they can control the outcome of wagers and machines even when there is no skill involved.[48] Some players of these games believe that during interactive phases of play (such as holding or nudging) they are able to influence the outcome. This element of skill is only perceived, as the outcome of any period of play is pre-determined and is not influenced by what the player does or does not do.

Demographic Profiles: Connecticut Gamblers

Problem and probable pathological gamblers are significantly more likely to be male (82 percent), 18-34 years old (34 percent) and have some college education (48 percent).

[48] Griffiths, M.D. (1991) "The psychobiology of the near miss in fruit machine gambling. Journal of Psychology," 125, 347-358.

Figure 27: Demographics of At-Risk and Problem Gamblers (NODS Screen)

		At-Risk Gamblers (165) %	Problem Gamblers (76) %
Gender	Male	63.8	81.8
	Female	36.2	18.2
Age	18 – 34	38.1	33.6
	35 – 44	20.0	23.8
	45 – 64	30.5	28.0
	65 and older	11.5	14.5
Ethnicity	Black/African American	15.0	9.2
	White/Caucasian	76.3	81.6
	Hispanic/Latino	5.6	9.2
	Other	3.1	0.0
Marital Status	Single	30.9	39.5
	Married	53.7	44.7
	Divorced	9.9	15.8
	Widowed	5.6	0.0
Education	High school or less	32.3	28.6
	Some college	31.7	48.1
	Bachelor's degree	22.4	18.2
	Postgraduate degree	13.7	5.2
Religion	Protestant	31.8	17.1
	Catholic	40.3	41.4
	Other	3.2	5.7
	None	24.7	35.7
Income	Under $25,000	9.2	7.3
	$25,000 to $50,000	25.0	21.7
	$50,001 to $75,000	23.7	21.0
	$75,001 to $100,000	22.4	17.6
	$100,001 to $125,000	5.3	11.3
	Over $125,000	14.5	21.0
Residence	Fairfield County	26.0	26.9
	Hartford County	26.0	24.7
	Litchfield County	3.9	5.4
	Middlesex County	2.6	4.8
	New Haven County	29.9	24.1
	New London County	3.9	7.5
	Tolland County	5.2	4.4
	Windham County	2.6	2.1

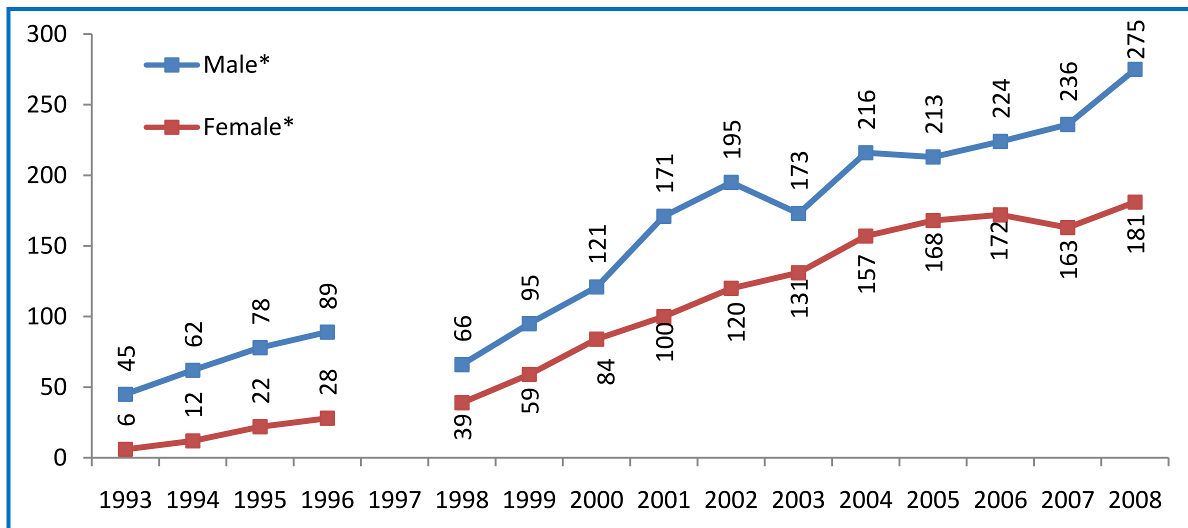
Figure 28: Demographics of Problem Gamblers (SOGS Screen)

		Problem Gamblers (50) %
Gender		
	Male	76.7
	Female	22.3
Age		
	18 – 34	38.5
	35 – 44	21.6
	45 – 64	26.0
	65 and older	13.9
Ethnicity		
	Black/African American	10.5
	White/Caucasian	83.7
	Hispanic/Latino	3.5
	Other	2.3
Marital Status		
	Single	31.8
	Married	52.9
	Divorced	12.9
	Widowed	2.4
Education		
	High school or less	27.1
	Some college	44.7
	Bachelor's degree	23.5
	Postgraduate degree	4.7
Religion		
	Protestant	31.7
	Catholic	36.6
	Other	4.9
	None	26.8

Spectrum also analyzed data obtained from the state's Division of Problem Gambling Services ("PGS") to further review the demographic makeup of problem gamblers. The division oversees the Bettor Choice program, a network of 17 clinics that offers counseling to problem gamblers.

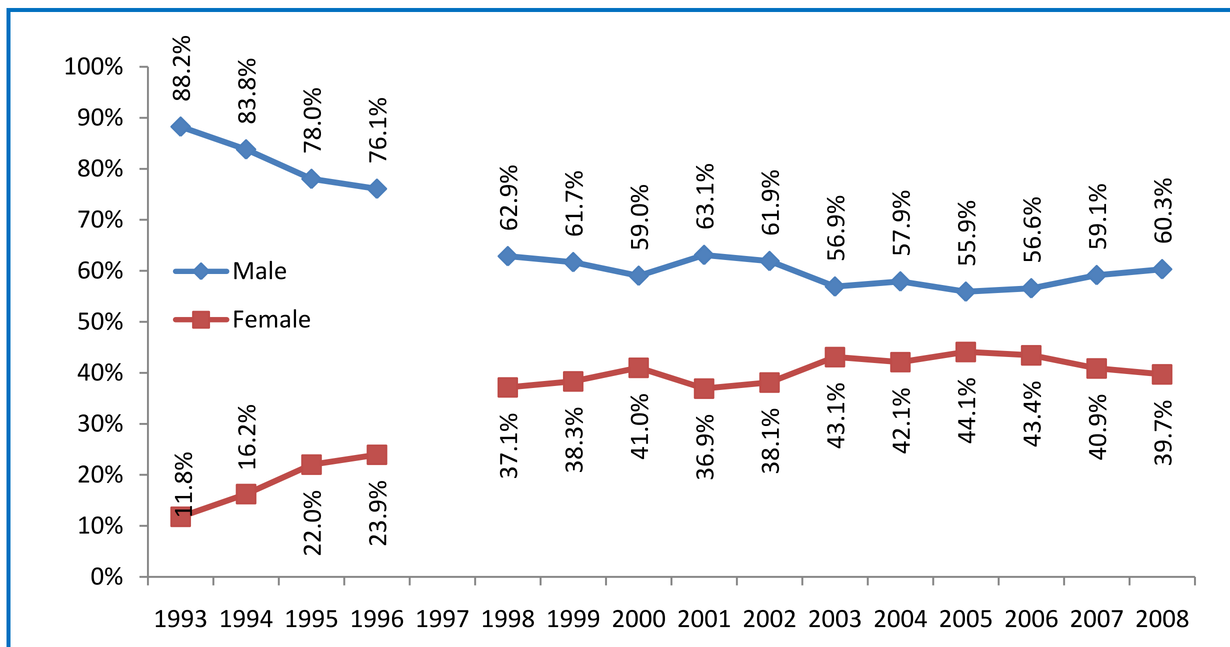
Gambling preferences among clients tend to reflect the facility's location and the time of year. The Norwich-based United Community and Family Services clinic treats primarily 30- to 50-year-olds, whose favorite game is slot machines. The New Haven clinic sees younger people who tend to gamble on the Internet. The clinic in Middletown reported seeing a mix of Internet gamblers, casino gamblers and sports-betting gamblers. The number of sports wagers increases at certain times of the year, peaking with 30 percent to 40 percent of referrals around football season.

Figure 29: Clientele by Gender in Problem Gambling Services



*1997 data not available
Source: Problem Gambling Services

Figure 30: Bettor Choice Clients by Gender and Year

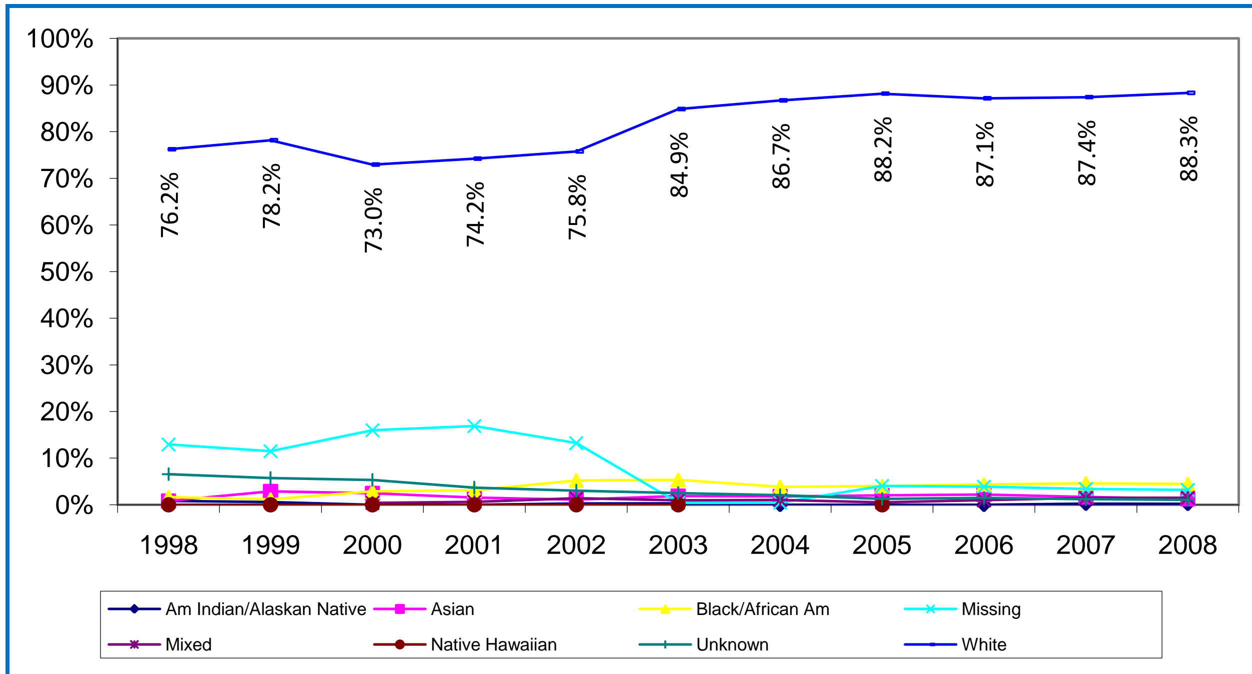


The gap between the genders in treatment has narrowed over time, going from a split of 88 percent male to 12 percent female in 1993 to 60-40 in 2008. The increase coincides with the opening of a second casino in Connecticut in 1996.

Bettor Choice client demographics vary by location as well as by time of the year and current outreach activities. Overall, clients are predominantly white, middle class, and middle aged. The demographics tend to mirror those of the surrounding cities or towns. For example, the Wheeler Clinic in Plainville treats almost 100 percent Caucasian, while its facility in Hartford

reported seeing more ethnically diverse clients -- significant numbers of African Americans and Latinos.[49]

Figure 31: Bettor Choice Program Clients by Race/Ethnicity



*Missing: Administrators could not locate data to identify clients
Source: Problem Gambling Services

The overall percentage of clients who identify themselves as African American has greatly increased since 1998. The number of clients who identify themselves as Hispanic is very low, less than 2 percent of the total in any one year.

To gain insight into the extent of problem gambling, we set up a round-table discussion with administrators, therapists, social workers, members of Gamblers Anonymous, other researchers in the field and individuals diagnosed with pathological gambling.

A number of participants emphasized that it was unfortunate that racial and ethnic minorities were not seeking treatment because there are gambling problems among those sections of the community. Another participant explained the possible barriers that could be keeping ethnically diverse populations out of care, especially those that may be low income:

> "In more economically marginalized groups, gambling is seen as a source of income to tide you over. It provides some hope, so the approach has to be different when working in those communities. We have to find out more about what works in those communities. We know what works well in White, middle-aged, middle income."[50]

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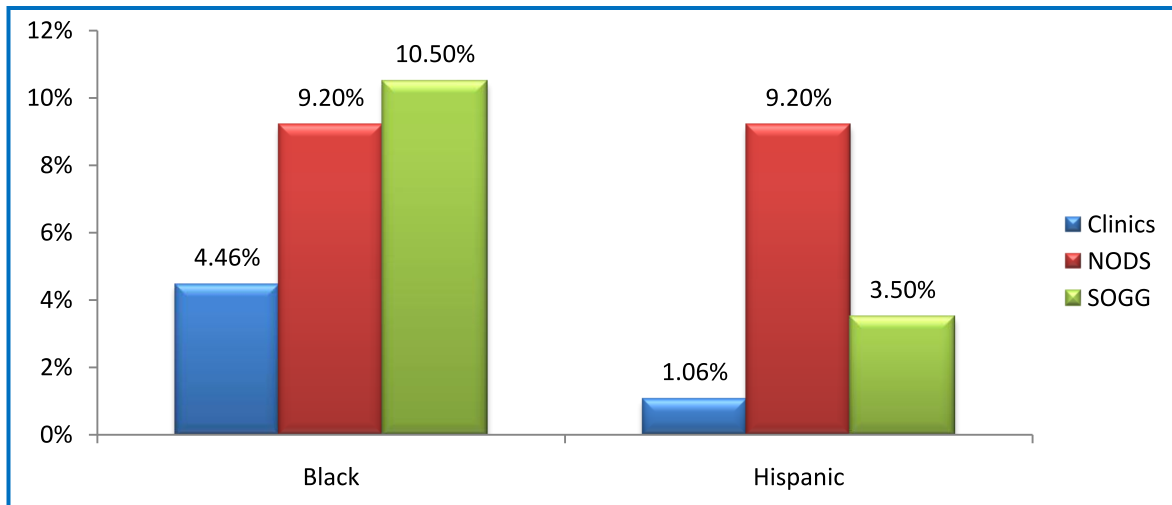
[49] Problem Gambling Services.
[50] Roundtable discussion with gambling treatment clinicians.

To see if this was the case, we compared the racial and ethnic makeup of the problem and pathological gamblers in the Spectrum study to those being treated in the clinics in 2008.

Figure 32: Percent of Problem Gamblers in State Clinics vs. Survey Results



Source: Problem Gambling Services, Spectrum Research

Both Blacks and Hispanics are greatly underrepresented at Bettor Choice clinics based on the demographic makeup of problem and probable pathological gamblers from our current prevalence study. There were too few members of other ethnic and racial populations to conduct a separate analysis for other groups. Because our survey failed to capture a representative number of Hispanic respondents (4.1 percent achieved, 6.4 percent weighted vs. 10.1 percent total in Connecticut, according to 2007 census), the difference in total number of those being treated in this group and actual number of problem gamblers of Hispanic or Latino origin is estimated to be even larger than what is represented in the chart.

PGS Director Lori Rugle acknowledged that the state needs to engage in outreach to minority groups. Chris Armentano oversaw Connecticut's problem gambling treatment program from 1987 to 2008, when he retired. He noted that the state provides no funding to promote the Bettor Choice program. An outreach effort of any type would significantly increase the number of residents seeking treatment, he said.

Impacts

The impacts of pathological gambling are complex and interconnected, ranging from financial and legal to medical and psychological. Spectrum was asked to look into "Impacts on the Individual" and "Impact on the Family."

The reality is that impacts on the individual do not occur without impacts on the family, the workplace and society as a whole. Many of the same impacts that society sees on the individual, it also sees on others, especially loved ones.

We gathered data for this section from a variety of sources, including our current prevalence survey, content analysis of archival data, semi-structured interviews, focus groups and a round-table discussion previously cited.

Figure 33: Effects on Everyday Life (From our Telephone Survey)

	Non-Problem Gamblers (2001) %	Problem & Probable Pathological Gamblers (85) %
Felt remorse	7.7	60.5
Unhappy home life	2.4	20.0
Difficulty sleeping	1.3	16.5
Decrease in ambition	0.2	15.1
Careless of their welfare or that of their family	0.2	15.1
Lost time from work	0.1	11.6
Affected reputation	0.3	5.9

Figure 34: What Gambling Can Make Gamblers Do

	Non-Problem Gamblers (2001) %	Problem & Probable Pathological Gamblers (85) %
Gambled longer than planned	17.2	76.5
Gambled until last dollar is gone	12.5	61.6
Returned to win more	15.8	61.2
Urge to celebrate good fortune by gambling	7.8	44.7
Returned to win back losses	1.4	43.5
Gambled to pay off debts	1.8	29.1
Borrowed to finance gambling	0.6	25.6
Gambled to escape worry	2.4	17.4
Sold possessions to finance gambling	0.2	12.9
Situations created an urge to gamble	1.0	10.6
Committed or considered committing an illegal act to finance gambling	0.3	9.3

Financial

Because gambling centers on money – the chasing, spending, winning and losing of money – it is appropriate that we begin this section with financial impacts. Scientific literature associates problem gambling with the following financial troubles:[51, 52]

- large credit-card debts
- second or even third mortgages
- illegal loans
- formal and/or informal loans
- loss of rent or mortgage funds
- eviction
- homelessness
- misuse of retirement funds
- bankruptcy
- poverty

Sometimes, gamblers commit criminal acts to finance their gambling or pay gambling debts. [53,54]

Our telephone survey compared the lifetime gambling habits of problem gamblers with those of non-problem gamblers:

- 62 percent gambled until their last dollar was gone compared to 12 percent for non-problem gamblers
- 29 percent gambled to pay off debts compared to 4 percent for non-problem gamblers
- 13 percent sold possessions to finance gambling compared to 1 percent for non-gamblers
- 26 percent borrowed to finance gambling compared to 1 percent for non-gamblers

Figure 35: Losses by Gambler Type

		Non-Problem Gamblers (2,011) %	Problem &Probable Pathological gamblers (85) %
Largest single day lost	Less than $10	18.2	4.7
	$11-$99	42.3	12.9
	$100 or more	37.8	81.2
Largest single year lost	Less than $100	44.0	9.4
	$100-$999	40.4	22.4
	$1,000 or more	9.9	57.7

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[51]Shagw, M.C., Forbush ,T, Schlinder, J., Rosenman, E. and DW Black. 2007. The Effect of Pathological Gambling on Families, Marriages, and Children. *CNS Spectr*. 2007;12(8):615-622.

[52] Lesieur, H.R. 1998. Costs and Treatment of Pathological Gambling, *Annals of the American Academy of Political and Social Science* (Gambling: Socioeconomic Impacts and Public Policy, J.H. Frey, special editor), March 1998.

[53] Ibid.

[54] Volberg, R.A. (2001). *Changes in gambling and Problem gambling in Oregon, 1997 to 2000*. Salem, OR: Oregon Gambling Addiction Treatment Foundation.

The lack of financial control is compounded by a need to fix the financial problems of their partners, often produced as much by a need to save face in front of friends and neighbors as to save joint finances. Spouses and significant others are often left playing a game of catch-up, trying to bail out the gambler and the family at the same time while dealing with all of the other issues at home that the problem gambler neglects. This behavior, although well-intentioned, can enable more gambling behavior by freeing up the time and giving the gambler the financial resources to gamble more.

We attended a PGS counseling session for family members in Middletown. During the session, family members related how gambling by their significant others had devastated their lives. One woman described how her husband lost more than $200,000 buying lottery tickets, destroying their credit and their finances. Another participant said his wife was so addicted to slot machine gambling that she forged the signature of their son on a check to enable her to gamble.

Of the seven participants, two were separated and three others are considering divorce.

A clinician summed up the sentiments of family members:

> "A vast amount of money gets eaten up by the compulsive gambler. Every so often you hear about someone hitting a tree or something, or a crime where someone steals a million dollars, but the real victims are the families. If you look at the number of people who are gambling around the state and you think about their families that are impacted; they are pushed beyond their limits. Imagine if you were poor and couldn't stop being poor. What would that be like?"

Bankruptcies

After extensive research that included a review of Connecticut bankruptcy filings and a number of interviews with prominent Connecticut bankruptcy lawyers, we could not delineate a clear relationship between gambling and bankruptcy in Connecticut. On a national level, we reviewed social science literature and previous studies. Some found a link between gambling and higher bankruptcy rates; others did not.

The federal bankruptcy forms used in Connecticut are of limited assistance because they do not indicate whether problem gambling was a factor. A problem gambler may have used a credit card or even a home equity line of credit, for example, to finance his or her gambling habit. The petition would not say whether such debt was gambling related. Nonetheless, several bankruptcy lawyers in Connecticut told us that problem gambling has indeed had an impact on bankruptcy filings, but quantifying that impact would be difficult.

Attorney David F. Falvey, who has one of the largest consumer bankruptcy law practices in eastern Connecticut, said while it was rare for gambling to have played a factor in bankruptcy petitions prior to casinos, it is commonplace today.[55]

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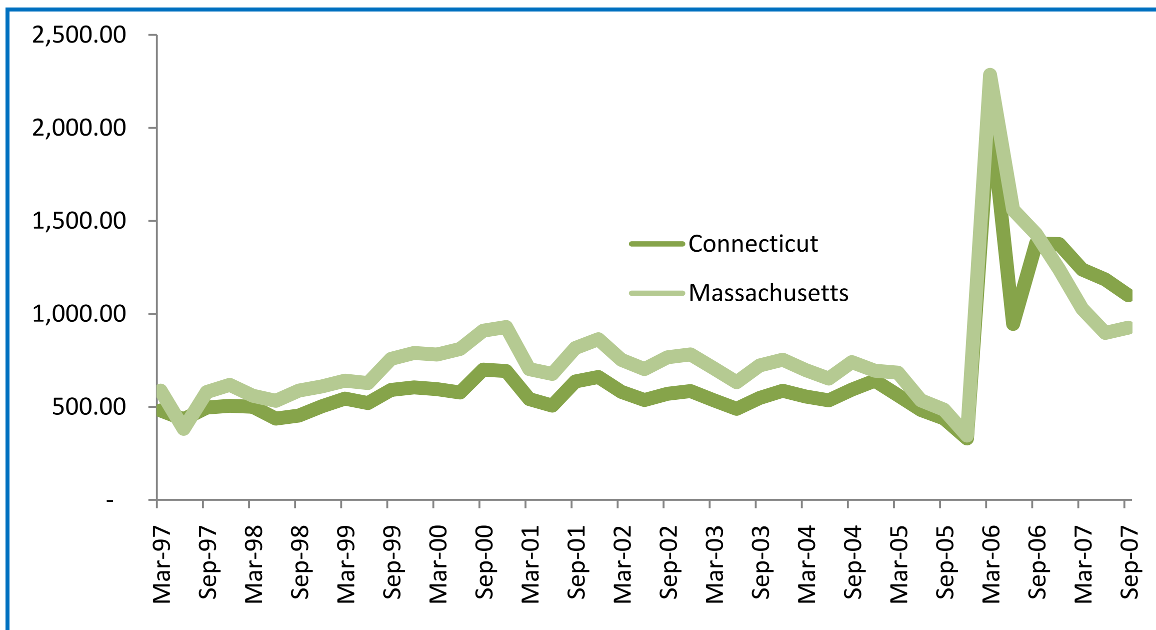
[55] Jeff Benedict, Hartford Courant, May 8, 2005, http://www.connecticutalliance.org/docs/20050508ALOSINGHAND.pdf.(accessed on August 13, 2008).

In eight of the past 12 years, New London County, where the two Indian casinos are located, exceeded the overall state of Connecticut bankruptcy rate. The rates were particularly high in 1997, 1998 and 1999. In those years, the rates exceeded the statewide rate by about 10 percent. Mohegan Sun opened October 12, 1996, giving New London County its second destination resort casino.[56]

While the increase in bankruptcy filings in Connecticut was less than the national rate, more than 11,000 taxpayers sought bankruptcy relief in 2004, an increase of nearly 4,000 from 1991, the year before the first casino opened in Connecticut with slot machines. That number grew to more than 15,000 the following year, but then subsided to about 4,000 in 2006[57]. That fluctuation can largely be attributed to changes in federal bankruptcy requirements. The spikes can be seen in the following chart, in which we compared the ratio of employment to filings in a state that has casinos (Connecticut) to a nearby state that does not (Massachusetts).

Figure 36: Ratio of Non-Farm Employment to Bankruptcy Filings, CT and MA



Source: American Bankruptcy Institute, US Bureau of Labor Statistics

Filings in Connecticut for the period 1991 to 2007 have actually been lower than rates nationally. In fact, Connecticut has consistently had one of the lower bankruptcy rates in the country. For the last three available reporting periods, Connecticut ranked 41st, 43rd and 35th among states in the ratio of the number of households to bankruptcy filings.[58]

The following table shows quarterly trends in Connecticut filings in relation to the United States and the rest of New England:

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[56] Administrative Office of the Courts.
[57] American Bankruptcy Institute.
[58] American Bankruptcy Institute.

Figure 37: Bankruptcy Filings by State, New England

Total bankruptcies (number of business and consumer filings, not seasonally adjusted)								
	US	NE	CT	ME	MA	NH	RI	VT
Mar-94	206,527	7,936	2,105	419	3,639	763	820	190
Jun-94	216,176	8,610	2,339	479	3,917	844	817	214
Sep-94	208,163	7,623	2,092	429	3,429	776	690	207
Dec-94	201,591	7,066	1,877	424	3,207	671	670	217
Mar-95	212,601	8,058	2,158	470	3,696	718	779	237
Jun-95	235,267	8,949	2,401	558	3,924	897	899	270
Sep-95	233,562	8,360	2,303	564	3,601	813	825	254
Dec-95	244,467	8,477	2,284	600	3,688	779	831	295
Mar-96	266,113	9,354	2,560	629	4,027	810	997	331
Jun-96	297,121	10,945	3,025	825	4,621	1,022	1,109	343
Sep-96	303,268	10,377	2,809	756	4,453	935	1,087	337
Dec-96	311,131	10,817	2,907	863	4,634	925	1,131	357
Mar-97	335,073	12,310	3,282	869	5,186	1,151	1,357	465
Jun-97	367,168	16,327	3,717	1,145	8,190	1,298	1,474	503
Sep-97	353,515	12,725	3,237	1,104	5,377	1,212	1,308	487
Dec-97	347,685	12,495	3,246	1,090	5,133	1,240	1,330	456
Mar-98	354,118	12,801	3,223	984	5,565	1,190	1,372	467
Jun-98	373,460	14,374	3,770	1,241	5,998	1,414	1,436	515
Sep-98	361,205	13,208	3,630	1,195	5,439	1,141	1,304	499
Dec-98	353,108	12,839	3,332	1,093	5,317	1,249	1,365	483
Mar-99	330,784	11,729	3,015	1,029	4,941	1,068	1,227	449
Jun-99	345,956	12,484	3,217	1,153	5,181	1,076	1,379	478
Sep-99	323,550	10,755	2,828	1,023	4,291	980	1,206	427
Dec-99	318,634	10,583	2,803	967	4,183	979	1,248	403
Mar-00	312,335	10,388	2,799	918	4,153	967	1,157	394
Jun-00	321,729	10,819	2,947	1,142	4,113	1,008	1,232	377
Sep-00	308,718	9,321	2,421	1,009	3,674	830	1,064	323
Dec-00	310,169	9,320	2,477	973	3,658	810	1,004	398
Mar-01	366,841	11,608	3,072	1,029	4,734	1,028	1,306	439
Jun-01	400,394	12,767	3,337	1,364	4,983	1,193	1,385	505
Sep-01	359,518	10,092	2,635	1,034	4,079	838	1,095	411
Dec-01	364,971	9,904	2,567	1,121	3,855	872	1,096	393
Mar-02	379,012	10,831	2,847	1,033	4,283	1,001	1,228	439
Jun-02	400,686	11,771	3,131	1,163	4,672	1,031	1,311	463
Sep-02	401,306	10,982	2,909	1,148	4,255	1,000	1,192	478
Dec-02	395,129	10,746	2,860	1,076	4,187	1,003	1,175	445
Mar-03	412,968	11,315	3,042	1,081	4,459	1,088	1,171	474
Jun-03	440,257	12,784	3,377	1,292	5,091	1,243	1,261	520
Sep-03	412,989	11,203	2,988	1,144	4,431	1,055	1,105	480
Dec-03	393,348	10,739	2,836	1,143	4,273	1,039	1,019	429
Mar-04	407,572	11,274	2,921	1,111	4,484	1,203	1,081	474
Jun-04	421,110	12,039	3,101	1,248	4,928	1,205	1,099	458
Sep-04	396,438	10,800	2,783	1,134	4,333	1,125	1,013	412

Total bankruptcies (number of business and consumer filings, not seasonally adjusted)								
	US	NE	CT	ME	MA	NH	RI	VT
Dec-04	371,668	10,687	2,612	1,014	4,661	1,117	930	353
Mar-05	401,149	11,361	2,910	1,060	4,591	1,276	1,088	436
Jun-05	467,333	14,311	3,465	1,494	6,032	1,367	1,408	545
Sep-05	542,002	15,964	3,789	1,891	6,662	1,580	1,428	614
Dec-05	667,431	21,511	5,107	2,169	9,421	1,872	1,915	1,027
Mar-06	116,771	3,157	786	227	1,388	322	301	133
Jun-06	155,833	5,239	1,785	324	2,090	464	397	179
Sep-06	171,146	5,012	1,216	377	2,278	550	433	158
Dec-06	177,599	5,561	1,238	399	2,652	594	493	185
Mar-07	193,641	6,422	1,350	484	3,127	696	583	182
Jun-07	210,449	7,429	1,441	678	3,671	736	672	231
Sep-07	218,909	7,472	1,542	577	3,558	776	768	251
Dec-07	226,413	7,259	1,546	564	3,353	774	791	231
Mar-08	245,695	8,544	1,878	588	3,973	895	931	279
Jun-08	276,510	9,613	2,155	848	4,164	1,008	1,108	330
Sep-08	292,291	9,493	2,119	799	4,178	998	1,088	311

Source: Federal Reserve Bank of Boston

Bankruptcy laws were substantially amended by the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005[59] ("BAPCPA"). This federal law instituted sweeping changes that make it more difficult for consumers to discharge a debt through bankruptcy. Fewer people are able to obtain the same degree of favorable relief as was available under the old law, and, as a result, many may now choose not to file. Consequently, prior to the new law taking effect on October 17, 2005, there was a substantial spike in the number of petitions filed and a marked decrease the following year. For the purposes of our analysis, we examined data through the year 2004, the year prior to the law taking effect.

In the period prior to passage of the BAPCPA, personal bankruptcy filings in the United States increased dramatically from 1980 to 2004, leaping from 288,000 to 1.5 million filings per year.[60] From 1991 to 2004, national filings increased by nearly 80 percent. In Connecticut, the increase was 51 percent.

Michelle J. White is a professor of economics at the University of California, San Diego, and a research associate at the National Bureau of Economic Research. She received her Ph.D. in economics from Princeton University in 1973. During the past several years, her research has focused on the personal bankruptcy system in the US.

An important question, according to White, is whether the rapid increase in filings during the period prior to enactment of the BAPCPA was due to opportunism. In other words, did consumers learn that the bankruptcy law was very pro-debtor and respond by irresponsibly assuming excessive debt, knowing that filing for bankruptcy would provide them a relatively easy way to rid themselves of the burden?

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[59] Pub.L. 109-8, 119 Stat. 23, enacted 2005-04-20.

[60] See Michelle J. White, NBER Working Paper No. 13265 Issued in July 2007, National Bureau of Economic Research, http://www.nber.org/papers/w13265 (accessed on August 11, 2008).

If this were the case, then we must question to what extent might those who filed for bankruptcy protection citing problem gambling as the precipitating cause have done so simply to rid themselves of inconvenient gambling debt.

According to US Bankruptcy Court records, 1,462 consumer bankruptcy petitions were filed between January 1998 and January 2005 by residents in 16 southeastern Connecticut towns. Those records show that 117, or 8 percent, of the petitioners, did report gambling losses within the year leading up to bankruptcy.[61] Falvey said the percentage of his clients with casino gambling debt is higher.

The survey commissioned by Spectrum Gaming Group indicates that the bankruptcy rate for probable pathological gamblers was as high as 20 percent, five times the rate for non-problem gamblers. Another study of Gamblers Anonymous members found that 22 percent declared bankruptcy.[62]

However, the Connecticut county with the highest bankruptcy rate is New Haven County, which in 2005 exceeded the statewide rate of 3.46 filings per 1,000 residents by more than one-third. The state's most heavily populated county, Hartford County, also had rates that consistently exceeded the state average.

Eugene S. Melchionne, a Connecticut bankruptcy attorney who is also Connecticut State Chairman of the National Association of Consumer Bankruptcy Attorneys, has more than 25 years experience as a bankruptcy attorney and has handled an estimated 750 bankruptcy cases. He estimates that about 15 percent of those cases had some gambling-related problem. Although Melchionne could not say empirically that gambling has led to an increase in bankruptcy filings, he stated in emails to us that he sees it more often now as a cause than he did 10 or 20 years ago. In an email, he told us:

> "It is an increasing problem. We find that there are two main causes to problem gambling in related bankruptcy cases. The first is economic difficulty. There is an increased interest in taking a chance to make things better economically when an individual is feeling the pinch or reduced income or increased bills.
>
> "The second cause is a change in a family situation such as a divorce or death of a marital partner. Gambling serves as a substitute for the void created by the loss of a life partner. The increase in the first cause is clear from the nation's current economic slowdown. The second is on the increase through what I perceive as increased advertising that casinos are 'fun.' Since they really are and the excitement fills a psychological need, it quickly becomes a substitute in a lonely person's life."

It should be noted, though, that establishing a clear, causal relationship between problem gambling and bankruptcy is a complicated matter, subject to different interpretations of data, multiple variables, and more recently, legislative changes that make time series comparisons difficult.

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[61] Ibid.

[62] National Research Council. (1999). *Pathological gambling: A critical review*. Washington, DC: National Academy Press.

Addressing the challenge of problem and pathological gambling is further complicated by the fact that a financially stressed individual may be plagued by other behavioral disorders such as drug and alcohol problems, as well as other types of mental illnesses, that may predate or exacerbate his gambling issues. Simply noting that certain types of behavioral disorders or consequences are associated with problem gambling does not necessarily mean that gambling was their primary cause.

This factor was cited by the National Gambling Impact Study Commission ("NGISC"), which was formed in 1999 to conduct a comprehensive analysis of the social and economic impacts of gambling. It noted:

> "Pathological gambling often occurs in conjunction with other behavioral problems, including substance abuse, mood disorders, and personality disorders. The joint occurrence of two or more psychiatric problems — termed co-morbidity — is an important, though complicating factor in studying the basis of this disorder. Is problem or pathological gambling a unique pathology that exists on its own or is it merely a symptom of a common predisposition, genetic or otherwise, that underlies all addictions?"[63]

There have been a number of efforts on the national level to address the issue of gambling on bankruptcy filings. The NGISC study was the first federal examination of gambling since 1976. During the intervening period that preceded the formation of the commission, at least one form of legal wagering became or was available in 47 states, and revenue from legalized gambling increased nationally nearly 1,600 percent to more than $50 billion annually.[64]

The National Opinion Research Center ("NORC") in its report to the NGISC noted, "The availability of a casino within 50 miles (versus 50 to 250 miles) is associated with about double the prevalence of problem and pathological gamblers."[65]

The relationship between the proliferation of gambling and increased bankruptcies was studied by Stuart A. Feldman, President of SMR Research Corporation. In a 1999 presentation before the House Subcommittee on Commercial and Administrative Law regarding the increasing number of bankruptcies in America, Feldman noted that among other factors:

> "The spread of casino gambling appears to be a problem. When we look at bankruptcy rates in counties that have major gambling facilities in them, those rates are higher than in counties that have no gambling facilities. … On the county map in Nevada, the closer you come to Las Vegas and Reno, the higher the bankruptcy rate generally gets. In California, the highest bankruptcy rates are in San Bernardino and Riverside Counties, which are closest to Las Vegas, and the fourth highest rate often is in Sacramento County, closest to Reno. In New Jersey, Atlantic County, which is where the casinos are, typically has either the highest bankruptcy rate or one of the two or three highest in the state. In

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[63] The National Gambling Impact Study Commission Final Report, p. 4-3.

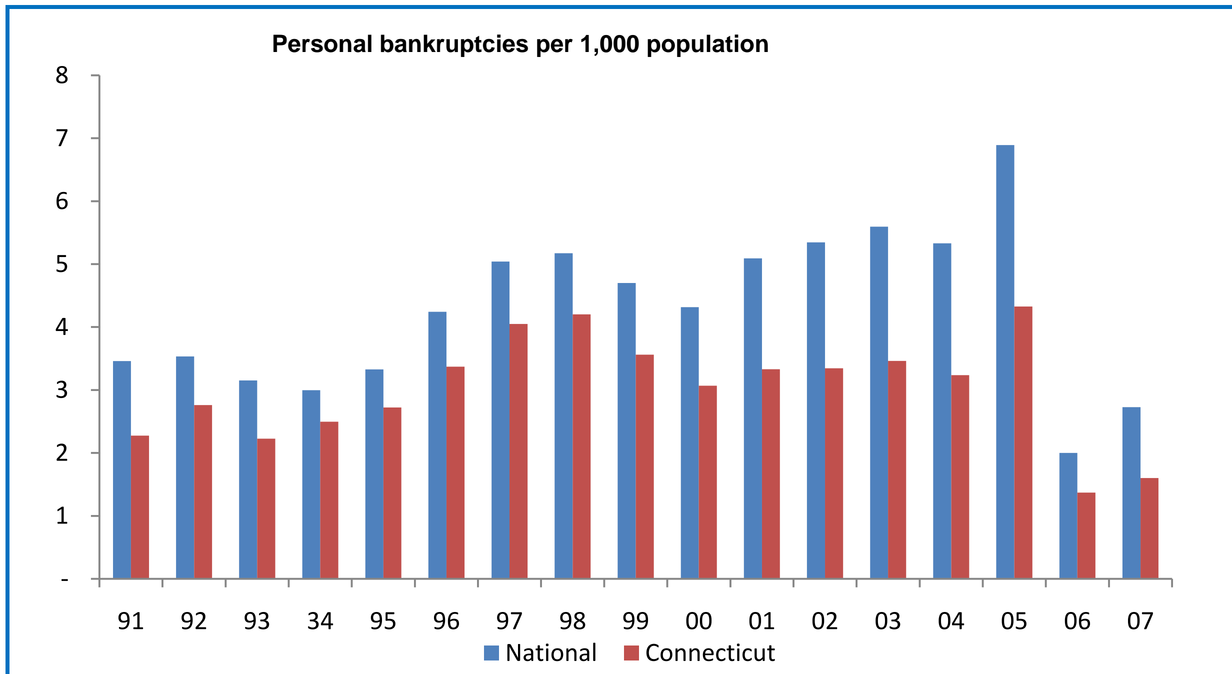
[64] Brett Pulley, "Commission on Gambling Prescribes Broad Changes," The New York Times, June 19, 1999, www.nytimes.com (accessed on August 13, 2008).

[65] NORC, "Report to the National Gambling Impact Study Commission, 1999, http://cloud9.norc.uchicago.edu/dlib/ngis/high.pdf.

Tennessee, the bankruptcy rate is highest in Shelby County, the heart of Memphis, which is right across the state line from the Tunica MS casino gambling complex, reportedly the largest outside of Nevada." [66]

However, as we reported earlier, our research revealed that, if anything, New London County, where the casinos are located, had lower bankruptcy rates than did New Haven and Hartford counties, which are much farther away. The state's two most urban counties also registered higher gambling participation rates as well as higher problem gambling rates. Connecticut is a relatively small state, with relatively short travel time from one end of the state to another, and this is factor that must be considered when comparing county bankruptcy rates.

Figure 38: Connecticut Bankruptcy Rate vs. National Rate



Source: US Administrative Office of the Courts - Reports F- 5A and US Department of the Census

[66] Stuart A. Feldman, President SMR Research Corp., "The Rise in Personal Bankruptcies: Causes and Impact," Presentation before the House Subcommittee on Commercial and Administrative Law, March 10, 1998.

Figure 39: Per-Capita Bankruptcy Rates by Connecticut County, 1991-99

Per 1,000 population

	1991	1992	1993	1994	1995	1996	1997	1998	1999
Filings, US	3.46	3.53	3.15	3.00	3.33	4.24	5.04	5.17	4.70
Filings, Connecticut	2.28	2.76	2.23	2.50	2.72	3.37	4.05	4.20	3.56
Connecticut as % of US	1.30%	1.28%	1.27%	1.26%	1.24%	1.23%	1.22%	1.21%	1.20%
Fairfield	2.06	2.57	1.94	2.15	2.25	2.57	3.10	2.99	2.50
Hartford	2.58	2.71	2.37	2.42	2.69	3.33	4.14	4.28	3.85
Litchfield	2.21	2.70	2.22	2.61	2.88	3.29	3.79	4.63	3.33
Middlesex	2.50	2.69	2.14	2.34	2.85	3.25	4.23	4.05	3.24
New Haven	2.27	3.13	2.64	3.18	3.51	4.52	5.11	5.47	4.67
New London	2.35	3.05	2.10	2.43	2.45	3.32	4.42	4.64	3.82
Tolland	1.34	1.57	1.31	1.46	1.54	2.01	2.44	2.12	1.79
Windham	2.32	2.86	1.68	2.11	2.32	3.44	4.21	4.76	3.89

Source: US Administrative Office of the Courts - Reports F- 5A, US Census Bureau

Figure 40: Per-Capita Bankruptcy Rates by Connecticut County, 2000-07

	2000	2001	2002	2003	2004	2005	2006	2007
Filings, US	4.32	5.09	5.35	5.60	5.33	6.89	2.01	2.73
Filings, Connecticut	3.07	3.33	3.34	3.46	3.24	4.33	1.37	1.60
Connecticut as % of U.S.	1.21%	1.20%	1.20%	1.20%	1.19%	1.18%	0.01	0.01
Fairfield	2.09	2.13	2.09	2.29	1.86	2.83	0.79	1.02
Hartford	3.33	3.64	3.55	3.81	3.45	4.87	1.43	1.66
Litchfield	3.36	3.47	3.60	3.70	3.71	4.74	1.50	1.88
Middlesex	2.99	2.82	3.04	2.87	2.71	3.93	1.46	1.65
New Haven	3.95	4.44	4.58	4.71	4.62	5.55	1.89	2.16
New London	3.19	3.48	3.60	3.13	2.90	3.92	1.41	1.53
Tolland	1.59	1.88	1.70	2.05	2.56	3.64	1.10	1.11
Windham	3.49	4.20	4.07	3.84	3.78	4.64	1.50	1.88

Source: US Administrative Office of the Courts - Reports F- 5A
http://www.census.gov/popest/counties/CO-EST2007-popchg2000_2007.html
http://www.census.gov/popest/archives/1990s/su-99-08/SU-99-8_CT
All population estimates for year ending on July 1

Health Impacts

Pathological gamblers have been found to be more likely to suffer from the following physical ailments:[67, 68]

- allergies
- respiratory problems
- nervous system disorders
- sleep disturbances
- back problems
- dental or oral problems
- obesity
- chronic tiredness
- colds and flu
- migraines
- gastric pains

In addition, they are more likely than low-risk individuals to have been diagnosed with tachycardia, angina and other liver disease independent of behavioral risk factors such as alcohol abuse, mood disorders and nicotine dependence.[69] As a result, pathological gamblers are also more likely to rate themselves as being in poorer overall health (Lesieur, 1998; Volberg, et al. 2006).

In our telephone survey, we asked respondents the following question: "How would you describe your general health over the past 12 months? Would you say it was excellent, good, fair or poor?" Problem and probable pathological gamblers were significantly more likely to rate themselves as being in "fair or poor" health than those who were non-problem gamblers (21 to 14 percent). A recent study of problem gambling prevalence in the state of California found similar results.[70]

This one-question measurement of general self-rated health has been found to be an excellent predictor of morbidity and mortality.

We also asked clinicians about health problems among pathological and problem gamblers. They indicated they saw evidence of sleep disturbances and a general lapse in caring for their health and that of their families.

Note that nearly 40 percent of problem and probable pathological gamblers experienced mental health problems compared to 26 percent for non-problem gamblers.

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[67] Bergh C, Kuehlhorn E. Social, psychological and physical consequences of Pathological gambling in Sweden. *J Gambl Stud*. 1994;10(3):275-85.

[68] Russo AM, Taber JI, McCormick RA, Ramirez LF. An outcome study of an inpatient treatment program for Pathological gamblers. *Hosp Community Psychiatry*. 1984;35(8):823-7.

[69] Moreaco et al.,2006.

[70] Volberg, R., Nysse-Carris, K. and Gerstein, R. (2006). *2006 California Problem gambling Prevalence Survey*, California Department of Alcohol and Drug Programs Office of Problem and Pathological Gambling.

Suicide

The impact of casino gambling on suicide rates and its related costs has been controversial in the field of public planning and health services. One study published in 2004 examining the effect of the introduction of new casinos on county-level divorce and suicide rates found that there was no widespread, significant increase when compared to economically and demographically similar counties that did not have casino gambling. According to the US Census Bureau, a county is the term for the largest geographic division within a state. There no longer is county government in Connecticut, but the Census Bureau continues to recognize them as geographical boundaries.

Another study published in 2002 showed that in metropolitan areas where a casino exists, there is a modest elevation in suicide rates. This same study also analyzed the data using a different methodology and concluded that there were no changes in suicide rates in metropolitan areas with or without casinos. However, the authors write that the finding of the moderate increase in suicide rates should not be summarily dismissed.[71] A metropolitan area is a federally designated geographical unit consisting of an urbanized area with a central city of at least 50,000 residents and a regional population of 100,000. They are referred to as Metropolitan Statistical Areas ("MSAs"), and are defined by the US Office of Management and Budget through Census Bureau guidelines.

A study in Oregon found that of the 1,700 gamblers who received publicly funded treatment in 2005-2006, more than 18 percent reported gambling-related suicidal thoughts. Oregon reported that roughly 9 percent of the 1,700 clients attempted suicide.[72]

The relationship between suicide and pathological gambling has been examined in several scientific studies. Most have found suicide rates high among pathological gamblers. A review of the published literature by Specker et al.[73] estimated that suicide attempt rates range from 12 percent to 24 percent among pathological gamblers.

As part of our research, we interviewed Connecticut Chief Medical Examiner H. Wayne Carver II, M.D., regarding four suicides in Connecticut since 2000 that may have been gambling related. In one case, Carver confirmed that a 49-year old Rhode Island man committed suicide in Stonington in September 2000. Carver said records indicated that he was in financial trouble, and gambled frequently at a Connecticut casino. Carver added that, in his 27 years as state chief medical examiner, he "anecdotally knows of two or three" other cases of suicide that may have been related to gambling problems. He noted that his office has "no way of tracking" gambling-related suicides because evidence of such a connection may be impossible to establish.

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[71] McCleary R, Chew KSY, Merrill V, Napolitano C, 2002. Does legalized gambling elevate the risk of suicide? An analysis of US counties and metropolitan areas. Suicide and Life-Threatening Behavior; 32(2), Summer 2002, p. 209-221.

[72] Marotta, Jeffery J., Service Delivery Overview: 2005-2007 Biennium. Salem OR, Department of Human Services, Office of Mental Health and Addiction Services.

[73] Specker SM, Carlson GA, Christenson GA, Marcotte M. Impulse control disorders and attention deficit disorder in pathological gamblers. *Ann Clin Psychiatry*. 1995 Dec;7(4):175-9.

Other Addictive Behaviors: Alcohol, Tobacco, Drugs

According to the National Research Council,[74] problem gamblers are more likely than non-problem players to report problematic levels of consumption of drugs, alcohol and cigarettes.

A recent national study of lifetime gambling prevalence and comorbidity[75] found that 73.2 percent of pathological gamblers had an alcohol-use disorder, 38.1 percent had a drug use disorder, and 60.4 percent had nicotine dependence.

The reason for this comorbidity (the presence of one or more diseases in addition to the primary disease) may be that alcoholism, substance abuse, smoking and pathological gambling are linked together by the same biochemical-rewards system. If an imbalance occurs in the chemicals that participate in this reward system, the brain may substitute craving and compulsive behavior for satiation.[76]

The most common comorbidity cited by clinicians in our qualitative interviews was alcoholism. According to the Centers for Disease Control, alcohol-use disorders ("AUD"), consisting of either alcohol abuse or alcohol dependency, is the third-leading lifestyle-related cause of death in the US. In 2003, there were more than 2 million hospitalizations and more than 4 million emergency room visits for alcohol-related conditions.[77]

People with alcohol disorders have higher cost and utilization of medical services than persons without such disorders.[78] In 1998, it was estimated that alcohol-related problems cost every individual in the United States roughly $683 each year.[79] Equivalent costs, assuming a 25.26 percent inflation rate from 1998-2007, would be $856 per person.

A 1998 national telephone survey, conducted by the National Opinion Research Center for the National Gambling Impact Study Commission, found that probable pathological and or problem gamblers had approximately seven times the rate of alcohol dependence than non-gamblers and low-risk gamblers.[80]

Nearly 15 percent of problem gamblers sought help for alcohol or drug use compared to 3 percent of non-problem gamblers, based on results of the Spectrum survey.

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[74] National Research Council. (1999). *Pathological Gambling: A Critical Review*, Washington, DC: National Academy Press.

[75] Petry NM, Stinson FS, Grant BF (2005): Comorbidity of DSM-IV pathological gambling and other psychiatric disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry* 66:564-574.

[76] Blum K, Sheridan PJ, Wood RC, Braverman ER, Chen TJ, Cull JG, Comings DE. The D2 dopamine receptor gene as a determinant of reward deficiency syndrome. *J R Soc Med.* 1996 Jul;89(7):396-400.

[77] CDC, Quick stats. General information on alcohol use and health. http://www.cdc.gov/alcohol/quickstats/general_info.htm. (accessed on March 12, 2007).

[78] Parthasarathy S, Weisner CM, Hu T-W, et al. Association of outpatient alcohol and drug treatment with health care utilization and cost: revisiting the offset hypothesis. J Stud Alcohol. 2001;62:89–97.

[79] National Institute of Alcoholism and Alcohol Abuse. *10th Special Report to Congress on Alcohol and Health from the Secretary of Heath and Human Services.* US DHHS June 2000. pg 364-371.

[80] National Opinion Research Center, 1999.

The health effects of smoking are well documented. The following is a list of known health effects:

- Smoking harms nearly every organ of the body, causing many diseases and reducing the health of smokers in general.[81]
- The adverse health effects from cigarette smoking account for an estimated 438,000 deaths, or nearly 1 of every 5 deaths, each year in the United States.[82]
- The risk of dying from lung cancer is 23 times higher among men who smoke cigarettes, and about 13 times higher among women who smoke cigarettes, compared with non-smokers.[43]
- Cigarette smokers are two-to-four times more likely to develop coronary heart disease than nonsmokers.[83]
- Cigarette smoking approximately doubles a person's risk for stroke.[84]
- About 90 percent of all deaths from chronic obstructive lung diseases are attributable to cigarette smoking.[43]

The effects of second-hand smoke on gamblers and employees at gambling venues have been explored in detail. Some relevant research findings are:

- The average level of cotinine (metabolized nicotine) among nonsmokers increased by 456 percent, and the average levels of the carcinogen NNAL increased by 112 percent after four hours exposure to secondhand smoke in a smoke-filled casino with a "sophisticated" ventilation system.[85]
- Smoke-filled casinos have up to 50 times more cancer-causing particles in the air than highways and city streets clogged with diesel trucks in rush-hour traffic. After going smoke free, indoor air pollution virtually disappears in the same environments.[86]

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[81] US Department of Health and Human Services. *The Health Consequences of Smoking: A Report of the Surgeon General*. US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004 [cited 2006 Dec 5], http://www.cdc.gov/tobacco/data_statistics/sgr/sgr_2004/index.htm.

[82] Centers for Disease Control and Prevention. Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses—United States, 1997–2001. Morbidity and Mortality Weekly Report [serial online]. 2002;51(14):300–303 [cited 2006 Dec 5]. Available from: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5114a2.htm.

[83] US Department of Health and Human Services. Reducing the Health Consequences of Smoking—25 Years of Progress: A Report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services, CDC; 1989. DHHS Pub. No. (CDC) 89–8411 [cited 2006 Dec 5], http://profiles.nlm.nih.gov/NN/B/B/X/S/.

[84] US Department of Health and Human Services. Tobacco Use Among US Racial/Ethnic Minority Groups—African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services, CDC; 1998 [cited 2006 Dec 5], http://www.cdc.gov/tobacco/data_statistics/sgr/sgr_1998/index.htm.

[85] Anderson, K.; Kliris, J.; Murphy, L.; Carmella, S.; Han, S.; Link, C.; Bliss, R.; Puumala, S.; Hecht, S., "Metabolites of Tobacco-Specific Lung Carcinogen in Nonsmoking Casino Patrons," *Cancer Epidemiology, Biomarkers & Prevention*, 12:1544-1546, December 2003.

[86] Repace, J., "Respirable Particles and Carcinogens in the Air of Delaware Hospitality Venues Before and After a Smoking Ban." *JOEM*, September 10, 2004.

Impact on Relationships

Problem and pathological gambling are associated with interpersonal problems, including arguments with family, friends and co-workers.[87] Clinicians noted that only a minority of problem gamblers seeking therapy have supportive relationships that survive problems associated with their disorder.

Many times, families are not equipped to cope with financial and social strains that problem gambling creates. This frustration is compounded by a lack of understanding of the nature of the disorder. Failing to recognize it as a disorder, significant others become frustrated, believing that the gambler could choose to stop gambling. By taking such a position, they often fail to assist the problem gambler in identifying the disorder and seeking assistance.

The following is a description of this cycle as described by one of the clinicians in our round-table discussion.

> "A lot of people see it as a moral issue. When the bottom does fall out, they come in with shame and embarrassment and guilt, supported by many people in their lives saying 'this is just you being stupid and weak' … that kind of thing.
>
> "We've made enough progress with other addictions that even though that still happens, we have a general consensus that addiction is a disease or a disorder or an illness. There is even a general consensus with family members where we hear them say, 'If you were drinking or using cocaine, I could understand.'"

In a study of family and problem gambling, Lorenz and Yaffee[88] surveyed 206 married Gamblers Anonymous ("GA") respondents about their medical and mental health and the health of their marital relationship during the "desperation phase" of their illness, when gambling was at its worse. This is when gamblers often alienate their friends and families.

During the desperation phase, 49 percent of the GA members indicated that their sexual relationship with their spouse was unsatisfactory, while 19 percent reported that their dissatisfaction continued even after they had abstained from gambling. Lorenz and Shuttlesworth found that 50 percent of the respondents indicated that their spouses lost interest in sex during periods of heavy gambling.

They further reported that 48 percent of their 206 married GA respondents stated they had seriously considered having an extramarital affair during their desperation phase; 23 percent reported having done so. Fifty-nine percent indicated they thought about separating from their spouses, and one third of the respondents eventually did separate.

A study involving women married to problem gamblers asked participants to recall emotions and symptoms they experienced when their partner's gambling was at its worst.[89]

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[87] Shaffer, H.J. & Korn, D.A. (2002). Gambling and related mental disorders: A public health analysis. *Annual Review of Public Health*, 23, 171-212.

[88] Lorenz, V. C., & Yaffee, R. (1988). Pathological gambling: Psychosomatic, emotional and marital difficulties as reported by the spouse*. Journal of Gambling Behavior, 4,* 13-26.

[89] Lorenz VC, Yaffee RA. "*Pathological gambling: psychosomatic, emotional and marital difficulties as reported by the spouse,"* Journal of Gambling Behavoir. 1988; 4:13-26.

Researchers documented anger or resentment (74 percent), depression (47 percent), isolation (44 percent) and guilt about contributing to the gambling problem (30 percent). Physical complaints included chronic or severe headaches (41 percent) and stomach and bowel ailments (37 percent). In 36 percent of the cases, the gambler wanted the spouse to join him in his gambling activities, and in most of these situations, the spouse complied. Eighty-six percent of spouses contemplated leaving their gambling spouses, and 29 percent did.

The Spectrum survey indicated that 52 percent of significant others of gamblers experienced periods of depression.

Much of the scientific literature on the effects of problem gambling on the family focus on domestic violence, but this is just a small proportion of the harm being done to families. As summarized by one of the clinicians in our round-table session:

> "What people don't understand is the degree of preoccupation in the family. Normal activities around the house stop happening. People aren't eating together. People aren't talking to each other. People aren't nurturing each other, children not doing homework. These are chronic, high stress effects – diminished social family functioning that destroys the kids. As for the kids, they then start doing their own things to cope; they drink and do drugs."

In our telephone survey, we found:

- 51.8 percent of problem gamblers versus 23.3 percent of non-problem gamblers admitted to having a period of two weeks or longer in their lifetime when they lost interest in most things that they usually enjoyed
- 15.1 percent of problem gamblers versus only 0.2 percent non-problem gamblers admitted that gambling made them careless of their own welfare and that of their families

This lack of interest and family neglect can happen for a range of reasons. A member of Gamblers Anonymous told us in an interview: "Gambling becomes everything to you."

A problem gambler (female) participating in one of our focus groups related the following: "I would tell my family to meet me at a restaurant, but… I would never show up. I left my family for days. They didn't know whether I was alive or dead."

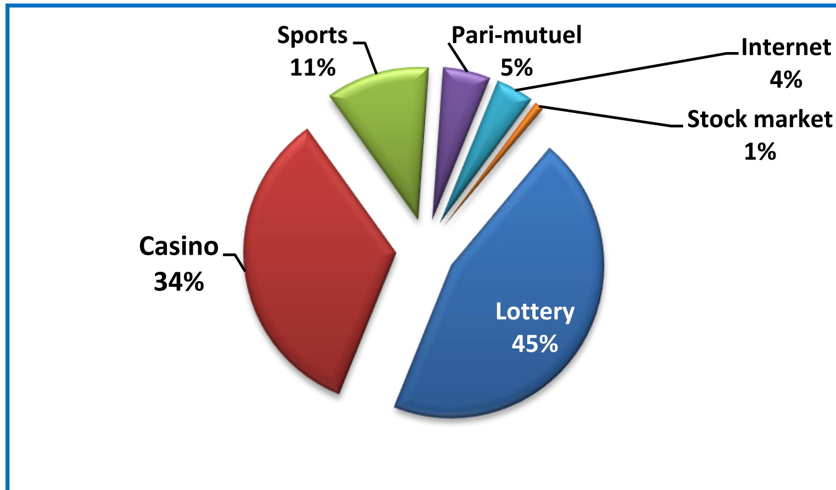
A secondary issue is the guilt and shame with which problem gamblers must cope. A problem gambler in one of our focus groups said: "You lose your kids' college fund, your mortgage. You are borrowing from friends and family – you are afraid to face them."

Extending beyond Connecticut boundaries

To ensure a complete understanding of this important issue, it is important to note that problem gambling and its related problems do not stop at municipal or state boundaries. This is illustrated in the following data gleaned from the neighboring Massachusetts Council on Compulsive Gambling.

The Massachusetts Council instituted a 24-hour Helpline in 1987, and since 1989, state law required that all gambling outlets post the number.[90] The Council reports receiving 1,472 calls to its Helpline in FY 2007, which ended June 30, 2007. The following chart summarizes the type of calls received:

Figure 41: Why People Called MA Council on Compulsive Gambling Helpline



Source: Massachusetts Council on Compulsive Gambling, FY 2007

More than one third of the calls came from people who had gambled at casinos, and those callers live in Massachusetts, a state that does not have casinos. This would lead to the reasonable conclusion that at least some of the costs associated with treating problem gamblers who play at casinos in Connecticut (and elsewhere) are effectively out-sourced to other states.

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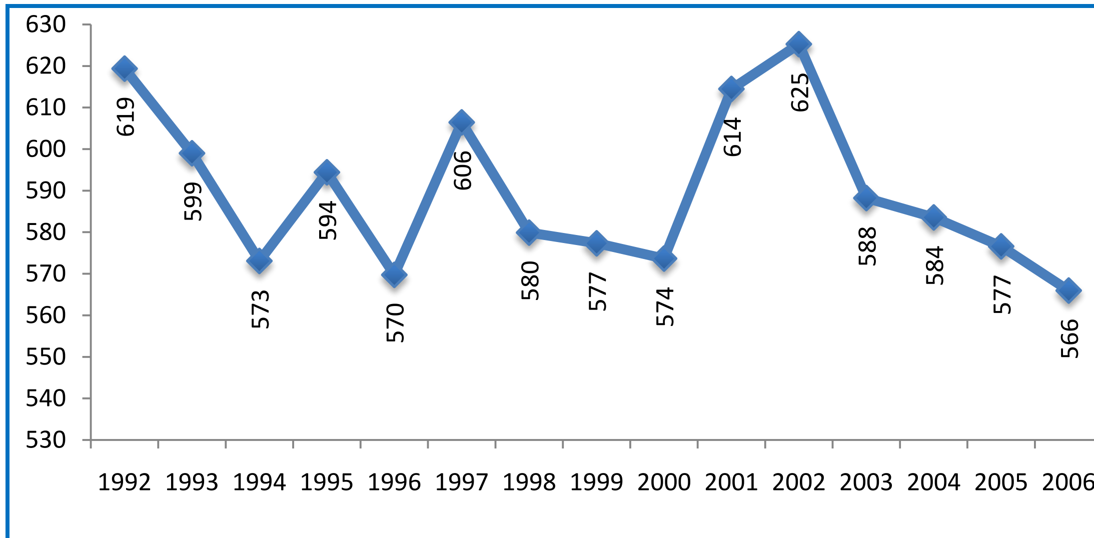
[90] Massachusetts Council on Compulsive Gambling.

Abuse and Domestic Violence

Figure 42: Connecticut Domestic Violence Rates per 100,000



Source: State of Connecticut Family Violence Detailed Report 2006

In the Connecticut Uniform Crime Reports, family violence is defined as "an arrest incident in which at least one member of a family or household causes or threatens to cause injury to at least one other member of that family or household."

Family or domestic violence and addiction have several common features, including loss of control; continuation despite adverse consequences; tolerance and withdrawal; involvement of the entire family; preoccupation or obsession; and defenses of denial, minimization and rationalization.[91]

Domestic violence takes many forms: physical violence, sexual abuse, psychological and emotional abuse, social abuse, financial abuse, harassment and stalking. According to a report by the National Research Council, 25 to 50 percent of spouses of compulsive gamblers have been abused.[92] A study of emergency room cases of intimate-partner violence showed that the odds increased 10.5 times when a partner was a problem gambler.[93]

The following chart illustrates trends in incidence of domestic violence per 100,000 for Connecticut from 1992 to 2006.[94]

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[91] Muelleman RL, DenOtter T, Wadman MC, Tran TP, Anderson J. 2002. Problem gambling in the Partner of the Emergency Department Patient as a Risk Factor for Intimate Partner Violence. *Journal of Emergency Medicine* 23 :307-312.

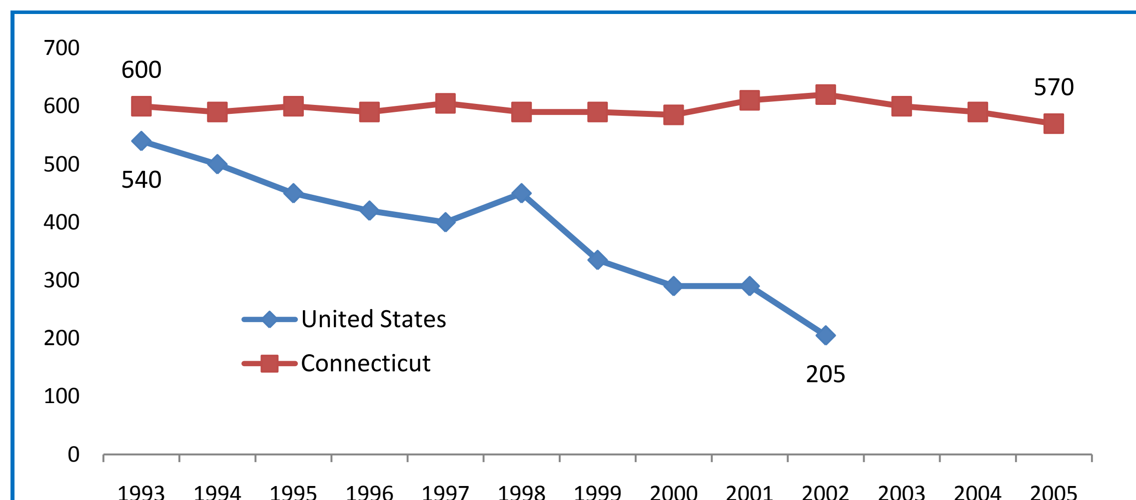
[92] University of Chicago, National Opinion Research Center . 1999. Gambling impact and behavior study: Report to the National Gambling Impact Study Commission.

[93] Muelleman RL, DenOtter T, Wadman MC, Tran TP, Anderson J. 2002. Problem gambling in the Partner of the Emergency Department Patient as a Risk Factor for Intimate Partner Violence. *Journal of Emergency Medicine* 23 :307-312.

[94] State of Connecticut Family Violence Detailed Report 2006. State of Connecticut Department of Public Safety Division of State Police, Crimes Analysis Unit.

Figure 43: Connecticut Family Violence Rates vs. National Rates

Domestic Violence Rate per 100,000 people



Source: US Department of Health and Human Services, Connecticut State Police, Crimes Analysis Unit

Although almost equal in 1993, state domestic violence rates have stayed relatively stable since that time, while domestic violence rates nationally have dropped on average by 9 percent each year. Statisticians and law enforcement personnel we interviewed could not offer an explanation as to why domestic violence rates in Connecticut differed so much than the national rate.

The most common types of domestic violence perpetuated by problem gamblers are not physical in nature. They are psychological, emotional, social and financial and, therefore, not readily recognized as abuse, even by the victim himself or herself.

It should be noted that domestic violence is one of the most "chronically underreported" crimes.[95] Only approximately one-quarter of all physical assaults against females by intimate partners are reported.[96]

In FY 2006, 540 Connecticut residents were turned away from shelters due to a lack of beds. The emergency shelters housed 977 women and 949 children during that fiscal year.[97]

Because of the emotional strain, it is likely that a child of a pathological gambler will end up doing poorly in school, manifesting behavioral problems in the classroom or failing to graduate. A supervisor at the Norwich Department of Social Services, speaking as a representative of the department, told us about a number of children misbehaving as a result of a parent's gambling problem.

One of the clinicians in our round-table session noted the lack of assistance or recognition within the school system for the children of problem gamblers:

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[95] US Department of Justice, Bureau of Justice Statistics, "Criminal Victimization," 2003.

[96] Tjaden, Patricia & Thoennes, Nancy. National Institute of Justice and the Centers of Disease Control and Prevention, "Extent, Nature and Consequences of Intimate Partner Violence: Findings from the National Violence Against Women Survey," (2000).

[97] Connecticut Coalition Against Domestic Abuse.

"As a child in the school system, you are going to hear, 'If your parents are getting a divorce, we have help for you.' If your parent is an alcoholic or an addict, we have help for you. If you are struggling with virtually any problem in your home, there is something here for you.' But you are not going to hear, 'If you have a parent or a grandparent or a sibling who is a gambler, there is help for you.' So what is the likelihood of that kid, who is not going to have an easy time going to anyone, anyway … is going to ask for help?"

Bland and colleagues[98] estimated that 17 percent of the children of pathological gamblers were physically and verbally abused. These percentages vary somewhat across studies. Lorenz and Shuttlesworth (1993) estimated that 10 percent of children experienced physical abuse from the pathological gambler. Even if the child is not the direct recipient of the physical abuse, they are still statistically more likely to suffer from long-term physical and mental health problems, substance abuse and the possibility of becoming a victim or perpetrator of violence as a result of witnessing physical abuse in the home.

In our telephone survey, we asked respondents about the effect, if any, gambling had on their lives. The first figure is for gamblers; the second for non-gamblers.

- difficulty sleeping (16.5 percent vs. 1.3 percent)
- irritability (18.8 percent vs. 7.8 percent)
- decrease in ambition (15.1 percent vs. 0.2 percent)
- loss of interest (51.8 percent vs. 23.3 percent)
- lost time from work (11.6 percent vs. 0.1 percent)
- affected reputation (5.9 percent vs. 0.3 percent)

Prevalence studies are designed to measure the extent of problem gambling in a general population. Categories include both problem and pathological gambling. Although problem gamblers in our prevalence study are significantly more likely to lose time from work, this is not the only cost to the employer. It is assumed that an employee who is not absent is being productive. However, even when employees are physically present at their jobs, their work product may often be lacking in quality. It is a phenomenon referred to as "lost (work) productive time," and is characterized by:

- Time not on task
- Decreased quality of work
- Decreased quantity of work
- Unsatisfactory employee interpersonal factors

These costs escalate the longer that employees are unable to cope with the difficulties that may arise in their personal lives. The compounding of problems is increased by the symptoms of the addiction itself: difficulty sleeping, a loss of interest in anything but gambling and a decrease in ambition.[99]

[98] Bland RC, Newman SC, Orn H, Stebelski G. 1993. Epidemiology of pathologic gambling in Edmonton, *Canadian Journal of Psychiatry* 38:108–12.

[99] Jauregui, M. and Schnall, P.L. Work, "*Psychosocial Stressors and the Bottom Line Unhealthy Work: Causes, Consequences, Cures"* Baywood Publishing Company, Inc. Amityville, New York. 2008.

The Connecticut prevalence of problem and probable pathological gambling based on the result of our survey is:

- 3.7 percent SOGS lifetime
- 3.3 percent NODS lifetime
- 1.5 percent SOGS past year
- 1.4 percent NODS past year

As of July 1, 2007, Connecticut's population of residents 18 or older was 2,666,750.[100] Between 60 and 63 percent of problem and probable pathological gamblers are employed full-time based on our prevalence study. We estimate that approximately 23,000 to 57,000 employees are currently costing their employees money through below normal-work quality as a direct result of problem gambling.

Medical Utilization

According to one research study (Morasco, et al.1996), gambling severity has been found to be associated with higher rates of medical utilization, with pathological gamblers more likely to have been treated in the emergency room in the past year than low-risk individuals, even after controlling for demographic characteristics, body-mass index, alcohol abuse and nicotine dependence.

The William W. Backus Hospital in Norwich is the hospital closest to the two Connecticut casinos. Although its charity-care costs are relatively low as a result of casino-provided health coverage for employees, the hospital has experienced significant costs related to treatment of gamblers. Casino patrons have suffered heart attacks, for example, at gaming properties. In some cases, the patrons were either underinsured or not insured at all, causing the hospital to sustain a significant loss of as much as $1 million.[101]

A clinician at the Hartford-based Wheeler Clinic, which is part of the Bettor Choice network, told us that the mental health system is being over-utilized because people are coming in for depression and anxiety "and no one asks about gambling." The Wheeler Clinic, founded in 1968, provides other "behavioral health services" for problems involving mental health and substance abuse.[102]

The telephone survey undertaken for this gambling-impact report showed that problem and probable pathological gamblers were significantly more likely than non-problem gamblers to have sought help for mental health issues (25 percent vs. 10.9 percent).

Criminal Justice System

Gambling addictions lead to financial problems and can eventually develop into desperate behaviors, many of which are illegal. In our telephone survey, we found that problem and probable pathological gamblers were significantly more likely than non-problem gamblers to have:

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[100] US Census Bureau, 2005-2007 American Community Survey. (accessed on May 19, 2009)
[101] Interview with Backus administrators, September 2008.
[102] Wheeler Clinic Online, http://www.wheelerclinic.org/about.php, (accessed on April 15, 2009).

- Written a bad check or taken money that did not belong to them to pay for their gambling (13.7 percent vs. 0 percent)
- Committed an illegal act to pay for a gambling debt (27.3 percent vs. 2.4 percent)
- Considered committing an illegal act to finance gambling (8.2 percent vs. 0.6 percent)

Federal and state prosecutors in Connecticut are concerned over a significant increase in embezzlements. There were 43 embezzlement arrests in 1992, the year the first Indian casino opened. In 2007, there were 214. No other state that reported 40 or more embezzlements in 1992 has had a higher percentage increase than Connecticut. The state's increase is nearly 10 times that of the national average. From 1997 to 2007, there were 1,853 embezzlement arrests in Connecticut.[103] The extent of embezzlements is discussed in detail in another section of this report.

The FBI and state crime reports do not indicate how many of the embezzlements were casino- or gambling-related, but our research shows that some of those who stole from their employer used either part or all of the money to gamble at the two Indian casinos.[104]

Among our findings:

- During an 11 year-period ending December 31, 2008, we found 31 newspaper articles involving separate incidents of money embezzled in Connecticut that was used to gamble at the casinos. Some of the incidents involved multiple arrests. There were embezzlements in other states, such as Massachusetts and Rhode Island. They were not included in our review.[105]
- The embezzled amount totaled nearly $8 million.

Overall Impact

Various studies in the past have attempted to measure the economic costs associated with problem gambling, usually referred to as "negative externalities." Negative externalities frequently refer to many of the impacts that we have discussed in this section, such as divorce, bankruptcy, mental and physical health issues, and arrest and incarceration.

It is extremely difficult to quantify and assign such economic costs. Every impact mentioned in this section can be mitigated by a multitude of other factors. And every impact has the ability to interact with other impacts to produce a synergistic effect that is greater than the effect one would expect given its individual components.

In addition, many of the impacts mentioned in this section are not easily quantified, such as emotional and financial abuse or the existence of conflict in a relationship. The difficulty in measuring impact comes from the lack of a standard methodology for measuring the value of these costs.[106] Because of this, a substantial diversity exists in results, with estimates of annual

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[103] Connecticut Uniform Crime Reports, FBI Crime in the United States.

[104] Interviews with prosecutors, local police departments, a review of newspaper articles and discussions with gambling treatment counselors.

[105] FBI, Crime in the United States; Uniform Crime Report, Connecticut State Police (2007 was the last year for which data was available).

[106] Walker, Douglass, *"Methodological issues in the social cost of gambling studies."* Journal of Gambling Studies (2003), 15(3): Pages 149-184, 2003.

costs ranging from $560 to $52,000 per problem gambler. All such estimates are based on assumptions and can be interpreted as demonstrating that the impacts of problem gambling are either minor or large.

That being said, the usual manner of calculating impact costs for problem gambling is to multiply the prevalence rate by the population, and estimate the cost per pathological gambler to arrive at a total social cost estimate.

As of July 1, 2007, there were 2,666,750 residents 18 or older in Connecticut.[107] Our survey indicates a probable pathological gambling prevalence rate of 1.2 percent (lifetime NODS) to 1.5 percent (lifetime SOGS). The baseline estimate of for gambling losses is $13,586 per pathological gambler.[108] It is a figure that has been used to determine the financial costs in several other gambling-impact studies. The losses of the pathological gamblers could therefore range from $435 million to $543 million.

Not all of that $13,586 loss per pathological gambler is a direct monetary cost to the state, but much of it is. Gambling losses represent money that could have been used to pay state and local taxes. There are also the indirect costs of counseling and related services to problem gamblers and their families. An example is the inability of pathological gamblers and their families to pay for hospital services that are often used. There is also a financial impact to the criminal justice system in prosecuting gambling-related crimes.

It would be imprudent to take our estimate as anything more than a ballpark figure. A full cost-benefit study would have to be undertaken to obtain a more accurate estimate of the impact on the state.

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[107] US Census Bureau, 2005-2007 American Community Survey. (accessed May 19, 2009)

[108] Grinols, E & Mustard, DB. Business Profitability vs. Social Profitability: Evaluating The Social Contribution Of Industries With Externalities, The Case Of The Casino Industry.

Problem Gambling Services

The state of Connecticut's outpatient program, established in 1982 in Middletown, is the oldest, continuously operating program in the nation, according to the National Council on Problem Gambling. It has expanded to include a network of 17 sites that are operated through "The Bettor Choice." Since 1998, the program has been administered by Problem Gambling Services ("PGS"), a division within the Department of Mental Health and Addiction Services ("DHMAS").

The lone state clinic in Middletown saw 100 clients in 1997.[109] In FY 2008, the figure for the 17 Bettor Choice clinics was 922.[110]

In addition to Bettor Choice, there are a number of other treatment options available for the problem gambler in Connecticut. They range from the use of a for-profit gambling counselor or psychologist to programs at Yale and the University of Connecticut.

PGS receives its money through the "Chronic gamblers treatment and rehabilitation program." The fund consists of contributions from the CLC and OTB facilities. PGS is required "to set aside not less than five per cent" of its funds for a contract with the Connecticut Council on Problem Gambling.[111] The CLC provided nearly 90 percent of the $2 million earmarked in FY 2009 for the chronic gamblers treatment fund.[112]

Bettor Choice clinics provide services at little or no cost, which is important because problem gamblers and their families are often in debt and unable to pay for treatment. Some services are free; others are billed according to income. The state takes gambling debts into account when establishing ability to pay. Medical insurance may cover all or part of the expense.[113]

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[109] WEFA GROUP June 1997, "*A Study Concerning the Effects of Legalized Gambling on the Citizens of the State of Connecticut.*"
[110] Bettor Choice program.
[111] State Statute, 17a-713.
[112] Problem Gambling Services.
[113] Ibid.

Figure 44: Location of Bettor Choice Clinics

Facility name	Locations
Positive Directions	Westport
Connecticut Renaissance	Norwalk, Stamford
Regional Network of Programs: Regional Counseling Services	Bridgeport
Problem Gambling Services	Middletown, Old Saybrook, New Haven
United Community and Family Services	Norwich, Jewett City, New London, Putnam
Wheeler Clinic	Hartford, Plainville
McCall Foundation	Torrington
Morris Foundation	Waterbury
MCCA Outpatient Counseling Center	Danbury, Middlebury

The Problem Gambling Service clinics in Middletown, Old Saybrook and New Haven provided treatment for about half of the Bettor Choice clients in 2008.[114]

Figure 45: Types of Problem-Gambling Therapy Offered in Connecticut

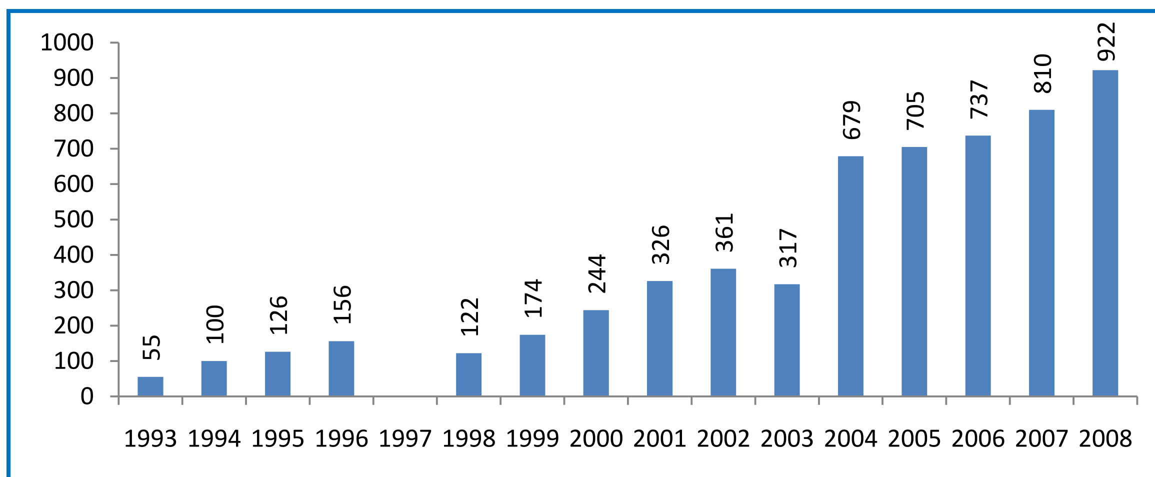
Does the State fund outpatient therapy?	Yes
Does the State fund residential therapy?	No
Reimbursement method (fee-for-service, capitated...)?	Fee for service, grants
What certificates/licenses are counselors required to have?	Masters level degree LCSW & licensed counselors/therapists

Source: Problem Gambling Services

While the number of clients has significantly increased since 2004, administrators explained that was the year that they developed a comprehensive system to better record client data. Prior to 2004, the different agencies that were part of the program did not keep records as detailed as are currently maintained. Nonetheless, PGS maintains that the increase in clients is still significant.[115]

[114] Bettor Choice program.
[115] Ibid.

Figure 46: Clients Enrolled by Year in Bettor Choice Programs



Source: Bettor Choice Program; 1997 data unavailable but WEFA report listed the number as being 100

Most of the treatment facilities receive between 20 to 40 new calls per month. Of these callers, roughly 80 percent pursue treatment. They are generally seen within a week.[116] More than 90 percent of the clients are pathological gamblers. One clinician noted: "The people who get there (Bettor Choice) are really ready to do something. … They've hit bottom."

The length of treatment ranges from two months to two years. Bettor Choice programs offer a range of outpatient services and therapies that include:

- Individual counseling sessions with a therapist for both gamblers and members of their families. (The primary form of treatment offered at Bettor Choice.)
- Group therapy for gamblers and family members. This type of therapy allows for mutual support and problem solving.
- Peer counseling for current gamblers to get support and share experiences with someone who has successfully dealt with the problems surrounding pathological gambling.
- Financial-recovery counseling for gamblers and their families to reduce financial pressures and manage debt.
- Psychiatric consultation and treatment to assess and treat co-occurring conditions such as anxiety and depression that may work as obstacles to recovery.
- Education of gamblers and their families to raise awareness of problem gambling.
- Marital and family therapy to help to improve family functioning. In these sessions, gamblers and their families learn effective communication within a supportive environment.

In addition to outpatient services, one facility, the Midwestern Connecticut Council on Alcoholism's McDonough House in Danbury, provides a five-day inpatient residential program for problem gamblers. It is meant as a respite for those who cannot reduce gambling between outpatient visits because they lack the support system or coping skills to do so. Clients follow an individualized treatment plan. They occupy two of 20 beds in a substance abuse treatment

[116] Ibid.

facility. A client seeking a full-scale residential treatment program that would include a stay of four to six weeks must go out of state.[117]

Inpatient treatment facilities are important because they "provide a protective environment that includes medical stabilization, support, treatment for psychiatric or addictive disorders, and supervision." The National Council on Problem Gambling lists 12 inpatient facilities on its web site that meet its guidelines. The closest to Connecticut is Williamsville Wellness in Hanover, Virginia. It offers a four-week program.[118]

Another facility that is not on the Council list but is closer to Connecticut is the KeyStone Center in Chester, Pennsylvania. It offers an "intensive inpatient" treatment for 10 to 30 days at a cost of $350 per day.

Forms of Treatment

Psychoanalytic

This approach seeks to understand motivational forces behind behavior and how both cognition and emotion can be translated into gambling behavior. It is based on the idea that all human behavior serves a purpose for those who are participating in the behavior. Even destructive behavior such as problem gambling can be adaptive in some ways, and that if the individual does not deal with the underlying problem, the person will be unable to deal with the disorder on a long-term basis. (Rosenthal and Rugle, 1994) (NAP).

By discovering, acknowledging and dealing with the underlying problem, the individual will more easily be able to avoid self-destructive behavior. For a time, this was the most common form of treatment for pathological gambling.

Behavioral

Behavioral approaches use classical conditioning to accomplish the goals of modifying gambling behaviors. Aversion therapies apply unpleasant stimuli, either physical or emotional, when they engage or think about engaging in the behavior that they are trying to overcome. Desensitization therapies such as imaginal relaxation try to desensitize the gambler to the excitement experienced while gambling, so that it is easier to resist the urge to gamble. Behavioral counseling uses verbal reinforcement of desired behaviors and is used in both individual and group settings. Contingency contracting, which is an extension of this, both rewards desired behavior and punishes undesirable behavior.

Cognitive and Cognitive-Behavioral Therapies

Cognitive and cognitive-behavioral therapies are based on the idea that gamblers have irrational beliefs about gambling risks, an illusion of control, biased evaluations of gambling

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[117] Problem Gambling Services.

[118] National Council on Problem Gambling, *"Inpatient and Residential Treatment Facility List,"* http://www.ncpgambling.org/i4a/pages/Index.cfm?pageID=3326. (accessed on April 30, 2009).

outcomes and a belief that gambling is a solution to their financial problems (Ladouceur et al., 1994). These therapies seek to change underlying beliefs about gambling and how to identify and cope with situations that put them at risk for relapse.

Pharmacological Treatments

There is no standard pharmacological treatment for pathological gambling because there no approved medication.[119] Among the medications that have been tested in clinical trials are anti-depressants, mood stabilizers and opioid antagonists.[120]

Addiction Based Treatments

These treatments involve a range of different techniques which were first used for the treatment of other addictive behaviors. They include the use of peer counselors, 12-step meetings, coping strategies for avoiding high-risk situations, gambling triggers and developing problem-solving skills for dealing with urges or cravings. Other aspects of treatment include family therapy and after-care planning, which includes identification of a support system; continuing involvement in Gamblers Anonymous; relapse prevention strategies; a budget and plan for financial restitution; a plan for addressing legal issues; and ongoing individual or group therapy, family therapy and medication.

Bettor Choice Strategies

The clinicians at Bettor Choice reported they employ a range of therapies and techniques. They described a more holistic approach based on the understanding that pathological gambling is a disorder that impacts the individual "mentally, physically, spiritually, emotionally and financially," and that all aspects must be treated to minimize the possibility of a relapse.

A clinician told us: "We've all adopted whatever works, whether you are working individually or with a family or in a group setting. We do a lot around relaxation, stress management and skill development to prevent a return to gambling as a coping strategy. We do a lot of work around social, recreational, leisure, spiritual involvement for support and a lot of trying to get people connected to other types of resources."

Because of the need for a holistic approach, the clinicians often end up wearing several hats at once: "You become therapist and case manager. You are coordinating a range of interventions, as well as case management, as well as counseling, as well as psychotherapy, as well as family therapy; but you have to do it all because there isn't the network out there that you would have for other addictions."

This lack of a network was explained in the following manner by another clinician:

> "In other substance abuse and mental illnesses, you often have an infrastructure where you could easily refer to your program's anger management or whatever

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[119] Petry NM (2007): Gambling and substance use disorders: current status and future directions. *American Journal on Addictions* 16:1-9.

[120] Ibid.

you needed. We have to be it. You could refer someone to something where the staff often doesn't have a clue about the person's gambling and oftentimes that can do more damage than good. It is about educating and creating an infrastructure that isn't there yet and at the same time trying to deal with the needs of the client."

Responsible Gaming Programs

The Connecticut Council on Problem Gambling ("CCPG") was responsible for developing the nation's first self-exclusion program at Foxwoods in 1994. Connecticut does not have a state-regulated self-exclusion program like other states; the agreements between the state and the two tribal nations did not address the issue.

Nonetheless, Foxwoods voluntarily agreed to implement one along with a responsible gaming program. So, too, did Mohegan Sun shortly after it opened. Under such programs, literature concerning responsible gaming is made available throughout the casino along with information about self-exclusion. A self-excluded gambler is subject to arrest if he or she gambles at a casino.

With so much information obtained today through online means, both casinos agreed to post responsible gaming material on their websites. But from May 2008 through January 2009, there was nothing on the Foxwoods web site concerning responsible gaming. And if one put "self exclusion" into the search area of the web site during that time period, an application appeared for the Philadelphia Foxwoods property that has yet to break ground.

CCPG Executive Director Marvin Steinberg noted that the Foxwoods website had significant information about responsible gambling on it for a number of years, and patrons could always easily obtain literature on the subject throughout the casino. However, he said a glitch resulted in the removal of responsible gaming information from the Foxwoods website when the site was changed in 2008.

"We are disappointed that this happened," Steinberg told us.

After Spectrum Gaming brought the problem to the attention of Foxwoods executive John Perry, the responsible gaming information was back on the site as of April 15, 2009, when we accessed it. (www.foxwoods.com)

In other states, casinos have been heavily fined for failing to comply with a responsible gaming policy. In Pennsylvania, a casino cannot open unless regulators have first approved such a policy.[121]

Meanwhile, Mohegan Sun's web site, http://www.mohegansun.com, has had responsible gaming information on its home page throughout 2008 and early 2009. The site was accessed in May 2008, in January 2009 and in April 2009.

Mohegan Sun was involved in the creation of a video for bus patrons that detailed the warning signs of problem gambling such as using food or rent money to gamble and lying to a

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[121] Pennsylvania Gaming Control Board.

spouse about it. It was played in December 2008 on buses leaving from Massachusetts cities in Quincy, Allston, Dorchester, Methuen, Lawrence, Lowell, Lynn, Worcester and Malden.[122]

The passengers watched the message on small DVD screens dubbed in Mandarin, Cantonese, Vietnamese or Khmer, all with English subtitles. Mohegan Sun agreed to play the video at the request of the Massachusetts Council on Compulsive Gambling and helped finance its production.

Casino executives recognize they have an obligation to confront the issue of problem gambling. Jeffrey Hartmann, executive vice president, said Mohegan Sun has made "this part of our business philosophy."[123]

Meanwhile, critics of self-exclusion programs say the casinos do not do enough to keep the self-excluded gamblers from returning. Members of our focus groups who self-excluded themselves say they often returned to gamble. One said a casino host berated her for self-excluding herself. Another said she continued to receive promotional materials.

Regulators in Missouri have fined several casinos for sending promotional materials to people on the exclusion list. The tribal gaming authorities at Foxwoods and Mohegan Sun have never imposed a fine for regulatory violations.[124]

A study of Mohegan Sun self-excluded patrons indicated that 20 percent returned to the casino. And of those that did return, one-in-five returned nine or more times.[125]

Non-state Funded Treatment Programs

The most commonly mentioned support group or 12-step program mentioned in our interviews and focus groups was Gamblers Anonymous ("GA"). GA has affiliates in most North American cities and has expanded internationally. Unlike those in Alcoholics Anonymous, GA members must not only help members and provide support for direct gambling cravings, it must also help members face legal and financial challenges. GA, like other support or 12-step programs, does not involve professional intervention. Instead, it relies on peer support. And it is often used as a "way of getting through day-to-day" -- as a long-term maintenance program versus a short-term solution. GA offers free membership to anyone who is a problem gambler or a recovering problem gambler.

GA is "the outgrowth of a chance meeting" in 1957 between two men with gambling problems. They began to meet regularly to discuss their gambling addiction and quickly agreed they needed to make "certain character changes" within themselves. In order to maintain abstinence, they felt it was important to help others. The first GA meeting was held in Los Angeles, California, on September 13, 1957.[126]

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[122] Casino executives, Mohegan Sun.

[123] Matt Carroll, "Asian casino goers get mixed message on gambling," *Boston Globe*, http://www.boston.com/news/local/articles/2008/11/20/mixed_messages/ (accessed on May 22,2009)

[124] Interview with officials of the Mashantucket Pequot Tribal Nation and Mohegan Tribe.

[125] Preliminary evaluation of a self-exclusion program, Marvin Steinberg, Connecticut Council on Problem Gambling (January 1, 2000 through March 21, 2002).

[126] Gamblers Anonymous, http://www.gamblersanonymous.org/history.html(accessed on April 29, 2009).

Traditionally, GA members in Connecticut have been male, middle-aged sports bettors.[127] According to one of our interview sources within GA, it was with the advent of the casinos that the numbers of women have increased. Now, in some GA meetings, women outnumber men. According to members at the administrative levels of the organization, ethnic minorities are still greatly under-represented.

Almost all participants from our focus groups who were pathological gamblers were GA members. Participants were not recruited because they were members of GA, but, as they explained, almost all interventions eventually lead to GA, which was seen as part of a plan to get one's life back on track. Other ways to seek help are the 2-1-1, state-funded United Way Helpline and professional counseling, such as that offered through the state-funded clinics.

Among focus group participants, there was a belief that there were not enough GA meetings in Connecticut. GA holds 24 meetings a week throughout the state. Alcoholics Anonymous holds 611 weekly meetings.[128]

Gam-Anon is the sister organization for Gamblers Anonymous and is designed to provide support for the spouse, family or close friends of problem gamblers. Gam-Anon helps members work through feelings of resentment and anger. There were five meetings a week in Connecticut as of May 2009. Gam-Anon's prevailing idea is: "The gambler will play as long as someone else will pay."[129]

There are a number of research and treatment centers throughout the state that assist problem gamblers. They include:

- The Problem Gambling Clinic at the Connecticut Mental Health Center, a joint effort of the center and Yale's Department of Psychiatry. It was founded in 1998 to conduct clinical research to help better understand the clinical and biological features of pathological gambling. During the past 10 years, the clinic has seen approximately 300 patients. Treatment is free.
- The Gambling Treatment and Research Center, located at the University of Connecticut Health Center. It was founded in 1998, and its main source of funding is grants from the National Institutes of Health. Treatment is conducted within the context of research studies. The center has treated more than 1,000 individuals with gambling problems. Individualized treatment ranges from eight sessions to six months aftercare, and all treatment is free.
- Asian Family Services in Hartford, the only licensed mental health agency in the state that concentrates on the growing Asian population. It was founded in 1996, and merged in 2007 with the Community Renewal Team. It provides counseling for individuals, groups, couples, families and children. Clinical staff at the facility help clients deal with a number of social problems, including compulsive gambling.
- The Family Intervention Center in Waterbury. It offers individual, family and group counseling and personnel interventions to people who are hurting as a result of emotional pressures or stress. The center specializes in treating chemical dependency

[127] Interviews with GA officials in Connecticut.
[128] Ibid, Alcoholics Anonymous, http://www.aa.org
[129] About Gam-Anon, http://www.gam-anon.org/about.htm (accessed on May 7, 2009).

but also treats other addictions, including problem gambling. There are set fees for service.

- The Alliance Behavioral Services in Groton. It provides outpatient treatment for gambling addictions among other mental health disorders. There are set fees for services.

Success Rates

Even in periods of remission, pathological gambling is a disorder that may yield a continuing stream of disabilities. This vulnerability to relapse may be effectively treated and kept in check. However, a period in which the individual is relatively free of symptoms does not indicate that the person is free of the disorder. Thus, success in treatment programs can be measured in more than one way.

PGS Director Rugle acknowledged that the agency needs to do a better job of collecting data so that success rates can be more accurately measured. At our request, she developed the following table that shows broad ranges for fiscal years 2003 through 2007. To do the review, administrators manually went through files to assess outcomes.

As the table indicates, roughly 90 percent of Bettor Choice clients reported reduced gambling following treatment. The same percentage continued to be employed while they were treated. About 70 percent reported they were "abstinent" at discharge.[130] Because the ranges are so wide, it is difficult to track improvement in the treatment of problem gamblers.

[130] Bettor Choice program.

Figure 47: Bettor Choice Treatment Outcomes

	2003	2004	2005	2006	2007
Percent of clients reporting reduced gambling	88 - 96	82 – 93	83 - 90	70 – 95	89 - 97
Percent of clients abstinent at discharge	66 - 78	53 – 84	47 - 74	40 – 80	63 - 78
Percent of clients free of arrest for criminal behavior during course of treatment	100	89 – 100	96 - 100	99 - 100	100
Percent of clients employed during treatment	94-96	54 – 90	79 - 96	75 - 100	90 - 93

Source: Better Choice Program

The bordering state of Rhode Island does a better job of monitoring its success rates. The program, operated out of Rhode Island Hospital, attempts to contact former patients every six months to assess progress. It posts follow-up research data on its website.

The research found that of 118 patients surveyed, 53 percent abstained from gambling six months after their treatment ended, and 52 percent abstained after 12 months. In another survey of 101 patients, the program reported that the average amount of money lost gambling in the month previous to treatment was $2,969, compared to an average of $522 for all patients (including those who have abstained) in the month following treatment.

One of the Bettor Choice facilities – United Community Family Services in Norwich – provided us with additional data to help measure success rates. From July 2005 through November 2008, clinicians at United Community Family Services enrolled 255 Connecticut residents. Our review shows:

- 205 attended three or more sessions, including the initial intake
- 180 clients reported decreased gambling activity
- 90 clients completed their treatment program
- 80 were gambling free three weeks before discharge
- 62 were working at discharge
- 55 were working at intake
- 58 were gambling free during the time clinicians worked with them
- 51 went on to seek additional help through GA or other counseling

One of the factors that affects the success rate at Bettor Choice is the lack of a long-term residential treatment facility. A round-table participant described a GA member who was homeless because he was unable to stop gambling between outpatient visits and GA meetings. The interviewed subject believed that a residential program would have helped him and those like him. Another roundtable participant, the mother of a pathological gambler, related the following:

> “Being the mother of a compulsive gambler, I won’t drag out the war stories, but my son did finally ask for help and I met him at a hospital, and I took him in, and he saw the psychiatrist. He was very upset, so I brought him in. He didn’t do drugs. He didn’t do alcohol. He only gambled. There was no place for him in the hospital.

> "I took him in on a Friday. They gave him an outpatient appointment for Tuesday of the following week. He was homeless by then. ... As for a mother, finally, you wait years for that one moment. You get excited to talk ... but he has to go. He's only a gambler. If he was an alcoholic, or a drug addict, that would be a different story. I wanted to take him out and pour a bottle of liquor down his throat so that he could get a place."

Connecticut sorely needs an in-patient residential facility that offers more than a five-day respite that can accommodate no more than two problem gamblers at a time. Problem gamblers are forced to go out of state for such treatment, an expensive proposition that results in some of them putting off treatment, according to PGS administrators.

Because GA does not see itself as a "treatment" program per se, it is not prone to refer to itself in terms of "success rates." Members come and go as they please.

Comparing Connecticut to Other States

We compared Connecticut's problem gambling program with those in 17 states, including nearby Rhode Island, Massachusetts and New York. A table detailing the different treatment programs appears at the end of this section.

The most recent data from either FY 2008 or calendar year 2008 indicates that, in terms of per-capita funding and even total spending, Connecticut compares favorably. At 59 cents, it ranks fourth of the 18 states we surveyed. The three states with higher per-capita spending were Oregon ($1.65), Iowa ($1.47) and West Virginia ($1.10.)

Connecticut's spending was more than twice that of New York ($0.24), three times that of Massachusetts ($0.17) and almost ten times that of Rhode Island ($0.06.) It is five times that of New Jersey and Pennsylvania, which both are at about 11 cents, and nearly identical to Nevada ($0.58) and Louisiana ($0.58), two states with major commercial casino gaming activity.

Connecticut is one of 18 states with funds set aside for problem gambling therapy.

In other states where casinos have a significant presence, casino funds are often used to pay for such programs. Connecticut's Lottery provides PGS with almost all of its money. In FY 2009, it provided nearly $1.9 million, or more than 90 percent of its budget.

There are states that do much more to confront problem gambling.

Oregon, like Connecticut, also has tribal gaming, with nine Indian casinos. The Oregon Lottery operates nearly 11,000 video poker machines in 2,077 bars and taverns across the state. It provides 10 percent of its net proceeds for problem gambling.[131]

Oregon's promotion budget of $1.2 million, funded by the Lottery, is more than the total that some states spend on problem gambling. It is equal to about half of the total spent in Connecticut, which comes from the CLC.[132]

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[131] Oregon Department of Human Services.
[132] Connecticut Problem Gambling Services, Interview with Lori Rugle, executive director of PGS

Spending the money to effectively promote responsible gaming has paid dividends for Oregon. An analysis of Oregon data shows a significant increase in the frequency of Helpline calls when Oregon Lottery's ads for treatment are run.[133]

Connecticut's failure to promote the Bettor Choice program is one reason why Oregon treats so many more people, according to Chris Armentano, the former director of PGS. The Bettor Choice program promotes itself through:

- The Internet
- Federal and state criminal justice systems
- Other social service agencies
- Gamblers Anonymous and other 12 step groups
- Former clients
- The Phone book
- The Helpline

Oregon's program is widely recognized as the best in the country, according to problem-gambling experts. It includes operation of an extensive quality control and evaluation component, an element that is lacking in Connecticut. It produces an annual report every year, explaining in detail programs offered, success rates and number of people counseled. The FY 2008 report is nearly 200 pages.

Unlike Connecticut, Oregon offers residential treatment. Ninety-nine clients were enrolled in the program in FY 2008. All treatment, including residential, is free to Oregon residents. The state is one of the few jurisdictions to witness a significant expansion in gambling availability and activity without a corresponding increase in problem gambling rates.[134]

Connecticut Helpline calls are answered by trained specialists at the state-funded United Way, toll-free 2-1-1 number. These specialists assist the caller in gathering information, exploring options for treatment and/or providing support. Referrals to treatment services and/or self help groups such as Gamblers Anonymous or Gam-Anon are often made.[135] But not all operators are specifically trained in gambling addiction treatment, according to PGS.

In contrast to the 2-1-1 Helpline in Connecticut, professional counselors with problem-gambling expertise staff Oregon's Gambling Help-Line. When appropriate, counselors conduct brief assessments and motivational interviews with callers. The counselor then makes referrals based on screening information, clinical judgment and available resources. To facilitate a successful referral, Helpline counselors use three-way calling to place the caller in contact with the referral agency and offer follow-up calls to provide further support.

For FY 2008, Connecticut ranked sixth out of the 18 states surveyed with a total problem-gambling appropriation of $2,087,850. Oregon ranked first with an appropriation of $6.19 million, followed by New York ($4.80 million), Iowa ($4.41 million), Louisiana ($2.50 million) and Florida ($2.09 million.)

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[133] Oregon Department of Human Services

[134] Oregon Department of Human Services

[135] Connecticut Council on Problem Gambling, http://www.ccpg.org/abouthelpline.html. (accessed on April 15, 2009).

Senator Donald Williams Jr., President Pro Tempore of the Connecticut Senate, acknowledged to us in an interview that the state needs to do more to better promote its problem gambling program: "Part of the problem is that we've become partners in encouraging people to gamble. Between the lottery and the casinos, gambling is omnipresent in Connecticut, and then somewhere in the fine print we give a number for Gamblers Anonymous."

Henry R. Lesieur, Ph.D., of the Gambling Treatment Program at Rhode Island Hospital in Providence, developed the South Oaks Gambling Screen in 1987, which is a widely used questionnaire to screen different populations for pathological gambling. He is recognized as an expert in the study of pathological and problem gambling.

Lesieur said Connecticut operates an effective, well-run outpatient treatment program. However, he pointed out many problem gamblers need considerably more than the once-a-week sessions offered to Connecticut residents.

Figure 48: States' Methods of Charging for Problem-Gambling Counseling

State	Reimbursement Method
AZ	Fee-for-service
CT	Fee for service, grants*
IA	Fee-for-Service
IL	Fee-for-service
IN	Capitated rate
LA	n/a
MI	Expense reimbursement
MN	Outpatient: Fee for service Inpatient: Capitated rate
MO	Fee for service
NE	Fee-for-service
NJ	Outpatient and inpatient: Fee for service
NV	Fee for service
NY	Net Deficit funding to 17 outpatient stand alone gambling programs and 20 community-based prevention programs.
OR	fee-for-service
PA	Reimbursement will be between approved providers and the DOH with a Participating Provider Agreement (PPA).
SC	Expense Reimbursement
SD	Fee for service. Contracted out; contracts awarded to agencies.
WA	Fee for service

*Based on ability to pay but collected less than $2,000 from clients in FY 2008.

Source: Spectrum research

Only five states – Indiana, Minnesota, New Jersey, Nevada and Oregon – directly fund inpatient services to any large extent. Connecticut has one facility funded through the Bettor Choice Program that offers inpatient therapy, but it is meant to be a respite as the duration is only five days.

Seven states – Arizona, Connecticut, Iowa, Nebraska, New York, Oregon and Washington – provide treatment for family members.

As we noted earlier, both the current and former director of PGS acknowledged that the state needs to engage in outreach to minority groups and obtain the funding to support appropriate services within those communities (Latino, African American, Native American and Asian American).

Connecticut counseled a record 922 clients in FY 2008, but Oregon – with its promotion budget of $1.2 million – counseled nearly 2,200 problem gamblers.

From 2001 to 2008, the Connecticut General Assembly increased the budget of PGS by 123 percent, from $932,693 to $2,077,850. But the increase pales in comparison to the ever-rising number of clients. During the same time period, the caseload increased 656 percent.

Nonetheless, as we noted earlier, Connecticut continues to compare favorably with most other gaming states in terms of per-capita funding and treatment. For example, it had nearly three times more problem gamblers in treatment than New Jersey (325), which has a casino industry roughly twice the size of Connecticut's.

In terms of percentage of funds spent on treatment services, of the 14 states reporting data, Connecticut (59 percent) ranks eighth. It spends 11 percent on administration, giving it a ranking of fourth among the 13 states reporting data.

Numbers from other states show the following:

- Nevada Gamblers Helpline (2007) reported 1,510 calls for assistance, with 1,111 of those calls requesting help and 399 requesting information.
- Louisiana's Problem Gambler Helpline (2007) reported 1,502 intake calls for direct help.
- Iowa's Helpline reported 2,198 callers seeking treatment in FY 2008.
- Mississippi's Helpline received 880 calls in FY 2007 seeking counseling. Three-quarters sought help for themselves.
- West Virginia's Problem Gamblers Helpline (2006) reported 1,316 people seeking assistance for their own or someone else's gambling problem. Of the persons who self-identified to Helpline staff, 68 percent were the gambler; 147 were the spouses or significant others of a problem gambler.

The following table compares programs in various relevant states, followed by state-by-state explanations.

Figure 49: Comparison of Problem-Gambling Services, Funding by State

State (Population)	FY08 Public Funding for Problem Gambling Programs	FY08 Number of problem gamblers counseled	FY07 Gambling Tax Revenues (in millions)	Per Capita Spending on Public Problem Gambling Funds
Connecticut	$2,087,025	922	$715	$0.59
(3,502,309)				
Percentage of funds spent on:				
Administration	11%			
Helpline	5%			
Counselor Training	2%			
Therapy Services	59%			
Prevention	10%			
Media/Public Awareness	4%			
Other Activities	9%			
Colorado	$156,932	16	$234	$0.02
(4,861,515)				
Percentage of funds spent on:				
Administration	10%			
Helpline	0%			
Counselor Training	10%			
Therapy Services	80%			
Prevention	0%			
Media/Public Awareness	0%			
Other Activities	0%			
Florida	$2,091,275	0	$1,341	$0.11
(18,251,243)				
Percentage of funds spent on:				
Administration	15%			
Helpline	22%			
Counselor Training	0%			
Therapy Services	0%			
Prevention	63%			
Media/Public Awareness	0%			
Other Activities	0%			
Illinois	$960,000	1,053	$1,458	$0.07
(12,852,548)				
Percentage of funds spent on:				
Administration	13%			
Helpline	2%			
Counselor Training	3%			
Therapy Services	71%			
Prevention	0%			
Media/Public Awareness	0%			
Other Activities	11%			
Indiana	$2,000,000	262	$1,072	$0.31
(6,345,289)				
Percentage of funds spent on:				

State (Population)	FY08 Public Funding for Problem Gambling Programs	FY08 Number of problem gamblers counseled	FY07 Gambling Tax Revenues (in millions)	Per Capita Spending on Public Problem Gambling Funds
Administration	2%			
Helpline	3%			
Counselor Training	9%			
Therapy Services	22%			
Prevention	9%			
Media/Public Awareness	0%			
Other Activities	55%			
Iowa	$4,418,000	947	$365	$1.47
(2,988,046)				
Percentage of funds spent on:				
Administration	6%			
Helpline	2%			
Counselor Training	2%			
Therapy Services	50%			
Prevention	9%			
Media/Public Awareness	23%			
Other Activities	8%			
Louisiana	$2,500,000	743	$706	$0.58
(4,293,204)				
Percentage of funds spent on:				
Administration	0%			
Helpline	14%			
Counselor Training	0%			
Therapy Services	86%			
Prevention	0%			
Media/Public Awareness	0%			
Other Activities	0%			
Massachusetts	$1,130,000	144	$896	$0.17
(6,499,755)				
Percentage of funds spent on:				
Administration	10%			
Helpline	9%			
Counselor Training	25%			
Therapy Services	3%			
Prevention	17%			
Media/Public Awareness	26%			
Other Activities	10%			
Mississippi	$250,000	5	$332	$0.08
(2,918,785)				
Percentage of funds spent on:				
Administration	*not available*			
Helpline				
Counselor Training				
Therapy Services				
Prevention				

State (Population)	FY08 Public Funding for Problem Gambling Programs	FY08 Number of problem gamblers counseled	FY07 Gambling Tax Revenues (in millions)	Per Capita Spending on Public Problem Gambling Funds
Media/Public Awareness				
Other Activities				
Missouri	$485,000	354	$680	$0.08
(5,878,415)				
Percentage of funds spent on:				
Administration	*not available*			
Helpline				
Counselor Training				
Therapy Services				
Prevention				
Media/Public Awareness				
Other Activities				
Nevada	$1,500,000	1,120	$1,035	$0.58
(2,565,382)				
Percentage of funds spent on:				
Administration	0%			
Helpline	0%			
Counselor Training	12%			
Therapy Services	60%			
Prevention	16%			
Media/Public Awareness	0%			
Other Activities	12%			
New Jersey	$970,000	325	$1,300	$0.11
(8,685,920)				
Percentage of funds spent on:				
Administration	*			
Helpline	*			
Counselor Training	*			
Therapy Services	30%			
Prevention	*			
Media/Public Awareness	*			
Other Activities	*****70%			
New York	$4,800,000	1,000	$2,386	$0.24
(19,297,729)				
Percentage of funds spent on:				
Administration	*not available*			
Helpline				
Counselor Training				
Therapy Services				
Prevention				
Media/Public Awareness				
Other Activities				
Oregon	$6,197,680	2,164	$659	$1.65
(3,747,455)				
Percentage of funds spent on:				

State (Population)	FY08 Public Funding for Problem Gambling Programs	FY08 Number of problem gamblers counseled	FY07 Gambling Tax Revenues (in millions)	Per Capita Spending on Public Problem Gambling Funds
Administration	8%			
Helpline	4%			
Counselor Training	2%			
Therapy Services	65%			
Prevention	21%			
Media/Public Awareness	0%			
Other Activities	0%			
Pennsylvania	$1,500,000	13	$1,225	$0.12
(12,432,792)				
Percentage of funds spent on:				
Administration	*not available*			
Helpline				
Counselor Training				
Therapy Services				
Prevention				
Media/Public Awareness				
Other Activities				
Rhode Island	$74,000	60	$324	$0.06
(1,057,832)				
Percentage of funds spent on:				
Administration	0%			
Helpline	0%			
Counselor Training	0%			
Therapy Services	100%	Provided to Rhode Island Hospital program		
Prevention	0%			
Media/Public Awareness	0%			
Other Activities	0%			
South Dakota	$244,000	244	$137	$0.30
(796,214)				
Percentage of funds spent on:				
Administration	5%			
Helpline	0%			
Counselor Training	0%			
Therapy Services	80%			
Prevention	0%			
Media/Public Awareness	0%			
Other Activities	15%			
West Virginia	$2,000,000	213	$659	$1.10
(1,812,035)				
Percentage of funds spent on:				
Administration	25%			
Helpline	20%			
Counselor Training	10%			
Therapy Services	25%			
Prevention	10%			

State (Population)	FY08 Public Funding for Problem Gambling Programs	FY08 Number of problem gamblers counseled	FY07 Gambling Tax Revenues (in millions)	Per Capita Spending on Public Problem Gambling Funds
Media/Public Awareness	10%			
Other Activities	0%			

Sources: US Census Bureau, Population Estimates, July 2007
Rockefeller Institute of Government
Association of Problem Gambling Service Administrators
Connecticut Department of Mental Health and Addiction Services, Division of Problem Gambling Services
Connecticut Council on Compulsive Gambling, Inc.
Connecticut Division of Special Revenue
Colorado Council on Compulsive Gambling, Inc.
Florida Council on Compulsive Gambling, Inc.
Illinois Department of Human Services, Division of Alcoholism and Substance Abuse
Illinois Gaming Board
Indiana Department of Family and Social Services Administration Division of Mental Health and Addiction
Iowa Department of Public Health, Office of Gambling Treatment and Prevention
Louisiana Department of Health and Hospitals, Office of Addictive Disorders
Massachusetts Council on Compulsive Gambling, Inc.
Massachusetts Department of Public Health, Bureau of Substance Abuse Services
Mississippi Council on Problem and Compulsive Gambling, Inc
Missouri Department of Mental Health, Division of Alcohol and Drug Abuse
Nevada Department of Health and Human services
The Council on Compulsive Gambling of New Jersey, Inc.
New York Office of Alcoholism and Substance Abuse Services
Oregon Department of Human Services, Problem Gambling Services
Pennsylvania Department Health, Bureau of Drug and Alcohol Programs, Problem Gambling Treatment Program
Rhode Island Gambling Treatment Program, Rhode Island Hospital
South Dakota Department of Human Services, Division of Alcohol and Drug Abuse
West Virginia Department of Health and Human Resources, Problem Gamblers Help Network of West Virginia

Program description: Connecticut

Public Funding: The Connecticut Chronic Gamblers Treatment and Rehabilitation Fund, in the Department of Mental Health and Addiction Services ("DMHAS"), is supported by dedicated funding requiring the CLC[136] and pari-mutuel facilities to contribute a portion of their annual revenues. DHMAS in turn allocated $95,000 in FY 2009 to the CCPG.

Helpline: The 2-1-1 Helpline, operated by United Way of Connecticut, is funded by the state of Connecticut. It provides information and referral on treatment services and local self-help programs. The Helpline is not gambling specific. The CCPG also develops awareness, education and prevention programs. It is primarily funded by the Mashantucket Pequot ($183,337 in '06) and the Mohegan ($216,000 in '06) Tribal Nations.

Treatment: DMHAS's Division of Problem Gambling Services oversees the Bettor Choice program, which consists of gambling-specific clinics at 17 locations. Programs offer outpatient services (individual, group and family therapy, financial counseling and psychiatric consultation). Clinicians hold at a minimum a masters degree. Many have at least five years

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[136] 1996 Public Acts 96-212, 98-250, 99-173, CGS § 12-818.

experience in treating problem gamblers. There is no residential treatment other than a five-day respite program. Some services are free, and others are billed according to income but based on past practice. Bettor Choice has rarely collected money from clients.[137]

Program description: Colorado

Public funding: In 2008, Colorado created a state-funded treatment program. Two percent of the funds in a gaming-tax account set up to compensate local governmental entities for casino impacts are now dedicated annually ($156,932 in FY 2008) to a Gambling Addiction Account. Beginning in 2009, the Division of Human Services will use this account to award annual grants to fund problem gambling counseling and also professional training, prevention and education. Counselors will be required to be nationally-accredited in gambling addiction.

Helpline: The Lottery and Division of Gaming Enforcement each contribute $5,124 per year to fund the statewide Helpline, which is overseen by the Problem Gambling Coalition of Colorado. Trained operators refer callers to local treatment providers (not state-funded) who are nationally certified in problem gambling or are state-licensed therapists or social workers.

Treatment: The Coalition awarded a $31,000 grant (FY 2007) to a separate program at the University of Denver's Problem Gambling Treatment and Research Center. The program provides free outpatient counseling and group therapy sessions.

Program description: Florida

Public funding: The Lottery contributes $1.1 million and the Department of Business and Professional Regulation -- which oversees pari-mutuel jai-alai and dog/horse racing, simulcast, poker rooms and racinos -- contributes $690,000 toward problem-gambling programs. Additional funding includes a mandated requirement of $250,000 per racino per year and a private contribution by the Seminole Tribe of $100,000 per year. State statute requires all funds to be used for awareness, education and prevention only. No state money is used for treatment.

Helpline: The Florida Council on Compulsive Gambling operates a 24-hour, toll-free Helpline which is staffed by trained specialists. It offers assistance, information and referrals to self-help programs, professional-treatment counselors and financial and legal advisors. The Council, through contracts with the state, is responsible for awareness, prevention/education programs, professional training and research.

Treatment: Helpline callers are referred to private, certified problem gambling treatment counselors or local mental health clinics for treatment. Treatment is on a fee-for-service basis with a sliding scale for income levels. One free consultation session with a compulsive gambling counselor is available to those unable to pay for private services.

Program description: Illinois

Public Funding: The state's program is funded by a General Fund annual appropriation and forfeited winnings ($550,000 in FY 2008) from self-excluded persons who returned to

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[137] Better Choice administrators.

Illinois casinos. Three non-profit organizations receive the forfeited winnings -- the Council on Problem Gambling, the Institute for Addiction Recovery and the Outreach Foundation.

Helpline: The Helpline is privately funded through voluntary contributions ($200,000 in FY 2008) from casinos, racetracks and the lottery. Chicago-based Bensinger DuPont & Associates operates it.

Treatment: The Department of Human Services, Division of Alcoholism and Substance Abuse, administers treatment services and certifies problem gambling counselors. The Division offers outpatient counseling, case management and early intervention services to individuals with problem-gambling disorders. There are seven treatment sites throughout the state that follow a manualized treatment protocol to address pathological gambling. Outpatient treatment is available to problem gamblers on a fee-for-service basis.

Program description: Indiana

Public Funding: The state's program is funded through ten cents of the admission tax collected from the 11 casino owners ($4.2 million). Additionally, a $500,000 per-year assessment on the state's two racinos is dedicated to the Problem Gambling Fund in the Division of Mental Health and Addiction. By statute, the division must allocate at least 25 percent of the funds derived from the admission tax to the prevention and treatment of compulsive gambling. But much of that money is used for treatment for other substance abuse programs. That diversion of funds will end in 2013.

Helpline: The state contracts with an Indianapolis-based United Way to operate a toll free, 24-hour-a-day Helpline, which is not specific to problem gambling. All callers are assessed and transferred to or given contact information for 20 state-funded, nationally certified problem gambling outpatient treatment providers and/or support services near their communities.

Treatment: State funding for problem gambling outpatient treatment is available for those who meet the financial eligibility criteria, which is determined by the client's income level (283 in FY 2008.) All treatment services (residential not available) are based on a plan developed by the client and a counselor.

Program description: Iowa

Public Funding: The Iowa Gambling Treatment Fund receives 0.5 percent of the gross lottery revenue, 0.5 percent of the adjusted gross receipts from casinos, forfeited winnings from voluntarily excluded persons and annual assessments of $75,000 from gaming compacts with two Native-American tribes. The fund supports the Office of Gambling Treatment and Prevention in the Department of Public Health. In FY 2008, $4,418,000 was appropriated to the Gambling Fund, and the balance ($1,690,000) was redirected to the Division of Addictive Disorders for substance abuse treatment in which gambling clients with substance abuse problems as well receive priority treatment.

Helpline: The Iowa Department of Public Health operates 1-800-BETS-OFF Helpline.

Treatment: The state's program provides specialized gambling outpatient counseling for gamblers, families and other concerned persons through a statewide network. Counseling services are provided on a sliding fee scale. Transitional housing facilities for individuals who