

**Clinical Care of Gambling Disorders:
Training, Experience, and Competence Among
VHA Psychologists**

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Problem gambling is a common, highly destructive disorder which is often overlooked by clinicians. Levels of clinical training, clinical experience, and professional competence for providing clinical services for problem gambling were examined in a survey

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of 181 clinical psychologists working in the Veterans Healthcare Administration (VHA). The results suggest that the majority of clinical psychologists have little or no formal training and little or no past or current clinical experience in the treatment of disordered gambling, nor do they see themselves as competent to evaluate or treat patients with disordered gambling. Most have not referred patients for treatment of problem gambling and do not know of a competent provider to whom they can refer. There is an identifiable subgroup, representing 9% of respondents, who do have more training, provide services, and see themselves as competent to provide care for patients with problem gambling. The amount of formal training is positively correlated with care provided and self-ratings of competence. Despite the lack of training and experience, most respondents expressed interest in receiving additional training. These data suggest that to improve rates of diagnosis and treatment of patients with problem gambling in mental health settings, additional training needs to be made available for mental health providers as a group, with specialized training for clinicians interested in specializing in this area.

KEY WORDS: pathological gambling; training; treatment.

Problem gambling is a destructive and costly disorder (Federman et al., 1998). Problem gamblers are at increased risk for depression (Becona, Del Carmen, & Fuentes, 1996), antisocial behavior (Blaszczynski, McConaghy, & Frankova, 1989), psychiatric hospitalization (Federman et al. 1998), and suicide (Lester, 1994; Phillips, Welty, & Smith, 1997). The impact on family members is also dramatic, with increased risk of mental health problems and suicide attempts among both spouses and children of problem gamblers (Lorenz & Shuttlesworth, 1983; Jacobs, 1989). Finally, there are very substantial costs to society, in terms of health care, lost work, and increased crime (Lesieur & Puig, 1987).

Among people who have contact with mental health professionals through treatment for psychiatric or substance abuse problems, the lifetime prevalence of disordered gambling approximately 29% (Shaffer, Hall, & Vander Bilt, 1997). Our prior work has shown that despite this high rate of problem gambling in mental health populations, (1) individual clinicians rarely identify problem gambling until it is severe, and (2) a small proportion of mental health agencies screen for this disorder (Federman et al., 1998). Fewer than two percent of patients at a Veterans Affairs Medical Center who were problem or pathological gamblers had a gambling problem or diagnosis of Pathological Gambling recorded in their medical records (Federman et al., 1998). In addition, the results of a pilot survey of facilities providing mental

health and substance abuse services found that only 10% of 30 facilities routinely screened for problem gambling (Federman et al., 1998).

This failure to recognize and treat disordered gambling until late in the disorder imposes increased costs on the gambler, their family, and society (Ladoucer, Pepen et al., 1994). A number of factors likely contribute to the under-diagnosis and failure to treat gambling problems, including the nature of the disorder, insufficient clinician training and practice, and ignorance of gamblers and their families regarding gambling and treatment options. The current study focuses on clinician training and practice in order to understand at least part of the apparent pattern of under-diagnosis and treatment.

Little is known about the training clinicians have received regarding gambling. Pathological gambling was included in the DSM-III in 1980 and has received increasing attention in the clinical, research, and popular press. There are reports of a corresponding increase in the availability of clinical services for gambling and qualified clinicians offering those services (Forman, 1999), but this has not been well documented. It is not clear what training the average clinician or mental health professional receives regarding problem gambling and how that training is related to their current practice. Infrequent diagnosis and poor evaluations may be due to the lack of training. The patterns of specialization and referral which develop around clinical populations are not well understood for problem gambling. For example, there are no data to indicate what percentage of clinicians (1) see their work including services for problem gambling and (2) refer patients for gambling problems.

Using a survey of clinical psychologists working within one of the largest mental health providers, the Veterans Health Care Administration (VHA), we have sought to test the following hypotheses:

1. Most clinical psychologists have received little or no formal training about problem gambling, have little or no past or current clinical experience with patients with problem gambling, and do not see themselves as competent to evaluate or treat patients with problem gambling.
2. Most psychologists have not referred patients for treatment of problem gambling and do not know of a competent provider to whom they can refer.

3. There is an identifiable subgroup of psychologists who are providing clinical services to a significant number of patients with problem gambling and who see this as part of their clinical practice. They have received significantly more formal training about problem gambling than other psychologists.
4. The amount of training a psychologist receives in providing services for problem gambling is positively correlated with the amount of clinical experience and current practice they report, as well their sense of competence to provide services to patients with problem gambling.
5. Given the growing awareness of problem gambling, more recent graduates will have greater graduate training, clinical experience, current practice, and competence in providing clinical services to this population than those who graduated years ago.
6. Most psychologists are interested and willing to receive additional training in the clinical care of problem gambling.

METHOD

This study surveys the training, clinical experience, and self-reported competence of a single professional group—clinical psychologists—within the VHA, the largest single mental health service provider in the United States and one of the largest employers of clinical psychologists in the world. Psychologists were chosen because they are among the mental health professionals who receive the most formal education in mental health issues. Most graduate clinical psychology programs are four to six years in length, including at least one year of full-time internship, with many psychologists completing post-doctoral fellowship training or other post-doctoral experience before licensure. To maintain their licensure, most psychologists are required to earn 10–20 hours of continuing education credits each year, with VHA psychologists required to complete 40 hours of continuing education each year. Therefore, psychologists are likely to have as much if not more formal training than other mental health professionals in the clinical care of problem gambling.

Survey Procedure

A 50-item survey assessing practitioner training, clinical experience, and self-report of competence in assessing and treating problem gambling was developed and distributed to the 400 clinical psychologists practicing in the VHA with addresses on Forum, the VHA intranet service. The sample with Forum addresses was selected due to ease of contact and because they represent mental health providers distributed across the United States.

The survey was sent to the 400 psychologists, along with a letter explaining the study. The questionnaire was anonymous. Thirty days after the first mailing, a second copy of the questionnaire along with a second letter was sent to all 400 psychologists again, asking those who had not completed it to do so. All questionnaires were received within 120 days of the initial mailing.

Sample

One hundred and eighty one questionnaires were returned. All were useable, resulting in a response rate of 45%. Table 1 summarizes the demographic and work characteristics of the sample and the characteristics of the patients with whom they work. The sample was composed of 113 males and 68 females. The mean time since obtaining their Ph.D. in psychology was nine years, with a range of one to 37 years. Ninety-eight percent of the sample was currently working at least part time in a clinical setting, with 56% working in an inpatient setting and 94% working in an outpatient setting. The mean age of respondents was 74 (S.D. = 8.5). Ninety-five percent worked at least 40 hours per week, mostly in outpatient clinical settings. Their clients were primarily middle-aged males with relatively low incomes, well distributed between urban, suburban, and rural settings. This appears to be fairly representative of the VHA mental health sample as represented by VHA statistics (Rosenheck & DiLella, 1999).

The Survey

The survey was developed specifically for this study to document clinician training and practice with respect to problem gambling. Initial items were reviewed by three clinical psychologists and two psychi-

Table 1
Background Characteristics of the Sample

<i>Variable</i>	<i>Mean/Percentage</i>	<i>S.D.</i>
Age	47.2	8.5
Gender		
Male	38%	
Female	62%	
Highest Degree		
Doctorate		
Master's		
Years since received highest degree	16	9.2
Specialty area		
Clinical Psychology	61%	
Addictions	6%	
Neuropsychology	8%	
Geropsychology	5%	
Rehabilitation/Vocational	8%	
Health	6%	
Administration	1%	
Missing	6%	
Average number of hours worked per week	44.3	7.1
Average number of hours spending direct clinical care	24.4	11.8
Average number of patients seen per week	29.5	20.2
Percentage of clients seen outside of the VHA	7%	20
Distribution of clients by clinical setting		
In-patient	23%	33%
Out-patient	25%	33%
Age distribution of current client		
21-40	23%	19%
41-60	55%	22%
61-80	20%	21%
81+	2%	4%
Annual income distribution of current clients		
<\$10,000	35%	31%
\$10,000 to \$24,000	44%	27%

Table 1 (Continued)

<i>Variable</i>	<i>Mean/Percentage</i>	<i>S.D.</i>
\$25,000 to \$50,000	16%	18%
>\$50,000	2%	4%
Distribution of clients by regional setting (urban, rural, suburban)		
Urban	46%	28%
Rural	32%	29%
Suburban	22%	21%
Percentage of female clients	14%	19%
Percentage of non-Caucasian clients	33%	23%

atrists who work with patients with gambling problems. The questionnaire was revised and then pretested on 20 mental health professionals. Their feedback on the items was then incorporated in the final version.

The final questionnaire has four sections. The first section contains 16 items about the respondents' background and demographics, current clinical work, and characteristics of their patient populations. The second section includes ten questions about the respondents' formal education and training, as well as other reading or educational activities with respect to problem gambling. Formal training is divided into four types, including graduate training, internship, post-graduate training, and continuing education. Other educational activities include journal articles read, professional books or book chapters read, non-journal articles read, consultation with colleagues, workshops attended, or material seen through the mass media. Ten equivalent questions are asked about education and clinical training for substance abuse.

The third section has six questions about prior clinical experience with problem gambling. Respondents are asked to record the number of patients seen in the following categories: patients seen in graduate training known to have significant gambling problems, patients seen in clinical practice (post-graduation) with a gambling problem, patients who initiated contact specifically looking for help with a gambling problem, patients evaluated for gambling problems, patients treated for gambling problems, and patients they had referred for treatment of gambling problems.

The final section consists of eight Likert scale items regarding current clinical practice with problem gamblers and self-perceived competence to assess, treat, and refer clients with problem gambling. Respondents are also asked to rate their willingness to receive additional professional training regarding problem gambling, to read articles given to them, and to attend a professional seminar on problem gambling. (The questionnaire items can be found in the appendix.)

Analyses

To test hypotheses 1 and 2, descriptive statistics summarizing training received, past and current clinical experience, self ratings of competence, rates of referral and knowledge of competent providers to refer to were examined.

To test hypothesis 3, we utilized a combination of variables to define the subgroup of respondents who are providing services for gamblers and who see this as part of their current practice. We chose to liberally define this subgroup of “specialists” as any psychologist who had either treated or evaluated ten or more patients, reported that either treating or evaluating patients was part of their current practice, and described themselves as competent to either treat or evaluate patients for problem gambling. This subgroup was compared to the remainder of the sample with respect to demographic and current practice variables using t-tests with Bonferroni’s correction for multiple comparisons.

To test hypothesis four, the amount of training received was correlated with the number of clinical cases seen, clinician report of whether they considered treatment or evaluation of problem gambling as part of their current practice, and whether they felt competent to treat or evaluate patients. T-tests with Bonferroni’s correction were performed on all correlations.

To test hypothesis five, the number of years since graduation was correlated with the formal training, current practice, and self rated competence. To test hypothesis six, descriptive statistics summarizing interest in receiving additional training were examined.

RESULTS

Strong support is found for hypothesis one. Tables 2 and 3 summarize responses to the formal education and training items regarding

Table 2
Formal Training—Problem Gambling (PG) vs. Substance Abuse (SA)

<i>Amount of Training Received</i>	<i>Graduate School</i>		<i>Internship</i>		<i>Post-Graduate Training</i>		<i>Continuing Education</i>	
	<i>PG</i>	<i>SA</i>	<i>PG</i>	<i>SA</i>	<i>PG</i>	<i>SA</i>	<i>PG</i>	<i>SA</i>
None	62%	12%	63%	7%	64%	23%	44%	5%
Brief mention in a class or seminar on an unrelated topic	16%	3%	14%	4%	7%	1%	11%	4%
Some reading or lecture in a class or seminar on an unrelated topic	9%	23%	9%	13%	7%	10%	11%	8%
Some reading or lecture in a class on addictions	10%	32%	10%	34%	16%	30%	15%	31%
A seminar, class, or lecture specifically about problem gambling	2%	16%	2%	14%	4%	11%	12%	12%
More than one class or seminar specifically about problem gambling	0%	14%	2%	23%	2%	2%	7%	40%

Table 3
Additional Sources of Training—Problem Gambling
vs. Substance Abuse

	<i>Problem Gambling</i>		<i>Substance Abuse</i>	
	<i>M</i>	<i>(SD)</i>	<i>M</i>	<i>(SD)</i>
1. Number of workshops attended**	0.6	(2.0)	10.3	(19.6)
2. Number of journal articles read**	3.6	(8.4)	42.3	(74.8)
3. Number of professional books/chapters read**	1.9	(5.3)	21.3	(31.3)
4. Number of non-journal articles read**	3.7	(8.5)	22.5	(49.1)
5. Number of times consulted with a colleague*	3.9	(8.7)	65.3	(134.4)
6. Number of times watched something through mass media*	5.0	(10.9)	25.8	(39.3)

* $p < .05$.

** $p < .0001$

both problem gambling and substance abuse. In general, little or no formal training about problem gambling had been received regardless of the type of training. Twenty-eight percent of the sample reported no formal training in any of the four formal settings and 45% reported no more than a brief mention in any of the four settings. Only 20% had at least one or more lectures specifically about problem gambling in any setting. Rates of training for problem gambling and substance abuse were compared using t-tests with Bonferroni's correction for multiple comparisons. Significant differences were noted for all training variables, with higher amounts of training in substance abuse than problem gambling for every variable ($p < .001$).

Table 4 summarizes the clinical experiences of the sample. The distributions of responses for all items in Table 4 are skewed toward the "no clinical experience" response. For example, while a mean of 12.6 patients known to have a gambling problem were seen in clinical practice, 22% of respondents reported never having seen a patient with a gambling problem and 72% reported having seen fewer than ten cases.

Table 4
Clinical Experience with Problem Gambling

<i>Item</i>	<i>Mean</i>	<i>SD</i>
A. Number of patients seen in graduate training known to have a significant gambling problem	3.2	10.9
B. Number of patients seen in clinical practice (post-training) known to have a gambling problem	12.6	24.6
C. Number of patients who initiated clinical contact for a gambling problem	3.1	13.5
D. Number of patients evaluated for gambling problems	10.2	50.0
E. Number of patients treated for gambling problems	3.8	15.1
F. Number of patients referred specifically for treatment of a gambling problem	4.0	17.5
G. Number of non-patients known to respondent who had problems related to gambling	5.0	11.9

The majority of psychologists reported that clinical care of patients with problem gambling was not part of their current clinical work (see Table 5). Fewer psychologists reported that treating patients with problem gambling was part of their clinical practice (13%), as opposed to evaluating patients with problem gambling (19%). Approximately one-third of the respondents felt competent to evaluate a patient with problem gambling, while only 15% felt competent to treat a patient with problem gambling.

Hypothesis two is also well supported. Fifty-six percent of all respondents had never referred a patient with a gambling problem for treatment and 94% had referred no more than 10 patients. Sixty-four percent reported that they do not know an appropriate provider to whom they could refer patients.

Hypothesis three is supported, suggesting that there is a subgroup of psychologists who are relatively well trained and active in providing care for this group. Seventeen respondents, or nine percent of the sample, met criteria for "specialist." When compared to the remainder of the sample, no significant differences were found on any demographic or current practice variables. Table 6 summarizes the differences in training and experience between the two groups. As ex-

Table 5
Responses—Current Practice, Competence, and Interest in Additional Training (5-point Likert Scale)

<i>Item</i>	<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Agree</i>
A. I feel competent to evaluate patients for problem gambling	13%	34%	21%	26%	6%
B. I feel competent to treat patients for problem gambling	20%	41%	24%	12%	3%
C. I know an appropriate provider who is competent to treat patients with problem gambling to whom I would refer patients	14%	37%	13%	24%	12%
D. Treating problem gambling is part of my current work	38%	38%	11%	11%	2%
E. Evaluating for problem gambling is part of my current work	31%	28%	21%	15%	4%
F. I am interested in receiving more training regarding problem gambling	4%	14%	32%	41%	8%
G. I would attend a professional seminar on problem gambling	4%	13%	28%	46%	9%
H. I would read some professional articles on problem gambling if they were given to me	2%	3%	11%	69%	14%

Table 6
Training, Experience, and Competence—High vs. Low
Frequency Providers

	<i>Low</i>		<i>High</i>	
	<i>Frequency</i>		<i>Frequency</i>	
	<i>%/M</i>	<i>(SD)</i>	<i>%/M</i>	<i>(SD)</i>
1. Attended at least one seminar, class or lecture specifically about problem gambling in:				
A. Graduate School*	1%		18%	
B. Internship*	3%		18%	
C. Post-Graduate Training*	5%		19%	
D. Continuing Education*	16%		53%	
2. Number of workshops attended*	0.5	(1.9)	1.4	(2.5)
3. Number of journal articles read*	2.7	(3.7)	12.0	(23.2)
4. Number of professional books/ chapters read*	1.6	(3.9)	4.6	(11.8)
5. Number of non-journal articles read*	3.1	(3.8)	9.7	(23.8)
6. Number of times consulted with colleagues*	3.2	(7.0)	11.3	(16.4)
7. Number of times watched some- thing in the mass media*	4.3	(10.2)	10.9	(15.3)
8. Number of patients seeing in graduate known to have a signifi- cant gambling problem*	2.7	(10.4)	7.6	(14.6)
9. Number of patients seen in a clinical setting (post-training)*	8.7	(20.2)	47.6	(32.6)
10. Number of patients who initiated contact for a gambling problem*	1.3	(3.1)	19.3	(39.0)
11. Number of patients evaluated*	2.6	(9.5)	79.3	(134.5)
12. Number of patients treated*	1.7	(6.6)	23.2	(40.3)
13. Number of patients referred*	2.1	(8.3)	21.5	(47.9)
14. Percent who know a provider to refer to*	32%		76%	
15. Percent interested in more training	48%		65%	

* $p < .001$.

Table 7
Correlations Between Problem Gambling Training and Clinical Experience, Current Practice, and Competence

	<i>Grad School</i>	<i>Internship</i>	<i>Post-Grad</i>	<i>CE</i>
<i>Clinical Experience</i>				
# patients seen with a gambling problem, post-graduate	.11	.35*	.36*	.46*
# patients seen, gambling was the focus of treatment	.22	.26	.31*	.29*
# patients evaluated for gambling problems	.19	.22	.21	.34*
# patients treated for gambling problems	.48*	.40*	.43*	.30*
<i>Current Practice</i>				
treating for problem gambling is part of my current practice	.24	.32*	.39*	.48*
evaluating for problem gambling is part of my current practice	.18	.26	.39*	.56*
<i>Self-Rated Competence</i>				
I feel competent to evaluate patients for problem gambling	.21	.30	.40*	.55*
I feel competent to treat patients for problem gambling	.27	.22	.37*	.46*

* $p < .01$.

pected, the group who had seen more than ten patients with problem gambling had significantly greater education in every setting, and had greater past clinical training experience. Their interest in receiving additional training was not significantly higher.

Hypothesis four is also well supported by these findings. All correlations between the amount of training received and the number of clinical cases seen, clinician report of whether they considered treatment or evaluation of problem gambling as part of their current practice, and whether they felt competent to treat or evaluate patients were positive and in the small to moderate range (see Table 7). Post-graduate training and training in continuing education settings were significantly related to clinical experience, current practice, and competence, while graduate school training was significantly related only to the number of patients treated for problem gambling.

No support was found for hypothesis five, that recent graduates had received greater formal training in problem gambling. The correlations between the number of years since graduation and formal training, current practice, and self rated competence ranged between $-.07$ and $.13$ and were not statistically significant.

Support was found for hypothesis six. Respondents' attitudes to-

ward receiving additional training can be seen in Table 5. About one half of the sample reported that they would be interested in receiving more training while 18% indicated that they would not be interested, and one third had no opinion. Moderate correlations are noted between attitude toward receiving additional training and current practice, suggesting that those who report working with patients with problem gambling are the most interested in additional training.

DISCUSSION

These data suggest that psychologists are inadequately trained to identify, evaluate or provide care for, or to refer the large number of mental health clients with co-morbid problem gambling. There is evidence that a pool of competent specialists is present. This subgroup is small, representing about 9% of the sample, though it may not be unreasonable small for a group of clinicians with a clinical specialty. The mean number of cases seen by this group is less than 50, suggesting that it is unlikely that this small group could be providing the needed care for the number of mental health patients with gambling problems. This group is not well known to potential referral sources, with almost two thirds of respondents reporting that they do not know an appropriate provider to refer to.

The low rates of training, current practice and referral raise concerns that a lack of knowledge and competence among practitioners is significantly limiting treatment for problem gamblers. Given these findings, it is likely that a motivated patient seeking treatment may have significant difficulty finding a competent provider, while a client with an undiagnosed gambling problem may not be identified. Other factors, such as low rates of help seeking by problem gamblers and their family members likely contribute to the low rate of experience among clinicians. If this is the case, as the general public learns more about problem gambling and its treatment, there will likely be a substantial increase in the number of patients seeking services, with the number of competent practitioners hopefully increasing to meet the demand. However, without specific efforts to increase training, including both basic training for all clinicians and more extensive training for specialists, the gap between the need for competent practitioners and the number of available providers will likely continue.

If additional opportunities for training are made available, the current data suggest that clinicians will take advantage of them, particularly those who have had at least some clinical experience with patients known to have gambling problems. The most widely used approach both for the basic training of all clinicians and for training of specialists appears to be continuing education. This format is relatively inexpensive to provide and is most closely related to clinician's practice and sense of competence to provide care. The use of informal approaches to training, such as independent reading, peer consultation, and education through the general media are also related to practice and self-reported competence, suggesting that clinicians are training themselves to provide care. In graduate school and internship settings, training regarding problem gambling is particularly low, and has not shown a significant increase over time.

Lack of clinician motivation to obtain training is an important factor. A full 50% of the sample did not express interest in receiving more training. This group tends to report little contact with patients with gambling problems and to express little confidence in their ability to assess problem gambling. While it is possible that these clinicians actually see few patients with gambling problems, it is more likely that they see problem gamblers but do not recognize the problem and so feel no need to gain additional training. Motivating this group to recognize the undiagnosed patient may be particularly important to increase the rate of diagnosis and referral for treatment.

To improve the preparedness of clinicians for meeting the clinical needs of clients with problem gambling, we make six proposals:

1. Training programs, including academic, practica, internship, post-doctoral and continuing education programs, should include at a minimum, identification of problem gambling and basic knowledge about treatment and referral resources.
2. Diagnostic and treatment questions should be routinely included on licensing exams.
3. Specialty training programs should be more readily available. Funding for internship stipends and training stipends targeting specialty programs in problem gambling would increase the number and geographical diversity of such programs (Forman, 1999).

4. Clinical centers should use simple screening items to identify clients with gambling problems. The use of one to three item screening instruments has been shown to effectively identify the majority of problem gamblers (Johnson, Hamer & Nora, 1998). The regular inclusion of these items into intake evaluations would force the 'raising of consciousness' among clinicians, while initiating treatment and referral for a large number of undiagnosed problem gamblers.
5. Clinical and research centers should develop integrated treatment programs for those with gambling problems and other psychiatric disorders. After all, most problem gamblers are dually diagnosed and more than one in four individuals with psychiatric or substance abuse disorders will have gambling problems during their lifetime.
6. Increase funding for clinical research into treatment approaches to problem gambling. The development of empirically validated treatment protocols will speed dissemination to the field.

The current study has several limitations. The self-report nature of the data raises questions about its validity, particularly in the area of self-rating of competence. Given that the respondents are professional clinicians, specifically trained in assessment, the validity of the self-report should be relatively high. A second limitation is the use of a single professional group, limiting the generalizability of these findings. The response rate of 45% is not uncommon among surveys of professionals, but raises questions about generalizability as well. Additional studies need to be done to determine whether these findings are consistent for other professional groups, and in other types of mental health organizations.

This study identifies a critical opportunity for the mental health community. Problem gambling is a common, highly destructive disorder, largely overlooked by clinicians. With growing public awareness of problem gambling and its consequences, the clinical community is being asked to play an increasing role through treatment. The current data indicate that with a coherent training strategy and follow-through, clinicians will be more prepared to respond to this call successfully.

APPENDIX A: QUESTIONNAIRE ITEMS*I. Demographics and Current Practice*

- A. Age
- B. Gender
- C. Highest degree
- D. Date received highest degree
- E. Specialty area
- F. Average number of hours worked per week
- G. Average number of hours spending direct clinical care
- H. Average number of patients seen per week
- I. Age distribution of current client
- J. Income distribution of current clients
- K. Distribution of clients by clinical setting (in-patient, outpatient, non-VHA)
- L. Distribution of clients by regional setting (urban, rural, suburban)
- M. Percentage of female clients
- N. Percentage of non-Caucasian clients

II. Training

- A. Problem Gambling
 - 1. Graduate school training in problem gambling
 - 2. Internship training
 - 3. Post-graduate training
 - 4. Continuing education
 - 5. Number of workshops attended
 - 6. Number of articles read
 - 7. Number of professional books/chapters read
 - 8. Number of non-journal articles read
 - 9. Number of times consulted with a colleague
 - 10. Number of times watched something through mass media
- B. Alcohol or Drug Abuse
 - 1. Graduate school training in problem gambling
 - 2. Internship training
 - 3. Post-graduate training
 - 4. Continuing education
 - 5. Number of workshops attended
 - 6. Number of articles read
 - 7. Number of professional books/chapters read

8. Number of non-journal articles read
9. Number of times consulted with a colleague
10. Number of times watched something through mass media

III. Clinical Experience

- A. Number of patients seen in graduate training known to have a significant gambling problem
- B. Number of patients seen in clinical practice (post-training) known to have a gambling problem
- C. Number of patients who initiated clinical contact for a gambling problem
- D. Number of patients evaluated for gambling problems
- E. Number of patients treated for gambling problems
- F. Number of patients referred specifically for treatment of a gambling problem

IV. Current Practice, Competence, and Personal Experience (5-point Likert Scale)

- A. I feel competent to evaluate patients for Pathological Gambling
- B. I feel competent to treat patients for Pathological Gambling
- C. I know an appropriate provider who is competent to treat patients with Pathological Gambling to whom I would refer patients
- D. Treating Pathological Gambling is part of my current work
- E. Evaluating for Pathological Gambling is part of my current work
- F. I am interested in receiving more training regarding Pathological Gambling
- G. I would attend a professional seminar on Pathological Gambling
- H. I would read some professional articles on Pathological Gambling if they were given to me

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