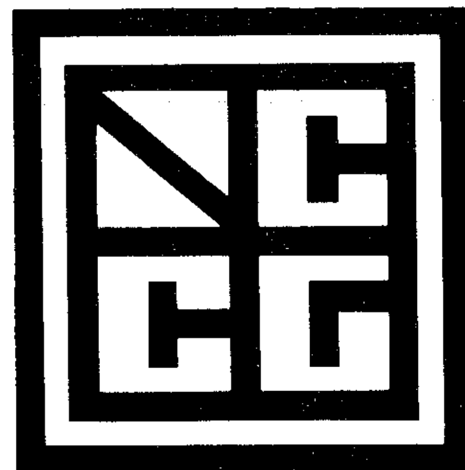
# JOURNAL OF GAMBLING BEHAVIOR

Sponsored by the National Council on Compulsive Gambling, Inc.

Volume 1
Issue 1
Spring/Summer 1985



ISSN 0742-0714
JGBE 1(1)1-75 (1985)

# Increasing Public Awareness of Pathological Gambling Behavior: A History of the National Council on Compulsive Gambling

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This article provides a history of the National Council on Compulsive Gambling. It includes a discussion of ambivalence toward gambling, the development of the disease concept, increased public participation and awareness of gambling, the enactment of state legislation, and public education strategies of the council.

## I. AMBIVALENCE—CONFUSION OVER THE USE AND ABUSE OF GAMBLING

In 1972, the Board of Trustees of Gamblers Anonymous in the New York City area requested their Spiritual Advisor, Monsignor Joseph A. Dunne, to establish a Council on Compulsive Gambling to do what they could not do because of anonymity—call national attention to the increasing problem of compulsive gambling in the United States. Unlike the National Council on Alcoholism, this organization would not have the benefit of Public Law 91-616, dated December 30, 1970, which authorized Federal monies in the amount of 40 million dollars to establish the National Institute of Alcohol Abuse and Alcoholism. The National Council on Compulsive Gambling, however, received support from members of Gamblers Anonymous, medical practitioners such as Dr. Robert L. Custer, pioneer of treatment services at Brecksville Veterans Administration Hospital, a few influential citizens, foundations, and a small paying membership. The goal of this Council would be education—making compulsive gambling known as a treatable illness; but this would take almost 10 years to accomplish.


*Journal of Gambling Behavior, Vol. 1(1), Spring/Summer 1985*
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The primary factors militating against the acceptance of compulsive gambling as a treatable illness would parallel the experience of practitioners in the field of alcoholism, namely, ambivalence on the part of Americans in general and health providers in particular as to the social impact of gambling. A study on the moral views of gambling was prepared by Raymond Bell for the Commission on the Review of the National Policy Toward Gambling (1976). In this study, the large majority of Protestant churches were seen to strongly oppose legalized gambling in any form, whereas Catholic Church leaders regarded gambling indifferently and as morally wrong only in its abuse. Jewish leaders fell somewhere between these views in condemning the abuse of gambling but allowing it for social purposes only (Bell, 1976).

The confusion in America over gambling and its implications was further complicated when proponents argued that the millions which were being poured into the coffers of organized crime could be diverted into legal gambling and used toward reducing taxes. The flaw in this argument would soon be apparent with the establishment of Off-Track Betting Offices in New York City in April 1971, making gambling available in every part of the city. A study done by the *New York Times* reported that rather than reduce the proceeds of local bookmakers, OTB would create a new generation of gamblers. Bookmakers actually increased their "take" from 40 percent to 60 percent in the subsequent year because of the tax of 5 percent on legal winnings, and the availability of credit, through illegal sources (*New York Times,* 1974).

Further rationalization of the social impact of gambling followed on the part of one state after another, creating the image that all was well since profits went for education and old-age assistance. This position put pressure on all state legislators across the country seeking an untapped resource for tax dollars.

The National Council on Compulsive Gambling was also confronted with a difficult education process directed at health providers and legislators in their perception of the compulsive gambler as a degenerate thief who gambled out of control as a result of greed, with total disregard for family, job, and community. The possibility that this individual suffered from a psychologically uncontrollable illness had not yet dawned on responsible leaders, family members, and the health professionals.

## II. THE DEVELOPMENT OF THE DISEASE CONCEPT

An essential factor that set the stage for the work of the National Council on Compulsive Gambling and the emergence of the disease concept was the founding of Gamblers Anonymous in 1957 in Los Angeles, California. A short time before, two men who were members of Alcoholics Anonymous were

being divorced by their respective wives in Reno as a result of their gambling. In desperation, they agreed that the 12 steps of recovery of Alcoholics Anonymous might also be applied to their gambling problem. They resolved to hold a new type of meeting when they returned to Los Angeles. This experiment was historic in that the identification of the gambling problem on the part of fellow sufferers ignited a spark of hope for more than 10 thousand compulsive gamblers in America. Within a few years, a spouses group in New York called Gam-Anon was also established for family members affected by the gambling problem. As Gamblers Anonymous and Gam-Anon developed in Cleveland, Ohio in 1972, some of their members were inspired to visit Dr. Robert L. Custer at the Veterans Administration Hospital and request his assistance in extending treatment programs geared for alcoholics to include compulsive gamblers as well.

It was fortuitous that in 1972 Dr. Robert L. Custer in Brecksville, Ohio and Monsignor Joseph A. Dunne in New York would establish programs for treatment and public education at the same time and thereby begin the process of gaining recognition of compulsive gambling as a public health problem. It would require eight years of activity before the definition adopted by the National Council and its Medical Director, Dr. Custer, would be accepted by the American Psychiatric Association in the Diagnostic Statistical Manual III—Disorders of Impulse Control, 312.31 "pathological gambling." In the meantime, important events would take place including a National Commission Study, the establishment of the National Foundation for the Study and Treatment of Pathological Gambling, Washington, D.C. in 1980, and a continuing program of public education on the part of the National Council via public and private funds.

## III. INCREASED PUBLIC AWARENESS

As concern for legalized gambling mounted across the country a standing commission of the federal government titled, "The Commission on the Review of the National Policy Toward Gambling," was empowered to study gambling in America. It worked diligently at this task from 1973 to 1976. All aspects of gambling were to be examined, including federal, state, and local gambling enforcement and legal and illegal gambling industries.

Personal interviews were conducted by the Survey Research Center of the University of Michigan in December 1975. A total of 1,736 interviews were completed for the national sample which was designed so that there was a high percentage of males and major city residents, thus insuring that data would be collected on bettors. In addition to the major sample, a special sample of 300 respondents was drawn from the three major urban areas of Nevada. To the surprise of researchers, some 61 percent of adults par-

ticipated in some form of gambling in 1974, and 68 percent reported having participated in some form during their lifetime. About 13 percent only placed social bets with friends, leaving 48 percent who participated in some form of legal or illegal gambling. Eleven percent of the population (15.5 million adults) participated in some form of illegal gambling. Nevada residents, having access to many forms of gambling, recorded a higher percentage of participation and a higher rate of addiction (Kallick, Suits, Dielman, & Hybels, 1979).

Estimates of the numbers of compulsive gamblers in the United States at this time varied from 6 to 9 million, as claimed by Gamblers Anonymous, to the analysis made by the National Commission, which estimated 1.1 million compulsive gamblers in the nation. In the Nevada sample, the incidence of compulsive gambling was approximately three times higher than in the national sample, thereby validating the conclusion of the Commission that availability was the key to increased incidence of addiction. The need for the National Council on Compulsive Gambling therefore was now evident, and public education leading to programs of training, treatment, and research was now a necessity. Truly, this was an organization whose time had come (Commission, 1976).

## IV. THE ENACTMENT OF STATE LEGISLATION

The significance of the Hughes Bill-Public Law 91-616, which established the National Institute of Alcohol Abuse and Alcoholism and authorized comprehensive health, education, training, and research programs for the treatment of alcohol abuse and rehabilitation of alcoholics, was not to be ignored in the field of compulsive gambling. The importance of legislation lies in the fact that each state must sooner or later recognize gambling as risk-taking behavior and authorize money for treatment for the victims of public policy. The point of departure between the states' reaction to alcohol legislation and gambling legislation is that while they may have legalized the sale of alcoholic beverages, they do not promote drinking, while on the other hand, to date, some 47 states plus the District of Columbia not only have legalized gambling but also promote what is considered the risk-taking behavior it can involve, with an eye to its own financial returns. The National Council, while neither favoring nor opposing legalized gambling, takes the position that states that legalize gambling have a responsibility to fund treatment programs.

To meet the growing impact of gambling in America, the National Council on Compulsive Gambling was incorporated as a nonprofit organization in 1975, producing nationwide media programs, literature, and a quarterly newsletter, with the help of a dedicated voluntary staff.

Appearing before the Legislature of the State of Maryland in May 1978, representatives of the National Council successfully supported House Bill 1311 in which Maryland became the first state to recognize that (1) "compulsive gambling is a serious social problem," (2) "availability of gambling increases the risk of becoming a compulsive gambler," and (3) "Maryland with its extensive legalized gambling has an obligation to provide a program of treatment for those who become addicted to gambling to the extent that it seriously disrupts lives and families." This bill authorized the funds to support the first treatment center for compulsive gamblers in association with Johns Hopkins University Hospital.

Connecticut followed in May of 1981 with a similar recognition of the need for treatment and rehabilitation of compulsive gamblers, establishing a pilot program which would be funded by the imposition of fees on jai alai and dog track racing, licenses, admissions to tele-track performances, and fees from corporations providing equipment and services.

New York, in October 1981, also passed legislation recognizing compulsive gambling as a treatable illness and authorized the Office of Mental Health the sum of $200,000 for education/prevention, treatment, training, and research. Two outpatient treatment programs were established in the state. This legislation was renewed in 1982 and has been increased $500,000 for the present session.

Following the opening of casinos in Atlantic City and a state lottery and daily number betting, Assemblyman Chuck Hardwick spearheaded the focus of legislative attention to the needs for state funds for compulsive gambling programs. Governor Thomas Kean of New Jersey approved funds to set up a Council on Compulsive Gambling in New Jersey as an affiliate of the National Council on January 1, 1983. This program operates under the Division of Alcoholism with a yearly contract and a budget of $110,000 and is designed to meet the statewide needs for education and to afford training to health providers, educators, and the criminal justice system. The New Jersey number for assistance is 800-GAMBLER. In 1984, this concern was now manifested further in the establishment of a treatment program for compulsive gamblers and their families at the John F. Kennedy Hospital in Edison, New Jersey.

The impact of gambling in New Jersey has also been seen in the number and attendance at Gamblers Anonymous meetings. The increased availability of gambling there has now more than trebled the number of Gamblers Anonymous meetings. Here, therefore, an observer can see the relation between availability and increased incidence of problem gamblers.

## V. PUBLIC EDUCATION STRATEGIES OF THE NATIONAL COUNCIL

From studies done analyzing the demographics of members of Gamblers Anonymous and Gam-Anon at their national conferences[2] (Lorenz & Shuttlesworth, 1983), it has been established that the majority of recovering gamblers obtained effective assistance not through their own efforts but rather as a result of the persistent and individual efforts on the part of spouses and family members. Apparently, the active gambler, in the state of denial and euphoria while gambling, is neither capable of nor interested in seeking help for himself or herself. The National Council, therefore, designs its public appeals with the spouse as a primary target—featuring a well-known personality of television and a phone number to be called. Printed matter such as brochures, newsletters, and newspaper columns, e.g., Ann Landers Column, etc., illustrate the Council, providing its address and phone number for the convenience of those who are concerned with the gambling problem across the country.

A second important group to be utilized is the network of Employee Assistance Programs, which use a broad approach to employee problems, namely, alcoholism and drug, marriage, and gambling problems. Here, gambling, the so-called "invisible illness," can be identified in connection with poor job performance and the client can be successfully referred on the basis of lack of productivity, lateness, absenteeism, and the presence of tension among fellow employees caused by the gambler's borrowing from them to pay gambling debts.

Communitywide education/prevention programs, however, have only begun to attract the interest of professionals in health care and education to the existence of the impact of gambling in the family structure. In New York City, it has been documented that only 4 percent of the public agencies asked about gambling in relationship to family disruption at the time of the in-take procedure (Grodsky & Kogan, 1976). In 1982, the National Council distributed information, brochures, and questionnaires to all community mental health centers in the State of New York. Less than 2 percent responded and few were aware of Gamblers Anonymous meetings as a referral source. Thus, in view of this experience and of limited funding, the National Council places its highest priority on the effective use of television, public service time, billboards, posters, and a wide distribution of printed brochures, newsletters, newspaper and magazine articles, and a dedicated effort to

replicate its activities locally with affiliate organizations. Presently, we do have such affiliate Councils in New Jersey, Connecticut, Massachusetts, and Pennsylvania.

There is a growing need, however, to reach two special at-risk populations—women and minorities. Historically, these two groups have been slow to respond to treatment and health care facilities, e.g., alcoholism facilities. With a greater degree of freedom in our society and the availability of credit, women are now seen to be participating in gambling activities in growing numbers. It may thus be hypothesised that there are an increasing number of compulsive gamblers among women, as is evidenced by reports of fraud and embezzlement of funds of banks and employers. Very few females, however, are seen in treatment centers and at meetings of Gamblers Anonymous.

There has also been slow recognition on the part of minorities, Blacks, Hispanics, Chinese, or Indians, to the therapy offered at Gamblers Anonymous and Gam-Anon. Cultural differences, sociological aspects, and peer involvement must be addressed in our out-reach, design, and staffing patterns, in order to attract minorities. The one exception is seen at Gamblers Anonymous groups in prisons, where all and sundry mix in an isolated yet pressurized and desperate environment. Our efforts, however, to establish new Gamblers Anonymous groups in prisons have met with shocking resistance on the part of authorities including mental health professionals. They seem to reject the suggestion that the identification of compulsive gambling and the utilization of Gamblers Anonymous meetings might serve to reduce the recidivism in prison populations (Martinez, 1983, pp. 134-143).

## VI. MEASURING THE IMPACT OF GAMBLING IN AMERICA

While legalized gambling has now been adopted by a majority of states in America, the estimate of the incidence of compulsive gambling, namely, 1.1 million, established by the National Commission in 1976, is clearly invalid today. Since that date, another study on incidence and prevalence was done in November of 1977 in Connecticut by Mark Abrahamson, Professor of Sociology, and John N. Wright, Research Associate, University of Connecticut, Storrs, Connecticut. This study indicated a slightly larger ratio of the population—almost 2 percent—who were found to be probable compulsive gamblers.[1] In 1979, Rickey Greene, an employee of the Office of Mental Health, did a survey in New Jersey which indicated that there was an increased number of compulsive gamblers in that State reaching a total of 350,000.[3] In the past, studies on the incidence and prevalence of compulsive gambling have suffered one basic flaw, namely, a lack of a measure to iden-

tify compulsive gambling. With the publication of the DSM III identifying "pathological gambling," 312.31, we feel that now criteria are available to enable researchers to do a more satisfactory job measuring the impact of gambling in America.

Therefore, if we accept the figure of 2 percent as an estimate of compulsive adult gamblers, especially in those states where legalized gambling is widespread, then the national figure rises to 2 to 3 million probable compulsive gamblers. Further, when we add to this estimate the fact that each compulsive gambler affects the life of 10 to 20 relatives, friends, and fellow workers, we have 20 to 30 million people who are an at-risk population, as gambling becomes more widely utilized and offered as public policy, usually without accompanying treatment programs in response to risk-taking behavior.

## CONCLUSION

All signs and symptoms outlined above point to an increasing national health problem requiring the attention of government at the federal level once again. It is hoped that Congress will set up some controls based upon a national review of incidence and prevalence, tighter regulations on the Gaming Industry, and funding sources for comprehensive education, prevention, training, treatment, and research, similar to those for which the Hughes Bill provides. History does repeat itself and the National Council on Compulsive Gambling was there.

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