Review of the First Year of an Overseas Military Gambling Treatment Program

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This study provides descriptive information and preliminary first-year outcome data on the only overseas military gambling treatment option currently available. Implemented in January 2003 within the Substance Abuse Rehabilitation Program, U.S. Naval Hospital, Okinawa, Japan, gambling treatment was developed as a specific track within the overall substance abuse program. The present study explores the various considerations and requirements for setting up such a program, as well as a description of individuals seeking gambling treatment and preliminary outcome data. Participants consisted of all gambling referrals (N = 35, 26 males; mean age, 33.2 years; SD = 8.93) obtained over the first year that gambling services were offered. A significant degree of depression, suicidality, and substance abuse problems were observed in the sample. Results revealed that the gambling program was easily implemented within an established substance abuse program. The program was effective in preventing suicides in both military members and eligible beneficiaries and was effective in facilitating the retention of military members with gambling problems.

Introduction

Gambling is a popular and expanding pastime in the United States. In fact, Americans annually spend more money on legal forms of gambling than on movies, music, sporting events, theme parks, and video games combined.

Approximately 82% of adults gambled in some form in 2000 compared to 61% in 1975. In 1974, the rate of compulsive gamblers was estimated to be 0.7% of the U.S. population, whereas current estimates of problem and pathological gamblers have been found to range from 1.4% to 2.9% to 5.4% of the population in various parts of the country.

Prevalence of pathological gambling in the military overall is estimated to be approximately 1.2% (Air Force, 0.7%; Army and Marine Corps, 1.4%; and Navy, 1.5%).

Slot machines were initially placed in military clubs in the 1930s and 1940s but were removed from military facilities in the United States in 1951 as a result of the Anti-Slot Machine Act. However, slot machines remained in overseas military facilities and are currently present in at least eight countries on more than 100 military bases (K.G. Haas, unpublished observations). The relationship between the availability of slot machines on overseas military bases and the risk for developing a gambling problem continues to be debated. The fact that few treatment options exist for military personnel, their family members, and other Status of Forces Agreement personnel, however, is not disputed. Before the start of the present program in Okinawa, no formal overseas treatment options for pathological gambling existed. Indeed, within the military overall, only one facility offers a program for pathological gamblers, a residential treatment program at Camp Pendleton, California, which averages 34 referrals per year (G. Garibaldi and M. Catanzaro, personal communication).

Pathological gambling is a complex disorder that is frequently comorbid with other conditions such as substance abuse, affective disorders, and suicidality. With respect to substance abuse, it is estimated that as many as 50% of pathological gamblers meet the criteria for substance use disorders. Depression is also commonly reported in individuals diagnosed with pathological gambling and as many as 76% of gamblers in treatment may also have a depressive diagnosis. Some gamblers report gambling to counter depressive symptoms and others report becoming depressed subsequent to the consequences of gambling.

Although depression is a significant issue for this population, the risk of suicide is a more imminent one. Suicide is a serious concern in this population, which routinely experiences increased risk-taking behavior, severe financial problems, marital separation and divorce, job loss, legal problems, and comorbid affective and substance use disorders. High rates of suicidal ideation or previous suicide attempts have been reported throughout the gambling literature. In a 1999 study by Maccallum et al., 38% (N = 50) reported suicidal ideation related to gambling; 8% were considered actively suicidal and 4% reported a previous attempt. Maccallum and Blassczynski found that 36% (N = 85) of gambling subjects reported past or current suicidal ideation. Petry and Kluks noted that of 342 patients assessed at the time of intake into gambling treatment, 32% had experienced suicidal ideation and 17% had made a suicide attempt. A review of the literature by Petry and Amentano for the years 1984 to 1998 revealed that studies reported rates as high as 48% to 70% of pathological gamblers who experience suicidal ideation and 13% to 20% who actually attempt suicide. Data from the military treatment program in Camp Pendleton supports the above concerns about suicidality. Between 1999 and 2002, of 80 individuals seeking gambling treatment (70 males, 79 active duty, modal age, 30–39 years), 35 noted that they had considered suicide in relation to their gambling (G. Garibaldi and M. Catanzaro, personal communication).

Given the diagnostic complexity and comorbidity issues associated with pathological gambling, the establishment of an overseas program for forward-deployed operational personnel required significant planning. Multidisciplinary services invol-
ing family counselors, financial specialists, chaplains, and mental health providers, as well as the resources of Gambler’s Anonymous were needed to ensure effective program development. Critical components of the program development process included a needs assessment, consultation with subject matter experts, staff training and development, multidisciplinary treatment planning, and awareness training/marketing.

Needs Assessment

A needs assessment was conducted with regard to what services and additional training/resources would be required. Before implementation of the treatment program, one of the substance abuse counselors received training stateside in gambling treatment, during which time he also liaised with a consultant from Trimeridian, Inc. (Indianapolis, Indiana), an organization that provides education, research, and gambling treatment program materials, to determine resource requirements.

Careful consideration of available resources was done and it was determined that gambling treatment services were able to be offered within the Substance Abuse Rehabilitation Program. This was chosen because it has been reported in the literature that gambling treatment programs can be effectively established within a primary substance abuse agency and because pathological gambling is frequently seen in populations of substance abusers. In studies of veterans in treatment for substance abuse, 13% to 33% also met the criteria for pathological gambling.

The following services were provided: psychological evaluation, group counseling, individual counseling, patient and family education, hosting of Gambler’s Anonymous, and access to a 24/7 addiction crisis counselor. Other agencies in Okinawa already provided financial counseling, mental health treatment, and marital/family therapy, and these were used regularly to augment services.

Consultation

The program was fortunate that a consultant from Trimeridian, Inc. took interest in the fledgling program and offered her expertise. She had previous experience with members of the military via testifying at gambling-related court martial and had an established interest in promoting gambling treatment services in the military. Consultation among counselors, the clinical psychologist, and the consultant was conducted on a regular basis throughout the inception and implementation of the program.

Staff Training and Development

One of the largest hurdles to implementation of the program was appropriate staff training. Existing rehabilitation staff were well versed in the treatment of substance disorders but were not educated regarding gambling, which is classified as an impulse control disorder and presents unique treatment challenges. To train all staff, Trimeridian, Inc. provided 30 hours of gambling education (the amount required to meet the education requirement for certification) to the substance abuse counselors on Okinawa as well as to 40 other substance abuse professionals from Okinawa, mainland Japan, and Korea.

Treatment Planning

Because of the high level of comorbid disorders and suicidal behavior reported in the literature, it was determined that individuals calling or presenting for assistance with their gambling problem would be afforded an evaluation within 24 hours. In addition to a traditional psychological evaluation, each individual was given the South Oaks Gambling Screen (SOGS), the Alcohol Use Disorders Identification Test (AUDIT), and the Beck Depression Inventory-II (BDI-II), the Therapy Efficacy Monitoring Scale (J. Cook, J. Garza, and D. Jones, manuscript submitted for publication) (TEMS), and a suicide risk assessment. The SOGS is a short self-report instrument, taking approximately 5 minutes for patients to complete. It addresses types of gambling, amount of money gambled, chasing losses, familial gambling, lying about losses, self-perception of the existence (or not) of a problem, loss of control, impact on relationships, impact on work, and sources of income used to finance gambling. The SOGS uses a cutoff of 5 of out a possible 20 points as an indication of possible pathological gambling; with higher scores representing increased levels of severity of the gambling problem. It has been shown to be highly correlated with DSM-III-R criteria for pathological gambling (r = 0.94). A more recent study using the SOGS and DSM-IV criteria revealed a high hit rate (0.96), high sensitivity (0.99), sufficient specificity (0.75), and low false-positive (0.04) and false-negative rates (0.10) in a large N = 1,589 gambling treatment sample.

The TEMS is a 35-question Likert scale measure, whose scores can range from 0 to 180, with higher scores indicating greater pathology and distress. The TEMS assesses four content domains: (1) symptom presence and severity (e.g., levels of insomnia, panic attacks, worry, and sadness), (2) level of distress about symptoms and other key areas (e.g., physical health and future), (3) level of functional impairment in multiple roles (e.g., work performance and home life), and (4) health behaviors (i.e., positive coping skills such as exercise and talking to family and negative health behaviors such as smoking and drinking alcohol). The TEMS possesses adequate reliability and validity as a generic measure of outcome in mental health care.

Immediately following the initial evaluation with the psychologist, the attending counselor met with each patient individually and provided him/her with the 24/7 Duty Counselor pager number, his/her first homework assignment, the time and location of the weekly Gambler’s Anonymous (GA) meeting, and his/her first individual and group appointment and discussed in depth alternatives to gambling. Group therapy occurred after working hours one time per week for 12 weeks. GA occurred one time per week also after working hours. Individual sessions were scheduled for as often as needed, usually of high frequency in the beginning of treatment until the patient had made contact with other gamblers in treatment and/or GA. Homework was assigned weekly for the 12 designated weeks of treatment. Continuing care was provided as needed, in conjunction with encouraged attendance at GA.

Awareness Training/Marketing

In the early stages of the development of this treatment program, multiple efforts were made to heighten awareness in Okinawa about gambling in general, pathological gambling, and...
treatment/support resources. Marine Corps Community Services requested their Marketing Department to construct an informational video, which was aired six times per day for 1 month on a local channel. This 5-minute video reviewed the symptoms of pathological gambling and how to receive help. MCCS marketing also developed a small informational poster, which was framed and placed in each of the USMC base club slot machine rooms. The Armed Forces Network provided both radio and television news spots, and articles were printed in both Stars and Stripes and the Okinawa Marine. In addition, all of the Navy chaplains, substance abuse professionals, Marine Corps Substance Abuse Control Officers, Navy Drug and Alcohol Program Advisors, and mental health providers in Okinawa were provided with information about the treatment program.

Referral Process

Access to the treatment program was made available to all four services and all eligible beneficiaries on a self-referral basis.

Participants

Participants were all from the gambling referrals obtained over the first 12 months of available gambling treatment, i.e., from January 21, 2003 to January 20, 2004. During the first year of services, 35 individuals were referred. Of these, 26 were male, 25 were active duty, and the mean age was 33.2 years (SD = 8.93, Fig. 1). Of the active duty individuals, 9 were USN and 16 were USMC, with an average active duty time served of 10.3 years (SD = 8.1). Seven were spouses of active duty members and three were Department of Defense civilians. See Figure 2 for rank specific information. All individuals were self-referrals, although four individuals were strongly encouraged to refer themselves due to legal problems related to gambling.

Most patients endorsed playing slot machines as their primary form of gambling in Okinawa, with one endorsing playing dice and one exclusively gambling on-line. Five patients endorsed a significant time spent playing bingo in addition to slot machines. Of interest is that the local form of gambling, pachinko, was not endorsed by any patient as a preferred form of gambling. Seven individuals noted that their games of choice were casino games, which were not available in Okinawa so they substituted these preferences with slot machines. All patients who contacted the program for assistance met the criteria for pathological gambling.

Results

The average reported debt per person was $11,407.35 (SD = $17,746.26) and average reported losses were $24,154.41 (SD = $33,125.22). There was a significant correlation between SOGS and losses (r = 0.44, p = 0.011) but not between SOGS and debt. There was a significant correlation between age and debt, with older patients having significantly more debt (r = 0.44, p < 0.009). There was no significant correlation between age and reported losses.

Descriptive statistics were reviewed for frequency of suicidal behavior, depressive disorders, and substance abuse. Of the 35 patients, 7 (20%) endorsed suicidal ideation. Of these individuals, three had made recent serious suicide attempts in relation to gambling problems (i.e., financial, legal, occupational, and marital) and four were experiencing what was considered to be serious suicidal ideation. No patients attempted suicide or re-experienced suicidal ideation once treatment had begun.

The mean score on the SOGS was 10.53 (SD = 4.16). The mean score on the BDI-II was 14.24 (SD = 12.96) and nine individuals received depressive disorder diagnoses in addition to the pathological gambling diagnosis. The mean score on the Alcohol Use Disorders Identification Test was 7.15 (SD = 7.82), and 14 individuals received diagnoses of a substance use disorder. The mean TEMS score was 61.62 (SD = 29.89). When indicated, individuals received appropriate care for comorbid disorders in conjunction with gambling treatment. The test run on pre- and post-BDI-II and TEMS scores was not significant.

Of the active duty patients, 21 of 25 were retained in the military. Four received disciplinary action and discharge from the military related to illegal activities and gambling (i.e., writing bad checks and/or being charged with unauthorized absence). Of note is that these four individuals did not refer themselves until after legal proceedings began. Treatment was offered before their discharges but was not able to be used for potential retention. The remainder of the patients sought help before they became involved or overly involved in legal or occupational trouble and to date have been retained in the military.

Discussion

This study describes a new military gambling treatment program as well as provides the first published data on the demographics of gamblers seeking treatment in the military. The majority of individuals were relatively well established in their
military careers and averaged approximately 10 years of active duty service. These findings were similar to the findings at Camp Pendleton between 1999 and 2002, during which the modal length of service was 9 to 12 years for active duty patients (G. Garibaldi and M. Catanzaro, personal communication).

Levels of depression, suicidality, and substance abuse were similar to those reported in the United States. The program was highly successful in eliminating suicide attempts in the treatment population. Of the seven individuals who presented with active suicidal ideation, none experienced reoccurrence and none attempted suicide during or after treatment. This is hypothesized to be attributable to the installation of hope by providing support as well as a step-by-step plan to solve gambling-related problems.

An unexpected finding with regard to substance abuse is that of 370 individuals treated during this time period for substance abuse problems in Okinawa, only 2 met the criteria for pathological gambling. This is likely due to the young age of the majority of individuals referred for substance-related services in Okinawa (modal age, 19–22 years). Although chosen outcome measures (i.e., BDI-II and TEMS) did not show quantitative improvement, it is considered likely that this is because of the small sample size, and investigation will continue.

The program was easily implemented within the existing military substance abuse program. Training augmentation was required for the counselors and the psychologist but no additional billets were deemed necessary, and the existing addictions program already had many supports in place needed by the gamblers. Preliminary retention numbers were quite promising, with those individuals coming to treatment before too many legal problems had accumulated being retained.

One future direction for research includes further delineating differences between active duty and civilian patients. There is evidence in the U.S. population which suggests that availability of gambling increases the risk of the development of a gambling problem. In addition there is some indication that in environments in which women may feel lonely and alienated—which is frequent in overseas locations where family and established friends are not available and spouses are often deployed—there may be an increased risk of developing a gambling problem. Indeed, the second most frequent referral received was for female spouses (20%). Thus, one future direction for research includes more comprehensive prevalence studies within the active duty and dependent populations overseas.

Another important area of research is to evaluate the impact of limited confidentiality, which exists in military mental health treatment. Anecdotally, many patients, particularly high-ranking active duty and general schedule employees had significant concerns about their confidentiality. Some of these individuals opted to remain in pastoral counseling exclusively and some opted for GA. It is important when advertising such a program and doing awareness briefs that it is understood that gambling does not adhere to the same guidelines as a substance abuse problem, where for active duty members the command is always aware of attendance. There is no such directive for gamblers and as such any gambling program in the military is generally confidential. Research indicates that one of the major factors involved in individuals not seeking treatment earlier is because of shame and secrecy, and this would appear to be exacerbated in a military setting. It helped that the program in Okinawa held treatment after hours in civilian attire, yet fear of discovery was still evident from anecdotal information obtained from chaplains and established patients about individuals who would not come in for services.

Perhaps the most important research direction is to conduct long-term outcome studies, which follow people beyond their tours in Okinawa. Although individuals may be retained after 1 to 12 months of treatment, this may not be the case after longer periods of time. For example, 6 to 12 months after treatment in civilian programs, only 42% to 50% of individuals report abstinence from gambling.

Future directions for the clinical program at Substance Abuse Rehabilitation Program include an intensive outpatient program for gamblers. This will allow for individuals from mainland Japan, Korea, and the various deployed Navy commands to utilize gambling treatment services in Okinawa. The current 12-week outpatient program does not meet the needs of operational or nonlocal commands. This will require some restructuring of the substance abuse intensive outpatient program. The patients will need to be integrated due to the relatively low volume of gamblers seen in treatment in comparison to those referred for substance disorders. The other difficulty faced by highly operational and deployed commands is follow-up after the initial intensive treatment period. To address this, an Internet-based continuing care plan is under consideration.

Conclusions

Overall, the preliminary evidence shows significant utility for a gambling program overseas. The financial investment for training and materials and the initial time investment in setting up the program and providing staff training were manageable for the command. These initial investments were considered entirely worthwhile and cost-effective when considering the careers, families, and lives preserved. As is true in all research, this project raises more questions than it answers. Of particular interest to discover will be: Are military members able to remain abstinent and preserve their careers in the long-term? Is existing aftercare adequate and will distance-based efforts be effective? Is there a need to implement gambling treatment within the other Navy substance abuse programs?

References


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