Integrated Care Model for Problem Gambling

Rick McNeese, Ph.D.
First Step Recovery and Wellness Center
Lincoln, Nebraska

The Midwest Conference on Problem Gambling and Substance Abuse
Kansas City, Missouri
August 13, 2004
Case 1

- 22 y/o male college student
- Depressed with recent relationship
- Deaths of sister and brother
- Had observed brother kill father
- Drinking beyond moderation, Internet gambling
- What would professional do?
Compulsive Gambling
Mental Health
Substance Abuse
Why Consider Treatment of Co-Morbid Disorders?  The Simple Truth..

- Co-morbidity is alive and well!
- Studies show that collaboration is important
- If counselor adds physician to treatment of alcoholism, abstinence *triples* at 12 month follow up
- What about compulsive gambling?
Why?

• Because this is what the problem requires!

• Have you ever...
  – Had a couple who needed marital counseling?
  – Had a family with child behavior problems?
  – Had a client with major depression or anxiety?
  – Had a chemically dependent gambler?
  – Had a client with a personality disorder?
  – Had a more complex diagnostic question?
  – Had a forensic issue requiring full assessment?
Why?
Mural dyslexia

The inability to see the handwriting on the wall!
"I have yet to see any problem, however complicated, which, when looked at in the right way, did not become still more complicated."

Poul Anderson
• Goal: Interdisciplinary approach to achieve 100% access and eliminate disparities by the year 2010

• Commitment to partnering with communities to build a comprehensive primary care system that includes mental health, behavioral health, and substance abuse services.

• First recognition of mental health and substance abuse as priority health concern
Case 2

- 47 y/o male
- Alcoholic
- Depressed
- What would professional do?

LMHP MFT CADAC CCGC Ph.D. FP
Case 3

- 47 y/o male
- Compulsive Gambler
- Depressed
- What would professional do?

LMHP  MFT    CADAC    CCGC    Ph.D.    FP
Eat a live toad in the morning and nothing worse will happen to you for the rest of the day.
Dual Disorder vs Co-occurring disorder

- Preference for **Co-occurring** - Kenneth Minkoff, M.D.
- "Dual" implies single entity with known treatment
- But terms such as primary and secondary is simplistic
- Interaction between conditions creates unique clinical entity
- Multi-systemic problems include chemical addiction, gambling, psychiatric, medical, relationships, economic, and legal dimensions
• Tolerance, withdrawal, and narrowing of interests
• Damage to family, work, social responsibilities
• Continuation despite self-harm
Comorbidity - Continued

- 28% of pathological gamblers chemically dependent (1.2% in nonpathological gamblers)
- Gamblers have 7 times rate of AOD dependence
- 30-50% of treatment seeking gamblers have substance use disorder (as high as 80%)
- Treatment seeking substance use clients, 9-30% have gambling problem
Comorbidity - Continued

- Adults with alcohol addiction are 23 times more likely to have gambling problem than those who don’t drink.
- Similar rates of depression, anxiety, and ADD in gamblers and addictions.
- Antisocial personality disorder also about 40% of male gamblers and addictions.
• Psychiatric patients have about 30% rate of addictive disorder

• In treatment settings, 40-80% of psychiatric patients have addictive disorder

• If addiction client, prevalence of psychiatric disorder is 35-50%
Importance of screening for cross addictions

- How to detect co-occurring disorders
  - Initial thorough and careful diagnosis
  - Monitor over time
  - Family history

- Risk of relapse increases
Case 4

- 45 y/o male, 75# overweight
- Sleep apnea
- Stroke in 1996 resulting in full disability
- What would professional do?

LMHP MFT CADAC CCGC Ph.D. FP
Integrated Care Screening Tool Description

Seven categories of self reported items

Chronic Medical Problems

Psychiatric Care

Psychological (Brief Symptom Inventory vs. SAS/SDS)

Michigan Alcohol Screening Test (MAST)

Drug Awareness Screening Test (DAST)

South Oaks Gambling Screen (SOGS)

Plus broad list of other items
Substance Abuse
N=110

- Compulsive Gambling 16.4%
- Drugs 55.5%
- Chronic Medical 20.9%
- Psychiatric 23.4%
- Psycho-logical 14.5%
- Eating Disorder 15.5%
- Suicide risk 26.4%
- Stress Symptoms 42.7%
- Abuse 32%
Mental Health
N=42

- Alcohol: 52.4%
- Gambling: 9.5%
- Drugs: 11.9%
- Chronic Medical: 38.1%
- Psychiatric: 31%
- Stress Symptoms: 81%
- Eating Disorder: 28.6%
- Suicide risk: 54.8%
- Abuse: 40.7%
Compulsive Gambling
N=45

- Gambling: 86.7%
- Substance Abuse: 73.3%
- Drugs: 26.7%
- Psycho-logical: 11.1%
- Psychological: 11.1%
- Eating Disorder: 20%
- Stress Symptoms: 55.6%
- Suicide risk: 44.4%
- Chronic Medical: 15.6%
- Psychiatric: 37.8%
- Abuse: 29.3%
Neurofeedback
N=39

Gambling 12.8%
Drugs 15.4%
Chronic Medical 48.7%
Alcohol 33.3%
Abuse 34%
Eating Disorder 43.5%
Psychological 23.3%
Suicide risk 41%
Psychiatric 33.3%
Developing a Basic Model of Care

Build It

Get It

Use It

Share It

Follow It

Measure It
Build It Multidisciplinary Team

• Develop a Team
• Difficult to do in rural areas without providers!
• But can extend few resources we do have
• Use cross training of merged group
• Develop connections with others in community
Never buy a car you can't push.
Get It  Identify multiple problems

- Cross training to acquire and use information
- Quick screen vs. Full Integrated Care Screen
  - Quick screen more multidisciplinary staff-friendly tool
  - Integrated Care Screen more thorough
- Completed on intake, scored, and start-up of Integrated Care Treatment Plan
- See Client Intake Worksheet
Importance of Problem Identification

- Engel’s Biopsychosocial Model
  - Medical, Individual, Marital, Family, Community, Cultural, Socio-political

- Minkoff’s Co-occurring work conceptualizes Low vs High Risk

- Screening can identify Low vs. High on multiple dimensions
Use It  Be Able to Treat Multiple Problems

Cross training necessary
Making Referrals
Staffing and coordinated treatment
Care management
Office literature and “vertical integration”
Implications for treatment
## BIOPSYCHOSOCIAL RISK ASSESSMENT

<table>
<thead>
<tr>
<th>DSM</th>
<th>ASAM</th>
<th>LOW</th>
<th>MEDIUM</th>
<th>HIGH</th>
</tr>
</thead>
<tbody>
<tr>
<td>AXIS I</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AXIS II</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AXIS III</td>
<td>1, 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AXIS IV</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AXIS V</td>
<td>4, 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk</td>
<td></td>
<td>Type I</td>
<td>Type II</td>
<td>Type III</td>
</tr>
<tr>
<td>Rating</td>
<td></td>
<td>Simple</td>
<td>Moderate</td>
<td>Complex</td>
</tr>
</tbody>
</table>

Would you treat these differently?
## Biopsychosocial Screening

<table>
<thead>
<tr>
<th>Axis I</th>
<th>ASAM</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gambling</td>
<td>3,3</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Sub Abuse/Dependence</td>
<td>3</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Mental Health</td>
<td>3</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Axis II</td>
<td>3,3</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Axis III</td>
<td>3,1,2</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Axis IV</td>
<td>6</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Axis V</td>
<td>4,5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Rating</td>
<td></td>
<td>Type I</td>
<td>Type II</td>
<td>Type III</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Simple</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>
## Biopsychosocial Screening

<table>
<thead>
<tr>
<th></th>
<th>ASAM</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Axis I</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gambling</td>
<td>3</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Sub Abuse/Dependence</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Mental Health</td>
<td>3</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Axis II</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Axis III</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Axis IV</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Axis V</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4,5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risk Rating</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Type I</td>
<td>Type II</td>
<td>Type III</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Simple</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

**Risk Rating:**
- Type I: Simple
- Type II: Moderate
- Type III: High
<table>
<thead>
<tr>
<th>Axis I</th>
<th>ASAM</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gambling</td>
<td>3</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Sub Abuse/Dependence</td>
<td>3</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Other Mental Health</td>
<td>3</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Axis II</td>
<td>3</td>
<td>1,2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Axis III</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Axis IV</td>
<td>4,5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Rating</td>
<td></td>
<td></td>
<td>Type I</td>
<td>Type II</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Simple</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

**Biopsychosocial Screening**

<table>
<thead>
<tr>
<th>Risk Rating</th>
<th>Type</th>
<th>Type</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I</td>
<td>II</td>
<td>III</td>
</tr>
<tr>
<td></td>
<td>Simple</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>
# Biopsychosocial Screening

<table>
<thead>
<tr>
<th>Axis I</th>
<th>ASAM</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gambling</td>
<td>3</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Sub Abuse/Dependence</td>
<td>3</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Mental Health</td>
<td>3</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Axis II</td>
<td>3</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Axis III</td>
<td>1,2</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Axis IV</td>
<td>6</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Axis V</td>
<td>4,5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Rating</td>
<td></td>
<td>Type I</td>
<td>Type II</td>
<td>Type III</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Simple</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>
# Biopsychosocial Screening

<table>
<thead>
<tr>
<th>Axis I</th>
<th>ASAM</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gambling</td>
<td>3</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Sub Abuse/Dependence</td>
<td>3</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Other Mental Health</td>
<td>3</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Axis II</td>
<td>3</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>1,2</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Axis IV</td>
<td>6</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Axis V</td>
<td>4,5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Rating</td>
<td></td>
<td>Type I</td>
<td>Type II</td>
<td>Type III</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Simple</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Axis</td>
<td>ASAM</td>
<td>Low</td>
<td>Medium</td>
<td>High</td>
</tr>
<tr>
<td>-----------</td>
<td>------</td>
<td>-----</td>
<td>--------</td>
<td>------</td>
</tr>
<tr>
<td>Gambling</td>
<td>3</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Sub Abuse/Dependence</td>
<td>3</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Mental Health</td>
<td>3</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Axis II</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Axis III</td>
<td>1,2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Axis IV</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Axis V</td>
<td>4,5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Rating</td>
<td>Type I</td>
<td>Type II</td>
<td>Type III</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Simple</td>
<td>Moderate</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>Axis I</td>
<td>ASAM</td>
<td>Low</td>
<td>Medium</td>
<td>High</td>
</tr>
<tr>
<td>---------------------</td>
<td>------</td>
<td>-----</td>
<td>--------</td>
<td>------</td>
</tr>
<tr>
<td>Gambling</td>
<td>3</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Sub Abuse/Dependence</td>
<td>3</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Other Mental Health</td>
<td>3</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Axis II</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Axis III</td>
<td>1,2</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Axis IV</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Axis V</td>
<td>4,5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Rating</td>
<td></td>
<td></td>
<td>Type I</td>
<td>Type II</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Simple</td>
<td>Moderate</td>
</tr>
</tbody>
</table>
Conceptualizing Treatment from Intake Information

Using Intake Form and Post It Notes

Help Client “Map Out” connections

Make connections to Gambling urge and acts
  • Click to edit Master subtitle style
Conceptualizing Treatment from Testing Information

Works especially well with MMPI-2 results

Pick 10-20 “strike home” statements

- Use 2 point codes or “feedback statements”

Write on Post It and Map Out
Conceptualizing Treatment from Client Self-Talk

Make list of client automatic self-talk

Repeat several times until impression of what client must be thinking and feeling occurs.

Check your experience with client.

Identify this “schema” and connect with gambling urge and activity.

Look for “payoff” of positive and negative reinforcement.
Follow It

Continuity over time

• One primary therapist over time
  – Choose therapist client gravitates to!

• Addiction as chronic relapsing disease

• Stress of predictable life cycle events

• Stress of unpredictable crisis
Integrate Treatment of Multiple Problems

- Work with team (Releases of Information)
- Progress Note to Physician (See MD Note)
- Respond to physician needs
- Develop common treatment plan
Measure It Outcome measures

- Increasing need for documented outcomes
- Accountability
- Research
- Funding support
- Measuring Treatment Outcomes, Patricia Owen, Ph.D
  - Hazelden Publishing
Maintain It Leadership, funding and business structure

• Takes commitment within the practice
• Takes support from outside the practice
• No magic funding resources at this time
• Need good communication, both clinical and operational
Implications

Cross training necessary

Collaborative or integrated care where multiple treatments available

Care management process and time

Documentation of treatment planning

Current trends exist at State level (LB 1083)
Importance of Medical Care

- Weisner, JAMA, Oct 10, 2002
- 285 patients received medical and SA tx
- 307 patients traditional addictions tx
- Both received 12 Step programs
- After 12 months, Integrated group were 3 times more likely to remain abstinent
What problems are presented by the co-occurring disorders

- Do worse and are more difficult to work with
- High utilizers of emergency and inpatient services
- Difficult to evaluate and diagnose
- Respond less well to standard treatments
- Frequently not compliant with available services
- Higher risk of suicide and violence
What problems

- Defy simplistic categorizations as primary, secondary or coequal entities
- Interaction between conditions creates unique clinical entity
- Despite coexistence of problems, treatment and funding agencies are separate
- Poor knowledge if “other” condition is being treated
What problems

• While many patients would benefit from active treatment of both conditions, many choose one form of treatment.

• Must modify different rules and regulations, creative psychopathy.
Serial treatment model

• Most common and weakest
Parallel treatment model

- But minimal coordination and little synthesis of approaches
Integrated treatment model

Very early stages of development when expanded to treat gambling in the typical dual disorder mix

Very little knowledge or data

Look to traditional dual disorder treatment models for guidelines
National Institute of Drug Abuse Model....Implications

- No single treatment is appropriate for all individuals
- Treatment needs to be readily available
- Effective treatment attends to multiple needs of individual
- Treatment must be assessed continually and modified
- Must stay in treatment for adequate time
Counseling and other behavioral therapies are critical.

Medications are an important element.

Dual disordered clients should have both treated in an integrated way.

Treatment does not need to be voluntary to be effective.

Possible drug use during treatment must be monitored continuously.

Recovery can be a long-term process with multiple episodes of treatment.
What are treatment principles?

Kenneth Minkoff, M.D.

- Welcoming
- Accessible
- Integrated
- Continuous
- Comprehensive
Treatment principles

- The most significant predictor of treatment success is presence of empathic, hopeful, continuous treatment relationship in which integrated treatment and coordination of care can take place through multiple episodes.
- Single clinician which follows client and who has skills and psychopharmacology access.
Treatment principles

- Co-occurrence is expectation, not exception
- Both diagnoses are primary and require simultaneous treatment
- Fit a Disease and Recovery Model
- No one type of dual diagnosis program
- Treatment depends on subtype of disorder, phase of recovery, severity, and motivation for treatment of each disease
Phases of Treatment

- **Phase I. Stabilization**
  - Stabilize acute condition and family
  - 4 weeks to 6 months

- **Phase II. Engagement**
  - Contemplation, Preparation, Persuasion
  - Motivational enhancement
  - Empathy, education, empathic confrontation
  - Admit powerlessness
Phases of Treatment

- Phase III. Prolonged stabilization
  - Active treatment
  - Maintenance
  - Relapse prevention

- Phase IV. Recovery
  - Ongoing
Barriers to Treatment

- Client resistance (or our poor understanding!)
- Treatment will be longer and more difficult
- Payment and reimbursement disparities
- Where are the programs?!
- Despite coexistence of problems, treatment and funding agencies are separate
- Poor knowledge if “other” condition is being treated
We could learn a lot from crayons: some are sharp, some are pretty, some are dull, some have weird names, and all are different colors but they all have to learn to live in the same box.