period of time, during which various clinical interventions may help them get ready for change.

STAFF CONSIDERATIONS

Integrated treatment requires that we develop clinical staff skills across the traditional professional boundaries and in new directions, including

1. Recruiting, hiring, and developing existing employees to obtain, dual credentials
2. Cross training of staff to recognize, refer, and cooperatively treat clients with a range of problems
3. Co-location of staff with specialized credentials throughout our service locations.

CLIENT ELIGIBILITY

Clients are appropriate for Treatment of a Pathological Gambling Disorders when:

1. The client demonstrates symptoms of an Axis 1, pathological gambling diagnosis.
2. IF there is a substance abuse diagnosis/or mental health diagnosis such as depression, it is amenable to outpatient treatment intervention at this level of score.
3. Treatment can realistically be expected to help the client improve and maintain their level of functioning
4. If there is suicidal ideation or other risks to safety; it is possible to develop an effective safety plan, which the client and/or others in their home environment will follow.
5. If there is a major mental disorder that affects or limits the effectiveness of the treatment process, the client is willing to be seen by a PhD or MD for diagnosis and concurrent treatment of the disorder; and to be compliant in treatment recommendations, including medication if recommended
6. There is reasonable motivation and cooperation from the client and significant others involved in the therapy

Clients are inappropriate for treatment of a Pathological Gambling Disorder when:

1. Client is unable to or unwilling to commit to and adhere to a safety plan to protect against self harm or harm to others
2. Client is unwilling to cooperate in obtaining medical or psychiatric treatment, or to follow these treatment recommendations
3. Client is assessed as needing a higher level of care
4. Client is medically at risk such as addiction or eating disorder at level of severity that health is affected
5. There is a high risk of domestic violence or child abuse, and the client(s) must be provided with a safe environment before engaging in the treatment process

SCREENING, ASSESSMENT AND TREATMENT PROCESS

SCREENING

The screening process utilizes accepted assessments for Pathological Gambling. These are the South Oaks Gambling Screening (SOGS) & the Gambler Anonymous Twenty Questions. A comprehensive gambling history is also gathered. There is also the knowledge of risk factors to detect problems that may present in combination with pathological gambling. It is important to routinely screen clients in the following areas.

- Mental Health Conditions
 - Depression
 - Bipolar
 - Anxiety
 - ADHD
- Substance Abuse
- Marital, Relationship, and Family problems including the potential for domestic violence, sexual abuse or assault, and child abuse
- Suicide ideation, behavior, history of attempts, recent attempts (See HFS Clinical Protocol for Suicide)

Whenever a screening indicates an area of significant concern, the therapist will be responsible for appropriate clinical follow up. They may either perform, or refer the client for, a more in depth clinical assessment of that issue. The case formulation should incorporate all relevant clinical findings into the recommendations for treatment.

CENTRAL INTAKE PROCESS

Central Intake workers perform the first level of screening. Their primary objective is to identify the client's reason for calling, clarify the presenting problem, and refer client to the initial point of service that is most appropriate. They will also explore and identify possible co-occurring problems that could be significant for the therapist to know in determining the appropriate type or sequence of treatment.

When Central Intake workers cannot determine the most appropriate initial point of service, based on the initial call, they may advise the client and therapist that a clinical interview is necessary before a specific program determination is made. The client will then be referred to the appropriate treatment options. Example: A client presents with psychiatric symptoms and substance abuse. In order to determine the exact sequence and combination of treatment, the client is told that an initial evaluation interview will be

scheduled, and the therapist will then help them determine appropriateness for the type, level, and sequence of treatment.

CLIENT SELF EVALUATION

As part of the initial evaluation process clients will be asked to complete self report, self evaluation, or other instruments which aid in screening for co-occurring problems. All self evaluation measures are reviewed by the therapist; and significant findings of the self evaluation are noted for further exploration in the initial evaluation interview and/or in subsequent treatment sessions.

PRETREATMENT ASSESSMENT or INITIAL EVALUATION

In the initial clinical interview, the therapist will fully explore the problem as presented by the client, including any related concerns which have been identified through the self evaluation materials or through the initial phone contacts, referral sources, or authorized collateral contacts.

The therapist may identify concurrent problems in need of clinical attention, or those for which a more in-depth or specialized evaluation is necessary. Additional assessment activities may be planned and carried out even concurrently, as treatment is initiated for any high risk or high priority problems presented by the client.

SCREENING INSTRUMENTS AND TECHNIQUES

Therapists will screen for a variety of issues during the clinical interview and throughout treatment as the need arises. In addition to open ended or structured interviews, which are guided by professional training, experience, and scope of practice; therapists may also use valid and reliable screening instruments. The following are available as options in the screening process:

Brief Psychiatric Rating Scale

Columbia Depression Scale for Adolescents

Beck Depression Inventory:

Geriatric Depression Scale

Child Depression Inventory:

Burns Anxiety Scale:

Connors Scale: for screening of attention deficit and other mental health problems of children and youth

SASSI (Substance Abuse Subtle Screening Inventory)

MAST or BRIEF MAST: Michigan Alcohol Screening Test

Geriatric MAST

Gambling Activity Questionnaire

South Oaks Gambling Screen

Gamblers Anonymous Twenty Questions

Abusive Behavior Inventory partner form or abuser form

YBOCS (Yale-Brown Obsessive - Compulsive Scale)

SOCRATES (stages of change measure)

URICA (University of Rhode Island Change Assessment)

Readiness Ruler (stages of change measure)

Other reliable and valid assessment instruments may be used with permission of the clinical supervisor.

Other specialized tests and assessments may be administered as needed by agency staff and consultants who are licensed psychologists

TREATMENT PROCESS

TYPES OF TREATMENT PROVIDED:

Heartland Family Service treats clients that are diagnosed as pathological gamblers use a range of individual, group, and family therapy; skill training groups, psycho-educational groups for individuals and family members; and psychiatric consultation

In addition, we can refer individuals that are diagnosed as pathological gamblers in seeking assistance with temporary housing, financial counseling, and other basic needs, to our emergency services programs.

CLINICAL MODEL

Effective models of intervention for clients diagnosed as pathological gamblers draw on the theory of cognitive behavior, motivational change, in addition to the dialectical behavior therapy model (DBT) of Marsha Linehan. It has demonstrated effectiveness in stabilizing the pathological gambling diagnosed client that is dually diagnosed individual and increasing the benefit they derive from concurrent treatment services. A comprehensive 30 hour training program on treatment of pathological gamblers as well as skill training groups based on this model are part of the clinical program for dually diagnosed individuals.

Family Systems theories, including structural and intergenerational family therapy and financial structuring are also an integral aspect of our clinical model. These theories provide a foundation for working with the families of dually diagnosed persons to support their progress.

In addition, psycho-educational programs have demonstrated effectiveness with clients that are diagnosed as pathological gamblers, and or dually diagnosed and their family members. This type of service educates the individual and significant others in understanding the nature of their conditions, the ways in which disorders may interact, how to cope when disorders are chronic, and how to support the individual in their recovery process.

TREATMENT FREQUENCY, INTENSITY AND DURATION

Due to the diverse nature of clients with a diagnosis of pathological gambling, & the propensity of dual diagnosis, treatment must be highly individualized. It is necessary to remain highly flexible to vary the intensity and frequency of treatment of clients diagnosed with pathological gambling as needed. During times of acute crisis when the goal is stabilization of the gambling behavior, addressing consequences, mental health and/or psychiatric symptoms and prevention of inpatient placement, clients that are diagnosed with be seen from one to five times weekly in a combination of group, family, and individual therapy, and psychiatric consultation.

Clients that are diagnosed as pathological gamblers will also benefit from increasingly less frequent service contacts, but will tend to benefit from long term supportive contacts with treatment professionals. Treatment duration should be expected at a minimum of six months, and for some individuals, the maintenance or relapse prevention phase needs to be open ended and long term.

CASE FORMULATION, TREATMENT PLANNING AND CASE COORDINATION

The formulation of treatment of a dually diagnosed individual is a unified statement of the case that addresses all relevant treatment needs.

This planning process includes consideration of the type and timing of services that will be effective. When there are multiple problems, how do we decide where to focus? Can a client be treated concurrently for different problems or are there times when it is critical to complete one course of treatment before addressing another area? Can two or more providers be helping a client accomplish the same treatment outcome?

When a client is served in more than one clinical program, a primary therapist is assigned. The primary therapist is responsible for overall client progress and coordination of treatment with other professionals, whether within the agency or with professionals from other agencies.

Client Consent and Authorization: Clients give consent to internal communication among Heartland Family Service professional staff when they sign their initial consent to treatment. As a courtesy, we will consult with them and inform them that we want to communicate with other Heartland Family Service providers.

However, if the client receives substance abuse services, it is necessary to obtain a specific written authorization from the client or legal guardian for Heartland Family Service staff to engage in case review, exchange of information, or case management.

An **Issue Check List** is completed as part of the treatment planning process. It may include any and all problems relevant to the client's care as identified by professionals, the client, and significant others in the client's life such as family, spouse, caseworker or probation officer. The highest priority issues are addressed in the treatment plan. As additional problems arise, the problem list is used to track them. As treatment objectives are achieved, additional issues from the problem list are added to the treatment plan.

A single therapy outcome or long term goal is established to unify the treatment that may be provided in different specialty areas. The initial treatment plan is developed cooperatively, to include the client, primary therapist, and other treating professionals as needed. Each clinical program area may identify and implement specific short-term goals and objectives, but the shared long-term goal keeps these efforts coherent.

REVIEW OF PROGRESS DURING TREATMENT

The frequency of progress review for dually diagnosed clients will vary along with the intensity of the treatment. At times when treatment is intensive in nature, progress may be reviewed as often as weekly, biweekly, or monthly. At a minimum, progress is reviewed every 90 days. Clients participate in progress reviews as part of their therapy process.

Periodic progress reviews may occur in program staffings, peer group supervision, by phone or e mail. Progress reviews are initiated by the primary therapist. These will include discussion of areas of progress, barriers to progress, and adaptations of treatment if there has been no progress.

GOALS OF TREATMENT

Treatment of Diagnosed Pathological Gamblers will be highly individualized. The following are offered as examples of an appropriate hierarchy of treatment outcomes, short-term goals and objectives, and interventions. They will vary with the stage of the treatment process. These should be personalized in cooperation with the individual client.

LONG TERM OUTCOMES

The therapy outcome is stated in terms of the result that the client hopes to achieve in this treatment episode. It should be consistent with the treatment duration given. The therapist helps refine the client's definition of successful treatment, and helps determine specific criteria for success.

1. Achieve and maintain abstinence from gambling, drugs and/or alcohol or other addictive behaviors
2. Stable lifestyle: remain independent and functional; prevent recurrence of quick fix solutions that create new consequences.
3. Rebuild & maintain a supportive social and family network
4. Establish and maintain a relapse prevention plan including indicators that additional treatment is needed.
5. Client will develop a critical/honest view of their gambling behavior & monitor associated consequences.
6. Client will use a harm reduction approach when engaging in the gambling activity of their choice.

SHORT TERM GOALS

These are stated in terms of how the client's behavior or life situation is expected to change as a result of therapy. These are one or more of the steps involved in achievement of the therapy outcome. These should be clear enough that the therapist and client will know they have been met.

1. Stabilize acute psychiatric and/or addictive symptoms
2. Achieve and maintain abstinence from psychoactive substances
3. Reduce and/or contain high risk or dangerous behavior
4. Strengthen family and other social support
5. Achieve/maintain medication compliance
6. Understand the nature of the disorder(s), their progression, and the recovery process
7. Address any safety related issue in the person's behavior and/or Environment
8. Increase coping skills (specify; problem solving, stress management, interpersonal skills, distress tolerance; etc.)
9. Identify relapse triggers

OBJECTIVES

Objectives state **skills** that the clients will learn; or **action steps** that the client +/-or therapist will take to meet each short-term goal.

Examples of Skills Objectives:

1. Learn specific coping skills such as a relaxation or self calming skill
2. Recognize personal triggers for relapse
3. Learn cognitive skills for controlling impulsive behavior
4. Take a time out when emotional discomfort occurs and a desire to escape/avoid results

Examples of Action Step Objectives:

1. Complete diary card daily and review in therapy
2. Make an appointment with primary care MD to assess physical symptoms
3. Contact YMCA for information about single family memberships
4. Obtain treatment history
5. Obtain psychiatric consultation and evaluation as needed

6. Obtain medical evaluation and treatment of associated health concerns
7. Identify family and other social support system strengths and deficits
8. Identify client motivation, readiness, and any obstacles to change
9. Engage with self help and support groups such as AA or Recovery

CLINICAL INTERVENTIONS

Clinical Interventions are performed by the therapist during the treatment process. An intervention is intended to bring about change in the direction that therapist and client have agreed upon as an outcome of therapy. Interventions are described, session by session, as they occur. They are documented on the progress note.

Examples of Interventions:

1. Assess for safety
2. Establish differential diagnosis
3. Psychiatric evaluation and medication management
4. Assess need for detoxification; refer
5. Assess health conditions; refer as needed
6. Referral for random drug screening
7. Skills training (mindfulness, self calming, problem solving, relapse prevention)
8. Referral to self help or support groups
9. Bibliotherapy; recommending reading, other resource materials to client
10. Case management to assist with benefits, housing, other needs for stable living circumstances
11. Individual, group and family therapy as needed
12. Monitoring of symptoms
13. Monitoring of relapse prevention plan

TERMINATION of TREATMENT

In preparation for termination of treatment, clinical staff and the client will develop an aftercare plan, which can be expected to help the client maintain the progress they have made in therapy. Aftercare plans may include

1. Referrals to other community services
2. Referrals to less intensive levels of care
3. Connections to self help and other forms of support groups
4. Relapse prevention plans

Clients may be terminated from integrated treatment when:

1. They have successfully met their treatment goals and an appropriate aftercare plan is developed to help them maintain progress
2. They are in need of a different level of care
3. There is a danger to self/others or environment is unsafe
4. They refuse to attend, participate, and/or cooperate in treatment process; consistently fail to attend appointments

QUALITY CHECKLIST FOR CLIENTS DIAGNOSED AS PATHOLOGICAL GAMBLERS

- Were all relevant symptoms and behaviors appropriately evaluated in the initial evaluation?
- Were appropriate types of screening instruments used in the initial evaluation?
- Was a comprehensive case formulation, addressing mental health, substance abuse, and relevant other issues, developed in the conclusion (Part 3) of the Initial Evaluation?
- Was the issues check list completed?
- Was a treatment plan developed with a single treatment outcome to which all treatment goals and objectives are directed?
- Does the treatment plan show evidence that pathological gambling, dual addiction as well as mental health/other concerns, is being addressed?
- Is the intensity of treatment appropriate to the client's level of need?
- Was the client referred for psychiatric treatment if not already involved?
- Is there evidence that the primary therapist is actively cooperating with other treatment providers and the client's psychiatrist?
- Are there indicators that the treatment is regularly reviewed and coordinated?
- Has the client progressed and if not, is there evidence that new strategies are being implemented?
- Is Aftercare planned?

REFERENCES AND RESOURCES

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